

## ***I* is for Information**

### **What are The Warning Signs of an Eating Disorder?**

#### **Detection is Not as Easy as it Sounds**

Sometimes it seems like there is no end to the guilt and frustration that family and friends feel in regard to a loved one's eating disorder.<sup>1</sup> One source that we have encountered frequently is captured in the following statement:

“I can't believe it took me so long to see 'it,' to figure out that things were out of control. I feel like such an idiot; it seems so obvious now, and I guess it was obvious to her friends.”

We understand this feeling, if only because it reflects the genuinely human desire to “be in touch with one's family or close friends,” to “be in control” and to be able “to do something instead of nothing.” However, we encourage family members and friends to go easy on themselves. Detecting an eating disorder is not that easy. Remind yourself that even veteran physicians, social workers, and psychologists often “miss” the diagnosis.

Here are some of the reasons that it is difficult, and may take a long time, to detect an eating disorder:<sup>2,1,3,4,5</sup>

- A number of the features of an eating disorder (e.g., fear of fat, drive for thinness, extreme weight loss, temporary “control over hunger”) are extensions of characteristics that are common and valued in our society. This makes it **hard to distinguish disorder and disability from “a bit too much of what is normative.”**
- People slipping into eating disorders are anxious, secretive, embarrassed and defensive about themselves for various reasons. They are also afraid of forfeiting control. **It is hard to detect complex problems when the person is secretive, defensive, and intent on maintaining control.**
- Family members are, in most cases, extremely busy these days—long hours at work or school, jobs or sports (or both) after school, getting together with friends, and so forth. It is not unusual for days to go by without family members sitting down to a meal together, or even having much chance to talk and enjoy each other's company. **It is hard to detect and work through complex problems**

**when people are extremely busy and expect each other to be independent and productive.**

### Warning Signs

It is indeed important to be alert for the:

#### Hallmark signs of Anorexia Nervosa

- stubborn food refusal,
- minimal and ritualistic eating,
- extremely low weight or dangerous weight loss

#### Hallmark signs of Bulimia Nervosa:

- uncontrollable binge-eating
  - (which means uncontrollably eating a larger amount of food than what others would eat in a similar time frame)
- purging: which includes:
  - self induced vomiting
  - diuretic abuse
  - laxative abuse
  - excessive exercise
  - fasting or refusing to eat for long periods of time to counter fear of weight gain

#### Hallmark signs of other forms of Eating Disorders:

- spitting and chewing foods
- binge eating and not purging
- purging and not binge eating

By the time these classic features are seen, correctly interpreted, and acknowledged, there is a good chance that considerable damage has been done and the problem may be life-threatening. This means that it is very important, if possible, to be alert for the signs of an eating disorder other than the “hallmark features.”

Following are some of the prominent “warning signs” of a serious eating disorder.<sup>6,7,8,9,4</sup> Note that, with the exception of evidence of purging, no one of them is all that alarming or inexplicable, in and of itself. That means **concerned family members and friends need to pay attention to the pattern of signs**. Specifically, with one exception, the more signs that are present and the more frequently you observe (“feel”) them, the greater should be your index of suspicion and concern, and the greater the need for the situation to be evaluated by a professional who has experience in these matters.

**The exception is evidence of purging.** Repeated self-induced vomiting and/or use of laxatives, diuretics, or enemas is cause for alarm and for a medical and psychological evaluation, whether or not the person has an eating disorder.<sup>10,1</sup>

- Withdrawal from, or avoidance of, activities that the person should be doing or has previously enjoyed doing, because of anxiety, embarrassment, and concerns about weight and shape.
- Expressions of increased anxiety or obsessive thoughts over calories, weight, body size and shape that do not diminish—and often intensify—as weight is lost.
- Excessive, rigid, exercise routines even if little food has been consumed. At times the excessive exercise is thought to “burn off” calories that are taken in or might later be taken in. The exercise regimen will be adhered to despite bad weather, fatigue, other obligations, illness, and injury. This exercise may, however, be a physical agitated like expression triggered by significant neurobiological disturbance as the person loses excessive amounts of weight below what is healthy and normal for her/his age and height.
- Preoccupation with weight, food, calories, dieting, food supplements, cooking, etc., to the extent that it consistently intrudes on conversations and interferes with doing other things.
- Ritualistic eating habits such as chewing every bite a specific number of times or cutting food into very small pieces.
- Fixated attention on calories
- Evidence of secretive self-induced vomiting, such as:
  - Bathroom smells or messes
  - Rushing to the bathroom immediately after a meal and then disappearing to one’s room, or returning to the kitchen with bloodshot eyes
  - Swelling of the sub-mandibular (under the jaws) salivary glands to yield “a puffy” or “chipmunk” facial appearance.
  - Unusual dental problems in a young person, such as erosion of the enamel at the base of the back of the lower front teeth, or loss of vertical height of the teeth.
  - Unusual and slow-to-heal cuts or sores on the backs of the fingers or knuckles of one hand (caused by the teeth, as one uses fingers to induce vomiting).
- Wrappers, advertisements, coupons, and other evidence of interest in and use of laxatives, diuretics, enemas, purgatives, or emetics (drugs such as syrup of Ipecac that are designed to induce vomiting in emergency instances of poisoning).

- Evidence of binge-eating, including the hoarding and stealing of food, or the consumption of amounts of food that are huge and clearly inconsistent with the person's size or weight.
- Alternating periods of severely restrictive dieting and overeating (binge-eating, overeating, constantly grazing). These phasic fluctuations are often accompanied by perceptible weight fluctuations of 10 or more pounds.
- Inexplicable (and unresponsive to treatment) problems with menstruation and/or fertility.
- Extreme concern about appearance, shape, or a particular weight ("I've got to get to 106 pounds; I've just got to!") as a defining feature of self-esteem. This "undue influence of weight and shape on self-concept" may be accompanied by dichotomous, perfectionist thinking (e.g., either I am "thin and good" or "fat, gross, and bad").
- Paleness, weakness, and complaints of being lightheaded or dizzy that are not accounted for by the circumstances or by other medical problems.

### Are Eating Disorders Really "Only About Eating and Weight?"

As is the case for so many aspects of the eating disorders, the answer to this question is complicated. Perhaps the best way to phrase it is as a combination of No "and" "Not only . . ."

#### "No"

**Negative body image, a pre-occupation with weight and shape, and disordered eating are the surface symptoms that express the underlying dynamics of the emotional illness (the "dis-ease") and the pain a person experiences.** Here we are reminded that eating disorders are a serious illness. The definition of an eating disorder involves serious problems created by attitudes, beliefs, and behaviors in regard to eating, not eating, the management of weight and shape, and the use of all these to cope with stress and with other problems.<sup>11,12,13</sup> For example, "We now know from research that anorexia nervosa is a brain disease with severe metabolic effects on the entire body. While the symptoms are behavioral, this illness has a biological core, with genetic components, changes in brain activity, and neural pathways are currently under study. "(Thomas R. Insel, MD Director of the National Institute of Health).

#### "Not Only" About Eating, Weight, and Shape: Co-Morbidity

**"Morbid" in this instance means "having to do with illness." Thus, "co-morbidity" refers to "co-occurring illnesses,"** that is, disorders that have a probability of co-occurring with eating disorders at a rate significantly greater than their baseline rate in our population.

Unfortunately, there are a number of psychological disorders that are “co-morbid with” the eating disorders.<sup>14,15,16,17</sup> Important examples for family members to be aware of are:

- **Depression** (co-occurs commonly in all eating disorders)
- **Social phobia** (social anxiety disorder; co-occurs more commonly in anorexia nervosa)
- **Obsessive compulsive disorder** (co-occurs more commonly in anorexia nervosa, as to “obsessional” characteristics, such as perfectionism and an insistence on order, routine, and symmetry)
- **Substance abuse** (co-occurs more commonly in bulimia nervosa and in anorexia nervosa with co-morbid binge-eating and purging).
- **Post-Traumatic Stress Disorder** (sexual abuse from childhood can cause a ripple effect of symptoms that develop into or trigger the development of binge eating disorder and bulimia nervosa more than anorexia nervosa)

In a materialistic culture that defines people in general and females in particular in terms of weight and shape and sexuality, the ingredients for development of an eating disorder make sense (and, for a while, “work”) for those who are predisposed to be anxious, fearful, impulsive, obsessive, and/or rigid.<sup>2</sup> It may not make sense to family members—and researchers are still trying to understand fully—but eating disorders become a way of coping and surviving for people.

**Significance for families.** To reiterate, **anorexia nervosa, bulimia nervosa, and EDNOS are serious illness** that have symptoms of uncontrollable eating, not eating, and desperate methods of weight and shape management. But they are also disorders of being and development, of the self and of relationships.<sup>18,12</sup>

This is one reason why recovery takes so long. But we see this also as a basis for hope, because the developmental spirit is strong in human being, in large part because it connects the personal (the self) with others such as caring family, friends, and therapists.

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<sup>1</sup> Herrin, M., & Matsumoto, N. (2007). *The parent's guide to eating disorders: Supporting self-esteem, healthy eating, & positive body image at home* (2<sup>nd</sup> ed.). Carlsbad, CA: Gürze.

<sup>2</sup> Gordon, R. (2000). *Eating disorders: Anatomy of a social epidemic* (2<sup>nd</sup> edition). Malden, MA: Blackwell.

<sup>3</sup> Neumark-Sztainer, (2005). *I'm, Like, So Fat!: Helping Your Teen Make Healthy Choices About Eating and Exercise in a Weight Obsessed World*. New York, NY: The Guilford Press.

<sup>4</sup> Smolak, L., & Levine, M. P. (2007). Recognizing & preventing adolescent eating disorders and muscularity Problems. *The Prevention Researcher*, 14(3; September), 15-17.

<sup>5</sup> Treasure, J. (1997). *Anorexia nervosa: A survival guide for families, friends and sufferers*. East Sussex, UK: Psychology Press.

- <sup>6</sup> Katzman & Pinhas, (2005), *Help for Eating Disorders: A Parent's Guide to Symptoms, Causes and Treatments*. Toronto: Robert Rose Incorporated.
- <sup>7</sup> Health Education Center, & Eating Disorders Institute. (1999). "How did this happen?" *A practical guide to understanding disorders—for teachers, parents and coaches*. Minneapolis, MN: Institute for Research and Education, HealthSystem Minnesota.
- <sup>8</sup> Levine, M. P. (1987). *Student eating disorders*. Washington, DC: National Education Association.
- <sup>9</sup> National Eating Disorders Association [NEDA] website = [www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)
- <sup>10</sup> de Zwaan, M., & Mitchell, J. Medical complications of anorexia nervosa and bulimia nervosa. In A. S. Kaplan & P. E. Garfield (Eds.), *Medical issues and the eating disorders: The interface* (pp. 60-100). New York: Brunner/Mazel.
- <sup>11</sup> Levine, M. P., & Hill, L. (1991). *A five-day lesson plan book on eating disorders: Grades 7 through 12*. Seattle: National Eating Disorders Association ([www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)).
- <sup>12</sup> Natenshon, A. H. (1999). *When your child has an eating disorder: A step-by-step workbook for parents and other caregivers*. San Francisco: Jossey-Bass.
- <sup>13</sup> Johnson, C., & Connors, M. E. (1987). *The etiology and treatment of bulimia nervosa: A biopsychosocial perspective*. New York: Basic Books.
- <sup>14</sup> American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., text revision) – *DSM IV-TR*. Washington, DC: Author.
- <sup>15</sup> Herzog, D. B., & Eddy, K. T. (2007). In S. Wonderlich, J. E. Mitchell, M. de Zwaan, & H. Steiger (Eds.), *Annual review of eating disorders* (part 1, pp. 35-50. Oxford, UK: Radcliffe Publishing.
- <sup>16</sup> Pallister, E., & Waller, G. (2008). Anxiety and the eating disorders: Understanding the overlap. *Clinical Psychology Review*, 28, 366-386.
- <sup>17</sup> Wolfe, W. L., & Maisto, S. A. (2000). The relationship between eating disorders and substance abuse: Moving beyond co-prevalence research. *Clinical Psychology Review*, 20, 617-631.
- <sup>18</sup> Andersen, A. E. (1985). *Practical comprehensive treatment of anorexia nervosa and bulimia*. Baltimore: Johns Hopkins University.