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MEDICAL ASPECT OF EATING DISORDERS AND OBESITY

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Eating Disorders

Nowadays in developed societies and cultures all around the world there is a clear preoccupation with size and weight, diet and exercise. The scale of the issue is remarkable, with research suggesting that in the USA for example, up to 50% of the population demonstrate problematic or disordered relationships with food, body and exercise, for instance by following fad diets or unusual food regimes (Gottlieb, 2014). This is referred to as disordered eating. An individual with disordered eating is often engaged in some of the same behaviour as those with clinical eating disorders, but at a lesser frequency or lower level of severity. Although people who exhibit disordered eating may be at risk for developing a full-blown eating disorder generally they are mentally well, there is an absence of compulsive thoughts or problems in regular functioning and generally any issues can be addressed through education. However, 35% of "normal dieters" progress to pathological dieting. Of those, 20-25% progress to partial or full-syndrome clinical eating disorders (Shisslak, Crago, & Estes, 1995).

Clinical eating disorders, (anorexia nervosa, bulimia nervosa, binge eating disorder and Other Specified Feeding or Eating Disorder [OSFED]), are biologically based, serious mental disorders which individuals typically acquire in mid-adolescence at a developmentally sensitive time (Klump et al, 2009). Clinical eating disorders are real, complex and often devastating conditions that can have serious consequences for health, productivity and relationships. They are not a fad, phase or lifestyle choice, they are serious, potentially life-threatening conditions that af-

fect a person's emotional and physical health and require professional intervention.

The rates of clinical eating disorders are much lower than those of disordered eating and are estimated to be around 1-3% of a population (Gottlieb, 2014). Eating disorders cut across race, colour, gender and socioeconomic categories. About 90% of those affected are female. The overall incidence and prevalence of anorexia nervosa and bulimia nervosa is stabilising in Western countries but increasingly younger people are affected. The incidence of EDNOS and binge eating disorder continues to rise, as does the combination of eating disorders and obesity. Most eating disorders share certain core features, including an extreme concern about eating, weight and body shape and the inability to control these, excessive self-evaluation, based on weight and shape, and engaging in often extreme weight control behaviours as a consequence (Fairburn & Bohn, 2005).

Types of clinical eating disorders

There are three main types of eating disorders: anorexia nervosa, bulimia nervosa, and binge-eating disorder. People with anorexia nervosa see themselves as overweight even though they are dangerously thin from starving themselves. People with bulimia nervosa eat unusually large amounts of food (binge eat) and then compensate by purging (vomiting, taking laxatives or diuretics), fasting or excessive exercise. People with binge-eating disorder binge but do not purge, and they often become overweight or obese. Eating disorders are not always black and white. A person with Other Specified Feeding and Eating Disorders (OSFED) may present with many of the symptoms of other eating disorders such as Anorexia Nervosa, Bulimia Nervosa or Binge Eating Disorder but will not meet the full criteria for diagnosis of these disorders. What causes an eating disorder?

The factors that contribute to the onset of an eating disorder are complex. No single cause of eating disorders has been identified however, known contributing risk factors include genetic vulnerability, psychological factors and socio-cultural influences.

Research regarding the biological or genetic component of eating disorders is ongoing. Studies so far show that certain chemicals in the brain which control hunger, appetite and digestion have been found unbalanced. Furthermore, eating disorders often run in families, perhaps because we learn coping skills and attitudes within our family environment. Psychological risk factors have been found to include: low self-esteem, feelings of inadequacy or failure; feeling out of control; response to change (often at puberty) and response to stress. People with eating disorders often display vulnerable personality characteristics such as having identity difficulties; a strong need for approval, being something of a perfectionist, having obsessive tendencies, irrational thinking and difficulty in coping.

Moreover people with eating disorders often have a history of troubled family and personal relationships, have been teased or ridiculed based on their size or weight and in many cases there is a history of physical or sexual abuse. Perhaps the most commonly acknowledged influences on eating disorders are the cultural pressures that glorify thinness and place value on obtaining the perfect body and the narrow definitions of beauty that include only women and men of specific body weights and shapes.

Eating disorders and mental illness

It is not uncommon for people with an eating disorder to also have an additional concurrent diagnosis of mental disorder. Studies have shown that depression, anxiety and substance dependence are the most common concurrent diagnoses (Braun, DL., Sunday, SR., Halmi, KA., 1994), but it is also significantly connected with obsessive compulsive disorder and some personality disorders. Almost 50% of people with eating disorders meet the criteria for depression and many times it is depression, rather than eating disturbances, for which people seek medical help and first come to the attention of medics. Alarmingly, eating disorders have the highest mortality rate of any mental illness.

Obesity

Eating disorders such as anorexia and bulimia are recognised as mental disorders with severe impairments and serious adverse outcomes but obesity is not always recognised as such despite its devastating medical and psychological consequences. Obesity is characterized by compulsive consumption of food and the inability to restrain from eating despite the desire to do so. These symptoms are remarkably parallel to those described in substance abuse and drug dependence, which has led some to suggest that obesity may be considered a "food addiction".

Psychiatrists are concerned about obesity because in addition to the well-known health risks to our patients, including type 2 diabetes, cardiovascular disease, hypertension, stroke, and certain forms of cancer, obesity is associated with psychiatric illness. Studies of obese individuals reveal high rates of psychiatric comorbidities, including eating disorders (especially binge eating disorder), depression, anxiety, and personality disorders. According to research, men with a BMI of 40 kg/m2 or greater are significantly more likely than normal-weight males to have current depression or a lifetime diagnosis of depression and anxiety. For women, being overweight (BMI ≥25 kg/m2) or obese is associated with a higher prevalence of depression or lifetime diagnosed depression and anxiety. A study of personality disorders showed that extreme obesity was associated with antisocial or avoidant personality disorders.

Treatment

The treatment of eating disorders is based on a multimodal model, recognizing that these disorders do not have a single cause or a predictable course. The treatment strategy is determined by the severity of illness and the specific eating disorder diagnosis. For the treatment of anorexia nervosa, the key elements are medical management, behavioural therapy, cognitive therapy and family therapy, while pharmacotherapy is at best an adjunct to other therapies. In bulimia nervosa, the treatment of choice is cognitive-behavioural therapy, but a greater improvement in mood and anxiety occurs when antidepressant therapy is added. In binge eating disorder, cognitive-behavioural therapy and interpersonal therapy produce

substantial and long-lasting changes and pharmacological treatment has often a useful role. As a result of the peculiar nature of OSFED, it is most effective to follow the treatments recommended for the eating disorder that most closely resembles the individual person's eating problem. For example, if a person presents with many but not all of the symptoms of Bulimia Nervosa, it is recommended for that person to seek the same treatment approaches recommended for people with Bulimia Nervosa.

Psychiatric management begins with the establishment of a therapeutic alliance, enhanced by empathic comments and behaviours, positive regard, reassurance, and support. A team approach is the recommended model of care. The role of the psychiatrist is multifaceted and includes: coordinating care and collaborating with other clinicians; assessing and monitoring eating disorder symptoms and behaviours; assessing and monitoring the patient's general medical condition; assessing and monitoring the patient's safety and psychiatric status and providing family assessment and treatment. Treatment plans often are tailored to individual needs and may include one or more of the following: psychotherapy; support or self-help groups; medical treatment; nutritional treatment; medication or hospitalization.

The situation in Malta

In Malta a national survey in which 2,008 respondents participated, found that 0.9% were currently suffering from an eating disorder while 2% had suffered from an eating disorder in the past. The figures also show that about a third of people with eating disorders start young, between the ages of 15 and 19. The survey showed that like the rest of the world, eating disorders in Malta are predominant among females. Males with eating disorders made up 1.2% of respondents. The most popular form is binge eating, (57%), followed by anorexia with 34%. 13% suffered from bulimia.

In all, nearly 1% of the Maltese population between 16 and 50 years is suffering from one or more of the three kinds of eating disorder – anorexia, bulimia or binge eating – and 2% have been afflicted at some time in the past.

Conclusion

It is essential to increase our education and understanding of eating disorders so that we can raise awareness about the impact of eating disorders in our society. Prevention, early intervention and management of eating disorders must be developed in both the general community and in those working in the health, fitness, education and media sectors. Research has shown that having the correct information and gaining the right education about eating disorders can help prevent an eating disorder from developing. Being informed can also alleviate the suffering of a person in the early stages of the illness and can reduce the stigma and misconceptions that often surround those who suffer from eating disorders. A person who has an eating disorder (or is at risk of developing an eating disorder) can often feel high levels of shame, embarrassment, confusion and denial. As a result, that person may need guidance and support from those around them to take the first steps towards preventing or treating their illness. It is therefore of great importance that parents, teachers, healthcare workers, sport and fitness coaches, government departments and media associations seek to deepen our level of understanding about eating disorders through consistent, thorough and effective communication.

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