

The Dark Side of Weight Control

With more and more people caught in the grip of eating disorders, we need better treatments—and a dramatic shift in cultural attitudes. *By Diane Guernsey*

TAKE IT FROM ME: anorexia nervosa and bulimia nervosa are nightmarish and terrifying. These illnesses are nightmarish because they make one of life's great pleasures—eating—a source of torment to victims and their loved ones.

And they are terrifying because they are insidious and stubborn, and they wreak horrible physical damage. Eating disorders are, in fact, the most deadly of psychiatric illnesses; they ultimately kill up to 20 percent of sufferers and are the top cause of death in girls and women aged fifteen to twenty-five.

Things have changed markedly since the days when, as a teenager, I embarked on a solitary, secretive struggle with bulimia (see "Bulimia: My Story," page 184). For one thing, eating disorders now afflict many more people. The estimates vary, but the National Eating Disorders Association (NEDA) states that, in the United States, 11 million adolescents and adults, both women and men, suffer from anorexia (self-starvation) or bulimia—compulsive binge eating alternating with purging through vomiting, laxative abuse and/or excessive exercise. (Another 25 million suffer from compulsive eating.)

Eating disorders have spread beyond their original cohort—white, upper-class adolescent girls—to a broader population. Although teenaged girls and college-aged women make up the majority of the cases, doctors see disorders in children of six, in women over thirty-five, in teenaged boys and in men. "The old stereotype is no longer accurate," says psychologist Doug Bunnell, the clinical director of the Renfrew Center, in Wilton, Connecticut, and a former president of NEDA. "All socioeconomic levels, ages, genders and ethnic groups are affected."

Unfortunately, a couple of things have not changed since my experience with the problem—at least, not enough. First, although public awareness is higher (thanks partly to celebrities such as Felicity Huffman and Jamie-Lynn Sigler, who have been open about their eating disorders; see "An Obsession's Progression," page 183), the general attitude toward the sufferers and their families still blends ignorance, awe and, often enough, scorn or disgust. Second, despite improved therapies, many patients are not adequately helped, and there aren't enough treatment centers. We're no longer in the Dark Ages, but we haven't yet reached the Enlightenment. Individually and collectively, we need to take a good, hard look in the mirror and make the changes necessary to do away with eating disorders.

CAUSES AND EFFECTS

The rising tide of new patients with eating disorders (mostly bulimics) stems partly from better detection, but it also reflects changes in cultural perspective. Over the past century or so, as Western societies have linked slenderness ever more closely to sexual attractiveness, social and professional status, and self-control, the pressure has grown for people to achieve slenderness—even if they die trying. (And this imperative has become all the more urgent as the number of overweight children has ballooned.) "Almost all bulimics start by dieting to reach the ideal," says Bunnell. "They can't sustain it, so they binge eat, then feel they must compensate by purging."

Our culture's pencil-slim standard—relentlessly reinforced by media images of models and movie stars and by countless weight-loss articles—has penetrated deep into our psyches. "One NEDA ad showed a young woman looking in a mirror,"

HOW TO RECOGNIZE THE SIGNS

Carolyn Costin, the founder and director of the Monte Nido Residential Center, in Malibu, California, wrote *The Eating Disorder Sourcebook* (Lowell, 1999), which lists the following red flags. (Some of these can occur in both anorexia and bulimia.)

ANOREXIA: The person avoids eating, even when hungry; counts calories in foods eaten; avoids more and more food groups; eats only nonfat or "diet" foods; may become a vegetarian; rigidly controls food by type, quantity and timing of meals; weighs himself or herself obsessively; goes on and off diets; is terrified of being overweight and/or gaining weight; feels guilty about eating; is preoccupied with fat in food and on the body; complains of being pressured by others to eat more; complains of being too fat even when a normal weight or thin; complains about specific body parts and asks for reassurance regarding appearance; constantly checks the fit of belts, rings and "thin" clothes for tightness; checks thigh circumference when sitting and space between thighs when standing.

BULIMIA: The person eats large quantities of food secretly; disappears into the bathroom after eating; vomits and either tries to hide it or is not concerned; may eat only very soft foods and/or drink lots of water to facilitate vomiting; "earns" food through exercising; uses exercise as a punishment for overeating; uses laxatives, diuretics, diet pills, caffeine pills, amphetamines and/or stimulants, enemas, ipecac syrup (which causes vomiting), herbs or herbal teas with diuretic, stimulant or laxative effects.

If a loved one displays even a few of these signs, contact a specialist. (Check NEDA's Web site for referrals.)

says Bunnell. "She's a skeleton, but she sees her very slender mirror image as huge. The trouble was, when we showed people the mock-up ad, we couldn't make the girl in the mirror thin enough so that they would reliably say, 'She looks too thin.'"

A FAMILY AFFAIR

In families, this "thin equals success, worth and love" message exerts a powerful influence, because it taps into parents' natural yearning for their children to look attractive and to excel. But that success-oriented ethos can lead to illness, even tragedy, when it's misapplied. Not only can parents have trouble realizing when the "get thin, stay thin" drumbeat has become too relentless, but they often don't understand how forcefully their message comes through. (See "Starved for Love," page 183.)

"We see families in which, before anyone has said good morning, the mom asks, 'Do I look fat in these jeans?' It's not directly stated, but the kids absorb that preoccupation," says psychiatrist Victor Fornari, the associate chairman of education and training at North Shore University Hospital, in Manhasset, New York. Small wonder that many children begin to fear food and eating. (Even faced with a literally starving child, some parents cannot relinquish their terror of fat, Fornari says. One couple refused treatment for their anorexic daughter, an aspiring ballerina, saying she wouldn't be able to dance properly if she gained weight.)

Clearly, society's pressures are communicated through parents, peers and the media, and those who want to counter them must be ready to buck the cultural norms. Easier said than done: ambivalence concerning women, food and eating has been around virtually forever. Take the Biblical story of the Creation: the first recorded instance of a woman eating was Eve's taste of the apple. The outcome? Not pretty, to say the least.

WHEN NATURE AND NURTURE COLLIDE

Cultural factors alone can't account for the rise in eating disorders: experts cite evidence that a tendency for developing anorexia and bulimia can be inherited, just as other psychiatric disorders are. Bunnell says, "Genetic predisposition is the gun, and society pulls the trigger." As scientists have studied the interplay between nature and nurture, they've gleaned insights into the temperamental qualities that put a child (or an adult) at risk.

"Perfectionism is one real predictor of anorexia," says psychologist Craig Johnson, the director of the Eating Disorders Program at the Laureate Psychiatric Clinic and Hospital, in Tulsa. Anorexics are prone to orderly, obsessive-compulsive thinking and are relentless when in pursuit of a goal, whether it's straight As or what one expert calls "virtuoso fasting." (Johnson is recruiting anorexics and their families for a multi-year genetic study; call 888-895-3886.)

Bulimics suffer profound mood swings, as well as high anxiety that they find intolerable. And, says Johnson, "for some an-

HOW TO INTERCEDE

If you're concerned that a loved one might have an eating disorder, it can be difficult to know how to tackle the subject. Pick a setting where you won't be interrupted or feel hurried, and try to convey understanding. "You can say to her, 'I'm worried about you,'" says social worker Kathy Kater. "She'll probably deny that anything is wrong, so you may have to push it. Most people with bulimia know they have a problem, but anorexics honestly believe they don't. You can say, 'I understand that this isn't a concern for you, but it is for me' or 'If it's not a problem, we'll find out.'"

Stick to specific, observable behaviors, advises Monte Nido's founder, Carolyn Costin. Try saying: "I've noticed that you're tired a lot lately and have difficulty eating with the family" or "I heard you throwing up, and I'm worried about your health" or "You seem really unhappy lately." She adds, "If there's no change in behavior, get professional help, and if your loved one refuses to go, go by yourself to get advice on what to do next. Don't wait; the possible consequences are too serious."

Once treatment has begun, be patient with the patient—and with yourself. Show affection with words, hugs and time spent together. Don't comment on weight or looks, avoid policing the patient's eating, don't blame yourself or the patient, and don't plead or make demands.

James Lock, psychiatric director of Stanford University School of Medicine's treatment program, urges parents to take time from other commitments, if necessary: "Medically, financially and psychologically, these disorders are extraordinarily expensive, and as with any significant illness, you should expect to take some family leave."

orexics and bulimics, even a short period of dieting or excessive exercising triggers a 'concentration-camp survivor' reaction: they cannot resist eating as fast and as much as possible. We suspect that the physiology of dieting sets off a genetically triggered vulnerability to binge eating." (About half of all anorexics eventually develop bulimia as well.)

Another discovery, Johnson says, is that an anxiety disorder often underlies anorexia and bulimia. Bingeing and purging ease anxiety by altering the brain's chemistry, he says. Consuming massive amounts of complex carbohydrates raises the brain's levels of serotonin (a mood elevator), so after downing carbs, patients feel calmed—but only until panic about weight gain sets in. Then they induce vomiting, and the body releases vasopressin, a natural sedative. "When bulimics stop these behaviors, anxiety breaks through, because it's no longer masked," says Johnson. "They feel as if they're crawling out of their skins."

This insight allows patients and their loved ones the healing realization that their symptoms, outwardly so bizarre, actually serve to muffle or suppress excruciating terror, rage or sadness.

"It can be hard to understand that starving or purging would feel good, but for some people, it does," says Margo Maine, author of *The Body Myth: Adult Women and the Pressure to Be Perfect* (John Wiley & Sons, 2005) and a cofounder of Maine & Weinstein Specialty Group, in West Hartford, Connecticut. "That emptiness afterward feels very soothing. Once you develop one of these patterns, it becomes very easy to use it as a ritual, just as you might a bath or a cup of tea."

WHAT'S KNOWN...WHAT'S NOT

NEDA board member Robbie Munn, a Manhattan psychologist, says many people view eating disorders as weaknesses or willful behaviors, when such conditions should be considered diseases like alcoholism or drug abuse. Although experts differ on this, many agree that, over time, the neurochemical changes associated with anorexia and bulimia help reinforce the behaviors.

Confusing matters is anorexia's unfortunate "glam" factor—our idealization of anorexics' slimness. "One psychologist said, 'I wish I had a little bit of anorexia,'" says Munn. "I asked her, 'Do you wish you had a little bit of alcoholism?' People don't understand what a slippery slope this can be, and how dangerous." Indeed, lethal. (See "The Damage Done," page 181.)

Greater awareness is vital, because without it, parents, spouses and others may miss a loved one's need for treatment. And the earlier treatment begins, the better the odds of recovery.

THE DIFFICULTY WITH TREATMENT

Even for those who get treatment, a happy ending is not a given. Success rates are uneven, and research is still spotty.

With anorexia, experience has taught clinicians that weight gain comes before counseling. "Psychotherapy involves abstract thinking and seeing different perspectives. That's hard to do when your brain is starving," says Bunnell. Only about 40 percent of anorexics recover fully; 40 percent recover partially, and the rest remain chronic cases, their health risks increasing over time.

With bulimia, 50 percent of patients are helped by a combination of cognitive-behavioral therapy, interpersonal therapy and/or antidepressants. Individual therapists mostly use a mix of techniques for anorexics and bulimics. Centers offer an array of inpatient and outpatient programs: individual, group and family therapy; nutritional counseling; and medications. (See "The Best Treatment Clinics," page 182.) Inpatient treatment can last up to six months, and for most patients, full recovery takes two to three years. "Treating these patients is an art, not a science," says Bunnell. It's a very expensive art as well. "Inpatient treatment costs as much as \$25,000 a month," says NEDA's chief executive officer, Lynn Greffe, adding that insurance companies rarely cover the cost.

A BRIGHT SPOT

One exciting treatment advance may improve recovery rates for adolescent anorexics and some bulimics. This is the outpatient treatment developed two decades ago at the Institute of Psychiatry at London's Maudsley hospital. The Maudsley method, relatively new to the United States, defies therapeutic convention by enlisting family members as partners in the treatment, which lasts about six to twelve months. In the first phase, they choose the teen's meals and make sure he or she eats, using their chosen strategies (abusive parents are screened out) and

meeting weekly with the supervising physician for coaching and assessment. "These kids are 'driving under the influence' of anorexia; it's difficult for them to collaborate at first," explains psychiatrist James Lock, who launched a Maudsley-style program at Stanford University and the University of Chicago in 1998 and, with psychologist Daniel le Grange, cowrote *Help Your Teen Beat an Eating Disorder* (Guilford Press, 2005). "But we believe that parents are the real experts on their kids; they know what will work best to get them to eat." In the second and third treatment phases, the teen gradually resumes control of his or her eating and returns to normal routines.

This get-the-family-involved approach works 80 to 85 percent of the time, says Lock, but only with newly diagnosed adolescents, not chronic cases. And it tends to cost far less than conventional therapies. Unsurprisingly, clinics and therapists increasingly offer family-based treatment; Lock and le Grange are recruiting patients for a study comparing it with individual treatment. (Call 773-702-0789 at the University of Chicago, or 650-723-7885 at Stanford University.)

AN OUNCE OF PREVENTION ...

In the end, one thing is clear: for parents, educators and children, prevention is by far the best course. What can be done to help kids steer clear of eating disorders? The answer? Plenty.

Manhattan psychiatrist Susan Sherkow, who founded a treatment center for mothers with eating disorders and their young children, urges parents to deal with their own hang-ups. "They need to back off from their obsessions with fitness and not being fat, because children pick up on this," Sherkow says. "School principals tell me they see kids open their lunch bag, count the calories on the labels and then throw away their lunch. Another huge trigger is moms' preoccupation with their little girls' waistlines. If a girl is slightly chunky, her mother may say something and make her feel self-conscious—or not say anything, but give a look."

Social worker Kathy Kater, who helps teachers and parents inculcate fourth- through sixth-graders with her curriculum on NEDA's Web site, says, "We teach about body-size diversity and how dieting increases your preoccupation with food and weight."

In *The Body Myth*, Margo Maine asks people to look at women who have made a difference in their lives: Whom do you love and admire? What does their body size have to do with that?

Fathers also play a crucial role, writes Maine in an earlier book, *Father Hunger: Fathers, Daughters & Food* (Gürze, 1991). Bunnell agrees: "Most men don't intuitively grasp the significance that weight and shape have for women. They need to learn not to make totally innocent comments like, 'Sweetheart, you're really looking good; I'm glad you've finally gained a couple of pounds.' He means it as encouragement, but she's devastated." But, Bunnell adds, men can offer their daughters and wives "the

experience of watching someone care so much, he'll stumble all over the place trying to get it right. And that means a great deal."

Finally, parents can be role models by eating pleasurably—and mindfully. "People who binge or binge-purge tend to eat mindlessly," says Maine. "In treatment, we find ways for it to become an experience where you sit down, take time and feel, 'This is going to be enjoyable.' With patients who undereat, we have rituals that encourage thinking about food positively—peeling an orange; looking at an orange; appreciating what an orange smells, feels and tastes like."

The notion of really, truly relishing food may seem unimaginable if you or a loved one is wrestling with an eating disorder. No one who is familiar with these ailments would understate their perils, but many, like me, believe that total recovery is possible—not guaranteed, but possible. And recovery may bring deeper nourishment. As one father told me, "My daughter once said, 'This was the worst thing that ever happened to me, but it was one of the best things that ever happened to my family, because it brought us closer together.'"

The National Eating Disorders Association (NEDA), the country's largest nonprofit eating-disorders organization, raises awareness, provides treatment referrals and advocates for research funding, treatment access and insurance coverage. For information, call NEDA at 800-931-2237 or visit nationaleatingdisorders.org. ✕

THE DAMAGE DONE

It is critical not to underestimate the risks of anorexia and bulimia. Although it can take years for fatal cardiac arrhythmias (caused by mineral and electrolyte imbalances) to develop, in some cases, death can come quickly. "I know a family whose daughter died of bulimia within thirteen months," says NEDA board member Robbie Munn. "She died in her bed at college." For those who recover, the long-term damage can be serious: calcium loss during adolescence can cause lifelong osteoporosis; one-quarter of anorexics never resume normal menstruation, impairing their fertility; and starvation can destroy portions of major organs.

HEALTH RISKS OF ANOREXIA: hair loss; brittle nails; fine hair growth (lanugo) on the face, back and arms; constipation; cessation of menses; anemia; lowered potassium, phosphorus and magnesium levels; lowered body temperature; kidney damage (possibly requiring dialysis); osteoporosis; irreversible brain atrophy; diminished cardiac capacity; lowered heart rate and blood pressure; cardiac arrhythmia. In the long run, almost half of all deaths associated with anorexia are suicides.

HEALTH RISKS OF BULIMIA: erosion of tooth enamel; swelling of the jaw and neck; irritation or rupture of the esophagus (potentially fatal); acid reflux (heartburn); low potassium levels (potentially fatal); electrolyte imbalances (possibly leading to cardiac arrhythmia or seizures); ipecac poisoning (ipecac, an emetic, can be fatal in cumulative doses); heart and kidney failure; constipation; colon damage (sometimes requiring surgical removal of portions of the bowel).

One Family's Nightmare

A teenager is emaciated. Her parents feel powerless. What next?

ELIZABETH'S ANOREXIA, which began in her junior year of high school, started out as most eating disorders do—quietly, in the wake of painful personal events. "My sister, who's my best friend, left for college," says Elizabeth.* "And I broke up with my boyfriend."

Almost without noticing, she lost more than ten pounds. Her sister, visiting home later that fall, expressed concern to their parents, John and Jane. They immediately took Elizabeth to a nutritionist. "I was absolutely livid," says Elizabeth. "The nutritionist asked, 'Why are you here?' and I said, 'Because my parents are dumb!'"

But to Elizabeth's parents, the exam was an eye-opener. "Elizabeth had lost a total of eighteen pounds by then," says Jane. "She'd always been lean, and she's five foot nine. The crazy thing was that she'd performed in a concert the week before, and so many people had come up to us afterward and said, 'I didn't realize how beautiful Elizabeth is!' She was fulfilling society's idealized model look—she looked chiseled, which is so unhealthy."

Her parents enrolled Elizabeth in outpatient treatment with a doctor, a psychologist and a nutritionist, but it made no difference. "All I could think of when I saw food was calories, calories, calories," Elizabeth says. "A friend gave me a pack of gummi bears, my favorite, and my first thought was, 'How do I get rid of these without hurting her feelings?'"

Over the next few weeks, Elizabeth lost more weight. Her doctor told her she had to stop playing lacrosse, and some of her friends started avoiding her. "Later they said, 'I couldn't help you, and it was so hard to see you shrinking, literally and metaphorically,'" she recalls.

Her parents echo this distress. "We were on pins and needles," says Jane. "Every meal was tense; you're trying not to focus too much on her eating, but you're also aware of your own. You avoid saying things like, 'I'm not going to eat that, because I had a fattening lunch.' You second-guess yourself all the time. And you watch for signs—she's asleep, and you check to make sure she's breathing. It was very hard."

Elizabeth's grades began to drop, and she felt tortured by her teachers' constant surveillance. She began fainting, and if

*Her name and those of her parents have been changed.

forced to eat, she would often vomit because her stomach was too small to hold an adequate amount of food. "She was throwing out her Ensure shakes and lying to us about it," says John. "After about six months, we had all reached the point of exhaustion."

In a pivotal, grueling session with her doctor and her parents, Elizabeth agreed to go to the highly regarded Laureate Psychiatric Clinic and Hospital, in Tulsa. "The night before I left, I sat on the kitchen floor, crying to my parents that it was all a big mistake, that I had fooled them into thinking I was worse than I really was," she says.

Her parents felt equally awful. "It's indescribable to drop your daughter off at a place with bars on the windows and kids with feeding tubes," says John. "You feel helpless. It's downright heartbreaking."

In her medical workup, Elizabeth's pulse was thirty-five—terrifyingly low. She started to realize how precarious her health was. Still, she clung to her illness. "I did everything they asked, because I was so anxious to get out, but I didn't really want to change; I didn't really think I looked so thin."

Gradually, her talks with her therapist, nutritionist and doctor changed her perspective. "My doctor made me see that how you conduct yourself in the hospital is how you conduct yourself in the real world. One day he said, 'Your parents say that you sob on the phone every night, yet you've never told me you're unhappy here. You're never truly honest with us. You say what you think we want to hear.' That was a milestone: I had an incredibly honest conversation with him then, telling him what I was afraid of in life, what was maybe at the root of my problems. He said, 'I like you more now than I ever have, because that vulnerability, which you think will make people reject you, will actually draw people to you.' That was important for me; before that, no matter how I felt, I'd always told people, 'I'm fine.'"

Eventually, Elizabeth learned to connect her food-phobic thoughts to upsetting events or feelings; she also got back in touch with good friends. "I hadn't realized how much my illness had affected me emotionally. I really was not me; I was a shell."

Finally, she says, "I decided it wasn't worth it. Why was I giving up so much for something that was tearing my health apart? It wasn't an epiphany, it was a process—waking up every day with the purpose of getting better." After she'd been at Laureate for two months, her doctors said she was healthy enough to go home.

Meanwhile, Elizabeth's parents were learning too. "When we told people about her, they were so supportive," says Jane. "That surprised us, and it made it much easier to be open."

John wishes he and Jane had spotted the red flags sooner. (See "How to Recognize the Signs," page 178.) "We learned that some kids are predisposed to eating disorders, and Elizabeth

had all the earmarks: she was super-responsible and a real perfectionist. There's just not enough education for parents that teaches them what to look for."

Reflecting on her anorexia, Elizabeth says, "When all that painful stuff happened with my sister and my boyfriend, I felt as if food and eating were the only things I could control." She agrees that cultural images, though not powerful enough to trigger eating disorders, do affect how girls view themselves. "When I see pictures of thin, thin women plastered on teenage girls' bedroom walls, that's incredibly disturbing." And she offers parents these words of wisdom: "Stay alert for signs that your daughter has an eating disorder. And keep telling her she doesn't need to look the way the models in the magazines look." D.G.

THE BEST TREATMENT CLINICS

Here are some of the most respected U.S. clinics.

ARIZONA: **Remuda Ranch**, Wickenburg; 800-445-1900; remuda-ranch.com. Founder and CEO: Ward Keller.

CALIFORNIA: **Lucile Packard Children's Hospital**, Stanford University Medical Center, Palo Alto; 650-498-4468; lpch.org. Director: Dr. James Lock. **Monte Nido Residential Center**, Malibu; 310-457-9958; montenido.com. Founder and director: Carolyn Costin. **Resnick Neuropsychiatric Hospital at UCLA**, Los Angeles; 310-825-5730; health-care.ucla.edu/npih. Director: Michael A. Strober.

COLORADO: **The Children's Hospital of Denver**, 303-764-8521; thechildrenshospital.org. Codirectors: Dr. Eric Sigel and Dr. Jennifer Hagman.

CONNECTICUT: **Wilkins Center**, Greenwich; 203-531-1909; wilkins-center.com. Founder and director: Dr. Diane Wilkins Mickley.

FLORIDA: **Fairwinds Treatment Center**, Clearwater; 800-226-0301; fairwindstreatment.com. Director: Dr. Pauline S. Powers.

ILLINOIS: **University of Chicago**, Department of Psychiatry; 773-834-5677; eatingdisorders.uchicago.edu. Director: Daniel le Grange.

MISSOURI: **McCallum Place**, Clayton; 800-828-8158; mccallum-place.com. Founder and director: Dr. Kimberli McCallum.

NEW YORK: **Mount Sinai Eating and Weight Disorders Program**, New York City; 212-659-8724; www.mountsinai.org/eatingdisorders. Director: Katharine L. Loeb.

NORTH CAROLINA: **Duke Eating Disorders Program**, Duke University Medical Center, Durham; 919-668-2281; eatingdisorders.mc.duke.edu. Director: Nancy Zucker.

OKLAHOMA: **Laureate Psychiatric Hospital and Clinic**, Tulsa; 918-491-3700; laureate.com. Codirectors: Craig Johnson and Dr. Ovidio Bermudez.

OREGON: **Kartini Clinic**, Portland; 503-249-8851; kartiniclinic.com. Founder and director: Dr. Julie O'Toole.

PENNSYLVANIA: **The Renfrew Center**, Philadelphia; 800-RENFREW; renfrewcenter.com. Director: Dr. Susan Ice.

WASHINGTON: **Seattle Children's Hospital Eating Disorders Program**; 206-987-2164; seattlechildrens.org. Director: Rose Calderon.