Comparison of Anorexia and Bulimia

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Anorexia nervosa and Bulimia nervosa are two of the most prevalent eating disorders in the world, especially that of the western culture. In the United States, 20 million women and 10 million men suffer from a clinically significant eating disorder at some point in their life (nationaleatingdisorders.org), making the prevalence of eating disorders for Americans to be 1 out of every 10. While many of the causative factors behind these disorders are similar, there are several key differences between anorexia nervosa and bulimia nervosa, including the various signs and symptoms, optimal therapeutic treatment, and nursing care.

ETIOLOGY

While the exact causes of eating disorders remain uncertain, a combination of many factors is thought to promote development of chronic unhealthy eating habits. With anorexia and bulimia, many of the psychological, interpersonal, and sociological factors are very similar. According to Mayoclinic.org, “Mostly affecting females and especially adolescents, anorexia has an onset of mid-adolescence whereas bulimia normally starts in late adolescence or adulthood.” Low self esteem and tendencies to be a perfectionist appear to represent a significant risk factor for development of anorexia and bulimia. Often times, people with a perfectionist personality will turn to unhealthy eating habits when they feel a lack of control in life or feelings of inadequacy. Perfectionists tend to see everything in life as “good” or “bad”, with no grey area in between, giving them the tendency to participate in extremist behaviors. Moreover, depression, anxiety, anger, emptiness or loneliness can lead a person to anorexia or bulimia development simply to help eliminate these negative feelings and allow them an area of life which they feel a sense of control. Sociocultural factors residing within both disorders include cultural pressures that place significant value on “thinness” or “body perfection”, cultural norms that have an extremely narrow definition of beauty, and mass media messages encouraging dieting to achieve an irrational definition of “beauty.” In particular, these media messages have a large impact on adolescents and often times, “dieting” turns into the unhealthy habit of chronic-dieting, starvation, or regurgitation after binging. Moreover, interpersonal factors causing an eating disorder include family disharmony or troubled relationships, difficulty expressing one’s emotions, a history of being ridiculed for weight or size, or a history of sexual or physical abuse. Especially for adolescents, family factors have a hefty impact on the prevalence of both anorexia and bulimia. “Specifically, female adolescents in the western culture are more vulnerable and effected by such factors as interfamilial conflict, parental preoccupation with eating and weight of their children or themselves, and unrealistic expectations for achievement” (Mayo Clinic, 2012). Here again, many of these factors cause the person to develop an eating disorder because they sense lack of control in other areas of their life. If not in attempt to feel control, the other prevalent causation of eating disorders is the unrealistic expectation to attain “body perfection.” While the perfectionist trait tends to lean more towards development of anorexia, these factors and personality traits are hallmark predictors for risk of developing either disorder. According to diffen.com, “binge eating is present in about 25-50% of patients with anorexia nervosa while it is present in 100% of patients with bulimia nervosa.” Therefore, often times a person diagnosed with one has also experimented in the unhealthy habits of the other disorder.

SIGNS AND SYMPTOMS

While causational factors seem very similar, signs and symptoms in anorexia and bulimia tend to be very different. People with anorexia lose weight by severely restricting their intake of food and/or excessively exercising in order to achieve or maintain body weight at or below the minimally normal weight. With patients suffering from bulimia, recurrent bing-and-purge eating cycles are how sense of control over weight is maintained. Often times, these patients have an intense fear of gaining weight or becoming “fat” even when they are underweight or within normal weight limits. A major clinical difference between anorexia and bulimia is that weight at diagnosis for anorexic patients is markedly decreased while it’s usually normal in those with bulimia. Also, patients with anorexia usually have hormonal imbalances, like low estrogen or testosterone, while patients with bulimia rarely exhibit abnormal hormone levels. Taking these hormonal changes into account, amenorrhea, or absence of menstrual period, is commonly present in patients with anorexia, while menstrual periods usually remain unaffected in patients with bulimia. Moreover, antisocial behavior is usually found in patients with bulimia while it is rare in patients with anorexia nervosa. Cardiovascular changes are more common in patients with Anorexia nervosa, such as decreased heart rate and decreased blood pressure, heightening the patient’s risk for heart failure. Reduction of bone density, muscle loss or weakness, severe dehydration, frail hair and skin, constipation, and growth of lanugo all over the body include the common signs and symptoms of anorexia. Emotional and behavioral signs of anorexia include refusal to eat, denial of hunger, fear of gaining weight, excessive exercise, flat mood, reduced libido, preoccupation with food, or lying about how much food has been eaten. For patient’s with bulimia, the health risks are very similar to those associated with clinical obesity. High blood pressure, high cholesterol levels, elevated triglyceride levels related to risk of heart disease, type II diabetes mellitus, and gallbladder disease are the most common. Moreover, the binge-and-purge cycle of Bulimia tends to have harsh effects on the entire digestive system, leading to electrolyte and chemical imbalances caused by excessive vomiting and dehydration. Electrolyte imbalances can lead to heart dysrhythmias and even heart failure. Frequent vomiting usually causes tooth decay and staining, along with inflammation and possible rupture of the esophagus. Peptic ulcers, pancreatitis, and potential for gastric ruptures are also common signs and symptoms. Common emotional and behavioral signs and symptoms related to bulimia include lack of control over eating, secrecy surrounding eating, eating large amounts of food at one time, and alternating between overeating and fasting. More specifically, signs of purging include going to the bathroom after meals, excessive exercising, smelling of vomit, or using laxatives or diuretics after eating.

TREATMENT AND NURSING CARE

Treatment for both anorexia and bulimia mainly focuses on the emotional factors causing the patient to participate in chronic unhealthy eating habits. For patients diagnosed with anorexia, the first physiological goal of treatment is getting the patient back to a healthy weight. “In severe cases, people with anorexia may initially require tube feeding along with frequent monitoring of vital signs, hydration level and electrolyte levels” (Segal, 2014). With both anorexia and bulimia, a psychologist works with the patient to help them develop behavioral strategies that will optimize therapy and healthy weight gain. Individual therapy, commonly cognitive behavioral therapy, helps the patient identify and change the behaviors and thoughts that contribute to anorexia or the bing-and-purge cycle of bulimia. For anorexic patients, developing a healthy perspective on food as “energy for the body” is the first step. Changing the patient’s thought processes about food, eating, and weight must be done before the patient can establish and maintain healthy eating habits. For bulimic patients, breaking the binging and purging cycle is first priority. The patient learns to monitor eating habits, avoid situations that trigger the binging cycle, and cope with stress in ways that don’t involve food. The next step for bulimic patients is to change unhealthy thoughts and patterns about food, weight, dieting, and body shape. The psychologist encourages the patient to explore their attitudes about eating and re-think the idea that self-worth is based on weight. The final step for bulimia treatment involves targeting emotional issues that caused the disorder in the first place. Therapy may focus on relationship issues, depression, anxiety, or self-esteem issues. This third step can be the hardest to complete since treatment must be individualized and often opens up very complex emotional issues that are difficult to alleviate. For both anorexic and bulimic patients, family based and group therapy is also used and begins with the assumption that the patient is not capable of making sound decisions regarding her eating habits and needs help and support from the family or peers. Since both disorders are largely driven by emotion, underlying issues can prove very complex; therefore, treatment must be individualized to optimize therapy.

CONCLUSION

With such a high prevalence of both Anorexia nervosa and Bulimia nervosa pervading the western culture, preventative education and optimizing therapy should be a priority concern. While there are several similar characteristics concerning the etiology of both anorexia and bulimia, signs and symptoms, nursing care and treatment are very different for both disorders.

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