Eating Disorders: when nutrition and psychology come together

Many psychiatric/psychological disorders affect the patients' metabolism even before treatment. For instance, Depression and Schizophrenia are a risk factor for Diabetes Mellitus. When pharmacotherapy is needed, the patients' metabolism is made even worse. Diabetes, hyperlipidemias as well as other metabolic problems start to bombard the psychiatric patient.

In the case of Eating Disorders, such as Anorexia Nervosa or Bulimia Nervosa, the patient struggles with an abnormal eating behavior and pattern which are pathological, very dangerous and often deadly. In any of the two cases, proper nutrition is compromised and medical comorbidities arise. For the two disorders, both, hereditary biological factors as well as psychological factors have been clearly researched and documented.

Anorexia Nervosa
This is a psychological disorder, not a nutritional one. However, the consequences are nutritional. In such a condition, which usually starts in adolescent females, the patient denies the idea that she or he is greatly underweight (BMI below 16; sometimes body weight 50% of normal). An Anorexic *perceives* herself or himself as fatter than she or he actually is. The problem is in the ***perception*** of body image and self. The *Anorexic* also *feels* an urge to continue losing weight by avoiding eating, fasting for very long times, despite normal hunger. Anorexics do feel hunger like everyone else.
Excessive *unhealthy* exercise is associated to this severe dieting to help the weight loss further. The excessive unhealthy exercise can cause dehydration, joint problems, muscle cramps etc… The average caloric intake of a person with anorexia nervosa can be as low as 600 calories per day, but there are extreme cases of complete self-starvation. It is a serious ***mental*** illness with a high incidence of mortality rate. Obviously, many nutritional deficiencies take place from micronutrients to macronutrients.

Some of the symptoms and signs of Anorexia Nervosa are:

- obvious, rapid, dramatic weight loss
- Russell's sign: scarring of the knuckles from placing fingers down the throat to induce vomiting
- Lanugo hair: soft, fine hair grows on face and body
- obsession with calories and fat content
- preoccupation with food, recipes, or cooking; may cook elaborate dinners for others but not eat themselves
- dieting despite being thin or dangerously underweight
- fear of gaining weight or becoming overweight
- rituals: cuts food into tiny pieces; refuses to eat around others; hides or discards food

- purging: uses laxatives, diet pills, ipecac syrup, or water pills; may engage in self-induced vomiting; may run to the bathroom after eating in order to vomit and quickly get rid of the calories
- may engage in frequent, strenuous exercise
- perception: perceives self to be overweight despite being told by others they are too thin
- becomes intolerant to cold: frequently complains of being cold due to loss of insulating body fat or poor circulation due to extremely low blood pressure; body temperature lowers (hypothermia) in effort to conserve energy
- depression: may frequently be in a sad, lethargic state
- solitude: may avoid friends and family; becomes withdrawn and secretive
- clothing: some may wear baggy, loose-fitting clothes to cover weight loss if they have been confronted about their health and wish to hide it, while others will wear baggy clothing to hide what they see as an unattractive and overweight body.
- cheeks may become swollen due to enlargement of the salivary glands caused by excessive vomiting

The management of Aneroxia should be done by a group of professionals and not just one alone. This team should include medical doctors (Endocrinologists, Gastrologists, Plastic Surgeons, and Orthopedists), clinical nutritionists, psychiatrist, clinical psychologists and should involve the family of the patient for support.

It is difficult to distinguish physical disorders from functional psychiatric disorders on the basis of psychiatric symptoms alone. Detailed physical examination and laboratory screening are indicated as a routine procedure in the initial evaluation of psychiatric patients. Most patients are unaware of the medical illness that is causative of their psychiatric symptoms. There are a variety of tests that may aid in the diagnosis of Anorexia Nervosa and the assessment of possible secondary effects caused by Anorexia Nervosa upon the patient.

Bulimia Nervosa

This is also a *mental* disorder not a nutritional one. Yet, like Anorexia, it has severe nutritional and medical consequences. When diagnosed, Bulimia needs immediate attention like Anorexia. The medical consequences of the behavior can be dangerous and even fatal. The patient who suffers from Bulimia strives to lose weight like an Anorexic except that in Bulimia the patient gets impulses that drive her or him to over-eat. This is not the case in Anorexia. Bulimics might eat up to 5000 calories in one meal as a result of an urge, an impulse. Evidently this is followed by a severe feeling of guilt which makes the patient so anxious about gaining weight that he or she relies on any possible way to get rid of the eaten food. The different ways to get rid of the excess eaten food are referred to as “purging” and include:

- Induced vomiting
- Use of laxatives, enemas, diuretics,
- Over-exercising

The symptoms and signs of a bulimic are:

- Dehydration and hypokalemia caused by frequent vomiting
- Electrolyte imbalance, which can lead to cardiac arrhythmia, cardiac arrest, and even death
- Inflammation of the esophagus
- Oral trauma, in which repetitive insertion of fingers or other objects causes lacerations to the lining of the mouth or throat
- Rupture of the stomach by the effort of throwing up
- Constipation
- Infertility
- Peptic ulcers
- Calluses or scars on back of hands due to repeated trauma from teeth
- Constant weight fluctuations

The frequent contact between teeth and gastric acid, in particular, may cause:

- Severe dental erosion
- Erosion of tooth enamel
- Swollen salivary glands[

The management of Bulimia is similar to that of Anorexia and should include a team of specialists. The management of Bulimia should be done by a group of professionals and not just one. This team should include medical doctors, clinical nutritionists, psychiatrist, clinical psychologists and should involved the family of the patient for support.

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