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That couldn't be my child ... or could it?

By Dr. David T. Tharp

"JILL" WAS YOUR TYPICAL 16-YEAR-OLD high school junior, perhaps prettier than most, smarter than most and definitely more active than most. She was head cheerleader, captain of the dance team, starter on the volleyball team as a sophomore, and a finalist in last year's state track meet, along with being a consistent straight-A student. She was the daughter, girlfriend, and leader in her church youth group that everyone wanted to be. When her parents got the call from the police station saying that their daughter had been arrested for shoplifting, they immediately thought it was a mistake and must be someone else's daughter.

On their arrival at the police station, Jill tearfully explained to her parents how stressed she had felt with finals week and had taken food from the local convenience store so that she could go off by herself to binge and then throw it up. She had already spent all of her birthday and Christmas money on food, only to see it swirl in circles and disappear into the toilet. She sobbed as she told her parents that this had been going on for three years and, she couldn't stop. She stopped for a few days, sometimes even a week, but it would return with vengeance, often throwing up ten times a day until nothing came except perhaps a few streaks of blood. Lying in bed that night, her parents kept repeating the question, "How could we not have known?"

Granted, Jill had gone through a period around age 12 when she was unhappy with a school change, had gotten extremely thin and seemed intent on losing more weight. Her pediatrician said that it was "a phase" that many girls go through, but she would come out of it as she started making new friends if no one made a big deal out of it. When she seemed to be gaining weight, the pediatrician seemed correct. They had also noticed that she

seemed to have a lot of scratches on her arms and legs, but she said these were caused by the new family puppy. Little did they know that their "perfect daughter" was already learning to cut her arms and legs with a fingernail file to relieve tension and emotional hurt when she was unable to find enough food on which to binge and then throw up by putting her finger or a toothbrush down her throat. It was a blessing and perhaps even lifesaving when Jill was arrested for shoplifting and was able to share her story. She was finally able to acknowledge that she had an eating disorder.

Many parents might say, "That couldn't be my son or daughter, because I would know if they were losing weight or throwing up or cutting themselves." Unfortunately, that is not always true. Anorexia and bulimia are often difficult to recognize because of the innate secrecy, shame and dishonesty that go along with them. Add to this that these young men and women often appear to be model citizens and pillars of emotional health and you have an illness that frequently is unrecognized prior to serious consequences.

Approximately 1% of female adolescents have anorexia nervosa, defined as losing at least 15% of one's normal body weight coupled with loss of menstrual periods. This may be by restricting how much one eats. At other times it is associated with bingeing and then attempting to get rid of the calories either through self-induced vomiting, laxative, diuretic, diet pill abuse or extreme compulsive exercise. Bulimia is characterized by cycles of bingeing and purging, and at times may alternate with anorexic behavior. Binges may average 1,000 calories but may be as high as 15,000-20,000 calories. Research indicates that approximately 1-4% of college-aged women have bulimia, and approximately 50% of those with anorexia eventually develop bulimia, as did Jill. Although only 10% of those with eating disorders are male, the number of affected males and of children ages 6-12 is growing rapidly.

We also know that 1-2% of adults in the United States struggle with binge eating disorder (bingeing without purging), including 30% of the women who seek treatment for weight loss.

Eating disorders have one of the highest mortality rates of any psychiatric illness. One study indicated mortality rates of up to 20%, but with treatment this may fall to 2-3%. Treatment tends to be long-term with ups and downs. Although statistics vary, approximately 50-60% fully recover, 20-30% partially recover and approximately 20% remain chronically ill. The cause of eating disorders seems multi-factorial, including genetics, family dynamics and early life experiences. Onset is frequently in the early teens or late teens and early adulthood. Unfortunately, histories of physical and sexual abuse are relatively common, particularly in those with bulimia and self-harming behaviors.

The effect on families can be devastating. Parents feel helpless, frustrated that they cannot "fix" the problem. They may feel guilty and blamed by each other or by society. Siblings may be frightened by what they see, hurt by the seeming emotional withdrawal of their sister or brother, and yet angry as it seems that all of the family's energies and resources are directed toward her.

> "Eating disorders have one of the highest mortality rates of any psychiatric illness. Early intervention by professionals improves the recovery rate..."

Early intervention by professionals improves the recovery rate, as eating disorders do not tend to heal themselves. Communication is crucial, as the anorexic or bulimic individual often wants help but is too ashamed to ask. And education … education of our young people, of their teachers and coaches, and of parents to notice the warning signs and not be afraid to get the help they need for the child.

Frequently the greatest hurdle is scaled when the thought, "That couldn't be my child," becomes, "Perhaps it could…"

Dr. David T. Tharp is a psychiatrist in Frisco with expertise in eating disorders.

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