

Eating Disorders 101



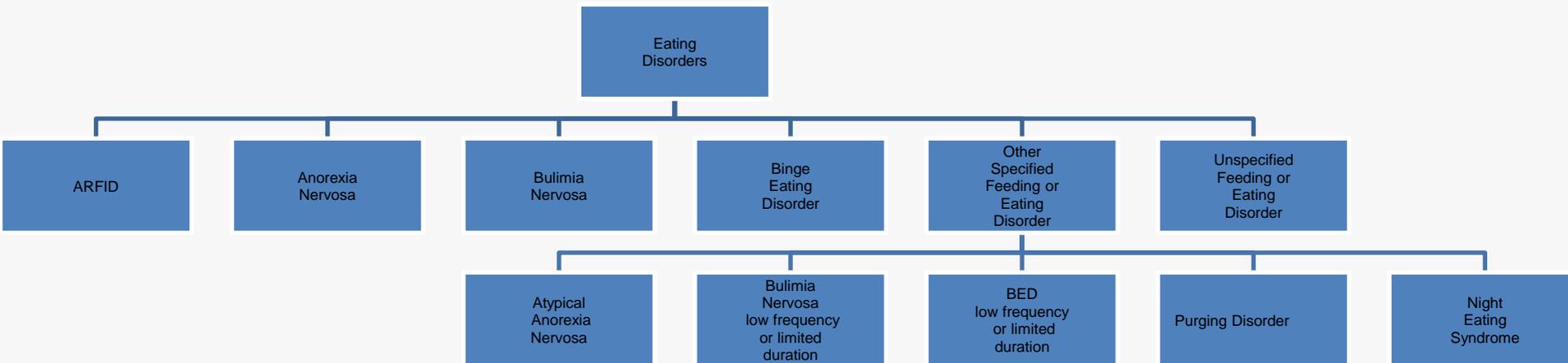
Walden Behavioral Care

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New England's Leading Provider of Services for the Treatment of Eating Disorders

DSM-V Structure for Eating Disorders

The DSM is the Diagnostic and Statistical Manual of Mental Disorders. It helps diagnose people and is used in charts, treatment plans, insurance and billing.



There are many different eating disorders. Some people may experience one at a time or several!

Anorexia Nervosa (AN)

A serious, potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss. Individuals with AN are unable or unwilling to maintain a body weight that is normal or expected for their age and height.

Facts

AN has the highest mortality rate of any psychiatric illness.

Depression is the most commonly noted psychiatric disorder in women with Anorexia (Kaye et al., 2004)

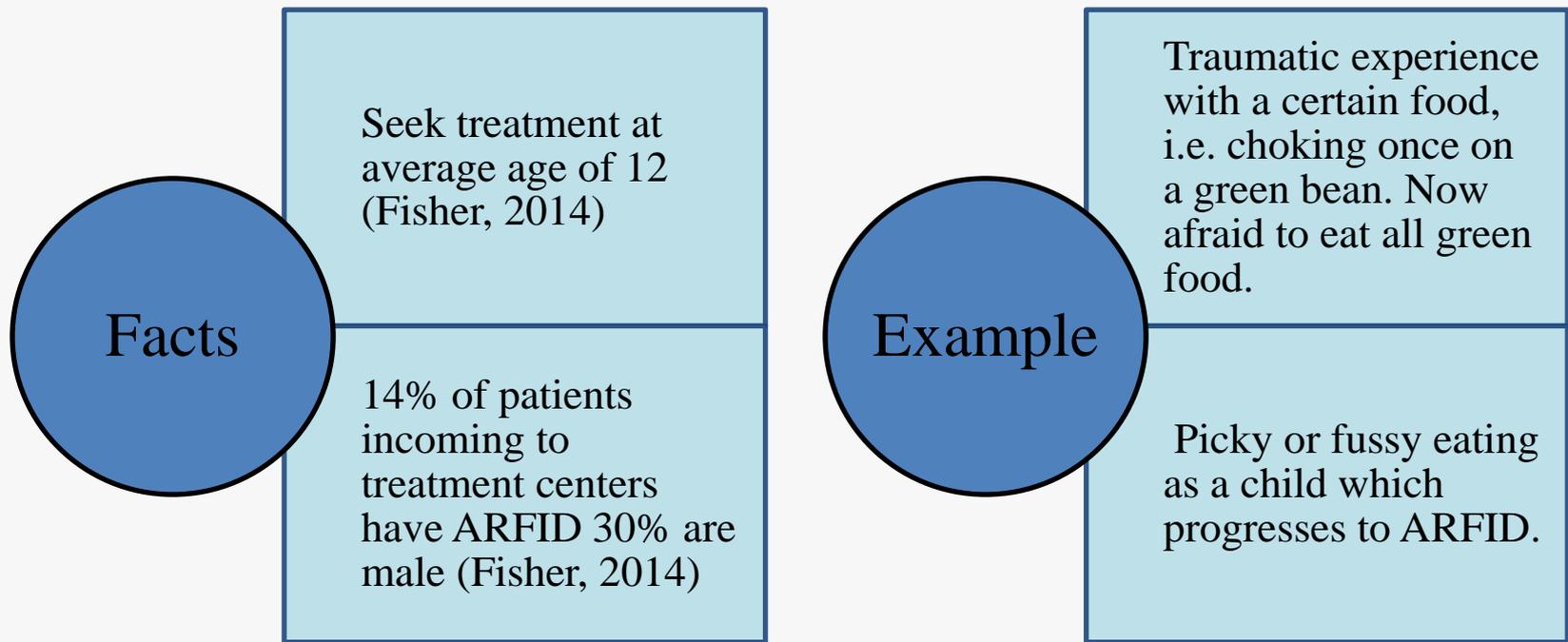
Statistics

Anorexia is the third most common chronic illness among adolescents. (Public Health Service, 2000)

50-80% of the risk of developing AN is genetic. (Kaye, 2007)

Avoidant/Restrictive Food Intake Disorder (ARFID)

An eating or feeding disturbance (lack of interest in eating or food; avoidance of certain food groups, textures/smells). Failure to meet the appropriate nutritional/energy needs. There is significant weight loss, nutritional deficit, relies on supplements, interference with day-to-day functioning. (DSM-V) Think anorexia with out body image issues.



Bulimia Nervosa (BN)

A serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-induced vomiting, excessive exercise, laxatives etc. designed to undo or compensate for the effects of binge eating. A person must binge in order to have bulimia nervosa (BN).

Facts

Highest period of risk for a female to develop BN occurs from ages 17-20. (Stice, Marti, Shaw and Jaconis, 2009)

Common characteristics of a person with BN may include impulsivity and engagement in risky behavior (s).

Statistics

For Adolescents, the lifetime prevalence of Bulimia is approximately .9% (Swanson et al 2011)

The standardized mortality rate for those suffering from BN is 1.9% (Arcelus et at., 2011)

Binge Eating Disorder (BED)

Binge Eating Disorder (BED) is characterized by recurrent binge eating without the use of inappropriate compensatory weight control behaviors.

Facts

BED is the most common eating disorder.

Common binge triggers can include; being alone, having unstructured time, being bored or drinking alcohol.

Statistics

On average, a typical binge lasts approximately 78 minutes. (Michelle May, 2010)

40% of those struggling with BED are men. (Harvard University)

Other Specified Feeding or Eating Disorder (OSFED)

The majority of those with eating disorders do not fall within the criteria for AN, BN or BED and are classified as OSFED. There are numerous variants of disordered eating that nevertheless are serious and require treatment.

Examples

Night Eating Syndrome, Purging Disorder, BED low frequency, BN low frequency, Atypical AN.

Statistics

147/165 ED patients diagnosed with OSFED (APA, May 2007)

Diabulimia

- Most often occurs in young women with Type 1 diabetes.
- Diabetes management requires attention to meal plan and dietary intake, often in the form of counting carbohydrates and sugar at every meal/snack.
- Manipulation of insulin to maintain and/or lose weight.
- Most common medical complications include:
 - Diabetic Ketoacidosis (build up of ketones in the urine)
 - Loss of eyesight
 - Decrease or loss of circulation in extremities



Disordered Eating or Eating Disorder?

Orthorexia

- Intense focus on eating “pure or “healthy” foods only. Usually driven by quality of foods vs. quantity. May choose to go without food instead of eating foods viewed as “unhealthy” or “processed.”

Picky and/or Fussy Eating

- Often seen in toddlers through latency-age children and usually outgrown by adolescence. May crave sweet and/or salty foods and have difficulty with bitter and/or sour foods.

Food Aversion

- May appear after having an unpleasant experience (choking, feeling ill) with a specific food, odor or in a certain place.

Night Eating

- Eating over 25% of daily calories after dinner; may engage in restricting behavior during the daytime. (NEDA)

Food Allergy or Eating Disorder

- 1/3 of people say they have a food allergy or alter their diet because of a suspected allergy.
- Only **6-8% of children under three**, and **2% of adults** have clinically shown that they are actually allergic to that food.



Medical Complications of Eating Disorders

Brain Complications:

Impaired Cognitive Function (Ability to Process and Concentrate)

Eye Issues:

Broken Blood Vessels and Retinal Detachment

Esophageal/Throat Complications:

Diminished Gag Reflex, Difficulty Swallowing, Esophageal Tears, Barrett's Esophagus, Esophageal Cancer, Reflux

Dental issues:

Cavities, Enamel Loss, Bleeding Gums, Tooth Decay/Rotting, Bleeding Gums, Tooth Loss

Cardiac Complications:

Loss of/Weakened Heart Muscle, Bradycardia/Tachycardia, Heart Failure, Edema, Heart Palpitations and Chest Pain, Sudden Cardiac Failure (Electrolyte Imbalances), Heart Disease

Glandular Issues:

Swollen Parotid Glands

Type-2 Diabetes

Kidney/Pancreatic Complications:

Chronic Dehydration, Low Potassium, Pancreatitis

GI Complications:

Stomach Aches, Constipation, Loss of Bowel Function, GI Bleeding, Gastric Rupture

Gallbladder Disease

Sexual Development Issues:

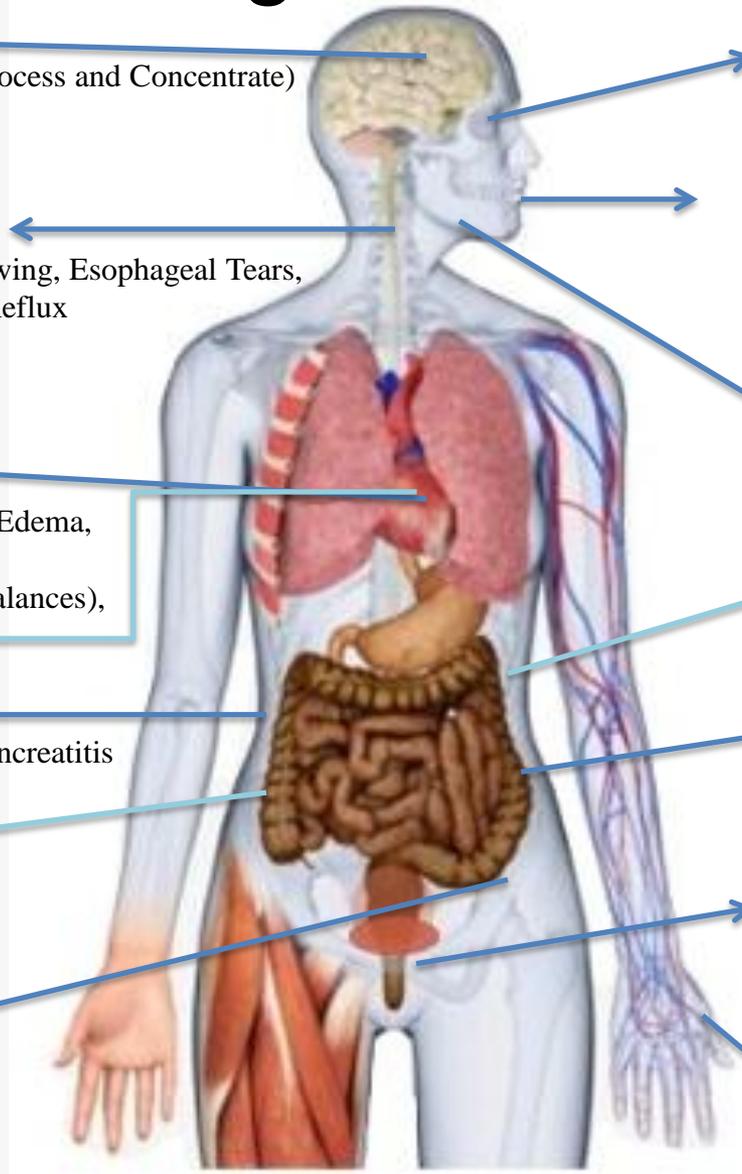
Delayed Puberty, Hormonal Imbalances

Menstrual/Fertility Issues:

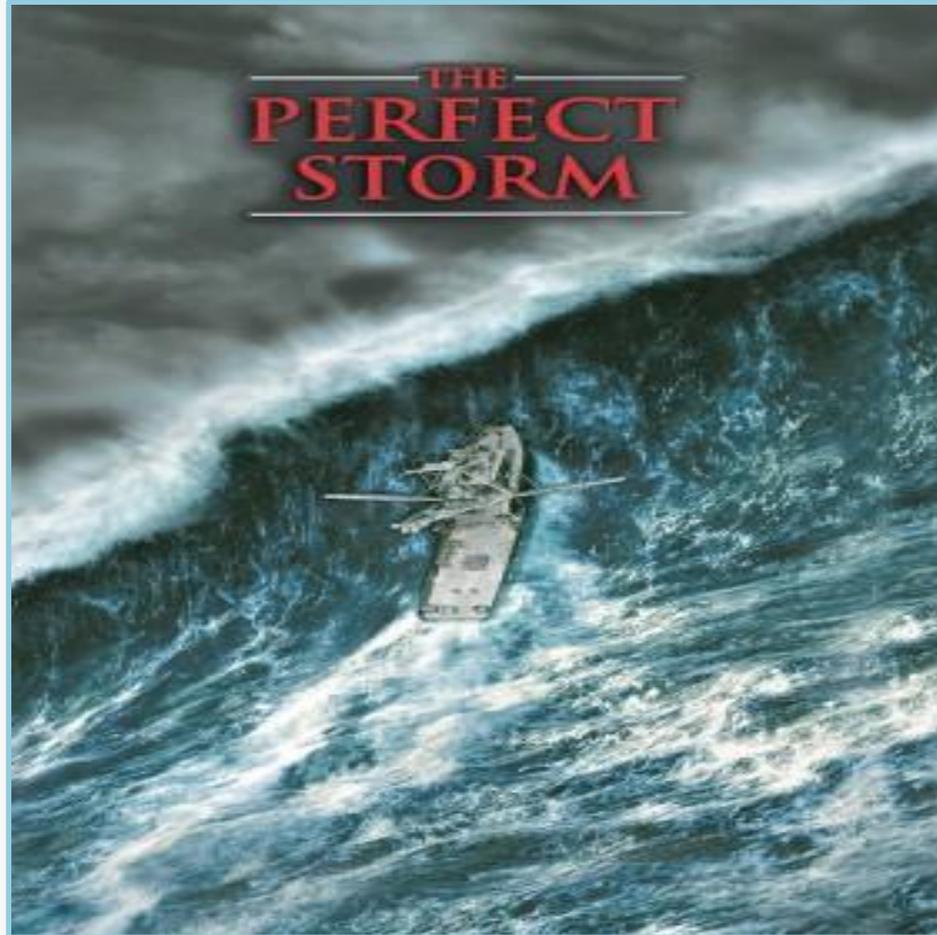
Menstrual Loss, and/or Irregularities, Infertility, Miscarriage, Premature Birth, Low Birth-Weight Infants

Hand Issues:

Calluses and/or scars on knuckles (Russell's Sign)



Where Do Eating Disorders Come From?



“Genetics load the gun and environment pulls the trigger.”
– Walter Kaye

Where Do Eating Disorders Come From?

The Biopsychosocial Model

Biological Factors

- **Genetics (family history)**
- **Instrumental delivery**
- **Twins**
- **Low birth weight**
- **Temperament**
- **Early or late puberty**

Psychological Factors

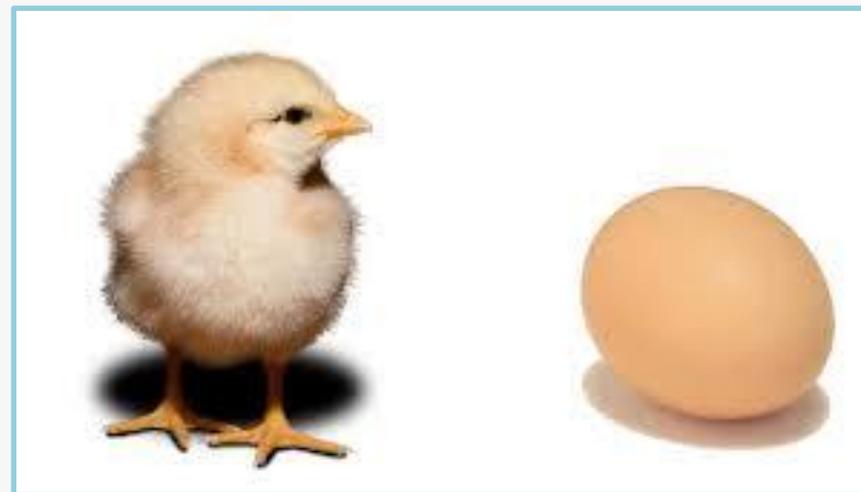
- **Cognitive distortions around body shape and size**
- **Emotional regulation problems**
- **Anxiety, OCD, Depression, Addictive D/O**

Social Factors

- **Values around thinness and beauty**
- **Dieting culture**
- **Family values around beauty, eating and exercise**
- **Peer related stressors**
- **History of abuse**

Co-Occurring Disorders

- The most common co-occurring disorder among patients struggling with an eating disorder are
 - Depression
 - Anxiety
 - OCD
 - Bipolar Disorder
 - Substance Abuse.
- The Prevalence of non-lethal self-injury among ED patients is approximately 25%. (Zanarini et al., 2004)



*It is still uncertain which disorder came first.

Co-Occurring Disorders - ADHD

- ❖ Girls with ADHD are 3.6x more likely to have an eating disorder than their peers.
- ❖ 11% of ADHD women vs. 1% of non-ADHD women are reporting Bulimia.
- ❖ Predisposing Factors: Poor planners, poor self-regulators, difficulty with decision-making, can be obsessive compulsive in nature, seek instant gratification, outcome-driven.



Co-Occurring Disorders – Autism Spectrum Disorders (ASD)

- Teenage girls with a diagnosis of ASD are at greater risk of experiencing eating disorder symptoms than are their control peers.
- 27% of girls with ASD report symptoms that fall within the eating disorders realm.
- Males with ASD are also at increased risk for low body weight and abnormal eating practices.

ASD and Anorexia Similarities

Attention to detail

Typically more self-centered

Lower sense of empathy

Fascination with detail

Tend to have a harder time with the eating process i.e. textures, tastes and smells.

Warning Signs/Symptoms

WARNING

Emotional

- Change in Mental Status
 - Irritability
- Difficulty Concentrating and/or Processing Information
 - Apathy
 - Withdrawal
- Express body image concerns

Physical

- Sudden weight loss (not due to medical), gain, or fluctuation in short time
- Feeling faint, cold, tired, or fatigued

Behavioral

- Diets or has chaotic food intake
- Excessive exercise (long periods of time, can't miss a day)
- Sudden Shift in Diet i.e. change to vegan or gluten-free
 - Frequent trips to bathroom
 - Wears baggy clothing
 - Avoidance of cafeteria

Pro-Mia and Pro-Ana Websites

- Users may engage in topics/discussion in an eating disorder-friendly environment.
- Motivation for continuing ED behaviors .
- Information for those new to using ED behaviors.
- Tips/techniques to keep parents/providers/family from noticing behaviors.
- May have a disclaimer prior to opening a web page and/or age limit, no way to enforce these consistently.
- Able to compare and comment on photos of other users.



Treatment

Only 10% of those struggling with an eating disorder will receive treatment.

So... What can you do?

How to Present Concern to a Friend or Family Member



- Be confident...don't walk on egg shells
- Do not judge them
- Provide them with specialists to contact
- Do not blame anyone
- Discuss genuine concern for health and well being
- Focus on describing your own experience of what you observe
- Stick to the facts
- Avoid arguing...just let them know what you are seeing

Helpful vs. Unhelpful

Ways to effectively help a person with an eating disorder:

- Validate that what they're going through is difficult.
- Help with emotional support, "I see you're having a hard time, what can I do to make this easier for you."
- Provide them with some people to call (therapists, dietitian, primary care doctor).
- Do not judge or become reactive when ED behaviors occur.

Phrases that are **unhelpful** to an ED patient during mealtime:



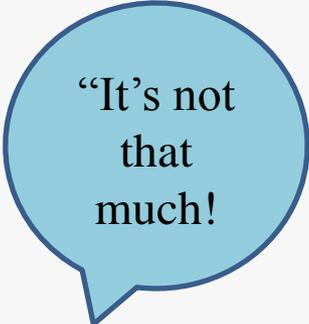
"Just eat."



"Are you trying to upset me?"



"Wow, that's a big meal!"



"It's not that much!"

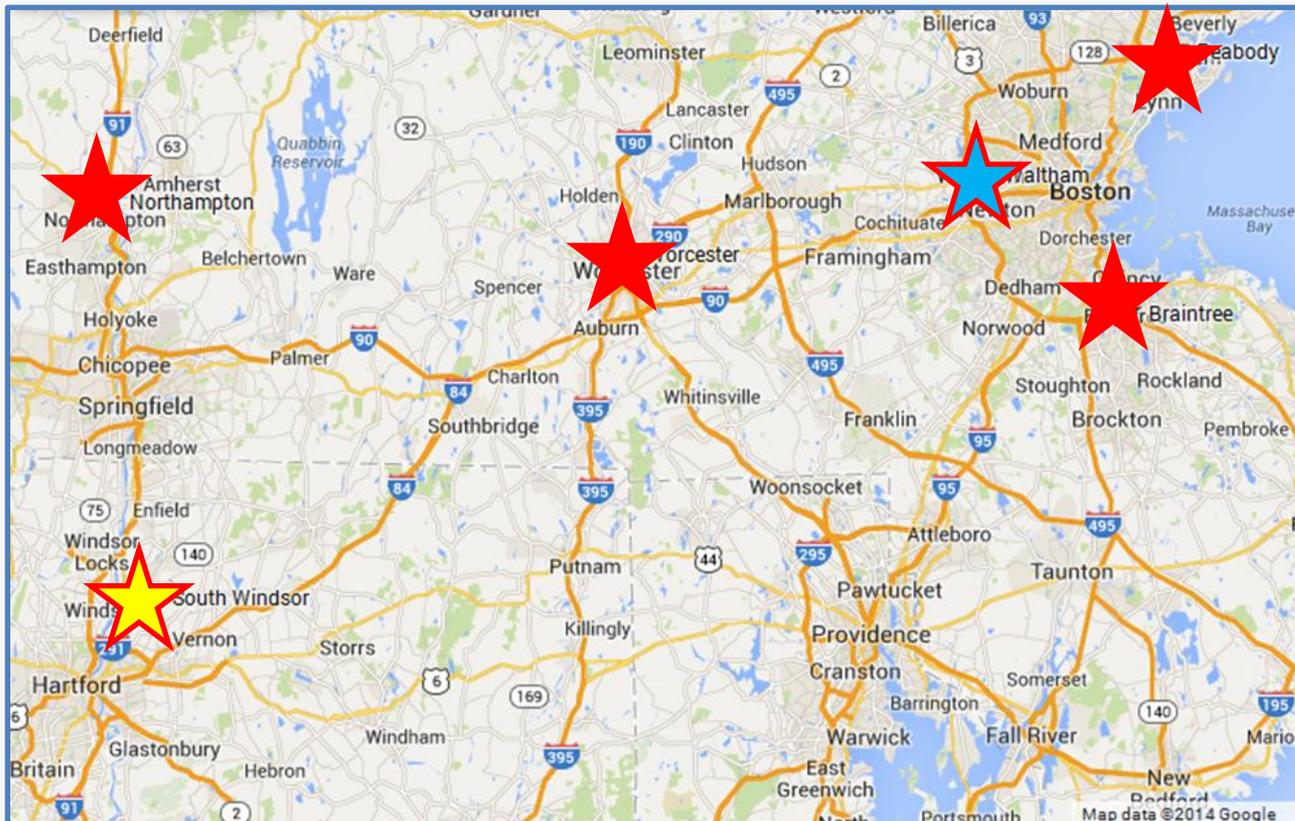
What Does Eating Disorder Treatment Look Like?

- **Inpatient:** person is in a hospital being monitored by doctors and nurses 24/7
 - Has severe medical complications due to the ED, unable to feed one's self
- **Residential:** 24/7 monitoring by staff with on-call nursing and doctors
 - Less severe than inpatient but must be out of home environment to break the ED cycle
- **Partial Hospitalization:** day treatment usually 5 days a week, person is living at home and going to program for part of the day
 - Person is able to feed themselves and participate somewhat in daily activities and life
- **Intensive Outpatient:** usually 3 days a week for 3 hours, also has an outpatient team
 - Person is able to engage in daily activities mostly but still needs monitoring by a treatment team
- **Outpatient:** person is able to participate in daily life activities and is working toward symptom free life
 - Outpatient providers consist of: therapist, primary care physician, dietitian and psychiatrist

Resources

- National Eating Disorders Association
 - www.Nationaleatingdisorders.org
- Binge Eating Disorder Association
 - www.Bedaonline.org
- Multi-Service Eating Disorders Association
 - www.Medainc.org
- Your Primary Care Physician or Therapist

Walden Locations



9 Hope Ave.
Suite 500
Waltham, MA 02453

62 Derby St.
Suite 6
Hingham, MA 02043

2 Corporation Way,
Suite 260
Peabody, MA 01960

150 Grossman Dr.
Suite 404
Braintree, MA 02184

335 Chandler St.
Worcester, MA 01602

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