Eating Disorders and Beyond:
NAADAC Alaska Training Institute
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"Unfortunately, in our culture, self-image and body image are inextricably entwined -- so it becomes extremely difficult to feel good about yourself when, every time you look in a mirror, you see only the negatives," Michelle May, MD
“Types” of Eating Disorders:

**DSM-5**
- Anorexia Nervosa: characterized by inability (not refusal) to maintain a healthy weight
- Bulimia Nervosa: characterized by binges followed by compensatory behaviors; a feeling of lack of control over food intake
- Eating Disorder Not Elsewhere Classified
- Binge-Eating Disorder: new to DSM-5

**Non DSM-5**
- Drunkorexia
- Diabulimia
- Orthorexia
- Anorexia Athletica
Anorexia Nervosa

A. **Refusal** Restriction of energy intake to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less then 85% of that expected) less than what is minimally normal or expected

B. Intense fear of gaining weight or becoming fat even though underweight or persistent behavior that interferes with weight gain

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial or persistent lack of recognition of the seriousness of the current low body weight.

D. In post-menarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)
In Anorexia

- For an anorexic, seeing food triggers fight/flight in the brain.
- Rather than food being comforting and needed for survival, it becomes anxiety-producing.
- Relationship between food and dopamine is skewed—food does not cause pleasure.
Key Point:

- ED patients frequently have high levels of anxiety and depression yet respond poorly to SSRI antidepressants.
- Research points to abnormal dopamine functioning in AN patients. Food is not as rewarding.
- Anorexia is the most deadly psychiatric disorder.
- Anorexia is more common in non-Hispanic females, but ED is seen in all ethnicities.
Bulimia Nervosa

A. Recurrent episodes of binge-eating. An episode of binge-eating is characterized by both of the following:
   1) Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
   2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
B. The binge-eating and inappropriate compensatory behaviors both occur, on average, at least twice once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
In Bulimia

- In bulimics, a full stomach produces increase anxiety that is only relieved by purging
- Vomiting is not the only form of purging
- In ED brains, perception of the body is skewed, leading to body dysmorphia
Physical Complications of BN

- Esophageal tears
- Gastrointestinal problems
- Constipation
- Swollen salivary glands
Binge-Eating Disorder:

A: Recurrent episodes of binge eating as characterized by:

1) Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B: The binge-eating episodes are associated with 3 or more:

1: Eating much more rapidly than normal

2: Eating until feeling uncomfortable full

3: Eating large amounts of food when not feeling physically hungry

4: Eating alone because of feeling embarrassed by how much one is eating

5: Feeling disgusted with oneself, depressed or very guilty afterward
Binge-Eating Disorder:

- C: Marked distress regarding binge eating is present
- D: The binge eating occurs, on avg., at least once a week for 3 months
- E: The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa

  
  **Mild**: 1-3 binge-eating episodes per week

  **Moderate**: 4-7 binge-eating episodes per week

  **Severe**: 8-13 binge-eating episodes per week

  **Extreme**: 14 or more binge-eating episodes per week
Eating Disorder-Not Otherwise Specified: Other Specified Feeding or Eating Disorder

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.

2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual’s current weight is in the normal range.

3. All of the criteria for Bulimia Nervosa are met except that the binge-eating and inappropriate compensatory mechanisms occur at a frequency of less than twice once a week or for a duration of less that 3 months. (Bulimia nervosa of low frequency and/or limited duration)

4. All of the criteria for Binge-eating Disorder are met except that the binge-eating and inappropriate compensatory mechanisms occur at a frequency of less than twice once a week or for a duration of less that 3 months. (Binge-eating disorder of low frequency and/or limited duration)

4. Purging disorder: Recurrent purging bx to influence weight of shape (vomiting, laxative/diruretic use) and the absence of binge-eating

5. Night eating syndrome: recurrent episodes of night eating, as manifested by eating after awakening from sleep or excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.
DSM-5 Changes for Eating Disorders

- “A persistent disturbance of eating or eating-related behaviors that result in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial function.”
- Same neural involvement of systems that involve self-control, reward; recognizing that these are not completely understood.
- Removed: Regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies.
- Removed: Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
- Cross-over occurs
Eating disorders are complex conditions that can arise from a variety of potential causes.

Once started they can create a self-perpetuating cycle of physical and emotional destruction.

- Scientists are still researching possible biochemical or biological causes of eating disorders.
- In some individuals with eating disorders, certain chemicals in the brain that control hunger, appetite and digestion have been found to be unbalanced.
- The exact meaning and implications of these imbalances remains under investigation.
Trends

- Drunkorexia
- Diabulimia
- Anorexia Athletica
- Orthorexia
Drunkorexia

- Self-imposed starvation or binge eating/purging combined with alcohol abuse
- More common in sorority & fraternity houses
- 30% of women don’t eat so that they can drink
Diabulimia

- Withholding insulin to manipulate or lose weight
  - Causes sugar to go into urine rather than the body
- Women with Type 1 diabetes are twice as likely to have an eating disorder as their non-diabetic peers.
- People with diabetes have to focus more on their food than others; food is more than just fuel and comfort
Orthorexia

- Refusing to touch sugar, salt, caffeine, alcohol, wheat, gluten, yeast, soya, corn and dairy
- Food that has contact with pesticides, herbicides or contain artificial additives are also out.
- Very rigid rules around food
Anorexia Athletica

Anorexia athletica, which literally refers to a loss of appetite caused by athletic activity, was identified by Dr. William Glasser in the 1970s. Dr. Glasser, who was studying long-distance runners at the time, coined the term “exercise addiction” to refer to the compulsive need for strenuous workouts.
EDs and Pregnancy

- Weight gain can be triggering
- Can be hard to insure adequate nutrition for the baby
- Can impair fetal development
RISK FACTORS FOR EATING DISORDERS:

- **Gender.** Teenage girls and young women are more likely than teenage boys and young men to have eating disorders.

- **Age.** Although eating disorders can occur across a broad age range - from preadolescents to older adults - they are much more common during the teens and early 20’s.

- **Family influence.** People who feel less secure in their families, whose parents and siblings may be overly critical, or whose families tease them about their appearance are at higher risk of eating disorders.

- **Emotional disorders.** People with depression, anxiety disorders and obsessive-compulsive disorder are more likely to have an eating disorder.

- **Dieting.** People who lose weight are often reinforced by positive comments from others and by their changing appearance. This dieting may be taken too far and lead to an eating disorder.

- **Transitions.** Whether it’s heading off to college, moving, landing a new job or a relationship breakup, change can bring emotional distress. One way to cope, especially in situations that may be out of someone’s control, is to latch on to something that they can control, such as their eating patterns, which can eventually lead to an eating disorder if taken to an extreme.
RISK FACTORS (CONT.)

- **Sports, work and artistic activities.** Athletes, actors and television personalities, dancers and models are at higher risk of eating disorders. Eating disorders are particularly common among ballerinas, gymnasts, runners and wrestlers. Coaches and parents may unwittingly contribute to eating disorders by encouraging your athletes to lose weight.

- **Media and society.** The media, such as television and fashion magazines, frequently focus on body shape and size. Exposure to these images may lead some people to believe that thinness equates to success and popularity.

Source: Mayo Clinic.com
Similar Traits in All Eating Disorders:

- Persistent lack of recognition or insight to their body: body dysmorphia
- Self-evaluation and self-esteem is based on body and/or food
- Guilt and shame about their body and/or food
- Preoccupation with food
- Avoidance of certain social events due to food
- Withdrawal from family and friends
Men and Eating Disorders:

- Estimated 35% percent of those with binge-eating disorder are male
- 6% of those will result in death
- Shame for men with Eating Disorders is intense “that’s something that happens to women”
- Just as women are experiencing more pressure to look a certain way or have a certain body, so are men.
- EDs in men/boys are often overlooked as providers do not associate EDs with males
Men and Eating Disorders

- 25-40% of people with eating disorders are males (Hudson, 2007).
- As many men as women want to change their weight (Andersen, 2000).
- Men engage in eating-disordered behaviors nearly as often as women (Mond, 2013).
- Eating disorders assessment tests underscore males (Darcy, 2014).
- Additionally, prevalence of eating disorders in males is greater than estimated because men are often too stigmatized to seek treatment for “women’s problems.” (Cohn, 2013)
Various studies suggest that risk of mortality for males with ED is higher than it is for females (Raevuoni, 2014).

Men with eating disorders often suffer from comorbid conditions such as depression, excessive exercise, substance disorders, and anxiety (Weltzin, 2014).
The desire for increased musculature is not uncommon:

- Crosses age groups
- 25% of normal weight males perceive themselves to be underweight (Atlantic, 2014)
- 90% of teenaged boys exercised with the goal of bulking up (Eisenberg, 2012)
- Among college-aged men, 68% say they have too little muscle (AOL body image survey).
Most males would like to be lean and muscular, which typically represents the ideal male body type.

Increased from the 1970s to 1990s (Labre, 2005). Exposure to these kinds of largely unattainable images leads to male body dissatisfaction (Blond, 2008).

The sexual objectification of men and internalization of media images predicts drive for muscularity (Daniel, 2010).
LGBT and Eating Disorders

- Lack of cultural awareness of this issue in the profession
- Lack of general support and understanding
- For lesbians: less likely to have body dissatisfaction but are more likely to have binge/purge habits
- For men: 7x more likely to binge and 12x more likely to purge than heterosexuals
- Even though gay men represent 5% of the male population, 42% of males with ED are gay.
- Non-white LGBTs have equal prevalence as white LGBTs
PTSD and self-harm

- An eating disorder is the ultimate form of self-harm
- A way to further express disgust with their body
- Typically around 25% of ED have cutting behaviors
- Another method of control and numbing
- Women are more likely to be self-harmers
- Treatment for EDs with PTSD will need to incorporate body work specific to the trauma/ED symptoms
Objectives of Treatment

- Learn how to follow a meal plan (NOT A DIET)
- Body Image work
- Alternative coping skills
- Understanding basic nutrition
- More understanding/insight about relationship with food
- Effects of eating disorders
- Learn to be more comfortable with eating
- Reducing/Eliminating eating disorder behaviors
Treatment Needs to Address:

- Body Image
- Self-Esteem
- Family Therapy
- Co-Occurring MH or CD
- Physical Health
  - Re-feeding
  - Nutritionist
- Healthy Exercise
By identifying where a person is in the change cycle, interventions can be tailored to the individual’s "readiness" to progress in the recovery process.

Interventions that do not match the person's readiness are less likely to succeed and more likely to damage rapport, create resistance, and impede change. Anything that moves a person through the stages toward a positive outcome should be regarded as a success.
For EDs

- It is not about the food…….the food functions as a manner of managing uncomfortable emotions.
- For this reason, treatment cannot just be about re-feeding and establishment of a healthy body weight
- For many in the field, ED is being considered a chronic, long-term illness (like addictions, diabetes, other chronic illness’) and requires life-long management
- Early intervention and long-term focused treatment are imperative
Barriers to Treatment

- Cost
- Insurance
- Availability of knowledgeable, capable programs & clinicians
- Patients must decide that the long-term benefits of recovery-based choices outweigh the short-term discomfort
- Clients may struggle with making this decision due to starved-brain or the delusional nature of ED
- Hard to agree it is a problem when the media says it isn’t....
What happens after treatment?

- Dietician
  - Create an evolving meal plan
- Medication and Medical Monitoring
- Aftercare
- ABA/EDA/OA
- Individual Counselor
- Adjunctive Counseling for MH or family
- Clients need specific ideas about how to change
  - Real-life practice: restaurant outing, meal selection, emotional regulation/distress, self-esteem, meal plan
  - Build self-esteem & self-efficacy
  - Establish healthy relationships with food and body
“What were you thinking?!?” Becomes “what were you feeling?”

When our beliefs are irrational,
Our thought patterns are irrational,
And our behavior frequently results in unexpected negative consequences.
Considerations for females

- Evolution: women have to value attractiveness in order to get a mate
- Dowry: women have been commodities to be sold/traded
- Women have to make themselves valuable to a potential husband
#1 wish for 11-17 year-old girls is to lose weight

- 53% of 13 year olds are unhappy with their body
- 78% of 18 year-old females are unhappy with their bodies
- Women are 3x more prone to anorexia and bulimia, and 75% more apt to have a binge eating disorder.

- 100 years ago: average age of menarche was 14.....now it is 12
- 1970s: breast development typically began at 11.
- 1997: breast development typically begins at 10 for Caucasian girls and 8-9 for African-Americans
Barriers to change/treatment

- Body dis-satisfaction has become the new “normal”
- Dieting is a “rite of passage”
- Beauty=value and a form of currency & competition
- It is code for our repressed feelings---uncomfortable, uncertain, unhappy, scared, guilt, shame
- Fat=code for bad or unhappy
- Devaluing female bodies has become a pastime
Society’s standard of Beauty

- First runway models were 155lbs
- First Miss America (1922) was 5’7” and 140 pounds
- Average Woman is 5’4” and 165lbs
- Average Miss America winner is 5’7” and 121lbs
- Average BMI of Miss America is 16.9 (WHO says normal BMI is between 18.5-24.9)
  - Only 2% of women worldwide fall into the “super model” range
What is “normal” consumption??

- Food & Alcohol are normal and accepted facets of our culture.
- What is “normal eating?”
- What is “healthy eating?”
- What is “good” or “clean” food?
- What is “bad” or “dirty” food?
- Who decides this?
Prevalence and Prevention (2011):

- Alzheimer’s: prevalence of 5.1 million
  - $450,000,000
- Autism: 3.6 million
  - $160,000,000
- Schizophrenia: 3.4 million
  - $276,000,000
- Eating Disorders 30 million
  - $28,000,000

Amount spent per affected patient on research:

- Alzheimer’s: $88
- Schizophrenia: $81
- Autism: $44
- Eating Disorders: $0.93
Thank You!

Questions and Discussion

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And I said to my body, softly.
‘I want to be your friend.’
It took a long breath. And replied,
‘I have been waiting my whole life for this.’
-Nayyirah Waheed