Eating Disorders: What Professionals Need to Know

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Disclosures:
We, Whitney Chappell, Jennifer Buckwash, and Tracie L. Pasold, have no disclosures related to real or apparent conflict of interest regarding the content of our presentation.

Topics to be Covered
• Overview of eating disorders, including DSM5 criteria, epidemiology, comorbidities.
• Medical complications of eating disorders.
• Etiology/risk factors associated with eating disorders.
• Eating disorders and Males.
• Treatment approaches.
• Prevention efforts; How loved ones can be supportive; personal story of recovery from an eating disorder shared by one of the workshop co-educators.
Overview of eating disorders, including DSM5 criteria, epidemiology, comorbidities

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Eating Disorders Impact all Systems of the Body and Cause Serious Medical Complications

Eating Disorders: A Guide to Medical Care and Complications
Medical Complications: Anorexia

- Cardiac problems
- Low heart rate
- Low blood pressure
- Shrinkage of the muscle
Medical Complications: Anorexia

• Osteopenia; osteoporosis

Medical Complications: Anorexia

• Muscle loss and weakness

Medical Complications: Anorexia

• Dehydration that, if chronic, can impact the heart, kidneys, brain
Medical Complications: Anorexia

• Dizziness, Fatigue, fainting
• Dry skin and hair, hair loss, brittle nails
• Growth of lanugo

Medical Complications: Anorexia

• Endocrine Problems
  • Thyroid abnormalities (metabolism, growth/development, body temp)
  • High cortisol
  • Abnormal glucose metabolism (Hypoglycemia, low blood sugar)
  • Alterations in growth hormone and insulin like growth factor – 1 (could stunt growth/height)
  • Amenorrhea

Medical Complications: Anorexia

• Constipation, decreased intestinal motility
• Delayed gastric emptying leading to early satiety and bloating
• Gastroesophageal reflux
• Cold intolerance
• Acrocyanosis
Medical Complications: Anorexia

• Orthostatic hypotension
• Headaches
• Decrease in brain mass (larger ventricles, decrease in grey matter)

Medical Complications: Bulimia

Medical Complications: Bulimia

• Swollen salivary glands (parotids)
Medical Complications: Bulimia

- Tooth enamel erosion, cavities

![Image of tooth enamel erosion and cavities]

Medical Complications: Bulimia

- Dehydration
- Electrolyte abnormalities:
  - Potassium, sodium, chloride, phosphorus, magnesium, calcium
- Can lead to cardiac problems and sudden cardiac arrest

Medical Complications: Bulimia

- Gastroesophageal reflux
- Sore throat, damage to vocal cords
- Esophagitis – precursor to Barrett’s esophagus
- Peptic ulcer disease (ulcers in the stomach)

Table 1. Electrolyte levels usually associated with vomiting, laxative abuse, and diuretic abuse

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<thead>
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<th>Method of Inducing</th>
<th>Sodium</th>
<th>Potassium</th>
<th>Chloride</th>
<th>Bicarbonate</th>
<th>pH</th>
<th>Sodium</th>
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*Note: Table adapted from "Medical complications of bulimia nervosa and their treatments," by P.S. Mehler, International Journal of Eating Disorders, 47:95-104. Copyright 2011 by John Wiley & Sons.*
Medical Complications: Bulimia

- Pancreatitis
- Cathartic colon syndrome

Medical Complications: Binge Eating Disorder
Medical Complications: Binge Eating Disorder

- High blood pressure
- High cholesterol
- Heart disease
- Diabetes mellitus
- Gallbladder disease

Eating Disorders: Mortality

- Highest of all psychiatric illnesses
- Up to 25% die
  - High rates of Suicide
    - Death from suicide 50 times more likely in AN patients; 1 in 5 deaths is by suicide
    - Rates similar for BN; 25-35% of BN patients report suicide attempts
  - Medical complications also result in death


Mortality

- Predictors of Mortality:
  - Older age at onset
  - Substance abuse
  - History of self-harming behaviors
  - Lower BMI at intake
  - Comorbid psychiatric conditions
  - History of psychiatric hospitalization
Etiology/risk factors associated with eating disorders

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Can we determine if someone has an eating disorder by looking at them?
Males and Eating Disorders: Are they *that* different from their female counterparts?

**Male Presentation**

- Descriptions of AN in *males* recorded as early as late 1600s early 1700s (Silverman, 1990)
- Up to 30% of AN and BN cases are males (Hudson, Hiripi, Pope, & Kessler, 2007)
- Much of Etiology detailed earlier applies to males (e.g., genetics, perfectionism, cognitive inflexibility, stress, obsessive-compulsive tendency, comorbid anxiety/depression) (Goddard, Carral-Fernández, Denneny, Campbell, & Treasure, 2014)
- Male presentation of AN or BN is similar to that of females

**Male Presentation**

- Males with Anorexia may differ from females:
  - More likely to report history of a history of overweight status, childhood obesity
  - Older age of onset?
  - Often report dieting impetus to avoid medical complications (Gueguen et al., 2012)
  - Twin or triplet status and lower gestational age at birth correlate with AN (Raevuori, Keski-Rahkonen, & Hoek, 2014)
  - Tend to score lower on ED sx measures despite equally severe pathology (Darcy et al., 2012)
Male Presentation

• Body image presentation may differ
  • Drive for thinness or drive for muscularity?
  • Gender role orientation can be a risk factor (Griffiths, Murray, Touyz, 2015; Murray, Rieger, Karlov, & Touyz, 2013):
    • Masculine gender role orientation = drive for muscularity and muscle dysmorphia presentation
    • Feminine gender role orientation = drive for thinness and Anorexia presentation
  • Males with feminine gender role orientation have higher prevalence of ED sx than masculine or androgynous (Pritchard, 2008)

Muscle Dysmorphia

• Intense drive for muscularity and leanness
  • Presentation very similar to ED (AN)
    • Excessive exercise; rigid routine
    • Extreme dieting; preoccupation with food/eating
    • Extreme guilt, anxiety followed by compensatory bxs if exercise/eating routine not followed
    • Body dissatisfaction; Excessive body checking
    • Use of body enhancing substances
  (Mosley, 2009; Murray, et al., 2012; Murray, Rieger, Touyz, & de la Garza, 2010)

Main difference between AN and muscle dysmorphia:
  • “Reverse Anorexia” – reverse body image psychopathology
  • Body image distortion of appearing small and thin despite actual muscularity
  • Debate regarding this dx as ED, OCD, or Body Dysmorphic Disorder spectrum (Murray, Rieger, Touyz, & de la Garza, 2010)
Testosterone as a Risk Factor

- Testosterone levels have been found to predict risk for eating pathology (Culbert, Burt, Sisk, Nigg, & Klump, 2014):
  - Prenatal testosterone exposure associated with lower risk
  - Higher levels of circulating testosterone during and after puberty associated with lower risk

Homosexuality as a Risk Factor

- Homosexuality among males has been found to account for significant variance in scores on measures of ED sx (Matthews-Ewald, Zullig, & Ward, 2014; Morgan, 2008; Russell & Keel, 2002).
  - Controlling for prominent factors such as depression, self-esteem, comfort with sexual orientation, athlete status
  - ED sx increase 10xs among gay and bisexual males compared to heterosexual males (Strong, Williamson, Netemeyer, & Geer, 2000).

- Both elevated drive for thinness (Kaminski, Chapman, Haynes, & Own, 2005) and drive for muscularity (Yolland & Tiggemann, 2003) have been found among gay males
  - ED sx and weight loss may function to alleviate sexual orientation confusion (Morgan, 2008)
  - Gender role orientation more strongly correlated with ED sx than homosexuality
Media as a Risk Factor

- Conclusions:
  - Successive increase in musculature across these years
  - Unrealistic, unattainable smaller waists with large chests and biceps
  - Male models estimated to have lost 12 pounds of fat and gained 27 pounds of muscle over the period of 25 years
Media as a Risk Factor

- Magazine models and advertisements focus on appearance ideal and how to achieve it
Modeling pressures to be thin also exist...
Media as a Risk Factor

- Media’s increased focus on males and muscularity has contributed to increased depression and body image dissatisfaction among males (Halliwell, Dittmar, & Onsborn, 2007).
- Body dissatisfaction highly correlated with AN and body dysmorphic disorder in males

Body Image as a Risk Factor

- Male body dissatisfaction prevalence comparable to that of females (Frederick et al., 2007)
  - Desire for “larger” physique though some also strive for thinness
  - Up to 90% of college aged males may experience body dissatisfaction
  - Boys as young as age 6 report desire for more muscle

Body Image as a Risk Factor

- Moderators of the relationship between body dissatisfaction and ED sx’s:
  - Poor impulse control, social anxiety, internalization of the media depicted body ideal (Dakanalis et al., 2015a)
- Moderators between body dissatisfaction and drive for muscularity and bulimic behaviors:
  - Emotion dysregulation, body checking, perfectionism, insecure-anxious attachment style (Dakanalis et al., 2015b)
Assessment

- Eating Disorder Assessment for Men (EDAM) (Stanford & Lemberg, 2014), 50 items assessing food issues, weight concerns, body image, exercise, disordered eating behaviors
- Drive for Muscularity Scale (McCreary & Sasse, 2000), 15 items assessing attitudes and behaviors related to muscularity
- Male Body Image Concerns Scale (Weisman et al., 2012), 6 items assessing body image concerns
- Male Body Checking Questionnaire (Hildebrandt, Walker, Alfano, Delinsky, & Bannon, 2010), 19 items assessing body checking behaviors

- Body Change Inventory (Ricciardelli & McCabe, 2002), 60 items assessing strategies used to change body and muscle size
- Exercise Dependence Scale-21 (Hausenblas & Symons Downs, 2000), 21 items assessing exercise behaviors and dependence
- Appearance and Performance Enhancing Drug Use Schedule (Hildebrandt, Langenbucher, Lai, Loeb, & Hollander, 2011), 210 items assessing appearance and performance enhancing drug use

Treatment

- Interventions for males should include treatment approaches used for females
- Assess issues specific to the male patient and tailor treatment accordingly (Strother, Lemberg, Stanford, & Turberville, 2012)
- Males with EDs tend to feel that society views ED as a female issue (Robinson et al., 2012)
- All male treatment environment is recommended (Weltzin et al., 2014)
- Multidisciplinary treatment team is ideal; associated with remaining in treatment longer
References


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Discussion/Questions