The Emily Program

The Multidimensional Nature of Eating Disorders

Keri Clifton
Outreach Manager
Prevalence in Minnesota

Estimated 202,357 Minnesotans struggle with an eating disorder

- **MN Adult (18-65 yrs old) Specific Data:**
  - 2.8% of 1,645,270 males in MN; that’s **46,067 men** in MN
  - 5.9% of 1,678,711 females in MN; that’s **99,044 women** in MN
  
  **Total: 145,111 MN Adults Struggle with an Eating Disorders**

- **MN ADOLESCENT (10-17 yrs old) specific data:**
  - 14.6% of 267,097 adolescent females in MN; that’s an estimated **38,996** adolescent females in MN
  - 6.5% of 280,762 adolescent males in MN; that’s an estimated **18,250** adolescent males in MN
  
  **Total: 57,246 MN Adolescents Struggle with an Eating Disorders**
In Treatment We Are Trying To Help Individuals...

• Eat and be active in tune with the body’s needs
• Eat when hungry and stop when satisfied
• Eat a variety of foods without a fear of fat
• Focus on health
• Appreciate the body
• Think critically about media
• Employ many coping skills
Types of Eating Disorders (DSM V)

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- OSFED
  - Atypical AN
  - Sub BN
  - Sub BED
  - Purging Disorder
  - NES
DSM-5: Anorexia Nervosa

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

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 persistent lack of recognition of the seriousness of the current low body weight.

Specify current type:

- Restricting Type: during the last three months, the person has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
- Binge-Eating/Purging Type: during the last three months, the person has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
DSM-5: 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 (for example, 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 (for example, 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, or other medications, fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least 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.
DSM-5: Binge Eating Disorder

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 (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances

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

B. The binge-eating episodes are associated with three (or more) of the following:

   (1) eating much more rapidly than normal
   (2) eating until feeling uncomfortably 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 afterwards

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for three months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.
DSM-5: Other Specified Feeding and Eating Disorders

• Atypical Anorexia Nervosa
  — All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual’s weight is within or above the normal range.

• Subthreshold Bulimia Nervosa (low frequency or limited duration)
  — All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than for 3 months.

• Subthreshold Binge Eating Disorder (low frequency or limited duration)
  — All of the criteria for Binge Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than for 3 months.

• Purging Disorder
  — Recurrent purging behavior to influence weight or shape, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, in the absence of binge eating. Self-evaluation is unduly influenced by body shape or weight or there is an intense fear of gaining weight or becoming fat.
<table>
<thead>
<tr>
<th>Weight control Practices:</th>
<th>Healthy eating behaviors</th>
<th>Dieting</th>
<th>Unhealthy weight control</th>
<th>Anorexia or Bulimia Nervosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical activity behaviors:</td>
<td>Moderate physical activity</td>
<td>Minimal or excessive activity</td>
<td>Lack of, or obsessive, physical activity</td>
<td>“Anorexia athletica”</td>
</tr>
<tr>
<td>Body image:</td>
<td>Body acceptance</td>
<td>Mild body dissatisfaction</td>
<td>Moderate body dissatisfaction</td>
<td>Severe body dissatisfaction</td>
</tr>
<tr>
<td>Eating behaviors:</td>
<td>Regular eating patterns</td>
<td>Erratic eating behaviors</td>
<td>Binge eating</td>
<td>Binge eating disorder</td>
</tr>
<tr>
<td>Weight status:</td>
<td>Healthy body weight</td>
<td>Mildly overweight or underweight</td>
<td>Overweight or underweight</td>
<td>Severe overweight or underweight</td>
</tr>
</tbody>
</table>

SIGNS AND SYMPTOMS OF EATING DISORDERS

In your interactions, you may notice one or more of the physical, behavioral, and emotional signs and symptoms of eating disorders.

**Physical**
- Weight loss or fluctuation in short period of time.
- Abdominal pain.
- Feeling full or “bloated.”
- Feeling faint, cold, or tired.
- Dry hair or skin, dehydration, blue hands/feet.
- Lanugo hair (fine body hair).

**Behavioral**
- Dieting or chaotic food intake.
- Pretending to eat, then throwing away food, eating in secret, hiding food, disrupting meals.
- Exercising for long periods of time.
- Constantly talking about food.
- Frequent trips to the bathroom.
- Wearing baggy clothes to hide a very thin body.
- Purging; restricting; binge eating; compulsive eating; compulsive exercising; abuse of diet pills, laxatives, diuretics, or emetics.

**Emotional**
- Complaints about appearance, particularly about being or feeling fat.
- Sadness or comments about feeling worthless.
- Perfectionist attitude.
Comorbidities

- Major depression
- Generalized Anxiety Disorder
- Panic disorder
- Suicidal ideation
- Self injury
- Binge drinking
- Nicotine and marijuana use
- Frequent exercise for females
People with eating disorders come in all sizes
Why do people get eating disorders?

Bio-Psychosocial Model of Eating Disorders

**biology**
- Food restriction
- Genetics
- Physical changes
- Puberty/Menopause
- Neurotransmitters

**psychology**
- Stressors
- Identity/self-image
- Personality factors
- Perfectionism
- Depression
- Coping

**social/environment**
- Cultural factors
- Pressure to “fit in”
- Normalization of dieting
- Media
Onset of Illness

- Age 10 or younger: 10%
- After age 20: 14%
- Ages 11-15: 33%
- Ages 16 to 20: 43%

Duration of Illness

- 1-5 years: 30%
- 6 to 10 years: 31%
- 11 to 15 years: 16%

*National Association of Anorexia Nervosa and Associated Disorders ten year study*
Medical Complications

- heart rate < 40 bpm
- blood pressure <90/60 mm Hg or orthostatic hypotension
- with pulse increase of 20 bpm or bp drop of >10-20 mm Hg/minute from lying to standing
- glucose < 60 mg/dL
- potassium < 3 mEq/L or other critical electrolytes
- temp < 97.0° F
- Dehydration
- poorly controlled diabetes
- high suicide risk
- Amenorrhea
- Bradycardia
- unexpected osteopenia or osteoporosis
Worried about Someone?

Start the conversation. If you suspect someone is struggling with eating disorder behaviors, ask if it is okay to discuss his or her eating habits. For example, “I’m concerned about your eating. May we discuss how you typically eat and your relationship with food?”

Ask more questions. These 6 assessment questions can help assess the situation. (Adapted from the SCOFF Questionnaire by Morgan, Reid & Lacy)

– Do you feel like you sometimes lose or have lost control over how you eat?
– Do you ever make yourself sick because you feel uncomfortably full?
– Do you believe yourself to be fat, even when others say you are too thin?
– Does food or thoughts about food dominate your life?
– Do thoughts about your body or weight dominate your life?
– Have others become worried about your weight and/or eating?

Give feedback. In this informal survey, 2 or more "yes" answers strongly indicate the presence of disordered eating. Refer as needed.
A Comprehensive Assessment

Assess
- Rate and amount of weight loss/change
- Nutritional status
- Methods of weight control

Review
- Compensatory behaviors
- Dietary intake and exercise
- Menstrual history in females (hormone replacement therapy including oral contraceptive pills)
- Comprehensive growth and development history, temperament, and personality traits

Physical Examination
- Supine and standing heart rate and blood pressure
- Respiratory rate
- Oral temperature (looking for hypothermia)
- Height, weight, growth charts for children and adolescents, nothing changes from previous measurements

Laboratory Evaluation
- Lab and imaging studies suggested can be found in AED’s Report 2011 – Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders

AED’s Report– Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders
Timely Interventions

• Patients with EDs may not recognize that they are ill and/or they may be ambivalent about accepting treatment. This is a symptom of their illness.

• Parents/guardians are the frontline help-seekers for children and adolescents with EDs. Trust their concerns.

• Help families understand that they did not cause the illness; neither did their child/family member choose to have it. This minimizes undue stigma associated with the disease.

• Monitor physical health including vital signs and laboratory tests.

• **AED’s Report—Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders**
Treatment

• Assessment
• Treatment can look a lot of ways:
  – Residential, or 24 hour care
  – Use of multi-disciplinary team including therapist, a dietitian, and a doctor
  – attending a group for an hour or for most of the day
• Treatment is dependent on what the person needs
• Family involvement in the treatment process is especially important
• Insurance
### Who does what, when, and how often?

<table>
<thead>
<tr>
<th><strong>DIETITIAN</strong></th>
<th><strong>THERAPIST</strong></th>
<th><strong>PHYSICIAN</strong></th>
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<tbody>
<tr>
<td>• Meal Planning</td>
<td>• Assesses/treats symptoms of related diagnoses (anxiety, depression)</td>
<td>• Medical monitoring and treatment of medical conditions related to ED</td>
</tr>
<tr>
<td>• Nutrition Education</td>
<td>• Monitor and address suicidal thoughts/self-injury</td>
<td>• Medication monitoring</td>
</tr>
<tr>
<td>• Establishment of wt range</td>
<td>• Explore etiology and maintaining factors of ED</td>
<td>• Weight monitoring</td>
</tr>
<tr>
<td>• Education regarding physical aspects of ED</td>
<td>• Body image</td>
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Empirically Supported Treatments for Eating Disorders

• Cognitive Behavior Therapy-Enhanced
• Dialectical Behavioral Therapy
• Family Based Therapy (Maudsley)
Recovery

• Recovery from an eating disorder is possible; people do get better.
  – Recovery is different for everyone

• People can be in treatment for awhile; it takes time.

• Even if someone “looks” better it doesn’t mean they really are. You can’t judge recovery based on looks.
“War” on Obesity

I don’t care what it said when you looked up your symptoms on the internet... you are not anorexic.

© Original Artist
“It is clear from reading magazines or watching television that public derision and condemnation of fat people is one of the few remaining sanctioned social prejudices in this nation freely allowed against any group based solely on appearance.”

Weight must be considered in context

There are 3 billion women who don’t look like supermodels and only 8 who do.
Health at Any Size

- Body fat can be beneficial
- Fat *in* the arteries and fat *on* the body are different and not necessarily related
- Men/women classified as “overweight” who exercise regularly and are physically fit have lower all-cause death rates than thin men/women who do not exercise
- Weight loss does not necessarily improve health or lengthen life
- “Thinner is better” – body weight is fairly unrelated to health status and death
Focus on Health

Resist the urge to diet. DIETS DON’T WORK IN THE LONG RUN and are a risk factor for eating disorders.
Rethinking Relationships with Food and Body Image

Recommendations on how to help teenagers maintain a healthy lifestyle without increasing risk for an eating disorder from Dianne Neumark-Sztainer PhD, MPH, RD

- Talk less, do more
- Losing weight does not necessarily mean improving health
- Model the behavior
- Encourage family meals and changes to the whole family's diet
- Keep the focus on overall health, not weight
- Ensure the person knows he/she has worth regardless of their weight
- Change language used around children’s weight
Normal Eating

“In short, normal eating is flexible. It varies in response to your hunger, your schedule, your proximity to food and your feelings.”

- Ellyn Satter, RD
Contact Information:

keri.clifton@emilyprogram.com
651.645.5323 ext. 1168

RESOURCES:

www.aedweb.org
www.eatingdisorderscoalition.org
www.tcme.org
www.mollykellogg.com
www.about-face.org
www.something-fishy.org

LOCATIONS
Washington
Minnesota
Ohio
Pennsylvania