Eating Disorders

Presented by

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Chapter 1: Eating Disorders

Retrieved from: National Institute of Mental Health, Eating Disorders: https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml

Retrieved from: National Institute of Mental Health, Eating Disorders: More than food: https://www.nimh.nih.gov/health/publications/eating-disorders/index.shtml

A. Introduction

There is a commonly held misconception that eating disorders are a lifestyle choice. Eating disorders are actually serious medical illnesses and often fatal illnesses that are associated with severe disturbances in people's eating behaviors and related thoughts and emotions. Obsessions with food, body weight, and shape may be signs of an eating disorder. These disorders can affect a person's physical and mental health; in some cases, they can be life-threatening. But eating disorders can be treated. Learning more about them can help you spot the warning signs and seek treatment early. Common eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

Remember: Eating disorders are ***not*** a lifestyle choice. They are biologically-influenced medical illnesses.

Who is at Risk for Eating Disorders?

Eating disorders can affect people of all ages, racial/ethnic backgrounds, body weights, and genders. Although eating disorders often appear during the teen years or young adulthood, they may also develop during childhood or later in life (40 years and older).

Remember: People with eating disorders may appear healthy, yet be extremely ill.

The exact cause of eating disorders is not fully understood, but research suggests a combination of genetic, biological, behavioral, psychological, and social factors can raise a person's risk.

What Are the Common Types of Eating Disorders?

Common eating disorders include **anorexia nervosa**, **bulimia nervosa**, and **binge-eating disorder**. If you or someone you know experiences the symptoms listed below, it could be a sign of an eating disorder—call a health provider right away for help.

What is Anorexia Nervosa?

People with anorexia nervosa avoid food, severely restrict food, or eat very small quantities of only certain foods. People with anorexia nervosa may see themselves as overweight, even when they are dangerously underweight. They may also weigh themselves repeatedly. People with anorexia nervosa typically wigh themselves repeatedly, severely restrict the amount of food they eat, often exercise excessively, and/or may force themselves to vomit or use laxatives to lose weight. Anorexia nervosa has the highest mortality rate of any mental disorder. While many people with this disorder die from complications associated with starvation, others die of suicide.

There are two subtypes of anorexia nervosa: a *restrictive* subtype and *binge-purge* subtype.

Restrictive: People with the restrictive subtype of anorexia nervosa place severe restrictions on the amount and type of food they consume.

***Binge-Purge*:** People with the binge-purge subtype of anorexia nervosa also place severe restrictions on the amount and type of food they consume. In addition, they may have binge eating and purging behaviors (such as vomiting, use of laxatives and diuretics, etc.).

Symptoms include:

- Extremely restricted eating and/or intensive and excessive exercise
- Extreme thinness (emaciation)
- A relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight

- Intense fear of gaining weight
- Distorted body image, a self-esteem that is heavily influenced by perceptions of body weight and shape, or a denial of the seriousness of low body weight

Other symptoms may develop over time, including:

- Thinning of the bones (osteopenia or osteoporosis)
- Mild anemia and muscle wasting and weakness
- Brittle hair and nails
- Dry and yellowish skin
- Growth of fine hair all over the body (lanugo)
- Severe constipation
- Low blood pressure slowed breathing and pulse
- Damage to the structure and function of the heart
- Brain damage
- Multiorgan failure
- Drop in internal body temperature, causing a person to feel cold all the time
- Lethargy, sluggishness, or feeling tired all the time
- Infertility

Anorexia Can Be Fatal. Anorexia nervosa has the highest mortality (death) rate of *any* mental disorder. People with anorexia may die from medical conditions and complications associated with starvation; by comparison, people with others eating disorders die of suicide.

What is Bulimia Nervosa?

People with bulimia nervosa have recurrent and frequent episodes of eating unusually large amounts of food and feeling a lack of control over these episodes. This binge-eating is followed by behaviors that compensate for the overeating, such as forced vomiting, excessive use of laxatives or diuretics, fasting, excessive exercise, or a combination of these behaviors. Unlike those with anorexia nervosa, people with bulimia nervosa may maintain a normal weight or be overweight.

Symptoms include:

- Chronically inflamed and sore throat
- Swollen salivary glands in the neck and jaw area
- Worn tooth enamel and increasingly sensitive and decaying teeth (a result of exposure to stomach acid)
- Acid reflux disorder and other gastrointestinal problems
- Intestinal distress and irritation from laxative abuse
- Severe dehydration from purging
- Electrolyte imbalance (too low or too high levels of sodium, calcium, potassium and other minerals), which can lead to stroke or heart attack

What is Binge Eating Disorder?

People with binge-eating disorder lose control over their eating. Unlike bulimia nervosa, periods of binge-eating are not followed by purging, excessive exercise, or fasting. As a result, people with binge-eating disorder are often overweight or obese. Binge-eating disorder is the most common eating disorder in the U.S.

Symptoms include:

- Eating unusually large amounts of food in a specific amount of time, such as a 2-hour period
- Eating even when you're full or not hungry
- Eating fast during binge episodes
- Eating until you're uncomfortably full
- Eating alone or in secret to avoid embarrassment
- Feeling distressed, ashamed, or guilty about your eating
- Frequently dieting, possibly without weight loss

B. Stories of Hope

Taylor Engle and Her Story: How to Take Your Life Back – Recovering from Anorexia

Retrieved from: https://www.eatingdisorderhope.com/blog/taylor-engle-story-how-take-life-back-recovery-anorexia

The first thing I noticed was the colors. The world, for so long a dull figment of my affinity for the dark and misunderstood, was forcing me to drink in its presence. And I did. At that point, it was my only hope. I drove to school in bewilderment. I was not concerned or thinking about any type of recovery.

I had spent the past three years convinced I saw the world sharper than ever, but two days of consistent carbs had changed my perspective entirely. The greenness of the leaves, the endless blue sky, the splashes of CSUF orange on the passing students. Spring and all of its earnestness. Cars' engines roared invigoratingly, forcing me to confront the fact that life was all around me. It had never stopped.

After parking my car illegally and forcing another fist full of almonds down my throat, I was electrified. I burst out into the balmy air and headed towards campus with more energy than I'd been capable of in years.

I was a little early for class, so I decided to sit on a bench, force another snack (very restricted), and people-watch. The students were fascinating to me; I felt like I'd never noticed them before.

They were going about their complex, vibrant lives out loud and in public. They were eating and laughing and yelling and making plans for the weekend. Meanwhile, I was sitting on a bench fervently eating a browning apple.

I became aware of how "other" I was. I'd known all along, but this time I didn't feel special for it. It hit me that I wasn't always so foreign to everyday life. I never thought it would be something I would have to grasp at understanding again, but suddenly I was willing to try.

The first time I admitted that I was anorexic was to myself, in the privacy of my bedroom. My mother and other concerned parties had approached me on the subject countless times over the past few years, but I had always laughed it off.

Of course, I wasn't anorexic! If I was, how would I have the energy to work out five hours a day? Although my meals were severely restricted, the fact that I still had three a

day felt like proof that I was “just fine.” I had no knowledge of eating disorders and the many different shapes and sizes they come in, or that I suffered from both anorexia and crippling exercise addiction.

While scrolling through food Instagram, a nightly ritual to help satiate my hunger (nonsensical, I know), I stumbled across a profile that caught my eye. It was filled with pictures of unorthodox meals that looked dangerously close to my everyday fare–not exactly on par with an experienced food blogger. After taking a closer look at the bio and captions, I realized this was the profile of someone in anorexia recovery. A sort of food diary for her to vent and hold herself accountable.

I tore through her captions, hungry for information. It struck me that I related to almost everything she had to say; I felt like it was something I’d written. But it was another six months of self-abuse before severe heart palpitations drove me to Urgent Care and forced me to face the truth: I couldn’t keep doing this for the rest of my life.

Growing up in a family with a history of vices, the word “recovery” for me was always synonymous with alcoholism or drug addiction. I figured I had done everything to avoid that fate for myself: I worked full time and kept a tight schedule. I was a senior in undergrad about to earn my degree. I didn’t get in trouble, and I didn’t make mistakes. I was a golden child, above the chains of mortality.

The first thing I felt when I realized I was in desperate need of recovery was a burning shame. As I’m sure you’ve gathered by now, I spent most of my life aiming for perfection, and this was raw, ugly. I’d never heard of anyone recovering from an eating disorder before, and it was something I had no idea how to navigate.

I was utterly aware of how common relapse was, according to the online community. Feeling unable to trust myself and desperate to get better, I made the decision to go public about my eating disorder.

Everyone’s approach to recovery is different. I chose to do it on my own. I knew myself: much too stubborn to listen to anyone, and going inpatient somewhere would only result in relapse.

However, I also knew I couldn’t fully trust myself to make the right decisions for my recovery, so I compromised by seeing a therapist. I also made the irrevocable decision to go public about my struggles. I was embarrassed to be so vulnerable, but I was

terrified of myself and knew it would hold me accountable in the future if I ever started to slip.

I was wrong on both accounts. Any embarrassment I was feeling came and went within the first minute of posting the photos, and then the comments started to flood in. Childhood friends, family members, acquaintances, and strangers alike were voicing their support and lauding me for my bravery.

From then on, I wouldn't merely be held accountable. I would be constantly reminded of my resilience, overwhelmed by the amount of love in my life and, most importantly, confided in by others who felt heard for the first time–much like I had so many months before.

Recovery is the most difficult thing I've ever had to overcome. It forced me to give in to desire. People who adopt eating disorders don't just do so to become skinny–we want control. No, we need control. And above all else, we need to not need. We're after independence, success, power, and we believe the only way we can do this is by restricting. The world is not going to hold us back ever again–we already have that covered.

Admitting to my hunger was the ultimate disgrace, especially because my body was craving so much. Several years of toying with my health came back to bite me. My body didn't trust me anymore, and so it held onto every ounce I fed it with avid desperation. After three years without one, my period came back. Every 2-3 weeks, for the first year. The hormones were raging even harder than they had the first time around at age 12. I felt like I couldn't keep my head on straight.

My memory was shit. My brain felt scrambled at best and damaged at worst. My appetite was fucking insatiable, for months and months and months on end. I was sweaty, tired, hungry, thirsty, confused, exhausted, terrified, embarrassed, and proud of myself on a daily basis. It was difficult to focus on a single task. I couldn't watch a heartfelt scene on TV without bursting into tears.

My moods transformed within minutes. These symptoms, among several others, persisted for over two years. The only thing that kept me going was the fact that, although nothing was easy, it was getting the tiniest bit easier day by day. I felt like it was too late to go back, so I forged on.

I began to challenge myself, taking myself out to lunches and dinners, and facing the menu with determination. I devoured greasy food with coworkers, going back for seconds. My roommates and I made giant meals together; eating with them eased the pain of the action.

I started to feel normal again. Eating became a bonding experience–a beautiful tradition, the world's language. I put away six pieces of toast at a time, convincing myself I was nourishing with every bite. I figured things couldn't get any worse, so I might as well do my best.

Research (and my therapist at the time) dictates that it typically takes as long as you were suffering to recover. March 4, 2020, marks the third anniversary of my decision to recover and signals my arrival at "full recovery," which has me reflecting on my journey.

I wanted to relapse so many times. I never want to understate that fact, or the general agony of recovery. I felt like a petulant child most days, incapable of interacting with the world. Socially, I had to start over. I had to learn again how to be a friend, a sister, a daughter, a lover. But I'm at the other end of the tunnel, and I can confidently say that every single day, every pound, every fear faced was worth it.
Today, in recovery, I dance. It was something I always loved to do while growing up–something that makes me feel beautiful and balanced and free. I've found my way back, after all these years.

I dance, and I laugh, and I eat. I moved to New York to write–something I've dreamed of since I was a little girl. Life doesn't feel like constant pressure anymore; I am enough. I have the love of my friends who have always stood by my side, as well as those I've picked up along the way. I have fun. I had no idea how much I was missing out on.

It's impossible to pinpoint an exact starting point or direct cause for my eating disorder. But at the end of each reason is a thread: fear. I was so sure of myself and so terrified I'd fail in every way possible.

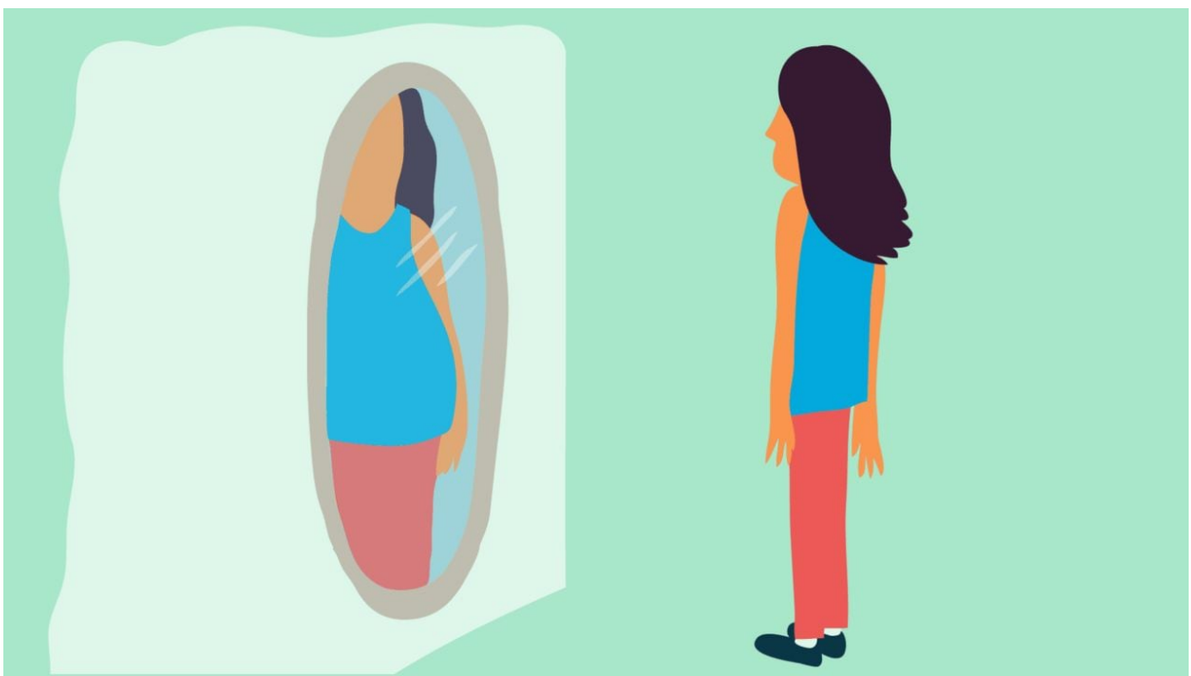
I thought I could cut out the bits and pieces of life that I didn't like. I thought hardening myself would make things easier to face. But it was practicing openness that gave me the balls to truly save myself, and be a better friend to those around me.

There are times I miss the sense of comfort my eating disorder provided me with. I equated having everything entirely under control with being unstoppable. I figured it was the only way to succeed. But life is so much better in color.

I don't think I'm done recovering. Or, maybe I am, but I'm definitely not done learning. I'm not done trying to become a better person, and I'm not done giving more love to myself than I did yesterday. I've gutted my demons one by one. Do not resuscitate.

Sarah's Story of Recovery and Fighting the Demon of Eating Disorders
Retrieved from: https://www.eatingdisorderhope.com/blog/sarahs-story-recovery-demon-eating-disorders

Hi, I'm Sarah. Meeting me in person, you probably wouldn't know my life was controlled by the demon of eating disorders for over fourteen years. Because I'm "recovered," I refer to eating disorders as a demon because, to me, that's what they were.



I never saw them as an illness, disease, or a negative voice in my head. In fact, I didn't even know I had eating disorders until I was twenty-four.
This demon first came to perch on my shoulder when I was around ten years old. Perhaps because I was so young, I thought it was normal. I mean, didn't everyone have a demon on their shoulder, whispering horrible lies into their ear?

My family was conservative Christian, and I was taught girls were supposed to do "girl things," and boys were supposed to do "boy things." I was a tomboy, though, and my mom would get frustrated and ask why I couldn't be more like my girly sisters. I didn't

know why, but I got annoyed when I was compared to them. I thought this meant something was wrong with me, and I started to dislike myself.

My mom and older sister dieted and exercised and seemed more innately “girly” than I was. I thought if I dieted and exercised, too, maybe I could make myself more girly. While I preferred being outdoors, climbing trees with my brothers, earning acceptance seemed more important at age ten.

Before long, my efforts to become less of a tomboy turned into a full-blown obsession with my body weight, body size, and clothes size. At some point in my teens, my determination to become girly morphed into pure self-hate and a subsequent need to disappear.
The demon on my shoulder told me I was worthless, and no one could possibly love me unless I was smaller, thinner, tinier. So, I restricted, binged, purged, and over-exercised with fervor. I believed the demon’s taunts that eating was not a privilege I deserved because I was pathetic and without value. In fact, I believed everything the demon said and did whatever it told me, including self-harm and suicidal thoughts.

I hid behind baggy clothes and thought of little else besides eating less and exercising more. Somehow, I thought shrinking away was what I deserved, and in some chance of fate, I could earn love by taking up less space. Looking back, I realized food, weight, and size were never the issues but were rather outward expressions of my unresolved emotional trauma and lack of self-love.

In my early twenties, I married a guy I barely knew, and I thought to start over clear across the country would make everything better. Getting away from the environment I thought had caused all my “problems” seemed logical, but the little demon followed me into my new life, and things got bad really quickly.

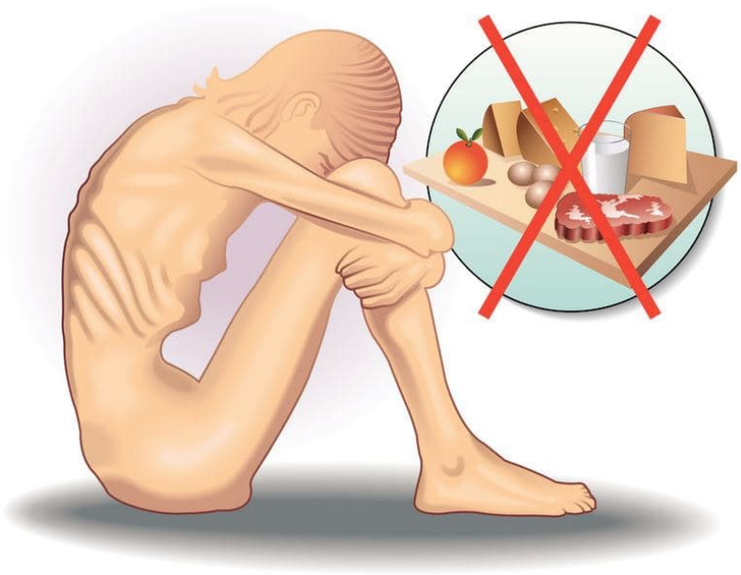
The man I married had his own unresolved trauma, and lashed out as a self-righteous gas-lighter in verbally, emotionally, and sexually abusive ways. Given my naivety and unstable mental and emotional states, I listened as the demon on my shoulder reaffirmed my husband’s words that I was undesirable and a horrible wife for disagreeing with his wish for polygamy. He sent me to therapy to fix my “issues” and [hopefully] become more agreeable to his demands.

It was in therapy that I learned how insanely dysfunctional the marriage was, how the demon of eating disorders had lied to me about my self-worth for much of my life, and how believing it was thoroughly destroying my unique value and potential.

It was in therapy I learned my unresolved emotional trauma tainted my perception of reality and hindered my ability to love, value, and celebrate me. It was in therapy I learned I had the power to cage the demon of eating disorders, throw away the key, and find health and wholeness through recovery.

Twelve years later, with a fitness coach, nutritionist, and mentor still by my side, I have learned to forgive myself, embrace myself, and honor myself. My journey has been long and tiring, and it's far from over, but I'm glad I reached out for help when I did. What are you waiting for?

C. Risk Factors



Eating disorders can affect people of all ages, racial/ethnic backgrounds, body weights, and genders. Eating disorders frequently appear during the teen years or young adulthood but may also develop during childhood or later in life. These disorders affect both genders, although rates among women are higher than among men. Like women who have eating disorders, men also have a distorted sense of body image.

Researchers are finding that eating disorders are caused by a complex interaction of genetic, biological, behavioral, psychological, and social factors. Researchers are using the latest technology and science to better understand eating disorders.

One approach involves the study of human genes. Eating disorders run in families. Researchers are working to identify DNA variations that are linked to the increased risk of developing eating disorders.

Brain imaging studies are also providing a better understanding of eating disorders. For example, researchers have found differences in patterns of brain activity in women with eating disorders in comparison with healthy women. This kind of research can help guide the development of new means of diagnosis and treatment of eating disorders.

How Are Eating Disorders treated?

It is important to seek treatment early for eating disorders. People with eating disorders are at higher risk for suicide and medical complications. Some people with eating disorders may also have other mental disorders (such as depression or anxiety) or problems with substance use.

Treatment plans for eating disorders include psychotherapy, medical care and monitoring, nutritional counseling, medications, or a combination of these approaches. Typical treatment goals include restoring adequate nutrition, bringing weight to a healthy level, reducing excessive exercise, and stopping binge-purge and binge-eating behaviors. Complete recovery is possible.

Specific forms of psychotherapy (or “talk therapy”) and cognitive behavioral approaches can be effective for treating specific eating disorders.

Treatment plans are tailored to individual needs and may include one or more of the following:

- **Individual, Group, and/or Family Psychotherapy**

  Retrieved from: https://keltyeatingdisorders.ca/treatment-options/psychotherapy/

  - Many different types of therapy are used to treat eating disorders. They usually involve talking with a trained professional. That person’s role is to help you to learn about yourself and to recognize and face your problem. With help, people with eating disorders can become more confident and learn ways to cope with difficult situations. Therapy can also help a person to deal with other mental health problems that are associated with eating disorders, such as anxiety, depression, or substance misuse. Therapy can be done on an individual basis, in a group, or with the person’s family.

    The forms of psychotherapy that are used to treat eating disorders are:

  - **Family-Based Therapy (FBT)**
    FBT is also known as the Maudsley Approach. FBT is an evidence-based treatment for youth with anorexia and bulimia nervosa. In FBT, parents play an active role in helping their child recover from an eating disorder. Parents

first learn to take back control of their child's eating, and help them eat what their body needs to get back to a healthy weight. Then parents slowly hand control of eating back to their child. When the child is ready, there is a brief final phase in which the family works on communicating about adolescent issues that may have been put on hold during the medical crisis of the eating disorder. Adolescent issues might include independence, peer and romantic relationships, or transitions to college/university. Family members are seen as the ones who know their loved one best. Parent involvement in treatment and support is especially important for children and youth with eating disorders. FBT should be given by a trained therapist who specializes in eating disorders.

In FBT, the person with an eating disorder and their family members usually meet with the therapist together. The therapist will likely ask all members of the family to join the sessions (this can include brothers and sisters, grandparents, or others who live at home together). FBT usually involves about 20 sessions with a therapist, in addition to regular medical appointments.

When a therapist works with a group of individuals and their families, it is called multiple family group therapy. This form can help families that are dealing with an eating disorder feel more supported and less isolated. It also gives them a chance to talk about and share ways of coping.

- **Cognitive-Behavioral Therapy (CBT)**

This form of treatment helps you understand the connection between your feelings and thoughts (cognitive) and your actions (behaviour). CBT is usually given in 10 – 20 sessions, but there may be as many of 40 sessions for people who are underweight. CBT can be used with groups or individuals.

CBT teaches people to recognize how certain thoughts and feelings may be connected to harmful behaviours. If they learn to change their thoughts, they

may be able to change their behaviour. In eating disorders, CBT is used to help people evaluate their thoughts about their weight, shape and self-image. They learn to reduce negative feelings and harmful behaviours such as strict dieting, binge eating or purging.

CBT is the leading treatment for adults with bulimia nervosa. It helps to decrease bingeing and purging. It also decreases the chance for these behaviours to return. We don't know as much about how well this treatment works for people with anorexia nervosa. But, CBT can help reduce the symptoms of other mental health problems in a person with anorexia nervosa such as depression or anxiety.

There is also a new form of CBT, known as CBT-E, or Enhanced CBT. It helps people to understand their eating problem and establish regular eating patterns. They work on reducing factors that keep the eating problem going and on preventing relapse. It was neweloped to treat a number of eating disorders (AN, BN, and OSFED).

- **Dialectical Behavior Therapy (DBT)**

  Dialectical Behavior Therapy is used to treat a variety of different mental health conditions, including eating disorders. DBT is a form of cognitive-behavioural therapy that helps people learn to change their behaviour. In DBT, you learn new skills and then have a chance to practice these skills.

  DBT focuses on how to:

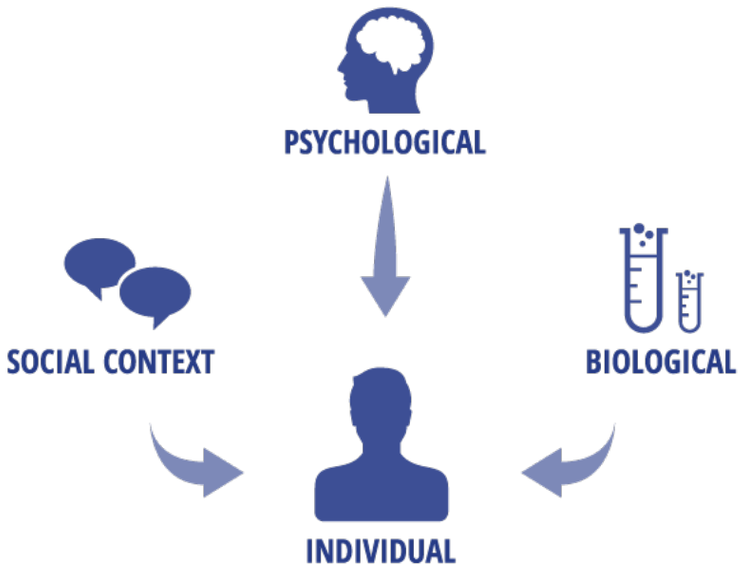
  - practice mindfulness
  - regulate emotion
  - tolerate distress
  - relate to others effectively

    In DBT, it is important for the individual and the therapist to build a strong, trusting relationship. They work together to identify behaviours that are self- harmful and to recognize the feelings and situations, which start or "trigger" these behaviours. Then they practice new skills to cope with "trigger situations." DBT typically has both individual and group sessions.

    In DBT, people learn to be aware (or mindful) of their feelings in certain situations, and how to control their reactions. For example,

a person with binge-eating disorder will learn to recognize the types of feelings that cause them to binge, a harmful behaviour. They may recognize that they binge when feeling anxious while under stress at work. DBT can help them start to manage these feelings of anxiety in a healthy way by using skills, which can include mindfulness or relaxation

- **Interpersonal Therapy (IPT)**
  This treatment helps people to recognize and solve problems in their relationships. It is called “interpersonal” because it focuses on the way we communicate or interact with each other.



When our interaction with another person is unpleasant, it can lead to a build-up of negative feelings. Feelings like these may be linked with symptoms of an eating disorder. For example, people with binge-eating disorder may binge eat after an argument with a loved one, or they may eat when they feel lonely. The focus of interpersonal therapy is not on changing eating habits. Instead, IPT helps people build stronger and healthier relationships with others. As they begin to feel better about themselves and their relationships, the disordered eating will often decrease or even disappear.

Interpersonal therapy can be used with groups or individuals.

Several types of therapies are effective in reducing symptoms in youth and adults with eating disorders. There has been research on all of the therapies listed above (CBT, CBT-E, FBT, DBT, and IPT). Other types of psychotherapy are also available, but there is less research on the how effective some of them are. If you are wondering which therapy would be the

best fit for you, or for a loved one who is struggling with an eating disorder, it is best to meet with a mental health professional.

- **Medical Care and Monitoring**

  Retrieved from: https://www.helpguide.org/articles/eating-disorders/eating-disorder-treatment-and-recovery.htm

  - Often, treatment will include regular monitoring by a medical doctor to make sure your health is not in danger. This may include regular weigh-ins, blood tests, and other health screenings.
  - **Residential treatment.** In rare cases, you may need more support than can be provided on an outpatient basis. Residential treatment programs offer around-the-clock care and monitoring to get you back on track. The goal is to get you stable enough to continue treatment at home.

- **Nutritional Counseling**

  - The treatment plan for eating disorders often includes counselling on nutrition. It is usually given by dietitians or nutritionists who specialize in eating disorders. They focus on healthy eating and changing harmful eating behaviours.

    People working with a dietitian or nutritionist learn:

    - what food and drinks you need to be healthy
    - how your body uses vitamins and minerals, and why they are important
    - how your body uses the nutrients in the food
    - how your eating habits can be linked to your emotions
    - how to plan and prepare appropriate meals and snacks
    - how to recognize fears you have about certain food groups
    - how even “feared” foods are important for your body to stay healthy

- **Medications**

  Retrieved from: https://www.mayoclinic.org/diseases-conditions/eating-disorders/in-depth/eating-disorder-treatment/art-20046234

  - Medications can't cure an eating disorder. They're most effective when combined with psychological therapy.

  - Antidepressants are the most common medications used to treat eating disorders that involve binge-eating or purging behaviors, but depending on the situation, other medications are sometimes prescribed.

    Taking an antidepressant may be especially helpful if you have bulimia or binge-eating disorder. Antidepressants can also help reduce symptoms of depression or anxiety, which frequently occur along with eating disorders.

    You may also need to take medications for physical health problems caused by your eating disorder.

Chapter 2: Common Types of Eating Disorders

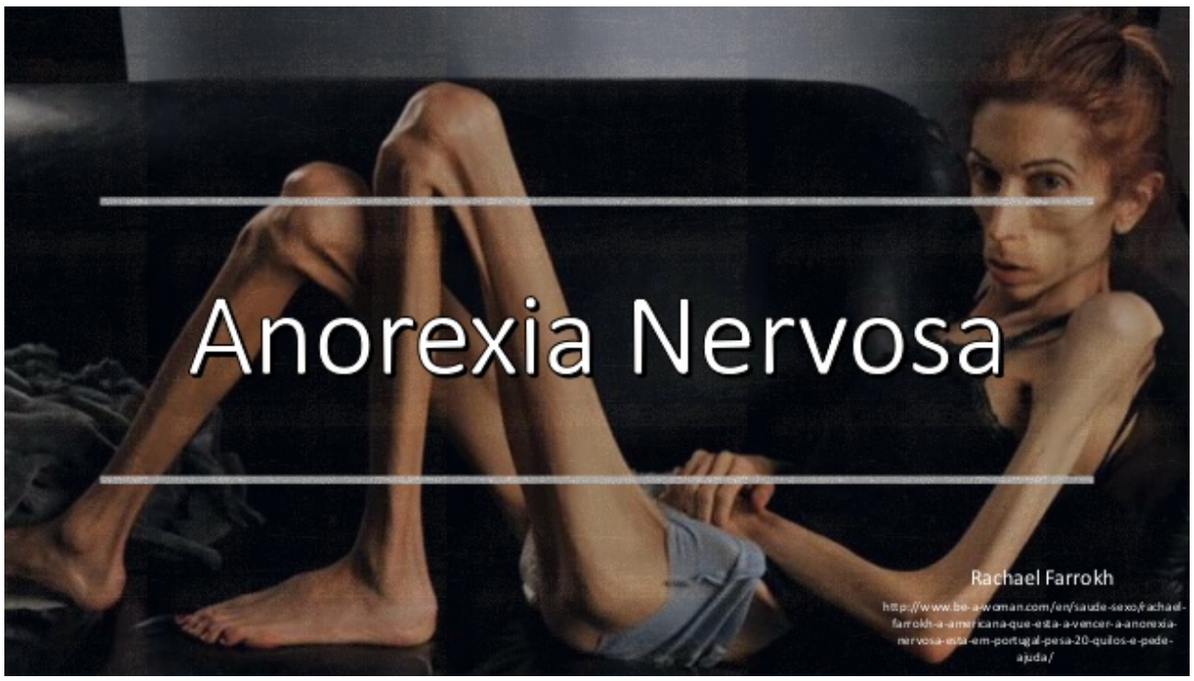
A. Anorexia Nervosa

Melinda Smith, M.A., Lawrence Robinson, and Jeanne Segal, Ph.D. Last updated: November 2019.

Retrieved from: Anorexia Nervosa; https://www.helpguide.org/articles/eating-disorders/anorexia-nervosa.htm

What is anorexia nervosa?

In today's image-obsessed culture, many of us worry about putting on weight or wish we looked different or could fix something about ourselves. That's only human. But if a preoccupation with being thin has taken over your eating habits, thoughts, and life, you may have the serious eating disorder, anorexia nervosa.



Anorexia can result in unhealthy, often dangerous weight loss. In fact, the desire to lose weight may become more important than anything else. You may even lose the ability to see yourself as you truly are. While it is most common among adolescent women, anorexia can affect women and men of all ages and is characterized by a refusal to maintain a healthy body weight, an intense fear of gaining weight, and a distorted body image.

You may try to lose weight by starving yourself, exercising excessively, or using laxatives, vomiting, or other methods to purge yourself after eating. Thoughts about dieting, food, and your body may take up most of your day—leaving little time for friends, family, and other activities you used to enjoy. Life becomes a relentless pursuit of thinness and intense weight loss. But no matter how skinny you become, it’s never enough.

- **Restricting type** of anorexia is where weight loss is achieved by restricting calories (following drastic diets, fasting, exercising to excess).
- **Purging type** of anorexia is where weight loss is achieved by vomiting or using laxatives and diuretics.

The intense dread of gaining weight or disgust with how your body looks, can make eating and mealtimes very stressful. And yet, food and what you can and can’t eat is practically all you can think about. But no matter how ingrained this self-destructive pattern seems, there is hope. With treatment, self-help, and support, you can break the self-destructive hold anorexia has over you, develop a more realistic body image, and regain your health and self-confidence.

Are you anorexic?

• Do you feel fat even though people tell you you're not?
• Are you terrified of gaining weight?
• Do you lie about how much you eat or hide your eating habits from others?
• Are your friends or family concerned about your weight loss, eating habits, or appearance?
• Do you diet, compulsively exercise, or purge when you're feeling overwhelmed or bad about yourself?
• Do you feel powerful or in control when you go without food, over-exercise, or purge?
• Do you base your self-worth on your weight or body size?

Signs and Symptoms of Anorexia

While people with anorexia often exhibit different habits, one constant is that living with anorexia means you're constantly hiding those habits. This can make it hard at first for friends and family to spot the warning signs. When confronted, you might try to explain away your disordered eating and wave away concerns. But as anorexia progresses, people close to you won't be able to deny their instincts that something is wrong—and neither should you. If eating and weight control your life, you don't have to wait until your symptoms have progressed or your health is dangerously poor before seeking help.

Food Behavior Symptoms

- **Dieting Despite Being Thin** – Following a severely restricted diet. Eating only certain low-calorie foods. Banning "bad" foods such as carbohydrates and fats.
- **Obsession with Calories, Fat Grams, and Nutrition** – Reading food labels, measuring and weighing portions, keeping a food diary, reading diet books.
- **Pretending to Eat or Lying About Eating** – Hiding, playing with, or throwing away food to avoid eating. Making excuses to get out of meals ("I had a huge lunch" or "My stomach isn't feeling good").
- **Preoccupation with Food** – Constantly thinking about food. Cooking for others, collecting recipes, reading food magazines, or making meal plans while eating very little.
- **Strange or Secretive Food Rituals** – Refusing to eat around others or in public places. Eating in rigid, ritualistic ways (e.g. cutting food "just so," chewing food and spitting it out, using a specific plate).

Appearance and Body Image Symptoms

- **Dramatic Weight Loss** – Rapid, drastic weight loss with no medical cause.

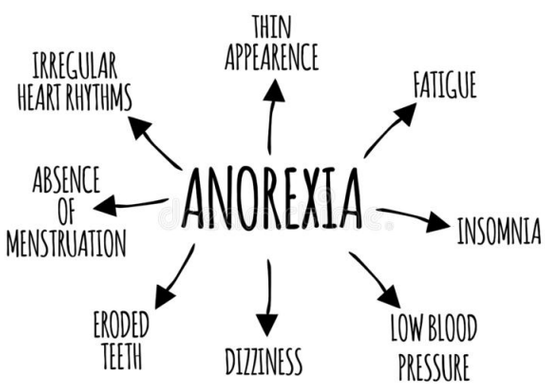
- **Feeling fat, Despite Being Underweight** – You may feel overweight in general or just “too fat” in certain places, such as the stomach, hips, or thighs.
- **Fixation on Body Image** – Obsessed with weight, body shape, or clothing size. Frequent weigh-ins and concern over tiny fluctuations in weight.
- **Harshly Critical of Appearance** – Spending a lot of time in front of the mirror checking for flaws. There’s always something to criticize. You’re never thin enough.
- **Denial that You Are Too Thin** – You may deny that your low body weight is a problem, while trying to conceal it (drinking a lot of water before being weighed, wearing baggy or oversized clothes).

Purging Symptoms

- **Using Diet Pills, Laxatives, or Diuretics** – Abusing water pills, herbal appetite suppressants, prescription stimulants, ipecac syrup, and other drugs for weight loss.
- **Throwing Up After Eating** – Frequently disappearing after meals or going to the bathroom. May run the water to disguise sounds of vomiting or reappear smelling like mouthwash or mints.
- **Compulsive exercising** – Following a punishing exercise regimen aimed at burning calories. Exercising through injuries, illness, and bad weather. Working out extra hard after bingeing or eating something “bad.”

Anorexia causes and effects

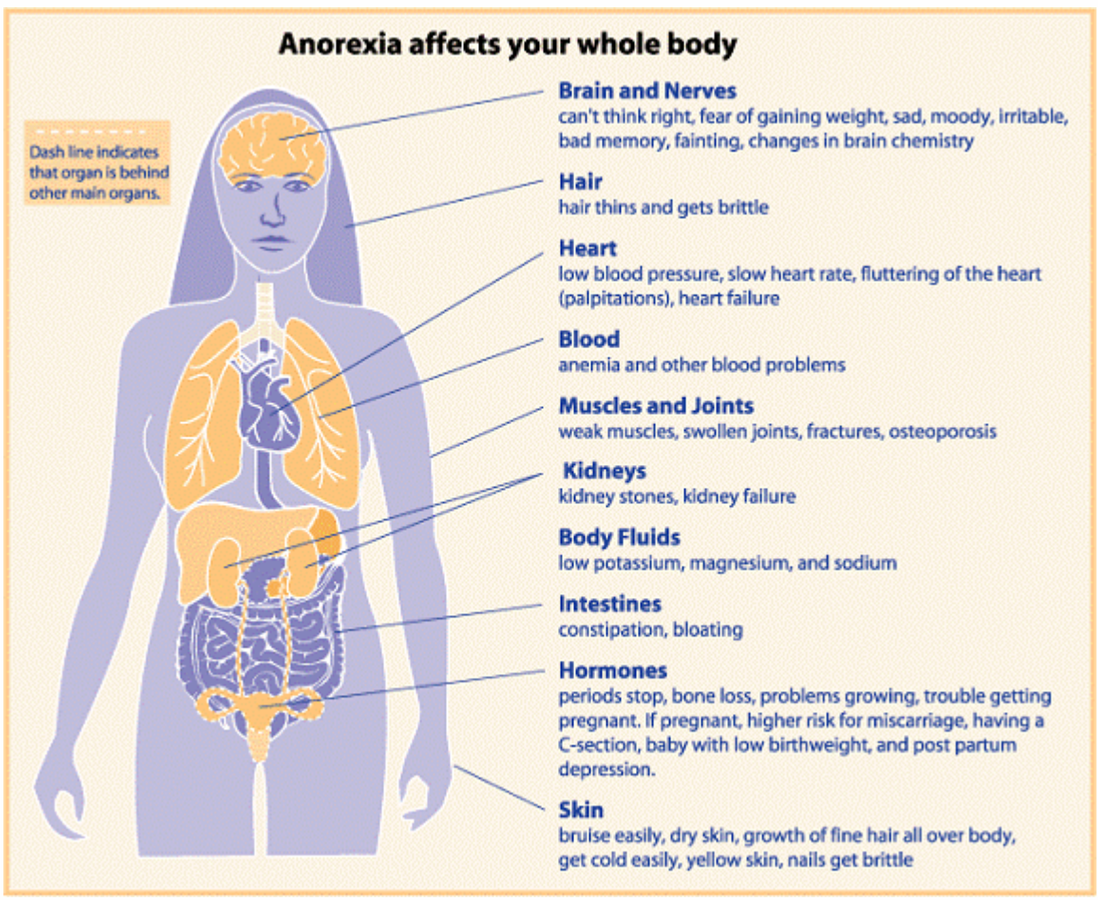
There are no simple answers to the causes of anorexia. Anorexia is a complex condition that arises from a combination of many social, emotional, and biological factors. Although our culture’s idealization of thinness plays a powerful role, there are many other contributing factors, including:



- Body dissatisfaction
- Strict dieting
- Low self-esteem
- Emotional difficulties
- Perfectionism
- Troubled family relationships
- History of physical or sexual abuse
- Other traumatic experiences
- Family history of eating disorders

Effects of Anorexia

While the causes of anorexia are uncertain, the physical effects are clear. When your body doesn't get the fuel it needs to function normally, it goes into starvation mode and slows down to conserve energy. Essentially, your body begins to consume itself. If self-starvation continues and more body fat is lost, medical complications pile up and your body and mind pay the price.



Source: *National Women's Health Information Center*

Getting help

Deciding to get help for anorexia is not an easy choice to make. It's not uncommon to feel like anorexia is part of your identity—or even your "friend." You may think that anorexia has such a powerful hold over you that you'll never be able to overcome it. But while change is hard, it *is* possible.

Admit you have a problem. Up until now, you've been invested in the idea that life will improve—that you'll finally feel good—if you lose more weight. The first step in anorexia recovery is admitting that your relentless pursuit of thinness is out of your control and acknowledging the physical and emotional damage that you've suffered because of it.

Talk to someone. It can be hard to talk about what you're going through, especially if you've kept your anorexia a secret for a long time. You may be ashamed, ambivalent, or afraid. But it's important to understand that you're not alone. Find a good listener—someone who will support you as you try to heal.

Stay away from people, places, and activities that trigger your obsession with being thin. You may need to avoid looking at fashion or fitness magazines, spend less time with friends who constantly diet and talk about losing weight, and stay away from weight loss web sites and "pro-ana" sites that promote anorexia.

Seek Professional Help. The advice and support of trained eating disorder professionals can help you regain your health, learn to eat normally again, and develop healthier attitudes about food and your body.

Medical treatment for anorexia

The first priority in anorexia treatment is addressing and stabilizing any serious health issues. Hospitalization may be necessary if you are dangerously malnourished or so distressed that you no longer want to live. You may also need to be hospitalized until you reach a less critical weight.

Anorexia Recovery Tip 1: Understand This is Not Really About Weight or Food

The food and weight-related issues are in fact symptoms of a deeper issue: depression, anxiety, loneliness, insecurity, pressure to be perfect, or feeling out of control. Problems that no amount of dieting or weight loss can cure.

The Difference Between Dieting and Anorexia

Healthy Dieting	Anorexia
Healthy dieting is an attempt to control weight.	Anorexia is an attempt to control your life and emotions.
Your self-esteem is based on more than just weight and body image.	Your self-esteem is based entirely on how much you weigh and how thin you are.
You view weight loss as a way to improve your health and appearance.	You view weight loss as a way to achieve happiness.
Your goal is to lose weight in a healthy way.	Becoming thin is all that matters; health is not a concern.

In order to overcome anorexia, you first need to understand that it meets a need in your life. For example, maybe you feel powerless in many parts of your life, but you can control what you eat. Saying “no” to food, getting the best of hunger, and controlling the number on the scale may make you feel strong and successful—at least for a short while. You may even come to enjoy your hunger pangs as reminders of a “special talent” that most people don’t possess.

Anorexia may also be a way of distracting yourself from difficult emotions. When you spend most of your time thinking about food, dieting, and weight loss, you don’t have to face other problems in your life or deal with complicated emotions. Restricting food may provide an emotional numbness, anesthetizing you from feelings of anxiety, sadness, or anger, perhaps even replacing those emotions with a sense of calm or safety.

Unfortunately, any boost you get from starving yourself or shedding pounds is extremely short-lived—and at some point, it will stop working for you at all. Dieting and weight loss can’t repair the negative self-image at the heart of anorexia. The only way to do that is to identify the emotional need that self-starvation fulfills and find other ways to meet it.

“I Feel Fat”

While your weight usually remains quite constant over the course of, say, a week, feelings of fatness can fluctuate wildly. Often, feeling fat is a mislabeling of other emotions, such as shame, boredom, frustration, or sadness. In other words, “I feel fat” really means “I feel anxious,” or “I feel lonely.” And those feelings are unlikely to ever be changed by a diet.

Anorexia Recovery Tip 2: Learn to Tolerate Your Feelings

Identifying the underlying issues that drive your eating disorder is the first step toward recovery, but insight alone is not enough. Let's say, for example, that following restrictive food rules makes you feel safe and powerful. When you take that coping mechanism away, you will be confronted with the feelings of fear and helplessness your anorexia helped you avoid.

Reconnecting with your feelings can be extremely uncomfortable. It's why you may feel worse at the beginning of your recovery. But the answer isn't to return to the destructive eating habits you previously used to distract yourself; it's to learn how to accept and tolerate all of your feelings—even the negative ones.

Using Mindfulness to Cope with Difficult Emotions

When you start to feel overwhelmed by negativity, discomfort, or the urge to restrict food, take a moment to stop whatever you're doing and investigate what's going on inside.

- **Identify the Emotion You Are Feeling.** Is it guilt? Shame? Helplessness? Loneliness? Anxiety? Disappointment? Fear? Insecurity?
- **Accept the Experience You Are Having.** Avoidance and resistance only make negative emotions stronger. Instead, try to accept what you're feeling without judging yourself.
- **Dig Deeper.** Where do you feel the emotion in your body? What kinds of thoughts are going through your head?
- **Distance Yourself.** Realize that you are NOT your feelings. Emotions are passing events, like clouds moving across the sky. They don't define who you are.

Once you learn how to accept and tolerate your feelings, they'll no longer seem so scary. You'll realize that you're still in control and that negative emotions are only temporary. Once you stop fighting them, they'll quickly pass.

New ways to Find Emotional Fulfillment

Once you understand the link between your emotions and your disordered eating patterns—and can identify your triggers—you still need to find alternatives to dieting that you can turn to for emotional fulfillment. For example:

- **If you are depressed or lonely,** call someone who always makes you feel better, schedule time with family or friends, watch a comedy show, or play with a dog or cat.
- **If you are anxious,** expend your nervous energy by dancing to your favorite music, squeezing a stress ball, or taking a brisk walk or bike ride.
- **If you are exhausted,** treat yourself with a hot cup of tea, go for a walk, take a bath, or light some scented candles.
- **If you are bored,** read a good book, explore the outdoors, visit a museum, or turn to a hobby you enjoy (playing the guitar, knitting, shooting hoops, scrapbooking, etc.).

Anorexia Recovery Tip 3: Challenge Damaging Mindsets

People with anorexia are often perfectionists and overachievers. They're the "good" daughters and sons who do what they're told, try to excel in everything they do, and focus on pleasing others. But while they may appear to have it all together, inside they feel helpless, inadequate, and worthless.

If that sounds familiar to you, here's the good news: these feelings don't reflect reality. They're fueled by irrational, self-sabotaging ways of thinking that you can learn to overcome.

Damaging mindsets that fuel Anorexia

- **All-Or-Nothing Thinking.** Through this harshly critical lens, if you're not perfect, you're a total failure. You have a hard time seeing shades of gray, at least when it comes to yourself.
- **Emotional Reasoning.** You believe if you feel a certain way, it must be true. "I feel fat" means "I am fat." "I feel hopeless" means you'll never get better.
- **Musts, Must-Nots, and Have-Tos**. You hold yourself to a rigid set of rules (*"I must not eat more than x number of calories*,*" "I have to get straight A's,"* "*I must always be in control."* etc.) and beat yourself up if you break them.

- **Labeling.** You call yourself names based on mistakes and perceived shortcomings. “I’m unhappy with how I look” becomes “I’m disgusting.” Slipping up becomes “I’m a “failure.”
- **Catastrophizing.** You jump to the worst-case scenario. If you backslide in recovery, for example, you assume that there’s no hope you’ll ever get better.

Put your Thought on The Witness Stand

Once you identify the destructive thoughts patterns that you default to, you can start to challenge them with questions such as:

- “What’s the evidence that this thought is true? Not true?”
- “What would I tell a friend who had this thought?”
- “Is there another way of looking at the situation or an alternate explanation?”
- “How might I look at this situation if I didn’t have anorexia?”

As you cross-examine your negative thoughts, you may be surprised at how quickly they crumble. In the process, you’ll develop a more balanced perspective.

Anorexia Recovery Tip 4: Develop a Healthier Relationship with Food

Even though anorexia isn’t fundamentally about food, over time you’ve developed harmful food habits that can be tough to break. Developing a healthier relationship with food entails:

  - Getting back to a healthy weight
  - Starting to eat more food

Changing How You Think About Yourself and Food

- **Let Go of Rigid Food Rules.** While following rigid rules may help you feel in control, it’s a temporary illusion. The truth is that these rules are controlling you, not the other way around. In order to get better, you’ll need to let go. This is a big change that will feel scary at first, but day by day, it will get easier.
- **Get Back in Touch with Your Body.** If you have anorexia, you’ve learned to ignore your body’s hunger and fullness signals. You may not even recognize them anymore. The goal is to get back in touch with these internal cues, so you can eat based on your physiological needs.

- **Allow Yourself to Eat All Foods.** Instead of putting certain food off limits, eat whatever you want, but pay attention to how you feel physically after eating different foods. Ideally, what you eat should leave you feeling satisfied and energized.
- **Get Rid of Your Scale.** Instead of focusing on weight as a measurement of self-worth, focus on how you feel. Make health and vitality your goal, not a number on the scale.
- **Develop a Healthy Meal Plan.** If you need to gain weight, a nutritionist or dietician can help you develop a healthy meal plan that includes enough calories to get you back to a normal weight. While you can do this on your own, you're probably out of touch with what a normal meal or serving size looks like.

Getting Past Your Fear of Gaining Weight

Getting back to a normal weight is no easy task. The thought of gaining weight is probably extremely frightening, and you may be tempted to resist.

But this fear is a symptom of your anorexia. Reading about anorexia or talking to other people who have lived with it can help. It also helps to be honest about your feelings and fears. The better your family and treatment team understand what you're going through, the better support you'll receive.

Helping someone with anorexia

While there are ways you can help someone with an eating disorder, you can't force the person to get better. Having anorexia can distort the way your loved one thinks—about their body, the world around them, even your motivations for trying to help. Add to that the defensiveness and denial involved in anorexia and you'll need to tread lightly. Waving around articles about the dire effects of anorexia or declaring, "you'll die if you don't eat!" probably won't work. A better approach is to gently express your concerns and let the person know that you're available to listen. If your loved one is willing to talk, listen without judgment, no matter how out of touch the person sounds.

- **Think of Yourself as an "Outsider."** As someone not suffering from anorexia, there isn't a lot you can do to "solve" your loved one's condition. It is ultimately their choice to decide when they are ready.
- **Encourage Your Loved One to Get Help.** The longer an eating disorder remains undiagnosed and untreated, the harder it is on the body and the more difficult it is to overcome, so urge your loved one to see a doctor as soon as possible.
- **Seek Advice From a Health Professional,** even if your friend or family member won't. And you can bring others—from peers to parents—into the circle of support.
- **Be a Role Model for Healthy Eating, Exercising, and Body Image.** Don't make negative comments about your own body or anyone else's.
- **Don't Act Like the Food Police.** A person with anorexia needs compassion and support, not an authority figure standing over the table with a calorie counter.
- **Avoid Threats, Scare Tactics, Angry Outbursts, and Put-downs.** Bear in mind that anorexia is often a symptom of extreme emotional distress and develops out of an attempt to manage emotional pain, stress, and/or self-hate. Negative communication will only make it worse.

B. Binge Eating Disorder

Melinda Smith, M.A., Lawrence Robinson, and Jeanne Segal, Ph.D. Last updated: November 2019.

Retrieved from: https://www.helpguide.org/articles/eating-disorders/binge-eating-disorder.htm

What is Binge Eating disorder?

All of us eat too much from time to time. But if you regularly overeat while feeling out of control and powerless to stop, you may be suffering from binge eating disorder. Binge eating disorder is a common eating disorder where you frequently eat large amounts of food while feeling powerless to stop and extremely distressed

during or after eating. You may eat to the point of discomfort, then be plagued by feelings of guilt, shame, or depression afterwards, beat yourself up for your lack of self-control, or worry about what compulsive eating will do to your body.

Binge eating disorder typically begins in late adolescence or early adulthood, often after a major diet. During a binge, you may eat even when you're not hungry and continue eating long after you're full. You may also binge so fast you barely register what you're eating or tasting. Unlike bulimia, however, there are no regular attempts to "make up" for the binges through vomiting, fasting, or over-exercising.

You may find that binge eating is comforting for a brief moment, helping to ease unpleasant emotions or feelings of stress, depression, or anxiety. But then reality sets back in and you're flooded with feelings of regret and self-loathing. Binge eating often leads to weight gain and obesity, which only reinforces compulsive eating. The worse you feel about yourself and your appearance, the more you use food to cope. It becomes a vicious cycle: eating to feel better, feeling even worse, and then turning back to food for relief. As powerless as you may feel about your eating disorder, it's important to know that binge eating disorder is treatable. You can learn to break the binge eating cycle, better manage your emotions, develop a healthier relationship with food, and regain control over your eating and your health.

Signs and symptoms

If you have binge eating disorder, you may feel embarrassed and ashamed about your eating habits, and try to hide your symptoms by eating in secret.

Behavioral Symptoms of Binge Eating and Compulsive Overeating

- Inability to stop eating or control what you're eating
- Rapidly eating large amounts of food
- Eating even when you're full
- Hiding or stockpiling food to eat later in secret
- Eating normally around others, but gorging when you're alone
- Eating continuously throughout the day, with no planned mealtimes

Emotional Symptoms

- Feeling stress or tension that is only relieved by eating
- Embarrassment over how much you're eating
- Feeling numb while bingeing—like you're not really there or you're on auto-pilot.

- Never feeling satisfied, no matter how much you eat
- Feeling guilty, disgusted, or depressed after overeating
- Desperation to control weight and eating habits

Do you have Binge Eating Disorder?

- Do you feel out of control when you're eating?
- Do you think about food all the time?
- Do you eat in secret?
- Do you eat until you feel sick?
- Do you eat to escape from worries, relieve stress, or to comfort yourself?
- Do you feel disgusted or ashamed after eating?
- Do you feel powerless to stop eating, even though you want to?

The more "yes" answers, the more likely it is that you have binge eating disorder.

Causes and Effects

Generally, it takes a combination of things to develop binge eating disorder—including your genes, emotions, and experience.

- **Social and Cultural Risk Factors.** Social pressure to be thin can add to the you feel and fuel your emotional eating. Some parents unwittingly set the stage for binge eating by using food to comfort, dismiss, or reward their children. Children who are exposed to frequent critical comments about their bodies and weight are also vulnerable, as are those who have been sexually abused in childhood.

- **Psychological Risk Factors.** Depression and binge eating are strongly linked. Many binge eaters are either depressed or have been before; others may have trouble with impulse control and managing and expressing their feelings. Low self-esteem, loneliness, and body dissatisfaction may also contribute to binge eating.
- **Biological risk factors.** Biological abnormalities can contribute to binge eating. For example, the hypothalamus (the part of your brain that controls appetite) may not be sending correct messages about hunger and fullness. Researchers have also found a genetic mutation that appears to cause food addiction. Finally, there is evidence that low levels of the brain chemical serotonin play a role in compulsive eating.

Effects of Binge Eating Disorder

Binge eating leads to a wide variety of physical, emotional, and social problems. You're more likely to suffer health issues, stress, insomnia, and suicidal thoughts than someone without an eating disorder. You may also experience depression, anxiety, and substance abuse as well as substantial weight gain.

As bleak as this sounds, though, many people are able to recover from binge eating disorder and reverse the unhealthy effects. You can, too. The first step is to re-evaluate your relationship with food.

Binge Eating Recovery tip 1: Develop a Healthier Relationship with Food

Recovery from any addiction is challenging, but it can be especially difficult to overcome binge eating and food addiction. Unlike other addictions, your "drug" is necessary for survival, so you don't have the option of avoiding or replacing it. Instead, you need to develop a healthier relationship with food—a relationship that's based on meeting your nutritional needs, not your emotional ones. To do this, you have to break the binge eating cycle by:

- **Avoiding Temptation.** You're much more likely to overeat if you have junk food, desserts, and unhealthy snacks in the house. Remove the temptation by clearing your fridge and cupboards of your favorite binge foods.
- **Listening To Your Body.** Learn to distinguish between physical and emotional hunger. If you ate recently and don't have a rumbling stomach, you're probably not really hungry. Give the craving time to pass.
- **Eating Regularly.** Don't wait until you're starving. This only leads to overeating! Stick to scheduled mealtimes, as skipping meals often leads to binge eating later in the day.
- **Not Avoiding Fat.** Contrary to what you might think, dietary fat can actually help keep you from overeating and gaining weight. Try to incorporate healthy fat at each meal to keep you feeling satisfied and full.
- **Fighting Boredom.** Instead of snacking when you're bored, distract yourself. Take a walk, call a friend, read, or take up a hobby such as painting or gardening.
- **Focusing on What You are Eating.** How often have you binged in an almost trance-like state, not even enjoying what you're consuming? Instead of eating mindlessly, be a mindful eater. Slow down and savor the textures and flavors. Not only will you eat less, you'll enjoy it more.

Importance of Deciding Not to Diet

After a binge, it's only natural to feel the need to diet to compensate for overeating and to get back on track with your health. But dieting usually backfires. The deprivation and hunger that comes with strict dieting triggers food cravings and the urge to overeat.

Instead of dieting, focus on eating in moderation. Find nutritious foods that you enjoy and eat only until you feel content, not uncomfortably stuffed. Avoid banning or restricting certain foods, as this can make you crave them even more. Instead of saying "I can never eat ice cream," say "I will eat ice cream as an occasional treat."

Binge Eating Recovery Tip 2: Find Better Ways to Feed Your Feelings

One of the most common reasons for binge eating is an attempt to manage unpleasant emotions such as stress, depression, loneliness, fear, and anxiety. When you have a bad day, it can seem like food is your only friend. Binge eating can temporarily make feelings such as stress, sadness, anxiety, depression, and boredom evaporate into thin air. But the relief is very fleeting.

Identify Your Triggers with a Food and Mood Diary

One of the best ways to identify the patterns behind your binge eating is to keep track with a food and mood diary. Every time you overeat or feel compelled to reach for your version of comfort food Kryptonite, take a moment to figure out what triggered the urge. If you backtrack, you'll usually find an upsetting event that kicked off the binge.

Write it all down in your food and mood diary: what you ate (or wanted to eat), what happened to upset you, how you felt before you ate, what you felt as you were eating, and how you felt afterward. Over time, you'll see a pattern emerge.

Learn to Tolerate the Feelings that Trigger your Binge Eating

The next time you feel the urge to binge, instead of giving in, take a moment to stop and investigate what's going on inside.

- **Identify The Emotion You're Feeling.** Do your best to name what you're feeling. Is it anxiety? Shame? Hopelessness? Anger? Loneliness? Fear? Emptiness?
- **Accept The Experience You're Having.** Avoidance and resistance only make negative emotions stronger. Instead, try to accept what you're feeling without judging it or yourself.
- **Dig Deeper.** Explore what's going on. Where do you feel the emotion in your body? What kinds of thoughts are going through your head?
- **Distance Yourself.** Realize that you are NOT your feelings. Emotions are passing events, like clouds moving across the sky. They don't define who you are.

Sitting with your feelings may feel extremely uncomfortable at first. Maybe even impossible. But as you resist the urge to binge, you'll start to realize that you don't have to give in. There are other ways to cope. Even emotions that feel intolerable are only temporary. They'll quickly pass if you stop fighting them. You're still in control. You can choose how to respond.

Binge Eating Recovery Tip 3: Take back control of cravings

Sometimes it feels like the urge to binge hits without warning. But even when you're in the grip of a seemingly overpowering and uncontrollable urge, there are things you can do to help yourself stay in control.

- **Accept The Urge and Ride It Out, Instead Of Trying To Fight It.** This is known as “urge surfing.” Think of the urge to binge as an ocean wave that will soon crest, break, and dissipate. When you ride out the urge, without trying to battle, judge, or ignore it, you’ll see that it passes more quickly than you’d think.
- **Distract Yourself.** Anything that engages your attention will work: taking a walk, calling a friend, watching something funny online, etc. Once you get interested in something else, the urge to binge may go away.
- **Talk to Someone.** When you start to notice the urge to binge, turn to a friend or family member you trust. Sharing what you’re going through can help you feel better and discharge the urge to binge.
- **Delay, Delay, Delay.** Even if you’re unsure if you’ll be able to fight the urge to binge, make an effort to delay it. Try to hold off for 1 minute. If you succeed. Try to stretch it out to 5 minutes. If you delay long enough, you may be able to avoid the binge.

Binge Eating Recovery Tip 4: Support Yourself With Healthy Lifestyle Habits

When you’re physically strong, relaxed, and well rested, you’re better able to handle the curveballs that life inevitably throws your way. But when you’re already exhausted and overwhelmed, any little hiccup has the potential to send you off the rails and straight toward the refrigerator. Exercise, sleep, and other healthy lifestyle habits will help you get through difficult times without binge eating.

- **Make Time for Regular Exercise.** Physical activity does wonders for your mood and your energy levels, and it’s also a powerful stress reducer. The natural mood-boosting effects of exercise can help put a stop to emotional eating.
- **Get Enough Sleep Every Night.** When you don’t get the sleep you need, your body craves sugary foods that will give you a quick energy boost. Sleep deprivation may even trigger food addiction. Getting plenty of rest will help with appetite control and reduce food cravings, and support your mood.
- **Connect with Others.** Don’t underestimate the importance of close relationships and social activities. You’re more likely to succumb to binge eating

triggers if you lack a solid support network. Talking helps, even if it's not with a professional.

- **Manage Stress.** One of the most important aspects of controlling binge eating is to find alternate ways to handle stress and other overwhelming feelings without using food. These may include meditating, using sensory relaxation strategies, and practicing simple breathing exercises.

How to Help Someone With Binge Eating Disorder

Since binge eaters often try to hide their symptoms and eat in secret, it can make it tough for family and friends to spot the warning signs. And you can't always identify a binge eater by appearance, either. While some are overweight or obese, others manage to maintain a normal weight.

The warning signs that you can spot include finding piles of empty food packages and wrappers, cupboards and refrigerators that have been cleaned out, or hidden stashes of high-calorie or junk food. If you suspect that your loved one has binge eating disorder, bring up your concerns. It may seem daunting to start such a delicate conversation, and the person may deny bingeing or become angry and defensive. But there's a chance that he or she will welcome the opportunity to share the struggle.

If the person shuts you out at first, don't give up; it may take some time before your loved one is willing to admit to having a problem. And remember: as difficult as it is to know that someone you love may be have an eating disorder, you can't force someone to change. The decision to seek recovery has to come from them. You can help by offering your compassion, encouragement, and support throughout the treatment process.

Tips for Helping Someone with Binge Eating Disorder

- **Encourage Him or Her to Seek Help.** The longer an eating disorder remains undiagnosed and untreated, the more difficult it will be to overcome, so urge your loved one to get treatment.
- **Be Supportive.** Try to listen without judgment and make sure the person knows you care. If your loved one slips up on the road to recovery, remind them that it doesn't mean they can't quit binge eating for good.

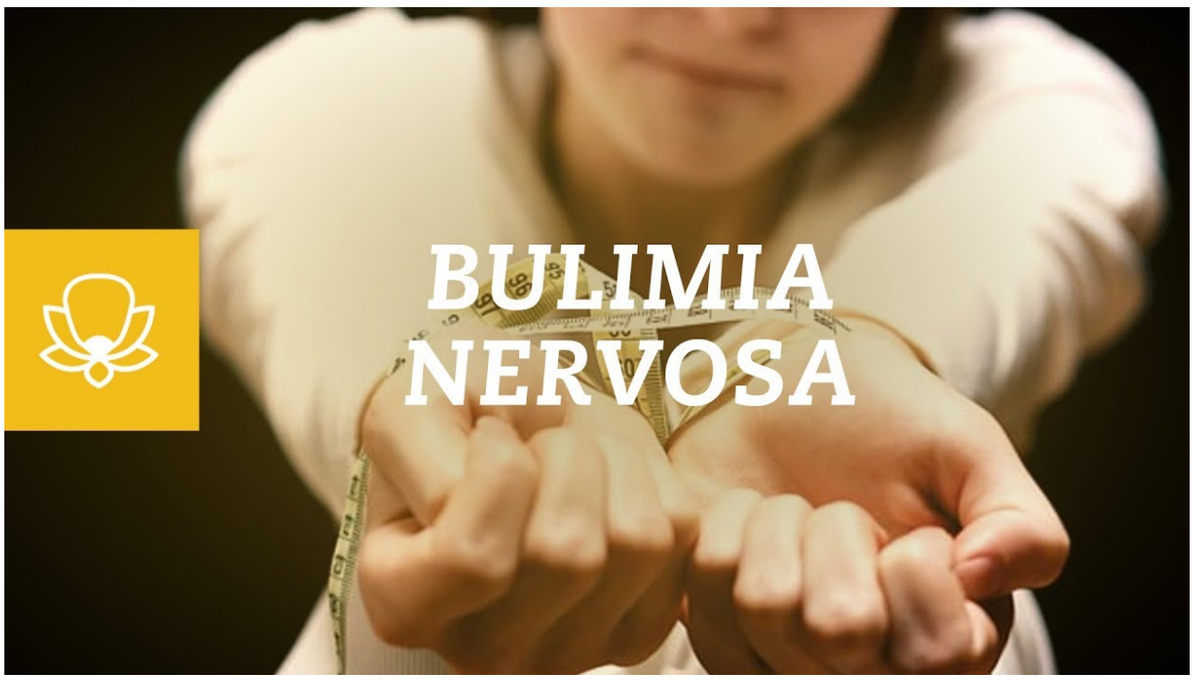
- **Avoid Insults, Lectures, or Guilt Trips.** Binge eaters feel bad enough about themselves and their behavior already. Lecturing, getting upset, or issuing ultimatums to a binge eater will only increase stress and make the situation worse. Instead, make it clear that you care about the person's health and happiness and you'll continue to be there.
- **Set a Good Example** by eating healthily, exercising, and managing stress without food. Don't make negative comments about your own body or anyone else's.

C. Bulimia Nervosa

Melinda Smith, M.A., Lawrence Robinson, and Jeanne Segal, Ph.D. Last updated: November 2019.

Retrieved from: https://www.helpguide.org/articles/eating-disorders/bulimia-nervosa.htm

What is Bulimia?



Many of us turn to food when we're feeling lonely, bored, or stressed. But if you have the eating disorder bulimia nervosa, overeating is more like a compulsion. Bulimia is characterized by frequent episodes of binge eating followed by extreme efforts to avoid gaining weight, often by vomiting, using laxatives, or exercising to excess. This vicious cycle of bingeing and purging can take a toll on your body and emotional well-being. It can cause damage to your digestive system and create chemical imbalances in the body that harm the functioning of major organs, including the heart. It can even be fatal.

While it is most common among young women, bulimia can affect women and men of all ages. When you're struggling with the eating disorder, life is a constant battle between the desire to lose weight and the overwhelming compulsion to binge eat. You don't want to binge—you know you'll feel guilty and ashamed afterwards—but time and again you give in. After the binge ends, panic sets in and you turn to drastic measures to "undo" your overeating, such as taking laxatives, vomiting, or going for an intense run. No matter how trapped in this vicious cycle you feel, though, there is hope. With treatment and support, you can break the cycle, learn to manage unpleasant emotions in a healthier way, and regain control of your life.

Not all Bulimics Purge

It's important to note that bulimia doesn't necessarily involve purging: physically eliminating the food from your body by throwing up or using laxatives, enemas, or diuretics. If you make up for your binges by fasting, exercising to excess, or going on crash diets, this also qualifies as bulimia.

Are you Bulimic?

- Are you obsessed with your body and your weight?
- Does food and dieting dominate your life?
- Are you afraid that when you start eating, you won't be able to stop?
- Do you ever eat until you feel sick?
- Do you feel guilty, ashamed, or depressed after you eat?
- Do you vomit or take laxatives to control your weight?

Signs and Symptoms of Bulimia

If you've been living with bulimia for a while, you've probably "done it all" to conceal your bingeing and purging habits. It's only human to feel ashamed about having a hard time controlling yourself with food, so you most likely binge alone. If you eat a box of doughnuts, then you'll replace them so your friends or family won't notice. When buying food for a binge, you might shop at four separate markets so the checker won't guess. But despite your secret life, those closest to you probably have a sense that something is not right.

Binge Eating Sign and Symptoms

- **Lack of Control Over Eating.** Unable to stop eating until the point of physical discomfort and pain.
- **Secrecy Surrounding Eating.** Going to the kitchen after everyone else has gone to bed. Going out alone on unexpected food runs.

- **Eating Unusually Large Amounts of Food** with no obvious change in weight.
- **Disappearance of Food,** numerous empty wrappers or food containers in the garbage, or hidden stashes of junk food.
- **Alternating Between Overeating and Fasting.** Rarely eating normal meals, it's all-or-nothing when it comes to food.

Purging Signs and Symptoms

- **Going to The Bathroom After Meals.** Frequently disappearing after meals to throw up. Running water to disguise sounds of vomiting.
- **Using Laxatives, Diuretics, or Enemas** after eating. Or taking diet pills or using the sauna to "sweat out" water weight.
- **Smell of Vomit.** The bathroom or even the person may smell like vomit. They may try to cover up the smell with mouthwash, perfume, air freshener, gum, or mints.
- **Excessive Exercising** after eating. Typical activities include high-intensity calorie burners such as running or aerobics.

Physical Signs and Symptoms

- **Calluses or Scars On Knuckles or Hands** from sticking fingers down their throat to induce vomiting.
- **Puffy "Chipmunk" Cheeks** caused by repeated vomiting.
- **Discolored Teeth** from exposure to stomach acid when throwing up. May look yellow, ragged, or clear.

- **Not Underweight.** Men and women with bulimia are usually normal weight or slightly overweight. Being underweight while purging might indicate a purging type of anorexia.
- **Frequent Fluctuations in Weight,** by 10 pounds or more due to alternating bingeing and purging.

Bulimia causes and effects

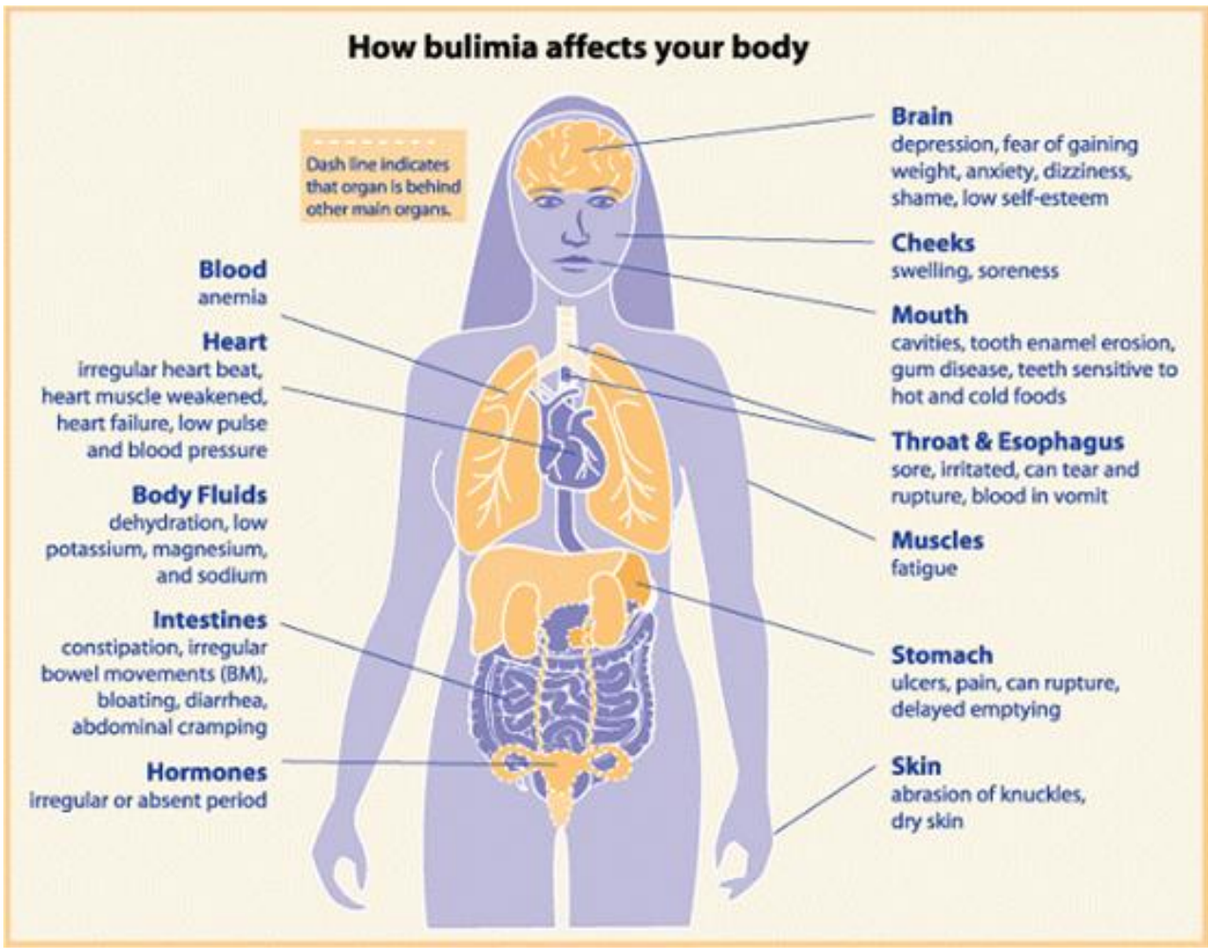
There is no single cause of bulimia. While low self-esteem and concerns about weight and body image play major roles, there are many other contributing factors. You may have trouble managing your emotions in a healthy way and use eating as an emotional release, bingeing and purging when you feel angry, depressed, stressed, or anxious.

Risk Factors for Bulimic include:

- **Poor Body Image**, particularly when paired with strict dieting.
- **Low Self-Esteem,** often stemming from depression, perfectionism, or a critical home environment.
- **Stressful Life Changes**, such as a breakup, going away to college, starting a new job, or going through puberty.
- **History of Trauma or Abuse.** This includes things such as sexual assault, childhood neglect or abuse, troubled family relationships, or the death of a loved one.

Effects of Bulimia

When you are living with bulimia, you are putting your body—and even your life—at risk. The most dangerous side effect of bulimia is dehydration due to purging. Vomiting, laxatives, and diuretics can cause electrolyte imbalances in the body, most commonly in the form of low potassium levels. Low potassium levels trigger a wide range of symptoms ranging from lethargy and cloudy thinking to irregular heartbeat and death. Chronically low levels of potassium can also result in kidney failure. Using ipecac syrup is also very dangerous, and can cause sudden death.



Source: *National Women's Health Information Center*

Getting Help for Bulimia

Regardless of how long you've struggled with bulimia, you can learn to break the binge and purge cycle and develop a healthier attitude toward food and your body.

Steps to Bulimia Recovery

- **Admit you have a problem.** Up until now, you've been invested in the idea that life will be better—that you'll finally feel good—if you lose more weight and control what you eat. The first step in bulimia recovery is admitting that your relationship to food is distorted and out of control.
- **Talk To Someone.** It can be hard to talk about what you're going through, especially if you've kept your bulimia a secret for a long time. You may be ashamed, ambivalent, or afraid of what others will think. But it's important to understand that you're not alone. Find a good listener—someone who will support you as you try to get better.
- **Stay Away From People, Places, and Activities That Trigger the temptation to Binge or Purge.** You may need to avoid looking at fashion or fitness

magazines, spend less time with friends who constantly diet and talk about losing weight, and stay away from weight loss web sites and “pro-mia” sites that promote bulimia. You may also need to be careful when it comes to meal planning and cooking magazines and shows.

- **Address any Underlying Mood Disorder.** It’s common for people with bulimia to also suffer from depression or anxiety. Getting help for co-existing conditions is vital to your bulimia recovery.
- **Seek Professional Help.** The advice and support of trained eating disorder professionals can help you regain your health, learn to eat normally again, and develop healthier attitudes about food and your body.

Bulimia Recovery Tip 1: Break the Binge and Purge Cycle

The first step in bulimia recovery is stopping the vicious cycle of bingeing and purging. In order to do this, it's essential that you quit trying to diet. Dieting triggers bulimia's destructive cycle of bingeing and purging. The irony is that the stricter the diet, the more likely it is that you'll become preoccupied, even obsessed, with food. When you starve yourself, your body responds with powerful cravings—its way of asking for needed nutrition.

As the tension, hunger, and feelings of deprivation build, the compulsion to eat becomes too powerful to resist: a "forbidden" food is eaten; a dietary rule is broken. With an all-or-nothing mindset, you feel any diet slip-up is a total failure. After having a bite of ice cream, you might think, "I've already blown It, so I might as well go all out."

Unfortunately, the relief that bingeing brings is extremely short-lived. Soon after, guilt and self-loathing set in. And so you purge to make up for bingeing to regain control. But purging only reinforces binge eating. Though you may tell yourself this is the last time, in the back of your mind there's a voice saying you can always throw up or use laxatives if you lose control again. However, purging doesn't come close to wiping the slate clean after a binge.

Purging Does NOT Prevent Weight Gain

Purging isn't effective at getting rid of calories, which is why most people suffering with bulimia end up gaining weight over time. Vomiting immediately after eating won't eliminate more than 50% of the calories consumed— usually much less. This is because calorie absorption begins the moment you put food in the mouth. Laxatives and diuretics are even less effective. Laxatives get rid of only 10% of the calories eaten, and diuretics none at all. You may weigh less after taking them, but that lower number on the scale is due to water loss, not true weight loss.

Bulimia Recovery Tip 2: Develop a Healthier Relationship to Food

Once you stop trying to restrict calories and follow strict dietary rules, you will no longer be overwhelmed with cravings and thoughts of food. By eating normally, you can break the binge-and-purge cycle and still reach a healthy, attractive weight.

- **Pay Attention To Your Hunger.** Don't wait until you're starving. This only leads to overeating! Eat as soon as you notice you're feeling moderately hungry.
- **Eat Regularly.** Don't skip meals. Try not to let over 4 hours pass without a meal or snack.

- **Don’t Restrict Foods.** When something is off limits, it becomes more tempting. Instead of saying “I can never eat ice cream,” say “I will eat ice cream as an occasional treat.”
- **Focus on What You’re Eating.** How often have you binged in an almost trance-like state, not even enjoying what you’re consuming? Instead of eating mindlessly, be a mindful eater. Slow down and savor the textures and flavors. Not only will you eat less, you’ll enjoy it more.

Bulimia Recovery Tip 3: Learn To Tolerate Unpleasant Feelings

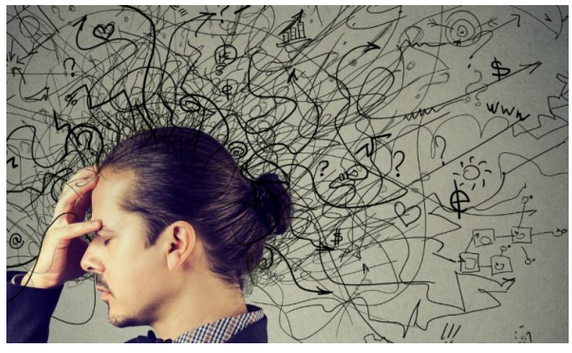
While bingeing is often triggered by overly strict dieting that backfires, it can also be a way to control or numb unpleasant moods or feelings.

The next time you feel the urge to binge, ask yourself if there’s something else going on. Is there an intense feeling you’re trying to avoid? Are you eating to calm down, comfort yourself, or to relieve boredom? If so, instead of using food as a distraction, take a moment to stop whatever you’re doing and investigate what’s going on inside.

- **Identify the emotion you’re feeling.** Is it anxiety? Shame? Hopelessness? Anger? Loneliness? Fear? Emptiness?
- **Accept the experience you’re having.** Avoidance and resistance only make negative emotions stronger. Instead, try to accept what you’re feeling without judgement.
- **Dig deeper.** Explore what’s going on. Where do you feel the emotion in your body? What kinds of thoughts are going through your head?
- **Distance yourself.** Realize that you are NOT your feelings. Emotions are passing events, like clouds moving across the sky. They don’t define who you are.

Sitting with your feelings may feel extremely uncomfortable at first. Maybe even impossible. But as you resist the urge to binge, you’ll start to realize that you don’t have to give in. Even emotions that feel intolerable are only temporary. They’ll quickly pass if you stop fighting them. You’re still in control. You can choose how to respond.

Bulimia Recovery Tip 4: Challenge Dysfunctional Thoughts



The bingeing and purging of bulimia is often fueled by dysfunctional, self-sabotaging ways of thinking that undermine your

confidence, color everything in an unrealistically negative light, and make you feel helpless, inadequate, and ashamed. But you can learn to put a stop to these unhealthy mental habits.

Damaging Mindsets that Fuel Bulimia

- **All-or-nothing thinking.** You have a hard time seeing shades of gray, at least when it comes to yourself. If you're not perfect, you're a total failure and might as well binge.
- **Emotional reasoning.** You believe if you feel a certain way, it must be true. "I feel fat" means "I am fat." "I feel hopeless" means you'll never get better.
- **Musts, must-nots, and have-tos.** You hold yourself to a rigid set of rules ("I must not eat such and such a food," "I have to get straight A's," "I must always be in control." etc.) and beat yourself up if you break them.
- **Labeling.** You call yourself names based on mistakes and perceived shortcomings. "I'm unhappy with how I look" becomes "I'm disgusting." Slipping up becomes "I'm a failure."
- **Catastrophizing.** You jump to the worst-case scenario. If you backslide in recovery, for example, you assume that there's no hope you'll ever get better.

Put your Thoughts on the Witness Stand

Once you identify the destructive thoughts patterns that you default to, you can start to challenge them with questions such as:

- "What's the evidence that this thought is true? Not true?"
- "What would I tell a friend who had this thought?"
- "Is there another way of looking at the situation or an alternate explanation?"
- "How might I look at this situation if I didn't have bulimia?"

As you cross-examine your negative thoughts, you may be surprised at how quickly they crumble. In the process, you'll develop a more balanced perspective.

Helping Someone With Bulimia

If you suspect that your friend or family member has bulimia, talk to the person about your concerns. Your loved one may deny bingeing and purging, but there's a chance that he or she will welcome the opportunity to open up about the struggle.

Either way, bulimia should never be ignored. The person's physical and emotional health is at stake. While you can't force anyone to get better, there are things you can do to help.

If your Loved One Has Bulimia

- **Offer compassion and support.** Keep in mind that the person may get defensive or angry. But if he or she does open up, listen without judgment and make sure the person knows you care.
- **Avoid Insults, Scare Tactics, Guilt Trips, and Patronizing Comments.** Since bulimia is often caused and exacerbated by stress, low self-esteem, and shame, negativity will only make it worse.
- **Set A Good Example** for healthy eating, exercising, and body image. Don't make negative comments about your own body or anyone else's.
- **Accept Your Limits.** There isn't a lot you can do to "fix" your loved one's bulimia. The person with bulimia must make the decision to move forward.
- **Take Care Of Yourself.** Know when to seek advice for yourself from a counselor or health professional. Dealing with an eating disorder is stressful, and it will help if you have your own support system in place.

D. Pica

National Eating Disorder Association

Retrieved from: https://www.nationaleatingdisorders.org/learn/by-eating-disorder/other/pica

Pica is an eating disorder that involves eating items that are not typically thought of as food and that do not contain significant nutritional value, such as hair, dirt, and paint chips.

Evaluation & Diagnosis

- There are no laboratory tests for pica. Instead, the diagnosis is made from a clinical history of the patient.
- Diagnosing pica should be accompanied by tests for anemia, potential intestinal blockages, and toxic side effects of substances consumed (i.e., lead in paint, bacteria or parasites from dirt).

Warning Sings and Symptoms of Pica

- The persistent eating, over a period of at least one month, of substances that are not food and do not provide nutritional value.
- The ingestion of the substance(s) is not a part of culturally supported or socially normative practice (e.g., some cultures promote eating clay as part of a medicinal practice).
- Typical substances ingested tend to vary with age and availability. They may include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal, ash, clay, starch, or ice.
- The eating of these substances must be developmentally inappropriate. In children under two years of age, mouthing objects—or putting small objects in their mouth—is a normal part of development, allowing the child to explore their senses. Mouthing may sometimes result in ingestion. In order to exclude developmentally normal mouthing, children under two years of age should not be diagnosed with pica.
- Generally, those with pica are not averse to ingesting food.

Risk Factors

- Pica often occurs with other mental health disorders associated with impaired functioning (e.g., intellectual disability, autism spectrum disorder, schizophrenia).
- Iron-deficiency anemia and malnutrition are two of the most common causes of pica, followed by pregnancy. In these individuals, pica is a sign that the body is trying to correct a significant nutrient deficiency. Treating this deficiency with medication or vitamins often resolves the problems.
- A medical professional should assess if the behavior is sufficiently severe to warrant independent clinical attention (e.g., some people may eat nonfood items during pregnancy, but their doctor may determine that their actions do not indicate the need for separate clinical care).

Additional Information

It is unclear how many people are affected by pica. It most likely is more prevalent in developing countries.

- Pica can affect children, adolescents, and adults of any genders.
- Those who are pregnant and craving nonfood items should only be diagnosed with pica when their cravings lead to ingesting nonfood items, and the ingestion of those items poses a potential medical risk (either due to the quantity or type of item being ingested).
- Pica can be associated with intellectual disability, trichotillomania (hair pulling disorder), and excoriation (skin picking) disorder

Treatment

The first-line treatment for pica involves testing for mineral or nutrient deficiencies and correcting those. In many cases, concerning eating behaviors disappear as deficiencies are corrected. If the behaviors aren't caused by malnutrition or don't stop after nutritional treatment, a variety of behavioral interventions are available.

Scientists in the autism community have developed several different effective interventions, including redirecting the person's attention away from the desired object and rewarding them for discarding or setting down the non-food item.

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

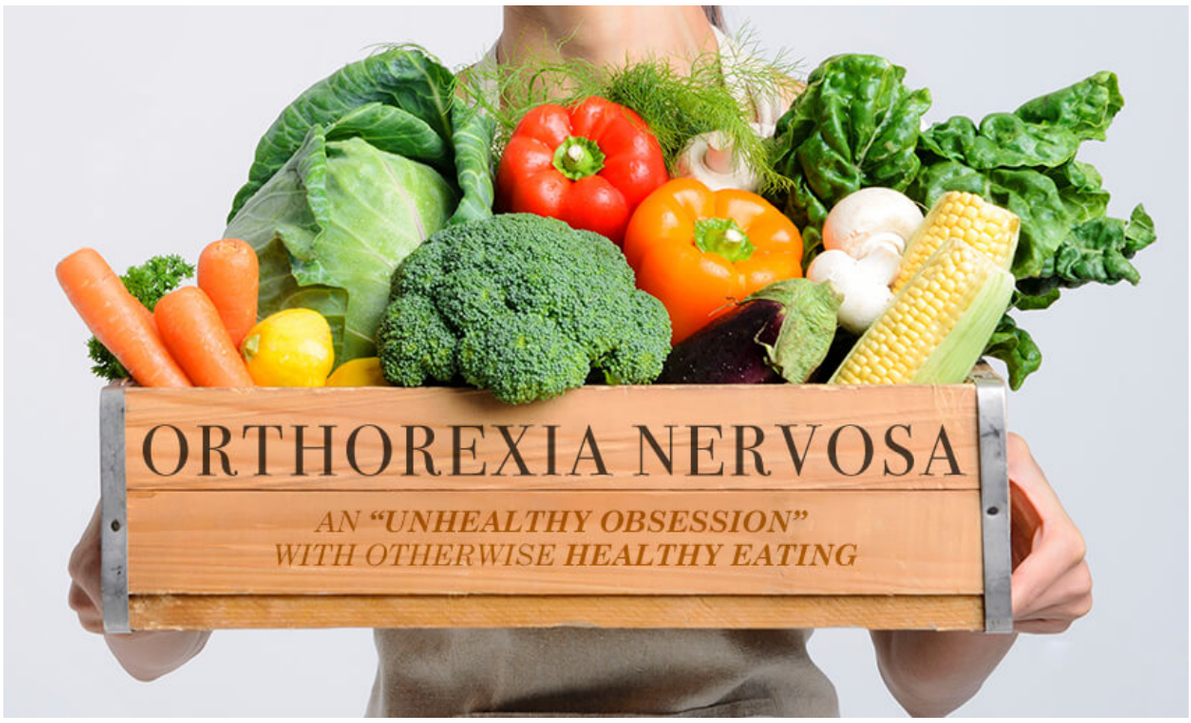
To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

E. Orthorexia Nervosa

Anne Artley and Melinda Smith, M.A. Last updated: February 2020

Retrieved from: https://www.helpguide.org/articles/eating-disorders/orthorexia-nervosa.htm

What is orthorexia?



Orthorexia, or orthorexia nervosa, is a damaging obsession with healthy eating and the quality and purity of food in your diet. The term, coined by American physician Steven Bratman, literally means "fixation on righteous eating." Although orthorexia is not officially recognized as an eating disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), obsessing over every ingredient in your diet, severely restricting the types of food you eat, and trying to eat the "perfect" diet can take a serious toll on your physical and mental health.

Orthorexia has become more widespread with the advancement of "clean eating." This is a form of diet that aims to limit consumption of processed foods and those that are high in sugar, unhealthy fats, and preservatives. It also involves choosing whole foods in their most natural state. For example, sticking to a vegan, gluten-free, dairy-free, raw food, or all-organic diet could all fall under attempts to "eat clean." However, orthorexia can develop out of any rigid way of eating, including the paleo and keto diets.

While many of these diets can be healthy, orthorexia takes things to extremes, becoming overly restrictive, often leading to excessive weight loss and even malnutrition and other health issues. And the impact goes far beyond the physical. Orthorexia can disrupt your day-to-day functioning, negatively affect your social activities, interfere with your relationships, and cause extreme emotional distress.

But your life and well-being doesn't have to revolve around what you eat. With treatment, self-help, and support, you can get back to a balanced and truly healthy way of eating and enjoying life.

The Difference Between Healthy Eating and Orthorexia

Healthy Eating	Orthorexia
You do your best to make nutritious food choices most of the time, but you're flexible when you need to be.	You stick rigidly to your diet and may refuse to eat or become anxious if you don't have access to food that meets your specifications.
You cut out certain foods for general health reasons, or because you physically feel better when you avoid them.	You cut out certain foods or even entire food groups because you view them as "bad" or "impure."
Your identity is based on various interests, friends, work, and hobbies.	Your identity is based largely on the purity and perfection of your diet.

Signs and Symptoms of Orthorexia

Since eating healthfully is normally an admirable goal, orthorexia is easy to overlook. But if you're worried that your diet is taking over your life, or worried about a love one's eating habits, asking the following questions can help.

Actions

Orthorexia is marked by certain patterns and behaviors. Do you (or your loved one):

- **Refuse to eat from entire food groups?** You may be depriving yourself of key nutrients.
- **Go out less with friends and family so that you'll able to stick to your diet?** If your desire to eat healthfully is limiting your social life, it may have gone too far.
- **Spend a lot of time planning your meals in advance?** If you've eliminated many ingredients from your diet, you'll find there's a lot you can't eat. You might also derive a sense of accomplishment from mapping out your meals and contemplating how to best achieve your health goals.
- **Devote a lot of time to researching nutritional components of food?** Has this replaced other activities you used to enjoy? Do you feel like you're always finding

ways that food could be unhealthy? This could include an obsession with ‘healthy lifestyle’ blogs or joining multiple Internet chat rooms on the subject.

- **Spend over your budget on food?** The more complicated your diet, the more expensive it can become.
- **Judge other people’s eating habits or encourage them to also limit certain foods?** There’s an aspect of morality attached to orthorexia. You may find yourself categorizing food as “good” and “bad.” You might also assign negative character traits to people who eat too much of a certain food.

Feelings

If you have orthorexia, you’ll experience many “highs” and “lows” related to your diet. At first, you may experience a rush of achievement and superiority. Often, though, orthorexia is a coping mechanism for hidden pain and other uncomfortable feelings. Do you:

- **Feel guilty after eating “bad” foods?** Even if eating healthfully is your overall goal, you should be able to enjoy a restaurant meal or a dessert out with friends from time to time.
- **Feel a heightened sense of accomplishment after eating “good” foods?** Orthorexia differs slightly from other eating disorders in that the focus, at least on the surface, is on health rather than losing weight. Therefore, there’s an aspect of purity involved, and the goal of ridding your body of “toxins.”
- **Find it difficult to eat a meal prepared by someone else?** You may feel out of control unless you know the specific ingredients of your meal.
- **Feel self-loathing when you stray from your diet?** Even when your eating regimen becomes increasingly harder to maintain, you base your self-esteem on how well you can follow it.
- **Find it difficult to concentrate on work or school because you’re thinking about food?** How does your body feel? You may feel tired or unfocused because you’re undernourished.
- **Follow a strict diet to feel more in control?** Reflect on what else is going on in your life. Are there other issues you feel you can’t control?
- **Care more about the idea of your food than the taste of it?** Are you very concerned with the source, and how your food is processed or packaged? For

example, you may worry if vegetables were exposed to pesticides, or whether nutrients were lost during cooking.

Identifying Orthorexia in Someone Else

It's not always easy to determine if you should intervene with a friend or family member who's following a strict diet. But if you've noticed more negative than positive changes in your loved one, it may be time to step in.

- **Has your loved one's diet compromised their safety or quality of life?** Have they lost weight drastically or cut out so many food groups that they're not eating much at all? Do they have to forgo activities and social situations because it doesn't fit in with their diet?
- **Is their eating pattern making them miserable?** Nutritious eating is important, but if it's sucking all the joy out of your loved one, how much does it really accomplish? Do they worry a lot about the quality or purity of their food? Do they get anxious when they can't find foods that meet their standards? These are red flags.
- **Does their dietary fixation resemble another condition?** Do they also exhibit symptoms of depression or anxiety? Does their preoccupation with healthy eating share similarities with obsessive-compulsive disorder? Have they struggled with any of these conditions in the past?

Is it Orthorexia or Anorexia?

While the outward motivation of orthorexia is different from anorexia, both eating disorders share the same desire to control life and uncomfortable emotions using food. Further, many people try to lose weight under the guise of bettering their health. Someone with orthorexia might opt for wild salmon over a low-calorie shake, or nutritional supplements over diet pills, but the goal is still the same. So, while aiming to eat healthfully is more socially acceptable than purging or drastically restricting calories, it's important to consider your true intentions for how you manage your diet.

- If you have anorexia, you might feel ashamed and try to hide any changes in your eating habits. People with orthorexia usually wear their diet as a badge of honor. If you have orthorexia, you may feel more inclined to encourage your friends to follow a similar path.
- Those with anorexia tend to focus on avoiding all food, while sufferers of orthorexia embrace meals they think are healthy.
- Do you pay particular attention to ingredients or the way food is prepared? If you have anorexia, you will likely be more concerned with caloric intake than specific nutritional value.

Orthorexia and Obsessive-Compulsive Disorder

Along with anorexia, orthorexia also shares symptoms with obsessive-compulsive disorder (OCD). Some similar tendencies include recurring thoughts about food and health that interfere with daily life, excessive stress over food contamination, and a compulsion to prepare meals in a specific manner. If you have orthorexia, your ritualized eating style also leaves little time for other activities.

Have you Started Exercising More?

Often, eating disorders, including orthorexia, are accompanied by over-exercise. This accelerates your weight loss to an unhealthy level. Again, if you're worried that your fitness routine has become excessive, think about how much it interferes with the other components of your life.

- Have you stopped seeing friends as often because you're either at the gym or avoiding situations where you'll have to eat a meal out?
- Are you so tired from exercising that it's affecting your performance at work or school?
- Do you feel guilty if you skip a day or think you didn't perform to an optimal level?

Underlying causes of orthorexia

As with other eating disorders, the root causes of orthorexia are complicated and wide-reaching. Although on the surface, your goal is to gain better health, often food becomes a means to work out other issues. Some underlying causes can include:

- **Fear of illness or health complications.** Perhaps you've had a health scare. Maybe you have a recurring ailment, such as headaches, and you've seen an improvement when you cut out certain foods. While a healthy diet can certainly help extend your life, the truth is, none of us will live forever—and it's important not to lose sight of the reasons you'd like to live a long, healthy life.
- **Desire for control.** If you feel the need for stringent control over your diet, consider whether you're trying to compensate for other areas in your life. This could include both health-related issues and other anxieties. In life, there's always an element of unpredictability. Getting to the root of your fears can go a long way toward regaining a healthy perspective.
- **Creating an identity.** Nowadays, it's easy to find passionate communities around certain food movements. For example, many people are adopting vegetarian and vegan diets in an effort to help the environment. Also, the more specific your diet, the more necessary it becomes to stick with people with similar

habits. While having a support group to encourage healthy habits is a positive thing, consider how much your eating habits isolate you from other friends and family members or how much your identity is dependent on food. You always want to nurture the other aspects of your identity that make you an interesting, well-rounded person.

Orthorexia Treatment and Recovery

First of all, recognizing that you may have taken your diet too far is no small feat. You're in the right place to start recovery. Keep in mind that healing is a journey. It will most likely feel strange at first to eat foods you haven't allowed yourself. You may at times question your decision to abandon your former strict diet, and even try to return to it from time to time. While it's natural to relapse occasionally, don't lose sight of the reasons why you decided a limited diet was no longer good for you.

First Steps Toward Recovery

- **Make a list of the ways your obsession with food has harmed others.** Have you lost friends because you've shamed them for the way they eat? Similarly, have you cut off any of your loved ones because they didn't follow a diet like yours? As painful as it may be, recalling incidents where you may have hurt someone's feelings over food is instrumental to the healing process. Reflect on times you ate at someone's house. Did you refuse to eat the meal they prepared? If you have children, consider how your lifestyle choices may have restricted them too.

- **Make a list of the ways your obsession with food has harmed yourself.** Be honest with yourself. How much time have you spent thinking about food and planning meals? Has it affected your performance at work or school? Have your thoughts about food prevented you from pursuing other goals and hobbies? Consider any relationships you've severed or neglected to obsess over food. Was maintaining your diet worth the isolation?

- **Find a mantra.** Find something positive that you can repeat to yourself when you get the urge to slip back into old habits. Something with the general message of "food doesn't define me," or "I'm more than my diet." Get creative or funny!

Exploring What's Fueling your Orthorexia

While it may have started as an attempt to eat healthier, often diets that turn into obsessions are coping mechanisms to avoid facing other issues. Trying to break away from your orthorexia may unearth some uncomfortable feelings. Do you find it difficult to introduce more foods into your diet? Why do you think this is the case? It may help to journal your thoughts to uncover your true motivations. If you know your eating pattern is unhealthy, but you can't seem to break away from it, it may help to talk to a therapist.

Accepting and managing uncomfortable feelings

After you've identified some of the feelings fueling your orthorexia, it's important to find a healthier response. This may make you feel worse at the beginning of your recovery. For example, if you've discovered that your orthorexia gives you an illusion of control, changing your eating pattern may cause your anxiety to come flooding back. But don't feel tempted to go back to your destructive diet; the key is to work toward accepting yourself and all of your emotions.

- **Figure out what you're feeling.** When you try to open up your diet, what emotions does this trigger? Is it anxiety? Helplessness? Loneliness?
- **Accept your emotions.** Denying unpleasant feelings doesn't make them go away. Instead, allow yourself to experience them without judgement.
- **Tune in to your experience.** Where do you feel the emotion in your body? What thoughts does it trigger?
- **Be objective.** Realize that these negative feelings don't define you. Think of them as passing storm clouds; they aren't permanent. Practicing mindfulness and activating your body's relaxation response can help.

Finding better coping mechanisms

Once you understand the underlying causes of your disordered eating, you need to find healthier coping mechanisms that fulfill you. Here are some ideas:

- **If you're anxious,** go for a walk; turn on some music and dance; or hold a cherished object. If you're using your food rituals as a way to block people out, recognizing this is the first step to removing your barriers. Getting a pet or interacting with animals is another way to get out of your head.

- **If you're depressed or lonely**, acknowledge that some of the root causes of orthorexia involve feeling part of a community or carving out an identity. Consider your other hobbies and passions that don't involve food. Maybe you could join a group that focuses on one of them. Also, volunteering can help open your eyes to the world beyond your diet.
- **If you're unfulfilled**, try to seek meaning in another way outside of food. For example, try meditation, find a spiritual community, or connect more with nature.

Developing a healthier relationship with food

As you're working through the underlying causes of your disordered eating, you may be wondering how to replace it. With so much advice on diet and nutrition out there, it can be hard to tell the good from the bad. Generally, we all need a balance of protein, fat, carbohydrates, fiber, vitamins and minerals to give us optimal energy and health. The key is, instead of aiming for perfection, look to include some of each food group in every meal. Replacing processed foods with fresh ingredients whenever possible is a good place to start. Similarly, cooking at home rather than relying on take-out is also helpful in maintaining a healthy diet. However, it's important not to think of certain foods as "off-limits." Instead, focus on moderation and be kind to yourself.

Replacing the Restriction Mentality

While it can feel scary at first to eat without a blueprint, after some time, you'll become more attuned to your body and better able to respond to what it needs.

- **Pay attention to your body's rhythms.** Don't eat unless you are hungry. Eat slowly and stop when you are full.

- **Eat mindfully—fully experience your food.** Mindful eating will help you gauge when you've had enough. Take note of your food's textures and tastes. Try to avoid eating while watching TV, working on the computer, or when otherwise distracted.
- **Be careful with food and fitness tracking technology**. Since they are so specific, regular use of them can intensify anxiety and obsessive behaviors. If you're struggling with orthorexia, you're probably already prone to perfectionism. It's good to measure your portions, but at the same time, don't deny yourself if you still feel hungry.
- **Don't ignore cravings (within reason!)** If you've had a healthy dinner, for example, you can allow yourself a scoop of ice cream as a treat.

How to help someone with orthorexia

Orthorexia, like any other eating disorder, distorts the way your loved one thinks. Attacking them or undermining their beliefs will only make them shut you out. They will dismiss you as someone who doesn't take their health seriously; in fact, your efforts may backfire and lead them to try to convince *you* that *your* lifestyle is the one that needs to change! Instead, try slowly establishing trust. If the person with orthorexia views you as an ally, you have a better chance at gaining ground with them.

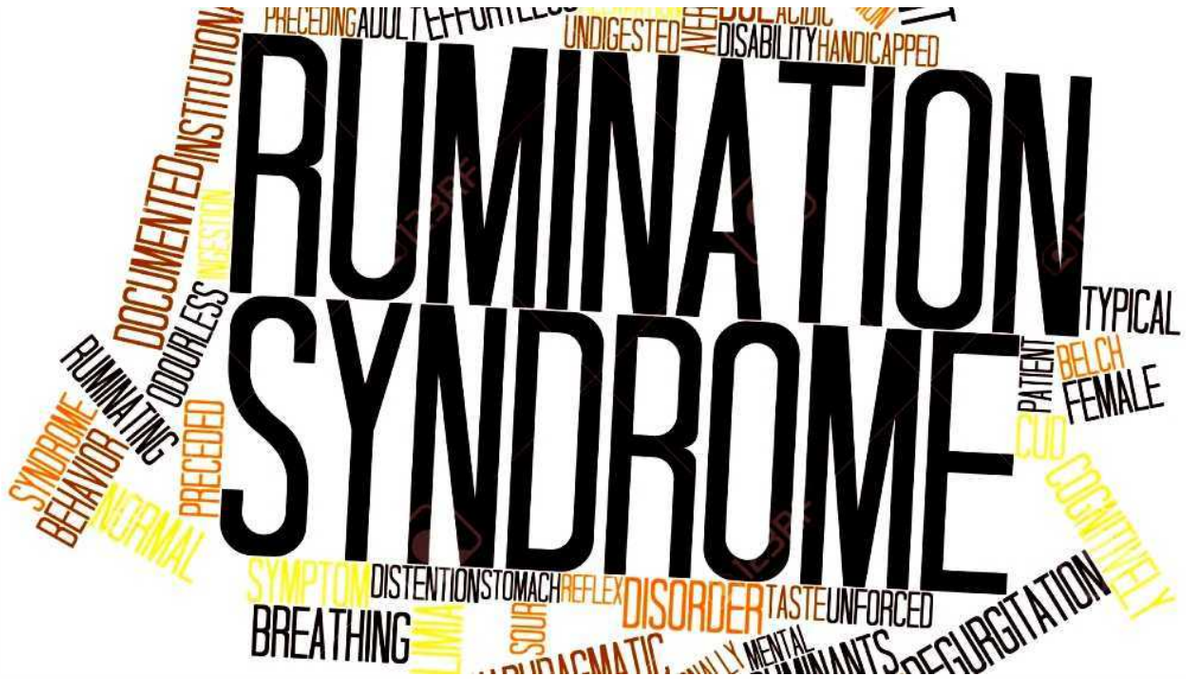
- **Agree with their stated motivations.** Acknowledge that diet is indeed a powerful tool for solving health problems, and that many advertised products

have too many additives. If they can see that you value the importance of a healthy diet, they'll be more likely to listen to you.

- **Share your own experiences.** If you've also struggled with the line between a healthy diet and extremism, you might want to share that with your loved one.
- **Seek advice from a health professional.** You can also enlist other friends and loved ones for support.
- **Avoid threats, emotional outbursts, and scare tactics.** Since orthorexia is often rooted in anxiety and self-doubt, you'll only make your loved one feel worse and break down the lines of communication.
- **Take the pressure off yourself.** You can't solve someone's eating disorder for them. Don't forget to take care of yourself and seek counseling to help manage your own feelings if necessary.

F. Rumination Syndrome

Retrieved from: https://rarediseases.info.nih.gov/diseases/7594/rumination-disorder



Rumination disorder is the backward flow of recently eaten food from the stomach to the mouth. The food is then re-chewed and swallowed or spat out. A non-purposeful contraction of stomach muscles is involved in rumination. It may be initially triggered by a viral illness, emotional distress, or physical injury. In many cases, no underlying trigger is identified. Behavioral therapy is the mainstay of treatment.

Symptoms

Signs and symptoms of rumination disorder includes the backward flow of recently eaten food from the stomach to the mouth. This typically occurs immediately to 15 to 30 minutes after eating. Rumination often occurs without retching or gagging. Rumination may be proceeded by a feeling of pressure, the need to belch, nausea, or discomfort. Some people with rumination disorder experience bloating, heartburn, diarrhea, constipation, abdominal pain, headaches, dizziness, or sleeping difficulties. Complications of severe disorder include weight loss, malnutrition, and electrolyte imbalance.

Cause

Rumination disorder may occur following a viral illness, emotional stress, or physical injury. It is theorized that while the initial stressor improves, an altered sensation in the abdomen persists. This ultimately results in the relaxation of the muscle at the bottom of the esophagus. To relieve this discomfort people with rumination disorder use abdominal wall muscles to expel and regurgitate foods. As a result of the relief of symptoms, the person repeats the same response when the discomfort returns. Overtime the person unconsciously adopts this learned behavior.

Some cases of rumination disorder occur without a precipitating event or illness. Other people with the disorder describe also having ingestion, which may serve as a trigger. Studies have shown that some people with rumination disorder also have depression, anxiety, or an eating disorder. These conditions may likewise play a role in rumination disorder. Conditions like depression and anxiety are known to be more common in people with other functional gastrointestinal conditions as well, for example irritable bowel syndrome.

Diagnosis

Diagnosis can be made by a clinical evaluation of the person’s signs and symptoms and history. The following diagnostic criteria is used to aid in diagnosis. These criteria must be met for the last 3 months, with symptoms beginning at least 6 months prior to diagnosis:

1. Repeated regurgitation and rechewing or expulsion of food that

a. Begins soon after eating
b. Does not occur during sleep

c. Does not respond to standard treatment for GERD

2. No Retching

3. Symptoms are not explained by inflammatory, anatomic, metabolic, or neoplastic processes

These criteria help distinguish rumination syndrome from other disorders of the GI tract, such as gastroparesis and achalasia where vomiting occurs hours after eating, gastroesophageal reflux where symptoms occur at night, and cyclic vomiting syndrome where the symptoms are chronic/persistent.[2]

Antroduodenal manometry can assist in making and confirming the diagnosis. Antroduodenal manometry involves putting a catheter through the nose into the stomach and small bowel to measure pressure changes.

Treatment

The main treatment of rumination disorder is behavioral therapy. This may involve habitat reversal strategies, relaxation, diaphragmatic breathing, and biofeedback. These types of therapies can often be administered by a gastroenterologist. Other professionals, such as nurse practitioners, psychologists, massage therapists, and recreational therapists may also be involved in care. Ensuring adequate nutrition is

essential and treatment will also involve managing other symptoms, such as anxiety, nausea and stomach discomfort (which may involve anti-depressive agents or SSRI's).

If behavioral therapy is unsuccessful, treatment with baclofen may be considered. There is limited data regarding optimal treatment of rumination disorder, but success with baclofen has been reported.

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G. Laxative Abuse

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/learn/general-information/laxative-abuse

Laxative abuse occurs when a person attempts to eliminate unwanted calories, lose weight, "feel thin," or "feel empty" through the repeated, frequent use of laxatives. Often, laxatives are misused following eating binges, because the individual mistakenly believes that the laxatives will work to rush out food and calories before they can be absorbed — but that doesn't really happen. Laxative abuse is serious and dangerous, often resulting in a variety of health complications and sometimes causing life-threatening conditions.

THE LAXATIVE MYTH

The belief that laxatives are effective for weight control is a myth. In fact, by the time laxatives act on the large intestine, most foods and calories have already been

absorbed by the small intestine. Although laxatives artificially stimulate the large intestine to empty, the “weight loss” caused by a laxative-induced bowel movement contains little actual food, fat, or calories. Instead, laxative abuse causes the loss of water, minerals, electrolytes, and indigestible fiber and wastes from the colon. This “water weight” returns as soon as the individual drinks any fluids and the body re-hydrates. If the chronic laxative abuser refuses to re-hydrate, they risk dehydration, which further taxes the organs and which may ultimately cause death.

HEALTH CONSEQUENCES OF LAXATIVE ABUSE

- Disturbance of electrolyte and mineral balances. Sodium, potassium, magnesium, and phosphorus are electrolytes and minerals that are present in very specific amounts necessary for proper functioning of the nerves and muscles, including those of the colon and heart. Upsetting this delicate balance can cause improper functioning of these vital organs.
- Severe dehydration may cause tremors, weakness, blurry vision, fainting, kidney damage, and, in extreme cases, death. Dehydration often requires medical treatment.
- Laxative dependency occurs from overuse, and can cause the colon stops reacting to usual doses of laxatives so that larger and larger amounts of laxatives may be needed to produce bowel movements.
- Internal organ damage may result, including stretched or “lazy” colon, colon infection, irritable bowel syndrome, and, rarely, liver damage. Chronic laxative abuse may contribute to risk of colon cancer.

TREATMENT

Overcoming laxative abuse requires working with a team of health professionals who have expertise in treating eating disorders, including a general physician, a psychiatrist, psychologist, or counselor, and a registered dietician. Support from close friends and family is also helpful. Meeting with others to talk over anxieties, concerns, and difficulties can greatly aid in getting through tough times in the recovery process.

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

H. Compulsive Exercise

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/learn/general-information/compulsive-exercisef

Compulsive exercise is not a recognized clinical diagnosis in the DSM-5, but many people struggle with symptoms associated with this term. If you are concerned about your or a loved one's relationship with exercise, please speak with a treatment professional.

WARNING SIGNS & SYMPTOMS OF COMPULSIVE EXERCISE

- Exercise that significantly interferes with important activities, occurs at inappropriate times or in inappropriate settings, or when the individual continues to exercise despite injury or other medical complications
- Intense anxiety, depression, irritability, feelings of guilt, and/or distress if unable to exercise
- Maintains excessive, rigid exercise regimen – despite weather, fatigue, illness, or injury
- Discomfort with rest or inactivity
- Exercise used to manage emotions
- Exercise as a means of purging (needing to “get rid of” or “burn off” calories)
- Exercise as permission to eat
- Exercise that is secretive or hidden
- Feeling as though you are not good enough, fast enough or not pushing hard enough during a period of exercise; overtraining
- Withdrawal from friends and family

HEALTH CONSEQUENCES OF COMPULSIVE EXERCISE

- Bone density loss (osteopenia or osteoporosis)
- Loss of menstrual cycle (in women)
- Female Athlete Triad (in women)
- Relative Energy Deficiency in Sport (RED-S)
- Persistent muscle soreness
- Chronic bone & joint pain
- Increased incidence of injury (overuse injuries, stress fractures, etc.)
- Persistent fatigue and sluggishness
- Altered resting heart rate
- Increased frequency of illness & upper respiratory infections

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

I. Eating Disorder Treatment and Recovery

Melinda Smith, M.A., Lawrence Robinson, and Jeanne Segal, Ph.D. Last updated: November 2019.

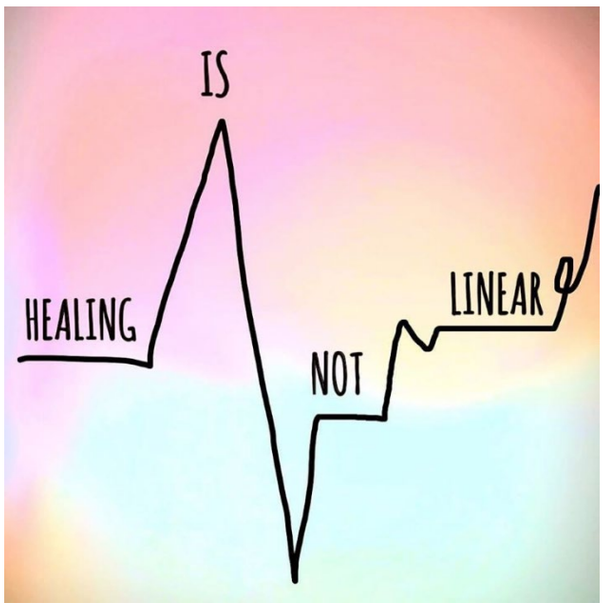
Retrieved from: https://www.helpguide.org/articles/eating-disorders/eating-disorder-treatment-and-recovery.htm

How do I begin recovery from an eating disorder?

The inner voices of anorexia and bulimia whisper that you'll never be happy until you lose weight, that your worth is measured by how you look. But the truth is that happiness and self-esteem come from loving yourself for who you truly are—and that's only possible with recovery.

The road to recovery from an eating disorder starts with admitting you have a problem. This admission can be tough, especially if you're still clinging to the belief—even in the back of your mind—that weight loss is the key to your happiness, confidence, and success. Even when you finally understand this isn't true, old habits are still hard to break.

The good news is that the behaviors you've learned can also be unlearned. Just as anyone can develop an eating disorder, so too, anyone can get better. However, overcoming an eating disorder is about more than giving up unhealthy eating behaviors. It's also about learning new ways to cope with emotional pain and rediscovering who you are beyond your eating habits, weight, and body image.



True recovery from an eating disorder involves learning to:

- Listen to your feelings.
- Listen to your body.
- Accept yourself.
- Love yourself.

This may seem like a lot to tackle, but just remember that you're not alone. Help is out there and recovery is within your reach. With the right support and guidance, you can break free from your eating disorder's destructive pattern, regain your health, and find the joy in life again.

Reach Out for support

Once you've decided to make a change, opening up about the problem is an important step on the road to recovery. It can feel scary or embarrassing to seek help for an eating disorder, so it's important to choose someone who will be supportive and truly listen without judging you or rejecting you. This could be a close friend or family member or a youth leader, teacher, or school counselor you trust. Or you may be more comfortable confiding in a therapist or doctor.

- **Choose the right time and place.** There are no hard and fast rules for telling someone about your eating disorder. But be mindful about choosing the right time and place—ideally somewhere private where you won't be rushed or interrupted.
- **Starting the conversation.** This can be the hardest part. One way to start is by simply saying, "I've got something important to tell you. It's difficult for me to talk about this, so it would mean a lot if you'd be patient and hear me out." From

there, you may want to talk about when your eating disorder started, the feelings, thoughts, and behaviors involved, and how the disorder has impacted you.

- **Be patient.** Your friend or family member will have their own emotional reaction to learning about your eating disorder. They may feel shocked, helpless, confused, sad, or even angry. They may not know how to respond or help you. Give them time to digest what you're telling them. It's also important to educate them about your specific eating disorder.
- **Be specific about how the person can best support you.** For example, you may want them to help you find treatment, accompany you to see a doctor, check in with you regularly about how you're feeling, or find some other way of supporting your recovery (without turning into the food police).

Eating Disorder Support Groups

While family and friends can be a huge help in providing support, you may also want to join an eating disorder support group. They provide a safe environment where you can talk freely about your eating disorder and get advice and support from people who know what you're going through.

There are many types of eating disorder support groups. Some are led by professional therapists, while others are moderated by trained volunteers or people who have recovered from an eating disorder. You can find online anorexia and bulimia support groups, chat rooms, and forums. These can be particularly helpful if you're not ready to seek face-to-face help or you don't have a support group in your area.

For help finding an eating disorder support group:

- Ask your doctor or therapist for a referral
- Call local hospitals and universities
- Call local eating disorder centers and clinics
- Visit your school's counseling center
- Call a helpline listed in the Get more help section below

Getting treatment for an eating disorder

While there are a variety of different treatment options available for those struggling with eating disorders, it is important to find the treatment, or combination of treatments, that works best for you.

Effective treatment should address more than just your symptoms and destructive eating habits. It should also address the root causes of the problem—the emotional

triggers that lead to disordered eating and your difficulty coping with stress, anxiety, fear, sadness, or other uncomfortable emotions.

Step 1: Assemble your Treatment Team

Because eating disorders have serious emotional, medical, and nutritional consequences, it's important to have a team of professionals that can address every aspect of your problem. As you search, focus on finding the right fit—professionals who make you feel comfortable, accepted, and safe.

To find an eating disorder treatment specialist in your area:

- Ask your primary care doctor for a referral
- Check with your local hospitals or medical centers
- Ask your school counselor or nurse
- Call a helpline listed in the Resources section below

Step 2: Address Health Problems

Eating disorders can be deadly—and not just if you're drastically underweight. Your health may be in danger, even if you only occasionally fast, binge, or purge, so it's important to get a full medical evaluation. If the evaluation reveals health problems, they should take priority. Nothing is more important than your well-being. If you're suffering from any life-threatening problem, you may need to be hospitalized in order to keep you safe.

Step 3: Make a Long-term Treatment Plan

Once your health problems are under control, you and your treatment team can work on a long-term recovery plan. Your treatment plan may include:

- **Individual or group therapy.** Therapy can help you explore the issues underlying your eating disorder, improve your self-esteem, and learn healthy ways of responding to stress and emotional pain. Different therapists have different methods, so it is important to discuss with them your goals in working towards recovery.

- **Family therapy.** Family therapy can help you and your family members explore how the eating disorder is affecting your relationships—and how various family dynamics may be contributing to the problem or impeding recovery. Together, you'll work to improve communication, respect, and support.
- **Nutritional counseling.** The goal of a nutritionist or dietician is to help you incorporate healthy eating behaviors into your everyday life. A nutritionist can't change your habits overnight, but over a period of time you can learn to develop a healthier relationship with food.
- **Medical monitoring.** Often, treatment will include regular monitoring by a medical doctor to make sure your health is not in danger. This may include regular weigh-ins, blood tests, and other health screenings.
- **Residential treatment.** In rare cases, you may need more support than can be provided on an outpatient basis. Residential treatment programs offer around-the-clock care and monitoring to get you back on track. The goal is to get you stable enough to continue treatment at home.

Step 4: Learn Self-Help Strategies

While seeking professional help is important, don't underestimate your own role in recovery. The more motivated you are to understand why you developed an eating disorder, and to learn healthier coping skills, the quicker you will see change and healing. The following tips can help:

- S**elf-Help tip 1: Learn healthier ways to cope with emotional pain**

It may seem like eating disorders are all about food—after all, your rules and fears about dieting and weight have taken over your life. But food itself isn't the real problem. Disordered eating is a coping mechanism for stress or other unpleasant emotions. You may refuse food to feel in control, binge for comfort, or purge to punish yourself, for example. But whatever need your eating disorder fulfills in your life, you can learn healthier ways to cope with negative emotions and deal with life's challenges.

The first step is figuring out what's really going on inside. Are you upset about something? Depressed? Stressed out? Lonely? Is there an intense feeling you're trying to avoid? Are you eating to calm down, comfort yourself, or to relieve boredom? Once you identify the emotion you're experiencing, you can choose a positive alternative to starving or stuffing yourself.

Here are a few suggestions to get you started:

- Call a friend
- Listen to music
- Play with a pet
- Read a good book
- Take a walk
- Write in a journal
- Go to the movies
- Get out into nature
- Play a favorite game
- Do something helpful for someone else

Coping with Anorexia and Bulimia: Emotional Do's and Don'ts

DO: • allow yourself to be vulnerable with people you trust • fully experience every emotion • be open and accepting of all your emotions • use people to comfort you when you feel bad, instead of focusing on food • let your emotions come and go as they please, without fear
DON'T • pretend you don't feel anything when you do • let people shame or humiliate you for having or expressing feelings • avoid feelings because they make you uncomfortable • worry about your feelings making you fall apart • focus on food when you're experiencing a painful emotion

Adapted from: *The Food and Feelings Workbook*, by Karin R. Koeing, Gurze Books

Self-Help Tip 2: Develop a balanced relationship with food

Even though food itself is not the problem, developing a healthier relationship with it is essential to your recovery. Most people with eating disorders struggle with issues of control when it comes to food—often fluctuating between strict rules and chaos. The goal is to find a balance.

- **Let go of rigid eating rules.** Strict rules about food and eating fuel eating disorders, so it's important to replace them with healthier ones. For example, if you have a rule forbidding all desserts, change it into a less rigid guideline such as, "I won't eat dessert every day." You won't gain weight by enjoying an occasional ice cream or cookie.

- **Don’t diet.** The more you restrict food, the more likely it is that you’ll become preoccupied, and even obsessed, with it. So instead of focusing on what you “shouldn’t” eat, focus on nutritious foods that will energize you and make your body strong. Think of food as fuel for your body. Your body knows when the tank is low, so listen to it. Eat when you’re truly hungry, then stop when you’re full.
- **Stick to a regular eating schedule.** You may be used to skipping meals or fasting for long stretches. But when you starve yourself, food becomes all you think about. To avoid this preoccupation, try to eat every three hours. Plan ahead for meals and snacks, and don’t skip!
- **Learn to listen to your body.** If you have an eating disorder, you’ve learned to ignore your body’s hunger and fullness signals. You may not even recognize them anymore. The goal is to get back in touch with these internal cues, so you can eat based on your physiological needs, not your emotions.

Self-Help Recovery Tip 3: Learn to accept and love yourself as you are

When you base your self-worth on physical appearance alone, you’re ignoring all the other qualities, accomplishments, and abilities that make you beautiful. Think about your friends and family members. Do they love you for the way you look or who you are? Chances are, your appearance ranks low on the list of what they love about you—and you probably feel the same about them. So why does it top your own list?

Placing too much importance on how you look leads to low self-esteem and insecurity. But you can learn to see yourself in a positive, balanced way:

- **Make a list of your positive qualities.** Think of all the things you like about yourself. Are you smart? Kind? Creative? Loyal? Funny? What would others say are your good qualities? Include your talents, skills, and achievements. Also, think about negative qualities you DON’t have.
- **Stop body checking.** Pinching for fatness, continually weighing yourself, or trying on too-small clothes only magnifies a negative self-view and gives you a distorted image of what you really look like. We are all very bad at detecting visual changes in ourselves. Your goal right now is to learn to accept yourself—and that shouldn’t depend on a number on the scale or a perceived flaw you think you see in the mirror.
- **Avoid “fat talk.”** It’s something many of us take part in without even noticing. Perhaps we make self-deprecating jokes about our appearance, criticize a celebrity for gaining a few pounds, or when we greet friends, we focus on how they look—their new outfit or newly toned physique, for example. But focusing on

appearance—our own or others—only leads to feelings of body dissatisfaction. Instead of telling others, “You look great!” try focusing on something other than appearance, such as “You seem really happy!” And avoid spending time with people intent on judging others by their looks.

- **Challenge negative self-talk.** We all have negative thoughts about our appearance from time to time. The important thing is not to base your self-worth on these thoughts. Instead, when you catch yourself being self-critical or pessimistic, stop and challenge the negative thought. Ask yourself what evidence you have to support the idea. What is the evidence against it? Just because you believe something, doesn’t mean it’s true.

Tips to Improve your Body Image

- **Dress for yourself, not others.** You should feel good in what you wear. Pick clothes that express your personality and make you feel comfortable and confident.
- **Stop comparing yourself to others.** Even people without an eating disorder experience feelings of anxiety and inferiority when they compare themselves to others on social media. People exaggerate the positive aspects of their lives on Facebook, Instagram and the like, brushing over their flaws and the doubts and disappointments that we all experience. If necessary, take a break from social media—and toss the fashion magazines. Even when you realize that the images are pure Photoshopped fantasy, they can still trigger feelings of insecurity. Stay away until you’re confident they won’t undermine your self-acceptance.
- **Pamper your body.** Instead of treating your body like the enemy, look at it as something precious. Pamper yourself with a massage, manicure, facial, a candlelight bath, or a scented lotion or perfume that makes you happy.
- **Stay active.** While it’s important not to overdo it with exercise, staying active is good for both your mental and physical well-being. The key is to differentiate between compulsive exercise—which is rule-driven, weight-focused, and rigid—and healthy exercise that is rule-free, fun, and flexible. Focus on activities you enjoy and do them because they improve your mood, not because they might

change how you look. Outdoor activities can be especially good at boosting your sense of well-being.

Self-Help Recovery Tip 4: Avoid Relapse

The work of eating disorder recovery doesn't end once you've adopted healthier habits. It's important to take steps to maintain your progress and prevent relapse.

- **Develop a solid support system.** Surround yourself with people who support you and want to see you healthy and happy. Avoid people who drain your energy, encourage disordered eating behaviors, or make you feel bad about yourself.
- **Identify your "Triggers."** Are you more likely to revert to your old, destructive behaviors during the holidays, exam week, or swimsuit season? Or are difficulties at work or in your relationship likely to trigger your disordered eating habits? Know what your early warning signs are, and have a plan for dealing with them, such as going to therapy more often or asking for extra support from family and friends.
- **Avoid pro-ana and pro-mia websites.** Don't visit websites that promote or glorify anorexia and bulimia. These sites are run by people who want excuses to continue down their destructive path. The "support" they offer is dangerous and will only get in the way of your recovery.
- **Keep a journal.** Writing in a daily journal can help you keep tabs on your thoughts, emotions, and behaviors. If you notice that you're slipping back into negative patterns, take action immediately.
- **Stick with your eating disorder treatment plan.** Don't neglect therapy or other components of your treatment, even if you're doing better. Follow the recommendations of your treatment team.
- **Fill your life with positive activities.** Make time for activities that bring you joy and fulfillment. Try something you've always wanted to do, develop a new skill, pick up a fun hobby, or volunteer in your community. The more rewarding your life, the less desire you'll have to focus on food and weight.

- **If you do lapse, don't beat yourself up.** Recovery is a process—and that often involves setbacks. Don't let feelings of guilt or shame derail your recovery, but think about how you'll handle the same situation next time. Remember: One brief lapse doesn't have to turn into a full-blown relapse.

J. Helping Someone with An Eating Disorder

Melinda Smith, M.A., Lawrence Robinson, and Jeanne Segal, Ph.D. Last updated: November 2019.

Retrieved from: https://www.helpguide.org/articles/eating-disorders/helping-someone-with-an-eating-disorder.htm

Understanding your loved one's eating disorder

Eating disorders involve extreme disturbances in eating behaviors—following rigid diets, bingeing on food in secret, throwing up after meals, obsessively counting calories. It's not easy to watch someone you care about damage their health—especially when the solution appears, at least on the outside, to be simple. But eating disorders are more complicated than just unhealthy dietary habits. At their core, they're attempts to deal with emotional issues and involve distorted, self-critical attitudes about weight, food, and body image. It's these negative thoughts and feelings that fuel the damaging behaviors.

People with eating disorders use food to deal with uncomfortable or painful emotions. Restricting food is used to feel in control. Overeating temporarily soothes sadness, anger, or loneliness. Purging is used to combat feelings of helplessness and self-loathing. Over time, people with an eating disorder lose the ability to see themselves objectively and obsessions over food and weight come to dominate everything else in their lives. Their road to recovery begins by identifying the underlying issues that drive their eating disorder and finding healthier ways to cope with emotional pain.

While you can't force a person with an eating disorder to change, you can offer your support and encourage treatment. And that can make a huge difference to your loved one's recovery.

Myths and Facts About Eating Disorder

Myth 1: You have to be underweight to have an Eating Disorder

Fact: People with Eating Disorders come in all shapes and sizes. Many individuals with Eating Disorders are of average weight or are overweight.

Myth 2: Only teenage girls and young women are affected by Eating Disorders.

Fact: While Eating Disorders are most common in young women in their teens and early twenties, they are found in men and women of all ages–from children to other adults.

Myth 3: People with Eating Disorders are vain

Fact: It's not vanity that drives people with eating disorders to follow extreme diets and obsess over their bodies, but rather an attempt tot deal with uncomfortable feelings.

Myth 4: Eating Disorders aren't really that dangerous

Fact: Eating Disorders are serios conditions that cause both physical and emotional damage. All Eating Disorders can lead to irreversible and even life-threatening health problems, such as heart disease, bone loss, stunted growth, infertility, and kidney damage.

Warning signs of an Eating Disorder

Many people worry about their weight, what they eat, and how they look. This is especially true for teenagers and young adults, who face extra pressure to fit in and look attractive at a time when their bodies are changing. As a result, it can be challenging to tell the difference between an eating disorder and normal self-consciousness, weight concerns, or dieting. Further complicating matters, people with an eating disorder will often go to great lengths to hide the problem. However, there are warning signs you can watch for. And as eating disorders progress, the red flags become easier to spot.

Restricting Food or Dieting

- Making excuses to avoid meals or situations involving food (e.g. they had a big meal earlier, aren't hungry, or have an upset stomach)
- Eating only tiny portions or specific low-calorie foods, and often banning entire categories

of food such as carbs and dietary fat
- Obsessively counting calories, reading food labels, and weighing portions
- Developing restrictive food rituals such as eating foods in certain orders, rearranging food on a plate, excessive cutting or chewing.
- Taking diet pills, prescription stimulants like Adderall or Ritalin, or even illegal drugs such as amphetamines (speed, crystal, etc.)

Bingeing

- Unexplained disappearance of large amounts of food in short periods of time
- Lots of empty food packages and wrappers, often hidden at the bottom of the trash
- Hoarding and hiding stashes of high-calorie foods such as junk food and sweets
- Secrecy and isolation; may eat normally around others, only to binge late at night or in a private spot where they won't be discovered or disturbed

Purging

- Disappearing right after a meal or making frequent trips to the bathroom
- Showering, bathing, or running water after eating to hide the sound of purging
- Using excessive amounts of mouthwash, breath mints, or perfume to disguise the smell of vomiting
- Taking laxatives, diuretics, or enemas
- Periods of fasting or compulsive, intense exercising, especially after eating
- Frequent complaints of sore throat, upset stomach, diarrhea, or constipation
- Discolored teeth

Distorted Body Image and Altered Appearance

- Extreme preoccupation with body or weight (e.g. constant weigh-ins, spending lots of time in front of the mirror inspecting and criticizing their body)
- Significant weight loss, rapid weight gain, or constantly fluctuating weight
- Frequent comments about feeling fat or overweight, or about a fear of gaining weight
- Wearing baggy clothes or multiple layers in an attempt to hide weight

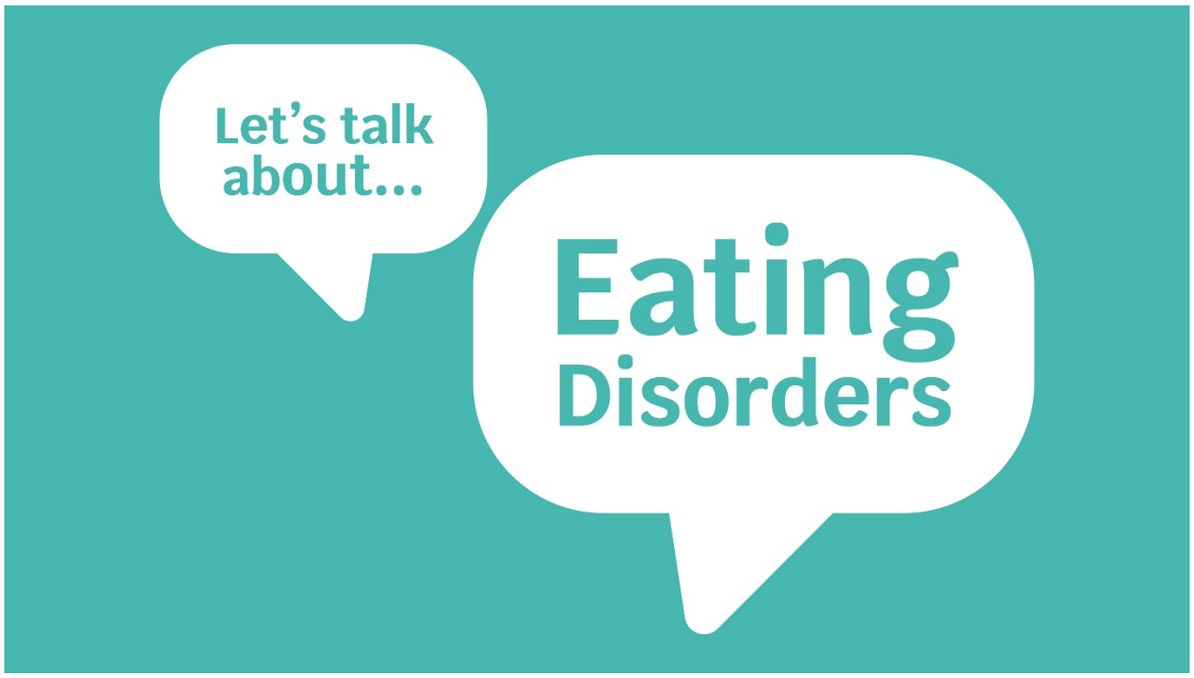
Worried about someone? Speak out!

If you notice the warning signs of an eating disorder in a friend or family member, it's important to speak up. You may be afraid that you're mistaken, or that you'll say the

wrong thing, or you might alienate the person. However, it's important that you don't let these worries stop you from voicing your concerns.

People with eating disorders are often afraid to ask for help. Some are struggling just as much as you are to find a way to start a conversation about their problem, while others have such low self-esteem they simply don't feel that they deserve any help. Whatever the case, eating disorders will only get worse without treatment, and the physical and emotional damage can be severe. The sooner you start to help, the better their chances of recovery. While you can't force someone with an eating disorder to get better, having supportive relationships is vital to their recovery. Your love and encouragement can make all the difference.

How to talk to someone about their eating disorder



The decision to make a change is rarely an easy one for someone with an eating disorder. If the eating disorder has left them malnourished, it can distort the way they think—about their body, the world around them, even your motivations for trying to help. Bombarding them with dire warnings about the health consequences of their eating disorder or trying to bully them into eating normally probably won't work. Eating disorders often fill an important role in the person's life—a way to cope with unpleasant emotions—so the allure can be strong. Since you may be met with defensiveness or denial, you'll need to tread carefully when broaching the subject.

- **Pick a good time.** Choose a time when you can speak to the person in private without distractions or constraints. You don't want to have to stop in the middle of the conversation because of other obligations! It's also important to have the

conversation at a time of emotional calm. Don't try to have this conversation right after a blow up.

- **Explain why you're concerned.** Be careful to avoid lecturing or criticizing, as this will only make your loved one defensive. Instead, refer to specific situations and behaviors you've noticed, and why they worry you. Your goal at this point is not to offer solutions, but to express your concerns about the person's health, how you much you love them, and your desire to help.
- **Be prepared for denial and resistance.** There's a good chance your loved one may deny having an eating disorder or become angry and defensive. If this happens, try to remain calm, focused, and respectful. Remember that this conversation likely feels very threatening to someone with an eating disorder. Don't take it personally.
- **Ask if the person has reasons for wanting to change.** Even if your loved one lacks the desire to change for themselves, they may want to change for other reasons: to please someone they love, to return to school or work, for example. All that really matters is that they are willing to seek help.
- **Be patient and supportive.** Don't give up if the person shuts you down at first. It may take some time before they're willing to open up and admit to having a problem. The important thing is opening up the lines of communication. If they are willing to talk, listen without judgment, no matter how out of touch they may sound. Make it clear that you care, that you believe in them, and that you'll be there in whatever way they need, whenever they're ready.

What Not To Do

- **Avoid ultimatums.** Unless you're dealing with an underage child, you can't force someone into treatment. The decision to change must come from them. Ultimatums merely add pressure and promote more secrecy and denial.
- **Avoid commenting on appearance or weight.** People with eating disorders are already overly focused on their bodies. Even assurances that they're not fat play into their preoccupation with being thin. Instead, steer the conversation to their feelings. Why are they afraid of being fat? What do they think they'll achieve by being thin?
- **Avoid shaming and blaming.** Steer clear of accusatory "you" statements like, "You just need to eat!" Or, "You're hurting yourself for no reason." Use "I" statements instead. For example: "I find it hard to watch you wasting away." Or, "I'm scared when I hear you throwing up."
- **Avoid giving simple solutions.** For example, "All you have to do is accept yourself." Eating disorders are complex problems. If it were that easy, your loved one wouldn't be suffering.

Encouraging a person to get help

Aside from offering support, the most important thing you can do for a person with an eating disorder is to encourage treatment. The longer an eating disorder remains undiagnosed and untreated, the harder it is on the body and the more difficult it is to overcome, so urge your loved one to see a doctor right away.

A doctor can assess your loved one's symptoms, provide an accurate diagnosis, and screen for any medical problems that might be involved. The doctor can also determine whether there are any co-existing conditions that require treatment, such as depression, substance abuse, or an anxiety disorder.

If your friend or family member is hesitant to see a doctor, ask them to get a physical just to put your worries to rest. It may help if you offer to make the appointment or go along on the first visit.

Treatments for eating disorders

The right treatment approach for each person depends on their specific symptoms, issues, and strengths, as well as the severity of the disorder. To be most effective, treatment for an eating disorder must address both the physical and psychological aspects of the problem. The goal is to treat any medical or nutritional needs, promote a healthy relationship with food, and teach constructive ways to cope with unpleasant emotions and life's challenges.

A team approach is often best. Those who may be involved in treatment include medical doctors, mental health professionals, and nutritionists. The participation and support of family members also makes a big difference in the success of eating disorder treatment.

- **Medical treatment.** The first priority is to address and stabilize any serious health issues. Hospitalization or residential treatment may be necessary if your loved one is dangerously malnourished, suffering from medical complications, severely depressed or suicidal, or resistant to treatment. Outpatient treatment is an option when the patient is not in immediate medical danger.
- **Nutritional counseling.** Dietitians or nutritionists can help your loved one design balanced meal plans, set dietary goals, and reach or maintain a healthy weight. Counseling may also involve education about proper nutrition.
- **Therapy.** Therapy plays a crucial role in eating disorder treatment. Its goals are to identify the negative thoughts and feelings that are behind the disordered eating behaviors, and to replace them with healthier and less distorted attitudes.

Another important goal is to teach the person how to deal with difficult emotions, relationship problems, and stress in a productive, rather than a self-destructive way.

Common Types of Therapy for Eating Disorder Treatment

Individual Therapy: Explores both the Eating Disorder symptoms and the underlying emotional and interpersonal issues that fuel them. The focus is on increasing self-awareness, challenging dysfunctional beliefs, and improving self-esteem and sense of control.

Family Therapy: Examines the family dynamics that may contribute to Eating Disorder or interfere with recovery. Often includes some therapy sessions without the patient–a particularly important element when the person with the Eating Disorder denies an Eating Disorder.

Group Therapy: Allows people with Eating Disorders to talk with each other in a supervised setting. It is to reduce the isolation many people with Eating Disorders feel. Group members support each other through recovery and share their experiences and advice.

Dealing with eating disorders in the home

As a parent, there are many things you can do to support your child's eating disorder recovery—even if they are still resisting treatment.

- **Set a positive example.** You have more influence than you think. Instead of dieting, eat nutritious, balanced meals. Be mindful about how you talk about your body and your eating. Avoid self-critical remarks or negative comments about others' appearance. Instead, focus on the qualities on the inside that really make a person attractive.
- **Make mealtimes fun.** Try to eat together as a family as often as possible. Even if your child isn't willing to eat the food you've prepared, encourage them to join you at the table. Use this time together to enjoy each other's company, rather than talking about problems. Meals are also a good opportunity to show your child that food is something to be enjoyed rather than feared.
- **Avoid power struggles over food.** Attempts to force your child to eat will only cause conflict and bad feelings and likely lead to more secrecy and lying. That doesn't mean you can't set limits or hold your child accountable for their behavior. But don't act like the food police, constantly monitoring your child's behavior.

- **Encourage eating with natural consequences.** While you can't force healthy eating behaviors, you can encourage them by making the natural consequences of not eating unappealing. For example, if your child won't eat, they can't go to dance class or drive the car because, in their weakened state, it wouldn't be safe. Emphasize that this isn't a punishment, but simply a natural medical consequence.
- **Do whatever you can to promote self-esteem.** in your child in intellectual, athletic, and social endeavors. Give boys and girls the same opportunities and encouragement. A well-rounded sense of self and solid self-esteem are perhaps the best antidotes to disordered eating.
- **Don't blame yourself.** Parents often feel they must take on responsibility for the eating disorder, which is something they truly have no control over. Once you can accept that the eating disorder is not anyone's fault, you can be freed to take action that is honest and not clouded by what you "should" or "could" have done.

Supporting a loved one's recovery

Recovering from an eating disorder takes time. There are no quick fixes or miracle cures, so it's important to have patience and compassion. Don't put unnecessary pressure on your loved one by setting unrealistic goals or demanding progress on your own timetable. Provide hope and encouragement, praise each small step forward, and stay positive through struggles and setbacks.

- **Learn about eating disorders.** The more you know, the better equipped you'll be to help your loved one, avoid pitfalls, and cope with challenges.
- **Listen without judgment.** Show that you care by asking about your loved one's feelings and concerns—and then truly listening. Resist the urge to advise or criticize. Simply let your friend or family member know that they're being heard. Even if you don't understand what they're going through, it's important to validate your loved one's feelings.

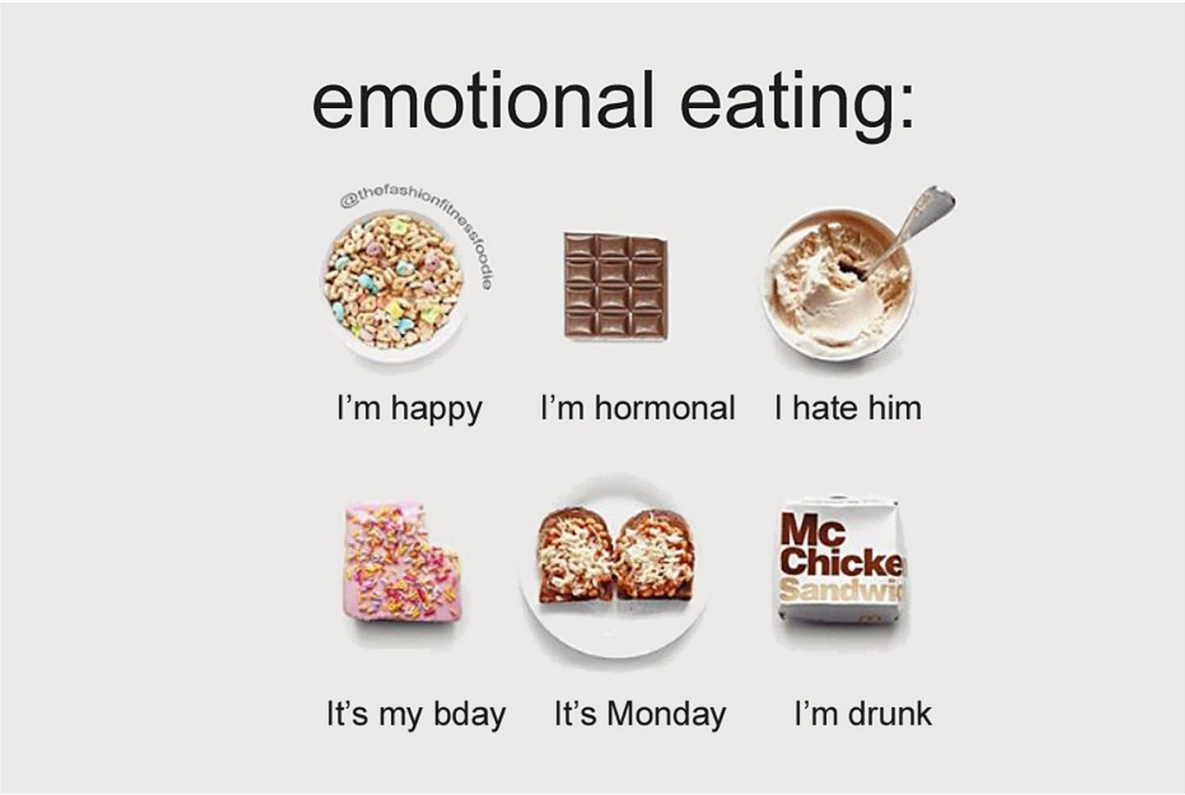
- **Be mindful of triggers.** Avoid discussions about food, weight, eating or making negative statements about your own body. But don't be afraid to eat normally in front of someone with an eating disorder. It can help set an example of a healthy relationship with food.
- **Take care of yourself.** Don't become so preoccupied with your loved one's eating disorder that you neglect your own needs. Make sure you have your own support, so you can provide it in turn. Whether that support comes from a trusted friend, a support group, or your own therapist, it's important to have an outlet to talk about your feelings and emotionally recharge. It's also important to schedule time into your day for relaxing and doing things you enjoy.

K. Emotional Eating and How to Stop It

Melinda Smith, M.A., Jeanne Segal Ph.D., and Robert Segal, M.A. Last updated: October 2019.

Retrieved from: https://www.helpguide.org/articles/diets/emotional-eating.htm

What is Emotional Eating?



We don't always eat just to satisfy physical hunger. Many of us also turn to food for comfort, stress relief, or to reward ourselves. And when we do, we tend to reach for junk food, sweets, and other comforting but unhealthy foods. You might reach for a pint of ice cream when you're feeling down, order a pizza if you're bored or lonely, or swing by

the drive-through after a stressful day at work. Emotional eating is using food to make yourself feel better—to fill emotional needs, rather than your stomach. Unfortunately, emotional eating doesn't fix emotional problems. In fact, it usually makes you feel worse. Afterward, not only does the original emotional issue remain, but you also feel guilty for overeating.

Are you an Emotional Eater?

- Do you eat more when you're feeling stressed?
- Do you eat when you're not hungry or when you're full?
- Do you eat to feel better (to calm and soothe yourself when you're sad, mad, bored, anxious, etc.)?
- Do you reward yourself with food?
- Do you regularly eat until you've stuffed yourself?
- Does food make you feel safe? Do you feel like food is a friend?
- Do you feel powerless or out of control around food?

The Emotional Eating Cycle

Occasionally using food as a pick-me-up, a reward, or to celebrate isn't necessarily a bad thing. But when eating is your primary emotional coping mechanism—when your first impulse is to open the refrigerator whenever you're stressed, upset, angry, lonely, exhausted, or bored—you get stuck in an unhealthy cycle where the real feeling or problem is never addressed.

Emotional hunger can't be filled with food. Eating may feel good in the moment, but the feelings that triggered the eating are still there. And you often feel worse than you did

before because of the unnecessary calories you've just consumed. You beat yourself for messing up and not having more willpower.

Compounding the problem, you stop learning healthier ways to deal with your emotions, you have a harder and harder time controlling your weight, and you feel increasingly powerless over both food and your feelings. But no matter how powerless you feel over food and your feelings, it is possible to make a positive change. You can learn healthier ways to deal with your emotions, avoid triggers, conquer cravings, and finally put a stop to emotional eating.

The difference between emotional hunger and physical hunger

Before you can break free from the cycle of emotional eating, you first need to learn how to distinguish between emotional and physical hunger. This can be trickier than it sounds, especially if you regularly use food to deal with your feelings.

Emotional hunger can be powerful, so it's easy to mistake it for physical hunger. But there are clues you can look for to help you tell physical and emotional hunger apart.

- **Emotional hunger comes on suddenly.** It hits you in an instant and feels overwhelming and urgent. Physical hunger, on the other hand, comes on more gradually. The urge to eat doesn't feel as dire or demand instant satisfaction (unless you haven't eaten for a very long time).
- **Emotional hunger craves specific comfort foods.** When you're physically hungry, almost anything sounds good—including healthy stuff like vegetables. But emotional hunger craves junk food or sugary snacks that provide an instant rush. You feel like you *need* cheesecake or pizza, and nothing else will do.
- **Emotional hunger often leads to mindless eating.** Before you know it, you've eaten a whole bag of chips or an entire pint of ice cream without really paying attention or fully enjoying it. When you're eating in response to physical hunger, you're typically more aware of what you're doing.
- **Emotional hunger isn't satisfied once you're full.** You keep wanting more and more, often eating until you're uncomfortably stuffed. Physical hunger, on the other hand, doesn't need to be stuffed. You feel satisfied when your stomach is full.
- **Emotional hunger isn't located in the stomach.** Rather than a growling belly or a pang in your stomach, you feel your hunger as a craving you can't get out of your head. You're focused on specific textures, tastes, and smells.

- **Emotional hunger often leads to regret, guilt, or shame.** When you eat to satisfy physical hunger, you're unlikely to feel guilty or ashamed because you're simply giving your body what it needs. If you feel guilty after you eat, it's likely because you know deep down that you're not eating for nutritional reasons.

Emotional Hunger vs. Physical Hunger

Emotional hunger comes on suddenly	Physical hunger comes on gradually
Emotional hunger feels like it needs to be satisfied instantly	Physical hunger can wait
Emotional hunger craves specific comfort foods	Physical hunger is open to options—lots of things sound good
Emotional hunger isn't satisfied with a full stomach.	Physical hunger stops when you're full
Emotional eating triggers feelings of guilt, powerlessness, and shame	Eating to satisfy physical hunger doesn't make you feel bad about yourself

Identify Your Emotional Eating Triggers

The first step in putting a stop to emotional eating is identifying your personal triggers. What situations, places, or feelings make you reach for the comfort of food? Most emotional eating is linked to unpleasant feelings, but it can also be triggered by positive emotions, such as rewarding yourself for achieving a goal or celebrating a holiday or happy event.

Common Causes of Emotional Eating

- **Stress** – Ever notice how stress makes you hungry? It's not just in your mind. When stress is chronic, as it so often is in our chaotic, fast-paced world, your body produces high levels of the stress hormone, cortisol. Cortisol triggers cravings for salty, sweet, and fried foods—foods that give you a burst of energy and pleasure. The more uncontrolled stress in your life, the more likely you are to turn to food for emotional relief.
- **Stuffing emotions** – Eating can be a way to temporarily silence or "stuff down" uncomfortable emotions, including anger, fear, sadness, anxiety, loneliness, resentment, and shame. While you're numbing yourself with food, you can avoid the difficult emotions you'd rather not feel.
- **Boredom or feelings of emptiness** – Do you ever eat simply to give yourself something to do, to relieve boredom, or as a way to fill a void in your life? You feel unfulfilled and empty, and food is a way to occupy your mouth and your time.

In the moment, it fills you up and distracts you from underlying feelings of purposelessness and dissatisfaction with your life.

- **Childhood habits** – Think back to your childhood memories of food. Did your parents reward good behavior with ice cream, take you out for pizza when you got a good report card, or serve you sweets when you were feeling sad? These habits can often carry over into adulthood. Or your eating may be driven by nostalgia—for cherished memories of grilling burgers in the backyard with your dad or baking and eating cookies with your mom.
- **Social influences** – Getting together with other people for a meal is a great way to relieve stress, but it can also lead to overeating. It's easy to overindulge simply because the food is there or because everyone else is eating. You may also overeat in social situations out of nervousness. Or perhaps your family or circle of friends encourages you to overeat, and it's easier to go along with the group.

Keeping an Emotional Diary

You probably recognized yourself in at least a few of the previous descriptions. But even so, you'll want to get even more specific. One of the best ways to identify the patterns behind your emotional eating is to keep track with a food and mood diary.

Every time you overeat or feel compelled to reach for your version of comfort food Kryptonite, take a moment to figure out what triggered the urge. If you backtrack, you'll usually find an upsetting event that kicked of the emotional eating cycle. Write it all down in your food and mood diary: what you ate (or wanted to eat), what happened to upset you, how you felt before you ate, what you felt as you were eating, and how you felt afterward.

Over time, you'll see a pattern emerge. Maybe you always end up gorging yourself after spending time with a critical friend. Or perhaps you stress eat whenever you're on a deadline or when you attend family functions. Once you identify your emotional eating triggers, the next step is identifying healthier ways to feed your feelings.

Find other ways to feed your feelings

If you don't know how to manage your emotions in a way that doesn't involve food, you won't be able to control your eating habits for very long. Diets so often fail because they offer logical nutritional advice which only works if you have conscious control over your eating habits. It doesn't work when emotions hijack the process, demanding an immediate payoff with food.

In order to stop emotional eating, you have to find other ways to fulfill yourself emotionally. It's not enough to understand the cycle of emotional eating or even to

understand your triggers, although that's a huge first step. You need alternatives to food that you can turn to for emotional fulfillment.

Alternatives to Emotional Eating

- **If you're depressed or lonely,** call someone who always makes you feel better, play with your dog or cat, or look at a favorite photo or cherished memento.
- **If you're anxious,** expend your nervous energy by dancing to your favorite song, squeezing a stress ball, or taking a brisk walk.
- **If you're exhausted,** treat yourself with a hot cup of tea, take a bath, light some scented candles, or wrap yourself in a warm blanket.
- **If you're bored,** read a good book, watch a comedy show, explore the outdoors, or turn to an activity you enjoy (woodworking, playing the guitar, shooting hoops, scrapbooking, etc.).

Pause when cravings hit and check in with yourself

Most emotional eaters feel powerless over their food cravings. When the urge to eat hits, it's all you can think about. You feel an almost unbearable tension that demands to be fed, right now! Because you've tried to resist in the past and failed, you believe that your willpower just isn't up to snuff. But the truth is that you have more power over your cravings than you think.

Take 5 Before You Give in To a Craving

Emotional eating tends to be automatic and virtually mindless. Before you even realize what you're doing, you've reached for a tub of ice cream and polished off half of it. But if you can take a moment to pause and reflect when you're hit with a craving, you give yourself the opportunity to make a different decision.

Can you put off eating for five minutes? Or just start with one minute. Don't tell yourself you *can't* give in to the craving; remember, the forbidden is extremely tempting. Just tell yourself to wait.

While you're waiting, check in with yourself. How are you feeling? What's going on emotionally? Even if you end up eating, you'll have a better understanding of why you did it. This can help you set yourself up for a different response next time.

Learn to Accept your Feelings–even the Bad Ones

While it may seem that the core problem is that you're powerless over food, emotional eating actually stems from feeling powerless over your emotions. You don't feel capable of dealing with your feelings head on, so you avoid them with food.

Allowing yourself to feel uncomfortable emotions can be scary. You may fear that, like Pandora's box, once you open the door you won't be able to shut it. But the truth is that when we don't obsess over or suppress our emotions, even the most painful and difficult feelings subside relatively quickly and lose their power to control our attention.

To do this you need to become mindful and learn how to stay connected to your moment-to-moment emotional experience. This can enable you to rein in stress and repair emotional problems that often trigger emotional eating.

Indulge without overeating by savoring your food

When you eat to feed your feelings, you tend to do so quickly, mindlessly consuming food on autopilot. You eat so fast you miss out on the different tastes and textures of your food—as well as your body's cues that you're full and no longer hungry. But by slowing down and savoring every bite, you'll not only enjoy your food more but you'll also be less likely to overeat.

Slowing down and savoring your food is an important aspect of mindful eating, the opposite of mindless, emotional eating. Try taking a few deep breaths before starting your food, putting your utensils down between bites, and really focusing on the experience of eating. Pay attention to the textures, shapes, colors and smells of your food. How does each mouthful taste? How does it make your body feel? By slowing down in this way, you'll find you appreciate each bite of food much more. You can even indulge in your favorite foods and feel full on much less. It takes time for the body's fullness signal to reach your brain, so taking a few moments to consider how you feel after each bite—hungry or satiated—can help you avoid overeating.

Practice Mindful Eating

Eating while you're also doing other things—such as watching TV, driving, or playing with your phone—can prevent you from fully enjoying your food. Since your mind is elsewhere, you may not feel satisfied or continue eating even though you're no longer hungry. Eating more mindfully can help focus your mind on your food and the pleasure of a meal and curb overeating.

Support yourself with healthy lifestyle habits

When you're physically strong, relaxed, and well rested, you're better able to handle the curveballs that life inevitably throws your way. But when you're already exhausted and overwhelmed, any little hiccup has the potential to send you off the rails and straight toward the refrigerator. Exercise, sleep, and other healthy lifestyle habits will help you get through difficult times without emotional eating.

- **Make daily exercise a priority.** Physical activity does wonders for your mood and energy levels, and it's also a powerful stress reducer. And getting into the exercise habit is easier than you may think.
- **Aim for 8 hours of sleep every night.** When you don't get the sleep you need, your body craves sugary foods that will give you a quick energy boost. Getting plenty of rest will help with appetite control and reduce food cravings.
- **Make time for relaxation.** Give yourself permission to take at least 30 minutes every day to relax, decompress, and unwind. This is your time to take a break from your responsibilities and recharge your batteries.
- **Connect with others.** Don't underestimate the importance of close relationships and social activities. Spending time with positive people who enhance your life will help protect you from the negative effects of stress.

Chapter 3: Other Specified Eating Disorder (OSFED) & Avoidant Restrictive Food Intake Disorder (ARFID)

A. Other Specified Eating Disorder (OSFED)

Retrieved from: National Eating Disorder Association

https://www.nationaleatingdisorders.org/learn/by-eating-disorder/osfed

Other Specified Feeding or Eating Disorders (OSFED) was previously known as Eating Disorder Not Otherwise Specified (EDNOS) in past editions of the Diagnostic and Statistical Manual. Despite being considered a 'catch-all' classification that was sometimes denied insurance coverage for treatment as it was seen as less serious, OSFED/EDNOS is a serious, life-threatening, and treatable eating disorder. The category was developed to encompass those individuals who did not meet strict diagnostic criteria for anorexia nervosa or bulimia nervosa but still had a significant eating disorder. In community clinics, the majority of individuals were historically diagnosed with EDNOS.

Research into the severity of EDNOS/OSFED shows that the disorder is just as severe as other eating disorders based on the following:

- Children hospitalized for EDNOS had just as many medical complications as children hospitalized for anorexia nervosa
- Adults with 'atypical' or 'subclinical' anorexia and/or bulimia scored just as high on measures of eating disorder thoughts and behaviors as those with DSM-diagnosed anorexia nervosa and bulimia nervosa
- People with EDNOS were just as likely to die as a result of their eating disorder as people with anorexia or bulimia

EVALUATION & DIAGNOSIS

Changes to the latest edition of the DSM were meant to clarify definitions of anorexia, bulimia, and binge eating disorder to more accurately diagnose eating disorders. Although this reduced the number of OSFED diagnoses, it remains a common diagnosis. In the DSM-5, a person must present with feeding or eating behaviors that

cause clinically significant distress and impairment, but do not meet the full criteria for any of the other disorders.

A diagnosis might then be assigned that addresses the specific reason why the presentation does not meet the specifics of another disorder (e.g., bulimia nervosa - low frequency). The following are further examples for OSFED:

- **Atypical Anorexia Nervosa**: All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range.
- **Binge Eating Disorder (of low frequency and/or limited duration)**: All of the criteria for BED are met, except at a lower frequency and/or for less than three months.
- **Bulimia Nervosa (of low frequency and/or limited duration)**: All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behavior occurs at a lower frequency and/or for less than three months.
- **Purging Disorder**: Recurrent purging behavior to influence weight or shape in the absence of binge eating.
- **Night Eating Syndrome**: Recurrent episodes of night eating. Eating after awakening from sleep, or by excessive food consumption after the evening meal. The behavior is not better explained by environmental influences or social norms. The behavior causes significant distress/impairment. The behavior is not better explained by another mental health disorder (e.g. BED).

WARNING SIGNS & SYMPTOMS OF OSFED

Emotional and behavioral

- In general, behaviors and attitudes indicate that weight loss, dieting, and control of food are becoming primary concerns
- Dramatic weight loss
- Dresses in layers to hide weight loss or stay warm
- Is preoccupied with weight, food, calories, fat grams, and dieting
- Refuses to eat certain foods, progressing to restrictions against whole categories of food (e.g., no carbohydrates, etc.)
- Makes frequent comments about feeling “fat” or overweight despite weight loss
- Complains of constipation, abdominal pain, cold intolerance, lethargy, and/or excess energy
- Denies feeling hungry
- Evidence of binge eating, including disappearance of large amounts of food in short periods of time or lots of empty wrappers and containers indicating consumption of large amounts of food
- Evidence of purging behaviors, including frequent trips to the bathroom after meals, signs and/or smells of vomiting, presence of wrappers or packages of laxatives or diuretics
- Appears uncomfortable eating around others
- Develops food rituals (e.g. eats only a particular food or food group [e.g. condiments], excessive chewing, doesn’t allow foods to touch)
- Skips meals or takes small portions of food at regular meals
- Disappears after eating, often to the bathroom
- Any new practice with food or fad diets, including cutting out entire food groups (no sugar, no carbs, no dairy, vegetarianism/veganism)
- Fear of eating in public or with others
- Steals or hoards food in strange places
- Drinks excessive amounts of water or non-caloric beverages
- Uses excessive amounts of mouthwash, mints, and gum
- Hides body with baggy clothes
- Maintains excessive, rigid exercise regimen – despite weather, fatigue, illness, or injury—due to the need to “burn off ” calories
- Shows unusual swelling of the cheeks or jaw area
- Has calluses on the back of the hands and knuckles from self- induced vomiting
- Teeth are discolored, stained
- Creates lifestyle schedules or rituals to make time for binge-and-purge sessions
- Withdraws from usual friends and activities

- Looks bloated from fluid retention
- Frequently diets
- Shows extreme concern with body weight and shape
- Frequent checking in the mirror for perceived flaws in appearance
- Has secret recurring episodes of binge eating (eating in a discrete period of time an amount of food that is much larger than most individuals would eat under similar circumstances); feels lack of control over ability to stop eating
- Purges after a binge (e.g. self-induced vomiting, abuse of laxatives, diet pills and/or diuretics, excessive exercise, fasting)
- Extreme mood swings

Physical

- Noticeable fluctuations in weight, both up and down
- Body weight is typically within the normal weight range; may be overweight
- Stomach cramps, other non-specific gastrointestinal complaints (constipation, acid reflux, etc.)
- Menstrual irregularities — missing periods or only having a period while on hormonal contraceptives (this is not considered a “true” period)
- Difficulties concentrating
- Abnormal laboratory findings (anemia, low thyroid and hormone levels, low potassium, low blood cell counts, slow heart rate)
- Dizziness
- Fainting/syncope
- Feeling cold all the time
- Sleep problems
- Cuts and calluses across the top of finger joints (a result of inducing vomiting)
- Dental problems, such as enamel erosion, cavities, and tooth sensitivity
- Dry skin
- Dry and brittle nails
- Swelling around area of salivary glands
- Fine hair on body
- Thinning of hair on head, dry and brittle hair (lanugo)
- Cavities, or discoloration of teeth, from vomiting
- Muscle weakness
- Yellow skin (in context of eating large amounts of carrots)
- Cold, mottled hands and feet or swelling of feet
- Poor wound healing
- Impaired immune functioning

HEALTH CONSEQUENCES OF OSFED

The health consequences of OSFED depend in part on which eating disordered behaviors are being used. It is important to recognize that OSFED is as serious as other eating disorders and should not be trivialized or underestimated. Health consequences of OSFED can be difficult to pinpoint, as it includes a number of conditions. Watch out for all of the signs already listed. The most important thing to look out for is attitudes about food and weight that conflict with a productive, satisfying life.

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

B. AVOIDANT RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

Retrieved from: National Eating Disorder Association; https://www.nationaleatingdisorders.org/learn/by-eating-disorder/arfid

Avoidant Restrictive Food Intake Disorder (ARFID) is a new diagnosis in the DSM-5, and was previously referred to as “Selective Eating Disorder.” ARFID is similar to anorexia in that both disorders involve limitations in the amount and/or types of food consumed, but unlike anorexia, ARFID does not involve any distress about body shape or size, or fears of fatness.

Although many children go through phases of picky or selective eating, a person with ARFID does not consume enough calories to grow and develop properly and, in adults, to maintain basic body function. In children, this results in stalled weight gain and vertical growth; in adults, this results in weight loss. ARFID can also result in problems at school or work, due to difficulties eating with others and extended times needed to eat.

DIAGNOSTIC CRITERIA

According to the DSM-5, ARFID is diagnosed when:

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
    - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
    - Significant nutritional deficiency.
    - Dependence on enteral feeding or oral nutritional supplements.
    - Marked interference with psychosocial functioning.
- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

RISK FACTORS

As with all eating disorders, the risk factors for ARFID involve a range of biological, psychological, and sociocultural issues. These factors may interact differently in different people, which means two people with the same eating disorder can have very diverse perspectives, experiences, and symptoms. Researchers know much less about what puts someone at risk of developing ARFID, but here's what they do know:

- People with autism spectrum conditions are much more likely to develop ARFID, as are those with ADHD and intellectual disabilities.
- Children who don't outgrow normal picky eating, or in whom picky eating is severe, appear to be more likely to develop ARFID.
- Many children with ARFID also have a co-occurring anxiety disorder, and they are also at high risk for other psychiatric disorders.

WARNING SIGNS & SYMPTOMS OF ARFID

Behavioral and psychological

- Dramatic weight loss
- Dresses in layers to hide weight loss or stay warm
- Reports constipation, abdominal pain, cold intolerance, lethargy, and/or excess energy
- Reports consistent, vague gastrointestinal issues ("upset stomach", feels full, etc.) around mealtimes that have no known cause
- Dramatic restriction in types or amount of food eaten
- Will only eat certain textures of food
- Fears of choking or vomiting
- Lack of appetite or interest in food
- Limited range of preferred foods that becomes narrower over time (i.e., picky eating that progressively worsens).
- No body image disturbance or fear of weight gain

Physical

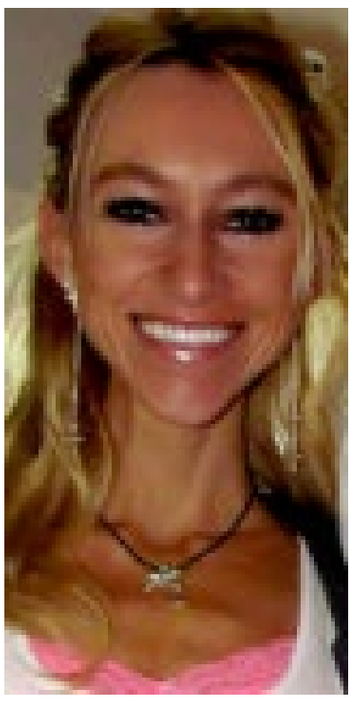
Because both anorexia and ARFID involve an inability to meet nutritional needs, both disorders have similar physical signs and medical consequences.

- Stomach cramps, other non-specific gastrointestinal complaints (constipation, acid reflux, etc.)
- Menstrual irregularities—missing periods or only having a period while on hormonal contraceptives (this is not considered a "true" period)
- Difficulties concentrating

- Abnormal laboratory findings (anemia, low thyroid and hormone levels, low potassium, low blood cell counts, slow heart rate)
- Postpuberty female loses menstrual period
- Dizziness
- Fainting/syncope
- Feeling cold all the time
- Sleep problems
- Dry skin
- Dry and brittle nails
- Fine hair on body (lanugo)
- Thinning of hair on head, dry and brittle hair
- Muscle weakness
- Cold, mottled hands and feet or swelling of feet
- Poor wound healing
- Impaired immune functioning

HEALTH CONSEQUENCES OF ARFID

In ARFID, the body is denied the essential nutrients it needs to function normally. Thus, the body is forced to slow down all of its processes to conserve energy, resulting in serious medical consequences. The body is generally resilient at coping with the stress of eating disordered behaviors, and laboratory tests can generally appear perfect even as someone is at high risk of death. Electrolyte imbalances can kill without warning; so can cardiac arrest. Therefore, it's incredibly important to understand the many ways that eating disorders affect the body.



Not Always As It Appears: Living with ARFID

National Eating Disorder Association

Retrieved from:
https://www.nationaleatingdisorders.org/blog/living-with-ARFID-recovery-story

Julie McDiarmid

3 years ago
ARFID

I was first diagnosed with anorexia nervosa when I was 12 years old. It was 1996, and I had never heard of the term in

my life, as eating disorders were not discussed anywhere near as often as they are now, and it was before the explosion of the internet, social media, etc. When the doctor told me I had anorexia, I had to ask what it was – I thought it was cancer or something! Even though I was very young and my disease was unintentional in that I wasn't consciously trying to lose weight, it was the truth: I was struggling internally and didn't know how to deal with that; therefore, I showed my pain externally.

This began a very long journey that I'm still on, but the disorder has evolved over the years as I've grown and matured. I now have zero desire to lose weight and I am not particularly preoccupied with what I look like. At age 32, I'm more concerned with becoming healthy because I want to be able to have children and live the best life that I can. However, even though I no longer consider myself anorexic in the traditional sense (wanting to lose weight, having poor body image, etc.), I am physiologically "stuck." Two years ago, I lost weight unintentionally to a very dangerous extent.

I made a deal with my doctor and therapist that if I could not get some weight back on in a certain amount of time, I would agree to be hospitalized. I tried hard, but despite my efforts, I lost even more weight in a battle with whatever was going on with my body and metabolism, and so I fulfilled my promise and was hospitalized for medical stabilization for two weeks at the Acute Center for Eating Disorders at Denver Health. This is the top medical stabilization hospital for the most severe eating disorders in the United States, so I knew something serious was going on.

While at Acute, I first learned of the term ARFID, which stands for Avoidant/Restrictive Food Intake Disorder. After speaking with a psychiatrist there, this term seemed to fit my experience much better than other eating disorders insofar as they are traditionally understood; in so many words, ARFID basically means that there is no intent to lose weight or struggle with body image, but that other factors (which can differ for each person) cause sufferers to have difficulty eating and, in turn, gaining weight.

After a lot of testing, I learned that my inability to gain weight is a result of several factors, the most prevalent being gastroparesis (very slow emptying of food from the stomach to the intestines in order to digest). Gastroparesis is incredibly painful, and because of this I have to be on a mostly liquid diet unless I want to spend hours curled up in extreme pain. What is incredibly frustrating, and what I hope readers will try to understand, is that very often people just see a very underweight person and make assumptions. I've even had people walk out of my life or distance themselves from me because they believe that I'm intentionally starving myself to death and they can't handle witnessing it. What I so wish they would do is simply reach out to me in kindness

and ask, so that I can explain the reality of ARFID, which seems to be a relatively newer term in the world of eating disorders, the pain of gastroparesis (which no one can truly understand the extent of without having experienced it), and that I am working hard with my outpatient team to find the best treatments for these so that I can heal.

I understand how hard it can be to ask someone about this, as it may feel intrusive or there may be fear of causing a negative reaction, but please understand that it is so much more hurtful to a sufferer if loved ones just make assumptions and back away. It causes even more loneliness than we already feel and causes me to isolate myself, which makes my anxiety worse and makes it harder to press on in seeking treatment. Opening the conversation gives us the option to explain what we're going through, and how you can be supportive. If this happened more, I truly believe sufferers would be more motivated to seek full recovery knowing they have a support system believing in them.

If you love someone who struggles with any kind of eating disorder, please understand that it's not always as it appears. Reach out, ask, support, encourage – we need you! And to all those struggling, please remember that you are not your illness.

What Exactly is ARFID?

National Eating Disorder Association

Retrieved from: https://www.nationaleatingdisorders.org/blog/what-exactly-arfid

Stephanie Elliot with Dr. Kim DiRé

2 years ago

ARFID

When my daughter was a toddler, she was what we considered a "picky eater." As she got older and her picky eating habits got more severe, we began to seriously worry. She didn't just clamp her mouth shut or shake her head "no" when new foods were set out for dinner. She would gag or choke if she tried anything new. Meals became a battle, with us trying to get her to eat something healthy, and her continuing to refuse.

Our daughter’s anxiety levels around food got extreme, and we knew that we had a problem when our family was unable to go out to dinner or attend social events without having to worry if there would be food our daughter could eat.

What we didn’t know at the time, and wouldn’t discover for nearly 15 years, was that our daughter had an eating disorder called ARFID, which is Avoidant/Restrictive Food Intake Disorder.

ARFID is often described as being a form of “extreme picky eating.” Dr. Kim DiRé, a trauma and eating disorder specialist, states that: "Avoidant/Restrictive Eating Disorder (ARFID) is an eating disorder like no other. The fear of food and/or the consequences translates in ARFID individuals as “if I eat that, I will die.” The physiological constriction of the mouth tissues, throat, and digestive tract from the fear stops the ability to eat a variety of foods. Malnutrition from ARFID causes many medical issues, including fatigue and loss of motivation. Because ARFID is a sensory disorder as well as an eating disorder, its cure is through somatic treatment."

My daughter physically could not try new foods or be near foods that made her uncomfortable. She would vehemently refuse to put anything unfamiliar into her mouth, even the smallest of morsels. We pleaded with her, we begged her, we bribed her, but to a person with ARFID, the fear of eating something new is so strong they refuse to eat...even though she was so hungry and wanted to eat. Those who suffer from ARFID are truly afraid they will choke, be poisoned, or die if they eat something they fear or disdain. This is a real somatic or body sensory disorder, with severe ramifications and it affects both boys and girls and can continue throughout adulthood if not treated.

When our daughter was finally diagnosed at age 15, we felt immense relief to know there was a name to her disordered eating. While ARFID is just as severe as anorexia, binge eating, or bulimia, it is different too. People with ARFID do not restrict their eating because of self-esteem, body issues, or the desire to be thin or to look different. The reason they do not eat is because they fear they will die.

Case studies show that many people with ARFID have suffered from a traumatic childhood experience: a choking incident as a toddler; a feeding issue as an infant; an umbilical cord around the neck during the birth; or even in-utero trauma. Difficult births or an incident that happens to the mother while the baby is in the womb can cause ARFID.

Most people with ARFID have a short menu of safe foods they will eat. These safe foods usually consist of “comfort” foods – white breads, french fries, sweets, chicken

nuggets, pizza, plain noodles, crackers, and cereal. When an ARFID sufferer has their safe foods, it is nearly impossible to get them to try something new.

People with ARFID suffer from depression and anxiety as a result from the fear, and then the inability to find a way to relieve the symptoms. When it presents in children, it's easy to become depressed and the anxiety becomes so high that they alienate, and they tend to withdraw from social events. A child with ARFID does not want to go to a birthday party and have all their friends ask them continuously, "Why won't you eat a hamburger or pizza?" or "Just try some pasta – you'll like it."

Children get tired of hearing all of the reasons they should eat and they shut down.

Doctors and therapists are working hard to learn how to treat ARFID. My daughter benefited from somatic experiencing therapy developed by Dr. Peter Levine, and somatic touch therapy. Her doctor would "turn off" her adrenals, which eased her anxiety, along with other somatic work, which gave her the shift in her tissues and textural tolerance to start to try new foods. Of course, there was more to it – a 20-week intense therapy program that involved one-on-one therapy, peer/group therapy, food graphing, a nutritionist, and eventual dinners out with the group.

Therapy and treatment are needed to help retrain the breached tissues in the body of a person with ARFID so that they will become tolerant of even trying the tiniest bite of something new. It is a sensory disorder that affects the body in a significant way. The healing of ARFID changes the lifestyle and nutritional foundation of the person in treatment. If you (or someone you know) think you have the symptoms of ARFID, know that there is help available and that NEDA is a source of this help.

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

C. Unspecified feeding or Eating Disorder

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/unspecified-feeding-or-eating-disorder

Unspecified feeding or eating disorder (UFED) applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functions predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.

The unspecified feeding and eating disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific feeding and eating disorder, and includes presentation in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

D. Health Consequences

Common Health Consequences of Eating Disorders

National Eating Disorders

Retrieved from: https://www.nationaleatingdisorders.org/health-consequences

Eating disorders are serious, potentially life-threatening conditions that affect a person's emotional and physical health. They are not just a "fad" or a "phase." People do not just "catch" an eating disorder for a period of time. They are real, complex, and devastating conditions that can have serious consequences for health, productivity, and relationships.

Eating disorders can affect every organ system in the body, and people struggling with an eating disorder need to seek professional help. The earlier a person with an eating disorder seeks treatment, the greater the likelihood of physical and emotional recovery.

CARDIOVASCULAR SYSTEM

- Consuming fewer calories than you need means that the body breaks down its own tissue to use for fuel. Muscles are some of the first organs broken down, and the most important muscle in the body is the heart. Pulse and blood pressure begin to drop as the heart has less fuel to pump blood and fewer cells to pump with. The risk for heart failure rises as the heart rate and blood pressure levels sink lower and lower.
    - Some physicians confuse the slow pulse of an athlete (which is due to a strong, healthy heart) with the slow pulse of an eating disorder (which is due to a malnourished heart). If there is concern about an eating disorder, consider low heart rate to be a symptom.
- Purging by vomiting or laxatives depletes your body of important chemicals called electrolytes. The electrolyte potassium plays an important role in helping the heart beat and muscles contract, but is often depleted by purging. Other electrolytes, such as sodium and chloride, can also become imbalanced by purging or by drinking excessive amounts of water. Electrolyte imbalances can lead to irregular heartbeats and possibly heart failure and death.
- Reduced resting metabolic rate, a result of the body's attempts to conserve energy.

GASTROINTESTINAL SYSTEM

- Slowed digestion known as gastroparesis. Food restriction and/or purging by vomiting interferes with normal stomach emptying and the digestion of nutrients, which can lead to:
    - Stomach pain and bloating
    - Nausea and vomiting
    - Blood sugar fluctuations
    - Blocked intestines from solid masses of undigested food
    - Bacterial infections

    - Feeling full after eating only small amounts of food
- Constipation, which can have several causes:
    - Inadequate nutritional intake, which means there's not enough in the intestines for the body to try and eliminate
    - Long-term inadequate nutrition can weaken the muscles of the intestines and leave them without the strength to propel digested food out of the body
    - Laxative abuse can damage nerve endings and leave the body dependent on them to have a bowel movement
- Binge eating can cause the stomach to rupture, creating a life-threatening emergency.
- Vomiting can wear down the esophagus and cause it to rupture, creating a life-threatening emergency.
    - Frequent vomiting can also cause sore throats and a hoarse voice.
- When someone makes themselves vomit over a long period of time, their salivary (parotid) glands under the jaw and in front of the ears can get swollen. This can also happen when a person stops vomiting.
- Both malnutrition and purging can cause pancreatitis, an inflammation of the pancreas. Symptoms include pain, nausea, and vomiting.
- Intestinal obstruction, perforation, or infections, such as:
    - Mechanical bowel problems, like physical obstruction of the intestine, caused by ingested items.
    - Intestinal obstruction or a blockage that prevents food and water from passing through the intestines.
    - Bezoar, a mass of indigestible material found trapped in the gastrointestinal tract (esophagus, stomach, or intestines).
    - Intestinal perforation, caused by the ingestion of a nonfood item that creates a hole in the wall of the stomach, intestines or bowels.
    - Infections such as toxoplasmosis and toxocariasis may occur because of ingesting feces or dirt.

- Poisoning, such as heavy metal poisoning caused by the ingestion of lead-based paint.

NEUROLOGICAL

- Although the brain weighs only three pounds, it consumes up to one-fifth of the body's calories. Dieting, fasting, self-starvation, and/or erratic eating means the brain isn't getting the energy it needs, which can lead to obsessing about food and difficulties concentrating.
- Extreme hunger or fullness at bedtime can create difficulties falling or staying asleep.
- The body's neurons require an insulating, protective layer of lipids to be able to conduct electricity. Inadequate fat intake can damage this protective layer, causing numbness and tingling in hands, feet, and other extremities.
- Neurons use electrolytes (potassium, sodium, chloride, and calcium) to send electrical and chemical signals in the brain and body. Severe dehydration and electrolyte imbalances can lead to seizures and muscle cramps.
- If the brain and blood vessels can't push enough blood to the brain, it can cause fainting or dizziness, especially upon standing.
- Individuals of higher body weights are at increased risk of sleep apnea, a disorder in which a person regularly stops breathing while asleep.

ENDOCRINE

- The body makes many of its needed hormones with the fat and cholesterol we eat. Without enough fat and calories in the diet, levels of hormones can fall, including:
    - Sex hormones estrogen and testosterone
    - Thyroid hormones

- Lowered sex hormones can cause menstruation to fail to begin, to become irregular, or to stop completely.
- Lowered sex hormones can significantly increase bone loss (known as osteopenia and osteoporosis) and the risk of broken bones and fractures.
- Reduced resting metabolic rate, a result of the body's attempts to conserve energy.

- Over time, binge eating can potentially increase the chances that a person's body will become resistant to insulin, a hormone that lets the body get energy from carbohydrates. This can lead to Type 2 Diabetes.
- Without enough energy to fuel its metabolic fire, core body temperature will drop and hypothermia may develop.
- Starvation can cause high cholesterol levels, although this is NOT an indication to restrict dietary fats, lipids, and/or cholesterol.

OTHER HEALTH CONSEQUENCES

- Low caloric and fat consumption can cause dry skin, and hair to become brittle and fall out.
- To conserve warmth during periods of starvation, the body will grow fine, downy hair called lanugo.
- Severe, prolonged dehydration can lead to kidney failure.
- Inadequate nutrition can decrease the number of certain types of blood cells.
- Anemia develops when there are too few red blood cells or too little iron in the diet. Symptoms include fatigue, weakness, and shortness of breath.
- Malnutrition can also decrease infection-fighting white blood cells.

MORTALITY AND EATING DISORDERS

While it is well known that anorexia nervosa is a deadly disorder, the death rate varies considerably between studies. This variation may be due to length of follow-up, or ability to find people years later, or other reasons. In addition, it has not been certain whether other subtypes of eating disorders also have high mortality. Several recent papers have shed new light on these questions by using large samples followed up over many years. Most importantly, they get around the problem of tracking people over time by using national registries which report when people die. A paper by Papadopoulos studied more than 6000 individuals with AN over 30 years using Swedish registries. Overall people with anorexia nervosa had a six fold increase in mortality compared to the general population. Reasons for death include starvation, substance abuse, and suicide. Importantly the authors also found an increase rate of death from 'natural' causes, such as cancer.

It has not been certain whether mortality rates are high for other eating disorders, such as bulimia nervosa and eating disorder not otherwise specified, the latter of which is the most common eating disorder diagnosis. Crow and colleagues studied 1,885 individuals with anorexia nervosa (N=177), bulimia nervosa (N=906), or eating disorder not otherwise specified (N=802) over 8 to 25 years. The investigators used computerized

record linkage to the National Death Index, which provides vital status information for the entire United States, including cause of death extracted from death certificates. Crow and colleagues found that crude mortality rates were 4.0% for anorexia nervosa, 3.9% for bulimia nervosa, and 5.2% for eating disorder not otherwise specified. They also found a high suicide rate in bulimia nervosa. The elevated mortality risks for bulimia nervosa and eating disorder not otherwise specified were similar to those for anorexia nervosa.

In summary, these findings underscore the severity and public health significance of all types of eating disorders.

Special thank you to Walter Kaye, MD, Professor of Psychiatry, Director, UCSD Eating Disorder Research and Treatment Program, University of California, San Diego

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

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Chapter 4: Co-Occurring Disorders & Special Issues

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/anxiety-depression-obsessive-compulsive-disorder

A. Co-Occurring Disorders

An eating disorder diagnosis can be challenging enough on its own, and many individuals have other issues that can accompany the eating disorder. Anxiety, depression, and obsessive-compulsive disorder (OCD) are just a few additional mental health diagnoses that frequently co-occur with eating disorders. Sometimes, these other disorders may be a result of eating

disorder behaviors, as binging, purging, and restricting can all cause psychological distress.

A co-occurring mental health diagnosis can begin around the same time as an eating disorder, can precede it, or can emerge after the eating disorder has already begun. Mood and anxiety disorders most commonly occur alongside eating disorders, and post-traumatic stress disorder is also common.

Some mental disorders can be risk factors for eating disorders, indicating that a person may be more likely to later develop an eating disorder. A study of more than 2,400 individuals hospitalized for an eating disorder found that 94% of the participants had a co-occurring mood disorder, with 92% of those in the sample struggling with a depressive disorder. Of the 56% of individuals who were diagnosed with anxiety disorders, 20% had OCD.

Recent research finds that 32-39% of people with anorexia nervosa, 36-50% of people with bulimia nervosa, and 33% of people with binge eating disorder are also diagnosed with major depressive disorder. 48-51% of people with anorexia nervosa, 54-81% of people with bulimia nervosa, and 55-65% of people with binge eating disorder are also diagnosed with an anxiety disorder.

Major Depressive Disorder is the most commonly diagnosed form of depression. Approximately 16.1 million adults aged 18 years or older in the U.S. had experienced at least one major depressive episode in the last year, which represented 6.7% of all American adults. Depression is the leading cause of disability in the United States among people ages 15-44.

Anxiety Disorders are the most common and pervasive mental disorders in the United States and can affect anyone at any age. Anxiety and stress are natural responses to every day stressors--if the feelings of anxiety are extreme and begin to interfere with one's daily life, then it may be a sign of an anxiety disorder.

Obsessive Compulsive Disorder (OCD) is the most common anxiety disorder to co-occur with an eating disorder. Those who have both disorders often develop compulsive rituals connected to food.

DEPRESSION

Warning Signs & Symptoms

- Feelings of emptiness and hopelessness
- Irritability, anxiousness, and guilt
- Feelings of exhaustion, severe tiredness
- Feelings of tension
- Loss of interest and energy
- Inability to concentrate or remember details
- Suicidal thoughts or attempts of suicide
- Changes in appetite – eating too much or too little
- Physical symptoms – aches and pains, cramps, headaches, digestive issues, breast tenderness, bloating
- Mood swings
- Panic attacks
- Sleep disturbances; sleeping too much or too little, insomnia

If you or someone you know express one or more of the following symptoms, please seek professional help.

Risk Factors

Key findings show that more than 8% of adults older than 20 years old reported having depression during a given two-week period. Most of us may feel anxious or depressed when dealing with a death in the family, losing a job or home, separation and divorce, financial instability; and other difficult situations can lead a person to feel sad, lonely and scared which are normal feelings and usually pass with time. If these intense

feelings interfere with daily activities, cause a high level of distress, or occupy your mind endlessly, you may have an anxiety disorder or depression — or both.

Depression can happen at any age and can co-occur with other chronic illnesses such as cancer, diabetes and heart disease. Risk factors include: personal or family history of depression, major life changes, trauma, or stress or certain serious illnesses and medications.

Health Consequences

The relationship between eating disorders and depression is a complex problem to understand, treat, and research. ADAA member Karen Cassiday authored a NEDA blog *Learning to Live Well with Depression and Eating Disorders* and explained that "the patient's concern is their body and eating." The other problem is that depressed patients can lack motivation and energy to complete any treatment because their depression symptoms of apathy fatigue, flat affect, and disturbed appetite are difficult to manage without also having the overlay of an eating disorder.

ANXIETY DISORDERS

Warning Signs & Symptoms

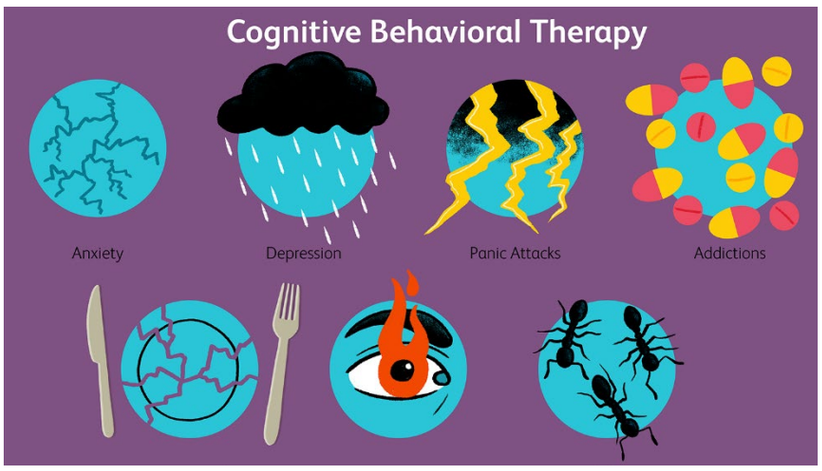
- Feeling nervous, irritable or on edge
- Having a sense of impending danger, panic or doom
- Having an increased heart rate
- Breathing rapidly (hyperventilation), sweating, and/or trembling
- Feeling weak or tired
- Difficulty concentrating
- Having trouble sleeping
- Experiencing gastrointestinal (GI) problems

If you or someone you know express one or more symptoms, please seek professional help.

TREATMENT

Anxiety/depression disorders and eating disorders may be treated at the same time and in the same manner. It is important to note that, recovery from one disorder does not ensure recovery from another, so it is necessary to seek help for both issues.

Cognitive-Behavioral Therapy



A well-established, highly effective, and lasting treatment called cognitive-behavioral therapy (CBT) focuses on identifying, understanding, and changing thinking and behavior patterns. Benefits are usually seen in 12-16 weeks, depending on the individual. In this type of therapy, the patient is actively involved in his or her own recovery, has a sense of control, and learns skills that are useful throughout life. CBT typically involves reading about the problem, keeping records between appointments, and completing homework assignments that practice and reinforce treatment procedures. Patients learn skills during therapy sessions, and they must practice repeatedly to see improvement.

Taking medications under a doctor's supervision and joining a support group are also sound treatment options.

Medication

Medication treatment is generally safe and effective, and is often used in conjunction with therapy. Medication may be a short-term or long-term treatment option, depending on severity of symptoms, other medical conditions, and other individual circumstances. However, it often takes time and patience to find the drug that works best for you.

Medications are commonly prescribed by physicians (e.g., family practice, pediatricians, OB-GYNs, and psychiatrists), as well as nurse practitioners in many states.

Four major classes of medications are used in the treatment of depression and anxiety disorders:

Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs relieve symptoms by blocking the reabsorption, or reuptake, of serotonin by certain nerve cells in the brain. This leaves more serotonin available, which improves mood. SSRIs (citalopram, escitalopram, fluoxetine, paroxetine, and sertraline) generally produced fewer side effects when compared with tricyclic antidepressants. However,

common side effects include insomnia or sleepiness, sexual dysfunction, and weight gain. They are considered an effective treatment for all anxiety disorders, although the treatment of obsessive-compulsive disorder, or OCD, typically requires higher doses.

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

The serotonin-norepinephrine reuptake inhibitor, or SNRI, class (venlafaxine and duloxetine) is notable for a dual mechanism of action: increasing the levels of the neurotransmitters serotonin and norepinephrine by inhibiting their reabsorption into cells in the brain. As with other medications, side effects may occur, including stomach upset, insomnia, headache, sexual dysfunction, and minor increase in blood pressure. Since these medications are deemed as effective as SSRIs, they are also considered a first-line treatment, particularly for the treatment of generalized anxiety disorder.

Benzodiazepines

This class of drugs is frequently used for short-term management of anxiety. Benzodiazepines (e.g., alprazolam, clonazepam, diazepam, and lorazepam) are highly effective in promoting relaxation and reducing muscular tension and other physical symptoms of anxiety. Long-term use may require increased doses to achieve the same effect, which may lead to problems related to tolerance and dependence.

Tricyclic Antidepressants

Concerns about long-term use of the benzodiazepines led many doctors to favor tricyclic antidepressants (e.g., amitriptyline, imipramine, and nortriptyline). Although effective in the treatment of anxiety, they can cause significant side effects, including orthostatic hypotension (drop in blood pressure on standing), constipation, urinary retention, dry mouth, and blurry vision.

Contact your physician if you experience side effects, even if you are not sure a symptom is caused by a medication. Do not stop taking a medication without consulting with the prescribing physician; abrupt discontinuation may cause other health risks.

Medications will work only if they are taken according the explicit instructions of your physician, but they may not resolve all symptoms of an anxiety disorder.

Treatment for eating disorders also includes nutritional management and nutritional counseling. Those who experience severe symptoms may require hospitalization to help stabilize their health.

Special thanks to ADAA and Dr. Richa Bhatia, MD, FAPA

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

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A. Diabulimia

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/diabulimia-5

Diabulimia is a media-coined term that refers to an eating disorder in a person with diabetes, typically type I diabetes, wherein the person purposefully restricts insulin in order to lose weight. Some medical professionals use the term ED-DMT1, Eating Disorder-Diabetes Mellitus Type 1, which is used to refer to any type of eating disorder comorbid with type 1 diabetes.

With the intense focus on food, labels, numbers (weight, blood glucose, A1c) and control, plus the many disruptions that occur in a person's metabolic system, we know that diabetes is a high risk factor for developing an eating disorder. Thus, a person may develop diabulimia or ED-DMT1 at any age and at any point after their diabetes diagnosis. Sometimes it begins with body image issues or a desire to lose weight, and sometimes it begins as diabetes burnout. Regardless of how it begins, treatment can be challenging as individuals with type 1 diabetes tend to show higher dropout rates and poorer treatment outcomes than other patients. Treatment regimens must address both the diabetes and eating disorder aspects of the disorder.

Diabulimia does not have a separate diagnostic code so a person's specific diagnosis will depend on their eating disorder behaviors. The diagnostic manual, DSM-5,

classifies insulin omission as a purging behavior, therefore it may be coded as bulimia nervosa if the person is binging then restricting insulin. It may be diagnosed as purging disorder if the person is eating normally and restricting insulin or anorexia nervosa if the person is severely restricting both food and insulin. Diabulimia can also be diagnosed as Other Specified Feeding and Eating Disorder (OSFED).

WARNING SIGNS & SYMPTOMS OF DIABULIMIA

Emotional and behavioral

- Increasing neglect of diabetes management
- Secrecy about diabetes management
- Avoiding diabetes related appointments
- Fear of low blood sugars
- Fear that “insulin makes me fat”
- Extreme increase or decrease in diet
- Extreme anxiety about body image
- Restricting certain food or food groups to lower insulin dosages
- Avoids eating with family or in public
- Discomfort testing/injecting in front of others
- Overly strict food rules
- Preoccupation with food, weight and/or calories
- Excessive and/or rigid exercise
- Increase in sleep pattern
- Withdrawal from friends and/or family activities
- Depression and/or anxiety
- Infrequently filled prescriptions

Physical

- A1c of 9.0 or higher on a continuous basis
- A1c inconsistent with meter readings
- Unexplained weight loss
- Constant bouts of nausea and/or vomiting
- Persistent thirst and frequent urination
- Multiple DKA or near DKA episodes
- Low sodium and/or potassium
- Frequent bladder and/or yeast infections
- Irregular or lack of menstruation
- Deteriorating or blurry vision

- Fatigue or lethargy
- Dry hair and skin

HEALTH CONSEQUENCES OF DIABULIMIA

The human body is surprisingly resilient and people with diabulimia often manage to function with much higher blood sugars than should be possible. Thus, the major consequences of diabulimia or ED-DMT1 are usually related to prolonged elevated blood sugar. These complications can be severe and irreversible, so proper treatment and early detection are critical

Patients with weight related insulin restriction were 3.2 times more likely to die over an 11-year study period, and to die an average of 13 years younger than those who didn't restrict insulin. It is incredibly important to understand the many ways that eating disorders affect a person with diabetes.

Short-term consequences:

- **Slow wound healing** - high blood sugar causes poor circulation, decreases the function of red and white blood cells, and damages small blood vessels; all of which delay wound healing and can sometimes progress into an ulcer in a person with diabetes.
- **Staph and other bacterial infections** – high blood sugar causes the body to produce certain enzymes and hormones that negatively affect the immune system and reduce the body's defense against infection. This risk of infection plus slowed healing heighten a person's chance of developing gangrene, sepsis or a bone infection.
- **Yeast Infections** – excess sugar allows the overgrowth of yeast, often in the vaginal area.
- **Muscle Atrophy** – without insulin, the body cannot utilize food and cells begin to starve so the body begins to break down muscle for fuel.

- **Menstrual Disruption** – without sufficient nutrition, a woman's estrogen levels fall which can keep menstruation from starting, or cause it to become irregular or stop completely; also when a woman's body senses starvation it will cease reproduction to conserve energy.
- **Severe Dehydration** – insulin deficiency puts the body into a state of starvation causing it to break down tissues to create ketones to use as fuel; in an attempt to expel the ketones in the urine the body ends up dispelling too much fluid.
- **Electrolyte Imbalance** – as the kidneys extract sugar and ketones to expel with urine, they also extract sodium and potassium which can lead to an extreme electrolyte balance, especially when combined with vomiting which often occurs with high ketone levels.
- **Diabetic Ketoacidosis** – people with type 1 diabetes will develop dangerous levels of ketones faster than others because the body needs insulin to transport ketones from the bloodstream into cells; without insulin, the ketones build up in the bloodstream faster than the kidneys can remove them causing the blood to become acidic. Not only does the acidic blood damage blood vessels, nerves and organs, but even a minor alteration in a person's blood pH can cause organ systems to shut down resulting in coma and sometimes death.

Long-term Consequences:

High blood glucose causes blood to become like sandpaper scraping and damaging blood vessel walls. In addition, blood that is acidic from ketones can cause vessel damage. The consequences of this damage are often seen in the eyes where tiny vessels begin to leak into the eyeball.

- **Retinopathy** - small black spots or "floaters" disrupting a person's vision; the bleeding may be stopped with treatment, but persistent or recurrent retinopathy can eventually lead to blindness.
- **Macular Edema** – swelling of the eye ball from excess fluid; if untreated it can eventually cause permanent damage to the eye.

Nerve fibers are particularly vulnerable to prolonged periods of high blood sugar. Many factors can damage the small nerves in the body including reduction in oxygen supply;

thick, sticky blood that has difficulty getting to the small capillaries that feed the nerves; and inflammation of the nerves.

- **Peripheral Neuropathy** – stabbing/burning/tingling pain, weakness or numbness in the hands, feet, legs and/or arms.
- **Gastroparesis** – slowed stomach emptying from damaged nerves preventing proper digestion and causing stomach pain, nausea and vomiting.
- **Vasovagal Syncope** – malfunction of the nervous system in response to stress or position change causing a sudden drop in blood pressure and heart rate and sometimes fainting.
- **Chronic diarrhea** or constipation – when nerves that control the intestines and colon are damaged, a person may experience abnormal fluid absorption or slowed motility.

Other organ damage.

- **Kidney disease** – High blood sugars make the kidneys work excessively hard causing damage to the kidneys filtering system. Kidneys begin leaking protein into urine and lose their ability to remove waste products and excess fluid allowing waste and fluid to build up in the body; it can eventually lead to kidney failure requiring frequent dialysis or kidney transplant.
- **Liver disease** – Although the specific mechanism is not well understood, we know that insulin deficiency results in non-alcoholic fatter liver - too much fat accumulated in the liver coupled with inflammation; in severe cases it can progress to cirrhosis and liver failure.
- **Heart disease** – hardening and narrowing of the arteries from high cholesterol.

Many of the above consequences can become fatal - sometimes over time such as kidney or heart disease and sometimes very quickly such as diabetic ketoacidosis.

- **Coma**
- **Stroke**
- **Death**

Without insulin, the body cannot utilize anything eaten putting the body into a state of malnutrition or starvation. As a result, in addition to the above complications a person with diabulimia can also incur the same consequences as someone with anorexia nervosa. And if a person engages in other forms of purging beyond insulin restriction, they can develop consequences associated with bulimia nervosa.

TREATMENT

- No matter where someone is at in their eating disorder or recovery, a multidisciplinary team is necessary to address the many entangled issues present with diabulimia or ED-DMT1. The best scenario for a patient is to see an endocrinologist, a dietician who has knowledge of both diabetes and eating disorders, and a mental health professional who specializes in eating disorders.

- Both healthcare professionals and patients need to remember that “good enough” diabetes management is the goal, not “perfect” control. The quest for perfection can lead to an increase in diabetes burnout and enhance all-or-nothing thinking which in turn can boost the eating disorder.
- Remaining in an outpatient setting should be contingent upon taking a minimum amount of insulin consistently, being able to eat enough food to maintain weight, and not engaging in degrees of purging that causes dangerous electrolyte imbalance.
- If the treatment team recommends a higher level of care, it’s important to choose a treatment center that has a specialty in diabulimia/ED-DMT1. Patients and healthcare providers can ask to review insulin reintroduction protocols, diabetes management and staff training in diabetes to determine a center’s true level of expertise, or reach out to Diabulimia Helpline which has a nationwide referral database for both centers and providers that have experience in both diabetes and eating disorders.
- Remember that diabulimia is a serious mental health disorder, thus it cannot be treated by simply reinforcing diabetes education or stressing the dangers of diabetes complications.

Special thanks to Diabulimia Helpline: www.diabulimiahelpline.org

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A. Pregnancy and Eating Disorders

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/pregnancy-and-eating-disorders

Pregnancy and parenting require a great deal of strength—physically, psychologically, and emotionally. During pregnancy, the growing baby receives all of its nourishment from the parent's body. While gaining weight is required for a healthy pregnancy, for those with eating disorders, having to gain weight can be very frightening.

Professionals recommend that disordered thoughts and behaviors are addressed before attempting to get pregnant. Eating healthy, well-balanced meals and maintaining a healthy weight for several months before conceiving and throughout pregnancy is important to protecting the health of yourself and your baby.

COMPLICATIONS OF DISORDERED EATING DURING PREGNANCY

Risks for the Pregnant Person: Poor nutrition, dehydration, cardiac irregularities, gestational diabetes, severe depression during pregnancy, premature birth, labor complications, difficulties nursing, and postpartum depression.

Risks for the Baby: Poor development, premature birth, low birth weight, respiratory distress, feeding difficulties, and other perinatal complications.

- **Anorexia nervosa:** Individuals can be underweight and may not gain enough weight during pregnancy. They risk having a baby with abnormally low birth weight and related health problems.

- **Bulimia nervosa:** Those who continue to purge may suffer dehydration, chemical imbalances or even cardiac irregularities. Pregnancy heightens these health risks.
- **Binge eating disorder:** Binge eating is often correlated with weight gain, which may lead to a greater risk of developing high blood pressure and gestational diabetes.

WHAT IF I BECOME PREGNANT WHILE STRUGGLING WITH AN EATING DISORDER?

Though having an eating disorder may decrease the chances of pregnancy, sometimes those with eating disorders do become pregnant. When this happens, steps should be taken to protect you and your baby. Professionals can address the specific needs related to pregnancy and disordered eating only if you are willing to be completely honest with them about your struggles.

If you are pregnant and struggling with disordered eating:

- **Be honest with your prenatal health provider** regarding past or present struggles with an eating disorder or disordered eating. If they aren't sensitive to your struggle and concerns, look for a provider who will be more considerate of your experiences.
- **Extra appointments may be necessary** to more closely track the growth and development of your baby.
- **Consult a nutritionist** with expertise in eating disorders before or immediately after becoming pregnant. Work with the nutritionist throughout the pregnancy to

create a plan for healthy eating and weight gain. It's often helpful to continue to see them postpartum.

- **Individual counseling and support groups** during and after pregnancy can help you cope with your concerns and fears regarding food, weight gain, body image, and the new role of parenting.
- **Other classes on pregnancy, childbirth, child development, and parenting skills** can also be helpful in preparation for this stage of your life.
- **Allow your prenatal health provider to weigh you.** This information is essential to tracking the health of your baby. If you would prefer not to monitor your weight gain, ask your doctor about standing on the scale backwards and instruct them to not share the number with you.
- **Talk to your doctor before attending a prenatal exercise class** to make sure it fits in with your recovery plan.

TIPS FOR HEALTHY BODY IMAGE DURING AND AFTER PREGNANCY

Be Aware of the Triggers of Pregnancy

The incessant counting, comparing, and measuring that happens during those nine months and beyond can tap into some of the very vulnerabilities that are linked to eating disorders and food and weight obsessions. Perfectionism, loss of control, feelings of isolation, and memories of childhood often bubble right to the surface. But if you're getting the support you need, you'll have a better chance of weathering those storms without resorting to self-destructive habits.

Resist the Urge to Shut Down or Close Off

Remember that there is nothing shameful about asking for help. It's the most courageous thing you can do for yourself and your baby. Look at your recovery as an ongoing process that will help you reach your full potential as an individual and as a parent.

Break the Cycle of Body Hatred

Allow yourself to celebrate the fact that your body is working some serious magic right now. Before you get stymied by stretch marks or focused on loose skin, take time to reflect on how you will teach your child—in your words and in your actions—that you appreciate your body. We have the power to help future generations grow up placing a higher value on good health than on weight and physical appearance. But before we can pass along those positive attitudes, we must first embrace them for ourselves.

Source:

Does This Pregnancy Make Me Look Fat? The Essential Guide to Loving Your Body Before and After Baby by Claire Mysko and Magali Amadei

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B. Substance Abuse and Eating Disorders

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/substance-abuse-and-eating-disorders

Substance Abuse and Eating Disorders

Substance abuse problems may begin before or during an eating disorder, or even after recovery. Those struggling with co-occurring substance use and disordered eating should speak with a trained professional who can understand, diagnose, and treat both substance use disorders and eating disorders.

Up to 50% of individuals with eating disorders abused alcohol or illicit drugs, a rate five times higher than the general population. Up to 35% of individuals who abused or were

dependent on alcohol or other drugs have also had eating disorders, a rate 11 times greater than the general population.

The substances most frequently abused by individuals with eating disorders or with sub-clinical symptoms include: alcohol, laxatives, emetics, diuretics, amphetamines, heroin, and cocaine.

Eating disorders and substance abuse share a number of common risk factors, including brain chemistry, family history, low self-esteem, depression, anxiety, and social pressures. Other shared characteristics include compulsive behavior, social isolation, and risk for suicide.

As with eating disorders, early intervention of substance use is essential.

THINGS TO CONSIDER WHEN SEEKING PROFESSIONAL INTERVENTION

- Find an eating disorder specialist that can also address substance abuse/dependence.
- Research levels of care and treatment providers to determine a plan that fits your specific needs.
- Most eating disorder treatment facilities are equipped to deal with patients who abuse over-the-counter diet pills, laxatives, emetics and diuretics, but not all are able to accommodate the patient that requires medical detoxification.
- Educate yourself, be proactive, and know that both these disorders are treatable. Seek treatment and find recovery.

WHAT IS "DRUNKOREXIA"?

Drunkorexia is a colloquial term that refers to altering eating behaviors to either offset for planned caloric intake from alcohol or to increase/speed the effects of alcohol. Not a clinical diagnosis and not necessarily indicative of a substance abuse problem, the term is often used in the context of college campuses, but disordered eating and binge drinking is a pattern that can be seen across all demographics.

Regardless of whether the behaviors become diagnosable conditions, the relationship between food restriction or purging behaviors and high levels of alcohol use puts individuals at risk for significant medical complications in the short term and long term. It's important that these dangerous behaviors be identified and treated as soon as possible.

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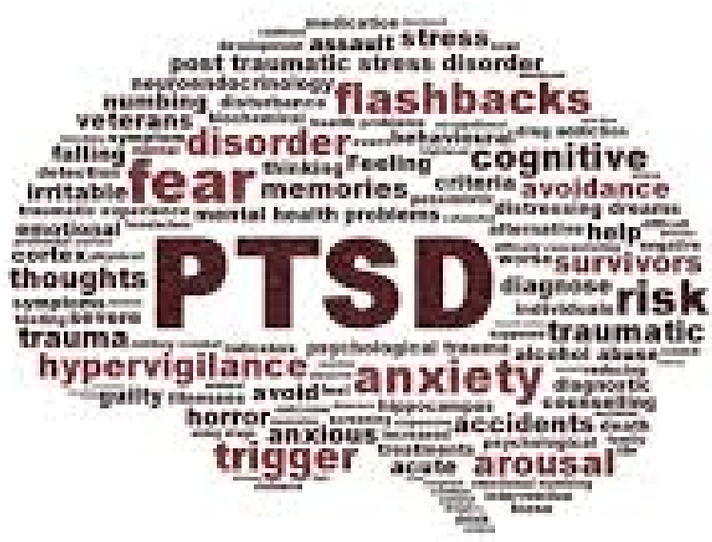
C. Trauma & PTSD

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/learn/general-information/trauma



Traumatic events are events that cause psychological, physical, and/or emotional pain or harm.

Traumatic events, especially those involving violence between people, have been found to be significant risk factors for the development of a variety of psychiatric disorders, including eating disorders—particularly those involving bulimic symptoms, such as binge eating and purging.

STRESS, TRAUMA, AND COPING

Stress is an unavoidable part of life, but sometimes when stress becomes overwhelming and overpowers our coping mechanisms (such as talking to a friend, meditating or journaling) it causes distress, disease, and dysfunction. Generally, when stress reaches the point where it causes emotional and/or physical problems, then it becomes traumatic.

Some people are at increased risk of stress, trauma, or negative events. This is determined by a combination of biological, psychological, and social factors, such as being prone to anxiety and/or depression and/or having inherited the personality traits of high harm avoidance (shy, fearful, worrying behavior) and/or acting on an impulse. What may seem to be of little or no concern to one person can be very traumatic to another, particularly to one with, or predisposed to, an eating disorder.

How we cope with stress can play an important role in whether or not stressful experiences become traumatic. Individuals with an avoidant coping style will not fare as well as those with an active coping style.

- **Avoidant coping:** associated with self-punishing thoughts and beliefs, which can be self-defeating and result in a negative medical outcome.
- **Active coping:** problem-solving style associated with better medical results.

EATING DISORDERS AND PREDISPOSITION TO STRESS

Available evidence suggests that eating disorder patients may be particularly sensitive or vulnerable to stress and its consequences:

- Individuals with anorexia nervosa and/or bulimia nervosa more often than not have a primary anxiety disorder, i.e., an anxiety disorder that began before the onset of their eating disorder.
- In addition, research indicates that individuals with eating disorders:
    - Are more likely to perceive threat or hostile intent from others
    - Exhibit high levels of anxiety sensitivity (a fear of behaviors or sensations associated with anxiety) characterized by fear of loss of control

- Are often over concerned or preoccupied with negative consequences
- Have exaggerated inhibition (self-restraint and the inability to act in a relaxed way) and anticipatory anxiety (tension over an expected negative outcome)
- Are sensitive to punishment and have difficulty adapting to change
- Weak central coherence: have difficulty “seeing the big picture,” but get hung up on the (often trivial) details

POSTTRAUMATIC STRESS DISORDER (PTSD)

One of the most important connections between having had traumatic or adverse experiences and the development of eating disorders and other related psychiatric problems is the presence of posttraumatic stress disorder (PTSD) or its symptoms. PTSD is a serious mental health condition that can develop when someone has been exposed to one or more traumatic events. PTSD symptoms include:

- Re-experiencing symptoms (e.g., flashbacks, nightmares, intrusive imagery)
- Hyperarousal symptoms (e.g., irritability or angry outbursts, exaggerated startle, problems concentrating, insomnia, being overly watchful and anxious)
- Avoidance symptoms (e.g., numbing, forgetting and avoiding trauma-related material)
- Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred (e.g., partial amnesia, negative beliefs about oneself, others, or the world, self-blame, constantly expecting the worst)

PTSD tends to be a chronic condition, especially when not adequately addressed and treated. For example, one of the findings from the National Comorbidity Survey was that over one-third of individuals with an index episode of PTSD still had the full syndrome 10 years later. Like many individuals with PTSD, it is not uncommon for eating disorder patients with PTSD, who tend to have more comorbidity and more complicated courses, to not get adequate assessment and treatment. Unresolved trauma and/or PTSD can be an important perpetuating factor in the maintenance of symptoms.

Two major national representative studies have shown that individuals with bulimia nervosa, binge eating disorder or any binge eating have significantly higher rates of PTSD than individuals without an eating disorder. These include the National Women's Study and the National Comorbidity Survey Replication; the highest rates of lifetime PTSD were 38% and 44% respectively in the BN groups. When partial or subclinical forms of PTSD are considered, then well over half of individuals with bulimic symptoms have PTSD or significant PTSD symptoms. In addition, traumatized people with eating disorders demonstrate high levels of dissociative symptoms, such as amnesia of traumatic material (being unable to remember the traumatic event), which are also factors that contribute to a negative medical outcome.

BINGE EATING, PURGING, AND TRAUMA

In much the same way abuse of certain substances is used to self-medicate, binge eating and/or purging appear to be behaviors that facilitate:

- Reducing the hyperarousal or anxiety associated with trauma
- The numbing, avoidance, and even forgetting of traumatic experiences

These behaviors are reinforcing, making it difficult to break the cycle. As a result, traumatic experiences and their destructive effects are not effectively processed and continue to cause problems. In this way, trauma, PTSD, and eating disorders can be very much intertwined.

TREATMENT

Individuals with an eating disorder complicated by trauma and PTSD require treatment for both conditions using a trauma-informed, integrated approach. If the trauma is not addressed during the treatment of an eating disorder, then it is likely that successful recovery will be thwarted. Important factors contributing to the success of treatment can include positive reactions by family members and close friends to disclosure about traumatic events, as well as strong support from family and friends. Although the best approach to address PTSD in the context of an eating disorder

remains elusive, work so far has focused primarily on cognitive processing therapy (CPT) integrated with traditional treatment for the eating disorder. Future research is likely to shed light on how best to treat this comorbid combination. A wealth of information on treatment options for PTSD for both the public and professionals is available from the National Center for PTSD.

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D. Stages of Recovery

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/stages-recovery

UNDERSTANDING STAGES OF CHANGE IN THE RECOVERY PROCESS

Recovery from an eating disorder can be a long process that requires not only a qualified team of professionals, but also the love and support of family and friends. It is not uncommon for someone who suffers with an eating disorder to feel uncertain about

their progress or for their loved-ones to feel disengaged from the treatment process. These potential roadblocks may lead to feelings of ambivalence, limited progress, and treatment drop out. Therefore, knowing about the Stages of Change Model, as defined by Prochaska and DiClemente, will help everyone involved better negotiate the road to recovery.

The Stages of Change in the process of recovery from an eating disorder are a cycle rather than a linear progression. The person may go through this cycle more than one time or may need to revisit a particular stage before moving on to the next. They may also go through the stages for each individual eating disorder symptom. In other words, if they are recovering from anorexia, they could be in the Action Stage for restrictive eating (e.g., eating three meals a day along with snacks, engaging in social eating, and utilizing support system) while, at the same time, they could be going through the Contemplation Stage for body image and weight concerns (e.g., becoming aware of how body image is tied to self-esteem and self-worth, defining oneself as a body or number, and identifying the negatives of striving for the "perfect body"). This is precisely why recovery from an eating disorder is complex and individualized.

The table below is a general breakdown of the Stages of Change for someone who is recovering from an eating disorder. If you are a parent or friend of someone struggling, you no doubt suffer right along with them, so it is crucial for you to pay attention to your own needs as well as be present for your child or friend during her recovery process.

WHAT ARE THE STAGES OF CHANGE?

There are five Stages of Change that occur in the recovery process: Pre-Contemplation, Contemplation, Preparation, Action, and Maintenance.

PRECONTEMPLATION STAGE

The Pre-Contemplation Stage is evident when a person does not believe they have a problem. Close family and friends are bound to pick up on symptoms such as restrictive eating, the binge/purge cycle, or a preoccupation with weight, shape, and appearance even before the individual admits to it. They may refuse to discuss the topic and deny they need help. At this stage, it is necessary to gently educate the individual about the devastating effects the disorder will have on their health and life, and the positive aspects of change.

- Do not be in denial of your child or friend’s eating disorder.
- Be aware of the signs and symptoms.

- Avoid rationalizing their eating disordered behaviors.
- Openly share your thoughts and concerns with your child or loved one.

CONTEMPLATION STAGE

The Contemplation Stage occurs when an individual is willing to admit that they have a problem and are now open to receiving help. The fear of change may be very strong, and it is during this phase that a psychotherapist should assist the individual in discovering the function of their eating disorder so they can understand why it is in their life and how it no longer serves them. This, in turn, helps the individual move closer toward the next stage of change.

- If your child is under the age of 18, insist that they receive professional help from a qualified eating disorder specialist.
- Educate yourself about the disorder.
- Be a good listener.
- Do not try to "fix" the problem yourself.
- Seek your own encouragement from a local eating disorder support group for family and friends.

PREPARATION STAGE

The person transitions into the Preparation Stage when they are ready to change, but are uncertain about how to do it. Time is spent establishing specific coping skills such as appropriate boundary setting and assertiveness, effective ways of dealing with negative eating disorder thoughts and emotions, and ways to tend to their personal needs. Potential barriers to change are identified. This is usually when a plan of action is developed by the treatment team, (i.e. psychotherapist, nutritionist, and physician) as well as the individual and designated family members. This generally includes a list of people to call during times of crisis.

- If supporting a loved one in their recovery, identify what your role is in the recovery process.
- Explore your own thoughts and beliefs about food, weight, shape, and appearance.
- Ask your child/loved one and the treatment team how you can be best involved in the recovery process and what you can do to be supportive.

ACTION STAGE

The Action Stage begins when the person is ready to implement their strategy and confront the eating disorder behavior head on. At this point, they are open to trying new ideas and behaviors, and are willing to face fears in order for change to occur. Trusting the treatment team and their support network is essential to making the Action Stage successful.

- Follow the treatment team's recommendations.
- Remove triggers from your environment: no diet foods, no scales, and no stress.
- Be warm and caring, yet appropriate and determined with boundaries, rules, and guidelines.
- Reinforce positive changes without focusing on weight, shape, or appearance.

MAINTENANCE/RELAPSE

The Maintenance Stage evolves when the person has sustained the Action Stage for approximately six months or longer. During this period, they actively practice new behaviors and new ways of thinking as well as consistently use both healthy self-care and coping skills. Part of this stage also includes revisiting potential triggers in order to prevent relapse, establishing new areas of interests, and beginning to live their life in a meaningful way.

- Applaud your loved one's efforts and successes.
- Continue to adjust to new developments.
- Redefine the boundaries at home as necessary.
- Maintain positive communications.
- Be aware of possible recovery backsliding.

A POSSIBLE SIXTH STAGE

The Termination Stage & Relapse Prevention. Relapse is sometimes grouped with the maintenance stage since recovery in nonlinear and it is not uncommon to return to old behaviors during the overall recovery process.

So, how do you know when it is time to discontinue treatment? With the understanding that this decision is best made in consultation with your treatment team, ask yourself the following questions:

- Have I mastered the Stages of Change in the major areas of my eating disorder?
- Do I have the coping skills necessary to maintain these changes?
- Do I have a relapse prevention plan in place?
- Am I willing to resume treatment in the future if necessary?

To prevent relapsing do not forget to ask for help, communicate your thoughts and feelings, address and resolve problems as they arise, live a healthful and balanced life, and remember that you would not have made it this far if it were not for your strong determination and dedication toward recovery.

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E. Warning Signs and Symptoms

National Eating Disorders

Retrieved from: https://www.nationaleatingdisorders.org/warning-signs-and-symptoms

The chance for recovery increases the earlier an eating disorder is detected. Therefore, it is important to be aware of some of the warning signs of an eating disorder.

This isn't intended as a checklist. Someone struggling with an eating disorder generally won't have all of these signs and symptoms at once, and the warning signs vary across eating disorders and don't always fit into neat categories. Rather, these lists are intended as a general overview of the types of behaviors that may indicate a problem.

If you have any concerns about yourself or a loved one, please contact the NEDA Helpline and seek professional help.

COMMON SYMPTOMS OF AN EATING DISORDER

Emotional and behavioral

- In general, behaviors and attitudes that indicate that weight loss, dieting, and control of food are becoming primary concerns
- Preoccupation with weight, food, calories, carbohydrates, fat grams, and dieting
- Refusal to eat certain foods, progressing to restrictions against whole categories of food (e.g., no carbohydrates, etc.)
- Appears uncomfortable eating around others
- Food rituals (e.g. eats only a particular food or food group [e.g. condiments], excessive chewing, doesn't allow foods to touch)
- Skipping meals or taking small portions of food at regular meals
- Any new practices with food or fad diets, including cutting out entire food groups (no sugar, no carbs, no dairy, vegetarianism/veganism
- Withdrawal from usual friends and activities
- Frequent dieting
- Extreme concern with body size and shape
- Frequent checking in the mirror for perceived flaws in appearance
- Extreme mood swings

Physical

- Noticeable fluctuations in weight, both up and down
- Stomach cramps, other non-specific gastrointestinal complaints (constipation, acid reflux, etc.)
- Menstrual irregularities — missing periods or only having a period while on hormonal contraceptives (this is not considered a "true" period)
- Difficulties concentrating
- Abnormal laboratory findings (anemia, low thyroid and hormone levels, low potassium, low white and red blood cell counts)
- Dizziness, especially upon standing
- Fainting/syncope
- Feeling cold all the time
- Sleep problems
- Cuts and calluses across the top of finger joints (a result of inducing vomiting)

- Dental problems, such as enamel erosion, cavities, and tooth sensitivity
- Dry skin and hair, and brittle nails
- Swelling around area of salivary glands
- Fine hair on body (lanugo)
- Cavities, or discoloration of teeth, from vomiting
- Muscle weakness
- Yellow skin (in context of eating large amounts of carrots)
- Cold, mottled hands and feet or swelling of feet
- Poor wound healing
- Impaired immune functioning

ANOREXIA NERVOSA

- Dramatic weight loss
- Dresses in layers to hide weight loss or stay warm
- Preoccupation with weight, food, calories, fat grams, and dieting. Makes frequent comments about feeling “fat.’
- Resists or is unable to maintain a body weight appropriate for their age, height, and build
- Maintains an excessive, rigid exercise regime – despite weather, fatigue, illness, or injury

BULIMIA NERVOSA

- Evidence of binge eating, including disappearance of large amounts of food in short periods of time or lots of empty wrappers and containers indicating consumption of large amounts of food
- Evidence of purging behaviors, including frequent trips to the bathroom after meals, signs and/or smells of vomiting, presence of wrappers or packages of laxatives or diuretics
- Drinks excessive amounts of water or non-caloric beverages, and/or uses excessive amounts of mouthwash, mints, and gum
- Has calluses on the back of the hands and knuckles from self- induced vomiting
- Dental problems, such as enamel erosion, cavities, discoloration of teeth from vomiting, and tooth sensitivity

BINGE EATING DISORDER

- Secret recurring episodes of binge eating (eating in a discrete period of time an amount of food that is much larger than most individuals would eat under similar circumstances); feels lack of control over ability to stop eating
- Feelings of disgust, depression, or guilt after overeating, and/or feelings of low self-esteem
- Steals or hoards food in strange places
- Creates lifestyle schedules or rituals to make time for binge sessions
- Evidence of binge eating, including the disappearance of large amounts of food in a short time period or a lot of empty wrappers and containers indicating consumption of large amounts of food

OTHERWISE SPECIFIED FEEDING OR EATING DISORDER (OSFED)

Because OSFED encompasses a wide variety of eating disordered behaviors, any or all of the following symptoms may be present in people with OSFED.

- Frequent episodes of consuming very large amount of food followed by behaviors to prevent weight gain, such as self-induced vomiting
- Evidence of binge eating, including disappearance of large amounts of food in short periods of time or lots of empty wrappers and containers indicating consumption of large amounts of food
- Self-esteem overly related to body image
- Dieting behavior (reducing the amount or types of foods consumed)
- Expresses a need to “burn off” calories taken inEvidence of purging behaviors, including frequent trips to the bathroom after meals, signs and/or smells of vomiting, presence of wrappers or packages of laxatives or diuretics

AVOIDANT RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

- Dramatic weight loss
- Limited range of preferred foods that becomes narrower over time (i.e., picky eating that progressively worsens)
- Fears of choking or vomiting
- No body image disturbance or fear of weight gain

PICA

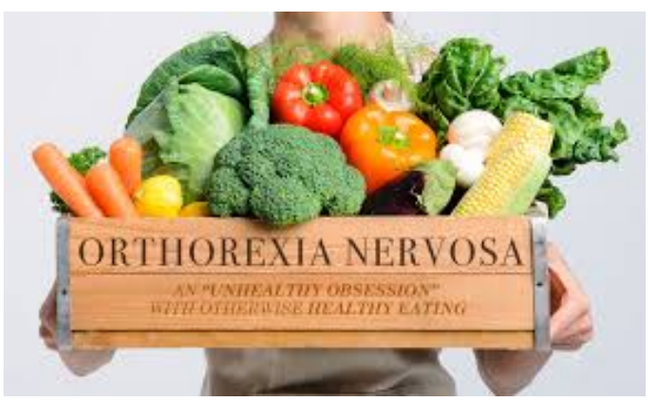
- The persistent eating, over a period of at least one month, of substances that are not food and do not provide nutritional value
- Typical substances ingested tend to vary with age and availability. They may include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal, ash, clay, starch, or ice

RUMINATION DISORDER

- Repeated regurgitation of food for a period of at least one month. Regurgitated food may be re-chewed, re-swallowed, or spit out
- If occurring in the presence of another mental disorder (e.g., intellectual developmental disorder), it is severe enough to warrant independent clinical attention

Other Food & Behavior Concerns

ORTHOREXIA



- Cutting out an increasing number of food groups (all sugar, all carbs, all dairy, all meat, all animal products)
- An increase in concern about the health of ingredients; an inability to eat anything but a narrow group of foods that are deemed ‘healthy’ or ‘pure’
- Spending hours per day thinking about what food might be served at upcoming events

- Body image concerns may or may not be present

COMPULSIVE EXERCISE

- Exercise that significantly interferes with important activities, occurs at inappropriate times or in inappropriate settings, or occurs when the individual exercises despite injury or other medical complications
- Intense anxiety, depression and/or distress if unable to exercise
- Exercise takes place despite injury or fatigue

DIABULIMIA

- Increasing neglect of diabetes management; infrequently fills prescriptions and/or avoids diabetes related appointments
- Secrecy about diabetes management; discomfort testing/injecting in front of others
- Fear that “insulin makes me fat”
- Restricting certain food or food groups to lower insulin dosages
- A1c of 9.0 or higher on a continuous basis

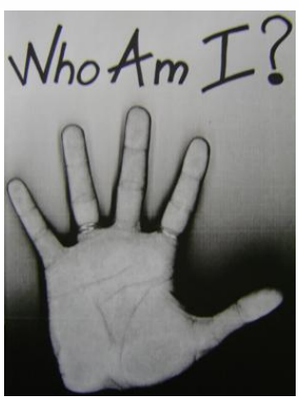
To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

Chapter 5: Identity & Eating Disorders

National Eating Disorders

Retrieved from: https://www.nationaleatingdisorders.org/identity-eating-disorders



Eating disorders have historically been associated with straight, young, white females, but in reality, they affect people from all demographics and are not caused by any single factor. They arise from a combination of long-standing behavioral, biological, emotional, psychological, interpersonal, and social factors.

Misconceptions about who eating disorders affect have real consequences, leading to fewer diagnoses, treatment options,

and pathways to help for those who don't fit the stereotype. Understanding that eating disorders don't discriminate is critical to making sure everyone has access to help and support. When it comes to identity and eating disorders, one's experience should be understood within the broader cultural context of oppression.

A. Athletes

Athletics are a great way to build self-esteem, promote physical conditioning, and demonstrate the value of teamwork, but not all athletic stressors are positive. The pressure to win and an emphasis on body weight and shape can create a toxic combination. Athletic competition can also be a factor contributing to severe psychological and physical stress. When the pressures of athletic competition are added to an existing cultural emphasis on thinness, the risks increase for athletes to develop disordered eating.

In a study of Division 1 NCAA athletes, over one-third of female athletes reported attitudes and symptoms placing them at risk for anorexia nervosa. Though most athletes with eating disorders are female, male athletes are also at risk—especially those competing in sports that tend to place an emphasis on the athlete's diet, appearance, size, and weight requirements, such as wrestling, bodybuilding, crew, and running.

RISK FACTORS FOR ATHLETES

- Sports that emphasize appearance, weight requirements, or muscularity (gymnastics, diving, bodybuilding, or wrestling).
- Sports that focus on the individual rather than the entire team (gymnastics, running, figure skating, dance or diving, versus teams sports such as basketball or soccer).
- Endurance sports such as track and field, running, swimming.
- Overvalued belief that lower body weight will improve performance.
- Training for a sport since childhood or being an elite athlete.

- Low self-esteem; family dysfunction (including parents who live through the success of their child in sport); families with eating disorders; chronic dieting; history of physical or sexual abuse; peer, family and cultural pressures to be thin, and other traumatic life experiences.
- Coaches who focus primarily on success and performance rather than on the athlete as a whole person.
- Three risk factors are thought to particularly contribute to a female athlete's vulnerability to developing an eating disorder: social influences emphasizing thinness, performance anxiety, and negative self-appraisal of athletic achievement. A fourth factor is identity solely based on participation in athletics.

PROTECTIVE FACTORS FOR ATHLETES

- Positive, person-oriented coaching style rather than negative, performance-oriented coaching style.
- Social influence and support from teammates with healthy attitudes towards size and shape.
- Coaches who emphasize factors that contribute to personal success such as motivation and enthusiasm rather than body weight or shape.
- Coaches and parents who educate, talk about, and support the changing female body

THE FEMALE ATHLETE TRIAD

The Female Athlete Triad includes disordered eating, amenorrhea, and osteoporosis. The lack of nutrition resulting from disordered eating can cause the loss of several or more consecutive periods. This in turn leads to calcium and bone loss, putting the athlete at greatly increased risk for stress fractures of the bones. Each of these conditions is a medical concern. Together they create serious health risks that may be life threatening. While any female athlete can develop the triad, adolescent girls are most at risk because of the active biological changes and growth spurts, peer and social

pressures, and rapidly changing life circumstances that go along with the teenage years.

Early intervention is critical in eating disorders recovery.

B. Disability Community

People with disabilities experience unique stressors that may contribute to the development and maintenance of an eating disorder. Though there is a lack of research examining relationships between disability and disordered eating, it is clear that eating disorders disproportionately impact some segments of the disability community.

Disabilities are conditions that significantly impact or limit one or more major life activity. Disabilities come in many forms and impact each person uniquely. They can be physical, emotional, or intellectual; while disabilities are often visually apparent, many people live with significant disabilities that are unnoticeable to others. The lack of research on disability and eating disorders is particularly unfortunate given the fact that it is estimated that 12.6% of Americans live with some form of disability. This staggering number makes it the world's largest minority group (Kraus 2017).

ABLEISM AND CULTURE

People living with disabilities contend with a cultural bias that views them as fundamentally different and inferior to the non-disabled majority. This prejudice, oppression, and exclusion of people with disabilities is known as ableism. Our culture of ableism tends to make the world feel quite inaccessible and unwelcoming to people with disabilities. Society, at large, frequently does not make the appropriate accommodations for different abilities and needs. As a result, people with disabilities face numerous barriers (both literal and metaphorical) every day. Although people with disabilities make up over 12% of the population, they are noticeably absent from popular culture (Kraus, 2017). Only about 2% of TV and film characters are depicted with disabilities, and those

characters are almost exclusively portrayed by able-bodied actors (Woodburn & Kopić, 2016).

The media continues to largely present and glorify a very homogeneous view of body size and shape, strongly skewing toward a tall and slender build. For most people, the bodily proportions over-represented in the media are dangerously unattainable (Bordo, 2003). People with disabilities often experience the same pressures to meet these body standards, are as likely as their able-bodied counterparts to develop eating disorders and disordered body image, but are in eating disorders treatment programs.

There is clearly a need for further research to expand our understanding of the connection between eating disorders and disabilities. While there is ample research examining each of these groups, there is very little examining the intersectionality between the two identities. Being a person living with a disability *and* an eating disorder is likely qualitatively different than being either a person with a disability or a person with an eating disorder. It is important to understand how those overlapping aspects of identity and life experience impact one another to be able to more effectively assess and treat members of these communities.

The extent to which physical disability impacts body image, a major aspect of eating disorders, is not clear. A 2009 study found that women with spinal cord injuries (SCI) may be more vulnerable to body dissatisfaction (related to both appearance and body function) than men with SCI (Bassett, Martin Ginis, Buchholz, & the SHAPE SCI Research Group, 2009). However, researchers found that among men and women with SCI, cognitive, affective, perceptual, and behavioral aspects of body image were all impacted by their injuries. Most participants also reported feeling disconnected from their bodies, not only due to lack of physical sensation, but also feeling emotionally disconnected (Bailey, Gammage, van Ingen, & Ditor, 2016). There is also evidence that patients with eating disorders who have mobility-related disabilities may be especially sensitive to body size if relying on the care of others to help them move their bodies (Cicmil & Eli, 2014). Feelings of being different from everyone around them and perpetually feeling “in the way“ has also been noted to negatively impact body image and disordered eating behavior among eating disorder patients with mobility-related disabilities (Cicmil & Eli, 2014). And people with self-reported “severe” disabilities were shown to experience greater body dissatisfaction than people with self-reported “mild” or “moderate” disabilities, regardless of how long they had been living with the disability (Taleporos & McCabe, 2007). These findings point to a need for greater understanding about how specific disabilities may uniquely impact the way people feel about their

bodies. Notably lacking is research on the intersection of congenital disabilities and eating disorders.

Another group of researchers found that eating disorders patients who had visual impairments reported profound body image disturbance, primarily perceiving their bodies through tactile sensations (body checking), comments from others, and kinesthetic awareness. Some individuals with disabilities may turn to eating disorders as a means to try to compensate for their disability or as a way to feel a sense of achievement (Cicmil & Eli,2014).

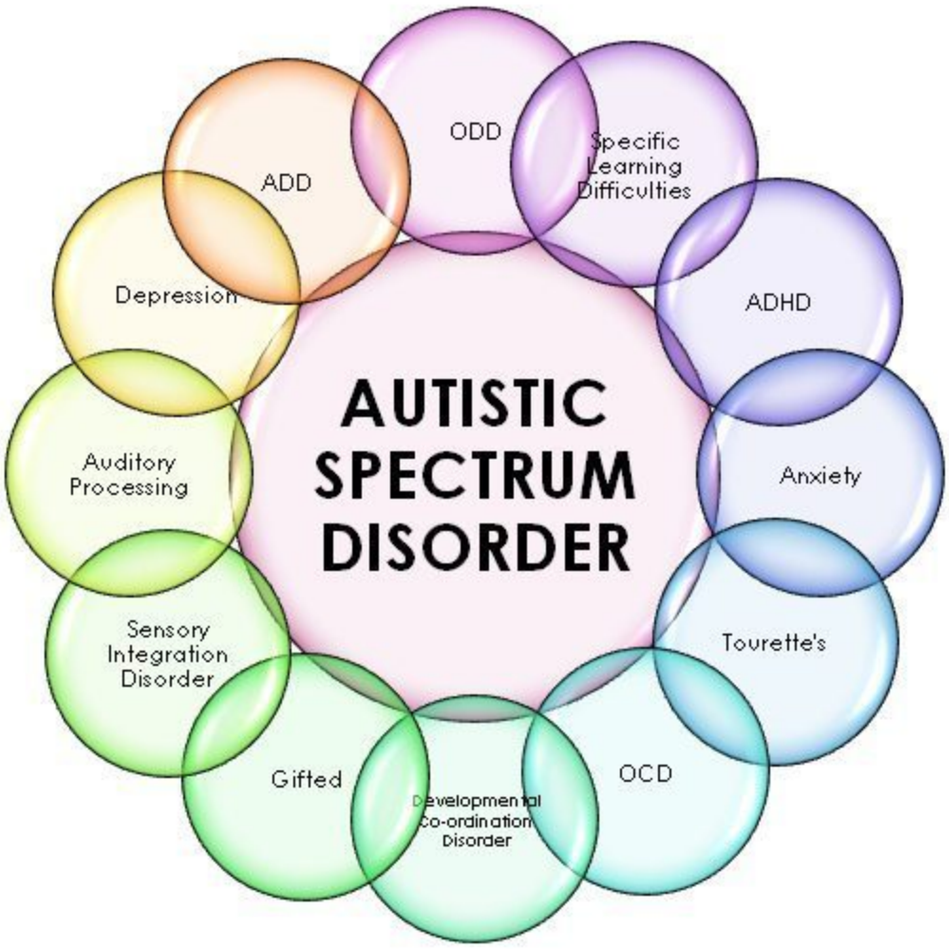
INTELLECTUAL DISABILITY

Intellectual disabilities (ID) are conditions that affect cognitive and adaptive ability. Persons with ID are quite heterogeneous in terms of the specific deficits they experience in social abilities, communication, thinking and reasoning, learning, and problem solving. It is estimated that 1 to 3% of the population lives with a diagnosed ID across their lifespan, but the exact prevalence is difficult to estimate because researchers of ID do not always use the same criteria in determining which individuals to include in their data. To be formally diagnosed, ID must be apparent before the age of 18*. Males are more likely to live with ID than females. The extent of support necessary for adaptive functioning determines the severity level for ID. ID falls under the umbrella of developmental disabilities (DD). Developmental disabilities are early-onset, lifelong conditions resulting in significant functional limitations, but not always intellectual deficits (www.asha.org).

About one-third of folks with ID, and up to 80% of adults with severe or profound ID, have eating or feeding issues such as problems chewing, sucking or swallowing, selectivity of texture or temperature and extreme food pickiness, behavioral disruption during meal times, and rumination or gastroesophageal reflux (Didden, Seys, & Schouwink, 1999; Gal, Hardal-Nasser & Engel-Yeger, 2011; Gravestock, 2000). Those with profound ID may be more likely to experience difficulty with feeding and eating skills and increased risk for aspiration compared to peers with mild or moderate ID (Gal, Hardal-Nasser & Engel-Yeger, 2011). These types of issues can have a severe impact on the health and well-being of individuals with ID, such as aspiration, poor growth, nutritional issues and deficiencies, and/or need for feeding tubes, all of which have major impacts on quality of life and could potentially lead to life-threatening issues. Pica is another type of eating disorder that is more common among folks with ID. Pica is a condition where non-nutritive items are regularly eaten, such as paper, rocks, dirt, etc.

Pica can be very dangerous and can lead to malnutrition, intestinal blockage or injury, and even death (American Psychiatric Association, 2013).

AUTISM SPECTRUM DISORDERS



Some estimates hold that as much as 20% of people with eating disorders have autism (Wentz et al., 2005). Research suggests that adolescent girls with anorexia may be more likely to exhibit elevated autistic traits such as difficulty with empathy, tendency to focus on oneself, and strong systemizing traits characterized by inflexibility and the drive to analyze and develop systems driven by rules. Girls who have autism spectrum disorder (ASD) diagnoses may have a unique vulnerability to developing anorexia because they may be directing the systemization toward managing food or obsessing over body weight (Baron-Cohen et al., 2013). Researchers have shown that people with ASD seem to be at a greater risk for developing binge eating disorder (BED), pica, and avoidant/restrictive food intake disorder (ARFID), all three of which are much more common among this population.

BARRIERS TO SUPPORT AND TREATMENT

- Difficulty finding appropriate help due to limited specialists dealing with feeding and eating disorders who also have expertise with physical disabilities, ID, AST, and/or other disabilities.
- Treatment for an eating disorder can be quite costly, as is living life with a disability. People with disabilities frequently spend more than those not living with disabilities. People with disabilities are overrepresented in the lowest economic brackets, living on a limited income or government-funded disability payment. Given all these circumstances, finding affordable care to treat an eating disorder can be extremely difficult, as recovering from an eating disorder often takes years of ongoing treatment.
- Simply getting from place to place can be a challenge for someone with a disability, making it especially challenging to access care in the traditional way.
- Medical professionals may overlook signs and symptoms of disordered eating, as they are often overshadowed by, or masked by, other symptoms of the disability. For instance, it is common for individuals who have sustained an SCI to experience significant muscle atrophy which can lead to noticeable weight loss and change in physique. There also can be appetite disturbances resulting from the SCI. Medical professionals (and individuals who see them) could greatly benefit from additional competency training for eating disorders screening among ALL of their patients, including those with disabilities.
- People with physical disabilities are regularly urged to diet and lose weight by medical professionals, often in derogatory or shaming ways, with the intention of increasing mobility.
- Depending on the type and severity of the eating disorder, many treatment programs require patients to attend for several hours a day, which could cause access issues for someone with a disability. For example, the treatment program schedule may interfere with essential activities of daily living (ADLs) that persons with disabilities must routinely attend to on a rigid schedule, such as bowel and bladder care.

CONSIDERATIONS IN SEEKING SUPPORT AND TREATMENT

- Individuals who need caregivers to help them type or write may prefer to fill out intake paperwork with the help of a therapist instead of their caregiver to maintain privacy. Many therapists have their paperwork digitized so they may be accessed online, which may make it easier for some to independently complete.

- There are more and more eating disorder treatment programs, therapists, and registered dietitians (RDs) offering telehealth options, allowing clients to log-on and participate in group and individual therapy via HIPAA compliant videoconferencing.
- There are also free online support groups that can be accessed from the comfort of your home.
- It is important to find eating disorder treatment professionals who understand the importance of flexibility with your schedule, to allow for your other self-care needs. which can be time-consuming and often require adherence to a rigid schedule. Take time to discuss your needs, some of which may be time-consuming and required on a specific schedule, with potential treatment providers before committing to one. Treatment will only be successful if you are able to consistently participate and feel comfortable with your providers!

Special thanks to Dr. Danielle Sheypuk and Dr. Patty Schroeder.

C. Eating Disorders in the Jewish Community

Eating disorders, as with any mental illness, show no boundaries between demographics, with several studies indicating a rise in the problem for Jewish women. The Jewish community is not immune to the various diet and health misconceptions, pressure to be thin, and biological and environmental factors that contribute to the rising numbers of eating disorders, anorexia nervosa, bulimia nervosa and binge eating disorder. Eating disorders affect the entire Jewish community, from the irreligious to the ultra-orthodox.

There is no single reason for the growing number of cases. No matter how we try to shelter or protect our children, their ideas about being thin and desire for perfection seep into their lives. Eating disorders in the Jewish community arise and manifest themselves very similarly to eating disorders in the secular world, and can be potentially life threatening. What differs however is the effect that culture has on the eating disorder as well as in the treatment and recovery process.

According to a recent article in the Washington Post, health experts say eating disorders are “underreported among Orthodox Jewish women and to a lesser extent others in the Jewish community, as many families are reluctant to acknowledge the illness at all and often seek help only when a girl is on the verge of hospitalization.” Reluctance to acknowledge an eating disorder is impacted by stigma of mental illness in Orthodox Jewish communities, as well as the importance of being thin for marriage arrangements among the ultra-Orthodox. As with the community at large, Jewish girls may turn to an eating disorder in an attempt to achieve what they believe is perfection and control. In Jewish Orthodox communities, an eating disorder may be used as a coping mechanism because it is perceived as more “socially acceptable” than other behaviors such as drug abuse.

Furthermore, just as with the general population, there are also individuals who unfortunately have suffered from various traumas and abuse and will turn to eating disorder behaviors as a way of expressing themselves. In the Orthodox community, while the dating processes are different than in the secular world, girls have reported hearing their mothers or other community members discussing how being thin is important for dating. With society’s notion that “thin is beautiful” surrounding us from allsides, it’s no wonder young girls when starting to date tend to focus on being thin rather than finding their soul mate. In one study of ultra-Orthodox and Syrian Jewish communities in Brooklyn, 1 out of 19 girls was diagnosed with an eating disorder, which is a rate about 50 percent higher than the general U.S. population.

Food is a central part of the Jewish culture and is prepared in abundance for Shabbat and Holiday meals. Preoccupations with food can exacerbate eating disorder issues for those who struggle. Eating disorder thoughts and pressures tend to be stronger during holiday times. The individual might “save” her calories during the week in order to indulge at the Shabbat or holiday meal, however, this usually leads to either bingeing or further restricting, due to the intense fear of overeating. Those who struggle may begin to omit traditional Shabbat foods, or participate but purge later. The inability to participate in formal exercise on Shabbat or holidays may lead the individual to take

extensive Shabbat/holiday walks or rush out to the gym as soon as Shabbat or the holiday is over.

With Shabbat, holidays, kashrut and other nuances of Orthodox Jewish life, the patient can often feel misunderstood or weary of clinicians from other backgrounds. Coupled with the stigma surrounding mental illness, these families are often unsure of where to turn and hesitant to take action. Therefore, the needs of a Jewish patient often times require specific knowledge on the part of the treatment team. The Orthodox Jewish community is slowly taking action and addressing these issues. The community has become aware that eating disorders are very serious and can be life threatening. The most effective treatment will be from individuals w ho are culturally sensitive and those that can collaborate with the appropriate treatment team.

D. Eating Disorders in LGBTQ+ Populations

LGBTQ+ identified folks experience unique stressors that may contribute to the development of an eating disorder. While there is still much research to be done on the relationships between sexuality, gender identity, body image, and eating disorders, we know that eating disorders disproportionately impact some segments of the LGBTQ+ community.

RISK FACTORS

LGBTQ+ people face unique challenges that may put them at greater risk of developing an eating disorder. Research shows that, beginning as early as 12, gay, lesbian, and bisexual teens may be at higher risk of binge-eating and purging than heterosexual peers.

Potential factors that may play a role in the development of an eating disorder may include:

- Fear of rejection or experience of rejections by friends, family, and co-workers
- Internalized negative messages/beliefs about oneself due to sexual orientation, non-normative gender expressions, or transgender identity

- Experiences of violence and post-traumatic stress disorder (PTSD), which research shows sharply increases vulnerability to an eating disorder
- Discrimination due to one's sexual orientation and/or gender identity
- Being a victim of bullying due to one's sexual orientation and/or gender identity
- Discordance between one's biological sex and gender identity
- Inability to meet body image ideals within some LGBTQ+ cultural contexts

LGBTQ+ youth also experience increased risks of homelessness or unsafe home environments:

- Up to 42% of homeless youth are LGBTQ+-identified
- 33% of youth who are homeless or in the care of social services experienced violent assault when they came out

BARRIERS TO SUPPORT AND TREATMENT

LGBTQ+ people, in addition to experiencing unique contributing factors, may also face challenges for accessing treatment and support. Common barriers may include a lack of culturally-competent treatment, which addresses the complexity of unique sexuality and gender identity issues, lack of support from family and friends, and insufficient eating disorders education among LGBTQ+ resource providers who are in a position to detect and intervene.

The emergence of LGBTQ+ youth drop-in centers, gay-straight alliances, LGBTQ+ community centers, and LGBTQ+ healthcare resources have created more safe spaces to access support and mental health care. However, many LGBTQ+ people still remain isolated in communities that do not offer such services/programs.

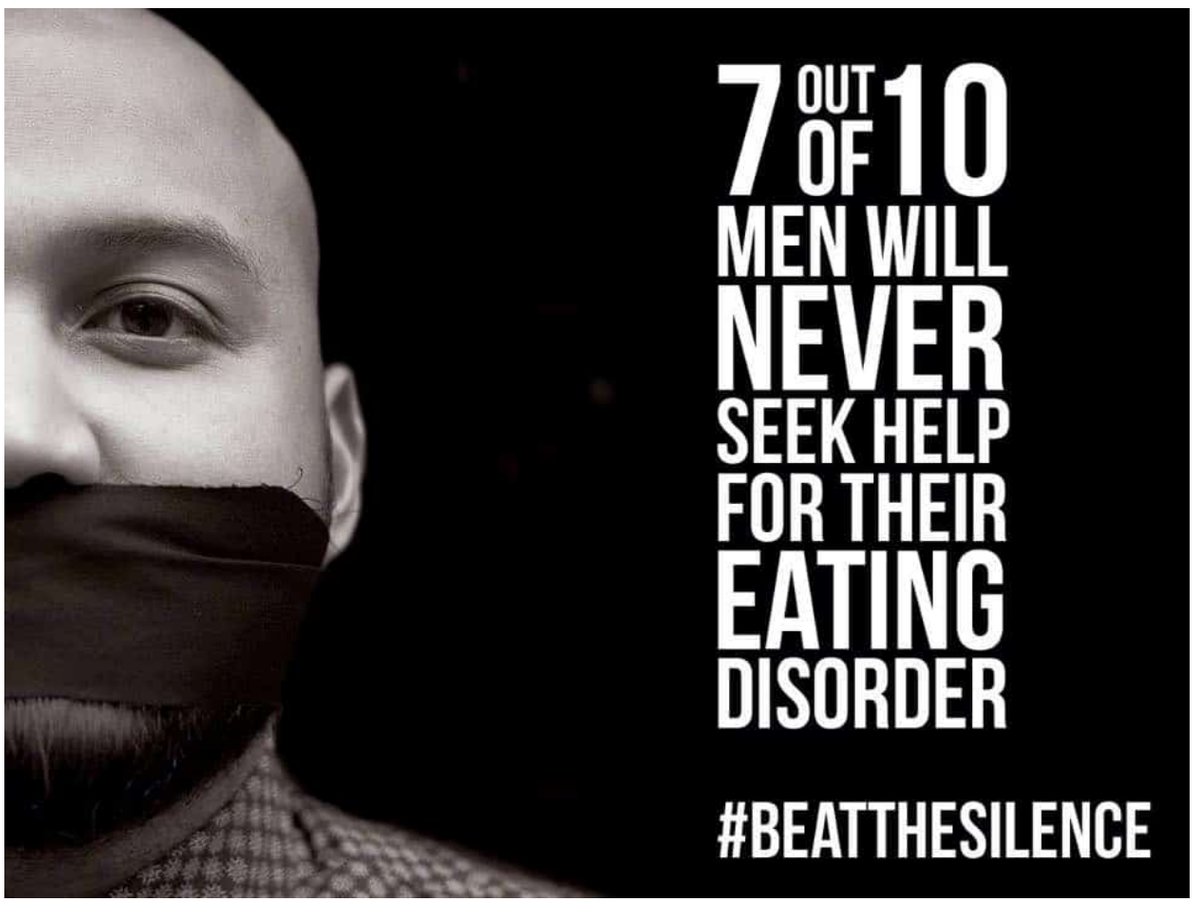
RESEARCH ON LGBTQ+ PEOPLE AND EATING DISORDERS

Research remains limited on eating disorders among LGBTQ+ populations. Existing research shows that:

- In one study, gay and bisexual boys reported being significantly more likely to have fasted, vomited, or taken laxatives or diet pills to control their weight in the last 30 days.
- Gay males are thought to only represent 5% of the total male population but among males who have eating disorders, 42% identify as gay.
- Gay males were seven times more likely to report binging and 12 times more likely to report purging than heterosexual males.

- Compared with heterosexual men, gay and bisexual men had a significantly higher prevalence of lifetime full syndrome bulimia, subclinical bulimia, and any subclinical eating disorder.
- Females identified as lesbian, bisexual, or mostly heterosexual were about twice as likely to report binge-eating at least once per month in the last year.
- Elevated rates of binge-eating and purging by vomiting or laxative abuse was found for people who identified as gay, lesbian, bisexual, or “mostly heterosexual” in comparison to their heterosexual peers.
- Black and Latinx LGBs have at least as high a prevalence of eating disorders as white LGBs.
- A sense of connectedness to the gay community was related to fewer current eating disorders, which suggests that feeling connected to the gay community may have a protective effect against eating disorders.

E. Eating Disorders in Men & Boys



Despite the stereotype that eating disorders only occur in women, about one in three people struggling with an eating disorder is male, and subclinical eating disordered behaviors (including binge eating, purging, laxative abuse, and fasting for weight loss) are nearly as common among men as they are among women.

In the United States alone, eating disorders will affect 10 million males at some point in their lives. But due in large part to cultural bias, they are much less likely to seek treatment for their eating disorder. The good news is that once a man finds help, they show similar responses to treatment as women. Several factors lead to men and boys being under- and undiagnosed for an eating disorder. Men can face a double stigma, for having a disorder characterized as feminine or gay and for seeking psychological help. Additionally, assessment tests with language geared to women and girls have led to misconceptions about the nature of disordered eating in men.

TREATMENT CONSIDERATIONS

Treatment is not one-size-fits-all. For any person, biological and cultural factors should be taken into consideration in order to provide an effective treatment environment.

Studies suggest that risk of mortality for males with eating disorders is higher than it is for females - early intervention is critical.

A gender-sensitive approach with recognition of different needs and dynamics for males is critical in effective treatment. Men and boys in treatment can feel out of place when predominantly surrounded by women, and an all-male treatment environment is recommended—when possible.

Men and boys with anorexia nervosa usually exhibit low levels of testosterone and vitamin D, and they have a high risk of osteopenia and osteoporosis. Testosterone supplementation is often recommended.

MEN AND BODY IMAGE

There are numerous studies on male body image, and results vary widely. Many men have misconceived notions about their weight and physique, particularly the importance of muscularity. Findings include:

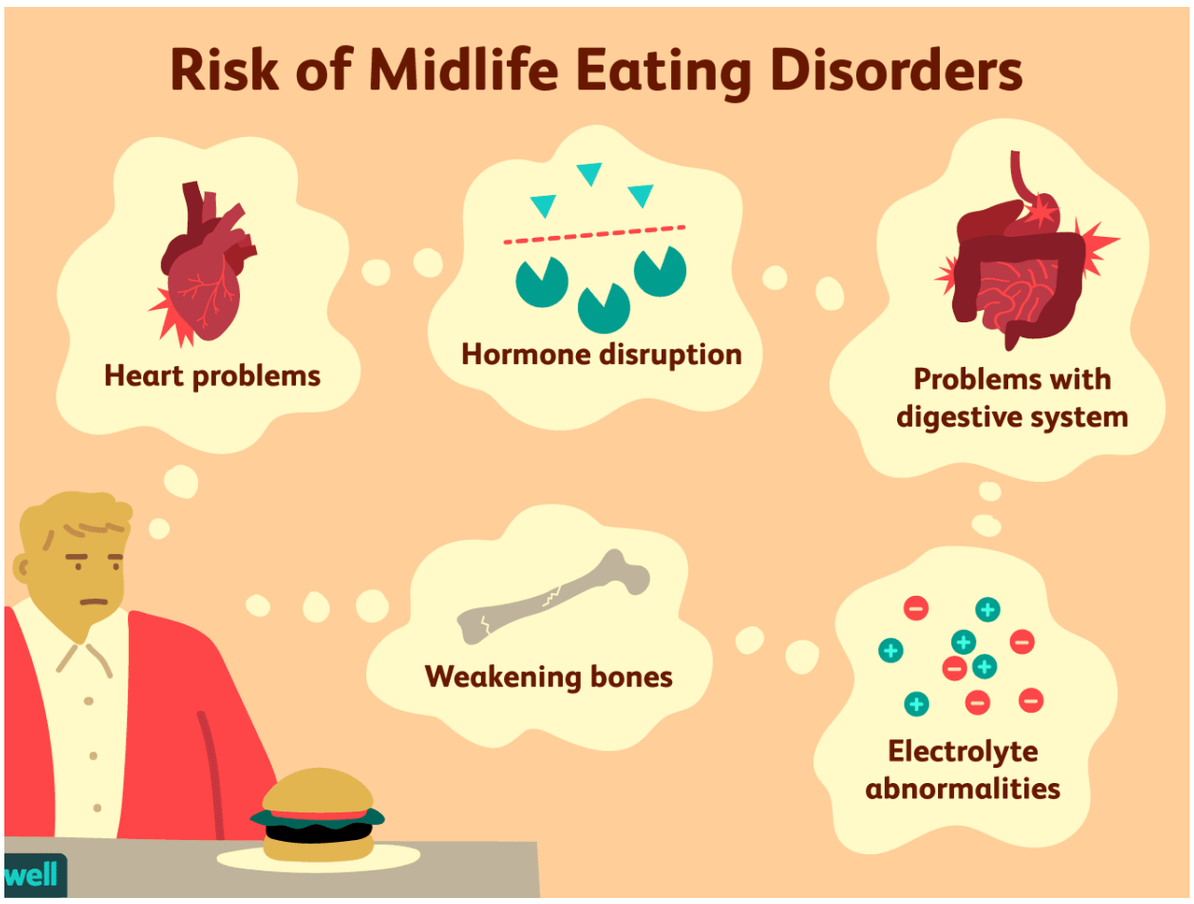
Most males would like to be lean and muscular, which typically represents the “ideal” male body type. Exposure to unattainable images in the media leads to male body dissatisfaction.

The sexual objectification of men and internalization of media images predicts drive for muscularity.

The desire for increased musculature is not uncommon, and it crosses age groups. 25% of normal weight males perceive themselves to be underweight and 90% of teenage boys exercised with the goal of bulking up.

Muscle dysmorphia, a subtype of body dysmorphic disorder, is an emerging condition that primarily affects male bodybuilders. Such individuals obsess about being adequately muscular. Compulsions include spending many hours in the gym, squandering excessive amounts of money on supplements, abnormal eating patterns, or use of steroids.

F. Eating Disorders in Midlife & Beyond



There is no age limit to disordered eating. Despite the damaging stereotype that eating disorders are a “teenager’s problem,” research shows that rates of eating disorders and body dissatisfaction occurring later in life are on the rise. Although the exact symptoms of eating disorders do not differ much from eating disorders at a younger life stage, the context can be drastically different.

Some older adults who suffer from an eating disorder have struggled since youth and have never recovered; others have recovered then relapsed. Some have had food and weight issues for years but were never incapacitated by them until now. While others,

faced with the challenges of adulthood and loss of status in a youth-obsessed world, develop rituals related to diet, exercise and appearance for the first time in their lives, which can lead down the slippery slope of an eating disorder.

HOW ARE EATING DISORDERS IN MID-LIFE AND BEYOND DIFFERENT?

Triggers to eating disorders and body image despair in older adults tend to differ and are often correlated with life-stage-specific events. Triggers in mid-life and beyond can include:

- Pregnancy
- Divorce
- Menopause
- Natural signs of aging
- Death of a loved one
- Retirement
- Empty nest
- Marriage of a child
- Becoming a grandparent
- Aging parents

Despite the fact that eating disorders are largely experienced the same way regardless of age, there are some differences people at mid-life and beyond. For example:

- Shame and embarrassment for having a “teenager’s problem”

- Greater awareness of what they have lost due to their eating or body image issues
- More obstacles to treatment due to other responsibilities
- Increased anxiety about appearance/ health due to natural aging process
- Multiple stressors and losses that accompany adult development

AGE-RELATED COMPLICATIONS

Older bodies often have less ease in bouncing back from an eating disorder, and gastrointestinal, cardiac, bone and even dental effects of eating disorders can worsen as people mature. This means clinicians should keep eating disorders on their radar regardless of the age of the patient.

G. People of Color and Eating Disorders

Eating disorders have historically been associated with heterosexual, young, white females, but in reality, they affect people from all demographics of all ethnicities at similar rates. People of color – especially African Americans – are significantly less likely to receive help for their eating issues.

- Black teenagers are 50% more likely than white teenagers to exhibit bulimic behavior, such as binging and purging (Goeree, Sovinsky, & Iorio, 2011).
- In a study of adolescents, researchers found that Hispanics were significantly more likely to suffer from bulimia nervosa than their non-Hispanic peers. The

researchers also reported a trend towards a higher prevalence of binge eating disorder in all minority groups. (Swanson, 2011).

- Asian, Black, Hispanic and Caucasian youth all reported attempting to lose weight at similar rates, while among of Native American adolescents, 48.1% were attempting weight loss (Kilpatrick, Ohannessian, & Bartholomew, 1999).
- People of color with self-acknowledged eating and weight concerns were significantly less likely than white participants to have been asked by a doctor about eating disorder symptoms, despite similar rates of eating disorder symptoms across ethnic groups. (Becker, 2003).

WOMEN OF COLOR AND EATING DISORDERS

Women of color in the United States face substantially more stress resulting from their membership in multiple subordinate groups than that caused by acculturation alone. Eating disorders in women of color may be, in part, a response to environmental stress (i.e. abuse, racism, poverty). Therefore, given the multiple traumas that women of color are exposed to, they may be more vulnerable to eating disorders.

When presented with identical case studies demonstrating disordered eating symptoms in white, Hispanic and Black women, clinicians were asked to identify if the woman's eating behavior was problematic. 44% identified the white woman's behavior as problematic; 41% identified the Hispanic woman's behavior as problematic, and only 17% identified the Black woman's behavior as problematic. The clinicians were also less likely to recommend that the Black woman should receive professional help (Gordon, Brattole, Wingate, & Joiner, 2006).

H. Size Diversity & Health at Every Size

Eating disorders can affect all kinds of bodies and you cannot tell by looking at someone if they have an eating disorder.

UNDERSTANDING SIZE DIVERSITY

Each person's genetic inheritance influences their bone structure, body size, shape, and

weight differently. We should appreciate those differences, encourage healthy behaviors, and treat every body with respect.

Your “ideal” body weight is the weight that allows you to feel strong and energetic and lets you lead a healthy, normal life.

Your body can be healthy across a wide range of weights. When searching for your ideal weight, charts, formulas, and tables may be misleading and should only be used under the guidance of a qualified expert.

Avoid comparing your body with your friends’ bodies or the people you see in advertisements or on your favorite TV shows. If you do compare yourself to others, try to remember that we are all naturally different, which means we all have special qualities.

HEALTH AT EVERY SIZE

The basic premise of health at every size, as written in Linda Bacon’s Book, Health at Every Size: The surprising truth about your weight, is that “Health at Every Size” (HAES) acknowledges that well-being and healthy habits are more important than any number on the scale.

Below are principles you can adopt in your everyday life:

1. Accept your size. Love and appreciate the body you have. Self-acceptance empowers you to move on and make positive changes.
2. Trust yourself. We all have internal systems designed to keep us healthy — and at a healthy weight. Support your body in naturally finding its appropriate weight by honoring its signals of hunger, fullness, and appetite.
3. Adopt healthy lifestyle habits. Develop and nurture connections with others and look for purpose and meaning in your life. Fulfilling your social, emotional, and spiritual needs restores food to its rightful place as a source of nourishment and pleasure.
4. Find the joy in moving your body and becoming more physically vital in your everyday life.
5. Eat when you’re hungry, stop when you’re full, and seek out pleasurable and satisfying foods.
6. Tailor your tastes so that you enjoy more nutritious foods, staying mindful that there is plenty of room for less nutritious choices in the context of an overall healthy diet and lifestyle.

7. Embrace size diversity. Humans come in a variety of sizes and shapes. Open to the beauty found across the spectrum and support others in recognizing their unique attractiveness.

There is no quick fix and no miraculous intervention. One specific "how-to" provided in Dr. Bacon's book is the following contract:

Today, I will try to feed myself when I am hungry.

Today, I will try to be attentive to how foods taste and make me feel.

Today, I will try to choose foods that I like and that make me feel good.

Today, I will try to honor my body's signals of fullness.

Today, I will try to find an enjoyable way to move my body.

Today, I will try to look kindly at my body and to treat it with love and respect.

Within the framework outlined, this approach does not focus on weight loss as the sole indicator of health or encourage self-destructive abandon in one's eating. -Dr. Deah Schwartz

EVERY BODY IS DIFFERENT

It is important to remember that every body is different. We all have different genetic and cultural traits. Even if everyone started eating the same things and did the same amount of exercise for a whole year, we would not all look the same at the end of the year. This is because each person's genetic inheritance influences their bone structure, body size, shape, and weight differently.

WHAT IS WEIGHT STIGMA?

Weight stigma, also known as weight bias or weight-based discrimination, is discrimination or stereotyping based on a person's weight. Weight stigma can increase body dissatisfaction, a leading risk factor in the development of eating disorders. The best-known environmental contributor to the development of eating disorders is the sociocultural idealization of thinness.

It is never acceptable to discriminate against someone based on their size, but shaming, blaming, and “concern trolling” happen everywhere – at work, school, in the home, and even at the doctor’s office. In fact, weight discrimination occurs more frequently than gender or age discrimination.

Despite its unfortunate prevalence, weight stigma is dangerous and can increase the risk for adverse psychological and behavioral issues, including depression, poor body image and binge eating.

Chapter 6: Risk Factors

Eating disorders are complex and affect all kinds of people. Risk factors for all eating disorders involve a range of biological, psychological, and sociocultural issues. These factors may interact differently in different people, so two people with the same eating disorder can have very diverse perspectives, experiences, and symptoms. Still, researchers have found broad similarities in understanding some of the major risks for developing eating disorders. The factors listed below may be applicable to those with anorexia nervosa, bulimia nervosa, binge eating disorder, or OSFED. Information on ARFID and pica risk factors are listed separately.

A. Risk Factors

BIOLOGICAL

- **Having a close relative with an eating disorder**. Studies of families have found that having a first-degree relative (like a parent or sibling) with an eating disorder increases a person’s risk of developing an eating disorder.
- **Having a close relative with a mental health condition**. Similarly, issues like anxiety, depression, and addiction can also run in families, and have also been found to increase the chances that a person will develop an eating disorder.
- **History of dieting**. A history of dieting and other weight-control methods is associated with the development of binge eating.
- **Negative energy balance**. Burning off more calories than you take in leads to a state of negative energy balance. Many people report that their disorder began

with deliberate efforts to diet or restrict the amount and/or type of food they were eating in the form of dieting, other causes can include growth spurts, illness, and intense athletic training.

- **Type 1 (insulin-dependent) diabetes**. Recent research has found that approximately one-quarter of women diagnosed with type one diabetes will develop an eating disorder. The most common pattern is skipping insulin injections, known as diabulimia, which can be deadly.

PSYCHOLOGICAL

- **Perfectionism**. One of the strongest risk factors for an eating disorder is perfectionism, especially a type of perfectionism called self-oriented perfectionism, which involves setting unrealistically high expectations for yourself.
- **Body image dissatisfaction**. Body image encompasses how you feel both about and in your body. It's sadly not uncommon to dislike your appearance, but people who develop eating disorders are more likely to report higher levels of body image dissatisfaction and an internalization of the appearance ideal.
- **Personal history of an anxiety disorder**. Research has shown that a significant subset of people with eating disorders, including two-thirds of those with anorexia, showed signs of an anxiety disorder (including generalized anxiety, social phobia, and obsessive-compulsive disorder) before the onset of their eating disorder.
- **Behavioral inflexibility**. Many people with anorexia report that, as children, they always followed the rules and felt there was one "right way" to do things.

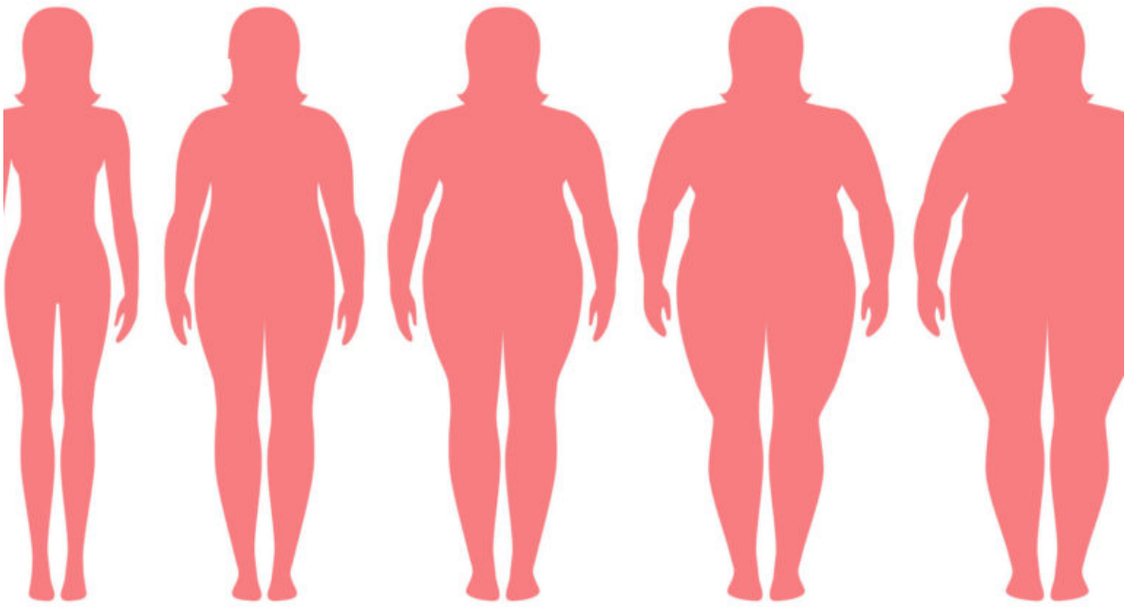
SOCIAL

- **Weight stigma**. The message that thinner is better is everywhere, and researchers have shown that exposure to this can increase body dissatisfaction, which can lead to eating disorders. Weight stigma is discrimination or stereotyping based on a person's weight, and is damaging and pervasive in our

society.

- **Teasing or bullying**. Being teased or bullied – especially about weight - is emerging as a risk factor in many eating disorders. The harmful effects of bullying have received increased attention in recent years, starting an important national conversation. 60% of those affected by eating disorders said that bullying contributed to the development of their eating disorder. Weight shaming needs to be a significant part of anti-bullying discussions, particularly in the context of the widespread anti-obesity messaging.
- **Appearance ideal internalization**. Buying into the message of the socially-defined “ideal body” may increase the risk of an eating disorder by increasing the likelihood of dieting and food restriction.
- **Acculturation**. People from racial and ethnic minority groups, especially those who are undergoing rapid Westernization, may be at increased risk for developing an eating disorder due to complex interactions between stress, acculturation, and body image. Within three years after western television was introduced to Fiji, women, previously comfortable with their bodies and eating, developed serious problems: 74% felt “too fat;” 69% dieted to lose weight; 11% used self-induced vomiting; 29% were at risk for clinical eating disorders.
- **Limited social networks**. Loneliness and isolation are some of the hallmarks of anorexia; many with the disorder report having fewer friends and social activities, and less social support. Whether this is an independent risk factor or linked to other potential causes (such as social anxiety) isn’t clear.
- **Historical trauma**, or intergenerational trauma, describes the ”massive cumulative group trauma across generations,” like with Jewish Holocaust survivors, Native American populations, and Indigenous groups that experienced European colonization. Research shows health consequences including “anxiety, intrusive trauma imagery, depression, elevated mortality rates from cardiovascular diseases as well as suicide and other forms of violent death, psychic numbing and poor affect tolerance, and unresolved grief” (Brave Heart, 1999). Similarities between the effects of eating disorders and historical trauma points to a need for more research and information that addresses these systems of oppression.

B. Body Image & Eating Disorders



Body image is defined as one's thoughts, perceptions, and attitudes about their physical appearance. How do you see yourself and feel about your body (e.g., height, shape, and weight) when you look in the mirror?

Positive body image is a clear, true perception of your shape; seeing the various parts of your body as they really are. Body positivity (or body satisfaction) involves feeling comfortable and confident in your body, accepting your natural body shape and size, and recognizing that physical appearance say very little about one's character and value as a person.

A negative body image, on the other hand, involves a distorted perception for one's shape. Negative body image (or body dissatisfaction) involves feelings of shame, anxiety, and self-consciousness. People who experience high levels of body dissatisfaction feel their bodies are flawed in comparison to others, and these folks are more likely to suffer from feelings of depression, isolation, low self-esteem, and eating disorders. While there is no single cause of eating disorders, research indicates that body dissatisfaction is the best-known contributor to the development of anorexia nervosa and bulimia nervosa (Stice, 2002).

Body image concerns often begin at a young age and endure throughout life. By age 6, girls especially start to express concerns about their own weight or shape, and 40-60% of elementary school girls (ages 6-12) are concerned about their weight or about

becoming too fat. (Smolak, 2011). Furthermore, over one-half of teenage girls and nearly one-third of teenage boys use unhealthy weight control behaviors such as skipping meals, fasting, smoking cigarettes, vomiting, and taking laxatives (Neumark-Sztainer, 2005). It is important to note that the age of onset differs depending on the individual, and these body image concerns may start younger, or never come up at all.

As with eating disorders, body image concerns can affect us all. While all ages, genders, and cultures are equally at risk for body image issues, there are traditionally different triggers and appearance-related pressures depending on one's gender. In our Western culture, girls often feel pressure to succumb to the societal appearance-ideal (sometimes referred to as the thin-, beauty-, or cultural-ideal), whereas boys are often faced with social pressures to be lean and muscular.

The body positive movement is making great strides to promote size diversity, body acceptance, and a healthier body image for all ages, genders, races, abilities, etc. It is important that we continue to embrace body diversity by recognizing all bodies as good bodies. While we all may have our days when we feel awkward or uncomfortable in our bodies, the key to developing positive body image is to recognize and respect our natural shape and learn to overpower those negative thoughts and feelings with positive, affirming, and accepting ones.

Accept yourself. Accept your body.

10 Steps to Positive Body Image

One list cannot automatically tell you how to turn negative body thoughts into positive body image, but it can introduce you to healthier ways of looking at yourself and your body. The more you practice these new thought patterns, the better you will feel about who you are and the body you naturally have.

1. **Appreciate all that your body can do.** Every day your body carries you closer to your dreams. Celebrate all of the amazing things your body does for you—running, dancing, breathing, laughing, dreaming, etc.
2. **Keep a top-ten list of things you like about yourself—**things that aren't related to how much you weigh or what you look like. Read your list often. Add to it as you become aware of more things to like about yourself.
3. **Remind yourself that "true beauty" is not simply skin-deep.** When you feel good about yourself and who you are, you carry yourself with a sense of confidence, self-acceptance, and openness that makes you beautiful. Beauty is a state of mind, not a state of your body.

4. **Look at yourself as a whole person.** When you see yourself in a mirror or in your mind, choose not to focus on specific body parts. See yourself as you want others to see you — as a whole person.
5. **Surround yourself with positive people.** It is easier to feel good about yourself and your body when you are around others who are supportive and who recognize the importance of liking yourself just as you naturally are.
6. **Shut down those voices in your head that tell you your body is not "right" or that you are a "bad" person.** You can overpower those negative thoughts with positive ones. The next time you start to tear yourself down, build yourself back up with a few quick affirmations that work for you.
7. Wear clothes that are comfortable and that make you feel good about your body. Work with your body, not against it.
8. **Become a critical viewer of social and media messages.** Pay attention to images, slogans, or attitudes that make you feel bad about yourself or your body. Protest these messages: write a letter to the advertiser or talk back to the image or message.

9. **Do something nice for yourself —** something that lets your body know you appreciate it. Take a bubble bath, make time for a nap, or find a peaceful place outside to relax.
10. **Use the time and energy that you might have spent worrying about food, calories, and your weight to do something to help others.** Sometimes reaching out to other people can help you feel better about yourself and can make a positive change in our world.

Developing & Modeling Positive Body Image

Dieting, drive for thinness, and body dissatisfaction are unhealthy actions and ideals that are often communicated to us and internalized from a young age. Once internalized, we may inadvertently perpetuate the cycle by passing those same ideals onto others—including children, students, patients, and communities. This harmful cycle can be stopped before disordered thinking turns into disordered eating; encouraging a happy and healthy relationship with your body are vital tools in eating disorders prevention. Please note that these tips are intended to adjust mindsets in order to prevent the spread of unhealthy attitudes and beliefs; they are not intended as clinical guidance for anyone struggling with an eating disorder.

CHANGING YOUR THINKING

- Examine your own attitudes, beliefs, prejudices and behaviors about food, weight, body image, physical appearance, health, and exercise. Identify any unhealthy attitudes derived from dieting, drive for thinness, and body dissatisfaction. Try to change these attitudes in your everyday life—for example, if you edit photos of yourself before posting them on social media, consider why you do so, how you feel when you do it, and what message you're communicating to yourself and others. Honestly examining your thoughts and feelings is the first step to replacing unhealthy attitudes with healthy ones.
- Mindful eating and healthy physical activity are part of a well-rounded lifestyle. Assess your eating and exercise habits; strive for balance and moderation over extreme measures.
- Encourage balanced eating of a variety of foods in moderation. Don't treat food as a reward or punishment; such behaviors set food up as a potential weapon for control. Discourage the idea that a particular diet or body size will lead to happiness and fulfillment. Encourage eating in response to body hunger. Allow all foods in your home.
- Don't constantly criticize your own shape (e.g., "I'm so fat—I've got to lose weight."). This type of self-criticism implies that appearance is more important than character, and that there is always room to 'improve' one's appearance. Promote and celebrate body positivity.

MODELING HEALTHY ATTITUDES FOR YOUNG PEOPLE

- **Set a positive example of a healthy and balanced relationship with food.** Don't talk about or behave as if you are constantly dieting; encourage eating a broad variety of foods in response to body hunger. Don't equate food with positive or negative behavior. The dieting parent who says she was "good" today because she didn't "eat much" teaches that eating is bad, and that avoiding food is good. Similarly, "don't eat that—it will make you fat" teaches that being fat makes one unlikable. Learn about and discuss with your sons and daughters the dangers of trying to alter their body shape through dieting. Trust your children's appetites; never try to limit their caloric intake—unless requested to do so by a physician for a medical problem.
- **Help children accept and enjoy their bodies and encourage physical activity.** Love, accept, acknowledge, appreciate, and value your children—out loud—no matter what they weigh. Convey to children that weight and appearance are not the most critical aspects of their identity and self-worth. Do not communicate the message that you cannot dance, swim, wear shorts, or enjoy a summer picnic because you do not look a certain way or weigh a certain

amount. Notice often and in a complimentary way how varied people are—how they come in all colors, shapes, and sizes. Show appreciation for diversity and a respect for nature. Link respect for diversity in weight and shape with respect for diversity in race, gender, ethnicity, intelligence, etc. Educate your children about the existence, the experience, and the ugliness of prejudice and oppression—whether it is directed against people of color or people who are overweight.

- **Devote yourself to raising non-sex-stereotyped children by modeling and living gender equality.** Develop a historical perspective on the politics of the control of women's bodies. Work toward and speak out for human rights: to fair pay, to safety, to respect, and to control of their bodies. Demonstrate a respect for people as they age, in order to work against the cultural glorification of youth and a tightly controlled ideal body type. Take people seriously for what they say, feel, and do, and focus less on the way they look. Give children the same opportunities and encouragement (in assignment of chores, choosing a sport, etc.) and avoid restricting children to gender-specific activities. Remain close to and supportive of your children as they experiment and struggle with body image, grooming and cosmetic issues, flirtatiousness and sexuality, etc. Talk to your children about the way body shape and sexuality are manipulated by the media and struggles to conform or not to conform.
- **Build self-esteem.** The most important gift adults can give children is self-esteem. When adults show children that they value and love them unconditionally, children can withstand the perils of childhood and adolescence with fewer scars and traumas. Self-esteem is a universal vaccine that can immunize a youngster from eating problems, body image distortion, exercise abuse, and many other problems. Providing self-esteem is the responsibility of both parents.
- **Encourage children to talk openly and honestly and really listen to them.** Encourage open communication and teach children how to communicate. Recognize that sociocultural pressures surrounding drugs, sexuality, body image, and perfectionism require great character strength, self-assurance, and decision-making in young children. Let them know that their opinions and feelings are valued. Encouraging young people to assert themselves helps them say no to pressures to conform. Feeling loved and confident allows them to accept that they are unique individuals.
- **Encourage critical thinking.** The only sure antidote to the tendency to conform to the powerful seduction of the media and peer pressure is the ability to think critically. Become a critical consumer of the media—pay attention to and openly challenge media messages. Talk with your children about the pressures they

see, hear, and feel to diet and to “look good.” Parents have to encourage critical thinking early, and educators have to continue the mission. We need to teach kids how to think, not what to think, and to encourage them to disagree, challenge, brainstorm alternatives, etc.

- **Develop a value system based on internal values.** Help children understand the importance of equating personal worth with care and concern for others, wisdom, loyalty, fairness, self-care and self-respect, personal fulfillment, curiosity, self-awareness, the capacity for relationships, connectedness and intimacy, individuality, confidence, assertiveness, a sense of humor, ambition, motivation, etc. Model this value system; examine, explore, and, if necessary, modify any appearance expectations you have about your child or the children you work with (e.g., ‘will they grow up to be pretty?’).
- **Teach children about good relationships and how to deal with difficulties when they arise.** People sometimes use food to express or numb themselves instead of dealing with difficult feelings or relationships. Because of messages that suggest that the perfect body will dissolve all relationship problems, young people often put energy into changing their bodies instead of their feelings or their relationships.
- **Be aware of some of the warning signs of eating disorders.** Understand that these warning signs can appear before puberty. Watch for: refusing typical family meals, skipping meals, comments about self and others like “I’m too fat; they’re too fat,” clothes shopping that becomes stressful, withdrawal from friends, irritability and depression, or any signs of extreme dieting, bingeing or purging.

Special thank you to Michael Levine, PhD, Paula Levine, PhD and Linda Smolak, PhD

Every Body is different

It is important to remember that every body is different. We all have different genetic and cultural traits. Even if everyone started eating the same things and did the same amount of exercise for a whole year, we would not all look the same at the end of the year. This is because each person’s genetic inheritance influences their bone structure, body size, shape, and weight differently.

So, how can you determine your ideal body weight? Well, your “ideal” body weight is the weight that allows you to feel strong and energetic and lets you lead a healthy, normal life. For example, when your body is healthy and at its ideal body weight, you are not too tired and you have the energy to interact with friends and family, participate in sports, and concentrate on school or work. While being overweight can be associated with adverse medical conditions, your body weight can be healthy across a wide range

of weights. When searching for your ideal weight, charts, formulas, and tables may be misleading and should be used under the guidance of a qualified expert. Focusing on eating balanced meals of nutritious foods and enjoying regular physical activity will help you to achieve balance and arrive at your ideal weight. Consult a qualified expert in medicine and nutrition for more information.

Most of all, avoid comparing your body with your friends' bodies or the people you see in advertisements or on your favorite TV shows. If you compare yourself to others, try to remember that we are all naturally different, which means we all have special qualities. Make a list of some of your strengths. What do you like to do? What makes you unique?

To make it simple, remember these keys to an ideal body:

- Treat your body with respect.
- Give it enough rest.
- Fuel it with a variety of foods.
- Exercise moderately.
- Resist the pressure to judge yourself and others based on weight, shape, or size.
- Respect people based on the qualities of their character and accomplishments, rather than just because of their appearance.

Listen To Your Body

- Choose a variety of foods that contribute to a healthy diet, and eat when you are truly hungry. Stop when you're full.
- Eat what appeals to you. Do this instead of any diet, and you're likely to maintain a healthy weight and avoid eating disorders.

SIZE DIVERSITY

Eating disorders can affect all kinds of bodies and you cannot tell by looking at someone if they have an eating disorder. Each person's genetic inheritance influences their bone structure, body size, shape, and weight

differently. We should appreciate those differences, encourage healthy behaviors, and treat every body with respect.

Media & Eating Disorders

We live in a media-saturated world and do not control the message. There is no single cause of body dissatisfaction or disordered eating. However, research is increasingly clear that media does indeed contribute and that exposure to and pressure exerted by media increase body dissatisfaction and disordered eating.

AMERICANS AND MEDIA CONSUMPTION

- Over 80% of Americans watch television daily. On average, these people watch over three hours per day.
- On a typical day, 8 – 18-year-olds are engaged with some form of media about 7.5 hours. Most of this time is spent watching television, though children play video games more than an hour per day and are on their computers for more than an hour per day.
- A content analysis of weight-loss advertising in 2001 found that more than half of all advertising for weight-loss products made use of false, unsubstantiated claims. (Hobbs, 2006).

THE EFFECTS OF MEDIA

Mass media provides a significantly influential context for people to learn about body ideals and the value placed on being attractive. Whenever you use media, think about who is paying for your attention. Consider how the message might affect someone's body confidence and if it is a message you want to support.

- Numerous correlational and experimental studies have linked exposure to the thin ideal in mass media to body dissatisfaction, internalization of the thin ideal, and disordered eating among women.
- Of American elementary school girls who read magazines, 69% say that the pictures influence their concept of the ideal body shape. 47% say the pictures make them want to lose weight. (Martin, 2010).
- Pressure from mass media to be muscular also appears to be related to body dissatisfaction among men. This effect may be smaller than among women but it is still significant.

- Conversely, Black-oriented television shows may serve a protective function; Hispanic and Black girls and women who watch more Black-oriented television have higher body satisfaction.

5 TIPS FOR MEDIA SELF CARE

1. **Choose and use media mindfully.** Be selective about your media use and choose media that supports your values and builds self-esteem and body confidence.
2. **Limit screen time and social networking.** Researchers studying body concern issues have found that the more time we spend in the media world, the more we are exposed to body perfect images, and the more vulnerable we are to compare our appearance to unrealistic body standards. Protect your self-image by monitoring the quantity and quality of your mainstream and social media time.
3. **Test the message for body positivity.** Use media literacy strategies to think critically about messages you consume and content you create on social media. Test for body positivity by asking key questions: Are the body depictions realistic or digitally altered? What does the message really mean? Why are they sending it? How might it affect someone's body acceptance? Who created and profits from the message? Before you text, tweet, post comments, and share photos and videos, ask yourself why you are sending the message, who you want to reach, and analyze its body positivity.
4. **Talk back to media about body image.** Tell people who profit from media and establish policies what you like and don't like about their body representations, why you feel this way, and what you plan to do about it — take a stand and refuse to read, view or listen to media or buy advertised products until they make changes.
5. **Advocate for positive body talk.** Use your social media capital to inspire others to use their voices to compliment authentic and diverse body messages, criticize unrealistic body ideals, and report body shaming. Shout out to media outlets, retailers, advertisers, and celebrity product endorsers who celebrate natural looks, healthy body size, and diverse body shapes, and call out ones that continue to promote unhealthy and artificial body norms. You can make a difference!

TIPS FOR BECOMING A CRITICAL VIEWER OF THE MEDIA

We spend more time than ever using media and everywhere we turn there are messages telling us how we should look that can make us feel less confident about our appearance. While we're probably not going to use less media, we can protect our self-

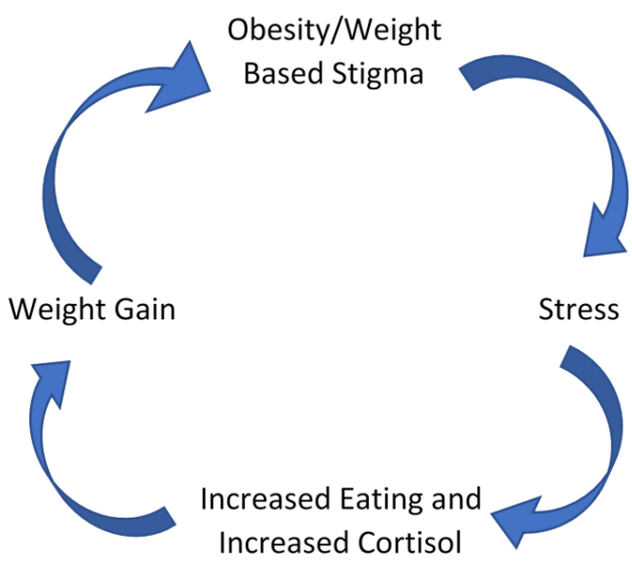
image and body confidence from media's narrow body ideals that reinforce the appearance ideal.

Media messages about body shape and size do not need to affect the way we feel about ourselves and our bodies. One of the ways we can protect our self-esteem and body image from the media's often narrow definitions of beauty and acceptability is to become critical viewers of the media messages we are bombarded with each day. When we effectively recognize and analyze the media messages that influence us, we remember that the media's definitions of beauty and success do not have to define our self-image or potential.

- All media images and messages are constructions. They are **not** reflections of reality. Advertisements and other media messages have been carefully crafted and are intended to send a very specific message.
- Advertisements are created to do one thing: convince you to buy or support a specific product or service. To do this, advertisers will often construct an emotional experience that looks like reality. Remember, you are only seeing what advertisers want you to see.
- Advertisers create their message based on what they think you will want to see and what they think will affect you and compel you to buy their product. Just because they think their approach will work with people like you doesn't mean it has to work with you as an individual.
- As individuals, we decide how to experience the media messages we encounter. We can choose to use a filter that helps us understand what the advertiser wants us to think or believe and then choose whether we want to think about or believe that message. We can choose a filter that protects our self-esteem and body image.

THE IMPACT OF WEIGHT STIGMA

Weight stigma poses a significant threat to psychological and physical health. It has been documented as a significant risk factor for depression, body dissatisfaction, and low self-esteem. Those who experience weight-based stigmatization also:



- Engage in more frequent binge eating
- Are at an increased risk for eating disorder symptoms
- Are more likely to have a diagnosis for binge eating disorder (BED)

Victims of weight stigma report physicians and family members are the most common source of weight bias. Among family members, weight-based teasing and diet talk are linked to binge eating, weight gain, and extreme weight control behaviors. Weight bias in health care is another important concern.

Research shows that healthcare providers, when talking to obese patients, tend to:

- Provide them with less health information
- Spend less time with them
- View them as undisciplined, annoying, and noncompliant with treatment.

THE PROBLEM WITH OBESITY PREVENTION CAMPAIGNS

Attention given to weight control has skyrocketed in recent years, ingraining words like "BMI," "obesity epidemic," and "diet" into our national vocabulary. Since the rise of national obesity prevention campaigns, the incidence of weight stigma has increased about 66%. The research is clear: overemphasizing weight can encourage disordered eating and have counterproductive effects.

Why I Smash Stigma

Jocelyn Resnick

8 months ago
Recovery

I started believing that I was broken and unworthy as an infant. I wasn't thin enough, I wasn't smart enough, I wasn't attractive enough, I just wasn't enough, period. I developed a full-blown eating disorder when I was 14 years old.

For most of my life, I let a cold, black and white metal scale dictate my worth. I stepped on and off of the scale throughout my childhood, my adolescence, and my early adulthood. I let an ambiguous number dictate how I felt about myself.

The scale told me who I should be. It told me that if I weighed less, I would be accepted by society. The scale was charged with control. There were many areas of my life that I lacked control in, but I always perceived power over that number. In addition, the scale

provided a source of validation. If I had worked out and eaten well, I expected the scale to provide a stamp of approval.

In high school, I was applauded and praised for losing weight. As the number dropped, the compliments rolled in. In actuality, I was miserable. I lost my menstrual cycle, isolated myself from my friends, and developed low bone mineral density. My health was going down the drain, but society naturally assumed that I was thriving!

My obsession with numbers led me to a career in health and wellbeing. I studied nutrition and exercise science throughout my undergraduate and graduate career. I was taught that “obesity” was the enemy, and so my life goal was to eradicate it (insert eye roll here). Ultimately, I wanted to teach other people how to be “healthy,” and I truly believed that weight loss was the answer.

Throughout my career, I was consistently reminded the importance of weight, body composition, and waist circumference. I had colleagues insist that scale smashing was unacceptable because the scale provided “valuable information” about health. I strongly believed that in order to be a true leader, I needed to model the societally constructed image of health and beauty. As I continued to embrace these thoughts and messages, I continued to live in my eating disorder.

Linda Bacon’s research on Health at Every Size (HAES)® changed my life. HAES® offers a weight neutral approach to health and well-being. It taught me to move and nourish my body from a place of self-love and self-compassion. Not only did I learn to stop fixating on a number, but I also learned to focus on my internal body cues instead. In therapy, I learned how to honor my emotions without controlling food.

I continued to learn that the pharmaceutical companies have a monopoly on obesity research and that health is not visible. In actuality, body mass index (BMI) is not correlated with health status and our weight is largely influenced by genetics. I thought that my negative relationship with nutrition and fitness was a willpower issue. I was wrong. It was actually a social justice issue related to weight stigma and the fear of fat.

When I first heard about the fat positive movement, I naturally panicked. Fat positivity contradicted everything that I had learned in school about heath. Society gives the word "fat" a negative connotation. We naturally assume that those who carry extra fat are "bad" or "lazy" and we therefore discriminate against those who live in larger bodies. In reality, "fat" is just a descriptor that should be completely neutral.

My weight had nothing to do with who I was as a person. It wasn't correlated with my commitment to public service, advocacy, and giving back to others. My weight was nothing more than the gravitational pull from the earth onto my body.

With time, I realized that loving my body at every size was the key to developing optimal health and well-being. As I embraced my figure, I removed a level of shame which ultimately led to a healthier relationship with nutrition and fitness.

On October 6, 2019 I attended the NYC NEDA Walk. I bought a raffle ticket to smash a scale piñata. Before I knew it, the raffle ticket number was called, and I was on the stage with a bat in my hand and 1,000 people standing in front of me.

That moment came with a strong sense of pride and imposter syndrome. I immediately thought, *Why me? There were so many people who had eating disorders that were worse than mine and deserve to smash the scale more than I do. I should have given the opportunity to somebody else.*

Luckily my therapist helped me see it through a different lens. Smashing the scale wasn't about who had it the worst. It was about connection. It was about opening myself up so that others could share a moment of pure joy and not feel so alone. It was about putting an end to my own invalidation and surrounding myself with those who empower me to be better and do better.

The moment was so much more than smashing a scale piñata. It was the smashing of shame, stigma, self-doubt, and the inner critic. Smashing the scale was the ultimate expression of infinite self-love and self-compassion.

My final words are: If you struggle, I give you endless permission to dismiss the number on the scale and to start celebrating the beauty that makes you uniquely you. My fellow warriors, keep fighting and never stop smashing!

To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

Chapter 7: Prevention

National Eating Disorders Association

Retrieved from: https://www.nationaleatingdisorders.org/learn/general-information/prevention

A. Prevention

Prevention

Prevention is any systematic attempt to change the circumstances that promote, initiate, sustain, or intensify problems like eating disorders. Eating disorders arise from a variety of physical, emotional, and social issues, all of which must be addressed for effective prevention and treatment.

Records of eating disorders exist throughout history and in cultures around the world. Since the 1950s, however, reports of all eating disorders have increased dramatically, especially in Western cultures. At the same time, people in these same cultures have increased dieting for weight loss and the amount of attention they pay to the food they eat and their body size and shape. This suggests that these factors may play a role in the development of eating disorders. Scientists believe that if they can reduce the risk factors for eating disorders, then they can reduce the chances that a person will go on to develop an eating disorder.

Prevention efforts may involve reducing negative risk factors, like body dissatisfaction, depression, or basing self-esteem on appearance, or increasing protective factors, like a non-appearance-oriented self-definition and replacing dieting and body snarking with intuitive eating and appreciation for the body's functionality.

Although it's too soon to say that any specific prevention program can reduce the rates of diagnosable eating disorders, these programs do show benefits in reducing risk factors for eating disorders, such as fasting, purging, and other unhealthy weight loss behaviors, as well as in decreasing disordered eating.

WHAT ARE PREVENTION PROGRAMS?

Prevention programs are systems and trainings developed in order to prevent eating disorder onset in a population. Prevention programs vary based on the size and nature of the group for whom the programming is intended. The Mental Health Intervention Spectrum, developed by the National Academy of Sciences (Committee on the Prevention of Mental Disorders, 2009), classifies different types of prevention programs according to their goals, methods and audiences:

- **Universal/primary prevention:** These are programs or interventions aimed at all people in a population (e.g., all adolescents in New York City or students in a health class). Designed to change public policy, institutions, and normative cultural attitudes and practices. The aim is to prevent the development of eating disorders in large groups with varying degrees of risk. Universal prevention may involve education, policy or legal action, and other environmental and larger social actions.
- **Selective prevention:** Intended to prevent eating disorders by targeting individuals who do not yet have symptoms of a disorder and are at risk for an eating disorder due to biological, psychological, or sociocultural factors (e.g., girls aged 10 to 13 who are facing puberty, experience sociocultural pressure for thinness, and have a parent with a history of an eating disorder). Selective prevention typically involves multisession, interactive curriculum.
- **Indicated/targeted prevention:** Targets people who are at high risk due to warning signs (e.g., mild ED symptoms) and/or clear risk factors (e.g., high levels of body dissatisfaction). The audience does not yet have an eating disorder. The goal is to stop the development of a serious problem and is aimed at the individual, rather than at effecting change in social policies, systems, or interpersonal behavior. Indicated prevention overlaps with traditional steps of clinical treatment: case identification to intervention to aftercare.

DOES EATING DISORDERS PREVENTION WORK?

There are many studies evaluating a variety of eating disorders and disordered eating prevention programs. Some of the major findings are:

General Findings

- Prevention programs can alter knowledge, attitudes, and behaviors associated with eating disorders and disordered eating.
- Various programs have successfully discouraged the development of eating problems in children, adolescents, and young adults.
- Much more research is needed concerning prevention. We are particularly lacking information about prevention programs that work with children, with males, and with people from a variety of ethnic groups.

Findings on Program Types

- Universal, selective and indicated/targeted prevention programs have enjoyed some success, though targeted programs may have had more success. Universal prevention is often difficult to research due to its focus on large-scale policy and normative attitudinal changes.
- There is particularly good evidence that targeted programs using a social learning theory, cognitive behavioral, media literacy, and cognitive dissonance approaches are effective with adolescents and young adult women from various ethnic groups.
- The cognitive dissonance approach encourages girls and women to question the media and cultural messages by asking them to speak out against the appearance ideal or other eating disorder risk factors through verbal, written, and behavioral exercises. The conflict between one's beliefs and actions creates psychological discomfort, motivating the individual to change their beliefs to match their actions.
- Programs that have shown some success include, but are not limited to, those that adopt an ecological approach, involving not only individual change but also changing the environment of teacher and peer behavior, media literacy programs, and programs that emphasize health.

B. Eating Disorder Traits as Strengths in Recovery

Heather Hower, MSW, LICSW, QCSW, ACSW

1 year ago

Anorexia

The focus in the eating disorders field is usually on diagnoses, symptoms, and related impairment. There has been little research, or even discussion, about negative traits that were present during the illness, which can be positive during and after eating

disorder recovery. This is particularly important because, for most people, these traits will persist throughout their lives. In addition, Walter Kaye, MD, has noted that these traits may confer advantages in professions.

Jenni Schaefer, BA, and Jenny Thomas, PhD, collaborated on their book, Almost Anorexic. In it, they provide a table of general eating disorder traits (e.g., perfectionism, obsessive-compulsiveness, sensitivity to emotional pain, intelligence), traits of those with anorexia (e.g., persistence, low risk-taking, attention to detail, preference for routine, ability to delay gratification), and traits of those with bulimia (e.g., impulsivity, risk-taking, need for new experiences, intolerance of routine). As an exercise, they request that individuals check off the traits that fit for them, identify their goals for the next six months, and then list the traits that will help them pursue their goals.

Given my personal history of anorexia, I identify with all of the anorexic traits, as well as all of the general eating disorder traits. Having been in recovery since 2012, I am doing my best to channel all of these characteristics in a productive manner, which benefits my work processes.

Persistence has been a key factor in my educational pursuits through graduate school, my daily practice as a professional ballerina, pursuing meaningful research studies on eating and bipolar disorders, cultivating relationships, and currently, creating the type of life that I want to live.

Low risk-taking dominated my life in anorexia, to the point where I missed out on a lot of fun adventures. Now in recovery, I take more calculated risks (for example, choosing which projects to do).

Attention to detail has always been important to me. In school, I maintained a 3.8 GPA due to my tendency to make sure that everything was correct. Today, I am the person in our research groups who handles the minutiae of planning presentations, and editing/submitting papers.

Preference for routine gave me a sense of security in anorexia. Each day, I went to school, then ballet, then did my homework. Now that I have a 3-year-old daughter, I understand the benefits of having a basic routine for her and myself in terms of her

sleeping, feeding, and playing schedule. We are both more regulated and pleasant to be around when we are following our routines!

Ability to delay gratification was a hallmark characteristic of my anorexia; I was able to avoid food and wait for the “reward” of a lower weight. Today, I can focus on other long-term goals.

Perfectionism is an ongoing trait that defines me. For my entire life, I have diligently worked at doing things to a very high standard, correspondingly trying to please others with my results. This has resulted in a lot of professional accomplishments, which have benefited my colleagues.

Obsessive-compulsiveness goes hand in hand with my perfectionism. In order to achieve my goals, I had to narrow my focus, and dedicate time and effort to the steps necessary for the projects. This single-mindedness, though, meant that I was able to complete tasks quickly.

Sensitivity to emotional pain has been a double-edged sword. I felt very “raw” when I had anorexia and tried to numb it by starving. However, I was also able to detect those emotions in others, connect with them, and respond in a way that was helpful for me as a therapist.

Intelligence allowed me to rationalize my anorexia as a way to cope with my overwhelming emotions and express my pain to others through my body (vs. my words). Despite my severe malnourishment, though, I excelled at school, ballet, and work, which enabled me to continue to function well in the eyes of others. In recovery, I am grateful that my now nourished brain is able to think clearly, make decisions, and focus on important life goals vs. those of anorexia.

References:

From Clinical Practice to Brain Research and Back-Anxiety in the Assessment and Treatment of Eating Disorders. Walter Kaye, MD, UCSD, Heather Hower, MSW, Brown University, Guido Frank, MD, University of Colorado Anschutz Medical Campus. International Conference on Eating Disorders (ICED) 2018 Workshop Presentation.

Almost Anorexic: Is My (or My Loved One’s) Relationship with Food a Problem? Jennifer J. Thomas, PhD, Harvard Medical School, Jenni Schaefer, BA. Table 3. Matching Your Positive Traits to Life Goals.

C. Recovery Doesn't Just Happen

Brittany Burgunder, C.P.C.

1 year ago

Recovery

Recovery doesn't just happen. It's also not some cliché buzzword tossed around to *"inspire"* you. Recovery is real. It's not a luck-of-the-draw deal where you put your name in a hat and hope to be chosen. It's a grueling, relentless, personal process that will push you beyond your limits over and over and over. Will you choose it?

At every stage of my struggle, my eating disorder was a result of a seed that got planted in my mind. Unfortunately, this seed was actually a weed that soon grew wildly out of control.

Despite misconceptions about eating disorders, this wasn't my choice. I was young and hurting. And I was trying to find ways to cope.

During my battle with anorexia, I fed the weed that was my eating disorder with vicious self-talk and behaviors, while my life starved. I couldn't see that I was suffocating. It was easier to distract myself by watering the weed than actually facing the root of the pain it hid.

During my battle with binge eating disorder, I nourished my weed with the same vicious self-talk that earlier led to different behaviors - leaving me hungry still. I couldn't see that I was suffocating—that the weed was growing larger.

During my battle with bulimia, I continued feeding the weed with the same vicious self-talk that once again left me empty inside. I couldn't see that I was, in essence, nearing a state of zero oxygen. And frankly, I didn't want to see it.

I didn't want recovery. I didn't believe in it. I told myself it was a trick. I became a better gardener to the eating disorder. I believed I deserved this self-destructive punishment. It kept me *"safe"* from having to face myself—what I feared most.

Eventually, I got tired of running from myself – from my pain. I paused and gasped for air. And in that moment of pause, I realized I had been running on a hamster wheel going nowhere. Reality hit me like a bolt of lightning.

NO ONE CAN SAVE YOU BUT YOU

No place, no thing, no one, no ifs ands or buts – no bargains!

But you can make a different choice now. Push any and all regrets aside. Don't tell me you want to. *SHOW ME.*

I've been down dark roads for much of my life. I know where running from fear, pain and self-hate leads. It leads to a life sentence in prison. I also know where working through the fear, discomfort, and self-hate leads. It leads to freedom. But only *YOU* hold the key. You've had it all along.

Quit comparing yourself to others.

Quit looking around for answers! Have your tried looking within?

You fear yourself. Face yourself.

Don't let fear interfere. We are all afraid. You aren't alone. It's how you use your fear that counts. Don't let it exhaust you – let it excite you. Change the narrative. You get one life.

Recovery does *NOT* mean going back to a painful life. Recovery means deliberately working through your pain and creating a brand-new life that feels good. Recovery does *NOT* mean you are immune to struggle or hardships. Accept that as fact now! Take the pressure off. You aren't perfect and never will be. Life has ups and downs. Recovery gives you the opportunity to experience life to its fullest as a participant, instead of watching it pass you by numb as a bystander.

I'm not here to preach to you, but rather offer some insight I wished I heard years ago from someone who had actually gone through the weeds experiencing the trials and tribulations of recovery.

Don't tell yourself you can't.

Don't tell yourself it's too hard.

Don't tell yourself it's not worth it.

Don't tell yourself it's too late.

And don't you dare ever tell yourself, "I give up."

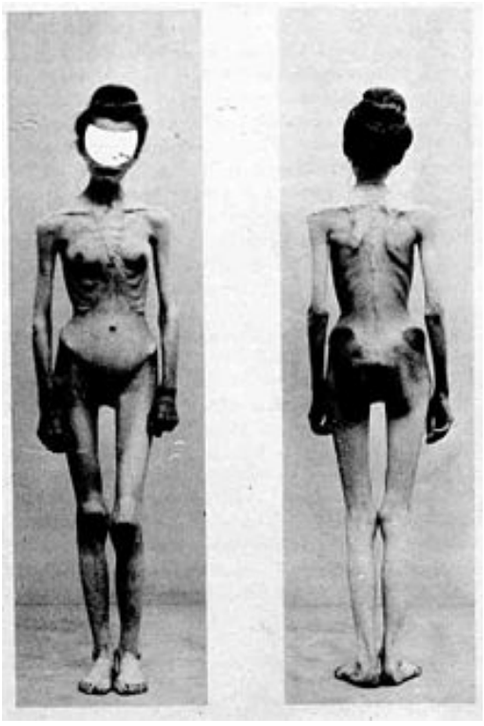
Get out your shovel and dig. Rip out the root of that weed wrongfully planted and plant something new. Then have patience as you watch your new seed grow and bloom – watch yourself bloom.

Recovery doesn't ***JUST*** happen.

But recovery ***DOES*** happen.

D. Statistics & Research on Eating Disorders

ANOREXIA



- At any given point in time between 0.3-0.4% of young women and 0.1% of young men will suffer from anorexia nervosa
- Several more recent studies in the US have used broader definitions of eating disorders that more accurately reflect the range of disorders that occur, resulting in a higher prevalence of eating disorders.
- A 2007 study asked 9,282 English-speaking Americans about a variety of mental health conditions, including eating disorders. The results, published in Biological Psychiatry, found that 0.9% of women and 0.3% of men had anorexia during their life.

Keski-Rahkonen A, Hoek HW, Susser ES, Linna MS, Sihvola E, Raevuori A, …, and Rissanen A. (2007). Epidemiology and course of anorexia nervosa in the community. American Journal of Psychiatry, 164(8):1259-65. doi: 10.1176/appi. ajp.2007.06081388.

- When researchers followed a group of 496 adolescent girls for 8 years, until they were 20, they found:
    - 5.2% of the girls met criteria for DSM5 anorexia, bulimia, or binge eating disorder.
    - When the researchers included nonspecific eating disorder symptoms, a total of 13.2% of the girls had suffered from a DSM-5 eating disorder by age 20.

Stice E, Marti CN, Shaw H, and Jaconis M. (2010). An 8-year longitudinal study of the natural history of threshold, subthreshold, and partial eating disorders from a community sample of adolescents. Journal of Abnormal Psychology, 118(3):587-97. doi: 10.1037/a0016481.

- Combining information from several sources, Eric Stice and Cara Bohon (2012) found that
    - Between 0.9% and 2.0% of females and 0.1% to 0.3% of males will develop anorexia
    - Subthreshold anorexia occurs in 1.1% to 3.0% of adolescent females

Stice E & Bohon C. (2012). Eating Disorders. In Child and Adolescent Psychopathology, 2nd Edition, Theodore Beauchaine & Stephen Linshaw, eds. New York: Wiley.

- Young people between the ages of 15 and 24 with anorexia have 10 times the risk of dying compared to their same-aged peers.

Smink, F. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. Current Psychiatry Reports, 14(4), 406-414.

Fichter, M. M., & Quadflieg, N. (2016). Mortality in eating disorders – Results of a large prospective clinical longitudinal study. International Journal of Eating Disorders, Epub ahead of print.

- Males represent 25% of individuals with anorexia nervosa, and they are at a higher risk of dying, in part because they are often diagnosed later since many people assume males don't have eating disorders.

Mond, J.M., Mitchison, D., & Hay, P. (2014) "Prevalence and implications of eating disordered behavior in men" in Cohn, L., Lemberg, R. (2014) Current Findings on Males with Eating Disorders. Philadelphia, PA: Routledge.

- Subclinical eating disordered behaviors (including binge eating, purging, laxative abuse, and fasting for weight loss) are nearly as common among males as they are among females.

Mond, J.M., Mitchison, D., & Hay, P. (2014) "Prevalence and implications of eating disordered behavior in men" in Cohn, L., Lemberg, R. (2014) Current Findings on Males with Eating Disorders. Philadelphia, PA: Routledge.

- An ongoing study in Minnesota has found incidence of anorexia increasing over the last 50 years only in females aged 15 to 24. Incidence remained stable in other age groups and in males.

Lai, K. Y. (2000). Anorexia nervosa in Chinese adolescents—does culture make a Lucas AR, Crowson CS, O'Fallon WM, Melton LJ 3rd. (1999). The ups and downs of anorexia nervosa. International Journal

of Eating Disorders, 26(4):397-405. DOI: 10.1002/(SICI)1098108X(199912)26:4<397::AID-EAT5>3.0.CO;2-0.difference?. Journal of Adolescence, 23(5), 561-568.

ARFID

- In a group of adolescents with eating disorders receiving treatment at a specialist clinic, 14% met criteria for ARFID. Those with ARFID were more likely to be
    - Younger, and
    - Male
- Many children with ARFID reported the following symptoms:
    - food avoidance
    - decreased appetite
    - abdominal pain
    - emetophobia (fear of vomiting)
- Nearly half of children with ARFID report fear of vomiting or choking, and one-fifth say they avoid certain foods because of sensory issues.
    - The same study found that one-third of children with ARFID have a mood disorder, three-quarters have an anxiety disorder, and nearly 20 percent have an autism spectrum condition

Fisher, M. M., Rosen, D. S., Ornstein, R. M., Mammel, K. A., Katzman, D. K., Rome, E. S., ... & Walsh, B. T. (2014). Characteristics of avoidant/restrictive food intake disorder in children and adolescents: a "new disorder" in DSM-5. Journal of Adolescent Health, 55(1), 49-52.

Nicely, T. A., Lane-Loney, S., Masciulli, E., Hollenbeak, C. S., & Ornstein, R. M. (2014). Prevalence and characteristics of avoidant/restrictive food intake disorder in a cohort of young patients in day treatment for eating disorders. Journal of eating disorders, 2(1), 1.

ATHLETES

- In a study of Division 1 NCAA athletes, over one-third of female athletes reported attitudes and symptoms placing them at risk for anorexia nervosa.

Johnson, C. Powers, P.S., and Dick, R. Athletes and Eating Disorders: The National Collegiate Athletic Association Study, Int J Eat Disord 1999; 6:179.

- Though most athletes with eating disorders are female, male athletes are also at risk—especially those competing in sports that tend to emphasize diet, appearance, size and weight. In weight-class sports (wrestling, rowing, horseracing) and aesthetic sports (bodybuilding, gymnastics, swimming, diving) about 33% of male athletes are affected. In female athletes in weight class and aesthetic sports, disordered eating occurs at estimates of up to 62%.

Sport Nutrition for Coaches by Leslie Bonci, MPH, RD, CSSD, 2009, Human Kinetics. Byrne et al. 2001; Sundot - Borgen & Torstviet 2004

- Among female high school athletes in aesthetic sports, 41.5% reported disordered eating. They were eight times more likely to incur an injury than athletes in aesthetic sports who did not report disordered eating.

Jankowski, C. (2012). Associations Between Disordered Eating, Menstrual Dysfunction, and Musculoskeletal Injury Among High School Athletes. Yearbook of Sports Medicine, 2012, 394-395. doi:10.1016/j.yspm.2011.08.003

- One study found that 35% of female and 10% of male college athletes were at risk for anorexia nervosa and 58% of female and 38% of male college athletes were at risk for bulimia nervosa.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- The prevalence of eating disorders in college athletes is higher among dancers and the most elite college athletes, particularly those involved with sports that emphasize a lean physique or weight restriction (e.g., figure skating, wrestling, rowing).

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Among female college athletes surveyed, 25.5% had subclinical eating disorder symptoms.

Greenleaf, C., Petrie, T. A., Carter, J., & Reel, J. J. (2009). Female Collegiate Athletes: Prevalence of Eating Disorders and Disordered Eating Behaviors. Journal of American College Health, 57(5), 489-496. doi:10.3200/jach.57.5.489-496

- In a survey of athletic trainers working with female collegiate athletes, only 27% felt confident identifying an athlete with an eating disorder. Despite this, 91% of athletic trainers reported dealing with an athlete with an eating disorder. 93% of trainers felt that increased attention needs to be paid to preventing eating disorders among collegiate female athletes. 25% worked at an institution without a policy on managing eating disorders.

Greenleaf, C., Petrie, T. A., Carter, J., & Reel, J. J. (2009). Female Collegiate Athletes: Prevalence of Eating Disorders and Disordered Eating Behaviors. Journal of American College Health, 57(5), 489-496. doi:10.3200/jach.57.5.489-496

- A study of female Division II college athletes found that 25% had disordered eating, 26% reported menstrual dysfunction, 10% had low bone mineral density, and 2.6% had all three symptoms.

Beals KA, Hill AK. The prevalence of disordered eating, menstrual dysfunction, and low bone mineral density among US collegiate

- Female high school athletes reporting disordered eating were twice as likely to incur a musculoskeletal injury as athletes who did not report disordered eating.

Jankowski, C. (2012). Associations Between Disordered Eating, Menstrual Dysfunction, and Musculoskeletal Injury Among High School Athletes. Yearbook of Sports Medicine, 2012, 394-395. doi:10.1016/j.yspm.2011.08.003

BINGE EATING DISORDER

NEDA has gathered data on the prevalence of eating disorders from the US, UK, and Europe to get a better idea of exactly how common eating disorders are. Although BED is not a new disorder, its new formal recognition in the research community has left far more gaps in the data on the incidence and prevalence of BED than for anorexia and bulimia.

- A 2007 study asked 9,282 English-speaking Americans about a variety of mental health conditions, including eating disorders. The results, published in Biological Psychiatry, found that 3.5% of women and 2.0% of men had binge eating disorder during their life
    - This makes BED more than three times more common than anorexia and bulimia combined.
    - BED is also more common than breast cancer, HIV, and schizophrenia.

Hudson JI, Hiripi E, Pope HG Jr, and Kessler RC. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biological Psychiatry, 61(3):348-58. doi:10.1016/j.biopsych.2006.03.040.

- When researchers followed a group of 496 adolescent girls for 8 years until they were 20, they found:
    - 5.2% of the girls met criteria for DSM5 anorexia, bulimia, or binge eating disorder.
    - When the researchers included nonspecific eating disorder symptoms, a total of 13.2% of the girls had suffered from a DSM-5 eating disorder by age 20.

Stice E, Marti CN, Shaw H, and Jaconis M. (2010). An 8-year longitudinal study of the natural history of threshold, subthreshold, and partial eating disorders from a community sample of adolescents. Journal of Abnormal Psychology, 118(3):587-97. doi: 10.1037/a0016481.

- Combining information from several sources, Eric Stice and Cara Bohon found that
    - Between 0.2% and 3.5% of females and 0.9% and 2.0% of males will develop binge eating disorder
    - Subthreshold binge eating disorder occurs in 1.6% of adolescent females

Stice E & Bohon C. (2012). Eating Disorders. In Child and Adolescent Psychopathology, 2nd Edition, Theodore Beauchaine & Stephen Linshaw, eds. New York: Wiley.

- Research estimates that
    - 28.4% of people with current BED are receiving treatment for their disorder
    - 43.6% of people with BED at some point in their lives will receive treatment
- BED often begins in the late teens or early 20s, although it has been reported in both young children and older adults
- Approximately 40% of those with binge eating disorder are male.
- Three out of ten individuals looking for weight loss treatments show signs of BED.

For further reading:

Westerberg, D. P., & Waitz, M. (2013). Binge-eating disorder. Osteopathic Family Physician, 5(6), 230-233.

BULIMIA

NEDA has gathered data on the prevalence of eating disorders from the US, UK, and Europe to get a better idea of exactly how common eating disorders are. Older data from other countries that use more strict definitions of anorexia and bulimia give lower prevalence estimates. Several more recent studies in the US have used broader

definitions of eating disorders that more accurately reflect the range of disorders that occur, resulting in a higher prevalence of eating disorders:

- At any given point in time, 1.0% of young women and 0.1% of young men will meet diagnostic criteria for bulimia nervosa.
- A 2007 study asked 9,282 English-speaking Americans about a variety of mental health conditions, including eating disorders. The results, published in Biological Psychiatry, found that 1.5% of women and 0.5% of men had bulimia during their life
- When researchers followed a group of 496 adolescent girls for 8 years until they were 20, they found:
    - 5.2% of the girls met criteria for DSM5 anorexia, bulimia, or binge eating disorder.
    - When the researchers included nonspecific eating disorder symptoms, a total of 13.2% of the girls had suffered from a DSM-5 eating disorder by age 20.
- Combining information from several sources, Eric Stice and Cara Bohon found that
    - Between 1.1% and 4.6% of females and 0.1% to 0.5% of males will develop bulimia
    - Subthreshold bulimia occurs in 2.0% to 5.4% of adolescent females

Have these numbers changed over time? The answer isn't clear. It does appear that, at least for the last two decades, the rates of new diagnoses of anorexia and bulimia have remained relatively stable.

- A Dutch study published in the International Journal of Eating Disorders found that new diagnoses of anorexia and bulimia remained relatively steady in the Netherlands from 1985-1989 to 1995-1999.
- Rates of bulimia increased during the 1980s and early 1990s, and they have since remained the same or decreased slightly
- A British study also found stability in new anorexia and bulimia diagnoses in both males and females, although rates of EDNOS diagnoses increased in both groups. (Please note that in the new DSM-5, EDNOS is no longer recognized and a new term of OSFED has been added, meaning Other Specified Feeding or Eating Disorder).

- Eating disorder symptoms are beginning earlier in both males and females, which agrees with both formal research and clinical reports.

Favaro A, Caregaro L, Tenconi E, Bosello R, and Santonastaso P. (2009). Time trends in age at onset of anorexia nervosa and bulimia nervosa. Journal of Clinical Psychiatry, 70(12):1715-21. doi: 10.4088/JCP.09m05176blu.

Hoek HW and van Hoeken D. (2003). Review of the prevalence and incidence of eating disorders. International Journal of Eating Disorders, 34(4):383-96. doi: 10.1002/eat.10222.

Hudson JI, Hiripi E, Pope HG Jr, and Kessler RC. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biological Psychiatry, 61(3):348-58. doi:10.1016/j.biopsych.2006.03.040.

Micali N, Hagberg KW, Petersen I, and Treasure JL. (2013). The incidence of eating disorders in the UK in 2000–2009: findings from the General Practice Research Database. BMJ Open, 3(5): e002646. doi: 10.1136/bmjopen-2013-002646.

Smink FR, van Hoeken D, and Hoek HW. (2012). Epidemiology of eating disorders: incidence, prevalence and mortality rates. Current Psychiatry Reports, 14(4):406-14. doi: 10.1007/ s11920-012-0282-y.

Stice E & Bohon C. (2012). Eating Disorders. In Child and Adolescent Psychopathology, 2nd Edition, Theodore Beauchaine & Stephen Linshaw, eds. New York: Wiley.

Stice E, Marti CN, Shaw H, and Jaconis M. (2010). An 8-year longitudinal study of the natural history of threshold, subthreshold, and partial eating disorders from a community sample of adolescents. Journal of Abnormal Psychology, 118(3):587-97. doi: 10.1037/a0016481.

van Son GE, van Hoeken D, Bartelds AI, van Furth EF, and Hoek HW. (2012). Time trends in the incidence of eating disorders: a primary care study in the Netherlands. International Journal of Eating Disorders, 39(7):565-9. doi: 10.1002/eat.20316.

BULLYING/WEIGHT SHAMING

- The best-known environmental contributor to the development of eating disorders is the sociocultural idealization of thinness.

Culbert, K. M., Racine, S. E., & Klump, K. L. (2015). Research Review: What we have learned about the causes of eating disorders - a synthesis of sociocultural, psychological, and biological research. J Child Psychol Psychiatry, 56(11), 1141-1164.

- By age 6, girls especially start to express concerns about their own weight or shape. 40-60% of elementary school girls (ages 6-12) are concerned about their weight or about becoming too fat. This concern endures through life.

Smolak, L. (2011). Body image development in childhood. In T. Cash & L. Smolak (Eds.), Body Image: A Handbook of Science, Practice, and Prevention (2nd ed.).New York: Guilford.

- 79% of weight-loss program participants reported coping with weight stigma by eating more food.

Andreyeva, T., Puhl, R. M. and Brownell, K. D. (2008), Changes in Perceived Weight Discrimination Among Americans, 1995–1996 Through 2004–2006. Obesity, 16: 1129–1134. doi:10.1038/oby.2008.35

- Of American elementary school girls who read magazines, 69% say that the pictures influence their concept of the ideal body shape. 47% say the pictures make them want to lose weight.

Martin, J. B. (2010). The Development of Ideal Body Image Perceptions in the United States.Nutrition Today, 45(3), 98-100. Retrieved from nursingcenter.com/pdf.asp?AID=1023485

- Up to 40% of overweight girls and 37% of overweight boys are teased about their weight by peers or family members. Weight teasing predicts weight gain, binge eating, and extreme weight control measures.

Golden, N. H., Schneider, M., & Wood, C. (2016). Preventing Obesity and Eating Disorders in Adolescents. Pediatrics, 138(3). doi:10.1542/peds.2016-1649

- Weight-based victimization among overweight youths has been linked to lower levels of physical activity, negative attitudes about sports, and lower participation in physical activity among overweight students. Among overweight and obese adults, those who experience weight-based stigmatization engage in more frequent binge eating, are at increased risk for eating disorder symptoms, and are more likely to have a diagnosis of binge eating disorder.

Andreyeva, T., Puhl, R. M. and Brownell, K. D. (2008), Changes in Perceived Weight Discrimination Among Americans, 1995–1996 Through 2004–2006. Obesity, 16: 1129–1134. doi:10.1038/oby.2008.35

- Children of mothers who are overly concerned about their weight are at increased risk for modeling their unhealthy attitudes and behaviors.

Andreyeva, T., Puhl, R. M. and Brownell, K. D. (2008), Changes in Perceived Weight Discrimination Among Americans, 1995–1996 Through 2004–2006. Obesity, 16: 1129–1134. doi:10.1038/oby.2008.35

- Weight stigma poses a significant threat to psychological and physical health. It has been documented as a significant risk factor for depression, low self-esteem, and body dissatisfaction.

Andreyeva, T., Puhl, R. M. and Brownell, K. D. (2008), Changes in Perceived Weight Discrimination Among Americans, 1995–1996 Through 2004–2006. Obesity, 16: 1129–1134. doi:10.1038/oby.2008.35

- Low self-esteem is a common characteristic of individuals who have eating disorders.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Perceived weight discrimination is significantly associated with a current diagnosis of mood and anxiety disorders and mental health services use.

Hatzenbuehler ML, Keyes KM, Hasin DS. Associations between perceived weight discrimination and the prevalence of psychiatric disorders in the general population. Obesity 2009;17(11)2033–2039

CO-OCCURRING DISORDERS

- Two-thirds of people with anorexia also showed signs of an anxiety disorder several years before the start of their eating disorder.
- Childhood obsessive-compulsive traits, such as perfectionism, having to follow the rules, and concern about mistakes, were much more common in women who developed eating disorders than women who didn’t.
- A study of more than 2400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, including:
    - 94% had co-occurring mood disorders, mostly major depression
    - 56% were diagnosed with anxiety disorders
- 20% had obsessive-compulsive disorder
- 22% had post-traumatic stress disorder
- 22% had an alcohol or substance use disorder
- Approximately one in four people with an eating disorder has symptoms of post-traumatic stress disorder (PTSD).

Tagay, S., Schlottbohm, E., Reyes-Rodriguez, M. L., Repic, N., & Senf, W. (2014). Eating disorders, trauma, PTSD, and psychosocial resources. Eating disorders, 22(1), 33-49.

- In women hospitalized for an eating disorder, 36.8% regularly self-harmed

- A 2009 study in the International Journal of Eating Disorders found that one in five women seeking treatment for an eating disorder had six or more signs of attention-deficit hyperactivity disorder (ADHD).
- Personality disorders also commonly occur in individuals with eating disorders.
- Among those with anorexia,
    - Restricting type: 20% had obsessive-compulsive personality disorder, 10% had borderline personality disorder
    - Binge-purge type:12% had obsessive-compulsive personality disorder, 25% had borderline personality disorder
    - Among those with bulimia:11% had obsessive-compulsive personality disorder, 28% had borderline personality disorder
- A 2014 study found that combined and analyzed data from 20 previous studies found signs of personality disorders in
    - 38% of people with EDNOS/OSFED
- 11% had obsessive-compulsive personality disorder
- 12% had borderline personality disorder
    - 30% of people with binge eating disorder
- 10% had obsessive-compulsive personality disorder
- 10% had borderline personality disorder
- Depression and other mood disorders co-occur with eating disorders quite frequently.

Mangweth, B., Hudson, J. I., Pope, H. G. Jr., Hausmagn, A., DeCol, C., Laird, N. M., …Tsuang, M.T. (2003). Family study of the aggregation of eating disorders and mood disorders.Psychological Medicine, 33, 1319-1323.

McElroy, S. L. O., Kotwal, R., & Keck, P. E. Jr. (2006). Comorbidity of eating disorders with bipolar disorder and treatment implications. Bipolar Disorders, 8, 686-695.

- There is a markedly elevated risk for obsessive-compulsive disorder among those with eating disorders.

Altman, S. E., & Shankman, S. A. (2009). What is the association between obsessive-compulsive disorder and eating disorders? Clinical Psychology Review, 29, 638-646.

- One study found that 73.8% of patients with binge eating disorder had at least one additional lifetime psychiatric disorder, and 43.1% had at least one current psychiatric disorder. Among lifetime disorders, mood, anxiety, and substance use

disorders were most common. Among current comorbidities, mood and anxiety were most common.

Grilo, C. M., White, M. A. and Masheb, R. M. (2009), DSM-IV psychiatric disorder comorbidity and its correlates in binge eating disorder. Int. J. Eat. Disord., 42: 228–234. doi:10.1002/eat.20599

- Up to 69% of patients with anorexia nervosa and 33% of patients with bulimia nervosa have a coexisting diagnosis of OCD.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Binge eating disorder patients with a co-occurring psychiatric disorder also had significantly higher levels of current eating disorder psychopathology, negative affect, and lower self-esteem than did patients with binge eating disorder without a co-occurring condition.

Grilo, C. M., White, M. A. and Masheb, R. M. (2009), DSM-IV psychiatric disorder comorbidity and its correlates in binge eating disorder. Int. J. Eat. Disord., 42: 228–234. doi:10.1002/eat.20599

- Certain psychiatric disorders, particularly obsessive-compulsive disorder, mood disorders and personality disorders, frequently are found among those with eating disorders, with estimates ranging from 42-75%.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- In a nationally representative survey, 95% of respondents with bulimia nervosa, 79% with binge eating disorder, and 56% with anorexia nervosa met criteria for at least one other psychiatric disorder. 64% of those with bulimia nervosa met criteria for three or more co-occurring psychiatric disorders.

Hudson JI, Hiripi E, Pope HG Jr, and Kessler RC. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biological Psychiatry, 61(3):348-58.

- In a study of women with eating disorders, 94% of the participants had a co-occurring mood disorder. 92% of those in the sample were struggling with a depressive disorder.

Blinder, B. J., Cumella, E. J., & Sanathara, V. A. (2006). Psychiatric Comorbidities of Female Inpatients With Eating Disorders. Psychosomatic Medicine, 68(3), 454-462. doi:10.1097/01.psy.0000221254.77675.f5

- 32-39% of people with anorexia nervosa, 36-50% of people with bulimia nervosa, and 33% of people with binge eating disorder are also diagnosed with major depressive disorder.

Hudson JI, Hiripi E, Pope HG Jr, and Kessler RC. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biological Psychiatry, 61(3):348-58.

"NIH Categorical Spending -NIH Research Portfolio Online Reporting Tools (RePORT)." U.S National Library of Medicine. U.S. National Library of Medicine, 3 Jul. 2017. Web. 11 Jan. 2018.

Milos, G., Spindler, A., Buddeberg, C., & Crameri, A. (2003). Axes I and II comorbidity and treatment experiences in eating disorder subjects. Psychother and Psychosom, 72(5), 276-285.

- 48-51% of people with anorexia nervosa, 54-81% of people with bulimia nervosa, and 55-65% of people with binge eating disorder are also diagnosed with anxiety disorder.

Hudson JI, Hiripi E, Pope HG Jr, and Kessler RC. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biological Psychiatry, 61(3):348-58.

NIH Categorical Spending -NIH Research Portfolio Online Reporting Tools (RePORT)." U.S National Library of Medicine. U.S. National Library of Medicine, 3 Jul. 2017. Web. 11 Jan. 2018.

Ulfvebrand, S., Birgegard, A., Norring, C., Hogdahl, L., & von Hausswolff-Juhlin, Y. (2015). Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. Psychiatry Res, 230(2), 294-299.

For further reading:

Anderluh, M. B., Tchanturia, K., Rabe-Hesketh, S., & Treasure, J. (2003). Childhood obsessive-compulsive personality traits in adult women with eating disorders: defining a broader eating disorder phenotype. American Journal of Psychiatry, 160(2), 242-247.

Eddy, K. T., Dorer, D. J., Franko, D. L., Tahilani, K., Thompson-Brenner, H., & Herzog, D. B. (2008). Diagnostic crossover in anorexia nervosa and bulimia nervosa: implications for DSM-V. American Journal of Psychiatry, 165(2), 245-250.

Friborg, O., Martinussen, M., Kaiser, S., Øvergård, K. T., Martinsen, E. W., Schmierer, P., & Rosenvinge, J. H. (2014). Personality disorders in eating disorder not otherwise specified and binge eating disorder: a meta-analysis of comorbidity studies. The Journal of nervous and mental disease, 202(2), 119-125.

Kaye, W. H., Bulik, C. M., Thornton, L., Barbarich, N., & Masters, K. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. American Journal of Psychiatry, 161(12), 2215-2221.

Kostro, K., Lerman, J. B., & Attia, E. (2014). The current status of suicide and self-injury in eating disorders: a narrative review. Journal of eating disorders, 2(1), 1.

Sansone, R. A., Levitt, J. L., & Sansone, L. A. (2004). The prevalence of personality disorders among those with eating disorders. Eating Disorders, 13(1), 7-21.

COMPULSIVE EXERCISE

- An estimated 90-95% of college students diagnosed with an eating disorder also belong to a fitness facility.
- An estimated 3% of gym-goers have a destructive relationship with exercise. Some studies have found that number may be even higher, including a 2008 Paris study that found that up to 42% of gym-goers have a destructive relationship with exercise.
- A study involving fitness professionals revealed that 100% of the participants believed that they would benefit from further education and guidelines for identifying and addressing eating disorders.
- There is a strong link between exercise compulsion and various forms of eating disorders.
- Between 40% and 80% of anorexia nervosa patients are prone to excessive exercise in their efforts to avoid putting on weight.

Jodi Rubin, ACSW, LCSW, CEDS, Destructively Fit®, Private Practice

Berczik, K., Szabo, A., Griffiths, M., Kurimay, T., Kun, B., Urban R., & Demetrovics, Z. (2012). Exercise Addiction: Symptoms, Diagnosis, Epidemiology, and Etiology. Substance Use & Misuse, 47, 403-417.

Holtkamp, K., Hebebrand, J., Herpetz-Dahlmann, B. (2004). The Contribution of Anxiety and Food Restriction on Physical Activity Levels in Acute Anorexia Nervosa. The International Journal of Eating Disorders, 36(2):163-71.1

Lejoyeux, M., Avril, M., Richoux, C., Embouazza, H. & Nivoli, F. (2008). Prevalence of exercise dependence and other behavioral addictions among clients of a Parisian fitness room. Comprehensive Psychiatry, 49, 353-358.

Manley, R. O'Brien, K. & Samuels, S. (2008) Fitness instructors' recognition of eating disorders and attendant ethical/liability issues. Eating Disorders: The Journal of Treatment & Prevention, 16(2), 103-116.

McLean Hospital: http://www.nutrition411.com/wp-content/uploads/2013/11/fitnessmanage0704.

Thompson, R. A., & Sherman, R. T. (2010). Eating disorders in sport. New York: Rutledge.

DIABULIMIA

- A review of studies published over the last 25 years on the prevalence of eating disorders and insulin restriction among people with diabetes shows that 30%-35% of women restrict insulin in order to lose weight at some point in their life. This number has remained relatively constant over the decades.
- A study of adolescents in 2000 across three Canadian cities found that young women with type 1 diabetes were 2.4 times more likely to have a diagnosable eating disorder and 1.9 times more likely to have sub-threshold eating disorder.
- In a more recent study, 1/3 of female patients and 1/6 of male patients with Type 1 diabetes reported disordered eating and frequent insulin restriction.
- People with diabetes often experience uncontrolled eating when they experience a low blood sugar. In Duke University's study of 276 individuals with type 1 diabetes the frequency of uninhibited eating contributed to 31.3% of insulin omission for weight management.

- A study of adolescents from Norway revealed that in addition to age, negative attitude toward diabetes and negative beliefs about insulin had the highest association with insulin restriction and eating disorder behavior.
- People with diabetes also have a higher risk for emotional states often associated with eating disorders. For example, an analysis of 42 studies found that diabetes doubles the likelihood of having clinical depression (1.7 – 2.9 times greater).
- While the majority of studies have been conducted within the type 1 diabetes population, there is case study and anecdotal evidence that the same prevalence and risk exists in any person with insulin dependence whether type 1 diabetes, type 2 diabetes or LADA (latent autoimmune diabetes of adults).

Polonsky WH, et al. Insulin omission in women with IDDM. Diabetes Care. 1994;(17):1178–1185.

Affenito SG, et al. Subclinical and Clinical Eating Disorders in IDDM Negatively Affect Metabolic Control. Diabetes Care. 1997; 20(2):182-184.

Goebel-Fabbri AE FJ, et al. Insulin restriction and associated morbidity and mortality in women with type 1 diabetes. Diabetes Care. 2008;31:415–419.

Jones JM, et al. Eating disorders in adolescent females with and without type 1 diabetes: cross sectional study. BMJ. 2000;2000(320):1563–1566.

Doyle EA, et al. Disordered Eating Behaviors in Emerging Adults with Type 1 Diabetes: A Common Problem for both Men and Women. J Pediatric Health Care. 2017;31(3):327-333.

Custal, Nuria, et al. Treatment Outcome of Patients with Comorbid Type 1 Diabetes and Eating Disorders. BMC Psychiatry. 2014;14:140.

Lee-Akers, Dawn. Biological and Psychological Risk Factors for Eating Disorders in Type 1 Diabetes. Poster presented at: Annual Conference of American Association of Diabetes Educators; 2017 Aug 4-7; Indianapolis, IN.

Merwin RM, et al. Disinhibited eating and weight-related insulin mismanagement among individuals with T1D. Appetite. 2014;81:123-130.

Wisting, Line, et al. Adolescents with T1D – The impact of gender, age, and health-related functioning on eating disorder psychopathology. PLoS ONE. 2015;10(11):e0141386.

Anderson RJ, et. al. The Prevalence of Comorbid Depression in Adults with Diabetes. Diabetes Care. 2001;24(6):1069-1078.

Bächle C, Stahl-Pehe A, Rosenbauer J. Disordered eating and insulin restriction in youths receiving intensified insulin treatment: Results from a nationwide population-based study. Int J Eat Disord. 2016 Feb;49(2):191-6

Bermudez, Ovidio, et al. Inpatient Management of Eating Disorders in Type 1 Diabetes. Diabetes Spectrum. 2009;22(3):153-158.

DIETING/"CLEAN EATING"

- In a large study of 14– and 15-year-olds, dieting was the most important predictor of a developing eating disorder. Those who dieted moderately were 5x more likely to develop an eating disorder, and those who practiced extreme restriction were 18x more likely to develop an eating disorder than those who did not diet.

Golden, N. H., Schneider, M., & Wood, C. (2016). Preventing Obesity and Eating Disorders in Adolescents. Pediatrics, 138(3). doi:10.1542/peds.2016-1649

- 62.3% of teenage girls and 28.8% of teenage boys report trying to lose weight. 58.6% of girls and 28.2% of boys are actively dieting. 68.4% of girls and 51% of boys exercise with the goal of losing weight or to avoid gaining weight.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Over one-half of teenage girls and nearly one-third of teenage boys use unhealthy weight control behaviors such as skipping meals, fasting, smoking cigarettes, vomiting, and taking laxatives.

Neumark-Sztainer, D. (2005). I'm, Like, SO Fat!.New York: Guilford.

- 35-57% of adolescent girls engage in crash dieting, fasting, self-induced vomiting, diet pills, or laxatives. Overweight girls are more likely than normal weight girls to engage in such extreme dieting.

Boutelle, K., Neumark-Sztainer, D.,Story, M., &Resnick, M. (2002).Weight control behaviors among obese, overweight, and nonoverweight adolescents. Journal of Pediatric Psychology,27, 531-540.

Neumark-Sztainer, D., &Hannan, P. (2001). Weight-related behaviors among adolescent girls and boys: A national survey. Archives of Pediatric and Adolescent Medicine, 154, 569-577.

Wertheim, E., Paxton, S., &Blaney, S. (2009).Body image in girls.In L. Smolak & J. K. Thompson (Eds.), Body image, eating disorders, and obesity in youth: Assessment, prevention, and treatment (2nd ed.) (pp. 47-76). Washington, D.C.: American Psychological Association.

- Girls who diet frequently are 12 times as likely to binge as girls who don't diet.

Neumark-Sztainer, D. (2005). I'm, Like, SO Fat!.New York: Guilford.

- Even among clearly non-overweight girls, over 1/3 report dieting.

Wertheim, E., Paxton, S., &Blaney, S. (2009).Body image in girls.In L. Smolak & J. K. Thompson (Eds.), Body image, eating disorders, and obesity in youth: Assessment, prevention, and treatment (2nd ed.) (pp. 47-76). Washington, D.C.: American Psychological Association.

- 95% of all dieters will regain their lost weight in 1-5 years.

Grodstein, F., Levine, R., Spencer, T., Colditz, G. A., &Stampfer, M. J. (1996). Three-year follow-up of participants in a commercial weight loss program: Can you keep it off? Archives of Internal Medicine 156(12), 1302.

Neumark-Sztainer D., Haines, J., Wall, M., & Eisenberg, M. (2007). Why does dieting predict weight gain in adolescents? Findings from project EAT-II: a 5-year longitudinal study. Journal of the American Dietetic Associatio, 107(3), 448-55

- 19.1% of teenage girls and 7.6% of teenage boys fast for 24 hours or more, 12.6% of girls and 5.5% of boys use diet pills, powders or liquids, and 7.8% of girls and 2.9% of boys vomit or take laxatives to lose weight or to avoid gaining weight.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- 12.6% of female high school students took diet pills, powders or liquids to control their weight without a doctor's advice.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Multiple studies have found that dieting was associated with greater weight gain and increased rates of binge eating in both boys and girls.

Golden, N. H., Schneider, M., & Wood, C. (2016). Preventing Obesity and Eating Disorders in Adolescents. Pediatrics, 138(3). doi:10.1542/peds.2016-1649

- In elementary school fewer than 25% of girls diet regularly. Yet those who do know what dieting involves and can talk about calorie restriction and food choices for weight loss fairly effectively.

Smolak, L. (2011). Body image development in childhood. In T. Cash & L. Smolak (Eds.), Body Image: A Handbook of Science, Practice, and Prevention (2nd ed.).New York: Guilford.

- Middle school girls who dieted more than once a week were nearly four times as likely to become smokers, compared to non-dieters.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- A content analysis of weight-loss advertising in 2001 found that more than half of all advertising for weight-loss product made use of false, unsubstantiated claims.

Wertheim, E., Paxton, S., &Blaney, S. (2009).Body image in girls.In L. Smolak & J. K. Thompson (Eds.), Body image, eating disorders, and obesity in youth: Assessment, prevention, and treatment (2nd ed.) (pp. 47-76). Washington, D.C.: American Psychological Association.

- Americans spend over $60 billion on dieting and diet products each year.

Hobbs, R., Broder, S., Pope, H., & Rowe, J. (2006). "How adolescent girls interpret weight-loss advertising." Health Education Research, 21(5) 719-730.

INSURANCE/LEGAL ISSUES

- Eating disorders are associated with some of the highest levels of medical and social disability of any psychiatric disorder.

Klump KL, Bulik CK, Kaye W, Treasure J, Tyson E. Academy for Eating Disorders Position Paper: Eating Disorders are Serious Mental Illnesses. Int J Eat Disord. 2009 Mar;42(2):97-103. doi: 10.1002/eat.20589.

- APA Practice Guidelines (2000 & 1993) reports these medical findings:

    - Physical consequences of eating disorders include all serious disorders caused by malnutrition, especially cardiovascular compromise.
    - Prepubertal patients may have arrested sexual maturity and growth failure.
    - Even those who “look and feel deceptively well,” with normal EKGs may have cardiac irregularities, variations with pulse and blood pressure, and are at risk for sudden death.
    - Prolonged amenorrhea (>6 months) may result in irreversible osteopenia and a high rate of fractures.
    - Abnormal CT scans of the brain are found in >50% of patients with anorexia nervosa.
- In 1996, Congress passed the Mental Health Parity Act, a law that requires plans to provide the same annual and lifetime overall limits for mental health benefits as for other health conditions. Eating disorders ought to receive health care coverage and research funding that is equal to that of medical disorders as well as psychiatric conditions categorized as serious forms of mental illness.

Klump KL, Bulik CK, Kaye W, Treasure J, Tyson E. Academy for Eating Disorders Position Paper: Eating Disorders are Serious Mental Illnesses. Int J Eat Disord. 2009 Mar;42(2):97-103. doi: 10.1002/eat.20589.

JEWISH COMMUNITY

In one study of ultra-Orthodox and Syrian Jewish communities in Brooklyn, 1 out of 19 girls was diagnosed with an eating disorder, which is a rate about 50 percent higher than the general U.S. population (Sacker, 1996).

LGBTQ+ COMMUNITY

- Transgender individuals experience eating disorders at rates significantly higher than cisgender individuals.
- Research is limited and conflicting on eating disorders

among lesbian and bisexual women.

- While research indicates that lesbian women experience less body dissatisfaction overall, research shows that beginning as early as 12, gay, lesbian, and bisexual teens may be at higher risk of binge-eating and purging than heterosexual peers.
- In one study, gay and bisexual boys reported being significantly more likely to have fasted, vomited, or taken laxatives or diet pills to control their weight in the last 30 days. Gay males were 7 times more likely to report binging and 12 times more likely to report purging than heterosexual males.
- Females identified as lesbian, bisexual, or mostly heterosexual were about twice as likely to report binge-eating at least once per month in the last year.
- Elevated rates of binge-eating and purging by vomiting or laxative abuse was found for both males and females who identified as gay, lesbian, bisexual, or “mostly heterosexual” in comparison to their heterosexual peers.
- Compared to other populations, gay men are disproportionately found to have body image disturbances and eating disordered behavior. Gay men are thought to only represent 5% of the total male population but among men who have eating disorders, 42% identify as gay.
- In a 2007 study of Lesbian, Gay and Bisexual (LGB)-identified participants, which was the first to assess DSM diagnostic categories, rather than use measures that may be indicative of eating disorders (e.g., eating disorder symptoms), in community-based (versus those recruited from clinical or academic settings) ethnically/racially diverse populations. Researchers found:
- Compared with heterosexual men, gay and bisexual men had a significantly higher prevalence of lifetime full syndrome bulimia, subclinical bulimia, and any subclinical eating disorder.
- There were no significant differences between heterosexual women and lesbians and bisexual women in the prevalence of any of the eating disorders.
- Respondents aged 18–29 were significantly more likely than those aged 30–59 to have subclinical bulimia.
- Black and Latino LGBs have at least as high a prevalence of eating disorders as white LGBs
- A sense of connectedness to the gay community was related to fewer current eating disorders, which suggests that feeling connected to the gay community may have a protective effect against eating disorders

Austin, S. Bryn, Sc.D.. 2004. Sexual Orientation, Weight Concerns, and Eating- Disordered Behaviors in Adolescent Girls and Boys. Journal of the American Academy of Child & Adolescent Psychiatry, V43.

Carlat, D.J., Camargo, CA, & Herzog, DB, 1991. Eating disorders in males: a report of 135 patients. American Journal of Psychiatry, 148, 1991.

Center for Disease Control and Massachusetts Department of Education. 1999. Massachusetts State Youth Risk Behavior Survey. National Gay and Lesbian Task Force (with National Coalition for the Homeless)

Ray, Nicholas. 2007. Gay, Lesbian, Bisexual and Transgender Youth: An Epidemic of Homelessness. National Gay and Lesbian Task Force and National Coalition for the Homeless.

Waldron, Jennifer J., Semerjian, Tamar Z., Kauer, Kerrie. 2009. Doing 'Drag': Applying Queer- Feminist Theory to the Body Image and Eating Disorders across Sexual Orientation and Gender Identity. In The Hidden Faces of Eating Disorders, Edited by Justine J. Reel & Katherine A. Beals, (63-81).

MARGINALIZED VOICES

- Despite similar rates of eating disorders among non-Hispanic Whites, Hispanics, African-Americans, and Asians in the United States, people of color are significantly less likely to receive help for their eating issues.

Marques, L., Alegria, M., Becker, A. E., Chen, C., Fang, A., Chosak, A., & Diniz, J. B. (2011). Comparative Prevalence, Correlates of Impairment, and Service Utilization for Eating Disorders across U.S. Ethnic Groups: Implications for Reducing Ethnic Disparities in Health Care Access for Eating Disorders. The International Journal of Eating Disorders, 44(5), 412–420. http://doi.org/10.1002/eat.20787

Becker, A. E., Franko, D. L., Speck, A., & Herzog, D. B. (2003). Ethnicity and differential access to care for eating disorder symptoms. International Journal of Eating Disorders, 33(2), 205-212. doi:10.1002/eat.10129

Wade, T. D., Keski-Rahkonen A., & Hudson J. (2011).Epidemiology of eating disorders. In M. Tsuang and M. Tohen (Eds.), Textbook in Psychiatric Epidemiology (3rd ed.) (pp. 343-360). New York: Wiley.

- Although eating disorders affect a higher proportion of males who identify as gay or bisexual than females, the majority of males with eating disorders are heterosexual.

Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating Disorders in Men: Underdiagnosed, Undertreated, and Misunderstood. Eating Disorders, 20(5), 346-355. doi:10.1080/10640266.2012.715512

- 15% of gay and bisexual men and 4.6% of heterosexual men had a full or subthreshold eating disorder at some point in their lives.

Feldman, M. B. and Meyer, I. H. (2007), Eating disorders in diverse lesbian, gay, and bisexual populations. Int. J. Eat. Disord., 40: 218–226.

- Black teenagers are 50% more likely than white teenagers to exhibit bulimic behavior, such as binging and purging.

Goeree, Michelle Sovinsky, Ham, John C., & Iorio, Daniela. (2011). Race, Social Class, and Bulimia Nervosa. IZA Discussion Paper No. 5823. Retrieved from http://ftp.iza.org/dp5823.pdf.

- In a study of adolescents, researchers found that Hispanics were significantly more likely to suffer from bulimia nervosa than their non-Hispanic peers. The researchers also reported a trend towards a higher prevalence of binge eating disorder in all minority groups.

Swanson SA, Crow SJ, Le Grange D, Swendsen J, and Merikangas KR. (2011). Prevalence and correlates of eating disorders in adolescents. Results from the national comorbidity survey replication adolescent supplement. Archives of General Psychiatry, 68(7):714-23.

- From 1999 to 2009, hospitalizations involving eating disorders increased for all age groups, but hospitalizations for patients aged 45-65 increased the most, by 88 percent. In 2009, people over the age of 45 accounted for 25% of eating disorder-related hospitalizations.

Zhao, Y., Encinosa, W. Update on Hospitalizations for Eating Disorders, 1999 to 2009. HCUP Statistical Brief #120. September, 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb120.pdf

- Teenage girls from low-income families are 153% more likely to be bulimic than girls from wealthy families.

Goeree, Michelle Sovinsky, Ham, John C., & Iorio, Daniela. (2011). Race, Social Class, and Bulimia Nervosa. IZA Discussion Paper No. 5823. Retrieved from http://ftp.iza.org/dp5823.pdf.

- From 1999 to 2009, the number of men hospitalized for an eating disorder-related cause increased by 53%.

Zhao, Y., Encinosa, W. Update on Hospitalizations for Eating Disorders, 1999 to 2009. HCUP Statistical Brief #120. September, 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb120.pdf

- A 2014 study found that rates of disordered eating have increased across all demographic sectors, but at a faster rate in male, lower socioeconomic, and older participants.

Mitchison, D., Hay, P., Slewa-Younan, S., & Mond, J. (2014). The changing demographic profile of eating disorder behaviors in the community. BMC Public Health, 14(1). doi:10.1186/1471-2458-14-943

- In a survey of college students, transgender students were significantly more likely than members of any other group to report an eating disorder diagnosis in the past year.

Diemer, E. W., Grant, J. D., Munn-Chernoff, M. A., Patterson, D. A., & Duncan, A. E. (2015). Gender Identity, Sexual Orientation, and Eating-Related Pathology in a National Sample of College Students. Journal of Adolescent Health, 57(2), 144-149. doi:10.1016/j.jadohealth.2015.03.003

- A study of 2,822 students on a large university campus found that 3.6% of males had positive screens for eating disorders. The female-to-male ratio was 3-to-1.

Eisenberg, D., Nicklett, E. J., Roeder, K., & Kirz, N. E. (2011). Eating Disorder Symptoms Among College Students: Prevalence, Persistence, Correlates, and Treatment-Seeking. Journal of American College Health, 59(8), 700-707. doi:10.1080/07448481.2010.546461

- Subclinical eating disordered behaviors are nearly as common among males as they are among females.

Mond, J.M., Mitchison, D., & Hay, P. (2014) "Prevalence and implications of eating disordered behavior in men" in Cohn, L., Lemberg, R. (2014) Current Findings on Males with Eating Disorders. Philadelphia, PA: Routledge.

- There were no significant differences between heterosexual women and lesbians and bisexual women in the prevalence of any of the eating disorders.

Ray, Nicholas. 2007. Gay, Lesbian, Bisexual and Transgender Youth: An Epidemic of Homelessness. National Gay and Lesbian Task Force and National Coalition for the Homeless.

- When presented with identical case studies demonstrating disordered eating symptoms in white, Hispanic and African-American women, clinicians were asked to identify if the woman's eating behavior was problematic. 44% identified the white woman's behavior as problematic; 41% identified the Hispanic woman's behavior as problematic, and only 17% identified the black woman's behavior as problematic. The clinicians were also less likely to recommend that the African-American woman should receive professional help.

Gordon, K. H., Brattole, M. M., Wingate, L. R., & Joiner, T. E. (2006). The Impact of Client Race on Clinician Detection of Eating Disorders. Behavior Therapy, 37(4), 319-325. doi:10.1016/j.beth.2005.12.002.

MEDIA

- According to The Nielsen Company, a U.S.-based global marketing and research firm that tracks media habits and trends worldwide, the average American

spends more than 11 hours a day using media—that is more than the average time spent sleeping or working each day.

- Among American youth ages 8-18, media are an ever-increasingly large part of their daily routines, fueled by the growing availability of internet-enabled mobile devices, which accounts for almost half of all their screen time. Teens ages 13-18 spend an average of 9 hours a day and tweens ages 8-12 average 6 hours a day using entertainment media. These amounts vary by race, income, and gender, and do not include using media in school or doing homework (Common Sense Media Inc., 2015).
- Teens and tweens use media for a variety of activities and have different favorites depending on their gender – boys like to play video games, and girls prefer using social media.
- According to the Dove Global Beauty and Confidence Report, 10,500 women and girls in 13 countries and found that beauty and appearance anxiety continue to be critical global issues and media are a key factor driving their concerns.
    - Approximately 7 in 10 women and girls report a decline in body confidence and increase in beauty and appearance anxiety, which they say is driven by the pressure for perfection from media and advertising’s unrealistic standard of beauty.
    - Almost 8 in 10 girls (79%) and even more women (85%) admit to opting out of important events in their lives when they don’t feel they look their best.
    - Nine out of 10 women say they will actually not eat and risk putting their health at stake when they feel bad about their body image. And 7 in 10 girls said they're more likely to be less assertive in their decisions when they're feeling insecure.
    - To counteract these unreal messages, a majority of women and girls around the globe are challenging media to portray more diverse physical appearances, age, race, body shapes, and sizes.

- In a study on social media, nearly all girls (95%) say they see the onslaught of negative beauty critiques on social media posts, comments, photos, and videos, and a majority see them at least once a week (72%) and wish social media were a space that empowered body positivity (62%).
- According to Common Sense Media, 41% of teen girls say the use social media to “make themselves look cooler.” Teens feel pressure to look good and cool online, but also feel social media helps their friendships and connections.
- One study of teen girls found that social media users were significantly more likely than non-social media users to have internalized a drive for thinness and to engage in body surveillance.
- Another study found social media use is linked to self-objectification, and using social media for merely 30 minutes a day can change the way you view your own body.

Statista, 2015

CommonSense Media, 2015

Perloff, R. M. 2014. Social Media Effects on Young Women’s Body Image Concerns: Theoretical Perspectives and an Agenda for Research. Sex Roles, DOI 10.1007/s11199-014-0384-6.

Tiggemann, M., & Slater, A. (2013). NetGirls: The Internet, Facebook, and body image concern in adolescent girls. International Journal of Eating Disorders, 46, 630–633. doi:10.1002/eat.22141.

Fardouly, J., Diedrichs, P. C., Vartanian, L. R., & Halliwell, E. (2015). Social comparisons on social media: The impact of Facebook on young women’s body image concerns and mood. Body Image, 13, 38–45. doi:10.1016/j.bodyim.2014.12. 002

Fardouly, J., & Vartanian, L. R. (2015). Negative comparisons about one’s appearance mediate the relationship between Facebook usage and body image concerns. Body Image, 12, 82–88. doi: 10.1016/j.bodyim.2014.10.004

MEN

- From 1999 to 2009, the number of men hospitalized for an eating disorder-related cause increased by 53%.

Zhao, Y., Encinosa, W. Update on Hospitalizations for Eating Disorders, 1999 to 2009. HCUP Statistical Brief #120. September, 2011. Agency for Healthcare Research and Quality, Rockville,

MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb120.pdf

- The most widely-quoted study estimates that males have a lifetime prevalence of .3% for anorexia nervosa (AN), .5% for bulimia nervosa (BN) and 2% for binge eating disorder (BED). These figures correspond to males representing 25% of individuals with AN and BN and 36% of those with BED. They are based on DSM-IV criteria.

Hudson, J., Hiripi, E., Pope, H., & Kessler, R. (2007) "The prevalence and correlates of eating disorders in the national comorbidity survey replication." Biological Psychiatry, 61, 348–358.

- In a study of 1,383 adolescents, the prevalence of any DSM-5 ED in males was reported to be 1.2% at 14 years, 2.6% at 17 years, and 2.9% at 20 years.

Allen, K., Byme, S., Oddy, W., & Crosby, R. (2013) "DSM-IV-TR and DSM5 eating disorders in adolescents: prevalence, stability, and psychosocial correlates in a population-based sample of male and female adolescents." Journal of Abnormal Psychology, 122, 720-732.

- A study of 2,822 students on a large university campus found that 3.6% of males had positive screens for ED. The female-to-male ratio was 3-to-1.

Eisenberg, D., Nicklett, E., Roeder, K., & Kirz, N. (2011) "Eating disorders Symptoms Among College Students: Prevalence, Persistence, Correlates, and Treatment-Seeking." Journal of American College Health, 59-8, 700-707.

- In looking at male sexuality and eating disorders, higher percentage of gay (15%) than heterosexual males (5%) had diagnoses of ED but when these percentages are applied to population figures, the majority of males with ED are heterosexual.

Feldman, M., Meyer, I. (2007) "Eating disorders in diverse, lesbian, gay, and bisexual populations." International Journal of Eating Disorders, 40-3, 218-226.

- Subclinical eating disordered behaviors (including binge eating, purging, laxative abuse and fasting for weight loss) are nearly as common among males as they are among females.

Mitchison, D., Hay, P., Slewa-Younan, S., & Mond, J. (2014). The changing demographic profile of eating disorder behaviors in the community. BMC Public Health, 14(1). doi:10.1186/1471-2458-14-943

- Various studies suggest that risk of mortality for males with ED is higher than it is for females.

Raevuoni, A., Keski-Rahkonen, Hoek, H. (2014) "A review of eating disorders in males." Current Opinions on Psychiatry, 27-6, 426-430.

- Men with eating disorders often suffer from comorbid conditions such as depression, excessive exercise, substance disorders, and anxiety.

Weltzin, T. Carlson, T., et al. (2014) "Treatment Issues and Outcomes for Males with Eating Disorders" in Cohn, Lemberg.

- A gender-sensitive approach with recognition of different needs and dynamics for males is critical in effective treatment. Males in treatment can feel out of place when predominantly surrounded by females, and an all-male treatment environment is recommended—when possible.

Weltzin, T. Carlson, T., et al. (2014) "Treatment Issues and Outcomes for Males with Eating Disorders" in Cohn, Lemberg.

Bunnell, D. & Maine, M. (2014) "Understanding and treating males with eating disorders" in Cohn, Lemberg.

MORTALITY

- Eating disorders are serious conditions that can have a profound mental and physical impact, including death. This should not discourage anyone struggling—recovery is real, and treatment is available. Statistics on mortality and eating disorders underscore the impact of these disorders and the importance of treatment.
- Eating disorders have the second highest mortality rate of all mental health disorders, surpassed only by opioid addiction.

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry, 13(2), 153-160.

- Anorexia has an estimated mortality rate of around 10%.

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with Anorexia Nervosa and other eating disorders. Archives of General Psychiatry, 68(7), 724-731.

- Among those who struggle with anorexia, 1 in 5 deaths is by suicide
- A Swedish study of 6,000 women who were treated for anorexia nervosa found that, over 30 years, women with anorexia nervosa had a six-fold increase in mortality compared to the general population. The researchers also found an increased mortality rate from 'natural' causes, such as cancer, compared to the general population. Younger age and longer initial hospitalizations were associated with improved outcomes, while comorbid conditions (e.g., alcohol addiction) worsened the outcome.

Papadopoulos, F. C., A. Ekbom, L. Brandt, and L. Ekselius. "Excess Mortality, Causes of Death and Prognostic Factors in Anorexia Nervosa." The British Journal of Psychiatry 194.1 (2008): 10-17.

- Researchers studied records of 1,885 individuals evaluated for anorexia nervosa, bulimia nervosa, and EDNOS at the University of Minnesota outpatient clinic, over 8-25 years. Researchers found an increased risk of suicide for all eating disorders studied. Crude mortality rates were 4% for anorexia nervosa; 3.9% for bulimia nervosa; and 5.2% for EDNOS, now recognized as OSFED.

Crow, S. J., Peterson, C. B., Swanson, S. A., Raymond, N. C., Specker, S., Eckert, E. D., & Mitchell, J. E. (2009). Increased mortality in bulimia nervosa and other eating disorders. American Journal of Psychiatry, 166(12), 1342-1346. DOI: 10.1176/appi.ajp.2009.09020247

For further reading:

Brown, CA and Mehler, PS. Medical complications of self-induced vomiting. Eating Disorders. 2013;21(4):287-94.

Brown, CA and Mehler, PS. Successful “Detoxing” From Commonly Utilized Modes of Purging in Bulimia Nervosa. Eating Disorders. 2012; 20(4): 312-20.

Insel, Thomas. "Post by Former NIMH Director Thomas Insel: Spotlight on Eating Disorders."National Institute of Mental Health. U.S. Department of Health and Human Services, 24 Feb. 2012.

Mehler, PS and AE Anderson. Eating Disorders. Baltimore: Johns Hopkins UP, 2010. Print.

Mitchell, J. E., & Crow, S. (2006). Medical complications of anorexia nervosa and bulimia nervosa. Current Opinion in Psychiatry, 19(4), 438-443.

PICA

- Between 4%-26% of institutionalized individuals are believed to have Pica.

Walke. C. E., Michael C. R.(2001), Handbook of Clinical Child Psychology, John Wiley and sons, 3ed edition 692-713.

SUBSTANCE ABUSE

- According to the National Center on Addiction and Substance Abuse, up to 50% of individuals with eating disorders abused alcohol or illicit drugs, a rate five times higher than the general population.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Up to 35% of individuals who abused or were dependent on alcohol or other drugs have also had eating disorders, a rate 11 times greater than the general population.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- The substances most frequently abused by individuals with eating disorders or with sub-clinical symptoms of these disorders include: caffeine, tobacco, alcohol, laxatives, emetics, diuretics, appetite suppressants (amphetamines), heroin, and cocaine.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- In a study looking at calorie restriction prior to alcohol consumption in college freshmen, 14% of the subjects reported restriction calories, with 6% reporting the behavior to avoid weight gain and 10% to enhance alcohol's effect.

Burke, S. C., Cremeens, J., Vail-Smith, K., & Woolsey, C. L. (2010). Drunkorexia: Calorie restriction prior to alcohol consumption among college freshman. Journal of Alcohol and Drug Education, 54(2), 17-35.

- Women with bulimia who were alcohol-dependent reported a higher rate of suicide attempts, anxiety, personality and conduct disorders and other drug dependence than women with bulimia who were not alcohol-dependent.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Eating disorders and substance abuse share a number of common risk factors, including brain chemistry, family history, low self-esteem, depression, anxiety, and social pressures. Other shared characteristics include compulsive behavior, social isolation, and risk for suicide.

The National Center on Addiction and Substance Abuse (CASA) at Columbia University. Food for Thought: Substance Abuse and Eating Disorders. The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York: 2003.

- Roughly 20% of men and women being treated for substance use disorders reported binge eating.

Grilo CM, Sinha R, O'Malley SS. Eating disorders and alcohol use disorders. Alc Res Health.2002;26:151–160.

- 24.8% of binge eating disorder sufferers have also struggled with a substance use disorder. Of men with BED, 40.4% report having struggled with a substance use disorder.

Schreiber, L. R., Odlaug, B. L., & Grant, J. E. (2013). The overlap between binge eating disorder and substance use disorders: Diagnosis and neurobiology. Journal of Behavioral Addictions, 2(4), 191-198. doi:10.1556/jba.2.2013.015

- In a study of women with bulimia nervosa, 31% had a history of alcohol abuse and 13% had a history of alcohol dependence.

Gregorowski, C., Seedat, S., & Jordaan, G. P. (2013). A clinical approach to the assessment and management of co-morbid eating disorders and substance use disorders. BMC Psychiatry, 13(1). doi:10.1186/1471-244x-13-289

- 25% of people with anorexia, 34% of people with bulimia, and 21% of people with binge eating disorder abuse or are dependent on alcohol.

Hudson J.I., Hiripi E., Pope H.G., Kessler R.C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biol Psychiatry, 61(3), 348-358.

Milos, G., Spindler, A., Buddeberg, C., & Crameri, A. (2003). Axes I and II comorbidity and treatment experiences in eating disorder subjects. Psychother and Psychosom, 72(5), 276-285.

Ulfvebrand, S., Birgegard, A., Norring, C., Hogdahl, L., & von Hausswolff-Juhlin, Y. (2015). Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. Psychiatry Res, 230(2), 294-299.

- 27% of people with anorexia, 37% of people with bulimia, and 23% of people with binge eating disorder abuse or are dependent on other substances.

Hudson J.I., Hiripi E., Pope H.G., Kessler R.C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biol Psychiatry, 61(3), 348-358.

Milos, G., Spindler, A., Buddeberg, C., & Crameri, A. (2003). Axes I and II comorbidity and treatment experiences in eating disorder subjects. Psychother and Psychosom, 72(5), 276-285.

Ulfvebrand, S., Birgegard, A., Norring, C., Hogdahl, L., & von Hausswolff-Juhlin, Y. (2015). Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. Psychiatry Res, 230(2), 294-299.

TRAUMA/PTSD

- What is “traumatic” to any given individual is best understood in light of the “three E’s,” i.e., Event, Experience, and Effects
- Available evidence suggests that eating disorder patients may be particularly sensitive or vulnerable to stress and its consequences.

- PTSD symptoms include (American Psychiatric Association, 2013): Re-experiencing symptoms (e.g., flashbacks, nightmares, intrusive imagery)
    - Hyperarousal symptoms (e.g., irritability or angry outbursts, exaggerated startle, problems concentrating, insomnia, being overly watchful and anxious)
    - Avoidance symptoms (e.g., numbing, forgetting and avoiding trauma-related material)
    - Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred (e.g., partial amnesia, negative beliefs about oneself, others, or the world, self-blame, constantly expecting the worst)
- Over one-third of individuals with an index episode of PTSD still had the full syndrome 10 years later.
- Unresolved trauma and/or PTSD can be an important perpetuating factor in the maintenance of symptoms.

Brewerton, T. D., & Dennis, A. B. (2015). Perpetuating factors in severe and enduring anorexia nervosa. In S. Touyz, P. Hay, D. Le Grange, & J. H. Lacey (Eds.), Managing Severe and Enduring Anorexia Nervosa: A Clinician's Handbook. New York: Routledge.

- Two major national representative studies have shown that individuals with bulimia nervosa, binge eating disorder or any binge eating have significantly higher rates of PTSD than individuals without an eating disorder. The highest rates of lifetime PTSD were 38% and 44% respectively in the BN groups. When partial or subclinical forms of PTSD are considered, then well over half of individuals with bulimic symptoms have PTSD or significant PTSD symptoms. In addition, traumatized people with eating disorders demonstrate high levels of dissociative symptoms, such as amnesia of traumatic material (being unable to remember the traumatic event), which are also factors that contribute to a negative medical.
- When partial or subclinical forms of PTSD are considered, then well over half of individuals with bulimic symptoms have PTSD or significant PTSD symptoms.
- In much the same way abuse of certain substances is used to self-medicate, binge eating and/or purging appear to be behaviors that facilitate:
    - Reducing the hyperarousal or anxiety associated with trauma
    - The numbing, avoidance, and even forgetting of traumatic experiences

These behaviors are reinforcing, making it difficult to break the cycle. As a result, traumatic experiences and their destructive effects are not effectively processed and continue to cause problems.

- Individuals with an eating disorder complicated by trauma and PTSD require treatment for both conditions using a trauma-informed, integrated approach.
- Although the best approach to address PTSD in the context of an eating disorder remains elusive, work so far has focused primarily on cognitive processing therapy (CPT) integrated with traditional treatment for the eating disorder.
- Future research is likely to shed light on how best to treat this comorbid combination.
- Unresolved trauma and/or posttraumatic stress disorder (PTSD) can be an important perpetuating factor in the maintenance of eating disorders symptoms.
- Binge eating and/or purging appear to be behaviors that facilitate reducing the hyperarousal or anxiety associated with trauma, and the numbing, avoidance, and even forgetting of traumatic experiences. These behaviors are reinforcing, making it difficult to break the cycle. As a result, traumatic experiences and their destructive effects are not effectively processed and continue to cause problems.

Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: focus on PTSD. Eat Disord, 15(4), 285-304. doi:10.1080/10640260701454311

- Individuals with bulimia nervosa, binge eating disorder, or any binge eating have significantly higher rates of PTSD than individuals without an eating disorder. Two major national representative studies found high rates of lifetime PTSD—38% and 44%—in those with bulimia nervosa.

Dansky, B. S., Brewerton, T. D., O'Neil, P. M., & Kilpatrick, D. G. (1997). The National Womens Study: Relationship of victimization and posttraumatic stress disorder to bulimia nervosa. International Journal of Eating Disorders, 21, 213-228.

Hudson, J. I., Hiripi, E., Pope, H. G., Jr., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biol Psychiatry, 61(3), 348-358. doi:10.1016/j.biopsych.2006.03.040

- When partial or subclinical forms of PTSD are considered, well over half of individuals with bulimic symptoms have PTSD or significant PTSD symptoms.

Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: focus on PTSD. Eat Disord, 15(4), 285-304. doi:10.1080/10640260701454311

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D., & Smith, B. N. (2012). Comorbidity of partial and subthreshold ptsd among men and women with eating disorders in the national comorbidity survey-replication study. Int J Eat Disord, 45(3), 307-315. doi:10.1002/eat.20965

- Traumatized people with eating disorders demonstrate high levels of dissociative symptoms, such as being unable to remember the traumatic event.

Brewerton, T. D. (2004). Eating disorders, victimization, and comorbidity: Principles of treatment. In T. D. Brewerton (Ed.), Clinical Handbook of Eating Disorders: An Integrated Approach (pp. 509-545). New York: Marcel Decker.

Brewerton, T. D., Dansky, B. S., Kilpatrick, D. G., & O'Neil, P. M. (1999). Bulimia nervosa, PTSD, and forgetting results from the National Women's Study. In L. M. Williams & V. L. Banyard (Eds.), Trauma and Memory (pp. 127-138). Durham: Sage.

- Individuals with an eating disorder complicated by trauma and PTSD require treatment for both conditions using a trauma-informed, integrated approach. Although the best approach to address PTSD in the context of an eating disorder remains elusive, work so far has focused primarily on cognitive processing therapy (CPT) integrated with traditional treatment for the eating disorder.

Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: focus on PTSD. Eat Disord, 15(4), 285-304. doi:10.1080/10640260701454311

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D., & Smith, B. N. (2012). Comorbidity of partial and subthreshold ptsd among men and women with eating disorders in the national comorbidity survey-replication study. Int J Eat Disord, 45(3), 307-315. doi:10.1002/eat.20965

Brewerton, T. D. (2004). Eating disorders, victimization, and comorbidity: Principles of treatment. In T. D. Brewerton (Ed.), Clinical Handbook of Eating Disorders: An Integrated Approach (pp. 509-545). New York: Marcel Decker.

SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. (14-4884). Rockville, MD: U.S. Department of Health and Human Services.

- Researchers found that women who were victims of assault were 1.86x more likely to develop bulimia than those who had not been victimized (26% v. 13.3%).

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D., & Smith, B. N. (2012). Comorbidity of partial and subthreshold ptsd among men and women with eating disorders in the national comorbidity survey-replication study. Int J Eat Disord, 45(3), 307-315. doi:10.1002/eat.20965

Brewerton, T. D., Dansky, B. S., Kilpatrick, D. G., & O'Neil, P. M. (1999). Bulimia nervosa, PTSD, and forgetting results from the National Women's Study. In L. M. Williams & V. L. Banyard (Eds.), Trauma and Memory (pp. 127-138). Durham: Sage.

- One study of veterans showed that military sexual trauma lead to nearly a two-fold increased likelihood of eating disorder diagnoses, especially amongst male veterans.

Blais RK, Brignone E, Maguen S, Carter ME, Fargo JD, Gundlapalli AV. Military sexual trauma is associated with post-deployment eating disorders among Afghanistan and Iraq veterans. Int J Eat Disord. 2017; 50:808-816. https://doi.org/10.1002/eat.22705

- According to one study, the majority of individuals with anorexia nervosa, bulimia nervosa, and binge eating disorder reported a history of interpersonal trauma. Rates of PTSD were significantly higher among women and men with bulimia nervosa and binge eating disorder. Subthreshold PTSD was more prevalent than threshold PTSD among women with bulimia nervosa and men with binge eating disorder.

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D., & Smith, B. N. (2012). Comorbidity of partial and subthreshold PTSD among men and women with eating disorders in the national comorbidity survey - replication study. International Journal of Eating Disorders, 45(3), 307-315.

- The National Institutes of Health (NIH) 2017 budget for PTSD research was $93 million, compared to $30 million for all eating disorders research.

NIH Categorical Spending -NIH Research Portfolio Online Reporting Tools (RePORT)." U.S National Library of Medicine. U.S. National Library of Medicine, 3 Jul. 2017. Web. 11 Jan. 2018.

- According to one study, rates of sexual violence were up to 48% of females & 68% of males with anorexia nervosa, up to 41% of females & 24% of males with bulimia nervosa, and up to 35% of females & 16% of males with binge eating disorder.

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For further reading:

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To use the NEDA screening tool, please click on this link: https://www.nationaleatingdisorders.org/screening-tool

To pursue further learning from NEDA look at their CME course here: https://www.nationaleatingdisorders.org/cme-course-physician-assistants

Conclusion

As shown, eating disorders are a very serious problem which affects the complete biopsychosocial system of an individual, and their loved ones. This course provided many way to assist those suffering from these difficulties.

End of the Course!