EATING DISORDERS

Abstract:

Eating disorders are serious illnesses that can become fatal. These disorders are associated with severe disturbances in thoughts, emotions, and preoccupations surrounding food, body weight, and physical appearance. There is often a misconception that eating disorders are a lifestyle choice rather than a serious illness. Anorexia nervosa, bulimia nervosa, binge-eating, and avoidant restrictive food intake disorder are among the most common eating disorders. Separating the person from the illness, called externalization, can be helpful by looking at the illness as the problem and the individual as the solution. Caring for someone with an eating disorder can be challenging but the more you know about eating disorders and truly understand eating disorders the easier it will be.

Learning Objectives:

1. Know the most common eating disorders.
2. Understand the risk factors associated with eating disorders.
3. Identify the treatments and therapies for eating disorders.
4. Know how to care for someone with an eating disorder.

Introduction

Eating disorders are serious mental health disorders. These disorders involve the consumption of much more or much less food than needed. These disorders disrupt the body's ability to obtain appropriate nutrition due to severe problems with thoughts and behaviors surrounding food. Eating disorders can affect the body's natural processes by disrupting electrolyte balances, creating deficiencies in needed minerals and vitamins, and can lead to issues with the heart, kidneys, and other vital processes. Eating disorders can possibly even lead to death. Eating disorders should not be disregarded as a phase or something someone will grow out of. Eating disorders are seriously disturbed thought processes and need to be addressed and treated when they first present themselves.

Types of Eating Disorders

According to the National Institute of Health, there are four primary classifications of eating disorders. There are subclasses that will be touched on briefly. Listed below are the four most common:

1. anorexia nervosa
2. bulimia nervosa
3. binge-eating disorder
4. avoidant restrictive food intake disorder

Anorexia Nervosa

Anorexia nervosa is a condition where food is avoided, severely restricted, or small quantities of only certain types of foods are consumed. These clients weigh themselves repeatedly, have a fear of gaining weight, and suffer from a distorted body image. Even when these clients are severely underweight, they may see themselves as overweight. There are two subtypes of anorexia nervosa:

Restrictive:

Clients with the restrictive subtype of anorexia nervosa severely limit the amount and type of food they consume. This could include counting

calories, skipping meals, restricting certain foods (such as all carbohydrates), and following obsessive rules, such as only eating foods of a certain color or appearance.

Binge-Purge:

Clients with the binge-purge subtype of anorexia nervosa also greatly restrict the amount and type of food they consume but may have binge-eating and purging episodes. Hallmarks of a binge eating episode include feeling out of control while eating a large amount of food; purging behavior's hallmarks are engaging in compensatory behavior after eating that may involve misusing enemas, laxatives, and/or diuretics, and/or self-inducing vomiting.

Anorexia can have numerous complications. At its most severe, it can be fatal. Death may occur suddenly, even when someone is not severely underweight. This may result from abnormal heart rhythms (arrhythmias) or an imbalance of electrolytes and minerals such as sodium, potassium, and calcium that maintain the balance of fluids in your body. Other complications of anorexia include:

1. anemia
2. heart problems
    a. mitral valve prolapse
    b. abnormal heart rhythms
    c. heart failure
3. bone loss (osteoporosis)
    a. risk of fractures
4. loss of muscle
5. in females, the absence of a period
6. in males, decreased testosterone
7. gastrointestinal problems
    a. constipation

b. bloating
c. nausea

8. electrolyte abnormalities
    a. low blood potassium
        i. constipation
        ii. feeling of skipped heartbeats or palpitations
        iii. fatigue
        iv. muscle damage
        v. muscle weakness or spasms
        vi. tingling or numbness
    b. low blood sodium
        i. nausea and vomiting
        ii. headache
        iii. confusion
        iv. loss of energy, drowsiness, and fatigue
        v. restlessness and irritability
        vi. muscle weakness, spasms, or cramps
        vii. seizures
        viii. coma
    c. low blood chloride
        i. fluid loss
        ii. dehydration
        iii. weakness or fatigue
        iv. difficulty breathing
        v. diarrhea or vomiting, caused by fluid loss

9. kidney problems

Anorexia nervosa can be fatal. It has an extremely high death (mortality) rate compared with other mental disorders. The mortality rate recovered from 42 published studies from The American Journal of Psychiatry, estimated the mortality associated with anorexia nervosa in these studies was 5.9% (178 deaths in 3,006 subjects). Clients with anorexia are at risk of dying from medical complications associated with starvation. Suicide is the second leading cause of death for people diagnosed with anorexia nervosa.

Bulimia Nervosa

Bulimia nervosa is a condition where clients consume large amounts of food frequently and do this on a current basis. These clients feel a lack of control over their behavior when it comes to consuming large amounts of food in short periods of time. This binge-eating is followed by behaviors that try to compensate for their lack of control surrounding food. These clients may force themselves to vomit, utilize excessive laxatives or diuretics, begin a period of fasting, begin to excessively exercise, or a combination of any or all these behaviors. Because some of the nutrients entered the body some absorption may have likely occurred, and therefore they are at a normal weight, slightly overweight, or possibly even underweight.

Untreated bulimia can lead to severe health issues and can become life threatening. Binge-eating and purging can harm the entire body and cause effects such as:

Cardiovascular:

1. irregular heartbeat (arrhythmia)
2. low blood pressure
3. heart failure

Gastrointestinal:

1. esophageal damage
2. pancreatitis

3. constipation
4. bowel obstruction
5. low blood sugar

Endocrine:

1. anemia
2. menstrual irregularities
3. bone loss (osteoporosis)
4. insulin resistance (which can lead to type 2 diabetes)
5. kidney failure

Neurological:

1. problems focusing and concentrating
2. seizures
3. sleep disorders and sleep apnea
4. stroke

Binge-eating Disorder

Binge-eating disorder occurs when clients lose control over the amount of food they are eating and have recurring episodes of eating unusually large amounts of food. Contrary to bulimia nervosa, periods of binge-eating do not follow the pattern of vomiting/purging, excessive exercise, or restrictive fasting. The result is clients with binge-eating disorder often are overweight or obese. Binge-eating disorder is the most common eating disorder in the U.S. Health risks associated with binge-eating disorder are:

1. weight gain/obesity
2. hypertension
3. high cholesterol
4. heart disease

5. type II Diabetes Mellitus
6. emotional and mental distress

Avoidant Restrictive Food Intake Disorder (ARFID)

Avoidant restrictive food intake disorder (ARFID), which was previously known as selective eating disorder, is a condition where clients limit the amount or type of food eaten. Unlike anorexia nervosa, clients with ARFID do not have an extreme fear of gaining weight or a distorted body image. ARFID usually has an earlier onset than other eating disorders and may begin anywhere from ages 6-12 years of age. Many children go through phases of picky eating, but this is not considered ARFID. A child with the diagnosis of ARFID does not eat enough calories to grow and develop properly. This could have serious consequences later in life. Adults diagnosed with ARFID do not eat enough calories to maintain basic body function such as immune function to prevent sickness. Because both anorexia nervosa and ARFID involve an inability to meet nutritional needs, both disorders have similar physical signs and medical consequences.

Dramatic restriction in types or amount of food eaten may involve only eating certain textures of food and or a lack of appetite or interest in food. There can be such a limited range of preferred foods that becomes narrower over time (picky eating that becomes progressively worse). There may also be fear associated with choking on food or the fear of vomiting food. Health conditions associated with ARFID are:

1. anemia
2. insomnia
3. impaired immune function
4. heart problems
    a. abnormal heart rhythms
5. bone loss (osteoporosis)
    a. risk of fractures

6. loss of muscle
    a. muscle weakness
7. in females, the absence of a period
8. in males, decreased testosterone
9. gastrointestinal problems
    a. constipation
    b. bloating
    c. nausea
    d. acid reflux
    e. abdominal pain
10. electrolyte abnormalities
    f. dizziness
    g. syncope

Other less known or less common eating disorders are listed below:

PICA

Some of the most commonly described types of picas are eating earth, soil, or clay (geophagia); ice (pagophagia); and starch (amylophagia). However, pica involving dozens of other substances, including cigarette butts and ashes, hair, paint chips, and paper have also been reported.

Clients with pica tend to eat nonfood substances that carry no nutritional value. This is quite common for children under the age of 2 to put non-edible objects in their mouth but this is quite different. The types of substances ingested depend on the client, their age, and their environment. Some things clients with pica commonly eat include:

1. chalk
2. soap

3. paint chips
4. clay

Common contributing factors for pica include:

1. mental or developmental disorders
2. childhood trauma
3. neglect
4. living in an under-resourced community
5. pregnancy
6. autism spectrum disorder (ASD)
7. iron deficiency
8. anemia

When Pica is long term it can result in bowel obstruction, bezoars (hard, packed partially digested food), and even toxicity. Ingestion of dirt and paint can lead to infections and heavy metal poisoning.

Clients with pica may also have a higher risk of:

1. nutritional deficiencies (malnutrition)
2. vitamin deficiencies
3. electrolyte imbalances
4. dehydration

The digestive system may also be seriously impacted by pica. When the body cannot break down nonfood substances, it can lead to injuries that may be life threatening in some cases, such as:

1. constipation
2. bowel obstruction (blockage)
3. perforation of the intestines

Rumination Disorder

Rumination disorder is repeatedly regurgitating recently eaten food. This is normally followed by spitting out, rechewing, or swallowing the contents. Clients who have rumination disorder do not normally experience nausea, involuntary vomiting urges, or feelings of disgust. Rumination disorder can be diagnosed in infants, children, and adults. There is very little awareness about the disorder because many times the condition is overlooked or misdiagnosed.

Clients with rumination disorder may avoid eating with others. They may cover their mouth and pretend to cough when regurgitating food. Even though rumination disorder could be seen as rude or socially inappropriate, those suffering from it are typically unable to resist the urge to regurgitate their food. Research has discovered a link between this eating disorder and neglect, stress, and lack of stimulation. Malnutrition or esophageal damage could occur if this disorder is not treated.

Purging disorder

Clients with purging disorder often use purging behaviors, such as vomiting, laxatives, diuretics, or excessive exercising, to control their weight or size. However, these clients do not binge eat. Purging disorders can lead to:

1. fainting
2. tooth decay
3. swollen throat
4. mood swings
5. irregular heartbeat and other heart problems
6. scarred hands (forcing fingers down the throat)
7. kidney failure
8. digestive issues or constipation

9. dehydration
10. nutrient deficiencies
11. electrolyte or chemical imbalances

Night Eating Syndrome (NES)

Clients with this syndrome frequently eat excessively at night, often after awakening from sleep. Clients with this syndrome normally eat one-fourth of their daily calories with dinner and rarely have an appetite in the morning. This disorder is linked to obesity which in turn is linked to many medical conditions such as heart disease, hypertension, and diabetes.

Other Specified Feeding or Eating Disorder (OSFED)

While it is not found in the DSM-5, this category includes any other conditions that have symptoms similar to those of an eating disorder but don't fit any of the disorders above.

Symptoms Associated with Eating Disorders

Anorexia Nervosa

Symptoms include:

1. extremely restricted eating
2. extreme thinness (emaciation)
3. a relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight
4. intense fear of gaining weight
5. 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:

1. thinning of the bones (osteopenia or osteoporosis)
2. mild anemia and muscle wasting and weakness
3. brittle hair and nails
4. dry and yellowish skin
5. growth of fine hair all over the body (lanugo)
6. severe constipation
7. low blood pressure
8. slowed breathing and pulse
9. damage to the structure and function of the heart
10. brain damage
11. multi-organ failure
12. drop in internal body temperature, causing a person to feel cold
13. lethargy, sluggishness, or feeling tired all the time
14. infertility

Bulimia Nervosa

Symptoms include:

1. chronically inflamed and sore throat
2. swollen salivary glands in the neck and jaw area
3. worn tooth enamel and increasingly sensitive and decaying teeth as a result of exposure to stomach acid
4. acid reflux disorder and other gastrointestinal problems
5. intestinal distress and irritation from laxative abuse
6. severe dehydration from purging of fluids

7. electrolyte imbalance (too low or too high levels of sodium, calcium, potassium, and other minerals) which can lead to stroke or heart attack

Binge-eating Disorder

Symptoms include:

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

Avoidant Restrictive Food Intake Disorder (ARFID)

Symptoms include:

1. dramatic restriction of types or amount of food eaten
2. lack of appetite or interest in food
3. dramatic weight loss
4. upset stomach, abdominal pain, or other gastrointestinal issues with no other known cause
5. limited range of preferred foods that becomes even more limited (“picky eating” that gets progressively worse)

Sometimes, ARFID can be connected to sensory disorders as well as autism spectrum disorder (ASD). Clients with ARFID might limit their eating to avoid foods with certain features they might be sensitive to, such as:

1. colors
2. smells

3. tastes
4. textures

Pica

Symptoms of pica occur as a result of the toxic or poisonous content as well as the bacteria in nonfood items that are ingested. The symptoms may include:

1. nausea
2. pain or abdominal cramping in the stomach
3. constipation
4. diarrhea
5. fatigue
6. behavior problems

Rumination Disorder

Symptoms include:

1. repeated regurgitation of food
2. repeated re-chewing of food
3. weight loss
4. bad breath and tooth decay
5. repeated stomach aches and indigestion
6. raw and chapped lips

Risk Factors Associated with the Development of Eating Disorders

Eating disorders normally appear during the teen years and early adulthood but may occur in early childhood or even later in life. Anyone can develop an eating disorder, but they are more common in women. A woman who has a mother or a sister with bulimia is 4 times more likely to develop

bulimia as well. Brain imaging has also shown that women who have been diagnosed with an eating disorder have different brain activity than women who have healthy eating patterns.

Researchers believe that eating disorders are caused by a complex interaction of factors. These include genetic, biological, behavioral, psychological, and social factors. Eating disorders have been shown to run in families and have a genetic component. Research continues with an attempt to identify DNA variation to help recognize who is or could be at a higher risk for developing an eating disorder. According to the National Association of Anorexia Nervosa and Associated Disorders, eating disorders affect at least 9 percent of the world's population.

Many factors can contribute to eating disorders, including:

1. genetic predisposition
2. cultural pressures
3. how you manage food
4. trouble coping with stress
5. underlying mental health conditions
6. avoidance

Anorexia Nervosa

The exact cause of anorexia is unknown. As with many diseases, it's probably a combination of biological, psychological, and environmental factors.

Biological:

Although it's not yet clear which genes are involved, there may be genetic changes that make some people at higher risk of developing anorexia. Some people may have a genetic tendency toward perfectionism, sensitivity, and perseverance, all traits associated with anorexia.

Psychological:

Some people with anorexia may have obsessive-compulsive personality

traits that make it easier to stick to strict diets and forgo food despite being hungry. They may have an extreme drive for perfectionism, which causes them to think they're never thin enough. And they may have high levels of anxiety and engage in restrictive eating to reduce it.

Environmental:

Modern Western culture emphasizes thinness. Success and worth are often equated with being thin. Peer pressure may help fuel the desire to be thin, particularly among young girls.

Bulimia Nervosa

Bulimia nervosa, like other eating disorders, is multifactorial, meaning there are many causes that can contribute to this disease and they can include:

1. neurochemical imbalances
2. trauma or abuse
3. anxiety disorder
4. depression
5. substance abuse
6. feelings of inadequacy
7. experiencing early puberty
8. having too little to eat during childhood
9. psychiatric symptoms

Binge-eating Disorder

There are many factors that can contribute to binge-eating disorder which are listed below.

1. adverse childhood experiences
2. parental depression
3. vulnerability to obesity

4. repeated exposure to negative comments about shape, weight, and eating

Avoidant Restrictive Food Intake Disorder (ARFID)

ARFID usually has an earlier onset than other eating disorders and may begin anywhere from ages 6-12 years of age. This disorder could have occurred as a result of a traumatic event early in life or the sensitivity to textures, colors, or tastes. ARFID is not ingesting enough nutrients to sustain a healthy functioning body. Risk factors are listed below:

1. sensory sensitivity
2. lack of interest in eating or low appetite
3. traumatic experience with eating (choking, vomiting, or other forms of gastroenterological distress)

Pica

Pica Risk factors include:

1. pregnancy
2. malnutrition or other nutritional deficiencies
3. a family history of pica
4. poverty
5. trauma and/or neglect
6. a co-occurring mental disorder such as schizophrenia, autism spectrum disorder; or an intellectual disability

Rumination Disorder

The exact cause of rumination disorder is not known; however, there are several factors that may contribute to its development:

1. physical illness or severe stress may trigger the behavior
2. neglect of or an abnormal relationship between the child and the mother or other primary caregiver may cause the child to engage in self-comfort (act of chewing is comforting)

3. attention seeking behavior

Treatments and Therapies for Eating Disorders

It is important to seek treatment early for eating disorders. Clients with eating disorders are at higher risk for suicide and medical complications. Clients with eating disorders can often have other mental disorders (such as depression or anxiety) or problems with substance use. Complete recovery is possible.

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

1. individual, group, and/or family psychotherapy
2. medical care and monitoring
3. nutritional counseling
4. medications

Treatments for Anorexia

The first goal of treatment for anorexia nervosa is getting back to a healthy weight. If your life is in immediate danger, you may need treatment in a hospital emergency room for such issues as a heart rhythm disturbance, dehydration, electrolyte imbalances, or a psychiatric emergency.

You can't recover from anorexia without returning to a healthy weight and learning proper nutrition. Those involved in this process, the care team may include:

Care Team

1. *A primary care doctor (PCP)*
    a. provide medical care and supervise your calorie needs and weight gain
2. *A psychologist or other mental health professional*
    a. work with you to develop behavioral strategies to help you return to a healthy weight

3. *A dietitian*
    a. offer guidance on getting back to regular patterns of eating, including providing specific meal plans and calorie requirements that help you meet your weight goals
4. *Your family or close friends*
    a. will likely be involved in helping you maintain normal eating habits

Psychotherapy

These types of therapy may be beneficial for anorexia:

Family-based therapy

This is the only evidence-based treatment for teenagers with anorexia. Because the teenager with anorexia is unable to make good choices about eating and health while in the grips of this serious condition, this therapy mobilizes parents to help their child with re-feeding and weight restoration until the child can make good choices about health.

Individual therapy

For adults, cognitive behavioral therapy, specifically enhanced cognitive behavioral therapy, has been shown to help. The main goal is to normalize eating patterns and behaviors to support weight gain. The second goal is to help change distorted beliefs and thoughts that maintain restrictive eating.

Medications

1. antidepressants (depression)
2. anxiolytics (anxiety)
3. antipsychotics
4. mood stabilizers

Treatment challenges in anorexia

One of the biggest challenges in treating anorexia is that clients may

not want treatment. Barriers to treatment may include:

1. thinking they don't need treatment
2. fearing weight gain
3. not seeing anorexia as an illness but rather a lifestyle choice

Clients with anorexia can recover. However, they're at increased risk of relapse during periods of high stress or during triggering situations. Ongoing therapy or periodic appointments during times of stress are essential for continued success.

Treatments for Bulimia Nervosa

Psychotherapy

1. Individual, family, or group psychotherapy
    a. (emotional experiences and relationships that have contributed to the bulimia)
2. Behavior or cognitive therapies
    a. (altering habits)
3. Cognitive therapy
    a. (countering the negative thoughts)

Medications

1. Antidepressants
    a. Selective serotonin reuptake inhibitors (SSRIs), in combination with the above-mentioned psychological therapies

Alternative treatments for bulimia

Most alternative therapies for bulimia do not address the root causes of the disorder, but they can be helpful in relieving some of the physical distress resulting from it while working on the root cause.

1. acupuncture
2. biofeedback

Treatments for Binge-eating Disorder

Therapy and counseling

Therapies and counseling that are utilized for clients experiencing binge-eating disorder.

1. individual counseling
2. cognitive therapy
    a. changing thought process
3. behavioral therapy
    a. changing behavioral processes
4. family therapy
5. group therapy
6. nutrition counseling

Medications

1. lisdexamfetamine (Vyvanse)
    a. approved by the FDA
    b. central nervous system stimulant
2. topiramate (Topamax)
    a. an anticonvulsant drug used for the treatment of epilepsy and prophylaxis of migraine
3. antidepressants
    a. binge eating disorder and depression share a strong connection
    b. 50% of people who binge are either currently depressed or were depressed in the past

Treatments for Avoidant Restrictive Food Intake Disorder (ARFID)

Therapy

1. cognitive-behavioral therapy (CBD)

    a. efforts to change thinking patterns
    b. recognizing distortions in thinking that are creating problems
    c. reevaluate these distortions in light of reality
    d. gain a better understanding of the behavior and motivation
2. psychotherapy
    a. talk therapy
    b. identify and change troubling emotions, thoughts, and behavior
3. day treatment
    a. involves spending the day in treatment, and then going home in the evening to spend the night
    b. intensive outpatient programs
    c. increased independence
    d. exposure to the community and experiences that support them
4. intensive outpatient treatment
    a. program runs 3-5 days a week for 3-5 hours a day
    b. therapeutic groups
    c. meals and nutrition education
    d. offsite outings to practice skills of daily living
    e. meets with the therapist and nutritionist at least once a week for individual sessions

Medications

1. Cyproheptadine
    a. first-generation antihistamine with additional anticholinergic, anti-serotonergic, and local anesthetic properties
2. Mirtazapine
    a. Antidepressant

3. Lorazepam
    a. Benzodiazepine
    b. treat anxiety and sleeping problems that are related to anxiety
4. Olanzapine
    a. Helps restore neurotransmitters in the brain
    b. Helps clients to think more clearly and positively about themself, feel less agitated, and take a more active part in everyday life

Treatments for Pica

Therapy methods that are utilized for the possible recovery from pica include:

Therapy

1. Mild aversive therapy
    a. teaching clients to avoid pica behaviors using mild aversions (consequences)
    b. reinforcing (rewarding) healthy eating behaviors
2. Behavioral therapy
    a. teaching a client coping mechanisms and strategies to change their behavior
3. Differential reinforcement
    a. clients learn to avoid pica behaviors by focusing on other behaviors and activities

Medications

1. Antipsychotic medication
    a. Zyprexa

Treatment of Rumination Disorder

Psychologist

1. behavioral psychologist
    a. (Diaphragmatic breathing training)

Therapy

1. behavioral therapy
    a. notice the pattern and work to correct it

Medications

1. Not normally used

The National Eating Disorders Association (NEDA)

The NEDA Network is a partnership between NEDA (National Eating Disorders Association) and other organizations dedicated to advancing the field of eating disorders and building a community of support and hope. There are nearly 20 member organizations, the NEDA Network provides a unified voice in the fight against eating disorders. There are virtual and in person support group meetings across the entire United States. To find out more go to:

https://www.nationaleatingdisorders.org/neda-network-virtual-support-groups

The NEDA has a support hotline. You can reach the confidential eating disorder Helpline Monday through Thursday from 11 AM until 9 PM EST, and Friday from 11 AM until 5 PM EST. You can utilize the chat within the helpline Monday through Thursday from 9 AM until 9 PM EST, and from Friday 9 AM until 5 PM EST by going to:

https://www.nationaleatingdisorders.org/about-us

The NEDA offers a screening tool for anyone who believes they may be at risk or if they believe someone they are caring for could be at risk. If there is a risk for suicide or self-harm call 911 or the Crisis Call Center @ 1-800-273-8255 or text NEDA to 741741.

https://www.nationaleatingdisorders.org/help-support/contact-helpline

Every 52 minutes someone dies as a direct result of an eating disorder. 28.8 million Americans experience an eating disorder during their lifetime. And every February, NEDA has an awareness week called "SEE THE CHANGE, BE THE CHANGE."

How To Raise Concerns About an Eating Disorder

Friends and family are often the catalysts for encouraging someone with an eating disorder to seek help. The client with an eating disorder could be unaware that there is an actual problem, they may be afraid or ashamed to seek help, or they are refusing to give up eating disorder behaviors while you are caring for them.

It never seems easy to discuss an eating disorder, especially with someone you care about. However, many clients in recovery from an eating disorder say the support of family, friends, and caring health care professionals was critical to them getting well. If you are wanting to talk with someone about an eating disorder here are a few things to remember.

1. Set a private time and place to talk. No one wants to have personal issues dissected in front of a crowd or other clients. Make sure you find a time and place where you can discuss your concerns without being rushed or in front of others. If it is a current client with a diagnosis of an eating disorder it is important to follow HIPAA.
2. Use "I" statements. Focus on behaviors that you have personally observed, such as "I have noticed that you aren't eating your meals." It's easy to sound confrontational which can cause a client to feel defensive. Instead, point out what you've observed. If you can, also point out behaviors not related to eating and weight, which may be easier for the person to see and accept.
3. Rehearse what you want to say. This may help reduce your anxiety and clarify exactly what you want to say. Other people have found writing out their main points helpful.
4. Stick to the facts. Raising concerns about a potential eating disorder can

bring up lots of emotions, and it's important not to let emotions take over the conversation. Talk about behaviors and changes you have observed in a calm manner and why you are concerned ("I have seen you run to the bathroom after meals and that makes me worried you might be making yourself throw up").

5. Removing the potential stigma is so vitally important. Remind your client that there's no shame in admitting there is a struggle with an eating disorder or other mental health problem. Lots of people will be diagnosed with these issues during their lifetimes, and many will recover.

6. Avoid being overly simplistic. Being told "Just stop" or "Just eat" isn't helpful. It can leave the client feeling frustrated, defensive, and misunderstood.

7. Be prepared for negative reactions. Some eating disorder clients are glad that someone has noticed they are struggling but others may respond differently. Some clients may become angry and hostile, insisting that you are the one with the problem. Others may brush off your concerns or minimize potential dangers. Either of these responses are very normal. It is important to reiterate your concerns, let them know you care and leave the conversation open.

The client may not receive comments very well. It is still important to share these concerns, so they know they are cared for and you are there for them. Sometimes just planting a seed may encourage them to seek help or acknowledge they are not following their treatment plan. The seed may not take root immediately, but over time, the concern from others can help move a client toward recovery.

If you suspect a medical or psychiatric emergency, such as threats of suicide or medical complications from eating disorder behaviors (such as fainting, heart arrhythmias, or seizures), seek medical attention immediately.

Case Study

The following case study was taken from PubMed. The case is a 25-year-old female who has been married for 5 years. She completed school

through the 10 grade and is a homemaker without any children. She was born into a Hindu upper social class family and lives with her husband's family in Urban Bangalore. She presented for care for a gradual loss of weight, and repetitive episodes of emesis over the past 2 years. She is experiencing menstrual irregularities for 1 year and has had no menses during the past 6 months.

During the 5 years of marriage, she was reported as being dull and inactive. She was, however, able to carry out activities of daily living adequately.

With symptoms of weight loss and amenorrhea, she was evaluated by a physician. A series of labs and testing were conducted for suspected tuberculosis, anemia, and abdominal tumors. However, all these tests returned well within normal limits except for having low hemoglobin.

She was referred to a gastroenterologist and an intestinal biopsy was completed to rule out malabsorption syndrome. A gynecological referral was requested to evaluate the amenorrhea and infertility. An endometrial biopsy was completed, and endometriosis was ruled out. An endocrinologist was requested but all testing returned as normal. No clear picture could be established of the loss of weight. The patient was referred for a psychiatric evaluation by her treating physician as she appeared less cheerful, dull, inactive, and had a decreased interest in sex.

During the psychiatric evaluation, it was difficult to establish rapport with the client and she was uncooperative. The client did express a depressed mood, become fatigued easily, experienced apathy, had decreased attention and concentration, and a bleak and pessimistic outlook about the future. She denied suicidal ideation.

The client's husband revealed an incident during their early days of marriage when he had casually remarked about her being slightly heavy in her thighs and waist and that she would look more beautiful if she reduced it. Since then, he noticed she began to avoid all foods with any kind of caloric value. He stated she gradually began to skip breakfast and would have minimal lunch. She began to avoid eating in front of other family members. It was reported that at times she would hide and eat, and/or would secretly go

into the bathroom and induce vomiting.

After repeated sessions, the client began to discuss her habits with the psychiatrist. When questioned about her purging/vomiting behavior, she reported being unable to tolerate the guilt associated with eating excessively. The client was re-evaluated and questioned about her eating habits. A premorbid personality assessment revealed the client was over concerned about physical appearance and was inspired by skinny models. She reported wanting to impress her husband with her beauty because he was attracted to skinny women. She recalled that her husband would repeatedly compare her with thin-looking girls on television and in magazines. She began to develop a morbid fear of looking fat and ugly. She began using soap and water enema and would occasionally use laxatives. Her weight dropped from 130lbs to 66lbs.

During clinical examination, her weight was 66lbs, height 5'4", and a BMI of 11.3%. She had lanugo hair on her face and looked emaciated. Her vitals were stable, her thyroid function was normal, serum electrolytes were normal, and her hemoglobin was 8 gm/dl. Clinical depression was ruled out and a diagnosis of atypical anorexia nervosa was made (according to ICD-10). The general health questionnaire (GHQ) and the eating disorder examination questionnaire (EDE-Q) were administered. She was admitted for inpatient care and started immediately on IV fluids. Initially, she developed facial edema that gradually reduced with fluid redistribution. A multidisciplinary team approach was employed. Psychological education with regard to the disorder was given. Nutritional rehabilitation was planned, where she was asked to maintain a diary about her intake of food. She was encouraged to eat food with high caloric value.

Post sessions with her family involved in the therapeutic process were asked to keep a watch on her purging behavior. The patient was simultaneously given a medication called Cyproheptadine and low-dose Olanzapine. Her weight gain after 1 week was 4.4lbs. The patient gradually became cooperative during the treatment process. Supportive psychotherapy was planned that provided a maximum understanding of the patient perspective. Techniques of insight-oriented psychotherapy and cognitive behavioral therapy were structured to address the cognitive distortions. She

was subsequently discharged with a 2-week follow up. Upon that follow up her weight gain at the end of 1 month was 8.8lbs. She continued to gain weight and at the end of 6 months, she had gained 33lbs. One year later, however, she relapsed, and she reported decreased intake of food and purging tendencies. This was immediately addressed through Psychotherapy and decreased food intake and purging tendencies were remitted. At the end of 2 years, her weight was stable at 121lbs with no further purging or bouts of decreased food intake.

Discussion

The above case study is an example of just how impactful our words can be to some individuals. Eating disorders have associations with how others view us (social), genetics, environment, neglect, and abuse, and pica is sometimes associated with a co-occurring mental disorder such as schizophrenia, autism spectrum disorder, or an intellectual disability. Awareness is key to supporting and identifying this vulnerable population. Learning to care for these clients can be challenging but sticking to the facts and removing the potential stigma is so vitally important.

As stated earlier, there is often a misconception that eating disorders are a lifestyle choice rather than a serious illness. Separating the person from the illness can be helpful by looking at the illness as the problem and remembering the individual is the solution.

RESOURCES:

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