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Professional Education Series

Support. Inform. Educate. Empower.

Eating Disorder Discovery and Recovery: A Health Professional's Guide to Collaborative Treatment and Care

TODAY'S AGENDA:

- Introduction & Housekeeping
- Speaker Introduction
- Presentation
- Q&A
- Closing

WEBINAR HOST:

Keith Hine MS, RD
VP of Healthcare, Sports & Professional Education
Orgain, LLC

WEBINAR PRESENTER:

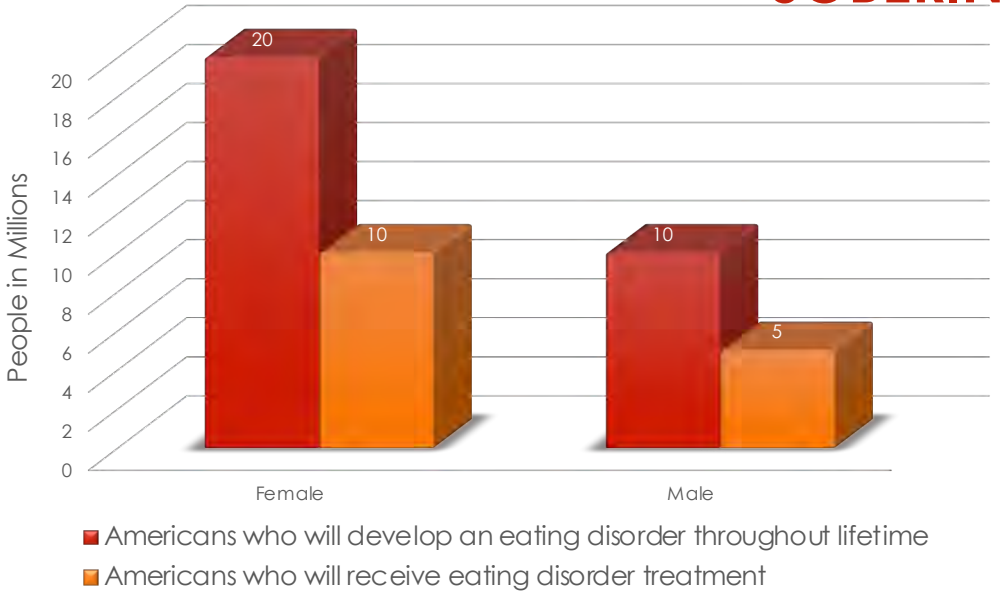
Susan Weiner MS, RDN, CDCES, FADCES
Owner and Clinical Director
Susan Weiner Nutrition, PLLC

EATING DISORDERS ARE ABOUT MORE THAN FOOD

- Complex mental health conditions that require medical and psychological intervention and ongoing support
- Relationship with food, weight and body image is all consuming
- Destructive to health and quality of life

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

EATING DISORDERS:
SOBERING STATISTICS



Rates of Help-Seeking in US Adults With Lifetime DSM-5 Eating Disorders: Prevalence Across Diagnoses and Differences by Sex and Ethnicity/Race, *Mayo Clinic Proceedings*, vol. 94, 8. Aug. 2019.

NOT A "WOMEN-ONLY" PROBLEM

- Eating difficulties and body dysmorphia, such as muscle dysmorphia, have a higher proportion of males to females, as compared to the rate anorexia and bulimia in males versus females
- Studies show that males with eating difficulties and disorders have a higher mortality rate than females
  - Stigma surrounding eating disorders as a "women-only" problem
  - Men are statistically less likely than women to reach out for help
  - Muscular individuals are often praised for their physique by healthcare professionals despite warning signs of underlying body dysmorphia and eating difficulties

Sweeting, Helen et al. "Prevalence of eating disorders in males: a review of rates reported in academic research and UK mass media." *International journal of men's health* vol. 14,2: 1415-1426. 2015.
Downs, James, and George Mycock. "Eating disorders in men: limited models of diagnosis and treatment are failing patients." *BMJ (Clinical research ed.)* vol. 376 o537. 1 Mar. 2022.

EATING DISORDERS AFFECT TRANSGENDER AND NONBINARY PEOPLE DISPROPORTIONALLY

- Complicated relationship between body image and gender identity
- Eating disorders may present in different ways
  - Example: Transmasculine individuals may restrict their eating in the hope it will prevent puberty

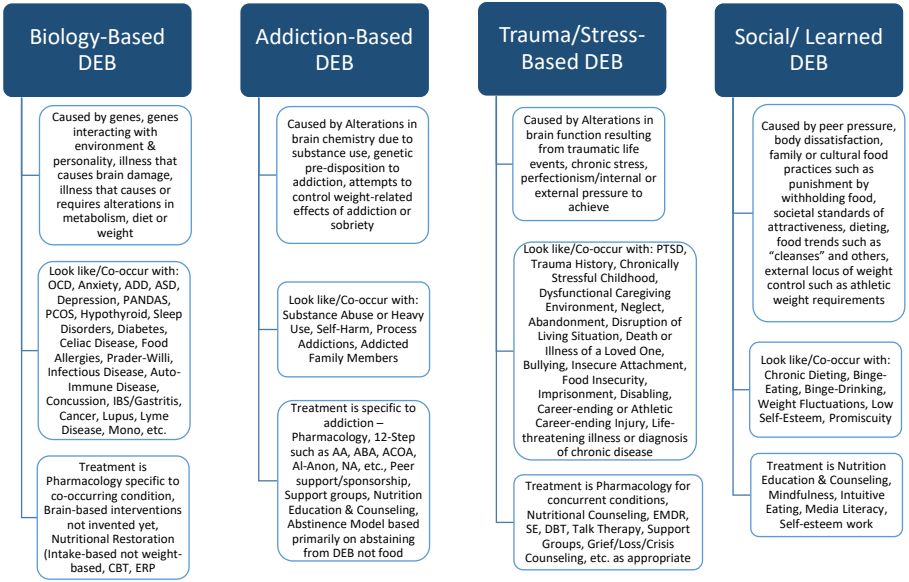
Photo: istockphoto.com

EATING DISORDERS EFFECT PEOPLE OF ANY:

- Age
- Gender
- Race
- Ethnicity
- Socio-economic group
- People of all shapes and sizes - ***often underdiagnosed in those who may be of a higher body weight***

Photo: pixbay.com

Origins of Dysfunctional Eating Behavior (DEB) Model



*With permission of Jessica Setnick

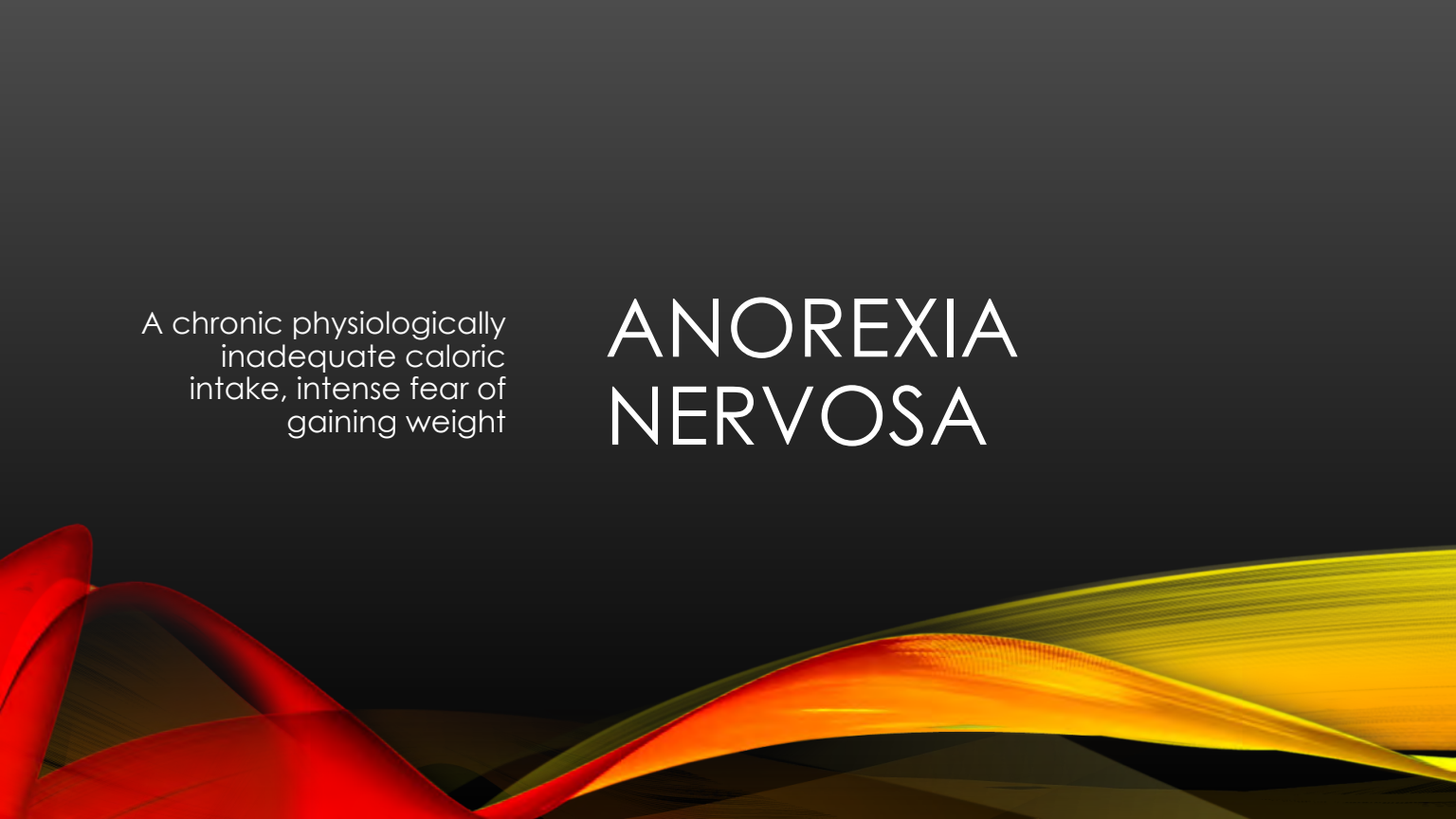
HIGH RISK GROUPS FOR EATING DISORDERS

- Young women
- Athletes
- Family history of eating disorders
- Seeking assistance for weight loss
- Food insecurity
- Seeking treatment for a condition that requires management of diabetes, celiac disease, food allergies or pregnancy

Photo: pixbay.com

ANOREXIA NERVOSA

A chronic physiologically inadequate caloric intake, intense fear of gaining weight



ANOREXIA NERVOSA

- May limit food intake or compensate for it through various purging behaviors
- May exhibit an intense fear of gaining weight, even when severely underweight

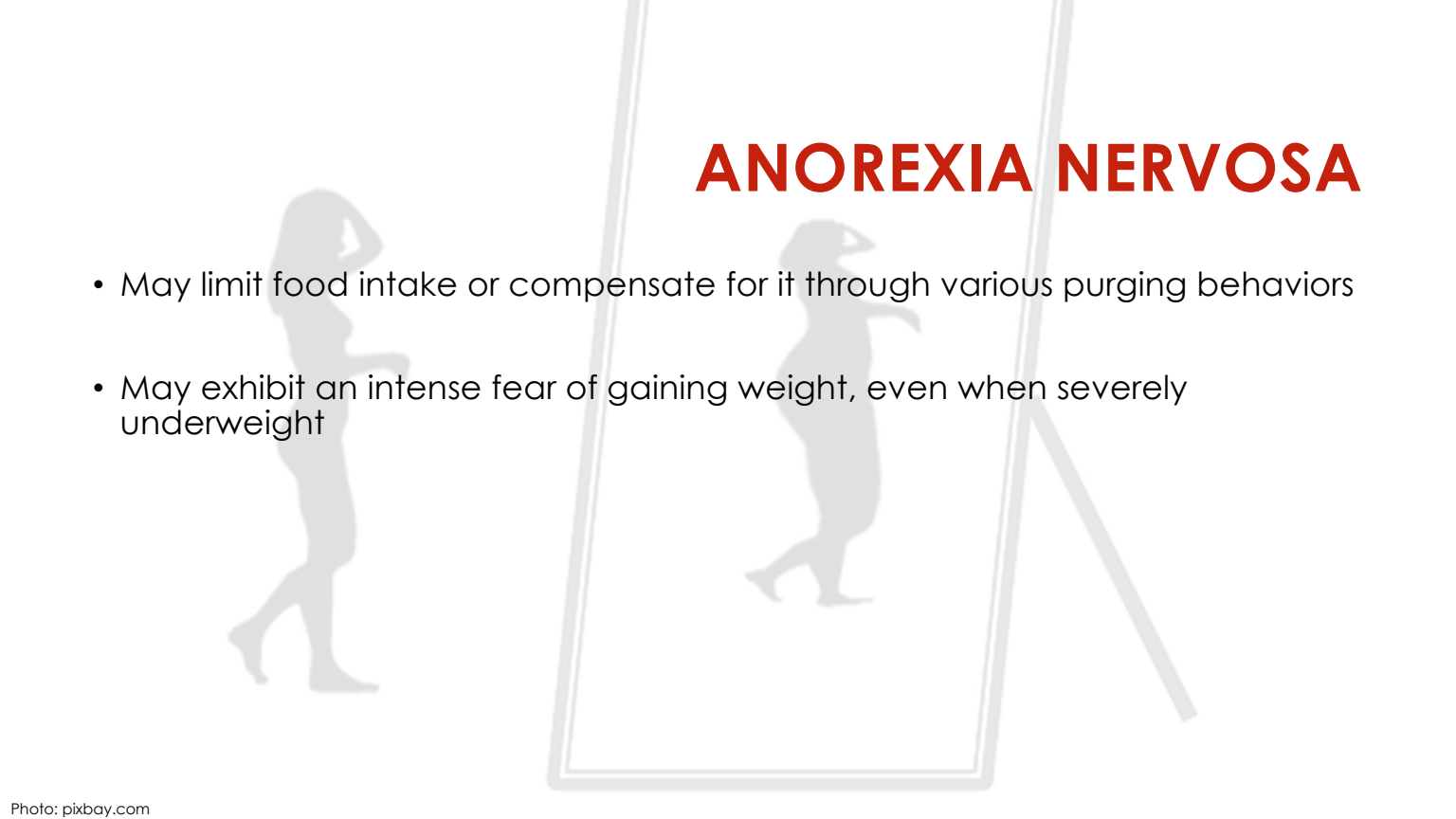


Photo: pixbay.com

May be considerably underweight compared with people of similar age and height
May follow restricted eating patterns and caloric restriction
An intense fear of or persistent behaviors to avoid gaining weight, despite being underweight
An unwavering quest of thinness and unwillingness to maintain a healthy weight
A heavy influence of body weight or perceived body shape on self-esteem
A distorted body image, including denial of being seriously underweight
May purge or vomit
May use and abuse laxatives
May exercise compulsively

BULIMIA NERVOSA & BINGE-EATING DISORDER

BULIMIA

A cycle of binging on food (in large amounts) and compensating with behaviors such as exercise or self-induced vomiting.

Photo: istockphoto.com

COMMON SYMPTOMS OF BULIMIA NERVOSA

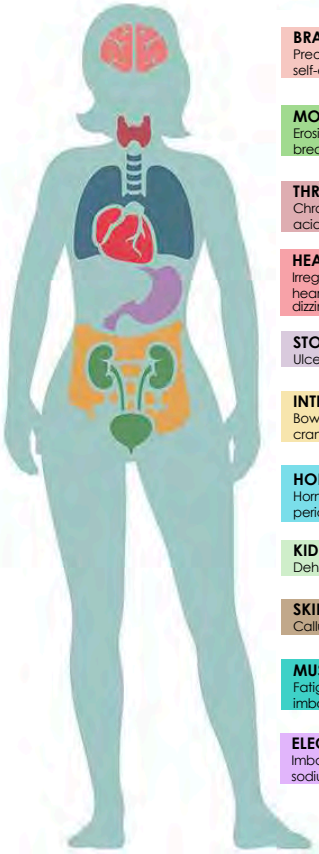
Recurrent episodes of binge eating with a feeling of lack of control

Recurrent episodes of inappropriate purging behaviors to prevent weight gain

Self-esteem overly influenced by body shape and weight

Fear of gaining weight, despite having an acceptable body weight

POTENTIAL EFFECTS OF BULIMIA NERVOSA



BRAIN
Preoccupation with food and weight, low self-esteem, anxiety, depression

MOUTH
Erosion of dental enamel, swollen jaw, bad breath, gum disease, tooth decay

THROAT/ESOPHAGUS
Chronic sore throat, indigestion, heartburn, acid reflux, inflamed or ruptured esophagus

HEART
Irregular or slow heartbeat, cardiac arrest, heart failure, low blood pressure, fainting, dizziness

STOMACH
Ulcers, pain, stomach rupture

INTESTINES
Bowel problems, constipation, diarrhea, cramps

HORMONES
Hormonal imbalance, irregular or absent periods, loss of libido, infertility

KIDNEYS
Dehydration

SKIN
Calluses on knuckles, dry skin

MUSCLES
Fatigue, cramps, caused by electrolyte imbalance, tiredness, lethargy

ELECTROLYTES
Imbalances in fluids and electrolytes such as sodium, potassium, and calcium

Illustration adapted from: eatingdisorders.org.au

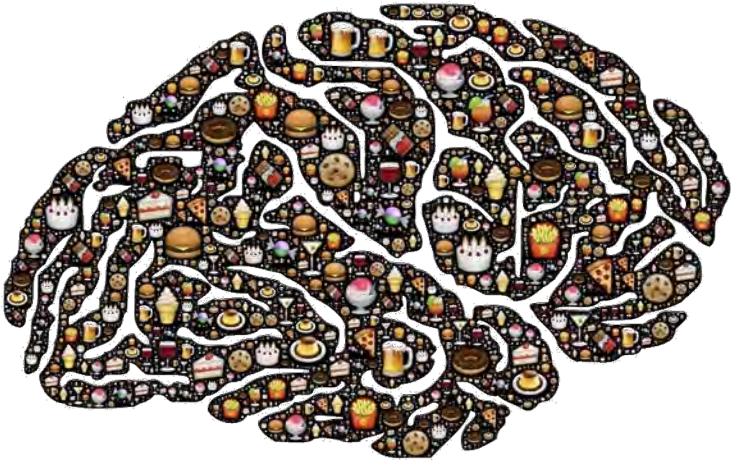
BINGE-EATING DISORDER

- The most common eating disorder, and typically the one health care professionals have the least knowledge about
- Challenges stereotypes, showing that people with eating disorders can have very thin physiques, or have normal weight, overweight, or obesity
- May occur in childhood, teen years, adulthood and in the elderly
- 2013 added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

Illustration by: Claire Milbrath

BINGE EATING DISORDER



- Regularly consume large amounts of food in short periods of time
- Do not engage in purge behaviors
- Often have overweight or obesity
- Behavior may increase risk of medical complications linked to excess weight such as cardiovascular disease, stroke or type 2 diabetes

Photo: pixbay.com

OVEREATING VS BINGE EATI SORDER (BED)

BED equiring 3 r more sy uding:

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

Photo: istockphoto.com

Consuming large amounts of foods rapidly, in secret and until uncomfortably full, despite not feeling hungry

Lack of control during episodes of binge eating

Feelings of distress, such as shame, judgement, disgust, or guilt, when thinking about the binge eating behavior

Typically, no purging behaviors, such as calorie restriction, vomiting, excessive exercise, or laxative or diuretic use, to compensate for the binging

Avoidant/restrictive food intake disorder

ARFID

Eating disorder characterized by persistent failure to meet appropriate nutritional and/or energy needs

Often associated with a psychiatric co-morbidity, especially anxiety and obsessive-compulsive disorder

Affect all genders and is more common in children and young adolescents

Associated with nutritional deficiencies and weight loss

Typically, don't have a drive for thinness, or body image distortion

ARFID: POTENTIAL CAUSES

Genetic Factors

- Eating Disorder may be familial illnesses and temperamental traits predisposing a person toward the illness

Molecular Hereditary

- Like many mental health conditions, hereditary can be a cause for some eating disorder behaviors. Every human is born with a genetic code, which may exhibit patterns in certain health conditions

Environmental Influence

- Influence from family members associated with meal preparation
- Observance of restrictive eating patterns from family members. (ie exposure to restrictive dieting)

Himmerich, Hubertus et al. "Genetic risk factors for eating disorders: an update and insights into pathophysiology." *Therapeutic advances in psychopharmacology* vol. 9 2045125318814734. 12 Feb. 2019.

Brigham, Kathryn S et al. "Evaluation and Treatment of Avoidant/Restrictive Food Intake Disorder (ARFID) in Adolescents." *Current pediatrics reports* vol. 6,2 (2018): 107-113.

ARFID: POTENTIAL CAUSES (CONTINUED)

Sociocultural Factors

- Cultural pressures to "join the clean plate club" or pressure to eat clean and healthy
- Increased interest in food processing or environmental impact on food can indirectly impact food intake
- Although different then anorexia, it can occur with anorexia due to healthy appearance expectations
- Moral beliefs that eating meat and dairy or how those items are prepared

Chadda, R. et al. "Socio-cultural factors in anorexia nervosa." *Indian Journal of Psychiatry* vol. 29(2): 107-111. April 1987.

ARFID: POTENTIAL CAUSES (CONTINUED)

Psychological Factors

- Obsessive Compulsive Disorder (OCD)
  - Symptoms can co-occur with OCD, including obsessions with food intake or preparation which can lead to ritualistic compulsions
- Anxiety
  - Anxiety can occur in people who experience fear around eating. They may avoid eating out of fear they may choke, vomit or die if they eat certain foods

Lesser, K. "More than picky eating- 7 things to know about ARFID." *National Eating Disorders Association (Blog)*. NKD.

An unhealthy focus on eating in a healthy way

ORTHOREXIA

ORTHOREXIA

- Not formally recognized in the DSM-5
- Obsession and fixation with "healthful" eating
- Studies show that orthorexia may be association with obsessive-compulsive disorder

WARNING SIGNS OF ORTHOREXIA

- Compulsion to check nutrition facts panel and ingredient list
- An increase in concern about the health of ingredients
- Eliminating food groups (ie all sugar, all carbs, all dairy, all meat, all animal products)
- Eliminate anything but a narrow group of foods that are deemed ‘healthy’ or ‘pure’
- Unusual interest in the health of what others are eating
- Spending hours per day thinking about what food might be served at upcoming events
- Showing high levels of distress when ‘safe’ or ‘healthy’ foods aren’t available
- Obsessive following of food and ‘healthy lifestyle’ blogs on social media (i.e. Twitter and Instagram)
- Body image concerns may or may not be present

ORTHOREXIA TREATMENT

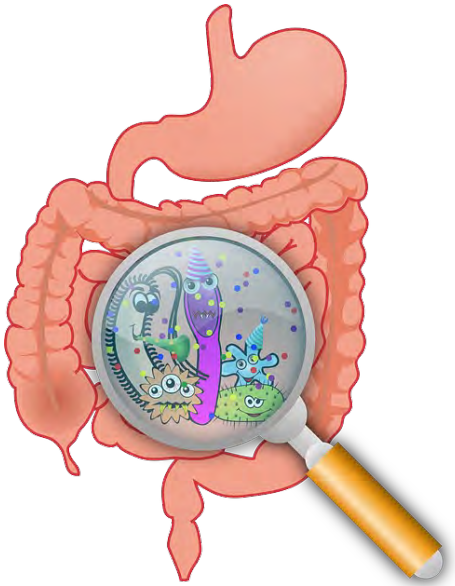
- Treatment similar to anorexia and/or obsessive-compulsive disorder
- Treatment typically involves psychotherapy to increase the variety of foods eaten and exposure to anxiety-provoking or feared foods
- Weight restoration as needed

Photo: health.clevelandclinic.org

Frequent, laxative use in when not clinically indicated

LAXATIVE ABUSE

LAXATIVE ABUSE: HEALTH CONSEQUENCES



- Electrolyte and mineral balances. sodium, potassium, magnesium, and phosphorus are necessary for proper functioning of the nerves and muscles, including the colon and heart. Imbalance can cause vital organ failure.
- Chronic laxative abuse and limited re-hydrations can severely tax the body and ultimately cause death. Severe dehydration can cause tremors, weakness, blurry vision, fainting, kidney damage and in extreme cases death.
- Colon stops reacting to usual laxative doses over time, and larger amounts of laxatives may be needed to produce bowel movements
- Stretched or "lazy" colon, colon infection, irritable bowel syndrome or liver damage. Chronic laxative abuse may increase the risk of colon cancer and the dysregulation of the gut flora

Photo: pixbay.com

DEHYDRATION REQUIRES

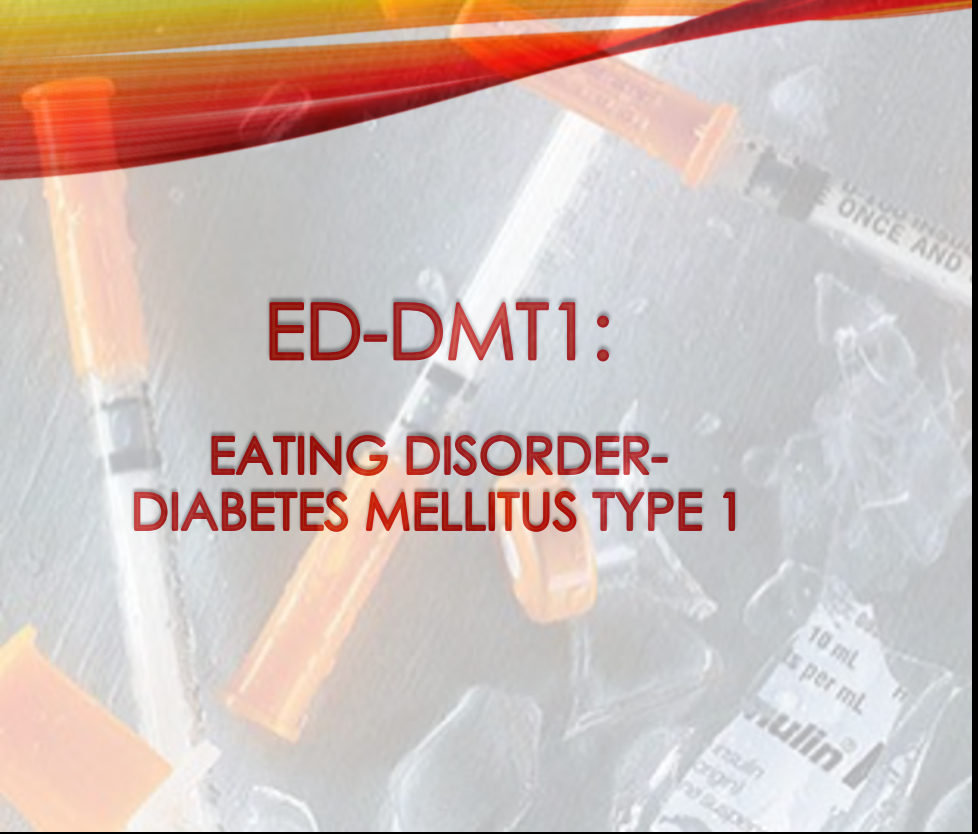
IMMEDIATE

MEDICAL ATTENTION!

ED-DMT1

Dual diagnosis of an eating disorder and type 1 diabetes

(AKA: "diabulimia")



ED-DMT1:

EATING DISORDER-DIABETES MELLITUS TYPE 1

- Dual dx of eating disorder and type 1 diabetes
- Restricting insulin for weight loss
- Not listed in DSM-5

Photo: pixbay.com

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

ED-DMT1 is …

- Restricting
- Restricting with purging
- Restricting with binging and purging
- Binging
- Self induced vomiting
- Laxative abuse
- Diuretic abuse
- Compulsive exercising

PLUS…

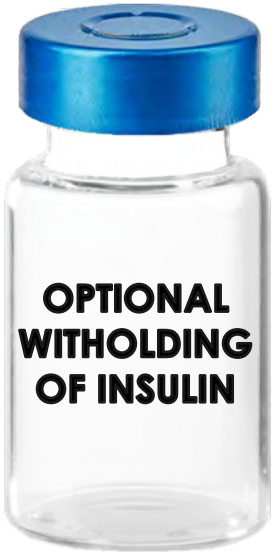


Photo: pixbay.com

DISORDERED EATING WITH DIABETES THRIVES IN SECRECY

So, what's the secret?

- Studies show 30-40% of Type 1 young women engage in this life-threatening behavior, as high as 50%
- Limited studies on males, minorities or gender-neutral individuals
- You may have innocently/accidentally discovered it for yourself
- It can happen to anyone, at any age
- It may kill you

Source: AN, BN, BED, Other Specified Feeding or Eating Disorder, Avoidant/Restrictive Food Intake DSM-5, Diagnostic Statistical Manual for Mental Disorders, May 2013

Photo: istockphoto.com

ED THOUGHT PROCESS CAN BE EXACERBATED WITH TYPE 1 DIABETES MANAGEMENT

- Pressure of perfect BG readings = perfect body, perfect weight, perfect blood sugars, approval from MD, family and educators.
- High focus on numbers = obsession on weight, A1C, blood sugars, minutes of exercise, calories, grams of carbohydrate.
- High focus on food = "good" and "bad" foods, fear of eating anything sweet or "bad" in front of others.
- Hypoglycemia (low BGs) may trigger bingeing.

Photo: istockphoto.com

Structuring a human approach

CLIENT CARE

WHY DO SOME PEOPLE SEEKING HELP WITH EATING DISORDERS AVOID DIETITIANS & NUTRITIONISTS?

Photos: istockphoto.com

TO WEIGH OR NOT TO WEIGH?

Give the client the option not to know their weight, for example by stepping onto the scale backwards so that the client cannot see the number ("blind weighing")

Speak generally about progress rather than discussing specific numbers if the client requests this

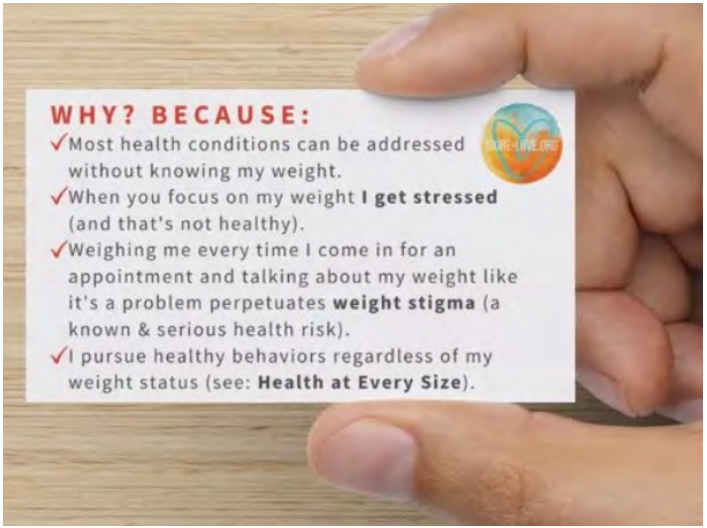
Avoid making comments about the client's weight during the weighing process, and avoid inadvertently saying the weight aloud while taking the reading or writing notes

Experience of being weighed particularly distressing because of the intense fear and/or shame that they feel about their weight

Photo: pixbay.com

DON'T WEIGH ME CARDS

Weigh-ins can sometimes lead to avoiding health checkups altogether



Photos: more-love.org/free-don't-weigh-me-cards/

Photo: pixbay.com

ASK THE RIGHT QUESTIONS

HOW TO START A CONVERSATION IF YOU SUSPECT AN EATING DISORDER

- "Many people worry about food and weight. Do you worry about these things?"
- "Are you satisfied with your eating patterns?"
- "Do you eat in secret?"
- "Do you ever make yourself sick because you feel too full?"
- "Do you ever feel you lose control over how much you eat?"
- "Have you recently lost weight?"
- "How do you feel when someone says you're too thin?"
- "Would you say food overtakes your thoughts?"
  - "Are there certain foods or food groups that you avoid? What are they?"
  - "What are your thoughts when you have eaten *forbidden foods*?"
  - "What do you do after you have eaten *forbidden foods*?"

RECOGNIZING SIGNS IN A LOVED ONE

- Not wanting to eat out or not wanting to eat with the family
- Eating in secrecy - finding empty bottles, wrappers, containers stashed or thrown away
- Noticeable change in how much a person is eating
- Increased or new secrecy around eating
- Increased or new concern over their body size, shape or weight
- Excessive exercising, severe anxiety/panic if they cannot exercise
- Increased moodiness/depression

Photo: verywellmind.com


Be aware of the individual's intense feelings of fear, guilt and shame
Nutritional Considerations: Eating Disorder Recovery Process
Continue to closely monitor disordered eating behaviors
Food monitoring can progress to a focus on variety and flexibility, internal awareness and self-trust

NUTRITIONAL CONSIDERATIONS IN EATING DISORDER RECOVERY

Photo: pixbay.com

EARLY RECOVERY:

- Refeeding as part of medical stabilization must occur prior to other interventions.
- Food monitoring focus is on regular patterns of eating.
- Adequate food intake depends on the duration and severity of malnutrition, existing patterns of eating or disordered eating (and compensatory behaviors), as well as age, gender and activity level.
- Hunger and satiety signals may still be interrupted and may not be an accurate gauge for adequate food intake.

NUTRITIONAL CONSIDERATIONS FOR EATING DISORDER TREATMENT

Nutritional status be individualized and assessed throughout treatment!

- **Anorexia Nervosa** (AN) includes weight and nutrition restoration. Nutrition education and regularly scheduled meal plans should be a part of this plan. Individuals with AN may be hypermetabolic (as their bodies try to rebuild tissue lost during starvation) and require higher calorie meal plans for initial modest weight gain, which is challenging for the patient.
  - **Important:** Refeeding syndrome must be carefully monitored (often seen in severe cases of AN).

- **Bulimia Nervosa** not always detectible from physical appearance and may be of normal weight or overweight. Nutrition therapy and education should explore food rules ("good vs bad foods"). Nutrition intervention may also include delayed gastric emptying, ulcers and esophageal reflux disease. Collaborate on development of meal plans and include discussion acknowledging that recovery and dieting cannot coexist.

- **Binge Eating Disorder** (BED) is often first recognized by a registered dietitian or nutrition professional, due to a person's desire to lose weight. Individuals with BED may have a lack of variety in their current eating plan and benefit from a consistent meal plan which incorporates a variety of foods. Binge eating is often a way of meeting emotional needs as food is used to feel or turn-off emotions.

*Treatment must be based on individualized nutritional assessment, metabolic needs and requirements.
** Complete blood work is essential including assessment of electrolytes and vitamins and minerals including: iron, selenium, copper vitamins D, C, Folate, B12, D.
*** Consider incorporation of Cognitive Behavioral Therapy (CBT) and Dialectical behavior therapy (DBT) as part of the overall treatment plan.

REFEEDING SYNDROME- MOST LIKELY TO OCCUR IN AN INPATIENT SETTING

Potentially lethal condition that may occur when aggressive nutrition is recommended to someone who has metabolically adapted to starvation.

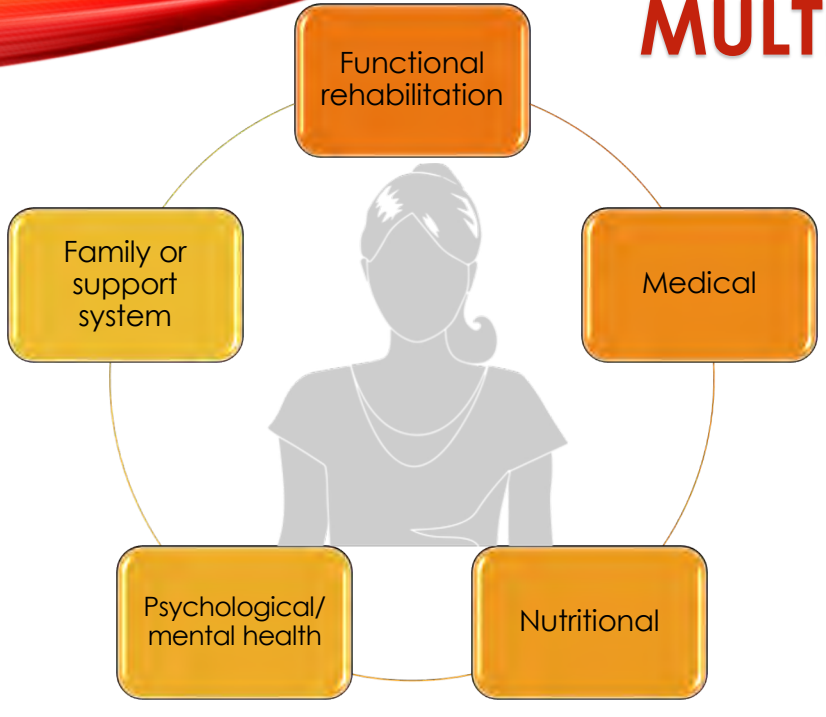
During starvation, the body conserves energy and protein by decreasing heart rate, blood pressure, metabolic rate, protein/enzyme production and gut activity.

Following the adaptation period, if parenteral, enteral or aggressive oral nutrition support is provided, abrupt metabolic changes occur.

Changes include: increase in heart rate, blood pressure and metabolic rate, hormone levels, stimulation of protein synthesis and replenishment of ATP, glycogen, reduced serum levels of potassium, magnesium, zinc and sodium.

Changes can lead to thiamine deficiency and severe or fata function of muscles nerves and brain function

MULTIDISCIPLINARY TEAM APPROACH



*Utilizing culturally respectful and non-judgmental language and communication

LEVELS OF CARE FOR EATING DISORDER TREATMENT (CONTINUED)

Intensive Outpatient Treatment

- Person is medically stable and does not need daily medical evaluations or monitoring
- Person is psychiatrically stable and able to function with daily activities
- Person continues to make progress in recovery

Partial Hospital

- Person is medically stable however, eating disorder impairs daily functioning, through without immediate risk
- Person requires daily assessment of physiologic psychological status
- Person is psychiatrically stable but unable to function in typical social, educational or vocational situations
- Person engages in daily binge eating, purging, fasting or very limited food intake or other pathogenic weight control techniques

Practice guidelines for eating disorders, 3rd edition. *American Psychiatric Association*. 2010.

LEVELS OF CARE FOR EATING DISORDER TREATMENT (CONTINUED)

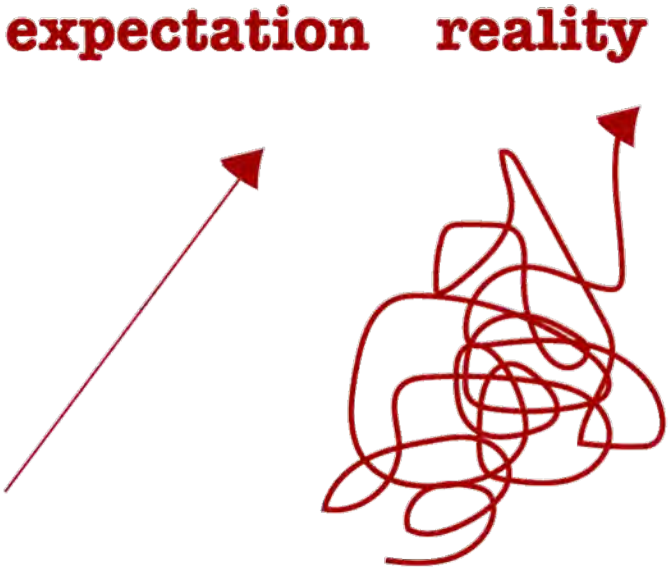
Residential

- Person is medically stable and doesn't require intensive medical intervention or treatment
- Person is psychiatrically impaired and unable to respond to partial hospital or outpatient treatment

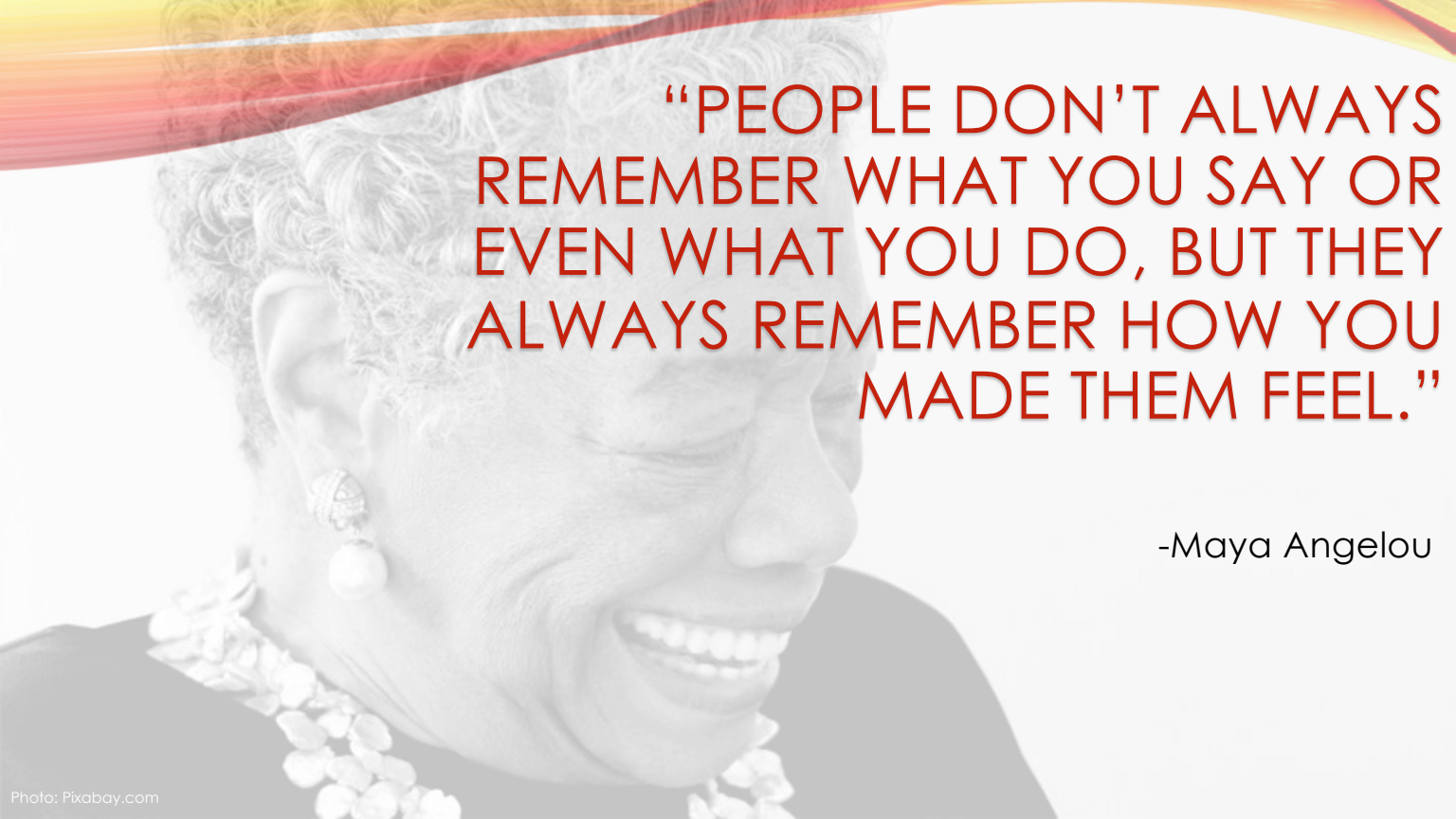
Inpatient

- Person is medically unstable as evidenced by:
  - Unstable or depressed vital signs
  - Acute health risk- supported by out-of-range laboratory findings
  - Complications due to coexisting medical issues (i.e., diabetes)
- Person is psychiatrically unstable as evidenced by:
  - Rapidly worsening symptoms
  - Suicidal or deemed unsafe

Practice guidelines for eating disorders, 3rd edition. *American Psychiatric Association*. 2010.



THE REALITY OF EATING DISORDER RECOVERY


“PEOPLE DON’T ALWAYS REMEMBER WHAT YOU SAY OR EVEN WHAT YOU DO, BUT THEY ALWAYS REMEMBER HOW YOU MADE THEM FEEL.”
-Maya Angelou
Photo: Pixabay.com

Thank You

susan@susanweinernutriion.com
www.susanweinernutrition.com
@susangweiner

QUESTIONS?

RESOURCES

1. American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).
2. Rates of Help-Seeking in US Adults With Lifetime DSM-5 Eating Disorders: Prevalence Across Diagnoses and Differences by Sex and Ethnicity/Race, *Mayo Clinic Proceedings*, vol. 94, 8. Aug. 2019.
3. Sweeting, Helen et al. "Prevalence of eating disorders in males: a review of rates reported in academic research and UK mass media." *International journal of men's health* vol. 14,2: 1415-1426. 2015.
4. Downs, James, and George Mycock. "Eating disorders in men: limited models of diagnosis and treatment are failing patients." *BMJ (Clinical research ed.)* vol. 376 o537. 1 Mar. 2022.
5. Himmerich, Hubertus et al. "Genetic risk factors for eating disorders: an update and insights into pathophysiology." *Therapeutic advances in psychopharmacology* vol. 9 2045125318814734. 12 Feb. 2019.
6. Brigham, Kathryn S et al. "Evaluation and Treatment of Avoidant/Restrictive Food Intake Disorder (ARFID) in Adolescents." *Current pediatrics reports* vol. 6,2 (2018): 107-113.
7. Chadda, R. et al. "Socio-cultural factors in anorexia nervosa." *Indian Journal of Psychiatry* vol. 29(2): 107-111. April 1987.
8. Lesser, K. "More than picky eating- 7 things to know about ARFID." *National Eating Disorders Association (Blog)*. NKD.
9. Wong, B. "PSA: You probably don't need to be weighed at the doctor's office." *Huffpost*. Jan. 2022.
10. Practice guidelines for eating disorders, 3rd edition. *American psychiatric association*. 2010.

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keith.hine@orgain.com

WEBINAR PRESENTER:

Susan Weiner MS, RDN, CDCES, FADCES
Owner and Clinical Director
Susan Weiner Nutrition, PLLC
susan@susanweinernutrition.com

GENERAL INQUIRIES:

medinfo@orgain.com