

Eating Disorders & Body Image

Roundtable Discussion

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Eating Disorders & Body Image

Learning Objectives

- Better Understand The Role Of Body Image Perceptions In The Development Of Eating Disorders (ED)
- Reinforce The Role Of Dietary Therapy In The Prevention, Treatment And Follow-Up Of ED Patients
- Identify Areas For Future Training and Research



Eating Disorders & Body Image

Three Questions

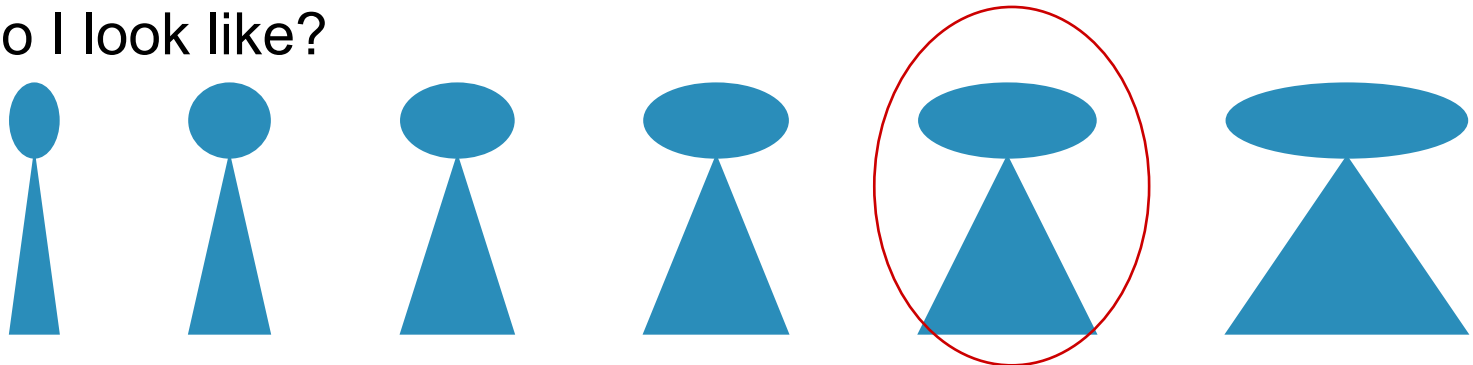
- What do we now know about the relationship between body image and eating disorders?
 - Are there validated tools to identify at risk individuals and is there a role for preventive education?
- What is the role of the Dietitian in the prevention, treatment and management of Eating Disorders?
- Building trust and rapport with ED patients to achieve positive dietary change – What works? What does not?
 - Can we design algorithms of dietary education and follow-up care for many Eating Disorder Syndromes to better treat and manage the condition?



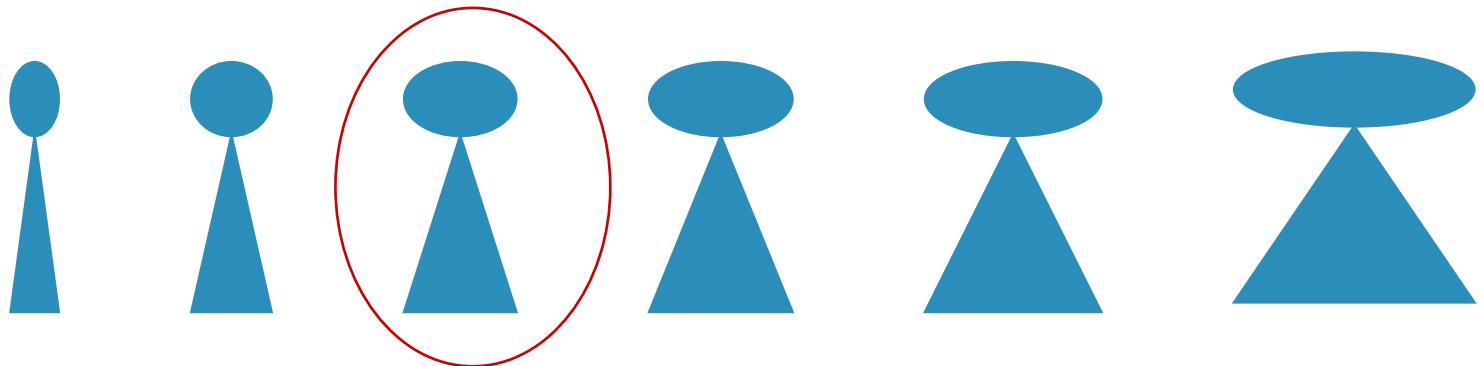
What about me?

Do I have issues with my body image?

What do I look like?



What do I want to look like?



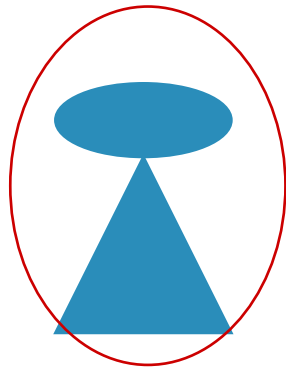
Body image defined...The way a person perceives or thinks about his / her body and how it looks to others.



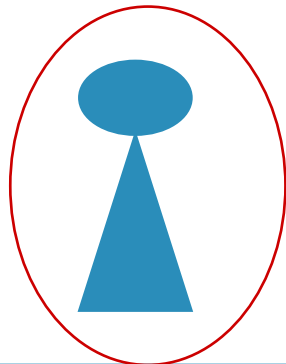
What about me?

Do I have an eating disorder?

- Here's what I look like...



- Here is what I want to look like...



- So, here's how I eat...
 - When I see food, I eat, I do not worry
 - When I eat food, I feel out of control
 - When I eat food, I worry & work it off
 - When I eat food, I worry & eat some more
 - When I eat food, I worry & puke it up
 - I constantly think of food, but cannot make myself eat
 - Others...



Food & Eating

- Food is Fun
- Eating is Enjoyable



Yet, why does this occur?



Food Phobia – In The News (June 2008)



“Rebecca Scowcroft, from Bolton, eats 15 squares of cooking chocolate and 10 chocolate fingers every morning while her family opt for a more conventional breakfast of toast, eggs and cereal. The schoolgirl, who is in perfectly good health, eats the same for lunch and Rice Krispies for dinner - but only if they are mixed in bowl of melted chocolate.”

"I don't just choose to eat that kind of stuff," she says in a forthcoming ITV1 documentary called My Child Won't Eat. "It's not because I'm being awkward. **Whenever I try any food I always get scared.**"



Definitions

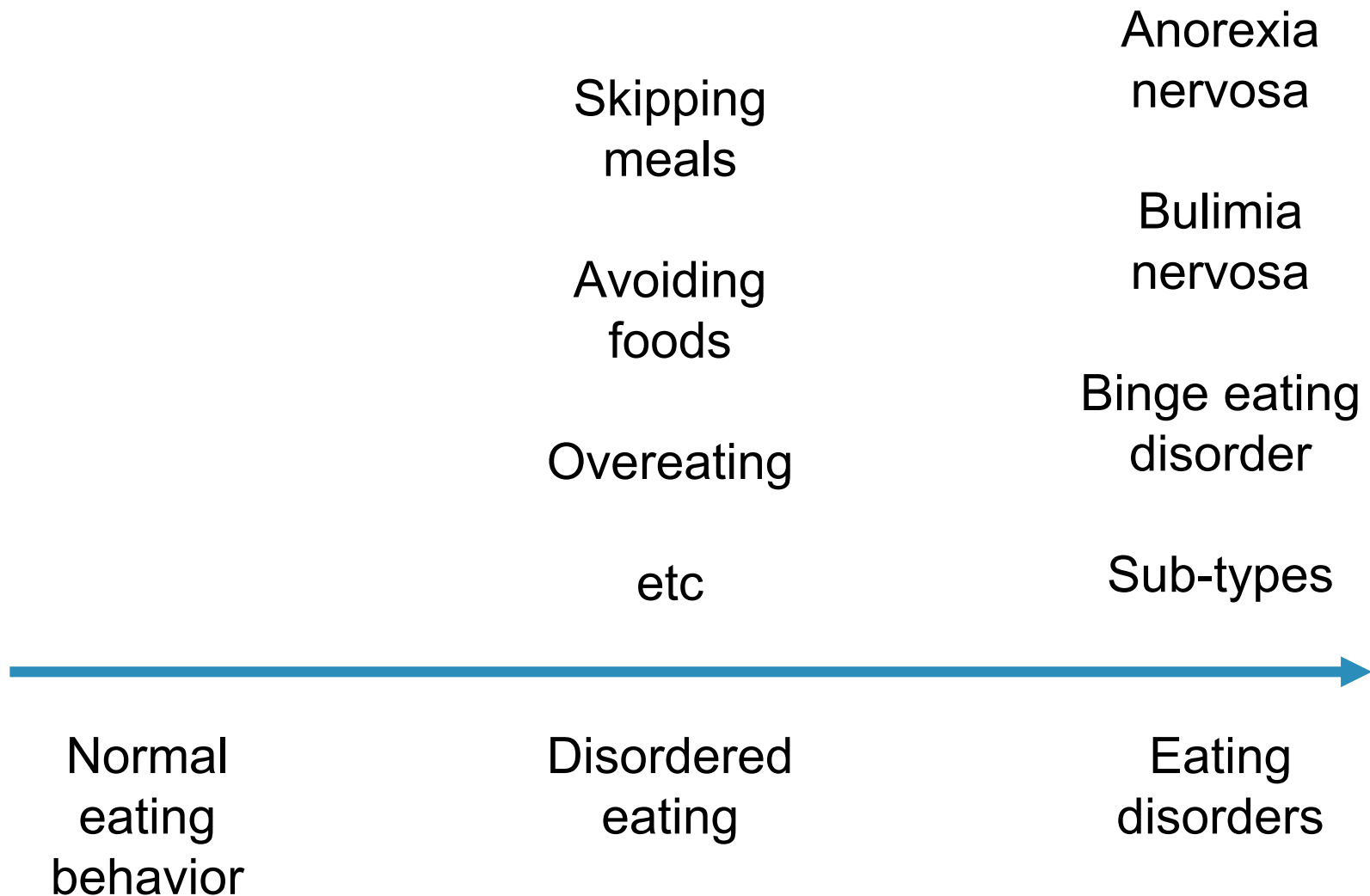
- Eating Disorders

- Anorexia Nervosa is a serious, potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss.
- Bulimia Nervosa is a serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-induced vomiting designed to undo or compensate for the effects of binge eating.
- Binge Eating Disorder (BED) is a type of eating disorder not otherwise specified and is characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.
- Other subtypes

- Treatments usually involves psychotherapy, nutrition education, family counseling, medications and hospitalization



The spectrum of eating behaviors



Eating Disorders – Differential Diagnosis

- **Body Image Variation → Dieting**

- Healthy eating
- Less fat, less sugar, small portions

- **Body Image Problem → Dieting**

- Food restriction: Quality & Quantity
- Weight loss, Fears weight gain
- Obsessed with thinness
- Disturbance of body perception & denial of weight loss / dieting

- **Anorexia Nervosa**

- Refusal to maintain body weight
- Fear of weight gain though very thin
- Undue reliance on body weight / shape on self esteem
- Denial of the seriousness of LBW
- Amenorrhoea (in females)

Diagnostic & Statistical Manual for Primary Care. AAP

Diagnostic & Statistical Manual of Mental Disorders.

- **Binge → Eating Variation**

- Occasional overeating / perception of overeating
- Intermittent concerns about getting fat but thoughts not pervasive, does not change eating behavior
- Normal weight gain is present

- **Purge / Binge → Eating Problem**

- Use of vomiting, laxatives, fasting or exercise to prevent weight gain
- Isolated episodes
- Episodes increase, perceptions of body shape get distorted, negative self evaluation

- **Bulimia Nervosa**

- Recurrent episodes of binge eating, compensatory behavior (at least 2 times a week for 3 months)
- Body shape & weight unduly influence self esteem



Prevalence

Studies from Malaysia

- Soo KL, Shariff ZM, Taib MN, Samah BA. Eating behaviour, body image, and self-esteem of adolescent girls in Malaysia. *Percept Mot Skills*. 2008 Jun;106(3):833-44.
 - 489 secondary school girls, ages 15-17 years
 - A total of 87.3% were dissatisfied with their own body size.
 - Dietary restraint and binge eating were reported by 36.0% and 35.4%, respectively.
 - Body Mass Index and body-size dissatisfaction were significantly associated with dietary restraint and binge eating, but self-esteem was significantly associated only with binge eating.
- Khor GL, Zalilah MS, Phan YY, Ang M, Maznah B, Norimah AK. Perceptions of body image among Malaysian male and female adolescents. *Singapore Med J*. 2009 Mar;50(3):303-11.
 - 2050 adolescents between 11-15 years
 - The majority (87 percent) were concerned with their body shape.
 - 20% of the females and 9% of the males with a normal BMI perceived themselves as fat



Let's discuss

- Prevalence
 - AN → 0.5 to 1% of women in US (Attia E, NEJM 2009)
 - Higher in women who participate in dance and selected sports
 - Smaller proportion of men
- Epidemiology
- Causes



Consequences of ED

- AN

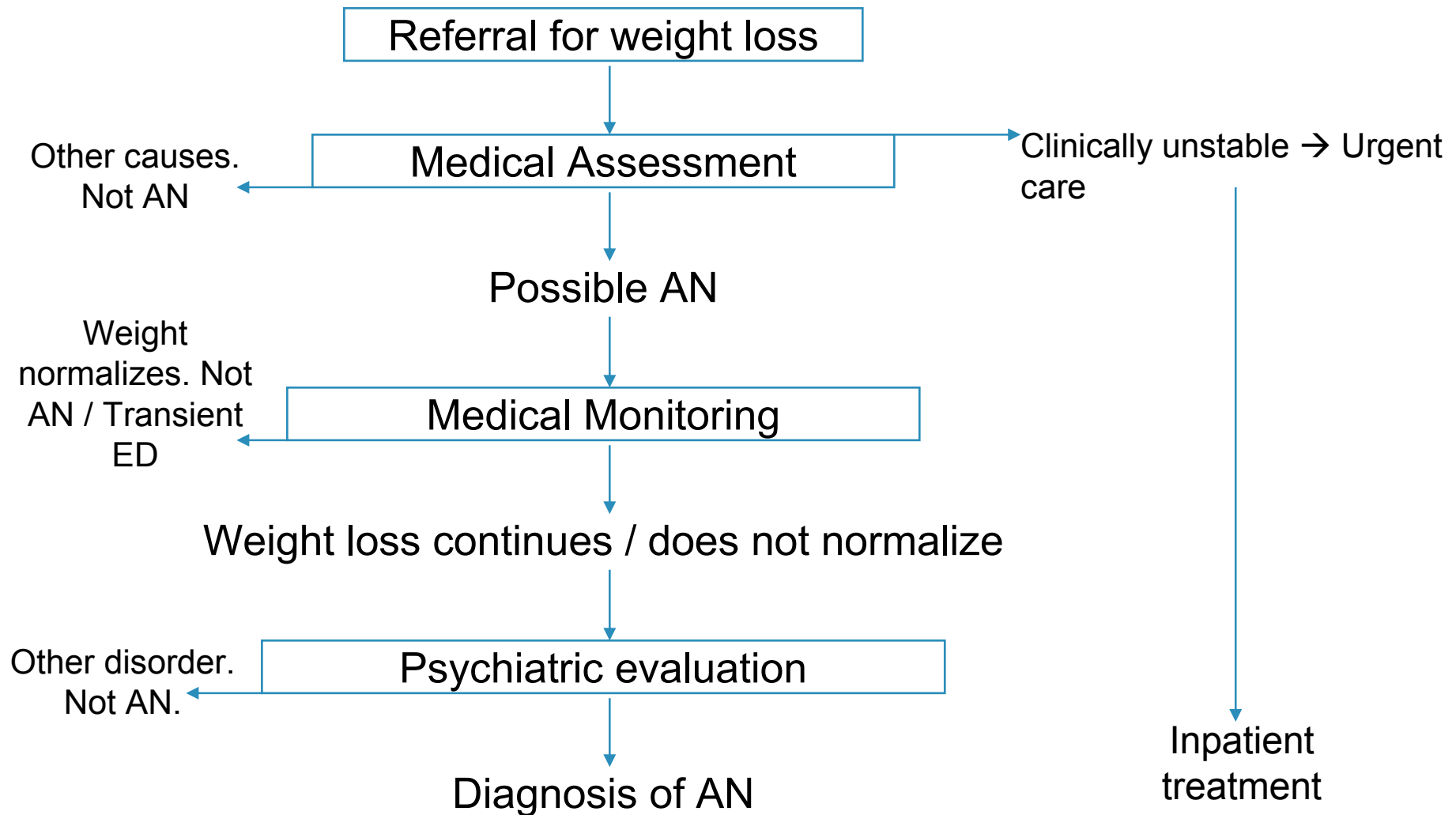
- Amenorrhea
- Hypothermia
- Loss of concentration
- Osteoporosis
- Bradycardia
- Cardiovascular instability
 - Weakness
 - Fatigue
 - Dizziness
 - Loss of energy
 - Fainting
 - Death
 - 5.6% of AN patients

- BN

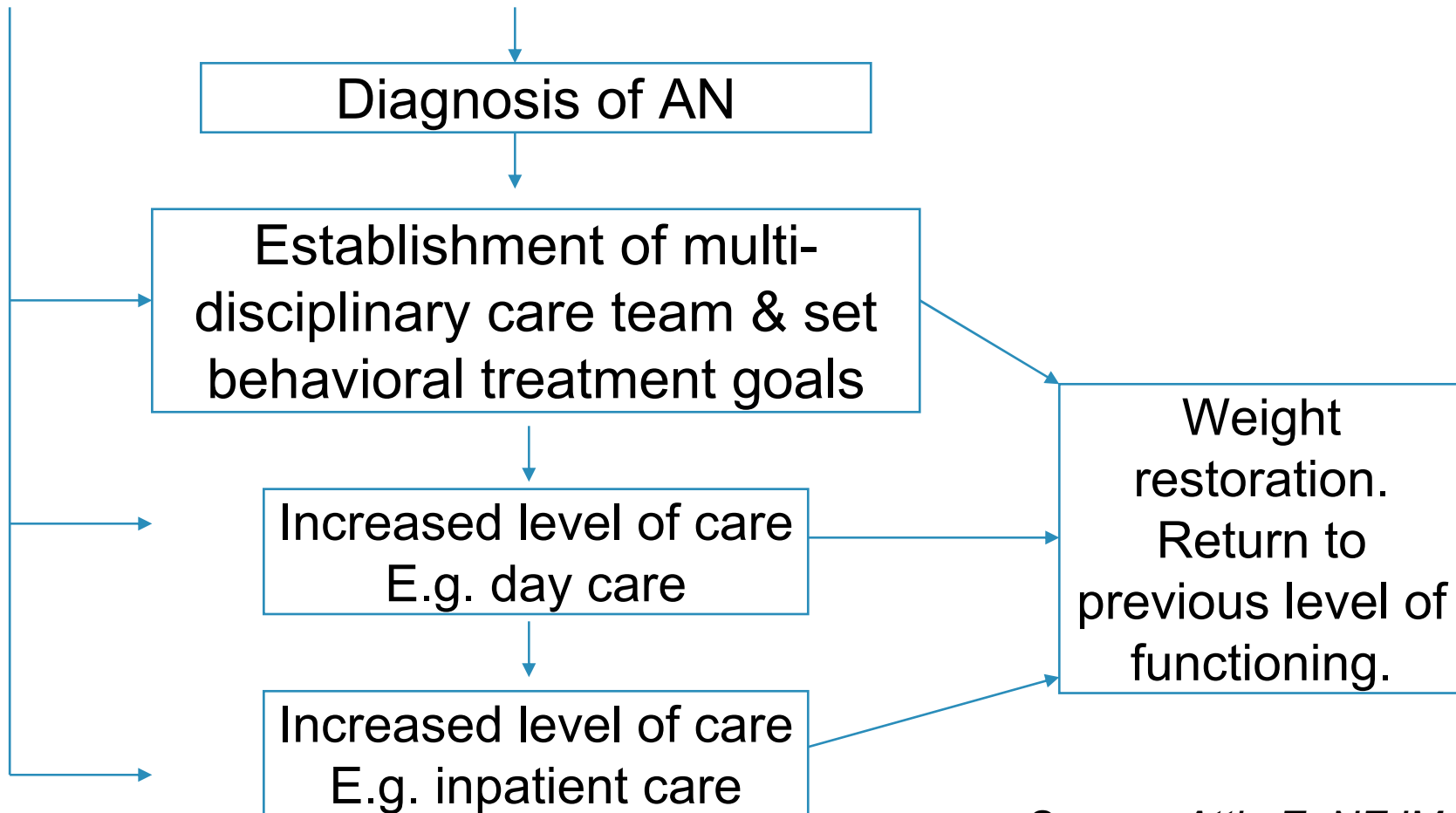
- Erosion of dental enamel
- Abrasion of knuckles of the metacarpophalangeal joints
- Enlargement of salivary glands
- Cardiovascular instability (caused by volume depletion & electrolyte depletion)
 - Weakness
 - Fatigue
 - Dizziness
 - Loss of energy
 - Fainting
 - Death



Steps in Evaluation & Treatment of AN

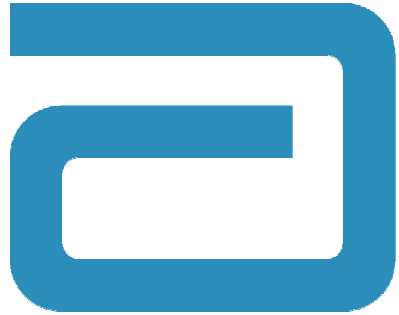


Steps in Evaluation & Treatment of AN – 2/2



*Source: Attia E. NEJM
2009*





Body Image Misperceptions and Eating Disorders

These are classified as mental disorders.

So, what's the role of the Dietitian?

Food Struggles – The Problem or The Symptoms



The screenshot shows a web browser window displaying a news article from Telegraph.co.uk. The article title is "The schoolgirl who eats nothing but chocolate". The sub-headline reads: "A 12-year-old girl has eaten almost nothing but chocolate all her life because she is so frightened of trying new foods." The author is Nicole Martin, Digital and Media Correspondent, and the article was last updated on 12:05PM BST 25 Jun 2008. The article includes a photo of a family and text describing the girl's diet: "Rebecca Scowcroft, from Bolton, eats 15 squares of cooking chocolate and 10 chocolate fingers every morning while her family opt for a more conventional breakfast of toast, eggs and cereal." It also mentions that the girl eats the same for lunch and dinner, but only if the items are mixed in a bowl of melted chocolate.



Characteristics of the ED patients

- ANs

- BNs

- BEDs

What are the opportunities? What are the challenges?



Steps to Working With ED Patients (Outpatient Care)

*Source: Pediatric Nutrition
Handbook. AAP 2009.*

- Step 1
 - Focus on the weight loss
 - Determine if intentional or unintended (rule out medical / other causes)
 - Tool: Questionnaire for Adolescent with Weight Loss
 - Do not try to determine underlying psychological factors
 - Confrontation / threatening situations → Denial or Resistance to change
 - Focus on nutritional habits, physical symptoms & health
- Step 2
 - Determine if weight control habits are excessive / unhealthy
- Step 3
 - Nutritional assessment to determine if pursuit of thinness is an overriding concern
- Step 4
 - Develop a plan of action → Bio + psycho + social approach



Steps to Success

1. Early recognition & restoration of physiologic stability
2. Establish trusting, therapeutic partnership with patient
3. Involve family
4. Team approach
 - Internist
 - Psychiatrist
 - Nutritionist

Source: Pediatric Nutrition Handbook. AAP 2009.



Challenges dealing with ED patients

- Are patient's goals in line with treatment goals?
- Weighing an ED patient, measuring skin fold and body fat
- Setting weight goals
 - To say or not to say → One number or should we set weight goal based on physiological / functional improvements
 - Aim for $\frac{1}{4}$ - $\frac{1}{2}$ kg per week (if possible)??
- Reading CBC and other lab values
 - Normal findings → “nothing is wrong”!!
- Food & exercise records → Journaling (?)
 - How real? Overestimation of serving size (up to +50%). Underreporting exercise
- Weight gain
 - Patient believes all weight gain is ‘fat’ gain
 - Can exercise be prescribed to build up LBM??



Setting Nutrition Goals

- Prescribing “calories” → Pros and Cons
 - Outpatients → 130% REE
 - + 5 calories → increase of 1 gram weight
 - Never start with more than 50% over current intake
 - → work up to calorie prescription (+100 / 200 kcal every 2 days)
 - Inpatients →
- Carbo:Protein:Fat:: 55-60%:15-20%:20-25% (Initial Fat?? 15 – 20%)
- Importance of daily meal and snack structure
- Portion distortion → Loss of knowledge of ‘appropriate portion’
- Fear of foods. Fear of fats. Fear of eating out / home cooked foods
- Delayed gastric emptying & related challenges
 - Role of liquid nutritional supplements over solid foods
- Role of vitamin & mineral supplements



Hospitalization

- LBW is not the only reason to admit
- Calorie Prescription
 - 130- 150% REE
- Mode of feeding
 - Oral, Enteral, Parenteral
- Refeeding challenges
 - Fear of weight gain
 - Fear of eating 'large' quantities → refusal
 - More is not always better
- Rapid replacement → refeeding syndrome
 - Fluid retention
 - Congestive heart failure
 - Hypophosphatemia

**Between 20 – 50%
of inpatients drop
out from inpatient
ED programs.**

**Relapse rate of 50%
in 1 year.**



Treatment in Day Care Setting

- 5 days a week → 8 hours a day
- Supervised eating
 - Ensure adequate calorie intake
 - Meal and post meal supervision
 - Preclude dysfunctional eating habits → vomiting or over exercising
 - Re-educate → new knowledge, skills and positive experiences with eating
 - Group shopping, food preparation, eating out,
 - Teach patients to develop alternate coping skills based on group processes



Care of the Dietitian dealing with EDs



Case Study

- Was 60 kg in high school
- Went to college,
- Started restrictive eating, intensive exercise, dropped to 45 kg in 2nd year at college
- Height 168 cm, weight 47 kg, BMI 16.8 (age 23 years)
- Seen every 3 weeks for 1 year since return from college by internist → No improvement
- Sees eating disorder specialist
- What would be the next steps?
- Is the patient a candidate for in-patient behavior therapy?
 - What would be the goals of the program?



Training? Research??

- What do we need to be better at what we do?



