Eating Disorders

UCMS Semester , Batch

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Eating Disorders

- Eating disorders (EDs) are psychiatric disorders with diagnostic criteria based on psychologic, behavior, and physiologic characteristics.
- Multidisciplinary approach is required in the clinical care of individuals with EDs and nutrition care plays a significant role in the prevention of EDs and related complications.
- Key nutrition therapies require expertise in nutritional requirements for the life stage of the affected individual, nutritional rehabilitation treatments, and modalities to restore normal eating patterns.

Diagnostic criteria for eating disorders.

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Anorexia nervosa. Types: Restricting or binge-eating/purging

Diagnostic and Statistical Manual of Mental Disorders (DSM) *IV*

- Exaggerated drive for thinness
- Refusal to maintain a body weight above the standard minimum (eg, <85% of expected weight)
- Intense fear of becoming fat with self-worth based on weight or shape
- Evidence of an endocrine disorder

Proposed for DSM V

- Restricted energy intake relative to requirements leading to a markedly low body weight
- Intense fear of gaining weight or becoming fat or persistent behavior to avoid weight gain, even though at a markedly low weight
- Disturbance in the way in which one's body weight or shape is experienced

Bulimia nervosa

DSM IV

- Overwhelming urges to overeat and inappropriate compensatory behaviors or purging that follow the binge episodes (eg, vomiting, excessive exercise, alternating periods of starvation, and abuse of laxatives or drugs)
- Similar to anorexia nervosa, individuals with bulimia nervosa also display psychopathology, including a fear of being overweight

Proposed for DSM V

- Recurrent episodes of binge eating with a sense of a lack of control with inappropriate compensatory behavior
- Self-evaluation is unduly influenced by body shape and weight
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Binge eating disorder

DSM IV

- Classified under eating disorders not otherwise specified

Proposed for DSM V

- Repeated episodes of overconsumption of food with a sense of a lack of control with a list of possible descriptors such as how much is eaten and distress about the episode
- Frequency described as at least once a week for 3 months

Eating disorders not otherwise specified

DSM IV

- Considered to be partial syndromes with frequency of symptoms that vary from above diagnostic criteria
- Distinguishing feature of binge eating disorder is binge eating, with a lack of self-control, without inappropriate compensatory behaviors

Proposed for DSM V

- Diagnostic criteria to be established for binge eating disorder
- Possible descriptions of eating problems such as purging disorder and night eating syndrome

Types of Eating Disorders

American Psychiatric Association (DSM-IV) Criteria

Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected)

B. Intense fear of gaining weight or becoming fat, even though underweight

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight

- In postmenarcheal females, amenorrhea (i.e., the absence of at least three consecutive menstrual cycles)
- 1. Restricting type: During the current episode of AN, not regularly engaged in binge eating or purging behavior
- 2. Binge eating–purging type: During the current episode of AN, regularly engaged in binge eating and purging behavior.

Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

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

B. Recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise

C. Binge eating and inappropriate compensatory behaviors both occurring, on average, at least twice a week for 3 months

D. Self evaluation unduly influenced by body shape and weight.

E. Disturbance not exclusively occurring during episodes of AN

1. Purging type: During the current episode of BN, regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas
2. Nonpurging type: During the current episode of BN, use of other inappropriate compensatory behaviors such as fasting or excessive exercise but not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enema.

Some of the abnormal eating behaviours in AN

- Abnormal timings of meals and snacks
- Avoidance of specific foods
- Subjective or objective binge eating
- Compensatory purging activity, including exercise
- Difficulty estimating portion size
- Dispropotionate time spent thinking about food
- Inability to define or eat a balanced nutrient intake
- Inability to identify hunger or satiety
- Inappropriate food combinations
- Reduced spontaneity and flexibility concerning food intake
- Abnormal speed of eating a meal

Nutrition assessment in Eating Disorders

- Identify nutrition problems that relate to medical or physical condition, including eating disorder symptoms and behaviors.
- Perform anthropometric measurements; including height and weight history, complete growth chart, assess growth patterns and maturation in younger patients (ages 20 years and younger)
- Interpret biochemical data; especially to assess risk of refeeding syndrome .
- Evaluate dietary assessment; eating pattern, core attitudes regarding weight, shape, eating.
- Assess behavioral-environmental symptoms; food restriction, bingeing, preoccupation, rituals secretive eating, affect and impulse control, vomiting or other purging, excessive exercise.
- Apply nutrition diagnosis and create a plan to resolve nutrition problems, coordinate plan with team members

Nutrition Therapy in Eating Disorders

- Calculate and monitor energy and macronutrient intake to establish expected rates of weight change, and to meet body composition and health goals.
- Guide goal setting to normalize eating patterns for nutrition rehabilitation and weight restoration or maintenance as appropriate.
- Ensure diet quality and regular eating pattern, increased amount and variety of foods consumed, normal perceptions of hunger and satiety, and suggestions about supplement use.
- Provide psychosocial support and positive reinforcement; structured refeeding plan.
- Counsel individuals and other caregivers on food selection considering individual preferences, health history, physical and psychological factors, and resources.

Nutritional Therapy for AN

1. Restoring Weight and improving eating habits:

- **It should have following objectives:-**
  - Weight and nutritional restoration with psychotherapy.
  - Weight gain is gradual and not precipitous.
  - Support to encourage patients to eat meals.
- Discussion of the "target" weight is one of the important initial tasks of weight restoration.
  - This should be done in context of achieving a healthy body weight including a healthy bone mass.

Nutritional Therapy for AN

- Nutritional therapy has three phases to the weight restoration process:
  - **weight stabilization and prevention of further weight loss,**
  - **weight gain, and**
  - **weight maintenance.**
- Although the duration of these phases vary, the weight restoration process is typically the longest and is obviously influenced by patient's state of malnutrition.
- Targeted rate of expected rate of weight gain should be determined in an individualized manner considering patient's state of malnutrition.
- Initial calorie prescription may range from1000 to 1600 kcal/ day (30 to 40 kcal/kg of body weight per day) with progressive increases in energy intake of 100 to 200 calorie increments every 2 to 3 days to promote a consistent and targeted rate of weight gain.

Nutritional Therapy for AN

- In most places, BMI of 18.5 kg/m^2 is being used as the minimal healthy weight for a patient over the age of 16 years.
- Although achievement of this minimal weight may not always be possible during inpatient treatment, the patient and his/her family should accept this as an ultimate goal of treatment.

- Rapid ***Refeeding*** may lead to massive edema or acute gastric dilation, and may increase resistance on the part of the patient.

Nutritional Therapy for BN

Energy prescription for weight maintenance:

a) If there is evidence of a hypometabolic rate provide 1500 to 1600 kcal/day diet if patient is hypometabolic.

b) If metabolic rate appears to be normal, provide DRI for energy if metabolic rate is normal.

c) Monitor body weight and adjust caloric prescription for weight maintenance.

d) Avoid weight reduction diets until eating patterns and body weight are stabilized.

Nutritional Therapy for BN

- BN patients need a great deal of encouragement to follow weight-maintenance versus weight-loss diets.
- They must be reminded that attempts to restrict caloric intake may only increase the risk of binge eating and that their pattern of restrained intake followed by binge eating has not facilitated weight loss in the past.
- A balanced macronutrient intake is essential for the provision of a regular meal pattern.
- This should include sufficient carbohydrates to prevent craving and adequate protein and fat to promote satiety.

Nutritional Therapy for BN

- CBT, a highly structured psychotherapeutic method used to alter attitudes and problem behaviors by identifying and replacing negative, inaccurate thoughts and changing the rewards of the behavior.
- CBT consists of three distinct and systematic phases of treatment:
  1. establishing a regular eating pattern,
  2. evaluating and changing beliefs about shape and weight, and
  3. preventing relapse.

Nutritional monitoring and evaluation

- Monitor nutrient intake and adjust as necessary.
- Monitor rate of weight gain, once weight restored, adjust food intake to maintain weight.
- Communicate individual's progress with team and make adjustments to plan accordingly

Nutrition Care coordination

- Provide counsel to team about protocols to maximize tolerance of feeding regimen or nutrition recommendations, guidance about supplements to ensure maximum absorption, minimize drug nutrient interactions, and referral for continuation of care as needed.
- Work collaboratively with treatment team, delineate specific roles and tasks, communicate nutrition needs across the continuum of settings (eg, inpatient, day treatment, outpatient)
- Act as a resource to other health care professionals and the family, provide education
- Advocate for evidenced-based treatment and access to care.

Thank You