Understanding Eating Disorders

With Professor Barry Carpenter & Dr Dasha Nicholls
Today’s learning objectives

- To identify the types of eating disorders and know how they differ from ‘normal’ concern about eating, weight and shape
- Recognise the early signs of disordered eating behaviour and how best to respond
- Understand the impact eating disorders may have on learning
- Know about the types of effective psychological treatments that are available
- Know who to contact and where to turn if you need more help
Who am I?

- A researcher in childhood feeding and eating disorders
- A Consultant Child and Adolescent Psychiatrist
- Worked in eating disorders field for 25 years
- Do lots of teaching and other work to improve clinical care for people with eating disorders
- A parent
What are eating disorders?

• Mental health disorders
  • Not defined by weight or appearance, but by thoughts, feelings and behaviours
• ‘A persistent disturbance of eating behaviour or behaviour intended to control weight, which significantly impairs physical health or psychosocial functioning’
• Driven by fear of fatness or extreme distress about eating behaviour
Disturbance of eating behaviour?

• Binge eating
• Restricted eating
Behaviour intended to control weight?

- Restricted eating (fasting)
- Self induced vomiting
- Excessive exercise
- Laxative, diuretic and other energy burning or appetite suppressing medications (e.g. caffeine, smoking)
Impairs physical health and psychosocial function?

• Impacts growth and development
• Stop periods
• Effects on the brain
• Results in osteoporosis
• High mortality

• Impairs Function
  • Impacts work
  • Relationships (family, peers, intimate)
  • Daily living
• Distress
POLL: Which of these eating disorders does not usually involve dietary restriction?

<table>
<thead>
<tr>
<th>Anorexia nervosa</th>
<th>Bulimia nervosa</th>
<th>Binge Eating Disorder</th>
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</thead>
<tbody>
<tr>
<td>Weight</td>
<td>Low, normal or high</td>
<td>Normal or high</td>
<td>Normal or high</td>
</tr>
<tr>
<td>Binge eating</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dietary restriction</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>Self induced vomiting</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Excessive exercise</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>Drive for thinness</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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DSM5 and ICD11 Feeding and Eating Disorders

• Pica
• Rumination Disorder
• Avoidant/Restrictive Food Intake Disorder (ARFID)

• Anorexia Nervosa
• Bulimia Nervosa
• Binge Eating Disorder
• Other Specified Feeding and Eating Disorders (OSFED) including purging disorder
ARFID

- Feeding/Eating disturbance
  - significant weight loss
  - significant nutritional deficiency
  - dependence on enteral feeding/nutritional supplements
  - marked interference with psychosocial functioning
- No weight/shape concerns

Three main subtypes proposed:
- individuals who do not eat enough/show little interest in feeding;
- individuals who only accept a limited diet in relation to sensory features;
- and, individuals whose food refusal is related to aversive experience
What is NOT an eating disorder?

• Vegetarianism, veganism or other nutritional choices
• Obesity
• Food phobias
• Fussy and picky eating
It is normal:

• for children to be fussy/picky about food, especially boys, and can be linked to sensory sensitivity. Most grow out of it.
• for children to become more self aware, from about age 10
• for children to care about how others see them
• for children to worry about being too fat
• for children’s eating to be affected by their mood
• for food to be one of the ways children assert themselves
Children differ from one another:

- in their sensitivity to sensory aspects of food (texture, smells, disgust)
- in their interest in food
- in their ability to self regulate (knowing when to stop)
## Myths & Facts

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
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<tbody>
<tr>
<td>• Eating disorders are just a faddy diet gone wrong</td>
<td>• Eating disorders are serious mental illnesses, requiring prompt and appropriate treatment.</td>
</tr>
</tbody>
</table>
Myths & Facts

• Myth

• No one ever really recovers from an eating disorder – you’ve got it for life

• Fact

• Eating disorders are treatable and full recovery is possible.
• There are serious long term consequences to physical health if conditions are not treated promptly.
• Some people develop a long term or recurrent eating disorder, but treatment is improving all the time.
Myths & Facts

Myth

• Eating disorders only affect high achieving girls from privileged backgrounds

Fact

• Eating disorders can affect people of any age, gender, culture, ethnicity or background.
• Girls and young women aged 12-20 are most at risk
• 20% are boys and men
## Myths & Facts

<table>
<thead>
<tr>
<th>Myth</th>
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<tr>
<td>• You can tell just by looking at someone if they have an eating disorder.</td>
<td>• Eating disorders are mental illnesses – involving someone’s thoughts, feelings and emotions.</td>
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<tr>
<td></td>
<td>• Eating disorders come in all shapes and sizes and not everyone affected will be underweight or look ill</td>
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</table>
Myths & Facts

Myth

• Eating disorders are a modern phenomenon.

Fact

• Eating disorders were first observed in the 1680s associated with saints...
• Restrictive eating disorders were identified as a mental health syndrome from 1890s onwards
<table>
<thead>
<tr>
<th>Myth</th>
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<tr>
<td>• Eating disorders are caused by bad parents.</td>
<td>• Parents don’t cause eating disorders</td>
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<tr>
<td></td>
<td>• Causes are complex and involve many factors</td>
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<tr>
<td></td>
<td>• Parents and families can play a vital part in helping their loved ones overcome an eating disorder, and the more they learn to understand the condition the more they can help.</td>
</tr>
<tr>
<td>Myth</td>
<td>Fact</td>
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<tr>
<td>Eating disorders can be a lifestyle choice.</td>
<td>People with eating disorders do not choose to be ill, and they are not ‘attention seeking’.</td>
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<td></td>
<td>They can find it very difficult to believe that they are ill, and hard to acknowledge it once it’s diagnosed. This is one of the most challenging aspects of how the illness affects someone’s thinking and behaviour.</td>
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<tr>
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<td>• People with eating disorders are just trying to look thin like their celebrity idols.</td>
<td>• People with eating disorders typically have low self esteem and may feel worthless. The eating disorder exacerbates these feelings, contrary to what the sufferer may hope.</td>
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</table>
What has changed since you were a child?

• Increased media exposure, including social media, to the ‘thin ideal’, ‘how to eat’ and other influencer impacts
• Increased focus on nutrition (information on packets etc)
• Antiobesity public health messaging
• ?Increased competition at an earlier age/other pressures
Body Confidence

What types of thoughts and feelings about one's body, weight and shape are typical in childhood?

What can you remember from your own childhood?
POLL: True or False?

20% (1 in 5) of 11-year-olds in the WHO region is overweight or obese?
Increasing prevalence of childhood obesity

Global Prevalence of Overweight in Girls
2000-2006

In the WHO European Region
1 in 3 11-year-olds is overweight or obese

% Overweight
< 5%
5-9.9%
10-14.9%
15-19.9%
20-24.9%
25-29.9%
≥30%
Self Reported data
Cultural message “Fat is disgusting”
Change for Life: Sugar Smart campaign
The challenge

• Addressing the obesity ‘epidemic’ without raising anxiety, guilt and shame about body weight and shape or morbid preoccupation with food and eating

• What can teachers do?
  • Promote positive body image and body confidence
  • Help young people recognise emotional triggers for change in eating behaviour
  • Challenge radical and unhelpful weight loss strategies
  • Challenge weight stigma in all its forms
Girls vs boys

• By age 9 self-perception and body shape satisfaction is different between boys and girls
• The heaviest children expressed the most discontent, having a low body-esteem, a desire for thinness and higher levels of dietary restraint.
• However, this desire for thinness and associated dieting motivation was apparent across the weight range and was more characteristic of girls than boys.
What puts children and young people at risk of an eating disorder?

- Being female!
- Negative body image
- Internalisation of the thin ideal
- Negative affect (feeling bad – low mood, anxious, angry)
- Perfectionism
- Low self esteem
- Coping style
- Cognitive style
Early Signs

EATING PATTERN CHANGES (n=49)
- Eating less (dietary restraint)
  - "Wasting small portions"
  - "Slipping meals"
- Selective & rule-bound beh. (dietary restriction)
  - "Going vegetarian"
  - "Not using cutlery"
- Secretiveness (hiding food)
  - "Packed lunches left under the bed"
- Other
  - "Not wanting to eat in front of others"

OBSERVED WEIGHT LOSS (n=27)
- "Clothes looking baggier, she was losing weight"

BINGE EATING/COMPENSATORY BEHAVIOURS (n=18)
- Over-exercising
  - "Wanting to walk everywhere when he used to get the bus"
- Purging behaviours
  - "Disappearing to the bathroom after meals"
- Over eating
  - "Snack frequently"

WEIGHT CONCERN (n=2)
- "After losing weight and reaching a good weight, continuing to try"

SOMATIC SYMPTOMS (n=7)
- Feeling sick after eating"
- "Reduced appetite"
- "Being cold"

EMOTIONAL & OTHER MH CONCERNS (n=10)
- Change in mood
  - "Mood swings"
- Social withdrawal
  - "Not wanting to talk with me"
- Anxiety
  - "Looking more anxious"
- Low self-esteem
  - "Dramatic increase in low self-esteem"

SHAPE CONCERN (n=22)
- Expressing concerns about being overweight/bulky image
- Wearing baggy clothes
  - "Clothes looking baggier"
- Expressing concerns about a particular part of the body
  - "Worry about large legs"
- Comparison to others
  - "Being aware of the size of her classmates and others"
- Indirect discomfort with the body
  - "Prolonged gazing in the mirror"

What was the first thing you noticed?

FIGURE 2 Thematic analysis with example quotes of parents’ responses to the question “What was the first thing you noticed?”
Eating Disorders as Brain Disorders

- Reduces stigma and shame
- Improves access to health care funding
- Value for parents and carers
- Increased neuroscience research funding
Eating disorders are severe mental disorders
Cognitive style vs cognitive development

I worked with a 9 year old boy who presented at the eating disorder clinic. He had stopped eating snacks of any kind and was intensively exercising alone in his room each day; as a consequence he was significantly underweight.

In our first family session when we started to ask G about what he thought normal eating was he said something to the following effect: "they tell us at school that snacks are bad, and that we all need to exercise more to make sure we don't get fat and lazy and the government say we should exercise more". 
# Stages of management

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<tr>
<th>Recognition</th>
<th>Assessment</th>
<th>Treatment</th>
<th>Post treatment</th>
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<tbody>
<tr>
<td>Family/patient/doctor/school</td>
<td>Risk assessment</td>
<td>Normalise eating and weight</td>
<td>Follow-up/review</td>
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<td></td>
<td>Medical stabilisation</td>
<td>Address weight and shape concerns</td>
<td>Treatment for other condition if needed</td>
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<tr>
<td></td>
<td>Engagement</td>
<td>Address secondary medical concerns</td>
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<td>Develop a psychological</td>
<td>Review progress</td>
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<tr>
<td></td>
<td>understanding</td>
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What is the right treatment?

Most young people (who have parental/carer support) with an eating disorder should be offered family therapy (in conjoint, separated or multifamily format) as first line treatment on an outpatient (or if too sick, day patient) basis.

If the above is not possible, appropriate or has not worked, individual approaches using focussed psychotherapy, CBT, motivational approaches or recovery based approaches should be offered within a specialist team context.
The Effect on Families

• Carers of people with ED present high levels of psychological distress and burden

• High levels of parent/carer distress may in turn influence/impact recovery (Zabala et al 2009)

• Carer interventions benefit carers and patients
If you think a child has an eating disorder?

• Don’t ignore it!
• Communicate – express concern (not praise!), explore
• Know your facts – when is it dangerous? what are your rights and responsibilities? Don’t keep secrets
• Know where to turn, don’t wait and see
Where can I turn for help?

• B-eat  www.b-eat.co.uk
• F.E.A.S.T.  www.feast-ed.org
• Eva Musby  https://anorexiafamily.com
• Men get eating disorders too  mengetedstoo.co.uk
• Books
  • Help your teenager beat an eating disorder by Lock and Le Grange.
  • ARFID : A Guide for Parents and Carers by Rachel Bryant-Waugh
Reflection points:

• How could you help the children you teach be more body confident? Are there any pressures on him/her to be other than he/she is?

• How could you encourage children to be responsible and independent around food and eating?

• Do you have concerns about talking to a child about their weight and their eating behaviour?

• How do you/does the school promote and model healthy eating and body confidence?
Aims recap

• To identify the types of eating disorders and know how they differ from ‘normal’ concern about eating, weight and shape
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• Know about the types of effective psychological treatments that are available
• Know who to contact and where to turn if you need more help

ACAMH Podcasts:  https://www.acamh.org/?s=eating+disordes&current_tab=podcast

https://www.nice.org.uk/guidance/ng69/chapter/Context