Eating and Weight Disorders
Quick overview

Eunice Chen, Ph.D.
Adult Eating and Weight Disorders
University of Chicago
Weight and Our Culture

- Discrepancy between biology and culture
- Culture of harmful messages
  1) Can’t ever be thin enough or buff enough
  2) Your weight is a moral issue
  3) Just eat more!
How to be Ken or Barbie

To be Ken:

- Grow 20 inches taller
- Have 10 more inches around the waist
- Have your chest expand 11 more inches

To be Barbie:

- Grow 24 inches taller
- Lose 6 inches around the waist
- Have your chest expand 5 inches
DSM-IV: Anorexia Nervosa

• Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., less than 85% of that expected, ICD-10 uses BMI less than 17.5)
• Intense fear of gaining weight or becoming fat, even though underweight
• Disturbance in the way one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of current body weight
DSM-IV: Anorexia Nervosa

- Amenorrhea, i.e., the absence of at least three consecutive menstrual cycles
- Subtypes
  - Restricting type
  - Binge eating / purging type (vomiting, laxative, diuretic abuse)
Body Mass Indices

Body Mass Indices = Mass in Kg / Height in Metres$^2$
OR (Mass in lbs / Height in inches$^2$) X 703

ICD-10
Anorexic range.................. Less than 17.5

WHO Criteria
Underweight ...................... Less than 18.5
Normal range .................... 18.5 to 24.99
Overweight ....................... 25.0 to 29.99
Obese ............................ 30 and over
Obese Class I .................... 30-34.99
Obese Class II ................... 35-39.99
Obese Class III .................. 40 and over
Medical problems associated with AN

- Menstrual or reproductive complications e.g. amenorrhea, infertility
- Osteopenia-decreased bone mass
- Gastrointestinal complications e.g. bloating, constipation, polyuria, abdominal pain
- Cardiovascular problems e.g. bradycardia, hypotension, cardiac arrhythmia, cardiac failure
- Renal and metabolic complications e.g. hypothermia, sensitivity to cold and heat, disturbed electrolytes due to vomiting and laxative abuse, anaemia
- Hematological problems
- Dermatological complications e.g. dry skin, head hair loss, brittle head hair, lanugo hair
- Neurological – fatigue, dizziness, hyperactivity
- Mortality
DSM-IV: Bulimia Nervosa

• Recurrent episodes of binge eating characterized by both of the following:
  – Eating in a discrete period of time an amount of food that is larger than most people would eat during a similar period of time or under similar circumstances
  – A sense of loss of control over eating during the episode
DSM-IV: Bulimia Nervosa

- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; excessive exercise
- Binge eating and compensatory behaviors average two times a week for three months
- Self-evaluation unduly influenced by body shape and weight
DSM-IV: Bulimia Nervosa

- Disturbance does not occur during an episode of Anorexia Nervosa
- Subtypes:
  - Purging Type (self-induced vomiting, misuse of laxatives, diuretics, or enemas)
  - Nonpurging Type (fasting, excessive exercise)
Medical problems associated with BN

- Fluid and electrolyte damage from purging e.g. metabolic alkalosis, hypochloremia, hypokalemia, dehydration
- Gastro-intestinal complaints e.g. salivary gland hypertrophy, constipation, Irritable Bowel
- Cardiovascular problems due to electrolyte problems
- Dermatological – Russell’s sign
- Neurological – headaches, poor problem solving
• Endocrine / Metabolic – irregular periods
• Renal problems
• Dental decay from vomiting
• Mortality
Psychological problems associated with AN & BN

- Preoccupation with food, weight and shape
- Depression, mood swings
- Loss of concentration
- Preoccupation and Anxiety about food
- Social withdrawal
- Low self esteem
- Obsessiveness
- Perfectionism
- Poor sleep
- Odd eating patterns
Diagnoses comorbid with AN & BN

- Major Depression
- Anxiety disorders e.g. OCD for AN
- Drug and Alcohol
- Personality disorders e.g. Borderline Personality disorders for BN and OCPD for AN
Epidemiology of AN & BN

- Adolescents and young women
- AN rarer Prevalence .9% BN is 1-2%
- AN Third most common chronic condition in adolescent girls and women, preceded only by obesity and asthma. WHO report
- BN Increasing over time in successive cohorts (Hudson, 2007)
Course and Outcome of AN

- Onset in adolescence, peaking 18 years
- 4 year follow-up studies 44% within 15% of recovered body weight, 25% ill and 5% dead
- Mortality up to 20% in 20 year studies (Steinhausen et al., 1991)
- Mortality 5 times that of same aged population. Major depression is only 1.4 times (NEJM, 1999).
Course and outcome of BN

- Onset late adolescence to early 20s
- 30% after AN, majority after dietary restriction
- Waxing and waning course
- 6 mths to 10 years outcome 50% fully recovered, 20% meet full criteria for BN and 30% relapse
- Mortality approximately 0.3% (Keel & Mitchell, 1997)
DSM-IV: Binge Eating Disorder

• Recurrent episodes of binge eating characterized by both of the following:
  – Eating in a discrete period of time an amount of food that is larger than most people would eat during a similar period of time or under similar circumstances
  – A sense of loss of control over eating during the episode
Research Diagnosis of DSM-IV: Binge Eating Disorder

• Episodes are associated with at least 3:
  – Eating much more rapidly than normal
  – Eating until feeling uncomfortably full
  – Eating large amounts of food when not feeling physically hungry
  – Eating alone because of being embarrassed by how much one is eating
  – Feeling disgusted with oneself, feeling depressed or feeling very guilty after overeating
DSM-IV: Binge Eating Disorder

• Marked distress regarding binge eating
• The binge eating occurs, on average, at least two days a week for six months
• The disturbance does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa
BED and Obesity

BED

OBESITY
Current understanding of BED

- Some BED clients are not obese but lifetime BED is associated with BMI over 40
- As many as 5-10% patients seen at university clinics have BED
- Community figures of 3.5% in women and 2% among men
- Most frequently occurring ED for men
- People come in for treatment are in 40s but onset in childhood
Obesity

• Chronic Medical condition not a psychiatric disorder
• Obesity is not caused by greed, laziness or lack of control
• 64% of US is overweight or obese
• Genetics loads the gun and the environment pulls the trigger
• Extreme dieting is not the solution for the majority of obese people.
• Overweight and obese people can be fit and healthy
• Medical problems include: hypertension, cardiovascular disease, Type II diabetes, some cancers, respiratory problems like sleep apnea, osteoarthritis
• Discrimination against overweight people.
EDNOS

- Does not meet full criteria for AN/BN.
- Includes BED
- For females, AN criteria except has regular menses.
- AN criteria met except that, despite substantial weight loss, current weight is in the normal range.
- BN criteria are met except that binge-eating and inappropriate compensatory mechanisms occurs < 2 xs /week or for < than 3 months.
- Regular compensatory behavior after eating small amounts of food (eg; vomiting after the eating 2 cookies) in individual with normal body weight
- Repeatedly chewing & spitting out, but not swallowing, large amounts of food.