Eating Disorders Awareness and Prevention: Strategies to Support Your Child

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Objectives

I. What is an eating disorder versus “normal eating”
II. Risk factors
III. Signs and symptoms
IV. Types of eating disorders
V. Strategies to reduce risk of eating disorders
VI. Strategies to support your child if they are presenting with eating disorder symptoms

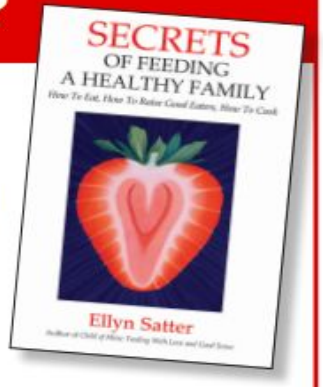
What is an eating disorder?

"...persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning."

(American Psychiatric Association, 2013)

Normal Eating

What is normal eating?



Normal eating . . .
is going to the table hungry, and eating until you are satisfied.

Normal eating . . .
is being able to choose food you enjoy and to eat it and truly get enough of it—not just stop eating because you think you should.

Normal eating . . .
is being able to give some thought to your food selection so you get nutritious food, but not being so wary and restrictive that you miss out on enjoyable food.

Normal eating . . .
is giving yourself permission to eat because you are happy, sad, or bored, or just because it feels good.

Normal eating . . .
is mostly three meals a day—or four or five—or it can be choosing to munch along the way.

Normal eating . . .
is leaving cookies on the plate because you will let yourself have cookies again tomorrow, or eating more now because they taste so great!

Normal eating . . .
is overeating at times, and feeling stuffed and uncomfortable . . . and undereating at times, and wishing you had more.

Normal eating . . .
is trusting your body to make up for your mistakes in eating.

Normal eating . . .
takes up some of your time and attention, but keeps its place as only one important area of your life.

In short, normal eating is flexible . . .
it varies in response to your hunger, your schedule, your food, and your feelings.

Statistics

In a large study of 14– and 15-year-olds, dieting was the most important predictor of a developing eating disorder. Those who dieted moderately were 5x more likely to develop an eating disorder, and those who practiced extreme restriction were 18x more likely to develop an eating disorder than those who did not diet.
(Golden., Schneider & Wood, 2016)

9% of the U.S. population, or 28.8 million Americans, will have an eating disorder in their lifetime.
(Deloitte Access Economics, 2020)

Less than 6% of people with eating disorders are medically diagnosed as “underweight.”
(Flament et al., 2015)

Eating disorders are among the deadliest mental illnesses, second only to opioid overdose.
(Arcelus et al., 2011)

Boys and girls were equally likely to engage in disordered eating, going against common assumptions. Therefore, boys face a similar risk to girls. The analysis also revealed that children with higher body mass indexes, as well as those further along in puberty, faced a higher risk.
(Cross, 2022)

Risk Factors

Biological

- Having a close relative with an eating disorder
- Having a close relative with a mental health condition
- History of dieting
- Negative energy balance
- Type 1 (insulin-dependent) diabetes

Psychological

- Perfectionism
- Body image dissatisfaction
- Personal history of an anxiety disorder, mood disorder, trauma history, and/or substance use
- Behavioral inflexibility

Social

- Weight stigma
- Teasing or bullying
- Appearance idealization
- Acculturation
- Limited social networks
- Historical trauma or intergenerational trauma

Warning Signs: Emotional & Behavioral

- Preoccupation with weight, food, calories, carbohydrates, fat grams, and dieting
- Refusal to eat certain foods, progressing to restrictions against whole categories of food (no sugar, no carbs, no dairy, no gluten, vegetarianism/veganism)
- Food rituals
- Skipping meals or taking small portions of food at regular meals
- Appears uncomfortable eating around others
- Withdrawal from usual friends and activities
- Frequent dieting
- Extreme concern with body size and shape
- Frequent checking in the mirror for perceived flaws in appearance
- Extreme mood swings
- Consistent chewing of ice or gum

(National Eating Disorders Association, 2022)

Warning Signs: Physical

- Noticeable fluctuations in weight
- Stomach cramps, other non-specific gastrointestinal complaints (constipation, acid reflux, etc.)
- Menstrual irregularities
- Difficulties concentrating
- Abnormal laboratory findings (anemia, low thyroid and hormone levels, low potassium, low white and red blood cell counts)
- Dizziness, especially upon standing
- Fainting/syncope
- Feeling cold
- Cuts and calluses across the top of finger joints
- Dental problems, such as enamel erosion, cavities, and tooth sensitivity
- Dry skin and hair, and brittle nails
- Swelling around area of salivary glands
- Fine hair on body (lanugo)
- Muscle weakness
- Cold, mottled hands and feet or swelling of feet
- Poor wound healing
- Impaired immune functioning
- Sleep problems

(National Eating Disorders Association, 2022)

DSM-5 Diagnoses: Feeding and Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Binge-Eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder
- Pica
- Rumination Disorder

- Other: Orthorexia, Compulsive Exercising, Diabulimia

(American Psychiatric Association, 2013)

Anorexia Nervosa (AN)

1. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
2. A disturbance in one's body image, through use of one's body weight or shape to unduly self-evaluate, or persistent lack of recognition of current low body weight.
3. Restriction of energy intake (i.e. calories one consumes) that result in significantly lowe weight within the context of one's physical health and/or developmental trajectory.

Subtypes:

- *Restricting type:* During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
- *Binge-eating/purging type:* During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

(American Psychiatric Association, 2013)

Bulimia Nervosa (BN)

1. Recurrent episodes of binge eating- an episode of binge eating is characterized by both of the following:
    a. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
    b. 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).
2. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

(American Psychiatric Association, 2013)

Binge Eating Disorder (BED)

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    a. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
    b. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what one is eating).
2. The binge-eating episodes are associated with three (or more) of the following:
    a. Eating much more rapidly than normal.
    b. Eating until feeling uncomfortably full.
    c. Eating large amounts of food when not feeling physically hungry.
    d. Eating alone because of feeling embarrassed by how much one is eating.
    e. Feeling disgusted with oneself, depressed, or very guilty afterward.
    f. Marked distress regarding binge eating is present.
3. The binge eating occurs, on average, at least once a week for 3 months.
4. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

(American Psychiatric Association, 2013)

Avoidant/Restrictive Food Intake Disorder (ARFID)

1. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
    a. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
    b. Significant nutritional deficiency
    c. Dependence on enteral feeding or oral nutritional supplements
    d. Marked interference with psychosocial functioning
2. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice
3. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced
4. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

(American Psychiatric Association, 2013)

Other Specified Feeding or Eating Disorder (OSFED)

1. This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.
2. The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder. This is done by recording “other specified feeding or eating disorder” followed by the specific reason.

Examples:

- Atypical anorexia nervosa
- Bulimia nervosa (of low frequency and/or limited duration)
- Binge-eating disorder (of low frequency and/or limited duration)
- Purging disorder
- Night eating syndrome

Pica

1. The persistent eating, over a period of at least 1 month, of substances that are not food and do not provide nutritional value.
2. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
3. The eating behaviour is not part of a culturally supported or socially normative practice.
4. There is typically no aversion to regular food intake.
5. If the eating behaviour occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.
6. Typical substances ingested tend to vary with age and availability. They may include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal, ash, clay, starch, or ice.

(American Psychiatric Association, 2013)

Rumination Disorder

1. Repeated regurgitation of food for a period of at least 1 month.
2. Regurgitated food may be re-chewed, re-swallowed, or spit out.
3. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).
4. The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.
5. If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

(American Psychiatric Association, 2013)

Unspecified Feeding or Eating Disorder (USFED)

1. Applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functions predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.
2. The unspecified feeding and eating disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific feeding and eating disorder, and includes presentation in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

(American Psychiatric Association, 2013)

Other: Orthorexia

- Cutting out an increasing number of food groups (all sugar, all carbs, all gluten, all dairy, all meat, all animal products).
- An increase in concern about the health of ingredients; an inability to eat anything but a narrow group of foods that are deemed ‘healthy’ or ‘pure.’
- Spending hours per day thinking about what food might be served at upcoming events.
- Body image concerns may or may not be present.

(National Eating Disorders Association, 2022)

Other: Compulsive Exercise

- Exercise that significantly interferes with important activities, occurs at inappropriate times or in inappropriate settings, or occurs when the individual exercises despite injury or other medical complications.
- Intense anxiety, depression and/or distress if unable to exercise.
- Exercise takes place despite injury or fatigue.

(National Eating Disorders Association, 2022)

Other: Diabulimia

- Increasing neglect of diabetes management (e.g. infrequently fills prescriptions and/or avoids diabetes related appointments)
- Secrecy about diabetes management with discomfort testing/injecting in front of others.
- Fear that “insulin makes me fat.”
- Restricting certain food or food groups to lower insulin dosages.
- A1c of 9.0 or higher on a continuous basis.

(National Eating Disorders Association, 2022)

What can I do as a parent to reduce risk?

- Model the behavior you want to see by shifting the way you think and speak about food and body weight and shape
- Adopt the mindset that food is medicine and All Foods Fit
- Use non-judgemental language to avoid language that labels food as good or bad, healthy or unhealthy, right or wrong
- When possible, decrease discussion and/or comments about bodies, weight, and shape
- When needed, speak about body, weight, and shape in neutral or positive language
- Validation without accomodation to avoid inadvertent reinforcement of disordered eating
- Encourage self and others to consume and engage in activity that makes them feel good
- Engage in commentary/discussions that are not eating related when consuming food
- Exchange maladaptive/unhealthy habits around food and body for adaptive/healthy ones
- Explore and seek support to develop adaptive/healthy means of coping

I think my child needs support. What do I do as a parent?

- Seek further assessment through a medical exam with a primary care physician and consultation with an eating disorder professional
- NEDA Eating Disorder Screening Tool: https://www.nationaleatingdisorders.org/screening-tool
- Separate the ED from your child (Remember - the ED has overtaken your child and most times your child does not have insight into the ED)
- Remove access to scales and media that is weight loss or body-image focused
- Monitor your child after snacks and meals
- Move away from discussion body shape or weight
- Stop all exercise or excessive movement (i.e., be mindful of late night exercise, bouncing legs, or excessive standing)
- Discuss all foods in a positive or neutral way
- Avoid negotiating with the eating disorder by preparing and plating foods without accommodating what the disorder will or will not eat
- Choose a supportive phrase which caregivers can repeat for consistent encouragement (e.g., I know it's difficult AND you need to eat it)

Resources

Books

- Secrets of Feeding a Healthy Family: How to Eat, How to Raise Good Eaters, How to Cook by Ellyn Satter
- Health At Every Size: The Surprising Truth About Your Weight by Linda Bacon
- Intuitive Eating by Evelyn Tribole, MS, RDN & Elyse Resch, MS, RDN
- Help Your Child Beat an Eating Disorder by James Lock, MD, PhD & Daniel Le Grange, PhD

Websites

- Ellyn Satter Institute, https://www.ellynsatterinstitute.org/
- National Eating Disorders Association, https://www.nationaleatingdisorders.org/
- HAES, https://www.nationaleatingdisorders.org/get-involved/the-body-project

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Time for Questions & Answers

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