

# Eating and Weight Disorders

## Quick overview

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# 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<sup>2</sup>

OR (Mass in lbs/ Height in ) X 703  
inches<sup>2</sup>

## 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 problemsolving

- 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

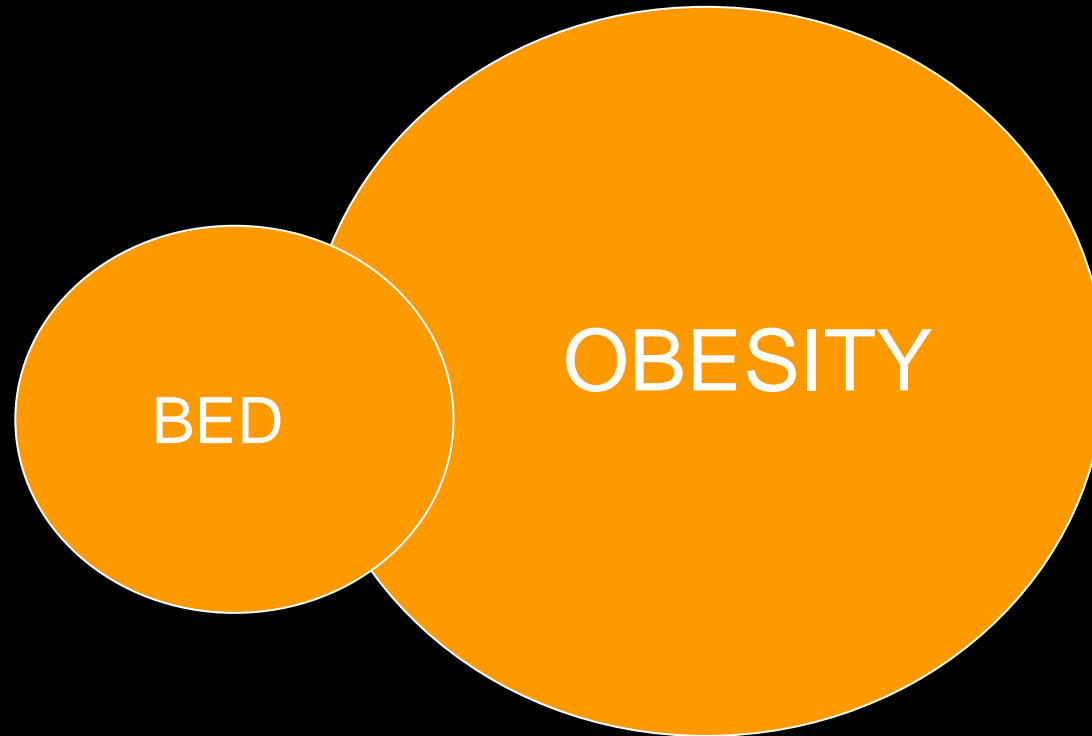
# Research Diagnosis of DSM-IV: Binge Eating Disorder

- 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





# 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.