ACADEMY OF NUTRITION AND DIETETICS
Pocket Guide to

Eating Disorders

SECOND EDITION

Jessica Setnick, MS, RD, CEDRD

eat right. Academy of Nutrition and Dietetics

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Second Edition

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Introduction

Whether it is in your patient population, among coworkers or colleagues, in family members or friends, or even in strangers, registered dietitian nutritionists (RDNs) are often the first to identify dysfunctional eating behavior. Whether or not the treatment of eating disorders falls within your specialty practice area, at some point in your career, you are bound to encounter situations that require your understanding of this complex issue. They are simply too common to avoid.[1]

Rough estimates suggest at least 13.5 million Americans meet criteria for anorexia, bulimia, or binge eating disorder.[1-4] A 2005 survey of 1,500 American adults reported that 4 of 10 either had or knew someone who had an eating disorder.[2] As an RDN, eating disorders may be more common among your peers than in the general community.[5,6] You may even have been motivated to enter the field because of past experiences with your own or a loved one's eating disorder.[7]

Sadly, only a small fraction of those with eating disorders ever enter, much less complete, treatment.[8] The reasons are many and include:

- denial of the illness and its severity (called anosognosia);
- fear that recovery will require weight gain or other undesirable consequences;
- feeling ashamed of behaviors and hiding them from fear of embarrassment;
- cost of treatment and inadequate insurance coverage; and

- general lack of awareness of eating disorders among those in the medical profession.

Because modern society's fixation on image and appearance can seem to condone, encourage, and reward pathological attempts at weight control, eating disorders are sometimes unnoticed until they are life threatening. A woman with anorexia is 12 times more likely to die at a young age[9] and 59 times more likely to commit suicide[10] than a woman of the same age without anorexia. Even in death, an eating disorder can remain undiagnosed, as the cause of death may be listed as a more immediate complication, such as heart failure or cardiac arrest.

Eating disorders do not discriminate. They afflict individuals of every race, age, and socioeconomic status. Although most research subjects to date have been female, the eating-disorder research community is slowly becoming more inclusive. Patterns may appear, but there is no "typical" eating disorder patient. It is dangerous and unethical for an RDN to rule out an eating disorder solely on the basis of gender, economic status, weight, age, appearance, mental capacity, or any other single factor.

Because nutritional rehabilitation is a cornerstone of eating disorder recovery,[11] your influence as an RDN is powerful.[1,12,13] Through education, you can raise awareness of the factors known to cause eating disorders and of their early warning symptoms; through assessment, you can identify eating disorders at their earliest stages; and through intervention, you can change the course of lives.

This book is intended to prepare you for when you encounter an individual with an eating disorder in your professional life. The Nutrition Care Process (NCP) format is followed throughout. The NCP is comprised of 4 steps and is outlined in detail in Appendix A; refer to Box 1.1 for a brief outline of the steps of the NCP.

Box 1.1 Nutrition Care Process[14]

Step 1—Nutrition Assessment

Nutrition assessment data have been organized into 4 domains:

- Food/Nutrition-Related History
- Anthropometric Measurements
- Biochemical Data, Medical Tests, and Procedures
- Nutrition-Focused Physical Findings
- Patient/Client History

Step 2—Nutrition Diagnosis

Nutrition diagnoses have been organized into 3 domains:

- Intake
- Clinical
- Behavioral-Environmental

Step 3—Nutrition Intervention

Nutrition intervention strategies have been organized into 4 domains:

- Food and/or Nutrient Delivery
- Nutrition Education
- Nutrition Counseling
- Coordination of Nutrition Care

Step 4—Nutrition Monitoring and Evaluation

Nutrition monitoring and evaluation outcomes are organized into 4 domains:

- Food/Nutrition-Related History Outcomes
- Anthropometric Measurement Outcomes
- Biochemical Data, Medical Tests, and Procedure Outcomes
- Nutrition-Focused Physical Finding Outcomes

Terminology

"Eating disorders" is the umbrella term currently used to describe abnormal and maladaptive eating and related behaviors with psychological and biological underpinnings. In the United States, the American Psychiatric Association (APA) oversees the establishment of criteria for defining psychiatric conditions. These are updated and published periodically in the *Diagnostic and Statistical Manual of Mental Disorders*, which is currently in its fifth edition (*DSM-5*).[15] Because the underlying cause or causes of eating disorders have not been confirmed, the current categorization of eating disorders is based on signs, symptoms, and behaviors. This system can be problematic, as individuals with similar or even identical symptoms may have different causative factors, different neurochemical imbalances, different disease processes, and different needs for treatment. This is one of the reasons why individualization of treatment is so essential.

In the *DSM-5*, more eating disorder types are described than ever before. These include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder (ARFID), night eating syndrome, purging disorder, and others. Each have their own diagnostic criteria, some more detailed than others (see Boxes 1.2 through 1.6, pages 6–10).[15]

Five of these diagnoses are grouped into a category called "other specified feeding and eating disorders" (OSFED). These are purging disorder, night eating syndrome, "atypical" anorexia, and bulimia and binge eating disorder "of low frequency or limited duration." In the past, these might have been categorized as "eating disorders not otherwise specified" (EDNOS). As with EDNOS, it is important to note that OSFED is not an eating disorder in itself, and also that those eating disorders within the OSFED category should not be considered less severe eating disorders.

They simply are variations of eating disorders that are not as well-defined as some of the others. Further research is needed on all of the disorders in this category.

The *DSM-5* introduced another new category, "unspecified feeding and eating disorders." This is not an actual disorder but rather a diagnostic code that can be used when a practitioner is unable to determine the details of a patient's eating disorder, for example, if the individual is unresponsive, uncooperative, or mentally altered. It is intended simply to be a placeholder until more information can be gathered.

Etiology of Eating Disorders

Binge eating, self-induced vomiting, excessive exercise, starvation, and other eating disorder behaviors are harmful and destructive, so why do they begin, and why do they persist? The answers are under investigation, and there are no definite answers yet. The effects of eating disorders on the body and brain are far better understood than their causes. It appears that both genetic and environmental influences contribute to the development of eating disorders,[11] but because research is generally initiated after the onset of the eating disorder and sample sizes are often small, it is unclear how much each factor plays a role.

Biological Factors

Early family studies suggested some heritability of eating disorders,[16,17] and later studies showed genetic markers are similar among family members with anorexia.[18] Twin studies have suggested that genetic contributions toward eating disorders may change during puberty,[19] that boys with a female twin are more likely to develop an eating disorder than those with a male twin,[20] and that binge eating disorder and bulimia may share genetic factors.[21] Neonatal

complications and the mother's health during pregnancy may also influence later eating disorder development.[22]

Box 1.2 *DSM-5* Criteria for Anorexia Nervosa

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

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

Specify Type

Restricting

During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (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

During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify Severity Based on Body Mass Index (BMI)

Mild: ≥ 17

Moderate: 16–16.99

Severe: 15–15.99

Extreme: < 15

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Box 1.3 *DSM-5* Criteria for 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 of time (eg, 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 and under similar circumstances.
   (2) A sense of lack of control over eating during the episode (eg, a feeling that one cannot stop eating or control what or how much one is eating).

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

C. The binge eating and inappropriate compensatory behavior both occur, on average, at least once a week for 3 months.

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

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify Severity Based on Average Number of Compensatory Behavior Episodes per Week

Mild: 1–3

Moderate: 4–7

Severe: 8–13

Extreme: 14 or more

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Box 1.4 *DSM-5* Criteria for Binge Eating Disorder

A. Recurrent episodes of binge eating, characterized by both of the following:

(1) Eating, in a discrete period of time (eg, 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 (eg, a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge eating episodes are associated with three (or more) of the following:

(1) Eating much more rapidly than normal.

(2) Eating until uncomfortably full.

(3) Eating large amounts of food when not feeling physically hungry.

(4) Eating alone because of feeling embarrassed by how much one is eating.

(5) Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior and does not occur exclusively during the course of bulimia or anorexia nervosa.

Specify Severity Based on Average Number of Binge Eating Episodes per Week

Mild: 1–3

Moderate: 4–7

Severe: 8–13

Extreme: 14 or more

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Box 1.5 *DSM-5* Criteria for Avoidant/Restrictive Food Intake Disorder

A. An eating or feeding disturbance (eg, apparent lack of interest in eating or food; avoidance of eating based on the sensory characteristics of food; concern about adverse consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

   (1) Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).

   (2) Significant nutritional deficiency.

   (3) Dependence on enteral feeding or oral nutritional supplements.

   (4) Marked interference with psychological functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. 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.

D. 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.

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Box 1.6 *DSM-5* Criteria for Other Specified Feeding and Eating Disorders

Atypical Anorexia Nervosa

All of the criteria for anorexia nervosa are met except that despite significant weight loss the individual's weight is within or above the normal range.

Bulimia Nervosa of Low Frequency and/or Limited Duration

All of the criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory behaviors occur on average less than once a week and/or for less than 3 months.

Binge eating Disorder of Low Frequency and/or Limited Duration

All of the criteria for binge eating disorder are met except that the binge eating occurs on average less than once a week and/or for less than 3 months.

Purging Disorder

Recurrent purging behavior to influence weight or shape (eg, self-induced vomiting; misuse of laxatives, diuretics or other medications) in the absence of binge eating.

Night Eating Syndrome

Recurrent episodes of night eating as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge eating disorder or another mental disorder including substance abuse and is not attributable to another medical disorder or to an effect of medication.

Regarding the perpetuation of eating disorder behaviors once they have begun, we are starting to understand

that the neurochemical changes associated with eating disorder behaviors are similar to those induced by drugs of abuse.[23,24] This may explain why individuals with eating disorders often struggle with other addictions.[25] Eating disorders also co-occur with anxiety, depression, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), attention-deficit disorder (ADD), and borderline personality disorder (BPD),[15] but whether the connections are cause and effect, genetic, environmental, or all of these, is yet unknown. Connections have also been suggested between eating disorders and hormonal imbalances, including polycystic ovary syndrome (PCOS), hypoglycemia, and menstrual irregularities not specifically related to nutrition.

Nonbiological Factors

In addition to a biological susceptibility, the formation of most eating disorders seems to require some environmental stimulus. Eating disorders are often reported to develop in proximity to a weight change, whether intentional or unintentional; to be injury-, illness-, or catastrophe-related; or to develop as an aftereffect of an emotional shock.

It is well understood that restriction of energy intake leads to biochemical and psychological changes that resemble eating disorders.[26] What is not understood is why some individuals who undertake low-calorie diets develop eating disorders while others do not. Often the social effects of weight changes are dramatically negative or positive, so regardless of an individual's original intention to lose or gain weight, criticism or praise for doing so can trigger an eating disorder if the biological susceptibility exists.

In some cases, weight changes that lead to eating disorders are preceded by one or more physically or emotionally disorienting events, referred to in the mental health field as "emotional trauma."[27,28] It is unknown if the biochemical effects of starvation are more strongly felt by those in

emotional distress. In these cases, the desire for weight loss may be a misplaced attempt to modulate stressful feelings and has been described as an effort to regain a sense of control.[11] Because of their effects on neurochemistry, eating disordered behaviors do, in fact, cause a temporary feeling of well-being. They create a positive feedback loop to perpetuate the behavior, even beyond the point where they become harmful or life-threatening.

The Dietitian's Role

RDNs contribute to many aspects of eating disorder treatment at every level of care.[29-35] Box 1.7 lists some of the functions an RDN may play in the treatment of eating disorders.

Am I Ready?

Every RDN has something to offer to an individual struggling with an eating disorder. The primary requirement is an interest in the field and willingness to learn. However, care of individuals with eating disorders is a specialty area of practice, and to be most effective, requires additional training beyond what is provided in school and internship programs.[15, 32-34, 36]

Therefore, if you are just starting to practice in this field, it is essential that you reach out to your supervisor, your treatment team, or a more experienced RDN for guidance. Also, you will want to focus your continuing education efforts on eating disorders and mental health. If you find yourself either doubting your abilities or "taking your work home with you," know these are common reactions, not signs that you are inadequate. Remember that the eating disorders field is filled with controversies and unanswered questions and that the diseases themselves have no known cure. Reach out for support from other dietitians, mental

Box 1.7 Role of the RDN in the Treatment of Eating Disorders

Evaluate the patient's current eating patterns and share findings with other team members. Develop an individualized plan for improvement to replenish nutritional deficiencies and promote optimal nutrition and growth.

Help the patient determine how to implement needed nutritional recommendations.

Identify dysfunctional and detrimental thoughts and feelings around food, eating, and body size, as well as knowledge and skill deficits that prevent the patient from implementing recommendations.

Explain the role of proper nutrition and eating in physical and mental well-being and provide education to challenge inaccurate beliefs about food.

Refer information about underlying life stressors to a mental health professional.

Offer active learning activities when appropriate, such as cooking, eating, or grocery shopping, to help teach new behaviors and acceptance of food-related tasks and environments. Model appropriate eating in shared experiential interventions such as restaurant meals.

Communicate frequently with other members of the interdisciplinary treatment team, including family members and significant others.

Educate parents and caregivers regarding eating disorders and nutrition as they relate to the treatment plan and recovery needs.

Teach group nutrition classes to patients, their families and caregivers, and lead group nutrition discussions that address dysfunctional eating and promote improved nutrition.

health professionals at your facility, or a support or networking group for eating disorder professionals, and seek out ongoing mentoring or supervision with a more experienced RDN or mental health professional.

If you realize that you are not interested in the field, you do not feel sympathetic toward individuals with eating disorders, or you get easily frustrated with slow or little

progress, you may choose not to seek out this patient population. When you encounter an individual with an eating disorder, as you occasionally will regardless of your specialty, speak with your supervisor for guidance, refer the individual to a different RDN, and ensure that you have moral support to help you cope with what can be a stressful situation.

Even with an affinity for eating disorder treatment, you will encounter individuals whose needs exceed what you can provide. When you are not sure what advice to give, simply respond without judgment that you will help the individual find an appropriate professional to help with his or her current situation. Then consult with your colleagues on available resources or other professionals located in your area.

Finally, if you realize that you are struggling with your own eating issues, or if you recognize that your work is triggering unhealthy thoughts or behaviors, know that this does not disqualify you from work as an RDN. You do need to seek help, and you may choose not to work with this patient population for a period of time. It is not necessary to be a "perfect" eater in order to help others. To be able to care for both your patients and yourself, awareness of your own thoughts, stressors, and behaviors is needed, as well as active engagement in your own recovery. This assures that when you are with patients, you are able to meet their needs without disregarding your own and that you can keep your own eating issues separate from the needs of your patients. A meeting with an experienced mental health professional or RDN is a starting place to assess your own relationship with food and determine how to proceed. Although it is not recommended that you discuss your eating disorder or your recovery with your patients, you can silently be a role model, showing that difficulties can be overcome.

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Appendix D

Additional Resources

Books, Workshops, and Resources from Dietitians

A New View of Eating Disorders: Dietitians and Family-Based Treatment, by Melanie Jacob, www.melaniejacob.com

Comprehensive Learning Teaching Handout Series on CD, by Sondra Kronberg, www.sondrakronberg.com

Eating Disorder Nutrition Therapy Training, by Marci Anderson Evans, www.marcird.com

Eating Disorders Boot Camp Home-Study Course, Training Workshop for Professionals; Advanced Eating Disorders Boot Camp: Special Forces Training Home-Study Course; and Eating Disorders Nutrition Counseling DVD, by Jessica Setnick, www.understandingnutrition.com

Food–Medication Interactions Handbook, 17th edition, by Zaneta Pronsky and Sr Jeanne Patricia Crowe, www.foodmedinteractions.com

Forms, handouts, and worksheets for work with eating disorders, by Lori Pereyra, www.nutritiousways.com

Francie White Inner Escapes workshops, www.dranitajohnston.com/workshops

Intuitive Eating: A Revolutionary Program That Works, revised edition; and professional trainings, by Evelyn Tribole and Elyse Resch, www.intuitiveeating.com

Love Your Body: Change the Way You Feel About the Body You Have, by Tami Brannon-Quan and Lisa Licavoli.

Molly Kellogg's Counseling Intensive for Nutrition Professionals workshop; *Counseling Tips for Nutrition Therapists: Practice Workbook Series*, Volumes 1 and 2, by Molly Kellogg, www.mollykellogg.com

Moving Away from Diets: Healing Eating Problems and Exercise Resistance, 2nd edition, by Karin Kratina, Nancy King, and Dayle Hayes, www.helmpublishing.com

Nancy Clark's Sports Nutrition Guidebook, 5th edition, by Nancy Clark, www.nancyclarkrd.com

Nutrition Counseling and Communication Skills, by Katharine Curry and Amy Jaffe

Nutrition Counseling in the Treatment of Eating Disorders, 2nd edition, by Marcia Herrin and Maria Larkin,

PCOS: The Dietitian's Guide, 2nd edition, by Angela Grassi

The PCOS Workbook: Your Guide to Complete Physical and Emotional Health, by Angela Grassi and Stephanie Mattei

The PCOS Nutrition Center Cookbook: 100 *Easy and Delicious Whole Food Recipes to Beat PCOS*, by Angela Grassi and Natalie Zaparzynski, www.PCOSnutrition.com

Pediatric Nutrition in Chronic Diseases and Developmental Disorders: Prevention, Assessment, and Treatment, 2nd edition, and coordinating self-study program, by Shirley W. Ekvall and Valli K. Ekvall

Winning the War Within: Nutrition Therapy for Clients with Eating Disorders, 2nd edition, by Eileen Stellefson Myers

Eating Disorder Professional, Educational and Advocacy Organizations

The Academy for Eating Disorders (AED), http://www.aedweb.org/

Adios Barbie, http://www.adiosbarbie.com/
Anorexia Nervosa and Associated Disorders (ANAD), http://www.anad.org/
ASPIRE, http://aspire-network.blogspot.com/2014/02/welcome-to-aspire.html
Association Anorexia Nervosa Bulimia Nervosa (ANBN) Belgium, www.anbn.be
Anorexia and Bulimia Quebec (ANEB), http://www.anebquebec.com/html/en/home/home.html
Australian and New Zealand Academy for Eating Disorders (ANZAED), http://www.anzaed.org.au/
Beating Eating Disorders, www.facebook.com/spreadingawarenesswhereitsneeded
BingeBehavior.com, http://bingebehavior.com/
Binge Eating Disorder Association (BEDA), http://bedaonline.com/
Bullemia.com, www.bulimia.com
The Butterfly Foundation, http://www.thebutterflyfoundation.org.au/
The Dirty Laundry Project (DLP), https://www.facebook.com/Dirtylaundryproject
Eating Disorders Coalition, www.eatingdisorderscoalition.org
Eating Disorder Hope (resources for coping with eating disorders), www.eatingdisorderhope.com
Eating Disorder Jobs (resources for professionals and job seekers), www.eatingdisorderjobs.com
Eating Disorder Parent Support (EDPS), http://eatingdisorderparentsupport.weebly.com/
Eating Disorders Association of New Zealand, (EDANZ), www.ed.org.nz
Eating Disorders Victoria (EDV), http://www.eatingdisorders.org.au
Elephant in the Room Foundation, https://www.EitRF.org/
International Association of Eating Disorders Professionals Foundation, www.iaedp.com

International Eating Disorders Action (IEDAction), http://iedaction.weebly.com/
International Federation of Eating Disorder Dietitians, www.ifedd.com
Islam and Eating Disorders, Maya Khan, http://waragainsteatingdisorder.com/
Michelle's Voice: The Society for Eating Disorder Awareness and Education, https://twitter.com/dmichellestory
Men Get Eating Disorders Too (MGEDT), http://mengetedstoo.co.uk/
Mentor Connect: Relationships Replace Eating Disorders, www.mentorconnect-ed.org
Multi-Service Eating Disorder Association, (MEDA), http://www.medainc.org/
National Association for Males with Eating Disorders (NAMED), http://namedinc.org/
National Eating Disorder Association (NEDA), http://www.nationaleatingdisorders.org/
National Eating Disorder Collaboration, Australia www.nedc.com.au/
National Eating Disorder Information Centre (NEDIC), http://nedic.ca/
National Initiative for Eating Disorders, (NIED), http://nied.ca/
Project Heal, http://theprojectheal.org/chapters-heal/toronto/
ReGlam Me, http://www.reglam.me/, Germany and global
SockIt to ED campaign, https://www.facebook.com/events/1517755561812119/
The Renfrew Center Foundation, http://renfrewcenter.com/renfrew-center-foundation
Trans Folx Fighting Eating Disorders (T-FFED), www.transfolxfightingeds.org/

Eating Disorder Certification Programs for Dietitians

Certified Eating Disorders Registered Dietitian (CEDRD), www.iaedp.com

CEDRD Certification Prep Class, by Jessica Setnick, www.CEDRD.com

Postgraduate Intensive Training for Dietitians Treating Eating Disorders, by the Institute for Contemporary Psychotherapy Center for the Study of Anorexia and Bulimia (ICP CSAB), http://icpnyc.org/csab/2-year-training-program

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ACADEMY OF NUTRITION AND DIETETICS
Pocket Guide to

Eating Disorders

SECOND EDITION

Whether or not the treatment of eating disorders falls within your specialty practice area, at some point in your career, you are bound to encounter situations that require your understanding of this complex issue. They are simply too common to avoid.

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