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EATING DISORDERS – LET'S BE CURIOUS

When reading the word "eating disorder", what comes to mind? Take a second to think about this. For many, it's the picture of a woman in her teens, emaciated, collarbones and ribs protruding through skin. As we started our respective careers working with clients diagnosed with eating disorder", we certainly had some pre-conceived ideas as well.

In the years we've worked with these clients we've learned the area of mental illness comprising of eating disorders is far more complex than what presents externally. We also learned how many of our clients are misdiagnosed and overlooked due to appearing normal in weight, or go through various well-intentioned, but none the less ill-equipped healthcare professionals before someone identifies and appropriately treats the eating disorder. These are some areas we feel are of use to doctors faced with these cases.

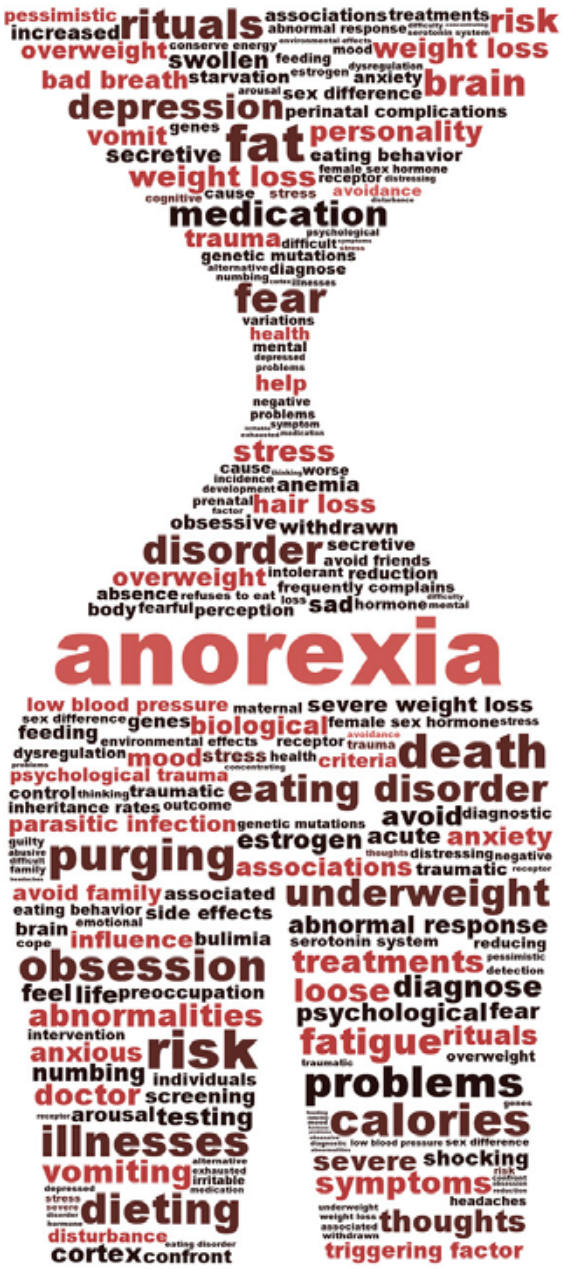
- **Eating disorders do not discriminate.** This might seem obvious, but healthcare professionals are only human and enter their rooms with preconceived ideas of what might be presented in a certain individual. Eating disorders present in any gender, race and socio-economic income bracket. Although eating disorders

often present in transitional periods (puberty, pregnancy etc.,) it can present at any stage of life. It's especially likely if vulnerabilities were present in early life such as disordered eating, morality and rigidity around food in family members and genetic predisposition to eating disorders.

- **Eating disorders have the highest mortality rate of all mental illnesses.** Death rates are high as a result of medical complications as well as suicidality in individuals who don't receive appropriate support or become hopeless over the long-term nature of the illness. Eating disorders are serious and can be life threatening so early intervention as well as long term supportive therapy and family support is paramount.

- **You can tell very little about a person's health, or whether they have an eating disorder by simply looking at body size or calculating BMI**. Two people who eat exactly the same number of calories and food types, with the same amount of movement are likely to have vastly differently sized and/or shaped bodies. Body size is a lot more complex than the sum of energy in and energy out. Variation in body type is most directly related to genetics, despite the myth that we're in control of our size and shape. BMI was introduced by a mathematician, not a physician, in the early 19th century. It was designed as a research tool and not as a measure of health. Taking only BMI into consideration can lead to stigmatisation or missing clients with eating disorders completely.

- **Eating disorders can present in a person with any body size**. Though BMI might be helpful in calculating risk on the lower side of the spectrum, this is often the main reason why an eating disorder in a person with a "normal-looking body" is missed. When diagnosing an eating disorder we need to take into consideration eating habits, weight fluctuations, restrictive, obsessive thoughts, obsessive exercise, body image concerns, body dysmorphia and emotional triggers around food and a lot more.
The DSM 5 now includes Eating Disorders Not Otherwise Specified, including Atypical Anorexia to account for the large number of people who have lost a significant amount of weight but remain in the "healthy range" according to BMI. Without this category, many individuals don't receive the critical care they need for the health risks of sudden dramatic weight loss. It also accounts for those who restrict their food intake, posing health risks while appearing not to look ill. This category includes Rumination Disorder, Purging Disorder and Night Eating Syndrome where suffering is experienced and has previously been overlooked. Many people within a normal weight category aren't acknowledged for the significant hopelessness and suicidality experienced by weight dissatisfaction and low self-esteem. We always need to recognise suffering without looking for quantifiable measures.



- **Eating disorders have a physiological impact on the sufferer**, such as loss of bone density, heart problems, gastro-enteral dysfunction, loss of menstruation, fertility problems, teeth erosion and the list goes on. Often the sufferer would present with a physical complaint, and the eating disorder goes unrecognised as the cause. Examples might include constipation, IBS, poor energy levels, fatigue or insomnia. Sufferers of eating disorders can go to great lengths to keep their behaviour a secret as a result of shame. Weight changes could be praised by professionals as a sign of improved health, without recognising the medical and psychological risks associated. Individuals with Eating Disorders wouldn't necessarily express concern to a medical professional about their weight fluctuations in the same way someone without an eating disorder might. For instance, they could present in an ER after fainting without looking like or admitting they have restricted their intake. Some professionals might make incorrect assumptions based on lack of insight, such as "you must have a problem with binge eating" to someone who is in a bigger body. Some might suggest a diet or personal trainer in response to a complaint about dissatisfaction with a patient's weight. Extremely important to note: Individuals who binge usually do so in response to starvation from dieting or restricting intake severely, the restriction needs to be treated in order to reduce bingeing.

Common signs to look out for:

- Significant distress due to obsession around food, weight or body image. This can include body dysmorphia, where one becomes obsessed about perceived flaws in appearance.
- Impact on a person's social life which become dictated by the presence or absence of certain foods. They struggle to enjoy food-related activities (birthday parties, dinners out, weddings, family meals) without significant distress.
- Relationships with their loved ones can lead to conflict around food, anger, irritability, impulsivity, shame and guilt, as well as other relational problems.
- Eating disorders have a high co-morbidity with other mental health disorders, especially mood disorders including depression and bipolar, anxiety disorders, substance use disorders and personality disorders.
- Eating disorders reveal themselves with extreme thinking around food and body such as "I can't live if I don't lose weight" or "I don't deserve to eat unless I exercise everyday" "I would rather die than put on weight".

Some of what we offer and find effective in treating people with eating disorders.

- Outpatient individual and group therapy.
- Family educational talks and family therapy. Making the family and loved ones allies in the treatment significantly improves the prognosis.
- Dietetics support and nutritional therapy. Treating a person with an eating disorder requires special understanding of the nuances of this illness, and is more than prescribing a meal-plan.
- Peer supervision and support

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References are available on request.