SimplePsych

Eating Disorders

Slides: B Chow
Edits: L Jia

Updated 2021

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Eating Disorders

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

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Feeding & Eating Disorders – Introduction

- Altered consumption/absorption of food
  - Impairs physical health or psychosocial functioning
- AN, BN, BED → mutually exclusive at any one time
  - Differ in clinical course, outcomes, treatment needs
- Pica → can be dx with any other feeding/eating disorder
- Cravings, compulsive behavior → resemble SUD
- Obesity → not a mental disorder
  - But robust assoc with number of mental disorders
  - Can be side effect of some psychotropic medications

Pica

Pica – Diagnostic Criteria

A. Eating **non-nutritive, non-food substances** for **>1 month**

B. Inappropriate to developmental level

C. Not culturally supported or socially normative practice

D. If occurs in context of AMD, sufficiently severe to warrant additional clinical attention

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Pica – Diagnostic Specifier

- *Specify if:*
  - **In remission**

Pica – Diagnostic Features

- Typical substances vary with age, availability
  - Paper, soap, cloth, hair, string, wool, soil, chalk, talcum power
  - Paint, gum, metal, pebbles, charcoal, coal, ash, clay, starch, ice
- Typically **NO aversion to food in general**
- Must be developmentally inappropriate
  - Suggest **min age 2** → exclude normal mouthing of objects
- May be assoc feature of AMD
  - Intellectual disability, autism spectrum disorder, schizophrenia
  - Must be sufficiently severe to warrant additional clinical attention

Pica – Associated Features

- Often no specific biological abnormalities
  - May have deficiencies in vitamins/minerals

- Usually comes to clinical attention due to medical complications
  - **Bowel obstruction from bezoar**
  - Intestinal perforation
  - Infections (toxoplasmosis, toxocariasis from ingesting feces/dirt)
  - Poisoning (lead-based paint)

Pica – Prevalence

- Prevalence = UNCLEAR
  - If intellectual disability → prevalence of pica increases with severity

Pica – Development & Course

- Onset
  - **Childhood onset** MOST COMMON → can be normal developing
  - Can occur in adolescence, adulthood → usually in context of AMD
  - **Pregnancy** → may have specific cravings
    - Only dx pica if behavior poses potential medical risks

- Course
  - Can be **protracted**
  - Can result in **medical emergency** (obstruction, acute wt loss, poisoning)
  - Can be **fatal** depending on ingested substances

Pica – Risk & Prognostic Factors

- Environmental
  - Neglect, lack of supervision, developmental delay

Pica – Culture-Related Issues

- May be culturally supported or social normative practice
  - Spiritual, medicinal, other social value
  - Do NOT dx pica

Pica – Gender-Related Issues

- Occurs in both males + females
  - Can occur during pregnancy → little known about course postpartum

Pica – Diagnostic Markers

- Imaging of abdomen → may show obstructions
- Blood tests → poisoning, infections

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Pica – Functional Consequences

- Can significantly impair PHYSICAL functioning

- Rarely sole cause of impaired SOCIAL functioning
  - Often occurs with other impairing disorders

Pica – Differential Diagnosis

- Other mental disorders
  - Autism spectrum disorder, schizophrenia, Kleine-Levin syndrome
- Anorexia nervosa
  - May be attempt to control appetite/weight → dx AN only
- Factitious disorder
  - Intentional ingestion as part of **falsification of physical symptoms**
- Non-suicidal self-injury in personality disorders
  - Swallowing potentially harmful items (pins, needles, knives)
  - Maladaptive behavior patterns

Pica – Comorbidity

- Most common comorbidities
  - **Autism spectrum disorder, intellectual disability**
  - To lesser degree → schizophrenia, OCD

- Associated with:
  - **Trichotillomania, excoriation disorder**
    - If comorbid → hair/skin typically ingested
  - Avoidant/restrictive food intake disorder → strong sensory component

- Consider possibility of:
  - GI complications, poisoning, infection, nutritional deficiency

Rumination Disorder

Rumination Disorder – Diagnostic Criteria

A. Repeated **regurgitation of food**, for **>1 month**
   - Regurgitated food may be re-chewed, re-swallowed, spit out

B. Not due to associated GI or AMC (GERD, pyloric stenosis)
C. Not exclusively during AN, BN, BED, ARFID
D. If occurs in context of AMD, sufficiently severe to warrant additional clinical attention

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Rumination Disorder – Diagnostic Specifier

- *Specify if:*
  - **In remission**

Rumination Disorder – Diagnostic Features

- Repeated regurgitation
  - Previously swallowed food brought up into mouth
  - May be partially digested → without nausea, retching, disgust
  - May be re-chewed, re-swallowed or spit out
  - Should be **frequent** (several times per week, typically daily)
  - May be described as **habitual or outside of control**

- May be diagnosed across the lifespan
  - Esp if intellectual disability

Rumination Disorder – Associated Features

- Infants
  - Characteristic position of **straining + arching back**
    - Head held back, making **sucking movements with tongue**
    - Appear to gain satisfaction from activity
  - May be irritable/hungry between episodes of regurgitation
  - **Weight loss + failure to gain weight** → common features in infants
    - Malnutrition despite apparent hunger, large intake

- Older children + adults
  - Malnutrition, esp if also restriction of intake
  - May attempt to disguise by placing hand over mouth/coughing
  - May avoid eating with others or eating prior to social situations

Rumination Disorder – Prevalence

- Prevalence data → inconclusive
  - Higher if **intellectual disability**

Rumination Disorder – Development & Course

- Onset → infancy to adulthood
  - Infants → usually between 3-12 months
    - Frequently remits spontaneously
    - But can be protracted, with medical emergencies, potentially fatal

- Course
  - Can have **episodic or continuous course**, until treated
  - If neurodevelopmental disorder → may be **self-soothing/stimulating**
    - Similar to repetitive motor behaviors (head banging)

Rumination Disorder – Risk & Prognostic Factors

- Environmental (predisposing in infants, young children)
  - Lack of stimulation, neglect
  - Problems in parent-child relationship
  - Stressful life situations

Rumination Disorder – Functional Consequences

- Malnutrition (secondary to repeated regurgitation)
  - May be assoc with **growth delay**
  - May negatively affect **development, learning potential**

- Social undesirability of regurgitation
  - May deliberately restrict food intake
  - May present with weight loss or low weight
  - More likely to affect social functioning in older children to adults (vs infants)

Rumination Disorder – Differential Diagnosis

- Gastrointestinal conditions
  - GERD, vomiting, gastroparesis, pyloric stenosis, hiatal hernia
  - Sandifer syndrome in infants

- Anorexia nervosa, bulimia nervosa
  - If due to concerns about weight gain

Rumination Disorder – Comorbidities

- Can occur with concurrent AMC/AMD
  - Dx is sufficiently severe to warrant additional clinical attention

Avoidant/Restrictive Food Intake Disorder

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ARFID – Diagnostic Criteria

A. **Eating or feeding disturbance**, manifested by **persistent failure to meet** appropriate nutritional/energy needs (1+/4):
   1. Significant **weight loss** (or failure to achieve expected weight gain)
   2. Significant **nutritional deficiency**
   3. Dependence on **enteral feeding or oral nutritional supplements**
   4. Marked interference with **psychosocial functioning**

B. Not due to lack of available food or culturally-sanctioned

C. **Not exclusively during AN/BN**, not due to disturbance in experience of one's body weight/shape

D. Not due to AMC or AMD, sufficiently severe to warrant additional clinical attention

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ARFID – Diagnostic Features

- Avoidance or restriction of food intake
  - Significant failure to meet nutritional/energy requirements
  - **Weight loss** → in C&A, not meeting growth expectations
  - **Nutritional deficiency** → may be similar to AN (bradycardia, hypothermia)
  - Dependence on **supplementary feeding** (enteral feed, PO supplement)
  - Psychosocial dysfunction → inability to eat with others, sustain r/s

- Not due to developmentally normal behaviors
  - Picky eating in toddlers, reduced intake in older adults

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ARFID – Diagnostic Features

- May be based on sensory characteristics of food
  - Color, smell, texture, temperature, taste
  - **"Selective/perseverant eating", "chronic food refusal"**
  - **"Food neophobia"**
  - May refuse to eat particular brands, tolerate smell of food eaten by others
  - May resemble heightened sensory sensitivity in autism

- May be a conditioned negative response
  - Following or in anticipation of an **aversive experience**
    - Choking, vomiting, traumatic investigation (usually GI)
    - **"Functional dysphagia", "globus hystericus"**

ARFID – Associated Features

- Lack of interest in eating food
  - Leads to weight loss, faltering growth
- Very young infants
  - May present too sleepy, distress or agitated to feed
- Infants
  - May not engage with caregiver during feeding or communicate hunger
  - In favor of other activities
- Older children, adolescents
  - May be assoc with more **generalized emotional difficulties**
  - Not meeting diagnostic criteria for anxiety, depressive, bipolar disorders
  - “Food avoidance emotional disorder”

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ARFID – Development & Course (1)

- Onset of food avoidance/restriction
  - Associated with insufficient intake or lack of interesting in eating
    - Most commonly develops in **infancy or early childhood**
  - If based on sensory characteristics of food
    - First **10 years** → may persist into adulthood

- Course → stable, long-standing
  - May persist into adulthood → may be assoc with normal functioning
  - Insufficient evidence to link to subsequent onset of eating disorder

- Manifests more commonly in children (vs adults)
  - May be long delay between onset to clinical presentation
  - Varied presentations (physical, social, emotional)

ARFID – Development & Course (2)

- Infants
  - May be irritable, difficult to console during feeding
    - May appear apathetic, withdrawal
  - **Parent-child interaction** may contribute to feeding problem
    - Presenting food inappropriately
    - Interpreting infant behavior as act of aggression or rejection
  - Inadequate nutritional intake → **may exacerbate associated features**
    - Irritability, developmental delays → further feeding difficulties
    - Infant temperament, developmental impairments may reduce responsiveness to feeding
  - If feeding/weight improves with **changing caregiver**
    - Consider parental psychopathology, child abuse/neglect
  - Growth delay → negatively affects development/learning potential

- Older children, adolescents, adults → **social functioning**
- All ages → **family function**, mealtime stress

ARFID – Risk & Prognostic Factors

- Temperamental
  - Anxiety disorders, autism spectrum disorder, OCD, ADHD
- Environmental
  - Familial anxiety
  - **Mothers with eating disorders**
- Genetic & Physiological
  - Hx GI conditions, GERD, vomiting

ARFID – Culture-Related Issues

- <u>May finding similar presentations in various populations</u>
  - US, Canada, Australia, Europe
  - Do not dx if related to specific religious/cultural practices

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ARFID – Gender-Related Issues

- In infancy, early childhood → genders equal
- If comorbid autism spectrum disorder → MALE predominance
- If related to altered sensory sensitivities due to physiological conditions **(pregnancy)** → usually not extreme, do not dx

ARFID – Diagnostic Markers

- Malnutrition, low weight, growth delay
- Need for artificial nutrition
- No clear underlying medical condition

ARFID – Functional Consequences

- Developmental + functional limitations
  - Impairment of physical development, social difficulties
  - Negative impact on **family function**

ARFID – Differential Diagnosis

- Other medical conditions → can dx BOTH (if sufficiently severe)
  - GI conditions, food allergies/intolerances, occult malignancies
  - May have assoc vomiting, nausea, loss of appetite, abdo pain, diarrhea
  - ARFID → beyond physiological effect, may persist after resolution
  - Underling AMC/AMD may complicate feeding/eating
    - Elderly, post-surgical patients, chemotherapy
- Neurological conditions → can dx BOTH (if sufficiently severe)
  - Oral/esophageal/pharyngeal structure/function
  - Hypotonia, tongue protrusion, unsafe swallowing
- Reactive attachment disorder → can dx BOTH
  - RAD → can lead to disturbed caregiver-child r/s → affect feeding/intake
- Autism spectrum disorder → can dx BOTH
  - Rigid eating behaviors, heightened sensory sensitivities
- Anorexia nervosa → **CANNOT dx both**
  - Shared common symptoms, difficult to distinguish after late childhood
  - May deny fear of fatness → "non-fat phobic anorexia nervosa"
  - ARFID may precede AN

ARFID – Differential Diagnosis

- Anxiety disorders
  - Specific phobia → eating problem NOT primary focus (can be difficult)
  - Social anxiety disorder → fear of being observed eating
- OCD → can dx BOTH
  - Preoccupation with food, ritualized eating behavior
- MDD → can dx BOTH
  - Appetite loss, reduced intake usually **abate with resolution** of MDD
- Schizophrenia → can dx BOTH
  - Delusional beliefs → odd eating behaviors, avoidance of specific foods
- Factitious disorder (in order to assume sick role)
  - Intentional describe more restrictive diets, more complications
  - Dramatic, engaging, but inconsistent
- Factitious disorder imposed on another
  - May induce physical symptoms (failure to gain weight)
  - Caregiver receives dx

ARFID – Comorbidity

- Most common
  - Anxiety disorders, OCD
  - Neurodevelopmental disorders (ASD, ADHD, intellectual disability)

Anorexia Nervosa

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Anorexia Nervosa – Diagnostic Criteria

A. **Restriction of energy intake**, leading to sig **low body weight**

B. **Intense fear or interfering behavior** about gaining weight/fat

C. Disturbance in **experience of one's body weight/shape**

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Anorexia Nervosa – Diagnostic Specifiers

- *Specify subtype:*
  - **Restricting type:** no binge/purge in **past 3 months**
  - **Binge-eating/purging type:** episodes of bingeing OR purgeing in **past 3 months**

- *Specify if:*
  - **In partial remission:** no longer fully meeting Criterion A (still B + C)
  - **In full remission:** none of the criteria met for sustained period

- *Specify current severity:*
  - **Mild:** BMI ≥17
  - **Moderate:** BMI <17
  - **Severe:** BMI <16
  - **Extreme:** BMI <15

Anorexia Nervosa – Subtypes

- Restricting type
  - Weight loss main via **dieting, fasting, excessive exercise**

- Binge-eating/purging type
  - Purging → **vomiting, laxative, diuretics, enemas**
    - May purge without binge-eating

- Crossover between subtypes → not uncommon
  - Describe **CURRENT symptoms** (vs longitudinal course)

Anorexia Nervosa – Diagnostic Features

- A) Persistent energy intake restriction
  - Below minimally normal level for age, sex, development, physical health
    - Usually after weight loss
    - In C&A → may be failure of **expected weight gain or maintenance**
  - (WHO/CDC) → BMI 18.5 = lower limit of normal
    - **BMI ≤ 17** = moderate/severe thinness, sig low weight
    - **BMI-for-age <5th percentile** = underweight (C&A)

- B) Intense fear of gaining weight/fat
  - **NOT alleviated** by weight loss → may actually increase
  - May not recognize/acknowledge fear → esp younger

Anorexia Nervosa – Diagnostic Features

- C) Disturbance in experience of body weight/shape
  - May feel **globally overweight**
  - May have **concern about certain body parts** (abdomen, buttocks, thighs)
  - **Checking techniques** (weighing, measuring, mirrors)
  - **Self-esteem** → highly dependent of perception of body shape/weight
    - "Impressive achievement", "extraordinary self-control"
    - Weight gain → unacceptable failure of self-control

- Usually brought to help by family
  - If presenting on own → usually distress over **somatic/psychological sx**
  - Rare to complain about weight loss (lack insight, denial)

Anorexia Nervosa – Associated Features

- Semi-starvation + purging → medical sequelae
  - Affects most major organ systems
  - **Amenorrhea, abnormal vital signs** → common
  - Mostly reversible (with nutritional rehab) → **NOT loss of BMD**
  - Purging behaviors may lead to **abnormal labs** (not always)

- May have depressive sx if seriously underweight
  - Low mood, social withdrawal, irritability, insomnia, decr interest in sex
  - If sufficient severe → may additional dx MDD

- Obsessive-compulsive features
  - Related + unrelated to food → may be exacerbated by undernutrition
  - If not related to food, body shape, weight → may dx OCD

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Anorexia Nervosa – Associated Features

- Rigidity
  - Eating in public, feelings of ineffectiveness, inflexible thinking
    - Desire to control environment, limited social spontaneity
    - Overly restrained emotional expression
  - **Binge-eating/purging type MORE impulsive**
    - MORE likely substance abuse

- Excessive levels of physical activity
  - Increase in activity often precedes disorder onset
  - May accelerate weight loss, may be difficult to control

- Misuse of medication
  - Manipulate dosages to achieve weight loss, avoid weight gain
  - If DM → may reduce insulin

Anorexia Nervosa – Prevalence

- 12-month prevalence in young females = **0.4%**
  - Less common in males → **FEMALES 10x higher**

Anorexia Nervosa – Development & Course

- Onset
  - Commonly during **adolescence/young adulthood**
  - Rarely before puberty or after age 40
  - Often assoc with **stressful life event**

- Course highly variable
  - Younger age→ atypical features, denying "fear of fat"
  - Older age → **longer duration** of illness, more sx
  - **Single episode, fluctuating pattern (relapses),** or **chronic course**
  - Most experience **remission within 5 years of presentation**
  - Hospitalization → to restore weight, medical complications
    - May have lower remission rates

- Death → commonly from medication complications or suicide
  - Crude mortality rate = **5% per decade**

Anorexia Nervosa – Risk & Prognostic Factors

- Temperamental
  - Anxiety disorders + obsessional traits in childhood → incr risk
- Environmental
  - Assoc with cultures/settings where **thinness is valued**
  - Occupations that encourage thinness (modeling, athletics)
- Genetic & Physiological
  - Incr risk of **AN/BN** in 1º relatives of AN
  - Incr risk of **bipolar + depressive disorders** in 1º relatives with AN
    - Especially binge/purge type
  - Higher concordance rates in monozygotic twins
  - Brain abnormalities on fMRI + PET (cause vs consequence?)

Anorexia Nervosa – Culture-Related Issues

- Across culturally + socially diverse populations
  - Probably most prevalent in post-industrialized, high-income countries
    - US, European, Australia, NZ, Japan
  - But uncertain incidence in low/middle-income countries

- Lower among Latinos, African Americans, Asians (in US)
  - May be due to lower rates of mental health utilization
  - Latinos may present more commonly without intense fear

- Lower rates of “fat phobia” in Asia

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Anorexia Nervosa – Diagnostic Markers

Hematology • Leukopenia common, loss of all cell types, but lymphocytosis • Mild anemia, thrombocytopenia • Bleeding problems (rare)	**Electrocardiography** • Sinus bradycardia • Arrhythmias (rare) • QTc prolongation
Serum chemistry • Dehydration (incr BUN) • Hypercholesterolemia • Incr liver enzymes and amylase • Decr Mg, Zn, Ph • Vomiting → metabolic alkalosis (incr bicarb, decr Cl/K) • Laxatives → mild metabolic acidosis	**Bone mass** • Low BMD, specific areas • Sig incr risk of fracture **EEG** • Metabolic encephalopathy (diffuse abn due to electrolyte abn)
Endocrine • T4 = low-normal • T3 = low (reverse T3 high) • Females → low estrogen • Males → low testosterone	**Resting energy expenditure** • Sig reduction

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Anorexia Nervosa – Diagnostic Markers

- Physical signs + symptoms → often due to starvation
  - **Amenorrhea common** → usually after weight loss
    - If prepubertal → may delay menarche
    - Constipation, abdo pain, cold intolerance, lethargy, excess energy
  - **Emaciation**
  - **Abnormal vital signs** → hypotension, bradycardia, hypothermia
  - **Lanugo hair** (fine downy body hair)
  - **Peripheral edema** (weight restoration, cessation of laxatives/diuretics)
  - **Petechia, bruises on extremities** → bleeding diathesis
  - **Yellowing of skin** → hypercarotenemia

- If self-induced vomiting
  - **Salivary gland hypertrophy** (esp parotid)
  - **Dental enamel erosion**
  - **Scars/calluses on dorsal surface of hand** (Russel's sign)

Anorexia Nervosa – Suicide Risk

- Increase suicide risk = **12 per 100,000 per year (0.012%)**

Anorexia Nervosa – Functional Consequences

- Range of functional limitations
  - Some maintain social + professional function
  - Others have sig social isolation + academic/career impairment

Anorexia Nervosa – Differential Diagnosis

- Medical conditions (GI, thyroid, cancer, AIDS)
  - No associated cognitions (fear, disturbance in experience)
  - AN can occur after weight loss assoc with medical condition

- Major depressive disorder → no weight cognitions
- Schizophrenia → no weight cognitions
- Substance use disorders → no weight cognitions
  - AN may use substances to reduce appetite
- Social anxiety disorder, OCD, body dysmorphic disorder
  - Whether sx only related to eating/food/body shape

- Bulimia nervosa → not severely underweight
- Avoidant/restrictive food intake disorder → no weight cognitions

Anorexia Nervosa – Comorbidity

- Bipolar, depressive, anxiety disorders → common comorbidities
  - Many have anxiety disorder/symptoms prior to onset
- OCD (esp with restricting type)
- Substance/alcohol use disorders (esp with binge/purge type)

Bulimia Nervosa

Bulimia Nervosa – Diagnostic Criteria

A. Recurrent **binge eating episodes**
   1. Eating excessive amount, over discrete period of time
   2. Sense of lack of control over eating

B. Recurrent **inappropriate compensatory behaviors** (purge)

C. Frequency = **weekly for 3 months**

D. **Self-evaluation** unduly influenced by body shape/weight

E. Not exclusively during anorexia nervosa

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Bulimia Nervosa – Diagnostic Specifiers

- *Specify if:*
  - **In partial remission**
  - **In full remission**

- *Specify current severity (based on **compensatory** behaviors)*
  - **Mild:** >1 episodes per week
  - **Moderate:** >4 episodes per week
  - **Severe:** >8 episodes per week
  - **Extreme:** >14 episodes per week

Bulimia Nervosa – Diagnostic Features

- A) Recurrent binge-eating episodes
  - **Excessive amount of eating** in discrete period (usually <2 hours)
    - Consider context (not celebration meal, not continuous snacking)
  - **Sense of lack of control** (inability to refrain or stop)
    - May have dissociative quality, may abandon efforts to control eating
    - Can be planned → tend to eat foods they would otherwise avoid
    - Characterized more by abnormal amount (not specific nutrient)
  - Typically **ashamed** → attempt conceal
    - Eat until uncomfortably/painfully full
  - Triggers = **negative affect** (MOST COMMON)
    - Interpersonal stressor, dietary restraint, boredom
    - Negative feelings (about body weight, shape, food)
  - Delayed consequences → negative self-evaluation, dysphoria

Bulimia Nervosa – Diagnostic Features

- B) Inappropriate compensatory behaviors (purging)
  - Usually several methods to prevent weight gain
  - **Vomiting** = MOST COMMON
    - Relief from physical discomfort, reduction of fear of weight gain
    - May become goal in itself
    - Stimulate gag reflex, vomit at will, syrup of ipecac
  - Laxatives, diuretics, enemas, medications (thyroid, insulin)
  - Fasting, excessively exercise

- D) Excessive emphasis on body shape/weight in self-evaluation
  - Extremely important in determining self-esteem

Bulimia Nervosa – Associated Features

- Typically within normal or overweight (BMI 18.5 – 30)
  - Uncommon among obese individuals
  - Typically restrict calories between binges

- Medical consequences
  - Menstrual irregularities, amenorrhea (possibly due to weight Δ, nutritional deficiencies, or emotional distress)
  - Fluid + electrolyte abnormalities from purging
  - Rare, but fatal cx → esophageal tears, gastric tears, cardiac arrhythmias
  - Repeated use of **ipecac → cardiac/skeletal myopathies**
  - Chronic laxatives → dependent for bowel movements
  - GI sx common, reports of rectal prolapse

Bulimia Nervosa – Prevalence

- 12-month prevalence in young females = **1 – 1.5%**
  - Peaks in **older adolescence/young adulthood**
  - Less common in males → **FEMALES 10x higher**

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Bulimia Nervosa – Development & Course

- Onset
  - Commonly in **adolescence/young adulthood**
  - Before puberty or after age 40 uncommon
  - Often **during/after episode of dieting to lose weight**
    - Can also be precipitated by multiple stressful life events

- Course
  - Usually persists for **several years**
  - May be chronic or intermittent (remission/relapse)
  - For many, symptoms **tend to diminish** (regardless of treatment)
  - Treatment, remission >1 year → better long-term outcome
  - Incr mortality rate (all-cause, suicide) → CMR = **2% per decade**

- Diagnostic cross-over
  - **10-15% initially BN** → to AN (commonly revert back to BN)
  - Some stop compensatory behaviors → BED or other specified

Bulimia Nervosa – Culture-Related Issues

- Roughly similar frequency in most industrialized countries
  - US, Canada, many European countries, AUS, NZ, Japan, South Africa

- Clinical studies in US → primarily white
  - Similar prevalence in other ethnicities

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Bulimia Nervosa – Gender-Related Issues

- More common **FEMALES**

Bulimia Nervosa – Diagnostic Markers

- Lab abnormalities
  - Fluid + electrolytes → **hypokalemia, hypochloremia, hyponatremia**
  - Vomiting → **metabolic alkalosis** (loss of gastric acid)
  - Laxatives, diuretics → **metabolic acidosis** (diarrhea, dehydration)
  - **Incr serum amylase** (salivary isoenzyme)

- Physical exam
  - Permanent **loss of dental enamel** (esp lingual surface)
    - Chipped, ragged, "moth-eaten"
    - More dental caries
  - **Enlarged salivary glands** (esp parotid)
  - Scars/calluses on dorsal surface of hand
  - Syrup of ipecac → cardiac + skeletal myopathies

Bulimia Nervosa – Suicide Risk

- Increased suicide risk

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Bulimia Nervosa – Functional Consequences

- Range of functional limitations
  - May have severe role impairment → most likely **social-life domain**

Bulimia Nervosa – Differential Diagnosis

- Anorexia nervosa, binge-eating/purging type
- Binge-eating disorder → no compensatory behaviors
- Kleine-Levin syndrome → no BN cognitions

- Major depressive disorder, with atypical features
  - Not BN cognitions

- Borderline PD → can have both dx

Bulimia Nervosa – Comorbidity

- Comorbidity is common
  - Incr bipolar + depressive disorders (can begin before, during, after BN)
  - Incr anxiety disorders
  - Mood + anxiety disturbances frequently remit after effective tx
- Lifetime prevalence of substance use = **30% of BN**
  - Esp alcohol or stimulants
  - Stimulants → attempt to control appetite + weight
- Personality disorders → most frequently **borderline PD**

Binge-Eating Disorder

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Binge-Eating Disorder – Diagnostic Criteria

A. Recurrent **binge eating episodes** (both of)
   1. Eating excessive amount, over discrete period of time
   2. Sense of lack of control over eating

B. 3+/5 associated symptoms
   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 **embarrassed** by how much one is eating
   5. Feeling **disgusted** with oneself, **depressed, very guilty afterward**

C. **Marked distress** about binge eating

D. Binge eating occurs **weekly for 3 months**

E. Not associated with inappropriate compensatory behavior, and not exclusively during BN or AN

DSM5

Binge-Eating Disorder – Diagnostic Specifiers

- *Specify if:*
  - **In partial remission**
  - **In full remission**

- *Specify current severity (based on binge-eating episodes)*
  - **Mild:** >1 episodes per week
  - **Moderate:** >4 episodes per week
  - **Severe:** >8 episodes per week
  - **Extreme:** >14 episodes per week

Binge-Eating Disorder – Diagnostic Features

- A) Recurrent binge-eating episodes
  - **Excessive amount of eating** in discrete period (usually <2 hours)
    - Consider context (not celebration meal, not continuous snacking)
  - **Sense of lack of control** (inability to refrain or stop)
    - May have dissociative quality, may abandon efforts to control eating
    - Can be planned → tend to eat foods they would otherwise avoid
    - Characterized more by abnormal amount (not specific nutrient)
  - Typically **ashamed** → attempt conceal
    - Eat until uncomfortably/painfully full
  - Triggers = **negative affect** (MOST COMMON)
    - Interpersonal stressor, dietary restraint, boredom
    - Negative feelings (about body weight, shape, food)
  - Delayed consequences → negative self-evaluation, dysphoria

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Binge-Eating Disorder – Associated Features

- Occurs in normal, overweight, obese individuals
  - Reliably assoc with overweight + obesity
  - But **most obese individual do not engage** in recurrent binge-eating

- Obese with BED
  - Consume **more calories** (vs non-BED obese)
  - Greater functional impairment
  - Lower quality of life
  - More subjective distress
  - Greater psychiatric comorbidity

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Binge-Eating Disorder – Development & Course

- Binge-eating, loss-of-control eating (without excessive intake)
  - Can occur in children, common in **adolescents + college-age samples**
  - May be prodromal phase of other eating disorders
  - Assoc with incr body fat, weight gain, incr psychological sx

- Typically begins in adolescence/young adulthood
  - In BED → **dieting FOLLOWS** binge eating
  - In BN → **dieting PRECEDES** binge eating
  - BED seeking tx → usually older than BN/AN seeking tx

- Persistent course → severity/duration comparable to BN
  - **Remission rates higher in BED** (vs BN/AN)
  - Crossover from BED to other eating disorders = UNCOMMON

Binge-Eating Disorder – Risk & Prognostic Factors

- Genetic & Physiological
  - BED runs in families → additive genetic influences

Binge-Eating Disorder – Culture-Related Issues

- Similar frequencies in most industrialized countries
  - Canada, US, European countries, Australia, NZ
  - In US → similar rates among white, Latinos, Asian, African-American

Binge-Eating Disorder – Functional Consequences

- Compared to BMI-matched controls (without BED)
  - Role adjustment problems
  - Impaired health-related quality of life, life satisfaction
  - Incr medical morbidity + mortality
  - Assoc incr health care utilization
- May incr risk for weight gain + obesity

Binge-Eating Disorder – Differential Diagnosis

- Bulimia nervosa
  - BED → no inappropriate compensatory behavior or dietary restriction to influence body weight before binge-eating episodes
    - May have frequent attempts at dieting
    - Higher rates of improvement

- Obesity
  - BED → higher levels of overvaluation of body weight/shape
    - Higher rates of psychiatric comorbidity
    - Effective psychological tx for BED (none for obesity)

- Bipolar & depressive disorders → can have both dx
- Borderline PD → can have both dx

Binge-Eating Disorder – Comorbidity

- Significant psychiatric comorbidity
  - Comparable to BN/AN
  - Most common = bipolar, depressive, anxiety disorders
    - Also SUD (lesser degree)
  - Linked to severity of **binge-eating** (not obesity)

Other Specified Feeding or Eating Disorder

Other Specified Feeding or Eating Disorder

- Does not meet full criteria
- Clinician chooses to specify reason

- Atypical anorexia nervosa: weight within/above normal range
- Bulimia nervosa (of low frequency/limited duration)
- Binge-eating disorder (of low frequency/limited duration)
- Purging disorder (absence of binge-eating)
- Night eating syndrome

Unspecified Feeding or Eating Disorder

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Unspecified Feeding or Eating Disorder

- Does not meet full criteria
- Clinician chooses NOT to specify reason