Carolina Resource Center for Eating Disorders

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Medical Provider Resource - Disordered Eating and Eating Disorders

Eating disorders are complex illnesses with biological, genetic, psychological, social, and developmental roots. They come in all shapes and sizes and they do not discriminate between age, gender, race, class, sexual orientation, socioeconomic background, or ethnicity. It is impossible to know whether a person suffers from an eating disorder, or its severity, solely on the basis of appearance.

Physical signs & symptoms

General
- Marked weight loss, gain, or fluctuations
- Malnourished (regardless of weight)
- Significant changes on growth chart, including slowed growth
- Delayed pubertal progression
- Cold intolerance
- Weakness
- Fatigue or lethargy
- Dizziness
- Muscle cramping, poor motor control
- Muscle, organ, and/or cerebral atrophy
- Syncope
- Hot flashes, sweating episodes

Oral/dental
- Oral trauma/lacerations
- Dental erosion and dental caries
- Perimolysis
- Parotid enlargement

Cardiorespiratory
- Chest pain
- Heart palpitations
- Arrhythmias
- Shortness of breath
- Edema

Gastrointestinal
- Epigastric discomfort
- Early satiety, delayed gastric emptying
- Gastroesophageal reflux
- Hematemesis
- Hemorrhoids and rectal prolapse
- Constipation

Endocrine
- Amenorrhea or irregular menses
- Loss of libido
- Low bone mineral density and increased risk for fractures
- Osteoporosis
- Infertility

Neuropsychiatric
- Seizures
- Memory loss/poor concentration
- Insomnia or difficulty sleeping
- Depression/anxiety/obsessive behavior
- Self-harm
- Suicidal ideation/suicide attempt

Dermatologic
- Lanugo hair
- Hair loss
- Dry skin and hair
- Brittle nails
- Yellowish discoloration of skin
- Callus or scars on the dorsum of the hand (Russell's sign)
- Poor healing

Psychological/behavioral signs & symptoms

All eating disorders may include some or all of these symptoms
- Eating alone
- High level of shame, guilt, disgust, embarrassment
- Mood swings, feeling worthless, unloved, or unaccepted
- Think about food often throughout the day and distress about food behaviors
- Comparison to others and/or distorted body image
- Difficulty concentrating and sleep disturbance
- Defensiveness when eating behavior is addressed
- Feeling out of control and shame over how much eating
- Self-esteem and self-worth tied heavily to body shape and weight
- Withdrawal from 'normal' activities/routines
- Failing performance in work, school, etc

Specific to Binge Eating Disorder (BED)
- Feel a lack of control around food
- Eating more rapidly than normal
- Eating until uncomfortably full
- Eating large amounts of food even when not feeling physically hungry
- Hiding/hoarding food
- BED behaviors may be the result of not eating enough food (restrict/binge cycle)

Specific to Anorexia Nervosa (AN)
- Obsession and rigidity with food, weight/shape/size, calories, dieting, and/or exercise
- Intense fear of gaining weight
- Frequent weighing and body checking
- Calorie restriction
- Denial of hunger or weight loss - lack of insight of severity of condition
- Withdrawal from usual friends and activities, avoids public eating

Specific to Bulimia Nervosa (BN)
- Consuming large amounts of food in a short period of time
- Use of compensatory behaviors after consuming calories including laxative/diuretic/enema use, self-induced vomiting, excessive exercise, use of diet pills, restricting/fasting, and chewing and spitting
- Fear of gaining weight

Specific to Avoidant/Restrictive Food Intake Disorder (ARFID)
- Avoidant due to sensory sensitivity
- Aversive due to fears
- Restrictive due to lack of interest or extreme pickiness
- Not due to a drive for thinness
- More common in children and young adolescents
- Often associated with psychiatric comorbidity (especially anxious and obsessive-compulsive features of Autism Spectrum Disorder)

About Other Specified Feeding and Eating Disorders (OSFED)
- Individuals suffering from maladaptive thoughts and behaviors related to food, eating, and body image but who do not meet all of the diagnostic criteria of the eating disorders listed above. The category was developed to encompass those individuals who did not meet strict diagnostic criteria but still have a significant eating disorder. Research into the severity of OSFED shows that the disorder is just as severe as other eating disorders. ***See https://crcfored.com/eating-disorders-101/ for more information***

Discussing Disordered Eating or Eating Disorder Concerns with Patients

Patients with disordered eating and eating disorders tend to avoid seeing doctors and seeking other forms of help due to fears of potential shaming.

You can help your patients by:
- Being thoughtful with your approach and language
- Considering their comfort and respecting boundaries
- Continuing to educate yourself about eating disorders
- Becoming familiar with resources and providers who specialize in the field
- Understanding that many commonly used words or phrases may have an unintended negative impact on the patient. Below are some examples of commonly used phrases that may be unhelpful or even harmful, along with some alternative phrasing.

Language matters	Harm reduction suggestions
Word/Comment/Question	***Alternative Phrasing***
Clean eating	Eat a variety of foods for energy, nourishment, and enjoyment
Healthy eating	Utilize gentle nutrition that includes all foods, including eating for pleasure and comfort.
You aren't eating enough/ just eat	Is your body getting enough energy to take you through your day? Are you supporting your body and brain adequately? How can you tell?
You eat too much/just don't eat so much - use portion control	Are you aware of hunger and fullness cues? Everyone overeats sometimes and that may be the result of not having eaten enough. Do you find yourself sometimes not eating enough only to overeat later?
Move more	Are you engaging in joyful and mindful movement that feels good? Is this a regular part of your life?
Get your steps in/exercise x minutes per day x days per week	Body size, shape, and weight vary, as do our food and exercise needs. Ask, "Have you been able to find the balance of movement that works for you?"
Overweight or obese	Larger body or higher weight
Thin or skinny	Smaller body or lower weight
You look so good	Compliment a person's personality, successes, or accomplishments, or how good it is to see them. "It's great to see you! What brings you in today?"
You look so healthy	It is not possible to ascertain one's health visually. This comment may reinforce eating disordered behaviors. Ask "How are you feeling?"
You have lost / gained weight since last visit	No commenting on weight or appearance for anyone. Ask "Have you noticed any changes since our last visit that you would like to discuss?"

Screening

Screening Assessment: SCOFF *(validated initial screening for adults)*
☐ S Do you make yourself Sick because you feel uncomfortably full?
☐ C Do you worry you have lost Control over how much you eat?
☐ O Have you recently lost more than One stone (6.35 kg or 14 lb) in a three-month period?
☐ F Do you believe yourself to be Fat when others say you are too thin?
☐ F Would you say Food dominates your life?
Two or more positive responses on the SCOFF indicates a possible ED and should prompt referral

Eating Attitudes Test (EAT 26) www.eat-26.com)

Questions that may be asked to get the conversation started

- Do you currently suffer with or have you ever suffered with an eating disorder?
- Have any members of your family suffered with an eating disorder?
- Are you dissatisfied with your eating patterns?
- Do you ever eat in secret?
- Does your weight affect the way you feel about yourself?

An answer of "Yes" to any of these questions is classified as an abnormal response and should result in a referral for further assessment.

Other questions that you may find helpful when concerned about disordered eating or an eating disorder

- Can you describe your relationship with food?
- What do you eat on an average day?
- What was the last thing you ate and when?
- Are there foods you avoid?
- Do you have 'strange' food combinations, eating habits, and/or rituals?
- Do you feel like food controls your life?
- Do you eat when you are not hungry?
- Do you have a limited range of preferred foods that have become narrower over time?
- Do you tend to see foods as 'good' or 'bad'?
- Do you have an increased concern about the ingredients in food?
- What is your exercise routine?
- Do you feel a need to 'burn off' calories taken in?
- Do you maintain a rigid exercise regime despite weather, fatigue, injury, or illness?
- Do you feel intense distress if unable to exercise?
- Do you take any diet pills, diuretics, and/or laxatives?
- How often do you weigh yourself?
- Do you have major stressors in your life that are difficult for you to manage?
- Do you ever feel hopeless because of your struggles with food and body shape/size/weight?

With 1 death every 52 minutes occurring in the U.S. as a direct result of an eating disorder, eating disorders have the second highest mortality rate of any mental illness.

With early intervention, full recovery is possible.
With treatment, the mortality rate of people with serious eating disorders falls from 20% to 2-3%.

Diagnostic tests indicated for all patients with a suspected eating disorder

Based on Academy of Eating Disorders Care Standards Guide 2021, 4th ed.
https://www.aedweb.org/medical-care-standards

BASIC TESTS	***POTENTIAL ABNORMAL FINDINGS AND CAUSES***
Complete blood count	Leukopenia, anemia, or thrombocytopenia
Comprehensive Metabolic Panel to include electrolytes, renal function tests and liver enzymes	**Glucose*: low - poor nutrition **Sodium*: low - water loading or laxatives **Potassium*: low - vomiting, laxatives, diuretics **Chloride*: low - vomiting, laxatives **Blood Bicarbonate*: high - vomiting, low - laxatives **Blood Urea Nitrogen*: high - dehydration **Creatinine*: high - dehydration, renal dysfunction, low - poor muscle mass **Calcium*: slightly low- poor nutrition at the expense of bone **Phosphate*: low - poor nutrition and early refeeding syndrome **Magnesium*: low - poor nutrition, laxative use **Total Protein/Albumin*: high - in early malnutrition at the expense of muscle mass or milk of magnesia use, low - in later malnutrition **AST, ALT*: high - starvation
Electrocardiogram	Bradycardia (low hear rate), prolonged QTc (>450msec), other arrhythmias
ADDITIONAL TESTS TO CONSIDER	***POTENTIAL ABNORMAL FINDINGS AND CAUSES***
Leptin	Low - malnutrition
Thyroid hormone testing	TSH: low or normal T4: low or normal - euthyroid sick syndrome T3: low if below metabolically healthy weight
Gonadotropins (LH and FSH) and sex steroids (estradiol and testosterone)	LH, FSH, estradiol (women) and testosterone (men) levels: low or low normal
Erythrocyte sedimentation rate (ESR)	ESR: low - starvation
Prealbumin	Prealbumin: low - in protein-calorie malnutrition but only reflective of the past 72 hours pre-test

How to be part of an ED team

The multidisciplinary team approach is widely recognized as the best practice in the treatment of eating disorders, when possible. Ideally, team members are experienced in the care of individuals with disordered eating. Each member of the treatment team has unique skills and responsibilities with respect to patient care. It is important to remember that eating problems exist on a spectrum and early intervention is recommended.

Team often includes

Primary Care Physician/Physician Assistant/Nurse Practitioner | Therapist(s) | Dietitian | Psychiatric Provider | Occupational Therapist/Speech-Language Pathologist(particularly when working with ARFID) | Support system (family, friends) | Support or therapy groups (in person or online)

General levels of care

Inpatient Hospitalization
Refer directly to IP if a patient is medically unstable (dangerously low heart rate, blood pressure, or potassium level) and requires constant medical monitoring, IV fluids, or tube feeding.

Residential Treatment (RTC)
Refer to RTC if a patient is medically stable, but needs supervision at all meals and snacks per day, needs more structure/supervision than PHP provides, or is severely impared in daily functioning.

Partial Hospitalization Programming (PHP)
Refer to PHP if a patient needs supervised multiple meals and snacks per day, needs more structure than IOP, or is unable to function normally in activities of daily life.

Intensive Outpatient Programming (IOP)
Refer to IOP if a patient has not made significant progress after 4 weeks in outpatient or if they would benefit from daily support and a group setting.

Outpatient
Refer to outpatient clinicians if the patient is able and willing to cooperate with treatment, eating disorder behaviors and symptoms interfere minimally with daily life, and minimal external structure is needed to eat appropriately and prevent compulsive/ compensatory behaviors.

North Carolina Directory of Professional Providers & Treatment Centers

As a nonprofit organization supporting those impacted by eating disorders, CRC for ED maintains a network of treatment providers and treatment centers through professional membership and sponsorship. The information in this Directory is supplied solely by the providers and facilities themselves and is not warranted by CRC for ED.

https://crcfored.com/directory/

Handling Weight

It is recommended that weights be taken only when absolutely necessary. Mishandled weight-related procedures can contribute to the development of disordered eating or an eating disorder and cause significant setbacks in recovery. Some offices use BP, heart rate, and blood oxygenation or respiration rate as standard vitals. When weighing is necessary, the following blind weight procedures are highly encouraged:

- Have the patient void in the office just prior to weighing
- Have the patient remove heavy outer clothing such as boots, coats, etc. and ask them to empty their pockets
- Have the patient weigh backwards so that they cannot see the number
- Weight should be documented without any comment or reaction, positive or negative
- If possible, avoid including weight (in lbs or kgs) or BMI in the patient portal and ensure that these numbers are marked out on any paperwork the patient receives.

BMI

BMI (body mass index), which is based on the height and weight of a person, can be an inaccurate measure of body fat content and it does not take into account muscle mass, bone density, overall body composition, and racial and sex differences.

BMI alone is not a valid measure of health.

What is HAES®?

Simply put, HAES® (Health at Every Size) represents a paradigm shift away from a weight-centric approach to health and health care to one that highlights body diversity and behavior change to attain desired health outcomes as opposed to focusing on manipulating weight and shape.

Health at Every Size® Principles

Weigh inclusivity
Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.

Health enhancement
Support health policies that improve and equalize access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional and other needs.

Eating for well-being
Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.

Respectful care
Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.

Life-enhancing movement
Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.

For more information: https://asdah.org

Disordered eating behaviors can be precursors to eating disorders.
95% of diets fail and most will regain their lost weight in 1-5 years | 35% of "occasional dieters" progress into pathological dieting (disordered eating) and as many as 25% advance to full-blown eating disorders. For more information: https://crcfored.com/eating-disorders-101/

Carolina Resource Center for Eating Disorders

Developing and connecting resources to assist and advocate for those impacted by eating disorders.

Carolina Resource Center for Eating Disorders (CRC for ED) is the only nonprofit in North Carolina supporting individuals, families, and professionals concerned with disordered eating and recovery from eating disorders.

To receive or provide support...

info@crcfored.com | 828.337.4685 | crcfored.com

This resource was made possible solely through the generosity of private donors. Carolina Resource Center for Eating Disorders' programming depends on personal contributions and sponsorships because eating disorders nonprofits are not generally awarded grant funding.

Thank you for making your tax deductible contribution through the link on our website or by mailing a check payable to CRC for ED to PO Box 18103 Asheville, NC 28814. Tax ID: 02-0739589