

Eating Disorders: Types, Triggers, Treatment

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Objectives

- Identify 2 symptoms an individual might present with prior to an eating disorder diagnosis.
- Identify 2 proactive, protective steps health care professionals can take in addressing weight to reduce the potential development of disordered behaviors.
- Identify 2 different levels of treatment and criteria for differentiating level of care needs.
- Identify 2 benefits from using the multi-disciplinary team/referral approach in eating disorder care.

Purpose and Preface

- Advance inter-professional collaboration related to health promotion and evidence based practice as it pertains to the prevention, diagnosis, and treatment of eating disorders while addressing the global increase of prevalence for women internationally across the life span.
- As many healthcare providers wage war on the obesity epidemic, eating disorders are also on the rise in the United States and around the world. While many healthcare professionals feel they lack the proper training to identify and treat eating disorders in their everyday practice, at a minimum, they can begin to engage in preventive measures.
- With further education and empowerment, those healthcare professionals can also be part of early identification and intervention which can drastically reduce the mortality and morbidity associated with eating disorders.

Purpose and Preface

- The duration of an individual's recovery can be shortened by early identification and immediate intervention. Healthcare professionals who operate with a multi-disciplinary approach to treatment have the opportunity to reduce the long-term effects of this illness and improve quality of life for the individual across the life-span.
- The detection, diagnosis, intervention, and treatment of eating disorders takes a team of practitioners focused on assisting the individual through an often overwhelming, confusing, and complicated process.
- Prevalence data suggests that all healthcare professionals are interacting with individuals who register on the spectrum of eating disorders. Even those individuals who only meet sub-clinical criteria for disordered eating and exercise are likely still doing a significant amount of harm to their bodies while often maintaining a "healthy" appearance and being overlooked by health care providers.

Eating Disorders: Types

Overview of Eating Disorders

- **Affects more than 10 million people**
 - **Women outnumber men 5:1**
- **Typically develop during adolescence or young adulthood**
 - **Eating disorders on the rise for women > 40 years old**
- **Co-occurs with other psychological disorders**
- **Recognition of disorder is critical to treatment**
 - **Whether or not you want to work with eating disorders...**

Anorexia Nervosa

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health) .
- Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Subtypes of Anorexia Nervosa

- Restricting type
- Purging type
- Specify Severity:
 - Mild: BMI ≥ 17 kg/m²
 - Moderate: BMI 16--16.99 kg/m²
 - Severe: BMI 15--15.99 kg/m²
 - Extreme: BMI < 15 kg/m²

Bulimia Nervosa

- Recurrent episodes of binge eating
 - Eating, in a discrete period of time (e.g. 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.
 - A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Bulimia Nervosa

- Levels of severity
 - DSM-5 has the clinician determine level of severity using the following criteria:
 - Mild: 1-3 episodes per week
 - Moderate: 4-7 episodes per week
 - Severe: 8-13 episodes per week
 - Extreme: An average of 14 or more episodes of inappropriate compensatory behavior per week.

Binge Eating Disorder

- **Recurrent episodes of binge eating:**
 - Eating within a short window of time (any 2-hour period) an amount of food that is larger than what most people would eat during a similar period of time and under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- **The binge eating episodes are associated with three or more of the following:**
 - 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 feeling embarrassed by quantity
 - feeling disgusted with oneself, depressed or very guilty afterward

Binge Eating Disorder

- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for three months
- Binge eating not associated with the recurrent use of inappropriate compensatory behaviors as in Bulimia Nervosa and does not occur exclusively during the course of Bulimia Nervosa, or Anorexia Nervosa methods to compensate for overeating, such as self-induced vomiting.
- Note: Binge Eating Disorder is less common but much more severe than overeating. Binge Eating Disorder is associated with more subjective distress regarding the eating behavior, and commonly other co-occurring psychological problems.

Binge Eating Disorder

- Levels of Severity
 - Mild: 1-3 binge-eating episodes per week
 - Moderate: 4-7 episodes per week
 - Severe: 8-13 episodes per week
 - Extreme: 14 or more binge-eating episodes per week

Other Specified Feeding or Eating Disorder (OSFED)

- OSFED
 - An individual must present with feeding or eating behaviors that cause clinically significant distress and impairment in areas of functioning, but do not meet the full criteria for any of the other feeding and eating disorders
 - A diagnosis might then be allocated that specifies a reason why the presentation does not meet the specifics of another disorder (e.g. Bulimia Nervosa- low frequency).
 - The following are further examples for OSFED

OSFED

- **Atypical Anorexia Nervosa:** All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range.
- **Binge Eating Disorder (of low frequency and/or limited duration):** All of the criteria for BED are met, except at a lower frequency and/or for less than three months.
- **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 behavior occurs at a lower frequency and/or for less than three months.

OSFED

- **Purging Disorder:** Recurrent purging behavior to influence weight or shape in the absence of binge eating
- **Night Eating Syndrome:** Recurrent episodes of night eating. Eating after awakening from sleep, or by excessive food consumption after the evening meal. The behavior is not better explained by environmental influences or social norms. The behavior causes significant distress/impairment. The behavior is not better explained by another mental health disorder (e.g. BED).

Guidelines for Assessing Eating Disorders

Laboratory Tests

Complete Metabolic Profile
CBC with Differential
TSH, Free T3, T4
EKG
Phosphorus
Magnesium
Amylase
Lipase
Liver Profile
U/A and Specific Gravity
Bone Density Scan
Uric Acid

Signs and Symptoms

Fatigue
Sleep Disturbances
Dizziness/Fainting
Weakness
Chest Pain
Shortness of Breath
Depression
Anxiety
Cold Intolerance
Broken Bones
Brittle Hair and Nails
Bloating/Heartburn
Abdominal Pain
Constipation/Diarrhea
Loss of Muscle Mass
Obsession with Exercise
Obsession with Calories, Food and Weight
Low Self-Esteem
Pale or "Gray" Appearance to the Skin
Vague or Secretive Eating Patterns
Use of Diet Pills, Laxatives, Ipecac Syrup or Enemas

Physical Examination

Blind Weight and Height in an Exam Room, Not a Public Scale
Wearing Light Gown, Empty Bladder
Measurements Taken by Provider
Ideally a Consistent Scale
Orthostatic Vital Signs and Temperature
Full Physical

Physical Findings Anorexia Nervosa

Weight Loss >15%
Emaciation
Bradycardia
Hypotensive
Hypothermia
Lanugo Hair (Soft, Downy, White Hair)
Carotenemia
Hyperkeratosis
Edema (Swelling)
Anemia
Amenorrhea (Loss of Menses)
Spontaneous Fractures

Bulimia Nervosa

Normal or Overweight
Hypertensive
Swollen Parotid Glands
Dental Erosions
Scars on Knuckles of Hands
Edema
Extremity Weakness
Esophagitis
Electrolyte Imbalance
Sore Throat

Eating Disorders: Triggers

Triggers

“Genes load the gun, environment pulls the trigger.”

- Cynthia Bulik, PhD, FAED, Director of UNC Center of Excellence for Eating Disorders, ANGI Study
- Genetic predisposition
- Stressors; highly individualized
- Trauma, PTSD
- Crisis and control
- Rejection and acceptance
- Developmental trajectory
- “The Perfect Storm”

Food: More Than Just Nutrients

- **Linked to personal emotions**
- **Source of comfort**
- **Release of neurotransmitters and natural opioids**
 - **Note: food used as a reward or bribe can lead to disordered eating/food hoarding/body image issues**
 - **Resources for parents and children:**
 - **Tummy Talk, Dr. Megan Osborne**
 - **Fearless Feeding, Castle and Jacobsen**

Body Image

- **Media promotion**
- **Social Media**
 - **Need for social acceptance**
 - **Influence and stress on young individuals**
- **Dieting (often rooted in poor body image or low body satisfaction) may lead to the development of DEED**

Eating Disorders: Triggers

Do No Harm

Let's talk about weight...

- How do you currently discuss weight/body image/health in your office/practice/place of work?
- How do you currently discuss weight/body image/health in your personal spaces?
- Consider the atmosphere, the messages, types of conversations around assessment areas/patient rooms
 - Good food, bad food
 - Scale jokes
 - Shame talk

Inclusive Treatment for Health Outcomes

“Ignoring either anorexigenic or orexigenic forces causes a disruption in homeostasis that may result in overcompensation. Because starvation is more of an immediate threat than obesity, the error in weight homeostasis is to preserve energy stores over leanness. Ignoring hunger cues can be as detrimental to maintaining leanness as ignoring fullness cues. Before resorting to artificial means to combat overcompensation, perhaps patient education could teach the value of tuning into homeostatic cues. Eating in this intuitive and intrinsic way may provide an effective and accessible means to stay healthy and avoid excessive weight gain.”

Lauren Outland, *Bringing Homeostasis Back into Weight Control*, School of Nursing, California State University Dominguez Hills, USA

Outland, J *Obes Weig los Ther* 2012, 2:2

<http://dx.doi.org/10.4172/2165-7904.1000115>

Language: What NOT To Say to Patients

- “You look better”
- “You look so much healthier now”
- “Your weight is healthier”
- “You are looking more normal”
- “You don’t need to come to my office anymore, you are fine”
- “Wow, you’ve lost/gained a lot of weight lately”
- “What you are feeling is completely normal for your age”
- “Why can’t you just eat something?”
- “You’ll probably end up back in the hospital again”
- “Your weight is good this week”

Language: What TO Say to Patients

- “You are thinking so much more clearly”
- “It’s good to see your sense of humor”
- “Re-nourishment has made you much more effective at communicating your needs”
- “Your concentration has really improved”
- “Your personality is really coming through now that your physical health has improved a little”
- “You should be proud of yourself for the steps you are taking to get/stay healthy”
- “You can talk to me if you need to”
- “This illness has a long course but there is hope”
- “Your health is improving”

Eating Disorders: Treatment

Treatment: Detecting

- Consider all people, all shapes and sizes
 - Gender
 - Race/ethnicity
 - Religion
 - Age
- Listen carefully for information given
 - “Glamour” Magazine
 - Attention-seeking: yes or no?
- Ask more questions and less “yes/no”
 - Peel the onion
- Refer
 - OBGYN, physician, psychiatrist, nurse practitioner, dietitian
 - IAEDP

“What’s Up Doc?”

- Weight is more than a number on a scale; it represents self-worth, self-control, and status to people with disordered eating.
- Height is not the only factor to be considered when determining Ideal Body Weight. A person’s frame, musculature, family history, health status, and weight and nutritional history also must be known.
- Anorexia is the disorder physicians study more, but bulimia is more frequent, harder to diagnose, more secretive, and often coexists with anorexia.
- Trauma is one of the precipitants for many with eating disorders. The eating disorder is a way to deal with the pain and other complicated emotions.
- Side effects of eating disorders intensify gradually. Laboratory values are not the whole story. Mood, concentration, thinking, energy, social interactions, and quality of life are affected much sooner. Physicians should discuss both the psychological and physiological consequences.

Resource: Dr. Margo Maine, National Eating Disorders Association

“What’s Up Doc?”

- Universal – unfortunately, eating disorders are universal now affecting females of all ages, even prepubescent children and males. They cut across socioeconomic, ethnic, and cultural groups in the U.S. and are now becoming a more global problem due to the impact of the media and the internet.
- Purging is not just vomiting. Laxatives, enemas, diuretics, excessive exercise, supplements, diet pills, medications, or alcohol to make one nauseous are other methods. Ask what the patient does to maintain or try to lose weight.
- Dieting is almost always a precursor to eating disorders. Take this subject seriously and educate your patients about the dangers of restricted intake (such as bingeing/hypometabolism).
- Office – your office may be full of eating disorder messages. Magazines, dietary warnings, height and weight charts, comments about weight can all contribute to eating disorder attitudes.
- Compassion, consistency, and care are what a physician offers to patients with eating disorders. This role is very important, but, alone, is not enough: refer to mental health specialists in eating disorders so the care can be comprehensive.

Screening for Eating Disorders

- Activity: “What’s going on with me?” - Evaluating Eating and Exercise Habits

What's Going On With Me?

Evaluating Eating and Exercise Habits

- **Do you spend time wishing parts of your body looked different?**
- **Do you skip meals?**
- **Do you count the calories or fat grams in anything you eat?**
- **Do you exercise so much that you are fatigued or have frequent injuries?**

If you answered "yes" to any of these questions, keep reading...

Living in our culture, it's not surprising if you feel you have to look a certain way to be happy or even healthy. You may think that dieting is a normal or even necessary part of life. However, constant concern about body weight and shape, fat grams and calories can start a vicious cycle of body dissatisfaction and obsession. The things you're doing to be thin can quickly *spin out of control* and become a serious, life-threatening eating disorder.

Just because you weigh yourself, skip meals, count calories, or over-exercise doesn't necessarily mean that you have an eating disorder. But you may be dealing with what's called "disordered eating."

What is Disordered Eating?

Disordered eating is when a person's attitudes about food, weight, and body size lead to very rigid eating and exercise habits that jeopardize one's health, happiness and safety. Disordered eating may begin as a way to lose a few pounds or get in shape, but these behaviors can quickly get out of control, become obsessions, and may even turn into an eating disorder. Even if you don't have a full-blown eating disorder, you may be missing out on living while you spend all your time dieting!

Wonder if you're dealing with disordered eating? Think about this...

- Do you constantly calculate numbers of fat grams and calories?
- Do you weigh yourself often and find yourself obsessed with the number on the scale?
- Do you exercise to burn off calories and not for health and enjoyment?
- Do you ever feel out of control when you are eating?
- Do your eating patterns include extreme dieting, preferences for certain foods, withdrawn or ritualized behavior at mealtime or secretive bingeing?
- Has weight loss, dieting, and/or control of food become one of your major concerns?
- Do you feel ashamed, disgusted or guilty after eating?
- Do you constantly worry about the weight, shape or size of your body?
- Do you feel like your identity and value is based on how you look or how much you weigh?

If you answered "yes" to any of these questions, you could be dealing with disordered eating. These attitudes and behaviors can take a toll on your mental, emotional and physical well being. It is important that you start to talk about your eating habits and concerns now, rather than waiting until your situation gets more serious than you can handle.

Screening for Eating Disorders

- Ask About:
 - Recent weight fluctuations
 - History of weight fluctuations
 - Report of meals eaten on previous day
 - Periods of bingeing or feeling a lack of control over food intake
 - Comfort with current weight/shape
 - Menstrual history
 - Family history of eating disorders, depression, chemical dependence
 - Desired weight
 - Actions taken to maintain, control, or alter weight
 - Any attempts to lose weight through laxatives, diuretics, diet pills, vomiting, enemas, exercise habits (how much? how often? why?)

Treatment

- The most valuable and long-lasting treatment outcomes for an eating disorder involve:
 - Psychotherapy/psychological counseling along with thorough attention to the patient's medical and nutritional needs via nutrition therapy and individualized medical care to include obstetrics and gynecology, internal medicine, gastroenterology, sports medicine, orthopedics, psychiatry, and pharmaceuticals
 - Tailored care based on the patient's current needs, problems, and strengths with a case manager/social worker.

Treatment Goals

- Restore health and stabilize healthy weight
- Developing healthy, flexible eating habits
- Normalize and restore regular, healthy eating and activity
- Listen to body cues regarding hunger, fullness, rest, activity
- Stabilizing accompanying symptoms and medical conditions of the eating disorder
- Reduce/minimize compensatory behaviors, e.g., purge behaviors

<http://www.nyeatingdisorders.org/eating-disorders-carers/treatment-goals.php>

Treatment Goals

- Body acceptance, self-esteem and improved body image
- Learning alternative healthy coping strategies for dealing with stressful situations
- Develop positive self-talk and self-care
- Increased connectedness with family and friends
- Eating disorders are no longer the focus of family/friend/significant other communications

Primary Treatment Team

- Non-negotiable:
 - Psychologist/Therapist/Licensed Counselor
 - Dietitian
 - Physician and supervised clinicians such as NP, PA
- Ideal, Case Dependent
 - Psychiatrist
 - Social Worker/Case Manager

Treatment Team: Expanded Approach

- PCP, Nurse Practitioner, PA, Nurses
- OBGYN
- Psychiatry
- Orthopedic
- Physical therapists, massage therapists, osteopathic manipulation/chiropractic
- Exercise Physiologists, Personal Trainers, Group Fitness Instructors
- Social work/case management/patient advocacy
- Psychiatrist
- Psychologist, therapist, counselor
 - Movement therapy
 - Creative arts therapy (music, art, drama)
 - Psychotherapy
 - Group therapy
- Nutrition: Registered Dietitian-Nutritionist (CEDRD), Dietary Aides, Dietary Technicians, Dietetic Interns, Chef, Grocery Procurement
- Dentist, Dental Hygienist

Treatment Team Approach

- Treatment team discussions can often provide insight and awareness for best case management
 - Disclosure to client may vary between clinicians over the course of treatment
 - Avoid triangulation
- Teaches clients to seek out professional help from experts in all areas
- Reiterates that health is multi-factorial

Levels of Care

- Inpatient Criteria
 - Medically unstable
 - Unstable or depressed vital signs
 - Lab findings presenting acute health risk
 - Dehydration, malnutrition, anemia, hypotension, electrolyte imbalances which could lead to cardiac complications
 - Complications due to coexisting medical problems (i.e. Diabetes)
 - Patient is psychiatrically unstable as determined by:
 - Rapidly worsening symptoms
 - Suicidal and unable to reach out for help

Levels of Care

- Residential
 - Highly structured treatment program for medically stable patients requiring constant behavioral supervision and access to nursing care around-the-clock.
- Residential Criteria
 - Patient is medically stable and does not require extensive medical intervention.
 - Patient is psychiatrically impaired and unable to respond to partial hospital or outpatient treatment.
 - Patient requires supervision making PHP or IOP in appropriate.

Levels of Care

- Partial Hospitalization Program (PHP)
 - A program for medically stable patients who need daily structured programming but do not require 24-hour supervision.
- PHP Criteria
 - Patient is medically stable but:
 - Eating disorder impairs functioning without immediate risk
 - Requires daily assessment (vitals, food intake, etc)
 - Patient is psychiatrically stable but:
 - Unable to function in normal social, educational, or vocational situations
 - Engages in daily binge eating, purging, fasting or very limited food intake, or other pathogenic weight control techniques

Levels of Care

- Intensive Outpatient Program (IOP)
 - Meets on average three times per week for three hours per day (evening or day-time)
 - Serves as step-down from residential or Partial Hospital program or as a step-up from outpatient treatment
- IOP Criteria
 - Group-based and may include coping skill development, interpersonal process, psychoeducational and expressive psychotherapy components
 - Includes on average one supervised meal per day led by therapist or registered dietitian Allows patients to remain in regular day-time activities (ie. work or school)

Levels of Care

- Outpatient
 - A program for medically stable patients needing structure and support to maintain sound trajectories toward eating disorder recovery.
- Outpatient Criteria
 - Patient is medically stable and does not require daily medical monitoring
 - Patient is psychiatrically stable and has symptoms under sufficient control in order to function in social, educational, or vocational situations normally and continues to make progress in recovery
- Goal Oriented
 - Tailored nutrition therapy for longterm maintenance of recovery
 - Reintroduction of fear foods and movement exploration

http://www.kantorlaw.net/documents/2011_IAEDP/0-American-Psychiatric-Assoc-Guidelines-Chart.pdf

- I wish more doctors knew/realized that weight is not the only indicator for health, and that weight alone is not even a good indicator. Having a cardiologist say that I needed to stay at the lowest healthy weight possible for my cholesterol was (1) not true, because my cholesterol levels didn't change and (2) really messed with me, because it got me on the mentality that smaller/less of me meant a healthier me.
- I wish all people realized that just because social media and weight loss companies think it's appropriate/normal to always be dieting, that it actually isn't! I wish people would STOP commenting on our sizes. Even if someone is trying to be "nice" by saying "oh you look so thin/tiny/small in that dress" it puts the mind on a different track about what is truly valued. It motivates the individual with the unhealthy behaviors to keep going. It leads me to think "now I should keep up whatever unhealthy behavior I have going to maintain this size that is finally receiving applause." So no more commenting on someone's size or body.
- I wish I had known that every diet, work out, website, restriction list would never, ever make me happy. That no matter how small I got, it was never small enough. That I had to "keep going". That it would suck out so much of my precious time. That it wouldn't help me in school, find a career, bring me closer to Jesus or my family and friends.

- I wish people didn't encourage me. Every time I lost weight in high school, every one told me I looked so much better, etc. My friends, parents, dance teachers... And you know, maybe by society's standards, I did look "so much better", but my body wasn't made to be that size. I wish I had known then that some people are just different sizes. Yes, we could all be a size x. But some people are just a size x because they are made that way. And other people don't eat, struggle with depression and anxiety, compromise their health, and live a life controlled by food and exercise to the obsession with getting to a place they were never designed to be. And then they get there, only to realize they still aren't happy. The only thing they've gained is more pressure and stress to stay that way or keep it up. It doesn't stop just because you "reached your goal". The "goal" on making your body something it's not supposed to be will never really be met.
- I'm glad I know all of these things now. I'm glad that my diet is now just food I eat, and not food rules or restrictions. I'm glad that I can choose to rest after a long day, even if I had plans to walk/go to yoga/etc. I'm glad that I can speak positively into people's lives that are struggling. I'm glad that I can deflect comments people make, and realize that they probably have a distorted perception of their own body/diet. I'm glad that food is just food, that I'm not scared of it or guilty by it anymore.

- I wish I knew that working out/moving your body wasn't a punishment, and wasn't something to do to get rid of the food you've eaten. I never thought of dance as a "work out" when I was a kid. But as I got older it became that way. I used to just love it, the music and movement and stretching of my muscles. But then it became more about the duration and how much I sweat or if I was sore the next morning. I still don't know if I've gotten the love of movement back completely. The "how long, how much, how hard" still lingers, and I think that's sad. Had no one ever associated dancing as a way to burn calories, I would still love it in its simplest form. I just hope no one ever ruins that for my kids.
- I wish parents realized that every time they put down their bodies or others, make comments about food or exercise, restrict food in the house, etc, that their children hear every word. And the more they hear it the more they believe it, deeply, because it's being spoken and reinforced over them.

Case Study

- 24yo W female diagnosed with Anorexia Nervosa
- Anxiety-Depression-OCD, Gastroparesis 2T eating disorder
- 20 months of outpatient treatment with RD
- Beginning wt of 83#
- Weight loss of 4 pounds over first 5 mo period
 - Starting BMI-17.3
 - Lowest BMI-16.5

Case Study: Fear Foods

- Peanut butter
- Whole milk
- Mayonnaise
- Ranch
- Cheese
- Cereal
- All meats
- White sauces
- Chocolate with peanut butter
- Regular/sweet potatoes
- Bread
- Must nuts except almonds
- Prepackaged snacks
- Cookies, cakes, ice cream

Case Study

- Triggers
 - Social media, magazines, television
 - Stress from school
 - Family situations (sick dad, grandparents, sister moving)
- Opposite Action (DBT)
 - Normal: feeling anxiety about an upcoming exam could serve as a motivator to study
 - Abnormal: feeling intense anxiety about eating supper at a restaurant could cause one to feel the urge to avoid socializing or going out to eat altogether
 - Opposite action would be to push yourself to have meals at restaurants(despite feeling afraid)

Case Study

- Where are we now?
 - Meets with dietitian and counselor weekly; psychiatrist bi-weekly
 - Weight gain of 14.6# over past 15 months
 - Current BMI 19.5
 - 98% IBW
 - Questions related to the case study:
 - Contact Leah Pierce at leahpiercerd@gmail.com

Objectives

- Identify 2 symptoms an individual might present with prior to an eating disorder diagnosis.
- Identify 2 different levels of treatment and criteria for differentiating level of care needs.
- Identify 2 proactive, protective steps health care professionals can take in addressing weight to reduce the potential development of disordered behaviors.
- Identify 2 benefits from using the multi-disciplinary team/referral approach in eating disorder care.

Resources

- Putting Eating Disorders on the Radar of Primary Care Providers
www.cwedp.ca
- Treatment Criteria – NEDA <https://www.nationaleatingdisorders.org/treatment-settings-and-levels-care>
- Levels of Care - NEDA Webinar
<https://www.nationaleatingdisorders.org/sites/default/files/NEDA%20Webinar%20Levels%20of%20Treatment.pdf>
- Levels of Care – APA http://www.kantorlaw.net/documents/2011_IAEDP/0-American-Psychiatric-Assoc-Guidelines-Chart.pdf
- Guidelines for Assessing ED
https://www.eatingrecoverycenter.com/wp-content/uploads/2015/09/Guidelines-for-Assessing-EDs-Card-_03.15.pdf

Questions?

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