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Identifying Eating Disorders

A Guide for Providers

Early Intervention Saves Lives

For people with eating disorders, early intervention can be life-saving. Unfortunately, studies indicate four-year to six-year delays, on average, between the onset of symptoms and when an individual finally seeks treatment, with stigma cited as the most impactful treatment barrier. (1)

When an individual is entrenched in their eating disorder, they are likely to experience difficulty in making objective decisions about treatment. It may be helpful to discuss the benefits associated with not delaying care with your clients. Early intervention can mean less time spent in treatment, a reduced likelihood of relapse, and fewer physical and mental health risks. Your ability to recognize early eating disorder signs (including those unrelated to weight) and encourage clients to seek help before symptoms escalate can have a life-saving impact.

Eating Disorder Statistics

- Eating disorders are among the deadliest mental illnesses. Anorexia nervosa has one of the highest mortality rates of any mental health condition, second only to opioid overdose.
- The lifetime prevalence of bulimia nervosa for adult women ranges from 1.7% to 2.0% and for adult men ranges from 0.5% to 0.7%. (2)
- People with anorexia are 56 times more likely to die by suicide than the general population.
- BIPOC are significantly less likely than white people to have been asked by a doctor about eating disorder symptoms. (3)
- Less than 6% of people with eating disorders are medically diagnosed as underweight. (4)
- 60% of adults with BED are not sure whether they need to receive help. (5)

1. Hamilton A, Mitchison D, Basten C, Byrne S, Goldstein M, Hay P, Heruc G, Thornton C, Touyz S. Understanding treatment delay: Perceived barriers preventing treatment-seeking for eating disorders. Aust N Z J Psychiatry. 2022 Mar;56(3):248-259. doi: 10.1177/00048674211020102. Epub 2021 Jul 12. PMID: 34250844.
2. Keski-Rahkonen A, Raevuori A, Hoek HW. Epidemiology of eating disorders: an update. Annual Review of Eating Disorders: CRC Press 2018:66-76.
3. Becker, A. E., Franko, D. L., Speck, A., & Herzog, D. B. (2003). Ethnicity and differential access to care for eating disorder symptoms. International Journal of Eating Disorders, 33(2), 205-212. doi:10.1002/eat.1012.
4. Flament, M., Henderson, K., Buchholz, A., Obeid, N., Nguyen, H., Birmingham, M., Goldfield, G. (2015). Weight Status and DSM-5 Diagnoses of Eating Disorders in Adolescents From the Community. Journal of the American Academy of Child & Adolescent Psychiatry, Vol. 54, Issue 5, 403-411.
5. Linardon, J., Rosato, J., & Messer, M. (2020). Break Binge Eating: Reach, engagement, and user profile of an Internet-based psychoeducation-al and self-help platform for eating disorders. International Journal of Eating Disorders, 53, 1719-1728.

If your clients are exhibiting medical or behavioral signs of disordered eating, contact our admissions team today to discuss care options.

(866) 651 - 7129

Eating Disorder Diagnoses

Anorexia Nervosa

Severe restriction of food intake or calories, an intense fear of gaining weight, and excessive weight loss.
Atypical anorexia: An eating disorder in which a person meets all of the criteria for anorexia but is not at a low body weight.

Avoidant/Restrictive Food Intake Disorder (ARFID)

More than just picky eating, individuals with ARFID often don't eat enough to meet their energy and nutritional needs. Unlike individuals with anorexia, people with ARFID tend not to worry about their weight or body shape. ARFID has a growing prevalence among adolescents.

Binge Eating Disorder (BED)

The consumption of food in a discrete period of time (e.g., within any two-hour period) that is larger than most people would eat during a similar amount of time and under similar circumstances. During this episode, an individual experiences a lack of control over eating.

Bulimia Nervosa

Periods of binge-eating (eating large portions of food uncontrollably) or excessive overeating, followed by purging or getting rid of calories usually through fasting, laxative use, or self-induced vomiting.

Other Specified Eating or Feeding Disorder (OSFED)

Symptoms that don't meet the strict diagnostic criteria of a specific eating disorder, but that significantly interfere with a person's functioning. Symptoms include obsession with food cleanliness or exercise, feeling overweight despite weight loss, loss of control when eating including impulsive or irregular eating habits, etc.

Diabulimia (ED-DMT1)

Diabulimia, though not a DSM diagnosis, is the colloquial name for the diagnosis of a person with eating disorders and type 1 diabetes who manipulates their insulin doses in an effort to control their weight. More formally, these behaviors are referred to as the dual diagnosis of "eating disorder-diabetes Mellitus type 1" or "ED-DMT1."

Eating Disorder Screening Questions

The SCOFF questionnaire is a simple, five-question screening measure to assess the possible presence of an eating disorder.

1. Do you make yourself sick because you feel uncomfortably full?
2. Do you worry that you have lost control over how much you eat?
3. Have you recently lost more than one stone (approximately 15 pounds) in a three-month period?
4. Do you believe yourself to be fat, even when others say you are too thin?
5. Would you say that food dominates your life?

Two "yes" responses indicate a possible presence of an eating disorder. Contact our team or visit **alsana.com/admissions** to schedule an assessment.

Signs, Symptoms, and Health Risks

Less than half of Americans with eating disorders ever receive treatment. (1) As providers, it is important to know there are significant disparities in terms of early detection and eating disorder diagnoses; symptoms are often missed in males, communities of color, and people in larger bodies. (2) Early eating disorder detection and treatment intervention can have a meaningful impact on clients' symptom severity, quality of life, treatment effectiveness, and mortality rates.

Medical Signs/Symptoms

- Noticeable changes in weight
- Bradycardia and/or orthostatic vital sign changes
- Delayed onset of menses or secondary amenorrhea
- Fatigue, cold intolerance, and/or dizziness
- Hair loss or thinning
- Cardiac failure
- Gastrointestinal dysfunction, including gastroesophageal reflux, disease, gastroparesis, constipation, and diarrhea
- Early satiety, bloating, and nausea
- Parotid gland enlargement
- Abnormal electrolytes
- Unexplained swelling
- Dental enamel erosion (with or without decay)
- Osteopenia or osteoporosis in premenopausal women
- Loss of libido

Behavioral Signs

- Sudden interest in weight loss diets (e.g., keto diet) or speciliazing diets (e.g., no sugar)
- Excessive/compulsive exercise
- Binge eating
- Self-induced vomiting
- Laxative, diuretic, and/or diet pill abuse
- Food chewing and spitting
- Insulin misuse (in diabetics)
- Marked distress and feelings of disgust, depression, or guilt

Health Risks

- Vital sign changes, including hypothermia, resting bradycardia, exertional techycardia, hypotension, and hypertension
- Cardiac arrhythmias
- Cardiac atrophy
- Heart failure
- Pericardial effusion
- Hypoglycemia
- Refeeding syndrome
- PseudoBartter's syndrome
- Electrolyte abnormalities
- Sialadenosis
- Edema
- Gastroparesis
- Gastroesophageal reflux disease
- Superior mesenteric artery syndrome
- Liver dysfunction
- Constipation
- Diarrhea
- Muscular weakness, including swallowing difficulties
- Amenorrhea in females
- Osteoporosis
- Diabetes mellitus type I or II
- Obstructive sleep apnea
- Polycystic ovarian syndrome

1. (Hudson JI, Hiripi E, Pope HG, Jr., Kessler RC. The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biol Psychiatry 2007;61:348-58.)
2. (Becker AE, Franko DL, Speck A, Herzog DB. Ethnicity and differential access to care for eating disorder symptoms. Int J Eat Disord 2003;33:205-12. | Austin SB, Penfold RB, Johnson RL, Haines J, Forman S. Clinician identification of youth abusing over-the-counter products for weight control in a large U.S. integrated health system. Journal of Eating Disorders 2013;1:40. | Austin SB, Ziyadeh NJ, Forman S, Prokop LA, Keliher A, Jacobs D. Screening high school students for eating disorders: Results of a national initiative. Preventing Chronic Disease 2008;5:1-10. | Marques L, Alegria M, Becker AE, et al. Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: Implications for reducing ethnic disparities in health care access for eating disorders. Int J Eat Disord 2010;44:412-20.)

Manifestations of **Eating Disorders**

***Psychological*:** depression, anxiety, OCD, insomnia, fear of gaining weight, shame, low self-esteem, substance misuse

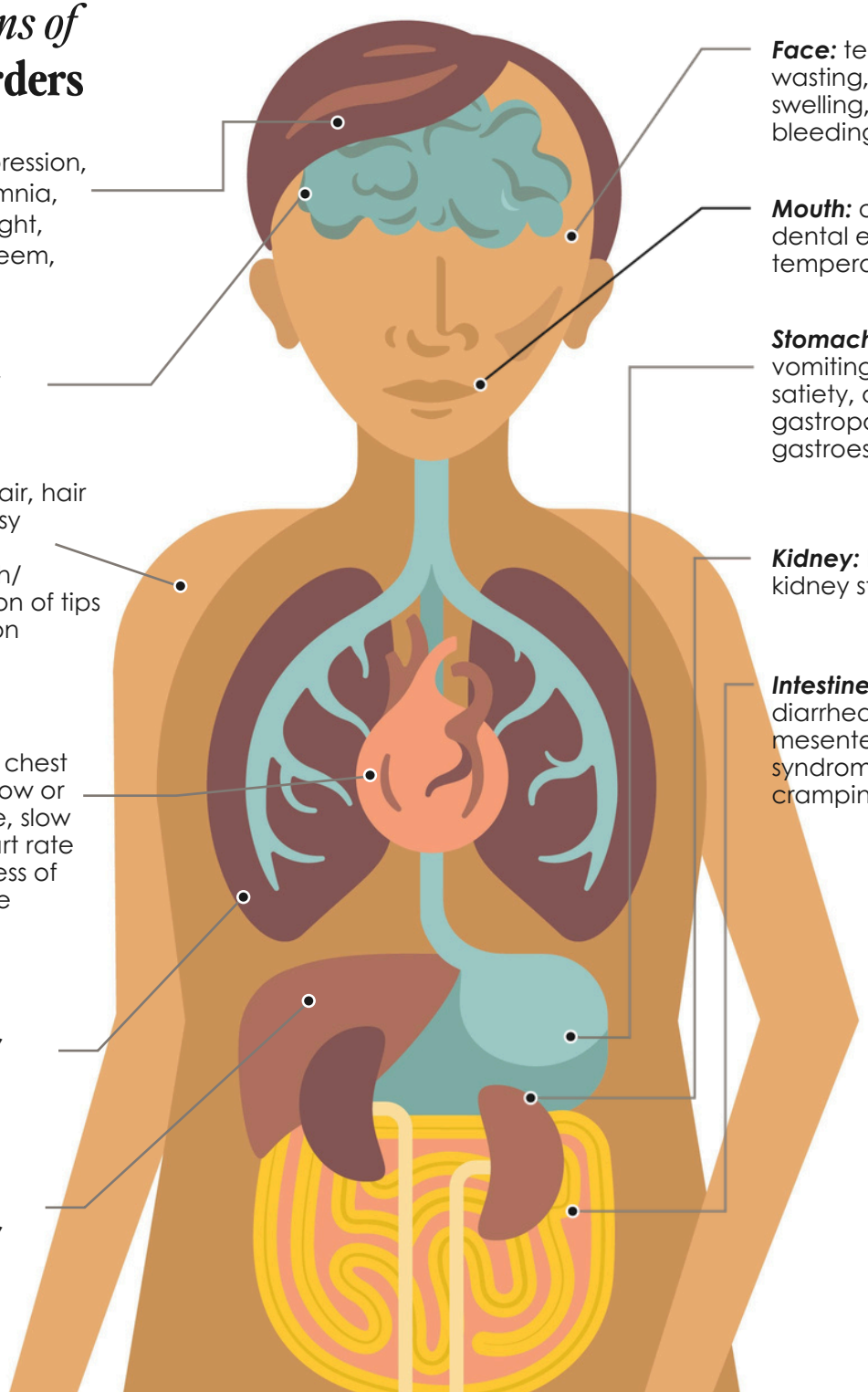
Neurological: memory difficulties, cognitive slowing, dizziness, fatigue

Hair/Skin: lanugo hair, hair loss, brittle nails, easy bruising, xerosis, acrocyanosis (bluish/purplish discoloration of tips of skin), abrasions on knuckles

Heart: palpitations, chest pain, arrhythmias, low or high blood pressure, slow heart rate, fast heart rate on exertion, shortness of breath, heart failure

Lungs: cough, shortness of breath, obstructive sleep apnea

Liver: starvation hepatitis, non-alcoholic fatty liver, coagulopathy



Face: temporal wasting, parotid swelling, nose bleeding

Mouth: caries, cavities, dental erosions, perimylolysis, temperature intolerance

Stomach: nausea, vomiting, bloating, early satiety, disease, gastroparesis, gastroesophageal reflex

Kidney: kidney failure, kidney stones

Intestines: constipation, diarrhea, superior mesenteric artery syndrome, villous blunting, cramping, rectal prolapse

Electrolytes: dehydration, low sodium, low potassium, high bicarbonate, low phosphorus, low magnesium

Endocrine: poorly controlled diabetes (I and II), metabolic syndrome, primary or secondary amenorrhea, irregular menses, osteopenia, osteoporosis, high cholesterol, abnormal thyroid function, difficulty conceiving, multiple miscarriages, decreased libido, hot/cold intolerance

Blood: low white blood cells, low red blood cells (anemia), low platelets

Musculoskeletal: muscle weakness, fractures

Eating disorders do not discriminate. These disorders affect individuals of **all ages, genders, and sexual orientations.**

American Psychiatric Association Level of Care Guidelines for Patients with Eating Disorders

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization	Level 4: Residential	Level 5: Inpatient Hospitalization
Medical Status	Medically stable to the extent that more extensive medical monitoring, as defined in levels 4 and 5, is not required.			Medically stable to the extent that intravenous fluids, nasogastic tube feedings, or multiple daily laboratory tests are not needed.	**Adults:** HR <40 bpm | BP <90/60 mmHg | Glucose <60mg/dl | Potassium <3mEq/L | Electrolyte imbalance | Temp <97.0 F | Dehydration | Hepatic, renal, or cardiovascular organ compromise requiring acute treatment | Poorly-controlled diabetes **Children & Adolescents:** HR near 40 bpm | Orthostatic BP changes (>20 bpm increase in HR or >10 mmHg to 20 mmHg drop) | BP <80/50 mmHg | Hypokalemia, hypophosphatemia, or hypomagnesaemia
Suicidality	If suicidality is present, inpatient monitoring and treatment may be needed, depending on the estimated level of risk.				Specific plan with high lethality or intent; admission may also be indicated in patient with suicidal ideas or after a suicide attempt or aborted attempt, depending on the presence or absence of other factors modulating suicide risk.
Weight as Percentage of Healthy Body Weight	Generally >85%	Generally >80%	Generally >80%	Generally >85%	Generally <85% | Acute weight decline with food refusal even if not <85% of healthy body weight
Motivation to Recover, including cooperativeness, insight, and ability to control obsessive thoughts	Fair-to-good motivation	Fair motivation	Partial motivation; cooperative; patient preoccupid with intrusive, repetitive thoughts >3 hours per day.	Poor-to-fair motivation; patient preoccupied with intrusive, repetitive thoughts 4-6 hours per day; patient cooperative with highly-structured treatment.	Very-poor-to-poor motivation; patient preoccupied with intrusive, repetitive thoughts and patient uncooperative with treatment or cooperative only in highly-structured environment.
Co-occuring Disorders, such as substance use, depression, or anxiety	Presence of co-morbid conditions may influence choice level of care.				Any existing psychiatric disorder that would require hospitalization.

American Psychiatric Association Level of Care Guidelines for Patients with Eating Disorders

<table>
<tr><th></th><th>Level 1:
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Partial Hospitalization</th><th>Level 4:
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Inpatient Hospitalization</th></tr>
<tr><td>Structure Needed for Eating/Gaining Weight</td><td>Self-Sufficient</td><td>Self-Sufficient</td><td>Needs some structure to gain weight</td><td>Needs supervision at all meals or will restrict eating</td><td>Needs supervision during and after all meals or nasogastic/special feeding modality</td></tr>
<tr><td>Ability to Control Compulsive Exercising</td><td>Can manage compulsive exercising through self-control.</td><td colspan="4">Some degree of external structure beyond self-control required to prevent patient from compulsive exercising; rarely a sole indication for increasing the level of care.</td></tr>
<tr><td>Purging Behavior, such as using laxatives and diuretics</td><td colspan="3">Can greatly reduce the incidents of purging in an unstructured setting; no significant medical complications, such as electrocardiographic or other abnormalities, suggesting the need for hospitalization.</td><td>Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging.</td><td>Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent, and disabling, despite appropriate trials of outpatient care, even if routine laboratory test results show no obvious metabolic abnormalities.</td></tr>
<tr><td>Environmental Stress</td><td colspan="2">Others able to provide adequate emotional and practical support and structure.</td><td>Others able to provide at least limited support and structure.</td><td colspan="2">Severe family conflict or problems or absence of family so patient is unable to receive structured treatment in home; patient lives alone without adequate support system.</td></tr>
<tr><td>Geographic Availability of Treatment Program</td><td colspan="3">Patient lives near treatment setting.</td><td colspan="2">Treatment program is too distant for patient to participate from home.</td></tr>
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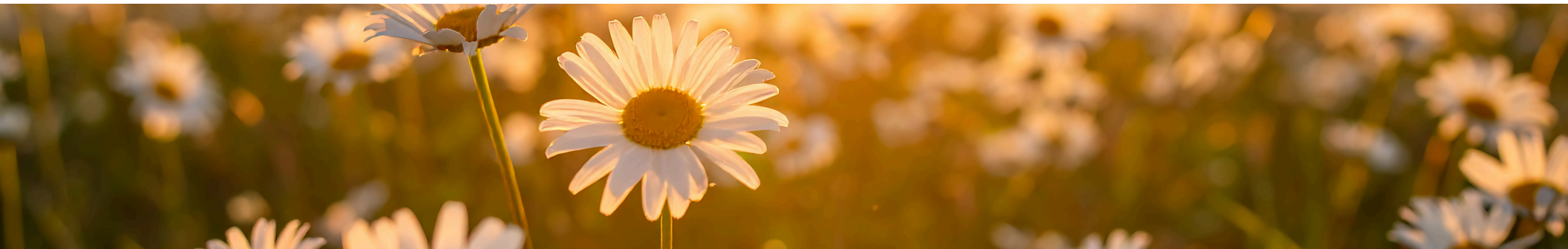

The Recovery Story **Framework**

We developed the Recovery Story as a way to provide a structured, level system to support clients throughout treatment. It offers families and providers a clear and consistent understanding about where their loved one or client is in their journey.

It's designed to hold the client accountable for their personal recovery goals and is used in all levels of care. Each chapter is an essential part of the whole story and provides a shared language for tracking progress, identifying challenges, and reinforcing the client's central role in their own healing.

Prologue

Clients will be oriented to our program, complete assessments, and set personal goals for their recovery.

Chapter One

Clients will identify the functions of their eating disorder and start to disconnect their identity from the disorder.

Chapter Two

Clients will utilize recovery behaviors and take a more active role, acting like the main character of their story.

Chapter Three

Clients will find a deep connection with and motivation for recovery. They choose healing over their disorder.

Epilogue

Clients demonstrate readiness and autonomy for next steps, whether transitioning levels of care or completing treatment.


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Have questions or need more info?
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Contact admissions at (866) 651 - 7129