EATING DISORDERS

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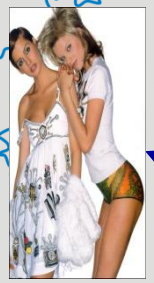
History of the Czech ED

AED CONFERENCE 2017

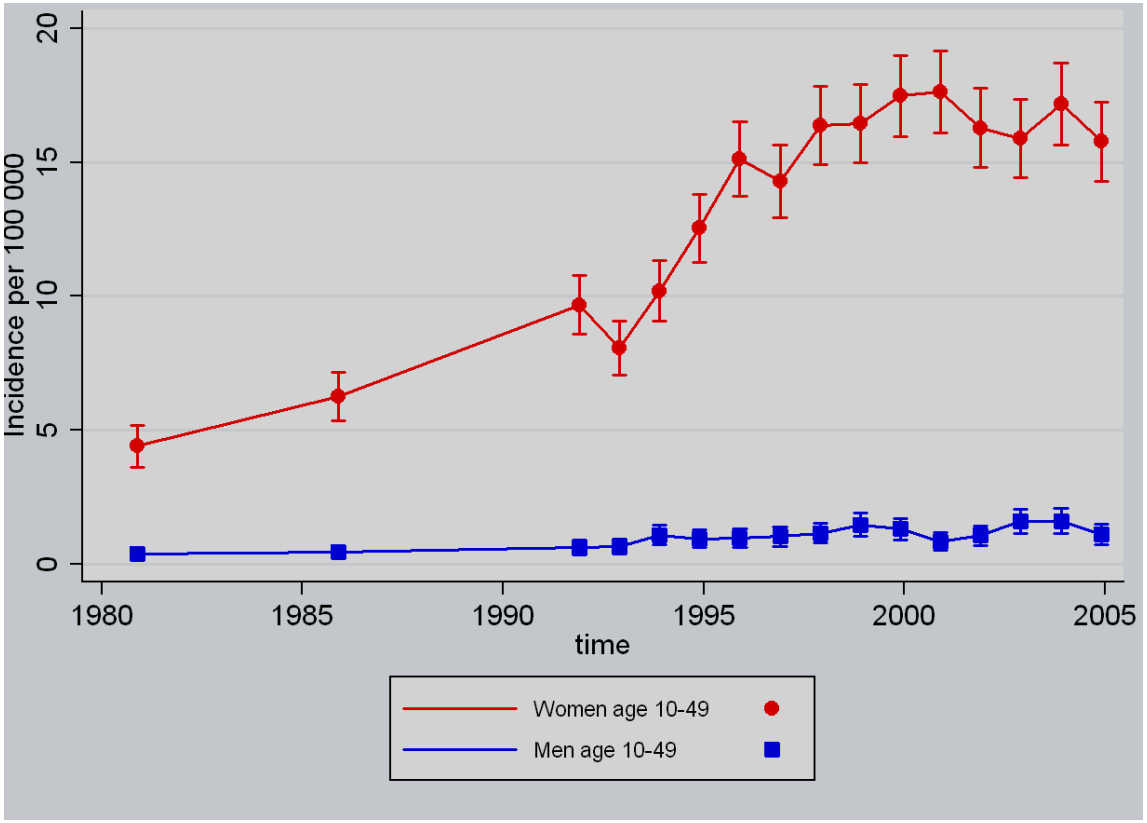
1989



1983

the Paleolithic period (35,000 B.C.E)

Hospitalization for ED/ 100 000 inhabitants (1981-2005) - Czech Republic



Pavlova et al. 2007

Epidemiology of Eating Disorders: Research and Practice

Anna Keski-Rahkonen

Professor of Mental Health

University of Helsinki, Finland

Young women	Young men
1 in 6	1 in 50

(Silén et al, in preparation)

Lifetime Prevalence of DSM-5 Eating Disorders in Finland, **People born in 1970s**

♀

Anorexia nervosa, 3.6%
Bulimia nervosa 2.3%
Binge eating disorder (BED) 0.7%
Other eating disorders 1.4%

♂

AN & BN
0.3-0.7%?
BED???

Lifetime Prevalence of DSM-5 Eating Disorders in Finland, **People born in 1980s**

♀

Anorexia nervosa, 6%

Bulimia nervosa 3%

Binge eating disorder (BED) 0.6%

♂

AN 0.3%

BN 0.2%

BED 0.3%

Other eating disorders: OSFED 1.4% , UFED 5%Other EDs: 1.8%

Eating Disorders Center Psychiatric Department Prague, CR

- Established in **1982-3** as the first in the Central and Eastern Europe .
  Hospitalization program 1-12 beds

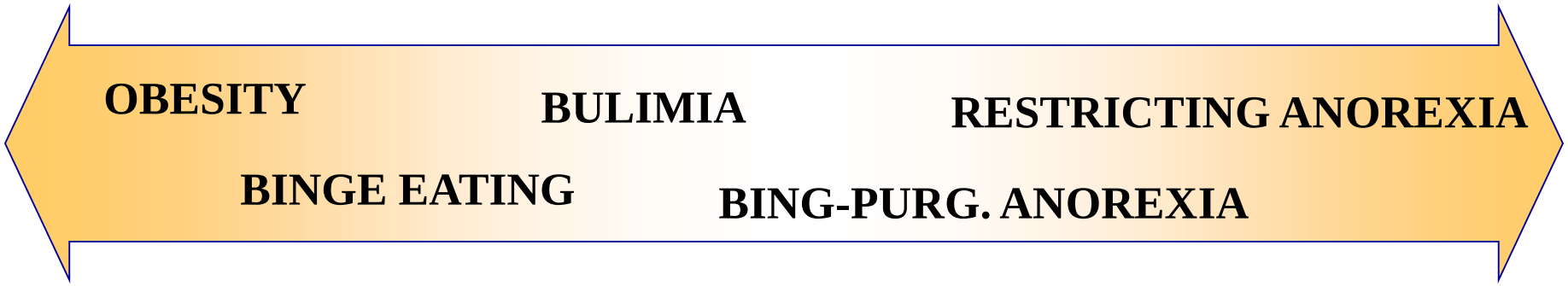
- Day care center **2002-3**
- Outpatient clinic, consultation and short motivational psychoeducation intervention,

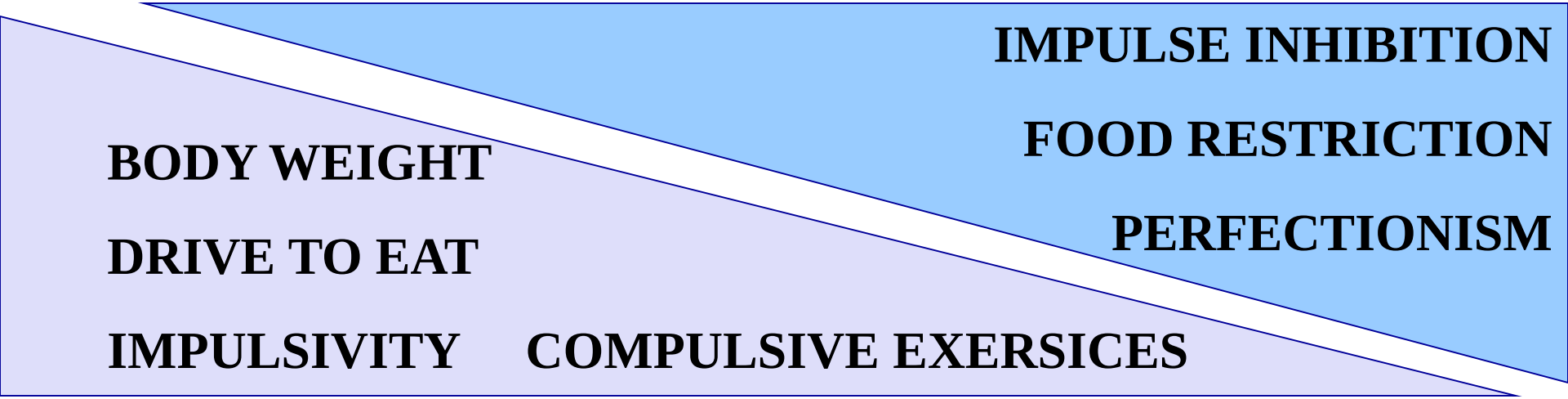
SAPPP

Svépomocná asociace psychogenních poruch příjmu potravy
sídlo: Ke Karlovu 11, 128 21 Praha 2, Psychiatrická klinika VFN

1992 – e-clinic

SPECTRUM OF EATING DISORDERS





Eating disorder spectrum – family history

Family history of leanness, diets

Family history of obesity

Mood Disorder - Family & Personal history - Substance Misuse

Parenting
Overinvolved - Critical/ignoring - Neglecting/Abusive

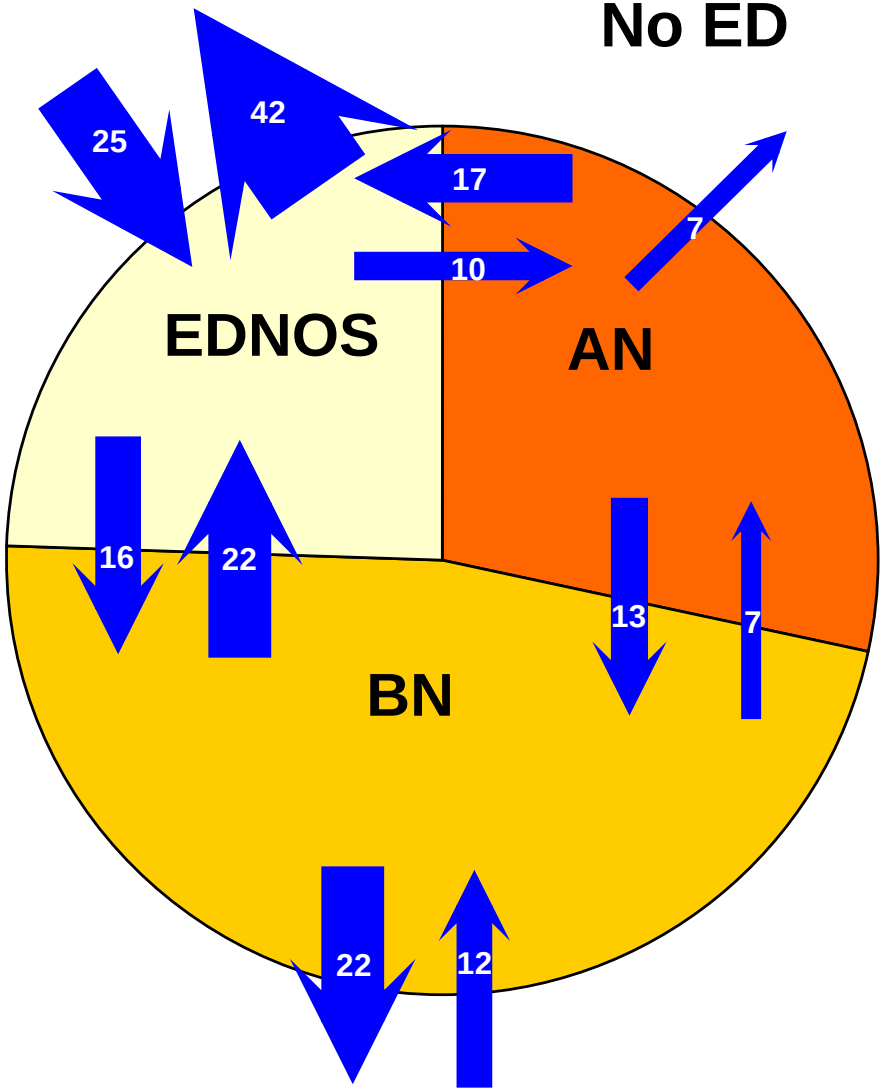
Restrictive AN

Binge-Purge AN

BN

Compulsivity

Impulsivity



Fairburn & Harrison 2003

Anorexia nervosa F50.0

a) Weight is maintained **at least 15% below** that expected (either lost or never achieved) , or Quetelet´s **body-mass index is 17,5 or less**. Prepubertal patients fail to make the expected weigh gain during the period of growth.

b) The **weight loss is self induced** by diets, avoidance of “fatting foods” and one or more following: self-induced vomiting, self induced purging, excessive exercise, use of appetite suppressant and/or diuretics.

Anorexia nervosa F50.0

c) There is **body image distorsion** in the form of a specific psychopathology with increasing emaciation the patient's feeling to be too large persists and she imposes herself a low weight threshold.

I'm so fat.

Anorexia nervosa F50.0

Endocrine disorder of **hypothalamic-pituitary-gonadal axis,** amenorhea in women men by lost of sexual interest and potency.

“masked” by hormonal replacement therapy

Elevated levels of growth hormone, cortisol, decrease thyroidal hormone and abnormalities in insulin secretion.

Prepubertal onset-delayed or stopped development on juvenile level (growth, breasts and the genitals).

Anorexia nervosa 307.1, DSM 5

- **Restricting type** –dieting, fasting,excessive exercise
- **Binge Eating/Purging Type** – self-induced vomiting, laxative diuretics and enemas
- At least weekly

Bulimia Nervosa F50.2

a) P**ersistent preoccupation with eating** and an **irresistible craving for food**, the patients have the **episodes of binge eating** during which a large amounts of food are consumed in a short period of time.

b) The patient attempts to **compensate** the **“fattening” effect of consumed food** by one or more following behaviour: self-induced vomiting, abuse of laxatives or diuretics, alternating periods of starvation, use of appetite suppressants, thyroid hormones or manipulation insulin(mainly in diabetic patients).

Bulimia Nervosa F50.2

- c) The psychopathology consists of
- **1.morbid dread of fatness** (the patient set herself or himself a sharply defined weight threshold below the premorbid weight that constitutes the optimum or healthy weight).
- 2.**frequent history of anorexia nervosa**, the earlier episode may have been fully or mildly expressed (mild form with moderate loss of weight and/or a transient phase of amenorhea).

Bulimia nervosa 307.51, DSM 5

Recurrent episodes of binge eating, characterized by:

Eating in a discrete period of time (2-hours)

definitely larger than most people would eat

Sense of lack of control

Recurrent inappropriate compensatory behavior to prevent weight gain

At least twice a week – once a week.

DSM 5 Binge Eating Disorder

Binge-Eating Disorder

Diagnostic Criteria **307.51 (F50.8)**

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
   2. 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).

B. The binge-eating episodes are associated with three (or more) of the following:
   1. Eating much more rapidly than normal.
   2. Eating until feeling uncomfortably full.
   3. Eating large amounts of food when not feeling physically hungry.
   4. Eating alone because of feeling embarrassed by how much one is eating.
   5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify if:

In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: 1–3 binge-eating episodes per week.

Moderate: 4–7 binge-eating episodes per week.

Severe: 8–13 binge-eating episodes per week.

Extreme: 14 or more binge-eating episodes per week.

Night Eating Syndrome - NES
Night Eating Syndrome - NEDS
Noctural Sleep - Related Eating Disorders (NSRED)

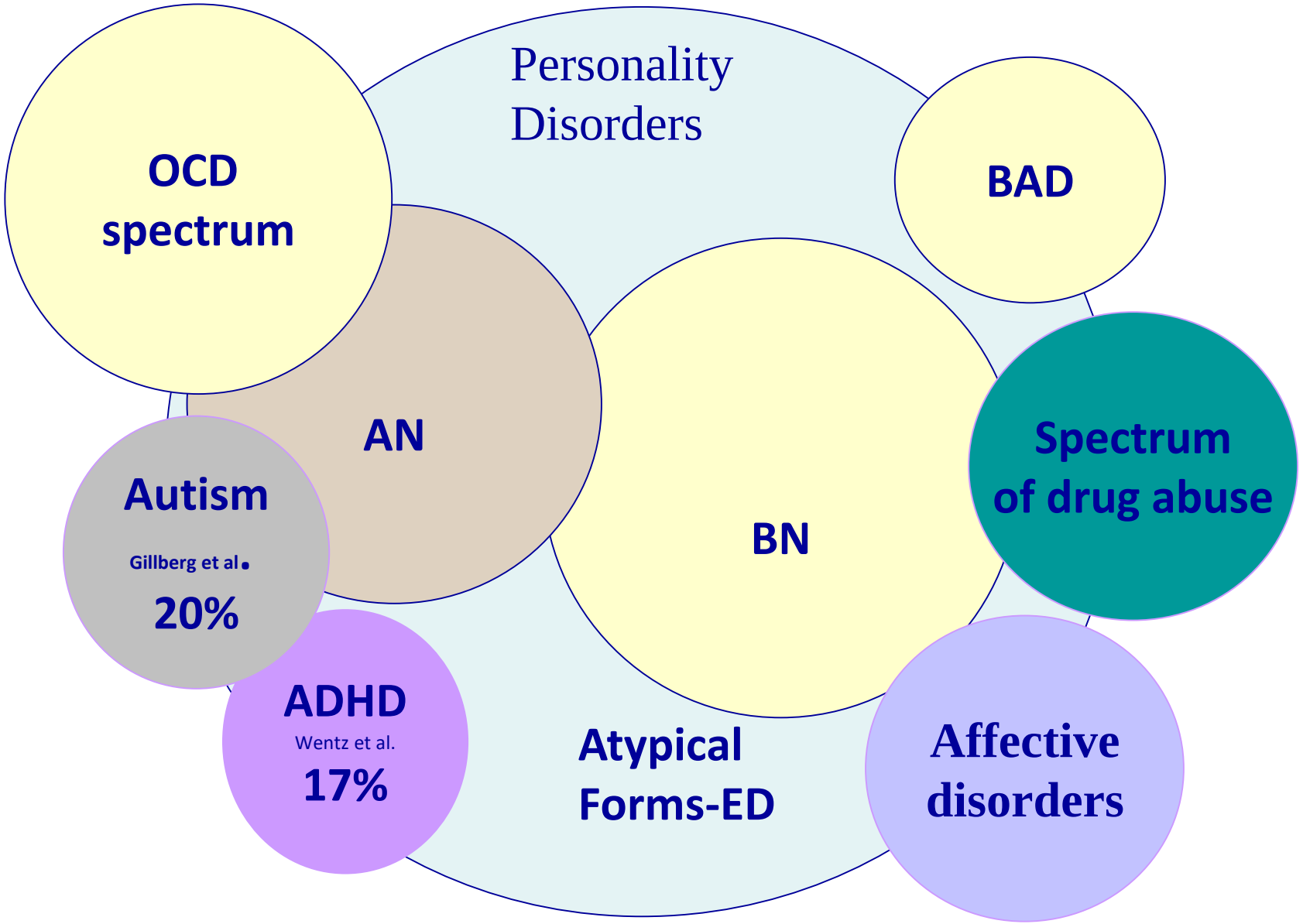
Described by Stunkard in 1955.
Overcoming Night Eating syndrom.
A Step by Step Guide to breaking the Cycle

Kelly C Allison Penn´s Night Eating Study

The Spectrum of Eating Disorders children and adolescent - DSM V

- ARFID Avoidant-restrictive food intake disorder
- Other Feeding and Eating Disorders (OSFED
  - Milder forms of anorexia, bulimia, BED
  - Purging disorder
  - Night eating syndrome
- Unspecified Feeding or Eating Disorder (UFED)

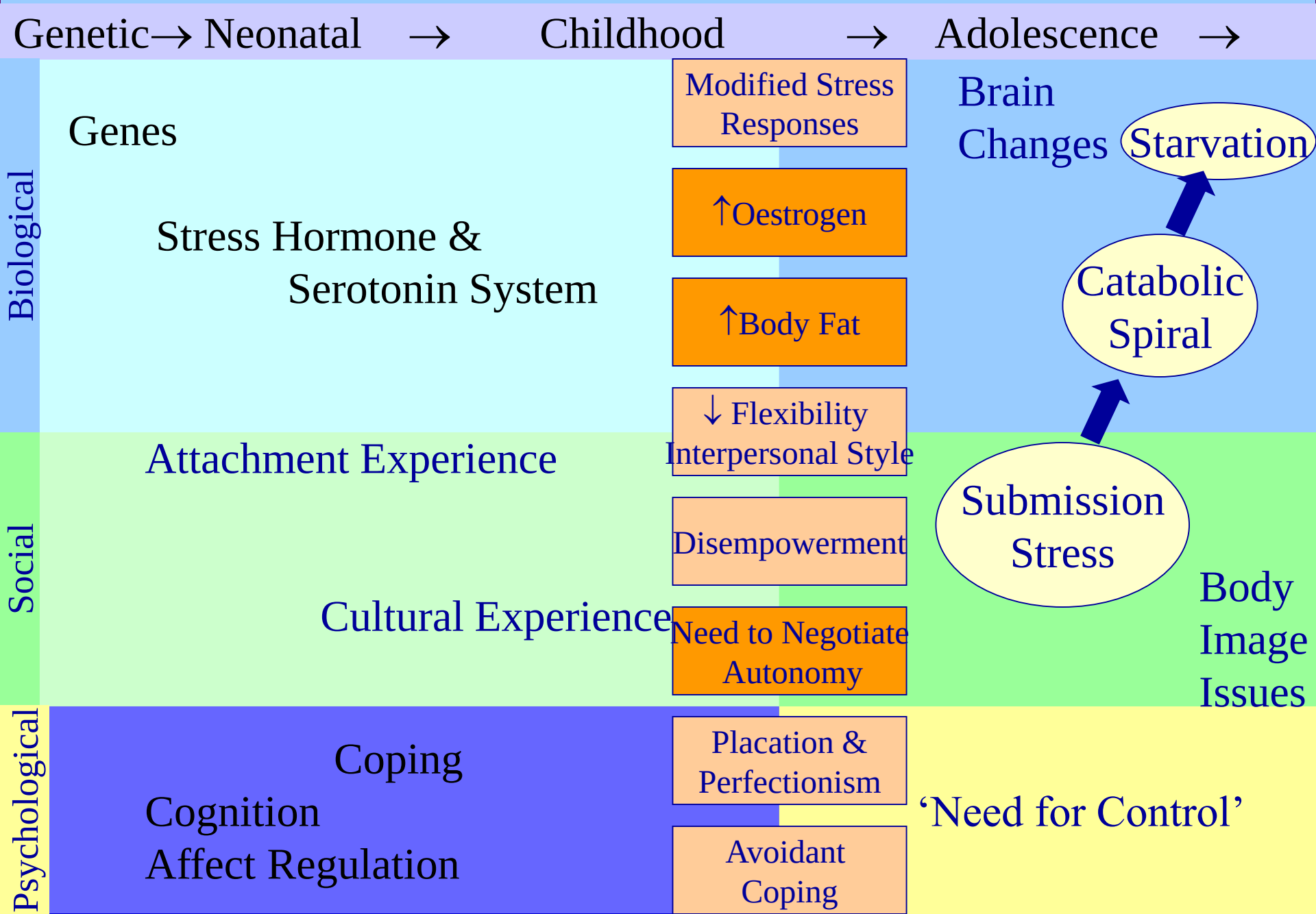
Comorbidity up to 65%



Risk Factors in Eating Disorders

- Environmental
  - media images
  - teasing from peers
- Family
  - maternal obesity and weight preoccupation
  - psychiatric disorders; substance abuse
- Behavioral
  - personality and psychological factors
  - developmental model

A Neurodevelopmental Model for Anorexia Nervosa



Biological risk factors

Genetic and epigenetic risk factors

- 58-88% of the risk for developing AN

  Bulik et al., 2000

- 5-HT2A promoter polymorphism

  Collier 1999

- Appetite homeostasis

  Hebebrand & Remschmidt, 1995

- OCPD temperamental traits

  Lilenfeld et al., 1998

Munn-Chernoff MA. Shared Genetic Risk between Eating Disorder and Substance-Use-Related Phenotypes: Evidence from Genome-Wide Association Studies Addiction Biology, 2020.

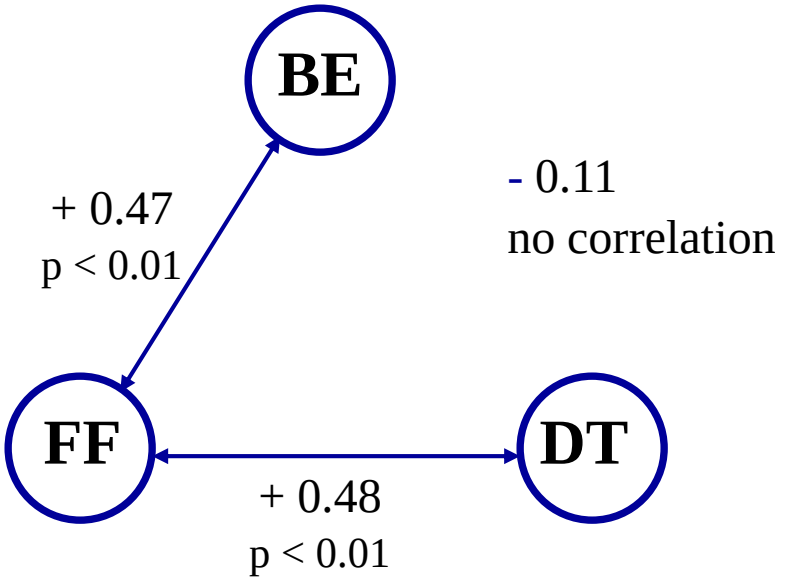
ED symptoms – 3 genetically stable factors

I BINGE EATING (BE)

II FEAR OF FATNESS/ COMPENSATORY BEHAVIOUR (FF)

III DRIVE FOR EXTREME THINNESS (DT)

	I	II	III
BN	+ +	+ +	
AN		+ +	+ +
BED	+ +	+	
EDNOS	+	+ +	+
OB	+	+	



Williamson et al, AJP, 2002

The activity-based anorexia model (ABA)

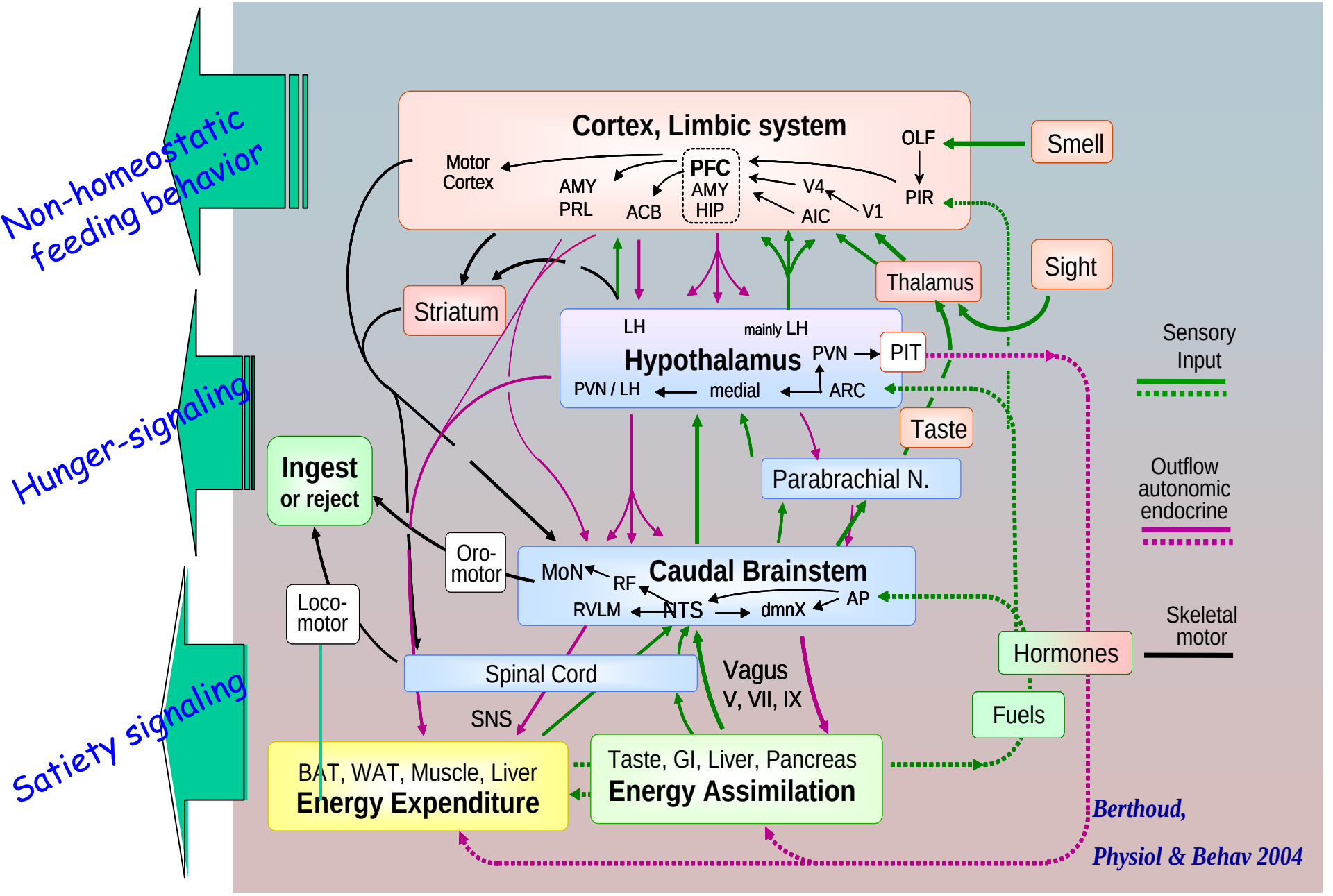
1 hr food access

+

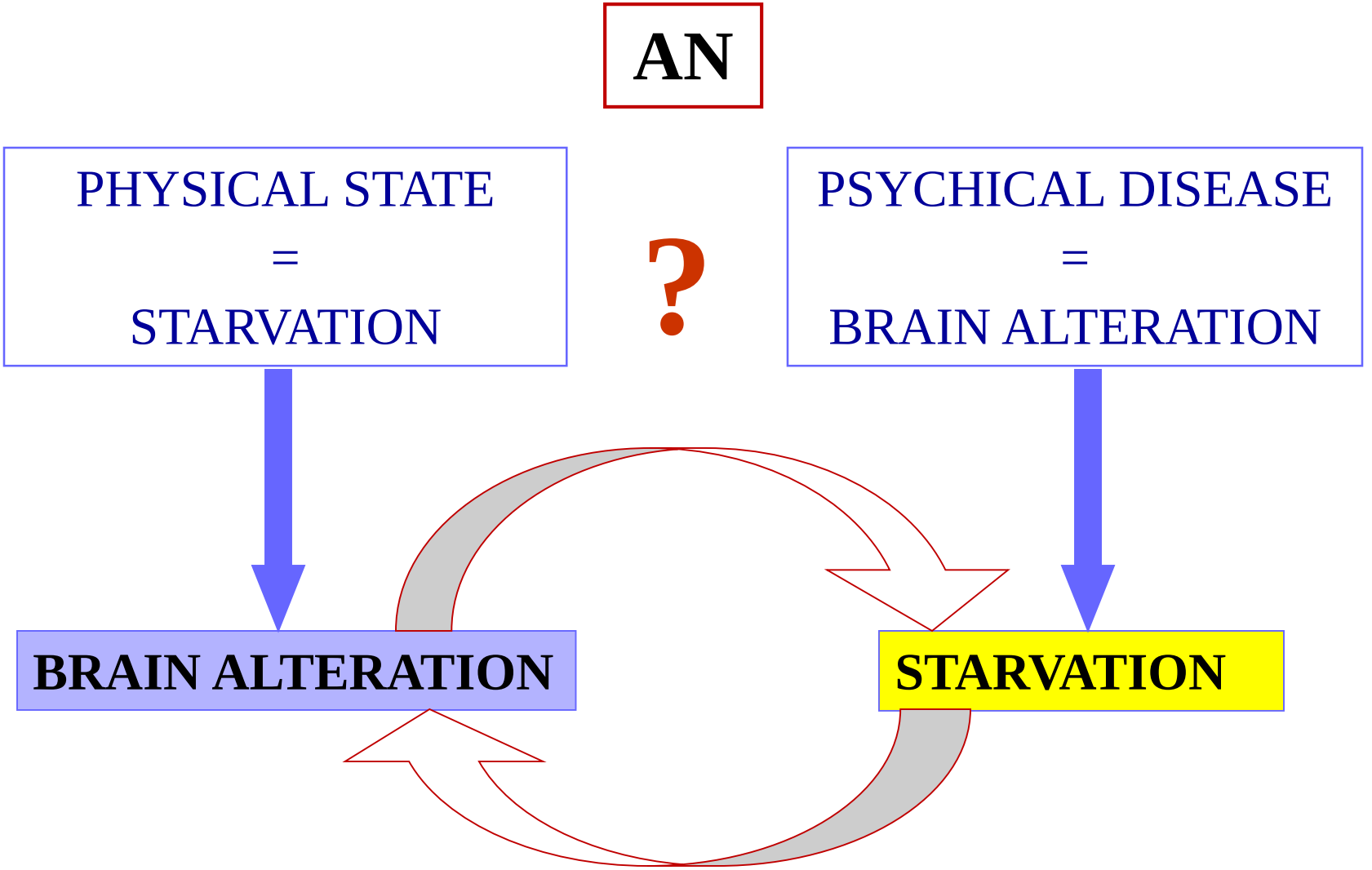
running wheel

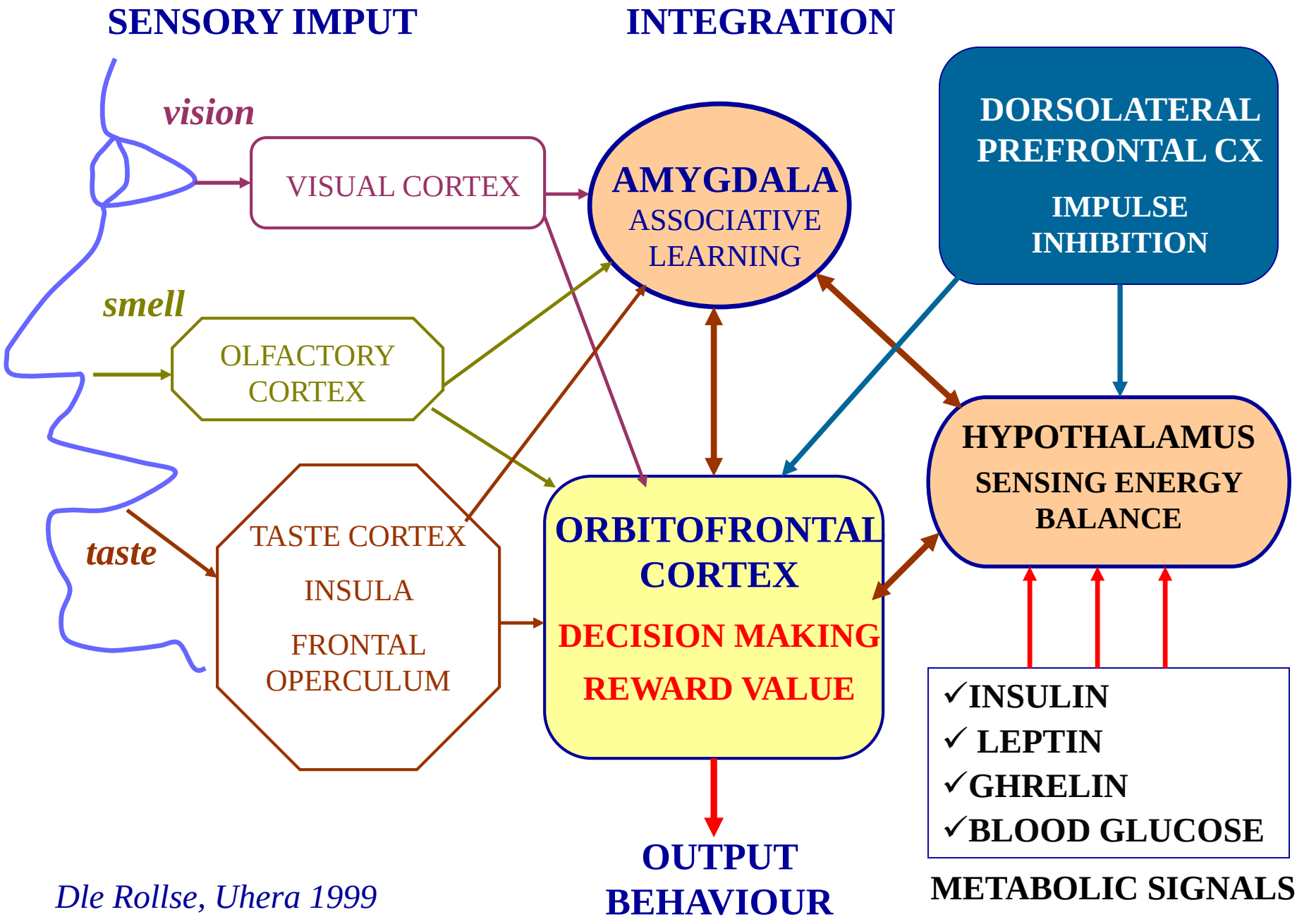
30-80% of AN patients are **hyperactive -** compulsive excessive exercises frequently hidden

Hebebrand et al, 2003

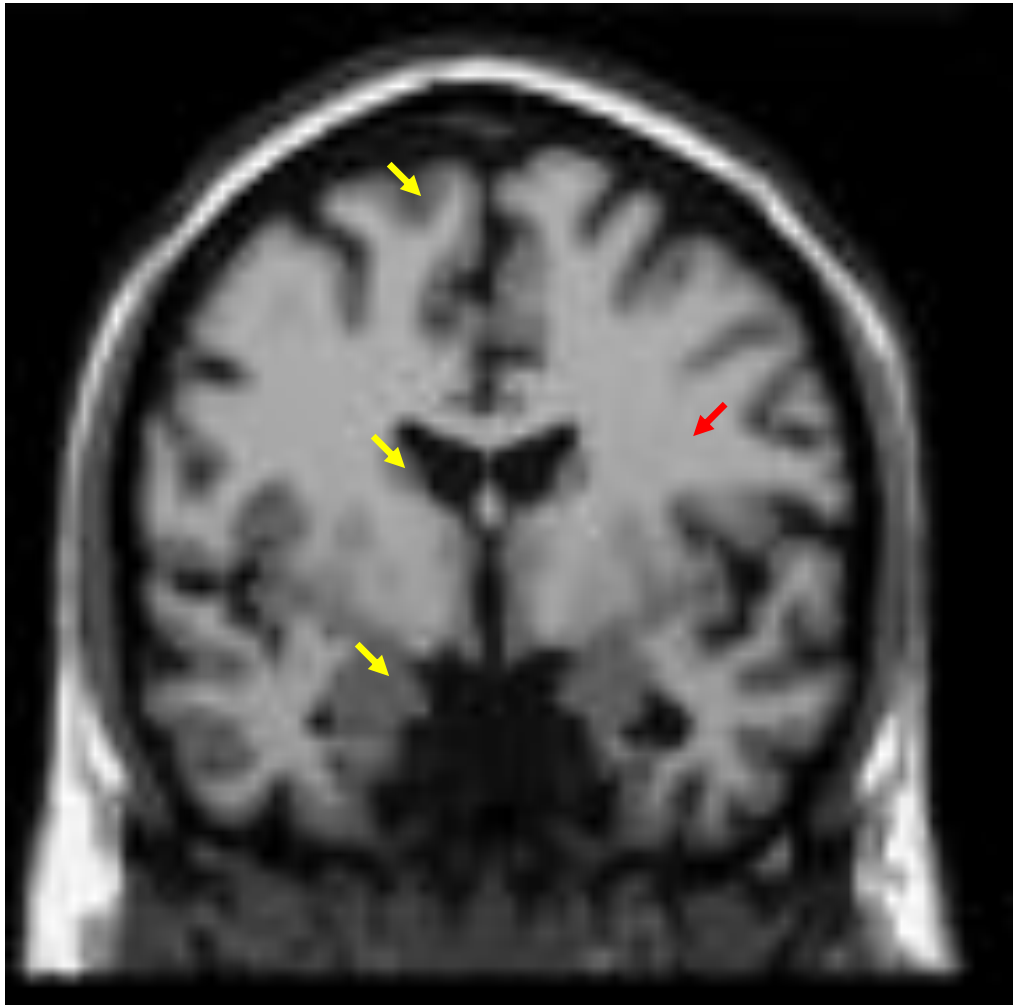

Non-homeostatic feeding behavior
Hunger-signaling
Satiety signaling
Cortex, Limbic system
Motor Cortex
AMY
PRL
ACB
PFC
AMY
HIP
V4
AIC
V1
OLF
PIR
Smell
Sight
Thalamus
Striatum
LH
mainly LH
Hypothalamus
PVN
PIT
PVN / LH
medial
ARC
Taste
Parabrachial N.
Ingest
or reject
Oro-
motor
Loco-
motor
MoN
RF
Caudal Brainstem
RVLM
NTS
dmnX
AP
Spinal Cord
Vagus
V, VII, IX
SNS
Hormones
Fuels
BAT, WAT, Muscle, Liver
Energy Expenditure
Taste, GI, Liver, Pancreas
Energy Assimilation
Sensory Input
Outflow autonomic endocrine
Skeletal motor
Berthoud,
Physiol & Behav 2004

Starvation & the Brain




SENSORY IMPUT
INTEGRATION
vision
VISUAL CORTEX
AMYGDALA
ASSOCIATIVE LEARNING
DORSOLATERAL PREFRONTAL CX
IMPULSE INHIBITION
smell
OLFACTORY CORTEX
HYPOTHALAMUS
SENSING ENERGY BALANCE
taste
TASTE CORTEX
INSULA
FRONTAL OPERCULUM
ORBITOFRONTAL CORTEX
DECISION MAKING
REWARD VALUE
✓INSULIN
✓ LEPTIN
✓GHRELIN
✓BLOOD GLUCOSE
OUTPUT BEHAVIOUR
METABOLIC SIGNALS
Dle Rollse, Uhera 1999

Brain atrophy



WHITE MATTER
(myelinated axons, lipids)

- decreased in acute AN
- normal after recovery

GREY MATTER
(neural cell bodies)

- decreased in acute AN
- decreased after recovery !!

Katzman 1996, 1997, 2001; Lambe 1997

Attachment: Biological Plasticity

- **HPA axis development modified by prenatal stress and postnatal maternal behaviour**
- **Adversity associated with poorly regulated & hyperactive stress responses in adult life.**
- **Mediated by 5HT system**

Francis & Meaney, 1999; Plotsky and Meaney, 1983; Smythe et al., 1994

Attachment Experience and Obstetric complications

- **Preconception:**
  - **4 x ↑Obstetric complications & Unresolved Loss**

Shoebridge et al.,2000, Andrews et al., 1999

- **Perinatal:**
  - **3 x ↑Obstetric complications**
  - **High parental trait anxiety & overprotection**

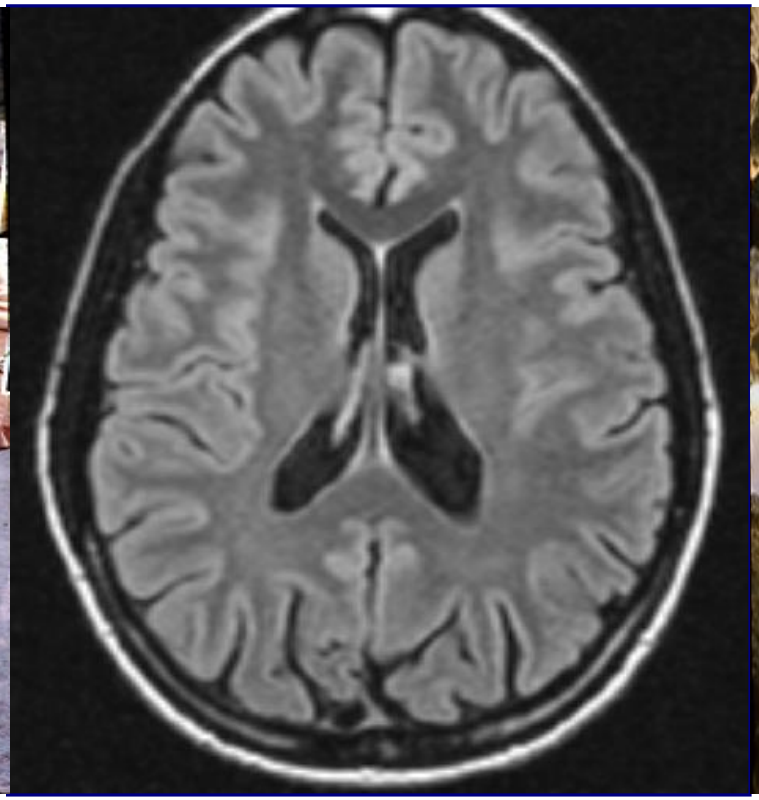
Shoebridge et al., 1999; Cnattingius et al., 1999

- **Insecure Attachment**
  - **Dismissive**

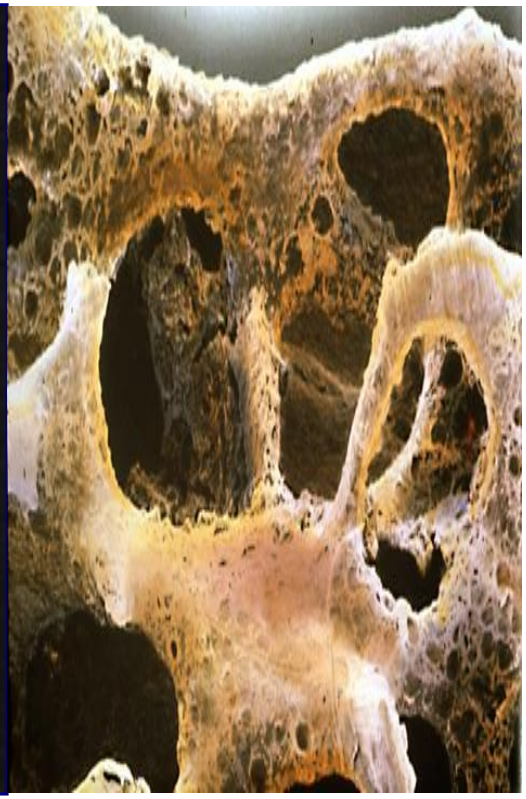
Ward et al., 2000

HOW TO „TRANSLATE“ TO PSYCHOEDUCATION

Genetics



Brain Atrophy



Osteoporosis

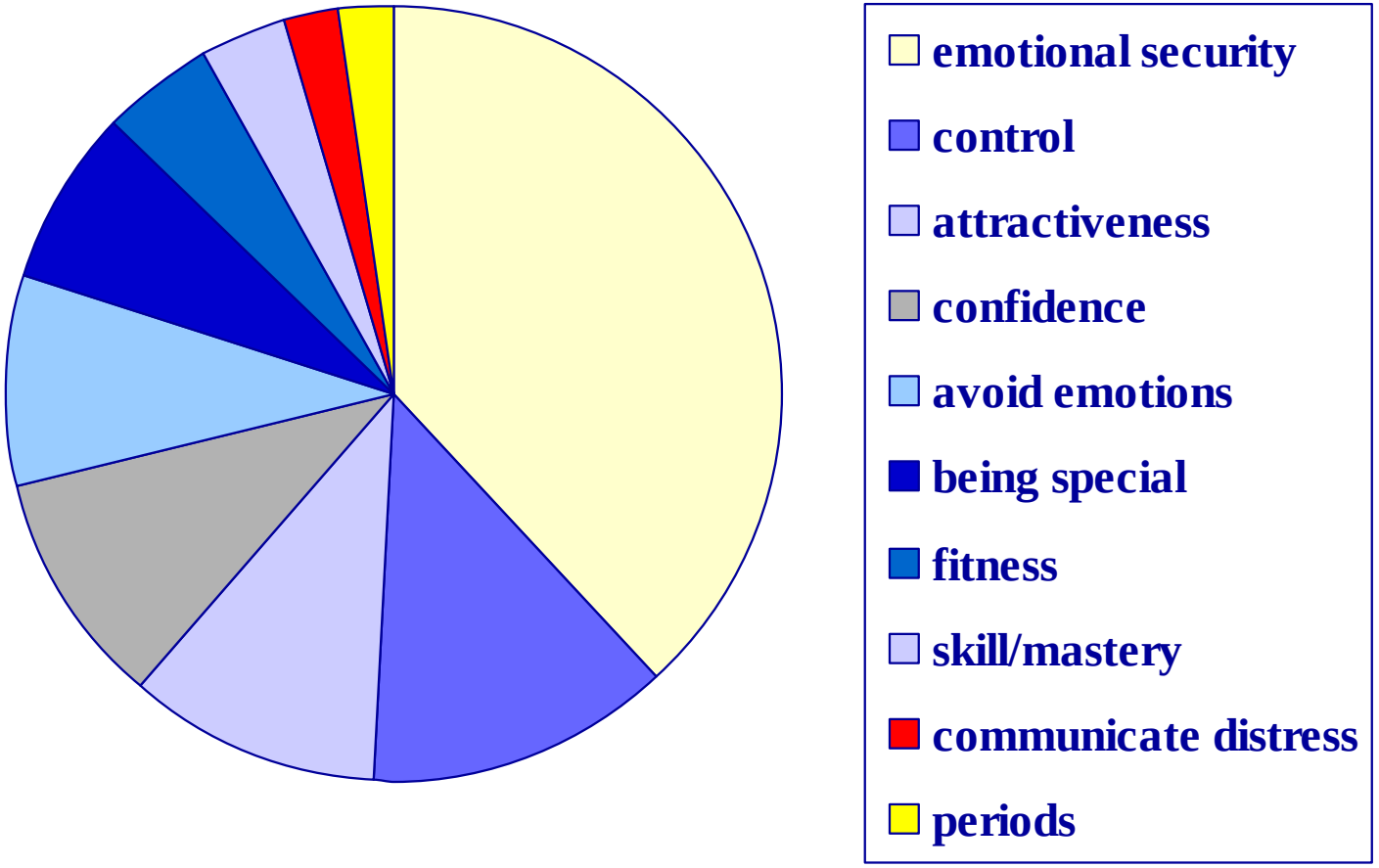
Psychological risk factors

Adolescent Transitions

- ↑ Oestrogen
  - HPA axis
  - brain development
- ↑ Fat mass
  - vulnerability in systems regulating appetite & weight
- Childhood submission → adult autonomy
- Cultural Transition Experience

Leung and Katzman , 1996

Perceived advantages of self-starvation: The sufferers' view



Serpell et al., 1998

Social risk factors

Risk professions, sports, social and printed media – beauty, fitness, contests, instagram

Course and Outcome

- 50% - 70% recovers
- 40% partial recovery/chronically ill
- 10% dies

Mortality in Anorexia nervosa

Crude Mortality Rates: 0-20% (depending on length of FU)
Meta-analysis of 42 outcome studies *Sullivan, 1995*

- Annual mortality rate 0.56 %;
- **12 x higher than in general population**

Review of 10 outcome studies reporting SMR
Nielsen et al., 1998

- SMR after 6 -12 years follow-up period = 9; (95% CI 7.5 to 11.5)
- Highest risk of death within the first year after presentation
- Lower weight at presentation → higher risk.

Risk of death from eating disorders: **3 times higher**
than in depression, schizophrenia or alcoholism

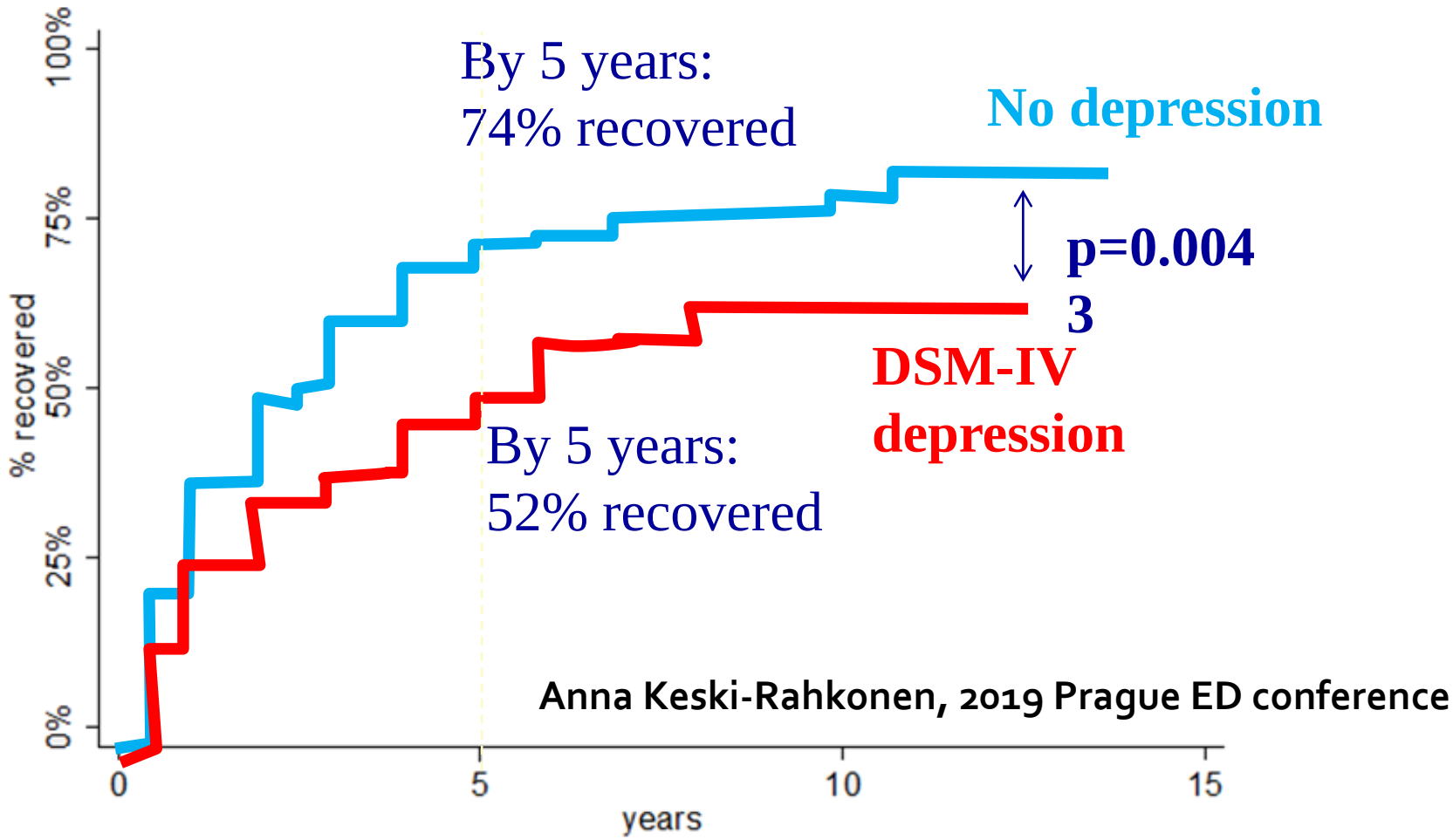
Harris & Barraclough, 1998

Causes of death in AN?

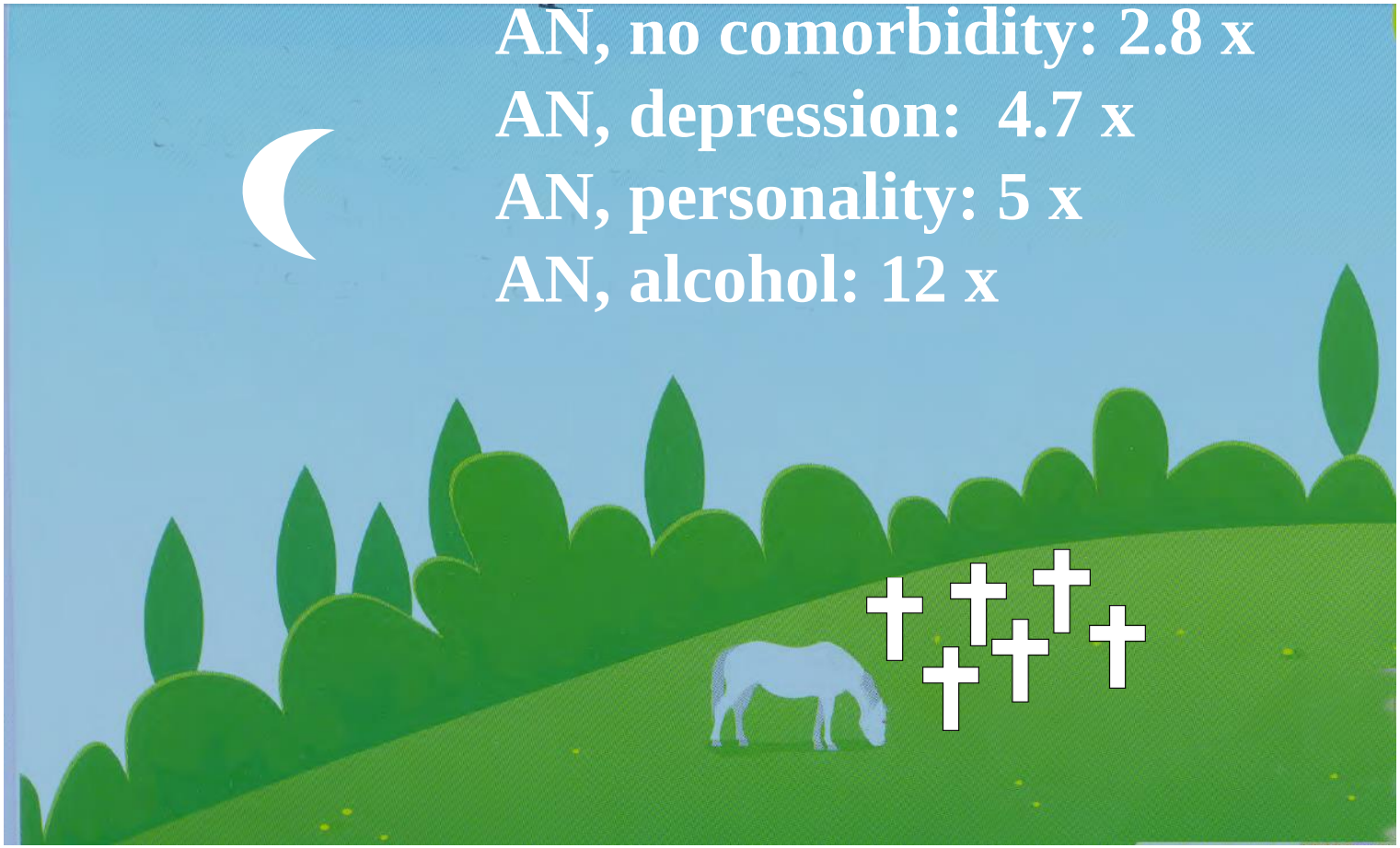
- Suicide: 20 to 40 %
- Eating disorder complications (infections, arrhythmia): 33 to 54%
- Unknown or other causes: 19 to 28%

Sullivan, 1995; Nielsen et al., 1998

Finnish women with Anorexia. Prediction based on comorbidity?



Risk of Death from Anorexia Nervosa



Kask et al 2016, PMID 27136502, Anna Keski-Rahkonen, 2019 Prague ED conference

Long-term care, SEAN and comorbidity

- **CHRONIC SEVERE EATING DISORDERS**: >50% of patients with AN need long-term multi-disciplinary care under enhanced **programs** and long-term involvement from specialist services and psychosocial services, forensic decision in involuntary treatment
- **DUAL DIAGNOSIS**: Many cases of AN& BN have significant co-morbid disorder
- OCD, anxiety disorders, PTSD, alcohol & substance misuse, personality disorder
- Diabetes, multiple alergies and intolerances to food

COST B6 ACTION
(ED multicentric study on treatment efficacy - 1993-2001)

country	% positive outcome AN	% positive outcome BN
CZ	31,5	32,2
D	20,6	32,2
F	25,7	-
GB	17,7	23,3
NL	49,5	56,2
PL	16,6	23,5
Spain	29,9	40,4

Cost - „Adequate therapy“

- As usual **$36 200 Adequate - $119 200**
- 1year survival **$30 180**
- Calculation /mortality, age, treatment response and mean duration of life/

Drake, R.E., Goldman, H.H., Leff, H.S., Lehman, A.F., Dixon, L., Mueser, K.T.,Torrey, W.C.: *Implementing evidence-based practices in routine mental health service settings. Psychiatr Serv, 52, 2001, pp. 179-82.*

Crow & Nyman 2004

	As usual	Adequate therapy Cost/ day US $
Hospitalization	7 days	45 days - $2000
Parcial hospitalization	15 days	20 days – $800
Psychotherapy (50min)	25 sessions	50 sessions $120
Medication	20 sessions	20 sessions $90
Fluoxetin (60mg)	2 roky	2 roky – $41

History of guidelines

1999: **iatr** **H: ED**
Standar

2002: **C** **car**

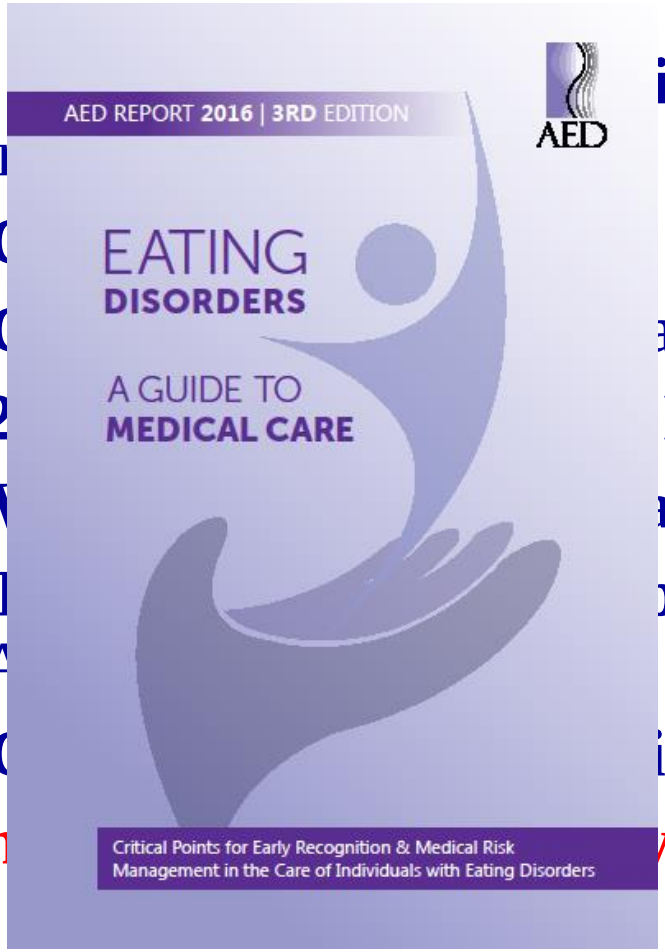
2004: **C** **acot**

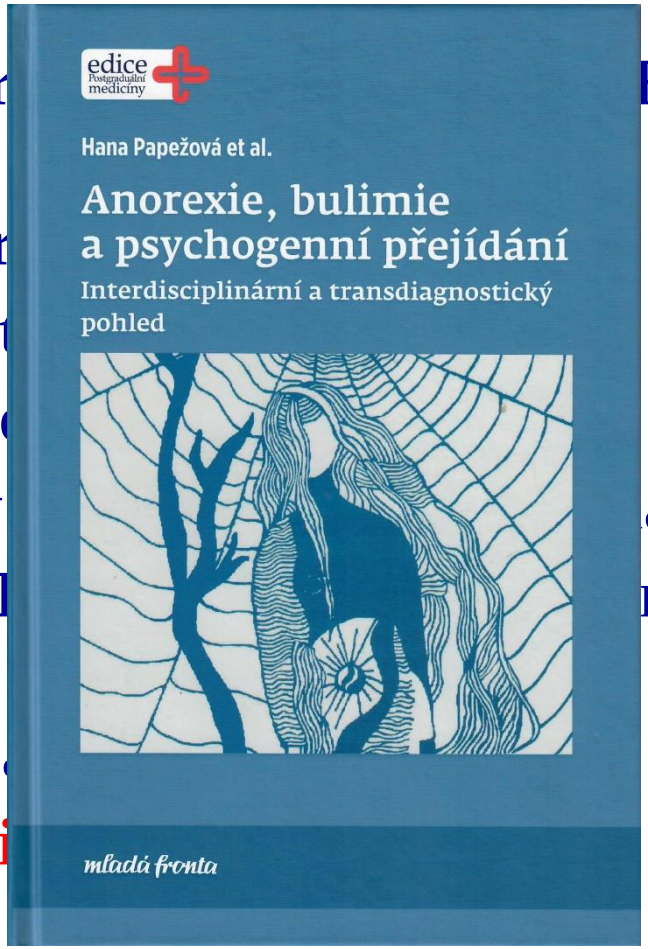
2006, 2 Inf

2011: **V** **apy** atry

2012: **I** **oy I** rs et al.
Child A

2018: **C** **ic c**
h **ychi**

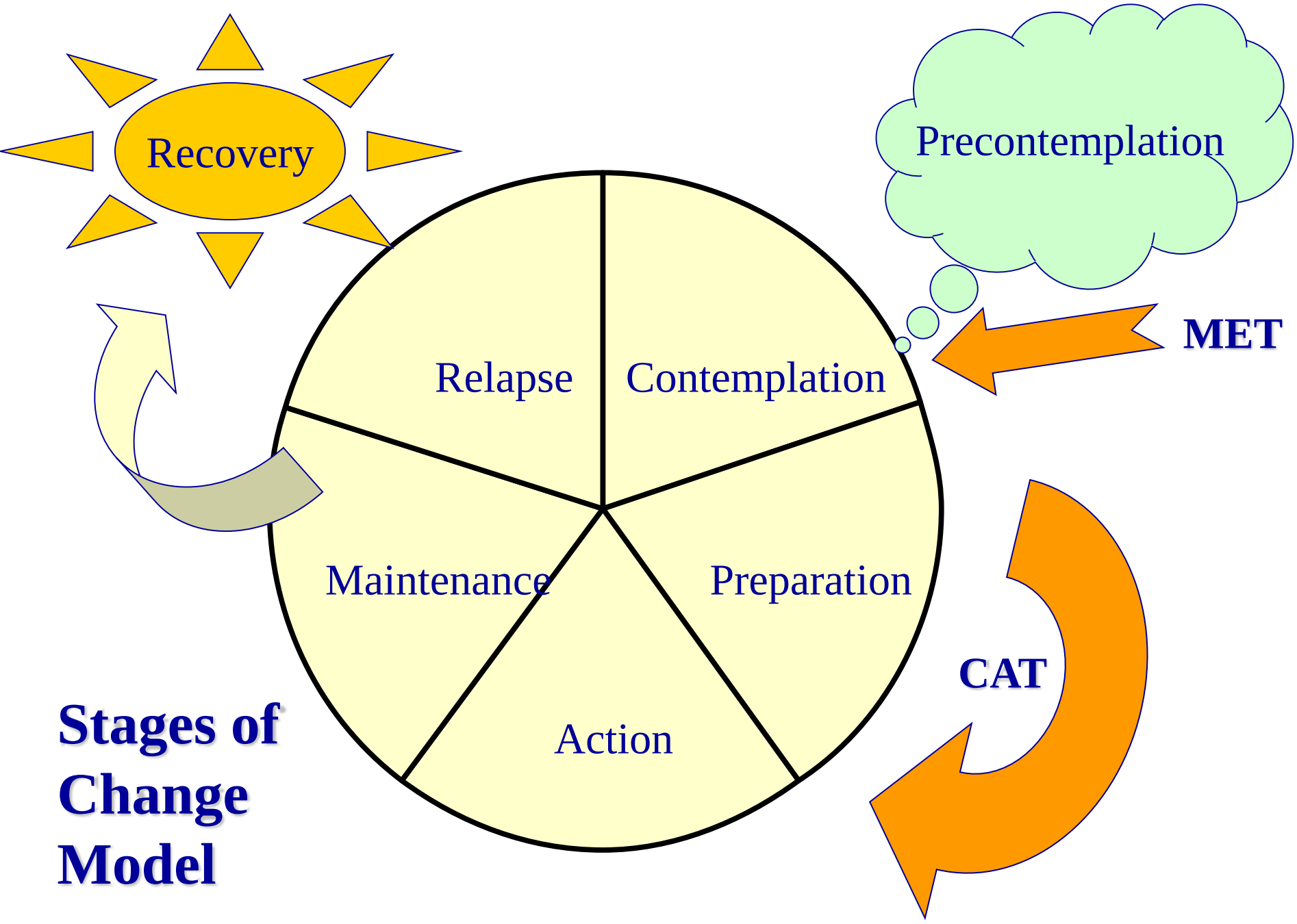




Therapeutic program

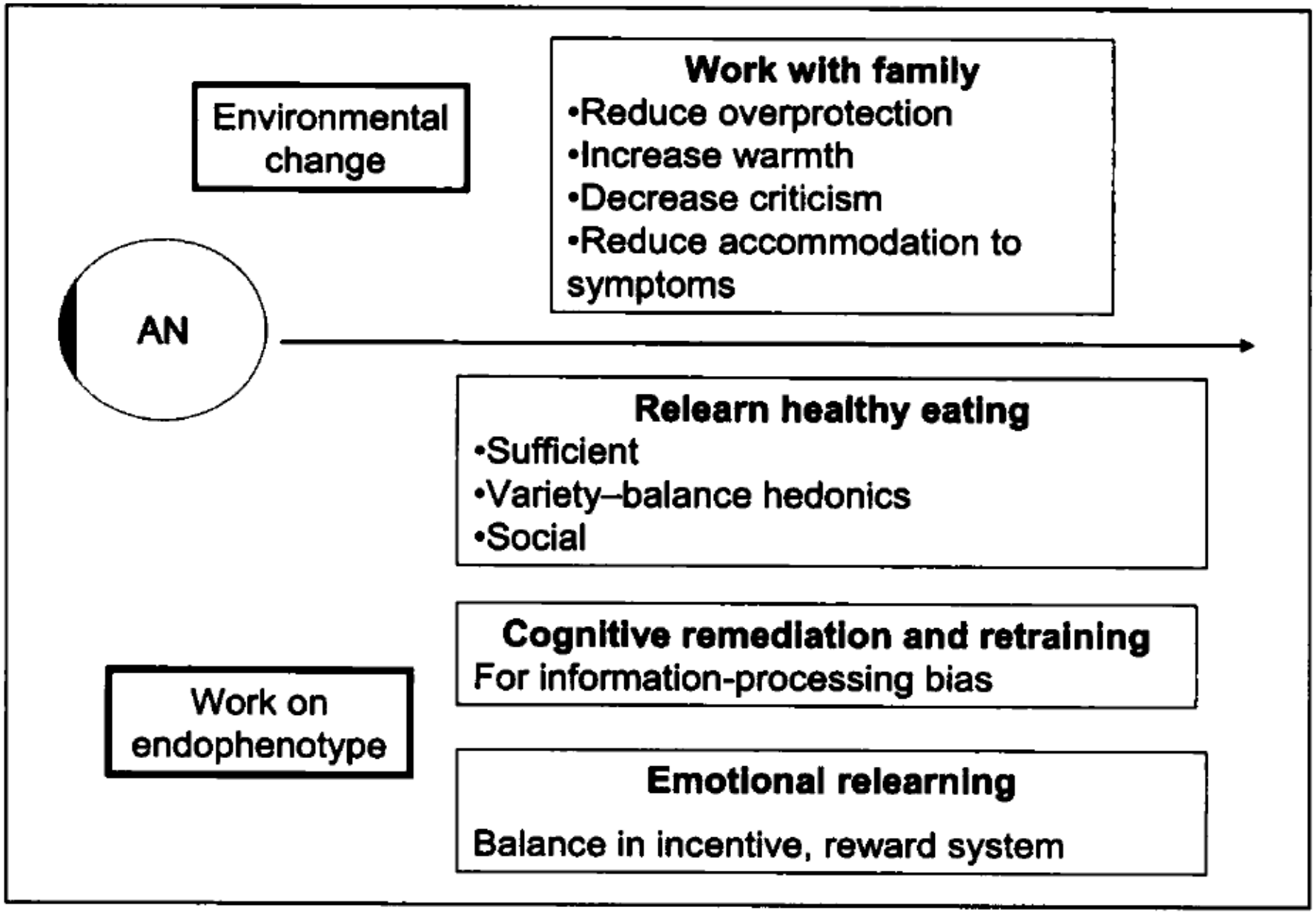
Program and therapy

- Use research-evidenced methods of screening & detection (including risk factors)
- Change the focus of intervention **from *weight* to *identity*.**
- Incorporate ethnic philosophies & beliefs into commonly used cognitive and control strategies



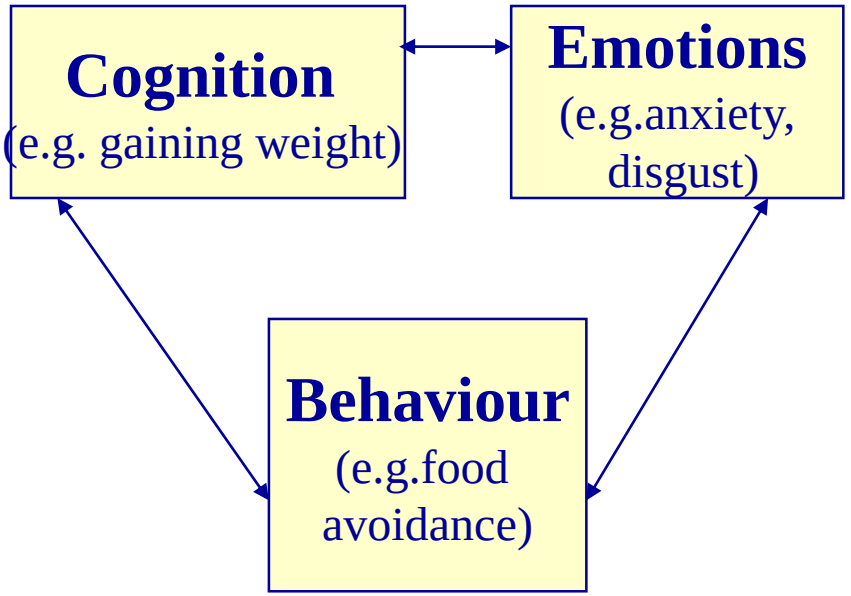
Stages of Change Model

Figure 2 Translating the endophenotype and maintaining factors into treatment



CBT for the eating disorders

- Making links between behaviour, cognitions and affect
  - modifying these in parallel

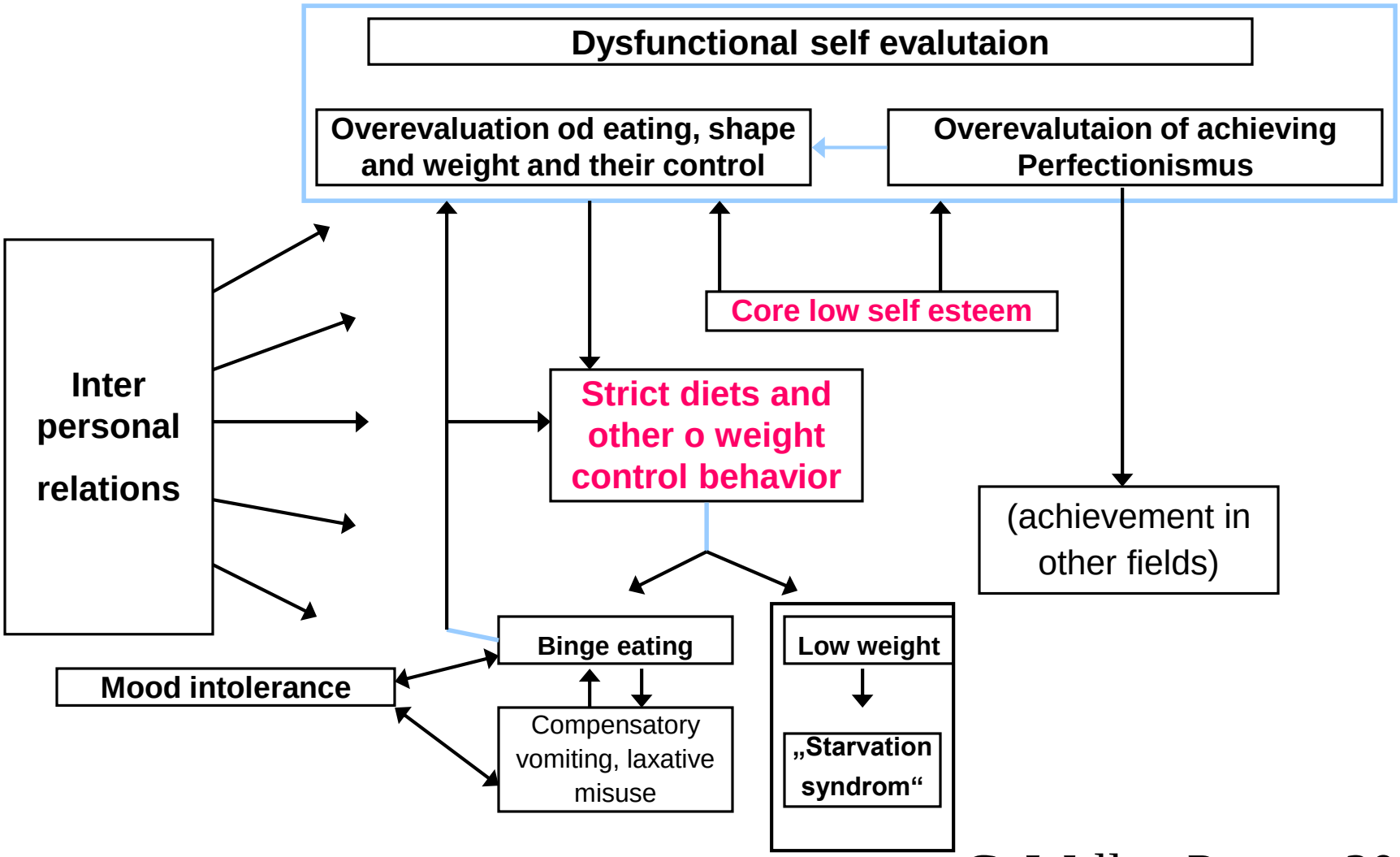


G. Waller, Prague 2005

Maintenance CBT model bulimia nervosa

- Central roles for:
  - poor self-esteem
  - rules and dichotomous thinking
  - beliefs about the importance of dieting and purging to keep weight low
- More of a role for affect in BED

Transdiagnostic cognitive-behavioral model of Eating Disorders



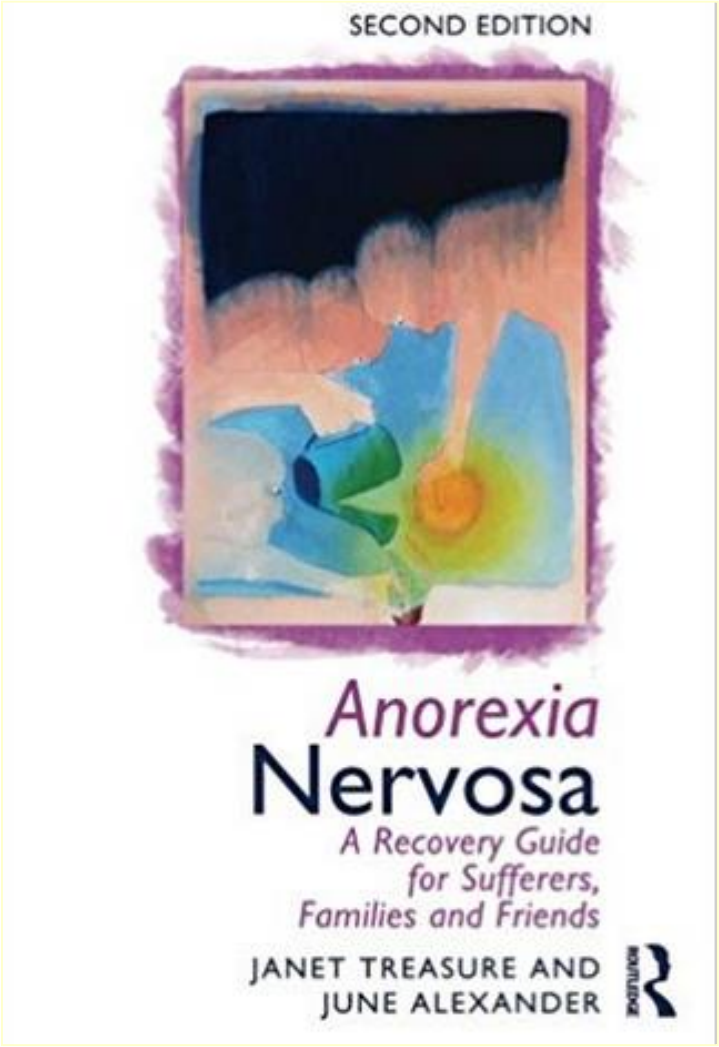
G. Waller, Prague 2005

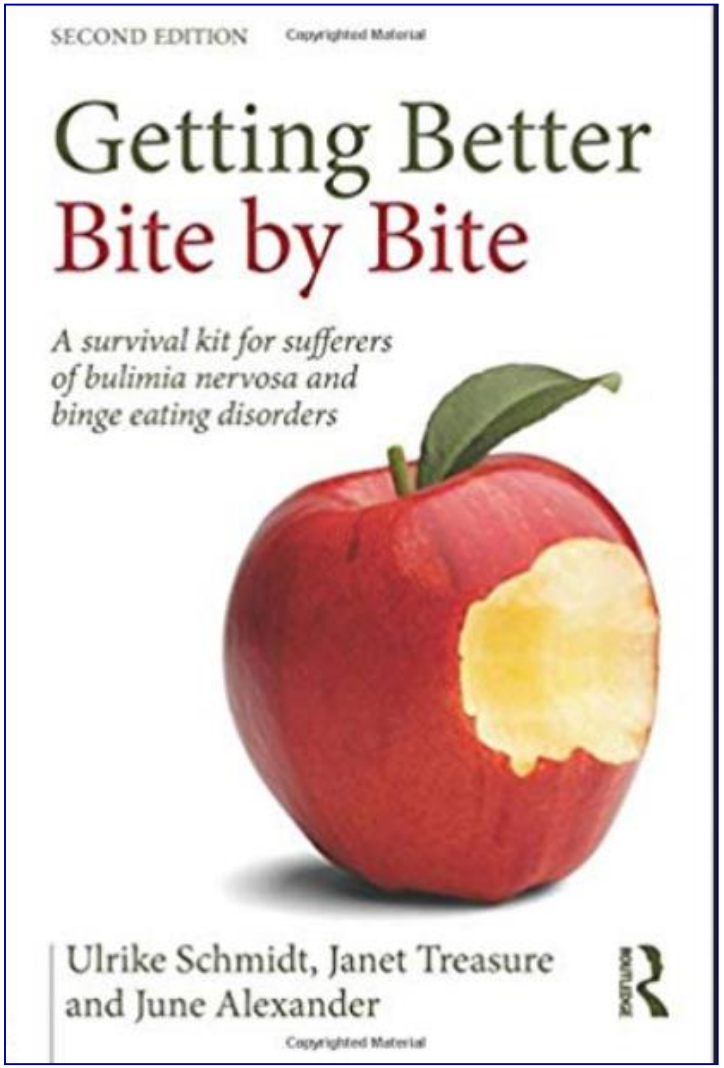
Cognitive Analytic Therapy

- Brief integrated focused therapy for NHS use - 16-24 sessions
- Draws from cognitive behavioural models and object relations theory
- Process of reformulation, recognition & revision
- Integration of tools from diverse areas to facilitate change

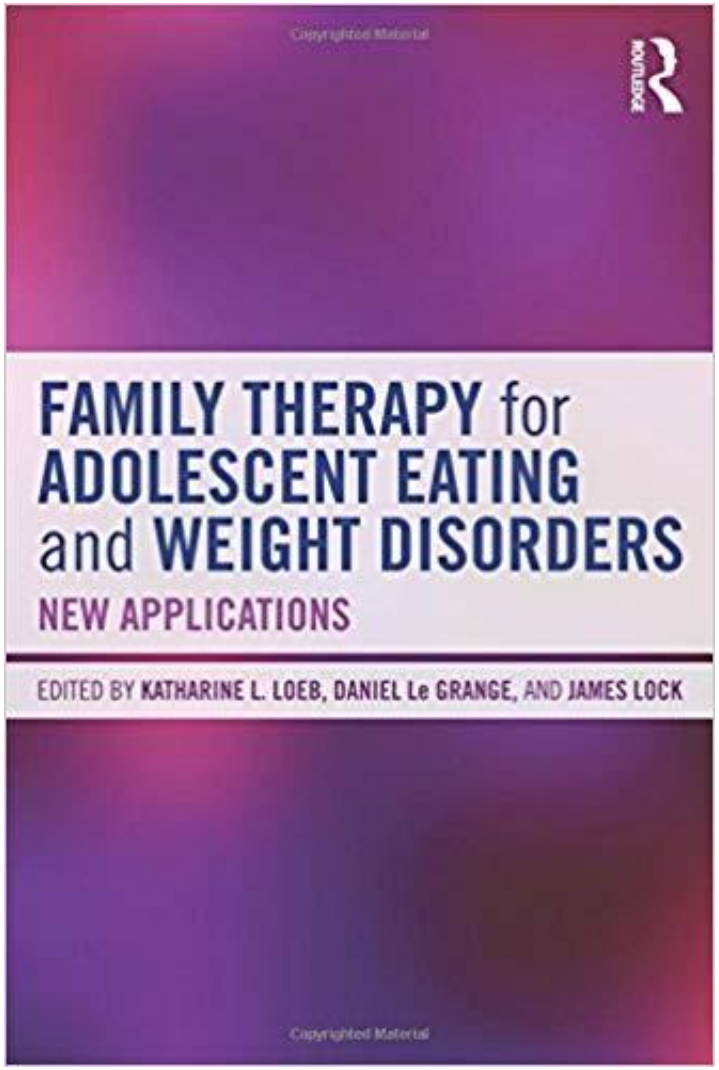
Frances Connan, 2003

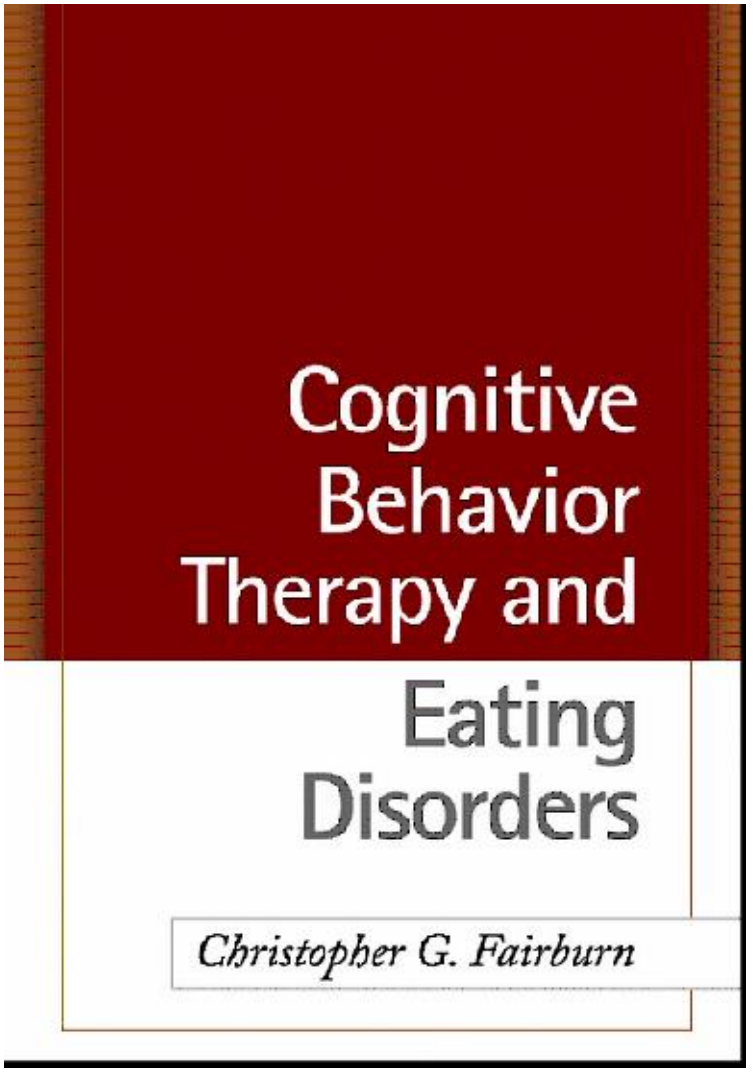
Cookbooks for Beginner Cooks





Cookbooks for Advanced Cooks





Compassion focused therapy for ED

- Today's talk – compassion focused therapy (CFT)
- The context for compassion and why we all need it in our lives
- What is compassion?
- What is self-compassion?
- The role of self-criticism and shame in the onset and maintenance of eating disorders?
- Practical exercises in Compassion Focused Therapy (CFT) for eating disorders.

Compassion websites

- www.self-compassion.org
- www.compassioninstitute.com
- www.compassionateliving.info

Gerard J. Butcher, Adjunct Assistant Professor, Dept. of Psychiatry, Trinity College Dublin, Ireland (Airija; Irlandiya) gerard@cognitivesolutions.ie EEEDN - Kaunas 2018

Predictors of Eating Disorder Treatment Outcome

Favorable prognosis:

- Fewer symptoms
- Shorter duration
- Higher BMI
- Low comorbidity
- High self esteem
- Interpersonal skills
- Greater motivation

At risk of dropping out:

- Weight suppression
- Bingeing and purging
- Depressive symptoms
- Impulsivity
- Comorbidity
- Low motivation

REVIEW

PMID: 26171853

Predictors of Treatment Outcome in Individuals with Eating Disorders: A Systematic Review and Meta-Analysis

EvaVall, BA (Hons)*
Tracey D. Wade, PhD

ABSTRACT
Objective: Understanding the factors that predict a favourable outcome following specialist treatment for an eating disorder may assist in improving treatment efficacy, and in developing novel inter-

lower depression, lower shape/weight concern, fewer comorbidities, better interpersonal functioning and fewer familial problems. Drop-out was predicted by more binge/purge behaviors and lower motivation to recover. For most predic-

Mentalisation Based Therapy-ED

- Always the dual track
- Challenges for the Therapist mentalisation
- Either-or, body OR mind
- Fear of threat of somatic crisis
- Feeling rejected
- Feeling unsucessfull

Prevention

Prevention goals

- Increase knowledge
- Promote acceptance
- Diversity & puberty
- Nature of eating d/o
- Discourage dieting
- Reduce teasing
- Media literacy

- **Self acceptance**
- **Increase self esteem**
- **Coping strategies**
- **Reduce body dissatisfaction**
- **Healthy eating**
- **Limit internalization**

Roll over sections of the food pyramid, or click on the nutrients

VEGETABLE GROUP: 3-4 SERVINGS

1 SERVING =
1 CUP LEAFY VEGGIES =
1/2 CUP OTHER VEGGIES

Buffet Feedback

NUTRIENT	YOUR INTAKE	MINIMUM DAILY
Food Energy (kcals)	887	**2200**
Protein (gm)	35	**50-70**
		75-100 for athletes
Carbohydrate (gm)	106	**275-300**
Dietary Fiber (gm)	6	**25**
Total fat (gm)	29	**50-70**
Vitamin C (mg)	98	**65**
Folate (mcg)	202	**380**
Calcium (mg)	355	**1200**
Iron (mg)	5	**15**

These are averages for women between the ages of 18-24. Each individual varies greatly depending on gender, body size, and lifestyle (i.e., amounts will be higher for those who are underweight and/or leading an active lifestyle, such as athletes.)

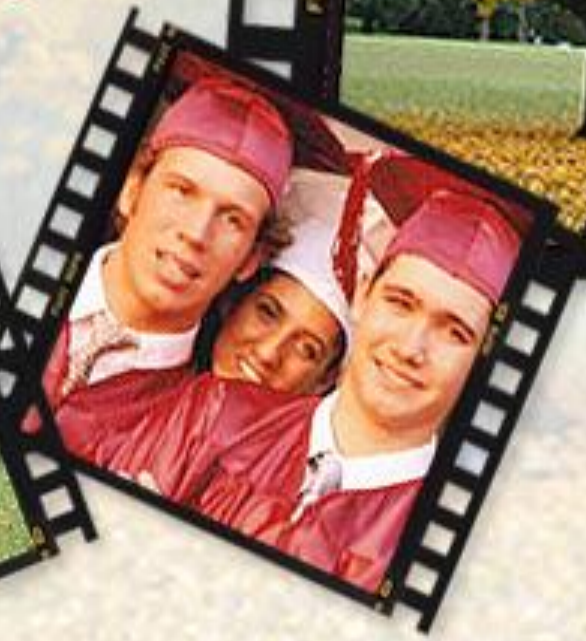
CONTINUE TRY AGAIN

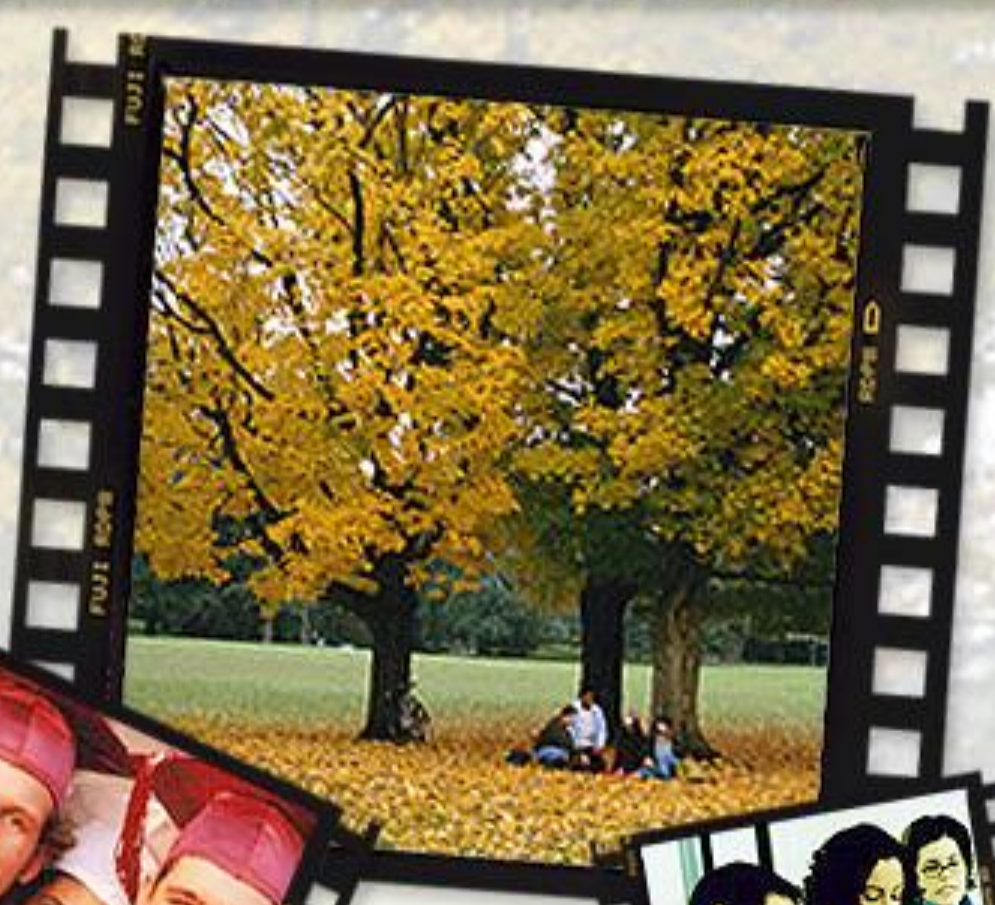
Back

Quit

CENTRAL UNIVERSITY

Food, Mood & Attitude





Research

Conferences on ED since 1997

Advances in Eating Disorders: Theory, Research and Practice, 2013

- Hegemony of hard-core research, the current reign of evidence-based practice,
- The demand for **rigid adherence to manuals** or to a particular form of therapy…
- **None of our current therapies** have better than a **70% full and sustained recovery** – we have a long way to go.
- We believe **open-minded clinical observation** and **experience, unhampered and creative thought**, hypothesis development, conceptual considerations, vigorous debate and **listening to our patients** are just as valuable sources.

Rachel Bryant-Waugh and Bryan Lask, 2013

The role of leptin and ghrelin in malnutrition and microbiom

Circulating leptin levels are in most of the malnutrition states decreased in paralelle with drop of body fat

Hypoleptinemia is rather the consequence than the cause of anorexia nervosa and most of the malnutrition states

Hypoleptinemia triggers **complex adaptive response to limited energy sources** (↓body fat).

This adaptation includes decreased energy expenditure, amenorrhea, immunodeficiency etc.

The "Gut" Feeling

How our GI tract can influence the CNS

Stress, dietary or environmental triggers

Microbiota changes

Gut epithelial breakdown – "leaky gut"

Neural, behavioral and mood changes

Immune activation by endotoxemia (LPS stimulation)

Changes in synaptic plasticity

Inflammatory cytokine production

Alterations in neurotransmitter levels

Blood brain barrier breakdown

The PRO-YOUTH network

Germany:

Center for Psychotherapy Research

Czech Republic:

Charles University, Prague

Romania:

University of Babes-Bolyai, Cluj-Napoca

Italy:

Studi Cognitivi, Milan

Ireland:

Trinity College, Dublin

Hungary:

Semmelweis University, Budapest

ands:

Stichting Rivierduinen, Leiden

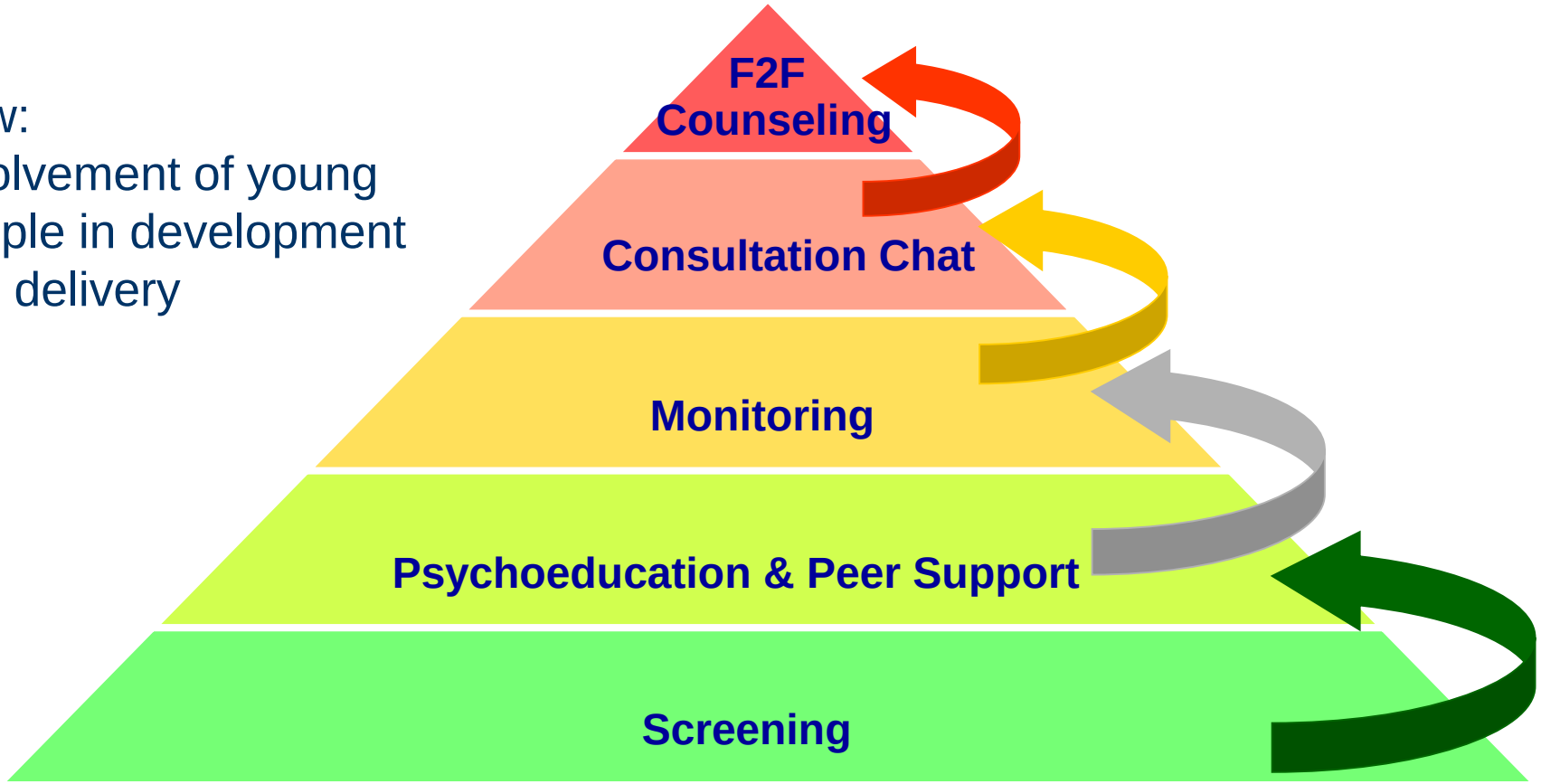
Avoiding protracted admissions
Failure to treat early leads to chronicity

PRO YOUTH Projekt 2011-2014

The PRO-YOUTH platform

Updated software, based on Es[s]prit and YoungEsprit (Bauer et al., 2009)

New:
Involvement of young people in development and delivery



Nine Truths about Eating Disorders

TRUTHS

1. Many people with eating disorders look healthy, yet may be extremely ill.
2. Families are not to blame, and can be the patients' and providers' best allies in treatment.
3. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.
4. Eating disorders are not choices, but serious biologically influenced illnesses.
5. Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses.
6. Eating disorders carry an increased risk for both suicide and medical complications.
7. Genes and environment play important roles in the development of eating disorders.
8. Genes alone do not predict who will develop eating disorders.
9. Full recovery from an eating disorder is possible. Early detection and intervention are important.

AED® Academy for Eating Disorders

Academy for Eating Disorders® | www.aedweb.org

Produced in collaboration with Dr. Cynthia Bulik, PhD, FAED, who serves as distinguished Professor of Eating Disorders in the School of Medicine at the University of North Carolina at Chapel Hill and Professor of Medical Epidemiology and Biostatistics at the Karolinska Institutet in Stockholm, Sweden. "Nine Truths" is based on Dr. Bulik's 2014 "9 Eating Disorders Myths Busted" talk at the National Institute of Mental Health Alliance for Research Progress meeting.

Leading associations in the field of eating disorders also contributed their valuable input.

The Academy for Eating Disorders® along with other major eating disorder organizations (Families Empowered and Supporting Treatment of Eating Disorders, National Association of Anorexia Nervosa and Associated Disorders, National Eating Disorders Association, The International Association of Eating Disorders Professionals Foundation, Residential Eating Disorders Consortium, Eating Disorders Coalition for Research, Policy & Action, Multi-Service Eating Disorders Association, Binge Eating Disorder Association, Eating Disorder Parent Support Group, International Eating Disorder Action, Project HEAL, and Trans Folx Fighting Eating Disorders, and other organizations) will be disseminating this document.

ACADEMY FOR EATING DISORDERS®

Nine More **Truths** about Eating Disorders: Weight and Weight Stigma

1. Weight is influenced by multiple factors, including biological, psychological, behavioral, social, and economic factors.
2. There is a complex relationship between weight and health that is different for each person. Body mass index is an imprecise proxy measure of adiposity and is not a direct measure of health.
3. Weight is sensitive and personal, as it is determined and experienced uniquely for each individual and, when appropriate to do so, should be approached thoughtfully and respectfully. At the same time, weight is a highly politicized issue with social and economic linkages that intersect with social inequalities.
4. Weight bias and weight-based discrimination are prevalent and have pervasive negative consequences for health, social relationships, education, employment, and income. Weight bias is one facet of the cultural appearance ideals that emphasize and idealize thinness and are implicated in the development and maintenance of disordered eating behavior.
5. All people, irrespective of their weight, deserve equitable treatment — in healthcare settings and society. Weight bias and weight-based discrimination are never acceptable.
6. Weight is assessed by objective physical measurement; whereas, the threshold of body mass index used to classify obesity is based on arbitrary medical convention. Eating disorders are defined by thoughts, feelings and behaviors, and obesity is not an eating disorder.
7. Accurate judgments about a person's cognitions, personality, or behaviors cannot be made on the basis of their weight and appearance, and eating disorders cannot be diagnosed on the basis of a person's weight or appearance. Eating disorders affect people across the weight spectrum.
8. Dietary restriction can increase the risk for developing an eating disorder and can be harmful for many individuals across the weight spectrum. This risk must be considered during discussions and interventions relating to diet and weight.
9. Positive body image, regardless of weight, protects against disordered eating and other mental health problems and is associated with better physical health outcomes.

AED®

AED Academy for Eating Disorders

Partnership, Chapter & Affiliate Committee

Minimum standard of care - cross-cultural action guidelines for Eating Disorders

This document is intended to provide direction to health care professionals who do not have access to specialized treatment for their patients with eating disorders.

5 basic facts about EATING DISORDERS:

- EATING DISORDERS frequently affect teenagers and young people but also children and adults of all genders, ethnic backgrounds, cultures and body weights.
- EATING DISORDERS are not lifestyle choices but serious mental disorders that cause patients to stop eating or to engage in binge eating and/or other dysfunctional eating behaviors and include several clinical presentations.
- EATING DISORDERS are self-destructive behaviors that the patient cannot control.
- EATING DISORDERS cause serious impairment, can have devastating chronic effects and have one of the highest mortality rates of all mental disorders.
- EATING DISORDERS can be treated. If an ED specialized team is not an option the therapy should involve a multidisciplinary team of health care professionals if available and involve caregivers/relatives if possible. Working with relatives to support patients through this process is recommended no matter what the kind of EATING DISORDER the patient is suffering from. Treatment should focus on the psychological, social, nutritional and medical aspects of eating disorders.

COMMON SYMPTOMS (patients show some, but not necessarily all, of these):

- Behavioral change e.g. fasting, restriction of energy intake, difficulty eating, denial of appetite, binge eating, self-induced vomiting, laxative abuse, diuretics or diet pills, excessive physical exercise.
- Body dissatisfaction
- Distortion of body image
- Strong desire to lose weight / intense fear of gaining weight
- Low self-esteem
- Psychological distress
- Preoccupation with food
- Depression and/or anxiety/mood swings
- Reduction of libido
- Lack of acceptance of illness
- Social isolation
- Physical symptoms
- Excessive weight gain/loss
- Absent or irregular menstruation
- Sleep disturbances

Patients with EATING DISORDERS often suffer from other mental and medical comorbid conditions that need to be addressed.

Always seek specialized eating disorder treatment (through well trained professionals within the eating disorders area) for a patient with an eating disorder if available!