EATING DISORDERS BOOT CAMP
INTRODUCTION: WHAT ARE YOU CALLING AN EATING DISORDER?

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AUDIO SECTION 1

INTRODUCTION: WHAT ARE YOU CALLING AN EATING DISORDER?

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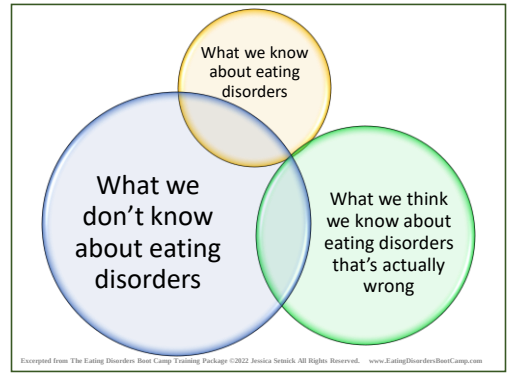

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Why Are We Here?

- Because eating disorders are far more common than we have been led to believe.
- Because your education and training have almost completely left out anything about eating disorders that applies to the real world.
- Because you worry that you're not doing the best for your patients.
- Because you feel isolated among your peers who aren't knowledgeable about eating disorders.

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How Did We Get Here?

- Today's appearance culture comes from historic body elitism intended to create a racist hierarchy.
- Our bodies are ongoing projects that we are required to "perfect" to be acceptable.
- Consumer culture needs us to believe perfection is attainable, yet unachievable.
- We are distracted trying to make our bodies different, while never changing the systemic roots or the inner discontent we feel.

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How Did We Get Here?

- The eating disorder field is relatively new and based on incorrect assumptions from the very beginning. Examples of baked-in mistakes:
  - Eating disorders are entirely psychological, stemming from internal conflict. FALSE
  - Eating disorders occur only in a individuals meeting certain physical characteristics. FALSE
  - Eating issues are differentiated by different outward symptoms. Everyone with the same symptom has the same disorder. FALSE

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The Myth of Objectivity

- What we call "science" and "research" are products of historic elitist practices that gatekeep who is allowed to participate EVEN IF THAT IS NO LONGER WHAT IS INTENDED.
- Hopefully no one in our field is intentionally racist, elitist, sexist, fatphobic, transphobic, heteronormative, etc. But unless they are actively working to NOT be those things, their research and outcomes are inherently tainted by the biased foundations of the field.

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Institutional Bias in the ED Field: Effects on Research

- Published research only included white, affluent, cis-gender, heterosexual-presenting females with underweight appearance.
- Literally NO ONE else.
- Anyone not meeting those criteria was CATEGORICALLY excluded, either due to "screening criteria" or because participants - individuals in treatment - were incorrectly considered to be a representative sample of all individuals with eating disorders.

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Institutional Bias in the ED Field: Effects on Education

- Eating disorders are still considered very rare – this is totally wrong. 1 out of 12 in US alone.
- Dietetics education leaves out ED because "most dietitians won't work with ED." But only a small fraction of individuals with ED will ever get specialty care. Many others will be seen by generalist RDNs or RDNs in other specialties.
- Eating disorder training and education in medical, nursing, and counseling programs is sparse to nonexistent, so personal nutrition philosophies are often prescribed.

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Institutional Bias in the ED Field: Effects on Treatment

- Until very recently there were NO residential options for anyone who did not identify as a cis-gender female.
- Primary care and emergency providers rarely consider eating disorders as a diagnosis for male-presenting patients until they have ruled out everything else and the individual is very, very ill.
- Weight loss is rarely identified as a potentially dangerous symptom of serious illness until it becomes severe, and sometimes not then.

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Institutional Bias in the ED Field: Effects on Diagnoses

- This bias is reflected in the DSM - the "official" diagnoses reflect the baked-in biases of those writing them, including fat-phobia, racism, ableism, genderism, etc. EVEN IF THOSE INDIVIDUALS DON'T INTEND TO BE BIASED.
- DSM-5 (2013) is the first-time menstrual status isn't mentioned in anorexia criteria.
- Also the first time Binge-eating Disorder could be diagnosed.

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Institutional Bias in the ED Field: Effects on Lives

- Weight loss recommended in lieu of appropriate medical care leads to preventable deaths… which then perpetuates weight as a cause of death rather than malpractice as the true cause of death.
- Individuals with eating disorders are harmed by recommendations for weight loss or inadequate nutrition in treatment.
- Lack of representation discourages individuals of marginalized identities from seeking care.
- Lack of low-cost resources.

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The Official List

Eating and Feeding Disorders DSM-5 and ICD-10 Codes
Updated September 2016

DSM-5	Diagnosis		ICD-10
307.1	**Anorexia Nervosa (AN)**	*Restricting Type*	F50.01
		Binge-Eating/Purging Type	F50.02
307.51	**Bulimia Nervosa (BN)**		F50.2
307.51	**Binge-Eating Disorder (BED)**		F50.81
307.59	**Other Specified Feeding/Eating Disorder (OSFED)**		F50.89
307.50	**Unspecified Feeding/Eating Disorder**		F50.9
307.59	**Avoidant/Restrictive Food Intake Disorder (ARFID)**		F50.89
307.53	**Rumination Disorder**		F98.21
300.7	**Body Dysmorphic Disorder**		F45.22
307.52	**Pica**	*Child*	F98.3
		Adult	F50.89

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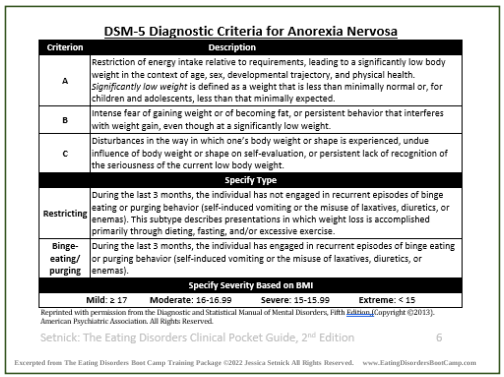

DSM-5 Diagnostic Criteria for Anorexia Nervosa

Criterion	Description
A	Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
B	Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
C	Disturbances in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
Specify Type	
Restricting	During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
Binge-eating/ purging	During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
Specify Severity Based on BMI	
Mild: ≥ 17 **Moderate**: 16-16.99 **Severe**: 15-15.99 **Extreme**: < 15	

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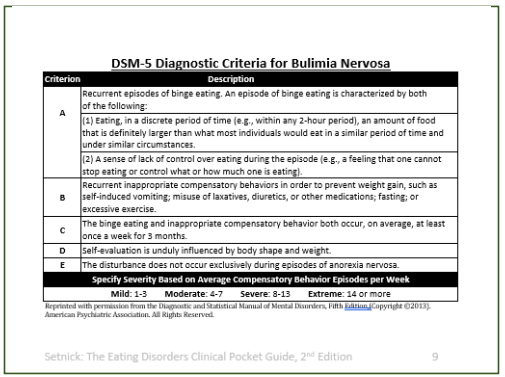

DSM-5 Diagnostic Criteria for Bulimia Nervosa

Criterion	Description
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 individuals would eat in a similar period of time and 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	Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
C	The binge eating and inappropriate compensatory behavior both occur, on average, at least once a week for 3 months.
D	Self-evaluation is unduly influenced by body shape and weight.
E	The disturbance does not occur exclusively during episodes of anorexia nervosa.
Specify Severity Based on Average Compensatory Behavior Episodes per Week	
Mild: 1-3 **Moderate**: 4-7 **Severe**: 8-13 **Extreme**: 14 or more	

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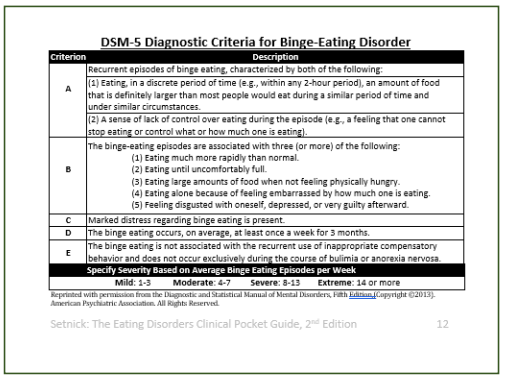

DSM-5 Diagnostic Criteria for Binge-Eating Disorder

Criterion	Description
A	Recurrent episodes of binge eating, 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 most people would eat during a similar period of time and 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 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 and does not occur exclusively during the course of bulimia or anorexia nervosa.
Specify Severity Based on Average Binge Eating Episodes per Week	
Mild: 1-3 **Moderate**: 4-7 **Severe**: 8-13 **Extreme**: 14 or more	

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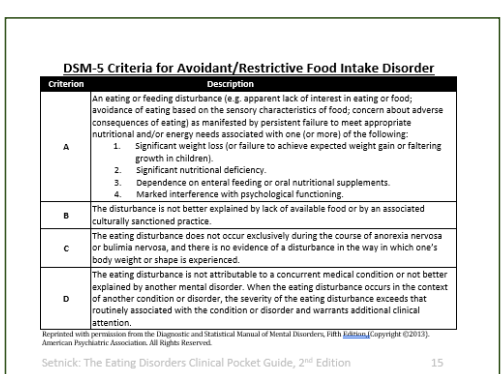

DSM-5 Criteria for Avoidant/Restrictive Food Intake Disorder

Criterion	Description
A	An eating or feeding disturbance (e.g. apparent lack of interest in eating or food; avoidance of eating based on the sensory characteristics of food; concern about adverse consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following: 1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children). 2. Significant nutritional deficiency. 3. Dependence on enteral feeding or oral nutritional supplements. 4. Marked interference with psychological functioning.
B	The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
C	The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
D	The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

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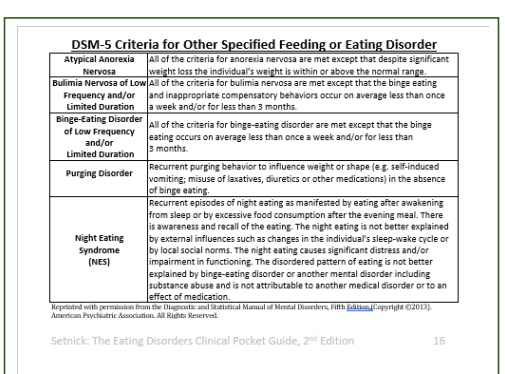

DSM-5 Criteria for Other Specified Feeding or Eating Disorder

Atypical Anorexia Nervosa	All of the criteria for anorexia nervosa are met except that despite significant weight loss the individual's weight is within or above the normal range.
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 behaviors occur on average less than once a week and/or for less than 3 months.
Binge-Eating Disorder of Low Frequency and/or Limited Duration	All of the criteria for binge-eating disorder are met except that the binge eating occurs on average less than once a week and/or for less than 3 months.
Purging Disorder	Recurrent purging behavior to influence weight or shape (e.g. self-induced vomiting; misuse of laxatives, diuretics or other medications) in the absence of binge eating.
Night Eating Syndrome (NES)	Recurrent episodes of night eating as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder including substance abuse and is not attributable to another medical disorder or to an effect of medication.

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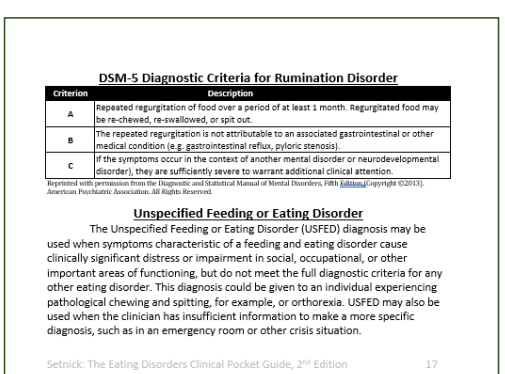

DSM-5 Diagnostic Criteria for Rumination Disorder

Criterion	Description
A	Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
B	The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g. gastrointestinal reflux, pyloric stenosis).
C	If the symptoms occur in the context of another mental disorder or neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Unspecified Feeding or Eating Disorder

The Unspecified Feeding or Eating Disorder (USFED) diagnosis may be used when symptoms characteristic of a feeding and eating disorder cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, but do not meet the full diagnostic criteria for any other eating disorder. This diagnosis could be given to an individual experiencing pathological chewing and spitting, for example, or orthorexia. USFED may also be used when the clinician has insufficient information to make a more specific diagnosis, such as in an emergency room or other crisis situation.

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DSM-5 Diagnostic Criteria for Body Dysmorphic Disorder

Criterion	Description
A	Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable by others or appear slight to others.
B	At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking,) or repetitive mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
C	The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D	The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.
Specify Type	
With muscle dysmorphia	The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is also preoccupied with additional body areas.
Specify Degree of Insight Based on Awareness of Mistaken Beliefs	
With good or fair insight: Aware beliefs are definitely or probably not true or may or may not be true.	
With poor insight: Beliefs are probably true.	
With absent insight/delusional beliefs: Completely convinced that beliefs are true.	

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Bottom line

Eating Disorder Diagnostic Criteria are standardized to facilitate research and description.

They DO NOT represent the human experience.

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Anyone who is suffering deserves to get help… regardless of whether they have received or meet criteria for an "official" diagnosis.

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Needs for ED Recovery:

A turning point

A reason to live

An identity without the eating disorder

Treatment for the underlying problem

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THANK YOU
for all you do.

Questions?
Info@UnderstandingNutrition.com

Schedule a training:
www.JessicaSetnick.com

Schedule a consultation:
www.tinyurl.com/talktojessica

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Hungry for more?

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