

Eating Disorders A Resource for Dentists



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With and sincere thanks to
Dublin Dental University Hospital

&

The Irish Dental Association

This resource has been adapted with thanks to
the National Eating Disorders Collaboration,
an Australian source for eating disorders
information and research.

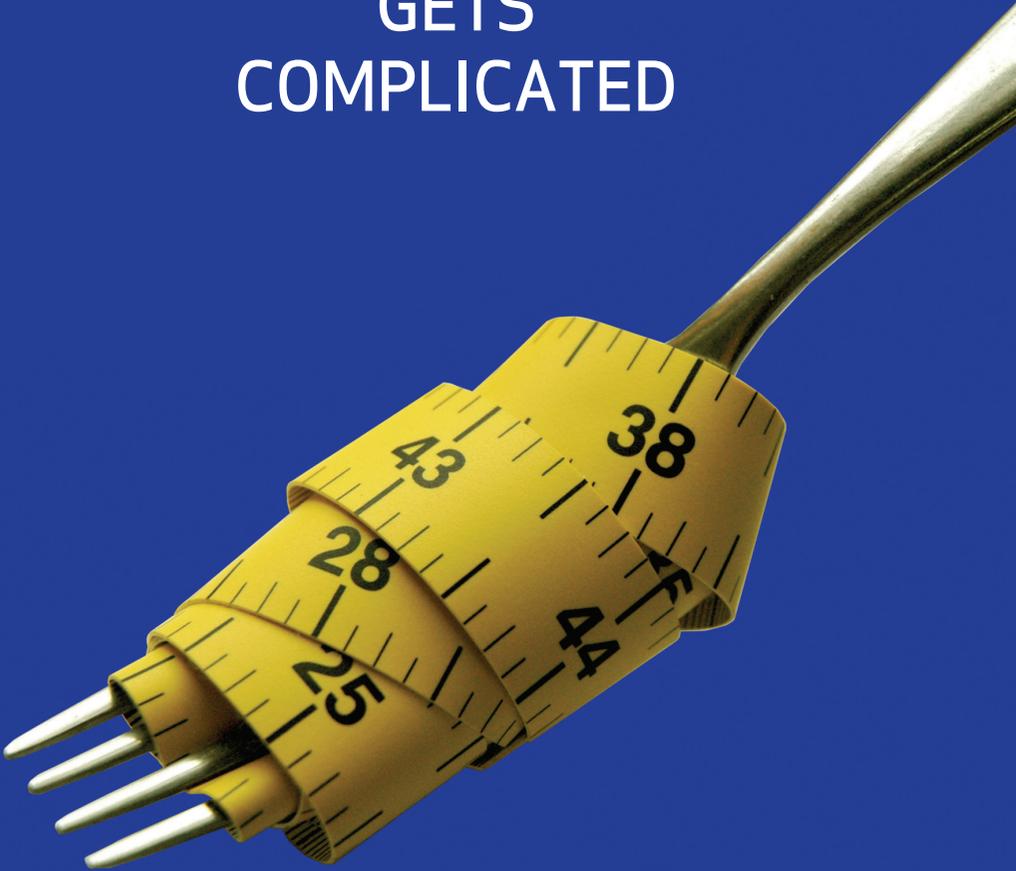


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LIFE
SOMETIMES
GETS
COMPLICATED



Introduction

Bodywhys - The Eating Disorders Association of Ireland - has developed this information resource to assist dentists and to provide suggestions about how they can support and guide individuals affected by eating disorders. The guide includes information about the types and characteristics of eating disorders, the risk factors associated with the development of eating disorders, potential implications for a person's health, including their oral health and also how dentists can respond to patients.

Dentists may be amongst the first healthcare professionals to observe some of the symptoms of an eating disorder and the potential complications in a patient. Often, the typical image that comes to mind in relation to an eating disorder is the severely emaciated frame of a young woman. Although this is one way a person with an eating disorder may present, there may be other symptoms which are less obvious. Eating disorders are extremely complex and when a patient is entrenched in the disorder, the complexity can increase.

NOTES

1. What Are Eating Disorders?

An eating disorder is a serious and complex mental illness. It typically features severe disturbances in a person's thought processes and their relationship with food, their body and weight. This may lead to significant complications for a person's quality of life, and in their physical and mental health. There are a variety of eating disorders, with different causes and characteristics. A common feature of an eating disorder is low self-esteem and an attempt to deal with psychological distress through a self-destructive relationship with food.

According to the Department of Health and Children, up to 200,000 people in Ireland may be affected by eating disorders with 400 new cases emerging each year, representing 80 deaths annually.¹ In 2016, 12% of all admissions for under 18s to Irish psychiatric units and hospitals had a primary diagnosis of eating disorders.² For anorexia nervosa, the peak incidence of onset is 14-18 years and for bulimia nervosa it is 14-22 years.³ Binge eating disorder most commonly presents in the late teens or early 20s.

Understanding Eating Disorders as a Coping Mechanism

An eating disorder is not a diet. It is a serious psychological illness. It develops as a coping mechanism that a person uses to manage how they are feeling. The behaviours and thought processes around food, weight and the body become a way of dealing with distress. For many complex reasons, an eating disorder provides someone with a sense of safety and feeling of control. Disordered eating behaviours can bring a sense of relief, and this may initially 'work' for a person for a period of time, because it allows them to feel okay. However, once trapped within an eating disorder, people often feel a need to maintain it in order to manage other parts of their life which may feel overwhelming. They don't know how they could cope without it. They may feel ashamed and frightened in discussing it. The longer an eating disorder continues the more entrenched it becomes and the greater the impact on a person's health and quality of life.

- Eating disorders are, in some cases, fatal.
- Denial and resistance to talking about it are common.
- Contrary to the misconception, eating disorders are not unique to young people or girls.
- No one single cause has been associated with the development of eating disorders.
- People directly affected may feel stigmatised due to negative stereotypes or misconceptions.
- Mental illnesses often require medical/physical and/or psychological intervention to promote recovery.

Presenting Signs and Symptoms ⁴

Eating disorders are often accompanied by a range of warning signs, symptoms and complications. Symptoms range from cardiorespiratory, neuropsychiatric, oral and dental, to gastrointestinal, endocrinological and dermatological. Examples may include:

- Frequent changes in weight/weight loss
- Failure to gain expected weight in a child or adolescent who is still growing and developing
- Wanting to lose weight when normal or underweight
- Dry, discoloured skin or fine hair growing on their face and body
- Poor circulation, fluid retention
- Difficulty sleeping, or concentrating
- Calluses
- Enlarged salivary glands
- Digestive problems such as cramps, wind, constipation, diarrhoea, a sore throat or mouth ulcers
- Loss of, or irregular periods
- Unexplained infertility
- Feeling weak, dizzy or tired
- Erosion of tooth enamel, tooth decay
- Muscle weakness
- Cardiac arrhythmias

All of these may be signs or symptoms of disordered eating behaviours, including restrictive eating, frequent purging and nutritional deficiencies or starvation. If you observe any of these signs, initiating a discussion with the patient to determine the cause of the problems is essential.

In anorexia nervosa, the medical complications are a consequence of weight loss and malnutrition.⁵ In bulimia nervosa, the medical complications are associated with the mode and frequency of purging.⁶

Patients with eating disorders may also present with depression,^{7,8,9} anxiety^{10,11,12} and suicidal ideation.^{13,14}

Common Presentations and Key Characteristics*

Anorexia Nervosa (AN)

The first contact with a General Practitioner (GP) is often made by a concerned family member, rather than the patient. Concerns expressed may be related to weight loss, food-related behaviours such as skipping meals, hiding food or adopting a restrictive diet. There may be a change in mood, sleep patterns and increased activity such as excessive exercise.

Typical psychopathological features:

- A persistent restriction of energy intake (food) leading to a person becoming significantly underweight (for what is expected for their age, sex, developmental stage, and physical health).
- Alongside this energy intake restriction and significant low weight, there must be (for diagnosis) an intense fear of gaining weight or of becoming fat, or a persistent behaviour 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 body weight.

These features may not all be present, easy to elicit or they may be denied. Denial of the seriousness of the weight loss or consequences, both physical and psychological is not unusual.

Established anorexia nervosa with signs of emaciation is usually obvious. However, patients may present initially in primary care with non-specific physical symptoms such as abdominal pain, bloating, constipation, cold intolerance, light headedness, hair, nail or skin changes. Amenorrhoea, combined with unexplained weight loss, in the population at risk should always prompt further enquiry.

Apparent food allergy/intolerance and chronic fatigue syndrome sometimes precede the development of an eating disorder and may cause diagnostic confusion. In younger cases, growth failure may be a presenting feature. In practice, typical cases should cause little difficulty when the time is taken to explore the history including corroborative information and the patient's attitude to the weight loss.

Indeed, diagnosis is often delayed when clinicians inadvertently collude by over investigating and referring to other specialties rather than confronting the possibility of an eating disorder.

**For full diagnostic criteria, please see Appendix 1*

In anorexia nervosa, although weight and body mass index (BMI) are important indicators of physical risk they should not be considered the sole indicators (as on their own they are unreliable in adults and especially in children).¹⁵

The effective management of anorexia nervosa depends on a full assessment of physical status, psychological features, risk and capacity to consent to treatment.

Young people are typically brought to the attention of the GP by concerned parents because of the extent of their weight loss. Other presenting features may include:

- Altered eating or dietary behaviour
- Excessive exercise
- Amenorrhoea
- Depressed mood and/or social withdrawal
- Self-harm
- Suicidal ideation

The young person may also present with physical complaints related to undernutrition including dizziness, fatigue and headache, or abdominal symptoms such as nausea or bloating, unexplained vomiting, lack of appetite and constipation. The young person may deny any problem and offer assurances for concerns.

Bulimia Nervosa (BN)

Typical psychopathological features:

- Repeated episodes of binge eating
- A sense of a lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating)
- Inappropriate compensatory behaviours aimed at preventing weight gain (self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting suppressants or excessive exercising)
- Self-evaluation is unduly influenced by body shape and weight

Compared to someone with anorexia nervosa, the patient with bulimia nervosa is more likely to be older and to consult a GP or dentist without the involvement of a family member. There may be a history of previous anorexia nervosa or of unhappiness with previous weight and attempts to diet. Questioning may reveal patterns of restriction, binge eating, purging and psychopathology.

Not infrequently, physical symptoms are presented which may be related to or consequences of purging or laxative use. These are parotid enlargement, Russell's sign (callus formation on the dorsum of the hand) and dental enamel erosion. Also common are electrolyte abnormalities, so urea and electrolytes should be routinely obtained. These symptoms, particularly in a young woman should be a 'red flag' in prompting the GP to consider further enquiry.

Where the patient does not disclose bulimia nervosa, a range of symptoms may present which should raise the index of suspicion. These include requests for help with weight loss, menstrual disturbance and the physical consequences of vomiting and laxative and diuretic use. Non-specific symptoms may include fatigue and lethargy.

Gastrointestinal disorders may be present including bloating, fullness, abdominal pain, irritable bowel syndrome type symptoms, constipation, diarrhoea and rectal prolapse as well as oesophagitis and gastrointestinal bleeding. Oropharyngeal symptoms may include a sore throat, parotid swelling and dental enamel erosion.

Binge Eating Disorder (BED)

Typical psychopathological features:

- Repeated episodes of binge eating
- A sense of a lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating)

Many people overeat from time-to-time, and many people often feel they have eaten more than they should have. Some people, however, feel distressed by their overeating. They feel out of control and binge on food in order to manage their negative mood or other feelings. There is a powerful craving for food which is experienced as overwhelming. They eat what most people would think is an unusually large amount of food.

Research indicates the men and women who binge eat experience comparable levels of clinical impairment.¹⁶ Effects of binge eating may include depression, stress, obesity and absence from work due to illness.¹⁷ A person with BED will most commonly present with a weight issue (overweight or obese), and associated problems that occur with being in the overweight / obese category. The person affected by BED may diet frequently, however, they will not engage in purging behaviour after a binge. Over time this can, but may not always, result in significant weight gain.

Binges almost always occur in secret, and an appearance of 'normal' eating is often maintained. The food that is eaten is usually filling and high in calories. It tends to be food that people regard as fattening, and which they are attempting to exclude from their diet. The food is usually consumed very quickly, and is seldom tasted or enjoyed. While in BED there is no purging, there may be sporadic fasts or repetitive diets, and often feelings of shame or self-hatred surface after a binge. A person affected by BED may find themselves trapped in a cycle of dieting, bingeing, self-recrimination and self-loathing. They can feel particularly isolated which can contribute to the prolonging of their experience.

Other Specified Feeding or Eating Disorder (OSFED)

Individuals who do not meet the criteria for AN, BN or BED may be diagnosed with Other Specified Feeding or Eating Disorder (OSFED), previously known as Eating Disorder Not Otherwise Specified (EDNOS).

Individuals affected by OSFED may experience clinically significant symptoms that are problematic and distressing. This may include disordered eating similar to other eating disorders or eating behaviours that are associated with distress, impairment and risk of pain, death or disability. It is important to emphasise that OSFED is no less serious of an issue than other eating disorders. Individuals affected by OSFED may present with emotional distress and impairment compared with those who do not have an eating disorder.

Avoidant/Restrictive Food Intake Disorder (ARFID)

In ARFID, a person may experience food disturbances to the point that they do not meet their appropriate nutritional and/or energy needs. This may be underlined by factors such as avoidance due to the sensory characteristics of food, a lack of interest in eating or food, or worries about the consequences of eating.

Individuals affected by ARFID may present with:

- Clinically significant restrictive eating leading to weight loss, or a lack of weight gain
- Nutritional deficiencies
- Reliance on tube feeding or oral nutritional supplements
- Disturbances in psychosocial functioning

Research has also identified behaviours and difficulties such as: ^{18,19,20}

- Food avoidance
- Restrictive eating
- Selective eating since childhood
- Decreased appetite
- Abdominal pain
- A heightened fear of vomiting and/or choking
- Possible food texture issues
- Generalised anxiety
- Gastrointestinal symptoms

To learn more about the characteristics of eating disorders, visit www.bodywhys.ie

Hidden Problem

Some patients may not be open or honest about their disordered eating behaviour. A person with disordered eating issues will often go to great lengths to disguise or hide their problem. They may be afraid to ask for help, and in some cases, they may not even realise they have a problem. For many people, speaking about an eating disorder may feel terrifying and shameful.

Patients may commonly present to a GP for weight loss medications or interventions. Symptoms will assist you in providing appropriate advice to the patient. Encouraging the patient to disclose or discuss their problem and seek help is vital.

Risks and Risk Factors

Individuals affected by eating disorders are at risk in terms of their own safety.²¹ This may include medically, psychologically, psychosocially and their capacity for insight and motivation.²² Eating disorders can also involve risks in terms of mortality and suicide.²³

Risk factors associated with the development of eating disorders include genetic and environmental issues. In addition, shape and weight-related concerns, dietary restraint, and a family history of an eating disturbance may contribute to the development of an eating disorder.^{24,25} Dieting attempts, stressful life events, low self-esteem and perfectionism may also be factors.^{26,27}

Common Myths

Myth No. 1 - Eating disorders are a female issue. FALSE. Eating disorders can occur in men and women, boys and girls. It is estimated that one in every 10 cases of an eating disorder is male, while for Binge Eating Disorder it is 1 in every 2 cases.

Myth No. 2 - Eating disorders are just a teenage issue. FALSE. An eating disorder can occur at any age from under 10 to over 70 years. The average age of onset is commonly during the teenage years or early adulthood. When you think about the life changes a person may undergo this stage of their life, you can understand why onset may occur during this time. Some people may experience an eating disorder for over 10 years whilst for others, an eating disorder can develop later in life.

Myth No. 3 - An eating disorder is a faddy diet. FALSE. An eating disorder is not a type of diet that somebody uses to lose weight. An eating disorder is a serious mental illness that has the **highest mortality rates of all psychiatric disorders**. It is a mistake to think that eating disorders are only about food and weight. They are about the person's sense of themselves, their self-esteem and self-worth.

Myth No. 4 - An eating disorder is a lifestyle choice. FALSE. A person does not 'choose' to have an eating disorder, and certainly living with an eating disorder is not about adhering to a certain type of lifestyle. A person becomes trapped in an eating disorder, and in a similar way to an addiction, feels compelled to continue engaging in the disordered eating behaviour in order to feel safe and secure. This compulsion replaces the conscious choice a person has, and they need help and support to be able to choose a different way of coping and living.

Myth No. 5 - An eating disorder is a phase. FALSE. An eating disorder is not a phase, it is not something that a person 'will grow out of'. It is much more serious than that and should be taken as such by all medical and treatment practitioners involved.



2. Impact on Oral and Dental Health

For some individuals, their experience of eating disorders (EDs) contributes to problems with their dental/oral health. Depression and fatigue in individuals who are extremely underweight may contribute to poor oral hygiene.²⁸ People affected by eating disorders may avoid attending healthcare professionals due to feelings of shame, guilt and denial. This includes a fear of attending and communicating with dental practitioners.²⁹ The presence of vomiting behaviour, and having had a prior negative experience with a dentist, may also contribute to feelings of anxiety and/or fear oral surgery.³⁰

Potential oral health complications from eating disorders include: ^{31,32,33,34,35,36}

- Tooth erosion
- Dental caries
- Burning tongue
- Angular cheilitis
- Dry lips
- Atrophic mucosa
- Increased risk of periodontal diseases
- Oral ulcerations
- Taste impairment
- Candidiasis
- Parotid gland enlargement
- Altered salivary flow rate

The erosive pattern associated with bulimia nervosa and gastroesophageal reflux involves primarily the palatal and lingual surfaces of teeth as opposed to dietary erosion which commonly affects the labial aspects. In some cases, the erosion also can affect the occlusal surfaces of molar and premolar teeth on which the process can be accelerated by attrition potentially leading to sensitivity and loss of occlusal vertical dimension. The dentist may therefore play a vital role by diagnosing such patterns and referring for medical diagnosis and treatment. Basic oral and dental health should be achieved first and in cases of bulimia nervosa, dentists should liaise with the patient's medical team in order to ensure that the vomiting cycle has been broken prior to attempting any complex restorative procedures.

NOTES

3. The Role of Dentists

Dental practitioners may be amongst the first clinicians to observe the health consequences of an eating disorder.³⁷ It is **not** the role of dentists to treat the underlying or psychological causes of an eating disorder, but encouraging the patient to seek help is a vital step towards recovery. Creating a comfortable environment for the patient is also an important part of discussing the issue.

If the patient's teeth or gums are in poor health, you will need to treat these to prevent further damage developing. In these cases, it may be advisable to use interim treatments such as acid-resistant materials.

It may be useful to keep some Bodywhys fact sheets or information packs about eating disorders in the waiting area.

Responding to Patients³⁸

Due to the nature of eating disorders, individuals may express intense ambivalence about change, recovery and seeking help. Some patients may seem defensive. A patient's level of self-criticism, though not necessarily apparent to others, may be high. Attempting to force an action plan on them may not be effective, at the outset. You can help them to talk to you if you ask around the issue, and communicate an understanding that, letting it go, and change, is difficult. Useful ways to engage include:

- Communicate concern and empathise.
- Remain calm.
- Avoid letting common myths cloud your perceptions.
- Show that you understand that there may be something other than food or weight troubling the person.
- Understanding an eating disorder as a coping mechanism should inform your initial approach.
- Ask questions about the duration and severity of the disorder such as the frequency of bingeing or purging, and current if any medical treatment the patient is engaged with.
- Do not focus on specific behaviours any longer than you need – move the focus from specific behaviours to ask how the person is feeling or whether there is something going on for them they would like to talk about.
- Avoid criticism or suggesting quick fixes.

- Discuss referral to other health professionals such as a GP, dietitian, psychiatrist, psychologist or other specialist may be advisable.
- For those aged under 18, it may be advisable to raise any concerns with the patient's parents and refer to a clinician for expert opinion and support.
- Encourage the patient to return regularly for dental care.

Key phrases and questions

- *I am noticing _____ on your gums/teeth/throat/tongue.*
- *This is something I have seen with people who purge food by vomiting/ _____*
- *Can you tell me a little more about the behaviours that might be having this effect on your mouth/teeth/gums/throat?*
- *I am concerned for you and it seems that there is an issue here that needs to be addressed.*
- *Do you have help available to you at the moment?*
- *Is there someone you might feel comfortable talking to?*
- *Because an eating disorder can affect your oral, mental and physical health, it is very important to seek professional advice and some additional support.*
- *Whilst you are seeking help, I would like to suggest some immediate options for improving your oral health.*

4. Referrals and Treatment

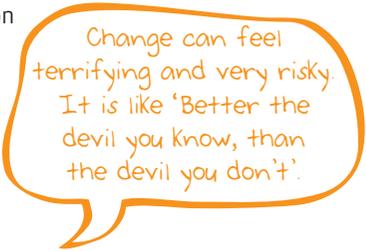
Early intervention is an important part of addressing the issue of eating disorders and in order to promote recovery. For many people, the first port of call is to attend a GP. The GP may carry out an assessment and refer to a specialist or psychiatrist for further support and treatment. Depending on a person's needs, patients may be offered psychotherapy, support from a dietitian, hospital or specialised treatment.

For an overview of treatment pathways please visit www.bodywhys.ie

What are the goals of treatment?

An eating disorder is comprised of different aspects: physical, psychological, behavioural and emotional. While treatment and recovery will address these different aspects, these aspects do not always change at the same rate. Overall, the goals of treatment need to include:

- Stabilisation of the medical and physical consequences of the eating disorder
- A strengthening of a sense of self, due to working on increasing low self-esteem, minimising clinical perfectionism, appropriate processing and dealing with emotions, and/or dealing with underlying trauma in some cases
- Cessation of the cognitive distortions and ideation around body image and eating behaviours
- Normalisation of eating habits / behaviours and restoration of nutritional wellness
- In women and girls, the resumption of regular menses
- Normalisation of weight
- Re-engagement in a full social life including family life



Change can feel terrifying and very risky. It is like 'Better the devil you know, than the devil you don't'.

It is crucial to understand that **an eating disorder is not a choice** that a person makes. As the disordered eating patterns increase, the person's sense of self outside of this diminishes, and they become imprisoned by the need to maintain the eating disorder. **The person feels compelled to continue with it due to a fear of not being able to cope without it.** This is why recovery can take a prolonged period of time and different aspects of the disorder change at different rates during the recovery process.

Remember - There is no 'one size fits all' when it comes to treatment. In order to engage the patient in dental treatment, they must feel that they have a voice in the decision making process.

Helpful hints for friends and family

- There is no one single cause that has been identified for eating disorders. Often parents feel that the eating disorder is their fault, that they have caused it, and it is important to help them to understand that we do not know why a person develops an eating disorder, and for the most part it is due to multiple factors.
- However, parents have a responsibility to ensure that their child gets the care and treatment they need, and they can help by trying to understand what is happening to their child.

Free Information and Resources

Bodywhys offers a range of leaflets and resources including, but not limited to the following:

- Eating Disorders - A Resource for Parents
- Eating Disorders - A Resource for General Practitioners
- Eating Disorders - A Resource for Dentists
- Eating Disorders - A Resource for Pharmacists
- Eating Disorders - A Treatment Guide
- Binge Eating: Breaking the Cycle. A self-help guide towards recovery

These and other resources can be obtained free of charge from **Bodywhys, P.O. Box 105, Blackrock, Co. Dublin** or email info@bodywhys.ie

5. Bodywhys Services

Bodywhys – The Eating Disorders Association of Ireland – is the national voluntary organisation supporting people affected by eating disorders.

PEOPLE CAN AND DO RECOVER

Our Services

“Like a helpline call in an email”, the Bodywhys **EMAIL SUPPORT SERVICE**, alex@bodywhys.ie. People email for support, a listening ear, information and signposting. This allows for increased anonymity and flexibility while providing the optimal level of support.

The Bodywhys **LOCALL HELPLINE 1890 200 444** is a listening, information / signposting service for people with an eating disorder, as well as family and friends. For up-to-date times of operation, see our website www.bodywhys.ie.

Bodywhys provides **ONLINE SUPPORT GROUPS**, **BodywhysConnect** (19+) and **YouthConnect** (13-18), for people with eating disorders only, which are particularly popular with those who wish to maintain anonymity or are living in an isolated area. The online groups operate 4-5 evenings per month and are based on our website at www.bodywhys.ie

Bodywhys provides **SUPPORT GROUPS** in Dublin city centre for those affected by eating disorders. We also run groups for friends and family members who may be in need of support. The groups are facilitated by trained volunteers and are free to attend.

The Bodywhys **PiLaR PROGRAMME** is a free four week education and skills programme for family members supporting a person with an eating disorder. Bodywhys runs these programmes in different locations nationally. Please email info@bodywhys.ie to put your name on the waiting list, and when one is near you you will be contacted. See www.bodywhys.ie for upcoming programmes and Bodywhys will contact you when a programme will be running in an area near you.

www.bodywhys.ie

The Bodywhys website provides a wide variety of information on eating disorders, treatment options and support services.

Also accessible from the site:

- Directory of service providers, searchable by location
- Links to other relevant eating disorder and mental health websites
- Reading list
- SeeMySelf, free online psychoeducation programme

Bodywhys services are available to carers as well as to those affected by eating disorders.

Mental Health First Aid Ireland

For professionals who do not have a background in working with people with eating disorders, the Mental Health First Aid guidelines may provide a useful starting place to support recognition and safe responses to people who are developing or experiencing an eating disorder. The guidelines provide an evidence-based set of general recommendations about how you can help someone with an eating disorder.

Information about Mental Health First Aid Ireland is available on www.mhfaireland.ie



6. Appendix 1

DSM-5™ Diagnostic Criteria for Eating Disorders³⁹

ANOREXIA NERVOSA

Core Features

Deliberate weight loss.
Fear of weight gain and fat.
Body image disturbance.

Diagnostic Criteria (DSM-5™)

- Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory and physical health.
- Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body 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.

SUBTYPES

Restricting - during the last 3 months the person has not engaged in recurrent episodes of binge-eating or purging behaviour (self-induced vomiting or the misuse of laxatives, diuretics or enemas).

Binge-eating / purging - during the last 3 months the person has engaged in recurrent episodes of binge-eating or purging behaviour.

Severity Scale

For adults this is based on BMI, for children and adolescents this is based on BMI percentile.

Mild	BMI > 17 kg/m ²	Severe	BMI 15-15.99 kg/m ²
Moderate	BMI 16-16.99 kg/m ²	Extreme	BMI < 15 kg/m ²

BULIMIA NERVOSA

Core Features

Pattern of dietary restriction broken by binges and then purges.

Diagnostic Criteria (DSM-5™)

- Recurrent episodes of binge-eating characterised by:
 - *Eating, 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 (a feeling that one cannot stop eating or control what or how much one is eating).*
- Recurrent inappropriate compensatory behaviours in order to prevent weight gain (self induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise).
- Binge-eating and compensatory behaviour both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Severity Scale

Mild	Average 1-3 episodes of inappropriate compensatory behaviours per week.
Moderate	Average 4-7 episodes of inappropriate compensatory behaviours per week.
Severe	Average 8-13 episodes of inappropriate compensatory behaviours per week.
Extreme	Average 14 or more episodes of inappropriate compensatory behaviours per week.

BINGE EATING DISORDER

Core Features

Recurrent episodes of binge eating which are not followed by compensatory behaviours, hence the person gains considerable amounts of weight.

Diagnostic Criteria (DSM-5™)

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both the following:
 - *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 in a similar period of time under similar circumstances.*
 - *A sense of lack of control over eating during the episode (e.g. feeling that one cannot stop eating or control what or how much one is eating).*
- The binge 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 being embarrassed by how much one is eating.*
 - *Feeling disgusted with oneself, depressed, or very guilty after overeating.*
- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behaviours as in bulimia nervosa, and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

OTHER SPECIFIED EATING DISORDER (OSFED)

Core Features

This category applies to presentations in which symptoms characteristic of an eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the eating disorders diagnostic class.

Examples are:

1. **Atypical Anorexia Nervosa:** A person develops all of the criteria for anorexia, except that, despite significant weight loss, a person may be within or above the normal weight range.
2. **Bulimia Nervosa of low frequency/limited duration:** A person may meet the criteria for bulimia, though binge eating or compensatory behaviours may occur, on average, less than once a week and/or for less than 3 months.
3. **Binge Eating Disorder of low frequency/limited duration:** A person may meet the criteria for binge eating disorder, though binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. **Purging Disorder:** A person may use purging behaviours to change their weight or shape, in the absence of binge eating.
5. **Night Eating Syndrome:** A person may experience recurrent episodes of night eating. This may occur following excessive consumption of food following an evening meal. The night time eating is not explained by external factors (medication, sleep cycle, other medical disorders) in a person's life and may cause significant distress and impairment in functioning. The disordered pattern of eating is not better explained by binge eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

Core Features

An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

Diagnostic Criteria (DSM-5™)

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.

The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

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.

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.

NOTES

7. References

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