Module 7 Lesson 1

Transcript

Hey everyone. Here we are talking all about mental health. I'm so excited to talk about this topic today because food, nutrition, and mental health are so connected. And if you're working with clients, you will, without a doubt, have an experience in this area, whether it's dealing with someone with emotional eating, or dealing with someone who struggles with disordered eating, which is the topic of this lesson. You've no doubt touched on this area. There's so much gray area on the subject, and it can be really delicate and difficult to navigate. Whether we're talking about classically defined binge eaters, or textbook people living with anorexia nervosa, disordered eating always comes down to control and coping.

Here's my game plan for today's lesson. I'm going to give you a couple of stories, I'm going to go through some definitions, and then I'm going to spend some time discussing the what-to-do's when you're working with someone who you suspect is dealing with an eating disorder. We'll start with some examples. I have a couple of memorable clients to share with you before we get into the nitty gritty of the lesson. I had a client, [Bonnie 00:01:17], who was 5'10 and 103 pounds. She'd been to more treatment centers than I can remember in her 27 years of life. She lost her teeth, her period, her friends and her home. Her illness owned her, and the most painful thing was that she held on so tightly to her compulsion to count calories, measure and plan her food, and weigh herself, that she missed her entire childhood, adolescence and the majority of her 20s.

She was able to make it through school, but missed big gaps of time because she was in patient and mental health hospitals. I had another client, [Alana 00:01:49], who was a teacher. Alana had a habit of going into the teacher's lounge. She would bring the donuts, birthday cake or whatever was on the communal table into the adjoining bathroom with her. She'd stuffed herself with all of it, and I'm talking about two dozen donuts or a whole sheet cake, and throw it all back up in no time flat. Sometimes these binges were over 5,000 calories. Nobody ever suspected her, and she was never caught, but it was really painful to hear how lonely and desperate she was. Again, like Bonnie, with Alana, it was coping and control that governed her.

Sadly, disordered eating is a mental health issue, and neither one of these women were in any control, nor were they coping healthfully. Disordered eating is a mental illness. A person cannot be mentally healthy and will themselves to restrict or binge. It just doesn't work that way. Eating disorders affect 20 million women and 10 million men at some time in their lives. They used to mainly affect upper socioeconomic white girls, but now we see disordered eating in kids, teens, adults and older adults at much higher rates. The most common types of eating disorder diagnoses

are anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder, pica and rumination disorder.

I'm going to go over the most common ones and give you definitions, so you really have a picture of the differences. I want to point out that we're talking about specific diagnoses here, and they all have specific criteria. As we go down the list, I'll touch on the types of eating disorders that don't have separate diagnoses at this time. Also note that these diagnoses are made by doctors and mental health professionals using the Diagnostic and Statistical Manual of Mental Disorders, otherwise known as the DSM-5. So let's start with anorexia nervosa. Anorexia nervosa is restricting food intake significantly. You'll see severe weight loss, fear of gaining weight, distorted body image, and often other side effects like irregular heart rate, numbness or coldness in the fingers or toes, and loss of menstruation.

Next, bulimia nervosa. Bulimia nervosa is characterized by eating huge amounts of food in a short amount of time. This is compensated many ways, through laxatives, purging, excessive exercising or diet pills. Again, you'll see distorted body image, feelings of being out of control, and shame with a fear of gaining weight. Next, binge eating disorder. This is similar to bulimia nervosa in that large volumes of food are consumed in a short period of time, but there's no compensation for it. These people need to have this behavior occur at least once a week for three months or longer to meet this diagnosis. Those who have binge eating disorder feel extremely ashamed, and guilty, and binge even when they're not hungry. This population may be normal weight, underweight, or you may see them overweight.

Body dysmorphic disorder is characterized by an abnormal preoccupation with appearance and body image. It's a mental health disorder where the affected person obsesses over a perceived flaw in appearance that may not even be noticeable to others. This person may spend hours in front of a mirror thinking about their flaw, and compare themselves to others constantly. This may affect social interactions, and often cause them to isolate. Less well known is avoidant/restrictive food intake disorder, also known as ARFID. This diagnosis is characterized by severely restricting food and nutrients without body image thoughts or concerns. It's often seen in people with autism spectrum disorder, though many other people can struggle with this too.

People with ARFID may restrict food due to a fear of vomiting from eating, or due to issues with factors like food texture or smell. It's basically extreme picky eating that results in nutrient deficiency and weight loss. Other specified feeding or eating disorder, or OSFED is the term used to diagnose the tons and tons of people who don't fall into the neat cookie cutter diagnostic criteria.

We have a lot of people who have signs and symptoms of an eating disorder, and they also need help and intervention, but they just don't fit the specific criteria for another diagnosis.

I'm seeing more and more people with orthorexia, which is not a diagnostic term yet, but includes people who refuse to eat anything that isn't considered perfectly healthy. This disease can be damaging socially, emotionally, and physically. Another example is atypical anorexia nervosa, which is all of the criteria for anorexia except without the weight loss. People with atypical anorexia are usually a normal weight or sometimes even considered overweight. This highlights the reality that it can be so tough to tell if someone is struggling with an eating disorder. Another diagnosis is pica, which is an eating disorder that involves eating items that aren't food, such as hair, dirt, and paint chips. Pica is often seen with other mental health disorders including intellectual disability, autism spectrum disorder and schizophrenia.

And finally there's rumination disorder. This is when a person regularly regurgitates food, and either re-chews and re-swallows it, or spits it out. With this, the regurgitation is pretty effortless. Breathing exercises and habit reversal are a big part of therapy here. People who struggle with disordered eating oftentimes terminate work without warning. I've done great work with clients struggling with recovery, eating, only to have them all of a sudden disappear due to relapse. I've reached out to reschedule and had no response, or to have a client tell me she'll circle back soon. I may never hear from that person again. I used to wonder what happened. Thanks to experience and wisdom in the field, I don't question myself so much here anymore.

I'm resigned that eating disorder recovery is really, really tough work, and I don't have to do the hardest work. We know it's the clients that are doing that. So I know many of my clients have lost their motivation, or decided to move on because the work we were doing was just too challenging for them. Here is where I sometimes need to take a step back and reach out to their therapist to make sure they are still being supported. If you've got a client, and have even the smallest suspicion that disordered eating is going on, ask them, “Have you ever been diagnosed with an eating disorder? Do you think about your body shape or a specific part of your body more than what you think is normal? Do you restrict your food intake? Do you think you have a problem with disordered eating?”

In your handouts, you will also see the SCARF questionnaire and a list of common physical ailments found in people with eating disorders. Disordered eating is not solely a nutrition-related issue. So the first line of defense is to get your client to a person who can diagnose them, either a physician or a mental health expert. If your client is already working with a therapist, you may want to see if you can get permission, both verbally and in writing to speak to the therapist. You never

want to work with a person who you suspect is dealing with disordered eating without a team. That team may include a therapist, maybe a physician, and sometimes other health professionals as well. Depending on where the client is in their illness, it may not be a good time to work with you. Or if it is a good time to work with you, you want to make sure, again, you're working with the other providers to give consistent messages.

It's really easy with this fragile population to make a well-meaning suggestion, only to find that you've triggered them. For example, a client may complain of severe GI distress, and you would typically recommend an elimination diet. But this is not the best course of action for someone struggling with anorexia. Or maybe you work with many weight loss clients, and you're always posting weight loss tips on Instagram. But this would be triggering to a client with an eating disorder. Don't be afraid to say that disordered eating isn't in your wheelhouse of specialization, but you're happy to work with the client if her BMI is within normal limits, or she has medical clearance and she's comfortable with working with you. You can also help the client find a well-qualified eating disorder dietician if you're not sure you're totally comfortable here.

This is an area where you really need to put client care, as always, first, and decide if you're truly the best professional for this person to be working with. If disordered eating is an interest of yours, I really encourage you to join support groups, attend continuing education seminars from reputable sources, and deepen your knowledge base before taking clients like this into your practice. Before we wrap up today's lesson, let's review some key points. Eating disorders are mental illnesses. The most common types of eating disorders are anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder, which includes orthorexia, body dysmorphic disorder, and atypical anorexia nervosa, pica and rumination disorder.

In the handout, we covered common physical ailments for people with eating disorders, so don't forget to check that out. And treatment for an eating disorder requires a multidisciplinary team, which may include a dietician, or a nutritionist, a therapist, a medical doctor, and a psychiatrist. Clients with eating disorders require individualized approaches. Strategies we commonly use with other clients may be triggering for clients with eating disorders, so be really cognizant of that. If you don't feel comfortable with working with this client, or you feel you aren't the best fit, refer this person to someone who specializes in eating disorders.

Thank you so much for joining me today for this lesson. I cannot wait to see you in the next one.