358 Eating Disorders

Definition/Cut-off Value

Eating disorders are characterized by severe disturbances in a person's eating behaviors and related thoughts and emotions (1). Eating disorders include, but are not limited to:

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge-Eating Disorder (BED)

Presence of eating disorder diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Participant Category and Priority Level

Category	Priority
Pregnant Women	I
Breastfeeding Women	I
Non-Breastfeeding Women	III, IV, V or VI

Justification

Eating disorders are caused by a complex interaction of genetic, biological, behavioral, psychological, and social factors (1). They are extremely prevalent in the United States and associated with the highest morbidity and mortality of any mental illness (2, 3, 4).

Comorbidities that commonly occur with eating disorders include anxiety, bipolar disorder, depressive disorders, and substance use disorders (5). If left untreated, eating disorders can be serious and even fatal. Eating disorders are associated with an increased risk of premature death, including from electrolyte disturbances, dehydration, suicide, and alcoholism, among other causes (6). Total annual mortality attributable to eating disorders amounts to 10,200 deaths per year, equating to 1 death every 52 minutes (4).

It is estimated that around 9 percent, or 28.8 million Americans, will have an eating disorder in their lifetime (2, 3, 4). The three most common eating disorders are:

- Anorexia Nervosa (AN) – involves a severe restriction of calories; there may be a fear of weight gain and strict "rules" about eating. AN is a syndrome of self-starvation involving significant weight loss of 15 percent or more of ideal body weight (7).
- Bulimia Nervosa (BN) – involves recurrent episodes of binge eating followed by compensatory behaviors collectively referred to as purging and can include exercise as such a behavior. This could include vomiting or using laxatives or exercising excessively. Patients with BN are, by definition, at normal weight or above (7).
- Binge-Eating Disorder (BED) – involves recurrent episodes of binge eating which are characterized by eating an amount of food that is larger than what most people would eat in a similar period of time under similar circumstances and a sense of lack of control over eating

during the episode. Unlike BN, periods of binge-eating are not followed by purging or excessive exercise. As a result, people with binge-eating disorder often are overweight or obese. (5, 8).

In the U.S., BED is the most common type of eating disorder (9). Other less common types of eating disorders include Avoidant/Restrictive Food Intake Disorder and Rumination Disorder (5).

While stereotypically associated with thin, White, affluent females, eating disorders can affect individuals of all ages, races/ethnicities, body weights and genders. Frequently appearing during the teen years or young adulthood, eating disorders may also develop during childhood or later in life. While eating disorders affect both genders, prevalence is higher among women than men (1).

There is a lack of eating disorder research among low-income communities, making it difficult to determine the prevalence, severity, and types of eating disorder pathology among this population (10). However, existing research shows that food insecure adults often deliberately restrict food for reasons other than weight and shape concerns and that this dietary restraint is nonetheless correlated with increased eating disorder pathology (11). Research also supports the notion that increased levels of food insecurity are associated with increased levels of eating disorder pathology (10).

Complications of Eating Disorders during Pregnancy and Postpartum

Research suggests that up to 7.5 percent of pregnant women are affected by an eating disorder (12). It was once thought that pregnancy was rare among women with eating disorders due to associated menstrual dysfunction. Although having an eating disorder can decrease the likelihood of becoming pregnant, a growing body of evidence has confirmed that not only can pregnancy occur during an eating disorder but that it happens more commonly than previously thought (13, 14, 15, 16). Eating disorders have been linked to poor health outcomes for pregnant and postpartum women including depressive symptoms during pregnancy, postnatal depression, and poor infant attachment or maternal bonding (17, 18, 19, 20, 21).

Other misconceptions about eating disorders and pregnancy include the perception that pregnancy motivates eating disorder patients to stop their behaviors; that it will be obvious if a pregnant woman has an eating disorder because she won't gain enough weight; and that as long as weight gain is adequate then eating disorders will not affect the pregnancy or its outcomes (22). Pregnant women with eating disorders may have specific maternal macro- and micronutrient deficiencies (12). When energy and nutrient stores are low and not sufficiently restored through healthy eating, as in AN, the mother can become severely malnourished which can lead to depression, exhaustion, and many other serious health complications (23). Women with BN who continue to purge during pregnancy are at increased risk of dehydration, chemical imbalances, or even cardiac irregularities (23).

Some women experience an exacerbation of eating disorder symptoms during pregnancy including body image disturbances and abnormal stress from normal pregnancy weight gain whereas other women with eating disorders may experience relief from their symptoms during pregnancy. However, one of the most supported conclusions based on the research is that regardless of whether an eating disorder improves during pregnancy, eating disorder symptoms frequently relapse to their highest level almost immediately after delivery (22).

For women with eating disorders, pregnancies are often unplanned and eating disorder pathology has been associated with various perinatal risks such as delayed development, prematurity, hypotrophy, stillbirth, difficult delivery, and postnatal depression (24). The following table summarizes the health outcomes for both the woman and infant that may result from an eating disorder.

Possible Health Outcomes for Women and Infants by Eating Disorder (17, 25, 26, 27, 28, 29, 30, 31, 32, 33)

	Anorexia Nervosa	Bulimia Nervosa	Binge-Eating Disorder*
Health Outcomes for Woman	• Higher risk of cesarean delivery • Hyperemesis • Higher risk of anemia • Antepartum hemorrhage† • Hypertension • Stillbirth • Miscarriage • Malnutrition • Electrolyte imbalance • Fluid imbalance • Bone loss • Changes in brain function	• Higher risk of cesarean delivery • Hyperemesis • Stillbirth • Miscarriage • Malnutrition • Electrolyte imbalance • Fluid imbalance • Postpartum depression • Wearing down of tooth enamel • Heart problems	• Higher risk of cesarean delivery • Gestational hypertension • Gestational diabetes • Bone loss • Heart attack • Stroke • Arthritis • High cholesterol • Miscarriage • Delivery complications • Postpartum depression
Health Outcomes for Infant	• Underweight • Low birthweight • Small-for-gestational-age • Slow fetal growth • Intrauterine growth restriction • Preterm birth • Microcephaly • Perinatal death	• Dehydration • Chemical imbalance • Cardiac irregularities • Microcephaly • Preterm birth • Low birthweight	• Large-for-gestational-age

*Added as a diagnosis to the DSM-5 in 2013, there is limited research on the health outcomes of BED for both the woman and infant.
† Bleeding from the genital tract in the second half of pregnancy (34)

Complications of Eating Disorders while Breastfeeding

Research is inconclusive as to whether eating disorders affect breastfeeding rates. Some research shows that women with a history of eating disorders may be slightly less likely to initiate breastfeeding, whereas other research shows no difference in initiation and cessation of breastfeeding between mothers with and without eating disorders (35, 36, 37). Although there is limited research on the impact of eating disorders on breastfeeding rates, returning to eating disorder behaviors in the postpartum period may result in a shorter duration of breastfeeding and may impact the interaction a mother has with her infant as well as her relationship with her partner (21, 38, 39).

Diagnosis and Treatment

The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-5) outlines the diagnostic criteria that must be met to diagnose an eating disorder (5). A person with an eating disorder may display one symptom or many, and a person's appearance may not always display the amount

of physical or emotional danger they are experiencing. Someone that appears to be a "healthy weight" can have an eating disorder and need treatment (40). Although there are formal guidelines that professionals use to diagnose eating disorders, as specified in the DSM-5, unhealthy eating behaviors exist on a continuum and the severity of individual criteria are considered in making a diagnosis.

There is no standardized screening for eating disorders during pregnancy and it is uncommon for a medical practitioner to screen pregnant patients for disordered eating symptoms (16, 40, 41, 42, 43). Women are often reluctant to inform medical staff of their struggle with eating disorders, likely the result of anxiety and guilt about harming the fetus (44, 45). Lack of screening and diagnosis has the potential to increase adverse health outcomes for women who do not receive treatment or assistance to address the eating behavior symptoms and/or pathology (46).

Treatment of eating disorders depends on the disorder and symptoms displayed, but typically involves psychological therapy, also known as psychotherapy (47). Depending on the severity of eating disorder symptoms, admission to a specialized residential or hospital-based treatment program can be lifesaving (48). Treatment plans are tailored to the individual's needs, should involve a multidisciplinary team such as a therapist, dietitian, and physician, and may include one or more of the following (1, 49):

- Individual, group, and/or family psychotherapy
- Medical care and monitoring
- Nutritional counseling
- Medications

Additionally, obtaining adequate health insurance coverage for inpatient treatment of eating disorders remains a challenge as one major issue plaguing discussions with insurers regarding reimbursement for the treatment of eating disorders is the apparent gap between research on variables associated with outcomes and the formulas used for reimbursement (50).

Implications for WIC Nutrition Services

The role of WIC is not to diagnose or treat an eating disorder but rather to reinforce and support the medical nutrition therapy that the WIC participant is receiving.

Discussing eating disorders, body weight, weight loss, or weight gain can trigger behaviors associated with eating disorders. Therefore, it is important for WIC staff to be sensitive when discussing eating disorders.

For individuals affected by an eating disorder, staff can (5, 25, 37):

- If available, refer the participant to a health care provider (HCP) with expertise in eating disorders. The participant can work with the provider to create a plan for healthy eating and weight gain.
- Reinforce nutrition counseling/advice that is provided by the eating disorder treatment team/plan.
- Encourage the participant to be honest with their HCP and WIC staff regarding past or present struggles with an eating disorder or disordered eating.
- Encourage the participant to seek or refer the participant to individual counseling and/or support groups during and after pregnancy to help them cope with their concerns and fears regarding food, weight gain, body image, and the new role of parenting.

- Encourage the participant to attend other classes on pregnancy, childbirth, child development, and parenting skills.
- Educate participants that it is important for their prenatal HCP to weigh them as this information is essential to tracking the health of baby.
- When possible, the CPA should coordinate with the participant's HCP to obtain referral data such as height, weight gain, etc. Additionally, encourage the participant to discuss with their HCP about blind weighing (36). If necessary, they can ask their doctor about standing on the scale backwards and instruct them not to share the number with them.
- Encourage the participant to talk to their HCP before attending a prenatal exercise class to make sure it fits with their recovery plan.
- Modify conversation with the participant to avoid topics that are likely to provoke eating disordered behaviors (e.g., topics related to body weight, body shape, and calories).

Clarification

Self-reporting of a diagnosis made by a medical professional should not be confused with self-diagnosis, where a person claims to have or to have had a medical condition without reference to a professional diagnosis. A self-reported medical diagnosis ("My doctor says that I have/my son or daughter has…") should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis. Although a self-diagnosis should not be used to assign risk, it should prompt the CPA to make a referral to a healthcare professional for diagnosis and treatment, as appropriate.

An eating disorder is diagnosed based on an individual's symptoms and experiences aligned with criteria defined by the American Psychiatric Association. The term disordered eating is a descriptive phase, not a diagnosis as defined by the American Psychiatric Association. It is possible to have disordered eating patterns that do not fit within the current confines of an eating disorder diagnosis (51). See risk #427-Inappropriate Nutrition Practices for Women to learn more about disordered eating.

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