Detecting Eating Disorders: Where Medical and Mental Health Converge

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Eating Disorders are a group of mental illnesses resulting in significant medical comorbidities. The type of foods and how they are consumed by patients leads to physical consequences directly correlating with the patient's mental health. The interdependency of physical and mental manifestations of these disorders has led to the American Psychiatric Association guidelines for a multidisciplinary treatment team. This mandated team includes physicians, dietitians, and mental health specialists: both psychiatrists and eating disorder certified therapists.

Eating disorders are difficult to detect both medically and psychologically. Cultural norms, personal bias, and lack of eating disorder training have led to these disorders being overlooked or misdiagnosed. The four main diagnoses for eating disorders are: Anorexia Nervosa with subtypes: Restricting Type or Binge-Eating/Purging Type; Bulimia Nervosa; Binge-eating disorder (BED) and Avoidant Restrictive Food Intake Disorder (ARFID). Atypical anorexia is a person in a larger body who has the thoughts and behaviors of anorexia even though their body doesn't represent emaciation. Clinically, these disorders overlap. They each include restrictive intake behaviors, excessive or obsessive movement or avoidance of movement. An eating disorder cannot be diagnosed based on appearance. Any of the eating disorders may present with any body size. It is important to note that these diagnoses are based on behaviors, not BMI or weight.

The prevalence of eating disorders has increased over the past decade and particularly during the COVID-19 quarantine. Diets, exercise, weight-loss regimes, and medications became daily social media, wellness, and healthcare discussions. The diet industry and messages to diet for "health" or "wellness" have normalized restrictive eating behaviors. "Eating in balance" is no longer recommended in health classes or physician offices. Society correlates a person's weight status with their health status. Weight loss medications are often overprescribed or misused by patients with undisclosed eating disorders. Up to 30 percent of patients seeking weight loss medications have an underlying eating disorder. The recent overwhelming influx of new and more effective weight loss medications is resulting in the exacerbation of eating disorders.

Physicians are often primary in the diagnosis of an eating disorder. It is imperative that all providers have a heightened awareness of the nuances of an eating disorder to make a timely diagnosis. Open lines of communication between mental health providers and a patient's primary care physician should become routine. This would enhance clinical outcomes in all patients with psychological and medical diagnoses as both providers could collaborate care and information leading to a unified diagnosis. In addition to the multitude of medical complications from eating disorders such as cardiac insufficiency, liver, kidney, and bone disease, the mental health consequences of eating disorders are the most impactful and devastating. Common co-occurring disorders include obsessive compulsive disorder, major depressive disorder, substance use disorder, post-traumatic stress disorder, and borderline personality disorder. Anorexic and bulimic patients are 7-18 times more likely to COMPLETE suicide. All eating disorder patients are 33% more likely to have suicidality. These patients are deeply suffering.

Each eating disorder has specific characteristics. Anorexic patients typically have underlying thoughts and emotions based on the irratational fear about becoming fat or unhealthy. In Bulimia, the underlying thoughts and emotions are about maintaining one's current body size with restricting behaviors, then

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bingeing followed by compensatory behaviors of purging. The person believes that purging behaviors maintain their body size. The abrupt cessation of purging without treatment results in undereating to avoid feeling full. Fullness is the trigger for purging behaviors. In BED, the underlying thoughts and emotions are striving for weight loss with restrictive behaviors. The consequential physical hunger leads to over consumption and intense anxiety over what was ingested. They cope with this anxiety by binge eating. ARFID patients have underlying thoughts and emotions about the textures, smells or taste of foods. They may present with a sudden onset of traumatic weight loss, often secondary to a choking experience or heightened anxiety from traumatic experiences such as a death or accident.

Physicians should note that the thoughts and emotions underlying eating disordered behaviors are illogical, reactive and impulsive. Eating disorders are progressive and the thoughts that might have been rational initially such as: "I want to get in shape" or "lower my cholesterol" often worsen and lead to physically unhealthy behaviors of eating and movement. Before telling the thin patient that they look "healthy", complimenting there new exercise plan for 2025, or remarking that another's hypertension would improve with weight loss, take a moment to ask everyone about their eating patterns. Most eating disorder patients are secretive or ashamed. They are not likely to disclose their eating disordered behaviors. They will take your advice and walk out the door to binge, purge, restrict and overeat until the only thing they think about is food and their reactions to it.

The thoughts and obsessions of an eating disorder are all consuming for these patients. They may present to the primary care clinic making comments about the scale "being off," wanting to lose weight, to "be healthy," or concerned about being "too thin" in the case of the patient with ARFID. It is important to hear their cues and ask the right questions. Ask your patients how they are eating rather than assuming what their diet consists of based on their weight. Never suggest that someone restrict whole food groups for weight loss. Patients of all body types often present with their eating disorder stating that they have been informed by a physician to lose weight without further guidance. A clinical interview assessing the thoughts and emotions behind the food, eating, and exercise habits is what is recommended. When interviewing patients listen for eating disorder clues: are they making weight and diet comments? Is there a family history? (eating disorders are highly heritable). Is there early osteoporosis in their mother, grandmother, and great aunts? Don't forget a social history. An eating disorder brings control to a chaotic or traumatic life.

Changing one's eating behaviors is NOT about willpower or intellectual ability. An eating disorder is NOT an addiction. An eating disorder is complex, and all aspects must be addressed for a patient to recover. In addition to the multidisciplinary approach, the specific, third wave of Cognitive Behavioral Therapies (CBT) have been researched to be effective for eating disorders. These evidence-based CBT therapies are techniques to move eating disordered thoughts from being ego-syntonic to ego-dystonic. These therapies are used in conjunction with specific nutritional guidelines and therapies under the medical guidance of a physician to bring complete healing and recovery to this special population of patients. Treatment is successful when a person learns to use new coping skills and coping behaviors for emotions and thoughts that are more effective than coping with food and movement behaviors.

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