ISSUES WITH BODY IMAGE, EATING DISORDERS AND DECISION-MAKING

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OBJECTIVES

• Recognize the frequency of co-morbid eating disorders in obese adolescents
• Basic precepts of obesity management as related to eating disorder development
• Recognize the role of body dissatisfaction in obesity and eating disorder development
**DSM-V AND EATING DISORDERS**

- Better recognition of EDs/FDs as spectrum
  - Anorexia nervosa
  - Bulimia nervosa
  - Binge-eating disorder
  - Avoidant/restrictive food intake disorder
  - Other specified ED/FD
    - Atypical anorexia nervosa
    - Bulimia (low/limited)
    - Binge-eating low/limited
    - Purging disorder

**OBESITY AND EATING DISORDERS**

- Rising comorbidity
  - From 1995-2015
    - Obesity w/binge-eating: ↑7.3x
    - Obesity w/strict dieting or fasting: ↑11.5x
    - Obesity w/purging: no change

**OBESITY AND EATING DISORDERS**

- Rising comorbidity
  - Risk factors
    - Dieting
    - Depression
    - Weight/shape preoccupation
    - Perfectionism
      - Socially prescribed
      - Self-oriented

**BINGE EATING**

- DSM V definition:
  - Large quantity of food over discrete time period
  - Sense of loss of control during episode
  - Binge eating episodes with 3 or more:
    - Rapid eating
    - Uncomfortably full
    - Large amounts of food when not hungry
    - Secretive eating/eating alone
    - Followed by disgust/depressed/very guilty
**BINGE EATING**

- DSM V definition:
  - Marked distress regarding eating episodes
  - At least weekly x 3 months on average
  - No compensatory behavior and not associated with other eating disorders

- Ask about “loss of control” during eating
- Treatment is multi-faceted
  - CBT
    - Family-based therapy
  - Consider SSRI
- Multiple resources on-line
  - Eating Disorders Association of Maine
  - maineeatingdisorders.org

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**ISSUE AT HAND**

“How do I encourage obese/overweight patients to pursue healthier weight without further increasing eating disorder risk?”

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**CLINICAL REPORT**

Guidelines for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

Dedicated to the Health of All Children

Preventing Obesity and Eating Disorders in Adolescents

Nevada, M.D., AAP; Monica Schneider, M.S., AAP; Dominick Wood, M.D., AAP

COMMITTEE ON NUTRITION, COMMITTEE ON ADOLESCENCE, SECTION ON OBESITY
KEY FACTORS TO ADDRESS

• Dieting
• Weight talk
• Weight teasing
• Family meals
• Body dissatisfaction

“I NEED TO GO ON A DIET”

PATTERNS IN MAINE YOUTH

• 2007 Youth Risk Behavior Survey
  – 46% students trying to lose weight
    • 64% high school girls trying to lose weight
  – 4x as many girls believed they were overweight than actually were
  – Weight loss strategies included:
    • 10% fasting
    • 6% vomiting
    • 5% diet pills

DIETING

• Project EAT study
  – Prospective/epidemiological study
  – 4746 middle- and high school students
    • Ethnic and economic diversity
    • Minneapolis/St. Paul
  • Dieters after 5 years and controlled for baseline weight
    – 2x inc. risk for overweight/obesity
    – 1.5x inc. risk for binge eating
DIETING

• Prospective cohort 14 and 15 yo
  – Dieting most important risk factor for eating d/o
    • “Severe” dieting
      – 12 months: 1 in 5 with new onset eating d/o
    • “Moderate” dieting
      – 12 months: 1 in 40 with new onset eating d/o
    • No dieting
      – 12 months: <1 in 500 with new onset eating d/o


BEST PRACTICE

• Family involvement in healthy lifestyle choices
  – Lifestyle modification
  – Supportive food environment
    • Family meals
    • Home-cooked meals
    • Less distracted meals
  – Decrease sedentary
  – Increase physical activity

WEIGHT TALK

“SHE’S GETTING A LITTLE CHUNKY”

• Comments made by family members about
  – Patient weight
  – Own weight
  – Other people’s weight
• Linked to higher rates of
  – Overweight
  – Eating disorders/disordered eating
WEIGHT TEASING

• Overweight adolescents experience weight teasing by family or peers
  – Females:
    • 40% early adolescent
    • 28% middle adolescent
  – Males:
    • 37% early adolescent
    • 29% middle adolescent

WEIGHT TEASING

• Weight teasing by family members predicts
  – Girls
    • Overweight
    – Doubles risk over 5 years
    • Binge eating
    • Extreme weight control behaviors
  – Boys
    • Overweight

BEST PRACTICE

• Educate families about impact of weight talk
  – Often done with good intention
• Families should limit discussions about weight and dieting
  – Patient
  – Others

BEST PRACTICE

• Avoid comments about weight
  – Patient
  – Others
• Conversation needs focus on health/healthy habits
  – BMI/weight is a proxy for health
• Inquire about mistreatment or bullying
“TIME FOR SUPPER”

FAMILY MEALS

- Improves dietary intake
  - Models healthier food choice
  - Parent-child interaction
  - Parental monitoring of eating behavior
- Protective against eating disorders

FAMILY MEALS

- Not all families are created equal
  - Project EAT examined family variables and relationship of family meals to disordered eating
    - Most family meals are protective
    - But there are exceptions....

FAMILY MEALS: MITIGATING FACTORS

- Boys
  - Pressure-to-eat
  - Low enjoyment of family meals
- Girls
  - Family weight-teasing
  - High levels of weight talk
  - Poor overall family function

**BEST PRACTICE**

- Higher frequency = higher protection
  - Aim for “most days” of the week
- Home-cooked is ideal
- Role model appropriate portion size
- Monitor content of conversation
- Toxic family environment decreases the benefit

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“I HATE THE WAY I LOOK”

**BODY DISSATISFACTION**

- High rates in teens overall
  - ~50% girls
  - ~25% boys
- Even higher in overweight teens
- Risk factor for
  - Eating d/o
  - Reduced physical activity (girls)

**BODY DISSATISFACTION**

- Obesity onset <16 yo correlates with
  - Greater body dissatisfaction
    - Regardless of current BMI
    - Lower self-esteem
    - Higher BMI

BODY DISSATISFACTION

- Comparison obese vs non-obese
  - Body dissatisfaction and self-esteem lower in girls than boys
  - Obese than normal weight
  - Depression higher in obese males than nl weight
  - No difference between obese and nl weight females


BODY DISSATISFACTION

- Psychological effects of obesity when effects of body dissatisfaction mediated:
  - No apparent difference between obese and non-obese
    - Self-esteem
    - Male and female
  - Depression
    - Male


BODY DISSATISFACTION

- Body shame appears to be a dominant factor in both obese and non-obese high school students
  - Vulnerability to disordered eating
  - Mediates relationship between low-self esteem and eating disorder risk


BODY SIZE ATTITUDES

- Attitudes toward body sizes are shaped by parental traits
  - Boys are particularly impacted by father’s attitudes and behaviors
  - Girls are impacted by mother’s attitudes and behaviors
    - Particularly dietary restraint
BEST PRACTICE

• Do not leverage body dissatisfaction as motivator
• Prevention is far and away the best option
  – As early as possible
  – Before mid-adolescence
• Many programs available for schools, teams, other social groups
• Cognitive behavioral therapy seems best option for individuals
• Aware impact of parental attitude and behavior

TAKE HOME MESSAGES

• Consider pre-existing eating disorders in overweight/obese patients
• Encourage healthy lifestyle
• Family meals: more = better (usually)
• Encourage healthy lifestyle
• Avoid “weight talk”
• Encourage healthy lifestyle
• Don’t use body dissatisfaction as weight loss motivator

And don’t forget…. healthy lifestyle

THANK YOU