Eating Disorders: Beyond the Stereotypes

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Disclosures

None

Learning Objectives

1

Recognize
the diversity of individuals affected by eating disorders.

2

Discuss
the current state of the science on diverse eating disorder presentations.

3

Integrate
culturally responsive and inclusive strategies into the assessment and treatment of eating disorders

Training Background

The Audience

Institution, organization, or practice setting
Role or position
Reason for attending this presentation

The Current Landscape

Eating disorders are prevalent, debilitating and life-threatening mental illnesses

Pediatric hospitalizations for eating disorders have **increased 139%** since 2002

The economic cost of eating disorders is estimated to be **$64.7 billion** annually

An estimated **10,200 deaths** occur annually in the US due to eating disorders

Eating Disorders by the Numbers

28.8 M

Americans will experience an eating disorder in their lifetime

16%

of ER patients screened positive for an eating disorder

1 in 5

females will experience an eating disorder before the age 40

Eating Disorders

Anorexia Nervosa

- Restriction of energy intake leading to significantly low body weight
- Intense fear of weight gain or becoming fat
- Overvaluation of shape and weight

Bulimia Nervosa

- Recurrent episodes of binge eating
- Recurrent inappropriate compensatory behaviors
- Overvaluation of shape and weight

Binge Eating Disorder

- Recurrent episodes of binge eating
- Binge eating episodes are associated with 3 or more additional features
- Marked distress regarding binge eating

Other specified feeding and eating disorder

Unspecified feeding and eating disorder

Activities

Visual settings

Edit

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When you hear 'eating disorder,' what assumptions or images come to mind?

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Who is Affected by Eating Disorders?

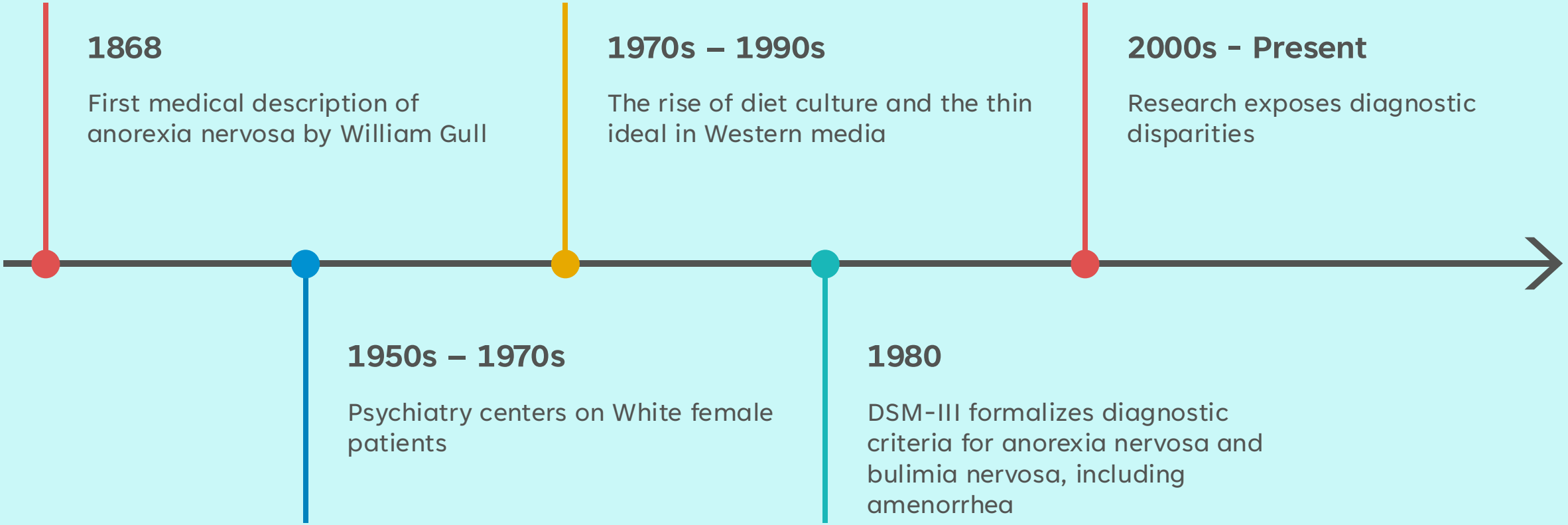
Skinny

White

Affluent

Girl

How Did We Get Here?



The stereotype did not emerge by accident – it was built into how we defined, studied, and represented eating disorders.

Why Does It Matter?

It shapes who gets diagnosed, who gets treated, and whose suffering is taken seriously

Patients who used public insurance were only one third as likely to receive the recommended mental health treatment for their ED as youth with private insurance

Patients meeting the standard diagnostic criteria for anorexia were 14 times more likely to receive the recommended treatment than those with atypical anorexia

When therapists were presented with descriptions of a fictional patient—identical except for race—they were less likely to recognize ED symptoms in the Black and Hispanic patient compared to the White patient

Intersectionality Matters

Weight

MYTH

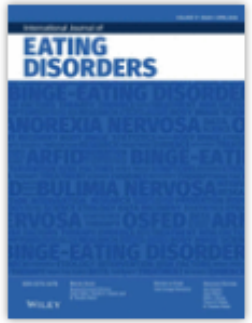
- Eating disorders = visibly underweight
- Easy to ”see” who is struggling
- Higher-weight individuals are at lower risk for eating disorders

REALITY

- Eating disorders occur across all body sizes
- Many individuals in larger bodies meet full criteria for eating disorders
- Atypical anorexia nervosa = same behaviors and severity without low weight
- Weight stigma can worsen symptoms and delay care

Weight is not an accurate predictor of who will develop an eating disorder.

Atypical Anorexia Nervosa



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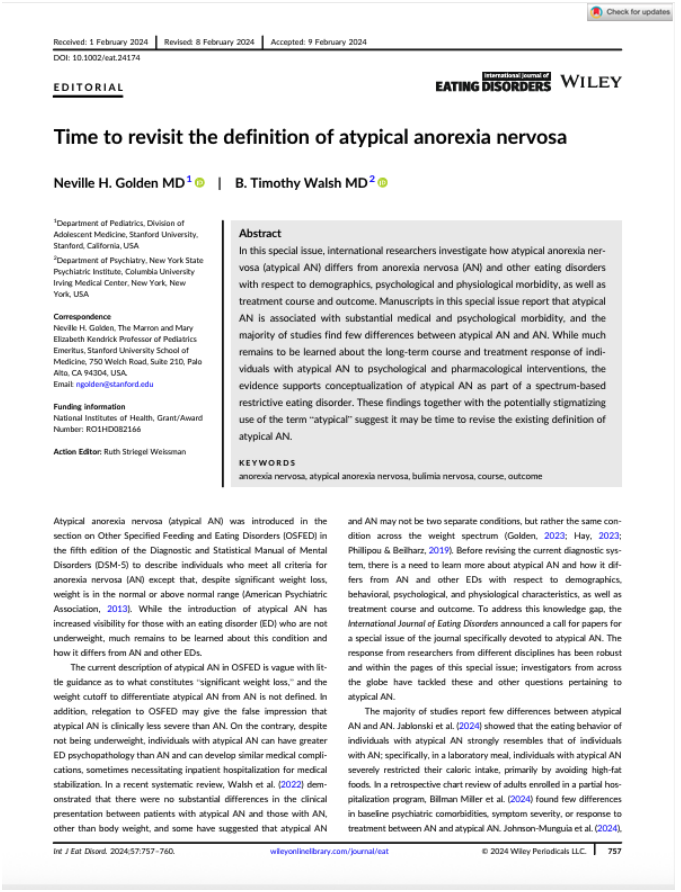

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EDITORIAL

EATING DISORDERS WILEY

Time to revisit the definition of atypical anorexia nervosa

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Abstract

In this special issue, international researchers investigate how atypical anorexia nervosa (atypical AN) differs from anorexia nervosa (AN) and other eating disorders with respect to demographics, psychological and physiological morbidity, as well as treatment course and outcome. Manuscripts in this special issue report that atypical AN is associated with substantial medical and psychological morbidity, and the majority of studies find few differences between atypical AN and AN. While much remains to be learned about the long-term course and treatment response of individuals with atypical AN to psychological and pharmacological interventions, the evidence supports conceptualization of atypical AN as part of a spectrum-based restrictive eating disorder. These findings together with the potentially stigmatizing use of the term "atypical" suggest it may be time to revise the existing definition of atypical AN.

KEYWORDS

anorexia nervosa, atypical anorexia nervosa, bulimia nervosa, course, outcome

Atypical anorexia nervosa (atypical AN) was introduced in the section on Other Specified Feeding and Eating Disorders (OSFED) in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to describe individuals who meet all criteria for anorexia nervosa (AN) except that, despite significant weight loss, weight is in the normal or above normal range (American Psychiatric Association, 2013). While the introduction of atypical AN has increased visibility for those with an eating disorder (ED) who are not underweight, much remains to be learned about this condition and how it differs from AN and other EDs.

The current description of atypical AN in OSFED is vague with little guidance as to what constitutes "significant weight loss," and the weight cutoff to differentiate atypical AN from AN is not defined. In addition, relegation to OSFED may give the false impression that atypical AN is clinically less severe than AN. On the contrary, despite not being underweight, individuals with atypical AN can have greater ED psychopathology than AN and can develop similar medical complications, sometimes necessitating inpatient hospitalization for medical stabilization. In a recent systematic review, Walsh et al. (2022) demonstrated that there were no substantial differences in the clinical presentation between patients with atypical AN and those with AN, other than body weight, and some have suggested that atypical AN and AN may not be two separate conditions, but rather the same condition across the weight spectrum (Golden, 2023; Hay, 2023; Phillipou & Beilharz, 2019). Before revising the current diagnostic system, there is a need to learn more about atypical AN and how it differs from AN and other EDs with respect to demographics, behavioral, psychological, and physiological characteristics, as well as treatment course and outcome. To address this knowledge gap, the *International Journal of Eating Disorders* announced a call for papers for a special issue of the journal specifically devoted to atypical AN. The response from researchers from different disciplines has been robust and within the pages of this special issue; investigators from across the globe have tackled these and other questions pertaining to atypical AN.

The majority of studies report few differences between atypical AN and AN. Jablonski et al. (2024) showed that the eating behavior of individuals with atypical AN strongly resembles that of individuals with AN; specifically, in a laboratory meal, individuals with atypical AN severely restricted their caloric intake, primarily by avoiding high-fat foods. In a retrospective chart review of adults enrolled in a partial hospitalization program, Billman Miller et al. (2024) found few differences in baseline psychiatric comorbidities, symptom severity, or response to treatment between AN and atypical AN. Johnson-Munguia et al. (2024),

Race and Ethnicity

MYTH

- Eating disorders are a “White problem”
- Eating disorders are rare in BIPOC populations
- Less screening is needed

REALITY

- Eating disorders affect people of all racial and ethnic backgrounds and prevalence is comparable across groups in many studies
- BIPOC are less likely to be diagnoses and to receive treatment
- Clinician bias and systemic barriers contribute to under-recognition
- Cultural stigma can delay help-seeking

Race and ethnicity do not protect against eating disorders, but they do impact who gets recognized and treated.

Socioeconomic Status

MYTH

- Eating disorders mainly affect wealthy individuals
- Less common in lower-income communities
- Lower finances = lower risk

REALITY

- Eating disorders occur across all socioeconomic levels
- Food insecurity and financial strain can increase risk for eating disorders
- Financial barriers can limit access to care
- Stereotypes lead clinicians to under-screen in lower SES populations

Socioeconomic status does not determine who develops an eating disorder, but it can strongly shape diagnosis and treatment.

Gender

MYTH

- Eating disorders are a “female issue”
- Eating disorders are rare in males
- Less relevant for LGBTQIA populations
- Symptoms look the same across genders

REALITY

- Eating disorders affect people of all gender identities
- Males represent a significant and underrecognized portion of cases
- LGBTQIA individuals experience elevated risk
- Gender norms and stigma contribute to delayed help-seeking

When we conceptualize eating disorders as ‘female’, we overlook the unique risk factors and presentations affecting males and LGBTQIA individuals.

Activities

Visual settings

Edit

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What other subgroups are you interested in learning more about?

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Other Groups

Neurodiverse

Pregnancy

Disability Status

Veterans and Service Members

Older Adults

Dual Diagnosis

10 minute Break

Learning Objectives

1

Recognize
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Integrate
culturally responsive and inclusive strategies into the assessment and treatment of eating disorders

You get a screen, and you get a screen, and you get a screen.

Everyone gets a screen!

Screening Tools

Screener Name	# of Questions	Validated Age	Diagnoses
Eating Disorder Examination Questionnaire (EDE-Q)	28	14 +	AN, BN, BED
Eating Disorder Examination Questionnaire Parent Version (EDE-Q-PV)	28	7 +	AN, BN, BED
Eating Disorder Examination Questionnaire Short Version (EDE-Q-S)	12	14 +	AN, BN, BED, OSFED
Stanford-Washington University Eating Disorder screen (SWED)	11	18-25	AN, BN, BED, OSFED
SCOFF	5	18-40	AN, BN
Nine Item ARFID Screen (NIAS)	9	10-76	ARFID
Pica, ARFID, Rumination Disorder Interview, ARFID Questionnaire (PARDI-AR-Q)	32	4 +	ARFID

EDE-Q

Questionnaire about eating disorder behaviors and cognitions over the past 28 days.

Scoring: Global score and four subscale scores (eating concerns, weight concerns, shape concerns, and restraint).

Global scores > 2.3 indicate probably eating disorder or any positive report of eating disorder behaviors.

Strengths: Well validated, can be used with ages 14 +, includes behavioral frequency items

Limitations: Lengthy, does not include ARFID symptoms, lack of agreement on clinical cutoff across studies, variable psychometric performance across subgroups

EDE-Q Variations

Parent Version (EDE-Q-PV)
Modified for parents/caregivers to complete about their children.

Scoring: Same as EDE-Q.

Strengths: Maintains validity of full questionnaire.

Limitations: Lengthy, does not include ARFID symptoms, limited validation compared to standard version.

Short Version(EDE-Q-S)
12-item shortened version that measures symptoms within past 7 days.

Scoring: Scores > 15 or any positive report of eating disorder behaviors.

Strengths: Brief, developed based on validated measure

Limitations: Does not include ARFID symptoms, limited validation compared to standard version.

SCOFF

5-item survey addressing core features of anorexia nervosa and bulimia nervosa

Scoring: A “yes” to two or more items indicates need for further assessment

Strengths: Brief and easy to score, well-validated, high specificity

Limitations: Less accurate for BED, ARFID, and OSFED, not for use in pediatric populations

S	Do you make yourself sick because you feel uncomfortably full?
C	Do you worry you have lost control over how much you eat?
O	Have you recently lost more than one stone in a three-month period?
F	Do you believe yourself to be fat when others say you are too thin?
F	Would you say food dominates your life?

Clinical Interviews

Screener Name	Administration Time	Validated Age	Diagnoses
Eating Disorder Examination	60-90 min	14 +	AN, BN, BED, OSFED
Mini International Neuropsychiatric Interview (MINI)	20-60 min	6 +	AN, BN, BED
Structured Clinical Interview for DSM-5 (SCID-5)	30-120 min	18 +	AN, BN, BED

Eating Disorder Examination

Interview about eating disorder behaviors and cognitions over the past 28 days.

Scoring: Same as EDE-Q.

Strengths: Well validated, can be used with ages 14 +, includes behavioral frequency items

Limitations: Does not assess ARFID, lengthy, requires training prior to administration, variable psychometric performance across subgroups

Dietary Restraint: restraint overeating, avoidance of eating, food avoidance, dietary rules, empty stomach

Eating Concern: preoccupation with eating fear of losing control, eating in secret, social eating, guilt about eating

Shape Concern: flat stomach, preoccupation with shape or weight, importance of shape, fear of weight gain, dissatisfaction with shape, discomfort seeing body, avoidance of exposure, feeling fat

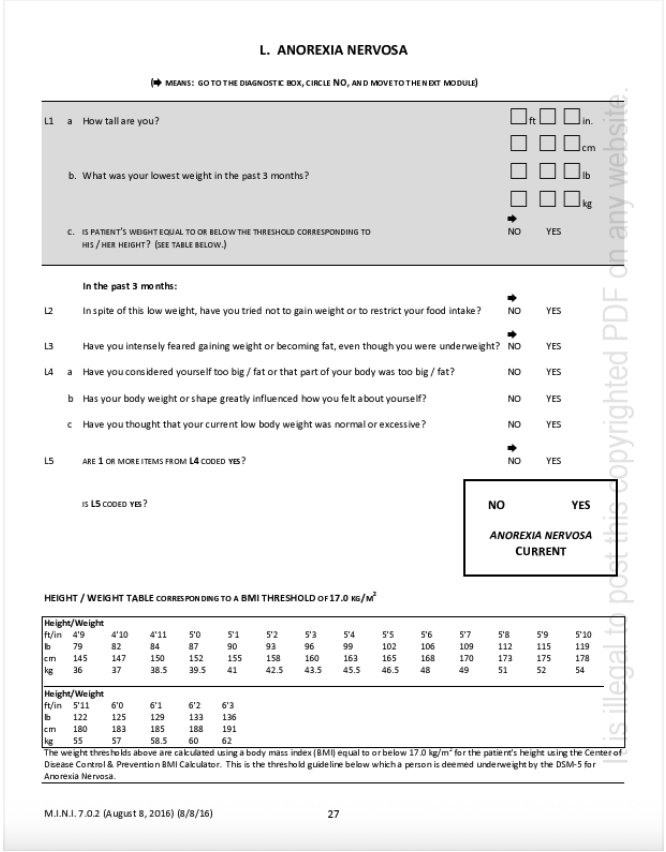
Weight Concern: importance of weight, reaction to prescribed weighing, preoccupation with shape or weight, dissatisfaction with weight, desire to lose weight

MINI

Semi-structured interview guide for major DSM-5 diagnoses, including AN, BN, and BED.

Strengths: Can be used with ages 6 +, quick

Limitations: Does not assess ARFID or OSFED, requires training prior to administration



L. ANOREXIA NERVOSA

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

L1 a How tall are you? ☐ft ☐☐in. / ☐☐☐cm

b. What was your lowest weight in the past 3 months? ☐☐☐lb / ☐☐☐kg

c. IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW.) ➡ NO YES

In the past 3 months:

L2 In spite of this low weight, have you tried not to gain weight or to restrict your food intake? ➡ NO YES

L3 Have you intensely feared gaining weight or becoming fat, even though you were underweight? ➡ NO YES

L4 a Have you considered yourself too big / fat or that part of your body was too big / fat? NO YES

b Has your body weight or shape greatly influenced how you felt about yourself? NO YES

c Have you thought that your current low body weight was normal or excessive? NO YES

L5 ARE 1 OR MORE ITEMS FROM L4 CODED YES? ➡ NO YES

IS L5 CODED YES?

NO	YES
	ANOREXIA NERVOSA CURRENT

HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.0 KG/M²

Height/Weight															
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lb	79	82	84	87	90	93	96	99	102	106	109	112	115	119
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kg	36	37	38.5	39.5	41	42.5	43.5	45.5	46.5	48	49	51	52	54

Height/Weight					
ft/in	5'11	6'0	6'1	6'2	6'3
lb	122	125	129	133	136
cm	180	183	185	188	191
kg	55	57	58.5	60	62

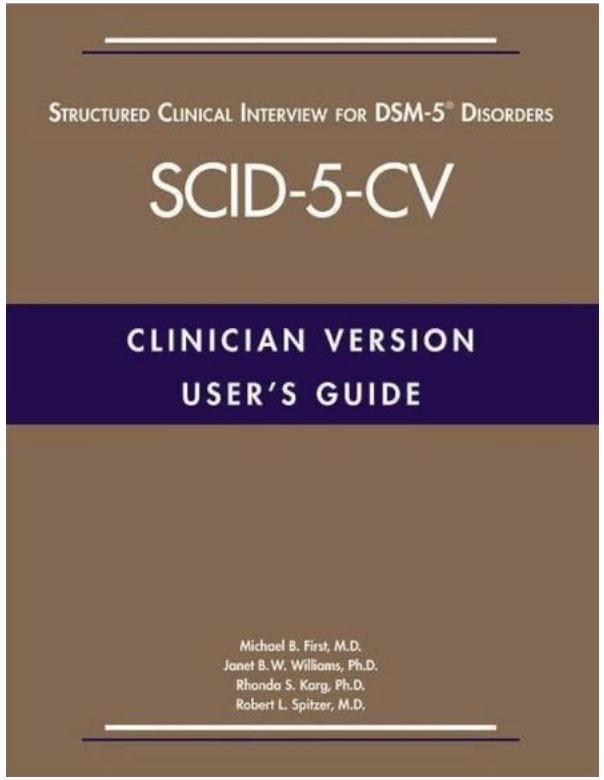
The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.0 kg/m² for the patient's height using the Center of Disease Control & Prevention BMI Calculator. This is the threshold guideline below which a person is deemed underweight by the DSM-5 for Anorexia Nervosa.

SCID

Semi-structured interview guide for major DSM-5 diagnoses, including AN, BN, and BED.

Strengths: Well validated, has a training manual

Limitations: Does not assess ARFID or OSFED, cannot be used with children, expensive, full ED module only contained in research version



Considerations for Use with Specific Subgroups

Males

- Lack of assessment of muscle-enhancing behaviors
- Lack of guidelines for objectively large eating episodes
- Impact of stigma and traditional masculine norms

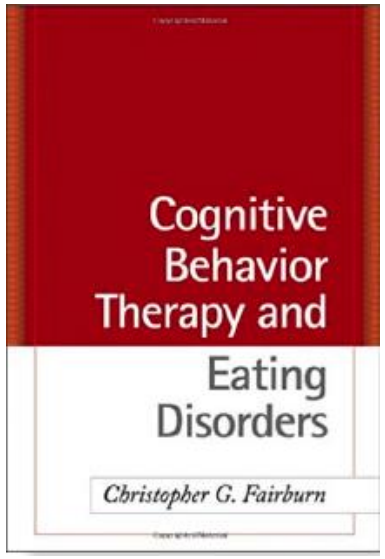
Marginalized Racial/Ethnic Groups

- Impact of culture-specific body image ideals
- Role of acculturation

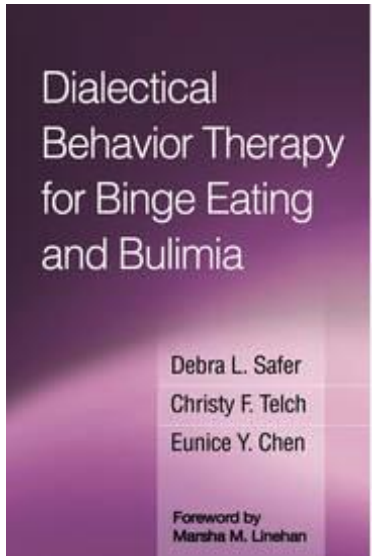
Sexual and Gender Minorities

- Impact of gender-specific body image ideals
- Impact of gender dysphoria

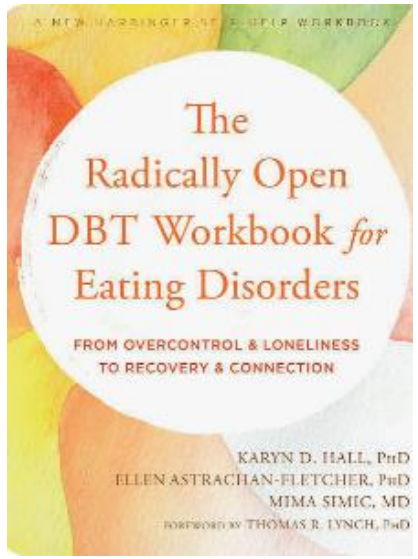
Treatment Models



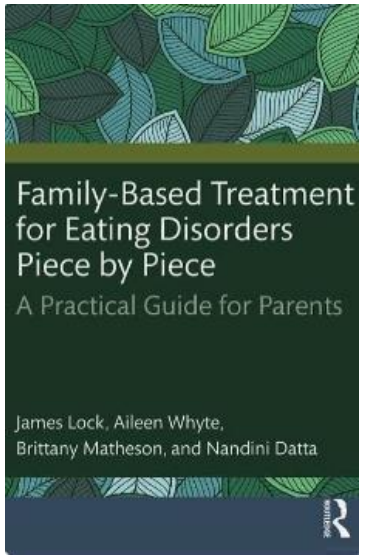
CBT-E



DBT

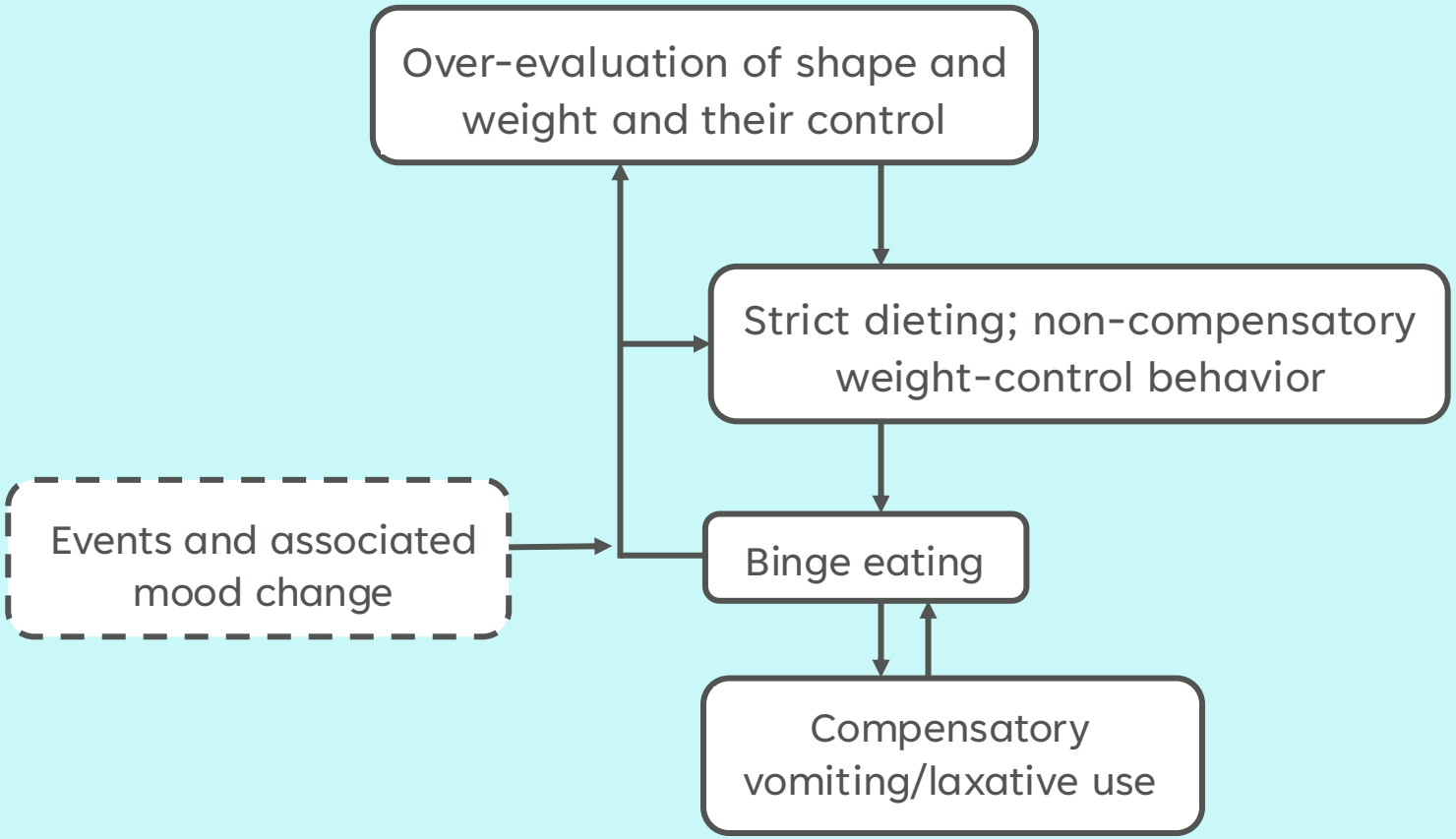


RO DBT



FBT

CBT-E Transdiagnostic Model



Case Example

- 40 year old Hispanic, cisgendered, heterosexual male
- Lower socioeconomic status and experiencing food insecurity
- Able-bodied and working in deliveries for major company
- Diagnoses of MDD, GAD, and BED

A: Age and generational influences

D: Developmental and acquired disabilities

R: Religion and spiritual beliefs

E: Ethnicity and race

S: Socioeconomic status

S: Sexual orientation

I: Indigenous heritage

N: National origin and language

G: Gender

Activities

Visual settings

Edit

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How might you adapt existing evidence-based treatments to be patient-centered and tailored to this patient?

SEE MORE

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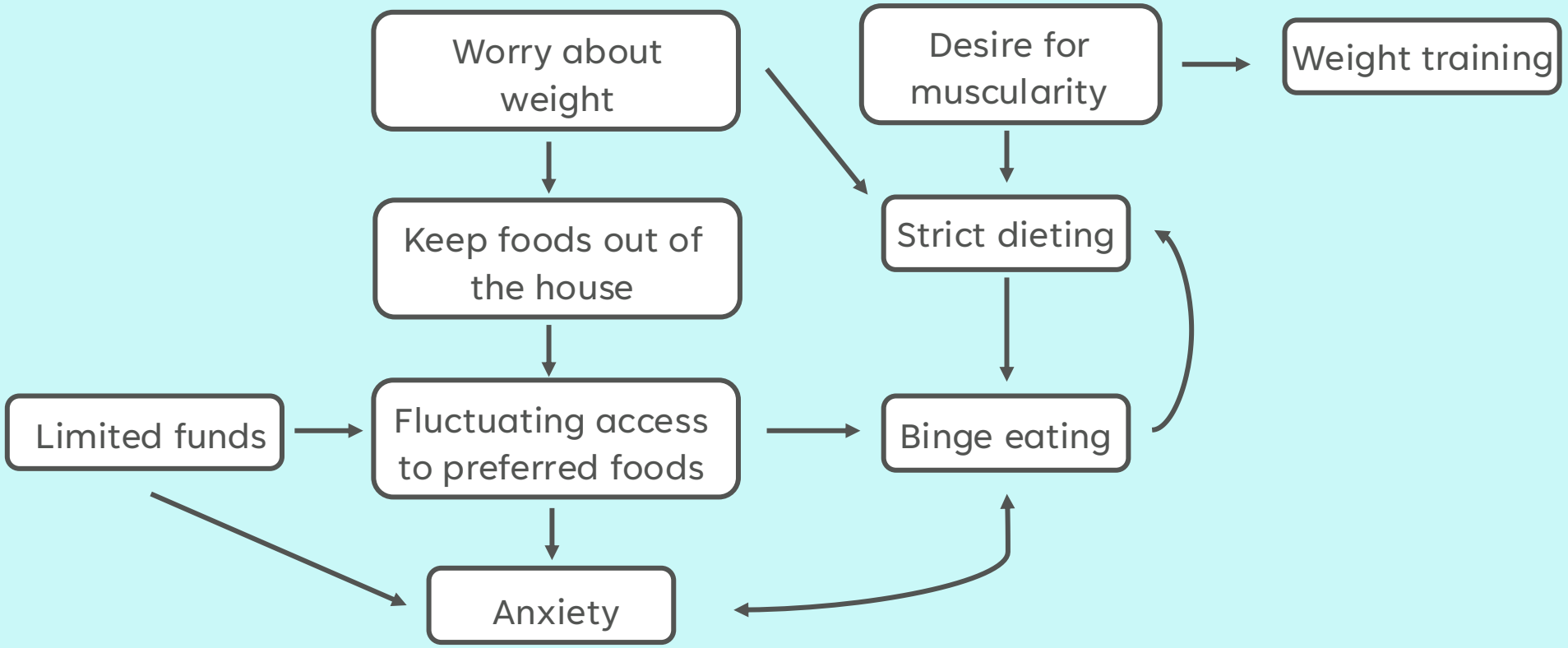
Modified Model



Treatment Modifications

Clinical Impressions

- **Food insecurity** contributing to cycles of scarcity and overeating
- **Cultural background** emphasizing masculinity, authority, and being a provider and protector
- **Anxiety** around using food assistance programs
- **Emotional distress** related to perceived loss of control and lack of muscularity

Treatment Considerations

- **Referrals** for food assistance and community resources
- Spacing of appointments to **accommodate financial strain** and psychosocial barriers
- Incorporation of **cognitive restructuring** to address unhelpful thoughts around muscularity and food insecurity
- **Coordination with nutrition services** to provide non-restrictive, culturally affirming guidance

Summary

Eating disorders do not discriminate, and bias limits detection.

Intersectionality shapes risk, presentation, and barriers to care.

Standard tools and approaches are not culturally neutral.

Equitable treatment requires intentional adaption, not just inclusion.

Question and Answer

Thank You

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