Body Image, Eating Disorders and Polycystic Ovary Syndrome

Terrill Bruere  APD 2014
“I have been diagnosed with Polycystic Ovary Syndrome and I don’t want to go on a diet or focus on my weight because I recovered from an eating disorder in 2012. The doctor says I will get diabetes or not have babies if I don’t do anything though.”
### History in a nutshell

<table>
<thead>
<tr>
<th>Age</th>
<th>Weight</th>
<th>Situation</th>
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<tbody>
<tr>
<td>Childhood</td>
<td>Normal in photos. Thought she was fat.</td>
<td>Only child. Mother ‘severe AN and personality disorder’ with excessive focus’ on Erin’s body. Remembers always being worried about body.</td>
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<tr>
<td>12-13 yo</td>
<td>As above.</td>
<td>Menarche 10yo. Puberty -‘melancholy and sad, developed AN to cope’.</td>
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<tr>
<td>12-22yo</td>
<td>Underweight. 42 – 45 kg average.</td>
<td>AN, depression, anxiety. Some treatment in paediatric services. Then ongoing underweight, restrictive eating and excessive exercise. Very sporadic menstruation, BMD OK. Intermittent counselling.</td>
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<tr>
<td>22yo</td>
<td>46kg BMI 18</td>
<td>Pregnancy, baby boy. Still living at home.</td>
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<tr>
<td>24yo</td>
<td>47kg</td>
<td>Moved out of home, reconnected with religion, decided to ‘recover from AN and give her son a better life’.</td>
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<tr>
<td>26yo</td>
<td>57kg</td>
<td>Study, work, new relationship. Antidepressants helpful. Noticed facial hair, acne, menstrual pain and irregularity.</td>
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<tr>
<td>27yo</td>
<td>63kg</td>
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<tr>
<td>28yo</td>
<td>72kg BMI 28</td>
<td>Diagnosed with PCOS. Planning pregnancy soon.</td>
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A bad name for a collection of symptoms...

PCOS - A syndrome, not a disease.

Diagnostic: (2 of 3)

- PCO (ultrasound)
- Reproductive -
  - Menstruation issues
  - Ovulation and fertility concerns
- Androgens –
  - Biochemistry – Hormonal changes (androgens)
  - Hirsute, hair loss, acne, Acanthosis nigrans

AND...

Metabolic:
- Genetic - Family diabetes or PCOS, infertility
- Metabolic syndrome indicators
- Weight management problems

Emotional and Psychosocial:
- Depression and anxiety
- Body image disturbance
- Eating, dieting disorders
- Psychosexual concerns
PCOS Statistics

- 25% of women have PCO
- Up to 20% of women may have PCOS
- 70% remain undiagnosed
- 50-70% have insulin resistance (90% some evidence of metabolic syndrome)
- 40% normal weight, 60% overweight (abdominal fat tissue and shape difference)
- 5 - 10 (7) times risk NIDDM, CVD
Genetics

Hormonal changes

Androgens (testosterone)

Insulin (insulin resistance)

↑ Androgens

Hirsutism, Hair loss, Acne

PCO, anovulation, ↑ oestrogen

Diabetes
Metabolic syndrome

↑ Body weight

Menstrual disturbance (bones OK)

Psychosocial issues: body image, self esteem, depression, anxiety, sexual health
PCOS hormonal changes including insulin resistance

Genetic advantage in times of feasting and fasting
Genetic disadvantage in current environment

i.e. Understandable
So why the eating disorder risk?

Issues arise during adolescence, early adulthood when also vulnerable to other BI/ED risks

Emphasis on diet, exercise, weight control for both health and emotionally important reasons – in a difficult culture

Chronic dieting, exercise regimes with poor outcomes

Appetite dysregulation – related to insulin and other hormones (poor satiety, food ‘cravings’)

Mood and PCOS

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<tr>
<td>Anxiety</td>
<td>34-57% (N 18% )</td>
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<tr>
<td>Depression</td>
<td>28-64% (N 7.1-8%)</td>
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+ likely to experience more severe anxiety and depression
PCOS and Body Image - Risk Factors

- Cultural norms + Body shape/weight difference
- Rapid body change that doesn't seem to make sense during adolescence or early adulthood
- Testosterone – the ‘male’ hormone, not being feminine
- Facial/other hair, ‘male’ pattern balding, difficult treatments
- Acne
- Fertility and menstruation
- Sexuality
PCOSQ - Significant reduction in HRQOL
5 domains: weight/menstruation/fertility/emotions/hair
Psychological/sexual disturbance high
BMI is a primary mediator for adolescents

Evidence in studies of PCOS links to BN and BED

Strong enough to recommend routine screening for treatment

Relieved there is an explanation finally for some of what she has experienced but confused by conflicting information and advice.

Not wishing to diet, focus on weight or control body - but PCOS requires lifestyle management with a weight emphasis as primary treatment.

‘Recovered’ but still recognises ‘eating disorder confusion’ about normal eating, appetite, physical activity. Cannot trust appetite, experiences difficulty judging quantities to eat or when to say no to food, knowing when exercise is normal and enough.

Coping with weight gain and body shape but concerned if it doesn’t stop.

Wants to have more children and avoid diabetes.
Debunk some common, simplistic myths:

- Insulin resistance and weight - **chicken and egg or mainly the chicken?**
- BMI – **when is and isn't a population measure useful**
- Weight alone = Health and Fertility
- Energy In = Energy Out  (Food = Exercise)

So... **Put health first then assess and negotiate weight and weight management goals – together, realistically, using good clinical judgement...and measure ‘success’ differently**
PCOS Number one therapy – Lifestyle management

1. Understanding of PCOS
2. Reduce insulin resistance with lifestyle change
3. Prevent weight problems and if there is an issue aim to realistically reduce by 5-10%
4. Screen for and avoid/treat dieting, eating or body image concerns
5. Prevent long term complications
Treatment - Lifestyle (‘Fit, well and healthy enough - in your own bones’)

**Physical activity** …… A mixture of variable activities that include some muscle resistance

**When to eat** …… regularly, every few hours, so food is spread over the day, helps appetite and mood

**What to eat** …… Sensible, well balanced meals and snacks that satisfy and lead to more even blood glucose swings over the day …… To the individuals taste and ‘style’

**How much to eat** …… The tricky bit. Begin with above and then…..
Appetite management - also helps mood

Cannot rely on usual eating cues to guide food quantities eaten

FIRST - Settle biological hormone issues

• Explain rationale
• Manage blood glucose to reduce insulin demand and improve excessive hunger and poor satiety
• Simple strategies (such as a bit less at a meal) if this is a known issue and there is no dieting thinking backlash
• Metformin if clinically indicated
Appetite Management

THEN - Follow with focussed mindful appetite work to rebuild and retain an internal locus of control around eating behaviour and food quantity management

eg identifying personal food preferences, exploration of normal physical hunger cues vs habit/emotional eating triggers vs hormonal effects on appetite - then development of better responses to eating cues
Erin now...

Bike riding to work twice a week, walking when can, not excessive

Mood better, appetite much more settled, menstruation improving

Can identify whether she likes the food she is eating and whether she is hungry or not

Recognising triggers to overeating, learning to make choices

Weigh reduced by 2-3 kg but trying not focus on this, happier with body shape and size

Thinking less preoccupied by food, body, weight

Referred to reproductive gynaecologist
Some hints to recognise potential PCOS in ED clients

• Weight and hormone history during adolescence and early adulthood. (Remember high exercise levels/dieting may mask PCOS symptoms)

• Menstruation issues (must be off OCP to screen for PCOS) – refer to specialist gynecologist if needed

• Rapid unexplained weight gain or PCOS symptoms emerging during treatment or recovery

• Bulimia or BED (? accompanied by excessive hunger)

• History of being a much higher weight in the past that doesn't make a lot of sense, often with family genetics of diabetes or bigger people

• Having more severe malnutrition symptoms at a higher BMI than expected, often associated with having dieted from a higher weight initially
Women need understanding, diagnosis, education, treatment, support .... And some self-defence strategies
Client and health professional resources, specialist clinic with telehealth option

General PCOS reference:
• Validate need for treatment of PCOS symptoms including hair management, fertility and mood concerns – then refer carefully

• Place in a cultural and environmental context – build awareness of community conflicting attitudes and beliefs about body and weight

• Develop strategies for difficult situations eg meeting a new health professional

• Look at everyday body image triggers – mirrors, clothing, shopping, parties, beaches, swimming pools, gyms – along with the thoughts and beliefs that accompany them (You don’t have to love all your body but you do have to accept it as it is now to care for it)
Eating Disorders

DSM 5 (recent change to diagnostic criteria)

Or

A continuum idea is useful

‘Living well’ with self and body

Independent of weight

Distress, preoccupation, less helpful behaviours and relationship with self and body
My soapbox – odd thoughts

How well is this person living with and managing their body, their health and their symptoms – and their self respect?

You can help insulin resistance without a specific weight emphasis

There is a difference between providing some flexible structure to guide someone's food and eating and providing a new set of rules to follow

Unrealistic goals sets someone up for future guilt, shame, self blame – but can be hard to resist for both the client and the professional

If talking about food immediately triggers ‘deprivation/dieting’ thinking and reactions – it usually isn't the right time to give specific dietary advice