Clinical Implications of Eating Disorders in Women with Physical Disabilities

Kaley Roosen, M.A.
Jennifer Mills, Ph.D. C.Psych.
Background

87 Spadina Road, Toronto.

SHEENA'S PLACE

hope and support for people with eating disorders
Background

- Prior physical illness → Eating Disorder & Disordered Eating Behaviours
- Higher than other mental illnesses
- Type of physical illness did not seem to matter
- Cystic Fibrosis, IDDM, Blind Women, Spina Bifida, Cerebral Palsy, Scoliosis, MS, Rheumatoid Arthritis, etc.
Background: Risk Factors

**Physical:**

- Early feeding
- Unintentional Weight Loss
- Obesity & The Pressure to Lose Weight
  - 25% disabled vs. 15%
  - >50% concerns regarding weight
  - Encouraged to lose weight by HCP
Background: Risk Factors

Psycho-Socio-Cultural:

- Risk for Mental Health issues
- Stress of Disability
- Peer Relations & Sexuality
- Family Over-involvement
- Culture of Thinness
  - “Dress to impress”
- Stigma Weight
- Culture of Ableism
Lack of Research

- Under utilize preventative health care
- “Complex Cases”
- Focus on physical disability
- Manifestation Differences?
- Stigmatization Theory - Individuals with disabilities possess ‘discrediting attributes’ which discount them from meeting mainstream socially constructed standards of beauty
Method (Roosen, in progress, 2014)

- Quantitative – Survey Based Study
  - 114 Females who identified as having a physical disability or significant mobility impairment
  - Compared to a control group

- Qualitative Analysis – Grounded Theory
  - Methodological Hermeneutics
  - 11 participants Part 1 – Disordered Eating
  - Selective Sampling
Measures (Roosen, in progress, 2014)

- Disability – RDRS, Subjective Rating Scales
- Disordered Eating – EDE-Q, EAT-26, Restraint Scale, Gnomally Binge Eating Scale
- Mental Health – BDI-II, BAI, RSES
- Body Satisfaction – BES, AII, PDSES*
Participants (Roosen, in progress, 2014)

- $n = 114$
- Age 16-40 ($M = 26.74$, $SD = 5.84$)
- Disability:
  - NMD (32%), CP (24%), SB (11%), musculoskeletal disorder or SCI (11%), arthritis (8%), amputation (4%), and other (11%)
  - 67% wheelchair; 12% walker/cane; 21% no regular mobility device
  - 75% congenital disability (Mean years disabled = 24)
Participants (Roosen, in progress, 2014)

- 60% ‘moderately-significantly’ impacted appearance
- 21% rated disability as ‘severe’
- Felt most ‘disabled’ physically & environmentally
- RDRS: ‘minimally’ disabled
Results (Roosen, in progress, 2014)

- 15% EAT-26 score over 20
- 5.5% engaged in binge-purge behaviours (4 weeks)
- 29% binge eating
- 17% underweight, 28% overweight, 13% obese
- 63% felt currently needed to lose weight
- 30% advised by a HCP; 48% by family
Results (Roosen, in progress, 2014)

- Participants with Disabilities had higher scores on measures of:
  - Body Dissatisfaction
  - Anxiety
  - Subjective Health Ranking

- Need to lose weight was equal; However, PWDs more likely to report different motives for weight loss.
Results (Roosen, in progress, 2014)

- Predictors of Disordered Eating and Poorer Mental Health in PWDs:
  - Health Status (RRS, EDE-Q, BES, BDI, BAI, RSES)
  - Subjective vs. Objective Disability
  - Years Living with Disability (BDI, BAI, Health, RSES)
  - Body Dissatisfaction & Appearance Investment
Results (Roosen, in progress, 2014)

- Emerging Themes Qualitative Analyses
  - Overall: Difference – Being the Other or an Outlier
    - Accepting that difference or trying to find their ‘normal’
  - Disability – Large part in the development and maintenance of disordered eating, weight management and body image.
- Variable & Complex
Results – Emerging Themes
(Roosen, in progress, 2014)

1. Multi-Purpose Function of Food
2. Compensation
3. Maintaining Control
4. Undesirable Obesity
5. Seeking Accessible & Knowledgeable Support
6. Dependency
7. Uphill Ongoing Struggle (Resorting to Restriction)
8. Barriers (Financial, Environmental, Attitudinal, etc.)
9. Resistance & Resilience
Clinical Implications: A Case Study

Case of “Carol”
- 32 year old woman with cerebral palsy
- 17 year history of Anorexia Nervosa
- Previous psychotherapy experience

Clinical Challenges
- Developing Rapport
- Medical Complications/Physical Limitations
- Attendant Services
- Access Issues
Strategies to Effectively Work with Patients with Physical Disabilities

- Explore your own assumptions/biases
- Accept when you don’t know something
- Collaborate on behavioural experiments
- Balance between accepting the disability and its limitations and pushing for change
- Be willing to challenge ED beliefs
- Get to know patient’s personal values & strengths
- Be willing to advocate
- Be willing to work with other health care professionals
- Ask patient how to best accommodate their needs
Future Directions

- Training of Health Care Providers
  - Doctors, Nurses, Dieticians
  - Personal Support Workers

- Sensitivity to Weight issues & Appreciation of complexity
- Knowledge of supports
Future Directions

- More Research
  - Guidance on calorie range or BMI
  - Involving persons with disabilities
  - Using Qualitative inquiry as well as traditional methods
Future Directions

- Advocacy Efforts
  - AODA
  - Economic Disadvantage
  - Accessible transportation
  - Supports live Independently
  - Accessible supports (treatment centres, recreational activities, preventative health care)
- Attitudinal Barriers
Thank you!

- kaley@yorku.ca
- jsmills@yorku.ca
- www.nedic.ca

We are all wonderwomen!
Acknowledgements

- Iris Sijercic & Olivia Dicostanzo
- Drs. Karen Fergus & Yvonne Bohr
- Dr. David Rennie
- Dr. Dave Flora

- All the women with physical disabilities who bravely and openly shared their experiences.

- This research was funded by:
  - Vanier Canada Graduate Scholarship, Canadian Institutes of Health Research (CIHR) Doctoral Research Award
  - Toronto Rehabilitation Institute Training Grant
  - York University Faculty of Graduate Studies Scholarships