

OBESITY AND

Eating Disorders:



A PATIENT AND PROVIDER PERSPECTIVE

by Kelly Broadwater, LPA, LCMHC, CEDS-C; and Melinda J. Watman, RN, BSN, MSN, CNM, MBA

Obesity and eating disorders (EDs) have more in common than most people realize. Both are complex, chronic conditions that often relapse. Both are dangerous to health, affecting many parts of the body—and sadly, both can be fatal.

These are biological diseases, not choices, but are often misunderstood and judged. Research shows that genetics, trauma, depression and anxiety can cause both obesity and eating disorders. Because of this, both need specialized, compassionate care from multiple experts. The reality is that many individuals living with obesity have also battled—or are still battling—an eating disorder.



UNDERSTANDING DIFFERENT EATING DISORDERS

Eating disorders come in many forms, but all involve an unhealthy relationship with food and body image. They most often appear with other mental health issues like anxiety or depression. The most recognized types include:

- **Binge Eating Disorder (BED):** The most common eating disorder in the U.S. People with BED repeatedly eat large amounts of food quickly and often feel guilt and shame afterward. Unlike bulimia, it does not involve vomiting, excessive exercise or use of laxatives. While not everyone with BED has obesity, weight gain over time is common.
- **Bulimia Nervosa:** Involves eating large amounts of food (binging) and then purging to “undo” the eating.
- **Anorexia Nervosa and Atypical Anorexia Nervosa:** Involve extreme restriction of food and intense fear of gaining weight. People with atypical anorexia may be at a “normal” or higher weight but still suffer serious health problems.

It’s important to know that the vast majority of people with eating disorders are in larger bodies, but because of weight bias, their disorders often go ignored or untreated. Eating disorders have the second-highest death rate of any mental health condition, and up to 20% of people with anorexia attempt suicide. Without treatment, eating disorders can cause serious mental and physical health issues that make managing weight even harder.

HOW STIGMA AND BIOLOGY PLAY A ROLE

For a long time, society has believed treating obesity is as simple as “eat less, move more.” Thankfully, we are now realizing it’s much more complicated—genes, biology, metabolism and brain chemistry all play a role. Eating disorders make this even harder.

Dieting and weight stigma (being judged for body size) can cause eating disorders to start or worsen. People who feel pressure to lose weight quickly may try extreme diets or harmful behaviors like starving themselves. This can lead to anorexia, bulimia or binge eating. The cycle of constant weight loss and gain—called “yo-yo dieting”—can damage metabolism and increase disordered eating. Studies show that people who experience weight-based discrimination are more likely to binge eat or eat emotionally to cope. This creates a vicious cycle of shame and disordered eating, leading to more weight gain and more stigma.

Brain studies using functional MRI scans show that people with BED and obesity often have increased brain activity in reward centers when they see high-calorie foods. This suggests that for some, eating may be about comfort, pleasure or stress relief, not just hunger.

TREATMENT MUST BE BASED ON COMPASSION, UNDERSTANDING AND SCIENCE—NOT JUDGMENT—TO BREAK THE CYCLE OF DISORDERED EATING AND WEIGHT STRUGGLES.



CLINICIANS NEED TO RECOGNIZE THAT OBESITY AND EDS CAN COEXIST AND ENSURE PATIENTS RECEIVE THE CARE THEY NEED.

HOW DO WE HELP?

To help people struggling with obesity and EDs, we must first and foremost stop blaming and shaming them. Treatment must be based on compassion, understanding and science—not judgment—to break the cycle of disordered eating and weight struggles.

Effective treatments include:

- **Cognitive Behavioral Therapy (CBT):** Helps people identify and change negative thoughts related to food and body image.
- **Intuitive Eating:** Encourages listening to the body's natural hunger and fullness cues instead of following diet rules.
- **Medical Treatments** (like medication or bariatric surgery) can also help but must be paired with psychological support to avoid ongoing disordered eating.

Obesity and EDs are deeply connected, and treating them as separate problems does a disservice to those who are struggling. Many individuals live in the space between—fighting a daily battle between wanting to lose weight and feeling powerless against disordered eating. By offering compassionate, science-based help, we can help break this harmful cycle.

Melinda's Story

Please note, this article may be triggering for some. Please do whatever is needed to take care of yourself while reading.

The story goes that when I was a baby, I wouldn't eat. They would try to coax me, and when I laughed, my mother would take a spoonful of food and shove it into my mouth. When I was done, she would burp me—and I would vomit. Coincidence? Or a sign of what was to come?

"I wake up and feel my hip bones, hoping they are sharp, strained, jutting upward, barely covered by flesh. I check to see how far my shoulder blades stick out and how many vertebrae I can count. I am never satisfied; I am never thin enough. The scale is my torturer, never showing a number I am relieved to see, regardless of how low it is."

Until recently, this was my reality—and I know I'm not alone. Obesity and eating disorders (EDs) often occur together.

I have both. My EDs include anorexia, binge eating disorder and bulimia—all fueled by a desperate pursuit to be the skinniest girl in the room. The idea of being "too thin" was completely foreign to me. I've had obesity since I was three years old and disordered eating almost as long. I internalized the message early on that "thin is good" and "fat is bad," which led to a lifetime of food restriction and deprivation. Despite restricting, my obesity worsened, as did my EDs.

In 2000, I had bariatric surgery, believing it would fix my self-stigmatization, body dysmorphia and obsession with food and weight. Physically, the surgery was successful, but nothing else changed.

I struggled with seeing my body as it was. I became obsessed with losing more weight, pushing my behaviors to extremes until I was down to 85 pounds. I would eat beyond the point of fullness and then purge—feeling temporary release from the tension inside me. But the relief never lasted, so I did it again and again, chasing that fleeting "high." The thought of giving it up was unthinkable—even as I destroyed my teeth, lost my hair, developed brain fog, and had someone think I must be undergoing cancer treatment.

This led to me almost dying—twice.

The first time, I fell and hit my head. In the ER, I was "found out" when my labs came back so dangerously abnormal that I was admitted to the hospital for 11 days until a bed opened up at an inpatient ED treatment center. Even though I was on death's door, I didn't want treatment. I said what I had to say to get out — and within three weeks, I was right back at it.

Two years later, I fell down a flight of concrete stairs, cracked my skull, and once again found myself in the ER—severely malnourished. I had no equilibrium, and when I tried to dry my hair, I had to stop several times because my arms ached from the exertion. Not long after, my friends and family staged an intervention. The words "We don't want you to die" were said repeatedly. Even my primary doctor told me, "You could die."

And then I hit rock bottom. One day, with my head in the toilet, sobbing, I realized I couldn't live like this anymore. That's when I decided to seek treatment for the second time. I spent three months in inpatient care, and it saved my life.

My recovery has been hard-earned, and I am forever grateful to my support system—my “village.” There was a time when it took all my strength to fight back the voices of my obesity and EDs colliding in my mind. Today, they are more like passing thoughts. I have fought so hard to get here—holding true to my treatment plan and knowing that recovery is my only option. And while I lose an occasional battle, overall, I am winning the war.

Now, I am my own advocate, making sure my healthcare providers understand the full picture. Because for years, there were countless missed opportunities for intervention. Clinicians must recognize that obesity and EDs can coexist—and ensure patients receive the comprehensive care they need.



About the Authors:

Kelly Broadwater, LPA, LCMHC, CEDS-C, is a psychologist and certified eating disorders specialist with more than 20 years of experience supporting higher-weight patients and those navigating metabolic and bariatric surgery. She is the co-author of BariEDucated and leads The Chrysalis Center for Counseling & Eating Disorder Treatment.

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ABOUT THE OBESITY ACTION COALITION (OAC)

The Obesity Action Coalition (OAC) is a National non-profit organization dedicated to giving a voice to individuals affected by obesity and helping them along their journey toward better health. Our core focuses are to elevate the conversation of weight and its impact on health, improve access to obesity care, provide science-based education on obesity and its treatments, and fight to eliminate weight bias and discrimination.



VIBRANT COMMUNITY



NATIONAL AWARENESS CAMPAIGNS



ANNUAL CONVENTION



ADVOCACY



PUBLIC EDUCATION

LEARN, CONNECT, ENGAGE

The OAC knows that the journey with weight can be challenging but we also know that great things happen when we learn, connect and engage. That is why the OAC Community exists. Our Community is designed to provide quality education, ongoing support programs, an opportunity to connect, and a place to take action on important issues.

Through the OAC Community, you can get access to:

- Weight & Health Education • Community Blogs
 - Community Discussion Forum
 - Ongoing Support • Meaningful Connections
- AND MUCH MORE**



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