Eating Disorder Overview

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Objectives

- Recognize anorexia nervosa, bulimia nervosa, binge eating disorder (BED) and avoidant restrictive food intake disorder (ARFID)
- Identify medical complications of eating disorders
- Explore key components in the complexity of treating eating disorders
- Understand basic treatment options and levels of care
- Case presentation

- It is often said among substance use recovery circles that no one sets out to be a substance abuser. The same is true for disordered eating patients. The Eating Disorder is often the result of a misstep in the effort to get something right or to push down something that seems not right, is feared, or feels overwhelming.
- Imagine yourself standing on the bank of a raging river, when suddenly the bank gives way. Drowning, you reach for something outside of you. You grab a log that takes you to safety. The water calms as you float downstream, yet you hold the log, afraid you might drown if you let go. You see your family and friends standing on the shore, calling to you to swim to safety, but you cannot swim effectively due to the need to cling to the log that saved your life.
- Many individuals with eating disorders feel shame for relying on something that is now inhibiting their ability to get where they want to go in life, and easily forget how that same thing was a tool in surviving difficult situations in the past. Similarly, giving up that tool can be threatening, as the way to safety is not assured without it.
- From *Eating by the Light of the Moon by Anita Johnson,PhD 2000, pp 19-20.* (Cook-Cottone, 2020, p. xx)

Case Presentation

Ashley is a 35-year-old female with a BMI of 26 who presents with trouble concentrating, difficulty sleeping, and bilateral shin pain.

Past medical history: GAD

Medications: 100 mg once daily Zoloft

Ashley reports she's been focusing on improving her health in 2024 after downloading the Noom app. She has started running daily and limiting carbohydrates. She notes by the end of each day she is so exhausted and hungry she will consume a large amount of food in a short period of time. She notes this causes abdominal discomfort and reflux which interferes with her sleep. She notes difficulty concentrating during the day. Lastly, the shin pain started in the last 2 weeks.

Eating Disorder Statistics

- The only mental illness with a higher mortality rate than eating disorders is opioid overdoses secondary to opioid addiction.
- Less than 6% of people with eating disorders are medically “underweight.”
- Eating disorders cause 10,200 deaths per year.
- Young people between the ages of 15 and 24 with anorexia have 10 times the risk of dying compared to their same-aged peers.
- About 26% of people with eating disorders attempt suicide.

Eating Disorder Statistics

- Transgender college students self-reported the highest rates of eating disorder and compensatory behaviors in a survey of 300,000; nearly 16% reporting having been diagnosed with an eating disorder compared to 1.85% of cis gender heterosexual women
- Despite having similar rates of eating disorder concerns non-Hispanic whites, African Americans, Hispanics, and Asian Americans are less likely to receive treatment for their disorder in the US
- Subclinical disordered eating is nearly as common among males as it is females
- Adolescents in African American families are 50% more likely than their white counter parts to develop a binge-purge eating disorder
- Adolescents in low SES families are 153% more likely to develop bulimia than high SES counter parts

Anorexia Nervosa

- DSM 5 Diagnosis:
  - Energy intake restriction leading to low body weight*
  - Intense fear of weight gain or persistent behavior interfering with weight gain
  - Overvaluation of body image, persistent lack of recognition of seriousness, disturbance in bodily experience and consistent drive for thinness.
- Two subtypes: restrictive and binge-purge type
- Prevalence: Between 0.9% and 2.0% of females and 0.1% to 0.3% of males will develop anorexia
- Mortality rate: 10% overall and 1 in 5 deaths are by suicide.

Bulimia Nervosa

- DSM5 Diagnosis:
  - Recurrent episodes of binge eating paired with compensatory behaviors used to prevent weight gain. Examples: self-induced vomiting, laxative or diuretic abuse, fasting, excessive/compensatory exercise.
  - Binge eating and compensatory behaviors occur at least once a week for 3 months
  - Overvaluation of self-image and drive for thinness
- Prevalence: Between 1.1% and 4.6% of females and 0.1% to 0.5% of males will develop bulimia

Binge Eating Disorder

- DSM5 Diagnosis:
  - Consuming a large amount of food in a short (typically within a 2 hr period) amount of time with a sense of lack of control during the episode
  - Binge eating must be associated with >/= 3 of the following:
    - Eating rapidly, feeling uncomfortably full after, eating when not hungry, eating alone because of embarrassment about food consumed, feeling disgusted/depressed/guilty after
  - Marked distress overall regarding binge eating
  - Binge eating occurs on average at least once a week for 3 months
  - No compensatory behaviors are associated
- Prevalence: 3.5% of women and 2% of men which makes BED 3x more common and AN and BN combined and is more common than breast cancer, HIV and schizophrenia

Avoidant Restrictive Food Intake Disorder (ARFID)

- DSM5 Diagnosis:
  - Eating or feeding disturbance based on the sensory characteristics of food, concern about adverse consequences (choking, vomiting are common) of eating which results in persistent failure to meet appropriate nutritional needs and are associated with one or more of the following:
    - Significant weight loss
    - Significant nutritional deficiency (inadequate intake, lab abnormality, etc.)
    - Dependence on enteral feeding or oral nutritional supplements
    - Marked interference with psychosocial functioning
  - Not related to food insecurity or cultural practices
  - Does not occur with anorexia or bulimia nervosa and there is no drive for thinness or overvaluation of body shape/size
  - Is not attributable to a concurrent medical condition or better explained by another mental disorder

ARFID cont.

- Autistic people are more likely to develop ARFID
- Children who don’t outgrow normal “picky eating”
- Anxiety disorders are commonly co-occurring

Orthorexia

- Not a formal DSM 5 diagnosis
- Often coexisting with diet culture and therefore may be praised in a medical setting
- May be presented as a socially acceptable reason to restrict
- Examples: fixation on "clean"/healthy eating, limiting food groups, concern about food quality
- Patients often present with rigid food rules and heightened anxiety about food and/or their health.

Case Presentation

What questions do you have for Ashley?

Medical Complications

- AN-R, AN-BP and BN have the highest acuity and require the closest medical monitoring.
- Medical complications come in all body shapes and sizes.
- Most common symptoms are dizziness/lightheadedness (especially with position changes), easily exerted, fatigue, cold intolerance, headaches, vision changes, epigastric pain, constipation, anxiety, and depression.
- Most common findings are bradycardia, lab abnormalities (hypokalemia should prompt high suspicion of self-induced vomiting), orthostasis, physical symptoms related to undernourishment, and low weight.

System	ROS	Physical Exam
General	Fever? Fatigue? Night sweats? Cold/hot intolerance?	General overview, bony prominences, hair (dull, thin)
HEENT	Tooth/mouth/throat pain? (especially bulimia) Difficulty swallowing?	Look at teeth (caries/erosion), tonsils (scarring), salivary glands, mouth ulcers, gum irritation, subconjunctival hemorrhage Palpate lymph nodes, palpate thyroid
Cardiovascular	Any chest pains? Palpitation? Shortness of breath? Dizziness/Syncope? Swelling or cramping in your legs?	Auscultate heart, look at legs/check for pitting edema (mitral valve prolapse, arrhythmias)
Abdominal	Any new abdominal pain? Early satiety/feel full quickly? Distention? Any history of heartburn/reflux? Any black/tarry stools? Any blood in your stools? Vomiting blood? Any constipation/diarrhea? Changes in bowel habits? Hemorrhoids?	Auscultate and palpate abdomen Look for scaphoid abdomen when lying down
Endocrine	Changes in menstruation? Loss of libido? Increased thirst? Frequent peeing?	May see breast atrophy
GU	Any difficulty with urination, frequency, urgency, burning or incontinence?	-
MSK	Aches or pains? (think stress fractures/overuse injuries)	Knees, shins, feet
Derm	Changes in hair or hair growth in new places (lanugo), hair loss, changes in skin color (yellowing, acrocyanosis, poor wound healing	Observe skin - sunken looking eyes, skin tone, wounds, russell's sign
Psych	Memory loss/poor concentration, difficulty sleeping, new or worse depression/anxiety, obsessive behavior, **self half, suicidal ideation/attempt**	Look at any self harm injuries (last one, amount, depth)

Outpatient Red Flag Behaviors/Symptoms

- > 24-hour purposeful fasting
- Rinsing: binge-purge behavior
- Stimulant laxative abuse or other drug abuse for weight/appetite manipulation
- Prolonged strenuous exercise or exercising in dangerous situations
- Hematemesis
- Symptoms of chest pain, palpitations, increased weakness/fatigue, hypoglycemia symptoms, difficulty breathing, easy exertion.
- Suicidality

Adult Eating Disorder Hospital Admission Criteria

- Weight less than 75 percent of ideal body weight, BMI < 15 or greater than 5 lbs of weight reduction for at least 1 week
- Resting HR < 40
- Blood pressure < 80/50
- Orthostatic changes in pulse > 20 beats per minute, diastolic blood pressure decrease > 10 mmHg, and systolic blood pressure decrease > 20 mmHg
- Arrhythmia (ex. Prolonged Qtc, non-specific ST or T-wave changes, including inversion or biphasic waves)
- Abnormal electrolytes
    - Hypokalemia < 2.8 (less than 2.4 is automatically IV infusions)
    - Hypophosphatemia < 1.5 automatically IV infusions
    - Hyponatremia < 125
    - Hypomagnesemia < 1
- Hypoglycemia < 45
- Temperature < 95 degrees Fahrenheit or cold/blue extremities
- Loss of consciousness due to low blood pressure or hypoglycemia
- Requiring detoxification due to significant abuse of laxatives, diuretics or other weight altering medications
- Decreased GFR < 60 ml/min
- Elevated LFTs > 500
- Inability to eat (ex. Gastroparesis, abdominal pain, mouth sores, superior mesenteric artery syndrome)
- At risk for refeeding syndrome → rapid weight loss with significantly restricted intake
- Suicidal thoughts/intent/plan

Case Presentation

Ashley lost 10 lbs in the last month

Resting HR is 54. BP normal without orthostasis.

Labs revealed glucose of 65. Remainder are unremarkable.

ROS: dizziness with position changes, fatigue, cold intolerance, palpitations with running, reflux at night, bilateral shin pain, trouble concentrating, anxiety

Other data you'd like to collect?

Treatment Complexities

- Anosognosia and how it impacts our patients
  - Also occurs with schizophrenia, bipolar disorder, stroke patients, and Alzheimer's
  - Differs from people who have internalized negative societal beauty standards, constructs, and pressures
- Body dysmorphia: inaccurate sensory information processing of one’s body shape and size
- Gender dysphoria*: An incongruence between one's experienced/expressed gender (and primary and/or secondary sex characteristics) and their natal gender
  - A strong desire to be rid of one's primary and/or secondary sex characteristics due to the incongruence between natal gender and experinced/expressed gender

Treatment Complexities

- Inaccurate diagnoses in minority populations and people in bigger bodies
  - Previously stereo-typed as being diseases afflicting affluent, white, women and adolescents
  - More data has indicated disordered eating across genders, age, racial and ethnic groups, social economic status, and individuals perceived as having average or increased body size

Ego Syntonic v. Ego Dystonic Mindset

- Ego Syntonic-to be consistent with one's self-concept
  - Lacking insight regarding harmful or disordered behaviors as they are congruent to who an individual is. State of being which makes AN notoriously difficult to treat, as such individuals may believe that they are acting consistently (i.e. not disordered) with how they truly are; they may believe that their behavior isn't damaging to them physically or to their relationships and that they need to lose weight. These patients may be highly resistant or even hostile toward change.
- Ego Dystonic-to be incongruent with one's self-concept
  - Such individuals have an awareness that their behaviors are "wrong" or disordered and are distressed by them. Often, patients with BN are distressed by their binge-purge behaviors and are seeking to change when treatment is initiated.

Adult Treatment

- CBT-E
  - Conceptualizes eating disorders as a "cognitive disorder" where AN, BN, and OSFED share a common core psychopathology of over evaluation of body shape and weight
    - Extreme fear of weight gain regardless of their actual body shape or weight
    - Increasingly restrictive food rules/avoidance and/or compensatory behaviors
  - Change is made by interrupting maladaptive eating patterns and assisting the patient in analyzing the effects and implications of those changes
    - Limited use of cognitive restructuring techniques typical of CBT such as automatic thoughts, assumptions, core beliefs, etc.
  - CBT-E can be adapted to a "broad form" to address clinical perfectionism, core low self-esteem, interpersonal problems, and co-occurring mental health concerns such as anxiety, depression, etc.
    - CBT-E is also adaptable to adolescents.

Adult Treatment (cont.)

- Embodiment theory of eating disorders is the fixation on appearance which has developed as a result of a consumption-oriented and objectifying culture in which the social value of the human body is limited to how closely its appearance resembles the sociocultural ideal (p. 27)
  - Culture and power structures as they pertain to the individual patient are just as important as cognitions and behaviors
- Embodiment Approach to Treating Eating Disorders (EAT-ED)
  - Focuses on developing insight, mindfulness, and the ability to utilize internal resources and external supports effectively, recognize internal (self-driven) and external (social) pressures and stress, as well as honoring internal emotions and other bodily sensations and adjusting cognitions accordingly
  - Intuitive eating is practiced
  - Change is made by developing and maintaining a positive relationship to oneself
    - Mindful self-care, self-regulation, emotional awareness, meaningful relationships

Adult Treatment (cont.)

- EAT-ED does acknowledge a substantial group of disordered eating patients who have "stressed and traumatized bodies" and may need extra care.
- To work with patients with eating disorders, you must take in to account their physiological arousal level and feelings of safety
- Other trauma-based interventions may be helpful, including EMDR, Prolonged exposure therapy, cognitive processing therapy, and ART

Adolescent Treatment

- Primary treatment modality for adolescents: FBT
- Family Based Therapy
  - Family based intervention focusing on education and parental support for creating and monitoring meals and snacks.
  - Provides structure for children and adolescents as well as support for adequate nutrition
  - Later stages includes allowing more independence and exploring and challenging underlying pathology (negative evaluation of body weight/shape)
- CBT-E can be adjusted for younger patients
- Research on EAT-ED suggests that tools for developing and maintaining a positive sense of self can be effective for treating ED in younger patients, and can be protective against ED in adolescents

Levels of Care

- Outpatient: 1-2 appointments per week with medically stable patients who can implement change between visits
- IOP: 3 days per week of treatment. Transitional level of care or for patients in outpatient setting requiring increased support
- PHP: 5 days per week of treatment. Transitional level of care
- Residential: 24/7 medically stable with severe and significant symptoms and behaviors
- Hospitalization: 24/7 medically unstable

Case Presentation

After showing concern for Ashley's restrictive eating, binge eating, and compensatory (purge) with exercise, she reports she experienced a sexual assault at a New Years Eve party this year. She identifies her recent behaviors are a form of self-harm and a coping mechanism for the trauma she experienced.

What recommendations do you have from here?

Questions?

Sources

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