EATING DISORDERS: ASSESSMENT & TREATMENT

ABOUT THE PRESENTER

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- Vice President, Outpatient & Psychological Services
- Compass Health Network-14 years next month
- Alumna of NPTC
- Specialties in Marriage & Family Therapy (MFT) & Integrated Healthcare (IHC)
- Thesis & Dissertation on Eating Disorders (EDs) and Disordered Eating (DO)
- Supervisor—Interns & Post Doctoral Residents
- Current president of Missouri Psychological Association (MOPA)

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OBJECTIVES:

1. Define, compare, and contrast the differences between and among each type of eating disorder (ED)
2. Recognize commonly used assessment tools
3. Understand most common comorbidities
4. Recognize the etiological factors of ED
5. Establish an understanding of diversity issues related to EDs
6. Understand treatment options and when to refer

OBJECTIVE 1: DEFINE, COMPARE, AND CONTRAST THE DIFFERENCES BETWEEN AND AMONG EACH TYPE OF EATING DISORDER (ED)

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Avoidant Restrictive Food Intake Disorder (ARFID)
- Other Specified Feeding or Eating Disorder (OSFED)
- Orthorexia*

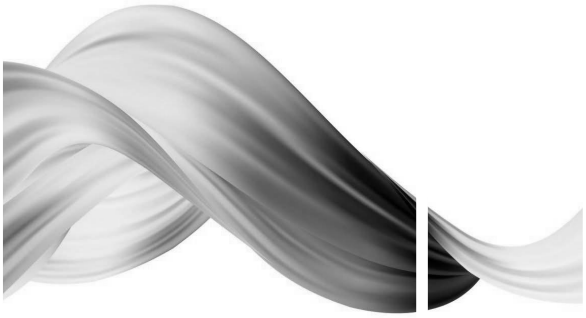
*Not in the DSM

DEFINITIONS: ANOREXIA

- 2 types:
  - *Restrictive*: People with the restrictive subtype of anorexia nervosa severely limit the amount and type of food they consume
  - *Binge-Purge*: People with the binge-purge subtype of anorexia nervosa also greatly restrict the amount and type of food they consume. In addition, they may have binge-eating and purging episodes—eating large amounts of food in a short time followed by vomiting or using laxatives or diuretics to get rid of what was consumed
- Extremely restricted eating and/or intensive and excessive exercise
- Extreme thinness (emaciation)
- A relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight
- Intense fear of gaining weight
- Distorted body or self-image that is heavily influenced by perceptions of body weight and shape
- Denial of the seriousness of low body weight

HEALTH CONSEQUENCES OF ANOREXIA:

- Mild anemia
- Thinning of the bones (osteopenia or osteoporosis)
- Muscle wasting and weakness
- Brittle hair and nails
- Dry and yellowish skin
- Growth of fine hair all over the body (lanugo)
- Severe constipation
- Low blood pressure
- Slowed breathing and pulse
- Damage to the structure and function of the heart
- Drop in internal body temperature, causing a person to feel cold all the time
- Lethargy, sluggishness, or feeling tired all the time
- Infertility
- Brain damage
- Multiple organ failure
- **Anorexia nervosa can be fatal**
  - It has an extremely high mortality rate compared with other mental disorders
  - People with anorexia are at risk of dying from medical complications associated with starvation
  - Suicide is the second leading cause of death for people diagnosed with anorexia nervosa



DEFINITIONS: BULIMIA

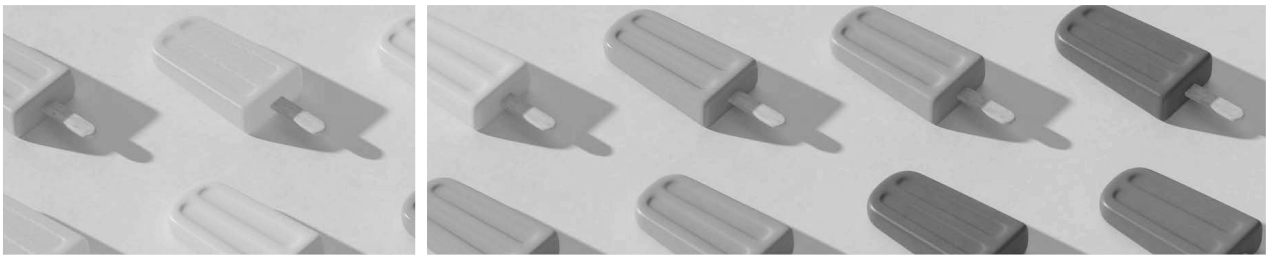
- Bulimia:
  - Recurrent episodes of eating unusually large amounts of food and feeling a lack of control over their eating
  - Followed by behaviors that compensate for the overeating to prevent weight gain, such as:
    - Forced vomiting,
    - Excessive use of laxatives or diuretics,
    - Fasting, and/or
    - Excessive exercise
  - May maintain a normal weight or be overweight

HEALTH CONSEQUENCES OF BULIMIA:

- Chronically inflamed and sore throat
- Swollen salivary glands in the neck and jaw area
- Worn tooth enamel and increasingly sensitive and decaying teeth from exposure to stomach acid when vomiting
- Acid reflux disorder and other gastrointestinal problems
- Intestinal distress and irritation from laxative abuse
- Severe dehydration from purging
- Electrolyte imbalance (too low or too high levels of sodium, calcium, potassium, and other minerals), which can lead to stroke or heart attack

DEFINITIONS: BINGE EATING DISORDER

- Binge Eating Disorder:
  - Eating unusually large amounts of food in a short amount of time
  - Eating rapidly during binge episodes
  - Eating even when full or not hungry
  - Eating until uncomfortably full
  - Eating alone or in secret to avoid embarrassment
  - Feeling distressed, ashamed, or guilty about eating
  - Frequently dieting, possibly without weight loss
    - As a result, they are often overweight or obese

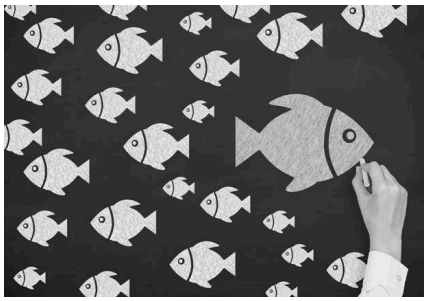


DEFINITIONS: ARFID

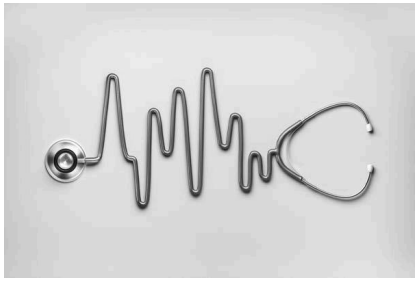
- Avoidant Restrictive Food Intake Disorder:
- Dramatic restriction of types or amount of food eaten
- Lack of appetite or interest in food
- Dramatic weight loss
- Upset stomach, abdominal pain, or other gastrointestinal issues with no other known cause
- Limited range of preferred foods that becomes even more limited ("picky eating" that gets progressively worse)

DEFINITIONS: OSFED

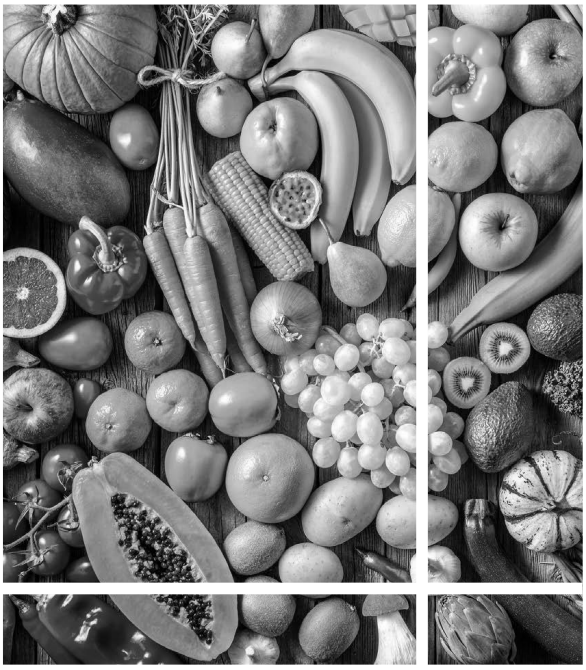
- Previously known as Eating Disorder Not Otherwise Specified (EDNOS)
  - Often denied by insurance,
  - But can be serious and life-threatening
- Recent research found that OSFED is the most common ED (3.8% women and 1.6% men have a lifetime prevalence)
  - **Atypical Anorexia Nervosa:** All criteria are met for anorexia nervosa, except despite significant weight loss, the individual's weight is within or above the "average" range
  - **Binge Eating Disorder (of low frequency and/or limited duration):** All of the criteria for BED are met, except at a lower frequency and/or for less than three months
  - **Bulimia Nervosa (of low frequency and/or limited duration):** All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behavior occurs at a lower frequency and/or for less than three months
  - **Purging Disorder:** Recurrent purging behavior to influence weight or shape in the absence of binge eating
  - **Night Eating Syndrome:** Recurrent episodes of night eating; eating after awakening from sleep, or by excessive food consumption after the evening meal



HEALTH CONSEQUENCES OF OSFED:



- A growing body of research has found that:
  - Compared to anorexia nervosa people with atypical anorexia experience similar symptoms of medical instability, and
  - Rapid weight loss at any body size can lead to serious life-threatening medical complications often associated with malnutrition
- Adolescents w/ OSFED are as likely to be hospitalized as their peers w/ AN
- Individuals w/ OSFED were found to be just as likely to die as a result of their ED as people with AN, BN, or BED
  - One study found that 33% of deaths attributed to EDs were associated with OSFED



DEFINITIONS: ORTHOREXIA

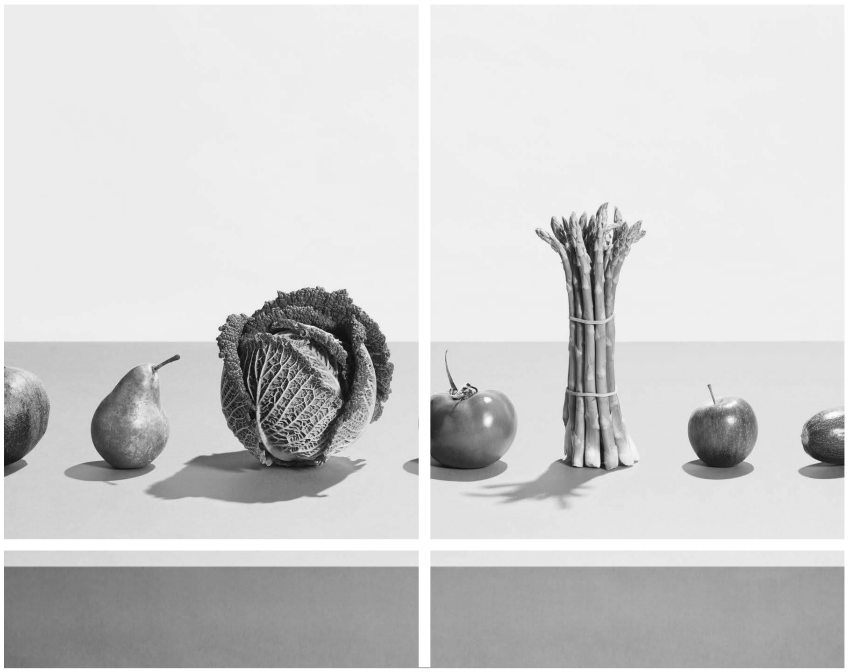
- This term was coined in 1997
- Refers to an obsession with proper or "healthful" eating
- Problematic when it becomes a fixation that can:
  - Damage well being
  - Experience health consequences
    - Such as malnutrition and/or
    - Impairment of functioning

SIGNS AND SYMPTOMS: ORTHOREXIA

- Compulsive checking of ingredient lists and nutritional labels
- An increase in concern about the health of ingredients
- Cutting out an increasing number of food groups (all sugar, all carbs, all dairy, all meat, all animal products)
- An inability to eat anything but a narrow group of foods that are deemed 'healthy' or 'pure'
- Unusual interest in the health of what others are eating
- Spending hours per day thinking about what food might be served at upcoming events
- Showing high levels of distress when 'safe' or 'healthy' foods aren't available
- Obsessive following of food and 'healthy lifestyle' blogs on social media
- Body image concerns may or may not be present
- Psychosocial impairments in different areas of life

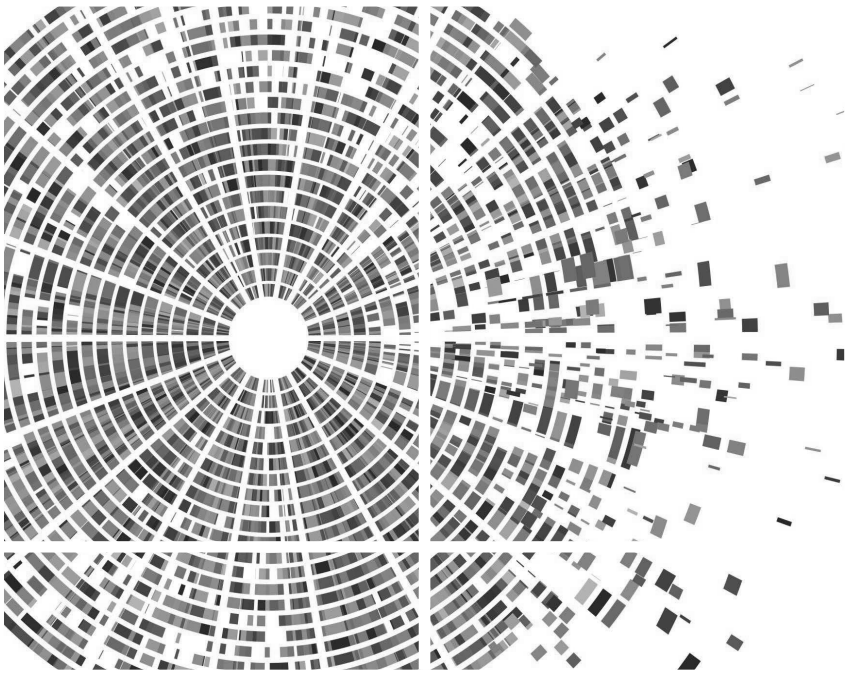
COMMONALITIES:

- AN, BN, and BED include binge eating (as a subtype of AN)
- All types involve a difficulty with food and eating
- Focused on control over food
- Discomfort with eating around others
- Mood swings
- "Safe foods"



DIFFERENCES

- AN requires a certain body mass index (BMI) to diagnose
- AN may NOT have a binge/purge cycle
- ARFID does NOT include body image disturbance or fear of weight gain
- DE may include more culturally normalized behaviors, and thus be considered subclinical
- BED does NOT include compensatory mechanisms



OBJECTIVE 2: RECOGNIZE COMMONLY USED ASSESSMENT TOOLS

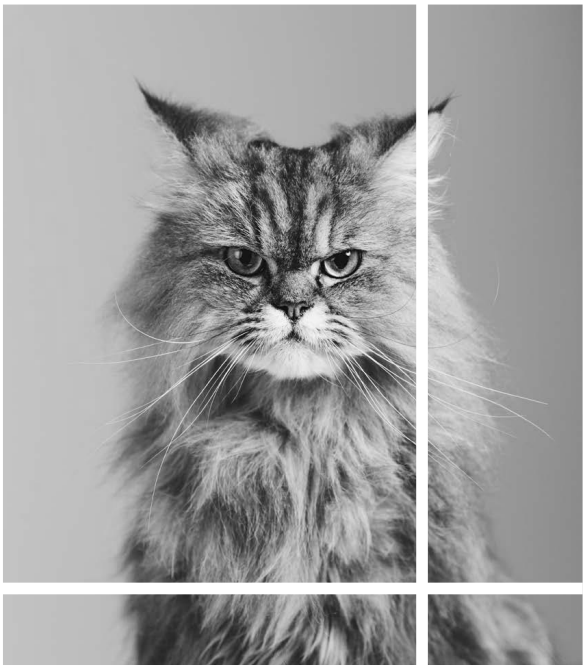
Eating Attitudes Test (EAT-26)

Eating Disorder Examination (EDE)

Eating Disorder Assessment for DSM-5 (EDA-5)

Structured Clinical Interview for DSM-5 (SCID-5)

Eating Disorder Screen for Primary Care (ESP)

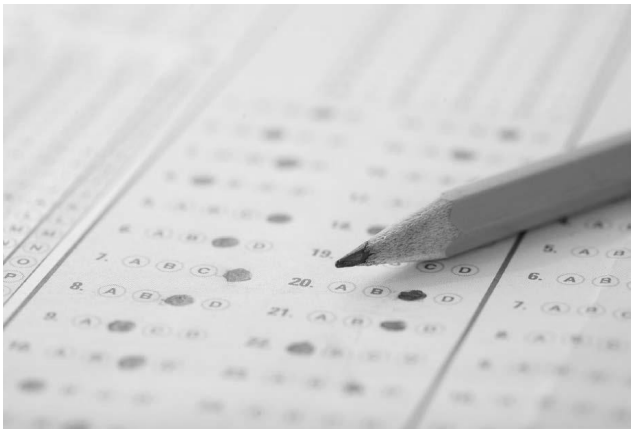


EATING ATTITUDES TEST (EAT-26)

- Widely used self-report measure
- Examines socio-cultural factors in development and maintenance of EDs
- Translated into many different languages
- Has been used in hundreds of studies
- Can be used in clinical and non-clinical settings (general and specialty)
- Designed to be administered by professionals
- Intended to be used for adolescents and adults
- https://www.eat-26.com

EATING DISORDER EXAMINATION (EDE)

- Semi-structured interview
- Measure thoughts/behaviors associated with EDs w/in past 28 days
- Contains 4 subtests:
  - Dietary Restraint
  - Eating Concern
  - Weight Concern
  - Shape Concern
- Reliable & Valid for distinguishing between diagnoses
- Multiple translations

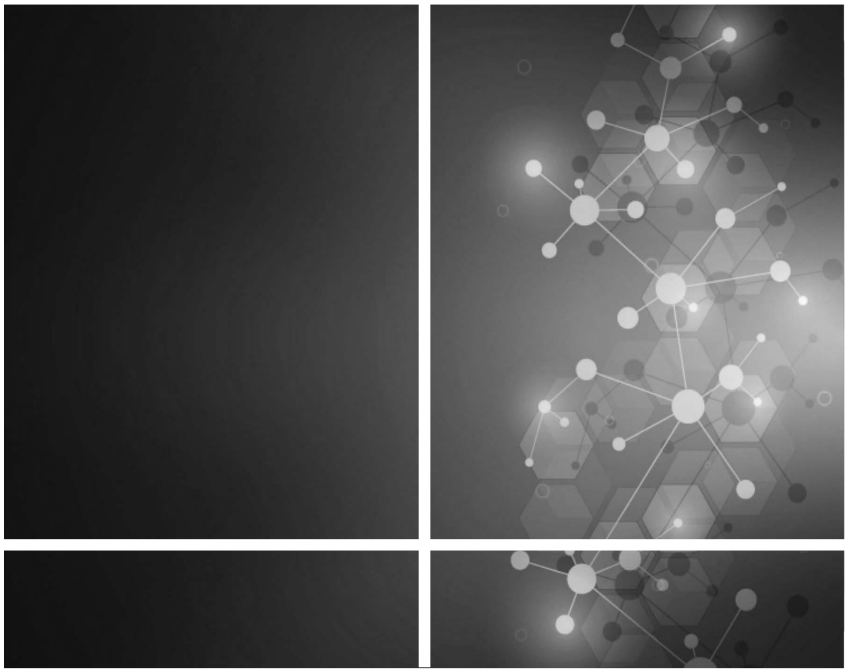


EATING DISORDER ASSESSMENT FOR DSM-5 (EDA-5)

- Semi structured interview
- Focus on diagnosis of DSM-5 EDs
- Skip-logic=different number of items for each respondent
- Reliability/validity:
  - ED diagnosis demonstrated
  - Fair/substantial agreement w/ diagnoses derived from EDE interview
  - Test-retest reliability of diagnoses was excellent/almost perfect
- English & Norwegian versions available
- Free online: https://eda5.org/

STRUCTURED CLINICAL INTERVIEW FOR DSM-5 (SCID-5)

- Semi-structured interview
- Used to diagnose the major DSM-5 diagnoses
- Currently no reliability and validity data available for SCID-5 eating disorder diagnoses
- Multiple languages
- Available for purchase at: https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5



EATING DISORDER SCREEN FOR PRIMARY CARE (ESP)

- 5 questions
  1. Are you satisfied w/ eating patterns?
  2. Do you ever eat in seceret?
  3. Does your weight affect the way you feel about yourself?
  4. Have any members of your family suffered with an eating disorder?
  5. Do you currently suffer with, or have you ever suffered in the past, with an eating disorder?
- Scored "yes" or "no"
- Any abnormal response indicates the need for further assessment

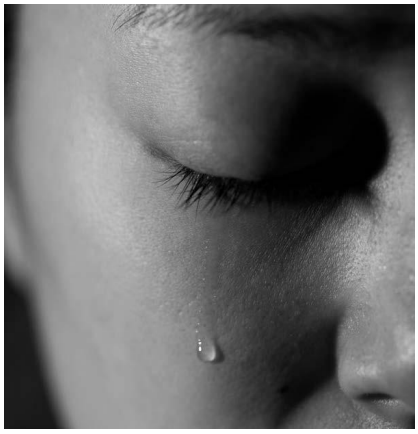
OBJECTIVE 3: UNDERSTAND MOST COMMON COMORBIDITIES

- Anxiety
- Depression
- OCD
- Borderline Personality Disorder
- Trauma
- Substance Use Disorders

COMORBIDITIES: ANXIETY

- Generalized Anxiety Disorder (GAD):
  - Excessive general worry and trouble concentrating
- Social Anxiety Disorder (SAD)
  - Intense fear of social interaction
  - Worried about humiliation
- Panic Disorder
  - Panic attacks/terror
- Phobia
  - Avoiding certain things or situations that make someone uncomfortable or fearful
- ***MUST NOT be about eating and weight
- ***Determine the FUNCTION of the behavior

COMORBIDITIES: DEPRESSION



- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight
- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue
- Feelings of low self-worth, guilt or shortcomings
- Difficulty concentrating or making decisions
- Suicidal thoughts or intentions
- Must last longer than 2 weeks

***Differentiation between TIMING of symptoms

OBSESSIVE-COMPULSIVE DISORDER

- Repetitive, unwanted, intrusive thoughts (obsessions)
- Irrational, excessive urges to perform certain actions (compulsions)
- May have insight, but are often unable to stop their thoughts and behaviors
- Obsessions OR compulsions
- Must differentiate from focus on eating disorder symptoms

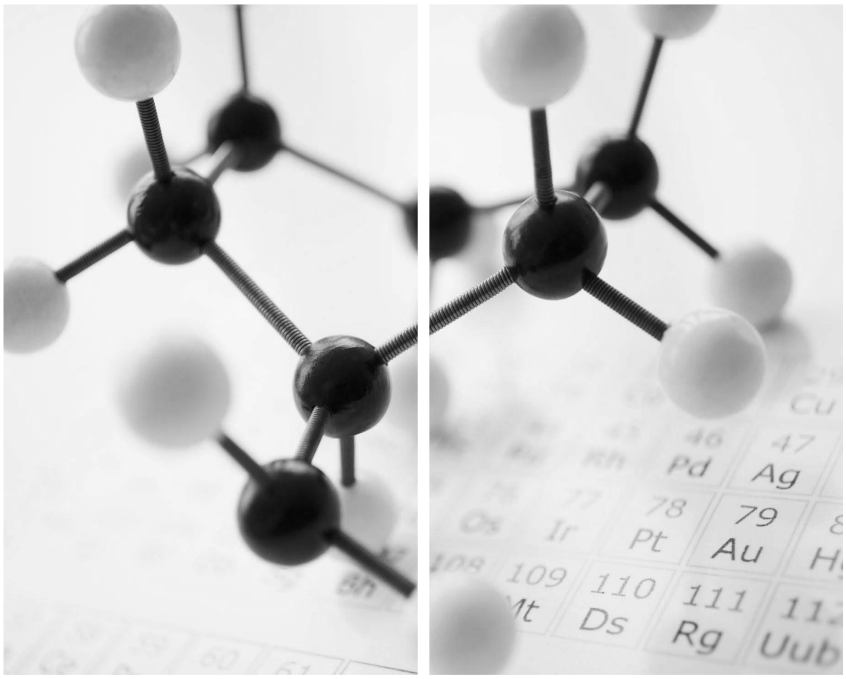
BORDERLINE PERSONALITY DISORDER, TRAUMA, & SUBSTANCE USE DISORDERS (SUDS)

OBJECTIVE 4: RECOGNIZE THE ETIOLOGICAL FACTORS OF ED

- Genetics
- Personality
- Media/social media
- Brain structure/biology
  - Serotonin
  - Dopamine

GENETIC FACTORS

- Genetic factors predispose for approximately:
  - 33-84% to anorexia nervosa
  - 28-83% to bulimia nervosa, and
  - 41-57% to binge eating disorder



PERSONALITY FACTORS

- Personality traits commonly associated with eating disorder (ED) are high:
  - Perfectionism,
  - Impulsivity,
  - Harm avoidance,
  - Reward dependence,
  - Sensation seeking,
  - Neuroticism, and
  - Obsessive-compulsiveness
- In combination with low:
  - Self-directedness,
  - Assertiveness, and
  - Cooperativeness

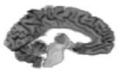
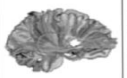
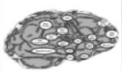
MEDIA

- Evidence from 50 studies in 17 countries indicates that social media usage leads to:
  - Body image concerns
  - Eating disorders/disordered eating, and
  - Poor mental health
- Via the mediating pathways of:
  - Social comparison,
  - Thin/fit ideal internalization, and
  - Self-objectification

- Specific exposures
  - Social media trends,
  - Pro-eating disorder content,
  - Appearance focused platforms, and
  - Investment in photos
- And moderators
  - High BMI,
  - Female gender, and
  - Pre-existing body image concerns
- STRENGTHEN the relationship

- While other moderators:
  - High social media literacy and
  - Body appreciation
- Are protective
  - Hinting at a 'self-perpetuating cycle of risk'

BRAIN STRUCTURE/ BIOLOGY

	**Neurochemistry**	○ Serotonin 1A receptor ↑ in ill AN, BN ○ Serotonin 2A receptor normall in ill AN, ↓ in rec AN ○ Hormones, Neuropeptides altered in ill EDs, often normalize with recovery; may interfere with appetite regulation and reward system ○ Cytokines ↑ in ill AN, BN, normalize with recovery
	**Gray Matter Volume and Cortical Thickness**	○ Cortical volume and thickness vary among studies in EDs probably due to the confounding factors malnutrition, dehydration, comorbidity, medication use, etc. ○ Lower volume or thickness in AN frequently normalize with weight restoration
	**White Matter Volume, Integrity and Structural Connectivity**	○ WM volume varies similarly to GM studies ○ Fractional anisotropy (FA) thought to reflect fiber integrity, tends to be lower in AN and BN ○ Lower FA may be compensated for in AN and BN with increased fiber development between insula and orbitofrontal cortex
	**Functional and Effective Connectivity**	○ ↑ and ↓ functional connectivity in DMN (interoception), SN (orientation to food stimuli) and ECN (decision making) in AN, BN ○ Effective connectivity to the hypothalamus in AN, BN may override hunger signals
	**Task-Based fMRI Studies**	○ Reward circuits are consistently altered to food stimuli in insula, striatum, orbitofrontal cortex ○ Altered prediction error response to food and monetary stimuli suggest altered dopamine circuit response in AN, BN, BED ○ Perception, ↑ and ↓ in insula, parietal and visual cortex to interoception or visual perception tasks ○ AN is associated with reduced insula neural taste discrimination ○ Cognition tasks often ↑ and ↓ brain response in AN although behavior response mostly normal ○ BN had ↑ striatal and worse behavior response when distracted by food images ○ Social interaction, Gentle touch and visual intimate stimuli were associated with ↓ brain response and ↓ pleasantness ratings
	**Microbiota and Microbiome**	○ ↓ Diversity of gut microbial cells (microbiota) in AN, may normalize with weight restoration

OBJECTIVE 5: ESTABLISH AN UNDERSTANDING OF DIVERSITY ISSUES RELATED TO EDS

Age: More common during teens and early 20s

Gender: Women and girls more likely to be diagnosed…men underdiagnosed?

Thinness v/ muscle

Culture: What are our assumptions?

Yet no reliable ethnic differences

Vocation/activities: Common among gymnasts, runners, wrestlers, and dancers

OBJECTIVE 6: UNDERSTAND TREATMENT OPTIONS AND WHEN TO REFER

Treatment plans include:

Psychotherapy (indiv, group, family)
Medical care and monitoring
Nutritional counseling, and/or
Medications

Typical treatment goals include:

Restoring adequate nutrition
Bringing weight to a healthy level
Reducing excessive exercise
Stopping binge-purge and binge-eating behaviors

TREATMENT OPTIONS

- Cognitive-behavioral therapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Dialectical Behavior Therapy (DBT)
- Narrative therapy
- Internal Family Systems
- Family therapy
- Multidisciplinary
  - Dietitian
  - Physician
  - Behavioral health expert

COGNITIVE BEHAVIORAL THERAPY

- Core concepts of CBT include:

1. Psychological issues are partly based on unhelpful ways of thinking
2. Psychological issues are partly based on learned patterns of behavior
3. Those living with these issues can improve with better coping mechanisms and management to help relieve their symptoms

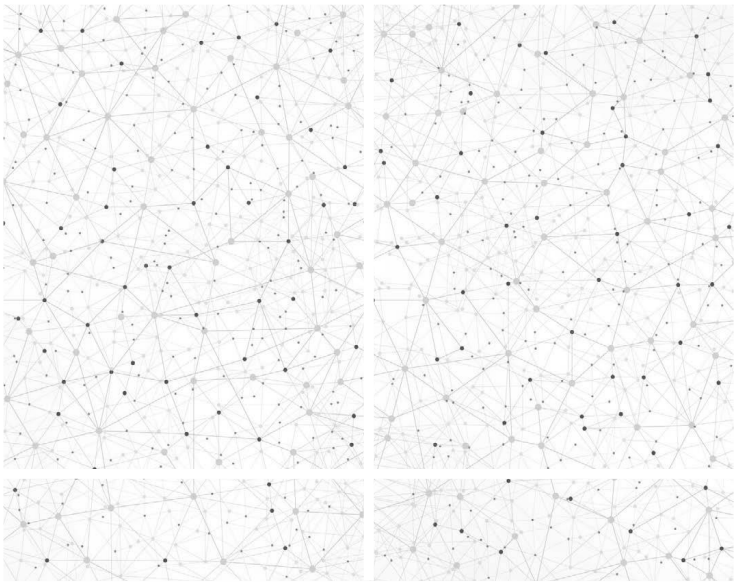
- May include use of homework, such as a food/exercise diary
- Cognitive restructuring/reframing
- Thought recording
- Self-talk

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

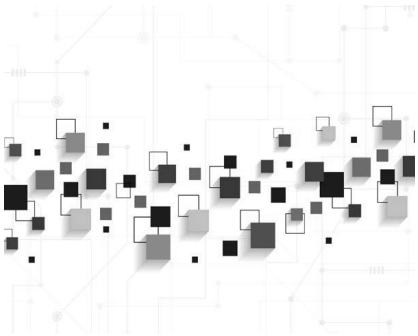
- A type of talk therapy aimed at helping people accept difficult thoughts and emotions, while
- Simultaneously making proactive, positive changes in their life
- Based on the idea that distress is not caused by negative thoughts or experiences in and of themselves,
- But rather the fixation on or attachment to these thoughts and emotions
- Instead of something that needs to be "fixed," negative thoughts are presented in ACT as part of the greater life experience
- Helps to create psychological flexibility→overcome disordered thoughts/behaviors

DIALECTICAL BEHAVIOR THERAPY (DBT)

- Helps people develop new coping and relationship skills
- Helpful because the ED behaviors can become a way to deal with upsetting feelings or relationship stressors
- 4 categories:
    1. Mindfulness
    2. Distress Tolerance
    3. Interpersonal Effectiveness
    4. Emotion Regulation



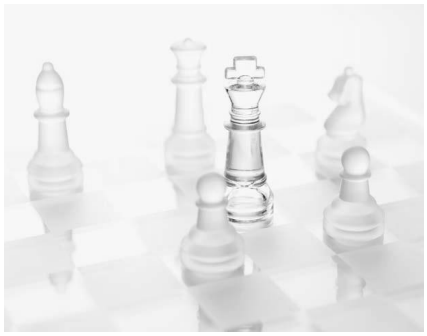
NARRATIVE THERAPY AND INTERNAL FAMILY SYSTEMS



- Narrative therapy
  - Non-pathologizing approach to therapy in which people remain the experts on their own lives
  - Views problems as separate from people
  - Assumes each person has the tools to reduce the impact of problems on their lives
- Internal Family Systems work
  - Views symptoms and behaviors as "parts"
  - Encourages client to take on a self-compassion led perspective
  - Model welcomes all "parts", allowing space for holistic healing

FAMILY THERAPY

- Boundaries
  - Enmeshment=attempt to create separate identity by exerting control
  - Permissive=lack of oversight of behavior
- Unrealistic expectations
  - Perfectionism
  - Rigid
  - Driven by success
- Marital discord/divorce
- Domestic violence/neglect/abuse



MULTIDISCIPLINARY TEAM APPROACH

- Widely recognized as best practice with disordered eating behaviors
- Team members include:
  - Physician
  - Nutritionist
  - Mental health professional
- Prognosis is directly relate to the duration of the illness
  - Early identification is necessary for early intervention
- Despite these efforts, overall prognosis is poor, with only 40-50% of patients with AN and BN progressing to complete recovery

OTHER RESOURCES

•**Project HEAL:** a nonprofit offering financial assistance for ED treatment, including funding and help navigating insurance

•**Equip Health:** a telehealth platform to support those with eating disorders via the evidence-based Family Based Treatment modality

•**Arise:** a new digital healthcare startup offering free and low-cost ED and disordered eating recovery programs

•**FEDUP Collective:** a trans-led group that helps trans people connect to free and low cost ED care, grocery funds, meal support, and more and maintains a list of trans-identified and trans-allied clinicians and a scorecard ranking ED recovery facilities for trans inclusion

•**Association for Size Diversity and Health:** an organization that promotes the Health at Every Size framework, provides resources for people affected by fatphobia, and is currently developing a directory of weight-inclusive healthcare professionals

•**National Eating Disorders Association:** a national organization that manages a helpline and has compiled a list of free and low cost resources, as well as information about accessing treatment

•**National Association of Anorexia Nervosa and Associated Disorders:** a nonprofit offering peer-led support for those with restrictive disordered eating habits, including a helpline, a mentorship program, treatment referrals, and a directory of eating disorder-informed clinicians

•**National Alliance for Eating Disorders:** a nonprofit offering virtual therapist-led support groups, referrals to treatment, and a helpline for those in need of support, as well as direct outpat

•ient services in South Florida

NEDA
Feeding hope.
National Eating Disorders Association

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THANK YOU

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