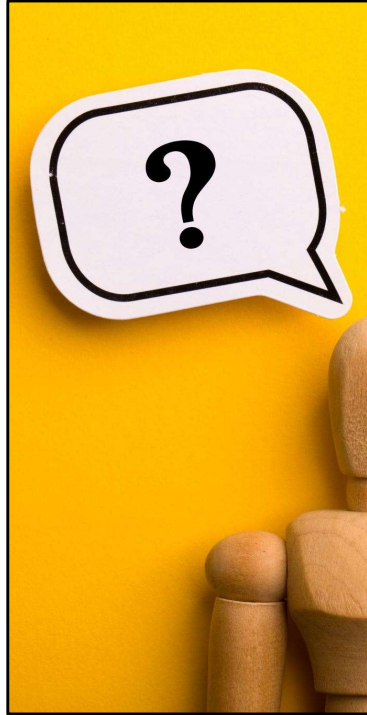


Eating Disorders: What you need to know

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Clinical Director**

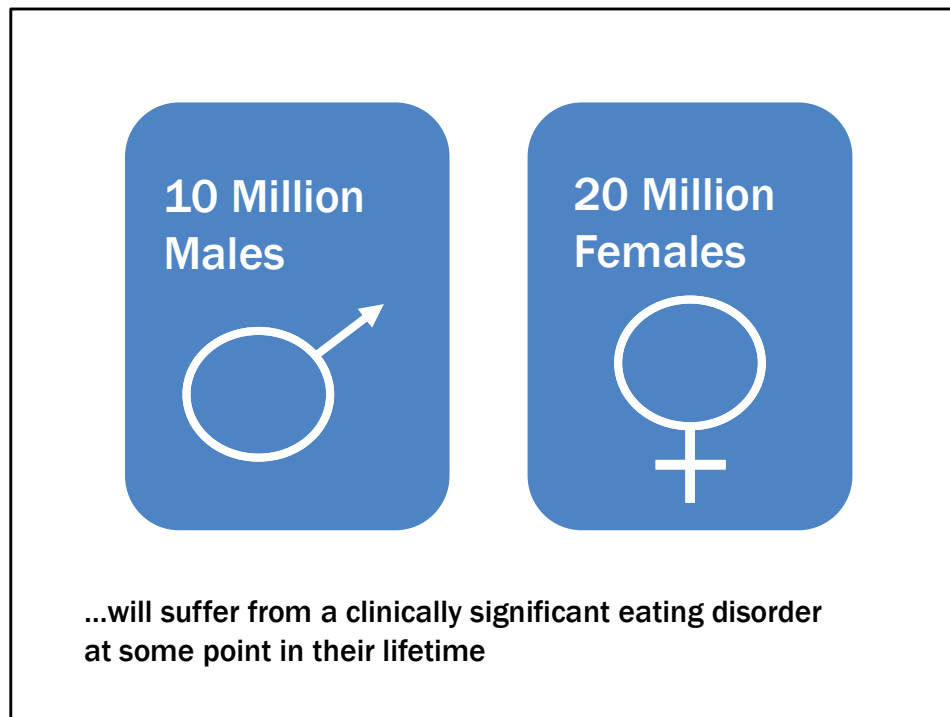


Melrose Center



Objectives

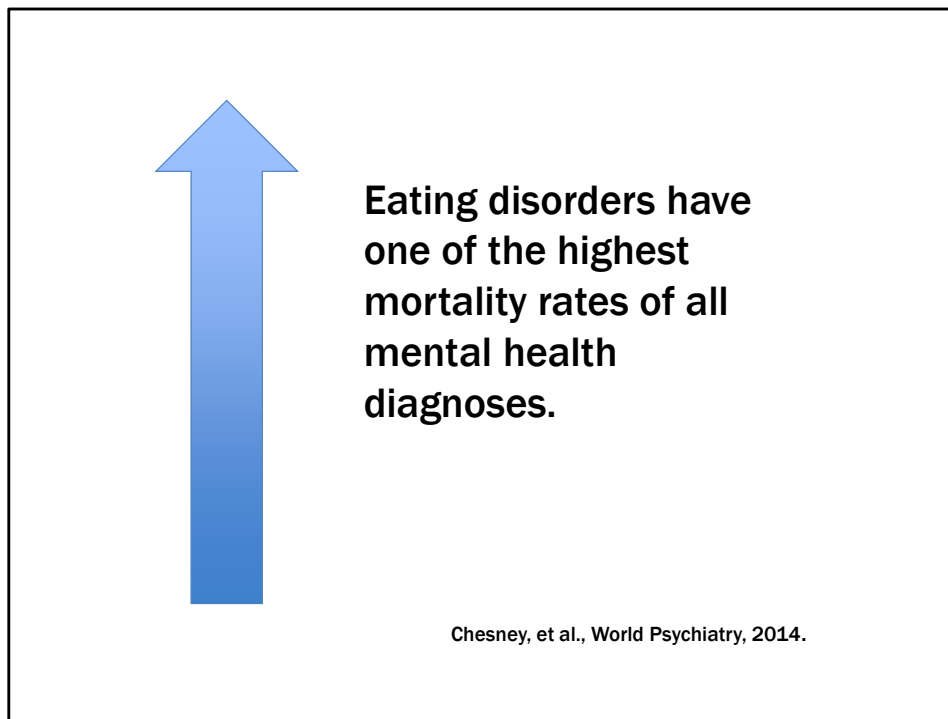
- Recognize warning signs and symptoms of EDs
- Discuss intervention & treatment of Eds
- Discuss ways you can help someone with an ED



30 million Americans (10 million males, 20 million females) will suffer from a clinically significant eating disorder at some point in their lifetime (Wade, Keski-Rahkonen & Hudson, 2011).



Only 1 in 10 will seek treatment



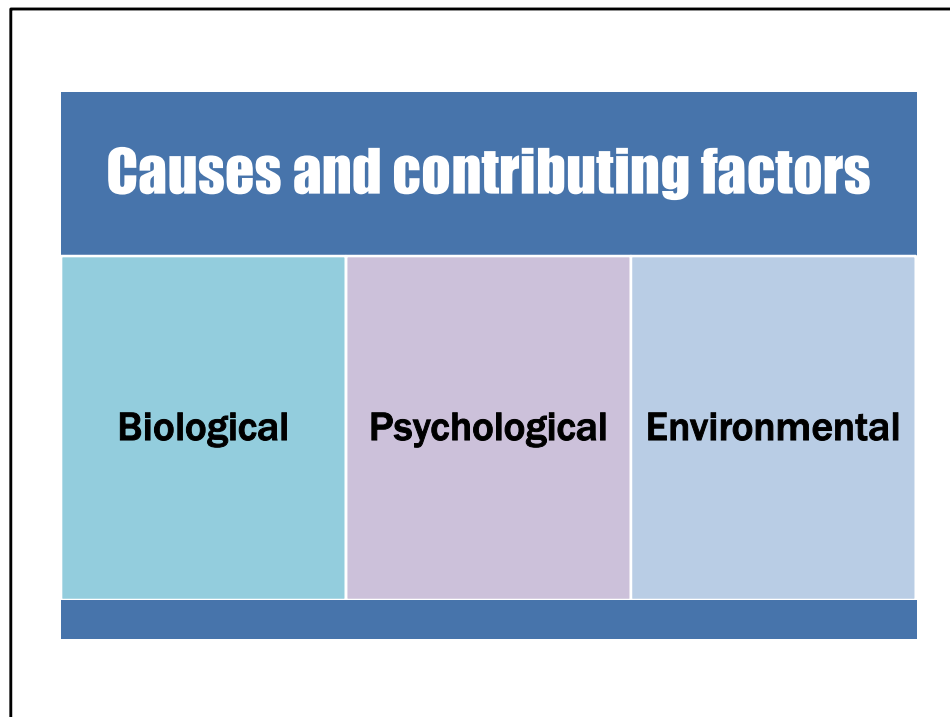
All cause mortality rate.

Eating disorders are serious. They die from organ failure from the result of starvation and also from suicide.

UP to 35% of people with AN attempt suicide at some point in their illness

Up to 35% of People with BN.

People with AN are 23times more likely to die from suicide than normal, this is higher than other psychiatric illness, depression is 20X, Bipolar is 15X.



Biological: Genetics, being female, early maturation

Psychological: History of OCD, anxiety, depression, history of substance abuse, personality traits: perfectionistic/impulsive, vulnerable to teasing/peer pressure

Environmental: Influence of peers and media, certain family dynamics, sports participation, culture of dieting, history of abuse or other traumas

What Does an Eating Disorder Look Like?



The prevalence of eating disorders is similar among Non-Hispanic Whites, Hispanics, African-Americans, and Asians in the United States, with the exception that anorexia nervosa is more common among Non-Hispanic Whites (Hudson et al., 2007; Wade et al., 2011)

Eating disorders do not discriminate. Eating disorders can affect people of all racial and ethnic backgrounds, sexual orientations, body types, gender identities and ages.

Bias & Diversity in Eating Disorders

People of color-especially African Americans - are significantly less likely to receive help for their eating issues.

EDs impact ALL kinds of bodies

Rates of eating disorders and body dissatisfaction on the rise later in life.

1 in 3 people struggling with an ED are male

Children as young as 8 are struggling with EDs

LGBTQ+: Gay & Bisexual males and transgender individuals at higher risk for EDs

Ethnicities: People of color with eating and weight concerns were significantly LESS likely than white participants to have been asked by a doctor about eating disorder symptoms despite similar rates of eating disorder symptoms across all ethnic groups.

Eating Disorders & Body Diversity: Perception remains that EDs occur in individuals who are underweight

Eating Disorder in middle and older age: Some have struggled since youth and have never fully recovered, some have recovered and relapsed, some have struggled with food and weight issues but never full ED.

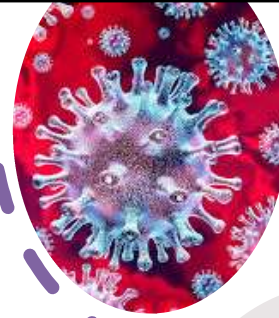
Eating Disorders and males: Eds are the most gendered of all psychiatric disorders. Male teen body dissatisfaction has tripled in the past 25yrs, men are much less likely to seek treatment for Eds due to the stigma that this is a “female disorder”

Eating Disorders and young Children: Mostly AN and ARFID – often start with dieting, most have anxiety disorders or OCD and perfectionistic, most active in sports, 97% avoid certain foods

LGBTQ+: 63% of gay males base their worth on their weight, in one of the largest survey studies of eating disorders amongst college aged individuals found that 15.8% of TG individuals reported an ED Dx vs. 1.85% of cisgender heterosexual females

COVID 19 & Eating Disorders

- Major life events often disrupt usual eating routines for most people.
- COVID 19 has created a perfect storm for people who struggle with weight and eating issues.
- Eating Disorders are already a disorder of isolation – the pandemic isolated us.
- Food supply issues.
- Early study on this showed increase in restriction and B/P episodes for those with preexisting EDS
- We have seen an influx of new patients with onset since pandemic – especially adolescents
- Challenges with treatment delivery



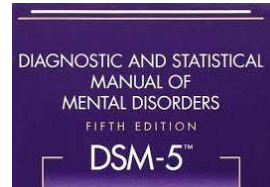
- More than 50% of US adults have reported a negative impact to their mental health due to stress and worry over COVID
- Our lives have been disrupted in a major way.
- Stress often impacts our eating and appetite and for some that can mean we turn to food to cope with stress, for others it means they have less of an appetite.
- There has been a lot of focus in the media regarding weight gain and COVID, “quarantine 15” “pandemic pounds” which is stressful for anyone but also very stressful and triggering for people with ED’s.
- Eating disorders are already a disorder of isolation and “hiding things from others” often times during normal times people with EDs start to isolate more as the ED worsens and a big part of our treatment is reconnecting and encouraging things like eating with others, etc. Which the pandemic has obviously impacted.
- Food supply issues have also been very difficult for people with EDs on each end of the spectrum. So people with AN often times eat in a more rigid way and those foods may be more difficult to find, stocking up for quarantine has also been very difficult for those with BED and BN as food that we typically may stock up on are foods with longer shelf-lives and be foods that people are prone to binge on.
- Exercise challenges: For folks who are used to exercising even in a moderate way have been challenged with gyms closed, the stress and anxiety of this has led some to increase exercise which isn’t necessarily a good thing and has driven some to resume


exercise in their homes .

- We have recently seen an increase in new patients whose onset of illness has been since pandemic. “time to get healthier” “stay in shape” Way to control something in an out of control situation.
- Challenges with treatment delivery with virtual hard to see them, weights, initially hard to get labs, vitals, etc. Have had to limit our capacity for higher need folks. Change up our programming.

DSM-5 Diagnoses

- **Anorexia Nervosa**
- **Bulimia Nervosa**
- **Binge Eating Disorder**
- **Avoidant/Restrictive Food Intake Disorder (ARFID)**
- **Other Specified Feeding or Eating Disorder (OSFED)**
- **Unspecified Feeding or Eating Disorder (UFED)**

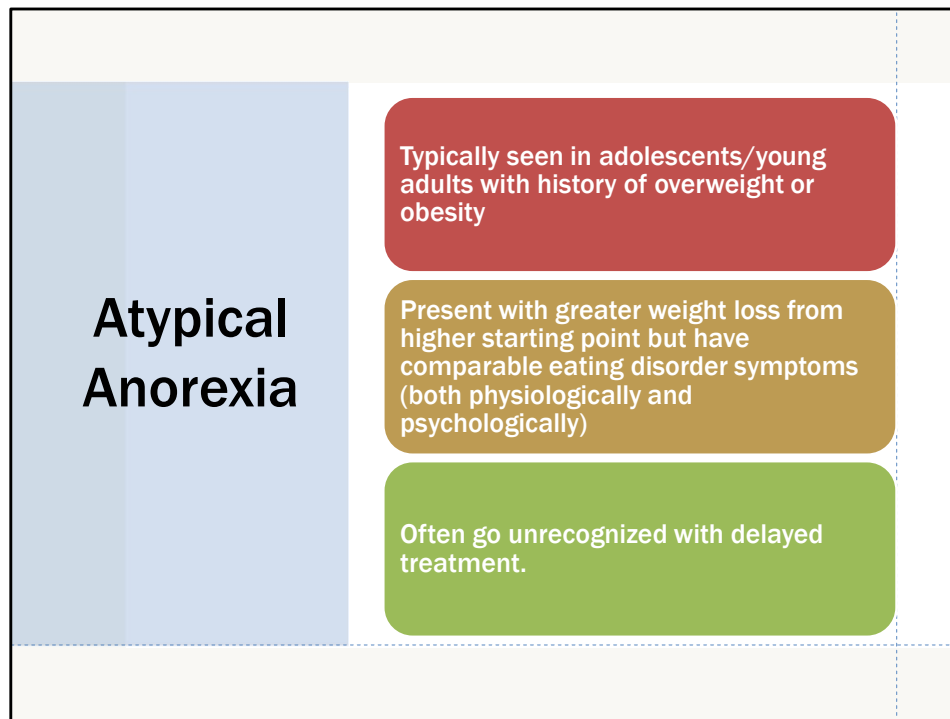




ANOREXIA NERVOSA

- Restriction
- Intense fear of gaining weight or of becoming fat
- Or persistent behavior that interferes with weight gain
- Disturbance in the way in which one's body weight or shape is experienced

- **Weight Loss**
- **Falling off growth curve**
- **Lanugo (soft, downy body hair)**
- **Always dressed in layers**
- **Pacing, constant movement**
- **Rigid, restrictive eating**
- **Not wanting to eat around others, making excuses not to eat**
- **Severe distress on discussion of weight or food**



Typically seen in adolescents/young adul

BULIMIA NERVOSA

- Binge Eating: eating a large amount of food in a set time period with lack of control
- Compensatory Behavior – exercise, purging, laxatives, diet pills
- Once a week for 3 months
- Extreme concern with body weight and shape



Characterized by eating large amounts of food--more than most people would eat in one sitting, and then getting rid of the food through vomiting, laxative abuse, or over exercise.

Symptoms include:

- Repeated episodes of binge eating and purging
- Feeling out of control during a binge
- Purging after a binge, (typically by self-induced vomiting, abuse of laxatives, diet pills and/or diuretics, excessive exercise, or fasting)
- Extreme concern with body weight and shape
- Frequency of binge eating and purging occur at least once a week for 3 months.

What is Binge Eating Disorder?

- Most prevalent
- More equal prevalence woman & men
- Most Unrecognized & undertreated
- Similar prevalence across racial groups
- Strongly associated with obesity

- Eating, in a discrete period of time (e.g. within any 2-hour period), **an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.**
- **lack of control** over eating during the episode
- much **more rapidly** than normal
- **until feeling uncomfortably full**
- when **not feeling physically hungry**
- **alone** –don't want people watching or asking questions
- Feeling **embarrassed**
- **Feeling disgusted** with oneself, **depressed or very guilty** afterward

Patient Factors:

- Not aware that BED is a disorder
- Discomfort in raising binge eating as an issue (shame/embarrassment)
- BED is secretive illness
- Perceived stigma



**Avoidant/Restrictive
Food Intake
Disorder (ARFID)**

Eating/Feeding Disturbance:

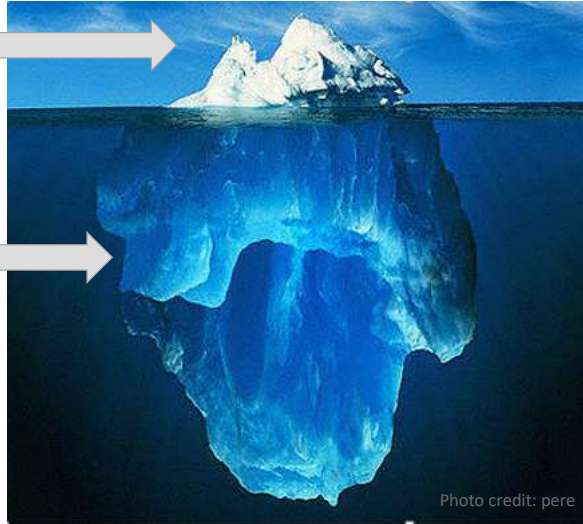
- Significant weight loss (or failure to achieve expected weight gain)
- Significant nutritional deficiency
- Dependence on enteral feeding or oral supplements
- Marked interference with psychosocial functioning

- An eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional or energy needs associated with:
 - Significant weight loss (or failure to achieve expected weight gain)
 - Significant nutritional deficiency
 - Dependence on enteral feeding or oral supplements
 - Marked interference with psychosocial functioning.

3 main presentations related to extreme picky eating (often due to sensory sensitivity), Lack of interest in food or eating, fear of aversive consequences

What we see

**What we
don't
SEE**





Medical Complications of Eating Disorders

Low blood pressure/pulse, risk of arrhythmias

Osteoporosis, fractures

Brain volume loss

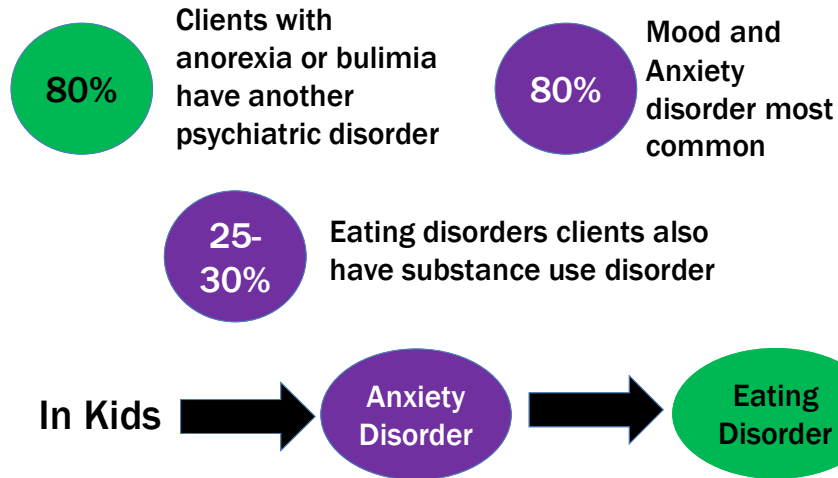
Delayed gastric emptying, gastroparesis

Muscle wasting

Lanugo on body, loss of hair from scalp

Decreased body temperature, hypothermia

Psychiatric Comorbidities



- High levels predict more severe eating disorder
- Substance abuse disorders in at least 25-30% of ED patients
- Anxiety disorders often precede onset of ED in children

Majority of studies have found significantly higher prevalence of trauma in ED patients compared to general population.

40.8% report childhood sexual trauma

35% report adulthood sexual trauma

37% of BN patients meet criteria for PTSD

21% of BED patients meet criteria for PTSD

Eating Disorder

Research had found that up to **50%** diagnosed with an eating disorder will struggle with substance abuse, whereas only 9% of the general population is diagnosed with SUD.

Substance Abuse

Conversely, **35%** of those who abuse substances have been found to have an eating disorder compared to 3% of the general population diagnosed with ED



Nearly 1 in 10 bulimia patients have a comorbid substance abuse disorder, usually alcohol use.¹²

Nearly 1 in 10 BED patients have a comorbid substance abuse disorder, usually alcohol use.¹²

Nearly 1 in 10 EDNOS patients have a comorbid substance abuse disorder, usually alcohol use.¹²

Research has found that ED often comes first

High Risk Eating and Activity Behaviors

- Severe Dietary Restriction (<500kcal/day)
- Skipping meals to lose weight
- Prolonged periods of fasting
- Self-Induced Vomiting
- Use of diet pills, laxatives, or diuretics
- Compulsive and Excessive Exercise
- Social isolation, irritability, fear of gaining weight, rigidity around foods and eating routines, body image distortion



Window of Recovery

- Full and lasting recovery can be achieved if the eating disorder is treated within **5 years from onset**.



An Eating Disorder Assessment is recommended when:



Any medical sx's:

- Feeling faint or fainting
- Shortness of breath/chest pains
- Any swelling in the extremities
- Feeling weak, fatigued
- Feeling cold, blue extremities
- Difficulty concentrating

Weight loss:

14 lbs in 3 mos

OR

10% in 2 months

Actively Engaging in ED
behaviors

Purging 1x or > week

BMI: 18 or lower



Unlike Most psychiatric disorders, eating disorders are associated with physical health complications and anyone with clinical responsibility for patients with eating disorders should be aware of this and have a plan for how to address.

Patient's health and safety are of utmost importance and cannot be neglected.

Treatment Modalities

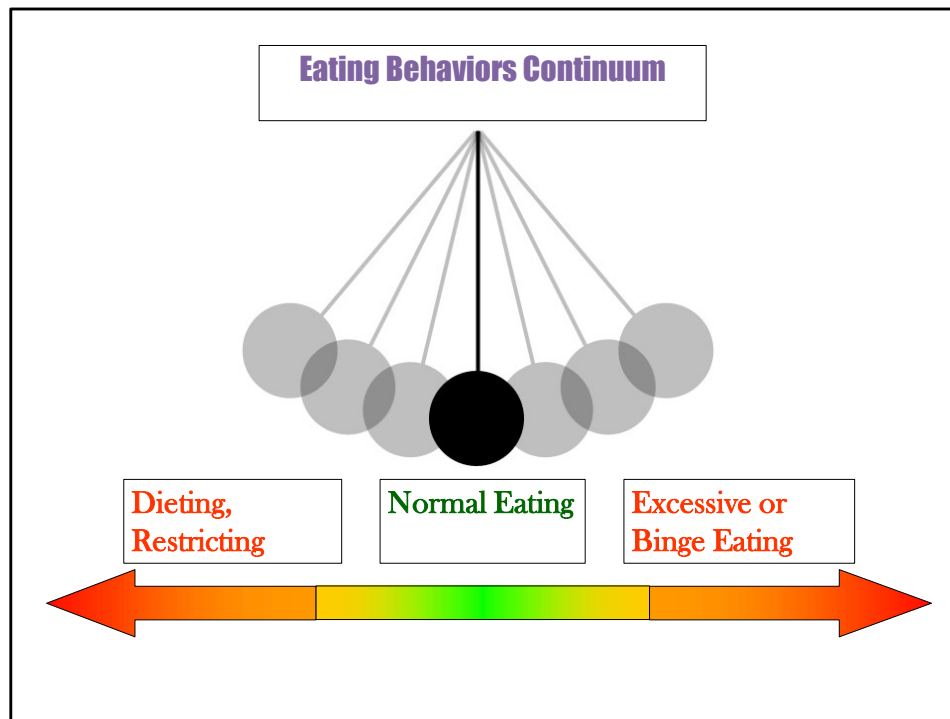
- Family Based Therapy (FBT)
- Cognitive Behavior Therapy Enhanced
- Dialectical Behavior Therapy (DBT)
- Radically Open Dialectical Behavior Therapy (RO-DBT)
- Cognitive Behavioral Therapy –Avoidant Restrictive (CBT-AR)



The Basics

1. **Regular Eating**
 - 3 planned meals, 2-3 planned snacks a day
 - Typically no more than 4 hours between
2. **Self-Monitoring**
 - Daily self-monitoring records of food intake, symptom use & context/comments
3. **Psychoeducation about Eating Problems**





All foods fit in moderation



❖ Stabilize medical condition

❖ Restore or stabilize weight

❖ Interrupt and reduce eating disorder symptoms

❖ Re-establish normal eating patterns

❖ Implement new behavioral strategies & skills

❖ Prevent relapse

GOALS OF TREATMENT

**What do I do if I'm
concerned someone
has an eating
disorder?**

Don't watch & wait!!!

If you suspect an eating disorder, or if known hx of eating disorder and client has increasing symptom use, refer to Melrose for initial assessment
Melrose does not require clients to "meet criteria" for initial assessment

What do I do?

- **Be aware of your own weight biases!**
- **Build trust & rapport** with the individual
- **Avoid psychologically loaded terms** such as “fat,” “weight gain”
- **Avoid giving your opinion** on the patient’s weight or physical appearance
- **Avoid placing shame, blame or guilt** on the person
- **Avoid giving simple solutions**

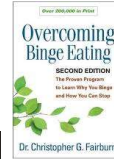
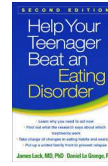
What can I say?

- Use "I statements" rather than "you" statements.
- Don't be vague, ask specific questions
- "I'm concerned about your weight, let's discuss this today"
- "Tell me how you feel about your body."
- "How do you feel when you are eating?"
- "How much time do you spend thinking about food?"
- "I'm worried about your eating. I would like you to see a specialist to talk more about your eating and how you are feeling about yourself."
- Follow up with the individual and ask what they heard and how they feel



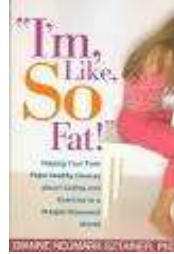
Resources

- **Help your Teenager Beat an ED**
 - Lock & Le Grange
- **Overcoming Binge Eating**
 - Christopher Fairburn
- **Sick Enough**
 - Jennifer Gaudiani



Resources

- I'm Like so Fat!
 - Dianne Neumark-Sztainer
- FEAST
 - <https://www.feast-ed.org/>
- NEDA
 - <https://www.nationaleatingdisorders.org/>
- Recovery Record App
- Rise up and Recover App
- Brighter Bite App



Melrose Center: St. Louis Park



- 30 beds intensive residential, 9 beds residential
- PHP, IOP, Group programming for BED and Family
- Plus initial assessments and outpatient services

Maple Grove

St. Paul

On the **Green Line**

- Initial Assessments
- Outpatient follow up with MD, RD, LP
- Video Visits

Burnsville

Woodbury

