Screening for Eating Disorders

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Agenda

- Overview of eating disorders; Review Malnutrition
- Screening Tools / Diagnosis / Medication
- Closer look into ARFID & binge-eating disorder
- Recognize signs and symptoms associated with eating disorders
- Review Levels of Care; Common Referral Sources

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A few Truths About Eating Disorders

- Many people with eating disorders look healthy yet may be extremely ill.
- Eating disorders carry an increased risk for both suicide and medical complications.
- Genetics and environment play important roles in the development of eating disorders.
- Full recovery from an eating disorder is possible. Early detection and intervention are important.

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Eating Disorder Forms

- Anorexia Nervosa
- Orthorexia*
- Bulimia Nervosa
- OSFED (other specified feeding or eating disorder)
- EDNOS (Eating Disorder not otherwise Specified)
- Diabulimia*
- ARFID
- Binge-eating Disorder

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Anorexia Nervosa

- **Restriction** of energy intake that leads to a significantly low body weight in the context of age, sex, development and physical health
- Intense **fear** of gaining weight or becoming fat, even when underweight
- Disturbance in the way in which one's body weight or shape is experienced, or denial of the seriousness of the current low body weight. **Poor body image**
- Atypical anorexia includes those individuals who meet the criteria for anorexia but who are not underweight despite significant weight loss.
- Mild, Moderate and Severe Protein-Energy Malnutrition is present

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Clinical Diagnosis can be used for all disorders eating disorders

Two or more symptoms must be present for diagnosis

- Mild Protein-Energy Malnutrition
  - NPO >7days or <75% intake for 2 weeks or more
  - 80-90 of IBW or BMI 17.1-18.5
  - Mild weight loss
- Moderate Protein-Energy Malnutrition
  - <75% energy intake >1 month
  - 70-79% IBW or BMI 16.1-17
  - Significant weight loss (see table)
- Severe Protein-Energy Malnutrition
  - <50% energy intake >1 month
  - <70% IBW or BMI <16
  - Severe weight loss (see table)
  - Measurably reduced hand grip strength
  - Severe muscle or fat loss (visual)

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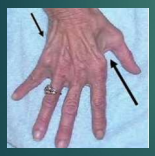
Physical Screening

- Hand Region
- Clavicle Region
- Temple Region



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Coding for Insurance

- ICD-10 Titles
- Primarily used in treatment codes (E43, E44, E44.1, E46)
  - Mild protein-calorie malnutrition
  - Moderate protein-calorie malnutrition
  - Unspecified severe protein-calorie malnutrition
  - Unspecified protein-calorie malnutrition

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Orthorexia

- Orthorexia is the term for a condition that includes symptoms of obsessive behavior in pursuit of a healthy diet. Orthorexia sufferers often display signs and symptoms of anxiety disorders that frequently co-occur with anorexia nervosa or other eating disorders

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Orthorexia behavior changes/signs

- Obsessive concern over the relationship between food choices and health concerns such as asthma, digestive problems, low mood, anxiety or allergies
- Increasing avoidance of foods because of food allergies, without medical advice
- Noticeable increase in consumption of supplements, herbal remedies or probiotics
- Drastic reduction in opinions of acceptable food choices, such that the sufferer may eventually consume fewer than 10 foods
- Irrational concern over food preparation techniques, especially washing of food or sterilization of utensils

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Bulimia Nervosa

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a **discrete** period of time in an amount of food that is larger than most people would eat during a similar period of time
  - A sense of **lack of control** over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.

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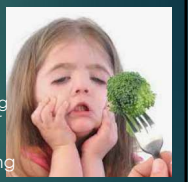
Avoidant/Restrictive Food Intake Disorder (ARFID)

- Knowns as the "picky eaters" "problem feeder"
- Restriction is not based around body image
- DSM-5 criteria: eating or feeding disturbance (subtypes)
  - apparent lack of interest in eating or food
  - Avoidance of eating based on the sensory characteristic of food
  - Concern about adverse consequences of eating (example: fear of choking aka phagophobia) or vomiting
- Any of the above with 1 or more of the following
  - Significant weight loss; significant nutritional deficiency; dependence on oral nutritional supplements; marked interference with psychological functioning



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ARFID Continued

- Can develop the moment the baby starts eating, depending upon the experience
  - Imperative for providers if you suspect ARFID to get a complete feeding/eating history starting at birth and working to present
  - Background on growth, were there distractions in the home around meals, eating patterns and attachment
  - Often missed and little attention to the WHY low appetite/avoiding, early experiences/therapeutic history

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ARFID vs Anorexia and other trends

- More boys, younger onset
- Many may already have pediatric therapy
- **Worry / Pressure** (parental/medical/school)
- More sensory/texture (sensory subtype)
- **Fear** of choking/vomiting common
- Anxious about sugar, pesticides, GMOs, chemicals
- Anxiety about "eating clean"

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ARFID Treatment

- Trauma/Coercion
  - May be around food early childhood

    …I was forced to sit until I ate. I pooped myself cus I thought I wasn't allowed to use the bathroom"

    …my dad berated my brother for pouring too much ketchup. He sobbed while Dad forced him to eat it wit a spoon

    …I sat a the table 'til I fell asleep and got spanked for not eating, still have problems with those foods"
- Working on not being "pressured" focus on improving the anxiety this will improve intake

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Binge Eating Disorder

- Binge eating episodes are associated with three (or more) of the following:
  - Eating much more rapidly than normal.
  - Eating until feeling uncomfortably full.
  - Eating large amounts of food when not feeling physically hungry.
  - Eating alone because of feeling embarrassed by how much one is eating.
  - Feeling disgusted with oneself, depressed, or very guilty afterward.
- The binge eating occurs, on average, at least once a week for 3 months.
- **KEY:** binge eating is not associated with the recurrent use of inappropriate compensatory behaviors (e.g., purging) as in bulimia nervosa

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Common Signs and What to ask

- Have you ever used food to cope?
- Transgender population higher at risk; LGBTQIA
- Do you eat at night out of habit?
  - Avoiding food all day then overeating
  - Eating in secret
- How do you manage your stress? Is there feeling of depression, guilt or disgusted with oneself after overeating?
- Yo-Yo dieting
- Eating large quantities until uncomfortably full, even when not hungry
- Recurring episodes of uncontrollable eating
- Previous addiction; smoking cessation
  - Addict Brain (dopamine/serotonin affected)

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BED: Driven by the Internalized Thin Ideal

- Advertising / Social Media /Culture
- Diet Industry has increased to 66.3 Billion
- Public Health "Obesity" Campaigns
- Food Confusion: Good and Bad Food
- "Health" Confusion
- Food Trends
- Fashion Industry
- Stress / Over worked

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Ways to treat BED

- Identify top triggers to eating → emotion attached → reframe and practice with new skill
- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- IF/Then Planning
  - "If I feel stressed.....then I will eat"
  - Assists stopping a behavior 60% more effective in changing a negative thought
- Behavior Chain Analysis
  - Draw it out in very specific detail; walk through the binge

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Comparative thoughts to self harm

Binge eating → Relief of negative affect
In a Similar Way That
Self-harm behaviors → Relief of negative affect

- Negative affect is most frequent precursor to binge eating (cf.Greeno, Wing, & Shiffman, 2000)
- Eds, are like suicidal behaviors, may function to regulate affect
- DBT is a skill specifically designed to teach adaptive affect regulation and to target behaviors resulting from emotional dysregulation

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Cognitive Behavioral

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When not to use DBT for Binge Eating/Bulimia

- With BED or BN clients with:
  - Severely chronic multiple symptoms
  - Actie suicidality
  - Combined borderline personality disorder and active substance abuse/dependance
  - Treatment of choice for above clients is the ORIGINAL comprehensive multimodal DBT program (see, e.g., Wisniewski, Safer & Chen, 2007)

A Rosewood Health Recovery Program

ROSEWOOD

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Binge Eating Disorder (BED) and Prevalence

- BED – 80% have some type of sexual trauma
- Higher rates of Substance Abuse and Dependence
- BED goes largely undiagnosed – shame and secrecy
- 30-40% of those seeking weight loss solutions have BED
- Still not covered by insurance unless medically complicated
  - Blood pressure, elevated blood sugar etc.
- Binge eating or loss-of-control eating may be as high as 25% in post-bariatric patients. [13]

Weight Increases with Time and Severity

- BED occurs in people of all sizes
- 19% normal weight
- 36% overweight
- 45% obese

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EATING DISORDER RISK FACTORS Conceptualization (3 P's)*

- Predisposing Factors
  - Genetic, Family Environment, the effects of environmental adversity, premorbid psychiatric conditions, cultural and societal pressures
- Precipitating Factors
  - Child Abuse, Adversity, Loss, developmental milestones, dieting behavior, body image issues, emotional dysregulation, poverty
- Perpetuating Factors
  - Starvation effects from chronic dieting, Unresolved PTSD, and ongoing family dysfunction

*Brewerton, T. Overview of Evidence on the Underpinnings of Bulimia Nervosa. In: Evidence-Based Treatment for Eating Disorders. 2009.

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Why Discuss?

- At least 30 million people of all ages and genders suffer from an eating disorder in the U.S. [1,2]
- Every 62 minutes at least one person dies as a direct result from an eating disorder.[3]
- About 38% of females and 16% of males with type 1 diabetes have disordered eating behaviors.[6]
- 16% of transgender college students reported having an eating disorder.[5]

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Why discuss continued

- ED have the highest mortality rate of any mental illness. The premature death rate associated with ED is **12 X's higher** than ALL causes of **death for females ages 15-24** and the third most chronic illness among adolescents.[5]
- *It is a progressive illness. 5-10% of anorexics **die within ten years** of onset, 18-20 % die within twenty years of onset, and only **50 % report ever being cured**.* APA *Practice Guidelines*
- The average age of ED sufferers is dropping (as young as elementary school), with peak onset among **girls ages 11-13**.
  - American Academy of Child & Adolescent Psychiatry

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Co-Occurring Disorders

Key presentations:

- Anxiety – meal times
- OCD – food rituals or EDBs
- Depression – increased desire for exercise
- Substance abuse
- PTSD – food traumas
- Borderline Personality

33-50% of anorexia patients have a comorbid mood disorder, such as depression.

Mood disorders are more common in the binge/purge subtype than in the restrictive subtype.[12]

About half of anorexia patients have comorbid anxiety disorders, including obsessive-compulsive disorder and social phobia.[12]

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Multidisciplinary Assessments

- Medical
- Nursing
- Dietary
- Psychological
- Psychiatric

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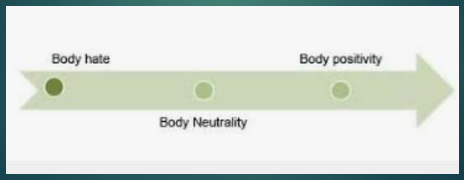
Treatment Priorities

- Medical stabilization
- Nutrition Stabilization
- Life Threatening Behaviors



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Medical Factors to Consider

- Bone Health even in Adolescents
  - Most recent DEXA scan; male and female
  - Early detection is key; bone loss more common in Anorexia and ARFID patients especially males
- Gastroparesis – true or secondary
- EDS or Joint hypermobility syndrome (JHS) - common in ED world
  - 14 types of EDS with hEDS and HSD more common but mis-understood. General 1 in 5,000 individuals worldwide however last year increase in prevalence of who we serve. 0.9% of our patients 2022 had this diagnosis. Maybe not so rare? 17/305

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Restoring Identity

- Our Goal is to help patients find their identity apart from food, weight, size or shape.
- Heal and stabilize the body
- Find meaning, value and purpose
- Find new ways to manage emotions / cope
- Body neutrality → Body Positive

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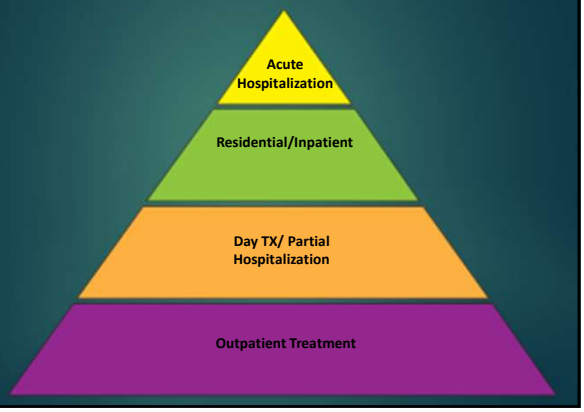
Treatment Setting Options



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Referral Programs and Education

Denver Acute - Colorado
Eating Recovery Center (ERC) – All Levels of care in CO, TX
Alsana - Missouri
Fairwinds – Clearwater Florida
Linden Oaks – Illinois
Monte Nido Sites – Clementine
https://www.edreferral.com

IAEDP
Phoenix Chapter
Eating Disorder HOPE (social media)

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Rosewood Programs and Levels of Care

Wickenburg, Arizona

- Rosewood Ranch Inpatient & Residential (Adult & Adolescents)
- BED Track (6 week design - 3 weeks Residential, 3 week PHP)
- Addiction Track
- Diabulimia Program with CDCES/diabetes educator on staff

Tempe, Arizona

- Rosewood Tempe Partial Hospitalization Program (Adult) + TL female bed only
- Rosewood Tempe Intensive Outpatient Program (Adult and Adolescent)

Scottsdale, Arizona

Rosewood Scottsdale Adolescent RTC all genders Opening Summer 2023

Arizona Virtual PHP & IOP Adults and Adolescents all genders

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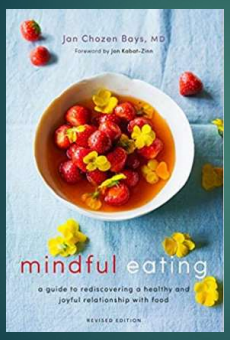
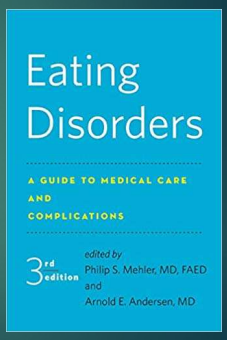
Resources





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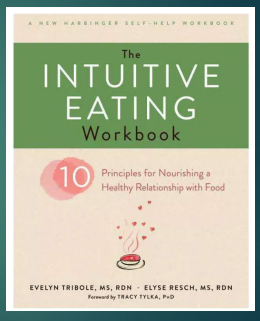

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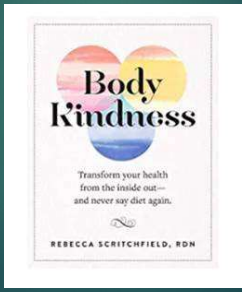
Body Image / Diet Focused Patients



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Thank you!

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