Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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WPPNT Reminders

How to join the Zoom webinar

- **Online:** https://dhswi.zoomgov.com/j/1606358142
- **Phone:** 669-254-5252
- Enter the Webinar ID: 160 635 8142#.
  - Press # again to join. (There is no participant ID)

Reminders for participants

- Join online or by phone by 11 a.m. Central and wait for the host to start the webinar. Your camera and audio/microphone are disabled.
- Download or view the presentation materials. The evaluation survey opens at 11:59 a.m. the day of the presentation.
- Ask questions to the presenter(s) in the Zoom Q&A window. Each presenter will decide when to address questions. People who join by phone cannot ask questions.
- Use Zoom chat to communicate with the WPPNT coordinator or to share information related to the presentation.

- Participate live to earn continuing education hours (CEHs). Complete the evaluation survey within two weeks of the live presentation and confirmation of your CEH will be returned by email.
- A link to the video recording of the presentation is posted within four business days of the presentation.
- Presentation materials, evaluations, and video recordings are on the WPPNT webpage: https://www.dhs.wisconsin.gov/wppnt/2024.htm

Eating Disorders: Symptoms, Treatment, and Ways to Support

Samuel Cares, PhD

Thursday, May 9th, 2024

ROGERS
Behavioral Health

About me

- He/him/his
- Clinical Psychologist
  - MSW at UW-Madison
  - PhD in Clinical Psychology at Northern Illinois University
- Supervisor – Adult Residential Eating Disorders at Rogers Behavioral Health
- Research interests: overlap between eating disorders and OCD
  - Conceptualization and treatment

Learning Objectives

Upon completion of this presentation, participants should be able to:

1. Understand signs of disordered eating and formal eating disorders
2. Have basic understanding of treatment interventions for eating disorders
3. Know how to assess for and support patients presenting with eating pathology

The Basics

Prevalence and diagnosis

PREVALENCE & MORTALITY

Percent of the U.S. population, or **28.8 million Americans**, that will **have an eating disorder in their lifetime**

10,200 deaths per year as a direct result of an eating disorder, equating to **1 death every 52 minutes**

EATING DISORDERS AFFECT EVERYONE:

- **All ages**, starting as young as 5 years old to over 80 years old
- **All races,** however, people of color with eating disorders are **half as likely to be diagnosed or to receive treatment**[1]
- **All genders**, with females being **2x more likely to have an eating disorder**
- **All sexual orientations**

COST TO ECONOMY & SOCIETY

$64.7 Billion Yearly economic cost of eating disorders

Additional loss of wellbeing per year **$326.5 Billion**

Cost Breakdown:

Productivity Losses ($48.6B)

Informal Care ($6.7B)

Efficiency Losses ($4.8B)

Health System ($4.6B)

COST TO HOSPITAL SYSTEMS:

53,918 ER visits

costing **$29.3M**

23,560 inpatient hospitalizations

costing **$209.7M**

LOSS PER GROUP:

$23.5B Individuals & Families

Caregivers provide 6 weeks of informal, unpaid care per year

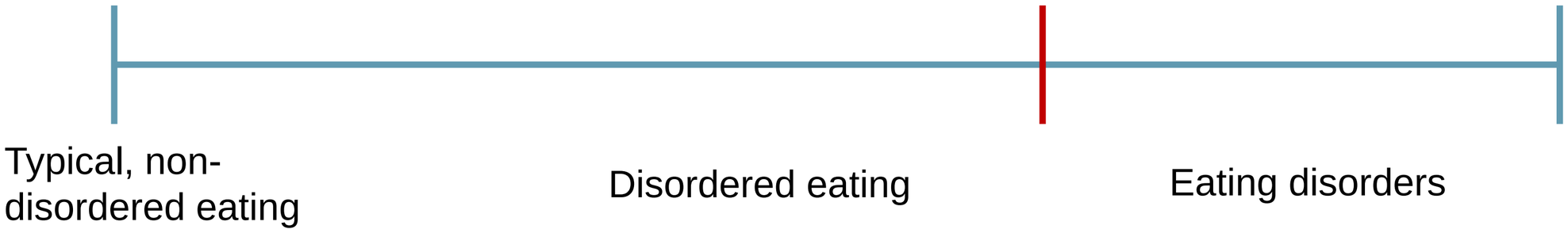
$17.7B Government

$16.3B Employers

$7.1B Society

Disordered Eating vs. Eating Disorders

- Disordered eating (DE): abnormal unusual, and subclinical eating behaviors that may or may not develop into an eating disorder
- Eating disorders (ED): Disturbances in eating-related behavior that cause clinically significant distress and functional impairment

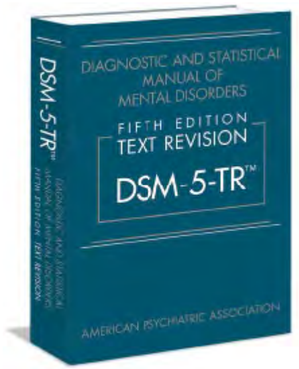


A few notes on dieting & body dissatisfaction

- 62.3% of teenage girls, 28.8% of teenage boys report trying to lose weight
- Over 50% teenage girls and nearly 1/3 teenage boys use unhealthy weight control behaviors (skip meals, fasting)
- 35-57% adolescent girls engage in crash dieting, self-induced vomiting, laxative use, diet pills, etc.
  - Overweight girls more likely to engage in extreme dieting
- Girls who diet frequently are 12x as likely to binge as girls who don’t diet
- Teenagers who dieted moderately were 5x more likely to develop an ED, and those with extreme dieting/restriction were 18x more likely to develop an ED
- On average, girls diet for the first time at age of 8
- **Americans spend over $71 billion on dieting and diet products each year**
- **95% of dieters will regain their lost weight in 1-5 years**

Eating Disorders

- Formal diagnoses (according to *DSM-5-TR*):
  - Anorexia Nervosa (AN)
  - Bulimia Nervosa (BN)
  - Binge Eating Disorder (BED)
  - Avoidant/Restrictive Food Intake Disorder (ARFID)
  - Other Specified Feeding or Eating Disorder (OSFED)
    - Atypical Anorexia Nervosa
  - Unspecified Feeding or Eating Disorder
  - Rumination Disorder
  - PICA



Anorexia Nervosa (AN)

- Hallmark feature: restricted energy intake leading to low body weight
- Other features:
  - Intense fear of weight gain or becoming fat (despite underweight)
  - Disturbance in way that body shape/weight is experienced
  - Undue influence of weight/shape on self-evaluation
  - Denies seriousness of low body weight
- Subtypes:
  - Restricting
  - Binge-eating/purging (binges are often “subjective”)

Atypical Anorexia

- Meets all criteria for Anorexia Nervosa, but not underweight despite significant weight loss and restriction
- No differences found so far in medical and psychological impacts of anorexia and atypical anorexia

AN: Common behaviors

- Dramatic weight loss
- Refusal to eat certain foods, progressing to whole categories
- Frequent comments about feeling “fat” or overweight despite weight loss
- Hiding body/baggy clothes
- Develops food rituals (excessive chewing, cutting into small pieces, moving food around on plate, eating in specific orders)
- Cooks meals for others without eating – high interest in food and cooking
- Withdrawal from usual friends and activities
- Concerns about eating in public
- Strong need for control
- Overly restrained emotional expression
- Limited social spontaneity

Bulimia Nervosa (BN)

- Hallmark features:
  - Recurrent binge-eating episodes
    - Eating, in a discrete period of time (e.g., 2 hours or less), an amount of food significantly larger than most individuals' food in similar period
    - Perceived loss of control over-eating (e.g., cannot stop or control quantity) during the episode
    - 3+ associated symptoms (e.g., pace, discomfort, disgust, embarrassment)
  - "Compensatory" behavior(s)
    - Purging (e.g., self-induced vomiting, misuse of laxatives/diuretics)
      - Myths of effectiveness of purging on weight control
    - Non-purging (e.g., excessive exercising, fasting)

Bulimia Nervosa

- Other features
  - Binge episodes and compensatory behaviors occur:
    - at least once a week
    - for at least three months
  - Self-evaluation is unduly influenced by weight and body shape

BN: Common behaviors

- Irregular eating
- Food rituals
- Disappears soon after eating
- Fear of eating in public or with others
- Frequently diets
- Withdraws from usual friends and activities
- Uses excessive amounts of mouthwash, mints, gum
- Hiding body/baggy clothes
- Extreme concern with body weight and shape
- Looks bloated from fluid retention
- Creates lifestyle schedules or rituals to make time for B/P sessions
- Secretive or hidden eating, shame around eating
- Maintains excessive exercise regimen regardless of weather, fatigue, injury

Binge Eating Disorder (BED)

- Hallmark feature:
  - Recurrent binge-eating episodes (no subsequent compensatory behaviors)
  - Episodes associated with at least three of the following:
    - Eating much more rapidly than normal
    - Eating until feeling uncomfortably full
    - Eating large amounts of food when not feeling hungry
    - Eating alone due to feelings of embarrassment
    - Feeling disgusted with oneself or guilty afterwards
  - Binge episodes occur at least once a week for three months

Other Specified Feeding or Eating Disorder (OSFED)

- Clinically significant disturbances in eating behavior that contain a specific set of features:
  - All features of anorexia, expect person is at normal body weight
  - All features of bulimia or BED, expect time/frequency of symptoms
  - Recurrent purging to influence weight/shape, without binge-eating
  - Recurrent episodes of night eating, which occur:
    - after the evening meal
    - upon awakening from sleep in the night

Unspecified Feeding or Eating Disorder

- Clinically significant disturbances in eating behavior that do not “fit” neatly into the any of the specific ED diagnoses:
  - Still cause significant emotional distress and/or impairment in functioning
  - Used when clinician chooses to not specify the reason criteria are not met for specific ED
  - More often used in situations where diagnostic information is insufficient (e.g., emergency room settings)

Other eating-related problems

Each of these disorders appears in *DSM-5*

- Avoidant/Restrictive Food Intake Disorder (ARFID)
  - Avoidance of eating due to: (a) lack of interest in eating, (b) aversion to sensory characteristics of food, and/or (c) anticipated consequences of eating (e.g., choking, vomiting, etc.)
- Rumination Disorder
  - Repetitive regurgitation of food, not due to medical condition
- Pica
  - Regular consumption of non-nutritive substances (e.g., rocks, chalk, paper)

Other eating-related problems

These disorders <u>do not</u> appear in *DSM-5*

- Orthorexia nervosa
  - Extreme preoccupation with consuming only biologically “pure” foods, leading to significant dietary restriction
    - Compulsive checking of nutrition labels and ingredients
    - Spending hours each day planning around meals and events
  - Weight/shape may or may not be present, but preoccupation with thoughts of food is just as severe as “classic” EDs
- “Bigorexia” (AKA, muscle dysmorphia)
  - Preoccupation with body build being too small or insufficiently muscular

Diversity considerations

Males

- ~25% of individuals with AN and are at higher risk of dying, in part because they are often diagnosed much later
- From 1999-2009 the number of men hospitalized for ED-related reason increased by 53%
- 3:1 female to male ratio
- 15% of gay/bisexual men and 4.6% of hetero men report full or subthreshold ED at some point in lives

LGBTQIA+

- 42% of men with eating disorders identified as gay
  - Gay males 7 times more likely to report binging and 12 times more likely to report purging than heterosexual males
- Significantly higher rates for transgender individuals than cisgender
- Mixed results about differences between heterosexual, lesbian, and bisexual women

Diversity considerations

Race/Ethnicity

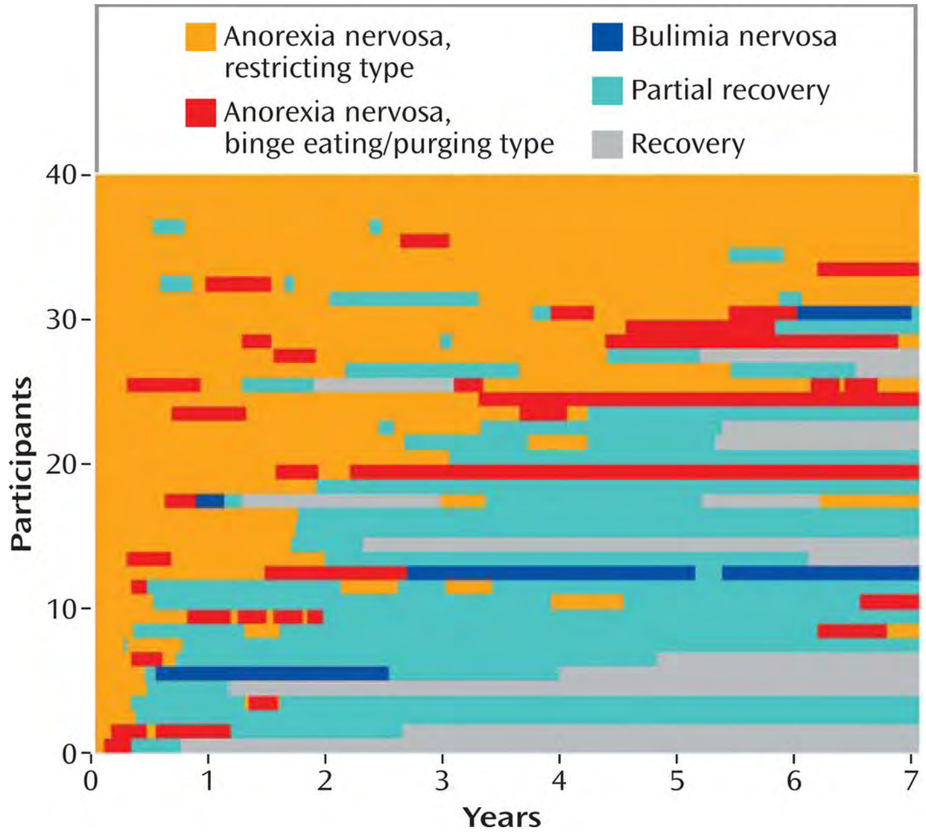
- Some research suggests similar rates of eating disorders among ethnic groups, but people of color significantly less likely to receive help compared to white people
  - Study looking at clinician response to case studies with identical disordered eating symptoms
    - 44% identified white woman's behavior as problematic
    - 41% identified Hispanic woman's behavior as problematic
    - Only 17% identified Black woman's behavior as problematic & were also less likely to refer for services
- Higher rates of bulimia binge-eating disorder in Hispanic adolescent females
- Black teenagers are 50% more likely than white teenagers to exhibit bulimic behavior

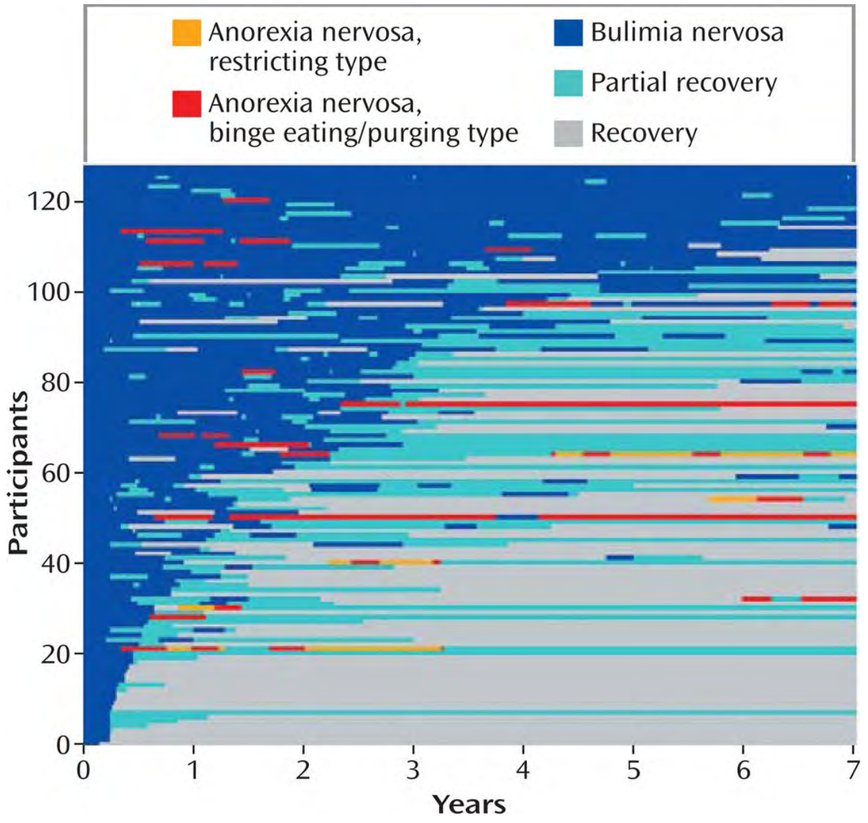
Diversity considerations

Socioeconomic Status (SES)

- Teenage girls from low-income families 153% more likely to be bulimic than girls from wealthy families

A note on diagnostic instability





Summary

	ARFID	AN – R	AN – B/P	BN	BED
Weight status	Typically below expected, but can range	Below expected	Below expected	Typically average	Typically average or higher
Restrictive eating – volume	May be present	Present	Present	Typically episodic	Episodic or absent
Restrictive eating – variety	Based on food characteristics	Based on calories	Based on calories	Episodic “trigger foods”	Typically absent
Binge eating	Absent	Absent (may be subjective)	Present	Present	Present
Compensatory behavior	Absent	Absent	Present	Present	Absent

Medical consequences

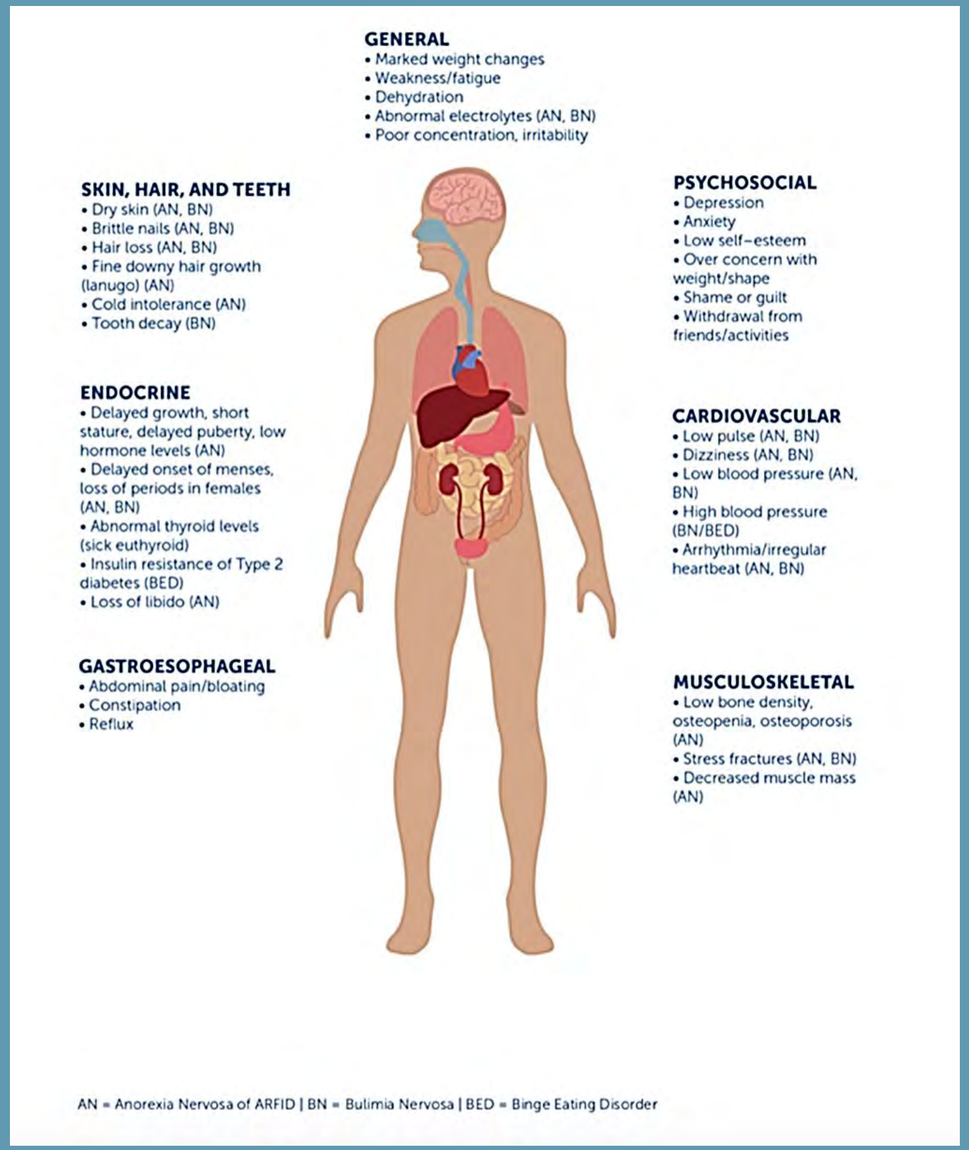
Obvious and less obvious signs of DE or ED

Minnesota Starvation Study (Ancel Keys)

- 36 healthy adult male conscientious objectors
- Protocol:
  - 3 months normal diet (3200 kcal daily)
  - 6 months semi-starvation (1570 kcal daily) with limited variety and intensive exercise
    - Lost ~25% body weight
  - 3 months restricted rehabilitation
  - 8 weeks unrestricted rehabilitation

Minnesota Starvation Study (Ancel Keys)

- Outcomes during semi-starvation phase:
  - Lower strength, stamina, body temperature, heart rate, libido
  - Obsessed with food
  - Fatigue, irritability, apathy, depression, social withdrawal
  - Some men showed distorted body image
- Outcomes during unrestricted rehabilitation
  - Behavior & cognitions normalized with weight restoration
  - Some engaged in extreme overeating
  - Abnormal eating habits persisted for months/years for some



Summary of Medical Complications

Patients don't have to be underweight to experience these effects, and some of these effects are long-term:

- Heart and circulation (Muscle loss)
- Decreased sex hormone production (infertility)
- Bone deterioration
- Intestinal (digestion slows, taste impaired)
- Muscle weakness
- Hair loss and excess growth
- Poor temperature regulation
- Impaired sleep

IMPORTANT!!!

Many individuals with diagnosed eating disorders have “normal” labs, leading to providers believing nothing is wrong.

What to look for

Obvious and less obvious signs of DE or ED

What to look for

Thinking

- Increasingly inflexible
- Preoccupation with food and eating
- Concern with weight, shape more than peers
- Impaired concentration
- Difficulty making decisions

Feelings

- Irritability and low mood
- Low self-esteem

Physical

- Intense, persistent hunger (can trigger fear about loss of control)
- Slow digestion (feel fullness after small amounts)
- Impaired taste

What to look for (continued)

Preoccupation

- Food/exercise-related social media
- Diet manuals, tips, podcasts
- Nutrition/health class

Maximizing

- Eating slowly or in privacy
- Eating every crumb/licking dishes
- Selection of eating-intensive foods
- “Souping” and thickening
- Hydroloading
- Salty & strong tastes, strange textures
- Massing of food at night

Other

- Avoidance of appealing foods
- Preference for monotonous diets
- Using food as reward, deprivation as punishment
- Reframing hunger as positive
- Fear that “if I started eating, I’d never stop”
- Wanting “permission” to eat

<INSERT TWO CASE EXAMPLES>

- Case examples to illustrate “what to look for”

Caution: Social Media Use

- Facebook whistleblower on internal research:
  - 13.5% of teenage girls said SI thoughts increased with Instagram use
  - 17 % said ED got worse after using Instagram
  - 32% said that Instagram increased body image concerns
- Significant association between social media use and DE behaviors
- Rise of “Pro-Ana” and “Pro-Mia” websites

What treatment looks like

Options and levels of care

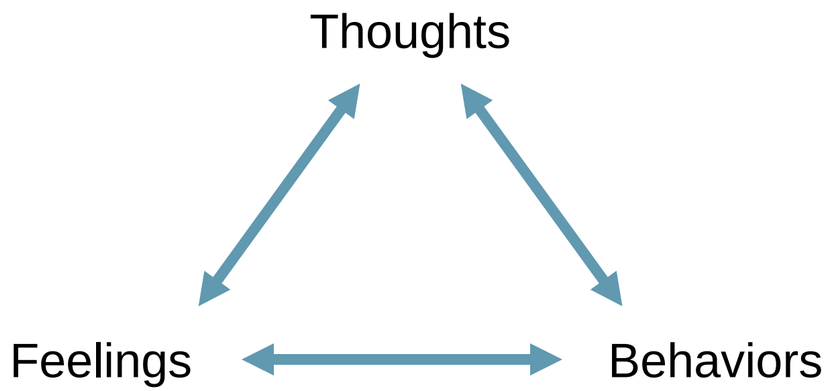
Diagnosis	Primary Intervention	Secondary Intervention
AN	FBT (kids), CBT-E	Exposure-based tx
BN	FBT (kids), CBT-E	Group-based tx
ARFID	???	CBT-AR
BED	???	CBT-E, exposure

Commonalities – Treatment Must Haves

- **Interdisciplinary treatment team**
    - Therapist, Registered Dietitian, Psychiatrist
- Normalization of eating behaviors
- Alteration of maladaptive patterns of behavior
- Emotion regulation and distress tolerance

Enhanced CBT (CBT-E)

- Overview:
  - Increase motivation
  - Reduce disordered eating behaviors
  - Improve body image and reduce overvaluation of weight and shape
  - Emotion regulation
  - Improved body image

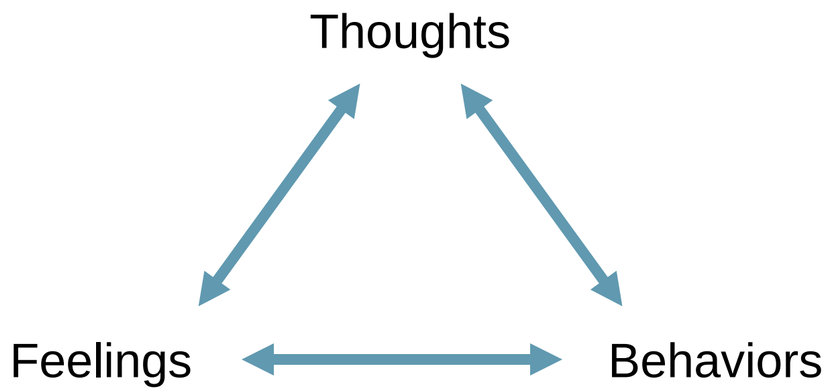


Family-Based Treatment (FBT)

- Overview:
  - Agnostic view of cause of illness
  - Consultative, nonauthoritarian
  - **Parental empowerment**
  - Externalizing illness
  - Initial focus on eating disorder symptoms
- Contraindications
  - Non-nuclear family (maybe)
  - Significant inability to engage family in treatment
  - Unhealthy familial stance on eating and/or exercise

Exposure-based treatment

- Overview:
  - Decrease anxiety
  - Decrease avoidance or maladaptive coping to feared situations
  - Alter behavioral responses, with secondary impact on thoughts and feelings



What you can do

How to support before referral

If you suspect someone you work with has an ED

What (not) to say/do

Do not refer to foods as “bad” or “unhealthy”

- DO maintain neutral to positive stance towards food

Do not tell someone to “just eat” or force feed

- Imperative to work with ED professional to address underlying concerns
- DO refer to an ED professional

Do not encourage long-term accommodation of disordered eating

- DO encourage short-term accommodations to increase nutritional intake while reaching out to ED professional

Do not ignore signs of medical instability (e.g., rapid weight loss, frequent purging)

- DO encourage individuals to seek medical attention as soon as possible
- DO remember that labs can appear “normal” even for folks with severe ED pathology

If you suspect someone you work with has an ED

Self-report assessment measures

Eating Disorder Examination Questionnaire (EDE-Q)

- Range, frequency, severity of eating disorder symptoms
  - Restraint, eating concern, shape concern, weight concern

Clinical Impairment Assessment Questionnaire (CIA)

- Impairment due to eating disorder symptoms:
  - mood and self-perception, cognitive fx, interpersonal fx, work performance

Yale-Brown-Cornell Eating Disorder Scale

- Symptom checklist and questionnaire
  - Preoccupations, rituals, total score

Nine-Item ARFID Screen (NIAS)

- 9-item measure
- Picky eating (sensory), appetite (lack of interest), fear (aversive consequences)

If you suspect someone you work with has an ED

Where to access further resources

National Eating Disorders Association (NEDA)

- https://www.nationaleatingdisorders.org/

F.E.A.S.T

- https://www.feast-ed.org/

Academy for Eating Disorders

- https://www.aedweb.org/home

International Association of Eating Disorders Professionals

- https://www.iaedp.com/

If you suspect someone you work with has an ED

Where to refer

Different levels of care:

- Inpatient
  - Acute medical stabilization and weight restoration
  - Significant SI/SH concerns
- Residential
  - High intensity treatment with 24/7 support
- Partial Hospitalization Program (PHP)
- Intensive Outpatient Program (IOP)
- Outpatient

That's all! Thank you!

Any questions?

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