Eating Disorder Awareness: Assess, Diagnose, and Refer!

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Goals of our time together

WHY are eating disorders so important to detect?

HOW does having an eating disorder increase risk of death by suicide?

How do we DETECT & DIAGNOSE an eating disorder?

How do we REFER patients with eating disorders?

How do we PREVENT eating disorders?

Why?

Of those with eating disorders…

95% are between the ages of 12 and 25

86% report onset prior to age 20 *(SAMHSA)*

40-60% of elementary school girls (ages 6-12) are concerned about their weight and are afraid of becoming overweight. *(Smolak, 2011)*

Time magazine estimates 80% of 4th graders have been on a diet

Over 50% of teenage girls and 30% of teenage boys use unhealthy weight control behaviors (ex, skipping meals, fasting, smoking cigarettes, purging) *(Neumark-Sztainer, 2005)*

35% of "normal dieters" progress to pathological dieting. Of those, 20-25% progress to partial or full-syndrome eating disorders. *(Shisslak & Crago, 1995)*

Anorexia has the highest mortality of ANY psychiatric condition, estimated to be 10%.

One in five of these deaths is from suicide.

This mortality rate is **12 times higher** than the death rate of ALL cases for females 15-24.

There is no medication to treat AN.

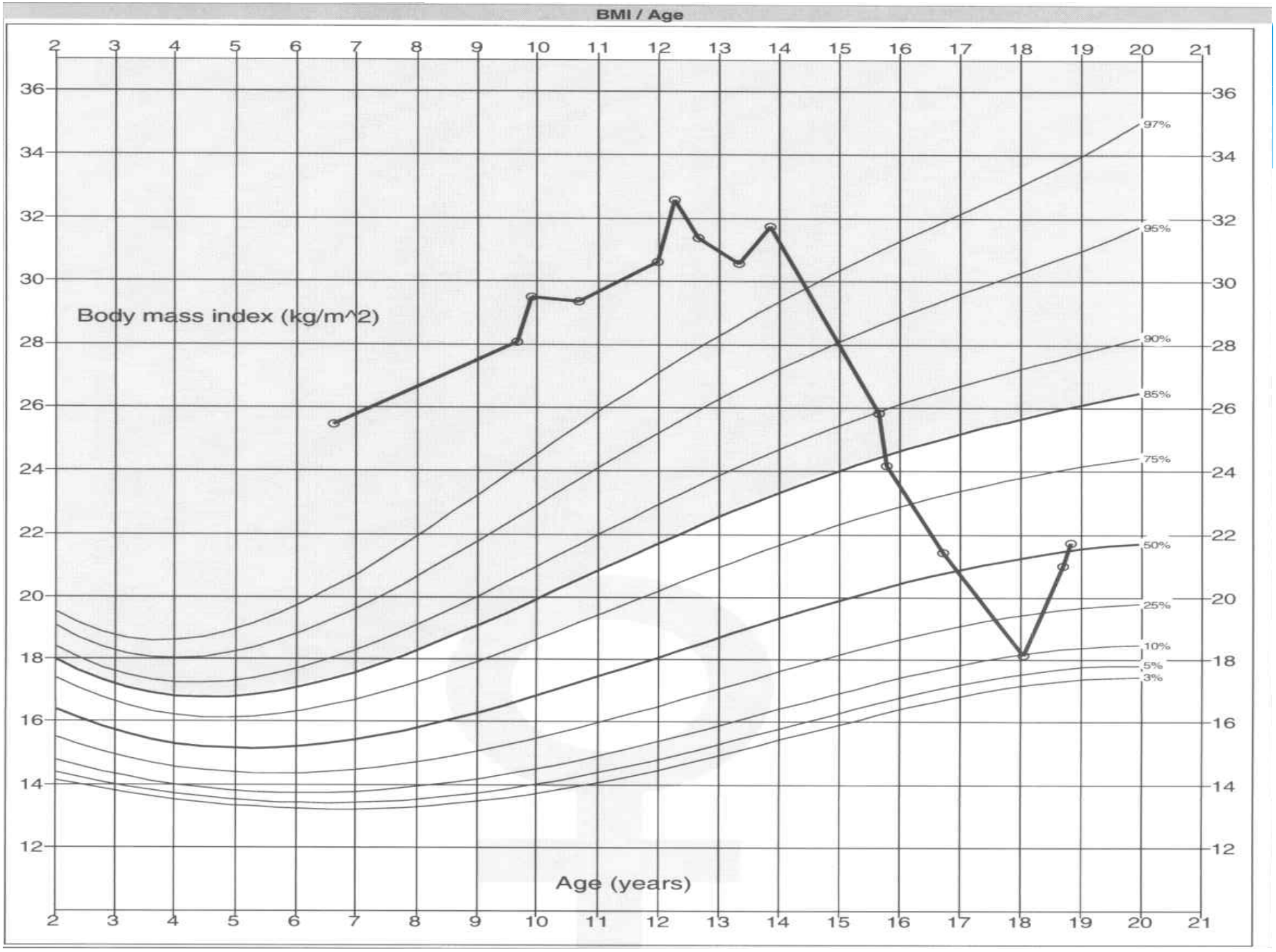
Source: ANAD.org

People can be starving at any size.

We cannot tell by appearance that someone has an eating disorder.

#1: Not all Anorectics are "underweight"

*DSM-5 criteria: Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, *developmental trajectory, and physical health.*


BMI / Age
Body mass index (kg/m^2)
Age (years)
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21
36 34 32 30 28 26 24 22 20 18 16 14 12
97%
95%
90%
85%
75%
50%
25%
10%
5%
3%

MAYO CLINIC

Growth Chart girls from 2 to 20 years

Pediatrics

Growth Chart, Girls 2–20 Years

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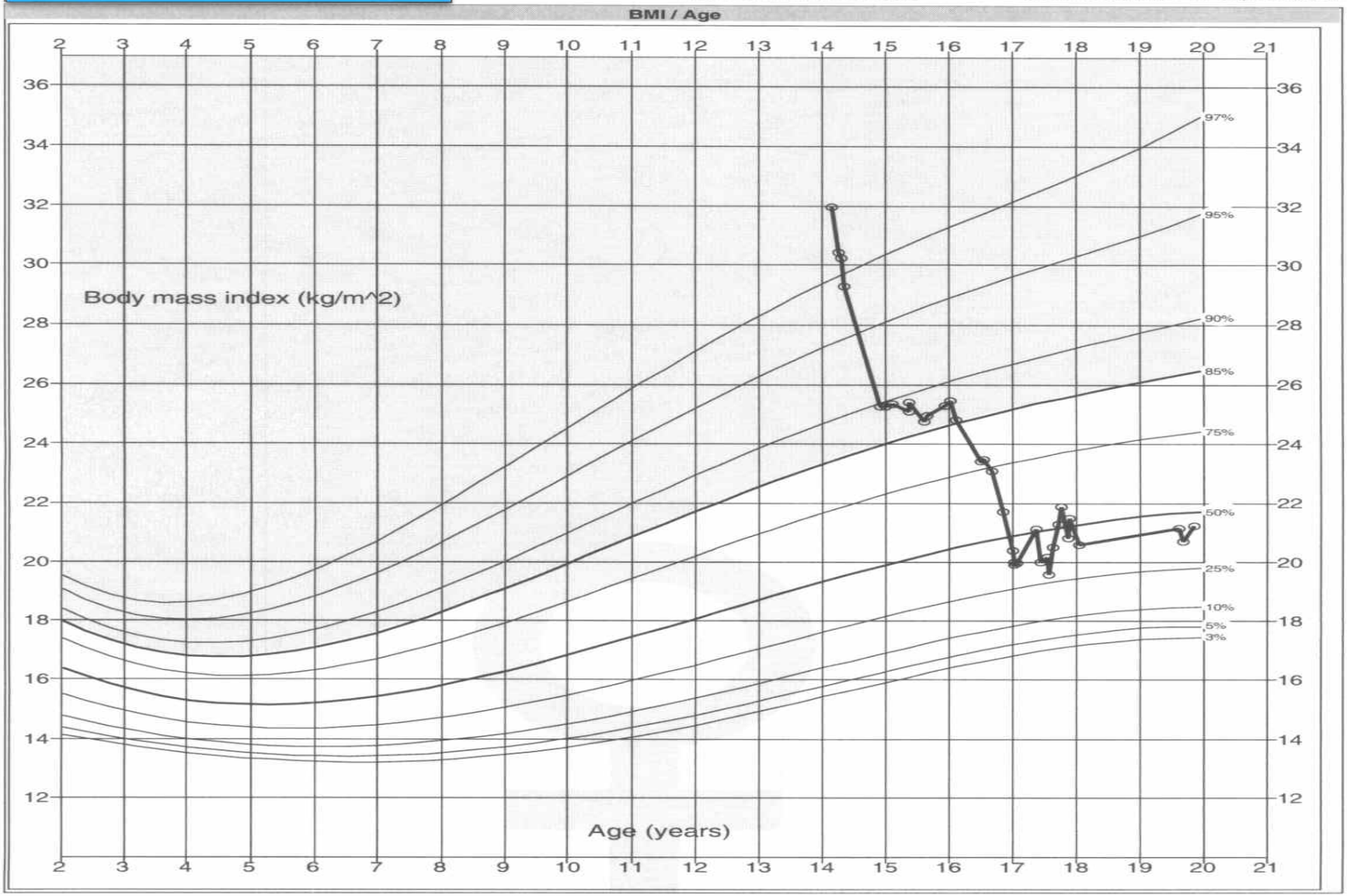


#2: Starvation makes people depressed, anxious and suicidal

Minnesota Starvation Experiment

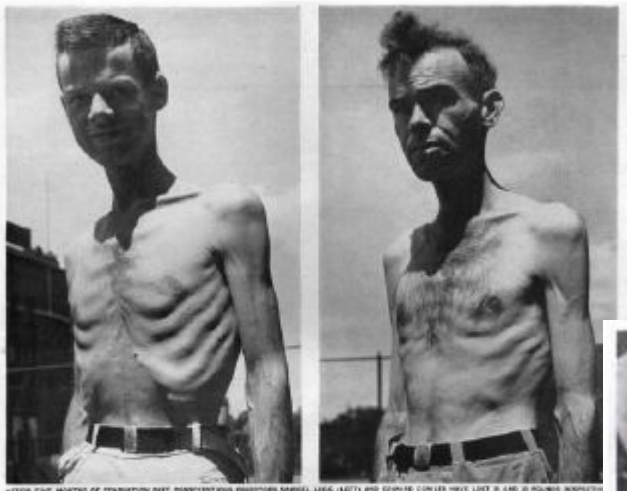


FIGURE 2 *Life* magazine photograph of conscientious object during starvation experiment. July 30, 1945. Volume 19, Number 5, 43. Credit: Wallace Kirkland/Time Life Pictures/Getty Images.

FIGURE 8.6. Minnesota volunteers after weight loss. Photo by Wallace Kirckland. Copyright 1950 by Life–Time–Warner.

GURE 8.5. Minnesota volunteers at mealtime. ›pyright 1950 by the University of Minnesota ess. Reprinted by permission.

#3: Eating Disorders behaviors reduce fear of death

Eating Disorder behaviors promote **callousness** through restriction, starvation, binging, purging, laxative use, overexercise, and extreme weight-loss methods (ice baths, dehydrating), **social isolation**, and increased **sense of burdensomeness** on loved ones.

This combination of ***suicidal desire*** and ***suicidal capability*** may explain why people complete suicide more than other psychiatric conditions.

Joiner 2005 *The Interpersonal Psychological Theory of Suicide (IPTS).*
Crow et al., 2008; Selby et al., 2010; Smith et al., 2013
Arcelus et al. 2011

Detecting Eating Disorders

Without treatment, ~20% of people with eating disorders will die.

With treatment this reduces to 2-3%.

Ask

Weight history

Lowest, highest, personal "goal"

*****Request growth charts *****

Methods of weight control

Restriction, binging (objective vs subjective), food rules

Purging (Type, frequency, intensity, duration)

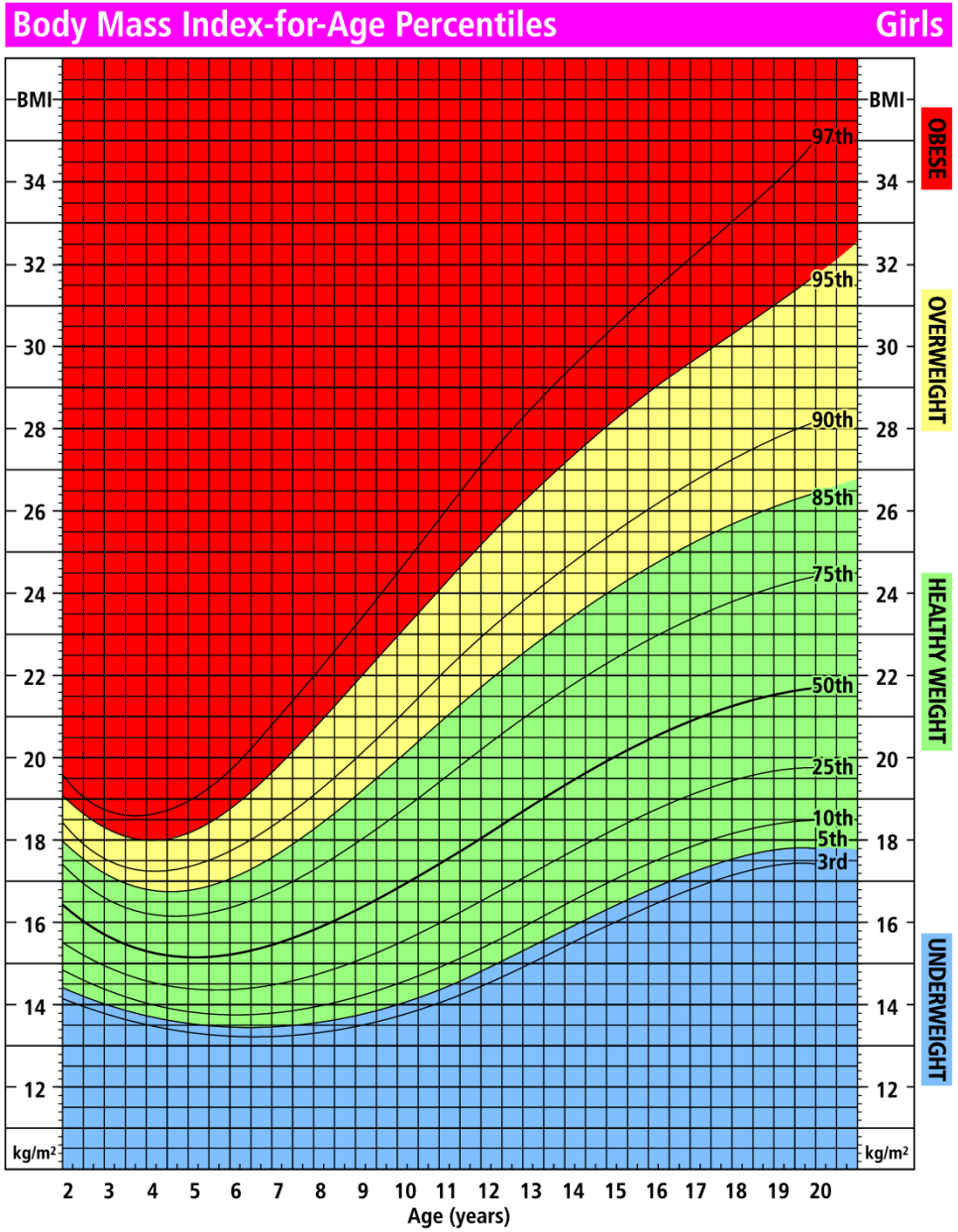
Exercise

Pills (laxatives, stimulants, natural supplements)

How to ask

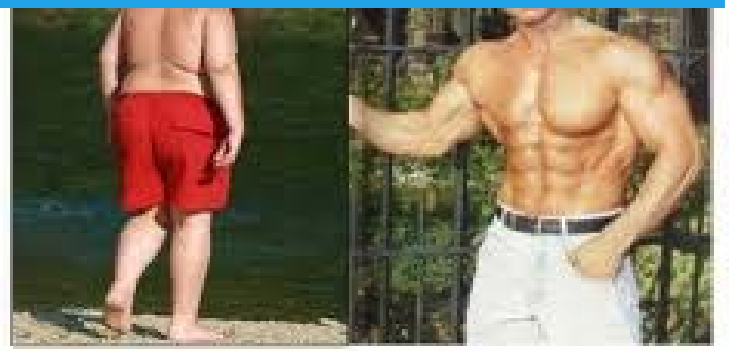
* "Typical day diet"
* "First wake up… what do you eat?" Specify amounts/types.
* "When do you eat next?" (Preferences, dislikes, gross or "bad" foods)
* Eating alone/with family? Separate food? Cooking?
* Food rules?

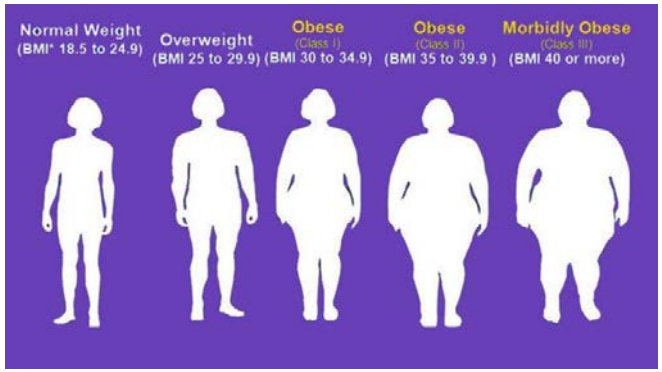
#4 Weight and metabolism are largely genetically determined.



BMI is deceptive

* Does not account for higher muscle mass, bone density, age or sex.
* Ranges do not correlate with mortality





Flegal et al. (2013). Association Of All-Cause Mortality with Overweight and Obesity. *JAMA Vol 309*

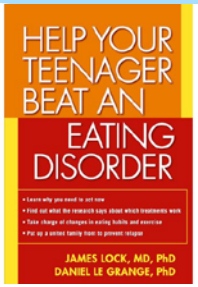
Overweight (BMI 25 <30) was associated with significantly lower all-cause mortality

#5 Food is your medicine

* Initial weight range is set
* "I just want to gain muscle"
* Inpatient: 4 lbs/week
* Outpatient: 2 lbs/week
* Calories: 1800 initially, increase by 300 every other day to 4200-4500
* "Underfeeding"syndrome

Garber et al. (2012). *Journal of Adolescent Health*

Family Based Treatment



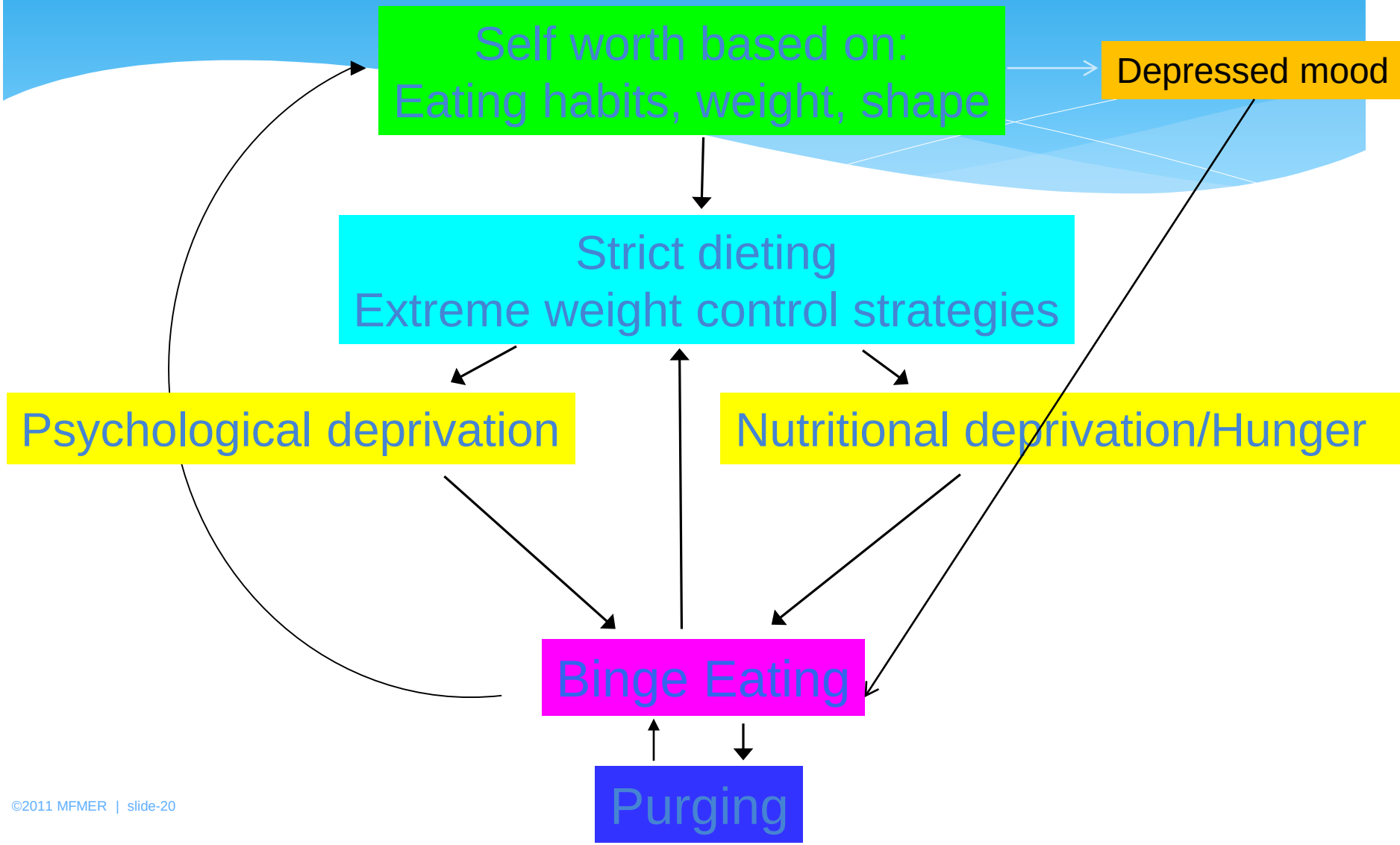
* Family is enlisted as a resource
* Adolescent no longer capable of making so ...es
* FBT demonstrates superior outcomes for adolescents with early onset and relatively short histories of AN
* Outcomes continue after 5 years
* Over 85% success rate

Lock et al., *Treatment manual for adolescent AN;* 2001
Eisler et al; *Arch Gen Psych*; 1997: 54;1025-1030
Robin et al; *J Am Acad Child Adolsc Psychiatry*;1999: 38;1482-1489
Russell et al;;*Arch Gen Psych*; 44;1987:1047-1056

Family Based Treatment

* Identify eating disorders early!
* Best assessment is to set weight gain expectations and assess patients ability to meet these goals
* Communicate importance of full weight restoration for recovery
* Set weight goals/be aggressive
* Patients need high kcal to gain weight
* Be authoritative
* Frequent follow-up on patients ability to meet weight expectations

Cognitive Behavioral Model of BN



Bulimia Nervosa and Binge Eating Disorder

* Normalize diet (no “good/bad foods” no “off-limit foods”)
* 3 meals, 2 snacks,
* Mindful eating
* Include 1-2 desserts daily
* Food/emotion logs

* CBT-E (augmentation with DBT skills can be helpful)

Indicators of Adequate Weight Restoration

* *Biomarkers* (resumption of menses, estradiol level, bone density)
* *Behaviors* (normalized eating, resumption of activities)
* *Psychologic status* (mood, thoughts)
* *Previous BMI percentile curve*
* *Pelvic Ultrasounds**

* Allen et al. (2010). *Eur Eat Disorders Rev* 18:43

Prevention of Eating Disorders

#6 Avoid Dieting

Dieting and Eating Disorders

Dieting is the **most important** and well-studied precipitant of **eating disorders** that include binge-eating and bulimia nervosa.

Onset of adolescent eating disorders: population based cohort study over 3 years
G C Patton BMJ 1999; 318:765–8

Most dieters regain weight with 5 years of dieting
(*Stunkard AJ. The Results of the Treatment for Obesity. NY State J Med. 1975*)

So what do we do?

1) Inform people that dieting may be counterproductive and even harmful

2) Do not use body dissatisfaction as a motivator for change

3) Regular family meals

4) Avoidance of weight talk

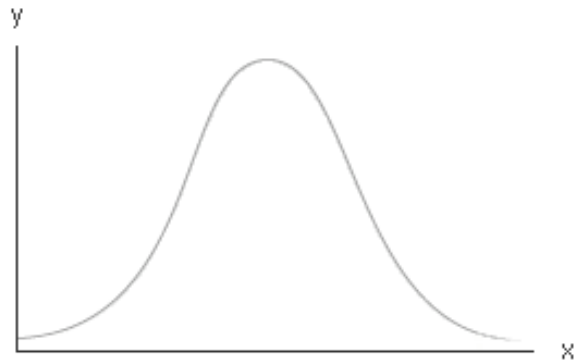
5) Address weight mistreatment

Preventing Obesity and Eating Disorders in Adolescents: What Can Health Providers do? Neumark-Sztainer PhD, Journal of Adolescent Health 2008

How to best support patients

* Avoid focus on heart rate, weight, blood pressure, other numerical measures such as vital signs
* Instead focus on individualized health goals
  * Can use zones (red, yellow, green)
  * BMI percentiles (use history as a guide, major change in percentiles)
  * Health is a spectrum and

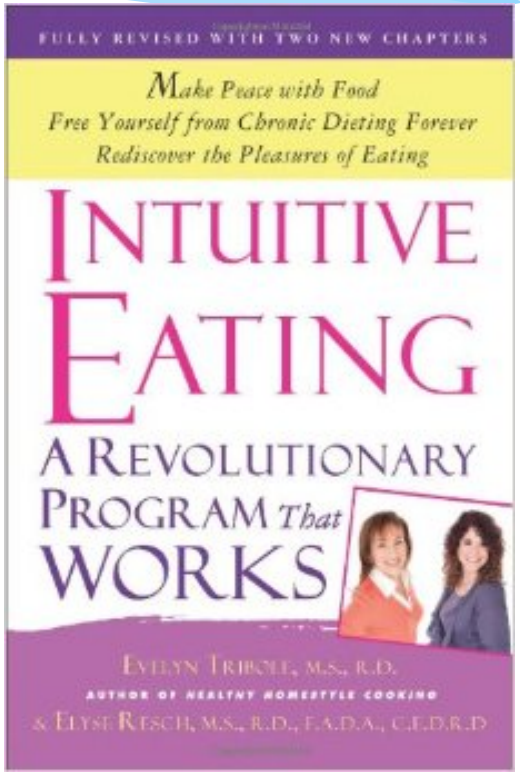
    a bell curve



Bell-Shaped Curve

How to best support patients

* Avoid saying "You look good!"
  * Comment on effort and engagement. "I love how you are working so hard" rather than physical appearance.
* Avoid quantifying amount of food such as "Eat More" or "Eat Less"
  * Evidence supports Intuitive Eating



In conclusion…

#1 People can be starving at any size

#2 Starvation makes people depressed and suicidal

#3 Eating Disorder behaviors reduce fear of death

#4 Weight and metabolism are largely genetically determined

#5 Food is your medicine

#6 Avoid Dieting (Send a consistent message that "health" is complex and determined by biometrics, activity level, behaviors, mood, and overall function).