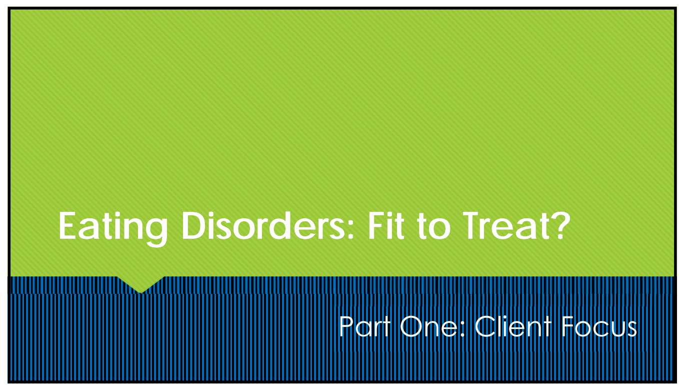
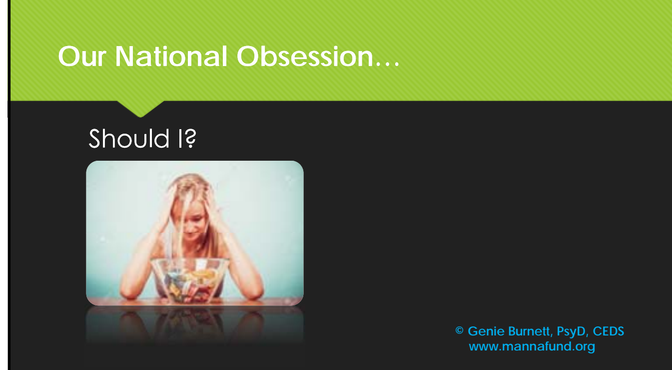

Eating Disorders: Fit to Treat?
Part One: Client Focus


Our National Obsession…
Should I?
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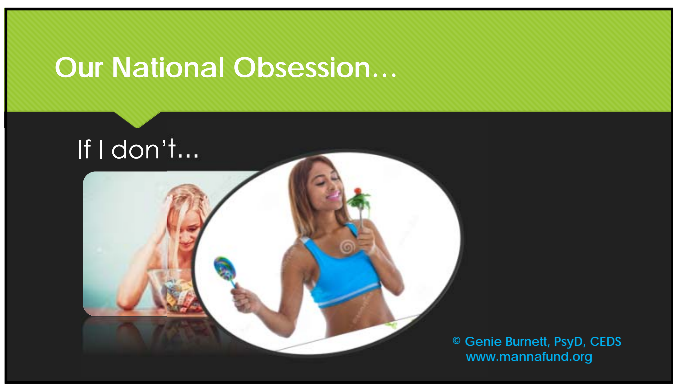
Our National Obsession…
If I don't…
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Our National Obsession…
I'm GOOD!
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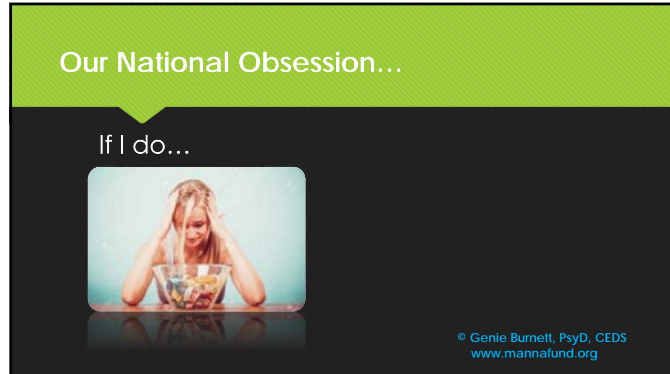
Our National Obsession…
If I do…
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Our National Obsession…
I'm BAD!
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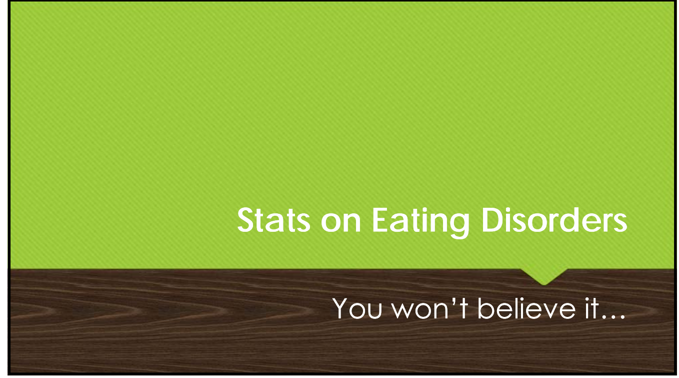

## National Stats

- Over half million teens have eating disorders; most never receive treatment
- The premature death rate associated with eating disorders is 12 X's higher than ALL causes of death for females ages 15-24.
- Individuals suffering with Anorexia Nervosa are *8x's more likely to complete suicide* than 14 to 25 years olds within the general population.
- The second largest population that is developing eating disorders are women 40-50

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## Duration of an Eating Disorder

- Age ***14-18 is the "high risk"*** time for development (86-94% of patients develop ED prior to age 20)
- *5-10 % of individuals suffering with anorexia die within ten years of onset*
- *18-20 % die within twenty years of onset, and only 50% report ever being cured. APA Practice Guidelines 2006*

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## Close to Home…

- Of the 50 states, the rate of ED in the population ranges from 3.33% to 3.66%
- Therefore, Out of 100 people, >3 has an eating disorder
- Georgia has the _____ largest state population of eating disorders in the United States

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## Close to Home…

- Of the 50 states, the rate of ED in the population ranges from 3.33% to 3.66%
- Therefore, Out of 100 people, >3 has an eating disorder
- Georgia has the **3rd** largest state population of eating disorders in the United States

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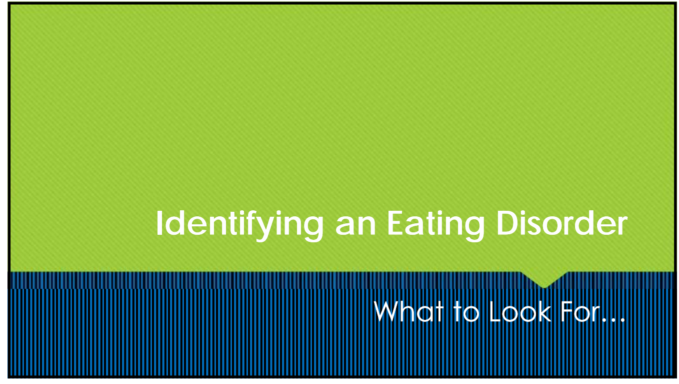
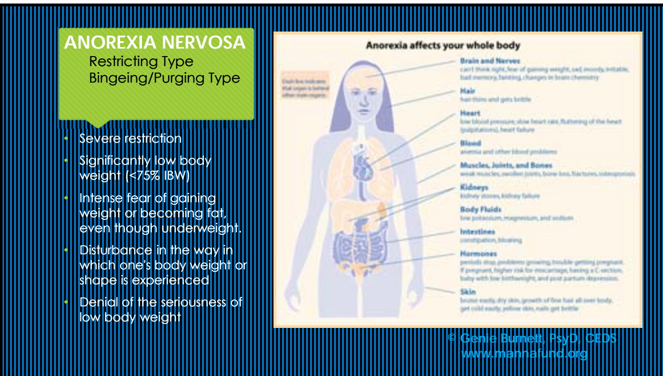

Identifying an Eating Disorder
What to Look For…


ANOREXIA NERVOSA
Restricting Type
Bingeing/Purging Type
Severe restriction
Significantly low body weight (<75% IBW)
Intense fear of gaining weight or becoming fat, even though underweight.
Disturbance in the way in which one's body weight or shape is experienced
Denial of the seriousness of low body weight
Anorexia affects your whole body
Brain and Nerves
Hair
Heart
Blood
Muscles, Joints, and Bones
Kidneys
Body Fluids
Intestines
Hormones
Skin
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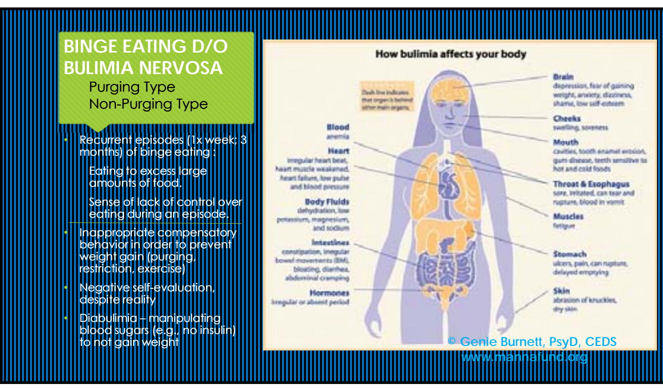
BINGE EATING D/O
BULIMIA NERVOSA
Purging Type
Non-Purging Type
Recurrent episodes (1x week; 3 months) of binge eating :
Eating to excess large amounts of food.
Sense of lack of control over eating during an episode.
Inappropriate compensatory behavior in order to prevent weight gain (purging, restriction, exercise)
Negative self-evaluation, despite reality
Diabulimia – manipulating blood sugars (e.g., no insulin) to not gain weight
How bulimia affects your body
Blood
anemia
Heart
irregular heart beat, heart muscle weakened, heart failure, low pulse and blood pressure
Body Fluids
dehydration, low potassium, magnesium, and sodium
Intestines
constipation, irregular bowel movements (BM), bloating, diarrhea, abdominal cramping
Hormones
irregular or absent period
Brain
depression, fear of gaining weight, anxiety, dizziness, shame, low self-esteem
Cheeks
swelling, soreness
Mouth
cavities, tooth enamel erosion, gum disease, teeth sensitive to hot and cold foods
Throat & Esophagus
sore, irritated, can tear and rupture, blood in vomit
Muscles
fatigue
Stomach
ulcers, pain, can rupture, delayed emptying
Skin
abrasion of knuckles, dry skin
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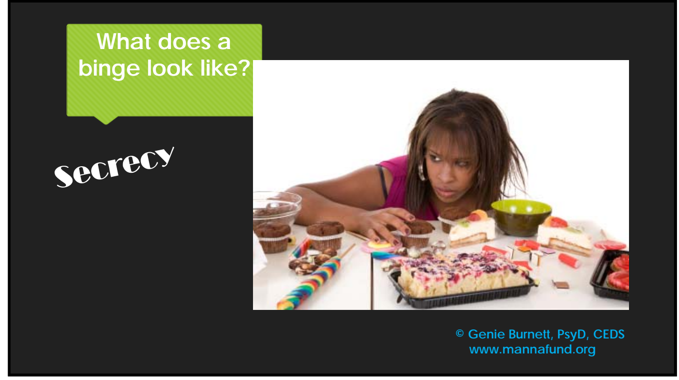
What does a binge look like?
Secrecy
© Genie Burnett, PsyD, CEDS
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What does a binge look like?
Secrecy
Emptiness
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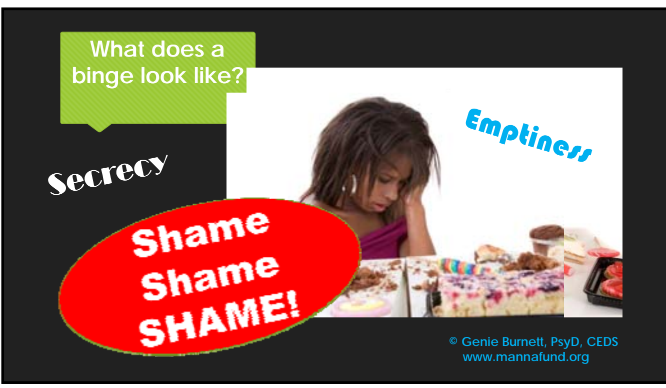
What does a binge look like?
Secrecy
Emptiness
Shame
Shame
SHAME!
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## New Diagnostic Categories

- **ARFID** – Avoidant/Restrictive Food Intake Disorder (ED NOT based on weight or body distortion)
  - Lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating
    - Persistent failure to meet appropriate nutritional needs associated with one (or more) of the following:
    - Significant weight loss (or failure to achieve expected weight gain)
    - Significant nutritional deficiency
  - Dependence on enteral feeding or oral nutritional supplements
  - Marked interference with psychosocial functioning

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## New Diagnostic Categories

- **OSFED** - Other Specified Feeding or Eating Disorders
  - AN, BN, BED that doesn't meet full criteria
  - Orthorexia – Low body weight (>75% IBW), focus on eating "healthy" only, over-exercising issues
  - Pica – eating things with no nutritional value
- Other Feeding Disorders

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## What "causes" an Eating Disorder?

- Combination of:
  - Genetics
  - Environment
    - Family interaction
    - Social Media
    - Media (TV, internet, billboards, etc)
  - Internal Pressure + External pressure = Need to be in Control (of self, usually)
  - Negative evaluation of body (whether through own thoughts or from others)
  - ➡ There is no ONE cause for developing an eating disorder.

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# Assessing for Eating Disorders

## Approaching a Patient with an ED

What to say:

- I'm really concerned about you. You medically aren't stable, & I want to help you get to a better place – medically and emotionally.
- Are you ok? Your doctor/body/etc say that you aren't.
- DON'T shame them for their body weight. No judgment zone.
- Tell them what steps need to be followed to ensure health. Often, they will hear you and no one else.

What to do:

- Refer them if you aren't comfortable working with EDs (be honest with yourself!) - Refer to CHOA if you are unsure, they have a protocol for EDs and kids
- Spend time talking with him/her, but don't engage in a power struggle
- Follow up on your referral
- Make sure that you don't act alone – have a ***team approach***

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## Assessment: SCOFF Interview

**SCOFF Screening Tool**

- Do you make yourself **Sick** because you feel uncomfortably full?
- Do you worry you have lost **Control** over how much you eat?
- Have you recently lost more than 15 **pOunds** in a three-month period?
- Do you believe yourself to be **Fat** when others say you are too thin?
- Would you say that **Food** dominates your life?

Answering "yes" to 2 or more = high likelihood for an ED

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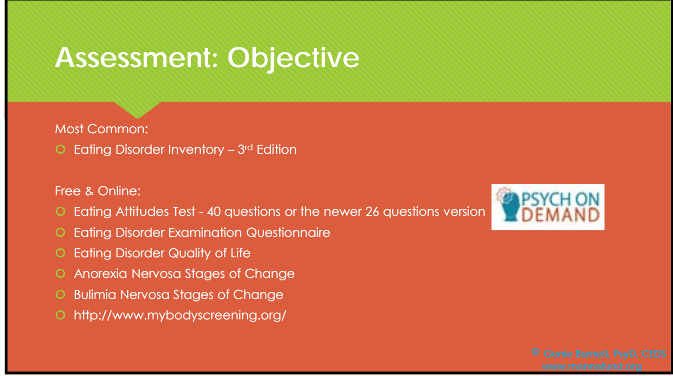
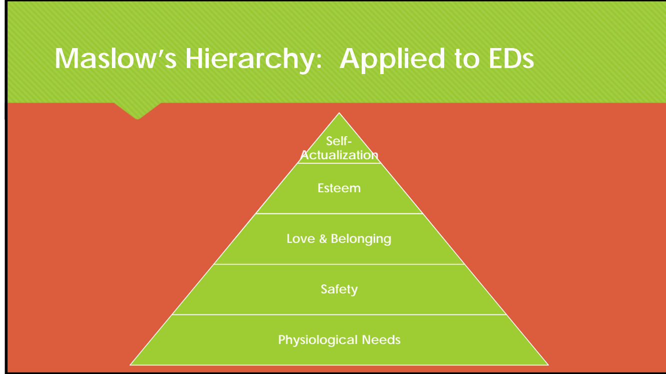
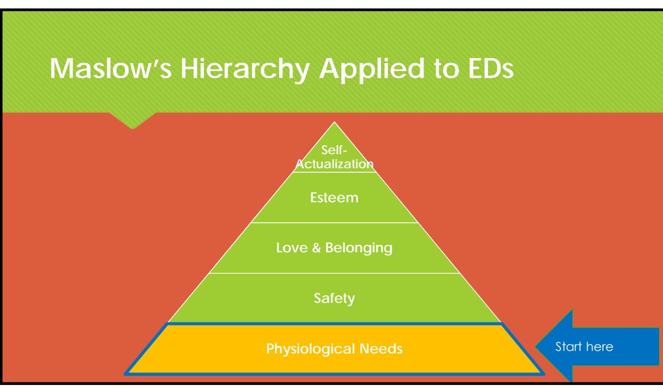
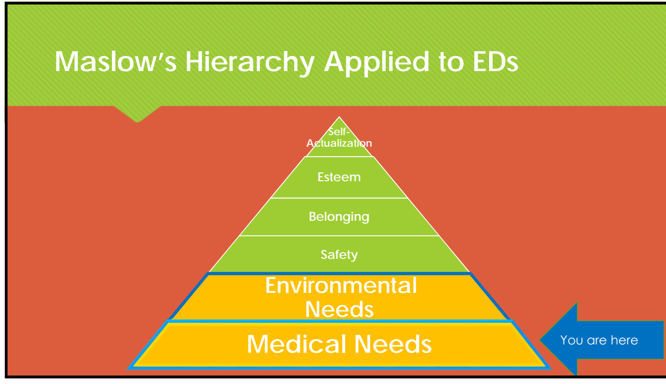
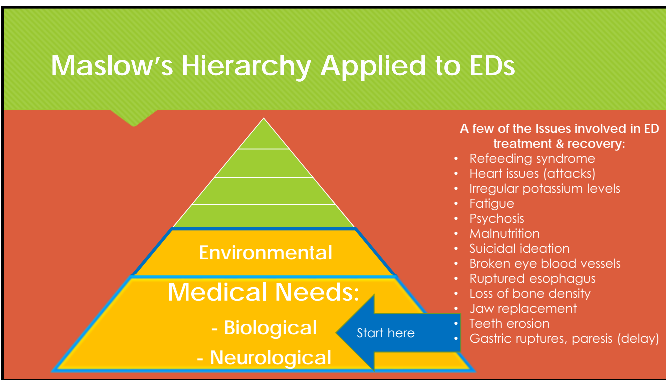
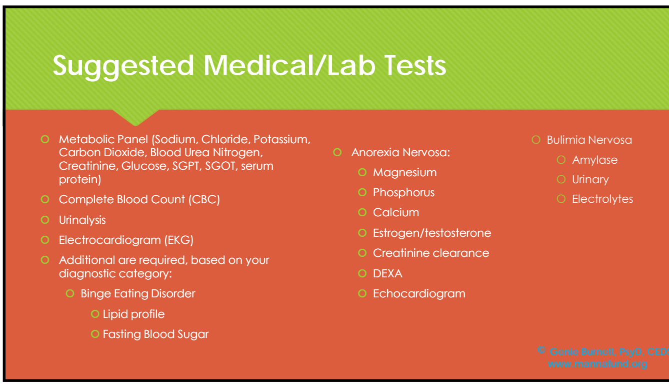

Assessment: Objective
Most Common:
Eating Disorder Inventory – 3rd Edition
Free & Online:
Eating Attitudes Test - 40 questions or the newer 26 questions version
Eating Disorder Examination Questionnaire
Eating Disorder Quality of Life
Anorexia Nervosa Stages of Change
Bulimia Nervosa Stages of Change
http://www.mybodyscreening.org/
PSYCH ON DEMAND


Maslow's Hierarchy: Applied to EDs
Self-Actualization
Esteem
Love & Belonging
Safety
Physiological Needs


Maslow's Hierarchy Applied to EDs
Self-Actualization
Esteem
Love & Belonging
Safety
Physiological Needs
Start here

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## Complicating Medical Issues

- Celiac Disease
- Diabetes
- Heart disease
- Liver disease
- Mitochondrial disease

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## Choosing Appropriate Levels of Care

| Issue | Outpatient | Intensive Outpatient | Partial Hospitalization | Residential | Inpatient |
|---|---|---|---|---|---|
| Medical | Medical monitoring is not required | | | Stable, may require medical monitoring initially | Severe medical issues requiring attention |
| Suicide | Not typically suicidal; has coping skills to cope with pain | | | | Intent, plan, or post-attempt |
| Weight | >85% | >80% | >80% | <85% | <85% |
| Meal plan | Self-sufficient | Self-sufficient | Needs structure to gain weight | Needs supervision at all meals or may act out | Requires supervision; can't control acting out |
| Compul-sive Bxs | Focus on managing triggers | Gaining insight, connecting bxs | Some, but better controlled | Struggling | Difficulty controlling |

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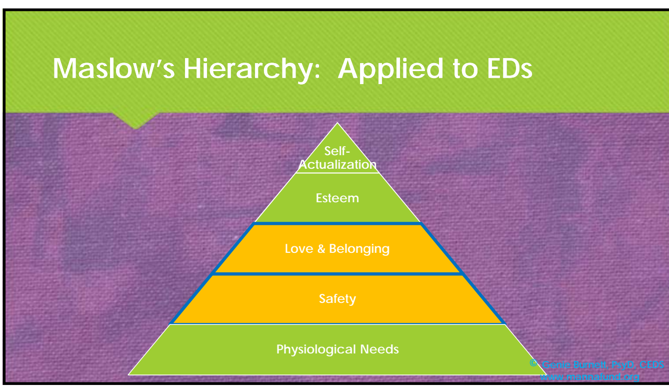
## Maslow's Hierarchy: Applied to EDs

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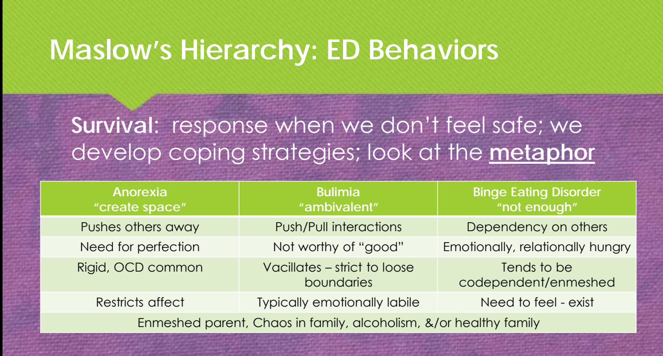
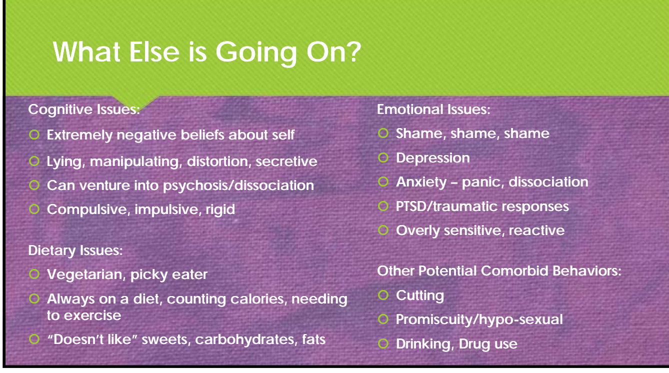



| Anorexia "create space" | Bulimia "ambivalent" | Binge Eating Disorder "not enough" |
|---|---|---|
| Pushes others away | Push/Pull interactions | Dependency on others |
| Need for perfection | Not worthy of "good" | Emotionally, relationally hungry |
| Rigid, OCD common | Vacillates – strict to loose boundaries | Tends to be codependent/enmeshed |
| Restricts affect | Typically emotionally labile | Need to feel - exist |
| Enmeshed parent, Chaos in family, alcoholism, &/or healthy family | | |



## People with EDs are…

- acting out their feelings. They typically don't feel heard or understood.
- not doing it on purpose. If they feel that they don't have control over their feelings, they will use what they can – their bodies and/or food
- unable to "just eat" or " just stop eating." there is a very powerful biological/behavioral pattern that has been established. (Think of your ongoing "habit", now break it…)
- feeling powerless. They don't believe that they have much control in their environment, so they control what they can – their body, food, and behavior
- emotionally disordered, but oftentimes cannot connect their feelings with their behaviors
- needing their eating disorder behavior to feel safe. When they can voice what is bothering them, they are more likely to change their behavior

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## Referring a Patient with Eating Disorder

Refer for an **ASSESSMENT:**

- Atlanta Center for Eating Disorders (adol, adult, males)
- Manna Treatment (adol, adult, males, Christian)
- Renfrew (adol, adult)
- Ridgeview (adol, adults)
- Veritas – coming soon to the medical center area (children, adolescents)

Requires a **TEAM approach:**

- Medical (CEDS – Anna Tanner, MD)
- Psychiatric
- Primary Therapist (Certified Eating Disorder Specialist suggested)
- Family Therapist (CEDS)
- Dietitian (Certified Eating Disorder - Registered Dietitian)

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## References


- PRACTICE GUIDELINE: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
- 2006 APA Practice Guidelines


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Thank you, thank you very much.

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TALK IT OUT!

gems of the heart

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