ADDRESSING EATING DISORDERS BY NON-SPECIALISTS IN MORE RURAL AREAS

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Goals

- Empower clinicians with knowledge to screen for, assess, triage, and manage clients with eating disorders.
- NOT how to TREAT eating disorders

What are eating disorders?

- Anorexia Nervosa (AN)
  - Restrictive
  - Binge/Purge
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Other Specified Eating Disorder (OSFED)
- Unspecified Eating Disorder (USFED)
- Avoidant/Restrictive Food Intake Disorder
- Pica (child or adult)
- Rumination Disorder

Important facts

- ALL EDs are serious disorders with life-threatening physical and psychological complications.
- EDs do not discriminate. By gender, age, SES, race, or size/shape.
- Weight is not the only clinical marker of an ED!
- Individuals with EDs may not recognize the seriousness of their illness and may be ambivalent.

Clinical Features

- Extreme concerns about shape and weight
  - Body checking, body avoidance, feeling fat, marginalization of other aspects of life
- Demanding dietary goals with multiple rigid rules
- Binge eating
  - Typically triggered by breaking diet rule or negative mood
- Self-induced vomiting
  - Relatively ineffective for weight control, but belief it is effective maintains binge eating
- Laxative/diuretic misuse
  - Completely ineffective for weight control
- Driven exercise

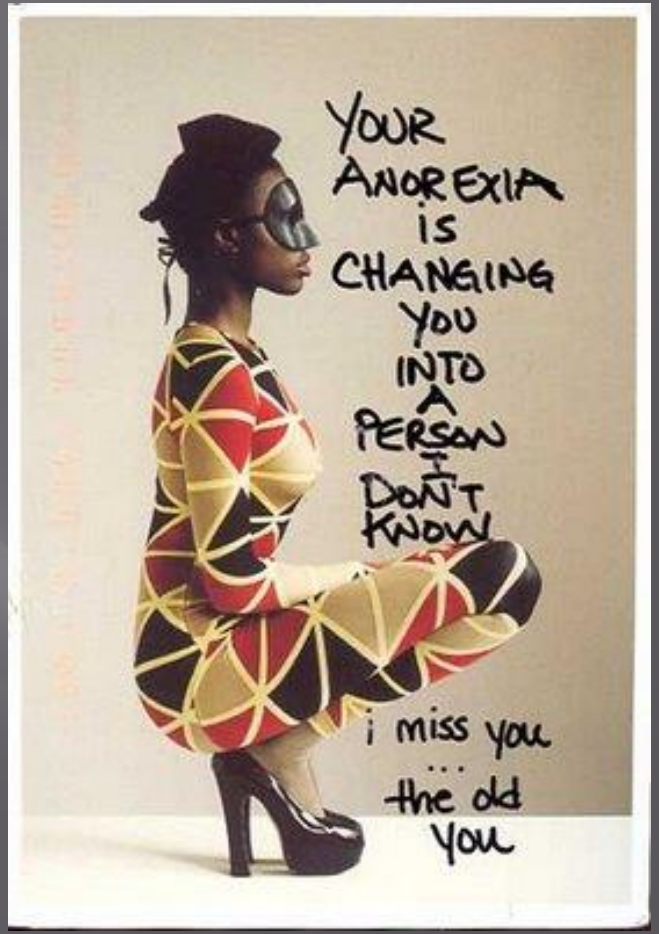
Associated Features: AN

Mood
- Low mood
- Increased irritability
- Anxiety
- Restrained emotional expression

Behavioral
- Heightened obsessiveness - Related and unrelated to food
- Substance use

Cognitive
- Concentration
- Inflexible thinking (black/white)
- "~~Need for control~~"
- Body image

Social
- Inward-looking and self-focused
- Social withdraw
- Diminished interest in sex



Associated Features: BN & BED

Mood disturbance (36-50%)

- Depressive symptoms
- Dysthymic D/O and MDD

Anxiety symptoms

Personality Disorders

- Frequently BPD

Substance Abuse

- Alcohol or stimulants
- Lifetime prevalence: 30%

Impulsivity

Perfectionism

Emotion Dysregulation

- Intense mood states and lability

Poor Interceptive Awareness

Medical Complications: AN/Restriction/ARFID

- Cold intolerance /Hypothermia, poor circulation
- Anemia
- Dehydration
- Kidney/renal failure
- Cardiac problems (bradycardia, low BP, arrhythmia, arrest)
- Presyncope/syncope (dizziness and fainting)
- Brain shrinkage
- Extreme fatigue
- Muscle loss
- Sex hormones
  - Amenorrhea
  - Infertility
- Osteoporosis/ osteopenia
- Constipation
- Intestinal slowing/ pain/dysfunction
- Poor sleep
- Dry skin & nails/poor wound healing/ Carotenoderma (yellowish skin)
- Hair loss
- Lanugo

Medical Complications: BN

- Esophageal tears
- Gastric rupture
- Cardiac arrhythmia
- Dehydration
- Electrolyte imbalances
- Swelling of brain immediately after vomiting
- Dental erosion and loss of teeth
- Oral lacerations
- Russell's sign
- Enlarged salivary glands
- Menstrual irregularity/ amenorrhea
- Chronic constipation

Where do eating disorders come from?

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- EDs are fundamentally biologically-based illnesses that are impacted by the environment.

- Genetic influences
- Temperament and Traits
- Neurology
- Culture
- Family
- Environmental

1. Screen
2. Assess
3. Triage
4. Management

When to assess

- Precipitous weight changes or fluctuations
- Children/teens: failure to gain expected weight or height, delayed pubertal development
- Sudden changes in eating behaviors
- Sudden or extreme changes in exercise patterns
- Body image disturbance, desire to lose weight (regardless of actual weight!)

When to assess

- DM1: poor glucose control or recurrent diabetic ketoacidosis
- Compensatory behaviors
- appetite suppressants, caffeine, diuretics, laxatives, ipecac, artificial sweeteners, sugar-free gums, dietary supplements misused

SCOFF (Screening for Eating Disorders in Adults)

- 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 ONE stone (14 lb) 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?

Score of 2 or more indicates likely AN or BN.

Triage

Goals of Treatment:

1. Medical stabilization
   - Medical clearance
2. Nutritional rehabilitation
   - Weight restoration
   - Regular eating
3. Normalization of eating behavior
   - Ceasing: restricting, binging, purging/compensatory bx
4. Psychosocial stabilization
   - Evaluate/treat comorbid dx
   - Re-engaging in life
   - Improved body image

Treatment

- Outpatient
  - Family-Based therapy
  - CBT-E
  - Dialectical Behavioral Therapy for Binge Eating/Bulimia
  - Exposure therapy/contingency management/FBT for ARFID

  - Nutritional Counseling
  - Monitoring by physician
  - Pharmacological
    - Fluoxetine
    - Antipsychotics

- Inpatient
  - Treating malnutrition and weight restoration
- Residential
- Partial, IOP

Management

- Treatment vs management

Reasons to manage rather than treat/refer

- Behavior is stable but needs cognitive work
- Barriers to getting treatment/no referral options
  - Look for quick improvement
  - Set limits from the start when they must go to higher level of care

When providing eating disorder management care as a mental health provider

- Provide informed consent
  - They may think they are getting treatment
  - EBTs for eating disorders are largely effective
- Know your limits
  - Be behaviorally specific
  - Set time-frames if necessary
- Keep consideration of more intensive services on the back-burner
- Consult…

Consult

- Know who in your community does provide evidence-based treatment for EDs
- Connect with providers. Ask if they would be willing to consult
- Good faith effort
- Want to show/document that your efforts are clinically sound and sensitive

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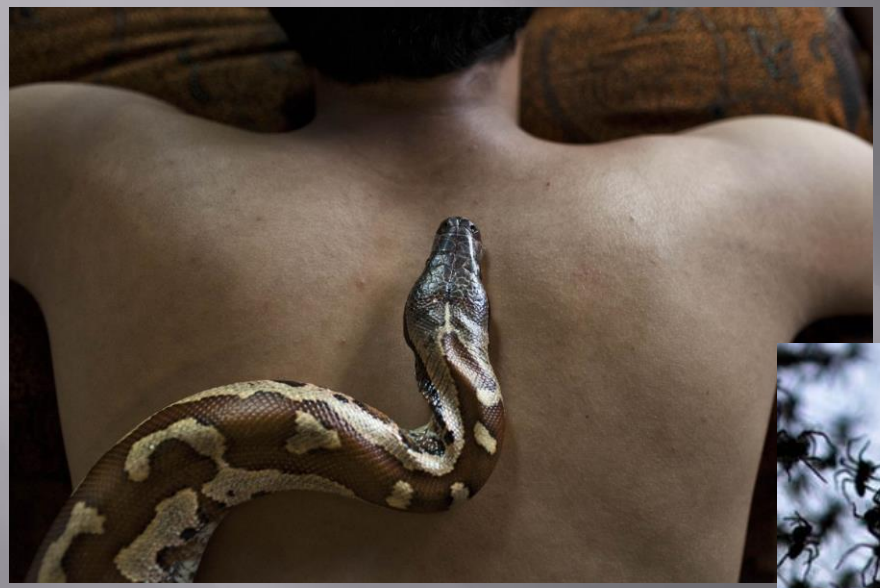
What can I do now?

- Screen/assess
- Triage
- Pts may not acknowledge they are ill or may be ambivalent
  - Psychoeducation
  - motivation enhancement commitment
  - rally outside support – TRUST PARENTS' CONCERNS
- Diffuse blame
- Risk
  - Up to 50% of mortality in ED due to suicide

What should we remember when interacting with someone with an ED?

If food is medicine…



What not to do…

- "Just eat/stop puking/eat a regular amount"
- Recommend diets/talk about your diet
- Talk about looks (collude with eating disorder)
- Assume this is just about looks
- Argue with them that they aren't fat
- Compare them to concentration camp victims
- Tell them they are selfish
- "It's only ____ calories!"
- Tell them how good they look when they lose or gain weight.

Do

- Be supportive
- Gently redirect body checking, fixation on calories, ect
- Give them choices (remember too many decisions regarding food choice can paralyze them)
- Assess for suicidality
- Let them know that there is hope and treatment works
- Encourage seeking evidence-based treatment
- Model healthy behavior (re: balanced dieting and exercise, NO FAT TALK, healthy emotional expression)

Questions?

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