Eating Disorders

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Early Identification and Proactive Treatment
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Disclosures

I have no actual or potential conflict of interest in relation to this program/presentation.
Goals

1. Review DSM-V criteria for Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorders.
2. Describe typical acute symptoms, course, and prognosis for Eating disorders.
3. Identify risk factors and obstacles in assessment for non-acute eating disorders.
4. Discuss goals for treatment of eating disorders.

Eating Disorders

- Pica
- Rumination Disorder
- Avoidant/restrictive food intake disorder
- Anorexia Nervosa (AN)
- Bulimia Nervosa
- Binge eating disorder
- Other specified eating disorder-Night eating syndrome
How do we know?

- **F/M 3:1**
- Males typically have a history of premorbid obesity
- Lifetime prevalence is 1-3% in females

**Prevalence**
DSM V Criteria

F50.0 Anorexia Nervosa

A. Energy intake restriction, leading to significantly low body weight. (Or make expected growth goals)

B. Intense fear of becoming fat
   - Not alleviated by weight loss

C. Distortion of body image – weight, size, shape

- DSM-IV TR (Amenorrhea-absence of 3 successive menstrual periods)
AN Subtypes

- Restricting type
  - Weight loss through dieting, fasting, or excessive exercise
  - NO bingeing or purging
- Binge eating-purging type
  - Regular bingeing and/or purging during current episode
  - May misuse laxatives, diuretics, diet pills, enemas

AN Subtypes

- Severity
  - Mild: BMI ≥ 17kg/m²
  - Mod: BMI 16-16.99kg/m²
  - Severe: BMI 15-15.99kg/m²
  - Extreme: BMI < 15kg/m²
F50.2 Bulimia Nervosa

A. Binge eating episodes
B. Recurrent inappropriate compensatory weight controlling behaviors
   - Purging 80-90%
C. Binge each and inappropriate compensatory behaviors both occur, on average, at least once/week for three months
D. Self-evaluation is unduly influenced by body shape/weight

Bulimia Nervosa

- Severity (based on #episodes of maladaptive compensatory behaviors)
  - Mild: 1-3 episodes per week
  - Moderate: 4-7 episodes per week
  - Severe: 8-13 episodes per week
  - Extreme: ≥ 14 episodes per week
**What is a “Binge”**

- Time(<2hrs)/Amount
- Lack of control

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**F50.8 Binge Eating Disorder**

A. Recurrent binge episodes (>1/week for 3m)
B. Associated features (3 or more): rapid eating, eating until uncomfortably full, eating when not hungry, eating alone because of embarrassment of amount, or disgust/guilt
C. Duration > 3 months
   No compensatory weight loss measures
Binge-Eating Disorder

**Severity**
- Mild: 1-3 episodes per week
- Moderate: 4-7 episodes per week
- Severe: 8-13 episodes per week
- Extreme: ≥ 14 episodes per week

*Severity not associated with body weight.*

Clinical Presentation
BULIMIA NERVOSA
- Salivary gland enlargement
- Enamel erosion
- Esophagitis
- Arrhythmias
- Normal weight or underweight
- Cellulitis
- Biochemical changes
  - T4
  - T3
  - TSH
  - CO2
  - Amylase
  - Diahrea
  - Edema

ANOREXIA NERVOSA
- Dizziness, confusion
- Dry, brittle hair
- Lanugo-type hair
- Low blood pressure, pulse, ECG voltage
- Orthostasis
- Cachexia
- Biochemical changes
  - WBC
  - Glucose
  - Total cholesterol
  - Carotene
- Stool retention
- Acrocyanosis
- Loss of menses
- Muscle wasting
- Diminishing DTRs
- Osteoporosis
- Dry skin
- Edema
- Growth retardation
- Hypothermia

Binge eating and purging
Weight loss and malnutrition
Differential Diagnoses for Eating Disorders

- Medical conditions: GI, endocrine, malignancy, AIDS
- Nocturnal Sleep Related Disorder
- Other Eating Disorder
- Obesity
- Mood Disorder
- Borderline Personality
- Klein-Levin syndrome
- Psychosis
- Substance use
- Obsessive Compulsive Disorder
- Social Anxiety Disorder
How do we identify the non-acute Eating Disorder patients?

Obstacles to Assessment/Treatment

- Patient factors
  - Patient minimization or hiding of behavioral and psychological symptoms
  - Diversity of symptom expression
  - Potential dualism or lack of patient motivation
  - Focus on symptom management rather than treatment of underlying condition
  - Treatment drop off rate
Obstacles

- Family factors
  - Family history of negative body image/maladaptive weight loss strategies, rigidity, or other mental illness

- Cultural/Societal factors
  - Normalization of thinness
  - Poor life style choices of peers
  - Media exposure

Obstacles

- Provider factors
  - Primary care time constraints
  - Limited information from patient
  - Provider attitudes towards Eating Disorders

Watch out for countertransference, and feelings of being manipulated.
Risk Factors

Consolidated Eating Disorder Model

**Predisposing**
- Individual
  - Birth weight
  - Gender
  - Temperament
  - Genetics
- Family
  - Parental mental illness/substance use
  - Parental eating patterns
- Society
  - Urban living
  - Extreme SES

**Potentiating**
- Individual
  - History of Obesity
  - Mood/anxiety
  - OCD, impulsivity
  - Personality
- Family/Social
  - Parental control behaviors with diet
  - Parental criticism/conflict
  - Acculturation
  - Media
  - Bullying
  - Lack of friends

**Outcome**
- Cognitive & Behavioral
  - Negative body image
  - Negative self-evaluation
  - Dietary restraint
  - Bingeing
  - Maladaptive weight loss strategies
- Anorexia
- Bulimia
- Binge eating
- Obesity

- Obesity
Individual

- Body image
- Perfectionism or Impulsive
- Dysregulated Moods
- Limited social outlets
- Athletes
Early Clinical Assessment

- **SCOFF**
  - 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 (15 pounds) in a three-month period?
  - Do you believe yourself to be fat when others say you are too thin?
  - Would you say food dominates your life?

- **EAT-26**

- **Yale-Brown-Cornell Eating disorder assessment**

Other Assessment Strategies

- **Motivational Interviewing**
- **Family collateral/collaboration**
Family Assessment

- Identify any family history of eating disorders, other psychiatric disorders, and obesity.
- Assess family dynamics (e.g., guilt, blame) and attitudes toward eating, exercise, and appearance.
- Identify family reactions to the patient’s disorder and the burden of illness for the family.

Course
Course

- Median delay from onset to treatment for AN is 15 years wait time for assessment
- Variable course
  - Relapsing
  - Remitting
  - Chronic
- Highest mortality rate of any psychiatric disorder
- 12 x greater cause of mortality between ages 16-25
- 50% deaths are cardiac; other half suicide

AN Prognosis

- 5-15% mortality over lifetime
- 1% die of their disease each year
- 25% complete recovery
- 50% partial improvement
- 25% continued anorexia
Bulimia Nervosa-Prognosis

- 10 year follow up:
  - 50% are symptom free
  - Some show gradual improvement
  - Some continue daily bingeing and purging

Treatment
Goals in Treatment

- Establish a therapeutic alliance
- Restore weight
- Collaborate with team
- Treat comorbid psychiatric illness
- The body is a unit; the person is a unit of body, mind, and spirit.
  - Future role for osteopathic manipulation?

Goals

- Minimize food restrictions.
- Reduce binge eating and purging behaviors, if present.
- Provide education regarding healthy nutrition and eating patterns.
- Encourage healthy but not excessive exercise.
- Enhance the patient’s motivation to cooperate and participate in treatment.
Acute Eating Disordered patients suffer severe medical comorbidities.

Non-acute Eating Disordered patients are difficult to identify in the community.

Assessment should include multiple sources.

Treatment should target both medical stabilization as well as mental stabilization.

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