Hiding in Plain Sight: Eating Disorder Screening, Treatment, Referral, and Collaboration

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Objectives

- Biological, psychological, and environmental eating disorder risk factors
- Strategies, tools or approaches that can be used to identify, treat and refer an individual with an eating disorder
- Value of and function of a multi-disciplinary team in the treatment of eating disorders

Prevalence, Mortality, and Risk Factors

Prevalence of Eating Disorders

- An estimated 20 million women and 10 million men in the US struggle with an eating disorder – nearly 1 in 10 Americans with a lifetime diagnosis

- This about 8% of adolescent females and 4% of adolescent males

- A recent review and meta-analysis of 32 studies found:
  - 22% of children and adolescents exhibited disordered eating behaviors
  - 30% for girls vs 17% for boys

  (López-Gil JF, et al. JAMA Pediatr. 2023;doi:10.1001/jamapediatrics.2022)

- Eating disorders affect all racial, ethnic and sexual minority groups, often in percentages higher than found in the majority population
  - Eating disorders have been identified in 63 countries and have a global prevalence of 4.4% in children and adolescents *(Erskine, Baxter, Patton, et. al. 2016, Pike and Dunn, 2015)*

Mortality in Eating Disorders

“Young people between the ages of 15 and 24 with anorexia have 10 times the risk of dying compared to their same-aged peers.”

Fichter, M. M., & Quadflieg, N. (2016). Mortality in eating disorders – Results of a large prospective clinical longitudinal study. International Journal of Eating Disorders, Epub ahead of print.

Over 10,000 deaths per year as a result of an eating disorder - nearly 1 every hour from eating disorder complications

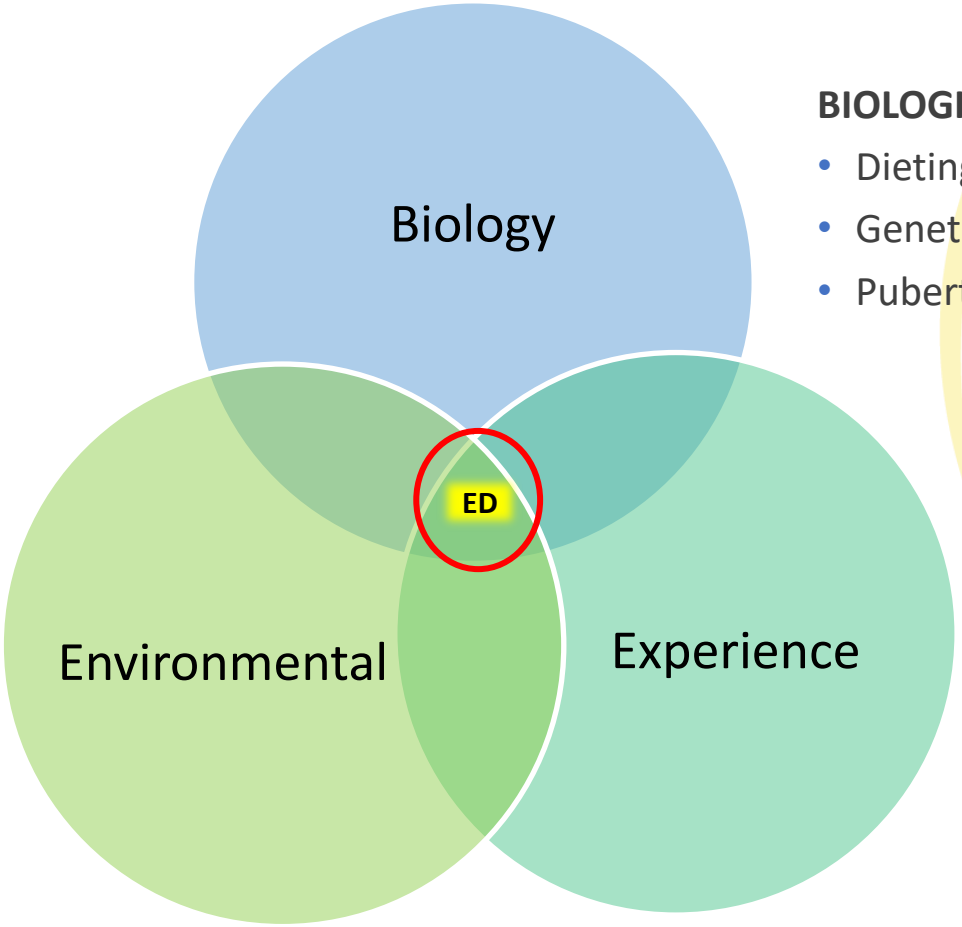
The suicide rate is calculated to be **31 times higher** for a person with and ED compared to their peers

20% of eating disordered persons will **die prematurely** as a result of their illness.

The average age of death due to an eating disorder is **34 years old.**

Eating disorders are biologically based brain illnesses influenced by environmental and psychological factors

Bio-Psychosocial Model of Eating Disorders



BIOLOGICAL INFLUENCES

- Dieting/Food exposure
- Genetics & Epigenetics
- Puberty/Menopause

ENVIRONMENTAL FACTORS

- Media messages
- Weight/appearance pressures
- Weight comments/teasing

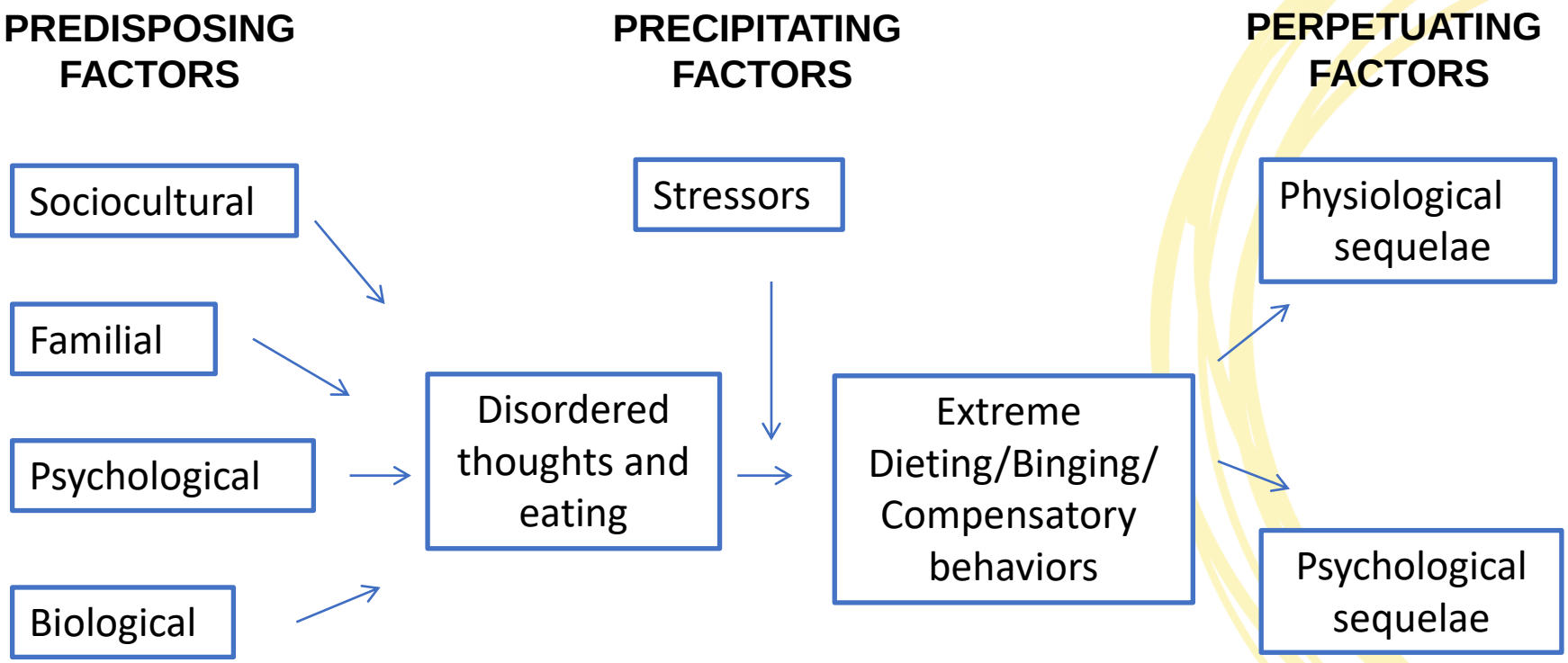
EXPERIENCE/ TRAITS

- Anxiety, depression
- Substance use
- Stressors
- Self-image
- Trauma

Factors that increase risk for eating disorders

- Genetics (family history)
- Childhood feeding problems
  - Failure to Thrive
  - Choking, swallowing difficulties
  - Picky eating
- Adverse Childhood Events
  - Trauma/Abuse
  - Divorce/death
  - Disruption of family structure
- History of being teased about weight or shape
- Food Insecurity
- Psychological/Emotional
  - Feelings of inadequacy/lack of control in life
  - Low self-esteem
  - Depression, anxiety
  - Perfectionism
- Unhealthy weight control practices
- Participation in sports
- Societal pressures to be “thin” and “perfect body”

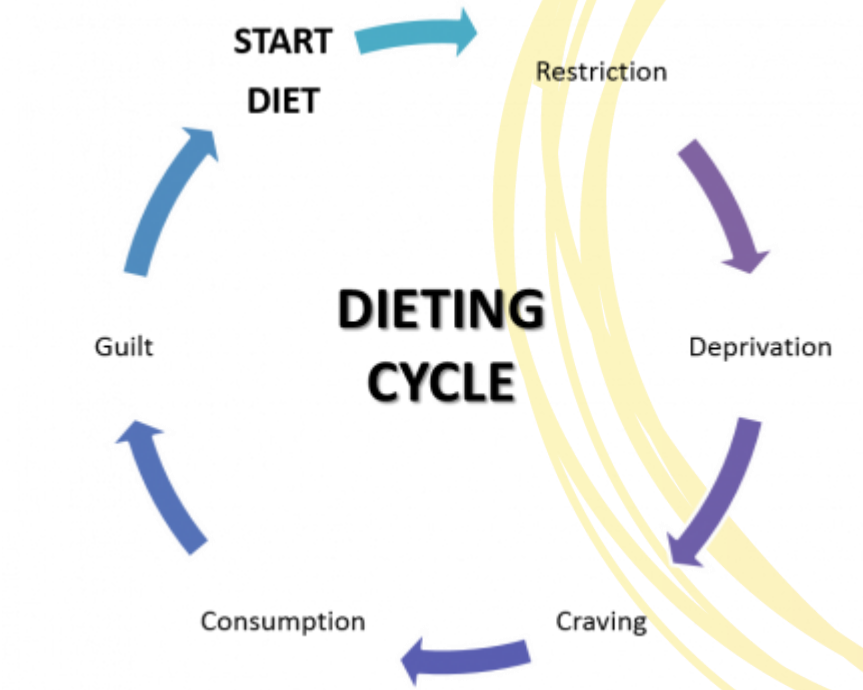
THE MULTI-DETERMINED AND SELF-PERPETUATING NATURE OF EATING DISORDERS



Adapted from Harper-Guifre, H. (1992) Overview of the eating disorders. In H. Harper-Guiffre & K.R. MacKenzie (Eds). Group psychotherapy for eating disorders. Washington, DC: American Psychiatric Press

When does it become an Eating Disorder?

- Is there a **pattern** of behaviors?
- Is there **preoccupation**?
- Is there **impairment**?



The restriction, manipulation, consumption, and/or overconsumption, of food is in service of underlying physical, emotional and psychological issues

Physical signs/behaviors

Mental preoccupation

Eating Disorders Diagnoses

Types of Eating Disorders

Anorexia Nervosa (AN)

- Inability to consume adequate nutrition, leading to low body weight or failure to meet growth trajectories
- Intense fear of food and weight gain
- Disturbance in body perception
- May include binge eating and purging

Bulimia Nervosa (BN)

- Binge eating, followed by purging (vomiting, laxatives, diuretics) or a non-purging compensatory behavior
- Self-evaluation is unduly influenced by body weight and shape
- Often “normal” weight

Binge Eating Disorder (BED)

- Binge eating accompanied by marked distress
- Absence of ‘compensatory’ behaviors
- Can be any weight; weight gain often occurs as eating disorder progresses

Avoidant/Restrictive Food Intake Disorder (ARFID)

- Failure to meet nutritional/energy needs due to eating or feeding disturbance
- Associated with weight loss, nutritional deficiency, or failure to meet growth trajectories

Other Specified Feeding or Eating Disorder (OSFED)

- Purging Disorder
- Atypical AN/BN
- BN/BED of Low duration/Frequency

Unspecified Feeding or Eating Disorder (UFED)

- Symptoms of feeding and eating disorder are present but do not meet full criteria for diagnosis
- Insufficient information for diagnosis

Atypical Anorexia: In Brief

Atypical Anorexia Nervosa (AAN)

- Inability to consume adequate nutrition, leading to rapid, significant weight loss or failure to meet growth trajectories
- Intense fear of food and weight gain
- Disturbance in body perception
- May include binge eating and purging

- Meets **all criteria** for **full A/N** except not low weighted
- Often times **overlooked or not assessed** due to **assumption weight loss is automatically desirable**
- As **prevalent and serious** as A/N
- **Impairment** in physical, social, and psychological functioning is **as or more severe** than in A/N
- **Medical signs** can include rapid weight loss, low HR, BP, cold/tired hair loss, lanugo, GI issues, brain fog, poor sleep
- **Emotional issues** include depression worsening, anxiety increasing
- Common **personality traits** include **perfectionism, harm-avoidant, persistence, obsessionally**

Avoidant Restrictive Food Intake Disorder: In Brief

Avoidant/Restrictive Food Intake Disorder (ARFID)

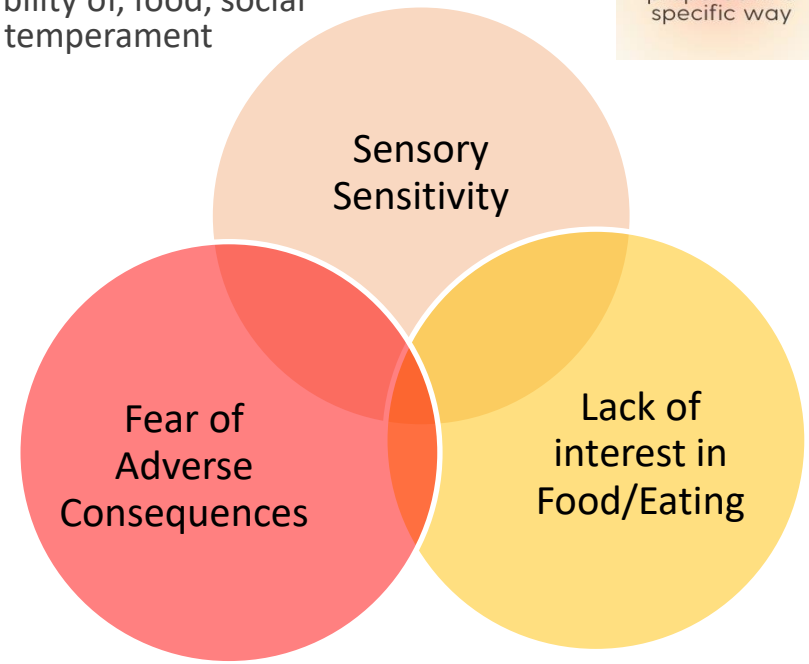
- Failure to meet nutritional/energy needs due to eating or feeding disturbance
- Associated with weight loss, nutritional deficiency, or failure to meet growth trajectories

- Approximately 15% of new eating disorder cases presenting for treatment
  - 20 – 30% of ARFID patients are male
  - Mean age of diagnosis is 11 y.o., symptoms often present earlier
- Early symptoms of avoidant/restrictive food intake disorder (ARFID) may be confused with picky eating.
  - Goes far beyond picky eating, and writing it off as "just a phase" may have serious implications
  - Can present as extreme selectivity (e.g., intake limited to 5 specific foods)
- The feeding or eating disturbances of ARFID can lead to problematic health effects due to nutritional and energy deficiencies.
  - Weight loss or failure to achieve appropriate weight gain still a main reason for diagnosis/being brought to medical attention and equally as underweight as those with anorexia nervosa
  - Desire to lose weight is NOT a driving force of the disorder
  - High likelihood of prior evaluation by other medical subspecialists due to other symptoms (Fisher et al., 2014; Cooney et al., 2018)
- Higher risk of developing ARFID include:
  - Individuals who have anxiety disorders or OCD
  - Those with ADHD
  - Individuals who are on the autism spectrum
  - Children who experience severe picky eating that does not improve with time

ARFID Subtypes

- Sensitivity to texture, temperature, appearance, taste, smell
- More likely to be sensitive to disgust
- Present early in life, influenced by genetic/biological factors
- Exposure to or availability of, food, social modeling, individual temperament

Refusal to eat due to fear of illness, choking, or vomiting	Anxiety at meal times	A lack of interest in food and/or liking very few foods
Requiring food to be prepared in a specific way	Avoiding certain food textures & consistencies	Anemia, low potassium, low hormone levels, slow heart rate



- Fear of choking or vomiting
- Fear of contamination, allergic or, neg. GI reaction
- Often more acute onset
- Behaviors shaped by event or circumstances

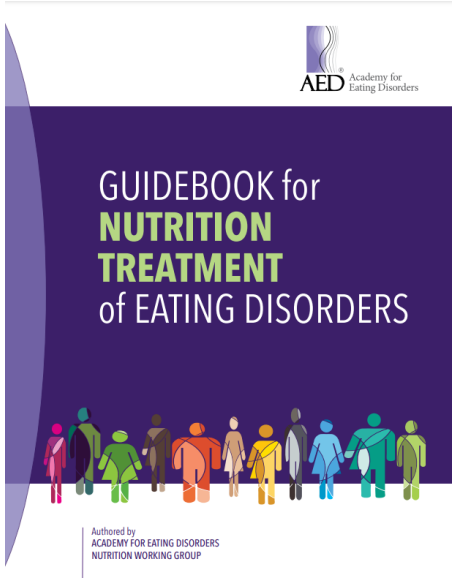
- Often starts in early childhood
- May be associated with failure to thrive
- Rarely gets hungry, satiated early in meal
- May have frequent GI or somatic complaints

Assessing for Disordered Eating

Signs And Symptoms of Eating Disorders

Physical

- Unusual and rapid weight fluctuations
- Fainting, fatigue, low energy, interrupted sleep
- GI discomfort, dysregulation, bloating
- Dry hands, hair or poor circulation
- Hair loss or development of lanugo
- For females, disruption in menstruation
- Chest pain or heart palpitations



Behavioral

- Dieting or chaotic food intake
- Preoccupation with food, weight, size and shape
- Excessive exercise
- Frequent trips to the bathroom
- Change in clothing style (sometimes to hide or to flaunt their body)
- Eating alone, isolation, emotional around food/meals

Emotional

- Severe mood swings
- Increased isolation, irritability, anhedonia
- Low self-esteem, complaints about body
- Sadness or comments about feelings of worthlessness
- Increase of depression, anxiety and/or obsessive compulsive symptoms

Questions you could ask

- Are there changes in eating, activity, sleep, feeling of wellbeing?
- Any concerns for you around your eating patterns?
- What percentage of the day are you thinking about food or weight or shape?
- Significant family-related events?
- If you do have concerns important to frame as “I” statements

Screening for an eating disorder

- **SCOFF Questionnaire by Morgan, Reid & Lacy – adapted**
- **Two or more "yes" answers strongly indicate the presence of disordered eating**
  - Do you feel like you sometimes lose or have lost control over how you eat?
  - Do you ever make yourself sick because you feel uncomfortably full?
  - Do you believe yourself to be fat, even when others say you are too thin?
  - Does food or thoughts about food dominate your life?
  - Do thoughts about your body or weight dominate your life?
  - Have others become worried about your weight and/or eating?

- **Eating Attitudes Test (EAT – 26) – can be used in clinical and non clinical settings to identify eating disorder risk**
  - **Yields a referral index if respondent scores positively**

Eating Disorder Screen for Primary Care (ESP)

A 5-question self-report screen derived from other eating disorder screens.

1. Are you satisfied with your eating patterns?
   – (A “no” to this question was classified as an abnormal response).

2. Do you ever eat in secret?
   – (A “yes” to this and all other questions was classified as an abnormal response).

3. Does your weight affect the way you feel about yourself?

4. Have any members of your family suffered from an eating disorder?

5. Do you currently suffer with or have you ever suffered in the past with an eating disorder?

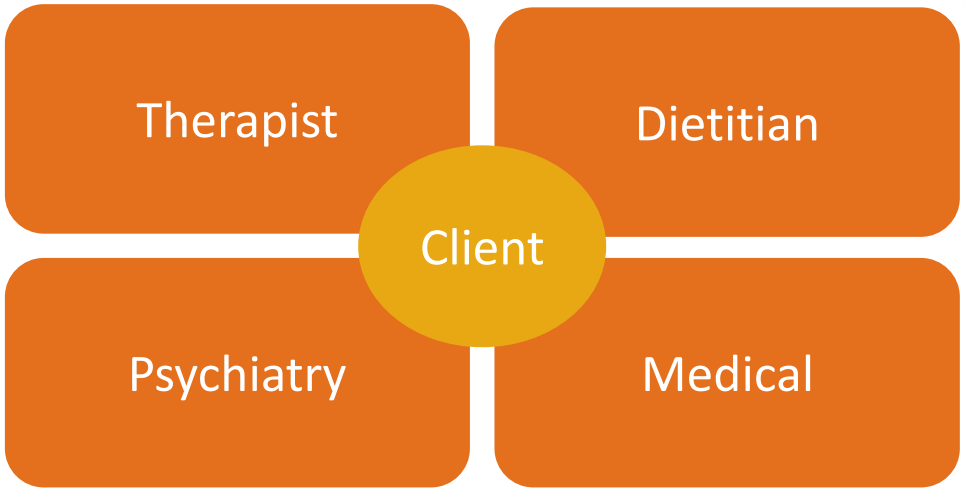
- Ages: Normed in a broad range of ages, including a small number of adolescents
- Languages: English
- Sensitivity/specificity: 100%/71% from a validation study combining a primary care population with a somewhat higher-risk population of university students [Cotton: 2003]
- Scoring: 3 or more abnormal responses are considered a positive screen for an eating disorder.

Dietitian and Therapist Collaboration in Treatment

Multidimensional Care Team

- Due to the bio-psycho-social nature, a **comprehensive assessment** is critical for assessing appropriate intervention

- Generally, those struggling with an ED need a **multi-disciplinary team** including therapy, nutritional counseling and medical
  - The #1 medicine for treatment is appropriate nutrition and that needs to occur **simultaneously** with therapy



Goals of Treatment

In treatment, we are trying to:

- Eat and be actively in tune with the body's needs
- Eat when hungry & stop when satisfied
- Eat a variety of foods without fear
- Focus on health
- Appreciate the body
- Think critically about media
- Employ adaptive coping skills

Benefits of Therapist and Dietitians Partnering in Care

- Dietitian brings depth of knowledge, training and experience that can address the management of the client's physical and nutritional state, help reduce/eliminate symptoms and behaviors, and support/direct the return to a normalized, appropriate eating pattern

- Allows the therapist to focus on the emotional/psychological aspects of the disorder, treatment and recovery

- Creates a treatment team that provides greater support for the client in their treatment and recovery

- Provides both providers the ability to consult with and strategize with a treatment partner

Eating Disorder Dietitian and Therapist Considerations

- Should be ED trained (ED-informed), and experienced working with ED clients
- Make sure treatment approaches align when adding to your multi-discplinary
- Discuss practice philosophy regarding weight-related issues
- Make sure practice setting and payment methods (insurance, etc) match your clients needs

Nutrition Interventions in the treatment of Eating Disorders

- Re-regulation of eating patterns
  - Self-Monitoring
  - Meal patterns
- Reducing restrictive eating
- Legalizing/normalizing foods
- Reintroducing challenge foods
  - exposure/response
- Restoration of flexibility and adaptability
- Incorporation of evidence-based therapeutic approaches
- Neutral language regarding food
- Mindfulness/mindful eating

Diet-related medical conditions with ED implications

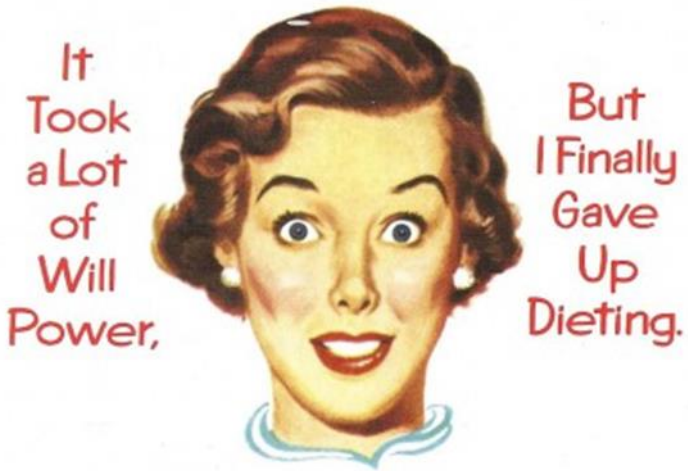
- Diabetes
- Celiac disease
- Crohn’s disease
- HTN/Dyslipidemia
- Feeding disorders
- Allergies and Intolerances
- Irritable Bowel Syndrome (IBS)
- Gastroesophageal Reflux Disease (GERD)
- Gastroparesis/Early Satiety
- Esophagitis
- Gas/Bloating
- Diarrhea/Constipation

Supporting the clients post-treatment

- Encourage neutral language around food, body and appearance
- Encourage and support variety, flexibility and self-compassion
- Ask about coping strategies, distress-tolerance skills and strategies they used in treatment, employ in current environment
- If client is returning to sport be aware of changes in weight, appearance, energy levels, academic performance, evidence of return of ED symptoms or behaviors

Changing language for all can help improve health and decrease risk for Eating Disorders and Disordered Eating

- **Focus on health.** Keep the focus on overall health, not weight. Losing weight doesn't automatically mean better health.
- **Behaviors improve health**. Losing weight is not a behavior. Eating well, moving well, sleeping well, and coping well leads to health.
- **Encourage family meals.** Reasonable changes to the whole family's way of eating can help the whole, not just the child or the adult. Eating together helps.
- **Value all.** Ensure the person knows he/she has value regardless of their weight or health status.
- **Talk less, do more.** Talk less about weight and food; model health improving behaviors more.
- **Rethink judgment**. Encourage language change about other's weight and your own. Weight stigma, weight bias, and weight focused language are prevalent, but that doesn't make them right or helpful.



Recommendations on how to help maintain a healthy lifestyle without increasing risk for an eating disorder from Dianne Neumark-Sztainer PhD, MPH, RD

Eating Disorder Treatment: structure and referral

Eating Disorder Levels of Care

- Immediate Medical or Psychiatric Stabilization
- Inpatient
- Residential
- Partial Hospitalization or Day Treatment
- Intensive Outpatient
- Outpatient

Factors to consider when considering referral to ED treatment

- Medical risk
  - severe kcal restriction, low weight
  - Co-occurring conditions that complicate care such as GI conditions, insulin-dependent diabetes, severe allergies
  - Binge frequency or amounts that result in client-reported involuntary vomiting or GI distress
  - Use of laxatives, diuretics or emetics following a binge (even if occasional or sub-diagnosic for bulimia
- Co-occurring mental health conditions (especially for non-therapist)
  - Substance use disorder
  - Severe depression or anxiety
  - Suicidal ideation
  - Trauma
- Physical, mental or emotional impairment severity that impairs clients ability engage in activities of daily life

Referral Process can be by Providers, Family Members, or Patients

- Start with the website of the eating disorder program near you
- Not sure what that is? www.findedhelp.com or head to your favorite search engine
- **Call** the program or **fill out a form** on their website
- Need help finding a program? The National Alliance for Eating Disorder helpline at 866-662-1235, Monday - Friday, 9:00 am - 5:30 pm EST
- No referral needed for eating disorder

How to refer and additional resources

- **Providers, family members, or individuals can start the process**
  - Call 612-402-3061 to speak to an admissions team member
  - Or fill out our online referral form https://veritascollaborative.com/for-professionals/refer-a-patient/
  - Reach out via www.gatherbh.com for direct outpatient referrals

- Is it an eating disorder? Take our **assessment quiz** to determine whether additional evaluation is needed
  - https://veritascollaborative.com/your-recovery/take-the-quiz/

Wrap Up

- Due to the bio-psycho-social nature, a **comprehensive assessment** is critical for assessing appropriate intervention

- Generally, those struggling with an ED need a **multi-disciplinary team** including therapy, nutritional counseling and medical
  - The #1 medicine for treatment is appropriate nutrition and that needs to occur **simultaneously** with therapy

- Therapists and Dietitians are both essential for patients with eating disorders to move forward in recovery!

Questions? Thank you!

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