

EATING DISORDERS

How to Assess and What You Need to Know

Bonnie Brennan, LPC, CEDS-S, CAI

The Problem

Eating Disorders are serious and lethal mental illnesses

Up to 30 million people of all ages and genders suffer from an eating disorder within the USA.

In females between age 15-24 with Anorexia, the mortality rate is 12x higher than the death rate of all other causes of death.

Binge Eating Disorder: most prevalent ED with prevalence rates (vary by criteria used) 2-4 X AN

3.5% - women; 2.0% - men, 2.8% lifetime prevalence in US.

Eating Disorders do not discriminate by gender, race, social status or age

50% of deaths of persons with Anorexia Nervosa are from suicide

The Problem: Co-Occurring Statistics

Between 30 and 50 percent of individuals with bulimia and 12-18 percent of those with anorexia abuse or are dependent on alcohol/drugs, compared to approximately nine percent in the general population.

Up to 35 percent of individuals who abuse or are dependent on alcohol/drugs also have an eating disorder, compared to up to three percent in the general population.

The Problem: Co- Occurring Statistics

www.nationaleatingdisorders.org

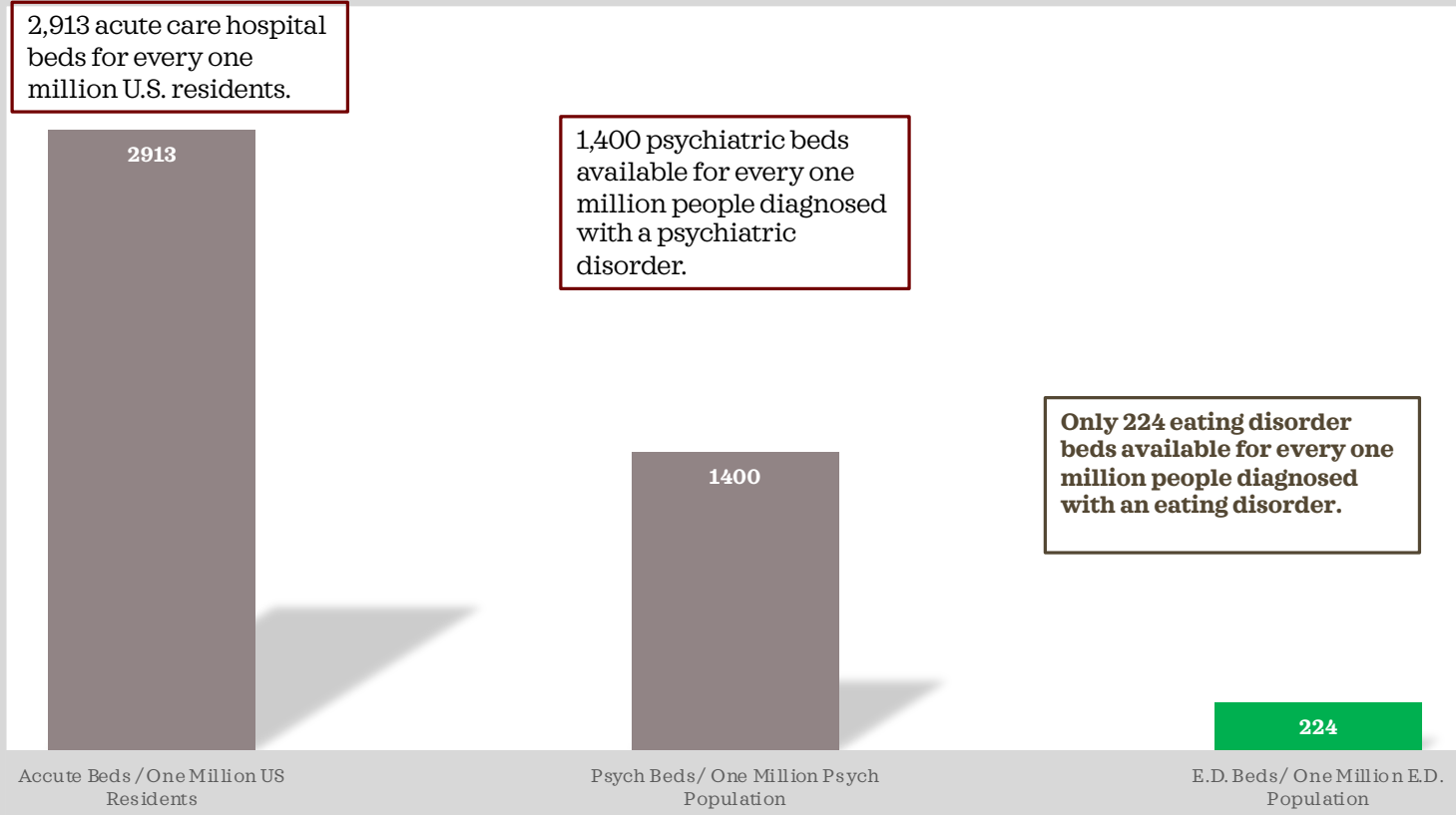
- A study of more than 2400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, including:
- 94% had co-occurring mood disorders, mostly major depression
- 56% were diagnosed with anxiety disorders
- 20% had obsessive-compulsive disorder
- 22% had post-traumatic stress disorder
- 22% had an alcohol or substance use disorder
- Approximately one in four people with an eating disorder has symptoms of post-traumatic stress disorder (PTSD).

The Problem: Co- Occurring Statistics

www.nationaleatingdisorders.org

- Personality disorders also commonly occur in individuals with eating disorders.
- Among those with anorexia,
 - Restricting type: 20% had obsessive-compulsive personality disorder, 10% had borderline personality disorder
 - Binge-purge type: 12% had obsessive-compulsive personality disorder, 25% had borderline personality disorder
 - Among those with bulimia: 11% had obsessive-compulsive personality disorder, 28% had borderline personality disorder
- A 2014 study found that combined and analyzed data from 20 previous studies found signs of personality disorders in
 - 38% of people with EDNOS/OSFED
 - 11% had obsessive-compulsive personality disorder
 - 12% had borderline personality disorder
 - 30% of people with binge eating disorder
 - 10% had obsessive-compulsive personality disorder
 - 10% had borderline personality disorder
- Depression and other mood disorders co-occur with eating disorders quite frequently.

Eating Disorder Treatment Disparity



2,913 acute care hospital beds for every one million U.S. residents.

1,400 psychiatric beds available for every one million people diagnosed with a psychiatric disorder.

Only 224 eating disorder beds available for every one million people diagnosed with an eating disorder.

Acute Beds / One Million US Residents

Psych Beds / One Million Psych Population

E.D. Beds / One Million E.D. Population

Source: US Census Bureau, American Hospital Association, Wall Street research, as of 2014

EATING DISORDERS DIAGNOSES

Anorexia Nervosa: Characterized by self-starvation, and excessive weight loss. AN is divided into two diagnostic categories, restrictive anorexia and binge/purge anorexia.

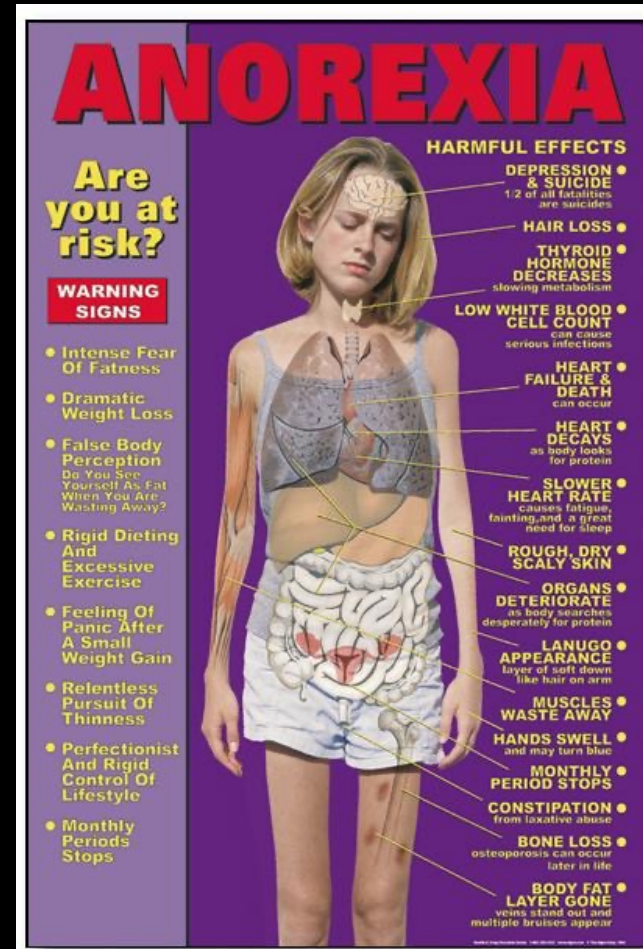
Avoidant/Restrictive Food Intake Disorder (ARFID): Usually found in childhood or infancy but can also be found in adults.

EATING DISORDERS DIAGNOSES

Bulimia Nervosa: Characterized by a cycle of bingeing and compensatory behaviors, such as self-induced vomiting, laxative abuse or exercising, designed to compensate for the effects of binge eating.

Binge Eating Disorder: Characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.

Other Specified Feeding or Eating Disorder (OSFED): Refers to abnormal eating or feeding without all the symptoms needed to be diagnosed with anorexia, bulimia or binge eating disorder. EG. Night eating syndrome.



PREDISPOSING BIOLOGICAL FACTORS

Family history of eating disorders or chemical dependency
Significant genetic contributions to eating disorders

Mood disorder, anxiety or depression

Traits/Temperament

Increased BMI prior to onset

Early onset puberty

PREDISPOSING ENVIRONMENTAL FACTORS

Go fast, highly competitive academic/social environment

Dieting culture—war on obesity

High risk sports/industry

Family history of severe dieting/exercise

Family constellation—enmeshed/disengaged

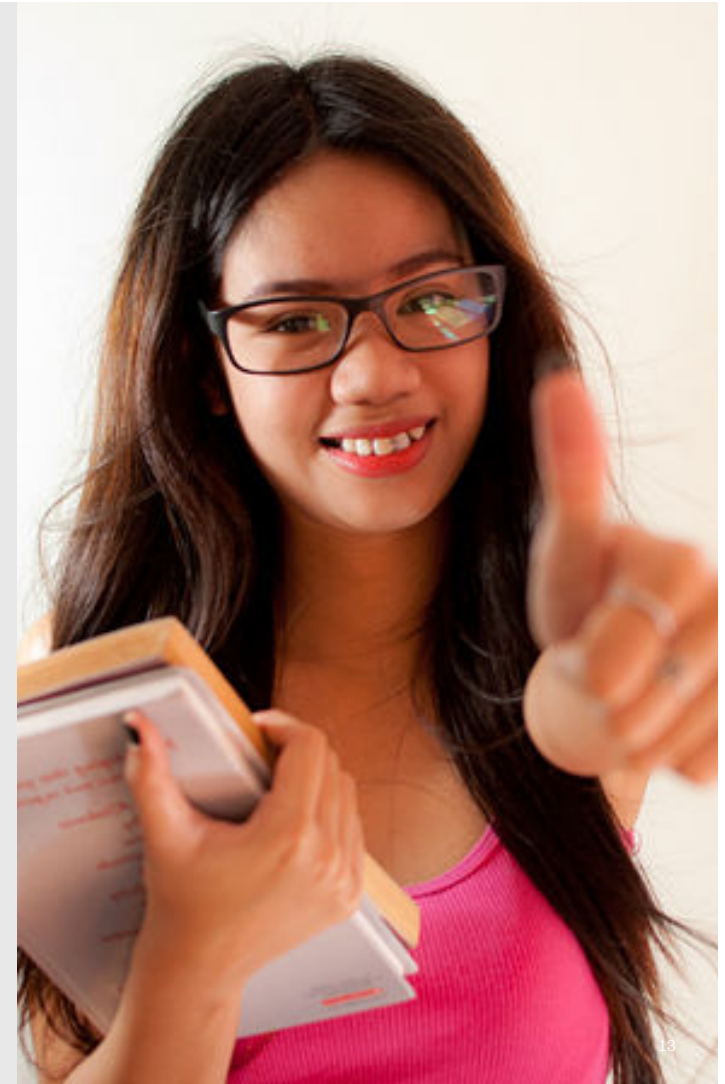
Genetic Studies

- Individuals with a mother or sister who had suffered from Anorexia Nervosa are:
 - 12 times more likely to develop Anorexia Nervosa
 - 4 times more likely to develop Bulimia Nervosa



Temperament in Anorexia Nervosa

- Harm avoidant
- Neurotic
- Obsessional
- Anxious
- Reward dependent
- Perfectionistic
- Low novelty seeking
- Very Low self-esteem



Temperament in Bulimia Nervosa

- Harm Avoidant
- Neurotic
- Obsessional
- Perfectionistic
- Anxious
- Low self-esteem
- Higher novelty seeking
- Impulsive
- Affective dysregulation



Behaviors that may be indicative of Eating Disorders

- Consistently leaving the table within ten minutes after eating a meal
- Stirring or playing with food rather than eating
- Skipping meals consistently
- Skipping a meal then over-eating at another meal
- Consistently tired or fatigued
- Consistently setting and communicating goals around getting physically “healthy”
- Exercising despite physical injuries
- Exercising more than 1.5 hours a day more than 4-5 days a week
- Restricting foods or food groups
- Talking about particular foods as “good” or “bad”
- Expressing concerns about being or becoming fat
- Gaining weight in treatment
- Inordinate amounts of conversation about food, weight, the body, and calorie intake
- Rigid eating patterns

EATING DISORDERS CAN HIDE BEHIND SUBSTANCE ABUSE DISORDERS

Many patients who suffer from substance abuse exhibit eating disorder behaviors that can often remain **undetected by his or her treatment team.**

Initially substance abuse may **mask** eating disorder behaviors, or be utilized as part of the eating disorder pattern.

As individuals with addictions and/or compulsive tendencies enter into abstinence, they may reach toward other **numbing mechanisms** such as eating disorder behaviors to help them cope with the unwanted thoughts, feelings and memories that emerge.

WARNING SIGNS



Consistently leaving the table within ten minutes after eating a meal



Stirring or playing with food rather than eating



Skipping meals consistently



Skipping a meal then over-eating at another meal



Consistently tired or fatigued



Consistently setting and communicating goals around getting physically “healthy”



Exercising despite physical injuries

WARNING SIGNS



Exercising more than 1.5 hours a day more than 4-5 days a week



Restricting foods or food groups



Talking about particular foods as “good” or “bad”



Expressing concerns about being or becoming fat



Gaining weight in treatment

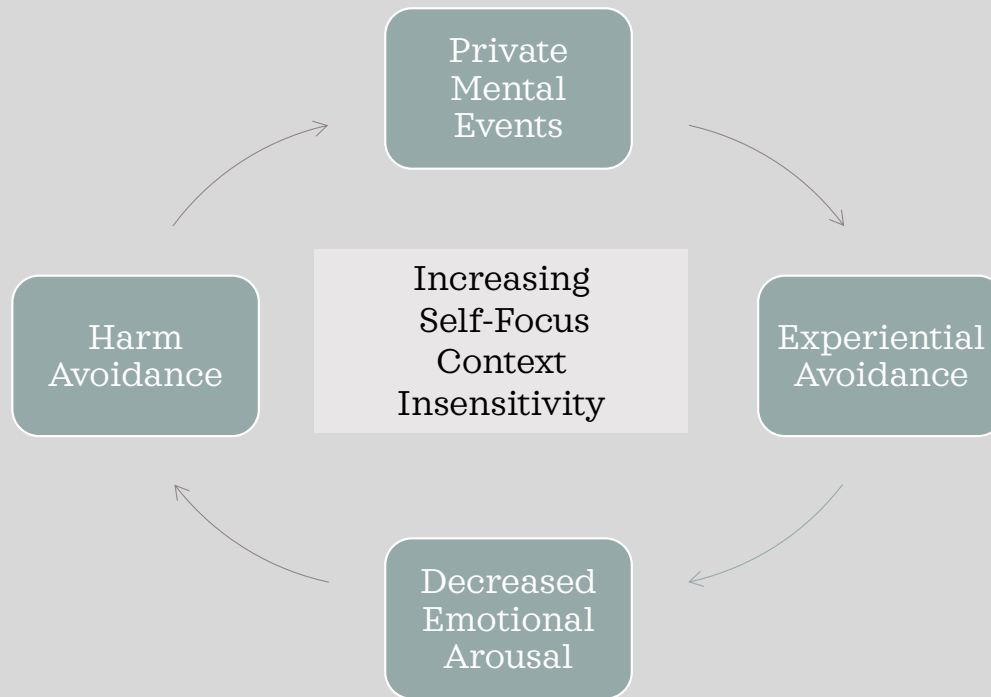


Inordinate amounts of conversation about food, weight, the body, and calorie intake



Rigid eating patterns

The Self-Sustaining Loop of Experiential Avoidance



Adapted from Hayes et al.,
2015



All Humans Experience Suffering

Our Attempt to Solve the Problem
Has Become the Problem

Functions of Eating Disorders

Control and
revenge

Numb out

Avoid
responsibility
and growing up

Attention

Set Boundaries

Self soothe

Disappear or
stay small

Protection

Avoidant Repertoire

ED client can often provide you with copious amounts of 'data.'

The content tends to lack soul

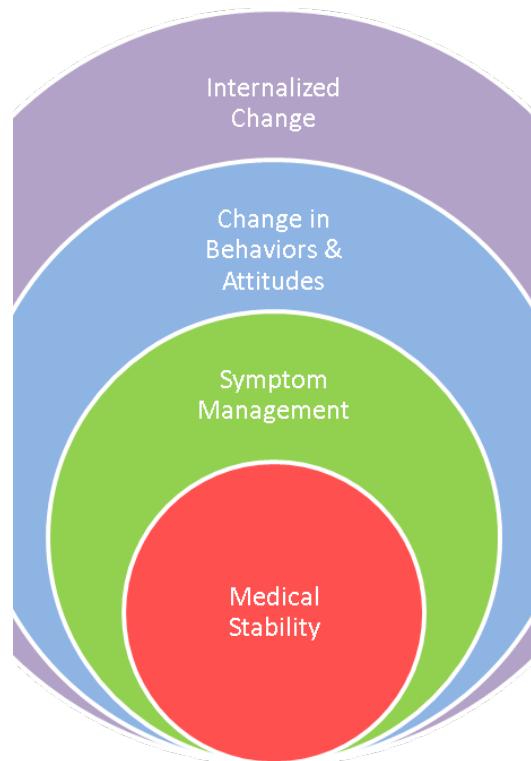
Impoverished sense of self

Going into content is logical and plays upon the human desire to problem solve...and it's a trap

Don't get lost in the details or chasing the truth!

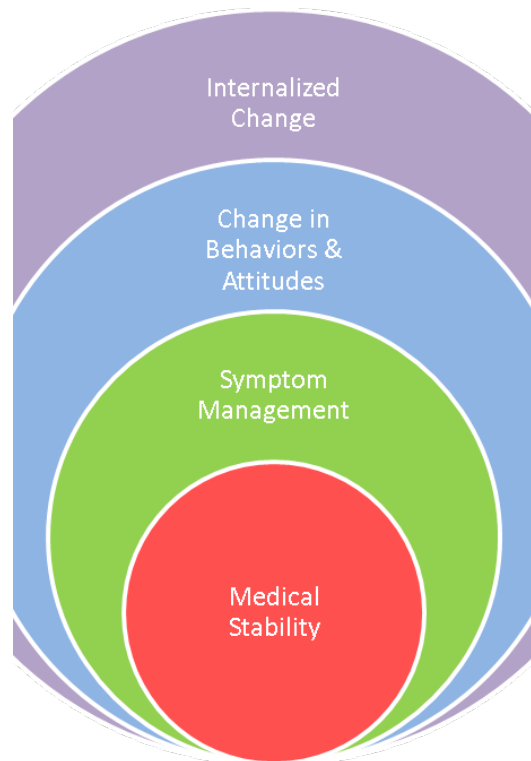
Gather objective data from others

Compassionately state your boundary and your convictions



Levels of CARE

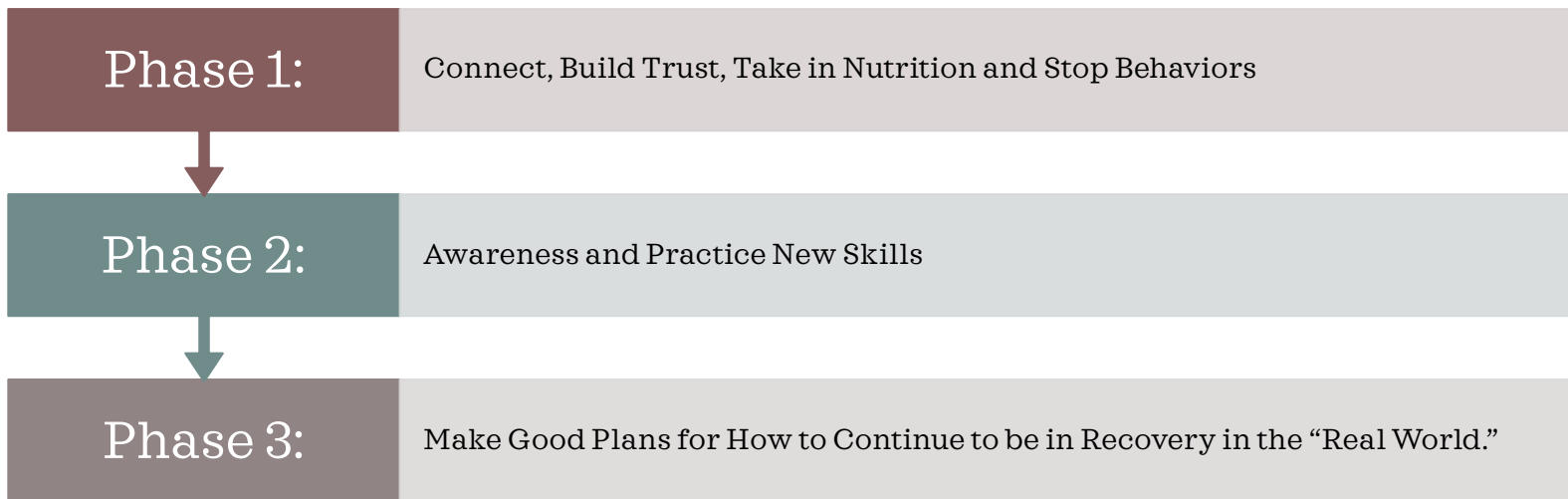
- Inpatient
 - Medically and/or psychiatrically unstable
 - Nursing care round clock
 - Daily Psychiatric rounding
- Residential
 - Need for 24 hour containment
 - Need for close staff supervision



Levels of CARE

- Partial Hospitalization
 - Day Treatment
 - Housed in community at night
- Intensive Outpatient
 - Group and experiential based programming 3 nights per week
- Outpatient Team
 - Therapist, Registered Dietitian, Physician

Phases of Treatment



Treatment Team

Psychiatrist

Therapist

Dietitian

Medical
Doctor

Groups

What do you
Do if you are
worried?



Use it as a gentle red flag



Do not assume the person has an eating disorder



Observe



Keep personal opinions about food and body to yourself



Let them know you care about them and you have noticed they might be having a hard time with something

What to Say:

- **DO:**

- What do you think about your body?
- Do you diet or attempt to lose weight in other ways?
- Do worries about eating or your body affect your day to day life?
- Do you ever try to make up for or “spend” calories after eating to keep from gaining weight?
- Do you ever feel out of control when eating or eating for reasons other than being physically hungry?

- **DON'T:**

- You don't look like you have an eating disorder
- I could stand to lose some weight myself
- You look good
- You look healthy
- Just eat healthier foods
- You don't look fat
- You are too skinny

HOW TO TREAT AN ED and SUD

Patients suffering from substance abuse and eating disorders may benefit from completing treatment for each condition in **immediate succession or simultaneously**.

As a substance abuse treatment professional, if you **observe any of the behaviors**, consult an eating disorders treatment professional to assess the patient.

If the patient is diagnosed with an eating disorder and is **medically stable**, the patient should ideally undergo a full detox and complete his or her substance abuse program before entering eating disorder treatment.

Consult an eating disorders treatment professional to determine the best course of action that complements the patient's substance abuse treatment plan.

A comprehensive treatment plan that **encompasses both conditions** helps patients achieve greater long-term recovery.

Intervention and Assessment Considerations

Ask ED programs about admission process

- May only admit certain days
- Waiting lists
- Need for medical information
- Determining level of care
- Insurance benefits may be different
- Admission process may be longer

Intervention and Assessment Considerations

- ED patients are not reliable self-reporters
 - Gather history from family and friends
 - Talk to previous providers
 - Request labs and blind weights
 - Reality is distorted by ED

Intervention and Assessment Considerations

- EDs are competitive!
 - Want to be the sickest
 - Fear of being “too fat” or “not sick enough” for care
 - Need to be told they meet criteria

Intervention and Assessment Considerations

- Involuntary Treatment
 - Very few options for involuntary ED treatment in USA
 - Typically patient is placed on MHH for assessment period and doctor petitions court for involuntary treatment due to grave disability if needed
 - May have court ordered tube feeds or medications
 - Can extend to outpatient setting
 - Does not extend across state lines

Guidelines when assessing medical status of eating disorders

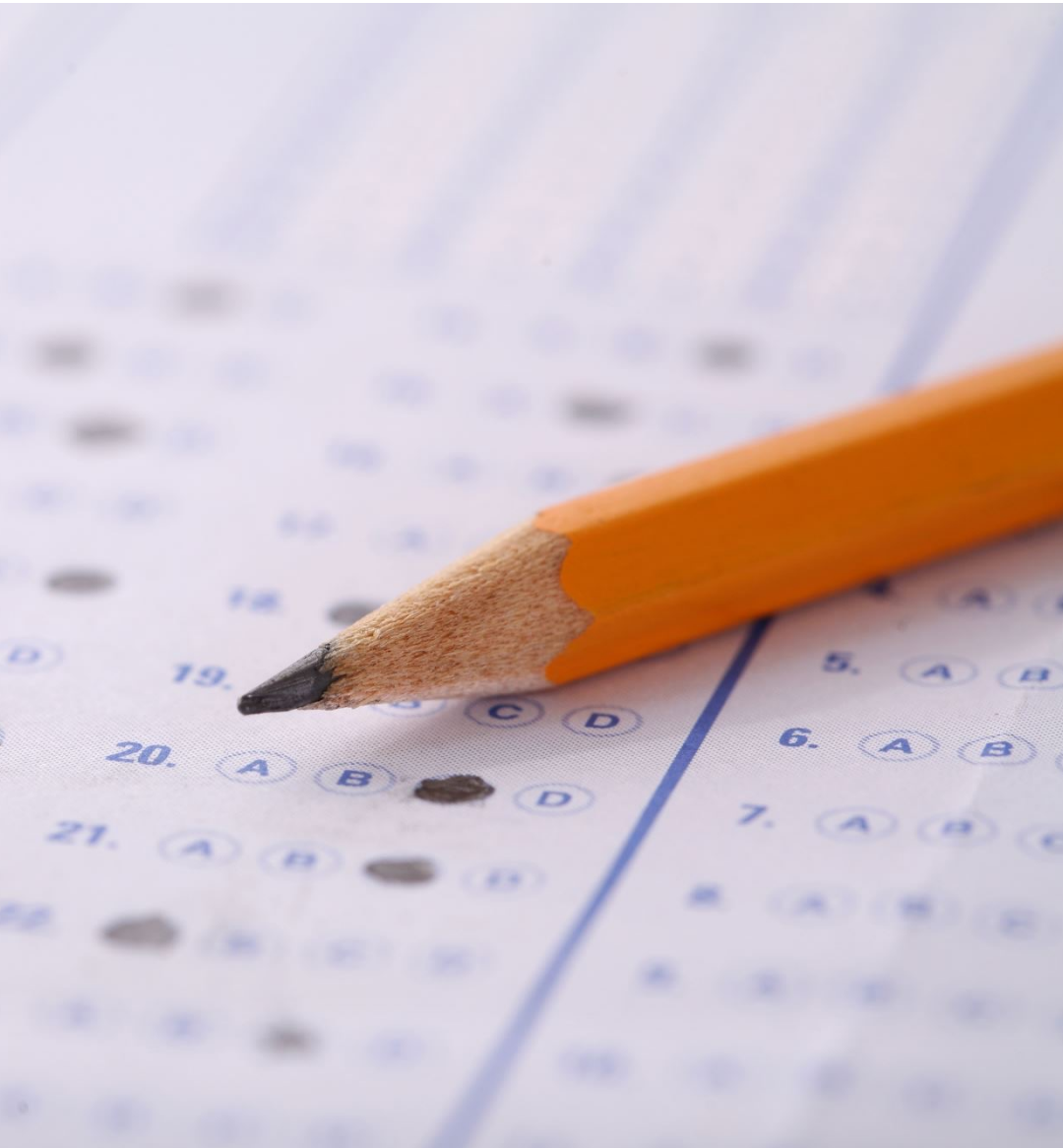
- Complete Metabolic Panel
- Phosphorus
- Vitals
- EKG
- Bone Density Scan
- Blind weight

When to Refer

- Weight loss with inability to gain
- Medical instability
- Suicidality
- Inability to contain purging behaviors
- “3 week” rule
- Daily functioning/inability to care for self
- Physical Symptoms
- Motivation

SCREENING: SCOFF Questionnaire

- The SCOFF Questionnaire has been validated in primary care practices and is a good tool given the short time it takes and ease of application.
- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?



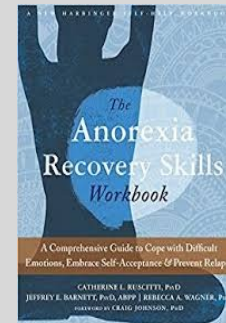
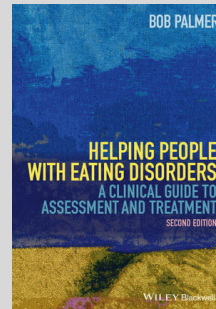
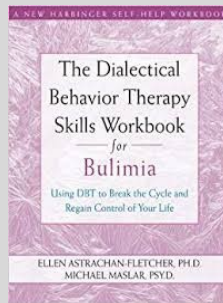
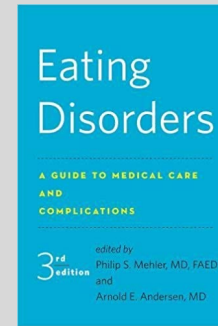
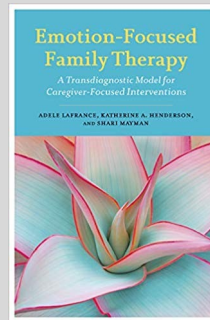
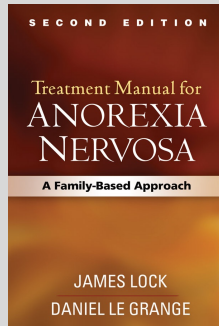
Evidence-Based Treatment Modalities

Behavioral Therapies:

- Acceptance and Commitment Therapy (ACT)
- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)

Family Therapies:

- Family Based Therapy (FBT)
- Emotion Focused Family Therapy (EFFT)



Resources to get you Started

Support Groups and Resources

- The Eating Disorder Foundation: <https://eatingdisorderfoundation.org/get-help/support-groups/>
- The Alliance for Eating Disorder Awareness: <https://www.allianceforeatingdisorders.com/support-groups/>
- The National Association of Anorexia and Associated Disorders (ANAD): <https://anad.org/get-help/about-our-support-groups/>
- Families Empowered And Supporting Treatment for Eating Disorders (FEAST): <https://www.feast-ed.org/>
- The National Eating Disorders Association: <https://www.nationaleatingdisorders.org/>

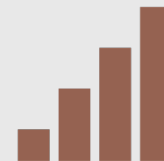
Bonnie Brennan Info



Email:
bonnie@brennancounseling.com



Website:
www.eatingdisorderintervention.com



Phone: 720-663-8699

QUESTIONS

