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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

EATING DISORDERS

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(SHE/HER)

UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

SPEAKER DISCLOSURES

- ✓ I work at the Eating Recovery Center in Bellevue
  - We take Medicaid (WA & OR)
  - I'm always happy to talk about eating disorders! Please reach out
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    - Riddlem2@uw.edu
    - Office: 425-214-9335

OBJECTIVES

1. Discuss why eating disorders matter
2. Learn how to screen for and diagnose eating disorders and understand why this is important
3. Outline of treatment, including where to treat and when to refer out
4. Explore special considerations of BED

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WHY TALK ABOUT EATING DISORDERS

- Eating disorders have a high morbidity and mortality
  - All eating disorders carry increased risk of death, both as a result of suicide and medical complications
- With 30 million people in the US with eating disorders, you will see these patients regardless of where you practice or what your focus is

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WHY TALK ABOUT EATING DISORDERS?

- These patients fall through the cracks
  - We hold certain assumptions about who has eating disorders

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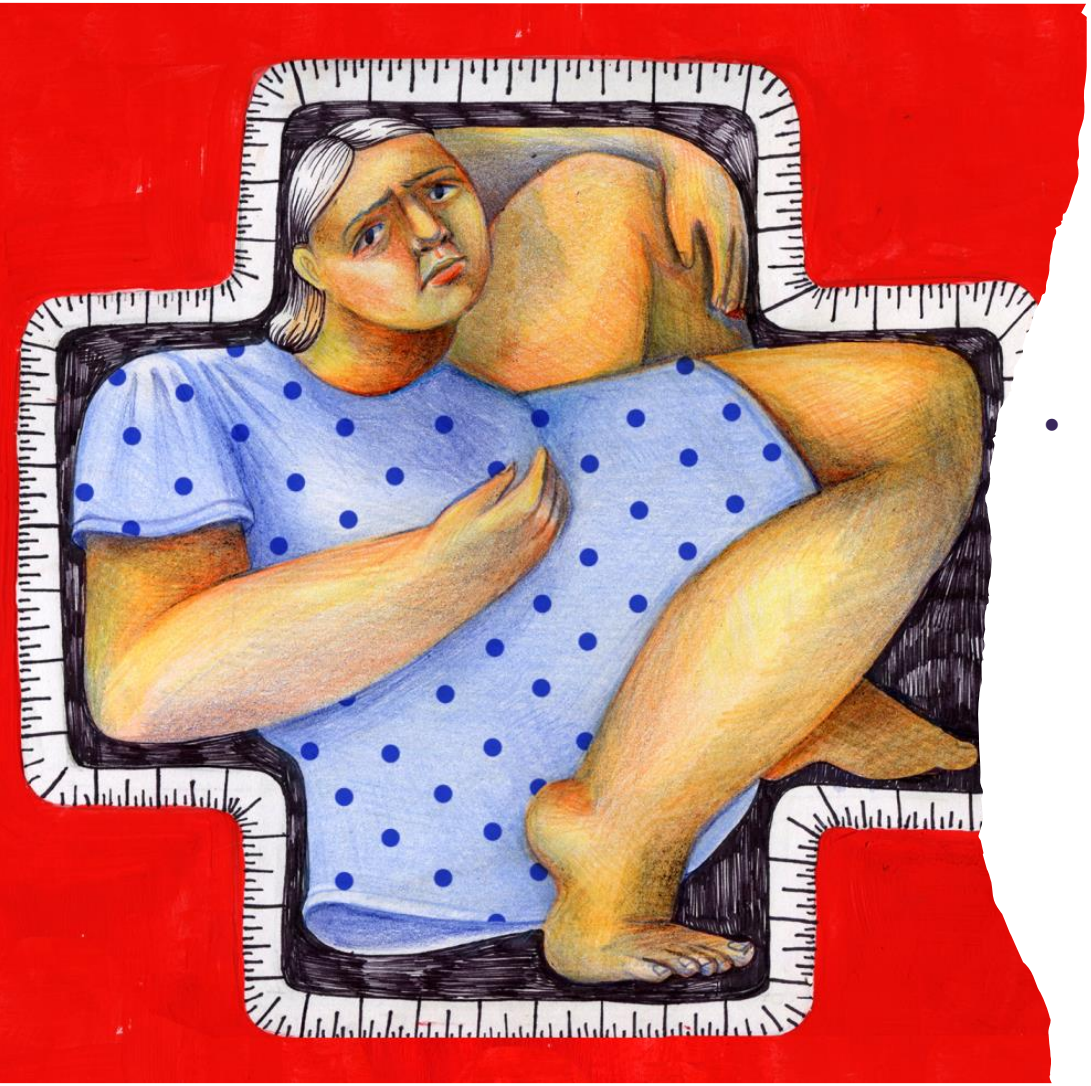

WHY TALK ABOUT EATING DISORDERS?

- Medical education perpetuates our cultural beliefs about food, weight, shape and health
  - We may worsen an underlying eating disorder by recommending weight loss strategies to someone struggling with disordered eating – these can lead to worsening of eating behaviors and/or avoidance of the medical system

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EATING DISORDERS

Anorexia nervosa

- Restriction of energy intake leading to low body weight
- Intense fear of weight gain or behaviors that interfere with weight gain
- Excess concerns about weight and shape

Bulimia nervosa

- Recurrent binge episodes associated with eating an excess amount in a discrete period and lack of control
- Compensatory behaviors to prevent weight gain
- Binge eating and purging occur on average at least weekly for 3mo
- Excess concerns about shape and weight

EATING DISORDERS

Binge Eating Disorder

- Recurrent binge episodes associated with eating an excess amount in a discrete period and lack of control
- **No** compensatory behaviors to prevent weight gain
- Binge eating occurs on average at least weekly for 3mo

Avoidant/Restrictive Food Intake Disorder

- Eating disturbance (i.e. concern about eating certain food types/textures) that prevents patient from meeting nutritional needs leading to:
  - Weight loss
  - Nutrient deficiency
  - Dependence on supplements/feeding tube
  - Interference with psychosocial
- Not in the setting of AN or BN or explained by other medical condition

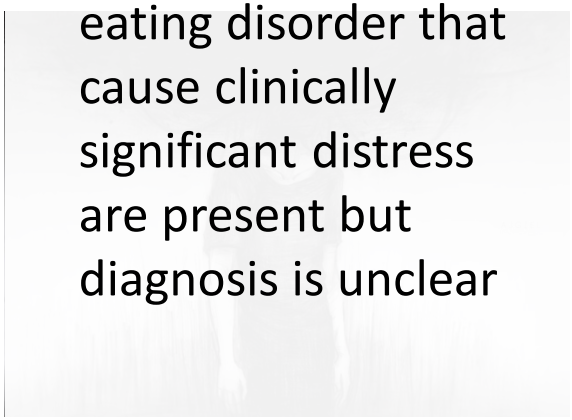
EATING DISORDERS

Other Specified Feeding & Eating Disorder

- Symptoms of an eating disorder that cause clinically significant distress or impairment but do not meet the full criteria for any of the other disorders
- i.e. Atypical anorexia, purging disorder, BN or BED of short duration/ low intensity

Unspecified Eating Disorder

- Symptoms of an eating disorder that cause clinically significant distress are present but diagnosis is unclear



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WHO TO SCREEN?

- American Academy of Pediatrics advocates the routine use of screening questions for all preteen and adolescent patients

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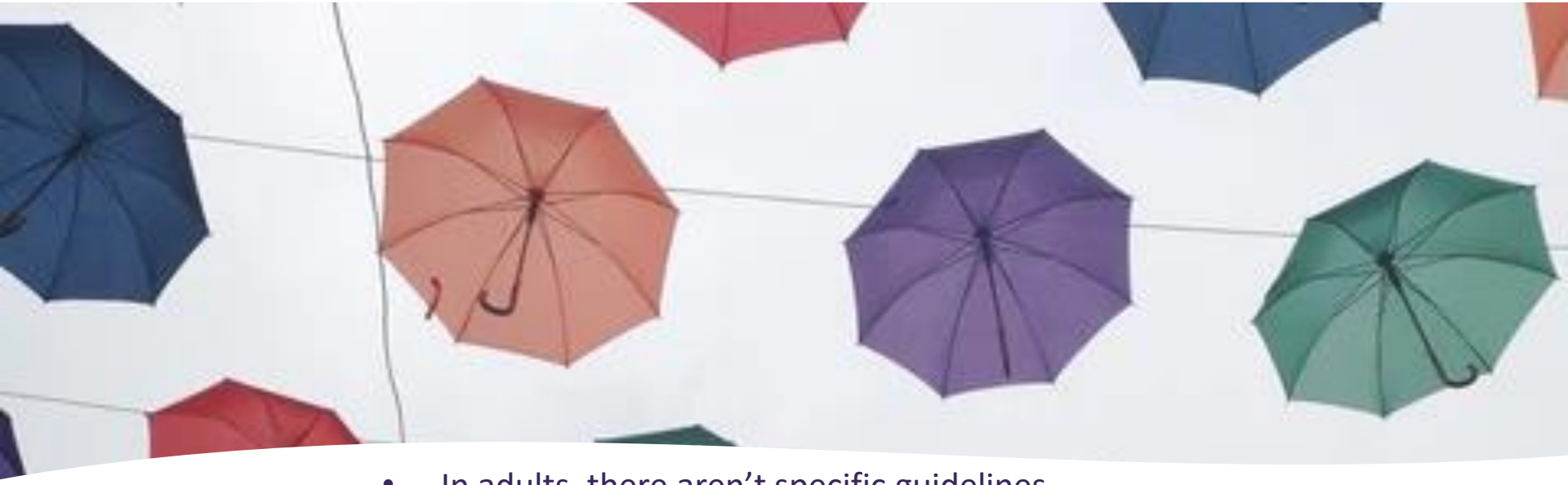

WHO TO SCREEN?

- In adults, there aren't specific guidelines
- Screen high risk groups
  - Young adults
  - Those in the LGBTQ community, particularly genderqueer individuals
  - Female-identified and genderqueer individuals under stress, with anxiety
  - Everyone with a family history of eating disorders
  - Everyone with rapid changes in weight or those seeking help with weight loss
  - Athletes

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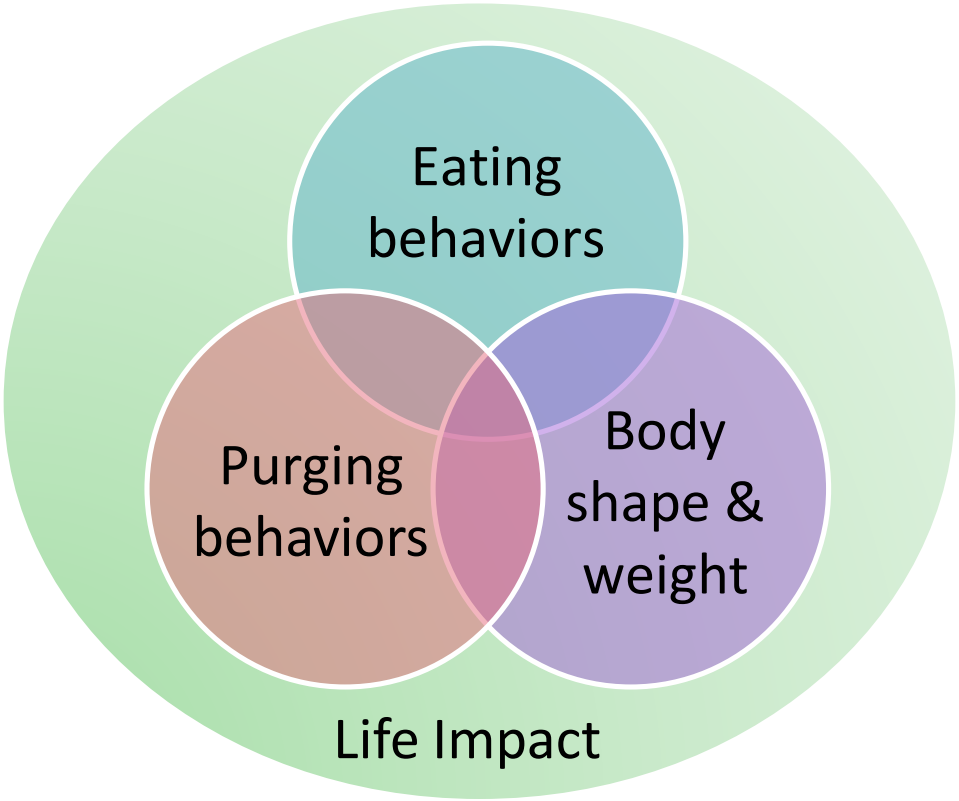
EATING DISORDERS: QUICK SCREEN

- Screen for Disordered Eating
  - Do you often feel the desire to eat when you are emotionally upset or stressed?
  - Do you often feel that you can't control what or how much you eat?
  - Do you sometimes make yourself throw up (vomit) to control your weight?
  - Are you often preoccupied with a desire to be thinner?
  - Do you believe yourself to be fat when others say you are thin?

- Two positive responses gives sensitivity 90.5% and specificity 57.5%

(Maguen et al, 2018)

MAKING A DIAGNOSIS



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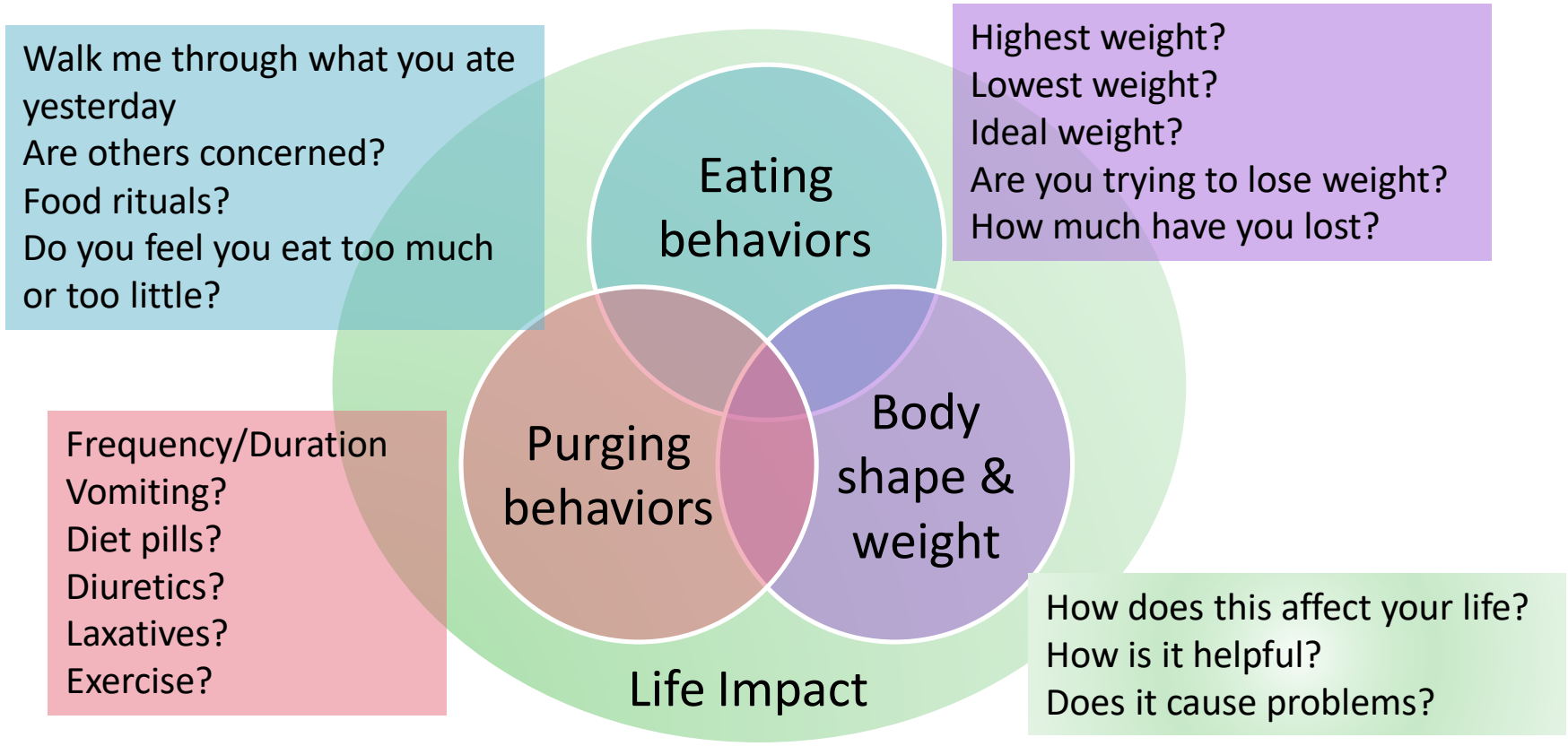
MAKING A DIAGNOSIS



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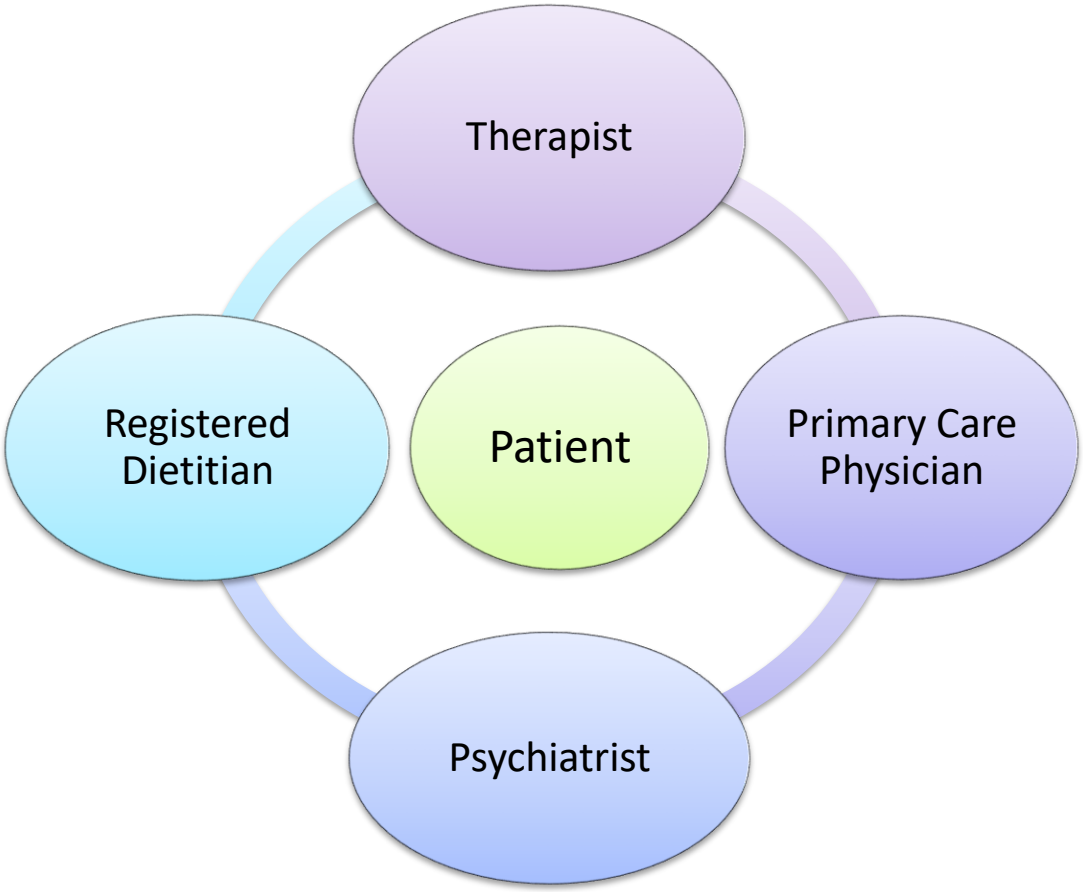
TREATMENT TEAM



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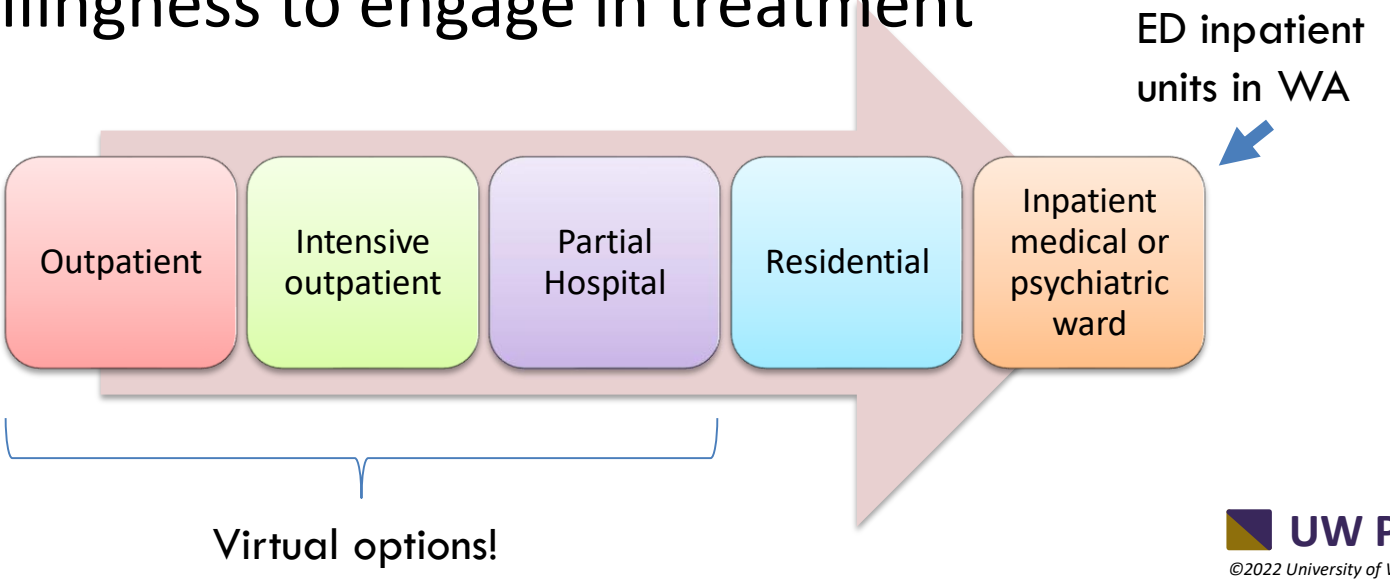
WHERE TO TREAT

- Whether a patient should be hospitalized for treatment depends on several factors
  - Medical stability
  - Comorbid psychiatric issues
  - Willingness to engage in treatment



MEDICAL EVALUATION

- These patients can have serious medical complications secondary to starvation or binge/purge behaviors
- Don’t make assumptions about medical stability based on weight

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MEDICAL ASSESSMENT

- Thorough physical exam
- Labs:
  - CBC, BMP, Mg, Phos, LFTs, TSH, free T4, Utox, UPreg
  - Consider: pre-albumin, urine electrolytes (diuretic use), amylase
- EKG
- Long-term weight-suppressed: DEXA scan

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FACTORS SUPPORTING HOSPITALIZATION

	Adults	Adolescents (12-19 years)
Heart rate	<50 bpm	<50 bpm
Orthostatic change in heart rate	Sustained increase of >30 bpm	Sustained increase of >40 bpm
Blood pressure	<90/60 mmHg	<90/45 mmHg
Orthostatic blood pressure	>20 mmHg drop in sBP	>20 mmHg drop in sBP
Glucose	<60 mg/dl	
Potassium	Hypokalemia	Hypokalemia
Sodium	Hyponatremia	Hyponatremia
Phosphate	Hypophosphatemia	Hypophosphatemia
Magnesium	Hypomagnesemia	Hypomagnesemia
Temperature	<96.0 F	<96.0 F
BMI	<15	<75% of median BMI for age and sex
Rapidity of weight change	Greater than 10% decrease in body weight within the last 30 days	Greater than 10% weight loss in 6 months or greater than 20% weight loss in 1 year
Compensatory behaviors	Occur multiple times daily and have either caused severe physiological consequences	Occur multiple times daily and have either caused severe physiological

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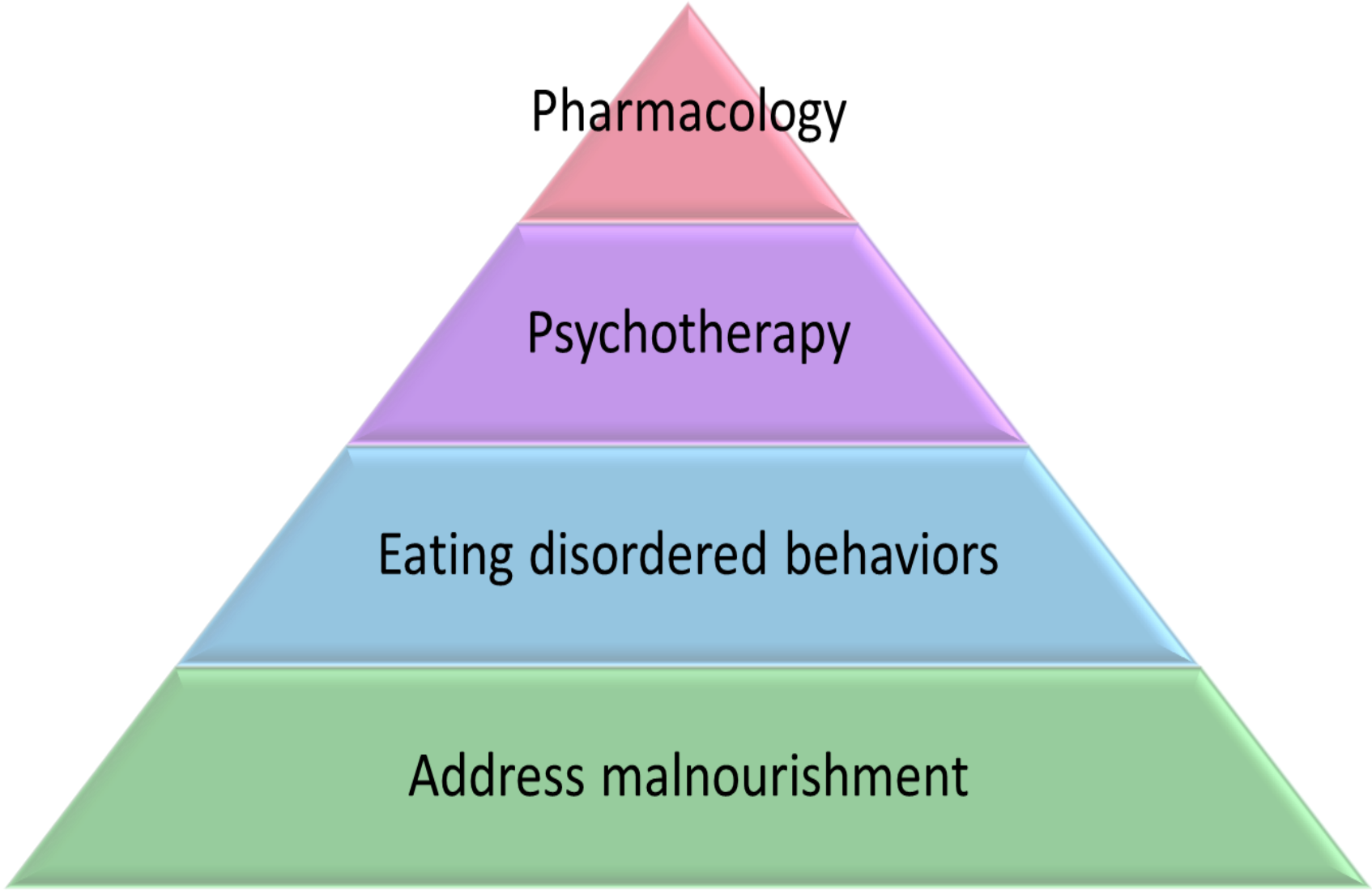
FACTORS SUPPORTING STEP-UP

- When to consider referral to a specialized center?
  - Medical instability – may need to be medically hospitalized first
  - Inability or unwillingness to change behaviors independently
  - Outpatient care not leading to a decrease in symptom frequency
  - Lack of access to specialized providers in the outpatient setting

TREATMENT



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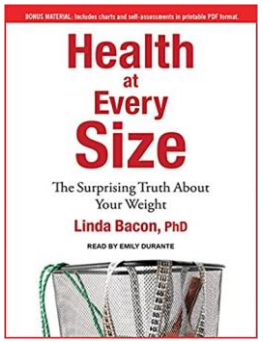
ADDRESS MALNOURISHMENT & ED BEHAVIORS



- Regardless of body shape and size, the majority of ED patients have some degree of malnourishment
  - Early in treatment, we work on identifying a target weight – based on weight history and trends
  - Target weight may or may not be near someone's "ideal" body weight
- Work with an RD to create a meal plan

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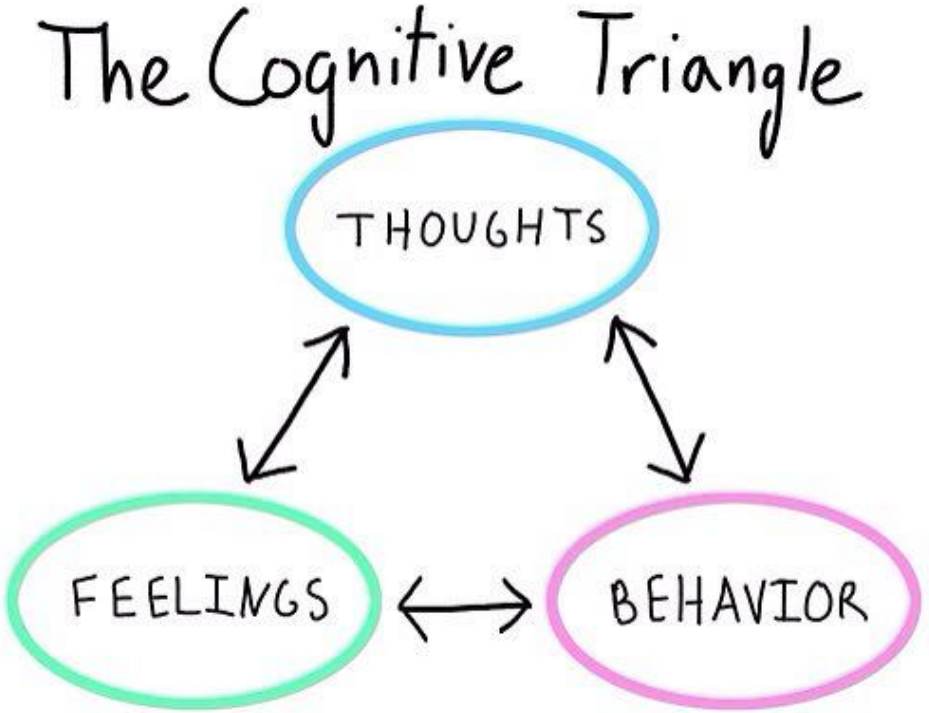
ENCOURAGE THERAPY

- AN: Nutritional counseling + Therapy is better than nutritional counseling alone – no one type of therapy is superior
- BN & BED: Good evidence that Cognitive Behavioral Therapy is effective intervention
- Therapy for psychiatric comorbidities, ie. trauma



CONSIDER MEDICATIONS

- Anorexia nervosa
  - Medications have limited efficacy at low weight
  - No FDA approved meds
  - Antidepressants may help prevent relapse
  - Antipsychotics have mixed evidence
- Bulimia nervosa
  - SSRIs are 1st line: Fluoxetine is FDA approved
  - Avoid bupropion due to increased seizure risk
- Binge eating disorder
  - SSRIs are 1st line
  - Lisdexamfetamine (Vyvanse) is FDA approved*

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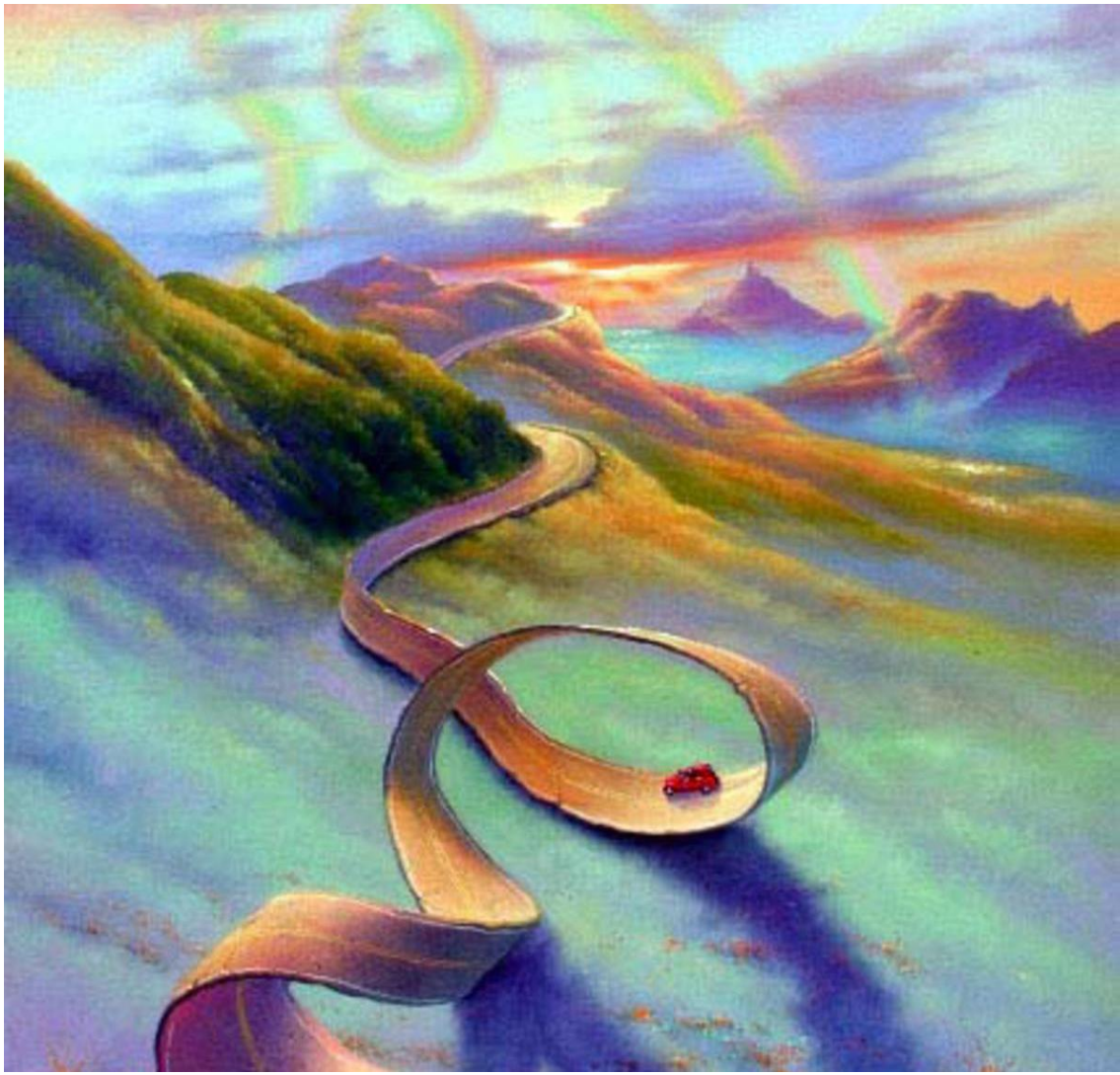
RECOVERY

Recovery has its ups and down



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CAREGIVER BURDEN

- Caring for these patients is incredibly emotionally taxing for loved ones and clinicians
- These cases can bring up very intense emotions
- Creating space to acknowledge this is an important part of this work

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WHEN IT'S NEVER ENOUGH

CARING FOR INDIVIDUALS WITH BINGE EATING DISORDER

Huge thanks to Lindsay Birchfield, MS, RD, CD

EPIDEMIOLOGY

3.5%
of American Women have BED

2%
of American Men have BED

1.6%
of Adolescents have BED

- Mean age of onset 23 - 25yo (older than BN or AN)
- Equally distributed across racial and ethnic groups

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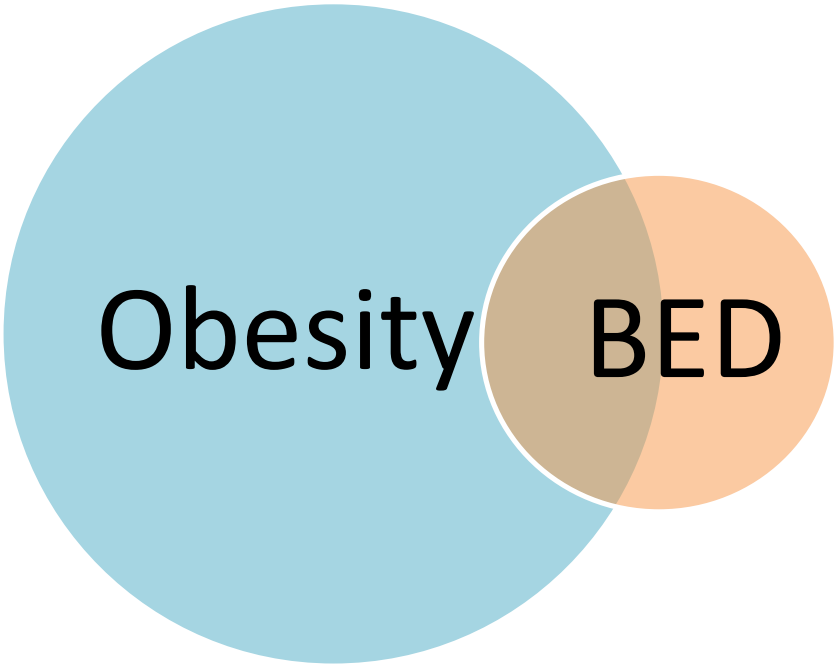

EPIDEMIOLOGY

- Not all obese patients have BED and not all BED patients are obese
- 36-42% of individuals with BED are obese
- Up to a quarter of patients with obesity struggle with BED

(Montano et al. 2016)

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ETIOLOGY OF BINGE EATING DISORDER

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http://binow.ru/wp-content/uploads/2013/09/razmyshleniya-o.jpg

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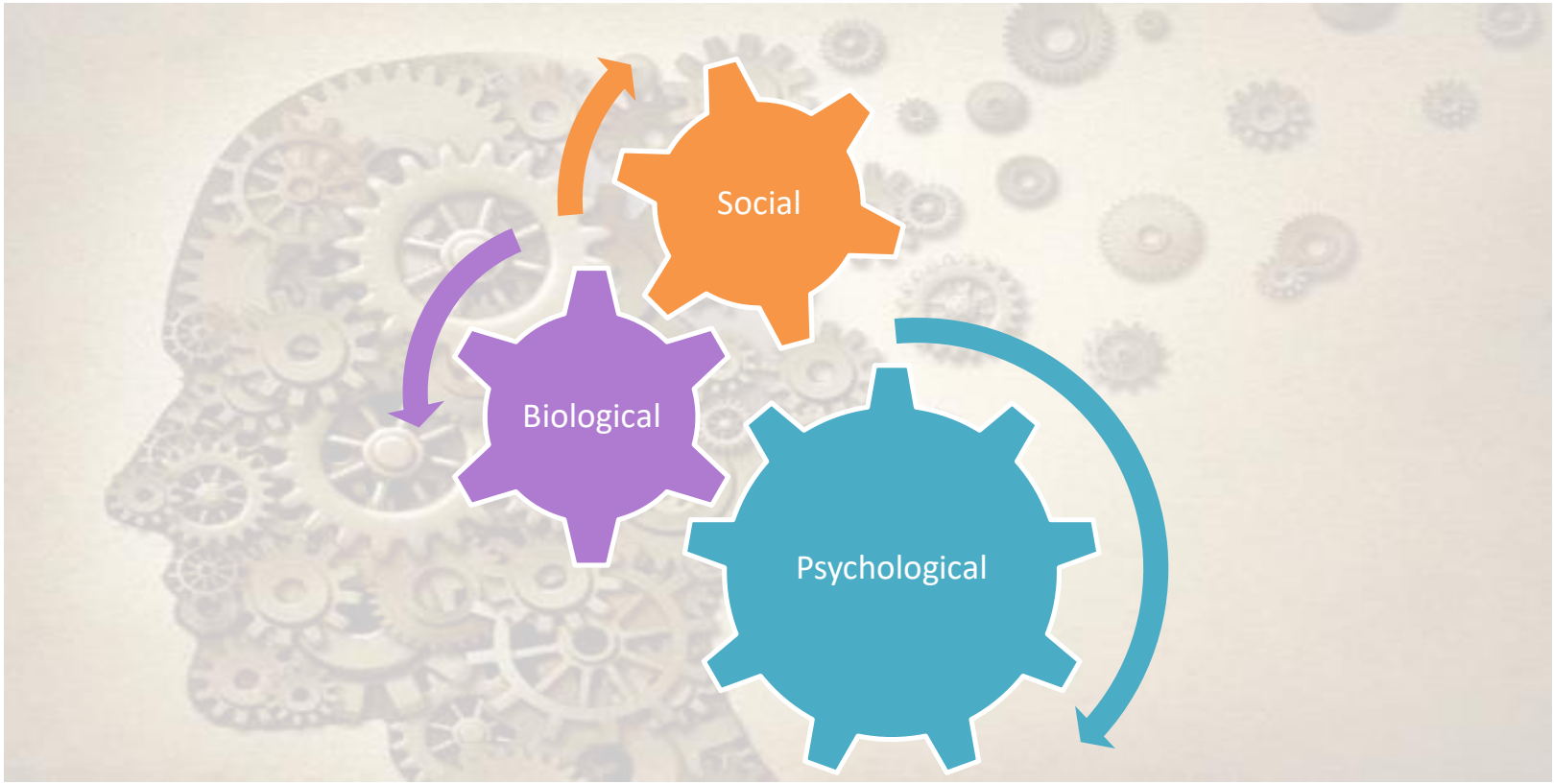

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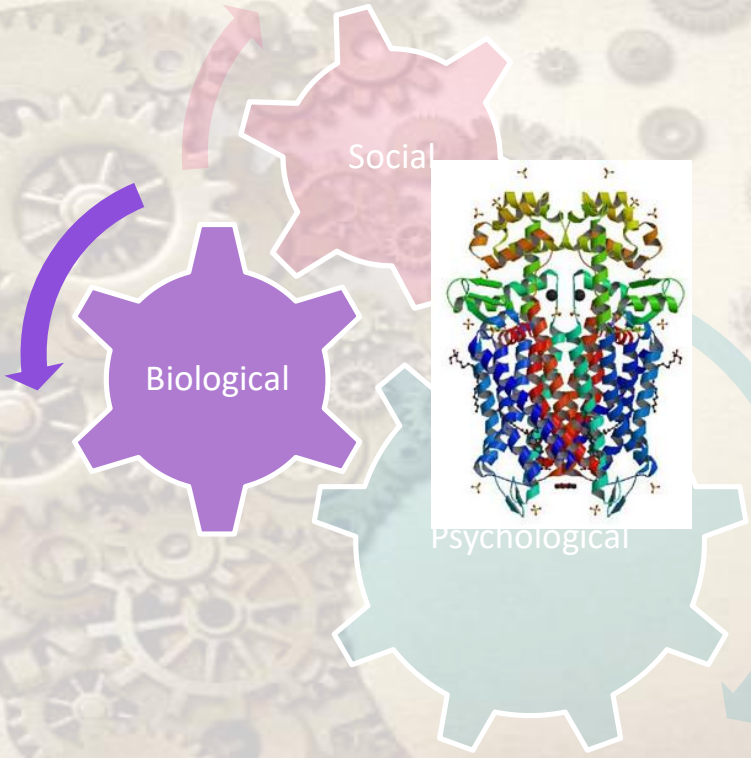

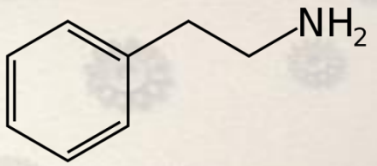

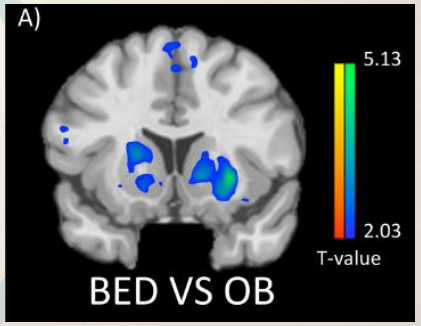

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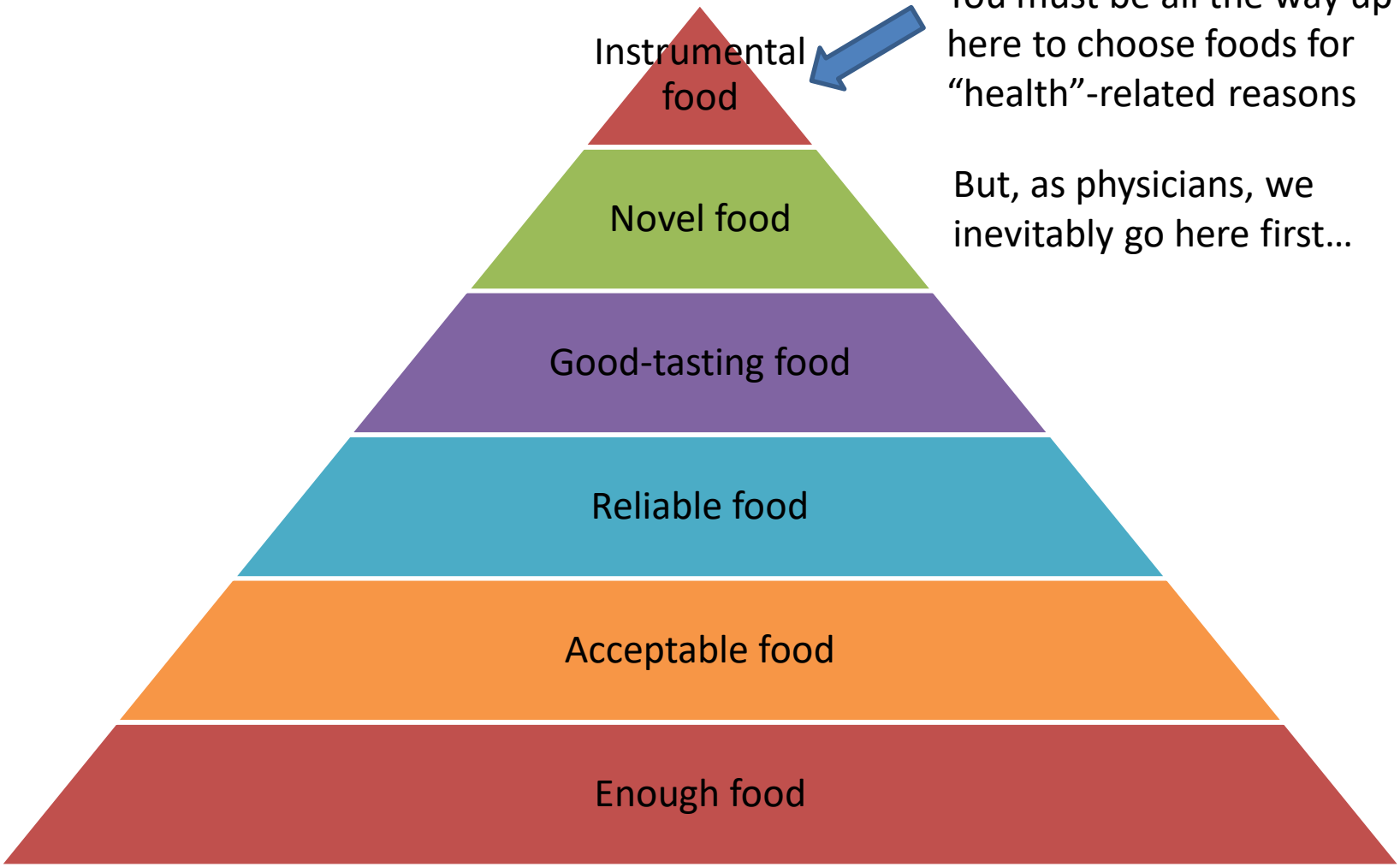
ADDRESSING BED

- BED treatment – maybe more so than other ED – really requires a multipronged approach that also openly addresses challenging topics like social inequities and personal/institutional/societal trauma in addition to beliefs about food and body shape
  - Honestly – we probably need to do more this in all our ED work (and all of mental health?) but it's a slow evolution

SATTER'S HIERARCHY OF FOOD NEEDS



You must be all the way up here to choose foods for "health"-related reasons

But, as physicians, we inevitably go here first…

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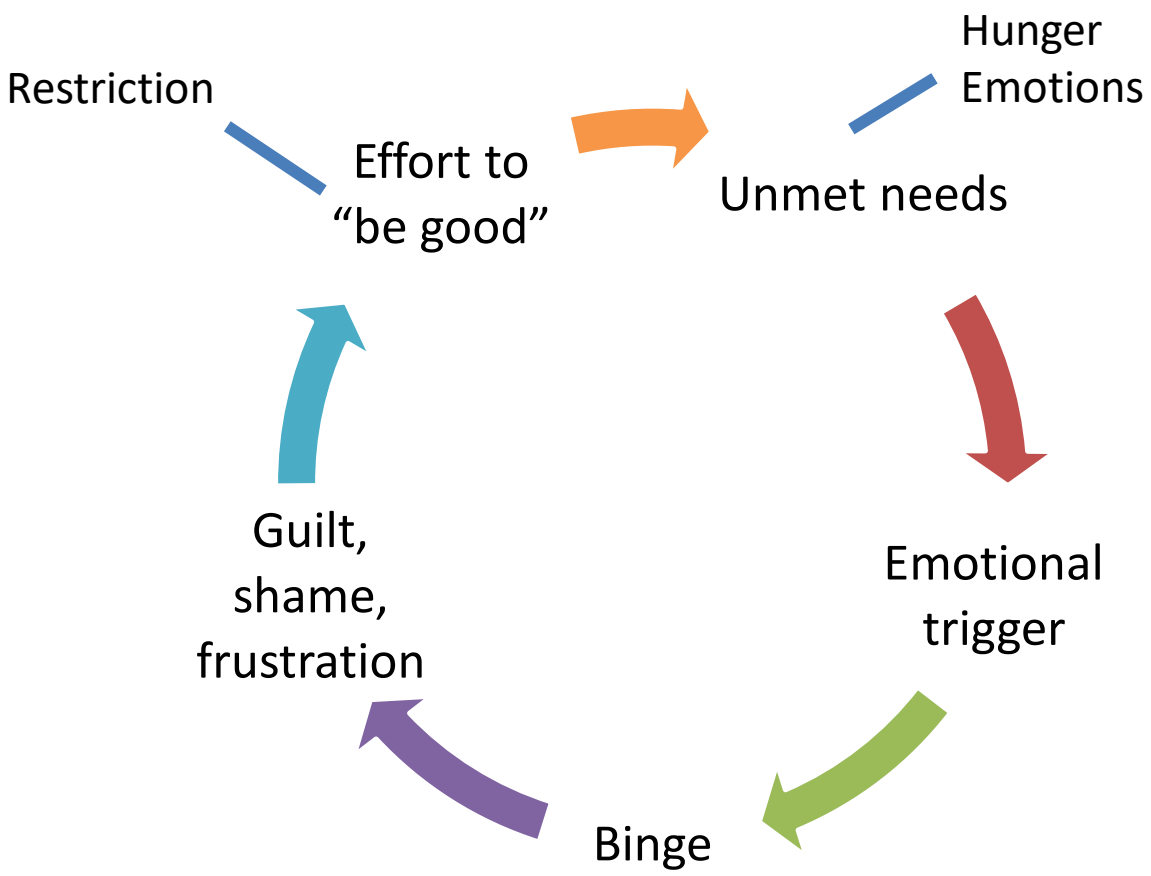
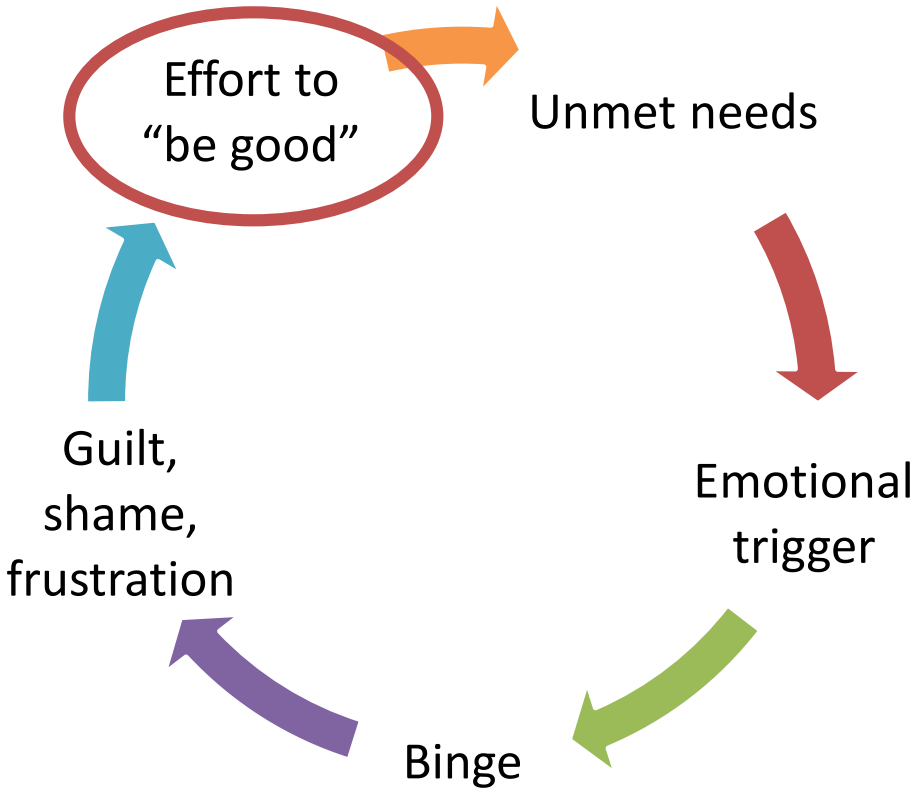
CYCLE OF BINGE EATING



"In short, food becomes one of the only successful ways to simultaneously numb and soothe and enact self-loathing. It's the perfect trifecta for someone to cope with a body that is deemed incorrect by the medical field and media."
– Lindsay Birchfield, MS, RD, CD

INTERRUPTING THE CYCLE



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INTERRUPTING THE CYCLE: PRESCRIBED PATTERN OF REGULAR EATING EATING

- Prescribed – Meal plans are provided to give patients structure and put organization and intention around food choices
  - Focus on Balance, Variety, Moderation…and Patient Empowerment
- Pattern –The emphasis is not on getting individual food or meal choices “right” or “wrong”, but rather, about exploring what, when, how, and why we eat
  - Shifting the focus to the larger pattern makes room for permission
- Regular Eating– Eating at consistent intervals throughout the day has multiple benefits

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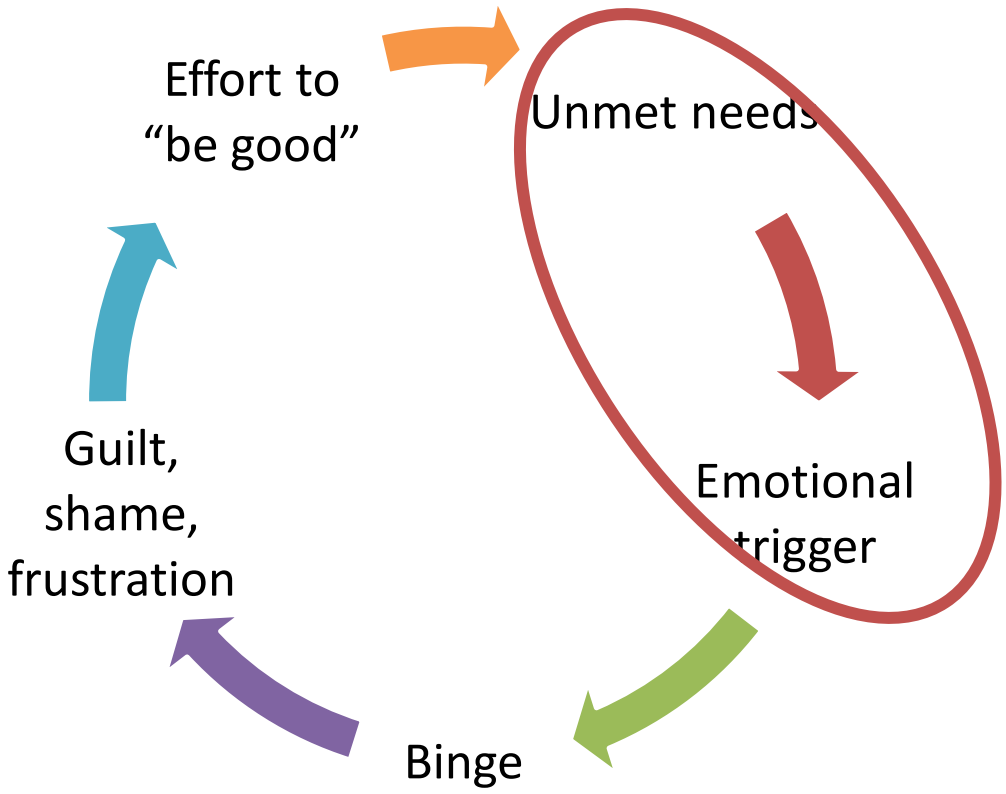
INTERRUPTING THE CYCLE



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UNMET NEEDS & EMOTIONAL TRIGGERS

- Work on identifying unmet needs
- Increase skill use
- Build social connections – including fat-affirming spaces
- Gentle nutrition and joyful movement to support wellbeing
- Mindful eating to promote emotional satisfaction
- Creating space, apart from food, for patient to experience feelings

CONCLUSIONS

- BED is the most common ED and stems from a variety of biological, psychological and social factors – it's not about will power
- Consider where someone is in their own food hierarchy
- Treatment focuses less on the binge behavior and more on the contributing factors

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THANK YOU!

Thoughts or questions?

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