ProjectTEACH

FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Project TEACH is New York State's Child/Adolescent & Perinatal Psychiatry Access Program.

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NEW YORK STATE | Office of Mental Health

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Treatment of Eating Disorders

NEW YORK STATE | Office of Mental Health

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Disclosures

- PCORI - START - Salary support
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Disclosures

None

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True or False

Anorexia Nervosa may have the highest mortality rate of all psychiatric disorders

Anorexia Nervosa

- A. Amenorrhea is a diagnostic criteria
- B. 15 % weight deficit is required to meet criteria
- C. Is rarely found in males
- D. A, B & C
- E. None of the above

Avoidant/Restrictive Food Intake Disorder (ARFID)

- A. Is not an eating disorder
- B. Is a feeding disorder
- C. Can be associated with Autism Spectrum Disorder
- D. A & C
- E None of the above

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Disclaimers

- If humor is used during this talk, it by no means is to suggest that there is anything humorous about these disorders, but rather, it is used as a vehicle for transmitting information in a palatable fashion

- Eating Disorders may have one of the highest mortality rates of all psychiatric disorders

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Is there a way to prevent eating disorders?

- How can we raise our children not to worry about whether they are thin enough?

- How can we feel good about ourselves without worrying about whether we are thin enough?

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Ambivalence towards treatment

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Treatment resistance

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Persuasion

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Perceived Coercion

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Compulsion

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What is often the first thing people say to one another when they meet after a period of time? (*when they wish to be nice*)

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Have you lost weight?

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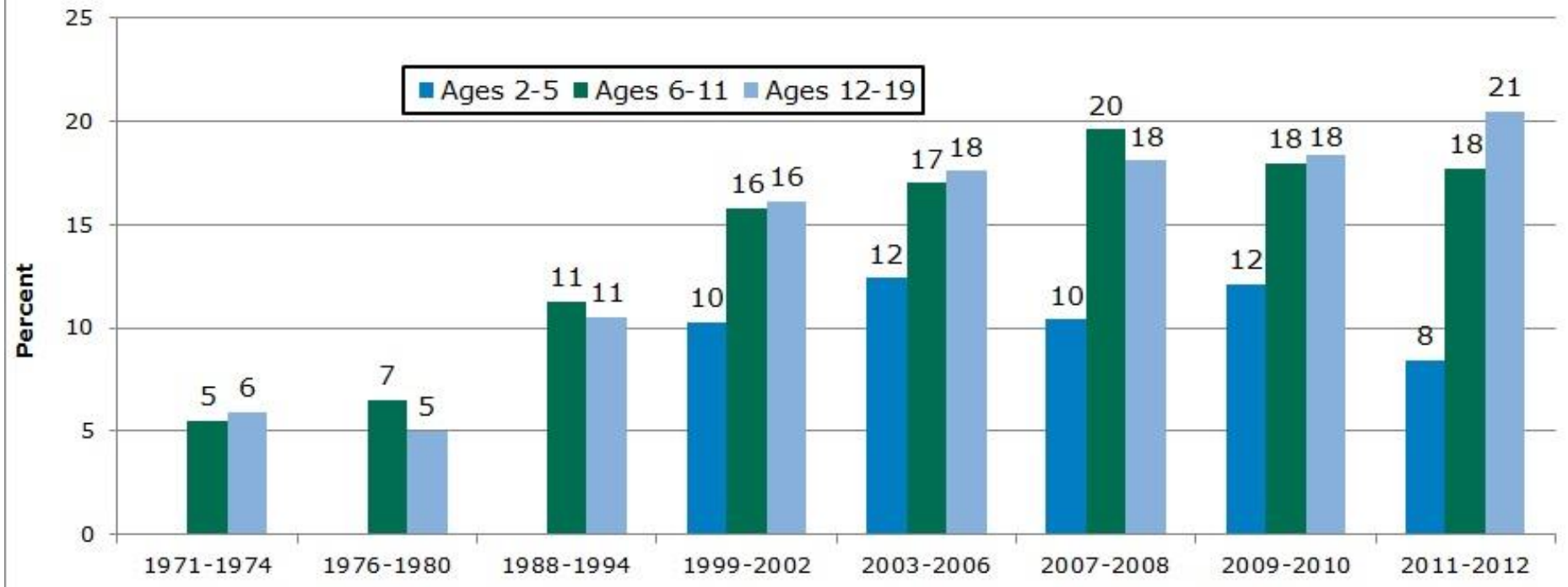
Personal Impact

- Given the prevalence of these disorders, it is likely that most people in this room either know a close family member or friend who has had an eating disorder, or has had one him or herself


NEW YORK
FEBRUARY 23, 2004
MOMMY, DO I LOOK FAT?
With childhood obesity in the news, anxious parents are putting babies on diets, banning carbs in school lunches, and hiring personal trainers for 5-year-olds. Is this about health—or their own fear of fat?
BY SARAH BERNARD

Figure 1

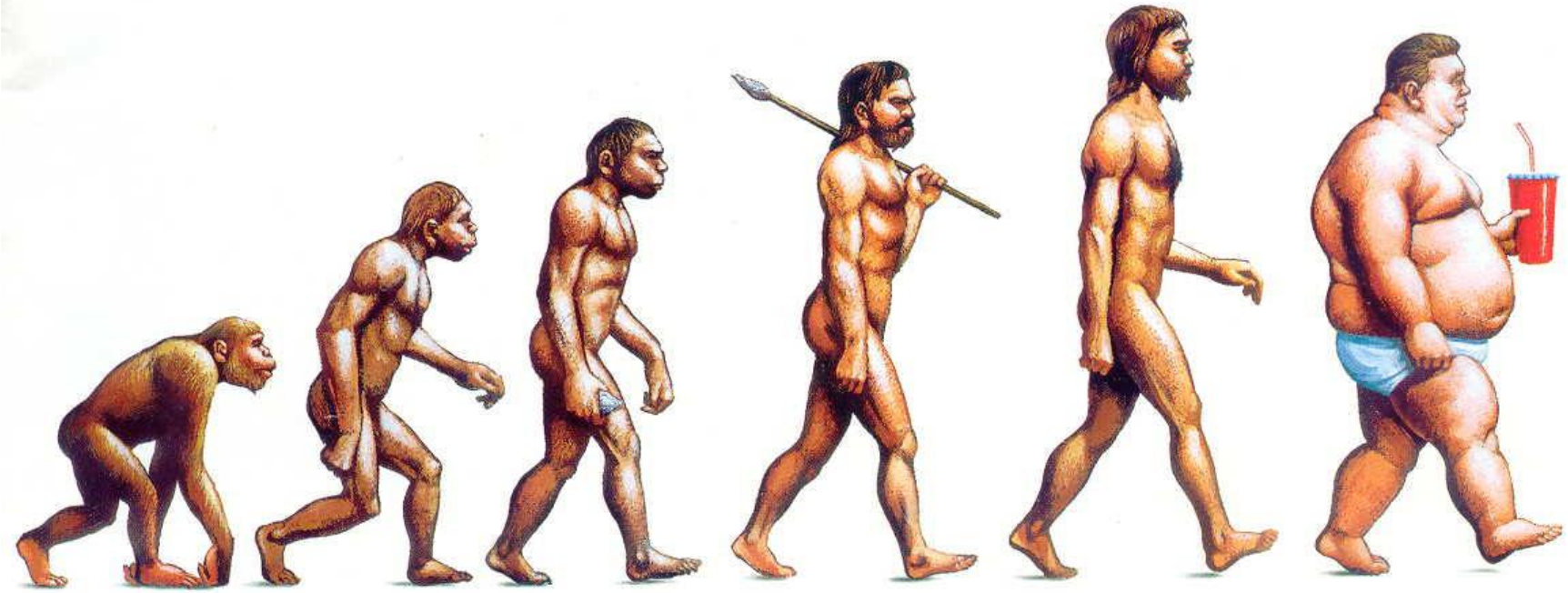
Percentage of Children Ages 2 to 19 Who Are Obese, by Age: Selected Years, 1971-2012



Sources: Data for 1971-1974: Troiano, R. P., Flegal, K. M., Kuczmarski, R. J., Campbell, S. M., Johnson, C. L. (1995) Overweight prevalence and trends for children and adolescents: The national health and nutrition examination surveys, 1963-1991. *Archives of Pediatrics and Adolescent Medicine, 149*(10), 1085-1091. Available at: http://archpedi.jamanetwork.com/article.aspx?articleid=517675. Data for 1976-1994: National Center for Health Statistics. (2003). Health United States, 2003 with Chartbook on Trends in the Health of Americans. National Center for Health Statistics.. Table 69. Available at: http://www.cdc.gov/nchs/data/hus/tables/2003/03hus069.pdf.Data for 1999-2002 from Hedley, A., Ogden, C., Johnson, C., Carroll, M., Curtin, L. and Flegal, K. Prevalence of overweight and obesity among us children, adolescents, and adults, 1999-2002, *JAMA, 291*(23): 2847-2850. Data for 2003-2006: Ogden, C., Carroll, M., and Flegal, K. High Body Mass Index for age among us children and adolescents, 2003-2006. *JAMA, 299*(20):, 2401-2405. Data for 2007-2008: Ogden C. L., Carroll, M. D., Curtin, L. R., Lamb, M. M., and Flegal, K. M. (2010). Prevalence of High Body Mass Index in US children and adolescents, 2007-2008, *JAMA, 303*(3), 242-249. Available at: http://jama.jamanetwork.com/article.aspx?artideid=185233. Data for 2009-2010: Ogden C. L., Carroll, M. ., Kit, B. K., and Flegal, K.M (2012). Prevalence of obesity and trends in Body Mass Index among US children and adolescents, 1999-2010, *JAMA, 307*(5), 483-490. Available at: http://jama.jamanetwork.com/article.aspx?volume=307&issue=5&page=483. Data for 2011-2012: Ogden, C.L., Carroll, M. D., Kit, B. K., & Flegal, K. M. (2014). Prevalence of childhood and adult obesity in the United States, 2011-2012. *JAMA 311*(8), 806-814. Available at: http://jama.jamanetwork.com/article.aspx?artideID=1832542

Child Trends DATABANK

The shape of things to come



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Treatment

- Begin with medical assessment to determine the needed **level of care**
- **Hypokalemia, bradycardia & orthostatic hypotension** may determine need for **inpatient medical level of care**

Levels of care to consider

-Inpatient Medical

-Inpatient Pediatric

-Inpatient Adolescent Psychiatric

-Inpatient Adult Psychiatric

-Inpatient Psychiatric Eating Disorder

-Day Treatment

-Intensive Outpatient Program

-Outpatient Treatment

EATING DISORDERS: CHARACTERISTICS OF LEVELS OF CARE

- Levels of care
  - Specialized pediatric or medical inpatient
  - General pediatric or medical inpatient
  - Specialized psychiatric inpatient
  - General psychiatric
  - Residential programs
  - Partial hospital
  - Intensive outpatient
  - Outpatient
- Characteristics of different settings
  - Unit security
  - Patient legal status
  - Physician on-site 24/7
  - Nursing on-site 24/7
  - Medical monitoring
  - Hours of operation
  - Able to maintain work/school
- Available interventions
  - Option for IV hydration
  - Option for nasogastric tube feedings
  - Option for treatment over objection
  - Medical management
  - Psychiatric management
  - Psychological management
  - Group-based therapies
  - Individual psychotherapies
  - Family psychotherapies
  - Meal supervision and support
  - Milieu therapy
  - Nutritional management
  - Multidisciplinary team-based management

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APA PRACTICE GUIDELINE FOR THE TREATMENT OF EATING DISORDERS

HTTPS://WWW.PSYCHIATRY.ORG/PSYCHIATRISTS/PRACTICE/CLINICAL-PRACTICE-GUIDELINES

2023

EATING DISORDERS: SCREENING

Statement 1 - APA recommends (1C) screening for the presence of an eating disorder as part of an initial psychiatric evaluation.

Rationale: Risk to health if present; estimated prevalence

	12-month prevalence	Lifetime prevalence
Anorexia nervosa	0.5% ♀ 0.1% ♂	1.4% ♀ 0.2% ♂
Bulimia nervosa	0.7% ♀ 0.4% ♂	1.9% ♀ 0.6% ♂
Binge eating disorder	1.4% ♀ 0.6% ♂	2.8% ♀ 1.0% ♂

- Prevalence rates have wide range of estimates based on the study design and country. Rates for eating disorders that do not meet full criteria are even higher.

EATING DISORDERS: QUANTITATIVE MEASURES

Statement 3 - APA recommends (1C) that the initial psychiatric evaluation of a patient with a possible eating disorder include weighing the patient and quantifying eating and weight control behaviors (e.g., frequency, intensity, or time spent on dietary restriction, binge eating, purging, exercise, and other compensatory behaviors).

Rationale:

- Establishes level of severity, in part aligning with DSM criteria.
- Permits tracking of relative changes in symptoms over time with greater reliability than retrospective recall.
- Consistent with suggestion in psychiatric evaluation guidelines and other guidelines to use quantitative measures.

EATING DISORDERS: PHYSICAL EXAMINATION AND OTHER SIGNS

Abnormal vital signs

- Possible indication of medical instability that warrants a higher-level care

e.g., heart rate <50 bpm, systolic blood pressure <90 mmHg, or temperature <36°C (96.8°F)

- Normal results may not exclude an eating disorder

Height, weight, and BMI

Evaluate initially, with weight obtained, ideally, at all visits (www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html)

Statement 4 - APA recommends (1C) that the initial psychiatric evaluation of a patient with a possible eating disorder identify co-occurring health conditions, including co-occurring psychiatric disorders.

Rationale:

- Physical health conditions can confound diagnosis, be associated with higher rates of eating disorders, and contribute to complications of eating disorders.
- Rates of psychiatric comorbidity are high (e.g., depression, anxiety, trauma-related disorders, ADHD, misuse of substances such as stimulants).

EATING DISORDERS: IDENTIFICATION OF CO-OCCURRING CONDITIONS (CONTINUED)

Substance use history such as…

- the use of caffeine, tobacco, alcohol, cannabinoids, and other substances
- cigarette smoking (including electronic cigarettes or vaping) to suppress appetite
- the use or misuse of prescribed or non-prescribed meds that suppress appetite (e.g., OTC weight loss products, stimulants) or enhance muscularity (e.g., supplements, androgens)

Trauma and suicide history such as…

- physical, emotional, or sexual abuse; bullying (including cyberbullying); neglect (including food insecurity); symptoms related to PTSD
- suicide risk, including current suicidal ideas, plans, or intentions, prior suicidal plans or attempts, and the presence of non-suicidal self-injury

Statement 12 - APA recommends (1B) that adolescents and emerging adults with anorexia nervosa who have an involved caregiver be treated with eating disorder-focused family-based treatment, which should include caregiver education aimed at normalizing eating and weight control behaviors and restoring weight.

Rationale:

- Support from the expert opinion and from a NMA of studies of psychotherapies in AN
- FBTs (with family in charge of the patients' eating) led to greater changes in BMI than no treatment and greater changes in %IBW than TAU.

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Treatment

- Perform a comprehensive psychiatric evaluation to determine the diagnosis and whether there is co-morbidity
- Rarely, do eating disorders present as the sole form of psychopathology
- Assess for safety and whether there is any suicidal or non-suicidal self injury (NSSI)

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How does the evidence support the treatment

- Begin with medical stabilization
- Food is the mainstay of treatment
- Family Based Treatment (FBT) is the evidence based approach for the younger patient

High Risk

This population requires close medical monitoring due to the risk of sudden death from hypokalemia and bradycardia

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Psychopharmacology of Eating Disorders

- There is no clear psychopharmacology for anorexia or bulimia nervosa
- Co-morbid conditions are often addressed (anxiety, depression, inattention, mood fluctuations, psychosis)
- SSRI may be helpful to reduce binge frequency in BN, however, CBT is the treatment of choice

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Psychotherapy of Eating Disorders

- FBT is the treatment of choice for AN, however, requires the capacity of the family to be engaged and cooperative
- CBT is the treatment of choice for BN
- DBT may be helpful to reduce suicidal thoughts, behavior as well as NSSI in individuals with an eating disorder (often with a trauma history)

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Psychotherapy of Eating Disorders

- Individual psychotherapy is important once there is medical stabilization, however, the evidence does not support that it is the treatment of choice for medical recovery

- Family Therapy is important, regardless of the age of the patient, however, in families with suspected abuse or neglect, it may be contra-indicated

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Nutritional Rehabilitation

- No meaningful psychotherapy can occur with the malnourished brain

- Food is the mainstay of treatment

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Historical perspective Anorexia Nervosa

- Medieval times- Fasting Saints
- 1873 - Sir William Gull – Anorexia Nervosa
- 1980 – DSM-III – Anorexia Nervosa (25 % weight deficit)
- 1987 – DSM-IV – Anorexia Nervosa (15 % weight deficit)
- 2013 – DSM-5 – Anorexia Nervosa

(elimination of amenorrhea criterion & percentage weight cut-off)

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DSM 5 criteria for Anorexia Nervosa

- Food restriction with low weight
- Intense fear of gaining weight or becoming fat
- Disturbance in body experience

Historical perspective
Bulimia Nervosa

Gerald Russell, 1979 –

"an ominous variant of anorexia nervosa"

- 1980 – DSM-III Bulimia Nervosa
- 1987 – DSM-III-R Bulimia Nervosa
- 1990 – DSM-IV Bulimia Nervosa
- 2013 – DSM-5 Bulimia Nervosa

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DSM 5 criteria of Bulimia Nervosa

- Recurrent episodes of binge eating
- A sense of lack of control over eating
- Recurrent inappropriate compensatory behaviors
- At least on average once per week for 3 months
- Self evaluation unduly influenced by shape or weight

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New: *Avoidant/Restrictive Food Intake Disorder*

ARFID

- Apparent lack of interest in eating, avoidance based on sensory characteristics of food, or concern about aversive consequences of eating

- The avoidance or restricted eating failure to gain as expected

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Course of illness

- Prognosis
- Mortality rates

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Minnesota Experiment of Human Starvation

- https://www.youtube.com/watch?v=8iH5htWIwo0

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Thank you