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FAMILIES THRIVE WITH GOOD MENTAL HEALTH



Assessment and Management of Eating Disorders

NEW YORK STATE | Office of Mental Health

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Eating Disorders

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Disclosures

We have no significant financial disclosures

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True or False

Anorexia Nervosa has 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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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

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



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Have you lost weight?

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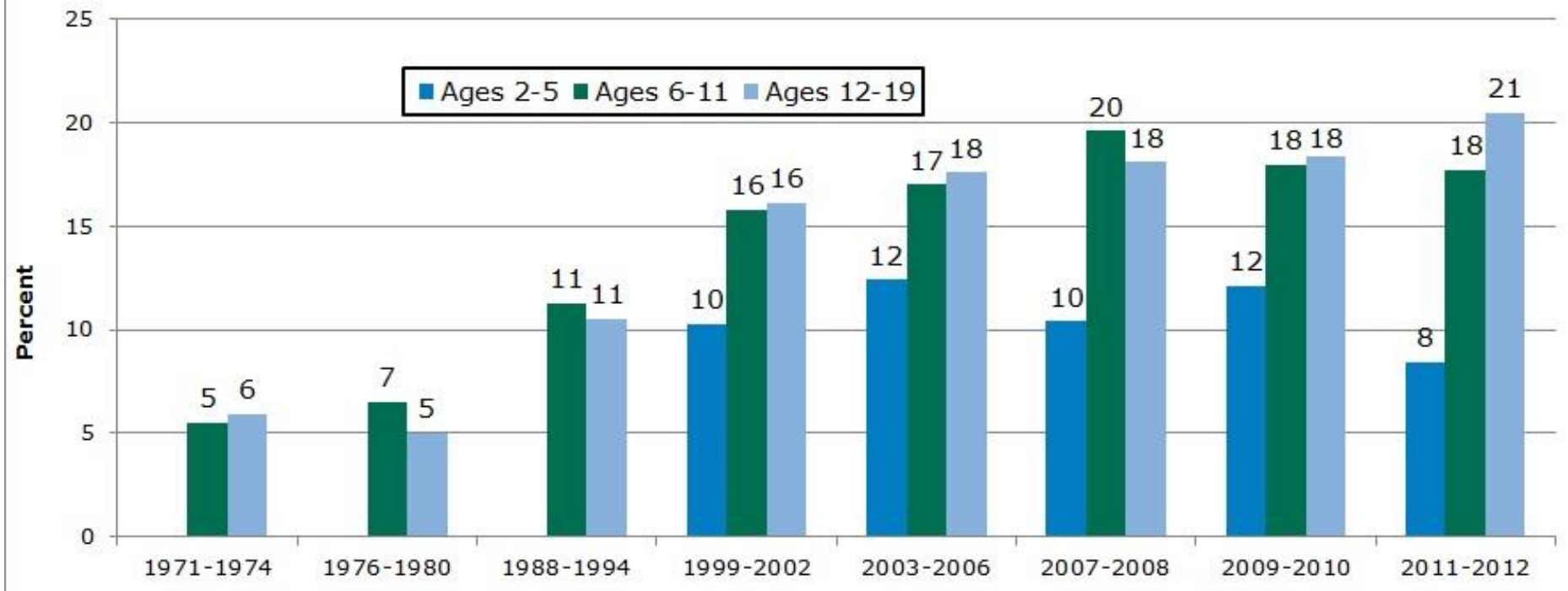
Personal Impact

- 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

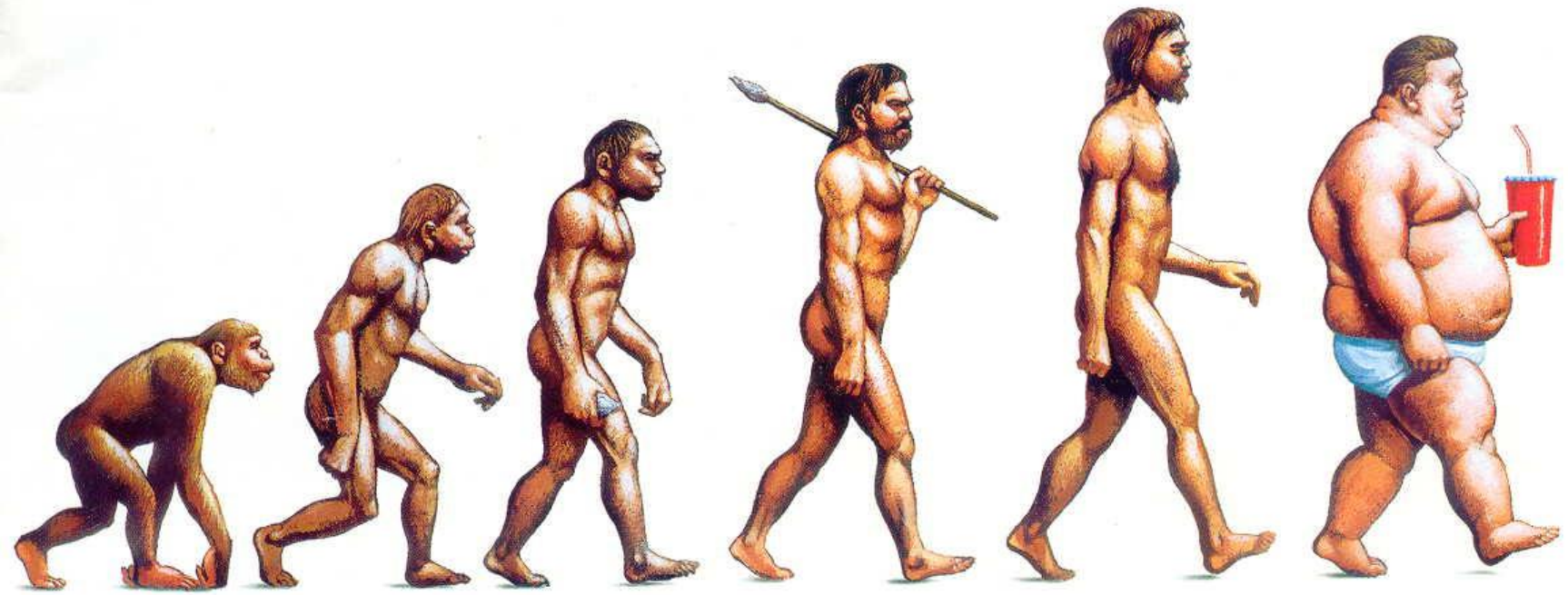
Percentage of Children Ages 2 to 19 Who Are Obese, by Age: Selected Years, 1971-2012



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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Initial Management

- **Medical "level of care" assessment**
- **Acute Pediatric/Medical ER/Inpatient**
  - Hypokalemia
  - Bradycardia
  - Orthostatic Hypotension

Levels of care to consider

-Inpatient Pediatric/Medical

-Inpatient Adolescent/Adult Psychiatric

-Inpatient Special Psychiatric Eating Disorder

-Day Treatment

-Outpatient/Intensive Outpatient Program

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APA PRACTICE GUIDELINE FOR THE TREATMENT OF EATING DISORDERS

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

2023

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EATING DISORDERS: SCREENING

Psychiatric Assessments should include screening for Eating Disorders

Rationale: Risk to health if present

	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 estimates based on the study design and country.
- Rates for eating disorders that do not meet full criteria are even higher.

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EATING DISORDERS: QUANTITATIVE MEASURES

Initial Eating Disorder Assessment should include exact weight and quantifying of 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
- Permits tracking of change with greater reliability than recall.
- Consistent with suggestion to use quantitative measures.

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EATING DISORDERS: PHYSICAL EXAMINATION AND OTHER SIGNS

Abnormal vital signs

- 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 and at all follow-up visits

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Assess for co-occurring health conditions and psychiatric disorders.

Rationale:

- Health conditions confound the diagnosis, are associated with higher EDO frequency and contribute to complications.
- Psychiatric comorbidity is common (depression, anxiety, trauma-related disorders, ADHD, misuse of substances such as stimulants).

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

Substance Abuse Disorders

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

Trauma History and Suicide Risk

- 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

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Planning Treatment

- Base treatment on comprehensive medical and psychiatric evaluations and assessment of co-morbidity
- Eating disorders rarely present as the sole psychopathology
- Assess for medical stability and safety first (suicidality or non-suicidal self-injury)

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Evidence-Based Management

- 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

Close medical monitoring due to the risk of sudden death from hypokalemia and bradycardia

Eating disorder-focused **Family-Based Treatment (FBT),** which should include caregiver education aimed at normalizing eating and weight control behaviors and restoring weight.

Rationale:

- Support from expert opinion and from a Network Meta-analysis of studies of psychotherapies for Anorexia Nervosa
- FBT (with family in charge of the patients' eating) led to greater changes in BMI than no treatment and greater changes in Initial Body Weight than treatment as usual.

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Psychopharmacology of Eating Disorders

- There is no medicine for anorexia or bulimia nervosa
- Co-morbid conditions should be treated
  - anxiety, depression, inattention, mood fluctuations, psychosis
- Fluoxetine (Prozac) may be helpful to reduce binge frequency in bulimia nervosa, but CBT is the treatment of choice
- Lisdexamfetamine (Vyvanse) can somewhat reduce frequency of binge episodes with Binge Eating Disorder

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Psychotherapy of Eating Disorders

- Family-Based Treatment (FBT) requires the capacity of the family to be engaged and cooperative (not playin')
- Cognitive Behavioral Therapy (CBT) is the E-B treatment for Bulimia
- Dialectical Behavioral Therapy (DBT) may reduce suicidal thoughts and behavior and non-suicidal self injury, especially with trauma history

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Psychotherapy of Eating Disorders

- Individual psychotherapy is important once there is medical stabilization.
- Family Therapy is important, regardless of the age of the patient, except with family-based abuse or neglect.

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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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DSM 5 criteria for Anorexia Nervosa

- Food restriction with low weight
- Intense fear of gaining weight or becoming fat
- Disturbance in body experience
- Eliminates amenorrhea and percentage weight loss criteria

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DSM 5 criteria of Bulimia Nervosa

- Recurrent episodes of binge eating
- A sense of lack of control of eating
- Recurrent inappropriate compensatory behaviors
- Average once per week or more for 3 months
- Self-evaluation unduly influenced by shape or weight

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ARFID

Avoidant/Restrictive Food Intake Disorder

- Apparent lack of interest in eating or avoidance based on sensory characteristics of food or concern about aversive consequences of eating (choking, vomiting)
- The avoidance/restricted eating leads to failure to gain as expected
- Often associated with sensory reactivity in Autism Spectrum Disorder

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Course of illness

- Prognosis
- Mortality rates

Framing the landscape

Even if the exact “12%” figure varies depending on the source, **GLP-1 medications have clearly become mainstream**, with:

- Increased direct-to-consumer advertising
- Social media normalization (“before/after,” appetite suppression narratives)
- Spillover into general cultural messaging about food, hunger, and weight

For children, this isn’t just about medication exposure—it’s about **how hunger, bodies, and food are being talked about at home and in media**.

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What children may be absorbing (indirect messaging)

A. Messaging about hunger

Parents on GLPs often experience:

- Reduced hunger signals
- Faster satiety
- Less emotional pull toward food

Child interpretation risk:

- “Hunger is something to suppress or override.”
- “Eating less = better/virtuous.”

This can subtly undermine:

- Interoceptive awareness
- Trust in internal cues (a key protective factor against EDs)

Messaging about bodies and control

GLPs often produce **rapid, visible body changes**.

Children may learn:

- Bodies are modifiable through external tools rather than internal regulation
- Weight loss is expected/normalized
- Appetite can (and maybe should) be medically controlled
- **Family food patterns**

GLP use sometimes leads to:

- Smaller portions
- Skipping meals (intentionally or due to low hunger)
- Simplified eating (e.g., protein + minimal extras)

Family-level shifts:

- Less structured shared eating
- Less emphasis on pleasure/social aspects of food
- Mismatch between parent intake and child developmental needs

Risk pathways toward EDO (not inevitable, but plausible)

The concern is not GLPs themselves—but **how the environment shifts around them**.

Key mechanisms:

Modeling disrupted cues

If a parent says:

“I’m not hungry all day—I just eat when I remember”

Child may internalize:

- Hunger isn’t reliable
- Eating regularly isn’t necessary

“Calorie deficit as virtue”

GLPs can make caloric restriction feel:

- Easier
- Less effortful
- Less uncomfortable

This can unintentionally reinforce:

- Undereating as a goal
- Less awareness of energy needs variability

Externalization of regulation

GLPs are powerful tools, but they shift regulation from:

internal cues → pharmacologic modulation

Children may then:

\

Important nuance: GLPs can move people *toward* or *away from* health

This is the core tension your group is naming.

For some individuals:

- Reduced inflammation, improved metabolic health
- Stabilized eating patterns
- Less binge–restrict cycling → **Movement *toward* health**

For others (especially with ED vulnerability):

- Reinforced restriction
- Blunted hunger cues → detachment from body
- Greater body/weight preoccupation → **Movement *away from* health (EDO risk)**

👉 So your clinical stance becomes:

The same intervention can have opposite psychological and developmental effects depending on context.

How to talk with families (practical language)

A. Normalize both truths

Use “both/and” framing:

“For some people, these medications help bring their body into better balance. For others, especially where eating patterns are already vulnerable, they can move things in the opposite direction.”

B. Make modeling explicit without blaming

Instead of: ❌ “This is harmful for your child”

Try: ✅ “Kids learn a lot from how we relate to food and hunger, even when we’re not talking about it directly.”

Focus on observable behaviors in the home

Key questions:

- Are meals still happening regularly?
- Is food still social/relational?
- Are children encouraged to respond to *their* hunger?

Separate adult treatment from child development

Language to offer:

“Your body and your child’s body have different needs right now. Even if your appetite is quieter, your child still needs consistent fuel and opportunities to learn their own hunger/fullness.”

Narrate differences explicitly

“My medicine changes my appetite, but your body tells you when you need food—and that’s important to listen to.”

Preserve food neutrality

Avoid: “I’m being good” - “I can’t eat that”

Shift to: “Different bodies need different things”

Protect interoceptive learning in kids

Encourage:

- Hunger awareness
- Fullness noticing
- Permission to eat

Screen for vulnerability Particularly if:

- Parent has ED history
- Child shows rigidity, anxiety, or body concerns
- Household language becomes weight-focused

High-yield clinical takeaway

A useful synthesis statement:

GLPs change the physiology of hunger—but children are learning the *meaning* of hunger from their environment. Our job is to ensure that, even if a parent's hunger is pharmacologically altered, the child's relationship with food remains developmentally intact.

If helpful, I can also create:

- A brief **discussion guide for your group**
- A **family handout**
- Or **case vignettes** to stimulate conversation

Create a family handout on this topic.

How to screen for ED risk in families using GLPs?

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True or False

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Anorexia Nervosa

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Questions