WELCOME.

THE PRESENTATION WILL START MOMENTARILY

Eating Disorders

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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)

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  - A. Is not an eating disorder
  - B. Is a feeding disorder
  - C. Can be associated with Autism Spectrum Disorder
  - A & C
  - None of the above
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.
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?
Ambivalence towards treatment
Treatment Resistance
Persuasion
Perceived Coercion
Compulsion
• 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)
• You look terrific!
• Have you lost weight?
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
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

Ages 2-5 □ Ages 6-11 □ Ages 12-19

Percent

<table>
<thead>
<tr>
<th>Year</th>
<th>Ages 2-5</th>
<th>Ages 6-11</th>
<th>Ages 12-19</th>
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<td>1971-1974</td>
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<td>2009-2010</td>
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<td>2011-2012</td>
<td>21</td>
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</table>

The shape of things to come
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

- Inpatient Medical
- Inpatient Pediatric
- Inpatient Adolescent Psychiatric
- Inpatient Adult Psychiatric
- Inpatient Psychiatric Eating Disorder
- Day Treatment
- Intensive Outpatient Program
- Outpatient Treatment
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)
How does the evidence support the Treatment

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

• Food is the mainstay of treatment

• Family Based Treatment (FBT) is the evidence based approach for the younger patient
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
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).
• 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.
Nutritional rehabilitation

• No meaningful psychotherapy can occur with the malnourished brain

• Food is the mainstay of treatment
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)
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
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
New: Avoidant/Restrictive Food Intake Disorder

- 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
Course of illness

• Prognosis

• Mortality rates
True or False?

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Minnesota Experiment of Human Starvation

- https://www.youtube.com/watch?v=8iH5htWlwo0
Acknowledgements

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