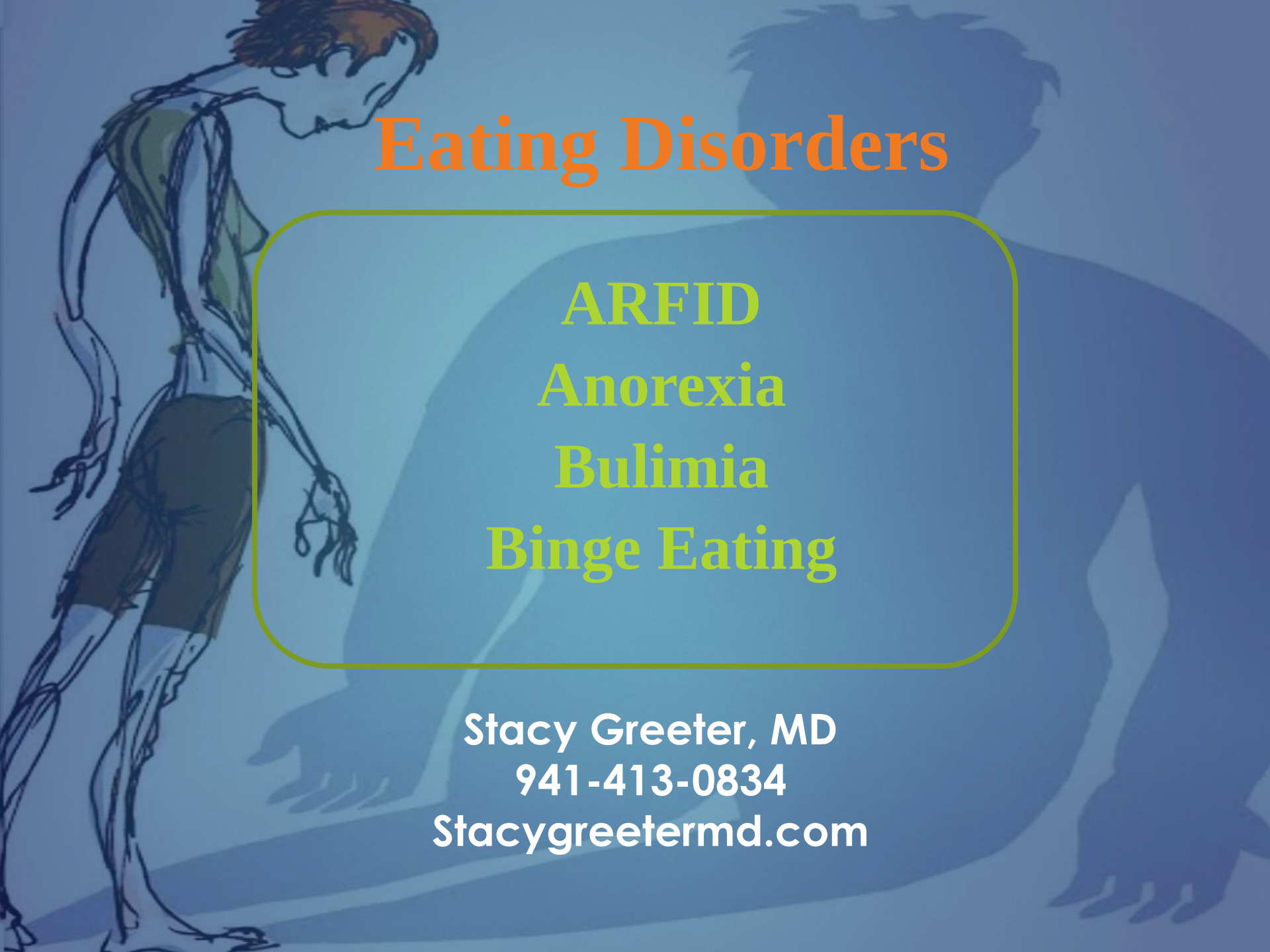


Eating Disorders

ARFID
Anorexia
Bulimia
Binge Eating

Stacy Greeter, MD
941-413-0834
Stacygreetermd.com

Treating Eating Disorders is a Call to Courage

Ask the questions that others are too uncomfortable to ask.

Let patients know, “I can handle whatever it is you need to tell me.”

Shame derives its power from being unspeakable.

-Brene Brown

Eating Disorders and Suicide

- Opioid Use Disorder and Anorexia Nervosa have the highest mortality rates of all psychiatric disorders.
- Suicide is the second leading cause of death among individuals with anorexia nervosa.
- Approximately one third to one quarter of patients with anorexia and bulimia nervosa have attempted suicide.
- Relative to gender and age-matched controls:
  - individuals with anorexia nervosa are 18 times more likely to die by suicide
  - Individuals with bulimia nervosa are 7 times more likely to die by suicide

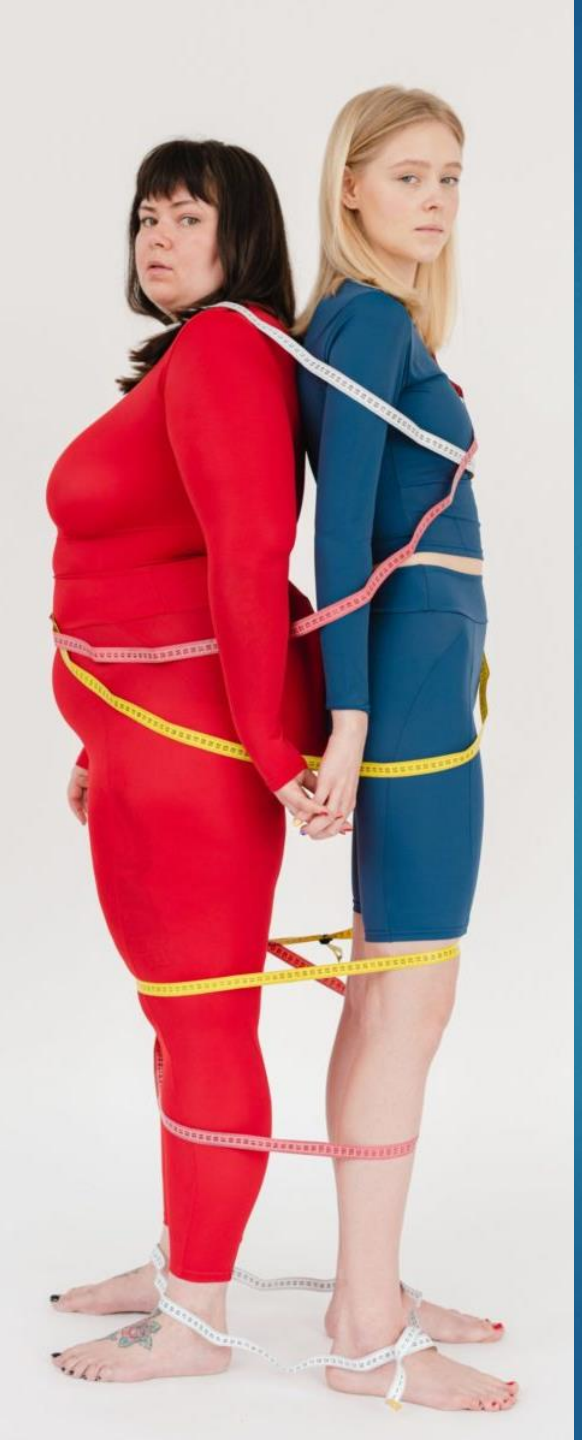
https://pubmed.ncbi.nlm.nih.gov/28846874/


It's just a phase all teenagers go through. They'll grow out of it.
She's just needs to stop being so superficial!
Her friends or her parents must have caused this.
I wish I had an eating disorder, then I could finally lose some weight.
Shame
Secrecy
Self-loathing
She's just been looking at too many magazines.
You don't look like you have an eating disorder!
Geez, just eat a cheeseburger.
Doesn't everyone have an eating disorder these days.

Anorexia Nervosa

- Restriction of food intake leading to a "significantly low body weight"
- Fear of becoming fat or gaining weight
- Distorted view of themselves as overweight
- Amenorrhea is no longer a criterion in DSM-5

- Two Types
  - **Restricting Type**
  - **Binge-eating/purging type**
    - Similar to Bulimia but there is no low weight criterion for Bulimia nervosa like there is for Anorexia nervosa.



Atypical Anorexia Nervosa

- Same psychological criteria as anorexia nervosa restricting type (intense fear of gaining weight and distorted view of body).
- Weight is within or above normal range.
- Less than 8% of patients struggling with eating disorders are actually under weight.

Most eating disorder patients will not be under weight.

They are in no less danger….

Table. Key Features of Different Eating Disorders[a]

Characteristic	Anorexia nervosa	Bulimia nervosa	Binge eating disorder	Avoidant/restrictive food intake disorder	Atypical anorexia nervosa
Key diagnostic features	• Restriction of energy intake relative to requirements leading to a considerably low body weight (defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected) in the context of age, sex developmental trajectory, and physical health • Intense fear of gaining weight or becoming fat, or persistent behavior to avoid weight gain, even though at a considerably low weight • Disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape or weight on self-evaluation, or persistent lack of recognition of the seriousness of current low body weight	• Recurrent episodes of binge eating accompanied by recurrent inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise • The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 mo • Self-evaluation is unduly influenced by body shape and weight	• Recurrent episodes of binge eating not associated with recurrent use of inappropriate compensatory behaviors • The binge eating episodes are associated with ≥3 of the following: (1) eating much more rapidly than normal, (2) eating until feeling uncomfortably full, (3) eating large amounts of food when not feeling physically hungry, (4) eating alone because of feeling embarrassed by how much one is eating, and (5) feeling disgusted with oneself, depressed, or very guilty afterward • Marked distress regarding binge eating • The binge eating occurs, on average, at least once per week for 3 mo	• An eating or feeding disturbance (eg, apparent lack of interest in eating or food, avoidance based on the sensory characteristics of food, concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with ≥1 of the following: (1) considerable weight loss (or failure to achieve expected weight gain or faltering growth in children), (2) considerable nutritional deficiency, (3) dependence on enteral feeding or oral nutritional supplements, and (4) marked interference with psychosocial functioning • The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice • The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced • The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder; when the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention	• All the criteria for anorexia nervosa are met, except that despite considerable weight loss, the individual's weight is within or above the normal range
Body weight	Markedly low	Usually normal	Normal or above normal	Low	Normal or above normal
Preoccupation with weight and shape	Marked	Marked	Present	Absent	Marked

[a] Adapted from the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition).[1]

Anorexia Nervosa

- **Etiology**
  - Highly heritable
    - 44% genetic concordance rate for monozygotic twins and 12.5% for dizygotic twins
  - Does occur in non-western and developing nations, though may present differently than fear of gaining weight, ie fear of abdominal fullness
  - **Not** just a cultural illness caused by barbie dolls and social media.
  - Does occur in men.

Anorexia Temperament

- Anorexia temperament often predates the illness
  - anxiety, perfectionism, inflexibility, harm avoidance, obsessive behaviors (order, exactness, and symmetry), asceticism, loss aversion, fear of failure
  - Increased anxiety in anticipation of food and decreased reward in response to food.
    - Food triggers anxiety rather than pleasure.
    - Affective blunting
  - Decreased interoceptive awareness
    - Decreased response to hunger cues

- Anorexia is actually protective against substance abuse disorders with lower rates than the general population.

Bulimia Nervosa Temperament

- Bulimia and binge eating disorder are associated with higher rates of substance abuse and difficulty delaying gratification.
  - Increased reward sensitivity to food.
  - Affective dysregulation
  - Impulsivity and sensation seeking often extends beyond food
    - Cutting and other self-injurious behaviors
    - Shop lifting
    - Drug and alcohol use
    - Borderline personality disorder

Bulimia Nervosa

- Screen for eating disorders in your higher weight patients as they are more likely to be missed.

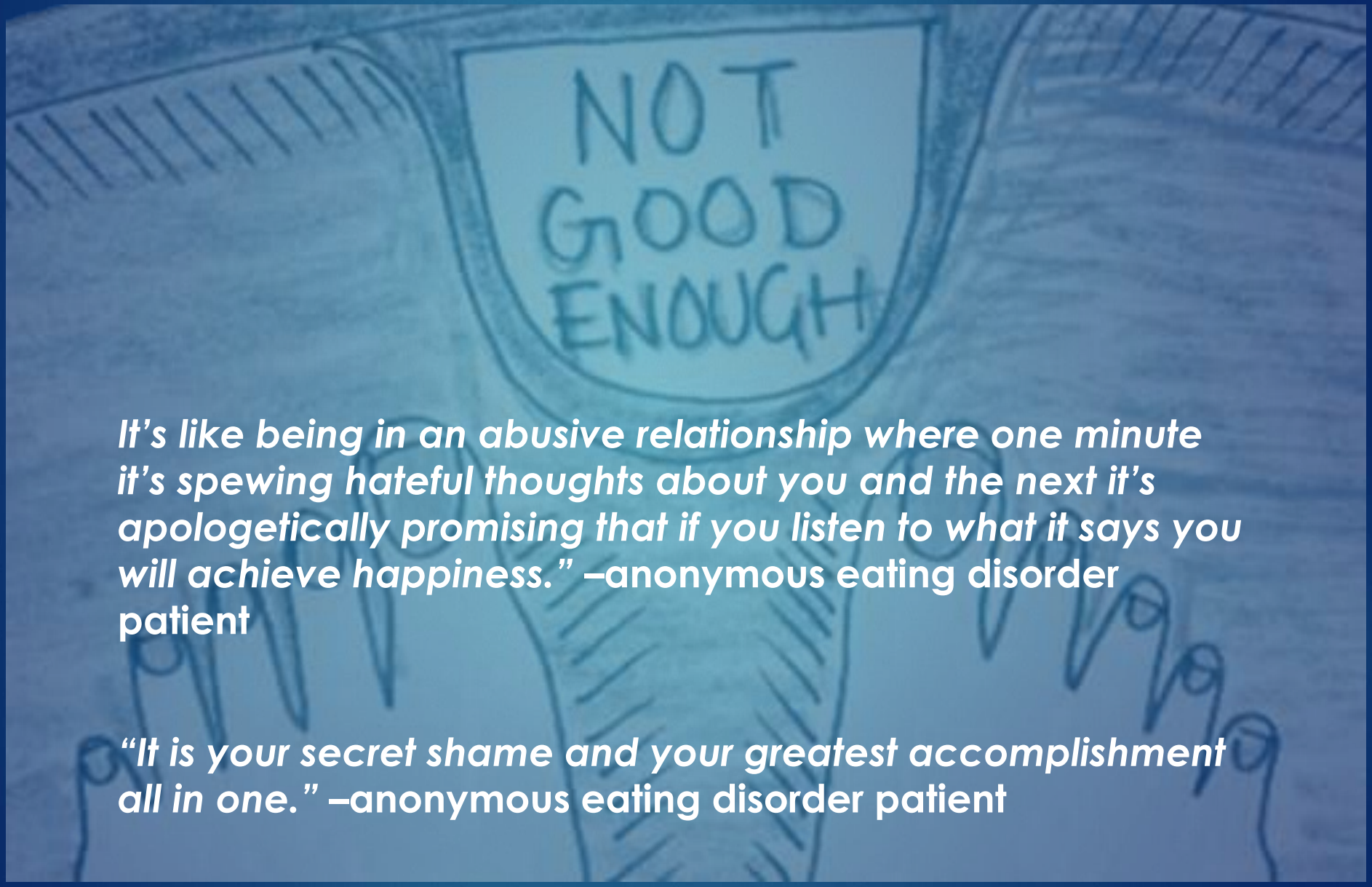
- Patients with eating disorders who are normal weight, still experience life threatening complications.

The Vicious Cycle of Eating Disorders

Government of Western Australia
North Metropolitan Health Service

Trading temporary relief for long term agony.

The Psychology of Anorexia



***It's like being in an abusive relationship where one minute it's spewing hateful thoughts about you and the next it's apologetically promising that if you listen to what it says you will achieve happiness."* –anonymous eating disorder patient**

***"It is your secret shame and your greatest accomplishment all in one."* –anonymous eating disorder patient**

The Psychology of an Eating Disorder

Self-worth is entirely consumed by being thin. Using eating disorder behaviors to feel "good enough."

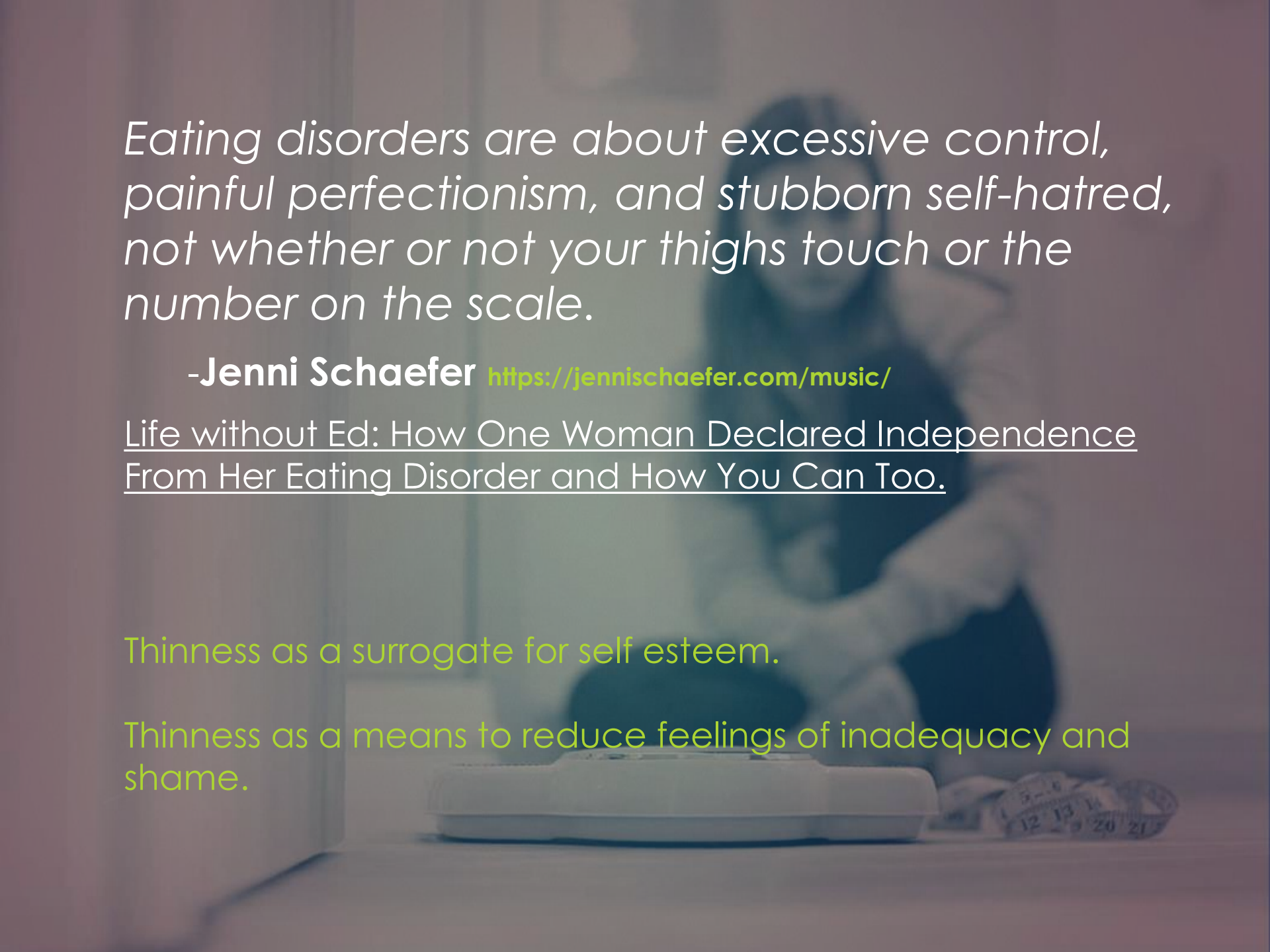
- *It's OK if I don't get an A on my test as long as I am thin.*
- *I am not the thinnest one on this elevator right now. Therefore I am fat and worthless.*

Feeling powerless/helpless and use eating disorder behaviors to feel in control.

- *Restricting means I am in control of my life. Eating means I am out of control and weak.*
- *Look at her eating that cheeseburger. She has no self-control.*

Delusion of being fat no matter how thin and that the key to decreasing painful feelings is losing weight.

- *If I just lose a few more pounds, then I will finally be happy.*



Eating disorders are about excessive control, painful perfectionism, and stubborn self-hatred, not whether or not your thighs touch or the number on the scale.

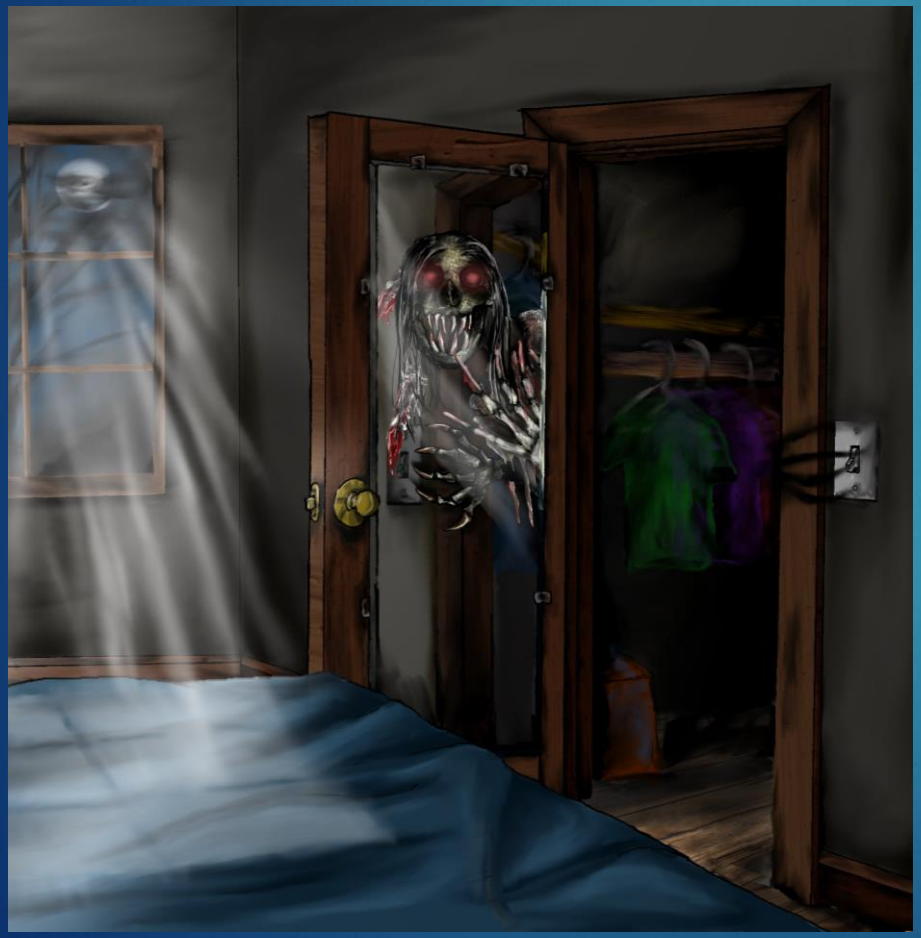
-**Jenni Schaefer** https://jennischaefer.com/music/

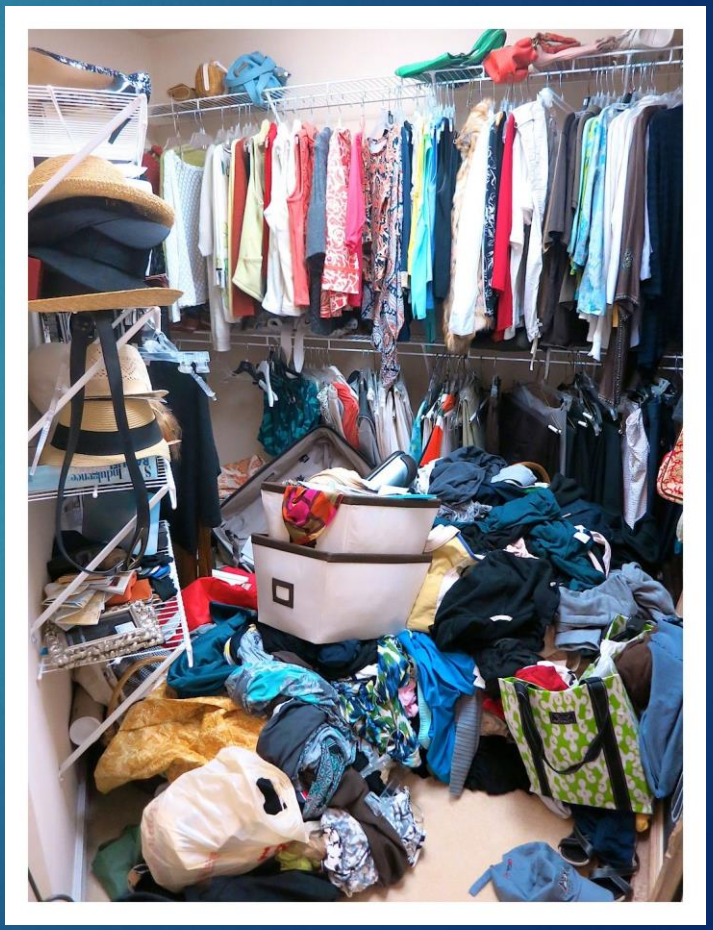
Life without Ed: How One Woman Declared Independence From Her Eating Disorder and How You Can Too.

Thinness as a surrogate for self esteem.

Thinness as a means to reduce feelings of inadequacy and shame.

Shame thrives in the darkness of secrecy and solitude. It cannot survive the light of open acceptance and human connection.

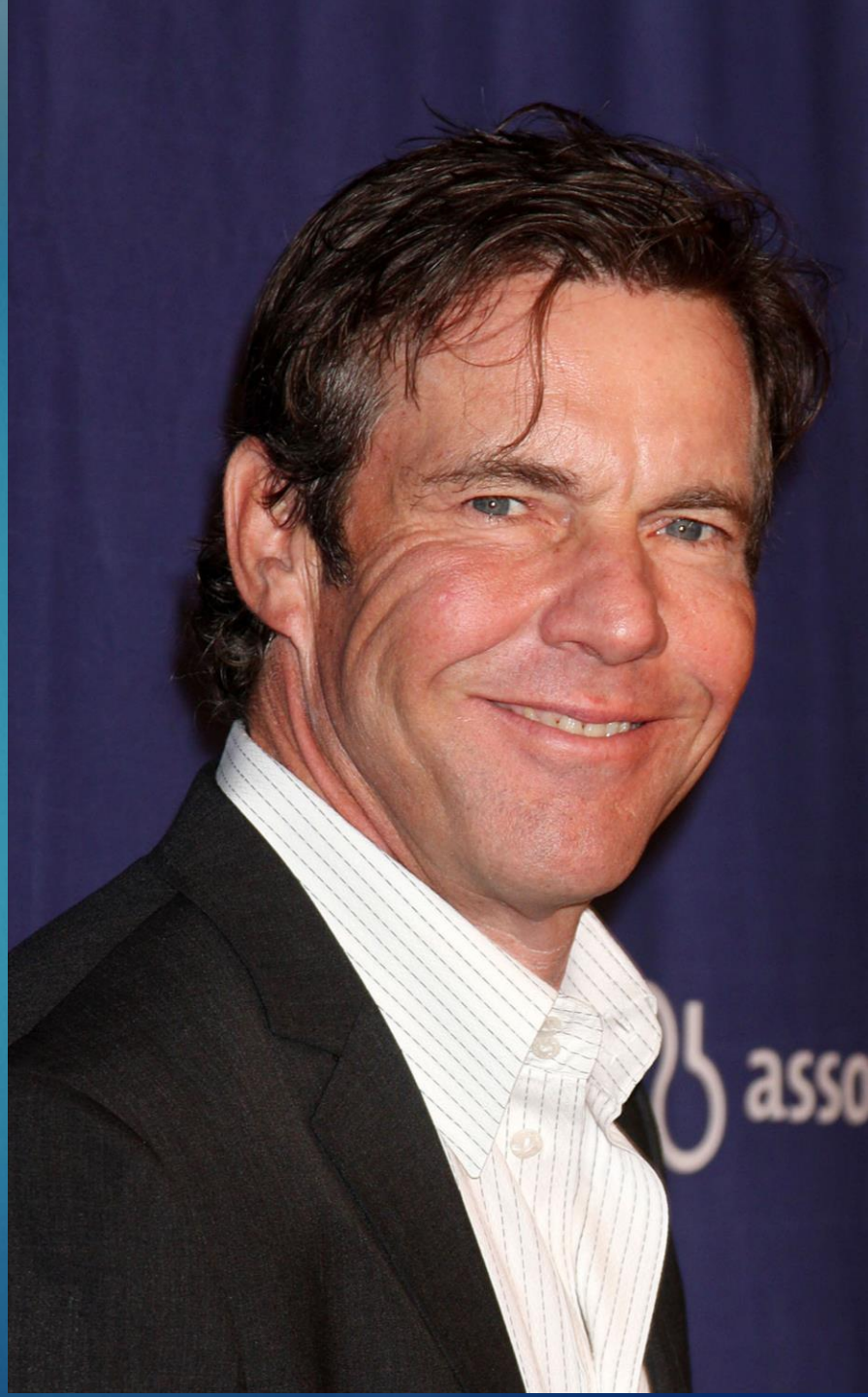




"My arms were so skinny that I couldn't pull myself out of a pool. I'd look in the mirror and still see a 180-lb. guy, even though I was 138 pounds."

— Dennis Quaid

https://www.youtube.com/watch?v=Sbbdee4N4yA



Increased Frequency of Eating Disorders in Transgender Patients

- A 2015 study found that transgender college students were four times more likely than cisgender peers to report an eating disorder.
- A 2013 survey of high school youth revealed that transgender students were three times more likely to restrict eating, nine times more likely to use diet pills, and seven times as likely to use laxatives to control their weight.

- Transgender females, gender-assigned at birth male patients often experience a pull to restrict to achieve a more feminine appearance.
- Transgender males, gender-assigned at birth females, often experience a pull to restrict to delay menstruation and development of breasts and other secondary sexual characteristics.

Let patients know…

- I can handle whatever you need to tell me.
- I will not reject you or dismiss you.
- I have the courage to discuss uncomfortable things with you directly.
- I expect you to relapse. That is part of the illness that we will handle together.
- Who can you share this information with next and get support from?

Shame derives its power from being unspeakable.

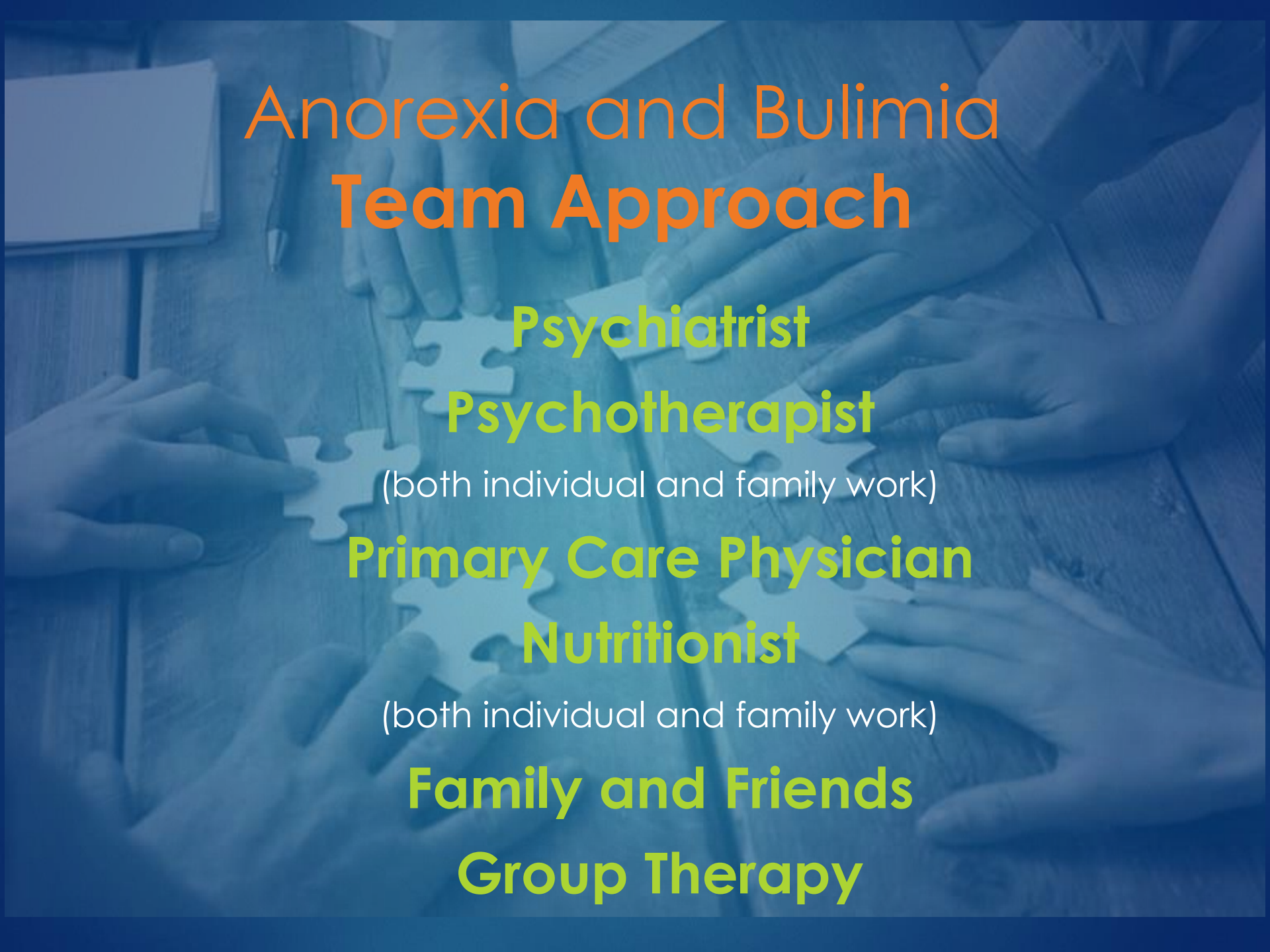
-Brene Brown

Direct Screening is Key!

- What bothers you about your body the most?
- How much of your day do you spend thinking about your weight/body?
- How much does your weight affect the way you feel about yourself?
- Do you worry that you've lost control over how much you eat?
- Do you feel like food dominates your life?
- Do others see your body differently than how you see yourself?

Screening Tools

- NEDA (National Eating Disorder Association Online Screening Tool)
  - https://www.nationaleatingdisorders.org/screening-tool
- EDY-Q (eating disorders in youth questionnaire) age 8-13
  - https://ul.qucosa.de/api/qucosa%3A14486/attachment/ATT-0/
- EDE-Q
  - https://www.corc.uk.net/media/1273/ede-q_quesionnaire.pdf



Anorexia and Bulimia
Team Approach

Psychiatrist

Psychotherapist

(both individual and family work)

Primary Care Physician

Nutritionist

(both individual and family work)

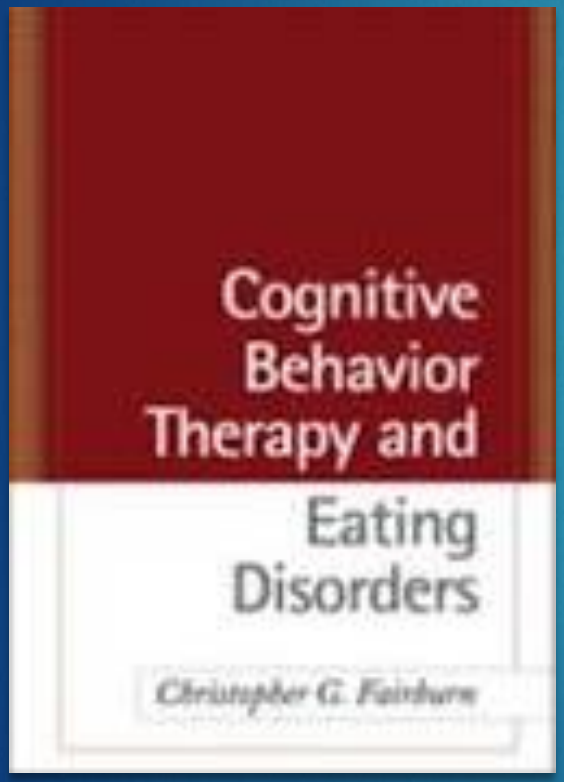
Family and Friends

Group Therapy

Psychotherapy with Eating Disorder Patients: An Overview

Psychotherapeutic Strategies

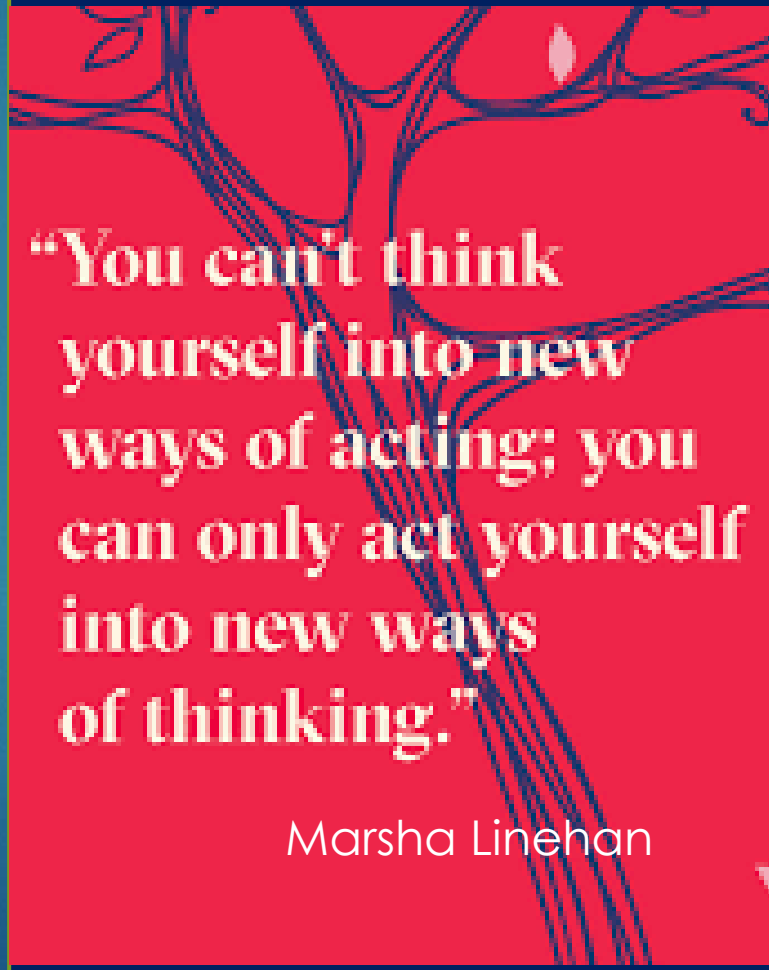
Cognitive Therapy



- Learn to reframe and contradict eating disorder thoughts.
  - Eating Disorder Self vs Healthy Self
  - Labeling Eating Disorder Thoughts
- Counteract all or nothing thinking, "I ate a donut so my day is ruined, I will now binge eat two boxes of donuts."
- Enhanced Cognitive Behavioral Therapy (CBT -E) by Christopher Fairburn is specifically designed for eating disorder treatment
- Thought -> Feeling -> Urge -> Action
  - Disrupting the cycle

Ten Phases of Eating Disorder Recovery

1. I don't think I have a problem.
2. I might have a problem, but it's not that bad.
3. I have a problem but I don't care.
4. I want to change and I don't know how and I'm scared.
5. I tried to change but I couldn't.
6. I can stop some of the behaviors but not all of them.
7. I can stop the behaviors, but not my thoughts.
8. I am often free from behaviors and thoughts, but not all the time.
9. I am free from behaviors and thoughts.
10. I am recovered.

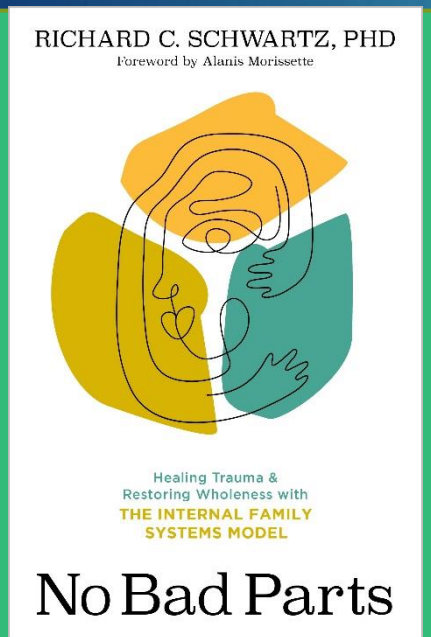


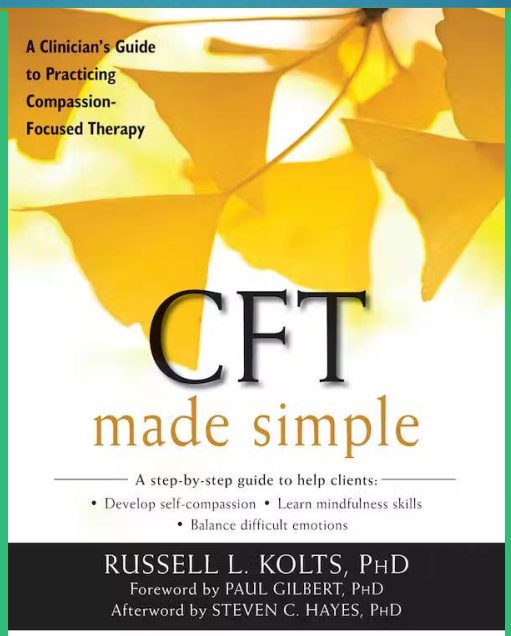
Psychotherapeutic Strategies

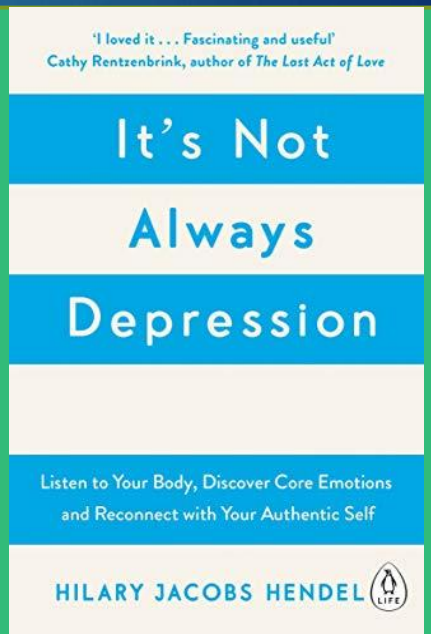
- **Decrease shame and blame.**
  - Eating disorder is an illness, not a personal failure/character flaw.
  - "You're not weaker than other people, people who don't have an eating disorder, who eat with ease. You are simply carrying heavier weight than them."
  - Eating disorder behaviors are just your best effort to cope with painful feelings, albeit ineffective.
  - Compassion Focused Therapy (CFT) dovetails nicely with this

Psychotherapeutic Strategies

- **Depersonalize the eating disorder thoughts.**
  - Teach patient to distinguish eating disorder thoughts from healthy thoughts and to cultivate the latter.
  - Externalize eating disorder by giving it a name, ie Ed.
  - Internal Family Systems (IFS) and Accelerated Experiential Dynamic Psychotherapy (AEDP) dovetail nicely with this







Psychotherapeutic Strategies

Mindfulness Practice

- Tuning in to hunger and satiety cues. Enhancing interoception.
- "I recognize the urge to binge. What am I feeling and what do I really need?"
- Practicing sitting with discomfort and not trying to "fix" feelings with food. "No feeling is final or fatal." – recovery warriors podcast
- "Challenge your thoughts, but feel your feelings!"
- Dovetails nicely with ACT (Acceptance and Commitment Therapy) and DBT (Dialectical Behavior Therapy)

Intuitive Eating vs. Mindful Eating

Intuitive Eating:

Rejects diet culture

Honors appetite

Encourages bodily respect

Mindful Eating:

Minimizes distractions while dining

Experiences food with the five senses

Requires eating slowly and chewing thoroughly

verywell

Food Journal Example

DATE_____

Time	Food and Amount	Hunger (Fullness)	Feelings	Urges/Purge
8:00	1 cup yogurt, an orange, ½ c granola	3-7	Feeling hungrier in the a.m.	N/N
10:30	Luna bar, coffee latte	3-5	Needed something, stressed	N/N
12:30	Turkey sandwich	3-6	Not quite satisfied, feeling anxious	N/N
4:00	Small bag of trail mix, apple	2-7	Lunch wasn't enough, got too hungry	Y/N
7:00	Bean and cheese burrito, chips (about 25) then lost count, salsa, guacamole ¼ c	3-8.5	Out with friends, too many chips, feeling guilty and frustrated with myself	Y/Y

From 8 Keys to Recovery From an Eating Disorder Workbook by Carolyn Costin and Gwen Schubert Grabb

Thought -> Feeling -> Urge -> Action

Eating Disorder Self

- Thought:
  - "She cancelled our plans. She doesn't care about me."
- Feeling:
  - Sad, hurt, angry, lonely, fat, ugly
- Urge:
  - "I want to binge to stuff down the anger, fill the loneliness, and numb out."
- Action:
  - Eating everything in the kitchen.

Healthy Self

- Thought:
  - "It's hard to be alone. I wonder why she cancelled"
- Feeling:
  - Sad, disappointed, hurt, lonely
- Urge:
  - "I want to call her and yell at her."
- Action:
  - Calling a different friend who is available to talk. When I am calmer, ask her why she cancelled and tell her how I feel.

Psychotherapeutic Strategies

- **Cultivate sources of self-worth that are not based on physical appearance or comparison to others.**
  - **Focusing less on accomplishment, and more on fulfillment, meaning, purpose, and connection.**
  - **"compare and despair" –** Life Without Ed by Jennifer Schaefer

"If you must count something, count your blessings instead of calories eaten and calories burned."

"If you must binge, binge on every experience life offers. Devour the sensations of the present moment and fill yourself with delicious dreams and magical moments."

"If you must purge, purge with tears, with laughter, with love…allow all the emotions to flow through you and be released into the energy of the universe."

"If you must restrict, restrict the negative self-talk and detrimental influences so that they don't impact the quality of your life or suffocate your soul."

8 Keys to Recovery From an Eating Disorder Workbook by Carolyn Costin and Gwen Schubert Grabb

Psychotherapeutic Strategies

Focus on gaining freedom vs following food and exercise rules

- ACT (Acceptance and Commitment Therapy)
- Move away from shame and towards what you fear.
- We sacrifice comfort, for freedom.

Psychotherapeutic Strategies

Nonjudgmental Anticipation of Relapses

- *"When you relapse, just do the next right thing"* – Jennifer Schaefer
- *"Never be afraid to fall apart because it is an opportunity to rebuild yourself the way you wish you had been all along"* – Rae Smith

Change begins with hope.

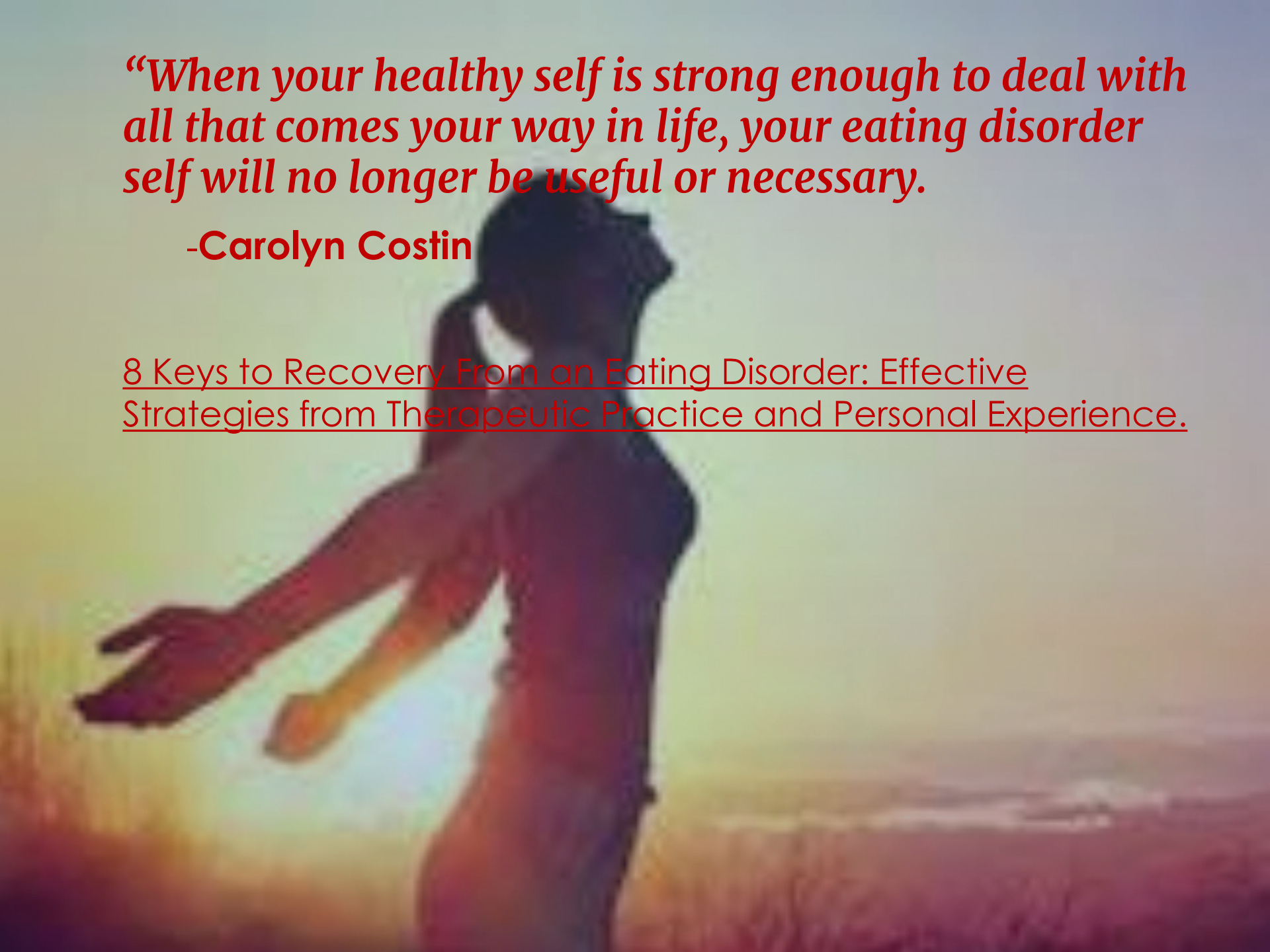
It is not enough for patients to want to change. They must believe that change is possible.

Let the patient feel your belief in their ability to heal themselves.

Motivational interviewing

- **Eliciting Reasons For Change and Increasing Desire for Change**
  - Writing assignment "Thanking Your Eating Disorder For How it Has Helped You."
    - Is it **really** true that it has done these things for you?
  - Writing assignment "If I Continue Listening to My Eating Disorder Self, Then I will Lose…."
- **Increase patient's confidence in their ability to change/heal themselves**
  - Writing Assignment to visualize and describe "A Day in My Life When I am Recovered."
  - Connecting to a peer mentor who has recovered.

Just hold the door open for them.....


"When your healthy self is strong enough to deal with all that comes your way in life, your eating disorder self will no longer be useful or necessary.
-**Carolyn Costin**
8 Keys to Recovery From an Eating Disorder: Effective Strategies from Therapeutic Practice and Personal Experience.

Eating Disorder Recovery Apps

Rise Up + Recover: An Eating Disorder Monitoring and Management Tool for Anorexia, Bulimia, Binge Eating, and EDNOS 12+

Recovery Warriors L.L.C.

Designed for iPhone

★★★★★ 4.6 • 249 Ratings

Free

RR: Eating Disorder Management 12+

Recovery Record

Recovery Record

★★★★★ 4.9 • 8.9K Ratings

Free

Brighter Bite - ED Recovery 12+

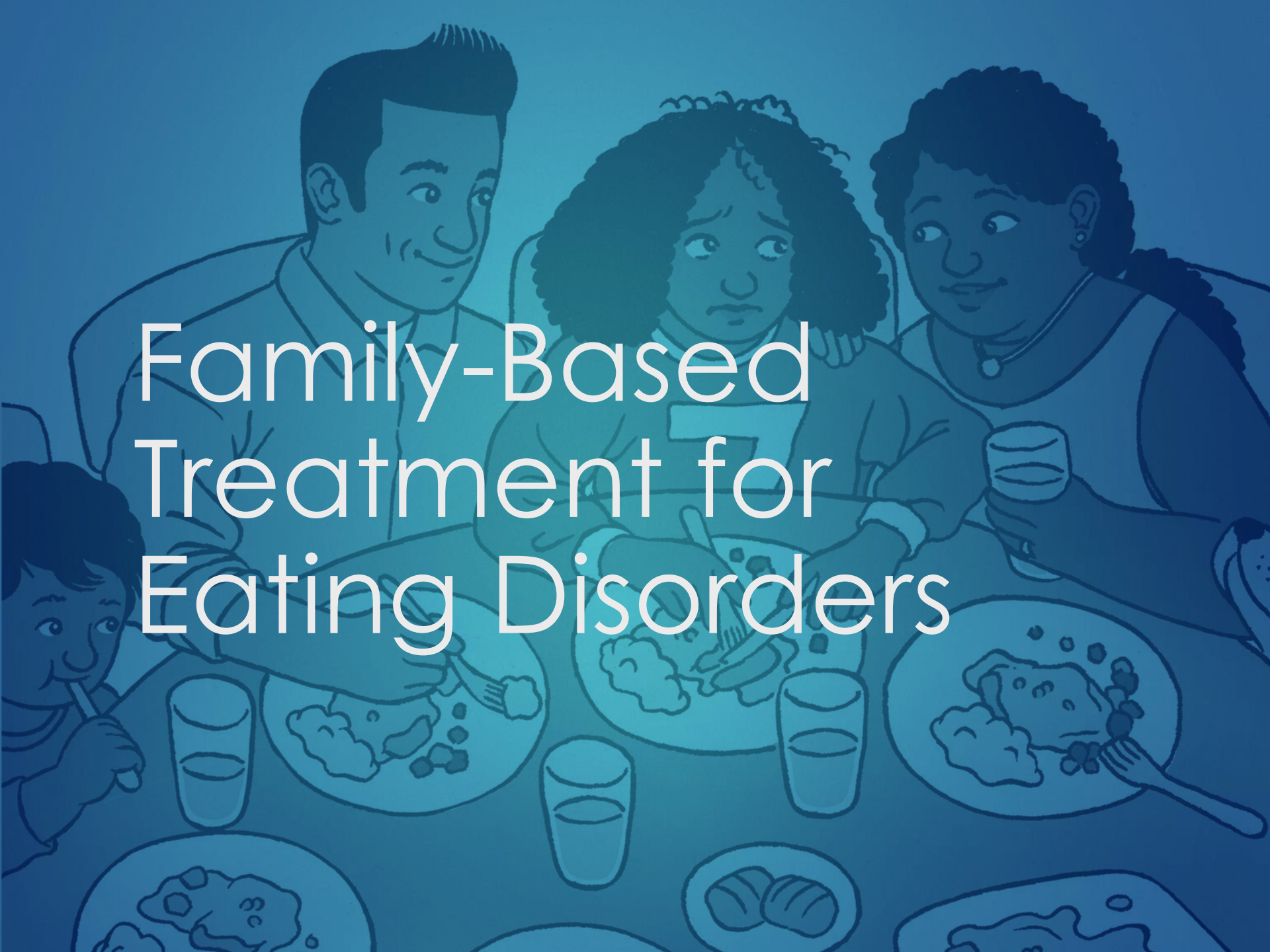
Recover From Eating Disorder

Brighter Bite LLC

Designed for iPad

★★★★★ 4.8 • 439 Ratings

Free



Family-Based Treatment for Eating Disorders

Family-Based Treatment

- Therapists coach parents in how to assist their child in eating.
- Therapist observes a family meal in the therapist's office and provides feedback o how parents assist child.
- Parents plan, prepare, and supervise their child's meals and are empowered as agents of change.
- Progress from full parental control to gradual return of control of eating to the adolescent.
- **Externalization of illness:** The illness is an external force that has possessed the child and is attacking their health. Parents and providers join forces with the healthy part of the teen to fight off the eating disorder.

Educate parents/spouses that …….

- This is a brain disorder and a life-threatening illness
- Their loved one can't just "snap out of it." Nor did they choose this disorder.
- **Externalize the disorder** (loved one vs eating disorder)
- Teach them to take an **empathic, nonjudgmental stance**.
- Let go of the need to understand "why this happened?" or "what caused this?" **No one is to blame for this illness.**
- Focus on **health and psychological recovery,** not their loved one's physical appearance.
  - Don't say "You gained 5 pounds and you look so much better!"
  - Say "The therapist says you are making great progress and I'm so glad to see you feeding yourself and getting healthier."

Empower parents/spouses to …….

- Have an active role in preparing meals and encouraging their loved one to eat under the nutritionist's guidance. Do not force your loved one to eat.
- Set up barriers to eating disorder behaviors under a family therapist's guidance.
  - Getting rid of the scale
  - Helping to distract their loved one and encouraging them to stay out of the bathroom after eating
- **Support and empathize with their loved one while having a zero tolerance towards eating disorder behaviors.**
  - "I love you. I'm absolutely not ok with you purging. How can I help?"
- *https://www.allianceforeatingdisorders.com/dos-and-donts-supporting-spouse-through-eating-disorder-recovery/*

Educate Friends/Family
First, do no harm.

Don't Say

- Why can't you just eat something?
- If you practiced self-control, you wouldn't binge.
- You would look so much better if you gained/lost weight.
- I wish I had an eating disorder! I could lose some weight.

Do Say

- Help me understand how difficult eating is for you right now.
- I'm sad that this illness has such power over you right now.
- How would you feel if you were stronger and healthier?
- What will you focus on when your food and weight don't occupy so much of your thoughts.

Peer Support and Connection to Others in Recovery is Key

Consider connecting with a mentor in recovery.

Eating Disorder Groups

International Association of Eating Disorder Professionals (IAEDP) Tampa Bay Chapter Free Eating Disorder Group

- https://www.iaedptampa.org/groups/

Free Eating Disorder Groups nationally

- https://www.allianceforeatingdisorders.com/eating-disorder-support-groups-and-programs/#support-groups

Eating Disorder Group

Eating Emotions or NOT!

A Therapeutic Group for Women with an Eating Disorder

Day: Saturdays starting March 18th thru May 13th, 2023 (9 weeks)

Time: 9:00a – 10:30a

Location: 1020 10th Avenue West #100, Palmetto, Fl 34221

Cost: $35* per session (*Cost will increase to $45 with less than 4 participants) *Some Insurances accepted*

Age Group: 25 and over

Registration is required

Please contact Tricia Sadler, LMHC for more information

941-281-5079

www.TJScounseling.com

triciajsadler@gmail.com

Consider Higher Level of Care

- **Consider residential treatment center or day treatment program if….**
  - Inadequate family support and needs supervision to prevent restrictive eating
  - Weight continues to be <85% of recommended weight
  - Need for structure to prevent compulsive exercising or purging

Center for DISCOVERY
Eating Disorder Treatment

25th ANNIVERSARY

FAIRWINDS
Treatment Center

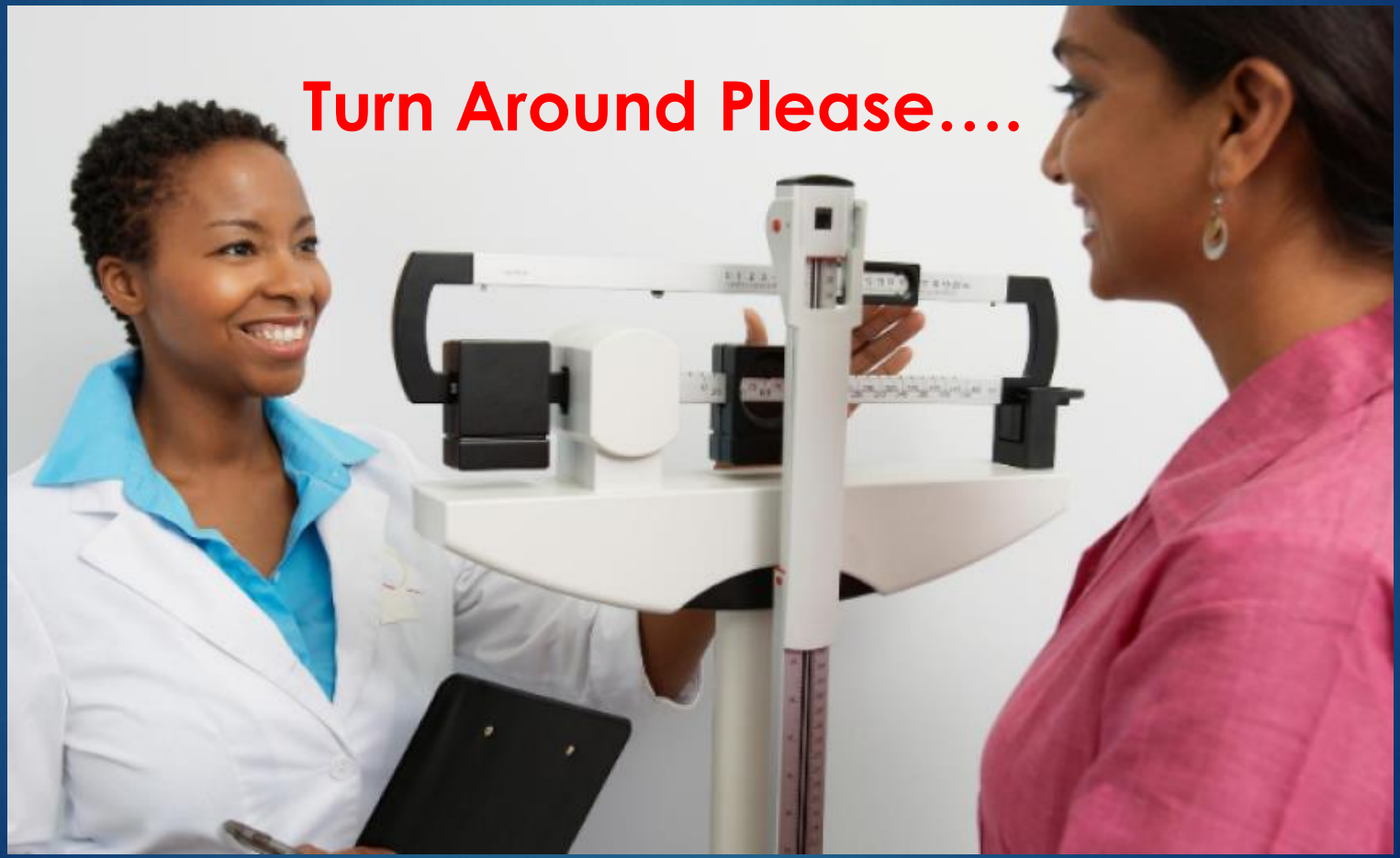
ROGERS
Behavioral Health

canopy cove

The Renfrew Center
FIRST IN EATING DISORDERS

Higher Level of Care for Eating Disorders

Medical Complications of Eating Disorders



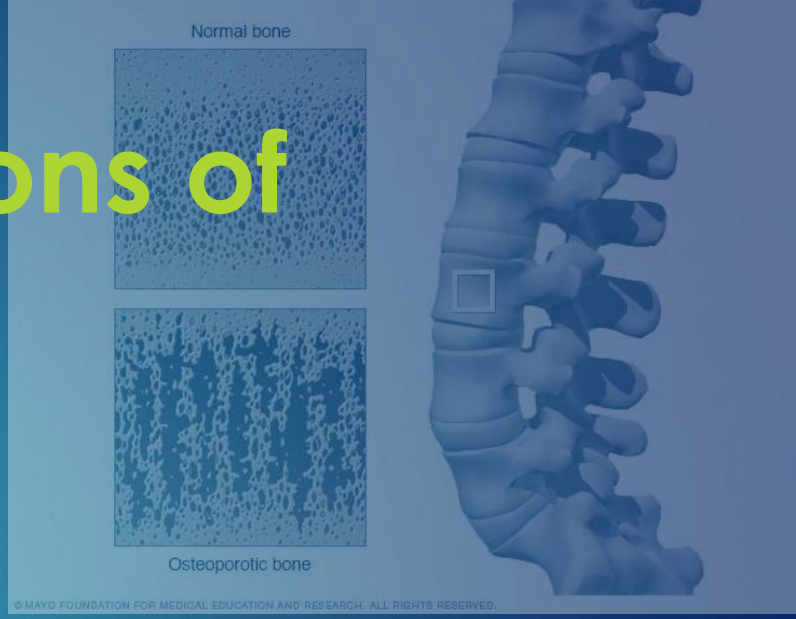
Cardiac Complications of Eating Disorders

- Responsible for about one third of deaths due to eating disorders.
- Weight loss causes decreased cardiac mass, especially left ventricular mass and thus decreased cardiac output.
  - In compensation, to lower cardiac workload:
    - Low heart rate
    - Low blood pressure
    - Decreased metabolic rate
    - Increased vagal tone
- Everyone needs an ECG!
- QT prolongation is associated with both anorexia and bulimia. (more severe in bulimia)
- Ipecac abuse can cause irreversible cardiomyopathy

Other Complications of Eating Disorders

- Endocrine
  - Low sex hormones
  - Higher rates of polycystic ovarian syndrome
  - Thyroid abnormalities
- Hematologic
  - Low blood count
  - Low platelets
  - Increased risk of infection

Other Complications of Eating Disorders



- Gastrointestinal
  - Delayed gastric emptying
  - High cholesterol
  - Superior mesenteric artery syndrome – severe pain after eating due to restriction of blood supply to the intestines
- Orthopedic
  - Low bone mass
  - Low bone density
  - Increased fracture risk
  - Particularly impacts trabecular bone of the lumbar spine
  - Women who develop anorexia in adolescence have lower bone mass than those who developed symptoms in adulthood.
    - Adolescence represents a critical window of time when optimal peak bone mass is accrued for women and thus anorexia during this time can permanently impact a woman's bone structure.

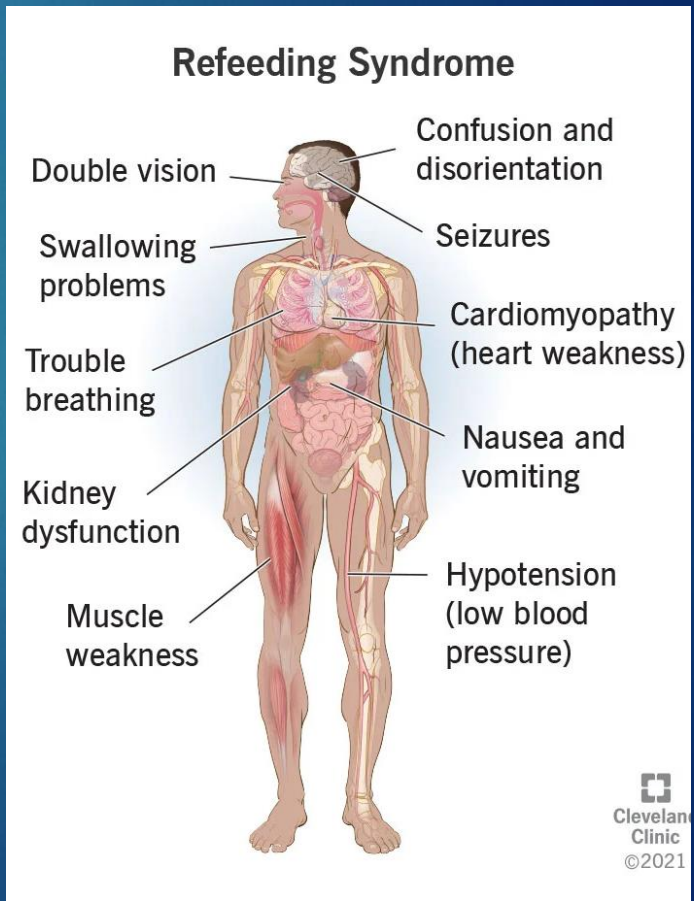
Medical Monitoring is Key Collaborate with Medical Professionals!

- ECG
- Osteopenia assessment – DEXA scan (inquire about fracture history)
- Blood work
  - CMP (note phosphorous and magnesium)
  - TSH
  - CBC with diff
  - Calcium, magnesium, phosphorous, ferritin
  - Amylase and lipase
  - Prolactin
  - Estradiol in females and testosterone in males
  - Vit D, thiamine, ferritin, B12, zinc
  - Consider FSH and LH testing

Caution While Restoring Weight

- As weight is restored, **metabolic rate rises rapidly**, so caloric intake must increase dramatically to maintain weight.
  - Patients with anorexia may need 3 times their predicted resting energy requirements to achieve appropriate weight gain.

- **Refeeding Syndrome**
  - When the body starts metabolizing glucose again, levels of phosphorous, magnesium and potassium can drop precipitously.
  - Low phosphorous can cause cardiac failure. Consider supplementation and monitor electrolytes during re-feeding.



Anorexia Nervosa Criteria for Hospitalization

- **Consider hospitalization if….**
  - Heart rate < 50 bpm
  - Blood pressure < 90/60
  - Glucose < 60
  - Electrolyte imbalances such as hypokalemia, hypophosphatemia, or hypomagnesemia
  - Temperature < 97 degrees
  - Hepatic, renal, or cardiovascular organ compromise

Anorexia Nervosa
Medication Strategies

- **SSRIs**
  - Fluoxetine has the largest body of evidence behind it.
    - also evidence for tricyclic antidepressants, including clomipramine
  - **SSRIs separate from placebo only if weight is restored.**
    - Tryptophan from the diet is required to manufacture more serotonin.
  - Especially effective for co-morbid OCD.
- **Zinc supplementation**
  - Superior to placebo for weight restoration in 3 randomized controlled trials
- **Olanzapine**
  - Effective for weight gain and OCD symptoms
- One study on medical marijuana (specifically delta -9-tetrahydrocannabinol) was negative.

Bulimia Nervosa
Medication Strategies

- SSRIs
  - Fluoxetine has the largest body of evidence behind it.
    - Therapeutic dosage in trials was at least 60mg/day.
  - Sertraline and fluvoxamine have good evidence behind them.
- Topiramate
  - Reduced frequency of binging/purging in two double blind randomized controlled trials
  - Unfortunate cognitive side effects
- Naltrexone
  - Mixed results for reducing binging/purging

- Wellbutrin is contraindicated due to seizure risk!

Binge Eating Disorder

Binge Eating Disorder
Diagnosis

- Do not engage in compensatory behaviors (restricting, exercising, purging).
- Binge eating episodes occur at least once a week for at least 3 months.
- The most common eating disorder (3% of the adult population).
- An estimated 30% to 40% of those seeking weight loss treatments can be clinically diagnosed with Binge Eating Disorder.

Binge Eating Disorder
Criteria for a Binge Eating Episode

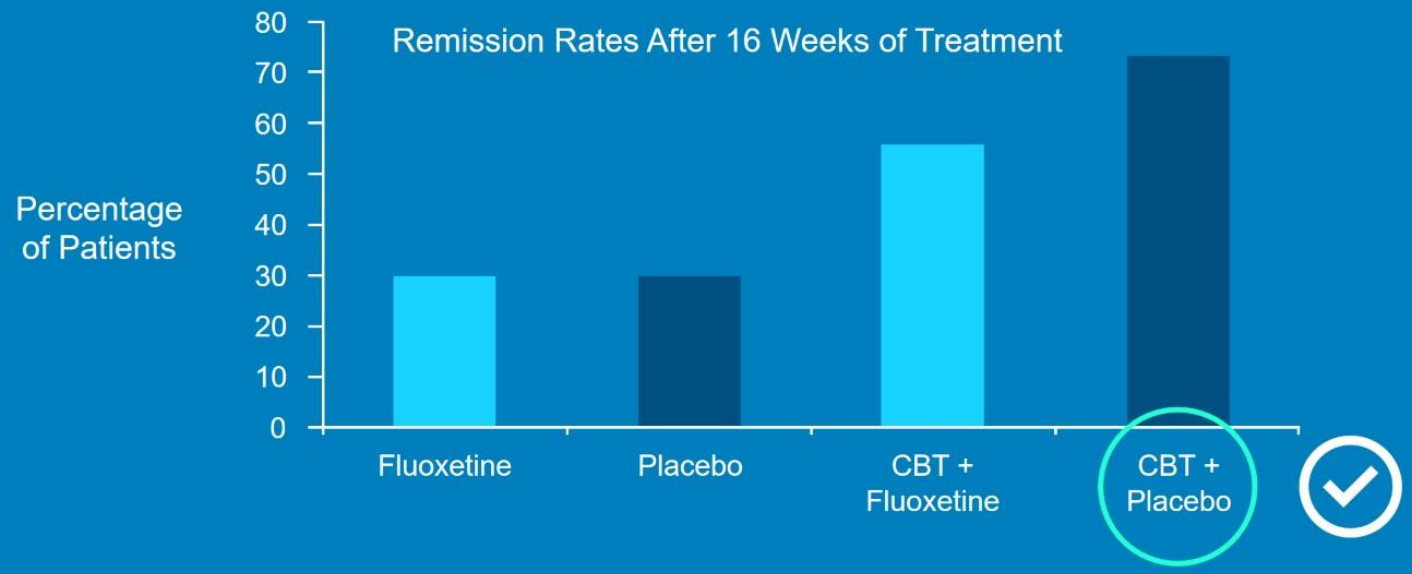
- Eating in a 2 hr period significantly more than what a typical person would eat
- Feeling out of control while eating
- Also associated with at least 3 of the below symptoms
  1. Eating much more rapidly than normal
  2. Eating until feeling uncomfortably full
  3. Eating large amounts of food when not feeling physically hungry
  4. Eating alone because of being embarrassed by how much one is eating
  5. Feeling disgusted with oneself, depressed, or very guilty after overeating

Binge Eating

- A binge is both a reward and a punishment.
  - May start as serving a self-soothing function and then become a compulsive finishing of everything even though they feel ill and uncomfortably full.
- Compulsive
  - Need to eat ALL of a food, even when it is not appetizing or they are not hungry.
- Secretive
- "Trigger" foods –
  - If I eat one cookie, I can't stop, I have to eat all the cookies.

Binge Eating Disorder

Fluoxetine and CBT for BED



Grilo, C. M., Crosby, R. D., Wilson, G. T., & Masheb, R. M. (2012). 12-month follow-up of fluoxetine and cognitive behavioral therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology*, *80*(6), 1108–1113.

Psychopharmacology Institute

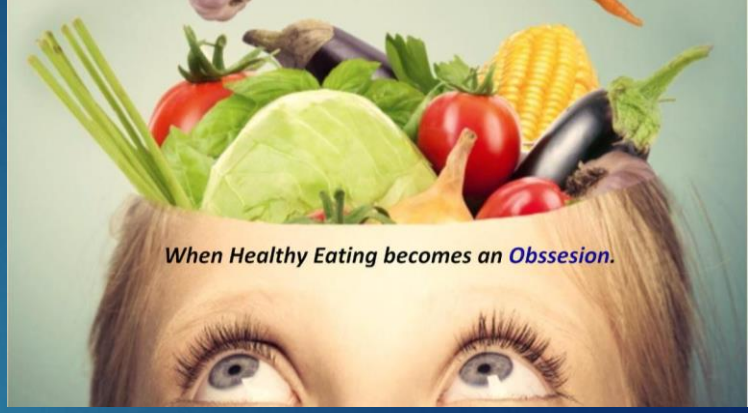
Binge Eating Disorder
Medication Strategies

- **Stimulants**
  - Vyvanse – has FDA approval
    - Dosages of 50-70mg were most effective
    - Low dosage such as 30mg did not separate from placebo
  - Methylphenidate has positive evidence as well
    - Suggests that it is not Vyvanse in particular but stimulant medications as a class that are effective in binge eating.
  - Therapeutic effect is not via appetite suppression
  - Is binge eating more impulse control disorder or an addictive disorder?

Binge Eating Disorder Medication Strategies

- Atomoxetine
  - Decreased obsessive cravings
  - Decreased binge eating and decreased weight
- Duloxetine
  - Decreased binge eating
- Topiramate
  - reduced binge eating and promoted weight loss
- Zonisamide
  - reduced binge eating and promoted weight loss
- Acamprosate and naltrexone have not shown clear efficacy

Orthorexia nervosa



- Obsessive focus on healthy eating causing risk to an individual's health
  - Strict dietary theory and set of beliefs about food
  - Compulsive checking of food ingredients
  - Inability to eat anything other than a narrow group of foods deemed "healthy" or "pure"
  - Extreme emotional distress in response to food choices that are perceived as unhealthy
  - Mental preoccupation (Spending hours a day thinking about food or researching diets/health)
  - May or may not have cognitive distortions re body image/weight
- May be a form of Obsessive Compulsive Disorder (OCD)
- Treated with cognitive behavior therapy and graded exposure to feared foods to restore variety.
- Not a formal diagnosis in DSM-V

ARFID (avoidant/restrictive food intake disorder)

- Failure to thrive in a child due to chronic starvation that is **not** driven by fear of weight gain.
  - Do not need to be underweight for diagnosis.
  - Often only eat bland "kid" foods (mac and cheese, vanilla ice cream)
  - Stick to only one brand of food
  - Co-morbid with anxiety disorders and autism
- Fear of choking/vomiting
- Sensory issues with food taste/texture
- Lack of interest in food/lack of hunger

Food refusal is NOT about control. **It is about seeking safety.**

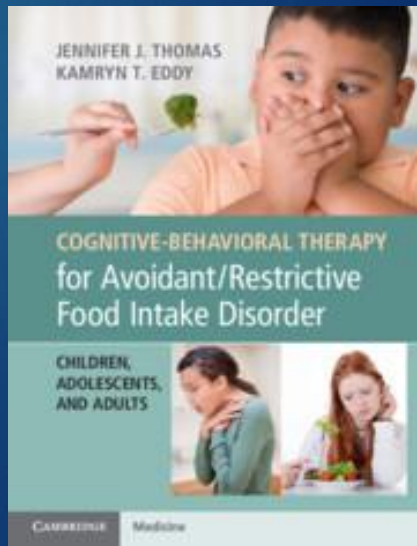
It's More than Just Picky Eating!

ARFID: Medical Evaluation

- Blood Work
  - CMP and CBC
  - Micronutrients such as Mg, Phosphorus, Zinc, Fe, Vit D, folate, B12
  - Consider total immunoglobulin IgA and tissues transglutaminase IgA for Celiac
- Physical Exam
  - cachexia, hypothermia, bradycardia, orthostatic tachycardia and hypotension, scaphoid abdomen, lanugo, and pallor
  - ECG if bradycardia or orthostatic, consider DEXA bone scan
- Differential
  - Celiac, IBS, tonsillar hypertrophy, achalasia

ARFID
(avoidant/restrictive food intake disorder)

- Treatment:
  - Occupational therapy for feeding, eating, and swallowing
    - https://ajot.aota.org/article.aspx?articleid=2652875
  - Nutritionist
  - Cognitive Behavioral Therapy
    - Includes graded exposure to previously avoided foods
    - Mass General has published a free CBT-AR workbook
      - www.tinyurl.com/4nwtwuvm



What Does CBT-AR look like?

4 stages over 20-30 sessions

1

LEARN ABOUT ARFID AND MAKE EARLY CHANGES

Keep records to figure out what maintains your symptoms; if you are underweight, increase the volume of your preferred foods; make early changes to variety

2

CONTINUE EARLY CHANGES AND SET BIG GOALS

Set goals to face your fears; continue increasing volume and/or food variety

3

FACE YOUR FEARS

Gain exposure with new or feared foods; taste small amounts at first, then incorporate larger amounts

4

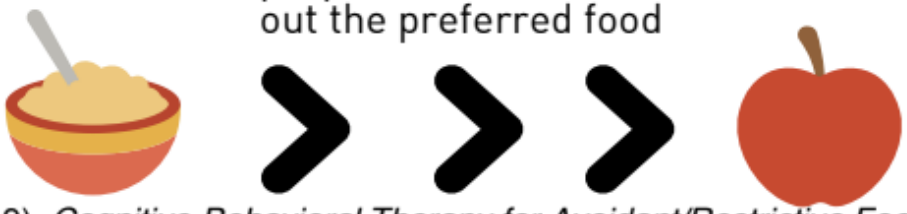
PREVENT RELAPSE

As part of completing treatment, develop a skills plan to keep practicing on your own

Here are some strategies for incorporating new foods into your meals and snacks at home

1 Fade it in

Start with a high proportion of a preferred food (e.g., applesauce) and add a small portion of a novel food (e.g., pieces of raw apple). Then gradually increase the proportion of the novel food while fading out the preferred food



Thomas, J.J. and Eddy, K.T. (2019). *Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, & Adults.* Cambridge: Cambridge University Press.

2 Add some spice

Preferred condiments and spices can act as training wheels for trying new foods. For example, add cheese to your broccoli, ketchup to your meat, ranch dressing to your carrots, or garlic salt to vegetables

3 Chain to a goal

Use a preferred food to chain to a novel food. For example, if you currently prefer potato chips, try veggie chips. Before you know it, you might feel comfortable trying raw veggies!

4 Switch it up

If at first you don't succeed, try, try again -but change it up! Try different presentations of novel foods. Think cooked versus raw, salted versus unsalted, etc

5 Deconstruct

If you have never tried a new food like pizza, try starting with one component of the food and then layering on individual components one-by-one. For example, try crust alone, then crust with cheese, then crust with cheese and sauce, and, finally, a slice of pizza!

Strategies for Eating Enough

1. Reduce discomfort after eating

Interoceptive exposures

*Increasing your tolerance of full sensations can help you eat enough

*Types of exposures you can do with your therapist in session are: pushing your belly out, gulping water, and spinning in a chair
- -Try all three and then practice the hardest
- -Plan practices as homework (e.g., chug several full glasses of water before lunch each day)

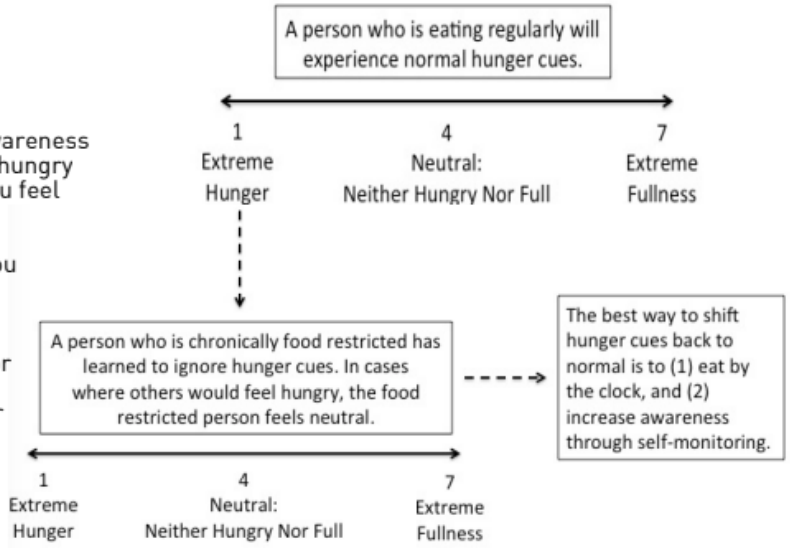
2. Increase your hunger

Recognizing Hunger Cues

*Over time, eating too little confuses your hunger and fullness cues

*The best way to help increase your awareness of hunger cues is to keep track of how hungry you feel before you eat, and how full you feel afterward

*To begin shifting your hunger cues, you will need to start eating at a 3 or 4 (neither hungry nor full), rather than waiting for a 1 (extreme hunger). You will also need to keep eating until a 6 or a 7 (extreme fullness), rather than stopping at a 4 or 5 (neither hungry nor full)



3.Increase enjoyment of eating

Notice what you like about your preferred foods

*Remind yourself of foods you have eaten during happy occasions, such as eating birthday cake with your friends and family

*Pick 5 foods you prefer or used to really enjoy and closely describe them using "The Five Steps" handout

ARFID
(avoidant/restrictive food intake disorder)

Medication Treatment

- Low dose olanzapine (1.25mg) or cyproheptadine an hour prior to meals
- Mirtazapine to increase appetite and reduce nausea
- SSRIs to reduce anxiety

Autism and ARFID

- Children with autism are 5 times more likely to have feeding and eating problems.
- Estimates of co-occurring ARFID and ASD range from 12.5% all the way up to 33.3% (Harris et al., 2019; Inouye 2021).
- Sensory Sensitivity
  - Sensory challenges and inability to tolerate food textures or food tastes
- Cognitive Rigidity/ Insistence on routine
  - Individuals with autism tend to feel safer with sameness and may resist changes to food type/routine.

For these children, food refusal is NOT about control. **It is about seeking safety.**

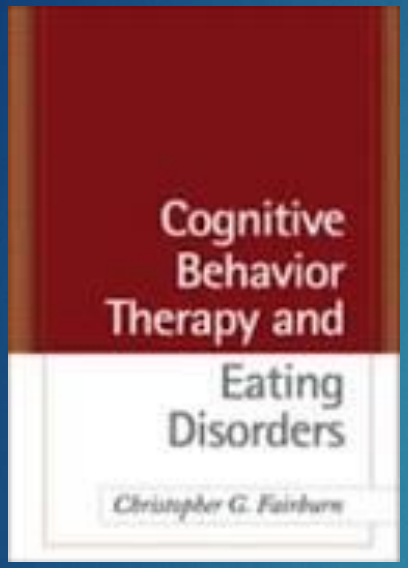
Eating Disorder Resources

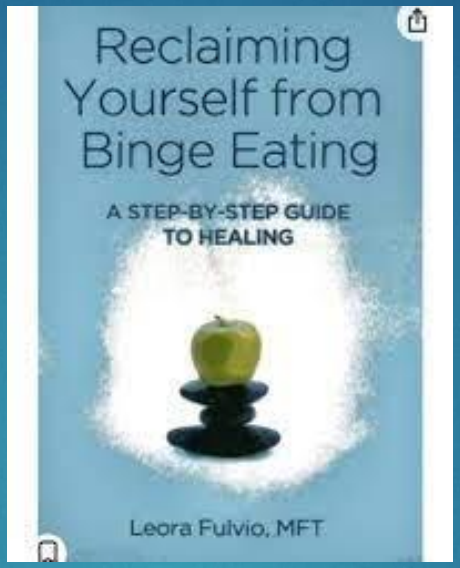
- NIMH pamphlet on eating disorders
  - https://www.nimh.nih.gov/health/publications/eating-disorders
- CBT-AR pamphlet
  - www.tinyurl.com/4nwtwuvm
- Podcast
  - https://recoverywarriors.com/podcasts/

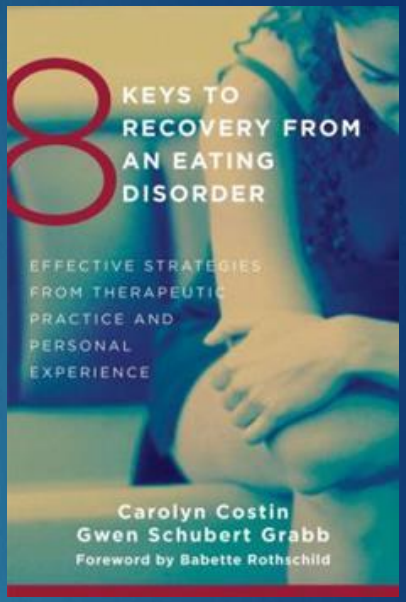
Eating Disorder Websites

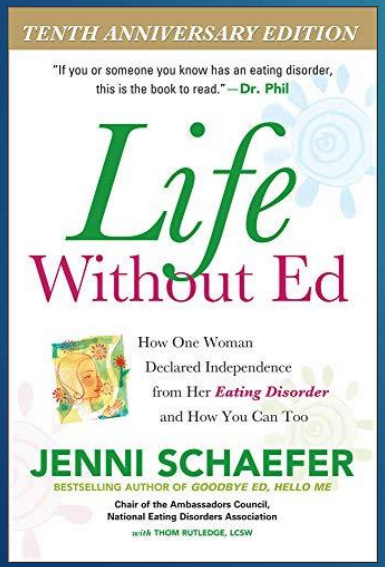
- **National Alliance For Eating Disorders**
  - https://www.allianceforeatingdisorders.com/
  - Supporting a spouse article
    - https://www.allianceforeatingdisorders.com/dos-and-donts-supporting-spouse-through-eating-disorder-recovery/
- **Academy for Eating Disorders**
  - https://www.aedweb.org/home
- **National Eating Disorders Association**
  - www.nationaleatingdisorders.org
  - www.thebodypositive.org
- **Recovery Warriors**
  - https://recoverywarriors.com/
- **International Association of Eating Disorder Professionals**
  - https://iaedp.site-ym.com/
- **Youtube video on treating ARFID**
  - https://www.youtube.com/watch?v=kx_uhFihxy8

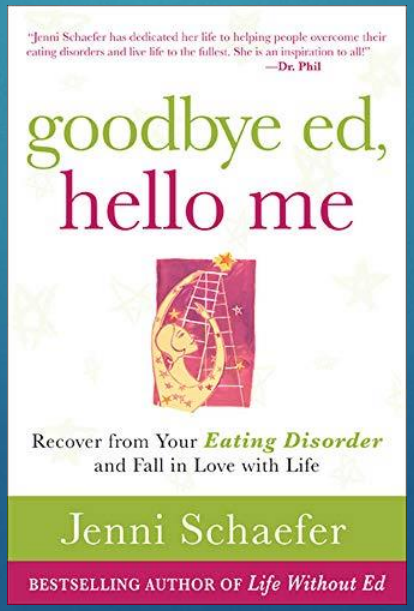
Some of my favorite books….

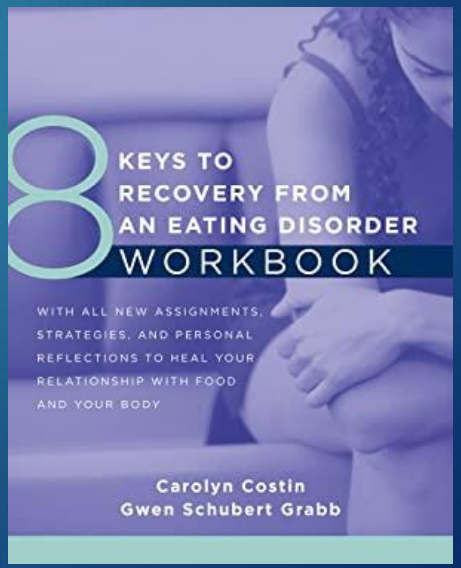












Eating Disorder Books

- It's Not About Food: End Your Obsession with Food and Weight by Carol Emery Normandi MFT and Laurelee Roark

- Banish Your Body Image Thief: A Cognitive Behavioral Therapy Workbook on Building Positive Body Image for Young People. by Kate Collins-Donnelly

- Life Without Ed: How One Woman Declared Independence From Her Eating Disorder and How you Can to. By Jenni Schaefer

- The Body Image Workbook: An Eight-Step Program for Learning to Like your Looks. by Thomas Cash, PhD.

- 8 Keys to Recovering from an Eating Disorder: Effective Strategies from Therapeutic Practice and Personal Experience. By Carolyn Costin and Gwen Schubert –also comes as a workbook

Eating Disorder Resources

- For Clinicians
  - https://academic.oup.com/ijnp/article/15/2/209/655624
  - https://focus.psychiatryonline.org/doi/pdf/10.1176/appi.focus.120401
  - https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders-guide.pdf
  - https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders-watch.pdf
- Jenni's Song
  - https://jennischaefer.com/music/

Email stacygreetermd@gmail.com to be invited to future presentations.

- Please visit my website for access to psychiatry bootcamp power point slides:
  - https://www.stacygreetermd.com/psychiatry-boot-camp


It's just a phase all teenagers go through. They'll grow out of it.
She's just needs to stop being so superficial!
Her friends or her parents must have caused this.
Shame
Secrecy
Self-loathing
I wish I had an eating disorder, then I could finally lose some weight.
She's just been looking at too many magazines.
You don't look like you have an eating disorder!
Geez, just eat a cheeseburger.
Doesn't everyone have an eating disorder these days.

You're not alone.
I'm with you.

I believe in your ability to fight this illness.

You're being so strong.

This is so hard.

Help me understand what you're going through.

Thank you for sharing this painful thing with me.

You did not choose this illness. You choose what you do next.

You are so much more than the shape of your body.

Discussion Questions

- What scares you most as a clinician treating eating disorders?
  - How do you handle this?
- How can psychiatrists (and other medical professionals) support eating disorder treatment better?
- Ideas for enhancing knowledge of eating disorders in both medical and mental health professionals in our community?
- Ideas for decreasing shame/stigma?

Any Other Questions For Me?