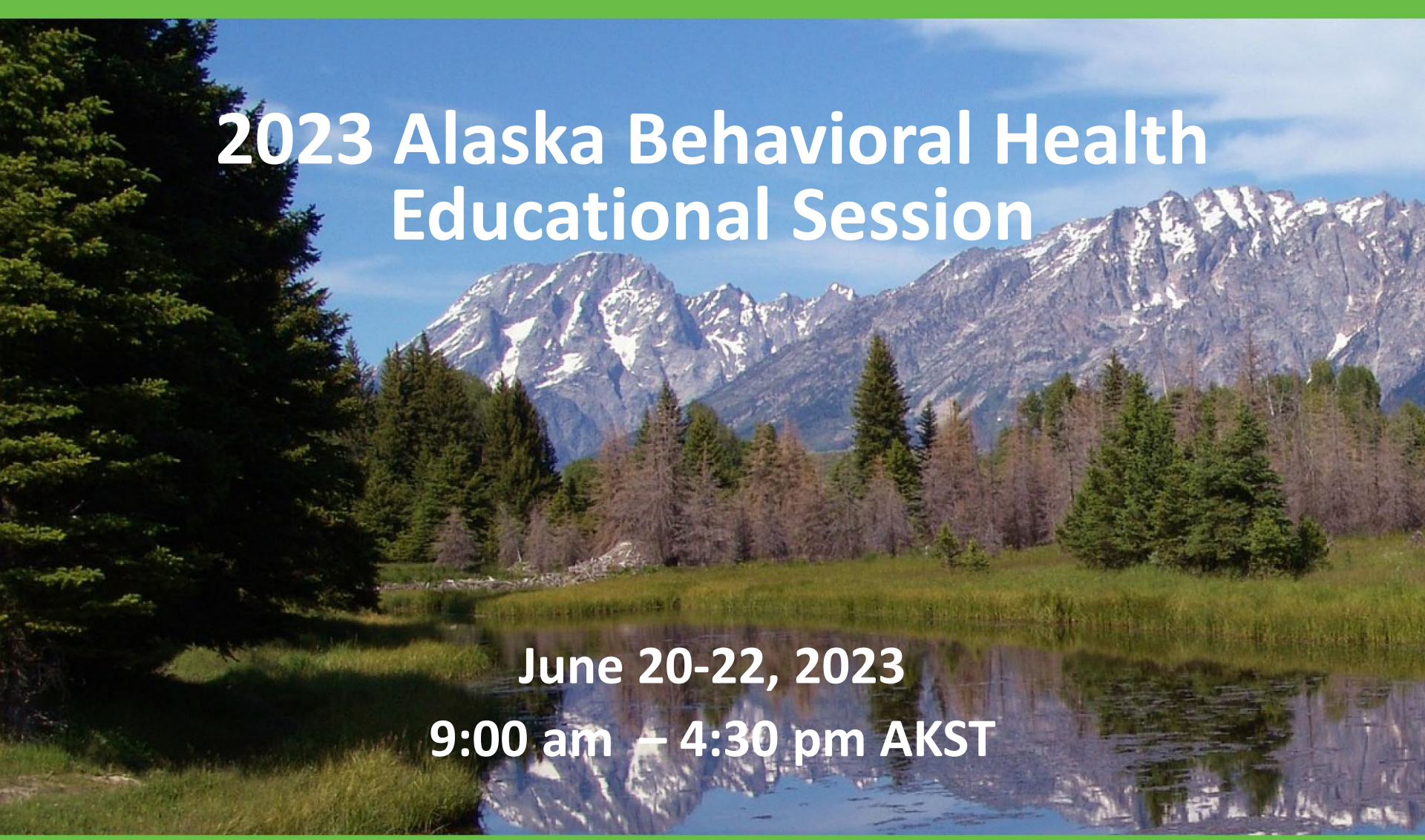


2023 Alaska Behavioral Health Educational Session

June 20-22, 2023

9:00 am – 4:30 pm AKST

Comagine Health

Comagine Health

Welcome and Introduction

Yvette Stratton, RN, BSN, CCM

Executive Director, Care Management, Comagine Health

Welcome to Forging Partnerships to Provide Optimum Behavioral Health Services for Alaska's Youth

Approved Provider Statements:

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, this activity has been planned and implemented by Alaska Native Medical Center (ANMC) and UAA Alaska Center for Rural Health and Health Workforce - Alaska's AHEC. ANMC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

CPE Credit will be posted to the online CPE Monitor system within 60 days following completion of each activity when applicable.

Contact Hours:

ANMC designates this activity for a maximum of 11.75 contact hours, commensurate with participation.

Financial Disclosures:

None of the presenters and planners for this educational activity have any relevant relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Requirements for Successful Completion:

To receive CE credit please make sure your attendance is recorded, actively engaged in the entire activity, and completed the course evaluation form.

For more information contact
jlfielder@anthc.org or (907) 229-1185

ALASKA NATIVE MEDICAL CENTER

Comagine Health

Eating Disorder (ED) Overview and Introduction

Beth Rose, MPA, Co-Founder and Board Chair AKEDA

Jenny Loudon, MPA, Co-Founder and Board Vice-Chair AKEDA

Grace Schumacher, RDN, CEDRD, OTS, Dietitian Nutrition Therapist, Nutrition Partnership, LLC

Introduction to Eating Disorders – A Medical, Mental, and Public Health Crisis

Presentation by

Jenny Loudon, MPA
Beth Rose, MPA,and
Grace Schumacher, RD, CEDS
Alaska Eating Disorders Alliance Co-Founders and Board Member

AKEDA
Alaska Eating Disorders Alliance



ABOUT THE ALASKA EATING DISORDERS ALLIANCE

Mission Statement

To provide help and inspire hope by engaging our diverse communities for Alaskans affected by eating disorders.

- Education
- Support
- Advocacy
- Body Confidence



Presentation Road Map



1. Myths and Truths of Eating Disorders
2. Evolution of eating disorder diagnoses – how we got here
3. Overview of eating disorder diagnoses
4. Social and economic costs of eating disorders

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MYTHS AND TRUTHS OF EATING DISORDERS

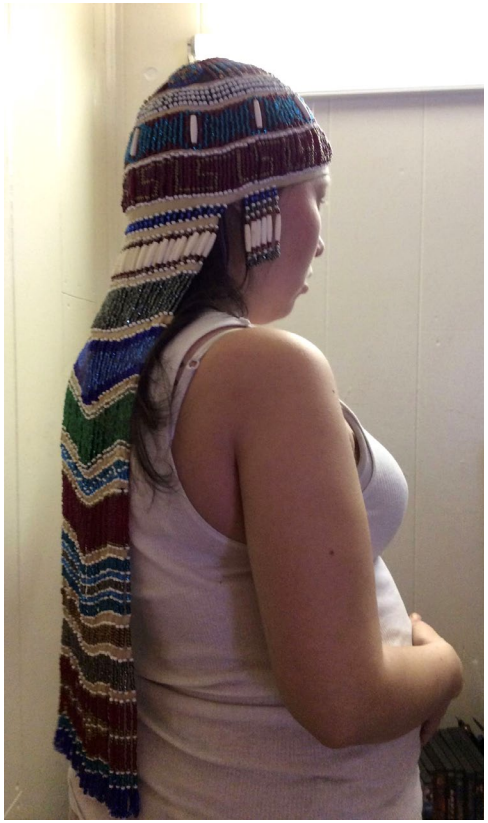
Eating Disorders – The Basics

Real, life-threatening illnesses with potentially fatal consequences.

Include severe disturbances in eating behaviors, patterns, and thoughts.

Involve extreme emotions, attitudes, and behaviors surrounding weight, food, and size.

Who Do Eating Disorders Affect?



- **Everyone.** People of all genders, ages, races, religions, ethnicities, sexual orientations, body shapes, and weights can be affected.
- As many as **20 million women** and **10 million men** will struggle with an eating disorder at some point in their lives.
- Estimated **65,000** Alaskans will experience an eating disorder.

Who is At High Risk?



- Adolescents (<25 years)
- Patients with medical morbidity (polycystic ovarian syndrome, diabetes, gastrointestinal complaints)
- Athletes
- Patients with a family history of eating disorders
- Patients seeking help for weight loss
- Active-duty Military, Military Dependents, and Veterans
- LGBTQ+
- Patients with certain temperaments
- Individuals in key transition periods

Causes of Eating Disorders



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Who Gets Treatment?

Most people with an eating disorder do not receive treatment

Various studies showing 20-57% of people with eating disorders never receive treatment

Patients with public insurance are one-third as likely to receive recommended treatment as patients with private insurance.

Research | Open Access | Published: 24 January 2023

Disparities in access to eating disorders treatment for publicly-insured youth and youth of color: a retrospective cohort study

Ruby Moreno, Sara M. Buckelew, Erin C. Accurso & Marissa Raymond-Flesch

Journal of Eating Disorders **11**, Article number: 10 (2023) | Cite this article

2075 Accesses | **2** Citations | **380** Altmetric | Metrics

People of color are significantly less likely to receive help for their eating issues

Ethnicity and differential access to care for eating disorder symptoms

Anne E Becker [1], Debra L Franko, Alexandra Speck, David B Herzog

Affiliations + expand

PMID: 12616587

DOI: 10.1002/eat.10129

www.akeatingdisordersalliance.org

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Nine Truths about Eating Disorders

TRUTHS

1. Many people with eating disorders look healthy, yet may be extremely ill.
2. Families are not to blame, and can be the patients' and providers' best allies in treatment.
3. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.
4. Eating disorders are not choices, but serious biologically influenced illnesses.
5. Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses.
6. Eating disorders carry an increased risk for both suicide and medical complications.
7. Genes and environment play important roles in the development of eating disorders.
8. Genes alone do not predict who will develop eating disorders.
9. Full recovery from an eating disorder is possible. Early detection and intervention are important.



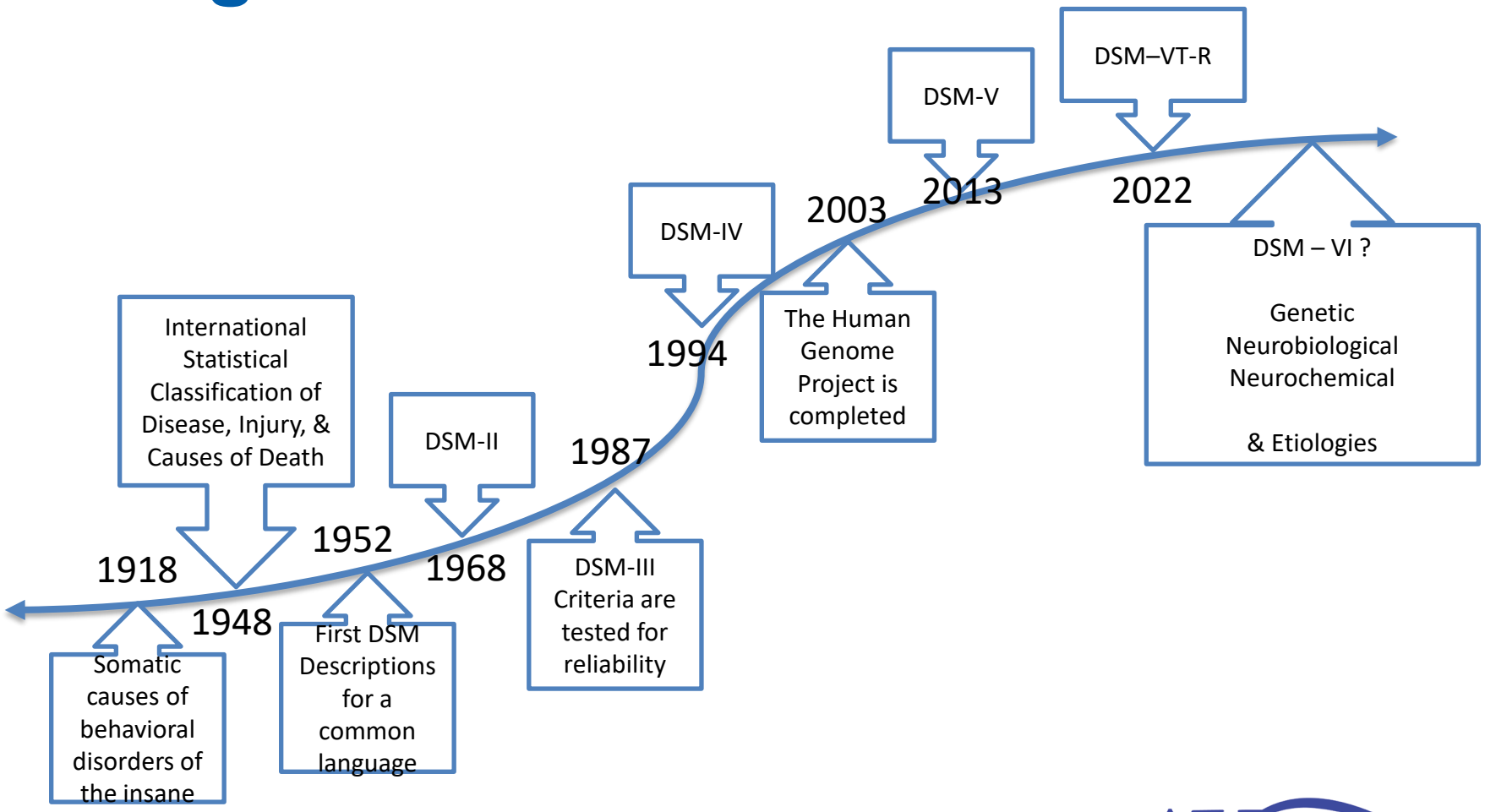
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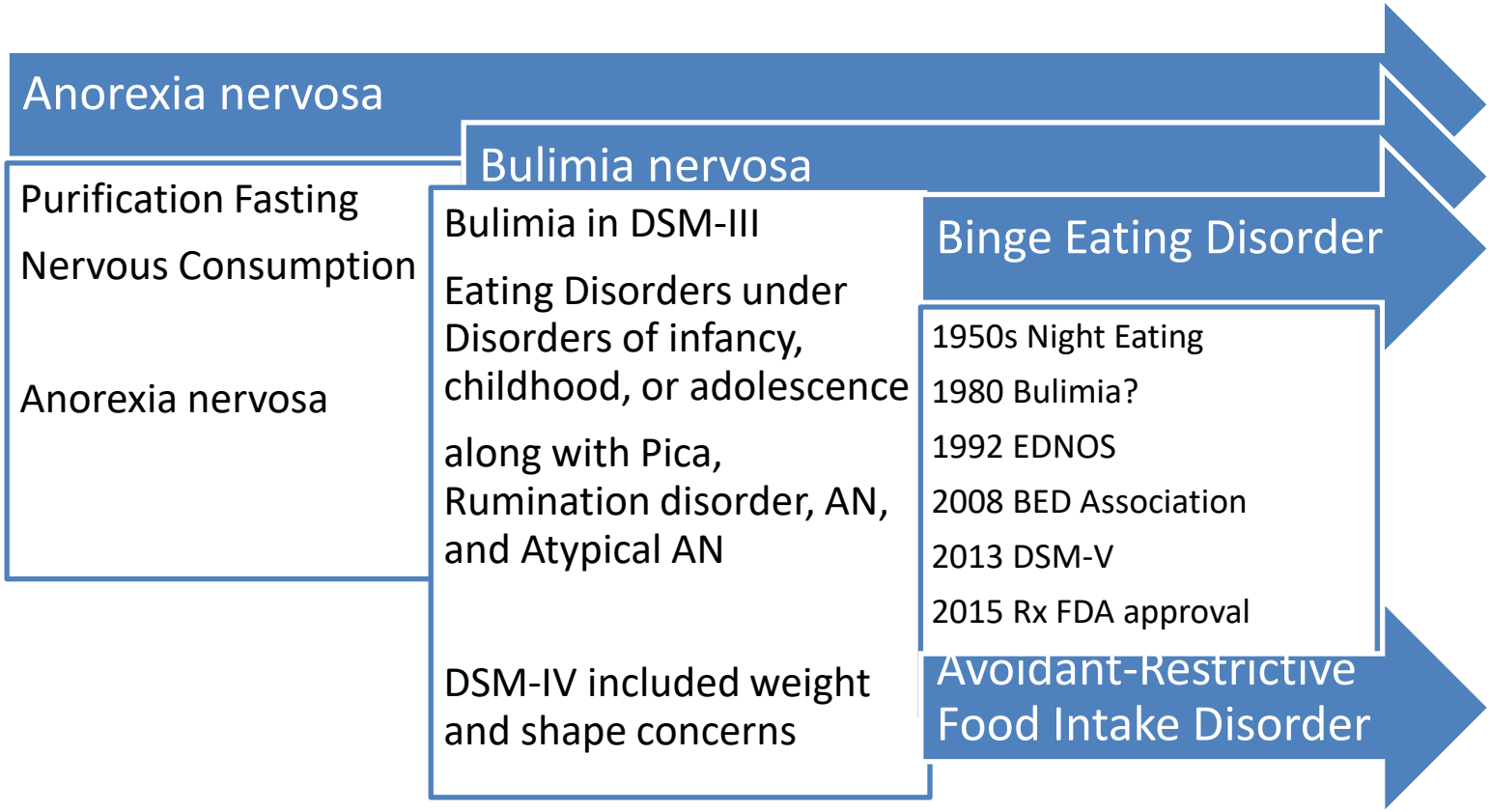
EVOLUTION OF EATING DISORDER DIAGNOSES – HOW WE GOT HERE

Historical Evolution of the Diagnostic and Statistical Manual



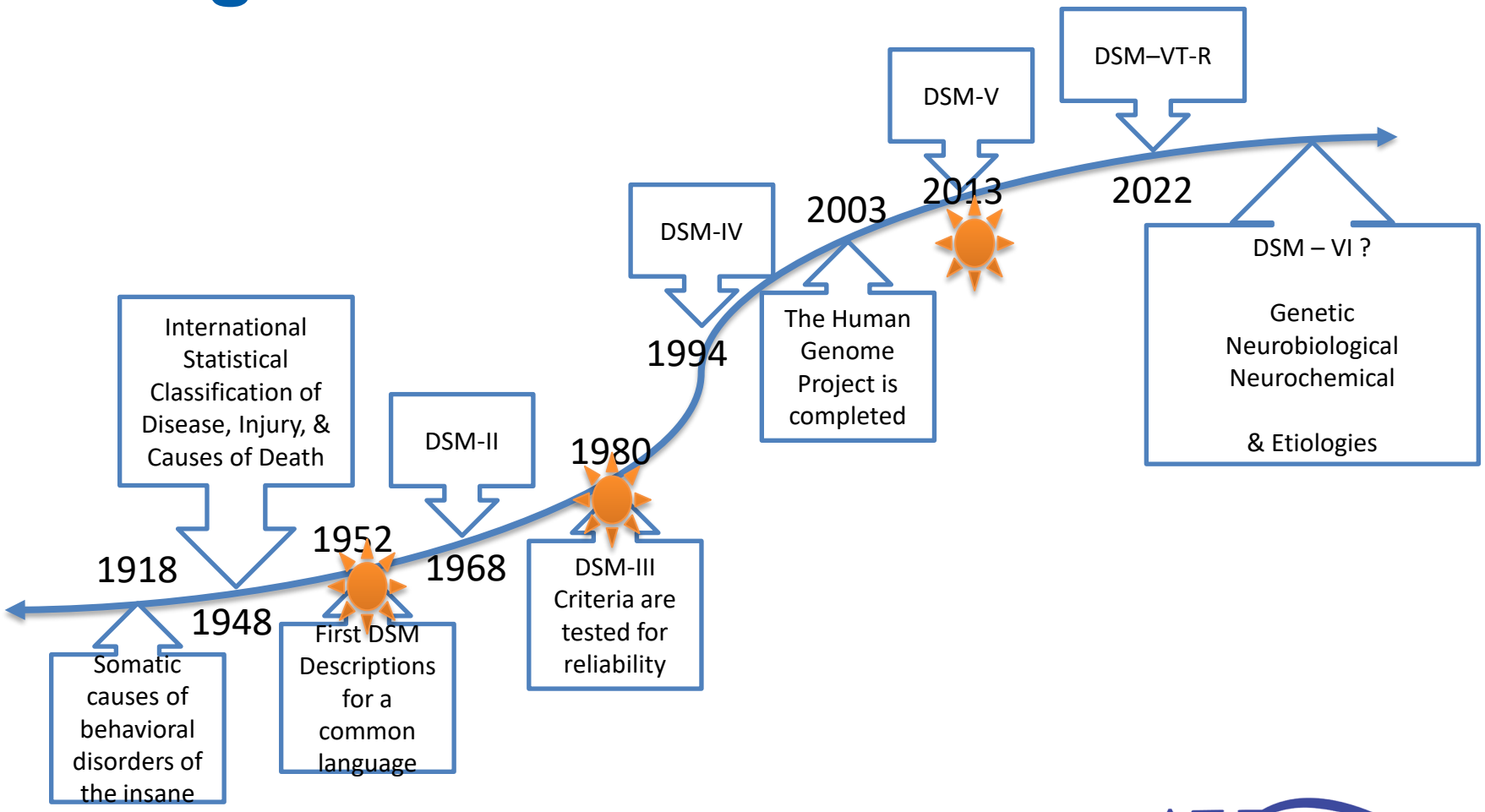
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Historical Evolution of Knowledge of Eating Disorders



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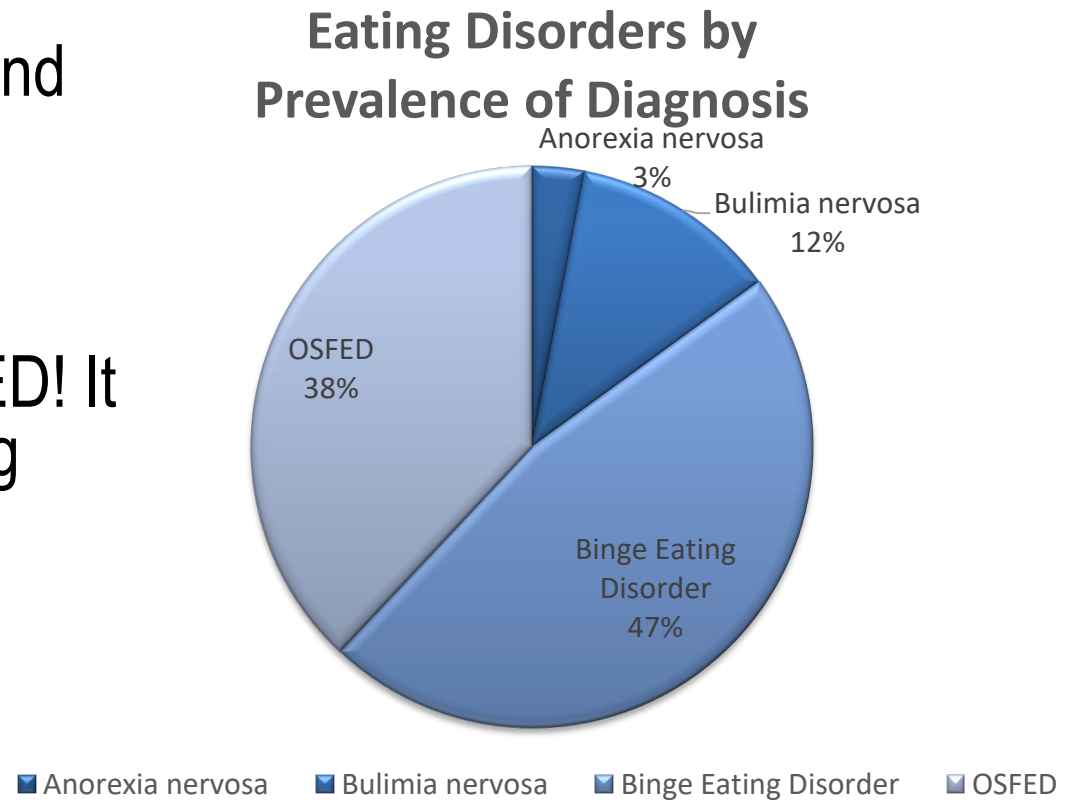
Historical Evolution of the Diagnostic and Statistical Manual



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Evolution of DSM Categories -- Commonalities

- Early identification and treatment – DON'T WAIT!
- Dieting is OUTDATED! It may trigger all eating disorder types.
- Healing is possible!



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EATING DISORDER DIAGNOSES, SIGNS & SYMPTOMS

Disordered Eating or Eating Disorder?



Helpful questions to ask

1) Do you eat differently when you are by yourself or with others?
2) How much time do you think about food or your body?
3) How much is food or exercise impacting your life?



DSM5 Diagnoses

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Other Specified Feeding or Eating Disorder (OSFED)
- Avoidant-Restrictive Food Intake Disorder (ARFID)
- Pica
- Rumination Disorder
- Unspecified Feeding or Eating Disorder (UFED)

Other Specified Feeding and Eating Disorders (OSFED)

- Most common eating disorder diagnosis
- Patient experiences significant distress and impairment, while not meeting full diagnostic criteria for any other disorder.
- Examples:
  - Patient who engages in restriction or binge or purge behaviors but at lower frequency or limited time;
  - Atypical anorexia
  - Purging disorder
  - Night eating syndrome

Binge Eating Disorder (BED)

- Characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.
- **Symptoms include:**
  - Indications that the binge eating is out of control, such as eating when not hungry, eating to the point of discomfort, or eating alone because of shame about the behavior
  - Feelings of strong shame or guilt regarding the binge eating

Bulimia Nervosa (BN)

- Characterized by **binge eating** and **compensatory behaviors**, such as self-induced vomiting, in an attempt to undo the effects of binge eating.
- **Symptoms include:**
  - Frequent episodes of consuming very large amounts of food followed by behaviors to prevent weight gain, such as vomiting, laxative abuse, and/or excessive exercise
  - Feeling of being out of control during the binge-eating episodes
  - Extreme concern with body weight and shape
  - Most people are of a normal weight

Anorexia Nervosa (AN)

- Characterized primarily by self-starvation and excessive weight loss
- **Symptoms include:**
  - Inadequate food intake leading to a weight that is clearly too low
  - Disturbance in the experience of body weight or shape
  - Intense fear of weight gain, obsession with weight, and persistent behavior to prevent weight gain
  - Inability to appreciate the severity of the situation

Atypical Anorexia Nervosa

Same behavioral and medical signs & symptoms, as well as risks as anorexia nervosa.

More common than anorexia in the general population (.1 % vs 3% prevalence)

2x death rate to age-matched peers, yet often underdiagnosed.

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Co-Occurring Behavioral Health Disorders

- High prevalence rates
- Can intensify eating disorders symptoms and impact treatment (recovery, level of care, drop-out)
- Most common comorbidities: Mood disorders, anxiety, substance abuse, post-traumatic stress disorder, obsessive-compulsive disorder, self-injury
- Treatment should address co-existing conditions and eating disorders

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EATING DISORDERS AS A PUBLIC HEALTH CRISIS – NATIONAL AND LOCAL PERSPECTIVES

Social and Economic Costs -- Prevalence

SOCIAL & ECONOMIC COST OF EATING DISORDERS IN THE UNITED STATES

Report by the Strategic Training Initiative for the Prevention of Eating Disorders, Academy for Eating Disorders, and Deloitte Access Economics

STRIPED — A PUBLIC HEALTH INCUBATOR — Strategic Training Initiative for the Prevention of Eating Disorders

LINK TO REPORT

Academy for Eating Disorders — AED

PREVALENCE & MORTALITY



Percent of the U.S. population, or **28.8 million Americans**, that will **have an eating disorder in their lifetime**

10,200 deaths per year as a direct result of an eating disorder, equating to **1 death every 52 minutes**



EATING DISORDERS AFFECT EVERYONE:



- **All ages**, starting as young as 5 years old to over 80 years old
- **All races**, however, people of color with eating disorders are **half as likely to be diagnosed or to receive treatment**[1]
- **All genders**, with females being **2x more likely to have an eating disorder**
- **All sexual orientations**

Social and Economic Costs

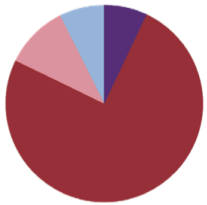
COST TO ECONOMY & SOCIETY

$64.7 Billion } Yearly economic cost of eating disorders

Additional loss of wellbeing per year { **$326.5 Billion**

Cost Breakdown:

- Productivity Losses ($48.6B)
- Informal Care ($6.7B)
- Efficiency Losses ($4.8B)
- Health System ($4.6B)



COST TO HOSPITAL SYSTEMS:

53,918 ER visits



costing **$29.3M**

23,560 inpatient hospitalizations



costing **$209.7M**

LOSS PER GROUP:



$23.5B Individuals & Families

Caregivers provide 6 weeks of informal, unpaid care per year



$17.7B Government



$16.3B Employers



$7.1B Society

[1]Sonneville KR, Lipson SK. Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. International Journal of Eating Disorders 2018: 1-9.

@HarvardSTRIPED @harvardstriped @STRIPED.Harvard

EDC EATING DISORDERS COALITION FOR RESEARCH, POLICY & ACTION

NEDA Feeding hope. National Eating Disorders Association

IFEDD The International Federation of Eating Disorder Dietitians

THE ALLIANCE for Eating Disorders Awareness

ANAD YOUR FUTURE IS WORTH FIGHTING FOR

NCEED National Center of Excellence for Eating Disorders

iaedp. Foundation International Association of Eating Disorders Professionals

meda multi-service eating disorders association

F·E·A·S·T

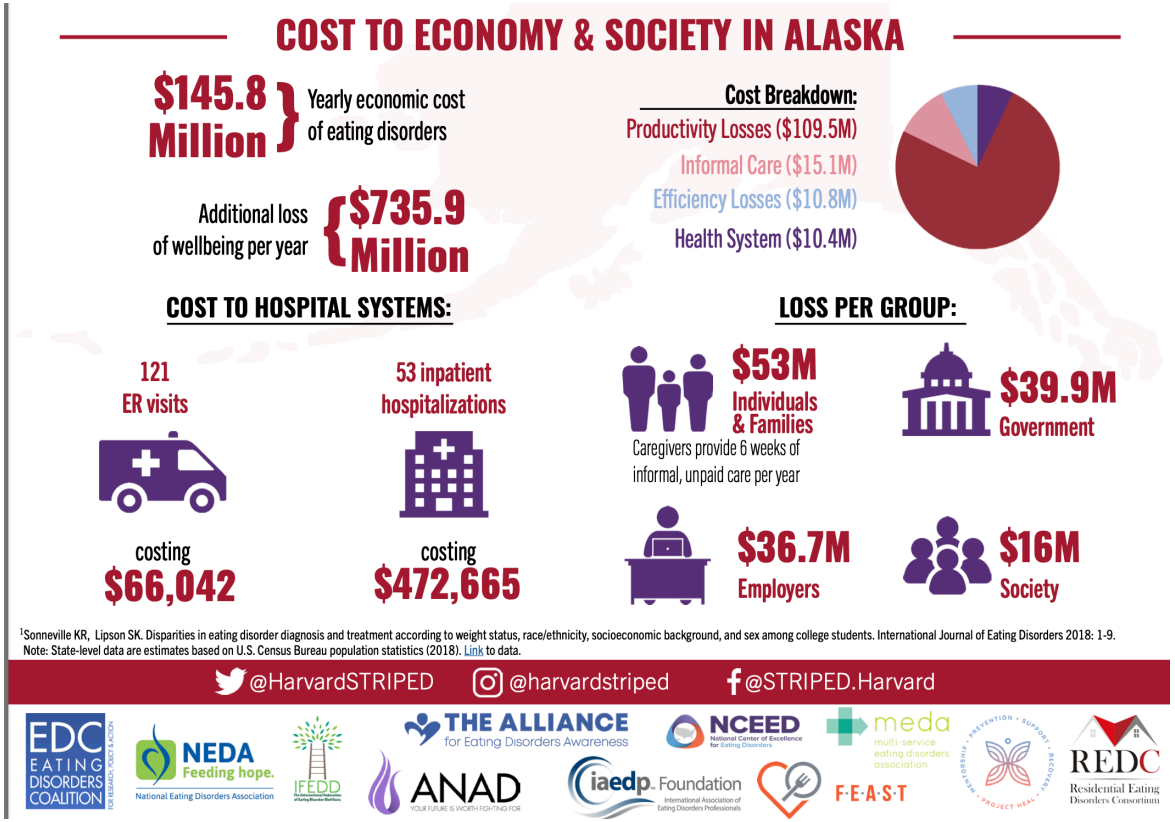
RECOVERY · SUPPORT · PREVENTION · LEADERSHIP · PROJECT HEAL

REDC Residential Eating Disorders Consortium

www.akeatingdisordersalliance.org

AKEDA Alaska Eating Disorders Alliance

Social and Economic Costs for Alaska



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Impact of Binge Eating Disorders on Daily Functioning

WHO Mental Health Survey Results

	Any Impairment		Severe Impairment	
	%	(SE)	%	SE
Work	31.2	(3.1)	4.9	(1.4)
Home management	33.9	(3.2)	5.8	(1.5)
Social life	38.1	(3.6)	8.2	(2.1)
Close relationships	35.7	(3.4)	5.4	(1.3)
Any of the above	**46.7**	**(3.4)**	**13.2**	**(2.4)**

NCEED
National Center of Excellence for Eating Disorders

PMC3628997

Impact of Binge Eating Disorders on Daily Living

WHO Mental Health Survey Results

	Any Impairment		Severe Impairment	
	%	(SE)	%	SE
Work	31.2	(3.1)	4.9	(1.4)
Home management	33.9	(3.2)	5.8	(1.5)
Social life	**38.1**	**(3.6)**	**8.2**	**(2.1)**
Close relationships	35.7	(3.4)	5.4	(1.3)
Any of the above	46.7	(3.4)	13.2	(2.4)

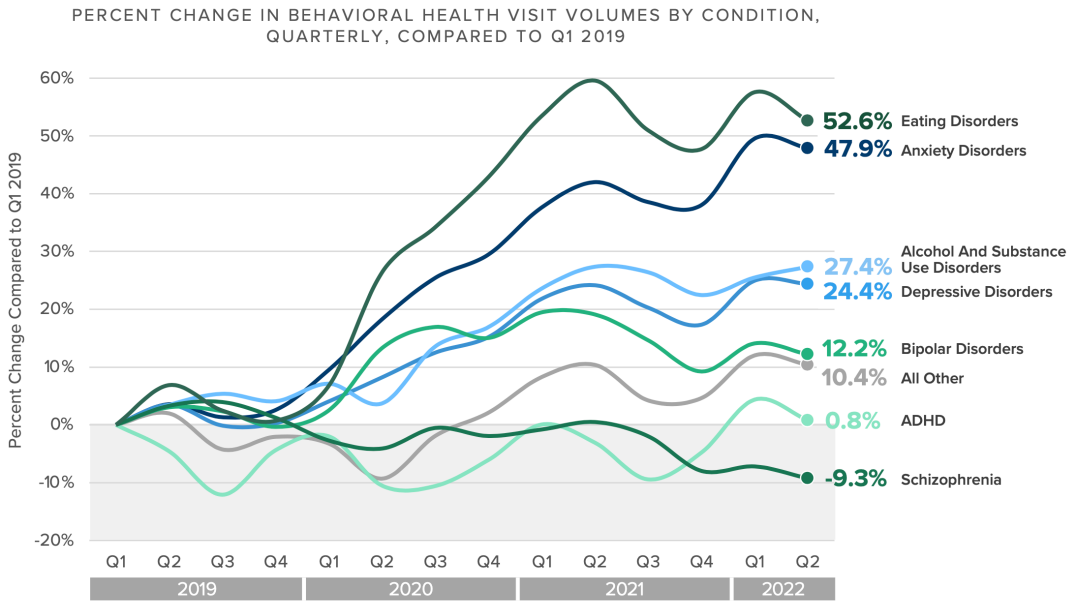
NCEED
National Center of Excellence for Eating Disorders

PMC3628997

Trends in Eating Disorders Prevalence Rates

Rate of Change in Behavioral Health Demand Varies by Condition

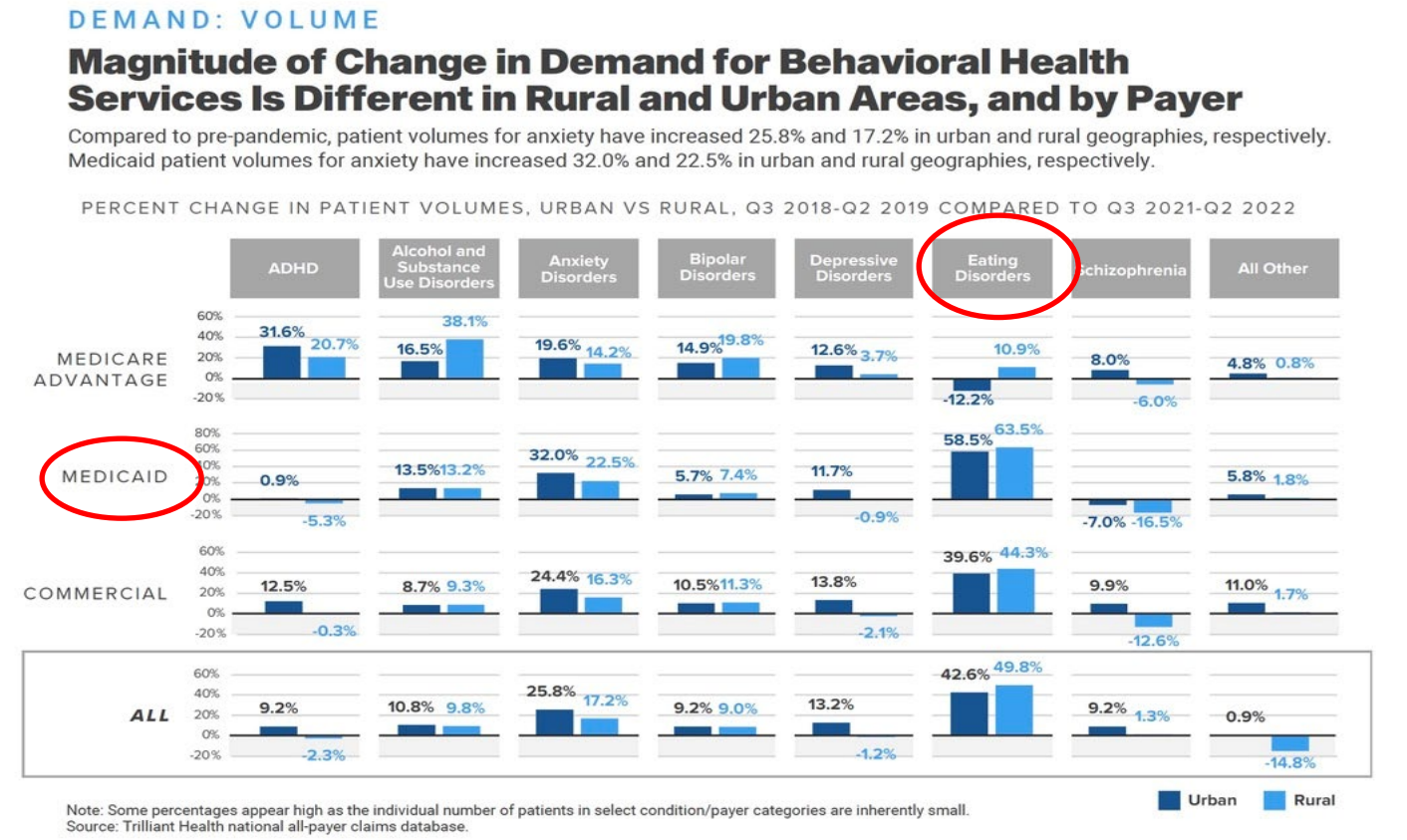
Visit volumes for eating disorders (+52.6%), anxiety disorders (+47.9%), alcohol and substance use disorders (+27.4%), depressive disorders (+24.4%) and bipolar disorders (+12.2%) have all consistently trended upwards since 2019. However, schizophrenia visit volumes were down 9.3% in Q2 2022 from Q1 2019.



Source: Trilliant Health national all-payer claims database.

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Increase in Eating Disorders Patient Volumes - Medicaid



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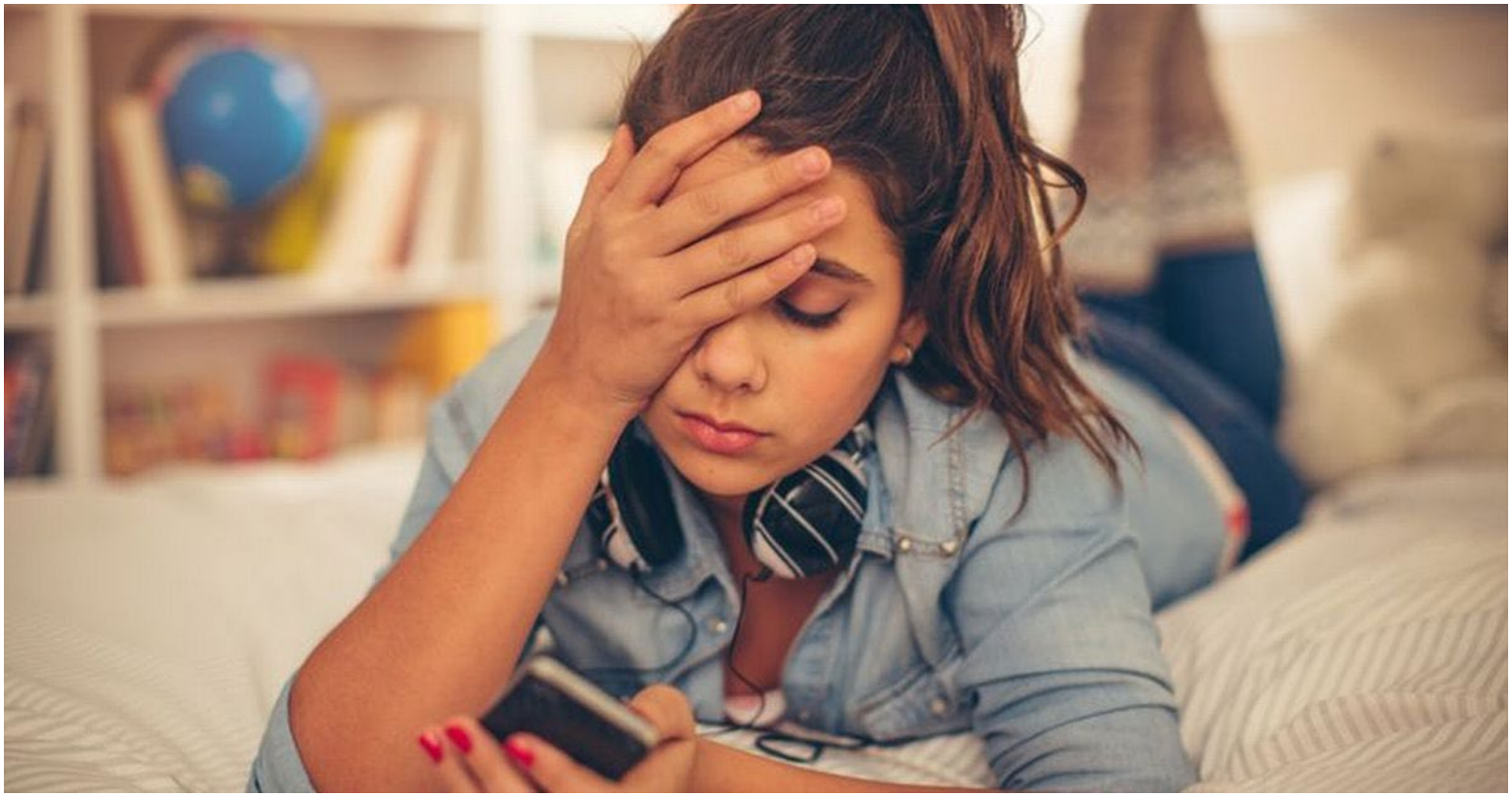
Surgeon General Dr. Vivek Murthy Issues Public Health Warning on Social Media



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Links between Social Media and Eating Disorders



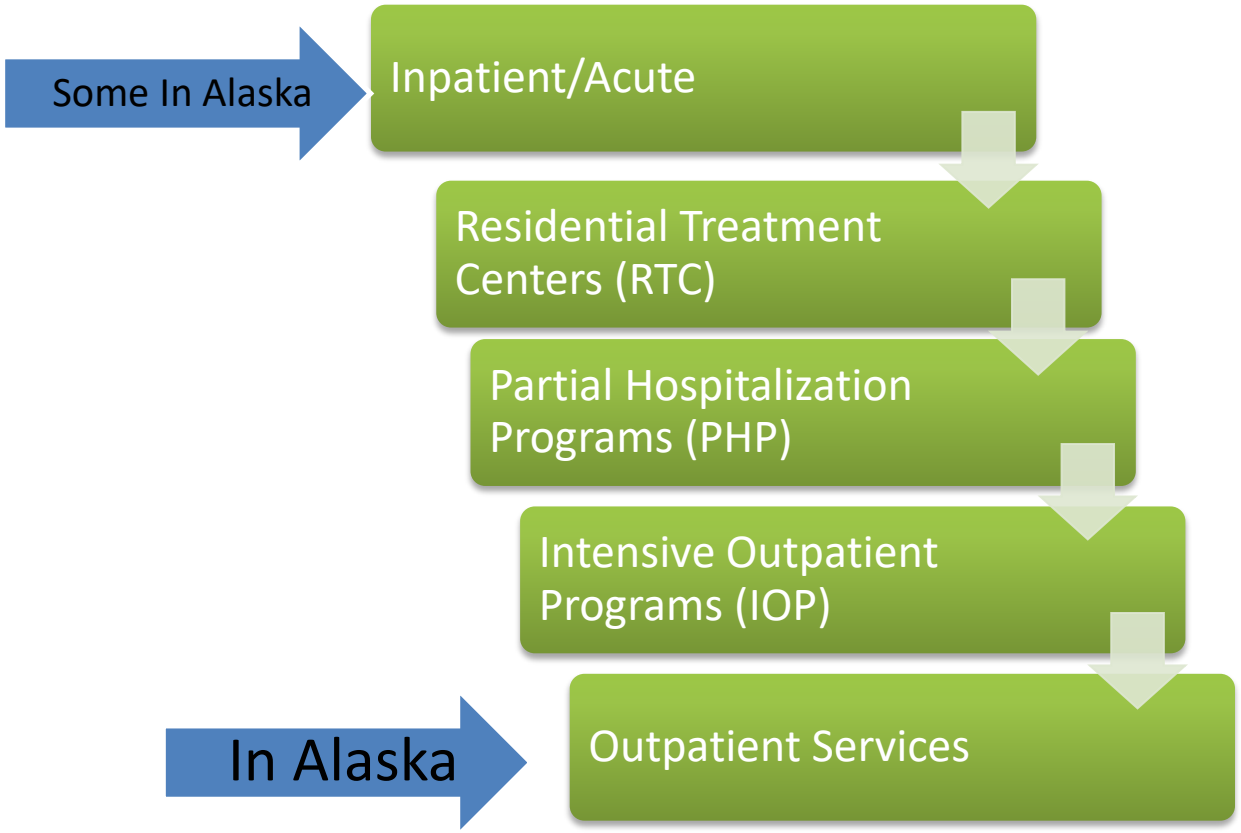
Dove Self-Esteem Project: The Cost of Beauty

- https://www.youtube.com/watch?v=2ngESNoacxM



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Treatment Levels



https://www.massgeneral.org/assets/mgh/pdf/psychiatry/edcrp_apa_2006_ed_tx_guidelines_table.pdf

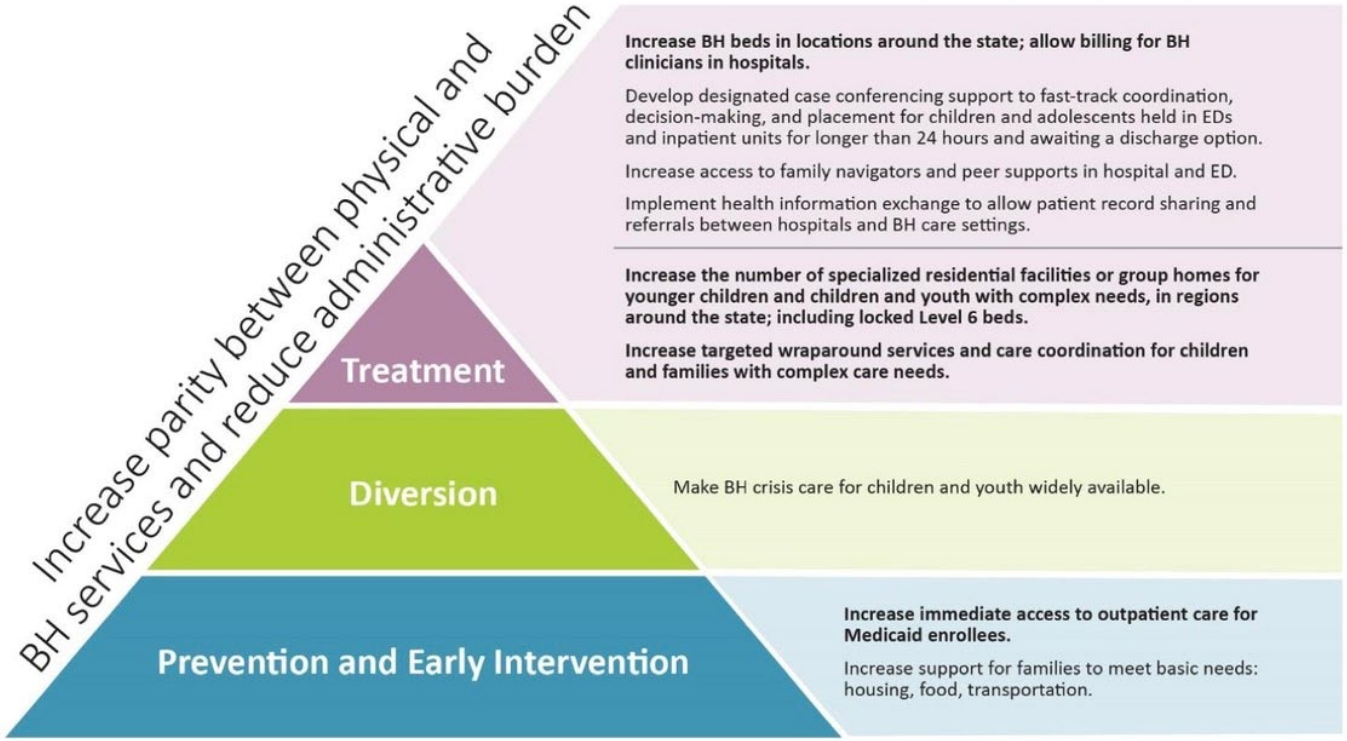
Treatment Levels



Also essential: Parent or Caregiver Training

Building on the Alaska Hospital and Healthcare Report

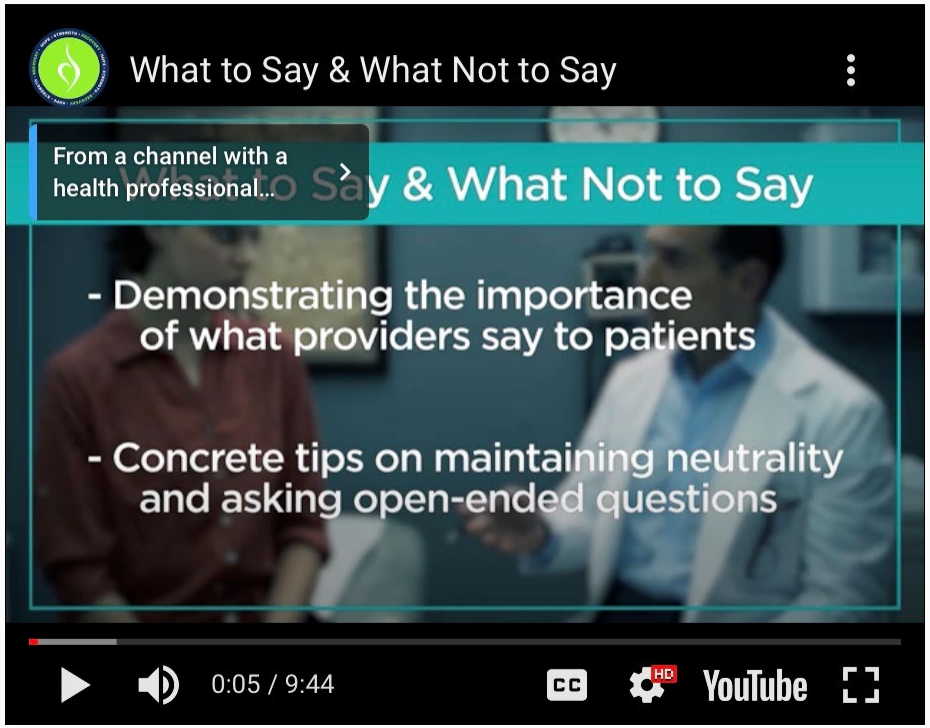
Figure 1: Prioritized Objectives for Building a Robust Continuum of Care



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What to say for Health Care Professionals

http://www.voutube.com/watch?v=MEMYVWyPNDE



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Body Image in Our Society

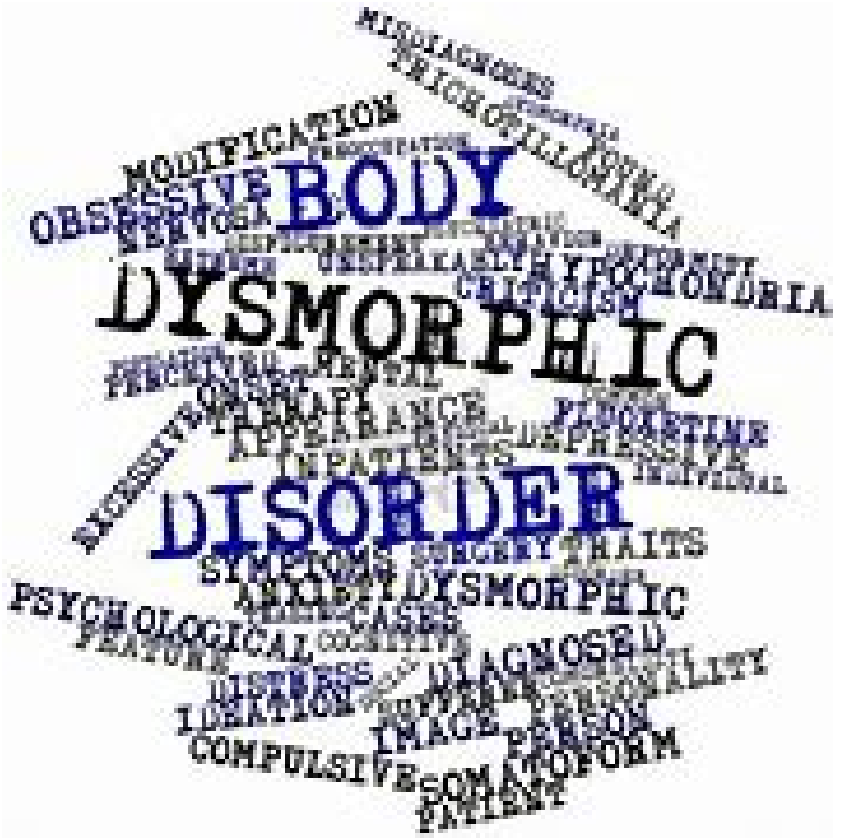
Diana Fornasier, RN, CBDCE, MSN-NP (Aus)

Cert. Diabetes ED and Management Diabetes Program Coordinator, Bristol Bay Area Health Corporation

BODY DYSMORPHIA

Body Dysmorphic Disorder (BDD)

DIANNA FORNASIER
RN, MSN-NP, CDCES



DISCLOSURE & BIO



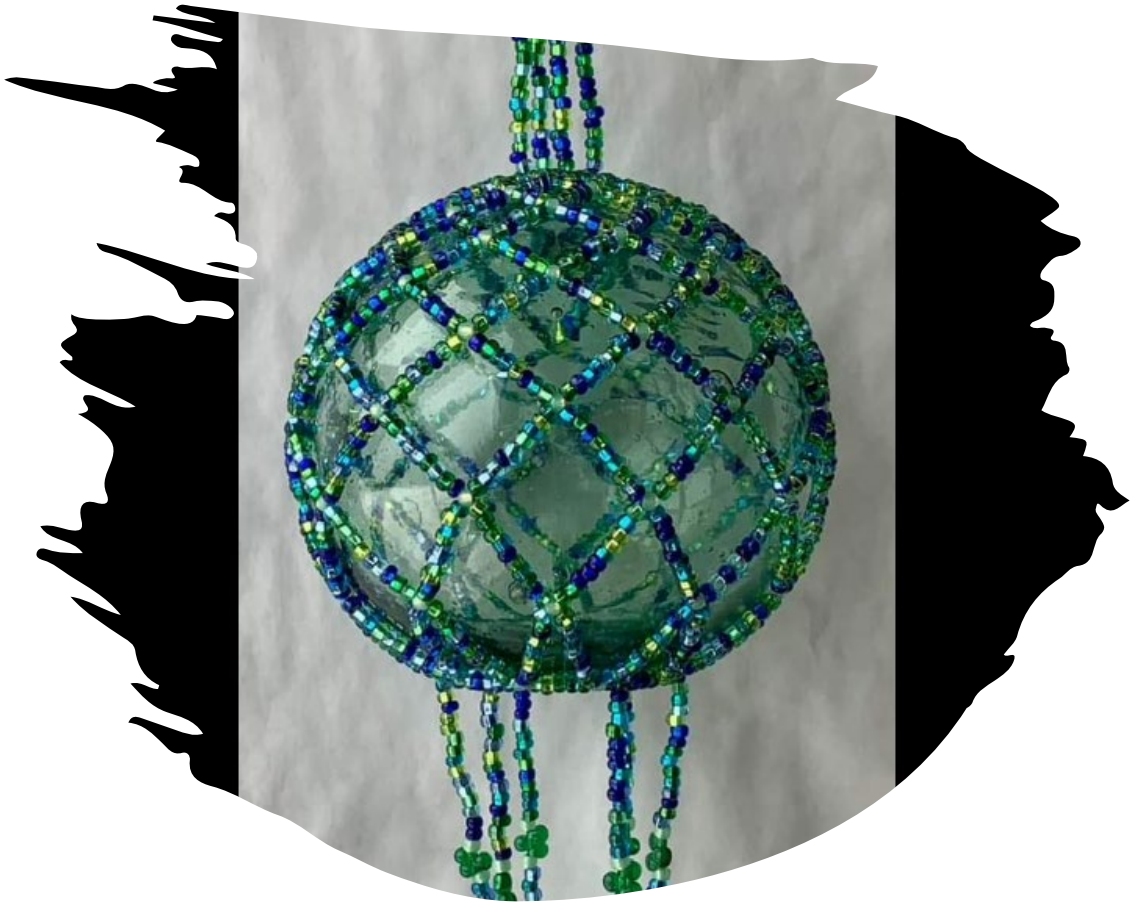
No Disclosures

Back ground

- 57years of age - Born in Australian. Lives and works in Alaska.
- Nurse Practitioner – endorsed in Australia. Master Degree in Nursing – Nurse Practitioner – 2016
- 25yrs + Working in diabetes with clients and ten years working in primary health care with patients with disorders and eating disorders
- Registered Nurse and Credentialled Diabetes Educator in both Australia and U.S.A
- Worked and lived in Rural Australia and Alaska
- Primary health care, remote/rural and regional within tribal health, not for profit and for profit.
- Lives and worked in Alaska, Oregon, Australia and New Zealand.
- Identifies strongly with father's Italian Heritage, raised in a rural as a minority.







BODY DYSMORPHIC DISORDER

- A mental illness.
- A distortion of reality by an obsessive focus on a perceived flaw in appearance.
- Formerly known as dysmorphophobia
- Flaw may be minor or imagined
- Obessional activities may occur daily trying to fix the perceived flaw
- Many cosmetic procedures
- Excessive exercise
- Excessive thoughts, persistent, intrusive thoughts around the perceived flaw
- Must be severe enough that interfere with daily functioning
- 3-8hrs a day preoccupied with thoughts around body image

DSM 5
Body Dysmorphic Disorder (BDD)

- **psychiatric condition defined in the dysmorphic disorder as a preoccupation with a perceived defect or flaw in one's physical appearance that is either not noticeable or only slightly observable by others.**
- The preoccupation is **severe enough to cause marked impairment** in social, academic, occupational, or other areas of functioning.
- To meet diagnostic criteria, an individual at some point during the illness must engage in repetitive behaviors, such as excessive mirror checking, camouflaging (i.e., covering up the defect with makeup, clothing, etc.), skin picking, excessive grooming, excessive weight lifting or pervasive mental acts such as comparing one's appearance to others.
- These **behaviors are typically time-consuming, difficult to control, and are distressing to the individual.**
- On average, these acts will last around **3 to 8 hours per day.**
- The perceived physical flaws **most commonly occur on the skin, hair, or nose, but any body part can be involved**.
- Individuals with this **disorder, on average, experience preoccupations with 5 to 7 different body parts throughout his or her life.**
- A subcategory of **BDD is muscle dysmorphia**, where an individual perceives his or her muscles to be too small or insufficient.
- Another form of this **disorder is BDD by proxy**, which involves an individual's preoccupation with a perceived physical defect in another person.

Ref: Nicewicz, H, Boutrouille, J. (2022). **Body Dysmorphic Disorder,** Body Dysmorphic Disorder - StatPearls - NCBI Bookshelf (nih.gov)

BDD – DATES BACK IN HISTORY

- 1891, Enrico Morselli, an Italian psychiatrist, coined the term dysmorphophobia to describe the condition of people who perceive themselves as flawed but with no apparent physical deformities.

- **1980** first recognized in the **DSM in 1980 as** an atypical somatoform disorder.

- **1987** classified as a distinct somatoform disorder.

- **DSM 5 now classifies BDD under obsessive-compulsive and related disorders**.

Sub types

Depending on the perceived flaw and ensuing dysregulated behaviors.

Muscle Dysmorphia

- Excessive patterns of rituals and strict eating behaviours
- Self esteem is resting on muscle build despite other valuable attributes
- Use of anabolic steroids

Body Dysmorphia by Proxy

Excessive preoccupation with another person's body appearance or minor flaw creating obsessive attention and mental energy about another person.

(International OCD Foundation, 2023)



PREVALANCE

1.9% in the community

2.2% of adolescent populations

3.3% of student populations

5.9% in adult outpatient psychiatric settings

7.4% in adult inpatient psychiatric settings

BDD is more commonly seen in cosmetic-related settings, such as in

cosmetic surgery (13.2%)

rhinoplasty surgery (20.1%)

dermatology (11.3%)

orthognathic surgery (11.2%)

Research **demonstrates variability with**

gender ratios with an estimated range between 1 to 1 and 3 to 2 of females to males.

In the psychiatric setting, the ratio of females to males is approximately equal.

In community settings, females appear to be affected at higher rates.

BDD most commonly starts during adolescence.

Ref: Nicewicz, H, Boutrouille, J. (2022). **Body Dysmorphic Disorder,** Body Dysmorphic Disorder - StatPearls - NCBI Bookshelf (nih.gov)





HOW EXTREME – OVERLAPPING EATING DISORDERS

Body dysmorphic disorder is present in at least 25% of people with anorexia nervosa,
and body image distortions are almost always present in these cases.

CAUSES

- Many possible causes - environmental, psychosocial, biological factors
- Negative evaluations or experiences about body or self image
- Abnormal brain function - ? Serotonin
- Excessive teasing or focus on a minor flaw
- Family history of similar disordered behavior
- Personality type
- Life Experiences
- Trauma & Abuse







SYMPTOMS

- Obsessive checking oneself in the mirror or avoiding mirrors
- Buying of clothes and accessory items excessively never being satisfied selections are right for them
- Picking skin with finger or tweezers
- Hiding body parts, scarves, clothing, excessive use of make-up,
- Avoiding social exposure
- Not believing when people say they are fine, beautiful, normal.
- Feeling anxious, depressed and ashamed
- Having perfectionist tendencies

MOST COMMON FIXATIONS

The most common features people tend to fixate about include:

- Face, such as nose, complexion, wrinkles, acne and other blemishes
- Hair, such as appearance, thinning and baldness
- Skin and vein appearance
- Breast size
- Muscle size and tone
- Genitalia



Ref: Body dysmorphic disorder - Symptoms and causes - Mayo Clinic

COMPLICATIONS

Complications

- Complications that may be caused by or associated with body dysmorphic disorder include, for example:
- Low self-esteem
- Social isolation
- Major depression or other mood disorders
- Suicidal thoughts or behavior
- Anxiety disorders, including social anxiety disorder (social phobia)
- Obsessive-compulsive disorder
- Eating disorders
- Substance misuse
- Health problems from behaviors such as skin picking
- Physical pain or risk of disfigurement due to repeated surgical interventions




5:33
START ON
CLEAR OFF
KITCHEN TIMER ON/OFF
CLOCK
OVEN LIGHT
OFF
LO
HI
FRONT


WHOLE BEAN
VANILLA NUT



RED FLAGS AND AT RISK

- Catching red flag signs early
- At risk teenagers – body image obsessional behavior identified early
- Constantly comparing self to others
- Feeling they are not as acceptable as peers in appearance
- Avoidant of photos, erasing self from photos
- Transgender

TREATMENT

- Counseling - Cognitive behavioral therapy & Talk therapy
- Medication best suited for this disorder Selective Serotonin Reuptake Inhibitors (SSRIs)
- Lifestyle changes – increased healthier eating, exercise, avoidance of chemical abuse, alcohol abuse, negative social groups

GOALS

- **reduce or eliminate obsessive and compulsive behaviors,**
- **to foster recognition of triggers**
- **improve management of the stress associated with the behavior**
- **In addition, a major goal of therapy is to help patients learn to view themselves in a non-judgmental fashion.**
- **To control symptoms and prevent relapse, treatment may continue for years.**



QUESTIONS



REFERENCES

American Psychiatric Association. *Understanding Mental Disorders: Your Guide to DSM-5*. 2015. American Psychiatric Publishing.

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Comagine Health

Break

Back in 10 minutes

Comagine Health

Eating Disorders are Whole Body Disorders – Part 1

Margaret Carlson Cosentino, DO

Family Medicine Physician, Southcentral Foundation

Eating Disorders- Whole Body Disorders

Margaret Carlson Cosentino DO



OBJECTIVES

- Common Eating Disorder types and presentation
- Recognize the physical manifestations of eating disorders
- Understand the serious medical complications of Eating Disorders



Disclosures



No financial disclosures

Board Member with the Alaska Eating Disorders Alliance (AKEDA)

EATING DISORDERS



Eating Disorders



SOCIAL & ECONOMIC COST OF EATING DISORDERS IN ALASKA

Report by the Strategic Training Initiative for the Prevention of Eating Disorders, Academy for Eating Disorders, and Deloitte Access Economics

STRIPED — Strategic Training Initiative for the Prevention of Eating Disorders

LINK TO REPORT

Academy for Eating Disorders (AED)

PREVALENCE & MORTALITY



Nine percent of Alaskans (64,915 people), will have an eating disorder in their lifetime

10,200 deaths per year nationally as a direct result of an eating disorder, equating to 1 death every 52 minutes

EATING DISORDERS AFFECT EVERYONE:

- **All ages**, starting as young as 5 years old to over 80 years old
- **All races**, however, people of color with eating disorders are half as likely to be diagnosed or to receive treatment[1]
- **All genders**, with females being 2x more likely to have an eating disorder
- **All sexual orientations**

COST TO ECONOMY & SOCIETY IN ALASKA

$145.8 Million Yearly economic cost of eating disorders

Additional loss of wellbeing per year **$735.9 Million**

Cost Breakdown:



- Productivity Losses ($109.5M)
- Informal Care ($15.1M)
- Efficiency Losses ($10.8M)
- Health System ($10.4M)

COST TO HOSPITAL SYSTEMS:

121 ER visits costing **$66,042**

53 inpatient hospitalizations costing **$472,665**

LOSS PER GROUP:

$53M Individuals & Families — Caregivers provide 6 weeks of informal, unpaid care per year

$39.9M Government

$36.7M Employers

$16M Society

[1]Sonneville KR, Lipson SK. Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. International Journal of Eating Disorders 2018: 1-9.
Note: State-level data are estimates based on U.S. Census Bureau population statistics (2018). Link to data.

@HarvardSTRIPED @harvardstriped @STRIPED.Harvard

EDC Eating Disorders Coalition · NEDA Feeding hope. · IFEDD · THE ALLIANCE for Eating Disorders Awareness · NCEED · meda multi-service eating disorders association · ANAD · iaedp Foundation · F·E·A·S·T · REDC Residential Eating Disorders Consortium

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ANOREXIA NERVOSA

Anorexia Nervosa (AN)

DSM-5 CRITERIA

- Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Atypical anorexia includes those individuals who meet the criteria for anorexia but who are not underweight despite significant weight loss.

Anorexia Nervosa

Defining features

- **Intense fear** of gaining weight
- **Restriction of energy** intake leading to significant or precipitous weight loss

Warning signs

- Dramatic weight loss
- Dresses in layers to hide weight loss or stay warm
- Preoccupied with weight, food, calories, fat grams, and dieting
- Refuses to eat certain foods, progressing to restrictions against whole categories of food
- Denies feeling hungry
- Cooks meals for others without eating
- Expresses a need to “burn off” calories taken in



Bulimia Nervosa (BN)

Bulimia Nervosa

DSM-5 CRITERIA

- Recurrent episodes of binge eating.
- An episode of binge eating is characterized by both of the following:
  - **Eating, in a discrete period of time** (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
  - **A sense of lack of control over eating during the episode** (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- **Recurrent inappropriate compensatory behavior** in order 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 three months.**
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Bulimia Nervosa (BN)

Defining Feature

- Eating an unusually large amount of food accompanied by a sense of loss of control followed by compensatory behavior

Warning signs

- Evidence of binge eating, including disappearance of large amounts of food in short periods of time or lots of empty wrappers and containers indicating consumption of large amounts of food
- Evidence of purging behaviors, including frequent trips to the bathroom after meals, signs and/or smells of vomiting, presence of wrappers or packages of laxatives or diuretics
- Appears uncomfortable eating around others
- Develops food rituals (e.g. eats only a particular food or food group [e.g. condiments], excessive chewing, doesn't allow foods to touch)
- Skips meals or takes small portions of food at regular meals
- Disappears after eating, often to the bathroom
- Any new practice with food or fad diets, including cutting out entire food groups (no sugar, no carbs, no dairy, vegetarianism/veganism)
- Fear of eating in public or with others
- Steals or hoards food in strange places
- Drinks excessive amounts of water or non-caloric beverages
- Has calluses on the back of the hands and knuckles from self- induced vomiting

BINGE EATING DISORDER

Binge Eating Disorder (BED)

DSM-5 Criteria

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - **Eating, in a discrete period of time** (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
  - **A sense of lack of control over eating during the episode** (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- The binge eating episodes are associated with **three (or more)** of the following:
  - Eating much *more rapidly than normal*.
  - Eating until *feeling uncomfortably full.*
  - Eating *large amounts of food when not feeling physically hungry*.
  - Eating *alone because of feeling embarrassed* by how much one is eating.
  - Feeling *disgusted with oneself, depressed, or very guilty afterward*.
- **Marked distress** regarding binge eating is present.
- The binge eating occurs, on average, **at least once a week for 3 months**.

Binge Eating Disorder (BED)

Defining features

- Eating an unusually large amount of food accompanied by a sense of loss of control

Warning signs

- Evidence of binge eating, including disappearance of large amounts of food in short periods of time or lots of empty wrappers and containers indicating consumption of large amounts of food.
- Appears uncomfortable eating around others
- Any new practice with food or fad diets, including cutting out entire food groups
- Fear of eating in public or with others
- Steals or hoards food in strange places
- Creates lifestyle schedules or rituals to make time for binge sessions
- Withdraws from usual friends and activities
- Frequently diets
- Shows extreme concern with body weight and shape
- Frequent checking in the mirror for perceived flaws in appearance
- Disruption in normal eating behaviors, including eating throughout the day with no planned mealtimes; skipping meals or taking small portions of food at regular meals; engaging in sporadic fasting or repetitive dieting
- Developing food rituals (e.g., eating only a particular food or food group [e.g., condiments], excessive chewing, and not allowing foods to touch).
- Eating alone out of embarrassment at the quantity of food being eaten
- Feelings of disgust, depression, or guilt after overeating
- Fluctuations in weight
- Feelings of low self-esteem

Avoidant/restrictive food intake disorder (ARFID)

- An eating or feeding disturbance manifested by persistent failure to meet appropriate nutritional and/or energy needs
- ARFID **does not** involve any distress about body shape or size, or fears of fatness.

Other specified feeding and eating disorder (OSFED)

- Category developed to encompass those individuals who did not meet strict diagnostic criteria for anorexia nervosa or bulimia nervosa but still have a significant eating disorder.
  - **Atypical Anorexia Nervosa**
  - **Binge Eating Disorder (of low frequency and/or limited duration,**
  - **Bulimia Nervosa (of low frequency and/or limited duration**
  - **Purging Disorder**: Recurrent purging behavior to influence weight in the absence of binge eating
  - **Night Eating Syndrome:** Recurrent episodes of night eating. Eating after awakening from sleep, or by excessive food consumption after the evening meal.

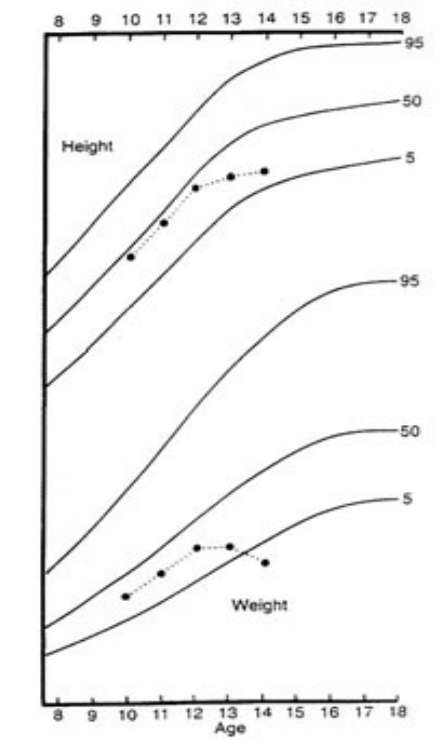


Physical Exam

Physical Exam

General Exam

- Marked weight loss, gain, fluctuations or unexplained change in growth curves or BMI percentiles in a child or adolescent who is still growing and developing
- Cold intolerance, including hypothermia, general chilliness, or cool hands and feet which may or may not manifest a blue or purple color
- Weakness
- Fatigue and reduced energy
- Presyncope (dizziness) / Syncope (fainting)



Age	Weight (lb)	Weight (kg)	Height (in)	Height (cm)
12	82	37	58.5	149
13	82	37	59	150
14	75	34	59.5	151

Physical Exam

EAR/NOSE/THROAT and EYES

- Oral trauma, lacerations, petechiae on back of throat
- Dental erosions and dental caries (cavities)
- Parotid gland enlargement and pain
- Cheilosis (cracked, sore skin at the corners of the mouth)
- Dry eyes, blurred vision
- Difficulty swallowing dry foods or liquids

CARDIORESPIRATORY

- Chest pain
- Heart palpitations and cardiac arrhythmias
- Bradycardia (low heart rate at rest)
- Hypotension (low blood pressure)
- Dyspnea (shortness of breath)
- Edema (swelling)

GASTROINTESTINAL and GENITOURINARY

- Epigastric discomfort
- Abdominal bloating
- Early satiety (fullness) and nausea
- Gastroesophageal reflux (heartburn)
- Hematemesis (blood in vomit)
- Hemorrhoids and rectal prolapse
- Constipation

Physical Exam

GASTROINTESTINAL and GENITOURINARY

- Epigastric discomfort
- Abdominal bloating\Early satiety (fullness) and nausea
- Gastroesophageal reflux (heartburn)
- Hematemesis (blood in vomit)
- Hemorrhoids and rectal prolapse
- Constipation

ENDOCRINE

- Shakiness, weakness, sweating, chest pressure, confusion, or nausea, which may signal hypoglycemia (a significant cause of death in eating disorders); hypoglycemia may also be asymptomatic
- Amenorrhea or oligomenorrhea (absent or irregular menses)
- Low sex drive (related to suppressed sex hormone production of estrogen/ testosterone)
- Bone fractures, including stress fractures due to low bone mineral density/osteoporosis
- Infertility

Physical Exam

NEUROPSYCHIATRIC

- Depressive/Anxious/Obsessive/Compulsive symptoms and/or behaviors
- Poor concentration or memory loss
- Insomnia
- Self-harm
- Suicidal thoughts, plans or attempts
- Reduced flexibility, creativity, spontaneity, with increasing rigidity around social engagements and mealtimes
- Seizures
- Substance use or abuse

DERMATOLOGIC



- Lanugo hair growth
- Hair loss



- Carotenoderma (yellowish discoloration of skin)
- Russell's sign (calluses or scars on the back of the hand associated with self-induced vomiting)



- Poor wound healing
- Dry, brittle hair and nails
- Fragile, dry skin that bruises or tears easily
- Sores or bruises over bony prominences

Diagnostic Evaluation



Diagnostic Testing

Basic diagnostic tests indicated for all patients with a suspected ED

Potential abnormal findings in a patient with an ED

- **Complete blood count**
  - Leukopenia, anemia, or thrombocytopenia
- **Comprehensive metabolic panel** to include electrolytes, renal function tests and liver enzymes
  - Glucose: LOW (poor nutrition)
  - Sodium: LOW (water loading or laxatives)
  - Potassium: LOW(vomiting, laxatives, diuretics)
  - Chloride: LOW (vomiting, laxatives)
  - Blood bicarbonate: Elevated (vomiting), LOW (laxatives)
  - Blood urea nitrogen: Elevated (dehydration)
  - Creatinine: Elevated (dehydration, renal dysfunction), LOW (poor muscle mass)
  - Calcium: slightly LOW (poor nutrition at the expense of bone)
  - Phosphate: LOW (poor nutrition and early refeeding syndrome)
  - Magnesium: LOW (poor nutrition, laxative use)
  - Total protein/albumin: Elevated (in early malnutrition at the expense of muscle mass or milk of magnesia use), LOW (in later malnutrition)
  - Aspartate aminotransaminase (AST), Alanine aminotransaminase (ALT): Elevated (starvation)
- **Electrocardiogram (ECG)**
  - Bradycardia (low heart rate)
  - Prolonged QTc (>450msec)
  - other arrhythmias
- **Other tests to consider**
  - TSH- Low or Normal
    - T4 Low or Normal (euthyroid sick syndrome)
    - T3 Low if below metabolically healthy weight
  - LH, FSH, estradiol (women) and testosterone (men) levels: Low or low normal
  - Prealbumin: Low (in protein-calorie malnutrition) – but only reflective of the past 72 hours pre-test

*It is important to note that laboratory studies may be normal even with significant malnutrition

Treatment



Treatment

Criteria Supportive of Hospitalization for Acute Medical Stabilization

- **Presence of one or more of the following**
  - ≤ 75% median BMI for age, sex, and height, or prolonged severe caloric restriction causing significant weight loss in the absence of underweight
  - Hypoglycemia
  - Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia and/or metabolic acidosis or alkalosis)
  - ECG abnormalities (e.g., prolonged QTc>450msec, bradycardia, other arrhythmias)
  - Hemodynamic instability • Bradycardia • Orthostatic hypotension • Hypothermia
  - Acute medical complications of malnutrition (e.g., syncope, seizures, cardiac failure, pancreatitis, etc.)
  - Acute severe food refusal unresponsive to outpatient treatment
  - Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (e.g., severe depression, suicidal ideation, obsessive compulsive disorder, type 1 diabetes mellitus)
  - Uncertainty of the diagnosis of an ED

Criteria for Acute Psychiatric Stabilization

- **Presence of one or more of the following**
  - Suicidal thoughts or behaviors
  - Aggression or unsafe behaviors
  - Other significant psychiatric comorbidity that interferes with ED treatment (anxiety, depression, obsessive compulsive disorder, mood instability)

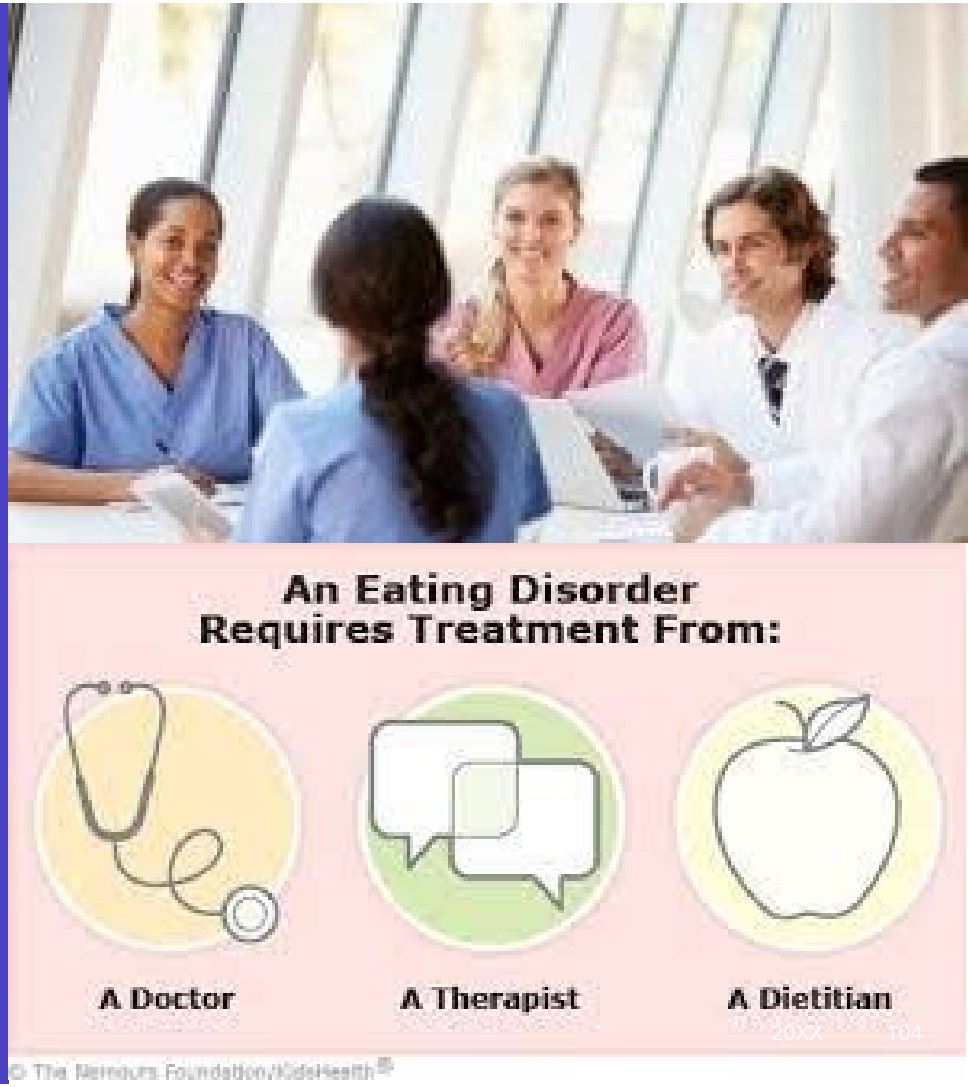
Refeeding Syndrome

Refeeding syndrome describes the **clinical and metabolic derangements** that can occur during refeeding (orally, enterally, or parenterally) of a malnourished patient.

- The **clinical features** of refeeding syndrome include
  - edema
  - cardiac and/or respiratory failure
  - gastrointestinal problems
  - profound muscle weakness
  - Delirium
  - Death.
- **Laboratory abnormalities**
  - Hypophosphatemia (most significant)
  - Hypoglycemia
  - Hypokalemia
  - Hypomagnesemia

Refeeding syndrome can occur in patients of any age and weight and is a potentially fatal condition requiring specialized care on an inpatient unit.

Treatment takes a Team



Treatment

IMMEDIATE

- Medical stabilization, nutritional rehabilitation to achieve weight restoration and address nutrient deficiencies, management of refeeding and its potential complications, and interruption of purging/compensatory behaviors should be the immediate goals of treatment for all patients with EDs.

ONGOING

- Following initial stabilization, ongoing evidence based treatment delivered by a multidisciplinary team of healthcare professionals with expertise in the care of patients with EDs is essential for full recovery.
- Optimal care includes medical, psychological, nutritional, and, for some patients, psychopharmacologic services. Family members (i.e., parents, spouses, partners) should be included in ED treatment whenever possible.

Treatment levels

INPATIENT

- Patient is medically unstable as determined by:
- Unstable or depressed vital signs
- Laboratory findings presenting acute health risk
- Complications due to coexisting medical problems such as diabetes
- Patient is psychiatrically unstable as determined by:
- Rapidly worsening symptoms
- Suicidal and unable to contract for safety

PARTIAL HOSPITAL

- Patient is medically stable but:
- Eating disorder impairs functioning, though without immediate risk
- Needs daily assessment of physiologic and mental status
- Patient is psychiatrically stable but:
- Unable to function in normal social, educational, or vocational situations
- Engages in daily binge eating, purging, fasting or very limited food intake, or other pathogenic weight control techniques

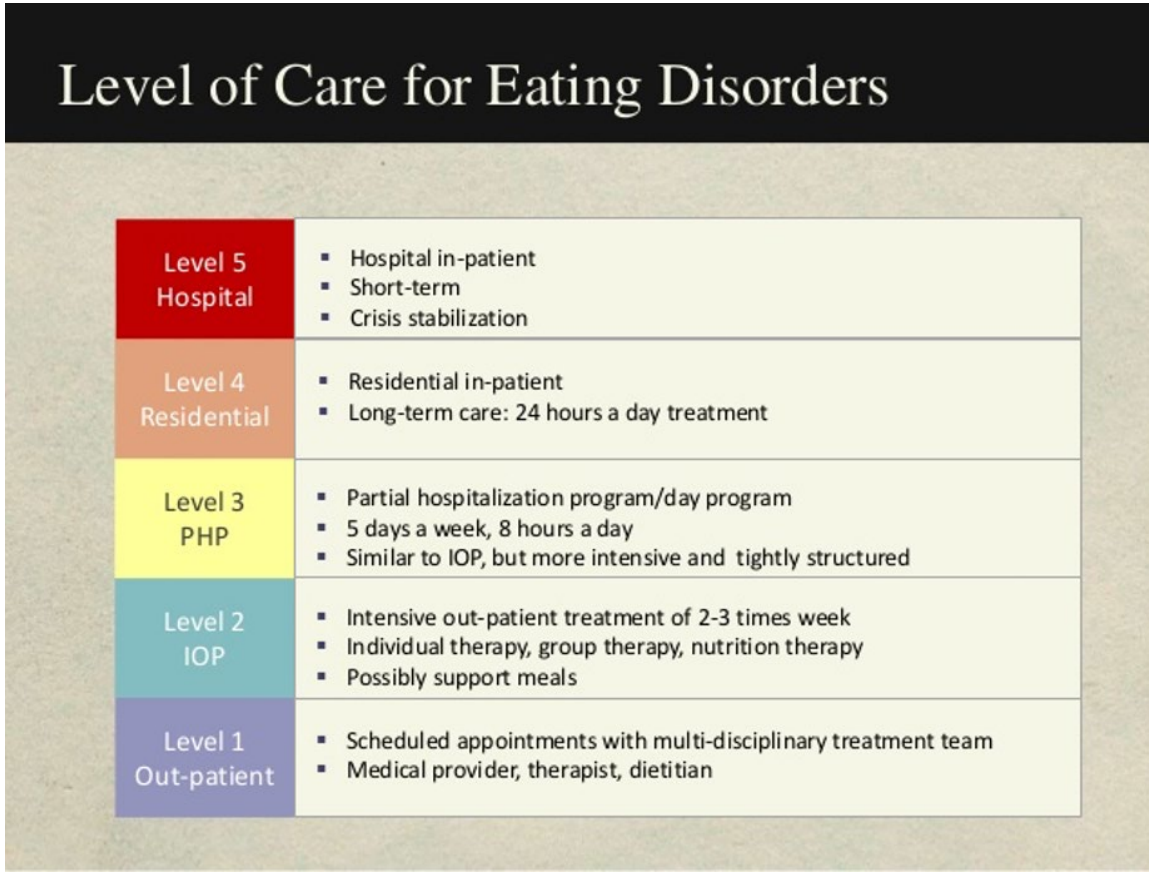
RESIDENTIAL

- Patient is medically stable and requires no intensive medical intervention
- Patient is psychiatrically impaired and unable to respond to partial hospital or outpatient treatment

Treatment Level

INTENSIVE OUTPATIENT/OUTPATIENT

- Patient is medically stable and does not need daily medical monitoring
- Patient is psychiatrically stable and has symptoms under sufficient control to be able to function in normal social, educational, or vocational situations and continue to make progress in recovery



RESOURCES

AED® Academy for Eating Disorders

https://www.aedweb.org/resources/publications/medical-care-standards

NCEED National Center of Excellence for Eating Disorders

https://nceedus.org/

NEDA Feeding hope.

https://www.nationaleatingdisorders.org/



Thank you

Margaret Carlson Cosentino DO

Comagine Health

Lunch break

Back in one hour

Comagine Health

Eating Disorders are Whole Body Disorders – Part 2

Katie Kajdan Bell, LPC, ATR

Art Therapy AK, LLC

Comagine Health

Pillars of Care

Gerald Baird, CMHC, MBA

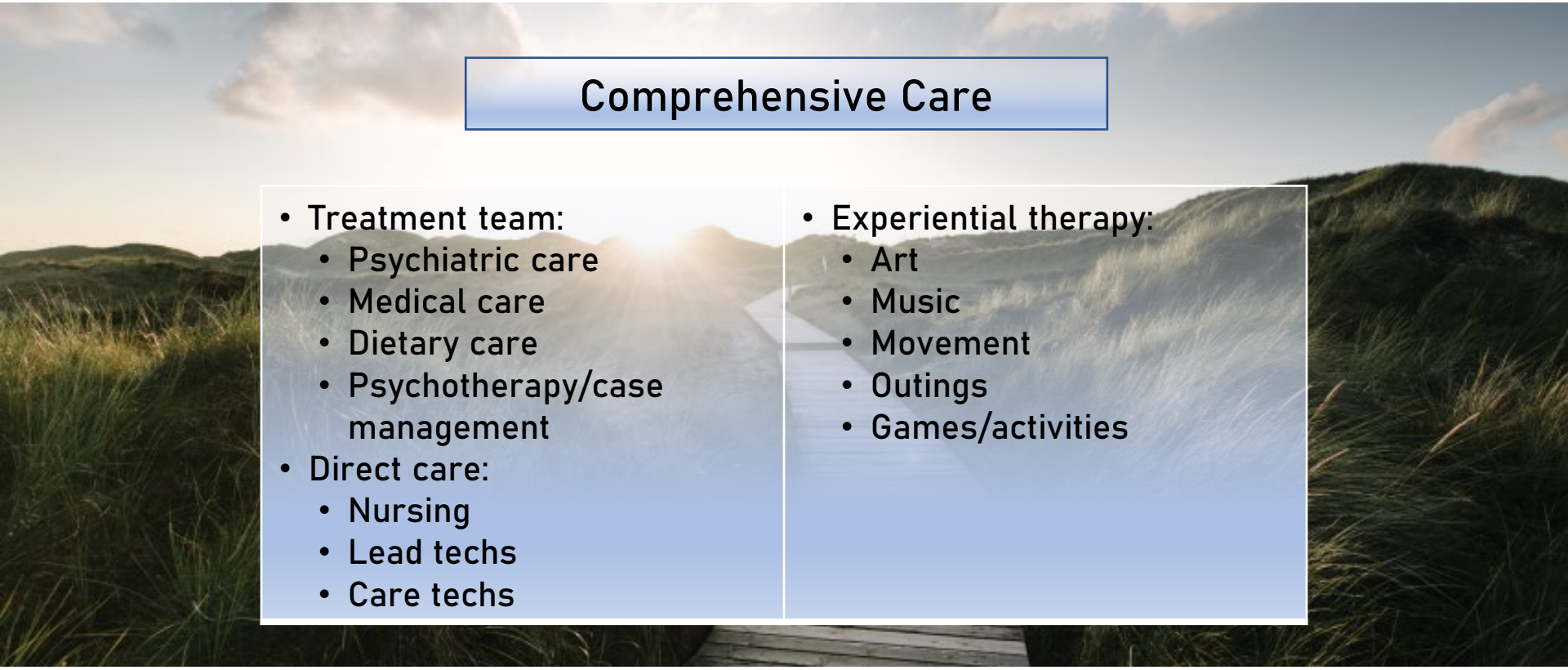
Clinical Program Director, Adult RTC Unit Center for Change



Eating Disorder Treatment: Best Practices

June 21, 2023

presented by Gerry Baird, LCMHC
Adult RTC Clinical Director
Center for Change



Comprehensive Care

- Treatment team:
  - Psychiatric care
  - Medical care
  - Dietary care
  - Psychotherapy/case management
- Direct care:
  - Nursing
  - Lead techs
  - Care techs

- Experiential therapy:
  - Art
  - Music
  - Movement
  - Outings
  - Games/activities

Eating Disorder Truths

1. Many people with eating disorders look healthy yet may be extremely ill.
2. Families are not to blame and can be the patients' and providers' best allies in treatment.
3. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.
4. Eating disorders are not choices, but serious biologically influenced illnesses.
5. Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses.
6. Eating disorders carry an increased risk for both suicide and medical complications.
7. Genes and environment play important roles in the development of eating disorders.
8. Genes alone do not predict who will develop eating disorders.
9. Full recovery from an eating disorder is possible. Early detection and intervention are important.

Source: National Eating Disorders Association

Levels of Care

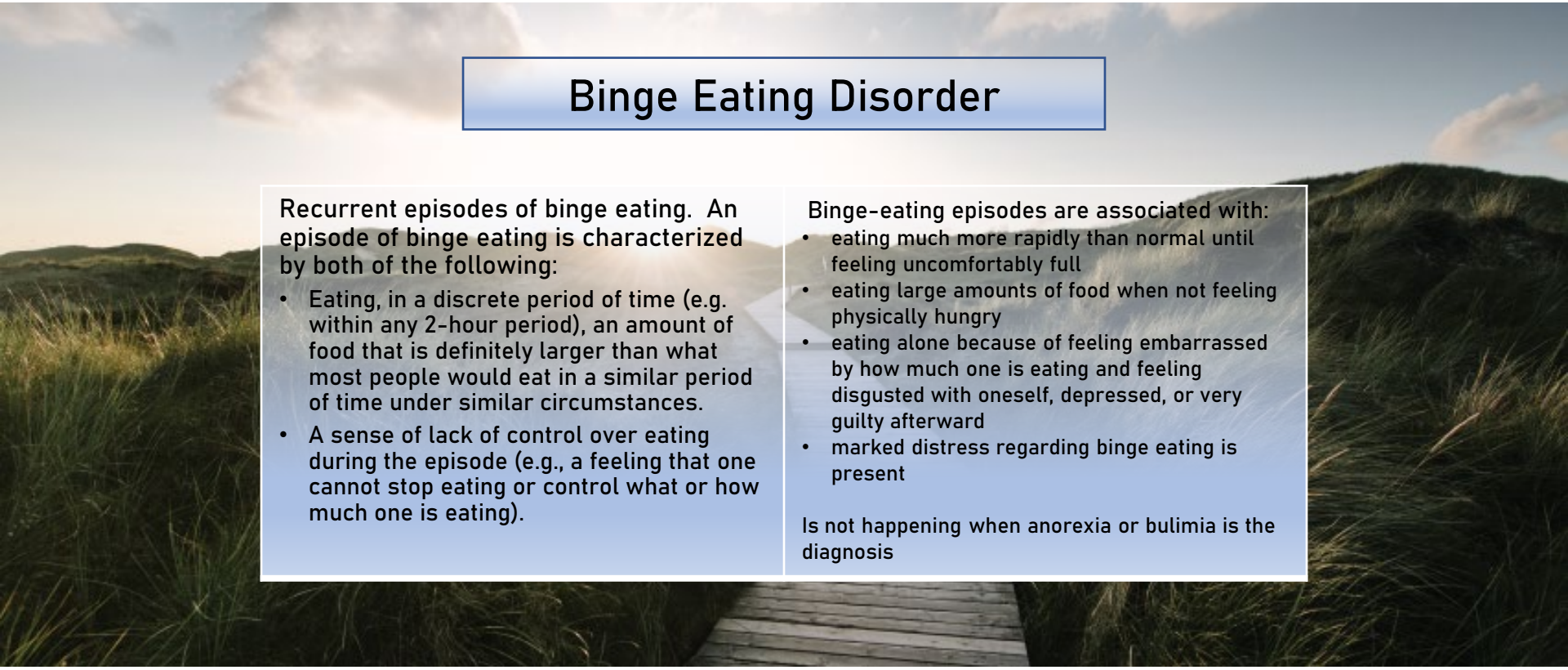
- Inpatient
  - Intensive psychiatric and medical care/monitoring
  - Twice a week dietary sessions, 4 therapy sessions per week
- Residential
  - 2 weekly therapy sessions
  - Weekly dietary session plus one check-in
  - Psychiatric and medical care/monitoring
- Partial Hospitalization Program (PHP)
  - 6 hours a day, 4-7 days per week
  - 2 weekly therapy sessions
  - 2 meals provided
  - Psychiatric and medical care/monitoring
  - Weekly dietary session plus one check-in
- Intensive Outpatient Program (IOP)
  - 3 hours a day, 3-5 days per week
  - 1 weekly therapy session
  - 1 weekly dietary session
  - 1 meal provided
  - Patient is responsible for obtaining outside medical/psychiatric care
- Outpatient
  - 1 weekly therapy session
  - 1 weekly dietary session
  - Patient is responsible for obtaining outside medical care

Anorexia

- Restriction of food leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
- Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

- Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

- Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).



Binge Eating Disorder

Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
- A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

Binge-eating episodes are associated with:

- eating much more rapidly than normal until feeling uncomfortably full
- eating large amounts of food when not feeling physically hungry
- eating alone because of feeling embarrassed by how much one is eating and feeling disgusted with oneself, depressed, or very guilty afterward
- marked distress regarding binge eating is present

Is not happening when anorexia or bulimia is the diagnosis

Bulimia

Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
- A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

- Binges and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

ARFID

ARFID (Avoidant/Restrictive Food Intake Disorder):

- Does not happen at the same time as Anorexia or Bulimia
- 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.

- Apparent lack of interest in eating or food
- Avoidance based on the sensory characteristics of food
- Avoidance based on fear of choking
- Significant weight loss
- Significant nutritional deficiency
- Dependence on enteral (tube) feeding or oral nutritional supplements
- Marked interference with psychosocial functioning

OSFED

Other Specified Feeding and Eating Disorder

<u>Two Examples:</u>

Atypical anorexia nervosa is diagnosed when all of the criteria for anorexia are met, except that despite significant weight loss, the individual's weight is within or above the normal range.

Purging disorder is characterized by recurrent purging in the absence of binge eating in individuals who are not underweight

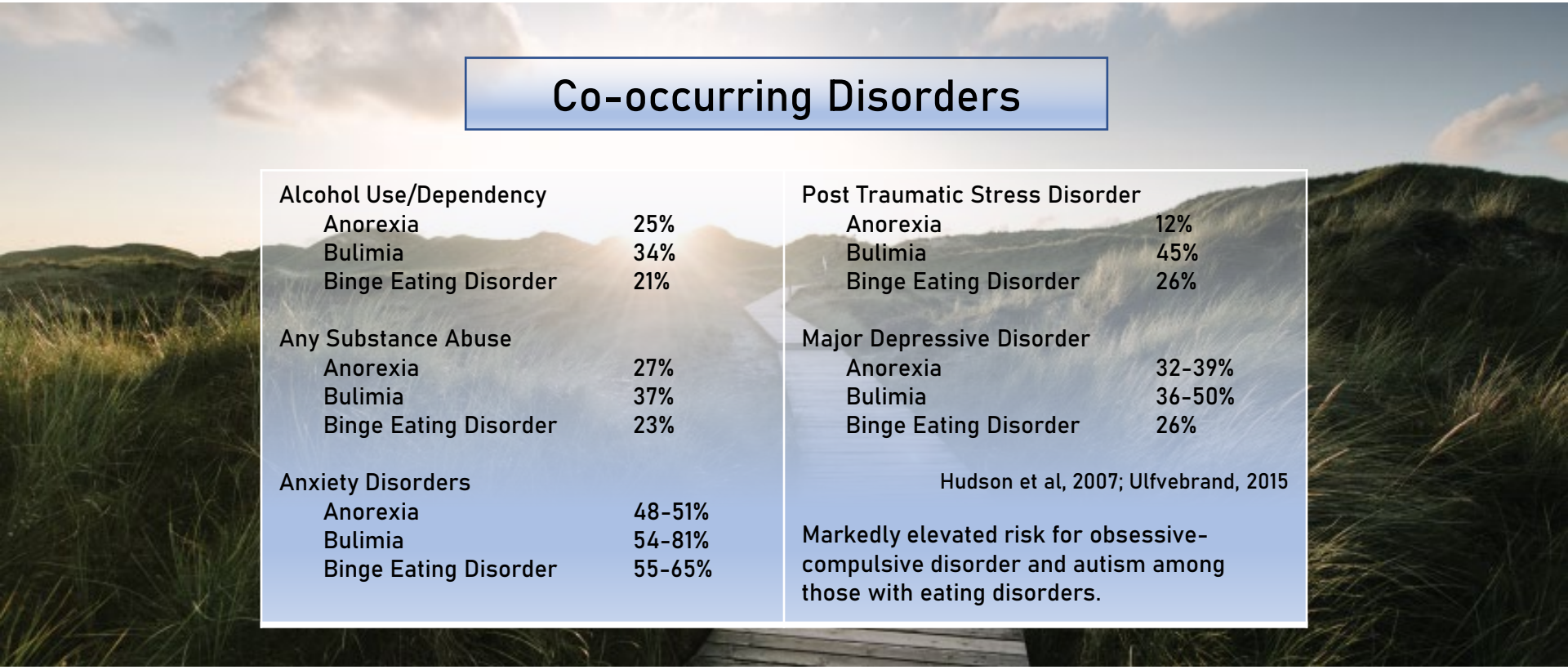
Risk Factors

- Being female
- Familial eating disorder history
- Family history of depression and anxiety
- Family history of substance abuse
- High BMI during adolescence
- Younger menarche onset
- Personality temperaments, impulsivity (binge eating disorder, bulimia)
- Perfectionism, ruminative worrying and harm avoidance (all ED diagnoses)
- Frequency and severity of dieting
- Exposure to fashion media, thin body ideal
- Participation in activities that require specific body type to be successful
- Lack of friends

Characteristics

- Difficulty trusting others/unreachable to others
- Difficulty setting boundaries
- Others oriented/highly discerning of others' needs and emotions
- Critical of self and others
- Obsessive/rigid thinking
- Sensitive/reactive

- Difficulty with moderation
- Hard time finding meaning in failure or setbacks
- Low self-esteem
- High levels of shame, feeling under attack
- Focus on productivity and achievement to define worth



Co-occurring Disorders

Alcohol Use/Dependency	
Anorexia	25%
Bulimia	34%
Binge Eating Disorder	21%
Any Substance Abuse	
Anorexia	27%
Bulimia	37%
Binge Eating Disorder	23%
Anxiety Disorders	
Anorexia	48-51%
Bulimia	54-81%
Binge Eating Disorder	55-65%

Post Traumatic Stress Disorder	
Anorexia	12%
Bulimia	45%
Binge Eating Disorder	26%
Major Depressive Disorder	
Anorexia	32-39%
Bulimia	36-50%
Binge Eating Disorder	26%

Hudson et al, 2007; Ulfvebrand, 2015

Markedly elevated risk for obsessive-compulsive disorder and autism among those with eating disorders.

Personality Disorders

Among those with Anorexia:

- Restricting type: 20% had obsessive-compulsive personality disorder, 10% had borderline personality disorder
- Binge-purge type: 12% had obsessive-compulsive personality disorder, 25% had borderline personality disorder

In women hospitalized for an eating disorder, 36.8% regularly self-harmed

Among those with Bulimia:

- 11% had obsessive-compulsive personality disorder, 28% had borderline personality disorder

8% of people with EDNOS/OSFED

- 11% had obsessive-compulsive personality disorder
- 12% had borderline personality disorder

30% of people with binge eating disorder

- 10% had obsessive-compulsive personality disorder
- 10% had borderline personality disorder

Other Complicating Factors

- Treatment providers feel high burnout rate
- Medical residents working with anorexia patients report higher anger, helplessness, and stress than with other patients

- Patients struggle to trust providers
- Patients do not want to change
- High mortality rate

Warren et al, 2012

Interventions

These illnesses are treated with therapeutic modalities such as:

- DBT
- CBT
- ACT
- RO-DBT
- Family therapy

Along with pharmacological interventions, including:

- Ketamine
- TMS

APA Screening Process

- Height and weight history
- Eating patterns (restricting, bingeing, purging, food avoidance, regurgitation, chewing and spitting, etc.)
- Breadth of food and variety, recent changes in eating behaviors
- Compensatory behaviors (purging, compulsive exercise, laxatives, diuretics, diet pills/illicit drugs)
- Assess patient's family/community support system

- % of time spent thinking about and engaging in food-related, body-related and compensatory behaviors and psychosocial impairment
- Eating disorder treatment history, including family history
- Co-occurring conditions (family and patient)
- Vitals: temperature, resting heart rate, orthostatic pulse and blood pressure, bloodwork, EKG, BMI, physical appearance (note: may be deceiving)

APA Guidelines

Anorexia:

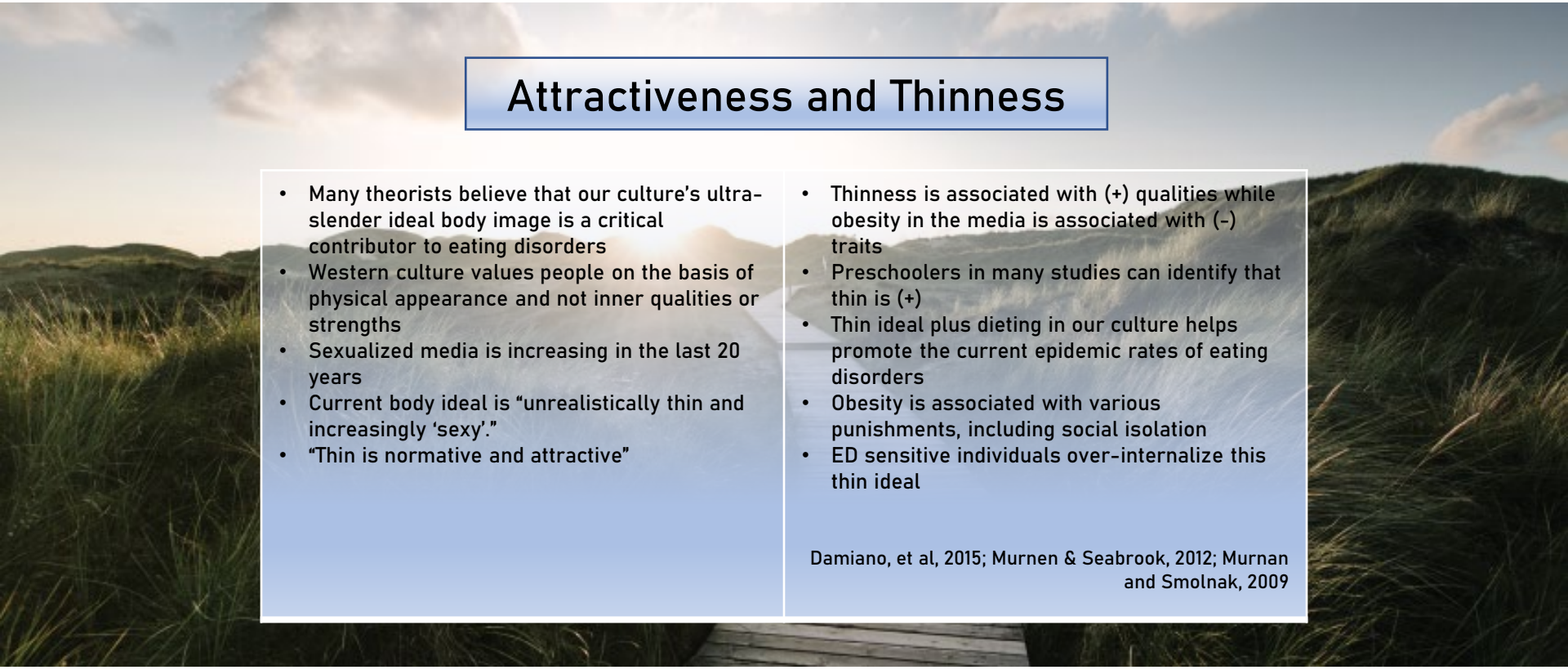
- Individualized goals for weekly weight gain and target weight
- Individual therapy that focuses on normalizing eating, addressing body image disturbance, and fear of weight gain
- Incorporate caregivers in treatment efforts

Bulimia:

- SSRI either initially or if therapy alone is not helping after 6 weeks
- Individual therapy that focuses on overcoming eating disorder/compensatory behaviors
- Incorporate caregivers in treatment efforts

Binge Eating Disorder:

- SSRI or lisdexamfetamine either initially or if therapy alone is not helping after 6 weeks
- Group or individual therapy that focuses on overcoming binge eating behaviors
- Incorporate caregivers in treatment efforts



Attractiveness and Thinness

- Many theorists believe that our culture's ultra-slender ideal body image is a critical contributor to eating disorders
- Western culture values people on the basis of physical appearance and not inner qualities or strengths
- Sexualized media is increasing in the last 20 years
- Current body ideal is "unrealistically thin and increasingly 'sexy'."
- "Thin is normative and attractive"

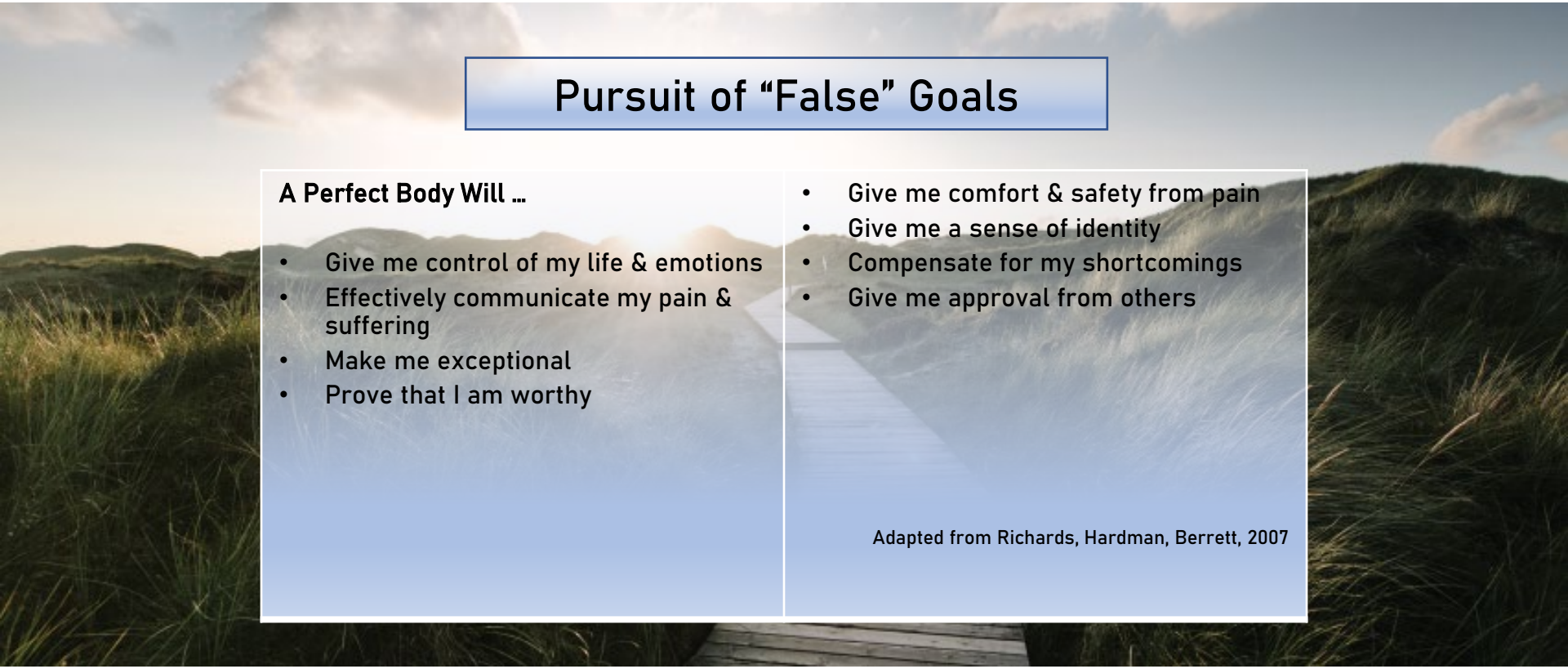
- Thinness is associated with (+) qualities while obesity in the media is associated with (-) traits
- Preschoolers in many studies can identify that thin is (+)
- Thin ideal plus dieting in our culture helps promote the current epidemic rates of eating disorders
- Obesity is associated with various punishments, including social isolation
- ED sensitive individuals over-internalize this thin ideal

Damiano, et al, 2015; Murnen & Seabrook, 2012; Murnan and Smolnak, 2009

Body Shame

- Up to 40% of overweight girls and 37% of overweight boys are teased about their weight by peers or family members.
  - Weight teasing predicts weight gain, binge eating, and extreme weight control measures.
- Weight-based victimization among overweight youths has been linked to lower levels of physical activity, negative attitudes about sports, and lower participation in physical activity among overweight students.
- Among overweight and obese adults, those who experience weight-based stigmatization engage in more frequent binge eating, are at increased risk for eating disorder symptoms, and are more likely to have a diagnosis of binge eating disorder.
- Children of mothers who are overly concerned about their weight are at increased risk for modeling their unhealthy attitudes and behaviors.
- Weight stigma poses a significant threat to psychological and physical health. It has been documented as a significant risk factor for depression, low self-esteem, and body dissatisfaction.
- Perceived weight discrimination is significantly associated with a current diagnosis of mood and anxiety disorders and mental health services use.

NEDA sources 2022



Pursuit of “False” Goals

A Perfect Body Will …

- Give me control of my life & emotions
- Effectively communicate my pain & suffering
- Make me exceptional
- Prove that I am worthy
- Give me comfort & safety from pain
- Give me a sense of identity
- Compensate for my shortcomings
- Give me approval from others

Adapted from Richards, Hardman, Berrett, 2007

Compulsive Exercise

- It's all about the MOTIVE
  - Compensating for calories consumed
  - Relieving guilt from eating
  - Necessary in order to "give permission" to eat
  - Coping method for: stress, control needs, self-respect, or avoidance of emotion

- Self-punishment versus true enjoyment
- As addictive process (may see increased substance use as exercise decreases)
- Consider less running, more yoga type exercise
- Fitness is critical for military personnel, athletes, first responders: a balancing act
- Running is the number one relapse predictor with exercise

Powers and Johnson, 2008

Signs of Overexercise

- Exercise as primary means of coping
- Exercise occurs despite injury
- Withdrawal effects (sleep & appetite disturbance, negative shift in mood, decreased concentration)
- Menstrual irregularity in women
- Decreased testosterone levels in men

- Overuse injuries
- Stress fractures
- Loss of bone density
- Decreased immunity
- Frequent colds, upper respiratory tract infections
- Inflexibility of exercise schedule
- Decrease in sport performance

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Comagine Health

Special Considerations in Working with ED Population: BH Comorbidities; Fostering Autonomy

Grace Schumacher, RDN, CEDRD, OTS

Dietitian Nutrition Therapist, Nutrition Partnership, LLC

Domains of Care for Eating Disorders

& Co-Morbid Presentations

Grace Ray Schumacher, RDN, CEDRD, OTS
(she/they)

Nutrition Partnership





Objectives

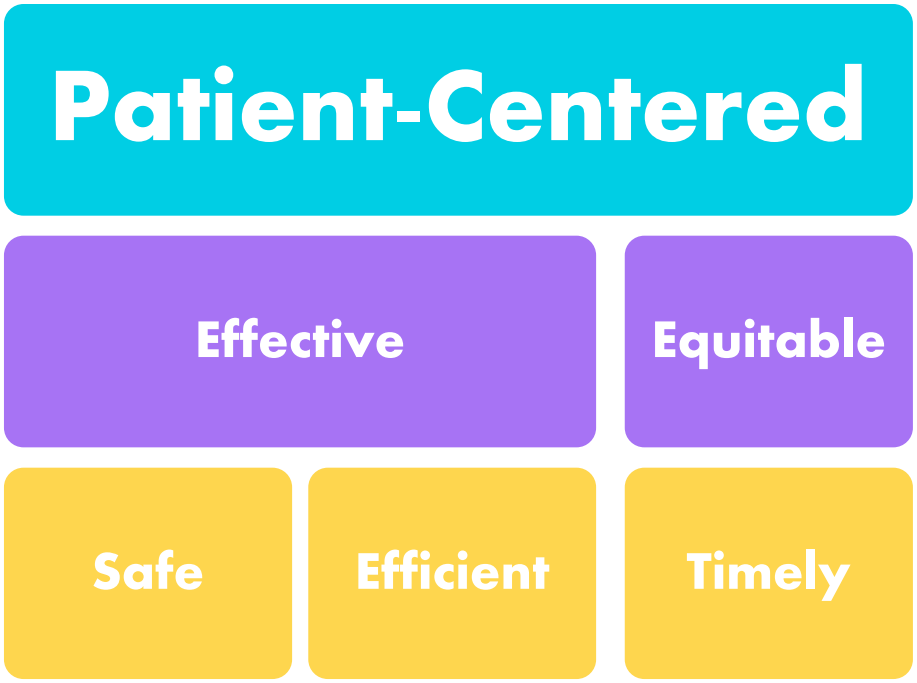
Describe ego states as pertaining to dysfunctional eating presentation and treatment modalities

Recognize best-practices for quality person-centered health care for eating disorders populations

Identify possible changes to clinical practice and community settings to align with principles for treatment engagement across presentations

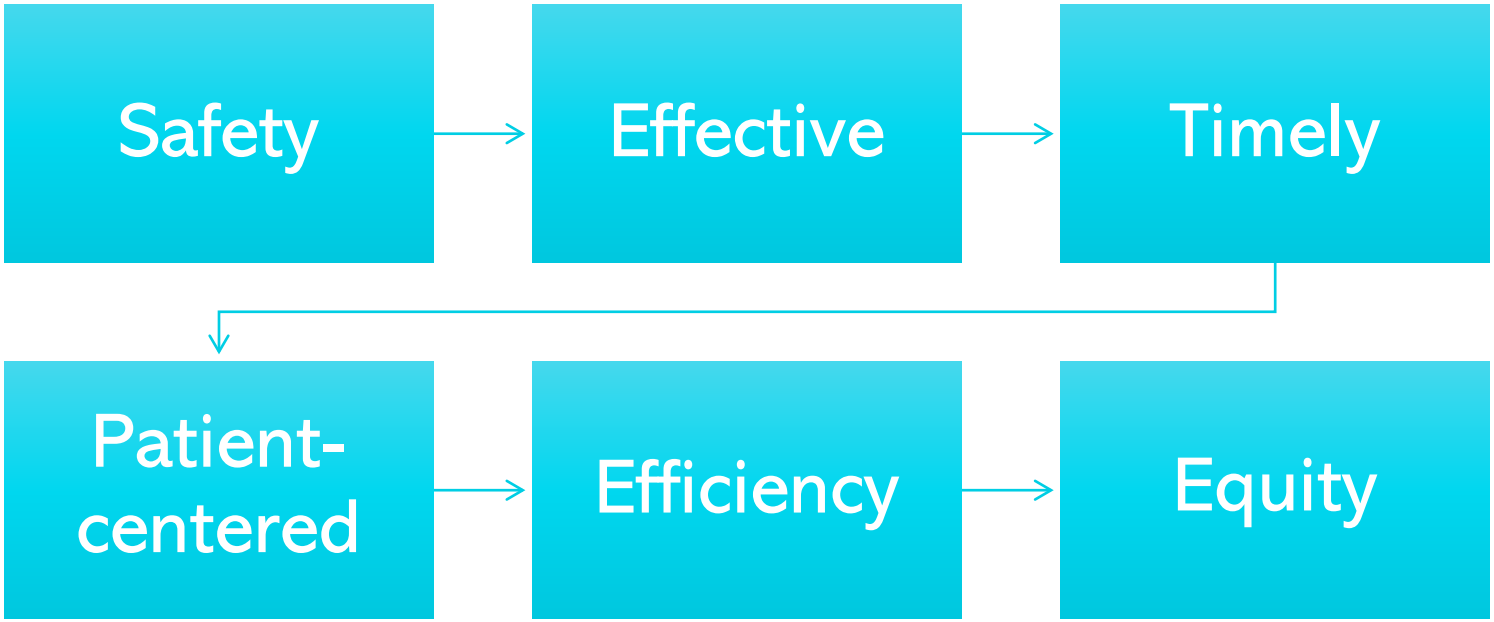
Domains of Quality Health Care

- **Patient-centered** — *providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions*.
- **Effective** — *providing services based on scientific knowledge to all who could benefit* and *refraining from providing services to those not likely to benefit*.
- **Equitable** — *providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.*
- **Safe** — *avoiding harm to patients from the care that is intended to help them*.
- **Efficient** — *avoiding waste, including waste of equipment, supplies, ideas, and energy*.
- **Timely** — *reducing waits and sometimes harmful delays for both those who receive and those who give care*.



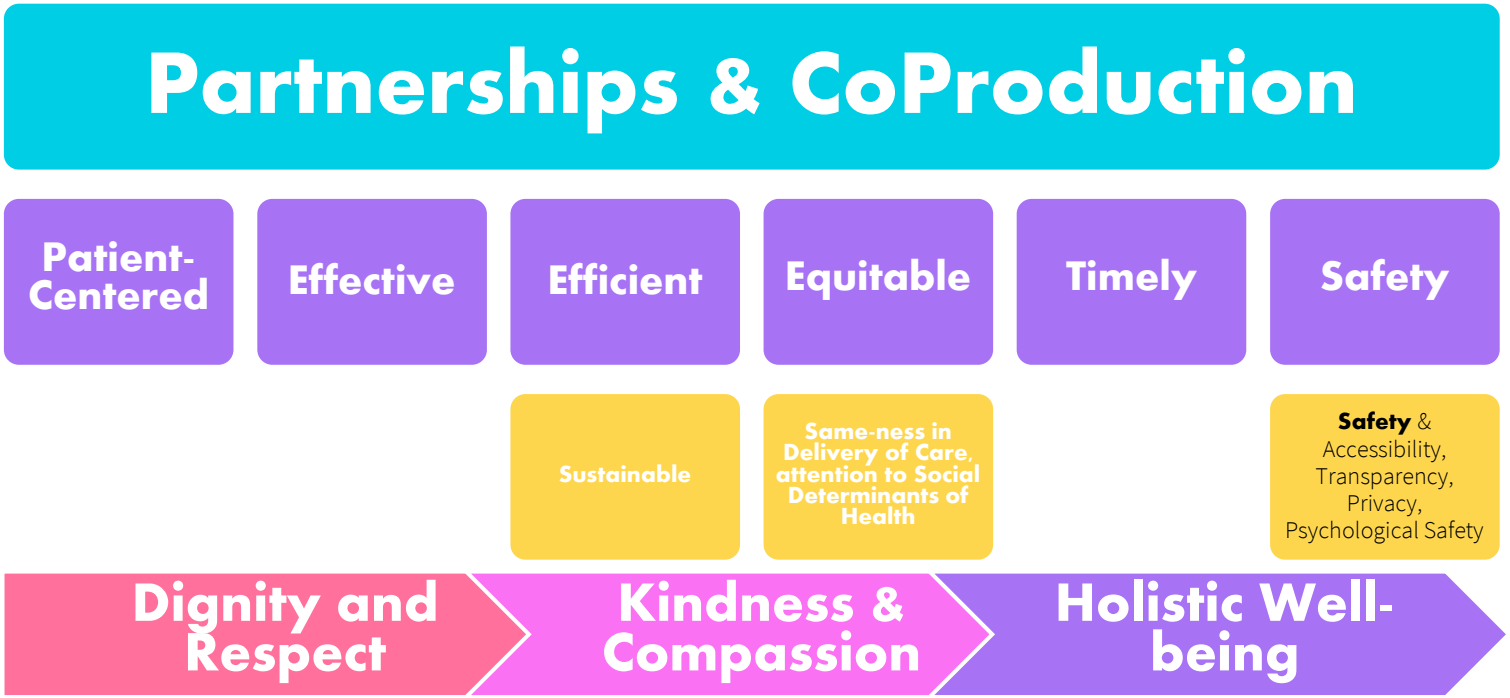
Committee on Quality of Health Care in America, Institute of Medicine, 2001

Extent of Domain Measures



Agency for Healthcare Research and Quality, 2022

New Considerations



Snively, 2022



Safety - Accessibility

Screening & Assessment

Limitations to Health Insurance

Black, Indigenous, and People of Color (BIPOC)

Culturally-Competent Care

Physical Disabilities

Neurodivergence

Larger Bodied

National Association for Anorexia Nervosa and Associated Disorders (ANAD), 2020; Crone et al., 2023

https://www.theprojectheal.org/

Adult Screening

SBIRT-ED

https://eatingdisorderscreener.org/

https://www.youtube.com/watch?v=Ekv75kGPmOw&t=117s



Pediatric Screening

Eating Disorder Inventory, child (EDI-C)
Bulimia Test - Revised (BULIT-R)
Eating Disorder Examination Questionnaire (ChEDE-Q)
Eating Attitudes Test (EAT), children’s version
Kids' Eating Disorder Survey (KEDS)

J Am Acad Child Adolesc Psychiatry 2015;54(5):412–425.



Safety - Transparency

Mutual Respect & Open Communication

Electronic Health Records (EHR) - Patient Access

Evidence-based Recommendations

Individualized Options

Informed Decision-Making

Improved Navigation through the Care System

Visibility & Accountability



Safety - Privacy

Confidentiality

Release forms for Collaterals

Encourage self-disclosure to caregivers when appropriate

The right to non-disclosure of diagnosis



Diversify Dietetics

Association for Size Diversity & Health

Safety - Psychological

Environment of Care Impacts

Weight Monitoring Protocol

Unsolicited recommendations for Weight Loss

Diagnosing and Documentation

Unconditional Positive Regard

Empathetic Detachment

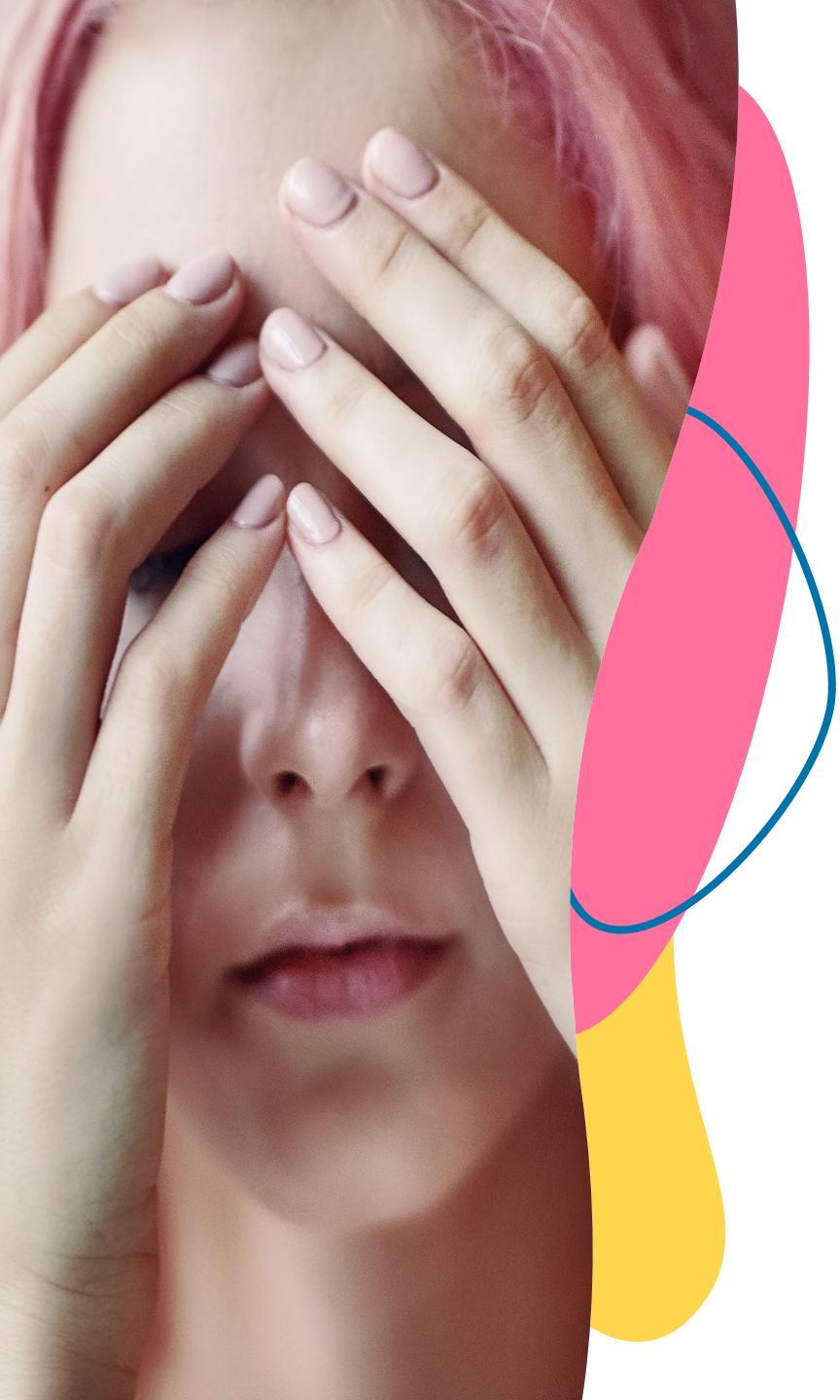
Cultural Sensitivity

Trauma-Informed

Safety = Engagement

Dawn-Elise Snipes PhD, LPC-MHSP, LMHC

Universal Access	Empathetic Detachment	Person-Centered Assessment	Cultural Sensitivity	Trauma Sensitivity
Regardless of Setting	Shared Understanding	Individual issues, needs, preferences, learning style, etc.	Cultural Barriers	Trauma impact on Mood & Social interactions
Welcoming	Non-Judgmental	Symptom Checklist	Recovery Environment	Willingness to participate in safety and self-care
Assess for multiple needs	Cooperative	Diagnosis & Terminology	Individual vs Collective	Guardedness
High Priority	Informed Recommendations – Options	Person-first language	"Family" may be non-traditional and influenced by culture or ethnicity	Foster Resiliency
Proactive Effort	Maintain Connection	Ongoing assessment		
	Foster Hope	Strengths or Skill Deficit		
		Confidentiality: Encourage self-disclosure		
		Contact Collaterals		



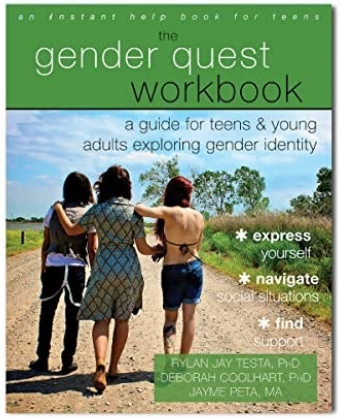
Person-Centered Care

- Empowers the person to participate in treatment and develop awareness of their environment and self
- Improves treatment motivation & compliance
- Comparatively rapid change
- Enduring improvements
- Right to receive treatment
- Focus on restoring health, harmony, and quality of life
- Respects Client-Clinician Responsibilities

“If you don't fit a particular narrative or stereotype, sometimes your eating disorder can go undetected.”

- Dr. Christine Peat, director of the National Center of Excellence of Excellence for Eating Disorders

Transgender Care

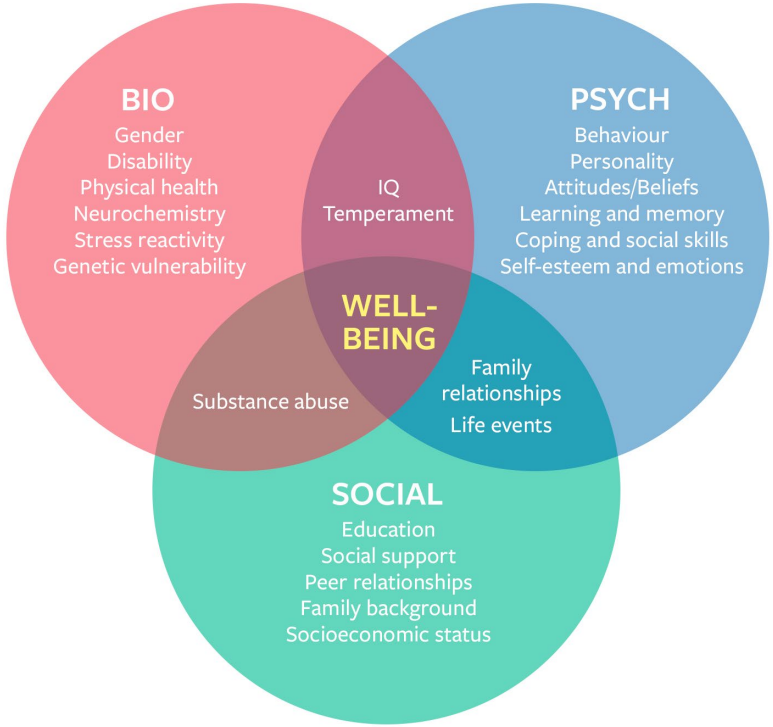


Therapist Recommended

- The root cause of the eating disorder is often different than for cis-gender people
- Presentation of the eating disorder often delays identification of gender dysphoria
- E.D. and gender dysphoria should be addressed synchronously

Case Conception

- Biopsychosocial Evaluation
- Initiating Events
- Recovery Environment
- Prior treatment interventions
- Strengths or Skills deficts



Coined by Roy Grinker in 1952 and expanded on by George Engel in 1977

Normal Eating



Consistent Feeding

Usually every 2-3 hours during waking hours in a meal/snack pattern. Sometimes "grazing"



Thoughtful Nutrition

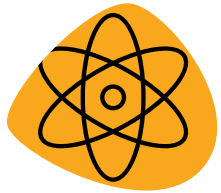
Giving some thought to nourishing foods, but not to the point of missing food pleasure, difficult decision-making or undue worry



Hunger-Fullness

Experiencing hunger prior to a feeding and eating to the point of fullness

Typically 3-4/10 to 7-8/10



Experiments

Experiencing "mistakes" for mindful learning. Examples: over-eating, under-eating, effects of food on physical sensation



Relaxed

Food thoughts & behaviors take some time as part of a balanced lifestyle that varies with schedule, food, hunger,, and emotions

Stages of change

Pre-Contemplation	No problem. No interest in changing behaviors.
Contemplation	Maybe there is a problem.
Preparation	Identification of the problem and need for change
Action	Changes, even if slow and non-linear
Maintenance	Presentation begins

Prochaska, J. O., & DiClemente, C., 1983

Precontemplation or Problem?



Weight Management

Concern for "overweight or "obesity"



Binary Food Paradigm

Desire to make food choices and help with cooking



Nutrition Knowledge

Label reading, Calorie counting...



Measure & Portion Control

Less is more



Diet Foods

Low-fat, Reduced-fat



Limit foods high in sugars

Fast foods, snack foods, soda, etc



Importance of Activity

Athletics and Working out



Influence of Media

Socially Engaged

clinical observations



CDC WSCC Model for School Learning & Health



School Engagement

- Weight self-monitoring
- Calorie Counting and Fitness App
- Nutrition Label-Reading
- "Portioning" and Measuring
- Food Diary
- MyPlate graphic and "Healthy Foods"
- Importance of Physical Activity
- Pseudoscience Food Mockumentaries

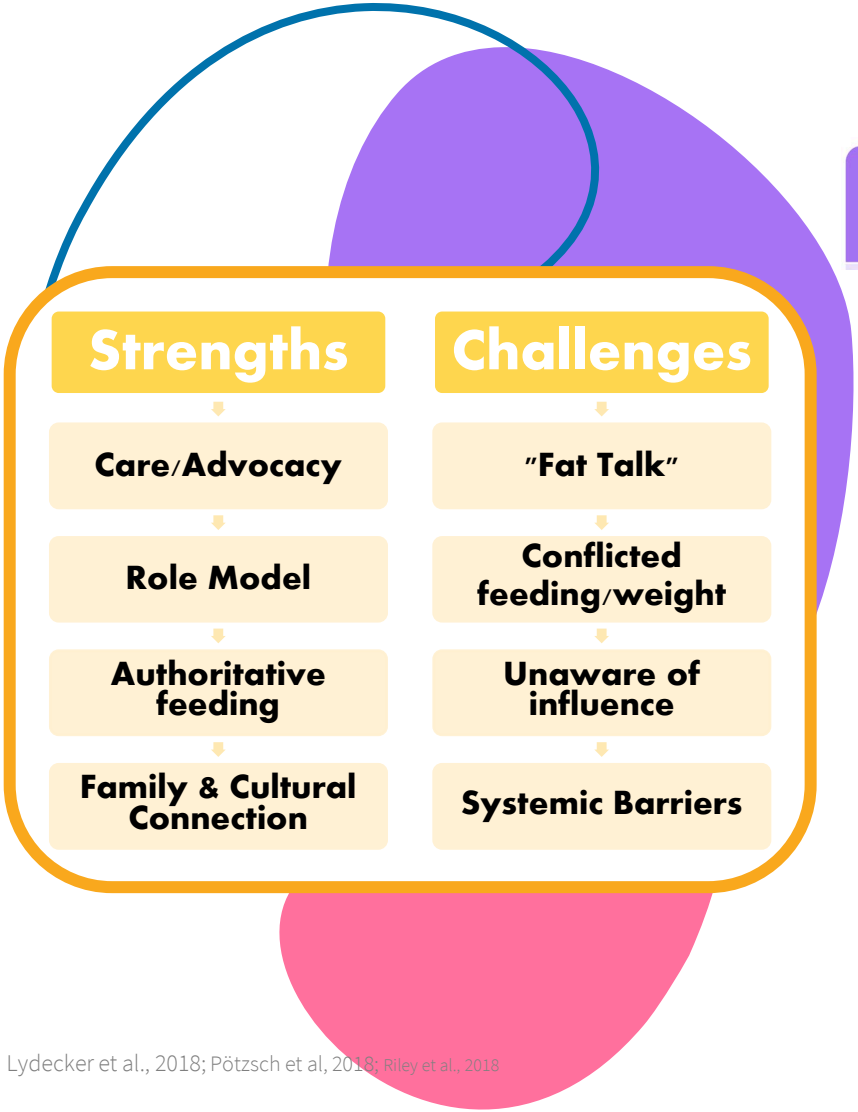


Universal Access | Empathetic Detachment | Person-Centered Assessment | Cultural Sensitivity | Trauma Sensitivity

Health Services

- Lack of empathetic connection
- Weight Stigma & Size-ism
- Emphasis on body weight & growth patterns
- Anti-Obesity Messaging
- Urges to discuss weight loss
- Encouragement for physical activity
- Inadequate food-questioning
- Lack of screening and 'Rule In' diagnoses
- Scripted or not evidence-based recommendations
- Separates the individual from the systems

clinical observations



Lydecker et al., 2018; Pötzsch et al, 2018; Riley et al., 2018



Parental Attitudes

- Caregiver's own relationship to food & body
- Weight bias, Stigma, and Worry
- Dieting, Weight-loss surgery
- Family Cohesion & Resiliency
- Extended family
- Food environment & meal styles
- Skill, Confidence, & Knowledge
- Food Access

Psychological Models

Ego-Syntonic

- Reflects the self-concept
- Is true to reality

Self-Discrepancy

- Actual versus Ideal
- Actual versus Ought

Ego-Dystonic

- Awareness of functional impairment
- Expression of a desire of the disorder not to persist

Mason, et al., 2016

"Self-Eclipsing"

Conceptually, the goal of treatment for an eating disorder is not only to decrease dysfunctional eating behaviors, but to increase adaptive and recovery skills.

Extinguish the Eating Disorder

Empower the client's sense of Self and agency



(Deliberto & Hirsch, 2019)

"Self-Eclipsing"

- **decrease dysfunctional eating behaviors**
- **increase adaptive and recovery skills.**
- **Extinguish the Eating Disorder**
- **Empower the client's sense of Self and agency**



Doing the Opposite



Avoid body checking

body pinching/measuring; cover mirrors



All foods fit

No 'bad' foods. Choose challenging foods.



Ignore external cues

Avoid Label reading, Calorie counting...



Intuitive Eating

Estimate for adequacy



No diet, low fat, or low-sugar foods

Regular Foods



Mindful Eating

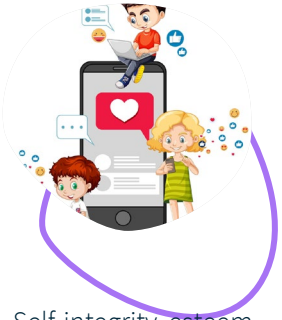
Increased awareness of physical sensations, thoughts, enjoyment, etc.



Valued movement, joy

Body Positivity

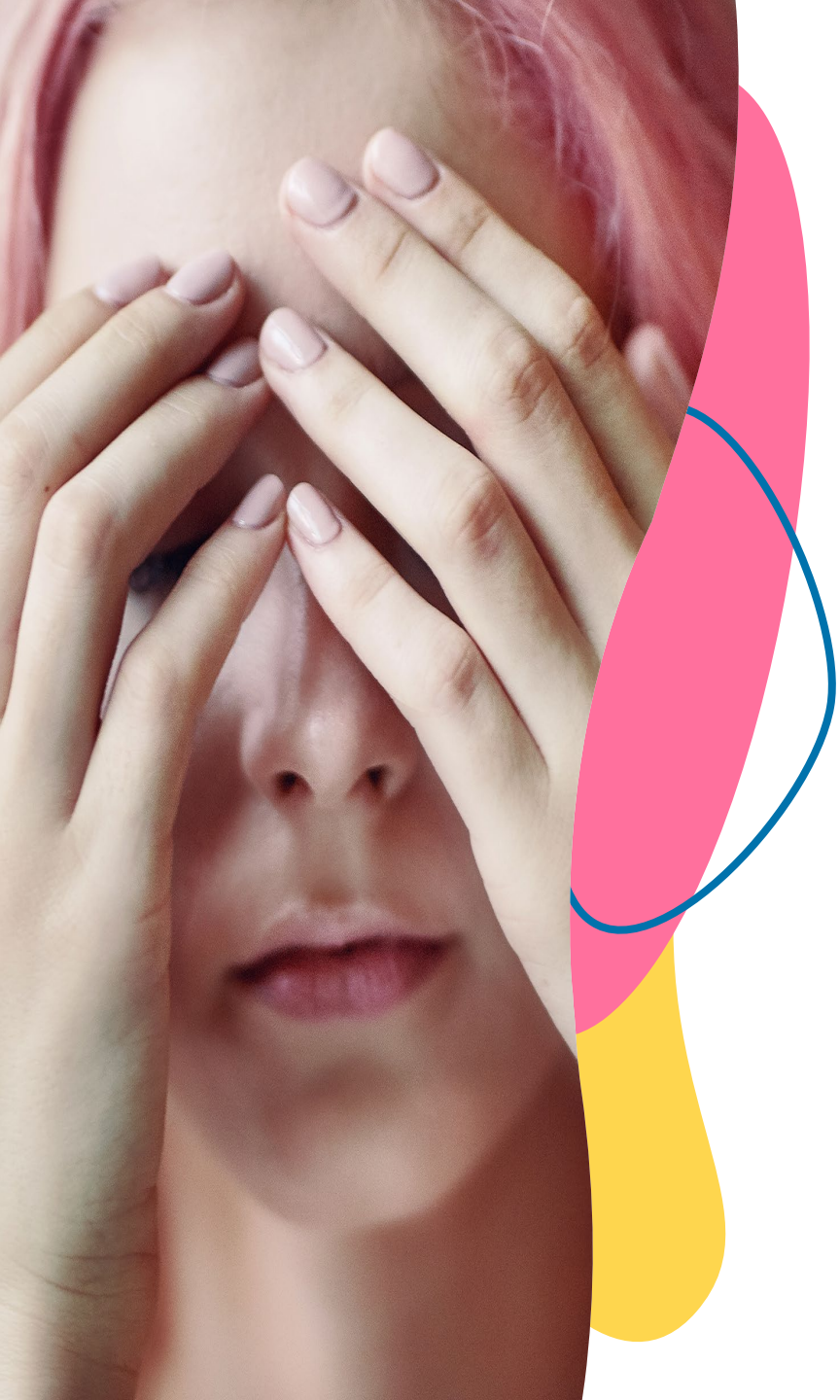
Body Liberation



Self-integrity, esteem

Social eating and food acceptance

Rejecting Diet Culture



Eating Disorders are a Public Health Crisis

DIVISION OF PUBLIC HEALTH STRATEGIC PLAN 2020-2025

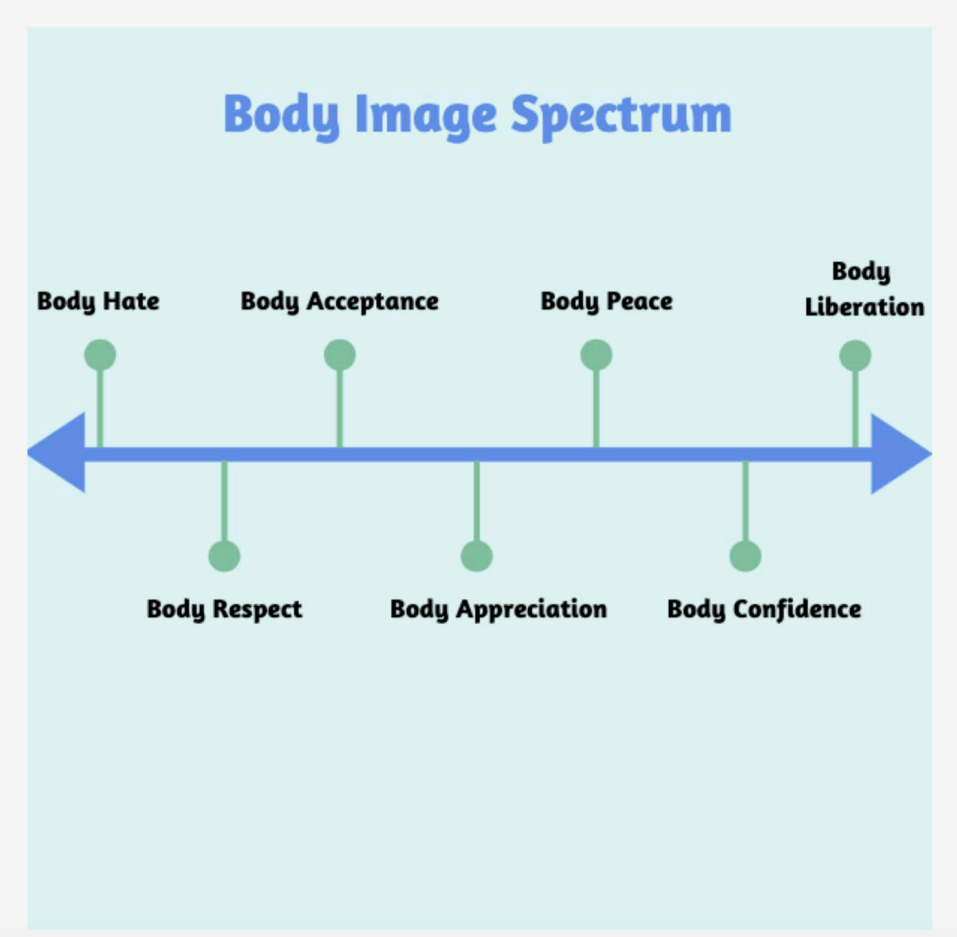
Vision: Healthy and resilient Alaskans today and tomorrow
Guiding Principles: Service, Health Equity, Integrity, Excellence, Leadership, and Dedication
Mission: To promote the health of Alaskans

CORE FUNCTIONS

- Serve as a strategist for existing and emerging public health issues
- Protect life, health and safety of all Alaskans and prevent injury and chronic disease
- Serve as the trusted source of public health information
- Strengthen essential public health partnerships, services, and infrastructure

GOALS

- Address risk factors and conditions that affect multiple aspect of health and well-being
- Increase availability of reliable, trusted public health data to improve the health of Alaskans
- Align public health information in ways that are useful, understandable and actionable
- Use quality improvement and performance management to improve processes and results
- Strengthen collaborative partnerships to achieve shared health outcomes
- Enhance the competency level and professional development of our workforce
- Provide management and leadership to ensure an efficient and effective public health system



Boteler and Raymond, nd.

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Thank you



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Nutrition Partnership

Comagine Health

Break

Back in 15 minutes

Comagine Health

Resources for Alaska Providers

Beth Rose, MPA, Co-Founder and Board Chair AKEDA
Jenny Loudon, MPA, Co-Founder and Board Vice-Chair AKEDA

Resources for Alaska Families & Providers

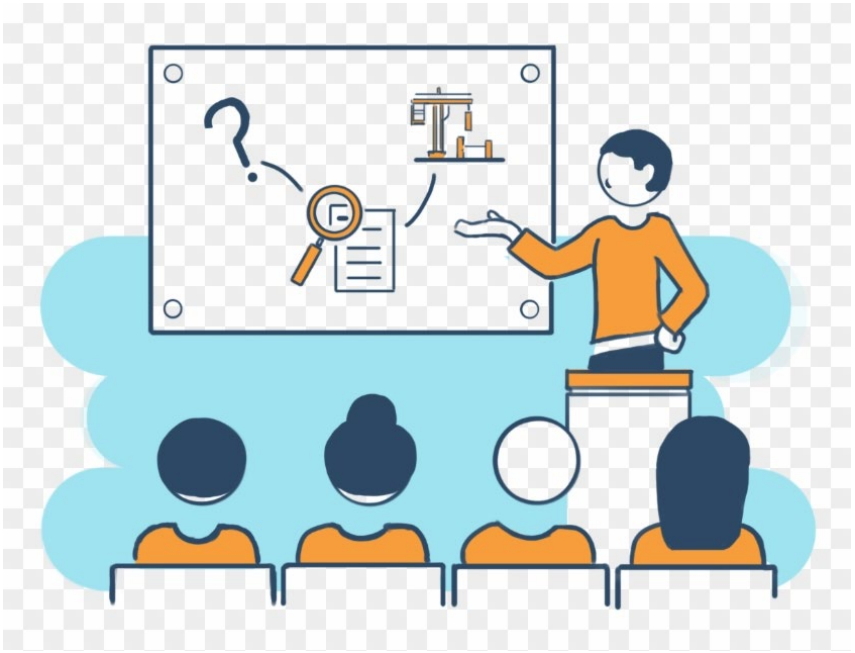
Presentation by

Jenny Loudon, MPA & Beth Rose, MPA
Alaska Eating Disorders Alliance Co-Founders

AKEDA
Alaska Eating Disorders Alliance

Professional Development – Tailored Presentations

- “Eating Disorders Essentials”
- “Making Peace with Your Body”
- “Eating Disorders in a School Setting”



Work with organizations such as:
Anchorage School District,

- Southcentral Foundation,
- Alaska Pediatric Partnership,
- Tanana Chiefs Conference,
- NAMI Juneau,
- Alaska Family Practice Residency,
- UAA & UAF,
- Alaska Behavioral Health

Professional Development

Completed 8 ECHO Sessions with 4 planned for Fall 2023



Webinars on Demand
Neurobioogy of Eating Disorders
with Dr. Laura Hill, PhD



On Demand 7.5 CEs
Eating Disorders Bootcamp
Jessica Setnick, RD, CEDS



Webinars On Demand
Medical Management of Eating Disorders in Outpatient Settings by Jennifer Gaudiani, MD

www.akeatingdisordersalliance.org

AKEDA
Alaska Eating Disorders Alliance

AKEDA Website

Information, Resources, Support Groups and more



www.akeatingdisordersalliance.org

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Referral Resources

https://www.akeatingdisordersalliance.org/alaska-treatment-options

Resources for treatment :
https://findedhelp.com

https://anad.org/get-help/treatment-directory/

Clinical Assessments:
https://www.theprojectheal.org

Finding Help For Acute or Crisis Needs

Mental Health Crisis and thoughts of Suicide – Text or Call 988

Medical Health emergency – Call 911

Emotional support and referrals for EDs Call ANAD at 888-375-7767

Local Support Groups



Friends & Family – 1x a month

Adults with Eating Disorders – 1x a week

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National Virtual Support Groups

The Eating Disorder Foundation

Offering virtual support groups, including some for specific subgroups, such as groups for adults aged 50+, groups for adults aged 30+, groups for men, and adults for LGBTQ+. Free registration is here: https://eatingdisorderfoundation.org/get-help/support-groups/sign-up/

FedUp

Offering virtual support groups for QTBIPOC folx with eating disorders. Free registration is here: **https://fedupcollective.org/resources**

ANAD

Offering virtual support groups, helpline, referrals to treatment centers. Free registration is here: https://anad.org/get-help/about-our-support-groups/

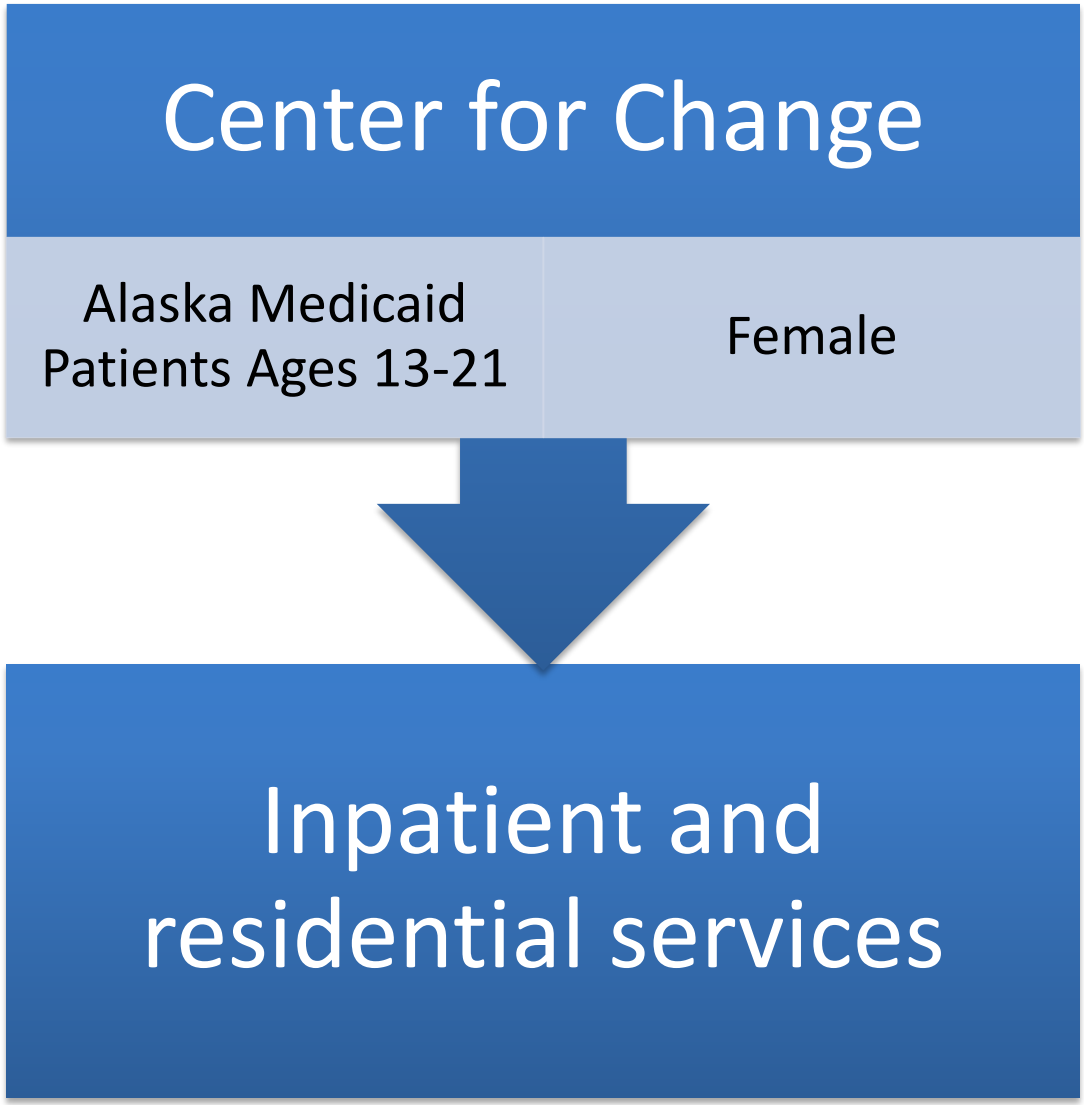
National Alliance for Eating Disorders Awareness

Offering virtual support groups for those seeking recovery and one for LGBTQ+ seeking recovery. Free registration is here: https://www.allianceforeatingdisorders.com/eating-disorder-support-groups-and-programs/#locations

Other Treatment Resources Alaskans Can Access

- **Gaudiani Clinic** – national eating disorders outpatient treatment that is licensed to see patients in Alaska via telehealth
- **Equip** – national virtual intensive program that is licensed in Alaska for adolescents.
- **Monte Nido** – national virtual intensive program that is licensed in Alaska for adolescents and adults

Residential Treatment for those on Alaska Medicaid



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Intensive Family Treatment (IFT) Video Resource

Free Self-Paced Parent Training Course for Alaskan Families

Are you an Alaskan parent of a child or adolescent with anorexia nervosa or restrictive eating issues? If so, this course is for you. AKEDA is offering a free, 7-module, virtual parent training course. A support/discussion group for families started in September, though parents can join anytime.

RSVP



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Eating Disorders And Athletes Documentary



AKEDA's Social Media

Recovery-Focused Social Media that is non-triggering



@alaskaeatingdisordersalliance



@akeatingdisordersalliance



@Alaska_EDA

www.akeatingdisordersalliance.org

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To learn more, contact:

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Comagine Health

Closing Remarks – Conference Wrap Up

Yvette Stratton, RN, BSN, CCM

Executive Director, Care Management

Thank you for the services you provide to Alaska Medicaid recipients, and for your continued efforts on their behalf.

Comagine Health

Thank you for attending!

You will be receiving an email from UAA with instructions about a survey.

This will be related to the conference presentations you have attended.

Please complete the survey if you would like to receive continuing education units.

Comagine Health



https://www.surveymonkey.com/r/RMVLSFP

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