Eating Disorders: An Integrated Treatment Approach

Jennifer Tolman, Ph.D.

"Never doubt that a small group of thoughtful, committed people can change the world.

Indeed, it is the only thing that ever has."

- Margaret Mead
Disclosure

There is no relevant financial information to disclose and no relationships with any commercial interest that influences any of the information presented here today.
Then & Now
Description of Eating Disorders

• Abnormal eating patterns & cognitive distortions related to food, weight, shape and size

• Emotional/Psychiatric
  – Disturbed body image
  – Preoccupation with becoming thinner
  – Fear of becoming fat
Types of Eating Disorders

• Anorexia Nervosa (AN)

• Bulimia Nervosa (BN)

• Eating Disorder, Not otherwise specified (EDNOS)
  – Binge Eating Disorder (BED)
  – Night Eating Syndrome (NES)
Cause of Mortality Among Disordered Eaters

(National Death Index, Crow, 1999)

- Other Medical: 55.8%
- Suicide: 22.1%
- Substance Use: 11.6%
- Traumatic: 10.5%
Diathesis-Stress Model

The term "diathesis" is used to refer to a genetic predisposition toward an abnormal or diseased condition.

Predisposition, in combination with certain kinds of environmental “stress”, results in abnormal behavior.
Specific Factors in the Development of AN and BN

• Biological
  – Genetic predisposition

• Socioenvironmental
  – Thin idealization
    • Media exposure
    • Comments from peers and supportive others, teasing

• Psychological
  – Thin-ideal internalization
  – Self-esteem
  – Beliefs about appearance & body weight and shape

• Behavioral
  – Dietary Restraint
Risk Factors for the Development of an Eating Disorder:

Genetic Factors
- Shorter gestational period
- Early puberty
- Serotonin activity
- Pregnancy complications—pre-term labor & severe birth trauma 3 times higher risk of AN

Biological

Of, relating to, caused by, or affecting life or living organisms

Related by blood or genetic lineage
Socioenvironmental

Anything that is a product of group life. As such it includes culture—the knowledge, attitudes and behavior patterns acquired through living with others.

Felix & Bowers, 1948
Psychological

• **Ethnicity** (Cargo, et al., 1996)
  – Issues of treatment, symptoms vs. diagnoses
  – White females show higher levels of body dissatisfaction at lower BMI levels (Fitzgibbon, et al, 2000; White & Grillo, 2005)

• **Acculturation** (Katzman, 1999)


• **Low self-esteem**

• **Weight concerns & negative body image**

• **Thin-ideal internalization**

• **Dysfunctional beliefs about appearances & body weight, shape and size** (Spangler & Stice, 2001)
Behavioral

- Dietary restraint
- Excessive exercise
- Self-induced vomiting
- Use of diet pills, diuretics, laxative, stimulants
Role of Overvalued Beliefs about Appearances

• Fuse beliefs about self with beliefs about appearance (Spangler, 1997, 1999; Cooper, 1997)
• Beliefs about appearance are hypothesized to result in body/weight dissatisfaction
• Leads to restrictive eating and other behaviors designed to control/alter body shape and weight
• Dietary restriction then leads to physical and psychological deprivation
• Produces strong hunger cues—focus on susceptibility to loss of control over eating (i.e., binge eating)
THUS…

• AN and BN may be initially driven by psychological beliefs, once dietary restriction is initiated, both physiological and psychological factors associated with food deprivation are thought to contribute to the perpetuation of eating disorders (Fairburn, Marcus & Wilson, 1993; Spangler, 1999)
Eating Disorders & Pregnancy

• Maternal and fetal complications
  – Delayed intrauterine growth
  – Premature birth
  – Low birth weight
  – Hyperemesis gravidarum
  – Gestational diabetes
  – Pre-eclampsia/hypertension
  – Higher frequency of Caesarean section deliveries
  – Low Apgar scores

(James, 2001; Micali, Treasure & Simonoff, 2007; Fairburn & Welch, 1990; Clark & Ogden, 1999; Kouba et al., 2005)
Symptomatology

• Binge eating episodes are the most prevalent inappropriate eating behaviors reported.

• Generally accompanied by weight gain.

• Prevalence of regular binge eating among women in first pregnancy is as high as 25-44%:
  – Occur more frequently among women with hx restrict & cannot maintain strict dieting behaviors.
  – Some overeat in response to depression.
  – Difficulty distinguishing adequate versus excessive weight gain.

(Abraham et al., 1994; Fairburn & Welch, 1990)
Other Concerns:

- EDs usually accompanied by anxiety and depression which may increase risk of:
  - Increase/decrease of food intake by mother
  - Low compliance with prenatal care
  - Substance abuse

(Heron et al., 2004; Bulik, Sullivan & Kendler, 2002)
Table 1. Frequency of any disordered eating or substance use behaviors before and during pregnancy (N = 129)

<table>
<thead>
<tr>
<th>Risk Behavior</th>
<th>Before Knowledge of Pregnancy (%)</th>
<th>After Knowledge of Pregnancy (%)</th>
<th>X² (df = 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binge eating</td>
<td>54 (45.0)</td>
<td>39 (32.5)</td>
<td>3.9</td>
</tr>
<tr>
<td>Self-induced vomiting</td>
<td>49 (40.5)</td>
<td>35 (28.9)</td>
<td>3.6</td>
</tr>
<tr>
<td>Diuretic use</td>
<td>2 (1.7)</td>
<td>2 (1.7)</td>
<td>0</td>
</tr>
<tr>
<td>Laxative use</td>
<td>6 (5.0)</td>
<td>4 (3.3)</td>
<td>0.4</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>35 (28.9)</td>
<td>14 (11.6)</td>
<td>11.3*</td>
</tr>
<tr>
<td>Other drug use</td>
<td>11 (9.1)</td>
<td>6 (5.0)</td>
<td>1.6</td>
</tr>
<tr>
<td>Cigarette smoking</td>
<td>26 (21.3)</td>
<td>14 (11.5)</td>
<td>4.3</td>
</tr>
</tbody>
</table>

*p < .01.

Other drug use       | 11 (9.1)                         | 6 (5.0)                         | 1.6        |
Cigarette smoking    | 26 (21.3)                         | 14 (11.5)                       | 4.3        |

*p < .01.
BN Symptoms During Pregnancy

(Crow et al, 2004)

![Bar chart showing the change in BN symptoms during pregnancy.](image-url)
The Study of Food Intake and Eating Behavior in Pregnancy

• $n=712$
• Patients with BE prior to pregnancy reported 3 times more BE during pregnancy relative to those who did not
• Higher incidence of BE among anxious women
• Low pre-gestational BMI was significantly associated with BE during pregnancy
• BE during pregnancy was also significantly associated with excessive weight concern during pregnancy
• One third women (27.8%, $n=198$) reported depressive symptoms during pregnancy and 31.5%, $n=224$) reported anxiety symptoms
• Increase of women with no history of excessive exercise to avoid weight gain
Goals for Treatment

- Build strong therapeutic alliance and outline scope of role
  - Instill hope
  - Demonstrate possibilities for nature of therapy
  - Try to move patient one step further along the path of change

- Educate patient about integrated approach
  - Three-pronged approach
    - Therapist
    - Dietician
    - M.D. (PCP & Psychiatrist, as needed)
Evidence-based treatment

• Binge-Eating Disorder—Group and individual CBT (Mitchell)

• Bulimia Nervosa—CBT (Spangler)

• Anorexia Nervosa—Paucity of research
  – Bulik et al. (2007) Review of Randomized Control Trials
  – Family-based Therapy focusing on parental control of renutrition
    is efficacious in treating younger, nonchronic patients (< 3 years)
      • Led to weight gain & psychological improvements
Integrated Treatment Approach

Why?
Because Eating Disorders are psychiatric disorders with medical & nutritional complications
Role of the Physician

- Manage medical complications:
  - Bradycardia, hypokalemia, anemia, hypotension, amenorrhea, esophagitis, constipation, syncope, palpitations, refeeding syndrome, etc.
  - Prescribe medications as indicated

- Work with R.D. to set weight range

- Work with R.D. on weight restoration

- Consult with treatment team members regarding patient’s medical status
Role of the Therapist

- Thorough assessment
- Educate patient & family regarding the disorder
- Cognitive Interventions
  - Work to decrease depressive symptoms, anxiety & OCD
  - Restructure thinking about self, the world and others
  - Work with patient to develop insight
- Behavioral Interventions
  - Encourage use of support system
  - Involve family as clinically indicated
- Teach new coping skills & behavioral responses
Role of the Dietician

• **Nutrition Assessment & Diagnosis**
  - Diet history
  - Weight history
  - Abnormal eating behaviors
  - Attitudes about weight loss
  - Relationship between emotions & food

• **Work with PCP to define appropriate weight range and restore weight**
  - Outpatient: 0.5-1.5 lbs per week
  - Residential 1.5-2.5 lbs per week
  - Inpatient 2-3 lbs per week
Role of the Dietician

• Implement nutritional treatment plan for duration of treatment
• Manage food and nutrition issues (e.g., meal planning)
• Address disordered eating behaviors
• Dispel myths about food/weight
• Help create new associations with food
Overlap in Integrated Approach

- Assessment information
- Issues of body image, meal planning, progress of nutritional rehabilitation
- Accountability
- Coordination of care
- Don’t suffer alone!
- Don’t worry alone!
“Dare to reach out your hand into the darkness, to pull another hand into the light.”

--Norman B. Rice
Assessment
• Patient’s perspective
  – What prompted the evaluation?—”Tell me why you’re here.”
  – Who prompted the evaluation?
  – Does the patient believe self to have an ED?
  – Patient’s ambivalence re: making changes
  – Insight
    • Tendency to minimize or deny severity of condition
Assessment Instruments

• Eating Disorder Questionnaire (EDQ; Mitchell, 2004)
  – 19 pages, before or as part interview, comprehensive
  – National database
  – Training

• Eating Disorder Inventory (EDI-3; Garner, 2004)
  – 91-item, forced choice, self-report
  – Normed ages 13-53
  – 12 subscales-Six composite scores of Eating Disorder Risk, Ineffectiveness, Interpersonal Problems, Affective Problems, Overcontrol, General Psychological Maladjustment

• Eating Disorder Inventory Symptoms Checklist (EDI-3SC; Garner)
  – Frequency of symptoms
Assessment Instruments

- Eating Disorder Examination (EDE, Fairburn, 1987)
  - Semi-structure to assess bx frequency
  - 4 sub-scales (restraint, eating concern, shape concern, weight concern)

- Eating Disorder Examination-Questionnaire (EDE-Q, Mond, et al)
  - Adapted from EDE
  - 41-item self-report, same subscale & global scale

- Eating Disorder Diagnostic Scale (EDDS; Stice, Telch & Rizvi, 2000)
  - 22-item self-report
  - Detects AN, BN & BED

- Beliefs About Appearances Scale (BAAS; Spangler, 2001)
Diagnostic Interview--History

- History of illness (patient / collateral information)
  - Point of first concern
  - ED symptoms
- Onset vs. maintenance
- Weight history, family weight history—EDs, obesity
- Hx of changes in weight and dieting
  - May be related to emotional / environmental experiences
  - May have been exacerbated by significant life change or interpersonal event
  - Weight loss programs, surgeries
Diagnostic Interview--Eating

• Eating Patterns—
  – Frequency of meals and snacks
  – Kcal intake
  – Use open-ended questions /poor historians
  – Family attitudes toward eating and accompanying behaviors
Diagnostic Interview—Compensatory Strategies

- Frequency of the behaviors
  - Dietary Restriction
  - Occurrence and frequency of bingeing
  - Occurrence and frequency of purging behaviors
  - Exercise
  - Pro-Ana Websites
Diagnostic Interview—Body Concern

• Body Image / Beliefs about appearance/ Body dissatisfaction
  – Fear of weight gain
  – Size estimation—does this change frequently or after meals, “obese” parts

• Pre-occupation, Food rituals, Body checking/mirror gazing, avoidance
Diagnostic Interview--Other

- Eating disturbance & occupational influence
- Medical complications—dental, esophageal tears, gastroparesis, delayed gastric emptying
- Impact on social functioning
Family’s Attitudes Toward Eating & Accompanying Behaviors

- Dieting, weight, shape, size, food rules, exercise
- Effect on relationships with food & exercise
- Comments re: overweight individuals that may be internalized, jokes, comments about weight loss or gain
Comorbid Diagnoses

- Assess SI & hx of self-harm
- Assess for MDD
- Anxiety (GAD, OCD, Social Phobia)
- Bipolar Disorder
- PTSD (may be related to trauma or sexual abuse)
- Substance Abuse—may be some reluctance—fears judgment
- Personality Disorders—will inform course & prognosis
- Global Assessment of Function
Other

• Highest & lowest weights
• Current height & weight
• Patient’s “ideal weight”
• View of self at current weight
• Medications
• Prematurity at birth
• Menarche—
  – Age and family hx of menstruation
  – Sustained (3 months or >) amenorrhea
  – Associated with weight change
• Treatment history