Eating Disorders In Our Community: A Real Problem in Need of Solutions

Wendy Oliver-Pyatt, MD

Founder and Director: Oliver-Pyatt Centers

Eating Recovery and Wellness Center of Nevada

Founder and Director of Psychiatric Services: Center for Hope of the Sierras

Chair: Academy for Eating Disorders Advocacy Committee

Author: Fed-Up! The Breakthrough Ten-Step No-Diet Fitness Plan (McGraw-Hill)

www.oliverpyattcenters.com

www.centerforhopeofthesierras.com

866-511-HEAL (4325)

Cellular: 775-250-2421

woliver@oliverpyattcenters.com

Diagnostic Criteria: Anorexia Nervosa

- Refusal to maintain body weight at or above a minimally normal weight for age and height (less than 85% of expected).
- 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.
- In post-menarche females, amenorrhea (absence of at least three consecutive menstrual cycles).

Diagnostic Criteria: Bulimia Nervosa

- Recurrent episodes of binge eating.
- Recurrent inappropriate compensatory behavior in order to prevent weight gain.
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- The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months
- Self-evaluation is unduly influenced by body shape and weight.

Additional Diagnostic Subtypes:

BULIMIA NERVOSA

- Purging type
- Non-purging type

ANOREXIA NERVOSA

- Restricting type
- Binge eating/purging type.

Not to be Forgotten: Eating Disorder NOS

- It is estimated that about 1/3 of those who present for treatment of an eating disorder fall into this category
- For example, anorexics who still have menses, chronic dieters who only purge when the eat a food they label fattening
- Insurance companies seek to exclude (eg CO); 30-40% of eating disorder patients who need residential treatment meet this criteria

Binge Eating Disorder*

- Eating in a discrete period of time an unusually larger amount of food
- A sense of loss of control over eating
- Also: eating more rapidly, until feeling uncomfortably full, when not physically hungry, alone, feeling disgusted with oneself
- Marked distress about the binge (but generally not as distressed as other ED patients about their binge eating)
- About 40% are men

*not yet a formal DSMIV diagnosis; strongly linked to obesity

Normative Discontent

- Do we live during an epidemic of self-hate toward our bodies?
- According to American Dietetic Association: 45% of women & 25% of men are on a diet at any one point in time
- Glamour found that out of 33,000 women, 75% considered themselves fat, while only 25% exceeded recommended weight, and 30% were underweight
- One survey found 90% of 17 year old girls were dieting.
- Extreme dieters were found to be 18X more likely to develop eating disorders

Diet=Weight loss? The Road to ___ can be paved with good intentions…

- Is this a delusion?
- Bodies of people losing weight rapidly decreased metabolism by 15% (New England Journal of Medicine)
- Dietary restraint is temporary in almost all cases
- Genetics influences dictate we have different body types, but we're all trying for the same thing!

Role of Dieting in Eating Disorders

- Dieting has become normative since 1970's
- Dieting entails replacing internally regulated (hunger-driven) eating with externally controlled eating
- Restrained eater must ignore internal signals
- Dieting promotes insensitivity to internal cues
- Eating Disorders BEGIN with "normal" dieting

Effects of Weight Cycling

- Damage to heart and cardiovascular system
- Reduces bone mass and increases risk of hip fractures
- Increase risk of gallstones
- May cause DNA damage or abnormal cell changes in breast tissue
- May increase risk of hysterectomy
- Causes physical weakness
- May alter tryptophan levels and effect serotonin function

Dieting: Conclusion

- Dieting in normal weight individuals is associated with adverse psychological consequences and should not be recommended.
- Dieting is a risk factor for the onset of Eating disorders
- Eating disorders begin with dieting

The Eating Disordered person has not learned how to take care of him/herself adequately

Epidemiology of Eating Disorders

- Young females are most vulnerable
- Binge eating & purging has been reported in up to 40% of young college women
- Only a small minority come to clinical attention (especially w/ Bulimia Nervosa)
- Over-represented among wrestlers, ballet dancers & models
- “Western” Illness

Eating Disorders: Who is affected and what help do they receive?

- Affects about 10 million women and 1 million males
- For females 15-24 death rate for Anorexia Nervosa is 12 X all other death rates.
- 1/3 of patients with Anorexia Nervosa receive mental health care
- 6% of patients with Bulimia Nervosa receive mental health care

Dieting Prevalence and Eating Disorders

- **81% of 10 year olds are afraid of being fat. 51% of 9 and 10 year old girls feel better about themselves if they are on a diet (Mellin et al., 1991).**
- **- The average woman is 5'4" tall and weighs 140 pounds. The average American model is 5'11" tall and weighs 117 pounds. Most fashion models are thinner than 98% of American women.**
- **- 91% of women recently surveyed on a college campus had attempted to control their weight through dieting, 22% dieted "often" or "always" (Kurth et al., 1995).**
- **- 35% of "normal dieters" progress to pathological dieting (Shisslak & Crago, 1995).**

Important Facts About Eating Disorders

- Eating Disorders have highest mortality of any mental illness
- AN is 3rd most common chronic illness of adolescents
- 25% of College age women engage in bingeing and purging
- Up 10 -20% of those with Anorexia will die due to AN related causes
- 42% of 1-3rd graders want to be thinner
- #1 wish of girls 11-17 is to be thinner
- 9% of 9 year olds have vomited to lose weight

Eating Disorder Research Funding vs Alzheimer's Disease and Schizophrenia

- Eating Disorders: 10 million people; 12 million dollars
- Alzheimer’s Disease: 4.5 million people; 647 million dollars
- Schizophrenia 2.2 million people; 350 million dollars
- $1.2 dollars per ED patient vs $159.00 per Schizophrenia patient

Family/Genetic Perspectives

- 4 of 6 published family studies found familial aggregation
- In twin studies genetic factors contributed more to A.N. than B.N.
- Studies are limited by small sample size and lack of blind diagnosis
- No significant relationship to family size & birth order

Behavior and Social Consequences

- Drastically reduced caloric intake (often is socially reinforced)
- Excessive exercise persists even when cachectic (often is socially reinforced)
- Bingeing, purging, laxative abuse, diuretic abuse, IPECAC
- Bizarre food behaviors
- Social Avoidance, loss of psychosocial functioning,
- Automobile accidents
- Substance Abuse (methamphetamines—and all of the problems associated with this)

Psychological Symptoms

- Depressed mood/dysphoria
- Social withdrawal/irritability
- Loss of libido
- Obsessional ruminations and rituals
- Reduced alertness and concentration

Psychiatric Co morbidity

- Lifetime risk of Affective Disorders is 84%
- Major Depression in 60% of patients with Anorexia Nervosa at intake
- Anxiety Disorders in 20% of patients with Anorexia Nervosa at intake
- Personality Disorders in 20% of patients with A.N. and 40% with A.N./B.N.

Similarities between Eating Disorders and Addictions

- Strong urges/cravings
- Loss of control
- Drugs/food regulate emotional state
- Preoccupation with repeated attempts to stop destructive behavior
- Denial/secretiveness
- Negative psychological/emotional consequences

Eating Disorders in Males

- Male to female ratio is about 1:10
- Males feel overweight when 15% over ideal body weight
- Females feel thin when less than 90% of ideal body weight
- Males feel thin when up to 105% of ideal body weight

MEDICAL PROBLEMS ASSOCIATED WITH EATING DISORDERS:

- Among all psychiatric conditions, eating disorders are associated with the highest frequency of medical morbidity and mortality among
- No organ system is spared

Medical Complications

- 18% mortality in a 33 year follow-up of severe anorexics (Theander, 85)
- 6X increase in mortality in shorter follow-up
- No other psych dx manifests as many medical conditions
- Most medical complications are similar to those seen in starvation

Endocrine Complications

- Hypothalamic Dysfunction/LHRH impaired
- Low FSH/LH/Estradiol
- Hypogonadotropic Hypogonadism
- Clinical evidence of Hypothyroidism
- Growth Hormone levels increased

Endocrine Complications

- Elevated plasma cortisol/dexamethasone non-suppression
- Decreased secretion of Vasopressin
- Low Testosterone in male anorexics

Cardiovascular Complications

- Cardiac abnormalities in up to 87% of pts
- Bradycardia (<60beats/min) common; (watch out for relative tachycardia in refeeding, and inadvertent assignment of bradycardia to athleticism)
- Hypotension in up to 85% of anorexics
- Arrhythmias
- Congestive Heart Failure
- EKG changes (low voltage in anorexia)

Factors that increase cardiac risk:

- Severe or rapid weight loss (EVEN IF THE PATIENT IS IN A “NORMAL WEIGHT RANGE”
- Purge frequency (electrolyte disorders)
- Ipecac (toxic to cardiac muscles)
- Comorbid physiologic disorders (eg diabetes, inflammatory bowel disease)
- Older age or underlying cardiac disease

Refeeding Syndrome:

- Because of weight loss, heart mass is reduced
- Reduction in heart mass makes it difficult for the heart to handle the circulatory blood volume
- This can result in heart failure
- In addition, changes in electrolytes can cause abnormalities in the contractile properties of the heart, which may also contribute to heart failure

Gastrointestinal Complications

- Dental caries/perimylolysis
- Benign enlargement of parotid gland
- Esophageal complications
- Acute gastric dilation during refeeding
- Delayed gastric emptying
- Duodenal dilation/acute pancreatitis
- Colonic complications

Electrolyte/Renal Complications

- Dehydration in up to 70% of anorexics
- Metabolic alkalosis
- Low body stores of phosphate
- Hypomagnesemia in 25%
- Renal calculi
- Hypokalemic nephropathy
- Peripheral edema

Skeletal Complications

- Adolescent girls are at peak risk for osteopenia
- Osteoporosis & stunted growth can be irreversible
- Osteoporosis is present within 2 yrs of onset of A.N.
- Fractures of long bones, vertebrae, & sternum

Hematologic Complications

- Pancytopenia common in severe anorexics
- Mild anemia & thrombocytopenia in 1/3
- Leukopenia in 2/3
- Spur cells causing decreased ESR
- Bone marrow hypoplasia

Metabolic Complications

- Lowered basal metabolic rate
- Hypercholesterolemia
- Altered glucose metabolism
- Impaired temperature regulation

Sleep Complications

- Normal weight bulimics are similar to controls
- Anorexics have less deep sleep & more disrupted sleep
- Total sleep time reduced
- Early morning awakening
- Shortened REM latency

Dermatologic Complications

- Languno on 1/3 of malnourished anorexics
- Dry, scaly skin with reduced collagen content
- Hypercarotenemia in 80% of anorexics
- Russell's sign

Remember: The First Three Stages of Change are Invisible

- Awareness
- Contemplation
- Preparation
- Action (needs a supportive and collaborative environment)
- Maintenance (presence of thoughts are still there)
- Termination

Psychological Treatment: Approach

- Psychoeducation is critical
- Reinterpretation of distortions
- Affective expression (improving recognition of feeling states; assist patient to recognize state of hunger and satiation; teaching mindfulness)
- Self-esteem (build on factors outside of weight; recognize cultural influences on self-perception)
- Notice ED as a coping mechanism; the one major way they've learned to cope
- Address major interpersonal problems
- Family therapy/group therapy
- EXPOSURE THERAPY; STRUCTURED, NATURALISTIC ENVIRONMENT IS CRITICAL TO POSITIVE OUTCOME

Obstacles to Seeking Help:

- Financial limitations and severe limitations by some insurance companies on treatment and adequate treatment durations authorized
- Disorder not viewed as problem
- Shame, guilt, secrecy prevail
- Difficulty telling the doctor/mistrust
- Fear of treatment &/or gaining weight
- Prior treatment experiences which were experienced as unhelpful or dehumanizing

Connection is the Key; Authenticity can get you there

- Hallowell study of 14,000 children asking what factors help children stay out of trouble?
- Not predictive=money, divorce, religion, grades
- The only predictive factor was obtained subjectively: The child reported feeling

a) Connected at home

b) Connected at school

Typical Problems faced by the "Insured" Eating Disorder Patient:

- Limited or no mental health coverage
- Exclusion of eating disorder from mental health coverage
- Exclusion of level of care needed to intensively provide needed treatment in least restrictive environment
- Insurance company cutting off treatment prematurely on basis of "not medically necessary", especially if the patient is a normal weight or near "normal" weight
- Doctors and/or case managers making decisions about authorization of treatment who have little to no experience treating eating disorders; overriding expert recommendations
- Lack of following guidelines developed by experts in field of Psychiatry and Adolescent Medicine.
- Case Examples:

States with Coverage for Eating Disorders:

- California
- Connecticut
- Delaware
- Maryland
- Minnesota
- North Dakota
- New York
- Rhode Island
- Vermont
- Washington
- West Virginia
- Colorado
- Massachusetts (currently being considered)

Outcome of Anorexia Nervosa

- Outcome studies drawn from most severe cases
- Long-term follow-up showed 18% mortality
- Younger age of onset is good prognostic indicator
- Mixed outcome results in anorexics with bulimic symptoms

Outcome of Bulimia Nervosa

- Studies drawn from brief interpersonal therapy group demonstrated that 1/2 recovered, 1/4 improved, 1/4 unchanged
- Course can be chronic, & waxing/waning but COMPLETE recovery is possible
- May have recurrences during stress
- In some, spontaneous remission after 1-2 yrs

TREATMENT WORKS; BUT IT IS FREQUENTLY NOT ACCESSIBLE EVEN TO THE "INSURED" PATIENT