
Eating Disorders: Practical Tips for Recognition Through Management

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Who Are We?

Jessica Van Huysse, PhD

- Clinical Psychologist
- Michigan Medicine
 - Clinical Director of the Comprehensive Eating Disorders Program
 - Research and education

Katie Miller, MD

- Family Medicine/Adolescent Medicine
- Michigan Medicine
 - Adolescent/Young Adult Clinic
 - Comprehensive Eating Disorders Program
 - Medical Education

Who Are You?

Overall Goal

Adolescent
Population



8 million
people in the
US struggling
with an eating
disorder

Peak age of onset:
14-19 years

3rd most common
chronic illness in teens

Eating Disorder
Illness & Mortality

Males: 10-
25% of eating
disorder cases

Increasing rates in
younger children, boys
and minority groups

Path/Objectives

Part 1: Early Identification

- Signs/symptoms
- Risk Factors



Part 3: Complications

- Health Impacts
- Hospitalization

Part 2: First Steps in Intervention

- Levels of care
- Goals of treatment

Part 4: Long-Term Management

- Time course
- Difficult issues

Part 1: Early Identification

Time to Vote

DOES THIS YOUNG PERSON HAVE AN EATING DISORDER?
WHICH ONE?





Yes:
Anorexia
Nervosa

Sam: 16 yo cross county runner, losing weight for faster times, BMI was 50%ile now <5%ile, parents and coach concerned, Sam thinks he is over-weight, limiting to 1600 calories/day, sneaking out of house to run an extra hour per day

Anorexia Nervosa (AN)

- **Restrictive eating** leading to lower than expected body weight
- **Fear of weight gain**, or behaviors that interfere with gain
- **Disturbance in body image**

Two Types: restricting or binge eating/purging



Yes:
Avoidant
Restrictive Food
Intake Disorder

Ellie: 11 yo always a picky eater but now failure to gain weight in the last year and mostly liquid diet due to fear of choking

Avoidant Restrictive Food Intake Disorder (ARFID)

- **Lack of interest in food or avoidance** based on sensory characteristics of food, or concern about aversive consequences (examples: choking or vomiting)
- **Failure to meet nutritional needs:** losing weight or not achieving expected gains, or dependence on liquid supplements via oral or tube routes
- **Not** attributable to **another eating disorder**, or medical condition
- **No distortion in body image**



Yes:
Binge Eating
Disorder

Ray: 18 yo, stressful 1st semester in college, weight up 30# in 3 months, hiding in dorm room 2-3 nights/week consuming very large quantities of food until he feels sick. Then goes to bed feeling ashamed.

Binge Eating Disorder (BED)

- Binge eating at least 1 time/week for 3 months, with at least 3 of the following:
 - Very rapid eating
 - Eating until uncomfortably full
 - Eating large quantities despite lack of hunger
 - Eating alone because embarrassed by amount
 - Feeling of distress or guilt after eating episodes
- Distress caused by the binge eating
- Not engaging in compensatory purging behaviors
- Not occurring in the context of AN or BN




Nope:
“normal” body
dissatisfaction

Tara: 13 yo constantly comparing self to models on Instagram, wants to have a flatter stomach, tries to eat “clean” and wants to improve her “thigh gap”

Current culture

- 50% of girls and 25% of boys are dissatisfied with their bodies
- 50% of girls and 25% of boys report dieting over the past year
- 9% of girls and 4% of boys report regular self-induced vomiting
- Frequent social media exposure → increases in negative body image and disordered eating behaviors


A young man with dark hair, wearing a black and white striped shirt, is sitting on a concrete staircase. He has a distressed expression, with his right hand pressed against his forehead. The background shows a modern building with large windows and a glass door.

Yes:
Bulimia
Nervosa

Jack: Tired of peers making fun of his weight, didn't have luck losing weight with exercise, for the past 4 months binge eating a few times per week followed by taking 5 ex-lax or inducing vomiting.

Bulimia Nervosa (BN)

- Binge eating at least 1 time/week for 3 months
 - Unusually large amount of food consumed in a discrete period
 - Perceived loss of control during episodes
- Purging behaviors after binge to limit weight gain at least 1 time/week for 3 months
 - Examples: vomiting, laxatives, diet pills, diuretics, fasting or exercise
- Weight/shape overly influence self-worth
- Not occurring in the context of AN



Yes:
Atypical
Anorexia
Nervosa

Sarah: 15 yo, severely restricting her calories for 3 months, weight down 10# to 60%ile BMI. Hates looking in the mirror, thinks of herself as obese, will not eat around friends or family.

Other Specified Feeding or Eating Disorders (OSFED)

- Eating issues which fall below the threshold for frequency/duration, or do not meet full criteria for above disorders
- One example:
 - Atypical AN—meets all criteria for AN but not low weight

Risk Factors

**7-12 x the risk if
relative with ED**

- Genetics
- Dieting behavior
- Athletics (weight classes, asthetics)
- Antecedent illness with weight loss
- For binge eating disorder: childhood obesity and negative body messages from family
- History of sexual assault/abuse
- History of early puberty in females

Red Flags/Common Presentations

- Abrupt changes in weight
- Distorted view of body weight or shape
- Excessive or rigid exercise regimen: despite injury, fatigue, illness, weather
- Loss of menses
- Increase in constipation/bloating or abdominal pain
- Preoccupation with weight/food/calories
- Change in eating patterns
- Withdrawal from friends and activities
- Unhealthy weight control measures
- Eating secretly, concerned about eating in public

Part 2:

First Steps in Intervention

Case

- 16 y/o female, competitive swimmer
- Noticeable weight loss
- Maintaining straight A's in school
- Spending lunch hour in school library, inconsistently eats lunch
- Seems to be more isolated from friends
- Peer approaches school counselor with concerns about her friend's poor body image and restrictive eating

Early Intervention

- What steps do you take if you are this young person's...

We are concerned about [student's name] because of some behaviors we've noticed recently. We've noticed [student] does [not eat lunch; eats very little; throws lunch away; always requests a restroom pass immediately after eating and becomes very agitated or upset if not given a pass at that moment]. I was wondering if you had any concerns or noticed anything recently.

Intervention

- What are some of the challenges?
 - Secretive nature of ED behaviors
 - Lack of recognition of seriousness of situation (by teen and/or parents)
 - Identifying appropriate treatment team
- Resources



Early Intervention: Primary Care

Complete history

Rate and amount of weight loss/change, growth history

Nutritional history, including dietary intake and restrictions

Compensatory behaviors

Exercise

Menstrual history

Full psychiatric history, including self-harm and suicidality

“Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders” created by the Academy for Eating Disorders (AED) Medical Care Standards Task Force

Early Intervention: Primary Care

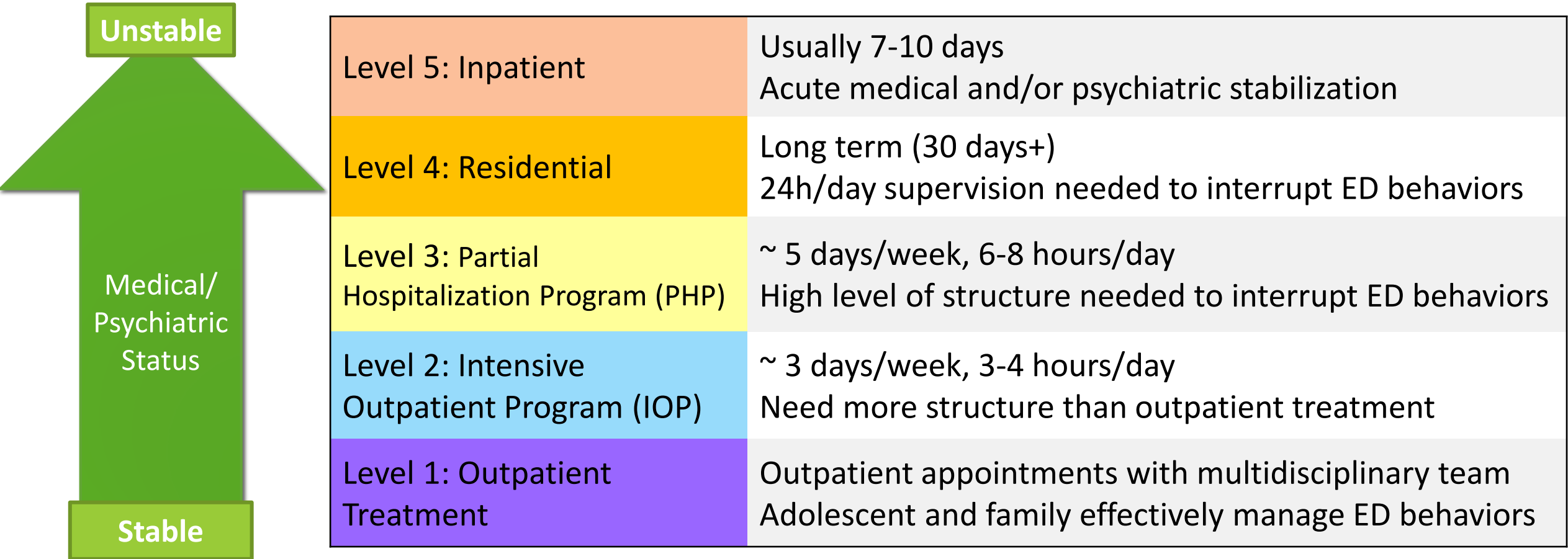
Initial Exam

- Height, weight, and body mass index
- Lying and standing heart rate and blood pressure
- Oral temperature
- Complete Blood Count (CBC)
- Comprehensive panel to include electrolytes, renal function, and liver enzymes
- Electrocardiogram (EKG)

Treatment goals

Medical and Nutritional Stabilization	Psychosocial Stabilization
Management of acute and chronic medical comorbidities and complications	Re-establishment of appropriate social engagement
Weight restoration (when necessary)	Improved body image
Resumption of menses	Elimination of disordered/ritualistic eating behaviors
Cessation of restrictive or binge eating and/or purging behaviors	Restore meal patterns that promote health and social connections

Levels of Care



Unstable

Medical/
Psychiatric
Status

Stable

Evidence-Based Psychotherapy

Family Based Treatment (aka Maudsley Approach)

- AN, BN
- Twice as likely to remit compared to individual treatment



Cognitive Behavioral Therapy for Eating Disorders

- BN, BED (more research needed in youth)
- Results in recovery in 40-80% of cases



Part 3: Complications

Match the health impacts to the eating issue:

Restrictive Eating

Growth failure/Pubertal delay
Cardiac arrhythmias
Low bone density
Cognitive slowing

Purging

Dental enamel erosion
Cardiac arrhythmias
Laxative dependence
Esophagitis/rupture

Binge Eating

Parotid gland enlargement
Metabolic syndrome
Non-alcoholic fatty liver disease

1. Growth failure/pubertal delay
2. Parotid gland enlargement
3. Dental enamel erosion
4. Cardiac arrhythmias
5. Metabolic syndrome
6. Laxative dependence
7. Non-alcoholic fatty liver disease
8. Low bone density
9. Cognitive slowing
10. Esophagitis/rupture

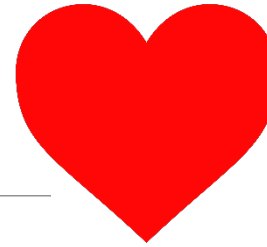
Anorexia Nervosa:



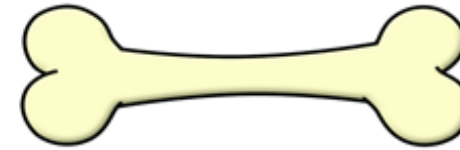
Stephanie, 19

- AN since age 13
- Very low weight
- Loss of menses for 3 years
- Hospitalizations for low heart rate and syncope
- Low bone density dx at 16
- College soccer, not able to play due to stress fractures

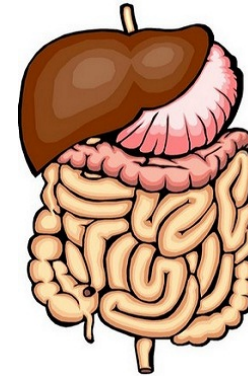
Impacts multiple systems:



- Thinned heart wall
- Low heart rate/blood pressure
- Arrhythmias



- Low bone density
- Growth delay/arrest



- Slowed GI motility
- Hepatitis



- Cognitive slowing
- Mood disorders

Bulimia Nervosa:



Hillary, 17

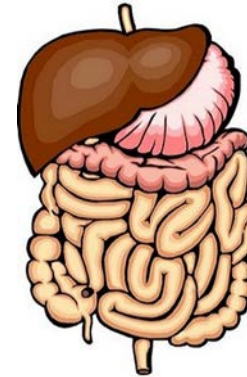
- Developed BN junior year of high school
- Purging methods: daily vomiting and laxatives
- Gained 20# in last yr
- Chronic esophagitis
- Hospitalized for hypokalemia and severe constipation

Impacts multiple systems:



Electrolyte abnormalities

Arrhythmias



Tooth enamel erosion

Parotid enlargement

Esophagitis/rupture

Constipation



Mood impacts

When to consider hospitalization?

Hospitalization for medical stabilization

<75% healthy body weight

Hypotension

Bradycardia

Severe dehydration

Severe hypokalemia or other electrolyte abnormality

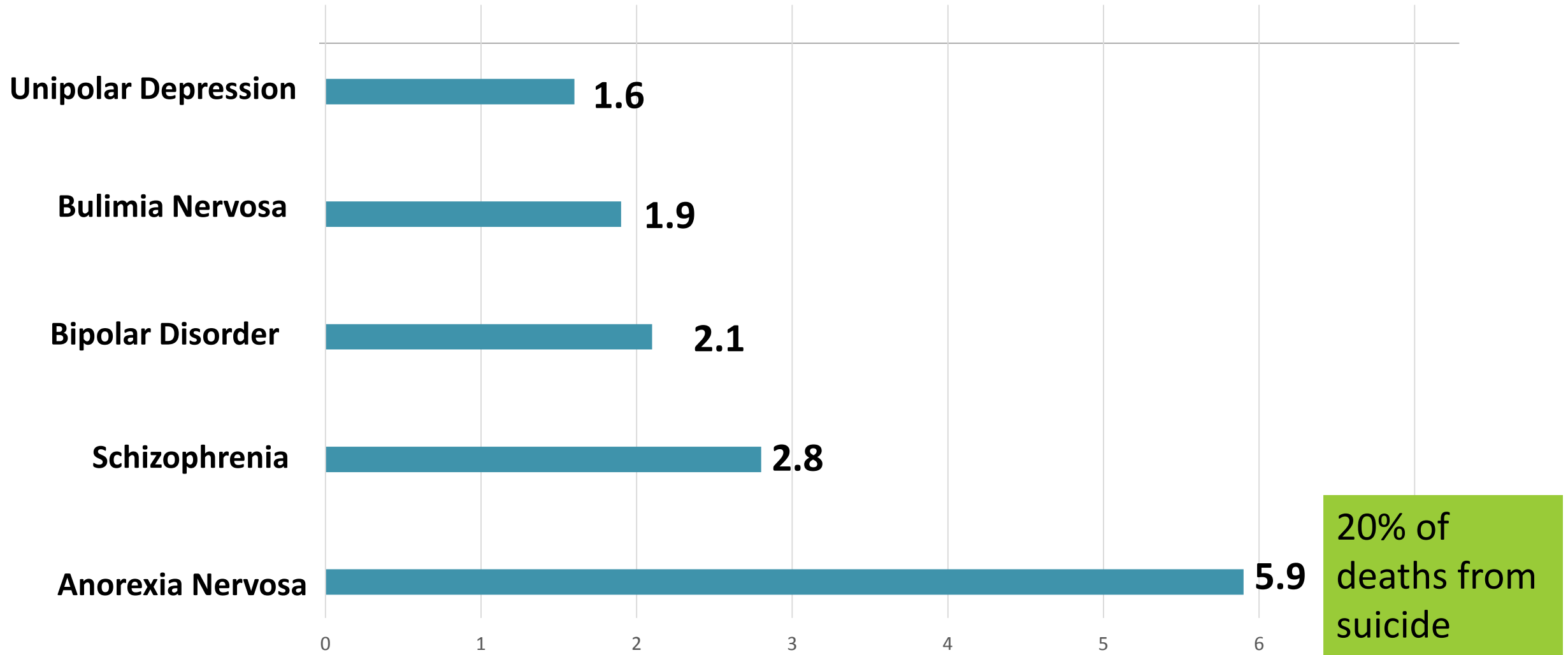
Acute medical complications: seizures, GI bleed, syncope

Hospitalization for psychiatric stabilization

Severe depression/suicidality

Behaviors are severe/out of control but medically stable

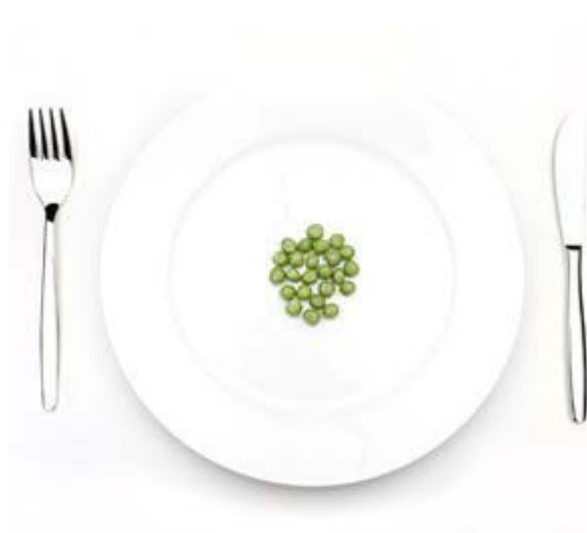
Mortality Risk Comparison



STANDARDIZED MORTALITY RATIO (ratio of observed to expected deaths)

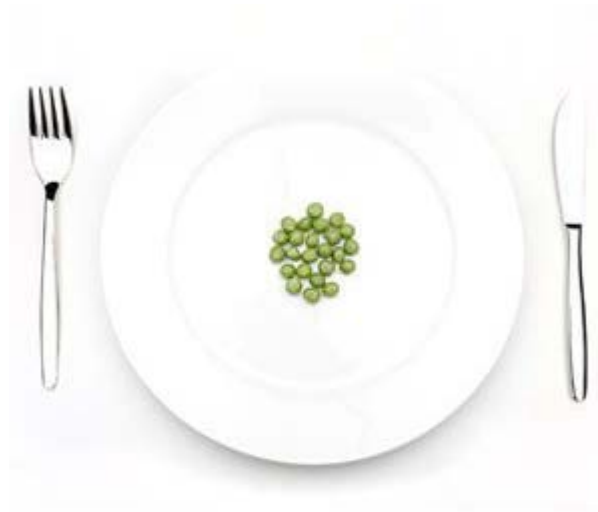
Part 4: Long-Term Management

Full recovery from an eating disorder is possible:
(TRUE/FALSE)

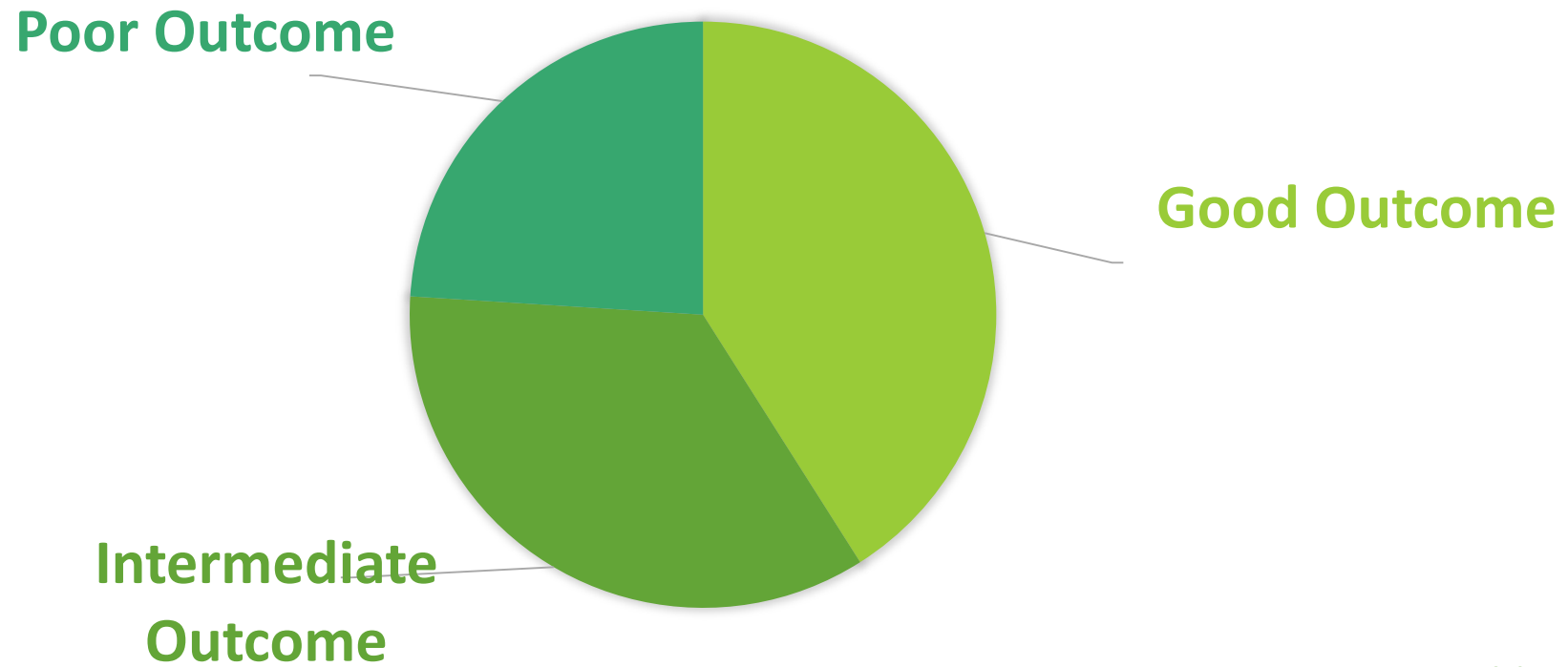


Full recovery from an eating disorder is possible:

TRUE!

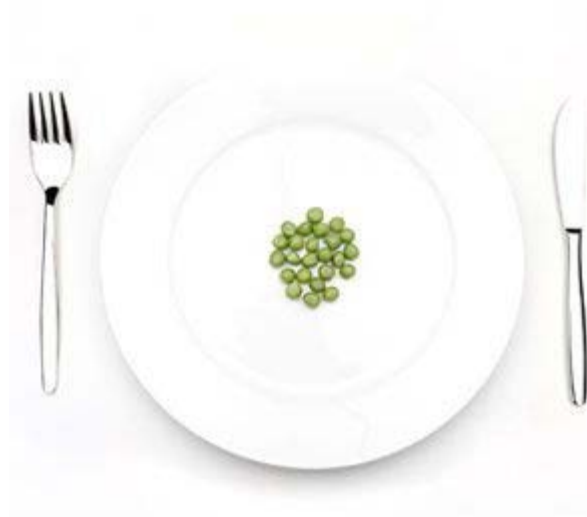


OUTCOMES OF CHILDHOOD/ADOLESCENT AN



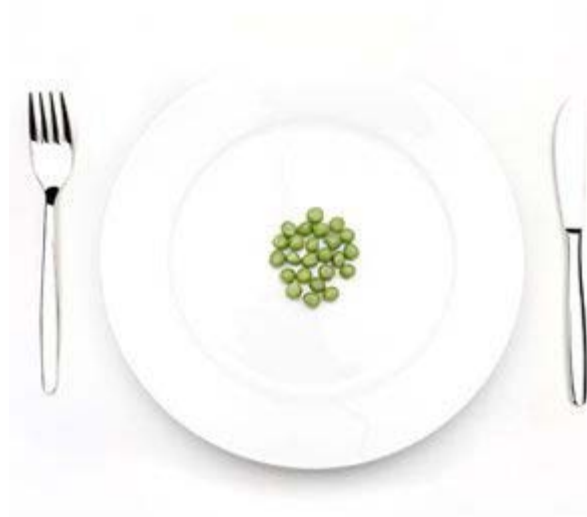
Herpertz-Dahlmann et al., 2018

Athletes can continue sports involvement during treatment:
(TRUE/FALSE)



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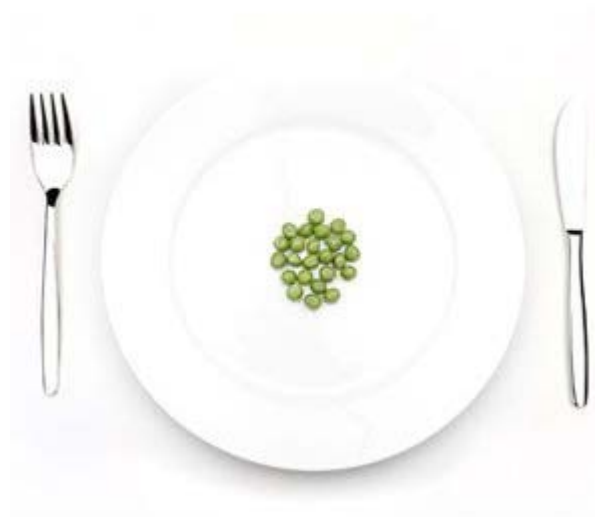
FALSE (almost always)



Indications of readiness to return to athletics

Medical/Physiological	Psychological
Maintaining appropriate weight	Endorses reduction in weight/shape concerns
Stable vitals, labs	No longer engaging in eating disorder behaviors
Able to eat flexibly	Can reflect upon signs that athletic involvement is interrupting recovery

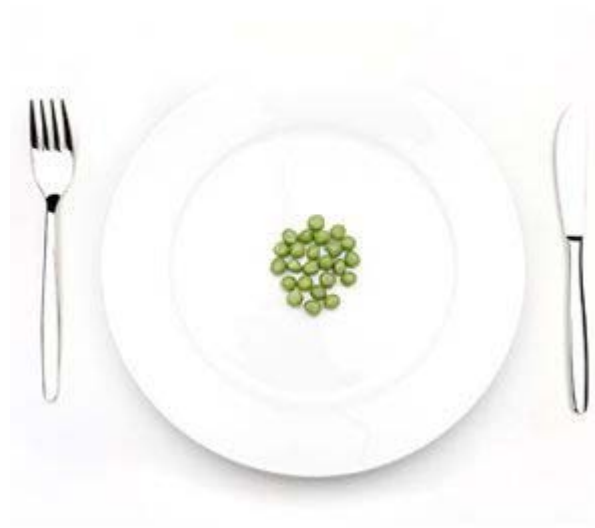
Parents and family are not to blame for development of the ED:
(TRUE/FALSE)



Parents and family are not to blame for development of the ED:

TRUE

Parents/family are often the greatest allies in treatment!



Difficult Management Issues

Refusing Treatment

Parent Unconcerned

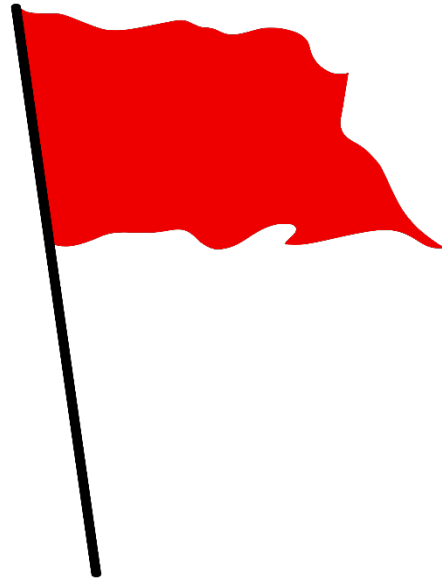
Secretive Behaviors

Bradycardia in an athlete

Take Home Points



Section 1: Early Identification



A change in eating patterns, weight or growth deserves attention

Section 2: First Steps in Intervention

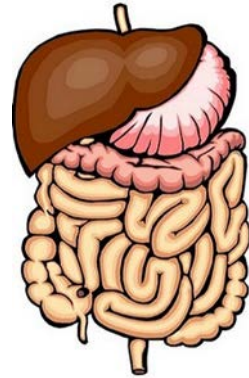
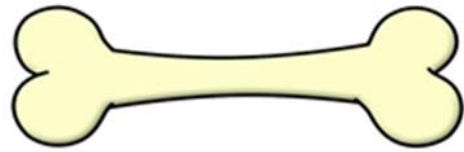
Nationaleatingdisorders.org



Maudsleyparents.org

Alert parents and provide resources.

Section 3: Complications



Section 4: Long-term Management



Full recovery is possible and early intervention increases the chance of full recovery.

Questions?
