



Eating Disorders Program

Eating Disorders in Primary Care

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Announcements

- New CAPP CME activity: CAPP Monthly Webinar Series recordings (on demand)
 - Can view webinar recordings on your own time and answer questions afterwards. If you get a passing score ($\geq 66\%$), then you're eligible for 1 hour CME and 1 hour American Board of Pediatrics MOC Part 2 credit for each webinar you complete in this way.
 - To sign up, please go to: <http://tinyurl.com/bdhhzubn>

Disclosures

No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose.

UCSF CAPP is supported by federal and state grant funding.

- The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) sponsors part of a federal award totaling \$2,670,000 with 17% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.
- CAPP is also sponsored by the California Department of Health Care Services Prop 56 Behavioral Health Integration Funding, in partnership with Anthem and Blue Cross.

Eating disorders lead to
severe medical consequences,
including death

Mortality in Anorexia Nervosa

- Individuals with EDs have significantly elevated mortality rates (6-8%)
- AN has one of the highest mortality rates of the psychiatric disorders
 - More than double that of schizophrenia and almost triple that of bipolar or major depressive disorder
- About one-third of deaths in AN are due to heart problems and one-fifth to suicide

Arcelus et al., 2011; Osby et al., 2000; Deter et al., 2005

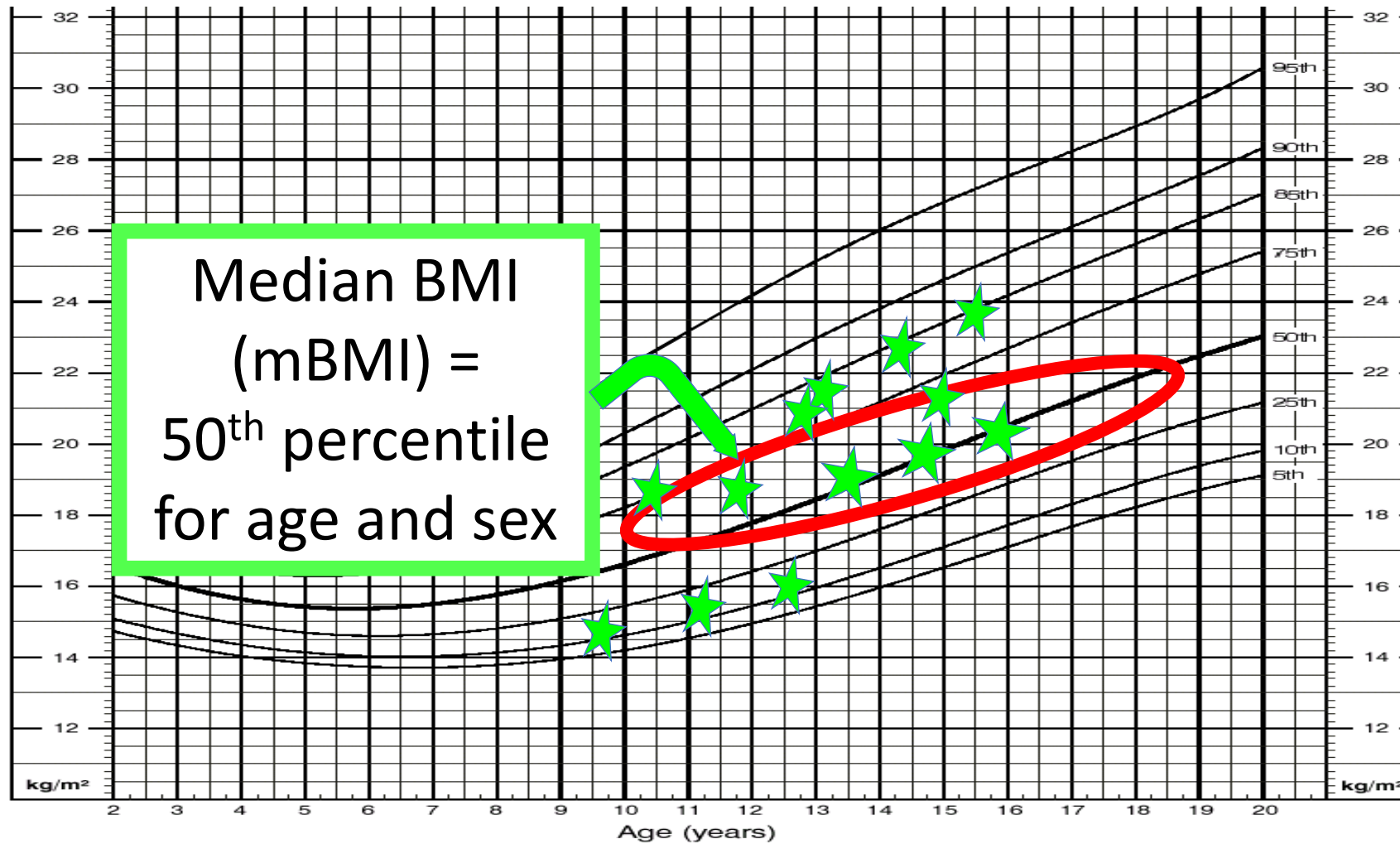
A diagnosis is not necessary!

- Identify concerning growth patterns
- Identify concerning behaviors
- Initial medical management
- Refer when appropriate

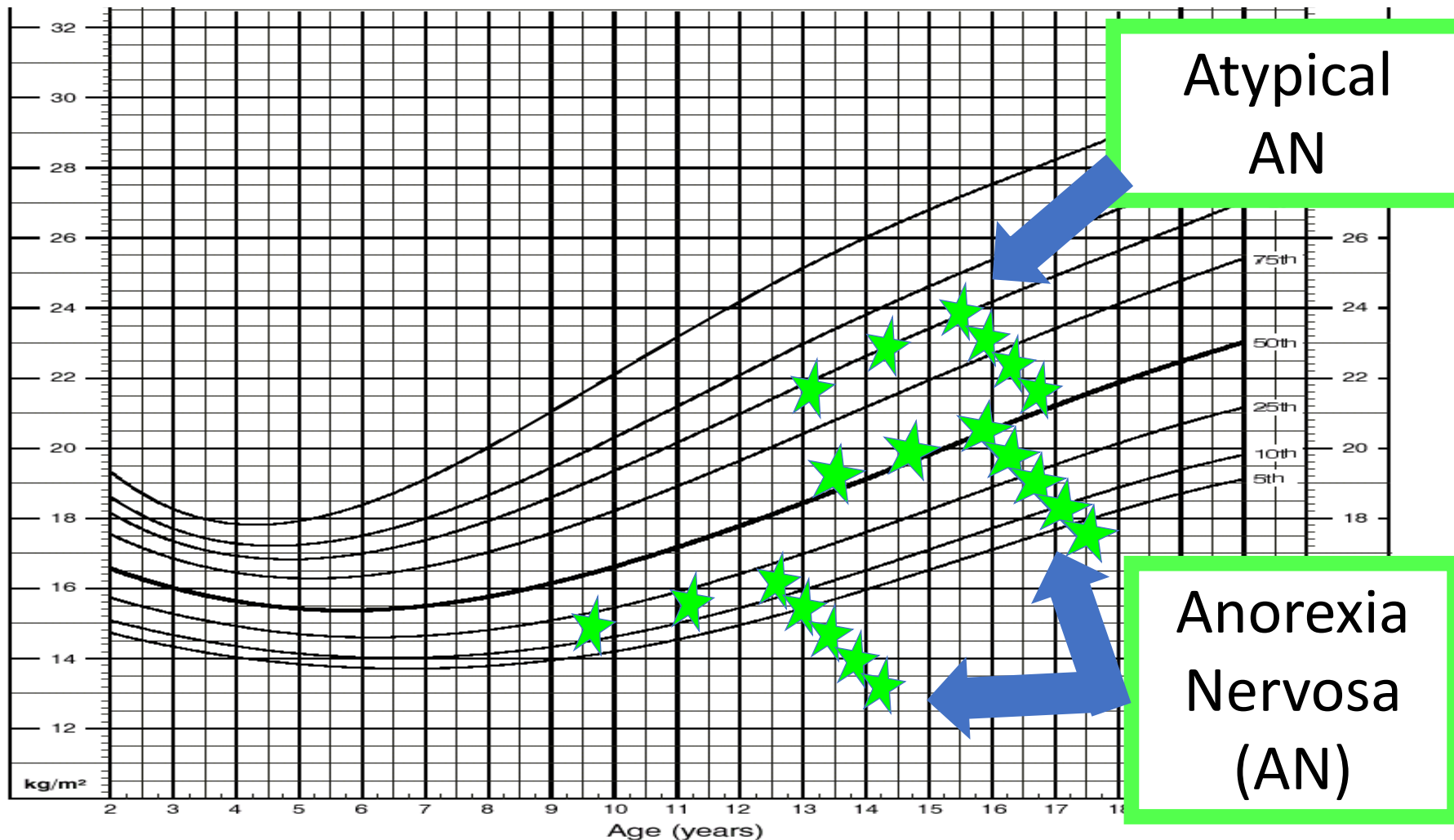
Evolving Diagnoses

- Anorexia Nervosa
- Atypical Anorexia Nervosa (OSFED) - *advocacy*
- Bulimia Nervosa
- ARFID
- Binge Eating Disorder
- More!

Normal growth takes many shapes

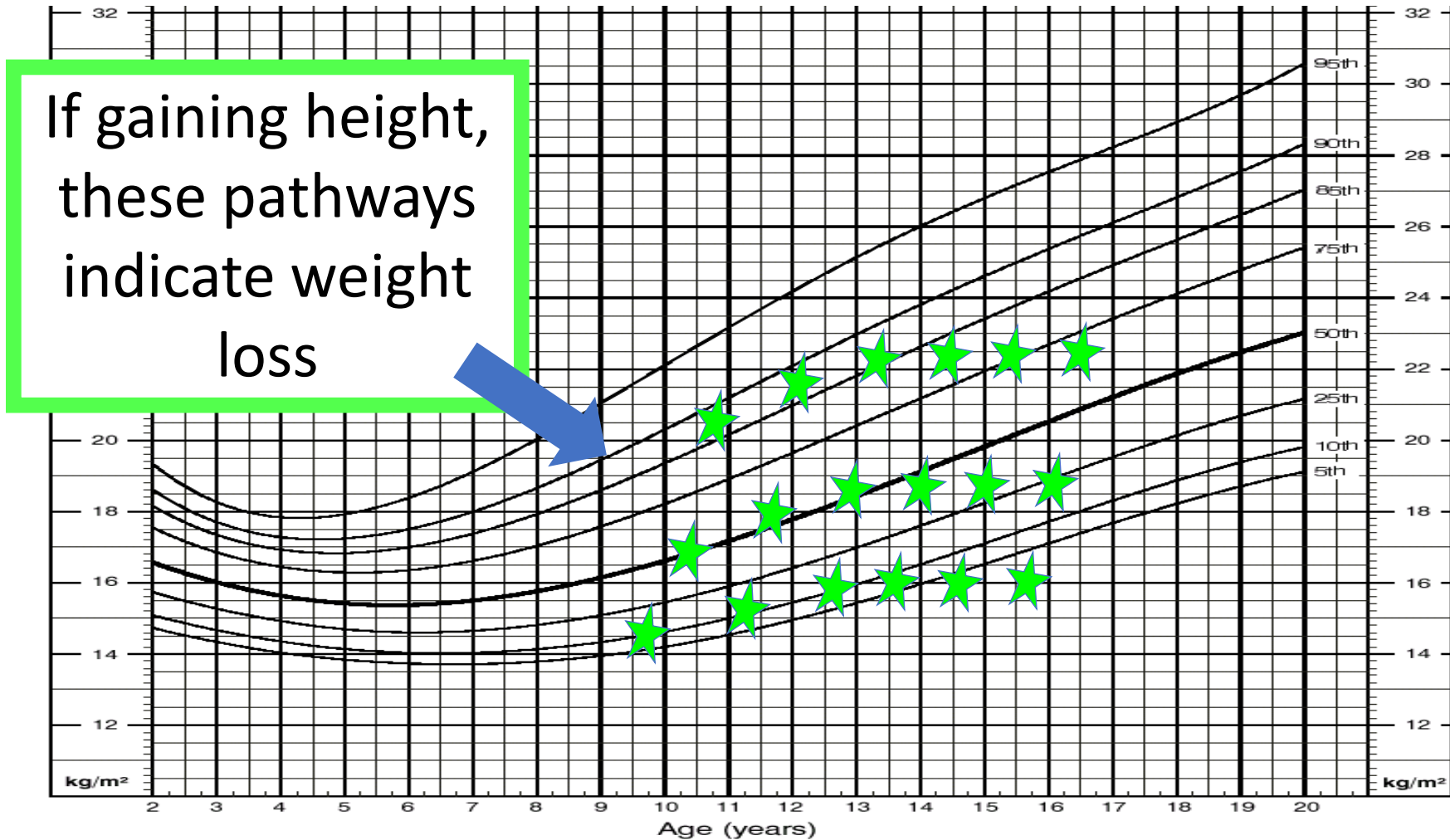


Concern: falling off BMI curve



SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

Concern: flat BMI curve



Weight loss indicating malnutrition

	Mild	Moderate	Severe
% mBMI*	80-90%	70-79%	<70%
BMI Z-score	-1 to -1.9	2 to 2.9	-3 or greater
Weight Loss**	>10% body mass loss	>15% body mass loss	> 20% body mass loss

* Percent median BMI

** Rapid weight loss may place a patient at increased risk of medical complications and increase severity of malnutrition

[SAHM Position 2015]

Weight Suppression

Comparing Jane to Typical AN

- Two girls with weight loss due to ED
- Both are 16 yr. old and 65 inches tall
- Both have lost “significant weight” via restriction, diet pills, purging, and excessive exercise
- Jill AN: 125 → 85 # → BMI 14.2 kg/m² = 40 # loss
- Jane AAN: 260 → 128 # → BMI 21.3 kg/m² = 132 # loss

→ Are these girls equally malnourished?

Weight Suppression

$$\text{Weight * suppression} = \left\{ \begin{array}{l} \text{Highest} \\ \text{historical} \\ \text{weight} \end{array} - \begin{array}{l} \text{Weight at} \\ \text{presentation} \end{array} \right\} \div \begin{array}{l} \text{Highest} \\ \text{historical} \\ \text{weight} \end{array}$$

Jill AN: 125 → 85 lbs = 40# loss, **32%** suppressed

Jane AAN: 260 → 128 lbs = 132 # loss, **51%** suppressed

Weight suppression predicts illness severity

Patients with greater weight suppression:

- Weight suppression, not admit %mBMI, associated with lowest 48-hr HR ($\beta = -0.398$, 95% CI -0.833 , -0.062 , $p=0.021$) [Garber 2015]
- Persistent amenorrhea [Seetharaman, Golden et al. 2017]
- Lower T3 [Aschettino-Manevitz 2012]
- Worse ED psychopathology [Lavender 2015; Berner 2013]

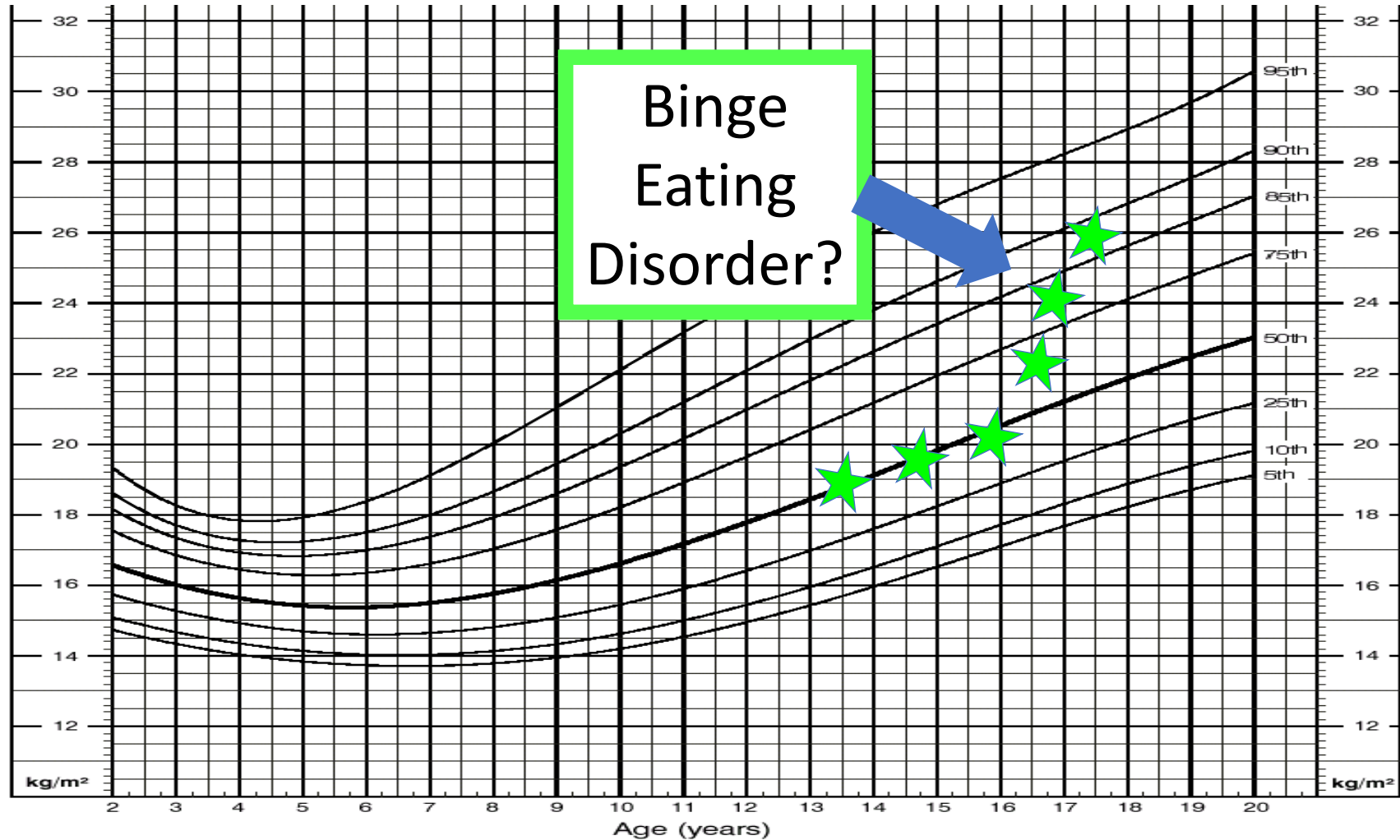
Rapidity of loss: another risk factor

Timeframe	Moderate	Severe
	<u>Percent of body weight lost</u>	
1 mo	$\leq 5\%$	$> 5\%$
3 mo	≤ 7.5	$> 7.5\%$
6 mo	≤ 10	$> 10\%$
12 mo	≤ 20	$> 20\%$

[AND and ASPEN consensus, 2012]

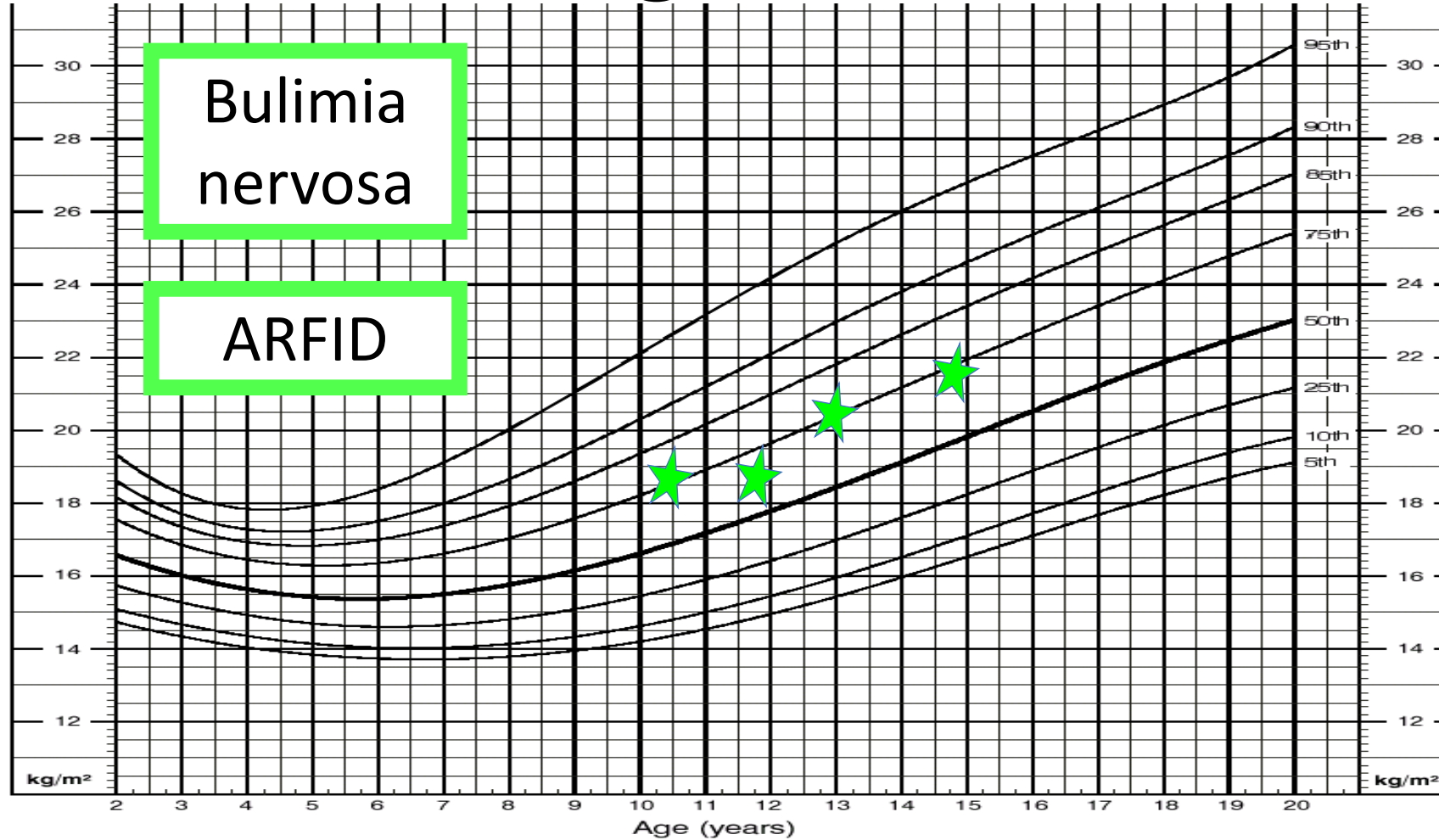
CDC Growth Charts: United States

Rapid weight gain



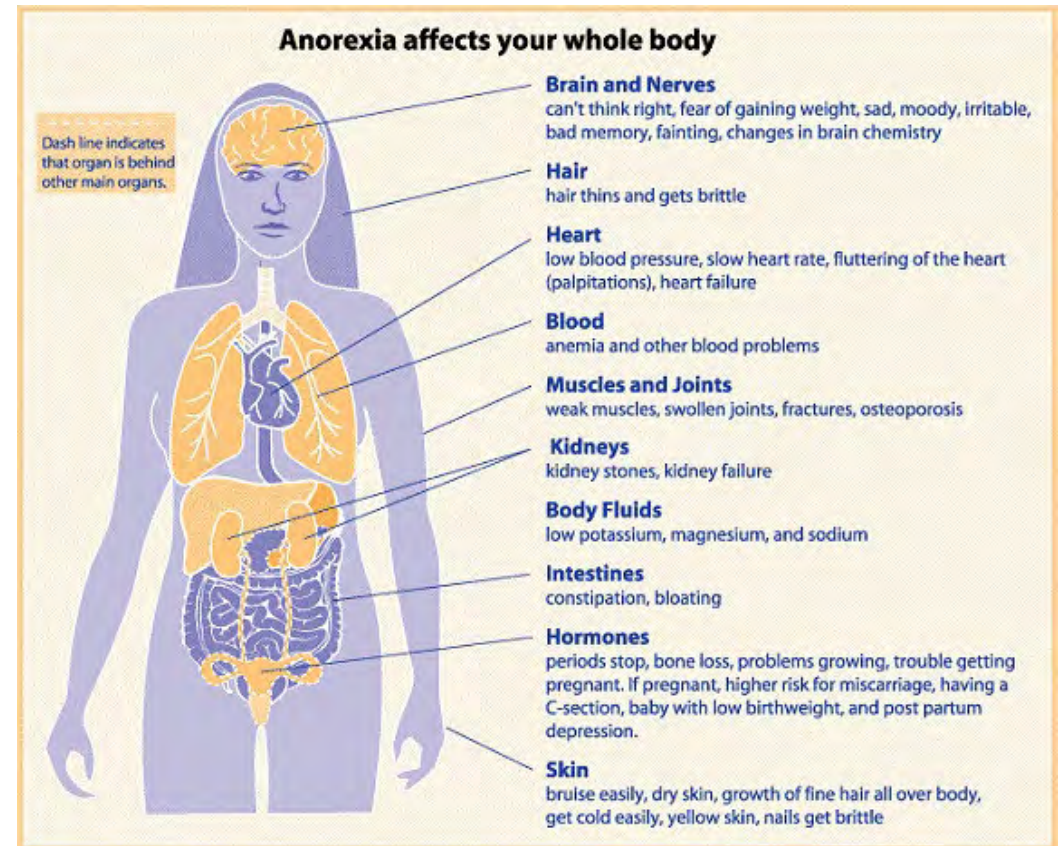
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

Normal growth does not rule out an eating disorder



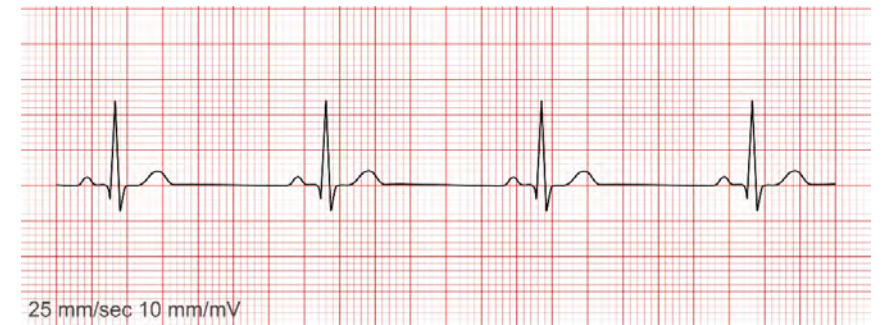
Medical Evaluation

- Height and Weight (in a gown)
- Vitals including orthostatics
- History and Physical Exam
- Careful review of growth charts
- EKG
- Laboratory Evaluation
- Referrals and Follow Up



Medical Tests

- EKG (sinus bradycardia, prolonged QTc, arrhythmia)
- Initial Labs (CBC, CMP, Mag, Phos, Lipid Panel, ESR/CRP, TTG/IgA, Zinc, Vitamin D, TSH)
- Labs for medical stability: BMP, Mag, Phos
- Urine sample (specific gravity, pH, UDS, hcg)
- Dual-energy X-ray absorptiometry (DXA) scans when amenorrhea is present for at least 6 months



Primary Care Treatment

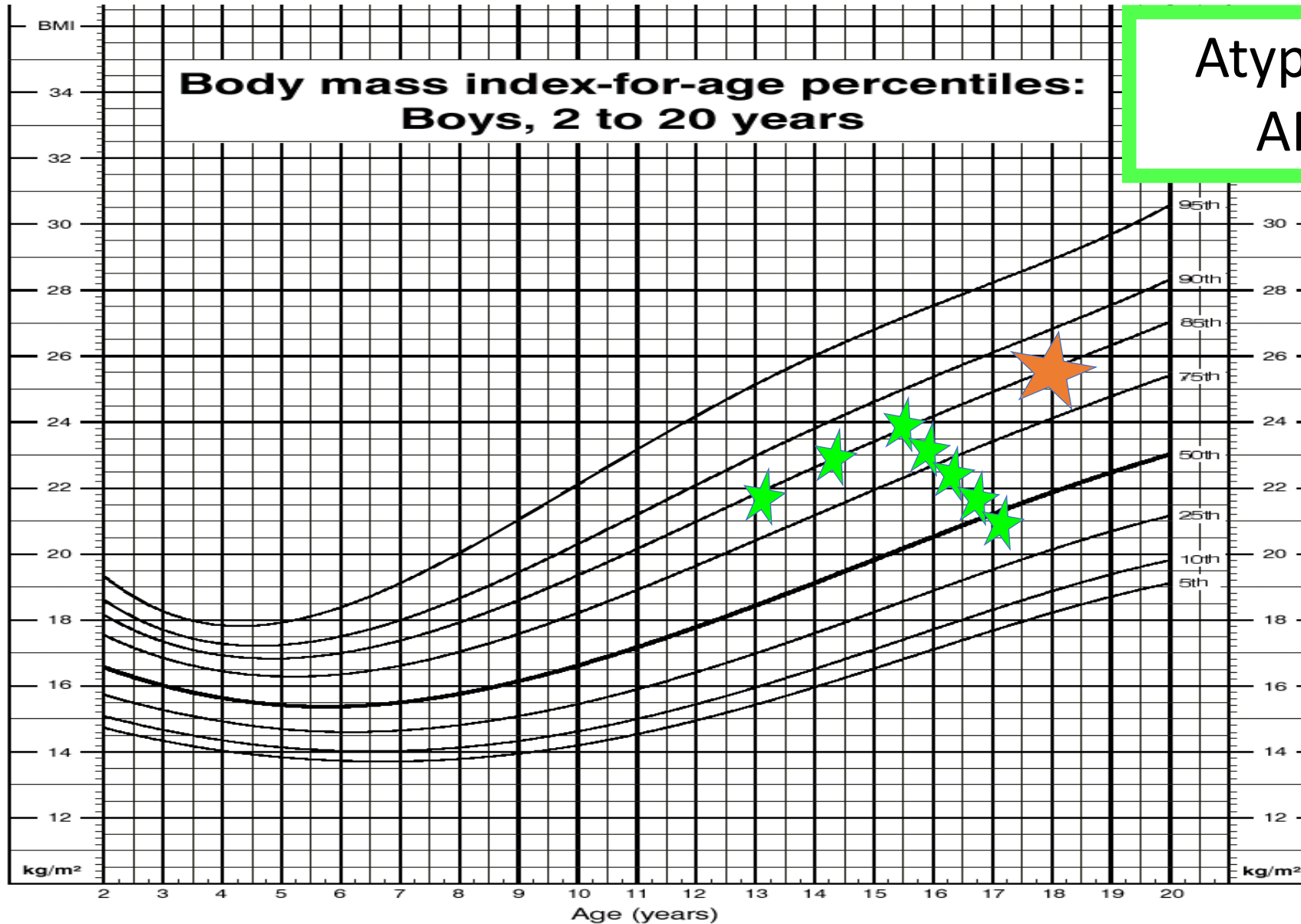
- Food is the best medicine
- Mobilize caregiver involvement
 - VERY nontraditional model for pediatricians when caring for AYA
- Medically stabilize abnormal vital signs and electrolytes
- Carefully monitor growth and development



Treatment Goal Weights

- Treatment goal weight (TGW) is a personalized, estimated target weight range for optimal recovery based on available growth records that takes into account normal expected growth in the next 12 months.
- **Return to historical growth trajectory (BMI) from age 4 on**
- If there is a lot of variation in growth history, consider what eating was like at various points (e.g., disordered eating, food insecurity) or weight at last menses
- If well above the growth curve (e.g., >99th percentile for BMI) and losing weight, minimum goal is no further weight loss

Treatment Goal Weights



Atypical
AN

Treatment Cadence

- If under treatment goal weight, frequent follow-up for weight check and vital signs until in TGW range or care established in an eating disorder program
 - Follow-ups every 1-2 weeks
- May space out visits once gaining weight steadily, in TGW range, or established with multidisciplinary team
- Touchpoint with family to empower caregivers with seriousness of illness and their critical role in recovery

Psychological eating disorder
symptoms are heavily
influenced by **malnutrition**

(And food is the ONLY medicine)

Supporting Weight Gain

- For weight gain, **aim for at least 1-2 lbs of weight gain per week.**
 - Some reputable eating disorders outpatient programs aim for 3-4 lbs per week.
 - Many individuals **require \approx 2500-5000 kcal/day** to achieve this goal due to metabolic changes during nutritional rehabilitation!
- Recommend **3 meals per day and 3 snacks**
 - Each meal/snack should include a caloric beverage (e.g., milk, juice)
 - Snacks should be like small meals and contain more than one food group
 - No diet foods (i.e., no sugar-free, low-carb, low-fat, or non-fat foods)
 - Favor calorically dense foods (fats, proteins, carbs)

Counseling Caregiver(s)

- **Caregiver(s) are 100% in charge** of preparing and plating meals/snacks, and ideally supervised by caregiver(s) or a trusted adult
- Limit negotiation and discussion around meals and snacks; limit child's presence in kitchen during meal preparation to limit negotiation
- Encourage caregivers to feed their child the foods that their family has always eaten
- Patient should return to all foods eaten prior to eating disorder onset
- Families do not need to eat the same portions as the patient

Psychopharmacology: Evidence Is Minimal

Use of SSRIs in EDs

- Food = medicine
- Typically do not start serotonergic medications until around 85% TGW
- If clear mood symptoms predated the eating disorder – could get SSRI on board sooner, beware side effects
- Fluoxetine is FDA approved for BN
 - Improves binge/purge frequency even in absence of mood disorder

Hospitalization Criteria

- **Bradycardia:** HR <50 daytime, <45 at night
- **Hypotension:** BP <90/45 mmHg
- **Hypothermia:** Temp <96° F
- **Orthostasis:** Increase in pulse (>40 bpm) or decrease in BP (>20 mmHg systolic, >10 mmHg diastolic)
- **Weight:** <75% **expected body weight** or ongoing weight loss despite intensive management

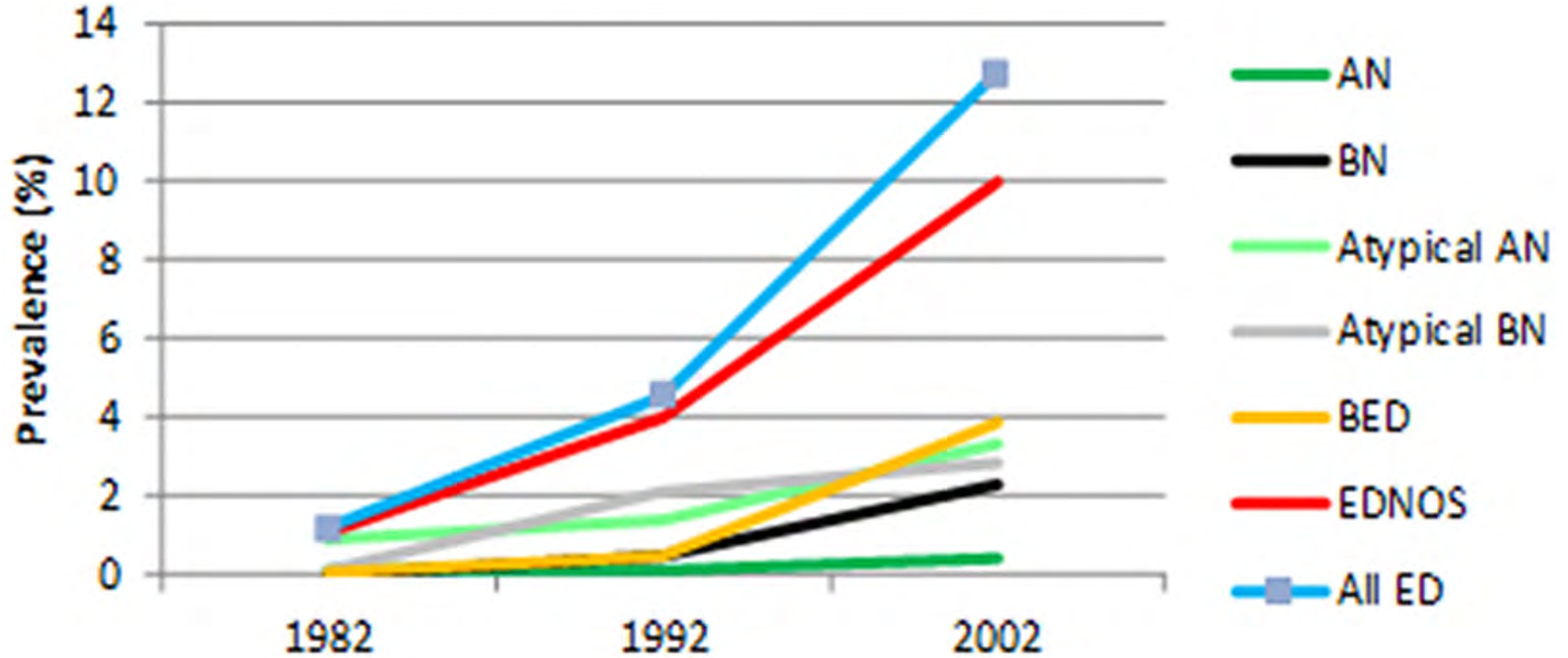
Hospitalization Criteria

- **Acute food refusal:** severe and/or prolonged food refusal (48 hours)
- **EKG abnormalities:** e.g., prolonged QTc, arrhythmia
- **Electrolyte abnormalities:** low potassium, phosphorus, magnesium, sodium, glucose
- **Other acute symptoms:** syncope, esophageal tears, intractable vomiting, hematemesis

Eating disorders transcend race,
ethnicity, gender identity, sexual
orientation, age, socioeconomic status,
body shape or size...



Prevalence Rates



Identity & Socioeconomic Correlates of Adolescent Eating Disorders Prevalence

Anorexia Nervosa

Some studies show no group differences, some show trend toward higher rates in non-Latinx White

Bulimia

Latinx & Black with highest prevalence


Binge Eating

Trend towards increased prevalence in non-Latinx Black & Latinx

People of color with eating/weight concerns were significantly less likely than white people to have been asked by a doctor about eating disorder symptoms (Becker, 2003) and given access to evidenced-based care (Marques et al., 2011)

Identity & Socioeconomic Correlates of EDs

Socioeconomic status NOT associated with eating disorders



Food insecurity is associated with increased Eating Disorders

Eating disorder prevalence higher among sexual and gender minority populations (when compared with cisgender heterosexual populations)

Huryk et al., 2021; Hazzard et al., 2020; Nagata et al., 2020

Early Signs



Cutting back on food intake or skipping meals



Avoiding eating with others/family



Changing food selections (cutting out foods, becoming vegetarian/vegan)



Exercising more



Making comments about body (often brought up by parents)



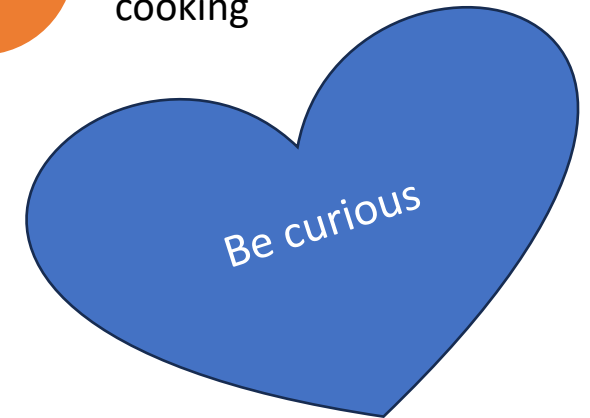
Reading recipe books, getting involved in cooking



Food going missing



Using bathroom after meals / vomit residue in toilet or shower



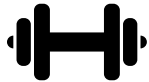
If concerns noted, evaluate:



- Feeling out of control with eating
- Pressure to look a certain way
- Obsessive thinking



24-hour diet recall



Exercise pattern



Goals with eating/exercise pattern changes



What have caregiver(s) done to help?

What is the youth's response?

Any compensatory behaviors

- Vomiting
- Obsessive/compulsive exercise
- Fasting
- Laxatives
- Diet pills
- Other

Note: explicit desire to lose weight or body image concern is not necessary for someone to meet criteria for an eating disorder

Patient vs Caregivers



Patients

- I'm not bingeing
- I'm not vomiting
- I'm getting my period regularly
- I'm an athlete. I'm not exercising to lose weight
- I'm fine with my body
- I'm fine with my weight
- I'm not scared of gaining weight

Caregivers

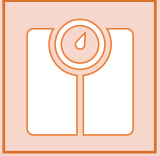
Caregivers

- I found bags of junk food hidden in her room
- They run to the bathroom right after meals, and we find vomit residue on the toilet
- I haven't bought sanitary products for her in 6 months
- Their coach says they train beyond what their teammates do
- They wear only baggy clothes
- He weighs himself a few times a day
- They won't eat more than 500 kcal per day



Weight is just one aspect of recovery, but often coincides with a recovered mind state

Treatment Goals



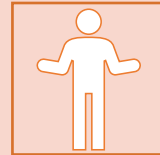
Weight restoration or stabilization



Normalization of eating patterns (regular, sufficient amount, increase variety)



Cessation of binge eating and compensatory behaviors



Later: Reduced weight/shape concerns; body acceptance

- Body image concerns typically do not improve until weight is restored and eating patterns are normalized
 - We cannot “talk someone out of” body image concerns
- Providers can redirect from debate about body shape/size “Right now, I know that the most important thing is that your body needs consistent nutrition”





Evidence-Based Treatment for Youth EDs

- Family-Based Treatment (initially puts caregivers in charge of nutrition)
- Cognitive-Behavioral Therapy (with family involvement when appropriate)
- Less evidence for youth but sometimes used: Dialectical Behavior Therapy
- Estimate 6-12 months of outpatient therapy
- Higher levels of care (IOP, PHP, Residential) sometimes needed, but not generally evidence-based

Behavioral Targets for Adolescents

- Emphasis on **behavioral recovery** (regular eating, decrease in ED behaviors such as purging, driven exercise) rather than insight or cognitive change
 - Cognitive change typically follows behavioral recovery and often occurs on its own

- Family-based approaches are best supported by the evidence
 - ED prevents good decision-making around nutrition; caregivers generally well-equipped to assist





Integrated Multidisciplinary Care

- **Psychotherapy** (individual or family evidence-based treatment)
- **Medical** monitoring and treatment, gown weights, support therapy, hospitalize if necessary
- **Nutrition** counseling (sometimes)

What if the patient doesn't want treatment?





If an adolescent is NOT interested in treatment enlist the family with Family-Based Treatment


If family is unable participate

Use motivational interviewing

Elicit-Provide-Elicit



What do you know about anorexia?



(strategically add info, correct misperceptions)

“What are your thoughts about what I shared?”

Amplify – but don't INSERT change talk


“You mentioned that the eating disorder has made it hard to be with friends, can you tell me more about that?”



Education



Externalization

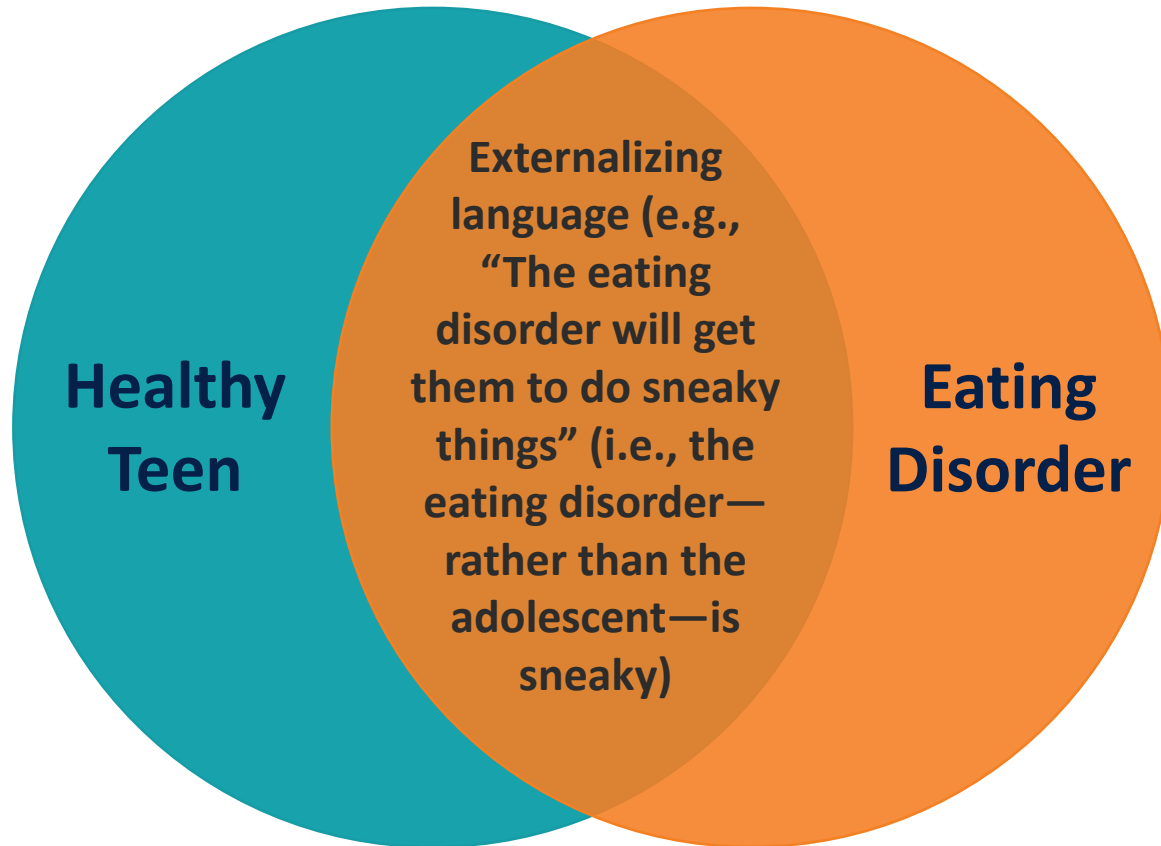


3 Meals a Day

How do I support
the family
when specialty care
is not available?

- Psychoeducation
- Illness externalization
- Early goal: increased and/or regular eating, decrease compensatory bxs
 - If wt gain needed: prescribe 3 meals and 3 snacks daily
 - If wt gain not needed, prescribe 3 meals and ≥ 1 snack daily, not going for more than 3-4 hrs w/o eating
 - Note: regular eating decreases binge episodes
- Role of reinforcement (restrictive EDs and ARFID)

Externalizing the Illness



How do I support the family when specialty care is not available?



- Involving caregivers or loved ones when possible
 - **Empowerment** – in most cases, caregivers have excellent instincts about their child’s nutritional/rest needs, and the ED is trying to convince them otherwise
 - Meal/snack support
 - When appropriate, ask caregivers to decide what, when, and how much the patient will eat, and monitor for completion
 - Protect against compensatory behaviors (e.g., use bathroom before meals, monitor afterward)

Caregiver-led nutritional rehabilitation IS:

Caregiver-led nutritional rehabilitation is NOT:

- Force feeding
- Meant to be punitive

- **An act of LOVE**
 - Most caregivers love their kids, and want to support them to fight an illness that they typically cannot fight consistently on their own
- A balance of warmth (toward the child) and firmness (against the ED)
 - “I see that the eating disorder is giving you a really hard time right now, and I need you take another bite. I will sit here next to you while you finish.”



How do I support the patient when specialty care is not available?

- General **coping** to address distress before/during/after meals, when having urges to engage in compensatory bxs, with wt checks, etc
 - Focus on **active coping** (eg distraction, deep breathing) rather than introspective or passive techniques (eg quiet mindfulness, reading, noticing body sensations)
- **Motivational interviewing** about how the ED is getting in the way
 - “How, if it at all, is the constant thinking about calories making it hard to do the things you like to do?”
- **Reinforce** any small changes
 - “That’s awesome that you added cheese back to your sandwiches – well done”
 - “I’m so glad that you were restful this week instead of going for a run”





Nutrition

- ALL families (regardless of resources) should feed what they normally serve their family
- When weight gain is needed:
 - Favor high density foods (proteins, fats, starches)
 - Caloric beverages with every meal and snack
 - Fruits, veggies, and other low-calorie foods should be used as garnish or vehicle for fats (e.g., carrots w/ ranch)

"We worried whether our food would run out before we got money to buy more."

Was that often, sometimes, or never true for your household in the past 12 months?

- Often true
- Sometimes true
- Never true
- Don't know

"The food that we bought just didn't last, and we didn't have money to get more."

Was that often, sometimes, or never true for your household in the past 12 months?

- Often true
- Sometimes true
- Never true
- Don't know

Radandt,2018



Food Bank
consider providing
info to all families

Food Insecurity & Low Resources



Nutritional Supplementation
Consider prescribing, most
insurances cover

Physical Activity

- If weight gain needed, rest typically recommended
 - Especially if vital signs are declining
- Rest is time-limited – goal is supporting patient to return to physical activity when they are ready
- When supporting patients to return to exercise:
 - Go low and slow
 - Consider both physical and psychological implications of exercise
 - If exercise is part of the eating disorder
 - Return only when eating disorder symptoms are improving
 - Encourage patient and family to identify physical activity that is enjoyable



Provider Tips

- Avoid commenting on appearance
- Do not collude with eating disorder
- Avoid shame
- Adolescents may not like their FBT therapist



Benign comments can be loaded:

- “You look so healthy” = “Whoa, you’ve gained a ton of weight”
- “You look fantastic” = “Wow, you’re so fat”
- “You’re made so much progress” = “You’re failing, you shouldn’t be going along with this plan to eat so much food”

When Hospitalization Is Needed: How to discuss with families

Not yet medically unstable:

- The hospital is a safety net. If you aren't able to eat, your body may become medically unstable. If that happens, we will need you to be taken care of in the hospital.

Medically unstable:

- Right now, the malnutrition is impacting X's [heart, body temperature, etc], and X needs support to increase their nutrition and restore their [heart functioning, etc]
 - Without this support, X's medical condition may worsen
- In the hospital, X will focus on eating, with lots of support from people who work with lots of young people with eating difficulties
 - The doctors will monitor X's body to make sure it's safe
 - Loved ones can visit, and a caregiver can stay overnight
 - You can bring your own clothes and some personal belongings
 - The hospital team will help you communicate with your school
- When X's body is medically stable, X will go home – this could take a few days or a few weeks



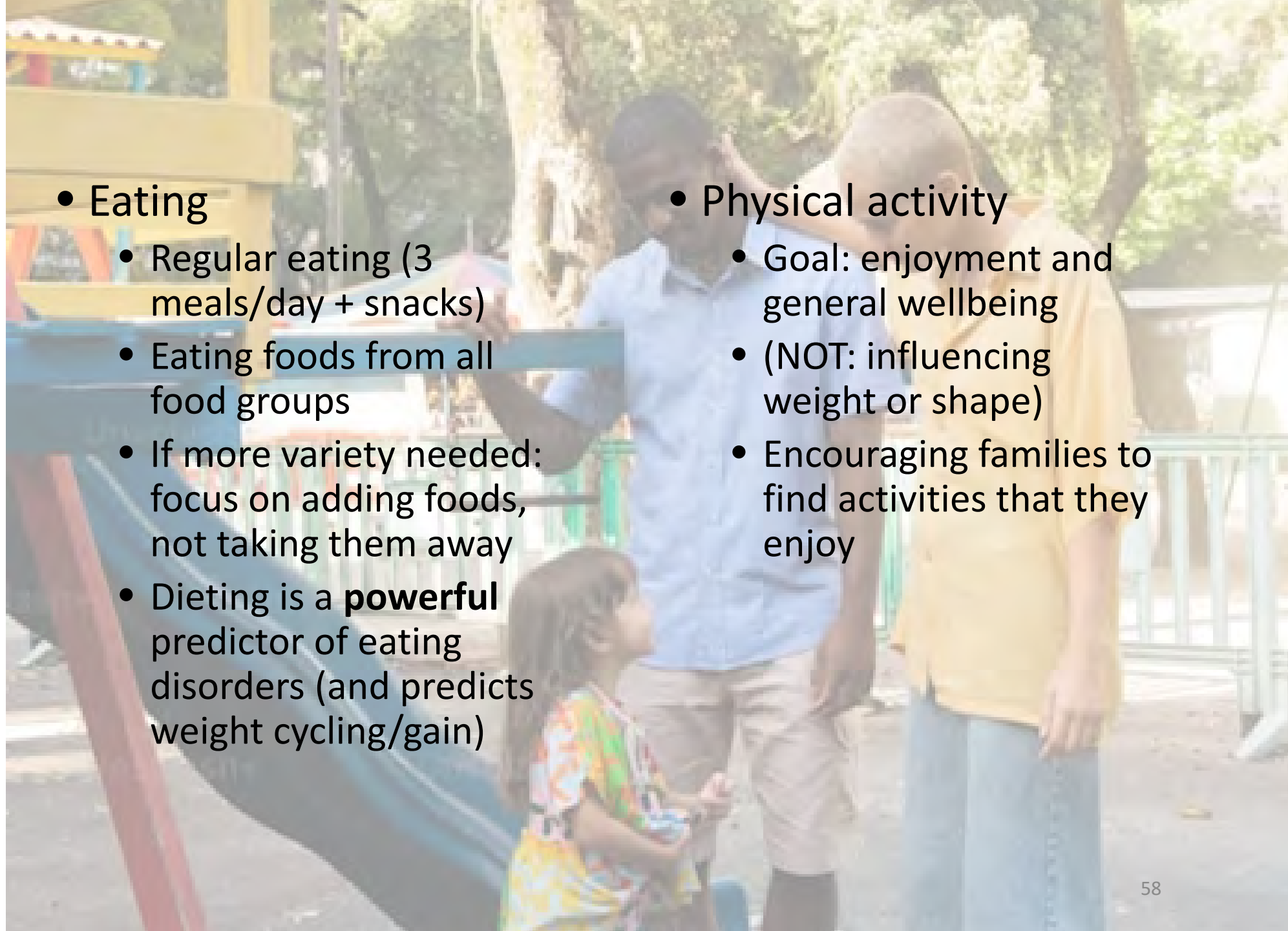
How do I
avoid
reinforcing
diet
culture for
all
families?

- Eating

- Regular eating (3 meals/day + snacks)
- Eating foods from all food groups
- If more variety needed: focus on adding foods, not taking them away
- Dieting is a **powerful** predictor of eating disorders (and predicts weight cycling/gain)

- Physical activity

- Goal: enjoyment and general wellbeing
- (NOT: influencing weight or shape)
- Encouraging families to find activities that they enjoy



Takeaways

1. Eating disorders are serious, and impact people of all backgrounds
 - Persistent and harmful myths about who is impacted by eating disorders keep folks from receiving appropriate care
2. Caregivers/parents DO NOT cause eating disorders, and are usually an important part of the care team
3. Nutrition and rest are the most important aspects of treatment
 - Body image will not improve until nutrition is restored
4. PCPs play an important role in ED detection and care



Welcome to the UCSF
Benioff Children's
Hospitals Child &
Adolescent Psychiatry
Portal

Connecting for Care

CAPP Resources

<https://capp.ucsf.edu/content/eating-disorders>

- Referral information
- Family and PCP guides for supporting young people with eating disorders

