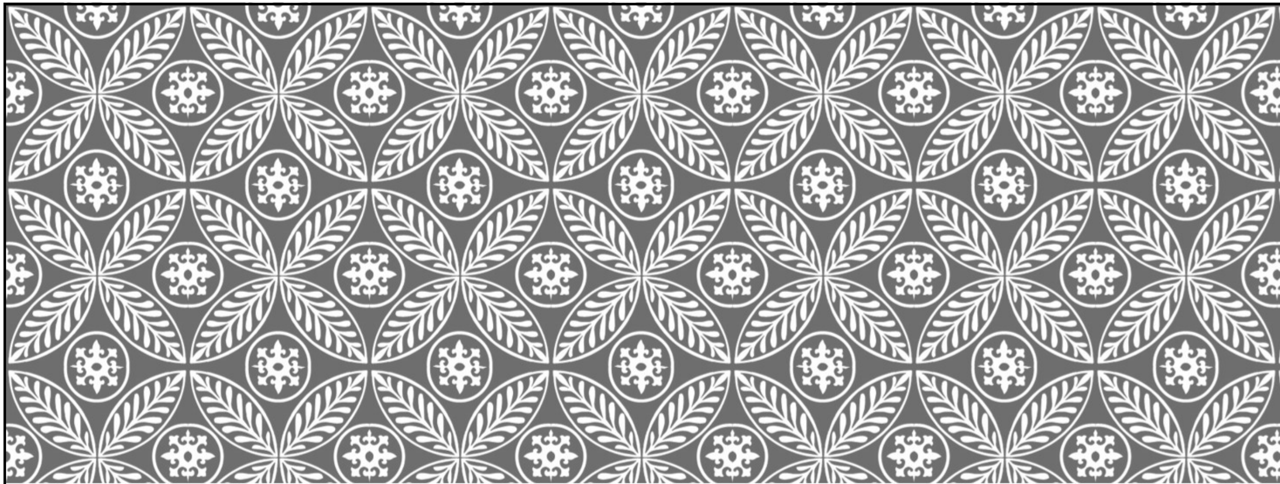


EATING DISORDERS IN RURAL COMMUNITIES: DIAGNOSIS, TREATMENT, AND ETHICAL CONSIDERATIONS

Kristen Rose, MEd, LPC, LIMHP, CCTP
Sidney Regional Medical Center

1

LEARNING OBJECTIVES

Discuss	Identify	Discuss
Discuss how to assess and diagnose eating disorders.	Identify evidence-based therapies and best practices when treating eating disorders.	Discuss unique challenges and ethical considerations when working with clients with eating disorders, especially in a rural setting.

2

3

EATING DISORDERS IN NEBRASKA

9% of Nebraskans will have an eating disorder in their lifetime. This is comparable to the national prevalence rate.

$381.5 million is the yearly economic cost of eating disorders in the state.

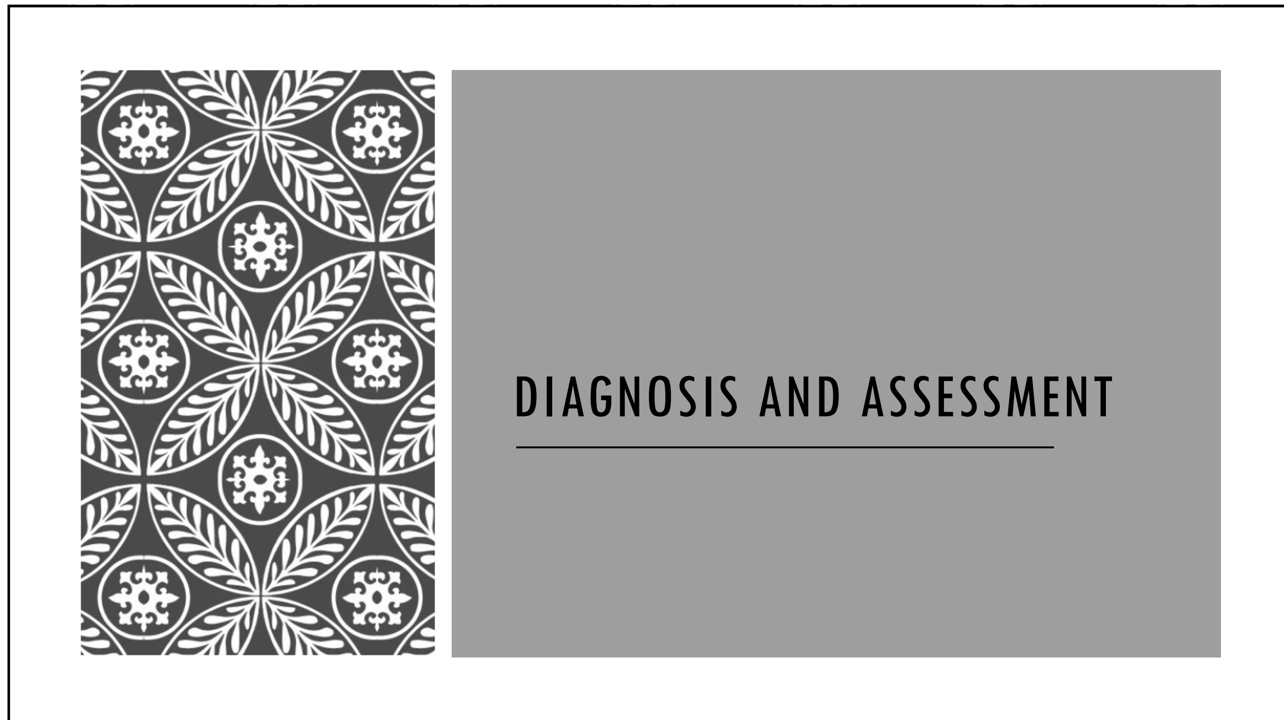
$172,779 cost in ER visits.

$1.2 million cost in inpatient hospitalizations.

Caregivers provide 6 weeks of informal, unpaid care per year. This results in a $138.6 million loss economically.

10,200 deaths/year nationally as a DIRECT RESULT of an eating disorder, equating to 1 death every 52 minutes.

4



5

FEEDING AND EATING DISORDERS

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- Pica
- Rumination Disorder
- Other Specified Feeding or Eating Disorders
- *Body Dysmorphic Disorder*

6

ANOREXIA NERVOSA (DSM-V-TR)

Restricting of energy intake relative to requirements 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 minimally expected.

Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weights gain, even though at a significantly low weight.

Disturbance in the way in which ones body is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of low body weight.

Restricting Type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behaviors (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).

- Mild: BMI less than 17
- Moderate: BMI 16-16.99
- Severe: BMI 15-15.99
- Extreme: BMI less than 15.

7

CHARACTERISTICS OF AN

Perfectionism: high need for order, consistency, exactness.
- Contributes to difficulty with transitions, change.

Cognitive rigidity, difficulty shifting sets.
- Preexisting trait or starvation induced.

Harm avoidance.

Interoceptive difficulties: difficulty accurately identifying/interpreting sensations (lack a sense of internal "compass") so have to rely on external information.
- Difficulty sensing themselves.

May be individuals who are more sensitive to visceral functioning.

Feelings of inadequacy; ineffectiveness.

Need for control/fear of loss of control.

Risk aversive.

8

MEDICAL CHARACTERISTICS OF AN

Decreased heart rate, blood pressure, temperature.

Lanugo.

Dry, yellow tinged skin.

Cold intolerance.

Hair loss.

Decreased gastric motility/delayed gastric emptying.

Sleep disturbance.

Hyperactivity/lethargy.

Amenorrhea (in women).

9

LONGER TERM PHYSICAL EFFECTS: AN

Decrease in cardiac muscle mass, shrinkage in heart volume, mitral valve prolapse.

Osteopenia and osteoporosis: chronic amenorrhea results in failure to achieve maximum bone growth (length and density) in adolescents, more frequent fractures.

Failure of the reproductive system to mature or reversal of maturity.

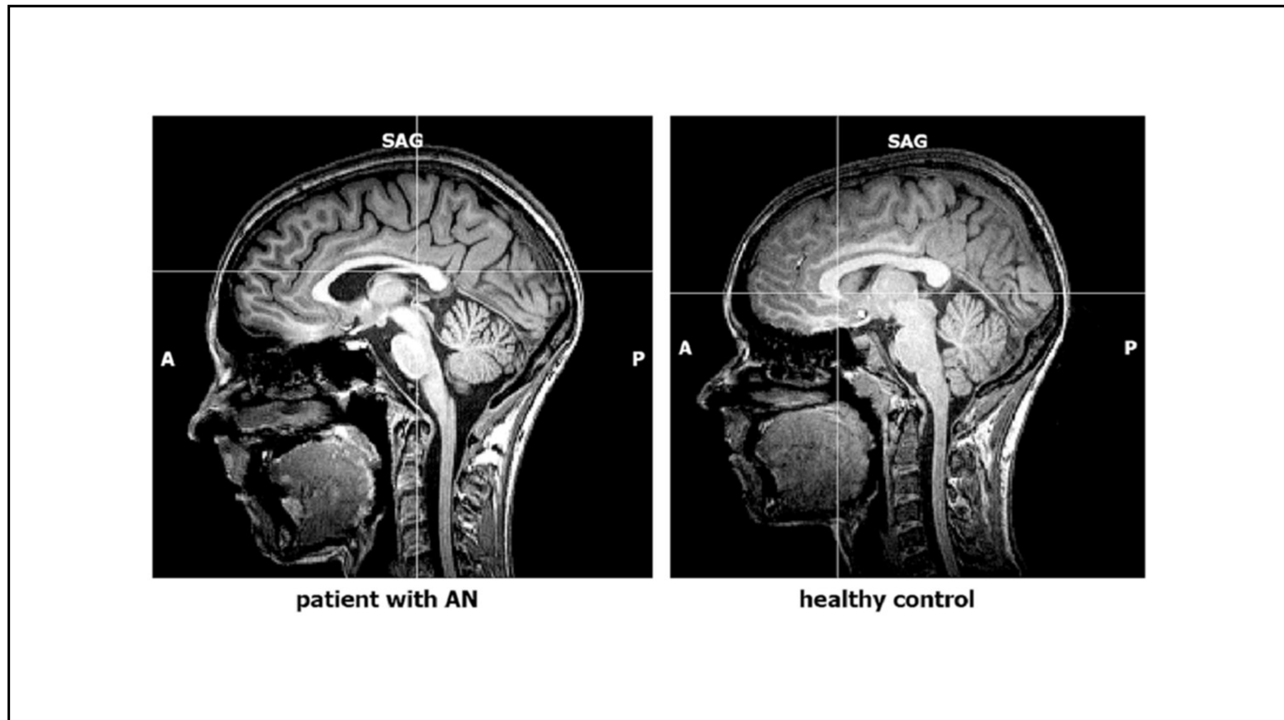
Electrolyte disturbances.

Renal damage.

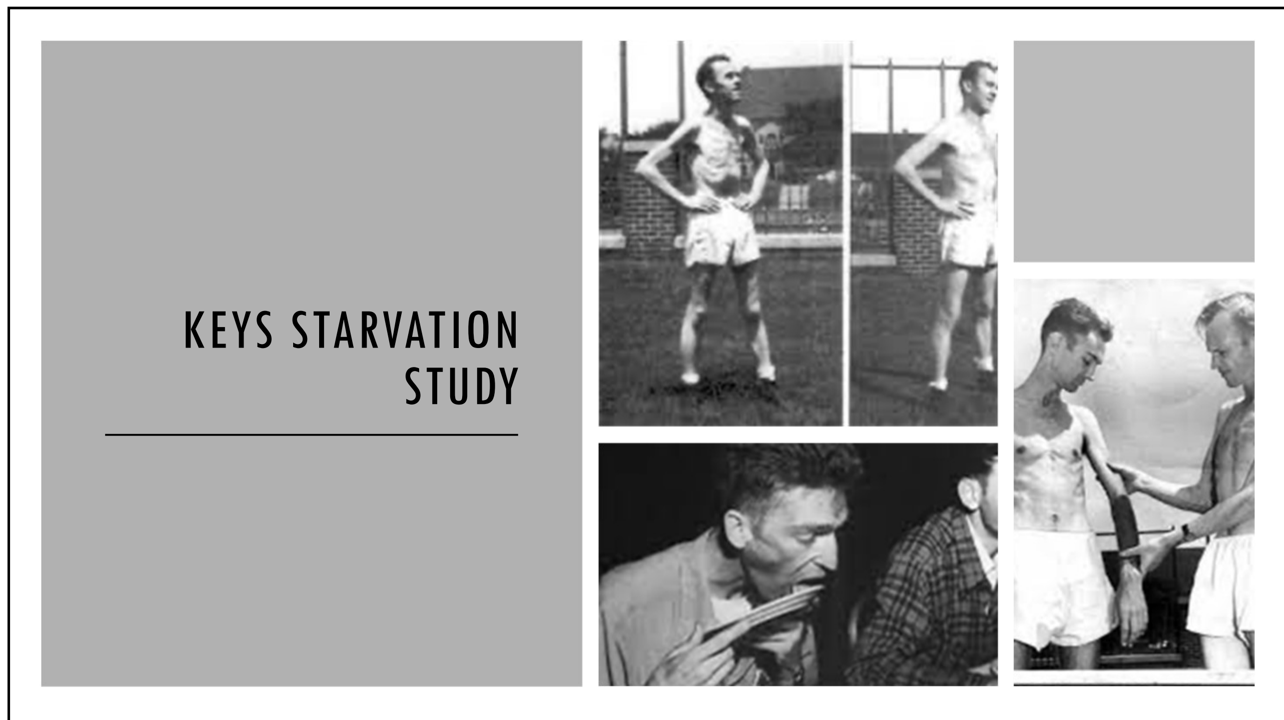
Changes in brain structure.

Body will cannibalize itself.

10



11



12

BULIMIA NERVOSA (DSM-V-TR)

Recurrent episodes of binge eating. An episode of binge eating is characterized by 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 individuals would eat in a similar period of time in a similar circumstance.
- 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 behaviors 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 averabe at least once a week for 3 months.

Self-evaluation is unduly influenced by body shape and weight.

The disturbance does not occur exclusively during the episodes of anorexia nervosa.

Mild: 1-3 episodes of purging/week
Moderate: 4-7 episodes of purging/week
Severe: 8-13 episodes of purging/week
Extreme: 14 or more episodes of purging/week

13

CHARACTERISTICS OF BN

Overlap with AN in terms of deficits in self-esteem, concerns about control, social anxiety.

Interpersonal sensitivity.

More likely to display histrionic/borderline/narcissistic personality traits, whereas people with AN exhibit more avoidant/dependent/schizotypal personality traits.

Tend to experience more distress over symptoms.

14

SIMPLE VS. MULTI-IMPULSIVE BN

May be most important sub-group differentiation.

"Simple" BN: less co-morbidity, may be primarily related to efforts to achieve social ideal and dietary restraint, obsessive compulsive traits, perfectionism.

"Multi-impulsive" BN: associated with multiple forms of impulsive, self-destructive behaviors (e.g., cutting), substance abuse, shoplifting; greater connection with emotional regulation difficulties; greater frequency of history of abuse.

15

MEDICAL CHARACTERISTICS OF BN

"Secretive syndrome": often no visible tell-tale markers in early stage.

Parotid gland enlargement ("chipmunk cheeks").

Loss of tooth enamel, increase in cavities.

"Russells sign": callous, scars, sores on the back of hand.

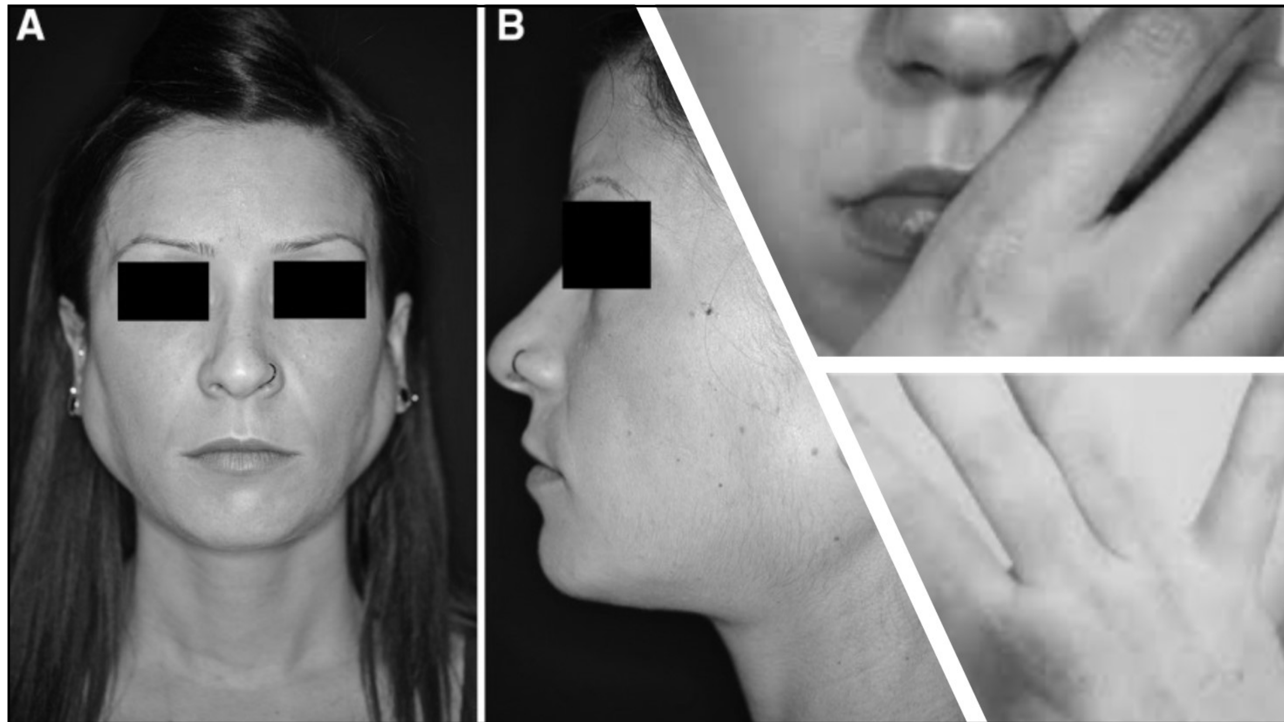
Electrolyte disturbances caused by purging (sudden risk of death).

Orthostatic changes in blood pressure.

Abdominal or intestinal pain, bowel changes.

Edema.

16



17

MAJOR MEDICAL DANGERS OF BN

Cardiac arrhythmias as a result of electrolyte disturbances.

Cardio myopathy (ipecac abuse).

Loss of gastric motility/elasticity associated with chronic laxative abuse.

Esophageal tear from self-induced vomiting.

Menstrual irregularities (decreased bone density).

Gastric reflux.

Seizures.

18

NEVER UNDERESTIMATE ONE'S POTENTIAL FOR LETHALITY.

19

BINGE-EATING DISORDER (DSM-V-TR)

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 a 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 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.

20

BINGE-EATING DISORDER, CONTINUED

Marked distress regarding binge eating is present.

The binge eating occurs, on average, at least once a week for 3 months.

The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Mild: 1-3 binge eating episodes/week

Moderate: 4-7 binge eating episodes/week

Severe: 8-13 binge eating episodes/week

Extreme: 14 or more binge eating episodes/week

21

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID) (DSM-V-TR)

An eating disturbance or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning

The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

The eating disturbance in not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional attention.

22

PICA (DSM-V-TR)

Persistent eating or nonnutritive, nonfood substances over a period of at least 1 month.

The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.

The eating behavior is not part of a culturally supported or socially normative practice.

If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability, autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

23

RUMINATION DISORDER (DSM-V-TR)

Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.

The repeated regurgitation is not attributable to an associated gastrointestinal or another medical condition (e.g., gastroesophageal reflux, pyloric stenosis).

The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or ARFID.

If the symptoms occur in the context of another mental disorder (e.g., intellectual disability, or another neurodevelopmental disorder), they are sufficiently severe to warrant clinical attention.

24

OTHER SPECIFIED FEEDING OR EATING DISORDERS

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

Bulimia nervosa (of low frequency and/or limited duration): All of the criteria for bulimia nervosa are met, except that binge eating and inappropriate compensatory behaviors occur on average, less than once a week and/or for less than 3 months.

Binge-eating disorder (of low frequency and or limited duration): All of the criteria for binge-eating disorder are met, except that the binge eating occurs on average, less than once a week and/or for less than 3 months.

25

OTHER SPECIFIED FEEDING OR EATING DISORDERS, CONTINUED

Purging Disorder: Recurrent purging behavior to influence shape or weight (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

Night Eating Syndrome: Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of a medication.

26

BODY DYSMORPHIC DISORDER (DSM-V-TR)

Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to appearance concerns.

The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

- With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other areas, which is often the case.

27

ORTHOREXIA NERVOSA

Steven Bratman, MD *Health Food Junkies* (2000).

Refers to a fixation on eating healthy food.

- The effortful act of eating the right food may even begin to invoke a sense of spirituality.

”A grim sense of self-righteousness that begins to consume all other sources of joy and meaning.”

”The meaning of life has been displaced into the bare act of eating.”

“It’s the quality of the obsession that defines orthorexia, not the desire to eat healthy food; it’s the absence of moderation, the loss of perspective and balance, the transfer of too much of life’s meaning onto food. When diet becomes an escape from life, it begins to resemble an eating disorder more than a sensible choice.”

28

OTHER TERMS OF NOTE

Diabulimia
- Media-coined term.
- Medical professionals will use the term ED-DMTI, Eating Disorder-Diabetes Mellitus Type1.
- The person purposely restricts insulin in order to lose weight.
- DSM-5 classifies insulin omission as a purging behavior.

Drunkorexia
- A term characterizing the replacement of meals with alcohol.
- Not a clinically appropriate term.

29

SCREENING TOOLS AND ASSESSMENTS

SCOFF
- Do you make yourself **S**ick (induce vomiting) because you feel uncomfortably full?
- Do you worry you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (approx. 15 lbs.) in a 3 month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Eating Attitudes Test (EAT-26)

Eating Disorder Examination (EDE)
- Eating Disorder Examination-Questionnaire (EDE-Q)
- Eating Disorder Examination-Questionnaire Short (EDE-QS)

Screen for Disordered Eating (SDE)

Compulsive Exercise Test (CET)

30

SCREENING TOOLS AND ASSESSMENTS: SBIRT-ED

Screening, Brief Intervention, and Referral to Treatment for Eating Disorders.

Easy-to-access tool for primary care providers.

Free to use.

Gets results and guidance in real time during visits.

Find appropriate discussion points based on patient risk level.

National Center for Excellence in Eating Disorders.

31

INTAKE

Assess ANY life-threatening risks (this is not just confined to suicidal ideations, plans, or intent).

Never underestimate one's capacity for lethal outcomes.

Never assume. Always ask.

There are likely over 200 eating disordered behaviors. The use of behaviors may be static and predictable or may change unpredictably.

There is no one motivation to change.

There may be other focuses of change that may be worth considering.

Eating disorder assessments are limited.

Acquire critical lab values.

Approach with nonjudgmental curiosity.

Accurate validation and appreciation for the function of symptoms may decrease defensiveness and increase receptivity.

Provide education.

32

INTAKE, CONTINUED

Current level of symptomatology including:

- Restriction
- Binge eating (objective vs. subjective)
- Self-induce vomiting
- Ipecac use
- Laxative and diuretic abuse
- Diet pills or abuse of prescription stimulants
- Exercise
- Weight and body checking
- Body image experience

33

INTAKE, CONTINUED

“How have the eating disordered symptoms interfered with your life?”

“What strategies have you used to try to stop?”

”What do you want to be different or change in your life?”

”Why do you think the eating disorder developed?”

”How has the eating disordered behaviors helped you? How have they hurt you?”

”If you don’t think the eating disorder is a problem, how would you know if it becomes a problem?”

“What do you imagine life will be like if you stay on this path (in a month, a year, 10 years, etc.)?”

“What do you hope to get out of the eating disorder?”

“How many ways do you exercise?”

34

35

COGNITIVE BEHAVIORAL THERAPY-ENHANCED

Cognitive Behavioral Therapy-Enhanced was developed by Christopher Fairburn

Directive therapies focused on the present (versus relational features of the rearing environment).

View the symptoms as a combination of irrational cognitions that need to be elicited, challenged, and replaced and behaviors that are reinforced (positively or negatively) by immediate consequences.

Consists of three stages

- Stage 1: Establishes control over eating and with behavioral techniques (self-monitoring, establish regular eating patterns, stimulus control).
- Stage 2: Reduces dieting and body image disturbance and trains patient to engage in problem solving.
- Stage 3: Works towards maintenance of progress and reduction of risk of future relapse.

36

COGNITIVE BEHAVIORAL THERAPY-ENHANCED

Efficacy shown for bulimia nervosa and binge eating disorder.
- Similar results are lacking for anorexia nervosa.

Has been adapted for adolescents.

Has been used in residential settings despite being created for outpatient settings.

Materials such as self-monitoring and patient education are available on Christopher Fairburn's website.

https://www.credo-oxford.com/4.1.html

37

DIALECTICAL BEHAVIORAL THERAPY

Originally designed to treat individuals with a personality disorder characterized by poor impulse control, self-destructive behavior, interpersonal difficulties and significant mood fluctuations.

Provided as a combination of individual CBT focusing on symptoms in order of decreasing urgency, and skills training that focus on building strength in four skill areas:
- Mindfulness
- Distress tolerance
- Interpersonal effectiveness
- Emotional regulation

Successful in treating bulimia nervosa in some controlled studies.

38

DIALECTICAL BEHAVIORAL THERAPY

Successful in treating binge eating disorder in uncontrolled studies.

Very limited efficacy with anorexia nervosa.

Interventions focused on the individual may fail to address family functioning.

Mindfulness raisin/orange exercise.

Can be beneficial for those with comorbidities.

39

FAMILY THERAPY

More often used when patients are children or adolescents are living at home.

Three phases developed by the Maudsley group:

- Refeeding the client.
- Negotiations for a new pattern of relationships.
- Termination.

Controlled studies have supported the efficacy of this intervention with anorexia nervosa.

40

OTHER MODALITIES

Interpersonal therapy.
- Originally developed as a control condition for CBT-E by Christopher Fairburn.
- Mixed success in studies.

Psychodynamic psychotherapy.
- Hilde Bruch, *The Golden Cage*
- John A. Sours, *Drowning to Death in a Sea of Objects*
- Relatively little empirical support

Equine-assisted therapy.
- Popular at residential treatment facilities.
- What occurs with the horses is a metaphor.

Art therapy.
- *Drawing from Within* by Lisa D. Hinz
- *Reflections of Body Image in Art Therapy* by Margaret R. Hunter

41

ETHICAL CONSIDERATIONS

42

CHALLENGES AND ETHICAL CONSIDERATIONS

Patient refusal and/or ambivalence.

Involuntary/compulsory treatment.

Coerced refeeding.

SEEDS/palliative care.

Lack of resources and issues treatment.

Recovery.

43

Oct 24, 2022 - News

Health care access especially worrisome in rural Arizona

Jessica Boehm

Share of need for primary care physicians met

As of Sept. 30, 2022

30% 45% 60%

D.C.

MedCityNews

MEDCITY INFLUENCERS, CONSUMER / EMPLOYER

Solving rural health is the key to a better healthcare system in the U.S.

Many of rural America's health problems can be traced back to access to care. Rural Americans face environmental and economic access biases that are very different from their urban and suburban counterparts.

By RYAN ATWOOD

Post a comment / Oct 25, 2022 at 9:00 AM

More Teenage Girls With Eating Disorders Wound Up in the E.R. During the Pandemic

A new C.D.C. study underscored the mental health issues facing teenagers in the past few years.

Give this article · Read in app

A patient care technician takes vitals of patients in the emergency room waiting area at Providence Mission

CHILD & TEEN HEALTH

Eating disorders spike among children and teens: What parents should know

April 21, 2022

By **Claire McCarthy, MD**, Senior Faculty Editor, Harvard Health Publishing

44

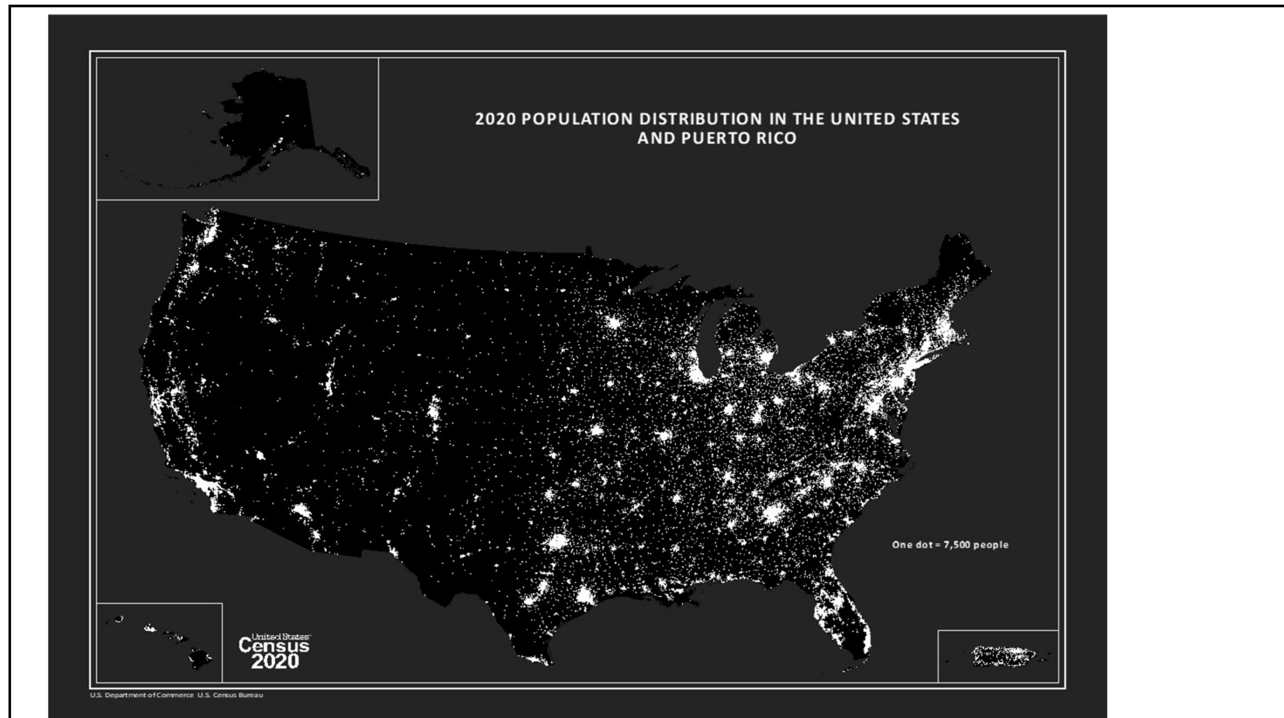
MENTAL HEALTH PROFESSIONAL SHORTAGE IN NEBRASKA

88 of the 93 counties in Nebraska are designated as federal mental health professional shortage areas.

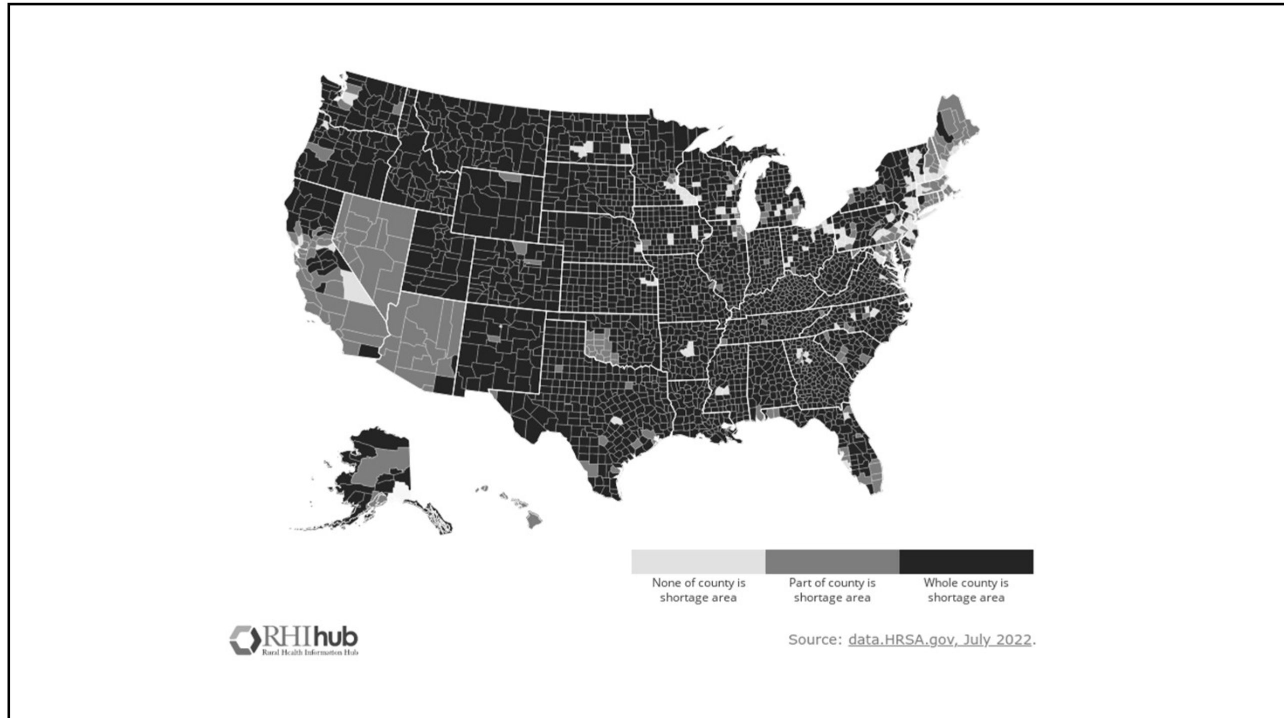
78 of the 93 counties in Nebraska have NO practicing psychiatrists.

That means 84% of the state lacks psychiatrists

45



46



47

EATING DISORDER THERAPISTS MAKE UP ONLY 0.52% OF MENTAL HEALTH PROVIDERS.

48

CHALLENGES FOR RURAL AREAS

Rural residents are more likely to not have health insurance.

Telehealth is not an adequate solution-many rural/frontier residents do not have adequate broadband internet or cellular service.

Highly unlikely to find an eating disorder specialist.

Distance from higher levels of care are specifically challenging.

Community (and providers) don't recognize symptoms of an eating disorder.

Overcoming the myth that eating disorders are a "big city" problem and not occurring in their communities.

49

INCREASE SCREENING FOR EATING DISORDERS

Screening can be used to identify and support people close to illness onset.

- Engages them early when treatment can be most effective, which requires less intensive setting.
- Can be helpful since most mental health providers in rural areas have waitlists.

Only around 30% of individuals are being screened for eating disorders in any given region.

No national standard for screening of eating disorders.

Many individuals are not identified as having an eating disorder in primary care.

- General practitioners feel unprepared to recognize eating disorders.

NP in Montana sought to improve screening (using the SCOFF questionnaire) in a primary care setting with mixed success.

SBIRT-ED.

50

EDUCATION

Providing eating disorder education to community stakeholders.
- Teachers, coaches, church clergy, local 4H leaders, etc.
- Increases likelihood of early intervention.
- Helps decrease eating disordered behaviors.

Educating medical professionals on medical side effects of symptoms of eating disorders.
- Again, increases likelihood of early intervention.
- Academy for Eating Disorders' "Purple Book" (Medical Guide).

51

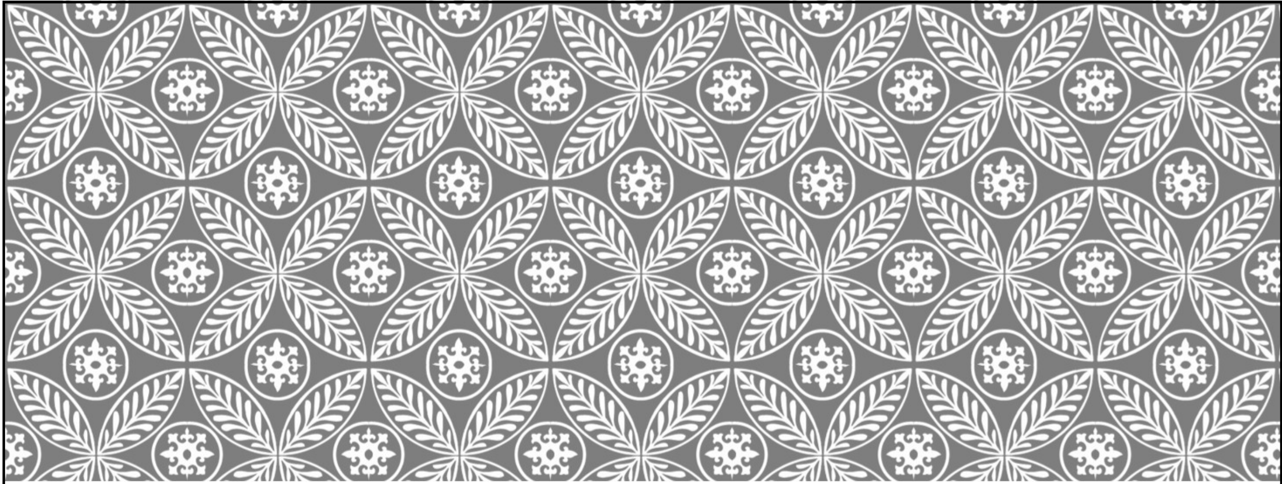
RESOURCES

International Association of Eating Disorder Professionals
- www.iaedp.com

Association of Eating Disorders
- www.aedweb.org

National Center for Excellence in Eating Disorders
- www.nceedus.org

52



QUESTIONS?

KRose@sidneyrmc.com

53