The Diagnosis and Treatment of Eating and Body Image Disorders

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The Nine Truths about Eating Disorders

- Truth #1: Many people with eating disorders look healthy, yet may be extremely ill.
- Truth #2: Families are not to blame, and can be the patients' and providers' best allies in treatment.
- Truth #3: An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.
- Truth #4: Eating disorders are not choices, but serious biologically influenced illnesses.
- Truth #5: Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses.
- Truth #6: Eating disorders carry an increased risk for both suicide and medical complications.
- Truth #7: Genes and environment play important roles in the development of eating disorders.
- Truth #8: Genes alone do not predict who will develop eating disorders.
- Truth #9: Full recovery from an eating disorder is possible. Early detection and intervention are important.

What is body image?

- **Body schema:** a „sketch" and knowledge about the body size and motor functions
- **Body image: a complex internal representation of our own body**
- Subjective experience determined by multiple factors
- Sight, visual, tactile and bodily cues, sensations
- Experiences, memories, expectations, feedbacks
- Aesthetics, attractiveness, sexual appeal
- Can be either positive or negative – however, the latter one is not equal with body image disorder

What is body image disorder?

- **A complex disorder of the experience of our own body**
- **Perception of one's own body or body parts and the information processing related to the body is distorted**
- Exclusively related to our own body
- Negatively experienced body weight, body shape, characteristics: e.g. considers her/himself fat, thin, or perceives certain body parts distortedly
- Dissatisfaction with the body
- Perfectionist body ideal: idealization of thinness and weight phobia.
- Negative body experience: anxiety, self-centred thinking.
- **The desire to change the body – including eating and body adjustment behaviors**

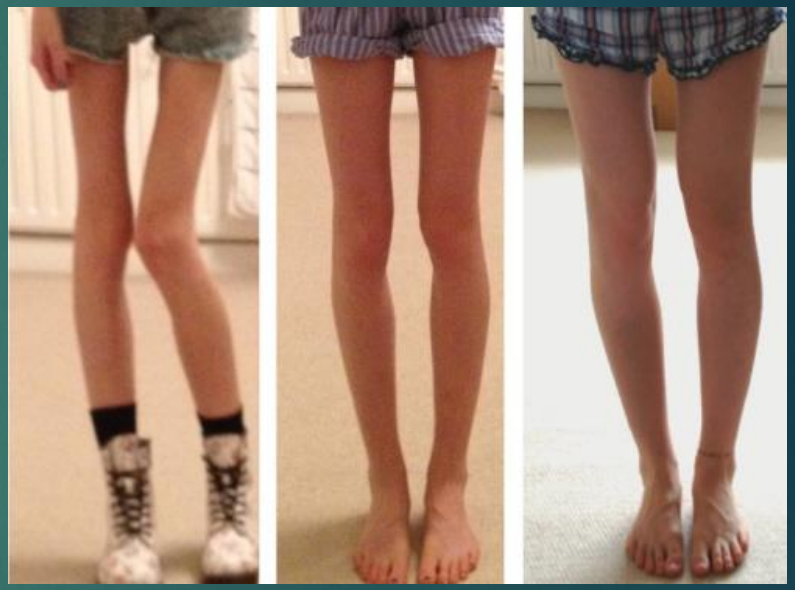
It all leads to an excessive drive to change the body

What can be the subject of this obsession?

- Body size, body shape, body weight: AN, BN
- Shape of some body parts: body dysmorphic disorder
- Muscle mass: muscle dysmorphia
- Body fat phobia: bodybuilding eating disorder
- Health: orthorexia, fitness training
- Body reshaping: plastic surgery

Why is it crucial to pay attention to eating and body image disorders?

- Non-clinical body dissatisfaction affects up to 60% of women.
- **It is a severe, complex psychiatric condition, often without any insight.**
- It is a central feature of eating disorders, but is often not treated.
- In 10 years 8%, in 20 years 20% of AN, 5% of BN patients die.
- Behind 15% of plastic surgeries.
- Associated disorders: depression, anxiety, OCD, social disorders + somatic complications!
- Up to 4-5% suicide rate!



How to recognize?
Diagnoses related to body image disorder (DSM-5)

Eating and/or body image concerns

Disorder	Eating disorder	Body image disorder
Anorexia nervosa	yes	Yes
Bulimia nervosa	yes	Yes
Binge eating disorder	yes	Partial/lacking
Mult-iimpulsive ED forms	yes	According to the type of the ED
Purging disorder	yes	Yes/partial
Avoidant/restrictive food intake disorder	yes	no
Pica	yes	no
Rumination	yes	Partial/no/BN behind?
Body dysmorphic disorder	no	Yes
Muscle dysmorphic disorder	Steroids, body buliding diet	Yes

Anorexia nervosa (DSM-V)

A. **Significantly low body weight** (weight loss leading to maintenance of body weight less than 85% of that expected): **BMI<18,5**

   (BMI<17,5; ICD-10)

B. **Intense fear of gaining weight or becoming fat**, even though underweight.

C. **Body image disorder:** 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 persistent lack of recognition of the seriousness of the current low body weight.

   (Amenorrhea, the absence menstrual cycle is not a criteria any more)

Subtypes of anorexia

Specify it:

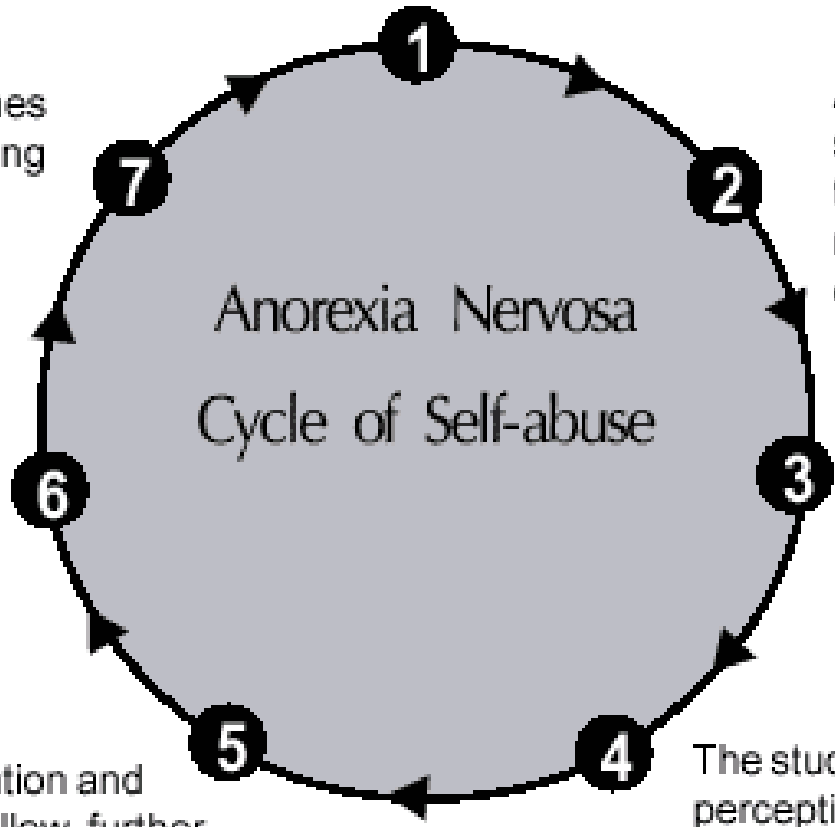
1. **Restricting type:** during the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

2. **Binge-eating/purging type:** during the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Health Complications of Anorexia

- Amenorrhea (cessation of menstrual cycle)
- Abnormally slow and/or irregular heartbeat
- Low blood pressure
- Anemia
- Poor circulation in hands and feet – hypothermia
- Muscle loss and weakness (including the heart)
- Dehydration/kidney failure
- Edema/swelling
- Memory loss/disorientation
- Chronic constipation
- Growth of lanugo hair
- Bone density loss/Osteoporosis

Eating Disorders: a vicious circle of self-abuse



1. Self-starvation can lead to obsessive thinking and compulsive behaviours centred on food and eating.
2. As less is eaten, the stomach shrinks and the student feels full more quickly when eating.
3. The resulting loss of muscle causes the stomach to protrude.
4. The student's perception, fantasies and fears of fatness are now reinforced.
5. Fluid retention and bloating follow, further reinforcing these fears.
6. The student's already distorted body image worsens.
7. As the student becomes more fixated on refusing food, in attempts to "correct" his/her body image, the disorder worsens.

Bulimia nervosa

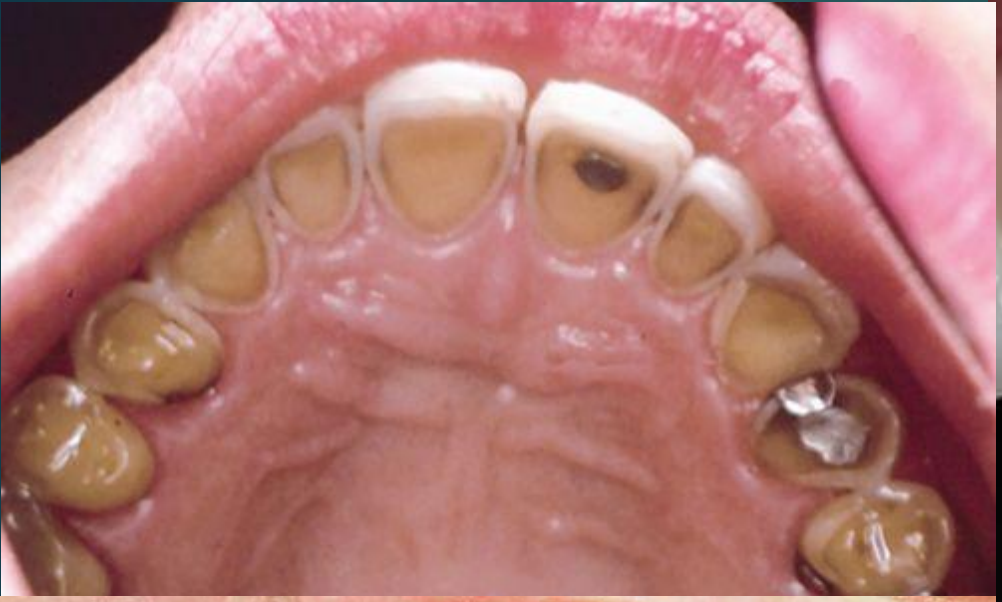
A. **Recurrent episodes of binge eating:**

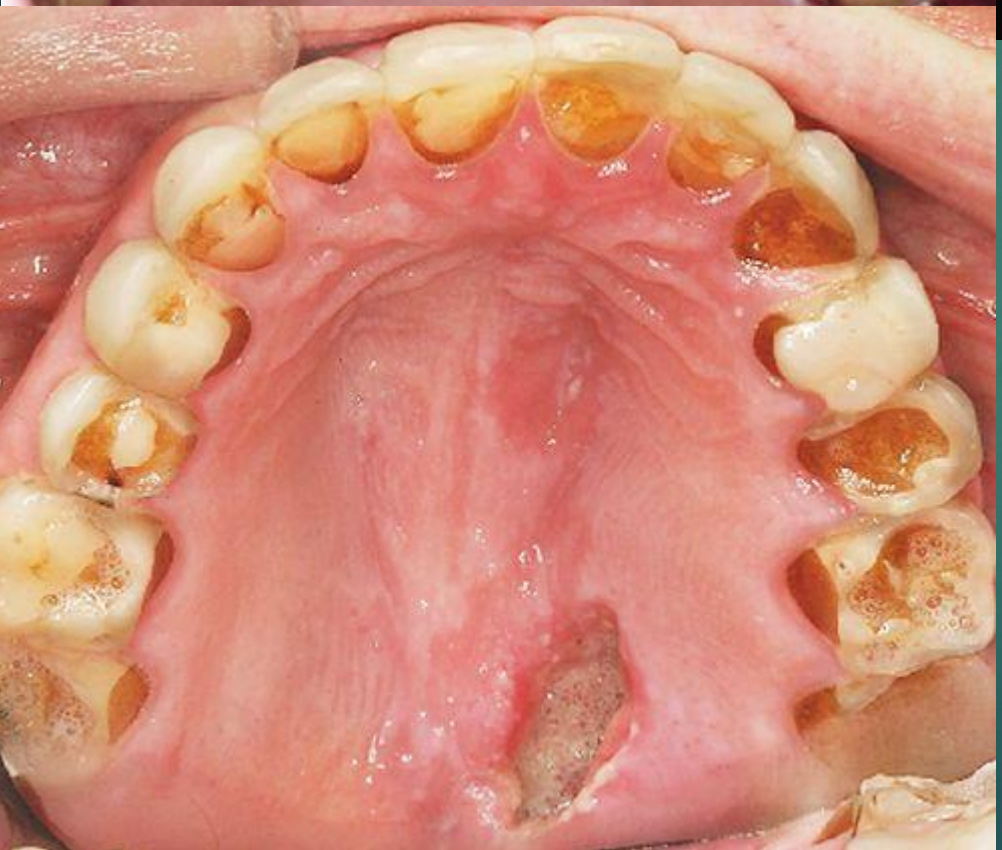
1. eating, in a **discrete period** of time, an amount of food that is definitely larger than most people would eat
2. a sense of **lack of control** over eating

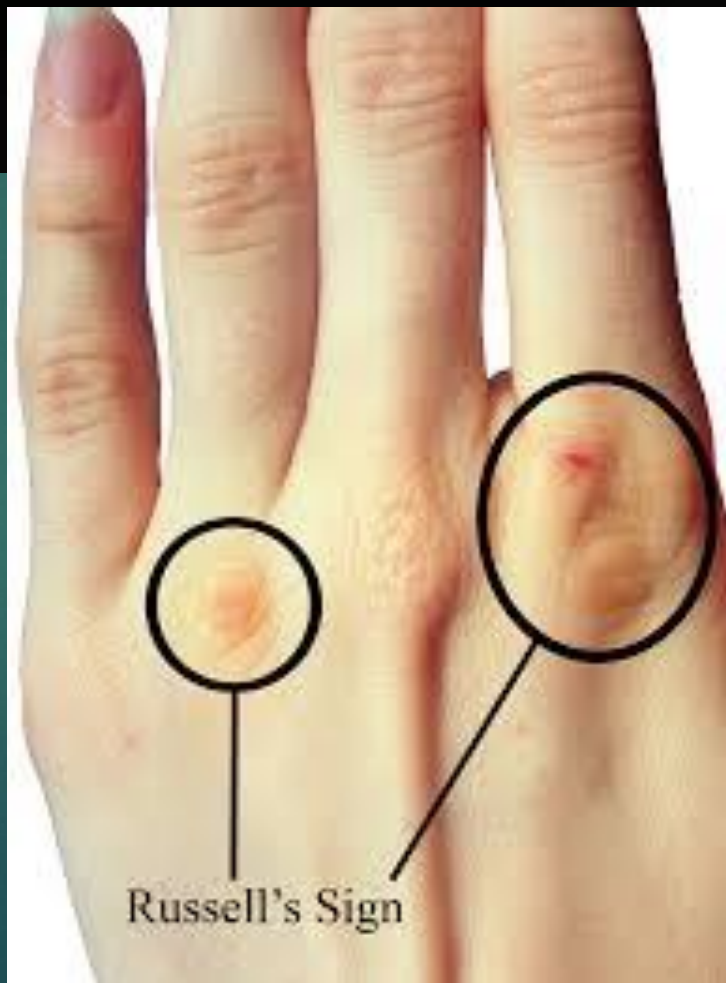
B. Recurrent **inappropriate compensatory behavior:** self-induced vomiting; misuse of laxatives, diuretics, enoas, or other medications; fasting; or excessive exercise.

C. **At least once a week for 3 months.**

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






Russell's Sign

Binge Eating Disorder

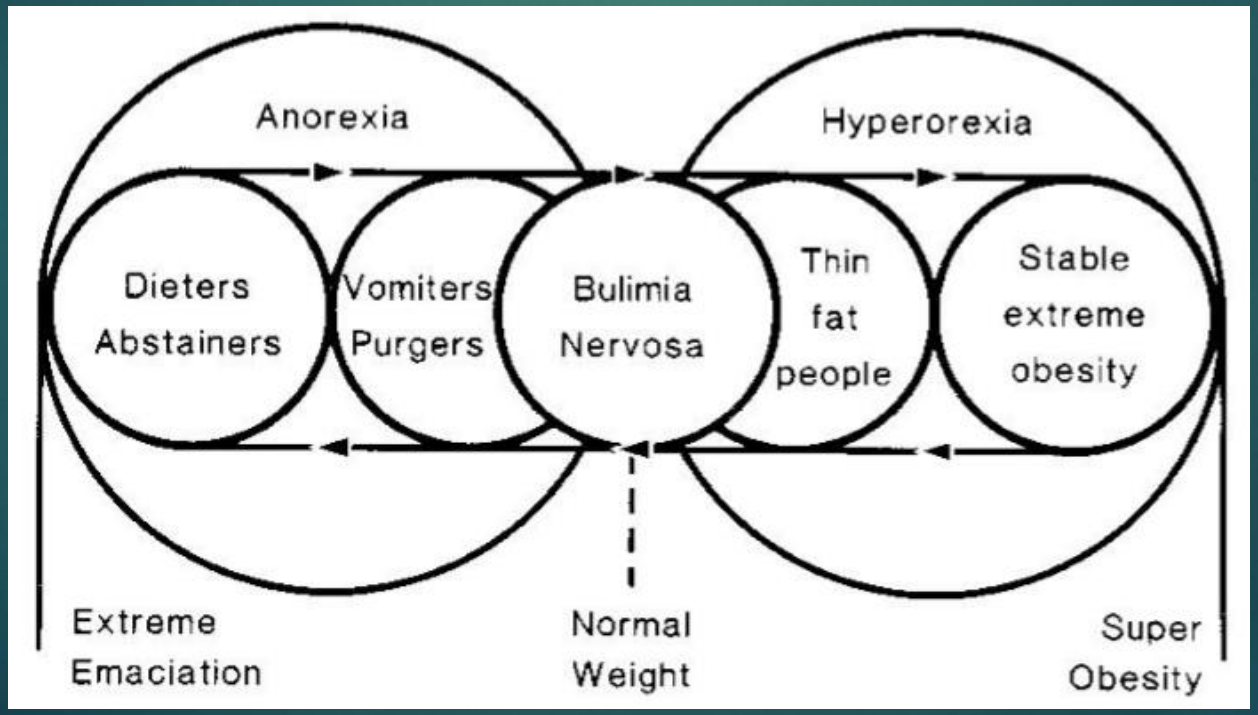
- **Recurrent episodes of binge eating at least once a week for at least three months.**
- What is the difference between a subjective and an objective binge?
- **Eating significantly more food in a short period** of time than most people would eat under similar circumstances
- The episodes are marked by **lacking control**.
- **No compensatory behaviour** + no BDD.
- Increased risk for obesity
- The most common eating disorder in the US
- 30% to 40% of those seeking weight loss treatments can be clinically diagnosed with BED.

The SCOFF questionnaire

Do you make yourself Sick because you feel uncomfortably full?	**Yes**	**No**
Do you worry you have lost Control over how much you eat?	Yes	No
Have you recently lost more than One stone in a 3 month period?	Yes	No
Do you believe yourself to be Fat when others say you are too thin?	Yes	No
Would you say that Food dominates your life?	Yes	No

Transition between disorders

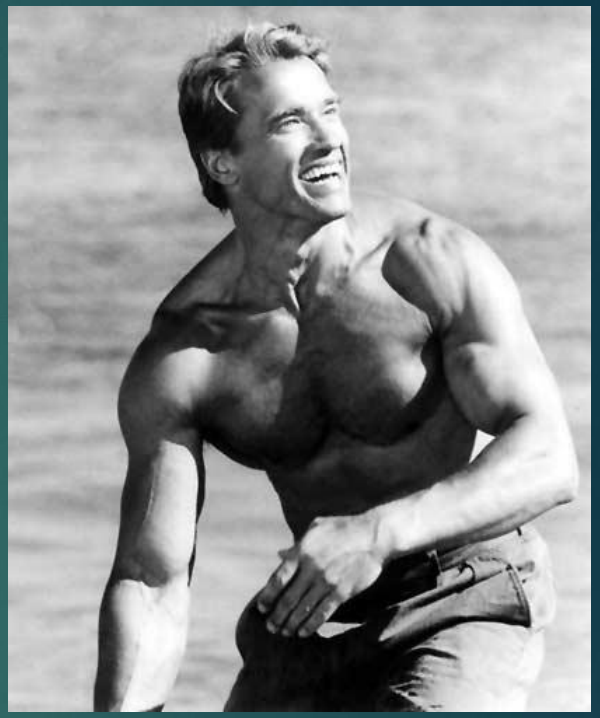
- A central dimension: **restrictive or impulsive** nature of the symptomology it is extremely important to take into account in beyond the diagnosis, because this determines the formation of symptoms and is related to personality functioning as well as to treatment outcomes.



Body dysmorphic disorder

- **The individual is preoccupied with 1 or more perceived defects or flaws in physical appearance that are not observable by others**
- **Performs repetitive behaviors** (e.g., mirror checking, excessive grooming, skin picking, or reassurance seeking) **or mental acts** (e.g., comparing his or her appearance with that of others) **in response to the appearance concerns**
- **Distress or impairment** in social, occupational functioning
- Prevalence: 2.4%; OCD spectrum, comorbid with affective, anxiety, personality and eating disorders.
- No (Hungarian) manual to cope with/intervene BDD.

Muscle dysmorphic disorder



Obsessive-compulsive preoccupation with muscularity, characterized by:

1. Body image disorder:

despite strong muscles they feel skinny

2. Phobia from being thin

3. Compulsive body-building

4. Anabolic steroid abuse

- Endogenous testosterone production may decrease!

5. Impaired social and intimate relationships

No guideline in MDD!

The big „WHY?”
The Etiopathogenesis of Eating Disordes

Eating disorders are complex psychosomatic disorders: Multifactorial aetiology + circular causality, with:

<u>Predisposing factors</u>
Individual risk factors:

- biological (genetics, neurotransmitters, etc.)
- premorbid obesity
- psychological (disorders of self perception, special personality characteristics, sexual of physical abuse)

Family risk factors:

- ED, diet of family members, affective disorder or alcoholism in the family, special family relationships, magnification of cultural values

Sociocultural risk factors:

- cultural norms, slimness ideal

<u>Precipitating factors:</u>

- Different stressors which cause dieting: life events

<u>Maintaining factors:</u>

- Cognitive and family reinforcements, effects of malnutrition
- Lack of social skills, isolation, depression, change in the family structure etc.

Background mechanisms

Symptoms	Brain region
Body image disorder	Parietal cortex
Spatial deficits	Parietal and frontal lobe
Increased anxiety	Frontal and limbic structures
Perseverative behavior	Frontal lobe, striatum
Agitation	Basal ganglia
Increased sense of reward	Nucleus accumbens
Impaired executive functions	Frontal lobe

The treatment of eating and body imge disorders

1. **Always work according to guidelines.**
2. **Apply a stepped care:** self-help, outpatient psychotherapy, combined with pharmacotherapy, inpatient
3. **It is good to know, the „why”, but rather try to save a life.**
4. **Work with triggers and maintaining factors!**

1. Always check the health risk first

Measure weight, heart rate and go to a lab test!

- Somatic complications, body mass index.
- Illness insight, motivation, previous treatments.
- Comorbid disorders, suicidal ideation, abuse
- Family characteristics

Inpatient treatment:

- BMI below 14, weight loss above 1 kg per week, systolic blood pressure below 80, body temperature below 35.5 C, heart rate below 45, arrhythmia, low potassium, diabetes

Psychiatric care:

- Suicidal ideation, major clinical disorders, psychosis

When is inpatient care equired? ED guideline: Hay et al. 2014

	Psychiatric admission indicated[a]	Medical admission indicated[b]
Weight	Body mass index (BMI) <14	BMI <12
Rapid weight loss	1kg per week over several weeks or grossly inadequate nutritional intake (<100kcal daily) or continued weight loss despite community treatment	
Systolic BP	<90 mmHg	<80 mmHg
Postural BP	>10 mmHg drop with standing	>20 mmHg drop with standing
Heart rate		≤40 bpm or > 120 bpm or postural tachycardia > 20/min
Temperature	<35.5°c or cold/blue extremities	<35°c or cold/blue extremities
12-lead ECG		Any arrhythmia including QTc prolongation, non-specific ST or T-wave changes including inversion or biphasic waves
Blood sugar	Below normal range*	< 2.5 mmol/L
Sodium	<130 mmol/L*	<125 mmol/L
Potassium	Below normal range*	<3.0 mmol/L
Magnesium		Below normal range*
Phosphate		Below normal range*

2. What are the triggers?

Check with eating diary and body image diary

Day ..... Monday ____ Date ____ March 19 ____

Time	Food and drink consumed	Place	*	v/l	Context and comments
6.30	Glass water	Kitchen			Feeling good this morning
7:10	Banana Bowl cheerios Skim milk Black coffee	Cafe			Normal breakfast
10:00	Apple Cereal bar	Desk at work			Didn't want to have this as having big lunch, but wanted to stick to plan.
1:00	Greek salad with feta cheese and dressing Roll water	Cafe			Decided that I would eat 3/4 of salad beforehand. Was pretty nervous the whole time, but was able to eat it and keep it down!
3:00	Yogurt	Desk at work			Thought about not eating this, but didn't want a huge gap.
6:30	Salmon (small piece) Rice (1/2 cup) spinach	Kitchen			Feeling ok.
9:30	Ice cream cone with hot fudge	Ice cream parlor with friends			Planned to have 2 scoops and was fine! Really enjoyed getting this with my friends as I usually don't go.

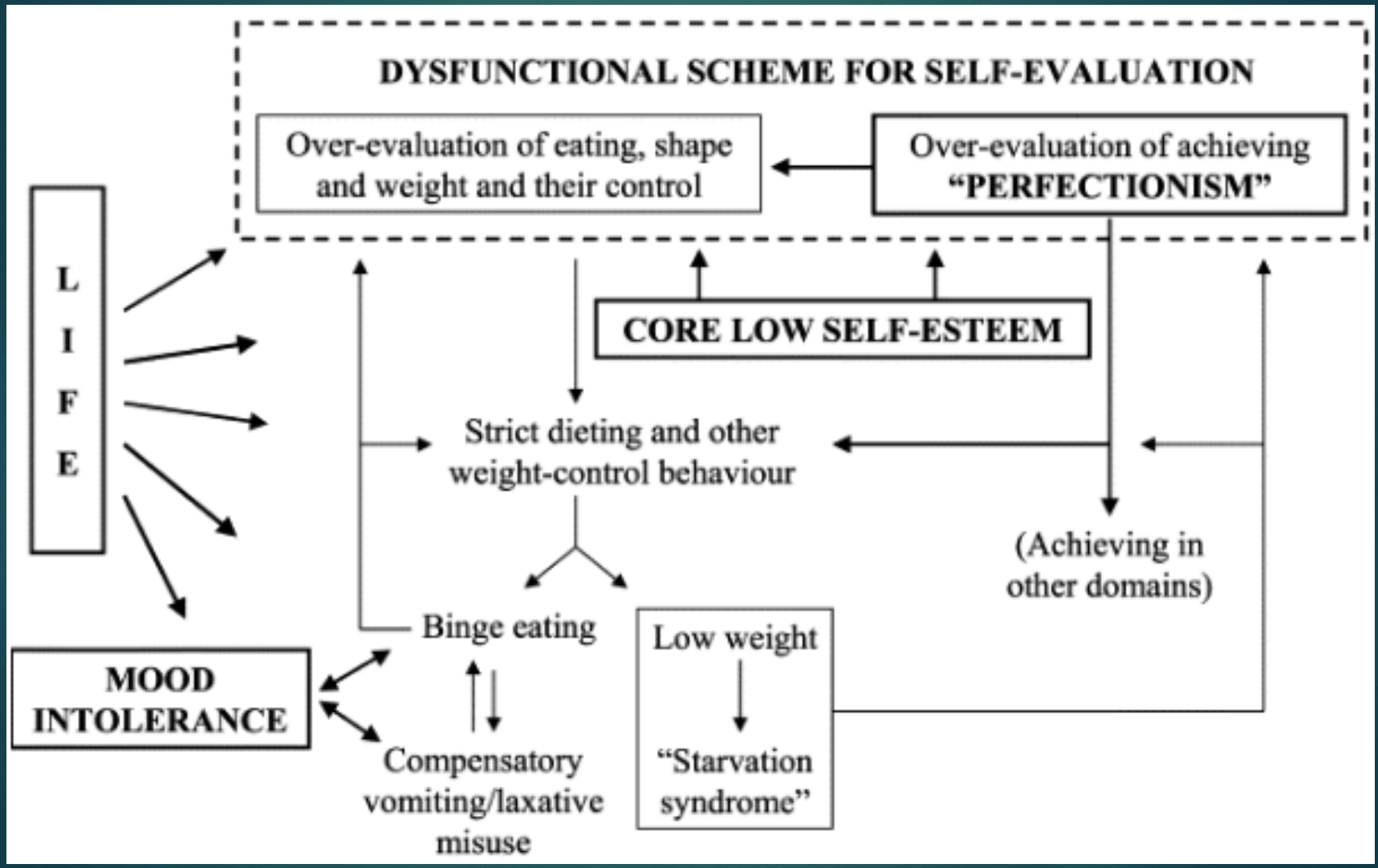
Body image diary

Aim: recognition and correction of negative automatic thoughts and negative schemas about the body.

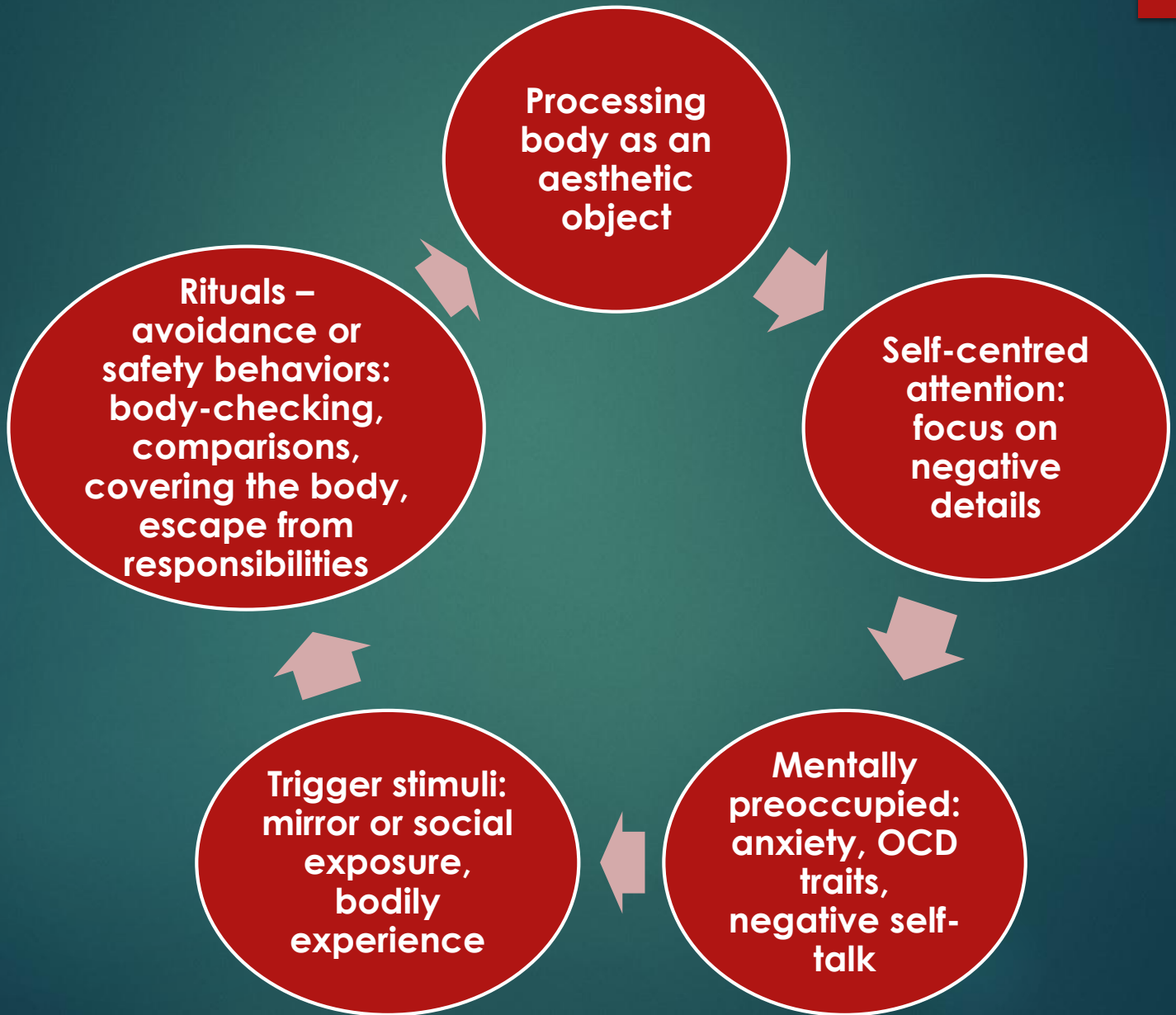
Place, time	Situation	Thoughts	Emotions and behavior	Are there any other interpretations?	More realistic thought	What can be done differently?
Home at night.	I greet him/her, waiting for a hug, but my partner does pay attention.	I am sure he/she is not attracted to me anymore. Of course, because I'm fat.	Shame, anger, withdrawal, nasty comments.	He/she is tired too. Maybe he/she is worried if I like him/her. We picked a fight yesterday. I see that he/she is ruminating.	I'm worried about my acceptability. That's why I hurt myself and my environment.	Less suspicious interpertation. Maybe I shall keep myself back, when I am frustrated.

3. What are the individual maintaining factors?

The transdiagnostic model of eating disorders (Faibrurn et al, 2008).



Maintaining factors of negative body image



4. Elimination of maintainig factors

1. Attention:
Attention is constricted to myself ←→conscious presence
I only pay attention to the object of dissatisfaction ←→ here's a whole human being

2. Comparison: avoid selective comparison
3. Avoidance: prevent hiding, e.g. big dresses and missed programs
4. Rituals: finish body-checking
5. Thinking: correcting negative sentences about myself
6. Moods: observing and controlling the effects of negative moods
7. Social factors: conflicts, activity and skill development

5. Exposure and response-prevention

- **E.g. Mirror, social and other body image situations:**
- **Avoiding stereotypical defences incl. avoidance and safety behaviors:** e.g. stop body-checking, hiding, comparisons and self-, disparagement
- **Gradual exposure:** at home, then in front of others
- **Negative self-talk:** shall be corrected to a realistic, neutral description vs. No studies on self-talk

6. Relationship factors

System-approach: Relational meaning and function of symptoms in homeostasis

Characteristics of psychosomatic families:

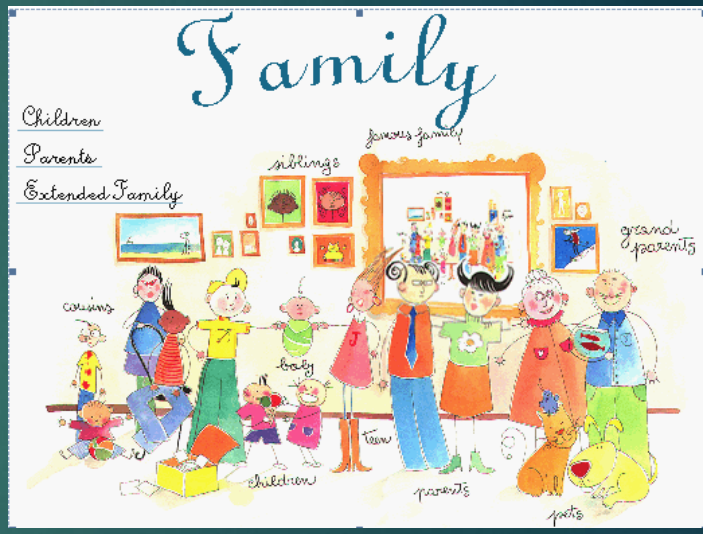
Enmeshment

Overprotection

Rigidity

Lack of conflict resolution

Involving the child in parental conflict



Communication:

Indirect, hidden

Ambivalent, flawed

Double bind

Invalidate each other's messages

"Introducing a child,,

7. Mood regulation and Non-specific factors

Mood regulation:

Relationships between emotions and body sensations

Distinguishing negative moods from negative bodily experiences

Do not over-identify yourself with your feelings, thoughts

Stress management skills

Improving self-esteem:

Expectations, vs. Values, positive inner speech

Activities related to positive body sensations

Reduction of perfectionism: realistic expectations and defined aims

Treatment of eating disorders

Stepped care

- In the first step generally self-help groups or psychoeducation is applied.
- Later: pharmacotherapy, outpatient group therapy.
- Outpatient psychotherapy, family therapy
- Intensive inpatient therapy

Treatment forms

- Pharmacotherapy
- Nutritive rehabilitation
- Psychoeducation and self-help
- Psychotherapy
- Integrated treatments

Pharmacotherapy

- It cannot be an exclusive treatment form
- AN: antidepressants may have a role
- BN: antidepressants are useful (SSRIs)
- Short term abstinence rate in the pharmacotherapy of BN is about 30%, the symptom reduction is about 70%
- Relapse rate is high (30-45%)
- High drop-out rate
- Drug dose may be higher as than depression (e.g. 60 mg fluoxetine)
- **Combination of pharmacotherapy and psychotherapy may be more effective**

Medical Nutrition Therapy

- An approach to stabilize medical conditions
- Normalization of food intake and eating behaviors

Components:

- **Intake assessment:** present and past dietary history, food records, dietary recalls, diet histories, food frequency questionnaires, biochemical indices + psychosocial data, sociological data, and activity level.
- **Dietary Modification:** may include supplemental nutrition, parenteral nutrition, and enteral nutrition
- **Patient education**
- **Aftercare:** dietary guidance evaluated periodically to monitor effectiveness

Psychotherapies

- Psychodynamic therapies
- Cognitive-behavioural therapies
- Interpersonal psychotherapy
- Family therapy
- Group therapies
- Body oriented therapy
- Hypnotherapy

Psychodynamic therapies

- Unconscious conflicts in the background e.g., fears from sexuality
- Sexual abuse in the history: about 25-30% of the patients (it is non-specific factor)
- Postponing of the adulthood (evolutionary theories)

Cognitive-behavioural therapies

- A proven therapy form of EDs
- Particularly for BN and BED
- Educational components
- Directly focuses on the problematic thinking and behaviors that sustain ED symptoms
- Also effective for addictions, mood disorders, personality disorders, and anxiety, which are comorbid with ESs
- Helps anger issues, low self-esteem, and physical health problems, such as pain or fatigue.
- CBT can be applied individually, in group settings, and can adapted for self-help

CBT interventions (Fairburn, 1993, 2005, 2008)

- Self-help recovery guidelines (Cooper, 1995; Túry, 2005)
- Food diary
- Normalization of daily meals
- Reducing dietary restraint
- Reducing over-evaluation of eating, shape and weight control
- Avoidance of body checking
- Modifying maladaptive thoughts related to eating

Dialectical Behavior Therapy

- **Mindfulness:** Observation, description, and participation are the fundamental mindfulness skills.
- **Interpersonal Effectiveness:** Includes effective methods for asking for what one needs, saying no, and strategies for dealing with interpersonal conflict.
- **Distress Tolerance:** Four sets of crisis endurance strategies are taught: distracting, self-soothing, improving the moment, and consideration of pros and cons.
- **Emotion Regulation:** strategies for recognizing and labeling emotions, identifying barriers to changing emotions, and increasing positive emotional events.

Family therapy

Dysfunctions of psychosomatic families:

- enmeshment
- overprotection
- rigidity
- avoidance of conflicts
- involvement of the child into parental conflicts

Recommendations:

- Family as a resource of the treatment.
- **For teenagers, especially in anorexia nervosa, family therapy is the first treatment method to choose**
- Controlled trials support the effectivity of family therapy

Treatment outcome

- **High mortality in AN:** about 8% after 10 years, 20% after 20 years
- **Rough estimation at follow-up:** 50% is symptom-free, 25% improves with remaining sypmtoms, 25% does not change

For Family and Friends

- You didn't CAUSE it.
- You can't CONTROL it.
- You can't CURE it.
- You can learn how NOT to CONTRIBUTE to it.
- You need to learn how to COPE with it.
- Take CARE of yourself.

- Avoid PANIC. It prohibits clear thinking and calm reactions.
- Recovery is a PROCESS. Two steps forward and one backwards.
- PROGRESS, not PERFECTION,is the goal. PATIENCE is critical.

- RESPOND instead of REACT.
- REMEMBER to listen.
- REFLECT and REASON before you speak.
- RECOVERY is a journey, a long ROAD that may include RELAPSE.
- REACH out to others for love and support.

Thank you for your kind attention!

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