Eating Disorder Training for Community Providers

Presented by
Therese S. Waterhous PhD, RDN, CEDS-S, FAED
Willamette Nutrition Source, LLC
www.willamettenutritionsource.com

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Handouts Available

1. Flow Chart for eating disorder decisions

2. Regional Oregon and West Coast Help and Resources

3. VeryWell article on Levels of care

4. Short Version of the EDE

5. Child EDE

6. Jacob's EDGE Tool

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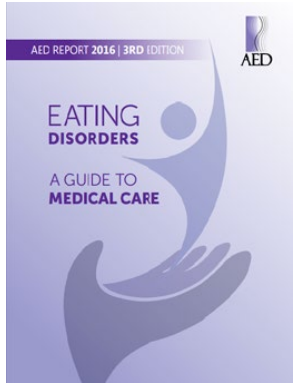
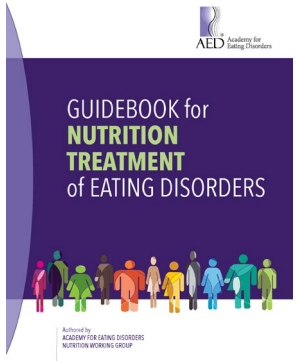
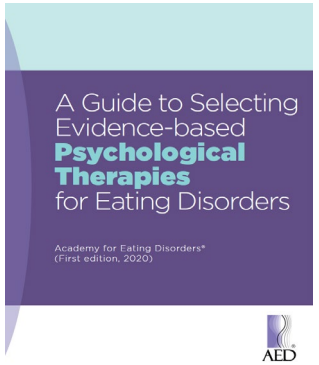
Resources Sent







- AED Guides for Medical Care, Nutrition Treatment and Psychological Therapies Guide
- How to Use These Resources

Learning Objectives-Lecture 3

1. Describe the next steps to take after screening a person and finding a positive screen for an eating disorder.

2. Be able to locate sources for referrals within the state of Oregon and surrounding region. (See handout)

3. Understand the components of medical, mental health and nutritional assessments and how each contributes to case conceptualization, leading to decisions on levels of care and treatment.

4. Know how to use some of the common measurement tools in eating disorders evaluation, which provide information on degree of illness severity and type of illness.

5. Learn the various levels of care for people with an eating disorder.

6. Describe the common co-occurring mental health conditions seen with eating disorders.

7. Be able to discuss hospitalization criteria (see flow chart handout)

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Review of the Screening Process

- The Eating Disorder Screen for Primary Care
- The SCOFF (**Sick, Control, One, Fat, Food**)
- Recall the high risk groups: **Adolescents, Women in major life transitions like pregnancy and menopause, Women with Polycystic Ovary Syndrome or Diabetes, Athletes** and people engaged in competitive activities and other activities such as dance where body shape and weight may be perceived as affecting performance
- **People identifying as LGBTQIA2S+**
- **People with a family history of eating disorders, as genetics plays a major factor**
- **People frequently asking for weight loss advice, chronic dieters**
- **Men and boys - often an overlooked group**

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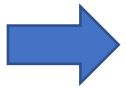
Screen, Then What?

- Next Steps  Further Evaluation, Diagnosis, then Treatment.
- Evaluate dietary intake, weight loss/gain history, exercise history, and attitudes about food and weight. Utilize a nutrition expert with eating disorders training.
- Evaluate mental status. Utilize a mental health expert with eating disorders training.
- Evaluate medical status. Does this patient need inpatient re-feeding to start, due to risk of re-feeding syndrome? Do they meet hospitalization criteria? (See pages 6 through 9 of the AED Medical Care Standards Guide)
- Make appropriate diagnosis, then evaluate for degree of severity and level of care. (Refer to diagnostic criteria provided in Lecture 1 and also in the AED Medical Care Guidelines, Pages 1 & 2.

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From the Medical Evaluation

- Conduct a Differential Diagnosis if this has not been done. Rule out other causes of loss of appetite, weight loss such as thyroid issues, cancers, Mast Cell Activation Syndrome, Addison's disease, visceral hypersensitivity syndrome, pelvic floor dysfunction.
- Evaluate all systems for any effects of disordered eating. Look at vitals, cardiac function, thyroid function, electrolyte status, Complete Blood Count
- May want to check leptin, sex steroid hormones, and consider a DEXA (bone scan).
- Determine degree of medical instability if present (will refer to hospitalization criteria next)
- Make a diagnosis if possible.

- See pages 4 through 9 of the AED Medical Care Guidelines for information on medical assessment

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From the Nutrition Evaluation

- Determine what current, actual eating is like, using a 3 to 5 day dietary record. Parents do this for a child or adolescent.
- Determine level of probable nutrient deficiencies so supplementation can be recommended if needed.
- Assess weight history, weight cycling, exercise history and current exercise patterns.
- Assess level of nutrition knowledge and possible nutrition “help” needed, such as meal plans.
- Assess family and cultural norms around food and assess for food insecurity.
- Evaluate for food rules, food and nutrition misinformation, body development misinformation.
- Assess disordered eating behaviors - frequency, type
- See pages 7 through 11 in the AED Nutrition Guidelines for more information on nutrition assessment and pages 18 through 22 for lab values related to nutrition.

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From the Mental Health Evaluation

- Take thorough history including family history of eating disorders or other mental conditions
- Evaluate overall mental health status
- Assess severity of disordered eating behaviors (will go over measures for assessment next)
- Evaluate for co-morbid mental health conditions - most frequent are anxiety, depression, PTSD, obsessive compulsive behavior, sensory processing issues.
- Evaluate resources, family functioning
- Determine correct diagnosis if this has not been done (See pages 1 and 2 in the AED Medical Care Guidelines for more information on diagnosis)

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Steps in the Process

Locate the Eating Disorder Decision Tree handout. We will go over this next.

1. Evaluate for medical stability.
2. Do nutrition assessment.
3. Do mental health assessment for the eating disorder behaviors and co-morbid conditions.
4. Assess family situation and resources.
5. Assemble the multidisciplinary team.
6. Decide on appropriate level of care and if hospitalization is necessary.
7. Initiate treatment that is effective for where this person is starting, as soon as possible.

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EATING DISORDERS DECISION TREE
Screening & Initial Evaluation

Use ESP to screen (attached). Consider having a PA, NP or RDN do screening.

Positive? Can you diagnose?

If you can diagnose:

Consult Diagnostic Criteria (see attached DSM 5 criteria)

Continue to evaluate for warning signs

Positive and Cannot Diagnose?

Consult handout: Regional Help & Resources

Refer to RDN, mental health specialist, NP or PA for further assessment.

•ASK ABOUT:

- Use of compensatory behaviors (i.e., self-induced vomiting, laxative abuse, dieting, fasting or excessive exercise) to influence weight after eating or binge eating
- Inappropriate use of appetite suppressants, caffeine, diuretics, laxatives, enemas, ipecac, artificial sweeteners, sugar-free gum, prescription medications that affect weight (insulin, thyroid medications, psychostimulants, or street drugs) or nutritional supplements marketed for weight loss.
- OR refer to a specialist

WARNING SIGNS***:

- Weight loss history-is it extreme?
- Weight stability-has weight fluctuated in past year or have multiple dieting attempts been tried?
- Vital signs-Bradycardia (slow pulse) present-heart rate<50bpm?
- Orthostatic changes in pulse- >20 bpm or >10 mm Hg (change in blood pressure & pulse)
- Temp <96 degrees F,
- Electrolytes-Serum potassium < 3.2 mmol/L or Serum chloride < 88mmol/L

Consult Hospitalization Criteria

IF Warning signs present or fits diagnostic criteria-

1. Refer to treatment center (see attached list for Oregon and Washington)
2. Or contact a local eating disorders provider.
3. IMMEDIATE NEED: Set up a local treatment team; Need to evaluate for appropriate level of care.

May need to admit for medical stabilization

Contact **Regional Help & Resources provider**
See the AED Booklets

****Do not assume a low heart rate is an "athletic heart" even if working with an athlete. Ask about food intake. If low for more than 2 days, assume the bradycardia is due to malnutrition. Understand this - eating disorders are a serious illness and not a personal choice. Do not assume that if your patient says they feel fine, that they are fine.*

When to Hospitalize

- Very low body weight- ≤ 75% median BMI for age, sex, and height, or prolonged severe caloric restriction causing significant weight loss in the absence of underweight.
- Hypoglycemia - low blood sugar
- Electrolyte disturbance(s)
- Hypokalemia - low blood potassium
- Hyponatremia - low blood sodium
- Hypophosphatemia - low blood phosphate and/or metabolic acidosis or alkalosis-blood Ph is off

A medical provider will have to order labs

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When to Hospitalize

- ECG abnormalities –abnormal heart rhythm
- Acute food refusal
- Hemodynamic instability
- Bradycardia-low heart rate
- Orthostatic hypotension-large changes in heart rate and blood pressure when changing positions
- Hypothermia-low body temperature
- Acute medical complications of malnutrition (fainting, seizures, cardiac failure, pancreatitis, etc.)

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When to Hospitalize

- Hospitalization Criteria for Acute Psychiatric Stabilization
  - Suicidal thoughts or behaviors
  - Aggression or unsafe behaviors
  - Other significant psychiatric comorbidity that interferes with ED treatment (anxiety, depression, obsessive compulsive disorder, mood instability)

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Refeeding Syndrome

- This is a condition to be aware of
- It happens to any person who has gone without food for several days. It is a condition seen with starvation.
- First assess the degree of starvation. Little to no food intake over the past 10 days, rapid or extreme weight loss are red flags. (Have a nutritionist do this if possible).
- It is seen once a person starts to be re-fed. There is a shift in electrolytes, especially phosphate, causing serum phosphate to drop to dangerous levels.
- If a person is in danger of refeeding syndrome, they should start refeeding in the hospital where they can be monitored.
- The danger passes after about a week of being fed.
- See pages 11 and 12 in the AED Medical Care Guide for risks of refeeding syndrome.

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Themes in Eating Disorder Measurement

- If we take a look at eating disorder questionnaires there are similar themes being measured.
- Restraint
- Over concern about body
- Feeling of fatness
- Avoiding food
- Desire to lose weight
- Preoccupation about food
- Thinking of ways to avoid food
- Guilt about eating
- Purging behaviors
- Exercise behaviors

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Measures to Assess the Eating Disorder (linked)

- The Eating Disorder Examination (EDE)
- The Eating Disorder Examination Questionnaire (EDE-Q)
- Child Eating Disorder Examination Questionnaire (Ch-EDE-Q8)
- Eating Disorder Examination-Adolescents
- EDE-QS-short version of the EDE-Q
- EAT-26
- Compulsive Exercise Test-CET
- Dietary analysis-24 hr. recall or several day food record
- Eating Disorder Global Evaluation

Source for EDE information: https://www.cbte.co/for-professionals/measures/

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The Eating Disorder Examination (EDE) and the EDE-Q Page

- The **Eating Disorder Examination (EDE)** is a diagnostic interview, which has been modified to reflect current DSM-5 diagnoses. As an interview, the **EDE** is designed to be administered by a clinician, and the developers recommend clinician training to ensure all concepts being assessed are well-understood.
- The **EDE** is frequently used in research settings where quantitative data are desired.
- The **EDE-Q** is the questionnaire rather than an interview and was adapted from the **EDE.** The **EDE-Q** is a self-report measure, which can be completed individually, or with the help of a clinician (explaining concepts such as binge eating).
- The **EDE-Q** is a 28 item questionnaire that retains the format of the EDE including the 4 subscales and global score. It also concerns behaviors over a 28-day time period and retains the scoring system of 0–6, with 0 indicating no days, 1=1–5 days, 2=6–12 days, 3=13–15 days, 4=16–22 days, 5=23–27 days and 6= every day
- **Both** measures assess past month cognitive subscales related to ED: restraint, eating concern, shape concern, and weight concern, as well as behavioral symptoms related to these concerns (e.g., frequency of binge eating, vomiting, use of laxatives or diuretics, and overexercise)
- **Both** instruments are available for free download from http://www.credo-oxford.com/7.2.html.

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EDE-QS-short version of the EDE-Q (linked)

We have a handout on this measure.

This is a 12 item measure derived from the longer EDE-Q

The EDE-QS is a brief, reliable and valid measure of eating disorder symptom severity that performs similarly to the EDE-Q.

It is useful for monitoring session outcomes over time and can be used in both treatment and research settings.

Reference: Development and Psychometric Validation of the EDE-QS, a 12 Item Short Form of the **Eating Disorder** Examination Questionnaire (EDE-Q)
Nicole Gideon, Nick Hawkes, Jonathan Mond, Rob Saunders, Kate Tchanturia, Lucy Serpell
PLoS One. 2016; 11(5): e0152744. Published online 2016 May 3. doi: 10.1371/journal.pone.0152744

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Eating Disorder Examination-Adolescents (linked)

The Eating Disorder Examination for Adolescents (EDE-A) is an adapted version of the EDE-Q, with 36 items and yielding the same four subscales and global score.

Sample questions:

On how many days of the past 14 days ... No days 1–2 days 3–6 days 7 days 8–10 days 12–13 days Every day

Have you been trying to cut down on food to control your weight or shape?

Have you gone for long periods of time (8 hours or more) without eating anything to control your shape or weight?

Have you tried not to eat any foods you like to control your weight and shape?

Have you tried to keep to any strict rules about eating to control your shape or weight? For example, a calorie limit, a set amount of food, or rules about what and when you should eat?

Have you wanted your stomach to be empty?

Has thinking about food or calories made it much harder to concentrate on things you are interested in; for example, reading, watching tv, or doing your homework?

Have you been scared of losing control over eating?

Have you had eating binges? Have you eaten in secret? (Do not count binges.)

Have you really wanted your stomach to be flat?

Source: https://www.corc.uk.net/outcome-experience-measures/eating-disorder-examination-questionnaire-ede-q/

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Child Eating Disorder Examination Questionnaire (ChEDE-Q8) (linked)

- Please see the handout of this questionnaire.
- This simple questionnaire shows some basic themes and types of questions asked of youth.
- Similar to the EDE-Q, the ChEDE-Q provides assessment of eating disorder psychopathology related to anorexia nervosa, bulimia nervosa, and binge-eating disorder.
- The ChEDE-Q does not assess symptoms of avoidant/restrictive food intake disorder, pica, or rumination disorder.
- This measurement has 8 questions that are rated on a scale of 0 to 6 and asks about behaviors over the past 14 days.

Reference: Int. J Eat Disord 2017 Jun;50(6):679-686. doi: 10.1002/eat.22658. Epub 2017 Jan 25

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EAT-26 (see below for copies/link)

The EAT 26 has 26 self-reported questions using a 6-point Likert scale to assess risk of disordered eating based on behaviors and thoughts.

Initially developed in 1982, the EAT-26 has subsequently been evaluated in multiple populations and in many countries.

- The EAT 26 can be used in ages 13 and older and is available in many languages.
- There is a children's version of the EAT 26 that can be used in ages down to 7. Children's EAT (ChEAT or cEAT)
- **Scoring:** Referral is advised for a total score ≥20, any positive responses in Part C, or "extremely low" body weight compared to age-matched norr
- The cutoff score of 20 for the 26-question ChEAT20 is also commonly used.

Free but requires permission to reproduce the link or download. Eat-26.com
Contact study authors to request access to the ChEAT. http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/ChEAT.pdf

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ARFID Measures

- The Pica, ARFID, and Rumination Disorder Interview (PARDI) is a semi-structured multi-informant interview that was created to diagnose ARFID in both children and adults.
- One of the most important features of the PARDI is that it can identify the severity of ARFID, as well as its various presentations, including sensory avoidance, fear of adverse reactions, and low interest in food.[3]
- The PARDI takes about 39 minutes to complete and is free to clinicians. It has been studied in patients with AFRID between the ages of 8 and 22 years old, but more research is needed to determine how useful it i

- Bryant-Waugh R, Micali N, Cooke L, et al. Development of the Pica, ARFID, and Rumination Disorder Interview, a multi-informant, semi-structured interview of feeding disorders across the lifespan: A pilot study for ages 10-22. *Int J Eat Disord*. 2019;52(4):378-387. doi:10.1002/eat.22958

Nine-Item ARFID Screen (NIAS)

- The Nine-Item ARFID Screen (NIAS) is a Likert scale with nine statements. A Likert scale is a way to gauge the intensity of a person's response to a question or statement. For example, the scale may ask a person if they "strongly agree," "somewhat agree," or "strongly disagree" with a question.
- An ARFID diagnosis is suspected if a person receives scores of greater than 10 on the NIAS picky eating subscale, greater than nine on the NIAS appetite subscale, and/or greater than 10 on the NIAS-fear subscales.[8]
- Researchers recommend that clinicians use the NIAS in combination with another validated eating disorder screening tool.

- 23520Burton MH, Dreier MJ, Zickgraf HF, et al. Validation of the nine item ARFID screen (Nias) subscales for distinguishing ARFID presentations and screening for ARFID. *Int J Eat Disord*. 2021. doi:10.1002/eat.

Compulsive Exercise Test

- Compulsive exercise is defined as exercise that significantly interferes with important activities, occurs at inappropriate times or in inappropriate settings, or when the individual continues to exercise despite injury or other medical complications (https://www.nationaleatingdisorders.org/learn/general-information/compulsive-exercise)
- Compulsive exercise is associated with intense feeling of anxiety and discomfort if the person is not able to exercise and it can be isolating. It is often used as a means to purge unwanted calories or used as a way to have permission to eat.
- Is often used as a means to control negative emotions and people with compulsive exercise symptoms often feel that they are not "good enough" unless constantly training or trying to improve physical performance.
- **The CET** has 24 self-report items that are designed to assess the core cognitive, behavioral and emotional features of compulsive exercise.
- Items are rated on a 6-point Likert type scale from 0 (never true) to 5 (always true) and generate five subscales: Avoidance and rule-driven behavior, exercise for weight control, mood improvement, lack of exercise enjoyment, and exercise rigidity.
- Higher scores on the CET indicate greater pathology.

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Eating Disorder Global Evaluation

- Please see the handout on this measurement
- The Eating Disorder Global Evaluation assesses both physiological as well as behavioral components of an eating disorder.
- It also measures frequency of physical symptoms and behaviors.
- It is not validated but has been found to be useful in clinical settings both as an instrument to measure severity, a way to measure progress, and as an education tool.
- It has a very specific behaviors list such as:
    a. prefers to eat with fingers
    b. uses condiments excessively
    c. prepping food for others but not eating it
- It can be given to clients to fill out on their own, or a clinician can do this with clients

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EDGE
Name _____ Date _____ ID#_____

Please mark box for any and all items that apply and rank 0-3.
0 = not applicable leave blank
1 = infrequent w/in the last month
2 = few times a week
3 = daily/many times a day

Physiological

- ☐ __Weakness, very tired
- ☐ __Low pulse _____bpm
- ☐ __Dizziness, dizziness upon standing up from seated position
- ☐ __Cold hands and feet
- ☐ __Daytime sleepiness
- ☐ __Chest pain or discomfort
- ☐ __Ankle or feet swelling
- ☐ __Constipation
- ☐ __Abdominal pain
- ☐ __Diarrhea
- ☐ __Vomiting
- ☐ __Nausea
- ☐ __Delayed gastric emptying (feel full immediately after eating small amounts)
- ☐ Stress fractures
- ☐ Abnormal menstrual periods
- ☐ No menstrual cycle ≥3 mo.
- ☐ Delayed menarche no menstruation by age 14
- ☐ __Dry skin
- ☐ __Brittle nails
- ☐ __Hair loss
- ☐ __Yellow-orange skin tone
- ☐ __White downy hair growth (lanugo)
- ☐ __Poor concentration
- ☐ __Memory loss
- ☐ __Cannot sleep at night – Hours slept at night (___)
- ☐ __Depression
- ☐ __Anxiety
- ☐ __Obsessive behavior
- ☐ __Obsessive thoughts
- ☐ __Over-concern with weight and shape

Behavioral

- ☐ __Active and restless, stand frequently when most people would sit
- ☐ __Disproportionate time spent thinking about food
- ☐ __Interest in recipes, food channel, and food shopping
- ☐ __Binge eating subjective or objective
- ☐ __Experience loss of control with eating
- ☐ __Hoards food; food seems to "go missing" especially sweets, cereals, high carb foods
- ☐ __Angry, tense, or hostile at meals
- ☐ __Excessive use of condiments (such as salt, ketchup, spices)
- ☐ __Cutting food into very small pieces before eating
- ☐ __Prefers to eat with fingers
- ☐ __Picks, blots, and tears apart food
- ☐ __Inappropriate food combinations
- ☐ __Eats food in a certain order
- ☐ __Hides food in napkins, pockets, gives to dog, throws food away
- ☐ __Chews/Spits
- ☐ __Avoidance of specific foods
- ☐ __Statements about being or eating "healthy"
- ☐ __Avoidance of social situations with food
- ☐ __Eats meals too fast
- ☐ __Eats meals too slow
- ☐ __Attempt to bargain about foods ("I will eat this if I don't have to eat that")
- ☐ __Inability to identify hunger
- ☐ __Inability to identify fullness
- ☐ __Unusually small portions
- ☐ __Inability to define or eat a balanced nutrient intake
- ☐ __Abnormal timing of meals and snacks
- ☐ __Offsetting food intake with exercise/food choices
- ☐ __Compensatory purging activity, including exercise
- ☐ __Difficulty estimating portion size
- ☐ __Purchasing and preparing food for other people, without eating it
- ☐ __Unusual rigidity and rituals around food
- ☐ __Rationing; not eating in the early part of the day to "save" food to be eaten later

Family Medical History

- ☐ Eating disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Substance abuse
- ☐ Obesity
- ☐ Other mental illnesses
- ☐ OCD
- ☐ MTHFR
- ☐ Other _____

After Assessments, then Treatment

- In reality, in the outpatient setting, not very many clinicians use validated measurement tools.
- Many clinicians are familiar with validated tools and use various questions from them.
- Once a diagnosis is made, the degree of psychopathology and medical compromise is determined, the nutritional needs and degree of compromise are determined, then where the person will be treated and how can be determined.
- Treatment is best decided upon by the whole multidisciplinary team.

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Multidisciplinary Teams

- You, as the mental health or medical provider, do not have to do all of this by yourself
- The medical provider needs to attend to medical complications, order appropriate lab tests, and if in a specific discipline, such as OB/GYN, attend to specific conditions that an ED could affect. (amenorrhea)
- Rely on well trained therapists and dietitians to do a lot of the behavioral work and most likely spend the most time with the patient. Well trained RDNs that are eating disorder specialists do have behavioral therapy training.
- Typical teams do include the medical provider/PCP, the dietitian, the therapist and sometimes a psychiatrist.
- Communication between team members is essential. Eating disorders are well known for “team splitting”. Yes this is difficult. We all need to advocate for extra time to work with eating disorders.

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Levels of Care

- **Outpatient treatment** typically entails individual, one-hour sessions once or twice a week with each individual provider.

- **Intensive outpatient treatment** (IOP) can be two to three sessions a week, a few hours each time, while the client lives at home and possibly works or attends school.

- **Partial hospitalization programs** (PHP) are usually held five days a week for six to 11 hours per day, allowing the client to sleep at home.

Levels of Care

- **Residential treatment centers** (RTC) provide 24-hour care for those who are medically stable but require supervision.

- **Medical hospitalization** provides in patient 24-hour care for those who require medical supervision and stabilization. Refer to the hospitalization criteria to know who needs this level of care.

- Which levels of care to consider depends on the degree of severity of the eating disorder. This article has things to consider when deciding on levels of care. https://www.verywellmind.com/levels-of-eating-disorder-treatment-4134267

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Best Eating Disorder Treatment

- **Early diagnosis** Many eating disorders develop during adolescence. Best prognosis is seen when the disorder is diagnosed early and effective treatment is initiated ASAP.
- **Effective treatment** This involves medical and nutritional stabilization first, then cessation of eating disorder behaviors. For adolescents and young adults the family is key to treatment. Many treatment modalities have evidence demonstrating effectiveness.
- **Multidisciplinary treatment** A well trained team, that communicates and shares decisions, promotes the best recovery. The team communicates the same message to the patient and family.
- **Continued treatment** and support into the maintenance phase. People are not well after going to a treatment center or when weight is restored.
- Treatment modalities will be discussed in detail in September

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