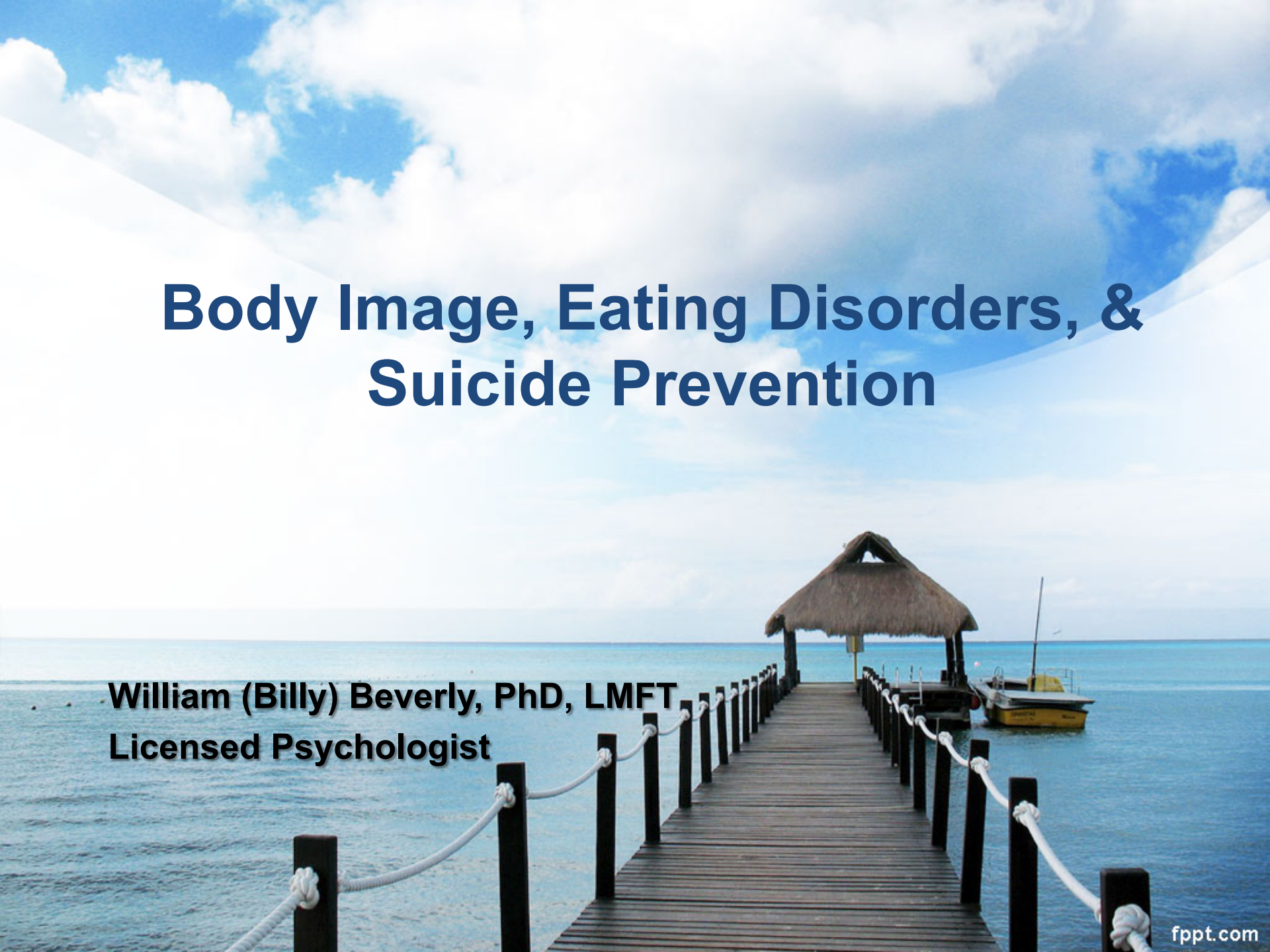
Body Image, Eating Disorders, & Suicide Prevention



William (Billy) Beverly, PhD, LMFT
Licensed Psychologist

“This ridiculous weakness is perhaps one of our worst melancholic instincts, for what can be more absurd than to be eager to go on carrying a burden of which we wish to be eased?, to hold our existence in horror, and yet to cling to it, to **gently caress the serpent that devours us** until it has eaten our hearts away?”

What Are Eating Disorders?

- Real, life-threatening illnesses with potentially fatal consequences.
- Involve extreme emotions, attitudes, and behaviors surrounding weight, food, and size.
- Caused by a range of biological, psychological, and sociocultural factors

9 Truths About Eating Disorders

1. Many people with eating disorders look healthy, yet may be extremely ill.

2. Families are not to blame, and can be the patients' and providers' best allies in treatment.

3. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.

National Eating Disorders Association

9 Truths About Eating Disorders

4. Eating disorders are not choices, but serious biologically influenced illnesses.

5. Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations, and socioeconomic statuses, while some groups are at significant risk.

6. Eating disorders carry an increased risk for both suicide and medical complications.

National Eating Disorders Association

9 Truths About Eating Disorders

7. Genes and environment play important roles in the development of eating disorders; nes alone do not predict who will develop eating disorders.

8. Co-morbidity is the norm.

9. Recovery from an eating disorder is possible. Early detection and intervention are important.

National Eating Disorders Association

DSM-5 Diagnoses

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Avoidant-Restrictive Food Intake Disorder (ARFID)
- Other Specified Feeding or Eating Disorder (OSFED)
- Eating disorders are complex and some eating issues will not meet diagnostic criteria. All must be taken seriously.

Anorexia Nervosa (AN)

- Characterized primarily by self-starvation and excessive weight loss
- **Symptoms include:**
  - Inadequate food intake leading to a weight that is clearly too low
  - Disturbance in the experience of body weight or shape
  - Intense fear of weight gain, obsession with weight, and persistent behavior to prevent weight gain
  - Inability to appreciate the severity of the situation

Subtypes of Anorexia Nervosa

- **Restricting type**: very low caloric intake; Could include over exercise with fasting

- **Binge-eating/purging type**: the person regularly engages in binge eating or purging behaviors
  - Common purging behaviors could include self-induced vomiting, misuse of laxative, diuretics, enemas, or other medications

- Longitudinal data reveal few differences between these two subtypes on severity of symptoms and personality

- Clients will often switch methods

- Not predictive of course of disorder, but reflects phase (DSM looks at last 3 months)

Medical Complications of Anorexia

- Anorexia nervosa can cause a number of medical complications:
  - Constipation, abdominal pain, in tolerance to cold, lethargy
  - Dry skin and lanugo
  - Anemia, infertility, impaired kidney functioning, cardiovascular difficulties, dental erosion, and osteopenia (bone loss)
  - Amenorrhea (loss of menstruation)

- Longitudinal Research: Anorexia
  - 20% of deaths due to suicide
    - 5% within 10 years
    - 50 times greater risk of suicide than the general population

- **Anorexia Nervosa has the highest mortality rate of the psychological disorders in the DSM**

Bulimia Nervosa (BN)

- Characterized by **binge eating** and **compensatory behaviors**, such as self-induced vomiting, in an attempt to undo the effects of binge eating.

- **Symptoms include:**
  - Frequent episodes of consuming very large amounts of food followed by behaviors to prevent weight gain, such as vomiting, laxative abuse, and excessive exercise
  - Feeling of being out of control during the binge-eating episodes
  - Extreme concern with body weight and shape
  - Most people are of a normal weight

- Among those who present for treatment the overwhelming majority (90-95%) are female

Medical Complications of Bulimia

- Repeated vomiting can erode dental enamel, particularly on the front teeth, and in severe cases teeth can become chipped and ragged looking
- The enlargement of the salivary glands, a consequence that has the ironic effect of making the sufferer's face appear puffy
- Electrolyte imbalances, rupture of the esophagus or stomach has been reported in rare cases, sometimes leading to death

Binge Eating Disorder (BED)

- Characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.
- **Symptoms include:**
  - Indications that the binge eating is out of control, such as eating when not hungry, eating to the point of discomfort, or eating alone because of shame about the behavior
  - Feelings of strong shame or guilt regarding the binge eating
- Gender differences

Avoidant-Restrictive Food Intake Disorder (ARFID)

- Characterized by lack of interest in food, fears of negative consequences of eating, and selective or picky eating.
- **Symptoms include:**
  - Reduced food intake and frequent complaints of bodily discomfort with no apparent cause
  - Lack of appetite or interest in food, with a range of preferred foods narrowing over time

- Similar to AN in that both involve food restriction, but AFRID does not involve any distress about body image

Other Specified Feeding or Eating Disorder (OSFED)

- A feeding or eating disorder that causes significant distress or impairment, but does not meet the criteria for another feeding or eating disorder.

- **Atypical Anorexia Nervosa**: criteria for AN met but weight is not below normal
- **Subthreshold Bulimia Nervosa**: criteria for BN met but with less frequent occurrences
- **Subthreshold Binge Eating Disorder**: criteria for BED met but occurs at a lower frequency
- **Purging Disorder**: purging without binge eating
- **Night Eating Syndrome**: excessive nighttime food consumption

Dimensional Perspective of Eating Disorders

- May be better to conceptualize eating disorders on a continuum instead of categorically

- Example: that 44 percent of high school females dieting at point in time shows that body image problems are not reserved to individuals who fall into these very restrictive categories.

Dimensional Perspective of Eating Disorders

- May be better to conceptualize eating disorders on a continuum instead of categorically

- Example: 1,500 female college students, 4 years
  - Only 1/4 had no eating-related concerns
  - 1/3 consistently attempted to limit or restrict food intake due to poor body image
  - 15% limited food intake and engaged in binging/purging
  - 7% appeared to meet diagnostic criteria for EDx

Co-Occurring Disorders

- High prevalence rates
- Can intensify eating disorders symptoms and impact treatment (recovery, level of care, drop-out)
- Most common comorbidities:
  - Mood disorders
  - Anxiety disorders
  - Substance abuse
- Treatment should address co-existing conditions and eating disorders

Comorbidity of Anorexia

- Anorexia may be associated with other psychological problems:
  - Obsessive-compulsive disorder
  - Generalized Anxiety Disorder
  - Major Depression (over 70%)
  - Substance Abuse (strong predictor of suicide), over 25% have co-occuring

Comorbidity of Bulimia

- Bulimia may be associated with other psychological problems as well:
  - Depression (especially those who self induce vomiting)
    - **50-70% will have co-occurring mood disorder**
  - Anxiety disorders (**over 80%**)
  - Personality disorders (particularly borderline personality disorder)
  - Substance abuse (particularly excessive use of alcohol and/or stimulants) **–Over 1/3 will have co-occurring**
  - Other self-harming behaviors such as cutting
- Approximately 15 percent of cases of bulimia nervosa have a history of anorexia nervosa (APA-DSM)

Age of Onset

- Both anorexia and bulimia nervosa typically begin in adolescence or early adulthood.

- Possibly correlated to hormonal changes, autonomy struggles, developmental issues, and problems with peers/family/relationships

Etiology of Eating Disorders

- The regulation of normal eating and body weight results from a combination of biological, psychological, and social factors

- Researchers have focused on each of these levels of analysis

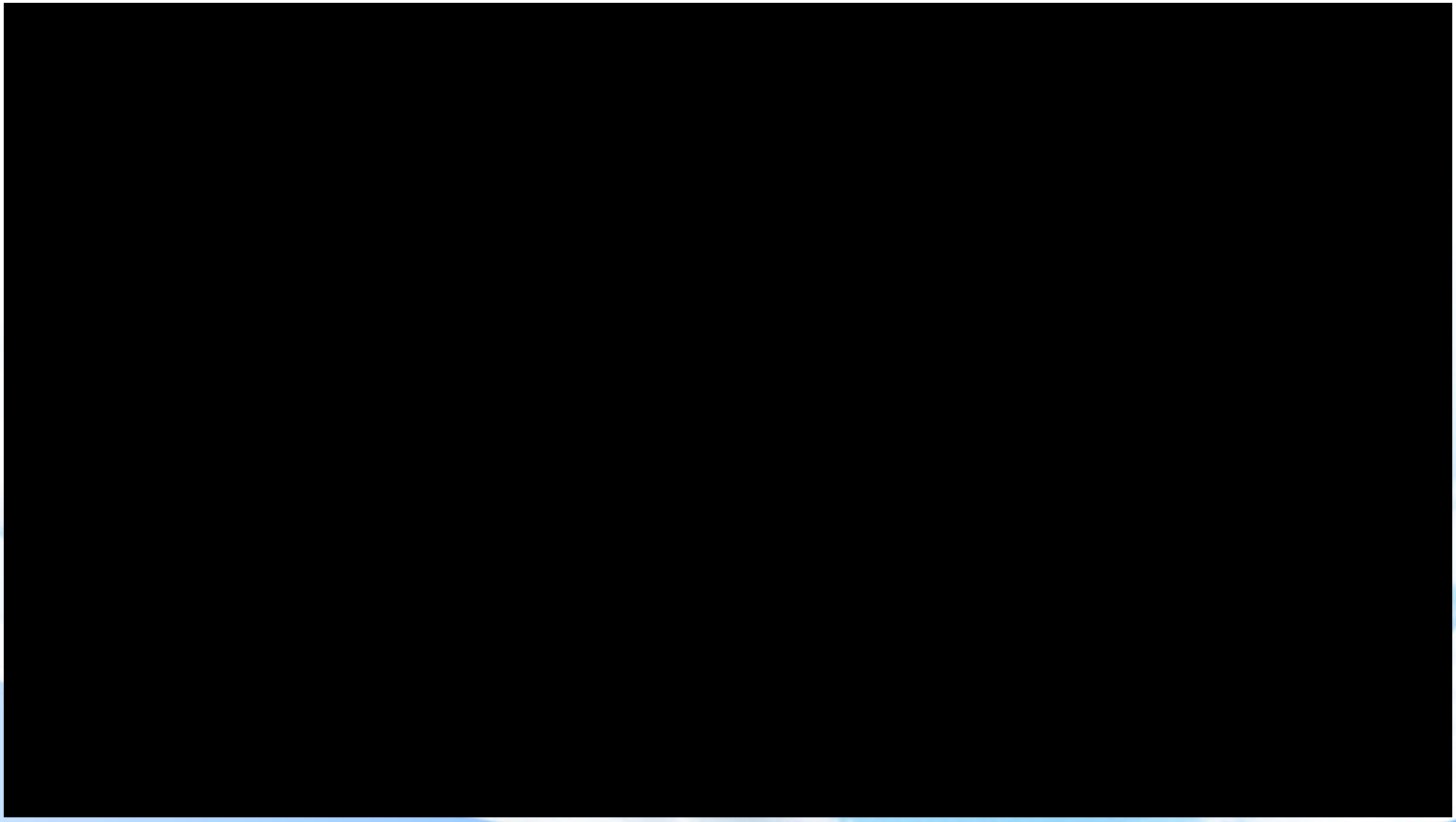
Socio-cultural stressors

- Affluence in industrial countries
- Social standard: thinness = beauty
- Media bombardment: thinness = success
- Media: women as sex objects
- Some sport requirements for thinness: gymnastics, distance running & ballet

Socio-cultural factors

- Garner & colleagues followed a group of 11-14 year old girls in **ballet school**

- Over 25% developed an eating disorder during the two years of the study



Social Factors

- The image of the ideal woman as extremely thin and the overriding value placed on young women's appearances are basic starting points in searching for the causes of eating disorders.
- Some supporting information:
  - More common among middle-and upper-class whites, more likely to equate thinness with beauty in women.
  - Increasing among higher SES African Americans
  - More prevalent in industrialized societies, where thinness is the ideal
  - More prevalent among Arab and Asian women who are in Western countries than living in native country
    - Egyptian women in Cairo Universities vs. London Universities (0 vs. 12%)

Sociocultural Factors

- Prior studies & survey research have revealed that compared to Caucasian teens, African American Adolescent girls have:
  - Less body dissatisfaction
  - Fewer weight concerns
  - More positive self image
  - Perceive themselves to be thinner than they are

Barlow & Durand, 2015; Celio et. al, 2002

Psychological Factors

- Scientists have not yet identified unequivocal psychological contributors to eating disorders

- Here, I am going to highlight 4 of the most promising approaches:
  - 1) control issues, 2) depression, 3) body image dissatisfaction, and 4) reactions to dietary restraint

Psychological Factors: Perfection/ Control

- A struggle for *control* is the central psychological issue in the development of eating disorders

- Researchers often use the term *perfectionism* to describe the endless pursuit of control anorexics have
  - Perfectionists set unrealistically high standards, are self critical, and demand a performance from themselves that is higher than is required by a given situation

Psychological Factors: Depression, Low Self-Esteem

- Depressive symptoms, and not necessarily clinical depression, are central factors in various specific aspects of eating disorders.

- Low self-esteem is a particular concern.

- Negative mood states, commonly trigger episodes of binge eating in bulimia nervosa.
  - The dysphoria may be brought on by social criticism or conflict, dissatisfaction with eating and diet, or an ongoing depressive episode.

Psychological Factors: Negative Body Image

- Negative Body Image- a highly critical evaluation of one's weight and shape
  - distorted body image
  - dissatisfaction with one's body image
- Body sketch outline

Psychological Factors

- One study revealed that women with bulimia judged that there bodies were larger after eating a candy bar and soft drink, whereas judgements by women in the control group were unaffected by eating the snack

Psychological Factors: Dietary Restraint

- Dietary Restraint- restricted eating.
  - Increases hunger
  - Increases frustration
  - Lack of attention to internal cues
- All make binge eating more likely

Psychological Factors: Dietary Restraint

- Why does dieting cause weight gain?
- Study:
  - Rats given junk food (better than boring pellets!)
  - Took away junk food (not pellets)
  - Observation of brain function: compared to NJF rats, they were stressed & anxious
  - JF rats then began to eat tons of pellets, which seemed to relieve their stress

Biological Factors:

– An extensive twin study of bulimia nervosa found a concordance rate of 23 percent for MZ twins and 9 percent for DZ twins.

Serious, Life-Threatening, & Treatable

- Eating disorders are **not fads or phases**, and they have the **highest mortality rate** of any psychiatric disorder.
- Serious effects on health, productivity, and relationships
- Early intervention increases likelihood of a full recovery.

SUICIDE RISK

- Arcelus and colleagues (2011): anorexia nervosa had a much higher premature mortality rate than schizophrenia, depression, bipolar disorder

- One in five of those deaths were due to suicide.

- Recent large-scale study by Zerwas et al. (2015) found that individuals with eating disorders (anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified) had elevated risks for both death by suicide and suicide attempts, as compared to people without eating disorders

- Fichter & Quadflieg, 2016 looked at early death rates in binge eating disorder in addition to the previously mentioned eating disorders and concluded that,

- "*suicide is a major concern not only in anorexia nervosa, but in all eating disorders, calling for intensive attention of all clinicians*."

Suicidality in Eating Disorders

- High rates of completed suicide in patients with AN
- 50-fold increased risk
- 2nd most common cause of death in meta-analysis of 42studies

•Rates of suicide attempts:

-- Approx. 20% of patients with AN

-- 25% to 35% of patients with BN

-- Franko DL, Keel PK. Clinicaly Psychology Review.2006;26:769-782

- One recent study of young girls with anorexia found that 60% of the participants exhibited suicidal behaviors and 49% exhibited self-harm behaviors.
  - Why higher than other reports?
- Comorbid psychopathology, including self-harm and suicidal behavior, is often found in patients with eating disorders (e.g. over 70% had co-occurring depression, 57% co-occurring addiction)

Recent studies have shown that within the eating disorder population:

- people with anorexia have the highest rate of completed suicide and…

- those with bulimia have the greatest number of attempts.

- Attempts by individuals with anorexia tend to be planned, while attempts by individuals with bulimia tend to be more impulsive

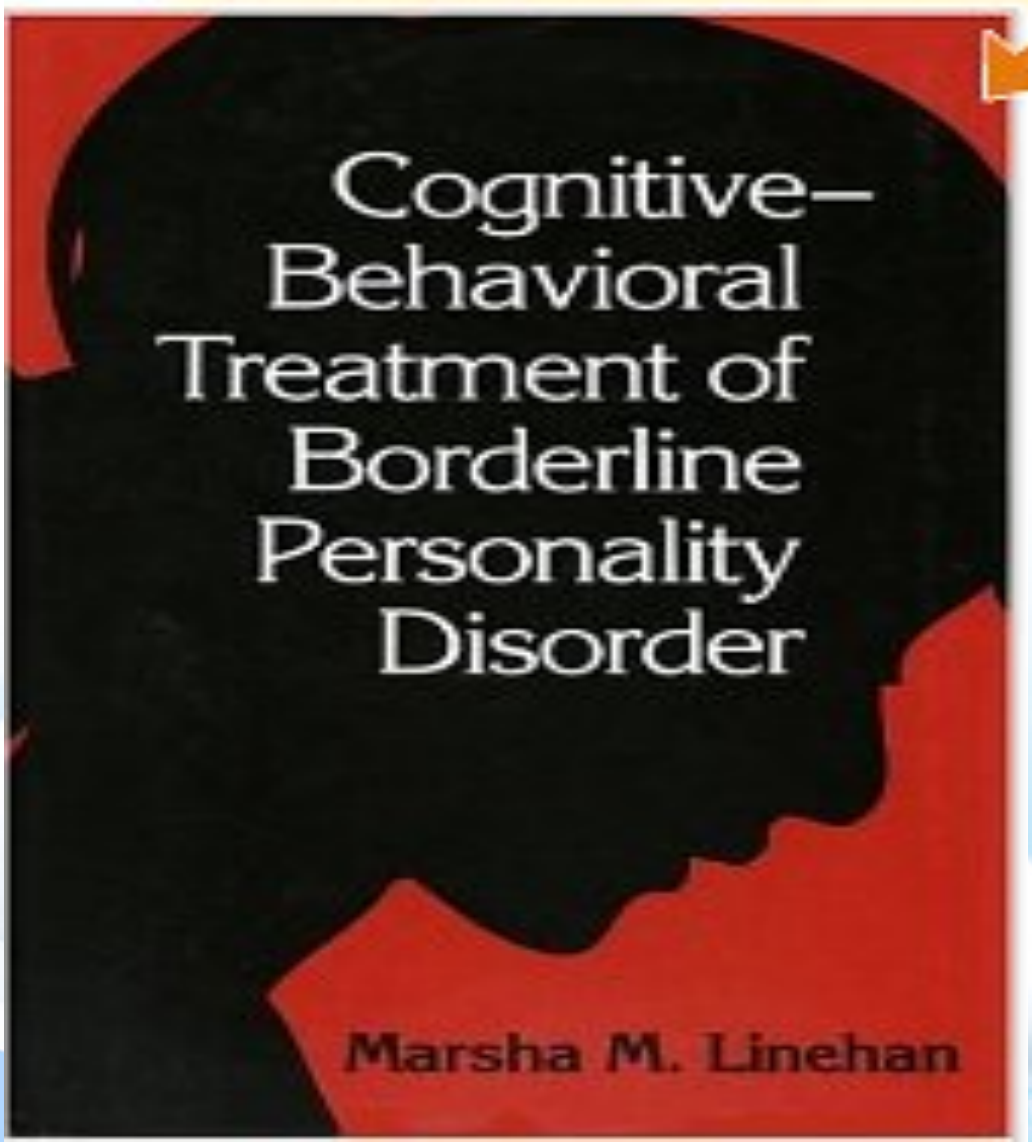
- Rates of substance abuse and cluster B personality disorder psychopathology appear to be higher in BN than in AN

(Bulik et al., 2004; Franko et al., 2005; Franko et al., 2006; Holderness, Brooks-Gunn, & Warren, 1994; Rosenvinge, Martinussen, & Ostensen, 2000)

TREATMENT & PREVENTION

Eating Disorders Treatment

- Effective treatment almost always involves a cognitive behavioral approach, and there are many variants of this


Cognitive–
Behavioral
Treatment of
Borderline
Personality
Disorder
Marsha M. Linehan

- The level of care is best determined through a comprehensive and specialized eating disorder evaluation.

Treatment Basics

- Initial assessment/diagnosis
- Interview providers
- Communicate with all involved
- Develop a multi-layered plan with multiple levels of care and interventions

Indications for Hospitalization 1

Physiologic

- Weight 30% or more below ideal body weight
- Severe metabolic/cardiovascular problems
- Unusual presentation (sxs of delirium etc)

Indications for Hospitalization 2

Psychiatric

- Severe depression or suicide risk
- Acute psychosis
- Uncontrollable binging & purging
- Acute food refusal
- Severe family dysfunction or family crisis

Outcome

- With Treatment, 50%-60% of patients recover
- 20-30% recover partially, i.e., continue to have dysfunctional eating, body image distortion, and impaired social relationships but do well in school/job
- Approximately 20% remain chronically ill
- AN has the highest rate of mortality of any psychiatric disorder*

O'Hara & Smith. (2007). Patient Education and Counseling.
Franko & Keel. (2006) Clinical Psychology Review.

Treatment: Anorexia Nervosa

- At present, drug treatments have **not** been found to be very effective in the treatment of anorexia nervosa

(Barlow & Durand, 2015; Crow et al, 2009; Walsh et. al 2006; Wilson & Fairburn, 2007)

Levels of Care

- Inpatient
- Residential
- Partial hospitalization
- Intensive outpatient
- Outpatient

Treatments for Anorexia Nervosa

- Hospitalization and refeeding
  - Hospitalize the patient and force him or her to ingest food to prevent death from starvation.
- Behavior therapy
  - Make rewards contingent upon eating. Teach relaxation techniques.
- CBT Techniques to help the patient accept and value his or her emotions.
  - Use cognitive or supportive-expressive techniques to help the patient explore the emotions and issues underlying behavior.
  - Raise the family's concern about anorexia behavior. If present, work with the family's tendency to be overcontrolling and to have excessive expectations.

Therapy vs. Nutritional Counseling

- Without attention to patient's underlying dysfunctional attitudes about body shape and image, as well as interpersonal disruptions in her life, relapse is very high

- CBT after weight restoration: 22% relapse at one year

- Nutritional Counseling after weight restoration: 73% relapse at one year

Barlow & Durand, 2015

Adolescents and AN Tx

- Family Therapy vs. Individual Therapy with adolescents:
  - 50% of Family Therapy patients in remission 1 year later
  - 23% of Individual Therapy patients in remission 1 year later

Treatments for Bulimia Nervosa

Cognitive-behavioral therapy	Teach the client to recognize the cognitions around eating and to confront the maladaptive cognitions. Introduce “forbidden foods” and regular diet and help the client confront irrational cognitions about these.
Interpersonal therapy	Help the client identify interpersonal problems associated with bulimic behaviors, such as problems in a marriage, and deal with these problems more effectively.
Tricyclic antidepressant and selective serotonin reuptake inhibitors	Help to reduce impulsive eating and negative emotions that drive bulimic behaviors.

- “Cognitive Behavioral Therapy remains the preferred treatment for Bulimia, and is superior to medication alone”

CBT for Bulima

- Results from a major randomized clinical trial:
- Compared 20 weeks of CBT to 2 years of psychoanalytic therapy
- Both treatments resulted in improvements, but:
  - At 5 months 42% of CBT patients recovered compared to 6% of Psychoanalytic therapy
  - After **2 years**, it was 44% and 15% respectively

https://www.ncbi.nlm.nih.gov/pubmed/24275909

Poulsen et al, 2014

BED-treatment

- Recent study compared SSRI (Prozac) to therapy in Tx of BED:

- Prozac was ineffective compared to placebo
- Prozac did not enhance effects of therapy
- Therapy was effective, including 1 year later

Key aspect of therapy….

- Therapy must address the patient's underlying dysfunctional attitudes about body shape, as well as disruptions in interpersonal life

- Ex. Nutritional Counseling vs. Psychotherapy

- Longitudinal Research: Anorexia
  - 20% die as a result of their disorder
    - 5% within 10 years

- A review of nearly fifty years of research confirms that anorexia nervosa has the highest mortality rate of any psychiatric disorder

(Arcelus, et al., (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*

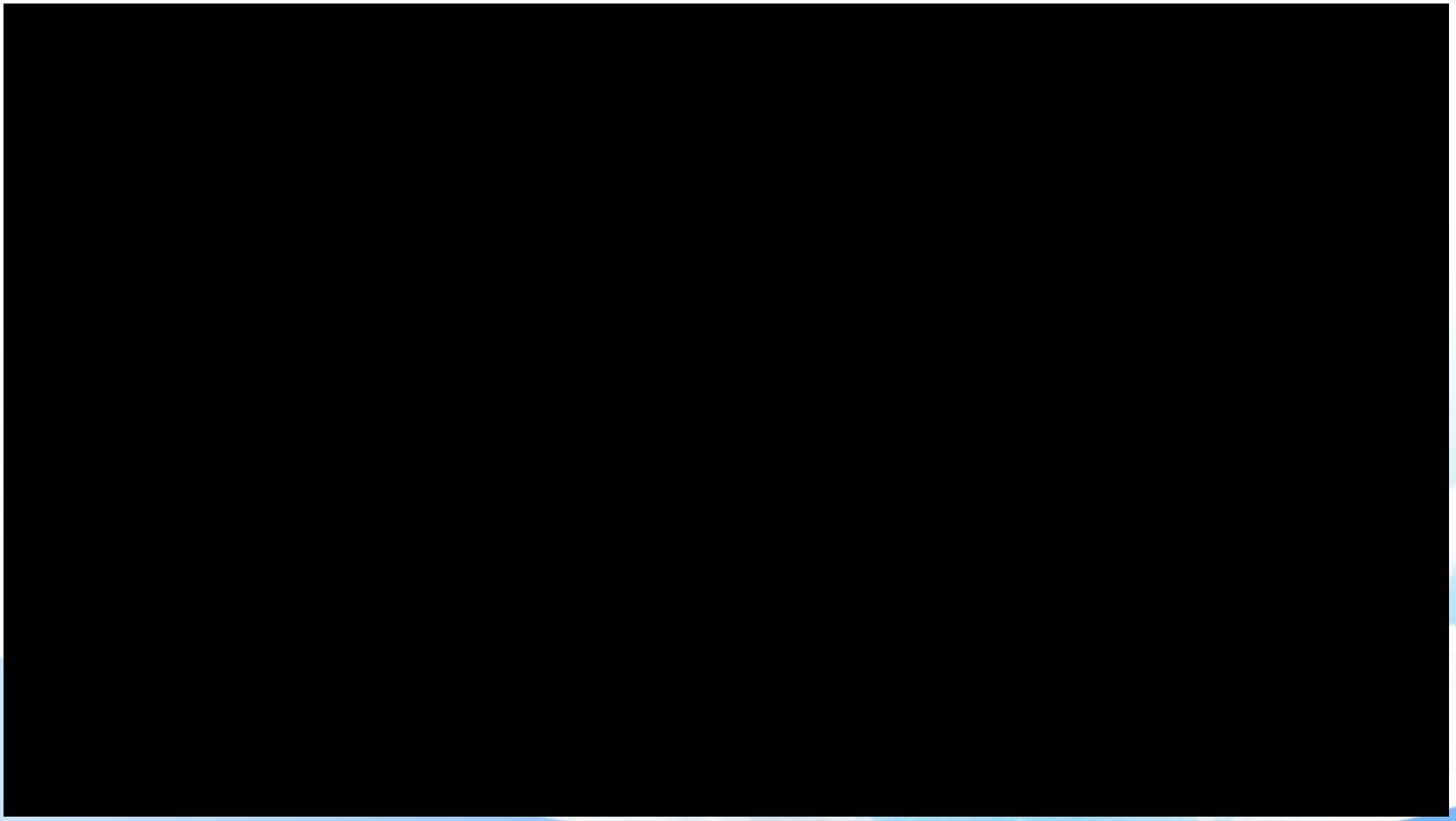
Anna westin act of 2015

•Kitty and Mark Westin knew their daughter's anorexia returned during her sophomore year of college. Anna's doctor recommended immediate hospitalization due to her 34 percent body weight loss, but the insurance company told them to take her home, saying treatment wasn't medically necessary.

- The Anna Westin Act of 2015 is written to help those affected by eating disorders get the care they need by focusing on improved training and clarity of mental health parity

- **Clarity of Mental Health Parity**: The Anna Westin Act of 2015 aims to provide better health insurance treatment coverage for those affected by eating disorders.

- The legislation clarifies the intent of former Congressman Jim Ramstad (R-MN) and former Congressman Patrick Kennedy (D-RI) to include residential treatment services in the Mental Health Parity and Addiction Equity Act of 2008 (the Parity Law), which required insurance providers to cover people with mental illness equally as those with other health issues



President recently signed into law!

How to Help your Loved One

DO:

•**Learn** as much as you can about eating disorders

•**Be honest** and vocal about your concerns

•**Be caring and firm**
•**Offer help** from a physician an/or therapist

•**Be a good role model**, practice what you preach

DON'T:

- **Place shame, blame, or guilt**
- **Make rules or promises** that you cannot or will not uphold
- **Give simple solutions**
- **Invalidate** their experience or try to **convince**
- **Give advice** about weight, exercise, or appearance
- **Ignore or avoid** the situation until it is severe or life-threatening

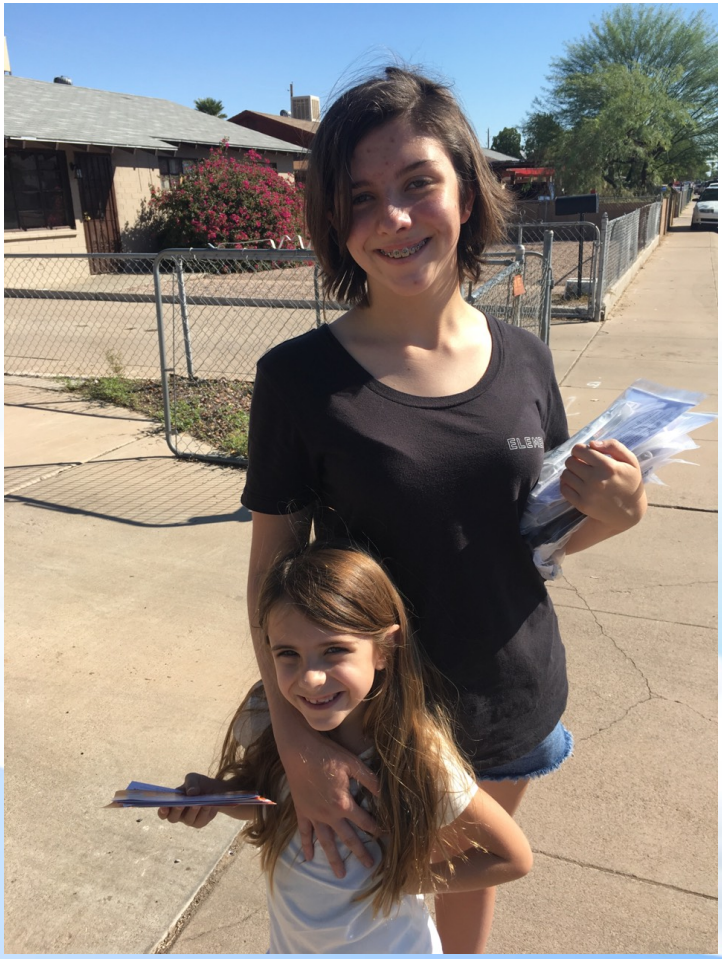
Talking about Eating Disorders

KEEP IN MIND:

- Don’t provide tips or play the numbers game.
- Emphasize the seriousness of eating disorders without portraying them as hopeless.
- Watch out for the appearance ideal.
- Don't focus on images or descriptions of the body at its unhealthiest point.

For further info:

- www.NationalEatingDisorders.org
  - Helpline: 800-931-2237
  - Business Line: 212-575-6200
- National Suicide Prevention Lifeline
  - 1-800-273-TALK (8255)



- https://www.youtube.com/watch?v=u5o582N3wOQ