

ALSANA

An Eating Recovery Community



Psychiatrist's Role in Eating Disorder Treatment

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Objectives

- What makes a Psychiatrist
- Roles of the Psychiatrist
- Overview of Eating Disorders
- Overview of co-morbidities within Eating Disorders
- Psychiatric treatment for Eating Disorders



"When someone is going through a storm, your silent presence is more powerful than a million, empty words."





Making of a Psychiatrist and the Role

Where do we start?



- Psychiatrist
 - MD, DO
- Psychiatric NP or PA
- Psychologist
 - PhD, PsyD.
- Therapist
 - LPC
 - LCSW, MSW
 - LMFT
- Registered Dietitian
 - RD
 - Nutritionist

Psychiatrists' Training and Experience



- Complete 4 years of undergraduate work at university.
- Complete 4 years of medical school to earn MD/DO.
- Complete 4 years of specialty psychiatric residency training
 - >13,000 hours of training
- Fellowships
 - Child/Adolescent Psychiatry
 - Addiction
 - Geriatric
 - Consultation/Liaison
 - Forensics

Psychiatrist's role in treating patients with eating disorders



- Alsana's psychiatric program is carefully architected to meet the unique psychiatric needs of patients with eating disorders.
- Build brain optimization and health resilience to provide a physical and neurological foundation for recovery.
- At Alsana, our psychiatrists are an integral part of the treatment team, working in conjunction with therapists, dietitians, nurses, and direct care staff to provide adaptive and transformative treatment.
- Evidenced based treatment

Psychiatrist's role in treating patients with eating disorders



- Psychiatrist will see patient within 24-48 hours of admission.
- Once every 7 days for follow-up while in residential and PHP.
- On-call 24/7 to respond to medical and psychiatric needs of the patient.
- In constant communication with the clinical team and leadership.
- Attends weekly treatment team meeting.

Psychiatrist's role in treating patients with eating disorders

- Biopsychosocial model
 - Biological
 - Psychological
 - Social
 - “Genetics load the gun and environment pulls the trigger.”
- Psychiatrists are uniquely qualified to treat patients with eating disorders.
 - Medical – medications, cardiovascular, GI, neurological systems.
 - Psychological – therapist
 - Nutrition/medications - RD



Types of Eating Disorders

- Diagnostic and Statistical Manual of Mental Disorders – dysfunction matters.
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant Restrictive Food Intake Disorder (ARFID)
- Other Specified Feeding and Eating Disorder (OSFED)
- Pica
- Rumination Disorder

- Anorexia Nervosa

- Restriction of energy intake leading to a significantly low body weight.
- Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though low weight.
- 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.

- Anorexia Nervosa
- Specifier
 - Restricting Type – During the last 3 months, weight loss is due to dieting, fasting, and/or excessive exercise.
 - Binge/purge type – During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviors (e.g. self-induced vomiting, laxatives, diet pills, diuretics, enemas, etc).

Eating Disorders

- Anorexia Nervosa
- Severity
 - Mild: BMI ≥ 17 kg/m²
 - Moderate: BMI 16 – 16.99 kg/m²
 - Severe: BMI 15 – 15.99 kg/m²
 - Extreme: <15 kg/m²

Atypical Anorexia Nervosa



- Found under Other Specified Feeding and Eating Disorders (OSFED).
- Inherent size bias to the use of the word “atypical.”
- All of the criteria are met for AN, except that despite significant weight loss, the individual’s weight is still within or above normal weight range.

Bulimia Nervosa



- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - Eating, in a discrete period of time (2hr period) an amount of food that is definitely larger than what most individuals would eat in similar time and circumstance.
 - A sense of lack of control over eating during the episode – cannot stop, or control how much one is eating.
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain.
- The binge eating and inappropriate compensatory behaviors both occur, on average, 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 episodes of AN.

Bulimia Nervosa



- Specifiers
 - **Mild**
 - An average of 1-3 episodes of inappropriate compensatory behaviors per week.
 - **Moderate**
 - An average of 4-7 episodes of inappropriate compensatory behaviors per week.
 - **Severe**
 - An average of 8-13 episodes of inappropriate compensatory behaviors per week.
 - **Extreme**
 - An average of 14 or more episodes of inappropriate compensatory behaviors per week.

Binge Eating Disorder



- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - Eating, in a discrete period of time (2hr period) an amount of food that is definitely larger than what most individuals would eat in similar time and circumstance.
 - A sense of lack of control over eating during the episode – cannot stop, or control 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 feeling 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.

Binge Eating Disorder



- Marked distress regarding binge eating is present.
- 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 and the binge eating does not occur during the course of AN or BN.

Binge Eating Disorder



- Specifiers
 - Mild
 - 1-3 binge-eating episodes per week.
 - Moderate
 - 4-7 binge-eating episodes per week.
 - Severe
 - 8-13 binge-eating episodes per week.
 - Extreme
 - 14 or more binge-eating episodes per week.

Avoidant/Restrictive Food Intake Disorder (ARFID)



- An eating or feeding disturbance:
 - Apparent lack of interest in eating or food
 - Avoidance based on sensory characteristics of food
 - Concern about aversive consequences to eating, -significant weight loss or failure to achieve expected weight gain or faltering growth in children.
- 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.

Avoidant/Restrictive Food Intake Disorder



- 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 AN or BN, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition of the disorder and warrants additional clinical attention.

Other Specified Feeding and Eating Disorder (OSFED)

- Criteria that doesn't fit into any one category.
 - Just as serious.
 - High percentage.
-



Eating Disorder Co-Morbidities

Lifetime Co-morbidity of Eating Disorders with Other Core Disorders
Among U.S. Adults Data from National Comorbidity Survey Replication
(NCS-R)

	Anorexia Nervosa (%)	Bulimia Nervosa (%)	Binge-Eating Disorder (%)
Any Anxiety Disorder	47.9	80.6	65.1
Any Mood Disorder	42.1	70.7	46.4
Any Impulse Control Disorder	30.8	63.8	43.3
Any Substance Use Disorder	27.0	36.8	23.3
Any Disorder	56.2	94.5	78

- When dealing with EDs, comorbidity is effectively “the rule rather than the exception,” particularly among those with bulimic features.

Psychiatric comorbidity in women and men with eating disorders results from a large clinical database



- Sample data from 7156 patients over 18 years of age were analyzed in this study, 97% women and 3% men.
- 70% of patient have at least one psychiatric disorder.
- The most common type of diagnosis in both male and female patients was anxiety disorders, where generalized anxiety disorder was the most common.
- About two-fifths met the criteria for any mood disorder, and major depression was the most common.
- Substance use disorder was found in about a tenth of the patients.

Prevalence of Comorbidities in Patients Hospitalized for EDs



- A study of more than 2400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, including:
 - 94% had co-occurring mood disorders, mostly major depression
 - 56% were diagnosed with anxiety disorders
 - 20% had obsessive-compulsive disorder
 - 22% had post-traumatic stress disorder
 - 22% had an alcohol or substance use disorder
- In women hospitalized for an eating disorder, 36.8% regularly self-harmed

Comorbidity with Anxiety Disorders



- 48-51% of people with anorexia nervosa,
- 54-81% of people with bulimia nervosa, and
- 55-65% of people with binge eating disorder are also diagnosed with anxiety disorder.
- Two-thirds of people with anorexia nervosa showed signs of an anxiety disorder several years before the start of their eating disorder.
- OCD is more commonly diagnosed in Anorexia Nervosa
 - Significantly higher prevalence rate for OCD among women with anorexia nervosa (16.2%) compared to women with bulimia nervosa (3.5%), and community controls (2%)

Comorbidity with PTSD

- Approximately one in four people with an eating disorder has symptoms of post-traumatic stress disorder (PTSD).
- PTSD occurs in about half of eating disorder patients in higher levels of care.
- Evidence shows that the eating disorder and PTSD should be treated concurrently.

Comorbidity with Mood Disorders

- 32-39% of people with anorexia nervosa,
- 36-50% of people with bulimia nervosa, and
- 33% of people with binge eating disorder are also diagnosed with major depressive disorder.
- Twenty-seven percent of patients with bipolar disorder diagnosis had a current DSM-5 eating disorder:
 - 12% had BED
 - 15% had BN
 - 0.2% had AN

Suicide and Eating Disorders

- Rates of suicide attempts range from
 - 3.0% to 29.7% in patients with anorexia nervosa
 - 10% to 40% in those with bulimia nervosa
 - 12.5% of individuals with binge eating disorder who presented for outpatient treatment had a lifetime history of attempted suicide
- Completed suicide in persons with anorexia nervosa have been reported to be up to 5.2 to 30 times higher than those of the general population.

Common Comorbid Substance Use Disorders

- Alcohol Use Disorder
- Cannabis Use Disorder
- Stimulant (*Amphetamine-type or cocaine*) Use Disorder
- Sedative, Hypnotic or Anxiolytic (*benzodiazepines*) Use Disorder
- Other Substance (*Laxative*) Use Disorder
- Tobacco Use Disorder
- Withdrawal from alcohol and benzodiazepines can be dangerous (*seizures, encephalopathy, delirium tremens, death*)

Eating disorders and Personality Disorders

- Among those with **anorexia nervosa**:
 - Restricting type: 20% had obsessive-compulsive personality disorder, 10% had borderline personality disorder
 - Binge-purge type: 12% had obsessive-compulsive personality disorder, 25% had borderline personality disorder
- Among those with **bulimia nervosa**:
 - 11% had obsessive-compulsive personality disorder, 28% had borderline personality disorder
- 38% of people with EDNOS/**OSFED** were found to have personality disorders
 - 11% had obsessive-compulsive personality disorder
 - 12% had borderline personality disorder
- 30% of people with **binge eating disorder** were found to have personality disorders
 - 10% had obsessive-compulsive personality disorder
 - 10% had borderline personality disorder



APPROACH TO PSYCHIATRIC MEDICATIONS

What is a Neurotransmitter?

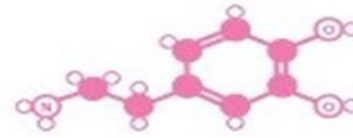
- Chemical substances acting as signaling molecules that enable the transfer of neuro signals throughout brain.

ADRENALINE

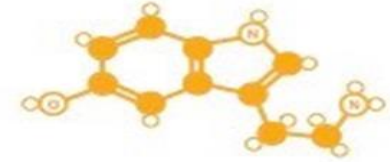
Fight or flight
neurotransmitter

NORADRENALINE

Concentration
neurotransmitter

DOPAMINE

Pleasure
neurotransmitter

SEROTONIN

Mood
neurotransmitter

GABA

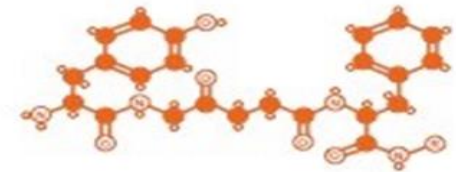
Calming
neurotransmitter

ACETYLCHOLINE

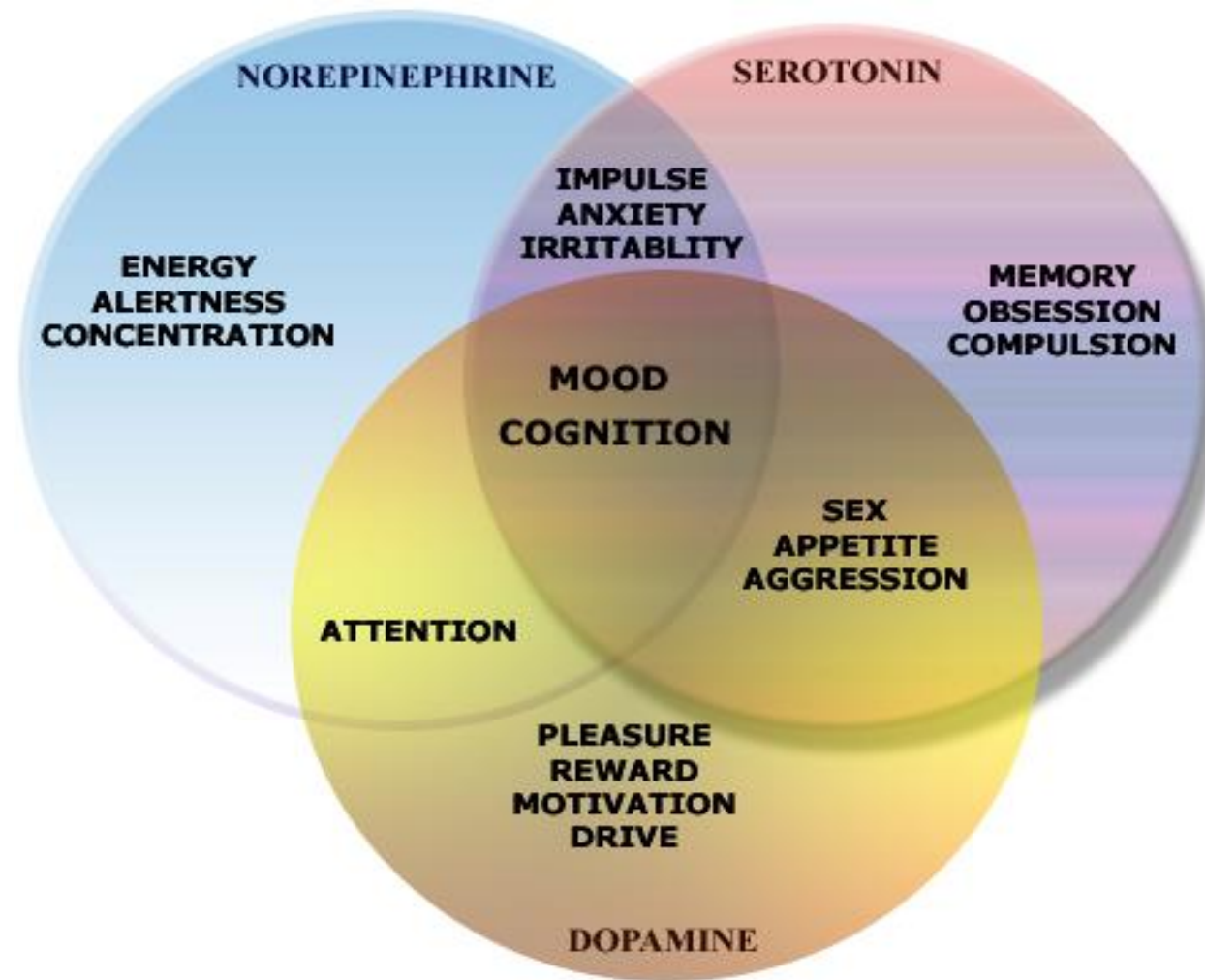
Learning
neurotransmitter

GLUTAMATE

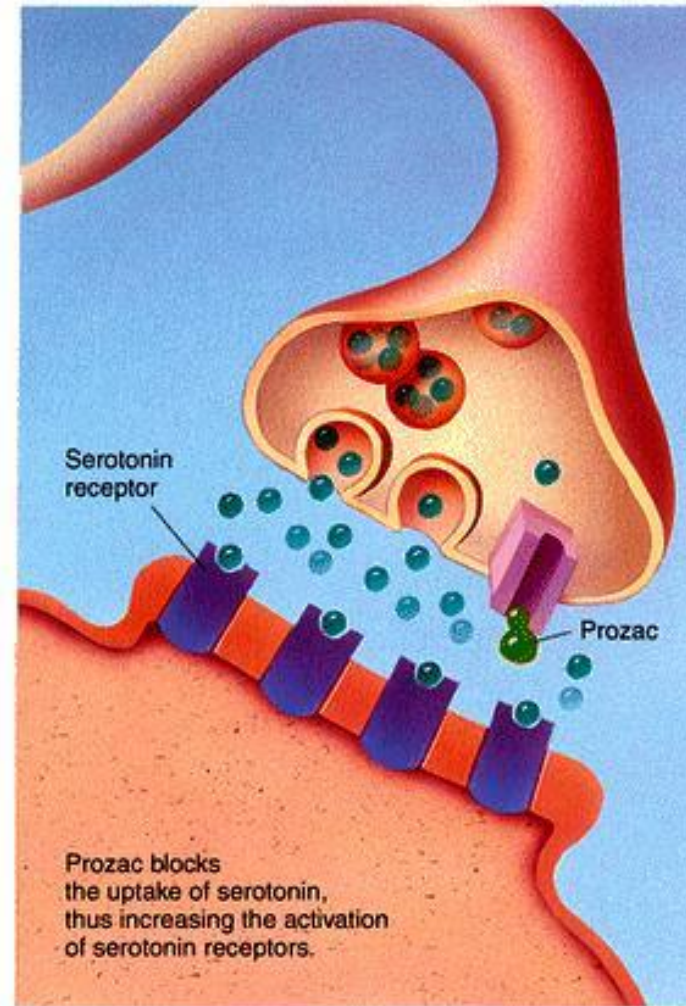
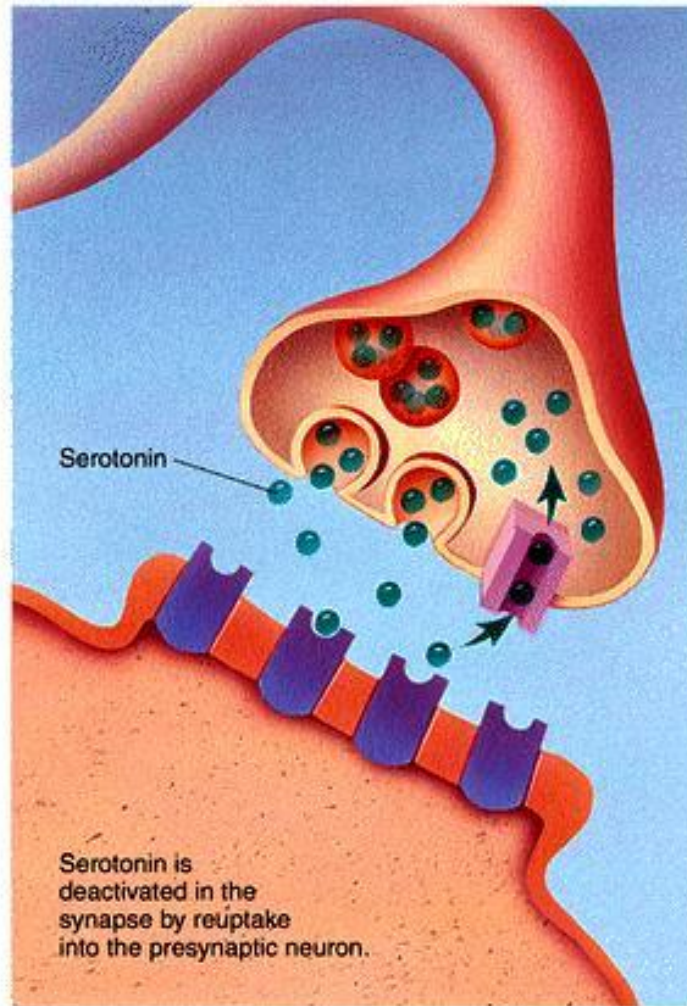
Memory
neurotransmitter

ENDORPHINS

Euphoria
neurotransmitter



► **Blockade of Serotonin Reuptake by Fluoxetine**



Psychiatric Medications

MEDICATION MYTHS:

- Google, WebMD
- “It will change who I am...I will be a zombie”
- “Uncle Mike took it and that is when he really became crazy...”
- “Once I take the medication and stop it, the depression will be worse because I will have withdrawal”
- “My daughter is really smart and determined and can do it on her own.”
- “I am strong enough to do this on my own.”
- “I don’t want to use it as a crutch.”

Psychiatric Medications

FACTS:

- Address their concerns.
- Psychotropic medications typically work on one of the 3 Neurotransmitter systems that helps to regulate mood
 - Dopamine
 - Norepinephrine
 - Serotonin
 -Glutamate....
- Psychiatric disorders and to a large degree, response to medications, are often genetic.
 - Family history is important.
 - Can consider genetic testing
- Psychotropic medications are meant to correct the imbalance that that has occurred in your neurotransmitter system and should not in any way “change your personality” or “make you not feel like yourself.”

Psychiatric Medications

- Two medications with FDA indication for treating eating disorders:
- Fluoxetine (Prozac) – Bulimia Nervosa
- Lisdexamfetamine dimesilate (Vyvanse) – Binge Eating Disorder
- **Bupropion (Wellbutrin) is contraindicated in anorexia nervosa and bulimia nervosa due to increasing risk of seizures**

Psychiatric Medications

- Taking medication is a choice.
 - Clinicians can provide the facts and clinical expertise
 - Choosing to take medication is up to the patient.
- Psychotropic medications are often used off label, and most do not have FDA indication in children or geriatric populations but are safely being used.
- Psychotropic medications are used off label when:
 - Studies or case reports show benefits
 - When benefits outweigh risks

Considerations in Choosing Psychotropic Medications



- High prevalence of impulsivity - avoid drugs that can be lethal in overdose or can cause severe drug interactions when combined with recreational drugs, laxatives, diuretics, appetite suppressants
 - Monitor EKG regularly if choosing drugs that can cause QTc prolongation (ex citalopram, tricyclics, atypical antipsychotics)
 - Prolonged QTc may result in fatal arrhythmia in the context of hypokalemia induced by vomiting or laxative abuse
 - Avoid drug-drug interactions and polypharmacy
 - Liver or kidney disease may slow metabolism of medications
 - Monitor labs, including lipid panel
-

Psychiatric Medications

- Once you start a medication, it is recommended to continue that medication for 9 months to 1 year.
- Inpatient, Residential or Day treatment is good time to try medication
 - 24/7 access to psychiatrist, nursing
 - Monitor for side effects, ex. “ suicidal thinking or behavior”
 - If not now, when?
- Will I need the medication again?
 - Statistics in Depression
 - 50% recurrence rate after the first depressive episode
 - 70% second
 - 90% third

Psychiatric Medication Classes

- **Antidepressants** – to be taken every day
- **Mood Stabilizers** – to be taken every day
- **Antipsychotics** – can be as needed or taken every day
- **Anxiolytics** – can be as needed or taken every day
- **Stimulants** – can be as needed or taken every day
- **Insomnia medications** – can be as needed or taken every day

- Educate patients that no psychiatric medications are proven to be safe in pregnancy (they are to be used if benefits outweigh risks, consult with reproductive psychiatrist)

Medications to Treat Eating Disorders

- Anorexia Nervosa—no approved medication, NUTRITION is the best treatment
 - SSRIs/SNRIs – decrease anxiety, OCD, depression
 - Antipsychotic medications: data supporting Aripiprazole (Abilify) and Olanzapine (Zyprexa) to target ED ruminating thoughts and distortions
- Bulimia Nervosa— Fluoxetine (Prozac) FDA approved, SSRIs reduce bingeing and purging
- Binge Eating Disorder— Lisdexamfetamine dimesylate (Vyvanse) is FDA approved for moderate and severe BED.
- Consider medications to treat co-occurring and/or underlying disorders driving the eating disorder such as depression, anxiety, PTSD, ADHD, insomnia

Medication Impact on Appetite

- Medications may cause **increased appetite** and/or weight gain
 - May affect compliance
 - Can intensify vicious cycle of restriction, bingeing and purging
 - Antipsychotics (olanzapine -Zyprexa, quetiapine - Seroquel, aripiprazole – Abilify)
 - Mood stabilizers (Depakote, Lithium)
 - TCA Antidepressants (amitriptyline, nortriptyline), SSRI – paroxetine, mirtazapine
 - Consider stopping these medications before diagnosing BED
- Medications may cause **appetite suppression** or weight loss
 - Stimulants (Vyvanse, Adderall, Ritalin)
 - Topiramate (Topamax)
 - Bupropion (Wellbutrin) (contraindicated in AN, BN)

Antidepressants

- **Uses:** Depression/dysthymia, anxiety, OCD, PTSD, eating disorders
- **Mechanisms (general):** increase levels of neurotransmitters/ receptors in brain, 4+ weeks
- **Classes:**
 - SSRIs—Selective Serotonin Reuptake Inhibitors
 - NaSSA - noradrenergic and specific serotonergic antidepressant
 - SNRIs—Serotonin and Norepinephrine Reuptake Inhibitors
 - DNRI – Dopamine and Norepinephrine Reuptake Inhibitors
 - TCAs – tricyclic antidepressants
 - MAOIs – monoamine oxidase inhibitors
- Mood stabilizers are not antidepressants.

Treating Anxiety

- First-line treatment for anxiety is **therapy** +/- medication
- Add SSRI for anxiety if indicated – SSRIs are indicated for GAD, social phobia, PTSD and OCD
- SSRIs: fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), escitalopram (Lexapro), fluvoxamine (Luvox)
- NaSSA: noradrenergic and specific serotonergic antidepressant: mirtazapine (Remeron) – indicated for GAD
- SNRIs: venlafaxine (Effexor), desvenlafaxine (Pristiq), duloxetine (Cymbalta)

Treating Mood Disorders

- Unipolar depression, dysthymia
 - SSRI, SNRI, DNRI, TCA, MAOI, ketamine, light therapy
 - Neuromodulation – rTMS (repetitive transcranial magnetic resonance), ECT (electroconvulsive therapy) , DBS (deep brain stimulation), VNS (vagus nerve stimulation)
- Bipolar disorder
 - Mood stabilizers – lithium, anticonvulsants (valproic acid, lamotrigine, carbamazepine)
 - Atypical antipsychotics – quetiapine, olanzapine, risperidone, ziprasidone, lurasidone, cariprazine
 - Bipolar depression – lithium, quetiapine, lurasidone, olanzapine-fluoxetine combo, cariprazine, may need to be aware of manic switch if using SSRI

Treating PTSD

- Effective psychotherapies:
 - Prolonged Exposure
 - Somatic experiencing
 - Cognitive Processing Therapy (CPT)
 - EMDR (Eye Movement Desensitization and Reprocessing)
 - Cognitive Behavioral Therapy (CBT)
- Antidepressants for PTSD: sertraline (Zoloft), paroxetine (Paxil), venlafaxine (Effexor)
- Other medications:
 - prazosin 1-10 mg for trauma related nightmares, insomnia, arousal; can drop blood pressure.
 - propranolol 10-20mg daily-tid for physical symptoms related to trauma; can drop heart rate.

Treating Insomnia

- First: sleep hygiene education – CBT-i!!
- Valerian Root (450–900 mg)
- Melatonin (3-10 mg)
- Calm powder (magnesium)
- PRN = As Needed
- Diphenhydramine (Benadryl) / Hydroxyzine 25-50 mg
- Trazodone 25-200 mg
- Doxepin 3-6mg
- Quetiapine (Seroquel) 12.5-300 mg, antipsychotic, may cause weight gain
- Mirtazapine (Remeron) antidepressant, may cause weight gain
- Avoid “Z drugs” zolpidem (Ambien) and benzodiazepines since habit forming

Conclusions

- Eating disorders are complex and involve:
 - Genetics
 - Personality and temperament traits
 - Dysregulation of neurotransmitters
 - Dysregulation of appetite neurobiology
 - Medical complications
- Consider these factors, in addition to current behaviors, when conceptualizing cases
- Understanding of neurobiology and co-morbidities informs medication management
- Consider referral to a psychiatrist who has expertise in the treatment of patients with eating disorders when your patient is not making progress, or has comorbid psychiatric conditions

- Questions?
 - Discussion
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