Flashtalk Spotlight: Eating Disorders - From ARFID to "Diabulimia"

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Introductions

Erin Hurst, MS, RDN, LD

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Objectives

1. Identify signs and symptoms of at least five (5) types of eating disorders.
2. Detail role of RD in eating disorder care.
3. List integral members of eating disorder treatment teams and when to refer out.

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Disclosures

Erin - no disclosures
Victoria- no disclosures
Emily- no disclosures

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Eating Disorders 101

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Eating Disorders Stats

- Incidence: 29M Americans (source)
- Mortality rate: 2nd highest after opioid addiction (source)
- 6% of cases represent the stereotype (source)

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Anatomy of Eating Disorders

Demographics

- BIPOC people half as likely to get diagnosed
- LGBTQ+ youth 3 times more likely to have ED
- Transgender college students 4 times more likely to get ED diagnosis and 32% reported using ED to modify their body
- Co-morbid conditions occur in 70% ED cases
  - Mood disorders most prevalent
  - TIDM associated with severe medical complications
  - Neurodivergence, especially ARFID, ADHD, and autism spectrum may overlap in upwards of 58% of cases
- Larger bodies less likely to be diagnosed and/or receive treatment for same behaviors than thin peers

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ED Diagnosis

DSM-5

- Anorexia nervosa
  - Restricting
  - Binge-eating/purging
- Bulimia nervosa
- Binge Eating Disorder
- OSFED
- PICA
- Rumination syndrome

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Warning Signs

Physical or Clinical Observations

- Amenorrhea
- Arrhythmia and/or bradycardia
- Brittle hair/nails
- Dental enamel erosions/gum disease
- Edema
- GI distress
- Hyperkeratosis
- Hypotension
- Hypothermia/thermodysregulation
- Lanugo
- Osteoporosis at young age
- Parotid gland enlargement
- Scars/calluses on fingers/hands
- Weight loss and/or fluctuations

Assessment

EAT-26

SCOFF

- How much of your day do you spend thinking about food or your body?
- How much of that time are you stressed about your food or body?
- Do you eat differently when you are around other people than you do when you are alone or around your safe people?
- Are there foods you used to eat but don't or can't eat anymore?

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"Diabulimia"

How to Identify, Intervene and Refer

Emily Welles, MS, RDN, CDCES

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Diabulimia Defined

DIA + BULIMIA

Type 1 Diabetes

Disordered compensatory behavior

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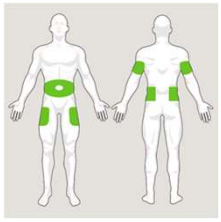
Diabulimia Stats



- Women with type 1 diabetes are 2.4 times more likely to be diagnosed with an eating disorder
- 30-35% of women and 11-17% of men omit or restrict insulin to lose weight
- Diabetes treatment emphasizes nutrition information and increased awareness of food intake. In addition, injections/ pump sites may trigger negative body image

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Emotional Warning Signs

- Increasing neglect of diabetes management
- Secrecy about diabetes management
- Fear of low blood sugars
- Fear that "insulin makes me fat"
- Extreme increase or decrease in diet
- Extreme anxiety about body image
- Restricting certain food or food groups to lower insulin dosages
- Preoccupation with food, weight and/or calories

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Physical Warning Signs

- Increase in Hemoglobin A1c
- Inconsistency with A1c and blood sugar readings
- Erratic blood sugars
- Extreme exhaustion, thirst, urination
- Increased hospitalizations for DKA
- Unexplained weight loss
- Constant bouts of nausea and/or vomiting

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Intervention- Questions to Ask

- How do you feel about your body and health?
- How much of your day do you think about your weight, body shape or food intake?
- Do you ever feel guilty after eating? How often?
- How do you feel about insulin?
- Is it hard to give your insulin sometimes? If so, why?
- Do you ever miss insulin injections? How often?
- How do you feel about having diabetes?

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Interventions

- From the responses you can assess what technique may be helpful
- Some include:
  - sharing facts
  - personal testimonials
  - role playing future self
  - self reflection (goals, values, activities)
  - making a plan
  - finding support
  - environment management

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Person Centered Language

Diabetic *(as a noun)* *"Are you a diabetic?"*	Person living with diabetes Person with diabetes Person who has diabetes *"Do you have diabetes?"*	• Person-first language puts the person first. • Avoid labeling someone as a disease. There is much more to a person than diabetes.
Control *(as a noun)* glycemic control; glucose control; poor control; good control; bad control; tight control	A1C Blood glucose levels/targets Glycemic target/goal Glycemic stability/variability	• Focus on neutral words and physiology/biology. • Define what **"good control"** means in factual terms and use that instead.
Compliant/compliance/ non-compliant/ non-compliance Adherent/non-adherent/ adherence/non-adherence	Engagement Participation Involvement Medication taking *"She takes insulin whenever she can afford it."*	• Compliance and adherence imply doing what someone else wants, i.e., taking orders about personal care as if a child. In diabetes care and education, people make choices and perform self-care/self-management. • Focus on people's strengths – what are they doing or doing well and how can we build on that? • Focus on facts rather than judgments.

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Referral Techniques

- Referrals may include a therapist, RD, diabetes educator or endocrinologist
- "I would love to continue to support you but I think we should add someone to your team with an expertise in diabetes/ eating disorders/ therapy."
- You may have patients who are resistant to referral. Highlight the medical necessity (if needed) and continue to hold true to boundaries.
- "I am not an expert in that area. If you'd like, I could get you connected to someone who is".

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References- Books

- Eating to Lose: Healing From a Life of Diabulimia by Maryjeanne Hunt
- DIABULIMIA: Diabetes + Eating Disorders; What It Is and How to Treat It by Grace Huifeng Shih RD MS
- Diabulimia: Towards Understanding, Recognition, and Healing by Aarti Esther Sharma
- Prevention and Recovery from Eating Disorders in Type 1 Diabetes- Injecting Hope By Ann Goebel-Fabbri

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References- Websites

- www.wearediabetes.org
- www.diabulimiahelpline.org
- www.beyondtype1.org

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References- Articles

- Eating Disorders and Diabetes: Screening and Detection- Amy Criego, MD, MS, Scott Crow, MD, Ann E. Goebel-Fabbri, PhD, David Kendall, MD, and Christopher Parkin, MS
- Eating Disorders and Type 1 Diabetes: Practical Approaches to Treatment- Stephanie Critchley MS, RD, LD, CDE, Marcia Meier BAM, RN, CDE and Dawn Taylor, PsyD, LP
- Eating Disorders in Persons with Type 1 Diabetes: A focus group investigation of early eating disorder risk- Margaret A. Powers, Sara A Richter, Diann M. Ackard, Catherine Cronemeyer
- Outpatient Management of Eating Disorders in Type 1 Diabetes- Ann E. Goebel-Fabbri, PhD, Nadine Uplinger, MS, MHA, RD, CDE, BCADM, LDN, Stephanie Gerken, MS, LD, RD, CDE, Deborah Mangham, MD, Amy Criego, MD, MS, and Christopher Parkin, MS

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ARFID: A Nutritional Overview

Victoria Wannemuehler, MS, RDN, LD

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What is ARFID?

- Avoidant Restrictive Food Intake Disorder
- New to DSM-5 (as of 2013), previously referred to as "Selective Eating Disorder"
- Similar in behavior to Anorexia Nervosa, however ARFID lacks the concerns of body image
- Different from picky/selective eating (more persistent, severe, associated with medical and psychosocial sequelae)
- Can hinder growth & development or maintenance of basic body function

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Diagnostic Criteria

-According to the DSM-5, ARFID is diagnosed when:

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.
- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

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

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

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Types of ARFID

1. Avoidant
   - Avoiding certain types of foods in relation to their sensory features
   - May feel sensitive to smells, textures, or appearance
2. Aversive
   - Avoidance of food out of fear of fear-based reactions to food
   - Fear of GI symptoms (vomiting, diarrhea), fear of choking, swallowing difficulties, pain, etc.
3. Restrictive
   - Shows little to no interest in food
   - May forget to eat altogether, show signs of a low appetite or get extremely distracted during mealtime
   - Extreme pickiness of foods

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The Three-Dimensional Model

- It is best to consider ARFID as a three-dimensional diagnosis, in that there are varying degrees of the subtypes present
  - i.e. the pt may have a mild degree of avoiding "chewy" textures, but have a severe aversion of foods that would induce vomiting
- Subtypes are not exclusive!
- The variations in subtypes and possible overlap has made developing best practice difficult

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Warning Signs and Symptoms of ARFID- Behavioral and Psychological

- Dramatic weight loss
- Dresses in layers to hide weight loss or stay warm
- Reports of constipation, abdominal pain, cold intolerance, lethargy, excessive energy
- Consistent vague GI issues (upset stomach, feeling full) around mealtimes without cause
- Dramatic restriction in types/amount of food eaten
- Only eating certain textures of food
- Fears of choking/vomiting or allergic reaction
- Lack of appetite or interest in food
- Limited range of preferred foods that narrows over time
- No body image disturbance or fear of weight gain
- Refusal of trying new foods
- Requiring foods to be prepared a certain way

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Warning Signs and Symptoms of ARFID- Physical

- Stomach cramps/non-specific GI complaints (constipation, reflux, etc.)
- Menstrual irregularities
- Difficulties concentrating
- Abnormal laboratory findings (anemia, low thyroid and hormone levels, low potassium, low blood cell counts, slow heart rate)
- Dizziness
- Fainting/syncope
- Feeling cold all the time
- Sleep problems
- Dry skin
- Dry and brittle nails
- Fine hair on body (lanugo)
- Thinning of hair on head, dry and brittle hair
- Muscle weakness
- Cold, mottled hands and feet or swelling of feet
- Poor wound healing
- Impaired immune functioning

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CURRENTLY, NO BEST PRACTICE GUIDELINES EXIST FOR THE TREATMENT OF ARFID

Current treatment methods use guidelines for other restrictive eating disorders and can be tailored to the individual.

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Treatment begins with identification and evaluation

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Nutrition Role in ARFID Treatment

- Avoid or correct malnutrition
  - Achieve/maintain a healthy weight
  - Correct nutrient deficiencies
- Maximize oral intake
  - Help patients recognize hunger/fullness cues
- Work to increase variety in diet
  - Eat foods from each of the five basic food groups (vegetables, fruits, grains, protein, dairy)
  - Help patient determine likes and dislikes beyond the influence of ARFID
- Empower patients to feel comfortable eating in public environments and social situations

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How can RDs treat ARFID?

- As mentioned previously, the treatment of ARFID requires a multidisciplinary approach and dietitians are vital to this process
  - Dietitians can treat ARFID in several capacities
  - Helping manage enteral nutrition/oral nutritional supplement regimen
  - Assisting families in fortifying foods, increasing nutrition in ways that pt will accept
  - Devising meal plans/assisting families in meal planning
  - Creating food logs with pts to review nutritional intake and food frequencies
  - Goal setting surrounding food exposure
- Establish a trust with your patient and family first before beginning therapeutic intervention
- Encourage pts and their families that no food is off the table, any food is acceptable at any meal

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Treating ARFID while Inpatient

- Interview to learn about patient's history, current and recent food likes, reinforcers that will help the patient to eat
- Goal of admission is to prevent further weight loss, correct lab abnormalities/vitals, and encourage PO intakes
- Meal plans should include many likes and familiar foods, less focus on nutritional balance
- Provide 3 meals daily, begin around 1200-1500 kcals/day, advance by 200-300 kcals/day pending labs to goal established by RD
- If the patient does not complete the meal offered, the calories missed will need to be made up using oral nutritional supplement (ONS)- calculate needed calories by estimating amount of food consumed and subtracting that from total calories provided by the meal (often on meal ticket) – 1 kcal for 1 mL using Ensure 1.0 product
- If unable to complete ONS, will need to place feeding tube (NGT) to administer ONS- the medical team should then determine if removing the NGT is appropriate

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Panel Discussion

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Panel Discussion

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