On anxiety

Several common themes across Anxiety Disorders, Trauma- and Stressor-related Disorders, and Obsessive-Compulsive and Related Disorders:

vulnerability, insecurity, powerlessness

This is why Substance Use Disorders are comorbid with Anxiety Disorders (particularly Social Phobia and PTSD), Psychotic Disorders, and Personality Disorders

Anyone know the first step of AA?

On anxiety

Scripture addresses the fear that comes from powerlessness – to accept and recognize that our power over our lives is limited and acknowledge that God is more powerful than us.

Psalm 90, the Lord's Prayer (Matthew 6:9-13), Jesus' struggle in Gethsemene (Matthew 26:39, 42; Mark 14:36; Luke 22:42)

Scripture also addresses the fear that comes from insecurity – that God is the one who is undergirds our lives and our faith regardless of what happens

Daniel 3:8-29, Esther 4, Romans 8:28-39

On anxiety

Scripture also addresses the fear that comes from vulnerability – that God is our strength and He fights for us

Psalm 27, 2 Corinthians 4:1,7-10, Psalm 56, Nehemiah 4, Matthew 10:30-31

Pica

A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.

B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.

C. The eating behavior is not part of a culturally supported or socially normative practice.

D. If the eating behavior occurs in the context of another mental disorder (Intellectual Developmental Disorder, Autism Spectrum Disorder, Schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Specify:

In Remission (if this is true)

Rumination Disorder

A. Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.

B. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).

C. The eating disturbance does not occur exclusively during the course of Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, or Avoidant/Restrictive Food Intake Disorder.

D. If the symptoms occur in the context of another mental disorder (Intellectual Developmental Disorder or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify:

In Remission (if this is true)

Avoidant/Restrictive Food Intake D/o (1/2)

A. 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:

   1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).

   2. Significant nutritional deficiency.

   3. Dependence on enteral feeding or oral nutritional supplements.

   4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

Avoidant/Restrictive Food Intake D/o (1/2)

C. 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.

D. 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.

Specify:

In Remission (if this is true)

Anorexia Nervosa (1/3)

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. 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.

Criteria of amenorrhea has been dropped from DSM-IV

Anorexia Nervosa (2/3)

Specifiers:

Restricting Type -

During the last 3 months, the individual has not engaged in recurrent episodes of binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-Eating/Purging Type –

During the last 3 months, the individual has engaged in recurrent episodes of binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Anorexia Nervosa (3/3)

Specifiers:

In Partial Remission –

After diagnosis has been given, when weight is no longer deemed "significantly low" for a sustained period of time, but either Criteria B or C or both continue to be present.

In Full Remission –

When none of the criteria are met for a sustained period of time.

Severity must be specified –

Mild: BMI $\geq$ 17 kg/m^2

Moderate: BMI 16-16.99 kg/m^2

Severe: BMI 15-15.99 kg/m^2

Extreme: BMI $<$ 15 kg/m^2

Anorexia Nervosa – Prevalence, etc.

Prevalence

- 0.3-0.9% of young women and 0.1-0.3% of young men are diagnosable with AN at some point in their lives
- estimates of 1.1-3.0% of adolescent girls diagnosable with Other Specified Eating Disorder, for just AN-symptoms alone
- prevalence among males estimated to be one-third that of females (75% female, 25% male)
- College campuses estimate 20% of students engaging in eating disorder behaviors
- higher prevalence among athletes, especially figure skaters, gymnasts, divers, wrestlers, rowers
- higher prevalence in dancers, bodybuilders
- some subthreshold AN due to pre-pubertal transgender management/coping

Bulimia Nervosa (1/2)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances

2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

Bulimia Nervosa

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

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

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specifiers:

In Partial Remission, In Full Remission

Severity specifier –

Mild: (1-3 episodes/week)

Moderate: (4-7 episodes/week)

Severe: (8-13 episodes/week)

Extreme: ($\geq$ 14 episodes/week)

Diagnostic Issues

Unlike individuals with Anorexia, individuals with Bulimia tend to be normal to somewhat overweight, and therefore, can “pass as normal.” Compensatory mechanisms are often done in secret and great pains may be taken to “appear normal.”

How much daily food intake? (semi-starvation vs. normal-range intake)

Is the individual able to eat more than they decided upon? (morbid fear vs. impulsivity and compensation)

How does the individual view themselves in terms of body size, weight, proportion, in comparison to themselves in the past, in comparison to their friends, and in comparison to the social norms?

How much weight difference exists between highest weight/clothing size, lowest weight/clothing size, and now?

Bulimia Nervosa – Prevalence, etc.

Prevalence

- 1.1-4.3% of the female population – Lifetime prevalence (NIMH estimates are higher)
- 1-year prevalence is 1-1.5%
- 58% of female college athletes, 38% of male college athletes at risk for BN

Ethnicity

- most individuals with Bulimia tend to be young, white, from affluent families, and living in competitive environments (school, home)

Onset

- ages 16-19

Bulimia Nervosa - Comorbidity

Many individuals with Bulimia started out with anxieties and rumination about weight, body size, body image concerns that they tried to address through excessive mental and behavioral control, particularly restricting food intake. Individuals with Bulimia tend to have more impulsivity and emotional instability and engage in other compensatory mechanisms such as purging or excessive exercise when unable to restrict intake.

Associated disorders frequently include Depressive Disorders coupled by low self-esteem. Likewise, anxiety-spectrum disorders are present.

Substance Use Disorders, particularly stimulants and alcohol are present with Bulimia (as high as 33%, Kinder, 1997).

Personality disorders, particularly Borderline Personality Disorder, is present in about 33-50% of individuals meeting criteria for Bulimia.

Shoplifting and sexual promiscuity (impulsive behaviors).

50% of individuals with Bulimia report history of sexual abuse (Hall, Tice, Beresford, Wooley, & Hall, 1989)

Bulimia Nervosa – Comorbidity

Wide range of medical/physical/physiological problems associated with purging mechanisms:

Vomiting:

- salivary gland enlargement
- erosion of dental enamel
- electrolyte imbalance (leading to cardiac arrythmias, renal problems, possible renal failure)
- sore throats, esophageal inflammation
- stomach ruptures

Enemas and laxatives:

- intestinal/rectal problems

Binge Eating Disorder (1/2)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat during a similar period of time under similar circumstances.
2. a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:

1. eating much more rapidly than normal.
2. eating until feeling uncomfortably full.
3. eating large amounts of food when not feeling physically hungry.
4. eating alone because of embarrassment by how much one is eating.
5. feeling disgusted with oneself, depressed, or very guilty afterward.

Binge Eating Disorder (2/2)

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once/week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in Bulimia Nervosa and does not occur exclusively during the course of Bulimia Nervosa or Anorexia Nervosa.

Specifiers:

In Partial Remission, In Full Remission

Severity specifier –

Mild: (1-3 episodes/week)

Moderate: (4-7 episodes/week)

Severe: (8-13 episodes/week)

Extreme: ($\geq$ 14 episodes/week)

Binge Eating Disorder – Prevalence, etc.

Prevalence

- 0.8% for males annually, 2.0% lifetime
- 1.1% of females annually, 3.5% lifetime
- the most prevalent specific Eating Disorder
- M:F ratio apprx: 2:3

Treatment

- estimated 30% of individuals who seek weight loss treatment are diagnosable with BED
- 43.6% of individuals with BED receive treatment at some point in their lives

Comorbidity

- Depressive Disorders (also a risk factor for BED)
- Anxiety Disorders, Substance-Related Disorders, Personality Disorders

Anorexia and Bulimia Nervosa - Etiology

Sociocultural Theories

- Higher incidence in westernized and industrialized countries reflect higher regard for thinness in those societies
- People are reinforced by compliments when thin/weight loss
- Admired people are thin, media equating beauty and worth with slimness, appearance, and external attributes such as image
- Basis of negative self-image if one considers oneself not thin
- Thinness is preserved to preserve worth, perceived attractiveness
- Changing societal ideals: 69% of Playboy centerfolds and 60% of Miss America contestants in recent years have weighed <= 85% of ideal body weight
- 40-60% of elementary school girls (ages 6-12) are concerned about their weight and/or becoming too fat. This concern persists throughout life. ~70% of them say that media pictures influence their concept of ideal body shape and 47% of them say the pictures make them want to lose weight

Anorexia and Bulimia Nervosa - Etiology

Sociocultural Theories

-~40% of kids are weight-shamed about their weight by peers/family members, contributing to increased incidence of low self-esteem, increased negative body image, binge eating, and use of compensatory behaviors

- Women believe their current weight is heavier than their most attractive weight which, in turn, is heavier than the ideal

- Women rate their ideal weight as much lower than men consider attractive

- Fiji Study of 2004

Eating Disorders - Etiology

Biological Theories

- Set-point theories of body fat content have genetic component

- Abnormalities of neurotransmitter homeostasis signaling satiation/hunger have been found for some individuals with bulimia (norepinephrine activates feeding, serotonin inhibits)

Eating Disorders - Etiology

Cognitive-Behavioral Theories

- Positive and negative reinforcement of bingeing and purging behaviors (or of restricting behaviors in AN)
  - bingeing allows for eating pleasure, purging reduces anxiety associated with fears of weight gain as well as decreases likelihood of weight gain
- Cognitions regarding behavior and self-image (core schemas) often based on one or several of the above bases of etiology
  - All-or-nothing reasoning

  Well, I ate one extra cookie, I might as well eat the whole box.

  Either I'm dieting and doing well or I'm overeating and messing up.
  - Catastrophizing events to extreme

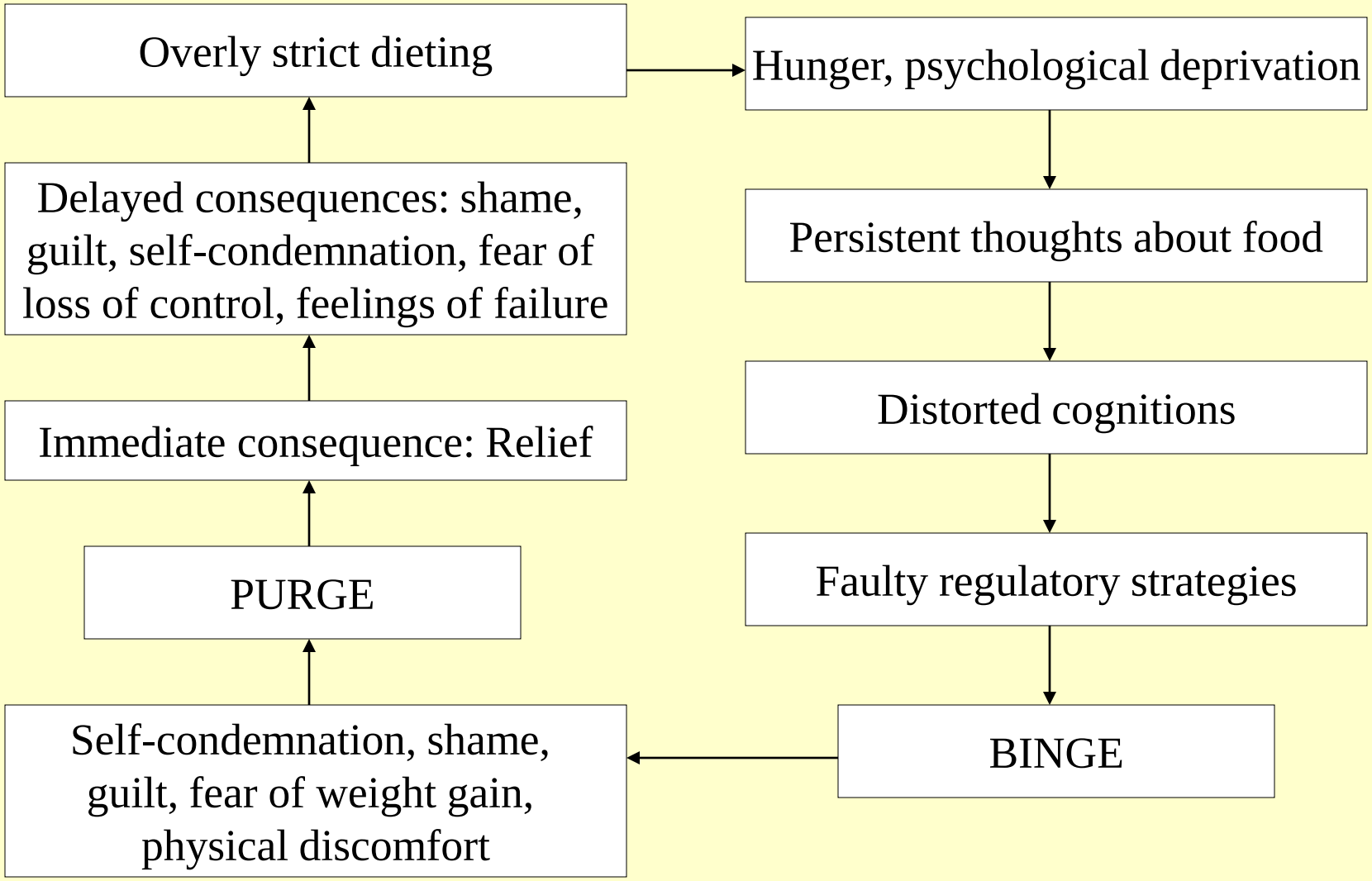
  If I gain 5 pounds, everyone will notice.

  I'm a complete failure.
  - Selective abstraction

  No one talked to me after class; it must be because I'm fat.

  If I lost 10 pounds, my whole life would be better.

Bulimia Nervosa - Etiology



Eating Disorders - Etiology

Family Systems Theories

- Eating disorders often surface in adolescence, and may be reflective of crises in that particular developmental stage around issues of identity formation, changing relationships with family, maturation into adulthood and coping with adult issues such as relationships, intimacy, and independence
- Families often chaotic, highly conflictual and/or neglectful, and tend to place high emphasis on outward appearances ("appearing normal") (Hsu, 1990)
- Symptoms can be seen as reflective of family's manner of dealing with conflict and affect (all-or-none), ways of dealing with lack of nurturance (bingeing) and getting rid of negative affect/ frustration/aggression (purging)
- Some families need a member to be "problemed" for homeostasis and the family member with the eating disorder fills this role. Shame often plays an outsized role in family homeostasis

Eating Disorders - Etiology

Psychodynamic Theories

- Believed to stem from physical caretaking being provided for by parents/others in childhood and substituted for/confused with emotional caretaking
- Centering around oral issues of being trust and mistrust: cared for physically but not cared for emotionally and conflict over having dependency needs and the rejection of these needs through displacement onto food

Eating Disorders - Treatment

Cognitive-Behavioral Therapy

1. Obtain a history of eating patterns of the disorder (may be related to life events and developmental stages - need to rule out comorbidity or incorporate treatments for these)
2. Behavioral analysis of binge and purge/restrict eating behaviors
3. Self-monitoring of eating behaviors and triggers including thoughts and feelings
4. Education of weight, body mass, hunger, satiety, ineffectiveness of restriction/purging
5. Challenge of cognitive distortions regarding eating
6. Cognitive restructuring of self-image, body-image, and self-concept (build self-esteem)
7. Provide regular eating schedule and problem-solving strategies (food charts and daily food monitoring)
8. Relapse prevention

Eating Disorders - Treatment

Dialectical Behavioral Therapy

Introducing, educating, and helping the individual improve skills in four domains:

1. Core Mindfulness – increases awareness of thoughts, feelings, and behaviors in the moment (allows one to act differently), helps to increases awareness of impulses to binge/purge or thoughts or feelings of distress or triggers that precipitate impulse to binge/purge
2. Distress Tolerance – increases ability to tolerate negative emotions and impulses, such as purging impulses or panic about eating too much using skills of distraction and alternate strategies
3. Emotion Regulation – increases ability to regulate negative affect
4. Interpersonal Effectiveness - increases ability to communicate effectively with others, including expression of needs and self-assertiveness

Eating Disorders - Treatment

Family Therapy

- Using a family lunch, bring dysfunctional transactional patterns into the open
- Improving dysfunctional communication patterns between family members through improved listening and speaking skills
- Increasing “honest” communication and tolerance for expression of anger, difference of opinions
- Defining appropriate boundaries between family members (facilitate meeting of emotional needs through other, more appropriate relationships rather than with children)

Eating Disorders - Treatment

Psychodynamic Therapy

- Facilitating understanding of split off ways of relating to family members/self through confrontation of defenses and interpretation of behavior patterns

- Increasing understanding of self and needs for emotional nurturance leads to greater integration of self and identity (identity integration vs. identity diffusion or fragmentation)

Eating Disorders - Treatment

Pharmacological Interventions

- tend not to be very helpful unless addressing comorbid symptoms such as depression and/or anxiety.
- unofficial peer pressure/recommendations re: use of substances.

Medical Interventions needed not to address the eating disorder per se but to address medical complications, such as esophageal inflammation, electrolyte imbalances, joint issues, etc.

Given high rate of comorbidity of depression and anxiety, treatment interventions must address presence of these symptoms simultaneously or separately (one treatment for depression, a separate treatment for eating behaviors)