Eating Disorders: The Importance of Interdisciplinary Team Treatment

March 10th, 2025

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MiEDA Mission: Raise Awareness Regarding Eating Disorders

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Case Presentation- Young Female

- Kim is a 15 year old female high school freshman
- Presents with concerns of dizziness and cold intolerance.
- Kim is withdrawn and difficult to engage today.
- Mom has been concerned about Kim's weight loss and eating habits for the past 2 visits with the pediatrician.
- Kim does not report feeling concerned and is happy with her weight currently.
- She denies any changes in her eating or exercise habits.

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Weight History/ Symptoms

- Kim has followed her growth chart with weight being in the 50th percentile since birth.
- Within the past 6 months she has fallen to the 20th percentile for weight.
- Her BMI is now 17 and she has lost about 10 pounds while also growing 2 inches.
- Mom reports that Kim started changing her food intake to try to “eat healthier” and get in shape for swimming about a year ago. Her older sister (17) started making some of the same changes.
- Kim had her first menstrual period when she was 13 and had it regularly until 6 months ago. She has not had a period consistently for the past 6 months.
- She is complaining of dizziness today and at times feels she is going to pass out. She reports always being cold, even in the summer or when it is warm inside the house/ car.

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Social/ Developmental History

- Mom reports Kim's developmental milestones were on target.
- Kim has always been the "good kid" in the family, in contrast to her older sister, who is more argumentative and pushes limits.
- Dad is a runner and is reportedly frustrated that his weight has recently increased.
- Mom has noticed Kim has been sleeping a lot more, has failed a few tests recently and seems to be more distracted.
- She has been spending more time in her room and less time with her friends or outside in the pool.
- Kim often shares that she does not want to go to school and did not join the swim team this year, as she has in the past.
- Mom has a history of depression, treated with medication.

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Therapeutic Role

Kelly Boprie, Certified Eating Disorder Specialist & LMSW

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Understanding the brain of Kim and malnourishment

Kim's brain is not receiving enough nourishment. Unfortunately, for these individuals if they stop eating enough for their growth needs or activity level, their restricted eating can lead to dramatic changes in the brain. Once started, it can be difficult for the young person to get "back to normal" without help. Because of the unique way the person's brain and body responds to limited nutrition, the longer they are malnourished, the harder it becomes to eat normally again - hence why the support of Family Based Therapy would be a helpful modality to treat Kim and equip her family.

Kim's brain is unable to understand the degree of malnutrition she is in. Due to the egosyntonic nature of her ED and limited insight about how "sick she is", her parents need to step in

Source: Eating Disorders and The Brain, FEAST Publication

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Early Intervention is Crucial

Researchers say an ongoing eating disorder can modulate the brain's reward circuitry. Dopamine that should be released due to a reward (like eating a good meal) is instead released by a punishment (like skipping a snack) - hence no positive reward, easier to skip and ignore hunger cues. Anorexia can cause your brain to shrink and the reward circuitry to reinforce disordered eating.

The earlier the intervention, the higher the chance of recovery versus the wait and see approach.

The most urgent task of early recovery is restoring the patient's normal weight with adequate daily nutrition. An undernourished individual's brain cannot recover

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For the parent

Knowing that the brain is operating differently in eating disorder patients can help families respond with less frustration: it can help to understand that this is not a set of choices or lack of motivation to change - externalize the ED.

No one is at fault, not the parent, not the child (Kim)

Parents and families need to focus on helping the child regain their health through normal eating, providing a warm and supportive family environment, and working with a multidisciplinary team with the most recent training and expertise.

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What Is Family Based Therapy (FBT or Maudsley Model)

FBT is a family based treatment approach for the treatment of anorexia in children and adolescences who are living in the home of their parents/caregivers.

FBT was developed at the Maudsley hospital in London during the 1980s and is manually based, following 3 phases.

FBT is the current gold standard form of treatment for anorexia nervosa in youth

LeGrange and Lock who came up with the manualized version of FBT say “the family is viewed as the patient’s best resource in recovery”. In FBT, parents/caregivers are tasked with the refeeding of their child.

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FBT continued

FBT does not imply that the family is to blame but the parents are mobilized to act

FBT centers around the idea that the child/teen needs to regain weight to restore normal thinking and functioning, and focuses strongly on weight restoration rather than the psychological aspects associated with this mental illness.

The emphasis initially is on BEHAVIORAL change, remember the brain is starved, insight is limited.

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Why FBT Outpatient

FBT lowers the need for hospitalization when done effectively (LeGrange 2013). To begin FBT, the child does need to be medically stable enough for this care.

In outpatient care, the focus/intervention is:

1. Restore weight
2. Put the child/teen development back on track

The individual and their family work with a team of health professionals, including a doctor, therapist and dietician, to ensure they are supported and following the treatment model effectively.

Sessions are structured, following the FBT manual, and treatment is done in 3 phases

*hospitalization may still be needed

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Kim to be assessed by her physician

Kim will need to be evaluated by her pediatrician or adolescent medical specialist (Dr. Lowery) The results of this medical workup will in part dictate what comes next; if her health care provider has concerns about medical stability, a medical hospitalization may be necessary prior to beginning FBT

During the medical workup, her physician will check for the effects of inadequate nourishment. This includes checking height and weight, which is necessary to evaluate how your child is progressing on their growth curve with a strong emphasis on looking at the growth chart. The medical provider will be assessing signs that your child's body is in a starved state. This can include slowed heart rate, low blood pressure, low body temperature, loss of period, loss of hair and other physical signs. Bloodwork will help evaluate signs of malnutrition, electrolyte imbalances, kidney functioning and hormone changes. An EKG can/should also be ordered to assess her heart.

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Quick Overview of the 5 Assumptions of FBT

1. Agnostic View of ED: parent and child are not to blame and not looking for a cause, we are treating what is
2. Non authoritarian therapeutic stance: join with the family - therapist as consultant and help parents figure out how to help and support their child to recover
3. Parents are responsible for weight restoration
4. Externalization - no pathologizing of client, do not negotiate with ED
5. Initial focus on symptoms - delay of other issues until clients is not as involved behaviorally and psychology with ED. Emph on behavior change - use weight chart/growth char

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Treatment Set up

Weekly

Conjoint

6-12 months

3 Phases

3 Phases

Phase 1: parents in charge of weight restoration; parents refeed in the home

Phase 2: Parents begin to hand control over eating back to teen/cjhild

Phase 3: Discuss adolescent development issues

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Phase One with Kim

Engage the family

Take a history of the development of the ED - onset, acuity, separate AN from Kim

Task the family with what it means to refeed in the home: structure and consistency, preparation

3 meals, 3 snacks daily at the same time with parents preparing, plating and supervising the entirety of the meal

Weigh Kim and discuss growth chart together (fell to 20% has always been in 50%)

Discuss movement - cessation of swim

Family meal

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Phase 2

Work with Kim and mom to start to give more responsibility to Kim to work on feeding herself

Start small - snack - Kim chooses

Weight needs to be close to 90% regained

Kim must be able to eat without significant struggle

Start to talk with treatment team about getting back into swim (gradual)

Phase 3

Weight is restored

Moving into weight/shape issues

Any adolescent development issues - identity, communication

Relapse Prevention - Kim and mom work together to identify areas of risk/vulnerabiltiy and problem solve around how to manage.

Nutrition Therapy

Emily Welles, MS, RD, CDE

Affiliate Professor Grand Valley State University

Founder of Emily Welles Nutrition LLC

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Why Nutrition Therapy?

- RD is an essential part of the team treatment providing a specific point of view for nutrition assessment and intervention
- RD may be the first to recognize eating disorder behaviors and encourage additional care from the medical or therapy team
- Dietary recall/ nutrition assessment may provide more useful information than blood work or other anthropometric measures, which are often “normal”
- RDs are uniquely training to work with malnutrition which is crucial before therapeutic measures can be impactful

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Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating Disorders

Nutrition Therapy Basic Goals

- Steady increase of nutrition and calorie intake
- Stabilization of meal and snack timing/ consistency
- Weight regain and stabilization if needed
- Nutrition education on importance of macro and micronutrients
- Food exposure to reduce fear surrounding food
- Body image distress investigation and rehabilitation

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Nutrition Assessment- ABCD

- **Anthropometric**
  - Height, weight, weight history
  - Blinded weight and ask about access to scale
  - Nutrition focused physical exam/ visual exam
  - Review of growth charts/ trends
- **Biochemical**
  - Review labs ordered and discuss that labs are often normal
- **Client history**
  - Social history
  - Medications
  - Laxative/ diuretic use
  - History of eating disorder treatment
  - Physical activity

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Nutrition Assessment- ABCD

- **Diet/ Nutrition**
  - 24 hour recall, including times
  - Fluid intake and frequency (including alcohol)
  - Eating patterns including restriction, binging
  - Foods avoiding/ fear foods
  - Allergies and intolerances
  - History of food tracking

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Nutrition Interventions

- Meals and Snacks
  - Consistent food intake
  - Exchange meal plan or plate by plate method
  - Rule of 3 simplified meal goals
  - Avoiding exact portion sizes, calories, numbers
- Nutrition Education
- Intuitive eating/ hunger scale
- Medical food supplements (Ensure/Boost)
- Enteral Nutrition (tube feeding)
- Weight monitoring
- Goal setting

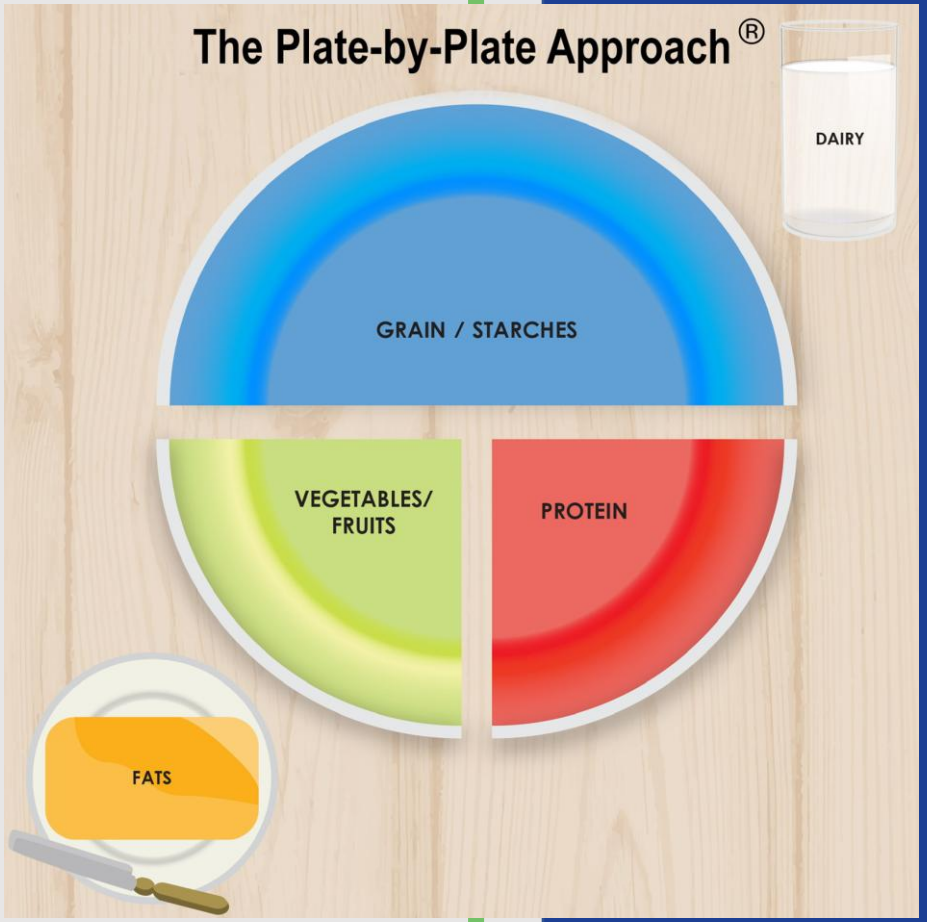
Exchange Meal Plan vs Plate by Plate

Each day I need:

Dairy	Protein	Grain	Fruit	Vegetables	Others
3	5	6	3	3	3

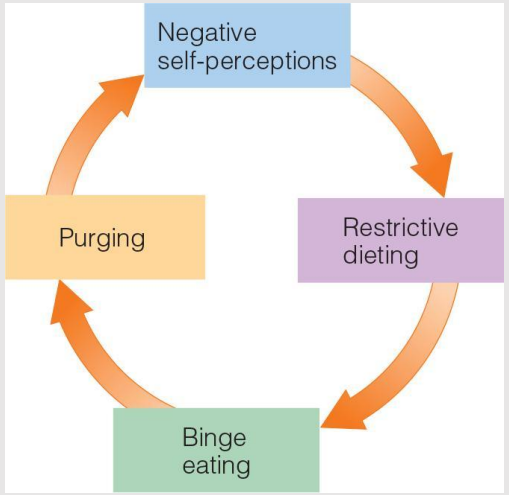
Sample meal pattern:

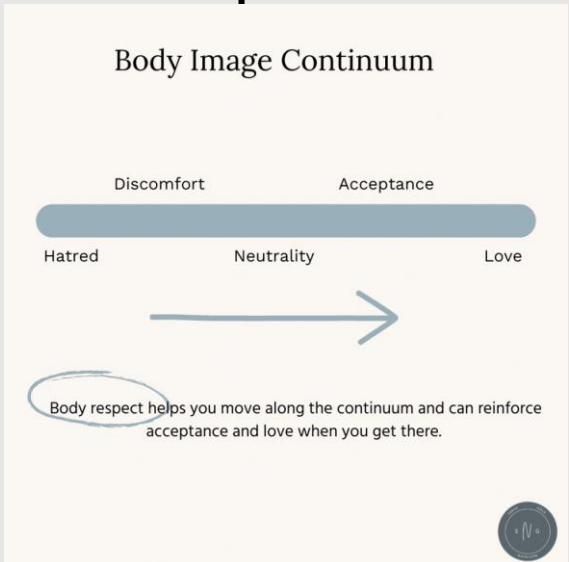
Breakfast	Lunch	Dinner
___1__Dairy	__1___Dairy	__1___Dairy
___1__Protein	__2___Protein	__2___Protein
___1__Grain	__2___Grain	__3___Grain
___1__Fruit	__1___Fruit	__1___Fruit
_____Vegetables	__1___Vegetables	__2___Vegetables
___1__Others	___1__Others	___1__Others



Nutrition Education

- Discussion of macronutrients, importance of carbohydrates/ fats/ proteins
- Discussion of hydration and importance
- Calorie intake needs for brain and body function
- Binge, restrict cycle and impact on hunger cues
- Body image distress and techniques





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Refeeding Syndrome

- More common in severely malnourished patients who have had very very low food intake for an extended period of time
- Not common in the outpatient setting
- Involves electrolyte imbalance and can impact heart function
- However, many experience GI distress such as bloating, constipation, diarrhea and gas.

Academy of Nutrition and Dietetics Pocket Guide to Eating Disorders

Weight Monitoring

- Options may include…
  - **Blind weights:** patient steps on backwards and does not see weight, should not be included in the medical chart to avoid patient portal access
  - **At home weights:** parent/ loved one weighing patient blindly at home and sending number to RD
  - **Remote scale monitoring:** blinded scale, sends the number to a dashboard for RD to view
  - **Exposure weights:** RD and patient see the number together and discuss feelings surrounding it
  - **No weight monitoring:** is not always necessary for patients to be weighed, if food intake is consistent and well reported

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A Warning About Weights/ Labs

- Lab values and weight numbers do not always reflect the level and longevity of malnutrition or disordered behaviors present
- Unfortunately, patients feel if their weight is not “too low” they are not sick enough for treatment or deserve treatment
- Many patients do not feel they are sick enough for treatment and state “I can still function as a working adult/ mom/ student/ etc”…but are we functioning at the highest potential?

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Nutrition Monitoring/ Evaluation

- Weight restoration if needed
- Food intake slowly rebuilding to baseline, establishing a consistent meal and snack pattern
- Moving towards intuitive eating, recognizing hunger/fullness cues
- Challenging fear foods, allowing all foods to fit in the eating pattern
- Reduction of symptoms, stability of lab values
- Positive relationship with exercise

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Eating Disorders
Clinical Presentation, Medical Management, Medical Complications

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Section Chief Adolescent Medicine

Assistant Dean for Diversity and Cultural Initiatives- MSU CHM

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Disclosures

- Organon ® - Nexplanon ® Trainer

Objectives

- Review of clinical presentation
- Discussion of identification and management
- Discuss pharmacotherapy
- Discussion of possible medical complications

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Awareness Is Key- Disparities

- BIPOC- Black, Indigenous and people of color, Native, Asian/Pacific Islander, Latino/a/e`, sexual diverse individuals are often under diagnosed in disorder eating
- Eating disorders are often stereotyped as thin, affluent white girls
- BIPOC individuals with eating disorders half as likely to be diagnosed or to receive treatment
- Minoritized patients are less likely to than white patients to received recommendations for referrals
- Black adolescents are 50% more likely than their White peers to exhibit bulimic behavior, such as binging and purging.
- Hispanic adolescents are more likely to have bulimia nervosa than non-Hispanic teens.
- Lack of culturally competent providers and therapists

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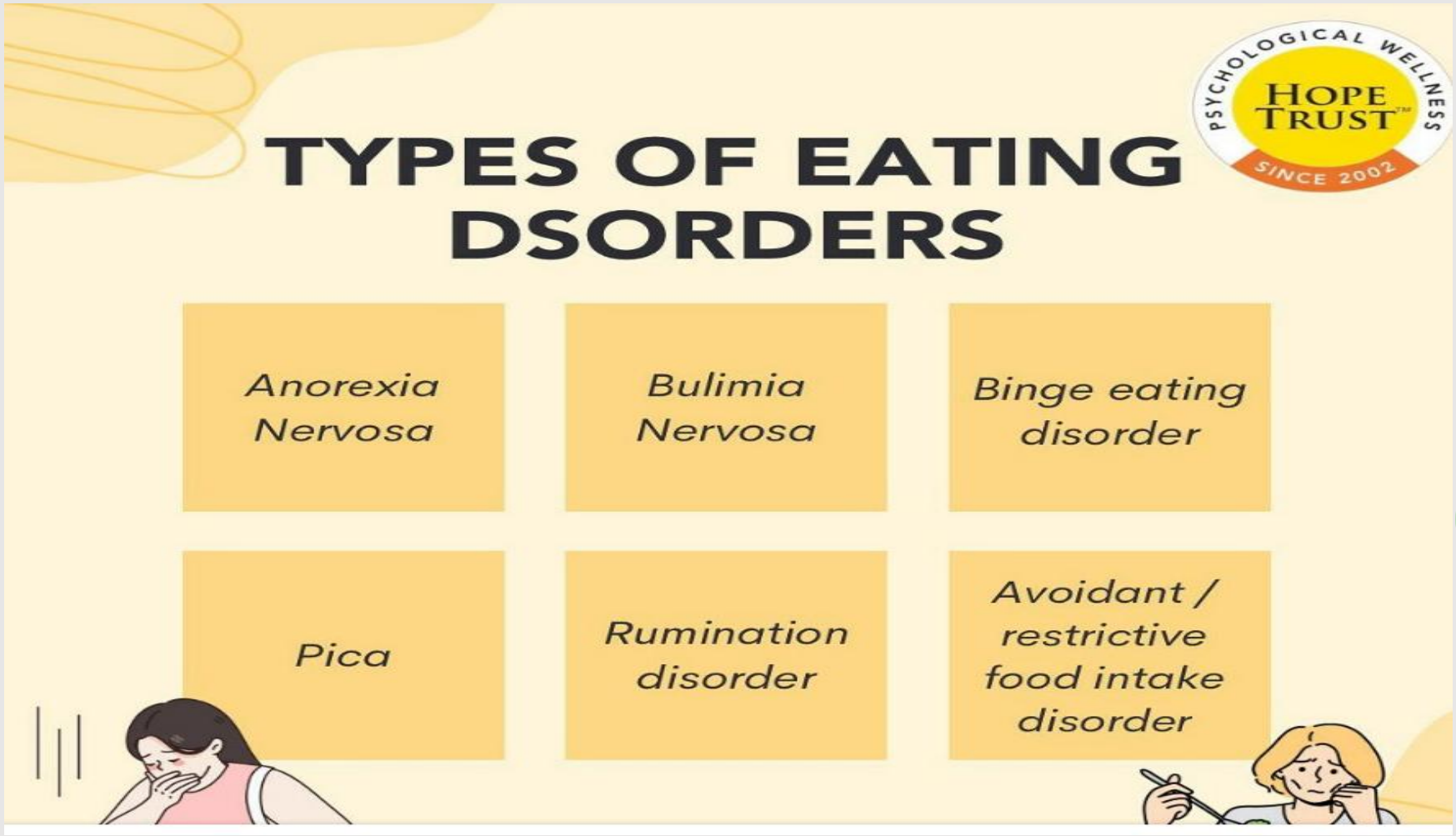
- Challenges in BIPOC Eating Disorders | Prevalence, Bias, and Treatment Barriers (withinhealth.com)
- Eating Disorders in BIPOC Populations (equip.health)



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https://www.facebook.com/hopetrust/photos/a.10157878779523082/10162047955008082/?type=3

Diagnostic Features- Anorexia Nervosa

- Persistent energy intake restriction
- Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain
- A disturbance in self-perceived weight or shape

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Psychological

- Depression
- Social Withdrawal
- Irritability
- Insomnia
- Diminished interest in sex
- Obsessive-compulsive
- Fears of eating in public
- Feelings of ineffectiveness
- Strong Desire to control ones' environment
- Rigid thinking
- Impulsivity

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Risk Factors

- Individuals with anxiety and obsessive traits
- Cultures and settings that value thinness
- Occupations or Interests that encourage thinness
- First degree relative

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Relative Energy Deficiency in Sport-REDS

- Female Athletic Triad is a subset
- Low energy availability that may or may not be related to disordered eating
- Menstrual dysfunction
- Low bone mineral density
- 2014 International Olympic Committee recommended change to more inclusive term – ”relative energy deficiency in sport”
- RED-S - fatigue, decreased performance, weakness, mood changes, change libido

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Screening

- Weight, Height, BMI
- Excessive weight concerns
- Inappropriate Dieting- Changes is diet
- Giving up Meat, Sugars, “White Foods’”
- Pattern of Weight Loss (or Weight Changes)
- Changes in Exercising Patterns
- Menstrual Changes

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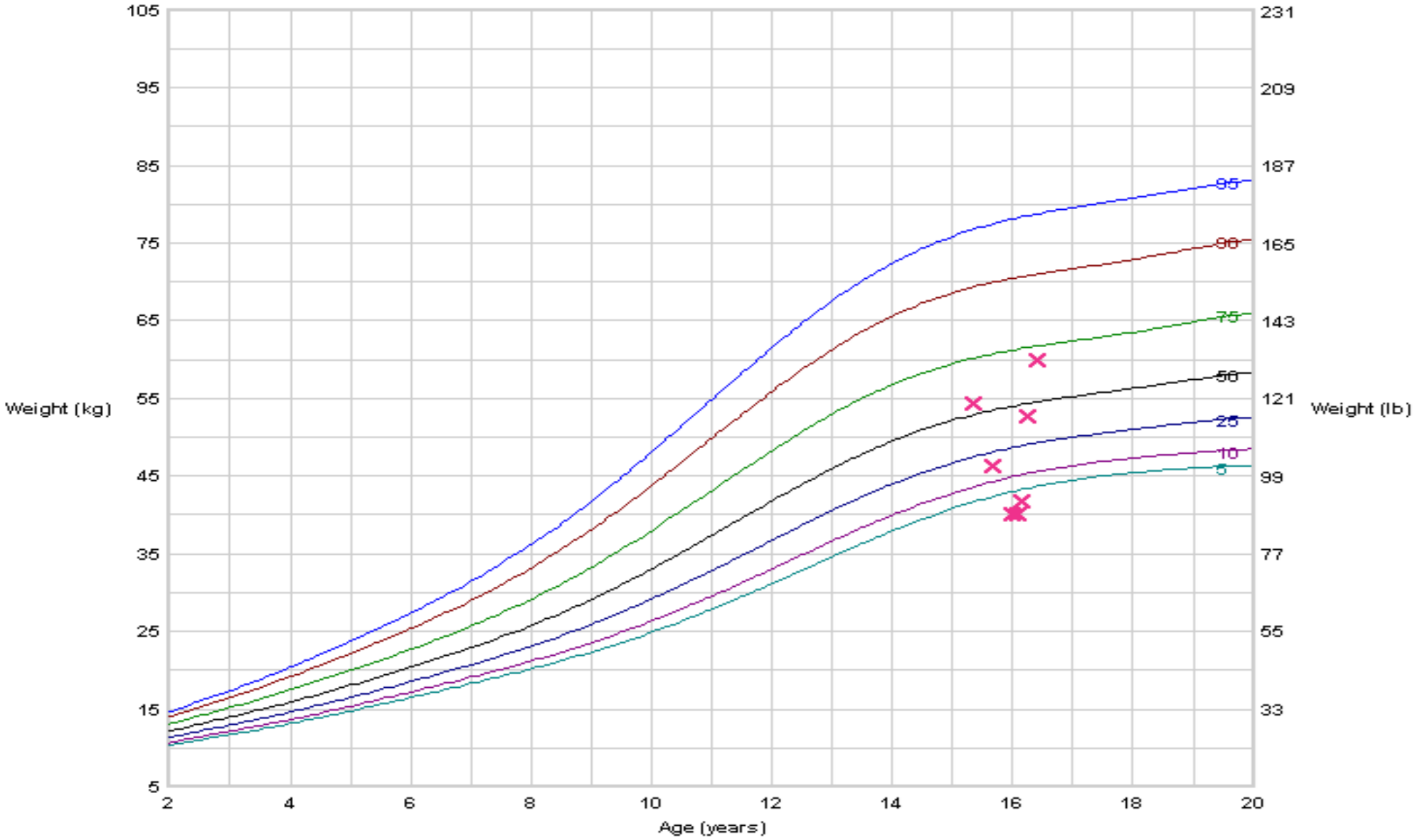
Growth Chart

Head Circum. | Length-for-age | Weight-for-length | Weight-for-age | BMI | Height Velocity | Parents' Height | Print | Print All | Refresh

Weight-for-age Percentiles (Girls, 2 to 20 years)

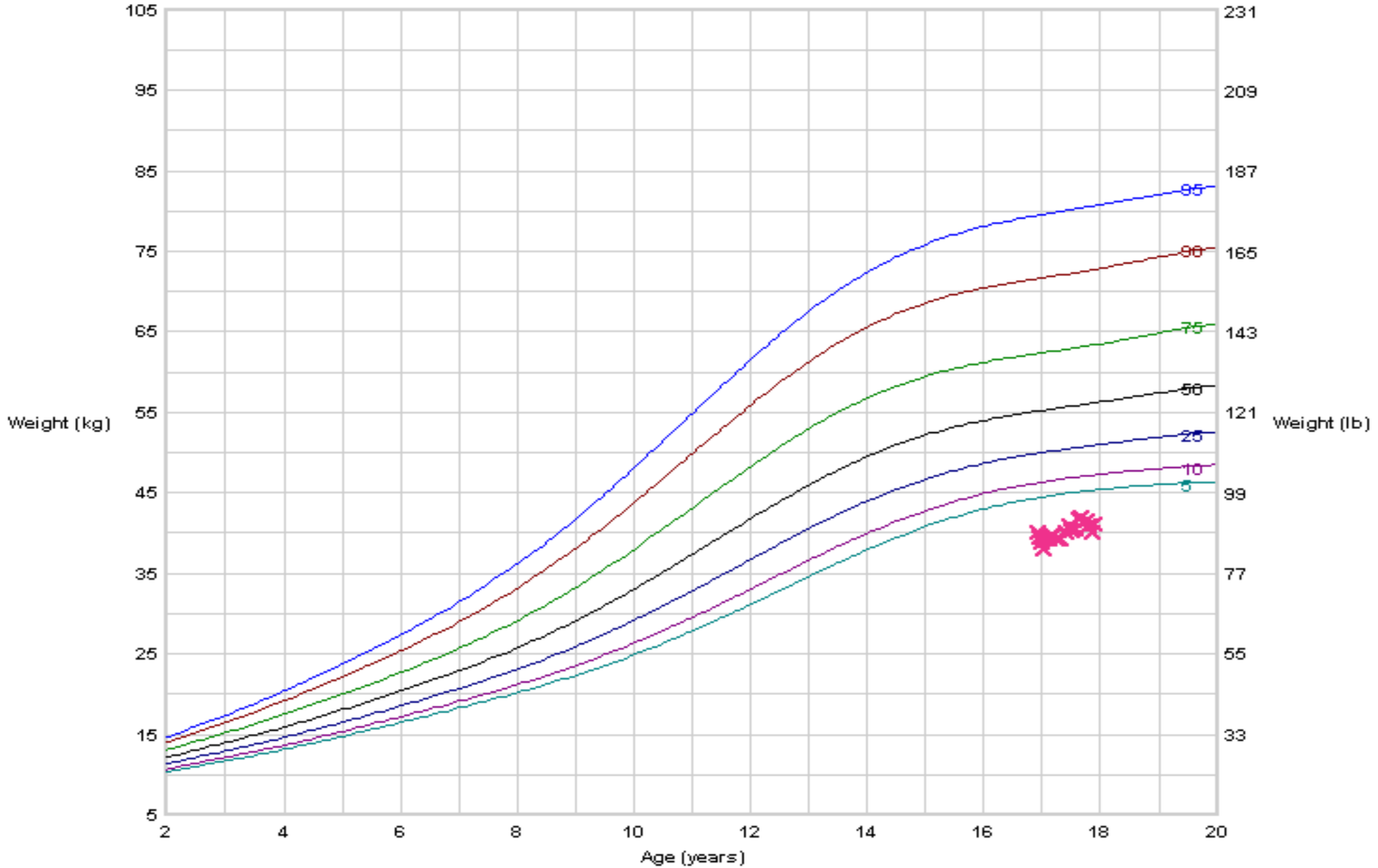
Zoom: 100% 100%



Source: Centers for Disease Control and Prevention (CDC)

ht-for-age Percentiles (Girls, 2 to 20 years)

Zoom: 100% 100%



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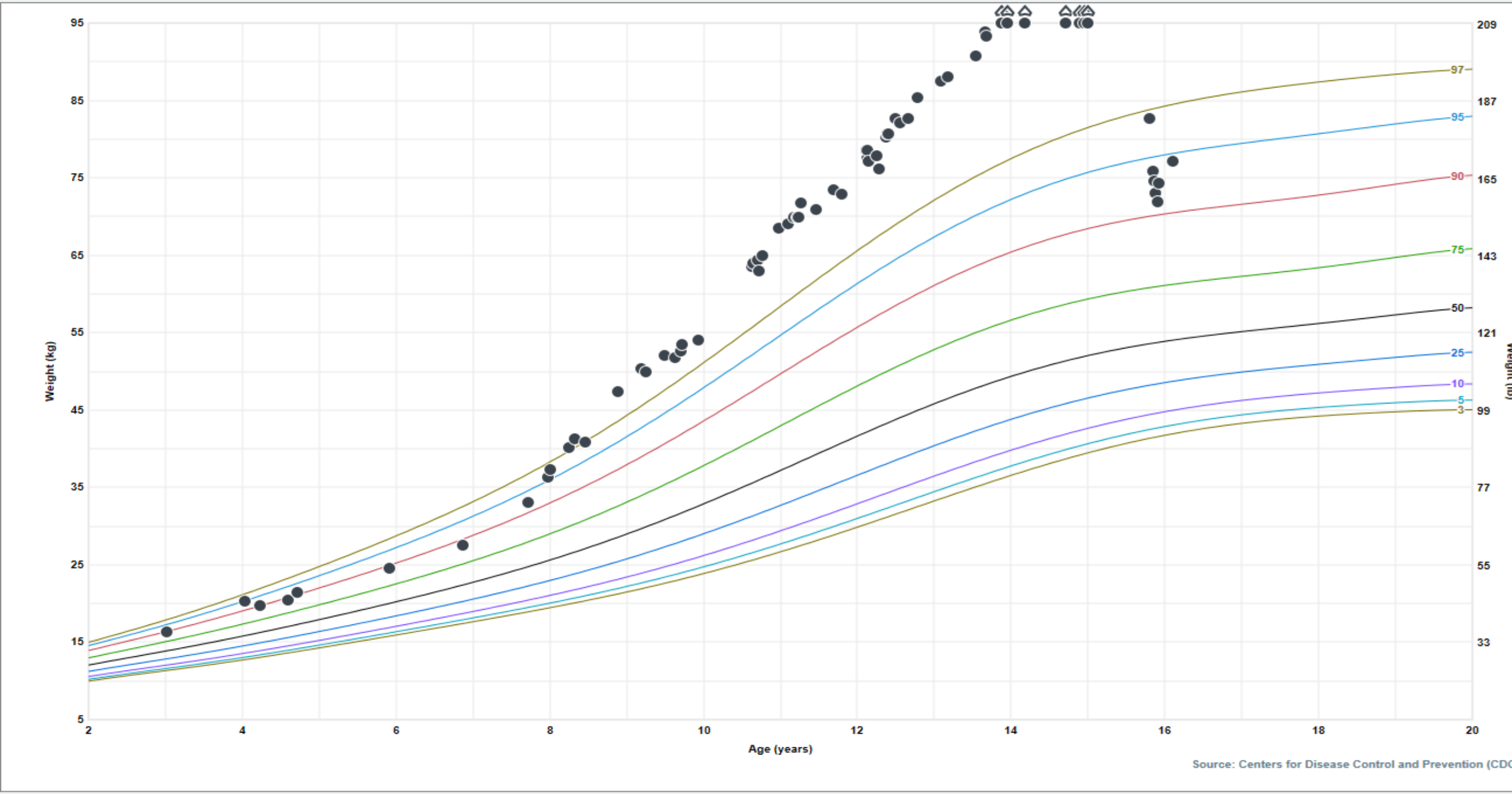

Source: Centers for Disease Control and Prevention (CDC

Screening

Additional questions:

- How much would you like to weigh?
- Assess Self Esteem
  - Tell me 3 good things about yourself
- Ask about family members and weight

EAT- Eating Attitude Test- Quick 26 item Questionnaire

HEAADDSS Assessment

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Eating Attitude Test

Eating attitudes test

	Always	Usually	Often	Sometimes	Rarely	Never	Score
1. Am terrified about being overweight	o	o	o	o	o	o	____
2. Avoid eating when I am hungry	o	o	o	o	o	o	____
3. Find myself preoccupied with food	o	o	o	o	o	o	____
4. Have gone on eating binges where I feel that I may not be able to stop	o	o	o	o	o	o	____
5. Cut my food into small pieces	o	o	o	o	o	o	____
6. Aware of the calorie content of foods that I eat	o	o	o	o	o	o	____
7. Particularly avoid foods with high carbohydrate content (ie, bread, rice, potatoes, etc)	o	o	o	o	o	o	____
8. Feel that others would prefer if I ate more	o	o	o	o	o	o	____
9. Vomit after I have eaten	o	o	o	o	o	o	____
10. Feel extremely guilty after eating	o	o	o	o	o	o	____
11. Am preoccupied with a desire to be thinner	o	o	o	o	o	o	____
12. Think about burning up calories when I exercise	o	o	o	o	o	o	____
13. Other people think that I am too thin	o	o	o	o	o	o	____
14. Am preoccupied with the thought of having fat on my body	o	o	o	o	o	o	____
15. Take longer than others to eat my meals	o	o	o	o	o	o	____
16. Avoid foods with sugar in them	o	o	o	o	o	o	____
17. Eat diet foods	o	o	o	o	o	o	____
18. Feel that food controls my life	o	o	o	o	o	o	____
19. Display self-control around food	o	o	o	o	o	o	____
20. Feel that others pressure me to eat	o	o	o	o	o	o	____
21. Give too much time and thought to food	o	o	o	o	o	o	____
22. Feel uncomfortable after eating sweets	o	o	o	o	o	o	____
23. Engage in dieting behavior	o	o	o	o	o	o	____
24. Like my stomach to be empty	o	o	o	o	o	o	____
25. Enjoy trying new rich foods	o	o	o	o	o	o	____
26. Have the impulse to vomit after meals	o	o	o	o	o	o	____
For all items except #25, responses receive the following value:							
	Always = 3	Usually = 2	Often = 1	Sometimes = 0	Rarely = 0	Never = 0	
For item #25, the responses receive these values:							
	Always = 0	Usually = 0	Often = 0	Sometimes = 1	Rarely = 2	Never = 3	

The cutoff score in screening patients for the presence of a Diagnostic and Statistical Manual of Mental Disorders-4 (DSM-IV) eating disorder is 20[1].

Reference:

1. Mintz LB, O'Halloran MS. The Eating Attitudes Test: validation with DSM-IV eating disorder criteria. J Pers Assess 2000; 74:489.

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SCOFF Questionnaire

1. Do you make yourself *sick* because you feel uncomfortably full?
2. Do you worry you have lost *control* over how much you eat?
3. Have you recently lost >*1 stone* (14 lbs) in a 3 month period?
4. Do you believe yourself to be *fat* when others say you are thin?
5. Would you say that *food* dominates your life?

≥2 indicates likelihood of AN or BN

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Eating Disorder Screen for Primary Care (ESP)

- Are you satisfied with your eating patterns? (*No* is abnormal)
- Do you ever eat in secret? (*Yes* is abnormal)
- Does your weight affect the way you feel about yourself? (*Yes* is abnormal)
- Have any members of your family suffered with an eating disorder? (*Yes* is abnormal)
- Do you currently suffer with or have you ever suffered in the past with an eating disorder? (*Yes* is abnormal)
- ≥2 – Abnormal screen

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Physical Exam Findings

- **Anorexia Nervosa**
  - Bradycardia
  - Orthostatic
  - Hypothermia
  - Murmur (1/3 with MVP)
  - Sunken cheeks
  - Lanugo
  - Atrophic breast/ vagina
  - Pitting Edema
  - Emaciated
  - Flat Affect
  - Cold Extremities, acrocyanosis
  - Oversized clothes

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Cachectic Appearance

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Evaluation

- CBC
- CMP
- TSH
- Calcium
- Magnesium
- Phosphorous
- EKG- significant weight loss, abnormal cardiovascular signs
- Most of the time normal unless severely ill

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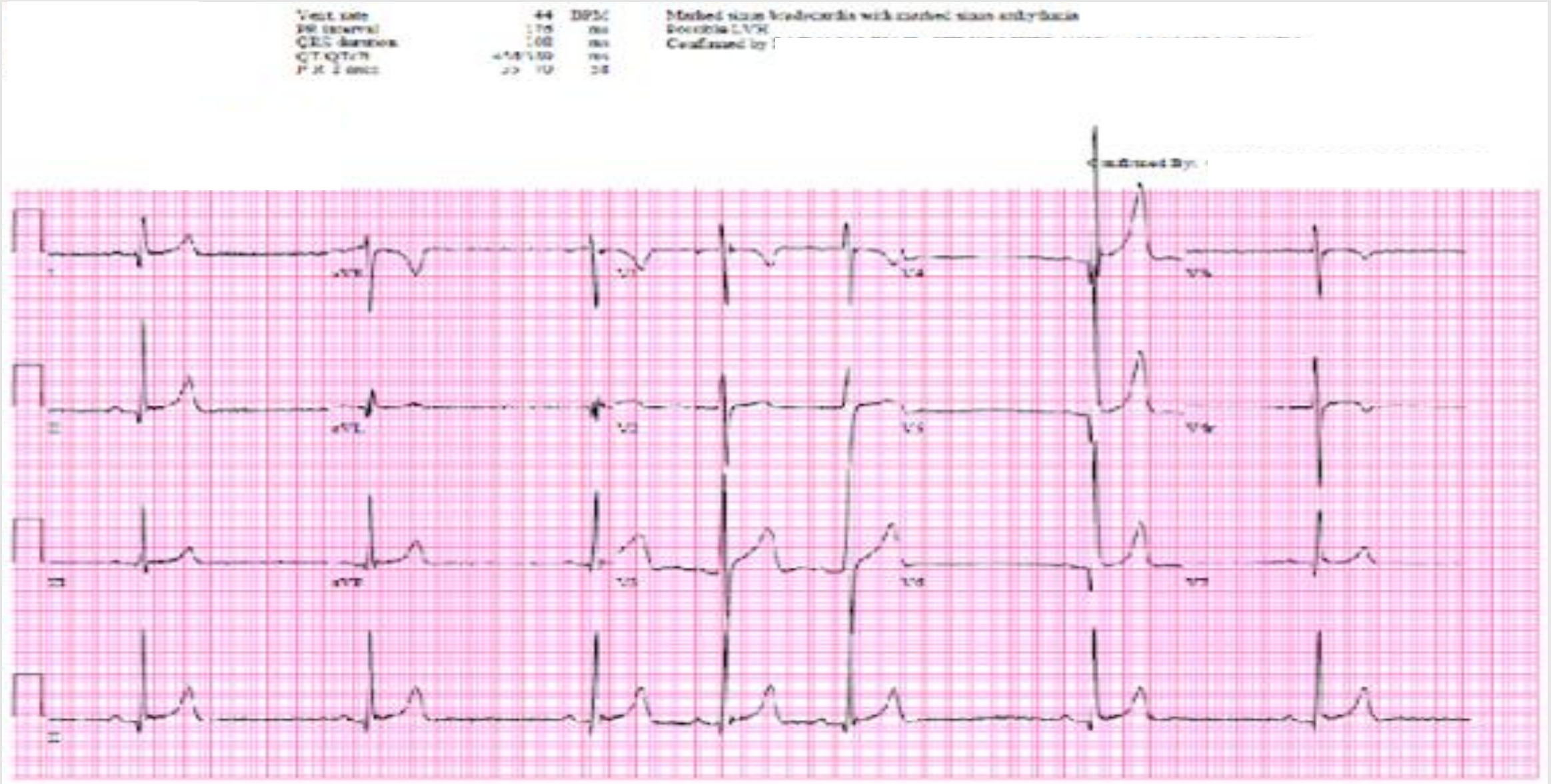

Complications

- Fluids and Electrolytes
  - Hypokalemia, hyponatremia, hyperchloremic alkalosis
- Vomiting- esophagitis, dental erosions, Mallory-Weiss tears
- Amenorrhea
- Cardiovascular- ECG changes, dysrhythmias
- GI- delayed emptying
- Renal- increased BUN
- Hematologic- leukopenia, anemia, thrombocytopenia
- Endocrine- euthyroid sick syndrome, osteopenia, osteoporosis
- Neurologic- cortical atrophy

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Criteria for Hospitalization

- Medical instability (eg, bradycardia near 40 beats per minute; blood pressure <80/50 mmHg; dehydration; or compromised cardiac, hepatic, or renal functioning)
- Weight <85 percent normal body weight, or rapid weight decline with food refusal despite outpatient treatment or partial hospitalization
- Suicidal ideation with high lethality plan or suicide attempt
- Poor motivation that necessitates supervision with meals, or cooperation with treatment that is contingent upon a highly structured environment
- Comorbid psychiatric conditions (eg, depressive, substance use, or anxiety disorders) that require hospitalization

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TABLE 6 Indications Supporting Hospitalization in an Adolescent With an Eating Disorder

One or More of the Following Justify Hospitalization
1. ≤75% median BMI for age and sex (percent median BMI calculated as patient BMI/50th percentile BMI for age and sex in reference population × 100)
2. Dehydration
3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia)
4. ECG abnormalities (eg, prolonged QTc or severe bradycardia)
5. Physiologic instability:
a. Severe bradycardia (HR <50 beats per min daytime; <45 beats per min at night);
b. Hypotension (90/45 mm Hg);
c. Hypothermia (body temperature <96°F, 35.6°C);
d. Orthostatic increase in pulse (>20 beats per min) or decrease in BP (>20 mm Hg systolic or >10 mm Hg diastolic)
6. Arrested growth and development
7. Failure of outpatient treatment
8. Acute food refusal
9. Uncontrollable binge eating and purging
10. Acute medical complications of malnutrition (eg, syncope, seizures, cardiac failure, pancreatitis and so forth)
11. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (eg, severe depression, suicidal ideation, obsessive-compulsive disorder, type 1 diabetes mellitus)

Reprinted with permission from the Society for Adolescent Health and Medicine.[85] ECG, electrocardiogram.

Identification and Management of Eating Disorders in Children and Adolescents (silverchair.com)

Medical Complications- Anorexia Nervosa

Medical complications of anorexia nervosa

Constitution/whole body
Cachexia and low body mass index
Arrested growth
Hypothermia
Cardiovascular
Myocardial atrophy
Mitral valve prolapse
Pericardial effusion
Bradycardia
Arrhythmia, which may cause sudden death
Electrocardiogram (ECG) changes
Increased PR interval
First-degree heart block
ST-T wave abnormalities
Hypotension
Acrocyanosis
Gynecologic and reproductive
Amenorrhea
Unplanned pregnancy and neonatal complications
Endocrine
Osteoporosis and pathologic stress fractures
Euthyroid sick syndrome
Hypercortisolemia
Hypoglycemia
Neurogenic diabetes insipidus
Poor diabetes control

Gastrointestinal
Gastroparesis (delayed gastric emptying)
Constipation
Gastric dilatation
Increased colonic transit time
Hepatitis
Superior mesenteric artery syndrome
Diarrhea
Renal and electrolytes
Decreased glomerular filtration rate
Renal calculi
Impaired concentration of urine
Dehydration
Hypokalemia
Hypomagnesemia
Hypovolemic nephropathy
Pulmonary
Pulmonary muscle wasting
Decreased pulmonary capacity
Respiratory failure
Spontaneous pneumothorax and pneumomediastinum
Enlargement of peripheral lung units without alveolar septa destruction
Hematologic
Anemia (normocytic, microcytic, or macrocytic)
Leukopenia

Neurologic
Cerebral atrophy (decreased gray and white matter)
Enlarged ventricles

://www.uptodate.com/contents/image/print?imageKey=PSYCH%2F67080&topicKey=14705&search=eating disorders&source=GraphicModalSid

4/23, 11:14 AM Medical complications of anorexia nervosa - UpToDate

Cognitive impairment
Peripheral neuropathy
Seizures
Dermatologic
Xerosis (dry skin)
Lanugo hair (fine, downy, dark hair)
Telogen effluvium (hair loss)
Carotenoderma (yellowing)
Scars from self-injurious behavior (cuts and burns)
Muscular
Muscle wasting
Vitamin deficiencies
Refeeding syndrome

Graphic 67080 Version 4.0

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Outpatient Management

- Close follow-up
- Same scales, gown, post void
- Multidisciplinary
- DEXA scan
- Consider depending on how long they are amenorrhoeic- 6- 12 months
- Hormonal therapy- controversial
- Will see in all subspecialties

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Outpatient Issues

- Can they go to school?
- If at school – No gym??
- Who monitors their meals?
- Do they take the elevator?
- You can work closely with the school

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Treatment

- Multidisciplinary- *TIME, TIME, TIME*
- Medical provider, nutritionist, mental health
- Family/Cognitive Behavioral Therapy
- Nutritionist
- “Food is the medicine that is required for recovery”… Stepwise up to 3 meals and 2-3 snacks

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Treatment

- Oral refeeding in preferred
- Generally 1200- 1600 calories, increase to 2000- 3000 kCal or more a day
- Goal 0.25- 1 kg of week gain per week

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Pharmacotherapy

- No FDA approved to treatment of AN
- Treatment may be targeted to the Anxiety, Depression, OCD comorbidities
- SSRIs- often used because of safety profile

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Pharmacotherapy- AN

- Olanzapine (Zyprexa®)- 2.5 -10 mg per day
- Have some dopaminergic and serotonergic receptors and reduce anxiety, agitation, depression, obsessional thinking
- Comorbid Depression- SSRI

  Avoid Tricyclics
- Olanzapine (Zyprexa®), Quetiapine (Seroquel ®), Risperidone (Risperdal®)
  - Some promise in decreasing agitation, obsession, depression, aggression
  - Not much increase in weight

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Prevention

- Promote healthy development
- Knowledge of Eating Disorders
- Idealization of Thinness
- Promote Body Satisfaction
- What Messages are you sending?
- Understanding the many complex issues that cause eating disorders

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Being Aware

- Most people with eating disorders aren't going to come up and say …"I excuse me, I have an eating disorder"

References

American Psychiatric Association

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Questions?

Thank you for joining us!

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