How to Treat Eating Disorders in an Outpatient Setting
Presenters~

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Welcome and Introductions

Brief Overview of Eating Disorders and Differentiating

Adaptive Functions of Eating disorders

Assessment Tools- ED-Q, Binge Eating Questionnaire, Athlete Questionnaire

Statistics
Nutrition

Use of Medication in treating eating disorders/ zinc and other supplement use

Treatment Modalities/Working with a multi-disciplinary team

When to refer to a higher level of care (NEDA Handout)

Strategies to bring back to the office (Video/Personal Stories/Testimonies)

Group Discussions-Case studies (diagnosis and how would you treat that client)

Importance of seeking help, who are my resources?

Summary-Wrap up; Questions, Resources, Handouts (online) Evaluations
When and Who is referring to us?

- Following Treatment; Inpatient, PHP, IOP, Residential
- Schools
- Primary Care Physicians
- Coaches, Athletic Trainers
- Registered Dietitians
- Insurance Companies
- Other therapists who don’t specialize in ED
What are eating disorders?

Eating disorders can develop during any stage in life but typically appear during the teen years or young adulthood. Classified as a medical illness, appropriate treatment can be highly effectual for many of the specific types of eating disorders. Although these conditions are treatable, the symptoms and consequences can be detrimental and deadly if not addressed. Eating disorders commonly coexist with other conditions, such as anxiety disorders, substance abuse, or depression.
Adaptive Functions of Eating Disorders

- Comfort, soothing, nurturance
- Numbing, sedation, distraction
- Attention, cry for help
- Discharge tension, anger, rebellion
- Predictability, structure, identity
- Self-punishment or punishment of “the body”
- Cleanse or purify self
- Create small or large body for protection/safety
- Avoidance of intimacy
A. Restriction of energy intake leading to the person being significantly under body weight.
B. Intense fear of gaining weight, behavior interferes with gaining weight.
C. Body Image disturbance, often highly influence self evaluation, denial of severity of illness.
D. Two Types; Restricting and Binge Eating/Purging Type

**Specify whether:**
ICD-10 (F50.01) Restricting Type
ICD-10 (F50.02) Binge-Eating/Purging Type
Partial Remission or Full Remission
Current Severity; Mild, Moderate, Severe, Extreme - this is based on Body Mass Index
Health Consequences of Anorexia

- Abnormally slow heart rate and low blood pressure, which means that the heart muscle is changing. The risk for heart failure rises as the heart rate and blood pressure levels sink lower and lower.

- Reduction of bone density (osteoporosis), which results in dry, brittle bones.

- Muscle loss and weakness.

- Severe dehydration, which can result in kidney failure.

- Fainting, fatigue, and overall weakness.

- Dry hair and skin; hair loss is common.

- Growth of a downy layer of hair called lanugo all over the body, including the face, in an effort to keep the body warm.
Bulimia Nervosa (BN)
DSM 5 307.51: ICD 10 F50.2

- Recurrent binge episodes (consumption of large amounts of food with loss of control)
- Recurrent use of inappropriate behaviors to prevent weight gain (vomiting, laxatives, exercise, diet pills, diuretics)
- Both bingeing and purging behaviors occur, on average, at least once/week for 3 months.
- Self-evaluation unduly influenced by weight/shape.
- Does not meet criteria for Anorexia.

Specify if: In partial remission or full remission

Specify current Severity: Severity is based on the frequency of inappropriate compensatory behaviors; Mild, Moderate, Severe, and Extreme.
Health Consequences of Bulimia Nervosa

- Potential for gastric rupture during periods of bingeing.
- Electrolyte imbalances that can lead to irregular heartbeats and possibly heart failure and death. Electrolyte imbalance is caused by dehydration and loss of potassium, sodium and chloride from the body as a result of purging behaviors.
- Inflammation and possible rupture of the esophagus from frequent vomiting.
- Tooth decay and staining from stomach acids released during frequent vomiting.
- Chronic irregular bowel movements and constipation as a result of laxative abuse.
- Peptic ulcers and pancreatitis.
Recurring episodes of eating large amounts of food, more than most people would eat in a similar circumstances in a short period of time.

Feelings of loss of control during binge episodes, as well as marked distress.

Binge episodes occur, on average, at least once/week for 3 month.
Most overweight individuals do not have binge eating disorder. However, of individuals with Binge Eating Disorder up to two-thirds are obese; people who struggle with binge eating disorder tend to be of normal or heavier-than-average weight.

- Health Risks for Binge eating disorder are most commonly those associated with clinical obesity. Some of the potential health consequences of binge eating disorder include:
  - High blood pressure
  - High cholesterol levels
  - Heart disease
  - Type II diabetes
  - Gallbladder disease
Fatigue

Joint pain

Sleep apnea

Psychological Effects

People struggling with binge eating disorder often express distress, shame, and guilt over their eating behaviors.

People with binge eating disorder report a lower quality of life than those without binge eating disorder.

Binge eating disorder is often associated with symptoms of depression.

Compared with normal weight or obese control groups, people with BED have higher levels of anxiety and both current and lifetime major depression.
This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important area’s of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorder diagnostic class.

- **Atypical Anorexia Nervosa**: meets all the criteria except weight category. Even though client has loss significant weight they still remain in within or above the normal range.

- **Bulimia Nervosa**: low frequency and/or limited duration.

- **Binge-Eating Disorder**: low frequency and/or limited duration.

- **Purging Disorder**: Recurrent purging behavior to influence weight or shape in the absence of binge-eating.
Orthorexia Nervosa

When “Healthy” becomes Obsession

www.LiberNetwork.com
Orthorexia nervosa is not currently recognized as a clinical diagnosis in the DSM-5, but many people struggle with symptoms associated with this term.

➢ Those who have an “unhealthy obsession” with otherwise healthy eating may be suffering from “orthorexia nervosa,” a term which literally means “fixation on righteous eating.”

➢ Orthorexia starts out as an innocent attempt to eat more healthfully, but orthorexics become fixated on food quality and purity.

➢ Every day is a chance to eat right, be “good,” rise above others in dietary prowess, and self-punish if temptation wins (usually through stricter eating, fasts and exercise). Self-esteem becomes wrapped up in the purity of orthorexics’ diet and they sometimes feel superior to others, especially in regard to food intake.

➢ Eventually food choices become so restrictive, in both variety and calories, that health suffers – an ironic twist for a person so completely dedicated to healthy eating. Eventually, the obsession with healthy eating can crowd out other activities and interests, impair relationships, and become physically dangerous.
Other disordered ways of eating

Chew and Spit: Exactly what it says.

Health consequences:

- **Mouth Ulcer’s** – while your chewing your body is producing acid this in turn produces mouth ulcers & trust me they hurt.

- **Swollen Glands** – from the spitting, looking like a chipmunk-

- **Rotting teeth** – due to acid and sugary foods leading to cavities, cracks and tooth rot.

- **Ulcerated stomach** – You may not be ingesting the food but all your sensory’s (see, hear, smell etc) think you are. You are seeing the food, smelling the food, tasting the food, your body produces stomach acid in preparation for the food. One of the most damaging is

- **INSULIN increase** – When you see, smell, taste food it triggers the release of insulin, which is not a good thing. Insulin raises appetite (more chew and spit), makes weight gain easier makes losing weight harder and in worst cases causes diabetes.
**Diabulimia**: is an eating disorder which may affect those with Type 1 Diabetes.

- It is the reduction of insulin intake to lose weight.
- It is considered a dual diagnosis disorder: where one has diabetes as well as an eating disorder.
- Diabulimia is generally associated with use of insulin, an individual with diabetes may also suffer from another eating disorder as well.
**Around Food**

- Dieting
- Avoiding a wide range of foods
- Never available for family meals or avoid
- Avoid eating in public
- New interest in “healthy, low fat, low calorie, or vegetarian diets or preparing new recipes/meals
- Inflexible about what, when, or how much to eat
- Unnatural focus on what others are eating
- Need to know calorie content of all foods
- Secretive or ritualistic eating (i.e. same time every day)
- Anger at others if pressed to eat
- Foods, especially carbohydrates, disappearing quickly from the house (secretive bingeing)
• **Activity:** Exercising intensely without pleasure or needing to compensate for eating.

• **Medically:** Failure to gain weight or height according to growth curve, weight loss at any time during childhood and adolescence.

• **Thinking:** A conviction that one is too large, hyper focus on body parts, body distortion.

• **Socially:** Social withdrawal, social anxiety.
Depression is most common co-occurring disorder with eating disorders.

- 36% in Bulimia Nervosa
- 31% in Binge eating disorder
- 15% in Non-binge eating groups

10-15% of restrictive anorexics have co-occurring OCD

BiPolar-2%-15% of clients with Eating Disorders also meet criteria for BiPolar

Borderline Personality Disorder-63.8% of clients with BPD meet criteria for an Eating Disorder.

- 21.7% specific for Anorexia
- 24.1% specific for Bulimia

30% of people with eating disorders have a trauma history.

AODA- 55% of people with eating disorders met criteria for alcohol abuse.

25% of women with bulimia reported a history of drug abuse.

Greatest co-occurring AODA and eating disorders is bulimia or anorexia with binge-purge subtype.
More important numbers and eating disorders

❖ Nearly one person dies from an eating disorder every 60 minutes.
❖ More than 30 million people in the US will suffer from an eating disorder.
❖ 13% of women over the age of 50 have an eating disorder.
✓ Eating Disorders have the highest rate of mortality of any other mental illness.
✓ Our teens are suffering; anorexia is the third most chronic illness among adolescents after asthma and obesity.
✓ Over 70% will not seek treatment due to stigma, misperceptions, lack of education, diagnosis, and access to care.
✓ Eating Disorders don’t just impact women. 10 million men in the US will face an eating disorder in their lifetime.
✓ Up to 80% of patients who seek and receive treatment will recover or go into remission.
✓ The majority of eating disorders begin between the ages of 18 and 25.
• 10% of diagnosed eating disorders are male
• Boys are 3x more likely to be trying to gain weight than females
• 41% of men are dissatisfied with their weight, whereas 55% of women are unhappy
• Men are more likely to over-exercise than purge

**Muscle dysmorphia** (also known as "megarexia", "bigorexia", or "reverse anorexia nervosa") is a disorder that is characterized by a fear of being too small, and perceiving oneself as small and weak even when one is actually large and muscular. The main characteristic of bigorexia is the thought that no matter how hard you try your body is never muscular enough. New research shows that muscle dysmorphia affects 1 in 10 gym going males.

• Bigoxeria-body builder- Preoccupation is more *shaped* based than *weight* based.
Dual Diagnosis and Co-Occurring Disorders

- Depression
- Anxiety
- Substance Abuse
- OCD
- Bipolar Disorder
- Post Traumatic Stress Disorder
- Self Injury
- Borderline Personality Disorder
The Female Athlete Triad (the Triad), is a term coined in 1993 by the American College of Sports Medicine. Refers to a syndrome commonly seen in athletic women.

- It involves the interrelated symptoms of (1) disordered eating, (2) menstrual irregularity, and (3) low bone mass.
How do you detect the Triad?

- **Low bone mass** may manifest as stress fractures or full fractures (e.g., in a long bone such as the tibia or fibula or as a compression fracture in the spine). Low bone density can be detected by a dual x-ray absorptiometry (DXA) scan.

- **Disordered Eating**: Anorexia Nervosa, Bulimia Nervosa, Binge Eating, Orthorexia. Commonly we see athletes with Anorexia or Bulimia.

- **Menstrual irregularity**: Missed cycles in athletes are not always an indication of the Triad, so it is important to have the athlete evaluated by a doctor for other medical problems that may cause amenorrhea (e.g., polycystic ovarian syndrome, other related women's issues, or a pituitary tumor).
Nutrition
Importance of educating clients on nutrition

- Registered Dietitians RD are and should be a part of your multidisciplinary team.
- Emphasize referring the client to seeing a RD for further nutritional evaluation.
- Some education may need to be done to start the process for a referral.
- Some information may include how calories affect functioning, food suggestions, meal/food record keeping tools, how energy affects performance in athletes/active people, etc..
Where do Calories Go?

- Our body needs a certain number of calories just for vital processes to occur. Whether or not you are moving, your lungs need to pump oxygen, your heart needs to pump blood, your kidneys need to excrete wastes, your liver needs to detoxify, and your brain needs to coordinate all that the body is doing.

- The average resting metabolism (the amount of calories your body needs at rest) varies, and is based on your sex, height, weight, and muscle mass. Example; A 5’2” 19 year old woman weighing 100 pounds still needs 1200 calories just to sit around all day and do nothing.
Where do calories go?

- Heart - 12% or 144 calories
- Kidney - 12% or 144 calories
- Liver - 23% or 276 calories
- Brain - 23% or 276 calories
- Skeletal Muscle - 30% or 360 calories
Treatment Approaches to Treating Eating Disorders

- Cognitive Behavior Therapy (CBT)
- Exposure Response Prevention (ERP)
- Dialectical Behavior Therapy (DBT)
- Harm Reduction
- Mindfulness
- Maudsley Model
- Group Therapy

Treatment Team approach; outpatient therapist, psychiatrist, registered dietician, school support, primary care physician (PCP), family (at times).
• **Cognitive-behavioral therapy** is based on the idea that our *thoughts* cause our feelings and behaviors, not external things, like people, situations, and events.

• Cognitive-behavioral therapy is considered among the most rapid in terms of results obtained. CBT is time-limited in that we help clients understand at the very beginning of the therapy process that there will be a point when the formal therapy will end.

• Clients need to be medically stable to be able to apply cognitive strategies.

• **Strategies:** Affirmations, Adjusting Rules, Spot the Thought, Beliefs-Think-Feel-Act
What are some of the main cognitions/behaviors we are targeting?

- Compulsive Exercising
- Overeating/Binge Behavior
- Perfectionism
- Body Image Disturbances
- Binge/Purge Cycles
- Restricting, calorie counting
- Monitoring numbers (scale, waist measurements, sit ups etc..)
- **Dialectical behavior therapy** (DBT) is a therapy designed to help people change patterns of behavior that are not helpful, such as self harm, suicidal thinking, and substance abuse. This approach works towards helping people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helping to assess which coping skills to apply in the sequence of events, thoughts, feelings, and behaviors to help avoid undesired reactions.

- **DBT** is composed of four modules, each with its own goals and skill sets; (1.)Mindfulness, (2)Distress Tolerance, (3)Emotion Regulation, (4)Interpersonal Effectiveness.
4 DBT MODULES

**Mindfulness:** the practice of being fully aware and present in this one moment.

**Distress Tolerance:** how to tolerate pain in difficult situations, not change it.

**Interpersonal Effectiveness:** how to ask for what you want and say no while maintaining self-respect and relationships with others.

**Emotion Regulation:** how to change emotions that you want to change.

**Strategies:** Teaching your client the four different modules through worksheets, at home activities (list of joys/pleasures), mindfulness experiments, and identifying values in one's life.
Exposure and Response Prevention (ERP)

- Exposure therapy is a method in behavior therapy purposed for treating anxiety disorders.
- Objective is to expose the individual to the situation that is provoking the anxiety.
- Focus is to desensitize one to their fears and distresses.
- Hierarchy

- ERP has proven to be a useful tool in \textit{treating eating disorders and anxiety} together.
- Strategy; developing a hierarchy, food exposures in the office, setting up social challenges outside the office.
The Maudsley Method, also known as Family-Based Treatment, can be characterized by an intensive outpatient treatment where parents are integrated as an active and positive role. The primary purposes of including parents in this approach are to incorporate and encourage participation in their child’s recovery journey.

- Originally designed to treat adolescent girls with anorexia however now targets other disorders/groups including bulimia, binge eating, childhood obesity, adolescents, and older adults.
- Main focus in applying this method is to have family/loved one involvement.
Phases of the Maudsley Method

**Phase I – Weight Restoration:** In Phase I, a professionally trained therapist concentrates on the various effects associated with anorexia nervosa, particularly physiological, cognitive, and emotional. A major focus of this phase is the restoration of the patient’s weight and the “re-feeding” component. A crucial psychological feature of this primary phase is substantiating the illness.

**Phase II – Returning control over eating to the adolescent:** Phase II encompasses the patient learning to progressively regain control over their individual eating habits again. This typically commences when the patient’s weight has reached approximately 87% of their ideal body weight.

**Phase III – Establishing healthy identity:** This phase is initiated when the patient is sufficiently able to sustain their weight above 95% of ideal body weight independently and refrains from engaging in restrictive eating behaviors. Focuses of treatments are primarily on the psychological consequences the eating disorder has had on the patient and the establishment of a healthier identity.

Most effective for individuals who have been struggling with an eating disorder for less than three years.
Group Therapy Techniques

- Recovery Boards (Collaging- what does recovery mean to you)
- Role Playing (separating self from ED, empty chair activity)
- Body Image - 30 day challenge
- Body Scan’s- Mindfulness activity
- Sharing your “Silliness” Ball activity
- What do you see in me? (index card activity)
- What’s on your playlist? Find a song that defines where you are in your eating disorder.
- DBT skills/challenges - Behavior Chain Analysis
• Therapists cannot prescribe but we can educate, consult, and assess need for medication.

• **Antidepressants (mainly SSRI’s) are most common** and helpful in targeting both mood and behavior. Commonly prescribed are Zoloft, Prozac, Paxil, Lexapro.

• **Vyvanse is the first FDA-approved drug** to treat binge eating disorder in adults. It's also used to treat ADHD. It is not clear how the drug works in binge eating, but it’s thought to control the impulsive behavior that can lead to bingeing. In studies, patients who took the medicine had fewer episodes of binge eating.
Treatment Team

- Therapist
- Psychiatrist
- Primary Care Physician
- Registered Dietician/Nutritionist
- Family/Loved Ones
- Group work
When is a higher level of care necessary in treating eating disorders?

• No change or an increase use of compensatory behaviors; increase exercise, purging, binging, diet pills, laxative use, diuretics.
• Rise in anxiety, depression, thoughts or plans of suicide.
• Rapid weight loss or gain
• Lab work- not always reflective of compromised health
• Handout- Different levels of care (NEDA)
Recommended Readings/Websites

READINGS

❖ “Goodbye Ed, Hello me” Author: Jenni Schaefer
❖ “Life Without ED” Author: Jenni Schaefer
❖ “8 Keys to Recovery from an Eating Disorder” Author: Carolyn Costin & Gwen Schubert Grabb
❖ “Your Dieting Daughter” Author: Carolyn Costin
❖ “Reclaiming Yourself from Binge Eating” Author: Leora Fulvio
❖ “Binge Control” Author: Cynthia M. Bulik, Ph.D
❖ “PR: A Personal Record of Running from Anorexia” Author: Amber Sayer
❖ “Eat What You Love, Love What You Eat For Binge Eating” Author: Michelle May, MD
❖ “Healing Eating Disorders with Psychodrama and Other Action Methods” Authors: Karen Carnabucci and Linda Ciotola
Websites

• National Association of Anorexia Nervosa and Associated Disorders  www.anad.org

• National Eating Disorder Association  www.nationaleatingdisorders.org

• Binge Eating Disorder  www.BingeEatingDisorder.com

• Resources & Information  www.EatingDisordersOnline.com

• Eating Disorder HOPE  www.eatingdisorderhope.com

• Eating Disorder Information and Referral Center  www.edreferral.com

• Female Athlete Triad Coalition  www.femaleathletetriad.org

• Am I Hungry  www.AmIHungry.com

• Maudsley Parents  www.maudsleyparents.org
Carolyn Costin’s
Definition of Recovered

~When you can accept your natural body size and no longer have a self-destructive or unnatural relationship with food or exercise. When food and weight take a proper perspective in your life, and what you weigh is not more important than who you are; in fact, actual numbers are of little or no importance at all. When you will not compromise your health or betray your soul to look a certain way, wear a certain size, or reach a certain number on a scale. When you do not use eating disorder behaviors to deal with, distract from, or cope with other problems.~
It’s a disorder not a decision.

Hope Organization; EatingDisorderHope.com

National Eating Disorder Association www.nationaleatingdisorders.org

Anorexia Nervosa and other Associated Disorders www.anad.org

Quast, R; SHED Productions 9 Steps To eating Disorder Recovery Groups

Carnabucci, K; Ciotola, L (2013). Eating Disorders with Psychodrama and Other Action Methods


Statistics data collected by Seda Ebrahimi, Ph.D; Director of Cambridge Eating Disorder Center www.eatingdisordercenter.org
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Thank You for joining us Today!