Eating Disorders 101

Core Skills and Competencies for Clinicians

Hello! I'm...

Caroline Whitaker

(she/her/hers)

I am the former Program Therapist and Director of Alumni Programming at Focus Integrative Centers, an ED IOP program in Knoxville, TN. In the seven years that I spent at Focus, I was responsible for conducting diagnostic assessments and biopsychosocial evaluations, creating and updating treatment plans, facilitating both individual and group therapy, coordinating level of care transitions, providing psychoeducation and community outreach, and managing the alumni/aftercare program for patients with eating disorders across Tennessee.

Objectives

1. Differentiate between the major eating disorder diagnoses using DSM-5 criteria.
2. Recognize common physical, psychological, and behavioral symptoms of eating disorders.
3. Identify the unique challenges that are inherent in working with disordered eating.
4. Gain a greater understanding of evidence-based skills and interventions that facilitate recovery from eating disorders.

Agenda

1 Get to Know ED

2 Treatment Process

3 Skills and Interventions

4 Discussion

01

Get to know ED

ED Statistics*

- At least 30 million people in the United States (about 10% of the US population) will meet clinical criteria for an eating disorder diagnosis at some point in their lifetime.
- Cisgender females comprise 85-90% of people seeking treatment for an eating disorders, while cisgender males comprise 10-15% of treatment-seekers.
- As many as 15% of people who identify as trans- or non-binary report that they have been diagnosed with an eating disorder.
- People belonging to non-heterosexual groups have a higher prevalence of eating disorders (7-9% of the LGB+ population).

- BIPOC are significantly less likely than white people to have been asked by a doctor about eating disorder symptoms, and are half as likely to be diagnosed or to receive treatment.
- Less than 6% of people with eating disorders are medically diagnosed as “underweight.”
- Eating disorders have the second-highest mortality rate of any mental disorder (behind opioid addiction), and is further complicated by the chronic nature of the disease and co-occurring mental health concerns.

Anorexia Nervosa

- 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.
- Intense fear of gaining weight or of becoming fat, and persistent behavior that interferes with weight gain, even though at a significantly 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; and persistent lack of recognition of the seriousness of the current low body weight.
- Two Subtypes:
  - Restricting Type
  - Binge/Purge Type

Levels of Severity (based on BMI):

Mild (≥17)
Moderate (16-16.99)
Severe (15-15.99)
Extreme (≤15)

Bulimia Nervosa

- Recurring episodes of binge eating (i.e., eating large amounts of food in a short period of time that exceed what most people would eat in similar circumstances, and/or experiencing a lack of control over eating during the episode).
- Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, enemas, diuretics, or other medications; fasting; or excessive exercise.
- Disturbance in the way in which one's body weight or shape is experienced; undue influence of body weight or shape on self-evaluation.
- Frequency criteria: The binge eating AND inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

Levels of severity:

Mild: *1-3 episodes* of inappropriate compensatory behaviors per week
Moderate: *4-7 episodes* of inappropriate compensatory behaviors per week
Severe: *8-13 episodes* of inappropriate compensatory behaviors per week
Extreme: *14+ episodes* of inappropriate compensatory behaviors per week

Binge Eating Disorder

- Recurring episodes of binge eating (i.e., eating large amounts of food in a short period of time that exceed what most people would eat in similar circumstances).
- Sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating); Eating beyond fullness, eating to the point of feeling physically ill, eating when not feeling physically hungry.
- The individual experiences intense shame or guilt around eating behaviors.
- May manifest via secretive behaviors, I.e., attempts to hide evidence of binges, hiding evidence of eating/hiding while eating.
- Frequency criteria: The binge eating AND inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

Avoidant-Restrictive Food Intake Disorder (ARFID)

- There is a disturbance in feeding/eating characterized by apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating.
- Persistent failure to meet appropriate nutritional and/or energy needs, as evidenced by one (or more) of the following: significant weight loss, nutritional deficiency, dependency on nutritional supplements, or interference in psychosocial functioning.
- No apparent body image concerns; there is no evidence of a disturbance in the way in which one's body weight or shape is experienced, and the individual's eating behaviors are not oriented towards changing their shape, weight, or appearance.
- Not attributable to/better explained by: lack of available food; associated culturally sanctioned practice; concurrent medical condition; another mental disorder.

Other-Specified Feeding and Eating Disorder (OSFED)

- This diagnosis includes clients who are experiencing ED symptoms that are clinically significant and causing distress and/or disruption to daily functioning, but may not fit perfectly within the specific diagnostic criteria of aforementioned diagnoses (e.g., Atypical Anorexia, Bulimia or BED with limited frequency, etc.).

- It is suggested that at least 33% of ED sufferers qualify for an OSFED diagnosis.

- Persons at the "subclinical" level of diagnosis are not safe from the effects of an eating disorder; in fact, they may be at higher risk of mortality or other medical complications due to not receiving timely, adequate treatment.

<u>Other ED concerns without formal diagnoses, but worth clinical consideration:</u>

- Orthorexia
- Diabulimia
- Drunkorexia
- Bigorexia

Physical Symptoms

- Dizziness, lightheadedness, feeling faint
- Loss of consciousness
- Cold intolerance
- Hair loss, brittle hair and/or nails
- Pale, dry, discolored skin and/or nails
- Lanugo – fine, downy fuzz on chest, stomach, back
- Yellowing or chipping of teeth; can later escalate into tooth decay
- Throat pain, bleeding
- Russell's Sign
- Changes in heart rate and blood pressure
- Osteoporosis, Osteopenia
- Changes in weight – noticeable gain, loss, failure to meet growth trajectories
- Abdominal pain
- Changes in GI functioning: constipation, diarrhea, acid reflux
- Bloating and/or swelling of extremities, parotid glands
- Weakness, fatigue
- Changes in sleep patterns
- Headaches, dehydration
- Easy bruising, brittle bones, wounds heal more slowly
- Changes in menstrual cycle, or amenorrhea

Psychological Symptoms

- Difficulty concentrating; brain fog; poor memory
- Undue influence of body image in overall evaluation of self-worth
- Feeling shame in relationship to their body, eating habits
- Distortion of body image, associated with anxiety about their body
- Intense fear of weight gain
- Internalized messages of "thin ideal".
- May minimize or repress feelings, OR may become increasingly agitated, defensive, prone to snapping
- High comorbidity of mental disorders, especially depression, anxiety, OCD, PTSD, and other addictions
- Comorbid trauma history
- Suicidal ideation
- Feelings of hopelessness
- Feelings of self-hatred
- Extreme, rigid thought patterns; perfectionism
- Impulsivity and/or compulsivity

Behavioral Symptoms

- Social withdrawal/social changes
- Changes in academic or extracurricular performance, motivation
- Constantly comparing body size to others; frequent reassurance seeking
- Excessive weighing
- Preoccupation with body reflection in mirrors/windows; preoccupation with "checking" their body (e.g., measuring wrist size, pinching parts of body, etc.)
- General changes in meal patterns: skipping meals, reducing portion sizes; increasing portion sizes, increasing frequency of meals/snacking, or constant grazing
- Using food (or lack thereof) to cope with stressors
- Compensatory behaviors – purging via vomiting, laxative abuse, compulsive exercising, etc.
- Spending much more time in the bathroom, especially around mealtimes (purging, binging)
- Hiding and hoarding food
- Cutting food into tiny pieces and moving it around the plate
- Excusing self from the table at mealtime, not eating in front of others
- Lying about having eaten; throwing or giving food away
- Eating the same foods every day, rigid food rituals, sudden dietary changes
- Excessive water or diet soda intake
- Refusal to maintain weight; extreme weight changes
- Obsessing about food
- Deception, lying, manipulative behavior to hide eating disorder

Disordered vs *Disordered*™

At one time or another, most people will experience some kind of disruption to their typical eating patterns, or "disordered" eating. These symptoms in isolation may not suggest an eating disorder – they may even be developmentally normal or culturally sanctioned. It is worth keeping an eye on these behaviors, however, due to the possibility of escalation into an eating disorder.

What might cause normal behaviors to evolve into abnormal behaviors?

Examples of disordered eating may include:

- Changes in appetite due to depression, grief, anxiety about upcoming situation
- Being a "picky eater"
- Irregular feeding schedules
- Religious practices
- Poor nutrition due to lack of access to resources
- "Fad" diets
- Hoarding food
- Stuffing

Etiology of ED

Psychodevelopmental Factors

- Puberty; changes in body's functions, appearance
- Developing personal identity; reconciling questions of gender, sexuality
- Life transitions; learning to deal with stress, new responsibilities, new environments
- Finding one's place in the world; finding meaning, worth, belonging.

Sociocultural Factors

- Peers and social groups
- Media
- Family values, lifestyle
- What is celebrated, what is rejected, what is modeled?
- Who holds privilege? Who is systematically disadvantaged?
- Environmental influences
- Cultural values (micro and macro)
- Trauma/abuse

Biological/Epigenetic Factors

- Brain chemistry
- DNA/genetics
- Personality/temperament

"Genetics load the gun, environment pulls the trigger"

Risk Factors for ED Development:

- Cultural norms that emphasize thinness, self-control, minimization of feelings, harsh criticism or judgment for body appearance and/or food choices
- Having a predisposition for anxiety, depression, other mental health conditions
- Having a family history of eating disorders
- Chronic stress
- Weight stigma
- Belonging to a marginalized group
- Experiencing bullying
- Social isolation, lacking belonging to social groups
- Athletes, especially in aesthetic sports or sports with an emphasis on weight monitoring and/or appearance
- Rigid thought patterns associated with perfectionism
- Low self-esteem
- Trauma, abuse, and/or neglect
- Diets

For Homework!

"Eating Disorders from the Inside Out"
- TED Talk by Dr. Laura Hill

Internationally-renowned ED researcher and treatment provider, Dr. Laura Hill, offers a thorough explanation of the neurobiology that underlies eating pathology and the recovery process.

"Eating Disorders from the Inside Out"
Dr. Laura Hill

Dorsolateral Prefrontal Cortex:
Executive functions, emotional regulation, pain perception, motivation, risk assessment

Ventrolateral Prefrontal Cortex:
Cognitive control, integration of sensory and motivational information, social and emotional processing, motor inhibition, language processing

Insula:
Self-awareness, sensory processing, emotional processing, pleasure seeking, autonomic function, cognitive function, social interaction

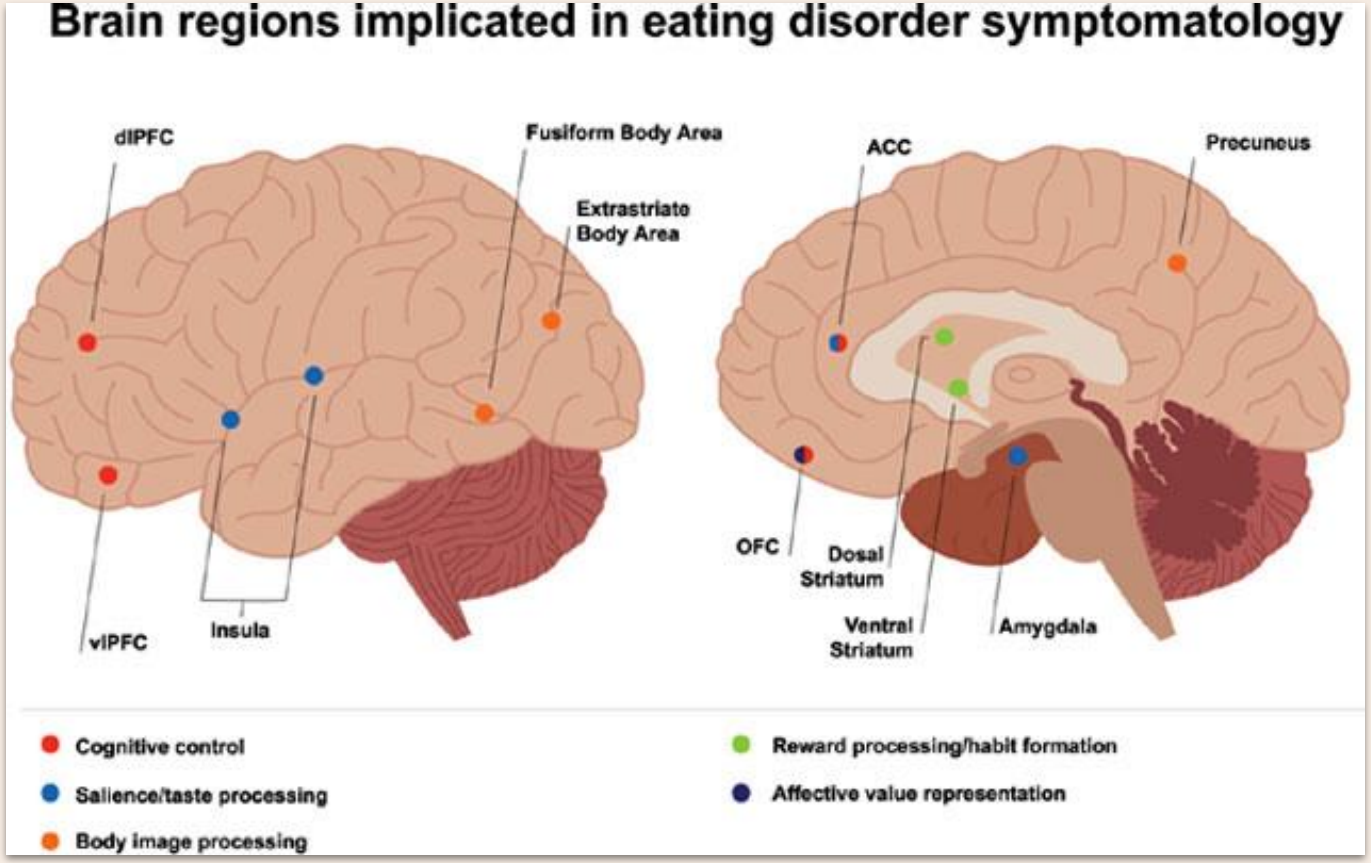
Fusiform Body Area:
Visual processing, object representation and differentiation (especially related to parts of the human body)

Extrastriate Body Area:
Body perception of self and others, action perception, distinction between self/others

Orbitofrontal Cortex:
Reward processing, decision-making, emotional regulation, social cognition, and sensory integration

Anterior Cingulate Cortex:
Executive functions, emotion regulation, pain processing, motor modulation, social cognition

Dorsal Striatum:
Motor control, cognitive functions, reward processing, habit formation



Ventral Striatum:
Reward processing, motivation and goal-directed behavior, addiction, social behavior

Amygdala:
Emotional processing, Fight/Flight response coordinator, sensory input

Precuneus:
Episodic memory, spatial navigation, self-awareness and personal identity, voluntary attention shifts, default mode network, mental imagery, and integration of information

Common Co-Occurring Conditions

- Anxiety disorders
  - Generalized Anxiety
  - Obsessive-Compulsive
  - Post-Traumatic Stress Disorder
  - Social Anxiety
- Mood Disorders
  - Major Depression
  - Bipolar I/II
  - Self-harm, Suicidality
- Personality Disorders
- Substance Abuse/Addictions
  - Drug/Alcohol
  - Sex Addiction
  - Shopping addiction/Shoplifting
- Neurodiversity*
- LGBTQIA*

02

The Treatment Process

What does a Treatment Team Look Like?

It takes a full team of people to tackle recovery!

- ED-Specialized Dietitian/Nutritionist: In addition to their medical and scientific training, they are also better equipped to provide the emotional and psychological support for ED recovery.
- Mental Health Professionals: This can include an individual therapist, family therapist, group therapist, trauma therapist, experiential therapist (art, dance, equine, etc.).
- Medical Providers: Including primary care physicians, medication management providers.
- Family and Social Support
- Environmental Support: Is the client's environment able to provide the safety and stability needed for recovery? Are there any obstacles to fair and equitable treatment?

Levels of Care

in Eating Disorder Treatment

INPATIENT

Medical problems requiring 24 hour monitoring
Psychiatric issues requiring 24 hour care
Need for highly consistent, controlled environment
Allow for nasogastric feeding if needed

RESIDENTIAL

Serious symptoms that persist in partial hospitalization
Lack of effective support at home
Safety issues that require 24 hour care
Difficulty prioritizing recovery in the home environment

PARTIAL HOSPITALIZATION

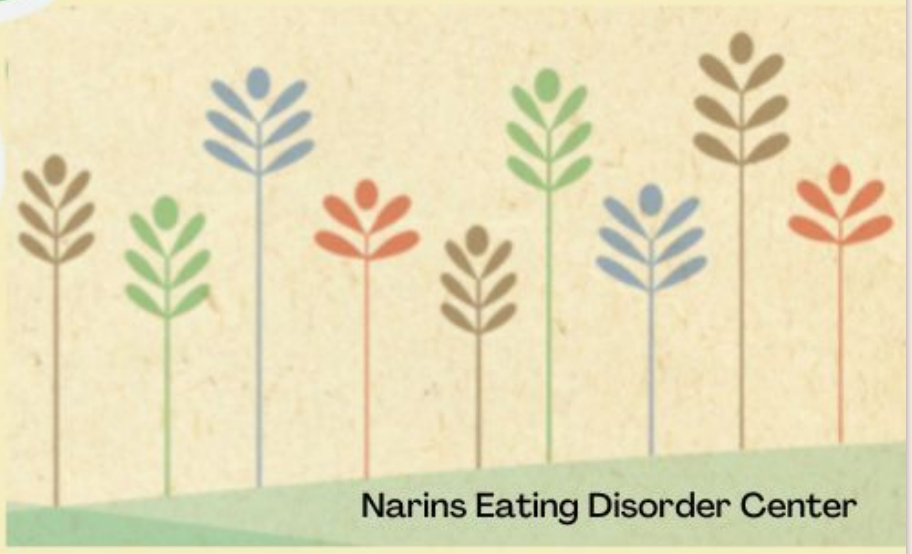
Serious symptoms with some medical risk identified
Lack of sustained progress in outpatient therapy
Difficulty implementing skills between sessions
Need for intensive, multifacted treatment

INTENSIVE OUTPATIENT

Benefit from multiple contacts per week
Longer sessions to allow for multiple interventions
Group sessions for peer support

OUTPATIENT

Mild to moderate symptoms
Able to implement change between visits
Low level of risk
Involves a team approach



10 Phases of Recovery

Established by Carolyn Costin, *8 Keys to Recovery*

1. "I Don't Think I Have a Problem"
2. "I Might Have a Problem, but it's Not That Bad"
3. "I Have a Problem, but I Don't Care"
4. "I Want to Change, but I Don't Know How and I'm Scared"
5. "I Tried to Change, but I Couldn't"
6. "I Can Stop Some of the Behaviors, but Not All of Them"
7. "I Can Stop the Behaviors, but Not My Thoughts"
8. "I am Often Free from Behaviors and Thoughts, but Not All the Time"
9. "I am Free from Behaviors and Thoughts"
10. "I am Recovered"

Remember:
It is normal to cycle through the different phases. It is also normal to make progress, fall back, then move forward again!

When evaluating whether a client needs intervention, ask yourself the following:

A) Is the client experiencing functional impairment as a result of their behaviors or symptoms?

B) Are the client's behaviors causing disruption to their occupational, academic, social, or emotional functioning?

C) Is the client distressed by their behaviors, or are the behaviors such that others in the client's life are concerned about them?

Rule of Thumb

03

Skills for Clinicians

At the core of every eating disorder...

... Is a person doing their best to meet their basic needs. Eating disorders can serve a variety of functions, including (but not limited to):

- Control
- Safety
- Seeking love, attachment, acceptance
- Numbing and/or avoidance
- Emotional release
- Self-medication
- Self-harm

These needs are not unique to ED-sufferers; these needs are common to ALL humans. (Yes, even you.)

Throughout the course of their recovery, your goal is to help your client discover new ways of meeting these basic needs, while encouraging them to be compassionate to themselves for the ways in which they leaned on their ED to survive.

The Log Metaphor
Dr. Anita Johnston

Consider The Context

- 81% of 10 year olds are afraid of being fat (Mellin et al., 1991).
- 46% of 9-11 year-olds are “sometimes” or “very often” on diets, and 82% of their families are “sometimes” or “very often” on diets (Gustafson-Larson & Terry, 1992).
- Over one-half of teenage girls and nearly one-third of teenage boys use unhealthy weight control behaviors such as skipping meals, fasting, smoking cigarettes, vomiting, and taking laxatives (Neumark-Sztainer, 2005).
- 35-57% of adolescent girls engage in crash dieting, fasting, self-induced vomiting, diet pills, or laxatives.
- Even among clearly non-overweight girls, over 1/3 report dieting (Wertheim et al., 2009).
- 42% of 1st-3rd grade girls want to be thinner.
- 81% of 10 year old children are afraid of being fat.
- About 85% of the women and 79% of girls said they opt out of important life activities when they don't feel good about the way they look.

Core Skills that Aid Recovery

- Emotion regulation
- Distress tolerance
- Urge surfing
- Interpersonal effectiveness
- Assertive communication
- Self-advocacy
- Setting healthy boundaries
- Cognitive flexibility
- Mindfulness
- Defusion

- SMART goal-setting
- Basic life skills
- Media literacy
- Diet Culture detox
- Nutrition education
- Clarity of values
- Committed Action
- Somatic integration
- Interoceptive awareness
- Coping and self-care skills

Dos and Don'ts

DO

- Help your client identify the function of ED behaviors.
- Validate the reality that prioritizing recovery means challenging diet culture; acknowledge the grief.
- Clearly label body privilege
- Remind your client that you want more and better for them than their ED does.
- Collaborate regularly with your client's other treatment providers
- Consult often!

DON'T

- Diagnose based on appearance/weight alone
- Give diet advice
- Recommend weight loss
- Talk about your own diet/exercise regimen
- Claim it's "just a phase"
- Guilt trip
- Lecture or preach
- Negotiate with the ED
- COMMENT ON YOUR CLIENT'S BODY

Screening Tools

Eating Disorder Screening for Primary Care (ESP)

Five questions taken from other questionnaires, as a quick and easy tool for general practitioners.

Eating Attitudes Test (EAT-26)

A 26-question screening tool that includes distorted body image, body weight, bulimic behavior, and self-control. Allows for a complete picture of symptoms and behaviors.

Eating Disorder Examination (EDE)

A diagnostic interview that reflects the current DSM-5 diagnostic criteria for eating disorders. Also available in the EDE-Q, a shorter version of the full exam. Both are considered gold-standard screening tools.

SCOFF Questionnaire

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Interventions

Body Neutrality

- It is difficult to make the jump from self-loathing to self-love. For many in recovery, body neutrality is a safe ground to land on: it emphasizes the importance of embracing the function of the body, and establishing a respectful, courteous relationship with the body.
- *Body image is the LAST thing to resolve in recovery. Your client can be in recovery AND still struggle with body image... but they can at least learn how to care for their body.*

ED Voice vs Healthy Voice

- Externalizes ED behaviors
- Honors the belief that each client has a version of themself that is capable of healing

Authentic Voice vs Indoctrinated Voice

- A concept introduced by Sonya Renee Taylor, author of *The Body is Not an Apology*.
- Highlights the impact of sources of power and oppression that influence the way we perceive and speak about our bodies

Interventions

ED as a Mirror of Life

- A technique introduced by Anita Johnston. Help your client explore how their behavior with food/eating/exercising represents underlying themes in their life at large.

Media/Social Media Literacy

- Clients need to understand the prevalence of targeted advertising, photoshop, and distorted perceptions that the internet perpetuates. Clients also need to learn about their specific reaction to constant exposure to targets of self-comparison, diet culture, and misinformation.

Diet Culture Literacy

- Help your client understand the extent to which diet culture permeates daily life; teach your client the signs of unhealthy diet and exercise regimens, as well as weight stigma and unrealistic body ideals.
    - **What is your client considering "healthy"?**

Interventions

Values Work

- A core tenet of Acceptance and Commitment Therapy (ACT), helping your clients develop clarity around their core values can help guide their recovery journey. Once core values are uncovered, you and your client can troubleshoot which actions bring them closer in alignment with their values, and which actions are misguided.

Boundaries and Interpersonal Effectiveness

- Help your client develop skills to set effective boundaries, express their needs clearly and without shame, strengthen their social support network, and limit exposure to recovery risks is crucial.

Find the Function

- Help your client understand the function of their disordered eating patterns. Allow them the space to explore the ways in which their ED helped them, and to grieve the need to let it go. Teach them to hold compassion around their disordered self as well as their recovering self!
- Use the “Log Metaphor”, “Letter to ED” exercises to prompt a discussion with your client

Interventions

Stability and Routine

- Recovery thrives when there is predictability and routine. Help your client identify where they can implement more structure, or any obstacles to establishing a routine.

"Nicy, Icy, Spicy"

- Help your client navigate food talk with a variety of pre-scripted responses, ranging from:
  - "Nicy" - lighthearted, humorous, and redirective
  - "Icy" - assertive, not elaborative
  - "Spicy" - confrontational

Neutralize Language around Food, Bodies, and Weight

- We use emotionally loaded language when referring to any of these topics. Help your client reframe their self-talk through a lens of objective, compassionate language.
- There is no good food or bad food, nor are there good bodies or bad bodies!
- **Fat is NOT a feeling!!!**
- **How does your client talk about themselves when they've eaten, when they haven't exercised, etc.**

Measuring Recovery

When measuring recovery, we look for the following indicators:

- Significant decrease in use of ED behaviors as the primary coping mechanism
- Consistent use of recovery skills outside of the treatment environment
- Ability to independently monitor physical needs, including food intake, movement, etc.
- Improvements in their ability to tolerate triggering situations and respond to stressors using core values and supports
- Better relationship with self
- General improvements in daily mood and functioning

Please note: none of these goals are measured in numbers! Numbers alone cannot determine progress in ED recovery.

Defining "Relapse"

Recovery is not a linear process, so slip-ups are not only common, they are expected. We call those "lapses". We do not measure recovery using a "tally" system.

Every day is a balance of positive and negative recovery influences that your client must navigate. There will be good days and bad days. What's important is that you recognize and acknowledge the progress they are making, and offer encouragement on the "off" days.

When to be Concerned

If your client is in immediate physical danger.
If your client is neglecting major life tasks
If your client is using ED behaviors more often than not

Sample Treatment Plan

Objectives

- Client will process the function, etiology, and triggers for ED thoughts, urges, and behaviors.
- Client will identify and process obstacles that impede appropriate self-nourishment.
- Client will identify and utilize alternative coping strategies that meet underlying needs that are masked by ED urges.
- Client will develop a plan for managing ED relapses/triggers.
- Client will develop a functional, compassionate relationship with themself and with their body, to the extent that body image triggers do not significantly impact ADLs, and to the extent that client's sense of self is not dominated by their body image.

Goals

- Reduce purging behaviors 1-2x/week
- Practice urge surfing for at least 5 minutes before acting on behaviors
- Utilize SMART goal-setting and values to identify long-term recovery goals
- Identify 5 body-neutral phrases to use to counter negative body talk
- Complete at least 3 meals and 2-3 snacks/day

Self-Examination

As an ally in recovery, one of the most important things you can do as a clinician is to examine and challenge your own opinions, attitudes, and beliefs about bodies, weight, food, etc.

Make no mistake - your client WILL notice any inconsistencies between what you tell them and how you act.

Be honest with yourself.

Recommended Reading

8 Keys to Recovery from an Eating Disorder
(+ workbook)
Carolyn Costin & Gwen Schubert Grabb

The Body is Not an Apology: The Power of Radical Self-Love
(+ workbook)
Sonya Renee Taylor

Eating in the Light of the Moon: How Women can Transform their Relationships with Food through Myths, Metaphor, and Storytelling
Dr. Anita Johnston

Life Without ED
Jennie Schaefer

Intuitive Eating: A Revolutionary Anti-Diet Approach
Evelyn Tribole & Elyse Resch

Health at Every Size
Dr. Lindo Bacon

Starving for Survival
Jason Wood

For an excellent list of book recommendations, check out this post from the Eating Recovery Center:
https://www.eatingrecoverycenter.com/resources/recommended-reading

Thank you!

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