About the Presenter

- Amelia Lamb, LCSW is a psychotherapist and clinical supervisor in private practice
- Team Leader of Renfrew Philadelphia Center City
- Experience in outpatient, intensive outpatient, partial hospitalization, and inpatient levels of care for eating disorder treatment
- Supervisor for social work interns and unlicensed mental health clinicians for eating disorder treatment
- Training experience with residents, medical staff, and auxiliary staff for eating disorder informed care

The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of previous or current employment.
Getting to know the Audience

Have you ever worked with anyone that struggled with an eating disorder?

A) Yes
B) No
C) Unsure
Diet Culture

- Americans spend over $60 billion on dieting and diet products each year (Hobbs, Broder, Pope, & Rowe, 2006).
- A content analysis of weight-loss advertising found that more than half of all advertising for weight-loss product made use of false, unsubstantiated claims (Wertheim, Paxton, & Blaney, 2009).
- 95% of all dieters will regain their lost weight in 1-5 years (Grodstein, Levine, Spencer, Colditz, & Stampfer, 1996) and multiple studies have found that dieting was associated with greater weight gain and increased rates of binge eating in both boys and girls (Golden, Schneider, & Wood, 2016).
Diet Culture

- According to The National Center on Addiction and Substance Abuse (2003):
  - 62.3% of teenage girls and 28.8% of teenage boys report trying to lose weight. 58.6% of girls and 28.2% of boys are actively dieting. 68.4% of girls and 51% of boys exercise with the goal of losing weight or to avoid gaining weight.
  - 19.1% of teenage girls and 7.6% of teenage boys fast for 24 hours or more, 12.6% of girls and 5.5% of boys use diet pills, powders or liquids, and 7.8% of girls and 2.9% of boys vomit or take laxatives to lose weight or to avoid gaining weight.
  - 12.6% of female high school students took diet pills, powders or liquids to control their weight without a doctor’s advice.
- 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. 35-57% of adolescent girls engage in crash dieting, fasting, self-induced vomiting, diet pills, or laxatives. Overweight girls are more likely than normal weight girls to engage in such extreme dieting (Neumark-Sztainer & Hannan, 2001).
- In a large study of 14– and 15-year-olds, dieting was the most important predictor of a developing eating disorder. Those who dieted moderately were 5x more likely to develop an eating disorder, and those who practiced extreme restriction were 18x more likely to develop an eating disorder than those who did not diet (Golden, Schneider, & Wood 2016).
Emotional/ Mental Warning Signs of Disordered Eating

- Skipping meals or taking small portions of food at regular meals
- Appears uncomfortable eating around others
- Any new practices with food or fad diets, including cutting out entire food groups (no sugar, no carbs, no dairy, vegetarianism/veganism)
- Withdrawal from usual friends and activities
- Extreme concern with body size and shape
- Frequent checking in the mirror for perceived flaws in appearance
- Extreme mood swings
Emotional/ Mental Warning
Signs of Disordered Eating

- In general, behaviors and attitudes that indicate that weight loss, dieting, and control of food are becoming primary concerns
- Preoccupation with weight, food, calories, carbohydrates, fat grams, and dieting
- Refusal to eat certain foods, progressing to restrictions against whole categories of food (e.g., no carbohydrates, etc.)
- Frequent dieting
- Food rituals
  - Eats only a particular food group
  - Excessive chewing
  - Doesn’t allow foods to touch
  - Food mixing
Physical Warning Signs of Disordered Eating

- Cuts and calluses across the top of finger joints (a result of inducing vomiting)
- Dental problems, such as enamel erosion, cavities, and tooth sensitivity
- Dry skin and hair, and brittle nails
- Swelling around area of salivary glands
- Fine hair on body (lanugo)
- Cavities, or discoloration of teeth from vomiting
- Muscle weakness
- Yellow skin (in context of eating large amounts of carrots)
- Cold, mottled hands and feet or swelling of feet
- Poor wound healing
- Impaired immune functioning
Physical Warning Signs of Disordered Eating

- Dizziness, especially upon standing
- Fainting/syncope
- Feeling cold all the time
- Sleep problems
- Noticeable fluctuations in weight, both up and down
- Stomach cramps, other non-specific gastrointestinal complaints (constipation, acid reflux, etc.)
- Menstrual irregularities — missing periods or only having a period while on hormonal contraceptives (this is not considered a “true” period)
- Difficulties concentrating
- Abnormal laboratory findings (anemia, low thyroid and hormone levels, low potassium, low white and red blood cell counts)
DSM-5 Feeding and Eating Disorders

- Anorexia Nervosa
  - Binge-Eating/ Purging Type
  - Restriction Type
- Bulimia Nervosa
- Binge-Eating Disorder
- Avoidant/Restrictive Food Intake Disorder
- Pica
- Rumination
- Other Specified Feeding Eating Disorder
  - Atypical Anorexia, Night Eating Syndrome, Purging Disorder, Bulimia, Binge Eating
  - Orthorexia, Diabulimia, Compulsive Exercise
- Unspecified Eating Disorder
Prevalence

According to The National Eating Disorders Association (NEDA), at any given point:

- Between 0.3-0.4% of adolescent and young adult women and 0.1% of men will suffer from anorexia nervosa
- Subthreshold anorexia occurs in 1.1% to 3.0% of adolescent females
- 1.0% of young women and 0.1% of young men will meet diagnostic criteria for bulimia nervosa.
- 3.5% of women and 2.0% of men had binge eating disorder during their life
Prevalence

‣ When Stice, Marti, Shaw, and Jaconis (2010) followed a group of 496 adolescent girls for 8 years, until they were 20, they found:
  • 5.2% of the girls met criteria for DSM5 anorexia, bulimia, or binge eating disorder.
  • When the researchers included nonspecific eating disorder symptoms, a total of 13.2% of the girls had suffered from a DSM-5 eating disorder by age 20.

‣ Stice and Bohon (2012) studied a group of adolescents with eating disorders receiving treatment at a specialist clinic, 14% met criteria for ARFID. Those with ARFID were more likely to be younger, and male
  • Nearly half of children with ARFID report fear of vomiting or choking, and one-fifth say they avoid certain foods because of sensory issues.
  • The same study found that one-third of children with ARFID have a mood disorder, three-quarters have an anxiety disorder, and nearly 20 percent have an autism spectrum condition
Co-Occurring Diagnoses

- Per the National Eating Disorder Association:
  - A study of more than 2400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, including:
    - 94% had co-occurring mood disorders, mostly major depression
    - 56% were diagnosed with anxiety disorders
    - 20% had obsessive-compulsive disorder
    - 22% had post-traumatic stress disorder
    - 22% had an alcohol or substance use disorder
  - Approximately one in four people with an eating disorder has symptoms of post-traumatic stress disorder (PTSD).
  - Two-thirds of people with anorexia also showed signs of an anxiety disorder several years before the start of their eating disorder.
  - Childhood obsessive-compulsive traits, such as perfectionism, having to follow the rules, and concern about mistakes, were much more common in women who developed eating disorders than women who didn’t.
### Myths vs Facts for Eating Disorder Stereotypes

- General misconception that those who struggle with Eating Disorders are “affluent, skinny, white girls”
- In a study on college students by Sonneville and Lipson (2018), females and those from a more affluent background were more likely to have an eating disorder diagnosis, perceive a need for treatment, and receive treatment for an eating disorder.
  - Those who were underweight were more likely to perceive the need for treatment, regardless of severity of symptoms.
  - White students were more likely to receive a diagnosis over any race.
  - In general, only 20-30% of people with symptoms received treatment for their eating disorder, but only 13.5% of this population sought treatment, likely due to their inclusion of OSFED as a diagnosis.

<table>
<thead>
<tr>
<th><strong>MYTHS</strong></th>
<th><strong>FACTS</strong></th>
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<tr>
<td>Eating disorders are only experienced by young, middle class, white girls.</td>
<td>Eating disorders can impact anyone.</td>
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<td>Medical intervention is only necessary for eating disorders when you’re physiological danger.</td>
<td>Any symptom is important to assess and early treatment is always best.</td>
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<td>Eating disorders are due to poor choices.</td>
<td>Eating disorders are mental disorders and bio-psycho-social diseases.</td>
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<td>Anyone that is severely overweight is suffering from an eating disorder.</td>
<td>You cannot tell if someone has an eating disorder by looking at them.</td>
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Myths vs Facts for Eating Disorder Stereotypes

- Ethnic minorities are less likely to be asked by a provider if they are struggling with disordered eating and are less likely to be referred to an eating disorder provider for symptoms (Becker, Franko, Speck, & Herzog, 2003).

- It is the case the non-white, lower income, higher weight, and non-female identified patients are less likely to get treatment. However, that is thought to be due to the stereotypes involved with eating disorders that make people less likely or able to receive treatment that they need.
  
  - Common barriers include finances, lack of insurance, not believing others could help, fear of being labeled, not being aware of available resources, feelings of shame, and feelings of discrimination (Cachelin, Reveck, Veisel, & Striegel-Moore, 2001).

A person’s genetic inheritance influences their bone structure, body size, shape, and weight differently. We should appreciate those differences, encourage healthy behaviors, and treat every body with respect.

Someone’s IBW (ideal body weight) allows you to feel strong and energetic and lead a healthy normal lifestyle and can be a range of weights that should be identified by a qualified expert.

The basic premise of health at every size, as written in Linda Bacon’s Book, Health at Every Size: The surprising truth about your weight, is that “Health at Every Size” (HAES) acknowledges that well-being and healthy habits are more important than any number on the scale.
Health at Every Size (HAES)

- Principles of HAES:
  - Accept your size. Love and appreciate the body you have. Self-acceptance empowers you to move on and make positive changes.
  - Trust yourself. We all have internal systems designed to keep us healthy — and at a healthy weight. Support your body in naturally finding its appropriate weight by honoring its signals of hunger, fullness, and appetite.
  - Adopt healthy lifestyle habits. Develop and nurture connections with others and look for purpose and meaning in your life. Fulfilling your social, emotional, and spiritual needs restores food to its rightful place as a source of nourishment and pleasure.
  - Find the joy in moving your body and becoming more physically vital in your everyday life.
  - Eat when you’re hungry, stop when you’re full, and seek out pleasurable and satisfying foods.
  - Tailor your tastes so that you enjoy more nutritious foods, staying mindful that there is plenty of room for less nutritious choices in the context of an overall healthy diet and lifestyle.
  - Embrace size diversity. Humans come in a variety of sizes and shapes. Open to the beauty found across the spectrum and support others in recognizing their unique attractiveness.
Levels of Care

‣ INPATIENT
Patient is medically unstable as determined by:
- Unstable or depressed vital signs
- Laboratory findings presenting acute health risk
- Complications due to coexisting medical problems such as diabetes
- Patient is psychiatrically unstable as determined by:
  - Rapidly worsening symptoms or Suicidal and unable to contract for safety

‣ RESIDENTIAL
Patient is medically stable and requires no intensive medical intervention
Patient is psychiatrically impaired and unable to respond to partial hospital or outpatient treatment
Levels of Care

‣ PARTIAL HOSPITAL
Patient is medically stable but:
Eating disorder impairs functioning, though without immediate risk
Needs daily assessment of physiologic and mental status

‣ INTENSIVE OUTPATIENT/OUTPATIENT
Patient is medically stable and does not need daily medical monitoring
Patient is psychiatrically stable and has symptoms under sufficient control to be able to function in normal social, educational, or vocational situations and continue to make progress in recovery

Engages in daily binge eating, purging, fasting or very limited food intake, or other pathogenic weight control techniques
The Treatment Team

- **Physician** (primary care physician, pediatrician, cardiologist, etc.)
  - Medical clearance and monitoring
- **Therapist**
  - Individual, family, couples, and group counseling
- **Dietician**
  - Meal planning, psychoeducation, supported meals
- **Psychiatric Provider**
  - Medication management
- **Nurses**
  - Medical monitoring, administering medications
- **Psych Techs**
  - Meal monitoring, movement monitoring
- **Patient**
  - Buy-in to programming, assessing for motivation, disclosure to staff
- **Patient’s Family and Supports**
  - Crucial for lower levels of care after residential/inpatient and relapse prevention
Types of Psychotherapy for Eating Disorders

- EVIDENCE-BASED TREATMENT
- ACCEPTANCE AND COMMITMENT THERAPY (ACT)
- COGNITIVE REMEDIATION THERAPY (CRT)
- DIALECTICAL BEHAVIOR THERAPY (DBT)
- FAMILY-BASED TREATMENT (FBT)
- INTERPERSONAL PSYCHOTHERAPY (IPT)
- PSYCHODYNAMIC PSYCHOTHERAPY
Individual Psychotherapy Approaches

- Motivational interviewing
  - Motivation will fluctuate throughout treatment through the stages of change
  - Identifying the values systems and discrepancy between a person’s core values and those fueled by the eating disorder and creating cost/benefit analysis for reasons to change/not change
Individual Psychotherapy Approaches

- **Cognitive-Behavioral**
  - Interrupt eating disorder behaviors (food restriction, excessive exercise, binge eating, purging)
    - Potentially restricting, suggest, or elicit supports to prevent patients from using the bathroom after meals, excessive movement and therapist-supported meal monitoring and coaching.
  - Establish normalized eating patterns with support of RD
    - Consistency in meal plan (even when not hungry) to help with regulation in hunger and fullness cues
  - Reframe unhelpful eating disorder related thoughts and their associated behaviors
  - Exposures for body image and fear foods
    - Planned binges, mirror, body tracing, fear foods, eating out, clothes shopping, etc
  - Teaching more adaptive responses to uncomfortable situations and emotions that increase urges for eating disorder symptoms or other maladaptive coping skills
    - Non-suicidal self injury, substance use, etc.
  - Skills training in mindfulness practices, radical acceptance, and learning to tolerate the full range of emotional experiences
  - Continuing work on co-morbidities (anxiety, depression, substance use, trauma work)
  - Establish a plan to prevent relapse
    - Including supports and collaborating with whole treatment team
Important Factors for Treatment of Adolescents

- **Family support is crucial towards recovery**
  - Family sessions
  - Multi-family groups
  - Family/Support Groups
  - Family meals
    - Psychoeducation on appropriate conversation topics during meals, plating, meal checking, bathroom monitoring, checking in after meals
  - Including non-family members
    - Peers, teachers, coaches, religious leaders, family friends, community supports

- **Case management and collaboration with schools**
  - Supported lunches
  - Breaks throughout day
  - “Buddy System” or meals with staff members
  - Potential shift in schedule or medical leave absence for higher level of care

- **Late summer months/ breaks in school and barriers to long-term treatment progress**
  - Trying to look at the long term positive outcomes, rather than the short term negative consequences of shortening or adjusting treatment to schedule of school
  - Psychoeducation for both parents and children with emphasis on:
    - Cognitive effects of eating disorder
    - Social isolation with increased symptom use
Case Example

22 year old mixed race female with OSFED (Subthreshold Anorexia Binge Purge Type) and Bipolar Disorder Diagnoses

- Levels of care: Medical Inpatient Hospitalization, Residential, Partial Hospitalization, Intensive Outpatient, Partial Hospitalization, Intensive Outpatient, Outpatient
- Patient Strengths: open and honest with staff, high motivation towards recovery (generally), supportive work environment, outspoken in groups and individual sessions, grew meaningful connections with peers
- Barriers to treatment: financial concerns, strained family relationships, substance use, racial stereotypes, and isolation
Case Example

Important aspects of treatment approach

- Medication management
- Motivation fluctuated throughout treatment
  - Values work, seeking internal motivation
- Symptom swapping (exercise, purging, restriction, substance use, self injurious behavior cycling throughout treatment)
  - Whack a mole
  - Distress tolerance skills training and limiting avoidance
- Lack of social supports in treatment
  - Trying to include “family” in any way
  - Searching for mixed-race support groups
- Cognitive reappraisals and work on core beliefs
  - Root rot analogy
- Progressive inclusion and exposure for fear foods
  - Starches, fats, candy planned binge
Please chat in questions to “ALL PANELISTS”!

Please also take a moment to fill out our Feedback Survey upon closing the webinar.
References


Thank you!

- Visit [www.ctacny.org](http://www.ctacny.org) to view past trainings, sign-up for updates and event announcements, and to access resources.

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