

“Understanding and Treating Eating Disorders”

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“Understanding and Treating Eating Disorders”

3 CEU Credit Hours

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













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Course Description:

This course covers the fundamental components for diagnosis and treatment of the various kinds of eating disorders as detailed in the DSM-IV-TR, including discussion of proposed disorders for the DSM-V.

Course Objectives:

At the conclusion of this course, the professional will be able to:

-    Describe the various diagnostic criteria for eating disorders.
-    Utilize assessment resources in the treatment of eating disorders.
-    Apply a variety of counseling strategies to decreasing symptoms and managing behaviors.
-    Compare, contrast and evaluate interpretations of eating disorders as mental health conditions within known models of etiology and maintenance.
-    Discuss various etiologic theories of eating disorders.
-    Provide teaching to clients, families, and community members to increase knowledge and understanding of eating disorders.
-    Evaluate your own feelings, beliefs, and attitudes about clients with eating disorders.

Course Outline:

Part 1: Course organization, Documentation and Introduction.

Part 2: Reading of the course materials (this document)

Part 3: Administration and Completion of the Evaluation of Learning

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3 Clock Hours / CE Credits



If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree** at **(800) 390-9536**. Your instructor is **Richard K. Nongard**, a Licensed Marriage and Family Therapist, Certified Clinical Hypnotherapist and a Certified Personal Fitness Trainer.

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“Understanding and Treating Eating Disorders”

INTRODUCTION

Eating is a basic inherent drive needed for human survival. However, disorders arising from this human physiologic behavior are increasingly prevalent and are associated with marked degrees of an array of medical and psychiatric co-morbidities, as well as significant mortality.

Eating disorders are among the most challenging illnesses confronting healthcare practitioners. Persons with eating disorders are excessively preoccupied with food, their weight, and the shape of their body. They are frequently under-diagnosed, and when diagnosed, are often treated incorrectly. Surprisingly, these individuals do not seek help because they do not believe that their condition is already considered an illness. Others will remain ill or die, even after years of treatment. However, with proper help, persons with an eating disorder can often learn to stabilize their eating patterns, maintain a healthy weight, and become less preoccupied with food.

This course will provide an integrated overview of the identification and treatment of eating disorders such as anorexia nervosa, bulimia, and other atypical eating disorders. Areas covered in this course include description and diagnostic criteria; historical background; course of illness; etiology, to include specific and nonspecific risk factors; assessment tools; and various multidisciplinary psychotherapeutic treatment approaches. There will be discussions on self-awareness of the learner’s own issues with food and weight, and client and family education as well as community-based care are incorporated, in effort to provide a holistic and continuous management of the disorder. Furthermore, proposed revisions to the eating disorders section of the much-anticipated publication of the DSM-V in 2013 will be covered, and clinical vignette examples will add realistic illustrations of the eating disorders being discussed.

COURSE OUTLINE

- I. **Description of Eating Disorders:** A full description of each eating disorder, etiology, temporal evolution, client presentation and perspectives, side-effects and maintaining factors.
 - Historical background and evolution of eating disorders
 - Definitions, diagnostic features and effects of:
 - Anorexia nervosa
 - Bulimia nervosa
 - Binge eating disorder
 - Eating Disorder Not Otherwise Specified
 - Binge eating disorder
 - Purging disorder
 - Night Eating Syndrome
 - Orthorexia
 - Obesity
 - Etiology
 - Biological Theories
 - Behavioral Theories
 - Family System Theories
 - Socio-cultural Theories
- II. **Psychometric Assessment of Eating Disorders: SCOFF Questionnaire**
- III. **Onset and Clinical Course**
- IV. **Medical Complications**
- V. **Treatment Modalities**
 - A. An Overview of Cognitive-Behavioral Approaches to Eating Disorders
 - B. Use of Dialectical Behavior Therapy in the Eating Disorders
 - C. Psychopharmacology
 - D. The Use of Information Technology in the Treatment of Eating Disorders
- VI. **Client and Family Education**
- VII. **Community-Based Care**
- VIII. **Self-Awareness Issues**
- IX. **Conclusion: Points To Consider When Working With Clients With Eating Disorders**

EATING DISORDERS

Eating disorders are syndromes, and are classified on the basis of the clusters of symptoms with which they present. Eating disorders are serious psychiatric illnesses impacting both the brain and the body. The most well-known eating disorders are **anorexia nervosa** and **bulimia nervosa**. In addition, there is a third category called **eating disorders not otherwise specified (EDNOS)**, which consists of binge-eating disorders and other severe conditions that are akin to anorexia nervosa or bulimia nervosa but do not match the official medical definitions of these illnesses.

Eating disorders can be viewed on a continuum, with persons with anorexia eating too little or starving themselves, persons with bulimia eating chaotically, and persons with obesity eating too much. Individuals with eating disorders are afflicted with negative thoughts and intense emotions about their body size and shape; they adopt unhealthy weight control practices and other abnormal eating habits, taking these measures to a dangerous extreme.

HISTORY

A brief history of eating disorders goes back to early times where the Ancient Romans used *vomitoriums* (lavatory chambers that accommodated vomiting) to relieve themselves after indulging at lavish banquets. African lore describes voluntary restrictors who refused to eat during times of famine so that their children would be able to eat. When the famine passed, some of these individuals, who were admired by peers, continued to refuse to eat in spite of the danger of dying.

Halmi (2003) carefully outlined several records and observations on the evolution of eating disorders, starting from the fasting of female saints during the Middle Ages up to the scientific studies in the 18th and 19th centuries that elucidated the real make-up of the condition in terms of its etiology, clinical manifestations, fatal complications and treatment modalities.

Halmi describes the selected subjects' constant struggle to avoid eating. Often the manner and reason for how they avoided food intake was based on the belief that

starvation is a holy sacrificial act to attain blessedness. **Princess Margaret of Hungary** (1242-1271) was believed to have anorexia nervosa—restricting type. She excelled in all her studies, in the chores of the monastery, and in the austerities of fasting and was never idle. She died with a clear alert mind and a poor wasted body at the age of 28. Who would have known that **Catherine of Sienna** could well be diagnosed with anorexia nervosa—binge eating / purging type - as she was observed to have inserted and then withdrew a specific reed from her throat to self-induce vomiting.

Later, in the second half of the seventeenth century, medical practitioners took a great interest in persons who seemed to have inappropriate eating patterns which resulted in the demise of some, particularly young females. The case of **Martha Taylor**, an 18-year-old English girl who had lost her menses, stopped taking all solid food, and became emaciated. She was examined by **John Reynolds** who described the act as “abstinence” and mentioned the age group of females, usually 14 to 20 years old, who succumbed to this condition.

Twenty-two years later, the severe form of “abstinence” was described by **Richard Morton** into two cases of typical anorexia nervosa symptomatology, and thus distinguished them from consumption.

Similar to John Reynolds, **Dr. Louis-Victor Marce** of Paris described several cases of young females, in pubertal stage, who had acts of “*inappetance*” that are somehow practiced to severe forms. He believed that these girls went into “precocious development,” which ultimately became the reason for the eating disorder. In relation to inappropriate coping in life’s dealings, the person undergoes symptoms that mirror a gastric disease, such as vomiting. Because of this, Marce conceptualized the experience as a gastric nervous disorder becoming cerebro-nervous.

The late 18th century focused on finding the correct treatments. In 1873, **Sir William Gull** of London and **Ernest Charles Laseque** almost simultaneously published papers on the description and treatment of “**hysterical anorexia.**” Gull recommended a treatment that to some extent is still followed: feeding at regular intervals with supervision by persons who have moral control over them, but he cited

the presence of relatives and friends as a negative support system. The term anorexia nervosa was then used.

The works of **E.L. Bliss** and **C.H. Branch** provided a clear understanding on the relationship of pituitary insufficiency and anorexia nervosa.

Bulimia nervosa was first described as a distinct syndrome in 1979 by **Gerald Russell** (Anderson & Yager, 2005).

In 1988, the social historian **Joan Jacobs Brumberg** expressed deep concern about the social pressures promoting anorexia nervosa and other eating disorders. She listed among the culprits magazines disseminating weight-reducing diets, the fashion industry catering to the slimmer figure, and television attributing sexual allure and professional success to the possession of a svelte figure. These concerns seem at face value to be entirely justified. She went further, however, in describing how Americans are competitive even about a disease, and regretted what she called “an army of health professionals and a deluge of publications and conferences since the 1970s.”

Proposals for the recognition of a new disorder, binge eating disorder, were put forward in the early 1990s, and accorded grudging recognition in an appendix of DSM-IV in 1994.

TYPES OF EATING DISORDERS

ANOREXIA NERVOSA: A Self-Starvation Disease

Lucy is 15 years old, 5 feet, 7 inches tall and weighs 92 pounds. She goes to school wearing exactly the same kind of clothes every day - sweatpants and three layers of shirts. Lucy's hair appears to be dry, brittle, and uncombed. An avid ballet student, she spends more than the time allotted for practice every day. Her parents have also noticed that she spends hours exercising even in the middle of the night. When they confronted her about this, Lucy used her upcoming recitals as the excuse. Because of her too much attention to ballet practices and long waking hours at night, her grades suffered. From being an A student, Lucy's grade performance in school fell to Bs, and then to barely

passing at all. She lost 20 pounds in the last 4 months and her menstrual periods have ceased.

Anorexia nervosa is a life-threatening eating disorder characterized by the person's refusal or inability to maintain a minimally normal body weight, intense fear of gaining weight or becoming fat, significantly disturbed perception of the shape or size of the body, and steadfast inability or refusal to acknowledge the seriousness of the problem or even that one exists (APA, 2000). Given the nature of this eating disorder, the term *anorexia*—which stems from the Greek terms *an*, meaning “without,” and *orexe*, meaning “appetite”—is misleading. Individuals with this illness are so focused on fighting hunger that it is hard for them to acknowledge that they have it; that's where the term *nervosa* fits in. People with anorexia are afraid that if they give in to their appetites and start eating, they won't stop.

About half of these persons will lose weight by drastically reducing their total food intake and some will also develop rigorous exercising programs (**restricting subtype**). The other half of these patients will also rigorously diet but will lose control and regularly engage in binge eating followed by purging behaviors. Some patients routinely purge after eating small amounts of food (Sadock & Sadock, 2003). Those with the **binge eating and purging subtype** engage regularly in binge eating followed by purging.

There are significant differences between anorexia nervosa patients who engage in bulimic or purging behaviors compared with those who consistently restrict their dietary intake. Impulsive behaviors such as stealing, drug abuse, suicide attempts and self-mutilations are significantly more prevalent in the binge-eating/purging type compared with the restricting type. The bulimic group of anorexia nervosa patients also has a higher prevalence of premorbid obesity, familial obesity, mood ability and debilitating personality characteristics; the latter are often in the context of a Cluster B or the impulsive personality disorder cluster. The binge-eating/purging type of patients is actually similar to persons with bulimia nervosa in all of these behaviors and characteristics. They are not classified as having bulimia nervosa because they have lost large amounts of weight and meet the criteria for anorexia nervosa. The specific mechanisms by which the binge-eating/purging type

patients are able to obtain and maintain large weight losses are still unknown and are being investigated.

Food-related preoccupation of persons with anorexia would range from grocery shopping, collecting recipes or cookbooks, counting calories, creating fat-free meals, and cooking family meals (Videbeck, 2011). They also may engage unusual or ritualistic food behaviors such as refusing to eat around others, cutting food into minute pieces, or not allowing the food they eat to touch their lips. These behaviors increase their sense of control.

Diagnosis

The three criteria for anorexia nervosa proposed by G.F.M. Russell over 20 years ago are still embedded in the latest *Diagnostic and Statistical Manual of Mental Disorders, Text Revision* (DSM-IV-TR; American Psychiatric Association [APA], 2000):

DSM IV-TR Criteria for Anorexia Nervosa

- **Refusal to maintain body weight at or above a minimally normal weight for age and height: Weight loss leading to maintenance of body weight <85% of that expected or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.**
- **Intense fear of gaining weight or becoming fat, even though under weight.**
- **Disturbance in the way one's body weight or shape are experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.**
- **Amenorrhea (at least three consecutive cycles) in postmenarchal girls and women. Amenorrhea is defined as periods occurring only following hormone (e.g., estrogen) administration.**

Adapted from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed, text rev. Washington, DC, American Psychiatric Association, 2000.

The body image disturbance of individuals with anorexia nervosa reflects the person's claiming to feel fat or believing that one area of the body such as thighs are too fat even when they are obviously underweight. Their body weight plays a dominant importance in their lives; therefore by losing weight and dieting they receive strong positive reinforcements later on. The security of being thin and of

dieting compensates for vast insecurities in other areas of life, such as interpersonal relationships and adult role expectations. Lastly, the person is in constant denial that their emaciated body is no longer healthy or attractive.

Amenorrhea, the key sign that the person has anorexia nervosa other than a noticeable weight loss, is attributed to a primary disturbance of hypothalamic function. The constant psychological stress and anxiety that the person is placing over her weight can bring about the full expression of this vulnerable risk factor, which then expresses itself in the form of amenorrhea. Malnutrition can perpetuate the amenorrhea, but is not primarily responsible for the endocrine disorder.

BULIMIA NERVOSA: A Disease with Less Obvious Signs

Jena is 30 years old, married, and a successful interior design consultant in a big company. She keeps well hidden the secret that she binges and purges, and has promised herself to stop to it many times. Her constant and uncontrollable craving for food and the self-induced vomiting that follows makes her feel guilty and ashamed, and she does not understand why she cannot stop her behavior. In one situation, when she was driving 15 minutes home from the grocery store, she consumed a package of cookies, a large bag of potato chips, and a pound of ham from the deli, all while crazy with worry that someone might see her eating in the car. As soon as she got home and into the house she dropped the groceries on the kitchen counter and raced for the bathroom. Tears streaming down her face, she vomits to get rid of what she has just eaten. As Jena leaves the bathroom to put away the remainder of the groceries, she again promises herself to stay away from all those bad foods.


Bulimia nervosa, often simply called bulimia, is an eating disorder characterized by recurrent episodes (at least twice a week for 3 months) of binge eating followed by inappropriate compensatory behaviors to avoid weight gain, such as purging, fasting, or excessively exercising (APA, 2000).

The amount eaten per episode by the person who binges varies but is typically between 1,000 and 2,000 kcal. In most cases, each binge is followed by compensatory self-induced vomiting or laxative misuse, but there is a subgroup of patients who do not “purge” (non-purging bulimia nervosa). The weight of most patients with bulimia nervosa is in the healthy range (BMI between 20.0 and 25.0), although some clients are overweight or underweight due to the effects of under-eating and overeating canceling each other out. As a result, these patients do not experience the secondary psychosocial and physical effects of maintaining a very low weight. Depressive and anxiety features are prominent in bulimia nervosa—indeed, more so than in anorexia nervosa—and there is a subgroup who engage in substance misuse or self-injury, or both. This subgroup, which is also present among some anorexia nervosa patients who binge eat, often attracts the diagnosis of borderline personality disorder.


Diagnosis


The diagnostic criteria included in DSM-IV-TR for bulimia nervosa are as follows (APA, 2000):


DSM IV-TR Criteria for Bulimia Nervosa


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

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

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

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

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

 **The disturbance does not occur exclusively during episodes of AN.**

Specify type:

- **Purging Type: During the current episode of BN, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.**
- **Nonpurging Type: During the current episode of BN, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.**

Adapted from American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed, text rev. Washington, DC, American Psychiatric Association, 2000.

EATING DISORDERS NOT OTHERWISE SPECIFIED (EDNOS)

Several years ago, clinicians and even the public are only aware of the two eating disorders. Presently, a new category is being added wherein individuals display most of the core clinical features of anorexia nervosa and bulimia nervosa but do not meet the criteria for the full syndrome. They are classified as having an **eating disorder not otherwise specified (EDNOS)**. **Purging disorder (PD)** is as an example of EDNOS together with **night eating syndrome**, and binge-eating disorder (BED).

Purging disorder (PD), as introduced by Keel and colleagues (Keel, 2007; Keel, Haedt, & Edler, 2005), is characterized by recurrent episodes of purging (i.e., self-induced vomiting, laxative misuse, diuretic misuse) in the absence of objectively large binge-eating episodes among individuals who are normal weight or overweight.

Night eating disorder (NES) is characterized by morning anorexia, evening hyperphagia (consuming 50% of daily calories after the last evening meal), and nighttime awakenings (at least once a night) to consume snacks. It is associated with life stress, low self-esteem, anxiety, depression, and adverse reactions to weight loss.

Binge-eating disorder (BED), on the other hand, is still being investigated to determine the classification as a mental disorder, and is listed as a research category in the DSM-IV-TR (APA, 2000). BED is an eating problem characterized by recurrent binge eating in the absence of the extreme weight control behavior seen in bulimia nervosa (Barlow, 2008). The essential features are recurrent episodes of binge eating; no regular use of inappropriate compensatory behaviors, such as purging or excessive exercise or abuse of laxatives; guilt, shame, and disgust about eating behaviors; and marked psychological distress.

Unlike those with bulimia nervosa or anorexia nervosa-B/P, individuals with binge eating disorder binge-eat when they are *not* physically hungry. That is, the binge eating does not occur as simply a physiological response to starvation (Woodside and Twose, 2005). Furthermore, the marked distress experienced by individuals with

binge eating disorder occurs not only following the binge, as in bulimia nervosa and anorexia nervosa-Binging/Purging, but *during* the binge eating as well.

ORTHOREXIA

Orthorexia is a term coined by Steven Bratman, MD, to describe his own experience with food and eating. It is not an officially recognized disorder, but is similar to other eating disorders - those with anorexia nervosa or bulimia nervosa obsess about calories and weight, while orthorexics obsess about healthy eating (not about being 'thin' and losing weight).

Orthorexia appears to be motivated by health, but there are underlying motivations, which can include safety from poor health, compulsion for complete control, escape from fears, wanting to be thin and improving self-esteem, searching for spirituality through food, and using food to create an identity.

Proposals for this disorder to be officially included in the publication of the DSM-V in 2013 will still have to be considered by experts on the field.

OBESITY

There are people who think that if you are obese, then by definition you must have a pathological relationship with food. Just as everyone who has a low body weight does not have anorexia, the notion that all individuals who have a higher body weight have an abnormal relationship with food is false. Being obese is not a simple problem of will-power or self-control, but rather a complex, multi-factorial disease.

Obesity means having an abnormally high proportion of body fat. A person is considered obese if he or she has a body mass index (BMI) of 30 or greater. BMI is calculated by dividing a person's weight in kilograms by height in meters squared. Binge eating is common among people with eating disorders and people who are obese. Binge eating that is not followed by purging may also be considered an eating disorder and can lead to weight gain. More than one-third of obese individuals in weight-loss treatment programs report difficulties with binge eating (Yanovski, 2002).

ETIOLOGY OF EATING DISORDERS

What makes these people behave erratically when it comes to their eating behaviors? What could be the reasons or causes of these disorders?

There is no specific cause for eating disorders. To name a single entity would be deleterious to the planned treatment modality later, because research has identified that eating disorders has a multi-factorial etiology.

Initially, dieting may be the stimulus that leads to their development. Behaviors and influences antecedent to the dieting experience can be categorized into problems of biologic vulnerability, developmental problems, and family and social influences. Disturbances in these categories propel the dieting behavior so that starvation effects, weight loss and nutrition effects, as well as psychological changes occur. Psychological and physiological reinforcement of the maladaptive eating behavior continues a sustaining cycle of core dysfunctional eating disorder behaviors.

In this article, we will be discussing the causative factors categorically into biologic theories, behavioral theories, family systems theory, and socio-cultural theories.

Biologic Theories. These are explanations related to genetic makeup or familial tendencies, the anatomical makeup of the brain to include the neurotransmissions of different neurotransmitters, and hormonal disturbances that contributes to the development of eating disorders.

Familial Genetic Theories. Studies of anorexia nervosa and bulimia nervosa have shown that these disorders tend to run in the families. If the person has a mother or sister who has anorexia, she is considered to be 12 times more likely than others with no family history of anorexia to develop anorexia nervosa and four times more likely to develop bulimia (ANRED, 2006). Twin studies indicate that 50% to 90% are at risk for anorexia and 35% to 83% are at risk for bulimia (DiscoveryHealth.com

Disease Center, 2003; Shives, 2008). With regards to obesity, research has concluded that genetics is 80% responsible for determining the tendency of the person to become obese later on. (Shives, 2008).

Probably the most exciting research study about the genetic cause of anorexia nervosa is the discovery of a form of a gene for Agouti-related protein (AGRP), a chemical messenger that stimulates appetite and is more frequently seen in anorexic persons. (Associated Press, 2001; Shives, 2008). The formation of leptin (a protein produced by fat cells) by an obesity gene is attributed to this form of eating disorder. Leptin acts on the hypothalamus and influences hunger and satiety. For obese individuals, a resistance to leptin's satiety effect is developed, thus making the person crave more food (Albu, Allison, Boozer et al., 1997).

Hypothalamic-Neuromediator Theories. Disruptions of the nuclei of the hypothalamus may produce many of the symptoms of eating disorders (Videbeck, 2011). Two sets of nuclei are particularly important in many aspects of hunger and satiety (satisfaction of appetite): the lateral hypothalamus and the ventromedial hypothalamus. Conclusions were drawn that deficits in the lateral hypothalamus result in decreased eating and decreased responses to sensory stimuli that are important to eating. In contrast, disruption of the ventromedial hypothalamus leads to excessive eating, weight gain, and decreased responsiveness to the satiety effects of glucose, which are behaviors seen in bulimia.

Hormonal, Neurotransmitter Secretion, and Chemical Mediator Theories. Activity of hormones such as thyroid-stimulating hormone, gonadotropin-releasing hormone, and corticotropin-releasing factors and neurotransmitters such as serotonin, dopamine, and norepinephrine that preserve the balance of energy output and food intake have been found to contribute to the development of eating disorders. According to this theory, nerve pathways descending from the hypothalamus work to control levels of sex hormones, thyroid hormones, and the adrenal hormone cortisol, all of which influence appetite, body weight, mood, and responses to stress.

High levels of enkephalins and endorphins also influence eating disorders. These are opiate-like substances that act on the central nervous system, producing analgesia, change in mood, drowsiness, and mental slowness. The gastrointestinal

tract motility and appetite are then diminished. These biologic changes may contribute to the denial of hunger in clients with anorexia nervosa. Clients with bulimia nervosa are in a euphoric state after vomiting because plasma endorphin levels are increased (Sadock & Sadock, 2003).

Behavioral Theories. Behavioral factors influencing the development of eating disorders encompass a wide range of psychological and psychodynamic theories.

For the anorexics, starvation is a form of self-punishment, with the unacknowledged purpose of pleasing an introjected or internalized parent. This parent is seen as imposing harsh restrictions on the otherwise well-behaved, orderly, perfectionist, hypersensitive individual (Shives, 2008). Individuals starve themselves to suppress or control feelings of emotional emptiness. They struggle for perfection to prove that they do not depend on others to validate their self-concept or self-esteem. Conversely, teenagers with problems managing anger are more likely to engage in bulimic behavior without purging than those who manage anger appropriately (Finn, 2004).

Fasting restores a sense of order to a female who fears the independence of adult femininity and fears of becoming like her mother. Fasting allows the person to exert control over herself and others.

Females develop an eating disorder because they believe their parents have never responded adequately to their initiatives or recognized individualities. Anorectic females have difficulty distinguishing personal wants from those of others and fear abandonment if they take independent action (Shives, 2008).

In obesity, people may be obese not because they eat too much but because they expend too little energy. These individuals may have an inherited trait low metabolic rate or resting energy expenditure (REE). This low energy expenditure, coupled with an inactive lifestyle, may cause weight gain or a difficulty in maintaining a healthy weight (White, 2000).

Psychosocial factors like the person's response to emotions such as loneliness, sadness, anger, or celebration; stressful interpersonal or family dynamics may also be contributing factors (Shives, 2008).

Family System Theories. Psychiatrists and family therapists have identified the connection of the type of family the person with eating disorder belongs to. The common denominator that these persons have is a dysfunctional family system. This type of family interaction is described as having parents who are over-controlling, authoritative, passive or emotionally distant. Basically, the attitudes and behaviors of parents have created a wall of conflict between their children - parents have high expectations for their child, where in turn the latter will resort to pursuing this excellence by starving, binging, or purging. Anorectics use the avoidance of food to gain attention and satisfy emotional needs. Bulimics soothe themselves with food.

Enmeshment (lack of clear role boundaries) in family structures is also one of the reasons implicated in eating disorders. Families with anorectic daughters are smothering toward their members - no defined roles and responsibilities, over-responsive to and overprotective of everyone else. Individual's needs are not met, feelings are not honestly acknowledged, and conflicts are not openly resolved. Anorexia is considered to be a symptom of a rigid family system's need and inability to change.

Childhood adversities were also identified as contributing factors to the development of eating disorders. In studies conducted by Johnson, Cohen, Kasen, and Brook (2002), they listed physical neglect or sexual abuse, low parental affection, low parental communication with the child, poverty, and low parental education as additional reasons for the disorder.

Socio-cultural Theories. The role of social media has placed the concept of slenderness as an expression of attractiveness. Much willful dieting occurs for the purpose of being more attractive. The need for acceptance by society has placed too much pressure on young adolescent girls, whose primary source of information is through media communication. Because what is accepted is the "size 10" (or even lower than that), and supermodels who are *obviously "skin and bones"* in appearance are the only capable persons to wear their modeled garbs, the fashion industry is also geared towards making dresses the same sizes as those of the supermodels. This now creates an impression to the young female adults that they have to be like those supermodels. Movie icons and other pop stars, mostly female and possess thin bodies,

have become a household icon for slenderness. This has also resulted to the commercial splurge of different dieting pills and regimens that promises guaranteed weight loss in the fastest way.

Other willful dieting occurs for the purpose of being more professionally competent; for example, ballet dancers, gymnasts, jockeys and wrestlers - all of whom have a high risk for developing an eating disorder. The need to excel and constant craving for perfection places them at possible risk for eating disorders.

ASSESSMENT OF EATING DISORDERS

A lot of patients with eating disorders do not seek for medical help until the signs and symptoms are already taking toll in the body. Before they know it, the condition has often already manifested into critical and even life-threatening complications. The clinician or health care provider should possess the right attitude and behavior in conducting the assessment process to elicit concrete and solid information that will help him/her in planning the right treatment modalities for the patient.

Prior to conducting the assessment, which is initially done in through an interview, the assessor should be aware that establishment of a trusting relationship is a prerequisite to eliciting accurate information from eating disorder patients. The assessor should communicate an empathic awareness of the mixed feelings many individuals experience about acknowledging certain symptoms, considering change, or starting treatment.

In this writing, a discussion on the SCOFF questionnaire is highlighted as the easiest and most commonly used structured interview for patients with eating disorders.

Developed by John Morgan at Leeds Partnerships NHS Foundation Trust, the SCOFF uses five simple screening questions and has been validated in specialist and primary care settings. Though not diagnostic, a score of 2 or more positive answers should raise your index of suspicion of a case, highlighting a need for more detailed history as delineated below.

SCOFF QUESTIONNAIRE:

Do you ever make yourself sick because you feel uncomfortably full?

Do you worry you have lost control over how much you eat?

Have you recently lost more than one stone (14 pounds) in a three month period?

Do you believe yourself to be fat when others say you are too thin?

Would you say that food dominates your life?

ONSET AND CLINICAL COURSE

Clients with eating disorders share similar clinical symptoms or warning signs including unusual thoughts, feelings, and behavior around food as well as an unhealthy amount of body fat or unhealthy body mass index (BMI).

Anorexia Nervosa typically begins between 14 and 18 years of age. In the early stages, clients often deny they have a negative body image or anxiety regarding their appearance. They are very pleased with their ability to control their weight and may express this. When they initially come for treatment, they may be unable to identify or to explain their emotions about life events such as school or relationships with family or friends. A profound sense of emptiness is common.

As the illness progresses, depression and lability in mood become more apparent. As dieting and compulsive behaviors increase, clients isolate themselves. This social isolation can lead to a basic mistrust of others and even paranoia. Clients may believe their peers are jealous of their weight loss and may believe that family and health care professionals are trying to make them “fat and ugly.”

Bulimia Nervosa usually begins in late adolescence or early adulthood; 18 or 19 years is the typical age of onset. Binge eating frequently begins during or after

dieting. Between bingeing and purging episodes, clients may eat restrictively, choosing salads and other low calorie foods. This restrictive eating effectively sets them up for the next episode of bingeing and purging, and the cycle continues.

Clients with bulimia are aware that their eating behavior is pathologic and go to great lengths to hide it from others. They may store food in their cars, desks, or secret locations around the house. They may drive from one fast-food restaurant to another, ordering a normal amount of food at each, but stopping at six places in 1 to 2 hours (Videbeck, 2011). Such patterns may exist for years until family or friends discover the client's behavior or until medical complications develop for which the client seeks treatment.

The table below lists the physiological symptoms of anorexia nervosa and bulimia nervosa.

ANOREXIA NERVOSA	BULIMIA NERVOSA
Complaints of constipation and abdominal pain	Loss of dental enamel
Cold intolerance	Chipped, ragged, or moth-eaten appearance of teeth
Lethargy	Increased dental caries
Emaciation	Menstrual irregularities
Hypotension, hypothermia, and bradycardia	Dependence on laxatives
Hypertrophy of salivary glands	Esophageal tears
Elevated BUN (blood urea nitrogen)	Fluid and electrolyte abnormalities
Electrolyte imbalance	Metabolic alkalosis (from vomiting) or metabolic acidosis (from diarrhea)
Leucopenia and mild anemia	Mildly elevated serum amylase levels
Elevated liver function tests	

MEDICAL COMPLICATIONS

Full blown eating disorders are like ticking time bombs waiting to explode at any moment. Since the disorder is mostly diagnosed in the late stages, the person may have succumbed to the consequences of the maladaptive eating pattern. The person deliberately excludes the intake of food into the body and this causes massive starvation of cells from the necessary nutrition it needs for homeostasis.

Complications like electrolyte imbalance (e.g., low potassium and low sodium) related to purging can result in muscle weakness, numbness and even seizure. As the person continues to starve, their obvious 'skin and bones' body appearance can lead to osteoporosis as the bones become brittle and prone to breakage. Cardiac contractility is also compromised as the body lacks sufficient electrolyte ions that are needed for cardiac muscle conduction. This predisposes the person to cardiac arrhythmias. In an article presented by Lupoglazoff, J. M, et al. (2001), they noted that “cardiac complications are common in adolescent anorexia nervosa and are the cause of a third of deaths.” In 2005, the very first case of fatal gastric rupture of an anorectic patient discovered after death was reported. An autopsy revealed an acute gastric dilatation and rupture without commonly observed ischemic damage of gastric wall structures (Sinicina, I., Pankratz, H., Büttner, A., & Mall, G., 2005). The cause of death for this patient is neurogenic shock.

In bulimia nervosa, serious medical consequences may occur because of alternating bingeing and purging. Just like the anorexic, the bulimic person may not seek treatment until a medical emergency occurs. These situations include chronic inflammation of the lining of the esophagus, rupture of the esophagus, dilation of the stomach, rupture of stomach, electrolyte imbalance or abnormalities, leading to arrhythmias of the heart and metabolic acidosis, chronic enlargement of the parotid glands, irritable bowel syndrome, rectal prolapsed, rupture of the diaphragm, chronic edema, and fungal infections of the vagina or rectum.

TREATMENT MODALITIES

After identifying the causes and risk factors, and conducting holistic assessment to the patient, (i.e., covering the physical and psychological data), the clinician or health care provider is now ready to implement the appropriate treatment modalities for eating disorders.

To date, there are numerous therapeutic strategies to manage eating disorders. Just like its etiology, no single therapy can treat the disorder on its own

accord. Because of the multiplicity of causative factors, the treatment should also be carried out in this manner.

Cognitive-behavioral therapy (CBT) is a treatment for a wide variety of eating disorder symptoms that has received considerable empirical support and continues to be the modality of choice for a variety of eating disorder clinical presentations. Strategies designed to change the client's thinking (cognition) and actions (behavior) about food focus on interrupting the cycle of dieting, bingeing and purging, and altering dysfunctional thoughts and beliefs about food, weight, body image, and overall self-concept.

The treatment program for anorexia nervosa includes four phases:

- **Phase I** outlines specific strategies for initiating treatment, orienting patients to CBT and assessing and enhancing motivation with the intent of promoting engagement in treatment.
- **Phase II** describes the weight gain protocol and interventions focused on the cognitive distortions and behavioral dysfunction pertaining to the patient's eating habits and weight.
- **Phase III** describes a schema-based approach, which addresses relevant issues that extend beyond the specific domain of eating and weight.
- **Phase IV** focuses on reviewing the course of treatment to consolidate gains and prepare to continue working independently after the therapy ends. Additionally, during the last phase of treatment, individuals prepare a personalized program of relapse prevention based on the course of therapy.

Regardless of the type of therapy being carried out, the helper must establish a therapeutic relationship with the patient. The therapist must have qualities of warmth, empathy, respect, and openness. He or she must be comfortable being active in sessions, thinking strategically, and providing structure and direction, especially at the beginning of treatment. Most importantly, the therapist must be able to suspend their own assumptions and judgments so that they can provide an

empathic balance of promoting change and enhancing understanding as patients grapple with recovery.

The following transcript describes the activities that need to take place in each phase.

PHASE I: Getting Started—Orientation to CBT, Engagement, and Motivation

☞ *Introduction to the Structure and Rationale of CBT*

Begin by introducing the structure and rationale of the treatment, explaining how CBT can help the patient, defining the structure of sessions that will be carried out, and establishing of therapeutic relationship. During this phase, the therapist also needs to emphasize to the patient the need for self-monitoring, weight monitoring, and works or activities to be carried out between sessions.

Every session has an explicit internal structure that includes: (a) weight assessment and discussion of weight status, (b) review of self-monitoring, (c) between-session work, (d) agenda setting, (e) working on core issues of the agenda, (f) setting goals for between-session, (g) work in the upcoming days, and (h) summarizing the session.

With all of this in mind, the therapist begins to present to the patient his/her eating pathology and its implications for current functioning. Initial weight record should be obtained and consistently monitored, even at home with a parent or at school with a nurse. It is important that an responsible, supportive adult accompany the patient during the weighing time. This will ensure accurate recording and help prevent masking or lying about the current weight.

Between-session tasks are activities designed for the patient to work on particular problematic behavior patterns, offering the opportunity to experiment with changes in the context of a supportive therapeutic environment.

Self-monitoring is not only limited to recording food intake but also includes recording social and emotional experiences and situations that contextualize the eating disorders. The therapist helps the patient begin to reconnect their emotional and interpersonal worlds with their eating by exploring contextual factors: (a) where

does the patient eat? (b) With whom does he/she eat? (c) how is he/she feeling?, (d) what was he/she thinking right before a meal?, (e) how did he/she manage to skip a meal when they were visiting with a friend?, and (f) what was he/she thinking and feeling before she binged?

Lastly, the therapist should provide psychoeducation covering the multiple causes of eating disorders, associated biological risks and sequelae, deleterious consequences of semi-starvation, relationship of weight gain to menstrual functioning, normalization of eating behavior, and basic nutritional education regarding the consumption of fat, carbohydrates, and protein in a healthy diet. Educating the patient in the early phase of the therapy provides a motivational factor for change of behavior.

PHASE II: Core cognitive and behavioral interventions for anorexia nervosa

Interventions that focus on identifying, understanding, and changing maladaptive cognitions and behaviors that serve to maintain the eating disorder are now carried out by the patient. The specific focus of Phase II depends on the patient's readiness and motivation for change. The therapist needs to use judgment in choosing the most appropriate and effective CBT interventions in relation to the specific issues of each patient.

- ***Weight Gain Protocol and Meal Planning.*** During Phase I, where the patient's weight is obtained, the therapist has to identify the need of the patient to change. Once it is established and clear to the patient, meal planning can be initiated. A meal plan is a helpful tool for teaching patients when, what, and how much to eat. In some cases, it can be helpful to engage a nutritionist in establishing a meal plan. The initial focus here is on helping patients meet their calorie goal with a subsequent focus on the quality and variety of food intake as weight gain progresses. Self-monitoring is an important tool for establishing normal eating habits and tracking progress.

- ***Behavioral Experimentation.*** This work requires the construction of a hierarchy of behavioral challenges and includes addressing the issue of forbidden

foods in a thoughtful manner to establish a stepwise sequence that steadily aids the individual in normalizing her eating.

- ***Identifying and Challenging Dysfunctional Thoughts.*** Patients are encouraged to engage in testing the validity or evidence of cognitions, and therapist and patients work together to formulate functional or adaptive “challenges” or responses to the dysfunctional thoughts.

- ***Preventing Weight Loss after Minimum Target Weight Has Been Achieved.*** The therapist can encourage the patient to take an experimental approach to recovery and gather evidence about what really does happen to their weight if they follow the maintenance meal plan. If necessary, ask him/her to try the experiment 1 week at a time. In terms of cognitive restructuring, it is useful to identify and challenge beliefs about weight maintenance and relapse.

- ***Addressing Body Image Disturbance.*** The repeated checking of body shape or weight (“*body checking*”) and the avoidance of seeing actual body shape or weight (“*body avoidance*”) have been hypothesized to maintain body image disturbance and contribute to increased dietary restraint. Treatment strategies directed at body image include:

- ❖ Psycho-education about the negative impact of body checking and body avoidance
- ❖ Exercises that help individuals distance themselves from negative body image thoughts
- ❖ Body image exposure exercises
- ❖ Cognitive work on developing other aspects of self-identity that enhance self-esteem.

In addition, it is useful to encourage patients to get rid of “sick” clothes that are too small for them and support them in obtaining comfortable clothing in an appropriate size. Wearing clothes that are too small draws their attention to their body size and shape. Wearing clothes that are too big or baggy is another form of avoidance and tends to be associated with negative body image. When addressing body image issues with the patient, it is especially important to validate their feelings and at the same time introduce doubt and distance about the associated beliefs

- ***Combating Excessive Exercise.*** It is therapeutic for patients to refrain from all exercise until related issues have been discussed in therapy and patients have maintained a minimum target weight for at least 1 month. Instead, encourage the use of behavioral strategies (e.g., distraction, delay, self-talk), stimulus control (e.g., disassemble exercise equipment, put gym membership on hold, hide running shoes), and making of thought records to assist patients in resisting urges to exercise. In addition, encourage physical activity that cannot turn into excessive exercise and that is not aimed primarily at weight control (e.g., some types of yoga, crafts, or social activities such as ice skating with friends). The emphasis should be placed on having fun, socializing, developing a skill, and improving health rather than controlling weight and shape or burning calories.

PHASE III: Schema-Based Cognitive Therapy and Related Clinical Issues

It is essential that the therapist support the patient's needs and desires to have control, mastery, and self-importance in life; these goals are normative and healthy. The therapist helps the patient separate the *goals* of achieving control, mastery, and importance from the *means*. Furthermore, the work of therapy is not to alter these goals but to work on how to achieve them more adaptively should be emphasized.

PHASE IV: Ending Treatment and Relapse Prevention

In preparing for the termination of treatment, the therapist and patient review specific CBT tools and strategies that the patient has found most helpful. This stage offers the patient the opportunity to describe an enhanced sense of self-efficacy as a result of the gains made in treatment. At this point, the therapist can reiterate that as long as the patient continues to employ what they have learned, they will be acting as their own therapist and thereby decrease their risk of relapse.

Cognitive-Behavioral Approach to Bulimia Nervosa.

CBT-E is an “enhanced” version of the leading evidence-based treatment for bulimia nervosa. It is described as “enhanced” for three main reasons:

1. The strategies and procedures used to address the eating disorder psychopathology have been refined and extended;
2. In certain subgroups of patients common additional maintaining mechanisms may be tackled, namely mood intolerance, clinical perfectionism, core low self-esteem, or major interpersonal difficulties;
3. The treatment has been adapted to make it suitable for all forms of eating disorder rather than just bulimia nervosa.

Like CBT for anorexics, CBT-E for bulimics has four stages:

- **Stage 1** aims to engage the patient in treatment and the process of change, to jointly create a formulation of the processes maintaining the eating disorder, to provide education, and to introduce two important procedures, “weekly weighing” and “regular eating.” Appointments are twice weekly for 4 weeks, preceded by an initial assessment session.
- **Stage 2** is a transitional stage whose aims are to review progress, identify barriers to change, modify the formulation as needed, and plan Stage 3. This stage generally comprises of two appointments, each a week apart.
- **Stage 3**, which is the main body of treatment, addresses the key mechanisms that are maintaining the patient’s ED; there are eight weekly appointments.
- **Stage 4**, the final stage in treatment, has two aims: (1) to ensure that the changes made in treatment are maintained over the following months; and (2) to minimize the risk of relapse in the long term. There are three appointments, each 2 weeks apart.

Following the end of treatment, there is a review appointment 20 weeks later.

There are, however, certain contraindications to embarking upon CBT-E straightaway: *compromised physical health, suicide risk, clinical depression, persistent substance misuse, major life events or crises, inability to attend treatment.*

The following text is an example on how CBT-E is applied to a client with bulimia nervosa (<http://www.iop.kcl.ac.uk>).

Step 1: FOCUS ON REGULAR EATING

The therapist should help the patient aim to eat three regular meals per day to reduce the urge to binge. The diet should be low glycemic index food to keep blood sugar levels constant. Educating the patient at this time about the medical consequences of weight reducing behaviors is important.

Step 2: ESTABLISH A THERAPEUTIC RELATIONSHIP

The aim is geared for a collaborative approach to the disturbed behavior. The therapist needs to identify in the patient other sources for the eating disorder, like child abuse, particularly sexual abuse, and child neglect.

Step 3: SPECIFIC STRATEGIES

Keeping food diaries. Food diaries are a mainstay for aiding recovery from bulimia nervosa, and can also be helpful in anorexia nervosa. A diary encourages linking of feelings (sadness, inadequacy, rejection, guilt etc) to food related behaviors - e.g., restriction, vomiting, exercising. A diary may take weeks for a patient to commit truthfully to, as it is often difficult to confront the pain of reality.

Behavioral strategies. Using the diary, the patient should be encouraged to see their behavior and how they may change it. For example:

- Visualize and develop in detail a healthy eating plan with the following targets that can be gradually approximated to: sufficient quantity of food for metabolic needs (>2000 kcal); sufficient variety of food nutrient; social eating.

- Decide that he/she will try not to vomit before 9am, and then 10am, etc.
- Decide on certain foods that feel 'safe' and eat those at times that feel more difficult.
- Plan to do something immediately after eating to take their mind off vomiting.
- Decide before starting eating how much they will eat, and try to stick to that.
- Only keep so much food in the house.
- Only go shopping with preplanned lists and limited money and avoid the sight and smell of highly palatable foods when hungry.

The patient will then work toward cognitive approaches once behaviors have been identified. Examples on how to go about this are designed to encourage the patient to identify their mis-beliefs, such as *'if I eat a chocolate bar I will put on 10 pounds,'* and underlying assumptions, such as *'all people who are fat are worthless.'* The therapist can help the patient challenge mis-beliefs by discussion and support from literature, and encourage them to practice this exercise in a consistent manner.

Step 4: TERMINATION PROCESS

The therapy should not end abruptly, and the patient should be encouraged to stick to the activities/behaviors they have developed in addressing their eating problems. Maintenance on these activities needs to be monitored by the therapist to ensure consistency.

Dialectical Behavior Therapy (DBT) in Eating Disorders

Dialectal behavior therapy (DBT) was conceived by Marsha Linehan originally for borderline personality disorders. The therapy is grounded on 3 core theories:

1. **Behaviorism.** The belief that behavior can be understood via the principles of learning theory such as positive and negative reinforcement. Thus, behaviors such as binge eating and purging are seen as **learned behaviors**. The major therapeutic implication being that if these behaviors can be learned, they can also be unlearned.

2. **Aspects of Zen practice.** There is a focus on mindfulness, being in the present, observing one's emotions without acting on them. DBT teaches patients psychological and behavioral versions of meditation skills usually taught in Eastern spiritual practices.

3. **Aspects of dialectical philosophy (originated by Hegel).** *Dialectical philosophy* is a fundamental world view concerning the nature of reality. It involves several principles, one of which is the principle of polarity. There is no one truth, for every truth-- for every thesis-- there is an antithesis-- an equal but opposite truth.

Everything is made of opposing forces and opposing sides. Gradual changes lead to turning points, where one opposite overcomes the other. Change is evolutionary, changes moves in spirals establishing truths on both sides rather than disproving one argument. Dialectics seeks a synthesis that honors truth on both sides. Emphasizes both and rather than either/or.


DBT therapists emphasize working with the tension between freedom and control.


This model is useful for therapists to balance pulling for change with acceptance of the difficulty of changing is useful in addressing the treatment ambivalence so characterize of eating disorder patients especially those with anorexia nervosa.


Eating disorder patients resent and resist treatment interventions, so DBT therapists are trained to use emotional, behavioral and validation strategies designed to acknowledge that symptom behaviors serve a meaningful function and represent a legitimate effort to deal with life circumstance (acceptance). Eating disorder patients frequently elicit strong negative reactions from therapists that are often incorrectly attributed to the patients' character. These reactions negatively influence treatment.


Eating disorder patients are often perceived as dishonest, vain and manipulative, which engenders a negative response. In contrast, understanding these behaviors as being related to a lack of skill in coping with unbearable anxiety or confusion engenders a more sympathetic and helpful response from treatment providers, friends and families.

There are **four modules** focusing on four groups of skills:

 **Mindfulness.** The mindfulness skills are derived from certain techniques of Buddhist meditation, although they are essentially psychological techniques and no religious allegiance is involved in their application. These techniques enable one to become more clearly aware of the contents of experience and to develop the ability to stay with that experience in the present moment.

 **Interpersonal Effectiveness.** Interpersonal response patterns taught in DBT skills training are very similar to those taught in many assertiveness and interpersonal problem-solving classes. They include effective strategies for asking for what one needs, saying no, and coping with interpersonal conflict.

 **Distress Tolerance.** Distress tolerance behaviors are concerned with tolerating and surviving crises and with accepting life as it is in the moment. Four sets of crisis survival strategies are taught: distracting, self-soothing, improving the moment, and thinking of pros and cons. Acceptance skills include radical acceptance, turning the mind toward acceptance, and willingness versus willfulness.

 **Emotion Regulation.** Emotion modulation skills are ways of changing distressing emotional states. 'Distress tolerance skills' include techniques for putting up with these emotional states if they cannot be changed for the time being.

DBT treatment can be carried out in different modes: individual therapy, group skills training, telephone contact, and therapist consultation. In any mode, the therapist needs to identify, prioritize and organize the many problematic behaviors with which eating disorder patients present:

☞ **Target One: Life Threatening Behaviors.** Suicidal and other imminent life-threatening behaviors and non-suicidal self-injurious behaviors are addressed first in treatment for eating disorder clients.

☞ **Target Two: Therapy Interfering Behaviors.** May occur within the context of treatment - attention is given to therapy interfering behaviors (TIB) to emphasize the necessity of a strong positive interpersonal relationship between patients and therapist. DBT uses the relationship to achieve therapeutic goals. The relationship is conceptualized in two ways, as being both the therapy itself and also the mechanism for effecting change. Examples of therapy interfering behaviors are missing sessions, lying, losing weight, restricting meals, showing up late to treatment - anything that

interferes with the relationship and therefore the treatment, and behaviors that burn out the therapist. Therapy interfering behaviors on the part of the therapist are those that create therapeutic imbalance (too much emphasis on change and not enough on validation), and those that demonstrate a lack of respect for the patient, such as arriving late for group.

☞ **Target 3: Quality of Life Interfering Behaviors.** This pertains to different factors that interfere with the treatment process, like housing issues, employment issues, or laxative use.

The bulk of treatment for eating disorder clients who are not suicidal or at imminent risk of death will fall within Targets 2 and 3. The therapist should attend to the immediacy of problem, solvability of problem, functional relationship of behaviors to higher priority targets, and the patients' goals.

Family Evaluation and Therapy for Eating Disorders

Family therapy may occur in conjunction with inpatient treatment, or may take place in an outpatient setting. Family therapy is particularly important when the patient is to return to the family home after treatment. The focus is on fostering open, healthy interaction patterns among members. Family therapy is challenging because patient and families may deny the eating disorder. Even when they admit a problem, they may minimize its extent. Families also may typically insist that there is no conflict and that they get along very well. To complicate matters, the patient may not be thinking clearly and may be unable to reason effectively enough to participate meaningfully.

Behavior family systems therapy (BFST) is an approach that blends behavior modification, cognitive therapy, and family therapy. For anorexia nervosa, BFST begins after the client is medically stable. It consists of four phases:

1. **Assessment.** The multidisciplinary team, consisting of dietitian, physician, psychologist, nurse, and other professionals who come together to coordinate care with the patient and family. Team members engage the family in

treatment and check the patient's weight weekly. They conduct history, behavioral analyses, and social and functional analyses.

2. Control rationale. The therapist encourages parents to “take charge” of the patient's eating and deals with their reactions. The therapist also coaches parents to develop an appropriate behavioral weight program.

3. Weight gain. The therapist begins to refine the weight-gain program and introduces non-food-related issues. He or she begins cognitive therapy interventions. Family psychotherapy and psychoeducation takes place.

4. Weight maintenance. Control over food gradually returns to the patient. Team members teach healthy ways of maintaining weight. Family interactions increasingly become the focus of treatment. The therapist fosters patient individuation.

Psycho-pharmacology

In conjunction with the different therapies, eating disorder patients are also prescribed different forms of medications to help manage the different psychological disturbances associated with the disorder. In anorexia nervosa, several classes of drugs have been studied:

- Amitriptyline (Elavil) and antihistamine cyproheptadine (Periactin) in high doses (up to 28 mg/day) can promote weight gain in inpatients with anorexia nervosa.
- Olanzapine (Zyprexa) is used for its antipsychotic effect on bizarre body image distortions and associated weight gain.
- Fluoxetine (Prozac) has some effectiveness in preventing relapse in clients whose weight has been partially or completely restored; however, close monitoring is needed because weight loss can be a side effect.

Since the 1980s, several controlled studies have been conducted to evaluate the effectiveness of antidepressants to treat bulimia. Drugs, such as desipramine (Norpramin), imipramine (Tofranil), amitriptyline (Elavil), nortriptyline (Pamelor), phenelzine (Nardil), and fluoxetine (Prozac) were prescribed in the same dosages

used to treat depression. In all studies, the antidepressants were more effective than were the placebos in reducing binge eating. They also improved mood and reduced preoccupation with shape and weight. Most of the positive results, however, were short term, with about one third of patients relapsing within a 2-year period (Agras, 2006).

Client and Family Education

One primary role in caring for patients with eating disorders is providing education to help them take control of nutritional requirements. This teaching can be done in the inpatient setting during discharge planning or in the outpatient setting. The therapist provides extensive teaching about basic nutritional needs and the effects of restrictive eating, dieting, and the binge and purge cycle. Patients need encouragement to set realistic goals for eating throughout the day. Eating only salads and vegetables during the day may set up patients for later binges as a result of too little dietary fat and carbohydrates.

For patients who purge, the most important goal is to stop. Teaching should include information about the harmful effects of purging by vomiting and laxative abuse. The therapist explains that purging is an ineffective means of weight control and only disrupts the neuroendocrine system. In addition, purging promotes binge eating by decreasing the anxiety that follows the binge. The therapist explains that if patients can avoid purging, they may be less likely to engage in binge eating. The therapist also teaches the techniques of distraction and delay either binging or purging, the less likely they are to carry out the behavior.

The therapist explains to family and friends that they can be most helpful by providing emotional support, love, and attention. They can express concern about the patient's health, but it is rarely helpful to focus on food intake, calories, and weight.

Community-Based Care

Treatment for patients with eating disorders usually occurs in the community settings. Hospital admission is indicated only for medical necessities, such as for patients with dangerously low weight, electrolyte imbalances, or renal, cardiac, or

hepatic complications. Clients who cannot control the cycle of binge eating and purging may be treated briefly in an inpatient setting. Other treatment settings include partial hospitalization or day treatment programs, individual or group outpatient therapy, and self-help groups.

Self-Awareness Issues

In handling patients with eating disorders, the therapist is highly vulnerable to the different emotions and reactions that the patients may exhibit during the therapy. The feeling of wanting to “take care of this child” is very common for the therapist as he/she has the first encounter with the patient. The ideal reaction of the patient towards the therapist is hostile because the patient sees the therapist to be the enemy for wanting him/her to eat. The patient will in turn hide or throw away food as anxiety about eating increases. The therapist must remember that this is a symptom of the patient’s anxiety and fear about gaining weight and not personally directed toward the helper. Taking the patient’s behavior personally may cause the therapist to feel angry and behave in a rejecting manner.

Because eating is such a basic part of everyday life, the therapist may wonder why the patient cannot just eat “like everyone else.” The therapist also may find it difficult to understand how a 75-pound patient sees herself fat when she looks in the mirror. Likewise, when working with a patient who binges and purges, the therapist may wonder why the patient cannot exert willpower to stop. The therapist must remember that the patient’s eating behavior has gotten out of control. Eating disorders are mental illnesses that develop a distortion in reality and perception.

The Use of Information Technology in the Treatment of Eating Disorders

Internet has proven to be helpful in many ways because it is easy to use, readily accessible, convenient, and efficient. The advent of using information technology in diagnosis and treatment has been adopted by many patients and health care practitioners alike as the most convenient way of seeking and providing medical help. Patients have reported experiencing high levels of support and acceptance as

they were able to disclose important information, and generally experienced positive feelings related to the endeavor.

E-mail and text messaging can be used to monitor patient status as well as enhance therapy sessions (Yager, 2001). Other potential advantages are that these forms of communication increase patient-clinician contact, resulting in patients spending more time on treatment-related content, and require relatively little of the clinician's time. Some of the potential disadvantages of e-mail and text messaging are that some e-mails or text messages may contain inappropriate or ethically challenging content (e.g., suicide threat), patients may be frustrated with slow responses from the clinician (compared to face-to-face sessions), or inadequate responses by the clinician. There are also concerns related to confidentiality; for example, messages may be read by someone other than the patient.

CONCLUSION:**Points to consider when working with patients who have eating disorders**

It may be impossible for a normal person to understand individuals with eating disorders. Some may label them as “*Ana Mia*,” “*bag of bones*,” or other derogatory words for anorexia/bulimia, or may judge them as “*too vain to become thin*.” It must be understood that they have a mental illness which needs immediate treatment.

However, the success of the treatment is not solely the responsibility of the patient nor the therapist. Family support and friends’ involvement are highly required as well. A relapse of the eating behavior can happen if the patient does not receive the necessary guidance, encouragement, and correct motivation during therapy sessions. A person can die from an eating disorder - from medical complications or perhaps suicide, attributed to depression concerning their self-esteem and body image disturbance.

To help the patient recover successfully, the therapist should be guided on the following important points:

- Be empathetic and nonjudgmental, although this is often not easy. Remember the patient’s perspective and fears about weight and eating.
- Avoid sounding parental when teaching about nutrition or why laxative use is harmful. Presenting information factually with chiding the client will obtain more positive results.
- Do not label clients as “good” when they avoid purging or eat an entire meal. Otherwise, patients will believe they are “bad” on days when they purge or fail to eat enough food.

Evaluation of the patient’s response to interventions and treatment is an ongoing process. Recovery is considered a life-long process.

The therapist must also evaluate the family's interaction patterns. Desired outcomes are that family members communicate directly with each other and deal openly with conflicts, and that parents relinquish previous patterns of over-control and over-protectiveness to allow the client an appropriate degree of autonomy. Even if the patient and family appear to have met these goals, most patients require follow-up treatment to reinforce behavioral changes and prevent a return of disordered eating.

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THANK YOU FOR YOUR PARTICIPATION IN THIS COURSE

To receive continuing education credit for this course, you must have read this entire text file.



You must also complete and return the Evaluation of Learning Quiz and pay the CEU fee.

(Instructions are on the next page.)

We always appreciate constructive input from our customers - even when it's 'negative', so please feel free to fill in the "Additional Comments" section of the Grade This Course evaluation when you submit your quiz and payment.

Richard K. Nongard, LMFT, CCH, CPFT

Executive Director

"Understanding and Treating Eating Disorders"

3 Continuing Education Clock Hours

Procedures to Receive CEU Credit:

- This document contains all of the course materials you needed to read.
- Now you must complete the required True/False Evaluation of Learning Quiz and submit it to our office along with your payment, in order to obtain your CEU certificate.

FOR ONLINE SUBMISSION:

Go back to www.FastCEUs.com and click the "QUIZ & PAY" link for this course.

On the page that opens, enter your information and take the T/F Quiz. When you click SUBMIT, the program will instantly grade your quiz, and provided you pass by at least 80%, it will then charge your credit or debit card.

Immediately, a new web page will open containing your Receipt and Certificate info, and a Link will be provided to access a fancy Certificate for you to Print and/or Save to your computer.

You will also receive an Email containing this same information and the link.

*You will **NOT** receive a paper certificate in the mail - This electronic system provides numerous options for you to print and save your CEUs.*

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Print the Quiz and Payment forms on the next few pages of this document, and complete the requested information.

Our 24-hour secure Fax number is **(888)-877-6020**.

If you fax your quiz and payment to us, please do NOT also mail it.

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EVALUATION OF LEARNING QUIZ - PAGE 1 of 4

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

***** OR *****

You may complete and submit this information ONLINE by following this link:

<https://www.fastceus-store.com/quizzes/index.php?extension=eating-disorders>

PLEASE NEATLY PRINT THE FOLLOWING INFORMATION:

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“Understanding and Treating Eating Disorders”

This 3 Hour CEU Course is **\$49.00**

CIRCLE: Master Card Visa Discover Card American Express Check Enclosed

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EVALUATION OF LEARNING PAGE 2 of 4

“Understanding and Treating Eating Disorders”

3 Hours of Approved Continuing Education Credit

The purpose of the following Evaluation of Learning questions is to:

- A.) Verify that you have read the required course materials
- B.) Demonstrate an understanding of the practical application of the course materials
- C.) Officially document your participation and completion of this course

➡ ANSWER THESE 20 T/F EVALUATION OF LEARNING QUESTIONS

- T F 1. I have read the entire required .pdf text file for this course.
- T F 2. Eating disorders can be viewed on a continuum.
- T F 3. Proposals for the recognition of a new disorder, binge eating disorder, were put forward in the early 1990s, and accorded grudging recognition in an appendix of DSM-IV in 1994.
- T F 4. Healthy people without eating disorders are so focused on fighting hunger that it is hard for them to acknowledge that they have it.
- T F 5. There are very little significant differences between anorexia nervosa patients who engage in bulimic or purging behaviors compared with those who consistently restrict their dietary intake. Almost all eating disorders are very similar and have the same characteristics.
- T F 6. Bulimia nervosa is an eating disorder characterized by recurrent of binge eating followed by inappropriate compensatory behaviors to avoid weight gain, such as purging, fasting, or excessively exercising.
- T F 7. Orthorexia is an officially recognized disorder in the DSM.
- T F 8. There is a single specific cause for all eating disorders.
- T F 9. Psychosocial factors like the person’s response to emotions such as loneliness, sadness, anger, or celebration; stressful interpersonal or family dynamics may also be contributing factors in development of eating disorders.
- T F 10. The role of social media has placed the concept of slenderness as an expression of attractiveness.
- T F 11. Bulimia Nervosa usually begins in late adulthood and is rarely seen in teens and young adults.

CONTINUED ➔

EVALUATION OF LEARNING (CONTINUED) PAGE 3 of 4**“Understanding and Treating Eating Disorders”**

- T F 12. In bulimia nervosa, serious medical consequences may occur because of alternating bingeing and purging.
- T F 13. Regardless of the type of therapy being carried out, the therapist has to establish a therapeutic relationship between his/her patient.
- T F 14. CBT-E is an “enhanced” version of the leading evidence-based treatment for bulimia nervosa.
- T F 15. Dialectal behavior therapy (DBT) can only be used in treating personality disordered patients, and should never be applied to eating disorders.
- T F 16. DBT therapists emphasize working with the tension between freedom and control.
- T F 17. Emotion modulation skills are ways of changing distressing emotional states and 'distress tolerance skills' include techniques for putting up with these emotional states if they cannot be changed for the time being.
- T F 18. Family therapy is particularly important when the patient is to return to the family home after treatment.
- T F 19. In handling patients with eating disorders, the therapist is highly vulnerable to the different emotions and reactions that the patients may exhibit during the therapy.
- T F 20. Eating disorders cannot be successfully treated.

GRADE THIS ONLINE COURSE! – Page 4

*It is helpful to us if you return this form via snail mail or fax,
along with your Quiz and Payment. Thank-you!*

Participant Assessment of Home Study CEU Course

“Understanding and Treating Eating Disorders”

3 Credit Hours

**Please Rate the Following Statements from 1-5
(1 being the Lowest, 5 being the Highest.)**

- _____ 1. I found the PeachTree Online Home Study Course Instructions simple to follow.
- _____ 2. I found the PeachTree Online Home Study Course materials to be of professional quality, and easy to read.
- _____ 3. I found the PeachTree Online Home Study Course materials to be of educational value, relative, and useful to my counseling practice.
- _____ 4. I completed the 3 Hour PeachTree Online Home Study Course in approximately 3 hours.
- _____ 5. I would take another PeachTree Online Home Study Course, and/or recommend them to a co-worker.

ADDITIONAL COMMENTS: