

# Eating Disorders:



*Recovery is Possible*

*Sherry Peters, LPC*  
*[www.brookhavenhospital.com](http://www.brookhavenhospital.com)*

# Goals:

- Define:

- ◆ Relative terms
- ◆ Prevalence





○ Provide practical insight:


- ◆ Review treatment options
- ◆ Identify errors in therapeutic approach
- ◆ Assist in building a positive body image
- ◆ Enable patient to establish healthy boundaries

- Provide a reference for:
  - ◆ Support & Prevention



Anorexia  
Nervosa





...is a refusal to maintain normal body weight ( an individual weighing less than 85% of a weight that is considered normal for their age and height), intense fear of gaining weight or becoming fat, even though underweight, disturbance in the way in which one's body weight or shape is experienced, undue/excessive influence of body shape on self-evaluation, and denial of seriousness of low body weight, and amenorrhea.



## Prevalence of Anorexia:

- Common age of onset: mid teens; in 5% of the patients it's in their early twenties.
- Lifetime prevalence (women) is 0.5% when narrowly defined- approximately 1.5 million (US).
- Individuals who are subthreshold for the disorder are more commonly found.
- Rate of occurrence among males is 1/10<sup>th</sup> of that in females.

# How to calculate Body Mass Index

- Underweight = <18.5
- Normal weight = 18.5-24.9
- Overweight = 25-29.9
- Obesity = BMI of 30 or greater

$$\text{BMI} = \left( \frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$$

$$\text{BMI} = \frac{\text{Weight in Kilograms}}{(\text{Height in meters}) \times (\text{Height in meters})}$$

# Bulimia Nervosa

- ...involves recurrent episodes of binge eating that have occurred at least twice a week for the past three months. A feeling of a lack of control over eating behavior during these binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise to prevent weight gain; and persistent over-concern with body weight and shape.





# Prevalence of Bulimia Nervosa:

- ◆ The onset of BN is usually in late adolescence/early adulthood.
- ◆ Lifetime prevalence among women range from 1% to 3% - up to 9.3 million (US).
- ◆ 90% of Bulimics are female
- ◆ Rate of occurrence among males is 1/10th of that in females.

# Eating disorder NOS



- ...includes disorders of eating that do not meet the criteria for any specific eating disorder.
- For females, all the criteria for Anorexia Nervosa are met except for regular menses.
- All of the criteria for Anorexia are met except that, despite significant weight loss, the weight is in the normal range.
- All the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at less than twice a week or for less than 3 months.

## Eating Disorder NOS Ctd.:

- The patient has normal body weight and regularly uses inappropriate compensatory behavior after eating small amounts of food.
- Repeatedly spitting out, but not swallowing, large amounts of food.
- Eating Disorder NOS is the most common ED.
- Binge-eating disorder is recurrent episodes of binge eating in the absence of regular inappropriate compensatory behavior characteristic of bulimia.

# Body Dysmorphia



- ❑ Preoccupation with an imagined defect in appearance if a slight physical anomaly is present.
- ❑ The preoccupation causes clinically significant distress/impairment in social or occupational areas of functioning.
- ❑ The preoccupation is not better accounted for by another [mental disorder](#) (e.g., dissatisfaction with body in [Anorexia](#)).

# ED most common in:

- Industrialized societies where there is an abundance of food and being thin is considered attractive.
- United States, Canada, Europe, Australia, New Zealand, and South Africa, with China & Japan on the incline.
- US- young Latin, Native and African American women, but the rates are lower than in Caucasian women.
- Female athletes involved in running, gymnastics, or ballet are at risk.
- Male body builders or wrestlers are at increased risk.

# Some ED causes



- ◆ Sexual, physical, and emotional abuse
- ◆ Societal pressures
- ◆ High achievers
- ◆ Perfectionism
- ◆ Loss of control
- ◆ Feeling like they have no voice
- ◆ Low self-esteem
- ◆ Genetics
- ◆ Self starvation may be an effort to gain validation
- ◆ Living in chaos

# Comorbidity of Eating Disorders



- Common comorbid conditions include major depressive disorder or dysthymia (50% to 75%), sexual abuse (20% to 50%), obsessive-compulsive disorder (25% with anorexia nervosa), substance abuse (12% to 18% with anorexia nervosa, especially the binge–purge subtype, and 30% to 37% with bulimia nervosa), and bipolar disorder (4% to 13%).

# Assessment

A decorative graphic consisting of two overlapping circles on the left and three separate circles on the right. The circles are light purple, with the leftmost one being solid and the others being hollow outlines.

- ◆ Usually Clinical interview
- ◆ Eating Attitudes Test
- ◆ Eating Disorders Inventory
- ◆ Body Shape Questionnaire

# Course and Prognosis



- ◆ As a general guideline, it appears that one third of patients fully recover, one third retain sub-threshold symptoms, and 1/3 maintain a chronic eating disorder.
- ◆ Anorexia Nervosa: Long-term follow-up shows recovery rates ranging from 44% to 76%, with prolonged recovery time (5 years).
- ◆ Mortality (up to 20%) is primarily from cardiac arrest or suicide. Good prognostic factors are admission of hunger, lessening of denial, and improved self esteem.

## Course and Prognosis, Ctd.



- ◆ Anorexia: Poorer prognostic factors are initial lower minimum weight, presence of vomiting or laxative abuse, failure to respond to previous treatment, disturbed family relationships, and conflicts with parents.
- ◆ Bulimia Nervosa- Little long-term follow-up data exist. Short-term success is 50% to 70%, with relapse rates between 30% and 50% after 6 months. These patients have an overall better prognosis as compared with anorexia nervosa patients.

# Course and Prognosis Ctd.



- Bulimia: Poor prognostic factors are hospitalization, higher frequency of vomiting, poor social and occupational functioning, poor motivation for recovery, severity of purging, presence of medical complications, high levels of impulsivity, longer duration of illness, delayed treatment, and premorbid history of obesity and substance abuse.

# Some Medical Complications of ED (weight loss related)

- ◆ Heart problems
- ◆ Low potassium
- ◆ Constipation
- ◆ Low blood pressure
- ◆ Fainting
- ◆ Dehydration
- ◆ Osteoporosis

# Some Medical complications due to Appetite Suppressant & Purging Abuse

- ◆ Tremors
- ◆ Cardiac problems
- ◆ Dehydration
- ◆ Dental caries
- ◆ Electrolyte abnormalities
- ◆ Gastrointestinal irritation, bleeding, or reflux
- ◆ Secondary renal failure



# Some Medical complications due to obesity

- ◆ edema
- ◆ hypertension
- ◆ diabetes
- ◆ cardiac problems
- ◆ chronic pain



# Treatment

- ◆ A holistic approach is best-mind/body/spirit.
- ◆ A comprehensive treatment plan including a combination of nutritional rehabilitation (development of an individualized meal plan), psychotherapy, and medication is recommended.
- ◆ The patient's weight and cardiac and metabolic status determines the acuteness of the illness and the need for hospitalization.

# Dialectical behavioral therapy



- Marsha Linehan, PHD, University of Washington, '93.
- DBT is a comprehensive treatment approach for people whose emotions create major problems in their lives (and for people around them). These emotions may be expressed in a destructive way (as in angry outbursts, violence, or depression and immobility), or avoided by behaviors such as suicide attempts, substance abuse, eating disorders, or impulsive actions.



- Skills training group - 4 units:

- ◆ Core Mindfulness
  - ◆ What skills
  - ◆ How skills
- ◆ Interpersonal Effectiveness
- ◆ Emotion Regulation
- ◆ Distress Tolerance



## Cognitive Behavioral Therapy

- ◆ Aaron Beck, 1960, Univ. of Pennsylvania.
- ◆ Based on principle that thoughts influence our feelings
- ◆ Event-thoughts-feelings-actions-results
- ◆ 3 levels of cognition; core beliefs (schemas), conditional assumptions, and automatic thoughts

# Conceptualizing the patient (example)

- ◆ Core Beliefs: I am vulnerable, bad, helpless and others are superior to me.
- ◆ Situation: Therapist and pt discuss pt difficulty paying her bills.
- ◆ Automatic thoughts : “My therapist is thinking I’m stupid.” “How Dare she judge me!”
- ◆ Reaction: Emotional- Anger. Physiological- Clenches her fist. Behavioral- Tells therapist that she’s not being helpful.

# CBT: Modifying core beliefs



- ◆ Cost-benefit analysis: Identify the advantages/disadvantages of maintaining core beliefs.
- ◆ Core belief log: Tracks day-to-day evidence that suggest a core belief is not 100% true (use Socratic questions).
- ◆ Life review: Pt re-evaluates core beliefs/reframe from adult perspective

# Behavioral Modification Strategies



- ◆ Activity monitoring & scheduling
- ◆ Graded task assignments
- ◆ Exposure
- ◆ In vivo exposure
- ◆ Imagined exposure

# Therapist errors in E.D. treatment



- ◆ Setting unrealistic expectations
- ◆ Depending on the patient
- ◆ Focusing too much on patient behavior
- ◆ Ignoring importance of emotional expression
- ◆ Taking too much control

Establish boundaries- encourage clients to:

- Teach clients to become assertive
- Own their thoughts, feelings, and behaviors- controlling others is an illusion
- Work through resentments-forgiveness
- Avoid unhealthy relationships
- Become safe and form positive relationships

# Improve body image



- Practice self-monitoring
- **Activators-** specific events and situations that trigger thoughts and feelings about your body
- **Beliefs-** thoughts, perceptions, and interpretations
- **Consequences-** your emotional and behaviorally reactions



# Improve body image Ctd.

- ◆ Challenge appearance assumptions:
  - ◆ Physically attractive people have it all.
  - ◆ Outward appearance is sign of inner person
  - ◆ I would be happier if I had the looks I wanted.
  - ◆ If people knew how I really look, they would like me less.
  - ◆ The media makes it impossible to be satisfied with my appearance.



## Improve body image Ctd.

- ◆ Talk back to the media's messages- e.g., Photoshop work, make-up jobs, plastic surgery, professional stylists, excessive exercise, strict diets, etc.
- ◆ Appreciate the way the body functions.
- ◆ See self as a whole person.
- ◆ Exercise moderately utilizing enjoyable exercise.
- ◆ Replace negative body image words with positive language.

# Spirituality in ED treatment



- Research literature supports the idea that religion and spirituality are good for people.
- People who are religious often have fewer bad habits which can reduce risk for health problem.



## Spirituality in ED treatment Ctd.

- ◆ Religiously and spiritually committed individuals are likely to report healthy and supportive relationships in their communities of faith.
- ◆ Prayer, meditation, and worship have been correlated with lower reported stress levels.
- ◆ Provides hope and a reason to live.



# Benefits of family involvement

- ◆ Can increase patient's motivation for treatment
- ◆ Resolving conflicts
- ◆ Establishment of healthy boundaries
- ◆ Support
- ◆ Provides insight into family dynamic



# Ways to build a support network

- ◆ Have a primary therapist/psychologist
- ◆ Group therapist
- ◆ A case manager
- ◆ Physician/Psychiatrist
- ◆ Clergy (pastor, priest, minister)
- ◆ Attend 12-step group
- ◆ Have a 12-step sponsor
- ◆ Friends and relatives
- ◆ Friend from volunteer organization

# Relapse prevention



- ◆ Identify triggers
- ◆ Use crisis coping skills
- ◆ Follow a meal plan
- ◆ Utilize support people  
(therapists/sponsors/friends/nutritionist)
- ◆ Journaling
- ◆ Anticipate slips/flops
- ◆ Walk in forgiveness (of self and others)
- ◆ Use a higher power
- ◆ Read positive affirmations 2x daily (AM and PM)



# ED support group websites

- ◆ [www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)
- ◆ [www.oa.org](http://www.oa.org)
- ◆ [www.anad.org](http://www.anad.org)
- ◆ [www.celebraterecovery.com](http://www.celebraterecovery.com)



# References

- Beck, Judith S., (2005). *Cognitive Therapy for Challenging Problems: What to do when the basics Don't work*, New York, NY: Guilford Press
- *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.
- Spradlin, Scott E. MA., (2003). *Don't Let Your Emotions Run Your Life: How Dialectical Behavioral Therapy Can Put You in Control*, Oakland, CA: New Harbinger Publications, Inc.
- Linehan, Marsha M. Ph.D, (1993). *Skills Training Manual for Treating Borderline Personality Disorder*, New York, NY: The Guilford Press
- Cash, Tomas F. Cash, PH.D. (1997). *The Body Image Workbook: An 8-Step Program for Learning to Like Your Looks*, Oakland, CA, New Harbinger Publications, Inc.

# References, Ctd.



- Landa, Carrie E. & Bybee, Jane A. (2007). *Adaptive Elements of Aging: Self-Image Discrepancy, Perfectionism, and Eating Problems*. *Developmental Psychology* Volume 43, Number 1, 83-93
- Thompson, Ron A. & Sherman, Roberta T. (1989). Therapist Errors in Treating Eating Disorders: Relationship and Process. *Psychotherapy, Volume 26, Number 1*
- Department Of Health and Human Services. National Institute of Health. (2010). Retrieved April 10, 2010 from
- [www.nhlbisupport.com/bmi](http://www.nhlbisupport.com/bmi)
- WikiHow: The How to Manual You can Edit. (2010). Retrieved April 10, 2010 from [www.wikihow.com](http://www.wikihow.com)