“Not Thin Enough”: Overcoming Barriers to Eating Disorder Treatment and Recovery

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Learning Objectives

1. Understand the complex etiology and pathology of anorexia nervosa (AN) and bulimia nervosa (BN) as they relate to clients' resistance to seeking or engaging in ED treatment.

2. Become an eating disorder-informed clinician by understanding warning signs and risk factors for AN and BN, utilizing a therapeutic approach with regard to suspicion of an ED, and identifying when outside referral may be necessary.

3. Develop an understanding of societal factors, as well as issues related to managed care, as they contribute to patients' resistance to seeking treatment. Advocate for clients who struggle with feeling valid in, or understanding the severity of, their illness.

Eating Disorder Myths vs. Facts

#1 Myth vs. Fact?

You can tell someone has an eating disorder based on their weight/BMI.

MYTH!

“Most people with an eating disorder are not underweight.

Although most people with eating disorders are portrayed by the media as emaciated, you can’t tell whether someone has an eating disorder just by looking at them. These perceptions can perpetuate the problem and may cause distress in eating disorder sufferers for fear of not being “sick enough” or “good enough” at their disorder to deserve treatment.

An individual can experience a severe eating disorder at any weight.”

National Eating Disorders Association, 2018

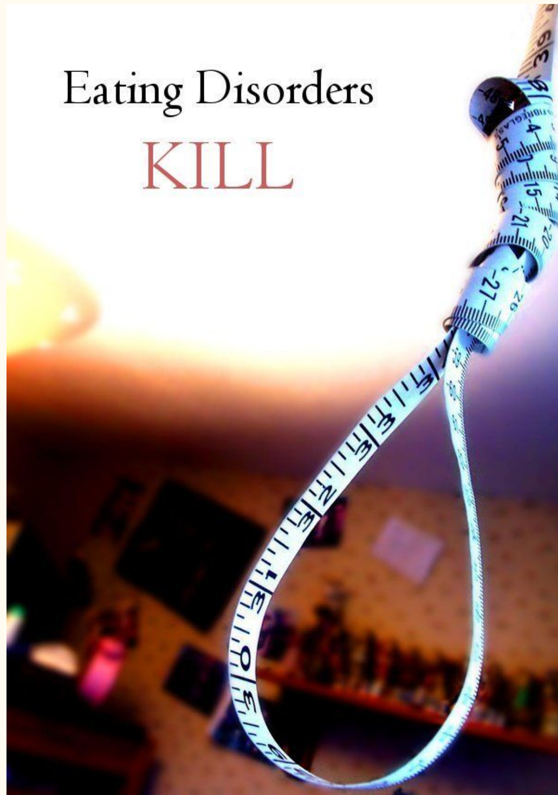
Less than 6% of people with eating disorders are medically diagnosed as “underweight.”

National Association of Anorexia Nervosa and Associated Disorders (ANAD), 2020

#2 Myth vs. Fact?

Eating disorders are among the deadliest mental illnesses, second only to opioid overdose.

FACT!



Mortality Rates of EDs:

Anorexia nervosa - 4%

Bulimia nervosa - 3.9%

Other specified feeding or eating disorders (OSFED) - 5.2%

(American Journal of Psychiatry, 2009)

#3 Myth vs. Fact?

Starvation mode is a real thing.

FACT!

As one restricts calories, one's metabolism slows to preserve body fact necessary for day-to-day functioning.

Part 1: Understanding Eating Disorders

Anorexia Nervosa

1. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Atypical anorexia includes those individuals who meet the criteria for anorexia but who are not underweight despite significant weight loss."

(National Eating Disorders Association, 2018)

Bulimia Nervosa

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    - 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.
    - 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, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.

(National Eating Disorders Association, 2018)

Binge Eating Disorder

- Recurrent episodes of binge eating. (Refer to previous slide)
- The binge eating episodes are associated with three (or more) of the following:
    - Eating much more rapidly than normal.
    - Eating until feeling uncomfortably full.
    - Eating large amounts of food when not feeling physically hungry.
    - Eating alone because of feeling embarrassed by how much one is eating.
    - Feeling disgusted with oneself, depressed, or very guilty afterward.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for 3 months.

(National Eating Disorders Association, 2018)

ARFID (Avoidant Restrictive Food Intake Disorder)

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
  - Significant nutritional deficiency.
  - Dependence on enteral feeding or oral nutritional supplements.
  - Marked interference with psychosocial functioning.

Orthorexia - NOT recognized in DSM-5

- Compulsive checking of ingredient lists and nutritional labels
- An increase in concern about the health of ingredients
- Cutting out an increasing number of food groups (all sugar, all carbs, all dairy, all meat, all animal products)
- An inability to eat anything but a narrow group of foods that are deemed ‘healthy’ or ‘pure’
- Unusual interest in the health of what others are eating
- Spending hours per day thinking about what food might be served at upcoming events
- Showing high levels of distress when ‘safe’ or ‘healthy’ foods aren’t available
- Obsessive following of food and ‘healthy lifestyle’ blogs on Twitter and Instagram
- Body image concerns may or may not be present

Risk Factors

Family history of ED, genetic predisposition

Body image dissatisfaction

History of dieting

Perfectionism

Hx of bullying

Hx of anxiety disorder

Trauma

*Acculturation

*Black and white thinking

Inflexibility

Family history of mental illness

Warning Signs

Psychological

- Preoccupied with body, food, and/or weight
- Intense fear of gaining weight
- Irritability/mood changes
- Withdrawing from friends and family
- Anxiety around food, meals

Behavioral

- Dieting, binge eating
- Hiding food, lying about food consumption
- Trips to the bathroom after meals
- Avoiding social situations involving food
- Body checking
- Rituals surrounding food and exercise
- Change in clothing style

Warning Signs (continued)

Physiological

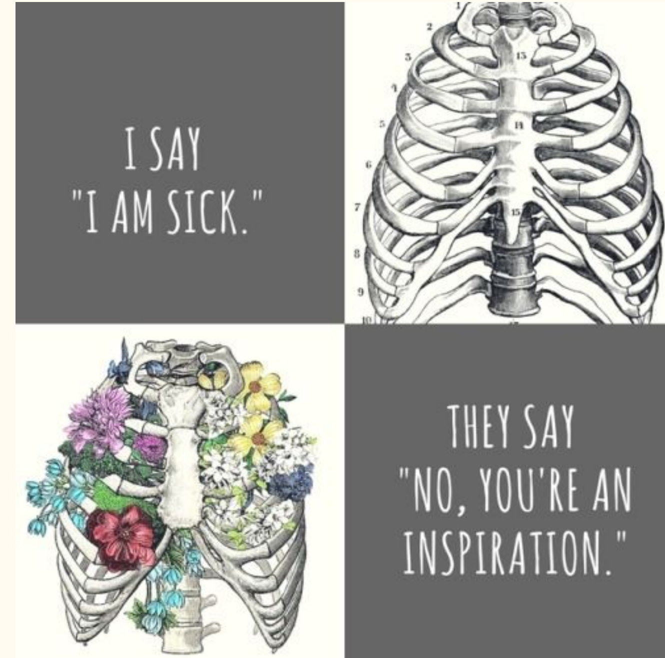
- Observable changes in weight - weight gain or weight loss
- Difficulty with attention and concentration
- Decreased energy
- Insomnia
- Increased sensitivity to cold

Societal Factors

Glorification of certain EDs

The “thin ideal”

Cultural norms of focusing on appearance and physical characteristics



“We turn skeletons into goddesses and look to them as if they might teach us how not to need.”

— Marya Hornbacher, Wasted: A Memoir of Anorexia and Bulimia

"As a child, fat
was the first word
people used to
describe me,
which didn't offend
me until I found out
it was supposed to."

-Blythe Baird

“When the Fat Girl Gets Skinny” - Blythe Baird

https://www.youtube.com/watch?v=16Tb_bZZDv0

Mental Health Disorder or Addiction?

Identifying stage of change

Motivational interviewing may be necessary

Meeting the client exactly where he/she/they are at

Secrecy

Addictions to:

- Watching number drop on scale
- Purging - release, a “high”
- Feeling hungry - biochemistry different in ED person vs. non-ED

EATING DISORDERS & CO-OCCURRING DISORDERS

In a nationally representative survey **of respondants with eating disorders, the following percentage met the criteria for one or more co-occurring disorders:**[6]

56%

RESPONDENTS WITH ANOREXIA NERVOSA

79%

RESPONDENTS WITH BINGE EATING DISORDER

95%

RESPONDENTS WITH BULIMIA NERVOSA*

***64%**

OF RESPONDENTS WITH BULIMIA NERVOSA FIT THE CRITERIA FOR 3 OR MORE DISORDERS

LEARN MORE: WWW.MYNEDA.ORG

CITATIONS: WWW.MYNEDA.ORG/INFOGRAPHICS

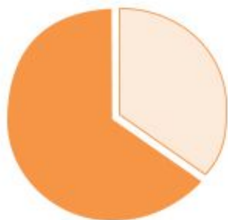
NEDA Feeding hope.

National Eating Disorders Association

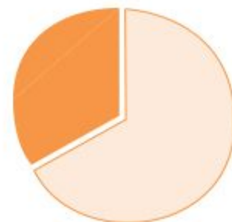
IT'S TIME TO TALK ABOUT IT

EATING DISORDERS & COMMON CO-OCCURRING DISORDERS: OBSESSIVE-COMPULSIVE DISORDER

There is a markedly elevated risk for obsessive-compulsive disorder among those with eating disorders.[3,5]



69% OF PATIENTS WITH ANOREXIA NERVOSA



33% OF PATIENTS WITH BULIMIA NERVOSA

LEARN MORE: WWW.MYNEDA.ORG

CITATIONS: WWW.MYNEDA.ORG/INFOGRAPHICS

NEDA Feeding hope.
National Eating Disorders Association

IT'S TIME TO TALK ABOUT IT

ACCORDING TO THE NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE:

50% OF INDIVIDUALS with eating disorders abused alcohol or illicit drugs, a rate **5X** higher than the general population.[1]

LEARN MORE: WWW.MYNEDA.ORG

CITATIONS: WWW.MYNEDA.ORG/INFOGRAPHICS

NEDA Feeding hope.

National Eating Disorders Association

Abuse/Trauma and ED

Reclaiming one’s body

Striving for control over one’s body

Trying to control having a certain body to avoid further abuse

Perpetuating cycles of ongoing abuse - emotional, physical

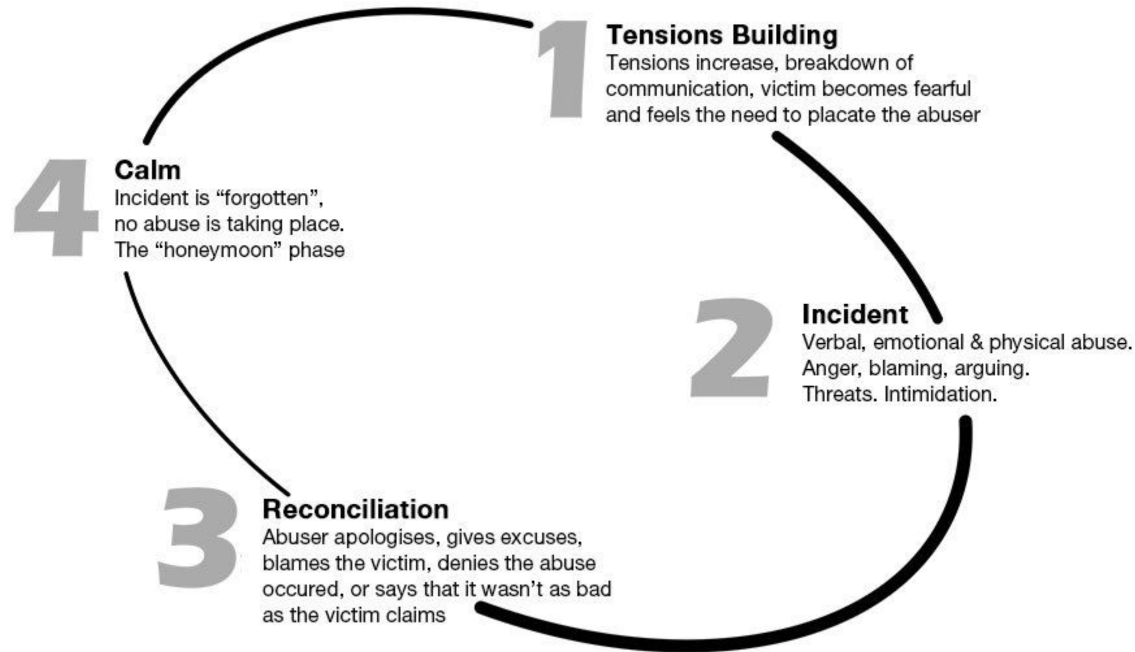
The “Love/Hate” Relationship

Inner conflict - understanding the health risks (both physical and mental/emotional) but continuing to strive for control and improving self-esteem

Roles of ED - best friend, source of structure, romantic partner, etc.

ED as an abusive partner - “trauma bond”

Have to face food multiple times a day every day for the rest of one’s life



How would you describe an eating disorder using the "Cycle of Abuse" model? Indicate for each stage of the cycle what an eating disorder sufferer may be experiencing.

The Burden of Shame

Need for control

Need to be viewed as self-sufficient

Certain EDs (bulimia, binge eating) more stigmatized

Resistance toward asking for help/support

Shame related to trauma

Part 2: Addressing Eating Disorders Clinically

Challenging Resistance

Validation and meeting the patient where he/she/they are at

Rapport is essential!

Seek to understand the role(s) ED thoughts and behaviors play in patients' lives - let this guide the clinical approach

The "why" of recovery - understanding motivations and alternatives

Understand the emotions that drive ED behaviors, and provide healthier alternative to have emotional needs met

The Voice Within

Differentiating ED voice vs. genuine healthy voice of the patient

Identifying and rewriting the inner dialogue (i.e. role play)

Understanding consequences of following the ED voice

- Benefits vs. detriments of continuing to “give in” to ED

Therapeutic Techniques and Interventions

EDs are not just mental health disorders

Important to include a medical team

Nutritional Counseling

Family systems approach

Psychiatry

Therapeutic Techniques and Interventions (continued)

Cognitive Behavioral Therapy (CBT)

Dialectical Behavior Therapy (DBT)

Acceptance and Commitment Therapy (ACT)

Family Therapy

When to Refer Out

Physical health dangers - need more intensive care

Scope of practice - comfort level of clinician

Higher LOC for ED behaviors and mental health

Not making progress or declining with regard to ED behaviors/sxs

Levels of Care

Least restrictive setting while still protecting the safety of the patient

- Residential - 3 months to a year
- Inpatient - medical necessity and/or psychiatric instability
- PHP/IOP
- Outpatient

QUESTIONS
ANSWERS

Part 3: Issues related to Managed Care

Managed Care

The Mental Health Parity and Addiction Equity Act, 2008 - equally favorable insurance coverage for mental health/addictions as to physical health

Managed Care (continued)

“The most common (and frustrating) reason for a denial is “the patient does not meet the criteria for medical necessity.” The specific criteria will vary from insurance company to insurance company, but some of the most common criteria include:

1. Weight—usually not low enough
2. Treatment History (mainly applies to precertification requests)
    - a) Patient has not tried a lower level of care prior to requesting a higher level of care
    - b) Patient’s condition is chronic and past treatments at the requested level of care have been ineffective
3. Lack of Progress in Treatment
    - a) Patient is not restoring weight
    - b) No reduction in behaviors
    - c) Lack of motivation in treatment
    - d) Inconsistent attendance
4. Absence of Behaviors (i.e. someone is doing too well in treatment and may be appropriate for a stepdown)
5. No medical complications”

Advocating for your Patient - Weight

“Patients with severe EDs are often within the normal weight range, especially with Bulimia Nervosa and EDNOS

The brain does not function at an optimal level below about 90% IBW, so if a patient meets the criteria in every other way but his or her weight is “not low enough,” you can make the argument that **the patient will actually be able to use program more effectively than if he or she were at a lower weight because the brain is nourished**. They will be in a better position to learn and to implement the skills taught in program.” - National Eating Disorders Association, 2018

Advocating for your Patient - Treatment Hx

Issue - Patient has not tried lower LOC before requesting higher LOC

Emphasize severity and risk of behaviors

Likelihood of failing in lower LOC

Issue - Past tx at requested LOC has been ineffective

Change in level of motivation, development of insight, change in support system

Different tx approach

Different goals for tx

Emphasize financial benefits - preventing the need for higher LOC

Advocating - Lack of Progress in Tx

Issue - Patient is not restoring weight

Weight restoration may not be the focus of tx

Identify reasons and planned intervention strategies

Issue - No reduction in behaviors

Highlight progress in other areas

Identify plan of interventions to reduce behaviors

Issue - Lack of motivation in tx

Emphasize influence external factors (i.e. need for more support)

Advocating - Absence of Behaviors

Issue - Patient doing “too well” in tx

Emphasize need for ongoing momentum with weight restoration

Successes in tx - learning/starting to implement skills

Emphasize emotional/mental health issues contributed to ED and the need for ongoing support and MH interventions

Advocating - No Medical Complications

Emphasize prevention if behaviors/symptoms continue

Review medical hx with patient

Sometimes, this is not a criteria for coverage depending on the insurance company

Discussion

Why might family therapy be considered a crucial treatment modality for eating disorders?

Clinically, what preventative measures might you take with someone struggling with an unhealthy relationship with food/disordered eating?

Which counseling theory do you personally feel would be best suited for working with a client with an eating disorder? What aspects/techniques of that theory do you feel would be most effective in working with a client with an eating disorder?

Activity

Develop a treatment plan for the following case:

You are completing an intake for 19 year old woman who is seeking out therapy to work on her "unhealthy relationship with food." The client reports "black-and-white" tendencies with her eating habits; she reports eating small snacks throughout the day and one "very large meal" at night. The client reports feeling like she cannot understand why she hasn't lost weight, even though she is trying to fit into a bridesmaid's dress for her sister's wedding. Client reports a history of OCD and anxiety, as well as feelings of worthlessness and poor body image. Client denies purging via vomiting, but does report laxative use several times a week as well as exercising 2-3 hours each day.

Health at Every Size (HAES) Movement

Principles of Health At Every Size®

1. **Weight inclusivity:** Accepting and respecting the diversity of body shapes and sizes
2. **Health enhancement:** Improving access to information & services; attending to physical, spiritual, social, economic, emotional, & other needs
3. **Respectful care:** Owning biases, ending weight stigma & discrimination
4. **Eating for well-being:** Promoting eating in a manner which balances individual nutritional needs, hunger, satiety, nutritional needs, and pleasure
5. **Life-enhancing movement:** Promoting individually appropriate, enjoyable, life-enhancing physical activity, rather than exercise that is focused on a goal of weight loss

Resources

National Eating Disorders Association (NEDA)

https://www.nationaleatingdisorders.org/

Association for Anorexia Nervosa and Associated Disorders (ANAD)

https://anad.org/

Eating Disorder Hope - Treatment Centers in NJ

https://www.eatingdisorderhope.com/treatment-centers/new-jersey-nj

Questions???