The Role of Behavioral Health Treatment for Clients with Eating Disorders

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Goals

- Describe criteria of and goals for all levels of care for eating disorder treatment
- Identify targets for behavioral interventions
- Identify how evidence-based eating disorder interventions can be adapted for use in a short-term treatment model
- List strategies to assist with co-occurring disorders
- Explain how to navigate and refer clients to higher levels of care
- Discuss care coordination strategies for bi-directional eating disorder referrals between primary care and behavioral health
Early Detection is Key!

- Patients rarely present directly for ED care
- Routine PCP or mental health for screening
  - Leveraging existing relationship
  - Identifying concerns in group settings
- Early diagnosis and treatment = better prognosis

Screening for Eating Disorders

- SCOFF
- Binge-Eating Disorder-7
- Eating Disorders Inventory-2
- NEDA Screener (https://www.nationaleatingdisorders.org/screening-tool)
Diagnosing Eating Disorders

• Diagnostic assessment:
  – Clinical interview
  – Eating Disorders Examination (EDE)
  – Structured Clinical Interview for DSM-5
  – EDE Questionnaire (PhenX Toolkit)

Treatment Overview

• Considerations
  – Medical stability
  – Need for/amount of weight restoration
  – Need for symptom interruption
  – Age
  – Family involvement
  – Level of care
Outpatient

- Medical: stable
- Suicide: none
- Weight: generally >85%
- Motivation for treatment: fair
- Co-occurring disorders: presence may determine treatment type and LOC
- Structure needed: self-sufficient
- Ability to control exercise: can manage on own
- Purging behaviors: can reduce on own (and medically stable) or not present
- Environment: access to support and structure
- Geography: lives near treatment setting

Intensive Outpatient (IOP)

- Medical: stable
- Suicide: none
- Weight: generally >85%
- Motivation for treatment: fair
- Co-occurring disorders: presence may determine treatment type and LOC
- Structure needed: self-sufficient
- Ability to control exercise: can manage on own
- Purging behaviors: can reduce on own (and medically stable) or not present
- Environment: access to support and structure
- Geography: lives near treatment setting

Partial Hospitalization (PHP)

- Medical: stable
- Suicide: none
- Weight: generally >80%
- Motivation for treatment: fair/somewhat/partial
- Co-occurring disorders: presence may determine treatment type and LOC
- Structure needed: needs some structure
- Ability to control exercise: some degree of external structure needed
- Purging behaviors: can reduce on own (and medically stable) or not present
- Environment: access to limited support and structure
- Geography: lives near treatment setting

Residential

- Medical: no IV fluids, NG tubes, multiple daily labs
- Suicide: none
- Weight: generally <85%
- Motivation for treatment: poor-fair
- Co-occurring disorders: presence may determine treatment type and LOC
- Structure needed: needs supervision during all meals
- Ability to control exercise: some degree of external structure needed
- Purging behaviors: can ask for/use support from others; use skills
- Environment: significant lack of support and structure
- Geography: treatment too distant to participate from home

Inpatient

- Medical: unstable; refer to Webinar 2
- Suicide: SI with plan and intent
- Weight: generally <85%; acute weight decline; food refusal
- Motivation for treatment: very poor-poor; preoccupied by intrusive thoughts; seemingly uncooperative
- Co-occurring disorders: presence may determine treatment type and LOC
- Structure needed: needs supervision during and after all meals
- Ability to control exercise: some degree of external structure needed
- Purging behaviors: needs supervision; unable to control multiple daily purging episodes
- Environment: significant lack of support and structure
- Geography: treatment too distant to participate from home


**Ongoing assessment***

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Higher Level of Care: Challenges

- Parental resistance to higher levels of care
- Student schedules
- Potential need for out-of-state care
- Bed availability
- Insurance coverage
- Providers not utilizing evidence-based practice
Structural Barriers to Treatment

- Lack of specialist therapists
- Lack of evidence-based care
- Poor dissemination of evidence-based intervention
- Limited insurance coverage

Targets of Treatment

- **MEDICAL STABILIZATION**
  - Management of acute and chronic medical comorbidities and complications
  - Includes resumption of menses (where appropriate)
- **NUTRITIONAL REHABILITATION**
  - Weight restoration
  - Restore meal patterns that promote health and social connections
- **NORMALIZATION OF EATING BEHAVIOR**
  - Cessation of restrictive or binge eating and/or purging behaviors
  - Elimination of disordered or ritualistic eating behaviors
- **PSYCHOSOCIAL STABILIZATION**
  - Evaluation and treatment of any comorbid psychological diagnoses
  - Re-establishment of appropriate social engagement
  - Improvement in psychological symptoms associated with ED
  - Improved body image

Treatment Overview

• Empirically supported options:
  – Enhanced cognitive-behavioral therapy (CBT-E)**
  – Family-based treatment (FBT)**
  – Dialectical behavior therapy
  – Acceptance Commitment Therapy

**Treatment overview does not equal to training

Why CBT-E?

• Theory-driven and evidence-based
• Suitable for a wide range of adult patients
  – “Transdiagnostic” in its scope
  – Designed for “complex patients”
• Experienced as acceptable to patients
• Tailored to specific eating problem and needs
• Scalability of treatment duration
• Manualized, 20-session treatment
Transdiagnostic Formulation

Adverse events and moods

Strict Dieting

Over-evaluation of shape and weight

Binge Eating

Low Weight

Compensatory vomiting / laxative misuse

Stages of Treatment

CBT-E MAP

Stage One – Starting Well

Stage Two – Taking Stock

Stage Three
Body Image

Dietary Restraint

Events, Moods and Eating

Stage Three – Setbacks and Mindsets

Stage Four – Ending Well
Stage 1
(Sessions 1-8)

- Sessions 2x/week
- Establish therapeutic relationship
  - Non-judgmental stance
  - Usual aspects of a good therapist
  - Show expertise
  - Establish trust
- Establish weekly weighing
- Educate re: weight and eating
- Prescribe regular eating patterns

Self-Monitoring

<table>
<thead>
<tr>
<th>TIME</th>
<th>FOOD AND LIQUID CONSUMED</th>
<th>PLACE</th>
<th>N C E L (M)</th>
<th>S N A C K (S)</th>
<th>N G U R G E (V, L)</th>
<th>CIRCUMSTANCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00</td>
<td>2 cups coffee with skim milk &amp; equal half a bagel</td>
<td>on-way to class</td>
<td>M</td>
<td></td>
<td></td>
<td>running, but feel dizzy - in control</td>
</tr>
<tr>
<td>1:00</td>
<td>1 pear</td>
<td>room</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:30</td>
<td>large bag pottles (choc)</td>
<td>room</td>
<td>S V</td>
<td></td>
<td></td>
<td>just got in from class; hungry and avoid eating</td>
</tr>
<tr>
<td></td>
<td>large chocolate muffin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>hunger; what am I doing - why do I keep doing this to myself? I had tried so hard to be good about eating</td>
</tr>
<tr>
<td></td>
<td>large bag pottles (choc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>large chocolate muffin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 oranges bread</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 oatmeal bars</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>peanut butter &amp; jelly sandwich</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>3 slices bread</td>
<td>room</td>
<td>S V</td>
<td></td>
<td></td>
<td>automatic - time of day</td>
</tr>
<tr>
<td></td>
<td>10 gram crackers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>already binged &amp; purged earlier; still depressed, out of control</td>
</tr>
<tr>
<td></td>
<td>1/4 jar peanut butter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:35am</td>
<td>10 pretzels</td>
<td>room</td>
<td>S</td>
<td></td>
<td></td>
<td>reading; felt empty after purges</td>
</tr>
<tr>
<td></td>
<td>8oz. Orange juice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Regular Weigh-Ins
**Stage 2**  
(Sessions 9-10)

- Sessions 1x/week
- Conduct joint review of progress
- Identify barriers to change
- Review the formulation
- Design Stage 3

**Stage 3**  
(Session 11-18)

- Sessions 1x/week
- Primary components
  - Shape and weight concerns
  - Dietary restraint
  - Events, moods, eating
Stage 4
(Sessions 19-20)

- Sessions 1x/weekly
- **Address concerns about ending treatment**
- Short-term maintenance plan
- Phase out self-monitoring and start at-home weighing
- **Plan for dealing with setbacks**
  - Identifying strategies
  - Realistic expectations
  - “Lapse” vs “relapse”
- Long-term maintenance plan

Why Family-Based Therapy (FBT)?

- Outpatient intervention
- Appropriate for children and adolescents living at home who are “medically stable”
- **Primary goals:**
  - Weight restoration/symptom reduction
  - Restore adolescent’s developmental status
- May involve brief hospitalizations to resolve medical concerns
- Manualized, 20-session treatment
FBT Treatment Style

• Parents lead the team
  – Appropriate control or “leadership position”
  – Parental control/leadership ultimately relinquished
  – Parent empowerment critical to treatment

• Therapist stance
  – Active but not authoritative
  – Collaborative
  – Trust for caregivers is conveyed through therapeutic stance

FBT Treatment Style (Cont’d)

• ED Conceptualization
  – Agnostic view of cause of illness
  – The child is not the same as his/her eating disorder
  – Behavioral change must occur first
  – Food is medicine
FBT versus Traditional Family Therapy

- ED ≠ expression of family dysfunction
  - ED = illness
  - Family = solution

- Limited addressing of problematic family patterns

- Consultation with interdisciplinary team

- “Family” = anyone involved with caring for/feeding the patient

Phases of FBT

- **Phase I**
  - Parents in charge of weight restoration

- **Phase II**
  - Parents hand control over eating back to the adolescent

- **Phase III**
  - Discuss adolescent development issues
### Phase I, Session 1

**Goals:**
- Engage the family
- Assess how the eating disorder affects the family
- Assess family functioning coalitions, conflicts, etc.
- Reduce parental blame

**Interventions:**
- Greet family in “sincere but grave” manner
- Create a “family story”
- Circular questioning
- Separate illness from patient
- Create intense scene concerning eating disorder
- Charging parents with the task of weight restoration

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### Phase I, Session 2: The Family Meal

**Goals:**
- Assess family structure
- Provide opportunity for parents to succeed in refeeding
- Assess family processes during eating

**Interventions:**
- Weigh the patient
- Observe patterns around eating, learning about food prep, food serving, meal times
- “One more bite”
- Align patient with siblings for support
Remainder of Phase I
(Session 3 – 10)

Goals:
– Keep family focused on eating disorder
– Help parents take charge of their child’s eating
– Mobilizing sibling support for patient

Interventions:
– Weigh patient
– Focus discussion on food and eating
– Support parental dyad, modify criticism toward patient, externalize illness
– Help family to evaluate efforts of sibling support

Guidelines for Transition to Phase II

– Weight is at minimum of ~95% EBW
– Patient eats without significant struggle
– Parents report feeling empowered to manage the illness
# Phase II
(Sessions 11 - 16)

## Goals:
- Maintain parental management until patient can gain or maintain weight independently
- Transfer food/weight control to adolescent
- Explore developmental issues

## Interventions:
- Weigh patient
- Assist parents in managing eating disorder and shifting control to patient
- Assist siblings in supportive role
- Highlight differences between patient’s own needs and those of eating disorder

## Guidelines for Transition to Phase III
- Weight is maintained at ~95% EBW
- Patient no longer engaging in eating disorder behaviors
Phase III
(Sessions 17 – 20)

Goals:
- Revise parent-child relationship in accordance with remission of eating disorder
- Review and problem-solve re: adolescent issues
- Terminate treatment

Interventions:
- Review normal adolescent development; establish that patient is back on age-appropriate trajectory
- Model problem-solving behavior
- Check parent relationship as a couple
- Discuss fear of/plan for relapse

Using EBP in a Short-Term Model

• Collaborative work with psychotherapy, nutrition, and medical monitoring to ready patient for treatment
• Introducing key concepts for evidence-based treatments
  – Collaborative weight checks*
  – Regular eating pattern and self-monitoring (adults)
  – Family in charge of refeeding (adolescents)
  – Externalize eating disorder (separate patient from ED)
  – Ongoing review of treatment goals (e.g., weight gain, behavior stabilization, symptom interruption)
  – Continue to enhance motivation
  – College contracts if needed
  – Involve family/support system
Stepped Care Approaches

• Technological advancements
  – Telehealth
  – Mobile apps

• Self-help interventions

• Establishing an inroad
  – Nutrition, PCP

Mobile App

Visit www.itakecontrolbinge.com for the iTakeControl app, a tool that empowers users to manage their binge eating.

It is a tool that provides a self-guided program based on proven principles of therapy.
Self-Help Resources

Overcoming Binge Eating
By Dr. Christopher G. Fairburn

Crave
By Cynthia M. Bulik, PhD

CBT-E Training

Centre for Research on Eating Disorders at Oxford (CREDO)

- CRED0 and its work
- Research on eating disorders
- Research on treatment dissemination
- Enhanced CBT (CBT-E)
- CBT-E - a new digital treatment for binge eating
- ‘Overcoming Binge Eating’ publication, lectures and workshops
- Financial support and donations
- Obtaining digital treatment or digital training

https://www.credo-oxford.com
FBT Training

TRAINER INSTITUTE
FOR CHILD AND ADOLESCENT EATING DISORDERS

MISSION
The purpose of the Training Institute is to disseminate evidence-based treatments for child and adolescent eating disorders. No current strategies are available for clinicians wishing to have such training in a systematic and quality-controlled manner. In addition, the institute will help provide tools, resources and forums with information useful family-based treatments and the skills mastered by clinicians.

The institute provides several levels of training for interested clinicians.

http://train2treat4ed.com

F.E.A.S.T.

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References


Questions