THE ASSESSMENT & TREATMENT OF EATING DISORDERS IN AN OUTPATIENT SETTING

PRESENTED BY: BRANDI STALZER, LIMHP, LPC
CONTENTS

• JUSTIFICATION FOR OP EATING DISORDER TREATMENT
• EATING DISORDER BEHAVIORS & THEIR FUNCTION
• INFORMATION TO OBTAIN IN ASSESSMENT
• LEVELS OF CARE & WHEN TO REFER
• ROLES ON THE TREATMENT TEAM
• EMPIRICALLY SUPPORTED TREATMENTS
• EVIDENCED BASED TREATMENTS FOR CO-OCCURING DISORDERS
• REFERENCES
JUSTIFICATION FOR OPA 
EATING DISORDER 
TREATMENT
JUSTIFICATION FOR OP EATING DISORDER TREATMENT

Table 1. Inpatient and outpatient treatment intensity and cost for female and male patients with anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS).

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Treatment</th>
<th>Outpatient Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female Patients</td>
<td>Male Patients</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>M</td>
</tr>
<tr>
<td>AN Days</td>
<td>111</td>
<td>26.0</td>
</tr>
<tr>
<td>Cost</td>
<td>17,384</td>
<td>24,394</td>
</tr>
<tr>
<td>Days</td>
<td>87</td>
<td>14.7</td>
</tr>
<tr>
<td>Cost</td>
<td>9,088</td>
<td>10,579</td>
</tr>
<tr>
<td>EDNOS Days</td>
<td>93</td>
<td>19.9</td>
</tr>
<tr>
<td>Cost</td>
<td>13,297</td>
<td>19,280</td>
</tr>
</tbody>
</table>

Note: Costs are reported in U.S. dollars.

## Table 2: Estimates of total hospital and caregiver costs

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total cost, * $</th>
<th>Median (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD</td>
<td></td>
</tr>
<tr>
<td>Hospital cost</td>
<td>51 349 ± 26 598</td>
<td>47 304 (15 790–194 618)</td>
</tr>
<tr>
<td>Caregiver cost</td>
<td>3 583 ± 1 904</td>
<td>3 146 (673–11 119)</td>
</tr>
<tr>
<td>Lost work productivity</td>
<td>766 ± 389</td>
<td>673 (93–2 080)</td>
</tr>
<tr>
<td>Lost leisure time</td>
<td>2 817 ± 1 588</td>
<td>2 565 (531–9 039)</td>
</tr>
<tr>
<td>Societal cost†</td>
<td>54 932 ± 27 864</td>
<td>49 807 (16 488–201 036)</td>
</tr>
</tbody>
</table>

*In 2013 Canadian dollars (US$1 = Can$1.03 in 2013).†Sum of hospital and caregiver costs.

JUSTIFICATION FOR OP EATING DISORDER TREATMENT

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Annual health care costs, odds of employment and earnings (2011 US$) associated with ED and mental health comorbidities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>MEPS respondents</strong></td>
</tr>
<tr>
<td></td>
<td>No ED</td>
</tr>
<tr>
<td>Annual health care costs</td>
<td>$3910</td>
</tr>
<tr>
<td></td>
<td>$96 to $3641 (0.012)</td>
</tr>
<tr>
<td>Odds ratio of being employed over past 12 months&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.67</td>
</tr>
<tr>
<td>Annual wage income&lt;sup&gt;d&lt;/sup&gt;</td>
<td>$29,872</td>
</tr>
<tr>
<td></td>
<td>$2093 to $7703 (0.48)</td>
</tr>
</tbody>
</table>

MEPS = Medical Expenditures Panel Survey; ED = eating disorders.

<sup>a</sup> All costs were inflation adjusted to 2011 US$ using the Price Index of the Bureau of Labor Statistics and the general inflation rate from the BLS.

<sup>b</sup> Controlling for age, gender, race/ethnicity, household size and years of education.

<sup>c</sup> Among MEPS respondents of age 18 years or above (48 respondents had ED).

<sup>d</sup> Among MEPS respondents of age 18 years or above who were employed.

EATING DISORDER BEHAVIORS & THEIR FUNCTION
EATING DISORDER BEHAVIORS & THEIR FUNCTION

A transdiagnostic view is taken.

• Problems with separate diagnostic categories include:
  • Clients "migrate" between diagnoses
  • Some clients with behavioral patterns do not fit into diagnostic criteria

• Implications of separate diagnostic categories is that separate treatment approaches are developed for each disorder

• Eating disorders are viewed as a single diagnostic category with common maintaining mechanisms.
  • Over-evaluation of shape and weight and their control as main mechanism

EATING DISORDER BEHAVIORS & THEIR FUNCTION

Overeating behaviors

• Binge-eating: specific episode of eating an objectively large amount of food where the individual experiences a sense of loss of control.

• Subjective binge: a binge in which the amount consumed does not meet the normal standards of a binge, but is perceived by the individual as a binge.

• Grazing: the tendency to eat continuously at food over a longer duration of time than experienced in a binge.

EATING DISORDER BEHAVIORS & THEIR FUNCTION

Restrictive behaviors

• Calorie-counting: the act of monitoring the caloric intake of food to keep a running total.
• Debting: creating a caloric deficit to accommodate for later eating
• Delayed eating: prolonging eating as a means of weight control
• Dietary restraint: limiting the amount of food consumed
• Dietary restriction: true under-eating in a physiological sense
• Dietary rules: highly specific dietary goals
• Food avoidance: limiting specific types of foods because of a perception that they will break dietary rules

EATING DISORDER BEHAVIORS & THEIR FUNCTION

Compensatory behaviors

• Excessive exercise: exercising to an extent that energy needs are not met

• Self-induced vomiting: a type of voluntary purging behavior; can be done as a non-compensatory behavior

• Laxative misuse: a purging behavior involving the use of laxatives, usually stimulant type

EATING DISORDER BEHAVIORS & THEIR FUNCTION

Shape control behaviors

- Body Image Disparagement: viewing oneself as disgusting or loathsome
- Body Dissatisfaction: a more common experience of disliking one’s appearance or body
- Body checking: the act of checking features of the body through methods such as pinching, excessive weighing, mirror checking, measuring, etc
- Body avoidance: the avoidance of situations that one may experience body image disparagement

**EATING DISORDER BEHAVIORS & THEIR FUNCTIONS**

<table>
<thead>
<tr>
<th>Item</th>
<th>ANR</th>
<th>APR</th>
<th>SNR</th>
<th>SPR</th>
<th>% of participants endorsing item sometimes or often (N=265)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. To escape/avoid/stop bad feelings</td>
<td>0.84</td>
<td></td>
<td></td>
<td></td>
<td>71.7</td>
</tr>
<tr>
<td>6. To relieve anxiety</td>
<td>0.82</td>
<td></td>
<td></td>
<td></td>
<td>74.0</td>
</tr>
<tr>
<td>23. To prevent bad feelings</td>
<td>0.78</td>
<td></td>
<td></td>
<td></td>
<td>50.5</td>
</tr>
<tr>
<td>24. To cope with/relieve stress</td>
<td>0.82</td>
<td></td>
<td></td>
<td></td>
<td>74.3</td>
</tr>
<tr>
<td>1. To reduce feelings of anger, sadness, loneliness, anxiety, etc.</td>
<td>0.74</td>
<td></td>
<td></td>
<td></td>
<td>83.0</td>
</tr>
<tr>
<td>15. To slow down racing thoughts</td>
<td>0.65</td>
<td></td>
<td></td>
<td></td>
<td>40.4</td>
</tr>
<tr>
<td>18. To feel relaxed</td>
<td>0.61</td>
<td></td>
<td></td>
<td></td>
<td>45.0</td>
</tr>
<tr>
<td>19. To feel something at all</td>
<td>0.56</td>
<td></td>
<td></td>
<td></td>
<td>43.4</td>
</tr>
<tr>
<td>13. To ground yourself/return from a dissociative state</td>
<td>0.56</td>
<td></td>
<td></td>
<td></td>
<td>28.7</td>
</tr>
<tr>
<td>3. To give yourself something to do when you are alone</td>
<td>0.49</td>
<td></td>
<td></td>
<td></td>
<td>72.9</td>
</tr>
<tr>
<td>21. To give yourself something to do when you are bored</td>
<td>0.46</td>
<td></td>
<td></td>
<td></td>
<td>60.4</td>
</tr>
<tr>
<td>20. To avoid being with other people</td>
<td>0.71</td>
<td></td>
<td></td>
<td></td>
<td>31.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>ANR</th>
<th>APR</th>
<th>SNR</th>
<th>SPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. To avoid having to do something unpleasant that you don't want to do</td>
<td></td>
<td></td>
<td></td>
<td>0.80</td>
</tr>
<tr>
<td>11. To avoid school, work, or other activities</td>
<td></td>
<td></td>
<td></td>
<td>0.80</td>
</tr>
<tr>
<td>14. To get attention</td>
<td></td>
<td></td>
<td></td>
<td>0.95</td>
</tr>
<tr>
<td>25. To receive more attention from family and friends</td>
<td></td>
<td></td>
<td></td>
<td>0.93</td>
</tr>
<tr>
<td>26. To get your parents to understand or notice you</td>
<td></td>
<td></td>
<td></td>
<td>0.83</td>
</tr>
<tr>
<td>10. To communicate to others how badly you feel inside</td>
<td></td>
<td></td>
<td></td>
<td>0.77</td>
</tr>
<tr>
<td>7. To let others know how desperate you were feeling</td>
<td></td>
<td></td>
<td></td>
<td>0.75</td>
</tr>
<tr>
<td>17. To feel special</td>
<td></td>
<td></td>
<td></td>
<td>0.75</td>
</tr>
<tr>
<td>2. To get a reaction from someone even if it's negative</td>
<td></td>
<td></td>
<td></td>
<td>0.57</td>
</tr>
</tbody>
</table>

Notes: ANR = Automatic-Negative Reinforcement; APR = Automatic-Positive Reinforcement; SNR = Social-Negative Reinforcement; SPR = Social-Positive Reinforcement.

## EATING DISORDER BEHAVIORS & THEIR FUNCTION

### Table 7
Confirmatory factor analysis and rate of reported reasons for purging.

<table>
<thead>
<tr>
<th>Item</th>
<th>ANR</th>
<th>APR</th>
<th>SNR</th>
<th>SPR</th>
<th>% of participants endorsing item sometimes or often (N = 248)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. To relieve anxiety</td>
<td>0.90</td>
<td></td>
<td></td>
<td></td>
<td>77.9</td>
</tr>
<tr>
<td>24. To cope with/relieve stress</td>
<td>0.91</td>
<td></td>
<td></td>
<td></td>
<td>74.2</td>
</tr>
<tr>
<td>8. To escape/avoid/stop bad feelings</td>
<td>0.86</td>
<td></td>
<td></td>
<td></td>
<td>71.3</td>
</tr>
<tr>
<td>23. To prevent bad feelings</td>
<td>0.83</td>
<td></td>
<td></td>
<td></td>
<td>72.2</td>
</tr>
<tr>
<td>1. To reduce feelings of anger, sadness, loneliness, anxiety, etc.</td>
<td>0.82</td>
<td></td>
<td></td>
<td></td>
<td>78.3</td>
</tr>
<tr>
<td>15. To slow down racing thoughts</td>
<td>0.70</td>
<td></td>
<td></td>
<td></td>
<td>49.2</td>
</tr>
<tr>
<td>19. To feel something at all</td>
<td>0.77</td>
<td></td>
<td></td>
<td></td>
<td>44.7</td>
</tr>
<tr>
<td>18. To feel relaxed</td>
<td>0.77</td>
<td></td>
<td></td>
<td></td>
<td>56.5</td>
</tr>
<tr>
<td>3. To give yourself something to do when you are alone</td>
<td>0.69</td>
<td></td>
<td></td>
<td></td>
<td>46.4</td>
</tr>
<tr>
<td>13. To ground yourself/return from a dissociative state</td>
<td>0.65</td>
<td></td>
<td></td>
<td></td>
<td>39.1</td>
</tr>
<tr>
<td>21. To give yourself something to do when you are bored</td>
<td>0.69</td>
<td></td>
<td></td>
<td></td>
<td>36.3</td>
</tr>
<tr>
<td>20. To avoid being with other people</td>
<td>0.84</td>
<td></td>
<td></td>
<td></td>
<td>27.0</td>
</tr>
</tbody>
</table>

Notes: ANR = Automatic-Negative Reinforcement; APR = Automatic-Positive Reinforcement; SNR = Social-Negative Reinforcement; SPR = Social-Positive Reinforcement.

EATING DISORDER BEHAVIORS & THEIR FUNCTION

• Core psychopathology impacts the over-evaluation on shape and weight:
  • Perfectionism
  • Low self-esteem
  • Interpersonal problems

INFORMATION TO OBTAIN IN ASSESSMENT
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- A typical evaluation for the treatment of eating disorders includes:
  
  Clinical Interview

  Objective Measures

  Nutrition Assessment

  Medical Evaluation

  Family Assessment
INFORMATION TO OBTAIN IN ASSESSMENT

Topics Addressed in the Initial Evaluation Interview

1. What the client would like to be different

2. Current problems with eating (as perceived by client and others), including:
   1. Eating habits
   2. Methods of shape and weight control
   3. Views on shape and weight

3. Impairment resulting from the eating problem
   1. Psychosocial impairment
   2. Physical impairment

4. Development and evolution of the problem

5. Co-existing psychiatric and general medical problems

6. Brief personal history

7. Family psychiatric and general medical history

8. Personal psychiatric and general medical history

9. Current circumstances and plans

10. Attitude to attendance and treatment

INFORMATION TO OBTAIN IN ASSESSMENT

<table>
<thead>
<tr>
<th>Measure</th>
<th>Constructs Assessed</th>
<th>Scoring &amp; Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eating Attitudes Test (EAT-26)</strong> (Garner Olmsted, Borh &amp; Garfinkel, 1982)</td>
<td>Anorexia Nervosa symptoms - Dieting - Bulimia - Oral Control</td>
<td>Responses ranging from &quot;never&quot; to &quot;always&quot; rates on 6-point Likert scale; Cutoff &gt; 20 indicative of eating disorder</td>
</tr>
<tr>
<td><strong>Eating Disorders Examination Questionnaire (EDE-Q)</strong> (Fairburn &amp; Beglin, 1994)</td>
<td>Global Eating Disorder Severity - Restraint - Eating Concern - Shape Concern - Weight Concern</td>
<td>36 items with response ranging from 0 &quot;never&quot; to 6 &quot;every day&quot; over previous 28 days; items scores averaged; Scores between 4 and 6 are considered clinically significant</td>
</tr>
<tr>
<td><strong>Clinical Impairment Assessment (CIA)</strong> (Bohn &amp; Fairburn, 2008)</td>
<td>Secondary Psychosocial Impairment</td>
<td>16 items with responses ranging from 0 &quot;not at all&quot; to 3 &quot;a lot&quot; over previous 28 days; item scores averaged</td>
</tr>
</tbody>
</table>

# INFORMATION TO OBTAIN IN ASSESSMENT

<table>
<thead>
<tr>
<th>Measure</th>
<th>Constructs Assessed</th>
<th>Scoring &amp; Interpretation</th>
</tr>
</thead>
</table>
| Eating Disorders Inventory (EDI-3) (Garner, 2004) | Eating Disorder Risk Scales  
- Drive for Thinness  
- Bulimia  
- Body Dissatisfaction  
Psychological Scales  
- Low Self-Esteem  
- Personal Alienation  
- Interpersonal Insecurity  
- Interpersonal Alienation  
- Introceptive Deficits  
- Emotional Dysregulation  
- Perfectionism  
- Asceticism  
- Maturity Fears | Cutoff of 14 for Drive for Thinness recommended for screening purposes |

INFORMATION TO OBTAIN IN ASSESSMENT

Medical evaluations may include (particularly in AN):

1. Vital signs (pulse, blood pressure, temperature, respirations)
2. Electrolytes, glucose, calcium, magnesium, phosphorus
3. Amylase
4. Complete blood count with differential
5. Thyroid function tests (T3, T4, and TSH)
6. Albumin, transferrin
7. BUN/creatinine
8. Urinalysis, stool guaiac
9. Liver function tests (SGOT, SGPT, bilirubin)
10. Bone density scan
11. Electrocardiogram

LEVELS OF CARE & WHEN TO REFER
LEVELS OF CARE & WHEN TO REFER

• Consider three factors when referring:
  • When a higher level of care is recommended (see following slides)
  • When you are unable to coordinate care (see following section)
  • When you have treatment interfering beliefs, biases, or behaviors
# LEVELS OF CARE & WHEN TO REFER

<table>
<thead>
<tr>
<th></th>
<th>Level 1: Outpatient</th>
<th>Level 2: Intensive Outpatient</th>
<th>Level 3: Partial Hospitalization</th>
<th>Level 4: Residential Treatment Center</th>
<th>Level 5: Impatient Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation to recover (i.e., cooperative ness, insight, ability to control obsessions)</td>
<td>Fair-to-good motivation</td>
<td>Fair motivation</td>
<td>Partial motivation; cooperative; patient preoccupied with intrusive, repetitive thoughts &gt;3 hrs/day</td>
<td>Poor-to-fair motivation; patient preoccupied with intrusive thoughts 4-6 hours a day; patient cooperative w/ highly structured treatment</td>
<td>Very poor-to-poor motivation; patient preoccupied w/ intrusive thoughts; patient uncooperative w/ treatment or cooperative only in highly structured environment</td>
</tr>
</tbody>
</table>

LEVELS OF CARE & WHEN TO REFER

<table>
<thead>
<tr>
<th></th>
<th>Level 1: Outpatient</th>
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<th>Level 5: Impatient Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-occurring disorders</td>
<td>Presence of comorbid condition may influence choice of level of care</td>
<td>Presence of comorbid condition may influence choice of level of care</td>
<td>Presence of comorbid condition may influence choice of level of care</td>
<td>Presence of comorbid condition may influence choice of level of care</td>
<td>Any existing psychiatric disorder that would require hospitalization</td>
</tr>
</tbody>
</table>

# Levels of Care & When to Refer

<table>
<thead>
<tr>
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<th>Level 5: Impatient Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure needed for eating/gaining weight</td>
<td>Self-sufficient</td>
<td>Self-sufficient</td>
<td>Needs some structure to gain weight</td>
<td>Needs supervision at all meals or will restrict eating</td>
</tr>
</tbody>
</table>

## LEVELS OF CARE & WHEN TO REFER

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<tr>
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<th>Level 5: Impatient Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to control compulsive exercising</td>
<td>Can manage compulsive exercising through self-control</td>
<td>Some degree of external structure beyond self-control required to prevent patient from compulsive exercising</td>
<td>Some degree of external structure beyond self-control required to prevent patient from compulsive exercising</td>
<td>Some degree of external structure beyond self-control required to prevent patient from compulsive exercising</td>
</tr>
</tbody>
</table>

# Levels of Care & When to Refer

<table>
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<tr>
<th></th>
<th>Level 1: Outpatient</th>
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<th>Level 5: Impatient Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purging behavior (laxatives and diuretics included)</td>
<td>Can greatly reduce incidents of purging in an unstructured setting</td>
<td>Can greatly reduce incidents of purging in an unstructured setting</td>
<td>Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications such as ECT or other abnormalities suggesting the need for hospitalization</td>
<td>Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging</td>
<td>Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent and disabling, despite appropriate trials of OP care</td>
</tr>
</tbody>
</table>

# Levels of Care & When to Refer

<table>
<thead>
<tr>
<th>Environme ntal Stress</th>
<th>Level 1: Outpa tient</th>
<th>Level 2: Intensiv e Outpatient</th>
<th>Level 3: Partial Hospitalization</th>
<th>Level 4: Residential Treatment Center</th>
<th>Level 5: Impatient Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others are able to provide adequate emotional and practical support and structure</td>
<td>Others are able to provide adequate emotional and practical support and structure</td>
<td>Others are able to provide at least limited support and structure</td>
<td>Severe family conflict or problems or absences of family so patient is unable to receive structured treatment in home; patient lives alone</td>
<td>Severe family conflict or problems or absences of family so patient is unable to receive structured treatment in home; patient lives alone</td>
<td></td>
</tr>
</tbody>
</table>

# LEVELS OF CARE & WHEN TO REFER

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Geographic availability of treatment program</th>
<th>Patient lives near treatment setting</th>
<th>Patient lives near treatment setting</th>
<th>Patient lives near treatment setting</th>
<th>Treatment program is too distant for patient to participate from home</th>
<th>Treatment program is too distant for patient to participate from home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Outpatient</td>
<td></td>
<td>Geographical availability of treatment program</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Treatment program is too distant for patient to participate from home</td>
<td>Treatment program is too distant for patient to participate from home</td>
</tr>
<tr>
<td>2: Intensive Outpatient</td>
<td></td>
<td>Geographical availability of treatment program</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Treatment program is too distant for patient to participate from home</td>
<td>Treatment program is too distant for patient to participate from home</td>
</tr>
<tr>
<td>3: Partial Hospitalization</td>
<td></td>
<td>Geographical availability of treatment program</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Treatment program is too distant for patient to participate from home</td>
<td>Treatment program is too distant for patient to participate from home</td>
</tr>
<tr>
<td>4: Residential Treatment Center</td>
<td></td>
<td>Geographical availability of treatment program</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Treatment program is too distant for patient to participate from home</td>
<td>Treatment program is too distant for patient to participate from home</td>
</tr>
<tr>
<td>5: Impatient Hospitalization</td>
<td></td>
<td>Geographical availability of treatment program</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Patient lives near treatment setting</td>
<td>Treatment program is too distant for patient to participate from home</td>
<td>Treatment program is too distant for patient to participate from home</td>
</tr>
</tbody>
</table>

LEVELS OF CARE & WHEN TO REFER

• Treatment professionals and client both bring schemas about eating, weight, and appearance into the therapy session

• As clinicians, it is your role to explore your own beliefs and biases
  • Taking the assessments used on clients can aid in gaining a better understanding
  • Also consider other assessments focused on bias selection such as the Harvard Implicit Bias Test
LEVELS OF CARE & WHEN TO REFER

Text “BRANDIS501” to 22333 to enter the poll.

• For each statement text (unless stated otherwise):
  • A for Strongly Agree
  • B for Somewhat Agree
  • C for Somewhat Disagree
  • D for Strongly Disagree
ROLES ON THE TREATMENT TEAM
ROLES ON THE TREATMENT TEAM

- Therapist/Psychologist
- Dietitian
- Physician/APRN
- Psychiatrist/APRN
- Other specialists
## ROLES ON THE TREATMENT TEAM

<table>
<thead>
<tr>
<th>Client Need</th>
<th>Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight restoration</td>
<td>Physician, nurse, dietitian</td>
</tr>
<tr>
<td>Medical complications</td>
<td>Physician, nurse</td>
</tr>
<tr>
<td>Psychological assessment</td>
<td>Psychologist, therapists</td>
</tr>
<tr>
<td>Psychiatric co-morbidity</td>
<td>Psychiatrist, nurse, psychologist, therapists</td>
</tr>
<tr>
<td>Family assessment</td>
<td>Therapist</td>
</tr>
<tr>
<td>Changing core cognitive distortions</td>
<td>Psychologist, therapists</td>
</tr>
</tbody>
</table>

# ROLES ON THE TREATMENT TEAM

<table>
<thead>
<tr>
<th>Client Need</th>
<th>Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychopharmacology</td>
<td>Psychiatrist, nurse</td>
</tr>
<tr>
<td>Healthy physical activity</td>
<td>Dietitian</td>
</tr>
<tr>
<td>Body image normalization</td>
<td>Psychologist, therapist</td>
</tr>
<tr>
<td>Behavioral relearning of everyday activities</td>
<td>Therapist, dietitian</td>
</tr>
<tr>
<td>Patient education</td>
<td>All team members</td>
</tr>
<tr>
<td>Relapse prevention</td>
<td>Psychologist, therapist</td>
</tr>
<tr>
<td>Discharge criteria</td>
<td>Psychiatrist, nurse, psychologist, therapist</td>
</tr>
</tbody>
</table>

EMPIRICALLY SUPPORTED TREATMENTS
EMPIRICALLY SUPPORTED TREATMENTS

- CBT-E
- FBT
- DBT
- ACT
EMPIRICALLY SUPPORTED TREATMENTS

• Three goals of CBT-E
  • Remove underlying psychopathology
    • Over-evaluation of shape and weight
  • Change maintenance behaviors
    • Specific to the case formulation
  • Ensure lasting results
    • Assumes setbacks may occur, and assists clients better respond to them

EMPIRICALLY SUPPORTED TREATMENTS

• Two forms of CBT-E
  • Focused
    • Standard form used with most clients
    • Goals are the same as previous slide
  • Broad
    • Designed to address pronounced and treatment interfering underlying psychopathology
      • Clinical perfectionism
      • Core low self-esteem
      • Marked interpersonal problems

EMPIRICALLY SUPPORTED TREATMENTS

• Duration of CBT-E
  • Client who are not underweight
    • 20 sessions over 20 weeks, plus initial assessment and post-treatment review appointments
  • Clients who are underweight (and can be treated outpatient)
    • 40 sessions over 40 weeks, duration largely determined by the amount of weight restoration to occur

EMPIRICALLY SUPPORTED TREATMENTS

EMPIRICALLY SUPPORTED TREATMENTS

- Case formulation – done jointly with the client in their own words
- **Self-monitoring** – through the use of monitoring log, not food log
- **Psychoeducation** – nutritional aspects completed by dietitian; therapeutic aspects completed by therapist
- Weekly weighing – could (should) be done by others on the team
- Regular eating – done jointly with dietitian; behavioral aspects reviewed with therapist

EMPIRICALLY SUPPORTED TREATMENTS

• Stage 2 - Taking Stock
  • Re-assess using EDE-Q and CIA
  • Identify and praise progress
  • Identify remaining psychopathology or any problems encountered in Stage One
  • Review treatment compliance

EMPIRICALLY SUPPORTED TREATMENTS

• Stage Three – Body Image
  • Self-evaluation – pie chart technique
  • Developing other domains – assist client in increase activities in other areas of life
  • Body checking -
  • Body avoidance
  • “Feeling fat”

EMPIRICALLY SUPPORTED TREATMENTS

• Stage Three – Dietary Restraint
  • Strict dieting
  • Food avoidance
  • Other dietary rules
  • Addressing undereating

EMPIRICALLY SUPPORTED TREATMENTS

• Stage Three – Events, Moods & Eating
  • Binge analysis – review of the event and problem solving
  • Proactive problem-solving
  • Addressing mood intolerance

EMPIRICALLY SUPPORTED TREATMENTS

• Stage Three – Setbacks & Mindsets
  • Educating the client
  • Return of the mindset

EMPIRICALLY SUPPORTED TREATMENTS

• Stage Four – Ending Well
  • Address concerns about ending
  • Ensuring maintenance – developing long-term or short-term maintenance plan
  • Phasing out interventions – specifically weekly weigh-ins and monitor sheet
  • Minimizing the risk of relapse

EMPIRICALLY SUPPORT TREATMENTS

• Family Based Treatments
  • Phase One
    • Responsibility is placed on parents
    • The seriousness of the disorder is emphasized
    • The “Family Meal” occurs
    • Therapist role is to shape behaviors through feedback to parent

EMPIRICALLY SUPPORT TREATMENTS

• Family Based Treatments
  • Phase Two
    • Client begins to negotiate return of control
    • Examination of the relationship between adolescent issues and the eating disorder
  • Phase Three
    • Exploring adolescent themes
    • Check in on the parental unit
    • Planning for future issues

EMPIRICALLY SUPPORTED TREATMENTS

• DBT for binge eating and bulimia
  • Pretreatment Stage
  • Core Skills – Interpersonal Effectiveness skills excluded
  • Greater focus on Relapse Prevention

• Others have researched standardized DBT w/ ED & BPD

EMPIRICALLY SUPPORTED TREATMENTS

• Few RCT exploring ACT efficacy compared to other treatments
• Utilized in some inpatient treatment centers
• Specific topics (e.g., body image) have greater research base

EVIDENCED BASED TREATMENTS FOR CO-OCCURRING DISORDERS
EVIDENCED BASED TREATMENTS FOR CO-OCCURRING DISORDERS

• To date, no dual diagnosis treatments exist for eating disorders.

• The current standard is to implement separate treatments for each diagnosis.

• Assessment should include deciphering if treatment should be concurrent or separate, and identify which presenting problem is primary and secondary.
EVIDENCED BASED TREATMENTS FOR CO-OCCURRING DISORDERS

<table>
<thead>
<tr>
<th></th>
<th>Anorexia Nervosa (%)</th>
<th>Bulimia Nervosa (%)</th>
<th>Binge Eating Disorder (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Mood Disorder</td>
<td>42.1</td>
<td>70.7</td>
<td>46.4</td>
</tr>
<tr>
<td>- Major Depressive Disorder</td>
<td>39.1</td>
<td>50.1</td>
<td>32.3</td>
</tr>
<tr>
<td>- Bipolar I or II Disorder</td>
<td>3.0</td>
<td>17.7</td>
<td>12.5</td>
</tr>
</tbody>
</table>

### EVIDENCED BASED TREATMENTS FOR CO-OCCURRING DISORDERS

<table>
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<th>Bulimia Nervosa (%)</th>
<th>Binge Eating Disorder (%)</th>
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</thead>
<tbody>
<tr>
<td>Any Anxiety Disorder</td>
<td>47.9</td>
<td>80.6</td>
<td>65.1</td>
</tr>
<tr>
<td>- Panic Disorder</td>
<td>3.0</td>
<td>2.9</td>
<td>13.2</td>
</tr>
<tr>
<td>- Generalized Anxiety Disorder</td>
<td>7.0</td>
<td>11.8</td>
<td>11.8</td>
</tr>
<tr>
<td>- Posttraumatic Stress Disorder</td>
<td>12.0</td>
<td>45.4</td>
<td>26.3</td>
</tr>
<tr>
<td>- Obsessive Compulsive Disorder</td>
<td>_</td>
<td>7.5</td>
<td>8.2</td>
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<th>Binge Eating Disorder (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Substance Use Disorder</td>
<td>27.0</td>
<td>36.8</td>
<td>23.3</td>
</tr>
<tr>
<td>- Alcohol Abuse or Dependence</td>
<td>24.5</td>
<td>33.7</td>
<td>21.4</td>
</tr>
<tr>
<td>- Illicit Drug Abuse or Dependence</td>
<td>17.7</td>
<td>26.0</td>
<td>19.4</td>
</tr>
</tbody>
</table>

EVIDENCED BASED TREATMENTS FOR CO-OCCURRING DISORDERS

MDD → CBT
PTSD → EMDR → PE → CPT
OCD → ERP
SUD → MI → CBT → DBT
BPD → DBT
REFERENCES
REFERENCES


REFERENCES


HANDOUTS

• Case formulation - http://www.credo-oxford.com/pdfs/F2.5_Transdiagnostic_CBT-E_formulation.pdf
• Harvard Implicit Bias Test - https://implicit.harvard.edu/implicit/selectatest.html
• Blank Monitoring Record - http://www.credo-oxford.com/pdfs/F5.3_Blank_monitoring_record.pdf
HANDOUTS


