Eating Disorders and Diet Culture: Culturally Attuned Mental Health Care

Sand Chang, PhD (they/them/their)
Santa Clara County Behavioral Health
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Introduction
Presenter Introduction

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- Psychotherapist, Certified EMDR Therapist, Trainer/Consultant, Independent Practice, Oakland
- Clinic Director, Octave, San Francisco
- Orientations/influences: Relational, Internal Family Systems (IFS), EMDR, DBT, feminist/social justice, Emotionally Focused Therapy (EFT)/attachment theory, Health At Every Size (HAES)
- Positionality / cultural intersections
Disclosure

I have no actual or potential conflict of interest in relation to this presentation.
Learning Objectives

1. Demonstrate an ability to differentiate basic concerns related to food, body, and the spectrum of what is characterized as eating disorders.
2. Apply culturally sensitive, trauma-informed, and respectful language in discussing bodies and weight.
3. Conduct a basic assessment of concerns related to food and/or body shape, size, or weight.
4. Describe at least two common relational (transferential or countertransference) dynamics that may occur in assessment or psychotherapy with people who have disordered eating.
<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>9:00</td>
<td>INTRODUCTION</td>
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<tr>
<td>9:15</td>
<td>DEFINING EATING DISORDERS</td>
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<td>10:00</td>
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<td>10:45</td>
<td>ASSESSMENT</td>
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<td><del>lunch</del></td>
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<td>CASE STUDIES</td>
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<td>4:15</td>
<td>Q&amp;A, EVALUATIONS</td>
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Reflection Exercise
Recognizing Diet Culture and Unconscious Bias

● Value judgements
  ○ Do I categorize foods as “good” or “bad”?  
  ○ Do I tell people they “deserve” to eat certain food?

● Do you reinforce diet culture as the norm?
  ○ Do I say things like, “Oh, just start again tomorrow?” or “It’s okay to cheat!”
  ○ Am I aware that 95% of intentional weight loss is unsuccessful and generally leads to weight gain, a sense of failure, and low self-esteem?

● Do I categorize bodies into healthy based on weight?
  ○ Do I use words like “obese” or “morbidly obese” without a critical lens of what this means?

● Am I engaged in a more subtle form of diet culture?
  ○ Do I promote “clean eating” or “fitness”?
  ○ Do I promote cutting out whole food groups?
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Defining Eating Disorders
Formal Eating Disorder Diagnoses (DSM-5)

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
Anorexia Nervosa: DSM-5 Diagnostic Criteria

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.
Anorexia Nervosa: Warning Signs

- Significant weight loss
- Distorted body image
- Intense fear/anxiety about gaining weight
- Preoccupation with weight, calories, food, etc.
- Feelings of guilt after eating
- Denial of low weight
- High levels of anxiety and/or depression
- Low self-esteem
- Self-injury
- Withdrawal from friends and activities
- Excuses for not eating/denial of hunger

- Food rituals Intense, dramatic mood swings
- Pale appearance/yellowish skin-tone
- Thin, dull, and dry hair, skin, and nails
- Cold intolerance/hypothermia
- Fatigue/fainting
- Abuse of laxatives, diet pills, or diuretics
- Excessive and compulsive exercise
Anorexia Nervosa: Health Complications

- Amenorrhea (cessation of menstrual cycle)
- Abnormally slow and/or irregular heartbeat
- Low blood pressure
- Anemia
- Poor circulation in hands and feet
- Muscle loss and weakness (including the heart)
- Dehydration/kidney failure
- Edema/swelling
- Memory loss/disorientation
- Chronic constipation
- Growth of lanugo (soft, fine) hair on body
- Bone density loss/Osteoporosis
Bulimia Nervosa: DSM-5 Diagnostic Criteria

- Recurrent episodes of binge eating characterized by BOTH of the following:
  - Eating in a discrete amount of time (within a 2 hour period) large amounts of food.
  - Sense of lack of control over eating during an episode.
- Recurrent inappropriate compensatory behavior in order to prevent weight gain (purging).
- The binge eating and compensatory behaviors both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.
Bulimia Nervosa: Warning Signs (1 of 2)

- Bingeing and purging
- Secretive eating and/or missing food
- Visits to the bathroom after meals
- Preoccupation with food
- Weight fluctuations
- Self-injury
- Excessive and compulsive exercise regimes — despite fatigue, illness, or injury
- Abuse of laxatives, diet pills, and/or diuretics
- Swollen parotid glands in cheeks and neck
Bulimia Nervosa: Warning Signs (2 of 2)

- Discoloration and/or staining of the teeth
- Broken blood vessels in eyes and/or face
- Calluses on the back of the hands/knuckles from self-induced vomiting
- Sore throat
- Heartburn/reflux
- Feelings of shame and guilt
- Self-criticism and low self-esteem
- High levels of anxiety and/or depression
Bulimia Nervosa: Health Complications

- Electrolyte imbalances that can lead to irregular heartbeat and seizures
- Edema/swelling
- Dehydration
- Vitamin and mineral deficiencies
- Gastrointestinal problems
- Chronic irregular bowel movements and constipation
- Inflammation and possible rupture of the esophagus
- Tears in the lining of the stomach
- Chronic kidney problems/failure
- Tooth decay
Binge Eating Disorder: DSM-5 Diagnostic Criteria

● Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  ○ eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
  ○ a sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)

● 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 afterwards

● Marked distress regarding binge eating is present.

● The binge eating occurs, on average, at least once a week for three months.

● The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.
BED: Warning Signs

- Eating large quantities of food, without purging behaviors, when not hungry
- Sense of lack of control over eating
- Eating until uncomfortably/painfully full
- Weight gain/fluctuations
- Feelings of shame and guilt
- Self-medicating with food
- Eating alone/secretive eating
- Hiding food
- High levels of anxiety and/or depression
- Low self-esteem
BED: Health Complications

- “Overweight or obese”
- Type II Diabetes
- Osteoarthritis
- Lipid abnormalities (Including increased cholesterol)
- Increased blood pressure
- Chronic kidney problems
- Gastrointestinal problems
- Heart disease
- Gallbladder disease
- Joint and muscle pain
- Sleep apnea
Prevalence of BED

- BED is the most common eating disorder by 5x
- Affects approximately 2.8 million people (3.5% of women and 2% of men)
- Affects biggest number of men of any EDO
- Most under-diagnosed ED (“Obesity” is focus – although 30% with BED not “obese”)
- 60-70% of those seeking bariatric interventions have BED
- % of BED in adults over their lifetime - racial distribution
  - 1.4% white
  - 2.1% Latino
  - 1.2% Asian
  - 1.5% African American
BED: Misconceptions

- Often viewed as a problem of will power, low self-esteem, depression...not ‘legitimate’ eating disorder
- Perception of binge eating increases stigma of obesity: ‘just stop overeating’ mentality
- BED target of more blame than other psychological disorders and other EDOs
- Patient comes into your office with assumption it is their fault – feeling as if they just cannot get themselves under control
The Diet/Binge Cycle

- negative thoughts
- diet (restriction)
- overeating
- deprivation
- shame

To stop binge eating, you have to stop dieting as a response to your binge
“Subclinical” Eating Disorders

• Atypical anorexia nervosa: Displays symptoms of anorexia but at “normal” weight
• Bulimia nervosa (of low frequency and/or limited duration): Binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
• Binge-eating disorder (of low frequency and/or limited duration): All of the criteria for binge-eating disorder are met, except the binge eating occurs, on average, less than once a week and/or for less than 3 months.
• Purging Disorder: Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting, misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
• Night eating syndrome: Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal.
Limitations of ED Diagnoses

When we overrely on DSM-5 for detecting disorders, we will miss huge segments of the population who have disordered eating or body image.

Many clients exhibit eating disorder symptoms but do not go detected because they do not meet full diagnostic criteria. This is true for men, people of color, and other groups that do not fit the ED stereotype.
Avoidant Restrictive Food Intake Disorder (ARFID)

- Feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs
  - Apparent lack of interest in eating or food;
  - Avoidance based on the sensory characteristics of food (texture, taste, appearance);
  - Concern about aversive consequences of eating (choking, vomiting);
  - Fear of new things (neophobia)
  - Sometimes lack of appetite
- Typically not associated with body/weight concerns
- Not explained by lack of available food, associated cultural practice, concurrent medical condition, or another mental disorder.
- People with autism spectrum conditions are much more likely to develop ARFID, as are those with ADHD and intellectual disabilities.
Orthorexia (not in DSM)

Obsession with proper or ‘healthful’ eating. Fixation on so-called ‘healthy eating’ is damaging well-being.

- 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
- High levels of distress when ‘safe’ or ‘healthy’ foods aren’t available
- Obsessive following of food and ‘healthy lifestyle’ blogs/media
- Body image concerns may or may not be present
Diet Culture (Christy Harrison)

Diet culture is a system of beliefs that:

● **Worships thinness** and equates it to health and moral virtue, which means you can spend your whole life thinking you’re irreparably broken just because you don’t look like the impossibly thin “ideal.”

● **Promotes weight loss** as a means of attaining higher status, which means you feel compelled to spend a massive amount of time, energy, and money trying to shrink your body, even though the research is very clear that almost no one can sustain intentional weight loss for more than a few years.

● **Demonizes certain ways of eating while elevating others**, which means you’re forced to be hyper-vigilant about your eating, ashamed of making certain food choices, and distracted from your pleasure, your purpose, and your power.

● **Oppresses people who don't match up** with its supposed picture of “health,” which disproportionately harms women, femmes, trans folks, people in larger bodies, people of color, and people with disabilities, damaging both their mental and physical health.
Statistics / Prevalence

- 8 year study of adolescents - 5.2% met criteria for ED
- Teens (15-24yo) w/AN have 10x higher risk of dying compared to same-age peers
- Males comprise 25% of those with AN, with higher risk of dying (Dx later and assumption males do not have ED)
- H.S female athletes - 41.5% reported disordered eating
- Black teenagers are 50% more likely than white teenagers to exhibit bulimic behaviors, such as bingeing and purging
- 2014 study found that ED rates have increased across all demographic sectors, but at a faster rate in male, lower socioeconomic and older folks.
- Transgender college students significantly more likely than members of any other group of college students to report an eating disorder diagnosis in the past year-2015 study.
- Teenage girls from low income families are 153% more likely to struggle with bulimia than girls from wealthy families.
- Only 20% of those with eating disorders fit the “emaciated body” stereotype.”
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Cultural/Societal Factors

- Imposition of Western/White beauty standards
- Media
- Healthism
- Fatphobia and diet culture
- Sexism
- Capitalism
- Racism
- Minority stress / oppression
- Poverty and food scarcity - now and historically/intergenerationally (e.g., The Great Depression)
Fatphobia and Its Racist Roots

- Sabrina Strings' *Fearing the Black Body* is an excellent book that goes in depth into the connections between fatphobia and racism

How the female body has been racialized for over two hundred years

There is an obesity epidemic in this country and poor black women are particularly stigmatized as “diseased” and a burden on the public health care system. This is only the most recent incarnation of the fear of fat black women, which Sabrina Strings shows took root more than two hundred years ago.

Strings weaves together an eye-opening historical narrative ranging from the Renaissance to the current moment, analyzing important works of art, newspaper and magazine articles, and scientific literature and medical journals—where fat bodies were once praised—showing that fat phobia, as it relates to black women, did not originate with medical findings, but with the Enlightenment era belief that fatness was evidence of “savagery” and racial inferiority.

The author argues that the contemporary ideal of slenderness is, at its very core, racialized and racist. Indeed, it was not until the early twentieth century, when racialized attitudes against fatness were already entrenched in the culture, that the medical establishment began its crusade against obesity. An important and original work, *Fearing the Black Body* argues convincingly that fat phobia isn’t about health at all, but rather a means of using the body to validate race, class, and gender prejudice.
Weight Norms and Gender Norms

● How people feel about their weight and their gender is highly susceptible to social influences and ideals.

● Like everyone else, trans clients are susceptible to prescribed ideals for masculinity and femininity (typically White/Western, but explore familial/cultural factors)
  ○ “Curvy” equated with feminine
  ○ “Skinny” equated with feminine
  ○ “Strong” or “muscular” equated with masculine

● Be aware that many of these norms or extremely ableist and classist
Familial Factors

- Historically, psychodynamic theory pointed toward controlling/enmeshed relationship with mothers as the source of eating disorders. Looks at symbolism of food and body image.
- Learning from parental/familial modeling (e.g., older sibling or parent has ED).
- Various forms of abuse
60% hereditary...risk factors/traits = vulnerability

- Anxiety
- Depression
- Obsessive/compulsiveness
- Obsessive preoccupation with weight
- Perfectionism
- Highly rigid
- Excessively sensitivity
- Overly preoccupied with symmetry & exactness
- Ritualized
- People pleasing
- Fear of failure disapproval & punishment
- Low self esteem
Food Insecurity

- Poverty and food insecurity erode people’s physical and mental health and support systems.
- Marginalized people face substantial barriers—including unemployment and underemployment and multilevel discrimination—which prevent them from affording adequate food.
- Many people report discomfort seeking food assistance due to discrimination/stigma
- Food insecurity tied to deprivation-binge eating cycle

Elevated Rates of EDs in Trans Communities

- Large survey of college students included “transgender” as demographic option
- Trans people were much more likely to say that they had received a diagnosis of an eating disorder in the past year
- Almost 16% of transgender participants reported being diagnosed with an eating disorder within the last year, compared to 1.85% of cisgender heterosexual women and 0.55% of cisgender heterosexual men.
- Trans participants also more likely to report compensatory behaviors

Examples of ED Presentations in Trans Clients

- Restriction
  - Can occur to have a smaller shape or fewer curves
  - To stop menses
- Binge eating
  - Can occur to manage stressors related to dysphoria or anti-trans discrimination/bias
  - Anecdotal accounts of testosterone increasing binge eating or purge behaviors in those with this history before hormones
- Compensatory behaviors
  - Purging or overexercise to combat hormone-related weight
- Intentional weight gain as strategy to hide gendered features
- Negative body image
  - Preoccupation with looking like feminine or masculine ideals
  - Preoccupation with looking like other “pretty” trans people
Why Elevated Risk? A Few Hypotheses

● Aspiring to traditional feminine/masculine ideals (Western, White)
  ○ “Curvy” equated with feminine
  ○ “Skinny” equated with feminine
  ○ “Strong” or “muscular” equated with masculine
  ○ Be aware that many of these norms or extremely ableist and classist

● Coping with minority stress

● Gaining a sense of control when other options for reducing dysphoria are not accessible

● Response to strict BMI requirements for surgery
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Assessment
Assessment

- Important to conduct thorough assessment with very specific, detailed food, exercise, and body image history
- Direct questioning about ED behaviors
- Being attuned to shame that can come up with anyone who is asked to answer these questions
A Few Brief Questions Cueing for Culture/Context

- How would you describe your relationship to body size, shape, or weight?
  - Do you have a sense of what an “ideal” body is for you? *What is that ideal based on?*
- How would you describe your relationship to food?
  - How is your relationship to food influenced by your *family or culture?*
- How is your view of your body affected by *how you are perceived in the world based on gender, race, or anything else?*
- Is there a time when you restricted your food, either by choice or involuntarily?
- Is there a time when you felt “out of control” with food?
  - If so, was there anything you did in response?
- Have you ever felt compelled to exercise or even “addicted” to it?
- Have you ever intentionally tried to change your eating or exercise in order to manage your weight or body size/shape?
Study: Four Simple Questions

The best individual questions for ruling in an eating disorder:
- Do you worry that you have lost control over how much you eat?
- Do you make yourself sick when you feel uncomfortably full?
- Do you currently suffer with or have you ever suffered in the past with an eating disorder?
- Do you ever eat in secret?

The best individual questions for ruling out an eating disorder were:
- Does your weight affect the way you feel about yourself?
- Are you satisfied with your eating patterns?

Brief Screening Question: 24-Hour Food Recall

● “Can you tell me what you have eaten in the past 24 hours?”
● Pay attention to not only content, but process/how the client responds to this question.
● Remember you are not to judge how “healthy” the person is - if you have those judgments come up, this may be a reflection of your own healthism or food concerns.
● Pay attention to:
  ○ Affect, tone, body (e.g., shame)
  ○ Range of precision to lack of memory (dissociation?)
  ○ The person’s commentary, explanation/apologies, judgment
● You can ask the same about exercise (in the past week)
Brief History Questions

- At what age did food/body/weight image concerns begin?
- What was access to food like growing up?
- Where did they get messages about bodies/weight? (School? Home?)
- Does anyone in their family/life have ED symptoms/history?
  - Dieting, binge eating, diagnoses that are linked such as Type II Diabetes?
- What is the client’s narrative about why ED symptoms/behaviors developed?
- When were symptoms the “worst”? Get specific.
- What have they tried to recover? What has worked? What hasn’t?
Assessment Tools

NEDA Online Screening Tool: https://www.nationaleatingdisorders.org/screening-tool

Eating Attitudes Test (EAT, EAT-26; Garner): 26-item self-report measure, 6-point scale that measures attitudes and behaviors.

Eating Disorder Assessment http://www.ori.org/files/Static%20Page%20Files/EDDS.pdf

Compulsive Exercise Test https://jennischaefer.com/cet/
Intuitive Eating Scale

Body Appreciation Scale

Body Appreciation Scale
Self Compassion Scale

Self Compassion Scale
● Online: http://self-compassion.org/test-how-self-compassionate-you-are/
● Different forms: http://self-compassion.org/self-compassion-scales-for-researchers/
Common Co-Occurring Mental Health Concerns

- Anxiety
- Depression
- OCD
- Substance Abuse / Addiction
- Other compulsive behaviors (e.g., shoplifting, impulsive spending, sex/love “addiction”)
- Trauma
- Traits: Perfectionism, low self-esteem, overcontrol, feeling “out of control”
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Multimodal Models: Treatment and Culture Shifting
Five Standard Levels of Care

- Inpatient Hospitalization
- Residential Treatment
- Partial Hospital (PHP)
- Intensive Outpatient Program (IOP)
- Outpatient Treatment
Inpatient Hospitalization: Criteria

Medical instability as determined by:
● Unstable/depressed vital signs or acute health risk
  ○ Hypothermia
  ○ Orthostasis - low blood pressure
  ○ Brachycardia - low heart rate
  ○ Less than 75% expected/ideal body weight
  ○ Electrolyte imbalance
● Other medical complications (e.g., diabetes)

Psychiatric instability:
● Risk to self, imminent suicidality
Inpatient Hospitalization: Course of Treatment

- Goal: Stabilize and plan for further treatment
- High level of supervision (medical monitoring, locked restrooms, supervised meals)
- Medical interventions as needed (feeding/hydration tubes, bedrest)
- Group-based treatment: coping skills, interpersonal process, psychoed, recreation, nutritional counseling, therapy
- Discharge after 48 hours medical stability
- For BN, stays can be brief (e.g., 7-10 days)
- For AN, stays tend to be longer (e.g., 2-6 weeks)
  - Focus on weight restoration
Residential Treatment: Criteria

- Medically stable; no medical intervention needed
- Psychiatrically impaired, needs higher level than PHP or IOP
Residential: Course of Treatment

- Medical monitoring
- All meals supervised
- Mostly group-based treatment, some individual or family therapy
- May include nutritional counseling
- Length of stay depends on: financial concerns or insurance coverage, clinical progress (e.g., 2 weeks, 1 year)
Partial Hospitalization Program (PHP): Criteria

Medical stability but:
- ED causes significant functional impairment; no imminent risk
- Need close monitoring of physiological and mental status

Psychiatric stability but:
- Unable to function in normal social, educational, or vocational situations
- Daily ED behaviors (binge eating, purging, restriction, etc.)
PHP: Course of Treatment

- 5 days/week, full day
- Supervised meals
- Group, individual, family therapy
- Nutrition counseling
- Average length = 4-6 weeks
Intensive Outpatient Program (IOP): Criteria

- Medical stability; does not need daily medical monitoring
- Psychiatric stability: symptoms relatively well managed; can function socially, vocationally, educationally
IOP: Course of Treatment

- Meets on average 3 times per week; 3-4 hours (day or evening)
- Group-based
- Includes 1 supervised meal/day
- Patients can continue regular activities (school, work, etc.)
- Average length = 4-6 weeks
Treatment Approaches

- Motivational Interviewing (MI) - looking at stages of change
  - Steps: DEARS
- CBT
- FBT - evidence based treatment used primarily with adolescents; based on DBT
- Family therapy
- Internal Family Systems (IFS) - ED “protector” parts
- EMDR - targeting triggers before unhelpful ED behaviors
- Narrative - ED externalized as a character
CBT approaches encourage clients to regulate eating habits by:

- Setting realistic goals
- Using self-monitoring when eating
- Modifying negative self-perception
- ID triggers, automatic thoughts, feelings, positive re-enforcers, negative consequences, ACRs and thought challenges

Interpersonal Therapy may be used for those who eat to cope with an underlying social problem. Helps individuals recognize this problem so they can better manage negative feelings without turning to food as a way to cope.
Binge Eating Disorder: Treatment (2 of 2)

Dialectical Behavior Therapy (DBT)
- May be used for those who binge eat to cope with a painful emotional experience. It helps patients with BED develop certain skills to reduce binge eating habits.
  - Mindfulness
  - Emotion regulation
  - Distress tolerance
  - Interpersonal effectiveness

- **Internal Family Systems** ~polarized parts of Self
- Nutritional Therapy
- Trauma resolution
- Expressive therapy
Health At Every Size (HAES)

HAES Curriculum:
https://haescurriculum.com/

Weight Science: Evaluating the Evidence for a Paradigm Shift

By Linda Bacon, Lucy Aphramor

- Current guidelines promote short-term weight loss.
- Most people will be unable to maintain long-term weight loss and do not achieve the supposed benefits of improved morbidity and mortality.
- This weight focus is not only ineffective at producing thinner, healthier bodies, but may also have unintended consequences: food/body preoccupation, cycles of weight loss/regain, distraction from other personal health goals, reduced self-esteem, eating disorders, and weight stigmatization and discrimination.
- Increased attention to ethical implications of recommending ineffective/harmful treatment.
- Randomized controlled clinical trials indicate: HAES approach associated with statistically/clinically relevant improvements in physiological measures (e.g., blood pressure, blood lipids), health behaviors (e.g., eating/activity, dietary quality), and psychosocial outcomes (such as self-esteem and body image).
- HAES achieves these health outcomes more successfully than weight loss treatment and without the contraindications associated with a weight focus.

The Weight-Inclusive versus Weight-Normative Approach to Health

**Weight-normative approach:** emphasis on weight and weight loss when defining health and well-being

**Weight-inclusive approach:** emphasis on health and well-being as multifaceted while directing efforts toward improving health access and reducing weight stigma

- Data reveal that the weight-normative approach is not effective for most people: high rates of weight regain/cycling from weight loss interventions, which are linked to adverse health and well-being.
- Weight stigma is also linked to adverse health and well-being.
- In contrast, data support a weight-inclusive approach, which is included in models such as Health at Every Size for improving physical (e.g., blood pressure), behavioral (e.g., binge eating), and psychological (e.g., depression) indices, as well as acceptability of public health messages.

https://www.hindawi.com/journals/jobe/2014/983495/
**Definition**

A model to support the health of people across the weight spectrum that challenges the current cultural oppression of higher-weight people. Specifically, the model seeks to: 1) end the stigmatization of health problems (obesity) and weight-based discrimination, bias, and stigmatizing practices within health care and other health-related industries, as well as other areas of life. The model acknowledges that weight is not a behavior or personal choice and that normal human bodies come in a wide range of weights and seeks alternatives to the overwhelmingly futile and harmful practice of pursuing weight loss.

**Principles**

1. Do no harm
2. Create practices and environments that are sustainable
3. Keep a process focus rather than end goals, day-to-day quality of life
4. Incorporate evidence in designing interventions where there is evidence
5. Include all bodies and lived experiences, a norm of diversity
6. Increase access, opportunity, freedom, and social justice
7. Given that health is multidimensional, maintain a holistic focus
8. Trust that people (and bodies) move toward greater health given access and opportunity

**Applied to policy**
- Provide environments that give access to all the things that support the well-being of human bodies of all sizes

**Within health care**
- Provide health interventions that give benefit to people at any size, without discrimination or bias

**In personal life**
- Provide yourself with the features of life you find sustainable, within the context of your life, that support your well-being

**Examples**

- Rooms for all ages, abilities and sizes
- Living wages to provide time for self care
- Nourishing, affordable, and accessible food
- End to weight discrimination in schools, insurance, workplaces, housing and so forth
- Regulation of weight loss advertising
- Support for communities and social networks
- Community involvement in making policy
- Medical research and education in health needs of higher-weight people
- End of structural racism and inequality
- Medical education on “best practices” for providing health care to higher-weight people
- Assist patients in developing long-term health practices rather than pursuing weight loss
- End BMI-based treatment decisions
- Require a plan of weight loss outcomes for all participants in weight change interventions and benefits for the majority before use
- Base practice on the lived experiences of patients: listen and learn
- Defend the therapeutic relationship
- Reconnect with your body’s cues to make decisions about what you need now
- Find playful and/or purposeful motives for moving that are not tied to weight loss goals
- When hurt, direct your anger to the person who hurt you rather than blaming your body
- Look for direct ways to improve life and health that do not require a thinner body
- Find others who are opting out of weight cycling and developing sustainable practices
- Know your worth is not based on health
**Definition**

A model to support the health of people across the weight spectrum that challenges the current cultural oppression of higher-weight people. Specifically, the model seeks to end (1) the stigmatizing of health problems (healthism) and (2) weight-based discrimination, bias, and iatrogenic practices within health care and other health-related industries, as well as other areas of life. The model acknowledges that weight is not a behavior or personal choice and that normal human bodies come in a wide range of weights and seeks alternatives to the overwhelmingly futile and harmful practice of pursuing weight loss.

**Principles**

1. Do no harm
2. Create practices and environments that are sustainable
3. Keep a process focus rather than end-goals, day-to-day quality of life
4. Incorporate evidence in designing interventions where there is evidence
5. Include all bodies and lived experiences, a norm of diversity
6. Increase access, opportunity, freedom, and social justice
7. Given that health is multidimensional, maintain a holistic focus
8. Trust that people (and bodies!) move toward greater health given access and opportunity
**Applied to policy**

Provide environments that give access to all the things that support the well-being of human bodies of all sizes

- Recess for all ages, abilities and sizes
- Living wages to provide time for self-care
- Nourishing, affordable, and accessible food
- An end to weight discrimination in schools, insurance, workplaces, housing and so forth
- Regulation of weight loss advertising
- Support for communities and social networks
- Community involvement in making policy
- Medical research and education in health needs of higher-weight people
- Redress of structural racism and inequality

**Within health care**

Provide health interventions that give benefit to people at any size, without discrimination or bias

- Medical education on “best practices” for providing health care to higher-weight people
- Assist patients in developing long-term health practices rather than pursuing weight loss
- End BMI-based treatment decisions
- Require >5 yrs of maintenance/outcomes for all participants in weight-change interventions and benefits for the majority before use
- Base practice on the lived experiences of patients: listen and learn
- Defend the therapeutic relationship

**In personal life**

Provide yourself with the features of life you find sustainable, within the context of your life, that support your well-being

- Reconnect with your body’s cues to make decisions about what you need now
- Find playful and/or purposeful motives for moving that are not tied to weight loss goals
- When hurt, direct your anger to the person who hurt you rather than blaming your body
- Look for direct ways to improve life and health that do not require a thinner body
- Find others who are opting out of weight cycling and developing sustainable practices
- Know your worth is not based on health
Principles of Intuitive Eating (1 of 10)

1. Reject the Diet Mentality

Throw out the diet books and magazine articles that offer you the false hope of losing weight quickly, easily, and permanently. Get angry at diet culture that promotes weight loss and the lies that have led you to feel as if you were a failure every time a new diet stopped working and you gained back all of the weight. If you allow even one small hope to linger that a new and better diet or food plan might be lurking around the corner, it will prevent you from being free to rediscover Intuitive Eating.

https://www.intuitiveeating.org/10-principles-of-intuitive-eating/
Principles of Intuitive Eating (2 of 10)

2. Honor Your Hunger

Keep your body biologically fed with adequate energy and carbohydrates. Otherwise you can trigger a primal drive to overeat. Once you reach the moment of excessive hunger, all intentions of moderate, conscious eating are fleeting and irrelevant. Learning to honor this first biological signal sets the stage for rebuilding trust in yourself and in food.
Principles of Intuitive Eating (3 of 10)

3. Make Peace with Food

Call a truce; stop the food fight! Give yourself unconditional permission to eat. If you tell yourself that you can't or shouldn't have a particular food, it can lead to intense feelings of deprivation that build into uncontrollable cravings and, often, bingeing. When you finally “give in” to your forbidden foods, eating will be experienced with such intensity it usually results in Last Supper overeating and overwhelming guilt.
4. Challenge the Food Police

Scream a loud *no* to thoughts in your head that declare you’re “good” for eating minimal calories or “bad” because you ate a piece of chocolate cake. The food police monitor the unreasonable rules that diet culture has created. The police station is housed deep in your psyche, and its loudspeaker shouts negative barbs, hopeless phrases, and guilt-provoking indictments. Chasing the food police away is a critical step in returning to Intuitive Eating.
5. Discover the Satisfaction Factor

The Japanese have the wisdom to keep pleasure as one of their goals of healthy living. In our compulsion to comply with diet culture, we often overlook one of the most basic gifts of existence—the pleasure and satisfaction that can be found in the eating experience. When you eat what you really want, in an environment that is inviting, the pleasure you derive will be a powerful force in helping you feel satisfied and content. By providing this experience for yourself, you will find that it takes just the right amount of food for you to decide you’ve had “enough.”
Principles of Intuitive Eating (6 of 10)

6. Feel Your Fullness

In order to honor your fullness, you need to trust that you will give yourself the foods that you desire. Listen for the body signals that tell you that you are no longer hungry. Observe the signs that show that you’re comfortably full. Pause in the middle of eating and ask yourself how the food tastes, and what your current hunger level is.
7. Cope with Your Emotions with Kindness

First, recognize that food restriction, both physically and mentally, can, in and of itself, trigger loss of control, which can feel like emotional eating. Find kind ways to comfort, nurture, distract, and resolve your issues. Anxiety, loneliness, boredom, and anger are emotions we all experience throughout life. Each has its own trigger, and each has its own appeasement. Food won’t fix any of these feelings. It may comfort for the short term, distract from the pain, or even numb you. But food won’t solve the problem. If anything, eating for an emotional hunger may only make you feel worse in the long run. You’ll ultimately have to deal with the source of the emotion.
8. Respect Your Body

Accept your genetic blueprint. Just as a person with a shoe size of eight would not expect to realistically squeeze into a size six, it is equally futile (and uncomfortable) to have a similar expectation about body size. But mostly, respect your body so you can feel better about who you are. It’s hard to reject the diet mentality if you are unrealistic and overly critical of your body size or shape. All bodies deserve dignity.
9. Movement—Feel the Difference

Forget militant exercise. Just get active and feel the difference. Shift your focus to how it feels to move your body, rather than the calorie-burning effect of exercise. If you focus on how you feel from working out, such as energized, it can make the difference between rolling out of bed for a brisk morning walk or hitting the snooze alarm.
10. Honor Your Health—Gentle Nutrition

Make food choices that honor your health and taste buds while making you feel good. Remember that you don’t have to eat perfectly to be healthy. You will not suddenly get a nutrient deficiency or become unhealthy, from one snack, one meal, or one day of eating. It’s what you eat consistently over time that matters. Progress, not perfection, is what counts.
Schedule / Agenda

9:00  INTRODUCTION
9:15  DEFINING EATING DISORDERS
10:00 ETIOLOGIES
10:30 ~break~
10:45 ASSESSMENT
12:00 ~lunch~
1:00  MULTIMODAL MODELS: TREATMENT AND CULTURE SHIFTING
2:30  ~break~
2:45  THE TREATMENT RELATIONSHIP(S)
3:45  CASE STUDIES
4:15  Q&A, EVALUATIONS
BREAK until 2:40
Schedule / Agenda

9:00 INTRODUCTION
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3:45 CASE STUDIES
4:15 Q&A, EVALUATIONS
The Treatment Relationship(s)
Interdisciplinary Model for Outpatient Care

- Physician
- Eating disorder therapist/specialist
- Nutritionist/dietician (as needed)
- Psychiatrist (as needed)
The Nature of ED Work

Eating disorders work requires:
● Attunement to what needs to be addressed immediately - ACTION AND
● Awareness that behaviors can be addressed more quickly, but overall recovery, especially full recovery, requires a longer PROCESS of challenging and replacing very compelling beliefs/narratives. It can be a slow, long road with many setbacks.
Establishing Goals, Looking for Discrepancies

Clients’ goals may differ from a treatment team’s goals. There may be discrepancies among the treatment team.

Medical stabilization
Not suffering consequences of ED
Weight restoration
Weight loss or avoidance of weight gain
Heal relationship with food
Control food
Address underlying feelings
AVOID underlying feelings
Countertransference

We live in diet culture. Common responses to clients include:
● What’s wrong with you? Get it together! “Just stop!”
● Judging someone as lazy or not having willpower.
● Feeling guilt/shame about our own bodies/food.
● Impostor Syndrome: Can I be a therapist if I don’t “look” healthy? Do therapists have to have a “look”?
● Wanting to fix or give advice: “Have you tried...?” - Sometimes very unethically giving advice to support weight loss. Telling people to make rules for themselves.
● Not challenging the unhelpful thoughts is being part of the problem.
● Disgust / fatphobia
● Fear that can come out as impatience, helplessness, frustration
Affirming Care: Recommendations

1. Do your work! If you have weight bias or internalized fatphobia, this is likely to affect your clients of all sizes. Be prepared to discuss your body in the room, whether you have thin privilege or live in a larger body.

2. Listen and mirror back the language the patient uses in describing concerns regarding food and body.

3. Check assumptions: Be aware that sometimes eating disorder concerns are related to weight, sometimes they are not.

4. Gather a thorough history of ED thoughts/feelings/behaviors and body image.

5. Do not assume anything based on the way a person looks (do proper assessment even if the person appears to be “normal” or “average” weight).

6. Refrain from telling trans people to just “accept” all aspects of their bodies as they are. Building a healthy/balanced body image takes time, and this can be invalidating.

7. Challenge your biases about gender and bodies.
   
   Example: Do I associate having curves with being feminine? Or consider flat/muscular bodies as masculine?
Schedule / Agenda

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10:30      ~break~
10:45      ASSESSMENT
12:00      ~lunch~
1:00       MULTIMODAL MODELS: TREATMENT AND CULTURE SHIFTING
2:30       ~break~
2:45       THE TREATMENT RELATIONSHIP(S)
3:45       CASE STUDIES
4:15       Q&A, EVALUATIONS
Case Studies
Case Study: Jordan

- 18yo Latinx nonbinary client (they/them/their)
- Just completed eating disorder inpatient program; primarily restrictive symptoms
- Cutting and chronic suicidal ideation
- Hospitalized twice; inpatient setting not able to adequately respond to nonbinary ID and needs for accessible environment
- Parents supportive but confused: “It would be easier if she just wanted to be a boy.”

What else do you want to know, and how might that affect how you proceed?
Case Study

Alan

- 43yo South Asian cisgender heterosexual married male client (he/him/his)
- Meets criteria for BED / nighttime
- Feels shame about having an ED, feels isolated and scared to tell people
- Believes he needs “willpower”
- Has tried many diets: Zone, Atkins, paleo, keto, Whole30, etc.
- Loses weight every time he diets, gains more back

*What else do you want to know, and how might that affect how you proceed?*
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Q&A / Evaluations
Resources

Association for Size Diversity And Health (ASDAH):
Binge Eating Disorder Association: bedaonline.com
BingeBehavior.com

Health At Every Size: https://haescommunity.com/
The Body Is Not An Apology: https://thebodyisnotanapology.com
Food Psych Podcast: https://christyharrison.com/foodpsych
TransFolxFightingEDs: https://www.transfolxfightingeds.org/

Anti-Diet by Christy Harrison
Fearing the Black Body by Sabrina Strings
Health At Every Size and Body Respect by Lindo Bacon
Intuitive Eating by Elyse Resch and Evelyn Tribole