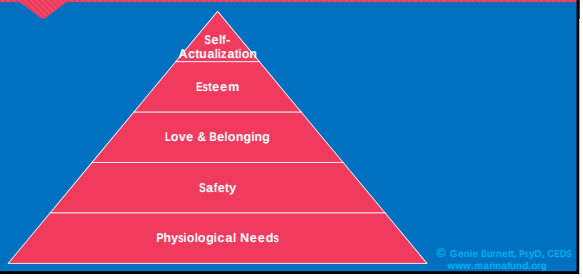
Eating Disorders: Fit to Treat?

Part Two: Therapist Focus

Would You Know an ED?

- Anorexia Nervosa
  - ARFID – Avoidant and Restrictive Feeding & Intake Disorder
  - Orthorexia
- Bulimia Nervosa
- Binge Eating Disorder
- OSFED - Other Specified Feeding or Eating Disorders

Maslow's Hierarchy: Applied to EDs



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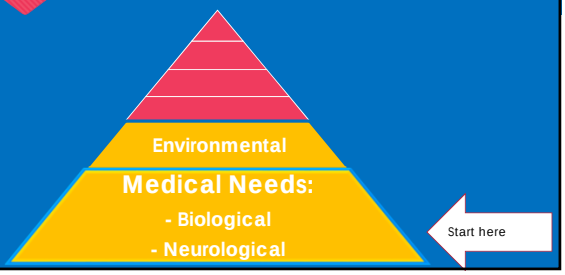

Maslow's Hierarchy Applied to EDs

A few of the Issues involved in ED treatment & recovery:

- Refeeding syndrome
- Heart issues (attacks)
- Irregular potassium levels
- Fatigue
- Psychosis
- Malnutrition
- Suicide
- Broken eye blood vessels
- Ruptured esophagus
- Loss of bone density
- Jaw replacement
- Teeth erosion
- Gastric ruptures, paresis (delay)

Key Ethical Considerations

Do They Know What They are Doing?

Multiple Issues to Consider

- Client's issues
  - Age
  - Gender
  - Sexuality
  - Medical
  - Dietary
  - Mental
  - Social
  - Trauma history
  - Familial
  - Genetic
  - Personality D/O
- Involving others
  - Is there anyone there?
  - Are they supportive?
  - Are they aware of the issues?
  - Do they follow through with recommend-ations?
  - Attitude towards the disorder?
- Involving other clinicians
  - Are they competent?
  - Are they supportive?
  - Do they make decisions with other clinicians or alone?
- Involving Treatment
  - Is it the right Level of Care (LOC)?
  - Are they providing the specific type of treatment that the client needs?

Main ACA Principles:

A. Counseling Relationship
B. Confidentiality and Privacy
C. Professional Responsibility to Clients
D. Responsibility to Clinicians
E. Evaluation, Assessment, & Interpretation
F. Supervision, Training & Teaching
G. Research & Publication
H. Distance Counseling, Technology, & Social Media

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Counseling Relationship

Respect for Autonomy, Rights & Dignity:

- Autonomy - grants the right to make informed choices about treatment without coercion or undue influence
  - Consider a client with AN – she is between 75-80% IBW, has a low heart rate (40-50 BPM), her blood pressure is orthostatic, and her face is gray. She appears to have clear thinking, and doesn't want to go to treatment. What do you do? (keep in mind that AN has the highest death rate in psychiatry, approximately 19%)
  - Should mental and allied health professionals be allowed to usurp the client's autonomy and force either hospitalization or coerce feeding?

Professional Responsibility to Clients

- **Beneficence -** Doing good, reducing harm in conflictual circumstances
- **Non-maleficence -** Do no harm
- The professional has the **responsibility** to ensure that the client has an understanding of the process and procedures that he/she may go through
- Client competence:
  - What do mental and allied health professionals need to know about how to determine competence and capacity among clients with eating disorders and in particular the client who is medically compromised by starvation?
  - Just treatment for clients with eating disorders involves using the least restrictive intervention to ensure client safety and promote good treatment outcomes (Fedyszyn & Sullivan, 2007).
- What happens when there is a conflict between the client's religious or cultural practices and potential eating disorder habits?
  - Fasting (religious reasons) vs. Restriction
  - Not eating meat vs. lack of protein in diet

Coercive and restrictive treatment strategies and disciplinary practices

- Involuntary hospitalization
- Guardianship orders
- Naso-gastric tube feeding
- Enforced nutritional replacements (liquid supplements in lieu of solid food)
- Supplementary feeding (additional snacks, meal add-ons, or nocturnal tube feeding)
- Unwanted pharmacotherapy (including drugs with side effects of weight gain)
- Surveillance at meals and in bathroom
- Bed rest and/or movement restriction
- Exercise restriction
- Restrictions of visits and activities contingent upon progress and compliance
- Removal of contraband items (i.e. diet soda, outside food, diet pills)
- Redirections for inappropriate meal-time conversation
- Redirections for rituals with food
- Behavioral contracts
- Measuring of food and calories consumed
- Other coercive or restrictive interactions with staff

Duty to Protect = Coercion?

- According to some professionals' interpretation, the ethical guidelines and code require clinicians to take action when a client's eating disordered behaviors have progressed to the point of life endangerment regardless of the client's expressed wishes (Griffiths & Russell, 1998; Werth, Wright, Archambault, & Bardash, 2003).
- To what extent do mental and allied health professionals have the right to employ other coercive tactics (e.g. implementing bed rest, restricting exercise, monitoring food intake and bathroom use, limiting visitors and a variety of other privileges) with clients in treatment for an eating disorder?
- When is there a duty to protect the client and how does the resolution of these issues vary when the client is a minor versus an adult?
- What do you do when a client refuses to eat/won't stop bingeing and/or purging, despite severe medical complications?

Responsibility to Clinicians

- Counselor competence: Creating *effective* psychological services
  - Being aware of own biases/wellness – Is he/she aware of their own body image/dietary/fat shaming issues? Should counselors make dietary suggestions or recommendations?
- Counselor supervision & consultation
  - It is STRONGLY encouraged that a clinician who is interested in working with eating disorders go through a structured program, such as iaedp
  - It is STRONGLY encouraged that a non-supervised clinician refer a patient to an individual who has appropriate credentials to treat an ED
  - It is a MUST that any clinician (MD, PhD, LPC, RD, etc) collaborate and confer with other treatment professionals when working with a patient with an ED. Clients are likely to lie, manipulate, distort, and get confused; this will be less likely in a "system" that has good communication and reinforcements.

Evaluation, Assessment, & Interpretation

- All assessments for EDs should be done by a competent, well-trained clinician
- No one test – or group of tests – can be used to accurately diagnose an individual with an eating disorder
- Evaluation of an ED:
  - Clinical interview
  - Medical evaluation (lab tests, etc)
  - Psychiatric evaluation (criteria as well as need for medication)
  - Dietary evaluation
  - Diagnostic assessments (e.g., EDI-III, personality, family interaction, etc)
  - Family interview

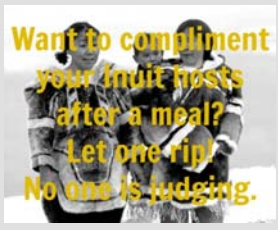
Distance Counseling, Technology, Social Media

- If the client is in the outpatient level of care, and the clinician follows the Ethics of TMH procedures, it is likely that it is ok to do distance counseling
- Any levels of care higher than Outpatient treatment, this is largely discouraged.
- Many individuals with eating disorders will use Social Media outlets to get their needs met
- Be aware of pro-anorexia and pro-bulimia websites:
  - http://www.proanatipsandtricks.com/
  - https://theproanalifestyleforever.wordpress.com/
  - https://missanamia.wordpress.com/tips-pro-mia/
  - http://pro-thinspiration.com/?hop=dsdikshant

Multicultural Issues in EDs

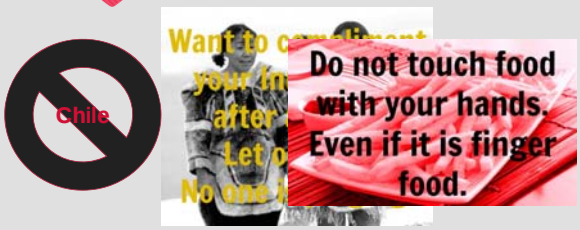
- Racial Practices (e.g.)
  - African American
  - Middle Eastern
  - Asian
- Religious Practices
  - Jewish
  - Catholic/Christian
  - Hindu
  - Muslim
- Gender differences
  - Female
  - Male
  - Transgender
  - Trans-sexual
- Familial Practices
  - Specific food, time, cooking rituals
  - Do they eat together?
  - Do they communicate?
  - Attitudes on exercise?

Multicultural Issues in EDs



Canada

Multicultural Issues in EDs



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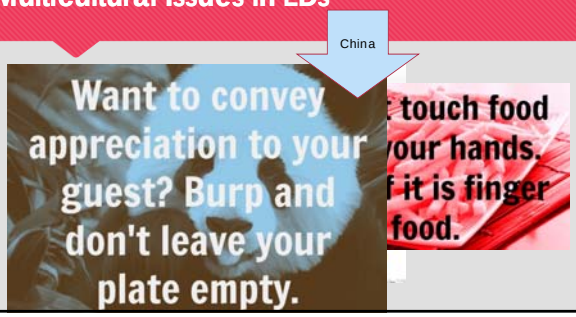

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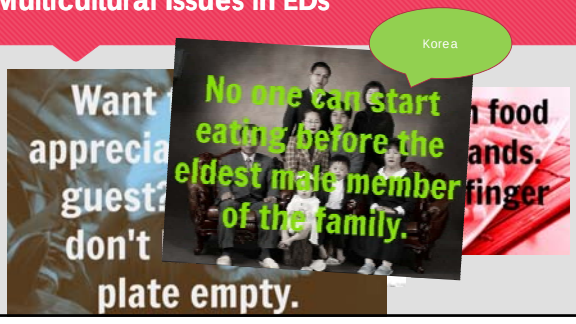

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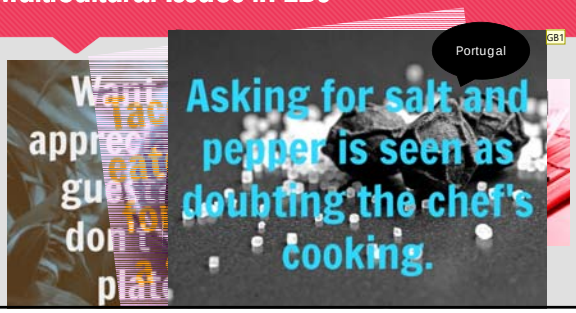


Food Rituals in EDs

Anorexia

- Spends more time cutting up food and pushing it around the plate than actually eating it?
- Insists on chewing each mouthful of food a specific number of times?
- Lives almost exclusively on low-calorie foods, like rice cakes, raw vegetables, and so on

Binge Eating

- Hoards food
- Food disappears incredibly fast
- Hides food wrappers that have been hidden/stuffed away
- May head to several drive thrus for binges

Bulimia

- Heads away from the table after meals, typically to secretive place
- "Has to" go and exercise compulsively
- Seems to punish self after having something "decadent"
- Runs water when in the bathroom

Slide 63

GB1 Genie Burnett, 10/3/2016

Who is able to treat an ED?
Where do you refer?
What levels of care are there?

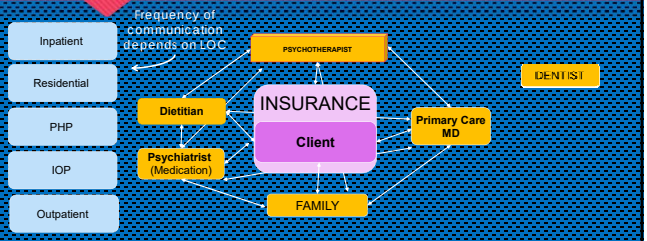
Certified Eating Disorder Specialist

iaedp – International Association for Eating Disorder Professionals

- CEDS: Medical, Psychiatric, Primary Therapist, Family Therapist
- CED-RD: Dietitian
- CED-RN: Nursing
- CEDCAT: Activities Therapist
- Requirements:
  - Online or in-person courses
  - Examination
  - Ongoing supervision – 2500 hours

Multidisciplinary approach to treating eating disorders

Template by Sondra Kronberg, RD



Choosing Appropriate Levels of Care

Issue	Outpatient	Intensive Outpatient	Partial Hospitalization	Residential	Inpatient
Medical	Medical monitoring is not required			Stable, may require medical monitoring initially	Severe medical issues requiring attention
Suicide	Not typically suicidal; has coping skills to cope with pain				Intent, plan, or post-attempt
Weight	>85%	>80%	>80%	<85%	<85%
Meal plan	Self-sufficient	Self-sufficient	Needs structure to gain weight	Needs supervision at all meals or may act out	Requires supervision; can't control acting out
Compul-sive Bxs	Focus on managing triggers	Gaining insight, connecting bxs	Some, but better controlled	Struggling	Difficulty controlling

Treatment: OMG…where does (s)he go?

State-based insurance isn't accepted MOST places

ASSESSMENT:

- CHOA – Full assessment, including inpatient care;
- Veritas – coming soon to the medical center area (children, adolescents, reserved Medicaid beds for residential)
- Manna Treatment – IOP/PHP assessment (adol, adult, males, Christian-friendly, scholarships, working on accepting Medicaid and CMOs)
- Atlanta-area, doesn't accept MKD/CMOs, but other insurance:
  - Atlanta Center for Eating Disorders (adol, adult, males)
  - Renfrew (adol, adult)
  - Ridgeview (adol, adults)

Coaching a Parent of Patient with an ED

What to say:

- I'm really concerned about your child. He/she medically isn't stable, and needs more care.
- Your child isn't doing this TO YOU. He/she is doing this in order to manage something that he can't. It's harmful to try to control or minimize or shame this behavior.
- This is a medical issue with an emotional wound. It's not for attention/sympathy, etc. It's a complex issue

What to do:

- Follow through with the parent. Make sure that he/she gets them the appropriate care
- Support the parent/caregiver; discourage shaming by the parent.
- Encourage him/her to follow through with all recommendations made by the team. No one can do this alone.
- ***Please don't undermine or sabotage the therapeutic relationship.*** It takes a village…

References

- Matusek, JA* & O'Dougherty-Wright, M. *Ethical Dilemmas in Treating Clients with Eating Disorders: A Review and Application of an Integrative Ethical Decision-making Model,*. Published online in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/erv.1036, 2010-07-30.
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Thank you, thank you very much.

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