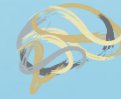




Department of Psychiatry

SCHOOL OF MEDICINE

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**



BRAIN HEALTH for all, for life.

Why Eating Disorders are no SCOFFing matter

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Objectives

- Identify similarities and differences with Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder
- List and identify common eating disorder behaviors
- Review validated screening/assessment tools for Eating Disorders
- Describe Evidence Based Treatment for Eating Disorders

What Eating Disorders Have you Treated in the Past

- [PollEv.com/stephanielehto155](https://www.pollEv.com/stephanielehto155)
- Send **stephanielehto155** to **37607**



Eating disorders...

What do you know about them?

Statistics

- More than 30 million people in the US are struggling with a clinical eating disorder, many more with sub-clinical eating disorders and disordered eating
- Over 70% of those who suffer with eating disorders will not seek treatment due to stigma
- 2.8% of American adults suffer from binge eating disorder in their lifetime
- Anorexia nervosa is the 3rd most common chronic illness among adolescents, after asthma and obesity
- One in five anorexia deaths is by suicide
- 50-80% of the risk for anorexia is genetic
- Anorexia is one of the most deadly illnesses, with a higher mortality rate than any other mental illness (second only to deaths caused by the opioid crisis)

General



- Severe illnesses with both mental and physical risk factors, causes, symptoms, and consequences
- Experience of severe disturbances in one's feeding/eating behaviors, self-image, and related thoughts and emotions.
- Typically accompanied by a preoccupation with food, body weight/shape/size, and rigid thinking/low cognitive flexibility

Subtypes-Official

Bulimia Nervosa

Anorexia Nervosa

Binge Eating Disorder

Subtypes-Official

Avoidant and
Restrictive Food
Intake Disorder
(ARFID)

Other Specified
Feeding and
Eating Disorder
(OSFED)

Subtypes-Unofficial

- Diabulimia
 - A person with diabetes (typically type 1 diabetes), where the person purposefully restricts insulin in order to lose weight
- Orthorexia
 - An obsession with extremely healthy or “clean” eating; beyond just wanting to eat healthy
- Drunkorexia
 - This individual restricts food and/or purges in order to “save calories” for drinking alcohol
- Pregorexia
 - Desire to control weight gain associated with pregnancy

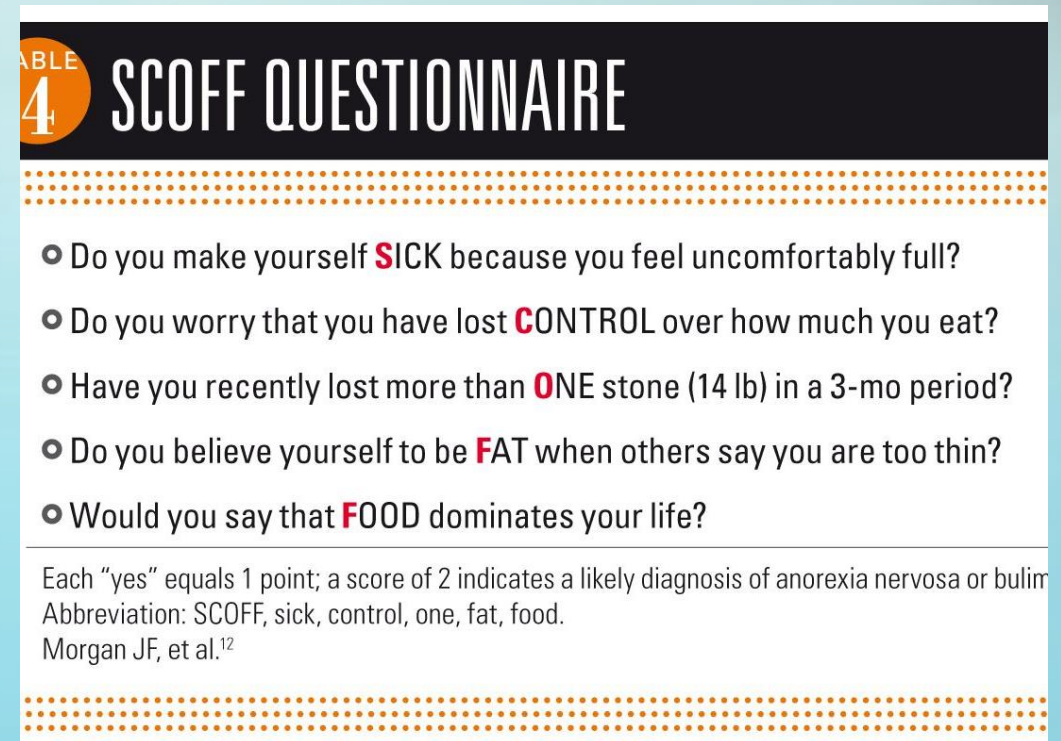
Consequences

- Serious and potentially life-threatening conditions
- Affect a patient's emotional and physical health
- Not just a fad or phase; you can't just grow out of it
- Can have lasting impacts on someone's health, productivity, and relationships



Assessment Tools: SCOFF

- SCOFF – UK standard tool for screening EDs in primary care
 - S – Do you make yourself feel sick (vomit) because you feel uncomfortably full
 - C – Do you worry that you have just lost control over how much you eat
 - O – Have you recently lost more than one stone (15 pounds) in a 3 month period
 - F – Do you believe yourself to be fat when others say you are thin
 - F – Would you say that food dominates your life
 - ** based on DSM-IV; answer yes to 2 or more is a sign of an ED



The graphic is a vertical rectangular box with a black header and a white body. The header contains the text 'TABLE 4 SCOFF QUESTIONNAIRE' in white, with '4' in a large orange circle. The body contains five bullet points, each with a red letter in bold. At the bottom, there is a line of text explaining the scoring and citation.

TABLE 4 SCOFF QUESTIONNAIRE

- Do you make yourself **S**ICK because you feel uncomfortably full?
- Do you worry that you have lost **C**ONTROL over how much you eat?
- Have you recently lost more than **O**NE stone (14 lb) in a 3-mo period?
- Do you believe yourself to be **F**AT when others say you are too thin?
- Would you say that **F**OOD dominates your life?

Each "yes" equals 1 point; a score of 2 indicates a likely diagnosis of anorexia nervosa or bulim
Abbreviation: SCOFF, sick, control, one, fat, food.
Morgan JF, et al.¹²

Hill et al., 2010

EDI-3

Eating Disorder Inventory-3

Professional Manual

David M. Garner, PhD

PAR

Assessment Tools: EDI-3

- Eating Disorder Inventory-3 (EDI-3)
 - Self-report measure, 13-53 years old, and 20 minutes to complete
 - 91 questions, Twelve scales
 - General Risk Factors
 - Drive for Thinness, Bulimia, Body Dissatisfaction
 - General Psychological Distress
 - Low self-esteem, Personal Alienation, Interpersonal Insecurity, Interpersonal Alienation, Interoceptive Deficits, Emotional Dysregulation, Perfectionism, Asceticism, Maturity Fears
 - Six composite scales:
 - Eating Disorder Risk, Ineffectiveness, Interpersonal Problems, Affective Problems, Overcontrol, General Psychological Maladjustment

Clausen et al., 2011;

<https://www.parinc.com/Products/Pkey/103>

Assessment Tools: EDE-1

- Eating Disorder Examination-Questionnaire
 - <http://cedd.org.au/wordpress/wp-content/uploads/2014/09/Eating-Disorder-Examination-Questionnaire-EDE-Q.pdf>
 - Developed as an alternative to the Eating Disorder Examination (which takes 30-60 minutes; is a semi-structured interview; considered the “gold standard” for ED assessment)
 - 28 Questions about the past 28 days with Subscales: Restraint, Shape Concern, Weight Concern, Eating Concern, and Global Score

Eating Disorder Examination Questionnaire (EDE-Q 6.0)

The following questions are concerned with the past four weeks (28 days) only. Please read each question carefully. Please answer all questions. Thank you.

Questions 1 to 12: Please select the appropriate response for each question. Remember that the questions only refer to the past four weeks (28 days).

On how many of the past 28 days...

	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1. ...have you been deliberately trying to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. ...have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your weight or shape?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. ...have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. ...have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. ...have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. ...have you had a definite desire to have a totally flat stomach?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. ...has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. ...has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. ...have you had a definite fear of losing control over eating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Assessment

Warning signs

Biopsychosocial Model of Eating Disorders and Causes

Gathering information on historic and current relationships with food and body, stressors, life changes, support (or lack of support)

Warning Signs

- Skipping meals or making excuses for not eating
- Rigid and restrictive diet
- Cutting out an increasing amount of foods and/or food groups
- Preoccupation and excessive focus on healthy eating
- Making own meals rather than eating what family/partner eats; bringing own food to gatherings where everyone else is eating the same thing
- Isolating and withdrawal from normal social activities
- Persistent worry or complaining about being fat, out of shape, gross, large, and talk of losing weight
- Checking in the mirror for perceived flaws and/or body checking bxs
- Calorie counting, checking of ingredients and nutrition labels
- Taking a long time to make decisions around food, whether it's what to eat or what food to buy



Warning Signs

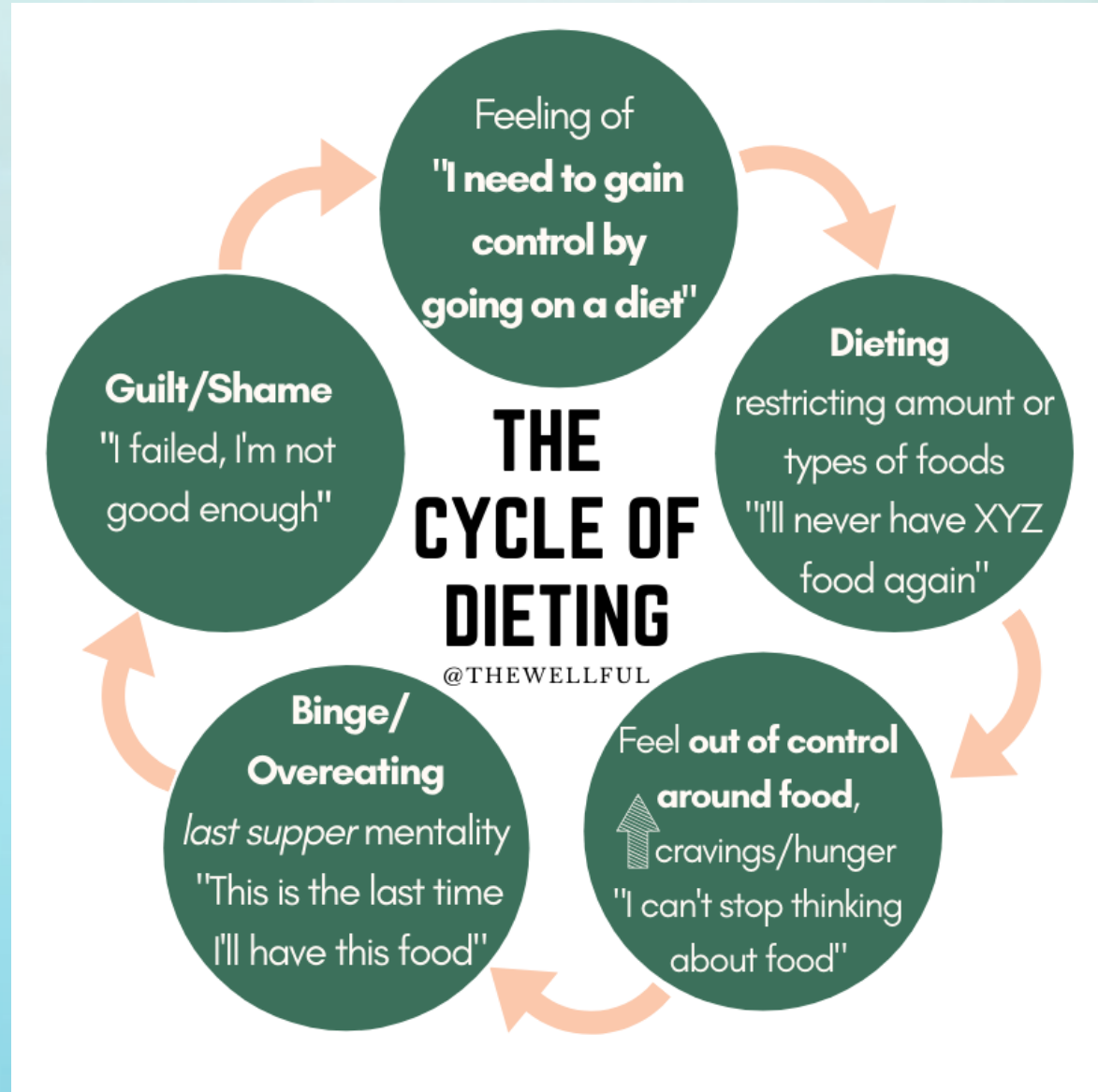


- Repeatedly eating large amounts of sweets or high-fat foods
- Use of dietary supplements, laxatives, or herbal products for weight loss
- Excessive exercise
- Physical side effects from purging (e.g. calluses; loss of enamel) Leaving during or right after meals to use the bathroom
- Eating in secret
- Refusing to eat at restaurants
- Having “safe” foods
- Eating much more food in a meal or snack that is considered normal
- Expressing shame, guilt, disgust, or depression about eating habits

Eating Disorder Behaviors

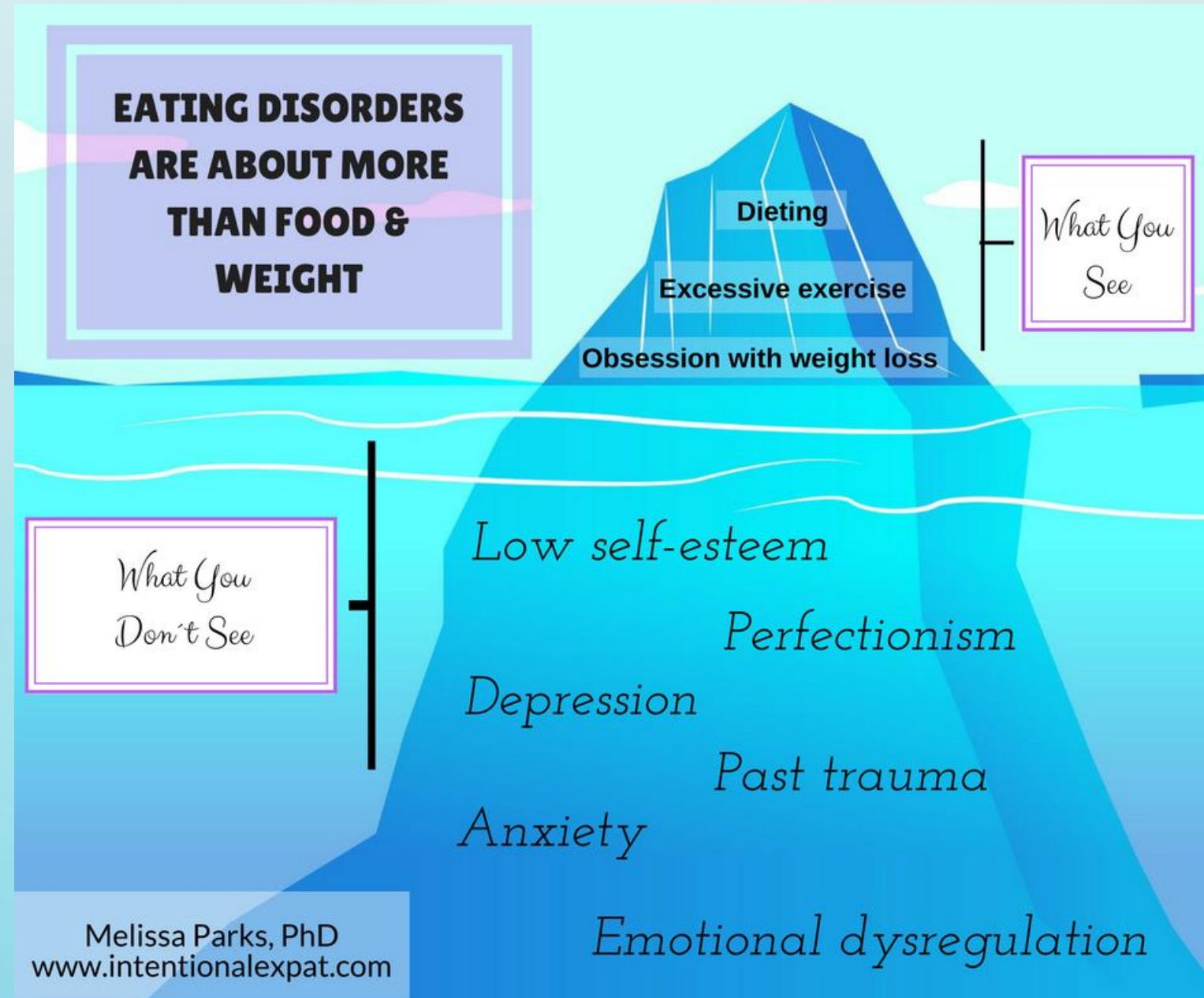
- Restriction of food groups
- Restriction of calories
- Distress with eating
- Ripping bread
- Moving food around plate
- Subjective and Objective Binges
- Self-induced vomiting
- Compulsive/overexercise
- Wrappers
- Restriction of water OR water loading
- Secretive eating

Binge-Restrict Cycle



<https://thewellful.com/editorial/stop-feeling-out-of-control-around-food>

Causes



Causes

Factors in the development of eating disorders:

- Dieting or restrained eating behavior
- Rigid dietary restrictions due to medical condition, aspects of culture, aspects of religion
- Desire to get fit/thin/healthier/more attractive
- Rigidity in thinking
- Biological/genetic vulnerability
- Medical and/or psychological co-morbidities
- Psychological and temperamental predispositions



Causes



- Transitions, stress, changes
- Desire for control
- Attempt to get rid of or avoid difficult emotions, feelings, and thoughts
- Family dynamics and developmental history
- Environment and societal influences
 - Involvement in activities or professions that focus on weight control, shape, size, appearance
 - Western culture's emphasis on thinness and the ideal body
 - Bullying and peer pressure/desire to fit in

Addressing factors that can reinforce the eating disorder or make it difficult to recover is key

- Positive reinforcement from society and social network
- Psychological reinforcement; false sense of control
- The belief that fat/full (and eventually healthy) is bad and to be avoided at all cost
- The role the ED plays in the patient's life
- The role the ED plays in the family system
- Unresolved or ongoing trauma
- Physiological reinforcement from starvation/malnutrition
- Perfectionism and other temperament traits



Insurance

- EATING DISORDERS ARE ASSOCIATED WITH SOME OF THE HIGHEST LEVELS OF MEDICAL AND SOCIAL DISABILITY OF ANY PSYCHIATRIC DISORDER
- Insurance coverage for treatment is notoriously an issue, leaving many unable to receive proper treatment or treatment at all.
- Many outpatient providers who specialize in eating disorders are self-pay, don't accept insurance, and don't take Medicare/Medicaid



Insurance

- Common reasons insurance won't pay/insurance cuts people in treatment:
 - Weight: not low enough
 - No medical complications
 - Treatment history
 - Lack of progress in treatment
 - Too much progress in treatment

"Second to deaths spurred by the opioid crisis, eating disorders have the **highest mortality rate** of any psychiatric diagnosis. Yet insurance companies resist covering **life-saving treatment.**"

NEDA Chief Policy and Strategy Officer
Chevese Turner in *The Hill*



What you can do



Level of care is determined by many factors, including clinical judgment not captured by these criteria.

	OUTPATIENT	INTENSIVE OUTPATIENT (IOP)	PARTIAL HOSPITAL PROGRAM/INTENSIVE DAY PROGRAM (PHP/IDP)	RESIDENTIAL TREATMENT	INPATIENT HOSPITALIZATION <i>(TEP collaborates with local hospitals for acute admission needs)</i>
Medical status	Medically stable	Medically stable	Some medical and/or psychiatric monitoring needed	Medical and/or psychiatric monitoring needed	Acute medical or psychiatric stabilization needed
Structure needed to eat and/or decrease ED behaviors	Self-sufficient. For adolescent, intensive family support available	Needs additional structure to manage eating behaviors and/or weight gain	Needs significant structure to manage eating behaviors and/or weight gain	Continual supervision and structure required to manage eating behaviors and/or weight gain	Continual supervision and structure required to maintain safety
% desirable body weight or degree of weight change	Typically >85% or weight change over more lengthy time period	Typically >80% or weight change over relatively short time period	Typically >80% or weight change over short time period	Typically >60% or rapid weight change	Typically < 60% or very rapid weight change
Motivation for recovery	Fair to good	Fair	Poor to fair	Poor to fair	Very poor to poor
Co-occurring conditions	Co-occurring conditions are minimally impactful	Co-occurring conditions may indicate higher level of care depending on severity and impact	Co-occurring conditions may indicate higher level of care depending on severity and impact	Co-occurring conditions may indicate higher level of care depending on severity and impact	Co-occurring medical and/or psychiatric conditions require acute care
Suicidality/Self-harm	No intent or plan	No intent or plan	Possible plan; minimal intent	Possible plan and intent	Intent and plan
Exercise	Able to control compulsive and/or excessive activity	Needs some structure to manage compulsive and/or excessive activity	Needs significant structure to manage compulsive and/or excessive activity	Continual supervision and structure required to manage compulsive and/or excessive activity	Continual supervision and structure required to maintain safety
Social Support	Some support	Some support	Limited support	Lacking structure or support outside of treatment setting	Safety compromised
Distance from treatment options may impact level of care decision	Treatment locally available	Treatment reasonably accessible	May need to travel for specialty care and may need overnight lodging	May need to travel for specialty care	May need to travel for specialty care

Adapted from 1. American Psychiatric Association Practice guideline for the treatment of patients with eating disorders (revision). *Am J Psychiatry* 2000 Jan;157(1 Suppl):1-39 and 2. Guideline Watch (August 2012): Practice Guideline for the Treatment of Patients with Eating Disorders, 3rd Edition. Yager J, Devlin M, Halmi K, Herzog D, Mitchell J, Powers P, Zerbe K. *Focus*, Volume 12 Issue 4, Fall 2014, pp. 416-431.

Special considerations

- Misconceptions and stereotypes about eating disorders have real consequences that can lead to fewer diagnoses, treatment options, and support for those who don't fit the stereotypical view of an eating disorder

Eating disorders can affect anyone.
They do not discriminate.



www.nimh.nih.gov/eatingdisorders

LGBTQ+ Community

- High prevalence in this community across all gender identities and sexual orientations
- Development of eating disorders related to unique stressors:
 - Negative messages about gender identity; gender norms
 - Identity/acceptance
 - Bullying
 - Discrimination
 - Shame around body vs. gender identity
 - Shame from family/others around identity/orientation, also lack of support
 - Body image distress around not being able to meet perceived body image ideal of gender identity



Case example

- 25-year-old Caucasian, female with AN-R, OCD, MDD, and history of trauma
- Considered treatment refractory eating disorder; in and out of treatment 14 times since 17 years old with continued relapses
- Did thorough assessment including sexual orientation and identity; Pt was visibly uncomfortable with question but identified as heterosexual
- After building rapport, Pt disclosed actually identifying as lesbian
 - Reports immense shame and lack of support from family
 - Eating disorder helped isolate, suppress sexual desire, and not have relationships, which “helped” patient avoid a key aspect of her identity
- Worked on identity development, as well as separating from eating disorder as identity
 - Challenged her to at least attend my sexuality group and eventually talk in group
 - Supported her in exploring identity outside eating disorder and heteronormative views/culture in family, treatment center, and society

Black, Indigenous, and People of Color

- Similar rates of EDs in BIPOC and non-Hispanic Whites, yet BIPOC are significantly less likely
 - To receive and seek help for eating issues
 - To receive a diagnosis of an eating disorder
 - To be asked by a doctor about eating disorder symptoms at a significantly less rate compared to white people
- Risk factors for this population:
 - Whiteness being the ideal of Western society; internalized shame and distress
 - Objectifying and fetishizing
 - Discrimination, prejudice, and stereotypes
 - Lack of access to care and lack of diversity amongst eating disorder specialists
 - Systematic racism

Case example

- 18 year old Black female, AN-R; Diagnosed 3 months prior to coming to treatment and active in eating disorder for about one year
- Ballet dancer; mother against Pt being in treatment because not wanting Pt to gain weight; mother thought Pt looked good and showed more love towards Pt when she was severely underweight and medically compromised. This was a big factor in Pt's relapse (as well as insurance not covering a full stay)
- Second stay in treatment, we attempted to work with Pt's mother and the pressure she was putting on Pt to stay thin Ended up revealing mother's deep-rooted fat-phobia AND internalized racism
 - Mother originally from Africa and had very negative views of Black Americans
 - Pt held some of the internalized racism as well which turned into self-hate; leading to eating disorder and self-harm

Case example

- Mother was unwilling to work on these things and it was interfering with patient's recovery
 - Brought Pt's father, sister, and brother in for family work
 - Assisted Pt in increasing assertiveness skills and boundaries, especially with her mother
 - Worked on identity, self-compassion, cognitive therapy to challenge/reframe some core beliefs
 - Had to talk with Pt about racism and cultural identity. Had to admit my limitations as Caucasian female
 - Supported Pt in exploring her identity as a Black American especially through body image (e.g. body size, as well as hair and Pt exploring how she actually wanted to wear her hair, which in fact was natural and not straightened)
 - Bringing Pt's sister and brother into therapy was KEY. They were not affected by mother and both felt very connected to their identity as Black Americans.
 - Pt doesn't do ballet anymore and is more connected to traditional African dance, as well as modern dance
 - Since 2020, she also made the decision to limit her interactions with her mother to next to none

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Religious communities

- Religion can play a role in the development or maintenance of an eating disorder
- High prevalence in the Orthodox Jewish communities
- Specific risk factors in religious communities:
 - High importance placed on being smaller and thinner/looking a certain way for arranged marriages (specific to Jewish community)
- Shame around mental illness
- Strict dietary rules and fasting
- Strict gender roles
- Shame around one's body
- Shame around sexuality



Men, older women, geriatric populations

- Men
 - Stigma around seeking help and even more stigma around the perception that eating disorders and body image concerns are only a women's issue
 - Assessments and psychological tools; even the initial dx had language and criteria geared towards women
- Older women
 - Older women are often overlooked in society
 - Changing roles
 - Menopause can cause body image distress
- Geriatric population
 - Eating disorders affect people of all ages
 - Assess for dementia and neurological issues
 - May need to set patient up with in-home care
 - Help with ADLs

Case example

- 76 year old Caucasian female, AN-B/P, abuse of laxatives that has led to episodes of incontinence, history of SUD but sober for many years, historic and current body image issues. Dementia and related disorders were ruled out
- Similar treatment (behavior interruption, addressing maladaptive coping skills and beliefs around food, body image, self), with some exceptions
 - Ended up having to do a lot of therapy with husband present due to Pt's cognitive impairment and the important role Pt would have to play outside of treatment
 - Pt was often on bed rest or needing to stay in her room due to episodes of incontinence as well as needing more rest related to age
 - Needed to focus on improving ability to complete ADLs and eventually setting up home health care to assist Pt and husband

People with disabilities

- Ableism and cultural bias that view people with disabilities as inferior and different from the non-disabled majority
- Specific risk factors and issues in this population:
 - Feelings of loneliness, feeling as though one does not fit in; bullying, shaming, discrimination; the world can feel unwelcoming and inaccessible
 - Body image is not just about weight and size; it becomes about ability
 - A feeling of disconnect from one's body, feelings of always being "in the way" or a burden
 - Medical professionals may overlook signs and symptoms of disordered eating due to these being overshadowed by or hidden by other symptoms of the disability

Weight diversity

- Weight itself is not a determining factor for an eating disorder
- Many individuals hesitate to get help because they do not feel they are “sick enough” if they are not thin or underweight



Weight stigma and discrimination

- Mistreatment and/or unfair treatment based on weight/size
- Many people who are deemed overweight are shamed and blamed about their appearance; not offered similar opportunities as someone who is thin
- Weight discrimination is significantly associated with higher use of mental health services as it poses a significant threat to psychological and physical health*



Psychiatric Co-Morbidities

- Research demonstrates that 55-97% of individuals diagnosed with an eating disorder also receive a diagnosis for at least one more psychiatric diagnosis
- Most common
 - Mood disorders
 - Anxiety disorders (particularly social anxiety)
 - OCD
 - PTSD
 - Substance use disorders
 - SH/SI



Information on this slide has been adapted from the National Eating Disorder Collaboration website

Case example

- 23 year old female. Diagnosed with eating disorder at 13 years old; AN-R.
- Support system was mainly her grandmother and brother. Father not in the picture and mother was not consistently around.
- History of watching her parents physically and verbally fight while she was younger. Notes that she would get terrible stomach pain when this would happen and sometimes would even vomit.
- Abusing marijuana multiple times, every day.
- Often complained that she was too full and her stomach hurt.
- Most treatment stays ended with her leaving AMA
- Missing piece that we found while working together the second time was a diagnosis of OCD and emetophobia.
- Combo of ERP, ACT, CBT, and DBT.

BDD Case Example

- 33 year old, female presenting for treatment of OCD. History of AN-R and extensive trauma
- AN-R was 7+ years managed and not an issue HOWEVER Pt presented with ongoing body image distress
- After more assessment and therapy, Pt's BDD presented
 - Preoccupied with perceived flaws on skin, specifically face
 - No skin picking, but a lot of scanning, camouflaging, AND she would often be late or no show to appointments because she was 1. compulsively checking skin in mirror and/or putting on makeup 2. ashamed of skin and how she perceives herself to look, so didn't want to be seen by people
- Utilized ERP with BDD as primary treatment, also utilized ACT and a lot of values-based work, as well as DBT focusing especially on assertiveness and taking up space
- Currently rarely wears makeup and hasn't missed a session (no showed or been late) since 2020

Case example

- 21 year old female, AN-B/P, MDD, GAD; diagnosed at 18 years old
- Ongoing self-harm, no sense of self, codependent with family, impulsive, low distress tolerance
- Held family anxiety and family had secondary gain from her remaining ill
- Used SH and eating disorder behaviors to attempt to get needs met and regulate emotions
- She would leave treatment and immediately relapse
- Psych testing showed cluster C personality disorder combo of OCPD, avoidant, and dependent personality disorders
- DBT, ACT, ERP around perfectionism, family therapy
- Referred to transitional housing; did much better outside of family system

Case example

- 33 year old male, AN-R and diagnosed since 15 years old. Also MDD and OCD
- Chronic suicidality and desire to be killed by his eating disorder
- Received ketamine and saw some improvement
- ACT, ERP, and CRT; instilling hope and finding value in life
- Family therapy focused on helping family move towards acceptance that son did not want to get better and wanted to die; grieving process
- Discharged and two months later died by suicide

Medical Co-Morbidities

- Eating disorders are one of the 12 leading causes of hospitalization costs due to mental health, with 11% of these admissions being due to life-threatening complications
- Individuals with AN have a mortality rate 5x higher than the general population, and those with BN are 50% more likely to die prematurely than those in the general population
- Impairments from both physical and mental health issues can decrease the quality of life and one's functioning, which in turn leads to increased health care utilization and decreased productivity

Notes on treatment

- Multimodal
- Team approach and united front
- Boundaries and consistency
- Involvement of family



When seeing a patient



- Place positive reinforcement on health, not weight loss
- Don't tell someone to “just eat” “eat more” or “just stop”
- Speak to support system and suggest strategies
- Provide resources
- Avoid using terms like “not too thin” or “not that bad/not too bad” with patients
- Don't use BMI to discount reported symptoms or as the only indicator for an eating disorder

Levels of Care

- Outpatient
- IOP
- PHP
- RES
- IP



Treatment essentials

- Medical management
- Medication/Psychiatry management
- Nutritional rehabilitation and weight restoration
- Cognitive and behavioral therapy
- Adjunct therapies
- Relapse prevention
- Family Involvement



Nutritional rehabilitation and weight restoration

- Increase caloric intake and expand variety of food selection
- Correct nutritional deficiencies
- Learning to recreate one's relationship with food and body
- Things to consider: Feeding tubes, bed rest, exercise/movement
- Refeeding syndrome



Psychotherapy

- Cognitive and behavioral therapy
 - Cognitive Therapy
 - Using different therapeutic skills, CT addresses:
 - Cognitive distortions and core beliefs
 - Food avoidance and ego-syntonic aspects of ED
 - Behavioral Therapy
 - Focus is on behavioral change and decreasing symptoms



Specific Modalities

- Cognitive Behavioral Therapy
 - Focus is on the beliefs, values, and cognitive processes that maintain the ED
- Acceptance and Commitment Therapy
 - Focus on changing your actions rather than your thoughts and feelings
 - Practice acceptance around thoughts and feelings
 - Identify core values and take committed actions towards goals that fulfill or move one towards these values

Specific Modalities

- Cognitive Remediation Therapy
 - Focus on thinking about your thinking style (big picture vs. detail oriented)
 - Increase cognitive flexibility, decrease rigid thinking.
 - Increase skills of set shifting and perspective taking
- Dialectical Behavior Therapy
 - Skill building around mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance
- Group therapy

Specific Modalities

- Interpersonal Therapy
 - Focus is on the resolution of a specified interpersonal problem area in one of four areas
 - Grief
 - Interpersonal role disputes
 - Role transitions
 - Interpersonal deficits
 - Healthy relationships and communication are related to maintenance of symptom reduction
- Psychodynamic Therapy
 - Focus is on understanding the ED's root cause
 - ED symptoms are viewed as expressions of underlying needs and issues; need to work through these issues

Specific Modalities

- Movement Therapy
 - Movement therapy focuses on reworking one's relationship with movement
 - Look at the function or the why behind the physical activity
- Exposure response prevention
 - Anxiety is commonly a core symptom of eating disorders
 - ERP can be used to address common ED fears
- Experiential Therapies
 - Drama, dance, art, music, equine, emotional support animal
- Adjunct therapies
 - ECT, TMS, Ketamine, DBS (when OCD is present)
 - These are typically used to treat eating disorder with a co-morbid condition (e.g. OCD, MDD, etc.)

Family Interventions

- Family Therapy is also useful in treating eating disorders
- Family Based Therapy (FBT; Maudsley method) is considered the best practice for eating disorders
 - Parents can help interrupt eating disorder behaviors
- Emotion Focused Therapy (EFT) and Emotion Focused Family Therapy (EFFT) can enhance FBT
 - Parents can provide emotion coaching



(Lafrance Robinson et al., 2015)

Relapse Prevention



- Eating disorders are viewed by most as chronic conditions. Work becomes about managing symptoms or in the case of EDs, managing thoughts and not acting on urges
- It takes time to be recovered and it is a common experience to relapse
- Relapse prevention is key and focuses on:
 - Identifying emotions and events that trigger ED bx
 - Create coping skills to manage stress, anxiety, and difficult emotions
 - Develop and identify a support system that is reliable

Treatment Summarized:

- Multi-disciplinary team
- Medication management
- Nutritional support
- Psychotherapy
 - CBT
 - DBT
 - ACT
 - Interpersonal therapy
 - CRT
 - ERP
 - Movement therapies
 - Family therapies

What is your biggest takeaway today?

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CU Anschutz OCD Program Presents

EXPOSURE PALOOZA

10-29-23

MOKSHA PATEL, MD

A successful hospital medicine physician at CU Anschutz. OCD ruled his life until brain surgery for OCD changed everything.

RACHEL DAVIS, MD

Vice Chair for Psychiatry Clinical Affairs at CU Anschutz. Living with OCD since childhood, she went from being terrified of her own body to becoming a living liver donor.

REV. KATIE O'DUNN

An ordained minister, interfaith chaplain, OCD advocate, and endurance athlete...specializing in the intersection between faith and mental health

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