
CORE WELLNESS
Evidence-Based Interventions for Eating Disorders: 3 CE
imt
Presented by:
Tara Deliberto, Ph.D.
Assistant Professor, Weill Cornell Medical College
Director, Eating Disorders PHP at New York-Presbyterian Hospital
Author, Treating Eating Disorders in Adolescents

CORE WELLNESS

About Core Wellness

Core Wellness is a dynamic training group offering evidence-based, practical workshops via live, webinar and home study delivery. Our passionate and knowledgeable trainers bring engaging and inspiring CE trainings that stimulate the heart and mind for client care and effective clinical skills.

Core Wellness LLC is authorized by the Board of Social Work Examiners in **MARYLAND** to sponsor social work CE programs (for LMSW, LCSW, LCSW-Cs) and maintains full responsibility for all content. The trainings qualify for Category 1 continuing education units (whether taken in person or via live interactive webinar). Our credits are also accepted by the Board of Professional Counselors of Maryland (LGPC, LCPC and MFTs) and Board of Psychologists of Maryland. Additionally, Core Wellness, LLC is recognized by the **NEW YORK** State Education Department's State Board for Social Workers #SW-0569 and the **NEW YORK** State Board for Mental Health Practitioners, #MHC-0167. For **other states**, contact your board & let us know if we can help!

Sign up for amazing deals and promotions today | **corewellceu.com**

About the Presenter

Tara Deliberto, PhD, clinical psychologist, is the first author of Treating Eating Disorders in Adolescents: Evidence-Based Interventions for Anorexia, Bulimia, and Binge Eating. She is an assistant professor at Weill Cornell Medicine, the medical college of Cornell University and opened as well as directed New York-Presbyterian Hospital's Eating Disorders Partial Hospitalization Program, where she now trains doctoral students in the treatment of eating disorders.

Through Weill Cornell Medicine, she maintains a private Integrative Modalities Therapy (IMT) practice in Manhattan, New York. Dr. Deliberto also maintains leadership positions at the Academy for Eating Disorders, and Eating Disorders: The Journal of Treatment and Prevention. Her published research has been widely cited in scientific publications and also has been discussed in the Harvard Gazette, Science Daily, and TIME. For more, visit www.IMT-ed.com

Agenda

- PART I: Eating Disorders Basics: Myths, Diagnosis, and Referral to Higher LoCs
- PART II: Overview of Evidence-Based Treatments for Eating Disorders

Stereotypes

- Imagine a person with an eating disorder. What does that person look like to you?
- The stereotype of a person with an eating disorder:
  - Young
  - Caucasian
  - Female
  - Underweight
  - Privileged
- But eating disorders do *not* discriminate!
- Eating disorders can impact people of any:
  - Age
  - Gender
  - Race
  - Weight
  - Socio-economic status

Moving Beyond Stereotypes

- On the inpatient unit, 75% of our patients are adults
- In the ED PHP, we take all willing adults & accept all insurance
  - Ages in the program have ranged from 19 to 68
    - About 1/5 patients had an ED onset after the age of 35
  - 2/3 of our enrolled patients have Medicare/Medicaid
  - More than 1/3 of our patients are male
  - 1/5 of our patients belong to a minority group
  - 15% of our patients have been overweight, an additional 20% are normal weight
  - Past patient example: male, African American, heterosexual, HIV positive, Ivy League educated, has schizophrenia & AN

What You Will Learn:

- This talk will focus on treatment of eating disorders across the lifespan with evidence-based interventions
- An overview of EBTs for AN, BN, BED, and OSFED
- Differences in treating adolescents and will be reviewed

Diagnosis Review

- **Eating Disorders = Shape / Weight Concerns; *Fear of Fatness***
  - **Anorexia Nervosa (AN):**
    - Underweight
    - Shape / weight concerns
      - » Subtypes:
        - Restricting Type (no binge and/or purge)
        - Binge/Purge Type (binge and/or purge)
  - **Bulimia Nervosa (BN):**
    - Not underweight (normal or above)
    - Shape / weight concerns
    - Recurrent purging
  - **Binge Eating Disorder (BED):**
    - Shape / weight concerns debatable
    - Recurring binge eating
  - **OSFED from DSM-5:**
    - Atypical Anorexia Nervosa (AAN)
    - Night Eating Syndrome
- **Feeding Disorders = No Shape/Weight Concerns; Sensory Issues and/or Specific Fear (e.g. choking, allergic reaction, etc.)**
  - ARFID
    - Body weight low relatively to what is personally healthy

Levels of Care

ED Treatment Intro

- ED treatment must address physical ***and*** psychological aspects of the disorder (especially w/ AN, BN, & ARFID).
- ED treatment is complex because professionals from many disciplines may be involved:
  - Physicians
  - Psychologists
  - Dieticians
  - Psychiatrists, etc.
- People w/ EDs often do not recognize or admit that they are ill
  - "anosognosia"
  - May truly believe they're overweight
  - May strongly resist treatment
  - If medically ill, may have to involuntarily commit

Levels of Care

- Inpatient, medical
  - Medical treatment of ED symptoms is the primary objective
  - Likely very little psychological treatment
  - Voluntary or involuntary
- Inpatient, psychiatric
  - ~8 hours of treatment per day, on a locked inpatient unit in a psychiatric hospital, for weeks/months
  - Voluntary *or* involuntary treatment
- Residential treatment
  - ~8 hours of treatment per day, living at a non-hospital facility, for weeks/months
- Partial Hospital Program (PHP) or Day Treatment Program
  - ~6-9 hrs per day, 5 days per week
- Intensive Outpatient Program (IOP)
  - ~2-3 hrs per day, 3-5 days per week
- Outpatient setting
  - ~1-2 hrs per week w/ individual (and perhaps group) therapist

Levels of Care

- Specific criteria for determining level of care are provided in a handout for this course
- It is beyond the scope of this presentation to discuss in that much detail
- We will review basic criteria here.

Inpatient, Medical

- For patients who require medical stabilization due to:
  - Extreme cases
  - Unstable or depressed vital signs
  - Laboratory findings presenting *acute* health risk
  - Complications due to coexisting medical problems such as diabetes
  - Watch for refeeding syndrome
    - (will discuss what this is later)

Inpatient, Psychiatric

- Hospitalization
  - Extreme cases are admitted for severe weight loss, frequent purging, and/or suicidality
  - Meal plans are used for nutritional needs
    - Intravenous feeding is used for patients who refuse to eat or the amount of weight loss has become life threatening
- Weight Gain
  - Immediate goal in treatment
  - Physician strictly sets the rate of weight gain
- Psychotherapy
  - Group, individual, family therapies
- Nutritional Therapy
  - Dietitian is often used to develop strategies for planning meals and to educate the patient and parents

Inpatient, Psychiatric

- For AN & ARFID, weight restore to 80% of ideal body weight In hospital (about a BMI of 16.7)
  - e.g. If someone would be healthy at 100lbs, they stay in inpatient until they gain to 80lbs
  - Watch for refeeding syndrome
- For BN, upwards of daily purging, usually w/ suicidality
  - Could depend on lab results

Residential Treatment

- Patient is medically stable and requires no intensive medical intervention
- Patient is psychiatrically impaired and unable to make adequate progress in partial hospital or outpatient treatment
- Patient requires long term treatment with 24 hour supervision

Partial/Day Programs

Partial/day program setting: step up and/or down from other levels of care

- Patient is medically stable
- Eating disorder impairs functioning, though without immediate risk
- Needs daily assessment of physiologic and mental status
- Unable to function in normal social, educational, or vocational settings
- Engages in daily binge eating, purging, fasting or very limited food intake, or other pathogenic weight control techniques

Outpatient and IOP

In both outpatient & IOP:

- Patient is medically stable and does not require daily medical monitoring
- Patient is able to function adequately in social, educational, or vocational settings and continue to make progress in recovery

Outpatient

Outpatient care options:

- Individual Therapy
- Family Therapy
- Group Therapy
- Medical monitoring
- Psychiatric medication management
- Dietician

IOP

Intensive Outpatient Program

- Same as typical outpatient plus:
  - Supervised meal 3-5x/week
  - Group therapy 3-5x/week

Overview of Current EBTs

Outpatient EBTs for EDs

- **Anorexia Nervosa (AN):**
  - Adolescents:
    - Family Based Therapy (FBT) by Locke & LeGrange
  - Adults:
    - CBT for Anorexia Nervosa by Kathy Pike
    - CBT-Enhanced (CBT-E) by Fairburn
    - ???
- **Bulimia Nervosa (BN):**
  - Adolescents:
    - Modified FBT by Locke & LeGrange
    - Integrative Modalities Therapy (IMT; Deliberto & Hirsch, 2019)
  - Adults:
    - CBT-E by Fairburn
- **Binge Eating Disorder (BED):**
  - Adolescents:
    - IMT
  - Adults:
    - Guided Self-Help from Overcoming Binge Eating by Fairburn
- **OSFED from DSM-5:**
  - Adolescents: FBT / IMT
  - Adults: CBT-E / ???

EBTs for AN in Adolescence

Before Introducing AN Treatment…

Eating disorders have the highest mortality rate of any psychological disorder

(Arcelus, et al., 2011)

Health Consequences of AN

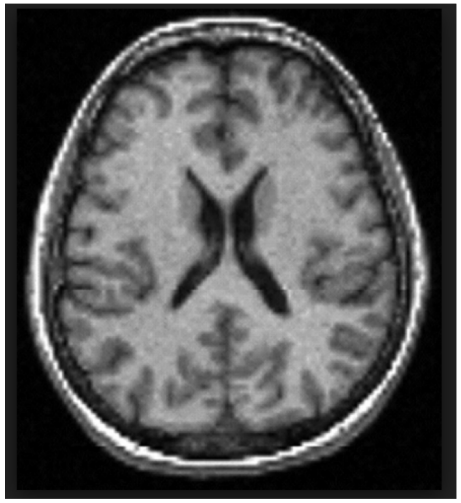
- Abnormally slow heart rate and low blood pressure
  - this mean that the heart muscle is changing
  - risk for heart failure rises as heart rate & blood pressure levels sink
- Reduction of bone density (osteoporosis)
  - Risk of injuries (esp. during exercise) increases
- Severe dehydration, which can result in kidney failure
- Fainting, fatigue, and overall weakness
- Dry hair and skin, hair loss is common
- Growth of a downy layer of hair called lanugo
- Low magnesium & potassium

Health Consequences of AN

- Refeeding syndrome:
  - Metabolic complication when malnourished pts are fed
  - Low concentration of phosphate → medical complications
  - Could be fatal
  - Other complications include:
    - Confusion
    - Coma
    - Convulsinos
    - Cardiac failure
  - Occurs more often when people have had nothing to eat for days
    - Especially after 20 consecutive days
  - Refeeding usually occurs within 10 days of eating again

Health Consequences of AN

- Cerebral atrophy ("brain shrinking") & less gray matter → :
  - more black and white thinking
  - less control over obsessions
  - higher degree of belief in negative thoughts



Brain shrinkage in anorexia nervosa

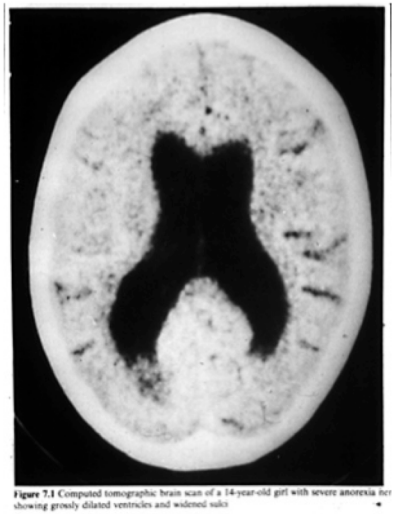


Figure 7.1 Computed tomographic brain scan of a 14-year-old girl with severe anorexia ner showing grossly dilated ventricles and widened sulci

↓ brain size especially grey matter (*Castro-Fornieles et al, 2008*)
↓ hippocampus *(Connan et al 2006)*
↓ Dorsal ACC *(Muhlau et al 2007; McCormick et al 2008)*

The Gold Standard AN Treatment

- Family Based Therapy (FBT) aka “Maudsley”
- Developed for adolescents – not adults - with AN
- Therapists inform carers of the medical dangers of AN (i.e. “setting the grave scene”)
- Carers prepare, serve, and monitor food
- Carers monitor ED behavior (e.g. purging)
- This is done until weight-restoration is achieved
- Carers slowly give food responsibility back over time

FBT Full Recovery Rate

- In FBT **41.8%** fully recovered (Lock, et al., 2010)
- Adolescent Focused Individual Therapy (AFT) vs FBT
  - Initial (*p*=ns, *t*104=1.9)
    - AFT 22.6%
    - FBT 41.8%
- 12 month follow-up
  - 12 month follow-up (*p*=.02, *t*104=2.5)
    - AFT 23.2%
    - FBT 49.3%
      - (Lock et al., 2010)

FBT Success Rates

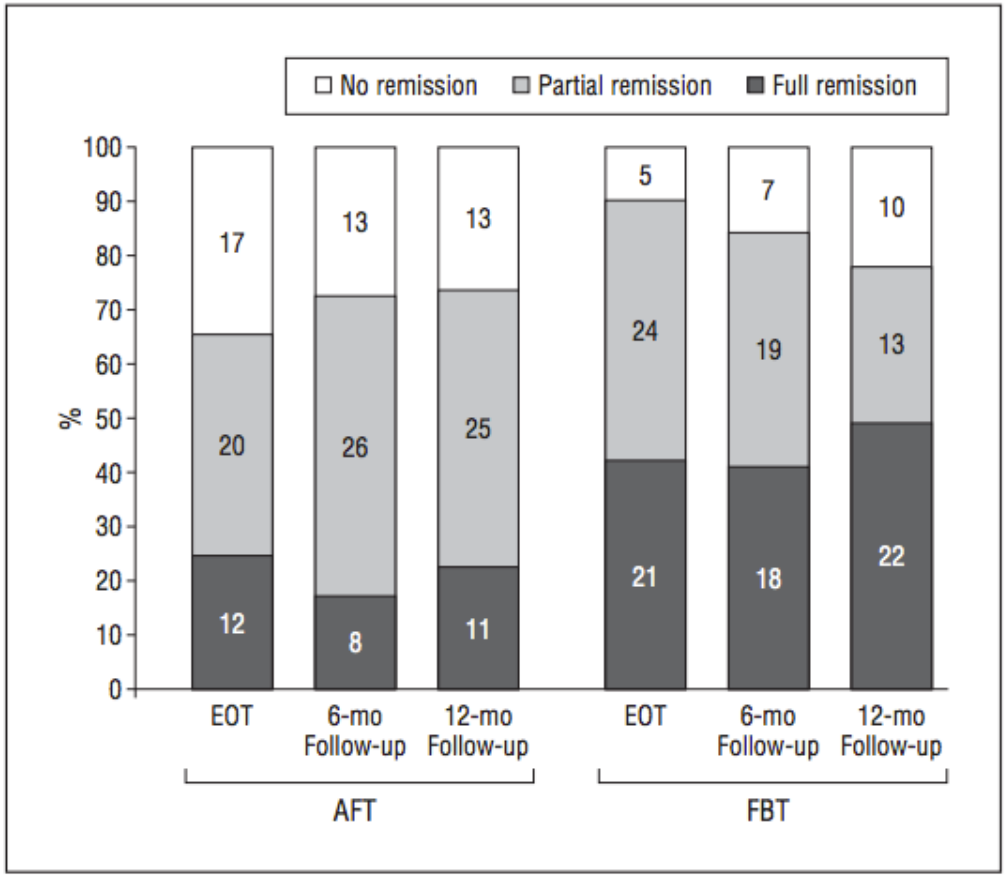


Figure 2. Observed partial and full remission rates by treatment assignment (end of treatment [EOT]: adolescent-focused individual therapy [AFT], n=49; family-based treatment [FBT], n=50; 6-month follow-up: AFT, n=47; FBT, n=44; and 12-month follow-up: AFT, n=49; FBT, n=45).

Opportunity for Improvement

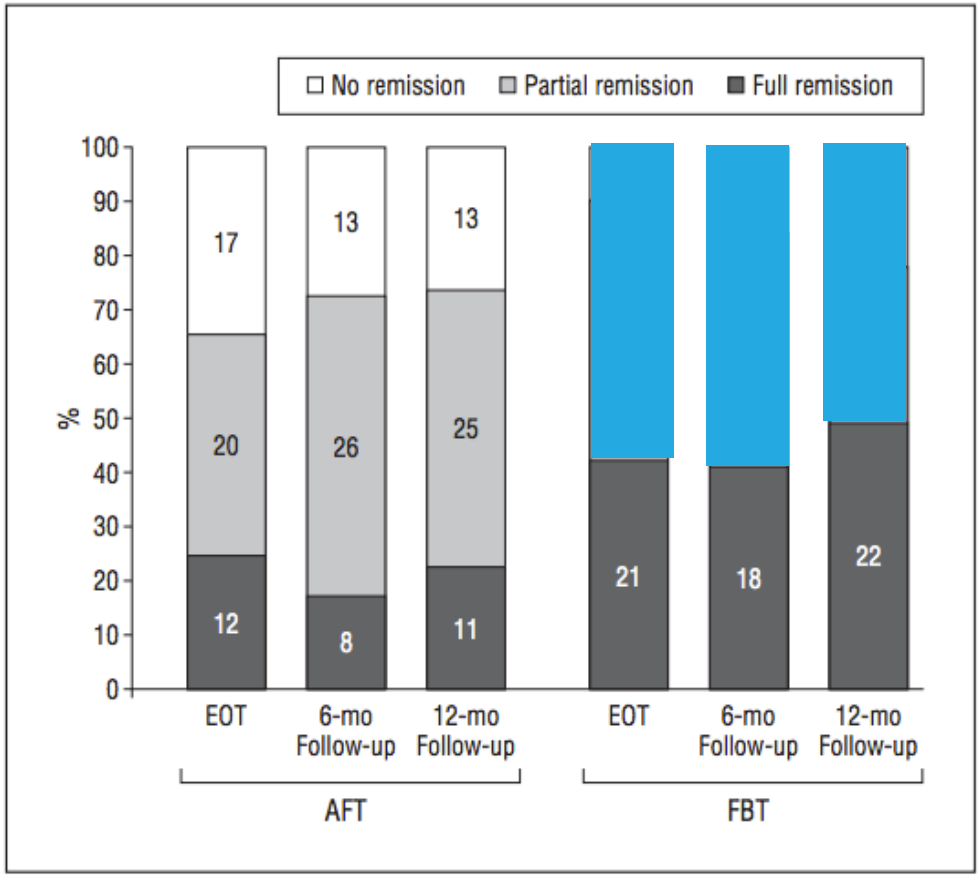


Figure 2. Observed partial and full remission rates by treatment assignment (end of treatment [EOT]: adolescent-focused individual therapy [AFT], n=49; family-based treatment [FBT], n=50; 6-month follow-up: AFT, n=47; FBT, n=44; and 12-month follow-up: AFT, n=49; FBT, n=45).

FBT Challenges

- Parents are overwhelmed, lost, and confused
  - Weeks into treatment: “wait, my child can’t help me prepare food?”
- Patients are very resistant to treatment and defiant towards parents having control
- Giving food responsibility back:
  - Too much too soon
  - Not quickly enough

FBT Limitations

- FBT is rather vague, no explicit direction is given
- Encourages parents to use past successes to guide re-feeding process
- Does not includes any skills training for the patient
- Does not address how to help patients help themselves to eat
- Does not address body image
  - We *say* body image improves over time... but it does for some, not for others. Often hear from patients:
    - "I'm just going to lose all of this weight later."
    - "I hate being normal weight now."
  - IJED Article: "Persistent body image disturbance following recovery from ED" (Eshkevari et al., 2014)

Evidence-Based Practice

- In practice, clinicians use a variety of evidence-based techniques to treat AN in adolescents
  - Mindfulness
  - CBT Skills
  - Body image interventions
- Dina Hirsch PhD and I collected evidence-based interventions and grouped them into the three treatment modalities of individual, group, and family therapy
- The material became a comprehensive collection now called Integrative Modalities Therapy (IMT)
- The clinician's manual and patient/family workbook will be published on 8/1 with New Harbinger

How IMT Differs from FBT

1. Has **tweaks** to FBT itself
2. Includes **skills training for patients**
3. Includes **eating-focused therapy**
4. Includes **body image therapy**

IMT Family Modality

Differences between FBT and IMT Family Modality:

- Specific directives given to parents
- Handouts given to parents with information
- Define ED & Recovery Behaviors (specific to stage of treatment)
- Shape ED & Recovery Behaviors
- Decrease ED Behaviors with rules
- Increase Recovery Behaviors with:
    - Gratitude / sometimes praise
    - Recovery Specific Positive Attention

THE *DO* SKILLS: TABLE

T **Together Eating:**
Eat when & what your child eats. Make meals and snacks as fun as they can be. Distraction is helpful.
"We'll all eat together. Let's talk about what we did today."

A **Appreciate the Struggle:**
Validate effort & show you know it's hard
"I know that cheese is a challenging fear food and that you are trying hard to fight your eating disorder."

B **Break it Down & Be Positive!**
Break eating down into steps & provide encouragement.
"It's great that you are halfway done. Let's each take a bite out of that bagel! I know you can do it."

L **Limit Setting:**
Be firm. Do not negotiate or give up.
"You need to complete the meal I served you."

E **Externalize the Eating Disorder:**
Separate your child from the eating disorder.
"I trust you but I don't trust the eating disorder. I need to see you complete your meal."

THE *DON'T* HABITS: ED WINS

E **Escalate**
"I absolutely don't care if you're scared to eat this! Just eat!"
Losing your cool won't make the situation any better. It will probably make it even harder for your child to finish their meal.

D **Disagree with Other Parent / Be on Different Pages**
"I know mom said you need to have mayo on your sandwich, but you don't have to eat it if you don't want it."
The eating disorder is strengthened when parents disagree.

W **Waiver**
"I'm not sure if you have to finish *all* of that. I guess it is ok not to eat that… well, nevermind, you should probably eat it."
Waivering gives the eating disorder an opportunity to win.

I **Impatience & Frustration**
"Just eat it already! I don't have time for this."
Impatience may cause your child to shut down & refuse to eat.

N **Nag**
"Come *on*. You would eat if you *loved* me. Do it for me!"
Nagging can make your child frustrated because it makes the process of eating about *your needs*, not theirs.

S **Sarcasm**
"It only took you an hour to eat 2 bites of a bagel."
Sarcasm belittles your child's efforts & is invalidating.

COPING WITH THE URGE TO RESTRICT

E ncourage yourself

A ct as if you will succeed

T hought distraction

M ake effective decisions

E xternalize ED

A ccept lack of control over food

L et go of judgments

S elf-soothing

Examining Evidence For & Against Homework

1. What is the thought/cognitive distortion?

_____

What is the evidence FOR this statement?

What is the evidence AGAINST this statement?

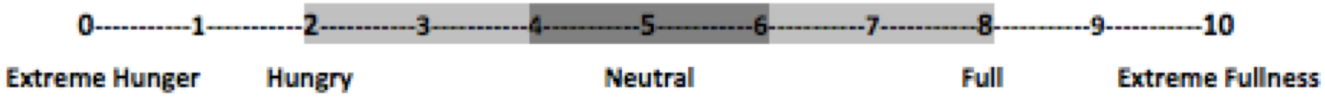
2. What is the opposite of the thought/cognitive distortion?

_____

What is the evidence FOR this statement?

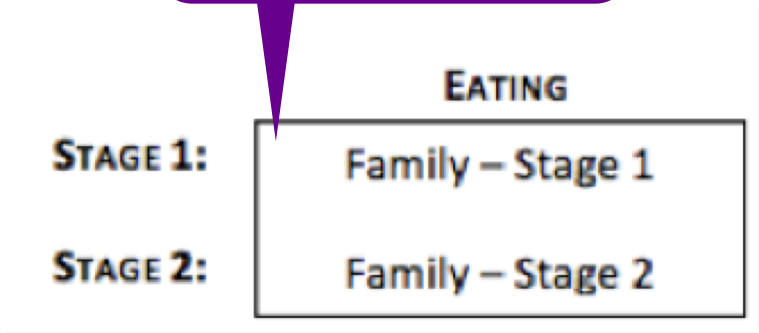
What is the evidence AGAINST this statement?

BITE Hunger & Fullness Scale



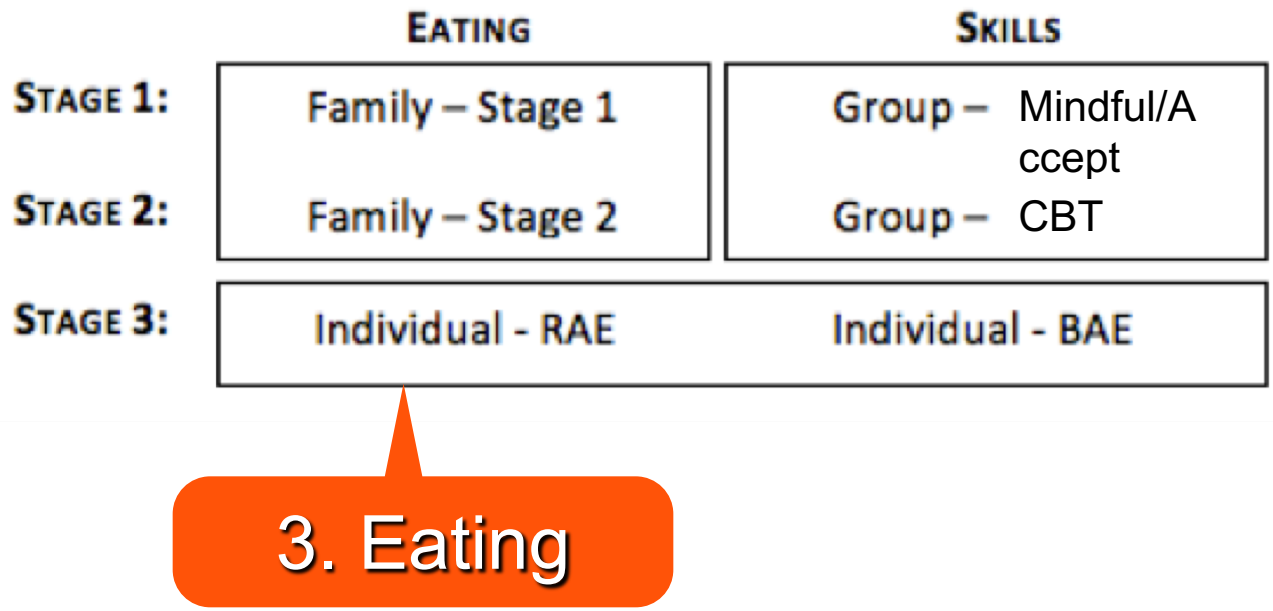
	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Breakfast														
Lunch														
Snack#1														
Dinner														
Snack#2														

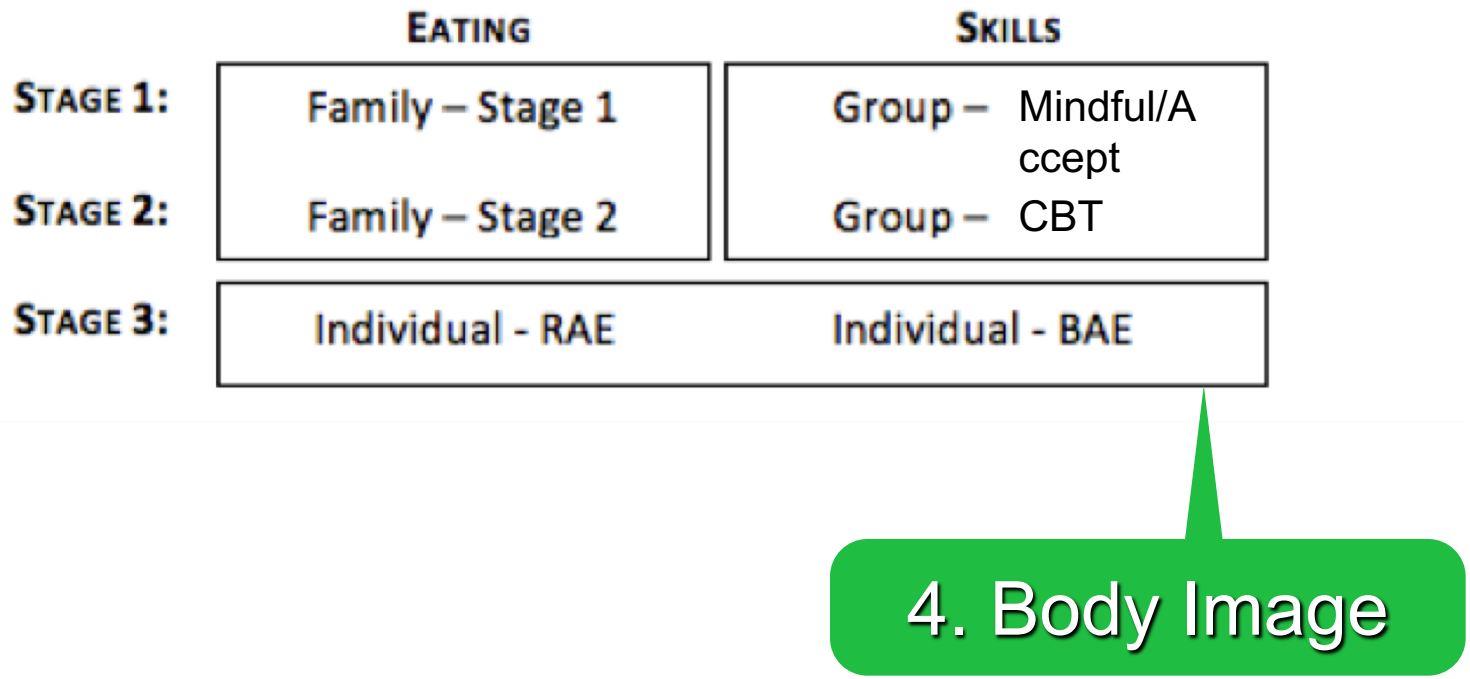
1. FBT



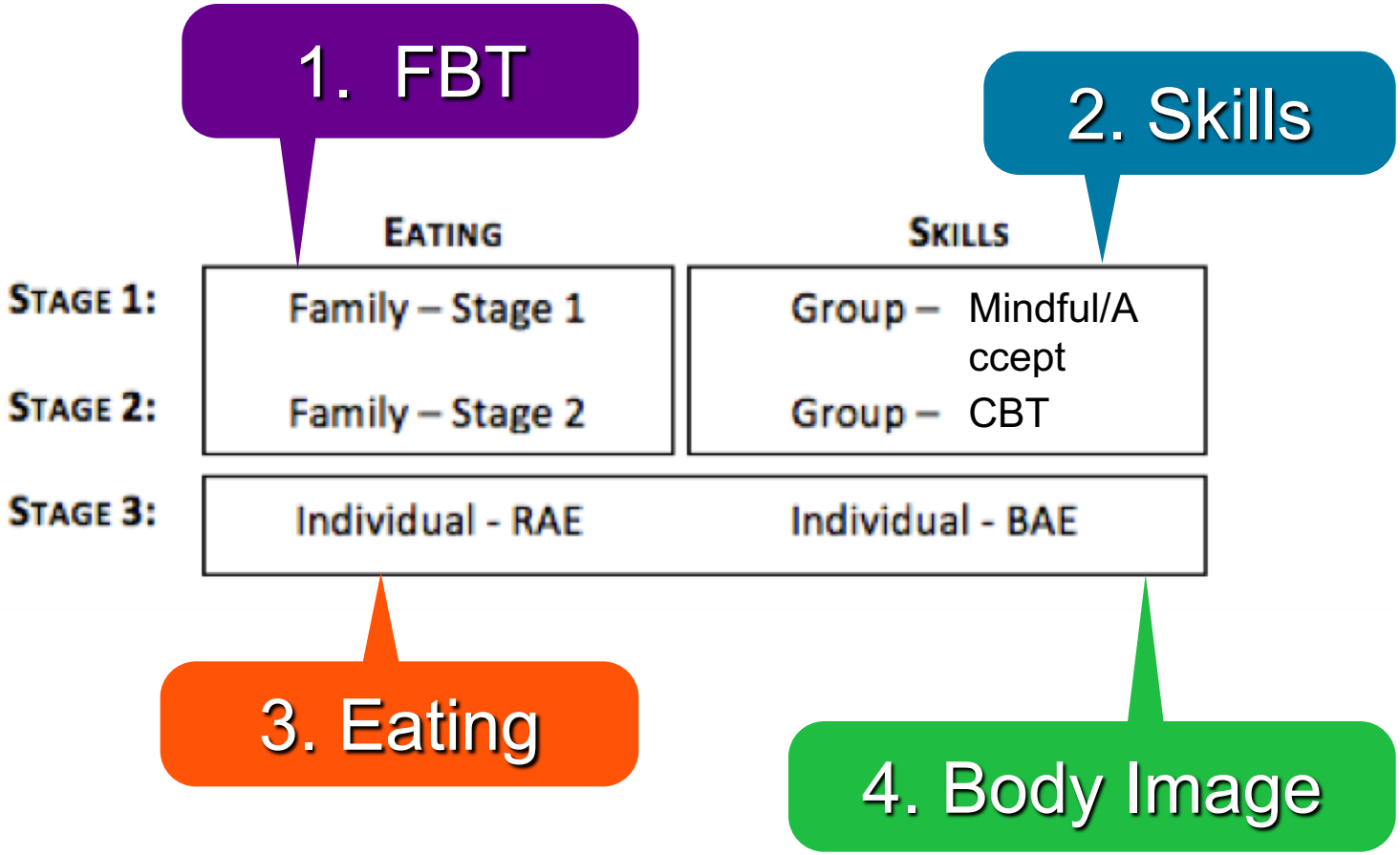
2. Skills

	Eating	Skills
Stage 1:	Family – Stage 1	Group – Mindful/Accept
Stage 2:	Family – Stage 2	Group – CBT


EATING
SKILLS
STAGE 1:
Family – Stage 1
Group – Mindful/Accept
STAGE 2:
Family – Stage 2
Group – CBT
STAGE 3:
Individual - RAE
Individual - BAE
3. Eating


EATING
SKILLS
STAGE 1:
Family – Stage 1
Group – Mindful/Accept
STAGE 2:
Family – Stage 2
Group – CBT
STAGE 3:
Individual - RAE
Individual - BAE
4. Body Image

IMT for Adolescents with AN



Summary of EBTs for AN in Adols

- FBT is a good EBT for adolescents with AN
- There is room for improvement
- Perhaps evidence-based practice approaches such as Integrative Modalities Therapy (IMT) could be helpful by:
  - Helping parents master refeeding
  - Adding in mindfulness, acceptance, and CBT skills for patients
  - Teaching patients regular and appetitive eating skills
  - Teaching positive body image skills

EBTs for AN in Adults

EBTs for Adults with AN

- CBT-E by Fairburn (will discuss more later)
  - CBT-E is technically transdiagnostic across EDs
  - Focuses on establishing regular eating (i.e. breakfast, lunch, dinner, snacks)
  - Cognitive distortions
  - Self-esteem, perfectionism, mood intolerance, interpersonal problems

EBTs for Adults with AN

- Pike's unpublished manual, CBT for anorexia nervosa, specifically for the treatment of adults
  - Focuses on:
    - increasing motivation
    - Cognitive restructuring
    - Behavioral change

EBTs for Adults with AN

- In practice, neither of these outpatient approaches typically result in weight gain, and therefore, recovery
- If a patient is particularly motivated, it can work
- These approaches do not include family or professional meal support
- They also do not focus on gaining weight, which is rather difficult to do

EBTs for Adults with AN

- Other research has examined both:
  - treatment at higher levels of care, where there is staff support at meals
  - as well as including family support
- Laura Hill PhD's 40-hour PHP week with family support
  - (Hill, Knatz, Wierenga, & Kaye, 2016)
  - Taught family how to support meals
- When creating NYP's ED PHP, created programming for family without patients to educate on meal support

In Practice

- Adolescents:
  - With adolescents, there is the ability to be much more strict
  - Parents can enforce rules and treatment attendance (or simply attend themselves and enforce rules at home)
  - There are rewards/consequences that can be reinforced with adolescents in practice (e.g. dance lessons are restricted)
- Adults:
  - Adults often require meal support
  - With adults, treatment can typically go much slower
  - Verbal reinforcement can be used, but implementing rewards/consequences is often impractical in outpatient, IOP, and PHP settings
  - Rewards/consequences can work in inpatient settings

Thoughts on AN Trx for Adults

- Rules of thumb:
  - If BMI is below 17.0, inpatient is absolutely required
  - If BMI is 17.0+, residential or PHP is recommended
- Recommendations:
  - Weight-restore at higher levels of care
  - Following weight restoration, use Pike's manual in outpatient
  - Read the APA's treatment guidelines
  - It can be dangerous to treat AN in outpatient settings
  - It is not just weight that must be considered, but lab work and EKG as well

EBTs for BN in Adolescents

EBTs for Adolescents with BN

- FBT has been reformulated for BN in adolescents
- Patients generally do not have the same degree of cognitive impairment / rigidity seen in AN
- Patient has more autonomy
- Patient can generally be more actively involved in meal selection and preparation
- Patients with BN do not need to be weight-restored

FBT for BN Limitations

- The limitations for FBT in BN are similar to AN
- As such, evidence-based *practice* approaches are often used clinically
- IMT can be used for the treatment of BN in adolescence

EBTs for BN in Adults

CBT-E for BN in Adults

- CBT-E has been shown to be a great treatment for BN in adults
- The establishment of regular eating is the focus
- Eating regularly:
  - Exposes patient to fears of eating appropriate amount of food
  - Exposes patient to fears of eating specific types of food
  - Decreases hunger
  - Decreases the chance for a future binge, and therefore, purge
- Cognitive distortions are also addressed
- This is a highly recommended approach!

EBTs for BED

EBTs for BED in Adols vs Adults

- There really is no specific gold-standard EBT for BED in adolescents
  - IMT, however, can be used
- CBT-E can be used to treat BED in adults, considering it is transdiagnostic
- The book by Fairburn, Overcoming Binge Eating, is a helpful intervention for adults
- The gold-standard EBT for BED in adults is guided self-help
  - This involves the therapist assigning reading in the book (e.g. a chapter per week), discussing the reading in session, and if the patient has a question, the therapist directs the patient to find the answer in the book

EBTs for OSFED

A Note on OSFED

- More than half of eating disorders are diagnosed as OSFED
  - (Keel, Brown, Holm-Denoma & Bodell, 2011)
- OSFED is *just* as dangerous as AN or BN, if not more
- Crow et al 2009 estimated crude mortality rates as:
  - 4% for AN
  - 3.9% for BN
  - 5.2% for EDNOS (now OSFED)
- This may be partly because symptoms that do not fit neatly into a defined disorder are not taken as seriously
- This is likely because atypical anorexia nervosa currently falls under this category

A Note on OSFED: AAN

- Atypical anorexia nervosa (AAN):
  - Severe restriction
  - Severe weight loss (e.g. 40lbs) in a short period of time (e.g. 5 months)
  - BMI does not fall in the underweight range (e.g. 18.5)
- In AAN, patients often:
  - Are very medically ill, as per lab work and EKG
  - Have medical illnesses that can be overlooked by doctors
  - Patient and doctors may assume that weight loss is “healthy”

EBTs for OSFED in Adols vs Adults

- There really is no gold-standard EBT for OSFED in adolescents
  - IMT, however, can be used
  - If the patient has AAN, FBT is highly recommended
- CBT-E can be used to treat OSFED in adults, considering it is transdiagnostic

AN Summary

- Adolescents with AN have a good EBT, FBT
  - There is, however, room for improvement
  - Perhaps evidence-based practice approaches such as Integrative Modalities Therapy (IMT) could be helpful
- Adults with AN:
  - Are best treated at higher levels of care
  - Need meal support
  - Could potentially benefit from CBT-E / CBT for
  - Could benefit from CBT-E/CBT after weight-restoration
- Weight restoration must come first
  - Plus, behavior change happens prior to cognitive change
  - Especially considering there are no effective medications

BN Summary

- Adolescents with BN:
  - Could benefit from FBT for BN
  - Perhaps evidence-based practice approaches such as Integrative Modalities Therapy (IMT) could be helpful
- Adults with BN:
  - Can greatly benefit from CBT-E

BED Summary

- Adolescents with BED:
  - Currently do not have specific EBTs
  - Perhaps evidence-based practice approaches such as Integrative Modalities Therapy (IMT) could be helpful
- Adults with BED:
  - Can greatly benefit from guided self-help

OSFED Summary

- OSFED is dangerous
- Many OSFED cases are Atypical AN (AAN)
- Adolescents with OSFED:
  - Currently do not have specific EBTs
  - FBT is helpful for AAN
  - Perhaps evidence-based practice approaches such as Integrative Modalities Therapy (IMT) could be helpful
- Adults with OSFED:
  - CBT-E can be used
  - Currently do not have specific EBTs

Evidence-Based Interventions

Using Interventions

- This section will guide you through key evidence-based interventions for eating disorders across the lifespan.
- Core treatment concepts will be introduced concepts
- Practical worksheets will be provided for you to use in session.

Food Logs

- Food Logs are an essential component to eating disorder treatment
- They provide insight into what exactly the patient is eating and remove generalities about eating “better” or “worse”
- They provide the patient with an exposure opportunity
  - Feeling of shame for eating or disclosing ED behaviors
  - Reflecting on food eaten, feeling anxiety
  - Social anxiety of sharing information on food eaten
- In short, they are essential

Food Logs and Regular Eating

- Food Logs help to establish regular eating (RE)
- RE is eating regularly throughout the day: breakfast, lunch, dinner, and snacks
- Establishing a pattern of regular eating cuts off other ED behaviors at the pass (e.g. binge eating, purging)
- Set goals of eating during each meal and snack time
- Determine at what times each meal / snack is eaten
- Provide reinforcement for meals / snacks being eaten at appropriate times
- Over time, the appropriate quantities of food is addressed followed by varieties of food

Food Logs and Regular Eating

- First you want to get the patient eating!
- The very next and most important goal is that they are eating ENOUGH in treatment.
- Not eating enough is very physically detrimental to health and it also contributes to later binge eating
- Once the quantity of food is appropriate, then challenging foods can be introduced
- Let's look at a food log in the Core Wellness / IMT Handout Packet!
  - [Note: Labeled **RAE Handout 6** at the top]

Appetitive Eating

- Approaches that generally recommend eating when hungry and stopping when full:
  - Intuitive Eating TM (Tribole, et al.)
  - Appetitive Eating (Craighead)
  - Regular and Appetitive Eating (RAE; Deliberto, et al.)

- Considering we're discussing EDs, we'll go with the RAE approach

Regular and Appetitive Eating (RAE)

- The regular portion to RAE makes sure that food is being eaten regularly throughout the day
- Setting this goal helps keep people with eating disorders ("ppl w EDs") behaviorally on track
- Within eating regularly, ppl w EDs can also start to notice hunger and fullness cues
- Eventually they can eat regularly and according to these cues
- Let's look at **RAE Handouts 13 and 15** in the packet

Body Acceptance

- Having a poor body image is, of course, an integral part of having an eating disorder… but how is it addressed?
- Body positivity is a hard sell with the ED crowd
- We focus on acceptance instead
- Acceptance is fostered through exposure
- Let's look at **BAE Handout 3** in the packet

Body Exposure

- There are several types of body image related exposures:
  - In vivo exposure:
    - E.g. mirror (Hildebrandt)
    - Not tying a sweater around one's waist
  - Imaginal
    - Imagining gaining weight
    - Imagining gaining weight and being rejected
    - Imagining that there is *nothing* you can do to lose weight
- Let's look at **BAE Handout 18** in the packet

Body Defusion

- You are not your body
- You are in your body
- Your body is like a car for your self
- In treatment, respect for the body should be fostered
- Let's take a look at **BAE Handout 21** in the packet

Family Involvement

The IMT Family Treatment Basic Concepts:

- Self-eclipsing eating disorders (SEEDs)
- RIBs and RABs
  - Reinforcement Allowing Behaviors (RABs)
  - Reinforcement Interfering Behaviors (RIBs)
- Rule setting / following
- Treatment planning
- ED and Recovery Behaviors in the context of family treatment

Family Involvement

What are Self-eclipsing eating disorders (SEEDs)?

- Let's review **IMT FAM Handout 1.6** in the packet

What are RIBs and RABs?

- Let's review **IMT FAM Handout 1.7** in the packet

What are the treatment rules and how are they followed?

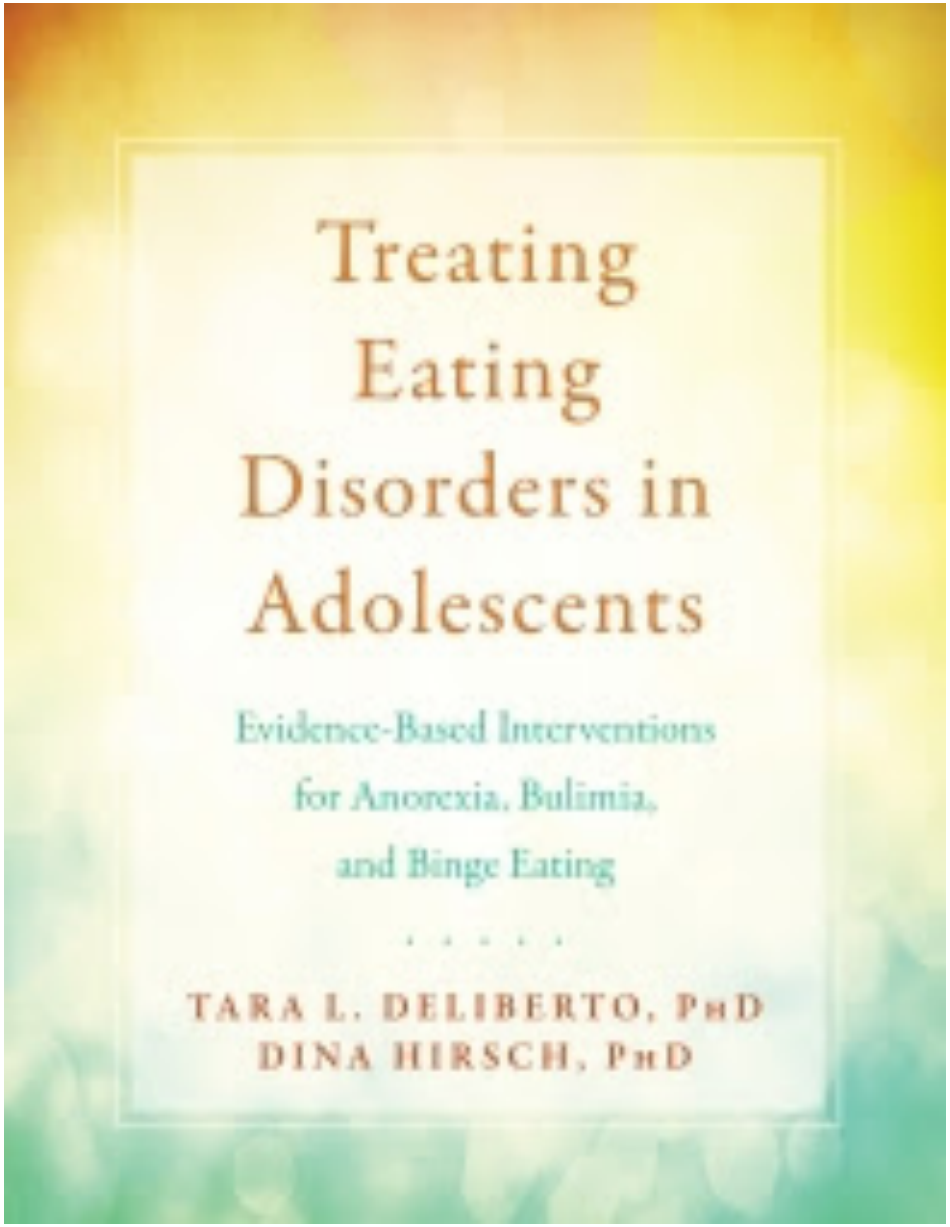
- Let's review **IMT FAM Handouts 1.8 & 1.11a** in the packet

What are ED and Recovery Behaviors in the context of treatment?

- Let's review **IMT FAM Handout 1.11b** in the packet

- Website: www.IMT-ed.com
- IMT's Online Community for Eating Disorder Professionals: [Group Site]

Learn More



Contact Info:

Tara Deliberto, Ph.D.

Email: tad9048@med.cornell.edu

Website: www.IMT-ed.com

Handout Packet

Core Wellness Workshop: Evidence-Based Interventions for Eating Disorders
Presenter: Tara Deliberto, PhD

Handout Source:
Treating Eating Disorders in Adolescents: Evidence-Based Interventions for Anorexia, Bulimia, and Binge Eating
By Tara Deliberto, PhD and Dina Hirsch, PhD
Published 2019 by New Harbinger
www.NewHarbinger.com/42235

CORE WELLNESS

+

imt

The Importance of Medical Clearance for All Eating Disorders

When working with people who do *not* have eating disorders, making a judgment call regarding which level of care is required can be made with a thorough verbal and/or self-report assessment by a licensed therapist. This is not the case with eating disorders! Because eating disorder behaviors impact the physical health of a patient, you cannot determine the level of care – whether it be medical hospitalization, psychiatric inpatient, residential, partial hospitalization program (PHP), day treatment, intensive outpatient program (IOP), or outpatient – simply by talking to or looking at a patient with an eating disorder. Self-report measures don't cut it either. We therapists need to collaborate with colleagues in other disciplines, specifically *medicine*. As a therapist, think of yourself as a project manager: your job is to help keep a patient and their carers *accountable* for health, but it is not your job to *determine* how often a patient needs medical examination, nor to interpret the results of one. A medical doctor needs to collect information such as lab work, an EKG, and a physical exam before a determination regarding level of care is made. Often a brief chat asking the doc to interpret the results is required before treatment at any level of care can commence.

Although it is not a therapist's responsibility to determine if a person is medically at risk or not, therapist input about appropriate levels of *psychiatric* care (e.g. partial hospitalization program) is needed. As such, you must communicate with the doctor to determine whether or not a given patient is appropriate for your practice. If a given patient's medical doctor is not familiar with the treatment of eating disorders, quickly send them practice guidelines for your country (e.g. the American Psychiatric Association's [APA] Practice Guidelines; Yager, Devlin, Halmi, Herzog, Mitchell, Power, et al., 2006). It may also be helpful to provide the patient's medical doctor with a copy of the AED's Medical Care Standards Guide (available at www.AEDweb.org). With an ability to communicate about the specifics of the practice guidelines as they relate to the results of the patient's tests, appropriate decisions can be made.

Prior to scheduling an evaluation to be considered for our program, we require that a potential patient send us the results of the following:

- A medical examination
- An EKG
- The following laboratory tests conducted:
    - CBC
    - CMP
    - Amylase
    - Magnesium
    - B12
    - TSH
    - HCG
    - Cholesterol (not fasting)

Although you may not be trained to read the results of these tests, you should facilitate a discussion with the medical doctor in which they are reviewed in relation to the level of care guidelines. For instance, although you may not know what all of the medical implications are if potassium, phosphorous, and magnesium are low, you do know that these are criteria for medical hospitalization from reading the guidelines. This should be discussed with the medical doctor and a treatment recommendation made with their input.

Tip: Facilitate Investigation of Potential Medical Symptoms Rather than Avoiding
There is an easy way to know if a patient is at medical risk or not: send them to a medical doctor! It is a tragedy for patients with eating disorders that fearful therapists turn them away due to blanket concerns about medical illness. Rather than turning away from treating people who *may* be medically ill, encourage *investigation* of potential medical illness. If a patient needs specialized medical care, it is within the discipline of medical doctors to call the shots. We need to develop a certain level of trust of our colleagues.

Referring to an Appropriate Level of Care

In the United States, we use the APA's Practice Guidelines (Yager, et al., 2006), parts of which are included below to inform level of care. Although excerpts of these guidelines are quoted below, it is highly recommended that the entire guidelines are downloaded from www.psych.org and reviewed. Please note that the numbers listed below are for children/adolescents and numbers are *different* for adults.

Inpatient Hospitalization Level of Care

Child or adolescent patients who meet *any* of the criteria that will be listed below should be referred to an *inpatient* of care. Please note that adult patients have a different set of medical criteria than children and adolescents. Relatively, adults have a greater number of medical issues that are cause for inpatient hospitalization (e.g. glucose <60 mg/dl, poorly controlled diabetes, temperature <97.0 degrees Fahrenheit, dehydration, organ compromise, etc.) than children and adolescents.

Below are some of the criteria listed in the APA Practice Guidelines for the inpatient hospitalization of children and adolescents, regarding eating disorders:

- Medically:
    - Heart rate near 40 bpm
    - Blood pressure <80/50 mmHg
    - Electrolyte imbalances, specifically:
        - Low potassium (i.e. Hypokalemia)
        - Low phosphorous (i.e. hypophosphatemia)
        - Low magnesium (i.e. hypomagnesemia)
    - Orthostatic blood pressure changes
        - (>20 bpm increase in heart rate or >10 mmHg to 22 mmHg drop)
- Weight Percentage:

- Generally <85% of healthy body weight
    - Notes:
        - This translates to a BMi of around 16.7
        - This only applies diagnoses specifically of either AN and ARFID
- Acute weight decline with food refusal, even if not <85% of healthy body weight
    - e.g. as in AAN
- If the person has BN, BED, AAN, or OSFED body weight criteria do not apply

- Behaviorally:
    - "Unable to control multiple daily episodes of purging that are severe, persistent, and disabling"
        - "despite appropriate trials of outpatient care, even if routine laboratory test results reveal no obvious metabolic abnormalities"
    - "Needs supervision during and after all meals" as well as snacks
    - Needs supervision in the bathroom
        - Please note that if one does not have personal experience working with people who have extremely severe eating disorders this may seem an invasion of privacy; however, having working in inpatient settings it is perhaps the number one behavioral intervention that can reduce the dangerous behavior of purging. In the context of reduced purging behaviors, this ultimately helps to restore a person's autonomy.
    - "Needs supervision during and after all meals"
    - Requires nasogastric feeding (e.g. feeding through a tube)
- "Motivation to recover"
    - "Very poor motivation"
    - "Patient uncooperative with treatment"
    - Patient is compliant with treatment only in a "highly structured environment"

Tip: Hospitalization on a Psychiatric vs Medical Unit Depends on the Local Resources
Whether a patient requiring hospitalization goes to a *psychiatric* or *medical* inpatient unit can largely depend on the resources available in your area. Each individual unit is able to accommodate different medical needs. For instance, a particularly *psychiatric* inpatient unit specializing in eating disorders may not be able to address low potassium (i.e. hypophosphatemia) through an intravenous potassium infusion. As such, a patient with hypophosphatemia may require treatment on an inpatient unit at a *medical* hospital prior to being discharged to a relatively lower level of care such as an inpatient *psychiatric* unit or residential treatment setting. The hospitals should know if they can accommodate the patient or not based on the patient's medical records. This determination is made by having the results of a patient's medical examination (e.g. lab work, EKG, doctor's report, etc.) sent to a given *psychiatric* setting for review. Someone there should be able to provide information about whether or not that psychiatric setting has the resources and capacity to treat the patient. If not, the patient may require *medical* care.

Residential Level of Care

For patients that do not have medical and psychiatric symptoms severe enough for inpatient hospitalization but who still have eating disorders on the severe end of the spectrum, residential treatment may be required. Unlike inpatient hospitalization which occurs in the context of a medical or psychiatric *hospital*, residential treatment is often conducted by professionals in a *house* where patients stay for a period of time (e.g. 6-8 weeks). Residential treatment for eating disorders is conceptually similar to "going to rehab" for a drug or alcohol addiction.

Below are some of the criteria listed in the APA Practice Guidelines for referring children and adolescents with eating disorders to a residential level of care:

- Medically
    - Deemed medically stable for residential and does not require an inpatient setting
    - According to the APA Guidelines: "Intravenous fluid, nasogastric tube feedings, or multiple laboratory daily tests are not needed."
- Weight Percentage
    - Generally <85% of healthy weight
        - Note: this only applies diagnoses specifically of either AN and ARFID
        - If the person has BN, BED, AAN, or OSFED body weight criteria do not apply
- Behaviorally:
    - Can implement the skill of asking for help from others in the environment
    - Can implement skills to inhibit purging behaviors
    - Patient requires supervision at meal and snack times
- "Motivation to Recover"
    - "poor-to-fair" motivation
    - In the context of treatment in a structured environment, patient is compliant

Partial Hospitalization Program (PHP) or Day Treatment Level of Care

If inpatient or residential treatment is not necessary, a patient may require treatment at a "partial hospitalization program" (i.e. PHP) or "day treatment" level of care. Although some programs are run through hospitals while others are run through private treatment centers, they share the commonalities of: multiple hours per day of treatment with a multidisciplinary team. At this level of care, patients go in for treatment during the day and sleep elsewhere (e.g. at home) at night. Each program will have different hours. For example, the specific PHP program at NewYork-Presbyterian Hospital that Dr. Deliberto established in 2016 for adults currently runs from 8:15am until 3:00pm, Monday through Friday. PHPs and day treatment programs for eating disorders have multidisciplinary teams with members from the disciplines of social work, psychiatry, as well as nutrition, and oftentimes psychology, pastoral care, art therapy, rehabilitation counseling, etc. Within the context of working together in concert to stabilize acute eating disorder behaviors at this level of care, professionals from each discipline contributes a tremendous amount to holistically treating the patient during each treatment day.

Below are some of the criteria listed in the APA Practice Guidelines for referring children and adolescents with eating disorders to a PHP or day treatment level of care:

- Medically
    - "Patient must be medically stable to the extent that more extensive medical monitoring as defined for [inpatient and residential treatment] is not required"
- Weight Percentage
    - Generally >80% of healthy body weight
        - Note: this only applies diagnoses specifically of either AN and ARFID
        - If the person has BN, BED, AAN, or OSFED body weight criteria do not apply
- Behaviorally:
    - Needs some structure
- "Motivation to recover"
    - "Partial motivation"
    - Cooperative

Intensive Outpatient Program (IOP) Level of Care

An intensive outpatient program (IOP) can be run through a hospital or private treatment setting. At an IOP level of care, patients attend program for relatively fewer hours per week than at the PHP or day treatment level of care. Some programs may offer IOP for a small number of hours a day (e.g. 2-3 hours) several days per week (e.g. 3-5) or a relatively greater number of hours per day (e.g. 5-6 hours) on fewer days per week (e.g. 2-3 days).

Below are some of the criteria listed in the APA Practice Guidelines for referring children and adolescents with eating disorders to a PHP or day treatment level of care:

- Medically
    - "Patient must be medically stable to the extent that more extensive medical monitoring as defined for [inpatient and residential treatment] is not required"
- Weight Percentage
    - Generally >80% of healthy body weight
        - Note: this only applies diagnoses specifically of either AN and ARFID
        - If the person has BN, BED, AAN, or OSFED body weight criteria do not apply
- Behaviorally:
    - "Can greatly reduce incidents of purging in an unstructured setting"
    - "Some degree of structure is needed beyond self-control to prevent patient from compulsive exercising"
- "Motivation to recover"
    - "Fair motivation"

Outpatient Level of Care

If you are going to be treating a patient at an outpatient level of care, it is important that they do not meet the medical and behavioral criteria for treatment at a higher level of care previously outlined. Because only partial information was included from the APA Practice Guidelines here, it is important to obtain a copy yourself for reference.

Below are criteria listed in the APA Practice Guidelines for treating children and adolescents with eating disorders at an outpatient level of care:

- Medically
    - "Patient must be medically stable to the extent that more extensive medical monitoring as defined for [inpatient and residential treatment] is not required"
- Weight Percentage
    - Generally >85% of healthy body weight
        - Note: this only applies diagnoses specifically of either AN and ARFID
        - If the person has BN, BED, AAN, or OSFED body weight criteria do not apply
- Behaviorally:
    - "Can greatly reduce incidents of purging in an unstructured setting"
    - "Can manage compulsive exercising through self-control"

        - This criterion likely references outpatient *individual* therapy for youth
        - In our clinical experience, outpatient treatment is also acceptable for medically stable children and adolescents who have behaviors that can be managed by willing and able carers at home
- "Motivation to recover"
    - "Fair-to-good" motivation
        - In our clinical experience, child and adolescent patients with poor motivation can still sometimes be treated in an outpatient setting with family interventions if carers are highly motivated, willing, and able to participate in treatment

<image CM1_Tip_Mar15> **Tip: Do Not See Potentially Ill Patients Who Refuse Medical Investigation**
If, for whatever reason, your patient refuses to be medically evaluated or their carers do not bring them to appointments, the implications must be directly discussed in session. If you do not have information about medical risk and the ability to discuss this with a medical doctor, it is likely wise not to continue with treatment. As such, treatment may need to be terminated or put on hold until the appropriate information is obtained. The exception to this is when treating BED in which there is currently no evidence for the presence of intolerance behaviors (e.g. the patient is motivated, forthcoming, etc.). As will be discussed below, however, intolerance behaviors covertly occurring can be identified upon medical examination in cases that present as BED, but are more accurately either BN or OSFED. <end tip>

Ongoing Medical Management in Treatment

Once the appropriate level of care is ascertained, the frequency of ongoing medical assessment will need to be determined by the medical doctor's a given patient's treatment team. If the patient is cleared for outpatient treatment, the patient's pediatrician is part of the treatment team with you. The same goes for any psychiatrists or dietitians the patient with whom the patient may be working. As such, each individual patient may have a unique treatment team. Regarding the frequency of medical assessment, the medical doctor on the patient's treatment team will determine this.

Although deferring to the medical doctor for frequency of visits is always recommended, it is often necessary to introduce the idea of ongoing medical management throughout the course of eating disorder therapy to the patient/family. If the medical doctor is not familiar with the treatment of eating disorders, this concept may need to be introduced to them before they determine the frequency of the visits. Again, we must develop a level of trust in medical doctors and their ability to contribute to the team.

Because it is the medical doctor's job to make recommendations regarding the frequency of medical visits needed for each individual patient, only *examples* of the types of medical management that may recommended for various disorders are provided here:

- *BED*: On intake, a medical examination with lab work is often necessary to rule out purging (e.g. based on amylase levels). Ongoing medical management of BED can be required relatively infrequently in comparison to other eating disorders, unless physical symptoms (e.g. acid reflux, diabetes, etc.) are present.
- *BN and OSFEDx*: The frequency of medical examinations and lab work varies depending on symptom severity. A general rule of thumb – as an example – is every several weeks. Patients with BN or OSFEDx may also be required to see specialists (e.g. gastroenterologists).
- *AN and AAN*: In the treatment of AN and many cases of AAN, patients often are required to have medical examinations and lab work taken at a higher frequency of about once per week or biweekly. Patients with AN or AAN may also be required to see specialists (e.g. cardiologists, endocrinologists, etc.).

Dangerous Behaviors to Note

In addition to common eating disorder behaviors (e.g. purging, compulsive exercise while dehydrated, etc.) being quite dangerous, there are some behaviors that may be particularly perilous worth mentioning here.

Although this is by no means a comprehensive list, note the following may be particularly perilous:

- If a patient is purging right after taking psychiatric medications, the medication might be coming up and not getting absorbed in consistent doses.
- Patients can be drinking alcohol and/or using drugs in addition to purging, which can result in electrolyte imbalances.
- Patients at *any* weight can be restricting water and fluid intakes, which can be particularly dangerous.
- Patients who are engaging in various combinations of the following behaviors may be particularly at risk of dehydration: restricting fluid intake, purging, abusing laxatives, engaging in compulsive exercise, and abusing alcohol.
- Patients who are underweight can have any number of electrolyte imbalances at any time.
- Patients who are *not* underweight but who are engaging in behaviors are *also* at risk for electrolyte imbalances.
- For patients who have severely restricted – especially those who have not eaten for many days in a row – there is a risk for *refeeding syndrome*. A non-medical way of describing this is the body "going into shock" after eating for the first time after a period of starvation. Refeeding syndrome could lead to a heart attack, stroke, coma, or death. As such, it is required that a patient be medically cleared before starting treatment and continued to be monitored.

Why Lab Work Is Helpful in Therapy

If a patient is purging, getting lab work can be very useful. It is *always* best to consult with a medical professional regarding the interpretation of lab results. At the same time, a non-medical therapist can learn the basics. For instance, amylase levels can be in the elevated when the patient is purging. Sometimes, however, the patient can be purging and the level is not elevated or the patient is not purging and it is elevated. This is why it is best to consult with a licensed medical professional! Regardless of occasional ambiguity, results can still be clinically helpful. For instance, if your patient denies ever having intentionally purged, however, lab results are starting to come back week after week with increased amylase levels, you might suspect purging. Confronting the patient on this issue may bring about disclosure of the behaviors. On occasion, we have had patients at higher levels of care with a co-morbid BPD who reported purging but amylase levels were *not* elevated. Having lab reports to objectively back up the team's assessments that eating disorder behaviors were *not* being engaged in has also been clinically useful.

RAE Handout 5: How Does Regular Eating Work?

Starting at the Beginning

In order to help yourself get safely off the emotional roller coaster that the eating disorder keeps you on, it is important for you to start at the very beginning. To ensure your safety and recovery, the first part of the eating disorder roller coaster that must be addressed is the behavior of restricting the overall amount of food you eat in response to your fear of weight gain.

Regular eating involves eating appropriate amounts consistently throughout the day, on a schedule. Unlike the strict adherence to rules that characterizes an eating disorder mind-set, regular eating is practiced flexibly. With regular eating, you are not encouraged to eat at an exact time. Instead, you are encouraged to eat at some point within a time range. You can discuss what time ranges work best for you with your therapist. Here is an example to help illustrate the point:

- Breakfast must be eaten between 7:00 a.m. and 8:30 a.m.
- Lunch must be eaten between 12:00 p.m. and 1:30 p.m. (or during a lunch period).
- Your first snack must be eaten between 3:00 p.m. and 4:30 p.m.
- Dinner must be eaten between 6:00 p.m. and 7:00 p.m.
- Night snack must be eaten between 8:00 p.m. and 9:00 p.m.

What Is Regular Eating?

Eating regularly is not to be confused with eating normally (that is, eating like "everyone else"). It means the consistent intake of food. Regardless of the type of eating disorder you have, eating regularly throughout the day is a very important part of recovery.

Because the eating disorder wants you to restrict food, the opposite must be done in recovery. For instance, an eating disorder may influence a person to skip (that is, restrict) breakfast. But in order to fight the eating disorder with regular eating, the person would have to eat not just breakfast but also lunch, dinner, and two snacks. The eating disorder will cause the person to feel negative emotions like anxiety, guilt, and disgust as a result of eating breakfast in addition to snacks and other meals, but it's necessary to stick to the plan of eating regularly, no matter what, in order to work toward recovery.

The eating disorder will very likely cause you to feel negative emotions about regular eating at first. Because the eating disorder makes it so scary to eat regularly, many people don't want to do it. But pushing yourself through the negative emotions will make you stronger. As you get stronger, your eating disorder will get weaker. Over time, your weakened eating disorder will be less and less able to make you feel negative emotions about regular eating.

RAE Handout 6: Five Non-RE Eating Disorder Behaviors and Five RE Recovery Behaviors

Non-RE Eating Disorder Behaviors		RE Recovery Behaviors
1. Skipping a meal or snack for any reason *My stomach is full, so I don't need a snack.*	→	1. Eating each meal and snack every day, no matter what *I'm really full and don't want a night snack. At the same time, I'll eat it so I can go out with my friends.*
2. Not eating an adequate amount of food *I'm not eating all that! I will eat whatever I am comfortable with.*	→	2. Eating adequate amounts of food *I am afraid to eat an adequate amount of food.* *At the same time, I know I have to get used to eating appropriate amounts of food in order to recover. Restriction is not part of recovery.*
3. Playing it safe by avoiding challenge foods *I'm not eating a cheeseburger. I'll have the turkey sandwich instead.*	→	3. Eating challenge foods *I will be anxious if I eat the cheeseburger. At the same time, I know I need to challenge myself to face my fears in order to recover.*
4. Measuring food in any way *How much butter is in that? Can you measure it out? Can I help you make dinner?*	→	4. Estimating amounts of food, or not knowing *My eating disorder wants to know how much butter is in this. At the same time, I have to eat it without knowing because that will help me eat more flexibly in the real world.*
5. Engaging in intolerance behaviors *It's not healthy to be inactive. I'm going to the gym, and there's nothing you can do to stop me.*	→	5. Tolerating negative internal experiences *My eating disorder wants me to exercise right now. At the same time, I need to listen to my treatment team, so I'll watch TV.*

Name _____ Day _____

Make as many copies of this handout as you need in order to keep a log of regular eating every day. On the lines that follow, write the time frame within which you plan to eat each meal or snack. Example: Lunch, 12:00 p.m.–1:30 p.m.

Breakfast _____ Lunch _____ Dinner _____

Snack 1 _____ Snack 2 _____

In the left-hand column of the following chart, indicate whether you ate each meal or snack within the planned time frame. In the middle column, indicate whether you ate any "challenge" foods during each meal or snack. In the right-hand column, record all the foods you ate during each meal or snack. Do not include caloric amounts.

Eaten Within Planned Time Frame	**Foods Eaten**	**Challenge Foods Eaten**
☐ Breakfast		
☐ Lunch		
☐ Dinner		
☐ Snack 1		
☐ Snack 2		

Regular Eating Log

RAE Handout 13: How Does Appetitive Eating Work?

Not Knowing If You're Hungry or Full

Once you have been eating regularly for some time, your body may start to naturally become hungry when it is time to eat a meal or snack. It may take a while, however, to start feeling hungry and full at the appropriate times. You also may not be able to read your appetite cues of hunger and fullness for a while, because having an eating disorder disrupts these signals. Even though you may not be able to tell if you're hungry or full at first, you'll get better with practice, as you do with any other skill you're learning.

It is important to remember that you must first meet your RE goals. Once they are met, you can start to focus more on appetitive eating goals. At the start of your learning about appetitive eating, you are not expected to be able to eat according to the general appetitive eating guidelines provided in this handout. It's a process. First you will learn to identify your signals of hunger and fullness. Then, over time, you will learn to use those signals as a guide.

It is also important to remember that there are no rules when you're eating according to your appetite; there are only guidelines, which were created to help you beat the eating disorder. But even though there are no rules, there are two sets of goals:

1. The first set of goals is to steer yourself away from the following behaviors:
   - Overriding feelings of hunger
   - Stopping before you are full
   - Eating when you are already full
   - Eating past the point of being full
2. The second set of goals is to steer yourself toward the following behaviors:
   - Eating when you are hungry
   - Stopping when you are full

Using the Hunger and Fullness Scale

You will learn to rate your hunger and fullness by using the Hunger and Fullness Scale. For instance, prior to a meal, the intensity of your hunger might be at 3. At several points during the meal, you will check in with yourself and attempt to gauge your hunger and fullness. You will continue to complete your meal. After your meal is completed, you will check in with your fullness level. Perhaps you are at 8.5. In this way, you will learn to track your hunger and fullness. When you're starting to eat according to hunger and fullness, it can be helpful to try to stay within the range between 2.5 and 8.5.

0	1	2	3	4	5	6	7	8	9	10
Extremely hungry		Hungry			Neutral			Full		Extremely full

Hunger and Fullness Scale

RAE Handout 15: Six Non-RAE Eating Disorder Behaviors and Six RAE Recovery Behaviors

Non-RAE Eating Disorder Behaviors/ Attitudes		RAE Recovery Behaviors/Attitudes
1. Skipping meals or snacks *I'm just too busy to eat. I have to skip meals.*	→ →	1. Eating meals and snacks on time *My health and recovery are a priority. As such, no matter how busy things get, I need to eat three meals and snacks every day no matter what.*
2. Overriding the sensation of hunger *I'm feeling hungry but I'm afraid to gain weight, so I'm going to not eat.*	→ →	2. Eating when hungry *I'm noticing I'm hungry, so I'm going to take a snack break now.*
3. Stopping before full *It makes me feel "fat" to be full, so I'm going to stop eating before I get too full.*	→ →	3. Eating until full *It is anxiety-provoking to eat until I am full, but recovery is about challenging myself. I am going to eat until I feel full.*
4. Eating past the point of being full *Eating is anxiety-provoking so I didn't eat all day. Now I'm eating and I can't stop even though I'm full. Plus, I plan on dieting tomorrow and this is my one chance to eat this food, so I'm going to keep on going.*	→ →	4. Stopping when full *I am starting to feel full so I'm going to stop right here. I can always have more of this food when I get hungry. I am no longer going to limit myself from having food, so I don't have to get it all in now.*
5. Avoiding eating foods you crave *I really am craving a burrito, but that has a fear food in it, so I'm going to avoid it.*	→ →	5. Allowing yourself to eat foods you crave *My body is craving a burrito because it needs the nourishment and nutrients provided by this food. The eating disorder is causing me to be afraid of eating a burrito, but in recovery I have to face by fears and practicing eating what I want to eat!*
6. Measuring amounts of food exactly *I need to know exactly how much I'm eating or I'll get anxious, so I'm going to measure out my cereal.*	→ →	6. Estimating portions of food *I am going to face my anxiety about not knowing exactly how much food is portioned out. I'm just going to estimate the portion by pouring an amount of cereal that looks about right in the bowl.*

Regular and Appetitive Eating Log

Name _____ Date _____

Make as many copies of this handout as you need in order to record information for every day that you use this log. Log the time of your meals and snacks as well as the foods you've eaten. Also check off any RAE recovery behaviors and non-RAE eating disorder behaviors that occur during each meal or snack.

Time	Foods I've Eaten	Challenges
Breakfast		
Lunch		
Snack 1		
Dinner		
Snack 2		

RAE Recovery Behaviors						
	Eating meals and snacks on time	**Eating when hungry**	**Eating until full**	**Stopping when full**	**Allowing myself to eat foods I crave**	**Estimating portions of food**
Breakfast	☐	☐	☐	☐	☐	☐
Lunch	☐	☐	☐	☐	☐	☐
Snack 1	☐	☐	☐	☐	☐	☐
Dinner	☐	☐	☐	☐	☐	☐
Snack 2	☐	☐	☐	☐	☐	☐

Non-RAE Eating Disorder Behaviors						
	Skipping meals or snacks	**Overriding the sensation of hunger**	**Stopping before full**	**Eating well past the point of being full**	**Avoiding foods I crave**	**Measuring amounts of food exactly**
Breakfast	☐	☐	☐	☐	☐	☐
Lunch	☐	☐	☐	☐	☐	☐
Snack 1	☐	☐	☐	☐	☐	☐
Dinner	☐	☐	☐	☐	☐	☐
Snack 2	☐	☐	☐	☐	☐	☐

Regular and Appetitive Eating Log

BAE Handout 3: Positive Body Image and Acceptance

Positive Body Image

Having a positive body image has nothing to do with how you look. The most physically beautiful person in the world can have a very negative body image. You can probably think right now of someone you know who you think is physically beautiful but who is very hard on themselves about how they look. Having a positive body image is about accepting your body as it, not trying to change it, not forcing it to be thinner or fitter before you can like it, and treating yourself well no matter what you look like. You don't obtain a positive body image by losing weight. You achieve it through the hard work that comes with body acceptance.

What Is Acceptance?

Fighting reality by trying to change it is unproductive and takes up a lot of mental energy. Acceptance means being OK with reality as it is, without acting on impulses to try to change it. When certain realities are accepted, all the mental energy you could have wasted trying to change it is yours to keep. You are free to do pretty much whatever you would like with that energy.

But acceptance sounds a lot simpler than it is. Because the process by which acceptance is reached involves feeling a lot of negative internal experiences, many people don't bother trying. Instead, they just keep fighting reality. But because acceptance has so many benefits, it is worth going through the trouble to work on.

Your Body Is What It Is

The first step toward accepting your body is acknowledging that it exists just the way it does, without trying to change it. Attempts that you have made to change your body may have brought you temporary feelings of accomplishment and pride, but the eating disorder will always want more and more. When the eating disorder is in control, your body will never be good enough, no matter how hard you try. Eating disorders create a bottomless pit of desire to change your body. It just never ends. In BAE treatment, the alternative you will work toward is to accept your body.

Tolerating Negative Internal Experiences

Not only does acceptance involve abandoning attempts to change your body, it involves tolerating the negative experiences that come along with giving up trying to change your body. True acceptance involves letting yourself experience whatever emotions (disappointment, sadness, anxiety, disgust, shame), thoughts (*I'm so fat*), urges (to engage in an eating disorder behavior), and physical sensations might come your way. Over time, and with practice, tolerating these experiences gets easier. The experiences also get less intense. Taken together, giving up trying to change your body, and tolerating negative internal experiences, will help foster acceptance and recovery.

BAE Handout 18: Pretending It's Forever

Let's Pretend

Let's pretend that for as long as you live, you will have exactly the same body size, shape, and weight as you have now. No matter what you do—dieting, exercising, undergoing liposuction, or trying anything else—your body will immediately return to exactly the same size, shape, and weight you have now. Take a few moments and imagine what that would be like to experience.

Questions (Part 1)

1. When you imagined having exactly the same body forever, how did you feel? Panicked? Relieved?

_____

_____

_____

2. Are you surprised in any way by your response?

_____

3. Until the reality of having the same body size, shape, and weight forever sinks in, which body-changing strategies (such as exercising) might you try?

_____

_____

_____

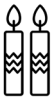
4. Would you make attempts to hide your body in public if you had to stay forever at this same body size, shape, and weight?

_____

5. Would you try to avoid looking at your own body if you had to stay forever at this same body size, shape, and weight?

_____

BAE Handout 21: Your Body Is Your Temple



You Are Not Your Body

You are so much more than your body! Your body is a vessel that carries you through life. Your body is not you. Your body is here to help you carry out your hopes, dreams, and intentions.

You Are You

In a way that is completely separate from your physical appearance, you have character, personality, interests, and love for certain people around you. In a way that has nothing to do with your physical appearance, these are the kinds of things that make up who you are as a person. You are *you*. You are *not* your body. You are *in* your body.

Thinking They Are The Same

From a place of fear, people shift their focus to manipulating the physical world (their bodies) and slowly lose touch with who they are in the process. But it is rare for people to make good choices from this place of fear and disconnection with themselves. If you end up so disconnected from yourself that your body seems to be all that really matters to you, then even more self-destruction ensues. In the eating disorder mind-set, people treat themselves poorly. This is the end result of fusing one's identity with one's physical body, and so it is important for you to remember that you are not your body.

Your Body Exists Only for You

Your body exists for you and only you. In the eating disorder mind-set, a person's whole sense of who they are is reduced to their body, and there is also a sense that their body exists for other people to admire, compliment, and judge. But the truth is that your body does not exist for other people to comment on, negatively or positively. It does not exist for them at all. Your body exists only for you.

Other People Are Not Their Bodies

The eating disorder mind-set is one of social comparison. A person is in the habit of objectifying not only their own body but also other people's bodies and then making comparisons. But this reduces you and other people to your bodies. Just as you are not your body, other people are not their bodies. In recovery, it is crucial for you to develop in a way that allows you to respect that you are not your body and that other people are not their bodies. Other people are not here to be reduced to their size and then measured against. Their bodies exist for them to carry out their hopes, dreams, and intentions, too. In recovery, it is important to respect others as well as yourself.

Honor Your Body

Your body is like a car for your soul or self. Just as you take care of your actual car, making sure it has enough gas and gets taken in for inspections and repairs, you have to take care of your body. You have to make sure it is properly nourished, that you go to the doctor for annual check-ups, and that you attend to your body when it gets hurt. In this way, you can honor your body from a place of respect. In short, you help your body, and your body helps you.

Questions

1. In what ways do you feel as if you've lost touch with who you are in the time you've had the eating disorder?

2. Describe your personality apart from the eating disorder. What are you interested in? Who are the people you love the most?

3. Do your personality, your interests, and your love for others help make you who you are?

4. Do you believe that you are not just your body?

5. In what ways was it destructive to confuse your body with who you are?

6. What emotions do you have when you think about confusing who you are with your body?

7. In what ways have you had the sense that your body existed for other people?

8. What emotions do you have when thinking about this?

9. In what ways was it destructive to confuse others with their bodies?

10. What emotions do you have when thinking about confusing others with their bodies?

11. In what ways can you honor your body, with respect, as the carrier of your self?

12. In what ways is approaching your body with respect different from approaching it with fear?

FAM Handout 1.6: Self-Eclipsing Eating Disorders

Eating disorders tend to take over, or eclipse, a person's sense of self. For instance, eating disorders are often marked by at least some of the following characteristics:

- Belief that eating disorder behaviors should be performed: "I need to lose more weight, even if it means engaging in restriction and purging."
- Apparent intention to continue performing eating disorder behaviors: "I am absolutely going to keep running fifteen miles a day—you can't stop me."
- Lack of ability to recognize functional impairment and the ramifications of the disorder, a deficit in awareness that is also known as *anosognosia*: "My doctor is overreacting. She says I'm at risk for a heart attack, but I'm not."
- Noticeable lack of insight: "I don't care what my treatment team says. I don't have an eating disorder."

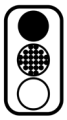
If an eating disorder has at least some of these characteristics, then it is a *self-eclipsing eating disorder* (SEED). Unlike other types of disorders, which people can express the desire to be without, a SEED often leaves a person unaware of how good things can be once the SEED is gone. A SEED has a way of tricking the person into thinking that it is desirable, and that things would be terrible without it. This is part of what makes a SEED so incredibly dangerous. People who are engaging in life-threatening eating disorder behaviors are tricked into thinking that they are doing what is healthy or even morally right.

Eating disorders have a fairly distinctive and unsettling way of swaying a person's morals and values. For instance, a person may believe that it is morally wrong to be fat, and that it is morally right to restrict food intake. A person's values are also impacted. Not only do many people with eating disorders value thinness, they value it more than the things they used to consider extremely important. In a popular Integrative Modalities Therapy group exercise, patients with current eating disorders consider and rank what their values were before they developed an eating disorder, and then they consider and rank their current values. For example, before having an eating disorder, many people ranked such values as family, spirituality, friends, and school at the very top of their values hierarchy. By contrast, people who currently have eating disorders rank thinness at the very top of their hierarchy of values, with thinness effectively outranking family, spirituality, friends, and school.

It is extremely problematic for people to place thinness above what they truly used to regard as important. A person with an eating disorder who values thinness is also tremendously afraid of gaining weight. The overwhelming fear of becoming "fat " takes over, and the person finds it difficult to think about anything other than getting "thin." With this mind-set, a person with an eating disorder engages in very dangerous behaviors to be sure of getting "thin." To make matters worse, these behaviors become dangerous habits that are difficult to get rid of. Think of them as being somewhat like the habit of smoking cigarettes.

Taken together—the extreme valuing of thinness, the terror of gaining weight, and current engagement in potentially life-threatening behaviors because of the eating disorder—these characteristics of a SEED make it too dangerous just to let the person carry on, in the hope that he or she will change without intervention. People whose eating disorders have reached this point need help before it is too late. Specifically, they need the help of their family members.

FAM Handout 1.7: Reinforcement-Allowing and Reinforcement-Impeding Behaviors



How Can I Help?

Before people can start saving themselves from an eating disorder, help from their family members is often necessary. But what can family members possibly do to help?

It turns out that family members can actually contribute quite a bit. This handout briefly discusses how eating disorder behaviors can be decreased over time, with help from the outside.

Reinforcement

The behaviors of animals (including the behaviors of people) are subject to reinforcement. Reinforcement of a behavior is a factor that increases the likelihood that the behavior will be repeated in the future. For instance, if a laboratory rat in a cage learns that pressing a lever makes food appear, then it is more likely to press the lever in the future. In this case, food serves as reinforcement of the lever-pressing behavior. Because the reinforcement of food was provided after the behavior of pressing the lever, it is the behavior of lever pressing that is more likely to occur in the future.

Just as a laboratory rat's behavior is subject to the laws of reinforcement, so are eating disorder behaviors. By contrast with this simple example, however, what reinforces a given person's eating disorder behaviors (such as restricting or avoiding foods, cutting up foods into tiny bites, exercising, taking laxatives, purging, and so forth) is more complex. To put it very simply for the purposes of this handout, eating disorder behaviors are reinforced primarily by the fact that they tend to reduce a person's intense and otherwise constant fear of "fatness." In other words, relief from fear serves as reinforcement.

At any given moment, a person with an eating disorder is extremely anxious about gaining weight. Therefore, if a person with an eating disorder exercises and gains temporary relief from fear of "fatness," the behavior of exercising is reinforced. The reinforcement of this behavior comes by way of the relief that exercise provides, and so exercise becomes a behavior that is more likely to be repeated in the future. Similarly, if a person with an eating disorder avoids eating pizza at lunch, the person gains a few moments of relief by having avoided "getting fat " because of pizza. This temporary relief reinforces the behavior of avoiding pizza. As a result, repeated avoidance of pizza becomes more likely.

Reinforcement-Allowing Behaviors

No carer can be expected to have a professional's level of knowledge and expertise regarding eating disorders. These disorders are extremely complicated, and knowing what to do is difficult. With guidance from an eating disorder specialist, however, carers can learn to detect any behaviors of their own that allow another person's eating disorder to be reinforced or enabled. We call these behaviors on the part of carers *reinforcement-allowing behaviors* (RABs). An example of a RAB is allowing a child with an eating disorder to participate as a member of a track team. In an environment that provides unlimited access to reinforcement of eating disorder behaviors, such behaviors can grow to be quite strong and life-threatening.

Reinforcement-Impeding Behaviors

In addition to detecting their own RABs, carers can help by actively blocking reinforcement of the eating disorder. We call such blocking on the part of carers *reinforcement-impeding behaviors* (RIBs). An example of a RIB might be serving pizza for lunch and blocking access to the option of having a salad instead.

Where to Go from Here

As we go forward, family therapy will focus on how to implement the treatment rules. Over time, by implementing these treatment rules, you will be decreasing your RABs and increasing your RIBs. In this way, you can help modify your child's eating disorder behavior before they can start to do so themselves.

FAM Handout 1.8: Twelve Treatment Rules for Carers (AN Version)

1. Carers choose the food.
2. Serve only full-fat and full-calorie foods.
3. Portion sizes must be sufficient to meet treatment goals.
4. Carers prepare the food.
5. Three meals and two snacks must be served every day.
6. As many meals and snacks as possible must be supervised.
7. All meals and snacks must be completed to the best of your child's ability.
8. If rule 7 is broken, portion sizes must be increased at the next meal or snack.
9. Activity and exercise must be limited according to the physician's recommendations.
10. Screen time must be monitored for eating disorder behavior carried out online.
11. All prescribed medications must be taken as directed.
12. After your child has eaten, one hour must pass before your child uses the restroom.

Dear Carers,

It is almost impossible for any carer to follow all these rules perfectly, all the time. That said, the more closely you can follow the rules, the better. Your therapist will help you figure out how best to implement these rules for your family.

FAM Handout 1.11: Treatment Involvement Plan (AN Version)

1. Carers choose the food.

   Who will be buying and choosing the food?

2. Serve only full-fat and full-calorie foods.

   What foods will be served?

   What foods and beverages are not allowed?

3. Portion sizes must be sufficient to meet treatment goals.

   What is the plan for judging whether portion and meal sizes are appropriate?

4. Carers prepare the food.

   What is the plan for preparing meals and snacks?

5. Three meals and two snacks must be served every day.

   What is the plan for regularly serving three meals and two snacks per day?

6. As many meals and snacks as possible must be supervised.

   What is the supervision plan for meals and snacks?

   Who is preparing what meals and what snacks, and on what days?

   Does the supervision plan offer less support than necessary?

   If so, how can the plan be changed over time to provide more support?

7. All meals and snacks must be completed to the best of your child's ability.

   What is the plan to foster completion of meals and snacks?

8. If rule 7 is broken, portion sizes must be increased at the next meal or snack.

   What is the plan for dealing with restriction?

9. Activity and exercise must be limited according to the physician's recommendations.

   What is the exercise plan?

10. Screen time must be monitored for eating disorder behavior carried out online.

    What is the plan for dealing with technology-related issues?

11. All prescribed medications must be taken as directed.

    What is the medication plan?

12. After your child has eaten, one hour must pass before your child uses the restroom.

    What is the bathroom plan?

FAM/PT Handout 1.17: Eating Disorder and Recovery Behaviors (BOB Version)

Eating Disorder Behaviors and Statements		Recovery Behaviors and Acceptance Statements
1. Pushing away meal and snack support *I don't need any help right now. It's annoying to have people watch me eat. It's just making me worse.*	→	1. Accepting meal and snack support *It's uncomfortable to have support during meals and snacks. At the same time, having the support will help me meet my treatment goals and recover.*
2. Playing it safe by avoiding challenge foods *I'm not eating a cheeseburger. I'll have the turkey sandwich instead.*	→	2. Eating challenge foods *I will be anxious if I eat the cheeseburger. At the same time, I know I need to challenge myself to face my fears in order to recover.*
3. Not eating an adequate amount of food *I'm not eating all that! I will eat whatever I am comfortable with.*	→	3. Eating adequate amounts of food *I am afraid to eat an adequate amount of food. At the same time, I know I have to get used to eating appropriate amounts of food in order to recover. Restriction is not part of recovery.*
4. Measuring food in any way, or interfering with others' preparation of food *How much butter is in that? Can you measure it out? Can I help you make dinner?*	→	4. Eating food that others have prepared and served *My eating disorder wants to know how much butter is in this. At the same time, I have to eat it without knowing because that will help me eat more flexibly in the real world.*
5. Skipping a meal or snack for any reason *My stomach is full, so I don't need a snack* or *I don't feel well, so I'm not eating dinner.*	→	5. Eating each meal and snack every day, no matter what *I'm really full and don't want a night snack. At the same time, I'll eat it so I can go out with my friends.*
6. Using an emotional outburst to avoid eating *I hate you! I'm leaving. It's not fair that I have to eat this food!*	→	6. Having negative emotions and still eating *I really don't want to eat. But I can be upset, and that's OK. I still have to eat.*

Eating Disorder Behaviors and Statements		Recovery Behaviors and Acceptance Statements
7. Exercising more than the doctor allows *It's not healthy to be inactive. I'm going to the gym, and there's nothing you can do to stop me.*	→	7. Adhering to your doctor's exercise guidelines *My eating disorder wants me to exercise right now. At the same time, I need to listen to my doctor during recovery, so I'll watch TV.*
8. Using the bathroom after a meal or snack before an hour has passed *I promise I won't throw up. I just need to use the bathroom.*	→	8. Waiting one hour after a meal or snack before using the bathroom *I really have to use the bathroom right now, but I know I just ate, so I'll wait. I know it's part of the treatment.*
9. Viewing pro–eating disorder content online *I need thinspiration and this weight-loss app to keep me on track.*	→	9. Viewing and using only approved websites and apps *I want to track my calories with this weight-loss app, but I won't, because that's part of my eating disorder.*
10. Not taking prescribed medication *You can't make me take medication!*	→	10. Taking prescribed medication as recommended *It seems unfair that I have to take medication, but right now I have to do anything that will help my health.*

Name _____ Day _____

Make as many copies of this handout as you need in order to keep a log of regular eating every day. On the lines that follow, write the time frame within which you plan to eat each meal or snack. Example: Lunch, 12:00 p.m.–1:30 p.m.

Breakfast _____ Lunch _____ Dinner _____

Snack 1 _____ Snack 2 _____

In the left-hand column of the following chart, indicate whether you ate each meal or snack within the planned time frame. In the middle column, indicate whether you ate any "challenge" foods during each meal or snack. In the right-hand column, record all the foods you ate during each meal or snack. Do not include caloric amounts.

Eaten Within Planned Time Frame	**Foods Eaten**	**Challenge Foods Eaten**
☐ Breakfast		
☐ Lunch		
☐ Dinner		
☐ Snack 1		
☐ Snack 2		

Regular Eating Log