UCSF Health
Eating Disorders Program

Treatment for Eating Disorders

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Agenda

- Orient to various levels of care and discuss indications for level of care
- Referral pathways
- BRIEF diagnostic overview
- Overview of evidence-based treatment
  - ARFID treatment
  - Family Based Treatment (FBT) for AN/Atypical AN/BN
  - Cognitive Behavioral Therapy (CBT) for transdiagnostic eating disorders
  - Dialectical Behavior Therapy (DBT) for transdiagnostic eating disorders

Levels of Care

Orientation and Appropriateness

Outpatient Care vs. HLOC

- Large advantage of outpatient is that patients can remain in their lives (home, school, work) and skills are more likely to generalize to every-day life
- Higher level of care may be necessary if weight control behaviors or ED symptoms are worsening or not improving, or if presentation is unlikely to respond to less intensive intervention
- Rapid early improvement predicts good prognosis in outpatient treatment (1lb/week weight gain, or 50% reduction in B/P symptoms)
- Clinicians have different thresholds on how long they're willing to hang in there with a case before recommending a higher level of care
    - Can depend to some extent on the treatment model

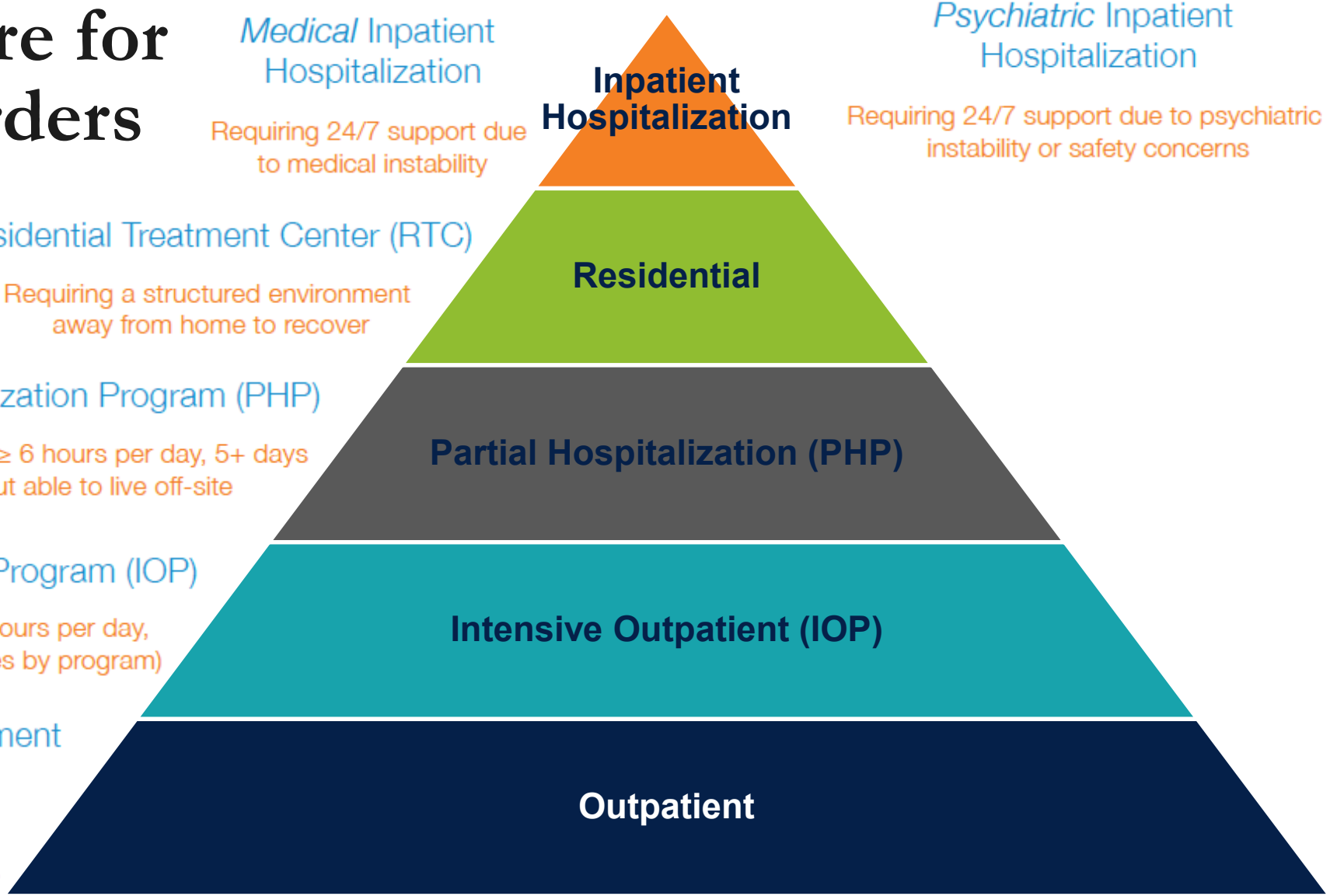
Levels of Care for Eating Disorders

Medical Inpatient Hospitalization

Requiring 24/7 support due to medical instability

Psychiatric Inpatient Hospitalization

Requiring 24/7 support due to psychiatric instability or safety concerns



Residential Treatment Center (RTC)

Requiring a structured environment away from home to recover

Partial Hospitalization Program (PHP)

Requiring support ≥ 6 hours per day, 5+ days per week, but able to live off-site

Intensive Outpatient Program (IOP)

Requiring support 3-6 hours per day, 3-5 days per week (varies by program)

Outpatient Treatment

Able to get sufficient support with interdisciplinary outpatient team, typically involving family and/or other social supports. May use medical hospitalization as safety net.

Guidelines Suggesting a Need for HLOC

- Significant medical instability, which may require hospitalization for acute medical stabilization
- Need for inpatient psychiatric treatment (e.g., significant suicide risk, aggressive behaviors, impaired safety due to psychosis/self-harm, need for treatment over objection or involuntary treatment)
- Co-occurring conditions (e.g., diabetes, substance use disorders) that would significantly affect treatment needs and require a higher level of care
- Lack of response or deterioration in patient's condition in individuals receiving outpatient treatment

American Psychiatric Association 2023

Guidelines Suggesting a Need for HLOC

- Extent to which the patient is able to decrease or stop eating disorder behaviors (e.g., dietary restriction, binge eating, purging, excessive exercise) without meal support or monitoring
- Level of motivation to recover, including insight, cooperation with treatment, and willingness to engage in behavior change
- Psychosocial context, including level of environmental and psychosocial stress and ability to access support systems
- Level of care access is influenced by logistical factors (e.g., geographical considerations; financial or insurance considerations; access to transportation or housing; school, work, or childcare needs)

American Psychiatric Association 2023

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]	Level 4: Residential Treatment Center	Level 5: Inpatient Hospitalization
Medical status	Medically stable to the extent that more extensive medical monitoring, as defined in levels 4 and 5, is not required			Medically stable to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed	*For adults:* Heart rate <40 bpm; blood pressure <90/60 mmHg; glucose <60 mg/dl; potassium <3 mEq/L; electrolyte imbalance; temperature <97.0°F; dehydration; hepatic, renal, or cardiovascular organ compromise requiring acute treatment; poorly controlled diabetes *For children and adolescents:* Heart rate near 40 bpm, orthostatic blood pressure changes (>20 bpm increase in heart rate or >10 mmHg to 20 mmHg drop), blood pressure <80/50 mmHg, hypokalemia,[b] hypophosphatemia, or hypomagnesemia
Suicidality[c]	If suicidality is present, inpatient monitoring and treatment may be needed depending on the estimated level of risk				Specific plan with high lethality or intent; admission may also be indicated in patient with suicidal ideas or after a suicide attempt or aborted attempt, depending on the presence or absence of other factors modulating suicide risk
Weight as percentage of healthy body weight[d]	Generally >85%	Generally >80%	Generally >80%	Generally <85%	Generally <85%; acute weight decline with food refusal even if not <85% of healthy body weight

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders *(continued)*

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]	Level 4: Residential Treatment Center	Level 5: Inpatient Hospitalization
Motivation to recover, including cooperativeness, insight, and ability to control obsessive thoughts	Fair-to-good motivation	Fair motivation	Partial motivation; cooperative; patient preoccupied with intrusive, repetitive thoughts[c] >3 hours/day	Poor-to-fair motivation; patient preoccupied with intrusive repetitive thoughts[c] 4–6 hours a day; patient cooperative with highly structured treatment	Very poor to poor motivation; patient preoccupied with intrusive repetitive thoughts[c]; patient uncooperative with treatment or cooperative only in highly structured environment
Co-occurring disorders (substance use, depression, anxiety)	Presence of comorbid condition may influence choice of level of care				Any existing psychiatric disorder that would require hospitalization
Structure needed for eating/gaining weight	Self-sufficient	Self-sufficient	Needs some structure to gain weight	Needs supervision at all meals or will restrict eating	Needs supervision during and after all meals or nasogastric/special feeding modality
Ability to control compulsive exercising	Can manage compulsive exercising through self-control	Some degree of external structure beyond self-control required to prevent patient from compulsive exercising; rarely a sole indication for increasing the level of care			
Purging behavior (laxatives and diuretics)	Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications, such as electrocardiographic or other abnormalities, suggesting the need for hospitalization			Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging	Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent, and disabling, despite appropriate trials of outpatient care, even if routine laboratory test results reveal no obvious metabolic abnormalities

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders *(continued)*

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]	Level 4: Residential Treatment Center	Level 5: Inpatient Hospitalization
Environmental stress	Others able to provide adequate emotional and practical support and structure		Others able to provide at least limited support and structure	Severe family conflict or problems or absence of family so patient is unable to receive structured treatment in home; patient lives alone without adequate support system	
Geographic availability of treatment program	Patient lives near treatment setting			Treatment program is too distant for patient to participate from home	

A thoughtful step-down transition plan is CRITICAL.

Treatment planning takes into account not only symptoms but also the individual's strengths, vulnerabilities, personality traits, developmental stage, motivation for treatment, social support network, and any other relevant factors.

Outpatient Care vs. HLOC

- Large advantage of outpatient is that patients can remain in their lives (home, school, work) and skills are more likely to generalize to every-day life
- Higher level of care may be necessary if weight control behaviors or ED symptoms are worsening or not improving, or if presentation is unlikely to respond to less intensive intervention
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Higher Levels of Care

- Evidence for the effectiveness of higher levels of care relatively marginal
- So much variability from program to program, and also within programs over time
  - Staff experience and turnover, leadership
  - Changes to patient make-up and milieu
- Whether or not HLOC is indicated also depends heavily on the available alternatives for treatment

Referrals

Partnership and County BH

Partnership HC and County BH System of Care

- Evaluation by county access team
- “Level of care assessment” by Bright Heart Health
  - Members can call Bright Heart Health directly or be referred by a provider (PCP, therapist, other county clinician)
  - Phone: (925) 621-8526
- Once both evaluations are completed, the county and Partnership HealthPlan of California (PHC) will coordinate care
- PHC Care Coordination will assist with connecting to services
  - Assist members in connecting to Bright Heart Health, facilitating labs/tests at PCP, transportation assistance, connection to a dietitian, and coordination with the PHC Behavioral Health team
  - Phone: (800) 809-1350

Diagnostic Overview

Anorexia Nervosa

- Restriction of energy intake leading to a significantly low body weight
- Intense fear of gaining weight or becoming fat **or** persistent behaviors that interfere with weight gain
- Disturbance in experience of body shape and/or weight **or** undue influence of shape/weight on self-evaluation **or** lack of recognition of seriousness of the low body weight

Atypical Anorexia Nervosa

- All of the criteria for anorexia nervosa are met
  - Except that despite significant weight loss, the individual's weight is within or above the normal range
- No explicit cut-off for "significant weight loss"
  - Some have suggested a cut-off of 10% body weight loss
- "Atypical" AN is far more common and just as serious
- Despite **significant weight loss**, BMI is not classified as "underweight"

ARFID

- Eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following:
  - Significant weight loss or failure to achieve expected weight gain milestones
  - Significant nutritional deficiency
  - Dependence on supplementary feeding to sustain adequate intake
  - Marked interference with psychosocial functioning

APA, 2013

ARFID

- Symptoms are not better explained by lack of food, culturally sanctioned practice, or developmentally typical behaviors
  - Religious fasting
  - Dieting
  - Picky eating in early childhood
  - Reduced intake in older adults
- Symptoms do not occur exclusively during the course of AN and there is no evidence of disturbance in the experience of shape or weight

APA, 2013

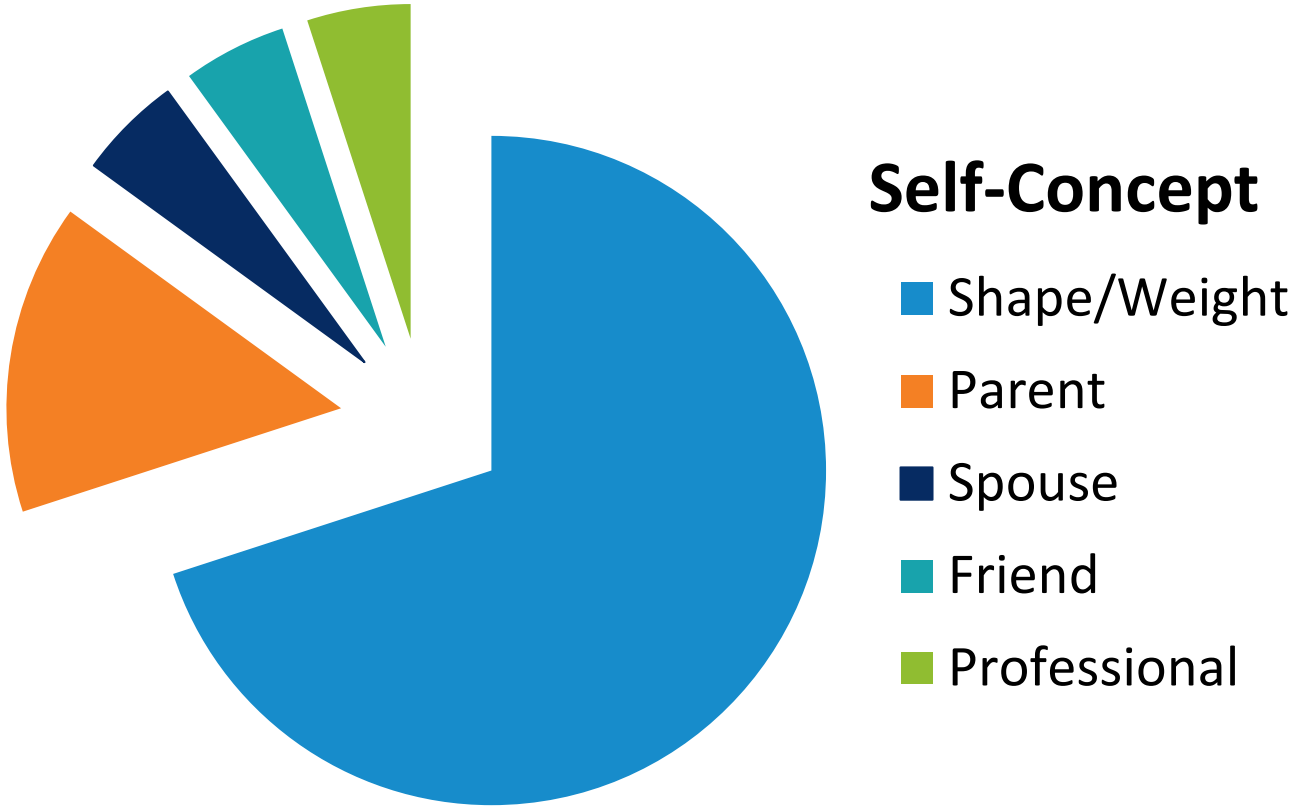
ARFID Subtypes

- Apparent lack of interest in eating (with weight loss/ medical compromise)
- Sensory sensitivity
- Fear of aversive consequences of eating (vomiting, choking, GI sx)

APA, 2013

Assessing the Importance of Shape and Weight

If you imagine all the things that influence how you feel about yourself as a person and put them in order of importance, where does your shape fit in? Your weight?



Fairburn et al., 2008

Bulimia Nervosa

Recurrent binge-eating episodes, defined as:

Eating an **unusually large amount of food** in a discrete period of time ***and*** an experience of **lack of control over eating** during the episode

Recurrent inappropriate compensatory behaviors designed to prevent weight gain

- Self-induced vomiting
- Misuse of laxatives, diuretics, or enemas, or other medications (e.g., insulin omission)
- Excessive exercise

APA, 2013

Binge Eating Disorder

Recurrent binge-eating episodes, defined as:

Eating an **unusually large amount of food** in a discrete period of time

and

An experience of **lack of control over eating** during the episode

Marked distress about binge eating, without compensatory behaviors

APA, 2013

Eating disorders transcend race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, body shape or size…

Overview to Treatment

Treatment Goals

Reverse or minimize medical and psychiatric complications by through the following goals:

- Weight restoration or stabilization
- Normalization of eating patterns: regular, sufficient amounts, increase variety and flexibility
- Reduce ED behaviors: binge eating, compensatory behaviors, counting, body checking, etc
- Reduce ED cognitions: overvaluation of shape/weight, fears (tolerance of uncertainty, loss of control)
- Restore normal development, address vulnerabilities/risk factors

Integrated Multidisciplinary Care

- **Psychotherapy** (individual or family evidence-based treatment)
- **Medical** monitoring and treatment, gown weights, support therapy, hospitalize if necessary
- **Nutrition** counseling

Why is collaborative care so important?

- Eating disorders are complex, require attention to multiple systems
- Hearing the same message from multiple providers is powerful (and hearing even slightly different messages undermines treatment)
- Reduce provider burn-out
- Multiple sources of information: self-report of purging + labs, medical gown weights + weekly therapy (clothed) weights

Medical Care

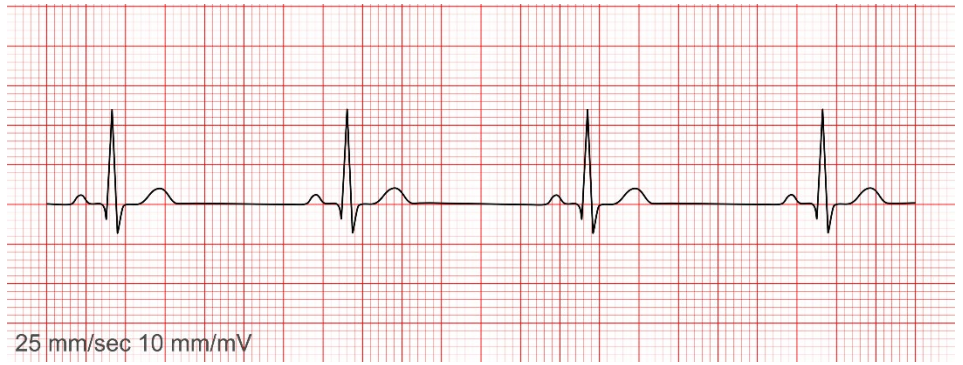
Overview

Medical Treatment

- Food is the best medicine
- Safe and monitored refeeding
- Medically stabilize abnormal vital signs and electrolytes
- Establish clear roles with team members and “stay in your lane”

Medical Tests

- EKG (sinus bradycardia, prolonged QTc)
- Labs (blood counts, organ function, vitamin deficiencies)
- Urine sample (specific gravity, pH)
- Vitals
  - Orthostatic heart rate and blood pressure (lying to standing)
  - Blinded weight in gown
- Dual-energy X-ray absorptiometry (DXA) scans when amenorrhea is present for at least 6 months



Inpatient Medical Stabilization

- Goal is to stabilize medically and assist with some weight restoration (not to treat the eating disorder); stays average about one week
- Hospitalization can serve as a sort of “safety net” for patients and their families when medically necessary
  - Not a failure of the caregivers, patient, or therapist
  - Parental alignment and empowerment can be strengthened during hospitalization period
- Treatment of the eating disorder resumes at a lower level of care upon discharge from the inpatient setting

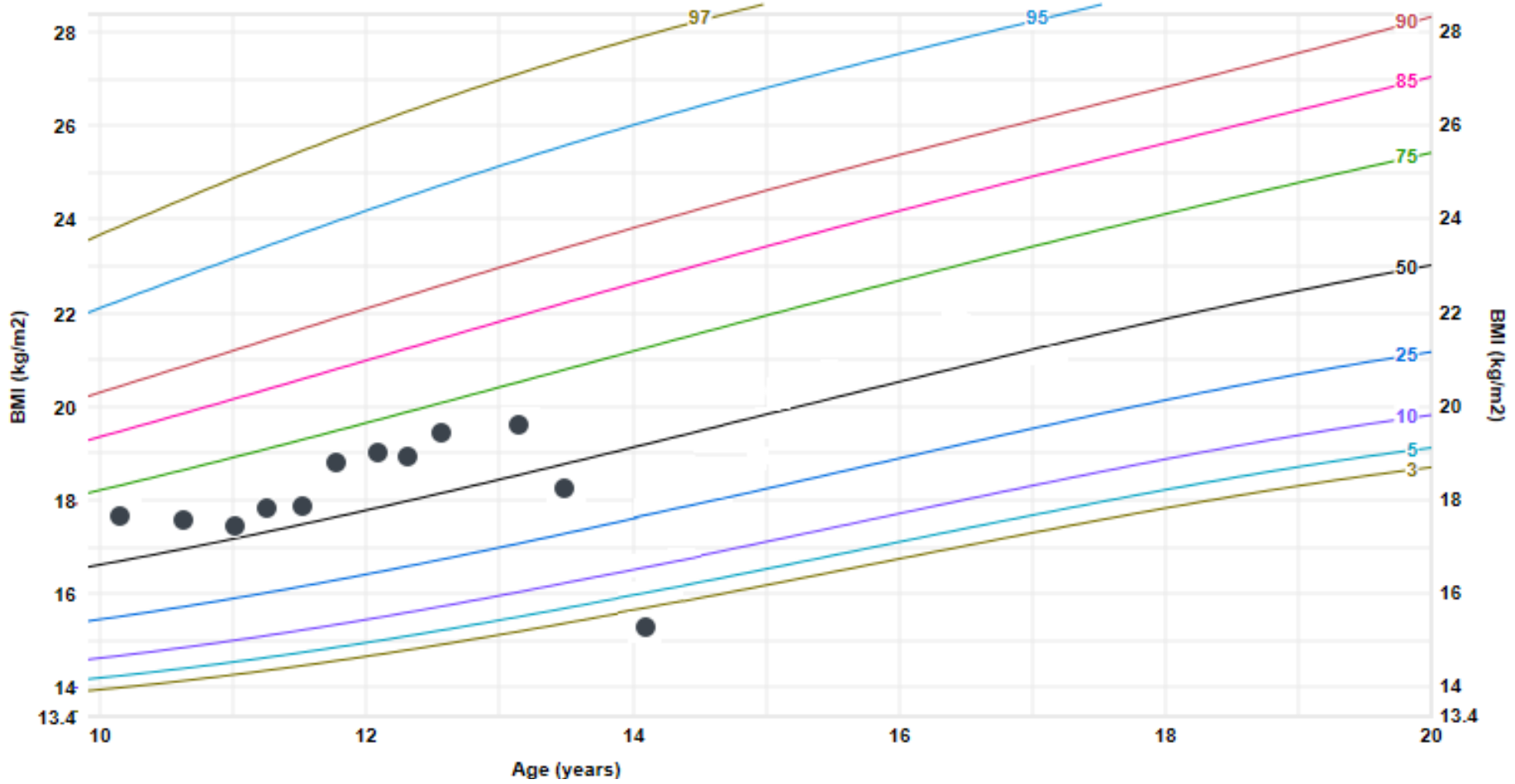
Hospitalization Criteria

- **Bradycardia**: HR <50 daytime, <45 at night
- **Hypotension**: BP <90/45 mmHg
- **Hypothermia**: temperature <96° F
- **Orthostasis**: increase in pulse (>35 bpm) or decrease in BP (>20 mmHg systolic, >10 mmHg diastolic)
- **Weight**: <75% expected body weight or ongoing weight loss despite intensive management

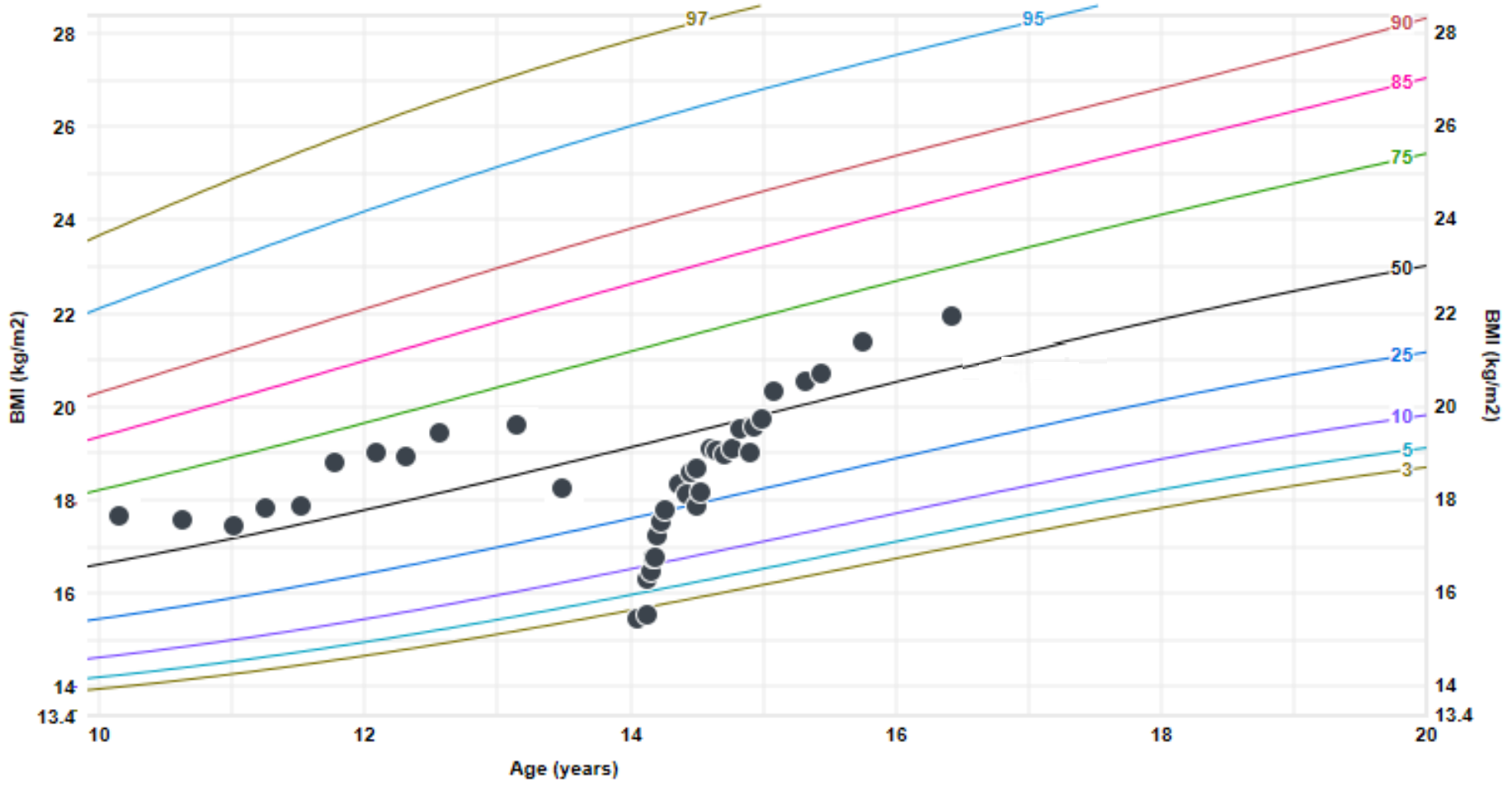
Medical Care

Setting Goal Weight and Supporting Weight Restoration/Stabilization

BMI-for-Age Growth Chart (14-year-old boy)



BMI-for-Age Growth Chart (14-year-old boy)



Estimating Treatment Goal Weight (TGW)

Highly individualized

- Use historical growth curves if/when available
- Consider other recovery signs
- Readjust as necessary
- Up to 85th percentile is in the “normal” range
- “Overweight” (85-95th percentile) corresponds to BMI 25-30 kg/m^2, which has **no increased morbidity/mortality in adults**

Accurso et al., 2019; Flegal, CDC

Weight Suppression Predicts Severity

Patients with greater weight suppression:

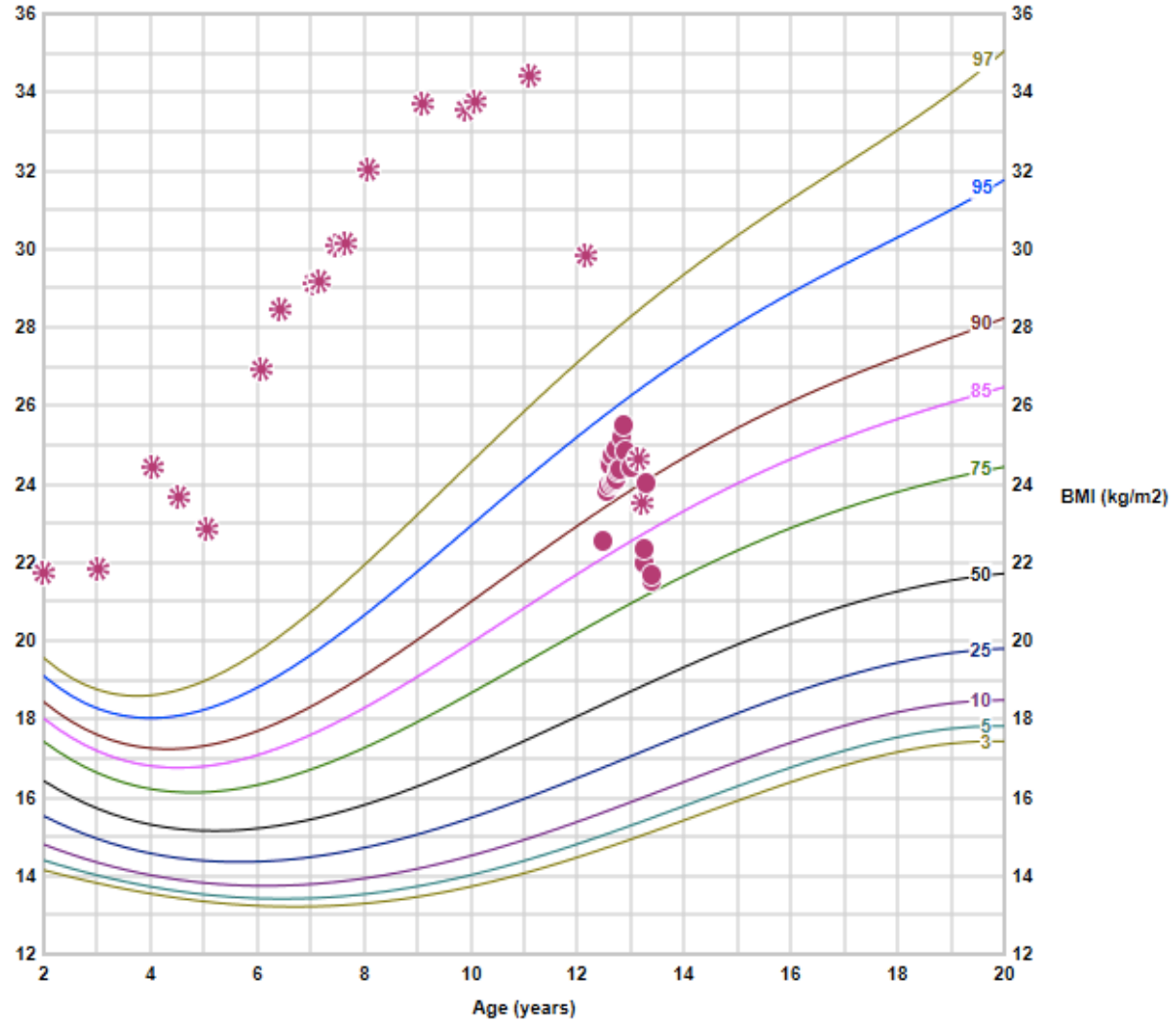
- Persistent amenorrhea
- Worse eating disorder psychopathology
- Faster loss associated with worse bradycardia
- Higher rates of relapse

Seetharaman, Golden et al. 2017; Lavender 2015; Berner 2013; Garber et al., 2019

Eating Disorders Across the Weight Spectrum

- BMI is a flawed method for assessing health risks associated with size/shape/weight
- Health outcomes are worse for those who weight cycle
- Those in larger bodies often experience untreated health conditions due to avoidance of medical care
- EDs are often missed in those in larger bodies

95th BMI percentile is often exceeded in atypical AN presentation



Best practices for talking about weight

- Height and weight are moving targets, changing with age
- Avoid reinforcing rigid beliefs about weight
- Be mindful of implicit and explicit *anti-fat bias: "the attitudes, behaviors, and social systems that specifically marginalize, exclude, underserve, and oppress fat bodies" –Aubrey Gordon*
- History of higher premorbid weight warrants restoration to higher BMI, with focus on **restoring healthy behaviors**
- Once stable, weight will fluctuate a bit

Implicit Association Test

Other signs of return to healthy weight

- Medical stability: vital signs, menstruation, energy, sleep
- Behavioral stability: eating adequately, flexibly, and willingly; sociability
- Psychological stability: concentration, mood, set-shifting, central coherence

Medical Care

Psychopharmacology

Psychopharmacology: Evidence Is Minimal

- Nutritional deficiencies may affect medication response
- Most mood symptoms improve with good nutrition alone
- Premorbid mood symptoms are more deserving of early medication consideration
- Sometimes the most powerful intervention is to eliminate physical discomfort/physical barriers to restoring nutrition

Medications in Anorexia Nervosa

- Food = medicine
- Typically do not start serotonergic medications until around 85% TGW
- If clear mood symptoms predated the eating disorder, could get SSRI on board sooner
- Limited evidence to support low dose atypical antipsychotics
- Patients with AN have an exquisitely sensitive gut/brain connection; choose wisely!

Medications in Bulimia Nervosa

- Fluoxetine is the best studied and most efficacious medication in bulimia nervosa, even in the absence of overt mood symptoms
- Likely need higher doses
- SSRI is first-line medication where evidence-based therapy fails (despite lack of FDA approval in adolescents)
- CBT alone superior to medication alone for BN in adolescents
  - Adding medication shows only modest benefit

Hughes, 1991

Medications for Binge Eating Disorder

- Vyvanse is the FDA-approved for BED treatment in adults
- Some off-label use of SSRIs
- CBT still seen as first-line treatment

Mental Health Care

Outpatient Therapy

Outpatient Evidence-Based Treatments

- Family-based treatment (FBT) for adolescents across diagnostic spectrum, and for young adults with AN
- Adolescent Focused Therapy (AFT) for AN if FBT is not feasible
- Cognitive behavior therapy (CBT) for adolescents with BN and BED if FBT is not feasible
- Enhanced CBT (CBT-E) for eating disorders (young adults)
- Family Based Shaping and Chaining for children/ adolescents with ARFID, or CBT for ARFID for adults to help children/adolescents eat a wider variety and types of foods

Outpatient Evidence-Based Treatments

- **Family-based treatment (FBT) is the first-line approach for child and adolescent AN, AAN, BN** (even some young adults)
- Cognitive behavioral therapy (CBT-E) may be appropriate for adolescent AN, AAN, BN
- Adolescent focused therapy (AFT) may be appropriate for adolescent AN
- Emerging evidence for dialectical behavioral therapy
- Limited evidence for adjunctive treatments (yoga, cognitive remediation, etc.) and pharmacotherapy

Practice Guidelines

NICE National Institute for Health and Care Excellence

NICE guideline

Eating disorders: recognition and treatment

NICE guideline

Published: 23 May 2017

www.nice.org.uk/guidance/ng69

Couturier *et al. Journal of Eating Disorders* (2020) 8:4
https://doi.org/10.1186/s40337-020-0277-8

Journal of Eating Disorders

REVIEW Open Access

Canadian practice guidelines for the treatment of children and adolescents with eating disorders

Jennifer Couturier[1*], Leanna Isserlin[2], Mark Norris[2], Wendy Spettigue[2], Melissa Brouwers[2], Melissa Kimber[1], Gail McVey[3], Cheryl Webb[1], Sheri Findlay[1], Neera Bhatnagar[1], Natasha Snelgrove[1], Amanda Ritsma[1], Wendy Preskow[4], Catherine Miller[5], Jennifer Coelho[6], Ahmed Boachie[3], Cathleen Steinegger[3], Rachel Loewen[7], Techiya Loewen[8], Elizabeth Waite[8], Catherine Ford[9], Kerry Bourret[10], Joanne Gusella[11], Josie Geller[6], Adele LaFrance[12], Anick LeClerc[13], Jennifer Scarborough[5], Seena Grewal[3], Monique Jericho[14], Gina Dimitropoulos[14] and David Pilon[11]

Abstract

Objectives: Eating disorders are common and serious conditions affecting up to 4% of the population. The mortality rate is high. Despite the seriousness and prevalence of eating disorders in children and adolescents, no Canadian practice guidelines exist to facilitate treatment decisions. This leaves clinicians without any guidance as to which treatment they should use. Our objective was to produce such a guideline.

Methods: Using systematic review, the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) system, and the assembly of a panel of diverse stakeholders from across the country, we developed high quality treatment guidelines that are focused on interventions for children and adolescents with eating disorders.

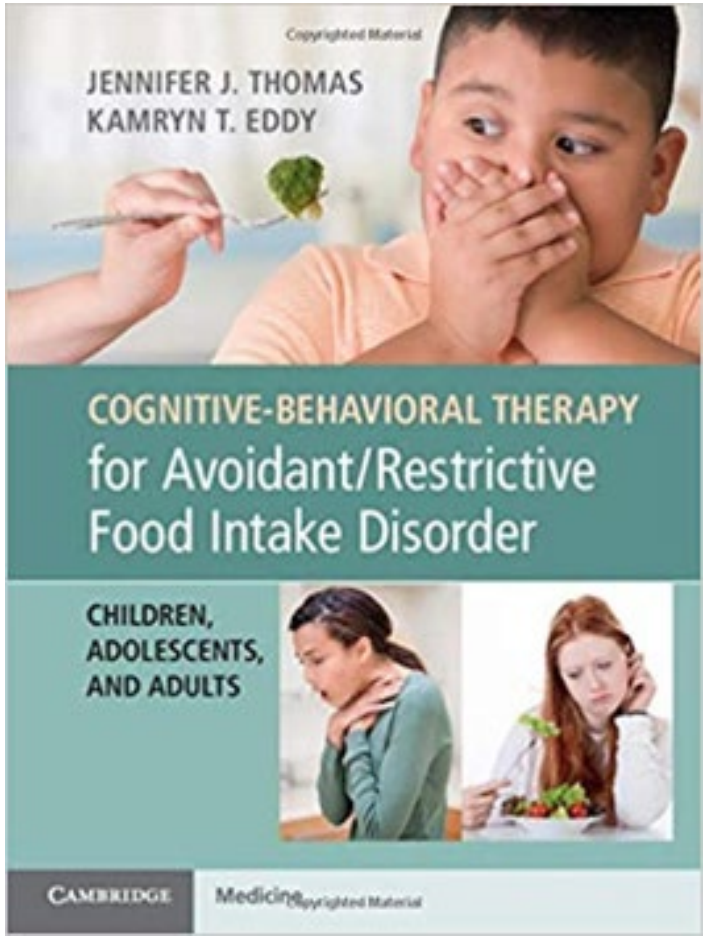
Results: Strong recommendations were supported specifically in favour of Family-Based Treatment, and more generally in terms of least intensive treatment environment. Weak recommendations in favour of Multi-Family Therapy, Cognitive Behavioural Therapy, Adolescent Focused Psychotherapy, adjunctive Yoga and atypical antipsychotics were confirmed.

How Well Does Treatment Work?

- Recovery rates about 50% with adolescents with AN (when receiving FBT) and for adolescents and adults with BN (FBT, CBT)
- Remission a bit higher for adolescents and adults with BED receiving CBT (50-70%)
- Online self-help treatments effective for BED
- Recovery rates closer to 25% for other treatments
- Relapse rates are somewhat high 1-2 years after recovery (between 31-44% across eating disorders)

Mental Health Care

ARFID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JENNIFER J. THOMAS
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COGNITIVE-BEHAVIORAL THERAPY
for Avoidant/Restrictive
Food Intake Disorder
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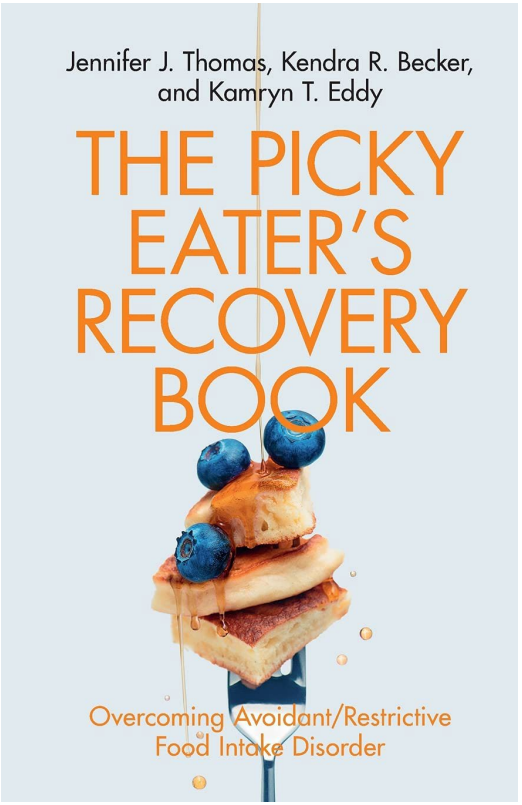

Jennifer J. Thomas, Kendra R. Becker,
and Kamryn T. Eddy
THE PICKY
EATER'S
RECOVERY
BOOK
Overcoming Avoidant/Restrictive
Food Intake Disorder

ARFID: Core Affective Constructs

disgust

fear

ARFID: Other factors

hyper-reactivity to sensory stimuli

intolerance of uncertainty

weak central coherence

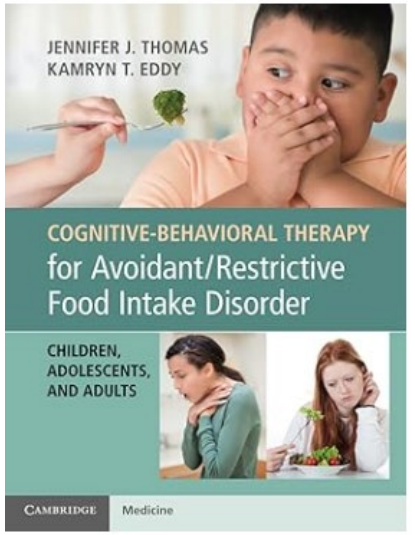
distress intolerance

low appetite

cognitive inflexibility

More than Picky Eating

- Abnormal developmental trajectory:
  - Early rejection of new foods; conditioning maintains behavior
  - Parents often feel disempowered



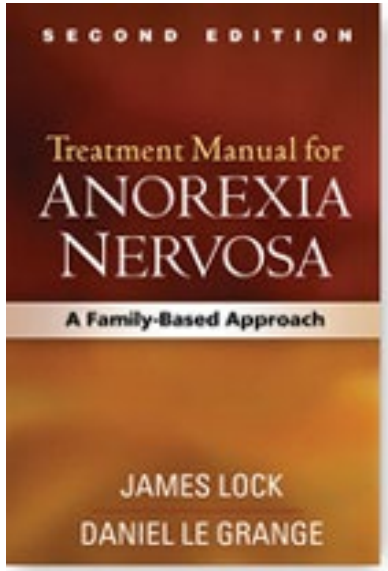
- Habituation to new foods:
  - Typical child: 8-10 presentations before food is no longer novel
  - "Picky" eaters: 10-20 presentations before food is no longer novel
  - ARFID: 50+ presentations before a food is no longer novel

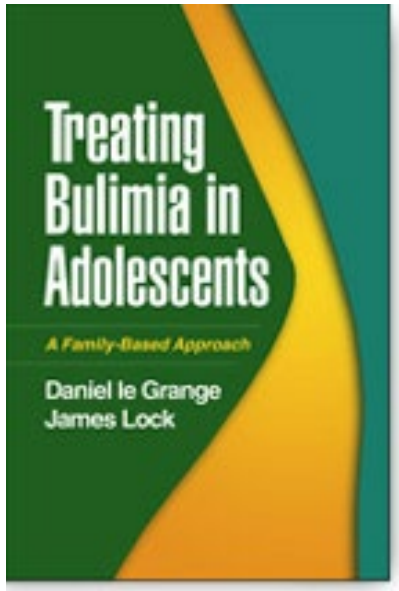
Treatment Goals

- Increase food variety
  - Expand preferences
  - Increase ability to try novel foods
- Consider age and motivation for treatment
  - Weight gain?
  - Nutritional deficiencies?
  - Functional impairment?

Mental Health Care

Family-Based Treatment





Family-Based Treatment

- FBT is the first-line therapy for adolescents with AN or BN who are medically stable (≈80% of clients)
- FBT is faster at helping with weight gain and reducing binge eating/purging, which is critical to minimize psychiatric/medical consequences
- Much fewer days in hospital
- Working with families in their “real world” settings supports long-term recovery, resulting in lower relapse rates

FBT Is the Best Treatment Available

FBT is acceptable

Dropout is low in both treatments, with no differences between treatments.
Higher caregiver therapeutic alliance predicts staying in treatment.

FBT works faster

Significantly more patients in FBT (38%) than AFT (20%) had achieved 95% mBMI within 3 months of starting treatment.

FBT works better for patients with more significant psychopathology

Patients with greater ED psychopathology, OCD symptoms, and purging had significantly better outcomes in FBT than AFT.

Lock et al, 2010; Le Grange et al 2012; Pereira et al, 2006

Behavioral Targets in FBT

- Emphasis on **behavioral recovery** rather than insight or cognitive change
  - Being firm with the ED and treatment plan can mean less rapport
  - Adolescents (particularly in the initial stages of family-based treatment—FBT) may not like their therapist very much

Weight Restoration

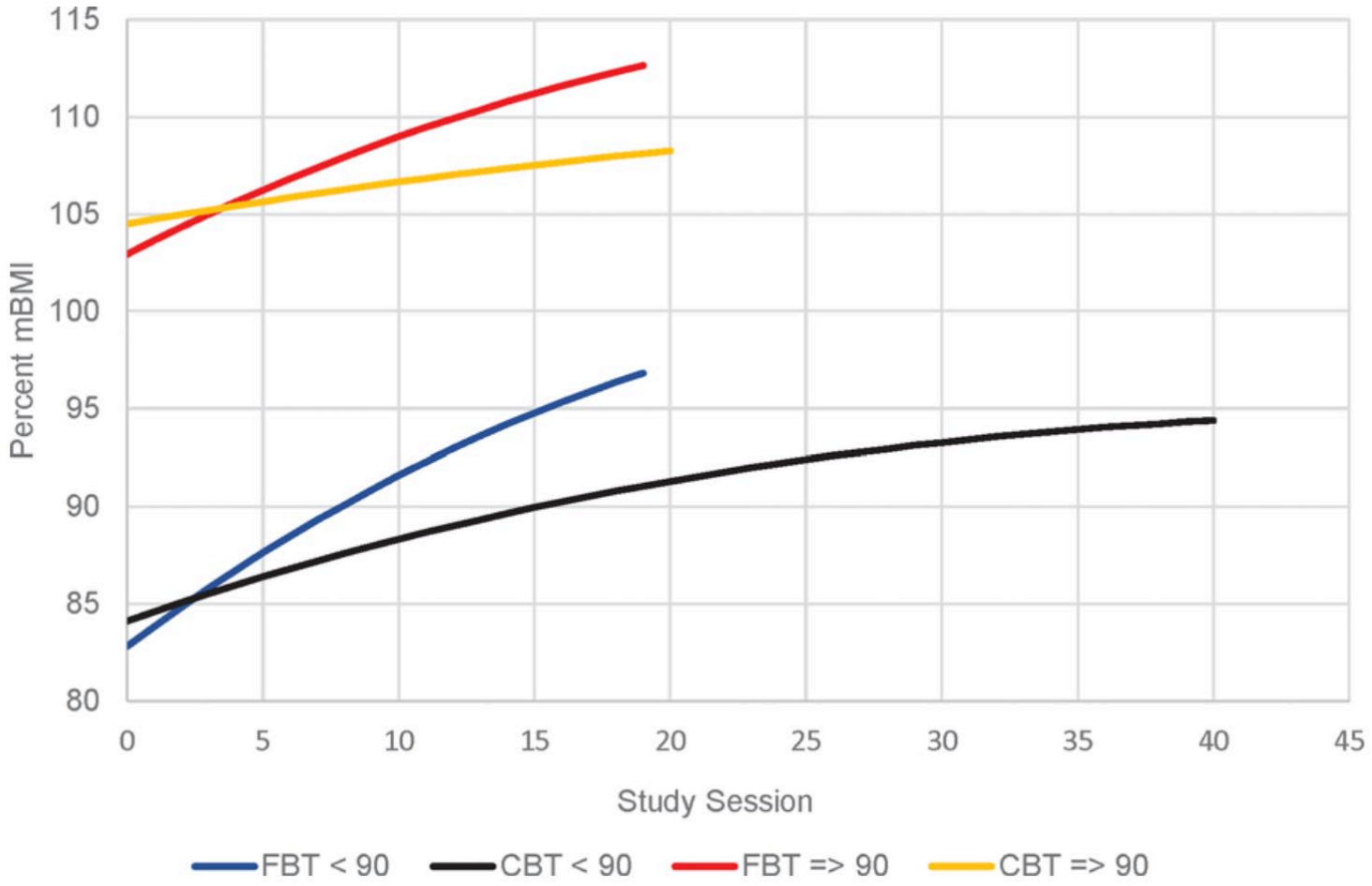


Fig. 2. Slope of weight gain (percent mBMI) for FBT *v.* CBT-E at EOT.

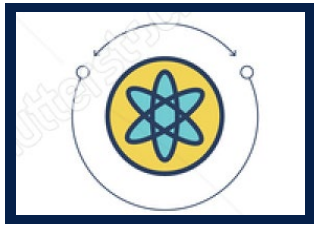
Le Grange, Eckhardt, Dalle Grave, Crosby, Peterson, Keery, Lesser, & Martell, 2020

Family-Based Treatment

- Approximately 12-20 sessions over 6-12 months
- Used across the diagnostic spectrum to restore weight and/or decrease binge eating and purging
- Parents are initially charged with renourishment
- Does not directly focus on “psychological issues” (e.g., control, shape/weight concerns)
- **Does not attempt to foster a readiness for change in the client**; food as medicine

Family-Based Treatment

- Appropriate for medically stable children, adolescents, and young adults
  - Brief hospitalization sometimes used to resolve urgent medical or psychiatric safety concerns
- Team approach: primary therapist and pediatrician are essential, often will involve child and adolescent psychiatrist, dietician, nurses
- Not appropriate in families with history of abuse or substantial neglect



Agnosticism

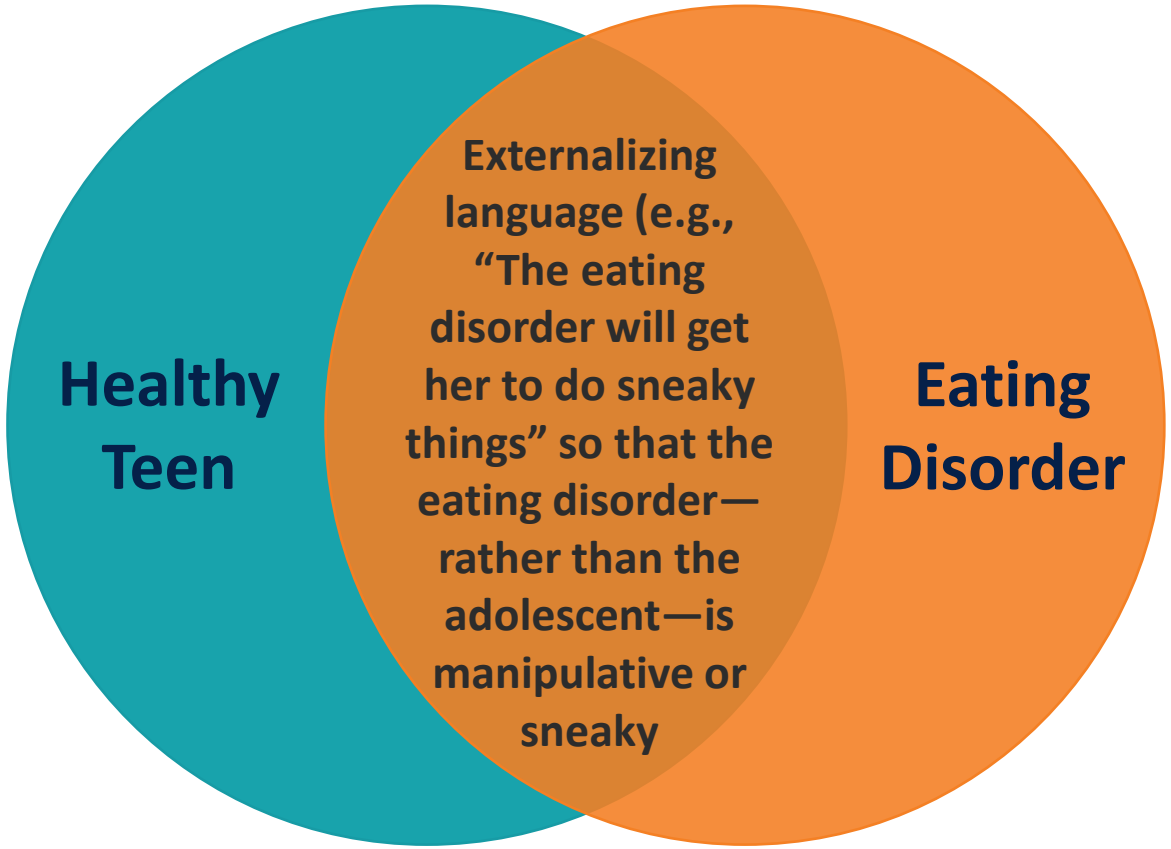
Clinician as consultant

Parents responsible for recovery

Externalization

Symptom-focused

Externalizing the Illness



What if the patient doesn't want treatment?

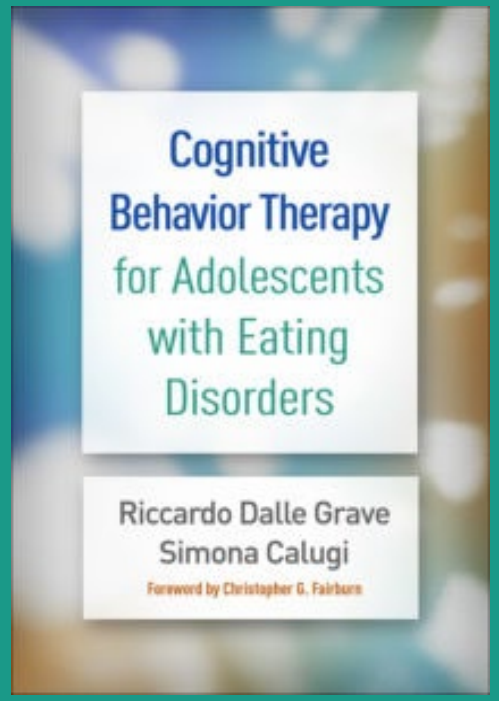
- For adolescents, we don't wait around for the client to want change; we enlist family's help through FBT
- When family unable to participate, we use a lot of motivational interviewing techniques
  - Elicit-Provide-Elicit

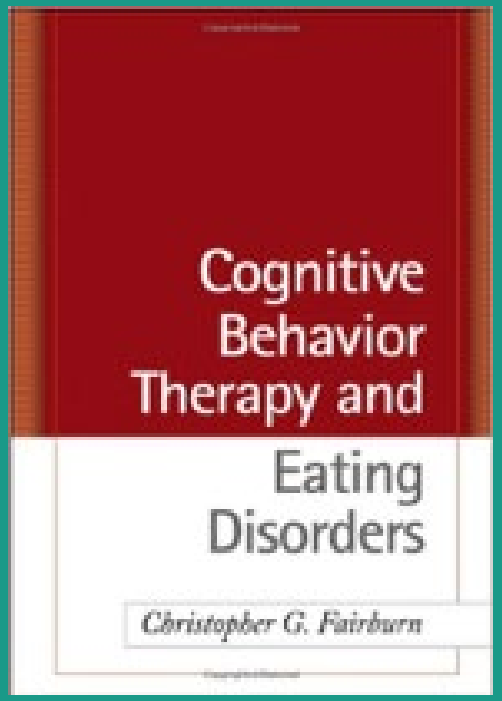
    What do you know about anorexia? [Pt provides their understanding, and therapist adds to this strategically, and corrects misperceptions as relevant.] **What are your thoughts about what I just shared?**
  - Amplify (but don't "insert") change talk

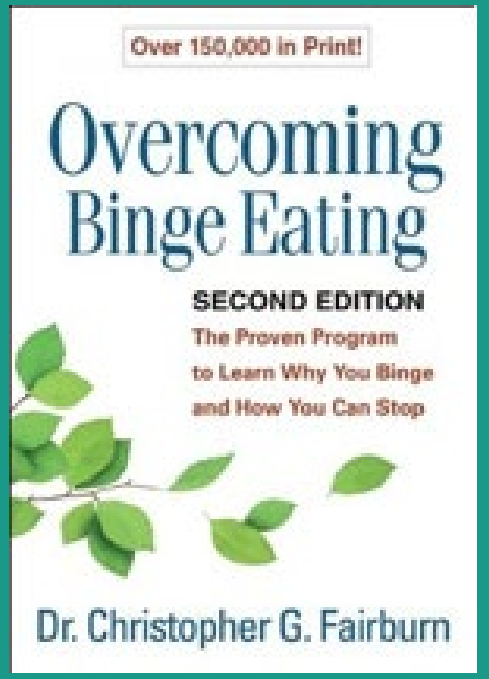
Mental Health Care

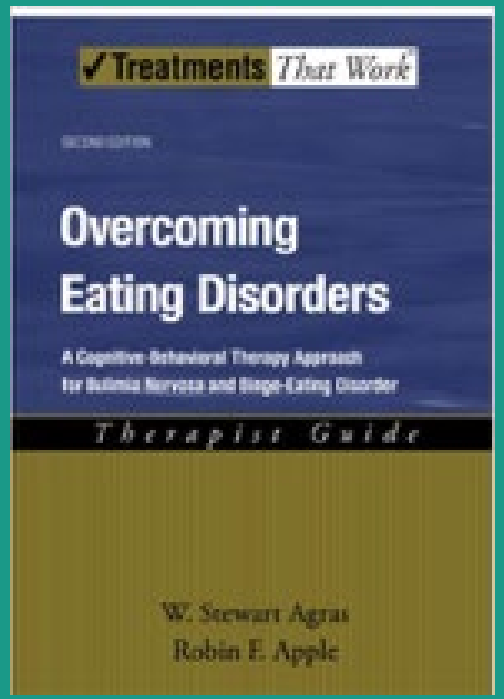
Cognitive Behavioral Therapy

CBT-E / CBT-A


Cognitive
Behavior Therapy
for Adolescents
with Eating
Disorders
Riccardo Dalle Grave
Simona Calugi
Foreword by Christopher G. Fairburn


Cognitive
Behavior
Therapy and
Eating
Disorders
Christopher G. Fairburn


Over 150,000 in Print!
Overcoming
Binge Eating
SECOND EDITION
The Proven Program
to Learn Why You Binge
and How You Can Stop
Dr. Christopher G. Fairburn


✓Treatments That Work
Overcoming
Eating Disorders
A Cognitive-Behavioral Therapy Approach
for Bulimia Nervosa and Binge-Eating Disorder
Therapist Guide
W. Stewart Agras
Robin F. Apple

Cognitive Behavioral Therapy

- Individual therapy; fade out frequency of visits
- Transdiagnostic, but seems to be most efficacious for BN and BED presentations
- Broad CBT-E added modules: clinical perfectionism, core low self-esteem, and interpersonal difficulties
- Caregivers or significant others still play a supportive role

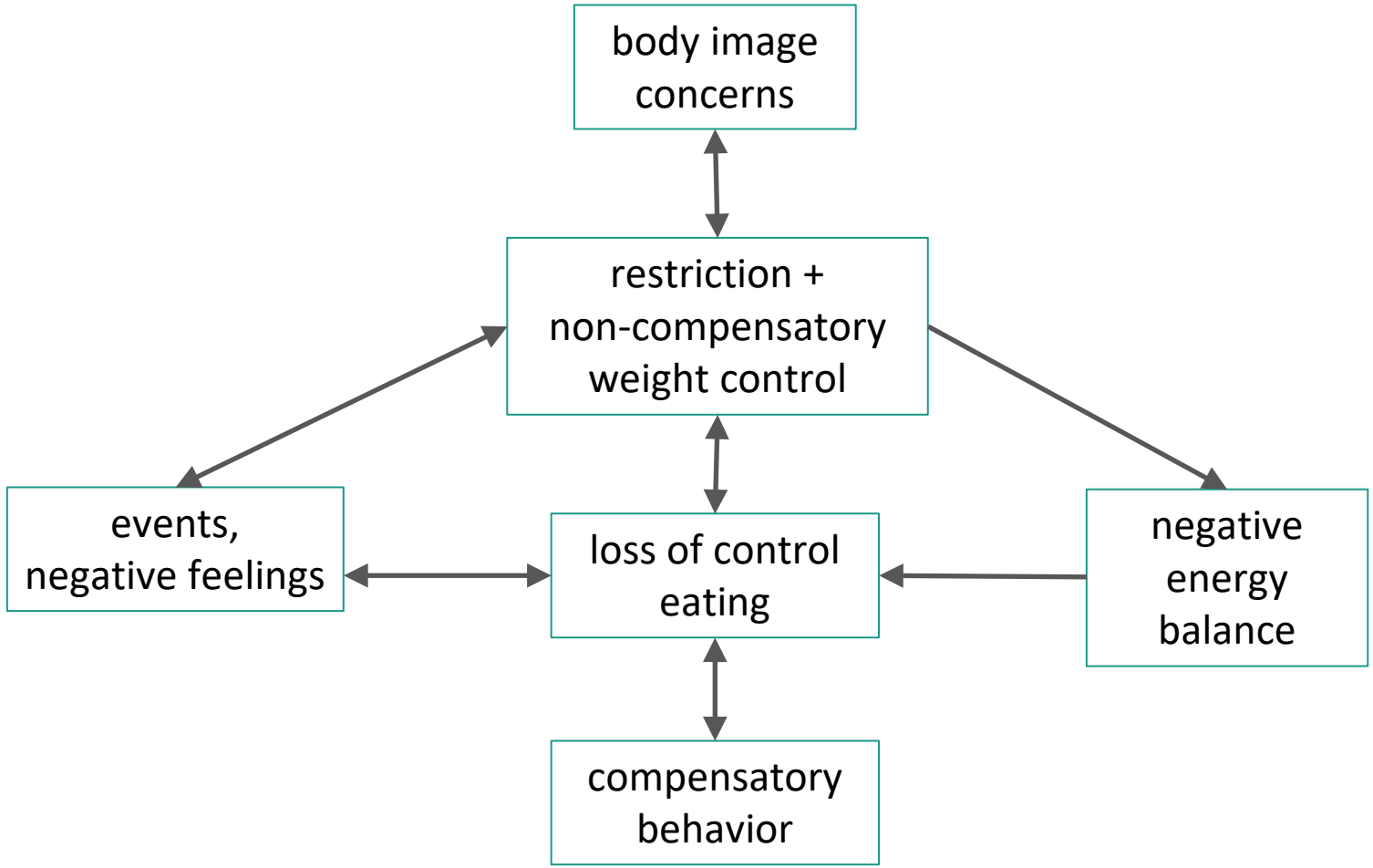
Cognitive Behavioral Therapy

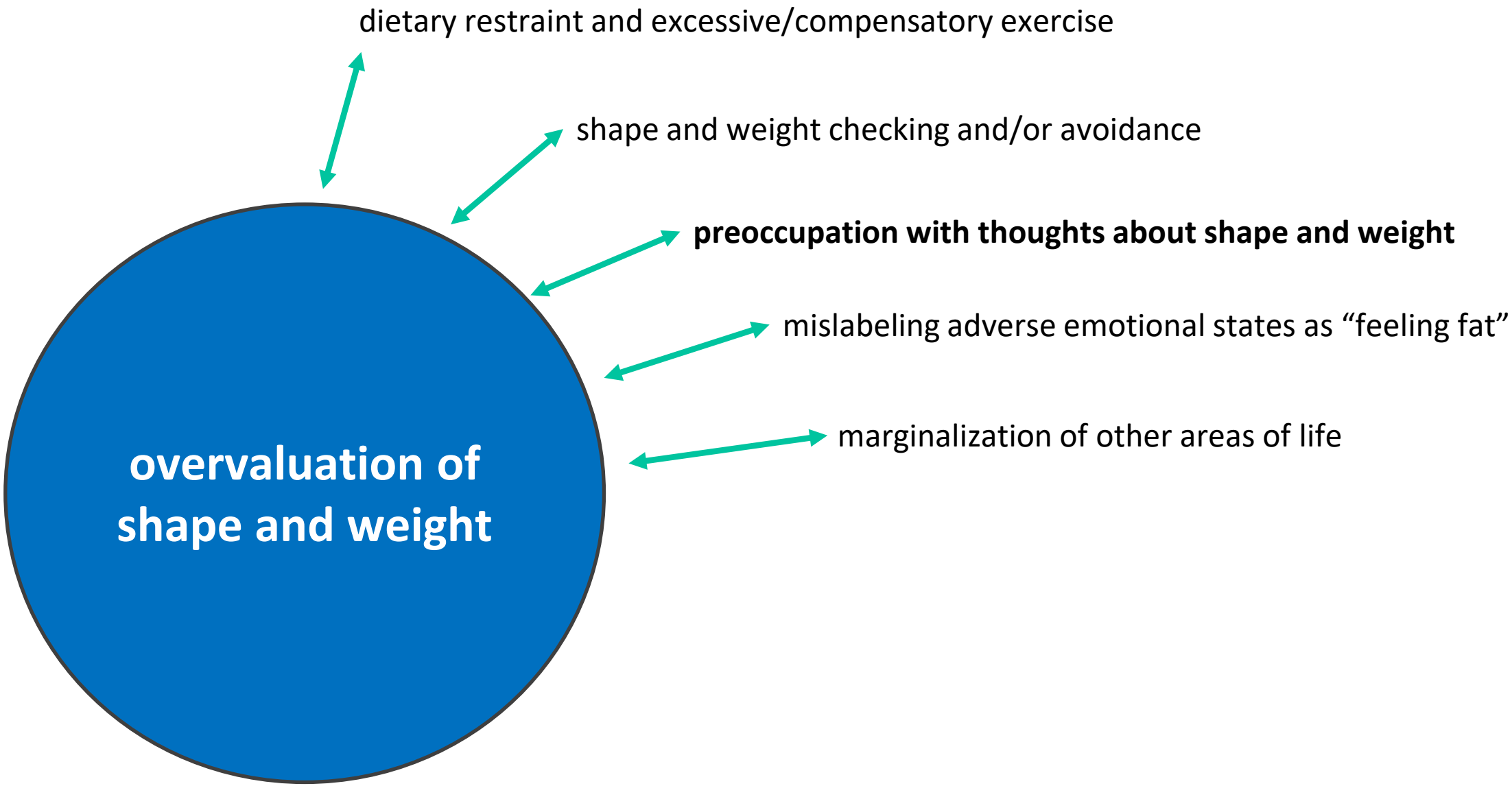
- Early topics and techniques
  - Reviewing the formulation
  - Assigning early goal of regular eating
  - Real-time self monitoring (meals/snacks, binge eating, compensatory behaviors, moods) with in-session review of homework
  - In-session weighing
  - Education about weight checking, how EDs develop and are maintained over time

Binge Eating Triggers

- Dietary restraint
- Negative mood
  - General
  - Specific to food and/or body
- Interpersonal stressors
- Boredom

CBT-E: Transdiagnostic Formulation




dietary restraint and excessive/compensatory exercise
shape and weight checking and/or avoidance
preoccupation with thoughts about shape and weight
mislabeling adverse emotional states as “feeling fat”
marginalization of other areas of life
overvaluation of shape and weight

Regular Eating

- Reduces binge tendencies and challenges restrictive behaviors
- Restores hunger/fullness cues (delayed gastric emptying)
- Highlighting thoughts, feelings, behaviors, and values that maintain ED
- Core components:
  - 3 planned meals and 2-3 snacks per day
  - No eating in the gaps
  - Not more than 4 hours between meals
  - Meals don’t count if followed by purging
  - If underweight, increase intake by approx. 500 calories/day

Self-Monitoring Form

Date/Time	Food/Liquid Consumed	Place	Binge?	Purge?	Context and Comments

Later Phases in CBT-E

- Body image
  - Self-esteem
  - Body checking/comparison
- Dietary restraint
  - Dietary rules
- Event-related changes in eating
  - Chain analysis
  - Coping skills

Later Phases in CBT-E

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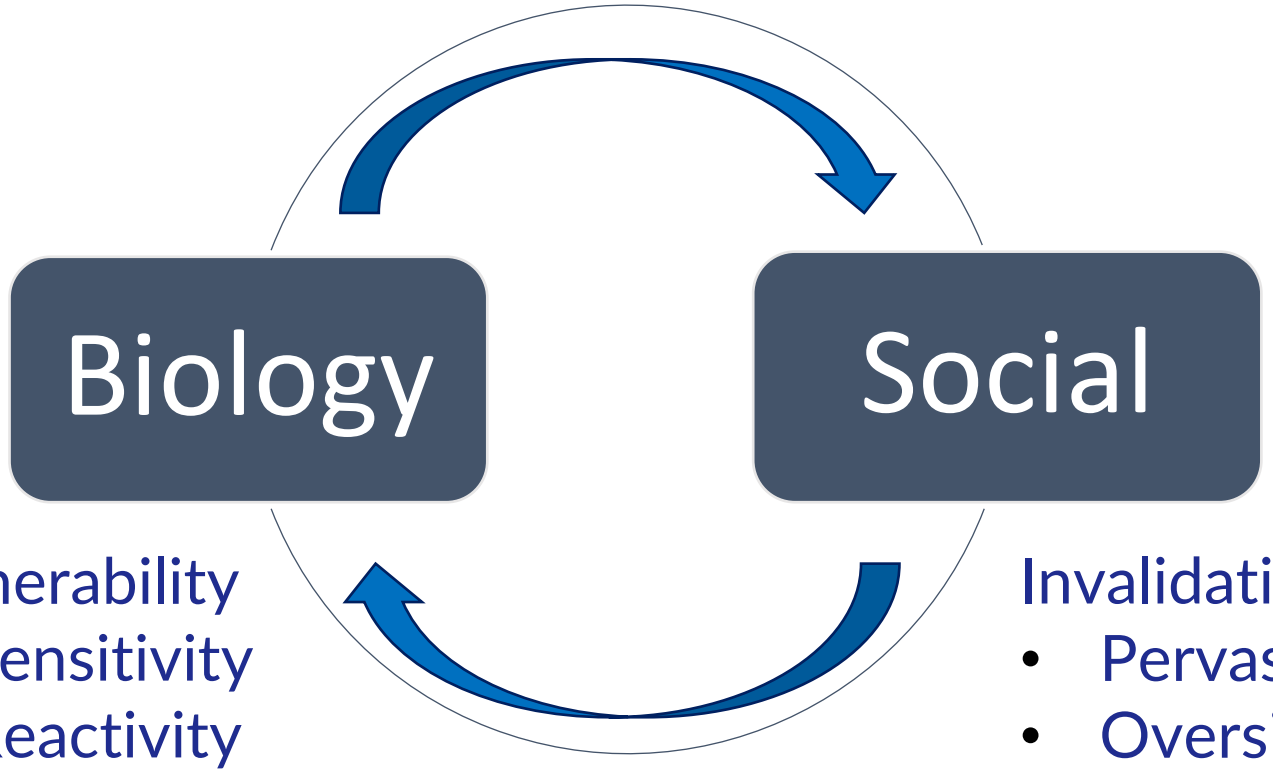
Mental Health Care

Dialectical Behavior Therapy

Dialectical Behavior Therapy

- DBT developed for adults with Borderline Personality Disorder (Marsha Linehan)
- Biosocial Theory of Pervasive Emotion Dysregulation – biological predisposition + invalidating environment
  - BN: emotional lability
  - AN: difficulty with identification/awareness of emotion, extreme avoidance of emotion; inhibited expression of emotion
  - Nutritional vulnerability: dysregulation of systems that regulate eating behavior
  - Impulsive or self-harming behaviors developed in an attempt at regulating emotion

Biosocial theory of pervasive emotion dysregulation



Emotional Vulnerability
- Emotional Sensitivity
- Emotional Reactivity
- Slow Return to Baseline

Invalidating Environment:
- Pervasive Invalidation
- Oversimplification
- Ignore/Punish Emotion Expression & Intermittently Reinforce Escalations

Comprehensive DBT

Weekly Individual Therapy

Improving Motivation

Weekly Skills Training Group

(if adolescent client, this includes parents too)

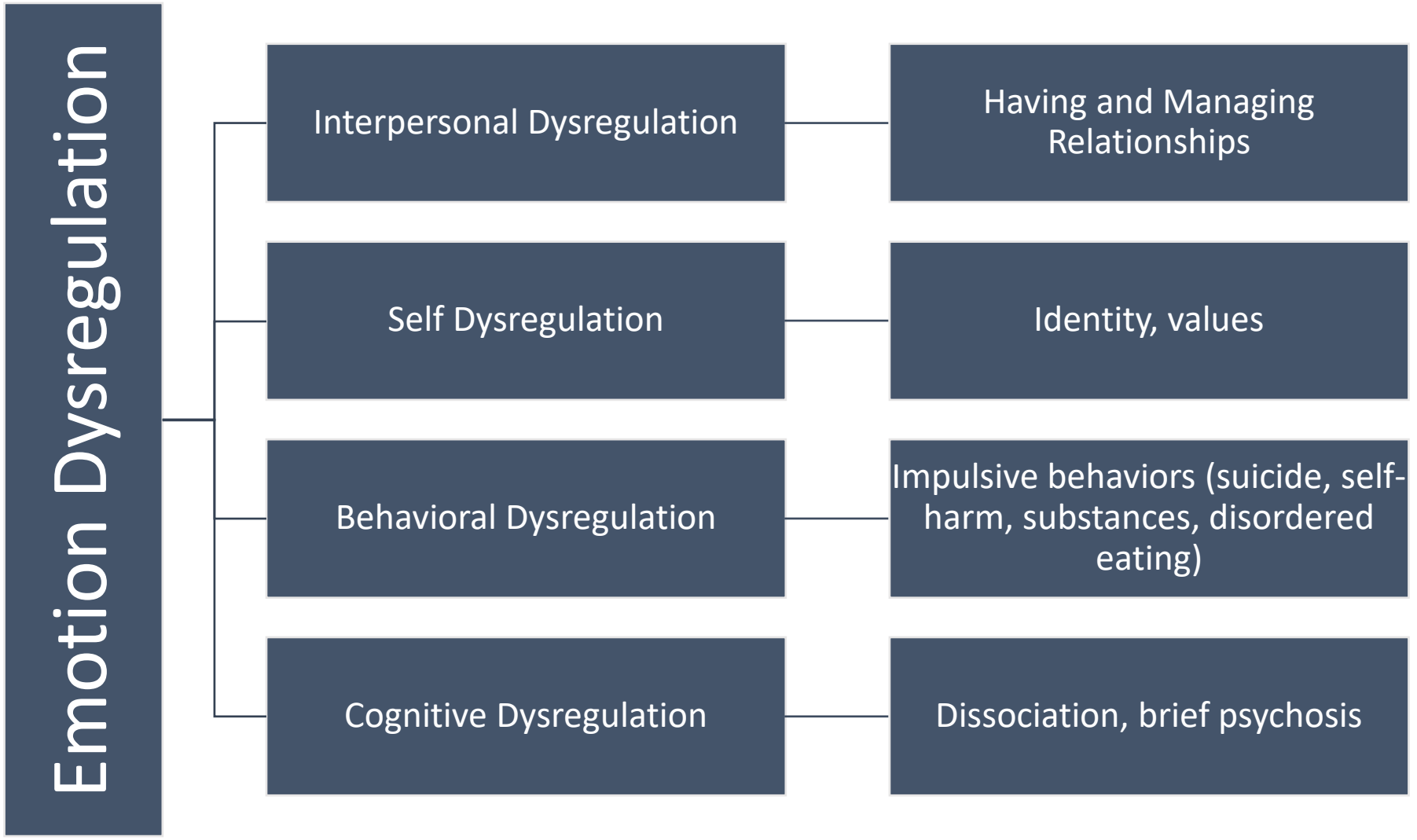
Enhancing Capabilities

Phone Coaching

Assuring Generalization

Therapist Consultation Team

Enhance therapist capabilities and motivation


Emotion Dysregulation
Interpersonal Dysregulation
Having and Managing Relationships
Self Dysregulation
Identity, values
Behavioral Dysregulation
Impulsive behaviors (suicide, self-harm, substances, disordered eating)
Cognitive Dysregulation
Dissociation, brief psychosis

Questions