Promoting Connection and Communication to Identify and Manage Eating Disorders on Campus: Part I

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Eating Disorders on Campus

- If left unidentified and not aggressively treated, ED's can become persistent and severe and lead to functional impairment, morbidity, and death.
- 95% of those who have ED's are ages 12 – 25.
- Approximately 40% of individuals with ED's report onset between ages 16 – 20.
- College-age students are among those at high risk for the onset of eating disorders (ED's).

Eating Disorders on Campus

- In a survey of 185 female students on a college campus, 58% felt pressure to be a certain weight, and of the 83% that dieted for weight loss, 44% were of normal weight

- 25% of college-aged women engage in bingeing and purging as a weight-management technique

- During freshman year a significant number of college students experienced an increase in one or more symptoms of disordered; eating; 25% began dieting for first time; 15% of women began binge eating for the first time; An ↑ in perceived stress, sense of ineffectiveness, and negative feelings about weight were associated with a worsening of disordered eating symptoms during the freshman year (Striegel-Moore et al., 2006).

- Approximately 10% of college females suffer from a clinical ED.

- The mortality rate associated with anorexia nervosa is 12 times higher than the death rate associated with all causes of death for females 15-24 years old

AED World Charter

The Rights of People with ED's and Carers:

I: Right to communication and partnership with health professionals

II: Right to comprehensive assessment and treatment planning

III. Right to accessible, high quality, fully-funded, specialized care

IV. Right to respectful, fully-informed , age-appropriate, safe levels of care

V. Right of carers to be informed, valued, and respected as a treatment resource

VI. Right of carers to accessible, appropriate support and education resources

www.aedweb.org

EATING DISORDERS ARE DISEASES OF DISCONNECTION

- Disconnect patient from herself and others
- Disconnect family from other families
- Disconnect family from staff
- Disconnect treatment team from one another

DISCONNECTION: The Essence of Eating Disorders

Disconnection the patient experiences ***intrapersonally***:

- from her/his authentic self (i.e., one's genuine thoughts, feelings and needs)
- from her/his body (i.e., accurate sensing and interpretation of bodily states)

Disconnection the patient experiences ***interpersonally*** with others

Disconnection the family experiences ***interpersonally*** with patient and others outside the family due to psychological distress related to caregiving

Intrapersonal Processes

- A series of activities occurring internally that (in normal growth and development) allow the individual to develop a coherent and integrated sense of self (Bowlby, 1969; Maine, 1995).

- Include biological and psychological activities that allow the individual to accurately sense and effectively process visceral, cognitive, and affective information.

- E.g., When an individual feels grief, intrapersonal processes include:
  - -stimulation of related neural circuits,
  - -the person internally sensing heaviness in her/his chest
  - -attempts to process and make sense of cognitive and affective information related to the loss of the loved one.

- Influence development of conscious and unconscious mental representations of the self (Siegel, 2012; Winnicott, 1965) and the individual's ability to be connected with her/his authentic self and body, (e.g., ability to embrace, tolerate, and regulate internal and external stimuli) (Gratz & Roemer, 2004; Miller & Stiver, 1997; Schore, 1994).

Interpersonal Processes

- **A series of activities occurring between individuals in relationship that (during normal growth and development) contribute to a strengthening of relationships with others and an increased feeling of perceived mutuality (i.e., mutual empathy, trust and understanding) (Genero, Miller, Surrey, & Baldwin, 1992; Jordan, 2010; Miller & Stiver, 1997).**

- **Include processes at work during expression of emotions, cognitions, and behaviors.**

- **<u>E.g., interpersonal processes characterizing grief can involve:</u>**
  - **tearfulness**
  - **expression of sadness**
  - **reaching out to others for support**

- **Influence development of identity, self-worth and self-efficacy.**

Intra- and Interpersonal Processes Interact

These processes interact in a reflexive way because the embodied self grows within the context of mutual connections with others (Chodorow, 1978; Miller and Stiver, 1997; Bowlby 1969; Piran and Mafrici, in press)

For example, the intrapersonal processes operating at the level of neurocircuits that regulate affect depend on interpersonal processes allowing for development of secure attachments (Bowlby, 1969; Main, 1995; Schore, 1994) and perceived mutuality in relationships with others throughout life (Miller and Stiver, 1997).

At the same time, the interpersonal processes operating when individuals experience perceived mutuality in relationships are facilitated by intrapersonal processes that allow for organization and regulation of emotion (Siegel, 2002; Schore, 1994).

Intra- and Interpersonal Processes

- **In healthy growth and development intrapersonal processes strengthen connections within the brain, the embodied self, and with close others.**

- **Illness states such as ED's can produce intra- and interpersonal processes that contribute to disconnection instead of connection (Cozolino, 2006; Kaye et al., 2009; Lask & Frampton, 2011; Schmidt & Treasure, 2006; Siegel, 2012).**

- **ED's can be viewed as *Diseases of Disconnection* (Tantillo, 2006; Tantillo & Sanftner, 2010a, 2010b) because they involve intra- and interpersonal processes contributing to disconnection from the self, the body, and close others.**

Disconnection Experienced Intrapersonally

"I don't think it's all about control. I think it's about the disconnect. [The eating disorder is about]… underlying emotions… for me it was very numbing like I just didn't want to feel. There were a lot of scary things going on that I just didn't want to deal with… it kept me very isolated. … that numbness is the ultimate disconnect. I think that is what I wanted… I didn't want to gain weight because I knew that…I would start feeling again.

Young adult with anorexia nervosa)

Disconnection Experienced Interpersonally

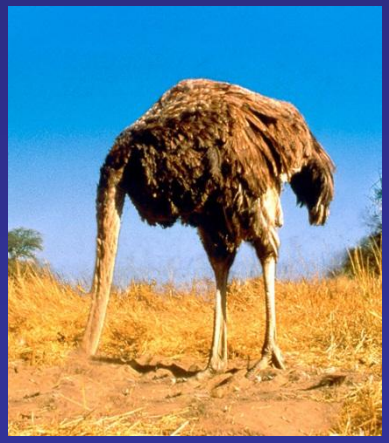
"You just think of an eating disorder as someone's having trouble with eating, but that really hit the nail on the head when you talked about disconnect and isolation because we saw M- becoming a different person…a younger kid. But we didn't realize how much we as a family had disconnected from other people… I was disconnecting from him (spouse) and her (patient)…I think it helps when you focus on the disconnection… helps to take the blame off people. Then you can focus on it as a disease…by starting to rebuild all those relationships, I was able to help her more. And to me, it was the biggest part of it."

(Mother of a young adult with anorexia nervosa)

Repeated Family Disconnections

- Negative relational messages preclude access to authentic experiences (e.g., unable to identify or express feelings of vulnerability).
- Use of strategies (unconscious) to manage underlying pain/conflict and ED symptoms…

Avoidance



Overprotective

Aggression

Serious and Repeated Disconnections

- Disconnections without relational repair are the most damaging in personal and therapeutic relationships because they provide:

  - Repeated lack of validation for patient and family experiences

  - Lack of empathy for difficulty of change.

- Erode perceived mutuality in relationships that promotes healing, growth, and recovery.

Interpersonal Disconnections

Disconnection: A disturbance in the flow of relationship that prevents or interrupts the experience of perceived mutuality and is characterized by:

- Low self-worth
- Disempowerment
- Low energy, tension, feeling locked up or out
- Feeling confused re: the self, other, and the relationship; intolerance of difference
- Wanting less connection; isolation

Perceived Mutuality (PM)



- **Perceived Mutuality (PM) in relationships is associated with:**

  -Mutual empathy and empowerment,

  -Protection against disconnection, and

  -Support repair of disconnections when they occur.

(Jordan 2010; Miller & Stiver 1997; Tantillo 2006; Tantillo & Sanftner 2010)

Engaging Patients and Families in Treatment: Naming and Repairing Disconnections

Identify and repair points of tension and disconnection patient and family experience in r/t the ED, recovery, and relationships.

Identify the points of tension and disconnections that occur among treatment team members including patients/family, providers, and others involved in the care of the patient (e.g., friends, school personnel, coach).

Develop perceived mutuality = mutually empathic and empowering connections with self and others that encourage disconnection from ED

Use an Integrated Relational/Motivational Approach to engage, assess, and treat patients and families.

Integrated Relational-Motivational Approach to EDs

Patient, family and therapist grow through:

- **Naming difference and disconnection**
- **Engaging in relational repair**
- **Strengthening communication and connection**

Clinician's Tasks:

- **Match motivational strategies to patient stage of change AND**
- **Create Perceived Mutuality in relationships with patient and family**

An Integrated Relational/Motivational Approach to Treatment of ED's

Stages of Change Theory (SOCT) allows the therapist to track patient stage of change and intervene with an effective change process (Prochaska, Norcross, and DiClemente, 1994) .

Motivational Interviewing (MI) A collaborative and client-centered approach that helps patients move along these stages because it resolves ambivalence about change and increases discrepancy between life values and goals and the impact of the ED (Miller & Rollnick, 1992).

Relational-Cultural Theory (R-CT) is at the heart of the integrated relational-motivational approach because it is specifically concerned with identification of intra- and interpersonal disconnections and the promotion of perceived mutuality in relationships (Jordan, 2010; Miller and Stiver, 1997; Steiner-Adair, 1991; Tantillo, 2004, 2006; Tantillo & Sanftner, 2010b)

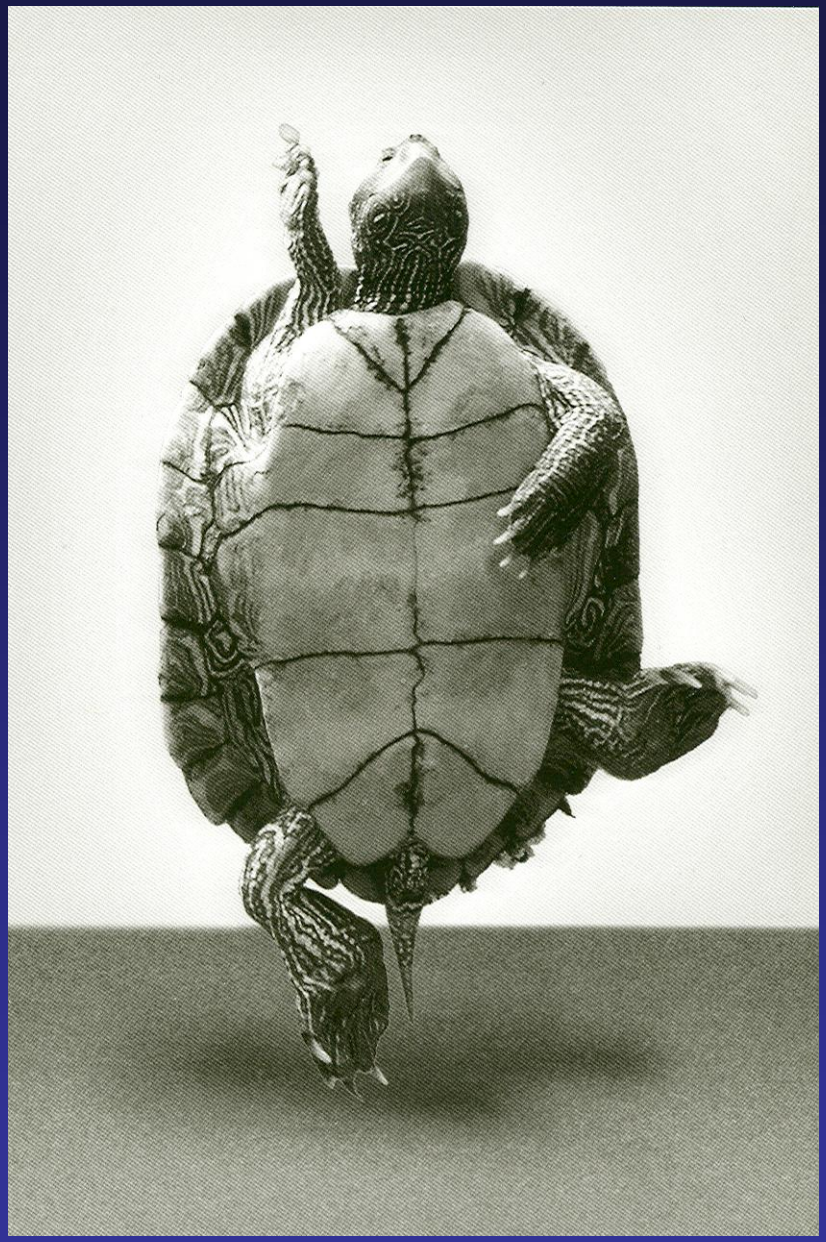
Lifetime Prevalence of Eating Disorders

- AN: Females =.9% Males = .3%
- BN: Females = 1.5% Males = .5%
- BED: Females = 3.5% Males = 2%

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). *Biological Psychiatry, 61,* 348-358.

DSM-IV TR Criteria for Anorexia Nervosa

- Refusal to maintain weight at or above minimally normal weight for age and height or failure to make expected weight gain (<85% of that expected).
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in how weight and shape are experienced; undue influence of weight and shape on self-evaluation, or denial of seriousness of current low body weight.
- In postmenarcheal females, amenorrhea (absence of 3 consecutive menstrual cycles).



Boogie Down

DSM-IV TR Criteria for Bulimia Nervosa

- Recurrent episodes of binge eating (eating in a discrete period of time an amount of food larger than most people would eat during the same time and under the same circumstances; sense of lack of control).
- Recurrent inappropriate compensatory behavior to prevent weight gain.
- Binge eating and compensatory behaviors occur at least twice per week x 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- Disturbance does not occur exclusively during episodes of Anorexia Nervosa.


2002, MALENE THYSSEN

Just Chilling

DSM-IV TR Criteria for Binge Eating Disorder

- Recurrent episodes of binge eating (eating in a discrete period of time an amount of food larger than most people would eat during the same time and under the same circumstances; sense of lack of control).
- Binge eating is associated with 3 or more of following:
  - eating much more rapidly than normal
  - eating until uncomfortably full
  - eating large amounts of food when not hungry
  - eating alone because of embarrassment
  - feeling disgusted with oneself, depressed, guilty
- Binge eating occur at least 2 days per week x 6 months.
- Marked distress regarding binge eating is present.

Comorbid Psychiatric Illness and Eating Disorders

- Affective Disorders
- Anxiety Disorders
- Substance Abuse
- Personality Disorders

Family History of Patients with Eating Disorders

Higher rates of:

Eating Disorders

Obesity

Affective Disorders

Anxiety Disorders

Substance Abuse

Personality Disorders

Mortality and Eating Disorders

- Eating Disorders have the highest mortality rate of all psychiatric illnesses.

- The mortality rate for AN is 5.6% per decade and up to 20% during a 20 year follow-up.

- AN has a 6-fold increase in mortality compared to general population. Also increased death rate r/t natural causes, e.g., cancer (Papadopoulos et al., 2009).

- Crow et al (2009) found elevated mortality rates for BN and EDNOS that were similar to those for AN and found high suicide rates for those with BN.

- Leading causes of death are suicide, starvation/purging (e.g., cardiac arrest), and alcohol abuse.

- 20-30% of deaths from AN are d/t suicide (Sullivan et al., 1995; Harris & Barraclough. 1998).

EATING DISORDERS AND SUBSTANCE ABUSE: A LETHAL COMBINATION

- **Alcohol–abusing women attempt suicide 4 times more often than non-alcoholic women. Among adults with alcohol use disorders, the suicide rate is equal to men. However, women attempt more often.**

- **Alcohol use at follow-up is one of the strongest and most consistent predictors of fatal outcome (Keel et al. 2003)**

- **1/3 of women with anorexia nervosa who develop alcohol dependence do not have alcohol-related problems at the beginning of their anorexia course (Keel et al. 2003) . Need good follow-up.**

- **Alcohol misuse is a recognized risk factor for suicide and is also found to be over-represented in women with anorexia who also have a history of suicide attempts (Favaro et al. 1997).**

EATING DISORDERS – DISEASES OF DISCONNECTION

Biopsychosocial Risk Factors:

Biology: Serotonergic Disturbance; Starvation; Binging/Purging

Psychology: Disconnections; Relational mismatches

Socio-Cultural: Toxic Societal Values that objectify women's (and men's) bodies and teachus to value ourselves from the outside in

Spirituality: Hopelessness; Meaninglessness; Isolation

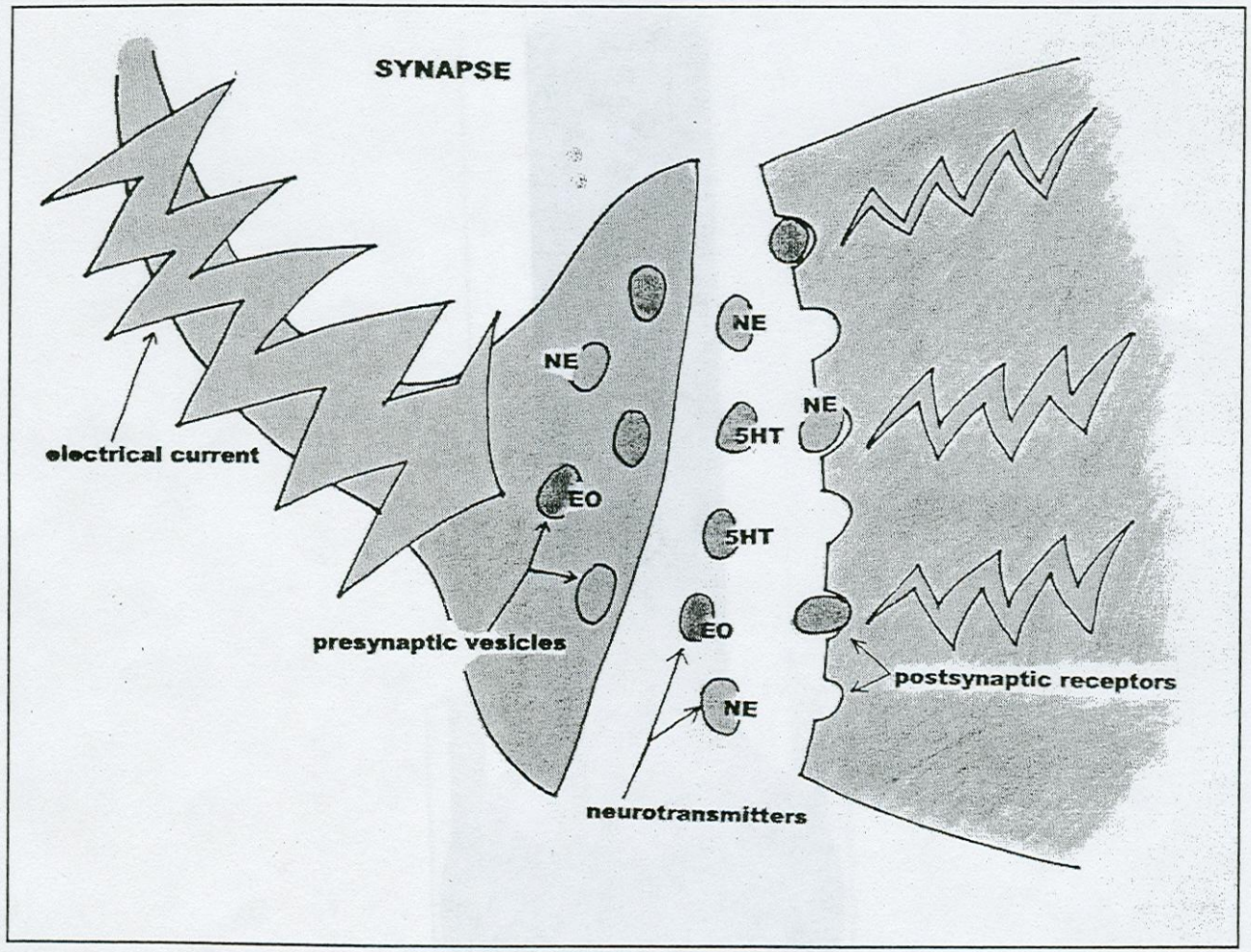
Intrapersonal Processes that Can Lead to Disconnection

Genes and Environment

Family aggregation, twin, and linkage and association studies all suggest a role for genetic risk & environment:

- **Heritability estimates: AN – 48%-76%; BN – 54%-85%**
- **Family morbidity and comorbidity**
- **What is inheritable may be eating regulatory mechanisms, temperament and character styles, and biologic predispositions such as ovarian hormone activity**
- **chromosome 1 (AN-R) and 10 (BN)**
- **polymorphisms on various candidate genes regulating body weight, appetite, eating behavior, and serotonin**
- **disconnection in how brain integrates information**

FIG.2 SYNAPSE



(Amy Banks, 2001)

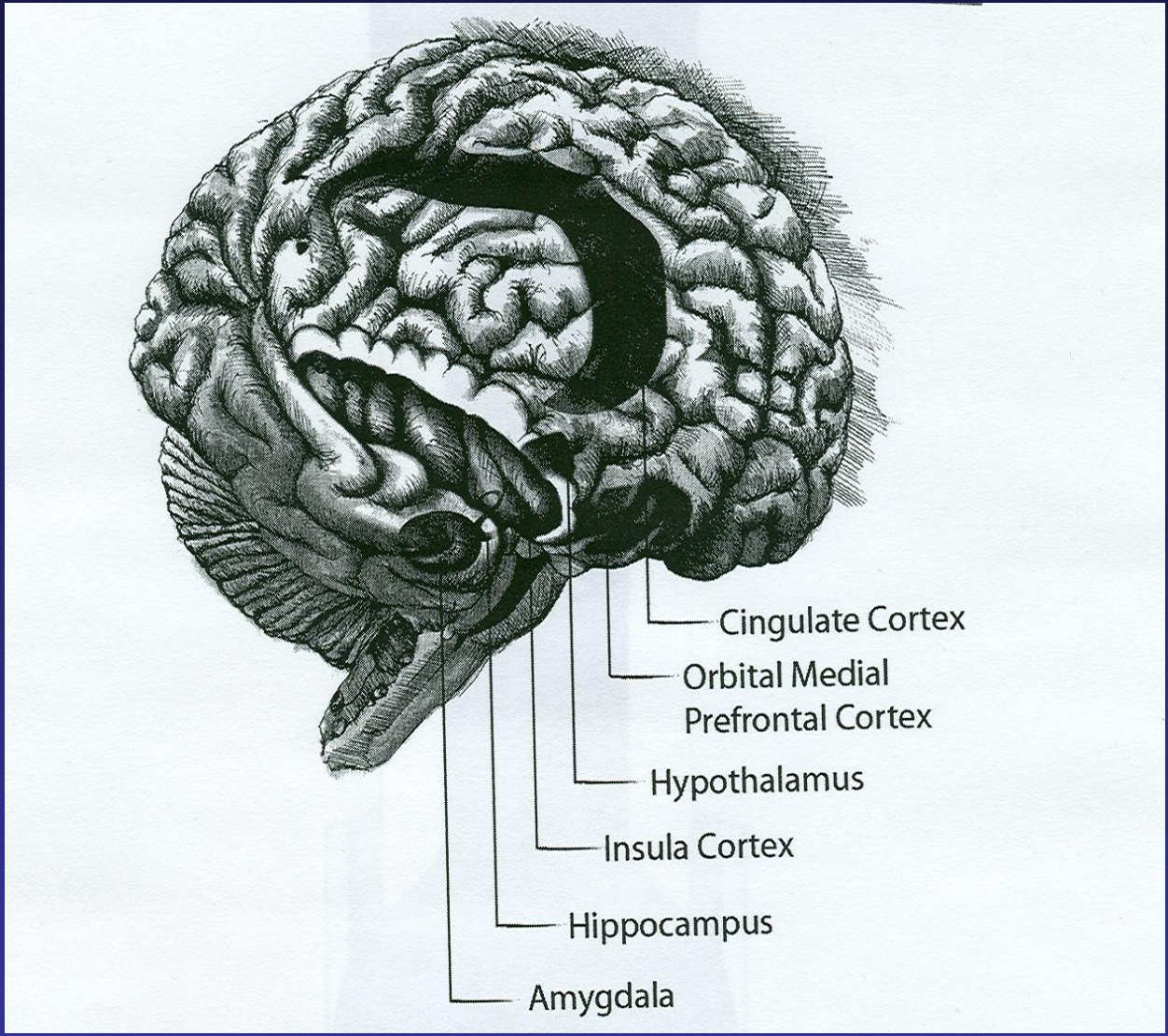


Figure 2.6 Structures of the social brain. The structures represented here are hidden beneath the surface of the brain (Cozolino, 2006 in Siegel, 2007, p. 39).

Disconnections Within the Brain

1. <u>Consistent findings:</u>
   a) unilateral hypometabolism, predominantly in the temporal region (66-75%)

   b) severe deficits in executive functioning (e.g., cognitive rigidity (poor set shifting) and in visuo-spatial memory (66%)

2. The hypometabolism & cognitive deficits persist at follow up, independent of weight/BMI, mood, EDE

3. There is a significant correlation between the hypoperfusion and the cognitive deficits

(Lask, 2006)

Key Dysfunctions in AN and Their Primary Structures

i) Distorted body image	Somato-sensory cortex
ii) Increased anxiety	Amygdala
iii) OCD and excessive drive	Basal ganglia
iv) Enhanced sense of reward	Nucleus accumbens
v) Visuo-spatial deficits	Parietal cortex
vi) Executive impairments	Frontal cortex

How might these be connected? (Lask, 2006)
Disconnection in neural circuits converging in the insula.

FIGURE 151. Subject Nos. 26, 20, 111, and 101 Sun-Bathing during the Final Week of Semi-Starvation. Photographed by *Life* photographer Wallace Kirkland. Copyright *Time, Inc.*

Keys, et al

The Biology of Human Starvation

U Minnesota Press

1950

SYMPTOMS OF LOW ENERGY INTAKE (STARVATION)

- Hair
- Skin
- Headache
- Fainting, dizziness
- Chest pain
- Constipation
- Loss of menses
- Fatigue, weakness
- Cold intolerance
- Irritability
- Depression
- Obsessive-Compulsive traits
- Social withdrawal
- Conflict
- Food related habits
- Body image distortion
- Loss of appetite

SIGNS AND SYMPTOMS OF VOMITING OR LAXATIVE ABUSE

Physical health

- Weight loss
- Electrolyte disturbance
  - ↓ K
  - ↑ CO_2
- Dental enamel erosion
- Low blood volume
- Knuckle calluses

Mental health

- Guilt
- Depression
- Anxiety
- Confusion

Kreipe, 2005

Interpersonal Processes that Can Lead to Disconnection

Family stress and illness can lead to an experience of decreased perceived mutuality

Family members at risk for increased disconnection:

- Experience of low self-worth/shame
- Disempowerment
- Inability to tolerate difference/tension
- Feeling “locked up or locked out” of relationship
- Self-doubt/confusion re: oneself, others and relationship
- Increased isolation.

My mother called to say she had left my daughter's birthday cake out on the counter. She said she forgot to put it away. She knew this could be a trigger for me. I said, "That's OK, mom. It's too late anyway." I had already binged on the cake…I didn't want her to make that cake anyway. My daughter had planned for me to get her a special princess cake, but my mother said she needed to bake her one. She didn't listen to me. She never listens to me…I guess my binging took care of all that.

(Holly, 1/05)

Disconnecting from Oneself to Maintain Connections

"In situations with family, it's so inappropriate to have different opinions,…the smallest trace of being different makes it easier to not be liked…I was so cautious of the way I sat and the words I used when I was over there tonight. I didn't want to make a wrong move, make the wrong comment, or even sit, walk wrong. I have to close off every part of myself when I'm with them. I have to lock it away."

(Betty, 10/21/03)

In the face of significant and especially repeated experiences of disconnection, we believe that we yearn even more for connection to others. However, we also become so afraid of engaging with others about our experiences that we keep important parts of ourselves out of connection; that is we develop strategies for disconnection.

(Miller, J. B., & Stiver, I.P. (1994). Movement in therapy: Honoring the strategies of disconnection. *Work in Progress*, No. 65, Wellesley, MA: The Stone Center; Miller & Stiver, 1997)

Mutual Relationships

Mutual relationships are characterized by:

"The Five Good Things:"

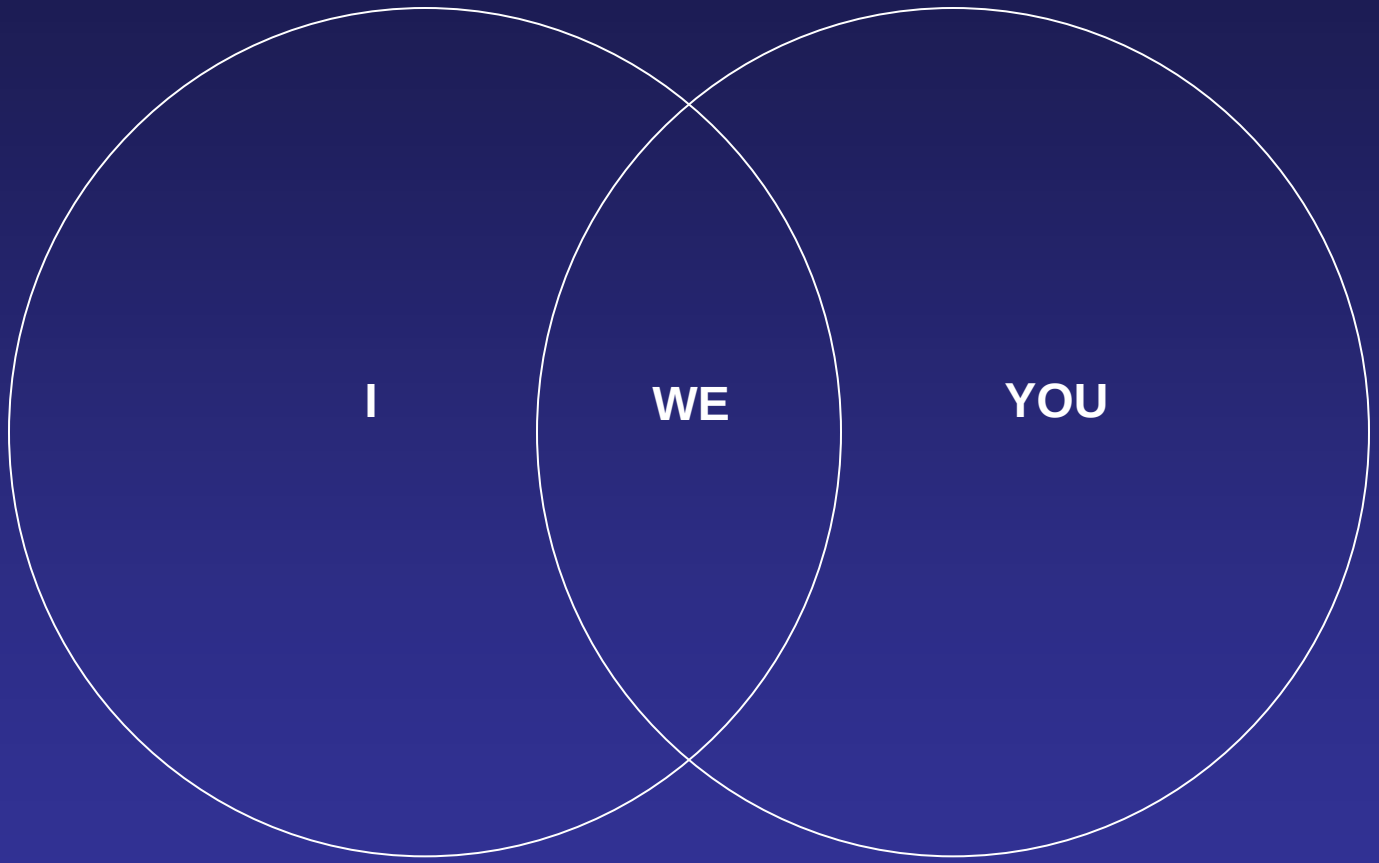
- **Self-worth**
- **Sense of energy/zest**
- **Increased clarity re: oneself, the other, and the relationship**
- **Increased sense of empowerment**
- **Increased desire for more connection**

Perceived Mutuality: The Healing Factor that Repairs Disconnections

- Bidirectional flow of thoughts, feelings, activity
- Sensing one influences others and allowing oneself to be influenced by others
- Involves emotional vulnerability, attunement, responsiveness to subjective experience of the other
- Takes in the wholeness of the other (similarities and differences)

(Jordan, 1986; Miller and Stiver, 1997)

Mutual Relationships



Mutual relationships honor the integrity of the connection between people and space for each person in the connection. Mutual relationships allow for difference in connection.

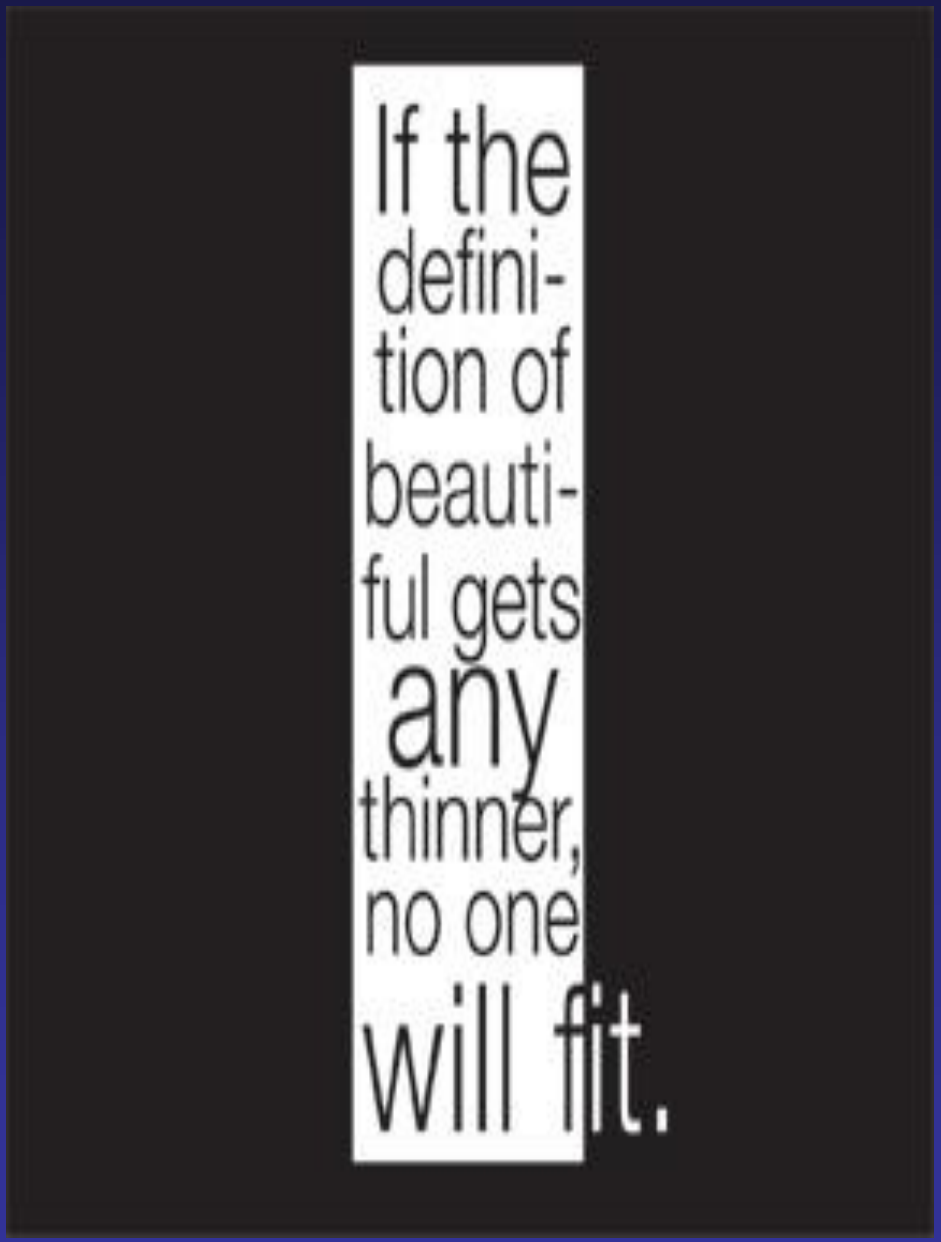
Relational Images and Meanings that Lead to Strategies for Disconnection

Relational Image: When I try to convey my experience, no one is listening to me.

Relational Meaning: This is because I am unlovable, unworthy, defective, to blame.

Strategies for Disconnection: (To avoid the pain r/t the above image and meanings and to maintain available connections) – e.g., eating disorder behaviors/thoughts & denial of illness.

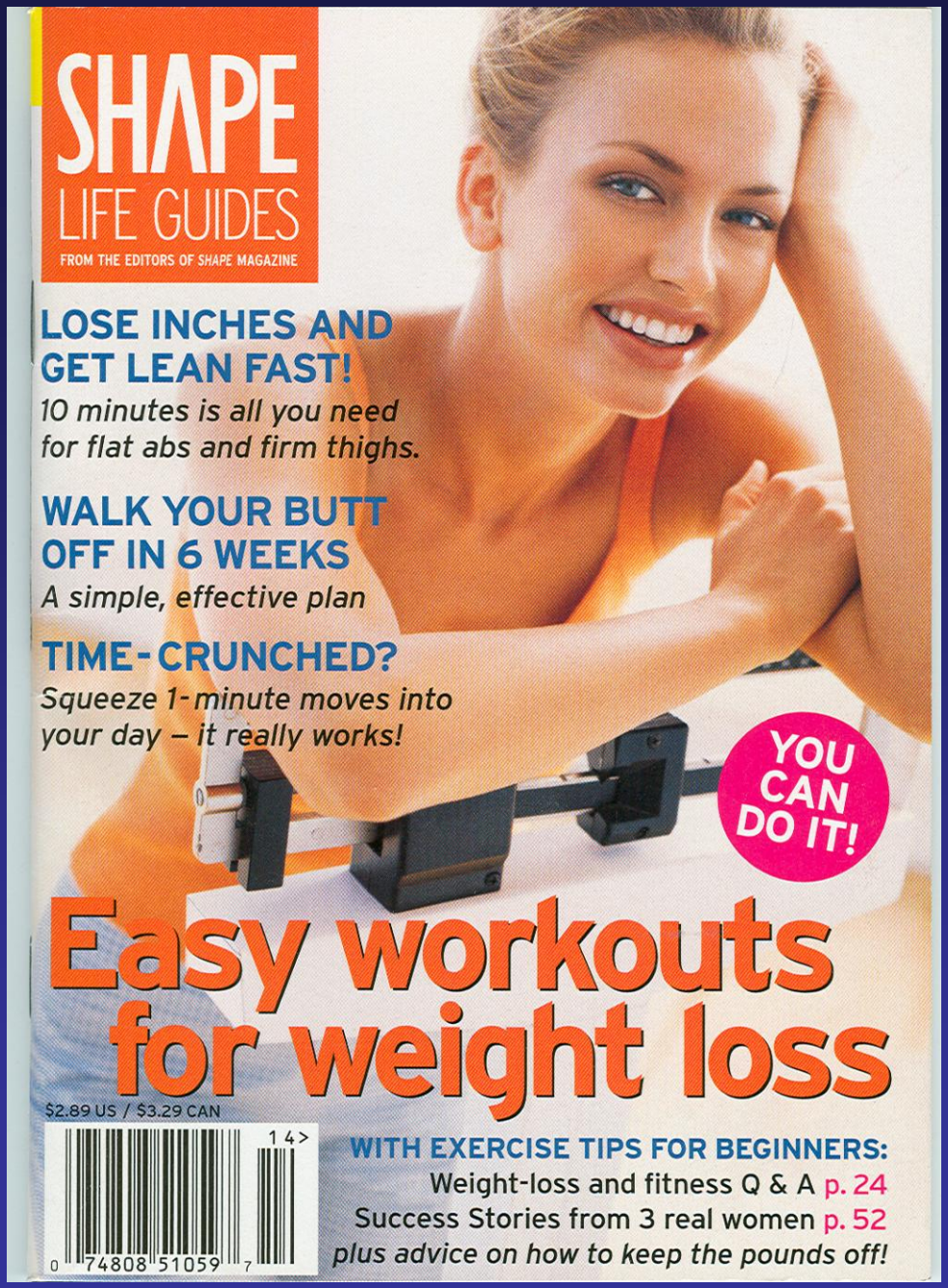
Sociocultural Values Promote Disconnection from Our Bodies and Ourselves


If the
definition of
beautiful gets
any
thinner,
no one
will fit.

Toxic Sociocultural Values That Promote Disconnection from Our Bodies and Ourselves

- Thinness, ultra-independence, control, appearance, performance, consumerism, individualism bordering on narcissism, etc.
- Linking control and success with thinness and appearance
- Objectifying women's bodies
- Socializing women and men to value themselves from the outside in
- Multiple, ambiguous, and contradictory role expectations for women
- Doing vs. Being (together) e.g., decreased family meals
- Emphasis on the "I" and the "me," not the "we"


God Bless America
Woman's World
THE WOMAN'S WEEKLY
WW reader Cheryl lost 33 lbs!
PIG OUT EVERY WEEKEND
and lose 5 lbs a week!
Discover the proven cheat-and-lose trick that cranks up your metabolism by bingeing on "forbidden" treats!
The breakthrough new pill that Guarantees good health!
Get your DREAM HAIR!
Salon tricks that'll give you hair this perfect!
Save hundreds with the Secret discounts most people overlook!
NEW RESEARCH How cocktails and shopping sprees can Lower your breast cancer risk!
Easy, delicious Spud-lovers' suppers!
Lemon-Raspberry Mousse Pie
No bake!
$1.49 March 30, 2004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10 minutes is all you need for flat abs and firm thighs.
WALK YOUR BUTT OFF IN 6 WEEKS
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Success Stories from 3 real women p. 52
plus advice on how to keep the pounds off!


RALPH LAUREN
Blue Label
asters.blogspot.com

SPECIAL WEIGHT-LOSS ISSUE!

Tons of Useful Stuff

Men's Health

LOSE YOUR GUT!

RESULTS IN JUST 9 DAYS

6-MINUTE MEALS FOR 6-PACK ABS!

MORE ENERGY INSTANTLY!

TAP YOUR SECRET SOURCE

LAUGH AT DANGER

NASCAR SUPERSTAR CARL EDWARDS SHOWS HOW

135 FAST HEALTH FIXES

LOOK YOUR BEST NOW!

More Sex, Hotter Sex! p.134

TONS OF USEFUL STUFF

Men's Health

Amazing New Plan!

LOSE YOUR GUT!

SCULPT YOUR BODY IN JUST MINUTES A DAY!

MUSCLE UP YOUR DIET

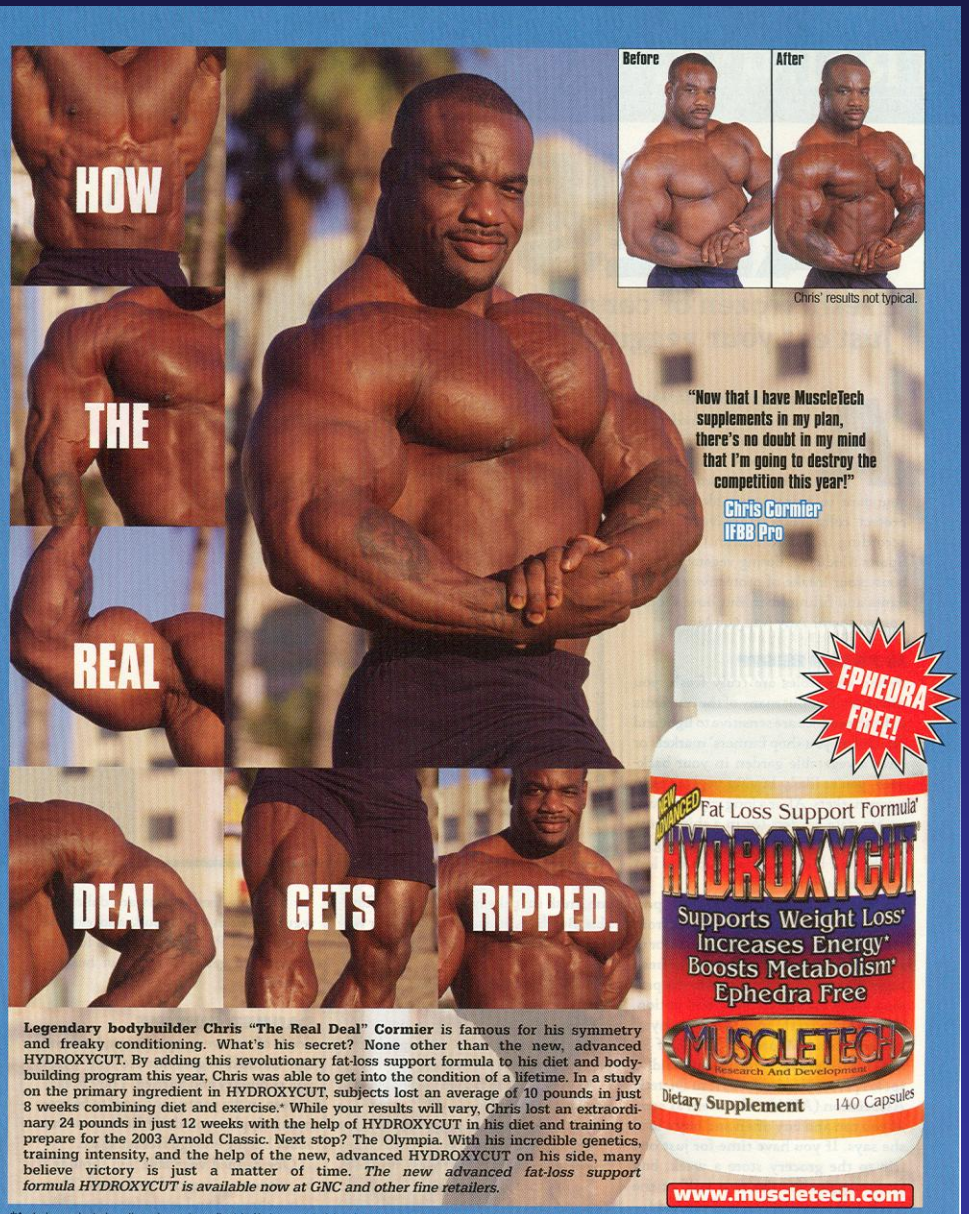
LOOK YOUR BEST NOW!

AVOID *THESE* MISTAKES

THE MIND/BODY WORKOUT

STRENGTH & CALM

Abercrombie



Legendary bodybuilder Chris "The Real Deal" Cormier is famous for his symmetry and freaky conditioning. What's his secret? None other than the new, advanced HYDROXYCUT. By adding this revolutionary fat-loss support formula to his diet and bodybuilding program this year, Chris was able to get into the condition of a lifetime. In a study on the primary ingredient in HYDROXYCUT, subjects lost an average of 10 pounds in just 8 weeks combining diet and exercise.* While your results will vary, Chris lost an extraordinary 24 pounds in just 12 weeks with the help of HYDROXYCUT in his diet and training to prepare for the 2003 Arnold Classic. Next stop? The Olympia. With his incredible genetics, training intensity, and the help of the new, advanced HYDROXYCUT on his side, many believe victory is just a matter of time. *The new advanced fat-loss support formula HYDROXYCUT is available now at GNC and other fine retailers.*

*A study conducted on the primary ingredient in Hydroxycut (calcium/potassium salt of 60% HCA extract from *Garcinia cambogia*) showed that subjects lost an average of 10 pounds in 8 weeks combining a 2000-calorie per day diet and 30 minutes of walking, 5 days per week. Individual shown has been remunerated. These statements have not been evaluated by the FDA. This product is not intended to diagnose, treat, cure, or prevent any disease. Read entire label and carefully follow directions. Regular exercise and proper nutrition are essential for achieving your weight-loss goals.

Select

Spirituality and Disconnection

- Meaninglessness
- Isolation – Condemned isolation
- Aloneness

EATING DISORDERS: DISEASES OF DISCONNECTION

Eating disorders are “diseases of disconnection” in which a biogenetically vulnerable individual has difficulty staying connected to and developing an authentic sense of self within relationships with others. This struggle is intensified with the effects of starvation, binging or purging and a culture that emphasizes thinness, appearance, and performance.

Evaluation for Eating Disorders

SCREENING TOOLS FOR WOMEN WITH EATING DISORDERS

SCOFF (Morgan & Lacey, 2000)

- Do you make yourself sick because you feel uncomfortably full?
- Do you worry that you have lost control over how much you eat?
- Have you recently lost more than 14 lbs in a 3 month period?
- Do you believe yourself to be fat when others see you as too thin?
- Would you say that food dominates your life?
- Each “yes” = 1 point; a score of 2 points indicates a likely diagnosis of anorexia nervosa.

TABLE 7.2. Clinical Interview Checklist

1. Demographic features; treatment history; circumstances surrounding the initiation of treatment and the decision to involve the family
2. Current body weight and weight history
   a. Current weight and height
   b. Weight range at current height
      - Highest and lowest weight
      - Highest stable weight prior to disorder onset
      - Chronology of weight changes year by year
3. Weight-controlling behavior (frequency, intensity, duration)
   a. Dieting, fasting
   b. Vomiting
   c. Spitting food
   d. Exercise
   e. Substance misuse to control weight
      - Laxatives
      - Diuretics
      - Emetics
      - Amphetamines
      - Cocaine
      - Alcohol
4. Binge eating and eating behavior
   a. Frequency of binge eating over past 3 months (note fluctuations and longest period of abstinence)
   b. "Binge foods" (foods eaten and those that trigger episodes)
   c. Typical times and settings for binge eating
   d. Mood before, during, and after episodes
   e. Experience of loss of control?
   f. Description of eating
      - Intake when adhering to restrictive dieting
      - Intake when violating restrictive pattern
      - Estimated caloric intake when adhering to restrictive pattern
      - Specific dietary "rules"
5. Attitudes toward weight and shape
   a. Level of disparagement (whole body and specific regions)
   b. Misperceptions of shape
   c. Hypothetical question: "If gaining 5 pounds would eliminate all symptoms, could you tolerate the gain?" What effect would the gain have on mood and self-esteem?
   d. Frequency of weighings, weight preoccupations, intrusive thoughts about weight, response to weighing
   e. Perception of others' attitudes about patient's weight
6. Physical symptoms (see Mitchell, Pomeroy, & Adson, Chapter 21, this volume, for details)
7. Psychological, interpersonal, and familial data
   Cover all standard assessment areas, with particular emphasis on depression, substance use disorders, impulse control, sexual abuse, vocational capacity, and quality of interpersonal and family relationships.

Garner, D., & Garfinkel, P. E. (1997). Handbook of Treatment for Eating Disorders (2nd ed). New York: The Guilford Press.

Key Evaluation Questions for Eating Disorders

- Any recent changes in weight?
- History of weight fluctuations?
- What were meals eaten day before exam? Is this a typical pattern of eating?
- Is the patient binge eating?
- Amount of exercise in a week?
- Regularity of menstrual periods?
- Any compensatory mechanisms?

Engaging with Patients in the Evaluation

1) Be empathic and non-judgmental and adopt a more normalizing attitude, during history taking.

"Today you talked about feeling depressed and anxious and that you use alcohol to decrease these feelings. I also noticed that you have calluses on your knuckles and you said you felt out of control when you eat. Other patients who have experienced these things often say they are also struggling with binging and vomiting. Is this something you have been struggling with too? I want to be sure I understand what you are experiencing so we can make the best plan for you after we our done with the evaluation."

Engaging with Patients in the Evaluation

2) Patients minimize symptoms – aim high and seek clarification

- "When you say you vomit twice/day, do you mean twice in one episode or two separate episodes of vomiting in the day?"
- "When you said you took a few laxatives, how many exactly is that? More than 20 per day? 10 per day? 5 per day?"

Essential Labs and Studies for Eating Disorders

- Serum electrolytes
- Creatinine
- BUN
- Thyroid Function Test
- CBC with differential
- Blood glucose level
- Urinalysis

Indicated Labs and Studies for Eating Disorders

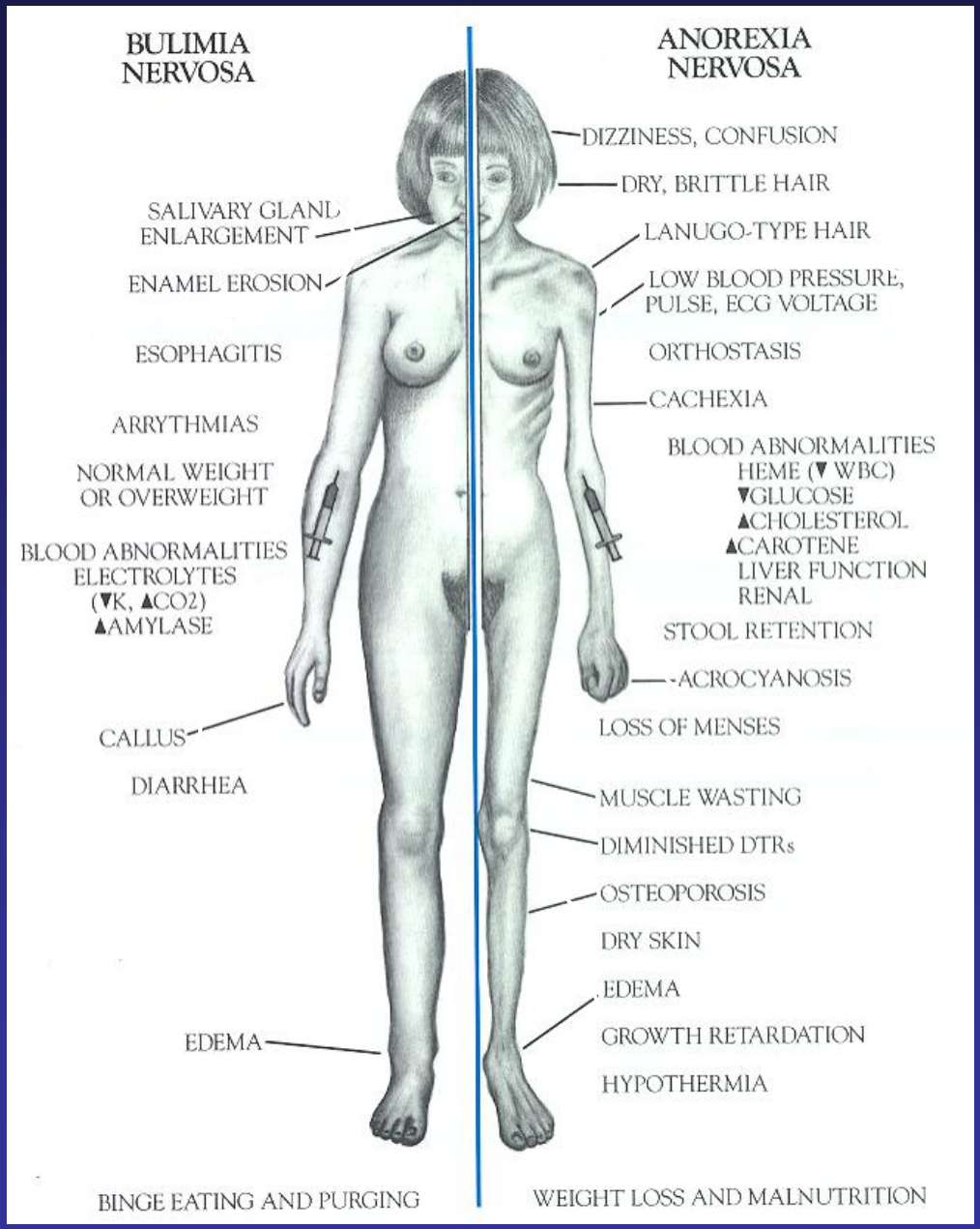
- EKG
- Cardiac ultrasonography
- Liver enzymes
- Stool specimens - guiac tests
- GI radiographic studies
- GI endoscopic studies
- Serum Amylase
- Calcium, Magnesium, Phosphorus
- Bone Density Studies

POSSIBLE TEST FINDINGS

- QT prolongation
- ST-T wave abnormalities
- Cardiomyopathy
- Diminished Cardiac Size
- Mitral Valve Prolapse
- Hypoglycemia
- Electrolyte Imbalance, e.g., hypophosphatemia, hypokalemia, hypochloremic alkalosis, hypomagnesemia, increased BUN, metabolic acidosis with low serum bicarbonate)

Signs and Symptoms Related to Malnutrition, Starvation, Dehydration, Purging and Refeeding

- Orthostatic BP Changes
- Weakness
- Dizziness
- Syncope
- SOB
- Palpitations
- Bradycardia
- Acrocyanosis
- Arrhythmia
- Peripheral/Pitting Edema
- Seizure Activity

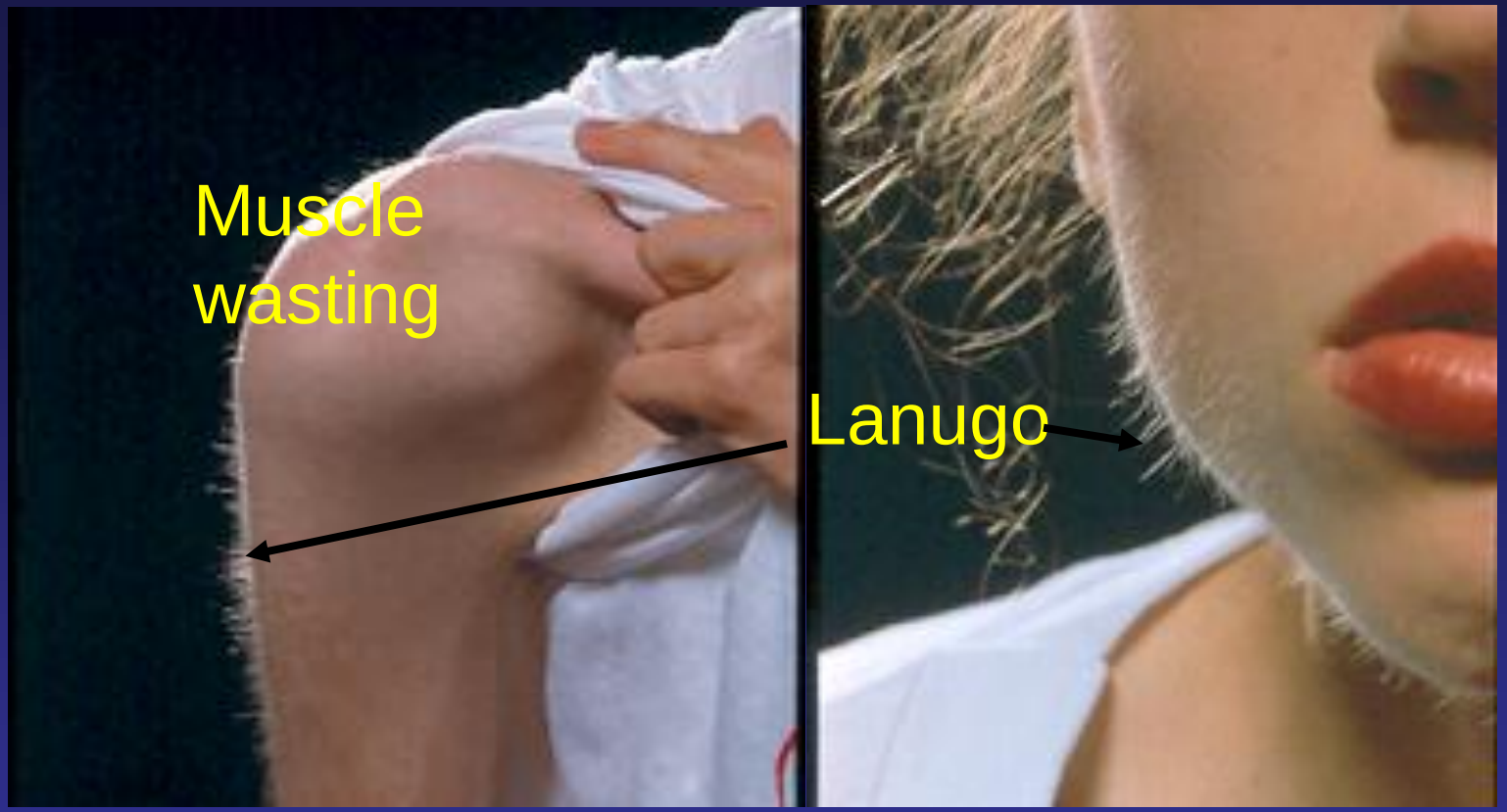


Affected Biological Systems

- Neurologic (CNS and PNS)
- Skin and Hair
- Cardiovascular
- Hematologic
- Hepatic
- GI: motility, absorption
- Endocrine (hypothalamic)
  - Thyroid
  - Growth hormone
  - Adrenal
  - Gonads
- Musculoskeletal

Kreipe RE. Assessment of Weight Loss in the Adolescent. Ross Labs. Columbus, OH 1988. Drawing by C. Lyons, MD

Malnutrition and Hypometabolism



- ⇓ Energy intake results in wasting of lean (muscle) > fat
- Metabolism occurs in the lean body mass>>>>>fat
- Energy conservation: ⇓ BMR; ⇓ Temp.; ⇓ HR; ⇓ Peripheral blood flow; ⇓ Physical activity
- ~70% of regained weight is lean body mass (Kreipe, 2007)

Indications for Hospitalization

- Severe malnutrition: Weight for height ≤75%
- Dehydration
- Electrolyte disturbances (e.g., hypokalemia, hypophosphatemia, or hypomagnesemia)
- Hepatic, renal, or cardiovascular organ compromise (e.g., cardiac dysrhythmia)
- Physiologic instability
  - Severe bradycardia or hypotension
  - Hypothermia ((e.g., <97.0°F)
  - Orthostatic pulse changes
- Acute food refusal
- Uncontrollable binging and purging
- Acute psychiatric emergencies
- Comorbid diagnosis interfering with treatment

http://www.adolescenthealth.org/html/eating_disorders.html

(Kreipe, 2005)

Weights taped around patient's chest. She added one weight each week.

Eating Disorders and Mental Status Changes

- Apathy
- Poor concentration
- Cognitive impairment
- Depression
- Irritability
- Lability

Eating Disorders: Dispelling Myths

- A patient can have normal lab values and have an eating disorder and be medically compromised
- Realize that a subgroup of patients starve themselves to look like they are in a “normal weight range for height and age.”
- Eating Disorders occur at any weight.

Treatment: It's All About Relationships

- **Parallels between relationships patient has with her/himself, others, and food and relationships among family and professionals**

- **What occurs on the team is a metaphor for what occurs within the patient, between the patient and family, and between the family and treatment team providers.**

Patients ↔ Families ↔ Providers

Growth in Connection

Increasing Collaboration and Communication Among Stakeholders

- Student
- Parents
- University Health Service Providers (physician, NP, dietitian)
- University Counseling Service Providers (therapist)
- Dean of Students (CARE Program)
- College Attorney (consultant)
- Primary Care Providers at home
- Therapist at Home
- Dietitian at Home

College Health Care Provider General Approach

- Validation (shame/secrecy)
- Direct and specific questions.
- Don’t assume
- Cognitive distortions, reasoning errors (all/nothing thinking, overgeneralizations, negative mental filtering, magnification, personalization, etc.)
- Be genuine, real (not opaque and distant)
- Name things
- Warmth and humor
- Be consistent and persuasive
- Educate
- Team approach and good communication helps avoid splitting

A RELATIONAL/MOTIVATIONAL APPROACH FOR PATIENTS WITH EATING DISORDERS

“Having an eating disorder is like being in a frying pan surrounded by horrendous flames. On the other side of those flames is recovery. My therapist and others are on the recovery side telling me to step out of the pan into the flames and to walk through the fire to reach recovery. I think to myself, “Are they nuts?!” Don’t they know how frightened I am to step into the fire? It will destroy me. I will die.This frying pan (eating disorder) is safe and protective because I know how to live in it. I know how to “be” in the pan.”

Cindy Nappa Bitter, 2001

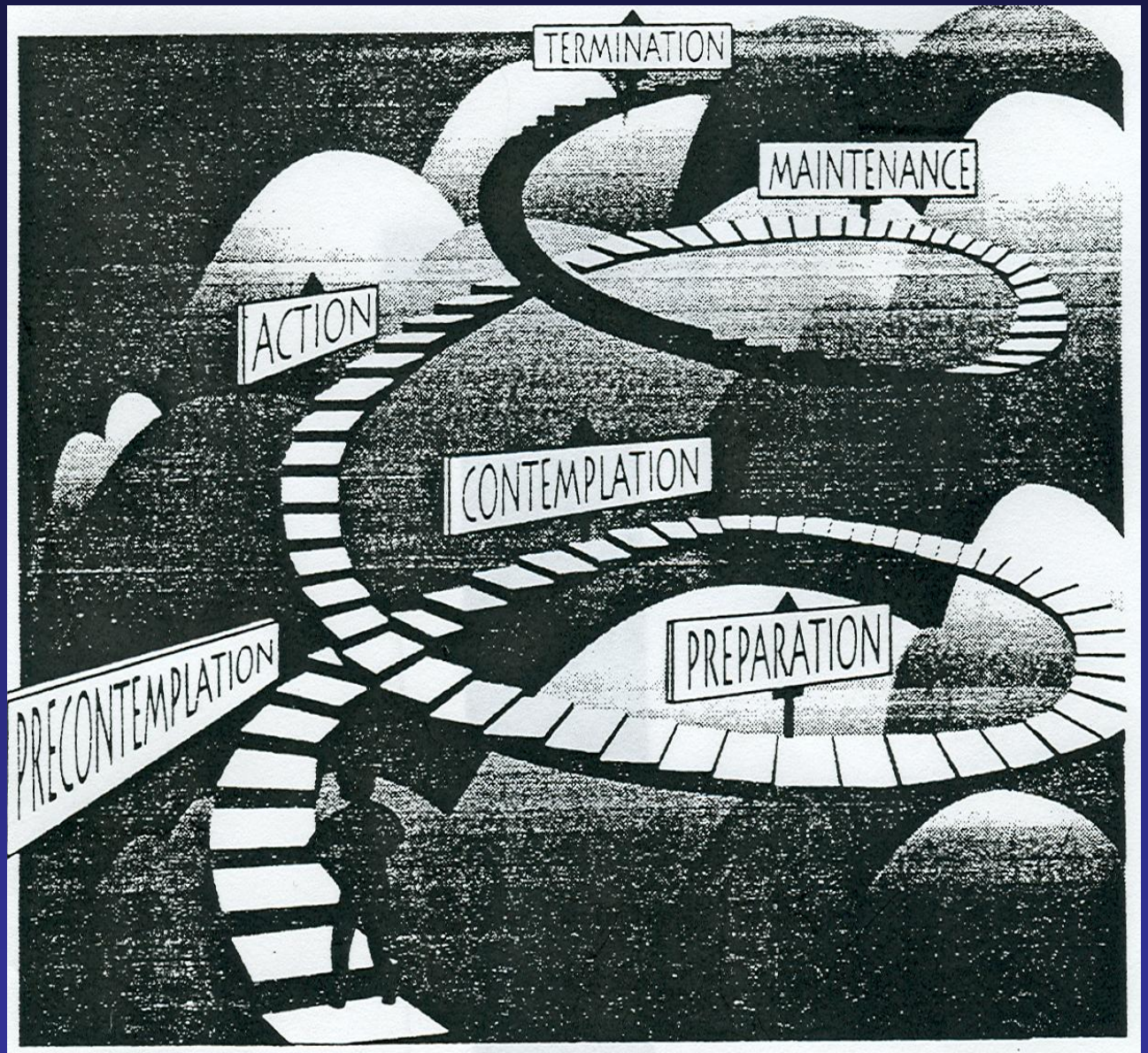


FIGURE 1. The Spiral of Change

Processes of Change

- Consciousness-raising
- Helping Relationships
- Social Liberation
- Emotional Arousal
- Self-reevaluation
- Commitment
- Countering
- Environmental Control
- Reward

- Prochaska, Norcross, & Diclemente, 1994

MOTIVATIONAL PRINCIPLES

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support Self-efficacy

(Miller & Rollnick, 2002)

Relational/Cultural Theory emphasizes that mutuality involves not only the therapist's ability to appreciate her/his impact on the patient, but also an openness to being moved by what the patient says and does, and a willingness to convey to the patient that s/he has been moved.

This process leads to increased self-empathy and mutual empathy among patients and family members, as well among patient/family and the therapist. Patients and family members realize their experiences do matter and can be part of relationship.

(Miller & Stiver, 1997; Tantillo, 2004; 2006; Tantillo, Nappa Bitter Adams, 2001).

The therapist's ability to remain aware of her/his own strategies for disconnection is important for movement with students and families along the entire spiral of change, but is especially critical in helping them jointly contemplate and eventually commit to change.

A Relational/Motivational Approach to Treatment of Eating Disorders

- Promote perceived mutuality
- Demystify the therapist's role and process of therapy
- Create shared value and expertise
- Normalize and validate symptoms/struggles
- Promote universality
- Be real, genuine, and emotionally present
- Learn the language and values of the student/family
- Build a new culture of shared meanings and common language with student and family
- Identify patient's (and family's) goals for treatment
- Let pts/family know that they affect you/that you value them

A Relational/Motivational Approach to Treatment of Eating Disorders (continued)

- Externalize the illness. Neither the student nor the family created the ED.
- Validate the burden incurred by the illness.
- Educate and share information
- Empower parents to empower their child.
- Encourage parents to work as a team
- Encourage parents to get respite and support for themselves.
- Remember that high expressed emotion is not helpful for the patient/family.

A Relational/Motivational Approach to Treatment of Eating Disorders

- Apologize/admit your own errors and limitations
- Model that it's OK to be imperfect so parents can feel comfortable with this as well
- Humor and humility
- Model an openness to difference and an ability to tolerate uncertainty, unpredictability and ambiguity
- Name all or nothing thinking and its negative impact
- Name relational dilemmas and let students see how you are thinking and feeling, while helping them name their own experience
- Create connection by allowing students in your head (how you think/feel)

A Relational/Motivational Approach to Treatment of Eating Disorders

- Raise consciousness re: stages and processes of change in recovery, the illness, and ways a patient may get in his/her own way.
- Help patient identify where s/he is on spiral of change and convey acceptance of this.
- Emphasize careful preparation for change to achieve action and sustained commitment to change
- Discuss and normalize feelings of denial and ambivalence

A Relational/Motivational Approach to Treatment of Eating Disorders (continued)

- Acknowledge the adaptive nature of the illness
- Identify meanings and purposes of the eating disorder
- Teach self-monitoring (identify connections among relationships with self, others, and food/the illness)
- Examine pros and cons of continuing or stopping eating disorder behaviors
- Examine discrepancies between patient's life goals/values and what they actually accomplish and experience with the illness
- Foster emotional arousal related to discrepancies and the negative effects of the eating disorder
- Identify supports/resources for recovery

A Relational/Motivational Approach to Treatment of Eating Disorders (continued)

- Educate students re: enabling vs. helping and mutual vs non-mutual relationships
- Balance self-care and care for others
- Introduce techniques for self-reevaluation (e.g., evaluation of present (negative consequences of the illness), as well as a forward looking assessment (a healthier and changed view of oneself).
- Emphasize the importance of thinking before acting, identifying all/nothing thinking, creating a new image of oneself in relationships with others without illness, and making realistic, informed decisions.

A Relational/Motivational Approach to Treatment of Eating Disorders (continued)

- Frame dilemmas in terms of the “we,” and put connection at the heart of the relationship
- Name disconnections and relational dilemmas quickly and engage in repair together
- Lapses and mistakes are opportunities for learning, not shaming (All of us)
- Foster communication/problem-solving skills.
- Remember all relationships naturally move from connection to disconnection and back. There are no perfect relationships. The best ones come from continual hard work and repair.

Increasing Collaboration and Communication Among Stakeholders

- If a student arrives with a known ED, obtain release to talk with parents whenever possible.
- If an ED is discovered once the student is on campus, work with the student to identify supports and promote disclosure.
- Obtain release of info to talk with parents and/or supports. The Disconnection perpetuated by secrecy and isolation is what kills individuals with ED's.
- Avoid Splitting. The ED does what it can to create disconnection. Work as a team. Be a unified front.

Increasing Collaboration and Communication Among Stakeholders

- The ED may be talking when you are interacting with the student.
- Do not assume therapy or medical monitoring is ineffective if the student complains about the practitioner.
- Do not assume that parents are ill-equipped to help or that they are not supportive of the student if the student complains about them.
- Check things out and corroborate information.
- More communication is better than less (schedule regular calls with stakeholders).

Disconnection Between the Carer and the Student

"I do not trust her anymore, especially with regards to what she told us she was eating…There is a lot of tension and conflict…She can be very distant. She is afraid that I meddle with her affairs. Our relationship lacks openness. I am afraid to say anything wrong."

"We just avoided the issues that became too awkward…because we could already see the sickness and the pain that she was in, and we didn't want to cause any more."

(Highet, Thompson, & King - focus groups with carers, 2005; Honey & Halse – in-depth interviews with parents of adolescents, 2005)

Disconnection Between Carers and Professional Team Members

"…we'd been [her] mum and dad for 16 years and we were used to working problems through with her, and then suddenly, these barriers came down and we felt that things were happening to her and being discussed with her and that we were being blocked out of it; yet we were the ones she had to come back to when they had had their little go with her."

(Tierney – qualitative interviews with parents of adolescents, 2005)

"There wasn't any other feedback other than, "Oh well that's difficult." And that's all the doctors would say."

(Honey, Boughtwood, Clarke, Halse, Kohn, & Madden, 2008 qualitative interviews with parents of adolescents, 2005, p. 47)

Increasing Collaboration and Communication Among Stakeholders

- Decide if you can offer specialty-based treatment or if you will provide general support and refer out to community-based, specialty-trained ED therapist.
- Ensure you have good supervision and assemble a strong multidisciplinary team. Designate a person to coordinate communication among stakeholders.
- If possible, establish identified providers who will work as a team with students with ED's.
- Establish a network of communication and support across campus (Dean's Office, University Health Service and University Counseling Center)

Increasing Collaboration and Communication Among Stakeholders

- Establish a visible and formal mechanism students, staff, and faculty can use to report concerns about a student (CARE Program)
- Train RA's about what to look for and the importance of timely report of concerns
- Use case review and treatment planning meetings to discuss management challenges and helpful strategies
- Obtain an ethics consultation and legal consultation as needed. DO NOT Treat the student in Isolation. The ED is hoping for this.

Increasing Collaboration and Communication Among Stakeholders

- Obtain input from all stakeholders when evaluating the student and making decisions referral and/or treatment.
- Send a written plan of care to all stakeholders to ensure continuity and consistency
- Clarify roles of all stakeholders involved with the student.
- Identify the students' supports on campus and at home. Involve them in treatment whenever possible to help them know how to offer support and promote recovery (including meal time assistance).

Attend Promoting Connection and Communication to Identify and Manage Eating Disorders on Campus: Part II

Carson Simms

Recovered Individual and University of Rochester Alumnus

Bharti Dunne

Mother and Outreach Specialist at Monroe Family and Youth Center

Amy Campbell JD, MBE

Assistant Professor, Center for Bioethics and Humanities and Dep't of Psychiatry, SUNY Upstate Medical University and SU College of Law

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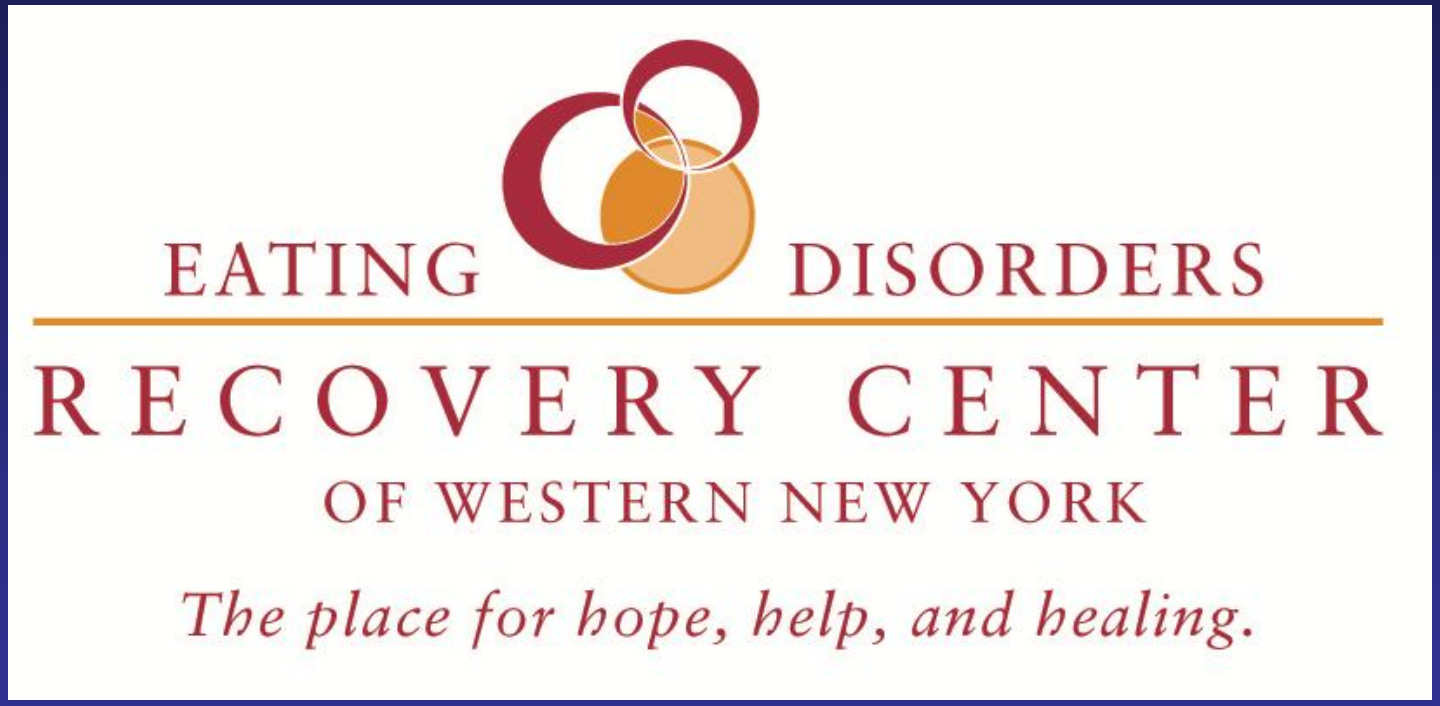
Ralph Manchester MD

Director, University Health Services, University of Rochester

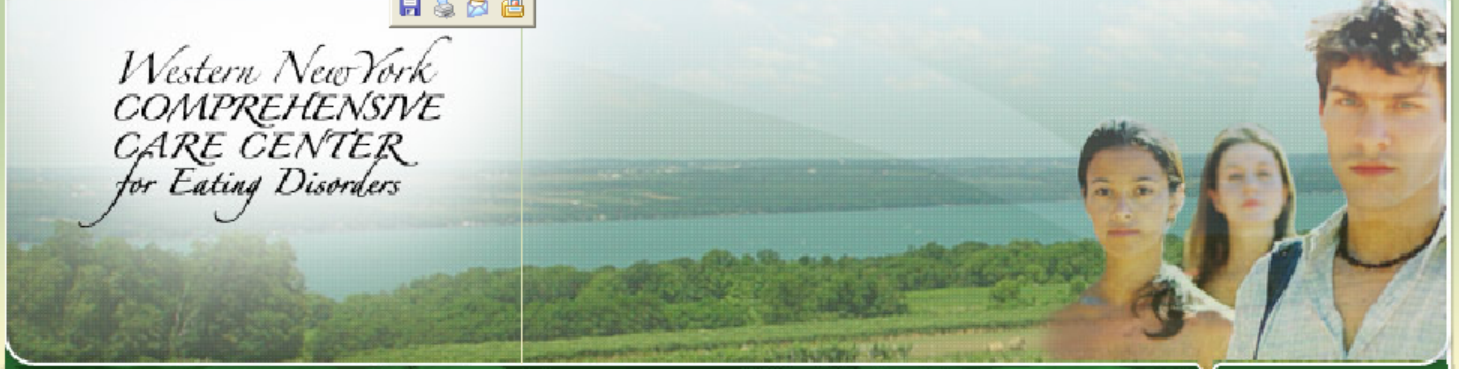
Mary Tantillo PhD PMHCNS-BC FAED

Director, Western NY Comprehensive Care Center for Eating Disorders


EATING DISORDERS
RECOVERY CENTER
OF WESTERN NEW YORK
The place for hope, help, and healing.

Draft Guidelines for NYSCCCEDs

1. Comprehensive and integrated services are provided to all individuals with diagnosed eating disorders.
2. CCCEDs provide/arrange for all required levels of care appropriate for individuals with eating disorders.
3. CCCEDs will have the capacity to provide or arrange for the full range of services appropriate for the care of individuals with eating disorders.
4. CCCEDs shall provide case management services for all individuals served by the Center.
5. Within the selected service area, the CCCED will sponsor programs that increase the awareness, early identification and treatment of eating disorders.
6. CCCEDs will conduct and participate in research programs to identify and address gaps in evidence based prevention and treatment methods.



HOME | EATING DISORDERS | NETWORK OF HELP | CONTACT US | LINKS

Welcome

Do you worry about your weight?
Do you ask for reassurance from others that you are not fat?
Do people get frustrated with you for constantly asking for reassurance?
Do you check yourself in the mirror to see if you've gained weight?
Do you check your body parts, like abdomen and legs, to see if they are fat?
Do you see yourself as overweight when others tell you are thin or too thin?
Do you view foods as safe or unsafe?
Do you go to great lengths to avoid foods that are fattening or unsafe?
Have you lost a significant amount of weight because you have restricted your food intake?
Do you starve yourself then overeat or eat large quantities and feel guilty?
After you overeat do you feel the need to purge?

New York State
Western New York Region

If you answered yes to one or more of these questions, you may have an eating disorder. Don't worry there is help.

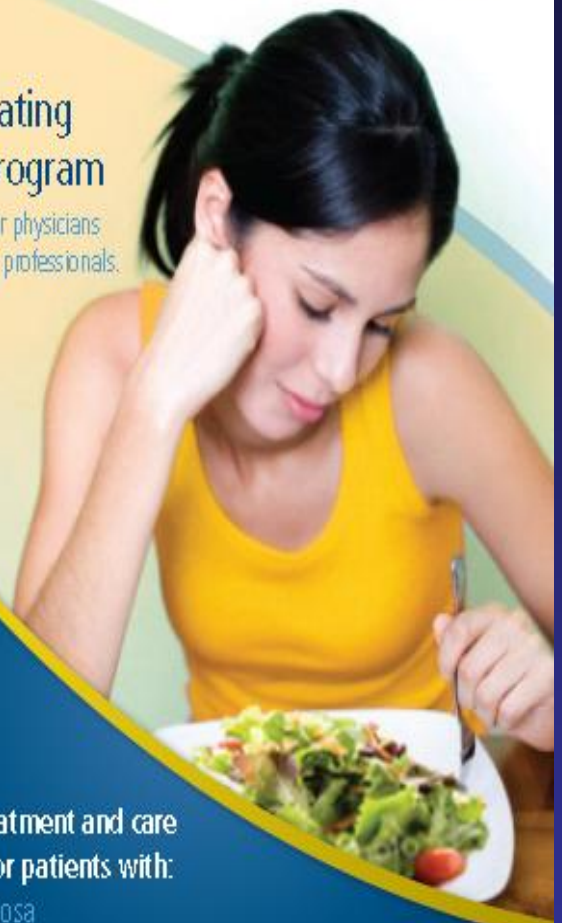
We are the Western New York Comprehensive Care Center for Eating Disorders (WNYCCCED). It's a big name but we offer big help. The WNYCCCED is one of three centers supported by the NY State Department of Health. Our centers form a network of services to help individuals and their families with eating disorders by providing early identification, case management services, individual assessment and awareness. The WNYCCCED can help you and your families in their journey toward recovery by understanding what creates and makes eating disorders happen. We also provide services that promote healthy and genuine thoughts, feelings, needs and behaviors. Please click on the map to find the locations nearest you. Then visit our "Network of Help" page to see all the resources that are available to you. Based on legislation developed by Senate Majority Leader Joseph A. Bruno that was signed into law in 2004 all our Centers follow the same guidelines, ensuring the quality and continuity of services offered statewide.

There is help, you don't have to deal with this alone, and our caring providers can put you on the right road to recovery.

GOLISANO
CHILDREN'S HOSPITAL

Pediatric Eating Disorder Program

A brief summary for physicians and other referring professionals.



Evaluation, treatment and care coordination for patients with:

- Anorexia nervosa
- Bulimia nervosa
- Eating disorders, not otherwise specified
  (including early or atypical conditions)

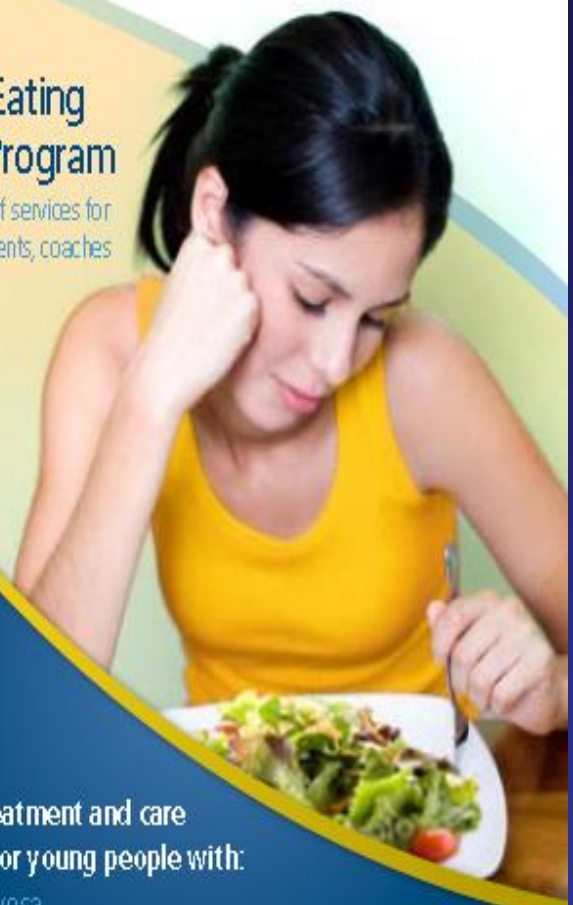
UNIVERSITY of ROCHESTER MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

GOLISANO
CHILDREN'S HOSPITAL

Pediatric Eating Disorder Program

A brief summary of services for young people, parents, coaches and counselors.



Evaluation, treatment and care coordination for young people with:

- Anorexia nervosa
- Bulimia nervosa
- Early or atypical eating disorders

UNIVERSITY of ROCHESTER MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

THE Healing CONNECTION LLC

585-641-0281 www.thehealingconnectionllc.com

Eating Disorders Partial Hospitalization Program, Fairport, NY

- 7 hour/day, Mon-Fri, 11:30 am to 6:30/7:00 pm (35hr/wk).
- Multimodal, multidisciplinary comprehensive treatment for adolescents and adults (≥ 12 years old).
- Normalization of eating, stabilization of weight, and improvement in other psychological or behavioral symptoms.
- Developmentally-informed, family-based, consumer-driven
- Multi-family Therapy, Family Therapy, Parenting Group, Group Therapy, Individual Therapy, Psychopharm Evaluation, Medication Maintenance, Nutritional Counseling, Therapeutic Meals, Case Management, Life Coaching, Yoga, and group work with recovered peer co-facilitators and family members.

St. Joseph's Villa of Rochester

Helena Boersma, MS, LMHC, NCC

Program Director

Harmony Place – Living Room

Websites for Eating Disorders Info

• National Eating Disorders Association NEDA	www.nationaleatingdisorders.org
• Academy for Eating Disorders	www.aedweb.org
• Eating Disorder Referral and Information Center	www.edreferral.com
• Bulimia Nervosa Resource Guide for Family and Friends	www.bulimiaguide.org
• Eating Disorders Recovery Center of Western New York	www.nyeatingdisorders.org
• Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.)	www.feast-ed.org
• Maudsley Parents	www.info@maudsleyparents.org
• The National Association for Males with Eating Disorders, Inc.	www.namedinc.org
• NIMH Booklet Eating Disorders	www.athealth.com/Add.eatingdisorder.html
• Gurze Books	www.bulimia.com

Eating Disorders: Good Outcomes

- Early onset
- Early intervention
- Friendships
- Motivation for and response to treatment

Eating Disorders: Poor Outcomes

- Severe eating pathology (conflicting reports)
- High frequency of vomiting
- Extreme weight fluctuations
- Impulsivity/Suicidal behaviors
- Low BMI
- Low BMI during inpt stay (<19)
- Duration of illness
- Poor Self-esteem

Factors that Increase Cardiac Risk in Eating Disordered Patients

- Severe and/or rapid weight loss
- Purge frequency (electrolyte disorders)
- Ipecac (emetine is toxic to cardiac muscle)
- Comorbid physiologic disorders (e.g., diabetes mellitus, inflammatory bowel disease)
- Older age or underlying cardiac disease