SPONSORED TOPICAL WEBINAR

An Educational Resource for APA members from McLean Hospital.

Treating Eating Disorders: The Importance of an Interdisciplinary Approach Across the Spectrum of Care

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David Alperovitz, PsyD



Holly Peek, MD, MPH

PRESENTERS

David J. Alperovitz, PsyD

- Program Director of Klarman Eating Disorders Center, McLean Hospital
- Assistant Professor of Psychology, Department of Psychiatry, Harvard Medical School

Holly S. Peek, MD, MPH

- Assistant Medical Director of Klarman Eating Disorders Center, McLean Hospital
- Instructor of Psychiatry, Harvard Medical School

DSM-5 Diagnostic Criteria



Anorexia Nervosa

- **Restriction** of food intake relative to requirements, leading to a significantly **low body weight**.
- **Intense fear of gaining weight** or becoming fat, or **persistent behaviors** that interfere with weight gain.
- **Body image disturbance**, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the illness

Anorexia Nervosa

BMI Severity:

- mild >17
- moderate 16-16.99
- severe 15-15.99
- extreme <15 (highest mortality)

Subtypes:

- Restricting Type
- Binge/Purge Type





Avoidant/Restrictive Food Intake Disorder (ARFID)

Eating disturbance causing failure to meet appropriate nutritional needs associated with 1 or more of the following:

- Significant weight loss
- Significant nutritional deficiency
- Dependence on enteral feeding or oral nutritional supplements

Not impacted by weight and shape/no body image component

Typically presenting as lack of interest in food, avoidance based on the sensory characteristics of food; concern about aversive consequences of eating (i.e., emetophobia, contamination fears)

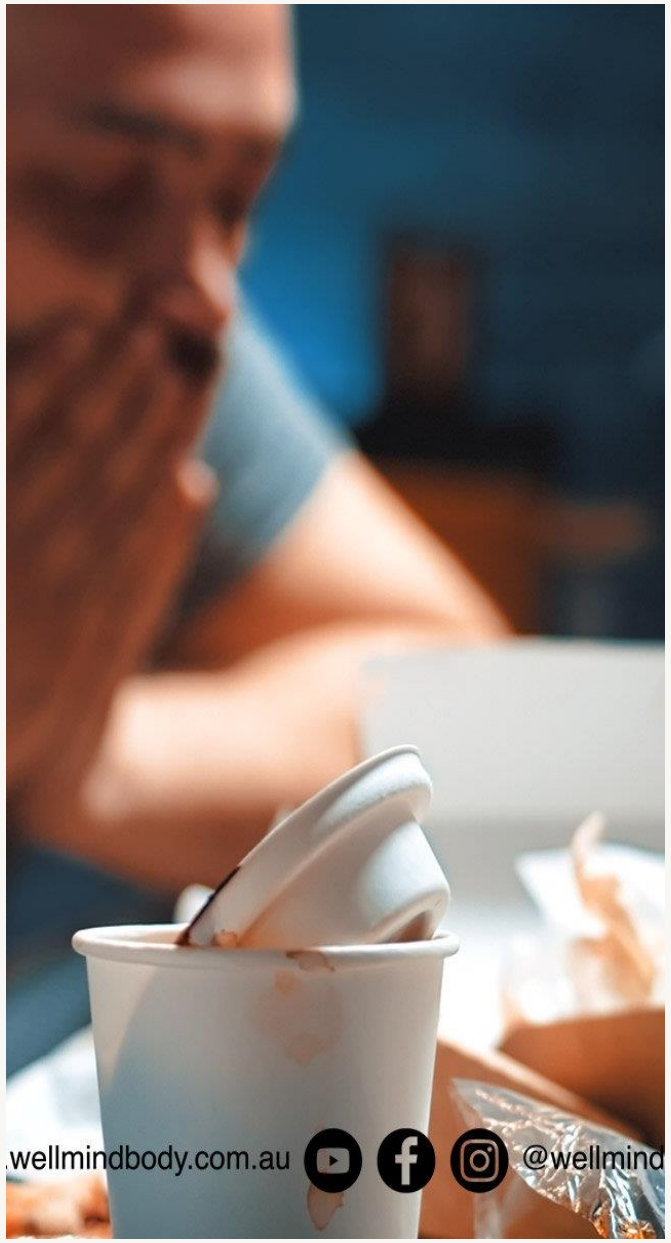
Bulimia Nervosa

- Recurrent episodes of **binge eating**
- Recurrent episodes of **compensatory behaviors**
- Self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; excessive exercise
- Self-evaluation unduly based on shape and weight

Severity based on number of compensatory behaviors per week:

- mild 1-3
- moderate 4-7
- severe 8-13
- extreme 14 or more





Binge Eating Disorder

- Recurrent episodes of **binge eating**
- Binges are associated with one or more of following: eating **rapidly,** eating until **uncomfortably full**, eating **large amounts when not hungry**, eating **alone because embarrassed**, feeling **disgusted or guilty**
- **Marked distress** when binge eating is present
- Not associated with regular use of compensatory behaviors
- Specify current severity (mild, moderate, severe, extreme) based on frequency of binge-eating

Other Specified Feeding or Eating Disorders

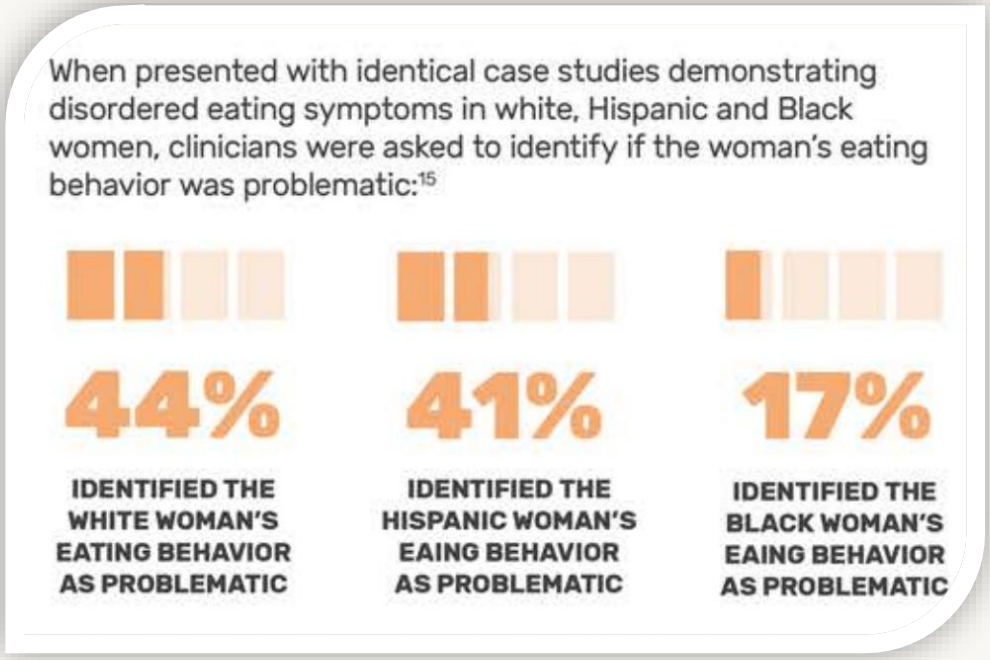
- Atypical Anorexia
- Bulimia Nervosa (of low frequency and/or limited duration)
- Binge Eating Disorder (of low frequency and/or limited duration)
- Purging Disorder
- Night Eating Syndrome

Anorexia vs Atypical Anorexia

- Atypical Anorexia is more common than anorexia nervosa
- May meet all criteria, except low weight
- Can still be malnourished and just as psychologically and medically problematic.



Eating Disorders in People of Color

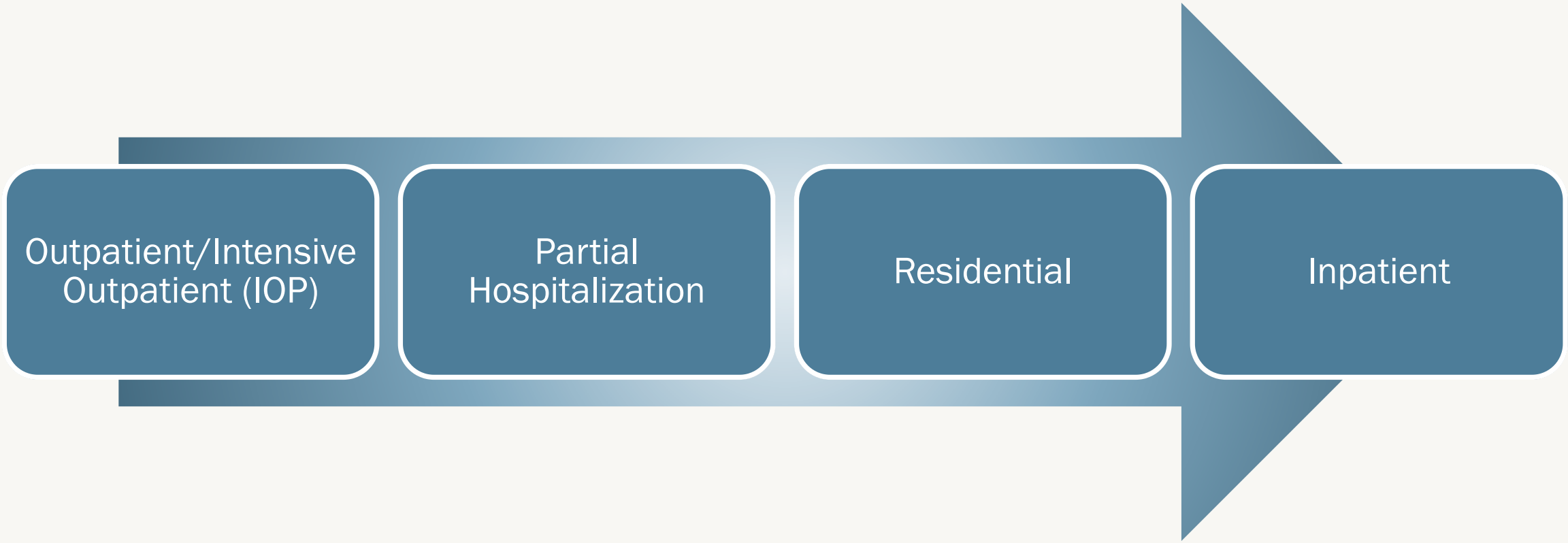


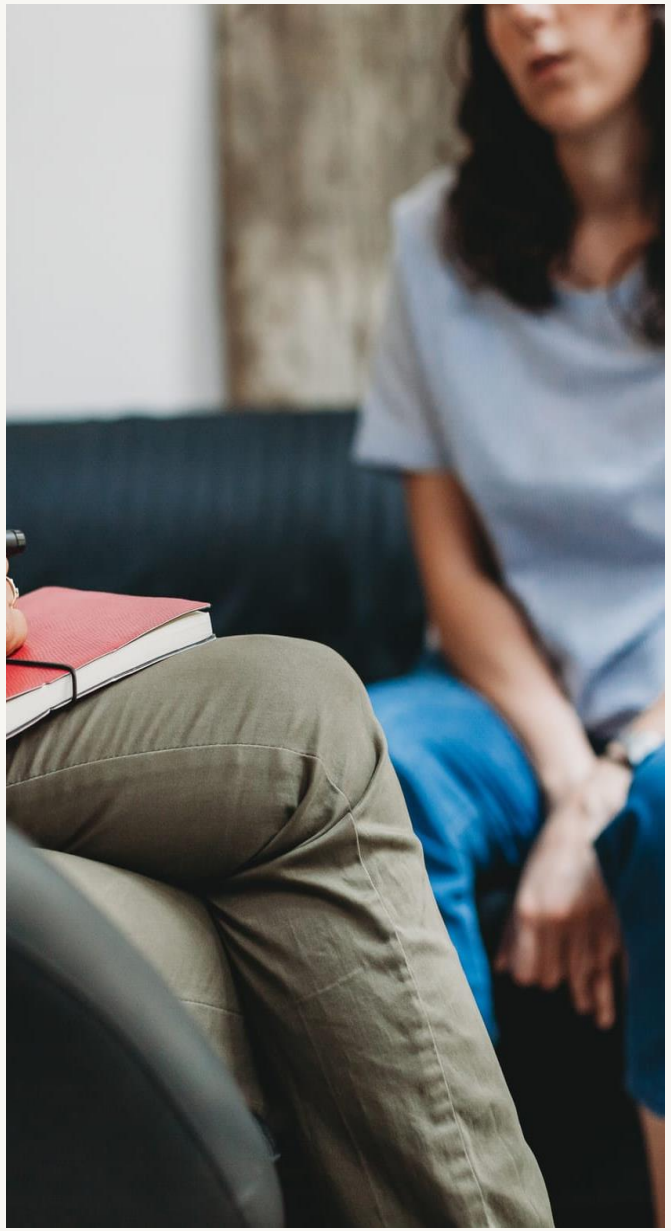
Despite similar rates of eating disorders among white, hispanic, black, and asian people in the United States, people of color are significantly less likely to receive help for their eating issues.

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Determining Level of Care for Treatment

Least intensive to most intensive





Intensive Outpatient (IOP)/Outpatient

- Patient is medically stable and does not need daily medical monitoring. >85% IBW.
- Patient is psychiatrically stable and has symptoms under sufficient control to function in normal social, educational, or vocational situations while continuing to make progress in recovery.
- IOP programs may offer several groups and/or supported meals a week.
- Patients in IOP often still see their outpatient providers concurrently.

Outpatient

Ideal outpatient eating disorder treatment team:

- Individual Therapist
- Family therapist
- Eating Disorder Specialized Dietician
- Psychiatrist
- Primary Care Provider/Medical Management

Any applicable adjunctive treatments

- Treatment of co-morbid conditions (ex. OCD/ERP therapist)

Partial Hospitalization



- Structure is typically 5-7 days a week, 9am-3pm.
- Patient is medically stable. >80% IBW.
- Needs daily assessment of physiologic and mental status.
- Eating disorder impairs functioning, though without immediate safety risk; unable to function in normal social, educational, or vocational situations.
- Patient engaged in eating disorder behaviors but motivated and able to use supports of PHP to reduce behavior use.

Residential

- Structure includes living at the treatment facility 7 days/week; unlocked unit; ability to move toward independence and taking passes in the community.
- Patient is medically stable to the extent that IV fluids, NG tube feedings, or multiple daily lab tests are not needed.
- Fair motivation and cooperative in the structured environment.
- Needs supervision and is also able to ask for and use support from others to not use ED behaviors.
- Unable to engage and respond to lower level of care (PHP or outpatient).





Inpatient

- Structure may include a medical hospitalization or an inpatient eating disorder facility
- Patient is medically unstable as determined by:
  - Unstable vital signs or EKG
  - Laboratory findings presenting acute health risk
  - Complications due to coexisting medical problems
- Patient is psychiatrically unstable as determined by:
  - Rapidly worsening symptoms or weight loss
  - Poor motivation/uncooperative with treatment without a highly structured environment
  - Needing supervision during and after all meals and bathrooms
  - Potential need for NG tube feeds for nutritional stabilization
  - Suicidal and unable to maintain safety

Types of Psychotherapy

One of the most important considerations when selecting a psychotherapist is the type of therapy they provide.

The following therapies currently have the most evidence for effectiveness.

Evidence Based Treatment

Many professionals now recommend the use of evidence-based treatment, which is “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.”

In eating disorder therapies, evidence-based treatment usually means that the therapy has been used in a research study and found to be effective in reducing eating disorder symptoms, encouraging weight restoration in underweight patients, and decreasing eating disorder thoughts.

Acceptance and Commitment Therapy (ACT)

- The goal of ACT is focusing on changing your actions rather than your thoughts and feelings.
- Patients are taught to identify core values and commit to creating goals that fulfill these values.
- ACT also encourages patients to detach themselves from emotions and learn that pain and anxiety are a normal part of life.
- The goal isn't to feel good, but to live an authentic life.
- Through living a good life, people often find they do start to feel better.

Carly M. Onnink, Yvoni Konstantinidou, Ashley A. Moskovich, Maria K. Karekla, Rhonda M. Merwin; *Acceptance and commitment therapy (ACT) for eating disorders: A systematic review of intervention studies and call to action*, Journal of Contextual Behavioral Science,

Cognitive Behavioral Therapy (CBT)

- CBT is based on several core principles, including:

  Psychological problems are based, in part, on faulty or unhelpful ways of thinking.

  Psychological problems are based, in part, on learned patterns of unhelpful behavior.

  People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.

Rebecca Murphy, Suzanne Straebler, Zafra Cooper, Christopher G. Fairburn; *Cognitive Behavioral Therapy for Eating Disorders*, Psychiatric Clinics of North America

Enhanced Cognitive Behavioral Therapy (CBT-E)

- A relatively short-term, symptom-oriented therapy focusing on the beliefs, values, and cognitive processes that maintain the eating disorder behavior.
- CBT-E aims to modify distorted beliefs and attitudes about the meaning of weight, shape, and appearance, which are correlated to the development and maintenance of the eating disorder.
- It is a “transdiagnostic” treatment for all forms of eating disorders.
- It was developed as an outpatient treatment for adults but is available as an intensive version for day patients and inpatients.
- When working with people who are not significantly underweight, CBT-E generally involves an initial assessment appointment followed by 20 treatment sessions over 20 weeks, lasting 50-minutes each.

Christopher G. Fairburn, Suzanne Bailey-Straebler, Shawnee Basden, Helen A. Doll, Rebecca Jones, Rebecca Murphy, Marianne E. O'Connor, Zafra Cooper,; *A transdiagnostic comparison of enhanced cognitive behaviour therapy (CBT-E) and interpersonal psychotherapy in the treatment of eating disorders,* Behaviour Research and Therapy

Dialectical Behavioral Therapy (DBT)

- A behavioral treatment supported by empirical evidence for treatment of binge eating disorder, bulimia nervosa, and anorexia nervosa.
- DBT assumes that the most effective place to begin treatment is with changing behaviors.
- Treatment focuses on developing skills to replace maladaptive eating disorder behaviors.

Family Based Treatment (FBT)

- Also known as the Maudsley Method or Maudsley Approach.
- A home-based treatment approach that has been shown to be effective for adolescents with anorexia and bulimia.
- FBT doesn't focus on the cause of the eating disorder but instead places initial focus on refeeding and full weight restoration to promote recovery.
- All family members are considered an essential part of treatment, which consists of re-establishing healthy eating, restoring weight and interrupting compensatory behaviors
- Ultimately the goal is returning control of eating back to the adolescent; and focusing on remaining issues.

Lock J, le Grange D. *Family-based treatment of eating disorders*. Int Journal of Eating Disorders

Interpersonal Psychotherapy (IPT)

- Interpersonal psychotherapy (IPT) is an evidence-based treatment for bulimia nervosa and binge eating disorder.
- IPT contextualizes eating disorder symptoms as occurring and being maintained within a social and interpersonal context.
- IPT is associated with specific tasks and strategies linked to the resolution of a specified interpersonal problem area.
- The four problem areas include grief, interpersonal role disputes, role transitions, and interpersonal deficits.

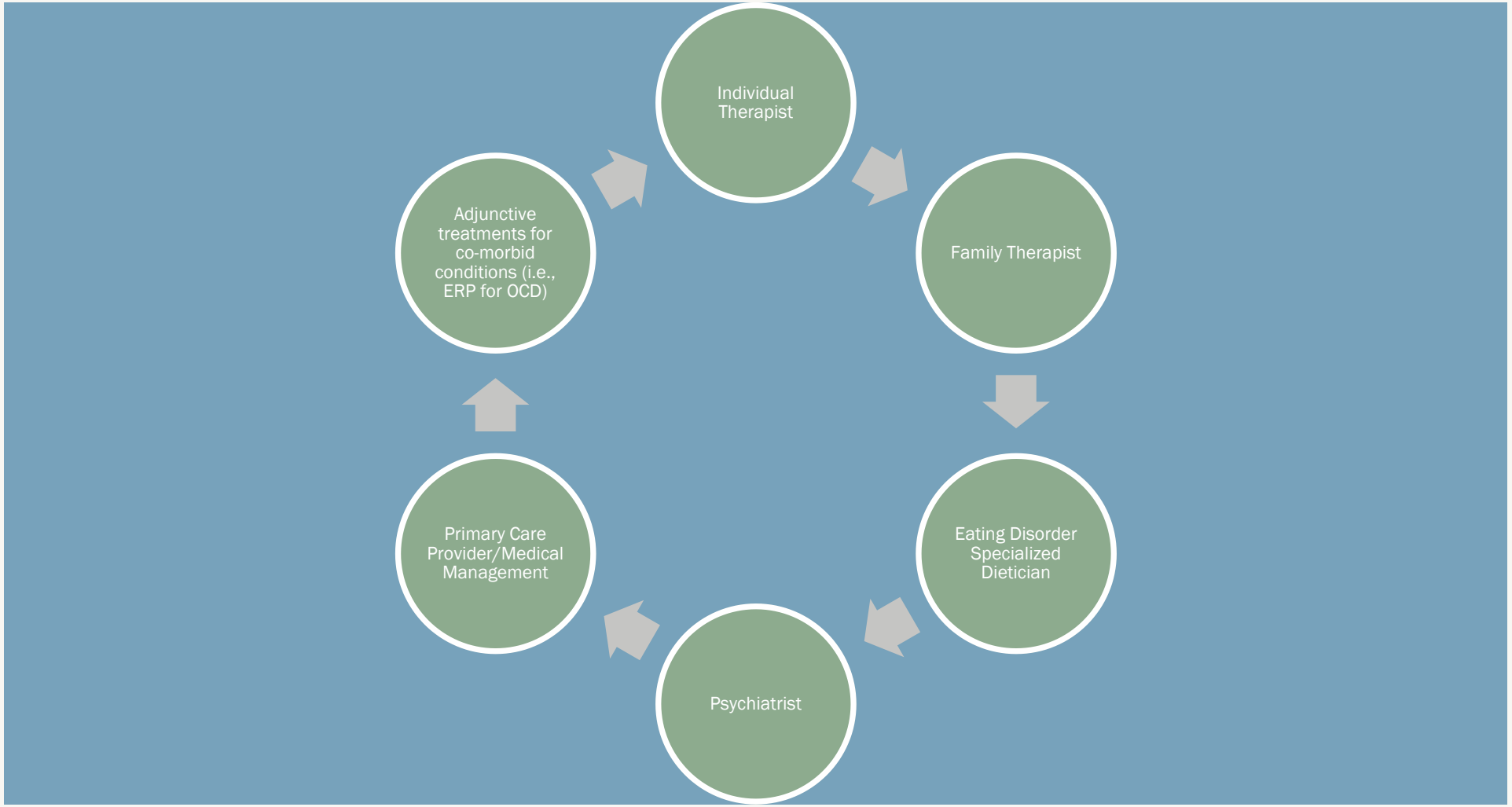
Psychodynamic Psychotherapy

- The psychodynamic approach holds that recovery from an eating disorder requires understanding its root cause.
- Psychodynamic psychotherapists view behaviors as the result of internal conflicts, motives and unconscious forces.
- If behaviors are discontinued without addressing the underlying motives that are driving them, then relapse will occur.
- Symptoms are viewed as expressions of the patient's underlying needs and issues and are thought to be resolved with the completion of working through these issues.

Abbate-Daga G, Marzola E, Amianto F, Fassino S.; *A comprehensive review of psychodynamic treatments for eating disorders*. Eat Weight Disorders

Interdisciplinary Team

Ideal Treatment Team





Working in a Team

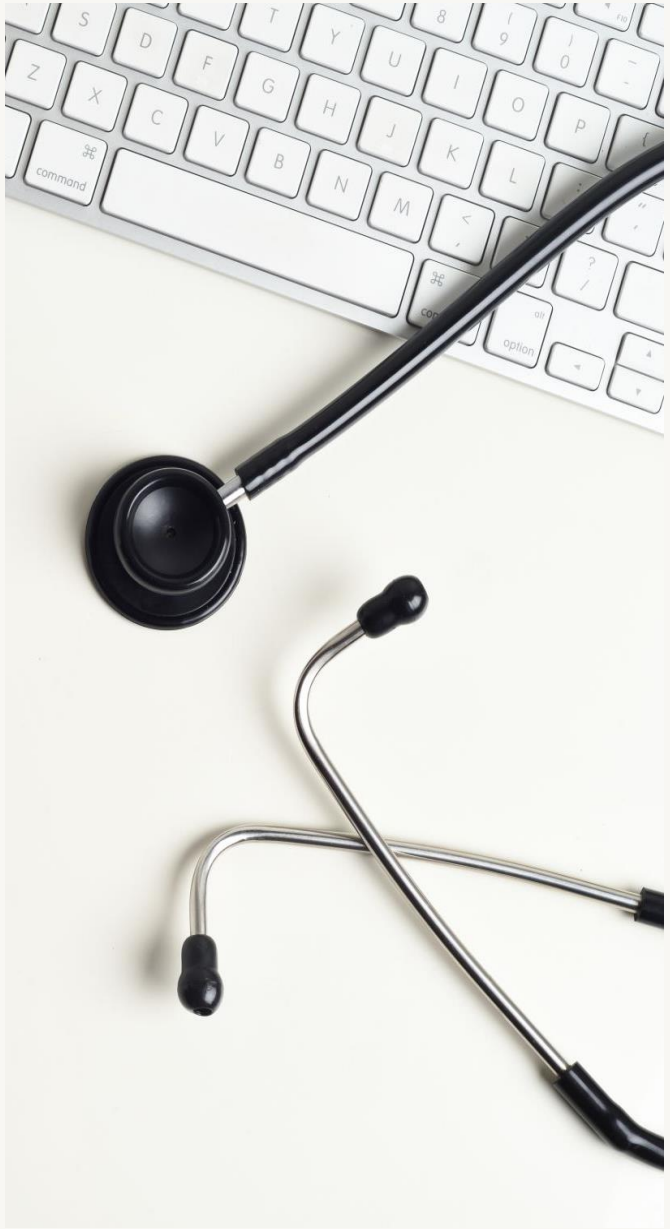
- Patients can be challenging for anyone to treat alone.
- Eating disorder treatment requires multidisciplinary involvement to provide optimal care (medical, nutritional, therapeutic, psychiatric).
- Each team member holds an important piece of the care and can communicate to other members via email, or other secure methods.
- Most communication occurs around step up/step down level of care or surrounding clinical concerns.

Case Presentation

Moving up and down levels of care

- 17 yo female with hx of anorexia nervosa.
- Currently at healthy weight of 130lbs; she has high urges to restrict and struggling with her body image. Has been seeing outpatient team and maintaining weight and functioning well.
- Outpatient Plan:
  - *Individual therapy 1x/week*
  - *Dietician 1x/week*
  - *Psychiatrist 1x/month*
  - *Family therapist 1x/week*
  - *PCP every few months, as she has been medically stable and following recs*
- The team gives periodic email updates to each other to update on their respective progress





2 weeks later…

The dietician notes that patient lost 8lbs in the last 2 weeks. Dietician lets the team know via secure email.

PCP makes an appointment to see the patient for labs/vitals. She notes that labs/EKG are stable; vital signs mild orthostasis

Therapist learns that patient had recent disappointment with college rejection, leading to increased restriction and worsening depression/anxiety. They continue to work on alternative coping strategies.

Team decides to give patient another week to stabilize weight, or will consider HLOC.

1 week later…

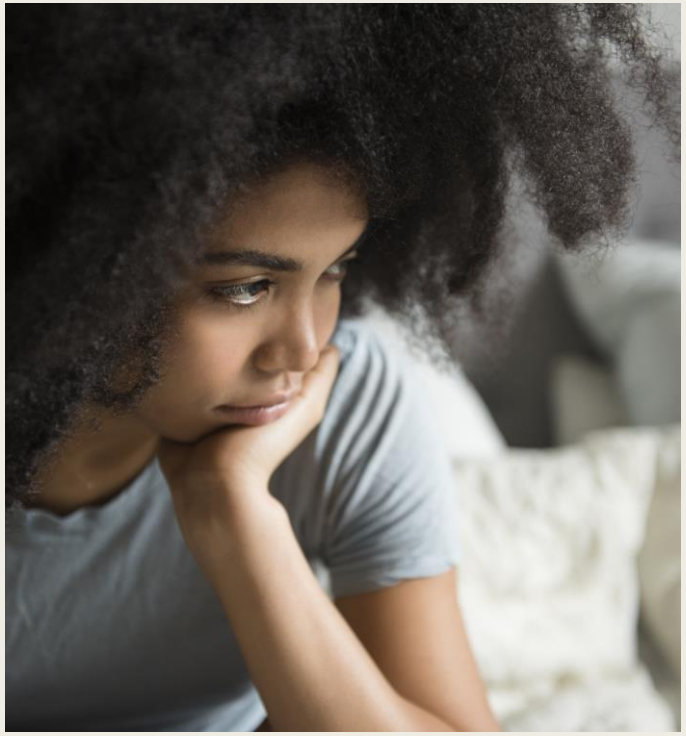
At PCP appointment, weight drops another 4 lbs, HR 45 BPM/orthostatic and pre-syncopal

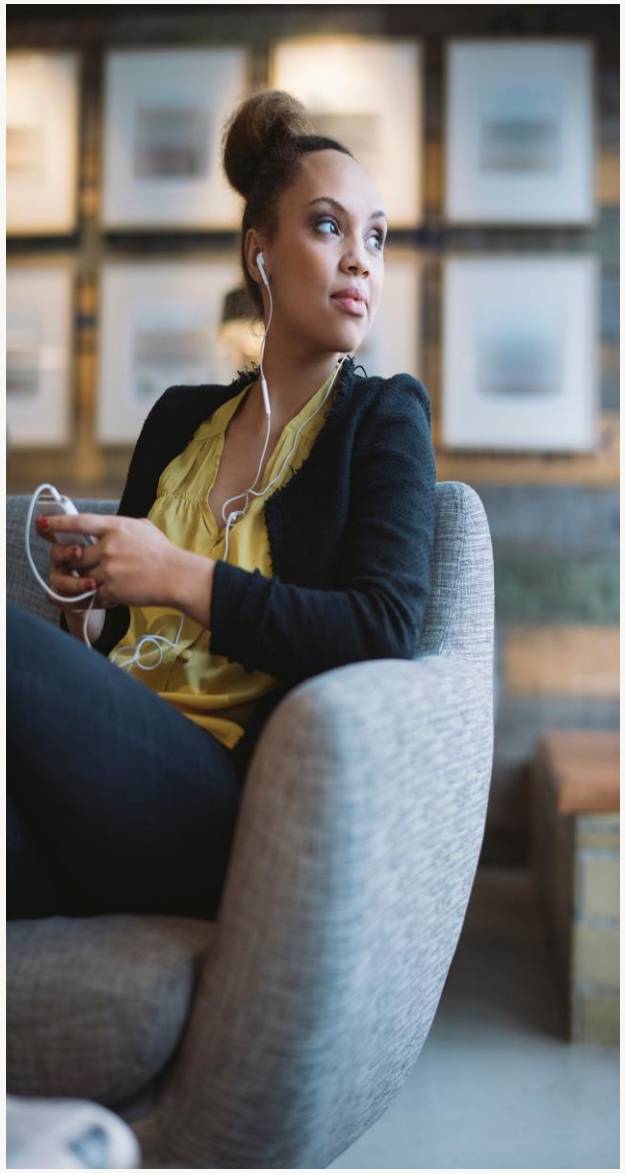
Parents note at family therapy that patient is secretly exercising in middle of the night for hours, witnessed food in trash, not eating unless supervised.

Patient reports increase in hopelessness to therapist and psychiatrist, having passive suicidal thoughts but willing to maintain safety.

Team determines residential level of care would be most appropriate due to:

- Need for weight restoration and regular medical monitoring
- Need for increased supervision at meals and overnight
- Inability to gain or stabilize weight at lower level of care
- Increase in suicidality needing more supervision/structure in safety assessment





1 week later…

Patient admitted to residential facility.

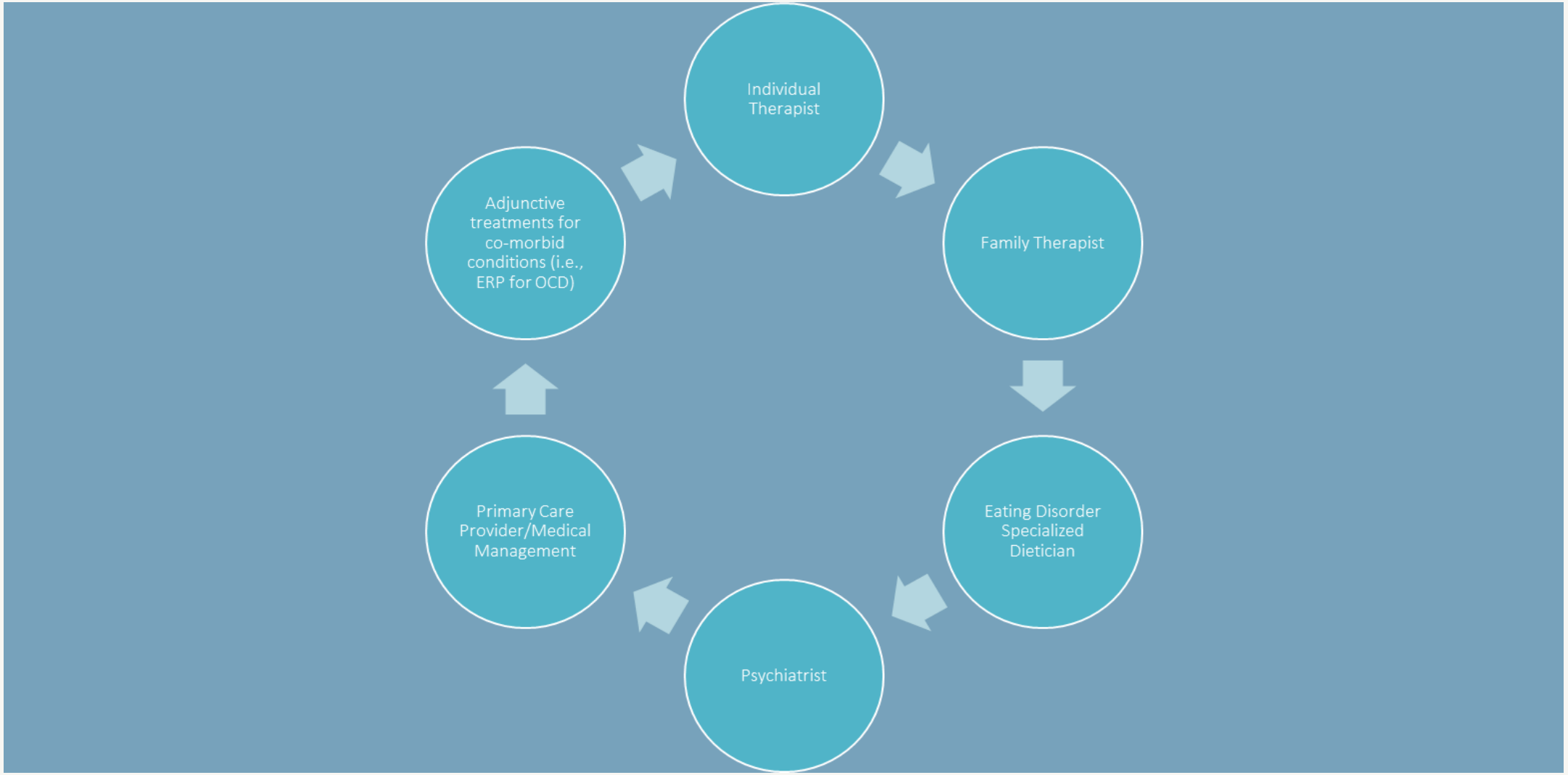
Works with residential team; communication with outpatient counterparts

Patient is at residential level of care for 4 weeks.

Successfully weight restored, improved depression/anxiety, able to demonstrate more independence on passes, high urges for restriction but able to use skills.

Steps down to PHP x 4 weeks → IOP/Outpatient

Outpatient team then resumes care with the patient.


Individual Therapist
Family Therapist
Eating Disorder Specialized Dietician
Psychiatrist
Primary Care Provider/Medical Management
Adjunctive treatments for co-morbid conditions (i.e., ERP for OCD)

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Thank You For Attending and Engaging With This Webinar:

Treating Eating Disorders: The Importance of an Interdisciplinary Approach Across the Spectrum of Care

Resources

Contact Dr. David Alperovitz
dalperovitz@mgb.org

Contact Dr. Holly Peek
hpeek@mgb.harvard.edu

McLean Eating Disorder Resources –
https://www.mcleanhospital.org/essential/eating-disorders

MEDA - Multi Service Eating Disorder Association -
https://www.medainc.org/

NEDA - National Eating Disorders Association -
https://www.nationaleatingdisorders.org/

AED - Academy for Eating Disorders -
https://www.aedweb.org/home

Klarman Eating Disorder Treatment Services –
https://www.mcleanhospital.org/treatment/klarman

AUDIENCE Q&A

FINAL THOUGHTS

- A recording will be emailed to you in 2 weeks. It will include the presentation slides.
- Take our survey immediately after the webinar has concluded.

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THANK YOU!

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