DEMYSTIFYING THE EATING DISORDER:

UNDERSTANDING THE RISK, SYMPTOMS AND TREATMENT

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The Renfrew Center of Center City Philadelphia

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FIRST IN EATING DISORDERS
CELEBRATING 35 YEARS

Goals for Today

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- Highlight complexity of eating disorders and possible warning signs in clients to look out for
- Quick review signs and symptoms of eating disorders and assessment tools and techniques that can be used
- Explore approaches and tools to work with adolescents and families
- Discuss process for referring client to higher level of care, as well as how to navigate barriers

ABOUT THE RENFREW CENTER

- **First residential treatment facility** in the nation for eating disorders, opened in 1985.
- Provides **expert treatment** for anorexia, bulimia, binge eating disorder, and related mental illnesses.
- Established as a **family-run business**, currently operating with **multi-generational leadership**.
- Accepts **430+ insurance plans** across the country and is a **preferred provider** for many insurance companies.
- Incorporates **The Renfrew Center Unified Treatment Model for Eating Disorders®**, integrating our relational approach with the latest scientific research.
- Offers **residential, day treatment, intensive outpatient, and outpatient services** including **virtual therapy**.

WE HAVE **35** YEARS OF EXPERIENCE

TREATED MORE THAN **85,000** ADOLESCENT GIRLS & WOMEN

19 LOCATIONS IN THE UNITED STATES

LOCATIONS NATIONWIDE

CA | FL | GA | IL | MA | MD | NC | NJ | NY | PA | TN

The Renfrew Center of Philadelphia – Spring Lane is located on a picturesque 27-acre wooded estate.

The Renfrew Center of Florida is located on a 10-acre former horse farm in Coconut Creek, near Boca Raton.

CONNECT WITH US

For more information about The Renfrew Center's programs and services, please contact **1-800-RENFREW (736-3739)** or visit **www.renfrewcenter.com**.

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Disordered Eating Continuum

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Body Confidence	Preoccupation with body shape/size & eating	Distress about body shape/ size & eating	Eating Disorders
■ Mostly positive feelings about body shape/size ■ No "good" or "bad" foods ■ Regular moderate exercise	■ Don't like the way parts of body look or consistently feel like losing a few pounds ■ Frequent thoughts about food, eating and body ■ Sometimes feel guilty or bad for what they have eaten and may "make up for it"	■ Thinking about food, eating and body interferes with daily activities ■ Rigidity in eating patterns ■ Working hard to change body and compensating for eating (vomiting, fasting, extreme exercising)	■ Anorexia Nervosa ■ Bulimia Nervosa ■ Binge Eating Disorder ■ OSFED ■ ARFID

Co-Morbid Conditions

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- Anxiety
- Depression
- Mood
- Trauma
- Substance Abuse

A study of more than 2400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, including:

- **94% had co-occurring mood disorders, mostly major depression**
- **56% were diagnosed with anxiety disorders**
  - **20% had obsessive-compulsive disorder**
  - **22% had post-traumatic stress disorder**
  - **22% had an alcohol or substance use disorder**

- *Tagay, S., Schlottbohm, E., Reyes-Rodriguez, M. L., Repic, N., & Senf, W. (2014). Eating disorders, trauma, PTSD, and psychosocial resources. Eating disorders, 22(1), 33-49.*

Brief Overview: Eating Disorders

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- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Other Specified Feeding and Eating Disorder (OSFED)
- Avoidant/Restrictive Food Intake Disorder (ARFID)

Key Symptoms

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Anorexia Nervosa

- Constant dieting
- Terrified of gaining weight, including minor fluctuations
- Frequently weighs self
- Has poor body image
- Food rituals
- Excessive exercise (B/P type)
- Is cold even when temperature is warm
- Talks excessively about calories, food, and cooking
- Body Checking
- Intense anxiety, guilt, fear associated with eating

Bulimia Nervosa

- Experiences & obsesses on frequent fluctuations in weight
- Depressed moods, secretive and withdrawn
- Always on a diet
- Uses the bathroom immediately after meals
- Has problems with their teeth
- Shame and guilt around eating

Bing Eating Disorder

- Eating alone/eating secretly
- Eating until uncomfortably full or sick
- "Performative Eating" around others
- Skipping or delaying breakfast
- Dieting & desire to lose weight
- Feelings of shame, guilt, disgust after eating
- Eating without hunger

ARFID

- Aversion to foods due to texture, disinterest, or fear of adverse consequences, such as vomiting
- Does not stem from concern about body image

OSFED

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50% of eating disorders are atypical, i.e., they fail to meet DSM V criteria for anorexia or bulimia nervosa

Atypical eating disorders are no less serious and present just as difficult challenges for treatment

Insurance companies may inappropriately reject payment for OSFED diagnosis

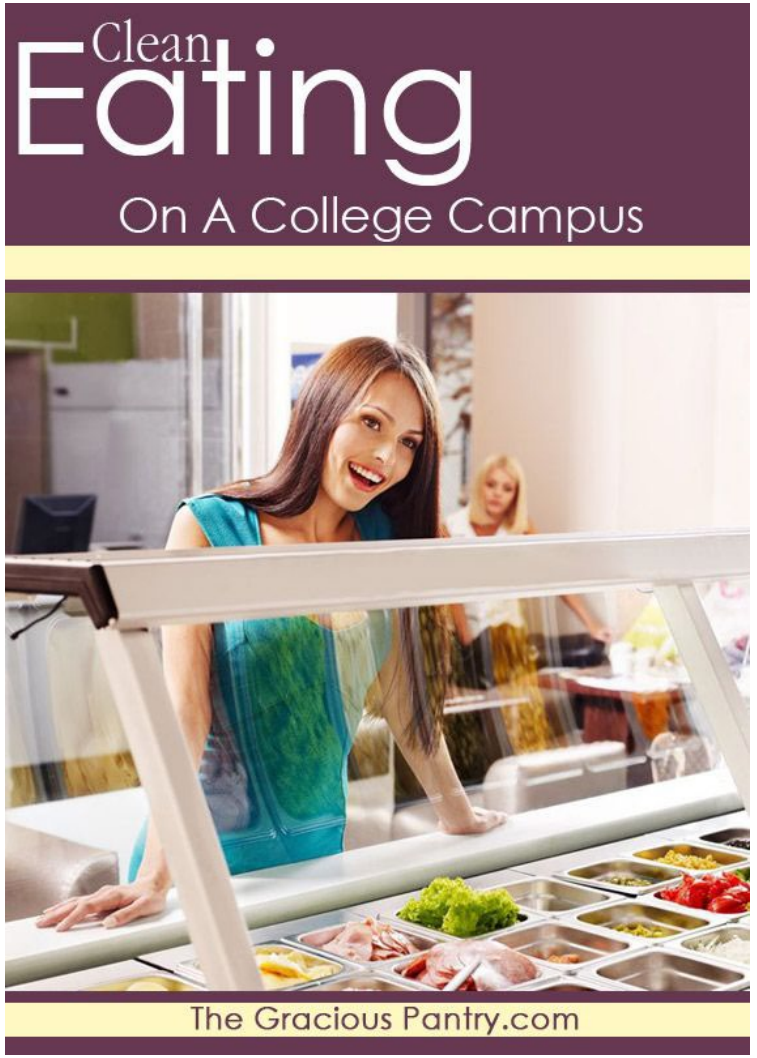
Subsyndromal eating disorders: Half progress to full illness in a few years

What's Diet Culture?

- Diet culture is a socially constructed value system
- Thinness synonymous with health and "wellness"
- Equates weight loss with health AND happiness
- Thinness = moral superiority
- Weight loss as means of higher status
- Pathologizes certain ways of eating while idolizing others
- Marginalizes those who do not fit narrow ideals of "health" or "fitness"

"Other" Trends on Campus

- Orthorexia and clean eating
- Compulsive exercise
- "Drunkorexia"
- Sub-clinical/disordered eating



ASSESSMENT

Questions to Consider

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- Can you eat when you are hungry and quit when you are satisfied?
- Do you stop eating because you think you should (opposed to because your body is satisfied)?
- Do you make food choices based on foods you enjoy?
- Do you compensate after you eat with exercise, laxatives, diet pills, or vomiting?
- Do you become physically uncomfortable (such as weak, tired, dizzy, a headache) when you under-eat or diet?
- Do you feel that your food selections include all foods? Including foods that are high in fat or calories?
- Do you have to eat in a certain pattern – always three meals a day or always at certain times of the day?

Questions for parents

- It's often important to get parent/guardian/support's perspective if you do suspect that an ED may be developing-

Questions to consider (typically asked to parents):

- Is there a history of any conflict or problems around the patient's early childhood eating such as picky eating, slow to finish meals, disinterest in food, medical problems or traumatic incidents that impacted your child's eating?
- When do you believe your child's eating issues and other problem's first began?
- Are there any family stressors?
- Describe the family culture around food and weight.
- Describe the patient's eating patterns/behaviors prior to the change in eating habits. (how many meals were they eating per day? How many snacks? Have they cut back their portion sizes? Have you noticed food rituals? Have you noticed frequent trips to the bathroom following meals? Is the patient more focused on exercise/their body?)

Important Assessment Considerations

Regardless of presenting problem at intake

Include assessment items about:

- Family culture around food (dieting, labeling foods, etc.)
- Body image concerns (frequent weighing, body checking, etc.)
- Food concerns (food insecurity, meal prep skills, etc.)
- Relationship to exercise and movement
- Identity (is it centered around food, weight, or exercise?)
- Family history of substance use

Consider frequently co-occurring concerns:

- Obsessive-compulsive tendencies
- Difficultly regulating mood (anxiety/depression)
- Trauma history
- Substance use (current and past use)

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INTERVENTIONS

Considerations

Tools

Intervention

- **Broaching the Subject-Preparation**
  - If you are suspicious, act- ask gentle questions, calmly express your concern, talk of your observations
  - Remember- people with eating disorders reject the idea that they have a problem
  - Do not be shy, dismiss or ignore symptoms or give up on the person
  - Let them know that you know they have a problem. It may be a long while before they themselves can confront and admit that they have a problem
  - Validate them without agreeing with the behaviors
  - Choose the moment carefully- a relaxed atmosphere is best, away from mealtimes
  - Do not go for browbeating- you do not need to win each battle
  - Be prepared for setbacks, especially initially

UT Goals:

1. **Understanding** how our emotions impact our ability to engage in authentic, mutual relationships.

2. **Learning** to courageously approach rather than avoid emotional experiences, including painful and uncomfortable emotions.

3. **Increasing** emotional tolerance and psychological flexibility to decrease the need for unhelpful coping behaviors.

4. **Building** emotional skills like self-empathy, self-efficacy and meaningful relationships.

Relational Connection

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Validate

behaviors have served an important function

Communicate

hope that recovery is possible

Express

your commitment to working with your client

Emotion Coaching

- **ATTEND** to the emotion
  - Notice AND pay attention to the emotion
- **LABEL** the emotion
  - Give words to the emotions, check in
- **VALIDATE** the emotion
  - Accept/allow/validate the emotion
- **MEET the NEED** of the emotion
  - Meet the emotional need, not solve the problem
- "Fix/problem solve"

Intervention

- **Broaching the Subject- Scripting**
  - Describe the facts as you see them calmly and with warmth:
    - *"I see you think….I think you feel…..I noticed that….How can I help?"*
  - Listen without judgment:
    - *"Everyone has different views. This is not the way I see things; I accept you feel differently."*
  - Listen carefully to the answers:
    - *"Sounds like this might be the way you see things….? Have I got that right?*
    - Use reflective listening and affirmation to build trust

Decisional Balance

CONS	PROS
(Reasons to stay the same)	(Reasons to change)
Praise and attention from others	Physical appearance is compromised-always look tired, pale skin, swollen
Makes me feel productive	Would like to be social and go out with friends
I'm comforted by food. It's the only pleasure I have	I am unable to feel good, positive emotions
Boosts self-esteem	I want to be able to think about something else besides weight, food, calories, numbers
I like the way my body looks	My partner is worried about me
It's an excuse to get out of things	I want my personality back
Gives me routine and structure	I'm tired of hiding my body
Been doing it for so long, it's part of me	

What not to do...

Compliment someone when they lose weight or diet

Encourage someone to lose weight

Talk negatively about your own body

Discuss measurements, weight, or clothing sizes

Think of foods as “good” or “bad”

Criticize your own eating

Assume that a person in a larger body wants or needs to lose weight

WHEN TO REFER

HLOC Criteria – When to Refer

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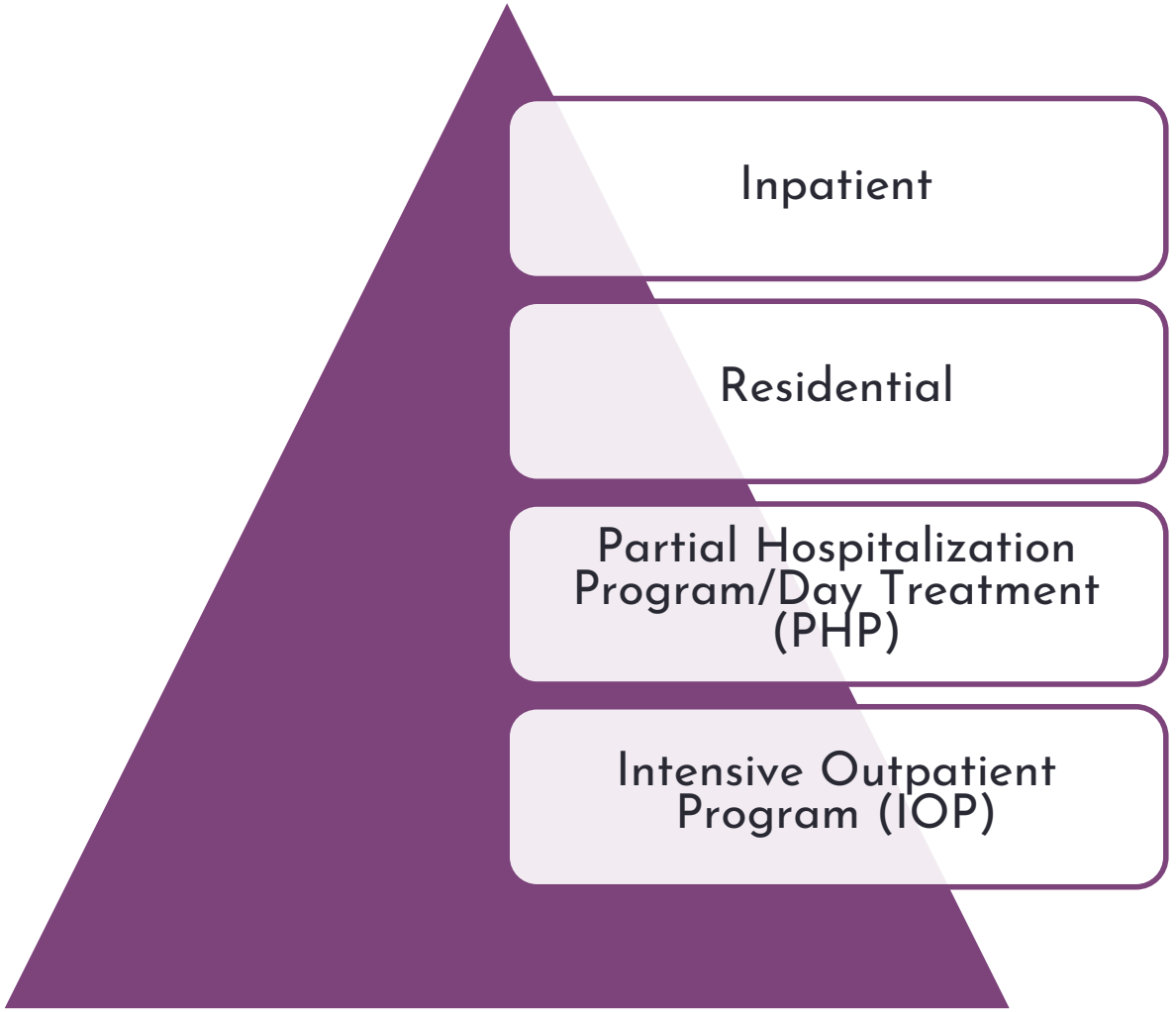
- Symptom usage/frequency
- Interference with academics and relationships
- Weight fluctuation-significant over short period of time, relative to each client's trends
- Safety concerns
- Lack of medication compliance
- Labs

Navigating Higher Levels of Care



Getting a Client to a HLOC

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Insurance Check

- Call to schedule intake assessment
- Admissions team verifies benefits and reports back

Assessment

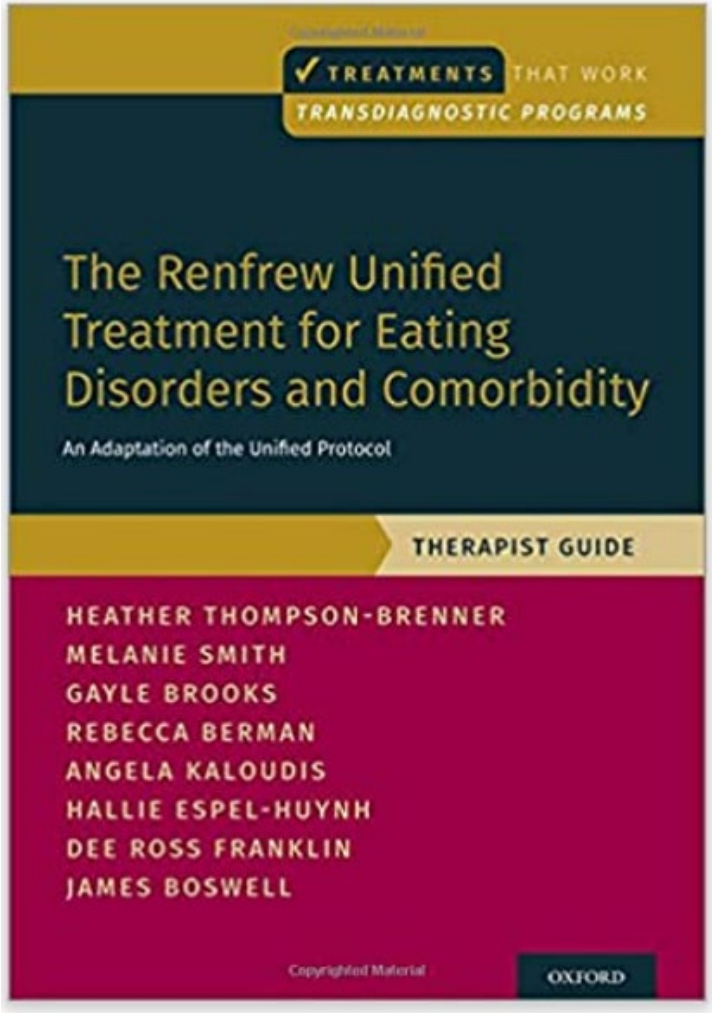
- Client is asked to get labs, EKG and signs releases for outpatient team
- 1-2 hour assessment with Intake Coordinator determines appropriate level of care

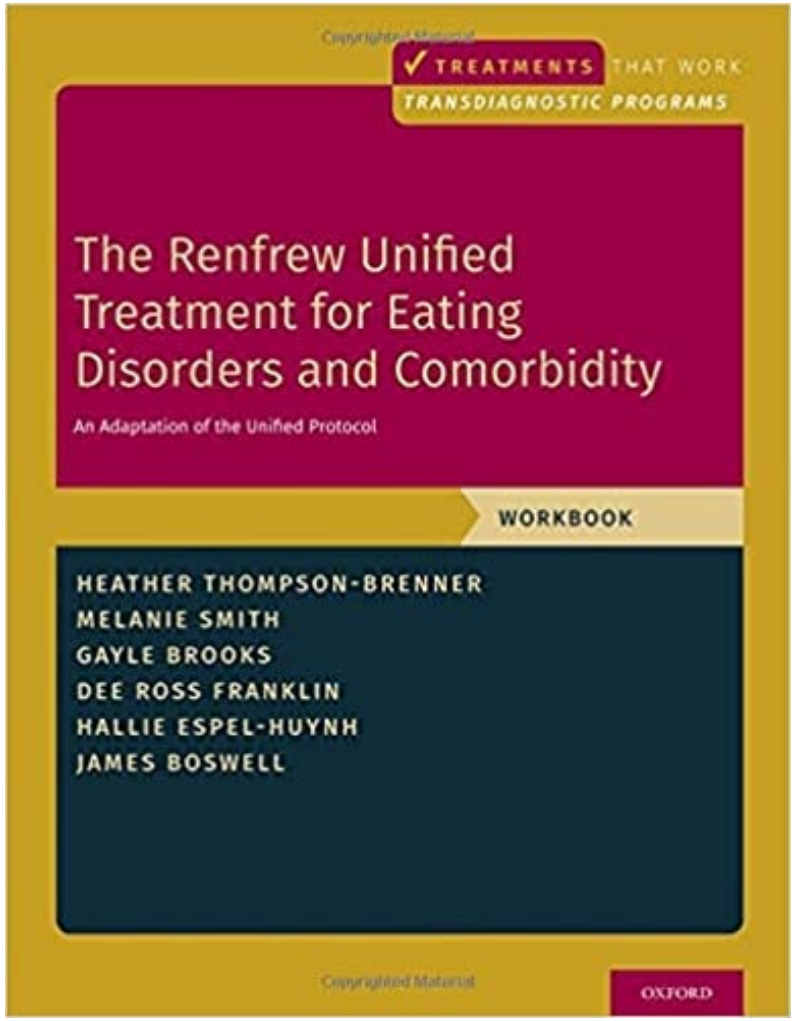
Treatment

- Level of care is recommended following assessment
- Client reports for orientation

RESOURCES

Want More UT Resources?





Resources for Professionals

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- Free virtual 2 CE events
- Professional webinars
- Annual Conference
- Case Consultation

Contact Information

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www.renfrewcenter.com.