WELCOME TO THE BELLA VITA

Residential Treatment, Transitional Living, Partial Hospitalization and Intensive Outpatient Programs and Outpatient Services
Cutting Edge Treatment of Eating Disorders
## Prevalence of Eating Disorders

- 9 Million Americans have an ED
  - 8 million women
  - 1 million men
- 1 in 200 American women have anorexia
- 2-3 in 100 American women have bulimia
- Nearly half of all Americans personally know someone with an ED
- 10-15% of Anorexics or Bulimics are Males

www.state.se.us/dmh/anorexia/statistics.htm
Mortality Rates

- ED has highest mortality rate of any Mental Illness
- 5-10% of Anorexics die within 10 years after contracting the disease; 18-20% of AN will be dead after 20 years; only 30-40% ever fully recover
- Mortality rate for AN is 12Xs higher than death rate of ALL causes of death in F 15-24
- 20% of AN will die prematurely from complications with ED including suicide and heart problems

www.state.se.us/dmh/anorexia/statistics.htm
Adolescents

- Anorexia is the 3rd most common chronic illness among adolescents
- 95% with ED are between 12 and 25
- 50% of girls between 11 and 13 see themselves as overweight
- 80% of 13 year olds have attempted to lose weight

www.state.se.us/dmh/anorexia/statistics.htm
Evaluation for Best Course of Treatment

- Medical Clearance with Recent Labs
- Psychological Interview
  - Individual & Family
- Nutritional Interview
  - Individual & Family
- Psychiatric Interview
- Psych Social Assessment
- Psychological Testing
Monitoring of Treatment

- Medical Labs and Tests when Needed
- Individual, Couples or Family Sessions
- Group Therapy
- Nutritional Counseling Weekly
- Psychiatric Follow-ups
- Weekly Case Conference with Treating Staff
- Discharge Planning
- Exit Interview with Psychological Testing
- Follow-up Interviews & Psych Testing
- Outcome Studies
Full Continuum of Care

- The Bella Vita in Los Angeles  CARF Accredited
- The Bella Vita in San Fernando Valley  CARF
- The Bella Vita in Santa Clarita  CARF
- The Bella Speranza Residential Healing  CARF
- The Bella Passione Residential Healing  CARF
- The Bella Verita Transitional Living
The Bella Vita: Treatment

- Individual Therapy and Group Therapy
- Stages of Change
- Family Focus
- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
- Sensorimotor
- Interpersonal Therapy
- Experiential Therapies
- Yoga and Meditation
The Effects of Starvation

- Symptoms manifested biologically through malnutrition
  - Anorexia Nervosa
    - Significant low body weight
    - Insufficient calories & nutrients to sustain body’s needs
  - Bulimia Nervosa
    - Purging through vomiting
    - Insufficient nutrients to sustain body’s needs
  - Binge Eating Disorder
    - Unhealthy eating - high processed foods
    - Insufficient nutrients to sustain body’s needs
Starvation Effects: Cognitive Changes

- Poor concentration
- Decreased alertness
- Decreased comprehension
- Impaired judgment
- Apathy

Of note: formalized IQ testing did not show signs of diminished intellectual abilities
Etiology of Eating Disorders

- Predisposing Factors
  - Sets the stage for eating disorders

- Precipitating Factors
  - Triggers eating disorders

- Maintaining Factors
  - Continues eating disorders
  - Critical to understand for treatment
## Predisposing Factors Contributing to Eating Disorders

- Personality elements (e.g. perfectionism, obsessive compulsive traits, difficulty expressing feelings and needs, poor coping skills, fear of rejection)
- Family (e.g. genetics, family dynamics)
- Socio-cultural focus on thinness
- Societal acceptance of dieting
- Societal mixed messages: health and junk foods
## Precipitating Factors Contributing to Eating Disorders

- Relational loss emotional or by death
- Significant life transitions (e.g. going to college)
- Evolvement: sports requiring slim physique
- Evolvement: high intensity aerobic exercise
- Physical illness
- Emotional, physical and sexual abuse
Precipitating Factors Continued

- Depression
- Anxiety
- Diets (e.g. high protein, low calories)
- Cultural attitudes as reflected in media
- Adolescent vulnerability (e.g. biological changes and focus on physical attractiveness)
- Comments made by others re: food, weight or appearance
Maintaining Factors Contributing to Eating Disorders: Symptoms

- Over-evaluation of shape, weight and eating control
- Thoughts and preoccupation on shape, weight and eating control
- Strict Diet
- Binge-eating
- Self-induced vomiting
- Laxative misuse
- Diuretic misuse
- Over activity
- Other unhealthy weight control behaviors
- Food checking
- Body checking
- Avoidance of body exposure
- Feeling fat
- Low weight & starvation symptoms

(Dalle Grave, 2002)
Maintaining Factors Contributing to Eating Disorders: Core Psychological Issues

- Mood Disturbance (emotional dysregulation)
- Low self-esteem
- Perfectionism
- Interpersonal difficulties
- Family Therapy (patient < 18 years old)

(Fairburn et al. 2003)
Why Letting Go of Maintaining Factors is Met with Resistance:

- ED distracts from difficult emotions
- ED is a means of power and control
- ED is a means to security/safety (predictable)
- ED is an excuse (for anything/everything)
- ED is an explanation (anything/everything)
- ED is an identity
- ED is a safer way to be angry
• ED is a way to avoid (people, intimacy, difficult situations)
• ED is a way to be “attended to”
• ED is a way to be special
• ED is a way to compete
• ED is a way to deal with eating/weight
• ED is a way to rebel
• ED is a way to self-abuse/punish (Thompson & Sherman 2003)
Timeline and Life Story

- Eating Disorder Timeline
  - Individual Factors
    - Genetic
    - Biological
    - Psychological
  - Familial Dynamics
  - Other Relationship Impacts
  - Cultural Influences

- Life Story
Psycho Educational

- Eating Disorder Symptoms
  - What is Anorexia?
  - What is Bulimia?
  - What is Binge Eating Disorder (BED)?

- Comorbidity
  - What is it?
  - What are specific to self and loved one?

- Stages of Change

- Family Dynamics

- Trauma

- Floater Group (Supports Individualized Plan)
  - Grief, Shame, Defense Mechanism, etc.
Binge Eating Disorder

- Uncontrolled, frenzied eating beyond the point of feeling comfortably full
- Intermittent fasts or diets, not accompanied by purging
- Body focused on extreme dissatisfaction with shape and weight; draws attention to face and nails to avoid body
- Body weight varies from normal to overweight to obese

Health Risk
- High blood pressure
- High cholesterol levels
- Type II diabetes
- Gallbladder disease
Anorexia Nervosa

- Refusal to maintain at or above the minimally normal weight for height and age
- Intense fear of gaining weight
- Distorted body image
- Loss of three consecutive menstrual periods
- Extreme concern with body weight and shape

(Social isolation, depression, anxiety, obsessive style, perfectionist, rigid cognitive styles, and sexual disinterest)
Bulimia Nervosa

- Repeated episodes of bingeing and purging
- Feeling out of control during a binge
- Purging after a binge (vomiting, excessive exercise, use of laxatives, diet pills, diuretics, or fasting)
- Frequent dieting
- Extreme concern with body weight and shape
  (Depression, anxiety, impulsivity, sexual conflicts, and intimacy issues)
Comorbidity

- Comorbid (adjective)
  - 1. (medicine) existing together with another medical condition

- Most Prevalent with Eating Disorders
  - Mood Disorders (40 to 70%)
    - Major Depression
    - Bipolar II
    - Dysthymia
  - Anxiety Disorders
    - Obsessive-compulsive disorders
    - “the lifetime prevalence for anxiety appear to be higher for patients with anorexia or bulimia” APA ED Guidelines, p. 59
Comorbidity Continued

- Substance Use/Abuse
  - 22% BN have criteria for alcohol abuse (APA ED Guidelines)
  - Increased Impulsivity (self-harm, shoplifting, laxative abuse, suicidal)

- Personality Disorders or PD Traits
  - Anorexic – Cluster C traits: sensitive, perfectionist, persevering, self-critical features, obsessive-compulsive, and avoidant.
  - Bulimic traits – Cluster B traits: impulsivity, emotional dysregulation, dramatic and narcissistic.

Mehler and Anderson, Edited 1999, p. 11
Comorbidity Continued

Differential Diagnosis

- PTSD
- Disorders of Extreme Stress, Not Otherwise Specified (DESNOS)
  - Disorder of Self-Regulation
  - “…chronic affect dysregulation is the hallmark feature of DESNOS, this symptom is secondary to disturbances in identity and relationships with others in BPD.”
- BPD
  - Attachment Disorder

Luxenberg, Spinazzola, and van der Kolk, Nov. 2001
Comorbidity Continued

• Medical Conditions
  • Caused by ED – can impact every major organ
  • In Addition to ED
  • Reversible?
  • Pregnancy and Fertility
  • Diabetes, Type 1 (AN & BN) – underdose insulin as form of purging
  • Crohn’s Disease
  • IBS
  • PCOS
  • Etc.
Treat Each Distinct Diagnosis

- AN and OCD
  - AN symptoms: restrictive eating
  - OCD symptoms: ritualistic practices, rigid thoughts, perfectionistic

- BN and PTSD
  - BN symptoms: bingeing, purging, laxative abuse, compulsive exercise
  - PTSD symptoms: hypervigilence, nightmares, flashbacks, and restricted range of affect
Stages of Change

- Pre-Contemplation: unable to recognize a problem exists
- Contemplation: know there’s a problem and looking at pros and cons of problem
- Preparation: committed to change with a goal
- Action: begin behavioral changes
- Maintenance: long-term to ward against return of unwanted behaviors
  - Individual
  - Family Member
  - Family System
Family Focus

- Family Session within the first week
- Family Therapist
  - Separate from Individual therapist
  - Systems focus
- Family Day
- No Blame
- Improve Communication
- Educate
- Eat Together
CBT Focus

- Decrease dietary restraints
- Establish regular, healthy eating patterns
- Challenge and change maladaptive beliefs regarding eating and weight
- Challenge distorted thinking which causes unnecessary uncomfortable emotional states (e.g. depression and anxiety)
Cognitive Behavioral Therapy

- CBT, IPT (interpersonal therapy), and pharmacotherapy have been applied and tested in treatment of BED (Binge eating disorder)

- Above shown in research to be most effective form of treatment for BED and Bulimia in research in 50% of cases

Cognitive Behavioral Therapy for Bulimics & Binge Eating Disorder

- The Event
- The Feelings, Thoughts, and Beliefs connected with the Event
- The Truths
- The Consequences: Positive & Negative
- Defining own Cognitive Distortions
- Defining Limiting & Distorting Beliefs
Steps in Cognitive Restructuring

- Monitor thinking & heighten the awareness of thinking patterns
- Identify, clarify, distill & articulate dysfunctional beliefs or thoughts in simplest form
- Examine the evidence or arguments for & against the validity & utility of dysfunctional beliefs

Garner et al., 1997
Steps in Cognitive Restructuring

• Come to a reasoned conclusion by evaluating the evidence for & against

• Make behavioral changes that are consistent with the reasoned conclusion

• Develop believable disputing thoughts & more realistic interpretations

• Gradually modify underlying assumptions reflected by more specific beliefs

Garner et al., 1997
Adapting Cognitive-Behavioral Therapy for Anorexics

- Anorexic thinking is ego syntonic
- Accepting the patient’s belief as genuine
- Addressing the phenomenological argument
- Using inconsistencies in core beliefs in different meaning systems

(Garner et al., 1997)
Assumptions: Body Image

- Physically attractive people have it all
- The first thing people notice about me is what is wrong with my appearance
- Outward appearance is sign of inner person
- If I could look as I wish, I would be happy
- By controlling my appearance, I can control my social & emotional life  (Cash 1997)
• Binge eating serves primarily to regulate affect
  (Heatherson & Baumeister, 1991; Polivy & Herman, 1993)

• To target difficulties of affect regulation in bulimia
  nervosa and binge eating disorder (Esplen et al., 1998 and Telch et al., 2000)

• Emotional dysregulation seen as a core problem in
  BED and Bulimia Nervosa understands binge eating
  and purging behavior as attempt to influence, change,
  or control painful emotional states(Safer, et al. 2001)

• Developed a modified manual of DBT: 20 group
  sessions & 20 weekly individual sessions; comprising of
  mindfulness skills, emotion regulation skills, and
  distress tolerance skills
Relationship: ED & Trauma

- ED pts with trauma histories show higher levels of subjective distress
- ED pts with trauma histories tend to have higher levels of comorbid depressive symptoms
- ED pts with trauma histories show greater impulsivity with self-harming behaviors
- ED pts with trauma histories are more likely to drop out of treatment, more treatment resistant
Complicated Trauma: Long-term Treatment

- Phase One: Stabilization.
  - Physical well-being; self-soothing; boundaries; support systems/environment. Psychoeducation to empower and decrease shame
  - Does not focus on trauma history; Focuses on developing present coping strategies
  - No “processing the trauma”-return to trauma-based patterns of coping
Complicated Trauma: Long-term Treatment

• Phase Two: Processing and Grieving of Traumatic Events
  • Exploring traumatic events in depth
  • Integrating experiences into coherent life narrative impacting self-perception and being in relationships
Complicated Trauma: Long-term Treatment

- Phase Three: Reconnection/reintegration with the world (General Psychotherapy)
  - Focus on present day issues
    - Reconnection with peers, moving on with life through exploration of pleasurable activities, meaningful work, bodily comfort and constructive relationships
  - Concerned with relationships with others and altering systems of meaning

Stages of Recovery are Fluid

Interpersonal Psychotherapy

• Eating Disorders are NOT about the food.
  IPT: to focus on food and eating does not alter the etiology of the disordered behavior
  IPT: the focus is on relationships, improving social functioning, increasing esteem, and generating positive affect.
  If these goals are met, IPT states that the eating disordered behavior will no longer be necessary.

William Randall, LCSW
IPT for ED: Theoretical Framework

- Laboratory Model of Therapy
  - Present Focused
  - The therapeutic relationship is the agent of change.
  - Creating a safe “lab” in which the client can practice different skills, roles, and patterns, without the fear of abandonment or retaliation.

William Randall, LCSW
Experiential Therapies

- Art Therapy
- Movement Therapy
- Storytelling
- Drama Therapy
- Dream Work
- Music Expression
THANK YOU