Treating Eating Disorders in Adolescence: Themes, Principles, and Interventions

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Introduction

1) Thank you for being here
2) MEB: loved one/adolescent & adult with ED
3) MEB: CD recovery
4) Psychologist: Psychology & MFT training + 37 yrs experience
5) 8 children, their spouses, 21 grandchildren, and 1 lovely and amazing wife
6) Experience in: wilderness tx, adol, ED, SUDS, trauma, spirituality in treatment
7) Let us be learners - QUOTE: Eric Hoffer
8) Much of what we talk about today with adolescents and ED can be generalized to adults suffering ED, trauma, and other related mental, emotional, additive illnesses and relational concerns
9) Expect didactic info, discussion, reflection, imagery, and possibly sharing, experiential activity
10) PowerPoint available: jill.lloyd@uhsinc.com
Concurrence: ED and other mental illness

• ED and depression 55 - 65%
• ED and anxiety disorders 35 - 45% (watch for/treat)
• ED and trauma/(abuse) 40 – 65%
• ED and PTSD 20 – 40%
• ED and personality disorders 25 – 40%
• AN and SUDS 27%
• BN and SUDS 37%
• BED and SUDS 23%
Concurrence: ED, SUDS other

- **Prognosis** is worse with increasing **complexity** of illness (PTSD, ED, MDD, and SUD)
- ED patients are more likely to abuse substances than general population
- Alcohol abuse w/ BN 33%, BED 21%, AN (R) 13% (B/P) 33%
- Patients with **anorexia are 19x** more likely to die from alcohol abuse than the general population
- Anorexia has the **highest mortality rate** of any mental illness
- Anorexia and Type1 Diabetes **extra high risk**
- Pronounced suicide risk with AN & BN
Benefits of treating ED & SUDS concurrently

- **The healing of the brain** in ED and SUDS **requires** both the absence of substances and presence of nourishment.
- The healing of the brain is required for therapeutic work to have minimal and maximal impact (a detoxed but malnourished brain still isn’t working well).
- A **contained** and structured environment **CAN** provide for both **detox** and **nourishment** – and all at the same time.
- Concurrent treatment Increases awareness of adaptive the function of both illnesses.
- **Core issues which underlie** symptoms of both illnesses are often the same.
- **In both illnesses: structure** – success – hope – motivation – work - recovery.
- It increases true honesty, accountability, and abstinence:
  - Decreases **symptom substitution**
  - **Breaks cycle of avoidance** via facing life without any addictive process (which should be one primary treatment goal).
- Experience teaches that **relapse with one illness will often bring** with it, relapse in the other.
Etiology and development of eating disorders

• Don’t know causes
• We know they are biologically influenced
• Heritability index 0.5 - 0.7
• We don’t have much on specific and identified genes
• We do have identified personality temperaments
• We know that starvation can create eating disorders (Ansel Keys studies in 1940’s)
• We know there are multiple and complex factors beyond biology
• We do know there are risk factors
• Risk factors can sometimes be direct treatment targets
Risk factors for development of eating disorders

• Being female
• Family member with ED
• Family Hx for depressive and anxiety disorders
• Family HX for substance abuse
• Early onset of menarche
• High BMI during early sexual and physical development
• Specific personality temperaments
• Exposure to fashion/ thin ideal media
• History of excessive, extreme, repetitive dieting
• Activities demanding specific body shape
Development of eating disorders

• Not so much # of Risk factors have impact when there is a “perfect storm”
• Epigenetics and the expression of genetic make-up
• Development and maintenance of ED are often for different reasons: both can be targets for treatment
• The illness often progresses in an adaptive and functional role from undeliberate behavior, to coping style, to addiction, to identity
• SLIDE compulsive cycle
• When we are treating ED we are treating identity: the development, loss of and the reclamation of identity
An Obsessive / Compulsive Addictive Cycle

Increase Social Support Network: Family/relationship therapy and increase relationship activity and intimacy

Withdrawal
From others emotionally and physically - lying, deceit, detachment, avoidance, secrets, hiding and isolation

Confront: Declaration, tell the truth, ask for help from sponsor, friends, family, God

Self Forgiveness vs Self Punishment Learning from experience vs. criticism

Primary Difficult Emotions
Fear, anxiety, insecurity, shame, guilt, loneliness, poor self-esteem, isolation, emptiness, pain

Secondary Difficult Emotions
Guilt, shame, disgust, feeling out of control and discouragement

Relief
Temporary relief due to cessation of anxiety, false sense of control or euphoria

Compulsive Behaviors
Acting out addiction (sex, drugs, alcohol, purging, exercise, binging and starvation)

Obsessive Thoughts
Unconscious distraction away from feelings and difficulties

Anxiety
Builds from ruminating thoughts and anticipation

Label Thoughts: Obsessive and attend to other thoughts

Ride out anxiety, serve others, ask for help, give self options & alternatives

Therapy: Look at beliefs, thought process, events, meaning, decisions and acceptance of feelings

Notice: First thoughts, make cycle conscious, increases empowerment, journaling helps link feeling thoughts

Steps in the Cycle
Arrows point to Interventions

Recovery: different meanings & uses of the word

- **Recovery**: To reclaim that which was lost
- Recovery: Beyond sobriety and abstinence – to reclaim and develop a life of what can be “becoming”
- “In recovery”: A disease model in which the disease will always be - even in sobriety
- “Fully Recovered”: An illness model in which many will fully walk away from illness never to go back.
- Only an individual truly knows their recovery
- Important: use term “recovery” in beneficial ways
- **Example**: Me 33 years – recovery?
Assessment: formal and measures

- DSM V, mental status exam, social history
- OQ-45, CAMOS, BDI
- SASSI
- APA guidelines for best practice to gauge decisions for level of care
- BSQ (Body Shape Questionnaire)
- EAT (Eating Attitude Test)
- EDI
- Use of other standardized or “designer” questionnaires
- Use of concurrent/ongoing measures TJC and “Practice Based Evidence”
- With ED – get into the details
  - Ask specific questions % of day spent thinking of body image, food, exercise, caloric intake/output
  - What have they eaten today?
  - How do you feel about your body this morning?
  - How did you feel after you ate this morning?
  - What are your good foods/bad foods?
  - What are your personal food rules?
  - How many times do you purge each and how many times per purge you purge?
APA guidelines for levels of care in ED treatment

• Considering all possible levels of care (Inpt, RTC, PHP, IOP, Outpt) use these criterion:
  • Medical stability/risk Suicidality
  • Weight as percentage Motivation to recovery
  • Obsessive thought Co-occurring illness
  • Structure needed Pt’s ability to control
  • Purging behavior Environmental
  • Geographic
Assessment: additional needs

- Refeeding syndrome risks
- Ability to contain exercise and purging
- Assess external (behaviors) and internal (thoughts, attitudes, beliefs)
- Assess thoroughly for all mental health and addictive illnesses (SUD, sexual addiction, mood disorders, anxiety, PTSD, OCD)
- Screen for SI and self-harm risk, Higher rates in both
- Observable warning signs
Refeeding syndrome

- Body adapts to starvation
- Nutritional support switches body from a catabolic to anabolic state

\[ \text{↑ glucose} = \text{↑ insulin} \]

- Electrolyte imbalance (Ph, mg, K+)
- Daily cardiac monitoring and frequent EKGs
- Labs daily
National Institute for Clinical Excellence (NICE) guidelines for management of refeeding syndrome:

Patients at risk for refeeding syndrome

- **One** or more of the following: OR
  - BMI < 16 kg/m2
  - Unintentional weight loss of >15% in the previous 3-6 months
  - Little or no nutritional intake for >10 days
  - Low levels of potassium, phosphorus, or magnesium before refeeding

- **Two** or more of the following:
  - BMI <18.5 kg/m2
  - Unintentional weight loss of >10% in the previous 3-6 months
  - Little or no nutritional intake for > 5 days
  - History of alcohol abuse or drugs including insulin, chemotherapy, antacids, or diuretics
Treatment begins with assessment and understanding: towards deeper understanding

1. Assessing the individual needs of the client
2. Assessing the eating disorder and related client beliefs
3. Assessing trauma: events, circumstances, impact, beliefs, decisions, coping, and meaning
4. Assessing the clients spiritual framework
5. Assessing spiritual nature, beliefs, and practices
6. Assessing the clients theory & model of change
7. Assessing the clients reasons to get well
8. Assessing the clients theory and model of self worth
9. Assessing the client’s sense of self worth and identity
10. Assessing the clients strengths, gifts, and offerings
Assessment beyond assessment

- Client model of change: What do you have to do?
- Client model of self worth: How do you know?
- Reasons for recovery?
- Client support system: Who is in your circle?
- Client support given: What do you have to offer?
- Client spiritual beliefs: Share one spiritual belief?
- Client spirituality: Spiritual hero and why them?
- Client sense of self, purpose, meaning, calling: last 72 hrs, change 1 thing in world, dream, deepest desire
- List of questions: “3 things proud of yourself for?”
- ACTIVITY: above/sharing
Assessment of potential compulsive exercise as part of eating disorder illness

- Exercise as form of purging?
- Exercise to compensate for calories consumed?
- Exercise to relieve guilt from eating?
- Exercise in order to “give permission” to eat?
- Exercise to meet underlying needs: power, control, self-respect, avoidance of emotional needs or stress?
- Exercise as punishment?
Observable warning signs of ED

- **Obsession** with weight and food.
- Talk reflects diet, thinness obsession
- Overly concerned about calories and fat grams in food
- Feels need to exercise all the time
  - when motive is about relief of obsession
  - when sick or exhausted
  - compensating for eating too much by exercising.

- **Skipping meals**
  - Drink water, diet soda, coffee, no kcal beverages to evade hunger, chew gum
- Extreme limits on fat, carbs, and/or protein
Observable warning signs of ED (cont…)

- Extreme and rigid rules about good foods/bad foods
- Keeping journals of calories/food eaten and/or expended
- Eating extremely slow or fast to control hunger.
- Goes on extreme diets (i.e., eating only clear soup or only raw veggies)
- Cuts food into tiny pieces
- Moves food around on the plate instead of eating it.
- Competes with others about how little they eat.
- Goes to the **bathroom** a lot, especially right after meals
A few helpful and simple models of treatment

• **Kurt Lewin**: Felt need and pain + hope = change

• **MEB model** for addictive process: structure + love = change

• **Structure** – success – hope – commitment - hard work - recovery

• **CFC / quasi-trans-theoretical**:
  1) Awareness & understanding
  2) Ownership and responsibility
  3) Commitment to change – all sacrifices necessary
  4) Self correction and giving back
Effective use of treatment and change models

- **Ask** ? What is my model ? Be conscious, deliberate and clear **activity/SHARE**
- **Ask** ? The client “What’s your model of change” Join the client and then teach as you go to reduce resistance “What’s it going to take ?”
Evidence based treatments for eating disorders

- CBT
- FBT – family led re-nourishment of the brain
- SSRI anti-depressants
Quasi-evidence based treatments for ED

- DBT
- ACT
- IRT
- Neuro-sensori treatments
- Experiential and expressive therapies
- Spiritual treatments
- Mindfulness treatments
- Anxiety and exposure treatments
- Trauma informed care and environments
Research on treatment of eating disordered adolescence

- Thompson-Brenner et al. (2014) 120 mixed ED adolescents, 8 mo. LOS, 2/3 on psych (for MDD) CBT strong assoc for pts with poor rel and pers functioning, dynamic therapy assoc W/ better global outcome overall. AN improved most, 33% of all clients recovered

- Jennifer Couturier (2007) Evidence based treatments hard to come by, need for family involvement

- Lock and le Grange Maudsley or FBT is now evidence based practice for children and adolescents
Foundation stones of treatment

- Children are spiritual (Lisa Miller)
- Spirituality #1 deterrent for our youth **GET BOOK !**
  3X 1/3: medicine, dietary, psychotherapeutic (team)
- **Re-nourish** the brain
- APA Guidelines as best practice markers
- Use of **structure**
- Use of **transitional and step down care**
- Abstinence a beginning goal and then growth & becoming
- Treat the **whole person** including the spiritual
- **Family therapy** beyond token gestures
- **Aftercare**, aftercare, aftercare
Treatment of Adolescent ED Clients would best focus on 5 core developmental needs

• 1) A sense of acceptance and belonging in a social sphere
• 2) A sense of being important and valued in the family
• 3) A sense of spirituality, purpose, and meaning in life which gives hope
• 4) A sense of self and identity
• 5) A growing set of principles in which one’s life is anchored

- Stephen Glenn & Michael Berrett
The process of identity formulation

1) PICTURE #1: Lucy. I am born with a soon to fade sense of my worth and identity (ages birth to young years)

2) PICTURE #2: In the Mirror. I am the reflection of what others see in me with their eyes and their hearts. I need a mirror to see me. You are my mirror (ages 1-2 & 5-12)

3) I am me only as I am independent from them: rebellion, separation, opposition (ages 3-4 & 13-17)

4) I am me and “OK” when I am the same as my peers (ages 11-14)

5) I am me and “OK” when I am different from everyone else (ages 15-18)
We become the mirror of spiritual identity for another: a negative or positive mirror
The process of identity formulation cont…

6) Identity conceptualized in knowing “what/who I am not” without knowing “what/who I am” (ages 15-18)

7) Identity conceptualized in questioning even abandoning legacy, yet not knowing where I am headed. A sense: separate & unique

8) I am me, whether I am the same, or different, matters not. I accept my uniqueness, yet care not about sameness or differentness. Principle versus approval driven. Beginning of mature sense of self (age 14-90)

9) I conceptualize self in terms of “who I am” and I don’t worry about “who or what I am not”

10) I stick with what I know about me and hold tight to that. I worry less about what I do not know about me

11) I accept who I am and gently strive towards who I can be

12) I go from spiritual exploration to individuation, from individuation to spiritual identity, I actively live my spiritual beliefs, and I am both “being” and “becoming”
Stuff happens: our sense of worth & identity suffers
Conceptualizing and strengthening spiritual identity through core component intervention

• THE NINE P’S OF PERSONHOOD

1) PHYSICAL SELF - body, life vehicle, gender, gender identification, sexuality, genetics, ability to move and do, competencies (hike)
   EXAMPLES: body type, explore DNA heritage tests, family illness Hx

2) PROGENITORS – biological and adoptive caretakers and ancestors (physical and spiritual)
   EXAMPLES: what they gave you want - don’t want, keep –not keep, assignments to spend time with progenitors with questions

3) PERSONALITY – (temperament) accepting pluses and minuses
   EXAMPLES: objective tests, ask for group feedback, self description

4) PASSION - find it and live it
   EXAMPLE: “what’s in your closet ?” JS, What do you get excited about ? What makes you want to get our of bed in the morning ? Design the doing of more of it !

5) PURPOSE - meaning, calling, want most to accomplish, tied to dreams
   EXAMPLE: Just start with and stick with what you DO know, What do you know deep in your heart you were meant to do ?
Conceptualizing and strengthening spiritual identity through core component intervention cont…

- 6) PERSPECTIVES – passion and purpose guide our viewpoint, opinion, beliefs,
  EXAMPLES: DECLARATION, STORY: dhb family reunion political line

- 7) PRIORITIES - passion and purpose become our priorities
  EXAMPLES: examine priorities vs. time, effort, decisions and realignment

- 8) PRINCIPLES - come from who we are, how we live, character, and create who we will be, our striving
  EXAMPLES: top 5 principles you live by? Why those important to you?

- 9) POTENTIAL - who we can become (integrity is conscious becoming)
  EXAMPLE: What do you want the unwritten eulogy to be?
  - M Berrett adapted from R. Allen
Differences adult versus adolescent: compared to adults adolescents need more:

- Structure, behavioral approaches, *experiential therapies (slide)*, encouragement, immediate praise, hope, help to create a positive vision of their future, clear and explicit directives, help in planning, explained roadmaps of where we are going, informal non-verbal therapy, family involvement, consistent messages that they are important, wonderful, and good enough, short-term, small, and achievable goals, education and opportunities to learn, small assignments and activities between sessions to keep the work going, quantity time to increase chances of quality time.
Tips on dietary approach for those with ED

- **Start with structure;** plated food and meal plans (plated water)
- **FBT approach with AN youth** with much family involvement
- Help of an ED experienced **dietitian** is essential
- Since ED has tendency to focus on rules, numbers, rigidity – gently move them away from counting calories
- **Increasing breadth of food choices** for a patient is important in recovery from an eating disorder.
  - Be cautious of “good/bad food” mentality.
  - They need to be challenged- if they have to tightly control it, they aren’t recovering
  - Use liquid supplements when solid meals fall short
- **Consider the eventual value of an intuitive** eating approach, listening to and trusting to one’s body
Tips on dietary treatment

- **Use wording** of “weight restore” and “re-nourish” instead of weight gain
- **Staff should eliminate “diet talk”** refrain from body image comments or exercise talk around patients
- **Wait 30 minutes** after meals before bathroom
- Clients can **sing in the bathroom** and/or have **door cracked**
- **Restrict any exercising** after meals/snacks
- **Hands on top** of the table, same with napkins
- **Plate food** for clients in the beginning of treatment
- **Weigh in back to scale**
- If water loading or hiding items at “weigh in” is high risk – weigh in gown only
Tips on dietary treatment

- Use **liquid supplementation** with falling short on solid food
- Encourage and **structure** have **3 small meals** and **3 snacks** a day
- Be judicious regarding caffeine intake, smoking, stimulant prescriptions, laxatives, stool softeners, diuretics
- **Exercise best light** and yoga or recreational versus hard aerobic (individualize and military consideration)
- **Pocket searches** after meals/snacks
- **Do comment on inner qualities** versus external appearance
  - You look good = I must look fat
  - You have light in your eyes, you look alive
  - I’m impressed with your integrity
- Be mindful of the shame attached to BN and BED versus a narrow, fragile, and false AN pride. **Treat Shame**
Initial Interventions for adolescents:

• 1) Make the Contact: **Approach** and go to the concern **rather than wait** - Ask

• 2) Approach with **tentativeness**: “I’ve heard, seen, or noticed”

• 3) **Express your concern** and your **good intent**

• 4) **Do not start with diagnosis** or labeling as “eating disorder” or “bulimia” Simply report observations and express your concerns

• 5) **Assess** severity of symptoms, motivation for recovery, stage of illness
Initial Interventions Cont…….

• 6) Assure **medical safety**: If in danger of suicidal or medical risk – take action now!

• 7) If medical or psychological de-compensation in youth is serious, mobilize family, and if necessary, **pursue DCPS involvement**

• 8) **If not** immediate danger – **work with youth** towards self action

• 9) **Steer the patient and family towards** referral to medical and clinical specialist if needed

• 10) Use “**forced choice**” if relationship allows, or if condition dictates necessity
Initial Interventions Cont…..

• 11) **Join their world** first and connect with them where they are: Join first, guide later
• 12) First learn from them, then teach them
• 13) **Honor confidentiality** in services offered
• 14) In individual counseling avoid talking numbers: “What would be talking about if not this…?”
• 15) Focus more on feelings, beliefs, concerns, fears, and less on particular behaviors
• 16) Don’t get bogged down in talk of fat, calories, weight
17) **Themes for intervention** can include: nourishment, honesty, openness, asking for help, deferring urges, connecting ED with needs, feelings, and beliefs, and finding new ways to meet needs, ask “What do you really need or want ?”

18) **Plant a seed** and open a door (my **STORY**: 4 years later)

19) Be **patient and keep door open** – they may walk through a door later

20) Establish yourself as a contact and support person

21) Remember that **nourishment is pre-eminent**
Core principles of treatment and recovery

• 1) Take the eating disorder/addiction off the pedestal & out of the swamp of shame
• 2) Find and nurture reasons for recovery
• 3) Separate the person from the illness
• 4) Embrace feelings without self judgment
• 5) Create structures which invite success, hope, commitment, sacrifice, hard work, and recovery
• 6) Creating social support, both given and received
Core principles of treatment and recovery (cont…)

- 7) Re-connection to self, others, spirituality, life
- 8) Giving and receiving love
- 9) Feel the fear and do it anyway: avoid only avoidance
- 10) The truth shall make you free: honesty accountability
- 11) Seek the therapeutic mirror of spiritual identity
- 12) Re-invent what you trust: listening to and following the heart
Taking the eating disorder off the pedestal and out of the swamp of shame

• 1) Deliver a message of **hope for full recovery**
• 2) Teach that the “elevation” of the ED is not a deficiency, but rather the “nature of the illness”
• 3) **Teach** the truth about ED as **mental illness**
• 4) **Teach** ED **risk factors** and “**perfect storm**”
• 5) Teach about the development of illness with connection to illness and disconnection from other
• 6) **Intervention**: Begin shedding shame with written life and ED **autobiographies** which can increase self understanding and compassion
Taking the eating disorder off the pedestal and out of the swamp of shame (cont…)

• 6) Teach that while you didn’t choose illness, you can choose recovery from it
• 7) Teach that recovery is not just a place to “get to” but also a way of living now, a choice in the moment
• 8) Take ED off Pedestal while elevating the client
• 9) Intervention: Spitting in the ED soup, and plant a few seeds (i.e, “It’s sad to see your loss of freedom as a slave to this illness”
• 10) Intervention: “You have become one of the best at that which doesn’t really matter.” What do you really want to become good at”
Taking the eating disorder off the pedestal and out of the swamp of shame (cont…)

• 11) Have client share what it is really like in illness
• 12) Have family and friends share what it is really like to have a loved one suffer with an eating disorder
• 13) Family session intervention: “All the ways I have been dishonest” and “What it’s like to be on the receiving end of the dishonesty”
• 14) Have family share their hopes and dreams for the client
• 15) Use power of group in healing shame
Find and nurture reasons for recovery

• 1) **Any reason** is a good reason
• 2) Every reason is an important reason
• 3) **Story:** Recovery group mis-step “If you don’t get better for yourself then you will never get better”
• 4) **STORY:** MEB 1) deserves better, 2) do it twice?
• 5) **Dismantle the client’s reasons to stay in the illness**
• 6) Teach patients why you want them to get better
• 7) Help clients write, voice, remember their reasons
Find and nurture reasons to recover (cont…)

- 8) Posting reasons in sight (sticky pad)
- 9) **Example**: Use of symbols and objects to remember reasons (i.e., ring)
- 10) **Strengthening reasons by declaring** them out loud
- 11) **ACTIVITY**: What was your reason for coming here
- 12) **Activity**: What was your reason for doing this work
- 13) **Ask?** What if you remembered that daily? Our clients?
Separate the person from the illness

1) Teach actively that the **client is not an illness**, yet suffers with an illness.

2) **Watch our language**: “a person suffering with bulimia” versus “she is bulimic” or “he is alcoholic”.

3) **Intervention**: Put the **illness “over there”** in writings to and from illness and in gestalt empty chair.

3) **Deepening principles of experiential intervention**: write about it, talk about it, write to it, talk to it, engage it in imagery, engage it in reality (use object).

5) **Talk for** the eating disorder to self, talk for yourself to the eating disorder.
Separate the Person from the Illness (cont…)

• 6) **Intervention:** Externalize the illness as an **object:** “kneeling at the **shrine** of the holy eating disorder”

• 7) **Intervention:** Externalize the separation via group intervention: the **re-enactment of the negative mind**

• 8) **Discuss the difference** between hearing versus following, agreeing with, and obeying the voice

• 9) Check out the book: “Life Without Ed” J. Schaefer

• 10) **Journal** what ED or the Illness tells me

• 11) Journal what I tell Ed or the Illness
Embrace feelings and self without judgment

• 1) Those suffering eating disorders and SUDS end up numbing, avoiding, or coping with emotion via their illness
• 2) The eating disorder/addiction becomes functional in the process of avoidance of emotion and action
• 3) The eating disorder/addiction becomes over time an illness of avoidance
• 4) Sadly, it’s not just painful emotion that is lost in this process. Positive emotion including joy is also lost
Embrace feelings and self without judgment

• 5) Traditional thought re: motive behind avoidance of emotion: “The emotion is too intense to handle”
• 6) A little known yet key reason that clients avoid emotion is because they judge themselves for their feelings harshly. This judgment may be more painful than the original emotion (e.g., anger = ungrateful)
• 7) STORY: MEB-Tx W/Adol-anger at dad-froze-I can’t
• 8) Teach the DBT skills including “witnessing of emotion”
Embrace feelings and self without judgment (cont…)

• 9) Teach the concept of descriptive truth versus evaluative truth

• 10) With clients who are disconnected from affect, watch for it and go to it in session. This teaches the client to go to emotion versus run from it

• 11) For theistic clients, let there be only one judge, God. For non-theistic clients, let there be no judge. Ask clients to give up the role of judgment
Create structures which increase success, which leads to hope, motivation & commitment, hard work, recovery, and becoming
The need for structures in treatment

- The **need for structure** in treatment of compulsive and addictive processes is absolute
- The **purpose** of structures is **make it difficult** to do illness and easy not to do illness
- Structures provide containment
- Structures give continuity
- Structures give direction
- Structures link the work together
- Structures and players in support systems create safety nets
- Structures lead to recovery
A therapeutic model: the blessings of structures in treatment

- Structures increase chances of success
- Success nurtures hope
- Hope nurtures motivation, commitment (willingness to do everything necessary), hard work, sacrifice, and endurance
- This leads to recovery and opens the door for becoming

- **STORY**: MEB client: (e.g. 6 days W/out purge: worlds record) **Example**: 30 day chip
Structure of behavioral intervention

1) Behavioral assignments are important “Do this” versus “Think about”

2) Have them create healthy rituals which become part of their daily life and which make ED behaviors more difficult

3) Scheduling is important as a structure

4) Build with the client, a therapeutic day as if in intensive care. Simulate it as best you can
Structure of behavioral intervention (cont…)

- **Assign**: Ask client to journal after therapeutic intervention their learnings – create their own personal self heal book
- **Assign**: Ask for client commitment to journal daily including: mistakes made, things learned, choices, decisions, successes had, progress made, feelings, deep desires, goals, impressions or messages of the heart, spiritual experiences, and “what I feel proud, good, or peaceful about today with myself”
Teaching as a structural intervention

- Teaching simple truths and concepts the client can take home:
  - Love and trust are not the same thing
  - **Trusting self** is more important than proving trustworthiness of others
  - Trust is specific and not necessarily global
  - **Love and approval are not the same**
  - ED all too often becomes the consolation prize
  - With ED full recovery is possible
  - ED is an illness of avoidance
  - **Avoidance maintains low self esteem**
  - Vulnerability is not stupidity - rather a gateway to emotional intimacy, relational closeness, and personal strength
  - The “Heart” is different than feelings and thoughts
  - **Discuss:** That change comes best from both outside in and the inside out
Creating social support: both received and given
The importance of emotional and social support

- **Research**: social support ameliorates the effects of stress
- Model of social support: emotional, information, assistance, feedback, belonging, relief (Keele, Berrett, others)
- Social support model of reciprocity: receiving and giving are both important
- **My research** findings:
  - Adolescents: The more support, the less life difficulty
  - Adolescents: the **ability to give** is of extreme importance
  - **Example**: Youth activities: participation in service transcends fun
- **Giving of oneself** including meaningful service is an **important part of recovery** (i.e., CFC choir, teaching, mentoring) I have something to offer
Creating emotional support: family intervention (cont…)

- In family therapy - empower family members to cease egg shell walking and to overcome their fear based obstacles to speaking up and helping
- Teach them how to support their loved one in the recovery process through an ENGAGED/ slide and respectful relationship (Story: Patch)
- Help all develop appropriate boundaries
- Assess and rigorously address any inter-generational roles, beliefs or patterns in the family which bolster the eating disorder
- Teach family members to look at their own lives and embrace self growth as a personal quest and a family ideal
Creating emotional support: family Intervention (cont…)

• Address family rules about food, body image, societal image, and direct and indirect expectations

• **Interventions**: multiple family therapy can be very powerful, healing and supportive (e.g. multi-family group: adopt a new family; mothers inner circle)
Creating emotional support: family intervention (cont…)

- Help families have **family meetings** where the client moderates the discussion around help needed, help received, and what is truly helping or not
- Help families have **family together time** where eating disorder/addiction **will not** be discussed at all – just the rest of life and doing something fun together
Re-connection to self, others, spirituality, life

1) **In addictive illness** the client becomes more connected to the illness, and less connected to self, others, higher power

2) Recovery requires **disconnection** from the illness and **reconnection** to that which is most important including relationships, self, passion, purpose, dreams

3) **Intervention**: Sharing via topic and **deepening**

4) **Intervention**: Daddy-daughter dance and sharing

5) **Example/story**: MEB Holiday gratitude sharing

6) Help the client **Use their spiritual beliefs** towards recovery

7) **ACTIVITY**: Spiritual Heroes
Giving and receiving love

1) Love is the **most powerful** source of healing
2) Our clients **often hold back** giving their love because they believe they have a defective gift to give
3) Our clients **resist receiving** love as they make themselves an exception in feeling worthy of it
4) Love and approval have often become one and the same to our clients. This leads to feelings of love loss
5) **Find ways** express love our clients – let them know that you care
6) **Activity**: How do you resist and reject love?
Giving and receiving love (cont…)

• 7) Refusal to ask for help, saying “I can get it,” or “I’ll be alright” are ways to resist love
• 8) Group intervention: love and tissues
• 9) Group intervention: thank you I know
• 10) Assign: to extend themselves for another: “You love those your serve”
• 11) Assign: to express love more vulnerably and fully
• 12) Story: the boy the dad and the big rock
Feel the fear and do it anyway: avoid only avoidance

• 1) **Book**: Feel the Fear and Do It Anyway by Susan Jeffers SLIDE X 1

• 2) **APA Book**: Clinical Paradoxes: Avoidance and Self Esteem by Bednar et al

• 3) Poor self esteem comes from a thousand different places

• 4) **What maintains** poor self esteem is avoidance

• 5) The eating disorders/addiction become illness of avoidance

• 6) **Exposure therapies** for avoidance and anxiety
You can do it!
Feel the fear and do it anyway: avoid only avoidance (cont…)

• 6) If we know what we will do in any set of circumstances, we have little to fear

• 7) STORY: the man with the burning sawmill

• 8) Ask clients what they avoided last night, or what they are avoiding in session right now. Make avoidance one theme in treatment

• 9) Intervention theme: after repeated avoidance – lets do it now in session
Feel the fear and do it anyway: avoid only avoidance (cont…)

• 10) **Group intervention**: Make the implicit explicit with *body image shame*, stand in middle of *circle* with all staring – get in touch with beginning of body image shame- see it differently, make a new decision

• 11) **Group intervention**: Number and letter out of hat, hula hoop, *dance*, or *sing* acapella

• 12) **STORY !**: MEB/OB marathon final exam & awakening on sense of self and having *voice*

• 13) **Example**: DHB family reunion – *we do hard things*: on the line obama vs. romney

• 14) **Slides X3**: Pole’ pole’
The truth shall make you free: honesty and accountability

- 1) Let clients know you will always and only tell the truth. **Commit** that to them
- 2) **Set a clear expectation** with them of their complete honesty
- 3) Help them understand the difference between honesty and openness
- 4) Teach them the principle of **self correction versus perfectionism** and the 24 hour self correction rule on honesty
The truth shall make you free: honesty and accountability (Cont…)

• 5) Teach that self correction is the pathway on which an honest life is lived, and that perfectionism is not the answer, and perfection is not possible

• 6) One step into accountability and honesty is to once again begin to make promises and commitments) (help clients use their integrity towards recovery)

• 7) Ask clients to again promise and commit. Better to commit and fall short than avoid commitment

• 8) STORY: Frodo and Sam “I made a promise” Promises are powerful
Seek the therapeutic mirror of spiritual identity

• 1) Our clients cannot see themselves the way they really are
• 3) Their body image is distorted, dysmorphic, and even sometimes psychotic. The same is true of their view of themselves, worth, and identity
• 4) Purpose, meaning, calling, deepest desires, and dreams are an important part of spiritual identity
• 5) These things become reasons for recovery
• 5) Activity: Share 1 thing you know about your life purpose
• 6) Story: MEB “You’ve gotta help the young people”
Seek the Therapeutic Mirror of Spiritual Identity

• 7) We hold up the mirror for them, so they can see what we see. We tell them what we see, and then we invite them to see the same thing.

• 8) **Story**: girl in group, then later on the unit comforting another “**that’s love**”

• 9) **Story**: daughter and granddaughter “That was so very brave last night on the phone with your friends”

• 10) We **create a mirror also with questions**, “What did you notice about you?” Which part of what you did are you proud of?” “Tell me the pluses and minuses”
Seek the therapeutic mirror of spiritual identity

11) Sometimes being the mirror for them to see means that we “give words” or “label” things they do for what they really are.

12) Help them see how great they are not just for what they do, but *for who they are* on the inside, including the intent of the heart.

13) We *teach them to find* or notice those things themselves.

14) They can solidify what they see, or find about themselves by *documenting* it in their journal.
Seek the therapeutic mirror of spiritual identity

• 15) Embracing self may require a new model of self and self worth beyond the western culture model of: appearance, achievement, and approval

• 16) Explore with clients a new model or way of knowing of self esteem and self worth “How do you know of the worth of your little sister ?”

• 17) Consider the idea of “being” and “worth is”

• 18) Consider indicators internal including intention, effort, love, gifts, talents, capacity developed and yet undeveloped, integrity, courage, principled living, passion, and purpose

• 19) ACTIVITY: What is yours? How do you know?
“Spiritual Identity is both a sense of who we are, and a sense of who we might become”

“It’s never too late to become who you might have been”
- George Eliot
Re-claim what you trust: listening to and following the heart

• 1) In the **addictive process**, clients **listen more to illness** and less to themselves (their hearts)

• 2) Clients often **believe** that they are in the **trouble** they are in **because they trusted** and listened to themselves. **The truth is** – we are most often in trouble when we stop listening to and trusting and following our own hearts
Re-claim what you trust: listen to and follow the heart

• 1) **Teach** directly that there are thoughts, and feelings, and also something deeper “the heart”

• 2) **Research** is reveals neural activity of the heart on it’s own, and messaging to the frontal cortex (McCraty)

• 3) **What is heart?** the heart is what ever it is to the individual, based on spiritual beliefs: sensitivity, sensibility, the unconscious mind, the best self, the real me, the wizard within, impression, intuition, God talking to me
Listening to and following the heart

• 4) The messages of the heart are most often quiet, profound, important

• 5) We know it is NOT “the heart” if the messages are NOT respectful, kind, uplifting, and encouraging. The heart always lifts us up, and never puts us down – even when the message is hard to hear

• 6) We can learn to listen to and follow the heart

• 7) We can learn to hear, but to refuse to listen to, agree with, follow, believe, or obey the negative mind. Heart is one replacement of “negative voice”
Listening to and following the heart

- 8) **Story**: Richardson Bike Mart
- 9) **Story**: The subway violinist
- 10) **Story**: The taxi driver
- 11) **STORY !**: girl SHS survival trip vs. end
- 11) **Activity/Reflection**: Thoughts this am? Feelings this am? What did you know in your heart this am? (hand, eyes, breathing) **Share**
- 12) **Ask**? What if we remembered what we knew in our hearts throughout the day?
- 13) **Ask**? What if our clients remembered?
Thank you so much for your time, your efforts in showing up, your presence and participation.

May God bless you in your noble efforts and your competent and kind service which decreases suffering in individual lives of the young people you serve.