Child, Adolescent, and Family Behavioral Health Fellowship

Didactic and Case Discussion Workshop Combined

June 23, 2023

ATTENDANCE LINK IN CHAT

Winner Winner Chicken Dinner (or gift card)

- Monthly Data Collection

Workshop Agenda

Time to Laugh Survey

Eating Disorders and Ages 13-21 by (10-12pm)

Meredith Nisbet, MS, LMFT, CEDS-SS

Short Break (~5 minutes)

Grounding Exercise

Case Discussion (12-1pm)

Emone Black, MA, NCC, LCMHCA, CCC

*Poll in zoom

Speaker Introduction

- Meredith Nisbet, MS, LMFT, CEDS-S
- Undergraduate degree Gender Studies from UNC-Chapel Hill
- Masters Degree in Marriage and Family Therapy from ECU
- National Clinical Response Manager @ Eating Recovery Center and Pathlight Mood and Anxiety Center
- Private Practice Therapist

What's Food Got to Do With It? Eating Disorders in Adolescence

Meredith Nisbet, MS, LMFT, CEDS-S

Meredith Nisbet, MS, LMFT, CEDS-S
@therapywithmere

A note on language

Yes, please!

“fat” – when used as a neutral descriptor rather than in a derogatory way. Similar to tall/short, old/young, etc.

“person of size”

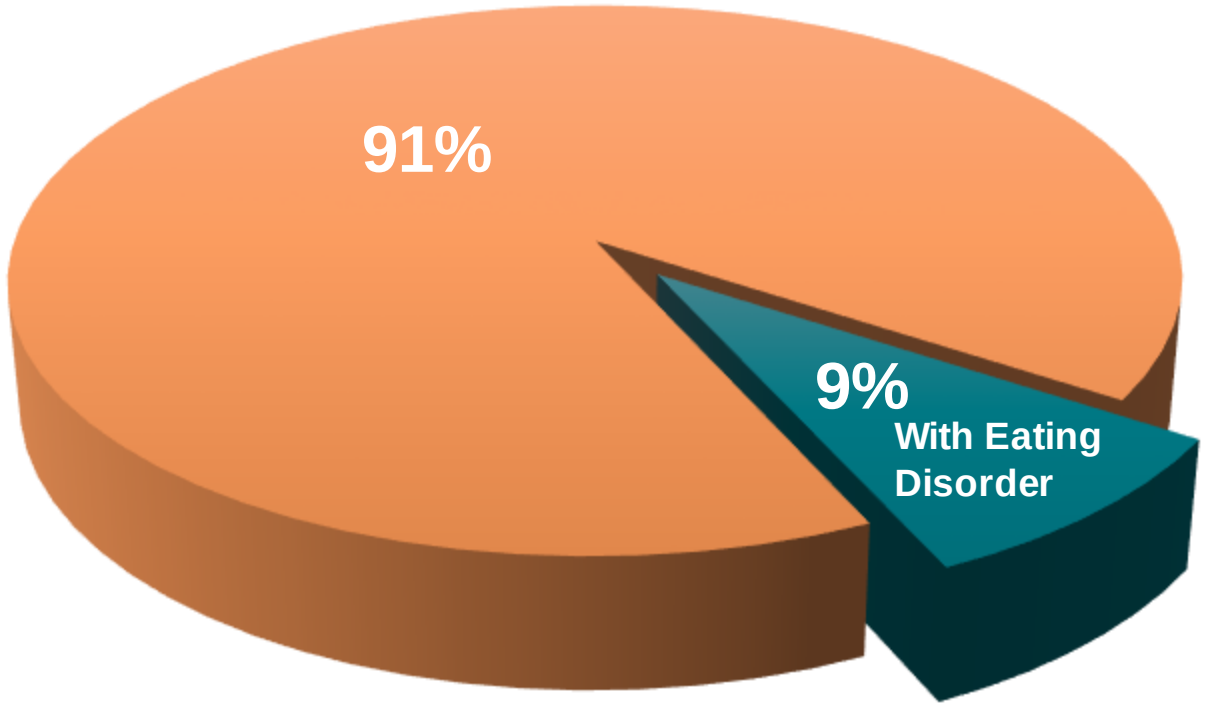
“person in a larger body”

No, thanks!

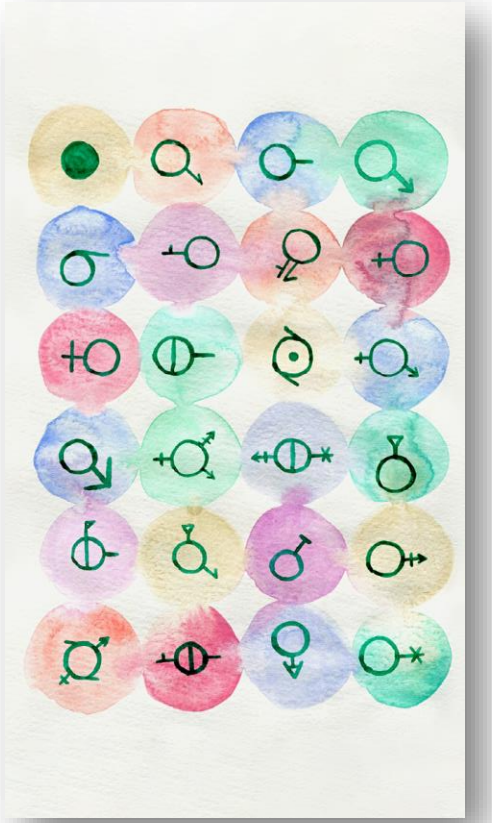
“fat” – when used derogatorily

“obese/obesity” – rooted in the medicalization/pathologization of bodies, often very triggering for larger bodied folks as it is resonant of negative healthcare experiences

Worldwide Population Impacted by EDs



Gender Identity Breakdown Studies



3:1 Female to male

Better data is needed regarding ED pervasiveness in non-binary/genderqueer/gender non-conforming communities.

Largest study pulls from college students

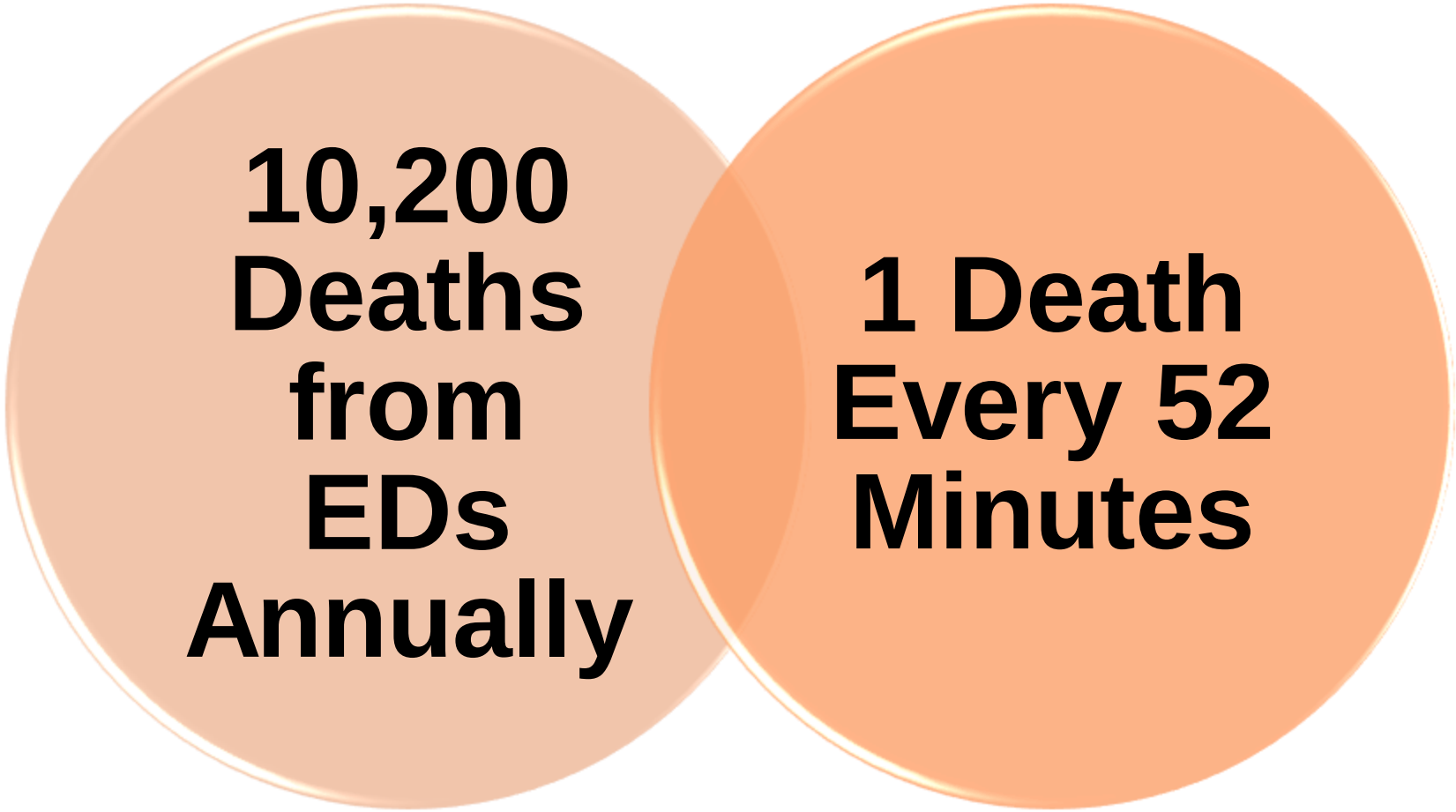
Genderqueer/gender non-conforming students were most likely to be at risk of eating disorder (38.8% of this group showed “clinically relevant” eating disorder symptoms), followed by trans women (37.1%), gender expansive students (34%), and trans men (34%).

Simone et al., (2022). Variability in eating disorder risk and diagnosis in transgender and gender diverse college students, Annals of Epidemiology, 70, 53-60

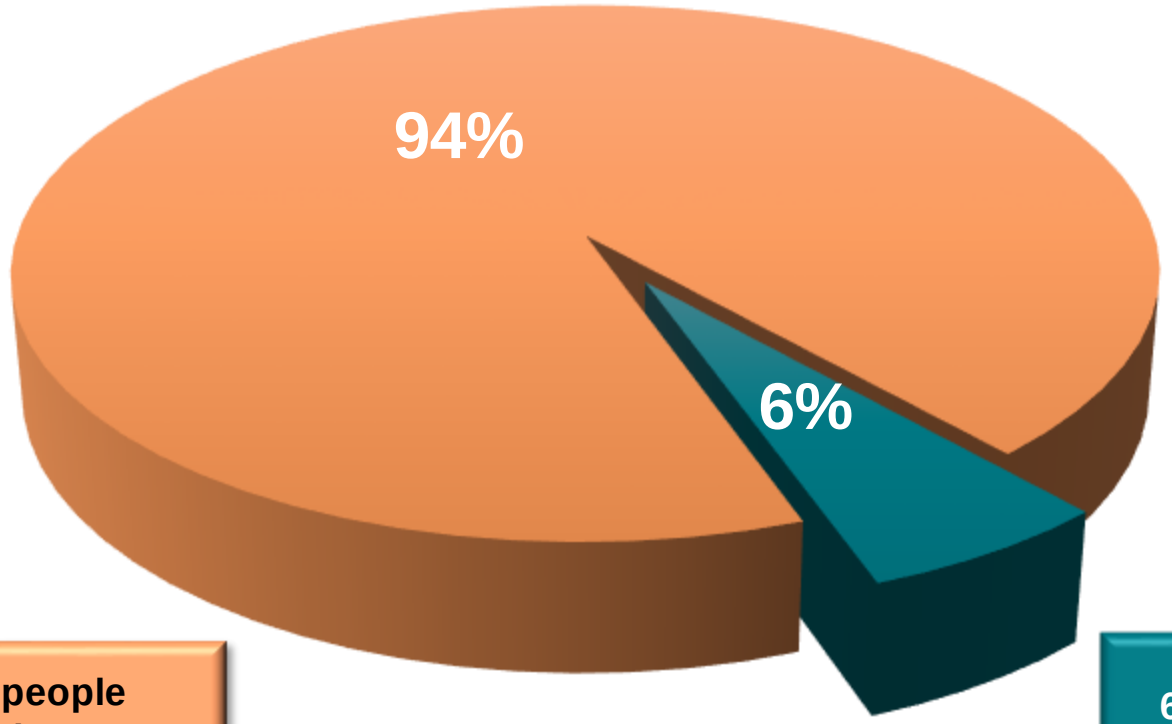

SOMEONE CAN STRUGGLE WITH A LIFE THREATENING EATING DISORDER IN ANY BODY AT ANY SHAPE OR SIZE.


Statements that prevent people from getting care for their eating disorder:
You don't look sick.
You look fine.
You haven't lost weight.
Your weight's not low enough.
You're still in a "normal" range.
You're not thin.
You're too big.
You look good.
But you're so healthy.

Eating Disorder Annual Toll



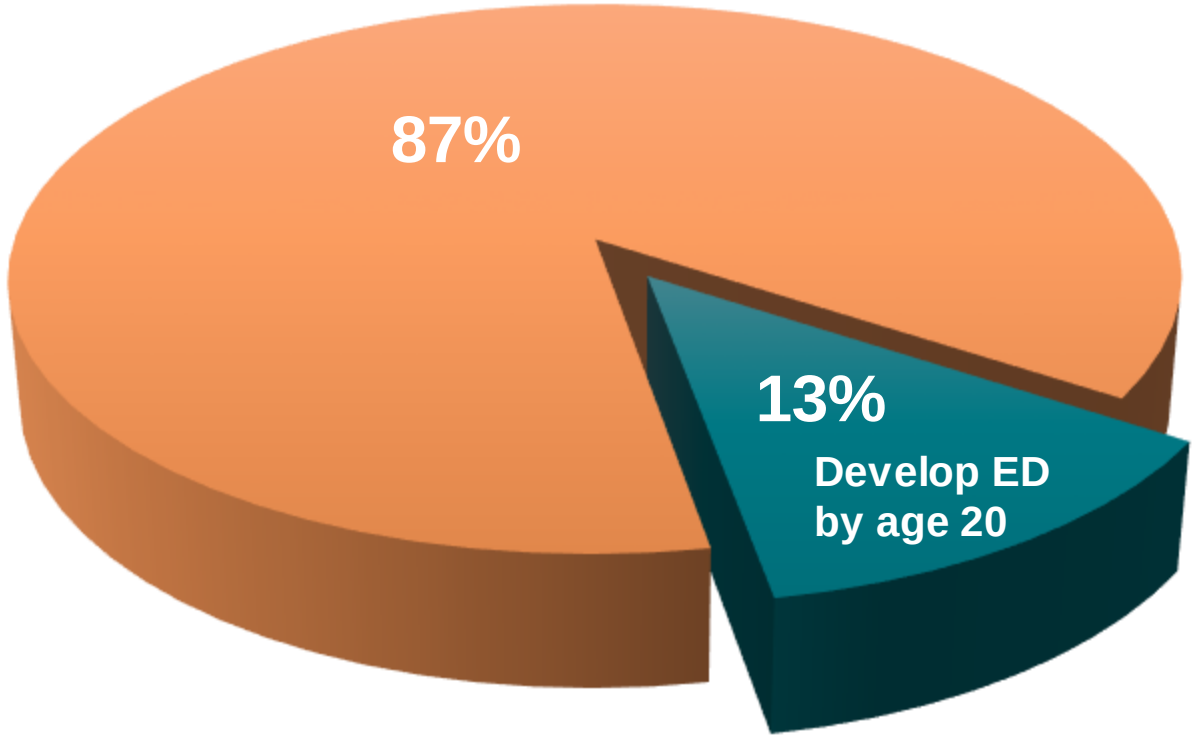
% of People with EDs Who Are Underweight



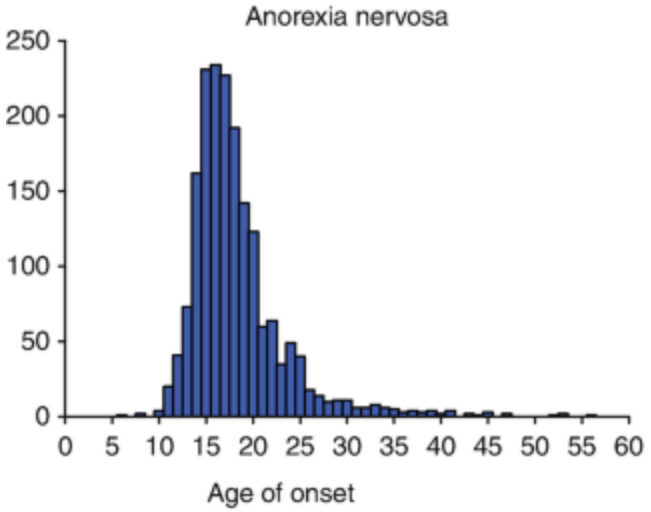
94% of all people with an eating disorder are at or above prescribed BMI.

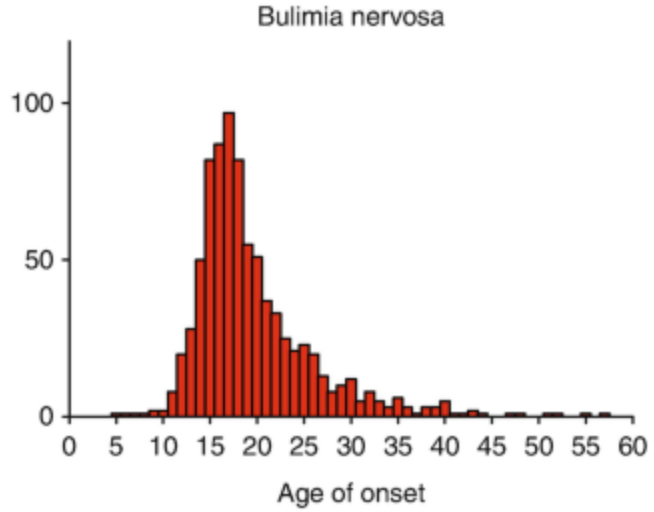
6% of all people with an eating disorder are under appropriate weight.

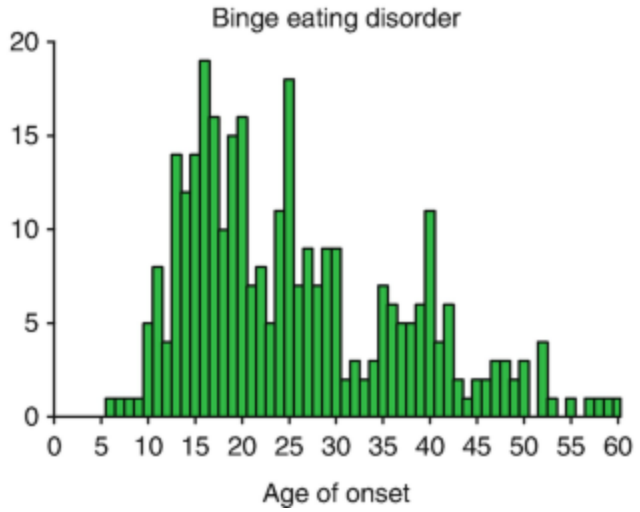
Adolescent Population and Eating Disorders

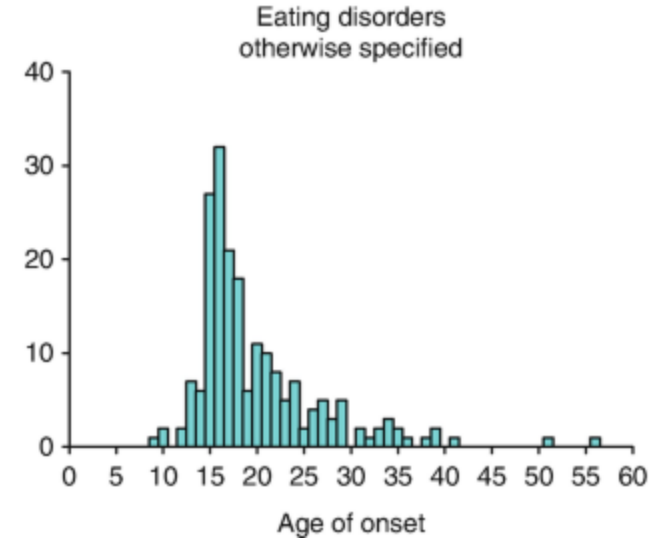


Average Age at Onset









Favaro, A., Busetto, P., Collantoni, E., Santonastaso, P. (2019). The Age of Onset of Eating Disorders. In: de Girolamo, G., McGorry, P., Sartorius, N. (eds) Age of Onset of Mental Disorders. Springer, Cham. https://doi.org/10.1007/978-3-319-72619-9_11

Adolescent Population, Weight Control, and Eating Disorders

2.7% of teens will experience an eating disorder in their lifetime

6.2% of girls and 2.8% of boys reported vomiting or taking laxatives in the past month to lose or maintain weight

42% of 1st-3rd grade girls want to be thinner

81% of 10 year old children are afraid of being fat

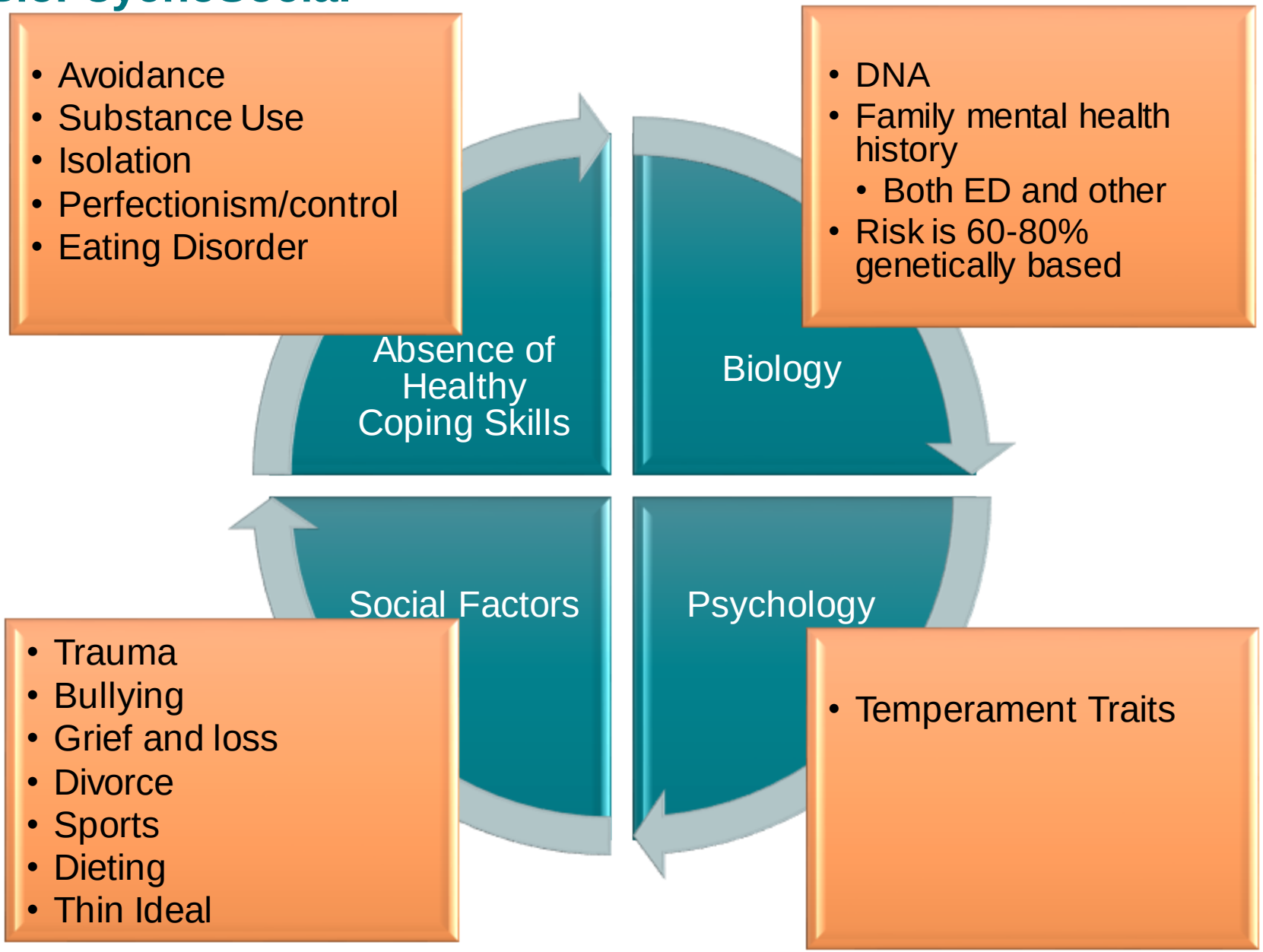
46% of 9-11 year-olds are “sometimes” or “very often” on diets

35-57% of adolescent girls engage in crash dieting, fasting, self-induced vomiting, diet pills, or laxatives

In a college campus survey, 91% of the women admitted to controlling their weight through dieting

Who Develops an Eating Disorder & Why?

The BioPsychoSocial



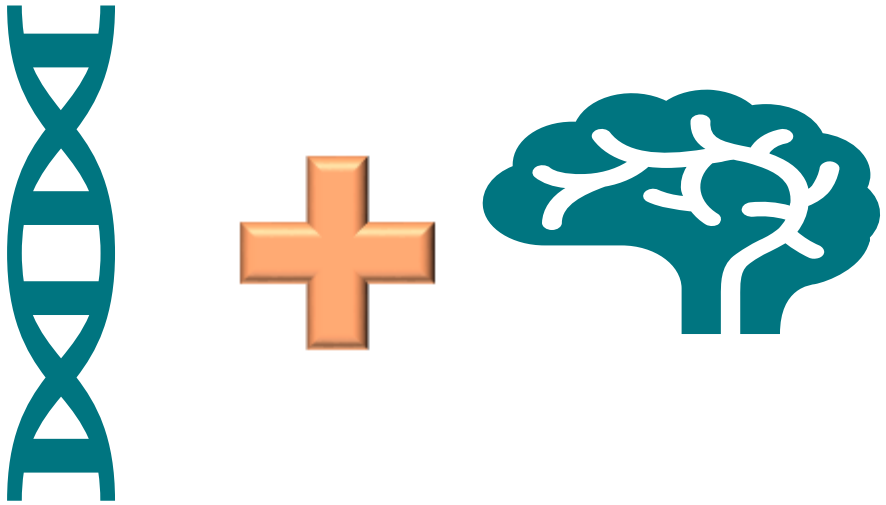
Mehler, P. S., MD, FAED, & Andersen, A. E., MD (Eds.). (2017). *EATING DISORDERS a guide to medical care and complications*. Baltimore, MD: JOHNS HOPKINS UNIV PRESS.

Biology

Altered serotonin and dopamine functions contribute to the dysregulation of appetite, mood, and impulse control in individuals with eating disorders.

60-80% of the risk of developing an eating disorder is related to genetics

Over 40 genes are involved in the regulation of eating disorder behaviors, motivation, reward, personality traits, and emotions.



Genetics Neurochemistry

Adverse Childhood Experiences

Reinecke et al., 2022

- Eating Disorder sample reported higher ACES scores compared to the national sample, including emotional and sexual abuse experiences
- Patients with binge eating disorder more likely to have had physical and emotional ACES
- OSFED patients more likely to have experienced high levels of household dysfunction

Table 3

ED sample compared to nationally representative sample

Total Sample				
Sample	**ACEs M (SD)**	Emo Abuse (%)	Phys Abuse (%)	**Sex Abuse** (%)
ED	**1.95 (1.90)**	35	16	**19**
Nat'l	**1.57 (4.72)**	34	17	**11**

Social and Environmental Factors

Complexity/transition/movement to different life stages

Engagement in activities focused on an ideal/"right" body shape/size

Dieting/unintentional weight loss

Trauma/ACEs

Diet Culture

Weight and Body Stigma in Treatment

Why do providers need to understand weight and body stigma?

Our own work as providers to unpack systemic oppression is crucial to the ethical and effective treatment of eating disorders; we have a duty of non-malfeasance.

"If we rely on standard diagnostic criteria for phenomena currently known as eating disorders, fat becomes something to be feared, something to resist, and something to prevent." - Friedman, Rice, and Rinaldi 2019

Non-Malfeasance

- As providers, we all follow a code of ethics that centers on non-malfeasance – essentially, do no harm.
- When we prescribe weight loss or restriction, perpetuate stigma around weight gain or higher weight, or engage in the promotion of diet culture, the research is clear. We are doing harm.
- It is our ethical responsibility to treat our clients with compassion, and respect for body diversity and autonomy, and to work to dismantle the many systems that disadvantage them.

Provider reflection questions

- What assumptions do I make about a person's character, intelligence, professionalism, health status, or lifestyle behaviors that is based only on weight?
- What are common stereotypes about people in larger bodies that I believe to be true? Why?
- What are my views about the causes of higher weight? How does this impact my attitudes about size diversity?
- How do these biases impact the care I provide to ALL patients?
- Our biases towards people in larger bodies parallel the patient's ED voice: glorifying low weight, weight loss, restriction, compensatory behaviors for weight management and demonizing weight gain, meal completion, not engaging in weight management behaviors

Evaluation & Diagnosis

Screening for ED in diverse bodies

- The SCOFF questionnaire has been previously popular for medical settings, but I generally discourage its' use when screening because:
  - Tries to do too much with too few questions
  - Does not focus on nuanced and diverse presentations, is a very basic screening

- Primary care, urgent care, ER settings – EDE-Q 17.0 (adapted)
  - Thinking of the last month, what do your eating habits look like on a daily basis? Does that change from weekdays to weekends?
  - Have there been any days in the last month that you haven't eaten anything?
  - In the previous 2 months, have your eating habits been the same or were they different?
  - Have you been consciously trying to restrict (or cut back) the overall amount you are eating, regardless of whether or not you were able to do so?

Screening for ED in diverse bodies

- Outpatient therapy or nutrition – EAT-26; exclude the BMI portion
  - 26-item questionnaire focusing on thoughts and behaviors independent of body shape, size, weight, or change
  - I find this questionnaire especially helpful for folks in outpatient who may not have enduring behaviors, but are struggling with significant cognitive disruptions from ED thoughts
  - Results of this can help frame need for support for patients who feel they aren't "sick enough" or don't "look like" they have an eating disorder

Part B: Questions

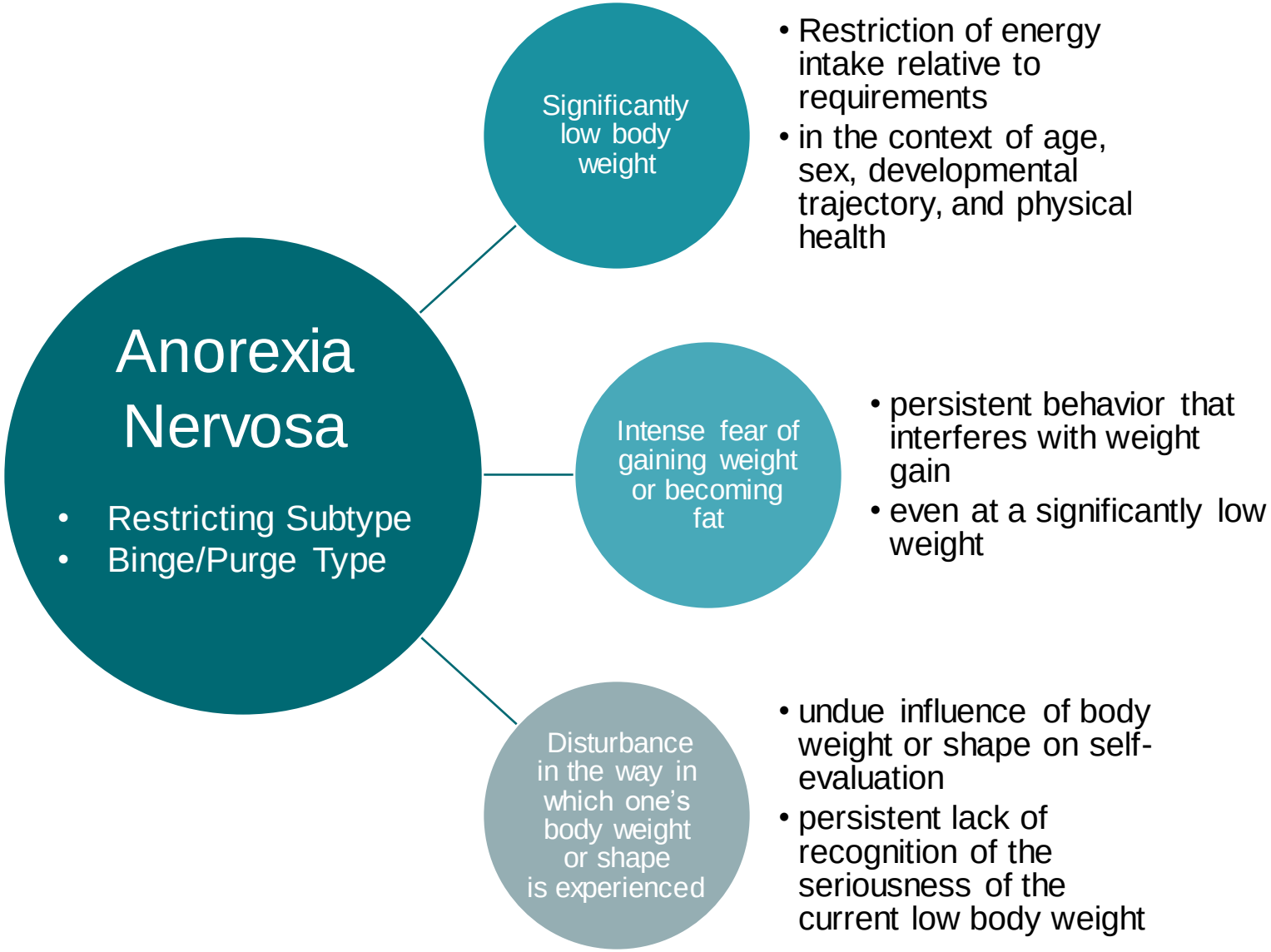
	Always	Usually	Often	Sometimes	Rarely	Never
1. I am terrified about being overweight.	○	○	○	○	○	○
2. I avoid eating when I am hungry.	○	○	○	○	○	○
3. I find myself preoccupied with food.	○	○	○	○	○	○
4. I have gone on eating binges where I feel that I may not be able to stop.	○	○	○	○	○	○
5. I cut my food into small pieces.	○	○	○	○	○	○
6. I aware of the calorie content of foods that I eat.	○	○	○	○	○	○
7. I particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	○	○	○	○	○	○
8. I feel that others would prefer if I ate more.	○	○	○	○	○	○
9. I vomit after I have eaten.	○	○	○	○	○	○
10. I feel extremely guilty after eating.	○	○	○	○	○	○
11. I am occupied with a desire to be thinner.	○	○	○	○	○	○
12. I think about burning up calories when I exercise.	○	○	○	○	○	○
13. I other people think that I am too thin.	○	○	○	○	○	○
14. I am preoccupied with the thought of having fat on my body.	○	○	○	○	○	○
15. I take longer than others to eat my meals.	○	○	○	○	○	○
16. I avoid foods with sugar in them.	○	○	○	○	○	○
17. I eat diet foods.	○	○	○	○	○	○
18. I feel that food controls my life.	○	○	○	○	○	○
19. I display self-control around food.	○	○	○	○	○	○
20. I feel that others pressure me to eat.	○	○	○	○	○	○
21. I give too much time and thought to food.	○	○	○	○	○	○
22. I feel uncomfortable after eating sweets.	○	○	○	○	○	○
23. I engage in dieting behavior.	○	○	○	○	○	○
24. I like my stomach to be empty.	○	○	○	○	○	○
25. I have the impulse to vomit after meals.	○	○	○	○	○	○
26. I enjoy trying new rich foods.	○	○	○	○	○	○

EAT-26; Garner et al. 1982

Lester, R.J. (2007)

Most Prevalent Diagnoses

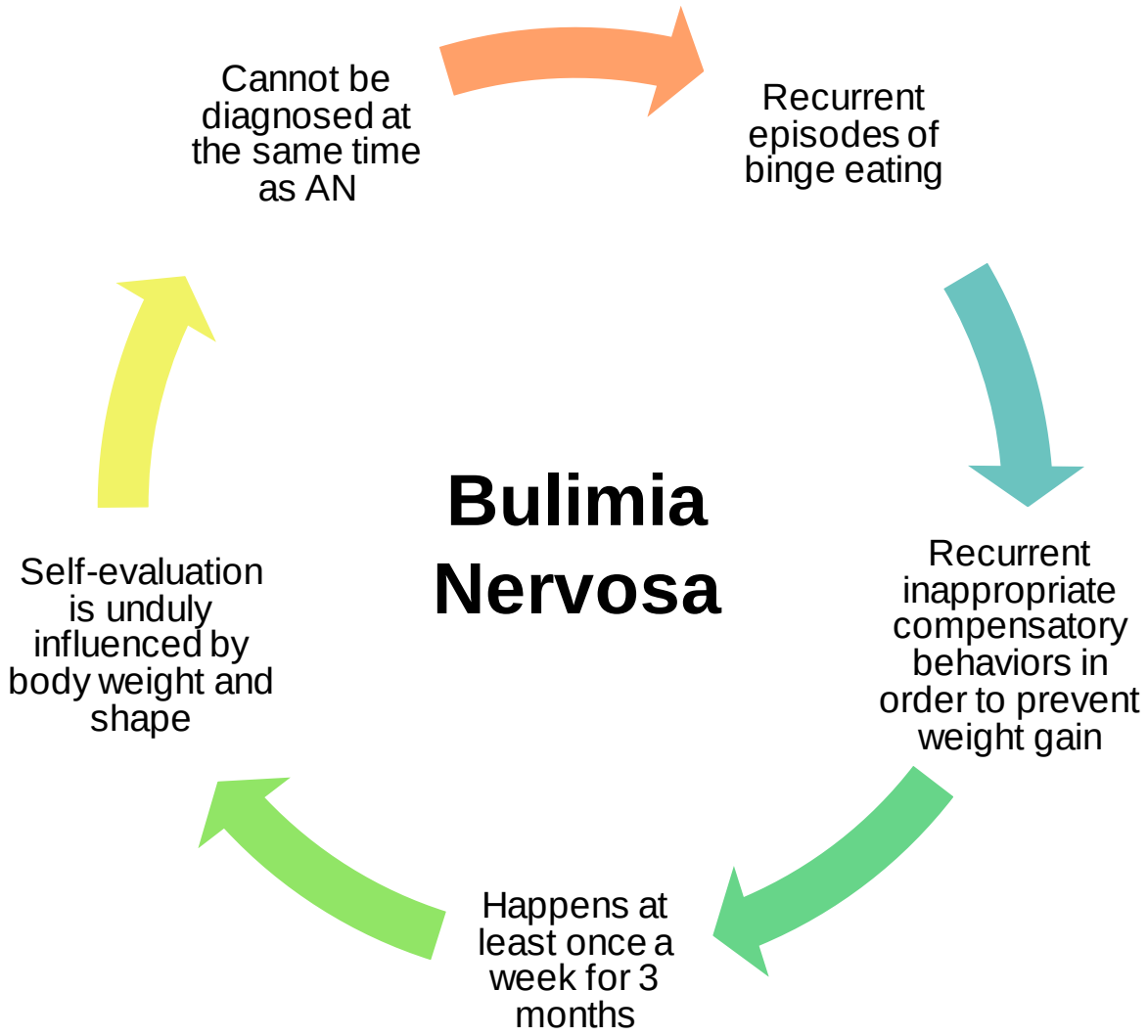
- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Avoidant-Restrictive Food Intake Disorder (ARFID)
- Other Specified Feeding and Eating Disorder (OSFED)



American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C.: American Psychiatric Association.

Helpful Assessment Questions for AN

- Do you struggle with an intense fear of gaining weight and becoming fat?
- Do you significantly restrict your food intake?
- Are there certain foods or food groups that are “off limits” to you?
- Do you count calories or macros or try to stay below a certain daily intake amount?
- Do you experience an extreme disturbance in your body image or experience regular negative thoughts about your body?
- Have friends or family expressed concern about your weight loss and eating habits?


Bulimia Nervosa
Recurrent episodes of binge eating
Recurrent inappropriate compensatory behaviors in order to prevent weight gain
Happens at least once a week for 3 months
Self-evaluation is unduly influenced by body weight and shape
Cannot be diagnosed at the same time as AN

Binge Eating Disorder

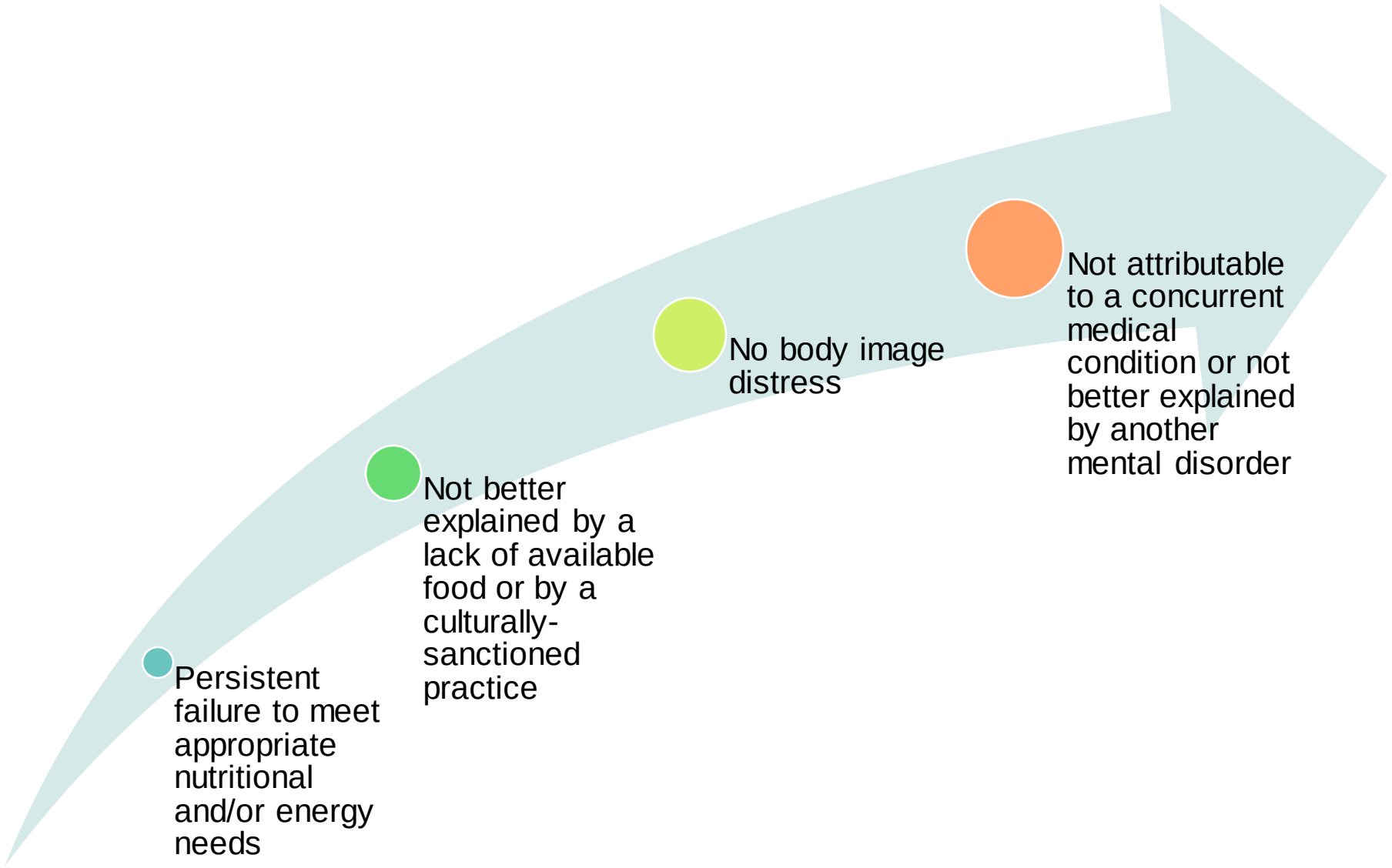
Recurrent episodes of binge eating

- Feeling out of control during binge
- At least once a week for 3 months
- Marked distress about binge eating

Binge eating episodes are associated with 3+:

- Eating more rapidly than normal
- Eating until uncomfortably full
- Eating large amounts of food when not hungry
- Eating alone because of embarrassment at how much one is eating
- Feeling disgusted with oneself; depressed or guilty afterward

Avoidant Restrictive Food Intake Disorder (ARFID)



Subtypes of ARFID

Sensory Sensitivity	Low Interest	Aversive Consequences
• Avoiding foods based on taste, texture, and/or other sensory characteristics	• Poor/low appetite • Low reward response to eating	• Choking phobia • Vomiting phobia • Fear of aversive GI response (e.g., pain, nausea)

Helpful Assessment Questions for ARFID

Do you struggle with a lack of interest in or avoidance of food or eating?

Do you avoid certain or most foods because you cannot tolerate the texture, mouth feel or consistency?

Have you had significant weight loss but are not concerned with the size or shape of your body? (Or is the individual not meeting growth milestones)

Is your food variety severely limited?

Do you experience anxiety when exposed to certain foods/if you cannot have your preferred foods?

OSFED

Atypical Anorexia

- Meets all AN criteria, except that despite weight loss, the individual's weight is within or above their "normal" range

Bulimia or BED of low frequency or limited duration

- Binge eating or binging and compensatory behaviors occur on average, less than 1x a wk and/or for less than 3 months

Less Commonly Seen

Pica

- Persistent eating of nonnutritive, nonfood substances for at least 1 month. Not culturally normative or supported, not developmentally appropriate.

Rumination

- Repeated regurgitation of food for at least a month, can be re-chewed, re-swallowed, or spit out. NOT exclusively in context of another eating disorder (AN-R, BN, etc.). Not medically related (reflux, GI).

UFED

- Symptoms characteristic of a feeding and eating disorder that cause clinical significant distress or impairment in social, occupational or other important areas of functioning, but do not fall into aforementioned categories of diagnosis

Subclinical Presentations

Orthorexia

Diabulimia

Case Vignettes

Kimberly

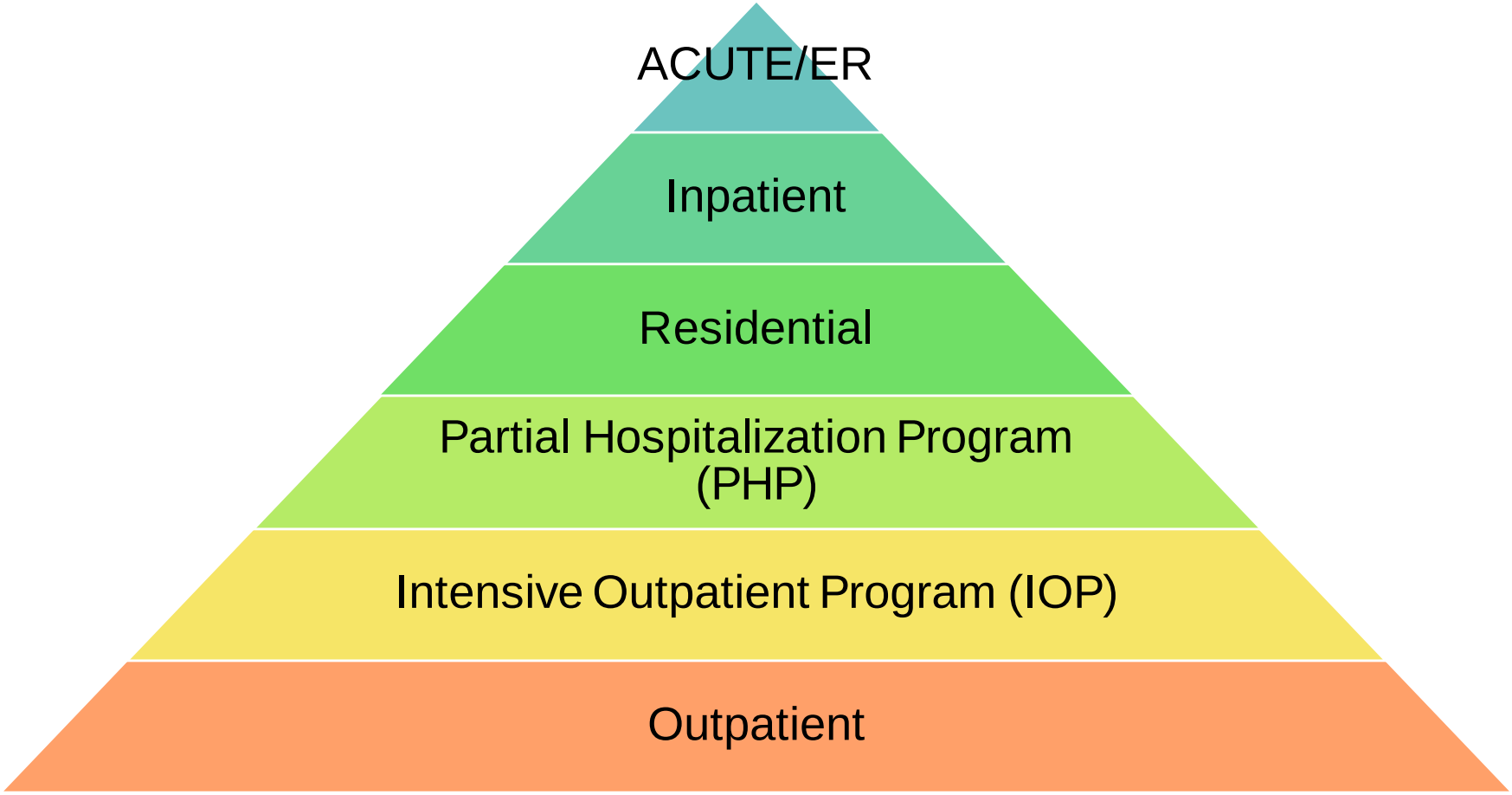
- 19yo female when entering treatment
- History of academic and athletic achievement, both parents are doctors, wealthy family with divorced parents
- History of anxiety and depression
- Presents after her previous therapist recommended she seek specialized care due to concerns re: compulsive exercising
- Upon evaluation, Kimberly reports exercising 2x per day for a total of about 2.5 hours; she also shares she is intentionally eating in a calorie deficit, reporting she eats 1600 calories per day. Kimberly reports preoccupation with food, participates in body checking during session (and reports regular body checking out of session), and often has trouble with memory and cognition during our conversations (loses train of thought, can't recall details or words).
- Kimberly reports over the last 3 months, she has lost 25lbs. She reports she would like to lose an additional 10lbs over the next month, because she's frustrated with the "fat on her stomach" and her "huge thighs." She shares her diet and exercise plan to help her lose 3lbs per week. Kimberly is 5'7" and prior to her 25lbs loss, she weighed 150lbs.

Treatment Considerations

Evidence-Based Modalities

- EFFT
- Family-Based Treatment
- ACT
- DBT
- RO-DBT

Levels of Care for Eating Disorders



Medical Care

- Eating Disorders are medical and psychiatric disorders, and can require urgent, medical intervention.
- If someone has been engaging in restriction, purging, binging, or laxative abuse, it is important to seek medical care from a provider with knowledge of eating disorders
- **Signs that may warrant medical intervention:**
- Insulin misuse
- Signs of dehydration
- Swollen parotoid glands, presence of blood in vomit
- Rapid weight loss (even if BMI is “normal”)
- Unstable vital signs such as low or irregular heart rates or low blood pressure
- Cardiac disturbances such as abnormal heart rhythms or heart failure
- Loss of consciousness due to low blood pressure; dizziness
- Electrolyte abnormalities such as low potassium, sodium or phosphorous.

Medical Testing

- Complete history and physical with orthostatic vital signs, height assessment and post void/ gown only weight
- Comprehensive serum metabolic profile, including phosphorus and magnesium
- Complete blood count
- Thyroid stimulating hormone
- Electrocardiogram (ECG), if clinically indicated

Family Systems Theory

Individuals are much better understood when NOT isolated from their systemic context.

Everything in the system impacts everything in the system.

Patterns of interaction create and maintain behaviors, both problematic and non-problematic.

Family systems seek homeostasis

People solicit each other's attention, approval, and support, and they react to each other's needs, expectations, and upsets. (The Bowen Center)

Common Care Pathways to Recovery

Healing relational patterns and trauma that contribute to systemic dysfunction

Teaching emotion identification and processing

Teaching alternative methods of nervous system regulation to decrease behaviors

Values-based living

Increasing psychological flexibility and connection with others (decreasing black and white thinking)

Mindfulness

Distress tolerance

When to Refer Out and Considerations for Referring Out

Threshold for referring to a HLOC facility

Immediate referral to a hospital is needed if a patient has had negligible intake for more than 5 days (regardless of body weight or BMI) or if their BMI is under 16

We highly recommend AGAINST referring ED patients to OP providers who promote themselves as working with "food addiction;" food addiction models are highly contraindicated for all ED patients, including BED, because abstinence models for food typically end up creating physiological and psychological priming for relapse

Referral Resources

- Local referral options - Carolina House, Veritas, UNC (Medicaid)
- National referral options - Eating Recovery Center, Center for Discovery, Monte Nido, Clementine (children)
- ED medical consults for folks with private insurance: Avance Care Chapel Hill (on Franklin St, formerly Mosaic Comprehensive Care)
- Resources for folks without insurance – The Manna Fund; outreaching to OP ED providers and inquiring if they offer pro bono or sliding fee scale options.
- Alliance for Eating Disorder Awareness
- Project HEAL
- ANAD and MEDA
- Eating Disorder Foundation (Denver-based)

Resources

Social Media Follows

- @with_this_body
- @bodyimagewithbri
- @ragenchastain
- @drrachelmillner
- @fitragamuffin
- @thecrankytherapist
- @intersectionalrecovery
- @veronicathedietitian
- @your_body_is_good
- @feelgooddietitian
- @streetsmart.rd
- @fatpositivetherapy

Reads and Listens

- Podcasts: Food Psych, Dietitians Unplugged, Maintenance Phase, Don't Salt My Game, Body Kindness, The F*ck It Diet Radio, Body Podcast, Life: Unrestricted, Mom Genes
- Books: Intuitive Eating by Evelyn Tribole and Elyse Resch, Body Kindness by Rebecca Scritchfield, Anti Diet by Christy Harrison, Fearing the Black Body by Sabrina Strings, Sick Enough by Dr. Jennifer Gaudiani

THANK YOU!

Questions/consultations:

Meredith.Nisbet@ERCPathlight.com

Eating Recovery Center

Pathlight Mood & Anxiety Center

Workshop Agenda

Grounding Exercise

Case Presentations to Big Group

Emone Black, MA, NCC, CCC, LCMHCA

Small Group Breakouts

Small Group Report Out to Big Group

Wrap up Questions

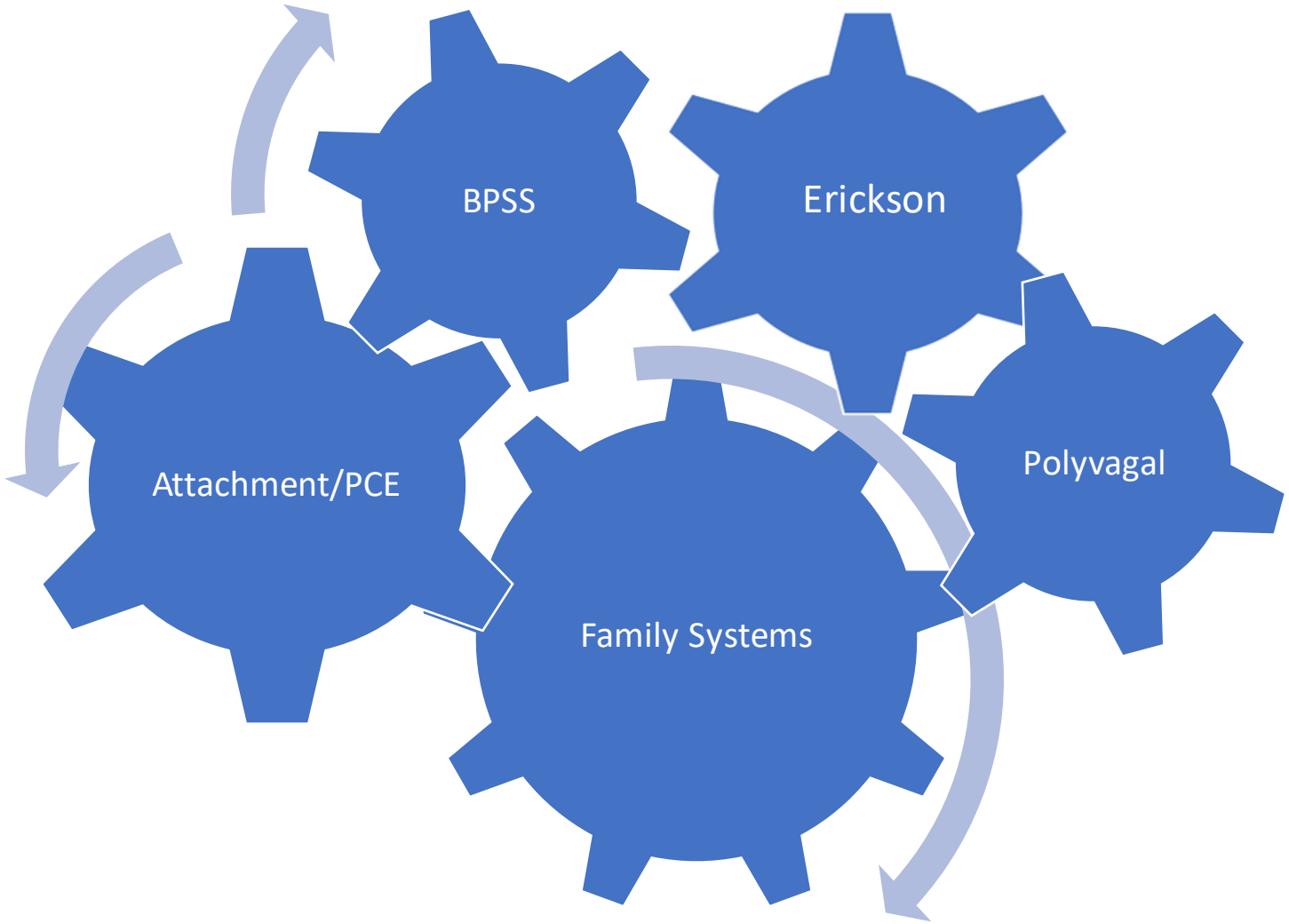
Grounding Exercise

- Safe Place

Speaker Introduction

- Emone Black, MA, NCC, CCC, LCMHCA
- NCCU Graduate with a Master's of Arts in Career Counseling and in Clinical Mental Health Counseling
- Pope Behavioral Health and Wellness in Durham
- Experience working with children, adolescents, and young adults with anxiety, depression, behavioral and emotional problems, ADHD, and autism.
- Passion is intergenerational families

Fellowship Curriculum Guidance



Reminder Disclaimer – *just a little clarity*

- We should never provide identifying information of any client or part of the client constellation.
- Suggestions or questions offered will be ***suggestions only*** and not meant to serve in lieu of clinicians seeking more in-depth colleague or supervisor consultation if needed.
- If there is a case that has an urgent need – please make sure that you seek consultation from a colleague or supervisor right away.

Case - Demographics

- Female: 13 years
- Erikson Developmental Stage: Identity vs. Role Confusion
- Strengths: friends are present, close with some family members including biological Dad, social media, makes bracelets, family pet cat
- Current Dx: PTSD, Major Depressive (recurrent), other specified anxiety disorder; suicidal ideation
- Presenting Concern: Sexual assault from stepfather/active court case

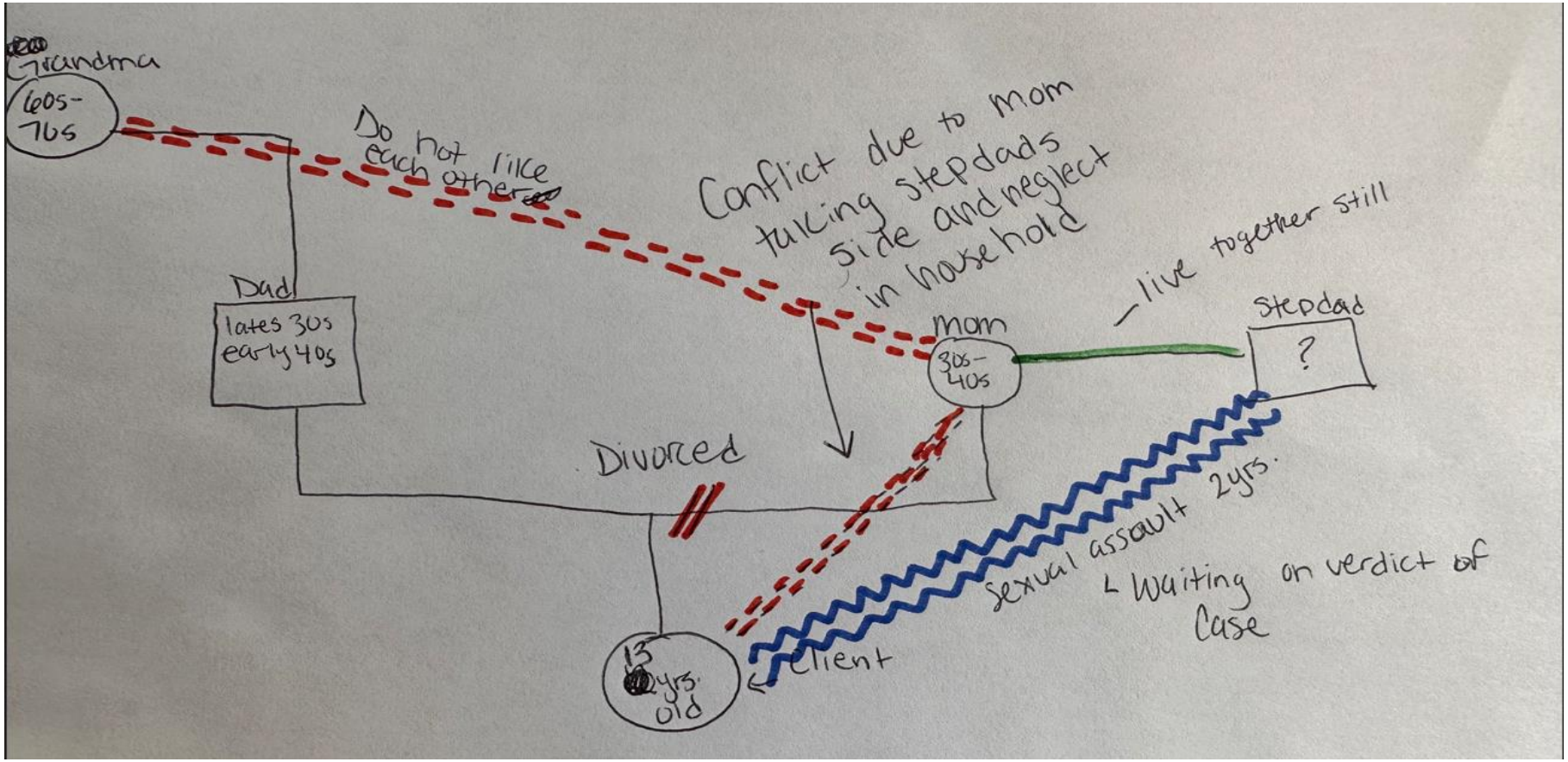
Family System

- Child lives with biological Dad
- Biological Dad is in his late 30's/early 40's and has a speech impediment
- Biological Mom currently lives with Stepfather
- Also a Paternal Grandmother is in the picture

BPSS Assessment

Biological Symptoms/Conditions	Psychological Characteristics
Client is healthy and does track after school. Client notes that her sleep is not the best as she sometimes wakes up at the middle of the night and nightmares/flashbacks. Possible acid reflux.	Client has a diagnosis of PTSD, major depressive disorder, and other specified anxiety. Client does not take medication.
Social/Relational Symptoms	**Spiritual Components**
Client used to live with mom and stepdad but lives with dad FT as last year it was reported stepdad sexually assaulted client. Made a handful of friends in school. Recently went to court against stepdad.	Client is not spiritual

Genogram


Grandma
60s-
70s
Do not like each other
Conflict due to mom taking stepdads side and neglect in household
Dad
late 30s
early 40s
mom
30s-
40s
live together still
Stepdad
?
Divorced
13
yrs.
old
client
sexual assault 2yrs.
Waiting on verdict of case

Therapist Questions/Focus

- Began with anxiety coping skills and CBT
- Would like suggestions on helping the patient through her trauma/depression.
- Client is open but somewhat elusive when exploring emotions.

Some Questions to Consider

- For the “IP,” who are the possible main attachment figures in their life now?
- Who else would you want to include in therapy?
- Ideas to “bring people into the room” even if they can’t be there.
- Do you think there is a circular causality process at play anywhere in the IP’s life that is part of the symptom development?
- What’s your understanding of the child/adolescent’s experience of their earliest years?

Some Questions to Consider

- If applicable, what might be some preventive points of discussion around mental/relational health you might have with the client and family member?
- How do you **feel** when you think about this case?
- **What would you do in your next two sessions? (*Groups please be sure to answer this question.)**
- Any areas to think of exploring second order change?

PADLET Links

- Padlet Link

Big Group Discussion

Logistic Wrap Up

- Submit Fellowship Monthly Data Collection for June
- Presentation/Case Discussion Workshop Evaluations
- Fellowship Attendance Check-Out