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Psychotherapeutic Approaches to Eating Disorder Recovery

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Disclosure

The content of this presentation does not relate to any product of a commercial entity; therefore, we have no relationships to report.

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Objectives

At the conclusion of this activity, participants should be able to successfully:

Recommend treatment providers to embrace a more eclectic approach to counseling patients with eating disorders

Develop a more broad appreciation of different theoretical orientations by introducing examples of specific interventions

Recognize the value of psychoanalytic approaches and interventions with patients with eating disorders
Psychotherapeutic Priorities (not specific to EDs)

In order of importance

• Therapeutic relationship

• Agenda setting
  o We must be working towards the same goals – the client’s
  o The complication of medical & psychiatric stabilization

• Therapeutic orientation, interventions & tactics
  o The least of thee 3 most important variables is our focus today
  o Use almost ANY approach, IF tailored to client’s specific needs
Manualized Treatments for Eating Disorders

Everything has its place

• Manualized treatments CAN be the primary therapeutic approach when treatment outcome is linked to:
  o Treatment of children & some adolescents as in Family Based Therapy (strong behavioral approach & essential parental role)
  o Development of specific skills determined to meet important therapeutic needs, as in DBT or ACT
  o Treatment fidelity of an inpatient, partial or intensive outpatient program (where daily consistency can be expected)
The Importance of Stabilization

Successful psychotherapeutic intervention requires

• A reasonably nourished & rested brain
• A commitment to life
  o Suicidal ideation as a coping skill (the Elevator Story)
• A willingness to navigate ambivalence
  o Eating disorders work – and they don’t (the Fortress & the Jail)
• A plan to survive successful resolution of the ED behaviors
  o When you take something away, and you don’t replace it...
Recommended Therapeutic Orientation

Eclectic or Multi-Modal Therapy

• Using more than one theoretical approach or orientation
• Psychotherapy is an art – the task is to find the best methods to achieve the goals of the client IN FRONT OF YOU.
• Get training in multiple techniques and theories
• Use your continuing education creatively
• Don’t expect all clients to accept your conceptual framework
  o Is it illness or adaptation? Is it resistance or protection?
Cognitive Behavioral Therapy

Feelings List & Worksheet

• Similar tactic as CBT’s A-B-C or DBT’s Chain Analysis
• Purpose is to identify feelings associated with urges
• Develop a more rich and descriptive vocabulary
• Identify the behavioral impact of the severity of emotions
• Empower the individual to see the NEED for emotional relief
• Stimulate curiosity about the effects of behavior on emotion
Psychodynamic Psychotherapy

Conference Room story

• Similar tactic adapted from treatment of MPD/DID
• Purpose is to broaden perspective of ED’s valued function
• Improve understanding of how ED affects balance of power within the individual’s identity
• Reframe how the valued function of ED could work within a healthy system
Psychoeducation

Neuroscience Didactics

• Helpful to demystify and destigmatize specific symptoms
• Better understand the effect of the Sympathetic Nervous System on learned coping skills
  o Fight, Flight or Freeze response (including dissociation)
  o Distinguished states from Feed & Breed or Rest & Digest states
• Polyvagal Theory, Emotional Freedom Technique (tapping)
• Reframe shame of symptoms as normal biological response activated during “a perceived threat”.
Motivational Interviewing

Exercise Physiology protocols

• Helping the client reframe their relationship with exercise
• Letting science be the counter balance to “feels right for me”
• Structured approach to help clients identify how their appearance goals tend to be ineffective (Rule of Specificity)
• When combined with psychodynamic work to identify possible emotional functions of behavior, exercise may have a better chance of results the client would appreciate.
Systems Theory Work or Attachment Theory Work

Pie Chart of Identity

Only 100% of a pie
Who am I?
How would I like it to be?
What comprises the ED?
Aligning with Opposites and Therapeutic Paradox

Sometimes the back door is the best way in

• Aligning with the client NOT letting go of behavior...yet!
  o The Great Car Giveaway Story

• Going into the behavior rather than away from it (bingeing)
  o Filling your home with the conflicted item to get tired of it
  o The Lean Baker

• Mindful Bingeing
  o Although it sounds contradictory, it’s a powerful experience
Trauma Treatment

Reducing the current impact of previous trauma

• Sometimes we develop coping habits in response to traumatic events. At the time, it may have seemed effective or unnoticeable, but with time & repetition, habits entrench
  o Abuse, assault, teasing & hazing, grief & loss, etc...
  o Injured athlete highly committed to physical rehabilitation
  o Heart attack survivor determined to get healthy

• EMDR to target earlier trauma or triggers for phobias
Body Image Therapies

Diversification of body image

• Physical Appearance
  o Culture and media influences
  o Ambivalence about beauty

• Physical Effectiveness

• Somatic experience
  o Desensitization and tolerating unpleasant sensations
  o Urge Surfing
Recommendations

There is no perfect therapeutic orientation, style or tactic
Let yourself adapt to the needs of each individual client
Share experiences with your multidisciplinary peers
Celebrate diversity in your continuing education
You already have different therapeutic orientations and
that is a good thing.
Voltaire: “Perfection is the enemy of the good”
Psychotherapy and Eating Disorders

Bringing the Subconscious To the Conscious
The Ego

A simple explanation for clients

• Our conscious mind spins with thoughts and thought patterns. This is the Ego.

• Ego is the part of the mind that mediates between the conscious and the subconscious. The Ego is responsible for reality testing and a sense of personal identity.
The Ego (continued)

• The Ego is the part of ourselves we present to the world.
• The Ego protects us from harm. Physical & emotional harm.
• It’s the continuous chatter (predominantly negative) in our heads.
• The Ego of an eating disorder client is mostly in a state of hypervigilance, in effort to portray their best selves. In other words, what they have learned and internalized to be outwardly acceptable.
The Therapist as a Detective

Behaviors are symptoms coming from the unconscious mind. They are clues.
Symptoms are windows into the authentic self.
Eating disorders are a result of a cognitive dissonance the ego and the authentic self.
Gather information that separates the ego from the authentic self. Who is the client beneath the ego?
The Ego builds a cage

In an effort to protect the client the ego traps the authentic self and creates who they believe they should be.

Each bar of the cage is an “I Should”.

The Self is Trapped.
The Ego builds a cage (continued)

Perfectionism

• My body is too big
• I have to be nice
• I have to choose a money-making career
• I have to exercise
• I can’t eat the foods I love
The Unconscious (The Self) finds a way to survive

When the Self is trapped it will bang on the cage

Anxiety & Depression

Coping Mechanism

- The Rioter
  - Bingeing / Purging (Bulimia)
  - Bingeing (Binge Eating Disorder)
- Insubordinate Restricting
  - Restricting (anorexia)
  - Eating Clean (orthorexia)
  - Self Harm (cutting, burning, biting)
Use of Theoretical Orientation

Unintentional Flow
• Mindfulness Theory
• Internal Family Systems
• Feminist Theory
• Psychodynamic Theory
• Jungian Theory
• Emotional Focused Therapy
• EMDR
Conclusion

As a Clinician it is important to be “In Self”

• Jump in
• Use your own style
• Trust your gut (Self)
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