The Role of Occupational Therapy in the Treatment of Eating Disorders

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Objectives

• Identify evidence based practices most appropriate in the treatment of eating disorders

• Explain the role of OT in the treatment of eating disorders

• Explain the therapeutic value of three OT interventions used in the treatment of eating disorders
Melrose Center: Leading the way in eating disorder care

Locations in St. Louis Park, Maple Grove and St Paul
Eating Disorder Diagnoses
Anorexia Nervosa

- “Restriction of energy intake relative to requirements;” “intense fear of gaining weight or of becoming fat;” and “disturbance in the way in which one’s body weight or shape is experienced” (APA, 2013)
• Young women with anorexia are 12 times more likely to die than are other women of the same age that do not have anorexia. (Sullivan, 1995)

• A study in 2003 found that people with anorexia are 56 times more likely to commit suicide than non-sufferers (Keel et al., 2003)

• Only one third of individuals struggling with anorexia nervosa in the United States will obtain treatment (EDH, 2017)
Eating Disorder Diagnosis/Classification

**Bulimia Nervosa**

- “Recurrent episodes of binge eating;”
  “recurrnet inappropriate compensatory behaviors in order to prevent weight gain;”
  and “self-evaluation is unduly influenced by body shape and weight” (APA, 2013)
• An estimated 4 percent of women in the United States will have bulimia in their lifetime; 3.9 percent of these individuals will die; and only 6 percent will obtain treatment (EDH, 2017).

• A study in 2010 that compared the prevalence and service utilization for eating disorders across ethnic groups in the U.S. found that bulimia was more prevalent among Latinos and African Americans than non-Latino Whites (Marques et al., 2010).
Other Specified Feeding or Eating Disorder (OSFED)

- Disorders of feeding or eating that “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” but do not meet the specific criteria for other eating disorders (APA, 2013)
• Research indicates the severity of OSFED is similar to that of anorexia or bulimia (NEDA, 2017)
  • Medical complications
  • Eating disorder thoughts and behaviors
  • Mortality rate
Binge Eating Disorder (BED)

- “Recurrent episodes of binge eating” where there is “marked distress regarding binge eating” and binges are “not associated with recurrent use of inappropriate compensatory behavior” (APA, 2013).
• A 2015 research publication indicated a 50% genetic risk for BED and that nearly 50% of BED patients have comorbid mood and anxiety disorders. The same study also identified 1 in 10 BED patients have a comorbid substance abuse disorder with the most prevalent being alcohol use. (Ulfvebrand et al., 2015)

• In 2007 it was determined that 3.5% of women and 2.0% of men in The United States will suffer from BED. This is more prevalent than AN and BN combined. (Hudson, et al., 2007)
Avoidant/Restrictive Food Intake Disorder (ARFID)

• “An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs” (APA, 2013).
ARFID cont.

- “The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one’s body weight or shape is experienced;” and “the eating disturbance is not attributable to a concurrent medical condition or better explained by another mental disorder” (APA, 2013).
• Those with ARFID are more likely to be young and male
• Nearly half of children with ARFID report fear of vomiting or choking
• One-fifth say they avoid certain foods because of sensory issues.
• One-third of children with ARFID have a mood disorder
• Three-quarters have an anxiety disorder
• Nearly 20 percent have an autism spectrum condition

(Fisher et al., 2014; Nicely et al., 2014; Ornstein et al., 2013)
## Melrose data - 2016

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Risk Factors

- Personal factors
- Genetic predisposition
- Neurobiology
- Environmental factors
- Sociocultural ideal
Co-occurring Psychiatric Diagnoses

- Depression
- Anxiety Disorders/Phobias
- Post Traumatic Stress Disorder (PTSD)
- Obsessive Compulsive Disorder (OCD)
- Personality Disorders, esp Borderline
- Chronic suicidality (Active or passive)
- Self-harm
- Substance Use Disorder (SUD)
Co-occurring Medical Issues

- Electrolyte imbalance
- Reduced Brain Mass
- Gastric or esophagus rupture (binging/purging)
- Kidney Failure, cardiac arrest
- Osteoporosis/Osteopenia
- Infertility
- Refeeding syndrome
- Periodontal complications
- Digestion complications
- Diabetic Ketoacidosis (DKA)
- Muscle Wasting, lanugo

Anorexia Nervosa has the highest mortality rate of any mental illness (Arcelus, Mitchell, Wales, & Nielsen, 2011)
Treatment Models at Melrose
Treatment Models

- Cognitive Behavior Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Radically Open Dialectical Behavior Therapy (RO-DBT)
- Family Based Therapy (FBT)
Cognitive Behavioral Therapy

Based on premise that our thoughts, feelings, and behavior all influence each other.

Changing maladaptive thinking can lead to a change in behavior and affect.

Dialectical Behavior Therapy

- Combination of cognitive and behavioral therapies
- Establishes coping mechanisms and skills to implement into everyday routine (Gleissner, 2016)
- Broken into 4 modules
  - Core mindfulness
  - Interpersonal effectiveness
  - Distress tolerance
  - Emotional regulation (Lenz et al., 2016)
Radically Open DBT

• Targets over controlled emotions and behaviors typically found in individuals diagnosed with anorexia

• Interventions strive to build traits such as
  – Openness to new experiences
  – Flexible responding
  – Emotional expression and awareness
  – Intimacy and connection (Lynch et al., 2013)
Family Based Therapy

• For adolescents and young people living with parents
• Based on the premise that parents are best treatment resource for recovery
• Consist of three phases
  1. Interrupting ED symptoms, promoting weight gain
  2. Gaining control of food choices
  3. Developing identity beyond ED (Krosmerly, 2015)
Eating disorder statistics tell us that in order for treatment to be successful, it must be multifaceted. It must include medical care, mental health care, and nutritional education and counseling.
Treatment Process

- Referral
- Evaluation
- Intervention
- Goal Assessment
Evaluation

• Initial Occupational Therapy Evaluation
  • Semi structured interview
  • “What are your goals while here at Melrose?”

• Additional Evaluation
  • Adult/Adolescent Sensory Profile
  • COPM
  • MOCA/SLUMS
  • CAM
  • ILS

• OT Group recommendations

• Individual OT recommendations

• Ongoing evaluation
Treatment Process

Intervention
Individual Sessions: Intervention Topics

- Body Image
- Employment & Return to work
- Leisure
- Life skills
- Coping skill use
- Sensory tools
- Life roles
- Socialization
- Cognition
- Time management & Routine
- Return to school
- Using supports
Skill acquisition groups
Skill generalization groups
Treatment Process
Frames of Reference
Framed Reference

• Model of Human Occupation (Bruce & Borg, 2002)
  – “A holistic model for practice, education, and research”
  – A system’s perspective that emphasizes the constant transaction of person, task, and environment.
  – Person as an open system
    • Input → Throughput → Output → Feedback → Input (etc.)
  – Three subsystems:
    • Volition (personal causation, values, interests)
    • Habituation (habits, routines, life roles)
    • Mind-brain-body performance skills
  – Environmental affords and presses
Framed Reference

• Cognitive Behavioral
  – “...a person’s cognitive function and beliefs mediate or influence [their] affect and behavior. [...] The goal of intervention is to change the person’s thoughts, which in turn will change the person’s behavior, ultimately improving the client’s daily function and sense of self efficacy.” (Bruce & Borg, 2002)

• Behavioral
  – “Built on experimental inquiry and principles of cognitive, social, and conditioned learning theories ... These principles are systematically applied through behavioral techniques and procedures that bring about behavior change within the individual, and build performance skills necessary for that individual to function successfully in his or her environment.” (Bruce & Borg, 2002)
Frames of Reference

- **Dynamic Interactional**
  - “A restorative cognitive rehabilitation approach used to enhance the functional performance of persons having cognitive impairment.” (Bruce & Borg, 2002)

- **Cognitive Disability**
  - “Describes the nature of cognitive processing impairments that compromise the ability for normal function, and identifies adaptations that will optimize the ability of cognitive disabled persons to function in their everyday world.” (Bruce & Borg, 2002)
  - Intervention not focused on cognitive change
Framed of Reference

- **Psychodynamic**
  - “How mental processes, including perceptions, thoughts, and feelings, that are in conscious awareness, as well as those that are not, influence one’s selection of, participation in, and satisfaction with occupation.” (Bruce & Borg, 2002)
  - Intervention focus: enhancing interpersonal communication, facilitating healthy emotional experiences, enhancing self awareness and self acceptance, and enabling patients to identify and pursue their own skills or interests outside of the ED.

- **Sensorimotor**
  - For individuals with difficulty processing sensation, which “relates to impoverished body image, confidence, and task or social behavior.” (Bruce & Borg, 2002)
  - Goal: improved ability to integrate sensory information
Specialty Tracks at Melrose
Specialty Tracks

Eating Disorder and Substance Abuse - EDSA

• Substance abuse are 4x more prevalent amongst people that suffer from eating disorders (Harrop & Marlatt, 2010).

Eating Disorder and Type 1 Diabetes - ED-T1DM

• A 14 year longitudinal study indicated 60% of patients with T1DM developed an eating disorder with 27% of them using insulin omission as compensation. (Diabetes Care 2015 Jul; 38(7): 1212-1217).

• Melrose is 1 of 5 ED-T1DM programs in the country.
Specialty Tracks

Family Based Therapy - FBT

- Statistically more effective than other treatments for adolescents, specifically 2x more effective on 6 and 12 month follow up (Arch Gen Psychiatry. 2010;67(10):1025-1032.)

- Family Learning Series – FLS
  - 4 week series that includes skill based and experiential groups in conjunction with therapy.

- Family Learning Day – FLD
  - Intensive day that focuses on application of skills in family unit.
Specialty Tracks

Binge Eating Disorder - BED

- Currently accounts for over 1/3 of all initial assessments at Melrose Center.
- 17 week program that includes therapy, RD, OT, PT, MD and psychiatry appointments and support.
- New in 2017: BED Relapse Prevention Group
  - Structured 16 week program that meets weekly with therapist.
Eating Disorder Prevention
Can Eating Disorders be prevented?

- **Individual protective factors**
  high self-esteem, confidence and positive body image

- **Family protective factors**
  family connectedness, happiness and healthy eating behaviors

- **Socio-cultural factors**
  a reduced emphasis on weight and physical appearance
Eating Disorder Prevention

• Normal eating is...
  – Flexible & Varies
  – Eating foods you like when hungry, until you’re satisfied
  – Sometimes over-eating, sometimes under-eating
  – using moderate constraint in food selection, but not being so restrictive you miss out
Eating Disorder Prevention

• Body positivity is...
  – Adopting more forgiving, accepting, & affirming attitudes towards our bodies, regardless of size
  – Focusing on health and well-being regardless of size
  – Recognizing that all bodies are equally valuable
  – “Honoring differences in size, age, race, ethnicity, gender, dis-ability, sexual orientation, religion, class, and other human attributes.”

• Body Positivity resources
  • www.summerinnanen.com
  • www.bodypositive.com
  • www.haescommunity.com
  • Dove Self Esteem Project (www.selfesteem.dove.com)

-Linda Bacon
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Check our website: Melroseheals.com

Find us on Facebook.com/MelroseCenter

Call Melrose for an intake: 952-993-6200
Reference List


Body Respect: What Conventional Health Books Leave out, Get Wrong and Just Plain Fail to Understand about Weight, by Linda Bacon, PhD., and Lucy Aphramor, PhD, RD.


Discussion Questions

• How do you envision this information being useful in your current practice/role?

• Have you ever worked with a client that you thought could benefit from a referral to Melrose?
  – Any personal or professional barriers to making a referral?
  – If you were concerned about a patient how would you approach them?