One size fits all...Or does it?
Exploring the benefits & limitations of facility-based BED treatment in both distinct and transdiagnostic milieus

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Welcome and Denial of Disclosures

Overview
- Historical Context of BED Understanding
- Transdiagnostic Discussion
- Bias, Stigma, and Privilege
- Acute Eating Disorder Treatment 101
- Nutritional Management of BED
- Therapeutic Management of BED
- Discussion of transdiagnostic eating disorder care: what this means and why it matters

Diagnostically Speaking...

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<tr>
<th>BED</th>
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| Recurrent episodes of binge eating (>1/week over 3 months) not associated with compensatory behaviors. | Restriction of caloric intake | Excessive exercise as a compensatory behavior.
| Marked distress in relation to binge eating. | Anorexic binge eating episode C (began over 3 months). | Disturbance in the way in which one’s body weight or shape is experienced.
| Intense fear of gaining weight. | Recurrent binge eating (>1/week over 3 months). | Undue influence of body weight or shape on self-evaluation.
| Disturbance in the way one’s body weight or shape is experienced. | Restrictive eating pattern over a period of 3 months. | Disturbance in the way in which one’s body weight or shape is experienced.
| Undue influence of body weight or shape on self-evaluation. | Disturbance in the way in which one’s body weight or shape is experienced. | Disturbance in the way in which one’s body weight or shape is experienced.
| Self-evaluation is unduly influenced by bodily image or weight. | Disturbance in the way in which one’s body weight or shape is experienced. | Disturbance in the way in which one’s body weight or shape is experienced.

The Bigger Picture: Separate vs Distinct Milieus

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Transdiagnostic Discussion

How do we make treatment accessible for those who would never seek out treatment?

Community ‘Support’

- Have you tried OA?
- If you binge on grains, STOP EATING GRAINS.
- Have you considered weight loss surgery?
- All you need are 1,200 calories a day...
- Measure out your portions CAREFULLY

“At some point in your life you’re going to have to start demanding what you deserve and be willing to walk away if what you require can’t be provided.”

— r.hain

Addressing Weight Stigma...Or at Least Naming It.

- We all have biases.
- Failure to acknowledge them is dangerous.
- Name your Privilege.

Weight Stigma and Bias

- Shame placed upon individuals based on weight or body size
- Suffer prejudice and discrimination because of their weight
- Judgment and biases predetermined by weight, body size, lifestyle
- Judgment of a person’s character, work ethic, and personality based on weight
- Can be communicated both directly and indirectly
- Negative attitudes affecting interpersonal interaction
- Inequalities in the employment, health care, and educational settings due to negative stereotypes that overweight and obese persons are lazy and incompetent
- Blames the individual
- Pathologizes bodies and body sizes
- Perpetuates the thin ideal
- Makes accessing appropriate medical care more difficult
- Makes accessing eating disorder care more difficult

Weight Stigma and Bias


**Weight Bias Among Health Professionals**

Physicians level of respect for patients decreases as body size increases.1

- A recent study of 5000 first year med students in US found 59% exhibited more negative attitudes towards fat people than towards racial minorities, GBTIQ patients and poor people. 1

- Health professionals who claim they specialize in treating “obesity” exhibit high fat bias including stereotypes such as “lazy,” “worthless,” “stupid,” and fat by “choice.”

- Implicit and explicit weight bias in a national sample of 4,732 medical students. Obesity (Silver Spring). 2014 Apr; 22(4) 1201-8

**Eating Disorder Professionals are NOT Immune**

- In a recent study of 371 ED professionals, 56% of those surveyed reported hearing or witnessing colleagues in the field make adverse comments about patients in larger bodies and/or exhibit negative weight-based stereotypes.

- 74% exhibited pessimism toward the ability of those in larger bodies to make behavioral changes or interrupt eating disorder symptoms.


**More than an Emotional Matter**

Weight Stigma Is Dangerous

- Multisystem psychological dysregulation related to perception of discrimination
  - Weight discrimination is the fourth most prevalent form of discrimination
  - 7180 adults aged 25-74 were included via random digit dialing
  - 4900 adults participated in MIDUS II
  - This paper examined 986 members with sufficient information to compute allostatic load or who had information on perceived weight discrimination

**Allostatic Load**

- After adjusting for BMI, detrimental effects of weight discrimination on allostatic load persisted
  - Metabolic Dysfunction
  - Cardiovascular Dysfunction
  - Inflammation
  - Glucose Dysregulation
  - Sympathetic and Parasympathetic NS dysregulation
  - Hypothalamic Pituitary (HPA) axis dysregulation

- Predicts mortality among the general US population.
- Predicts mortality among obese hypertensive and type 2 diabetic adults.
- Predicts mortality among obese hypertension and type 2 diabetic adults, 10 year follow-up.

**Allostatic Load**
Allostatic Load

Getting into Treatment

Overheard in a Transdiagnostic Milieu

“She is my worst nightmare.”

“You’re out of control.”

“But a little weight loss wouldn’t hurt…”

“I’m scared of letting go of the reigns. And turning into you.”

“That can’t be healthy.”

“I’d shouldn’t have come to treatment.

“I’m not sick enough…”

Acute Eating Disorder Care 101

- Typically focused on managing clients with high acuity:
  - Compliance.
  - Control.
  - Safety.
  - Distraction with food.
  - Limited, regulated movement.

BED Care 101

- Curiosity
- Somatic awareness
- Freedom to Experiment
- Embodied self-care
- Rejection of the weight loss goal
- Sharing HAES research

- Mindful Attention with Food - Intuitive Eating

Nutritional Management of BED, VERY Simplified

- Malnourished bodies come in ALL sizes
- Nutritional focus:
  - Mindful Eating
  - Somatic Awareness
  - Hunger/Fullness/Satiety
  - Rejection of Diet Mentality/Cultural Noise
  - Understanding the Role of Feelings and Food Choices
  - UNLEARNING what has been taught

- Reclamation of body wisdom and body trust
**What is Mindful Attention to Food?**
- Thoughtful, curious eating
- Five Senses Analysis
  - Paying enough attention to be able to describe what you’ve eaten
  - Recognizing and responding to hunger cues
- A Seinfeld Episode
- AND SOMETIMES, SIMPLY CHOOSING WHAT YOU WANT TO EAT IN THE MOMENT

**Freedom with Movement**
- Healing from BED requires an embodied practice
- Movement with focus on body connection vs. body modification
- Body Connection vs. Disconnection
  - Yoga as an effective treatment for BED
    - Reduction in binge eating symptoms without specific nutrition guidance or input
    - Increased body-mind connection → reduction in symptomatology
    - Development of positive rapport with one’s body
  - Increased general physical and emotional wellbeing

**Evidence Based Treatment for Eating Disorders**

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**Arguable Therapeutic Benefit of a Transdiagnostic Milieu**
- CBT is evidence based for both
- Marginalizing to separate BED and make it the “other” ED
- Those with BED may have a history of AN or BN
- Splitting the diagnosis may reinforce shame or weight stigma
- More treatment options (Fewer distinct programs exist than combined/easier access to care)
- Body image, self-worth, feelings of powerlessness, hopelessness are consistent across dx

**Acknowledging these Truths...Our Clients Need Treatment**
- One of the most important conversations to have with your client may be around whether to seek BED-specific care or not
- Naming client fears and anxieties
- Naming weight bias as a potential treatment issue
- Acknowledging that treatment will look and feel different for clients in different bodies
- Advocating for the best care of the client

**Making Room for All Bodies**
- Consider your space
- Consider your reading materials
- Consider your artwork
- Consider your facility/office accessibility
- Consider your medical equipment
- Kindness, curiosity, compassion, and science
**Arguable: Therapeutic Benefit to Distinct Milieu**

- Pt comfort, more likely to seek tx with people who have same sx
- More focused behavior based tx, symptom specific examples, discussion
- “Safe”
- Staff may more more interested and invested if working in a distinct program.
- Precautions for other disorders do not need to be in place (100% of meal completion, or supplementation, locked bathrooms).
- Motivation differences among dx
- Medical differences (vital signs, weight frequency protocal differ)

**What providers in both settings need to know**

- There is no evidence to suggest that one approach is better than another
- Clients are likely to want individualized treatment regardless of milieu makeup
- Body size/shape comparisons will occur in both distinct and transdiagnostic milieus.

**Helping a client determine which avenue is “best”**

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**Consider This:**

- Accessibility
  1. Physical location and proximity to one’s home and/or work
  2. Financial Feasibility (insurance coverage, travel expenses to and from)
  3. Age/Gender Identity
  4. Medical Necessity/LOC
- Comfort Level (transdiagnostic or distinct)
- Other (co-morbid conditions, schedule, symptom pattern across time, family involvement, etc)

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**Case Study: AB**

- 38 year old, married woman
- Very high stress job
- History of “eating for comfort” from age 9 in the context of family stress
- Weight loss efforts made from age 9, “although looking back, I was normal.”
- Organized diets through HS and college: “I’ve done it all.”
- Binge eating began at the end of college/wedding stress:
  - Ate “all the off limits foods I could get my hands on with any emotional stress.”
-- Continued attempts at dieting

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**Case Studies**
Case Study: AB
- Came for three sessions then disappeared x 10 months
- Returned to RD after additional ‘failed diets.’
- Binge eating increased in volume and frequency - ‘this is scary…’
- Transdiagnostic PHP treatment provided meal plan with exchanges
- Persistent hunger expressed to RD without modification to meal plan
- ‘Successful’ x 2 weeks, then it felt like a diet again.’
- ‘I FAILED TREATMENT…’

Case Study: CD
- 57 year old single woman with ‘a lifetime of overeating’
- Sneaking food from her dieting mother at age 4
- Began dieting at age 20 and binging ‘at 20 and a half…’
- Agoraphobia and social anxiety
- Binges shifted from once per day at age 20 to up to 6 times per day at age 56
- Job loss
- Social isolation
- Lots of pressure from PCP for bariatric surgery

Case Study: CD
- Residential transdiagnostic treatment x 3 months (great reviewer and amazing insurance!)
- Treatment began with meal plan and limitations around exertion
- Fed when she was hungry (this takes guts)
- Somatic awareness improved significantly
- In the moment assessment of hunger and fullness
- Curiosity with food and how it made her feel
- Initiated a yoga practice and began fun, flexible movement

THANK YOU!
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