Chapter 9

# Eating Disorders: A Treatment Apart. The Unique Use of the Therapist's Self in the Treatment of Eating Disorders

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Additional information is available at the end of the chapter

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**Abstract**

Treatment skills that serve general mental health practice, though applicable to eating disorder care, by themselves will not suffice to meet the uniquely pressing demands and requirements of treating these life-threatening disorders. Eating disorders adversely influence every aspect of human functioning, demanding a comprehensive and integrative approach to care. Because eating disorders disrupt the patient's relationship with self and others, the quality of the therapist's versatile and integrative use of self within the therapeutic relationship can become the single most significant intervention in achieving successful healing outcomes. The intensity of professional challenges within the treatment process reflects the urgency behind the patient's need to heal. Treatment efficacy is achieved through the therapist's commitment to a timely, intentional, and practicable fulfillment of clearly established goals, uniquely tailored to each patient and eating disorder. The self-integrated psychotherapist, as case manager, is required to manage a complex landscape of pathology and strengths, regression and healing, diverse professional and familial resources, transference and countertransference phenomena and, with skillful proficiency, traditional as well as nontraditional (neurophysiological) treatment interventions and approaches to care. This chapter highlights key elements in the therapist's V.I.A.B.L.E. (Versatile, Integrative, Action-oriented, outcome-Based, Loving, and Educative) use of self in facilitating the healing of the eating disordered patient and malnourished brain.

**Keywords:** eating disorders and neurobiology, anorexia nervosa, bulimia nervosa, binge eating disorder, eating disorder treatment, eating disorder recovery, the eating disorder therapist's unique use of self, managing eating disorder resistance to healing, mindfulness in psychotherapy, the VIABLE eating disorder practitioner, family's role in eating disorder treatment, integrative psychotherapy, somatosensory education, neurophysiological treatment interventions, outpatient team in eating disorder treatment, milieu treatment for eating disorders, emotionally integrated therapist, psycho-

therapeutic relationship in eating disorder treatment, set point weight theory, mind-brain-body connection in eating disorder treatment, Feldenkrais Method of Somatic Education©, trauma-informed yoga, body image, self image

## 1. Introduction

Although considered mental health disorders, eating disorders (ED) carry dire physiological risks and complications resulting from severe and prolonged dietary restriction [1]. Ranking among the 10 leading causes of disability among young women [2], they have the highest mortality rate of any psychiatric disorder [3–5]. Symptom presentation is diverse and unique to each patient, demanding an equally diverse and integrative treatment process and path to recovery. Though the agenda of any treatment process will be responsive to the demands of the therapeutic moment, it is the eating disorder practitioner's focused intentionality, goal clarity, and sustained vision of complete and comprehensive recovery that best serve the process. *Every* moment of care is a pivotal moment in care, demanding precision in judgment and incisive decision-making to avoid, or redirect, a treatment process that may have gone off course or become ineffective. The work of conducting ED treatment can be as challenging for the therapist as for the patient. Both patient and professional face the challenges of tolerating and accommodating the ambiguities and frustrations of an inevitably unpredictable, yet critical, healing process. By modeling steadfast commitment to treatment engagement and goals through a mindful therapeutic attachment, therapists empower and embolden their ED patients to follow their lead.

## 2. Eating disorders are diseases

With disease origins in genetics and in brain structure and function, the risk of death by suicide in patients with Anorexia nervosa (AN) is 57–58 times the expected rate in similar age and gender populations [6]. Crude mortality from suicide or medical complications from starvation or compensatory behaviors associated with the illness is 9% [7, 8]. The impact of ED symptomatology on the individual is wide-ranging and potentially irreversible. Through the loss of muscle mass, the malnourished heart decreases in size, affecting heart rate and blood pressure. The main causes of sudden death in ED are those related to cardiovascular complications [9]. Twenty-five percent of individuals with AN experience a chronic or continuously relapsing course [7, 8].

Cerebral atrophy due to enduring AN was initially thought to lead to an irreversible reduction in gray matter volume [10]. It was later proven that long-term weight restoration might eventually lead to a restoration of gray matter and structural normalcy, though not to fully normalized functionality [11]. Anorexic patients with amenorrhea or irregular menses, even after structural brain changes had been resolved, displayed significant cognitive deficits across

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a range of tasks [12]. Co-occurring conditions central to the ED diagnostic process carry significant implications for ED treatment and prognosis. Depression, anxiety, mood disorders, attention-deficit/hyperactivity disorder (ADHD), posttraumatic stress disorder (PTSD), diabetes, food allergies, gastrological disorders, addictions, and personality disorders create the warp and weft of the integrative fabric of these disorders.

Low weight and higher cortisol levels are correlated with greater structural brain abnormalities [13]. Malnutrition is of particular concern during the critical stages of early brain development in childhood, adolescence, and young adulthood. "Epidemiology and diagnosis, medical complications, nutritional concerns, psychological issues, treatment, and treatment outcome for adolescents [and children] with ED differ from those for adults, with particular emphasis on pivotal medical and developmental issues unique to the peripubertal period" [14]. Profound and diverse emotional effects of ED on mind and body can be deeply traumatic to patients who in many cases are too young and emotionally undeveloped to have acquired the skills required to cope with the challenges of disease, as well as recovery, processes. The development of new cases of ED has been steadily increasing since 1950 [15, 16]. Children under the age of 12 admitted to the hospital for ED rose 119% in less than a decade [17].

Since the fourteenth century, with the first diagnosis of AN, there has been "historical drift" in the rapid acceleration in new presentations of eating-related pathology as seen in symptom variability and gender representation [17]. Diagnoses have become increasingly differentiated and refined in their definition. Forms of AN have become distinguishable as "restrictive, or purging type." Bulimia nervosa (BN) is diagnosable as "purging, or restrictive type," the diagnostic differentiation denoting distinctive personality characteristics. Eating disorders not otherwise specified (EDNOS) and binge eating disorder (BED) are examples of the evolution of eating disorder pathology. Binge eating disorder is the most likely ED diagnosis to be missed, as the intermittent patterns of binging and starvation result in a normal and constant weight. The onus is on the enlightened clinician to probe actively, and with sensitivity and reassurance during diagnostic assessments to uncover these and other hidden ED, as well as related problems that might include activity disorders/excessive exercise with the intention to lose weight, orthorexia, diabulimia, body image disturbances, night eating syndrome (NES), rumination, chew and spit (CHSP), body dysmorphic disorder, etc.

Of particular significance within the ED field, historical progression is evident in the introduction of the diagnosis "avoidant/restrictive food intake disorder" (ARFID), replacing feeding disorder of infancy and early childhood in the American Psychiatric Associations' Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [18]. The manual describes ARFID as "an eating or feeding disturbance (e.g., apparent lack of interest in eating, food-avoidance based on the sensory character of food, and/or concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs." Pediatricians all too frequently miss this diagnosis in infants, children, and adolescents whose patterns of weight and height appear to be normal on growth charts. It is left to ED experts to recognize and understand these atypical "picky eating" disorders, so as to guide increasing numbers of patients and parents to early diagnosis and integrative treatment options. The ever-changing course of ED presentation demands the practitioner's commitment

to professional continuing education, intellectual curiosity, and the willingness to recognize and accommodate the evolution of developments within the ED field through clinical responsiveness within mainstream practice.

## 3. ED treatment is a treatment apart

Ironically, it is the rare graduate school of mental health practice that offers curriculum specialty training in the treatment of ED. A student studying for her Master's degree at a highly reputed school of social work inquired as to why the absence of ED-related courses. She was told that specialty training was "unnecessary and redundant" based on the proliferation of generic courses that address the emotional issues underlying and driving these diseases. These educators and administrators were of the mind that the methodology for treating ED consists of "techniques and approaches indistinguishable from those offered by *any* highly skilled mental health clinician." This widespread misconception is not uncommon in teaching curriculums that fail to recognize ED as neurophysiological, and potentially lethal, diseases in their own right.

In actual fact, clinical strategies, techniques, and methodologies for ED treatment management and recovery are, in many respects, *not* unlike those that are applicable to more generalist types of mental health care. However, the lethality of these disorders, the integrative nature and demands of their treatment, and the need for the therapist's unique use of self in confronting the challenges they present, clearly set these diseases apart in their manner of treatment. "Though in some respects elusive, the tools of this treatment trade are actually supremely accessible; in many respects they are disarmingly simple and hardly strangers to us. We know them all; we know how to implement them. We have only to learn *why, how* and *when* to offer *which* of our previously acquired techniques and skills. The outcomes we seek lie in the use of *self* in response to the unique demands of the ED patient and treatment moment [19]".

If not actively healing, ED pathology becomes increasingly entrenched, reshaping the structure and function of the brain. By fragmenting the patient's core self and taking over its role as "director of operations," the ED creates radical changes within the patient's personality and physiology. Compounding treatment challenges, parents or life partners of ED patients invariably find themselves confused and helpless in the face of their loved one's emotional withdrawal. The typical ED patient's ambivalence about, and resistance to recovering puts therapists and patients at cross-purposes from their very first treatment encounter, and beyond. The ED therapist comes to the treatment process seeking a commitment to a recovery process that will restore life quality and reintegrate the patient's fragmented core self. The patient typically enters the treatment process denying disease, or clinging to the ED for his or her very survival. Emotionally flexible therapists need to use themselves deftly, exercising nuanced creativity and skills in facilitating and sustaining a meaningful therapeutic connection capable of evoking the patient's motivation to heal.

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### 3.1. The ED therapist requires a flexible use of self within the ED treatment process

For those who believe that the best therapist to treat an eating disorder is one who has suffered from an ED, I would counter that assumption with the notion that one need not be a horse in order to become a horse doctor. Approximately one-third of all ED practitioners have struggled with, and recovered from, a clinical ED. "The lifetime prevalence of an ED among professionals was 33.2% for females, and 2.23% for males. Note that 38.8% of treatment facilities reported hiring clinicians with a history of an ED" [20]. Practitioners who have suffered an ED are likely to have developed an exquisite sensitivity to the experience of ED patients. However, just as easily they could find themselves experiencing what is known as countertransference, an emotional reaction of the therapist to the subject's contribution. Triggered by the resonance of dormant issues, countertransference reactions could impede the quality of therapeutic responsiveness.

The empathic, emotionally integrated and developmentally evolved ED therapist who is a seasoned and sensitive veteran of life and its challenges within *any* context, should be qualified to manage and competently treat these disorders. The practitioner's *own* self-integration and emotional flexibility is a springboard for "response-ability," preparing him to intercept and accommodate the unexpected curve balls of the ED recovery process. In particular, it is the practitioner's skillful use of self within a trusting and mindful therapeutic connection that enhances the patient's internal strengths, evoking her faith in her own capacity to heal, and in the treatment process as a vehicle for change. In accruing self-trust within this connection, the patient ultimately comes to rely on her own newly acquired, sustainable coping capacities that far outweigh the benefits of her past reliance on her ED, now becoming irrelevant and obsolete.

Like the patients they treat, therapists too, strive to grow and develop as human beings throughout the course of personal and professional life experiences. The effective eating disorder practitioner will have accessed and encountered himself, putting his own emotional and cognitive "house in order" in preparation to access and connect with the patient who seeks to accomplish the very same goal. Through self-reflection and self-acceptance, the emotionally flexible therapist becomes capable of retrieving and integrating the emotional aspects of his own psyche that may have been lost, denied, avoided, or repressed in the creation of his or her own self-integrity. Through an active and palpable presence within the therapeutic moment, the therapist's self-integration inspires healthy role modeling. The ED patient's successes will be dependent not only upon *what* the therapist thinks and knows, but on modeling after *the way* he thinks, acts, and responds.

Though diverse and broad-spectrum ED treatment techniques and strategies enhance learning and change, healing occurs essentially through the *process of the recovery journey* itself. Emotional, cognitive, and behavioral learning required for recovery is enhanced within the framework of a powerfully human and loving therapeutic connection. The therapist's use of self within the context of the therapeutic relationship can be seen as the global positioning system (GPS) that charts the route to full recovery, replete with "rerouting" directions for the inevitability of wrong turns and setbacks as part of the journey. Ultimately, patients acquire the practice and resiliency they need to navigate life's roads confidently on their own. The ED healing process becomes a metaphor for life itself… for human tasks that evolve toward

maturational development through the stimulus of learning within the context of nourishing human relationships. It is not uncommon for recovered individuals to express gratitude for having had the opportunity to define, refine, and refresh the "gestalt" of their very existence through the process of ED healing.

### 3.2. Treating ED is not for the weak at heart

As the treatment process is steeped in patient resistance and denial, and often complicated by mood, personality, and attachment disorders, the ED patient population is capable of arousing intense emotions within practitioners. The ED corrodes the patient's internal strengths, impairing judgment and the capacity to benefit from treatment. The ED individual fears giving up a disorder that (falsely) promises a guarantee of competency and self-control in the face of life's exigencies and unpredictability. Even on the verge of full recovery, patients describe a sense of "longing" for their ED. ED therapists need to prioritize attention to the patient's potential to return, by default, to old behavioral symptoms, such as recurring weight loss or stagnation, binging and purging, excessive exercise, etc particularly at times of stress, even after a healthy eating lifestyle appears to be securely in place.

It is not atypical to find that parents of teen or child ED patients will feel more needy of the therapist's attention, coaching, guidance, and support then does the identified patient. Therapists who treat ED individuals do well to have achieved a substantial degree of comfort and competency in treating complex family systems, as it is incumbent upon the practitioner who treats the individual patient to treat the family system as well. ED treatment occurs in clinical offices for 1 or 2 hours per week. The recovery process happens at home, 24/7, in the company of the entire family system, every member impacted by the ED's presence. If uninformed, well-intentioned family members may inadvertently enable problems in attempting to eradicate them. Involved parents and enlightened siblings are a boon to the struggling child, treatment team, and recovery process. Therapists need to empower parents by offering permission and courage to stand up to the child who, through the voice of the ED, may attempt to dictate the parameters of care, at home and in the treatment office; ie. "I will not discuss eating, because it will make me feel more anxious and I will cry." "I don't have a problem and I don't need treatment. I can handle this myself."

### 3.3. Countertransference phenomena can contribute to treatment resistance

Within the context of the countertransference phenomenon (where the person in treatment redirects feelings for others onto the therapist), self-awareness, honest intention, and clear boundaries become the therapist's parachute. The capacity to remain vulnerable and receptive to others, the benchmark of our humanity, allows therapists to stay real, encourage trust in the treatment relationship, and facilitate learning. Through self-awareness and attention to the treatment process, therapists need to resist the temptation to collude with the resistant patient who consciously or unconsciously deflects the focus of attention in treatment away from the tough challenges of food talk, symptom abatement, and recovery demands. Therapists need to contain their desire to "fix" the overly dependent patient's problems by being overly ready to prescribe answers and solutions, a message implying that easy short cuts can resolve

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complex problems simply. "There is a time for expert opinion, but not in the place of first building the patient's own motivation as an active, not passive, participant" [21].

The countertransference phenomenon need not be an impediment to treatment, but can function as a vehicle for the patient's learning. When faced with emotional challenges within the treatment context, as practitioners, we need to do precisely what we counsel our patients to do; that being, to take control where we can, and where control evades us, to cope as best we can in an effort to achieve treatment goals. Miscommunications and misunderstandings are common fare within any in-depth human relationship. During times of patient discontent, the practitioner does well to readily encourage feedback of all types, particularly when it is negative, modeling transparency and a sincere willingness to accept responsibility and seek problem solutions through discussion and accommodation. Complaints typically contain invaluable learning for the patient, as well as the practitioner. Intention and goals need to be shared, and the patient's honesty applauded. The therapist's response through self-disclosure needs to be purposeful, motivated by the intention to enhance the patient's self-awareness, learning, and change. When effective, it can deepen the patient's access to affect and the promotion of self-regulation. "Following self-disclosure, the therapist should immediately shift the focus back to the patient and her response" [22]. The following is an excerpt from a letter I wrote to a codependent parent of an 11-year-old anorexic patient, who corroborated with this child's choice to leave treatment precipitously.

> "…In considering N's leaving treatment at this juncture, what becomes apparent to me is that her malnourished brain is not equipped to make rational decisions of this sort on her own. I believe she is frightened to the point of panic, and understandably so, at the thought of meeting the required demands of recovery from a disease she feels she cannot live without. In leaving this treatment relationship, however, it appears that she is 'shooting the messenger.'
>
> In a situation like this, it is the parents' trust in, and support for, the therapist and therapy process that carries the day. One of the factors that leads to, and exacerbates N's ED is her feeling of being out of control, overly powerful, and therefore unsafe within her own skin. By giving in to her unrealistic ploy to avoid treatment, a parent becomes an unintentional enabler of the ED. Flip side, the parent who can remain steadfast in understanding and supporting the treatment process becomes an invaluable advocate for both child and recovery. The eating disorder has to be confronted, and in the process, so must N. In observing her response to outpatient care, I believe a higher level of care would be an appropriate alternative for her under these circumstances."

## 4. Achieving "VIABLE-ity" in eating disorder practice

Along with clarity of intention, relentless urgency of purpose, and an integrative, goal-driven vision of successful recovery outcomes, the ED specialist exhibits distinguishing qualities represented in the acronym V.I.A.B.L.E. [19], which stands for Versatile, Integrative, Action-

oriented, outcome-Based, Loving, and Educative. It goes without saying that though all of the characteristics described here are essential qualities of ED practitioners, many have broad applicability to skillful generalists, as well. General psychotherapy skills alone, however, are insufficient to manage the lethality of the ED, the unique complexity of the treatment and recovery processes, and in many instances, the depth of the victims' resistance to healing.

## 5. Seeking V.I.A.B.L.E. treatment through the therapist's Versatility

### 5.1. Utilize diverse treatment approaches, modalities, and strategies within ED treatment

Approaches to treatment are determined by (1) the nature of the disease and its unique symptom presentation, (2) the age of the patient, (3) the patient's physical and developmental status, and (4) the overall emotional health and availability of the patient's family system. The technically skilled and seasoned ED psychotherapist needs to be capable of integrating traditional "best practice" methodologies with alternative types of interventions, to accommodate the diverse nature of ED pathology which impacts behavior, emotions, cognition, sensation, mood, physiology, nutrition, and the neuroplastic brain. The versatile practitioner's use of dialectical behavior therapy (DBT) and cognitive behavioral therapy (CBT) treatment techniques and strategies is designed to systematically ameliorate distortions within the patient's cognition, self-perception, and judgment. The assignment of behavioral tasks to counteract habitual, ritualistic, and entrenched thoughts and actions inspires new learning, the motivation to heal, and accountability within the change process, while creating new neuronal pathways in the recovering brain. The recent advent of mindfulness-based cognitive behavioral therapy (MCBT), designed to help people who suffer from repeated bouts of depression and chronic unhappiness, combines the ideas of cognitive therapy with meditative practices and attitudes. Dialectical behavior therapy (DBT), too, incorporates the quality of mindfulness as a central component of treatment.

The Maudsley Method of Family-Based Therapy (FBT), not to be confused with conjoint family systems therapy, has been considered a "best" evidence-based practice for treating eating disorders in young children and families. The method follows a manualized protocol dictating the roles that parents need to assume in their child's refeeding process. Early phases of FBT minimize the significance of the therapeutic connection between the practitioner and child where the child is not yet developmentally capable of separation from parents, or is too emotionally undeveloped to absorb and benefit from the values and insights imparted through treatment. In the latter phases of FBT, as the child becomes developmentally more self-reliant and present, the relational context of the therapist/child connection becomes increasingly relevant.

Acceptance and commitment therapy (ACT) is a branch of cognitive therapy that acknowledges the centrality of the therapy relationship. Successful outcomes are achieved through acceptance and mindfulness strategies, coupled with commitment and behavioral change strategies, which result in psychological flexibility. "ACT focuses on full acceptance of present experience and mindfully letting go of obstacles as clients identify and pursue their life goals"

[22]. Such mindfulness strategies in psychotherapy cultivate moment-to-moment awareness as a curative mechanism that serves most forms of psychotherapy across the board [22]. By attending to their own experience in the present moment, therapists become more open to, and accepting of, whatever awareness emerges in that experience and in the experience of the other, to include body sensations, affects, and thoughts. Current studies suggest that in successful treatment alliances, therapists are perceived as being warm, understanding, and accepting, approaching their patients with an open, collaborative attitude. In developing these qualities, mindfulness qualities in psychotherapy practice deepen the therapeutic relationship [23].

The transdiagnostic approach to eating disorders, Unified Protocol (UP) is an emotion-focused cognitive-behavioral treatment developed to be applicable across the full range of anxiety and related disorders. Consisting of four core modules, it increases emotional awareness, facilitates flexibility in appraisals, identifies and prevents behavioral and emotional avoidance, and provides situational and interoceptive exposure to emotional cues [24]. "Clinicians are often faced with the difficult task of treating individuals with complex clinical presentations that require them to use multiple protocols or to tackle several problems at once, with little empirical data to guide them. Transdiagnostic treatments may help eliminate the need for multiple diagnosis-specific treatment manuals and simplify treatment planning, overall" [25–27].

Motivational interviewing is also highly relevant to ED treatment in light of ongoing ambivalence about, and fear of, recovery that essentially immobilizes patients, particularly within the precontemplative stage of treatment. Through motivational strategies and tools, family involvement, therapist-patient relationship quality, the use of medication, and behavioral contracts, therapists assess and shepherd readiness for change by suggesting realistic goals that the patient feels are within her reach. Therapists do well to use the patient's own incentives and logic, impaired as they may be, as a place to start: "So, am I understanding correctly that you believe the more weight you lose, the more popular you become at school? Are you saying that in the throes of your disease now, you are feeling increasingly happier and more secure?"

### 5.2. Enhance the partnership between patient and brain through neurophysiological treatment approaches

Among the more novel adjunctive treatments for ED are those that occur through enhancing the vibrant partnership between patient and brain. Like a beaver building a dam to change the distribution of water in the aftermath of natural forces, the patient who is inspired by the therapist to "put aside an obsessive focus on the past in order to reconsider, rethink, and re-create the course and flow of the present, has a hand in mindfully creating a far-reaching and lasting influence on brain structure and function to affect the future" [22].

ED are disorders of self-sensing and self-perception. Anorexic patients experience an altered capacity to process and integrate bodily signals. Their sensation of body parts is distorted, experienced as dissociated from their holistic and perceptive dimensions [28]. In stimulating regions of the brain that lie beyond the scope of talk therapy, neurophysiological treatment interventions that integrate brain, body, and mind have been shown to increase sensory

awareness and self-awareness, both elements essential to ED recovery. Twenty-first century research and imaging technology has demonstrated the neuroplastic brain's capacity to regenerate, reconfigure, and heal itself through adjunctive, noninvasive, neurophysiologically based somatosensory treatment interventions (those dealing with the embodied nervous system) by informing, integrating and healing the brain through creating connectivity between and body and brain. Various forms of somatosensory education hold the potential to facilitate recovery from ED and body image disturbances. Despite this, such practices have not yet become part of mainstream clinical ED practice.

### *5.2.1. The Feldenkrais Method*

Dr. Moshe Feldenkrais recognized the value of systematic exploration and reorganization of sensory motor aspects of self-image during the early part of the twentieth century. Through pleasurable, sequential forms of movement with attention, *the Feldenkrais Method of Somatic Education*© stimulates sensory integration by reconnecting individuals consciously with their unconscious sensorimotor repertoire. Facilitation of the method is accomplished through the verbally guided directives of a Feldenkrais practitioner in Awareness through Movement© group lessons; or through gentle, nonverbal, hands-on Functional Integration© lessons, which connect and integrate the sensing body and brain. In a controlled study within a multimodal treatment program, ED inpatients participating in adjunctive Feldenkrais treatment were shown to increase their acceptance of, and contentment with, problematic zones of their body. Other results indicated "the development of a felt sense of self, self-confidence, and a general process of maturation of the whole personality" [29]. Easily accessible demonstrations of short and simple Feldenkrais movements have become available via the Internet for use in professional offices and patients' homes. ED therapists do well to encourage patients to reinforce mindful neurophysiological healing at home, as "sustained practice solidifies learning" [30]. Integrating body and brain leads to the integration of the total self, awakening the patient's potential for realizing new options in *all* life spheres. By verbally processing somatosensory experiences with the patient either during the movement experience, or in its aftermath, therapists help patients fully understand how the functions of somatic education parallel and complement the functions of the psychotherapy process by increasing awareness of a sense of mind/body wholeness and a unified perception of self.

### *5.2.2. Trauma-Informed Yoga*

*Trauma-informed yoga* regulates the nervous system, bringing it from a dysregulated state to a unified, centered state. Unprocessed traumatic memories stored in the brain become recycled when triggered, creating imbalanced patterns of nervous system activation. Yoga naturally regulates the overwhelmed nervous system by bringing unconscious content from trauma-related neurological and muscular patterns into consciousness. Teaching the use of breath, which evokes self-regulation, and facilitating close attention to present-moment awareness of self, yoga shifts sympathetic nervous system arousal to a balanced parasympathetic sense of calm and relaxation. Yoga has been shown to promote affect tolerance of physical and sensory experiences associated with fear and helplessness [31]. The trauma-informed yoga practitioner

needs to conduct a full assessment of the patient's nervous system imbalances in order to provide postural movements that accommodate the individual's unique needs. For ED patients suffering from co-occurring substance abuse or addictions, yoga-breathing practices may be useful in counteracting all types of urges brought on by environmental triggers that could result in relapse [31].

#### *5.2.3. Eye Movement Desensitization Reprocessing*

A growing body of research points to *eye movement desensitization and reprocessing* (EMDR) as a highly successful, (mindful) method for treating a variety of conditions, including trauma [32]. Traumatic experience becomes locked in the brain and body. As an integrative psychotherapy approach involving interpersonal, experiential, and body-centered techniques, EMDR processes traumatic memory stored in the brain. Given the direct correlation between the trauma of sexual abuse and the onset of ED, this methodology can be considered a helpful adjunctive resource in the treatment of ED.

#### *5.2.4. Neurofeedback training*

Parts of the traumatized brain remain out of synch with other parts of the brain, leaving the trauma victim unable to take in neutral information without fear, and unable to learn freely from life experience. *Neurofeedback training* (NFT) represents an effective alternative for modifying neurophysiological activity in the brain that contributes to specified impaired cognitive processing and emotional and behavioral dysregulation. Noninvasive instruments measure physiological activity, then "feed back" information to the user, a process that enables individuals to reverse the effects of trauma and depression by integrating brain function, and allowing the patient to change the course of neurophysiological activity to improve health and performance.

#### *5.2.5. Transcranial magnetic stimulation*

Another form of noninvasive technological brain intervention that has been used successfully with ED patients includes *transcranial magnetic stimulation* (TMS), which sends low dose magnetic pulses to parts of the brain associated with unrelenting depression. The technique has been shown to ease depression and improve mood when medication has been insufficient to relieve depressive symptoms for patients with a severe and enduring ED (SEED).

### 5.3. Manage resistance by tapping into personal and external resources

The process of recovery typically feels worse to the patient than does the pathology of disease. It is up to the psychotherapist to penetrate and break through treatment resistance to facilitate patient engagement, from the very first meeting, and throughout the recovery process. Treatment resistance can be seen in the patient's failure to: (1) recognize and accept the ED diagnosis, (2) engage in the treatment process, (3) attend sessions consistently, (4) attempt to comply with food plans, and (5) include parents and family in treatment where appropriate. When resistance and/or accompanying denial interferes with the treatment process, the

mindful and empathic therapeutic connection and the creative use of diverse resources can become motivational. Tools existing within the clinician's "professional toolbox" include the following:

*5.3.1. Tool #1: Recognize and celebrate the patient's internal strengths*

As early as the first diagnostic session, the therapist's capacities to inspire, build, and nurture trust in the therapy relationship and treatment process lays the groundwork for treatment engagement, patient self-acceptance, and healing. Instilling trust in the patient's existing strengths and potential for growth, particularly at treatment outset, is the glue that upholds and sustains an otherwise fragile, tentative, and ambivalent precontemplative treatment connection and process. Planting the seeds of self-trust ultimately provides patients the stamina to sustain recovery efforts through challenging treatment junctures. Reframing a situation can recapture, refresh, and restore the healing process through trust development. As an example, by empathically reframing the ED to be the patient's well-intentioned bid for self-survival, the therapist dismantles her fears that she is crazy and culpable. In addition, it inspires hope in the implication that she will soon become capable of discovering more reliable, less self-destructive means of coping with discomfort and adversity.

Positive change can be identified in the demonstration of the patient's: (1) growing commitment to treatment, (2) connection with the therapist, (3) capacity to identify feelings, (4) increased capacity to recognize and verbally communicate needs, (5) growing independence and self-determination, (6) healthy eating lifestyle, (7) improved coping capacities, and (8) improved quality of daily function. By recognizing and acknowledging the elusive or disguised nature of recovery progress, personal growth, and resiliency, therapists evoke optimism and incentive to heal. Constructive life lessons frequently reside in mistakes, if not failures.

> J returned from college with a sad confession. She had begun to slide back into her purging patterns. "I'm a failure" was her message, clear and simple. Her doctor and nutritionist had both read her the riot act. Her lesson from me was not about how to eat better or become more disciplined, but about how to view the situation from a more positive and realistic framework, helping her to differentiate normative recovery patterns from significant relapse. "So," I observed, "Let's take a look at what *has* changed!" I helped her see that she had become more ready to be honest with herself and with others, more acutely aware of precipitants to her regressions. Her digressions had become more contained; now isolated incidents, they were no longer the start of extended patterns of dysfunction. General problem-solving in other life spheres improved, as had her relationships with others. Increasingly aware of her needs and feelings, she was becoming increasingly assertive in communicating those needs, both within, and outside of, treatment sessions. She was, in fact, progressing well in her ED recovery.

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*5.3.2. Tool #2: Rally your forces: tap into the network of family resources*

Though baffled, fearful, and generally uninformed, by default, parents and families become witnesses to their child's struggles in kitchens, bathrooms, grocery stores, and restaurants. Parents need to learn to understand the disease, its effects on their child, and the unpredictability (and necessity) of the recovery process. They need knowledge, guidance, and skills to respond effectively, and with sensitivity, to their child's efforts to recover, and to mediate the effects of the ED on the greater family system, particularly at meal times. Life partners of ED individuals, as well, need to learn to interpret the significance of changes they see, or may not see, throughout the course of treatment, be they in the form of progress or regression, or both. Family members need to keep pace with the ongoing development of the recovering individual's strengths, which will influence the ever-changing nature of their support for their loved one throughout the treatment process. When the psychotherapist takes on the dual roles of individual and family therapist, treatment efficacy becomes streamlined, simultaneously guiding the family along the same continuum of growth and change that the identified patient travels, and at the same pace. Treating family members conjointly with the identified patient avoids the potential for the practitioner to breach confidentiality by enabling family members to speak for themselves, openly, willingly, and face to face.

*5.3.3. Tool #3: Consider a referral to a psychopharmacologist for a medication evaluation*

Psychopharmacological medication is meant to help people feel, and function, better. If and when medications fail to result in either or both of these outcomes, it is clearly time for the psychotherapist to recommend a medication reevaluation, or possibly, a second opinion. When a treatment process is stagnating or regressive, a medication reassessment holds the potential to break through neurochemical barriers in the brain that contribute to entrenched resistance to healing. The psychopharmacological specialist in the treatment of ED seeks to balance brain chemistries, optimize brain function, and facilitate the patient's potential to benefit from the treatment experience. Malnutrition, co-occurring mood disorders, depression, anxiety/obsessive compulsive disorder (OCD), and ADHD (in some cases brought on by the disease itself) highlight the importance of the input of a skillful psychopharmacologist as part of the ED outpatient professional team. Medications are not meant to provide a cure, but to facilitate healing through the psychotherapy process. It is important to recognize that until the starving brain has been refed, the benefits of using medication will be less than optimal.

ED patients commonly resist consideration of the medication option, fearing the unknown, the possible side effect of weight gain, or taking the "easy way out" in the face of an ED that demands willful deprivation and self-discipline. Some patients are afraid to "contaminate" their body. Others, who consider medication to be the "last resort," fear that they will ultimately discover themselves to be beyond help. It is critical for the knowledgeable psychotherapist to reduce the patient's (and family's) resistance to the medication option by preparing them for the medication evaluation, describing benefits and possible side effects of relevant medications, establishing realistic expectations, quieting fears, etc.

Because of the breadth of factors that contribute to and co-occur with ED, psychopharmacologists need to diagnose mental health status fully, and in depth, before providing medication.

Though fluoxetine (prozac) has been shown to be beneficial in treating AN and BN, medications affecting serotonin neurotransmitters can be contraindicated, creating suicidal tendencies in cases where there may be a yet undiscovered underlying mood disorder. Stimulants prescribed for ADHD can suppress appetites in patients with AN. Hormone replacement therapy, commonly prescribed for anorexic patients, does not enhance bone density, but masks the loss of natural menses. "The commonly prescribed use of estrogens for anorexic patients to bring on a period in seeking bone density enhancement may create a false picture indicating that the skeleton is being protected against osteoporosis. Thus, the motivation to regain weight, and adhere to treatment of the ED, may be reduced. Hormone and oral contraceptive therapy should not be prescribed for young women with amenorrhea and concurrent ED. The most important intervention is to restore menstrual periods through increased nutrition" [33].

## 6. V.I.A.B.L.E. treatment incorporates an Integrative style of thought and action

### 6.1. Sustain a "big-picture" perspective through envisioning, and seeking, a complete ED recovery

ED therapists need to be myopic, even while functioning as visionaries. The seasoned ED practitioner integrates knowledge with instinct, intention with flexibility, and diversity within structure, holding onto the "big picture" of disease and recovery even while attending to the small details of behavioral change. With ED, small changes become the stuff of vast transformations. In validating the patient's feelings, thoughts, and ideas, the therapist makes sense of them for the patient within the larger picture of the disorder, of the narrative of her life, and of her relationships with food, self, and loved ones.

As integrationists, ED therapists piece together submerged and disparate facets of the patient's personality to foster the re-creation of the patient's true and authentic integrated self. In uncovering, discovering, differentiating, then reintegrating all parts of the patient's exiled self, disclosed and undisclosed, systematically and intentionally, the 1000 piece puzzle of the patient's holistic self slowly reassembles itself into an integrative fabric through the recovery process. As integrationists, practitioners play diverse roles in the life of the ED patient, as teacher, mentor, cheerleader, confidant, case manager, and "parent" in supporting and containing the patient to her point of readiness for flight into recovery as an autonomous, independently functioning, self-possessed, self-regulated, human being.

### 6.2. Be prepared to "understudy" multiple roles within the treatment team

In taking on the responsibility of case manager, it is up to the outpatient ED psychotherapist to put together an outpatient team of expert treatment professionals capable of tending to the broad-based needs of the ED patient throughout the course of care. Defying compartmentalization, ED symptoms need to be recognized and professionally managed by every member of the team. Wearing diverse professional "hats," each team member acts as a representative of the wider healing process, capable of mediating all spheres of pathology. Particularly in

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smaller, less diverse, rural communities, where trained and experienced professionals may not be readily accessible, the need for an integration of knowledge, skill sets, and a multifaceted use of self becomes particularly critical. Members of the professional team, including medical doctor, psychopharmacologist, individual/family therapist, and nutritionist, need to understand and "understudy" each other's parts, learning essentially to "speak each other's lines" as needed, fluently, throughout the treatment process.

As an example, where an at-risk anorexic child patient resists treatment engagement with the outpatient psychotherapist, the familiar and authoritative pediatrician may step in to become active in monitoring weight and vital signs regularly, actively demanding accountability and improvement. In the absence of timely change, the pediatrician's recommendation for a higher level of care potentially carries the day. In response to a patient who is starving herself, my nutritionist team partner would typically ask the patient to consider the fact that she is abusing herself, inquiring "what that might be about." Following such an exchange, she would attend to the issue of introducing behavioral change into the patient's eating lifestyle. Even in the latter stages of recovery, there is rarely a session that goes by without my inquiring about how one's eating-related progress is going.

### 6.3. Encourage families and life partners to become advocates for recovery

Apart from parents of child patients, life partners and siblings become witnesses, and potentially effective supporters of ED recovery as well, when properly prepared for the task. Siblings of adolescents with AN have been shown to demonstrate poorer psychosocial adjustment than their peers, both before and after the identified patient's FBT recovery efforts. Clinicians and parents need to become aware of sibling difficulties and to offer additional support if required [34].

When a family member contacts me by phone or email to discuss concerns about his or her loved one's recovery, my response is always inclusive, welcoming them to attend conjoint family sessions for open and mutual discussions. The patient who refuses to participate in an occasional conjoint meeting with family or partner raises a therapeutic issue that demands attention and resolution.

Any concerns about privacy disclosures or confidentiality breaches when the family joins the individual patient in conjoint family treatment become unfounded, a non-issue, as family members are brought together to air their *own* immediate concerns and issues, willingly, and by choice, to one another. Except in extreme instances of dysfunction within family systems, parents or spouses need to become part of the fabric of treatment, in various ways, to varying degrees, and at various points within the healing process.

In those instances where a married ED patient enters treatment, the marital dyad becomes the primary family system. Involving the spouse in treatment potentially enriches and facilitates the identified patient's recovery.

> C. was a compulsive exerciser, waking at 3:00 AM to make time for eight hours of exercise daily. She would fulfill her computer-based employment responsibilities while exercising on machines. Interfering with the lives of family members in the

context of daily living and travel, her compulsions began to undermine her marriage. Ultimately, C's husband felt compelled to supercede the eating disorder by taking control of his wife's behaviors, threatening to leave the marriage if she did not comply with his directives to give up exercise completely. Having done so, as she restored her weight, her extreme body image discomfort finally prompted her to seek ED treatment. This patient refused to consider taking medication to diminish her anxiety, compulsions and occasional panic attacks.

It became apparent that C's husband needed to attend a conjoint couple's therapy session to become educated about her need for a gradual increase in her own *self*-regulation as part of her recovery. The session facilitated a plan for a treatment arrangement at home allowing her to attempt to return very gradually to a normal degree of exercise in the hope of overcoming her compulsive urges towards extremes in behaviors and thinking *in all areas of life*. Conjoint sessions provided the backdrop for a more complete recovery and a healthier, stronger marriage.

### 6.4. Integrate diverse treatment milieus and levels of care when necessary

Levels of care for ED treatment range from the most restrictive (hospitals and long-term residential facilitates) to less restrictive alternatives (group partial hospital programs (PHPs), intensive outpatient programs (IOPs), and individual outpatient therapy with an outpatient team of ED experts providing therapeutic, medical, psychopharmacological and nutritional services to individuals and families. The latter is the least restrictive outpatient level of care, allowing the patient to remain in her home environment with the support of loved ones, fulfilling her life roles at school or work, side by side with friends. A higher level of care becomes a consideration primarily when the patient faces immediate physiological or emotional risk, requires forcible refeeding, or when the outpatient team alternative proves unworkable due to the patient's treatment resistance or progress stagnation. Higher levels of group care enforce refeeding, provide cognitive and behavioral immersion, offer emotional exposure to peer support, and enhance internal strengths and coping resources, ultimately setting the stage for the patient to make subsequent long term progress through recovery efforts within less restrictive outpatient care.

Choosing the appropriate care level, at the right time, can optimize the course of treatment for each individual patient, impacting one's engagement in treatment, one's time spent in treatment, the nature of the weight gain process, and the extent to which emotional goals are attained. In some instances, the referral to a higher level of care, at the right moment, could potentially insure that the window of readiness for treatment engagement and healing is captured rather than lost forever. In transitioning into or out of a program successfully patients and parents need preparation to understand what to expect and to establish realistic goals for themselves within the upcoming experience.

A pediatrician who universally prescribes higher levels of care as a child's initial entry into ED treatment in order to “save parents time and money,” believes it is more efficacious to bypass the option of diagnostic assessment through an

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outpatient treatment team of ED professionals. Such a universal prescription misleadingly implies that restrictive environments are more beneficial than those permitting recovery within the context of daily living; that all patients, and all recoveries, are alike; and that restrictive treatment programs "cure" ED patients.

## 7. Seeking V.I.A.B.L.E. treatment through an Action-oriented treatment style

### 7.1. Any ED diagnosis can be considered a call to action

An ED waits for no one. Unless it is healing, the condition is progressing. The diagnosis of an ED is frequently elusive. Through a deep understanding of these diseases, seasoned therapists develop a capacity to anticipate or intuit their presence, a skill rooted in diagnostic acuity. Within the context of human connection, the astute therapist reads 'between the lines' of the therapeutic moment, guiding an inquiry and early detection of physiological, developmental and emotional gaps in the patient's psyche and body image.

> E was a 29-year-old woman who began treatment with me for depression and relationship problems. In response to her description of her college days where she spoke of herself as being perfectionistic, highly compulsive, and depressed, I chose to wonder aloud if she had ever struggled with an ED or other eating related issues. "My God!" she responded. "How did you know? I have never told a soul!" By understanding the emotional configuration of her personality, I was able to intuit and surmise the possible existence of a past or ongoing ED. In learning that my hunch had been correct, I better understood the breadth and depth of her treatment needs.

Learning to identify suspicious clusters of symptoms potentially shines a light on existing, future, or past ED that might otherwise have remained undisclosed. In making the educated guess, therapists learn to "connect the dots" of conversation and affect. At times, making an eating disorder diagnosis can be much like observing a disparate grouping of stars and seeing a constellation. By anticipating the unspoken (based on information that *has* been offered), by discerning which topics require further investigation, and by actively probing the possibility of earlier patterns of behavioral impulsivity and compulsions such as self-mutilation/cutting, childhood shoplifting, promiscuity, substance abuse, and excessive exercise, therapists become capable of revealing hidden, or yet undisclosed, underlying ED and co-occurring conditions.

### 7.2. ED require an active, purposeful, and on-going diagnostic process

ED offer little leeway for cursory assessment of both the disease and recovery status, throughout the course of treatment. An ongoing diagnostic assessment of recovery, which may be considered the flipside of an ongoing diagnostic assessment of pathology, enriches the treatment process, motivating new directions for growth and change. Assessment of recovery status might reveal a possible resurgence of resistance and regression, which could signify a

worsening pathology. Recovery derailments can be gradual or sudden, temporary or enduring, minor or significant, at times warranting consideration of a higher level of care or tapping additional personal and professional resources (family, team, psychopharmacological medication) for support, as needed. Effective ED treatment demands *ongoing* positive change in the form of recovery progress, both immediate and long term, behavioral and emotional, throughout the duration of care.

### 7.3. In managing a moving target, ED practitioners dare not take their hands off the wheel

The ED therapist moves and motivates people with the intention of moving and motivating the healing process. Authoritative action, not to be confused with authoritarian demands, produces desired outcomes. Micromanagement and the imposition of directives, judgments, projections, or boundary intrusions replicate the role of the overly controlling ED, denying the patient self-determination, a most pivotal component of recovery. In response to the momentum behind a forward-moving disease, therapists need to carefully monitor, then shepherd, the pacing of recovery change. Except in the case of young children who are developmentally unprepared to take on the tasks of self-determination throughout recovery, or of highly resistant patients whose malnourished brains have impaired their capacity to make responsible decisions, the use of "*soft power*" can produce positive outcomes. The nonjudgmental therapist's radical acceptance of the patient can redirect the forces of resistance..

> An 18-year-old anorexic patient declared, "I can fix myself. I don't need therapy." I replied, "I'm all for that plan. You are, and will always be, the primary person responsible for your own recovery. I am basically here as a coach, cheerleader and collaborator. So why don't you try to follow your own meal plan this week, and let's talk about how things go when we meet again. Be sure to journal your efforts, so together we can gauge your progress and determine your next steps.

#### *7.3.1. Taking action demands courage in ED patients as well as practitioners*

Action-based behavioral tasks and strategies, such as the patient's journaling, or in-office meals eaten in the company of the therapist, create accountability, and can become strong motivators for change. As important diagnostic tools, such strategies can shed light on an elusive process of ED recovery change.

> A recovering anorexic patient, who had made brilliant progress in integrating regular and nutritious meals into her life, spoke of having skipped lunch three times one week because of mounting stressors at work. After legitimizing her urges, and identifying the feelings that evoked them, I discussed the normalcy of an occasional and intermittent regression during eating disorder recovery, not to be considered a relapse. I requested that she attempt to resume eating lunches daily and journal her efforts and struggles, successes and failures, to be assessed together in our quest for understanding and problem-resolution during our next meeting. In another instance of an anorexic patient's strong resistance to considering the inclusion of lunch into her eating lifestyle, I planned to conduct the next

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few sessions over lunch together, side by side, in-office or at a restaurant, supporting her efforts, providing exposure, processing fears.

Actively engaged practitioners model energy, initiative, and resolve. A study showed that when therapists make referrals to higher levels of care and encourage patient follow through, of those patients who were offered a phone number, 37% made contact; when the counselor took initiative to place the referral call for the client, 82% completed the referral [21]. The therapist who chooses to remain passive, nondirective, or more like a friend by avoiding tough therapeutic issues in an effort to protect the patient's comfortability and trust, enables the ED. "Toughness" is a sign of a practitioner's clear intention to support positive change.

In reminiscing about her ED treatment, a recovered patient once commented, "You knew things that were in my head and heart even before I did, and you recognized what I was capable of doing even before I did. Best of all, I couldn't get away with anything because you knew the drill, and were not afraid to challenge me."

Healing therapeutic connections ride on the therapist's capacity to sustain the fragile balance between discomfort and learning, and between learning and change.

## 8. Seeking V.I.A.B.L.E. outcome-Based treatment

### 8.1. If at first you do not succeed, try something different

If one technique does not work, it is incumbent upon the practitioner to find another that will. As a therapist, I am a Machiavellian proponent of doing what works, whatever that may entail. Nontraditional, "outside-the-box" treatment alternatives have been shown through evidence-based controlled studies to carry the potential to achieve positive outcomes for ED. If an intervention works for a single individual, offering that option to other ED individuals becomes a legitimate and viable option.

At age 13, M and her mother attended outpatient therapy sessions together for several months and saw a pediatrician and nutritionist weekly. Despite this, her AN remained intractable. Whatever weight she was able to gain, she readily lost. Still, she resisted medication and a higher level of care. Insisting that she could 'recover on her own,' her resistance to recovery intensified and she began to miss therapy sessions. In my effort to rescue a now fragile treatment process, I offered M the unique opportunity to discontinue therapy temporarily, going it on her own, utilizing the knowledge that she had already gleaned through treatment to date. This plan stipulated the singular requirement that she see her doctor weekly for monitoring of weight and vital signs. I also extended an invitation to her mother to attend coaching sessions with me regularly, without M, which she readily accepted. Feeling 'heard,' and grateful to be allowed to try her own hand at recovery, after 3 weeks, M requested permission to join her mother in her return to treatment.

In her absence from treatment, M made peace with the idea of seeking a higher level of care. She ultimately agreed to attend an intensive after-school outpatient program, under the stipulation that if she did not gain sufficient weight there, she would enter a higher-level full-day partial hospital program. Having been offered an opportunity for self-determination, M felt an enhanced sense of trust and connection with me. Prior to starting higher-level care, she reached out to me on several occasions for my support and reassurance about what was now her own decision.

### 8.2. The proactive therapist sustains a clearly boundaried, but palpable, presence in the heat of the treatment trenches

T was a 12 year old who had begun her descent into AN; at the start of her session, she sat in the car, bawling. Her mother rang my doorbell to ask what to do, as her daughter refused to get out of the car for her third therapy session. I instructed her to return to the car and speak with her daughter, setting clear but loving limits, and making authoritative demands… T would either come into the session to continue her outpatient work, or she would need to enter an ED program. Crying hysterically, T refused to get out of the car. At that point, I donned my boots and jacket and began this session on the street, in front of my office, in the snow. I told her how relieved and optimistic I felt to see that she was finally beginning to get in touch with her feelings, which made her so much more accessible to getting the help she so richly deserved. Reframing and educating, meeting and joining with her where she was, I applauded her integrity and courage in expressing herself. Standing up to her mother would hopefully become a prelude to standing up to her ED. Feeling genuinely understood, T began to experience hope and a sense of relief as she followed me into my office that day, where we proceeded to have a break-through session. [19]

### 8.3. Rules, like therapists, require flexibility

In an imperfect world of ED treatment and recovery, hard and fast rules may occasionally need to be bent in offering the most practicable solutions for patients. In nuanced decision-making, ED therapists become models of thought and action.

An intake therapist at a renowned outpatient treatment center refused to assess a patient for admission because she needed two more pounds to reach her 'safe' body mass index goal. This patient was asked to attend an in-patient program to restore her weight first, in the interest of "optimizing the therapy process." Though motivated to achieve recovery through a higher level of care to support her re-feeding efforts, the patient became caught up in a catch-22. She would either have to enter a financially prohibitive in-patient milieu, or gain the required pounds in a less restrictive environment. Both alternatives were daunting to her. Though declared medically stable by a medical doctor who was monitoring her weekly, her recovery efforts floundered.

> By disregarding the "psycho" and "social" aspects of the bio/psycho/social disease, this intake counselor placed too much emphasis on the criteria of weight alone in determining the patient's preparedness for treatment. This diagnostic assessment needed to take into consideration the patient's readiness and motivation for recovery, her financial constraints, and her medical monitoring, in addition to her weight. A short-term weekly contract for a stipulated amount of weight gain, in-program, might have been a more appropriate and workable alternative.

### 8.4. Don't stop until you are there. Advocate proactively within health policy systems

As neurobiological disorders with their origin in genetics, EDs were declared legitimate "biologically based mental illnesses" by the Academy for ED in 2006, deserving of medical insurance coverage. Congress succeeded in eliminating discrimination in health care coverage against people who have mental health disorders in the passage of the Emergency Economic Stabilization Act of 2008, which took effect in 2010. Despite these advancements, insurance coverage for ED treatment remains spotty, with some companies denying coverage totally and others denying longevity of coverage. Some insurance companies appear to be more amenable to providing coverage for diagnostic codes that indicate less serious, more ephemeral, types of diagnoses. In some instances, companies have considered the normal weight ED patient not appropriate for coverage.

In dealing with insurance companies, advocacy from personal and professional mentors needs to be active and focused. Communications need to be traced to the top of the bureaucratic pyramid in seeking assurance that the company assumes appropriate responsibility for its decision against coverage for the ED patient, particularly if a patient's health is at risk. The insurance company needs to be made aware of their liability if they refuse to cover a patient who dies for lack of care. Most insurance carriers allow families to appeal the refusal of coverage, and some now hire in-house employees to assist consumers in such appeals. Most higher-level ED programs and facilities offer the assistance of a specialized coordinator/advocate, hired to intercede and develop trusting relationships with insurance companies for the benefit of patients. Some residential programs offer scholarships for patients who would otherwise be unable to afford to take advantage of a costly, but life-saving, treatment milieu.

## 9. Seeking V.I.A.B.L.E. treatment through the Loving/caring therapeutic relationship

### 9.1. The treatment relationship as an intervention

According to Daniel Siegel, "Relationships are woven into the fabric of our inner world. We come to know our own minds through our interactions with others" [35]. Emotional, cognitive, and behavioral learning is enhanced within the framework of a powerfully human and loving therapeutic connection. "Love is not something that we generate; it is found in the activity of intimately attending" [22]. Because ED are disorders of relationship and attachment, the

quality of relational connection or attunement between the ED therapist and patient is pivotal. The healing connection between therapist and eating disordered patient becomes the prototype and practice ground for all healthy relationships, as the conduit for the return of the ED patient's exiled core-self. Though the patient's resistance to letting go of the disorder may be a primary source of the ED clinician's initial treatment challenges, the quality of the therapy relationship is frequently the "deal breaker" when ED treatment fails. Conversely, it can be the quality of the treatment connection that transforms the therapist's goals and intentions into fertile seeds of successful outcomes within a safe and trusting treatment environment. Studies have found that "…the model of therapy simply does not make much difference in therapy outcome. Empathy accounts for as much and probably more outcome variance than does specific intervention" [22]. Empathy not only helps the patient to feel better and feel "felt," it may create a new state of activation with coherence in the moment that improves the capacity for self-regulation [35].

The foundation of the healing therapeutic connection exists within brain physiology. Neuroimaging studies of structural brain changes associated with the process of relationship within psychotherapy demonstrate that relational experiences in psychotherapeutic treatment result in detectable changes in the brain. "The aim of the talking cure…from the neurobiological point of view is to extend the functional sphere of influence of the prefrontal lobes" [30]. "The intention of therapy is to work through the effects of isolation and disconnection, as they play out in life and in therapy, toward the goal of reconnection and restoration of mutual connection. For the patient, this results in a greater capacity to act, increased clarity, enhanced self-worth, and the desire for more connection, while remaining present and accessible in his or her shared humanity" [22]. According to Christopher Germer, "Given that there is little empirical evidence that (treatment) effectiveness improves with experience, continuing education, licensing, professional degree, clinical supervision, or any other marker of professionalism, and given the importance of the therapeutic relationship, the larger challenge is to find a way to help cultivate the qualities of excellent therapists" [22].

### 9.2. Engage in strategies that reinforce the strength of therapeutic connections

Mindfulness in psychotherapeutic practice creates strong connections between people. The mindfulness process requires the therapist's and patient's attention and "presence" within the treatment moment, where the inception of psychotherapeutic change takes place. Daniel Siegel describes presence as "being aware, in a receptive state of what is happening as it is happening. This receptivity correlates with a brain state in which there is intentionality, awareness, conscientiousness, and nonjudgmentalism in interacting with others, promoting rewarding relationships" [36]. Mindfulness in psychotherapy practice allows patients a greater capacity to choose whether to act on one's urges, a concept that is particularly relevant to the treatment of BN, characterized by impulsivity and self-dysregulation. Mindfulness in psychotherapy stimulates the patient's ever-changing neuroplastic brain to learn. As the brain learns, people change and heal; as people change and heal, the brain alters in structure and function, ultimately stimulating further changes.

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Recognizing and addressing the patient's newly emerging, fledgling strengths throughout the course of treatment reinforces the patient's self-acceptance and empowerment, facilitating trust in the therapeutic connection, but not without reservations. Low self-esteem and the fear of becoming fat and out of control render some ED individuals wary about trusting the therapist's positive affirmations. In the face of a complimentary observation, the self-hating patient may distrust the accuracy of the therapist's perceptions. ED patients may also fear (1) recovery from a much coveted disorder, (2) the therapist's terminating treatment before she feels ready, and (3) being expected to demonstrate strength and competency that she does not possess. Through a deeply sensitive understanding of the ED mind, and carefully worded subtleties of self-expression, the knowledgeable practitioner can avoid making well-intentioned comments that might inadvertently raise anxiety or stimulate regression in the ED patient.

> "You are looking great," can all too easily be interpreted as "You have gained weight and look fat." "You don't have too much weight to gain," a comment offered as encouragement to an anorexic teen with a dysregulated eating lifestyle, would clinch the patient's belief that she is already fat and that continuing to follow her meal plan would only make her fatter. A pediatrician mentioned the "benefits of eating fatty acids" in encouraging the inclusion of fish in an anorexic adolescent's diet; that patient resolved never to eat fish again.

It is never too late to repair a moment of distortion by investigating and processing it, clarifying and resolving misinterpretations, either as they occur, or after they have happened. The therapist's full transparency behind a misconstrued but well-intentioned comment can deter a patient's anxiety and potential for recovery derailment. Patients feel reassured and become capable of developing increasing trust in the therapist who substantiates positive comments by citing the origin of a complimentary observation and the thought process behind it.

> "Here's what has led me to remark about what I see as your substantive progress and the growing strengths you have achieved." Is there any part of what I am saying that you might accept as being an accurate description of yourself?
>
> "You know, when I offer positive feedback to you, I am aware that it must be difficult for you to hear because of how poorly you think of yourself. Can you tell me what it feels like for you to hear the positive things I am saying about you?"

It is not unusual for patients who may idealize their therapist to forego sharing what they consider to be shameful self-revelations, for fear of giving rise to judgment or disapproval. Therapists might anticipate and diffuse such a dynamic by wondering aloud "if such a thing might ever happen within our own treatment relationship." Welcoming a potential problem by putting it 'on the table' can stave off its occurrence, creating an atmosphere of total acceptance.

Another strategic tool that therapists might use to nurture and reinforce a genuinely caring connection with patient and family is to offer ready accessibility between sessions when needed, throughout care, always within the confines of exquisitely honed professional boundaries. I invite and welcome contact with patients who are in crisis, and with parents who

have inquires or observations that deserve immediate attention. The process of learning and change exists in life, both within, and beyond, the therapeutic hour.

## 10. Seeking V.I.A.B.L.E. treatment through Education of self and others

### 10.1. Myth busting

The impact of ED pathology on the malnourished brain typically fosters cognitive distortions and illogical beliefs, which give rise to self-destructive thoughts and actions. ED therapists need to anticipate and address cognitive distortions, myths, and misconceptions about ED, educating patients and parents about the realities of these disorders, and their impact on the brain, mind, and body. Educating oneself first is prerequisite to educating others. Because misconceptions about ED are widespread, it is essential for professionals to know, and patients to learn, what is true and what is not. EDs are not exclusively female disorders, nor are they disorders of childhood. "Ten million men will suffer from an ED in their lifetime, and 13% of women over 50 have ED symptoms. Note that 70% of them will not seek treatment due to stigma, as well as lack of education, diagnosis, and access to care [37]." Two misconceptions that prevent ED individuals from seeking recovery assistance are the beliefs that ED are addictions, and therefore they are incurable. In fact, the genetic clusters in familial deoxyribonucleic acid (DNA) that predispose an individual to ED onset may contain substance and 'process' addictions, which are addictions to activities. However, ED are *not* addictions (primary, relapsing diseases of the brain). In addition, EDs are curable in approximately 80% of patients who receive effective care and who are willing to seek complete recovery [37].

### 10.2. Take responsibility for recognizing what you may not know

A professional's lack of education about ED and their treatment can be misleading and potentially dangerous for the ED patient in recovery.

> An anorexic patient spent three years with a highly regarded psychiatrist who refused to acknowledge her ED as a pivotal aspect of her personhood or treatment. His theory was that "her symptoms were too complex to be an ED." He perceived the ED symptoms as being tangential and secondary to other "more core" co-occurring problems, assuming that once these were treated and resolved, the ED would disappear. She ultimately left this therapist to seek specialized ED treatment. His parting warning was, "Don't let anyone "treat you like an ED patient. Your problem is much deeper than that." This physician was right in his allusion to the fact that her problems ran deep and wide, though wrong in thinking that an ED diagnosis and treatment would exclude the recognition and treatment of a myriad of commonly co-occurring conditions. In the face of a complex and integrative system of comorbidity, attention to one's eating lifestyle and weight-regulation issues not only saves lives, but also can provide a behavioral foothold in unmasking, and simultaneously treating, co-occurring problems.

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### 10.3. Understand the role of weight in eating disorder treatment and recovery

The role of weight in the diagnosis and treatment of ED is perhaps the most misleading of all the commonly held misunderstandings about ED and their recovery. Patients need to understand that severe and prolonged dietary restriction and weight loss can lead to serious physical and neurological complications. At the same time, they need to understand that weight restoration alone in an underweight ED individual is not a predictable criterion for recovery. Most patients and parents, and all too many professionals, believe that the *only* requirement for medical rehabilitation for an ED is removing the immediate danger of death due to malnutrition. This is not the case. In fact, electrolyte imbalances due to purging behaviors in a normal weight ED patient can lead to sudden death.

Weight "restoration," is not to be confused with weight "gain." They both represent one single strand of the larger fabric of ED healing. Weight gain and normalizing blood tests and vital signs are significant in indicating *improved* eating and brain function, marking the patient's *potential* to achieve a full, integrative ED recovery, cognitively, emotionally, physically, and neurophysiologically. For the anorexic patient, full and *sustainable* weight restoration to the body's "set point," along with restoration of the menses and hormonal normalization, will ultimately normalize brain function and development. Attaining one's set point weight, marking full weight restoration and a normalized function of brain and body, leads to the reversal of amenorrhea. Each person has a set point weight to which he or she naturally gravitates. Bodily fluctuation from that point may diverge a few pounds in either direction, but the fit body at its set point weight will rarely gain or lose weight beyond its natural range.

> I conceptualize the set point weight as being like an ocean's tide. When the moon is new, gravitational forces may not exert a pull on a body of water as strongly as when the moon is full. The rising tide, be it slightly higher or lower, always approaches, (but does not exceed,) a certain point on the shore… with the exception of tropical storms or other natural forces. The set point weight is equally consistent, expected to fluctuate ever so slightly, but always hovering close to the water line." [19]

It is ultimately the patient's healthy and fearless relationship with food, restoration of weight to set point, normal hormonal health, and reintegration of the fragmented core self that become the cornerstone of a full ED recovery.

Regular weigh-ins can be an important accountability tool for the underweight patient. Patients who fear that any amount of weight gain will lead to the loss of self-control through binging and obesity, do best when weighed "blind," so their weight remains undisclosed to them, even while available to clinicians and parents when appropriate. It is counterproductive for clinicians to identify an "ideal weight" or to offer anorexic patients the "carrot" of reaching a specific "target weight" as their goal. The body mass index (BMI) has been proven an unreliable reflection of a healthy nutritional state [38]. No one, not a nutritionist, patient, or physician, can set an arbitrary target weight and expect its achievement to lead to recovery. The *body alone*, through the process of ingesting healthy, balanced, regular meals, is the only accurate determiner of its ideal weight for its own unique structure and function.

If a nutritionist or physician says, "It is important for you to gain another five pounds (to reach the low end of normal on the growth charts,) the patient hears," "Five pounds is all I need to gain in order to get everybody off my back;" "Five pounds gained will still allow me to stay skinny without being considered sick. If I gain 6 pounds, I will have become fat." Patients' misconceptions about food and weight need to be corrected. Such false notions include: food is fattening; the more one eats, the more weight one gains; when it comes to food, less is more; healthy eating is fat-free and sugar-free eating. Patients and families need to learn that food restriction damages the functions of the healthy metabolism, which burns calories and fat.

### 10.4. Understand that "almost recovered" is not synonymous with ED recovery

Within the context of eating disorder recovery, "almost recovered" does not apply. The term "relapse" should not to be confused with the patient's *choice* not to recover to one's set point weight during treatment. Full recovery, marked by the reintegration of the core self and the emotional flexibility that comes with it, obsoletes the usefulness of an ED as a coping tool. Where there has been a full ED recovery, ensuing life crises may at times evoke a brief return to disordered behaviors, but such regressions will invariably be temporary, if not momentary. Most will be reversible through the ex-patient's coping skills or through a few "refresher" treatment sessions. This, in light of the reality that no small change in the direction of healing is lost on the receptive brain. Having learned to walk does not preclude one's capacity to crawl, though the evolutionary benefits of becoming upright and using feet for locomotion clearly creates the brain's incentive to *continue* to use the most efficacious and practicable alternative. "So smart is the brain, when we permit it, even after doing something a million times the wrong way, doing it right even one time feels so good that the brain-body system recognizes it immediately as right" [39].

### 10.5. ED practitioners need to educate patients and families about the importance of the brain, mind, and body connection

In treating the ED patient, practitioners also treat the patient's brain. The ED professional community needs to develop a greater breadth and depth of understanding of the organ that they treat. In addition, they need to educate their patients to do the same, in recognizing the brain's role in evoking ED pathology and in fostering ED recovery. The brain is an *embodied* system, extending beyond its skull case [32]. Sensory receptors throughout the body communicate with the cranial brain via the spinal cord through "bottom up" stimulation. By educating patients and families about the ever-increasing accessibility of neurophysiological interventions available for mainstream ED practice, the vast potential to create a brain/body partnership in healing can provide direction, optimism, and a sense of "can-do" within the process of recovery.

Human experience affects brain change, and brain change, in turn, affects human experience. In light of the diversity of symptom presentation and bio-psychosocial consequences of ED, the integration of a variety of differentiated treatment approaches and clinical interventions best accommodate the integrative needs and demands of the ED patient within the treatment

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moment. The more varied and integrative the experience, the greater is the possibility of changes facilitating the healing reintegration of the fragmented self. ED treatment techniques such as the Feldenkrais Method, trauma-informed yoga, Nia, dance therapy, and Tai Chi, in offering movement with attention, access the more primitive subcortical regions of the brain where talk therapies do not reach, thereby globally upgrading and integrating brain function.

### 10.6. Partially recovered ex-patients may subsequently return to ED treatment to complete the tasks of full recovery

Practitioners cannot be assured that skill mastery and an expert use of self, alone, will guarantee successful recovery outcomes within the first round of treatment efforts. Some partially recovered patients may choose to terminate treatment prematurely, feeling emotionally unprepared or unwilling to face and resolve the underlying emotional issues driving the disorder. Other patients, who have made significant progress in the recovery of healthy eating behaviors, may choose not to fully restore their weight to set point range. In both instances, they will leave treatment with their ED in tow. In order to sustain recovery gains, recovery must be within all spheres of pathology.

Life experience can be a potent teacher to those who have left treatment to practice and hone their new coping skills on their own. Recovered patients come to realize the extent of the residual ED's limitations on happiness within their present lives. Where the eating disorder treatment relationship has been of quality and the work meaningful, partially recovered ex-patients may return to psychotherapy for relatively short stints when needed, after months or even years have passed, seeking to resolve emotional tasks left unfinished. Resuming treatment a second time around holds great potential for the patient to develop a healthier relationship with self and others, fully closing the circle of a complete recovery. The return to "refresher" treatment has particular potency within the first two years following termination of initial treatment efforts.

#### *10.6.1. Case study 1*

> N, a highly effective businesswoman, after struggling with her anorexia for 20 years, was able to recover a healthy enough eating lifestyle to adequately nourish her brain and body through her first round of care, which included treatment programs and extensive outpatient treatment. She found safety, however, in her decision to cling to remnants of her disease, so she never stopped restricting certain foods, and continued to obsess over distortions in body image. Ultimately, she became embroiled in an emotionally abusive love relationship with a bully who kept her as enslaved emotionally as did the tyranny of her eating disorder. N returned to treatment to hone and build upon the skills she had previously acquired, to develop the courage and wherewithal to stand up to, and free herself from, the victimization of this love relationship. In recognizing how her relationship with this man paralleled the nature of her connection to her ED, she developed an increased sense of self-determination, and ultimately, empowerment to leave him. Breaking out of her habitual patterns of co-dependency and powerlessness

facilitated her self-esteem, upgrading her life quality and moving her closer to a full ED recovery.

*10.6.2. Case study 2*

An adult anorexic female who had developed seizures as a result of malnutrition, precipitously left ED treatment after developing a healthy eating lifestyle that restored much of her lost weight, and ultimately put an end to her seizures. It appeared that she was not ready to respond to my encouragement to complete her recovery by working through critical issues of low self-esteem and co-dependent passivity within her important life relationships. Having left treatment without fully recovering, she developed other self-destructive habits (mild addiction processes) to replace her ED behaviors. Three years went by before she sought treatment again to work through relationship problems with her defiant teenage son and with her husband, who wished for a deeper emotional connection and expressions of intimacy.

Having matured and mastered the changes she had begun to achieve in her initial round of care, she returned to care having become developmentally ready to augment and practice, through life experience, the emotional strides she had made in her earlier ED treatment. She came to understand that her precipitous departure from her initial treatment was based on her feelings of worthlessness and the sense that she did not deserve to improve the quality of her existence more than she had done. Her renewed treatment reinforced her self-esteem, self-determination, and self-integration. Her marriage became stronger as she became stronger, her son began to heal through her newly empowered parenting, and she achieved a state of self-forgiveness and self-acceptance that led to an unfamiliar, but genuine, sense of well-being. The self that had been lost to her for so long had made a palpable comeback, leaving her feeling happier and fully grounded. No longer feeling socially awkward, timid, and insecure with others, her renewed spontaneity, emotional courage, and empowered flexibility led her to the sense that she had become "a new person."

## 10.7. Take care of yourself as a practitioner

Where a patient's enduring symptoms of pathology stem from the characterological nature of personality structure, expectations for recovery and growth may show less promise in some cases. Characterological disturbances in ED patients are generally less amenable to change, despite the therapist's expertise and commitment to the patient and treatment process. Such diagnoses are hard to discern, especially in youngsters, and may remain unknown, hidden, or otherwise undefined during much of the treatment process. Though characterological personality dysfunctions carry significant consequences for treatment, prognosis, and interpersonal dynamics within the therapeutic attachment, their presence does not necessarily preclude ED recovery, nor the achievement of substantive maturational gains and emotional

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development throughout the process of treatment. In facing the challenges of treating these complex disorders and personalities, therapists need to learn to take as good care of themselves as they do of their patients, keeping expectation for themselves, as well as their patients, realistic. In such cases, professional consultation can be affirming and validating, enlightening one's work, refreshing one's awareness that each patient carries his or her own genetic and biologically determined predilections toward healthy or unhealthy functioning that must be taken into consideration, respected, and managed.

In treating the adolescent brain, unpredictable and acting out behaviors become the norm. Practitioners need to recognize and accommodate the not yet fully formed adolescent brain under the influence of emerging hormones, which will be less capable of positive responsiveness to treatment as seen in the patient's less than responsible judgment, choices, and behaviors. Treating ED adolescents begs the question of how to distinguish the chaotic and underdeveloped functioning of a normal adolescent brain, from the malnourished ED brain that awaits refeeding, or from the brain of a young patient with serious mental health conditions that might ultimately warrant a diagnosis of characterological personality dysfunction(s). The distinction, which typically will remain unclear during adolescence, essentially lies in the *extent* of disruptive and disingenuous functioning in the context of the patient's daily life. Conditions that may connote a more serious prognosis for adolescents include: an irrevocable quality of manipulating others; an extreme lack of empathy for loved ones; a refusal to appreciate the consequences of one's actions; and a cognitive structure that is based upon persistent lying. Asking all adolescent patients to stretch beyond the reach of their brain development best serves their treatment. Therapists need to approach the adolescent patient with clear expectations and requirements, firmly backed by empathy [17].

## 11. Conclusion

Current data suggests that eating disorder recovery lies in a complex interplay between weight status, normalization of stress hormones, and global hormonal well-being for optimal brain function and ongoing brain maturation [17]. Four core principles of effective eating disorder treatment include: (1) changing the neurobiological context, to include nutritional rehabilitation, weight normalization and stability, without the interruption of compensatory behaviors as symptom substitutions; (2) treating psychiatric comorbidities to remission; (3) addressing external environmental changes; and (4) connecting to maintenance factors for recovery [17].

Unique requirements of the emotionally evolved, flexible, and integrated eating disordered psychotherapist find their roots in one's commitment to a steadfast clarity of intention and purpose throughout an action-based, goal-driven treatment dynamic. Setting the facile eating disorder therapist apart from the generalist psychotherapist is his capacity to master, and then transcend, left-brain technical skills through right-brain empathic intuition in neurophysiological connection with the patient's right brain. The practitioner's self-acceptance precedes his capacity for full acceptance of the ED patient. It takes a special kind of professional to find gratification in a journey that is typically as arduous as it is extensive. It is the “phoenix” of

the patient's reemerging unified self that arises "out of the ashes" of a debilitating disease, however, that makes the treatment of eating disorders as gratifying, and at times, as joyful, as it is challenging.

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### Abbreviations

| | |
|---|---|
| AN | anorexia nervosa |
| ADHD | attention deficit/hyperactivity disorder |
| PTSD | posttraumatic stress disorder |
| BN | bulimia nervosa |
| EDNOS | eating disorder not otherwise specified |
| NES | night eating syndrome |
| CHSP | chew and spit |
| BDD | body dysmorphic disorder |
| ARFID | avoidant/restrictive food intake disorder |
| BED | binge eating disorder |
| ED | eating disordered |
| GPS | global positioning system |
| DBT | dialectical behavior therapy |
| CBT | cognitive behavioral therapy |
| MCBT | mindfulness-based cognitive behavioral therapy |
| FBT | family-based therapy |
| ACT | acceptance and commitment therapy |
| UP | unified protocol (transdiagnostic approach to ED treatment) |
| TMS | transcranial magnetic stimulation |
| SEED | severe and enduring eating disorder |
| OCD | obsessive compulsive disorder |
| DNA | deoxyribonucleic acid |
| EMDR | eye movement desensitization and reprocessing |
| NFT | neurofeedback training |

| | |
|---|---|
| PHP | partial-hospital program |
| IOP | intensive outpatient program |
| GCFP | Guild Certified Feldenkrais Practitioner |
| BMI | body mass index |

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