EATING DISORDERS AND OBESITY

BEHAVIORAL DEFINITIONS

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Persistent preoccupation with body image related to grossly inaccurate assessment of self as overweight.
4. Undue influence of body weight or shape on self-evaluation.
5. Strong denial of the seriousness of the current low body weight.
6. In postmenarcheal females, amenorrhea (i.e., the absence of at least three consecutive menstrual cycles).
7. Escalating fluid and electrolyte imbalance resulting from eating disorder.
8. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
9. Recurrent episodes of binge eating (a large amount of food is consumed in a relatively short period of time and there is a sense of lack of control over the eating behavior).
10. Eating much more rapidly than normal.
11. Eating until feeling uncomfortably full.
12. Eating large amounts of food when not feeling physically hungry.
13. Eating alone because of feeling embarrassed by how much one is eating.
14. Feeling disgusted with oneself, depressed, or very guilty after eating too much.
15. An excess of body weight, relative to height, that is attributed to an abnormally high proportion of body fat (Body Mass Index of 30 or more).

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LONG-TERM GOALS

1. Restore normal eating patterns, healthy weight maintenance, and a realistic appraisal of body size.
2. Stabilize medical condition with balanced fluid and electrolytes, resuming patterns of food intake that will sustain life and gain weight to a normal level.
3. Terminate the pattern of binge eating and purging behavior with a return to eating normal amounts of nutritious foods.
4. Terminate overeating and implement lifestyle changes that lead to weight loss and improved health.
5. Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse of the eating disorder.
6. Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of the eating disorder.
7. Develop coping strategies (e.g., feeling identification, problem-solving, assertiveness) to address emotional issues that could lead to relapse of the eating disorder.

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SHORT-TERM OBJECTIVES

1. Honestly describe the pattern of eating including types, amounts, and frequency of food consumed or hoarded. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the historical course of the disorder including the amount, type, and pattern of the client's food intake (e.g., too little food, too much food, binge eating, or hoarding food);

	perceived personal and interpersonal triggers and personal goals.
	3. Compare the client's calorie consumption with an average adult rate of 1,900 (for women) to 2,500 (for men) calories per day to determine over- or undereating.
	4. Measure the client's weight and assess for minimization and denial of the eating disorder behavior and related distorted thinking and self-perception of body image.
2. Describe any regular use of unhealthy weight control behaviors. (5)	5. Assess for the presence of recurrent inappropriate purging and nonpurging compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise; monitor on an ongoing basis.
3. Complete psychological tests designed to assess and track eating patterns and unhealthy weight-loss practices. (6)	6. Administer psychological instruments to the client designed to objectively assess eating disorders (e.g., the *Eating Inventory; Stirling Eating Disorder Scales*; or *Eating Disorders Inventory-3*); give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response.
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)	7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees

with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

5. Cooperate with a complete medical evaluation. (11)	11. Refer the client to a physician for a medical evaluation to assess negative consequences of failure to maintain adequate body weight and overuse of compensatory behaviors; stay in close consultation with the physician as to the client's medical condition.
6. Cooperate with a nutritional evaluation. (12)	12. Refer the client to a nutritionist experienced in eating disorders for an assessment of nutritional rehabilitation; coordinate recommendations into the care plan.
7. Cooperate with a dental exam. (13)	13. Refer the client to a dentist for a dental exam to assess the possible damage to teeth from purging behaviors and/or poor nutrition.
8. Cooperate with a psychotropic medication evaluation by a physician and, if indicated, take medications as prescribed. (14, 15)	14. Assess the client's need for psychotropic medications (e.g., SSRIs); arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated.
	15. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects.
9. Cooperate with admission to inpatient treatment, if indicated. (16)	16. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is a danger to self or others due to a severe psychiatric disorder (e.g., severely depressed and suicidal).
10. Verbalize an accurate understanding of how eating disorders develop. (17)	17. Teach the client a model of eating disorders development that includes concepts such as sociocultural pressures to be

thin, overvaluation of body shape and size in determining self-image, maladaptive eating habits (e.g., fasting, binging, overeating), maladaptive compensatory weight management behaviors (e.g., purging, exercise), and resultant feelings of low self-esteem (see *Overcoming Binge Eating* by Fairburn; *The Eating Disorders Sourcebook: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders* by Costin).

11. Verbalize an understanding of the rationale for and goals of treatment. (18, 19)

18. Discuss a rationale for treatment consistent with the model being used including how cognitive, behavioral, interpersonal, lifestyle, and/or nutritional factors can promote poor self-image, uncontrolled eating, and unhealthy compensatory actions, and how changing them they can build physical and mental health-promoting eating practices.

19. Assign the client to read psychoeducational chapters of books or treatment manuals on the development and treatment of eating disorders or obesity that are consistent with the treatment model (e.g., *Overcoming Binge Eating* by Fairburn; *Overcoming Your Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder-Workbook* by Apple and Agras; *The LEARN Program for Weight Management* by Brownell for weight loss).

12. Keep a journal of food consumption. (20)

13. Establish regular eating patterns by eating at regular intervals and consuming optimal daily calories. (21, 22, 23)

14. Attain and maintain balanced fluids and electrolytes, as well as resumption of reproductive functions. (24, 25)

15. Identify and develop a list of high-risk situations for unhealthy eating or weight loss practices. (26, 27)

20. Assign the client to self-monitor and record food intake (or assign "A Reality Journal: Food, Weight, Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material to reinforce and facilitate motivation to change.

21. Establish an appropriate daily caloric intake for the client and assist him/her in meal planning.

22. Establish healthy weight goals for the client per the Body Mass Index (BMI), the Metropolitan Height and Weight Tables, or some other recognized standard.

23. Monitor the client's weight (e.g., weekly) and give realistic feedback regarding body weight.

24. Monitor the client's fluid intake and electrolyte balance; give realistic feedback regarding progress toward the goal of balance.

25. Refer the client back to the physician at regular intervals if fluids and electrolytes need monitoring due to poor eating patterns.

26. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client's uncontrolled eating and/or compensatory weight management behaviors.

27. Direct and assist the client in construction of a hierarchy of

	high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors.
16. Learn and implement skills for managing urges to engage in unhealthy eating or weight loss practices. (28)	28. Teach the client tailored skills to manage high-risk situations including distraction, positive self-talk, problem-solving, conflict resolution (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise), or other social/ communication skills; use modeling, role-playing, and behavior rehearsal to work through several current situations.
17. Participate in exercises to build skills in managing urges to use maladaptive weight control practices. (29)	29. Assign homework exercises that allow the client to practice and strengthen skills learned in therapy; select initial high-risk situations that have a high likelihood of being a successful coping experience for the client; prepare and rehearse a plan for managing the risk situation; review/process the real life implementation by the client, reinforcing success while providing corrective feedback toward improvement.
18. Identify, challenge, and replace self-talk and beliefs that promote the anorexia or bulimia. (30, 31, 32)	30. Conduct Phase One of Cognitive Behavioral Therapy (see *Cognitive Behavior Therapy and Eating Disorders* by Fairburn) to help the client understand the adverse effects of binging and purging; assigning self-monitoring of weight and eating patterns and establishing a regular pattern of eating (use "A Reality Journal: Food, Weight,

Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material.

31. Conduct Phase Two of Cognitive Behavioral Therapy (CBT) to shift the focus to eliminating dieting, reducing weight and body image concerns, teaching problem-solving, and doing cognitive restructuring to identify, challenge, and replace negative cognitive messages that mediate feelings and actions leading to maladaptive eating and weight control practices (or assign "How Fears Control My Eating" from the *Adult Psychotherapy Homework Planner* by Jongsma).

32. Conduct Phase Three of CBT to assist the client in developing a maintenance and relapse prevention plan including self-monitoring of eating and binge triggers, continued use of problem-solving and cognitive restructuring, and setting short-term goals to stay on track.

19. To begin to resolve bulimic behavior, identify important people in the past and present, and describe the quality, good and poor, of those relationships. (33)

33. Conduct Interpersonal Therapy (see "Interpersonal Psychotherapy for Bulimia Nervosa" by Fairburn) beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships, highlighting themes that may be supporting the eating disorder (e.g., interpersonal disputes, role transition conflict, unresolved grief, and/or interpersonal deficits).

20. Verbalize a resolution of current interpersonal problems and a resulting termination of bulimia. (34, 35, 36, 37)

34. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss.

35. For disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.

36. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role and taking steps to gain mastery over the new role.

37. For interpersonal deficits, help the client develop new interpersonal skills and relationships.

21. Parents and adolescent with anorexia agree to participate in all three phases of family-based treatment of anorexia. (38, 39, 40)

38. Conduct Phase One (sessions 1–10) of Family-Based Treatment (see *Treatment Manual for Anorexia Nervosa: A Family-Based Approach* by Lock et al.) by confirming with the family their intent to participate and strictly adhere to the treatment plan, taking a history of the eating disorder, clarifying that the parents will be in charge of weight restoration of the client, establishing healthy weight

goals, and asking the family to participate in the family meal in session; establish with the parents and a physician a minimum daily caloric intake for the client and focus them on meal planning; consult with a physician and/or nutritionist if fluids and electrolytes need monitoring due to poor nutritional habits.

39. Conduct Phase Two of Family-Based Treatment (FBT) (sessions 11–16) by continuing to closely monitor weight gain and physician/nutritionist reports regarding health status; gradually return control over eating decisions back to the adolescent as the acute starvation is resolved and portions consumed are nearing what is normally expected and weight gain in demonstrated.

40. Conduct Phase Three of FBT (sessions 17–20) by reviewing and reinforcing progress and weight gain; focus on adolescent development issues; teach and rehearse problem-solving and relapse prevention skills.

22. State a basis for positive identity that is not based on weight and appearance but on character, traits, relationships, and intrinsic value. (41)

41. Assist the client in identifying a basis for self-worth apart from body image by reviewing his/her talents, successes, positive traits, importance to others, and intrinsic spiritual value.

23. Follow through on implementing the five aspects of the LEARN program to achieve weight loss. (42, 43)

42. Assign the client to read the LEARN manual (see *The LEARN Program for Weight Management* by Brownell) and then review the five aspects of the program (i.e., Lifestyle,

Exercise, Attitudes, Relationships, and Nutrition), that will be emphasized over the next 12 weeks.

43. In weekly sessions, systematically work through the five aspects of the LEARN program manual (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition), applying each component to the client's life to establish new behavioral patterns designed to achieve weight loss.

24. Verbalize an understanding of relapse prevention and the distinction between a lapse and a relapse. (44, 45)

44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid, and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, binging, then purging).

45. Identify with the client future situations or circumstances in which lapses could occur.

25. Implement relapse prevention strategies for managing possible future anxiety symptoms. (46, 47, 48)

46. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse.

47. Develop a "maintenance plan" with the client that describes how the client plans to identify challenges, use knowledge and skills learned in therapy to manage them, and maintain positive changes gained in therapy.

48. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and

adjust to life without the eating disorder.

26. Attend an eating disorder group. (49)

49. Refer the client to a support group for eating disorders.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	307.1	Anorexia Nervosa
	307.51	Bulimia Nervosa
	307.50	Eating Disorder NOS
	xxx.xx	Binge Eating Disorder
	316	Psychological Symptoms Affecting Axis III Disorder (e.g., obesity)
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
307.1	F50.02	Anorexia Nervosa, Binge-Eating/Purging Type
307.1	F50.01	Anorexia Nervosa, Restricting Type
307.51	F50.2	Bulimia Nervosa
278.00	E66.9	Overweight or Obesity
307.50	F50.9	Unspecified Feeding or Eating Disorder
307.59	F50.8	Other Specified Feeding or Eating Disorder
301.6	F60.7	Dependent Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.