HEAL: Recovering from Eating Disorders Together Group

Case Study & Evaluation

SOWK 662 Integrative Seminar

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Abstract

This case study will explore how eating disorders not only impact the person struggling with this disease, but their family as well, this is especially true during adolescents. Out-patient family-based treatment will be highlighted for this population. This case study will follow four female youth, between 14 and 17 years old, that have been diagnosed with Anorexia Nervosa. They, along with their parents, attended an outpatient eating disorder treatment via the HEAL: Recovering from Eating Disorders Together Group, with the goal to achieve a healthy weight and overcome the psychopathology their eating disorders are rooted in.

Introduction

Anorexia Nervosa is one of eight eating disorders specified within The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Eating disorders are serious psychological disorders that impact 4% of the population that typically emerge during adolescence (Couturier, et al., 2020). The DSM 5 outlines the severity of Anorexia Nervosa based upon one's Body Mass Index and defines the disorder as:

> "Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health. [A] significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected. [An] intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight. [And a] disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-

evaluation, or persistent lack of recognition of the seriousness of the current low body weight" (American Psychiatric Association, 2013, p. 338).

The American Psychiatric Association (2013) notes that Anorexia Nervosa has two subtypes that can be found with the DSM 5, they encompass:

- "Restricting Type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior. This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise" (p. 339)
- "Binge Eating / Purging Type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior" (p. 339).

Relevance to Social Work

Catching and treating eating disorders early is particularly important because rates of fatality due to this disease are high. Most notably in Anorexia Nervosa, where we see fatality rates increase by 5.6% each decade that someone is ill (Couturier, et al., 2020). As a result, it is important to provide early interventions to see positive outcomes for those seeking treatment for eating disorders.

However, youth impacted by eating disorders are an underserved population, due to improper screening and lack of specialized training (Lafrance et al., 2013). This is especially true in rural centers that do not have specialized eating disorder programs. Outpatient treatment often does not offer the frequency and intensity a youth in the throes of an eating disorder often requires. Also in this arena, a therapist's training and experiences in treating eating disorders vary greatly.

As a social worker, I adhere to a Code of Ethics that outlines a number of values and ethical practices. The aforementioned gaps in services present in eating disorder treatment call me to respond under the Pursuit of Social Justice and Integrity in Professional Practice social work values. Moreover, I practice from a Feminist and Anti Oppressive Lens, both of which examine how structural inequality impact one's mental health and overall wellness (Brown, 2019).

Eating Disorder research and evidence-based practices are largely based upon caucasian girls and women. This is not an uncommon occurrence as Kimberly Crenshaw (2019) cites that the foundation in which most disciplines, research, and ways in which information is disseminated is rooted in racial hierarchy and colonialism. This is an issue, as the practices developed thus far may not meet people's needs based upon gender, age, ethnicity, and more. We have so much more work to do around eating disorder research and treatment in general; more so, around developing an understanding of cultural and gender needs, establishing practices, and developing competencies to support those facing intersectionality in addition to their eating disorder.

Case Description

Four young ladies, all of whom have received a diagnosis of Anorexia Nervosa, agreed to participate in a family-based eating disorder group. Three of the girls were diagnosed with Anorexia Nervosa - Restrictive Type and one of the youth was diagnosed with Anorexia Nervosa - Binging / Purging Type. This young lady identified inducing vomiting and engaging in excessive exercise as a means of purging.

The group participants were all in the contemplation to the action stage of the Transtheoretical Model. This was assessed from empirical data collected through the Readiness

and Motivation Questionnaire, which is a self-report measure that assesses stages of change, internality, and confidence regarding eating disorder symptoms encompassing: dietary restriction, binging, along with, cognitive and compensatory behaviors (Iyar, 2019). Youth who presented as pre-contemplative were directed to individual services where they would be exposed to Motivational Interviewing to prepare for future group opportunities.

The girls participating in the group range in age from 14 to 17 years old. Two girls have intact families, one girl lives with her mom and does not have a relationship with her dad and one girl has divorced parents who both agreed to partake in treatment to collaboratively support their daughter's recovery.

Comorbidity

Three of the four girls had comorbid diagnoses, primarily encompassing anxiety disorders. One of which also had an ADHD diagnosis. There were no reported concerns around substance use by the youth or their families. However, all four of the girls disclosed nonsuicidal self-harm, two of which were still engaging in self-harm behavior. One of the participants disclosed having previously acted on urges to end her life. She required medical attention following such, however, she did not sustain lasting consequences from this occurrence. This young lady also has a history of trauma, having been sexually assaulted 2 years ago by a peer. She has previously attended trauma-informed therapy, which was reported to have been helpful.

Risk Assessment

Risk around eating disorder behavior, self-harm, suicide, and substance use was assessed every week with each group participant. Group participants were provided with crisis support information and boundaries were outlined around accessing the Recovery Record App, as it was not to be used during times of crisis. A special focus of treatment was placed on suicidal

ideation, as the vast majority of fatalities associated with eating disorders do not die from starvation or medical complications, but from suicide (Shelby, 2010).

This may be explained by the Interpersonal-Psychological Theory of Suicidal Behavior Shelby et al. (2010) explained that "three proximal, jointly necessary, and jointly sufficient causes" need to be present before someone takes their life, which are, "feelings of perceived burdensomeness, a sense of thwarted belongingness, and acquired capability to enact lethal self-injury" (p. 635). People struggling with Anorexia Nervosa often perceive themselves as a burden to their loved ones, as well, as feel misunderstood. Lastly, people who struggle with Anorexia Nervosa have the capacity to cause and endure pain to themselves, making this population particularly vulnerable to suicide.

Method

The family-based eating disorder group meets for 90 minutes weekly for the duration of 10 weeks. The group primarily takes place virtually due to Covid 19 restrictions, however, there was an opportunity to meet for orientation in person. This was reported as a positive process by the girls and their parents. In addition to the weekly group session, there were two weekly check-ins between the group therapist and each of the families via the Recovery Record App.

Follow-up sessions were scheduled to occur 3 weeks, 6 weeks, and 9 weeks post group. These were formatted to include an individual check-in as well as a group check-in. These primarily occurred virtually, however, a couple of families attended the office for their individual check-ins.

Treatment Contingencies

In order for the girls to participate in the group, each participant needed to be deemed medically stable by their medical team. A multidisciplinary team was developed for each

participant, which included the group therapist, a general physician or pediatrician, a psychiatrist, a clinical dietician, and the referring therapist (if applicable).

Parents were also screened for current or a history of eating disorders before entering the group. We know that a child is eleven times more likely to develop Anorexia Nervosa when one of their parents is struggling or has a history of struggling with Anorexia Nervosa themselves (Brewerton & Baker, 2014). Psychoeducation and empathy were offered during parent screenings to lessen the impact of parental blame and or shame that occurs when genetic and environmental factors play a role in a child's mental health.

Two mothers identified having long standing body image issues, citing that they have tried every diet in the books. One mother had previously been treated for an eating disorder in her youth and early adulthood, however, cited being in recovery for more than a decade. One mother disclosed feeling preoccupied with her weight and cited that when she misses a workout this causes her distress. She was open to the idea of attending the group under the agreement that she would attend individual therapy for herself to address these concerns. One of the three dads cited feeling self-conscious about his weight in his younger years, however, denied engaging in diet/gym culture.

HEAL: Recovering from Eating Disorders Together Group

The HEAL Group was designed to provide support to both the youth and the parent simultaneously. HEAL consciously pulls from a number of modalities that support the treatment of eating disorders. Due to the serious implications of Anorexia Nervosa, careful consideration was placed on what modalities would be used to form the Family-Based Eating Disorder Treatment Group.

Family-Based Dialectical Behavioral Therapy

Research has demonstrated that Dialectical Behavioral Therapy (DBT) is effective in treating eating disorders. From a DBT stance, people struggling with eating disorders easily become dysregulated and have a small window of tolerance that stems from environmental and intrapersonal factors (Wisniewski, et al., 2018). Dichotomous thoughts are superseded by acceptance and validation through the use of mindfulness and behavioral techniques (Wisniewski, et al., 2018). This allows room for two opposing thoughts, feelings, or experiences to be acknowledged as co-occurring, such as, “I want to get better” and “I’m terrified of getting fat” or “I want to trust you” and “I'm terrified of losing you”.

When working with youth, Family-Based DBT has proven to be most effective, as parents and youth learn how to practice mindfulness, understand the purpose of emotions and develop healthy coping and interpersonal skills together. This allows for environmental changes to occur that support healing and recovery. This comes down to parents being able to provide a validation of their child's experience, creating room for the youth to see things from the parent's perspective, this is known as walking the middle path.

Attachment-Based Narrative Therapy

Narrative Therapy helps people see the world from different perspectives, as it proposes that people come to know themselves through stories we have been told and told ourselves based upon experiences we have had (Dallos, 2004). This is especially powerful when a person has come to define themselves by their disorder, which often happens when someone has Anorexia Nervosa, due to the pervasive and insidious nature of the disease. When practicing from a narrative lens, the person is not the problem, the problem is the problem (Dallos, 2004). Instead of submitting to the story of being sick or being the girl with an eating disorder, in the group,

youth will have the opportunity to externalize Anorexia through a number of experiential activities to support a new story where Anorexia Nervosa is an unwelcome visitor.

Attachment-Based Narrative Therapy looks at how relationships between the child/youth and their primary caregiver(s) shape their stories, and, the relationship primary caregiver(s) have with their children shape their stories (Dallos, 2004). It is through exploring how our social and relational understanding is intrinsically tied to the way we view the world that we can acknowledge our stories and begin the process of unpacking them (Dallos, 2004). In order for youth to be able to do this, their environment needs to be adaptable, in turn, parents need to be part of the process; after all, it's their stories that have come to inadvertently shape their children's stories.

Emotion-Focused Family Therapy

In addition to skills learned in DBT, a special focus needed to be placed on learning how to provide a loved one with deep validation and become their emotion and behavior coach. EFFT Therapists provide caregivers with gentle guidance, empowering them to attune to their child's emotional and practical needs; in turn, this increases their loved one's emotional self-efficacy and strengthens the familial bond (Robinson, et al., 2015). Over time, as parents use new skills to support their loved ones, they develop a sense of mastery in understanding and coping with duress, rendering eating disorder symptoms unnecessary.

Analysis

As it may already be evident, I practice from an eclectic lens, however, my practice is deeply rooted in Attachment Theory. I could go into the theoretical underpinnings that Bolwy and Ainsworth developed, but I think that Brene Brown sums attachment and its inherent need nicely when she says “Connection is why we're here. We are hardwired to connect with others,

it's what gives purpose and meaning to our lives, and without it, there is suffering" (audiobook) This connects directly to working not only with the youth or even with their caregiver, but with the systems in which the youth interacts with. Working from a family based and interdisciplinary scope of practice is informed by the Ecological Systems Theory which poses that people's environments or systems contribute to the development of self (Guy-Evans, 2020). The Microsystem is where Attachment Theory and the Ecological Systems Theory intersect; and, it is the microsystem that the psychosocial interventions that the group targets (Guy-Evans, 2020).

Intervention

Overall, for the four youth and their caregivers, the family based group intervention provided a vehicle and an opportunity to heal from Anorexia Nervosa. Taking a multidisciplinary approach allowed for the group therapist to focus on the psychosocial intervention, while knowing that treatment aspects outside of the therapeutic scope were being managed by capable professionals.

An unintentional, yet positive factor that came to light throughout offering a family based group was the healing that occurred within parents attending the group with their loved ones. In a way, the group became a dual treatment. The moms and dads both actively engaged in demonstrating vulnerability around their relationship with food, diet and gym culture, and their bodies. There was a sense of connection and catharsis throughout the group.

Areas to Grow

Due to the timing, with the group running during a pandemic, we need to meet virtually for most of our interactions with one another to adhere to Covid 19 protocols. This interfered with group development and in particular, delayed the norming stage of the group process where people begin to feel more comfortable and are able to engage from a place of vulnerability with

one another. If utilizing a virtual platform is still a requirement the next time group is offered, extending group sessions, along with integrating more interactive components, such as Kahoot Games, early on could potentially mitigate this.

It was noted that the group participants were all females, even though the group was not advertised to a specific gender. Going forward, an emphasis will be placed on acknowledging and challenging socially constructed gender stereotypes that are common amongst eating disorders. Those who identify as male, nonbinary, or trans, who are impacted by eating disorders, are grossly underserved. As such, I want to ensure that going forward an emphasis is placed on the group being advertised and facilitated with a gender-neutral lens.

Conclusion

Involving parents was a calculated risk, as there was a screening process for parents, as well as youth. When involving parents, there is the risk that they would not follow through and in turn, send their child deeper into the disorder. However, all group participants completed group together. Some group sessions were missed; however, family members were able to connect with the group therapist between sessions to catch up. Ultimately, I would run a family based group again, however, moving forward, I would stagger in parent-only group sessions to better support EFFT dissemination and integration. In addition to this, I look forward to expanding my practice to include a caregiver support group and siblings' group. As mentioned before, I recognize that my training and consequently the services that I offer are based upon research rooted in racial hierarchy, as well as, traditional gender norms. I am committed to seeking out and implementing services that support those impacted by eating disorders and intersectionality.

Evaluation

Mixed methods were used to evaluate the efficacy and outcomes of the Heal: Recovering From Eating Disorders Together Group. Quantitative information was gathered in the form of The Readiness and Motivation Questionnaire which was implemented during the screening and assessment phase of treatment. Further quantitative data was collected through The Eating Attitudes Test (EAT-26) at the beginning, mid, and end sections of the group. The EAT-26 is a highly respected self-report questionnaire that is standardized to measure symptoms characteristic of eating disorders (Garner, 2021). Along this same timeline, participants completed a DBT Checklist, serving as a self-report of areas of struggle divided into the four dimensions of DBT.

Qualitative data was collected through Narrative Therapy experiential exercises that were conducted at the beginning and at the end of the group. These encompass a guided visualization exercise entitled The River Story and letter writing “A Letter to my Body” and “My Body’s Letter to Self”. During post-group sessions, clients were interviewed to collect further qualitative data and to assess lasting effects that group had on youth struggling with Anorexia Nervosa.

Lastly, both qualitative and quantitative were gathered during risk assessments on an ongoing basis. As well as, during collaboration and consultation with the youth’s multidisciplinary team. For instance, physicians reported BMI information at the onset, midpoint, and at the end of the group and clinical dieticians made note of changes to dietary treatment plans based on one’s progression/regression.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Brewerton, & Baker Dennis, A. (2014). *Eating Disorders, Addictions and Substance Use Disorders*. Springer Berlin / Heidelberg.

Brown. (2019). *Anti-Oppressive Counseling and Psychotherapy* (1st ed.). Routledge. https://doi.org/10.4324/9781315110097

Brown, B. (2013). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent and lead.* [audiobook] London, England: Portfolio Penguin.

Couturier, Isserlin, L., Norris, M., Spettigue, W., Brouwers, M., Kimber, M., McVey, G., Webb, C., Findlay, S., Bhatnagar, N., Snelgrove, N., Ritsma, A., Preskow, W., Miller, C., Coelho, J., Boachie, A., Steinegger, C., Loewen, R., Loewen, T., … Pilon, D. (2020). Canadian practice guidelines for the treatment of children and adolescents with eating disorders. *Journal of Eating Disorders*, 8(1), 4–4. https://doi.org/10.1186/s40337-020-0277-8

Couturier, Pellegrini, D., Miller, C., Bhatnagar, N., Boachie, A., Bourret, K., Brouwers, M., Coelho, J. S., Dimitropoulos, G., Findlay, S., Ford, C., Geller, J., Grewal, S., Gusella, J., Isserlin, L., Jericho, M., Johnson, N., Katzman, D. K., Kimber, M., … Webb, C. (2021). The COVID-19 pandemic and eating disorders in children, adolescents, and emerging adults: virtual care recommendations from the Canadian consensus panel during COVID-19 and beyond. *Journal of Eating Disorders*, 9(1), 46–46. https://doi.org/10.1186/s40337-021-00394-9

Crenshaw. (2019). *Seeing Race Again* (1st ed.). University of California Press.

Dallos. (2004). Attachment narrative therapy: integrating ideas from narrative and attachment theory in systemic family therapy with eating disorders. *Journal of Family Therapy*, 26(1), 40–65. https://doi.org/10.1111/j.1467-6427.2004.00266.x

Garner, D. (2021). *The eating attitudes test (EAT-26)*. https://www.eat-26.com/

Guy-Evans, O. (2020 Nov, 09). Bronfenbrenner's Ecological Systems Theory. [online]. Available at: https://www.simplypsychology.org/Bronfenbrenner.html

Iyar, Cox, D. W., Kealy, D., Srikameswaran, S., & Geller, J. (2019). Is stage of change enough? Confidence as a predictor of outcome in inpatient treatment for eating disorders. *The International Journal of Eating Disorders,* 52(3), 283–291. https://doi.org/10.1002/eat.23026

Lafrance Robinson, Boachie, A., & Lafrance, G. A. (2013). “I want help!”: Psychologists’ and physicians’ competence, barriers, and needs in the management of eating disorders in children and adolescents in Canada. *Canadian Psychology*, 54(3), 160–165. https://doi.org/10.1037/a0032046

Selby, Smith, A. R., Bulik, C. M., Olmsted, M. P., Thornton, L., McFarlane, T. L., Berrettini, W. H., Brandt, H. A., Crawford, S., Fichter, M. M., Halmi, K. A., Jacoby, G. E., Johnson, C. L., Jones, I., Kaplan, A. S., Mitchell, J. E., Nutzinger, D. O., Strober, M., Treasure, J., Joiner, T. E. (2010). Habitual starvation and provocative behaviors: Two potential routes to extreme suicidal behavior in anorexia nervosa. *Behaviour Research and Therapy*, 48(7), 634–645. https://doi.org/10.1016/j.brat.2010.03.016

Wisniewski, Hernandez Hernandez, M. E., & Waller, G. (2018). Therapists' self-reported drift

from dialectical behavior therapy techniques for eating disorders. *Eating Behaviors : an International Journal*, 28, 20–24. https://doi.org/10.1016/j.eatbeh.2017.12.001