



## EDC-Denver Treatment:

# The Bio-Psycho-Social-Spiritual Treatment Model

| By Susan Coppage Peterson, MA, Executive Director of Eating Disorder Center of Denver

In the previous issue of HealthReach, we addressed the empowerment model that serves as the framework within in which treatment occurs at EDC-D. In this issue we further detail



the components of our bio-psycho-social-spiritual model. In psychiatric care, the bio-psycho-social-spiritual model has become an

assumed aspect of treatment yet its importance requires careful attention and constant review. Eating disorders are complex issues which require a multidimensional approach for individuals to understand their illness and gain access to the tools that support recovery. In general, treatment consists of addressing the four main structures that support both the illness and the return to health. The following is a brief description of these structures which are then expanded in the articles written by our clinical management team.

**Biological:** Although the diagnosis of eating disorders are barely three decades old, recent research has documented the biological foundation of eating disorders. Genetic studies show that Anorexia Nervosa is as inheritable as Schizophrenia and Bipolar disorder and that if a woman has a sister or mother who had Anorexia Nervosa, she is 12 times more likely to develop the illness and 4 times more likely to have Bulimia Nervosa.

In addition to the genetic factors, eating disorders present with potentially life threatening physical conditions. These include

electrolyte imbalances, anemia, altered defenses against infection, abnormal heart rates, and higher incidents of sudden death. Anorexia is the most lethal psychiatric illness with one out of 200 patients dying every year.

Numerous co-morbid psychiatric conditions exist with eating disorders, including anxiety disorders, obsessive-compulsive traits, mood disorders and substance abuse. All of these biological conditions require medical interventions from monitoring labs to prescribing psychotropic medications as well as providing appropriate nutrition and close supervision by medical specialists.

**Psychological:** In addition to the psychiatric illnesses that co-exist with eating disorders, there are often sophisticated psychological defense mechanisms that become ingrained in eating disordered individuals. Eating disorders can develop as a way to guard against a sense of powerlessness – either real or perceived. Individuals experience a feeling of relief as they binge, purge, restrict or practice food rituals. This initial experience of relief is gradually replaced by increased anxiety and despair as natural consequences begin to occur due to the eating disorder:

medical complications, social isolation, relationship problems, cognitive impairment, self hatred, shame and guilt.

Treatment requires one to look at how the eating disorder has served to protect the individual and what fears exist in relinquishing the illness. Treatment offers the opportunity to experience feelings that have been circumvented by the eating disorder and feelings related to letting go of eating disordered behavior and practicing new direct ways of experiencing life.

**Social:** Cultural pressures to have thin, perfect bodies is a multi-billion dollar business that is expressed through media, clothing and product sales, athletic endeavors and at times – in family systems. These pressures support the development of eating disorders in women who are predisposed to the illness. Cultural pressures also create great challenges to those in recovery.

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# Biological

| By Ken Weiner, MD, Medical Director

The biological component of eating disorders is now well established. Anorexia Nervosa is as inheritable as Schizophrenia and Bipolar Disorder in fact, if a



young woman has a mother or sister with Anorexia Nervosa she is 12 times more likely to develop Anorexia Nervosa and 4 times more

likely to develop Bulimia Nervosa. Family histories demonstrate a higher incidence of major depression and alcoholism in first degree relatives of individuals with eating disorders. Until the human genome is better elucidated the best way to identify those individuals with the genetic predisposition is their temperament. Those prone to Anorexia Nervosa tend to be anxious, perfectionist, risk avoidant with low novelty seeking and low self esteem. Individuals who are at higher risk for Bulimia Nervosa are also anxious and perfectionist with low self esteem, but have high novelty seeking leading to multi-impulsive behaviors.

Medication management of eating disorders is another area which speaks to a biological basis. Recent open label studies have demonstrated a positive

effect on weight gain and body image distortion of atypical antipsychotic medications (Olanzapine ie: Zyprexa) most probably mediated through an effect on dopamine receptors. Selective Serotonin Reuptake Inhibitors (SSRIs) most notably Fluoxetine (Prozac) has been shown to reduce the incidence of relapse in weight restored anorexics (ie: greater than 85% of ideal body weight). Finally SSRIs have also been shown to reduce binge purge episodes in Bulimia Nervosa even in patients without significant depression.

In addition to the role of genetics and information provided by medication studies eating disorders present with life threatening physical conditions. The purging in Bulimia Nervosa can cause electrolyte abnormalities leading to cardiac arrhythmias as well as cancer of the esophagus and/or esophageal rupture. Anorexia Nervosa is the most lethal psychiatric illness with a mortality rate of one in 200 individuals every year. In fact, those with Anorexia Nervosa for 20 years have a greater than 20% chance of dying from the disease. The most common causes of death are the medical effect of starvation, sudden

death, or suicide. In his classic study of starvation in conscientious objectors during World War II. Ansel Keys clearly demonstrated the psychological changes and ritualistic behaviors which accompany severe starvation. More recently functional neuro-imaging (Spect and Pet Scans) have shown dramatic evidence of brain changes in individuals with Anorexia Nervosa.

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Clearly eating disorders have complex biological components with many medical and psychiatric manifestations. To provide the highest quality of care at the Eating Disorder Center of Denver I have recruited a nationally recognized, board certified psychiatrist, Dr. E. Rick Bishop, who has over 20 years of experience treating eating disorders. The two of us oversee the multidisciplinary treatment teams to ensure that each patient's treatment is individualized and focused and that co-morbid psychiatric conditions are appropriately diagnosed and treated. In addition, EDC-D has two board certified internists who carefully monitor the physical and medical conditions of all patients. This extensive medical presence is what allows the center to effectively treat very sick individuals in a partial hospitalization setting, allowing for maximum improvement without institutionalization. The PHP model, while incredibly intense and effective, is also cost effective and managed care friendly.

## The Bio-Psycho-Social-Spiritual Treatment Model

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Treatment serves to expose external messages that may feed eating disordered thoughts and behaviors and re-direct individuals to personal-internal values, beliefs and thoughts that support healthy body image and self-esteem.

**Spiritual:** Eating disorders are often accompanied by strong feelings of disconnection. Individuals feel disconnected from themselves (body, mind and spirit) as well as from others. Feelings of shame and embarrassment may further separate them from spiritual connections they once felt. Individuals struggling with the illness often ask "why me" and look for meaning in their illness and return to health.

Treatment offers the ability to re-connect, to develop a personal sense of wholeness and to explore belief systems that may maintain the illness or support health.

# Psychological

| By E. Rick Bishop, MD Outpatient Psychiatrist

The psychological aspect of the bio-psycho-social-spiritual model lies at the crossroads of the other dimensions. Our biological, social, and spiritual natures interact to create our unique psychological being. One can think of the mind or psyche as the integrator of these dimensions.

Our psyche must take the biological, social and spiritual aspects of being and make them work together for well-being. This is the ultimate expression of empowerment.



Eating disorders can be thought of as attempts to balance one's "emotional

economy" through psychological defense mechanisms and tactics which seriously disturb the "body economy." These patterned and inflexible responses to anxiety, a rising from both internal and external sources, can provide the eating disorder sufferer only temporary respite while potentially causing long term detrimental effects on the body such as infertility, osteoporosis, and premature aging. The goal of treatment, therefore, is to achieve a unity of mind body function so that the "global economy" is balanced.

The psychological disturbances seen in eating disordered individuals are indicative of attempts to manage an emotional life felt to be out of control and disempowered. Sensing emotional vulnerability and isolation, the eating disorder sufferer is in survival mode. This form of damage control is often characterized by disconnection from body and feelings, imposition of external rules and standards, and limiting relationships to shallow, superficial interactions. The eating disorder can be conceived as a self-contained effort to cope

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with a threatening world. Unfortunately, the eating disorder behaviors only intensify pre-morbid personality traits and anxiety they seek to ameliorate.

From the psychological perspective, recovery from an eating disorder of any type involves increasing self-awareness, flexibility of responses, and mind-body coherence. Self-awareness starts with developing mindfulness skills to observe the way things actually are, not as they appear to be. One becomes aware of one's programming or preconditioning in a supportive, reflective environment. There is the recollection of one's inherent competence and the natural order of things.

Overcoming the inflexibility of the eating disorder, that is the rituals, patterns, and rule governance, opens one to new possibilities and creative problem solving. Treatment provides the support necessary for the eating disorder sufferer to try out new experiences, especially with food and relationships, empowering the person to trust their intuitive processes over rigid rules and behaviors.

Finally, treatment seeks to restore mind body coherence with which we are all born. We all seek to act spontaneously without having to suppress conflict. This is not possible with an eating disorder where the very act of eating is conflict laden, where one's body does not match one's expectations, and where one's internal experience does not inform one's actions in a way to promote well-being. Such incoherence is the essence of the mind body conflict underlying the suffering of the eating disordered individual.

Resolving this conflict means finding mind body unity. Finding mind body unity means discovering one's true nature and the "global balance."



# Social

| By Tamara Pryor, PhD, Clinical Director

There is a body of evidence that suggests that eating disorders pervasive among young women today may, in part, be the by-product of a society that overvalues physical attractiveness and devalues that which is feminine.

The portion of our cultural context which we at EDC-D believe contributes to the development of an eating disorders consists of two underlying messages. First, women are primarily judged by their physical attractiveness and only secondarily by their personality features or accomplishments. Second, only a narrow portion of the age/body, weight continuum is deemed attractive and acceptable – namely, young and thin. The images of female attractiveness presented in the mass media reinforce these cultural notions regarding women, body weight/shape, and beauty.

An assumption in our culture is that a woman's primary role, and sense of worth, is based upon being an object of beauty and sexual desire. This view of women permeates our culture to such an extent that we may not even be aware of how our beliefs and actions correspond to it. Research has shown that one of the most frequent, and effective, methods used by women to derogate a potential competitor for a man's attention is to criticize that woman's personal appearance. The beauty trap is also evident at the occupational level. There are only two professions in which women consistently earn greater incomes than men for the same type of work – fashion modeling and prostitution. In both cases women are valued entirely for their bodies; a "good personality," intelligence, or an educational degree are not prerequisites.

Everywhere the message is the same: women are judged primarily according to their physical attractiveness, with the ideal held up on the television screen and magazine page for all to admire. On a daily basis we are bombarded with media images telling us what is beautiful, desirable and sexy. There is usually the implication that if we make a particular purchase,

or use a certain product, we will transform into the images presented in those advertisements. Inherent in these images is the message that physical perfection is possible, and that if we do not attain it, we have no one to blame but ourselves.

Today as our society struggles with alarming rates of childhood and adult obesity, the image of the ideal female centers around thinness. Thin becomes representative of success, beauty, and happiness; fat is failure, ugliness, and shame. When you think about it, the eating disorder symptoms make sense. What a creative solution to a dilemma of how to be valued as a female. If women feel it is important to make and maintain relationships. Then society is telling them how to do this. ... by being thin and "looking pretty."

The question remains: What can we do about it? We as individuals have little power to affect an entire culture and the powerful industries built on the beauty myth. However, at EDC-D, the empowerment model starts with the understanding that the patient has the



**Our cultural context:**  
 women are judged by their physical attractiveness and only secondarily by their personality, features or accomplishments. Only a narrow portion of the age/body, weight continuum is deemed attractive and acceptable - namely, young and thin.

ability to effect their own change. In groups such as: Body Image, Body Image and Cultural Issues, Feminine Identity, Self-Esteem, and Sensing the Self, the patient are empowered to do the following:

- Develop a critical awareness of media images and the messages they imply
- Make a conscious effort to be less critical of their own and other's appearance
- Become more conscious of the language used to describe the body
- Work to define themselves in multiple ways and to clarify their own values thereby differentiating from the external pressures of societal messages

# Spiritual

| By Susan Coppage Peterson, MA, Executive Director

When faced with a life threatening illness, and the prospect of a long road of recovery, it is natural for individuals to ask, "why me?"

Finding meaning in one's life is part of the human journey and the core concept behind spirituality. Individuals with eating disorders and other psychiatric illnesses face a great deal of shame and guilt from the dilemma of feeling out of control of their lives. When their illness negatively impacts the lives of those they love – guilt is magnified.

Through exploration of one's values and beliefs about themselves and their illness, patients can re-evaluate shame-based thoughts and learn to treat themselves more compassionately. In addition, experiencing compassion from the treatment team and peers offers patients the ability to practice being their authentic selves and releases them from constant self-judgment and/or self-absorption.

When the shadow of illness has become so great that a person can't see beyond their own experience they are often left feeling disconnected and isolated. Addressing spirituality in recovery supports one's ability to see beyond the shadow to the opportunities for connectedness – in community, in nature and in relationship with a greater power that dwells not only outside of them but within them as well.

When patients have strong religious ties, their recovery requires an understanding of their illness within their established belief system. Even more so, if their religious traditions can offer them specific ways to practice recovery; health can be reinforced. For example, one Catholic patient with anorexia explored the multitude of biblical messages about one's body being a temple and created ways to enter into meals as a spiritually nourishing ritual rather than a ritual that fed only her illness. A Jewish patient addressed

how unprepared she was for the ritual of Bat Mitzvah – she was not ready to enter into womanhood at twelve years old. So as part of her entry into recovery she created a Bat Mitzvah for a twenty-four year old – she integrated her beliefs with a sense of empowerment and readiness to embody health as a young woman.

Accepting one's experiences in life – both the joys and the sorrows, requires a willingness to explore that which goes beyond our understanding. Having the opportunity to share our stories in community and bear witness to the stories of others is a step in the process of naming the unnameable and sitting with mystery. By the very act of risking being seen, one can begin the journey of understanding that can lead to a compassionate, connected life.

Addressing spirituality in recovery supports one's ability to see beyond the shadow to the opportunities for connectedness - in community, in nature and in relationship with a greater power that dwells not only outside of them but within them as well.

## EDC-Denver 4th Anniversary Celebration – Friday, November 4th

**1:00-3:00 Professional Workshop:** *Emotion Regulation & Eating Disorders: Effective Treatment Interventions*  
E. Rick Bishop, MD & Sue Woodmansee, MS, OTR, TEP, CAC

**3:00-6:00 Open House:** Come and tour our new expanded center in Suite #1010. Meet the EDC-D Staff as well as former patients. Refreshments will be provided.

**3:30-4:30 Lecture:** *Healthy Body Image*, Carolyn Jones, RN, MS, LPC

**5:00-6:00 Lecture:** *Families and the Healing Process*, Enola Gorham, MSW, LSW & Ken Weiner, MD

**7:00-9:00 PM Playback Theatre West Performance:**  
Lindsay Auditorium in Sturm Hall on the University of Denver Campus 2000 East Asbury Ave, Room #281, Denver, CO 80208

**For your complimentary tickets, call 303-771-0861 or "Contact Us" at [www.empoweringchange.com](http://www.empoweringchange.com)**

# Programs at EDC-Denver

## Partial Hospitalization Program (PHP):

Available to individual patients who are 16 years and older. Patients attend seven days a week, 11 hour days with shortened weekend schedules. This highly structured program includes: Medical and Psychiatric evaluation and follow-up, Individual therapy, Family/Couples Therapy, Group Therapy, Psycho-educational groups and Nutrition therapy including three meals and two snacks per day. **Housing is available.**

## Evening Intensive Outpatient Program (EIOP):

An integrated program meeting three times per week comprising of: thirteen hours per week of therapy including psycho-educational groups, group therapy, multi-family group, DBT and three meals. Also included are a weekly individual session, nutritional monitoring/consultation and psychiatric oversight. These groups are presented on a 12 week rotation and are open for patients to join at any time. Sessions are held for this program Monday, Wednesday, & Friday: 5-9 PM.

**Outpatient Services** provide an effective alternative for individuals whose symptoms do not require a more intensive setting. Patients can also participate in one or more of our Outpatient Services to enhance work with outside treatment providers.

Our services include: Individual and family/couples therapy; group therapy including DBT and aftercare; Psychiatric evaluation, therapy and medication monitoring; gastric bypass evaluations, and nutritional counseling.

## Support Groups:

**Aftercare Group:** An open recovery group consisting of individuals in recovery who have completed an intense eating disorders program at EDC-D or other national programs. Tuesdays 5:30-7:00 PM.

**DBT Skills Training:** Didactic and experiential education in four different skill areas: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Monday 5-6:30 PM.

**Body Image 101:** A 12-week ongoing group utilizing cognitive behavioral and experiential techniques to mend the relationship between a woman and her body. Tuesdays 5:30-7:30 & Thursdays 5:30-7:00

**Family & Friends Support Group:** A free, open support group to family and friends of individuals struggling with an eating disorder. 1st & 3rd Thursdays of each month, 6 PM. The Eating Disorder Foundation, 3003 East Third Ave., Suite 110, Denver, CO 80206. Please RSVP to Enola Gorham at (720) 889-4231

**Please Contact Us For A Free Assessment**  
 to our intensive programs or to schedule an outpatient appointment:  
 303-771-0861 Or toll free: 1-866-771-0861

**EDC-Denver 4th Anniversary Celebration**  
 November 4th.  
 See details and information on page 5 or at [www.empowerchange.com](http://www.empowerchange.com).

**Boulder Networking Luncheons**  
 October 27th, 2005 at the Boulder Cork  
 11:30 am - 1:30 pm  
 Adult Onset Eating Disorders:  
 Assessment & Treatment  
 Presented by Dr. Tamara Pyror  
 Please call 303-771-0861 to RSVP

**Denver Networking Luncheons**  
 Will be held in January, March, May, July, September, and November in 2006.  
 Please call 303-771-0861  
 for dates and details.

**Colorado Springs Networking Luncheons**  
 November 11th & December 9th  
 Please call 303-771-0861 to RSVP

## Upcoming Events:



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