NAVIGATING COMPLEXITY: ETHICAL CONSIDERATIONS IN THE TREATMENT OF EATING DISORDERS

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What's so special about treating Eating Disorders?

- Capacity/Autonomy
- Boundary Issues
- Resource Allocation

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Competency

- Being competent involves knowledge, technical skills, and emotional competence. (Assessing and Managing Risk in Psychological Practice: An Individualized Approach. The Trust, 2016)
  - **Clinical Expertise**
    - Training
    - Experience
    - Personal History
  - **Use of Evidence Based Practice**
  - **Self and Cultural Awareness**
  - **Clinician Wellness**

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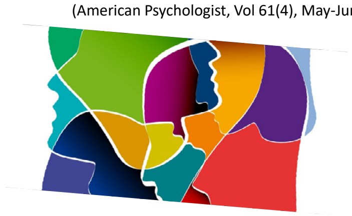
Expertise

- Expertise -Expertise develops from clinical and scientific training, theoretical understanding, experience, self-reflection, knowledge of current research, and continuing education and training.
- Evidence Based Practice - The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

(American Psychologist, Vol 61(4), May-Jun 2006, 271-285)



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Knowledge

- American Psychiatric Association. (2006). Treatment of Patients with Eating Disorders, Third Edition.
- Guideline Watch (August 2012). Practice Guideline For The Treatment Of Patients With Eating Disorders, Third Edition
- Treasure, J., Schmidt, U., van Furth, E. (2010). The Essential Handbook of Eating Disorders.
- Dancyger, I.F. & Fornari, V.M. (2014) Evidence Based Treatments for Eating Disorders: Children, Adolescents and Adults, Second Edition.
- Maine, M., Hartman McGilley, B. & Bunnell, D.W. (2010). Treatment of Eating Disorders: Bridging the Research-Practice Gap.

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Evidence Based Practice

Encompasses a number of competencies that promote positive therapeutic outcomes. These competencies include:

1. Conducting assessments and developing diagnostic judgments, systematic case formulation, and treatment plans;
2. Making clinical decisions, implementing treatments, and monitoring patient progress;
3. Possessing and using interpersonal expertise, including the formation of therapeutic alliances;
4. Continuing to self-reflect and acquire professional skills;
5. Understanding the influence of individual, cultural, and contextual differences on treatment;
6. Seeking available resources (e.g. consultation, adjunctive or alternative services) as needed;
7. Having a **cogent rationale for clinical strategies**.

(APA Policy Statement on EBPP August 2005)

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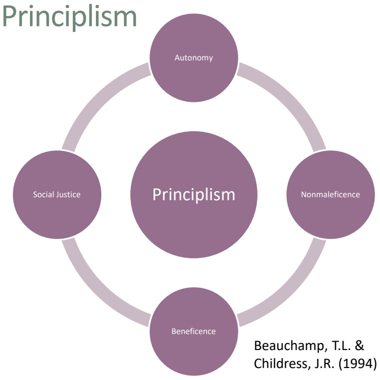
Principlism



Principlism guides the decision making process in the care of individuals with eating disorders

Beauchamp, T.L. & Childress, J.R. (1994)

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AUTONOMY

Principle allowing people to make decisions about themselves for themselves, respecting human dignity

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Informed consent

The client's right to decide whether to participate in treatment after the practitioner fully describes the services rendered in a manner that is understandable by the client.

- *Goals of therapy*
- *Risks and benefits of therapy*
- *Approximate length of the process*
- *Alternatives to therapy*
- *Fees and services*
- *Qualifications and background of the clinician*
- *Treatment procedures*
- *Limits of Confidentiality*

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Confidentiality

- Approximately 20% of complaints made against Clinicians are due to confidentiality and privacy issues. (Wheeler & Bertram, 2019).
- Most violations of confidentiality occur when clinicians accidentally allow their protective mechanisms to break down.
- State and federal law generally permit patients access to at least some portion of their records.
- Under the Privacy Rule, the primary ground for refusing patients' request for copies of their clinical records is that in your professional judgment it is "reasonably likely to endanger the life or physical safety of the individual or another person"

The Trust 2006, Assessing and managing risk in psychological practice: An Individualized approach

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THE THERAPEUTIC CONTRACT

Standard Features

1. Therapeutic Process including parameters based on Principlism
2. Fees, 3rd Party Payers
3. Confidentiality and Exceptions
4. Clarification of role when working with couples, families, and children
5. Accessibility
6. Emergency Info
7. Social Media Use
8. Discharge - Termination

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The Adolescent Treatment Contract

- Clarify the specifics of confidentiality from the first meeting
- Be aware of the "unofficial" boundaries between the adolescent/guardian/you
- Be aware of the parents' rights to information re: teen's treatment.
- Maintain open communication with the family/adolescent
- Continued renegotiation of privacy or boundaries may be needed as child develops, circumstances change

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NON-MALEFICENCE

Principle that actions should not harm others

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Active & Passive Harm

Active Harm

- Inappropriate Interventions (trauma, re-feeding)
- Excessive workups to look for a medical cause for symptoms
- Abandonment
- Boundary Violations

Passive Harm

- Failure to recognize your own counter-transference that hinders the client's progress.
- Failure to develop a biopsychosocial treatment plan and instead relying on single modalities. e.g. Medication alone, therapy without attention to weight restoration.
- Failure to discuss confidentiality
- Failure to establish clear and consistent boundaries.

Anderson, A. (2008). Eating Disorders Review: Current Clinical Information for Professional Treating Eating Disorders. Vol 19/No.2 ; Ethical Conflicts in the Care of Anorexia Nervosa Patients.

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Boundary subtext: How? Why?

- Business relationship for social science majors ☺
- Friendly vs. Friends
- Being with and not becoming
- Where you end and client begins
- Models healthy boundaries for the client
- Keeps client focused on goals, not relationship
- Prevents Splitting Teams
- Safeguards a client's expectations for future services
- Reduces Compassion Fatigue

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Boundary subtext: Social Media

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- Social Media Guidelines
  - Include Social Media Policy use and expectations in Informed Consent
  - Cannot assume a client understands the therapeutic relationship and need for boundaries
  - Recognize the limits of data sharing
  - Keep professional/ personal social media presence separate

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BENEFICENCE

Principle of doing good; Maximize benefits to individuals and society

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Beneficense

- Limiting treatment options
- Tube feeding
- Monitoring bathroom privileges
- Exercise restriction
- Meal monitoring/plating
- Required nutritional replacements
- Blind weights
- Other Health Issues i.e., Diabetes
- **General Principal:** Make decisions that support good, humane care, respecting the wishes of competent patients and intervening respectfully with patients whose judgment is severely impaired by their psychiatric illness when interventions are likely to benefit the patient

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JUSTICE

Principle requiring that benefits and harms should be equally distributed among people, including fair allocation of resources

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Justice

- Validation from supports
- Payor limitations
- Access to services
- Gender affirming care
- Racial disparity
- Cultural Bias
- Least restrictive environment
- Advocacy and participation in legislative initiatives

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ETHICAL DECISION MAKING

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Ethical Decision Making Model

- Forester-Miller Model - Forester-Miller, H., & Davis, T. (1996). A practitioner's guide to ethical decision making. Alexandria, VA: American Counseling Association.
- Wheeler, A.M. and Bertram, B. (2019). The Counselor and the Law, Eighth Edition.
  - Define the problem/dilemma(s)
  - Identify the Client's worldview
  - Review/Understand the law, ethics codes and institutional policy
  - Be alert to personal influences
  - Obtain outside perspective
  - Enumerate the options and consequences
  - Decide and take action
  - Document decision making and follow-up actions

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Common Pitfalls During Diagnosis and Assessment

- Failure to explore financial/insurance issues before the assessment process
- Insufficient Assessment Tool/Questions
- Failing to assess medical fragility
- Failure to review custody information for adolescents
- Not involving the family during an adolescent assessment
- Gathering information based solely on self report
- Failure to refer to the appropriate level of care
- "Unavoidable" dual relationships

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Common Pitfalls

- Pressing client for "Justice" or advocacy
- Failure to appreciate the power of your own values/beliefs
- Failing to provide additional resources as needed
- Failure to communicate effectively with other providers
- Power plays that look like FBT
- Failure to support families and support systems as the client continues in treatment
- Failure to consider medications or other interventions due to fear of client response
- Personal Assistance/Availability

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Common Pitfalls

- Failure to engage in ongoing assessment of client's needs and impact of treatment on the client.
- Unconscious stereotyping and cultural tunnel Vision
- The caretaking therapist/boundary violations
  - Overidentification with client
  - A need to be liked
- Failing to consult with or seek out supervision
- Failure to evaluate your influence on your client
  - Transference/counter transference
- Working beyond your scope
- Failing to be aware of best practice guidelines

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Common Pitfalls (Developmental) Working with Adolescents

- Physiological
  - Bone density and indeterminate fertility issues
- Cognitive
  - Frontal lobe development
- Familial/environmental
  - Often do not have experience with a "voice",
  - "Imaginary audience"
  - Special issues regarding informed consent and confidentiality.
  - Academic breaks that put additional stress on academic and social development
  - Identification of the "Patient/Client"

The Trust 2006, Assessing And Managing Risk In Psychological Practice: An Individualized Approach

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Common Pitfalls in Referral/Termination

- Maintaining patients in an inappropriate level of care.
  - Involuntary commitment
- Referring based on your own Counter-Transference
- Perceived patient abandonment related to 3rd party payors
- Gifts (ugh!)
- To guard against these Pitfalls:
  - Address limitations of treatment and terms of termination at the outset of treatment (Informed Consent)
  - Ensure Agreement on Goals and expected completion of those goals
  - Ensure ongoing and open discussion of the client's progress toward those goals

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Key Elements of Risk Management

- **Informed Consent**-Increases patient autonomy by increasing participating in decision making. Associated with beneficence. The secondary goal is to increase patient's investment in treatment.
- **Documentation**-Related to the moral principal of beneficence and nonmaleficence. Its purpose it to promote patient welfare such that it demonstrates that a reasonable standard care was used in conceptualizing, planning, and implementing treatment. It also ensures communication between collaborating professionals.
- **Consultation**-Helps insure competence. Treatment providers must have competency enhancing strategies that include continuing education and a system for quality feedback.

(Assessing and Managing Risk in Psychological Practice: An individualized Approach, 2006.)

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Ethical Resilience

- Be aware of the Law/State Statutes
- Ongoing reflection
- Practice transparency and discussion of your own ethical behaviors and others (think-aloud processes)
- Remain open to feedback.
  - *Social Psychologist David Dunning Ph.D. reported "A little pointed feedback might be the exact motivator people need to work on their shortcomings."*

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Do This... Every Day.

1. Be mindful of the number of chronic or acute patients on your caseload.
2. Take care of yourself and have outlets for consultation/supervision/therapy as needed to reduce burnout.
3. Be aware of underlying biases and cultural tunnel vision that may exist relating to culture, gender, food.
4. Be reflective of your impact on your client, including your own ED history, if applicable.

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CARLY

Carly is a 30-year-old, Caucasian female. She and her husband have been married for seven years. Carly has struggled with anorexia the since the age of 15. Initially, Carly's eating disorder began when she wanted to "eat a little more healthy"; though as she became increasingly stressed throughout high school, restricting behaviors and exercising behaviors increased. At 16, when she reached an IBW of 84% and began showing symptoms of depression, her parents insisted she begin seeing an outpatient therapist. Through therapy, Carly developed an awareness of her tendency to withdraw, and turn to her eating disorder as a way of feeling more confident and more control of her life – especially in new or stressful circumstances. Her parents required her to be at a "healthy weight" in order to go to college and Carly worked to meet that minimum. During her freshman year in college, Carly's eating disorder symptoms again increased.

But, when she met her husband in their sophomore year in college, Carly began to see a remission of restricting behaviors, though exercising continued, and Carly was able to maintain a minimum weight range. Then, as she approached graduation and she and her husband begin planning their wedding, Carly began to see restricting behaviors re-emerge. By the time she was married, restricting and exercise behaviors had become more increasingly problematic. Carly was admitted to residential treatment centers at age 25. She did not seek step-down care because she was out of FMLA. Though her ED symptoms continued (albeit at a lower severity than prior to residential treatment), she continued to feel her ED was something that was "all hers" and would always be with her.

After trying to conceive for two years, she is now pregnant and struggling with major depression and anorexia. She admits that the relationship with her husband is very strained. He is frustrated with her ongoing struggles with her eating disorder and she is hoping that a baby will help that relationship. Carly and her husband have experienced considerable strain over the years, and their marriage is struggling. You have a release to her OB/GYN, who states that Carly is gaining the expected amount of weight required for the baby; though Carly herself is still only 90% IBW for a non-pregnant woman.

Carly maintains that she is able to continue providing adequate nutrition for the baby; having increased her meal plan to accommodate the baby's needs and reducing the intensity of her exercise. She maintains that, having gotten pregnant, she must be healthier than she has been in the past, and is not motivated to work on her eating disorder, but would like to address her depression.

What are the ethical issues that are most salient in this scenario?
How would you proceed with this client?
What basic principles are most relevant in making ethical decisions about this case?
How would you manage the risk or protect your ethical decisions?

JANE

At 25, Jane - a multi-racial (mother is Caucasian, and father is African American) female, has just completed her Master's degree in counseling. Three years ago, during her senior year in college, she sought treatment in the University Counseling Center for bulimia. Prior to that, Jane had experienced periods of restricting, purging through exercising and self-induced vomiting since the age of 14, whenever she felt her weight was getting out of control. Jane's mother is a secretary, and Jane's father is an electrician. They have always been very supportive of her and expressed pride in her accomplishments – especially because neither of her parents finished college, though both attended for a short time. She is their only child. Jane describes herself as "self-motivated" and believes that the cycles of her eating disorder were a way for her to manage her own negative appraisals and internal drive to better herself.

She notes that her eating disorder behaviors ebbed and flowed over the years, becoming more problematic during times of stress, disappointment, or heartache. She noted that during adolescence, much of her ED seemed to be tied to fears of others' judgment, and feeling she needed to always work harder to be "good enough". Currently, she has been symptom-free for almost two years. She is thankful that she was able to overcome her eating disorder, and now that she is a therapist, would like to help others struggling with an eating disorder. Jane is active in her church and acts as the Coordinator of Events for her church's young adult social group. She seeks out ED education events all the time and works hard to network with other providers.

She believes that the empathy and understanding that she experiences for those struggling with an eating disorder can be of benefit in her therapeutic relationships even as she is not sure how open she plans to be regarding her own recovery process. In part, she is conflicted with the knowledge that many women of color do not seek treatment for eating disorders, and wants to be an advocate. However, she also recognizes that her own recovery is fairly new and feels very privately about that. Nonetheless, she feels certain that she is able to push away her own counter transference that might arise, in favor of attending to her clients' own needs. Jane has sought you out to provide supervision for her practice.

She tells you she understands how important supervision is and she is proactively engaging in self-care and because she has heard that burn-out and compassion fatigue frequently happen with therapists who treat eating disorders. Her passion for helping those with eating disorders is unmistakable and she is clearly driving herself hard to be successful in this field.

What are the ethical issues that are most salient in this scenario?
How would you proceed with this client?
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How would you manage the risk or protect your ethical decisions?

KAYLA

Kayla is an 18-year-old Caucasian female, diagnosed with Type I Diabetes at age 10. You are seeing her during her first year in college, which is approximately 8 hours from her parents' home, to help address the stress and anxiety she is experiencing as a freshman. Kayla reports that her parents are a big support, but they worry about her (both as loving parents, and due to her health condition) – especially being so far away. But, because Kayla has always been a straight "A" student, a compassionate and conscientious teen, who has independently managed her diabetic care for several years, they are confident in Kayla's ability to be independent so far away. Kayla has an endocrinology team back home and follows up with her team when she is at home, though recently missed her three-month follow up appointment on her last visit home.

You have obtained a release of info for her Endocrinology team as well as an Emergency Release of information for her parents. Her father is her financial guarantor and her insurance is in his name. She has told her parents that she is working on "adjustment issues" in therapy. Kayla's parents do not know that she has been withholding insulin to help counteract the "Freshman 15" pounds that she has gained in her first year; and she is insistent that she does not want her parents to know what she is doing. She tells you that she has it "all under control" and will start taking her insulin dosage as prescribed as soon as she loses the weight. She has roommates who are aware she is diabetic, but they have no idea of her insulin manipulation.

Kayla reports that she is scared of disappointing her parents, but she is becoming increasingly depressed and has significant fear that she will "always be fat", if she does not get the extra weight off now.

What are the ethical issues that are most salient in this scenario?
How would you proceed with this client?
What basic principles are most relevant in making ethical decisions about this case?
How would you manage the risk or protect your ethical decisions?

JESSIE

Jessie is a 15-year-old DFAB and a sophomore in high school. Jessie lives with her parents, a brother, age 12 and a sister, age 8. Jessie presented for treatment after her parents began to suspect that she was purging after the dinner meal. They found trash bags of vomit in her room, which Jessie told them was because she had "experimented" with purging "a couple of times" when she ate a little too much and felt sick. After confronting her, Jessie's mother began to suspect that she was purging in the shower. Each time her parents address the issue with her, Jessie become angry and verbally combative. They are a busy family, and Jessie particularly has a very active schedule. She plays soccer, has a busy social life and takes guitar lessons.

She has a witty personality and a lot of friends, though she is increasingly becoming argumentative with her parents about almost everything, but especially when they begin to push her on, what they believe to be an eating disorder. Her parents are also concerned that Jessie may have been smoking marijuana, as they could smell the odor when she returns from being out with friends. Jessie insists that she is not smoking marijuana, but rather has been around other kids (not her close friends) who were smoking. They present for treatment with you after they have told Jessie they would take her phone from her if she did not seek counseling for her eating disorder. When you meet with Jessie, she seems open, cooperative, and generally happy.

When asked what her goals for treatment are, she reported that she wants to stop eating so much that she feels sick, wants her parents to trust her more, and wants to stop worrying about what others think of her. Her parents state that they want to trust Jessie more, help stop her purging behaviors, and develop healthy habits that will help her achieve her goals. As you begin treatment with Jessie, you review with she and the family the confidentiality expectations and what to expect from you. Now that you have met with Jessie about four times, she has begun sharing much more earnest details of her life, including that fact that he identifies with the male gender, has been regularly smoking marijuana, purging at least once a day, whenever he can get away with it, and has begun sneaking out at night with his girlfriend.

What are the ethical issues that are most salient in this scenario?
How would you proceed with this client?
What basic principles are most relevant in making ethical decisions about this case?
How would you manage the risk or protect your ethical decisions?

CARMEN

Carmen is a 36-year-old Hispanic female. Carmen has been a larger size most of her life and has consulted with a surgeon regarding gastric bypass surgery. The surgeon evaluates Carmen and feels that a gastric bypass would be an appropriate option for her. He asks Carmen to have a series of tests, including a psychological evaluation. The evaluator feels that Carmen needs more counseling prior to undergoing weight loss surgery, and that the primary focus of this counseling should be in developing coping skills to decrease binging behavior. Carmen is told to seek the services of a counselor and dietitian skilled in treating eating disorders. This counselor may send the surgeon a note when he or she feels that Carmen has the appropriate coping skills to manage the binging. Carmen contacts her insurance company and receives a list of eating disorder specialists.

She contacts Sarah, a social worker with 10 years of experience in treating eating disorders. In her initial session with Sarah, Carmen explains why she is seeking treatment for her binge eating. Carmen clearly states that her ultimate objective is to have gastric bypass surgery. She also provides Sarah with a copy of her psychological evaluation, which suggested that Carmen also struggles with Depression and PTSD. Sarah has seen a lot of very unfortunate cases of individuals who had serious health complications from continuing to binge or overeat after such surgery. She is also aware that many individuals enter treatment with a goal of having weight loss surgery, but eventually come to realize the genesis of their “weight problem” and become less interested in the surgery and more interested in long term ED recovery. Sarah and Carmen meet for five months.

After about two months, Carmen’s depression became more prominent, and Sarah referred her to a psychiatrist, who prescribed Vyvanse for Carmen’s binge eating behaviors. After about five months, Carmen’s compulsive eating has decreased to once per night, but her weight has not changed. Carmen is pushing Sarah to write the letter that will allow her to continue with the surgery process. Unfortunately, Sarah is still mindful of all the post-bariatric problems that can occur and does not feel comfortable with the surgery or writing the letter. Furthermore, she suspects that the reduction in bingeing may be connected to the Vyvanse, and fears that Carmen may increase her bingeing after discontinuing the Vyvanse.

What are the ethical issues that are most salient in this scenario?
How would you proceed with this client?
What basic principles are most relevant in making ethical decisions about this case?
How would you manage the risk or protect your ethical decisions?

LISA

Lisa is a 29-year-old Caucasian female. She lives with her boyfriend and her 7-year-old daughter. She has no contact with her daughter's father or her own parents. According to Lisa, she was physically and sexually abused by her own father and has never allowed her daughter to have contact with her perpetrator. She has no relationship with her mother, as she felt her mother was unwilling to stand up to her father when Lisa told her about the abuse. Lisa has come to you because she is struggling with binging and purging every other day. She works as a waitress at night and, while she does not binge at work, often binges and purges at the end of her shift. Despite her purging behavior, Lisa has continued to gain approximately 15 pounds on her 5'1 frame over the last three months.

She reports that she experiences anxiety and something "close to panic attacks" every day and has learned to avoid most situations that make her anxious. After working with Lisa for a few weeks, you Lisa tells you that the one situation that she cannot avoid is "swinging", which she does regularly with her boyfriend. They belong to an online network of swingers and engage in sexual activity at least once every two weeks. Lisa reported that she used to enjoy the swing scene, but now that she has gained weight, feels very self-conscious about the activity. Her boyfriend's answer to this is "lose the weight".

In fact, their sex life has been a source of conflict lately – as each time Lisa has told her boyfriend she does not want to connect with other sexual partners he has physically assaulted her, such that she is unable to go into work the next day (approx. 4 times in the past 6 months). You are admittedly a bit uncomfortable about this new revelation – not judgmental – but this type of a sexual relationship is different than your own monogamous relationship and or the polyamorous relationships of some of your other clients. You are also feeling angry that Lisa is being abused because of her reluctance to participate. Recently, her doctor prescribed Ativan to help with her anxiety and that has helped.

At this point, Lisa acknowledges that she needs to get a handle on her ED – in part because she is aware that her daughter is old enough to start picking up on her eating habits. She is admittedly less motivated to reduce the purging, because she does not feel she can maintain an acceptable weight. Furthermore, Lisa reports that after purging, she feels so much calmer… "almost better than Xanax!". However, she is deeply troubled by the bingeing behavior and would really like help to eliminate that behavior altogether and would like to start with that as her primary goal.

What are the ethical issues that are most salient in this scenario?
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