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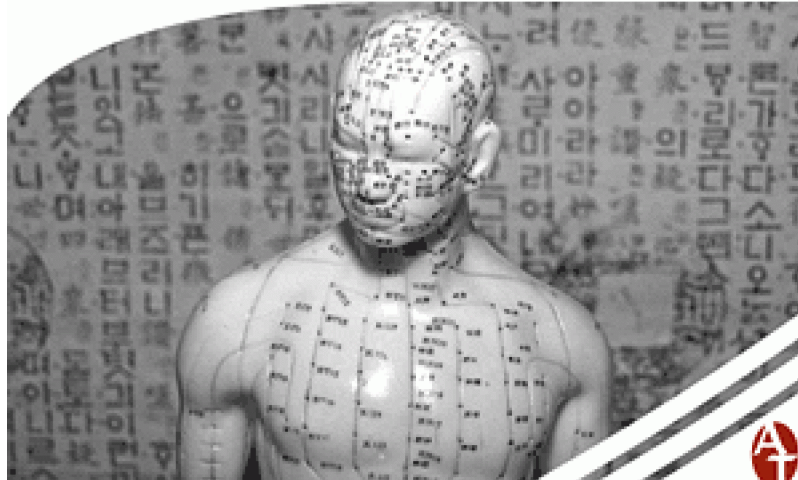

CHINESE & ASIAN MEDICINE

TCM and the Treatment of Eating Disorders

Norah McIntire, LAc

Over the past decade, I have seen a growing interest in how our medicine can help those suffering from eating disorders. I receive emails and phone calls from fellow practitioners and students who have contacted me because I treat eating disorders. Inevitably the discussion turns to point selection, herbal formulas, and treatment strategies.

While the concern with treatment protocols and approaches is understandable, in my experience it is not the most difficult or challenging aspect of treating eating disorder patients. Because eating disorders are uniquely insidious, dangerous, and difficult to treat, before focusing on pattern diagnosis and treatment, a discussion of basic case management strategies is critical for providing a safe treatment experience for those with eating disorders.

Eating disorders are remarkably dangerous illnesses. Complications of anorexia nervosa include heart muscle shrinkage, slow and irregular heart beats, kidney failure, osteoporosis, heart failure, and death. Complications of bulimia nervosa include electrolyte imbalances, heart arrhythmias, tooth erosion, esophageal tears, laxative dependence, emetic toxicity, heart failure, and death. Mortality rates are elevated in anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (EDNOS), and anorexia nervosa has a mortality rate higher than other psychiatric illnesses.

This high risk can be partially explained by the sinister and complex nature of eating disorders. Unlike other health problems, inherent in eating disorders is patient resistance to recovery combined with an impaired perception of one's self. It is very difficult, if not impossible, to interact with the person without also interacting with the eating disorder, which can be thought of as almost an additional entity that translates conversations, images, and ideas into its own voice to drive self-destructive behavior. In this setting, otherwise benign conversations and information can have an unexpectedly dangerous edge.

Eating disorders (and their treatment) also occur in a cultural setting that actively interferes with recovery from weight, body image, and eating issues. We are assaulted with media images and headlines that celebrate and encourage thinness and very specific body ideals. Patients are awash in unhealthy beauty standards that actually support imbalanced thoughts and goals since losing weight and being thin are socially rewarded. Such an environment does nothing to support efforts to re-establish or foster a healthy, loving respect for our bodies.

Given these qualities of eating disorders, certain case management strategies become crucial to successful and safe treatment. Some of these strategies may seem obvious, but I have personally seen excellent and experienced practitioners unknowingly complicate cases by not being aware of and protecting against the dangers outlined below.

The first concept is to be mindful that suggestions that would be helpful and uncomplicated for another patient can be very problematic for an eating disorder patient. A common instance of this has to do with dietary recommendations, especially advising a patient to avoid certain foods or engage in a very strict nutritional regimen.

Even if these instructions are completely appropriate for the patient's pattern of disharmony, the suggestion that certain foods are "bad" can create panic for an eating disorder patient. I have worked with patients whose eating disorder behavior worsened when an alternative practitioner attempted to put them on a strict dietary regimen or handed them a list of foods to avoid. This unintentionally fosters phobias about certain foods and ultimately creates additional obstacles to full recovery. A fear of all dairy products is a greater obstacle to an eating disorder patient's health than is the occasional consumption of dairy products, despite the patient's Spleen deficiency and dampness.

An additional example of this has to do with instructions for herbs and supplements. Being as specific as possible about dosages and timing helps create boundaries for the eating disorder. Otherwise, any confusion or room for improvisation by the patient can be an opportunity for the eating disorder to rear its ugly head. "You should take 1 teaspoon of magnesium right before bed" is more helpful than "You should take 1 to 3 teaspoons of magnesium in the afternoon or evening."

The second management issue is ensuring that your office is a safe place for someone with an eating disorder. Again, seemingly benign elements can create disastrous consequences. Do you have a scale in your office that your patients can use unsupervised? Access to a scale can wreak havoc on an eating disorder patient's psyche and treatment plan. It is not unusual for an eating disorder patient to be working with a doctor or nutritionist who keeps track of the patient's weight for them, thereby relieving them of the terror of gaining weight and obsessing about a number on the scale. Having a patient discover her/his own weight in the middle of this process can completely upend a patient's progress. If you absolutely need a scale in your office, control patient access to it and use it only with patients who require it.

What does your waiting room contain? Does it contain magazines that are filled with articles and ads extolling the virtues of being thin, unwrinkled, and beautiful? Does the literature in your office have information about "cleanses" or diets? Having a discerning eye about what information your patients encounter immediately before their treatments can help create a safer environment for them. This is arguably true for all patients, but it is especially important for those fighting eating disorders.

Thirdly, treatment of eating disorders often requires being a "team player" and working cooperatively with other types of practitioners, including a psychotherapist, Western physician, and

nutritionist/dietician. Close collaboration is essential with eating disorder clients for several reasons. It ensures that each practitioner is aware of what the others are doing and any concerns the team may have about the patient. Given how dangerous eating disorders are, this closer, coordinated monitoring provides basic safeguards for the patient's safety and ensures the patient is treated at the appropriate level of care.

This cooperation also prevents the patient from being given seemingly contradictory suggestions, which can create tremendous anxiety and undermine the patient's commitment to the treatment plan. Criticizing or contradicting another practitioner to the patient presents an opening for the eating disorder to "divide and conquer" the practitioners, giving the patient a reason to stop engaging in the treatment process. It is preferable, for instance, to contact the nutritionist directly to discuss a concern about a dietary or supplement recommendation rather than voicing your disagreement to the patient. This allows the concern to be addressed and keeps the united front against the eating disorder intact.

Working closely with other providers also provides support while treating these dangerous disorders. This support can be important because these challenging cases can take their toll on treatment providers. Practitioners who specialize in eating disorders have a very high rate of burn out. The complex and chronic nature of these diseases can make them very frustrating and taxing to treat. Knowing you have a team of providers with you can help.

Eating disorders are undoubtedly challenging to treat. However, our medicine has some very important advantages for treating these issues. Our emphasis on treating the whole person, our understanding of the connection between the mental/emotional and physical aspects of our being, and the adaptability of our modalities for individual treatment all hold great potential to help a patient find her/his way out of an eating disorder. By implementing basic patient management strategies, we can put this profound medicine into practice while keeping the patient safe. We can then take our rightful place as a valued and effective member of a patient's treatment team.

References

1. Arcelus, J., Mitchell, A.J., Wales, J. & Nielsen, S. (2011). Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders: A Meta-analysis of 36 Studies. Arch of Gen Psychiatry. 2011; 68(7): 724-731, doi: 10.1001/archgenpsychiatry.2011.74.

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