Ethical Considerations in Outpatient Eating Disorder Treatment

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Ailm Therapy

Objectives

- Identify your discipline's code of ethics and limitations surrounding scope of practice and competence.
- Describe how specific competing ethical principles complicate ethical decision making in the treatment of eating disorders.
- Understand the various levels of care in the treatment of eating disorders.
- Determine when a patient's needs are outside of your scope of practice and how to proceed.

Ethical guidelines do not provide a clear answer to every challenge in counseling; however, they can provide a structure from which to guide decisions and interventions (Warren & McGee, 2013).

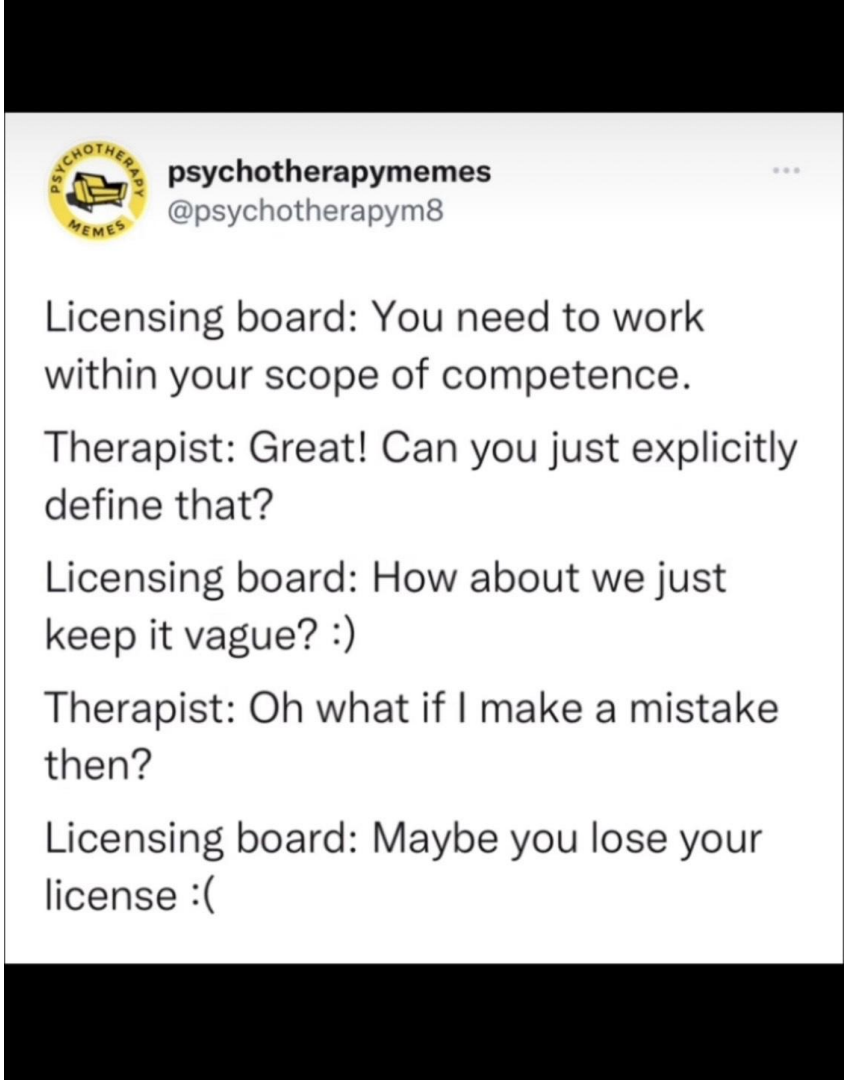
What makes eating disorders ethically complex?

With increased clinical concerns, ethical challenges are more numerous (Warren & McGee, 2013):

- Treatment resistance and outright refusal is common due to ego-syntonic nature of the disorder
- Ambivalence, Relapse
- High mortality rates
- Autonomy vs. Non-maleficence

Unintentional maleficence (harm):

- Failure to refer
- Reliance on single treatment modality (ie focus on therapy without consideration for nutritional rehabilitation or medical stabilization)
- Cooperating or aligning with the eating disorder



Source: Instagram
@psychotherapymemes

What is competence?

- Training: “Insufficient and inadequate” graduate and post-graduate training opportunities (Wilson, Grillo & Vitousek, 2007, p 207)
- Education: Diagnoses & presentations, treatment modalities, need for some knowledge of medical and nutritional issues.
- Ability to work/collaborate as a team - required to be minimally competent (Williams & Haverkamp, 2010)
- Self awareness & attitudes, understanding biases (Warren & McGee, 2013)

With a lack of specialized providers, waitlists, or lack of awareness (both with themselves and their clients) clinicians may be tempted to practice outside of scope.

Mental Health Counselors (ACA):

C.2.a. Boundaries of Competence
Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.

C.2.b. New Specialty Areas of Practice
Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm.

Social Workers (NASW):

1.04 Competence
(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

Psychologists (APA):

> 2.01 Boundaries of Competence
> (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
> (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies

Dietitians (Academy of Nutrition and Dietetics):

> Foundational components of health care and medical ethics include:
>
> Autonomy - ensures a patient, client, or professional has the capacity and self-determination to engage in individual decision-making specific to personal health practice.
> Non-Maleficence – the intent to not inflict harm.
> Beneficence - encompasses taking positive steps to benefit others, which includes balancing benefit and risk.
> Justice (Social Justice)– supports fair, equitable, and appropriate treatment for individuals and fair allocation of resources.
>
> Practice using an evidence-based approach within areas of competence, continuously develop and enhance expertise, and recognize limitations.
> Practice within the limits of their scope and collaborate with the inter-professional team.

Physicians (AMA) - “first do no harm”

But...

You as a provider are responsible for identifying your own areas of competence.

“Mental health professionals lack systemic criteria against which to assess their competence to provide psychotherapy to eating disordered clients.” (Williams & Haverkamp, 2010).

ACA: A.11.a. Competence Within Termination and Referral
If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship.

Beneficence vs. Nonmaleficence

"Extensive range of specialized competencies in at least five domains is required for the provision of minimally ethical eating disorders psychotherapy." (Williams & Haverkamp, 2010)

Extensive Core Knowledge and Skills

Interdisciplinary Teamwork

Specialized Therapeutic Relationship Skills

Professional Responsibility

Therapist Characteristics

Ability to Conceptualize + Awareness of Limitations in Self/Client + Appropriate Use of Interventions = **Competence**

Interdisciplinary Treatment Team

Therapist

Dietitian

Physician

Psychiatrist

Supervisor

Support System: Family, friends, groups, recovery coach

Liability

Adult patients provide consent to treatment. Children/Adolescents have parents or guardians who consent to treatment.

- Informed Consent
- Treatment Agreements if higher level of care is needed.
- Understand and identify your personal limits/comfort level with ED.
- Intake Packet: Informed Consent, Limitations, Referral Policy, Termination Policy (in line with ethical standards), Release of Information to include extended team and supports.

Documentation:

- “Patient meets criteria for higher level of care but refuses, endorses understanding of risk.”
- “Therapist addressed recommendations for higher level of care or increased support needs.”

Supervision and Consultation

Levels of Care

Medical Stabilization - Hospital

Inpatient

Residential

Partial Hospitalization Program (PHP)

Intensive Outpatient Program (IOP)

Outpatient

Access to certain levels of care comes with inherent barriers: geography, insurance, finances, personal responsibilities, client willingness/motivation

APA Level of Care Guidelines – Eating Disorders

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]	Level 4: Residential Treatment Center	Level 5: Inpatient Hospitalization
Medical status	Medically stable to the extent that more extensive medical monitoring, as defined in levels 4 and 5, is not required			Medically stable to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed	*For adults:* Heart rate <40 bpm; blood pressure <90/60 mmHg; glucose <60 mg/dl; potassium <3 mEq/L; electrolyte imbalance; temperature <97.0°F; dehydration; hepatic, renal, or cardiovascular organ compromise requiring acute treatment; poorly controlled diabetes *For children and adolescents:* Heart rate near 40 bpm, orthostatic blood pressure changes (>20 bpm increase in heart rate or >10 mmHg to 20 mmHg drop), blood pressure <80/50 mmHg, hypokalemia,[b] hypophosphatemia, or hypomagnesemia
Suicidality[c]	If suicidality is present, inpatient monitoring and treatment may be needed depending on the estimated level of risk				Specific plan with high lethality or intent; admission may also be indicated in patient with suicidal ideas or after a suicide attempt or aborted attempt, depending on the presence or absence of other factors modulating suicide risk
Weight as percentage of healthy body weight[d]	Generally >85%	Generally >80%	Generally >80%	Generally <85%	Generally <85%; acute weight decline with food refusal even if not <85% of healthy body weight

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders *(continued)*

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]	Level 4: Residential Treatment Center	Level 5: Inpatient Hospitalization
Motivation to recover, including cooperativeness, insight, and ability to control obsessive thoughts	Fair-to-good motivation	Fair motivation	Partial motivation; cooperative; patient preoccupied with intrusive, repetitive thoughts[e] >3 hours/day	Poor-to-fair motivation; patient preoccupied with intrusive repetitive thoughts[e] 4–6 hours a day; patient cooperative with highly structured treatment	Very poor to poor motivation; patient preoccupied with intrusive repetitive thoughts[e]; patient uncooperative with treatment or cooperative only in highly structured environment
Co-occurring disorders (substance use, depression, anxiety)	Presence of comorbid condition may influence choice of level of care				Any existing psychiatric disorder that would require hospitalization
Structure needed for eating/gaining weight	Self-sufficient	Self-sufficient	Needs some structure to gain weight	Needs supervision at all meals or will restrict eating	Needs supervision during and after all meals or nasogastric/special feeding modality
Ability to control compulsive exercising	Can manage compulsive exercising through self-control	Some degree of external structure beyond self-control required to prevent patient from compulsive exercising; rarely a sole indication for increasing the level of care			
Purging behavior (laxatives and diuretics)	Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications, such as electrocardiographic or other abnormalities, suggesting the need for hospitalization			Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging	Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent, and disabling, despite appropriate trials of outpatient care, even if routine laboratory test results reveal no obvious metabolic abnormalities

TABLE 8. Level of Care Guidelines for Patients With Eating Disorders *(continued)*

	Level 1: Outpatient	Level 2: Intensive Outpatient	Level 3: Partial Hospitalization (Full-Day Outpatient Care)[a]	Level 4: Residential Treatment Center	Level 5: Inpatient Hospitalization
Environmental stress	Others able to provide adequate emotional and practical support and structure		Others able to provide at least limited support and structure	Severe family conflict or problems or absence of family so patient is unable to receive structured treatment in home; patient lives alone without adequate support system	
Geographic availability of treatment program	Patient lives near treatment setting			Treatment program is too distant for patient to participate from home	

Source. Adapted and modified from La Via et al. (100).

Note. In general, a given level of care should be considered for patients who meet one or more criteria under a particular level. These guidelines are not absolutes, however, and their application requires physician judgment.

[a]This level of care is most effective if administered for at least 8 hours/day, 5 days/week; less intensive care is demonstrably less effective (101).

[b]If the patient is dehydrated, whole-body potassium values may be low even if the serum potassium value is in the normal range; determine concurrent urine specific gravity to assess for dehydration.

[c]Determining suicide risk is a complex clinical judgment, as is determining the most appropriate treatment setting for patients at risk for suicide. Relevant factors to consider are the patient's concurrent medical conditions, psychosis, substance use, other psychiatric symptoms or syndromes, psychosocial supports, past suicidal behaviors, and treatment adherence and the quality of existing physician-patient relationships. These factors are described in greater detail in the APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* (84).

[d]Although this table lists percentages of expected healthy body weight in relation to suggested levels of care, these are only approximations and do not correspond to percentages based on standardized values for the population as a whole. For any given individual, differences in body build, body composition, and other physiological variables may result in considerable differences as to what constitutes a healthy body weight in relation to "norms." For example, for some patients, a healthy body weight may be 110% of the standardized value for the population, whereas for other individuals it may be 98%. Each individual's physiological differences must be assessed and appreciated. For children, also consider the rate of weight loss. Finally, weight level per se should never be used as the sole criterion for discharge from inpatient care. Many patients require inpatient admission at higher weights and should not be automatically discharged just because they have achieved a certain weight level unless all other factors are appropriately considered. See text for further discussion regarding weight.

[e]Individuals may experience these thoughts as consistent with their own deeply held beliefs (in which case they seem to be ego-syntonic and "overvalued") or as unwanted and ego-alien repetitive thoughts, consistent with classic obsessive-compulsive disorder phenomenology.

Assessing for Severity

What do you ask outpatient clients to assess their level of risk?

Eating disorder behaviors and frequency, mood symptoms, functioning/impairment

Coordinate with team - united front

- EDE-Q: Eating Disorder Examination Questionnaire
- PHQ-9: Patient Health Questionnaire
- EDGE: Eating Disorder Global Evaluation (RD)
- NEDA Eating Disorders Screening Tool
- SCOFF Questionnaire
- SBIRT for Eating Disorders

When & How to Refer

First, communicate concerns and need to patient. Transparency is key.

If outside of your scope, refer out ASAP unless there are limitations - if that's the case, then make sure you have supports in place.

Consult, consult, consult!

Seek supervision as needed

Build a network and resources

Explore virtual or national resources

Resources

AED Purple Book & Resources

iaedp

NEDA Screening Tool

EDGE for Dietitians

EDE-Q

SBIRT for Eating Disorders

References

Codes of ethics: APA, ACA, NASW, AMA, AND

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Questions?

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