Healing Eating Disorders: an Interview with Mehri Moore, MD, and Raven Bonnar-Pizzorno, MS, RD, CD

Interview by Karen Burnett

***Mehri D. Moore, MD**, is a board-certified psychiatrist, has specialized in the treatment of eating disorders for over twenty years, and is widely regarded as one of the Pacific Northwest's leading authorities on eating disorders and related family issues. She is founder of the Moore Center in Bellevue, Wash. In addition, she frequently lectures on and provides training in the treatment of eating disorders. Prior to founding the Moore Center, Dr Moore was the medical director of the eating disorder program at Swedish Medical Center.*

***Raven Bonnar-Pizzorno, MS, RD, CD**, is director of nutrition and dietary services at the Moore Center in Bellevue, Wash., and holds a master of science degree in nutrition from Bastyr University. She co-authored a research study through the Vitamins and Lifestyle Study at the Fred Hutchinson Cancer Research Center.*

Integrative Medicine: A Clinician's Journal (IMCJ): Dr. Moore, would you please tell us about your background, where you grew up, where you studied, how you became interested in medicine, psychiatry and eating disorders.

Dr Moore: I grew up in Tehran, Iran, and went to medical school at the University of Tehran. I left when I was 23 and have lived in the state of Washington, except for a few years on the East Coast for more training. I became interested in medicine when I was in high school and I was really interested in science. In Iran, we use a French educational system, so you go directly from high school to medical school if you're interested in sciences. While I was in medical school, I became interested in psychiatry and pediatrics. First, I tried to pursue a career in pediatrics. During my internship, I also did a psychiatry rotation, which then got my interest and caused me to further my education in psychiatry.

IMCJ: Did you do your medical training then in Philadelphia?

Dr Moore: I did. After graduating from medical school, I did my internship in pediatrics in Massachusetts, a residency in adult psychiatry at the University of Washington, and a fellowship in child psychiatry in Philadelphia.

IMCJ: From there, how did you decide to focus on eating disorders?

Dr Moore: While doing my fellowship at Philadelphia Child Guidance Clinic, I became interested in working with eating disorder patients from a family therapy perspective and decided that this was an area that I was passionate about.

IMCJ: As the founder and medical director of the Moore Center, you have provided the state of Washington with its most comprehensive and longest established treatment facility for eating disorders. Can you describe to us how the center came to be and the history of the center?

Dr Moore: When I finished my training, I returned to the state of Washington from Philadelphia and worked as the medical director of the Ballard Eating Disorder Program, which later became part of Swedish Medical Center. After I stepped down from the medical directorship, I started The Moore Center in Bellevue utilizing some of the models that we used at Ballard and also at Philadelphia Child Guidance Clinic. We started as an outpatient eating disorder clinic and also had an intensive outpatient program. Over time, we have expanded and now offer a full continuum of care including a Partial Hospitalization Program, Intensive Outpatient Program and several step-down programs. . Our Partial Hospitalization Program operates Monday through Friday, for 10 hours a day. We provide a structured schedule of both group and individual therapy components and also provide them with all of their meals.

IMCJ: Dr. Moore, treating eating disorders is notoriously difficult because of the complexity of underlying causes. Looking at anorexia, could you please explain some of the factors involved in this disease?

Dr Moore: The reason that it's particularly difficult to treat anorexia is because of distortions the patients perceive in their body image. There is a constant battle between working on restoring weight and the fear of weight gain. Sometimes it seems like you take two steps forward and one step back.

IMCJ: Would you say that anorexia and bulimia are increasing in this country?

Dr Moore: What we have noticed is that the age onset of anorexia is decreasing but that the overall incidence remains the same. For bulimia the incidence rate has increased over time in this country. The incidence rate of binge-eating disorders is rapidly increasing.

IMCJ: Could you describe that, please?

Dr Moore: Binge Eating Disorder is defined by when a patient engages in eating a large amount of food in a short period of time. They feel completely out of control and compelled to eat to the point that they are overfull and often get sick, but they don't necessarily use a compensatory mechanism like vomiting or using laxative as bulimics do. In other words, binge eating disorder is really bulimia without the purging behavior.

IMCJ: Is this a new phenomenon?

Dr Moore: I'm not quite sure that it is a new phenomenon as much as we are labeling it better now and defining it more. We have clear diagnostic criteria for it and in the next Diagnostic and Statistical Manual of Mental Disorders the disorder will most likely be included so that people that suffer from this disorder can actually get insurance to cover their treatment.

IMCJ: Is this disorder specific to developed countries?

Dr Moore: It is hard to say, but obviously, we see that more in this country. But if you look at the socio-economical aspects of it, you can see that there is more prevalence, let's say, in the working class population or people that are struggling financially. Often food is the only source of comfort or pleasure for them, but the constant struggle between dieting and withholding from food then–for people that have biological predisposition–leads to the binge eating disorder. Binge Eating Disorder is more prevalent in developed countries where there is more of an emphasis on dieting. If exposed to the diet mentality, people who have a biological predisposition can manifest this disorder. In fast paced, economically driven societies, people experience high levels of stress and often turn to food as a coping mechanism.

IMCJ: I see. What is the connection between disordered eating and addiction? Perhaps you were touching on that when you just spoke of stress and eating as a coping mechanism.

Dr Moore: There are brain studies that show that there are certain areas of the brain and certain neurotransmitters that are stimulated and overactive in the eating disorder population which are very similar to the addict population. There is not necessarily a universal voice in the scientific community linking eating disorders and addiction. From my experience, many of my eating patients have a first-degree male relative with chemical dependency or alcoholism which suggests that there is likely a genetic link to these two disorders. Also, around twenty percent of our eating disorder patients struggle with some type of chemical dependency issues. That's a very interesting question. The AA philosophy, the OA philosophy, particularly, sees overeating, compulsive eating, or even binge eating as another form of addiction. And then, of course, the scientific community doesn't necessarily see that connection. There are brain studies that come to focus, showing that there are actually certain areas of the brain and certain neurotransmitters that are stimulated and become overactive in this population, very similar to the addict population. So there's not necessarily a universal voice in this, but what, frankly and experientially, I have seen is that a lot of our patients have a distant relative or immediate relative that has history of alcoholism or drug addiction, not as much in our anorexic population but a lot in our bulimic population. So sometimes we see it as the other side of the same coin.

Raven Bonnar-Pizzorno: If I can add, a lot of our patients think that they are more addicted to foods than they really are. They often tell us that "if I eat that cookie, I'm going to eat all of them because I am addicted to them and can't stop." Then in the treatment process, they practice eating a cookie as part of a balanced meal and learn that they can just eat one.

IMCJ: Dr. Moore, how do you handle coexisting psychiatric conditions that accompany eating disorders such as obsessive-compulsive disorders or depression?

Dr Moore: Almost 90% of our patients have a coexisting psychiatric disorder. The most common is depression, although anxiety disorder, attention deficit disorder (ADD), and obsessive-compulsive disorder are also very prevalent conditions in our patient population. Both medication and psychotherapy are used to treat these co-occurring disorders.

IMCJ: If you treat those issues, does it make the treatment of the eating disorder easier to tackle?

Dr Moore: Eating disorder symptoms often mask the underlying co-occurring psychiatric disorders. To access those issues, providers have to address the eating disorder first.

IMCJ: You have to note the center's success in treating eating disorders. Can you explain your philosophy for treatment? For example, it seems that you feel family therapy is important. Can you discuss that?

Dr Moore: Our philosophy is that eating disorders are very complex illnesses and require a comprehensive approach to treatment. For that reason, we use a multidisciplinary team as a way of creating enough intensity to break long established patterns. Our philosophy is to address the patient from difference dimensions, providing not only individual therapy but also nutritional counseling, group therapy and family therapy. Family therapy is very helpful, particularly helpful for our younger patients who live at home.

IMCJ: Are families usually receptive to being involved?

Dr Moore: In my experience the majority of families are receptive. We've had very few disengaged families.

IMCJ: What is the importance of group therapy versus individual therapy?

Dr Moore: Group therapy a successful mode of therapy for the

majority of patients. However, they have to be divided based on developmental needs which creates a homogenous experience. The group provides an environment where they can talk about feelings since patients use the eating disorder as a way of filtering feelings. Patients learn to express their feelings in a more acceptable way. They understand that they're not alone in this recovery process and that there are other people who think and feel exactly the same way. They are all involved in this really wholesome activity, and it creates an energy that propels them through recovery.

IMCJ: Is there ever a risk that they'll encourage each other toward negative behaviors?

Dr Moore: There's always risk, but in my experience, that risk is really minimal. Patients are often distorted about their body size. They are baffled when our other patients describe the same feelings when they are in the group and they get a reality check, they calm down and understand that they are distorted or they are terribly body focused.

Oftentimes, parents are concerned about whether their children are going to be contaminated in some way from a group setting. What I tell them is that patients are exposed to that constantly through media or in the school system, so contamination is everywhere. What we provide in a group is containment and making them really take ownership and talk about their underlying feelings and thoughts, not as much focusing on body, but focusing more on the underlying issues.

Mehri D. Moore, MD

IMCJ: Your center provides art, music, yoga, and other methods to cope with stress. Do you believe that this helps people with eating disorders because the eating disorders function as a coping mechanism for some people, and therefore, stress reduction is an important part of treating eating disorders?

Dr Moore: Exactly. We try to include a lot of experiential work, not only art and yoga and music therapy, but team building and other types of experiential work where they have to deal with their sense of self in the context of their peers. Yoga is a really helpful mode to become present with your body. It's a way of getting in touch with that three-dimensional experience of your body. Most of our patients are two dimensional when it comes to their body image. Stress triggers eating disorder behaviors and if we teach out patients different tools to manage stress, it helps reduce their eating disorder behaviors.

IMCJ: I notice that your program allows patients to continue with their regular lives while in treatment. In other words, to continue going home in the evening or to continue interacting with people at work. Do you think that involvement with their lives is an important part of learning to deal with the real world?

Dr Moore: It is really important for them to be able to have one foot in their real lives and one foot in the therapy and recovery process. It's important for the treatment team to see what the stressors and triggers are for patients so that they can bring them into therapy and we can work with them. Having one foot in their real life normalizes their experience.

IMCJ: Could you describe the risk profile for someone with an eating disorder?

Dr Moore: Eating disorders are caused by a variety of factors. That includes social pressures, media, and cultural expectations—expectations that are unrealistic for the majority of us. Genetic predisposition also plays a factor, as we see eating disorder in families across generations. A majority of our patients are highly rejection sensitive, perfectionists, and rigid. They have a hard time with change and they are routine seekers. They are very reward oriented and are typically people pleasers. This need for perfection predisposes them to feeling that they're not good enough unless they achieve something. That feeling of not being good enough is the underlying issue of self esteem that never gets perfected in their minds. They're constantly driven to reach that state of perfection that isn't feasible.

IMCJ: Is there a factor of control seeking?

Dr Moore: It's a big issue. If you are a perfectionist, you often try to control the variables in your environment. You're always anticipating what changes are occurring so that you have preparation to deal with uncontrollable situations. That kind of rigidity is the underlying motivation that makes them not only control their environment but control themselves, control what they are eating, or control what they are thinking and what they are feeling.

IMCJ: Do you follow up with your patients after they have left treatment to determine whether or not the treatment has been successful?

Dr Moore: We do. Patients in our day treatment program, once discharged, go into a less restrictive but still intensive outpatient program. After that they step down into once-a-week or once-every-other-week visits with their dietician and their therapist. When they are symptom-free they get discharged, and we will continue following them. We now have about a year of data collected that really does show that our relapse rate is a lot less than the national average.

Raven Bonnar-Pizzorno, MS, RD, CD,

IMCJ: Isn't it increasingly males as well as females involved now?

Dr Moore: We see more males coming forward to get treatment. It's hard to know whether the incidence rate has increased or if there is less of a stigma for males seeking treatment. We have seen, particularly in the last year, an upsurge in our male population.

IMCJ: Ms. Bonnar-Pizzorno may I ask how you came to this work? What your background is, where you grew up, and what led to your interest in nutritional issues?

Raven Bonnar-Pizzorno: I grew up in Seattle and was raised in a medical family. Joseph Pizzorno, ND is my father. I studied at the University of Washington and Bastyr University. I became interested in nutrition from listening to Buck Levin, RD, PhD; nothing is more fascinating than nutrition when described by Buck. I became interested in working with eating disorders during my dietetic internship. I actually did a rotation at the Moore Center. It is very rewarding to see people become human beings again and heal their relationship with food.

IMCJ: Please describe how you feel dieticians and nutritional experts can contribute to assessment and treatment of patients with eating disorders.

Raven Bonnar-Pizzorno: We do four key things. We help the patient improve their health. We provide a reality check for the patient, their families, and for their other health-care providers. We monitor behaviors and we provide education. Nutrition is the foundation of someone's physical health, and it can have a stabilizing effect on mental health. The research shows that the effectiveness of psychotherapy in a malnourished person is really limited until they are getting enough blood sugar to their brain. We also know that anti-depressants have limited effectiveness in a malnourished person because they don't have enough free proteins in the bloodstream for the medication to bind to.

IMCJ: What kind of knowledge about nutrition do most people with eating disorders have when they come to the center?

Raven Bonnar-Pizzorno: [laughing] My colleagues and I will never be able to count calories as well as our patients do. Unfortunately, there are a lot of reasonable principles of nutrition and exercise that really get taken to the extreme in eating disorders. They're also very receptive to a lot of the diet crazes that are out there and take those to the extreme, too. There's definitely a lot of misinformation, which we address in the education that we do. An example: People often feel that if they don't exercise on a given day that they shouldn't eat anything at all that day. So we talk about things like resting metabolic rate—what the body needs to function—even if we didn't get out of bed all day.

IMCJ: Your facility has demonstration kitchens and supported mealtimes. What are these mealtimes like for patients? What is a supported mealtime?

Raven Bonnar-Pizzorno: In our facility, patients are either assembling a simple breakfast or lunch, like a sandwich, or plating hot food for dinner. It's all under the monitoring of one of the nutrition staff. We're checking that their portions are correct for following their meal plan and that there are normalized combinations of food. During the actual mealtimes, there's a lot of monitoring for disordered behavior. Are they excessively cutting up their food? Are they refusing to close their lips around the fork when they take a bite? There are long lists of such behaviors that we're looking for. We really try to keep the eating disorder away from the table during mealtimes. The process of eating—and eating as much as someone needs to—is often very challenging. There's also emotional support around completing their meal.

IMCJ: Do you, as the head of the Nutritional Department, need to monitor the calories per patient? Is it that specific?

Raven Bonnar-Pizzorno: At the day hospital's level of treatment, all of their food intake is recorded and calculated and charted.

IMCJ: What about teaching patients how to eat out at restaurants, do you offer guidance for that kind of behavior?

Raven Bonnar-Pizzorno: Absolutely, we do restaurant outings. Patients have to order their own food. The nutrition staff helps them figure out how to portion the meal so that it follows their meal plan. Part the experience is just about desensitizing becausea lot of our folks really struggle with social eating, as well. A therapist attends the outing, too, to process and support.

IMCJ: You mentioned earlier that there are certain nutritional deficiencies that can make it harder for patients with eating disorders to recover, such as lack of protein and lack of sugar for the brain. Are there any other absences that can exacerbate the situation if someone is fasting or low on nutrients?

Raven Bonnar-Pizzorno: Across the board, there are a lot. Potassium deficiency is the one that we're most concerned about because it can be life-threatening. That occurs in people who purge, who abuse laxatives, or in people with anorexia as well. We're in the Pacific Northwest, so it's very common for our patients to have a vitamin D deficiency, and many of our patients are depressed. There's a lot of low vitamin B12 levels due to restricting, specifically of animal foods. There's a lot of essential fatty acid deficiency. The US, in general, isn't getting enough omega-3s, and then specifically in the eating-disorder population fats are usually a fear food and even more severely restricted.

IMCJ: Are you offering vitamins and supplements in addition to specific foods that are particularly helpful to people with eating disorders?

Raven Bonnar-Pizzorno: Yes, definitely. Anemia is another common deficiency. Thiamine is an important one when patients start the refeeding process. It helps to reduce their risk of refeeding syndrome, which is a life-threatening condition.

IMCJ: Could you explain that please?

Raven Bonnar-Pizzorno: If a person who's starving starts eating too much food too fast, their blood sugar levels go high. All the phosphorus then moves out of the bloodstream and into cells causing a dangerously low phosphorus level, which can be life-threatening. Restoring low phosphorus levels to normal is key, but supplementing with thiamine helps to reduce that risk.

IMCJ: You mentioned earlier that there's a resistance to consuming fat. Is there a correlation between people with eating disorders and choosing vegetarian diets?

Raven Bonnar-Pizzorno: Yes. Any time there's a socially acceptable excuse for restricting food intake, our patients will use it. There's a lot out there that people use to restrict.

IMCJ: How do you combat problems with dehydration and changes in metabolic rate and other physiological things that happen with fasting? When patients come in, do you do a complete work-over to see what state they're in?

Raven Bonnar-Pizzorno: It's very common for patients to be dehydrated. It may be due to restricting fluid intake. It may be due to purging or laxative abuse. We do a lot of work to encourage fluid intake and to explain things like, "your ongoing headaches and constipation are probably due to dehydration. Let's see if you feel better if you drink some more water." Sometimes they need to get IV fluids with their primary-care doctor. It is very person-specific.
It is very common for people to have suppressed metabolism because of the restricting. We just have to consistently meet their needs with their meal plan and then the body returns to normal. Hypermetabolism is a common phenomenon when people are underweight and refeeding. Unfortunately, they just need more and more food intake to restore weight when they have hypermetabolism.

IMCJ: Are there occasionally thyroid issues or is that not usually involved?

Raven Bonnar-Pizzorno: There often are. That's one of the things we test for in our routine lab work. Being underweight can actually cause labs to look a little hypothyroid, and it often returns to normal when their food intake improves. They follow up with their primary care physician for any abnormalities in the thyroid.

IMCJ: How long does it take for a patient with an eating disorder to learn better nutritional habits? Is it a matter of weeks or a matter of months?

Raven Bonnar-Pizzorno: I think it depends on how long they've been in the disorder and how severely they're in the disorder at the time that they start treatment, but certainly months.

IMCJ: Dr. Moore, what is the outlook for treating future eating disorders in this country? Has public understanding of this illness improved?

Dr Moore: I think that we are doing a better job of informing the public [through the] schools and also [through] the media. The eating disorder community has been much more active in working with the legislature and representatives to really make them aware of the illness and the fact that it requires ongoing care and treatment, like any other medical illness. We are doing a better job, but of course we're not there. We need to continue our effort, and campaign to make it more understandable for the public that it's not just a condition or vanity problem, but that there are definitely structural problems. This is a medical entity that needs treatment like anything else.