1: Describe the diagnostic criteria for anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). Include all types (binging/purging AN, restrictive AN, purging BN, non-purging BN), and discuss which type of eating disorder you believe Paris presents with. Provide examples to support your rationale. (Nelms, 269-270)

- **Anorexia Nervosa (AN), General:**
  - Refusal to maintain body weight at the minimum normal weight for age/height
    - Maintaining weight less than 85% of expected weight
  - Underweight, but has a tremendous fear of gaining weight or being fat
  - Denial of how serious current low body weight is, distorted perception of body weight/shape
  - Amenorrhea; absence of at least 3 menstrual cycles consecutively.
    - Or only having periods with hormonal control

- **Types of Anorexia Nervosa:**
  - **Restricting Type:** During the current period of anorexia, binge-eating or purging behaviors have not been present.
  - **Binge-Eating/Purging Type:** During current period of anorexia, binge-eating or purging behavior have occurred.

- **Bulimia Nervosa (BN), General:**
  - Recurring episodes of binging:
    - Eating an amount of food that is larger than most people would eat during the similar time and situation within any 2 hour time-period.
    - Lacking control over eating during the binge, feeling that they cannot stop eating or control how much they are eating.
  - Recurring purging/inappropriate behavior to prevent weight gain.
    - Ex: self-induced vomiting, abuse of laxatives, diuretics, enemas, medications, fasting, or excessive exercising.
  - Binge eating with inappropriate compensatory behaviors occurring both an average of twice a week for 3 months.
  - Self-worth/evaluation is extremely impacted by body shape & weight.
  - Does not occur exclusively during episodes of anorexia

- **Types of Bulimia Nervosa (BN):**
  - **Purging Type:** During current period of bulimia nervosa, self-induced vomiting, misuse of laxatives, enemas, and diuretics has occurred.
  - **Nonpurging Type:** During current period of bulimia, other inappropriate behaviors (like fasting and/or excessive exercise) have not been used but the person has not had self-induced vomiting, or misuse of laxatives, enemas, diuretics, etc.

- **Binge-Eating Disorder:**
  - Recurring episodes of binging:
    - Eating an amount of food that is larger than most people would eat during the similar time and situation within any 2 hour time-period.
    - Lacking control over eating during the binge, feeling that they cannot stop eating or control how much they are eating.
  - Distress about binge-eating
  - Binge-eating is associated with at least 3 or more of these characteristics:
    - Eating much faster than normal
    - Eating until feeling uncomfortably full
    - Eating large amounts of food when not feeling hungry physically
    - Eating alone because of embarrassment about how much the person is eating
    - Feeling depressed, disgusted with self, or extremely guilty after eating
- Binge eating not associated with inappropriate compensatory behaviors (such as purging, fasting, or excessive exercise) & does not occur exclusively during course of anorexia or bulimia nervosa.
- Binge eating occurs at least 2 days a week for 6 months, on average.

- **Paris**: The patient has the binge-eating/purging type of anorexia because:
  - Amenorrhea (hasn't had menstrual period in over 2 years)
  - Misusing laxatives every other day w/very good understanding of drug

2: Describe the common psychological, socioeconomic, and environmental characteristics of an individual with AN. (Nelms, 270).

- **Environmental/socioeconomic Characteristics**:
  - Family hx of mood disturbances
  - Physical or sexual abuse as a child
  - Feeling that there is little social support from family members
  - Pressures on females for being thin from societal messages

- **Psychological Characteristics**:
  - Low self-esteem
  - Elevated harm avoidance
  - Perfectionism
  - Conscientiousness
  - Persistence
  - Obsessiveness

3: What does research indicate about the possible role of genetics in eating disorders? (Nelms, 270-271).

- There is no specific gene for AN, BN, or EDNOS
- However, a person's risk for developing an eating disorder is larger if another person in immediate family member has an eating disorder, which may mean that genetics play a role.
- EX: If an identical twin has anorexia, the other twin has a 55% chance of becoming anorexic also. Fraternal twins would only have 5% chance of developing the disorder.

4: How does binge eating disorder (BED) differ from BN?

- Binge eating disorder is different than bulimia because the person does not try to purge or use other methods of maintaining body weight. Instead, the person feels disgusted and depressed about their binges.

5: What is the long-term prognosis for AN, BN, and BED? (Escott-Stump, 248.) & (Nelms, 272-274) & (http://www.aedweb.org/Course_and_Outcomes.htm)

- According to Escott-Stump, the majority of patients with EDs make a full recovery.
- According to Academy for Eating Disorders:
  - **AN**:
    - 50% Recover
    - 33% Improve somewhat
    - 20% remain chronically ill
    - Not as good of prognosis as bulimia nervosa
  - **BN**:
    - 50% recover
    - 30% improve somewhat
    - 20% continue to meet full-time criteria for BN
    - After 10 years, full recovery occurs in 50% of patients

- **Long-Term Consequences**:
- **AN**:
  - Bone mineral density may not reach the expected level for the patient's age and gender especially if AN develops in teenage years when the bones are developing and bone mineralization is peaking.
50% of females eventually develop osteoporosis
50% of males eventually develop a reduction in mineral density of femoral neck and lumbar vertebrae.

BN:
- Frequent vomiting can cause permanent erosion to tooth enamel
- Tearing of the esophagus or GERD can occur
- Rupturing of the stomach
- Renal damage with long-term laxative use

BED:
- Obesity and increased risk for obesity-related diseases

6: Describe the medical consequences associated with AN, BN, and BED. (Nelms, 271-274).

AN:
- Cold intolerance (hands and feet)
- Dry skin
- Alopecia
- Cardiac arrhythmias
- Low luteinizing hormone & follicle-stimulating hormone
- Reduced gastric emptying
- Constipation
- Lanugo (fine body hair)
- Salivary gland enlargement
- Acrocyanosis (fingers/toes with bluish tint)
- Hypercarotenemia (orange skin from large amounts of vegetables with carotenoids)
- Bardycardia
- Hypotension
- Orthostatic hypotension
- Hypothermia
- Anemia
- Leukopenia (low WBC count)
- Low plasma glucose
- High serum total cholesterol
- Low-normal serum values for thyroid hormones (T3 and T4)
- Dehydration
- Hypokalemia
- Metabolic alkalosis
- Reduced bone mineral density
- Amenorrhea

BN:
- Russell Sign: Callus on back of hand from using hand to vomit
- Cardiomyopathy/cardiac arrhythmias/electrocardiographic changes (if using syrup of ipecac)
- Loss of dental enamel
- Cavities
- Enlarged salivary gland
- Esophagitis (inflamed esophagus)
- GERD
- Tearing esophagus (Mallory-Weiss tears)
- Constipation/Laxative dependence
- Alkalosis
- Hypochloremia
- Hypokalemia
- Hypotension

BED: (http://win.niddk.nih.gov/publications/binge.htm)
- Stress
- Trouble sleeping
- Headache
- Muscle ache
- Menstrual problems
- Weight gain:
  - Increased risk for Type 2 diabetes, high blood pressure, cholesterol, gallbladder disease, heart problems, etc.


- **Starvation:** Long periods of time without eating any or enough food that the body requires to sustain normal functioning. The body responds by reducing overall energy needs.
- **Purging:** In any eating disorder where the goal is to "undo" or compensate for ingested calories. Ex. Self-induced vomiting, misuse of laxatives, enemas, colonics, diuretics, excessive exercise.
- **Binge-eating:** Defined as:
  - Eating a large amount of food that is larger than most people would eat in within 2 hours.
  - Lack of control over eating during episode
  - Eating faster than usual
  - Eating until uncomfortably full
  - Large amounts of food when not hungry
  - Eating alone because of embarrassment of the amount of food
  - Feeling disgusted or depressed afterwards

8: Describe the metabolic response to voluntary starvation. Compare Paris's signs and symptoms to the metabolic response to starvation. (Gropper, 362-364).

- Overall energy needs adapt to less food and decrease (metabolic rate decreases 20-25 kcal/kg/day)
- Metabolic fuel shifts to protein-sparing. Instead of gluconeogenesis dominating which is the case in the fasting state, lipolysis takes over and becomes the major supplier of fuel.
- Fatty acids become primary fuel for heart, liver and skeletal muscles.
- The glycerol from the fat breakdown is converted to glucose for the brain.
- Ketone bodies are produced and can also be used in the brain and muscles with adaptation.
- Eventually (~3 months or more) when fat stores run out the body starts using essential proteins for fuel which causes liver and muscle function loss. Eventually death occurs if starvation continues.
- Paris' signs & symptoms:
  - Emaciated, tired-looking
  - Bradycardia (slowed heart rate)
  - Labs showing signs of malnutrition (low albumin, prealbumin, magnesium)
  - High glucose levels- may indicate fatty acids backbones are being converted to glucose for brain

9: To be successful, treatment of eating disorders must include a team approach among physicians, registered dietitians, and psychologists. Describe the role of each in treatment. (Nelms, 274).

- **Physicians:** Assess medical status and provide medical treatments, medications, etc. to help patient with any medical problems they’re dealing with as a result of eating disorder. This may be to restore electrolyte imbalances, take laboratory tests, vital signs, etc. Also specialized physicians may be involved if the problem is focused on a certain aspect, such as renal doctors during kidney failure.
- **Registered dietitian:** Assess nutritional status of patient, address patient’s food and nutrition issues/behaviors, and to monitor responses to treatment. Also to communicate findings with other members of the team when necessary. Develops a nutrition plan, continual support for patient to accomplish goals that were established.
Psychologists: Psychologists are involved to help the patient realize their problems that caused them to develop an eating disorder, to discuss personal issues they are having and how they can overcome them, to establish better self-esteem and body image, and to be a support system. The psychologist engages in therapy to help the patient recover; there are many different approaches to treating ED's.

10: Why might it be necessary to include a psychiatrist as a member of the treatment team?
- Psychiatrists may be part of the treatment team because depression and other psychological conditions like mood disorders are common in eating disorders. The patient may help recover if their depression is treated or neurological imbalances are stabilized via medications. The psychiatrist can provide a psychological angle and have the ability to prescribe medications.

11: Briefly, what are the primary nutrition therapy goals for acute diagnosis of AN? How will these goals change as treatment progresses? (Nelms, 274)
- Acute AN:
  - Restore electrolyte imbalances and closely monitor for signs of refeeding syndrome.
  - Restoring pt's weight to at least 90% of expected weight (usually through normal oral feedings)
    - Initially energy intake should be 30-40 kcal/kg of body weight which is then advanced with the patient's progress. During weight gain, energy intake can be as high as 70-100 kcal/kg.
- As Treatment Progresses:
  - Energy intake shifts to 40-60 kcal/kg body weight to maintain weight and allow for proper growth for kids and adolescents.
  - Quitting weight loss behaviors
  - Improving eating behaviors
  - Improving emotional and psychological health

12: What are the primary nutrition therapy goals for BN? (Nelms, 275).
- Reduce bingeing and purging cycle
- Normalize patient's eating habits
  - Using a set schedule of snacks and meals that help patient not be hungry which can trigger a binge.

13: What are the primary nutrition therapy goals for BED?
- Establish regular pattern of eating to replace binge eating, using alternative behaviors to avoid bingeing.
- Eliminate all aspects of restrained eating and "forbidden" foods
- Correct imbalances that have occurred as a results of BED. (weight, electrolytes, etc.)

14: Describe prevention strategies that could reduce a person's risk of developing AN, BN, or BED. (http://www.nationaleatingdisorders.org/nedaDir/files/documents/handouts/EDsPrev.pdf)
- **Primary prevention**: programs that are created to prevent eating disorders before they begin.
  - Student Bodies Prevention Program at Stanford and Washington University; gives tools about assessing self-esteem body image, etc. while also giving information about nutrition, exercise, etc.
  - Operation Beautiful: a series of books that started from a blog that enforces the beauty everyone has in each of us, promoting self-esteem and positive body image.
- **Secondary prevention** (sometimes called “targeted prevention”) refers to programs or that encourage the early awareness of an eating disorder—recognize and treat an eating disorder before it takes over someone's life. The sooner an ED is discovered and addressed, the better the chance for recovery.
- **Avoiding yo-yo dieting or crash-dieting**: these usually cause people to restrict too much which leads to bingeing or unhealthy ideals like cutting entire food groups or eating excessively low calories which can lead to eating disorders.
- **Go to counseling**: If someone is having psychological issues either intrapersonally or interpersonally, a psychologist or counselor can help them express their emotions and find a healthy outlet for their problems.
• **Don't strive for perfection:** Realizing there is no such thing as a perfect body or a perfect diet and that we are all different is key to not developing an eating disorder.

15: **What are the typical differences in body weight between someone with AN and someone with BN?** (Nelms, 271).

- Someone with AN has very low body weight, DSM-IV classifies someone with AN to be someone with less than 85% expected weight for age and height.
- Someone with BN is usually in a normal weight range.

16: **Calculate and interpret Paris’s BMI.**

- 68 inches → 1.727 m
- 115 lbs → 52.27 kg
- \(52.27 kg / (1.727 m)^2 = 17.5 \text{ kg/m}^2\)
- This is considered underweight. The cutoff for diagnosing anorexia is not defined (Nelms, 271), but a BMI of 17.5 is low. Some sources believe that below 16 \(\text{kg/m}^2\) is considered anorexia, whereas other sources say that 17.5 \(\text{kg/m}^2\) is the cutoff point.

17: **What would be an appropriate weight for her in 1 month? In 3 months? In 1 year? Describe the rationale for choosing the weight values you did.** (Nelms, 275).

- **1 month:**
  - **Inpatient:** 123-127 lbs
  - **Outpatient:** 117-119 lbs
- **3 months:**
  - **Inpatient gone to outpatient:** 124-131 lbs
  - **Outpatient:** 119-123 lbs
- **1 year:**
  - 126-154 lbs
- **Rationale:**
  - **Hamwi equation for IBW:** 100 + (5)8= 140 lbs +/- 10%
    - IBW: 126-154 lbs
  - Recommended weight gain for inpatient treatment is 2-3 lb/week and outpatient is 0.5-1 lb/week.
  - After a year, even if she gained the minimum amount in outpatient treatment (2 lbs/month) she would be at a healthy weight range.

18: **Calculate the outpatient treatment energy requirements for Paris.** (Nelms, 275).

- **Beginning treatment:**
  - 30-40 kcal/kg/day
  - 30 x (115/2.2)= 1,568 kcals/day
  - 40 x (52.27)= 2,090 kcals/day
  - **1,568-2,090 kcals/day for beginning outpatient treatment**
- **Active weight gain:**
  - 70-100 kcal/kg/day
  - 70 x 52.27= 3,659 kcals/day
  - 100 x 52.27= 5,227 kcals/day
  - **3,659-5,227 kcals/day for active weight gain**
- **Weight Maintenance**
  - 40-60 kcal/kg
  - 40 x 52.27= 2,090 kcals/day
  - 60 x 52.27= 3,136 kcals/day
  - **2,090-3,136 kcals/day for weight maintenance in outpatient therapy**
19: Using her 24-hr recall, calculate this patient’s current energy and protein intake. (see attached)
   - **Energy**: 126 kcals/day
   - **Protein**: 4 gm/day

20: List any nutrition problems within the intake domain using the appropriate diagnostic term.
   - Inadequate energy intake
   - Inadequate oral food intake
   - Inadequate fat intake
   - Inadequate protein intake
   - Inadequate carbohydrate intake
   - Inadequate fiber intake

21: Evaluate Paris’s lab results. (Pagana, pgs. 440-441, 473, 416, 267, 266, 203, 519, 543)

<table>
<thead>
<tr>
<th>Lab</th>
<th>Patient's Lab Results</th>
<th>High or Low?</th>
<th>Possible Causes/Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin</td>
<td>3.0 g/dL</td>
<td>Low</td>
<td>Malnutrition &amp; Overhydration</td>
</tr>
<tr>
<td>Prealbumin</td>
<td>14.5 mg/dL</td>
<td>Low</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>Sodium</td>
<td>148 mEq/L</td>
<td>High</td>
<td>Laxative use</td>
</tr>
<tr>
<td>Potassium</td>
<td>3.0 mEq/L</td>
<td>Low</td>
<td>Laxative use &amp; insufficient dietary intake</td>
</tr>
<tr>
<td>Magnesium</td>
<td>1.7 mg/dL</td>
<td>Low</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>Glucose</td>
<td>115 mg/dL</td>
<td>High</td>
<td>Prolonged fasting, stress, moderate to intense exercise (interfering factor)</td>
</tr>
<tr>
<td>CPK (Creatine phosphokinase)</td>
<td>146 U/L</td>
<td>High</td>
<td>Recent strenuous exercise (interfering factor), hypokalemia, possible heart problems</td>
</tr>
<tr>
<td>HDL-C</td>
<td>60 mg/dL</td>
<td>High</td>
<td>Excessive exercise</td>
</tr>
<tr>
<td>T3- Resin uptake</td>
<td>70 mcg/dL</td>
<td>Low</td>
<td>Hypoproteinemia (protein malnutrition)</td>
</tr>
<tr>
<td>WBC</td>
<td>4.6 x 10^3/mm^3</td>
<td>Low</td>
<td>Dietary deficiency (ex. vitamin B12, iron deficiency)</td>
</tr>
</tbody>
</table>

22: During nutritional repletion, Paris should be monitored closely for refeeding syndrome. What are the characteristics of refeeding syndrome? (Nelms, 92-93)
   - Refeeding syndrome can occur during repletion of starved patients such as those who are malnourished, long-term history of poor oral intake, patients who have not eaten much in the last several days due to being NPO or having lack of appetite.
   - During starvation the body shifts to use ketones as fuel and when refeeding occurs and glucose is present again, a large amount of phosphorous, magnesium, potassium, and thiamin are needed for glucose metabolism. This causes the levels to drop and severe problems can occur if these levels are not watched carefully and refeeding has to be done slowly.
   - Hypomagnesemia
     - tremor
     - muscle twitching
     - cardiac arrhythmias
     - paralysis
• Hypokalemia
  o cardiac abnormalities
• Thiamin deficiency
  o Wernicke’s encephalophathy
• Low phosphorous
  o hemolysis
  o impaired cardiac function
  o impaired respiratory function
  o possibly death

23: Why was the EKG ordered? (Nelms, 272)
• An EKG was ordered because AN puts you at risk for several heart conditions including:
  o Bradycardia (slow heart rate, <60 beats/minute)
  o Hypotension (low blood pressure, systolic BP <90 mmHg)
  o Orthostatic hypotension (low blood pressure when you stand)
  o Cardiac arrhythmias (disruption of heart beat pattern, irregular heart beat)
  o Electrocardiographic abnormalities (determine rate of heartbeat, size of chambers, heart tissue damage, etc)

24: Identify a minimum of five questions that the dietitian would ask regarding Paris’s purging behaviors.
1. How many laxatives do you take?
2. How do you feel before you take the laxatives? After?
3. How often do you exercise and for how long?
4. What type of activities do you do for exercise?
5. Do you use any other purging methods such as self-induced vomiting or chewing and spitting?

25: Paris asks you for a list of “good” foods to eat and “bad” foods to avoid. What should you tell her?
• There really are no "good" or "bad" foods. All foods can and should be incorporated into a healthy diet. Whole and natural foods such as fruits and vegetables are great, but a healthy diet should be well-rounded and include birthday cake and chocolate on occasion.

26: From the information gathered, list possible nutrition problems within the behavioral–environmental domain using the appropriate diagnostic term.
• Harmful beliefs/attitudes about food- or nutrition-related topics (possibly)
• Self-monitoring deficit
• Disordered eating pattern
• Excessive physical activity (possibly)
• Inability or lack of desire to manage self-care

27: Select two nutrition problems and complete PES statements for each.
• Inadequate oral food/beverage intake (NI-2.1) related to history of disordered eating patterns and purging as evidenced by energy intake of 6% (126 kcals) of estimated energy needs (1,568-2,090 kcals/day).
• Inability or lack of desire to manage self-care (NB-2.3) related to reverting to restricting and purging food after attempts to cease behaviors as evidenced by current BMI of 17.5 kg/m² and self-limited dietary intake of 126 kcals daily on nutrient analysis.

28: For each PES statement written, establish an ideal goal (based on signs and symptoms) and an appropriate intervention (based on etiology).
• PES #1:
  o Goal:
Average daily energy intake of 1,568-2,090 kcals to begin treatment.

Intervention:
- Nutrition Education (E) - purpose of nutrition education (E-2.1) for the purpose of training leading to knowledge to modify distribution, type, or amount of food and nutrients within meals (ND-1.2).

PES #2:
- Goal:
  - Reduction of purging and restricting behaviors (<2 x per week) with goal of cessation.
- Intervention:
  - Coordination of Nutrition Care (RC) - Referral to RD with different expertise, i.e. eating disorder specialist (RC-1.2) for the purpose of nutrition counseling (C) to increase ability to manage care and eliminate restricting and purging behaviors.

29: When should you schedule your next counseling session with Paris?
- I would think she would be a moderate-to-low risk patient and in an inpatient setting I would see her in 3-5 days and outpatient I would see her in 2 weeks.

30: What parameters can be used to measure Paris’s response to treatment?
- Monitoring progress & outcomes:
  - Anthropometric measurements (if she has gained weight, body fat, etc.)
  - Lab Values (to see if malnourishment has improved and electrolytes restored)
    - Albumin/prealbumin, sodium, potassium, magnesium, glucose, etc.
  - General attitudes and beliefs about treatment and her progress
    - If she is motivated, depressed, positive/negative about treatment
  - Physical signs
    - Lanugo, temporal wasting, etc

31: What would you assess at this follow-up counseling?
- I would assess all of the following from question #30.
- In addition, I would ask to record a food journal and would review it at the session. She could potentially be deceptive at this step, but it would help me to get an idea of where she is at in her treatment as far as progress.
- I would also ask her what problems she has been facing and what support she is getting from her family and friends so that we can work on solving current problems and reaching new goals.

32: What medical conditions warrant residential or inpatient treatment?
(http://addiction.lovetoknow.com/wiki/Criteria_for_Hospitalization_for_Anorexia)
- Weight loss exceeds 25% of total body weight over 3 months
- Infection of any kind (anorexia can complicate infection)
- Heart rate falls below 40 beats per minute (bradycardia) or above 110 beats per minute (tachycardia)
- Vomiting of blood
- Severe dehydration
- Anemia
- Abnormally low temperature
- Abnormally low serum potassium (hypokalemia)
- Electrolyte imbalances
Compare three eating disorder treatment facilities (e.g., discuss treatment options, treatment model, and the facilities' professional staff).

<table>
<thead>
<tr>
<th>Treatment Facility</th>
<th>Treatment Options</th>
<th>Treatment Model</th>
<th>Professional Staff</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>John Hopkins Advantage</strong></td>
<td>-Integrated inpatient</td>
<td>Full continuum of care w/individualized plans</td>
<td>-Director: M.D.</td>
<td>-Nationally recognized program with over 30 years experience in the</td>
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<tr>
<td>(<a href="http://www.hopkinsmedicine.org/psychiatry/specialty_areas/eating_disorders/">http://www.hopkinsmedicine.org/psychiatry/specialty_areas/eating_disorders/</a>)</td>
<td>-Partial (day) hospital</td>
<td>-Behavioral, cognitive, dialectical, and supportive therapies in group settings and one-on-one</td>
<td>-Assisting director: M.D.</td>
<td>treatment of anorexia nervosa, bulimia and other eating disorders</td>
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<td>-Outpatient</td>
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<td>-Attending psychiatrists</td>
<td>-Family therapy, parent training and family support group</td>
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<td>-Nurse managers</td>
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<td>-Clinical nurse specialist</td>
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<td>-Admissions coordinator: M.S.</td>
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<tr>
<td><strong>Victorian of Newport Beach</strong></td>
<td>-Inpatient treatment with 4 &quot;step-down&quot; levels</td>
<td>Individualized treatment plans that apply multi-disciplinary approach to treatment while following the 12-step recovery principles.</td>
<td>-psychiatrists</td>
<td>-In Newport Beach</td>
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<td>(<a href="http://www.eatingdisordertreatment.com/discover-the-victorian/how-the-victorian-program-works">http://www.eatingdisordertreatment.com/discover-the-victorian/how-the-victorian-program-works</a>)</td>
<td>-Intensive outpatient treatment</td>
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<td>-psychologists</td>
<td>-Offers an “at home” setting</td>
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<td>-marriage and family therapists</td>
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<td>-nurses</td>
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<td>-addictionologists</td>
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<td><strong>Avalon Hills</strong></td>
<td>-Adult Residence</td>
<td>Stage-based readiness model of change</td>
<td>-Leadership: Ph.D.</td>
<td>-Offers experimental therapy and activities such as animal-assisted</td>
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<td>-Clinical Psychologists</td>
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<td>-Exercise department</td>
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<td>-Direct Care: M.S.</td>
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<td>-Educational Department</td>
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<td>-Admissions Department</td>
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