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Treating Eating Disorder Symptoms in the context of Comorbidity

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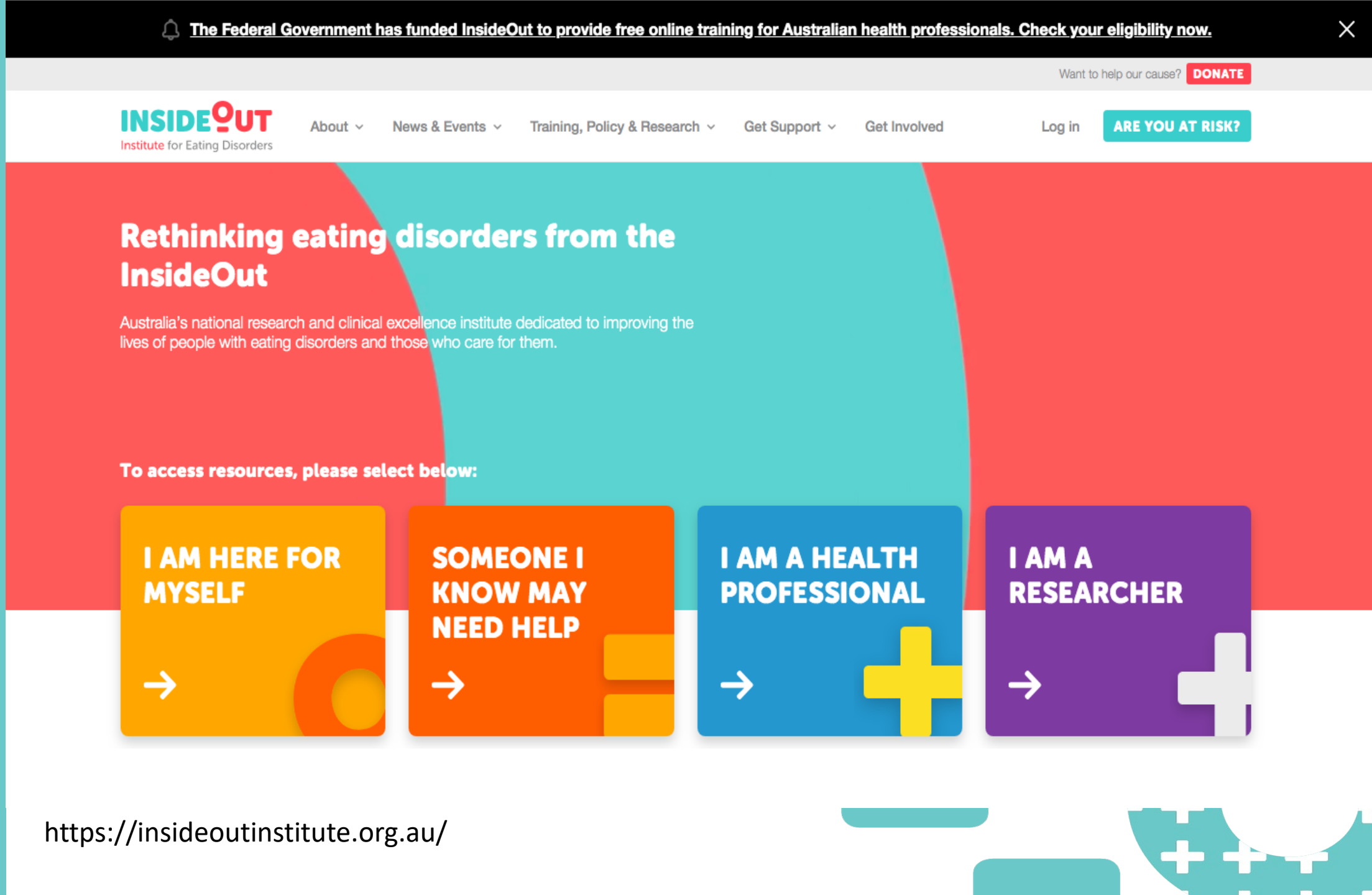

https://insideoutinstitute.org.au/

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Comorbidity in eating disorders
is the NORM
not the exception

NSW GOVERNMENT Health

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What are eating disorders?

- Eating disorders are mental illnesses marked by overvalued ideas, extreme **fears** (phobias), obsession and compulsions centering around food, weight and shape
- Often accompanied by depression, preceded by childhood anxiety disorders and/or co-morbid with other psychiatric disorders (D&A, Axis II, OCD)
- Anorexia first described 1873, introduced to DSM-I (1952) DSM-III Eating Disorder
- BN first described 1980's included in DSM iv
- BED only included in DSM 5
- EDNOS OSFED

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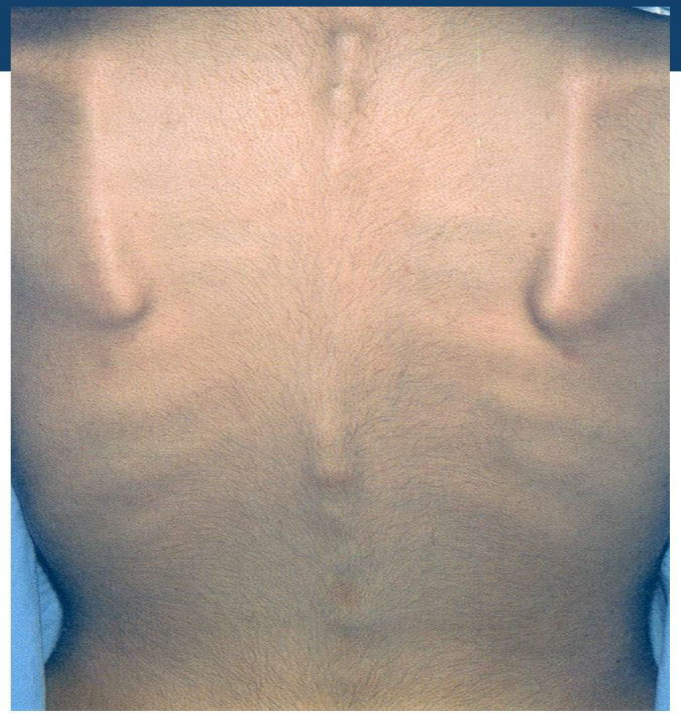
What are Eating Disorders?



https://youtu.be/BVKYT8iXFtM?t=61

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Co-morbidity

- Lifetime **psychiatric comorbidity** is high in EDs
- AN – 56-98% lifetime comorbidity, BN – 88-97% (Hughes et al, 2013), BED – 79% (National Institute for Mental Health)
- Highest across all EDs is major depressive disorder and anxiety disorders
- Other mood disorders, substance use and personality disorders, trauma
- Significant **medical comorbidities**

Psychiatric co-morbidity

- Dual diagnoses - poorer prognosis, higher misdiagnosis, increased social and psychosocial impairment, decreased quality of life, higher rates of mortality and a more chronic course of illness (Bodell, Brown, & Keel, 2012; Hughes, et al., 2013; Pollock & Forbush, 2013)

- More likely to seek treatment than those with a single diagnosis
- But **are often excluded** from treatment programs & intervention/outcome trials

IDEALLY…

Mental and other healthcare teams should collaborate to support integrated treatment of physical and mental comorbidities

BUT

The Health System is not structured to deal with these comorbidities in this integrated, collaborative way

Instead, patients with comorbidities are labelled “tricky”, “resource draining”, “treatment resistant”, “non-compliant”

STILL

Eating disorder behaviours serve very similar functions as other coping behaviours like D&A, gambling, self-harm…and can be targeted in therapy in the same way. The interventions we bring to other coping behaviours can be helpful for ED behaviours

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IOI Screener & EDE - Q

Self-report tool which assesses eating disorder pathology

On how many of the past 28 days:

1. Have you been deliberately *trying* to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?

0 days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day

2. Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?

0 days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day

InsideOut's online screener and online Eating Disorder Examination Questionnaire (EDE-Q), which is automatically scored, graphed and normed online

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Treatment Principles
Person-centred care

- Collaboration & empathy
- Engagement is crucial
- Externalising - see the person as separate to the illness
- Ambivalence is core part of an eating disorder – roll with resistance
- Stages of change – meet patient at motivational stage of change
- Clear communication – be aware of cognitive impairment
- Avoid comments about physical appearance (*'you don't look like you have an eating disorder; you're looking so much healthier'; you look good')*

These clients are engaging in a constant battle with the eating disorder.

We need to work **with** the person, **against** the illness.

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Treatment Principles: The Multidisciplinary Team

- Medical Practitioner
  - General Practitioner (GP)
  - Psychiatrist/Paediatrician
- Mental Health Professional
  - Clinical Psychologist/Psychologist
  - Social Worker
  - Occupational Therapist
- Dietitian (depending on the type of treatment)

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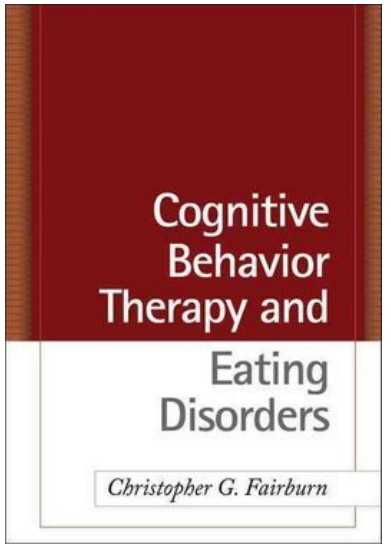
Treatment Principles:
Primary Targets of Therapy for EDs

1. Being under weight (below BMI 19) or striving to be
2. Binge eating – deprivation driven, emotionally driven & other
3. Purging behaviours
4. Excessive exercise
5. Over-evaluation of weight and shape in structure of self
   - Core psychopathology
6. Over-evaluation of control over-eating in structure of self
   - Especially concerned with details of eating
7. Dietary restriction & restraint
   - Physiological and psychological deprivation
   - Dietary rules
8. Food as a numbing, avoiding or coping strategy: Event/mood triggered eating or restriction
9. Other functions the ED may serve: protection, avoiding maturity, re-organising the family, identity, something for me
10. Poor quality of life, or very limited quality of life domains: relates to identity
11. Faulty beliefs and food weight shape

Treatments:
Cognitive Behavioural Therapy for Eating Disorders

- Cognitive Behavioural Therapy (CBT) for EDs (CBT-ED)
- CBT-Anorexia Nervosa (AN) (CBT-AN)
- CBT for Bulimia Nervosa (BN) and Binge-eating Disorder (BED) (CBT-BN and CBT-BED)



Originally adapted from CBT for depression and anxiety the first manuals for treatment of AN and BN were published in 1980's

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CBT for Eating Disorders

- Focuses on interaction between overvalued ideas regarding weight and shape and strict dieting that leads to disordered eating behaviours
- Includes prescription of regular normalised eating, graded exposure to feared foods, monitoring and challenging behaviours & distorted thoughts
- Targets restriction, binging, purging, exercise, body checking & avoidance as key behavioural targets
- Also targets perfectionism, mood intolerance, low self-esteem, and interpersonal problems

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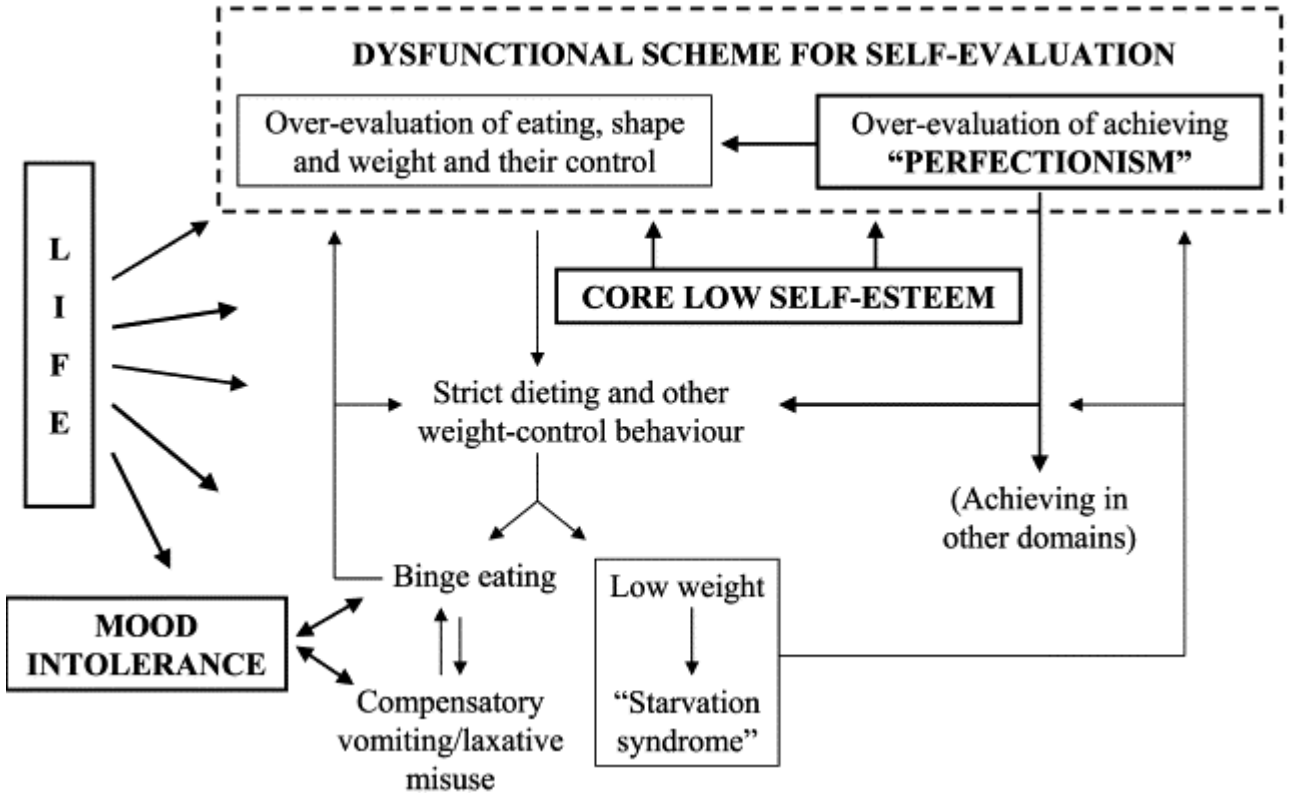
Formulation



Created jointly
"Work in progress"

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Stage 1: Starting Well

Four Aims:

1. Engagement, need for change, maintain engagement
2. Increase understanding of problem:
   I. Personalised formulation
   II. Establish real-time self-monitoring
   III. Personalised psycho- education
3. Psycho-educate about weight and weight change (reduce concerns about weight)
4. Introduce and establish regular eating

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Collaborative Weighing

- **Requires training** – very triggering for client
- Opportunity to educate about weight
- Provides objective data
  - Fear of weight gain when changing eating habits
- Therapist can help with interpreting number and managing reaction
- Challenges checking / avoidance behaviours
- Duty of care

One cannot interpret a single reading as meaningful data

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Regular Eating

- Foundational part of treatment for any ED
- Nutritional rehabilitation, weight restoration
- Results in decrease in binge eating
- Provides structure and predictability
- Improved hunger and fullness cues

3 planned meals + 2-3 snacks
Not eating outside of this

Cognitive challenging of dietary rules

- Address unhelpful beliefs regarding dieting
  - E.g. “if I eat this kit kat, I may as well binge”, “If I eat a burger I will gain 5 kg”
  - Follow up with behavioural tasks
    - May do exposure in session
  - Encourage social eating and eating out
- “Supermarket exercise”
  - Systematically challenge feared foods
- Strict rules might include:
  - Only eating certain no. KJ / day
  - Eating less than others present
  - Only using certain plates/ cutlery
  - Not eating in front of others

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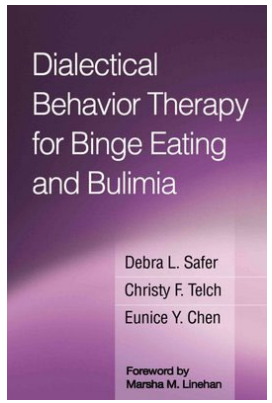
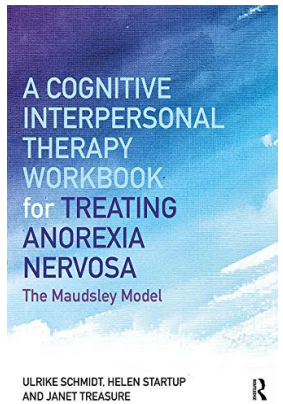
Other treatments

- Motivational Enhancement Therapy
- Specialist Supportive Clinical Management (SSCM) for all EDs
- Maudsley Model of Anorexia Treatment in Adults (MANTRA)
- Interpersonal Therapy (IPT) for BN, BED
- Dialectical Behavioural Therapy (DBT) for BN, BED
- Focal psychodynamic therapy for all EDs





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MET: How does ambivalence present in EDs?

Illness denial

Treatment refusal

Presenting with other problems

"Sabotage" of treatment

Rationalising

Defensive

Secrecy

Lack of behavioural change

Premature discontinuation

Stages of Change

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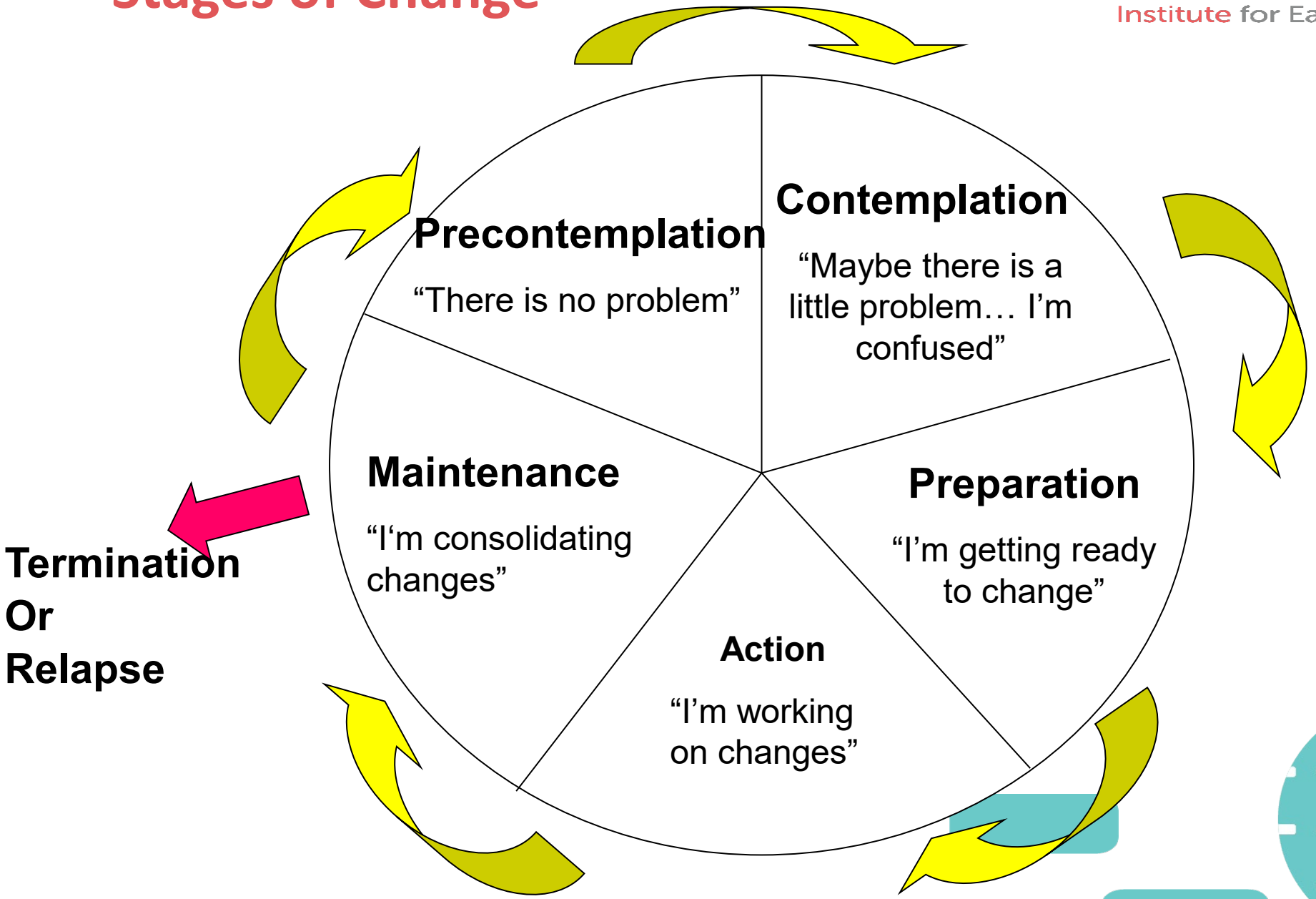

“OARS”: The Backbone of MET

- Ask **Open**-ended questions
- **Affirm**
- Listen **Reflectively**
- **Summarise**

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Methods for eliciting change talk

Evocative open-ended questions:

- *How do you want your life to be different?*
- *How confident are you that you could stop?*
- *What effect has the eating disorder had on your life?*
- *How important is it for you to change this?*
- *What do you think you might do about it?*

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Methods for eliciting change talk (2)

Looking backwards

- *What has changed in your life since the ED?*
- *What were things like before this?*

Looking Forward:

- *If you managed to overcome this, how would you like things to be different?*
- *5 years from now, how would you like your life to be? How would it be if the ED was still around? If it wasn't?*

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Principles of MET: "EARS"

1. **E**xpress Empathy
   - Seek to understand
   - Unconditional positive regard (Rogers 101)
   - Highlight that ambivalence to change is normal
2. **A**mplify Ambivalence
   - Understand the ambivalence
   - Not argue with it
3. **R**oll with Resistance
   - Resistance is an interpersonal phenomenon
   - Resistance is a signal of dissonance
4. **S**upport Self-efficacy
   - Encourage a "can do" attitude!
   - Allowing client's ownership of ability to change

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"Roll with Resistance"

- Amplified reflection:
  - Client: I don't know what the big deal is. Everyone is way too worried about me
  - Therapist: So from your point of view, your partner has no reason to be concerned about your eating
  - Client: Well I guess she has some reasons. It seems to cause her a lot of stress.
- Reflect the emotion
  - Client: What would you know, you don't have this
  - Therapist: Are you concerned I won't be able to help (vs listing your credentials)

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Stage 1 Primary Targets

Dialectical Synthesis

Severe Behavioral Discontrol → Behavioral Control

(this includes all ED behaviours)

- Decrease
  - Life-threatening behaviors
  - Therapy-interfering behaviors (client and therapist)
  - Quality-of-life interfering behaviors
    - Eating Disorder Behaviours included here
- Increase behavioral skills

Core Mindfulness
Distress Tolerance
Interpersonal Effectiveness
Emotion Regulation
Self-Management

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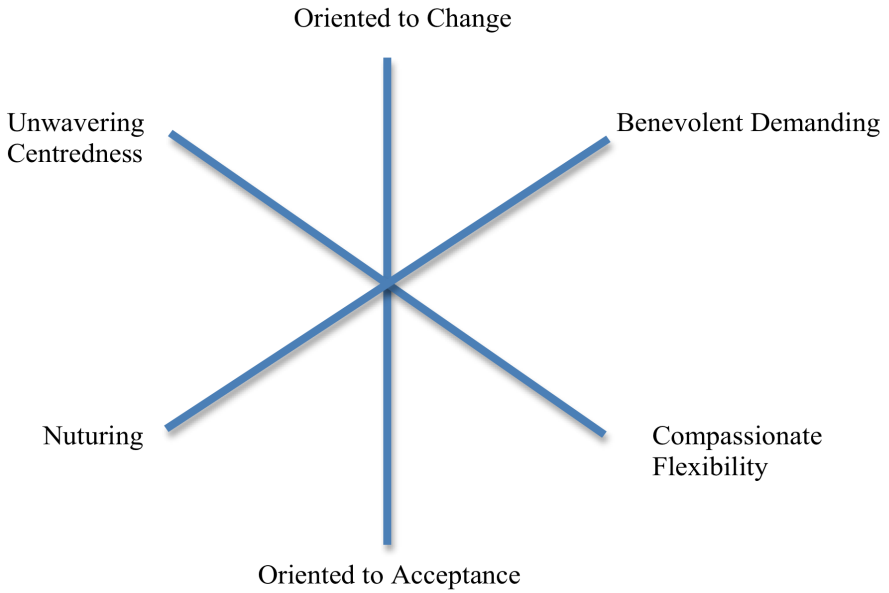
DBT Assumptions about Therapy

- Patients Are Doing the Best They Can
  - Even when they say they were just not trying
  - Telling patients to try harder, invalidation ineffective
- Patients want to improve
  - If they have presented or called for help a part of them must want to improve
  - Still analyse all the factors that interfere with motivation
  - Seeing failure to improve as failure of intent decreases motivation
- Patients need to do better, try harder and Be more motivated to Change
  - Your job to analyse deterrants and negative reinforcers and to motivate and help do better
- Patients may not have Caused all of their own Problems but they have to Solve them anyway
  - Change will not happen by coming to therapy, gaining insight and receiving nurturance
  - Therapist cannot save patient AND patient cannpt do it alone
  - Important to pt out especially in crisis
- The lives of the suicidal clients are Unbearable as they are currently being Lived
  - Their appraisal is valid
  - We must change life

Therapist Characteristics



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Chain Analysis

- Behavioural technique (behavioural analysis)
- Analysing a specific instance of behaviour
- Events and factors leading up to
- Idenitify important factors influencing or controlling the behaviour
- Including elements in environment that trigger
- Skills and motivational deficits interfering with ability to avert
- Solve the problem behaviour by generating solutions to identified elements of CA

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SSCM-SE Aims

- To achieve relief of the core symptoms of the eating disorders
- To encourage more normal eating
- To facilitate some weight gain when needed (reduction in B/P)
- To reduce the impact of the patient's eating disorder on their quality of life
- To foster and maintain a therapeutic relationship between patient and clinician that facilitates the establishment of normal eating
- Particularly good match for chronic or highly ego-syntonic ED presentations

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Focus on Quality of Life

- Family relationships
- Intimate relationships
- Friendships
- Work (job / education)
- Leisure / interests
- Social activities
- Financial stability

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Outline of an SSCM Session

- Review patient's general progress
- Monitor target symptoms
- Use Target Symptom Checklist
- Review patient's general progress (how are things going?)
- Acknowledge and praise ANY attempts at changes, roll with resistance
- Review the patient's eating patterns through dietary recall or dietary diary
- Support and encourage regular eating
- Weighing

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Example of an SSCM Target Symptom Checklist

Name: **Session number:** **Date:**

Changes since last session:
(note frequency /severity where appropriate)

Weight:.....kg Change since last session:.....kgs

Eat regular meals:_____

Exercise rules: _____

Caffeine use: _____

Self-harm: _____

Self-confidence: _____

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A world-first early intervention strategy

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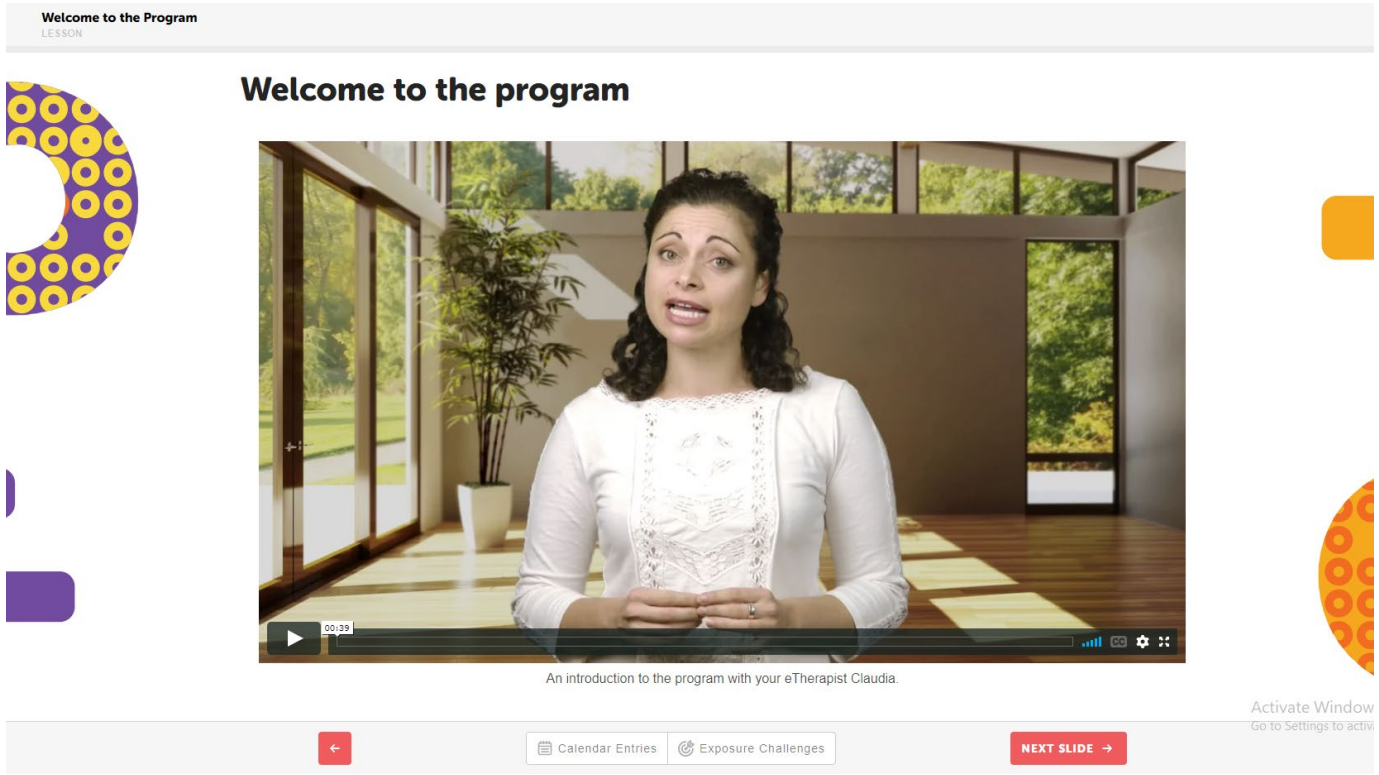
E-Therapy for Eating Disorders



Pure-Self help
Guided Self-help
4 or 10 sessions

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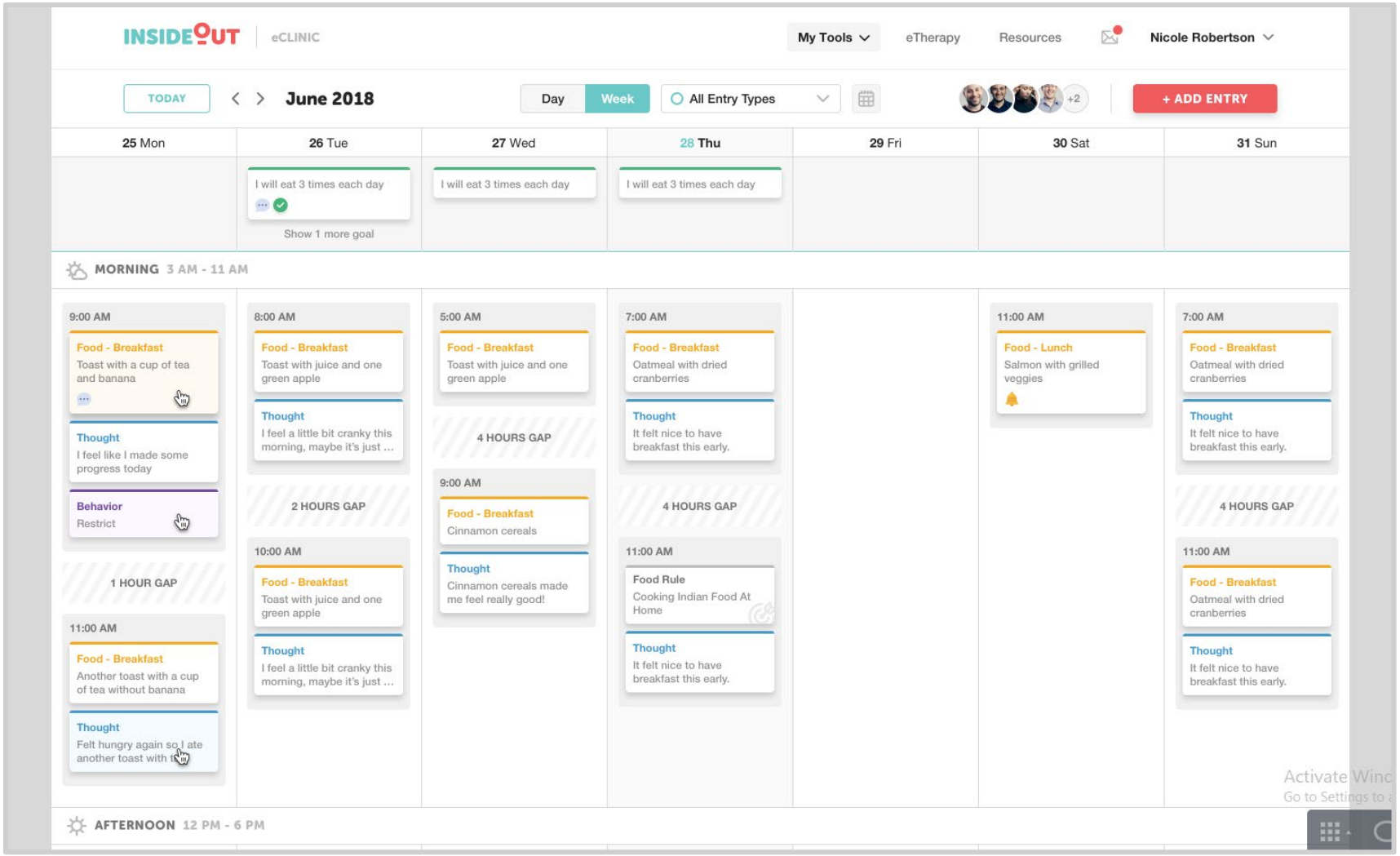
‘My Tools’



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Rethinking eating disorders from
the inside out