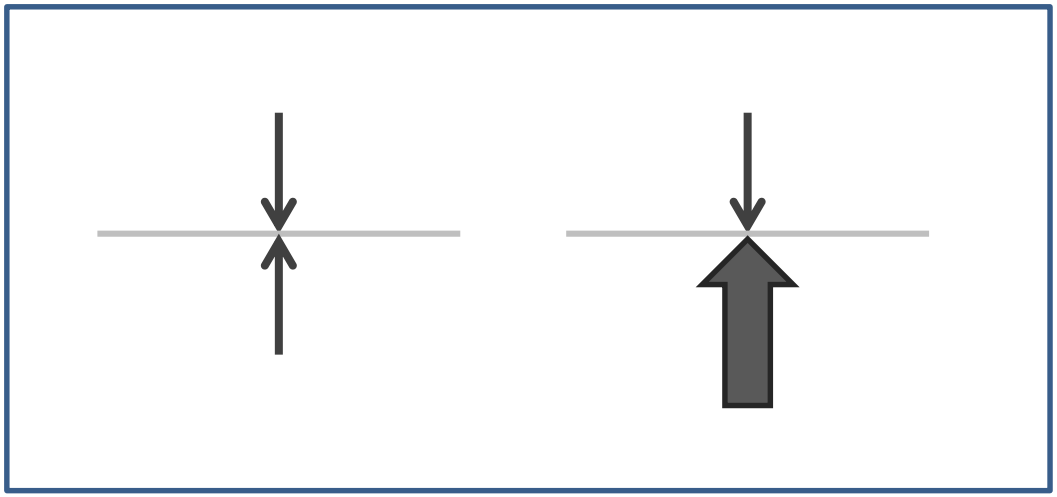
Working with eating disorders

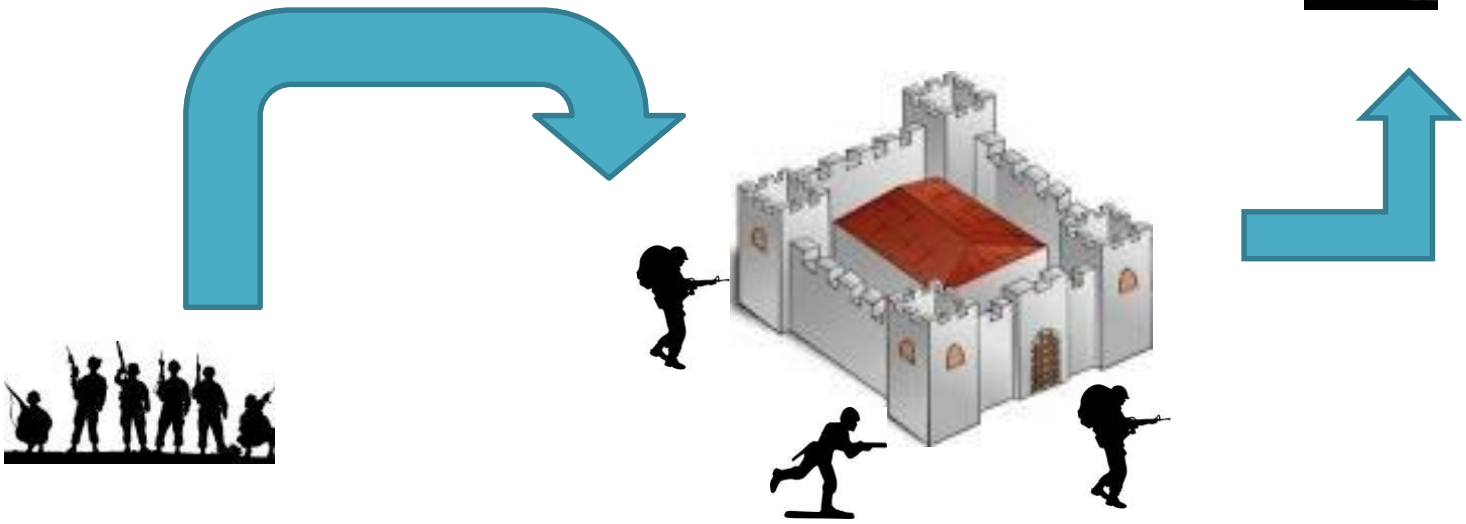
Neurobiologically informed dynamic approaches to psychotherapy

Outline

- Overview of what we know about EDs
- Reconceptualising eating disorders within the limitations of our practice environments
  - Otherwise known as the “relax and breathe, it’s just an eating disorder” approach
- Ways of working – 7 guiding principles
- What evidence is there that this is what I should be working on?

Psychoeconomics





Anorexia Nervosa

- RARE: estimated 0.4% of population (DSM-5)
- Females : males = 10:1
- Starvation biology results in predictable changes to mood, behaviour, and physiology (see Dr Ancel Keys 1944-45 "Minnesota Starvation Experiment")
  - Mood fluctuations; memory and attentional impairments; inhibition and shifting executive functions; and cognitive flexibility
  - Attentional and psychiatric improvements observed after refeeding (Kingston et al., 1996; Matsunaga et al., 2000)

- Best therapy delivered *before* Diagnostic Criteria A reaches clinical severity (In adults BMI sig > 17) or once in partial remission (Criterion A not met for a sustained period)
- Physiological factors require immediate treatment *before* therapy can be effective – IF Criterion A is present, this is necessarily the focus of first-line treatment

DO NOT begin therapy while the body is in a starvation state!!

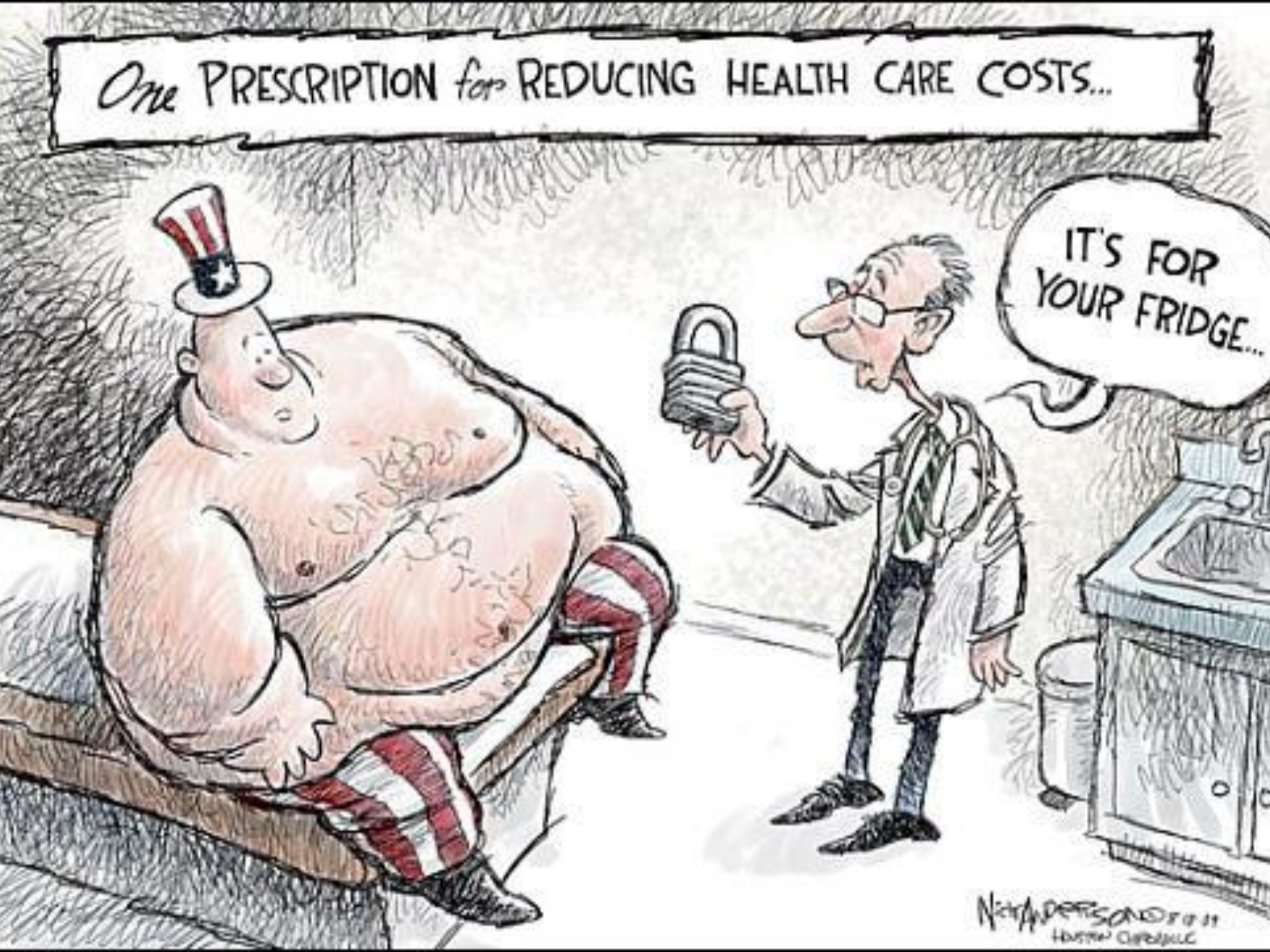
Age, duration, and severity matter!!!

Bulimia Nervosa and Binge-Eating Disorder

- Prevalence:
  - BN = 1-1.5% with 10:1 (M:F)
  - BED = 1.6% (F) and 0.8% (M) (DSM-5)

- Distinguishing factor – presence/absence of compensatory behaviours

- Manualised CBT (Latest contribution by Murphy, Straebler, Cooper, & Fairburn, 2010) received an A rating in NICE (2004) guidelines for BN treatment
  - Meaning: CBT eliminates symptoms in 30-50% of cases…hmmm…and this is after participants with dual diagnoses and personality disorders have been excluded.


One PRESCRIPTION for REDUCING HEALTH CARE COSTS...
IT'S FOR YOUR FRIDGE...

What’s happening up there?

Why not binge on broccoli?

- Typical binge = high carbohydrate, fat, or sugar foods
- Binge-eating of sugar and (possibly) fats may have addictive-like properties.
- Strong evidence in rat samples:
  - Excessive Dopamine released (sensitised system)
  - Compensatory changes that produce withdrawals, anxiety symptoms, decrease in body temperature when sugar removed,
  - During normal feeding, Dopamine response fades out after repeated exposure to food (loses its novelty)
  - With sugar, Dopamine release is recurrent, allowing the brain to adapt (i.e., more and more is craved)
- Craving responses similar to drug cravings – anxiety becomes multiply determined (biologically *and* psychology)

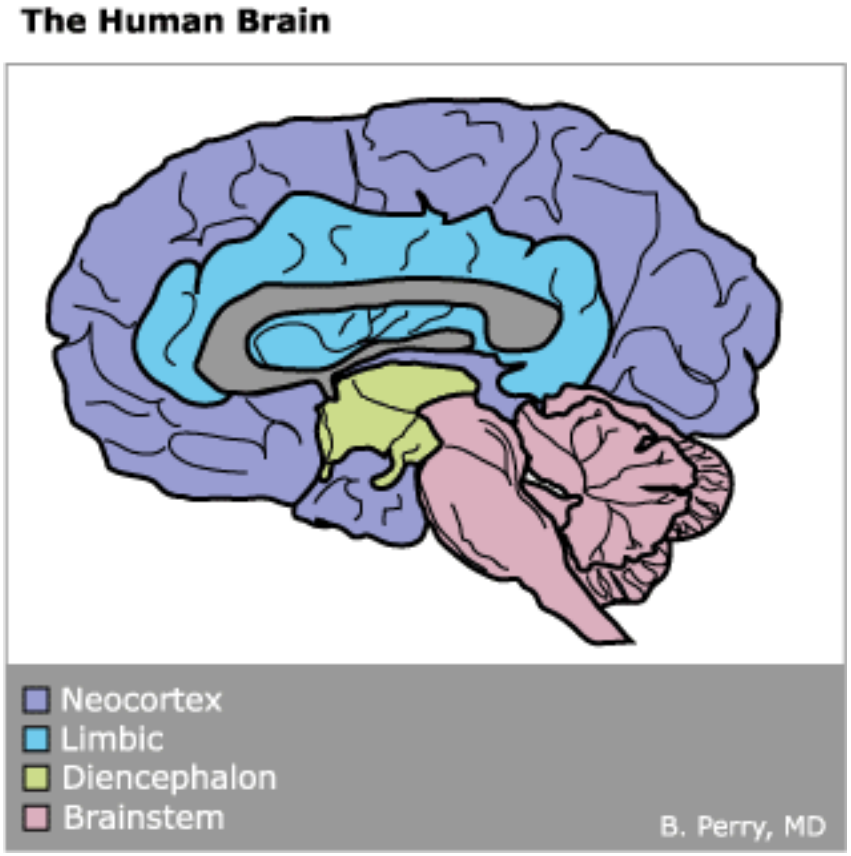
(Avena, Rada, & Hoebel, 2009)

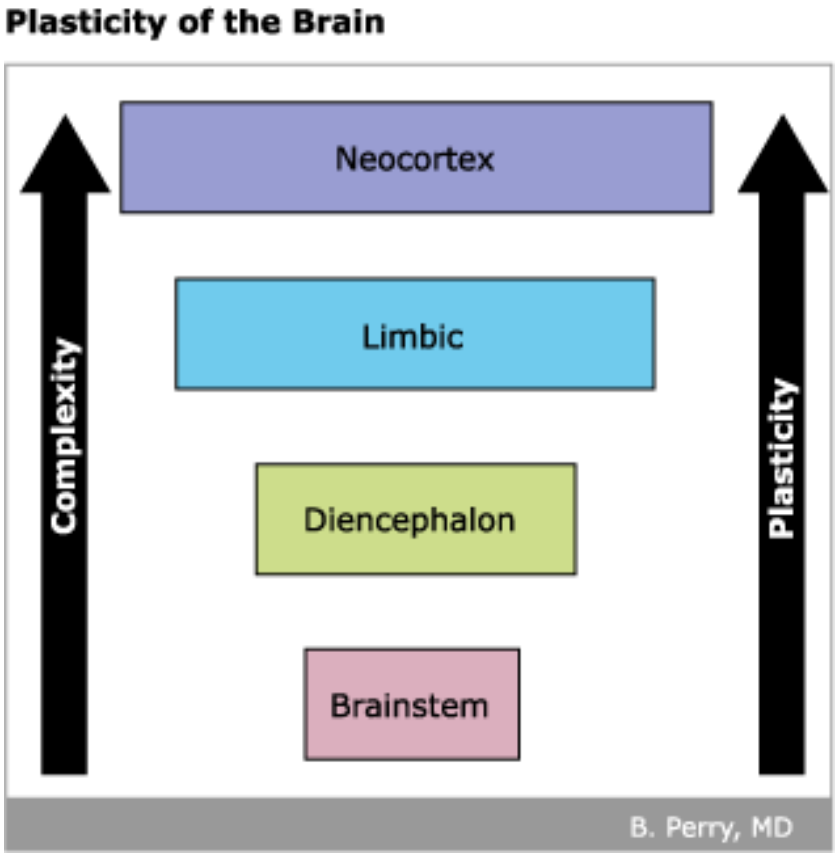
Conditioning

- Operant
  - Stimulation of reward pathways (+ve reinforcement)
  - Removal of anxiety (-ve reinforcement)
- Classical?
  - Taste/smell/sight triggers reflex deactivation of biological attachment system (experienced as soothing)

On what level should I intervene?

- On what level are triggers conceptualised to provoke pathology?





The problem with a “content” focus

- Neurophysiological/neurochemical experience *cannot* be compartmentalised
- We make the assumption that people who exhibit a set of observable behaviours form a homogeneous group.
- The EDs provide an interesting litmus test for the dominant, present philosophy of diagnosis and treatment within Psychology/Psychiatry

Psychodynamic Principles

A rose by any other name…

- Mechanisms of change in CT are *not* those presumed by the theory (Kazdin, 2007)
- Blind investigators have difficulty determining which manualised treatment has been provided from verbatim session transcripts (Ablon & Jones, 2002)
- Active ingredients across brand name therapies look similar… (Goldfried & Wolfe, 1996; Kazdin, 2008)
- Psychotherapy Process Q-Sort (Jones, 2000)
- Three common factors (Castonguay et al., 1996):
  - Working alliance
  - Implementation of a specific treatment modality
  - Experiencing: client "gains awareness of previously implicit feelings and meanings" (p. 499)

1. Focus on affect and expression of emotion

- Range of affect
- Therapist helps client to describe and put words to feelings that the client may not recognise or acknowledge
- Therapist is tentative
  - Ask/check
  - Engage in accuracy-checking
- Management of ambivalence!!
  - Competing feelings
  - It can help to externalise or concretise so that neither feeling is lost while exploring the other

2. Exploration of attempts to avoid distressing thoughts and feelings

- Management of strategies that are used to avoid feeling
  - defenses, resistance, avoidance strategies, etc.
- Linking ED behaviours to the affective experience underlying these behaviours
  - NOT in an attempt to shift the behaviours
  - Trust the process: symptoms will shift as the affects driving them become catharted

3. Identification of recurring themes and patterns

- Therapist as a pattern archaeologist
- Look for associations and connections in the things that are said (or not) in therapy.
- When do admissions, investments, avoidances, etc., occur in therapy?
- What occurs just prior to these?
- Look for symbolism and metaphor in this
  - Language, narratives, and stories influence clients' personal and social realities
  - Identifying important metaphors and drawing on these in therapy can assist with relationship building, symbolising emotion, uncovering and challenging tacit assumptions, working with resistance, and updating frames of reference (Lyddon, Clay, & Sparks, 2001)

4. Discussion of past experience (developmental focus)

- Early experiences affect our experience of, and relation to, the present. Period.
- Nevertheless, the most useful expeditions to the past are ones that the client initiates.
  - If one is to understand the power that emotions that have their origin in the past have on the present, one must understand and link both past and present.
  - However, be careful not to make conceptual leaps that a kangaroo might be envious of.

5. Focus on interpersonal relations

- The mind and the brain are designed to express themselves in the context of interpersonal relationships
- Stable and automatic patterns of behaviour, particularly where they relate to self-soothing (as in the EDs) can have attachment-related links.

6. Focus on the therapy relationship

- Under conditions of empathic attunement, and in the absence of therapist self-investment, the therapeutic relationship will be used by clients to produce an exemplar repetition of interpersonal experience, expectation, and perceived reality.
- E.g., body image fears may be activated
- Opportunity to enhance flexibility, resilience, and mentalizing in the context of interpersonal relationships.

7. Exploration of fantasy life

- Even if your orientation is structured, be mindful of associative material.
- Patients may require considerable help to say what is on their mind
  - Management of this in a facilitative manner is essential for the creation of a medium-to-long-term therapy frame.
- Desires, fears, fantasies, dreams, and daydreams can contain rich material regarding the ways in which a client:
  - Views self
  - Views others
  - Makes sense of experience (perception)
  - Avoids particular experiences
  - Derives joy and meaning

Don’t I need years for that…?

- Common features of psychodynamic therapy across other modalities
- Evidence that these features might be responsible for change, even in shorter term models
- Maintenance of a strong **working alliance** in the context of an **established intervention model** that contains the flexibility for client **experiencing** to occur.

What is successful treatment with an ED?

- Symptom remission?
- Foster new capacities and resources?
  - What capacities?
  - What resources?
- Repair developmental ruptures/fixations?
- Increase range of tolerable affect?
- Others?

Questions

- Case Study group work (if time)
- Identification of aspects of “experiencing” that are most difficult for you to facilitate in the context of:
  - Your place of practice
  - Your preferred practice orientation/s
  - Your personal factors and history

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