You want me to do *what* with my anxiety?

Exposure Therapy & Eating Disorders

Melanie Smith, PhD, LMHC, CEDS-S
Director of Training

Maintaining Factors of Eating Disorders

Effects of altered nutrition

Cognitive rigidity/pro-ED beliefs

Relational response to ED behavior

Temperament: harm avoidant, perfectionistic

Neuroticism: anxiety about anxiety!

Experiential Avoidance (limited behavioral repertoire) & Emotional Intolerance of negative affect

Key maintaining factor for many psychiatric illnesses:

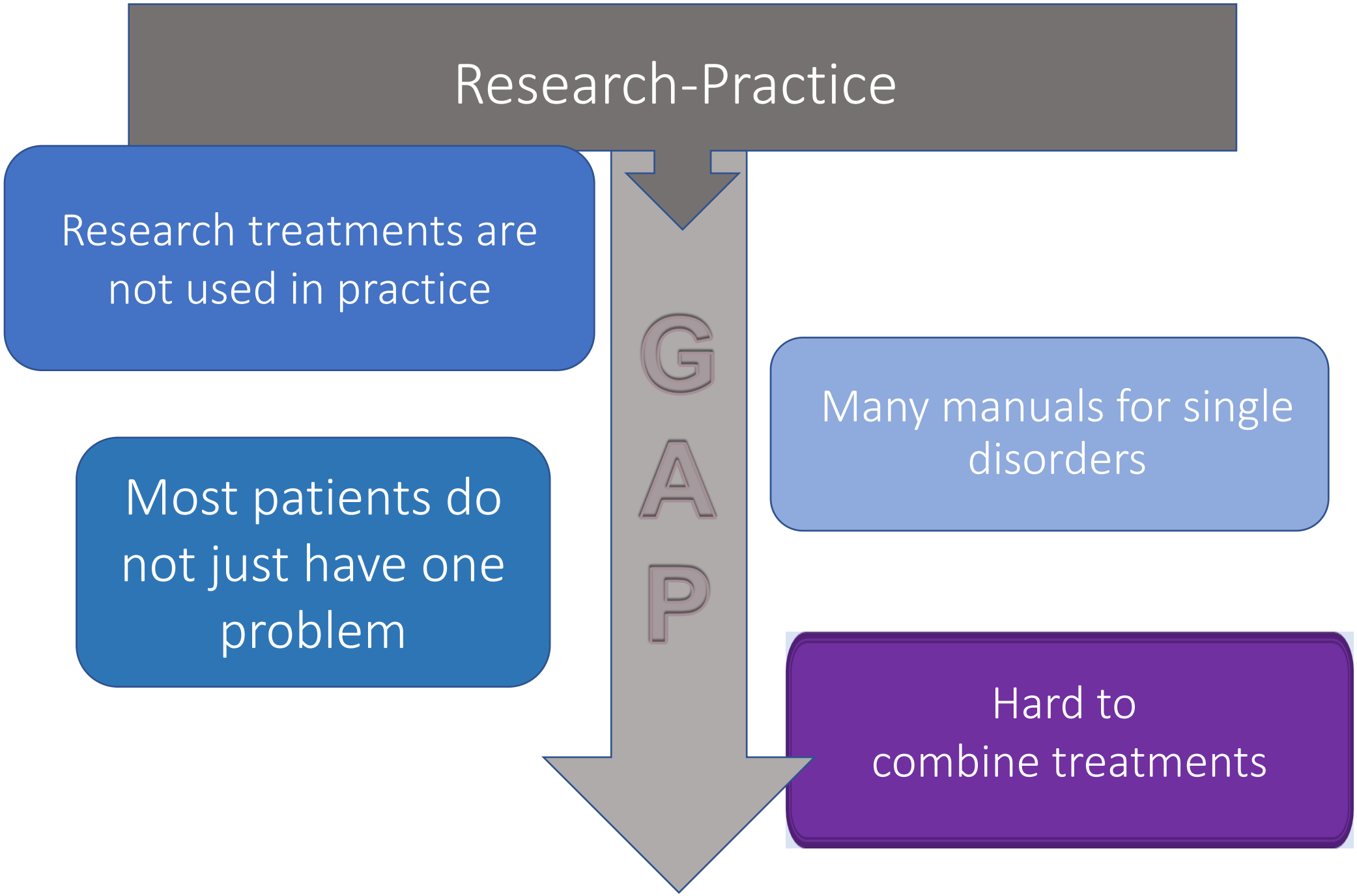
Drive to avoid negative emotional experiences

Recovery requires experiential challenge (doing things that have been habitually avoided) and reducing avoidance strategies

Evidence Based Practices (EBPs)

Research supports efficacy of specific treatment approaches, but the field struggles to implement these in routine treatment settings

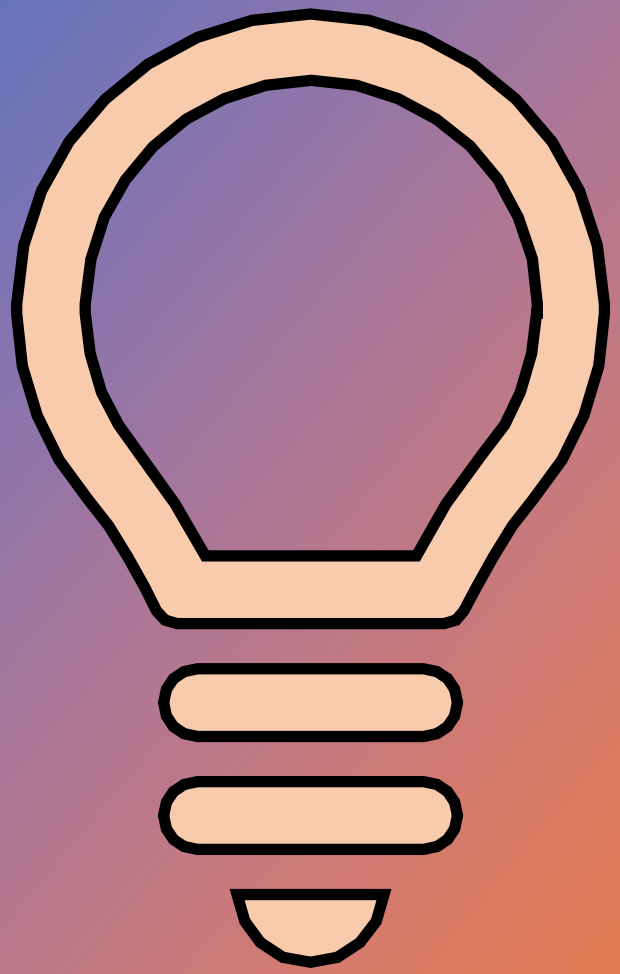
(Aarons, Hurlburt, & McCue Horwitz, 2011; Nathan & Gorman, 2015)


Research-Practice
Research treatments are not used in practice
Most patients do not just have one problem
GAP
Many manuals for single disorders
Hard to combine treatments

Barriers to EBP use with EDs

- **Severe disorders with high mortality rates** (Arcelus et al., 2011; Crow et al., 2009)
- **High comorbidity**
- **Adapting protocols to treatment settings** *(research lab ≠ real world)*
- **Lack of training, education, institutional support**

  (Lowe et al., 2011; Wallace & von Ranson, 2011)
- **Diverse presentations**
- **Poor recovery/high relapse rates** (Wonderlich & Mitchell,1997)



Solution to the Problem

Transdiagnostic approach that integrates evidence-based treatment principles to treat the same shared underlying problems that drive different emotional disorders

Evidence-based, Transdiagnostic Principles

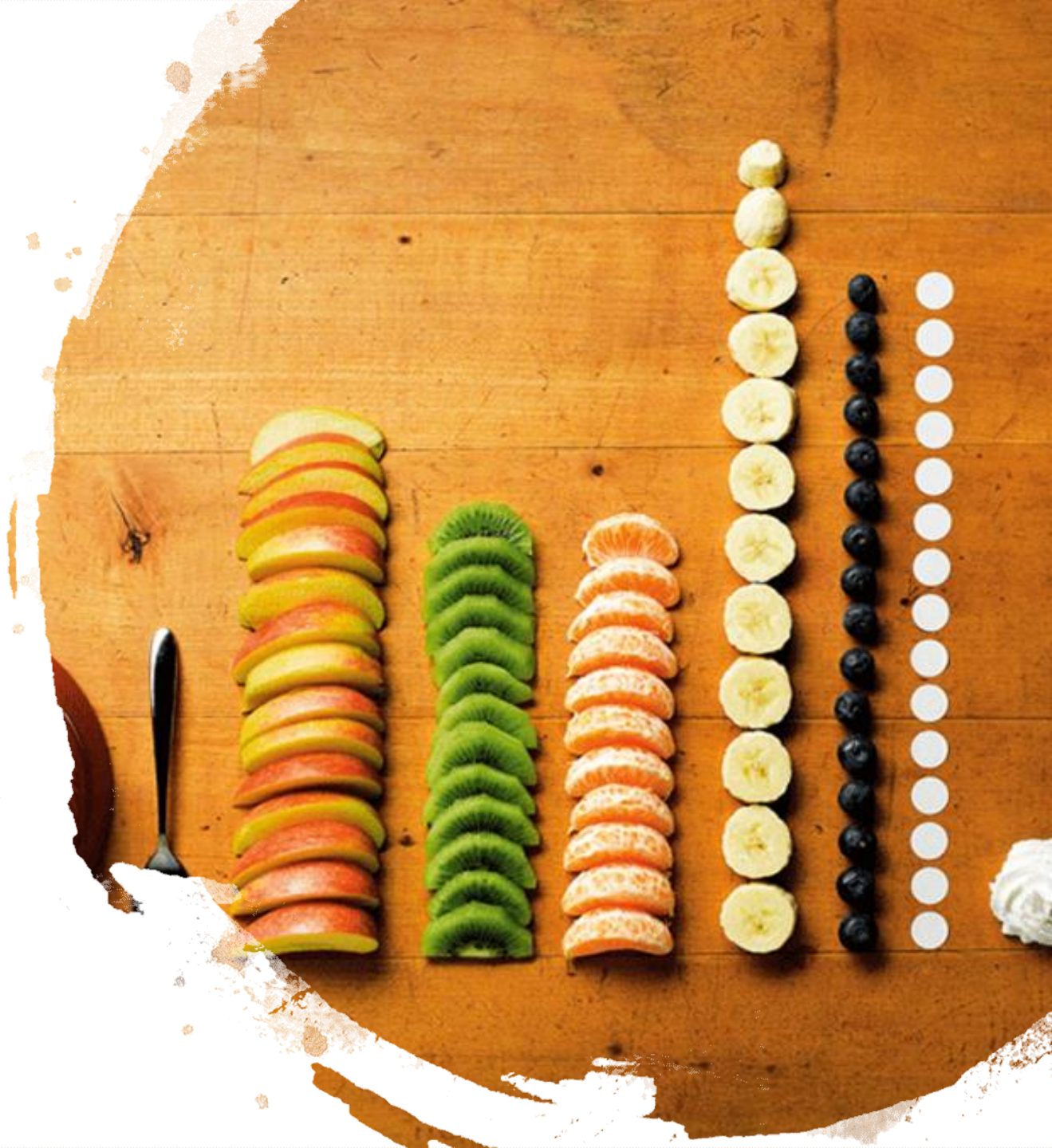
- Re-evaluating maladaptive cognitive appraisals
- Changing maladaptive action tendencies associated with emotions
- Preventing emotion avoidance
- Utilizing emotion exposure procedures to promote tolerance
- Increase psychological flexibility & emotion regulation

Eating disorders are emotional disorders

Eating disorder pathology--“behavioral attempts to influence, change, or control painful emotional states” (Wonderlich & Lavender, 2018)

Self report studies suggest that worsening mood prior to a binge/purge episode & sharply improved mood following the event (Smyth et al., 2007; Haedt-Matt, & Keel, 2015; Kukk & Akkerman, 2017)

ED behaviors across diagnoses function to regulate affect & provide momentary relief from aversive emotions (Mallorqui-Baque et al., 2018)



Patterns of learned behavior

View emotional experiences as **unwanted** and **intolerable**

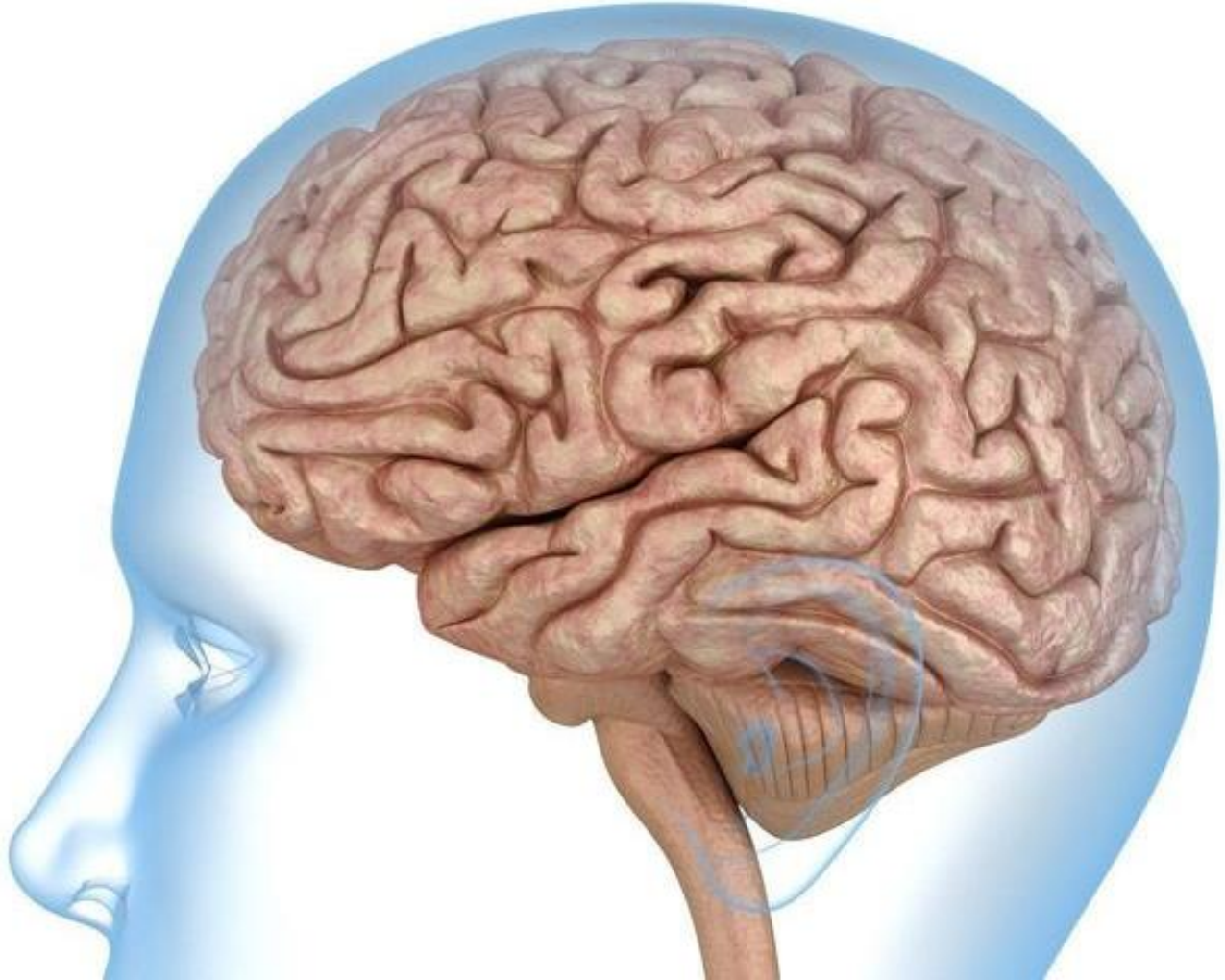
Use symptoms to **avoid, control or suppress the intensity** of uncomfortable emotion

ED patients are **stuck in this short-term solution cycle** with their limited range of emotion regulation strategies

Negative Reinforcement: the GOOD feeling you get when you take something BAD away.


Our minds respond to danger by creating solutions for survival.
Freeze,
Run,
Hide!

What if “the tiger” is a scary ***internal*** experience?



EXTERNAL DANGER VS. INTERNAL DANGER

We cannot escape **perceived** internal danger (painful and scary thoughts, intolerable sensations)

Our adaptive minds create solutions for surviving **perceived** internal danger

An unpleasant internal experience is treated in the same way as an external problem; it becomes a negative event to avoid or eliminate

The Avoidance Problem

Attempts to **avoid** uncomfortable and painful emotional experiences drives unsafe, threatening and dangerous behavior **(symptom use)**

Certain emotions can remind us of a time when we felt unsafe or were unsafe, but **the emotion itself is not unsafe**

Emotions themselves are not unsafe, dangerous or threatening

Approach mindset vs. Avoid mindset

- Lay out the rationale early in treatment.
- All treatment decisions are based on this foundation

Evidence-based principles of emotion exposure

Exposure stimuli

But it’s not about the stimulus itself

Facilitate corrective learning through:

Building emotional tolerance

Disconfirmation of expected negative outcomes

- Including, “I must do X to avoid Y.”
- Including, expectation of not being able to cope

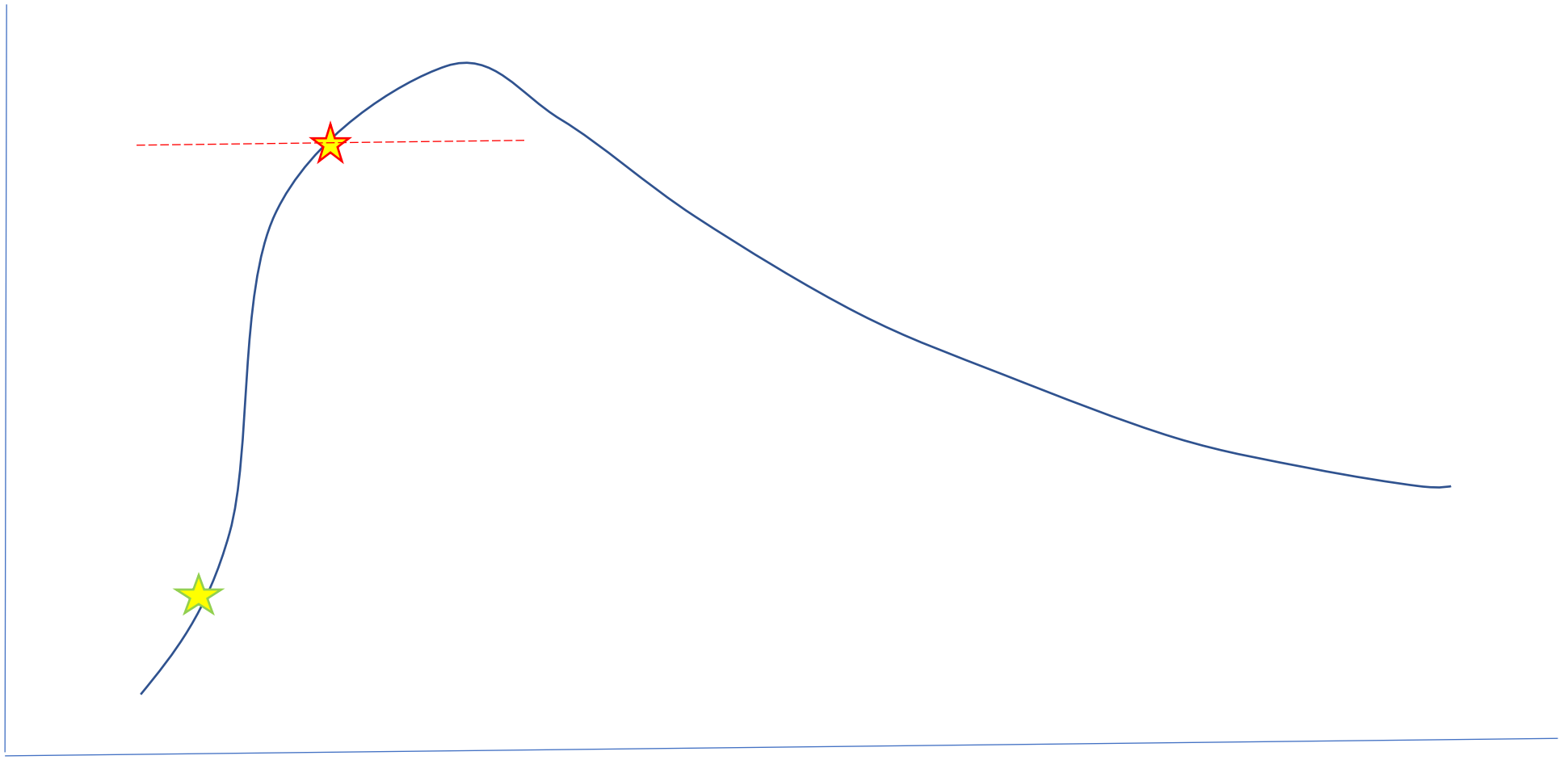
ALL Exposures are EMOTION Exposures

What's the point?

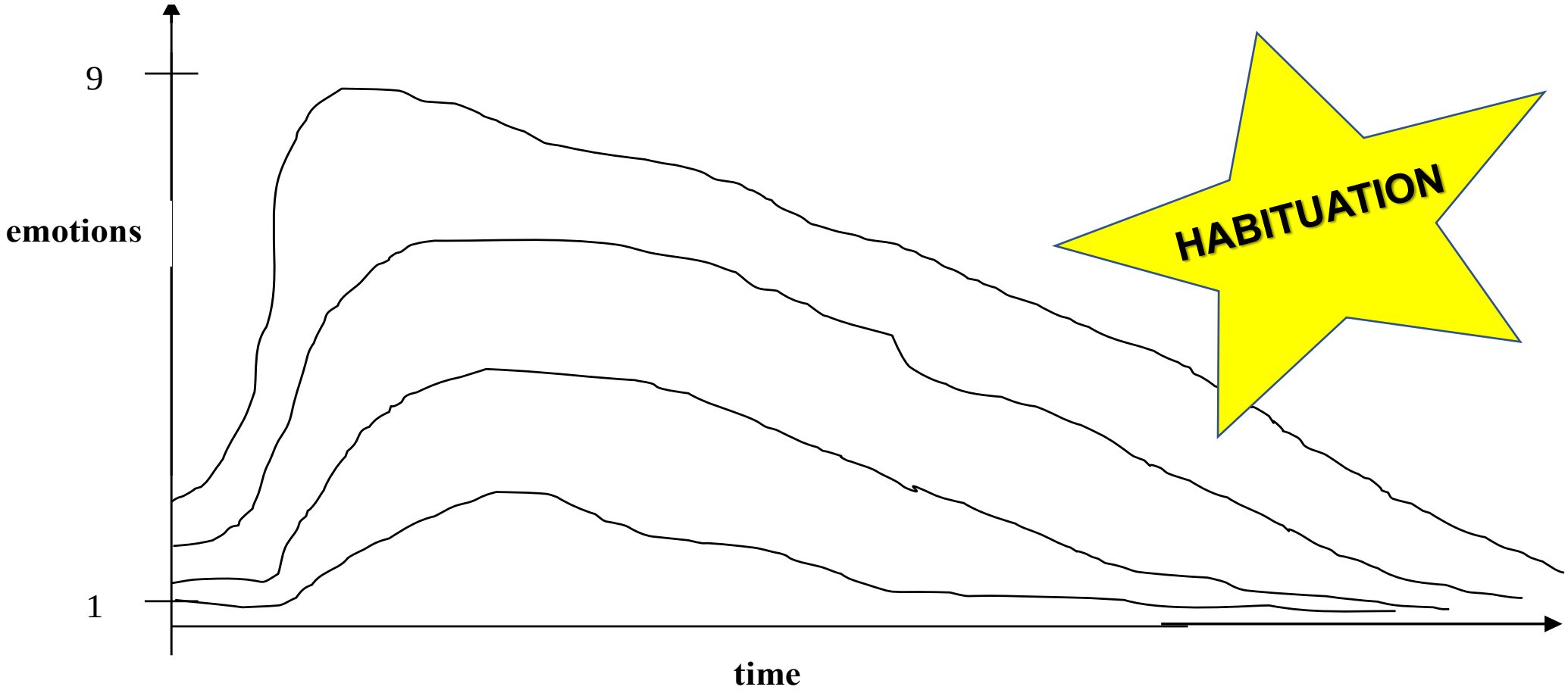
Primary goal is **not** to reduce the experience of negative emotions or physiological arousal.

The goal is to **promote tolerance of emotions** within a structure that enhances the consolidation and retrievability of inhibitory learning ***(to NOT act)*** over contexts and time.

Natural course of emotions, with & without interruption



Decrease in emotional intensity over time with repeated practice



Conducting Emotional Exposures

- Proper structure
- Expectations (Before & After)
- **No SAFETY Behaviors**
- "Desirable Difficulty"
- Variety of stimuli & context
- Repetition, Repetition, Repetition

Setting the stage for success: building a hierarchy

- Must be individualized. What gets in the way of their life & recovery?
  - Include multiple domains: food, body image, social
- Rate experiences based on level of distress and level of avoidance
- Be specific
- Start low-to-middle. No flooding! Build self-efficacy, emotional tolerance & trust in the process.
- … but also don't start too low

Do Not Avoid		Hesitate To Enter But Rarely Avoid		Sometimes Avoid		Usually Avoid		Always Avoid
0	1	2	3	4	5	6	7	8
No Distress		Slight Distress		Definite Distress		Strong Distress		Extreme Distress

Know what to expect: Common Avoidance behaviors during exposures

Behavioral	Cognitive	Safety behaviors
• Hesitation • Pacing, shaking • Asking for reassurance • Looking away, other postural issues (hands in pockets or folded arms) • Compulsions/ rituals/undoing	• Distraction • Dissociation (“pretending”) • Thought suppression • “Steaming through” • Use of humor • Procrastinating • Over-discussing	• “Stuff”: cell phone, water, medication, good luck charm, etc. • Being with a “safe” person • Doing it in the office vs. in natural setting

And what about me?

Behavioral	Cognitive	Safety Signals
• Cheerleading • TMI • Humor*	• Own thoughts • Own ‘stuff’/insecurity	• What are you bringing for you or ‘just in case’ for the pt?

Open weighing

Novel (and controversial) exposure intervention

Open Weighing vs. blind weighing

- ***Evidence*** to support practice of open weighing

Evidence

Exposure

- Opportunities for **exposure** to weight and self to shape and weight related fears

- Overtime leads to **reduction** in **distress** and fear related **behaviors** about body shape or weight

Emotion Tolerance

- Treatment as usual: BLIND weights
- We have been successful past 5 years with open weights
- Monitored like we monitor vital signs
- An important emotional factor

Waller, 2014; Forbush et al., 2015

Making the case for open weighing

WHY?

- Provides opportunity for pts to be exposed their own shape & weight-related fears.
- Overtime this actually leads to a reduction in distress and fear-related behaviors in response to viewing weight!

HOW?

- Weight trends should be discussed during nutrition session.
- Emotional response to knowing weight should be processed in nutrition & therapy sessions in an ongoing way.
- **With empathy. SO. MUCH. EMPATHY.**

"Is it ever OK to use blind weights?"

Blind weighing is a behavioral avoidance strategy aimed at controlling distressing emotion. *But …*

- If weight is NOT a valid recovery metric for the patient, and you are therefore not monitoring weight as part of the treatment
- There are occasions where it will be used as a *temporary* intervention to provide extra structure and support
- Indicated for safety issues, medical reasons, treatment-interfering behaviors
- Treatment team should decide together re: the appropriateness of open vs. blind weights.

Interoceptive exposure

Novel (and controversial) exposure intervention

What is an interoceptive exposure?

Exercise designed to build tolerance of uncomfortable physical sensations

Origins of interoceptive exposure (IE)

- IE is a behavior therapy intervention originally developed for the treatment of panic disorder (Barlow, Craske, & Cerny, 1989; Klosko, Barlow, Tassinari, & Cerny, 1990)
- Designed to target fearful responding and sensitivity toward physical sensations associated with anxiety and fear
- Core component of txs shown to reduce panic attack frequency & fear of physical sensations that occurs as a primary feature of panic disorder (Barlow, Gorman, Shear, & Woods, 2000; Craske, Rowe, Lewin, & Noriega-Dimitri, 1997)
- IE is, therefore, regarded as an essential component of empirically supported treatments for panic disorder.

Interoceptive that target common emotional experiences & sensations

Exercise	Physical Symptom(s) Induced
Running in place	↑ heart rate, ↑ temperature, sweating
Spinning	Dizziness, nausea, out of control
Hyperventilation	Lightheaded, blurred vision, numb/tingle
Narrow straw breathing	Shortness of breath
Tense body	Muscle tension, fatigue
Hand/Wrist Weights	Fatigue, motor retardation

Transdiagnostic uses of IE

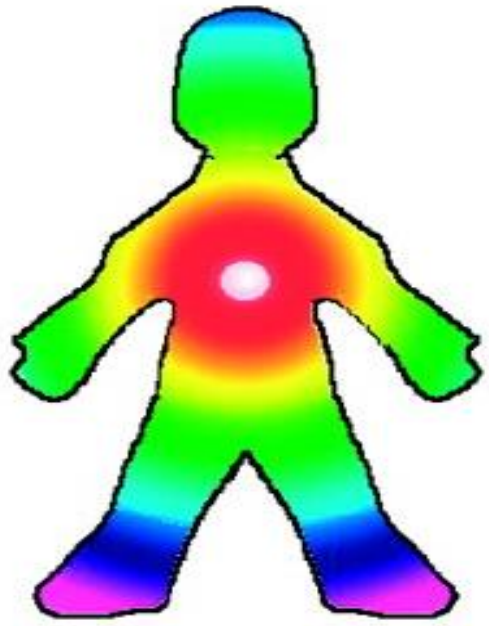
- PTSD (Wald & Taylor, 2007; Wald & Taylor, 2008; Wald, Taylor, Chiri, & Sica, 2010)
- Irritable bowel syndrome (Craske, Wolitzky-Taylor, Labus, et al., 2011)
- hypochondriasis (Walker & Furer, 2008)
- chronic pain (Watt, Stewart, Lefaivre, & Uman, 2006)
- emetophobia (Hunter & Antony, 2006)
- smoking cessation (Zvolensky, Yartz, Gregor, Gonzales, & Bernstein, 2008)

Expanding the scope of IE

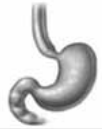
- Transdiagnostic relevance of interoceptive constructs has become increasingly recognized in diverse problem areas, including other anxiety disorders, depression and eating disorders.
- **All emotions have somatic features**
  - Therefore, physiological arousal is relevant to any disorder with a core emotional component (Barlow, 2002; Ekman & Davidson, 1994)
- Despite high comorbidity rates with anxiety and recent attention to interoceptive constructs, until recently IE has received minimal explicit attention in eating disorders.

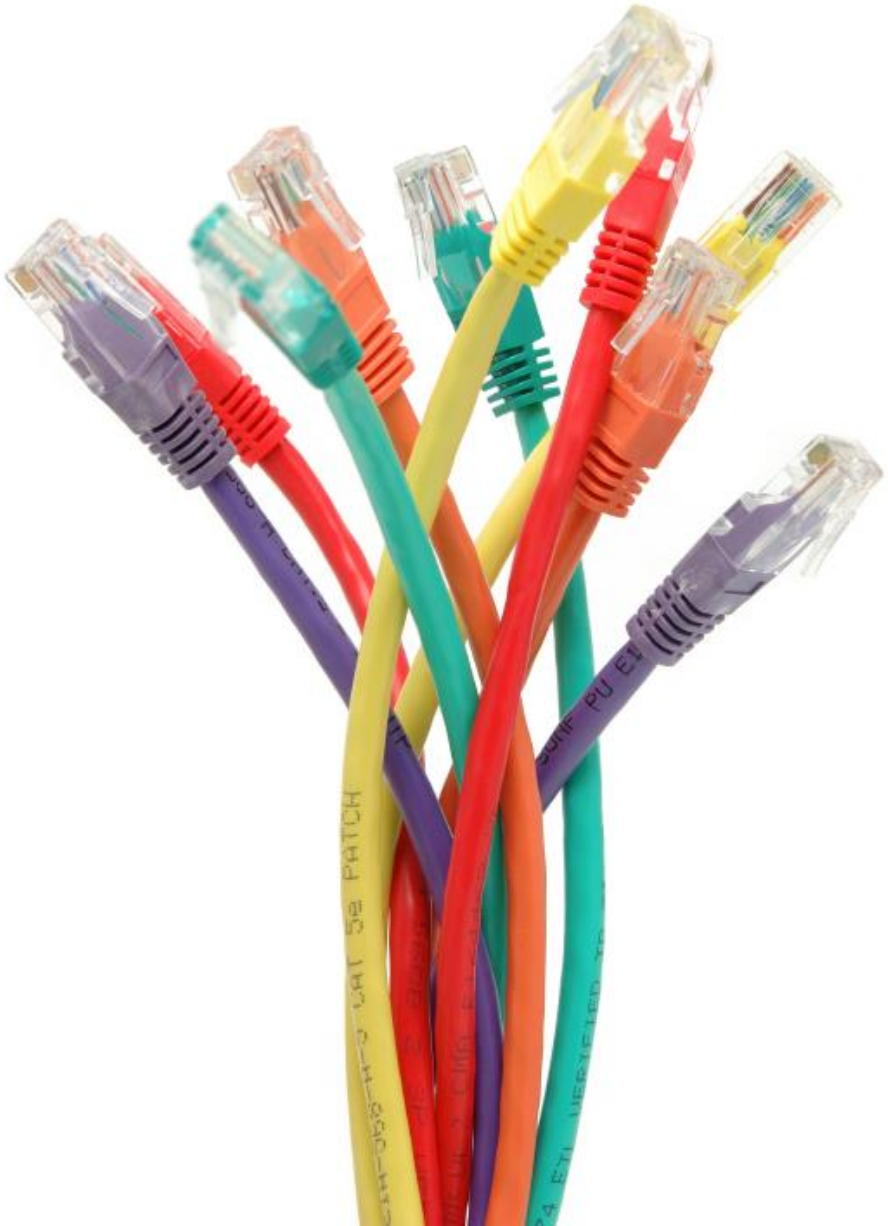
Why is it important to build tolerance to physical sensations for individuals with ED?

Individuals with ED often have irregular interoceptive sensitivity



Merwin et al. (2013) Emotion regulation difficulties in anorexia nervosa: Relationship to self-perceived sensory sensitivity. *Cognition & Emotion, 27* (3), 441-452.

Disease	Interoceptive Sensitivity "hypo"	"normal"	"hyper"
Depression			
			
Anxiety Disorders			
Alexithymia			
			
Eating disorders			

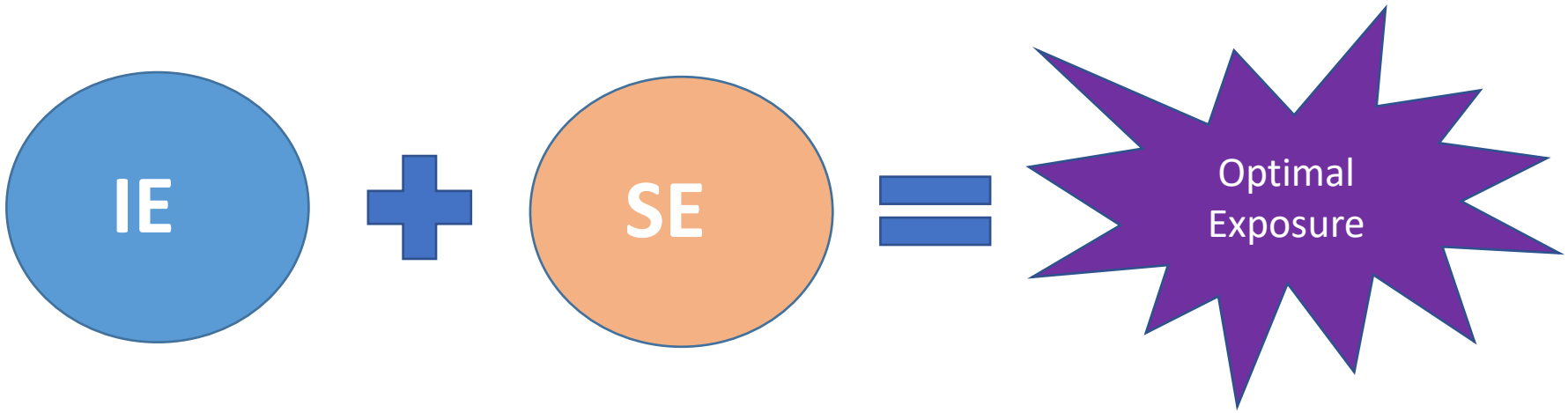


The wires get crossed

- Eating/digestion-specific and emotion-focused interoceptive awareness & sensitivity both appear to be implicated in the development, maintenance, and treatment of eating disorders (Merwin et al., 2010; Zucker et al., 2013)
- Interoceptive cues related to anxious or fearful arousal, sadness, shame, hunger, satiety, scents, tastes, and mechanoreception ***that have become associated with weight gain or body image*** can all be coupled with and/or trigger amplified anxiety (Vocks et al., 2011).

Trends in exposure therapy with ED

- Eating and digestion-specific physiological cues, such as hunger, satiety, nausea, fullness, bloating and mechanoreception (e.g., pressure from clothing, stretching of skin) are gaining more attention and may represent a new frontier in exposure therapy for eating disorders (Zucker et al., 2013)
- IE meant to be done IN CONJUCTION with situational exposures, not as a replacement



ED-SPECIFIC INTEROCEPTIVE EXERCISES

Exercise	Physical Symptom(s) Induced
Drinking large amount	Fullness, distention, stomach upset
Tight clothing or belt	Negative arousal
Scents/Tastes/textures	Negative arousal, disgust, active digestive physiology
Leg spread or “jiggle”	Negative arousal

STEPS TO CONDUCT INTEROCEPTIVE EXPOSURE

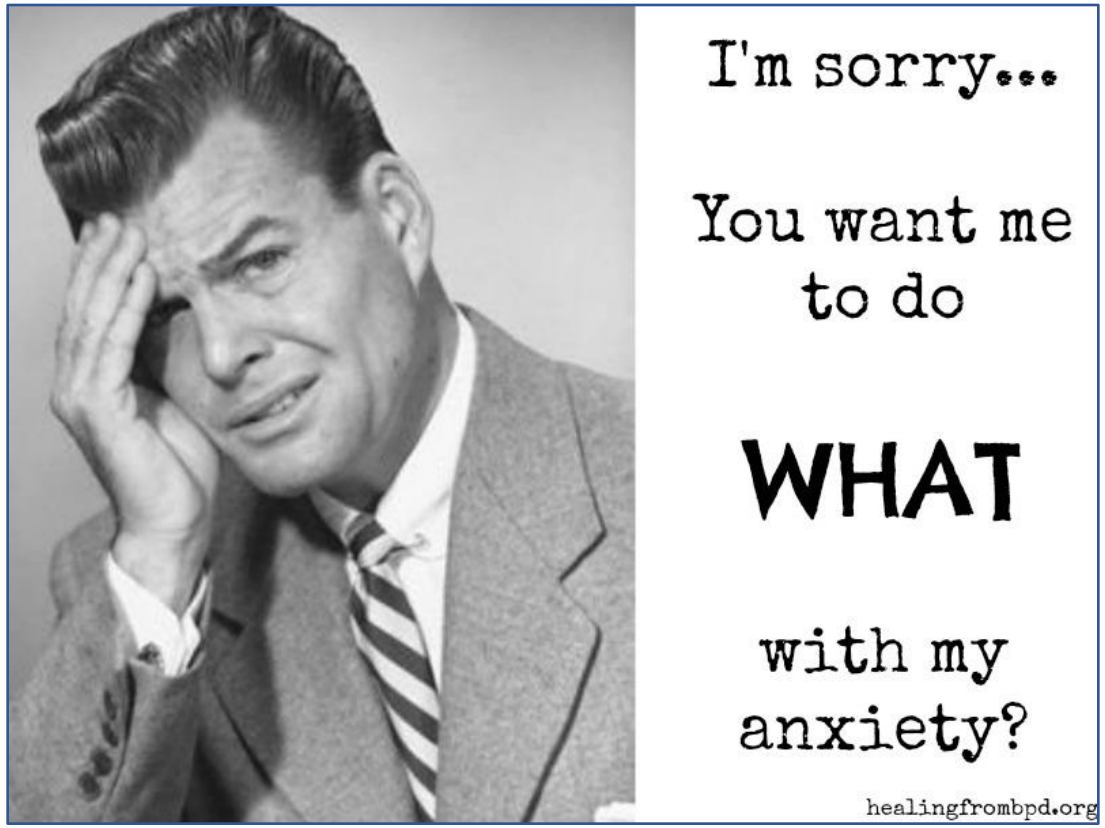
- MUST start with psychoeducation & treatment rationale!
- Explanation of the exercise (how? how much? how long?)
- Anticipatory distress rating
- Conduct exercise
- IMMEDIATELY:
  - Sensations
  - Intensity (0-8)
  - Distress (0-8)
  - Similarity (0-8)

Step by step

- Opportunity to demonstrate emotional curve
- It's been 60 seconds … 2 minutes …
  - Intensity: more, less, the same?
  - Distress: more, less, the same?
- **Always have an answer!**
  - Tolerance already developed
  - Lack of similarity with personal experience of distress/intense emotionality
  - Well-practiced avoidance/disconnect
- Ok, let's do it again!

2nd time around …

- You still have residual physical symptoms, what do you think is going to happen?
- Repeat same check-in process after, BUT "compared to the first time …"
  - Intensity: less, more, the same?
  - Distress: less, more, the same?



Interoceptive Do's and Don'ts

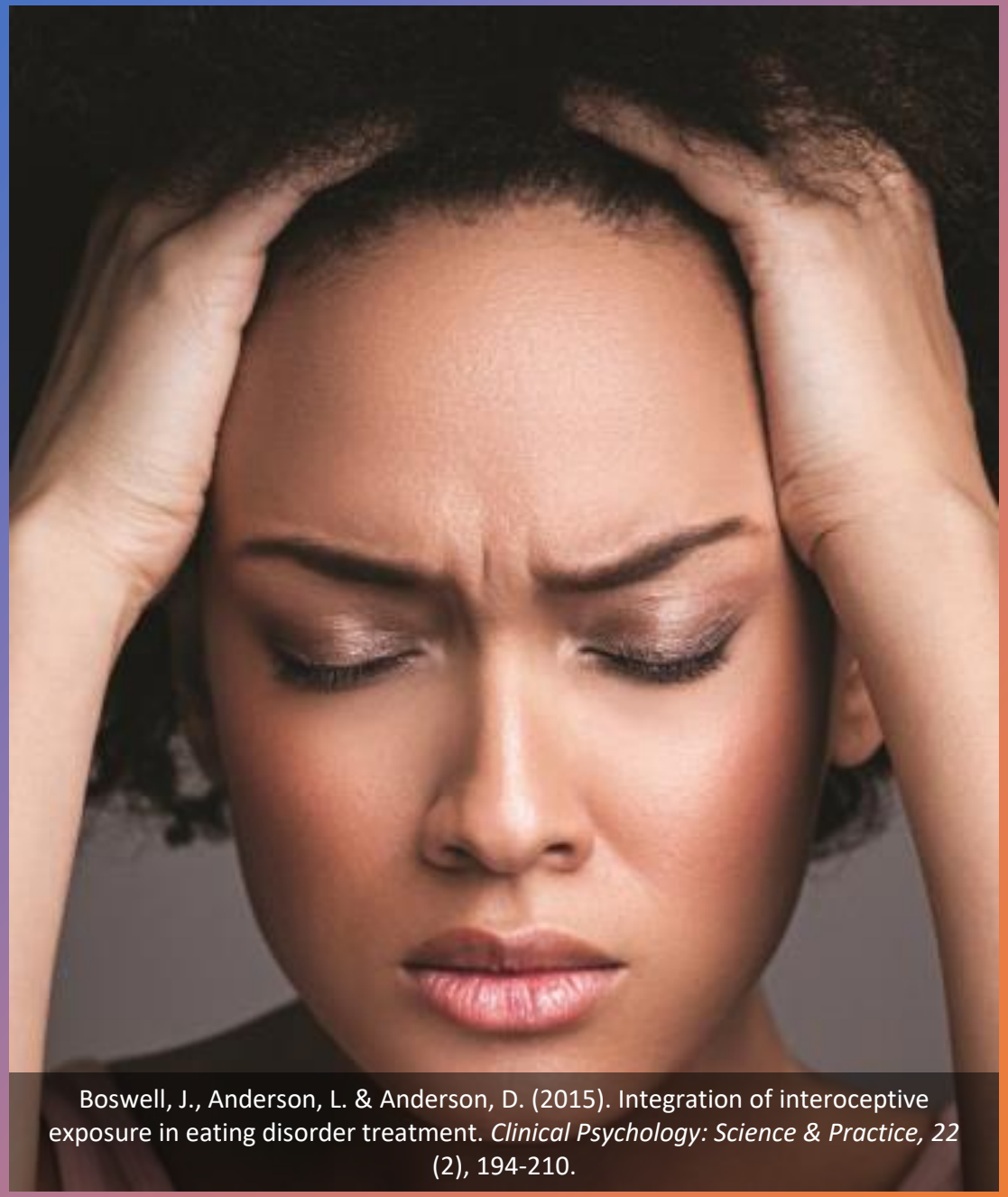
Do perform exercises with patient

Don't forget to assess for injuries or medical conditions

Do make sure the patient is not engaging in safety behaviors or minimizing the physical effects of the exercise e.g., want to minimize use of reappraisal

Don't let patient stop the exercise before they experience any physical sensations (must go beyond perceived limit)

Do address the patient's *interpretations* of their physical sensations prior and after



Boswell, J., Anderson, L. & Anderson, D. (2015). Integration of interoceptive exposure in eating disorder treatment. *Clinical Psychology: Science & Practice, 22* (2), 194-210.

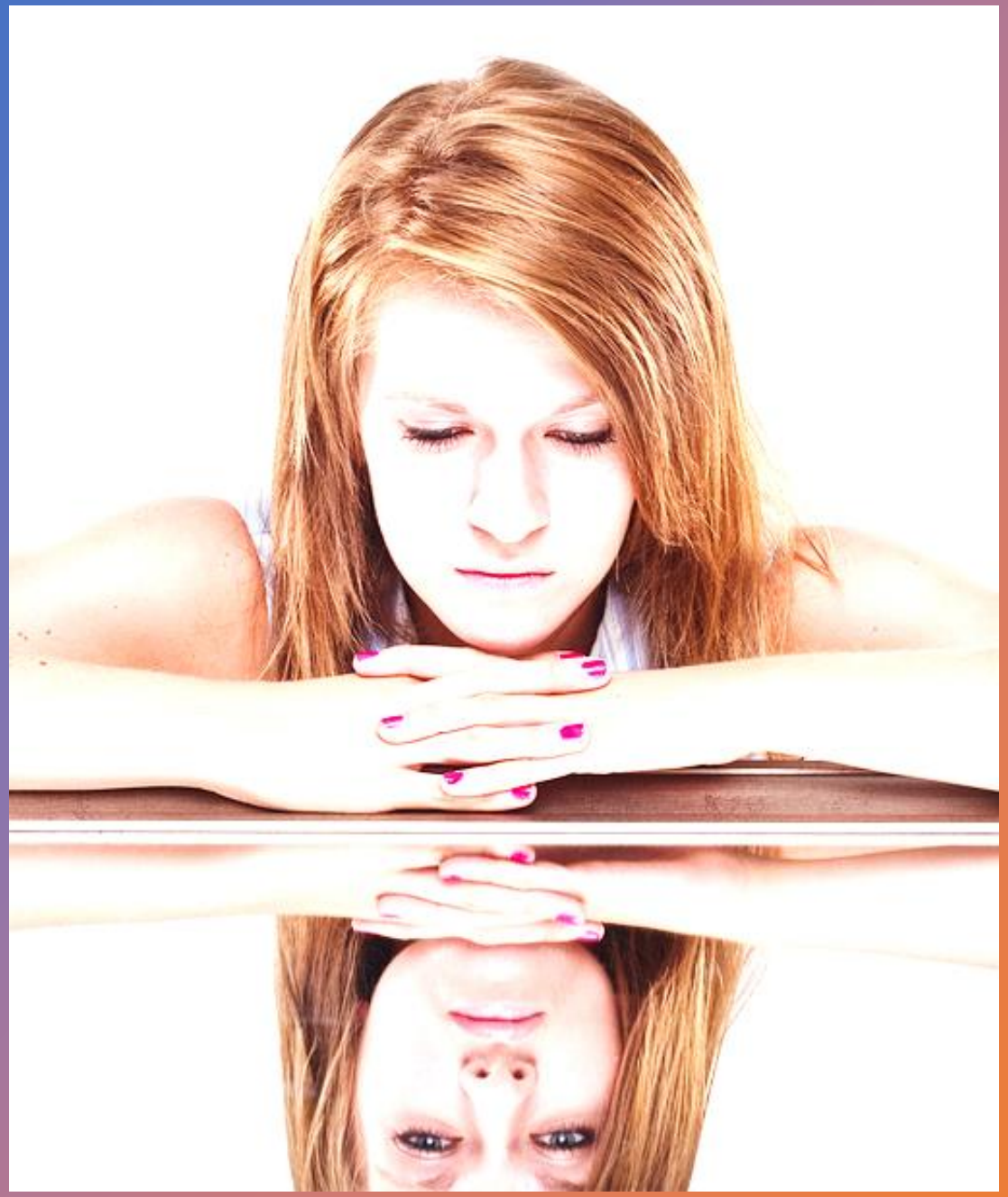
Suffering for the sake of suffering?

No! Evidence to suggest that building tolerance to uncomfortable sensations promotes change in individuals with ED.

Patient understanding of the rationale and willingness to experience the discomfort is essential!

Body image exposure

Novel (and controversial) exposure intervention



Body Image Exposure

Viewing Body = Stimulus of Emotion

Abstaining from ritualized checking or avoidance

Describing appearance in neutral language

*Learning to tolerate negative emotions that are associated with one's body

Step by step

- Clinician demonstrates first
- Review expectancies & get SUDs rating
- Start from top of head all the way down to feet & back up again.
- Use detailed, descriptive language that is non-evaluative in nature

Non-evaluative language

My eyes are almond-shaped

There is a space between my eyebrows

My lips are light pink, the bottom lip is slightly fuller than the top

Evaluative/judgmental language

Fat, chubby, thick, big

Thin, skinny, small

Pretty, ugly, gross

Clinician behaviors

Explain rationale & expectations for the exercise thoroughly.

What it is … and what it isn't

- What it is: a tolerance building exercise
- What is isn't: an exercise designed to increase body image satisfaction -- at least not immediately

Start and end with empathy (and use it in the middle too!)

Fly on the wall, who intervenes if necessary. Notice if they:

- Skipped over any parts/sections
- Spent too much time on any part/sections
- used judgmental language
- shifts in affect
- Other avoidance behaviors (subtle or overt)

Case example

Exposure protocol: ED & severe food allergies

Background information

Demographics & relevant history

- 24 yr SCF
- “Airborne” allergies. Carries epi-pen
  - History of anaphylaxis
  - History of intubation while awake

Diagnoses

- AN-Purging Type
- MDD
- PTSD

Complicating factors

Reported “airborne allergies” & other food allergies
Very limited number of foods she could/would eat
Flashbacks during exposures
Patient feeling of being a burden on parents and parents’ invalidation
Vested interest in the severity of her allergies
Previous treatment history with minimal change
Trained as an EMT

Treatment planning

Build rapport and trust

- Consistency in responding was key

Identify emotions & physical sensations associated with strong emotions

- Helped to differentiate between anxiety/panic and anaphylaxis

Work on hierarchy

- Earlier than typical

Planning Exposures

- Important for patient to know & be on board with the plan
- Including medical/nursing/dietary consultation before & support during

Identified negative core beliefs as a result of trauma

Re-appraisal of automatic thoughts

Hierarchical exposures

- Interoceptive exposure: Straw breathing (increasing time to 2 minutes)
- Eat lunch (no allergens) in therapist office with interoceptive
- Walk through dining room for one minute AFTER all trays removed
- Return lunch tray in dining room while other trays (with possible allergens) were still present in room
- Eat half of meal in dining room with therapist present
- Eat entire meal in dining room with therapist present
- Eating entire meal, without therapist, with other patients (and possible allergens) in the dining room

Contributions to change

Patient's willingness to complete exposures, despite strong emotional response

Rapport and trust between patient and therapist

Disconfirming negative expectancies through exposure experiences.

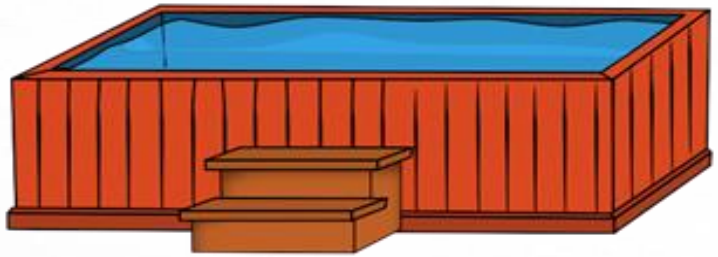
Sticking with it – even when it was hard! Repetition. Repetition. Repetition!

Accepting that progress would be small & slow. Celebrating ALL progress ☺

Directly addressing roadblocks

- VALIDATE, VALIDATE, VALIDATE!
- Many roadblocks were in direct response to past experiences of feeling invalidated and shamed

NOTE TO SELF



Do not cannonball into hot tub!

In a Nutshell

Symptom Reduction

As **emotional tolerance** and **psychological flexibility** increases

the need for **maladaptive coping behaviors** decreases.

thank you

The Renfrew Center
FIRST IN EATING DISORDERS

Melanie Smith, PhD, LMHC, CEDS-S
Director of Training
msmith@renfrewcenter.com