The Renfrew Center
FIRST IN EATING DISORDERS

I Can Do Hard Things:
Overcoming Clinician Fears About Exposure Therapy for Eating Disorders

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Let's start with a quick survey …

On a scale of 1-10, what is your comfort level with the idea of utilizing exposure therapy with ED clients?

How much do you agree with the following statements?

- Most clients have difficulty tolerating the distress exposure therapy evokes
- Exposure therapy works poorly for complex cases, such as when the client has multiple diagnoses
- Clients are at risk of decompensating (i.e., losing mental and/or behavioral control) during highly anxiety-provoking exposure therapy sessions
- Compared to other psychotherapies, exposure therapy places clients at a greater risk of harm

Therapist Beliefs About Exposure Scale (Deacon et al., 2013)

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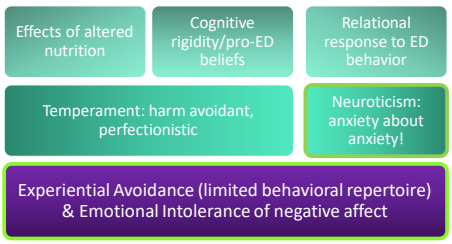
Maintaining Factors of Eating Disorders



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Core disturbance/mechanism

Experiential Avoidance

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

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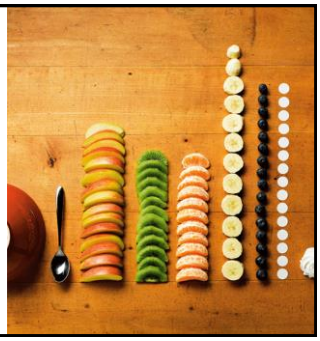
Eating disorders are emotional disorders

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)



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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.

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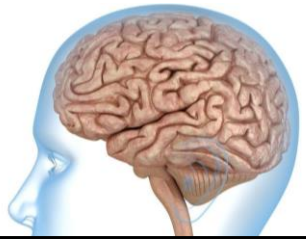
What if "the tiger" is a scary ***internal*** experience?



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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

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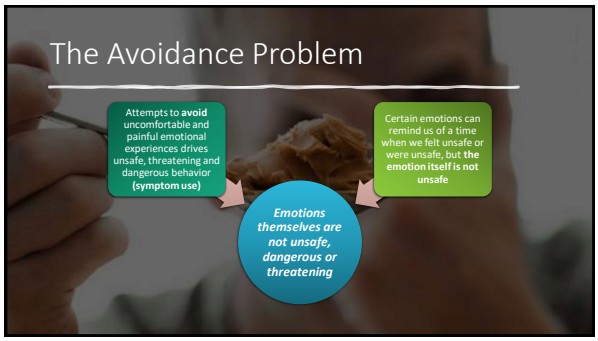
The Avoidance Problem
Attempts to **avoid** uncomfortable and painful emotional experiences drives unsafe, threatening and dangerous behavior **(symptom use)**
Certain emotions can remind us of a time when we felt unsafe or were unsafe, but **the emotion itself is not unsafe**
Emotions themselves are not unsafe, dangerous or threatening

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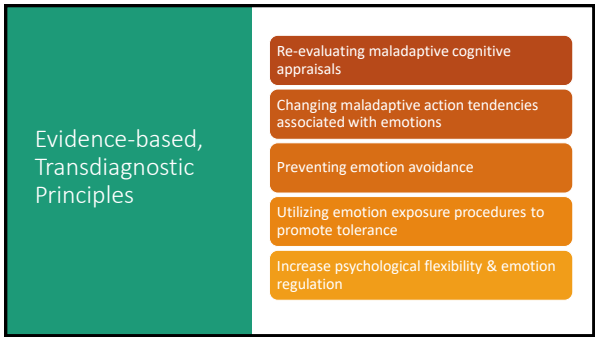
Evidence-based, Transdiagnostic Principles
Re-evaluating maladaptive cognitive appraisals
Changing maladaptive action tendencies associated with emotions
Preventing emotion avoidance
Utilizing emotion exposure procedures to promote tolerance
Increase psychological flexibility & emotion regulation

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Empirical Support for Exposure Therapy
Exposure Therapy is considered **the** treatment of choice for a range of anxiety-related disorders:
Phobias
Panic Disorder
Social Anxiety Disorder
Obsessive-Compulsive Disorder
Posttraumatic Stress Disorder
Generalized Anxiety Disorder

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Empirical Support for Exposure Therapy with EDs

Efficacy in eating disorders is rapidly gaining support

(Becker et al., 2019; Boswell et al., 2015; Boswell et al., 2019; Butler & Heimberg, 2020; Farrell et al., 2019; Griffen et al., 2018; Hildenbrandt et al., 2021; Levinson et al., 2020; Mulkens et al., 2018; Reilly et al., 2017; Steinglass et al., 2011; Wright & Waller, 2020; Zucker et al., 2019)

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Types of Exposures

In vivo exposure: Directly facing a feared object, situation or activity in real life.

Imaginal exposure: Vividly imagining the feared object, situation or activity.

Virtual reality exposure: In some cases, virtual reality technology can be used when in vivo exposure is not practical.

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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)

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Research-Practice Gap:

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

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Solution to the Problem

Demystify the process and outcome of exposure therapy through adequate training in the theoretical foundations & adequate practice of the skills to build clinician self-efficacy

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Evidence-based principles of emotion exposure

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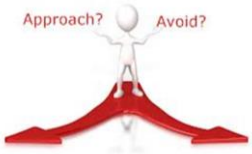
Approach methods vs. Avoid methods



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

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Exposure stimuli

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It's not about the stimulus. It's about the response

Exposure facilitates 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

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Exposure therapy process & outcomes

Habituation	Over time, people find that their reactions to feared objects or situations decrease.
Extinction	Exposure can help weaken previously learned associations between feared objects, activities or situations and bad outcomes.
Self-efficacy	Exposure can help show the client that they're capable of confronting their fears and can manage the feelings of anxiety.
Emotional tolerance	Client can learn to attach new, more adaptive beliefs about feared situations, and can become more comfortable with the experience of fear.

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The BIG Picture

Primary goal is **not** to reduce or prevent 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.

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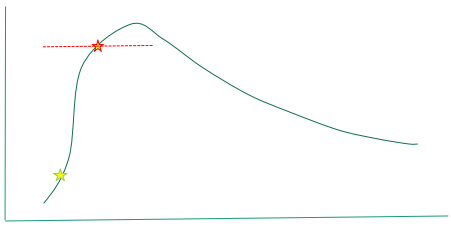
Natural course of emotions, with & without interruption



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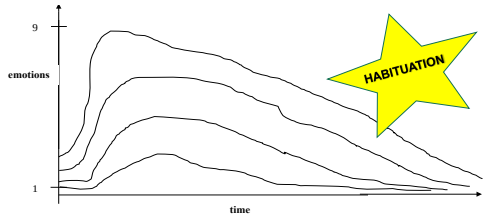
Decrease in emotional intensity over time with repeated practice



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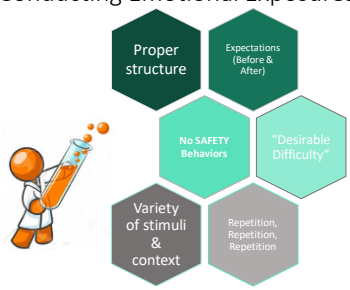
Conducting Emotional Exposures



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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

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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

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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?

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Interoceptive exposure

Building tolerance to uncomfortable bodily sensations

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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.

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Interoceptive that target common emotional experiences & sensations

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

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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)

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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.

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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			

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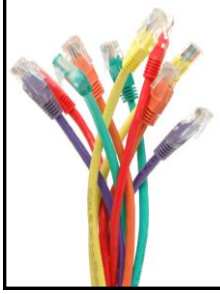

The wires get crossed

- 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).

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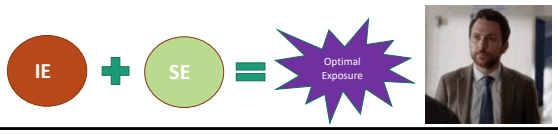
Trends in exposure therapy with ED

- 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



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ED-SPECIFIC INTEROCEPTIVE EXERCISES

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

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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)

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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!

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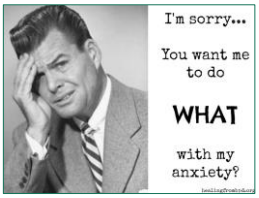
2nd time around …

- 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?



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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

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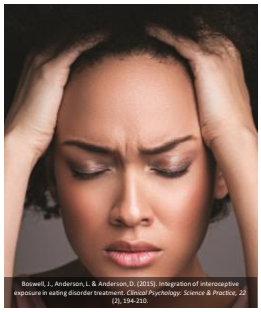

Boswell, J., Anderson, L. & Anderson, D. (2015). Integration of interoceptive exposure in eating disorder treatment. *Clinical Psychology: Science & Practice, 22* (2), 194-210.

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!

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Mirror exposure

Building tolerance to emotions associated with body image

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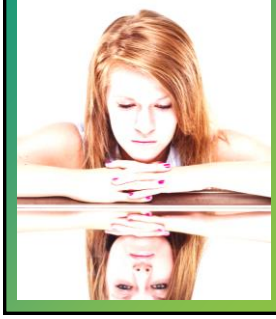

Mirror Exposure

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

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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	Evaluative/judgmental language
My eyes are almond-shaped	*Fat, chubby, thick, big*
There is a space between my eyebrows	*Thin, skinny, small*
My lips are light pink, the bottom lip is slightly fuller than the top	*Pretty, ugly, gross*

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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)

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Case example

Exposure protocol: ED & severe food allergies

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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

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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

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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

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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

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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

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Symptom Reduction

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

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

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thank you

The Renfrew Center
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