BINGE EATING TO ANOREXIA:

CAN ONE EATING DISORDER TURN INTO ANOTHER? SHIFTING DIAGNOSIS

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Agenda

Explore	Explore diagnosis shifts in eating disorder treatment.
Examine	Examine the individual, relational and societal factors that contribute to shifts in diagnosis.
Learn	Learn evidence-based strategies to treat emotional maintaining factors to prevent symptom substitution.
Address	Address the role of both the support system and the clinician in treating maintaining factors.

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A Note On Today's Webinar

This is a BIG topic to cover!

- We will cover a lot AND there will be so much more to do

Limitations in research in the eating disorder field

- Diagnostic overlap and fluidity: the EXACT topic we are covering is a noted limitation in research
- Sampling bias
- Measurement limitations: self report
- Limited longitudinal data
- Intervention and treatment gaps
- Stigma
- Funding

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Diagnostic Crossover / Shifts in Eating Disorders

Studies suggest that ED patients tend to change between different illness states over time

There is increasing awareness in the literature of the elevated likelihood of diagnostic crossover; research examining specific diagnostic profiles potentially misses outcomes where symptom experience transforms rather than alleviate

Diagnostic crossover may be mistaken for recovery

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Eating Disorders Review: Signs & Symptoms

Anorexia Nervosa

Signs of Anorexia include:
- Not eating when hungry
- Not eating enough
- Not eating certain foods
- Extreme fear of gaining weight
- Extreme exercise
- Obsessive thoughts about food, weight and exercise
- Rigid, perfectionistic
- Distorted view of body size

Bulimia Nervosa

Signs of Bulimia include:
- Binge eating
- Purging via self-induced vomiting, exercise, laxatives, diuretics
- Extreme fear of weight gain
- Obsessive thoughts about food and body size
- Impulsivity
- Weight changes in a short period of time
- Swollen face and/or neck
- Dental issues

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Eating Disorders Review: Signs & Symptoms

Binge Eating Disorder

Signs of Binge Eating Disorder include:
- Eats large amounts of food
- Eats much more quickly than normal
- Eats to the point of feeling uncomfortably full
- Eats alone or in secret because of shame and embarrassment
- Feels disgust or guilt after eating
- Negative body image
- Typically no purging behaviors

Avoidant Restrictive Food Intake Disorder (ARFID)

Signs of ARFID include:
- Picky/selective eating habits
- Sensory issues with food
- GI symptoms
- Fears of choking/vomiting
- Food allergies
- OCD/anxiety
- Foods that are “safe” and “unsafe”
- Some perceive certain types of food as inedible and describe food using non-food substances

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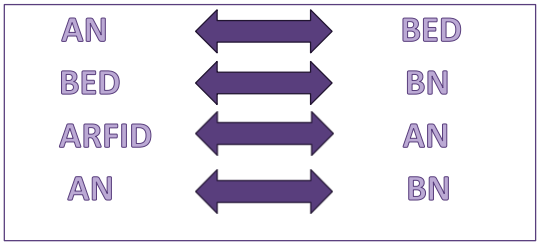
Diagnostic Crossover / Shifts in Eating Disorders



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Research on Diagnostic Crossover / Shifts in Eating Disorders

- Most studies of diagnostic crossover in eating disorders suggest that the likelihood of transitioning from a restricting eating disorder to a binge-spectrum eating disorder is almost twice the likelihood of the reverse
- Patients with AN are prone to shift from AN-R to AN-BP subtypes (and vice versa). Longitudinal studies have found that patients with AN-R will evolve into AN-BP in rates ranging from 9.5% to 64%
- Crossover form AN-BP to BN have been found in rates of 54% in 7 years of follow-up studies Two studies documented diagnostic crossover occurring from ARFID to anorexia nervosa in 3% and 12% of individuals.
- Findings may suggest that ARFID lack of interest could be a noteworthy precursor to a restricting eating disorder, and may protect against later development of a binge-spectrum eating disorder.
- By contrast, long-standing patterns of irregular eating and fasting through both ARFID and later transition to anorexia nervosa may contribute to increased risk for binge eating

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WHY DOES DIAGNOSIS SHIFTING OCCUR?

Diagnostic Hierarchy
Emotional Functions of Eating Disorders

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Eating Disorders, Identity, Social Acceptance

Identity
- Eating disorders can become deeply intertwined with sense of self
- Diagnosis and symptom presentation can become descriptors of the individual
  - AN: Controlled, disciplined
  - BN: Out of control, impulsive
  - BED: Glutenous, lack of will power
  - ARFID: Picky, child-like

Social Acceptance
- Human instinct and drive towards connection and acceptance from others
- Normalization ED behaviors and glorification of thinness
  - **ED as a tool for social acceptance**

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Influence of Weight Stigma

Research point to the moral associations of certain ED behavioral symptomology and cultural attitudes towards different body sizes (e.g., anti-fat bias), as part of the underpinning for why certain EDs are understood as 'better' or 'worse'

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Systemic Pressures and Stressors

Media Messages
- Diet culture, weight stigma, anti fat messages are prevalent in all media forms
- Weight loss medication marketing

Social Media
- Comparison to others
- Acute awareness of intimate details of others lives including food intake, exercise and use of weight loss medications

Community
- Race, culture and ethnicity norms
- Sexual Orientation specific norms
- Gender specific norms

Family
- Generational patterns and norms
- Exposure to judgement or criticism

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Research – Influence of Weight Stigma

- AN and BN are often described via binary oppositions - success and failure, control and out-of-control, strength and weakness - despite sharing many of the same diagnostic features and having relative high rates of diagnostic crossover
- Behaviors associated with AN, such as extreme dieting/self-starvation, the hallmark behavior of AN, have long been referred to as a form of ultimate control where an individual defies, conquers, and transcends their corporeal needs and desires.
- Individuals with BN do not 'conquer' their body via the same kind of disembodied will (i.e., self-starvation) like in AN. Instead, behaviors associated with BN (e.g., binge eating and purging) are described in terms of bodily desires overcoming the individual.

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Diagnostic Hierarchy

AN

BN

BED

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Diagnostic Hierarchy

- Existing research indicates that hierarchies and stigma exist among ED diagnoses whereby certain ED diagnoses are associated with higher levels of shame, guilt, and self-disgust
- Those who had experienced crossover from AN to BN and/or BED, it was found that being diagnosed with BN (after AN) stimulated feelings of shame and a sense of moral failure
- **From BED or BN to AN. Movement "up" the diagnostic hierarchy could induce different moral emotions such as pride**

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Eating Disorders are not just about food and weight

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Not Just About Food and Weight

Eating Disorders are Emotional Disorders.

Regardless of the specific behavior, eating disorder symptoms are often attempts to cope with uncomfortable emotions. This can look like avoidance of uncomfortable emotions, distraction from them, numbing, disconnecting or even immediate short-term relief.

This is also why just stopping the behaviors or making changes to weight is not enough to fully heal.

When the behaviors stop, the emotions continue and frequently become even more intense. With no adaptive way to manage, it is likely that another symptom will emerge to serve that function. This is how symptom swapping or substituting happens. One behavior may have stopped, but the need for managing distressing emotions has not.

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Maintaining Factors of Eating Disorders

- Temperamental propensity to experience negative affect more intensely and frequently;
- Eating/digestion-specific and emotion-focused interoceptive awareness & sensitivity
- Tendency to view emotional experiences as unwanted and intolerable
- Maladaptive emotion regulation behavioral strategies (attempts to avoid or dampen the intensity of uncomfortable emotion)

- FEAR: Something bad is going to happen and I won't be able to manage

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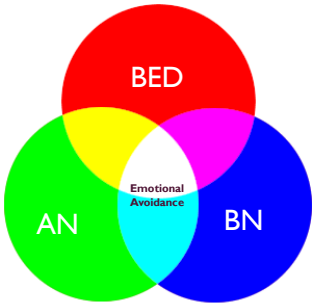

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Patterns of Learned Behavior

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

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

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

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Understanding Emotional Tolerance

Avoiding, Suppressing and Controlling WORK in the short term

Short term: Decreases emotions in the moment, patient and family feels immediate relief

AVOID → RELIEF

EMOTION → SUPRESS/CONTROL → RELIEF

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Understanding Emotional Tolerance

Avoiding, Suppressing and Controlling DO NOT WORK in the long term

Long term: The family will be responsible for providing relief

EMOTION → SUPRESS/CONTROL → RELIEF

REINFORCEMENT

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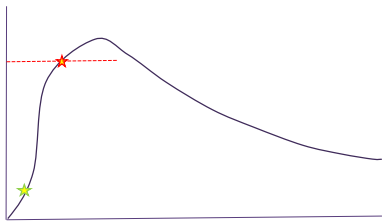
Natural Course of Emotions With & Without Interruption



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Eating Disorders are Emotional Disorders

Behavioral attempts to influence, change, or control painful emotional states

Function to regulate affect/provide momentary relief from aversive emotions

Therefore, recovery requires **experiential challenge** (doing things that have been habitually avoided) and reducing avoidance strategies

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INTERVENTIONS

Target experiential avoidance via Emotion Exposures
Bring in supports
Utilize the therapeutic relationship

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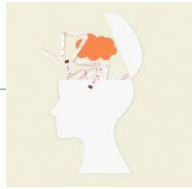
EMOTION EXPOSURES

Mood Induction
Interoceptive Exposures



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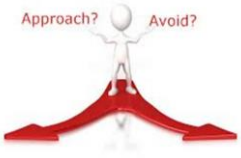
Approach mindset vs. Avoid mindset

- Lay out the rationale early in treatment.
- Buy in and willingness are necessary
- Inclusion of support system



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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.

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Mood Induction

Method: using songs, images, film clips, and so on to invoke a powerful emotion

Purpose:

- Observe differences in level of comfort & discomfort
- Notice when & what we do to escape those emotions
- **Learn it is possible for the emotion to decrease in intensity on its own**

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Why use media?

- Why not? It's everywhere!
- Induce emotion in session and practice not avoiding.
- Clients can bring in their own clips and helps to build connection.
- Practice skills – application in the moment
- Emotions exist everywhere, all the time!
- Emotions are what allow for true connection.

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Mood Induction Considerations

- Variability in stimuli
- Gauge of intensity
  - Still picture alone
  - Still picture + music
  - Video
- Your own level of discomfort

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Mood Induction Recording Form

Stimuli (e.g., video clip, song, image)	Primary emotional response	Intensity (0-10)	Secondary emotional response	Intensity (0-10)
	Emotions: Thoughts: Physical Sensations: Behaviors/Impulses:		Emotions: Thoughts: Physical Sensations: Behaviors/Impulses:	

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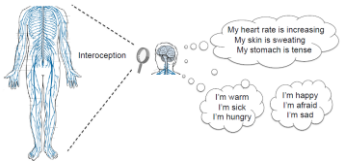

What is an interoceptive exposure?

Exercise designed to build tolerance of uncomfortable physical sensations

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

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Interoceptive Exercises

EXERCISE	SYMPTOM INDUCED	TIME/AMOUNT
Running in place	↑HR, ↑body temp, sweating	60 seconds
Spinning	Dizziness, nausea, loss of control	60 seconds
Hyperventilation	Lightheaded, numb/tingling	60 seconds
Narrow straw breathing	Shortness of breath	120 seconds
Tense body	Muscle tension, fatigue	60 seconds
Hand/wrist weights	Fatigue, motor retardation	Variable while completing tasks
Head rush	Dizziness, lightheaded, pressure	5 head drops & lifts

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ED-specific Interoceptive Exercises

Sensation/Symptom to be induced	Interoceptive exercise
Fullness, bloating, gastric functions	Gulping water or Pushing abdominal muscles out
Mechanoreception/tactile discomfort	Tight clothing or Tightening belt
Intense awareness of skin/body parts	Wet clothing
Feeling of body weight sinking into seat	Sit on very soft surface (pillows, bean bag)
Feeling of body, legs, buttocks "spread"	Sit on hard, flat surface

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Assessing for "similarity"

- To find the best, most helpful exercise for the client some **experimentation** may be required.
- Interoceptive exercises that produce physical sensations (and corresponding emotional response) that are **similar** to what the client feels during panic are the ones that we want to focus on & repeat.

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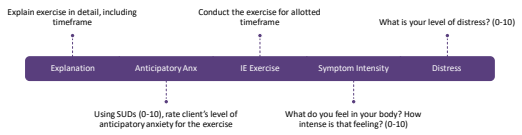
Interoceptive Exposure: Step-by-step



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Clinician Rules of Exposure

Do

- Do perform exercises with patient
- Do make sure the patient is not engaging in safety behaviors or minimizing the physical effects of the exercise
- Do address the patient's *interpretations* of their physical sensations prior and after

DON'T

- Don't forget to assess for injuries or medical conditions
- Don't stop the exercise before they experience any physical sensations (must go beyond perceived limit)
- Don't ask your patient to do anything you wouldn't do yourself

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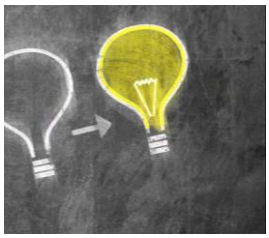
What if?



If the exercise is not producing the anticipated sensation or response, it is important to be curious and explore the following possibilities?

- Has tolerance already developed?
- Lack of similarity with personal experience of distress/intense emotionality?
- Well-practiced in avoidance/disconnecting?

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Repetition, Repetition, Repetition

- Repetition is required for any complex learning/skill
- 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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Connection

Support focus is on connection as a means of symptom reduction

- Emotion Coaching
- Connection Promoting Behaviors

Increasing connection and community as a protective factor in navigating weight stigma

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Ideal Support Responses to Eating Disorders

St. Bernard Response

- Calm
- Steady and consistent
- Loving and empathic

Dolphin Response

- Nudges towards safety
- Coaches
- Gently persuades

Adapted from *Skills-Based Learning for Caring for a Loved One with an Eating Disorder* by Janet Treasure, Grainne Smith and Anna Crane

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Emotion Coaching

1.) **ATTEND** to the emotion
    Notice AND pay attention to the emotion
2.) **LABEL** the emotion
    Give words to the emotions, check in
3.) **VALIDATE** the emotion
    Accept/allow/validate the emotion
4.) **MEET** the **NEED** of the emotion
    Meet the emotional need, not solve the problem

5.) "Fix/problem solve"

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Clinicians Are Humans Too

Clinician Emotions

- Most clinicians go into the field to help
- Clinicians have emotions and lived experiences that influence therapeutic interactions

Clinicians Have Feelings Too

- What are your expectations of clients based on diagnosis?
- How are these expectations rooted in bias? Experience?
- How are these expectations rooted in <u>your needs?</u>
- How are these expectations impacted by perceived lack of progress with complex presentations?

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Clinicians Are Humans Too

If we are uncomfortable with the emotion that a patient or situation is evoking, we may respond out of the desire to <u>stop/avoid/manage our own emotions.</u>

Are your clinical decisions and actions
fueled by your need to change your emotional experience?

What emotions are you
uncomfortable experiencing?

- Personally?
- Professionally?

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Clinician Bias – Client Fears

Do you treat clients with different diagnoses differently?

- Anorexia:
  - Clinicians are more concerned about medical stability and weight due to restriction and/or compensatory behaviors
  - Clinician hesitancy to treat due to perceived risk and liability; low insight into disorder
- Bulimia:
  - Clinicians concerned about medical stability due to compensatory behaviors
  - Clinician hesitancy to treat due to perceived risk and liability; may extend to co occurring issues
- Binge Eating Disorder:
  - Clinicians less concerned about medical stability
  - Clinicians less hesitant to treat; clients perceived as more motivated for change due to alignment with systemic weight stigma and beliefs surrounding eating behaviors
- ARFID
  - Clinicians hesitant to treat due to lack of knowledge and experience – picky eating?
  - Clinicians less hesitant to treat due to lack of body image concerns

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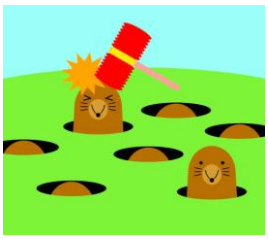
Clinician Bias – Client Fears

While eating disorder diagnoses present differently, all eating disorders need the same intensity, quality and urgency of treatment

How do we as clinicians ensure that we are not replicating the fears our clients experience regarding eating disorder symptoms and diagnosis?



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Increasing Clinician Awareness

Date/ Time	Situation	Physical Sensations	Thoughts	Behaviors	What happens next? Consequences

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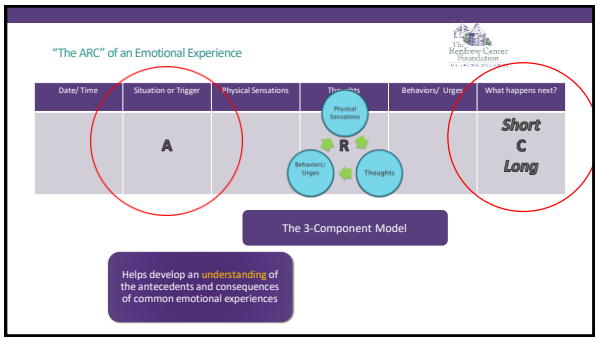

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Increasing Clinician Awareness

Antecedents for Clinicians

- Internal factors
- Environmental factors
- Systemic factors
- Historical

Short vs Long Term for Clinicians

Short Term
- Temporary relief

Long Term
- Uncomfortable in the short term
- Aligned with values

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Diagnosis Utility

- What is the best way to classify eating disorders?
- What is the clinical validity and utility of diagnostic categories?

Do you / how do you use diagnosis in your work with clients?

Addressing shame within eating disorder diagnosis hierarchy
- Acknowledge
- Validate
- Express unconditional positive regard and support

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Questions ? Thoughts ?

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