Psychotherapy

Valerija Sipos, Ulrich Schweiger

Treatment of Eating Disorders by Emotion Regulation

Kohlhammer

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This book is dedicated to the Venerable Ayya Khema. She taught us the principles of mindfulness. Our encounter with her had a huge impact on the paths we chose in our life.

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Foreword

Since ancient times it has been known that mental disorders and abnormal eating patterns are closely linked, as is the case with loss of appetite and impaired mood (melancholy). Anorexia nervosa was mentioned in the 19th Century as the first specifically described eating disorder (Gull 1997; Lasegue 1997) , whereas Bulimia nervosa (Russell 1979) and binge-eating disorder (Spitzer 1991) were not described until the end of the 20th century. Specific forms of treatment for eating disorders were first introduced and developed in the last decades of the 20th century.

The best evaluated manual-based, cognitive-behavioural therapeutic approach for the treatment of eating disorders was developed by Chris Fairburn, and is referred to as Cognitive-Behavioural Therapy - Expanded (CBT-E). This treatment method employs a psychological paradigm which focuses on the phenomenon that restrictive eating behaviours in particular are able to compensate for disturbed self-esteem (Fairburn, 2008) . CBT-E successfully reduces symptoms, irrespective of the severity of the disease. With a short duration of illness, absence of comorbidity and favourable psychosocial circumstances it can restore even global psychosocial functioning and quality of life. So why develop more behavioural methods? For one thing, remission rates achieved with CBT-E (up to 45 %) have significant room for improvement. Significant limitations arise with the treatment of eating disorders when they are embedded within complex emotion regulation difficulties.

This manual therefore sets a different tone. Scientific data has shown that a disturbance of emotion regulation is a significant cause of psychopathology (Kring and Sloan, 2010) and that it is also an important aspect of eating disorders. In this manual, we therefore rely on the basic assumption that inadequate skills in emotion regulation represent the major sustaining factor for the disorder. This approach is supported by the fact that training of these skills has already proven effective in patients with borderline personality disorder and comorbidity (Chen et al. 2008; Cooper et al. 2007; Telch et al. 2001) .

We consider this manual to be within the framework of the psychotherapy development conceptualised as “third wave of behavioural therapy”. Methods within this development abstain from an abstract disputation of thought content from so-called dysfunctional cognitions (for example, the thought “I’m too fat” in a patient with anorexia nervosa). Instead, these new methods deal with the skills that are lacking in certain patient groups in the interpersonal, emotional, and meta-cognitive domains. In this context, psychotherapy is dedicated more to procedural and emotional learning processes. Another common feature is that themes such as acceptance, mindfulness, dialectics, values, spirituality, fusion-defusion, schemata, relations, but also metacognition and other improvements in cognitive psychology

receive attention. All methods within this development adhere to a learning theory framework (Hayes 2004) .

The manual is based on the 28 years of experience that the two authors have had in the treatment of eating disorder patients at the Max Planck Institute of Psychiatry, at the Roseneck Clinic in Prien am Chiemsee and in our special ward at Lübeck for patients with eating disorders and personality disorder. Ideas for this manual and psychotherapeutic techniques were incorporated over this time from a variety of sources by attending workshops, reading books and conducting interviews before they were adapted for the treatment of patients with eating disorders. Particularly worthy of mention are individuals such as Frederic Kanfer (Kanfer et al. 1965), Karl-Martin Pirke (Pirke et al. 1986), Manfred Fichter (Fichter, 1989), Marsha Linehan (Linehan, 1993), Martin Bohus (Bohus and Wolf 2009) , Matthew McKay (McKay et al. 2007) , Steven Hayes (Hayes et al. 1999), James McCullough (McCullough 2001) , Adrian Wells (Wells, 2009), John Williams (Segal et al. 2002), Jon Kabat-Zinn (Kabat-Zinn, 2008), Christopher Fairburn (Fairburn, 2008), Achim Peters (Peters et al. 2004), David Barlow (Barlow et al. 2011) as well as the meditation masters the Venerable Ayya Khema (Khema, 1988) and the Venerable Nyanabodhi. An important philosophical source was a book written by Peter Sloterdijk, namely "You must change your life" (Sloterdijk, 2010) .

This manual describes a therapeutic option for patients with eating disorders (anorexia nervosa, AN, bulimia nervosa, BN, binge eating disorder, BED, and eating disorder not otherwise specified (EDNOS), especially when the comorbidity of a borderline personality disorder or other mental disorders are present.

Valerija Sipos and Ulrich Schweiger

Handling of the manual

The manual should be handed out to the patient either in parts or in full so that he or she is then able to work through it in full. It represents the common basis both for the patient and the therapist. The manual can either be systematically worked through from the start or an individual strategy may be chosen based on the specific problem of the patient. Such a focus is typically required when the manual is used in combination with a hospitalisation where time is restricted. The manual can be used as a component of an intensive inpatient or outpatient therapy. In this context it can usefully be integrated into group therapies, individual therapies, therapeutically accompanied mealtimes, sports therapies, mindfulness exercises, social skills building exercises and any other complementary activities. It can also be used in an exclusive therapeutic setting or as a self-help manual.

The manual contains information materials and worksheets, but should not be misunderstood as being a psychotherapy cookbook. The focus should remain on the individual psychological paradigm for each patient and the skills that the patient needs in the long term for escaping the vicious cycle of their eating disorder. The therapist should choose the worksheets to work through using this objective as his starting point.

Part 1

1 Symptoms of the eating disorder module

1.1 Who is this manual for?

The treatment of eating disorders through emotion regulation is aimed at patients who suffer from an eating disorder and other related problems. This module is intended to assist the patient in becoming an expert with his or her own problem. There are many individual variations of eating disorders. In order to plan your treatment accurately, it is important that you know what symptoms are present and what symptoms are not present. If you are unsure whether an eating disorder is a major problem for you, just work through the module and discuss any outstanding issues with your therapist.

For an eating disorder to be present, two criteria must be fulfilled:

1. The eating behaviour must be altered (e.g., intense fasting, vomiting of food) *and*
2. The altered eating behaviour leads to physical endangerment (e.g. underweight, disruptions of mineral metabolism) or psychological impairment (e.g. your whole attention is directed towards thinking about food, depression).

Eating disorders are often associated with problems of emotion regulation. This manual deals with this relationship between emotions and eating behaviour.

1.2 Symptoms of an eating disorder

If you're wondering whether you are suffering from an eating disorder or not, or if you suffer from an eating disorder and you want to characterise this disease more precisely, then go through the list and consider which symptoms apply to you (worksheet 1).

☐ Are you underweight or overweight?

To determine this, you need to know your body weight and body size. For measuring purposes use a calibrated scale and a calibrated height measurement device

(e.g. at your GP). Weigh yourself before breakfast in the morning in light clothing. Your body height must be measured without wearing any shoes. The formula BMI = weight (kg) / height^2 (m^2) can be used to calculate the body mass index. You can find BMI calculators on the internet, e,g, at http://www.bmi-calculator.net/.

The BMI in young women is too low if it less than 18 kg / m^2, whereas over 26 kg / m^2 it is too high. Health endangering obesity starts at a BMI of 30 kg / m^2.

For men, the same relationship exists between BMI and health as it does in women, even if higher limits are given in some tables.

For women and men who engage in power sports, higher BMI limits apply. During the course of a healthy aging process the BMI increases slightly, i.e. a slightly higher BMI is associated with a maximum life expectancy.

For children there is no simple "rule of thumb" for the normal range of weight. It is therefore necessary to use either special tables derived from the internet or paediatric textbooks to determine whether the BMI of a child or adolescent lies within the reference range. These tables use percentiles. Underweight or overweight is considered as the weight below the 3rd or 5th, or above the 95th or 97th percentile.

Waist girth: Waist girth measurements are designed to assess body fat distribution. If a woman's waist girth exceeds 88 cm and a man's exceeds 102 cm it is assumed that the volume of abdominal fat (visceral or intra-abdominal fat) is too high. It is important to measure horizontally with a tape measure while standing upright, half-way between the lower ribs and upper edge of the pelvis, and while exhaled and with a relaxed abdominal wall. If you are unsure about this you can let your doctor do the measurement.

☐ Do you think a lot about food and food related matters?

An important indicator of an eating disorder can be if you constantly think about food or think about your eating behaviour so that it affects your ability to concentrate.

☐ Do you restrict your calorie intake?

Check which of the following behaviours are typical for you:

- O Multiple daily weighings for closely monitoring changes in body weight
- O Avoidance of high-calorie, fatty or carbohydrate-containing foods
- O Skipping meal components such as desserts or even whole meals
- O Chewing and spitting out food
- O Precise determination of the calorific content of meals, e.g. by weighing and use of calorie tables
- O Avoidance of foods whose calorific content is not clearly identifiable, e.g. where someone else has prepared some soup
- O Use of sweeteners, fat substitutes and light products
- O Use of appetite suppressants or nicotine for appetite control

- O (Self) limitation to one or two meals per day
- O Limitation to a certain number of very small meals
- O Consumption of large quantities of fluid before meals in order to restrict intake of nutrients
- O Restriction of fluid intake in order to make it more difficult to eat (e.g. thirst or dry mucous membranes)
- O Shopping for food which you know you do not like to eat in order to control your own eating habits
- O Hoarding of food that is looked at but not eaten
- O Use of salt, pepper and other spices to make food difficult to eat
- O Use of specific thoughts to make the consumption of food that you would otherwise like to eat unappealing. For example, the notion that chocolate is contaminated with mouse droppings or the notion that the chef spat in the soup
- O Avoidance of eating publicly in order to avoid distraction while eating
- O Avoidance of eating publicly due to shame about one's eating habits or to prevent others commenting on your eating behaviour
- O Use of constricting abdominal belts, confining clothing or muscular tensing in order to create an early feeling of satiation when eating
- O Use of tongue piercings or self-injury in the oral cavity to make it more difficult to eat

☐ Do you try to undertake something once you have eaten?

This refers to all behaviours intended to remove liquids or other energy sources rapidly from the body once they have been consumed.

- O Vomiting, either automatically, after stimulation of the throat, or assisted by chemical substances that promote vomiting, such as cough syrup or salt solutions, or vomiting promoted by revolting thoughts
- O Consumption of herbal or chemical laxatives
- O Consumption of herbal or chemical diuretic agents
- O Use of thyroid hormones (to increase the basal metabolic rate)
- O Excessive exercise, i.e. exercise that no longer serves an individual's health or well-being, but which merely burns calories
- O Intentional tightening of the muscles (isometric exercises)
- O Intentional shivering (by wearing thin clothing) to consume calories
- O Intentional sweating to lose fluid (e.g. longer visits to the sauna without adequate fluid replacement)
- O Omission of insulin (if you have type 1 diabetes) to excrete sugar in the urine

☐ Do you eat at unusual times or without a fixed structure?

- O Is food consumption distributed throughout the day and without any fixed mealtimes?
- O Do you eat sweets instead of meals?

- ○ Do you eat under stress when it is not your mealtimes?
- ○ Do you eat only one meal a day?
- ○ Do you eat more than four meals and snacks per day?
- ○ Do you eat the majority of food at night, after 20:00 and before 06:00 in the morning?
- ○ Do you eat at night when you wake up?

☐ Do you binge eat?

The term binge eating describes an episode of food consumption during which normal control is lost or not even exercised. If amounts of food are eaten which in terms of calorific consumption far exceed those of a normal meal, this is referred to as objective binge eating. A precise calorie limit has not been defined, but often 1000 kcal is taken as a limit (one exception to this rule comprises meals that are taken on days of intense physical labour or exercise). Food consumption that is unplanned or unwanted, but which do not objectively represent quantities exceeding normal levels of intake can also be subjectively perceived as a binge. With binge eating, foods are typically consumed that would otherwise be "forbidden" or avoided. With a longer lasting eating disorder binge eating episodes are often precisely planned, i.e. foods are purchased specifically for binge eating and plans are made to ensure that nobody interferes with the binge eating. If you are unsure of whether you undertake binge eating or not, make detailed records and discuss them with your psychotherapist or doctor.

☐ Are there any signs of physical danger?

Eating disorders endanger your physical health and can entail serious and dangerous consequences. Pay particular attention to the following points and let your doctor examine you!

- ○ Underweight
- ○ Overweight
- ○ Disturbances of electrolyte metabolism (most commonly: inadequate levels of potassium and phosphate)
- ○ Disturbances in heart rhythm
- ○ Changes in blood pressure
- ○ Disrupted renal function
- ○ Sex hormone disorders (such as menstrual disorders)
- ○ Disorders of bone metabolism (e.g. fractures occurring at low loads, decreased bone density values upon measurement)

☐ Does your eating disorder restrict your activities or quality of life?

Eating disorders can lead to severe restrictions of performance at school or work because they draw immensely on concentration and energy resources. In addition,

quality of life can also suffer. Preoccupation with food can displace leisure activities or the maintenance of friendships so that there is a danger of falling into isolation and withdrawing from social interactions. With eating disorders where underweight is also present, an increased performance and activity may be present during the early stages of the disease. This situation can conceal the fact that the eating disorder is actually a disease. However, this activated state is at best only temporary.

If several of the above apply and quality of life is affected, you should - if you have not already done so - speak to a specialist who can then carry out a detailed diagnosis.

Common problems associated with eating disorders (comorbidities)

An eating disorder will sometimes be the only psychological problem that a person suffers from. Quite often, however, it can also appear alongside other disorders. Look at the list below to see which situation applies to you.

☐ Depression

- ○ You are usually in a bad mood
- ○ You no longer have interest in things that were once important or enjoyable
- ○ You suffer sleep disorders (you do not feel regenerated after sleeping, or you suffer inadequate or even excessive sleep)
- ○ You suffer a lack of drive
- ○ You have an increased perception of pain and other unpleasant bodily sensations
- ○ You have a tendency to ponder and brood, and to worry and ruminate (preoccupation with earlier mistakes)
- ○ You entertain thoughts of not wanting to live any more or even worse, to kill yourself

☐ Anxiety

- ○ You avoid crowds, department stores, subways, car journeys, heights, flying, certain people or certain social situations
- ○ You suffer panic attacks (sudden attacks of intense anxiety with physical signs and a fear of dying or going crazy)
- ○ You preoccupy yourself with concerns and worry (frequent thoughts of the bad things that might happen in the future without any reasonable cause of danger)
- ○ You have compulsions (thoughts that might appear to be exaggerated, but which might compel you to do something to counteract them. For example, the idea: "After touching that doorknob I now have germs on my hands" which then leads you to constantly wash your hands at every opportunity)