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PUTTING THE EATING BACK IN EATING DISORDERS

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Introduction

Eating is a complicated process that involves interactions between the homeostatic system, internal and external motivators, and self-regulatory control processes (1). The self-regulatory system is where an individual's goals, values, and meaning are integrated, and from there decisions about eating can be made (1). But, if eating disorders (EDs) are *biopsychosocial* disorders, then every one of those three areas that already makes "normal" eating complicated becomes more scrambled. Thus, symptoms are maintained intrapersonally and interpersonally by the positive and negative responses the eating disorder elicits (2). Particularly when one considers that EDs, especially anorexia nervosa (AN), are often *egosyntonic* (3), meaning that the behaviors, values, and feelings are in harmony with or acceptable to the needs and goals of the individual. This is classically exhibited in patients with AN who deny that they have a problem, even when markedly underweight and experiencing health complications.

It is estimated that approximately 50% of people with EDs suffer from obsessive-compulsive spectrum disorders (4), which includes obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder (OCPD). OCD is an anxiety disorder characterized by intrusive obsessions that lead an individual to engage in repetitive behaviors, even though he/she may realize that the obsessions are unreasonable (5). OCPD is a personality disorder characterized by extreme perfectionism, desire to be in control of situations, inflexibility, and preoccupation with orderliness and rules (6). Up to 60% of patients with anorexia are diagnosed with comorbid anxiety disorders (7), under which OCD falls, and these factors may be both risk and maintenance factors for EDs (2). Therefore it is worth examining OCD concepts to see if any will benefit treatment providers' understanding of patients with eating EDs.

The Intersection of ED and OCD

Treasure et al. propose that EDs develop, "from an abnormality in emotional learning and memory processing related to food or cognitive representations of food in the form of weight and shape (1)." Negative food associations could be related to any of the following: traumatic experiences that involved food, weight, or shape; threatening information about food, weight, health; learning about food fears from others; and developmental factors. Schmidt and Treasure suggest that ED behaviors (especially restrictive AN) are a mechanism with complex defensive functions, which act to reduce external and internal threats (2). Often the negative food experiences lead to *experiential avoidance*, which occurs "when the person is unwilling to remain in contact with particular private experiences (e.g. bodily sensations, emotions, thoughts, memories…) and takes steps to alter the form or frequency of these events and the contexts that occasion them (2)."

The glaring similarity between EDs and OCD is that patients report engaging in behaviors that are organized around an irrational belief, which result in avoidance of sufficient caloric intake (7). The symptoms that manifest to cope with adverse experiences include several components that are similar to OCD and/or OCPD, such as: perfectionism and rigidity, meticulous attention to details, body checking, reassurance seeking, ordering, magic ritualizing, and terror of making mistakes (2,8). For the individual with an ED this is the typical "black and white" thinking or other cognitive distortions that they may exhibit. A cognitive distortion that was originally associated with OCD but may be specific

to eating pathology is *thought-shape fusion* (TSF) (8,9), which can be described as "a belief that merely thinking about eating a high-caloric food leads to perception of weight gain and moral transgression, as well as increased body dissatisfaction (9)." Specifically there is some research showing that patients with anorexia-restrictive subtype are less capable of diffusing TSF because of reduced ability to re-label pathological mental events as unusual (9).

The longer an individual stays in a chronically starved state, the more unpleasant eating will be, as he/she encounters feeling bloated, nauseous, and overfull, thus eating further threatens the physical and emotional equilibrium (2). When taken to an extreme, these often result in rituals regarding food, exercise, and weight (to name a few) (1):

- Precise planning: e.g. "*If I eat this, then I will run this long"*
- Magical/superstitious thinking: e.g. "*I need to carry, store and prepare my food separately from the food of other people in order to prevent calorie contagion."*
- Ritualized counting applied to cutting, biting, chewing; and of course calorie counting
- Food rituals: such as eating foods in a certain order, picking things apart, etc.
- Certain exercises before and after meals

Obviously there are several areas where the similarities between EDs and OCD can be seen. Over time these neural patterns set in and become the default steps to reduce anxiety and emotions. The factors that maintain the illness are often intensified by starvation and, conversely, begin to relent when the patient moves to a healthier weight range (2). As Treasure et al.(1) eloquently put it: "Recovery therefore entails the unlearning of these conditioned responses, an extinction process which involves the production of new non-fear extinction pathways, as opposed to the erasure of old pathways."

Exposure with Response Prevention

Exposure with Response Prevention (ERP) is a strategy that Treasure et al. (1) suggest which is commonly used in OCD treatment and occasionally in social anxiety treatment. Steinglass et al. (7,10) also found that using the ERP model helped decrease anxiety and increase caloric intake in individuals with AN. ERP begins with identification of anxiety and feared consequences, and then moves on to exposing the client to the triggering experience that kicks off the obsessions (anxiety about calories, strong urges to engage in unhealthy compensation behaviors, etc.). The session is in a supportive setting where compulsions (running, purging, etc.) are not allowed, or at least put off for as long as possible. Instead, the intervention focuses on enhancing the client's awareness of physical and emotional symptoms, and articulation of fears. Over time and repeated exposure, the patient experiences habituation of anxiety and confirmation that the feared outcomes did not occur (7) (e.g. immediate obesity, loss of control, etc.). Often the client is encouraged to make a hierarchy list of foods or situations to tackle and start from the bottom and work their way up. These exposures could happen in a variety of ways, to name a few:

- Meal support
- Bringing challenge foods to sessions, eating it, and then sitting through the resulting emotions
- Not engaging in disordered eating behaviors or self-harm for a certain amount of days
- Self-care "vacations"
- Grocery store trips
- Cooking and eating meals

Conclusions

A client's exposure can be as small as adding a teaspoon of margarine to dinner every day, or eating a taste of a binge food without eating the entire amount or purging afterwards. It is impossible for anxiety to continue at that initial sky-high level, but it means putting off the short-term gratification of yielding to the obsession-compulsive tug, and instead working for the long-term gratification of recovery. Easier said than done, but it can be done. Encourage a client to choose one challenge food for the week, or even a month if that is what it takes. Working toward recovery involves tackling those eating challenges, and they cannot be tackled without exposure. Practice makes progress, and progress will eventually lead to whatever the client's recovery will look like.

About the Author

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