Accuracy, empathy, and alliance in the treatment of eating disorders: A clinical perspective

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University of Hawaii

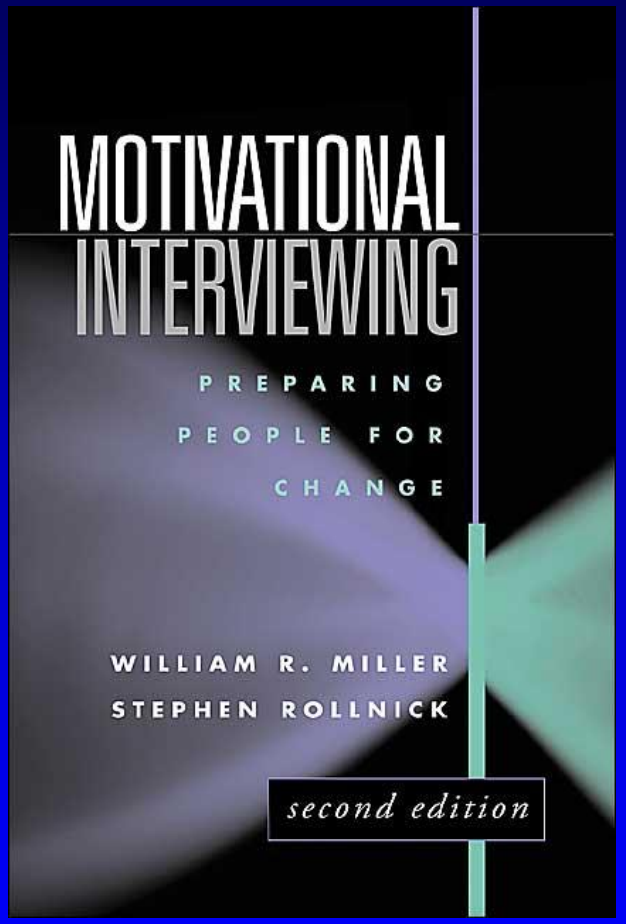
10th London International Eating Disorders Conference, March 2011

My assignment is to give an essentially clinical perspective

– but a focus on technique doesn't fit the format

Skills acquired in two-day MI workshops

decay during the first few months post-training



We have ~25 minutes

Recommendations for therapists' set and style
(Vitousek, Watson, & Wilson, 1998)

- be attuned to the patient's perspective
- be respectful of individuality and autonomy
- be collaborative
- be honest
- be curious
- be focused and systematic
- be patient

I’m going to step back to take a broader perspective
on accuracy, empathy, and alliance in the ED field,

with a couple of reflections on how we’re coming along

It’s not self-serving to say that the going can be rough for clinicians in this specialty area

Light-duty leave

from their work with EDs

“But I did so little, and the patients just got well!”

Even specialists struggle to understand AN
both accurately and compassionately –

and many admit to finding it “mysterious”

Common descriptors for AN

- baffling
- mystifying
- puzzling
- impenetrable
- “non-understandable”

Clinicians may be more reluctant to own up
to persistent problems with empathy and alliance

but here is the verdict of one recovered patient …

Psychotherapists do not like anorexics,
and anorexics do not like psychotherapists.

- *MacLeod, 1982, p. 121*

I’ve worked in the ED field long enough
to reminisce and compare past with present,
and here are some impressions* …

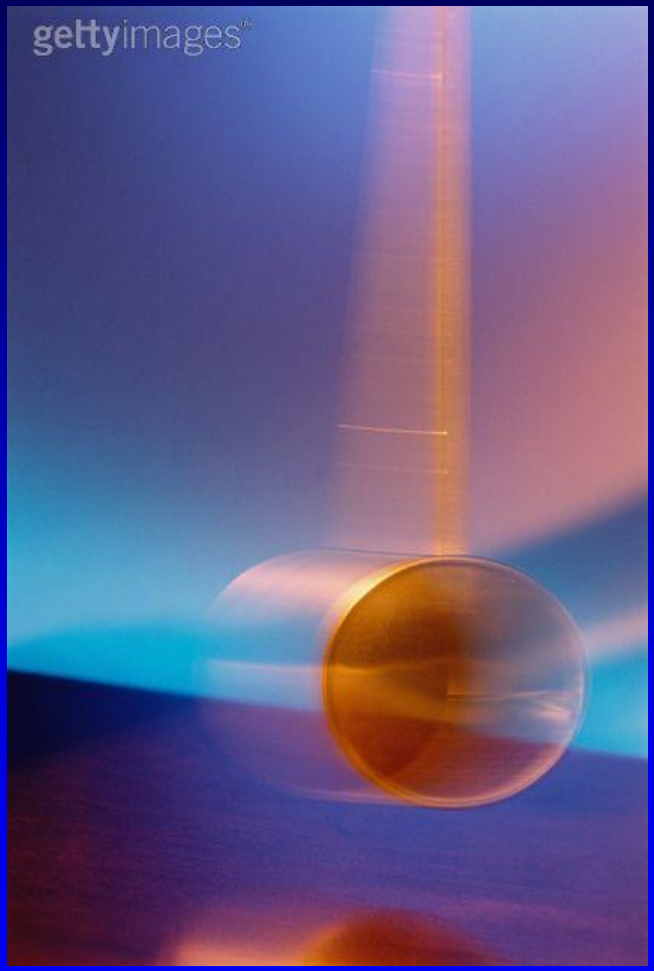
* reliability and validity not guaranteed

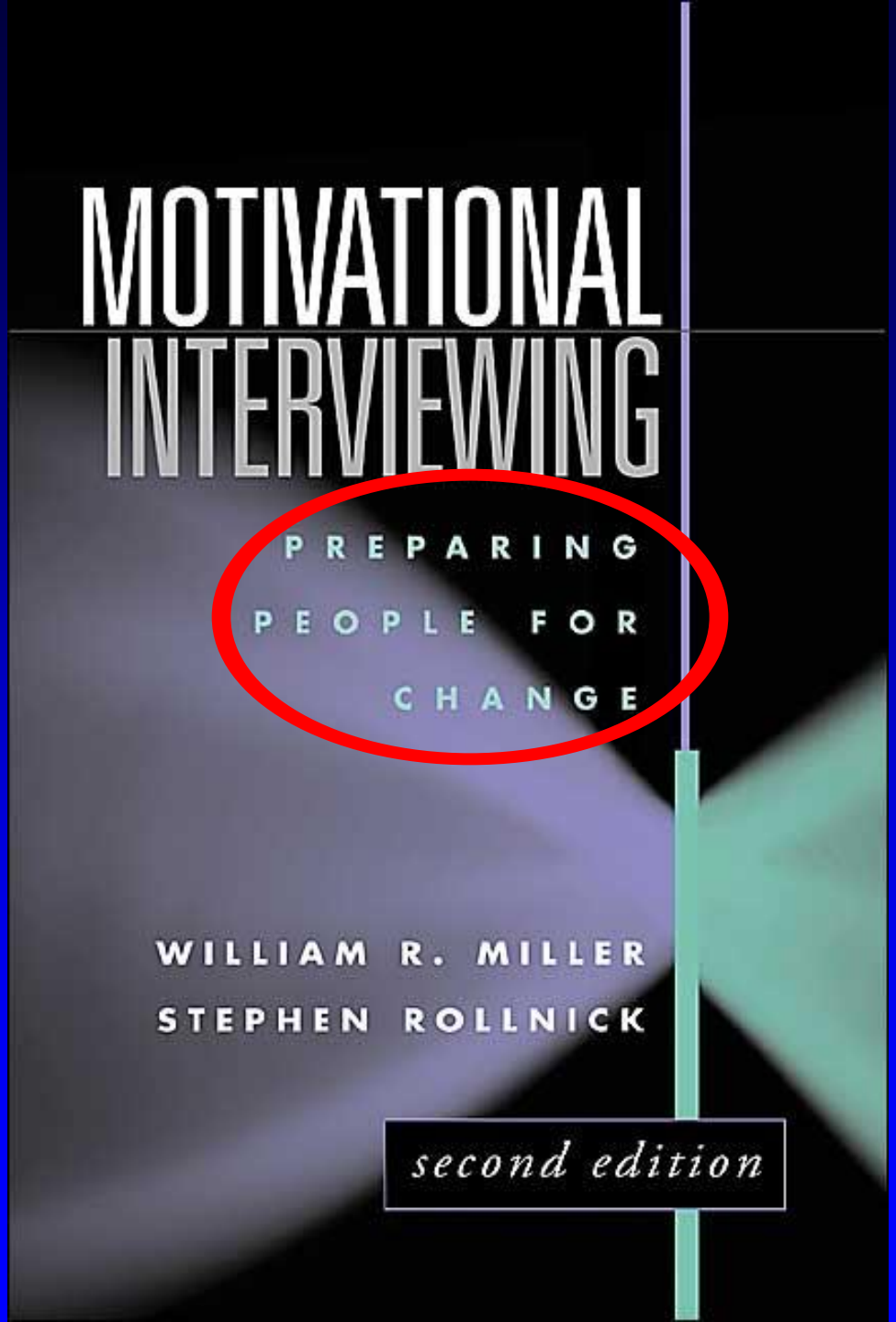
We’re doing a better job of talking with our patients

Likely contributors

- broad developments in the treatment field (e.g., MI, DBT)
- increasingly specific descriptions of ED therapies (e.g., manuals on CBT, FT)
- heightened interest in ED patients' own perspectives on motives, symptoms, and the prospect of change

Recently, we've started to feel somewhat let down
by motivational methods
because they didn't do the trick, after all …

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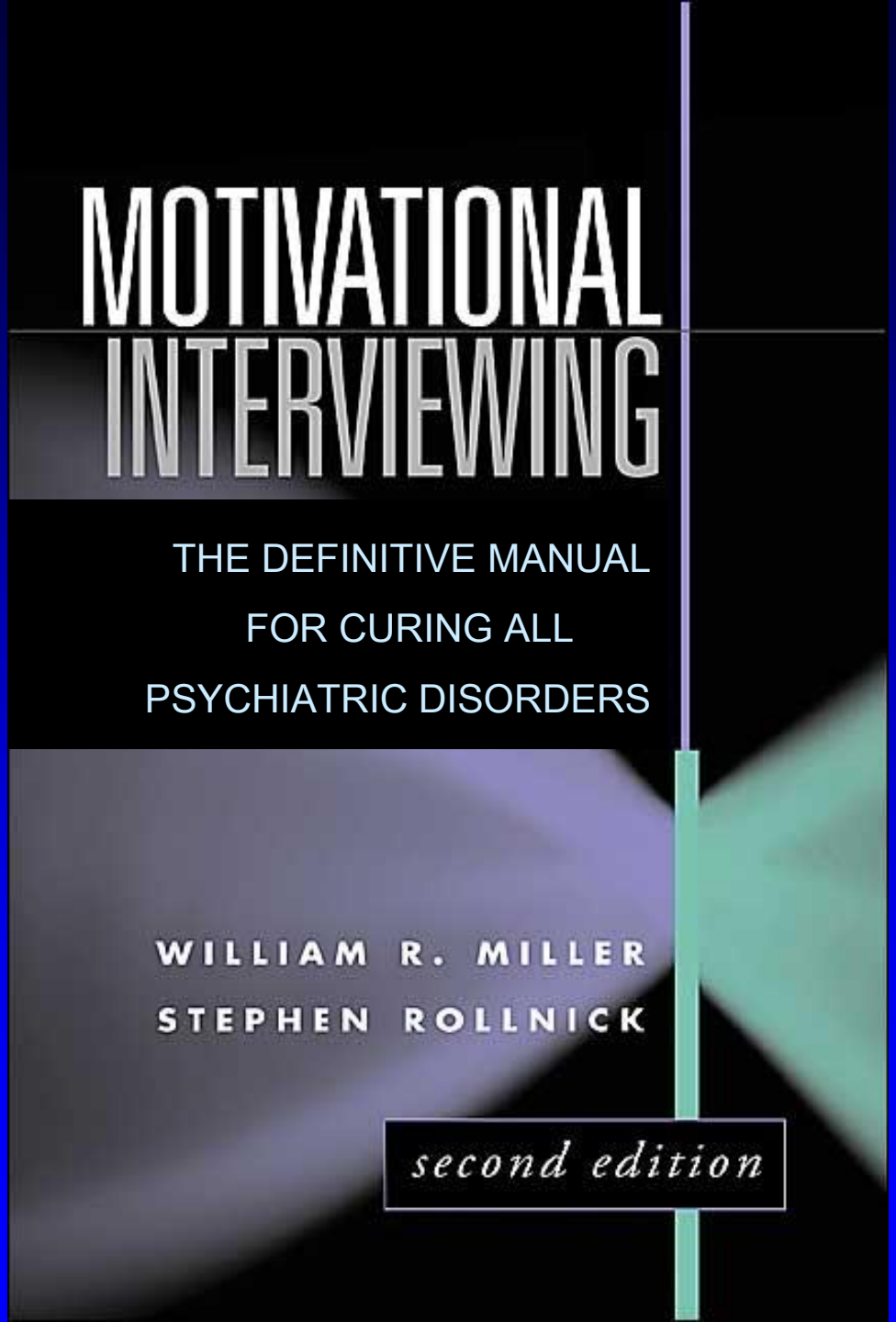
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Which of these should go?

- be attuned to the patient's perspective
- be respectful of individuality and autonomy
- be collaborative
- be honest
- be curious
- be focused and systematic
- be patient

It should be noted, too, that we may be doing a better job of talking about talking with our patients,

without actually using the styles we endorse

[Research on MI has obtained] near-zero correlations between clinicians' self-perceived competence [and] their actual observed proficiency [in rated samples].

- *Miller & Rollnick, 2009, p. 136*

Another positive change:

We’re more invested in finding ways to see these disorders that bypass blame

We do a better job of appreciating and communicating the difficulty of change

I don’t know that we’ve learned to listen to what patients say or to observe what they do more thoughtfully and analytically

We still have trouble coming to terms with AN itself

The disorder has some rather awkward features

Image Bank

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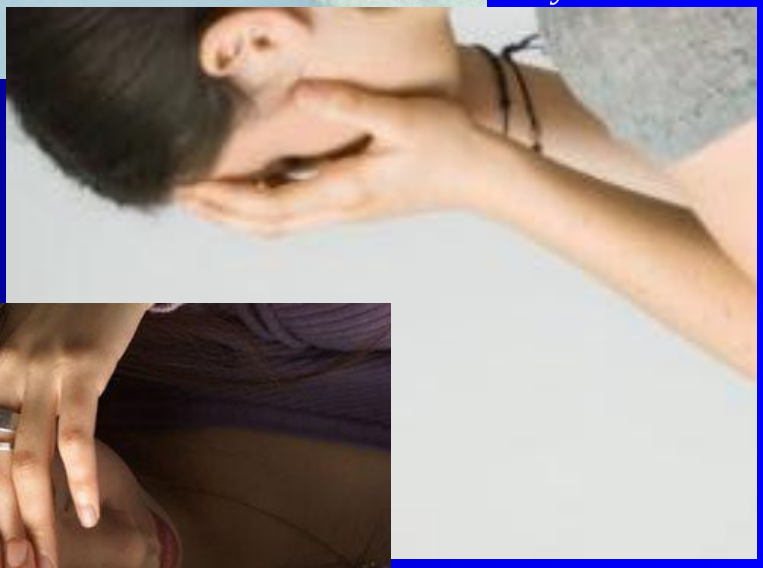
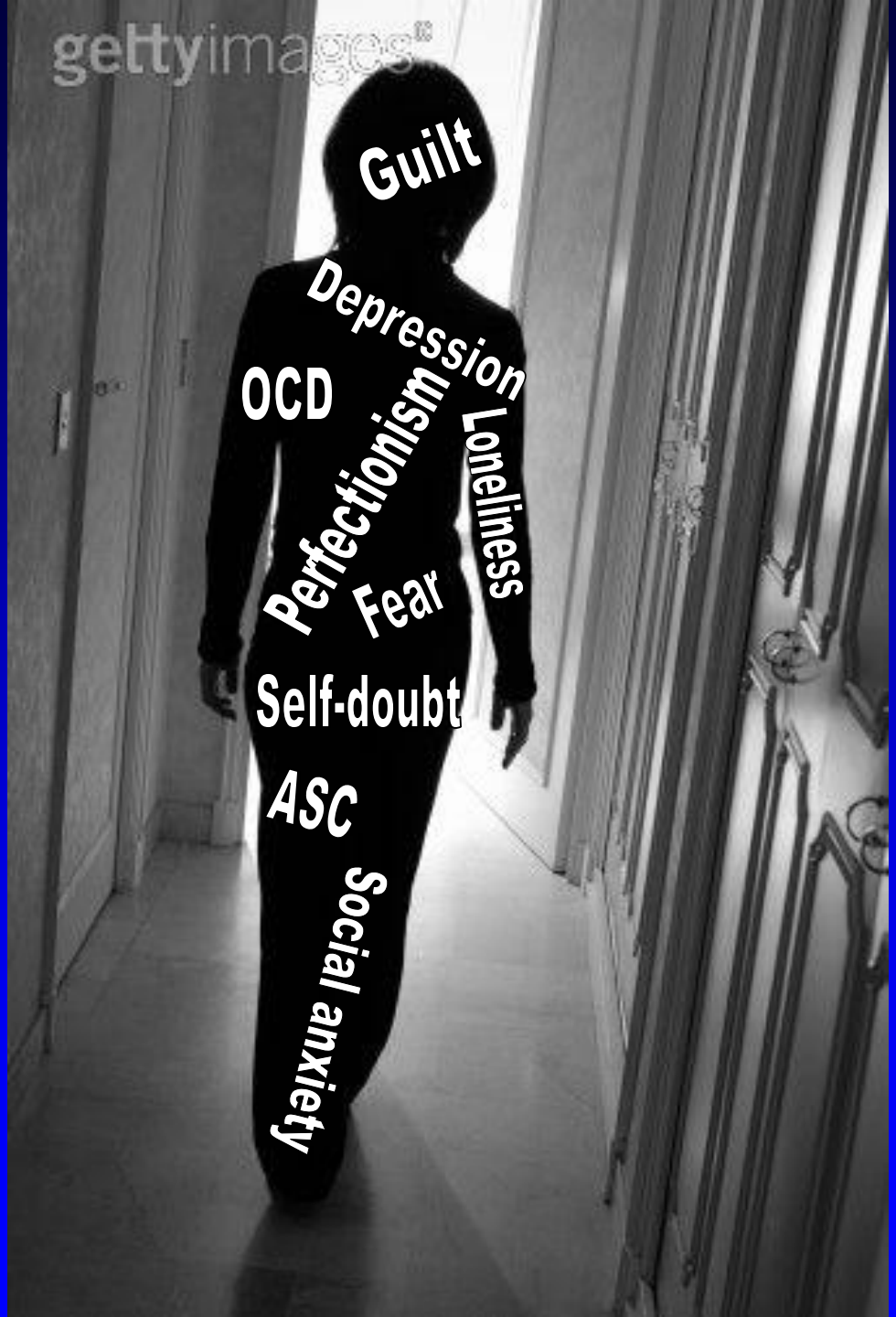



Guilt
Depression
OCD
Perfectionism
Loneliness
Fear
Self-doubt
ASC
Social anxiety

Pride
Guilt
Effortfulness
Desire
Superiority
Competition
OCD
Perfectionism
Self-doubt
ASC
Cultivated fears
Anxiety


NOTE TO SELF
DATE:
RE:
CC:
URGENT
REQUIRES FOLLOW-UP
DON'T FORGET
TO BE FILED
MEMORIZE THEN BURN
BRILLIANT IDEA
LATE-NIGHT MUSING
JUST A THOUGHT
HOPELESSLY RANDOM
NOT ACTUALLY TO SELF
THINK BEFORE YOU EAT -
no more snacking on impulse!
Never forget: Fat is poison, and
cheese is just smelly, rotten fat
that makes you fat
Remember how disgusting
you looked at 100 lbs.
Get back on track right now and
STOP BEING A LAZY PIG!
RECEIVED BY SELF

OCD patients don’t need sticky notes to remember to wash their hands …

… or agoraphobic patients

to remain indoors

These features are highly distinctive –

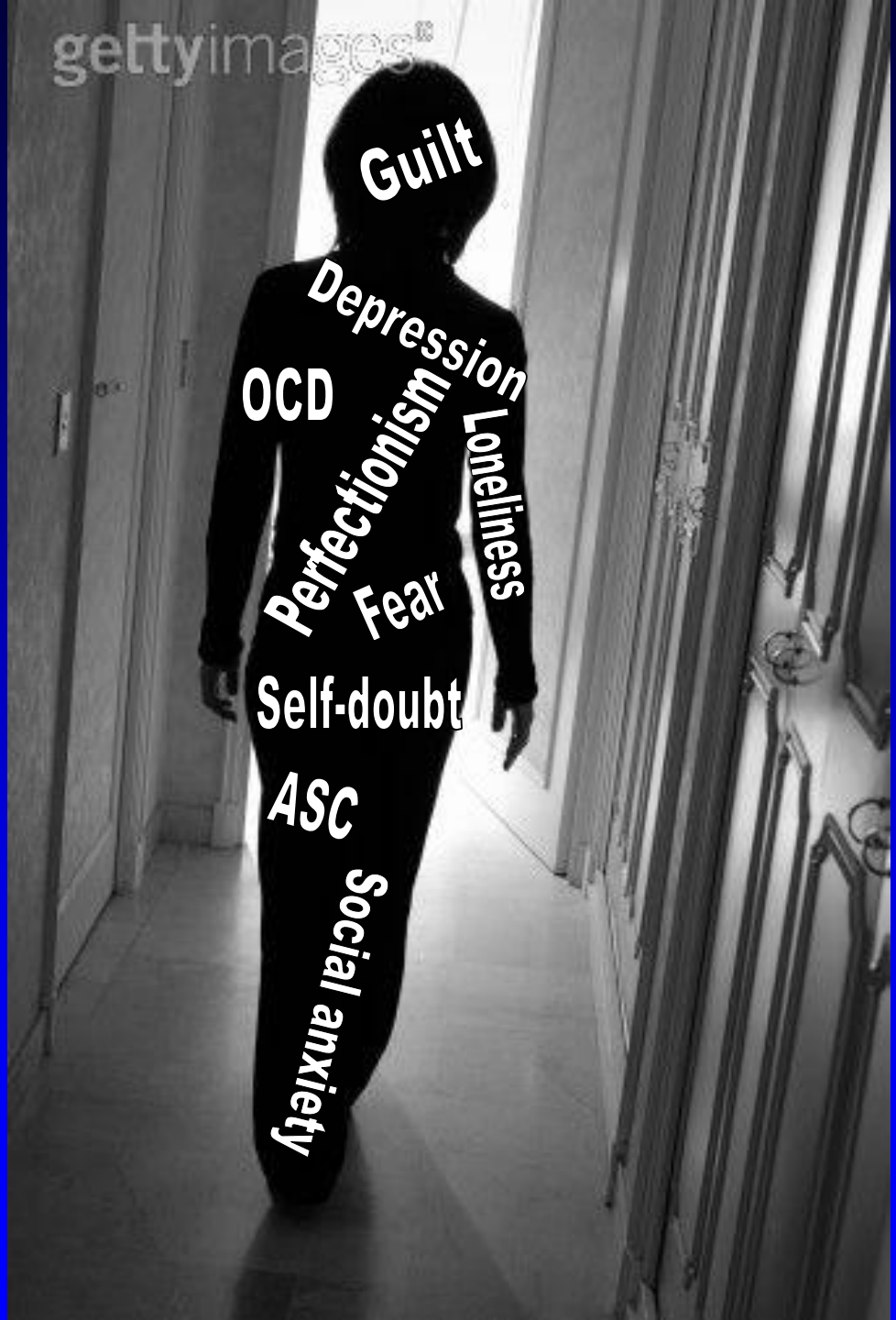
and almost certainly contribute to our problems in treatment

"That's just the Anorexic Voice,
and I don't want to hear it"

~~Pride~~

~~Effortfulness~~

~~Superiority~~



~~Competition~~

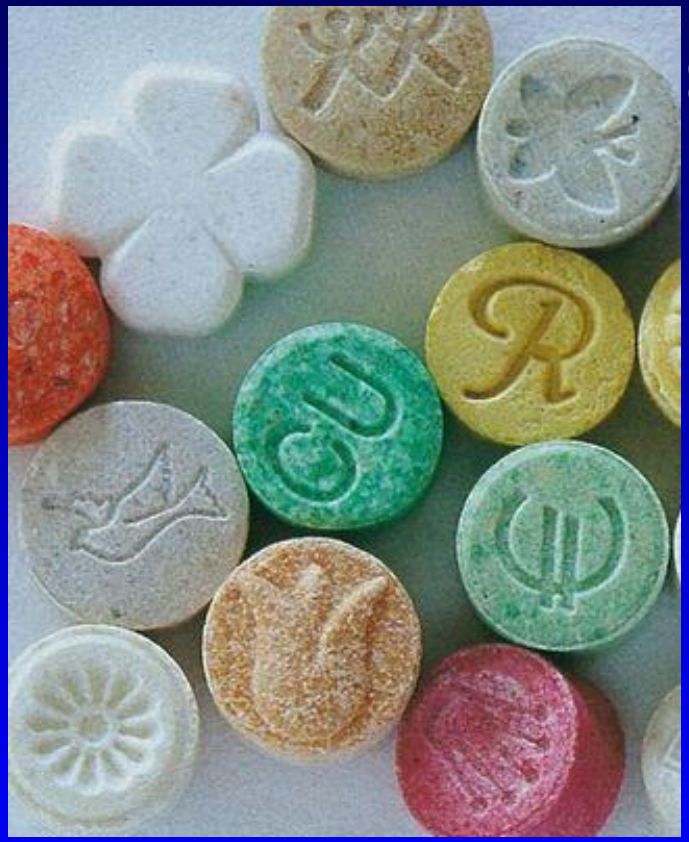
~~Desire~~

~~Cultivated fears~~

The term “accurate empathy” has two components:

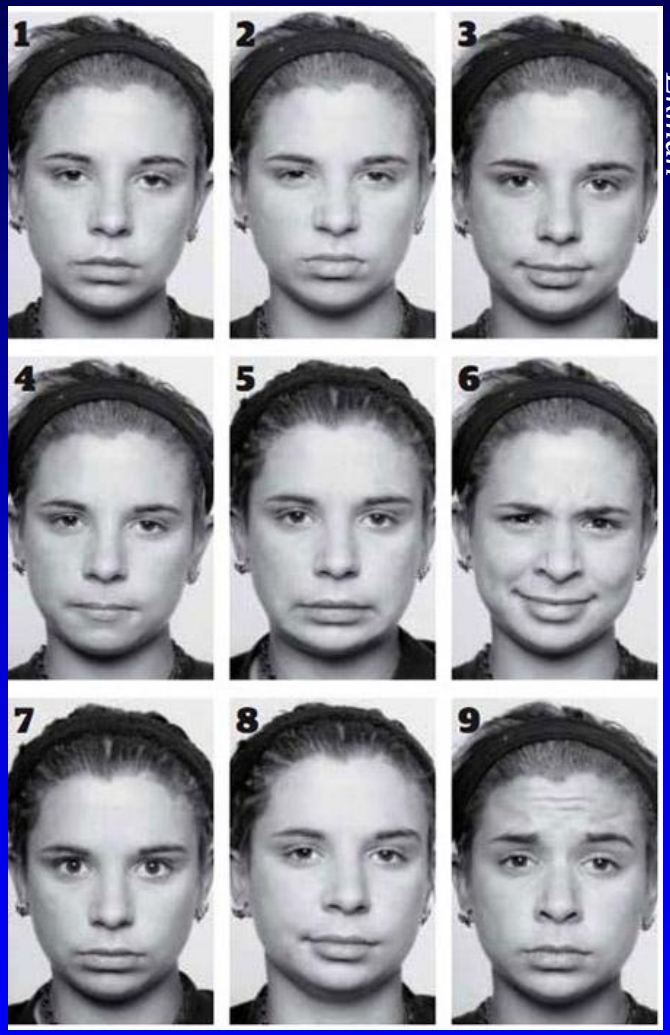
We feel attuned to others’ experience,
and we actually get it right

MDMA (aka ecstasy or the “love drug”)
has been called an *empathogen*
on the basis of its apparent power to promote
social connectedness and understanding



In a recent study comparing the effects
of MDMA, meth, and placebo,
both drugs increased aspects of social approach
behavior and warm-and-fuzzy feelings

MDMA, however, actually decreased
the accuracy with which subjects could identify
threat-related signals in the faces of others



Ekman

Although it might increase feelings of interpersonal connection, ecstasy can subtly impair interpersonal competence.

- *Bedi et al., 2010, p. 1139*

No empathogen, after all –

just positively skewed distortion

An instructive analogy for the ED field?

Some of the devices we adopt in an effort to relate more positively to our patients may be pseudo-empathogens, too

Here are three popular constructs …

It’s not really <u>you</u>, it’s:

- your brain disorder
- your anosognosia
- an Alien Anorexic Invader

Talking Points

It’s not about eating and weight*

* your thoughts, feelings, and behaviors notwithstanding
(and despite the central focus of our best-supported treatments)

It’s not a question of choice*

* though we expect you to make different choices henceforth
(and can’t treat you effectively if you won’t)

Some quick clarifications …

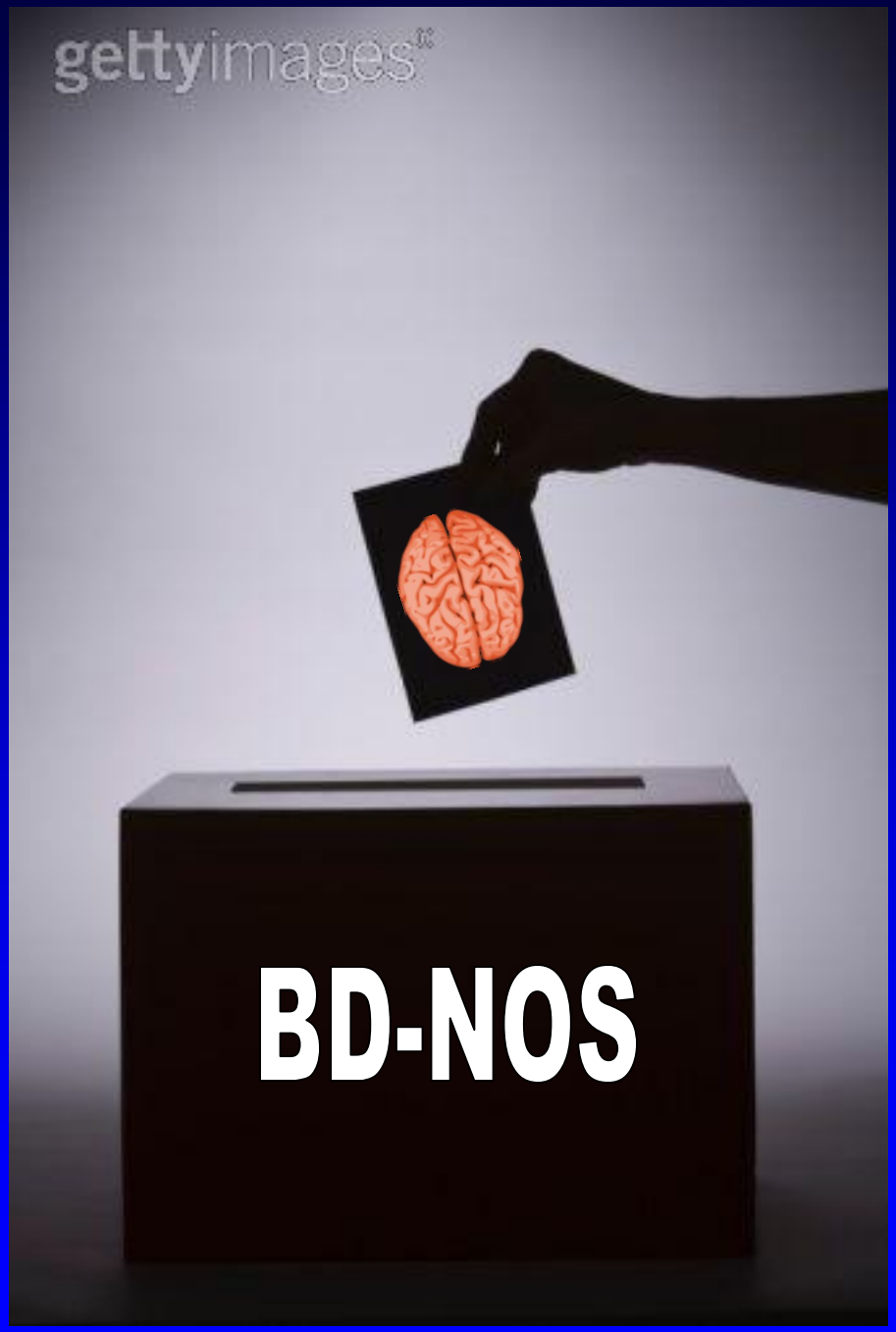
Each of these formulations
contains more than a kernel of truth

- AN is inarguably a brain disorder (what else could it be?)
- denial of illness is a notable feature
- a person with acute AN is in many senses “not herself”
- it’s not all about eating and weight
- capacity to choose is clearly constrained

But there are problems with each of these constructions – particularly when we ask them to bear more of the load of AN than they can reasonably support

… and especially when we're not sure what we mean when we invoke them

At this point in time, when we endorse the construct of “brain disorder” in our field …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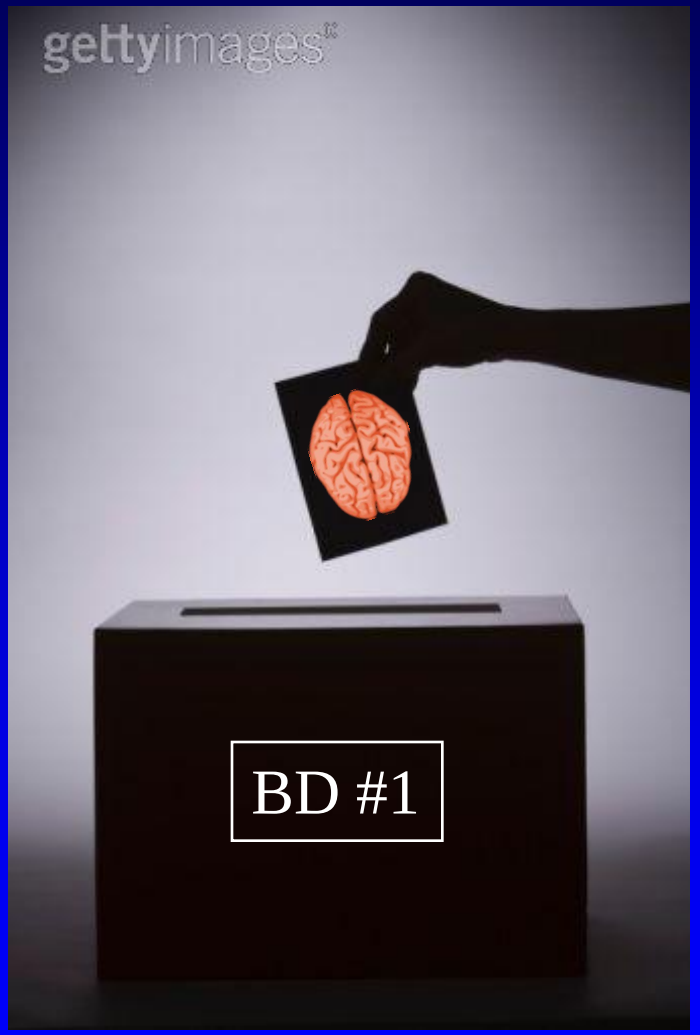
BD-NOS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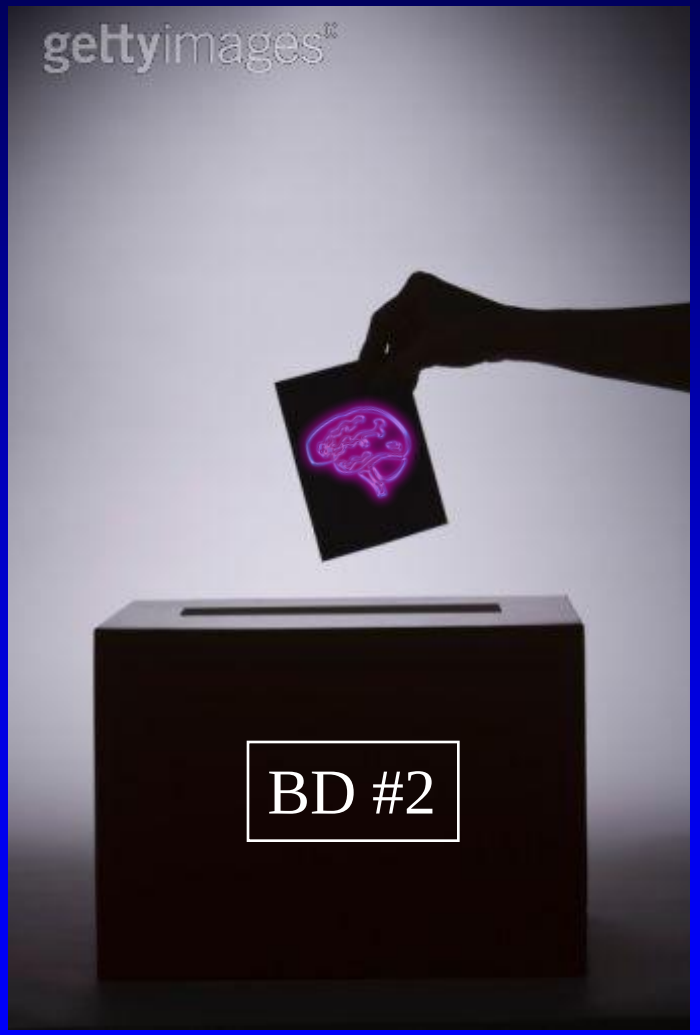
BD #1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BD #2


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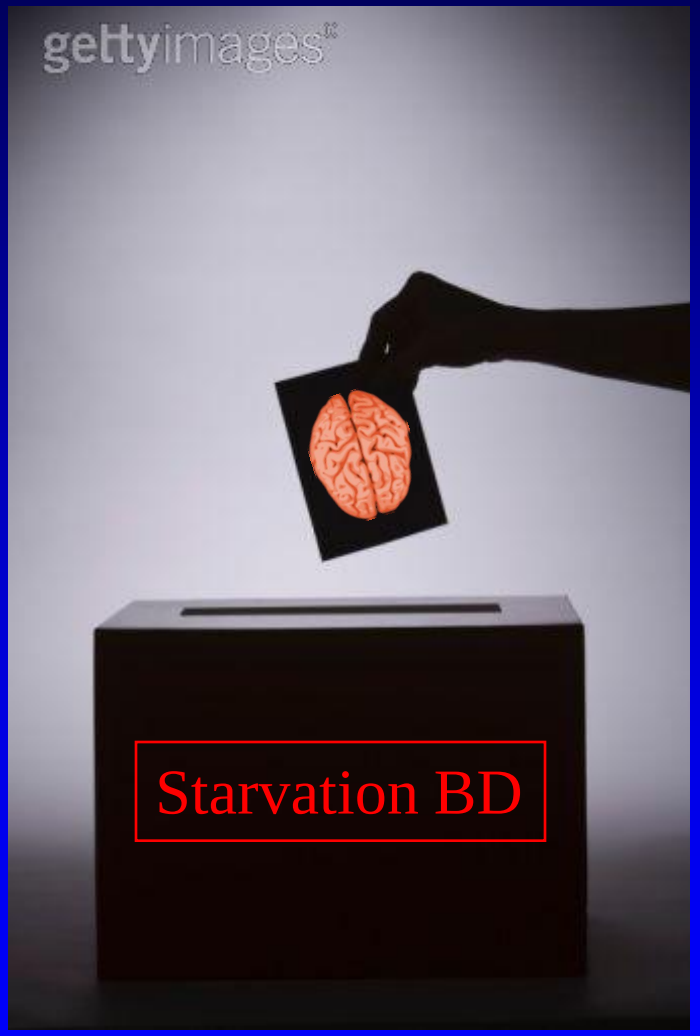
BD #3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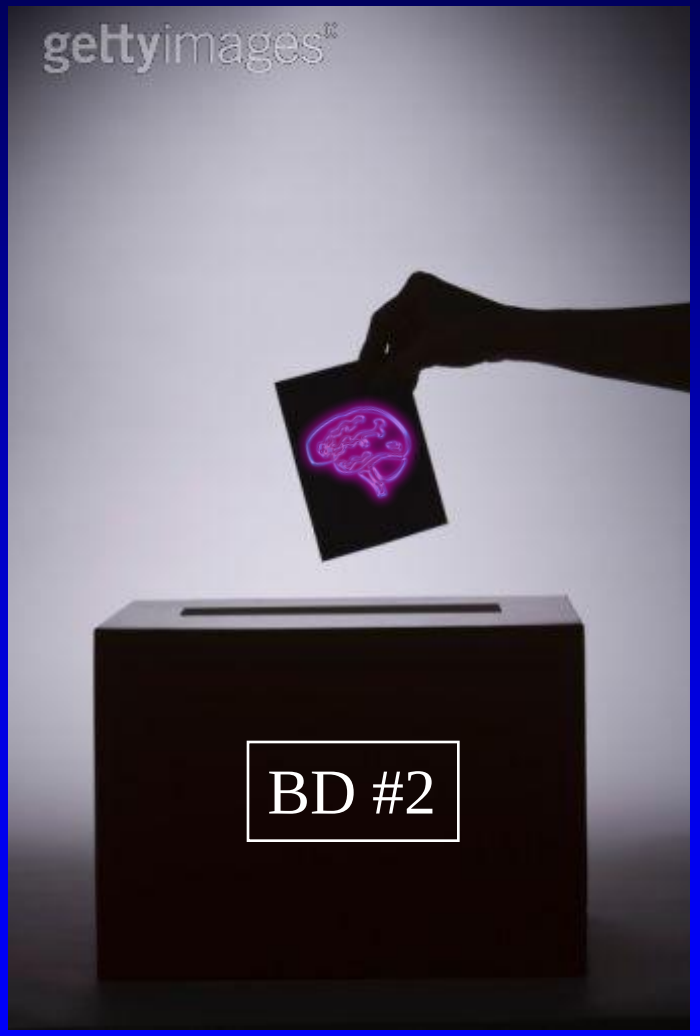
Starvation BD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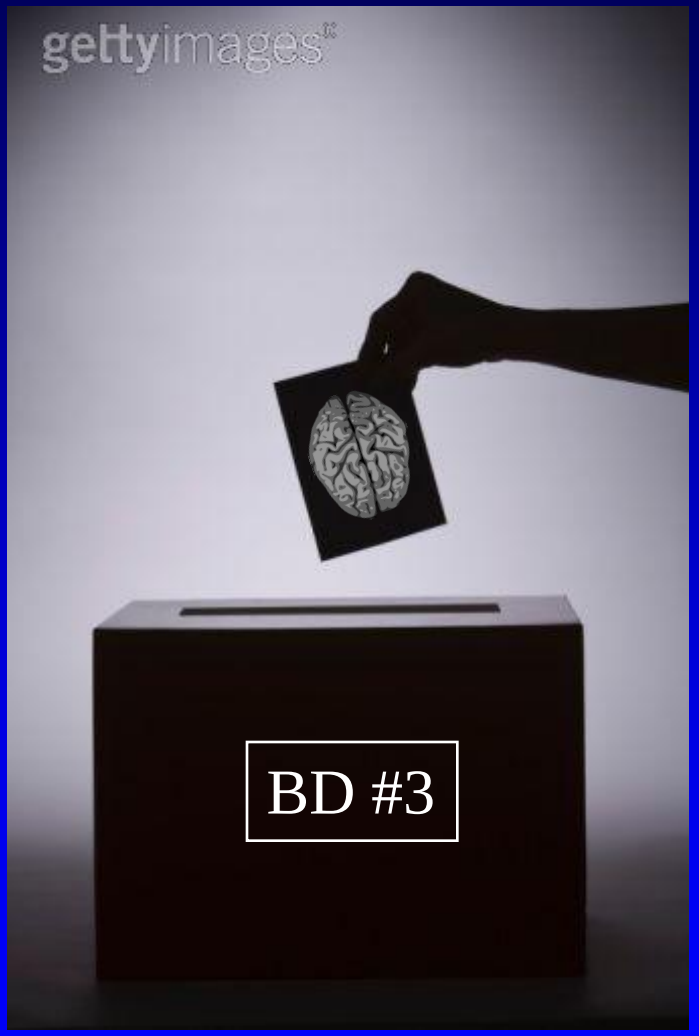
BD #2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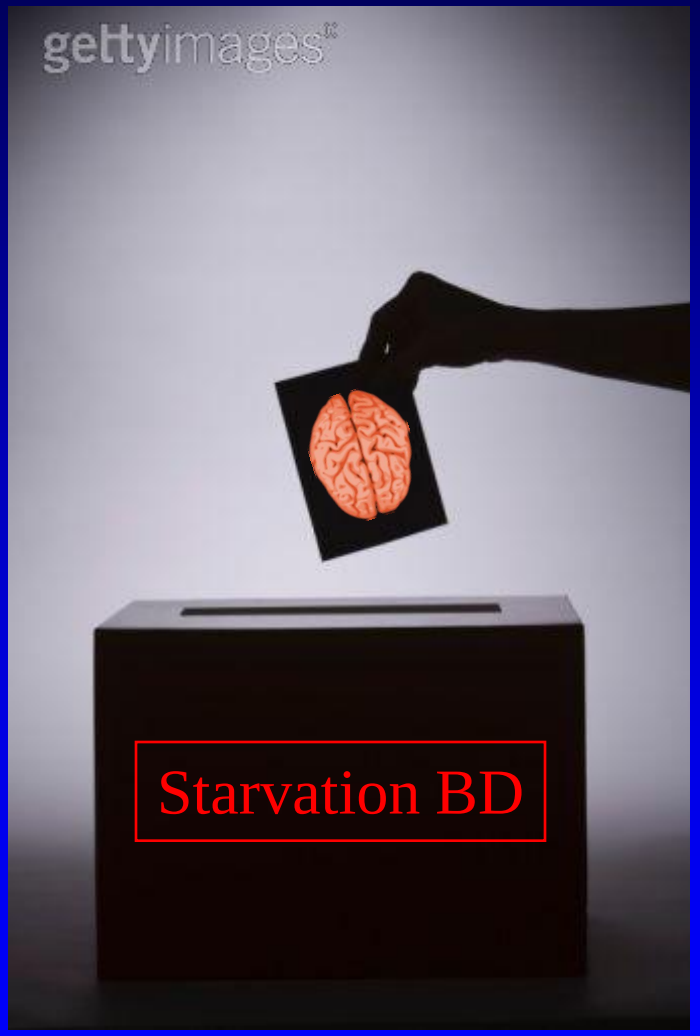
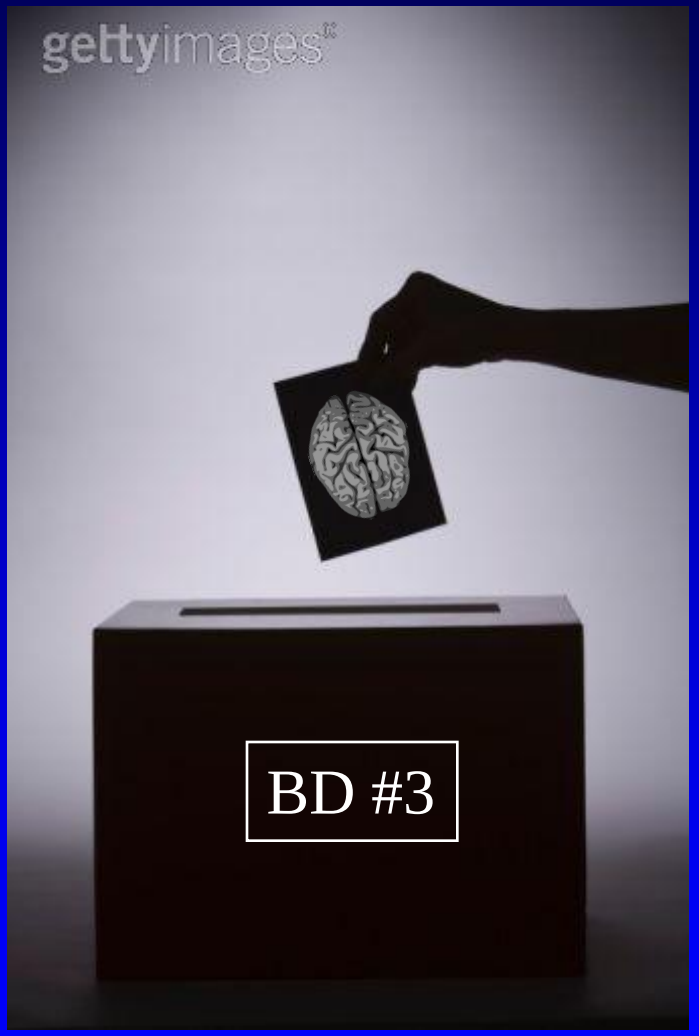

Starvation BD


Hard-wired
traits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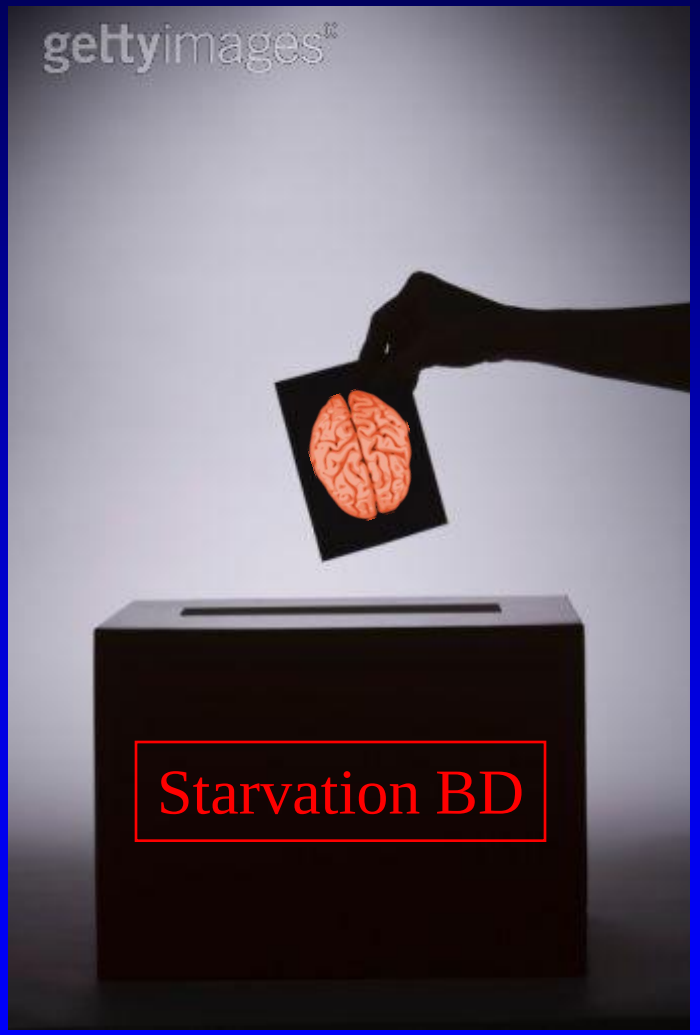
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Starvation BD


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Hard-wired
traits


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Something
AN-specific?

I have little doubt that at least Models #1 and 2
will yield clarifying – and perhaps useful – information

But at present, the popularity of the BD construct
cannot be explained by the knowledge base

Suchan et al., 2009

Getty Images

… at least in part because it lets us detour around the bumpier bits of AN


good
girl


bad
brain

I think we make similar use
of the Alien Anorexic Invader …

and the premise that elements of volition are absent from this disorder

So what is the problem?

If there is some truth to these constructions …

And they make it easier to bypass blame …

And get AN taken more seriously …

And explain it to parents …

And side with our patients …

Why be concerned?

1

The matter of accurate empathy

There is no Alien Anorexic Invader

… and AN is about eating and weight

(as well as other things – which vary)

When we denature the disorder in this way,
we imply that AN would be trivial if it did concern such matters

And that's really terribly awkward … since it does

Here’s what baffles me:

The idea that patients forfeit the right to compassion

if they do have a hand in their suffering

If that’s true … we’re all in big trouble

in our own daily lives

2

They can’t work around

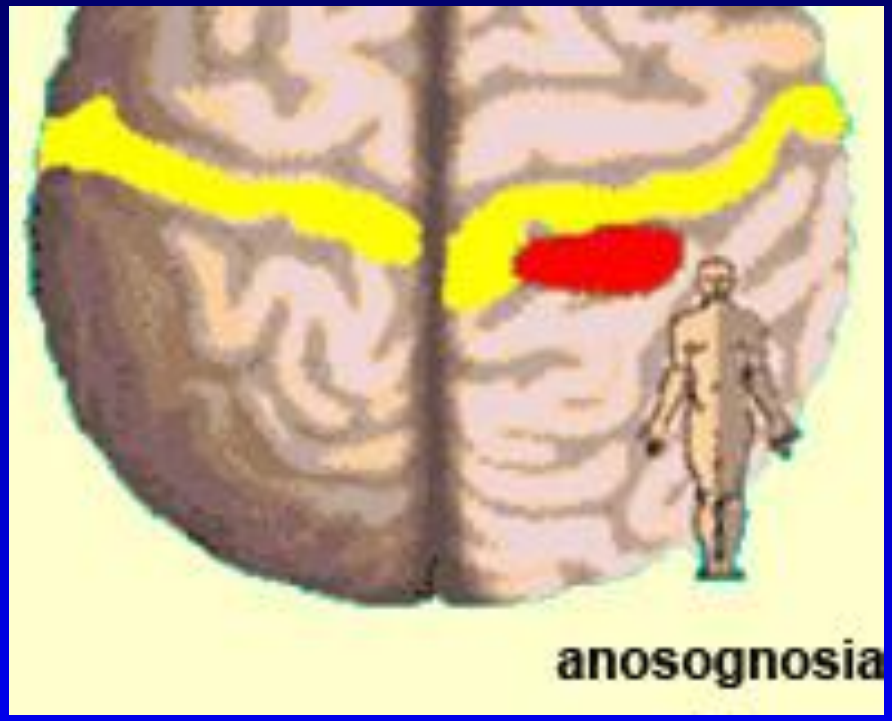
the central problems of treatment

The “anosognosia” example

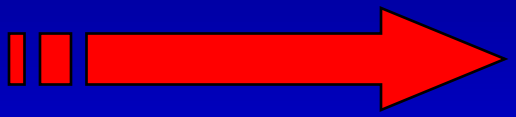
Clendenning Museum

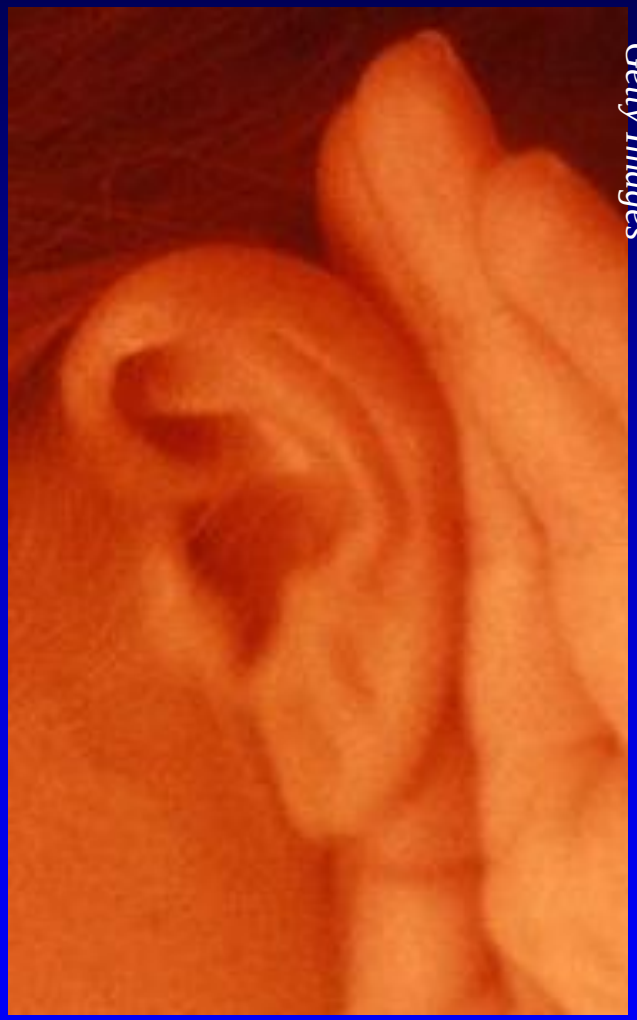
The term comes to us from neurology,

by way of schizophrenia



TheBrainMcGill





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Just one example of how far we have to stretch

the construct to cover the case of AN …

There are apparently a lot more anorexics out there than when I first started treatment. Now it seems like everybody and their sister has an eating disorder.

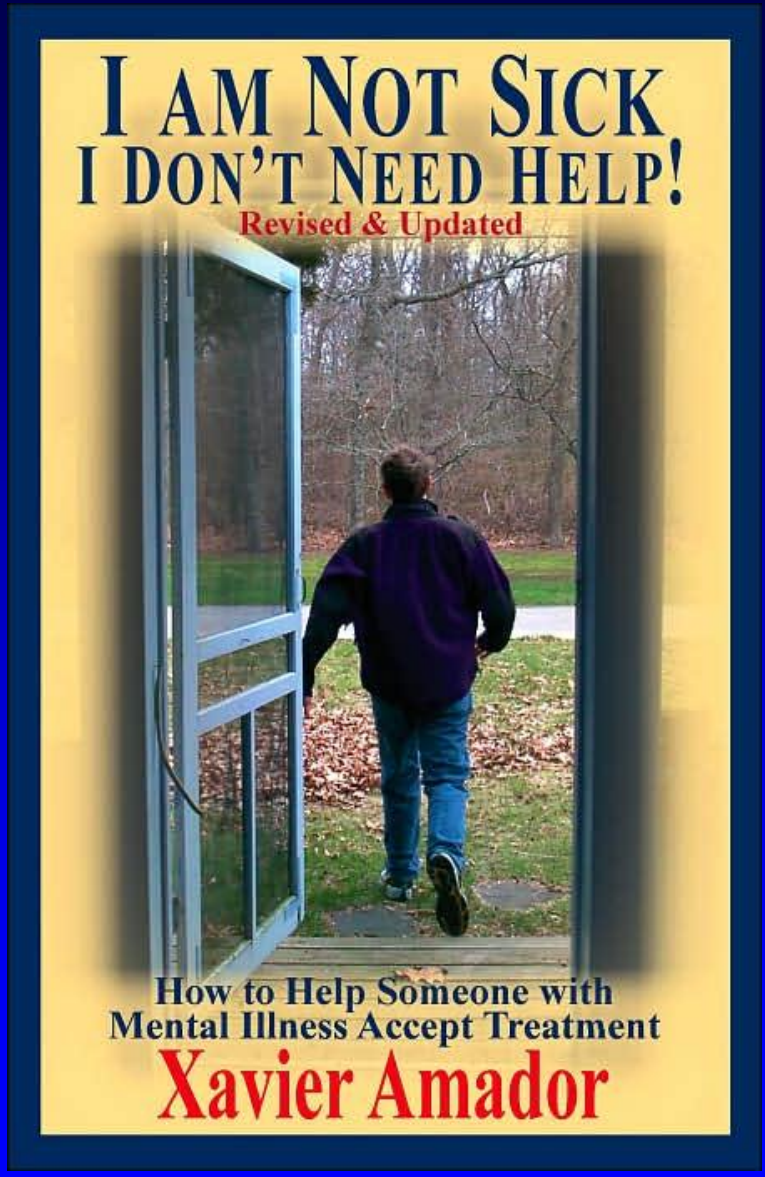
It kind of – don't make fun of me – but it kind of upsets me. It takes away the specialness … I mean, God! You know? I kind of get angry because they get the name without the work.

- *Clinic patient*

If this is anosognosia – it’s traveled a very long way

TheBrainMcGill

We might find it helpful to begin
by consulting experts in other disorders
where the pattern is prominent

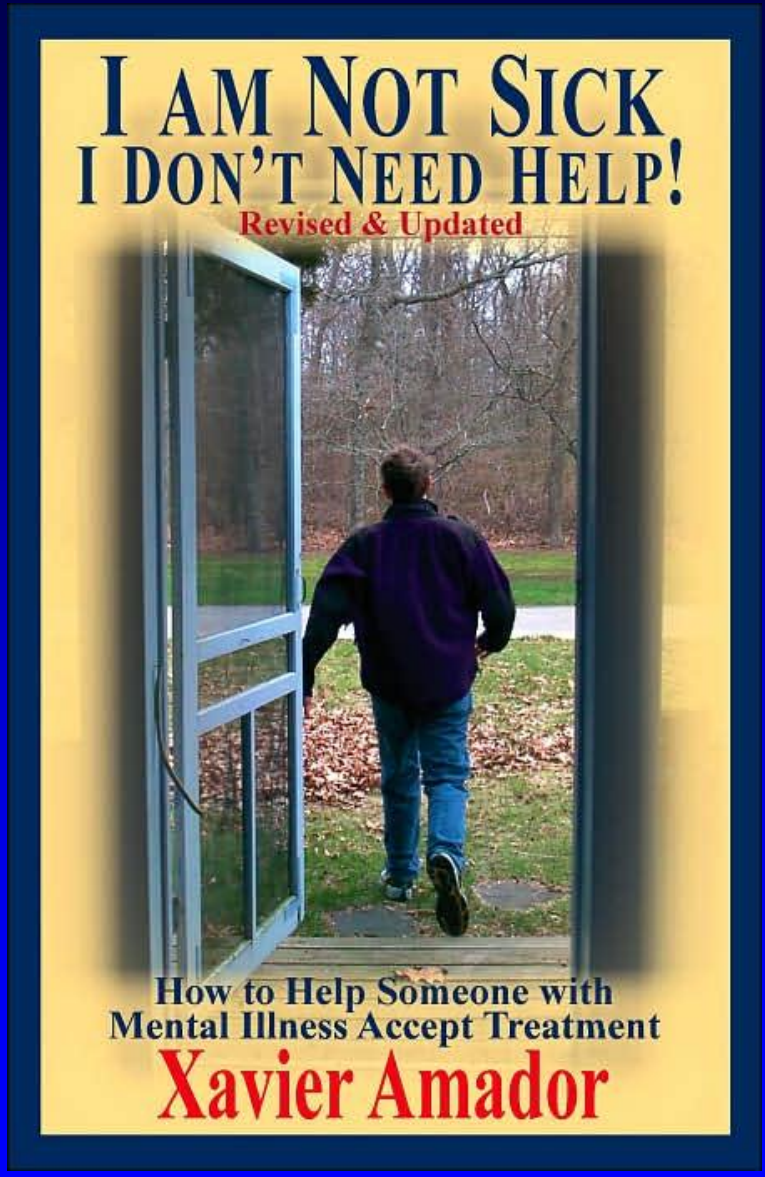


Perhaps the best-recognized authority knows the problem from two perspectives:

Professional and familial

So what advice can he offer our field,

if we adopt the construct?



In most cases, a “medical model” or benevolent paternal ethic is the wrong approach to treating patients with anosognosia.

- *Amador, 2007*

The first step is to stop arguing and start listening to your loved one in a way that leaves him feeling that his point of view – including his delusional ideas and belief that he is not sick – is being respected.

- *Amador, 2007, p. 43*

The emphasis is on acknowledging that your loved one has personal choice and responsibility for the decisions he makes about his life.

- Amador, 2007, p. 48

By saying this, I empower the patient … More important, it comes from my heart. I believe it.

- *Amador, 2007, p. 85*

3

I think we can do better

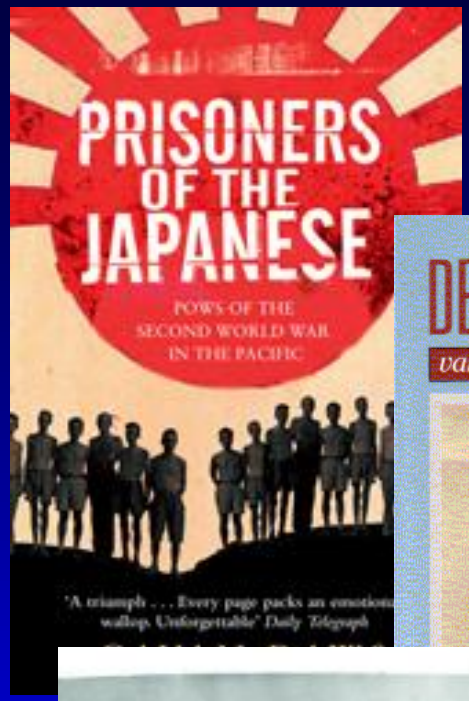
These constructs attempt to make AN more sympathetic

by making it more strange

In my own clinical work, I've always found it most helpful to de-mystify the disorder – to make it more accessible, lawful, and/or familiar to both patients and families

It’s not a question of normalizing AN itself –

but of translating its component parts into terms we can better understand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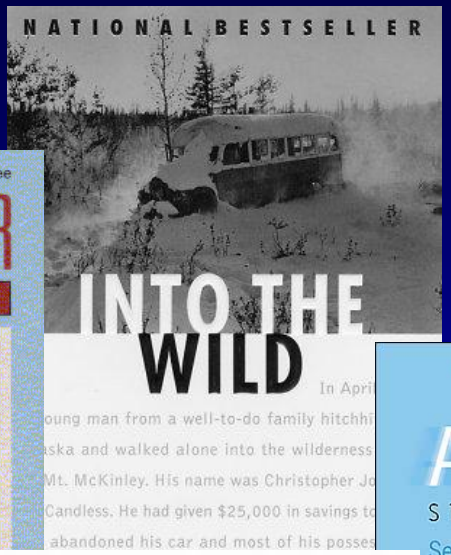
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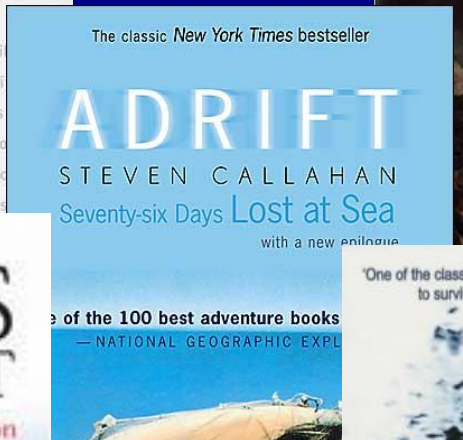
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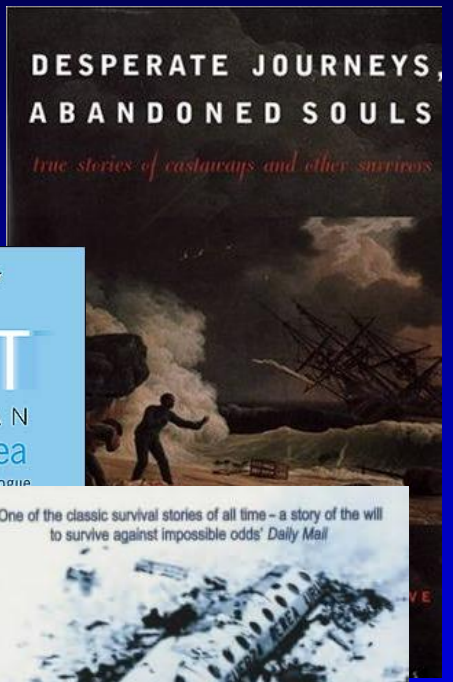
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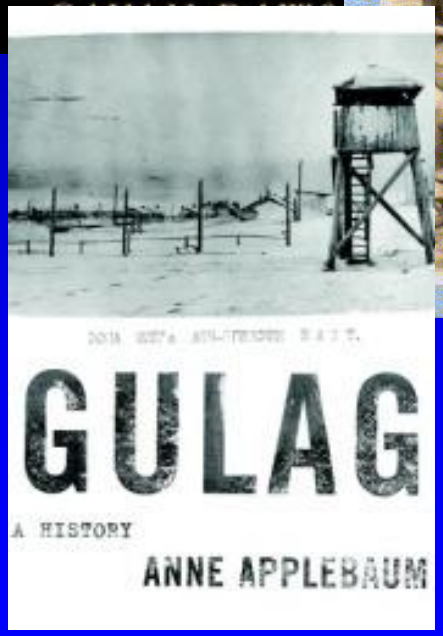
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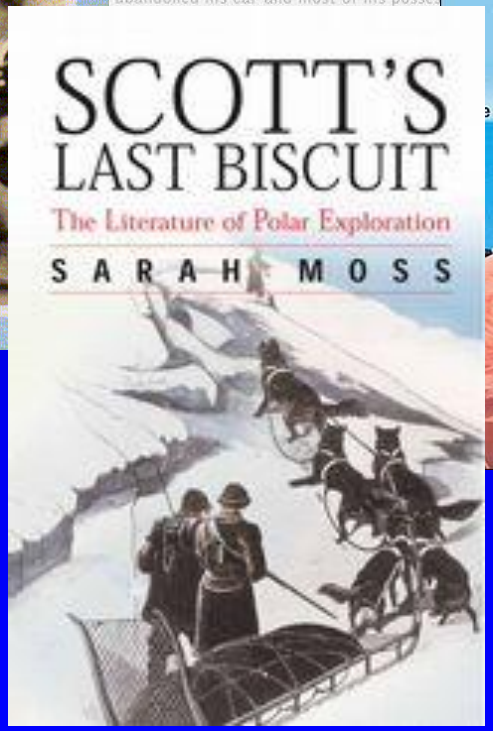
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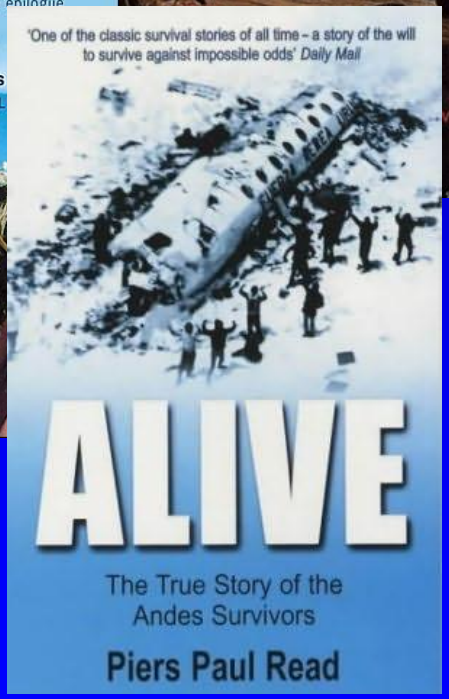
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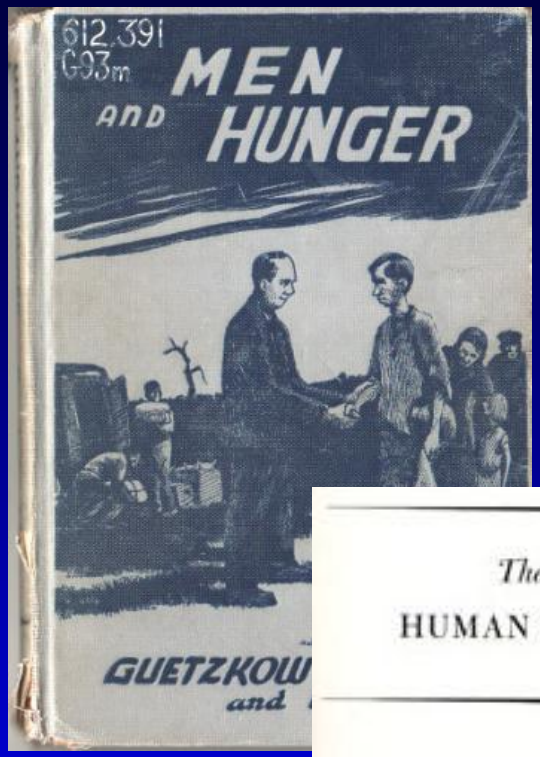
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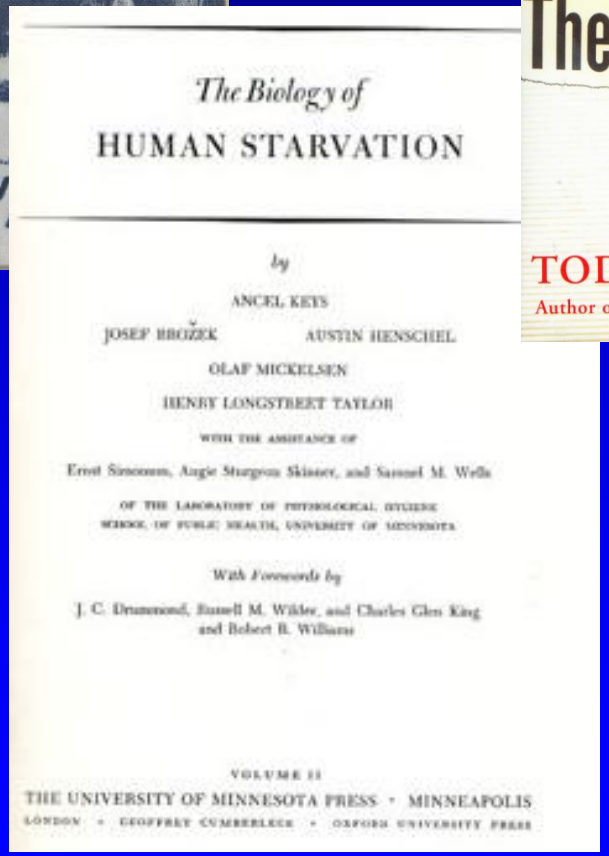
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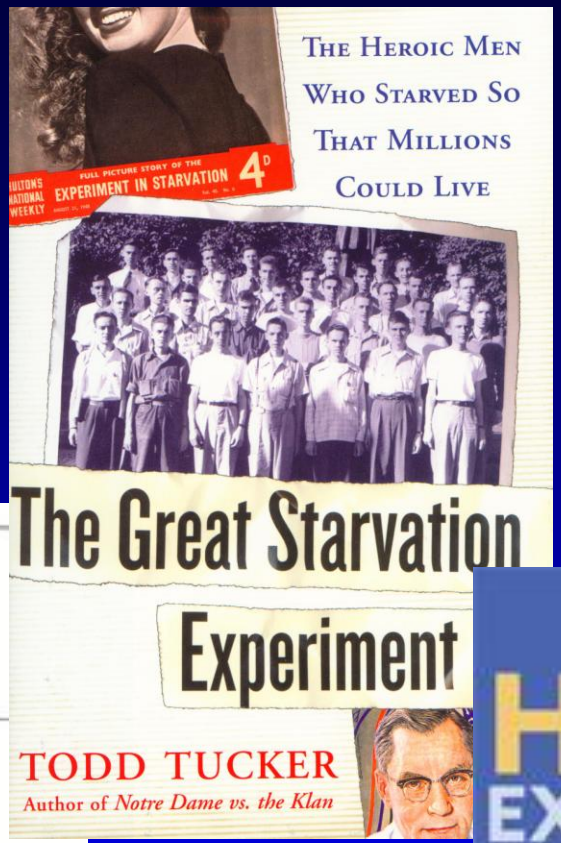
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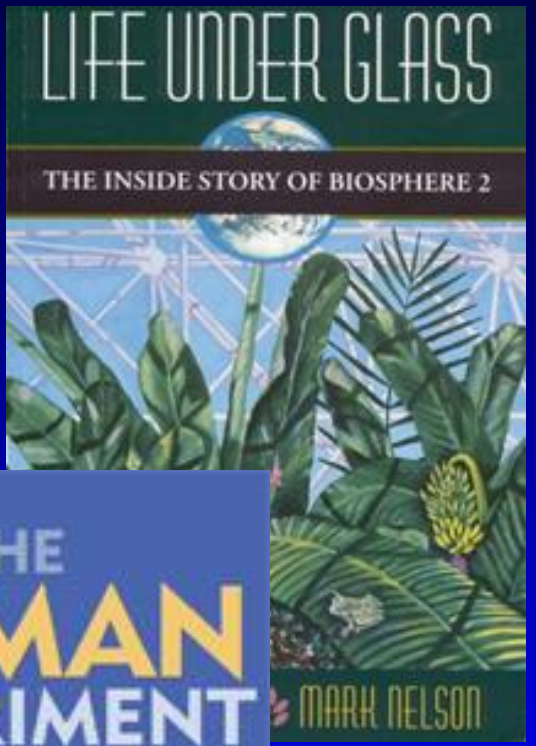
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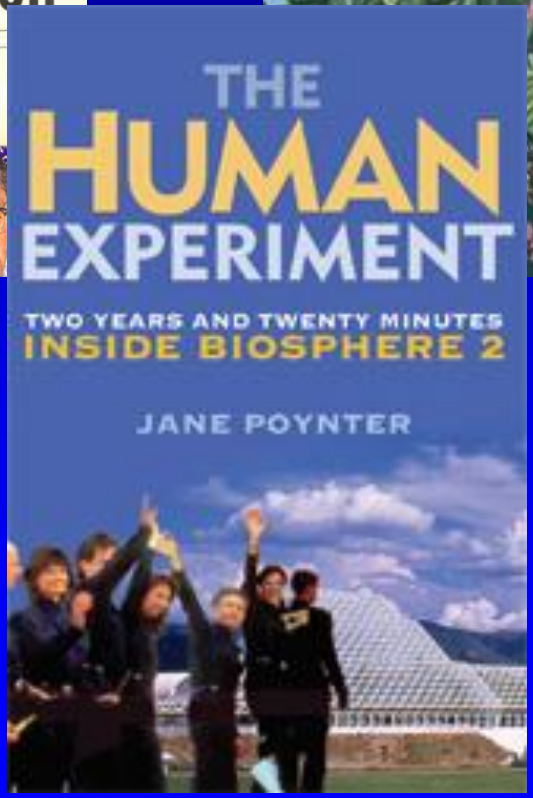
THE
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TWO YEARS AND TWENTY MINUTES
INSIDE BIOSPHERE 2
JANE POYNTER

The things starving people do
are highly predictable and fundamentally “normal”

and they are not “anorexic”

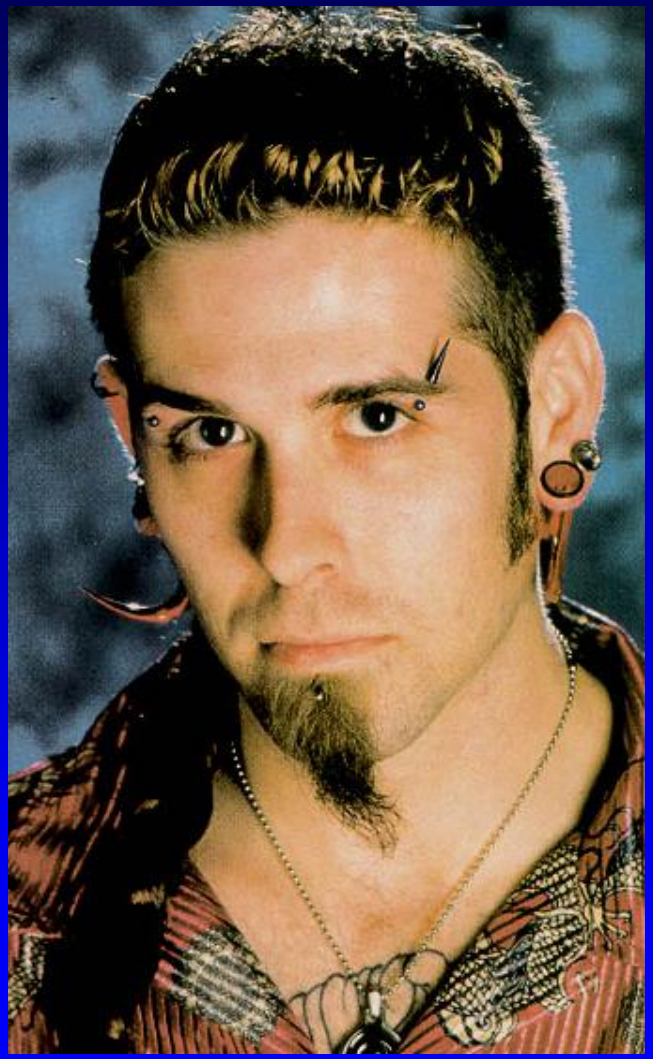
When I’m trying to explain to parents why their daughters might lie and cheat and manipulate,
I don’t invoke anosognosia or an anorexic alien …

I ask them to think of something they value profoundly …

… then to consider how they might respond

if someone threatened to take it away

17-year-old daughter
with a Dreadful Boyfriend



How can we normalize something
as profoundly disturbed as the inability
to see one's own appearance?

That one is easy:

Facelift and comb-over

Taking an “extra-diagnostic” perspective on AN may help us understand it more accurately and more compassionately

It may also help us devise and deliver more effective treatments

Not just accurate empathy,

but radical acceptance

For our patients' sake most of all,
we need to come to terms with the disorder they have