MINDFULNESS AND EATING DISORDERS: WHAT’S SCIENCE GOT TO DO WITH IT?
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ABSTRACT

Eating Disorders, more than most other mental health problems, negatively impact both mind and body. Reciprocally, mindfulness approaches can significantly benefit both mind and body in a measurable, objective way. This workshop will assess the current research on how mindfulness can improve the physical and cognitive aspects of eating disorders.

OUTLINE

I. History of The Relaxation Response
II. History of Mindfulness/Spiritual Approaches
III. History of Integration of Mindfulness and Psychotherapy
   A. Current Brain/Body Research
   B. Methodological Challenges
IV. Linehan’s Use of Mindfulness in Dialectical Behavior Therapy
V. Eating Disorders: Disorders of Mind and Body
   A. Dissociation
   B. Anxiety/Compulsivity
   C. Perfectionism
   D. Mindfulness Based Eating Awareness Training
VI. How Mindfulness Can Address Key Cognitive Symptoms of ED
VII. How Mindfulness Can Address Key Physical Symptoms of ED
   A. Body Scans
   B. Yoga
VIII. How Mindfulness Can Address Key Affective Symptoms of ED
IX. Case Examples of Using and Integrating Mindfulness Strategies
I & II: HISTORICAL BACKGROUND
- Zen & Psychoanalysis in the 50's
- Transcendental Meditation in the 60's/70's
- Benson/Borysenko: The Relaxation Response in the 80's
- The beginnings of “new age” thinking in psychotherapy, including mindfulness meditation in the 90's
- Jon Kabat-Zinn's Contributions--90's to the present

III: HISTORICAL BACKGROUND
Integrating Mindfulness and Psychotherapy
- Current Brain/Body Research
- Methodological Challenges
  - Inconsistent definitions (e.g., MBSR, MBCT; mental trait/spiritual path/cognitive process)
  - No true double blind studies,
  - Self-report limitations,
  - How to “standardize” interventions.

IV. Linehan's Groundbreaking Use of Mindfulness in Dialectical Behavior Therapy
- Target population and application to Eating Disorders
- Behavioral principles, dialectical philosophy, Zen-like acceptance based skills.
- Mindfulness skills module.
V. EATING DISORDERS: DISORDERS OF MIND/BODY/SPIRIT

- Cognitive Issues: Dichotomous, catastrophic thinking, perfectionism, dissociation.
- Body Concerns: Disruption of healthy physiological processes—metabolism/hormonal rhythms/appetite/energy
- Emotions and Spirit: Affective dysregulation, alexithymia, anxiety, lack of self-acceptance.
- Kristeller's Mindfulness Based Eating Awareness Training (MB-EAT)

VI. HOW MINDFULNESS CAN ADDRESS KEY COGNITIVE COMPONENTS OF EATING DISORDERS

- Non-judging
- Meta-awareness
- Perspective taking
- Presence/being in the present moment

VII. HOW MINDFULNESS CAN ADDRESS KEY PHYSICAL COMPONENTS OF EATING DISORDERS

- Body scans
- Observing and regulating the breath
- Yoga as an adjunct to psychotherapy
- Appetite awareness
- Mindful eating
- Walking meditations
VIII. HOW MINDFULNESS CAN ADDRESS KEY AFFECTIVE COMPONENTS OF EATING DISORDERS

- "Urge surfing" without acting out
- Emotion regulation
- Distress tolerance
- Self-compassion

QUESTIONS FOR CASE EXAMPLES

1. How/when would you consider introducing the recommendation for mindfulness/meditation approaches with this case?
2. What key cognitive/affective/physiological/behavioral symptoms might be targeted from meditation techniques?
3. What strategies might you use with a particular patient's "resistance" or hesitance to utilize meditation?
4. What in-session protocols might you offer for demonstration/modeling?

CASE EXAMPLE #1:
A YOUNG FATHER WITH ANOREXIA

Rob was a 35 year old father of two in a troubled marriage where his couple's therapist referred him for assessment of an eating disorder. For years, Rob rigidly adhered to a strict diet, and two extensive workout sessions per day before and after work at his local gym. With no college education, he had moved to the top of the hierarchy in the IT department of a large, national manufacturing company. He was his family's sole breadwinner, and he supported his wife's parents in a "mother-in-law suite" in his modest house. His wife was highly volatile emotionally and abdicated child care as soon as he arrived home from work/workouts. He felt trapped and could not label his emotions. The marital therapist had worked with the couple for nearly 2 years and saw that Rob carried the lion's share of finances/home maintenance/child care, with little improvement in his wife's contributions. The therapist was concerned that, while Rob looked muscular and toned, he seemed thinner than when they began and had become increasingly rigid about his twice daily workouts, which were often 2 hours or more in length. He had been a heavy child, was teased about his weight, and got married to his first girlfriend at age 20. Initially in individual therapy, he said he did not know how he felt, but was trying to be logical about his circumstances.

After initial medical checkups revealed low blood sugar but no other physical danger signs, Rob was extremely reluctant to give up any of his workout time. He was, however, willing to start his morning workout and end his evening workout with a 20 minute breath meditation c.d. to "de-stress" because he thought that was "logical." Remarkably, he took to the recommendation like a duck to water, which lead to a whole month meditation class instead of one of his workout days. Four years later, he decided to divorce and relocate with his daughters, now meditating daily, and exercising 1 and 1/2 hours 3 times per week.
CASE EXAMPLE #2:
A 28 YEAR OLD YOGA INSTRUCTOR WITH BULIMIA

Elise had a long history of eating disorders dating back to her childhood years. She had a history of attempts with all the major diets (e.g., Jenny Craig, Weight Watchers, Nutrisystem, etc.) and many of Philadelphia’s top docs for dieting (e.g., Judith Singer, T. “The Neuroscience of Compassion.” Presentation to the World Economic Forum, March 9, 2015. http://www.weforum.org). She was always tall as a child, reaching 5’10” as an adult, which reinforced feeling larger than her peers, though early photos showed a tall, solidly built child/adolescent, but not an obese one. Thus, Ann-Marie had a long history of eating disorders dating back to an adolescent era with anorexia. Although she had normalized her weight in her twenties and had a relatively contained exercise regimen that was within medically safe limits, she remained self-critical about her appearance, compulsive about her yoga routines, and symptomatic at least 3 times per week when she binge and purged at the end of a long day of restriction because of her over-booked schedule.

The third daughter of a high-powered fundamentalist physician/nurse couple, with siblings who were also physicians, Ann-Marie struggled to find her own identity within her family of origin. She saw the only family member who left the west coast to live and lived a less religiously bound life-style, though her yoga community had features of the childhood ritualistic structure.

Elise was quite frank about herself for perceived “perfections.” She ended against her own “hypocrisy,” a yoga teacher preaching healthy lifestyle who herself had a serious eating disorder. It was challenging to offer a non-judgmental mediation techniques that were both blended and contrast with the tools she utilized and promoted in her role as yoga instructor. Since her yoga breathing tended to be integrated with the physical poses, within therapy, simple sitting breath meditations were recommended. She found the phrase “don’t just do something, sit there.” A helpful reminder to accept the present moment without frenetic activity. She began to give her patient when she had binge/purge urges. She herself sought and found a body scan meditation she liked which led to a mindful eating meditation and the introduction of better nutritional distribution of intake throughout the day.

SELECTED BIBLIOGRAPHY