

ACT FOR EATING DISORDERS

Acceptance and Commitment Therapy (ACT) is a relatively new behavioural therapy that posits that most psychological suffering is associated with 'experiential avoidance', i.e., efforts to avoid situations that are painful or to try and get rid of unwanted private experiences, including unpleasant thoughts and feelings. Whilst this often works well in the short-term, in the long-term it is generally not effective and in fact, often creates more suffering. For example, someone with Bulimia Nervosa or Binge Eating Disorder, may encounter a painful situation and binge eat as a way to avoid the emotions associated with the experience. In the short-term, this may help to numb them out to the situation that was difficult, however, in the long-term, he/she may experience shame and frustration as a result of the bingeing and this may then lead to purging. In addition, the original stressful situation is likely still there to be dealt with.

ACT is gaining increasing empirical support across a variety of clinical disorders. Research has shown that these methods are beneficial for a broad variety of clinical problems, including depression, anxiety, stress, substance abuse, and psychotic symptoms. The benefits are also useful for clinicians: ACT has been shown empirically to alleviate clinician burn-out.

At the time of writing, the evidence for the use of ACT with Eating Disorders is not established. There are a number of trials currently underway at present. At a philosophical level, ACT is a good fit for Eating Disorders as the difficulties experienced by people with Eating Disorders, can be conceptualised as experiential avoidance. All Eating Disorders involve a behavioural rigidity with most behaviour focused on food and weight. Experiential avoidance occurs at 2 levels: on an overall level, the Eating Disorder may be functional in avoiding life experiences, e.g., failure. At a specific level, eating is usually associated with intense painful emotions and hence, is avoided. Consequently, intervention can occur on parallel lines of pursuing a full life overall and on a micro level of changing people's relationship with food.

ACT aims to help patients develop a different relationship with their cognitions and emotions in order to make choices based on their values instead of avoidance. The goal of ACT is to increase 'psychological flexibility', or the ability to enter the present moment more fully and either change or persist in behaviour when doing so serves valued ends. The scientific basis underpinning ACT is called Relational Frame Theory (RFT) and this is an extensive basic research program on an associated theory of language and cognition. This theory suggests there are 2 key constructs which contribute to psychopathology: experiential avoidance and cognitive fusion. It is suggested that these processes occur amongst all human beings to some extent and are exacerbated in conditions leading to a psychiatric diagnoses.

Working with patients with Eating Disorders is generally acknowledged as challenging work - this is a patient group who are tormented by their inner private events and also highly ambivalent to change. Hence, as clinicians to be with people who are clearly suffering to a large extent but also are reluctant to let us help them, can be very frustrating for clinicians. Because the therapy identifies the difficulties of experiential avoidance and cognitive fusion as being relevant to all human beings, the same aim of psychological flexibility is relevant for us as clinicians.

There are 6 main components in ACT which taken together establish the development of psychological flexibility. Each of these 6 components will be briefly outlined with examples of how these processes relate to working with people with Eating Disorders, from the perspective of both patient and clinician.

Values

Values are chosen qualities of action consistent with the things that you care about and ultimately what matters to you. For example, honesty may be a value or being a caring friend may be a value. They are like directions on a compass in that they can never be obtained as an object but can guide us as a direction to be heading towards. Often times in Eating Disorders, people have lost contact with their values in their pursuit of a certain weight or shape. Hence, this component of the therapy encourages people to make choices based on what they value instead of avoidance of feelings / pursuit of thinness. It can be useful in terms of ambivalence as it steps aside from the power struggle around weight and shape and allows patients to stay in control in making choices according to their values. Helping people tap into their values is often instrumental in increasing motivation to make behavioural change.

For people that have lived with Eating Disorders for a long time, discussing values can be painful as they get in touch with the costs of what's been missed in their lives.

For clinicians, if we find ourselves becoming frustrated at the lack of change or the ambivalence, it can be useful to tap into what sort of clinician we want to be and have that guide our behaviour and the way we relate to our patients.

Contact with the present moment

Contact with the present moment means paying attention and being consciously aware of connecting with whatever is happening right here, right now. It is often referred to as mindfulness. Sometimes we can be talking to someone and then realise after a few moments that we haven't heard a word they are saying. Contact with the present moment involves being really present, in whatever you are doing at that time, in just that moment. ACT promotes ongoing nonjudgmental contact with psychological and environmental events as they occur. The goal is to have patients experience the world more directly so that their behaviour is more flexible and their actions more consistent with the values that they hold.

People with eating disorders are often fearful of their emotions or they don't understand them. Mindfulness helps people learn to be aware of their thoughts and feelings and to be present with them moment by moment. With both Anorexia Nervosa and Bulimia Nervosa, large portions of time are spent thinking about the past or the future, ruminating over events that have occurred or worrying about what to eat, how to get through social situations where food is involved. Whilst this is happening, people are generally not in contact with the present moment and hence, missing out on huge portions of their own life.

For clinicians, if we notice our thoughts wandering as the person talks, we can use mindfulness in session to re-focus our attention and to be present with the patient.

Defusion

Defusion means learning to step back or detach from thoughts, so that you are watching your thinking instead of getting caught up in it. In contrast to CBT, the emphasis with defusion is not on changing the content of the thoughts, rather on changing one's relationship with thoughts. The result of defusion is usually a decrease in believability of, or attachment to, private events rather than a change in how much the thought occurs.

Patients with Eating Disorders hold on to many beliefs about their eating behaviours and themselves, as if they were real. In Anorexia Nervosa, the belief that 'I am fat' is very common and despite an observer strongly disagreeing that the person is fat, the belief is usually tightly held onto and not amenable to challenging. From an ACT perspective, the aim would be to step back and see the thought as a thought without attempting to restructure the content.

When progress is slow, clinicians can feel hopeless that change is possible and buy into thoughts that the patient isn't going to get better and that the situation is hopeless. Defusion can help in stepping back from thoughts and connecting instead with our values as to the kind of clinician we want to be.

Acceptance

The aim of acceptance is to help people accept private experiences that may be painful or unpleasant by being actively aware of and making room for painful feelings and sensations to be there without struggling against them. It is taught as an alternative to experiential avoidance. For example, patients with anxiety are taught to feel anxiety, as a feeling, fully and without defense; Acceptance (and defusion) in ACT is not an end in itself. Rather, acceptance is fostered as a method of increasing values-based action.

The pre-cursor to looking at acceptance is to help people recognise how efforts to avoid emotions generally causes further emotional suffering. Bingeing or restricting or over exercising can be seen as behaviours to avoid current emotional experiences that often take away from the capacity to participate in valued activities. For example, someone may pursue exercising as a form of compensation and hence, not be able to attend a social function or spend time with loved ones.

As clinicians we often see our patients living restricted, miserable lives and want to reach in and drag them out of there. Which would be fine if it worked! However, this is often about us not being able to accept the feelings that show up for us in their presence. Acceptance can be used to help us meet the patient where they are at and accept whatever is there to be accepted in the process.

Self as context

Self as context refers to the part of us that is able to be aware of our flow of experiences, i.e., whatever we are thinking or feeling or doing at any moment without attachment to them or an investment in which particular experiences occur. In other words, it points to a self where we are the context for our private mental experiences. It refers to a self that is not limited to what we think and feel. A useful metaphor to describe this is that thoughts and feelings are like clouds in the sky where we are not the clouds, but instead we are the sky behind them, holding whatever comes and goes.

At times for patients with Anorexia Nervosa, the intensity of emotion when they are eating can lead to the experience that the feeling is not survivable. Developing a sense of the permanence of ourselves and that thoughts and feelings are transient, can help people to make contact with a space that feels safer whilst continuing to engage in valued activities. Self as context can also be useful when people are fused with a conceptualised self such that they define themselves based on physical appearance.

For clinicians, it can help us make contact with a self that can tolerate all difficult experiences that happen in the therapy room, knowing that we have survived difficult moments before and can do so again.

Committed action

Committed action means taking action guided by your values. ACT encourages participating in increasingly larger patterns of action linked to chosen values. In this regard, ACT looks very much like traditional behaviour therapy, and most behaviour change methods can be fitted into an ACT protocol, including exposure, skills training, goal setting, etc. Committed action refers to concrete goals that are values consistent and can be achieved (unlike the value itself which is the overarching direction for the behaviour). Behaviour change efforts often trigger contact with psychological barriers that are addressed through other ACT processes outlined above.

The committed action component of ACT for Eating Disorders looks similar to the behavioural components of other protocols for Eating Disorders. The values component points towards what action is needed and defusion, contact with the present moment, acceptance and self and context help break down the barriers to taking committed action.

The overarching aim in ACT is to take all of these 6 components together to develop psychological flexibility i.e., the ability to be in the present moment, with awareness and openness, and take action, guided by your values.

More resources about Acceptance and Commitment Therapy can be found at www.contextualpsychology.org

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