Can You See My Pain Before I Disappear: The Co-occurrence of Eating Disorders and Self-Injury

Denise M. Styer, Psy.D., Clinical Director
Center for Eating Disorders and Self-Injury
Alexian Brothers Behavioral Health Hospital
(847) 755-8187

© 2011 Alexian Brothers Behavioral Health Hospital
ASSESSING CO-OCCURRING DISORDERS
Eating disorders have the highest mortality rate of any mental illness
One cannot tell that someone has an eating disorder just by looking at them
What is an Eating Disorder?

• Symptom, or sign, that there is a problem
• Sign of problems related to self-esteem, regulation of feelings, feeling helpless or out of control
• Range: normal eating, occasional dieting, frequent eating, compulsive overeating, bulimia to anorexia
• Important Values: acceptance, self-worth, safety, overeating, fear, loss of control, being attractive, being in shape, being “good enough”, being “in control”
Proposed Changes to Anorexia Nervosa in DSM-5: Criteria A

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.

• Removal of “Refusal” and 85%
Proposed Changes to Anorexia Nervosa in DSM-5: Criteria B

B. Intense fear of gaining weight or becoming fat, or **persistent behavior that interferes with weight gain**, even though at a significantly low weight.

• Allows for inclusion of those who deny fear of weight gain
Proposed Changes to Anorexia Nervosa in DSM-5: Criteria C and Amenorrhea

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

• Criteria D of DSM-IV-TR: Amenorrhea is removed
Proposed Changes to Anorexia Nervosa in DSM-5: Subtypes

• **Restricting Type**: during the last three months, the person has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

• **Binge-Eating/Purging Type**: during the last three months, the person has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
Proposed Changes to Bulimia Nervosa in DSM-5: Criteria A

Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) Eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

(2) A sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating).
Proposed Changes to Bulimia Nervosa in DSM-5: Criteria B, C, D & E

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications, fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.
Proposed Changes to Bulimia Nervosa in DSM-5: Specify Type

Purging Type: During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Nonpurging Type: Recommendation to delete this subtype has been made due to how closely it resembles individuals with Binge Eating Disorder.
Proposed Addition in DSM-5: Binge Eating Disorder, Criterion A

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances

2. a sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)
Proposed Addition in DSM-5: Binge Eating Disorder, Criterion B

B. The binge-eating episodes are associated with three (or more) of the following:

1. eating much more rapidly than normal
2. eating until feeling uncomfortably full
3. eating large amounts of food when not feeling physically hungry
4. eating alone because of feeling embarrassed by how much one is eating
5. feeling disgusted with oneself, depressed, or very guilty afterwards
**Proposed Addition in DSM-5: Binge Eating Disorder, Criterion C, D & E**

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, **at least once a week for three months**. *(Criterion D for BED is recommended to be similar to criterion C for Bulimia Nervosa)*.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course Anorexia Nervosa, Bulimia Nervosa, or Avoidant/Restrictive Food Intake Disorder.
Proposed Addition in DSM-5: Binge Eating Disorder, Rationale to add

- **Family history** studies that BED tends to run in families and is not a simple familial variation of obesity

- Distinct **demographic** profile with a greater likelihood of male cases, older age, and a later age of onset.

- BED is associated with **lower quality of life** than obesity

- BED also shows a **greater likelihood of co-occurring medical issues**

- BED have a **more positive response to specialty treatments** than to generic behavioral weight loss treatments
Proposed Change in DSM-5: Feeding & Eating Conditions Not Elsewhere Classified

Replace ED – NOS

Atypical Anorexia Nervosa
All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual’s weight is within or above the normal range.

Subthreshold Bulimia Nervosa (low frequency or limited duration)
All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than for 3 months.
Proposed Change in DSM-5: Feeding & Eating Conditions Not Elsewhere Classified

Subthreshold Binge Eating Disorder (low frequency or limited duration)
All of the criteria for Binge Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than for 3 months.

Purging Disorder
Recurrent purging behavior to influence weight or shape, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, in the absence of binge eating. Self-evaluation is unduly influenced by body shape or weight or there is an intense fear of gaining weight or becoming fat.
Night Eating Syndrome

Recurrent episodes of night eating, as manifested by eating after awakening from sleep or excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better accounted for by external influences such as changes in the individual’s sleep/wake cycle or by local social norms. The night eating is associated with significant distress and/or impairment in functioning. The disordered pattern of eating is not better accounted for by Binge Eating Disorder, another psychiatric disorder, substance abuse or dependence, a general medical disorder, or an effect of medication.
Proposed Change in DSM-5: Feeding & Eating Conditions Not Elsewhere Classified

Other Feeding or Eating Condition Not Elsewhere Classified

This is a residual category for clinically significant problems meeting the definition of a Feeding or Eating Disorder but not satisfying the criteria for any other Disorder or Condition.
NSSI
(Non-Suicidal Self Injury)
Definition of Non-Suicidal Self-Injury


• Other Terms:
  • Non-suicidal self-directed violence

• Do not differentiate non-suicidal from suicidal intent
  • Self-injurious behavior
  • Self-harm or deliberate self-harm
Definition of Non-Suicidal Self-Injury

(Continued)

• NSSI is distinguished from suicidal behaviors involving an intent to die, drug overdoses, and socially-sanctioned behaviors performed for display or aesthetic purposes (e.g., piercings, tattoos).

• Resulting injuries may be mild, moderate, or severe
NSSI & DSM-5: Criteria A

• Engaged in intentional self-inflicted damage to the surface of his or her body
  ▪ 5 or more days in the past year
  ▪ NSSI induced bleeding or bruising or pain
  ▪ For purposes not socially sanctioned
    • e.g., body piercing, tattooing, etc.
  ▪ Expectation that the injury will lead to only minor or moderate physical harm.

• Absence of suicidal intent
  ▪ Either reported by the patient or inferred
    • Frequent use of methods that the patient knows, by experience, not to have lethal potential.

• Not common and trivial nature
  ▪ Picking at a wound or nail biting.
NSSI & DSM-5: Criteria B

NSSI associated with at least 2 of the following:

- Negative feelings or thoughts
  - Depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.

- Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to resist.

- The urge to engage in self-injury occurs frequently, although it might not be acted upon.

- The activity is engaged in with a purpose
  - Relief from a negative feeling/cognitive state
  - Interpersonal difficulty or induction of a positive feeling state.
  - The patient anticipates these will occur either during or immediately following the self-injury.
**NSSI & DSM-5: Criteria C & D**

- Behavior and consequences cause clinically significant distress or impairment
  - Interpersonal, academic, or other important areas of functioning.
- Behavior does not occur exclusively during states of psychosis, delirium, or intoxication.
  - Behavior is not part of a pattern of repetitive stereotypes (e.g., autism)
  - The behavior cannot be accounted for by another mental or medical disorder
    - i.e., psychotic disorder, pervasive developmental disorder, mental retardation, Lesch-Nyhan Syndrome
NSSI & DSM-5: NOS

NSSI-NOS Type 1, Subthreshold:
- Meets all criteria, but has injured himself or herself fewer than 5 times in the past 12 months.

NSSI-NOS, Type 2, Intent Uncertain:
- Meets all criteria for NSSI, but also intended to commit suicide in addition to other functions.
Why NSSI?

Why Not…

...Cutters?

- Derogatory
- Pejorative
- Labels the person instead of the behavior
  - Self-Identifier
- Exclusive
**NSSI is more than just cutting...**

<table>
<thead>
<tr>
<th>Hair Pulling</th>
<th>Picking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinching</td>
<td>Scratching</td>
</tr>
<tr>
<td>Rubbing</td>
<td>Eraser Burns</td>
</tr>
<tr>
<td>Embedding</td>
<td>Carving</td>
</tr>
<tr>
<td>Burning</td>
<td>Ingestion</td>
</tr>
<tr>
<td>Fighting</td>
<td>Excessive Piercings...</td>
</tr>
<tr>
<td>Punching Walls</td>
<td>Putting self in risky situations</td>
</tr>
<tr>
<td>Biting</td>
<td>Asphyxiation</td>
</tr>
</tbody>
</table>
## “Tools”

<table>
<thead>
<tr>
<th>Medical Equipment</th>
<th>Other Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utility blades</td>
<td>Cork screw</td>
</tr>
<tr>
<td>Needles</td>
<td>Knives</td>
</tr>
<tr>
<td>Razor blades</td>
<td>Pill cutter</td>
</tr>
<tr>
<td>IV butterfly/test tubes</td>
<td>Glass</td>
</tr>
<tr>
<td>Lighters</td>
<td>Knitting needles</td>
</tr>
<tr>
<td>Screws</td>
<td>Curling irons</td>
</tr>
<tr>
<td>Body Piercing jewelry</td>
<td>Matches</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>Teeth</td>
</tr>
<tr>
<td>Medication</td>
<td>Insulin</td>
</tr>
<tr>
<td>Paper clips</td>
<td>Pens</td>
</tr>
<tr>
<td>Clothes Pins</td>
<td>Fingernails/Hands</td>
</tr>
<tr>
<td>Staples</td>
<td></td>
</tr>
</tbody>
</table>
Eating Disorders & NSSI

- Between 25-40% of patients treated for eating disorders also engage in non-suicidal self-injury (NSSI).

- Eating Disorders diagnoses and Level of Care Guidelines do not include co-occurring NSSI.

- Despite the high prevalence of co-occurring eating problems and NSSI, few programs have treatments that specifically address both problems.
Eating Disorders & NSSI

• Similar difficulties with core issues:
  
  • Self-regulation
  
  • Cognitive distortions
  
  • Self-perception
  
  • Managing perception/experience of body parameters
  
  • Self-hatred, self-disgust
Eating Disorders & NSSI: Categories

• Similar/different purposes of behavior and function of the body
  
  • Induce sense of well being by using body to increase endorphins (restricting, binging or purging, by NSSI)
  
  • Punishment
  
  • Managing sensory overload
  
  • Perception of being in control
  
  • Managing or decreasing intensity of affect
SELF-REGULATION MODELS (Levitt)

Individualized Case Management and Family Therapy

Psychoeducation

Alternative Coping Skills Acquisition

Safety Culture

Relapse Prevention

Medication Management

Physical Health & Nutrition

School Intervention

Self-Regulation BASICS

Pattern Recognition & Interruption

Foundational Skills

Student of Self

Containment

Trigger Identification

Self-Help and Community Resources

Co-Occurring Diagnoses Tracking

Lifestyle Management Skills

SYSTEMS THEORY

MOTIVATIONAL INTERVIEWING

MILIEU MANAGEMENT

(Erikson, Bowen, Miller & Rollnick)

ABS R
TREATMENT MODEL

COGNITIVE & BEHAVIORAL MODELS

“THIRD WAVE” MODELS

(Beck, Meichenbaum, Linehan, Hayes)
Formulation of Co-Occurring Disorders in the ABSR Model

• Formulation of co-occurring disorders in the context of treating Eating Disorders relies on:
  • Detailed functional assessment
  • Detailed clinical formulation

• Identifying underlying vulnerabilities:
  • Internal: Emotional, Chemical, Cognitive
  • External: Family functioning, Situational
Formulation of Co-Occurring Disorders in the ABSR Model

• A central part of the ABSR model is the communication of the assessment and clinical formulation to the patient.
  • Teaching the patient the self-regulatory model and the clinical formulation, the patient is given an opportunity to either remain
    » Passive or reactive position ("psychological victim position", i.e. “It’s not my fault; It’s always my fault”) or
    » Active or proactive position ("psychological survivor", i.e. “I will make things happen”) (Levitt, 2004).
Formulation of Co-Occurring Disorders in the ABSR Model

• Throughout the course of treatment, the therapist helps the patient to monitor whether he or she is progressing towards the “survivor” position and creating a healthier approach to self-regulation, or if he or she is assuming a “victim” position and continuing on a chronically unhealthy course that maintains the Eating Disorder and co-occurring disorders.

• Ultimate goal is for the patient to decide to “take charge” of regulating her or his behavioral, affective and psychological state in a healthy manner (Levitt, 2004).
Eating Disorders & NSSI: Categories

- **Eating Disorder & Co-occurring NSSI**
  - ED *and* NSSI = can overlap but behaviors often serve separate functions
  - Coexist: ED = ED, NSSI = NSSI
  - Often engage in ED and NSSI with similar frequency and severity
  - Prevalent body image issues, including distortions
  - Underlying self-regulatory functions but each behavior may serve mostly separate functions
Eating Disorders & NSSI: Categories

• **Primary vs. Secondary**
  - ED and NSSI often overlap; each one serves the other
  - Rotate through symptoms and urges

• **When ED Primary**
  - ED primary presenting issue for admission (ED with NSSI)
  - NSSI can serve as “punishment” in eating disorder reasoning
  - Impulses for NSSI often subsequent to eating & body image distress
  - Traditional body image issues, prominent body-hate
Eating Disorders & NSSI: Categories

• **Primary vs. Secondary** (cont.)

• **When NSSI Primary**…
  - NSSI primary presenting issue for admission (NSSI with ED)
    - Traditional ED behaviors have a “bonus” function, or serve primarily as self-harm
    - Body image issues related to purpose/function of body (i.e. can’t tolerate being connected to body) vs. traditional appearance or size issues.
    - Usually more focused on self-hate vs. body-hate
Eating Disorders & NSSI: Categories

Assessment and Determination of “Primary vs. Secondary”

- Onset of symptoms
  - Which one came first? (If can determine)
  - Pervasive
- Frequency of urges
  - Time, intensity and duration
  - Time between action urge and behavior
  - If don’t do behavior, what happens?
- Context
Clinical Formulation

In essence, Eating Disorders behaviors can be intentional, purposeful and deliberate ~ although not causing overt, immediate tissue damage

... Eating Disorders **reinforce** NSSI

- Restricting: punish, deprive, emptiness = ache
- Purging: punish, degrade,
- Laxatives: inflict pain, discomfort, punishment, confine to home
- Binging: eating without enjoyment, punish by subsequent fullness/discomfort and shame
- “Scars”: emaciation, prominent bones, obesity, baggy clothing
Eating Disorders & NSSI: Categories

• “Pseudo-Eating Disorder”:
  • When ability to engage in NSSI is reduced
  • Frequency and severity of NSSI is reduced, mode of injury decreases in effectiveness
  • Look like ED in early stage of onset -- Disordered Eating vs. Eating Disorder
  • Incorrectly assessing insulin manipulation as related to “Diabulimia” vs. self-harm
  • ED behaviors function primarily as NSSI to regulate
  • Less struggle with traditional body image issues
At Alexian, we recommend

- Assess and treat both *simultaneously*
- Designate primary if possible
- Assess beliefs about the purpose and function of their bodies
- Work with the patient where they are at
- Assess purpose and function of behaviors in relation to body image
- Increase tolerance for being grounded in and connected to body
Thank you!

Denise M. Styer, Psy.D.
(847) 755-8187