Transcript for ACT for food restriction and anorexia with Dr Rhonda Merwin

Rhonda Merwin: [00:00:02] what is this doing for you? And then, course, the way out is in right? To go into experience into , what if you could have these emotions without having sort of turn to the eating disorder with we can create space for some of these feelings and it could be okay to experience them. And then, , life could open up more broadly from that place
Diana Hill: [00:00:19] you're listening to Dr. Rhonda Merwin on psychologists off the clock.

We are four clinical psychologists here to bring you cutting edge and science-based ideas from psychology to help you flourish in your relationships, work and health.
Debbie Sorensen: [00:00:40] I'm Dr. Debbie Sorensen, practicing in mile high Denver, Colorado.
Diana Hill: [00:00:44] I'm Dr. Diana Hill, practicing in seaside Santa Barbara, California.
Yael Schonbrun: [00:00:48] From coast to coast, I'm Dr. Yael Schonbrun, a Boston-based clinical psychologist and assistant professor at Brown University.
Jill Stoddard: [00:00:54] And from sunny San Diego, I'm Dr. Jill Stoddard, director of the Center for Stress and Anxiety Management.
Debbie Sorensen: [00:01:00] We hope you take what you learn here to build a rich and meaningful life.
Diana Hill: [00:01:03] Thank you for listening to Psychologists Off The Clock. Today's episode is one that is really near and dear to my heart. I, my background is in researching in disorders and I've worked in that area for a long time and one of the things that I have found most challenging and most rewarding in working with men and women with you disorders is that the disorder can get so entrenched that you feel like you can't get in there.
To help people change. And what Dr. Merwin offers us is the cutting edge strategies from ACT that they're using in, programming for eating disorders that actually give you a little bit of breathing room so that people can start to move in the direction of recovery.
Debbie Sorensen: [00:01:47] Yeah. I think that's really helpful. It's also helpful, I think, for, for people to listen who are just having trouble understanding this restrictive eating pattern. You know, whether it's a friend, family member. One of your therapist's clients, there's sometimes there's a reaction to that kind of behavior of like, why would you do that?
You know? It doesn't make any sense. It's dangerous, et cetera. And so there can be that like inability to understand it. And I think Dr. Merwin does a really good job of helping make sense of it. Like why people do this, what function it serves for them. It helps actually have probably more compassion for it.
Diana Hill: [00:02:19] Yeah. And not responding with the just eat or you don't look fat or, you know, some of those traps that I think even collisions can, can get into, this is, uh, one of those episodes where when I was listening to Dr. Merwin

talk, I was. Wishing that I had a notepad just writing down all of her wisdom, because it's an example of someone who's at the cutting edge, forefront of research in the area of eating disorders.
And in particular, the most difficult to treat eating disorder, uh, anorexia. So. What she has to offer is incredibly useful in terms of increasing willingness in terms of how to apply these ACT concepts, uh, with struggle. And I would say, get out your notepad, take some notes, and you might want to listen to this one a couple of times because she's fantastic.
Dr. Rhonda Merwin is an associate professor in the department of Psychiatry and Behavioral sciences at Duke university. Dr. Merlin conducts research focused on the mechanisms and treatment of eating disorders.
Her work focuses specifically on restricted eating disorders like anorexia and on eating disorders among individuals with type one diabetes. Dr. Merwin is a peer reviewed ACT trainer and the director of the ACT at Duke research clinical and training program in Duke university school of medicine.
She's also the lead author on acts for anorexia nervosa, a guide for clinicians, which she coauthored with Dr. Nancy Zucker and Dr. Kelly Wilson. Welcome to the show Dr. Merwin. It's so great to see you.
Rhonda Merwin: [00:03:49] Thank you. Nice to be here.
Diana Hill: [00:03:51] we're going to be talking a lot about anorexia today and restricted eating in more in sort of general along that continuum.
I think a good place to start with something that I read. , in your book, which really struck me, and what you write is individuals with anorexia are doing exactly what society has told them. Make sense to be a good person. Can you speak to that?
Rhonda Merwin: [00:04:16] Sure. Um, you know, I think that, uh, one thing to say is that, You know, in our society we're sort of inundated with these messages that self discipline and self control is, uh, is, is a good thing, but specifically around, eating and weight and we sort of inserted morality. Into eating, uh, in a really profound way, uh, that, you know, they're good, are good and bad foods, and that you're a good or bad person depending on sort of, um, you know, how you meet what you eat.
You know, we'll, we'll often hear people say, you know, I was bad today as if they need to sort of repent for their sins of eating chocolate cake and those kinds of things. So, you know, so it was, that was one of the things that was sort of prompting that, right? Is we're given, uh, you know, all these messages that this is like controlling your eating is, You know, is, is something very virtuous and important in our, in our society. And, you know, when that's taken to an extreme level, right? People really suffer profoundly. When I think about this quote, one of the things that I think about is the, the, um, a long history of anorexia nervosa. And, you know, people sort of think about it as being a very, um, present day kind of issue, internalization of the thin ideal, you know, when those kinds of things really. got pushed at, at sort of a societal level, but you can go back and you can actually see, um, you know, some pretty well documented cases of self starvation in the middle ages and beyond.
And at the time, these women, they're, these cases are all women from, from history. But these women, who were able to overcome the biological impulse to

feed and to nourish their body and starve themselves literally to death were seen as pure and divine and possessing a special gift from God. And when you like watch it, when you trace that history sort of forward.
What you see is that the religious sort of connotations or whatever kind of fall out a bit, but, but there's still that same level of admiration and all, and, you know, they're described in some of these early writings as miraculous maids.
And so you can just see us so deeply embedded in the human psyche that it's that, you know, and it goes way back that it is really special and virtuous to override our biological impulses, including the impulse to eat and to, and to feed ourselves.
, so that was, that was part of what, what that quote was, was also about, was sort of reflecting , on that broader history and the value of self-restraint. over biological impulse.
Diana Hill: [00:06:44] So it begins with some of that morality or following what societal expectations are, but there's sort of a. Uh, a switch that can get flipped in the process where actually some of the brain and body changes that happen as a result of restricted eating make it become quite entrenched. And I think about, maybe a group of five, uh, high school students decide to go on a diet together. And one of those five that diet turns into a either a subclinical eating disorder or uh, maybe even anorexia. Can you walk us through what, what's happening for that, for that one person that it actually leads to the development of something that is quite intractable and can be a lifetime of real suffering.
Rhonda Merwin: [00:07:32] Yeah, yeah. And you know, so, so in the really early, stages of restrictive eating and weight loss, you get all of that, societal sort of reinforcement, right? So versus just this like, Oh, you look great and you, you know, have you lost some weight and some of those things. And for some people, that initial reinforcement, then just sort of.
Perpetuates more and sort of an intensification of, of efforts at weight loss. And then once the, once the one is sort of sufficiently under nourished, there's all of this stuff that happens to the body that serves as sort of maintenance factors. So when you get to a, per, to a certain threshold, you have,
biological adaptations to starvation that just perpetuate the problem. So for example, initially you might feel really hungry, but then later those hunger cues are going to mute and it's just the body's just going to quiet because it, it, you know, it's not that helpful to signal, right. It's sort of going into the starvation, like as if there was a.
 famine or something like, the, the thing to do is to sort of shut off those cues and just kind of like, you know, if there's no food to be had. so you get those kinds of adaptations. The other things you get is, you know, over time people start to lose their, lose their mentees, right?
 the body shuts down and the extra. activities in order to conserve energy and that sort of, that, and the slowing of the heart and, you know, the Brady cardia that comes on and those kinds of things. You know, , feel like a quieting of the body that for somebody that might have felt really quite anxious or, , like overly distracted by their internal noise, this feels like super nice.
 and feels very in control? So once you get to a certain level of undernourishment, you have those biological changes that sort of perpetuate the

problem. You also have like disruptions in. Cognitive and emotional faculties, right? Where people can't sort of think as clearly and , their emotions are just shifting in, in different, in different ways, initially more disruptive and then later quiet.
And so it's just, they're losing all of that information from the body that would normally cue them, cue more adaptive responses and, you know, and so they just become almost like these robots at some point. Also though, in your question is why that one person? So, out of that group of, uh, young people, for example, the star dieting, you know, , there are certain temperament features that will predispose some of them to just kinda keep going with it.
Uh, so things like harm, like high harm avoidance. which manifests as sort of like being in kind of an anxious, inhibited type. and high perfectionism are both really highly associated with restrictive eating patterns. Um, so that was certainly a, a vulnerability factor. , interpersonal sensitivity is another factor that you see a lot with folks that, um, really move into more extreme restrictive eating and those kinds of things.
So, you know, so these are people that are anxious, inhibited. Obsessional, afraid of making mistakes, afraid of being rejected by people. And so they might take these things to an extreme, especially once they get that initial reinforcement that feels like I'm doing good. I'm doing right. People, you know, people are, um, you know, seeing, seeing that, that I'm okay.
Right? So then that just kind of keeps, uh, keeps going. there's some literature too on sort of neuro biological differences.
So some people that are really local processors rather than global processors. So they tend to see the details, like , see the trees and miss the forest. people that are real local processors and really detail oriented are also going to be. more likely to, to get really sort of hooked in these patterns of calorie counting and, sort of obsessive deep, you know, detail focus of whether they're, , meeting all of their, uh, all of their, all of their goals and whether there's any small change in their body and all those kinds of things.
So that's another kind of, predisposing factor.
Diana Hill: [00:11:14] and that's why you'd see a lot of co-occurrence with things like obsessive compulsive. Disorder. And a lot of these features are, are genetically linked. So especially with anorexia in particular of the eating disorders that plays a role one of the analogies that I'll sometimes use with clients is, that they're like a sea anenome.
And if you ever go to the beach and walk along the shore and you see the sea anenome as you go and you try and touch them, they're so, they're so sensitive to their environmental stimuli that they just
close up and, and then when they close up, they actually can't take any, anything else in. So it's not only can they not take in the food, they're protecting themselves by closing up, but they also can't take in the other stimuli in life.
And that's the sort of turning down the volume what you write about in your book is. This functional analysis of not only are you turning down the volume of your hunger signals, but the whole volume of life turns down and becomes quite narrow and the core component of emotional avoidance and, and the role that that plays in the maintenance of an eating disorder and reinforcement of eating

disorder.
So I'd love for you to talk about a functional analysis, how you conduct that cause something really different in your approach. And then the role of emotional avoidance in that process.
Rhonda Merwin: [00:12:31] Okay. Yeah. And w, and I love your metaphor. I might have to like hijack that metaphor. That's lovely. Yeah. And the, and the incredible amount of safety that comes and predictability as people certain draw in and, and really narrow life down to just the next meal.
You know, that's sort of like a simpler sort of thing. Just the next meal, , functional analysis. So, uh, that's, that's a big topic cause a big, you know, topic near and dear to my heart. You know, I came through, uh, Kelly Wilson's lab and, , for those who don't know, Kelly, Kelly Wilson is one of the co developers of, of ACT, and a staunch behaviorist, you know, some people come to the ACT model and don't start with a lot of that behavior analytic kind of language, but I sort of grew up at more in that, in that frame.
And so. this piece about functional analysis. ACT, , is a functional analytic or functional contextualist stick, intervention, meaning that focus more on function of how behavior functions rather than its form or what it looks like. And that's why a lot of the stuff that we talk about today could be applicable to the whole continuum of eating, uh, pathology, but also lots of other kind of clinical problems and those kinds of things because some of the things are just a, it's just the same.
It just looks different. And it's. Clinical presentation maybe, but functionally might, might be the same. so, , so function over form, how does behavior function for the individual and in their life? And then, context, right? So everything's like acting contexts, which those things, , work together.
So when I'm thinking about somebody with anorexia nervosa or restrictive eating patterns, I'm trying to think about what is the historical situational context in which this set of behaviors emerged from this. For, for this individual. and I'm really starting that in the very, the first clinical interview.
So, , a lot of clinical interviews might focus very much on sort of the diagnostics and those kinds of things from this approach. I'm thinking less about making sure that we're hitting all the diagnostic criteria and more about like the historical timeline of events where, where did restrictive eating or dieting or concern about one's appearance first emerge in the individual's life.
And I'm trying to go backward and forward in time. Around those key periods to see what was happening before that. What thoughts, feelings, difficult situations were sort of emerging. And then, you know, how did focusing on dieting or restricting their eating or changing those behaviors in some way, you know, their eating behaviors in some way, impact then how they felt.
, so when I'm getting, when I'm in a clinical interview and I'm getting some of that historical information about their life, I often like draw a timeline and, and Mark these places where these things first emerge and, and any kind of key, you know, shifts in their presence, right? So. Um, you know, if there was a time period where it was really, you know, these symptoms were exacerbated, or another time period where they were pretty, you know, pretty quiet, you know, where their body concerns were pretty quiet.

I'm wanting to know about all the contextual variables around those shifts and change to try and identify how are these behaviors functioning for this individual. How did they improve their situation or make them feel better. Safer, more secure or more masterful, more effective, more in control, you know, all of those kinds of things.
So I'm trying to discern the function through that historical timeline.
Diana Hill: [00:15:44] and
that's a really important thing to do because. It helps the client see the eating disorder, not just as, Oh, this popped up in my life, but it serves an important role for me. And that's why I'm holding on so tight to it. We had a need a Johnson on the show who wrote eating in the light of the moon, which is all about myth and metaphor and women and food.
Fantastic. And one of her very, very foundational metaphors is about the log and how at a time when maybe you were floating in the river and it got really rough. You grabbed a hold of this log and it saved your life in some way. And that's why it's so hard to let go. It's so hard to let go. So the functional analysis component of seeing that , through your lifeline is such an important process, not for you as a therapist, as for you as a therapist, but also for the client
yeah. So what next? What next? Yeah.
Rhonda Merwin: [00:16:34] Well, and I love that, you know, log that saved your life, and hopefully we'll get to talk a little bit about kind of, honoring our, appreciating the gifts of the eating disorder is such an important intervention for people that, that they, that they get that you as a therapist, get how important this has been to them.
How it's really helped them in their life. Um, cause otherwise it's gonna feel like. You know, you have the shield of armor and now we just want to sort of rip this armor away, right. Without appreciating like how it's protected you, how it's helped you, how it's been sort of near and dear. after the historical timeline and, and you're starting to sort of work with, with the person. There's a couple other key places where I, I really do a lot of, uh, a functional assessment or, or a couple of key interventions or therapeutic activities that do that. One is getting people to start to notice the eating disorder, what we call the eating disorder volume.
So times when their concerns about eating or their body or, or weight. is higher. often people will think that it's this real steady thing. And if they're restricting across the whole day, it might feel pretty continuous. But if you start to, if you teach them to start to notice the notice those little variations in their volume.
 then they can start to appreciate how it's functioning in their daily life. Right. So right now it's at a nine. Okay. What was happening right before that moment where the, you know, eating and weight and dah, dah, dah, really sort of came into focus and got really loud, like what was going on?
What were you feeling right before that showed up and sort of redirected your attention, redirected your energy, or sort of offered itself as a solution and often people were feeling some painful. Or uncomfortable, emotions. so we really teach people to notice the changes or variation in the eating sort of volume, and to see that as a flare, sort of a signal flare to look around at, the, situation and what they might be experiencing in that moment and what the eating sorta might

be functioning to take them away from.
And in that moment,
Diana Hill: [00:18:27] Right? So an example of that might be someone is having a family dinner and all of a sudden they just don't want to eat. They can't eat. , there's no way I can eat this dinner. And if you start to look on packet, look around at what happened at that dinner table. Did someone make a comment? Was there somebody there? Was there something that happened right before that moment? And for oftentimes for an individual that you can disorders, there's a lack of awareness of that. Uh, what's happening emotionally for them. So doing this, dissecting it down to these little mini chain analyses almost of in the moment with what's happening also helps build that emotional awareness of how it's, you know, sort of symptoms are almost always linked to something, uh, beforehand.
Rhonda Merwin: [00:19:11] Yeah. And, and attention will narrow down so much for folks that they really will say, no, no. In that moment, it, it was, it was the, it was the food, it was the food that was upsetting. And it absolutely is true that that was, that that was an element of their experience and your, and what else was going on.
Right. We're trying to sort of broaden their vantage points so they can take in. The full range of their experience, including what other emotions might've been present or other things that might've been happening that influenced how they were feeling about that food, um, in that moment or about themselves or their worth or their bodies or, or whatever.
the other thing that I was just gonna mention is, the term clinically relevant behaviors that actually comes from FAP, from Functional Analytic Psychotherapy. but clinically relevant behavior CRVs that you might see in session are also like little signal flares. So what I mean by that is, orienting to the body, the size of the body, for example, in the mid, in the midst of a session might be a clinically relevant behavior that we might pause and say.
So we were just talking about this friend. And then next thing you know, , we know we've turned to, or you know, your, your attention is turned to the size of your thighs or what it feels like to be, you know, in your body in this moment. you know, what was showing up for you in that conversation. Like if we go back in time, just moments before your attention turned to your thighs, was there anything showing up , that you might sort of notice right now with me. they might notice, for example, feeling disconnected from that friend or feeling like people don't want to reach out to them feeling unlikable, different antecedents sort of show up. But it takes sort of, kind of slowing them down in that moment when you see a CRB a clinically relevant and then looking like, what was, what was going on like right before that.
, so those are the different ways in which we do functional assessment . one of the thing about the eating disorder volume and just any of these activities are sort of slowing down and observing is, uh, from an ACT perspective, you're really sure enough that observe herself.
And you're sort of separating them out from the eating disorder. So now I'm the person observing changes in my experience and my thoughts, my feelings, my, uh, body sensations, my attention, whatever. But I become the observer of that, and I'm not just kind of completely globbed onto the eating disorder itself.

Diana Hill: [00:21:22] . So, so you start with this really detailed functional analysis of not only the history of the eating disorder, but the volume of the eating disorder in their life when it's up and down, and then in the moment in the session, functional analysis. And then that gives you a little bit of a roadmap of, okay, where are we going to go?
how are we gonna tackle this thing? Something that, I really found valuable from your book as part of that functional analysis is to not only look for the emotional avoidance that the, in terms of eating disorder behaviors that are used to manage emotions, quiet emotions, but also other types of behaviors.
That individuals with eating disorders may engage in that are a pretty patterned emotional avoidance. So you wrote things like working long hours, not taking breaks, people pleasing, being compliant, excessive morality, seeking reassurance over apologizing, being the best. And some of these behaviors are also very characteristic for individuals that struggle with anorexia.
Can you talk about that constellation of emotional avoidance,
Rhonda Merwin: [00:22:28] Yeah, yeah, absolutely. There's this natural transition point where as you start to identify like, how is this, how is the eating disorder of restrictive eating functioning in your life? Like how is it, helping you sort of feel better about yourself or your situation or whatever that is.
It's not too big of a leap to then ask. What are the other behaviors that do that for you? Right? So restrictive eating helps you feel, for example, for example, sense of mastery or maybe like you're good enough, right? In some way. Maybe that's the only time that you like, feel like you're sort of good enough is when you are, meaning your, your, your goals and, eating and weight loss.
then you might ask, is there any other places in your life where, where, you know, any other behaviors that you do in order to feel that in order to feel a greater sense of, uh, mastery or accomplishment or like you're enough and, you know, people will start to diversify, you know, start to describe these other, behaviors that might be very diverse or look very different than restrictive eating and weight control, but are functioning in exactly the same, the same way.
this piece uh, , which in some ways is an expansion of the functional assessment but also is important intervention, really highlights how the topography, the behavior is pretty irrelevant, really is how it functions for the individual, , as a way to manage feelings or for avoidance and control.
one of the things that you might notice when you look at that list is that a lot of those things are also going to be things that are going to be reinforced by. Other people, right? Like, you know, people like it when we're compliant and we don't rock the boat or if we work long hours, right?
The boss is going to say, I'm so glad that you stayed and got that done. Um, right. So, so the same, uh, reinforcement patterns sometimes happen, uh, with these as well, but it has the same consequence and that the person ends up being depleted, if not physically, emotionally depleted. because of these things.

Diana Hill: [00:24:20] That egosyntonic nature of the eating disorder in terms of how it becomes part of the identity, but also. Why people like me, if you go in and you start to just take it away, this is like taking away the log. Uh. You're going to be in big trouble because the person is going to hold onto it tighter.

And one of the next steps that that you write about after you've done this functional analysis is how do we increase willingness, increase motivation to maybe loosen up your grip a little bit and you walk us through some of these steps that it seems like they're drawn a lot from.
Motivational interviewing and also just your understanding of, uh, of what helps increase willingness. Some of the things that you, that you do feel counter intuitive, like taking time to appreciate the emotional benefits of anorexia, taking time to validate the fear of losing these benefits, really appreciating the rigid, um, self regulation and how it's been helpful.
Can you talk about how you work towards increased willingness to. Loosen up that grip on not only the inner sort of behaviors, but also some of these other types of emotional buttons,
Rhonda Merwin: [00:25:31] Yeah. Yeah. Yeah. Well, and, and one thing to say about that, I would say one thing, and then I tell you six things, right? But, uh, one thing to say about that is just that you sometimes also get pushed back from the environment, right? Because people are used to them being, for example, compliant or are working long hours or people pleasing in some way, or, you know, whatever.
Diana Hill: [00:25:49] struggle. How do you do this? Still be an athlete.
Rhonda Merwin: [00:25:54] Absolutely. Well, and even parents will get, you know, sort of nervous, , as, as they, uh, learn that what but what we're trying to get their child to do is actually to be less hard on themselves to work.
Less hard, you know, and some parents like it makes them a little nervous. I mean, in part because they've seen their child be so hard on themselves when they don't give 110%, so they're sort of worried about what are the consequences for my, for my child. But also, there's lots of other things going on for parents in, in those moments too.
They see these things as desirable, that they're working hard to, you know, go to the top of the Ivy league colleges and things like that. often talk to the, to the, to the parents and, and, and the, and the other people in the person's environment that, you know, anorexia and, some of this, some of the striving is actually poured from the same vessel.
And that we don't want to take away this person's drive to, be kind or work towards goals or all those kinds of things. But we just want them to engage at flexibly. that these behaviors are like fine things to do as long as they're sort of taking into account them themselves and not in a punitive, rigid, application .
, so your question is how do you get people to be willing to commit. Fair met with a different way of being to potentially let go of, of restriction and you know, addressing the environment and making sure the environment will come along and help you reinforce these new patterns , as part of that, these new adaptive behaviors, you want the environment to cooperate with that.
 but how do do it with the individual? I mean, I think that we've, we've touched on a couple of them. One thing is that appreciating the gifts thing is, is huge. Like. The gifts that the eating disorder has given to that individual. And unless they appreciate that they, unless they know that you get that, , they're not going to really trust you in this process of sort of handing, handing that over.
 that other piece that we talked about in terms of, creating a little distance

between the individual and the eating disorder where they become the observer, , is also another, another piece. because if he can create a little space between the individual and, and the eating disorder, then, you can enhance willingness to, uh, do a really honest.
Look at, how that is or is not working for them, right? If there's, if there's not any space there. So a threat to the self, right, to, to think about kind of changing this, but if you can create a little space in there, through these things, like using the evening sort of volume and other sorts of externalizing strategies where the eating disorder is separate from that individual and they can start to look at like, how does it.
How does it help me? And how does it hurt me? , does it have costs for my, deeply held personal values, ? Is it actually sort of costing something, , that I really care about? And, I think , this piece of work. People, most often go sideways here if they're trying to do an ACT model because , we're so used to doing things like pros and cons lists and, , trying to help people do these kind of, , exercises and sort of logically arrive at the conclusion that they should give this up. but, but it's not motivated. I mean, there's a lot of logic in there, but it's not motivated by logic. Usually it's motivated by deep emotional needs. Right. The need to feel competent or worthy or enough, and to sort of pit that against the negative consequences of low weight that may or may not happen.
Right. Osteoporosis.
Diana Hill: [00:29:04] going to get nowhere with that. And, and not only that, they will smell it from a mile away that here you are as a therapist and you're trying to get them to point B. Can we just get you to point B of seeing how bad this is? Because people in their lives have done that. Up the wall, do for them, for them. And, and actually , it's quite a, a shock when you start going in and talking about,

good. what is it about it that, how do you feel so superior? How do you feel empowered? How do you feel safe in your body? Tell me all about that. And it makes sense. And that's why I think that opening quote that , I so appreciated that you offer in this book.
, I was a clinical director that IOP and we gave them two books upon their entry into the program. We gave them Anita Johnson's eating in the light of the moon, but we also gave them life without ed, by Jenny Schaefer. And it's a book about a woman who has sort of called her eating disorder ed and she, and it's basically an abusive relationship that she's trying to break up with and she falls in love with them and brings them back in and it's so good and warm and cozy and gives, he gives her all this appreciation, but then he becomes abusive again, so she kicks him out.
And that's more of what the relationship looks like and that, that process of seeing, like you said, separating the self. Uh, from the eating disorder voice and the, the, the concept of the , but also seeing the benefits of why you keep on going
Rhonda Merwin: [00:30:27] Yeah, yeah, yeah.

that piece is so important and so in so challenging, uh, in a lot of, in a lot of ways. But so a couple other pieces about how do you, how do you help create, um,

some, some willingness here? So one thing that I would say is, so, so you're not leaning on pros and cons, right? You're doing this, you're doing this other thing of trying to help people make experiential contact with the ways in which.
The eating disorder, um, is like an abusive partner. Right? And the ways in which it sort of is, is harmony harming them or limiting their lives. but, but you're trying to get them to make experiential contact with it. You're not trying to sort of tell them that that's the way it is or, , push this agenda.
You're, you're, you're basically trying to get them just to slow down and look around their life and like, in what ways is life. Limited in ways that they wouldn't choose. Like what do they not have the opportunity for because they're spending all the time at the, at the gym or because of the rigid, you know, the rigid way in which they manage their eating.
Like, are there things that are missing that they, that they deeply care about? I often find that people actually think that, um, they sort of have this, this belief that if Finn, then I'll have connection, for example, with other people like they've, it's sort of like a means to the end of something that they still care about and what they're not contacting is no matter how much they engage, that even sort of, they're getting further away from the thing that they actually want and most desire in some cases.
When you're getting to that. You know, the broader values and, and things like that. So they certainly desire to get away from painful feelings, but they also desire other things in, in their, in their lives, and often think that being thin is kind of a prerequisite for that. Um, so getting people to, to sort of, , let go of, that strategy to kind of come up against the unworkability of that strategy.

Diana Hill: [00:32:12] So you're leading us into some of the six core processes that you address with ACT. And maybe even before we do that, I think it would be helpful to pause and ask why ACT. Because there's been a lot of different approaches to try and tackle, especially with anorexia, which is a very challenging, disorder to recover from and very, uh, lethal in terms of, risk factors associated with it.
Why did you decide to pursue ACT as a treatment approach?
Rhonda Merwin: [00:32:45] Oh, that's a big question. The dominant approach, at least within cognitive behavioral therapies or second wave cognitive behavioral therapy focuses a lot **on the topography**. Right. What the behaviors look like, Fairburn describes it, for example, as, even sores or cognitive disorders, there's an overvaluation of, um, of body weight and shape and an evening to sort of filter the sort of biases, you know, biases the perspective on the world.
And, , it's very much about. What it looks like in that way. which I think is a, you know, fine approach. People have lots of different ways of working on these things. ACT, goes under that to look at the function, like why the focus on eating,
what is restrictive eating, and, narrow attention to body weight and shape. What does that do for the individual? some of that focus on, , on the topography that can kind of really get you sideways a little bit in treatment.
Like you might spend her old time then almost engaging in the avoidant repertoire, right? Talking with them about body weight and shape, which is what

they do to
Diana Hill: [00:33:47] Oh my gosh. I probably played 50 minutes sessions talking about what someone ate that
week.
Rhonda Merwin: [00:33:51] exactly. exactly. Right.
Diana Hill: [00:33:54] in these weeds
Rhonda Merwin: [00:33:54] Right? And an ACT allows you to sort of step out of that sort of cut to function.
what is this doing for you? And then, course, the way out is in right? To go into experience into , what if you could have these emotions without having sort of turn to the eating disorder with we can create space for some of these feelings and it could be okay to experience them.
And then, , life could open up more broadly from that place. when someone says why, why ACT, we could actually tick through all the processes and we could spend a lot of time kind of talking about what each might kind of buy you a bit. And I'm not sure if that's what you, um, if that would be helpful or if that's what you would want to do.
I could focus on just values for a second. Sort of highlight that one. You know, if you think about people that are, prone to restricted eating and, and, uh, this kind of like over control of, of anorexia nervosa, one of the things that the eating disorder does, um, and as part of a broader repertoire of is it gives rigid rules for life, right?
For what to eat. When to eat it, all this kind of stuff. and part of that is , driven by, , a lack of sort of self direction if not knowing like, who I am and, and, and you know, what direction I to go in my life, right? That this rule system of anorexia and sort of the broader rule system, which they operate like, you know, gives them some kind of path.
when you, uh, introduced values, you're giving them sort of an alternative model. Flexible adaptive thing to organize around. it seems to serve an organizing function, for individuals with the, with these behavior patterns and like, instead of rigid rules and punitive over control. That leaves them deprived and depleted physically and emotionally.
You're giving them something else that is life building. Um, and still has some structure to it, right? Still provides them with some sort of guideposts to know if they're going in the direction so they're not completely get kind of lost at sea.
Diana Hill: [00:35:45] It reminds me of when I used to do sort of a outward bound kind of backpacking trips they would give you, rather than the trail, the map of the trail system, they'd give you a compass.
Rhonda Merwin: [00:35:54] Oh,
Diana Hill: [00:35:54] And the map. Right. And if you go on the trail system, something goes wrong with that trail or you can't cross that river cause the trail has been washed out.
You're in trouble. But if compass, you can still get where you want to be going with a lot more flexibility, a lot more resources available to you. Yeah. Yeah. So moving out of rules into values can be quite liberating.
Rhonda Merwin: [00:36:14] yeah, yeah. Well, and the other thing that, so, so we could go into each of the different processes and why they're sort of used useful

for, for this population in particular. And I said, well, let's ha, you know, we can highlight values. We can also , highlight acceptance, right? As certainly, and this goes back to, , ways in which we've described anorexia nervosa as being an experience phobia.
, that part of what's going on for people is like a fear of feeling of. Feeling and feeling too much, um, or experiencing life in a way that is unpredictable or, or, uh, uncontrolled. And so, actress just so perfectly matched to that. , cause it's all about being able to sort of allow, uh, experience to be what it is, um, without over attachment or aversion, you know, to just sort of allow it to be what it is.
And then when I think of a fusion, and as , one of the ice processes, I think about, the cognitive rigidity that you sometimes see in these folks and how, if our goal from an ax perspective is actually just to change how people relate to their thoughts.
We don't have to change the content of their thoughts. Then we don't have to wait , to loosen up that rigidity and have anything change, right. In order to get behavior change in order to enhance their lives and stuff like that.
Diana Hill: [00:37:23] and just a pause on that. the content and the experience inside the mind of someone that's struggling with an Eunice order is quite torturous. I mean, this is like a kind of a big deal because what, what they experience is first thing, they wake up in the morning, the mind is yelling at them, giving um, direction, telling them how they're a bad person.
If they don't do this, , it's can be quite loud and quite debilitating. And it expecting that, that we have to have that change before we can change any of our ways we operate in the world. , it's not gonna get you very far. . That's one of the things that I actually see people coming in that actually is one of their motivators is it's so painful to be with my thoughts, like all this other stuff about the disorder I really like, but man, my, my head is, is a painful place to live in.
So I think apt gives give some freedom there too, of not necessarily , those thoughts don't go away and actually even have clients that are. Really fully recovered from the behaviors of the disorder. But man, those thoughts still show up and going in for a work meeting, and I'm thinking I could just not eat today and it would be so helpful.
Rhonda Merwin: [00:38:30] yeah, yeah. They fade into, you know, as people start to behave differently, they become more like background noise instead of like right in their face. , and some people will describe more space in between right. Before it sort of shows back up. But yeah. They, they don't go, they don't seem to go anywhere permanently.
I actually can't think of, , very many clients that I've worked with and, and the, you know. Let's see, 15 years or something that I've been, uh, here at Duke that, that have said, Oh yeah, I never have an eating disorder thought anymore. You know that in times of stress that'll show up again. Just like a, you know, that is that signal flare, right?
So it shows up. So then you'd pause and you say, Oh, where did that thought come from? I must be feeling something. Something must be showing up that I need to attend to, that I need to notice and appreciate and honor or whatever.
Diana Hill: [00:39:15] So values, and then we have acceptance, and then we have diffusion.

Rhonda Merwin: [00:39:19] people with, , with, at least with anorexia nervosa and probably with, You know, broadly with restrictive eating, they live mostly in their head, they're not really in there and inhabiting their body.
They've, they've escaped that and they're, and they're mostly living in their head and thinking about, the future and how they can prevent. You know, mistakes or the past and what they may have done that was not, that that wasn't good enough or not right.
So there's, they're living through more mostly verbal constructions in the head through, plans and rules and use scripts and all those kinds of things. Rather than dynamically attuned to their, to their bodies and, and experiences that are happening on folding sort of moment to moment to moment.
So then you get into , diffusion and present moment processes of ACT and how they can be helpful in terms of helping people get out of their head and just living in this space. And start to kind of connect up to the present moment that they're in. And over time, the goal is to attune to your emotional experiences and your, and your hunger and your satiety, and start to use those cues to guide behavior and more adaptive ways and, and make sure that your needs are met both physically and emotionally.
You know, so two minutes of being the goal and to do that, you've got to get out of your head and sort of into your body,
Diana Hill: [00:40:33] I think there's an important point in that, especially with the appetite awareness component and and tuning in with your, with your body that. Early on, those signals are actually so disrupted by the malnourishment that, that we can't do that quite yet. And even in your discussion of, the treatment, you might take a bit of a family based approach, which, uh, for some people might sound quite counterintuitive of having the family.
Structure, what the, what the, client is going to eat and be with them and help them through eating those meals. But that's also in part because of the nature of this sort of tricky nature of the eating disorder that we can't quite go yet. Even though it's a goal to listening to your hunger and fullness cues, we can't quite trust them when you're malnourished.
Can you speak to
Rhonda Merwin: [00:41:19] Yeah, absolutely. Because yeah, not only do you not really have access to, to them, , either because hunger is sort of quieted or because you've just been so good at ignoring them that you don't have good access to them or you actually have to actively defy them in order to, to restore weight.
So you might feel kind of early satiety that need to, to just actively kind of defy that. Or you might feel like, I don't feel hungry. I don't feel like eating and needing to actively defy that. And you know, it's a meal times. It's time to eat. And so we use a lot of, like, at the very beginning, a lot of contingency, like sort of logical consequences and things like that.
and really structuring. meals and snacks, you know, multidisciplinary team approach. Of course, that includes the nutritionist and all those kinds of things. So, so clients that they are in those early stages are really, , having to follow kind of meal prescriptions.
And we're using other behavioral strategies to try to sort of compel that and get

people nourished enough where they can be really fully a participant in. And treatment. And then it isn't until much, much later that we start to try to do some more appetite awareness kinds of things where they're, where their body is sort of awake enough, it's restored enough, that they can start to trust those cues and use them and be more, more flexible.
and with young people, we use . Parents, but , when you, when you have like an older client is a lot more tricky. in those early stages to figure out how to, uh, compel eating
Diana Hill: [00:42:42] And this is where looking at restrictive eating very much on a continuum where, for individuals that are just struggling with some restrictive eating and, and rule-bound type of behavior, appetite awareness may be without, you know, being malnourished or underweight appetite awareness may be actually a really excellent place for , individuals that are subclinical or at risk for eating disorders.
That'd be a great place to go to, but that's where having that assessment, where are we along the continuum in terms of your ability
to carry that out. , we use this metaphor of a self parent. and this is coming out of the parenting literature, we're not really talking about.
Rhonda Merwin: [00:43:15] Parents, in this, in this metaphor, but, but actually people being their own parents. the two different dimensions of parenting, and it creates kind of four quadrants. So, as a parent, you can have, , high or low expectations or demands on your child.
And then those things, those demands could be implemented in a way that has either high or low warmth. And that once you put those tooth in, the intersection of those things creates these different parenting styles. And we think of anorexia nervosa as being someone who has adopted sort of an, a, uh, you know, an authoritarian parenting style with respect to their own.
A parent and parenting themselves, you know, being their own self parent, deciding when they're going to eat, when they're going to sleep, when they're going to work, when they're going to play, that they've adopted this, this, strategy of like, rigid structure, obedience, punishment, harsh. it's that quadrant where there's high expectations, high demands, but low warrants.
And we think about this as kind of moving people, in the direction of being a warm and attuned parent. So a parent that still has expectations and boundaries and those kinds of things. the expectations for behavior are sort of clear, but it's in the context of high warmth. And so it's very, attuned and respectful of the individual, and it flexes appropriately and, all of that kind of thing.
So thinking about the continuum of. Eating pathology. We use this metaphor a lot, , how can we move from like this kind of drill Sergeant parenting, right? Where you're like, you know, no, you will, you will March. And I don't care if you're tired to this kind of attunement where you say, you know, I'm feeling fatigued.
What do I need right now? Or I'm feeling sad. What do I need right now? , or hungry or, you know, full or whatever. And so we're trying to move people and that, that, parenting frame. If you do it in a metaphor for way where you were like, really, I'm helping them sort of see themselves as caring for themselves the way you would care for a child, that they are actually sort of their parent.

It pulls on, some compassion and warmth that we, that we have towards children you are your own parent, like you are taking care, of yourself as sort of your job, in session, what I might do is I might say. You know, can you imagine talking to a child like that?
Like I want you to imagine saying the things that go through your head, like to a child. So you, so things like you're lazy, get up. I don't care if you're tired, I don't care if you're hungry, you can't eat any, you know, I want you to imagine sort of saying that to a child.
And what is it like to sort of say that, what would it be like to say that to a younger version of yourself. You know, and it's, and it's not as though I'm trying to change whether they have those cognitions. I'm, I'm, I'm trying to help them cause, cause these are actually, , these are actually actions more than their thoughts. They're ways in which they sort of like talk to themselves to keep themselves in line and sort of doing the things that they want them to do. So I'm not really trying to change their thoughts as much as I'm trying to highlight, um, how they're treating themselves with respect to their own signals.
And their own sort of attunement. And then, you know, what would it be like to be a compassionate self parent? What would it be like to be kind to yourself, to actually say to yourself, like, I, I, I see that you're hungry, or I see that you're sad, or I see that you're hurting in some way. the Hungary one is a little tricky and I don't usually do that one early on.
People can more appreciate some of these other ones more that they can appreciate that one. , but it can be a really powerful metaphor for people to, to start to think of themselves as their own caretaker. and that they've adopted a style, a parenting style, self parenting style or strategy.
 and that it works for some things, like, for example, keeping them in line and making sure that they meet the next goalpost, but that it is not without incredible pain and suffering that they really ended up like in neglected or abused child because of the ways in which they're. caretaking themselves
Diana Hill: [00:47:05] power of, of using the parenting style is that often the flip of the fear of letting go of not being so punitive is that I'm going to become. Permissive and I'm just going to fall like you don't know. Like I would just completely lose control. I would just fall apart. I would never get out of bed. I would know like I'd be a mess.
And, and so bringing in this, this concept of what is. A compassionate parent that also is, has parents have limits. , parents set boundaries around things and do have expectations, but it's warm kind expectations that are also with , a hope for you to live a good life. And so part of living a good life is go to school.
Then you're, you know, you, you, you eat your breakfast and you do it. You do the tasks of living that contribute to that. So it finds that that middle path that is, between these two places of complete rigidity or complete premise Vivity and especially I think for individuals that have done more of a move into, okay, now I've experienced some binge eating.
Or I've experienced some bulemia that can feel really scary and out of control. So how do we find our way into that? Isn't either of those that isn't the, the rubber band pulled so tight that life is unmanageable, or the rubber band that flings across the room.

Rhonda Merwin: [00:48:27] Yup, yup. Well, and in the, uh, parenting quadrants, you know, the bottom quadrant, that's like low expectation, low demand, and high warmth. That's sort of the premise of quadrant.
And we, and you know, sometimes we'll just draw these quadrants out and, you know, talk to people about sort of like moving between this authority Terria and, you know, hard line to this real permissive sort of space. And, you know, how can we find this place in between where we can hold guidelines or expectations sort of.
Uh, lightly, right? Um, and take your feelings into account that we don't have to sort of abandon them either. You know, sometimes people are really scared. You may have, you may have seen this with some of your folks really scared to have, like once they go through that place of like letting go of their hard rules and start to actually sort of be more.
Kind and responsive to themselves. They're sometimes scared to have any limits. Like it actually is almost like traumatic. It reminds them of this time of, of real deprivation.
Diana Hill: [00:49:24] see that a lot with exercise, so maybe someone has stopped exercising because there was a lot of abuse around their body and exercise. It's so hard to go back in and do it in a way that isn't abusive or it's am so scared to go to an exercise class or to move my body or go for a walk because I'm afraid of
that part of me that gets so punitive and harsh and to have that relationship with yourself that you're afraid of your own self is. Um,
Rhonda Merwin: [00:49:51] It's a traumatic, it's a traumatic event though, to B to B. either that starved, if they really have pushed their, their body weight to place, or to just be that punitive to oneself. I mean, it's like having had, you know, an abusive relationship.
I mean, things are great metaphor fruit for that, you know, both, both. I like love and it's helpful to me. Uh, and , they've been really harmed, so they're afraid.
Diana Hill: [00:50:17] . So I've got to ask you, , you've dedicated your career to, um, one, you work at Duke medical center with some of the most severe and chronic cases probably come to see you. And, um. I think my first question is, is why did you pursue this work? What is, what is the value for you behind doing this work?
And then the second question is, how do you practice your own, kind parenting with yourself, , in doing the work and taking care of yourself.
Rhonda Merwin: [00:50:49] Yeah. So, so with regards to the, so the first question about why, why this work? I didn't expect to find myself here actually. and necessarily, I'm in college, so this is, you know, this is getting. Longer ago than I'd like to admit. , I worked as a psych tech, so this is during my bachelor's, right?
So I know very little at this point. I'm just sort of hobbling my way through my bachelor's and, taking some psychology classes and stuff, but I wanted to get into the field. So I went and started working as a psych tech at a group home for emotionally and behaviorally disturbed girls.
That sort of look, that's how it was. That's the tagline, emotionally, behaviorally disturbed girls. So these were young ladies with all kinds of, , difficulties, anxiety,

depression. Some of them were, had abusive situations or were dependent on the blacks and municipal, sort of a kind of mix of, , reasons that people were there.
Some had, some had to be there. , because of a court orders and various things. So it was a, it was a range. We actually didn't have that many eating disorders, believe it or not. I got very little exposure to eating disorders, but what I got a lot of exposure to at that time was the narratives of these young ladies, right?
And hearing the story, the self narratives, these ideas of who they thought they were, what they thought they could do. , what their, , life was about, and watching how much that narrowed and boxed them in. and, and how much that limited, yeah. Just sort of limited in box them in, in, in their life.
it was around that time that I start thinking , how can I help set some young ladies free? Like if I could go to school to learn to do something, I'd want to learn. , how can I help set. some of these, young women free and, and , in some way so that, , they could have their narratives without their narratives having them, you know, that these things could go through their heads and they still could choose big lives that they wanted.
And so it was really more that, , and so I came to graduate school with an intersection like self esteem and self concept and those kinds of things. And I stumbled into Kelly Wilson's lab really with this interest and did a lot of, uh, uh, my research was actually in relational frame theory, which is the theoretical and empirical underpinnings of the ACT model.
it's about language and cognition and how words function and all that kind of stuff. My interest was how we, uh, learn, uh, you know, sort of self, uh, you know, me good or me bad kind of things, right? How we learn, learn that. And, I did some real basic learning studies about can you disrupt that?
Can you give new learning histories and sort of shift and change, , create some flexibility in how tightly people hold those narratives. So I was doing some real kind of basic. Research in the laboratory operate, you know, human laboratory kind of kinds of stuff, around self narrative. So it wasn't even until I got to Duke that I was like, Oh wow, this is a population for which, these kinds of ideas of like, , am I a failure?
Am I a disappointment? Am I bad person? where it has created such profound struggle and deprivation, cause I've seen really extreme cases of anorexia and bulimia nervosa. And this piece about the self and the self narratives was sort of in that and thinking about that and then thinking about how, is it that we have no treatments that are, you know, at the time when I first got here in 2005, you know, there's been some things have happened since then.
But, , at 2005, I was thinking, how is it that we don't have anything better for anorexia nervosa? and so that's, that's really how I sort of stumbled in it and started sort of, sort of working in the area and thinking that actress, just a beautiful match. for this problem,
Diana Hill: [00:54:13] That's beautiful. What, what about the self care component? And here's my question. Does, does Kelly Wilson really get you a yoga pass when you're his graduate student?
Rhonda Merwin: [00:54:22] So I will
Diana Hill: [00:54:23] He says he does

Rhonda Merwin: [00:54:25] well, I will say that Kelly has gone through many stages, so, so Kelly himself is quite, you know, he's, he's, he's passionate, as we all know, and a little bit obsessive, right? So you can get sort of narrowed in on something. When I was in graduate school, it was not yoga actually. Um, we never did yoga.
That was never part of what we did.
Diana Hill: [00:54:44] You can't go to a workshop now with Kelly without him doing some kind of arm
Rhonda Merwin: [00:54:48] Oh, absolutely. No. And, and you know what's funny is when I was in grad school, it was, it was almost the complete opposite, and that his obsession was coffee. So he would like, we'd go to his house and he'd ground. Yeah. He's probably still loves that, but he'd go ground these beans and create these like concoctions.
And,
Diana Hill: [00:55:06] I think it went coffee to Kiefer. To yoga.
Rhonda Merwin: [00:55:10] sounds right. That sounds right.
Diana Hill: [00:55:11] Okay. Sorry. So yeah, so self care during graduate school and even maybe self care now, how do you, how
Rhonda Merwin: [00:55:16] Yeah. Well, and you know what I would say about what I learned from Kelly that's related to this, um, is that, you know, he taught me one to just, he, he would say behave. And what he meant is go out in the world and do things cause the environment will shape you.
And if you hide out in the corner because of some self narrative, right? Um, you're not gonna like be shaped by the environment. You're not going to move and do things the way that you want to sort of do things and move the world in the way you want to. Uh, move the world. And so, you know, he, he, he taught me to behave anytime you to do what matters.
And I think that when you're doing what matters, like deeply, that that's a form of self care, not that then you devote every moment to that. Right. What matters? Lots of things matter. Um, you know, my daughter matters and the kids, you know, the kid that's also sitting on my couch or the young, uh, woman or the older woman that's sitting on my couch, I see men too, but I'm just thinking about more my eating disorder clients tend to be women.
so doing what matters can look different, but if it, but if it's what matters to you, then it feeds you. I don't think we ever really talked about, the mechanics beyond that, right? Like, make sure you're sleeping enough, make sure you're eating enough. But that certainly has become quite a focus for me as I've thought about eating disorders as a lack of attunement. to one's needs. And so I try to practice, , staying attuned, like, what is it that I need?
If it's an emotional or a physical thing, what is it that I need? And so that's been more of a later lesson, I suppose. , so, you know, behave, do what matters, and then, , make sure that you're being a kind self parent along the way.
Diana Hill: [00:56:46] I love it. Thank you. Well, for those that want to get a really, in depth, understanding of how you're using ACT with, with anorexia, how you're conducting these functional analyses, what each one of these six core processes would look like , in treatment. I really highly recommend your book. , it's an excellent book on eating disorders.

It's an excellent book on ACT. And then it's an excellent book on really tailoring this approach to working with individuals with eating disorders. And it makes me feel. Just really grateful to you for, uh, and your coauthors, Nancy Zucker and Kelly Wilson to putting all of this into a manual that, that practitioners can use and hopefully they find useful in this really challenging, but also really rewarding work in working with men and women who struggle with restrictive eating.
So thank you, Dr. Rhonda Merwin, and it's just a delight to have you on the show. You're brilliant. You're fantastic. And you're also just really human and , so appreciate you.
Rhonda Merwin: [00:57:51] Thank you so much. I appreciate it
Diana Hill: [00:57:54] Thank you for listening to Psychologists Off The Clock.
Yael Schonbrun: [00:57:56] You can find us on iTunes, Facebook, Twitter, and Instagram. Please help us out by writing a review on iTunes.
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