# Cognitive Behavioral Therapy for Eating Disorders

## A Comprehensive Treatment Guide

Glenn Waller, Helen Cordery
Emma Corstorphine, Hendrik Hinrichsen
Rachel Lawson, Victoria Mountford
and Katie Russell

CAMBRIDGE
Medicine

CAMBRIDGE www.cambridge.org/9780521672481

This page intentionally left blank

# Cognitive Behavioral Therapy for Eating Disorders

## A Comprehensive Treatment Guide

This book describes the application of cognitive behavioral principles to patients with a wide range of eating disorders: it covers those with straightforward problems and those with more complex conditions or comorbid states. The book takes a highly pragmatic view. It is based on evidence published, but stresses the importance of individualized, principle-based clinical work. It describes the techniques within the widest clinical context, for use across the age range and from referral to discharge. Throughout the text, the links between theory and practice are highlighted in order to stress the importance of the flexible application of skills to each new situation. Case studies and sample dialogues are employed to demonstrate the principles in action and the book concludes with a set of useful handouts for patients and other tools. This book will be essential reading for all those working with eating-disordered patients including psychologists, psychiatrists, nurses, occupational therapists, counsellors and dietitians.

**Glenn Waller** is Consultant Clinical Psychologist with the Vincent Square Eating Disorders Service, Central and North West London Mental Health NHS Trust and is Visiting Professor of Psychology at the Institute of Psychiatry, King's College London.

**Helen Cordery** is a Registered Dietitian with the St. George's Eating Disorders Service, and Kingston Hospital NHS Trust.

**Emma Corstorphine** is a Principal Clinical Psychologist with the St. George's Eating Disorders Service, South West London & St George's Mental Health NHS Trust and Visiting Research Fellow at the Institute of Psychiatry, King's College London.

**Hendrik Hinrichsen** is a Principal Clinical Psychologist with the St. George's Eating Disorders Service, South West London & St George's Mental Health NHS Trust and Visiting Research Fellow at the Institute of Psychiatry, King's College London.

**Rachel Lawson** is a Senior Clinical Psychologist, South Island Eating Disorders Service, Canterbury District Health Board, and Visiting Research Fellow at the Institute of Psychiatry, King's College London.

**Victoria Mountford** is a Chartered Clinical Psychologist with the St. George's Eating Disorders Service, South West London & St George's Mental Health NHS Trust and Visiting Research Fellow at the Institute of Psychiatry, King's College London.

**Katie Russell** is a Chartered Clinical Psychologist with the St. George's Eating Disorders Service, South West London & St George's Mental Health NHS Trust.

# Cognitive Behavioral Therapy for Eating Disorders

## A Comprehensive Treatment Guide

Glenn Waller

Helen Cordery

Emma Corstorphine

Hendrik Hinrichsen

Rachel Lawson

Victoria Mountford

Katie Russell

CAMBRIDGE
UNIVERSITY PRESS

CAMBRIDGE UNIVERSITY PRESS
Cambridge, New York, Melbourne, Madrid, Cape Town, Singapore, São Paulo

Cambridge University Press
The Edinburgh Building, Cambridge CB2 8RU, UK
Published in the United States of America by Cambridge University Press, New York

www.cambridge.org
Information on this title: www.cambridge.org/9780521672481

© G. Waller, H. Cordery, E. Corstorphine, H. Hinrichsen, R. Lawson, V. Mountford and K. Russell 2007

This publication is in copyright. Subject to statutory exception and to the provision of relevant collective licensing agreements, no reproduction of any part may take place without the written permission of Cambridge University Press.

First published in print format 2007

ISBN-13 978-0-511-27814-3 eBook (EBL)
ISBN-10 0-511-27814-4 eBook (EBL)

ISBN-13 978-0-521-67248-1 paperback
ISBN-10 0-521-67248-1 paperback

Cambridge University Press has no responsibility for the persistence or accuracy of urls for external or third-party internet websites referred to in this publication, and does not guarantee that any content on such websites is, or will remain, accurate or appropriate.

Every effort has been made in preparing this publication to provide accurate and up-to-date information which is in accord with accepted standards and practice at the time of publication. Although case histories are drawn from actual cases, every effort has been made to disguise the identities of the individuals involved. Nevertheless, the authors, editors and publishers can make no warranties that the information contained herein is totally free from error, not least because clinical standards are constantly changing through research and regulation. The authors, editors and publishers therefore disclaim all liability for direct or consequential damages resulting from the use of material contained in this publication. Readers are strongly advised to pay careful attention to information provided by the manufacturer of any drugs or equipment that they plan to use.

**To our families.**

# Acknowledgments

We would like to thank a range of people and organizations for their inspiration and support in writing this book. They include:

- our colleagues on our multidisciplinary teams (particularly Joan Brunton, for her advice on medical risk matters);
- our employers (South West London and St. George's Mental Health NHS Trust; Kingston Hospital NHS Trust; Central and North West London Mental Health NHS Trust);
- the trainees, students and assistants who we have worked with;
- the clinicians and researchers who have inspired us; and
- the patients who have provided both challenges to our preconceptions and support for our work.

# Contents

*Preface* *page* xxiii

**Section I Introduction**

1 The philosophical and theoretical stance behind CBT 3
1.1 The importance of evidence 3
1.2 Dealing with the whole person in treatment 4
1.3 Clinician stance: the curious clinician 4
1.3.1 Collaborative working relationships 5
1.4 The transdiagnostic approach 6
1.4.1 Using the transdiagnostic model in practice 7
1.5 Themes in the process of treatment 7
1.5.1 Short-term discomfort in order to achieve long-term gain 8
1.5.2 The patient becoming his or her own therapist 9
1.5.3 Continuum thinking 10
1.5.4 Goal-setting 10
1.6 The value of case formulation 11
1.7 The importance of behavioral experiments 11

2 Broad stages in CBT and format of delivery 13
2.1 Broad stages in CBT for the eating disorders 13
2.2 Duration of treatment and when to expect change 14
2.3 Format of treatment 15

3 What the clinician needs to establish before starting 16
3.1 Medical safety 16
3.2 Risk assessment in eating disorders 17
3.3 Who is at medical risk? 17
3.4 Assessing acute risk at the beginning of treatment 18

3.4.1 Recent weight changes 19
3.4.2 Non invasive tests for muscle strength: the sit up, squat, stand (SUSS) test 20
3.5 Care planning in response to the baseline physical tests 21
3.6 Assessing chronic risk 21
3.7 Monitoring risk during treatment 22
3.7.1 When to stop CBT because medical risk is the priority 22
3.8 The value of a multidisciplinary working environment 23
3.9 Preparing the physical environment 25
3.10 Trouble-shooting: realistic expectations of CBT 25
Summary 27

Section II Core clinical skills for use in CBT with the eating disorders

4 Assessment 31
4.1 Areas covered in interview 31
4.1.1 Demographic information 32
4.1.2 Eating behaviors 32
4.1.3 Measuring the patient's height and weight 33
4.1.4 Psychosexual functioning and history 34
4.1.5 Central cognitive elements 34
4.1.5.1 Body concept/dissatisfaction 34
4.1.5.2 Body percept 35
4.1.5.3 Fear of fatness and weight gain 35
4.1.6 Eating disorder diagnosis 36
4.1.7 General health 37
4.1.8 Comorbid behaviors and psychological disturbances 37
4.1.9 Risk assessment 38
4.1.10 Treatment history 38
4.1.11 Family structure 38
4.1.12 Life history 38
4.1.13 Client's motivation and goals for treatment 39
4.1.14 Treatment preferences 39
4.1.15 Additional assessment of cognitions, emotions and behaviors 39
4.2 Trouble-shooting in the assessment phase 39
4.2.1 Extended assessment 40
4.2.2 Therapy-interfering behaviors 40
4.2.3 Address the patient's refusal to be weighed 40

5 Preparing the patient for treatment 42

6 Motivation 44
6.1 Context for motivation: understanding the patient and building a relationship 44
6.1.1 Understanding the patient's position 44
6.1.2 The clinician's position 45
6.1.3 Clinician and patient investment 46
6.1.4 Stages of change 47
6.1.4.1 Precontemplation ("not ready") 47
6.1.4.2 Contemplation ("thinking about it") 48
6.1.4.3 Preparation ("getting ready for change") 48
6.1.4.4 Action ("ready, set, go") 48
6.1.4.5 Maintenance ("hanging in there") 48
6.1.5 Willingness and resources: two components of change 49
6.2 Assessing motivation for change 50
6.2.1 Questionnaire and interview measures 50
6.2.2 Pros and cons lists 50
6.2.3 The "miracle question" 51
6.2.4 Motivation as a moving target 55
6.3 Tools and techniques to enhance motivation 55
6.3.1 Friend or foe letters 56
6.3.2 Life plans 57
6.3.3 Writing to oneself in the future 58
6.3.4 Pros and cons of change 59
6.3.5 Problems and goals 60
6.3.6 Developing and using a summary flashcard 61
6.4 Trouble-shooting: common problems in motivational analysis and enhancement 61
6.4.1 Addressing fluctuations in motivation 61
6.4.2 Pros and cons of the change process 62
6.4.3 Letting go of the eating disorder 64
6.4.4 When the patient is not ready to change 66

7 A guide to important dietary and nutritional issues 68
7.1 What food is used for in the eating disorders 68
7.2 A beginner's guide to nutrition: what clinicians and patients need to know 69
7.3 What should a basic meal plan look like? 71
7.3.1 Meals 76
7.3.2 Snacks 76
7.3.3 Calcium-rich foods 77

7.3.4 Fruit and vegetables 78
7.3.5 Traditional desserts/fun foods 79
7.3.6 Fluid requirements 79
7.4 Food planning versus counting calories 81
7.5 Helping patients to improve diet: getting started 82
7.5.1 Planning changes in diet 83
7.5.1.1 Timing of eating 84
7.5.1.2 Content 84
7.6 Working with patients who are underweight or overweight 85
7.6.1 Managing weight gain in underweight patients 85
7.6.1.1 How much extra does the patient need to eat to gain weight? 85
7.6.1.2 Changes in metabolic rate/energy needs during weight gain 86
7.6.1.3 How to practically manage weight gain in low-weight patients 87
7.6.2 Patients who are overweight or obese 87
7.6.3 Vegetarianism and veganism 88
7.6.4 Vitamin and mineral supplements 90
7.6.5 Activity 91
7.6.5.1 Healthy activity levels 91
7.6.5.2 Compulsive versus excessive activity 91
7.6.6 Alcohol 92
7.6.6.1 Advising patients on appropriate alcohol consumption 92
7.6.7 Patients needing individual dietetic input 93
7.7 Psychoeducation topics in dietetic work 94
7.8 Summary 95

8 Case formulation 96
8.1 What is a case formulation? 96
8.1.1 Why do we need individualized formulation in CBT? 97
8.2 Constructing a formulation: general points 97
8.2.1 How to get started: some basic principles 97
8.2.2 Which cognitive-behavioral models can guide your formulation? 98
8.2.3 Formulating transdiagnostically 98
8.3 Understanding and formulating bulimic cases 99
8.3.1 A dysfunctional system for evaluating self-worth 99
8.3.2 Extreme dietary rules and rule violations 99

8.3.3 Longer-term consequences: dieting versus bingeing and purging 100
8.3.4 Emotion-driven eating behaviors 100
8.3.5 How to do it: essential steps in constructing a case formulation 101
8.3.5.1 Focus on the patient's eating problems 101
8.3.5.2 Uncover the patient's dietary rules 101
8.3.5.3 Introduce the idea of emotion-driven bingeing 102
8.3.5.4 Identify overevaluation of eating, shape and weight 102
8.3.5.5 Obtain feedback and use the formulation to guide treatment 102
8.3.5.6 Formulation example: the dialogue with a patient with a bulimic presentation 102
8.4 Understanding and formulating restriction-based cases 106
8.4.1 Starting the formulation with restrictive cases 107
8.4.2 Formulation example: the dialogue with a patient with anorexia nervosa 107
8.4.2.1 Dialogue 107
8.4.2.2 Drawing Karen's draft formulation 110
8.5 The more complex the patient, the more important the formulation 110
8.6 Checking whether your formulation is accurate 110
8.6.1 Parsimony 111
8.6.2 Behavioral experiments are the next step 112
8.7 How to get good at formulating 112

9 Therapy interfering behaviors 114
9.1 Naming the reasons for therapeutic disruption: therapy interfering behaviors 115
9.1.1 A framework for understanding treatment: the river analogy 116
9.2 Responding to therapy interfering behaviors 116
9.2.1 Using short-term contracts 117
9.2.2 The five-minute session 117
9.3 Particular patient groups 119

10 Homework 120
10.1 Explaining homework 120
10.1.1 Audiotapingof sessions for review as part of homework 121
10.2 General guidelines for agreeing homework assignments 122
10.2.1 Explainthe rationale for the homework to the patient 122
10.2.2 Askthe patient to explain the rationale for the homework to you 122

10.2.3 Specifyexactly what the patient should do and how they should do it 123
10.2.4 Practicethe homework assignment with the patient in the session 123
10.2.5 Askthe patient about any concerns regarding carrying out the homework assignment 123
10.2.6 Summarizethe homework 123
10.3 Dealing with homework non-compliance 124

11 Surviving as an effective clinician 126
11.1 The physical aspects of an eating disorder 126
11.1.1 Physicalrisks in the eating disorders 126
11.1.2 Theact of weighing in the therapeutic relationship 127
11.1.3 Weightas a communication 127
11.1.4 Dealingwith food-related issues without panic 128
11.2 The nature of the disorder 128
11.2.1 Theegosyntonic nature of symptoms 129
11.2.2 Chronicity 129
11.2.3 The‘‘special’’ patient 130
11.2.4 ‘‘Manipulation’’ 130
11.3 Personal characteristics of patients and clinicians 130
11.3.1 Whatbrings us to this work? 131
11.3.2 Issueswith body image 131
11.3.3 Powerdifferentials 131
11.3.4 Howthe patient relates to the clinician 132
11.4 How to survive as an effective clinician 132
11.4.1 Acollaborative stance 132
11.4.2 Supervision 133
11.4.3 Teamworking 133
11.4.4 Balancedworking 134
11.4.5 Takingcare of ourselves when personal matters may impact on us 134
11.4.6 Makingmistakes or letting the patient down unexpectedly 134
11.5 Summary 135

12 Setting and maintaining an agenda 136
12.1 General agenda of all CBT sessions 136
12.1.1 Monitoringmood and eating 136
12.1.2 ‘‘Standing’’agenda items 136
12.2 How to set the agenda 137
12.3 Some practical points about agenda setting 137

12.3.1 Do it collaboratively 137
12.3.2 Keep an eye on time 137
12.3.3 Maintain appropriate flexibility 138
12.3.4 Solving problems that arise when working within the agenda 138
12.3.4.1 Problem 1: the first problem discussed takes up too much time 138
12.3.4.2 Problem 2: the patient has set the agenda but is unwilling to stick to it 138

13 Psychoeducation 140
13.1 When to use psychoeducation 142
13.2 How to use psychoeducation effectively 142
13.3 Using the internet as a psychoeducation resource 143
13.4 Key psychoeducation topics 143
13.4.1 The psychological effects of starvation 143
13.4.2 The use of the "energy graph" to help the patient to understand their energy requirements 145
13.4.2.1 Step 1: preparing the patient for the use of the energy graph 146
13.4.2.2 Step 2: completing the energy graph with the patient on the whiteboard 146
13.4.2.3 Step 3: making links between the patient's eating pattern and their levels of energy throughout the day 148
13.4.2.4 Step 4: discussing with the patient how they can start to normalize their energy supply 148
13.5 Some myths about eating that can be addressed through psychoeducation 150
13.5.1 Myth 1: My bingeing is uncontrollable and happens at random 150
13.5.2 Myth 2: I can learn to control my eating through restriction 151
13.5.3 Myth 3: vomiting after bingeing is an effective strategy to prevent weight gain 151
13.5.4 Myth 4: taking laxatives is an effective strategy to prevent weight gain 152
13.5.5 Myth 5: using vomiting and taking laxatives is not really dangerous to one's health 152
13.5.6 Myth 6: eating food before going to bed results in significant weight gain, because the body is not "burning off" the food while you sleep 152

13.5.7 Myth 7: fat/carbohydrates make people fat and therefore need to be avoided 152
13.6 Summary 153

14 Diaries 154
14.1 Rationale for use of diaries 154
14.2 What does a diary look like? 155
14.3 How to address difficulties in completing diaries 157
14.4 Reviewing the diary with the patient 158
14.5 Advanced diary monitoring 159
14.6 When to stop using food diaries 160
14.7 The limitations of food diaries 160
14.8 Summary 161

15 The role of weighing in CBT 162
15.1 Constructing a weight graph 163
15.2 The weighing procedure: case example 165
15.3 What can the patient learn from the weekly weighing? 167
15.4 Introducing the idea that the patient's weight might be genetically determined 170
15.5 Challenging the patient's belief that their weight will increase uncontrollably 171
15.6 The role of weighing in the future 172
Summary 174

**Section III Core CBT skills as relevant to the eating disorders**

16 Socratic questioning 177
16.1 How to engage in the process of Socratic questioning 177

17 Downward arrowing 179
17.1 How to do it 180
17.2 Case example: Sarah 180
17.3 Trouble-shooting 182

18 Cognitive restructuring 183

19 Continuum thinking 184
19.1 Addressing negative automatic thoughts and core beliefs: working with single dimensions 184
19.2 Addressing conditional beliefs: working with two dimensions 185

20 Positive data logs 187
20.1 Case example 187
20.2 Trouble-shooting 188

21 Behavioral experiments 190
21.1 How to design effective behavioral experiments 191
21.1.1 Hypothesis-testing experiments 191
21.1.2 Discovery experiments 192
21.2 Observational experiments 192
21.3 Surveys 193
Summary 194

**Section IV Addressing eating, shape and weight concerns in the eating disorders**

22 Overevaluation of eating, weight and shape 197
22.1 Cognitive and behavioral manifestations of the overevaluation of eating, shape and weight 198
22.2 Case formulation using overvalued beliefs 199
22.3 Alerting the patient to the importance of overevaluation: the self-evaluation pie chart 202
22.4 Cognitive and behavioral treatment strategies for modifying overevaluation of eating, weight and shape 205
22.4.1 Cognitive restructuring 206
22.4.1.1 Evaluating evidence for and against the belief 206
22.4.1.2 The use of continuum thinking in modifying overvalued beliefs 208
22.4.1.3 Surveys 211
22.4.2 Behavioral experiments 213
22.4.2.1 Behavioral experiments to address beliefs about uncontrollable weight gain 214
22.4.2.2 Behavioral experiments to address beliefs about acceptability to others 220
22.4.3 Using the "anorexic gremlin" to assist in implementing CBT techniques 221
22.5 Summary 223

23 Body image 224
23.1 What is body image? 225
23.2 The aim of treatment: acceptance rather than satisfaction 226

23.3 Background to treatment of body image 227
23.3.1 Developing a formulation to understand body image 227
23.3.1.1 Using imagery to explore the meaning and emotional valence of body image 228
23.3.1.2 Uncovering beliefs associated with body image 228
23.4 Psychoeducation regarding body image 229
23.4.1 Understanding the functions of the body 229
23.4.2 The role of physiology 230
23.4.2.1 Set point model 230
23.4.2.2 The need for body fat tissue for healthy biological functioning 230
23.4.3 The role of societal attitudes towards beauty 231
23.5 Treatment of body image 231
23.5.1 Cognitive restructuring 232
23.5.1.1 Using a pros and cons matrix 232
23.5.1.2 Monitoring body awareness and judgements 232
23.5.1.3 Mislabeling emotions 233
23.5.2 Behavioral experiments 233
23.5.2.1 Body avoidance and checking 233
23.5.2.2 Body comparison 234
23.5.3 Exposure-based methods 235
23.5.3.1 Body image exposure 235
23.5.4 Imagery and body image 236
23.5.4.1 Using imagery to challenge the anorexic voice 236
23.5.4.2 Imagery work when beliefs about body image relate to early negative experiences 237
23.6 Summary 238
Summary 239

**Section V When the standard approach to CBT is not enough**

24 Comorbidity with Axis I pathology 245
24.1 General principles 245
24.2 Depression and low self-esteem 246
24.2.1 Assessment 246
24.2.2 Formulation 246
24.2.3 Treatment 247
24.2.3.1 Cognitive restructuring 248
24.2.3.2 Behavioral activation and experiments 249

24.3 Obsessive-compulsive disorder 249
24.3.1 Assessment 250
24.3.2 Formulation 250
24.3.3 Treatment 250
24.3.3.1 Cognitive restructuring 251
24.3.3.2 Behavioral experiments 253
24.4 Social anxiety and social phobia 253
24.4.1 Assessment 254
24.4.2 Formulation 254
24.4.3 Treatment 256
24.5 Posttraumatic stress disorder 258
24.5.1 Assessment 258
24.5.2 Formulation 258
24.5.3 Treatment 259
24.6 Impulsive behaviors and multiimpulsivity 262
24.6.1 Assessment 263
24.6.2 Formulation 264
24.6.3 Treatment 264

25 Comorbidity with Axis II pathology 266
25.1 Working with emotional regulation: dialectical behavior therapy methods 267
25.2 Working with beliefs about emotions: cognitive-emotional-behavioral therapy for the eating disorders 269
25.2.1 Origins of affect regulation problems 270
25.2.2 An introduction to CEBT-ED 270
25.2.3 Formulation for CEBT-ED 271
25.2.4 Intervention 271
25.3 Working with core beliefs: schema-focused CBT for the eating disorders 273
25.3.1 Preparing the patient for SFCBT 273
25.3.2 Assessment 274
25.3.3 SFCBT formulation 274
25.3.3.1 General principles 275
25.3.3.2 Individual case formulation 277
25.3.4 Intervention 278
25.3.4.1 Historical review 279
25.3.4.2 Diaries and dysfunctional thought records 280
25.3.4.3 Therapy records 280
25.3.4.4 Flashcards 280

25.3.4.5 Positive data logs 281
25.3.4.6 Schema dialogue 282
25.3.4.7 Using others as a reference point 283
25.3.4.8 Imagery rescripting 283
25.3.5 Working on residual eating issues and other behaviors 283
25.3.6 Relapse prevention 283
Summary 285

**Section VI CBT for children and adolescents with eating disorders and their families**

26 CBT for children and adolescents with eating disorders and their families 289
26.1 Diagnostic categories 290
26.2 Considerations when working with this age group 291
26.2.1 General considerations 291
26.2.1.1 Intellectual and emotional capacities 291
26.2.1.2 Identity formation 291
26.2.1.3 Working with families 292
26.2.1.4 Education 293
26.2.1.5 Friendships and peers 293
26.2.2 Specific considerations when working with young people with eating disorders 294
26.2.2.1 Physical issues 294
26.2.2.2 Clinician stance 295
26.2.2.3 Motivation: the young person and their family 295
26.2.2.4 Tips for aiding engagement 296
26.2.2.5 Confidentiality 298
26.2.2.6 Comorbidity 299
26.2.2.7 The importance of working within a multidisciplinary team 299
26.3 Assessment 300
26.3.1 The purpose of assessment 301
26.3.2 What information do you want? 302
26.3.3 Tips to aid in getting the information required 302
26.4 Motivation 303
26.4.1 Motivational techniques 304
26.5 Case formulation 306
26.6 Interventions 309

26.6.1 Motivational enhancement 310
26.6.2 Cognitive-behavioral change 310
26.6.2.1 General considerations 311
26.6.2.2 Techniques for addressing eating, weight and shape concern 312
26.6.2.3 Techniques for working with eating disorders that do not have weight and shape concern at their core 316
26.6.2.4 Working with the relationship with the clinician 318
26.6.3 Preparation for the real world 320
26.6.4 Recovery and relapse management 321
26.6.4.1 Relapse management 321
26.7 Endings 323
26.7.1 A planned ending at the preagreed end of CBT 323
26.7.2 A planned ending at the transition between child/adolescent and adult eating disorder services 325
26.7.3 Ending in sub-optimal circumstances 326
Summary 329

**Section VII Endings**

27 What to do when CBT is ineffective 333

28 Recovery 334
28.1 Defining recovery and the recovery process 334
28.1.1 Cognitive factors: overevaluation of eating, shape and weight 335
28.1.2 Emotional factors 335
28.1.3 Behavioral change 336
28.1.4 Physical factors 337
28.1.5 Social factors 337
28.1.6 Achieving goals 338
28.1.7 Objective measures 338
28.2 Applying recovery definitions to a heterogeneous population 338
28.3 The stages of change model revisited 339
28.4 Recovery as a process: using these models in the clinical setting 341
28.5 Agents of change 341
28.6 The patient's perspective on the recovery process 343
28.7 What is *not* recovery (including identifying pseudo-recovery) 344
28.8 Weight gain and obesity 344

28.9 The clinician's perspective: knowing when to end treatment 345
28.10 Summary 346

29 Relapse management and ending treatment 347
29.1 Troubleshooting 348
29.1.1 Patients who will not end 348
29.1.2 When treatment has not worked 348
29.2 Planning for further change 349
29.3 Understanding, acceptance and management of risk 349
29.4 Relapse prevention 349
29.5 The final session 350
Summary 351

Conclusion: cognitive behavioral therapy for the eating disorders 353

References 354

Appendices
1 Semi-structured interview protocol 365
2 Psychoeducation resources 376
3 Food diary 431
4 Behavioral experiment sheet 433

*Index* 435

# Preface

This book is about the application of cognitive behavioral therapy (CBT) to the wide range of eating disorders. It is intended to be a clinician-oriented tool, useful in practice, rather than a comprehensive review of outcome studies (see below). It is based on the experience of a team who have a strong CBT philosophy, and who have spent a considerable time in working with patients to develop methods that are helpful in patient recovery. Those methods are based on a combination of:

- existing CBT methods – taken from the broad CBT literature, as much as from the eating disorders literature
- clinical suggestions from a range of sources
- innovation from within our team.

We have not reviewed the evidence on treatment or on underlying pathology. There are many excellent reviews indicating that CBT is a powerful tool in the bulimic eating disorders (e.g., Fairburn & Harrison, 2003; National Institute for Clinical Excellence, 2004). These indicate that CBT is as good as any other psychological or pharmacological therapy for bulimia nervosa and binge eating disorder, and that it is the best therapy in many cases. However, those reviews also indicate that CBT has limitations. Even when it is applied thoroughly, many patients do not recover with this approach. Our experience suggests that there is a key set of problems in the use of CBT with the eating disorders:

- It is often applied rigidly, focusing on protocols rather than the underlying cognitive-behavioral principles.
- Most such protocols are designed for patients with bulimia nervosa or binge-eating disorder. There are fewer for anorexia nervosa, and almost none for the other atypical eating disorders (which form the largest number of cases – e.g., Fairburn & Harrison, 2003).
- Most protocols do not describe what to do when there is significant comorbidity (e.g., concurrent anxiety disorders or personality disorder).
- Many practitioners who suggest that they are using CBT are not doing so in any meaningful way. At the milder end of this problem, there are clinicians who are

using protocols that are outdated; at the more severe end, there are practitioners who simply label their work as CBT, but do not appear to deliver a treatment that is recognizable as CBT (e.g., Tobin, 2005).

This book is intended for those who wish to use CBT in a way that can help a wide range of patients – both those with straightforward problems and those with more complex eating disorders and comorbid states. We also acknowledge that there will be a number of patients who are not able to use cognitive-behavioral treatments, often because they have more pressing needs for physical stabilization or because the patient is in a setting where CBT cannot be implemented.

Given the diversity of patient presentations, we do not believe that it is possible to develop a definitive protocol. Therefore, the book is based on cognitive behavioral principles, rather than presenting a protocol *per se*. There are certainly key cognitions and behaviors to be targeted and tasks to be achieved, and some need to be addressed before others. However, a firm grasp of the underlying principles will be the most important tool that the clinician can have in his or her toolbox. We will use case studies to illustrate this principle in action. In order to simplify the text, we have referred to patients as female throughout, in deference to the much higher number of females with eating disorders. However, this book is based on our experience of working with both females and males, and we apply the same principles regardless of patient gender. A further distinction to note is that we have generally referred to "clinicians" rather than "therapists" throughout. The distinction is an important one to us, since we adhere to the principle that "therapist" is a role rather than a person in CBT. To be truly successful, CBT requires the handing over of the "therapist" role from the clinician to the patient as the treatment proceeds. Otherwise, we find that change in the patient's condition is hard to achieve and is not maintained. It will also be noted that we use the term "patients" to describe the people with eating disorders, rather than "customers," "clients" or "service users." This term is used not because of adherence to any specific model, but because it reflects the language that these sufferers say that they prefer in clinical settings. Finally, we have assumed that the majority of this clinical work will take place in an outpatient setting, although that does not mean that we see CBT as being impossible to implement in day- and in-patient settings.

Before proceeding, we acknowledge our debt to the many clinicians who have inspired our work. However, we have been aided just as much by our patients, who have helped us though collaborating as cotherapists in their own treatment, working hard with us to come up with solutions.

Section I

# Introduction

This section details issues that need to be addressed before we outline the cognitive behavioral treatment of the eating disorders. We begin with the philosophical and theoretical basis of the CBT approach. We then consider the broad stages of treatment and the formats in which CBT can be delivered. Finally, we consider what the clinician will need to establish before starting to implement the CBT approach.

1

# The philosophical and theoretical stance behind CBT

This chapter outlines key philosophical points that drive our use of CBT: the use of evidence; a focus on the person and not the diagnosis; clinician stance; themes that emerge repeatedly in CBT; clear formulation; and the central role of behavioral experiments. The techniques outlined in later chapters follow from this clinical philosophy.

## 1.1 The importance of evidence

We believe strongly in the philosophy of evidence-based clinical practice. To ignore the relevant evidence is to deny the best treatment to the patient. However, this philosophy has two difficulties.

First, it does not allow for patient variables – particularly the importance of patient expectations about treatment effectiveness and patient preference for particular therapeutic approaches (National Institute for Clinical Excellence, 2004). We find that an explanation of likely outcomes from different approaches is usually sufficient to allow the patient to make clinically appropriate choices (or to understand the limitations of the chosen approach). Sometimes, the patient will indicate a preference for a treatment that is unlikely to be effective. For example, there might be indicators in the formulation that make one approach unlikely to be unsuitable, or the patient might set limits that make it impossible to modify cognitions, emotions or behaviors (e.g., refusing to be weighed, meeting only once a month). In either case, we would discuss the limits to any change that are imposed by such behaviors that interfere with the process of therapy (Linehan, 1993).

Second, evidence-based practice requires good evidence regarding the best treatments, and that evidence base is currently inadequate. While there is evidence that CBT is the fastest, most effective form of psychological intervention for bulimia nervosa and binge eating disorder patients (e.g., Fairburn & Harrison, 2003), many patients with those disorders do not improve with this approach

(e.g., Wilson, 1999). Furthermore, there is little to support the specific use of CBT with anorexia nervosa or with the very large number of atypical cases (Fairburn & Harrison, 2003; National Institute for Clinical Excellence, 2004).

Therefore, as well as evidence-*based* practice, we advocate evidence-*generating* practice. We are aware of many excellent CBT practitioners who are undertaking innovative work that is beneficial to patients where there is no clear evidence base. We believe that it is important that clinicians report on their findings, in order to enhance the evidence base on the treatment of both routine and complex cases. The routine identification and recording of key clinical variables (e.g., cognitions about loss of control over weight; body checking) allows clinicians to demonstrate ways in which practice should be changed.

## 1.2 Dealing with the whole person in treatment

We take the stance that rather than treating a stereotypical "eating-disordered patient," we are treating an individual with an eating disorder. This theme is one that is reflected in the way that we write about CBT throughout this book. Holding this view enables the clinician to see the patient as an individual, rather than as a host of symptoms to fit into a model. Although there is a limited number of relevant symptoms, the range of reasons why people use those symptoms is wide and varied, and those reasons need to be understood to enable the patient to change. In taking the stance of treating an individual with an eating disorder, we aim to enable the patient not to be defined by his or her problem or by stereotypes that accompany such a diagnosis.

## 1.3 Clinician stance: the curious clinician

Geller, Williams & Srikameswaran (2001) point out the importance of having a "clinician stance" – a philosophy underlying treatment approaches (see below). Such a philosophy is needed to guide decisions and actions in new settings. It allows us to explain the importance of our actions to ourselves, to patients and to others. Such an understanding requires us to be clear about the elements of CBT that have to be there if we are to work in this framework – the "non-negotiables."

The clinician's stance in therapy should be consistent and coherent. This is much easier to achieve if the stance is underpinned by a clear treatment philosophy. Without such a philosophy, the risk is that actions in therapy become inconsistent and reactive (and hence much less likely to be effective). This stance should be one that is shared by all clinicians involved in the patient's care, and such an approach requires a collaborative team approach

that has the patient at the heart of the generalized philosophy of care. Geller, Williams & Srikameswaran (2001) describe this approach as having a "mission statement."

In keeping with Geller, Williams & Srikameswaran (2001), we advocate that the clinician's stance should be one that:

- fosters self-acceptance (allowing that there is a reason for the disorder, but also accepting the need for change)
- is active rather than passive
- is collaborative (based on the assumption that the client is responsible for change)
- involves curiosity, and a willingness to learn from the patient
- is transparent.

We also draw from the work of motivational interviewing when developing our stance. We aim to:

- be authoritative rather than authoritarian, so that the patient sees the clinician as a useful source of information, techniques and strategies, rather than as a further person issuing orders or prescribing behavioral or dietary change
- avoid being critical or confrontative (e.g., about impulsive behaviors)
- avoid intellectualization (e.g., engaging in a discussion with the patient about the general validity of body mass index norms means that the patient has distracted from his or her own core issues)
- avoid arguments with the patient, as this is likely to polarize the clinician and patient rather than facilitating collaboration.

We present this stance to our patients as requiring us to move from being "head to head" with them to being "shoulder to shoulder" in collaborating towards common goals.

### 1.3.1 Collaborative working relationships

Our stance involves a strong advocacy of true multidisciplinary working, with the patient at the heart of the professional and clinical structure. Indeed, we see the most important collaboration as that between the clinician and the patient. CBT is only really viable when the patient can be helped to become her or his own therapist, and this is an early part of our discussions with the patient.

The clinician needs to be strategically minded, in order to focus on helping the patient to win the war with the eating disorder, rather than being drawn into fighting (and losing) the immediate battle for supremacy in the session. There is no benefit to keeping this strategic approach from the patient. An open clinician is more likely to earn the patient's trust.

Our CBT involves collaboration with the whole range of professions within our team (psychologists, dietitians, nurses, occupational therapists, medical staff,

psychotherapists, administrative staff) who can contribute to the patient's care. We also see it as important to liaise with other clinicians in the case (e.g., general practitioners) and carers, particularly where the patient has complex needs. Again, in keeping with the spirit of collaboration, work with other clinicians and carers should aim to be authoritative rather than authoritarian.

## 1.4 The transdiagnostic approach

Historically, the eating disorders have been described in terms of diagnostic groups, with early attention focused on anorexia nervosa (e.g., Russell, 1970), followed by bulimia nervosa (e.g., Russell, 1979). The only other such category to receive such attention has been binge eating disorder, which is categorized as one of the atypical eating disorders, or eating disorders not otherwise specified (EDNOS; American Psychiatric Association, 1994). However, existing diagnostic schemes are of limited utility to the clinician. In particular, it has become clear in recent years that the largest single "group" is the EDNOS cases, and that patients do not remain in the same diagnostic group over time (e.g., Fairburn & Harrison, 2003). These limitations mean that our best therapies are not geared up to be effective with the majority of our patients, although this issue is being addressed in current work (e.g., Fairburn *et al.*, 2003).

While it can be important to understand what is meant by diagnostic labels, we find that the most effective clinical approach is to focus on cognitions, emotions and physical states that relate to the individual's restrictive and bulimic behaviors. Many of our patients have both forms of eating pathology, and so we need to consider their common roots and their interaction.

One response to this inadequacy of diagnostic schemes is to develop more and more complex diagnostic schemes (e.g., Norring & Palmer, 2005). However, those schemes do not seem to promise greater precision (e.g., the definition of a binge has become less definite over time). Therefore, an alternative approach has been proposed. Waller (1993) has suggested dispensing with diagnosis, and focusing on the core cognitive content that is common to behaviors across the eating disorders. This change of focus has led to the development of models more specific to behaviors that are common across diagnoses (e.g., Heatherton & Baumeister, 1991; McManus & Waller, 1995).

More recently, Fairburn *et al.* (2003) have formalized this approach under the title of a "transdiagnostic" CBT model of the eating disorders. This model is based on understanding the core pathology of patients presenting with a wide range of disturbed eating patterns. It has many characteristics in common with Slade's (1982) functional analytic approach to the eating disorders, with a similar stress on

the use of food to re-establish perceived control in the context of poor self-esteem and perfectionism. However, the model also has a cognitive component that was lacking in Slade's model. The transdiagnostic model departs from Fairburn's previous models (e.g., Fairburn, 1997; Fairburn *et al.*, 1999), in that it considers some general antecedents that are not specific to the eating disorder (especially "core low self-esteem"). It also incorporates elements from other therapeutic models, including dialectical behavior therapy (Linehan, 1993) and interpersonal psychotherapy. Such developments are leading to a convergence between maintenance models (e.g., Fairburn, 1997) and models that take account of early antecedents to eating pathology (e.g., Slade, 1982; Waller *et al.*, in press).

These transdiagnostic models center on beliefs relating to the overevaluation of eating, weight and shape (especially the perceived consequences of loss of control over eating and weight change). The other cognitive, emotional, physical and behavioral elements of the eating disorders are understood in terms of how they lead to and maintain these cognitions.

### 1.4.1 Using the transdiagnostic model in practice

As proposed by Waller (1993) and Fairburn *et al.* (2003), the transdiagnostic model results in CBT that links cognitions, emotions and behaviors regardless of diagnosis. This allows for a much more flexible use of therapy, which can be targeted on the individual patient's presentation, whether or not that patient fits a sub-category. We find it important to avoid being distracted by diagnosis, as many individuals can meet the same diagnostic criteria while requiring very different formulations and interventions. Therefore, in common with Ghaderi (2006), we aim to build a formulation around the central cognitions (e.g., "If I eat outside my normal, very rigid diet, then I will not be able to stop and I will inevitably gain huge amounts of weight."). We find it critical to get the patient's own expression of those cognitions, and to fit them to the broader formulation (see Chapter 8). Our experience is that patients readily understand the concept of a formulation that is independent of their diagnosis, as many are already unconvinced by the relevance of diagnosis. Avoiding a focus on specific diagnoses also helps those patients with partial syndromes, who are often anxious about whether they merit treatment because they do not feel that they have a serious enough problem (e.g., "But I don't binge that often, so the vomiting must be my own fault.").

## 1.5 Themes in the process of treatment

When thinking about the process of treatment, we find it useful to hold a number of themes in mind. These function to link the component parts of the treatment

in a comprehensive whole. They act as unifying constructs that set the scene for CBT, provide a context for understanding difficulties and create a vehicle for refocusing treatment.

### 1.5.1 Short-term discomfort in order to achieve long-term gain

Successfully negotiating change always involves tolerating short-term discomfort in order to reach longer-term chosen goals. Such change not only requires an ability to withstand a certain level of distress, but also the capacity to keep those longer-term goals in mind (see Chapter 6 on motivation and Chapter 25 on distress tolerance). This task of change is more complex for patients with eating disorders. Not only must they tolerate the short-term distress of developing a regular pattern of eating and weight stabilization/gain, but (in order to initiate this process and as a result of it) they are exposed to their thoughts and feelings. These are the very aspects of themselves that they have been trying so hard to avoid through their eating behaviors (see Chapter 8 on formulation).

It is useful to discuss this theme at the outset of therapy, to prepare patients for the fact that initially treatment may result in an increase in behaviors and distress (the opposite of what most expect). It is also useful to return to this theme when working with anxiety triggered by the introduction of new tasks and strategies (e.g., weekly weighing; the introduction of a previously avoided food into an eating plan). In discussing the likely experience of therapy with the patient, we use the ''Coast of South America'' analogy, usually introducing it at the beginning of treatment and referring to it throughout treatment (using a map where the person does not have the necessary mental map).

**A trek along the coast of South America**

This is one way in which we think about the process of treatment of and recovering from an eating disorder. Often, when people start treatment, they think that they are at their worst point and that the situation is going to improve in a straightforward linear style.

However, it does not work like that. Instead, the process of recovery can best be likened to a trek along the coast of South America. Often, people will find that the situation tends to get a bit worse at the beginning (equivalent to being in southern Chile and then dropping down to the southernmost tip of South America). This is to be expected, as you have spent a long time trying to avoid thinking about your difficulties, and now we are asking you to focus on your eating, cognitions and other behaviors. Also, your eating disorder has been helping you in some ways, and now we are talking about taking this away.

After you have been in treatment for a while, you will begin to see positive changes (beginning to trek up the coast of Argentina). However, these will not be in a straight line. You will have good weeks and more difficult weeks. This is perfectly normal. Sometimes people plateau for a while and then continue upwards. Overall, the trend will be improvement. Sometime external factors such as relationships or work will flare up, affecting your eating disorder treatment.

You are likely to be coming to the end of your treatment when you are about halfway up Brazil. As you can see from the map, this means that your progress does not stop here. We believe that you will continue your recovery – or trek along the coastline – by putting into place all the work that we have done together, such as challenging your negative thoughts and keeping to your eating plan, and you will reach the top tip of the coast of South America.

### 1.5.2 The patient becoming his or her own therapist

In a sense, this theme is more similar to a concrete goal than the others because it is something that can be worked towards and measured. However, it is discussed here because it is the central tenet that underlies treatment, recurring throughout and providing continuity to the process.

CBT is most likely to be effective if the clinician and patient work towards the patient becoming his or her own therapist. This theme runs through most of the strategies employed in CBT, from those occurring within sessions (e.g., agenda setting) to those occurring outside of sessions (e.g., homework). Successfully negotiating this shift in responsibility for change makes the difference between "one-hour-a-week therapy" and "168-hours-a-week therapy." This theme is also made evident in negotiating the time-limited nature of treatment, and in detailing expected progress and the process of recovery (e.g., complete symptom relief is not necessarily expected by the end of treatment, as it is anticipated that patients will continue to work towards resolving their difficulties long after they have stopped attending sessions, consolidating the gains they have made in treatment and building upon them).

Delegating responsibility for behaving therapeutically to the patient is a particularly useful theme to hold in mind during work on motivation, as this shifts patients' beliefs (or hope) that therapy can simply be "done" to them. Of all the themes, it can be the one that the patient is most reluctant to take on board, at least initially. The patient may see the responsibility for being the therapist as lying exclusively with the clinician. Here it can be useful to return to the theme of short-term relief versus long-term costs (e.g., the avoidance of responsibility for change is a short-term coping mechanism, with negative longer-term consequences).

### 1.5.3 Continuum thinking

Another theme underlying CBT is the need to escape from rigid, black-and-white thinking. All thoughts, feelings and behaviors can be seen to exist on a continuum, reflecting the fact that there are degrees of intensity to our experiences. Problems occur when the intensity of our experiences is too far towards either end of this continuum. For example, anxiety serves an important function in terms of alerting us to problems and motivating us to resolve them. However, it becomes an unhelpful experience when it becomes too intense, beginning to interfere with our day-to-day functioning.

The opposite of such a perspective is one that considers experiences as black and white. For example things are either good or they are bad, people are either successful or they are failures. This all or nothing way of viewing things does not allow for degrees of experience, or shades of gray. It is rigid and does not allow a consideration of change. It is also not an accurate representation of experience and thus will impact upon an individual's functioning in all aspects of their lives.

Black-and-white thinking moderates the impact of risk factors and the person's responses to treatment. Therefore, this theme needs to be discussed with the patient at the outset of treatment, in order to understand the patient's expectations about the process and goals of CBT. For example, the goal of treatment is one of moving slowly from one state towards another, rather than making an immediate switch between two opposite and conflicting positions. This theme can also be returned to throughout treatment when black-and-white thinking, feeling and behaving are encountered, so that the patient can be encouraged to see the benefits of partial change rather than focusing on the failure to change completely. Perceiving thoughts, feelings and behaviors in this way means that patients can become more flexible, more easily adapting to their environment.

### 1.5.4 Goal-setting

Most of our patients have black-and-white thinking patterns that permeate their lives. Therefore, it is not surprising that they bring this way of considering the world to their expectations of treatment. Many want to make the immediate jump from having an eating disorder to being well, and it is important to use Socratic questioning to consider whether that is possible (or even desirable, since it could leave patients feeling that they have no relapse strategy when they make small slips back). Hence, we stress the importance of short-, medium- and long-term goals, where the steps are always achievable. We also stress that we are likely to be working with short- and medium-term goals in therapy, as the patient's long-term goals are likely to take many years to achieve. Therefore, when we address short- and medium-term goals, we encourage the patient to think about whether his or her long-term goals can be achieved without going though this intermediate stage.

However, in keeping with the transfer of the role of therapist from clinician to patient, we stress that he or she needs to bring this thinking into his or her dealing with everyday life. We also encourage patients to consider long-term goals as potentially flexible, as they are allowed to change their mind as they develop (as most people do).

## 1.6 The value of case formulation

Case formulation is essential to ensure that a working collaboration is established with the patient, and to guide CBT. We address formulation in detail in Chapter 8. However, it is important to be clear with the patient about the rationale for focusing on this element of CBT. We aim to make four key points in discussing the formulation with the patient.

First, the formulation should be seen as "work in progress." We discuss it as a preliminary understanding of patients' problems, with the caveat that it will be amended with them during treatment, as new information emerges. Such an approach signals to the patient that this is their treatment, and that they will need to play an active role in recovery, rather than being a passive recipient of the clinician's wisdom. Second, the formulation enables a working alliance to be built with the patient, as this can be the first time that some sense has been made of what may appear to the patient to be a raft of unconnected behaviors. Third, having such an understanding can make the problem seem more solvable to both patient and clinician. Fourth, our patients often present with comorbid problems, and a formulation can help to guide the order in which those problems are treated. Finally, and most importantly, case formulation guides effective treatment, helping the clinician to take a general theory or model and to apply it to the individual patient. Our eating-disordered patients present with many complex behavioral difficulties. A good formulation should provide a "road map" for treatment. Returning to the formulation throughout treatment (and modifying it where necessary) can help the clinician to monitor that all remaining maintaining factors have been addressed.

## 1.7 The importance of behavioral experiments

In this book, we stress the importance of integrating the cognitive and behavioral elements of CBT for the eating disorders. We agree with the view (with its strong empirical backing) that the eating disorders are characterized by specific cognitions about eating, weight and shape (e.g., Fairburn *et al.*, 2003). However, changing those cognitions effectively depends on behavioral experiments, as has

been shown in other areas of psychopathology. Cognitive restructuring alone is less effective, in our experience. Behavioral therapies alone are equally ineffective when treating the eating disorder as a whole (e.g., Fairburn *et al.*, 1995). Nor is it adequate to deliver cognitive therapy (e.g., cognitive restructuring regarding the risk of weight gain based on psychoeducation and previous experience) while encouraging behavioral change (e.g., change in diet), unless the two are integrated such that the behavioral change is used to test the beliefs (e.g., change in diet to determine if this has the strongly anticipated disastrous impact on weight). Cognitive behavioral therapy for the eating disorders is dependent on that type of integration. Therefore, the use of behavioral experiments to change cognitions is a key theme of this book (see Chapters 21 and 22).

Our experience is that many CBT clinicians come to focus on cognitive challenges to address the key beliefs. This shift in focus occurs because many patients describe changing their behaviors as impossible (or express willingness to change but then fail to do so). However, as outlined above, to work with the cognitions alone is to miss the potential of CBT. Indeed, to shift attention to working primarily with cognitions appears to *discourage* change, by training the patient to avoid or escape the demands of treatment. Therefore, we stress the importance of behavioral experiments – without using them to change the cognitions, the treatment is not CBT.

2

# Broad stages in CBT and format of delivery

It can be reassuring for the clinician to be able to stick to a protocol where the specifics of treatment are outlined in advance. Of course, this approach depends on the protocol being relevant to the individual patient with whom one is working. However, our experience of the eating disorders is that our patients are far more diverse than protocols would lead one to expect. That diversity shows in clinical presentation, motivation, engagement in treatment, interpersonal issues, comorbidity and many other areas. Consequently, we find it inappropriate to follow protocols too rigidly. Rather, this book is based on the need to apply principles flexibly and appropriately.

## 2.1 Broad stages in CBT for the eating disorders

To summarize, while useful protocols can be written for CBT for the eating disorders, they are often insufficient for the delivery of treatment for the individual patient. There are broad stages of treatment, but they do not form a clear sequence. The stages overlap, some need to be addressed at different points for different patients (e.g., working with impulsivity), some need to be continuous throughout treatment (e.g., motivational enhancement), and we often return to a stage that has already been ''completed'' (e.g., in revising the formulation). It is easier to see the stages as themes, whose beginning is more identifiable than the ending. The useful stages that we identify are (in a roughly typical order of onset in therapy):

- Engagement of the patient and, where appropriate, family and carers
- Assessment
- Explanation of treatment and its boundaries
- Comprehensive formulation
- Planning of treatment with the patient
- Motivational enhancement
- Psychoeducation

- Introduction of structure to dietary intake
- Addressing of central targets using CBT techniques
- Weight gain/stabilization
- Working with comorbidity and other problems
- What to do when CBT is not working
- Relapse prevention
- Endings.

These themes are reflected in the structure of the rest of this book. We argue that successful CBT for the eating disorders depends on having a clear clinician stance, which involves being prepared to move flexibly between these stages in order to ensure that one is addressing the individual's needs, while keeping in mind the overall tasks and goals of treatment and returning to them. Thus, a rigid adherence to the list of broad stages outlined here might be reassuring for the clinician, but such rigidity is not part of CBT for the eating disorders, and the outcomes are likely to be less positive than if the techniques are applied flexibly.

## 2.2 Duration of treatment and when to expect change

Change in CBT is as individual as the problems and difficulties with which the individual presents. The duration of treatment should be determined accordingly. In keeping with the theme of encouraging the patient to become his or her own therapist, we find that having a set number of sessions is a useful tool in focusing the treatment on the importance of change now, rather than at some unspecified point in the future. Therefore, we usually fix the duration of treatment on the basis of the assessment and preliminary formulation, making this rationale clear to the patient. In keeping with other clinicians' recommendations, we find that 20 sessions are sufficient for most cases where the individual has a bulimic or an atypical bulimic problem. However, we will normally offer 40 sessions where the individual needs more sessions to reach a healthy weight. (If the patient's weight is so low as to present primarily as a medical and nutritional risk, then we do not offer CBT at that stage.) Where the problem involves substantial comorbidity (e.g., personality disorder, multiimpulsivity), then we add sessions as appropriate (usually 10–20 sessions) in order to work on other related issues. Where the patient proves not to need such a long period of treatment, we will reduce it as appropriate.

We aim to introduce behavioral change at as early a stage as possible. Agras *et al.* (2000) have identified the importance of reducing purging behaviors at an early stage as an index of the likely effectiveness of CBT. We find the introduction of structured eating to be a key element in generating the other behavioral changes,

such as bingeing and weight gain/stabilization. In cases where the central target is bulimic pathology, we focus on the patient gaining control over most of the bulimic behaviors over the first 10–15 sessions. However, other behaviors may take longer, and we aim for a sustained reduction in these behaviors posttreatment, during the follow-up stage. Where weight gain is a key target, the aim is to establish weight change slowly and continuously over approximately 30 sessions, although sometimes we will support a period of stabilization part way through, to enable patients to feel confident about their ability to stop weight gain when they have reached their final target. Modifying other behavioral problems (e.g., social anxiety) is less of a target in the early stages, but is often targeted from mid-treatment onwards.

Where treatment breaks are needed (due to life circumstances, motivational issues, etc.), we aim to negotiate those breaks in advance. We frame such breaks as being an opportunity to test out beliefs and behavioral changes (e.g., "Your belief is that taking a break will show that you have learned to cope with the world well enough not to need your eating behaviors: I am not sure if that is the case. Therefore, I suggest that we see if your view is right, or if it would be worth continuing with the behavioral experiments that you have been doing until now.").

We are also clear with the patient that we do not expect all cognitive and behavioral change to take place necessarily within the course of therapy, as there are many changes that can occur at a later point. This is a key consideration when discussing the patient's role as his or her own therapist, and in collaborating over decisions about ending therapy.

## 2.3 Format of treatment

CBT for the eating disorders can be delivered in a variety of formats and settings. While most of the evidence relates to the effectiveness of individual, face-to-face contact with patients with bulimic symptoms, delivered in outpatient settings, group CBT has also been used effectively with these groups. There is evidence that guided self-help (using a manual or a computer-delivered variant) is useful in some bulimia nervosa and binge eating disorder cases.

There is far less evidence relating to the treatment of anorexia nervosa and atypical cases (e.g., Fairburn & Harrison, 2003), and little on the delivery of CBT in day-patient and in-patient settings. However, our experience is that CBT can be valuable in such cases, although there is a greater need to individualize the approach to the pathology and to the constraints of the setting.

3

# What the clinician needs to establish before starting

In this chapter, we address the importance of being prepared for the cognitive-behavioral treatment. Given the nature of the eating disorders, this includes: ensuring that the patient is medically safe; having a functional multidisciplinary team; preparing the physical environment; and having realistic expectations of CBT.

## 3.1 Medical safety

Whilst many psychiatric illnesses have physical manifestations (e.g., self-cutting; dizziness related to panic attacks in anxiety disorders), eating disorders are unusual because of the extent to which physical health can be compromised and because of the major physical risks that can occur as a consequence. It is vital that the clinician should hold in mind that eating disorders have the highest mortality of any psychiatric illness, and that the responsibility for ongoing physical monitoring will be a large part of his or her clinical responsibility. This does not mean that the clinician has to be an expert on medical issues: rather, he or she needs to know when to involve other clinicians who are more qualified to deal with medical risk. This section is therefore aimed at providing guidance about:

- how to monitor physical risk;
- when to involve medical practitioners for more intense monitoring of patients at higher risk, and agreeing a care plan to minimize risk;
- when to stop CBT because physical risk has become the priority.

However, this section is not intended to replace the input of medical practitioners in the treatment of individual patients, and clinicians are strongly encouraged to formulate a protocol with relevant clinicians in their team regarding the management of issues related to physical risk (see below for further discussion regarding who could be part of this team).

## 3.2 Risk assessment in eating disorders

Readers are encouraged to access the document "A guide to medical risk assessment for eating disorders" written by the team at the Maudsley Hospital (http://www.eatingresearch.com). The document gives detailed advice on medical risk assessment, and is an excellent tool for both medically and non-medically trained practitioners. Our advice follows that protocol closely.

The factors involved in the assessment of risk in people with eating disorders should include:

- Medical risk, as discussed below.
- Psychological risk (i.e., suicide risk).
- Psychosocial risk.
- Insight/capacity and motivation. This can be assessed through monitoring how the patient responds to treatment. If the patient is at high physical risk, but has no insight into this, meaning that the patient is unable to reduce the risk (e.g., through stopping weight loss), it may be necessary to consider the use of compulsory treatment to ensure that the patient receives the treatment he or she needs.

## 3.3 Who is at medical risk?

All patients with an eating disorder are at medical risk to some degree. Weight (or body mass index) is only one aspect of this. For example, a patient with a body mass index (BMI) of 15 but who is losing weight at 1 kg a week is likely to be more at risk than someone who has kept a stable BMI of 13 over many years. The frequent use of purging (vomiting, laxatives, diuretics) greatly increases physical risk, especially if the patient is underweight. In addition, the following features indicate an elevated medical risk, which needs to be closely monitored:

- excessive exercising at a low weight (due to cardiac risk)
- blood in vomit (which may be due to serious esophageal or gastric tears)
- inadequate fluid intake in combination with poor eating, including purging (due to the risks related to dehydration)
- rapid weight loss, especially if the patient is underweight (BMI $< 20$) (see below for further details)
- factors that disrupt ritualized eating habits (since the patient will be very unlikely to be able to replace the foods lost, leading to a deterioration in physical condition).

It is also important to be aware that other behaviors that a patient may use can increase medical risk and exacerbate the above issues. Excessive

alcohol intake and use of street drugs are two examples of such behaviors that increase risk.

## 3.4 Assessing acute risk at the beginning of treatment

Before therapy starts it is important to assess medical risk. In all cases, we request that the patient attends a general practitioner for the following baseline tests, and that the results are sent on to us for review and care planning:

| Test | Rationale |
|---|---|
| Urea and electrolytes | To assess for electrolyte imbalance, dehydration, kidney function. |
| Liver function tests | To assess for damage to liver secondary to low weight and/or alcohol misuse. |
| Full blood count | To assess for bone marrow suppression secondary to low weight. |
| Thyroid stimulating hormone (TSH) | To exclude thyroid abnormalities for weight loss (NB thyroid levels may be reduced in low-weight individuals, or in people on very restrictive diets). |
| Erythrocyte sedimentation rate (ESR) | To exclude physical causes of weight loss, such as an infection, chronic inflammatory or systemic illnesses. |

Prior to assessment, if the patient is known to be at a low weight (BMI < 15) or is losing weight very rapidly (0.5—1.0 kg per week or more), we ask for the following tests in addition to the baseline tests:

| Test | Rationale |
|---|---|
| ECG | To assess effect of extreme state of starvation on the heart (specifically QT interval and cardiac arrhythmias). |
| Pulse and blood pressure (sitting and standing) | To assess stress on cardiac systems and the effects of dehydration. |
| SUSS test | To assess proximal muscle weakness and whether extensive muscle failure has occurred (see below). |
| Phosphate | To assess for risk of refeeding syndrome (secondary to resumption of eating), which can cause respiratory or cardiac failure. This is more relevant for low-weight patients (e.g., BMI < 15), patients with concurrent infections or high alcohol intakes, or patients who fast for extended periods. |

If the patient with an eating disorder (particularly binge eating disorder) is known to be obese (BMI > 30), or overweight (BMI > 28) with risk factors

(such as high cholesterol/lipid levels, diabetes or impaired glucose tolerance), or has direct family members who suffer from cardiovascular disease or diabetes, then we ask for the following tests to supplement the baseline tests:

| Test | Rationale |
|---|---|
| Fasting lipid levels | To test for risk factors for coronary heart disease (such as high cholesterol and lipid levels). |
| Random/fasting blood glucose | To test for the presence of diabetes mellitus (type 2), or impaired glucose tolerance (indicative of the likelihood that diabetes will develop). |
| Blood pressure | Hypertension (high blood pressure) is a risk factor for cardiovascular disease (coronary heart disease and stroke). |

Such patients should be asked if they smoke cigarettes, as this also increases risk of cardiovascular disease. If such risk factors are identified, then the patient needs to have ongoing monitoring and possibly drug treatment via their general practitioner. Since weight loss is an important treatment goal for these eating-disordered patients, the clinician may need to have an ongoing dialogue with the general practitioner regarding the fact that treating the eating disorder is the first step in the long-term goal of permanent weight loss. It should be stressed that the weight loss itself may not occur for some time, since the treatment of the eating disorder per se is known to have little or no effect on weight, but makes weight loss possible (see Chapter 7 for further details).

### 3.4.1 Recent weight changes

As stated above, recent weight changes can give an important indication of medical risk. Continued weight loss of 1.0 kg a week or more over at least three weeks is of concern, especially if the patient is already underweight. This rate of weight loss is indicative of extreme starvation, and indicates that the body is probably breaking down muscle to obtain the energy it needs. In these situations, it is not just proximal muscle that is broken down (i.e., arm and leg muscles). Organs such as the heart are also likely to be affected. If the patient is very underweight (a BMI of 15 or less), then a drop of 0.5 kg a week is of a similar level of concern, because the body has fewer reserves of energy to fall back on and a state of urgency will be reached more quickly. Children or adolescents also need more urgent interventions, because their physical health is compromised at a much earlier stage than in adults. For this reason, we would recommend that regular physical examinations are part of the assessment and ongoing care of all children and adolescents with an eating disorder.

If weight has continued to drop for more than the last eight weeks, this indicates that the person is continuing to cut food out of their diet and/or is excessively active (rather than making initial cuts to her diet that led to weight loss, but which the body has adapted to, thus leading to a stabilization of weight). As such, it could indicate that the patient has lost control of the situation and may not be able to stop this downward spiral on their own. While this situation may not place the individual at immediate risk, this patient needs ongoing physical monitoring and a plan put into place to address the possibility that physical health will deteriorate, especially given that they are likely to have limited insight into the seriousness of the position, or limited capacity to change.

If possible, patients should be asked to come up with ways to prevent further deterioration themselves or in collaboration with the clinician. However, regardless of whether the patient plays an active role in this planning or not, the care plan should be shared with the patient. This is because the care plan can be a motivating tool in itself, since the patient can see that the continued loss of weight has implications that the patient may not want, and that the health care professionals involved in his or her care are taking the situation very seriously (presenting the consequences as inevitable, rather than being the clinicians' choice).

In summary, where weight is dropping quickly (0.5—1.0 kg or more per week, dependent on the patient's starting weight), or when weight has continued to drop for more than eight weeks, then a medical assessment and care planning are priorities due to the increased physical risk. It is also a clear indication that CBT is not working, even if the patient appears well engaged in the process and reports a strong motivation to change the situation, and signifies that CBT needs to be put on hold while the physical risk is addressed.

### 3.4.2 Non-invasive tests for muscle strength: the sit up, squat, stand (SUSS) test

Muscle strength should be assessed in very low-weight patients or underweight patients who are losing weight rapidly (0.5—1.0 kg or more per week). This can be done easily in the treatment setting using the SUSS test. This tool gives a strong indication of whether the patient is in physical danger when used on its own, but is best used in conjunction with other tests (e.g., blood tests, ECG).

- *Squat.* The patient is asked to squat down on the haunches and asked to stand up without using the arms as levers or to balance, if at all possible.
- *Sit up.* The patient is asked to sit up from lying flat on their back on the floor without using the arms as levers, if at all possible.

| | | Concern | Alert |
|---|---|---|---|
| Squat/stand test | Unable to get up without using arms for balance | + | |
| | Unable to get up without using arms for leverage | | + |
| Sit up test | Unable to sit up without using arms as leverage | + | |
| | Unable to sit up at all | | + |

If the patient scores in the ''concern'' area, then an urgent medical review is needed, including more invasive and ongoing physical tests (e.g., ECG and blood tests). However, if the patient scores in the ''alert'' area, then an immediate assessment is needed by a medical physician (e.g., via accident and emergency or the casualty room), since a failure to be able to sit up or stand from squatting indicates that not only does the person have reduced muscle bulk, but that starvation is so extreme that the muscle has now stopped working. If proximal muscle is not working, then there is a high possibility that other muscle (such as the heart and intercostal muscles around the lungs) may also decompensate, leading to great and immediate clinical risk.

## 3.5 Care planning in response to the baseline physical tests

If any of the baseline tests come back with abnormal results, then this needs to be discussed with a suitable medical practitioner, and a plan for ongoing monitoring during treatment should be drawn up. If physical risk is deemed to be very high, then it is likely that psychological interventions (including CBT) are unsuitable at present, and that ongoing medical monitoring (including the possibility of admission to a specialist in-patient eating disorder unit or a medical admission) is needed. If all the tests come back within normal ranges, it is still important to repeat relevant ones if the patient increases the frequency of purging, consistently loses weight, reports feeling physically unwell or reports any of the conditions described in Section 3.3.

## 3.6 Assessing chronic risk

Much of this section addresses the acute, potentially life-threatening risk that can be present in people with eating disorders. However, there are also chronic risks that are not usually life threatening, but which can greatly affect patients' quality of life and physical health, and therefore need to be attended to by both the clinician and patient. These are detailed in Table 3.1.

**Table 3.1.** Common physical risk factors in the eating disorders

| | Osteoporosis (brittle bones) | Dental problems | Diseases related to obesity |
|---|---|---|---|
| Risk factors | Low weight (BMI < 18.5) and amenorrhea for more than 2 years | Vomiting for more than 6 months | BMI > 30, or |
| | | Very high fruit intake (due to the acid content) | BMI > 28 plus risk factors |
| Monitoring tools | Bone scan | Regular dental appointments | See above |
| Treatment | Achieve a body weight where menstruation occurs naturally | Stop vomiting | Initially stop bingeing, stabilize eating, and reduce fat and sugar intake |
| | | Avoid brushing teeth just after vomiting | Once eating disorder treated, aim for slow weight loss |
| | | If unable to stop vomiting, discuss options with the dentist | |
| Contraindications | Bisphosphonates, as there may be a future risk to unborn babies, and/or a theoretical increased risk of cancer | N/A | N/A |

## 3.7 Monitoring risk during treatment

Much of the information discussed above will be of use during the therapy process. In fact, it is much easier to assess risk in these situations due to the fact that the clinician has reliable information about recent weight changes, and has developed more of an understanding of the patient's insight or capacity to change. It is important to have plans in place if the patient's physical condition deteriorates.

### 3.7.1 When to stop CBT because medical risk is the priority

CBT involves enabling patients to change both behaviors and cognitions in order to improve their life. If weight continues to drop, for example, then it is important to recognize that the therapy is not enabling the patient to make these changes.

This is perhaps obvious on paper, but sometimes the patient can be so enthusiastic and appear so motivated that it is relatively easy for both the clinician and patient to overlook continued weight loss, or other factors that increase physical risk. This is why supervision and discussion with other team members is vital.

If the patient's medical condition continues to deteriorate despite the clinicians' best psychological and biological efforts to avert this (e.g., involving a dietitian to help increase food intake to stop weight loss), then it is vital that the clinician should acknowledge that the psychological treatment is not working, and work to transfer the patient to a more suitable treatment. Such treatment might involve in-patient care (either specialist eating disorders or medical treatment). It might be appropriate for the clinician to offer short-term "holding" work, especially if he or she is the only professional seeing the patient on a regular basis, but this should be for a limited time only, and would not be an option if the patient is at immediate risk. It is impossible to give firm guidelines about the clinical criteria for this decision, since each patient must be individually assessed, but generally if the BMI drops below 14 then medical care and consolidation is a priority.

## 3.8 The value of a multidisciplinary working environment

CBT is most likely to be effective when it entails collaborative work between all those involved in the patient's care. Those involved can vary from one or two others (e.g., clinician with GP and dietitian) right up to a full multidisciplinary team with additional input from local community mental health team and GP. We use a "hub, spoke and rim" model (see Figure 3.1) to guide our thinking on working collaboratively, and to ensure effective communication between those

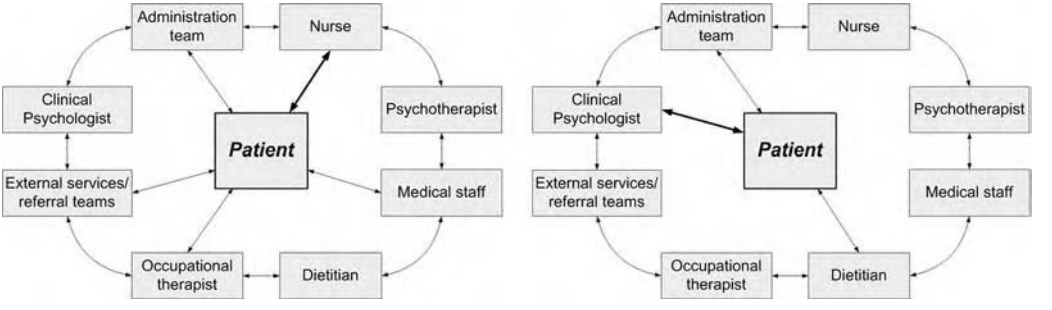



Figure 3.1 Examples of the "hub, spoke and rim" model of multidisciplinary care (thick arrows indicate the central clinical relationships). The case on the left illustrates a case with a greater need for multidisciplinary input.

involved. In this model, all clinicians might have an input into the care of the individual patient, but they communicate throughout (rather than operating independently) to ensure that the package of care is shaped to the individual patient. The aim is to identify the minimum level of input necessary to meet that patient's needs (with the benefit of reducing potential confusion caused by too many clinicians being involved). This model has the patient at the center or "hub," with "spokes" linking to those individuals who are actively working with the patient. The thick arrow indicates the individual who has the most contact with the patient (e.g., the individual clinician for a simple case being treated as an outpatient). The "rim" indicates links in communication from clinician to clinician. Although some clinicians may not be actively involved in the patient's care, the arrows indicate they may be usefully involved as a means of support and advice for the clinician involved.

Our experience is that CBT gains from the different perspectives that others can offer. Fellow health workers with different professional and theoretical orientations help us to think "outside the box" in dealing with complex patients. Their perspectives can cover aspects of treatment where the CBT practitioner has less expertise (e.g., medical consequences of behaviors, ensuring that the patient has access to benefits so that he or she can attend treatment), and can provide a check that all elements of risk have been covered.

Given the complexity of many cases, making clinical decisions as a team is important. Here, a multidisciplinary team is a distinct asset. First, other members of the team enable us to step back and think about the rationale behind those decisions. For example, some patients might benefit more from other types of therapy, such as psychodynamic interventions or an approach where the patient is not currently motivated to change but is willing to work with the clinician to remain safe. Second, the team can support the individual clinician in making difficult decisions. For example, there can be pressure from the patient, the patient's family and other health professionals to forego aspects of treatment in order to engage the patient (e.g., a non-negotiable such as weekly weighing). Other members of the team can support our clinical decision in the face of that pressure, remind us that there are reasons for needing to maintain boundaries, or help us to see alternative ways of dealing with such problems.

Treatment planning should involve thinking with other professionals about whether the patient might benefit from their expertise. Some groups of patients require more specialized intervention than the clinician is able to provide (e.g., pregnant patients, those with health complications such as diabetes). The patient will require continued input from the medical referrer. Liaising with the patient's physician prior to beginning treatment should clarify who is managing each

aspect of the patient's care. Complex patients need a good care plan to be in place prior to beginning CBT, involving local general mental health services. Such support reduces the risk that other factors will make CBT ineffective. For example, rapid access to a generic mental health care professional means that crises (e.g., onset of suicidal ideas) can be dealt with within an environment and a plan that leave the patient feeling contained.

Whilst multidisciplinary working is very important in providing the best care for the patient, it is vital that all professionals involved work from the same viewpoint about aspects of the patient's care. If there are differences of opinion, then they must be kept separate from the team members' work with the client. To ensure this separation, all those involved in a patient's care need to discuss such issues before they impact on the patient.

## 3.9 Preparing the physical environment

It is worthwhile to consider what we have found to be necessary environmental conditions for employing CBT with eating-disordered patients (apart from the broad set of CBT skills themselves, as represented in this book). We find it crucial to have the following available:

- a reasonably quiet room
- access to a set of high-quality weighing scales (calibrated every six months), with a high upper limit (up to 200 kg) in a private space
- access to a stadiometer (height measure)
- a white board, pens and eraser (e.g., for drawing energy graphs, formulations, pros and cons lists)
- tape recorder and a good omnidirectional microphone (for recording sessions)
- plenty of paper (for clinician and patient)
- food diaries (see later chapters)
- psychoeducational materials, especially on foods and the impact of the eating and related behaviors (see Chapter 13)
- tissues.

It is also useful to be able to access video-recording equipment.

## 3.10 Trouble-shooting: realistic expectations of CBT

A substantial number of patients fail to engage with treatment (e.g., Coker *et al.*, 1993) or drop out of therapy (e.g., McKisack & Waller, 1997; Mitchell, 1991; Waller, 1997). However, of those patients who do stay in treatment, many comply poorly with therapy tasks (e.g., homework, behavioral experiments, cognitive restructuring). Such patients are likely to be part of the substantial numbers who

fail to benefit from CBT (e.g., Fairburn & Harrison, 2003). We find that the patients who fail to benefit from CBT are often:

- those with substantial comorbid states (both axis 1 and axis 2)
- those who engage in a range of impulsive behaviors
- those with a history of trauma and dissociation
- those who are ambivalent about moving on from their eating disorder
- those who feel pushed into treatment.

However, there are clear exceptions, with some such patients doing extremely well. These characteristics require substantial attention to matters of motivation (Chapter 6), therapy-interfering behaviors (Chapter 9) and comorbidity (Chapters 24 and 25). However, we also find that it is important to consider issues of patient confidence in the possibility of change, clinician stance and clinician investment (Chapters 1 and 6). The aim must be to ensure that the clinician encourages and allows the patient to focus on the eating behaviors themselves.

It is important to consider ending treatment if these factors are not amenable to change, or to consider that CBT is not the right therapy for this patient at this time. If the patient is not ready to engage in active treatment at all at present, then the prospect of long-term motivational work (while ensuring physical safety) can be considered. Alternatively, other treatment modes might be more appropriate to the individual patient (e.g., Fairburn *et al.*, 1995; Murphy *et al.*, 2005). There is no strong evidence for matching patients to treatments. However, we find that the patients who benefit more from therapies with a strong interpersonal basis are those who have a history of significant separation and loss experiences.

## Summary

We have outlined the elements that need to be in place before undertaking CBT with the eating disorders. These include an understanding of the practical and philosophical bases of CBT, as well as the practical supports and frameworks that need to be in place before we ever see the patient. The next sections outline the implementation of CBT with this population, though the points made in this section should not be neglected throughout that treatment.

## Section II

# Core clinical skills for use in CBT with the eating disorders

In this section, we address skills that are generic to work in the eating disorders. These include:

- Assessment
- Motivation
- Applying dietary and nutritional knowledge
- Case formulation
- Dealing with therapy-interfering behaviors
- Planning homework
- Dealing with the stress inherent in working with such cases.

We also consider skills that are more specific to CBT as applied to the eating disorders, including:

- Agenda setting
- Psychoeducation
- Diary keeping
- Weighing the patient (as an example of identifying and focusing on a key behavioral target and clinical outcome)
- Working with the therapeutic relationship.

These skills are necessary in working with the eating disorders, regardless of whether or not one is using CBT. Indeed, many are relevant to any psychological intervention for any disorder. However, we have addressed those skills within a framework of CBT for the eating disorders, to illustrate how those principles can be applied flexibly to individual patients.

4

# Assessment

A good assessment is key to any CBT. It needs to be broad-based, driven by the existing evidence base and by the information that the patient brings to the session. It should also consider the wider picture, to decide whether the eating problem is the primary one, or whether other matters need to be addressed before one can reasonably hope to help the patient change eating cognitions and behaviors. It also needs to be stressed that the assessment must attend to process as well as content, since much can be learned from the way in which the patient presents and interacts in the session. It is important to consider and acknowledge patients' feelings about being present, and to determine how much it was their idea to come along and what they hope to get from the experience.

We have developed a semi-structured interview (see Appendix 1) to drive the assessment, which we will usually supplement with a number of self-report questionnaires. The aims of assessment include: gathering enough information to establish if the patient has an eating problem (defined either in terms of diagnosis or in terms of behaviors and cognitions that manifest in significant distress); what comorbid behaviors and disorders the patient presents with (if any); risk assessment (physical as well as psychological); and the patient's level of motivation for change. Finally, we aim to gather enough information (e.g., history, family structure) to develop a preliminary formulation with the patient, in order to drive the initial stages of treatment.

## 4.1 Areas covered in interview

Appendix 1 contains the semi-structured interview protocol that we use to guide the assessment of the patient's eating disorder and related features. It has been developed (and revised over time) through discussion within our larger outpatient multidisciplinary team. This covers areas that we consider to be key in deciding if CBT is appropriate for the patient. We are not rigid about the order in which

we cover these areas, as long as we cover the topics. We allow about 90 minutes for this assessment.

### 4.1.1 Demographic information

We ask patients to confirm what they prefer to be called, and to confirm their age. We ask for current and past employment or educational status, as establishing this information allows us to see what impact the eating disorder has had on the level of functioning.

### 4.1.2 Eating behaviors

The information collected here is seen as provisional, to be confirmed through use of diaries as CBT begins. Past and current behaviors are noted, in order to determine change versus stability. The patient is asked:

- What they would eat on a typical day and at different times of the day, in order to understand eating patterns (e.g., are they restrictive, chaotic, governed by rules about time, etc.).
- Fluid intake, as they may be putting themselves at risk of physical health problems secondary to dehydration (especially in the case of frequent vomiting and laxative use) or excessive fluid intake.
- Any foods that are specifically avoided, and the reasons for this avoidance. The patient may state they have specific food allergies or intolerances, although the validity of this can be hard to establish until the eating disorder has been resolved.
- Rituals around food and the reasons for this behavior. Rituals can include eating food in a specific order or always eating a certain number or combination of foods. These questions can uncover if the ritual is driven by compulsive behavior (the belief that something negative will occur if they do not consume food in this way) or by beliefs that might require some corrective psychoeducation (e.g., the incorrect belief that food will be purged in the reverse order to the order in which it was consumed).

Where there is any evidence of bingeing, purging and other compensatory behaviors, the patient is asked about:

- Frequency of bingeing over a week.
- The types of food on which they binge.
- The amount of food eaten in these episodes, in order to see if the binges are objective (large amounts of food) or subjective (small or normal amounts). Patients are also asked if they feel out of control while bingeing.
- Frequency of vomiting, whether it is linked to binge-eating, and if there are any rules around vomiting (e.g., must vomit until bile is seen).

- Triggers to the bingeing and purging behaviors (to get a sense of the function the behavior is serving, e.g. affect regulation as well as a response to starvation).
- Use of laxatives, diuretics and diet pills (including type and dose).
- How much they exercise and what exercises they complete. We aim to establish the difference between healthy exercise and excessive exercise (while there are no firm guidelines about this, we define excessive exercise as four or more hours per week with the intent of losing weight). The patient is asked if the activity has a compulsive element (e.g., is there a rigid number of sit-ups that must be completed?). We label the exercise as compulsive if the patient believes that something bad might happen (not pertaining to weight or shape) if they did not complete the exact number of exercises.
- Any other purging behaviors (e.g., chewing and spitting food).

### 4.1.3 Measuring the patient's height and weight

Accurate measurement of weight and height is essential for working out a body mass index for the patient (BMI = weight [kg]/height $[m]^2$). A significant minority of patients are reluctant to be weighed, so we have to explain that weighing and measuring height is a non-negotiable of assessment (see below). We explain to the patient that we are unable to treat them if we cannot be certain about physical safety, and that CBT will require being aware of weight. We use the following guidelines to ensure accurate and consistent weight and height.

#### Height

Ensure that:

- patient removes shoes and is wearing light indoor clothing
- patient stands under height measure with:
  - heels together
  - arms relaxed at side
  - legs straight
  - shoulders relaxed
  - looking straight ahead
- head, buttocks, shoulder blades and heels against the height measure
- nothing obstructing headboard (e.g., pony tail)
- patient inhales deeply (from diaphragm) and holds breath during measurement
- read height straight on (not from below/above)
- record height to the nearest 0.5 cm.

#### Weight

Weight is sometimes manipulated by the patient (e.g., water loading, carrying weights). Such manipulation can often be identified through comparison

of weights across sessions, through blood testing and through understanding weight change or stability that is not compatible with the reported dietary intake. Therefore, these guidelines are for the *reliable* measurement of weight, rather than implying *validity* of measurement:

- use the same set of scales each time
  - ensure that scales are set to zero each time
  - ensure that the scales are regularly calibrated for accuracy (and that the patient is made aware of this accuracy before the initial weighing)
- patient to empty bladder before weighing
- remove shoes and weigh in light clothing (as above)
- record weight to the nearest 0.1 kg.

It is equally important to establish what has been happening to the patient's weight in the past 8–12 weeks. If the patient has been losing weight at the rate of faster than 1 kg a week, their health might be seriously compromised. It can be difficult to obtain accurate previous weights, as many referrers do not weigh the patient. We have experience of receiving referrals where the referrer has relied on the patient's self-report of their weight, and that can frequently be very inaccurate (especially if the patient is overweight or underweight). Finally, the patient is asked for their ideal weight (to give the clinician an insight into what the patient may be aiming for and the degree of motivation), and what the lowest and highest adult weights have been.

### 4.1.4 Psychosexual functioning and history

The patient is asked about current and past menstrual function (current frequency and nature of periods) and about factors that might interfere with that function (contraception, polycystic ovaries, pregnancy, breast-feeding or menopause). We enquire about the patient's age at menarche and the reaction to the onset of periods. Any history of absence of periods is linked to weight history. We also enquire about any history of pregnancy or termination/miscarriage. We ask about the history of sexual relationships in order to determine whether this has followed a typical developmental pathway.

### 4.1.5 Central cognitive elements

#### 4.1.5.1 Body concept/dissatisfaction

Patients are asked how they feel about their body (likes/dislikes it), and if their feelings differ for different parts of the body. At this stage, we ask about body checking practices (e.g., are parts of the body checked by pinching folds of skin or by measuring around certain areas?).

#### 4.1.5.2 Body percept

We assess disturbance of body percept using several methods, according to the circumstances. Patients can simply be asked how they see themselves when looking in the mirror, and whether other people agree with what they see. We might draw patients' attention to BMI, and whether it is compatible with their perceptions of the body relative to those of other people (e.g., "The numbers suggest that you are below the normal weight band for your height. Does that match with what you see when you look in the mirror? Do you find that other people agree with you when you say that you are overweight? Does their disagreement mean that you tend to avoid ever discussing the topic? How does that affect your ability to get a balanced viewpoint?").

Finally, if the patient can tolerate a direct challenge of this sort, disturbance of body percept can be ascertained by asking the patient to complete an exercise with you. (This exercise might be less suitable to do if the patient has concerns about physical proximity/threat, as it involves coming into close proximity with that individual. Particular care should clearly be taken when the clinician and patient are of different genders. We would recommend that if the patient is of a different gender to the clinician callipers should be used.) We ask the patient to hold their hands out straight in front (palms flat and vertical, thumbs facing upwards). The patient is then asked to estimate how wide their waist is, by moving the hands in or out to the appropriate point. The patient is encouraged to look at their waist in order to make this estimation. The clinician demonstrates the exercise for the patient. The clinician then stands in front of the patient, mirroring the size estimate that the patient has made using their own hands (or callipers if available). The patient is asked to rate their certainty about the rating (e.g., "If you had £100 to bet on your being accurate, how much would you stake on your waist being at least that large?"). The patient is then asked to walk into the gap made by the clinician's hands, and to examine the accuracy of their estimation. The discrepancy can be distressing to the patient if they have a long history of avoiding any experience that might confirm (or disconfirm) their belief about how large they are. The patient is then asked to consider reasons why the estimate is so far out, and to consider how the erroneous percept might be acting to maintain beliefs (e.g., avoids getting into social situations that might allow anyone to compliment them on their appearance or express concerns about how thin they have become).

#### 4.1.5.3 Fear of fatness and weight gain

These overvalued ideas can be addressed directly, or by asking the patient how they would feel if they gained a small amount of weight (e.g., 1 kg), and how they would react if this did occur (e.g., restriction, purging).

### 4.1.6 Eating disorder diagnosis

Although diagnosis has limited clinical utility in the eating disorders (e.g., Fairburn *et al.*, 2003), we use the available information to produce a DSM-IV diagnosis. The criteria for anorexia nervosa, bulimia nervosa and atypical cases (eating disorder not otherwise specified) are given in Tables 4.1—4.3. It should be

**Table 4.1.** DSM-IV criteria for anorexia nervosa (American Psychiatric Association, 1994)

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. 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 denial of the seriousness of the current low body weight.
4. In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles (a woman is considered to have amenorrhea if her periods occur only following hormone, e.g. estrogen, administration).

Anorexia nervosa is divided into two subtypes: restricting type and binge-eating/purging type.

**Table 4.2.** DSM-IV diagnostic criteria for bulimia nervosa (American Psychiatric Association, 1994)

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   a. Eating, in a discrete period of time (e.g., within any two-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.
   b. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
2. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting; or excessive exercise.
3. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Bulimia nervosa is divided into two subtypes: non-purging (for those only using restricting and excessive exercise to prevent weight gain) and purging subtype.

**Table 4.3.** Summary of DSM-IV diagnostic criteria for atypical eating disorders/eating disorder not otherwise specified (EDNOS) (American Psychiatric Association, 1994)

An atypical eating disorder occurs when a patient's symptoms fail to meet the full criteria for either anorexia nervosa or bulimia nervosa. Patients receive the diagnosis of the disorder their symptoms appear to match most closely (e.g., atypical bulimia nervosa or atypical anorexia nervosa), although at times it can be difficult to discern into which subtype the person falls.

Binge eating disorder (BED) is currently cited as a subset of EDNOS. BED is defined as "recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of bulimia nervosa."

stressed that the quality of diagnosis is very much dependent on the quality of information received, and the diagnosis reached at assessment should not be assumed to be fixed (Fairburn & Harrison, 2003).

### 4.1.7 General health

It is important to ask about developmental history of physical health (e.g., diabetes), and to consider states that might have had an impact on current eating and related pathology (e.g., a history of asthma can involve treatment using steroids, resulting in weight gain). It is likely that some physical health investigations will have to be undertaken with most patients (see Chapter 3). Screening for general health at this point should determine the type of investigations needed, their frequency and their urgency. It needs to be decided if a physician should see the patient urgently or if the investigations can be handled through more routine routes (e.g., seeing the family doctor). Most patients fall into the latter category, but a significant minority require more urgent attention. Broadly, the patient should have a review by a physician as a matter of urgency if any of the following apply:

- BMI is 13 or below.
- There is recent rapid weight loss (more than 1 kg per week) over several weeks.
- The patient reports fainting, dizziness or blackouts.
- Evidence of ketoacidosis (e.g., breath has a distinctive sweet smell, similar to nail varnish remover or pear drops).

Suggestions about tests that should be arranged (according to presenting physical state) are given in Chapter 3.

### 4.1.8 Comorbid behaviors and psychological disturbances

The patient is asked whether they have any history or current use of a range of impulsive behaviors (self-harm, including hitting, burning, self-cutting, and overdosing; alcohol and substance misuse; compulsive spending; stealing; risky

sexual behavior) and compulsive self-harming behavior (e.g., picking skin; hair pulling). The functions of these behaviors and their relationship to the patient's history are also discussed.

The patient is asked about the presence of a range of other symptoms, which might indicate the presence of features that are commonly comorbid with the eating disorders (low self-esteem; perfectionism; anxiety; depression; obsessive-compulsive disorders; posttraumatic stress disorder; personality disorders; dissociative features). We find it more useful to focus on the features than on the issue of whether the patient meets criteria for a full comorbid disorder.

#### 4.1.9 Risk assessment

Having established the symptom profile, a standard risk assessment is carried out, considering the risks inherent in the eating and related behaviors. We ask the patient about any significant depression, and associated suicidal ideation or intent. We also ask about any forensic history, and consider potential risk to others (including child protection issues, where appropriate).

#### 4.1.10 Treatment history

The patient is asked to detail any previous or current psychological or psychiatric treatment (medication and psychotherapeutic) for eating or other disorders. We ask the patient to describe the type of treatment involved (although many are not aware of the nature of their psychological therapies). They are also asked how effective those treatments were, and what element of those treatments was helpful or unproductive, in order to help the clinician individually tailor the CBT.

#### 4.1.11 Family structure

A detailed description of family structure is undertaken, including a genogram, quality of relationships over time, and family psychiatric and weight history. Relationships (partners, friends) are also discussed. The aim is to understand what relationship factors might have contributed to the person developing an eating disorder, and if any relationship issues play a maintaining role in the problems. We aim to understand the patient's experience growing up in their family, and particularly the emotional environment it provided and the development of emotional management skills.

#### 4.1.12 Life history

Beyond the usual information gathered in a developmental history, we ask about any history of trauma (including abuse, losses, separation, bullying and teasing). We will often draw a time line of the person's eating and related problems on the whiteboard, as this can help to bring order to a large amount

of information (particularly if the person has a long history of eating disorders and other problems). Patients report that they find this a useful exercise in making links between events and behaviors. Weight history is included on the time line.

### 4.1.13 Client's motivation and goals for treatment

We work with the patient on identifying the goals for treatment in order to get an initial impression of motivation. However, as clinicians can be poor at estimating readiness for change, at least in anorexia nervosa, (Geller, Williams & Srikameswaran, 2001) we see this assessment as the beginning of a continuing process of motivational enhancement work. We also identify any obstacles to treatment (e.g., employment, distance, child-care), as a low level of motivation is often associated with the patient citing a large number of obstacles that will make it impossible to attend treatment sessions. Personal strengths and social supports are considered in this element of the assessment.

### 4.1.14 Treatment preferences

In order to maximize the likelihood of engagement, we ask the patient if they have any specific needs or preferences about variables where we can offer a real choice (e.g., gender of the clinician; times when the patient can attend).

### 4.1.15 Additional assessment of cognitions, emotions and behaviors

We ask the patient to complete self-report measures of relevant cognitions (disorder-specific and schema-level beliefs), comorbid emotional states (e.g., anxiety, depression) and behaviors (e.g., binge eating, self-harm). These are used to develop a full formulation (see Chapter 8) and as baseline measures for evaluation of treatment progress and outcome. They include: the Eating Disorder Examination Questionnaire (Fairburn & Beglin, 1994); the Beck Depression Inventory (Beck & Steer, 1993a); the Beck Anxiety Inventory (Beck & Steer, 1993b); and the Young Schema Questionnaire – Short Form (Young, 1998).

## 4.2 Trouble-shooting in the assessment phase

Not all assessments neatly go to plan. Flexibility is essential, while maintaining the principle of ensuring that the necessary information is maintained. For example, some patients are so low in motivation that it is critical to dedicate the early stages of assessment to motivational work, prior to being able to work towards the assessment itself. Some important points are outlined here.

### 4.2.1 Extended assessment

At times, we use an extended assessment (about 4–6 sessions) to gather further information before reaching any decision about treatment options. For example, if the patient has difficulty in describing diet or other behaviors (e.g., grazing vs. bingeing), we will use a period of diary-based eating/behavior monitoring to clarify the behaviors.

### 4.2.2 Therapy-interfering behaviors

The assessment is often the time when therapy-interfering behaviors (Linehan, 1993) come to the fore. The role of these behaviors in therapy is detailed in Chapter 9. However, there are some such behaviors that we sometimes see at this stage, including:

- rudeness to administration staff
- more or less subtle denigration of all previous therapy/clinicians
- pointing out of mistakes in questionnaires.

Such behaviors often indicate forthcoming problems in engagement and motivation, and need to be addressed early on in the process.

### 4.2.3 Address the patient's refusal to be weighed

There are two non-negotiables here for the CBT practitioner, and the rationale for each must be clear in the clinician's mind for those occasions where the patient declines being weighed. As with all non-negotiables, they must be transparent and explained to the patient.

First, regular weighing is essential to establish the patient's physical safety, and we make it clear that we will not be able to work with a patient who will not allow us to weigh them. This is presented as being very much the patient's decision, but that our hands are tied by the need to ensure their safety if we are to be involved. Our experience is that very few patients decline when this reason is explained in that way. Some will ask if they can defer until next time, but are usually amenable to the explanation that our experience shows that the anxiety will be as high next time, and that all we would be doing is putting off an inevitable task. If the patient does continue to refuse to be weighed, we assume that this may be because they have learned that refusal often leads clinicians to act as if it were unimportant, continuing the assessment regardless. Rather than risk reinforcing such a belief, we will terminate the session at this point, and ask the patient to contact us to arrange the next session when they are ready to make the necessary commitment to this essential element of therapy. Our experience is that the patient usually does return to assessment and allows weighing to proceed. On the rare occasion where this is not the outcome, then we end the CBT, making it clear that we cannot see any way to work therapeutically if we cannot be sure of the patient's safety.

Second, we present the issue of patients knowing their weight as a non-negotiable of CBT (regardless of whether they are underweight or not), since they will need to be aware of the consequences of their actions once treatment commences (e.g., to be able to test the belief that their weight will rise if they eat normally). We discuss an option where the patient can *not* know their weight, but stress that this is highly unlikely to be associated with recovery, as the best that is likely to be achieved is stability of the condition.

5

# Preparing the patient for treatment

An important part of the early elements of treatment is to prepare the patient for what is involved. Without such information, we would not expect the patient to be able to make an informed choice about what they are undertaking. Before even meeting the patient, we provide the following written summary of what is involved in CBT for the eating disorders:

The treatment lasts for 6–12 months and consists of two parts. First, an agreed number of weekly individual therapy sessions (usually 20–40) of 50 minutes, then a series of spaced follow-ups with your clinician to ensure progress is maintained. At the first meeting, there is an opportunity to discuss the programme fully and to answer any questions you may have. You and your clinician will work together to develop a plan of therapy. This will include how often you will need to attend, your goals for treatment, and the skills that you might want to learn. In order to give yourself the best opportunity for the programme to work, you need to attend regularly and to follow the treatment plan, which includes an agreement to weekly weighing, to using a structured eating plan and to self-monitoring of your food intake. CBT is based on the view that our thoughts, beliefs and ideas affect the way we feel and act towards others and ourselves in daily life. The focus of CBT is mainly on "the here and now", rather than the past. Therefore, the initial focus of this type of therapy is on your current thinking (your "cognitions"), behavior and ways of communicating. This information will be gathered from you using the self-monitoring diary, which you will be asked to complete. When you start CBT, your clinician will ask you to fill our several self-report questionnaires. The purpose of this is to help you and the clinician to figure out quickly what kinds of problems you do have and don't have, and the extent of your difficulties. In CBT, you and your clinician will set an agenda for each session. The agenda might include a review of the previous sessions, one or two current problems, a review of your homework, and setting homework assignments for the next week. An important part of CBT is homework. Just as you would expect a music teacher to provide guidance on how to play the instrument when he or she is not there, you will be expected to practice skills you have learnt in the session outside therapy. Research has shown that patients who carry out homework assignments get better faster and stay better longer. Your homework assignments may include keeping track of your eating behaviors, moods and thoughts, collecting new information, and changing the way you communicate with others. You and your clinician will identify specific

goals at the beginning of treatment, and you will be able to modify these goals as you continue with therapy. The advantage of having goals is that it will allow you to evaluate later on in treatment whether or not your problems are improving. If you and your clinician decide it would be helpful there is scope within this approach to explore how some of your early experiences may have contributed to beliefs that maintain your current problems. If appropriate there is also scope within this approach to help you develop skills in understanding, managing and expressing emotions that you have previously found intolerable. Finally, as part of treatment, the clinician will regularly ask for your feedback to clarify what strategies have been useful to you and to determine what works for you and what does not.

We also provide information about the eating disorders and treatment expectations reflecting current best practice (particularly the guidelines for patients from the National Institute for Clinical Excellence, 2004). This information puts our treatment into context (e.g., the number of sessions recommended for treatment of bulimia and anorexia nervosa).

We make it clear that CBT involves expectations of both the clinician and the patient (e.g., boundaries, attendance). We also stress the importance of focus and structure to make sure that the treatment progresses. However, we make it clear that the approach is collaborative, aiming for the patient to become their own therapist so that they can engage in treatment 168 hours per week. It is also important to stress the role of non-negotiable elements of treatment (e.g., weighing, homework) and the importance of tasks such as recording sessions and listening to them afterwards.

Overall, we draw patients' attention to the fact that we aim to build on existing strengths, as well as teaching new skills, so that they are able to see that they have a lot to do but that they have already got a foundation of skills to their credit. We talk about the patient's fears about how long treatment is likely to take, and how the patient might need to change life and expectations in order to cope with this period of tension and change. We stress the contrast between the short-term difficulty of change (with the accompanying feeling of being out of control and being worse) and the long-term benefits.

6

# Motivation

## 6.1 Context for motivation: understanding the patient and building a relationship

Patients with eating disorders frequently experience conflict within themselves when they attempt to change their behaviors. This is due to the fact that there are both positive and negative aspects to the symptoms that they experience (Crisp, 1980; Serpell *et al.*, 1999). This can manifest itself overtly in an expressed ambivalence to change or covertly through a range of therapy-interfering behaviors (see Chapter 9), such as cancelling appointments, arriving late, forgetting to complete homework tasks. Thus, although clinician and patient might both be motivated to achieve something, they can find that they are striving to reach different goals. The resulting experience for the clinician is a perception that those with eating disorders are particularly challenging to treat. For patients, the experience can be one of feeling invalidated, unheard and coerced. This can be particularly relevant for patients who feel compelled to enter treatment by external factors (e.g., family, partners, work). This is a time when it is clearest that CBT (and any other treatment) will fail without the patient being an active part of the therapy partnership.

### 6.1.1 Understanding the patient's position

Some eating disorder symptoms are referred to as *egosyntonic*, reflecting the fact that patients see these behaviors as acceptable and consistent with their beliefs about themselves. In the early stages of their weight loss, patients often report feeling proud and empowered by their weight loss, and frequently report receiving praise and admiration from those around them. In order for the clinician to be able to understand the patient's position, the possible positive reinforcers for the eating disorder should be considered. These are numerous and varied, but may include:

- social factors (e.g., attention gained through food restriction and by conforming to cultural models of slimness)

- psychological factors (e.g., the sense of mastery and achievement gained through fasting and affect regulation)
- physical factors (e.g., endorphin production)
- functional avoidance (e.g., not having to make difficult decisions about relationships, education, etc.).

In addition, the patient is likely to have a range of negative experiences as a result of their eating disordered behaviors (e.g., shame resulting from bingeing and vomiting) that make it hard to gain support for change. The patient is also likely to fear change (e.g., how to manage distress in the absence of their eating behavior; will recovery reveal an empty life?). All of these factors will impact on thoughts and feelings about treatment, and the likelihood that they will engage in treatment.

In order to gain insight into the patient's position, particularly the egosyntonic nature of thinness and self-control, Vitousek *et al.* (1998) encourage clinicians to engage in the following exercise for themselves. Imagine yourself facing the following scenario:

> I am a clinician who specializes in the detection and prevention of unhealthy relationships between parents and children. After careful assessment of your family, I am convinced that it was a terrible mistake for you to have your daughter. You may feel quite attached to her at the moment, but in the long run it simply won't work out. Whatever pleasure *you* may think you are getting out of this relationship, a detached and objective observer can see that you are losing a great deal too. You are tired and rundown, you lack sufficient energy for many of the activities you used to find rewarding, you spend less time with your friends and sometimes your work has suffered. You have become so preoccupied with this child that you are unable to make a realistic assessment of how she has actually affected your life. Therefore, I have decided to take your daughter away. I can appreciate you feel angry with me just now, and may not believe it is my right to interfere – but eventually you will come to understand that I have acted in your own best interest. With your child gone, you will be able to return to the life you had before you became a parent.

Our experience is that this exercise can provoke strong feelings in the clinician (as it is meant to), thus helping to convey the patient's position and the frustration that may arise from feeling that one's opinions are being ignored or invalidated. Since this experience is one that many of our patients have faced on a regular basis, we aim to ensure that the clinician does not repeat that invalidation for the patient, as it is likely to decrease alliance and motivation.

### 6.1.2 The clinician's position

In line with Geller, Williams & Srikameswaran (2001), we believe that there are two aspects to effective treatment for those with eating disorders: stance

and technique. Without the first, the second is of academic interest only. This topic underpins much of our treatment of the eating disorders, and not just how we motivate the patient. Therefore, we have already outlined how the clinician brings a "mission statement" to treating the eating disorders (Chapter 1). That mission statement (and the accompanying transparency of purpose) underpins motivational work. Taking the key points from that earlier section, we find it useful to consider the following specific matters when aiming to motivate the patient:

- *Fostering self-acceptance*. This incorporates skills of explaining to the patient that you understand their position and the reasons that they have had to engage in these patterns of thinking and behaving (comprehensive validation; Linehan *et al.*, 2002) and that you are able to see how the problems and the therapy impact on mood (accurate empathy; Vitousek *et al.*, 1998). We work with the patient to understand the reason for the disorder, but also accept the need for change. Our aim is to reduce the shame and helplessness that patients frequently experience, providing a framework for understanding how things have developed in the way that they have, why they will not change overnight, but that change is a possibility.
- *Being active rather than passive*. Although what it is possible to do in the short term will depend on the patient's stage of change, the clinician must maintain an active stance, assisting the patient to reflect upon the situation and to make informed choices about how to proceed. Clinician passivity is incompatible with the behavioral change and experimentation that are key to CBT.
- *Being collaborative*. We are explicit about the fact that only the patient has the power to change their behavior, and thus only they can hold the responsibility for this. We present the clinician's role as being to facilitate change by being a source of ideas and knowledge. Thus, we aim to create an environment where the clinician and patient each know that they can pool their knowledge, experience and skills to achieve a meaningful and effective outcome.
- *Being curious, genuine and willing to learn from the patient*. We use this element of clinician stance to validate the patient's experience and to help them to clarify thoughts and feelings (allowing them to synthesize information and reach conclusions independently). We aim to redress the power imbalance that inevitably exists between clinician and patient, minimizing misunderstandings about developmental and maintaining mechanisms. The Socratic style is highly useful here (Beck *et al.*, 1979, 1993) — see Chapter 16.

### 6.1.3 Clinician and patient investment

Geller (2005) has also raised a third factor that must be understood: disparity between the degree to which the clinician and the patient are invested in treatment.

For example, if the clinician is overinvested in treatment relative to the patient (e.g., the clinician sees weight gain as only being useful if the patient gets to a particular weight, but the patient sees it as more important to gain less weight), then the patient is likely to be diverted from their limited motivation to change by the need to fight off the pressure that the clinician is bringing to bear. In such circumstances, it can be more important for the clinician to reduce his or her expectations of what the patient should be aiming to achieve in the short term, so that it is possible to work with the patient on enhancing their limited motivation. At times, we find that we have to call a halt to "active" treatment, so that there is time to address the factors that are affecting the patient's level of investment.

For example, when a bulimic patient is emphatic that they wish to try out a particular diet (which is unsustainable in objective terms) because they are convinced that it will stop the binge eating, it is tempting to spend a significant amount of therapy in trying to persuade them to change their mind and engage in the treatment that we believe is more likely to be effective. The consequence is that the patient and clinician are pushing in different directions as a result of the clinician's failure to recognize that his or her investment in the patient changing is higher than the patient's own investment, thus the patient's motivation to change falls. Recognizing the differences in investment allows the clinician to find a course of action that is more compatible with the long-term goal of engaging the patient in CBT. For example, the proposed diet can be treated as a behavioral experiment (see Chapters 6 and 7), where the patient's belief about the viability of the diet is tested out relative to an alternative belief (e.g., such a diet is unlikely to reduce binge frequency). Although the clinician might see the possibility that the CBT *could* go faster, he or she must also recognize that it will not do so if different levels of investment make it less likely that CBT will be collaborative.

### 6.1.4 Stages of change

We have found the Stages of Change model (DiClemente & Prochaska, 1998) useful when thinking about a person's level or stage of motivation. Many readers may already be familiar with this, but a brief summary follows for those who are not.

#### 6.1.4.1 Precontemplation ("not ready")

In this stage, patients are not ready to even contemplate a change in the foreseeable future (e.g., the next six months), possibly as a result of being unaware that their behaviors have negative consequences. In the case of those with eating disorders, they often perceive the eating disorder as the solution to their problems, rather than seeing it as the problem itself. Patients in this stage are unlikely

to be interested in reading, talking or thinking about changing their behavior, and are often characterized as resistant or unmotivated to change.

#### 6.1.4.2 Contemplation (“thinking about it”)

In this stage, the patient is ready to take in more information about the possible change, and is more interested in the topic in general (e.g., thinking that they might make changes in the next six months). They are more aware of the “pros” of changing, but are also acutely aware of the “cons.” Although the contemplation stage can be encouraging to the clinician, patients can remain stuck in this stage for long periods of time, trapped by the ambivalence created by the balance between costs and benefits of change or by the fear of failing to change.

#### 6.1.4.3 Preparation (“getting ready for change”)

In this stage, the patient has made the decision to change, and intends to take action shortly (e.g., in the next month). However, during this period, the patient will be developing a plan of action (e.g., devising a regular eating plan; distancing themselves from others with alcohol or eating problems; recruiting family members for support). It is important for the clinician and the patient to remember that a good preparation period optimizes the chances of success.

#### 6.1.4.4 Action (“ready, set, go”)

This is the stage where patients make specific, overt modifications in their life-styles. However, it is important to remember that it is not the beginning of the process of change. Perhaps the most common mistake that the clinician and patient can make in the change process is jumping to take action before they are ready. When they *are* ready, this stage is where the patient learns to “walk the walk” on a day-to-day basis, and to trouble shoot the problems that come up in keeping to their new plan.

#### 6.1.4.5 Maintenance (“hanging in there”)

This is the stage where patients work to prevent relapse, and can be the hardest part of treatment. The patient is tempted to relapse, at the same time as becoming more confident that they can continue to change.

In applying the stages of change model within CBT, it is critical to remember the following:

- Although the stages represent ordered categories along a continuum of motivation to change, transition between them is not linear or in one direction only. Patients will often revert to an earlier stage of change, and relapse prevention is dependent on recognizing this and reacting accordingly.

- To be effective, interventions need to be matched to the patient's stage of change. For example, trying to introduce a regular eating plan for a patient who is in the precontemplation stage will be ineffective, creating anxiety and frustration in all those involved in the treatment. An intervention based on understanding and validating the patient's current experience is more likely to lead to a positive outcome.
- Patients are likely to be at different stages of changes for each of their different eating disordered behaviors (e.g., they may be in the action stage of change with regards to changing their bingeing but in the precontemplative stage with regards to their restrictive eating). However, behaviors are usually linked in a cycle of maintenance (e.g., restriction triggers bingeing which in turns triggers restriction — see formulation, Chapter 8), meaning that unless the patient is motivated to change both behaviors, neither can be changed on a long-term basis.

### 6.1.5 Willingness and resources: two components of change

Significant and sustained behavioral change depends upon two distinct but related components: willingness (wanting to change) and resources (having the skills and opportunity to change). Willingness to change can be enhanced substantially through two related skills (Geller, 2002a; Linehan, 1993): comprehensive validation and draining. *Comprehensive validation* refers to avoiding blaming the patient for the problems, instead discussing the patient's symptoms as being understandable (rather than random or "bad" behavior), both in the context of the past and in the current situation. It allows the clinician to accept all of these aspects of the problem (without blaming the patient) while not accepting that the problem must inevitably continue into the future. As formulation skills improve, this approach becomes continuous from formulation onwards. *Draining* is the process of repeatedly asking the patient about their concerns and frustrations (e.g., with treatment), accepting that they are real concerns, and asking for more of what is troubling them. This process is similar to downward arrowing.

However, it is important that both the clinician and the patient are aware that willingness (e.g., the motivation to stop bingeing) frequently exists without the necessary resources (e.g., the capacity to tolerate the distress that bingeing usually masks). Both are needed if change is to be achieved, and attempting change without both of these components in place will result in a sense of failure and hopelessness in all those involved. Therefore, there needs to be attention in therapy to building the patient's resources (or confidence in those resources).

## 6.2 Assessing motivation for change

Motivation for change varies from patient to patient, and there is some evidence that this level correlates with the behavioral presentation. For example those with bulimia nervosa are more likely to be in the "action" stage at the beginning of treatment (Blake *et al.*, 1997), while those with anorexia nervosa are less likely to be so prepared for change. It is also important to understand whether the patient is motivated to change eating, rather than other symptoms. For example, most patients are keen to seek relief from food preoccupation, depression, anxiety, bingeing and purging, but are less enthusiastic about changing their dieting behavior. Even for those who report a high level of motivation to change all aspects of their eating behaviors, some work should be done in this area. Such change is difficult, and all those who engage in it are likely at some point to need reminding of why they embarked on change in the first place.

### 6.2.1 Questionnaire and interview measures

A comprehensive assessment of a person's level of motivation is needed before CBT begins, as it is impossible to begin appropriate and effective treatment without identifying shared goals. There are several useful measures of motivation for patients with eating disorders (e.g., Cockell *et al.*, 2003; Geller, 2002b; Geller & Drab, 1999; Rieger *et al.*, 2002; Serpell *et al.*, 1999). Most of these measures consider the pros and cons of change, taking into account the egosyntonic nature of eating pathology as well as its drawbacks. We find the Cockell *et al.* measure particularly valuable, because it addresses functional avoidance (e.g., not having to face developmental issues or relationships) as well as pros and cons of the eating behaviors. In addition, other strategies have been suggested for measuring motivation (e.g., Keller & Kemp-White, 1997; Miller, 1995; Treasure & Bauer, 2003).

### 6.2.2 Pros and cons lists

The most direct way of developing an individualized analysis of motivation is to ask the patient to prepare a list of the pros and cons of their eating disorder, and we will usually demonstrate this on a whiteboard. However, we find that this is most effective as a technique when we ask the patient to complete the two lists for homework, then ask them to divide the pros and cons into those that are short- and long-term. This way (and usually to their surprise), the patient can see that the valued benefits are primarily short term, and that

the drawbacks are longer term and more pervasive. For example, a patient with a restrictive disorder might produce the following list initially:

| Pros of current eating pattern | Cons of current eating pattern |
|---|---|
| • Feeling in control | • Tired |
| • Able to deal with hunger | • Physically unwell |
| • No pressure to decide about university | • Family putting pressure on me to eat |
| • Avoid men being interested in me | • Have to go to hospital |
| • Others admire my self-restraint | |

but go on to develop it into the following:

| | Pros | Cons |
|---|---|---|
| **Short term** | • Feeling in control<br>• Able to deal with hunger<br>• No pressure to decide about university<br>• Avoid men being interested in me | • Tired |
| **Long term** | • Others admire my self-restraint | • Feeling that my life is out of control<br>• No energy to think<br>• Physically unwell<br>• Family putting pressure on me to eat<br>• Have to go to hospital<br>• Life is going nowhere<br>• No one cares for me – they are just worried about what I eat |

The imbalance between the short- and long-term outcomes is a powerful tool for making the patient consider the viability of their behaviors in the long term. The task of changing can be reframed as one of taking a short-term risk (losing the transitory "pros") for a positive long-term outcome (losing the more persistent "cons").

### 6.2.3 The "miracle question"

We have found some of the questions used in solution-focused therapy (de Shazer, 1988; Jacob, 2001) useful in this element of the assessment for CBT. In particular, the "miracle question" can be used to find out what a patient wants to change, and what "recovery" means for them. It can also start a process of thinking about the future, which is a helpful introduction to some of the other motivational enhancement strategies discussed below.

**Table 6.1.** Key questions for the "miracle question"

| Question | Underlying aim and principle |
|---|---|
| What do you notice is different, if you wake up and the miracle has happened? | Identify shared therapeutic targets |
| What has stayed the same? | Identify aspects of life that the patient wishes to retain |
| If zero equals the worst life can be and ten equals the miracle, where are you? | Identify current status, enhance motivation, provides realistic and stepped approach |
| What is going to get in the way of the miracle? | Identify potential stumbling blocks to therapy (e.g., pressure from partner to stay thin) |
| How is the eating disorder going to help you get to the miracle? | Highlight the cost of the eating disorder and the incompatibility of this and the patient's "miracle" |
| What are the signs that part of the miracle is already happening? How did you manage that? | Enhancing motivation, amplifying exceptions, and fostering self-efficacy in the patient |

The miracle question aims to get the patient to imagine and describe in detail how their life would be if their problems were resolved (not necessarily the eating disorder, but what are perceived as the problems). Often, patients get used to what life is like with problems, and it is important to develop an image of what life would be like without those difficulties. It also ensures that clinician and patient have a shared understanding of the therapeutic goals. Furthermore, it enables the patient to state what they do not want to change or what they want to keep about their current life. We find it useful to start this in the session, and to ask the patient to write up and expand for homework. The following case example illustrates the use of the miracle question with a patient who has a restrictive eating pattern that has begun to impact on her life in a substantial way. Karen is a 22-year-old woman with a diagnosis of restrictive anorexia nervosa. She is currently taking her second year out from university. She has a seven-year history of restriction, which started in the year following her mother's death.

Case example: using the miracle question with Karen

| | | Aim and principles underlying intervention |
|---|---|---|
| Clinician | Imagine when you go to bed tonight, a miracle happens, which means that all your current difficulties are resolved? When you wake up, what will you notice that might make you suspect that the miracle has happened? Then what will happen as the day progresses? | *Introducing the possibility and potential benefits of change. Encourage the patient to describe an entire day, including lots of cognitive, behavioral, physical and affective examples.* |

| | | Aim and principles underlying intervention |
|---|---|---|
| Karen | The first thing that I would notice is that I would wake up at a normal time, not in the middle of the night because my stomach hurt. I would be happy. . . looking forward to the day, instead of being scared about what I was going to be made to eat, what arguments there were going to be about food. In fact I probably wouldn't even be thinking about food. I would be back in my house I share with friends at university, not living with my father and stepmother. I would get up and have a shower and get dressed, just putting on the first outfit I saw, and not checking in the mirror for ages. | |
| Clinician | Would other important people — friends or family — know that a miracle has happened? What would they notice? | *Aim to develop as realistic and concrete picture as possible, as some patients (particularly chronic) will find it extremely difficult to imagine life without an eating disorder. Highlight how significant others may perceive the patient and their difficulties.* |
| Karen | As I walk downstairs, probably the first things my flatmates would notice about me is I look well and happy, I sit down for breakfast and don't rush off for a run. I'm not cold. I would be happy to see my friends and to chat with them and my head wouldn't be so full of thoughts about food and weight. | |
| Clinician | What would happen next? What would your day entail? | *Keeping patient on task.* |
| Karen | I'd be off to a lecture or the library. I'd probably meet friends for lunch or maybe I would be rushing to finish an essay, but I wouldn't be really stressed about my work like I was before. I guess I would just be living my life and having fun, instead of constantly worrying about the number on the scales and counting calories and so on. | |
| Clinician | OK, so it sounds like you've got a pretty clear picture of how life would be if the miracle happened. I am wondering how close do you think you are to the miracle right now? On a | *Encouraging the patient to rate her progress, and enhancing motivation by demonstrating she is part way there.* |

| | | Aim and principles underlying intervention |
|---|---|---|
| | scale of 0–10, if 10 equalled the miracle, where would you put yourself? | |
| Karen | Not very close, I feel like my anorexia is ruling my life, I'm still living at my dad's and I can't get back to university yet. I would say 2. | |
| Clinician | OK, are there any signs that the miracle might be starting to happen? | *Eliciting steps to the miracle and amplifying exceptions.* |
| Karen | Well, I suppose now, there is a bit of me that recognizes I have a problem and I've come to see you to get some help. | |
| Clinician | Yes, that's a good start. So in your miracle, you're back at university, spending time with friends, and not preoccupied with your eating and weight. Can you tell me how your anorexia is going to help you achieve this? | *Highlighting the* cost *of anorexia and the incompatibility with other goals.* |
| Karen | It's not, not at all. My anorexia is the thing that is stopping me from living the life I want. | |
| Clinician | So, having described your miracle – getting back to university and your friends, being free from obsessions about food and weight – how do you feel about change now? | *Summarizing and encouraging patient to move from precontemplation to contemplation phase.* |
| Karen | I want my miracle. I want to get better. It's going to be really hard work and I'm not sure if I can do it, but now I see how my life could be different. | |
| Clinician | So, what would be the first steps you would need to undertake, to move to, say a 3 or 4, on the path to the miracle? | *Achievable goal setting.* |
| Karen | Well, I've got to keep coming here. I guess I should try to follow the eating plan and to keep my food diaries. | *Patient moves to action phase.* |
| Clinician | That's great. For homework, would you be able to write up your miracle, and some of the beginning steps you need to take to get there – like you have just said? | *Reinforcing the session content.* |
| Karen | Yes. | |

As demonstrated above, the miracle question enables the patient to move away from their problems, and to explore where they would like to be. It amplifies exceptions to the problem, and highlights positive indicators that demonstrate the miracle might have started. This can give the patient hope that they can achieve their ''full'' miracle. Asking the patient to rate where they are on the way to the miracle allows for future subjective evaluation of progress. The miracle question can be particularly valuable when working with those with chronic eating disorders, who often are focused on the present and cannot imagine a future.

### 6.2.4 Motivation as a moving target

A note of caution should be added at this point. A patient's motivation can vary, often dramatically, across the course of treatment. We frequently see such changes even within an individual session. An example of this might be the patient with bulimia nervosa who reports a high level of motivation of change at the start of treatment, but who becomes resistant once there is discussion of the idea of introducing previously avoided foods. Geller and colleagues (Geller, 2002) have demonstrated that clinicians are poor at judging motivation early in treatment, tending therefore to overestimate the likely benefits of therapy. Thus, although it is important to evaluate motivation at the start of treatment, it can be unproductive to spend too much time trying to assess it as if it were a fixed entity. It is more useful to agree on a means of assessment that makes sense for the patient, and to focus on those events (inside and outside therapy) that enhance or reduce motivation. For example, we often ask the patient to monitor the volume/influence of their ''eating disorder voice'' (e.g., ''I am fat''; ''I need to lose weight''). As with many beliefs and emotions in the patient's private world, a CBT approach allows us to conceptualize motivation for change as an explicit and observable phenomenon, thus making it more accessible to negotiation, ultimately decreasing its power as a negative influence.

## 6.3 Tools and techniques to enhance motivation

We present here an overview of methods that we have found useful, drawn from the eating disorder literature, from the broader literature and from our own experience. To be effective, motivational enhancement must address the following themes. The patient needs to be enabled to:

- get a sense of their potential for change, through examining personal resources
- consider both the advantages and the disadvantages of their behaviors, both in the short term and in the long term

- reflect on where they are now, where they want to be in the future and whether the difference can be addressed through the use of their current strategies (particularly eating behaviors).

In selecting an appropriate motivational technique for a patient, a number of issues need to be considered, including stage of change, broad life circumstances, flexibility of thinking (which can be compromised if the patient is severely malnourished) and severity of illness. For less severe patients (often those with bulimia nervosa) who are maintaining friendships, work and relationships, the more straightforward "Problems and Goals" technique can be sufficient. For cases with greater severity or ambivalence, a more thorough exploration is likely to be necessary (e.g., using the miracle question, friend or foe letters, or looking five years into the future – see below). Such patients are likely to need the help of the clinician to begin to imagine life without an eating disorder, particularly if they have been ill for a significant time. The benefit of these latter approaches is they enable patient and clinician to acknowledge some of the positives of the eating disorder, and can reassure the patient that the aim of treatment is not to change them completely.

Change of any sort is difficult because you have to tolerate a reasonable amount of discomfort in the short-term in order to reap the longer-term benefits. Changing an eating disorder is particularly difficult, because one of its functions is to help you not to think about a lot of things you will need to focus on in our sessions to help you recover. Therefore, it is important that we spend some time thinking about what changes you would like to make and why. Even if you already feel this is clear in your head, it is still an important exercise to do because parts of treatment will be harder than others. Having your goals and your reasons for trying to achieve them written down in black and white will help you to boost your motivation during those times.

We have found the following strategies useful.

### 6.3.1 Friend or foe letters

This technique (Serpell & Treasure, 2002; Serpell *et al.*, 1999) involves asking the patient to write two letters: one to their eating disorder as a friend, and one to their eating disorder as an enemy. Writing such letters can enhance motivation by allowing the client to reflect on the downside of their eating disorder and even getting angry at it. They can also encourage the working alliance, as the clinician acknowledges the aspects of the eating disorder that are valued by the patients. Table 6.2 gives examples of this sort of letter.

The letters can then be explored further, including the emotions that may have arisen during the writing. Often, themes such as physical impact, guardianship and loss are evident in the letters. Personalizing an eating disorder in this way

**Table 6.2.** Examples of "friend and foe" letters

Think about how your anorexia/bulimia affects you. Write a letter to your anorexia as a friend, and a letter to anorexia as your enemy.

Dear anorexia my friend,

You are the only one who really understands me and makes me feel secure. When my mother died, you were the one that was there for me. You helped me get through it when everyone around me was cracking up. When I had to start at that new school, you befriended me, when I felt left out. The other girls didn't matter anymore. You make me feel good knowing I have more willpower and strength than others. I started to get respect and compliments from others. You help me to know what I should do, you make life secure and safe. Anorexia, you help me to keep looking good, even when I don't have the energy, you drive me to keep going. I can always rely on you to be there.

Yours,
Karen

Dear anorexia my enemy,

You pretend to be my friend, but you have ruined all my other friendships, relationships, work and stopped me from having a life. I have given up everything I enjoy. You have been with me for seven years now and in that time I have lost so much. I used to be happy and carefree and looking forward to life. You have left me lonely and isolated. I had to drop out of university because I couldn't concentrate on work anymore and the doctors said I was too ill to stay. You are nothing but a bully and a liar. You say you will keep me safe, but why did I end up in hospital? You have caused me so many arguments with my family. You are constantly criticizing me and telling me I am not good enough. You have left me ill, I haven't had a period for ages, and my hair is falling out. I am always tired and cold. You say I look good, but in my stronger moments, I know that is a lie too. Anorexia, you are not my friend, you are my enemy. You sneaked into my life when mum died, and I was vulnerable, but I don't want you anymore.

Karen

can sometimes lead to the generation of strong emotions, particularly anger, which we have found to be an extremely potent motivating factor. The letters can be used to develop the "pros and cons" list (see below).

### 6.3.2 Life plans

Patients with eating disorders expend a lot of energy in surviving day to day. It takes an enormous amount of physical and emotional stamina to maintain a restrictive eating pattern and then to endure repeated cycles of bingeing and purging behavior. Therefore, the patient's focus tends to be on the here and now, making a consideration of the short-term advantages of their behaviors much easier than a consideration of the longer-term consequences (see below). This latter consideration is necessary if the patient is going to develop and maintain the motivation to change behavior.

In order to help the patient to think more broadly, we will ask them to prepare a "life plan" to evaluate the viability of change to meet their goals, given their current coping strategies. To do this, we:

1. Ask the patient to consider where they want to be in a year in terms of the following areas: family, intimate relationships, friends, career, health, personal development/leisure/hobbies and self-esteem.
2. Ask the patient to predict how things will be in each of the above areas of their life if they are unable to resolve their eating disorder.
3. Ask them to repeat this exercise for five and ten years' time.
4. Ask the patient to summarize their thoughts and feelings about doing this exercise.

The future-oriented nature of this task will make it difficult for some patients. Therefore, although it can be set for homework, in some cases it will be more appropriate to begin it in the session. This task can also be introduced after the miracle question, with the aim of firming up the patient's miracle and explicitly appraising how the eating disorder is going to impact on the miracle.

### 6.3.3 Writing to oneself in the future

In order to develop life plans, many patients find the following exercise useful. We ask the patient to imagine themselves in the future, and to consider their life retrospectively. This is best done twice:

- considering the way that life has improved without the eating disorder and the work needed to get over the eating disorder
- considering life as having remained the same, with the eating disorder.

The following is an example of a letter that can serve as an example for the patient who finds it hard to envisage such change.

Dear Karen

I'm writing this from the future to let you know how I am now. I finished my treatment for anorexia five years ago. Although there have been ups and downs, I do feel a lot better and stronger now. As I always wanted to I have got my own flat – it is a one bedroom flat and I have spent a lot of time decorating it. I am now back at university and finishing my degree in archeology – it was good to finally get back to that. I have a boyfriend who is kind and funny and helps me when I feel down. I also have a good group of friends and enjoy socializing – something I never thought I would do. I am slowly learning to accept myself at a healthy weight.

How are you now? I remember how the anorexia used to be the one thing I could control, that no one could take away. Losing weight was the one thing I was better at than everybody else. I thought I had found the answer. Then it just got harder and harder. Are you still struggling to reach your ideal weight, and never happy no matter how much you lose? I remember how I was

always so tired and cold and my joints hurt. Everybody was worried about me but I couldn't understand why. I had to drop out of university as well.

Getting better took so much hard work and time. Some days I wanted to give up. But I reminded myself how I wanted my life to be like, and with support from others, I managed to keep going. Try to remember to take small steps, and to take every day as it comes,

Love
Karen

In contrast, Sarah (a 24-year-old with bulimia nervosa, purging subtype) wrote the following letter, imagining that she had not resolved her eating disorder.

Dear Sarah

I am writing to you five years from the future. Life is pretty miserable. I am still bingeing and vomiting, although it has got worse. I look terrible, partly because of all the vomiting and partly because I feel so low I cannot be bothered. I don't have much energy, and seem to spend all my time worrying about my eating and weight. I don't see my friends as much, because I tend to avoid restaurants and food-related occasions. Jonathon left me about three years ago – he couldn't take my moods anymore or the constant reassurance seeking about my weight. Sometimes I am happy and forget about my bulimia, but that never lasts long. I've started drinking in the evenings by myself now – I know it's not good but at least I get a break from thinking about food and weight. Sarah, please do something about your eating disorder now, I wish I had.

Yours truly, Sarah

### 6.3.4 Pros and cons of change

Extending the methods outlined above for assessing the pros and cons of having an eating disorder, this is one of the most powerful tools in helping patients to understand the potential value of change. The patient makes a list of the advantages and disadvantages of staying the same or changing. The following is an example of a list prepared by Sarah (the bulimic patient in the previous example letter):

| | Pros | Cons |
|---|---|---|
| **Staying the same** | • Relieves stress<br>• Helps me to control my weight if I'm careful enough | • Damage to my body<br>• Mood swings |
| **Changing** | • Improve relationship with boyfriend<br>• Think about food normally | • I won't be able to cope with my feelings<br>• I will have to cope by myself |

Sarah was then asked to divide those items into those that are short term versus long term:

| | | Pros | Cons |
|---|---|---|---|
| **Staying the same** | Short term | • Relieves stress<br>• Helps to control my weight now (but this might not work as a long-term weight control method) | • Mood swings<br>• I won't be able to cope with my feelings |
| | Long term | | • Damage to my body<br>• Mood swings |
| **Changing** | Short term | • Improve relationship with boyfriend<br>• Think about food normally | • It will be scary to change in the short term |
| | Long term | • I could learn a more effective way to cope with feelings | |

Our patients usually find that most of the advantages of maintaining the eating disorder are successful on a short-term basis only (e.g., immediate blocking of feelings, comfort). In the long term, staying the same is unlikely to help, and may lead to feeling worse.

### 6.3.5 Problems and goals

Patients often find that they have lost perspective on what they would like to be different about their lives, and how that might be achieved through use of long-term strategies and planning towards concrete goals. Drawing up a list of problems and goals helps the patient to consider and clarify what aspects of their life they would like to change (Cooper *et al.*, 2000), and to plan specific targets for change. For example, taking Sarah's case again:

| Problems | Goals |
|---|---|
| Binge eating – I hate the loss of control and the secrecy | To stop bingeing and eat normally<br>To understand why I keep bingeing |
| Vomiting – my throat hurts and I feel exhausted all the time | To cut down the urge to binge<br>To stop vomiting |
| Dividing food into safe and unsafe foods, only comfortable eating safe foods, and avoiding "junk" foods and food I used to enjoy | To eat a normal diet, which is a mix of healthy and less healthy foods, without worrying<br>To start eating avoided foods, including takeaway |

| Problems | Goals |
|---|---|
| Checking my thighs many times a day | To stop body checking<br>To be less concerned with my shape and weight |
| Judging myself as a success or a failure depending on whether I've gained or lost weight | To gain a more realistic perspective and to experience achievement through other means (e.g., relationships, career) |
| To get my life back (hobbies, family, friends) | Rejoin my netball team (for healthy, social activity)<br>Make an effort to improve relationships with family and friends |

### 6.3.6 Developing and using a summary flashcard

Throughout the motivational enhancement process, we ask the patient to summarize their thoughts and feelings about the experience of doing these tasks and the conclusions that are reached. We ask them to put the summary on a flashcard (updated as necessary), which can be accessed readily. This allows them to reflect on the process and to make an informed choice about how they wish to proceed. It also provides an accessible motivational enhancement tool for later in therapy, as and when the patient hits internal and external obstacles that threaten to undermine the change process.

## 6.4 Trouble-shooting: common problems in motivational analysis and enhancement

As mentioned earlier, a patient's motivation for change will fluctuate during treatment, particularly when attempting to give up more egosyntonic behaviors. Motivation needs to be reviewed on a regular basis, and frequent "booster" sessions of motivational enhancement may be required.

### 6.4.1 Addressing fluctuations in motivation

As a first step, when the patient describes their motivation as waning (e.g., reporting that the eating disorder "voice" is starting to exert a stronger influence on thoughts, feelings and behaviors – see below), we jointly review the motivational work done to date. We also find it useful jointly to review the goals set at the beginning of treatment and acknowledge the steps the patient has already taken. Some patients expect that they should have achieved their goals immediately, and we find it useful to draw on the patient's personal experiences of helping others to learn something new. For example:

When you teach people to swim, do you expect them to be able to do it straight away? How do you react if they can't do it immediately? Does getting angry with them help them learn it faster?

Most patients are then able to reflect that it is normal to find it difficult to learn something new, particularly when it is of high emotional content.

### 6.4.2 Pros and cons of the change process

A further technique that we find useful is to extend the pros and cons matrix developed at the beginning of the motivation process (see above). As before, we use the whiteboard to draw rows denoting pros and cons or the change process. However, three columns are used: ''Before/start of treatment,'' ''Now'' and ''Future.'' This is started in the session and extended as homework. As an example: Kate has been in treatment for six months. At the start of treatment she was bingeing and purging, and her BMI was 15.1. During treatment, she finally lost her job due to her eating disorder. She has managed to instigate a routine of 2–3 meals a day. Her weight has increased to a BMI of 16.8, but eating is a constant struggle and she feels unable to work on further weight gain.

| | | Aims and principles underlying interventions |
|---|---|---|
| Clinician: | Kate, today we have been talking about how stuck you're feeling at this point in your treatment. If I understand you correctly, you have made some changes, such as gaining some weight and introducing regular meals, but you are struggling to move forwards. Some of the time, you wonder whether it would be better to go back to how things used to be. | *Summarizing and reflecting the patient's position* |
| Kate: | Yes, at least before, I felt that I was in control. | |
| C: | I'm wondering if things actually feel worse now? | *Empathizing with the patient* |
| K: | Yes. | |
| C: | At the moment, you're stuck in a very difficult position, not knowing whether to go forward or backwards. Can you remember back to the beginning of treatment, we made a list of your pros and cons of change? | *Linking current situation to past* |
| K: | Yes. | |
| C: | I'd like to do something similar to that except reflecting where you are now. How does that sound? | *Checking acceptability with patient* |
| K: | OK. | |

The clinician draws a table with two rows marked ''pros'' and ''cons,'' and three columns, ''before,'' ''now'' and ''after.'' In a similar process to the original pros and cons task, clinician and patient collaboratively complete the table (see Table 6.3). It may be useful to have the original task available to encourage

**Table 6.3.** Kate's pros and cons of the change process

| | Before | Now | Future |
|---|---|---|---|
| Pros | Happy with my weight<br>Didn't have to think about problems<br>Felt in control | More insight into my difficulties<br>Sometimes I feel a bit better<br>Stopped bingeing<br>Stopped laxatives<br>Less tired<br>Haven't fainted recently | Get rid of my eating disorder and get my life back<br>Be normal around food<br>Get a job that I enjoy<br>Feel in control in a way that I can enjoy<br>No preoccupation with eating, shape and weight<br>Healthy enough to go to dance classes |
| Cons | I was always tired<br>Bingeing – felt disgusting<br>Using laxatives – really hurt<br>Always worried about gaining weight<br>Arguments with my family<br>Stopped seeing friends<br>Wasn't allowed to dance anymore | I finally lost my job<br>Can't stand the way I look<br>My family are on my back all the time about "looking well," and pressuring me to eat even more<br>Closer to relapse here | Still need to gain some weight<br>Have to decide about going to university after all |

reflection on how the pros or cons may have changed; for example, Kate was able to reflect that although at the time of the original task she thought she was in control of her eating, with hindsight she realizes this is not the case.

The bold line is added in order to make the point that staying at the current position is likely to be very difficult, and the dotted lines indicate the "permeability" of the position. In other words, trying to be "a bit anorexic" is not tenable, and one can either go forward to positive change (which is hard but potentially rewarding) or retreat to the original anorexic position (which may appear initially more attractive, but is ultimately frustrating). This helps patients to escape from the black and white thinking of "I have achieved nothing" versus "I am totally cured" – a critical change in thinking, as it means that the patient can see that they have benefited from their efforts, but still has a way to go to get to a point where they are stable and happy. We find that this encourages patients to see the benefits of making the final changes needed.

Using Socratic questioning, Kate was able to explore the list. She realized that although she *feels* stuck, she has made significant steps. She was also able to reflect that she has a tendency to idealize the past, thinking "If only I were losing weight,

all my problems would disappear.'' She noted that whilst the length of the list of cons gradually reduced the further she moved to the future, the list of pros gradually increased. It was noted that the ''Now'' column was in fact the most balanced, reflecting Kate's sense of ''stuckness'' and her struggle to move forwards. Kate and the clinician then explored the potential costs and benefits of further change and remaining static:

| | | Underlying aims and principles of intervention |
|---|---|---|
| Clinician: | We've been discussing how most of your pros are in the ''now'' and ''future'' column and most of the cons are in the ''now'' and ''before'' column. Looking at your ''Now'' pro box, I'm wondering if you want to keep those things in the future, for example to remain binge and laxative free? | *Summarizing and highlighting new information* |
| Kate: | Yes | |
| C: | I'm going to erase this line here *(between ''now'' and ''future'')* and thicken this line here *(between ''now'' and ''before'')* to show this change. So you have started this process of moving towards the future. (*Exploration is continued for the ''cons'' row)* | *Clarifying on the diagram* |
| K: | Seeing it written down makes it easier to remember why I am doing this. I don't want to stay where I am because that means that I am closer to getting ill again and I don't want that. | |
| C: | What you're saying is that you can't stay in the middle, because that puts you at risk of going backwards. It's the most difficult place to be. | *Making the link that you cannot be ''part anorexic''* |
| K: | Yes and although I do feel a bit better than I did, I know that I can't stay here, because I want to get on with my life – get another job and be more independent of my family. | |

### 6.4.3 Letting go of the eating disorder

Earlier, we noted that many patients see the eating disorder as being a friend or as part of their identity. This can become an issue later in therapy, as the patient seems to find it hard to give up on that relationship. A patient may make clinically and personally significant changes over the course of treatment (e.g., improved mood, getting a job, re-establishing friendships, improved self-esteem, some

weight gain, improvement in eating), but still regard themselves as anorexic or bulimic. This case of black and white thinking will make it hard to make the final changes in behavioral and cognitive symptoms.

Using Socratic questioning, the patient can be asked to outline the positive changes that they have made. The clinician can then ask: "Given all these changes, I am wondering why you are still holding onto the eating disorder? What purpose is it serving for you now?" A common answer is that the patient cannot imagine life without the eating disorder (seeing it either as a friend or as an integral part of their identity). The following is one way of exploring this belief, through developing continuum thinking to replace black and white thinking.

A line is drawn on the whiteboard, with the left end marked "Me with the eating disorder" and the right end marked "Me without the eating disorder" (see Figure 6.1). The patient is then asked to define or describe how they know that they have the eating disorder (how do they feel, what do they do, etc.), and this list is added to the left end of the line. The clinician then asks if there are any times (no matter how small) when the patient does not notice or feel as if they have the

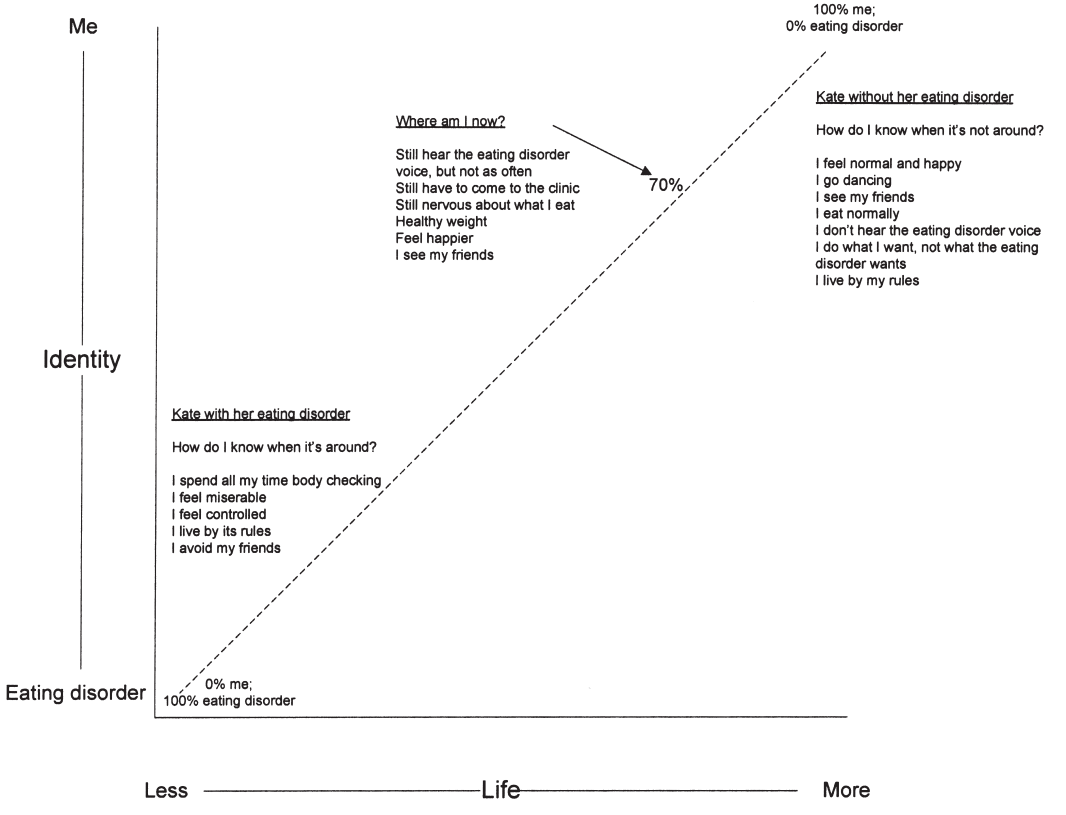



Figure 6.1 Do I need my eating disorder?

eating disorder (e.g., when out with friends and having fun). Gradually, a picture of what life could be like without the eating disorder is developed and added to the right side of the graph. The patient is then asked to give a percentage split of times when they are or are not eating-disordered, and to place a mark on the line to show where they see themselves lying on that continuum at present.

To move closer to the non-eating disordered end of the line, the patient is asked to identify the times when they still feel their eating disorder is noticeable, so that they can consider strategies to overcome this (e.g., if they still experience an "anorexic voice" on occasions, they might need to develop cognitive challenges to the authority of that voice). The aim of this intervention is to encourage the patient to reflect on the increasingly small role that their eating disorder takes and to consider whether, in actual fact, they can imagine themselves as an individual with an identity without the eating disorder.

### 6.4.4 When the patient is not ready to change

Sometimes, we work with a patient who is not yet ready to change their eating behaviors, or one who can make some changes but cannot achieve complete symptom reduction. This might be because there are practical blockages to treatment (e.g., being in an abusive relationship that they are not yet ready to leave, receiving priority medical treatment), or because they are locked in a preaction stage of change. In order to avoid damaging the possibility of future therapeutic rapport, it is important to ensure that our response to such patients is not dismissive or hostile. Rather, we acknowledge that the patient has come as far as they can *at this stage*, and instead might benefit from an approach that focuses on maximizing quality of life while living safely with the eating disorder. We do this in the context of acknowledging that the patient might need to live longer with the consequences of their behaviors before they are able to shift from a short- to long-term view that is necessary in developing readiness to change. We have found the analogy below useful when discussing this with patients:

**The itchy jumper**

Your eating disorder is like a jumper. When you first put it on, it keeps you nice and warm. However, it is not a "top of the range" jumper, and so after a while starts to get a bit itchy and irritating. Sometimes you might feel like taking it off, but you know that if you do you will be cold, so you put up with the itchiness. With time, however, the itchiness gets harder and harder to tolerate. It gets more and more uncomfortable, and although the jumper still keeps you warm you start to think whether there might be better ways of keeping yourself warm.

If you decide the time has come to take off your jumper it is important first to explore the other ways that you might be able to keep yourself warm *(planning stage within Stages of*

*Change model)*. However, if you are going to go down that line, at some point you will have to take the itchy jumper off and be cold for a period while you try out some other ways of keeping warm. This might feel more uncomfortable in the short term, but in the longer term it will allow you to keep warm in an itch-free way.

If you do not feel able to change your eating behaviors at present, this might be because your jumper has not yet become itchy enough for you to want to risk being cold. If this is the case, you might need to continue wearing your jumper for a bit longer. At the same time, however, it could be helpful to explore other ways that can keep you warm, maybe ones that you can practice whilst still wearing your itchy jumper.

7

# A guide to important dietary and nutritional issues

All clinicians working in eating disorders need to have a basic knowledge of food and dietary needs, since an altered food intake is the primary symptom of all these disorders, and developing a regular pattern of eating is a key behavioral goal of treatment. Although many patients claim to have a good dietary knowledge, the majority do not, and beliefs that they do have may be seen through "eating disordered spectacles" (i.e., based on their eating disorder rather than on healthy eating principles). In most cases, it is not necessary for patients to see a specialist dietitian for the basic dietary advice needed to effect recovery. However, there are important exceptions to this rule, which will be covered later on. We recommend that clinicians working with eating disorders should have access to a dietitian to be able to discuss cases and nutritional issues, as well as to refer patients to when necessary.

## 7.1 What food is used for in the eating disorders

The development of an eating disorder involves a movement away from food being used mainly for positive reasons (e.g., pleasure, maintenance of physical health) to it being used much more for avoidance of negative experiences (e.g., coping with emotional problems). This can be conceptualized by describing a hunger continuum with physical hunger and emotional hunger being the two extremes. In today's Western society, even those who do not have an eating disorder eat for emotional and habitual reasons (e.g., eating because of boredom, or going to the cinema and having popcorn because that is the normal thing to do), as well as due to pure hunger. However, for most people most of the time, the main drive to eat is physical hunger. In comparison, the motivation to eat/not to eat in people with an eating disorder would tend to swing much further towards the emotional hunger end of the spectrum. Therefore the goal of eating disorder treatment is to bring the motivation more towards the physical end of the

continuum during treatment (perhaps even more towards physical hunger than the general population) because of the effect the eating disorder has had on the patient's ability to regulate their food intake as a physical reflex, as described below.

In the eating disorders, the physical drive to eat is ignored or avoided to the point where patients find it hard to identify what real hunger feels like. For example, in conditions of low weight, there is delayed gastric emptying, meaning that it takes much longer for food to pass from the stomach to the small intestine (around four hours rather than two in normal weight people), where the absorption of nutrients takes place. This results in patients feeling uncomfortably full on very small amounts of food but is part of the normal response to semi-starvation, and greatly improves after a few weeks of regular eating. Similarly, there is evidence that a period of being at a low weight temporarily alters normal physiological recognition of hunger and satiety even after returning to a normal weight (e.g., a tendency to binge-eat following anorexia nervosa). In addition, emotional states have an effect on hunger (e.g., feeling anxious leading to a suppression of hunger due to the fight or flight response, or increased "emotional" hunger in response to negative feelings). Combined with physical alterations to hunger, such disturbances mean that patients often really struggle to know when to eat and how much to eat, even if they are well motivated to do so.

Therefore, it is unrealistic to expect patients to just switch back to normal eating without some guidance and advice, and it is the aim of this section to give non-nutritionally trained clinicians the basic knowledge and background skills to be able to help the patient improve their food intake and relationship with food.

## 7.2 A beginner's guide to nutrition: what clinicians and patients need to know

This section aims to give a very basic overview of nutrition principles. It does not replace the individualized advice a dietitian may give a patient, but does give some basic information on the principles and application of dietetic principles.

It is important to remember that all foods are a mixture of nutrients (e.g., bread is primarily a carbohydrate, but contains protein, fiber, minerals and a very small amount of fat). Therefore, foods should not be viewed as "good" or "bad" and although it can be difficult to avoid common misconceptions, it is important for the clinician to avoid defining foods in this way.

There are seven core nutrients, which are mixed differently in different foods:

- Protein
- Carbohydrates
- Fats

} The groups that provide energy (see psychoeducation leaflets for further information about these)

- Minerals
- Vitamins
- Dietary fiber
- Water (not officially a nutrient, but still essential for life)

Many patients have misconceptions and/or have been given inappropriate information about the core nutrients, especially the energy providing ones (carbohydrate, fat and protein, as well as alcohol, which is discussed later on), and it is important to provide relevant psychoeducation to help the patient rectify these inappropriate beliefs. However, since all foods are a mixture of nutrients it is more practically useful to discuss food groups with patients, as described next.

Foods that have a similar nutrient mixture are grouped into one of the five food groups, which form the basis of the format for current healthy eating guidelines. There are various ways in which a "healthy" diet can be represented, and this is the one used in the UK (The Balance of Good Health. Reproduced with permission from the UK Health Education Authority, 1994 — see Figure 7.1 for the diagrammatic version):

- Bread, cereals and potatoes
- Meat, fish and alternatives
- Milk and dairy products (as well as some fortified soya products)
- Fruits and vegetables
- Foods containing fat, foods containing sugar.

We separate the "foods containing fat and foods containing sugar" group into two further sections:

- *Essential fats*. These provide essential fatty acids and vitamins (e.g., vitamins D and E), which are necessary for health (see psychoeducation leaflets for further information) and need to be eaten on a daily basis.
- *Luxury items or "fun foods"* (e.g., chocolate, cake, rich desserts). These do not provide any nutrients that other food groups cannot provide, but can be eaten as part of a healthy diet if eaten in moderation and in the context of a diet that provides all other nutrients. To recover fully, patients need to be able to consume these foods in normal quantities as part of a healthy diet. However, it is important to address other aspects of the diet before this, so that the patient's diet improves generally and they develop more confidence about how their body utilizes food.

Figure 7.1 Healthy eating schematic. Note that whilst this diagram displays the proportion of food groups needed in the diet, it is important to recognize that it is not what each plate of food should look like.

Table 7.1 shows examples of foods and the food groups to which they belong. Of course, the key task is to take this knowledge and to turn it into meaningful meal plans that the patient can use, which we will discuss now.

## 7.3 What should a basic meal plan look like?

The following points all refer to the relevant dietary aspects for patients with eating disorders. There needs to be a different angle to the dietary advice given to our clients compared to the messages that the general population receive. The focus for the general population needs to relate to the higher risk of health problems secondary to consumption of high-fat, high-sugar, low-fiber diets in combination with a low activity level (obesity, cardiovascular disease, diabetes, some forms of cancer, etc.). These messages to reduce fat, increase fruit and vegetable intake and increase activity levels can be misread or taken to extremes by eating disorder patients. The focus of our work needs to be in bringing relevant food intake up to a normal/appropriate level (i.e., starchy carbohydrates, proteins, fats, dairy foods and the inclusion of normal amounts of luxury items like cake), whilst ensuring that the intake of fruit and vegetables does not replace other vital food groups and that activity levels are not unnecessarily excessive.

The standard meal structure that we use is shown in Figure 7.2, and should be copied for patients to work from (substituting for brands as appropriate in different countries). It is based on a more transdiagnostic approach to dietary

**Table 7.1.** Examples of different foods and the food groups to which they belong

| | Bread, other cereals and potatoes | Meat, fish and alternatives | Milk and dairy foods | Fruit and vegetables | Fats important for health | Foods containing fat/sugar |
|---|---|---|---|---|---|---|
| **What food is included?** | Bread and crackers | Meat | Milk | Fresh, frozen and canned fruit and vegetables, and dried fruit | Margarine | Chocolate |
| | Pasta and couscous | Fish (white and oily) | Cheese | | Butter | Crisps |
| | Rice | Poultry | Yoghurt | A glass of fruit juice counts once per day | Oils | Sweets |
| | Potatoes | Meat products (e.g., sausages) | Fromage frais | | Oily salad dressing (mainly from polyunsaturated or monounsaturated sources, not saturated) | Pastries |
| | Breakfast cereals | Fish products (e.g., fish fingers) | Calcium-enriched soya products | | | Cakes |
| | Cracked wheat (bulgar) | Eggs | | | | Rich puddings |
| | Oats | Lentils and pulses (e.g., kidney beans, baked beans) | | | | Sugar added to foods |
| | Plain biscuits (e.g., crackers) | Vegetarian products (e.g., Quorn, tofu) | | | | |
| | | Nuts and seeds | | | | |

Table 7.1. (*Cont.*)

| | Bread, other cereals and potatoes | Meat, fish and alternatives | Milk and dairy foods | Fruit and vegetables | Fats important for health | Foods containing fat/sugar |
|---|---|---|---|---|---|---|
| **Main nutrients they provide** | Carbohydrate (starch)<br>Dietary fiber<br><br>Some calcium and iron<br>B vitamins | Protein<br>Iron<br>B vitamins, especially<br><br>B12<br>Zinc<br>Magnesium | Calcium<br>Protein<br>Vitamin B12<br><br>Vitamins A and D | Vitamin C<br>Carotenes (a form of vitamin A)<br><br>Folate<br>Dietary fiber<br>Some carbohydrate | Fats<br>Vitamins D and E<br><br>Essential fatty acids | Mainly provide fat and sugar, but many contain other nutrients |
| **How much to choose** | Should be eaten every 3–4 hours, to include a good portion at each meal, plus at some snacks | Most people need 2 portions per day, although some need three | Most people need three portions per day | Five portions per day | Small portion (such as 2–3 teaspoons) at most meals, but especially lunch and dinner | Most "normal eaters" consume 1–3 portions per day |

**Basic Eating Plan**

This plan is a simple menu guide for one day, but can be used as a guide for eating over a longer period. It is important that you eat all the carbohydrate foods *in italics*.
Whole grain and higher fiber types may satisfy hunger better.

The difference in amounts relates to people's differing energy needs. Over time, you will be better able to judge the amounts you need, but to start with you are advised to follow the plan fairly precisely. The asterisks show where other foods can be substituted (see opposite for appropriate replacements).

| | |
|---|---|
| **Daily** | 200-300mls (1/3 – ½ pint) of milk for teas and coffees |
| **Breakfast** | Fruit juice or fruit<br>*6 tablespoons of breakfast cereal (30 – 50g)* * with milk/yoghurt<br>*1-2 large slices of bread* ** with butter/margarine and jam or similar |
| **Mid morning** | 1 portion fresh fruit / 2 plain biscuits (e.g. Rich Tea, Digestive), or similar |
| **Lunch** | *2-4 large slices of bread* **<br>Meat/fish/cheese/pulses/beans/nuts/seeds or eggs<br>Vegetables or salad<br>**Dessert** – 1 carton of yoghurt (not diet) and a portion of fruit |
| **Mid afternoon** | 1 portion of fresh fruit / 2 plain biscuits/ a cereal bar / scone / teacake |
| **Dinner** | Meat/fish/cheese/pulses/beans/nuts/seeds or eggs<br>*2-4 large slices of bread* **<br>Vegetables or salad<br>**Dessert** *** |
| **Supper** | *1-2 slices of bread*/ *crumpet*/ *muffin* with butter/margarine or *2 plain biscuits*, plus a milky drink |

An adequate amount of fluids is between 1.5-2 litres (8-10 cups) drunk throughout the day.

Figure 7.2 Basic eating plan.

**Substitutions**

Lunch and evening meals may be interchanged, as may items themselves, although the format of the meals should remain as shown. The list below gives alternatives to the foods marked with asterisks, and you can substitute the appropriate quantities as you wish. Aim for a variety of foods in your eating plan to help you achieve a balanced diet.

| | |
|---|---|
| **Cereal *** | 6 tablespoons of breakfast cereal<br>30g / 1oz of lighter cereals e.g. Rice Krispies / Special K<br>50g / 2oz of heavier cereals e.g. muesli, Bran Flakes etc.<br>2 Weetabix / Shredded Wheat |
| **2 large slices of bread** ** | 3 small slices of bread<br>1 large / 2 small bread rolls / 1 bagel<br>50-75g (2-3oz) rice, pasta, couscous (dry weight)<br>4-5 egg sized potatoes / 3 small roast potatoes / 18 small chips<br>200 – 250g jacket potato<br>2 scoops / 3 heaped tablespoons mashed potato<br>120g / 4oz pizza |
| **Dessert ideas *** ** | Small slice of cake<br>Small tin of rice pudding / Individual dessert (not diet types)<br>50g chocolate bar<br>2 scoops ice cream |

Figure 7.2. (*cont.*)

prescription, centering on the principle that we are moving towards a dietary intake that minimizes the risk of losing control of food intake through consuming a diet that is eaten regularly throughout the day and is based on a wide variety of foods. So, the principles for dietary prescription are basically the same regardless of whether you are working with patients with anorexia nervosa, bulimia nervosa or binge eating disorder.

Having begun by outlining the meal plan (Figure 7.2), we go on to explain its different components (meals and snacks).

### 7.3.1 Meals

As stated above, the three meals are an integral part of any meal plan, and time should be spent helping the patient develop appropriate and sustaining meals. Table 7.2 gives the basic construction of each meal, and more is given on each food group below.

We advise that each main meal (midday and evening meal) should consist of two courses (e.g., main course and dessert). Breakfast would also ideally be two courses, such as toast and cereal, but this guideline is less rigid.

### 7.3.2 Snacks

While most patients can accept that they need three meals a day, many struggle with the fact that snacks form an important part of their diet. This can be for many reasons. For example, they might have grown up in a family that did not allow snacks, or they might associate snacking with losing control through bingeing or gaining weight. It is worth spending some time discussing the patient's view of snacks, and if they have reservations about them these need to be discussed. However, it is the exception rather than the rule that snacks are not needed, as most people need to have one to three planned snacks a day. The exceptions are

**Table 7.2.** Schematic construction of individual meals

| Breakfast | Lunch and evening meal |
|---|---|
| • Starchy carbohydrate | • Starchy carbohydrate |
| • Calcium food | • Protein |
| • Fruit or vegetables | • Fat |
| • Protein (optional) | • Fruit or vegetables |
| • Fat (optional) | *Dessert* |
| | • Calcium food |
| | • Dessert/fun food |

those people of very slight build who fall at the lower end of the normal range for weight and height (e.g., girls and young women of Asian or Chinese origin). However, it is important to avoid being too rigid with this ''rule,'' as even this group may need to be able to eat more regularly than three times a day.

The type of snack needed will depend on when it falls between meals, how active the person has been since last eating and their actual body weight. For instance, an intense exercise class is likely to increase the person's need for food, whilst someone who weighs 100 kg or more is going to need more to eat over the course of a day than someone who weighs 50 kg. There are two basic principles to work towards:

- If the period between meals is longer than 3–4 hours, blood sugar will start to drop, making the person more hungry and likely to binge. Therefore, a starchy or protein-based snack is needed (e.g., plain biscuits, oatcakes, muesli bar are carbohydrate snacks; protein-based snacks would include a yoghurt or a handful of nuts).
- If the gap between meals is less than 3–4 hours, then fruit or a hot drink would be more suitable.

However, it is important to be guided by what the patient says about how hungry they get, as well as your own knowledge of how hungry you get if you have a long gap between meals, or engage in exercise. It is better to encourage more snacks rather than fewer, as the risk of bingeing is much greater if food intake is below requirement and not adequately spaced out, whereas the risk of weight gain from eating one or two appropriate snacks too many each day is slight (see Chapter 13 for further explanation of this).

It is important not to make the mistake that the patient can avoid a snack at the end of the day. It is a fallacy that food eaten later at night converts to fat and an appropriate snack may well help the patient to sleep better (no-one sleeps well if they are hungry). Many people eat their evening meal relatively early (about 6pm) and then do not go to bed until 11pm or midnight, so are likely to get hungry by then. It is also worth encouraging a snack if the patient drinks alcohol in the evening, especially if dinner is eaten several hours earlier (if at all). This is because alcohol reduces blood sugar, which increases hunger either then or perhaps the next day. However, the other point to note about alcohol is that it reduces impulse control. Thus, if the patient is drinking a lot of alcohol, then the scene is set for a binge later on. Many people recovering from an eating disorder find that they need to avoid alcohol for a while because of this. Alcohol is covered in more detail later (this chapter, Section 7.6.6).

### 7.3.3 Calcium-rich foods

All adults need three portions of calcium-rich foods a day to achieve their daily requirements for this mineral (700 mg). This is to minimize risk to bone health.

That need is accentuated if the patient is at a low weight (BMI < 18.5) or, if female, has had long episodes of not having menstrual periods. Some patients may be prescribed calcium supplements for these reasons, although there is only weak evidence that such supplements are effective. However, these patients' diet should still contain calcium-rich foods, as such a diet also provides other nutrients (and these patients may occasionally forget to take their supplements). Children and adolescents also need more than adults do. Males between 11 and 18 years old need the equivalent of four portions of calcium-rich foods a day, whilst females of this age need 3–4 portions. Breastfeeding also leads to an increase in calcium requirements (a further 550 mg per day, or a further two portions of calcium-rich food). One portion of calcium-rich food (providing 200–250 mg calcium) is as follows:

- 200 ml (1/3 pint) milk (full fat, semi-skimmed or skimmed)
- One average pot of yoghurt (125–150 g)
- 40–50 g cheese
- An average portion of cheese or white sauce made with milk (around 90 g)
- An average portion of tofu (bean curd).

Other foods contain calcium, but the dairy foods are the best source as they contain calcium in a form that is more readily absorbed. If a patient avoids dairy foods for any reason (such as being vegan, or because they have been medically diagnosed as dairy intolerant, or have self-diagnosed themselves), it is important for a dietitian to assess the diet, to make sure the patient is achieving their calcium requirements. This is especially true if they are at a low weight or been amenorrheic for some time. The justification for the avoidance needs to be discussed in depth at the appropriate stage in therapy, as it is possible it is part of the eating disorder.

### 7.3.4 Fruit and vegetables

Most people are aware that healthy eating guidelines recommend consuming five portions of fruit and vegetables each day. However, many people with eating disorders view fruit and vegetables as "safe" and very healthy, which means they can end up eating much more than this, usually to the detriment of other important food groups. This can greatly increase feelings of fullness, especially in lower weight people who have delayed gastric emptying due to semi-starvation, and it can contribute to gastrointestinal bloating, diarrhea in some, constipation in others and wind. An excessive intake of fruit can also increase the risk of dental problems due to the high acid content and relatively high sugar of most fruits. Therefore, it is important to stress that, until the rest of the diet is more balanced, the recommended intake of five pieces per day is the maximum that should be consumed.

Fruit juice is an alternative to fresh fruit (as is dried or tinned fruit), but it is important that it is not consumed excessively, due to its sugar and acid content. People with eating disorders are at a higher risk of dental problems, especially if they vomit, are at a low weight, or both. The acid and sugar in fruit juice can contribute to dental problems, even though it is natural sugar. It is best to consume fruit juice with a meal, because more saliva is secreted after eating, which helps neutralize the acid. Because of its sugar content (around 9 g per 100 ml, compared to cola which is around 11 g per 100 ml) and its low fiber content, fruit juice is counted as fruit only once during each day. Therefore, it only contributes one portion of fruit/vegetables per day to the target of five, regardless of the amount drunk.

### 7.3.5 Traditional desserts/fun foods

Although the priority is to improve the patient's intake of nutritious foods, learning how to include "treats" in the diet is an important step towards recovery. This group includes traditional puddings (like sponge and custard), snack foods (like chocolate bars or crisps) and "junk" foods (like burgers and fries). In the past, such foods were associated with celebrations (e.g., birthday cake), but today they are a normal part of people's diets. Normal eaters typically consume between one and three servings of these foods a day — a level of intake that is in line with healthy eating recommendations.

These foods are important in treating the eating disorders for three reasons. First, the inclusion of this type of food in a diet plan will help prevent overeating or bingeing, because regularly eating a normal amount of them means that the patient is less likely to crave them at other times. Second, consumption of such foods is a part of normal social eating in today's society so needs to be addressed to enable patients to socially integrate with their peers. Finally, for patients who need to gain weight, these foods can be a useful way of adding important calories in an acceptable form. People generally need a lot more calories to gain weight than they originally think, and some will need to eat an unusually high amount of these foods. In this circumstance, supplement drinks might be better. These are high-energy, nutritious drinks, which can be used to supplement the diet of people with a poor appetite. See below for more information about this.

### 7.3.6 Fluid requirements

How much the patient drinks (non-alcoholic beverages) is a further factor that needs to be considered. Many patients do not drink within the recommended range (Hart *et al.*, 2005) for a number of reasons, such as being unable to recognize

their thirst (which may be an extension of the patient's difficulty in recognizing hunger and satiety/fullness due to the physical and psychological effects of the eating disorder) or as a way to manipulate their body (either internally to themselves, such as suppression of hunger, or externally to others, such as manipulation of weight).

Generally, we need to drink 1.5–2 liters of fluids per day, but this can vary greatly with external temperature, humidity, altitude, body weight and surface area, plus activity levels. As a general rule, 30–35 ml per kg body weight will give you a rough guide of how much someone needs to drink (unless requirements are raised, for example in very hot weather). Thus, a person of 50 kg will need to drink 1500–1750 ml a day, whereas someone who weighs 100 kg will need 3–3.5 liters a day. Intakes much higher than this would be indicative of using drinking as an eating-disordered behavior (e.g., drinking to reduce feelings of hunger, or to manipulate weight). At the other end of the spectrum, some patients drink very little, and probably suffer from chronic dehydration. Table 7.3 gives an overview of different problems seen in over- and under-hydration.

Many people have misconceptions about fluids (e.g., only water counts as fluid, caffeinated drinks are dehydrating). However, those beliefs need to be corrected for both clinician and patient. For example, fluids are found in all drinks (including tea and coffee), as well as being present in all foods. Similarly, contrary to popular belief, caffeine is not dehydrating if taken in moderate amounts (Maughan & Griffin, 2003). We advocate that patients should partake of a range of drinks, not just one type. Suitable drinks include (but are not limited to) water,

**Table 7.3.** Impact of imbalance in liquid intake

| Effects of dehydration | Effects of overhydration |
|---|---|
| *Moderate dehydration* can lead to:<br>• Reduced alertness and concentration<br>• Increased tiredness<br>• Reduced ability to make decisions<br>• Reduced reaction times<br>• Headaches and nausea<br>• Constipation<br>• Increased risk of developing renal stones (if already susceptible) | Can lead to very low sodium levels in the blood, which can cause:<br>• Confusion and circulatory problems<br>• Fits, coma and possibly death in extreme cases |
| *Severe dehydration* can lead to all of above, plus:<br>• Heart failure<br>• Kidney failure | |

low-sugar squashes, herbal teas, ordinary tea, coffee, low-sugar fizzy drinks and fruit juice. While there is no need to avoid caffeine, it is wise not to drink large quantities of caffeinated drinks (i.e., ordinary coffee, tea, low-sugar cola drinks, "energy" drinks). We advise patients to minimize their intake of very strong drinks (e.g., espresso). The only limitation that we impose on what liquids can count as fluid intake is that we exclude alcoholic drinks, as alcohol can lead to dehydration.

This list gives approximate quantities of fluid contained in different containers, to facilitate calculation of daily intake:

| | | | |
|---|---|---|---|
| Tea cup/plastic cup | 150–175 ml | Average glass | 150 ml |
| Average mug | 200–250 ml | Tall tumbler | 300 ml |
| Large mug | 300 ml | Carton of juice | 200–250 ml |
| Slim can of drink | 250 ml | Standard can of drink | 330 ml |

## 7.4 Food planning versus counting calories

When discussing food with patients it is very important to avoid using calories to define and label what they need to eat, even if this is the only way the patient can think about and manage their food. Calorie counting is a characteristic of eating disorders and dieting, whereas planning food is a much healthier way to manage intake. There are many reasons why using calories to define food is inappropriate, as outlined by Herrin (2003, p. 78):

- Counting calories is time consuming and difficult to do with accuracy.
- Determination of the calorie needs of specific individuals is inexact.
- Counting calories can become a compulsive behavior.
- If the patient is following a balanced meal plan (as described above), which satisfies their hunger without their becoming overfull, and if their body weight is stable and as expected, then calorie intake can be assumed to be adequate.
- Counting calories does not enable the body to relearn how to regulate food intake through the patient's assessing and responding to hunger and satiety.

There are other reasons against using calories, but a further important one is that counting calories only takes into account energy, not any other nutritional needs such as carbohydrate, protein, fat, vitamins and minerals.

However, it can be appropriate to discuss calories when defining how much more the patient needs to eat to gain weight, or stop losing weight (see Section 7.5.1 below), so long as the patient can relate to this and the clinician explains what this means in real terms (e.g. "On average, your weight is dropping

by around 0.2 kg a week, which means that we need to add around 200 kcal[1] per day to what you are currently eating, for example a cereal bar and a piece of fruit, to stop it dropping further''). Working out how much energy is needed to stop weight loss is described below.

Instead of using calories, the clinician is advised to use the standard meal plan to identify gaps in the patient's food intake (e.g., ''I see that you only ate chicken with vegetables last night, when you also needed a starchy carbohydrate like a jacket potato. This seems to happen fairly frequently, so we need to think about this''). This meal plan provides some different portion sizes, but many patients need more guidance than this (often the lower weight patients). Other patients (often patients with a more impulsive background) can eat more than they need to (for instance, by following the upper portion sizes when they need the lower ones), so may find more specific guidance helpful. Therefore we have included information on normal portion sizes (see Appendix 2) that can be used with patients. These have a range of energy contents (see Table 7.4), but if the patient consumes a variety from each group, this will average out. The information is designed as a guide for the clinician, although the average energy content could be used with a patient as a guide to help them work out how much of a specific food needs to be eaten, so long as the patient can avoid becoming obsessive about getting exactly the ''right'' energy content.

It is worth reiterating to patients that the key to making a healthy diet is to choose a variety of foods. If the lower end of the energy range is always consumed then the person will need to eat more food (e.g., an extra snack) to maintain their weight. Conversely, if the upper end of the energy range is consistently eaten, then weight is likely to be higher than necessary.

## 7.5 Helping patients to improve diet: getting started

All of this probably seems quite straightforward in theory, but what you see in your patient's food diary is likely to be a long way from what we are recommending, especially in the beginning of therapy. Whilst there are no ''gold standards'' for what to address first, below are some ideas about what order to tackle issues in. Do not expect your patient to be able to follow the eating plan straight away, because even if they do then they will need a lot of support to keep

[1] The amount of energy released from food is known as kilocalories (kcal), or kilojoules (kJ) – the latter being the more scientifically accurate way to express energy content. However, most people are more familiar with the use of the term 'calorie'. One kilocalorie is equal to one calorie, which is equal to 4.18kJ. For the remainder of this book the energy content of foods will be expressed as calories, abbreviated to 'kcal'.

**Table 7.4.** Range of energy/calorie contents of different food groups (using the portion sizes recommended in Figure 7.2)

| | Average energy (kcal) content | Range of energy content in the group |
|---|---|---|
| Breakfast cereal | 140 | 110–220 |
| Starchy carbohydrate portion | 170 | 120–260<br>NB higher end of range relates to larger portion, e.g. 75 g rice |
| Protein | 180 | 75 (75 g tuna)–240 (2 sausages) |
| Fats | 90 | 70–100 |
| Vegetables/salad (except potatoes) | 25 | 15–95 |
| Fruit | 60 | 25–90 |
| Light desserts/snack | 160 | 100–230 |
| Traditional dessert | 300 | 250–400 (can be more) |

it going. Generally, changes made at an appropriately controlled rate are more likely to be permanent, whereas sudden changes are difficult to sustain over a longer time.

It is also important to note what is happening to the patient's weight while you are working on the diet. If a restrictive patient's weight is stable because of overeating/bingeing at other times (or because they are eating more than they are reporting), there is less urgency (in terms of management of physical risk) to make dietary changes. However, if their weight is consistently dropping (especially if it is dropping faster than 0.5 kg per week), there is more urgency to address their eating and improve the structure of their diet.

### 7.5.1 Planning changes in diet

Obviously, it is important to talk with your patient about what they feel they could change first. At this stage, motivational work is very useful, so that the patient has reasons to change aspects of their diet to achieve specific results (e.g., improved concentration at specific times of the day, feeling more in control, improved skin, minimizing risk to bone health). This tends to work better than the authoritarian approach (e.g., saying "You need to gain weight, and this is what you need to eat to achieve this."). Some patients do need to be given more direction to start with, but as time progresses it is important to help the patient to take more of a lead in suggesting and directing dietary changes.

We find that the following are useful changes in different domains of eating. However, they are not in sequences, as where we begin depends on the patient's presentation, chronicity, level of overvalued ideas and targets.

#### 7.5.1.1 Timing of eating

- Reduce the number of long periods between planned eating episodes. The optimal gap between snacks and meals is 3–4 hours. To start with, the focus is less on content as the aim is to get used to eating planned food regularly.
- Make sure breakfast is eaten one hour (at most) after getting up, to refuel after the long fast overnight.
- Lunch is ideally taken at some point between 12 and 2pm, unless the patient works shifts and has an altered sleep pattern.
- Dinner would be best taken 6–8pm, but this is more flexible. Obviously, dinner late at night is not ideal if going to bed soon after, because it may cause indigestion or other short-term symptoms (not because the food gets stored as body fat, which is a common dietary myth).

#### 7.5.1.2 Content

Studies into appetite control have shown that meals that are well balanced in carbohydrate, protein and fat, and that provide adequate energy are most satisfying, and thus protect against loss of control of eating (e.g., bingeing, or grazing on uncontrolled amounts of food across the day due to physical hunger). This also means that when faced with a situation that is emotionally charged which would usually result in bingeing, the person who has eaten enough to meet their physical needs is more likely to be able to react rationally than if physically hungry, thus reducing the risk of losing control of eating due to emotional reasons.

- Ensure regular consumption of starchy carbohydrates. Each meal needs to be based on carbohydrates, as do snacks if the meal was eaten 3–4 (or more) hours ago.
- Incorporate a source of protein at lunch and at dinner.
- After carbohydrate and protein, the meals should have some added fat. This is because not all protein and carbohydrate foods contain fat (e.g., lentils, baked beans), and those that do not provide the correct overall balance of different types of fat (i.e., saturated, polyunsaturated, monounsaturated fats; for example, the primary fat in cheese is saturated, so the use of a margarine made from sunflower or olive oil improves the balance of saturated to unsaturated fat).
- Ensure that the portion sizes of carbohydrate, protein and fat are adequate by comparing them to the average portion sizes provided in Appendix 2. Vegetables or salad are also necessary for health but have a weaker effect on appetite control. Information on the portion sizes for these can also be found in Appendix 2.
- Main meals should be two courses. Lunch and dinner should incorporate a dessert, because this enhances the patient's ability to control the intake of potentially difficult foods (e.g., a traditional dessert) as they will be less hungry

due to the consumption of the main course. Also, for most people the consumption of something sweet at the end of the meal signifies the end of the eating episode.

- Breakfast should also ideally consist of cereal plus toast to provide an adequate opportunity for refuelling of carbohydrate stores (glycogen) following the overnight period of fasting. However, if the person prefers more regular, smaller snack-like meals instead of larger meals, this guideline is not so rigid.

## 7.6 Working with patients who are underweight or overweight

There are weight-related issues to consider with regard to both of these patient groups.

### 7.6.1 Managing weight gain in underweight patients

Patients who need to gain weight to overcome their eating disorder will need a lot of support to manage both their food and the emotions that weight gain and less restrictive eating will bring up for them.

The National Institute for Clinical Excellence (2004) recommends a weekly weight gain of 0.5 kg in outpatient settings. In our clinical experience it can be very difficult to achieve this rate of weight gain in many anorexic patients, where a gain of 0.2–0.4 kg is more of the norm. If this is the maximum a patient feels they can achieve then it is important to accept this, since pushing the patient faster than they feel able to go could result in them beginning to binge, or dropping out of treatment. So long as weight is increasing and the patient is well engaged in the treatment process any weight gain is positive. This view is supported by UK Royal College of Psychiatrists (2005) guidelines on nutritional management of anorexia nervosa. However it needs to be acknowledged that the patient may not reach a healthy weight during this treatment phase if weight gain is at a slow rate. This issue is discussed further in the recovery section (Chapter 28).

This Royal College of Psychiatrists report also recommends regular monitoring of urea and electrolytes if weight gain is 0.3 kg a week or more, and recommends that such patients are prescribed a complete vitamin and mineral supplement (see below).

#### 7.6.1.1 How much extra does the patient need to eat to gain weight?

Although patients (and clinicians) can imagine that weight gain is easy (“I just have to look at a cream bun and I put on pounds”), in fact it requires a large amount of food to be consistently eaten over weeks and months (rather than just

days) to achieve weight gain. On average, to gain 0.5 kg per week, it is necessary to eat 500 kcal daily (the size of an average main course of a meal) over and above the amount needed to maintain weight (about 2000 kcal per day for women, and 2500 kcal per day for men). So if an anorexic person needs 1700 kcal to maintain weight, they will need to increase their intake to around 2200 kcal a day to gain 0.5 kg each week.

Figures on the amount needed to gain weight vary across sources, often due to differing assumptions. It can be explained to the patient that to make 1 kg of muscle requires around 5000 kcal, whereas to build 1 kg of fat requires around 9000 kcal. Usually, the ratio of body fat to muscle weight is 50:50. Hence, an overall weight gain of 1 kg requires around 7000 kcal to be consumed over and above normal requirements. If the weekly aim is to gain 0.5 kg, then this equates to half the energy required to gain 1 kg — 3500 kcal, which spread over the week is 500 kcal a day (Salisbury *et al.*, 1995).

Initially, over the first 10—14 days, there may be more rapid weight gain due to:

- fluid retention related to the increased food intake (increased intake of carbohydrates, proteins and foods that may be more salty than foods previously eaten will lead to some temporary water retention)
- the cessation of dehydrating behaviors such as vomiting or laxative abuse.

Patients will need a lot of support to continue eating in the face of these short-term weight changes, and may find this information on short- and long-term weight changes to be of use.

#### 7.6.1.2 Changes in metabolic rate/energy needs during weight gain

Once the patient has been able to commence weight gain through increasing their diet, it is important to be aware that at some stage they will need to increase food intake further to continue weight gain. There are several reasons for this. First, at a low weight metabolic rate will be reduced as an effect of semi-starvation. Once food intake improves, metabolic rate will also improve, increasing the amount of calories required (which can be recognized by the patient when they no longer feel cold all the time, or no longer have blue fingers or toes, or when they generally feel less irritable). Second, activity levels may be low due to tiredness and fatigue. Once the patient feels better physically, they are likely to increase activity levels (often appropriately, but sometimes inappropriately), which burns off more energy. Third, weight that is gained will be a mixture of muscle and adipose tissue. This increased muscle will require energy to function (as will the body fat, but to a lesser degree). Finally, as weight increases, more energy will be required to move the person around. Also, if the person is only marginally underweight (say a BMI of 18—19), weight gain will possibly be more adipose tissue than muscle, which requires more energy to build, as described above. The process of building

(anabolizing) body tissue can increase metabolic rate itself, but this is more commonly seen in patients gaining 1 kg or more per week (usually those being treated as in-patients). In these cases, food intake will need to be reduced gradually over 10–14 days to slow the metabolic rate (and the weight gain) down to a normal level and to achieve weight stability. De Zwaan *et al.* (2002) provide a useful overview of this topic.

#### 7.6.1.3 How to practically manage weight gain in low-weight patients

When working with patients to gain weight, it is important to compare their current diet to the meal plan/format of a normal food intake. The gaps that are identified need to be plugged to bring the person's food intake up to a normal level. If weight is very low to start with (say a BMI of 15 or thereabouts), or food choices are very low in calories (e.g., cottage cheese, very little fat, no luxury items like chocolate), this should be all that is needed to achieve weight gain. However, as weight gain increases, or if the patient is at a higher starting weight, the requirements for food may exceed what could be considered a healthy diet.

There are several choices that can be made about where to go next. One choice would be to incorporate high-calorie supplement drinks to supplement what is already eaten. The other choice is to increase the consumption of high-calorie options like chocolate, traditional desserts, pastry, sugary drinks (the latter need to be taken with meals rather than alone, to minimize their effect on teeth). Each option has pros and cons. For example, some people associate supplement drinks with being ill, meaning that they want to avoid using supplements, whilst others may prefer the fact these drinks need to be prescribed, making them feel like medicine that needs to be taken for a specific time, then stopped. Other patients feel very unhealthy eating lots of sugary and fatty foods. Each person will have different opinions about what feels most comfortable for them, and other factors affecting choice may come into play, such as whether the patient's GP is prepared to prescribe supplement drinks for a patient. The important thing to realize is that however the patient chooses to tackle gaining weight, they should feel in control of the process (bingeing to gain weight is obviously far from ideal). It can help the patient to be reminded that her weight gain diet is only for the short-term, and that once she is at a normal weight food intake can be reduced to a more normal level.

### 7.6.2 Patients who are overweight or obese

As the prevalence of people who are overweight (BMI of 25–29.9) or obese (BMI $>$ 30) rises in the general population, it is to be expected that the number of people attending for treatment of an eating disorder who are overweight

or obese will also increase. In addition, the weight loss seen in many eating disorders appears to increase the risk of weight rising above what is considered a healthy range (BMI of 20–24.9) at a later point. Many of the men of the Minnesota Experiment on starvation (Keys *et al.*, 1950) struggled to control their weight over the years following the experiment. This poses a difficulty for the clinician because healthcare professionals advocate appropriate weight loss in obesity, whereas many overweight or obese people with eating disorders have been through multiple weight loss and regain cycles, resulting in an ever-increasing weight, plus poor morale and self-esteem due to repeated failure to lose weight.

The National Institute for Clinical Excellence (2004) concludes that there is very strong evidence that treatment for an eating disorder does not affect weight in overweight/obese individuals, and goes on to recommend that weight is addressed during or after treatment for the eating disorder. We advocate that the patient aims for weight stability through healthily controlling food intake (and obviously cutting out bingeing) during treatment, since continued binge eating is strongly linked to further weight gain (Agras *et al.*, 1997). That said, patients with a more structured eating pattern, where the bingeing is a discrete problem, may find that treatment does effect a modest weight loss. Once the eating disorder is less of a pressing issue and food intake is more stable, the focus can then turn to weight loss. However, since obesity is a chronic health problem, this work needs to continue with more generic services (e.g., the GP) or specialized services (e.g., obesity services) after treatment for the eating disorder is completed.

Table 7.5 summarizes the factors associated with successful weight loss and weight loss maintenance (Elfag & Rossner, 2005). Many of the factors involved are central to the goal of CBT of the eating disorders, and therefore successful treatment of the eating disorder gives the patient the best possibility for successful weight loss in the future.

The issue of weight loss in overweight/obese individuals is difficult issue for the patients that it directly affects, but can also be a difficult issue for the clinician. The drive to lose weight is so strong (from healthcare professionals and from the media) that it can feel like we are failing the patient to aim for weight stabilization rather than weight loss. However, we advise clinicians to take a step back and see the resolution of the eating disorder as the first step in the long process of weight management. It is also worth reviewing life-long weight changes, as many of the patients we see seem to have never had a period of weight stability (albeit at a high weight) throughout their entire life.

### 7.6.3 Vegetarianism and veganism

Many patients with eating disorders are vegetarian, although many are not strictly so, in that they will eat fish or poultry. One of the tasks of therapy is to ascertain

**Table 7.5.** Factors associated with weight loss maintenance and weight regain (Elfag & Rossner, 2005)

| | Weight maintenance | Weight regain |
|---|---|---|
| Physical factors | Physically active lifestyle | History of weight cycling |
| | Achieving weight loss goal | Disinhibited eating |
| | More initial weight loss | Binge eating |
| | Regular meal pattern | Sedentary lifestyle |
| | Consumption of breakfast | Perceiving barriers for weight loss behaviors |
| | Less dietary fat, more healthy foods | |
| | Reduced frequency of snacks | |
| | Self-monitoring (food diaries) | |
| | Flexible control over eating | |
| Psychological factors | Capacity to cope with life | Eating in response to negative emotions and stress |
| | Capacity to handle cravings | |
| | Self-efficacy | More passive reactions to problems |
| | Autonomy | Poor coping strategies |
| | "Healthy narcissism" | Lack of self-confidence |
| | Motivation for weight loss = more confidence | Psychopathology |
| | | Dichotomous (black and white) thinking |
| | Capacity for close relating | |
| Other factors | Stability in life | Attribution of obesity to medical factors |
| | | Psychosocial stressors |
| | | Lack of social support |
| | | More hunger |
| | | Motivation for weight loss comes from medical reasons or from other people |

whether the vegetarianism is part of the eating disorder, or whether it predates the eating disorder. If it is the former, then therapy needs to address this, aiming for the reintroduction of the excluded foods by the end of therapy. However, it is also very important to respect individuals' beliefs, and if they want to remain vegetarian then it is important to ensure the diet is nutritionally adequate. This can be achieved by ensuring that the patient is consuming adequate non-meat or fish protein choices in each main meal (such as eggs, nuts, seeds, pulses and beans, tofu and textured vegetable protein), since these provide the iron (to prevent anemia) that would normally be provided by the meat and fish. If the patient is anorexic, vegetarian and working towards weight gain then they will need a multivitamin and mineral supplement to ensure an adequate mineral intake.

It is important to watch out for patients who eat dairy foods as their protein source in every meal, avoiding other sources of protein. Although dairy foods

are generally adequate in terms of protein, they are fairly low in iron and can be very high in fat (e.g., most cheeses). If eaten to the exclusion of other protein-rich foods, there is a possibility that the person may not consume enough iron in their diet, resulting in iron deficiency anemia, plus weight may increase inappropriately because of the extra fat and energy consumed from these choices.

Vegan diets are more restrictive than vegetarian. As a result they tend to be a lower energy density, meaning that more bulk needs to be eaten to ensure the same nutrient intake. This can make weight gain in a low-weight, vegan anorexic very difficult, and possibly dangerous (e.g., higher risk of acute gastric dilatation). In addition, the diet can lead to impaired absorption of minerals such as iron, zinc and calcium (due to the high phytate content from plants). It is important to explain to a vegan patient working on weight gain that their veganism increases their risk and may necessitate admission, where they may have no choice but to adopt a less restrictive diet. Either way, this patient group needs referral to a dietitian to ensure they are consuming a nutritionally adequate diet, and that risks inherent in treating this group of patients are reduced to a minimum.

### 7.6.4 Vitamin and mineral supplements

The food plan described earlier will provide enough vitamins and minerals for most people, meaning that there would be no need for supplements. However, since most patients take some time to adhere to the plan, thus only slowly improving the quality of their diet, there is a potential use for such supplements. Patients at a low weight, or working towards weight gain also need a multivitamin and mineral supplement since the diet consumed is likely to be deficient in one or more essential nutrients, and weight gain increases the micro-nutrient need. However, it is important to be aware that patients may feel there is less pressure to improve their diet because they are taking a supplement. If this is the case, they need to be reminded that even the most complete supplement will not provide all the nutrients that a balanced diet should provide (e.g., the large number of antioxidants in fruits and vegetables are missing from supplements), and that supplements can be more costly than the food they replace.

If it is decided that the patient needs a supplement, or the patient is keen to take one, they need to be advised to take a multivitamin and mineral supplement that provides at most 100% of the requirements instead of taking a single specific supplement, such as zinc. This is because diets do not tend to be deficient in only one nutrient, and taking specific nutrients can impact on the absorption of other nutrients (e.g., a high intake of zinc interferes with iron and copper absorption).

Finally, it is important to recognize that multivitamin and mineral supplements tend to be low in calcium, since calcium is very bulky and would make the supplement too large to take. Care must therefore be given to ensure the patient is consuming enough calcium in their diet (see above).

### 7.6.5 Activity

Activity levels are a further issue that needs to be assessed in all patients with eating disorders. Many patients are overactive, perhaps attending formal exercise classes several times a week, exercising excessively on their own (e.g., walking several hours a day or night), and/or burning off large amounts of energy through daily activities (e.g., cleaning). It is important that the reasons for this are discussed (e.g., calorie burning, managing of emotions, obsessive-compulsive disorder) and addressed in the therapy. This would probably include education on the fact that activity only accounts for 15–30% of total energy requirements, with normal bodily processes (e.g., circulation, respiration, repair, digestion) accounting for the rest (see the psychoeducation sheet on metabolic rate for further information). Other patients can be very inactive, which also impacts on health and weight.

#### 7.6.5.1 Healthy activity levels

The UK Department of Health recommends that: ''at least 30 minutes a day of at least moderate intensity physical activity on five or more days of the week reduces the risk of premature death from cardiovascular disease, and some cancers, and significantly reduces the risk of type 2 diabetes, and it can also improve psychological well being'' (Department of Health, 2004). The focus of the report is the prevention of conditions associated with obesity, but the recommendations made can be applied to most patients with eating disorders, except those patients who are extremely emaciated where physical activity would be high risk. The recommendations made in this report are a minimum, and it goes on to say that 45–60 minutes of moderate intensity activity per day may be needed to prevent obesity, and that for children and young people a total of at least 60 minutes of at least moderate-intensity activity (including that which improves bone health) is required each day. However, these recommendations assume physical safety, and that the motivation for the activity is primarily to improve health, as described below.

#### 7.6.5.2 Compulsive versus excessive activity

It can be difficult to ascertain whether the activity level that patients report is excessive, since so much depends on the context for the activity. However, it seems more important to focus on the motivation for the activity, since the motivation is

more likely to be of a compulsive nature in people with eating disorders (Adkins & Keel, 2005). Ways of assessing whether activity is compulsive would include asking (or observing) whether the person would be (or continues to be) active following injury or whether they become acutely distressed if they cannot partake in their normal activity level. A handout for patients on compulsive activity is included in the psychoeducation section.

### 7.6.6 Alcohol

As discussed earlier, alcohol can have a detrimental effect on food management. It reduces blood sugar, meaning that it increases hunger, whilst it also reduces impulse control, thus making it harder for people to resist impulses. So, an increase in hunger coupled with a reduction in ability to say "no" means that bingeing can be a problem, either whilst the person is drinking, or even the next day, when blood sugar may be lowest (especially if coupled with a reduced food intake).

It is also important to note that alcoholic drinks do contain a lot of energy, which also provides virtually no other nourishment – they are truly "empty calories." Our experience tells us that many patients are surprisingly unaware of the fact that alcohol contains calories at all, and the amount of calories that alcoholic drinks do contain. The calorie content of alcohol is second only to fat (fat contains 9 kcal per gram, alcohol 7 kcal per gram, protein 4 kcal per gram and carbohydrates 3.75 kcal per gram). Therefore, even spirits such as vodka will contain 52 kcal per 25 ml (1 unit), or 73 kcal per 35 ml serving. This will have little impact on calorie intake if taken in small quantities, but if drunk to excess will have a more substantial impact. In addition, most alcoholic drinks contain other energy sources, usually sugar (alcopops, liqueurs, cocktails), but also sometimes fat (cream liqueurs, cocktails with cream). Mixers can also contain extra sugar, although most people tend to choose diet versions, which are calorie free.

#### 7.6.6.1 Advising patients on appropriate alcohol consumption

Many patients with an eating disorder will also have issues with alcohol, some of which may need input from appropriate alcohol services prior to working on their eating disorder. However, many patients will not need this type of specialized input, but will still need advice about what is an appropriate alcohol intake. The following tips may be of use:

- Drink according to UK Government guidelines – no more than 14 units a week for women and 21 units a week for men. Table 7.6 details the content of different alcholic drinks.
- Avoid binge drinking – stick to 2–3 units a day or less if you are a woman, 3–4 units a day or less for men. Have two alcohol-free days after an episode of heavy drinking.

**Table 7.6.** Average alcohol and calorie content of typical alcoholic drinks

| Type of drink | Serving size (metric/imperial measures) | Alcohol content | Approximate calorie content |
|---|---|---|---|
| Wine 12–14% ABV | 125 ml (NB Most pub measures = 175–250 ml) | 12% = 1.5 units; 14% = 1.75 units | 12% = 95 kcal |
| Beer 4% ABV | ½ pint (280 ml) | 1.15 units | 90 kcal |
| Beer 5% ABV | ½ pint (280 ml) | 1.40 units | 95 kcal |
| Cider 5% ABV | ½ pint (280 ml) | 1.40 units | 110 kcal |
| Vintage cider 15% ABV | ½ pint (280 ml) | 3.7 units | 280 kcal |
| Stout (e.g., Guinness) 4% ABV | ½ pint (280 ml) | 1.15 units | 85 kcal |
| Spirits (e.g., vodka) 40% ABV | 25 ml | 1 unit | 55 kcal |
| Liqueurs (e.g., Pernod) 40% ABV | 25 ml | 1 unit | 80 kcal |
| Fortified wines (e.g., port) 20% ABV | 50 ml | 1 unit | 80 kcal |
| Cream liqueurs (e.g., Baileys) 15% ABV | 50 ml | 1 unit | 165 kcal |
| Alcopops (e.g., Bacardi Breezer) 5% ABV | 1 bottle = 275 ml | 1.72 units | 200 kcal |

One unit = 8 g of alcohol; ABV = alcohol by volume.
*Source:* Food Standards Agency (2002); Kellow and Walton (2006).

- Never drink alone. This is important for many reasons, not least because the risk of bingeing is greatly increased, and alcohol can increase feelings of depression.
- Drink alcohol with a meal, rather than on an empty stomach.
- Encourage the patient to plan their alcohol consumption before a social event. It is important they decide how much and what they will drink, and how they can politely refuse further drinks.

### 7.6.7 Patients needing individual dietetic input

Whilst the diet of the majority of patients can be handled by clinicians who have access to the above information and who have the opportunity to discuss cases with a dietitian, there are some patients who need direct input from a dietitian. These tend to be patients with comorbid physical illnesses/conditions that necessitate input from other medical teams (e.g., diabetes, pregnancy), so in reality regular liaison and input from medical teams that includes dietetic input is perhaps the requirement, instead of dietetic input per se. We recommend ongoing

dietetic/medical input when working with eating-disordered patients with the following conditions:

- Children and adolescents with eating disorders (as it is the parents who take responsibility for the patient's food, the dietitian will need to work with the family, not just the patient).
- Pregnancy/breastfeeding.
- Diabetes mellitus (type 1 and type 2).
- Obesity related heart disease, the aim being to improve the diet, which may or may not bring about weight loss.
- Inflammatory bowel disorders – Crohn's disease and ulcerative colitis (note that this is different from irritable bowel disorder).
- Coeliac disease (an allergy to wheat and wheat products).
- Medically diagnosed, or suspected food allergy.
- Cystic fibrosis.
- HIV/AIDS.
- Neurodegenerative disorders such as multiple sclerosis or Huntingdon's disease.
- Physical disability (if the patient is confined to a wheelchair, weighing becomes very difficult).

This list is not exhaustive. Nor is it a foregone conclusion that such patients will need individual dietetic input, but the eating disorder and other comorbid psychological illnesses may make it difficult for the patient to take responsibility for the life changes that these conditions necessitate. Therefore, it is likely that the majority will need further input from relevant clinicians.

## 7.7 Psychoeducation topics in dietetic work

We find that it is crucial to be able to provide authoritative information on the contents of foods, so that patients can absorb the information without feeling bullied. This is particularly important when it comes to helping the patient to develop "alternative" beliefs for the purposes of Socratic challenges (see Chapter 22). Consequently, we have developed a range of dietetic sheets on topics that patients (and clinicians) find useful. These are reproduced in Appendix 2. The topics of those sheets are detailed below:

### A. Getting started - practical information about improving food intake

- The advantages of regular eating.
- General points to help normalise your food intake.
- Hunger.
- How much do we need to drink (non-alcoholic drinks).
- Examples of different foods and the food groups they belong to.

- Grading foods - a chart to identify what foods are easily managed, and what foods are currently avoided.

**B. Health consequences of unchecked eating disorder behaviors**

- The effects of semi-starvation on behaviour and physical health (the Minnesota Experiment).
- Complications of food restriction and low weight / anorexia nervosa.
- Complications of bulimia nervosa (especially laxative abuse & vomiting).
- The effects of self-induced vomiting on physical health.
- The effects of laxative abuse on physical health.
- The effects of diuretic abuse on physical health.
- Exercise and activity.
- Bone health and osteoporosis.

**C. Issues that perpetuate the disorders**

- The effect of purging on calorie absorption.
- Weight control in the short and long term.
- Why diets don't work.
- The effect of premenstrual syndrome (PMS).

**D. Basic nutritional facts and principles**

- Metabolic rate / energy expenditure (or how the body uses food).
- Normal eating.
- Proteins - some basic facts.
- Carbohydrates - some basic facts.
- Fats - some basic facts.
- Fruits and vegetables.
- Alcohol.

## 7.8 Summary

We have seen in this chapter that, due to the effect of both physical and emotional aspects of the disorder, patients with eating disorders should not be expected to return to being able to regulate their food intake appropriately without help and guidance. In order to facilitate recovery, the patient needs to adopt a well-structured eating pattern of three meals and two or three snacks per day, regardless of how hungry they feel. In this way, the patient's eating becomes more driven by the physical element of hunger (perhaps even more so than normal eaters), rather than the emotional element. It is important that the clinician offers continued reassurance that normal appetite control will occur more quickly if the patient follows a more structured eating pattern from as early on in treatment as possible.

8

# Case formulation

Clinicians, particularly if they lack experience, can feel overwhelmed by the complex nature of the problems presented by patients with eating disorders. Many of these patients show substantial comorbidity with other disorders (see Chapters 24 and 25) and clinicians are sometimes unsure about which of the patient's problems to tackle first, how to intervene appropriately and effectively, and how to track the patient's progress in therapy. A case formulation allows the theory of CBT to be applied to clinical practice, which is why clinicians should always have a formulation (whether the patient's problems are complex or reasonably straightforward). The formulation helps the clinician to develop an understanding of the patient's difficulties, plan treatment and select appropriate treatment strategies.

In this chapter, we consider the formulation of the eating disorders themselves. More complex cases can often require different ways of making sense of the range of symptoms, either seeing them as distinct or as interlinked. We address the formulation of more complex cases in a later part of the book (Chapters 24 and 25).

## 8.1 What is a case formulation?

We find it most useful to represent the patient's difficulties in the form of a diagram, as suggested by other clinicians (e.g., Fairburn, 2004; Slade, 1982). The diagram that we use represents the processes that maintain the patient's eating disorder (Fairburn, 2004), but also considers the earlier antecedent factors where appropriate. The diagram is developed jointly with the patient, thereby enabling a shared understanding of the patient's problem between clinician and patient. The formulation helps the patient to step back from their eating disorder, and (often for the first time) to understand what is maintaining it. In psychological terms, the case formulation helps the patient to develop "metacognitive awareness" (i.e., an understanding of their thoughts, feelings and behavior).

The formulation also allows the clinician to communicate their provisional understanding of what the patient has told them, and provides a ''roadmap'' that will be used throughout treatment to guide the choice of interventions.

### 8.1.1 Why do we need individualized formulation in CBT?

While theoretical models are often relatively simple and clear, the information that patients bring to therapy is often complex and unclear. For this reason, applying theoretical models in practice is difficult. Having a theoretical model is important because it guides the clinician towards looking for particular constructs (e.g., distorted beliefs about eating, weight and shape) and processes (e.g., regular body checking) that are commonly present in patients with eating disorders. It also helps the clinician to determine the extent to which a particular case is typical or atypical. While cognitive-behavioral theories provide sources of such *general* explanations and hypotheses about the nature of patients' eating problems, an individualized case formulation spells out the *specific* explanations and hypotheses that apply to the particular patient. The ideal case formulation combines the patient's personal experiences with the clinician's knowledge of theories, scientific principles and research findings, thereby providing an overall understanding that the patient has not been able to see before and that the clinician could not see without the patient's help.

## 8.2 Constructing a formulation: general points

Butler (1998) has outlined three main principles that should guide the development of a case formulation. First, the formulation should be based on a theory and reflect an attempt to put that theory into practice. Second, the formulation should remain hypothetical in nature throughout treatment, so that it can be further modified as therapy progresses and new information comes to light. Finally, the formulation always should be kept as parsimonious as possible, to make it less confusing for all parties and to ensure that it is accessible to patient, clinician and others.

In the next section, we will describe how to construct a case formulation for patients with eating disorders. For a more general discussion of the role of formulation in cognitive-behavioral therapy, readers are referred to reviews by Butler (1998) and Persons and Thompkins (1997).

### 8.2.1 How to get started: some basic principles

Once the patient is sufficiently motivated, a simple formulation can be tentatively constructed on the whiteboard. We usually introduce this process by saying to the

patient that: ''It would be useful to summarize what you have told me so far in a way that would help us to make some more sense of your eating problems.'' The initial formulation will usually focus on the problem behaviors and the maintenance of the patient's problems, rather than on their etiology. Throughout the process of formulating, we use Socratic questioning to explore the key elements of the patient's difficulties. Right from the start, we emphasize that the initial formulation is only a beginning (marking it ''Draft 1''), and that it will be modified as we and the patient get a better understanding of the problems.

The formulation should always use the patient's terms and expressions as much as possible, and the clinician should start with a problem that the patient wants to change. In the majority of patients, this will be their eating. The formulation is introduced as a ''map,'' which helps the patient and clinician to know where they are going and what problems they need to tackle. This will then help them to decide which behavioral and cognitive strategies they might want to use to help the patient overcome their problems.

Fairburn (2004) has argued that the initial formulation should not include comorbid problems, such as alcohol abuse or self-cutting, as this is likely to confuse the patient and distract from the main initial goal of treatment, which is to help the patient to normalize their eating. However, we have found that it is often helpful to include other behaviors (e.g., self-harm) that serve similar functions (e.g., emotional avoidance), in order to prepare the patient for the possibility that other behaviors will be substituted when addressing eating patterns.

### 8.2.2 Which cognitive-behavioral models can guide your formulation?

Several different cognitive-behavioral models for the treatment of eating disorders have been proposed (e.g., Cooper *et al.*, 2004; Fairburn *et al.*, 1999, 2003; Waller *et al.*, 2005). More recent models have emphasized the emotion-regulation function of eating behaviors, and are generally more complex. While all of these models are supported by research evidence, the best-validated one for bulimia nervosa is that proposed by Fairburn (1997). Thus, we recommend this as a good starting point for learning to formulate eating problems, before considering more complex models (e.g., Cooper *et al.*, 2004; Waller *et al.*, 2005). However, such models tend to have the drawback that they focus more closely on diagnoses than is justified by the heterogeneous nature of the patients who attend for treatment. While some cases can be formulated using diagnosis-based models, many cannot.

### 8.2.3 Formulating transdiagnostically

In keeping with this concern about trying to formulate according to assumptions about the validity of diagnostic schemes, we find that the majority of cases are better understood by understanding the key behaviors, cognitions and emotions.

This approach is partly reflected in the model of Fairburn *et al.* (2003). However, in the absence of evidence for any one model, we also incorporate elements of the models proposed by Slade (1982), McManus and Waller (1995), Cooper *et al.* (2004) and Waller *et al.* (in press) in order to develop an individual-centered case formulation that can guide treatment. The examples that we provide below reflect this mix of models. While the formulation of working with a case that has more bulimic features more closely reflects Fairburn's (1997) model (with its good level of evidence-based support), the formulation of a more restrictive case is more of an amalgam of models (based on our experience of effective treatment in such cases), due to the lack of any clear evidence base for CBT with restrictive disorders.

## 8.3 Understanding and formulating bulimic cases

While Fairburn's most recent model is transdiagnostic (Fairburn *et al.*, 2003), it is derived from a common template – Fairburn's original model for bulimia nervosa (e.g., Fairburn, 1997). This model will now be described, followed by a case example of how it can be applied in clinical practice.

### 8.3.1 A dysfunctional system for evaluating self-worth

Fairburn (1997) argues that patients have a "dysfunctional system for evaluating self-worth," which maintains the disorder. They judge themselves largely, or sometimes exclusively, in terms of their eating, weight and shape, and their ability to control these aspects. Other clinical features are thought to *result* from this core psychopathology (such as extreme weight-control behavior, body checking, avoidance behaviors, preoccupation with thoughts about eating, shape and weight).

### 8.3.2 Extreme dietary rules and rule violations

Instead of adopting general guidelines for eating (e.g., eating what is healthy or what they like), patients try to follow extreme and highly personal dietary rules (e.g., "I can't ever eat after 5 pm"; "I should never eat fatty foods"). In practice, following these rules often proves extremely difficult, if not impossible, in the short or long term. Fairburn argues that bingeing occurs when the patient's dietary rules get broken in any way (even minor dietary slips). These rule violations are interpreted by the patient as evidence of a lack of self-control, leading them into abstinence violation – the temporary abandonment of their efforts to restrict eating, and thus bingeing on the foods they do not normally allow themselves. This is due to the body's craving for these foods.

### 8.3.3 Longer-term consequences: dieting versus bingeing and purging

The longer-term consequences of this behavioral pattern are as follows. First, patients develop a characteristic pattern of eating – periods of intense dieting, followed by episodes of bingeing. Second, bingeing increases the patient's belief that they cannot control their eating, so they start to restrict again. Third, patients often continue bingeing because they believe that taking laxatives and vomiting are effective ways to control their weight. This belief is incorrect – while many patients believe that self-induced vomiting is an effective way to avoid weight gain following a binge, the reality is that this behavior only gets rid of less than half the food they consumed during a binge (see Appendix 2). This explains why even women who vomit every time they eat are not necessarily underweight. In contrast to what many patients believe, laxatives have little effect on calorie absorption and diuretics have no effect at all (see Appendix 2). What patients lose when they take laxatives is water.

### 8.3.4 Emotion-driven eating behaviors

A subgroup of patients with eating disorders have a poor ability to tolerate distress (Fairburn *et al.*, 2003; see also Chapter 25). Most are intolerant of negative emotional states (e.g., anger, anxiety, depression), but others find positive moods hard to tolerate (e.g., excitement; Lacey, 1986). These patients use a range of behaviors to modify their mood states, including bingeing, vomiting, exercise, self-harm and substance abuse.

Some cognitive-behavioral models of eating psychopathology place greater emphasis on the relationship between emotional states and the use of eating behaviors (e.g., Cooper *et al.*, 2004; McManus & Waller, 1995; Waller *et al.*, 2005). These models argue that emotion regulation is one of the key functions of patients' eating behaviors (i.e., restriction and bingeing/vomiting). For example, the schema-focused cognitive-behavioral model of Waller *et al.* (2005) suggests that restrictive and bulimic behaviors result from the primary and secondary avoidance of emotion. While primary avoidance of emotion (dominant in restrictive disorders) involves the avoidance of affect arising in the first place (e.g., perfectionism, the ongoing suppression of emotions), secondary avoidance of emotion (dominant in bulimic disorders) involves the reduction of affect once it has been triggered (e.g., self-harm, social withdrawal, negative self-talk).

When constructing the formulation, the clinician should be aware of the emotion-regulation function of eating behaviors, and integrate this information into the formulation where appropriate. While the current evidence base suggests that not all patients use eating behaviors to manage their emotions, this link will be of relevance in a significant subgroup of patients. However, based on our experience it is not always necessary to include emotional factors

in the initial formulation. As outlined below (Section 8.6.1), parsimony is central — focusing initially on the factors that most commonly maintain disordered eating (restricting and the following of extreme dietary rules) before addressing additional factors (e.g., emotional states, comorbid problems, etc.).

### 8.3.5 How to do it: essential steps in constructing a case formulation

When applying the transdiagnostic cognitive model in practice, the clinician should start the formulation process by asking the patient to identify their biggest problems (eating-related or otherwise). Draining (the uncovering of the patient's full range of concerns — see Chapter 6) is a useful strategy in accessing such beliefs, and the clinician should at some point begin to formulate around one of the patient's expressed concerns. During this discussion, the clinician needs to link the patient's various problems (e.g., the patient might state that their biggest concern is their relationship, but this might be the case because they are striving to keep their eating disorder a secret). The following are a set of considerations that we use when formulating, and an example of the process of putting this into practice.

#### 8.3.5.1 Focus on the patient's eating problems

At some point, it is likely that the patient will label some aspect of their eating behavior (e.g., binge eating, vomiting or restricting) as a concern. Most patients will acknowledge that bingeing encourages dieting and increasingly stringent rules. They also accept that vomiting and laxative use permit binge eating, given the belief that these behaviors can compensate for bingeing and prevent weight gain. Some patients acknowledge that vomiting encourages binge eating because they find it easier to vomit on a full stomach. What is usually harder for patients to accept is that restriction itself encourages bingeing (this is covered in more detail in the psychoeducation section — Chapters 7 and 13).

#### 8.3.5.2 Uncover the patient's dietary rules

At this point in the formulation process, the aim is to uncover some of the patient's "rules." The clinician may already have an idea about what these might be from the diary and from what the patient has said in previous sessions. These rules are integrated into the formulation, and the perceived consequences of breaking those rules are discussed. We discuss the way in which those rules demonstrate "black and white thinking" and "abstinence violation." The notion of "banned foods" is also highlighted. Using Socratic questioning and drawing on previous examples, the clinician explores when binge eating is most or least likely to happen, helping the patient to understand that binges are more likely following periods of restriction.

#### 8.3.5.3 Introduce the idea of emotion-driven bingeing

Sometimes, patients will talk about exceptions (e.g., when they have eaten regularly but still binged). At this point, we explain how life problems can lead to negative emotions and bingeing can be used to block awareness of these emotions. Most patients are aware that they sometimes binge when upset, when trying to block feelings or when having to make decisions. We explain that there are two pathways for bingeing – hunger-driven and emotion-driven – and that both might need to be addressed.

#### 8.3.5.4 Identify overevaluation of eating, shape and weight

If the patient has not already stated that weight is the most important thing, we ask when and why it became so important to restrict. Using the patient's language, we add the "overevaluation of eating, shape and weight" component to the formulation. Often, the background to this can be added to the top of the formulation (e.g., childhood experiences of trauma, lifelong comments about weight and shape, athletics training). The feedback loops are then discussed (e.g., how do the behaviors serve to maintain the patient's perception of low self-worth), including acknowledgement that some feedback loops operating in the short term (e.g., emotional blocking) are experienced positively, while the longer-term ones (e.g., lower level of self-esteem) are more negative experiences.

#### 8.3.5.5 Obtain feedback and use the formulation to guide treatment

The formulation is then copied down and given to the patient. (Alternatively, the patient can be asked to take notes while it is written out on the board.) For homework, the patient is asked to review the formulation over the week, redraw it and make changes if necessary. If the patient decides that the formulation is not sensible and needs major changes, this can be discussed. At the next session, once there is agreement on the revised formulation as a working model, we ask the patient what they think should be addressed as treatment targets if the formulation is accurate. This is often a very revealing question, as the patient who has fully grasped the formulation will identify the same points that the clinician does. Throughout treatment, the formulation should be kept nearby during every session so that both clinician and patient can quickly refer to it whenever this is required (e.g., to explain a new behavior) and amend it accordingly.

#### 8.3.5.6 Formulation example: the dialogue with a patient with a bulimic presentation

In the following section, we provide an example of a discussion between patient and clinician, and show how this information can be used to construct a formulation of the patient's problems. The patient, Sarah, is a 24-year-old woman with a diagnosis of EDNOS (atypical bulimia nervosa of the purging subtype,

because she did not binge to the full frequency criteria). She lives with her partner, Jonathon.

The evolving formulation diagram follows the dialogue, and therefore reflects a patient-generated and individualized extension of Fairburn's (1997) template. (Numbers in parentheses relate to the relevant element or link in the formulation diagrams that follow.)

*Dialogue*

| | Aims and principles underlying intervention |
|---|---|
| *Clinician*: Sarah, we've been talking about the difficulties that you've been having recently. What I want to do is to draw a map with your help to see how they all link in. I wonder, can you tell me what's been bothering you most? | *Introducting the idea of a formulation diagram to the patient.* |
| *Sarah*: My relationship . . . I feel like I'm lying to Jonathon about what I'm eating and when I'm sick . . . I get stressed because I feel he's trying to control what I eat. | *Identification of the patient's most significant current problems.* |
| *C*: OK, let's put that up on the board. What else is difficult? | |
| *S*: Well, also at work, I'm having problems with my boss, he's giving me too much work and I don't feel I can tell him. I suppose as well, I worry about my health, because I know what I'm doing – the bingeing and vomiting – isn't good for me | |
| *C*: I'll put down the bingeing and vomiting here. Have you noticed any patterns with the bingeing – what triggers it? | |
| *S*: Yes, when I feel stressed at work or I've had an argument with Jonathon (**1**) and then it just makes me feel even worse for hiding it | ***Link 1:*** *Binge eating is often triggered by arguments with her boyfriend or by difficulties with her boss.* |
| *C*: Are there any other things which trigger bingeing? | |
| *S*: Sometimes I'm just so hungry . . . because I try not to eat anything until the evening . . . or I get obsessed with food, I just can't stop thinking about it. Then I feel so guilty, I have | |

| | Aims and principles underlying intervention |
|---|---|
| to be sick. If I vomit then I won't put weight on, as well . . . and once I've decided I'm going to vomit I binge because I know the food I'm eating doesn't count. | |
| *C*: OK, so let's put an arrow in here (**2**) – the bingeing leads to you be sick because you feel guilty. | ***Links 2 and 3:*** *Binge eating acts as an emotional release, but then triggers vomiting, as Sarah feels guilty.* |
| *S*: Yes, but also . . . it sounds strange, it's like an emotional release, I feel better, and then I feel guilty and worse than before. (**3**) | |
| *C*: So the bingeing and vomiting seem to help you feel better emotionally . . . at least for a short time . . . and then it sounds like you feel worse gain. Just now, you mentioned that you often feel hungry, because you've been dieting . . . and you get obsessed with food. I'm just going to add those here. And you mentioned a couple of what we call "rules" – "I mustn't eat until the evening" and "I have to eat more in order to be able to vomit better." | *Introduction of the idea of "dietary rules."* |
| *S*: Yes. | |
| *C*: What we find is that strict dieting, like you're doing at the moment, and having rules about eating, often leads to bingeing. Firstly, people are much more likely to binge when they get very hungry. Secondly, how do you feel when you break one of your rules? | ***Links 4 and 5:*** *Intense restriction and rules regarding food trigger binge eating through the mechanisms of hunger and abstinence violation. In turn, the intense restriction is driven by the overevaluation of eating, shape and weight (e.g., "My weight is all-important to me").* |
| *S*: I feel really bad . . . I can't even do a simple thing like stay on a diet . . . I' ve totally blown it. | |
| *C*: This is something we call "all or nothing thinking" – some people, if they think they've eaten too much, aren't too bothered and just think they will cut down a bit the next day. For others, it becomes a disaster, and once | |

| | Aims and principles underlying intervention |
|---|---|
| they think they've blown it, they give up trying altogether, leading to a binge. (**4**) | |
| *S*: I see. | |
| *C*: I'm wondering why it's so important for you to keep to your diet and these rules? | |
| *S*: Because my weight is all-important to me . . . I've got to be thinner. | |
| *C*: Right, I'm just going to add that here (**5**). So we can see that there are two pathways that lead to you bingeing and vomiting. One is the emotional pathway . . . when you feel stressed or upset . . . to help you cope and release some tension. The second way is the hunger pathway, when you're very hungry or you break a rule. It seems like both of them end up with you feeling worse and reinforcing your ideas that you can't cope or control your weight and eating. Does that make sense to you? Does it match what's going on for you? (**6**) | ***Link 6:*** *Bringing the formulation together and completing the links. The clinician can highlight the two pathways (emotion- and hunger-driven) that trigger binge eating and the maintenance cycle in which Sarah is now trapped.* |
| *S*: Yes . . . I'd never thought of it this way before . . . it all just felt like a big mess. | |
| *C*: So, looking at this, what do you think we need to do . . . to help you? | |
| *S*: I suppose . . . try not to binge when I get upset . . . to do something else . . . and to cut down on the rules and dieting. | |
| *C:* OK, so this is only the first "map." We'll be adding to it and changing it as we go along. What I'd like you to do is take a copy away with you and think about it. Add on anything we've forgotten, or any more rules you notice. | |

### *Drawing Sarah's draft formulation*

Figure 8.1 illustrates the formulation that was being drawn out on the board during the dialogue above.

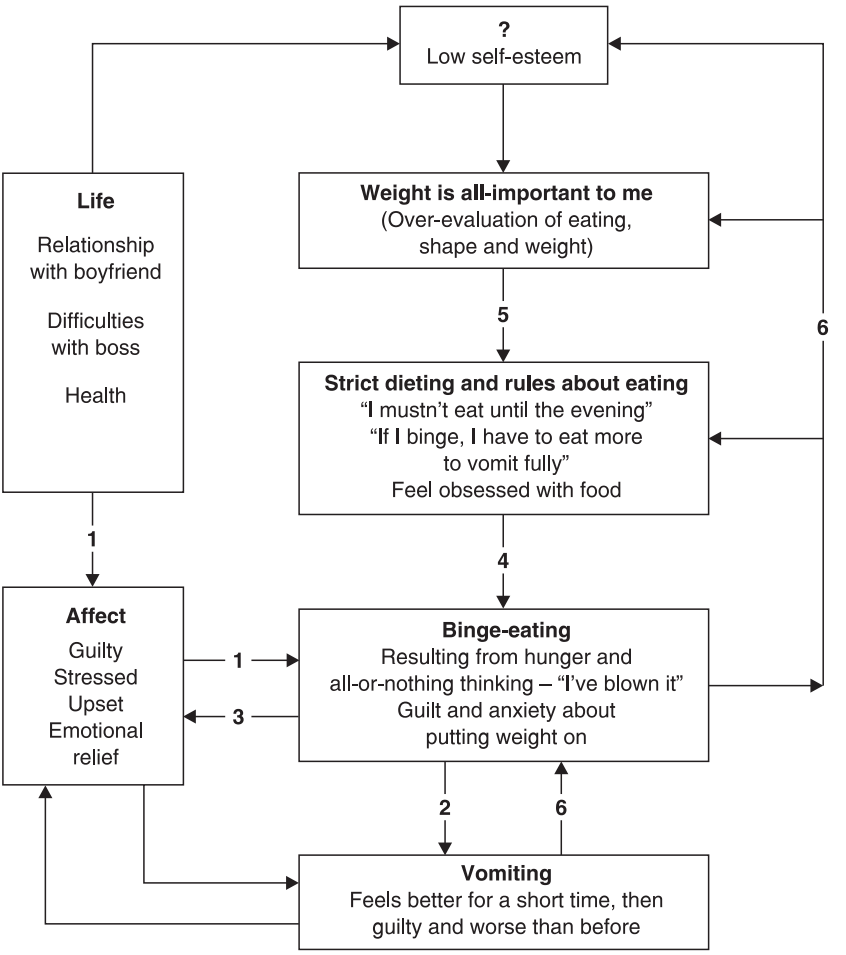



Figure 8.1 Formulation for Sarah.

## 8.4 Understanding and formulating restriction-based cases

While earlier formulations of restrictive cases have tended to focus on different elements of the case, we find it important to formulate such cases in terms of the cognitive, emotional, behavioral, physiological and motivational factors that are relevant to the individual. It is also important to consider and explain the presence of bingeing and purging behaviors that are commonly found in underweight patients. Key elements in the formulation include: the sense of personal control and the immediate positive reinforcement that the patient can experience from restriction (e.g., Slade, 1982); the emotional numbing that restrictive patients report (e.g., Waller *et al.*, in press); the loss of opportunity for positive reinforcement (e.g., due to social isolation); and the roles of body checking

(e.g., Fairburn *et al.*, 1999). We consider with the patient the evidence (e.g., Garner, 1997; Keys, 1950) that starvation can produce and maintain many of these effects (e.g., social withdrawal, preoccupation with food, lack of interest in activity, bingeing, low mood, anxiety and mood swings).

### 8.4.1 Starting the formulation with restrictive cases

The same procedure as above is adopted as for the bulimic disorders. Again, we use ''draining'' initially to identify the patient's main current problems, and then start formulating the patient's eating problems using the template for anorexia nervosa. In the case of anorexia nervosa, the discussion will most often include the role of starvation in reinforcing the anorexia. It is important to be aware that starvation can lead to impaired cognitive functioning and social withdrawal. This link can reinforce the patient's tendency to overevaluate eating, shape and weight (e.g., through generating more rigid black and white thinking). More importantly, we will spend additional time in ensuring that the patient is able to understand the formulation, as we find that we often need to proceed more slowly and return to specific points in order to allow the patient time to engage with the formulation.

### 8.4.2 Formulation example: the dialogue with a patient with anorexia nervosa

In this section, we provide an example of a discussion with a patient with anorexia nervosa (Karen, who was mentioned earlier), using it to construct a formulation of the patient's problems.

#### 8.4.2.1 Dialogue

| | Aims and principles underlying intervention |
|---|---|
| *Clinician*: So, we are going to focus on putting together what's called a formulation – so that we have an idea of how you have got to where you are now, and also what is keeping it going. | *Introducing the idea of a formulation to the patient* |
| *Karen*: OK. | |
| *C*: Can you remember when you first thought about losing weight? What was happening in your life? | *Exploring factors related to the onset of the patient's restrictive behavior.* |
| *K*: I think I started dieting when I was 15. I was at school and the other girls started talking about dieting and looking good. I was really unhappy because of everything that was happening. | |

| | Aims and principles underlying intervention |
|---|---|
| My exams were coming up but I couldn't concentrate on them at all . . . I was worried I was going to fail them (**1**). | |
| *C*: Can you tell me a bit about what was happening? | ***Link 1:*** *Patient reveals initial triggers to her restriction* |
| *K*: Well . . . it was when my Mum died . . . and my Dad just couldn't cope. He sent us away to live with our grandparents. I lost all my friends and had to start a new school. There was no one to talk to (**1**). | |
| *C*: It sounds like that must have been a very difficult time, losing your mother and then the change of moving to a different area to live with your grandparents. Sometimes, in those kinds of situations, it is hard to grieve properly for the person who has died or to talk about how you were feeling. | |
| *K*: Yes, I couldn't talk to Dad — he was too upset. I started working really hard because I had to be perfect (**2**) — I didn't want to cause any more problems. But I found it so hard to work — I couldn't think straight. Everything felt so out of control (**3**). The more I tried to make everything OK for everyone, the worse it seemed to be. | ***Links 2 and 3:*** *Perfectionism and need for control contribute to patient's initial decision to diet* |
| *C*: And what happened when you started to diet? | |
| *K*: It gave me something to think about . . . to focus on. And I realized I was good at it. The other girls would have a chocolate bar but I could keep going. I realized I could control my weight and my eating, even if everything else was a mess. | |
| *C*: And how did you feel? | |
| *K*: The other girls were really impressed. I used to get a buzz when I'd lost some weight (**4**). | ***Links 4 and 5:*** *Improvement in mood and sense of control reinforce dieting* |

| | Aims and principles underlying intervention |
|---|---|
| And then I'd just be thinking about what I could cut out next (**5**). | *behavior, and leads to an intensification of restriction over time* |
| *C*: Did it always feel good? | |
| *K*: No, I'd eat something and then be really anxious about putting weight on and have to exercise or make sure I skipped the next meal. I'd always be worrying about the next meal (**5**). | |
| *C*: You got a buzz from the dieting but that would quickly turn to anxiety, and that would lead to increasing your dieting . . . You talked about all the other difficulties and changes that were going on at that time. Did the anorexia affect those? | |
| *K*: Yes. Somehow, I didn't have to think about them anymore. I could block them out. I went numb (**7**). | ***Link 7:*** *Restricting numbs the patient's negative emotional states* |
| *C*: The anorexia meant you avoided all the difficult feelings and problems. | |
| *K*: Yes, I knew I couldn't sort them out, and the weight and eating seemed more important. | |
| *C*: So you were losing quite a bit of weight . . . how did that affect you? | |
| *K*: At first, I don't think I noticed anything – I just felt good. Now, it's harder and harder to concentrate. I don't really see anyone – I don't have the energy or the interest (**6**). | ***Link 6:*** *Patient realizes that she is feeling less energetic and has become increasingly focused on her weight and shape* |
| *C*: How do you feel about the way you look now? | |
| *K*: Sometimes I know I look too underweight. But this is the one thing I have left. I know it started off with the dieting and wanting to be thin, but now it seems too scary not to have it. I don't know how I would cope. Whenever anything bad happens, I know that I want to diet even more. | |
| *C*: It seems like you're describing this cycle here, where the anorexia helps you to avoid problems and helps you feel good – even if only for a short time – and this is what keeps the | ***Link 8:*** *Clinician concludes the vicious cycle, and checks his/her understanding with the patient* |

| | Aims and principles underlying intervention |
|---|---|
| anorexia going. But we also have this arrow here — which shows that actually you end up feeling more out of control than before — with your eating and everything else (**8**).<br>*K*: Yes, it's like I'm trapped — no matter how hard I try, it's never good enough. | |

#### 8.4.2.2 Drawing Karen's draft formulation

Figure 8.2 shows the formulation that was drawn out on the board during the dialogue above. The numbers in parentheses show where the model was modified as the formulation discussion proceeded.

## 8.5 The more complex the patient, the more important the formulation

Whilst a formulation is always important, it is particularly so when one is working with patients presenting with complex and multifaceted problems, because part of the process of formulating involves the development of a comprehensive problem list. The formulation also provides a framework for understanding how the patient's different problems are related. For example, a formulation might help a patient who binges and vomits, uses alcohol and self-harms to see that all of these behaviors reflect ways of dealing with strong negative emotional states. In other words, an apparently complex set of comorbid problems can often be formulated in a relatively simple framework. This understanding helps the patient to learn to identify and label these emotional states when they arise, and to consider trying out alternative ways of dealing with them. Formulations of such complex cases are considered in Chapters 24 and 25.

## 8.6 Checking whether your formulation is accurate

Butler (1998) has outlined ten tests to check the accuracy of a formulation. These are given in Table 8.1.

Because of its hypothetical nature, a formulation can never be shown to be conclusively right or wrong. However, it should provide a plausible explanation for the patient's problems to clinician and patient, as well as being comprehensible to others (e.g., the supervisor, other colleagues). The key issue

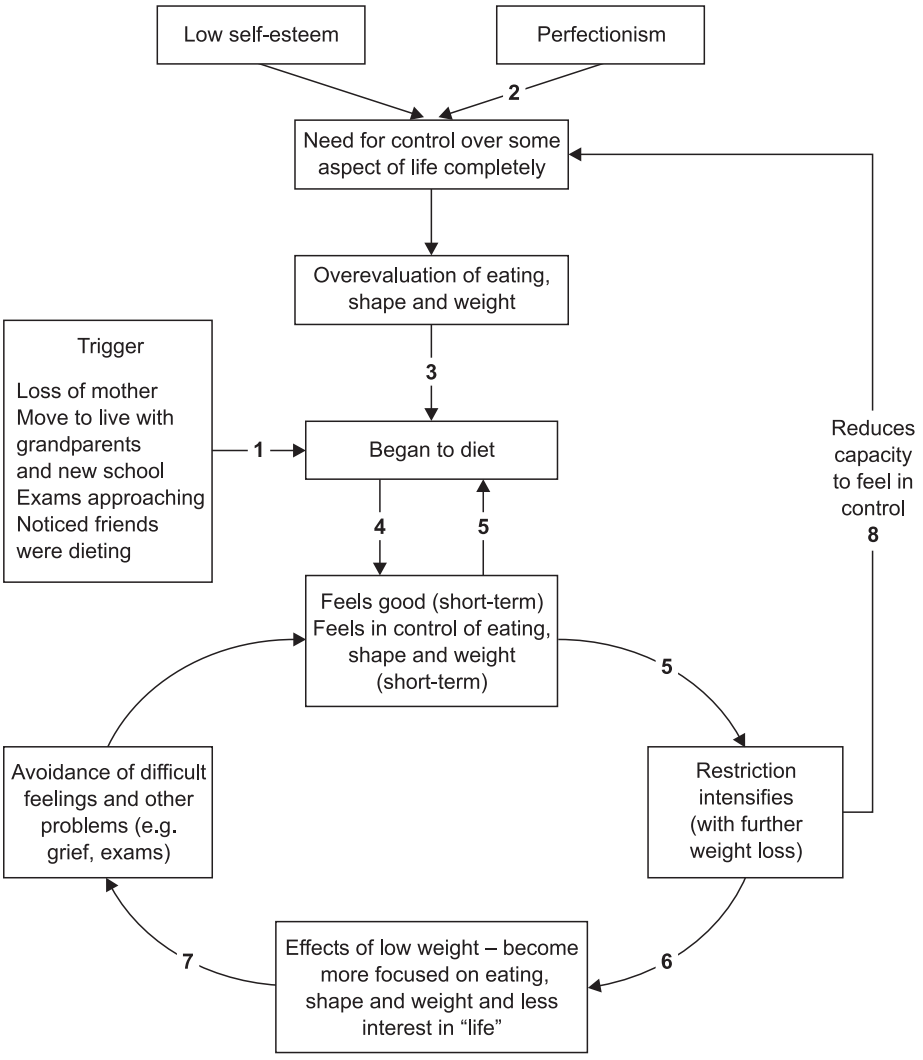



Figure 8.2 Draft formulation for Karen.

is that the clinician and patient must be willing to accept the formulation as a useful "work in progress" (i.e., accept that it is a draft that will further evolve over time).

### 8.6.1 Parsimony

In general, a formulation that is simple, clear and easy for others to understand is more readily testable and more useful than one that is unnecessarily complex. Equally, a formulation that is specific, rather than general, has clearer implications of what needs to happen in therapy in order for the patient's problems to resolve.

**Table 8.1.** Ten tests to check the accuracy of a formulation (adapted from Butler, 1998)

| |
|---|
| 1. Does the formulation make theoretical sense? |
| 2. Does it fit with the evidence (the patient's symptoms, problems, reactions to experiences)? |
| 3. Does it account for predisposing, precipitating and perpetuating factors (e.g., early experiences, core belief, specific trigger situations)? |
| 4. Do others think it fits (i.e., the patient, supervisor, colleagues)? |
| 5. Can it be used to make predictions (e.g., about difficulties, about aspects of the therapeutic relationship)? |
| 6. Can it help you to work out how you might test these predictions (i.e., to select interventions, to anticipate the patient's responses and reactions to experiments)? |
| 7. Does it fit with the patient's past history (strengths as well as weaknesses)? |
| 8. Does treatment based on the formulation progress as would be expected in theory? |
| 9. Can it be used to identify future sources of risk or difficulties for this person? |
| 10. Are there important aspects of the patient's problems that are left unexplained by the formulation? |

Finally, the simpler a formulation is, the easier it is to communicate to the patient and others. Therefore, the principle of parsimony applies here.

### 8.6.2 Behavioral experiments are the next step

Ultimately, the test of a formulation is what happens when the clinician and patient start to test the hypotheses that can be derived from it, using behavioral experiments (see Chapters 21 and 22). Even if a formulation is accurate (or at least internally consistent), it is not useful for treatment purposes unless it is used to drive behavioral experiments that test the patient's main hypotheses. If treatment is not proceeding well, then both the formulation and the treatment implementation may need to be revised.

## 8.7 How to get good at formulating

We would recommend that clinicians regularly discuss and review formulations with supervisors or colleagues, in order to learn how to make formulations more simple and concise. We find it useful to always think of the formulation as a set of hypotheses, rather than as a statement of facts.

The most important skill to develop in this area is to admit to and learn from our mistakes — recognizing how to use the formulation to improve matters when treatment is failing. A formulation that is simple, clear and well-articulated is likely to strengthen patient–clinician collaboration and enhance the patient's

motivation, as they start to perceive their eating problem as manageable rather than unresolvable. The formulation becomes particularly important when:

- your efforts to help the patient fail (i.e., the treatment strategies do not help the patient to feel better or the treatment goals are not being met)
- the patient finds it difficult to complete homework assignments (see also Chapter 9)
- the patient experiences a major setback after a time period when their eating difficulties had much improved.

In these cases, a good formulation helps clinician and patient to understand what is getting in the way of the patient's progress, and is useful in helping them to identify which of his or her working hypotheses might need revision. Clinician and patient can then reformulate aspects of the patient's problem and revise the treatment plan. In contrast, a clinician working without a formulation will be tempted randomly to try out another intervention strategy at that point. However, as the use of this strategy is unlikely to be based on their understanding of the main factors involved in the maintenance of the patient's problems, it is less likely to be helpful in achieving the treatment goals.

9

# Therapy interfering behaviors

A key issue with some patients is their engagement in therapy. Many do not always appear to be dedicated to change, often manifesting as poor attendance or a failure to undertake homework in a useful way (e.g., leaving it at home, doing it in ways that miss the point about clarifying food intake). While the reasons for this lack of engagement often appear plausible, e.g.:

- last-minute difficulties in arranging child care
- illness
- transport difficulties
- work commitments
- refusal to be weighted

they can also appear avoidable, e.g.:

- oversleeping
- forgot the appointment
- left homework behind
- repeated wish to change therapy or clinician
- thought that non-attendance would not matter.

Whatever the reason, a lack of consistency and engagement is liable to disrupt therapy, and makes it less likely that the patient will benefit.

It is vital that the clinician does not allow the CBT to be made less effective. This can happen for two reasons. First, the therapy is disrupted, making it less likely that the patient will be able to incorporate the lessons learned from cognitive restructuring and behavioral experiments. Second, the clinician loses faith in the patient's commitment, and can become angry at the patient or dismissive of efforts that they make. Thus, both the patient and the clinician can contribute to the therapy's failure when disruptions occur.

Where there are difficulties in engaging the patient in change, they should be raised with the patient, in a non-judgemental way. A more phenomenological approach makes it less likely that the patient's position will

become entrenched. We often use analogies to illustrate the point for the patient, such as:

> It is rather like going to your doctor with a problem, but not being willing to describe your symptoms or take any medicine. It does not matter how much you want to get treatment and how much the doctor wants to help you – nothing can be done to help you, and you end up with the illness continuing.

## 9.1 Naming the reasons for therapeutic disruption: therapy interfering behaviors

We draw heavily from Linehan's (1993) concept of a non-judgemental approach to dealing with behaviors that confound therapy. She has introduced the concept of *therapy interfering behaviors*: understanding behaviors in terms of their impact on treatment, rather than by labeling them as "accidental" or "wilful." Rather than blaming the patient for being uncooperative or bemoaning the unavoidable problems that get in the way of therapy, it is more effective to talk to the patient about the impossibility of therapy in the context of irregular/unpredictable appointments, homework not being completed, etc. The clinician needs to be very explicit that the patient is not being blamed, and that it is very regrettable, but that the patient needs to consider whether there is anything that can be done to facilitate treatment happening, e.g.:

> Looking at the last five sessions, you have had to cancel two at short notice, and you did not bring the homework to another one. Clearly, you feel that it is very difficult for you to take the time off work, but we do really have to consider whether you have space in your life to do therapy at present. It seems that you want change, but that you would have to make a greater commitment to that change. I wonder if we can get to grips with the reasons that you are having such problems, and decide if you can prioritize the therapy or whether we should be taking a break from it right now. A break would have the benefit of meaning that you can sort out the things that are getting in the way of therapy, though it might make it hard for you to get the motivation to get back into treatment. I suppose that the benefit of staying on is that you could get on with change, though it would be hard to face up to making therapy a priority. You really need to decide which of those options you want to pursue right now.

We find that making the bigger problem explicit (rather than getting caught in the trap of always trying to solve the smaller problems, such as child care) makes it far more likely that the patient will recognize his or her contribution to the difficulties in therapy, and results in behavioral changes that show much better engagement. It appears that this results in change and a better engagement in therapy because there is no need to defend oneself when one is not being blamed for the problem, but is being given a "no-fault" way of understanding and solving it.

### 9.1.1 A framework for understanding treatment: the river analogy

This analogy can be used to give the patient a framework for understanding the aims and processes of CBT (and, indeed, many other treatment approaches), in order to consolidate the patient's motivation to engage and allay some of their anxieties about doing so. It is useful to return to this theme to refocus treatment when a patient's motivation is low (e.g., when patients are struggling with a particular aspect of changing their behavior). It can be introduced in the following way:

> When people come for treatment, they frequently feel overwhelmed by their problems and helpless to do anything to change them. It is like they are being swept along by a fast-flowing river, and it is taking all of their energy to keep afloat. They may be trying to swim, usually without much success because the current is so strong, or grabbing onto bits of debris that pass them in an effort to keep their head above water. Alternatively all of their energy may be consumed by treading water. Either way, the river decides where they are headed – not them.
>
> The aim of treatment is to help people to swim to the edge of the river and climb onto the bank. From here they are able to observe the river, its currents, and its course. From this vantage point they will be able to see and evaluate their options (whilst in the river this would not have been possible) – to get some boots and explore the shallow waters; to build a bridge and observe the river from the other bank; or to build a raft and navigate their own course along the river. Alternatively they can choose to dive back into the river and resume their struggle.
>
> When we step back from a problem, other options that we are not able to see when we are immersed in our difficulties present themselves. From this distance, we are able to consider those options in a way that would not be possible when we are immersed in only one. The strategies the patients will learn during treatment are all ways of helping them to climb onto the bank of the river, and to discover and consider their options.

It can be used to remind them that the aim of treatment is to enable them to explore other options – not to direct them towards a particular one (in line with the philosophy of Socratic questioning). The eating-disordered option remains open to them, but engaging in treatment will make it an option in the future rather than an inevitability.

## 9.2 Responding to therapy interfering behaviors

The next step in response to any disruption of this sort is to make it clear that the patient's participation is necessary for therapy to work:

> Therapy is not something that can be "done" to you. I can only help you to change if you are prepared to participate. If you are not an active therapist for yourself, then this will not work.

The therapy interfering behaviors (and the reasons for those behaviors) should also be included in the patient's formulation, to explain and predict the difficulties that they will encounter in getting and accepting help. This message can be repeated, but continued therapy interfering behaviors mean that the individual's motivation to change needs to be questioned and developed (see Chapter 6).

### 9.2.1 Using short-term contracts

An important step can be the development of a short-term contract (e.g., 3–4 sessions), with clearly operationalized goals (e.g., keeping a food diary, including quantities eaten, times and hunger levels) and consequences (e.g., extension or termination of treatment). Such contracts ensure that the patient understands that therapy is something that is not open-ended but is contingent upon participation. Just as importantly, such a contract can focus the clinician, who might need to step back from the process of trying to encourage general participation, and who might need to operationalize goals and consequences (both of which can be difficult to remember when one is struggling to get the patient just to take part in therapy). This can be helpful in allowing the clinician to consider stopping treatment where it might be the best course of action, without feeling that one is being "mean" to the patient.

### 9.2.2 The five-minute session

Many patients who have a long history of poor collaboration in therapy are used to spending many sessions on why they find it so hard to undertake tasks (e.g., homework, attendance), and more sessions on failed efforts to try new methods of achieving those same tasks. In those cases, the clinician needs to stand back far enough to be able to see that the one consistent pattern is that the patient remains unchanged across a long period of time. Thus, repeated problems in collaboration might indicate a patient who is reluctant to change or one who is afraid of different experiences, but they certainly indicate a clinician who is off-track. In effect, the clinician can be rewarding escape/avoidance from the task in hand, by continuing to see the patient but without ever challenging the central problem.

One of the most powerful tools to re-engage a patient who is undertaking therapy interfering behaviors is the brief session. In one session, the clinician should undertake a comprehensive review of the therapy interfering behaviors, always expressing genuine understanding that there are things that can make therapy difficult, while stressing the likelihood that therapy will not be able to progress without those problems being resolved. A short contract

(maybe four to six sessions) should be agreed, including specific tasks that need to be achieved in that time. As soon as those conditions are breached (for example, at the next session), then the patient needs to understand that therapy is totally dependent on their participation, and that the clinician is unable to proceed until the work has been done. Again, the clinician should express the belief that the patient can undertake the task, and then end the session and agree to meet next time (arranging the interval around how long the patient thinks it will take to do the task) to discuss how the task went. For example, the following intervention might be used after finding out at the beginning of the session that the agreed homework (dietary records) has not been completed:

> I think that we are rather stuck here. As we agreed last time, there is nothing useful that we can do about your eating disorder without a clear idea of what you are eating. I appreciate that you believe that you can remember it, but people's memories are universally unreliable – that is why we ask for the diaries to be kept at the time. Even if you could remember perfectly, it would still take the majority of this session to reconstruct the diary, which would mean that there was no time to do all the other work that is needed. Without time for that, the diary becomes pointless. Now, I appreciate that there has not been much opportunity this week, but this really relates to that point we made last session about prioritizing this work if you want to have a chance to deal with your eating patterns. I have no doubt at all that you can keep a diary like this, so it now becomes a matter of whether you can make the time to deal with this. As there is nothing more that we can do today, I suggest that we end there and make another appointment for when you will have had a chance to do the work – keeping your food diary for a week.

The brevity of the session means that the patient realizes that the therapy is contingent on their participation. Our experience is that this gives a powerful message to the patient – linking the therapy to the patient's actions (or lack of them). We find that the patient returns to therapy in a much more collaborative role, with a marked reduction in therapy interfering behaviors (and with a completed diary). Despite our concerns, it is very rare that the patient does not return for the next session.

However, imposing a very brief timeframe on a session in this way can feel punitive to the clinician. It is important to use supervision to ensure that the real reason for acting this way is to give the patient the best long-term prospect of change, so that the clinician is able to contain his or her short-term anxiety about the potential negative impact of this course of action. The key is explaining the brevity of the session to the patient honestly, as an inevitable consequence of the failure to progress, while always expressing one's belief that the patient can undertake the necessary task.

## 9.3 Particular patient groups

Our experience indicates that therapy interfering behaviors are particularly associated with some forms of comorbidity. For example, dissociation can manifest as poor memory for tasks, while multiimpulsivity can result in the patient attending while intoxicated. The abandonment fears in borderline personality pathology can manifest as failure to attend (testing the clinician's commitment). Finally, there are elements of narcissistic personality that need to be addressed in order to facilitate therapy (e.g., keeping the focus of therapy on the patient's difficulties, rather allowing therapy to stray onto an attack on the clinician's shortcomings). These comorbid states are addressed more fully later in the book, but their impact on therapy needs to be addressed openly with the patient when the relevant behaviors occur.

10

# Homework

Homework is an essential part of CBT for eating disorders. Typical assignments include self-monitoring, changing the structure and content of one's diet and the conducting of behavioral experiments (e.g., the introduction of previously avoided foods to test out beliefs about weight gain). The purpose of homework is to help the patient gather data, to understand the factors that drive and maintain their behaviors and to test some of the ideas that they have learnt during therapy.

## 10.1 Explaining homework

The clinician should make it clear to the patient early on in treatment that homework is not an optional extra, but forms a central part of treatment, linking to the need for the patient to become their own therapist. Research has shown that patients who complete homework assignments do significantly better in CBT.

Assigning homework effectively can be more difficult than some clinicians think. Inexperienced clinicians sometimes tend to think that it should be relatively easy for patients to do basic CBT assignments, such as food monitoring or completing thought records. As a consequence, they often spend insufficient time preparing the patient for these tasks. For example, a novice clinician might say to a patient:

> Here is a food monitoring diary. I would like you to use it to write down what you have had to eat and drink over the week. I think it might be useful for you to complete that, so that we get a better understanding of your eating.

The problem with such instructions is that they do not acknowledge the detailed preparation and practice that effective monitoring requires. Leahy (2001) summarizes this problem: "Simply assigning self-help homework is not enough to get a patient to change. Asking a patient to complete thought records may seem clear enough to the clinician, but it will almost certainly be extremely

vague and threatening to the patient.'' As a consequence, homework can become a source of frustration for both clinician and patient, and may ultimately be abandoned.

When agreeing on an assignment, the clinician should explain clearly what the patient is required to do, and how the task relates to the overall goals of treatment. Finally, assignments should be set collaboratively by patient and clinician *throughout* the session, rather than being selected in a rush at the end.

In the following section, we review some general guidelines for homework assignments. This is to ensure that the patient gets the most out of these tasks. We then provide some ideas about how clinicians can address patients' non-compliance with homework assignments.

### 10.1.1 Audiotaping of sessions for review as part of homework

The idea of audiotaping sessions fits with the transparent nature of the CBT approach, and serves the dual function of providing a memory aid and a further opportunity to digest and reflect on what has been discussed in session. We routinely ask patients to bring an audiotape to record each session, and we encourage them to listen to the session over the subsequent week. Most patients will use a single tape, which means that each new session is recorded over the previous one. However, some patients prefer to keep their recordings of particular sessions and bring a new tape from time to time.

This seemingly simple task is frequently experienced by patients as distressing, as they not only re-experience what could have been a difficult session but they are exposed to a raft of self-critical thoughts about their current situation and presentation in the session. It is therefore important to provide a clear rationale for this task and ensure that space is given in each session to discuss their experience of it. Here it can be useful to revisit the themes of the river analogy (the tape offers a way of standing back from their experiences and observing them ''from the bank of the river''), becoming their own therapist (it enables the patient to digest and reflect upon what has been discussed in session) and short-term versus long-term implications (e.g., what may in the short term be a distressing experience can have positive longer-term consequences).

To enable patients to tolerate the distress provoked by this task and to optimize their use of the material, we have found it useful to guide their listening of the tape by asking them to think about the following questions:

1. *When listening to the tape, what are your thoughts and feelings?* This encourages the patient to begin to make links between their thoughts, feelings and behaviors.

2. *Listening to yourself on the tape, was there anything that you were thinking or feeling that you weren't able to communicate/share, and if so, what made it difficult to do so?* This encourages the patient to reflect on their interaction with the clinician in the session, which can lead to a consideration of their interaction with others in the outside world.

## 10.2 General guidelines for agreeing on homework assignments

In order to assign homework assignments effectively, clinicians should go through a number of steps, which are described below and illustrated with examples. Further information on the practicalities of setting homework tasks can be found in Leahy (2001).

### 10.2.1 Explain the rationale for the homework to the patient

Homework will normally be overtly linked to the goals of the previous session. Before setting a homework task, the clinician should explain to the patient why the homework task makes sense in the context of the treatment goals. In addition, the patient's concerns about the task should be openly discussed. Just because the clinician thinks a certain homework task is a good idea, this does not mean that the patient thinks likewise. The clinician might say something like:

> From what we have just discussed, it seems that you have had little opportunity to practice observing your thoughts in situations when you eat something in public and you start feeling as if others are judging you. I wonder if it would be helpful for you to learn how to identify negative automatic thoughts in these situations more quickly. What do you think?

In this case, the idea of introducing thought records follows on from what was previously discussed in the session. The aim is to help improve the patient's ability to identify negative automatic thoughts.

### 10.2.2 Ask the patient to explain the rationale for the homework to you

Once the clinician has explained the rationale for the homework, it should not be assumed that the patient understands it. Instead, the clinician might ask the patient to repeat in their own words what they think the point of the assignment is:

> Can you tell me in your own words why it might be useful for you to write down everything you eat and drink over the next week? What is your understanding of why this may be a helpful thing to do?

Clinicians who do this are often surprised to find that the patient has difficulty understanding the point of a particular assignment. If the patient has difficulty understanding the point of the task, the clinician should take time to explain it,

until the patient can see how and why the task will help them to move further towards their goals.

### 10.2.3 Specify exactly what the patient should do and how they should do it

For a homework task to be effective, it should be as specific as possible. For example, simply saying to the patient that they should record their eating might be highly confusing for the patient, and they might end up either not recording at all or recording highly inconsistently. Such an assignment may also convey the message that the clinician is not 100% clear about what needs to be done and why. Instead the clinician should review the format of the diary in detail with the patient.

### 10.2.4 Practice the homework assignment with the patient in the session

Once selected, the clinician and the patient should practice the homework task together in the session. The easiest way to do this is by using a recent example. In the case of a food monitoring record, this might involve writing down what the patient has eaten prior to coming to the session or on the day before. Practicing the homework in the session gives the clinician the chance to address questions that otherwise would only have arisen after the session has ended (e.g., ''Do I need to record the contents of a binge?'').

### 10.2.5 Ask the patient about any concerns regarding carrying out the homework assignment

When the patient appears ambivalent about a homework assignment, it is important that the clinician is open and receptive to this. The clinician might say:

> It seems to me that you are not completely sure about this homework. Are there any concerns you have about it? It would be helpful if we can discuss your concerns openly, as they might be entirely valid. I want to make sure this homework is ''do-able'' and not too overwhelming for you.

Encouraging an open discussion of the patient's concerns regarding the homework does not mean that the clinician will need to drop the assignment or change to another one. However, it gives the patient the opportunity to clarify how the assignment fits into the wider picture of treatment, and to raise any problems of which the clinician may not have been aware.

### 10.2.6 Summarize the homework

We find it useful to provide the patient with a summary sheet to complete as a part of the homework each week. This sheet aims to help the patient to:

- Summarize their eating pattern (including number of meals, snacks, episodes of bingeing and compensatory behaviors) prior to the session. This encourages

them to begin to take responsibility for identifying gaps and potential areas for further work.
- Consider significant experiences during the week within a CBT framework by recording them in terms of their thoughts, feelings and behaviors. This is the essential first step towards cognitive restructuring.
- Begin to identifying times when things have gone well or better. We have found that this orients the patient to look for exceptions to the problem, strengths that can be built upon, and the beginnings of change, all of which are important in strengthening motivation for further and continued change.
- Contribute to the agenda and gradually take more responsibility for structuring the treatment.

The summary sheet should be reviewed at the beginning of each session and used to set the agenda. Over time, it enables the patient to work towards the specific goals of regularizing eating and reducing eating behaviors, conceptualizing their experience within a CBT framework, contributing to the agenda and completing homework, thus leading to the broader goal of becoming their own therapist.

## 10.3 Dealing with homework non-compliance

Many patients with eating disorders are reluctant to complete homework assignments. In many cases, such reluctance will be related to issues of motivation, in which case the clinician might consider introducing the idea of the "five-minute session" (see Chapter 9). However, occasionally patients' inability to complete homework assignments may be related to comorbid depression. In any case, non-compliance with homework should be made a priority agenda item. For example, the clinician may wish to explore what the patient thought would happen if they had completed the homework assignment, and what evidence they have for this belief. The clinician can use a number of questions to help the patient evaluate negative thoughts and beliefs regarding homework assignments. Some useful ones are:
- What are the costs and benefits of doing homework generally?
- What is a better alternative?
- What is the evidence for and against the idea that homework does not work?
- What homework would you assign yourself?
- What would you recommend to a friend in your position?
- How is your pessimism regarding homework similar to other thoughts you have about getting better?
- What reason would you have to believe that the clinician would think less of you if you did not do the homework in a specific way?

- Would you be willing to experiment with doing a little bit of homework, so that we can evaluate its effectiveness?

It is often useful to give the patient a homework task that involves challenging their reasons for not doing homework. Other strategies that can be helpful include getting the patient to set their own homework assignments, and/or giving them smaller amounts of homework.

A straightforward way to minimize the occurrence of homework non-compliance is to start the assignments together with the patient in the session. This allows the clinician to challenge the patient's concerns early on. As noted above, the clinician should always be able to explain the homework to the patient, and ensure that the patient understands the rationale for it.

11

# Surviving as an effective clinician

Eating-disordered patients are acknowledged as one of the most challenging patient groups to work with (Vitousek *et al.*, 1998). There are several reasons for this, including: the physical risks involved; the chronic nature of the cases; and the fact that there are often egosyntonic elements to the disorder. Those who present with comorbid personality disorder can particularly test clinicians. The personal characteristics of both patients and clinicians also impact upon the dynamics of the therapeutic relationship. In this chapter, we aim to encourage the reader to take a reflective stance to these and other relevant issues. In order to remain an *effective* clinician, it is important to be aware of how such issues may challenge us. We need to understand and respond to our own characteristics, including perfectionism, anxiety and over- and underinvestment in the patient changing. The pressures are likely to be alleviated or worsened by the clinical setting (e.g., stressors are likely to differ across out-patient, day-patient and in-patient settings).

## 11.1 The physical aspects of an eating disorder

This patient group experiences high levels of physical risk. However, it is also necessary to consider the other physical issues that go along with the eating disorders (e.g., weighing the patient).

### 11.1.1 Physical risks in the eating disorders

The eating disorders have particularly high levels of physical risk (e.g., due to starvation, self-harm, electrolyte imbalances). This often creates a tension that the clinician (and team) needs to manage. The clinician needs to balance the desire to deliver therapy and maintain a therapeutic alliance with the need to set and hold clear and firm boundaries regarding physical risk. Whilst all such decisions need to be made within the context of a multidisciplinary team, it is worth remembering that all clinicians in the multidisciplinary team (e.g., psychologists, psychotherapists, nurses, dietitians) need support from a medical practitioner to a lesser

or greater degree. This lack of knowledge about all aspects of the eating disorder can increase a clinician's anxiety, impairing his or her confidence in the therapy room. This anxiety about the patient's physical state can be exacerbated by pressure from concerned families or other health professionals.

To reduce these concerns, multidisciplinary working is essential, including input from medically trained staff (either within or outside the team). We explain to patients that ensuring physical safety is essential, and that the relevant investigations (e.g., blood tests) are non-negotiable if the patient wishes to stay in therapy. Furthermore, for patients at risk of continued physical deterioration, clear boundaries are set at which consequences will occur (e.g., a hospital admission if the patient declines to a certain weight or BMI, or if physical investigations are abnormal). Such a way of working ensures that a decision is not left solely to one clinician. Having non-negotiables and clear boundaries reminds us of the importance of our underlying rationale, rather than allowing us to be diverted into making exceptions for ''special'' patients.

### 11.1.2 The act of weighing in the therapeutic relationship

Clinicians new to the field of eating disorders might assume that weighing the patient and measuring height are the responsibility of ''someone else,'' rather than of the clinician delivering the individual therapy. The physical act of weighing the patient (requesting removal of shoes and heavy clothing) may feel intrusive and unusual. However, as discussed in Chapters 4 and 15, there are a number of incontrovertible reasons for the clinician weighing the patient if CBT is to be effective. Some patients may refuse to be weighed. As above, the clinician needs to hold this as a non-negotiable of therapy, whilst delivering a clear rationale to the patient.

### 11.1.3 Weight as a communication

The patient's reports of eating will often not be consistent with changes in weight, and it is vital that any such discrepancy should be discussed and resolved in collaboration with the patient. Furthermore some patients may insist that they are finding treatment really helpful, yet the weight graph demonstrates that they are struggling to maintain or gain weight. It is useful to explore with the patient the fact that reported behaviors and weight are incompatible, and to help the patient to think about why this may be (e.g., eating less than they can acknowledge, or finding it hard to report binge episodes). It is important to avoid becoming stuck in a ''head to head'' confrontation, in which all the patient can hear is the clinician suggesting that they are untruthful. Using a collaborative approach can enable the patient to understand and disclose the inconsistencies in their report.

### 11.1.4 Dealing with food-related issues without panic

Similarly to the issue of weighing the patient, the clinician also needs to take responsibility for advising the patient on issues related to food. It is known that many professionals working in this area are untrained in nutrition and nutritional knowledge is relatively poor in them (Cordery & Waller, 2006), and that many patients exhibit a far greater knowledge of certain aspects of nutrition (e.g., calorie content of foods) than the clinician. Hence, it can feel anxiety-provoking to have to address patients' food consumption, and any questions or anxieties they may have, especially if the patient feels very strongly about a certain issue. This is why it can be useful to have a dietitian within the team, as this professional can offer much support, education and reassurance to the clinician (as well as working with those patients who need individualized support). It is also important to remember that sudden, abnormal weight increases (i.e., that do not follow the recent trend of weight changes) of 0.5 kg in a week or more are likely to be due to fluid, rather than changes in fat/muscle. Therefore, the patient's diet does not need to be changed in response to such fluctuations, as this then makes it impossible to identify what caused the weight to drop in the next week (i.e., it could have been because of the change in diet, or because of the fact weight would have returned to normal without any changes).

It is also worth remembering that achieving predictability of energy balance (e.g., how much food is needed for long-term weight changes) is not an exact science, even if the patient is in a setting where food is relatively well controlled (e.g., an eating disorders unit). Although research tells us that weight gain is directly linked to calorific intake (e.g., if one is prescribed *this* diet, one's weight will increase by *this* amount), in reality, the variety of food available and other variables (exercise/activity, natural fluctuation) mean that such certainty is unattainable. It can be very easy to get caught up in the patient's anxiety about having an extra biscuit per day, for example, when in reality it is only when food intake alters by at least 200–300 kcal per day (usually more) that weight will change, and that the amount of food needed is substantially greater when the target is substantial weight gain (see Chapter 7). Hence, it is inappropriate to spend large amounts of time "perfecting" the diet, or changing it each week in response to fluid fluctuations.

## 11.2 The nature of the disorder

Many of the features typically seen in eating-disordered patients can contribute to a clinician feeling overwhelmed. Those features include: the egosyntonicity of some symptoms; the chronicity and severity of the disorder; and the "blocking" presentation seen in some patients.

### 11.2.1 The egosyntonic nature of symptoms

Many patients perceive some of their symptoms (particularly weight loss and a sense of control over eating, shape and weight) as highly desirable, and seek to eliminate the egodystonic symptoms whilst retaining the positive aspects. In contrast, the egosyntonic nature of the symptoms can feel frustrating for clinicians, who can see how damaging the associated behaviors are for the individual. If this disparity of viewpoints is not explored, it can lead to confrontation, disengagement, confusion and despair for both parties.

It is necessary to discuss with the patient why it will not be effective to try to hold on to part of the eating disorder in the long term (or even short term). For example, an underweight patient with bulimic behaviors who had significantly reduced their level of bingeing and vomiting was unable to work towards a healthy weight range. The clinician shared the rationale for reaching a healthy weight, but the patient still felt unable to work towards this. After discussion, it was collaboratively agreed to terminate active treatment. Although it may seem that this is not ideal, it was important that the decision was reached collaboratively, rather than the patient feeling compelled to ''drop out'' of treatment because they were not being listened to. This allowed the patient to feel that it was acceptable to return to treatment when their (initial) preferred strategy had failed to allow them to regain the life that they wanted.

In considering how the patient perceives the disorder, the clinician also needs to be aware of how the patient got to treatment. This is particularly true in adolescent cases, where the decision has usually been taken by the parents and may not be what the young person wanted at all. In an adult service, there can be similar pressures, even though they can be (slightly) more subtle. For example, the individual might feel pressured by their spouse, by fear of losing their job or by instructions from their university or college tutor. Thus, the clinician may be faced with a hostile individual whose motivation for recovery is low.

### 11.2.2 Chronicity

As discussed in Chapter 28, when it comes to recovery, people with eating disorders are a heterogeneous group. While some will recover with relatively little input, other patients present with long and chronic histories of disturbance and require far more work. Treating such patients can feel like an impossible task. However, it is not unheard of for patients with long histories to recover or to make substantial improvement. Taking a long-term perspective can help the clinician manage such work. The issue of clinician investment (see below) is also important in these cases.

### 11.2.3 The "special" patient

Teams also need to be aware of what can be known as the ''special'' patient, and of the need to keep channels of communication open within the team when such a patient is being treated. This theme was first identified in relation to in-patient settings (Main, 1957). However, it is applicable to many settings, given that these patients (and particularly the more complex and challenging ones) will have a number of individuals and agencies involved in their care.

If a patient is treated as ''special'' or if treatment is excessively compartmentalized (e.g., team members fail to communicate openly), the potential for splitting of the team is high. For example, many clinicians will have had the experience of a patient disclosing a ''secret'' to them alone, only to discover at a later date that the patient has disclosed the same secret to a number of team members, all of whom have been told they are the only one who knows this. At a more day-to-day level, when one is working with a dietitian, regular discussions between professionals are vital to ensure that treatment does not become polarized into ''food'' and ''feelings,'' with the CBT therapist neglecting the behavioral aspects of the disorder. It is also not uncommon for the roles to be reversed. For example, the patient might take food issues to the CBT clinician, and end up discussing emotional issues with the dietitian. This dichotomy is inappropriate and is unlikely to result in a positive outcome. Good communication between clinicians can quickly highlight this problem.

### 11.2.4 "Manipulation"

The term ''manipulative'' is one that is sometimes used to describe eating-disordered patients. In our experience, this is not helpful, and often reflects the clinician's (and team's) struggle to work effectively with an individual. Use of this term, or others like it, should be prompt to take a step back and consider the difficulties. It can be useful to try and understand the patient's behavior from their position. The patient's behavior is likely to be driven by distress, or by difficulty in admitting problems, rather than by an active desire to ''deceive'' or ''manipulate'' the clinician. Again, using a collaborative and reflective stance to explore these issues with the patient is advised.

## 11.3 Personal characteristics of patients and clinicians

Both the clinician and the patient have personal characteristics that have a bearing on the therapeutic work. In reflecting on one's own characteristics, it is often worth the clinician taking a developmental stance and considering how he or she has changed or remained the same over time (e.g., confidence increasing

over time). It is also the case that many patients share characteristics with their clinicians (e.g., perfectionism), and this can make it hard to develop an objective perspective to help the patient change to a more functional approach to life.

### 11.3.1 What brings us to this work?

While some clinicians reading this book will have chosen to work in specialist eating disorder clinics, others will be generic workers for whom eating-disordered patients comprise merely part of a varied (and large) caseload. Whichever category you fall into, we encourage reflection of your attitudes and emotional responses to these patients. An understanding of possible similarities with our patients – notably perfectionism, dichotomous thinking and anxiety – may also influence our work.

Many clinicians overinvest in the likelihood of patient change. This seems to be partly a product of seeing oneself as being a ''white knight,'' arriving on the scene to rescue the patient from this ''terrible disorder.'' Such a perspective is understandable, given the factors that might have led the individual to become a clinician in the first place. Just as we have highlighted the ''special'' patient, one must also be aware of setting oneself up as the ''special'' clinician who will cure this patient where others have failed. Signs that such a dynamic exists include a sense that only you understand this patient, and a belief that you are the only one in which the patient confides. Equally, high levels of perfectionism may lead to self-criticism should we fail to ''cure'' a patient.

### 11.3.2 Issues with body image

Clinicians who work with eating-disordered patients need to have an understanding of their own attitudes towards body image, and how they perceive themselves. For instance, a clinician who has issues about his or her own weight may project unrealistic expectations onto their patients (e.g., expecting overweight patients to lose weight), and then get upset when the patient ''fails.'' We also need to be able to manage the questions that patients may throw at us.

### 11.3.3 Power differentials

This field is one in which it is vital to reflect on how we relate to our patients. Whilst there is always variation in both pools of individuals, both patients with eating disorders and their clinicians can include a preponderance of young, well-educated females. The clinician needs to be able to reflect how the similarities and differences between patient and clinician can influence the therapeutic relationship. Some patients may wish or even perceive you to be their friend. How does one manage to set and maintain boundaries in this context?

For male clinicians, other issues may also be pertinent. For some patients, this may be the first positive experience of a relationship with a male, and the patient may develop romantic feelings. All clinicians, but perhaps particularly senior male clinicians, need to acknowledge the number of inappropriate relationships between male clinicians and eating-disordered patients (regardless of therapeutic modality), and operate in environments that are transparent enough to avoid any risk of such abuse.

### 11.3.4 How the patient relates to the clinician

In some cases, the clinician may find it difficult to develop a therapeutic relationship with patients who may be alexithymic or have a tendency to engage in primary avoidance of affect as a general strategy. The clinician may in turn experience this style as cold, distant and disinterested. Supervision can assist the clinician to see this as a general personality style rather than as a rebuff of the clinician's attempts to engage. Patients with a high degree of shame may present similar difficulties in engagement. In a somewhat different manifestation, some patients have a high degree of approval seeking or "people-pleasing," due to their early experiences. Such patients might find it difficult to let the clinician know that a particular intervention is unhelpful or distressing, or might avoid showing the "real" self for fear of rejection or disapproval.

Given the long-term course of some eating disorders, it is unsurprising that a number of patients will have had previous treatment episodes. For some, these experiences will have been negative, and the clinician will have to work hard to develop a therapeutic alliance with an individual who may be apprehensive or even hostile. Exploring the features that contributed to the earlier negative experience is helpful for both clinician and patient. Finally, it is important that the clinician should be aware of the impact of his or her own characteristics on the patient (e.g., many patients have had experiences that make them likely to be afraid of working with a male or female clinician).

## 11.4 How to survive as an effective clinician

We have highlighted some of the issues that potentially contribute to clinician disengagement and burnout. We find that a combination of the following assists us in managing such stressors.

### 11.4.1 A collaborative stance

As highlighted at the beginning of the book, the clinician's stance is vital. When working with this patient group, we find that the most effective

philosophy underpinning our work is to focus continually on the need to work collaboratively with the patient and with colleagues, rather than entering into conflict with the patient or with others involved in their care (''shoulder to shoulder'' rather than ''head to head''). At the level of interacting with the patient, it is important to avoid collusion or confrontation, remaining objective and authoritative. The use of boundaries and non-negotiables provides a safe and containing experience for both clinician and patients. The rationale for such boundaries and non-negotiables should always be discussed with patients. When this is done, patients are more likely to be accepting of limits, even if they do not like them (Geller, 2002a).

### 11.4.2 Supervision

As highlighted throughout the book, supervision is essential for effective cognitive-behavioral work. Supervision may take a variety of formats, but they typically include individual supervision from a senior clinician or group supervision with peers. Within a service, supervision must be acknowledged as an essential and respected as such. The CBT model lends itself to a supervisory format (Padesky, 1996). We would encourage reflecting on process as well as content. Having space to share frustration as well as to consider work that goes well is vital. Discussion of cases can provide fresh insight, and is important in alerting the clinician to potential problems (e.g., overinvestment in certain patients). Supervision can also stimulate and inspire the thinking of both parties. The development over time of the supervisory relationship can provide much support for the clinician, particularly when other stressors may be pertinent (see below).

There are several themes applicable to the delivery of CBT that are also relevant to consider in the context of supervision. In encouraging our patients to adopt realistic goals, we must also do the same ourselves. This realistic approach might involve accepting that some patients will not make a ''full recovery,'' or recognizing that it is not appropriate to take responsibility for ''fixing'' external factors, such as poor relationships. Adopting a long-term perspective can help the clinician to assume a realistic approach.

### 11.4.3 Team working

As discussed in Chapter 3, multidisciplinary team working is essential to provide coherent and effective care. The use of team decision-making can relieve the pressure on individuals, and ensure that boundaries are held appropriately. Joint working can be particularly supportive in the case of extremely complex patients and of those with severe personality issues. The team culture needs to

enable clinicians to discuss and voice their anxieties or struggles with more challenging patients without a fear of being judged. Support may be provided informally or more formally in the supervision context.

### 11.4.4 Balanced working

A balanced working life is essential in reducing the risk of burnout. This balance is likely to involve incorporating a variety of activities (including research, professional development and training others). Equally, a caseload that is balanced in terms of complexity can help clinicians to maintain perspective.

### 11.4.5 Taking care of ourselves when personal matters may impact on us

It is important to recognize that events that occur outside of our working lives can impact on how we are in the therapy room with patients. Obvious examples of such issues could include a family bereavement or illness, divorce or relationship breakdown. More subtle issues might be the patient struggling with their children or not prioritizing the health of an unborn baby, if the clinician himself or herself is trying to start a family. What is important is that the clinician should be aware of such issues, and take steps to care for himself or herself during difficult times. Such self-care requires acknowledging that we are not automatons, who can shut personal issues away in a box at home.

### 11.4.6 Making mistakes or letting the patient down unexpectedly

Given the challenging nature of this patient group, it is not unrealistic that sometimes we feel more able to be empathic with our patients than at other times. Also, we are not perfect and will make mistakes, either around practical advice (e.g., food prescription) or in our provision of emotional support (e.g., not picking up on an issue until after the session). Sickness is also unavoidable, and can mean the therapist will need to cancel a session unexpectedly. What is important is that we endeavor to take appropriate responsibility (i.e., not too much or too little) for the issue, and that we repair any fracture in the working relationship. Such repairs can be difficult to achieve, especially if the patient ''attacks'' us for our faults. However, to do so will allow the patient to see that we are human, that it is acceptable to make mistakes, and that we are strong enough to admit when we are wrong. Such an admission might feel difficult at the time, but in the longer term it will allow a more real relationship between patient and clinician.

## 11.5 Summary

This chapter has aimed to consider some of the issues that might impact on our ability to survive as an effective clinician and to consider some of the mechanisms that might assist in that survival. Consideration of these issues is essential, if we are to deliver effective and ethical treatment to patients while running and developing a team that is motivated, supported and engaged in their work.

12

# Setting and maintaining an agenda

Agenda setting is the process of putting together a list of possible issues that patient and clinician want and need to address in a particular session, including regular items (such as weighing and reviewing the diary) and "one-off" items (such as preparing for a holiday or a meal out with family). The setting of an agenda reminds the patient that specific problems will be addressed during treatment, and the clinician should convey the message that the clinician and patient will be working jointly on specific problems in a systematic fashion.

## 12.1 General agenda of all CBT sessions

While each session's agenda needs to be individualized, CBT for the eating disorders involves going over a number of "standing items" and routine tasks that should be part of every session.

### 12.1.1 Monitoring mood and eating

Prior to each session, if relevant, we might ask patients to complete self-report measures of eating behaviors, depression and anxiety, and to summarize their eating behaviors (see Appendix 3 for the relevant monitoring sheets).

### 12.1.2 "Standing" agenda items

In keeping with other clinicians (e.g., Fairburn, 2004), we recommend that every treatment session should follow a similar structure. We spend the first part of the session reviewing the patient's food monitoring records, completing the weighing experiment and plotting and reviewing the weight chart. We usually allow about 10–15 minutes for these tasks. We tend to review the diary first in order to allow us to discuss the patient's beliefs about weight gain in the context of being clear about what they have actually eaten, so that current and alternative beliefs can be generated (see Chapter 22).

Following the completion of these tasks, we set the agenda together with the patient for the remainder of the session (about 30 minutes), which we then work through. We always allow five minutes at the end to confirm the homework tasks and the date and time of the next meeting.

## 12.2 How to set the agenda

The idea that CBT sessions are structured can be explained to patients in the following way:

> In each session, we will follow a certain structure. The first part of each session will be focused on reviewing your eating over the preceding week and then weighing you. Once we have done that, we will set an agenda for the remaining 30 minutes or so. Every week, I will ask you to think *before* you come to the session about problems that you would like to put on the agenda, and to prioritize those items which you think are most important for us to discuss. I will do the same, and in the session we will together decide which items most urgently need addressing. I will also provide you with a weekly summary sheet, like this one here, where I would like you to write down your main agenda points for the session. In that way we can make sure that we don't miss something that is important to you. We will end each session with a review of the main points that we have covered and planning the homework, and I might ask you for some feedback about how you feel things are going.

## 12.3 Some practical points about agenda setting

We find it important to consider the following issues when setting an agenda.

### 12.3.1 Do it collaboratively

The setting of the agenda should be done collaboratively with the patient. The emphasis should be on giving the patient as much control as possible over the choice of items and the order in which these issues will be addressed. However, this choice needs to be balanced with the necessity to work through the regular agenda items that form part of every session (e.g., weighing, food monitoring records) and with the fact that some important elements in effective CBT will need to be introduced by the clinician, and might be temporarily unpleasant for the patient to engage in (e.g., reductions in body checking).

### 12.3.2 Keep an eye on time

Throughout the session, the clinician needs to keep a close eye on the time to ensure that the agenda is covered within regular session time. Given the time constraints, it is often more realistic to put only two or three items on the agenda, than overloading it with four or five (see below).

### 12.3.3 Maintain appropriate flexibility

It is essential to maintain a degree of flexibility when working within an agenda. For example, when something important that was not on the agenda emerges half way through, it is essential that this should not simply be ignored or treated as unimportant (which is how the patient is likely to see it if we ask them to wait until the next session). However, it is equally important not to be so flexible that the agenda is continually interrupted when that is not necessary. For example, if the patient spends the whole session worrying about having gained weight, it can be unproductive to spend the time reassuring the patient and trying to get them to engage in cognitive challenges. It might be more effective simply to proceed with the weighing experiment. It is important to identify patterns of such interruptions (e.g., the patient brings a completely new problem for the agenda each week) and to discuss with the patient how such patterns are stopping you get to the necessary work. This sort of issue can be discussed by making sense of whether there are recurring issues or behaviors that are making it hard to progress with the CBT.

### 12.3.4 Solving problems that arise when working within the agenda

#### 12.3.4.1 Problem 1: the first problem discussed takes up too much time

Occasionally, when discussing an agenda item, the clinician realizes that most of the time could be spent on this topic. In this case, she or he should remind the patient of the amount of time that was initially allocated to the issue, and give the patient the choice to decide what they would like to do:

> I am aware that we have been talking about the last weekend for the last 15 minutes, and you also wanted to talk about your concerns about a dinner at work that is coming up next week. Do you want us to continue with the discussion about last weekend for a little while longer, or shall we move on to the issue of the dinner?

This gives the patient an opportunity to learn to structure the session time. We have found that taking such action early helps to avoid later disappointments or feelings of anger on part of the patient, when the patient realizes that they did not get the chance to discuss something that was important to them.

Over time, the patient should become increasingly more able to structure the session time themselves. In the ideal situation, the time-keeping process will eventually become reversed, with the patient being able to initiate what should happen next (i.e., ''I know you are going to ask me to predict my weight now''). This is a sign that the patient has been socialized into the process of CBT.

#### 12.3.4.2 Problem 2: the patient has set the agenda but is unwilling to stick to it

Another common problem is that the patient sets the agenda, but then diverges from it. When this happens, the clinician should identify this deviation and

address the matter directly with the patient. Patients might engage in this behavior unknowingly (e.g., they may have a tendency to avoid talking about problems that are likely to bring up strong emotions). The clinician can address the behavior in the following way:

Sorry Anna. Can I interrupt you there for a second? I've been listening to what you have been saying, but it seems to me that we have moved away from what we had initially decided to talk about. Remember that we had decided to talk about how you felt on Friday evening after your friend cancelled your meeting at the last minute? Is there a particular reason why you moved away from talking about that?

If the clinician notices that the patient's divergence from the agenda reflects a general pattern of avoidant coping, which is getting in the way of working productively in the sessions, she or he might say the following:

It seems to me that we sometimes end up talking about things that are not really part of our agenda, and that are not relevant to your eating difficulties. Is it just me, or do you find that too? Patients sometimes feel uncomfortable talking about bad things that happened over the previous week, because they worry that their negative feelings will come back if they talk about it. Has that ever happened to you in our sessions? Would it be helpful for me to point it out to you if I feel we are getting off track? If I am wrong, I am very happy for you to tell me. I just think that it gives us the chance to understand what is happening.

In most cases, it is enough for the clinician to bring this process to the patient's attention. The tape-recording of the session is often useful at this point, because it allows the patient to reflect on the process while listening to the tape as part of their homework. However, when the patient has a consistent tendency to diverge from the agenda, the clinician might also want to link this to the clinical formulation. This process can be initiated in the following way:

How does this avoidance fit with the formulation? Let's have a look. Can you relate it to anything we talked about in previous sessions? How does it fit with your emotional inhibition core belief that we talked about two sessions ago?

13

# Psychoeducation

Psychoeducation is the term used to describe any education that is used to help the patient evaluate their own relationship with their eating disorder. As such, it is different to standard didactic education, where the principles are broad and do not necessarily relate to the individuals' personal situation. Therefore, for psychoeducation to be effective, it needs to involve both a review of specific facts and an opportunity to reflect on how they impact on the individual. The topics covered in psychoeducation are more likely to be based on scientific facts around nutrition, physiology and the medical implications of eating-disordered behaviors, but can also address societal and cultural issues such as the cultural ideal of thinness in Western society. Table 13.1 lists the psychoeducation topics that we find useful to address, and Appendix 2 contains the linked psychoeducation sheets that we have developed for patients. In keeping with the individualized approach described above, these are presented as a menu for the clinician to select from, rather than being a list that should be delivered whole. However, this list of resources is not expected to be all that a patient might find useful. Whilst the core eating disorder behaviors remain relatively stable, subtle shifts in trends of behaviors used will occur all the time. To keep up to date with such developments we suggest that the clinician and patient use the internet as a source of useful information. We discuss this topic further below.

Psychoeducation has been a key part of treatment for eating disorders since the 1980s, based on the premise that it helps patients to understand the nature of their eating-disordered behaviors and to change their thinking. In particular, it can be seen as an important source of information for the patient to generate alternative cognitions for examining and testing (e.g., "Maybe I need significantly more calories than I am eating right now to gain weight."). However, it is important not to view psychoeducation as an alternative to therapy, since it does not attempt to modify the underlying thoughts and cognitions that drive the behaviors. Rather, in the eating disorders psychoeducation

**Table 13.1.** Basic psychoeducation topics/handouts (all are in Appendix 2)

**Getting started: practical information about improving food intake**

The following leaflets are designed to support the eating plan (see Figure 7.2). Their aim is to help the patient make the necessary changes to their diet for effective CBT.

1. The advantages of regular eating
2. General points to help normalize food intake
3. Hunger
4. How much do we need to drink (non-alcoholic drinks)
5. Examples of different foods and the food groups to which they belong
6. Grading foods: a chart to identify what foods are easily managed, and what foods are currently avoided

**Health consequences of unchecked eating disorder behaviors**

1. The effects of semi-starvation on behavior and physical health (the Minnesota Experiment)
2. Complications of food restriction and low weight/anorexia nervosa
3. Complications of bulimia nervosa (especially laxative abuse and vomiting)
4. The effect of self-induced vomiting on physical health
5. The effects of laxative abuse on physical health
6. The effects of diuretic abuse on physical health
7. Exercise and activity
8. Bone health and osteoporosis

**Issues that perpetuate the disorders**

1. The effect of purging on calorie absorption
2. Weight control in the short and long term
3. Why diets do not work
4. The effect of premenstrual syndrome (PMS)

**Basic nutritional facts and principles**

1. Metabolic rate/energy expenditure (or how the body uses food)
2. Normal eating
3. Protein: some basic facts
4. Carbohydrates: some basic facts
5. Fats: some basic facts
6. Fruits and vegetables
7. Alcohol

can be seen as necessary but not sufficient for CBT to take place. For psychoeducation to be effective, it needs to be interwoven with the use of cognitive and behavioral strategies that help the patient to establish the validity of the new information.

## 13.1 When to use psychoeducation

Psychoeducation is generally introduced early in treatment, but can (and should) be reviewed and revisited at later stages, if and when the need arises. As none of us retain every aspect of new information in one go, it is important to go over specific points whenever an opportunity presents itself. It is also important to remember that if the patient is at a low weight, very restrictive in their eating, or very anxious, their concentration and ability to process new information may be affected. Audio-taping the session and giving the tape to the patient can therefore be helpful, as it allows the patient to review the information discussed at a later stage (see Chapter 10). Also, as the patient progresses through therapy, they are likely to be able to evaluate material in different ways, and this will hopefully enable them to address more challenging questions about how they use food to cope with emotional issues, and to develop a better understanding of the links between what and when they eat and the impact this has on feelings.

## 13.2 How to use psychoeducation effectively

Psychoeducation should be delivered in a non-judgmental, respectful way in response to specific questions or dilemmas. It is important not to have a list of standard issues that the clinician feels he or she must cover, before going on to address the underlying psychological issues. Rather, psychoeducation should be interwoven with the use of CBT strategies. Most often, this is done by reviewing the patient's food diary, and then linking the psychoeducational information to CBT strategies, such as behavioral experiments. Psychoeducation is therefore tailored to the individual's current needs. It is also important to remember that the same point may need to be addressed at different times and in different ways to enable the patient to alter their views permanently. Effective psychoeducation therefore requires patience, gentleness, persistence and empathy on the part of the clinician.

There are several psychoeducational issues that the clinician might wish to prioritize early on in treatment. Examples include education about eating-related behaviors that may affect the patient's health (e.g., dental health related to persistent vomiting; osteoporosis related to low weight and amenorrhea), or that are potentially life-threatening (e.g., stomach rupture related to bingeing; cardiac involvement following severe purging). However, psychoeducation is not a list of scare tactics designed to frighten the person into changing. Most patients have spent years developing socially driven misconceptions about how their body works and what is ''normal,'' partly aided by the constant bombardment of messages claiming to be ''the answer'' or ''the truth'' about food and weight issues.

It is therefore very important to allow the individual the space and opportunity to reflect on and discuss relevant points, thus allowing them to come to their own (hopefully more healthy) conclusions. If this space is not available, there is a danger of the clinician becoming yet another source of dogma, thus failing to equip the patient with a foundation of understanding that will last beyond the therapeutic process.

## 13.3 Using the internet as a psychoeducation resource

As stated above, the resources provided in this book are designed to provide a basic range of literature on relevant psychoeducation topics. However, there are likely to be times when these leaflets do not cover what the clinician and patient need. In these circumstances, the clinician is advised to utilize other material for psychoeducation purposes, such as the internet. Whilst the internet can provide extremely useful information on an unlimited number of areas, it is important to recognize that it is, to all intents and purposes, unregulated. Therefore, while some material will be valid, there will also be information that is out of date, incomplete, inaccurate, not based on research, and so on. In particular, it is important to warn patients that the pro-anorexia websites that exist are not likely to be useful sources of information, and to encourage the patient to consider whether accessing those websites is going to be helpful to them in attaining their goals. However seductively those websites are presented, the patient needs to question the motivation of the sufferers who post them. The patient may also filter out more suitable information, choosing information that supports their inaccurate beliefs about the world. To address this, it may be appropriate for both clinician and patient to look on the internet for the required information in the week between sessions and compare the balance of information obtained.

## 13.4 Key psychoeducation topics

Two key psychoeducation topics need to be discussed early on in treatment to enable the patient to start engaging in cognitive and behavioral changes. These are: (1) the psychological consequences of starvation and (2) the body's healthy energy requirements.

### 13.4.1 The psychological effects of starvation

Keys and colleagues explored the effect of starvation on humans in the 1950s (Garner & Garfinkel, 1997). This study was on 36 psychologically and physically healthy men. During the first three months of the study, the participants were asked to eat normally while their behavior, psychology

and eating patterns were studied in detail. In the subsequent six months, the men's food intake was limited to approximately half, leading the men to lose about 25% of their original body weight, if not more (some men got down to a BMI of 14). In the third phase, the men were re-fed over a further three months.

While the participants' responses to the starvation varied to some extent, all men experienced dramatic changes in their physical, psychological and social functioning during the starvation period. Most surprisingly, many of these changes persisted during the rehabilitation phase (the last three months), and beyond.

We have found it useful to share the results of this study with patients in order to help them obtain a better understanding of the relationship between their own behaviors and the symptoms that result. Discussing the results of the Keys study in detail with patients can be extremely helpful in order for them to be able to identify that the majority of their symptoms are likely to be due to food restriction. While not all patients with eating difficulties are underweight, many have been in the recent past, and many also have the tendency to restrict their food intake over long periods during the day (e.g., eating nothing until the afternoon). The symptoms resulting from this are often similar to those reported by the participants of the Keys study.

The following symptoms related to starvation may be of interest to the patient. Further details on the Keys study and on the symptoms that are characteristic of starvation can be found in the relevant psychoeducation leaflet in Appendix 2 and in Garner and Garfinkel (1997).

- *Physical changes*. Participants reported a number of physical changes as a result of starvation, which included constant tiredness and apathy, and feelings of physical weakness. In addition, many reported headaches, gastrointestinal discomfort and a reduced tolerance for coldness.
- *Changes to eating attitudes and behaviors*. The majority of participants in the study displayed an increased preoccupation with food and a tendency to hoard food.
- *Emotional changes*. Feelings of depression, anxiety and irritability became more common as participants entered the starvation state. Many started neglecting their personal hygiene.
- *Social and sexual changes*. Participants reported a marked reduction in their sexual interest and difficulties in maintaining close social relationships. In addition, they tended to socially isolate themselves and to feel socially isolated and inadequate.
- *Cognitive changes*. Most participants reported impaired concentration and alertness, and some noted difficulties in comprehension.

When discussing the Keys study, patients may be encouraged to consider which of their own symptoms are compatible with those reported by the participants in the starvation experiment. Many patients will not have thought about their psychological and social symptoms as related to their eating. By re-framing these symptoms as a direct consequence of their restriction, the patient can start considering the impact of their eating behaviors on their health and well-being.

Clinicians should keep in mind that most patients are unaware of the wide-ranging physical, emotional and cognitive changes associated with low weight or restriction. These changes should be integrated into the discussion of the energy graph (see later in this section). It is important to normalize these changes, explaining that they are a biological indicator that the body is receiving insufficient amounts of food. It is therefore not surprising that the individual is preoccupied by food/tempted to binge/dizzy, etc. Menstrual functioning can be disturbed in normal weight bulimic women if they have a chaotic eating pattern. Dry or poor skin, dry hair and brittle nails are associated with insufficient fat in the diet. Tryptophan is an amino acid (a building block of proteins), responsible for encouraging serotonin uptake. Therefore if a diet is deficient in protein, serotonin may be depleted, leading possibly to lowered mood and depression. In addition, lack of carbohydrates and fluids are associated with headaches.

### 13.4.2 The use of the "energy graph" to help the patient to understand their energy requirements

The second key psychoeducation strategy we use to help patients understand how their body works is the energy graph. The joint construction of such a graph together with the patient often facilitates significant behavioral change in the patient. We typically introduce the graph in one of the first few sessions (usually after having done the formulation; see Chapter 8). The energy graph helps the patient to understand: (1) why their body needs a regular supply of energy throughout the day; (2) what happens when this energy (in the form of food) is not regularly supplied; and (3) the relationship between insufficient energy supply and feelings of tiredness, a lack of energy and other symptoms.

Although we talk about the body's need for energy, the most significant source of energy for helping our patients gain more appropriate control over eating is carbohydrate. This is because carbohydrate is a vital fuel for all body organs (especially the brain) and other tissues (e.g., muscle), but the body's store is comparatively small, lasting at most around 24 hours if not replenished. Carbohydrate is stored as glycogen in both muscle and liver, but it is the liver store that is of most importance for our patients, as it is this store that helps maintain a constant blood sugar level between meals. A low blood sugar sends a powerful message back to the brain to increase hunger, thus potentially triggering

bingeing or uncontrolled eating in susceptible individuals, such as eating-disordered patients. Therefore, the aim is to enable the patient to consume regular amounts of starchy carbohydrates across the day (an average sized meal will keep blood sugar stable for around four hours), thus ensuring that the supply of carbohydrate for the coming hours comes from the last meal/snack consumed, rather than the carbohydrate stores. The rationale here is that it is best to avoid the risk of bingeing related to low blood sugar by ensuring supply meets demand wherever possible. (The possibility of bingeing following periods of restriction is ever present in all eating disorders, even if the patient does not currently engage in bingeing. This is due to normal physiological responses to a lack of food.) However, it is important to restate that the other components of a healthy diet are also vital in helping the patient gain control over eating, but that carbohydrates (and specifically starchy carbohydrates) form the structure upon which the rest of the diet hangs.

#### 13.4.2.1 Step 1: preparing the patient for the use of the energy graph

The energy graph should always be drawn out on the whiteboard, and be based on a particular day from the patient's diary. We usually pick a day that reflects the patient's typical eating structure over the previous week. We then ask the patient to take us through the day step-by-step, explaining what they consumed at different times and why. The focus here is not so much on the context in which the eating occurred, than on what exactly the patient ate at a particular time. For the energy graph to be maximally effective, the patient will need to have recorded everything they consumed over the week, and done this with a sufficient amount of detail (i.e., exact portion sizes of meals). The particular psychoeducation points to highlight will vary from patient to patient.

#### 13.4.2.2 Step 2: completing the energy graph with the patient on the whiteboard

First, we draw a graph on the whiteboard, with a time line on the X-axis (e.g., 8am−11pm) and the patient's energy level on the Y-axis. In the middle of the graph, the clinician should mark a "healthy energy range" (see Lines 1 and 2 on the Y-axis), which can be explained as the energy range "within which the patient's body functions best." Note that we use the term "energy" (rather than "food" or "carbohydrates," for example), as this labeling moves away from the issue of food content to the physiological consequences of the patient's behavior. Going through the food record step-by-step, we now start drawing a line indicating the patient's energy levels. This line follows the patient's account of their food intake in chronological order as they went through the day.

Figure 13.1 provides an example of an energy graph for a patient with bulimia nervosa. This patient starts the day without breakfast (Point A), meaning that their

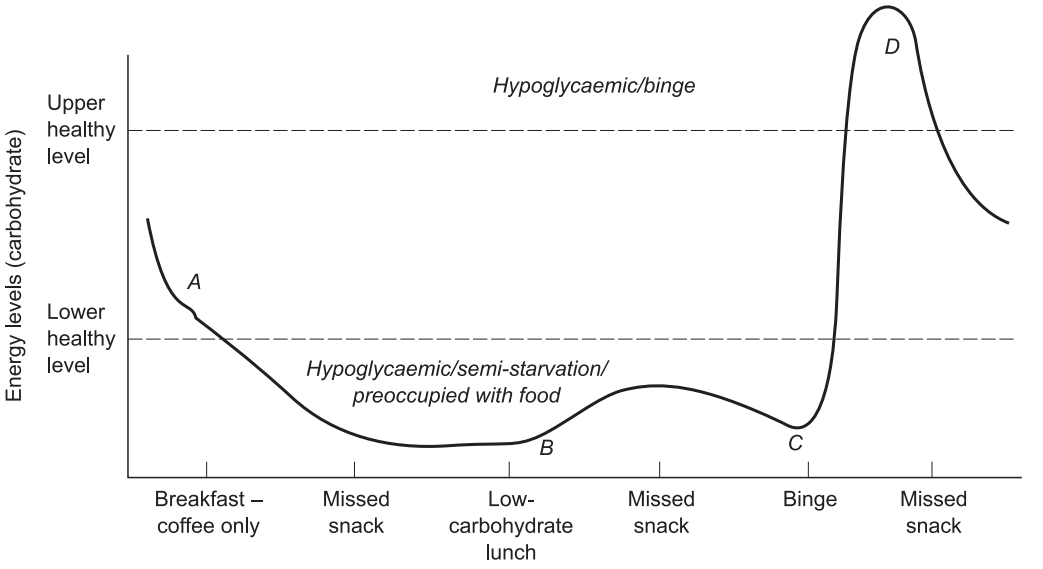



Figure 13.1 An illustration of the energy levels associated with a restrictive/bulimic dietary intake, showing the levels of carbohydrate available to the patient when restricting through the day followed by binge-eating to make up carbohydrate levels.

energy levels are close to the bottom line from the start of the day. For lunch, they eat two pieces of fruit and a low-fat yoghurt (Point B). While their energy line temporarily moves up, the food consumed is not sufficient to re-balance the body's energy requirements. As the patient's energy level drops further after lunch, they move further below the healthy energy range. At that point, they start experiencing cravings for high-carbohydrate high-sugar foods (e.g., chocolate, cakes) due to the body's increasingly urgent need for energy. The food cravings indicate that the patient's body is now in "semi-starvation mode," and the risk of bingeing increases.

While some patients are able to withstand the urge to binge for a considerable amount of time, most will eventually give in as the body's need for energy becomes too strong (Point C). In the example, the patient experiences an "uncontrollable urge" to consume fast-acting carbohydrates (mainly contained in high-sugar foods, such as cakes and chocolate) and eventually engages in a binge. The resulting oversupply of the body with high-sugar foods causes the patient severe anxiety, due to their belief that they will gain significant amounts of weight as a result. Through vomiting they try to get rid of the food eaten (Point D), not realizing that a significant proportion of the calories she has consumed will still be absorbed by the body. Also, insulin levels remain high to enable the body to utilize the carbohydrate consumed, even though the level of carbohydrate that the body

will absorb is now much lower. This has the effect of lowering blood sugar even more (see Section 13.5.3, below).

The clinician should track the patient's levels of tiredness or energy, concentration and preoccupation with food over the course of the day. For example, did they feel more or less tired or energetic as the day went on? It is possible that rather than feeling less energetic, the patient feels more energetic. This is likely to be because the stress hormones released as a result of short-term restriction can lead to a "buzz" that the patient perceives as heightened awareness (as required in the "fight or flight response"). If no food is eaten then an energy slump invariably follows. The times when the patient experienced dizzy spells, headaches or food cravings can also be added. If the individual overexercises, this should also be added and the energy-line in the graph lowered accordingly, to reflect the resulting energy loss.

The graph frequently highlights a number of points about the patient's energy input. First, the regular energy supply (e.g., "planned" meals, excluding binges) is likely to be small and insufficient, leading to strong feelings of hunger at different points during the day. Second, many patients report long periods (between four and ten hours or more, not including overnight) during which they do not consume any food. Third, in most cases the patient will have restricted on carbohydrates. Accordingly, the patient's reported binges are likely to include foods high in carbohydrate (e.g., potatoes, fries, pasta, bread, rice), which reflects their body's attempt to readjust the lack of energy supply.

#### 13.4.2.3 Step 3: making links between the patient's eating pattern and their levels of energy throughout the day

If appropriate, the clinician should make a link between the patient's reported long periods without food and their increased urges to binge, their preoccupation with food, poor concentration, irritability, and so on, dependent upon the problems they and the clinician identify. For many patients, the most difficult time may be the end of the working day, resulting in a binge as soon as they step in through the front door, or before. The example of many people stopping off for a chocolate bar (due to a sudden "energy slump"), on their way home from work can be used. The focus throughout this exercise should be an understanding that the binge is a direct result of the patient's restriction of their energy supply to their body.

#### 13.4.2.4 Step 4: discussing with the patient how they can start to normalize their energy supply

Next, the clinician should explore with the patient possible solutions to their current energy supply, and ways of remaining within the healthy levels (above starvation/craving, and below bingeing levels). For example, the clinician may explain that starchy carbohydrates (bread, pasta, potato, cereals, and so on) tend

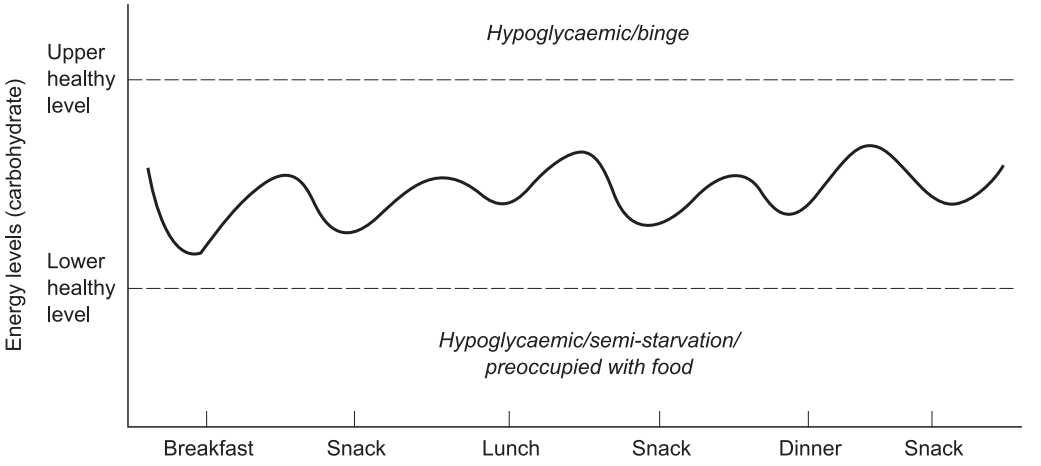



Figure 13.2 An illustration of the energy levels associated with healthy dietary intake, showing the levels of carbohydrate available to the patient when following a structured meal plan.

to release energy slowly, whilst high-sugar foods (e.g. chocolate and sweets) release quick bursts of energy, but result in a rapid energy drop shortly afterwards. The clinician draws a line on the graph, which reflects the energy levels of a person following a healthy eating pattern of three main meals and three snacks per day (Figure 13.2). This line will reflect the regular increases and drops in energy as the person goes through the day. It is particularly important to show how the individual's energy level falls over the course of the night and starts at a very low level (hence the name the first meal of the day is given: ''break/fast''), to emphasize the importance of eating both the evening snack and breakfast.

The patient is then asked how this graph compares with their own current energy levels across the day, drawing a graph of their own likely levels in keeping with their dietary intake (including binges) (see Figure 13.1). The difference for the clinician to highlight here is the frequency and spacing of meals, which ensures that the person with a healthy eating pattern does not enter the semi-starvation mode. It is also useful to stress that the carbohydrate associated with the binge is usually fast-acting, simple carbohydrate, and is often associated with high levels of fat (e.g., pastries, chocolate). The individual takes in a high number of calories which they cannot use there and then, meaning that they are stored as fat. Thus, if the patient's weight is stable, the number of calories being absorbed is the same whichever eating pattern is employed, but their energy levels will be unstable and not conducive to recovering from their eating disorder or achieving normal day-to-day goals. Also, the diet is unhealthy, leading to a very strong likelihood of weight gain and ill health related to high fat and sugar intake in the future, even if weight is currently stable.

To emphasize this point, the clinician may wish to provide the patient with a copy of the eating plan (see Table 4.3), and discuss with them the recommended intake of food required for weight maintenance. Most patients will be surprised at the amount of food that needs to be consumed simply to maintain their weight. Again, the patient should be asked to reflect on this information in the light of their own intake.

The clinician can then enquire what the patient thinks would need to be done for them to stop having binges (in bulimic disorders) or improve concentration and mood (in restrictive disorders). In many cases, this leads the patient to realize that a normalization in their eating pattern will probably lead a reduction of these problems. At the end of the discussion, the clinician should encourage the patient to decide upon a specific change to their eating that they could implement as homework during the following week. Introducing breakfast is most desirable as a starting point. It may also be helpful to provide the patient with a psychoeducation leaflet outlining practical tips regarding their eating structure (see Figure 7.2).

## 13.5 Some myths about eating that can be addressed through psychoeducation

Patients often report additional beliefs about eating that can be addressed through psychoeducation. In the following section, we describe a number of ''myths about eating'' that we have most commonly encountered in our practice, and briefly discuss how they can be addressed. A selection of useful handouts for patients explaining the psychoeducational principles relating to each of these (and other) beliefs can be found in Appendix 2.

### 13.5.1 Myth 1: My bingeing is uncontrollable and happens at random

An important point for the patient to understand early on in treatment is that binges do not happen ''at random,'' nor are they directly caused by the particular emotional state the patient experienced at the time of the binge. While emotions on their own may cause binges in a small minority of cases, research shows that in most people with eating difficulties their binges are the consequence of a highly restrictive or disorganized way of eating. It can be helpful to explain to the patient that binges occur because of physical reasons (hunger) and psychological reasons (e.g., anger, boredom). The experience of strong negative emotions in the context of such a highly restrictive diet may cause some of these binges. This explanation forms the basis for asking the patient to start changing the structure and content of their eating, which is one of the most central behavioral interventions for bulimic disorders.

### 13.5.2 Myth 2: I can learn to control my eating through restriction

Patients often talk about the importance of gaining control over their eating, mistakenly believing that increased restriction will help them to attain such control. Based on their understanding of the effects of starvation, it is worth asking the patient how easy they found it to reduce their food intake when they first started restricting. Many will report that their restricting initially resulted in a "buzz" and an increase in their levels of energy. The clinician can explain that this is a "natural side-effect of starvation" which lasts for a while, but that starvation becomes harder and harder as the body's reserves reduce. In this way, the very behavior that the patient thinks will help them to control their eating is, perversely, the behavior that will lead them increasingly to experience a lack of control. This hypothesis can be then examined historically with the patient (e.g., "Before you developed your eating disorder, when you were still eating regularly, did you feel out of control in the way that you do right now?"). The clinician may wish to provide the patient with the relevant information about the effects of starvation to emphasize this point (see Appendix 2).

Many patients who relax their restrictive food intake do find that they feel very hungry in the following days and weeks. This is a normal response to starvation (as experienced by the men in the starvation study) and can be explained that the body has been very threatened by the lack of food and is "cashing in" on the increased food intake to try to ensure that this risky situation is avoided at a later date (and is also one of the reasons why so many people with anorexia nervosa become bulimic). Whilst it will feel safer for patients to revert to a more restrictive pattern of eating, the clinician needs to encourage the patient that this is a short-term problem and that eating a balanced diet that meets their physical needs will drastically reduce the risk of bingeing.

### 13.5.3 Myth 3: vomiting after bingeing is an effective strategy to prevent weight gain

Studies carried out in laboratory settings (Kaye *et al.*, 1993) have shown that on average 1200 kcal are retained after self-induced vomiting, regardless of whether the binge was relatively small (defined as about 1500 kcal) or large (defined as about 3500 kcal). In addition, because the body is still expecting to have to absorb the food eaten, the insulin levels are still high, leading to a low blood sugar level. This increases hunger and the risk of possible further bingeing. These issues can explain the steady weight gain often seen in binge eaters, and patients should be made aware that bingeing significantly increases their risk of weight gain, even if this is regularly followed by vomiting. In addition to explaining this link to the patient, the clinician may provide the patient with the relevant psychoeducation leaflet (see Appendix 2), which explains this process in more detail.

### 13.5.4 Myth 4: taking laxatives is an effective strategy to prevent weight gain

While many patients believe that laxatives are effective in minimizing calorie absorption after a binge, research evidence suggests otherwise. The number of calories digested after laxative use is decreased by only about 10%. This is because only water (along with valuable electrolytes) is lost, not calories. Laxatives primarily affect the emptying of the large intestine, which occurs after calories from food have already been absorbed from the small intestine. To further clarify this point, the clinician may wish to provide the patient with the relevant psychoeducation leaflet (see Appendix 2).

### 13.5.5 Myth 5: using vomiting and taking laxatives is not really dangerous to one's health

Contrary to the beliefs of many of our patients, vomiting and laxatives have many physical risks – the most important is electrolyte disturbance (potassium, chloride and sodium), which may result in cardiac arrhythmias and can cause sudden death. Further information on this point can be found in the relevant psychoeducation leaflet (see Appendix 2).

### 13.5.6 Myth 6: eating food before going to bed results in significant weight gain, because the body is not "burning off" the food while you sleep

It should be explained to the patient that people gain and lose weight over longer periods of time than they think – weeks and months, rather than hour by hour. In order to gain weight, a person needs to take in substantially more calories than the body needs over a long period of time. What really matters is the amount of food and drink consumed over the course of a week, a month or longer. Another key point to understand in this context is that our body's metabolism does not stop working just because we are sleeping. Even when we are sleeping, our heart is beating, our blood is circulating, our brains are working (e.g., we are keeping normal bodily processes going and possibly dreaming), meaning that we still use up energy and burn off calories. Further information about the issue of time of eating and weight can be provided to patients by copying the relevant psychoeducation leaflet (see Appendix 2).

### 13.5.7 Myth 7: fat/carbohydrates make people fat and therefore need to be avoided

Since most people with an eating disorder come into treatment having spent huge amounts of time and energy controlling their weight, they are often well-versed in the latest popular weight loss schemes. Usually these focus on one or more of the main energy-providing nutrients (carbohydrate, fat or protein). What is interesting to observe is that with time, the food group that is "demonized" shifts and can even come full circle. For instance, in the 1960s and 1970s, when carbohydrates were felt to be the "cause" of weight gain, low-carbohydrate diets

were extremely popular, and eating disorder patients were seen to strictly limit the amount of carbohydrate they consumed. In the 1980s and 1990s it was excessive dietary fat that was felt to lead to weight gain, a fear that the eating disorder world again picked up on, and patients presented with extremely low fat intakes. The recent popularity of the Atkins diet (a very low carbohydrate diet) and patients' fears of carbohydrates shows that this cycle has indeed come full circle. In truth, it is an excess of calories in any form that leads to weight gain, not the direct effect of fats or carbohydrates *per se*. We have a direct need for all of these energy-providing nutrients (protein, fat and carbohydrate) in a balanced intake – indeed it is ensuring that the diet contains enough of all of these in a balanced diet that protects the patient from bingeing due to physical hunger.

These myths (and others) often underlie patients' disordered eating behaviors, and they should be addressed whenever the clinician feels they are getting in the way of progress in treatment. However, in most cases the provision of this information by the clinician is insufficient to ensure their impact on the patient's behavior. We therefore strongly recommend that the clinician complements the psychoeducation component of the session by providing the relevant written information (Appendix 2).

## 13.6 Summary

This chapter has highlighted some of the key psychoeducational principles that form the basis of effective cognitive-behavioral treatment of patients with eating disorders. Psychoeducation information should be interwoven with CBT strategies in order to help patients to test out whether or not this information applies to them. By providing new information that can be tested by patient and clinician with the help of behavioral experiments, patients can learn to understand the relevance of these principles to themselves over time.

14

# Diaries

Food monitoring diaries are a key part of cognitive behavioral therapy for the eating disorders, and can be viewed as the cornerstone of effective treatment. The diary provides vital information regarding the patient's eating pattern, cognitions, behaviors and emotions, enlightening both the clinician and the patient. A key aim of monitoring is to enable patients to develop and internalize skills in regular eating and recognize triggers and risk factors relating to their eating-disordered behaviors. It can be used to clarify goals and evaluate progress. The diary is most effective when used in conjunction with the formulation, encouraging increased insight and motivation for behavioral change. The completion of food monitoring diaries is one of our treatment non-negotiables.

## 14.1 Rationale for use of diaries

As monitoring eating behaviors can be an anxiety-provoking task, some patients are reluctant or even hostile to the idea of completing a diary; therefore it is vital that a clear rationale is given. We often introduce the diaries in this way:

> One of the most important parts of your treatment is what we call the food diary. In this diary, we will be asking you to record all the food you eat, and when you eat, but also the thoughts and feelings that you have throughout the day. By looking at your diary, we can begin to make links between your eating pattern and things that are happening to you that might be affecting your mood, and how your mood and thoughts relate to your binge-eating/vomiting/restriction. It is important that this is written down, because often things get forgotten over the course of a week, and because it will be impossible for me to understand what is going on for you and to help if I don't have an accurate picture. We will then look at your diary together at the beginning of each session.

For patients who remain unconvinced as to the usefulness of diaries, we use the following analogy:

> Imagine a shopkeeper whose shop is losing money. He must take some action – otherwise he is going to go bankrupt. He can do one of three things. First, he can rush around making lots of different changes, raising prices, discounting prices, sacking staff, hiring staff, in the hope that one of these will make the difference and his profits will improve. What might be – if any – the disadvantages of this strategy? If he adopts this strategy, he will probably be left feeling quite exhausted and rather helpless about his ability to change things. Can you see any similarities between this and your current approach to solving your eating disorder?
>
> The second option is that he can sit down and think about what has worked in the past, what products have sold well, which staff have performed well. And he can make his changes according to this information. Can you think of any disadvantages of this strategy? It is certainly a better strategy than the first one, but there is a weakness in this plan of action. The shopkeeper is relying on his memory, and unfortunately the human memory is not infallible. All sorts of things can interfere with its functioning: lack of sleep, alcohol, emotions, or just time.
>
> His third and last option is to keep detailed records, to identify the patterns of sales and losses, and to make his changes according to this. There are two advantages to this. First, it is the most accurate way of making decisions about change. Second, if the shopkeeper continues to keep records whilst implementing his changes, he will be able to evaluate accurately whether or not his changes are having the desired impact. How does this third strategy relate to the difficulties you're experiencing at the moment?

At this point, we use Socratic questioning to encourage the patient to see how their strategy of not monitoring themselves means that they either respond in a panicked way (option 1) or by overgeneralizing in thought and behavior and increasing the risk of bias or overlooking relevant information (option 2). We stress that option 3 has short-term costs (e.g., the time taken to complete the diaries, the potential shame in considering eating patterns), but is the only strategy that allows for constructive change in the long-term eating pattern and the rest of life. We stress that such change will arise through internalization of skills, and that the latter stage of treatment will focus on maintaining an adaptive pattern independently of food diary monitoring.

In striving for effective monitoring, it can be useful for the clinician and patient to discuss any anticipated problems in recording, and to problem-solve in advance. See Chapter 10 for some common problems and possible solutions.

## 14.2 What does a diary look like?

We give our patients ready-made weekly food diaries. This has many advantages. It highlights the importance of the diary, provides a standard, clear format,

and reduces the potential for the patient to forget or not to have suitable materials to hand. Figure 14.1 shows an example of a diary page. A blank version is provided in Appendix 3. The patient records all foods and fluids consumed on the left-hand side of the page, grouping them together as appropriate to indicate meals and snacks. The clinician can then quickly see the structure of each day's eating. Recording the timing of meals is crucial, as this can indicate physiological triggers to eating behaviors. The patient is also asked to indicate what foods (if any) contribute to a binge or purge episode, grouping them with a bracket and ticking the relevant column(s). Diaries can be tailored to include the use of other eating-disordered behaviors such as chewing and spitting, excessive exercise or laxative misuse. For patients with alcohol or drug misuse issues, consumption of these items can also be recorded in the diary.

On the right-hand side, patients are asked to record thoughts, emotions and behaviors — food and non-food related — that occurred during the day. This should particularly include events that they think triggered changes in their eating. We stress that because human memory is not infallible, it is important for recording to be as close to the event as possible to ensure accuracy (referring to the shopkeeper analogy, strategy two). Asking patients to recall what they ate two days ago, or what happened just before their last binge can demonstrate this fallibility. This means that the patient has to find a way to have the food diary with them at all times and that they have to find or make the time and space to complete it.

DAY: *Monday*

DATE: 5th March

| Time | Quantity | Food/Drink | Binge? | Vomit? | Thoughts - Feelings - Events |
|---|---|---|---|---|---|
| 9am | 1 small<br>1 | Apple<br>Tea with skimmed milk | | | Slept badly, woke up freezing.<br>Waited till everybody left the house before getting up so I could have breakfast without being hassled. |
| 11am | 1<br>1 | Crispbread<br>Coffee with skimmed milk | | | |
| 1pm | 1<br>1 | Small salad<br>Tea with skimmed milk | | | Went to the gym after lunch for 2 hours. Felt really good afterwards. |
| 7pm | Two portions<br>1 | Pasta with tomato sauce<br>Tea with skimmed milk | | Yes | Big row at dinner with my step mum saying I need to eat more. So angry, why can't they just leave me alone, can't they see the fat on me? |

Figure 14.1 Example of a food diary for an anorexic patient who uses vomiting as a compensatory behavior.

The patient and clinician should anticipate situations in which recording might be difficult, and discuss how these can be dealt with. For example, many patients initially have concerns about how to continue recording when they are going out to a meal or when they are at a party. In most of these situations, it will be possible for the patient to go to the bathroom (if they are with a group of people) or to find another space where they can be undisturbed. The clinician might stress that food monitoring is an essential ingredient of successful CBT, and that the recording needs to be done even when the patient does not feel like doing it.

## 14.3 How to address difficulties in completing diaries

Many patients will have had previous experience of monitoring their food in or out of therapy. That experience may have proved negative, often because the previous clinician has not reviewed the completed diaries or because those diaries have not incorporated monitoring of cognitions and emotions. If the patient reports prior negative experiences, these are discussed when the diaries are first introduced to reduce the likelihood of repeating difficulties.

Patients can have difficulties in completing the diaries for many reasons. In exploring such problems with the patient, it is first important to identify the reason for not completing the diary and to empathize with the experience (which might have been anxiety driven). This is a good opportunity to continue socializing the patient into the CBT model, by asking the patient to identify the thoughts and emotions that led to the difficulties in utilizing the diary. You may also need to explore the experience of having to tell you, the clinician, about failing to complete the diary. Concerns or difficulties that commonly become apparent include:

- writing down what they eat will make them worse
- shame or embarrassment in showing the diary to the clinician
- fear that someone else may find the diary
- time consuming
- inaccuracy due to leaving too long a gap between eating and recording
- not understanding the importance of monitoring
- deciding to use their own format
- recording what the patient thinks the clinician wants to see.

Clinician response should be determined by the reason for not completing the diary. The ''shopkeeper analogy'' (described above) can be introduced or revisited. If the patient has managed to complete some of the diary, praise their efforts and discuss the importance of complete monitoring (again, you can use the shopkeeper analogy – if the shopkeeper only monitors half the week, how does he know it is reliable?). We encourage the patient to evaluate the pros and cons of

keeping a diary, and attempt to problem-solve the difficulty in a collaborative manner. It is our experience that the solution will be far more effective if it is patient-generated.

Sometimes, patients decide to jettison the food diary and use their own version. Almost inevitably, this is not as clear as our version (e.g., hard to see spacing of meals, or may omit to record cognitions and emotions). We then praise the patient for monitoring their eating, whilst gently pointing out the reasons for using the standard format and asking if their method can achieve the true goals of recording.

Many patients struggle to include everything in their diary. Sometimes, clinicians may have serious concerns over the accuracy of the diary. For example, some patients report that they eat very little and deny bingeing, but they maintain a stable weight. Again, this is a topic that can be pursued in the manner of the curious clinician:

> I'm a little puzzled when we look at your diaries. I've noticed that over the past month or so, you've reported a fairly restrictive eating pattern, yet your weight has remained stable. Sometimes, patients forget to record everything in their diaries or sometimes they feel embarrassed about recording if they have a binge. I wonder if these fit with what is going on for you, or if there is another reason that might help us understand this?

If a patient is unable initially to record the content of a binge, we encourage them simply to mark that a binge has occurred. In this way, we can still begin to identify triggers and patterns. The patient can begin to add the content of the binge when they are more comfortable.

Occasionally, repeated failure to complete the diary reflects wider issues of engagement and motivation or a fear of worsening their preoccupation with eating and weight. We tend to frame such a failure to engage with the task as a therapy-interfering behavior (Linehan, 1993) (see Chapter 9).

## 14.4 Reviewing the diary with the patient

As with all homework, it is essential to review the diary with the patient. Not only will it provide you with important information — it will reinforce for the patient the value that you attach to the diary. It is likely the patient has put considerable effort into completing the diary, which needs to be acknowledged.

The manner in which one reviews the diary will alter over the treatment program, depending on the stage of treatment and the current treatment focus. We will often focus on early diaries in some detail, using the style of the "curious clinician." We will always ask the patient how they experienced using the diary, and if they became aware of any aspect related to their eating. Reviewing the diary with the patient enables the clinician gently to point out links between behaviors

and consequences (e.g., restriction during the day led to an evening binge; a decision to restrict even harder follows an argument with mother or partner). We will also comment on the spacing and regularity of eating and the energy-providing quality of the food consumed. The aim is to link patterns observed in the diary to the formulation, thus enabling collaborative clarification and expansion of the formulation.

Towards the middle of treatment, the reviewing of the diary may be more concise, focusing in greater depth on the days or situations where patients report particular struggles (e.g., identifying triggers for residual binges). As throughout CBT, the aim of the diaries is to encourage the patient to reflect and become their own therapist. Thus, as treatment progresses, we would expect the patient to summarize their diary for us, rather than vice versa. For example:

I think my week went pretty well. I had one binge – on Wednesday – I recorded it in my diary. I think what happened is that I had an argument with my boyfriend on Tuesday night, so I was upset and worrying about it all day on Wednesday, and then the trains were delayed, so by the time I got home I was starving, angry and upset. I just went straight to the kitchen and had a loaf of bread.

There will be a move towards internal monitoring and reduced reliance on the diary as a trigger for regular and planned eating. Towards the end of treatment, the diaries will be less of a focus, and will be gradually phased out (see below).

## 14.5 Advanced diary monitoring

Depending on the patient, it can be clinically useful to alter the way in which the diary is used. We would always advocate the use of flexibility and invention in CBT, in the context of a sound rationale.

For patients who binge-eat, some may be able to reduce objective binges fairly quickly, but continue to struggle to accept that what they feel is (subjective) bingeing is actually relatively normal eating. To encourage reflection and evaluation, we may ask the patient to label everything they eat as one of the following:

- subjective binge
- objective binge
- normal eating
- treat foods
- forbidden foods.

We introduce the idea of eating as lying on a continuum between rigidity and chaos, rather than being a black and white construct. Many patients conceptualize their eating behaviors in a dichotomous style, in which any deviation from their

normal pattern is regarded as too much, a sign they are out of control, and for which immediate compensation is necessary. Together, patient and clinician discuss how people with normal eating may move along the line, according to context (e.g., overindulging at Christmas followed by a diet and new gymnasium membership in January). We aim to allow the patient to see how their current style (e.g., rigid eating and cognitive style) differs from that of people without an eating disorder, and how the latter style enables these individuals to accommodate variety without anxiety. Thus, our aim for the patient is for them to be able to manage their eating flexibly and adaptively.

## 14.6 When to stop using food diaries

When the patient has stabilized eating and weight, it may be time to consider reducing diary use. Some patients will feel anxious about this shift, while others will be thrilled to be able to stop. We suggest a phased reduction, first using a basic tick chart to indicate that they have had meals and snacks. If the patient can use this without a return to problem behaviors or a change in weight, it is then appropriate to stop food monitoring completely. In the spirit of the patient becoming their own therapist, we remind them that there may be times when they wish to record their eating again as a temporary measure, perhaps when they are experiencing some difficulties or new temptations to binge or restrict.

## 14.7 The limitations of food diaries

Whilst the food diary is an invaluable tool to gain an insight into the patient's relationship with food, there are limitations to its use. Whilst it can give us a picture of a patient's general food intake, it will not be an accurate indication of their precise nutritional intake. The range of portion sizes and energy density (e.g., low fat/calorie products compared to standard products) of foods is now so wide that without detailed questioning it is impossible to get an accurate idea of actual energy and nutrient intake. This type of input is more in line with dietetic work rather than CBT work. Having said this it is important to get a basic idea of the patient's normal portions of foods, especially starchy carbohydrates (such as bread, breakfast cereal, potatoes, pasta or rice) and comparing it to the recommended portion sizes (see Figure 7.2), since these are central to successful dietary control.

Further, the accuracy of food records will be affected by when the diary is filled in. Everybody, not just people with an eating disorder, will unintentionally forget food that has been consumed, particularly snacks, if asked to recall their food intake some time after eating. This is one of the reasons why we encourage patients

to record their food intake as and when they eat, and to carry their diary with them wherever they go.

Finally, and perhaps most importantly, what is recorded in the food diary will be highly subjective, depending on what the patient thinks they are expected to be eating, and/or their feelings regarding what they are eating. For example, clinical experience suggests that some patients with more restrictive tendencies may complete their diary to show that they are eating more than they actually are. Similarly, patients with more bulimic tendencies may feel very ashamed of their consumption of food in general, but especially high-calorie foods, either in binges or in controlled eating, leading to the omission of these foods. Furthermore, there may be a tendency for some patients to complete the diary according to what they think the clinician wants to see, rather than strictly accurately. Lara *et al.* (2004) have shown that the majority of women misreport that they tend to mis-report (both under- and overreporting) their eating. It is possible that these figures are higher in women with an eating disorder, given the degree of emotional distress they experience around eating. Therefore, it is wise to view what is recorded in the diary as an overview of what the patient is eating, and also to sensitively query whether they are accurately recording what they are eating if it does not appear to match what we would expect the patient to need to eat for their weight.

## 14.8 Summary

The completion of food monitoring records (combined with weekly weighing) is probably the single most powerful tool in the treatment of eating disorders (see above and Appendix 3). The food records provide information about the patient's key eating behaviors, their feelings and thoughts related to their eating, and the context in which these behaviors occur. However, it is vital to remember that the food diary is primarily a therapeutic tool rather than simply a record — accurate or not — of the patient's eating.

15

# The role of weighing in CBT

The patient should be weighed by the clinician, both to monitor physical safety and to work in a CBT framework. Weekly weighing is a central part of CBT for the eating disorders, as it allows the patient and clinician to directly test some of the core cognitions underlying the patient's eating disorder (e.g., "If I eat a regular diet of three meals and three snacks per day, my weight will increase uncontrollably"). While the actual act of weighing can be completed within a few minutes, it is the (more time-consuming) setting up of specific predictions prior to the weighing that turns this process into a powerful behavioral experiment. By asking the patient to make predictions about changes to their weight every week, the "weighing experiment" can help to shift some key cognitions over time. To make this process maximally effective, we recommend educating the patient about the physiology of weight fluctuation and weight gain at some point at the beginning of treatment using the relevant psychoeducation leaflets (see Appendix 2).

In-session weighing should begin in the first week of treatment. However, the clinician needs to explain the rationale for such weighing carefully to the patient, as many are fearful about being weighed. We have found it useful to introduce the idea in the following way:

> Most patients with eating disorders are concerned that their weight will shoot out of control once they start changing their eating to a more healthy pattern. By monitoring your weight on a weekly basis, we can ensure that we track all changes to your weight regularly, and ensure that nothing too drastic happens without us knowing about it. The aim of this weekly experiment is to find out whether or not your weight will go up if you start changing your eating. If we do not do this, then it is likely that your fears of weight gain will mean that you never change your eating.

The clinician should explain that a weight fluctuation of plus/minus one kilogram over a week is normal (i.e., it happens in everyone and is healthy). If the patient weighs themselves repeatedly at home, they should be encouraged to stop and

to make a commitment to be weighed only in the session. This is because the patient who weighs themselves repeatedly at home will focus on the fluctuations rather than on the overall trend in weight (see Chapter 13).

Over the longer term, the weekly weighing will enable patient and clinician to make links between the patient's eating (and other behaviors such as body checking) and weight change. If the patient is extremely fearful about being weighed, the clinician should explore the reasons for this early on using Socratic questioning (see also Chapter 16). A small number of patients blankly refuse to be weighed or to know their weight. In this case, the clinician should explain that weighing (and the patient knowing the outcome) is a treatment non-negotiable in CBT (see also Chapter 9). Our experience is that it is extremely rare that patients will continue to refuse to be weighed if the rationale is explained and adhered to. If patients continue with their refusal, this may need to be addressed by the clinician as a therapy-interfering behavior.

## 15.1 Constructing a weight graph

Relatively early in therapy (but no earlier than the fourth session, so that the patient's weight is not "pinned" to a single point in their head), the clinician and patient construct a weight graph, drawing on weight bands that would be objectively overweight, normal weight and underweight. Using the patient's language, we label the sections on the graph (e.g., "anorexic," "skinny," "slim," "normal," "curvy," "slightly overweight," or whatever other word the patient chooses). If appropriate, the position of the patient's ideal weight should also be discussed. A target band (not a specific weight) that would reflect a healthy weight for the patient should be identified. The patient's first four weight measurements are then plotted on the graph, with the clinician highlighting the natural variation in the weight over those weeks. The clinician should reiterate that the graph cannot be interpreted using a single reading.

In subsequent sessions, the graph should be examined prior to the weighing, and the patient should be asked to mark on the graph (e.g., using a red pen) to indicate how much weight they think they will have gained. This can be done in two ways. First, the prediction can be done simply on a week-by-week basis. Second, the amount of weight change can be monitored in a cumulative fashion. The second strategy is likely to highlight more dramatically the disparity between reality and the patient's fear about their weight shooting up (e.g., "Now I understand why you try so hard to restrict your eating – if you are afraid that your weight is going to shoot up as the cumulative line suggests, then I can see how anxious you would be and why you are working so hard to hold onto control."). When the predicted cumulative weight exceeds the y-axis on the graph,

the cumulative line can be re-started. The clinician may also wish to highlight the difference in the steepness of the curve over time, as the patient's predictions improve. Once the prediction has been made, the weighing itself takes place, so that the prediction can be tested and the disparity between prediction and actuality can be considered. We offer the patient the opportunity to have their own copy of the weight chart, which can be brought to every session. As they learn that their predictions (e.g., current belief that eating normally leads to weight gain) are wrong, we encourage them to consider other potential explanations for their belief that they will gain weight. At this stage, we usually find that the patient begins to consider links between emotions (e.g., anxiety) and beliefs.

Figure 15.1 shows an example of a weight chart for Rita. The graph has been labeled using her own language. In addition, key weight-related goals (e.g., the return of menstruation; getting back to college or work) can be marked. It can be seen that the steepness of the cumulative prediction line (dotted line, squares) contrasts sharply with the actual weight line (solid line, diamonds). However, the cumulative prediction line changes angle as her predictions become more accurate. The focus is on encouraging Rita to maintain "flexible control" (i.e., asking her to remain within a band, rather than trying to retain a specific target weight). The figure illustrates a common practical difficulty with such graphs – the predicted weight gain line goes up so rapidly and so much that it goes off the top of the page, and we therefore have to restart the line from the beginning. However, the benefit of having this line is that it reflects the patient's strong anxiety about weight gain, and how that anxiety impacts on their eating.

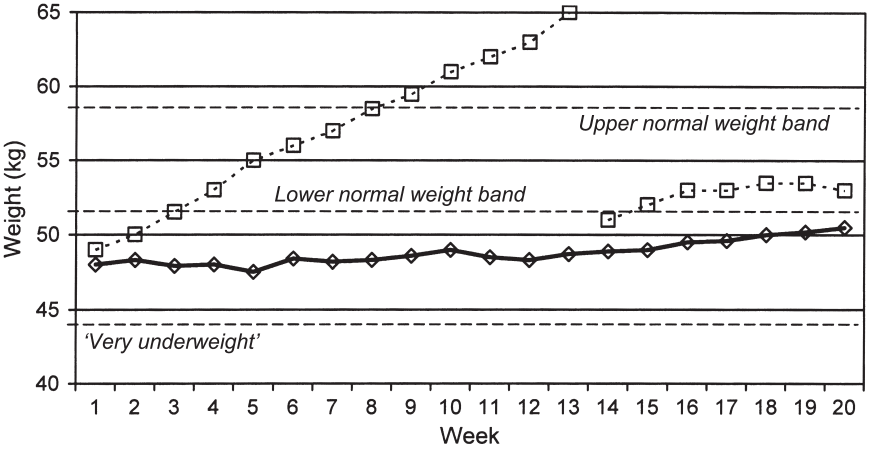



Figure 15.1 Example of a weight chart.

## 15.2 The weighing procedure: case example

The weighing procedure should follow a protocol that includes questions to prepare the patient for the cognitive change that is likely to result. We have found a number of questions to be helpful. These are illustrated in the following example of a dialogue between the clinician and patient. The patient (Seema) suffered from EDNOS (normal weight purging behavior):

| | Aims and principles underlying intervention |
|---|---|
| Clinician: Can you remember what your weight was last week? | |
| Seema: Yes, it was 54.7 kilos. | |
| C: Do you think your weight has changed since last week? What do you think your weight has done? | *Examine the patient's beliefs.* |
| S: My weight has definitely gone up. | |
| C: How much weight do you think you have put on since last week? | *Making the existing belief concrete.* |
| S: Two kilos. | |
| C: What indications or evidence do you have that you have put on two kilos? | *Seek evidence for the belief, and determine its strength.* |
| S: I have eaten more, so I must have. Also, I feel bloated and my clothes feel much tighter. | |
| C: Before we go and weigh you, I would like to ask you a few questions. How sure are you that you have put on weight – from 0 = not at all, to 100 = totally? If you had £100, how much of that would you bet on your weight having gone up by the amount you said? *(Over time you add up the imaginary total in money the patient would have lost across the sessions.)* | |
| S: It's at least 57 kilos, I'd bet £70. | |
| C: What are the chances that your weight has gone down? | *Consider and rate the alternative belief.* |
| S: Absolutely impossible – 0%. | |
| C: How much would you bet on your weight not having gone down? | |
| S: £100. There is no way it has gone down. | |
| C: If we should find out that, despite the way you feel now, your weight has stayed the same or gone down over the last week, what would that mean? | *Examine the implications of different outcomes for each belief.* |

| | Aims and principles underlying intervention |
|---|---|
| S: Well, I can't believe that would happen, but maybe it would mean that how I feel about my body tells me nothing about what weight I am? *(or my clothes feeling tight does not necessarily mean that my weight has gone up; my perception of my weight/body is distorted.)* | |

Once the weighing has been completed, the clinician should point out the difference between the patient's prediction and their actual weight. In order to put the patient's current weight into context, the clinician should return to the weight chart and plot the weight jointly with the patient while discussing any changes (see above). The patient will typically observe that their weight is either not changing at all, or that it is changing less dramatically than they think.

| | Aims and principles underlying intervention |
|---|---|
| Clinician: What do you make of the fact that your weight has gone down, although you were 70% sure that it would go up. | *Revisit the implications of the outcome for the alternative hypotheses.* |
| Seema: I just don't understand it . . . I've been feeling so fat all week . . . may be judging my weight on how I feel isn't accurate. | |
| C: So when you feel X *(e.g., you feel bloated, your clothes feel tight)*, what does that say about whether or not you have put on weight? | |
| S: Maybe, that I can't tell anything about what my weight has done that way. | |
| C: How does this fit with the results from previous weeks? | |
| S: I seem to be pretty useless at getting my weight right. | |
| C: How likely is it that you will correctly predict whether or not your weight has increased next time? *(Check how this belief changes over time.)* | |
| S: I don't know, because we've been doing this for a while now and I keep getting it wrong. It's just quite unlikely that I'll get it right next time. | |

| | Aims and principles underlying intervention |
|---|---|
| C: How could we test this idea further that how your body *feels* does not tell you very much about what your weight is doing? | *Begin to set up behavioral experiments.* |

It is important that the clinician reiterates frequently that any weight changes from one week to the next are meaningless, and that any judgements of possible changes have to be made in the context of the preceding four to eight weeks of therapy.

## 15.3 What can the patient learn from the weekly weighing?

Over time, the weighing experiment will allow the patient to arrive at a number of conclusions. The patient and clinician can summarize these in the following way:

- Physical sensations of being ''bloated'' or clothes feeling tighter are at best unreliable indicators of weight loss or gain.
- The patient's visual perception of their body is distorted. This is something that applies to most people, whether or not they suffer from an eating disorder. What we see in the mirror is heavily influenced by how we feel about ourselves. For example, if one feels low one might predict that one's weight is higher than when one feels positive. This emotional influence on perception makes it very difficult for anyone to see their body objectively. Therefore, checking one's body in the mirror will tell one very little about whether or not one has gained weight. This point can be further highlighted by carrying out the body checking experiment (see Chapter 23).
- Weight varies naturally from day-to-day and week-to-week, due to changes in the amount of water that is stored in the body. Our bodies consist of at least 65–70% water. A change in weight on the scales from one week to the next tells us little about whether or not actual body weight has gone up or down. It only tells us how much more or less liquid one has in one's body this time compared to last time.
- The only way one can know whether weight has gone up or down or remained stable is by weighing oneself over a minimum period of four weeks, and see how the average level compares with the average level over the previous four weeks. If there is a significant change above and beyond what one would expect due to natural weight fluctuation (about $\pm 1$ kg), one's weight may have changed (whether up or down).

- One is more likely to remember the weeks when weight has gone up, unless the belief about the inevitability of weight gain is considered explicitly. With the weight chart out of sight, we find it useful to ask the patient to estimate the proportion of weeks when their weight has risen. They will routinely respond by saying that their weight has gone up on substantially more weeks (e.g., 75%) than is the case when the chart is reviewed (e.g., 30%). There is usually a corresponding underestimation of the number of weeks when they believe it has fallen.

Sometimes, patients find it difficult to arrive at these conclusions even following a discussion. In this case, the clinician can try to help to interpret the results from the weighing by going over the weight graph. The clinician might say the following:

| | Aims and principles underlying intervention |
|---|---|
| Clinician: One ongoing behavioral experiment that we have been carrying out for the last few weeks is the "weighing experiment." Every week I ask you to predict your weight, and then we weigh you to see whether or not your prediction is correct or not. If you consider the evidence that we have gathered so far, what do you think you've learned from doing the weighing experiment? | *Review the experiment that has been going on.* |
| P: I'm not sure. | |
| C: What do you think your weight has done over the two months? Has it changed significantly or more or less stayed the same? | |
| P: I don't know. I think it's gone up. | |
| C: OK, let's have a look at the graph *(shows graph)*. If you look at the graph, how much has your weight changed since we started therapy? | *Contrast the evidence from the data with the individual's beliefs.* |
| P: Hmm. It's not really changed much at all. It seems to go up, down, up, down. | |
| C: So what evidence do we have that your weight has changed over the last eight weeks? | |
| P: None — it hasn't really changed much at all. | |

| | Aims and principles underlying intervention |
|---|---|
| C: Over the last eight weeks, can you remember what made you think that your weight had gone up? | |
| P: It is usually that I feel bloated and my clothes feel tight, and I then conclude that my weight must have changed. | |
| C: If you consider the weighing results from the last eight weeks, what would you say that feelings of bloatedness or your clothes feeling tighter tell you about any changes to your weight? | |
| P: Nothing much. Even when I felt bloated my weight has not always gone up. | |
| C: How much do you believe that right now? | |
| P: About 70%. | |
| C: If you see your body as bigger in the mirror from one week to the next, what does that tell you about any changes in your weight? | |
| P: It does not tell me anything because my perception of my body is distorted. | *Summarize and re-rate the alternative belief.* |
| C: How much do you believe that right now? | |
| P: About 60%. | |

If the patient has been able to improve their eating structure and/or content significantly over the preceding weeks, the clinician can add:

| | Aims and principles underlying intervention |
|---|---|
| C: Given that you have been able to change the structure and/or content of your daily food intake over the last weeks, what have the consequences been in terms of your weight? | *Review impact of having changed behaviors.* |
| P: Surprisingly, my weight has not changed much. Certainly not as much as I initially thought it would. I still can't quite believe it. | |
| C: So do we agree that, from the evidence you have collected so far, increasing your food intake and/or | |

| | Aims and principles underlying intervention |
|---|---|
| changing your diet has not led to a significant increase in your weight? | |
| P: Yes, that's right so far. | |
| C: How does that fit with what you believed before we started therapy? | |
| P: In the beginning I believed 100% that my weight would go up a lot – by at least 3–4 kilos per week. I don't believe that any longer. | *Review beliefs.* |
| C: How do you explain that your weight hasn't increased as much as you thought it would? | |
| P: I think it fits with what you said about the body's metabolism. Maybe by eating more regularly, my body has started working properly again and I am burning my food more efficiently. | |
| C: How much do you believe right now that your weight will stay more or less the same if you continue with the diet as you have done in the last 5 weeks? | |
| P: 70%. I wish I could believe it more, but I don't quite trust it yet. | |
| C: How can we test further whether or not what we discussed about how the body works is true or not? | *Extend the behavioral experiment.* |
| P: I'm going to continue with the eating plan that the dietitian recommended, and I'm going to try out some of foods from my "avoided foods" list as a behavioral experiment. | |
| C: Excellent idea! Let's have a look at the list and select some foods that you can try out this week, and see what predictions you would make about the outcome of that sort of change. | |

## 15.4 Introducing the idea that the patient's weight might be genetically determined

In conjunction with the weighing experiment, it is worth explaining to the patient that there is considerable evidence suggesting that our weight is genetically influenced. Research suggests that our minimum weight cannot be significantly

altered over the long term (Fairburn, 2004). This hypothesis is called "set-point theory." While this theory has not been confirmed by all scientific research, we find that patients often see it as a useful explanatory construct. We explain that, according to set-point theory, if one eats a healthy regular diet and engages in reasonable exercise, our bodies gravitate towards a particular weight, and fluctuate around that weight (1–2 kg up or down on a weekly basis, as mentioned above). If one tries to move away from that natural weight through the use of drastic measures (e.g., denying the body essential foods such as fat, protein or carbohydrates), the risk of bingeing increases. Most of our patients deny their bodies the food they need to function healthily, thereby keeping their weight at an artificially low and unhealthy level (for them). The price patients have to pay for this restriction is that they have binges (at times when they start craving the foods their body needs and they deny themselves), which they then try to compensate for by vomiting or taking laxatives. It should be explained to the patient that the aim of any treatment has to be to help them to live and eat more healthily. This means helping them to eat regular healthy meals (which might or might not lead them to put on weight) and, if they do gain some weight, helping them to accept this weight as the one that they are "meant to be" (wherever it may be within the healthy BMI range).

Regarding the issue of "healthy weight," the clinician needs be aware that BMI is not adjusted for cultural differences. For example, the average BMI among black-British and Afro-Caribbean women appears to be slightly higher than that of white women. By contrast, the average BMI of Asian women may occasionally be lower.

## 15.5 Challenging the patient's belief that their weight will increase uncontrollably

What frequently stops patients from experimenting with healthy eating is the belief that their weight will increase uncontrollably as a result. The clinician therefore needs to assist the patient to challenge the evidence for this belief. First, it is worth exploring how the patient knows that this will happen if they eat a healthy regular diet. Usually, patients have no direct evidence for this, engaging in selective abstraction. They may remember a time in the past when they were overweight, or they were teased by others. However, it is often difficult to get clear evidence as to whether they were eating a healthy balanced diet at that time.

Next, it is important to examine the patient's assumptions about metabolic rate being stable, especially as their weight rises towards a normal level. It can be valuable to use psychoeducation here, to allow the patient to realize that metabolic

rate changes might mean that a simple increase in eating does not lead to a continuous increase in weight. We emphasize that the metabolic rate changes and return to weight stability are supported by the literature. However, patients existing beliefs mean that it is not uncommon for the patient to experience high levels of anxiety with regard to changing to a healthier pattern of eating.

The next step might be a discussion about how this ''new theory'' can be tested with the help of a behavioral experiment (see Chapters 21 and 22). An obvious experiment is for the patient to try sticking to a healthy diet (regardless of bingeing and vomiting) for a fixed period of time (with the option of going back to the ''old way of doing things'' after that time if they feel that this is not manageable), and to make a prediction about what their weight will do during that time. We set up the experiment to compare two hypotheses, only one of which can be correct: the patient's hypothesis that this will lead to significant weight gain, versus the hypothesis that it will not (developed from the psychoeducational materials, where possible). As part of the psychoeducation, we draw the patient's attention to the fact that gaining substantial amounts of weight rapidly is difficult, and that it requires a diet that goes well beyond the amounts suggested by the clinician in order to put on the weight that the patient predicts.

## 15.6 The role of weighing in the future

It is important to consider the role and meaning of weighing at all stages in treatment. The theme of ''becoming one's own therapist'' is highly relevant to this. At the start of treatment, many patients will be split between a position of extreme avoidance of weighing themselves and knowing their weight, and excessive checking of weight, several times a day. For reasons discussed above, neither of these positions is compatible with progress or recovery. Therefore, at the start of treatment, the clinician will take the main responsibility for weighing (although the patient will need to take responsibility for knowing and working with their weight). This is also important as the clinician holds the responsibility for the physical safety of the patient.

Towards the end of treatment, patient and clinician need to explore how the patient can take on this responsibility themselves. An example of this might be that the patient takes responsibility for monitoring their weight at home rather than being weighed in the clinic. If a patient completes treatment but remains reluctant to know or monitor their weight appropriately, this is a clear indicator of residual difficulties.

There are a number of issues which mean that continued consideration of weight is essential. A significant increase or decrease in weight is potentially a

sign that all is not well, and the patient needs to be able to respond to this. For example, the men in the starvation study (Keys *et al.*, 1950) experienced quite severe weight fluctuations for several months (if not years) following the end of the experiment. Therefore, it is important to appreciate that weight may fluctuate quite substantially following the end of treatment if it is not monitored appropriately, even if treatment has been successful. In addition, people recovering from an eating disorder are not immune to the risk of obesity, which is so prevalent in today's society. In fact, clinical experience tells us that our patients may be more prone to weight gain than non-eating-disordered individuals. Therefore, as part of a relapse management plan, a patient needs to be able to weigh themselves regularly (approximately fortnightly/monthly, but definitely not more frequently than weekly as this only shows fluid changes) to be able to monitor the situation. They should expect that weight would fluctuate by around 2 kg over a month, so that if their average weight were 55 kg, they would probably see a fluctuation between 54 and 56 kg. Any weight change above or below this range could indicate difficulty and possible relapse, thus meaning that the patient would be wise to return to using their food and mood diary to identify difficulties before they take hold. However, it is important to recognize that many treatment programs involve getting the patient to a minimum healthy weight (around a BMI of 20), and that weight can be a lot higher and still be in the healthy range (BMI = 20−25). Therefore, a patient might notice a slight shift upwards, but this may just be because they have been able to be less rigid about their food, thus leading to a slight increase in weight.

## Summary

In this section, we have addressed a range of skills and knowledge bases that are essential in working with the eating disorders within a CBT framework, although many of the same skills are equally relevant to other approaches to the eating disorders. We will now proceed to consider the key CBT skills that underpin the change in cognitions, emotions and behaviors across psychological disorders, before narrowing down to the eating disorders themselves.

## Section III

# Core CBT skills as relevant to the eating disorders

In this section, we consider how generic CBT skills can be used to treat a range of symptoms that are common in the eating disorders, but that might occur in a wider range of disorders. Although this section will act as an introduction to both cognitive and behavioral techniques, more attention will be paid to cognitive techniques, as behavioral experiments are dealt with in substantial detail in Chapter 23. This section will be followed by a more specific focus on the application of key CBT methods to the specific pathology of the eating disorders.

16

# Socratic questioning

Socratic questioning (also called the ''Socratic method'') is a technique that cognitive behavioral therapists use to explore the content and meaning of patients' experiences, and to help patients to consider an alternative point of view. Socratic questioning is based on the following five principles (Wells, 1997):

1. The clinician asks questions that the patient is able to answer.
2. The clinician's questions are directed towards a certain goal. That might be (1) to find out more about the patient's way of thinking, feelings or behavior in a particular situation, or (2) to help the patient to consider an alternative perspective.
3. The questions are open-ended rather than closed (''when,'' ''what'' and ''how'' questions, rather than ''why'' questions).
4. The patient does not feel interrogated by the clinician.
5. The clinician tries to genuinely understand the patient's experience (i.e., puts him- or herself ''into the patient's shoes'').

## 16.1 How to engage in the process of Socratic questioning

Socratic questioning consists of three types of verbal structures: (1) general questions, (2) probe questions and (3) reflections (Wells, 1997).

*General questions* are designed to open up a specific area of enquiry. The clinician usually asks about a specific incident that may have happened to the patient in order to explore their thoughts, feelings and behavior at that time. For example, a typical general question might be ''What happened the last time when you had a binge?''

Examples:

1. When was the last time you engaged in bingeing/vomiting/restricting?
2. What was the first thing you noticed?
3. Which feelings did you notice most strongly?
4. What thoughts went through your mind? What were you thinking?

5. What physical symptoms did you notice?
6. What images did you notice or experience?

*Probe questions* are aimed at clarifying a particular point or obtaining more detailed information. Once the clinician has opened up a particular area of inquiry, she or he will go through a number of specific questions to obtain a better understanding of the patient's thoughts, feelings and behaviors in that situation. For example, the clinician might ask questions such as "Can you remember where you were and what you were doing just before the binge happened?" or "Did you notice anything that might have triggered the binge?" or "How did you feel emotionally after you vomited?" Often, probe questions explore the perceived worst possible consequences of not coping or not using safety behaviors. For example: "What do you think would have happened if you had not vomited at that point?"; "So, you believe that vomiting is an effective strategy to ensure that you don't gain weight after a binge? How do you know that?"

Examples:

1. When you felt angry and upset in that moment, what did you do to cope with these feelings?
2. If you had not binged at that point, what is the worst thing that could have happened?
3. If you get on the scales today and you find that your prediction is right, what would be the worst thing about that?
4. If the number on the scales is about one kilo higher this week than last week, what does that mean about your weight?
5. How much do you believe right now that your weight will have gone up?
6. What will you do if your weight keeps going up next week?

Finally, *reflections* are brief summaries of what the patient has just said, which are usually combined with a follow-up probe question to obtain more specific information (e.g., "When you felt lonely and sad because your friend hadn't turned up, did you do anything to make yourself feel better?"). Reflections aim to convey the message to the patient that the clinician is listening and understanding what they are saying.

17

# Downward arrowing

The cognitive-behavioral model hypothesizes that there are three levels of thought: automatic thoughts, assumptions and core beliefs. These levels of cognition have different characteristics in terms of specificity, conditionality and attribution: automatic thoughts tend to be situation-specific; assumptions are conditional; and core beliefs are global, unconditional and internal. In the eating disorders, automatic thoughts and assumptions focus (among other things) on eating, shape and weight, masking more global, specific core beliefs related to, for example, failure or lovability. Focusing on surface-level thoughts may be at the expense of addressing core beliefs that are maintaining the disorder. For example, a patient with a core belief such as "I'll always be alone" may have automatic thoughts such as "I am so fat" or "I am a bad person" and assumptions such as "If I am fat, people will not want to know me" and "If I lose weight, I will be a better person."

Downward arrowing is a technique that can be used to identify underlying assumptions and core beliefs. It is a way of moving past the automatic, surface-level beliefs, particularly those associated with eating, shape and weight, to the core beliefs triggering and maintaining these thoughts. With some patients, downward arrowing can uncover core beliefs quickly, whilst for other patients this may take a period of weeks. It is crucial that the clinician is empathic to the patient's reaction — although the core belief may have been part of the clinician's working hypothesis for some time, it may be the first time the patient has realized the depth of the belief and the intensity of the associated feelings. It is equally important to use the individual's language when identifying the core belief. For example, an individual with core beliefs centering on failure might express this as: "I'm a dead loss." Indications that you have reached the bottom line or core belief are usually when the individual keeps coming back to the same statement or demonstrates a negative shift in affect.

## 17.1 How to do it

First, it is important to build up a picture of the situation. We might ask "When was the last time that you felt really (emotion)?," or use an example from a thought record or diary that the patient has kept that week. The patient is encouraged to recall the situation, with the clinician prompting by enquiring about thoughts, feelings, triggers, senses and images.

Second, the patient is asked to identify the most distressing thought. At this point, downward arrowing questions can be introduced. The process of downward arrowing is as follows:

1. Using key questions to explore the most distressing thought, the patient and the clinician begin to elicit assumptions related to self-acceptance and acceptance by others.
2. The clinician summarizes the assumptions, and checks they are accurate.
3. Building on this, the clinician uses questions again to move to the next level, eliciting core beliefs.
4. Again, the clinician summarizes and checks that the core beliefs elicited reflect the patient's perception accurately.

Key questions can include:

- If that's true, so what?
- From your point of view, what does it mean to be X?
- What's so bad about _____?
- What's the worst part about ____?
- What does that mean about you?
- What would that say about you?
- What does it say about who you are?
- So what does it mean to you if you can't be X?
- What does it mean to other people if you're not X?
- What's the worst it could mean or say about you?
- What does it say about what other people think about you?
- What is the worst that other people could think about you?

## 17.2 Case example: Sarah

Sarah came to the session reporting a binge episode, which had been triggered by seeing herself in the mirror in a clothing store changing room. The clinician decided to introduce downward arrowing to elicit possible underlying beliefs.

| | Aim and principles underlying intervention |
|---|---|
| *Clinician:* So, Sarah, we've been talking about this episode in the changing room, which triggered a binge. I wonder if we could explore this a bit more. Can you recall being in the changing room? | *Focusing on the memory to activate detail about the experience* |
| *Sarah:* Yes, I wanted to buy a dress. I took it into the changing room and started to get changed. Then I caught sight of myself in the mirror, and I was absolutely disgusted. All I could see was rolls of fat. I wanted to cry. | |
| *C:* So, it sounds like you were feeling pretty upset. Can you remember what thoughts were running through your mind? | *Identifying negative automatic thoughts* |
| *S:* "I'm disgusting and a blob" and "I'm just going to get bigger and bigger." | |
| *C:* OK, which of those thoughts upsets you the most? | |
| *S:* Er, I think it's "I'm disgusting and a blob." | |
| *C:* "I'm disgusting and a blob" – that was the thought that was really distressing you when you were in the changing room. From your point of view, what does it mean to be disgusting and a blob? | *Beginning downward arrowing* |
| *S:* It's horrible, I don't like myself, I've got no self-control or will power. | |
| *C:* So, what do you think is the worst thing about not liking yourself or having no will power? | |
| *S:* Other people will think I'm lazy and a slob. They'll find me disgusting too. If I'm fat, they won't want to know me. | |
| *C:* So when you saw yourself in the mirror, you thought "I'm disgusting and a blob," which led to you thinking that you were lazy and had no will power, and that other people wouldn't want to know you. Is that right? | *Further downward arrowing* |
| *S:* Yes. | |
| *C:* I suppose I'm wondering, what do you think is the worst part about all of this? | |
| *S:* (beginning to cry) It means that no-one will ever want to know me. Jonathon is going to find me disgusting and leave me. | |

| | Aim and principles underlying intervention |
|---|---|
| *C:* If that were to happen, what would it say about you? | |
| *S:* No-one will ever want to be with me. I'll never find anyone that likes me. | |
| *C:* And what do you think that other people would think about you? | |
| *S:* That I'm a slob, I'm lazy, they wouldn't want to know me, they wouldn't even want to talk to me. | |
| *C:* In your opinion, what does all this say about you? | *Reaching the "deepest" thought* |
| *S:* I'm totally unlovable. | |
| *C:* And from your point of view, what is the worst thing about that? | |
| *S:* That's it, that's the worst thing – I am unlovable. | |

In this case example, the clinician has followed the process outlined above, encouraging Sarah to recall the incident, and to describe her thoughts and emotions during the event. The clinician elicited Sarah's assumptions regarding laziness and that if she is fat, others will not want to know her. Further downward arrowing elicits the core belief "I'm totally unlovable," which is confirmed by the shift in affect and Sarah's own assertion that this is the bottom line.

## 17.3 Trouble-shooting

One aspect of this technique that CBT clinicians can struggle with is getting stuck with repeating: "What is so bad about that?" Not only may this appear insensitive to the patient, but clinicians can also feel that they are asking the obvious and sounding mechanical. It is important to vary questions, moving from self to other perceptions (e.g., "What does that mean about you?" and "If that was true, what do you think others would say about you?"). In addition, asking what it means from the patient's point of view increases accuracy, sensitivity and relevance (e.g., "From your point of view, what does it mean to be overweight/lazy/stupid/etc.?").

18

# Cognitive restructuring

Socratic questioning and downward arrowing, the techniques introduced in the previous chapters, are broadly aimed at eliciting and uncovering distorted cognitions, ranging from negative automatic thoughts to core beliefs. The techniques introduced in this and the following chapters are aimed at challenging and then testing out these cognitions. Indeed, we have found the most effective strategy is to use cognitive restructuring and continuum thinking to "loosen" the belief, followed by a behavioral experiment to actively confirm or disconfirm it.

The focus of cognitive restructuring is to enable the patient to amend their initial (distorted) thought, based on a review of the evidence. An alternative thought is generated, which represents a more balanced viewpoint. An important point to note is that cognitive restructuring should aim to generate a *balanced* thought – it is not "positive thinking." Further, since many patients will have held these distorted beliefs for a long time, change is unlikely to be immediate. It is worthwhile for clinician and patient to remember that an important step is introducing a seed of doubt, such that the patient can consider the possibility that the initial thought may not be 100% accurate. Introducing such doubt is essential in enabling the subsequent introduction of behavioral experiments. Patients often struggle with this shift because they grasp the principle logically but find it hard to believe emotionally. Again, the patient can be reassured that the process of change may be slow, and that being aware that their belief could be faulty is progress, even if they do not yet judge this to be true.

Cognitive restructuring is a vital skill, and therefore time should be taken in introducing it. Many patients find the tasks difficult, and we frequently reiterate that it may take time to master the skill. Using a thought record can provide a clear structure. Chapter 22 provides a full description of the process of challenging a belief and developing an alternative belief that is central to the eating disorders.

19

# Continuum thinking

One of the key themes in the eating disorders is dichotomous thinking by patients. Continuum work is an effective technique in working with this black and white style of thinking (e.g., Padesky, 1994). With this work, we aim to help the patient to understand that life is about ''shades of grey.'' Continuum work can be used at the level of underlying assumptions (e.g., ''If I am fat then I am disgusting'') and at the level of core beliefs (e.g., ''I am a bad person''). Such work involves working either with a single continuum or with multiple continua, depending on the nature of the cognitions involved.

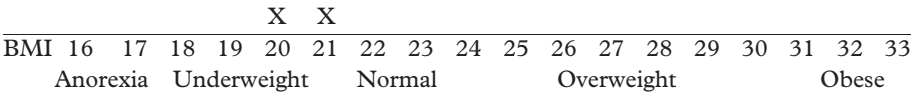
## 19.1 Addressing negative automatic thoughts and core beliefs: working with single dimensions

We often use a single continuum when dealing with patients' negative automatic thoughts about being either thin or fat. For example, many patients see any weight gain as evidence that they have become fat. Using a continuum of BMI (e.g., in a weight chart) can help the patient to understand that their reaction is an example of black and white thinking, rather than evidence of a qualitative change in their state. This can then lead into a discussion of what the patient understands by ''being fat.''

### Case example

Over four weeks Fiona had gained 2 kg and her weight had now stabilized. Fiona's BMI had gone from a BMI of 20 to a BMI of 20.8. Fiona interpreted this as her becoming ''fat.''

| | Aim and principles underlying intervention |
|---|---|
| Fiona: I am so fat . . . look how much weight I have gained! | *Identifying the negative automatic thought.* |

| | Aim and principles underlying intervention |
|---|---|
| Clinician: I would like to spend some time on this issue. What I would like to do is to draw a line with BMIs on it, and then figure out where you fit on this line . . . OK? | *Starting to problem-solve. Representing the information in a concrete form that is amenable to objective assessment.* |
| Fiona: OK | |
| Clinician: Let's put the line up here. Let's label the line based on the scientific terms we have discussed before. Do you remember what we talked about? | |
| Fiona: We talked about anyone having a BMI of less that 17.5 being in the anorexic range, 17.5 to 20 as being underweight, 20 to 25 is the normal range, 25 to 30 is the overweight range, and 30 plus is obese. | *Reviewing the patient's memory of objective criteria.* |
| Clinician: OK — let's place these on our line and then add your old BMI and your new BMI to our line. What do you make of that? | |
|  | |
| Fiona: Well I guess I am still at the low end of the normal range and I have not gone straight from thin to fat. However, I still feel fat and I am scared I am going to keep gaining weight. | *Patient generates the alternative thought, contrasted with the feared outcome. Plan developed to allow the two to be tested.* |
| Clinician: OK, well we are going to keep weighing you to see what happens with your weight, and we will also be spending some more time thinking about why you feel fat. | |

A one-dimensional continuum is also a helpful strategy when working with core beliefs (Padesky, 1994) that may underlie an eating disorder. For example, it can be used if a patient has an unconditional belief that they are a failure (see Chapter 25 on how to work with core beliefs).

## 19.2 Addressing conditional beliefs: working with two dimensions

In the eating disorders, it is often the case that two unhelpful ideas have been linked. Common examples we encounter are: "If I am thin then I will be

successful''; ''If I am thin then I will be attractive''; ''If I am thin then I will be happy''; and conversely ''If I am fat then I will be ugly''; or ''If I am fat then I will get no respect.'' Padesky (1994) describes the technique for working with linked ideas as ''two dimensional charting of continua.'' A full description of how to work with dual dimensions is provided in the next section (addressing eating, weight and shape concerns in the eating disorders).

20

# Positive data logs

In working with negative beliefs (at whatever level), the task of the clinician is not only to assist the patient to find evidence against maladaptive beliefs but also to help them develop more adaptive cognitions. Positive data logs are an effective tool in assisting the patient to gather data in support of a more adaptive belief (e.g., Padesky, 1994). The role of positive data logs is to assist the patient to correct information-processing errors, which means they tend to dismiss any potential adaptive information. When working with schema-level beliefs, positive data logs require focused, systematic collection of evidence, as the nature of maladaptive schemas means they will fight for survival, and the patient may have difficulty looking for evidence of an aspect of themselves they find hard to believe exists. We have found Padesky's (1994) "schema as prejudice" metaphor (see schema work section for further explanation of this metaphor) is extremely helpful in explaining information-processing errors, and therefore the rationale behind positive data logging.

## 20.1 Case example

Over the last few sessions of therapy, Roberta had developed with her clinician the more adaptive core belief she was "worthwhile." She was asked to rate how much she endorsed this new core belief on a scale from zero to one hundred percent (zero = "does not believe it at all"; 100 = "believes it completely"). She rated her belief as 10 percent. She was asked weekly to make this rating in order to monitor the development of the new core belief. Roberta was introduced to the idea of positive data logging through the "schema as prejudice" metaphor.

In order to develop categories in which positive data could be gathered, Roberta was asked several questions. She was asked how she would know if she was more worthwhile. She was unable to answer this question, as she did not see herself as having many positive attributes. In order to assist Roberta, the question

was asked about other people she knew and loved or might love in the future (such as a child). She was asked how she knew that her best friend was worthwhile. She was asked: ''If you had a child, how would you know he or she was worthwhile?'' Roberta was able to develop a list of qualities indicating what made someone worthwhile based on these two questions. She was asked if she believed any of these qualities would apply to her, and she was able to develop a short list.

Among other qualities, Roberta rated ''kindness'' as a quality that meant she saw herself as worthwhile. Evidence of kindness to Roberta was when one helped others. As Roberta had a tendency to discount anything she did to help others, a list of what might be considered ''helping others'' was generated in the therapy session, in order that Roberta would be able to identify this information and record it in her data log. Roberta was asked to gather information each day on when she helped others. As she worked in a ''helping profession,'' Roberta was able to record many episodes of helping others over the week, and when this was discussed in the therapy session the following week she could see that she had been discounting this information previously. Over the following weeks, Roberta continued to gather positive data on the other categories she had generated and re-rate her sense of being worthwhile.

## 20.2 Trouble-shooting

The patient may return with very little data gathered in their logbook. Padesky (1994) suggests that it is hard for patients to look for evidence that they do not believe exists, as maladaptive core beliefs will block/filter (as a survival strategy) any adaptive information. Initially, in order to support the patient to gather this data the clinician should listen carefully for any data that spontaneously occurs in therapy that supports the new adaptive core belief and use Socratic questioning to help the patient examine this evidence. We find it can help the patient if you discuss with them that initially they may need to take an objective/intellectualized stance to gathering data (e.g., to say ''It does not matter if I don't believe emotionally that this is evidence for my adaptive core belief at this point, but might someone else believe that?'').

Our experience has been that when some patients start to collect positive data the environment can be so toxic it serves to confirm old negative core beliefs instead. For example, one patient had a partner who insisted she always went with him to a pub he liked with his friends. When she began to log positive data for the belief ''I am an interesting person'' very little evidence was generated, as she had nothing in common with the people in this environment, and any time she attempted to start conversation on something she was interested in her boyfriend

belittled her. The failure to generate any positive data was examined in detail. It was decided she would try again at the more neutral setting of her workplace. In this environment she was able to generate positive data that supported her new belief. However, she also learnt from her first experience that she needed to think more about her relationship with her partner and develop more of her own friends with whom she had things in common.

21

# Behavioral experiments

Behavioral experiments are: ''planned experiential activities, which have the main purpose of helping clinician and patient to obtain new information. This information helps to (1) test the validity of the patient's existing beliefs about themselves, others and the world, (2) construct and/or test new, more adaptive beliefs about themselves and the world, and (3) contribute to the development and verification of the cognitive formulation'' (Rouf *et al.*, 2004). All behavioral experiments have the purpose of testing patients' predictions about some form of danger. For example, they all require that the patient exposes themselves to a feared situation, and acts in a way that helps them to test out the belief. An exception to this is the survey technique. In this case, patient and clinician put together a number of questions that would help to test the patient's beliefs and collect new information by interviewing other people, or by observing others.

In general, behavioral experiments have three aims:

- They help the patient understand the main ideas underlying CBT – understanding that beliefs have been learned and can be unlearned, that all beliefs can be tested and revised.
- They help the patient to reattribute beliefs – the patient might understand that the reason why they believe something is not because that is how the world is, but because they learned to see the world in this way when they grew up because of the environment they were in.
- They help to change how the patient feels in certain situations – for example, patients who might feel terrified and out of control when looking at their weight on the scales might over time stop feeling anxious as they stop believing that their weight will spiral out of control.

Behavioral experiments should always be linked to the case formulation (see Chapter 8). They offer patients a way to test out their anxious predictions, which arise from their assumptions and core beliefs.

## 21.1 How to design effective behavioral experiments

Rouf *et al.* (2004) have identified four steps in the design and implementation of effective behavioral experiments. These are: (1) planning, (2) experiencing, (3) observation and (4) reflection. In practice, this works in the following way: First, based on the case formulation of the patient's problems, clinician and patient plan an experiment to test one of the patient's beliefs (P). The patient then carries out the experiment (E), observes the results (O) and, together with the clinician, reflects on the implications of the experiment for their belief (R). Next, clinician and patient plan further experiments (P), and the cycle continues.

Rouf *et al.* (2004) distinguish two types of behavioral experiments, which correspond to the basic research methodologies commonly used in the social sciences. These are *hypothesis-testing* (answering the question: "Is it true that . . . ?") and *discovery* (answering the question: "What would happen if . . . ?"). Which type of experiment is selected depends on the kind of cognition targeted and the patient's stage in treatment.

### 21.1.1 Hypothesis-testing experiments

Hypothesis testing experiments can be divided into three subtypes.

*Testing hypothesis A.* These are experiments that test the validity of a particular thought. For example, a patient with bulimia might believe that eating a regular healthy diet will lead them to put on significant amounts of weight. Before patient and clinician can test an alternative explanation (e.g., that the patient's weight will not go up significantly), they test the patient's belief by gradually changing the structure and content of the patient's diet to reflect a more healthy eating pattern, and determining whether their weight rises.

*Testing hypothesis A versus hypothesis B.* This second type of experiment compares the patient's original belief with a new alternative perspective that might be more helpful. For example, over time the same patient with bulimia may come to question their original belief and develop (with the help of the clinician) the alternative possibility that "eating a regular healthy diet does not significantly affect my weight." Clinician and patient may then design a series of experiments to further test which of the two propositions better accounts for the observable pattern of change or stability in the patient's weight over time.

*Testing hypothesis B.* In this type of experiment, patient and clinician test the newly acquired perspective. Usually, these types of experiments are used at a later stage in therapy. For instance, a patient with bulimia who has reached their natural weight by following a regular healthy diet may be more willing to test out a number of foods that they have previously avoided. Alternatively, the clinician may ask

the patient to ''widen the bandwidth'' by trying out foods they have never eaten before or by eating significantly more food over the week to test the belief that this can lead to significant weight gain.

### 21.1.2 Discovery experiments

These types of experiments are appropriate when patients genuinely have no idea about the cognitive and behavioral processes that maintain their current difficulties. Usually, it will involve doing something that the patient has never done before, and for which they will therefore have no clear prediction of outcome. The point of the experiment in this case is for the patient (and clinician) to find out what happens if the patient puts themself into an unfamiliar situation or acts differently in a familiar situation. For example, a patient with anorexia may never have organized a dinner for friends because of the fear that ''nobody would come.'' The clinician might suggest to the patient that they set up the dinner, invite friends and then observe what happens. Another experiment might involve the patient talking to a friend, their partner or a parent in a different way. For example, if the patient often inhibits the spontaneous expression of their true feelings when with a close friend, the experiment might involve trying to be more open about their feelings. In another context, the patient may decide to talk more assertively to a person who is putting them down or bullying them. Following the experiment, clinician and patient can jointly consider the implications of the patient's discoveries for the formulation and the treatment plan.

## 21.2 Observational experiments

Rouf *et al.* (2004) define active experiments (as outlined above) as ones in which the patient takes the lead role. By contrast, in observational experiments the patient is purely an observer. These latter experiments are particularly useful when being actively involved in an experiment is too distressing for the patient due to their negative (or even catastrophic) beliefs about what will happen. An example might be a patient who is scared about eating in public. Often these patients have beliefs about the reactions of others to eating certain foods in their presence (i.e., that others will notice and stare at them, or that they will make comments or humiliate them). By allowing the patient to observe the clinician in a café, where he or she might eat a number of ''forbidden'' foods identified by the patient, the patient can scrutinize others' reactions to the clinician behaving in this way. This can help to test their predictions without having to be

actively involved. The next step might be for the patient to try the experiment themselves.

## 21.3 Surveys

Survey experiments consist of collecting data through observation of events, or by interviewing other people. In the treatment of eating disorders, we most often use surveys to test patients' beliefs about what other people consider important. For example, various patients have conducted surveys, asking friends and colleagues about what they find attractive about women, or what makes them feel satisfied with their body. The following sample questions are from a questionnaire that was devised with a patient to test their belief that, like them: "Most people constantly think about their body shape and weight, and would like to be slimmer."

- How happy are you with the way you look?
- What has the greatest influence on how you feel about yourself? (Give options, including physical appearance.)
- How often do you think about your body shape/weight?
- What feelings do you have before you begin a meal?

Often, it is useful for that patient to ask a number of friends and colleagues, and for the clinician to also ask a number of people. It is generally useful to aim for about 10 people each as this gives patient and clinician a number high enough to do some basic statistics (e.g., "In terms of percent, how many people reported that they are happy with the way they look?"). Also, survey questions should always move from the general to the specific. For example, in a blushing survey one might start by asking about others' opinions about blushing ("What do you think when you see someone blush?"), and then move on to more specific questions that directly test the patient's beliefs later on in the survey ("Would you say that people who blush in the middle of a conversation without apparent reason are weak or incompetent?").

## Summary

In this section, we have outlined the CBT skills that are essential in changing cognitions, emotions and behaviors across a range of disorders, considering their general use in the eating disorders. The following section addresses those CBT techniques as used specifically to target the core cognitive elements of the eating disorders: overvalued ideas about eating, weight and shape, and body image.

Section IV

# Addressing eating, shape and weight concerns in the eating disorders

So far, we have considered the ways in which generic CBT skills can be used to treat a range of symptoms that are common in the eating disorders, but that might also occur in a wider range of disorders. In this section, we focus on the cognitive-behavioral treatment of the two central cognitive targets specific to the eating disorders:

- overvalued cognitions regarding eating, weight and shape
- body image.

While this section will revisit some of the techniques addressed in the previous section, these chapters detail more specific techniques for the modification of those cognitions.

22

# Overevaluation of eating, weight and shape

Over the years of developing our cognitive-behavioral understanding of the eating disorders, the most common theme has been the substantial emphasis that individuals with eating disorders place on their weight, shape and eating. This undue influence of body shape and weight on self-evaluation is a key diagnostic criterion for the eating disorders. Asking a patient about their weight or eating is likely to elicit high levels of anxiety, reflected in a range of cognitions (e.g., "I can't even *think* about putting on weight!"). Indeed, many patients are so concerned that one of the first questions they may ask is if you are going to make them gain weight. Weighing the patient is often when we see the full extent of the patient's anxiety, allowing us (clinician and patient) to understand fully the importance of the overevaluation of eating, shape and weight in maintaining the disorder. This overevaluation of eating, shape and weight can apply to any eating-disordered patient regardless of diagnosis or weight. Within the CBT model, such cognitions and the associated anxiety are conceptualized as arising from a dysfunctional *safety behaviour* for evaluating self-worth (e.g., Fairburn *et al.*, 2003). While most people judge themselves on a range of aspects of their lives, eating-disordered patients judge themselves much more exclusively against this limited set of criteria (e.g., being thin). This limited cognitive focus results in an equally limited behavioral repertoire (e.g., controlling food intake). Thus, the limited set of cognitions and behaviors develop into a self-maintaining system of positive reinforcement, as reflected in current CBT models (Cooper, 1997; Cooper *et al.*, 2004a; Fairburn *et al.*, 2003). The system is even more strongly maintained by the development of restrictive eating as a *safety behavior*, where the patient avoids eating in order to reduce the perceived risk of a negative outcome (e.g., uncontrollable weight gain), rather than avoiding eating in order to achieve a perceived positive outcome (e.g., weight loss).

The importance of these cognitions extends beyond the immediate maintenance of the behaviors during the eating disorder. In many cases,

CBT is more effective in reducing patients' behavioral symptoms than in reducing their excessive concerns about shape and weight (e.g., Wilson, 1999). Given the role of the overevaluation of eating, shape and weight in such cases, this pattern of behavioral change without the accompanying cognitive shift means that there is a risk of relapse in many such cases.

The importance of the overevaluation of eating, shape and weight as a core maintaining mechanism means that it is critical that these beliefs are seen as key targets of treatment. Both the clinician and the patient should be clear that it is essential that those beliefs are modified if CBT is to result in long-term behavioral change. As highlighted in Chapter 6, eating disorder symptoms often have an egosyntonic component and a patient may have much invested in maintaining their belief system. Indeed, it is not unknown for those around the patient (e.g., partner) to be part of this system and encourage assumptions such as "If I am thin, I am more attractive" and "If I gain weight, my partner will leave me." With patients who are reluctant to amend their belief system, we will explore this using a motivational stance, emphasizing the rationale and explaining our concerns regarding the risk of relapse. We discuss such modifications with our patients as a non-negotiable of effective CBT, as, ultimately, sustained behavioral change is highly unlikely if such an evaluative schema remains.

## 22.1 Cognitive and behavioral manifestations of the overevaluation of eating, shape and weight

As outlined in the previous chapter, the CBT model postulates that there are three different levels of cognition: negative automatic thoughts, assumptions and core beliefs. Clinicians will be familiar with patients who report a number of negative automatic thoughts (e.g., "I'm fat," "I'm greedy"), related to eating, shape and weight. Such negative automatic thoughts are often driven by the assumptions or "rules for living" that the individual holds. Cognitions involved in the overevaluation of eating, shape and weight often fall into the category of an *assumption*. Such cognitions are often conditional (i.e., they are expressed or can be restated as "if . . . then . . ." statements). Assumptions can often be seen as an individual's way of overcoming or compensating for a core belief and providing structure or "rules" for living. For example, an individual with the core belief "I'm inadequate" may also have an assumption "If I'm thin, I'm more successful" as a means of managing their core belief, as dieting now offers them a way of possibly becoming "adequate." We elicit these assumptions from food and thought records, and through the use of standardised measures (e.g., Cooper *et al.*, 1997; Hinrichsen *et al.*, 2006).

Whilst assumptions are often about the link between eating behaviors and bodily change, they can also be about the link between eating, shape and weight and personal, social or aspirational outcomes (e.g., perceived intelligence, popularity, success in work). Adding these to the formulation (see Chapter 8) can help the patient to understand how these assumptions or rules (as we often call them) are maintaining their eating disorder. It also helps us to plan treatment, using the strategies outlined later in this chapter.

Therefore, before trying to modify the overevaluation cognitions, it is vital to explore the patient's own beliefs, to understand their idiosyncratic expression. We always use the patient's language, and find it helpful if they can coin a phrase that personalizes ''overevaluation of eating, shape and weight'' (e.g., ''My weight is all-important to me''; ''I can't stop thinking about fat on my belly''; I am obsessed with my weight'').

Most patients will report one or both of two key beliefs: their eating being likely to go out of control (e.g., ''I cannot eat one biscuit, because I will simply eat and eat until they are all gone''); and their weight going out of control (e.g., ''If I eat normally, then my weight will shoot off the scale''). In order to gear CBT to the individual, it is critical to put these beliefs into the patient's own words. However, individual patients will have other beliefs that maintain the eating behaviors, at the level of either negative automatic beliefs or of dysfunctional assumptions. These include cognitions related either to how the patient believes others will perceive them (e.g., ''If I eat dessert, others will think I'm greedy'') or to their self-perception (e.g., ''If I eat less than others, I am somehow superior to them''). These beliefs need to be elicited from the patient (using techniques such as diary recording, Socratic questioning and downward arrowing), clarified and rated for strength.

Once these beliefs have been defined, they need to be built into the individual formulation, in order to build a plan of treatment for the individual patient. The modification of these cognitions requires two procedures, both of which are based directly on Socratic questioning: direct cognitive challenges (cognitive restructuring) and behavioral experiments. Each is discussed at length in this chapter and elsewhere (e.g., Cooper *et al.*, 2000).

## 22.2 Case formulation using overvalued beliefs

As we have outlined above, overvalued beliefs are of primary importance in understanding the eating pathology. Therefore, it is important that the clinician and patient should have ''overevaluation of eating, shape and weight'' (or a more patient-specific variant) in the case formulation (see Chapter 8). The clinician and

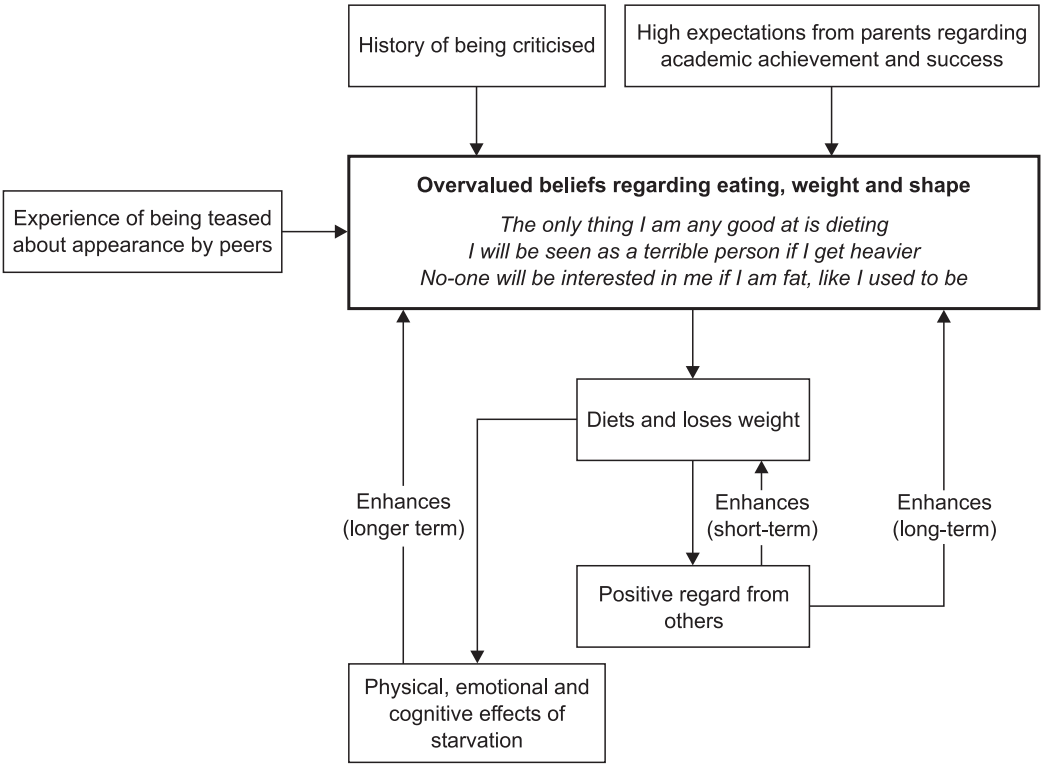



Figure 22.1 Formulation showing the central role of beliefs regarding eating, weight and shape in the development and maintenance of an eating disorder.

patient need to discuss how these overvalued beliefs are maintaining the disorder, and how it will be necessary to implement specific treatment strategies to target such cognitions. Figure 22.1 shows an example of a routine formulation, with greater detail given to these cognitions, used to explain to the patient the specific cognitions that drive their eating-disordered behaviors.

Patients will sometimes find it hard to imagine that their thoughts and behaviors could be incorrect, or that they could be modified. Padesky (1994) has highlighted the concept of prejudice as a helpful analogy for discussing this with patients. A prejudice is a belief that is held with such conviction that it is as if it were the truth, when, in fact, it is not the truth. However, the person who holds the prejudice has extreme difficulty in grasping that it is an opinion only, and that others may not share it. To help our patients understand that they may have a self-directed prejudice (e.g., ''I'm fat''; ''I am a failure''), Padesky suggests asking our patients to think of someone they know who has a prejudice. For example, that person might be racist or sexist, or might support a different football team or hold the belief that ''all women drivers are rubbish.'' Socratic questioning can be

used to explore how this prejudice affects their friend. Generally, the patient will determine that their friend will maintain their prejudice in the face of all contradictory evidence, often ignoring or rubbishing such evidence. A helpful description of this concept is provided by Kennerley (2000), and she has also elaborated upon the football fan analogy – the belief that your team is the best results in a loss being explained as the referee's poor eyesight, bias and so on! Most patients will begin to draw parallels with their own "prejudices." We will discuss with patients that since they have held their "prejudices" for so long, we do not expect these to change overnight; however, we would like to encourage them not to assume that a thought or belief is automatically true. Since they have spent so long looking for evidence that fits only their prejudice, we now need to look for evidence in a more balanced fashion. This exercise can be usefully followed up by reminding the patient that some ideas that were held very firmly in the past have proven to be totally incorrect (e.g., people used to believe that the earth was flat and that it was the center of the universe, and it took a lot of argument before they could believe that this was wrong). We will also talk about the role of cognitive dissonance in maintaining such beliefs. For example

> I can understand why you might see your body as huge – after all, you have had to put so much effort into dieting that you have to be able to convince yourself that there is a point to it. That is a very normal human way of thinking – we tend to emphasize the things that we put the most effort into.

Occasionally, a patient will insist that they have no concerns about eating, weight and shape. For example, the patient might say that their eating has been at a low level for a prolonged time period because they have been eating "healthily" (e.g., only fruit), and will express surprise that this eating pattern has been related to their weight loss. We find it most effective to treat this statement as a working hypothesis (to build into the formulation, albeit temporarily), and suggest to the patient that we develop a new diet that reflects the necessary nutrients that make up a balanced diet and that they should try this for a week or two. This allows clinician and patient to discover if the working hypothesis is correct. If it is not (as is commonly the case) and the patient is unable to eat in a more balanced way, then we are able to use Socratic questioning to begin to explore the possibility that they have a strong pattern of beliefs relating to the overevaluation of eating, weight and shape. This results in a formulation that the patient is more likely to accept as a basis for treatment.

A few eating-disordered patients will state that they used to have such a belief system, but that it is no longer present, and this turns out to be accurate on further probing. These are usually patients who have been ill for a number of years. In many cases, the overevaluation of eating, shape and weight was present

when the disorder began, but the function has shifted over time. Usually, in such cases, the function has shifted to one of emotion regulation (e.g., McManus & Waller, 1995). In these cases, we would explore what has changed about the patient's belief system and how they evaluate themselves now, modifying the formulation accordingly (possibly adding the overevaluation as a "defunct" part of the formulation, so that the patient can see its role in the development of the disorder). In such cases, treatment is more likely to be focused on emotional antecedents and maintaining factors (see Chapter 25).

## 22.3 Alerting the patient to the importance of overevaluation: the self-evaluation pie chart

Whilst many patients will be aware of the importance they place on controlling eating, shape and weight, they may be less aware of how this interacts with other areas of their life and the limitations of such a belief system. We find that the "self-evaluation" pie chart, as illustrated by Fairburn (e.g, Fairburn, 2004), is a very useful starting point to get patients thinking about the way that they evaluate themselves. We introduce it as follows:

> Most of us judge ourselves on aspects of our lives. What do you judge yourself on? What are the things that make you feel good about yourself if they're going well, or bad about yourself if they're not going well? . . . I'm going to draw a circle on the board, like a pie chart, and then we'll fill it in with the things you've suggested. What do you want to start with . . . and what proportion should we allocate to that?

It might be necessary to prompt the patient, or to give examples (e.g., "My friend plays the piano very well, and this is important to them"). One of the advantages of doing this exercise on the whiteboard is that you are able to alter the proportion allocated to each life domain.

Figure 22.2 shows an example of a completed pie chart. As patients look at their pie chart on the whiteboard, they often realize that the overevaluation of eating, shape and weight is far more important than they had previously acknowledged. They have a variety of emotional reactions to this, and many are shocked, sad, angry or guilty that other factors (such as family or relationships) are outweighed so heavily by the focus on their appearance. Clinician and patient can then explore the pie chart together:

> Looking at your pie chart, what do you think about the way you judge yourself? In what ways is it helpful or unhelpful to think like this?

One important point is to note the order of priority given to different elements of life. We complete the pie chart clockwise from the top, and we stress that the

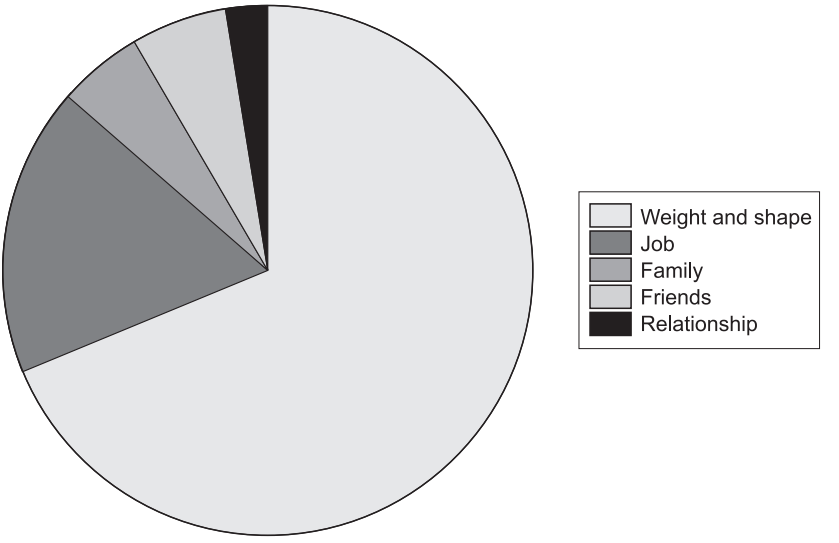



Figure 22.2 Patient's current self-evaluation pie chart.

patient tends to prioritize eating, weight and shape, putting it first (and often expressing guilt about how little is given to friends, family, etc., at the end, but being unable to change that).

Using Socratic questioning, we aim to alert the patient to two potential difficulties with their current method of self-evaluation, and to encourage them to develop alternative strategies. First, there is the "all your eggs in one basket" dilemma, demonstrating how the patient is engaging in a highly risky strategy. If it goes wrong, they will feel really bad (e.g., "If I gain a pound, I feel terrible"). A useful analogy is that of the workaholic who is made redundant, and feels they have nothing left in life. The aim is to encourage the patient to consider a more balanced self-evaluation schema, such that they will be able to cope with disappointment or failure in one domain by identifying success or happiness in another or across several others.

The second difficulty that we identify is in the choice of domain. The use of eating, weight and shape as the key domain has the inherent problem that such goals are very difficult to achieve and maintain, and that they are very costly. Socratic questioning can be used to help the patient to explore the following:

- They will always see someone who is slimmer or more attractive than they are (especially as their body image is potentially distorted), making it impossible to identify themselves as the best.
- This domain is particularly susceptible to the problem of "shifting goal posts," the most clear example of which is the continued downshifting of an "acceptable" weight.

- Focus on this domain comes at huge personal cost (e.g., ill health, hospitalization).
- Focus on this domain limits the ability to succeed in other domains (e.g., to concentrate at work, maintain friendships, have children), and may even be internally inconsistent (e.g., a restrictive diet can limit the ability to succeed in terms of exercise).

Some patients state that they are no different from lots of people they know, who place importance on their appearance. This is an opportunity to introduce continuum thinking. Acknowledge that most non-eating-disordered people will place some value on their appearance, including control of eating, shape and weight. However, using Socratic questioning, it is possible to elicit from the patient how those people differ from the patient, in that their concern about eating, shape and weight is tempered by self-evaluation in other domains, allowing them to feel successful even if they are not the thinnest person they know. Where it is apparent that this other person *does* place the same degree of emphasis on eating, shape and weight, it is usually possible to reframe this person as having an eating problem, and to elicit a suggestion from the patient that this person seems to have many of the same problems as the patient does.

Treatment for the eating disorder needs to be framed as a trade-off — we are working not only to decrease the importance of the eating, shape and weight domain, but also to increase the importance of a range of other existing or new domains. Without that trade-off, it is hard to motivate the patient to engage in treatment, as they feel that they will be left with a void. With this in mind, a useful homework exercise is to get the patient to draw an ''ideal'' pie chart: how they would like their life domains to be balanced in order to achieve their personal values (Vitousek, 2005). An example is included in Figure 22.3, to contrast with the ''current'' pie chart. By asking the patient what they used to do or always wanted to do, preexisting personal values can be revived and new ideas can be generated. It can be particularly useful to consider what the patient used to do before the eating disorder emerged. For example, the pursuit of thinness might have led them to give up hobbies or friends (e.g., in order to avoid restaurants). This pie chart is often completed differently from the other, in that everything else is considered before weight and shape. When the patient does this, it is worth reflecting on the change in emphasis in their thinking at a broader level (food, weight and shape are not just less important, but also are no longer the priority).

We commonly encounter two issues when using this method. First, for some people, the current pie chart may appear more balanced than others, until discussion reveals that the dominant theme is the need to be perfect in all domains on the pie chart. It is important to highlight this pattern with the patient, to raise the questions of whether they are attempting too much (making them likely to fail

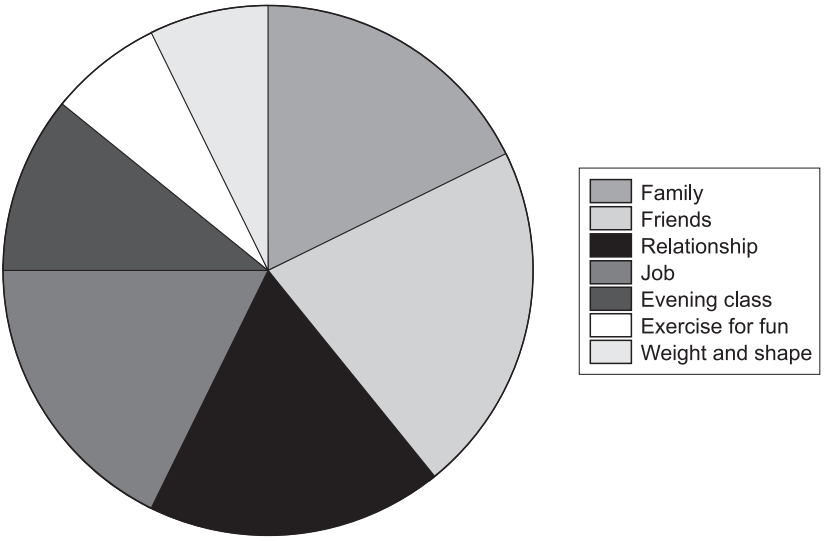



Figure 22.3 Patient's ideal self-evaluation pie chart.

in all domains) and how they could her bring their life back into balance. These patients are likely to be those with high levels of perfectionism (e.g., Shafran *et al.*, 2002; Slade, 1982) and those with a general style reflecting broad overevaluation of achievement (e.g., Fairburn *et al.*, 2003), and treatment might need to be modified in accordance with this. Second, the patient might express concern that they will not be able to make the complete transition to having no focus on eating, shape and weight. This is a cue to return to the issue of continuum thinking, stressing that this domain can still be represented, but to a lesser degree.

## 22.4 Cognitive and behavioral treatment strategies for modifying overevaluation of eating, weight and shape

Before detailing treatment strategies, it is important to reiterate that this chapter is focused purely on modifying the overevaluation of eating, shape and weight. The techniques used will be discussed more broadly in the next chapter, in relation to the modification of a wider range of beliefs and behaviors.

We use two key strategies to address the overevaluation of eating, shape and weight: *cognitive restructuring* and *behavioral experiments*. These have already been discussed in Chapters 18 and 21, but here we are specific about applying these tools to the core pathology of the eating disorder. We find these interventions work most effectively if cognitive restructuring is used first to "loosen" the belief and introduce the possibility that the belief may not be 100% accurate,

in the spirit of the "curious clinician." Alternative beliefs can be tentatively hypothesized. This is followed up by the behavioral experiment, which can provide concrete evidence to support the alternative belief and discredit the original belief or vice versa. Actually carrying out the planned behavioral experiment and encouraging patients to modify behaviors (such as body checking, use of laxatives, and excessive weighing) is essential in enabling the patient to modify their beliefs at a cognitive and emotional level.

### 22.4.1 Cognitive restructuring

#### 22.4.1.1 Evaluating evidence for and against the belief

Using Socratic questioning to help the patient to restructure these beliefs consists of six key stages. Using a thought record is a useful way of structuring this process and encouraging the patient to identify such thoughts as part of their homework.

- *Step 1 — Understanding the "current belief."* If the belief is an assumption, clarify the belief as an "if . . . then . . ." statement, using the patient's own language (e.g., "No-one likes you when you are fat" might become "If I am fat, then people will not like me"). In addition, ask for a rating of the strength of that belief (e.g., 90%). It is also important to explore when and how the belief was developed and to see if the belief can be narrowed down, e.g., people may become "men." Patients often take such beliefs as the "truth," but exploring the development of the belief (including identifying a time when the patient did not think like this) can begin to enhance insight and flexibility.
- *Step 2 — Consider the evidence in favor of the belief.* While the patient will often be able to come up with supporting evidence quickly (e.g., "Kids in my class told me that they did not like me because I was fat"), it can surprise the patient that the amount of evidence is not particularly extensive. The clinician might have to explore this evidence with the patient more fully, to ensure that the range of cognitive distortions can be identified (below). This must be based on genuine interest on the part of the clinician, so that the patient feels that the clinician really wants to know about their beliefs, rather than feeling that the clinician is simply pointing out that their beliefs are poorly founded. Such an approach is implicit in the "curious clinician" stance.
- *Step 3 — Consider the evidence against the belief.* Unsurprisingly, this can be considerably harder for the patient in the first instance. Therefore, it is important to help the patient to develop this evidence base from their past experience (and, again, to identify the cognitive distortions that lead

the patient to miss or discount that evidence). Questions that can help must be based on an acceptance that this is the patient's belief (rather than making the patient feel that you doubt them), and might include:

- "Has there ever been a time when you haven't thought like this?"
- "Has there ever been a time when this hasn't happened – you didn't binge after having pizza?"
- "Do your friends or family agree with your belief that you are fat, or do they tend to argue with you?"

- *Step 4 – Identify the cognitive distortions that might explain adherence to this belief.* We find it useful to discuss cognitive distortions in general with the patient during the psychoeducation stage, and then to revisit the topic to encourage the patient to be clear about how those distortions might be affecting their beliefs and behaviors. We will often encourage the patient to develop a flashcard of their most common distortions. For example:
  - black and white thinking (e.g., "I can't eat just one biscuit, I have to eat the whole pack") (see Section 22.4.1.2 for more detail on specific approaches to this distortion)
  - catastrophization (e.g., "If I go over 55 kilos, my life will be over")
  - superstitious thinking (e.g., "Even thinking about eating normally will make me put on weight").

  We also ask patients to imagine how they would feel or act if they did not have these distortions (e.g., "I would have to spend far longer working out whether people find me acceptable"; "I might not be so quick to beat myself up"), so that we can understand the pros and cons of these ways of "simplifying" the world.
- *Step 5 – Developing an "alternative belief."* The alternative belief is one that contradicts the "current belief," although it will tend to be less rigid. The contrast between of the evidence for the current belief (e.g., "People will stare at me and comment if I don't cover myself up as much as possible") and the evidence that it no longer applies or that it was limited at the time (e.g., "That used to happen at school, but it was about those particular 'friends' being cruel") should result in an alternative belief (e.g., "Maybe people will not comment on me any more than they do about others, and it might not matter anyway"). Again, ask the patient to rate the strength of that belief (e.g., 30%). The strength of this belief is likely to be less than the "current belief," therefore the next (and final) stage is key in modifying the maladaptive belief.
- *Step 6 – Seek evidence that allows the beliefs to be contrasted.* Doing this will involve both further historical review and examination of current experience. For example, the patient can be encouraged to monitor whether their eating is out of control (e.g., record how many times they eat a "forbidden" food without

binge-eating, in order to determine the accuracy of their belief; identify whether the best predictor of a binge is the eating of a "forbidden" food or the failure to eat carbohydrates over the previous 12 hours) or the behavior of others towards them (e.g., identify whether others treat them differently because they have eaten breakfast). We use this homework to encourage the patient to consider how they would feel or act if they did not have to operate by the rules derived from their overvaluing of eating, weight and shape (e.g., how would they feel after eating dessert, if they did not have a belief that it would make others think they were greedy?). This allows us to work with the patient on evaluating the pros and cons of holding such beliefs. Again, this re-evaluation can be beneficial in itself, but is most valuable in freeing up the patient's thinking enough that they can begin to undertake the behavioral experiments detailed below.

#### 22.4.1.2 The use of continuum thinking in modifying overvalued beliefs

A particular issue with our patients is that they hold very rigid beliefs that are highly personalized, making it difficult to allow the patient to challenge cognitions using cognitive restructuring as outlined above. Therefore, it is essential that we work with the black and white thinking in order to make such flexible thinking possible. Continuum thinking is a well-established technique in CBT (Padesky, 1994). However, we find that we need to work with continua in a more complex way, teaching the patient methods of challenging the interaction of two beliefs at a time. For example, if the patient believes: "Only thin people are successful people," then we will use the following variant on continuum thinking.

- *Step 1*. Write down the current belief and rate its strength ("Only thin people are successful people" – 90% certain).
- *Step 2*. Ask the patient to write down the names of ten people who they know (friends, family or acquaintances, but not themselves). The identity of those people should only be limited if the belief is specific in a relevant way (e.g., if the patient believes that only thin *women* are successful, then the list should consist of women).
- *Step 3*. Ask them to draw a line, with one end of the line marked "thinnest" and the other end marked with a term that expresses the opposite (in the patient's own language – e.g., "least thin"; "fattest"), and to place the ten people at the appropriate places on that line (starting with the people who occupy the extreme points on the line). It is important to note that some patients may express difficult feelings at labeling people in this way, and may welcome reassurance that this needs to be done for the sake of the exercise. Up to now, this is conventional continuum thinking.

- *Step 4.* On a fresh sheet of paper (to avoid the influence of the previous continuum), ask the patient to repeat step 3, but with the line marked "most successful" to "least successful" (again, with terms that make sense for the patient). You now have two continua, based on the same ten people.
- *Step 5.* Reframe the current belief as a diagram (see Figure 22.4), saying: "So, your belief is that only thin people are successful. If I have that right, when we put these two lines together like this *(drawing them at right angles on the white board)*, then we map your chosen ten people onto that graph, they should fall along this line *(drawing a line at 45 degrees to both axes)* – thin people will be successful, fatter people will be less successful and everyone else will fall along the line accordingly. Have I got that right?" *(Patient agrees.)* "OK, but you also said that you believe this only 90%, not 100%, so it is likely that they will not fall exactly on the line in every case. So let's give a little slack here, and say that people will fall very close to the line, even if not exactly on it. How about we say that they should all fall within this tight envelope around that line *(drawing an ellipse to replace the diagonal line, with the tightness of the ellipse determined by the strength of the certainty rating)*. Is that fair?" *(Patient agrees.)* "What would it say about your belief if these people did not neatly fit this pattern (generating an alternative belief), and how strongly do you believe that?" *(Usually 0% or some other very low confidence rating)*.
- *Step 6.* Testing the accuracy of the current belief depends on the "curious clinician" stance, being open to whether the idea is right or not: "Right – let's see how accurate that is. Let's start with someone from your list." *(Plotting the first person, chosen randomly or in alphabetic order, on the graph.)* Our experience is that the individuals the patient has chosen always fail to verify their belief (i.e., they show up scattered around the graph, rather than on the prediction line or in the ellipse). It is important to work through all ten people without passing any judgement on the accuracy of the individual's placement on the graph (relative to the patient's prediction), so that the clinician is able to maintain the Socratic position and get the patient to work further on this, rather than feeling that they know less than the clinician. Therefore, the clinician needs to say something along the lines of: "OK – I think that we need to think about this belief of yours. It does not seem to fit to the people who you have chosen. What might be going on here?"
- *Step 7.* The patient should be encouraged to re-rate the strength of their belief, and to try to reframe it (e.g., did we have the right attribute to associate with thinness; did they pick the wrong ten people?). Patients will often conclude that the importance of thinness must be that it is associated with a different attribute to the one they originally chose (e.g., attractiveness rather than success). This takes us directly into the next stage.

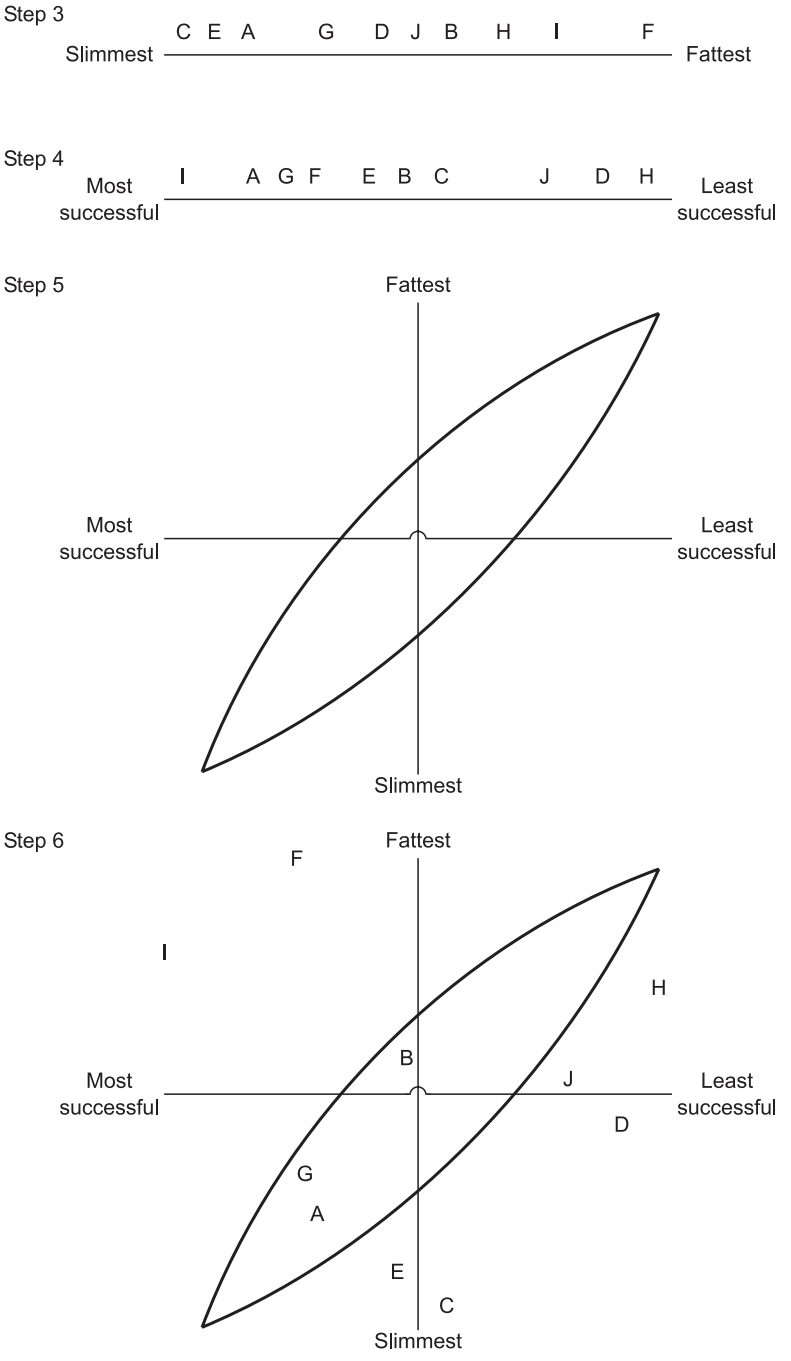



Figure 22.4 Diagrammatic demonstration of key steps in the process of mapping pairs of continua to test out the belief "Thinner people are always more successful" (each letter refers to one person).

- *Step 8*. The patient is asked to repeat this exercise for homework, in order to see if they can work out what attributes are reliably associated with thinness, restriction, etc. Again, the beliefs can be discussed with the clinician and rated for strength at first, but the patient can take over the guidance of this stage.
- *Step 9*. The clinician uses Socratic questioning to encourage the patient to identify that the ''thinness results in attribute x'' belief is not viable, but that it is more important to understand that ''attribute x'' (e.g., control, happiness, friendships) may be the key to what is being sought. This leads to discussion of other possible ways of achieving ''attribute x,'' rather than dieting, etc.

Again, this technique is valuable in freeing up the individual's thinking sufficiently to allow them to consider the possibility of engaging in behavioral change and experiments. There are two points that are important to note. First, the patient will sometimes say that they can see that the rule does not apply to other people, but that it applies to them. A useful supplement to Socratic questioning at this point is to ask why they apply this rule only to themselves. This approach is often a means of tapping important cognitions at the level of core beliefs, and commencing modification of such schema-level beliefs (see Chapter 25).

Second, the patient's diagrams will sometimes show that there are two people who routinely occupy the positions that most exemplify the belief (e.g., an overweight sister who is seen as unattractive/foolish/unintelligent: a thin mother who is seen as attractive/sensible/bright). In such cases, it can be useful to help the patient to identify that they are basing their belief system on two significant people who are themselves unrepresentative of the other people who the patient knows. Again, consideration of why they are judging themselves in this way can lead them to relax their comparisons enough that they can try behavioral experiments, or can lead into consideration of schema-level beliefs.

#### 22.4.1.3 Surveys

Where the patient finds it hard to generate evidence in order to contrast a current belief with its alternative, a survey can be an effective way of widening their perspective. This can be a particular issue when the belief is one that is about others' opinions rather than anything that can be made objective (e.g., ''Other people are always confident about the way that they look'') or when the belief is hard to test through behavioral experiments because it is too dependent on chance or on the behavior of others (e.g., ''I am not pretty enough to get a boyfriend''). We suggest carrying out a survey to test such beliefs (setting them up in contrast with potential alternative beliefs), where the individual and the clinician each seek evidence in parallel. The reason for both seeking evidence in this way is to show that the views expressed are not simply a case of the patient's friends being kind or the clinician trying to bias the findings.

The clinician suggests that the views of ten other people are sought (ten people is convenient for calculating percentages later). These can either be individuals who work in the clinic or people the patient knows. Independent and anonymous contributors are often the most valuable, as they allow the patient to accept the opinions as objective. The patient and the clinician will develop the questions together. Since patients may have a tendency to generate questions that fit their original beliefs (e.g., ''Is it important for your partner to be thin?''), it can be useful for the clinician to encourage the inclusion of other more open questions (e.g., ''What are the three most important characteristics in a partner?''). The relevant questions are printed on a sheet of paper and given to individuals, with the clinician and the patient each responsible for getting five respondents over the coming week. The patient's current belief needs to be contrasted with the alternative belief, and each needs to be rated (e.g., ''No-one will think that a woman could get a boyfriend unless she is thin'' – rated 85%; ''Other people will think that being thin is not the most important asset in getting a boyfriend'' – rated 20%). The survey will allow those beliefs to be tested, thus helping the patient to consider alternative interpretations and potential behavioral experiments.

*Case example: Gemma*

Gemma believes that it is essential that she is thin in order to have a boyfriend. She predicts that everybody will share this belief, and will put ''having a good body'' as top of their list of what they look for in a partner. Gemma and the clinician agree that she will ask each will ask five friends and acquaintances to list the top three characteristics they look for in a partner. When the clinician and Gemma review the findings in the following session, Gemma is surprised to discover that the survey has generated a variety of responses (e.g., sense of humor; kindness; interesting; nice hair), and that thinness is not even mentioned by most. The therapeutic discussion moves towards Gemma considering other reasons why she does not have a boyfriend at present (e.g., being unimpressed with the men she currently knows; avoiding social events due to her concerns about her appearance).

We frequently use video recording as a means of enhancing this method when working with overvalued beliefs about weight and shape (e.g., ''I am so fat, I look 6 months pregnant''). The patient is asked to rate their certainty of this belief and of the alternative belief. We will make a short video of the patient (often with them trying to exaggerate the characteristic that they are concerned about – e.g., trying to use a posture that they believe acts to emphasize their waistline). The video can be used to test out the beliefs (e.g., ''The first thing that people will notice about me is my belly'' – rated 90%; ''Most people will see other

things about me, rather than my belly'' – rated 5%). Again, this allows for direct comparison of key beliefs, through asking people to identify the things that they most noticed in the video about the patient. Again, this element of cognitive restructuring is often the first step towards setting up specific behavioral experiments (e.g., wearing clothes that do not mask the body, and finding that this does not cause adverse comments).

### 22.4.2 Behavioral experiments

The three cognitive restructuring techniques described above are aimed at 'loosening' a strongly held belief and developing possible alternative beliefs. In many cases, it is likely that despite such interventions, the patient still holds the original belief to a high degree. At this stage the rationale for conducting a behavioral experiment can be introduced.

The key to a successful behavioral experiment is the clear identification of the belief driving the behavior, and concrete predictions from the patient about what will happen if their fear is well-founded (i.e., evidence for the ''current belief'') and what will happen if their the fear proves unfounded (i.e., evidence for the ''alternative belief''). The experiment should be established collaboratively, in the style of the curious clinician, to avoid the patient feeling pressured into generating alternatives that do not feel personally relevant. Socratic questioning should be used to determine alternative predictions. As the patient may often think that there are no alternatives, it can be helpful to incorporate information from the psychoeducation that has been carried out previously (see Chapter 13) to assist in generating such predictions.

There are two important points for conducting behavioral experiments that the patient needs to be clear about. First, the experiment requires making a specific change, while holding constant as much as possible of the rest of life including eating behaviors (e.g., adding a snack each day will not inform the patient about its potential impact on weight if they compensate by adding to their exercise regime). During behavioral experiments addressing feared weight gain, we ask the patient to avoid weighing themselves between sessions. We explain to the patient that this allows us to avoid them giving up on the experiment simply because there is a one-off fluctuation in weight on one day of the week between sessions. Second, an ''accidental'' experiment (e.g., the patient changes their type of yoghurt because their favored brand was not on sale, and it has no impact on their weight) is less likely to be effective than a ''planned'' experiment (e.g., the patient deliberately changes to a new yoghurt to determine if it has the anticipated impact on weight). The planned experiment is more likely to be effective because the individual has to evaluate the ''alternative'' belief in advance, making the result harder to discount after the event. However, this does not

mean that ''accidental'' experiments are not valuable; in some cases they may be beneficial in encouraging the patient to try the planned experiment by demonstrating that current beliefs are not 100% accurate.

#### 22.4.2.1 Behavioral experiments to address beliefs about uncontrollable weight gain

The following example demonstrates a behavioral experiment, designed to test the belief that uncontrollable weight gain will follow from eating normally. As always, it is important to start a behavioral experiment at the level that generates some anxiety for the patient, but that anxiety should not be so overwhelming that the patient is unable to execute it. The same principles apply regardless of the amount that the patient fears eating (whether it is three meals a day or a biscuit a week) or the pattern (e.g., to start eating at fixed times).

*Case example: Karen*

Karen is in treatment for restrictive anorexia nervosa. Although she is well engaged and motivated, she is finding it difficult to increase her intake to three meals every day. Together, Karen and her clinician have identified that her difficulty is driven by her belief that eating three meals a deal will cause her weight to shoot up. The key element is that the proposed behavioral change should generate cognitions that result in anxiety, albeit at a tolerable level. If there is no such anxiety (e.g., the patient believes that the proposed behavioral change will not have any impact on her weight), then it is unlikely that the cognitions being challenged by the behavioral experiment are critical ones.

| | | Aim and principles underlying intervention |
|---|---|---|
| *Week 1* | | |
| *C.* | So, Karen, it seems like you're pretty convinced that if you eat three meals a day, your weight is going to shoot up. | *Establishing the ''current'' belief* |
| *K.* | Yes, that's definitely what would happen. | |
| *C.* | OK, I can see now why it has been so difficult for you to eat three meals. I wonder though, how we can be sure that what you think is going to happen will actually happen? Do you think we could try an experiment? | |
| *K.* | Mmmm, OK. | |
| *C.* | How much weight do you think you would put on in a week, if you were to eat three meals a day? | *Firming up the prediction* |
| *K.* | Definitely five kilos! | |
| *C.* | And how certain are you of that, on a 0 to 100 scale? | *Estimate certainty of belief* |

| | | Aim and principles underlying intervention |
|---|---|---|
| *K.* | 95% — maybe more. | |
| *C.* | So you are pretty definite about that outcome. OK, so what other possible outcomes are there? | *Developing the "alternative" belief, based on prior psycho education* |
| *K.* | Well, I remember all that stuff in the handout you gave me about how hard it is to put on weight — how much you have to eat. So I suppose that I *should* consider that I wouldn't put on much weight at all, but I really find that hard to believe. | |
| *C.* | Can you be more specific about that alternative, even if it is pretty hard to believe? | *Firming up the alternative belief* |
| *K.* | Well, I guess my weight would stay about the same — maybe increase by 1 kg at the most — but I can't imagine that happening! | |
| *C.* | How strong would that belief be, on that same 0—100 scale? | *Allow that the numbers will not add up to 100% — it is not critical, unless they miss 100% by a very wide margin (might indicate a third belief to consider)* |
| *K.* | No more than 5%. Probably 0%, if I am honest. I really cannot see any way that I would gain only one kilo if I ate like that. | |
| *C.* | OK. And then there is that issue of natural weight fluctuation that we have talked about — it is really impossible to draw any conclusions about how your weight is going on the basis of one week's weight change. So we need to think about how long you would need to change your behavior in order to test out these two beliefs. If your weight were to go up as you predicted, how many weeks would you need to see it going up like that before you could be sure that it really was rising? | *Two related things are happening here: reduction in the risk of black and white thinking about weight change, and setting the scene for the stance needed when weighing the patient (see below)* |
| *K.* | Two weeks. Three at most. | |
| *C.* | Can you write that prediction down, along with your certainty rating . . . good. Now, let's think about that alternative belief — that your weight would not go up. How long would your weight have to stay the same, or rise by no more than a kilo per week, before you could be sure that belief was right. | |

| | | Aim and principles underlying intervention |
|---|---|---|
| *K.* | Hard to say. I guess that I should say one week, because I am so sure that belief is impossible, but I think I want longer. Can we say four weeks? | |
| *C.* | Of course we can. So that belief would make you expect to see no weight gain, or at least no more than four kilos over the next four weeks. But your belief in that is about 0% to 5%. Have I got that right? | |
| *K.* | Yes. | |
| *C.* | Can you write down that prediction too, along with your certainty rating . . . good. | *Get the beliefs and predications documented for consideration in next session* |
| *K.* | So what do I need to do to see whether I am right or not? Are you going to make me eat more? | *Patient tries to shift responsibility for the behavioral experiment to the clinician. The clinician returns this to the patient, who proposes the experiment. The clinician then reminds her of the need to use the full time frame needed. Note the use of "your" current and alternative beliefs (rather than an alternative belief), to maintain the patient's ownership of the beliefs (and hence the experiment)* |
| *C.* | What do you think you could do to check out your "current belief," and compare it with the "alternative belief"? | |
| *K.* | I suppose that the only way is to try eating as we discussed. If I eat those three meals a day for a week, then I will at least be able to convince you that I am right, and that you cannot expect me to eat like that. | |
| *C.* | So you are going to try for a week at first? Then we can see which belief might be accurate, and plan from there, but I would not get excited about just one week. Even if you do not gain all that weight in one week, or even gain none, we need to remember those normal weight fluctuations — the longer you keep it going, the more certain you can be about which belief is more accurate. | |
| *K.* | OK — then let's try it for a couple of weeks at first, as I said. Three if I can bear it. | |
| *C.* | If that will work for you, then let's try it out. Let's get that in your homework diary . . . three meals a day, each day . . . the "current belief" and how strong it is, and the "alternative belief" | *Agreeing a homework task — the behavioral experiment* |

| | | Aim and principles underlying intervention |
|---|---|---|
| | and how strong it is. So, between now and when we meet next week, you will try to have three meals a day as many times as you can — the more you do, the more reliable the experiment will be. Then next week we can see what has happened to your weight. Then we can start to see how valid your belief is. Let's get that into your prediction log. | |

Figure 22.5 shows the prediction log that is kept to demonstrate the cognitions that are being compared, along with the firm predictions that the individual makes from the behavioral challenge. A blank version of this log is provided as Appendix 4.

| | | |
|---|---|---|
| *Week 2* | | |
| *C.* | So, we've had a week of doing the experiment. How many days did you manage to have three meals? | *Checking compliance with the behavioral experiment* |
| *K.* | *(Checks summary sheet at end of diary)* Six days out of seven. It was *so* hard. | |
| *C.* | And have you weighed yourself in between our sessions? | |
| *K.* | No, but I really wanted to. I feel so fat! But I kept reminding myself about what we discussed — about those fluctuations. | |
| *C.* | Your "current belief" was that if you ate three meals a day all week, your weight would go up by five kilos. You have managed the meals on six days, so how much do you think you will have gained when we weigh you? | *Reiterate the predictions if the experiment has been done in full, or get a modified prediction if it has not (as in this case)* |
| *K.* | At least four kilos — 100% certain. Maybe even the full five kilos — I probably believe that one about 95%. | |
| *C.* | And that "alternative belief" was that your weight would go up no more than one kilo — maybe even no change at all. How much do you believe that? | |
| *K.* | Not at all — can I have a negative score on the 0—100 scale? | |
| *C.* | Then let's see which is correct. Time to weigh you. Now remember, this is one week, and there is almost nothing that we can learn conclusively from one week. It is important that we do not go in for black and white thinking, and decide that your weight is dropping or rising on the basis of the | *Repeating the importance of treating this week as a single data point, where multiple data points will be needed to be certain about the predictions (see above)* |

| | | Aim and principles underlying intervention |
|---|---|---|
| | difference between last time and today. However, we will chart it, and then look back at the trend when several weeks have elapsed and the randomness evens out. I think you suggested four weeks would be the time that would make sense to you, so we will just use today's weight as the first of four weights and take an average in a few weeks. | |
| | *(The clinician takes the patient's weight, which has not changed substantially, and they jointly chart both her actual weight and the gain predicted from the "current belief")* | |
| *K.* | I can't believe it – my weight has stayed almost the same. | |
| *C.* | So what does that say about your two beliefs? | *Comparing the beliefs, given this first data point, while stressing that this is only one week against a background of random fluctuation (therefore not a trend)* |
| *K.* | Well, I suppose that I ought to say that my belief is wrong, but I am not sure. | |
| *C.* | Given what we said about the need to look at change over a number of weeks, I can see why you might want longer to make your mind up. Maybe it is more important to think about how confident you are about your "current belief" and your "alternative belief". So, how do you rate your confidence in your "I am going to go up by five kilos" belief now? | |
| *K.* | Well, not as much – maybe 70%? I'm stunned – it can't be right. | *Change in strength of beliefs is a good predictor of change in the beliefs themselves* |
| *C.* | And your "my weight will stay stable" belief? | |
| *K.* | Er . . . a bit more . . . maybe 20%? I know that doesn't add up to 100%, but it feels right. | |
| *C.* | Well, to make sure it's not a fluke and that something strange has not happened – how about if we repeat the experiment over the next week, and see what happens next time? Then we can work up to that average over four weeks of doing the experiment, and compare it to the last four weeks, to get an idea of whether there is any reliable pattern that supports either of the two beliefs. | *The clinician needs to be entirely objective about this change in weight, regardless of what has happened. Stressing the need to maintain the planned experiment by drawing no immediate conclusions, and continuing in the agreed time frame* |
| *K.* | OK. | |

| Belief to be tested (Rate belief 0-100%) | Experiment: What will I do to test the belief? When will I do it? | Prediction: What exactly do I think will happen? How will I know whether it has happened or not? (Rate belief 0-100%) | Alternative prediction: What else might happen? (Rate belief 0-100%) | Outcome: What actually happened? Was the original prediction correct? | Re-rate cognition: On balance, what is my view now? How do I rate the beliefs above in the light of the experiment? | Plan: What can I do now to further test the belief? |
|---|---|---|---|---|---|---|
| *"If I eat normal meals, my weight will shoot up."* (99%) | To eat three meals a day every day for one week, and see what happens to my weight. Need to do this over at least three weeks to be certain, because of random fluctuations. | *"My weight will increase by 5kgs every week"* (95%) | *"My weight will stay the same, or increase slightly – by no more than 1kg each week"* (0%) | Weight increased by 0.2 kg. My prediction was incorrect - my weight didn't increase nearly as much as I'd thought. | Original belief = 70%. Alternative belief = 20% | Continue the experiment, so that I can be clearer about which belief is accurate. |

Figure 22.5 Karen's behavioral experiment sheet.

This process is continued over a number of weeks until the patient learns that the original belief is not accurate, and that they can eat three meals a day without significant weight gain. Then, the experiment can be elaborated or developed to further test associated beliefs (e.g., ''If I eat 'junk' food like pizza or chips, my weight will definitely shoot up''). Our experience is that the patient becomes more willing to take greater ''risks'' as the process continues into subsequent experiments, thus speeding the process. Again, the amount eaten is not something that can be set for all patients (e.g., it could be a biscuit a week, or allowing any food at all before noon). Nor can there be a fixed timeframe for the experiments. The key is to determine that the proposed behavioral change addresses cognitions that drive a level of anxiety that is significant but manageable. Such changes can only be determined in collaboration with the patient (or, in the longer term, by the patient alone when they have grasped the principles of behavioral experiments). The perceived consequences will also differ (e.g., ''My stomach will get bigger''; ''I will binge more''), but the process of setting predictions to compare cognitions remains the same.

In the spirit of collaboration, it is important that the clinician does not set up the experiment as the ''expert'' who can foresee the outcome. The ''curious clinician'' stance will allow the clinician to say: ''I do not know which of your beliefs is right – I know what the books might say, but I also know that people are variable, and it is possible that you are an exception (e.g., only needing 1000 cal per day to get by). Therefore, we both need you to try this experiment in order

to show which belief is accurate.'' Repeating the experiment enables the patient to confirm and extend the findings. The experiment is likely to be challenging beliefs that have been rigidly held for years. Therefore, the patient will need time to incorporate this new information into their belief system.

Clinicians learning about behavioral experiments often ask what happens if the experiment ''goes wrong'' and the patient's belief is supported. Given the extreme nature of many patients' predictions (e.g., gaining a kilogram a week over an extended period), this is unlikely to be the case over time (as it would require an extremely large increase in intake, rather than simply adding in a small amount of extra food). However, random fluctuations in weight or the environment can mean that the belief is supported for a short time (e.g., weight will occasionally go up by a kilogram in a week). The key element here is to be clear that such fluctuations can occur, and to remind the patient that this was why there was an agreement to carry out the experiment over time. We find it is most effective to state this *prior* to weighing the patient (see Karen's example). The problem here is not the patient's belief system as much as the clinician buying into the patient's black and white thinking. The value of the ''curious clinician'' approach is that it allows us to engage in genuine exploration of the situation without becoming entangled and diverted by the patient's emotional reaction.

Further examples of frequently used behavioral experiments are given in Table 22.1.

#### 22.4.2.2 Behavioral experiments to address beliefs about acceptability to others

Some patients believe that they have to be thin to be acceptable to other people. Patients may state a belief such as: ''Other people cannot accept me unless I'm thin.'' A female patient with this belief may experience frequent automatic thoughts that they will not be able to find a boyfriend as: ''Men only care about the way women look.''

Underlying this belief is the assumption that the patient cannot be liked for who they *are* but only for how they *look*. Consequently, asking them to engage in behavior that could lead to a change in weight and shape feels extremely threatening. When this belief is combined with the belief that eating normal regular meals will lead to significant weight gain, patients may appear very resistant to the idea of change. One effective way to test this belief is to ask the patient to collect more information from people close to them. An example of this (Gemma) is given earlier in this chapter (Section 22.4.1.3). A less direct approach to this experiment is for both clinician and

**Table 22.1.** Examples of behavioral experiments to address the overevaluation of eating, shape and weight

| Cognition to be tested | Possible behavioral experiment |
|---|---|
| "If I eat dessert, people will think I'm greedy" | To eat dessert in front of colleagues or family and see if they say I am greedy or comment on it |
| "If I eat pizza/take-away food/chocolate, I will lose control and end up bingeing" | Plan a specific time to try a feared food, using graded exposure |
| "If I don't weigh myself three times a day, my weight will go out of control" | To limit weighing to once a week for a planned amount of time, to test impact on weight |
| "If I gain one pound, I will gain one hundred" | To aim to eat more for a week to gain a pound, to see if that is continued |
| "I am so fat, other people must think I'm pregnant" (underweight patient) | Video experiment with survey – patient to try to appear pregnant (e.g., standing while trying to push belly out), and others to say what they first notice about the person in the video |
| "If I gain weight, people are going to notice *and* they are going to find it unacceptable" | The patient should enter a place they normally attends (e.g., work canteen) wearing extra layers of clothing (or some other way of changing their shape) and purchase items as normal. Five minutes later, a friend of the patient comes in and asks the counter clerk if she/he noticed that the patient had been in, and whether there was anything unusual about her |

patient to ask various people about what makes someone attractive, to test the patient's beliefs.

### 22.4.3 Using the "anorexic gremlin" to assist in implementing CBT techniques

For some patients, implementing the CBT strategies described above will happen fairly naturally. However, for others, implementation can be a real struggle. This may be particularly pertinent to individuals with a chronic eating disorder history. Often, such difficulties arise not through a lack of motivation on the patient's part, but through limited insight and difficulties in separating themselves from the eating disorder. Clinicians will be familiar with the experience of a patient who grasps CBT intellectually, but reports that it has little impact at an emotional level. Likewise, some patients may struggle with applying CBT effectively *away* from the therapy session. Such patients can present difficulties. Both clinician and patient are aware that the patient

is working hard, yet there is little discernable change, leading to frustration on both sides.

Such difficulties may arise in part from the ingrained nature of anorexic thinking patterns, which reflects the egosyntonic element of anorexia. (Although such difficulties occur in all diagnoses, we have found them to be more common in individuals with an underlying restrictive presentation and drive for thinness.) This manifests as difficulty in distinguishing adaptive, healthy cognitions and maladaptive, distorted cognitions, leading to difficulty in identifying and challenging negative automatic thoughts and maladaptive core beliefs.

In order to address these limitations, we have developed a technique known as working with the ''anorexic gremlin'' (Mountfort & Waller, 2006). Over a number of sessions, we work collaboratively with the patient to develop a description of their eating disorder as a living organism*. This process involves gathering details with regard to appearance, size, shape, voice, and so on. The patient will label the organism as they feel most appropriate. Many patients freely refer to their ''anorexic voice,'' and we have found that most do not have any problem engaging in this exercise. We ask the patient to observe their gremlin, noting its characteristics and personality. Over a week, we may ask them to record when it is around, when it is loudest, and so on. We then go on to conceptualize the gremlin as a self-maintaining organism that is fighting with the patient to survive using any tactics necessary. Such tactics might include: bullying the patient (e.g., ''You are not allowed to eat any chocolate''); making promises (e.g., ''If you go to the gym tonight, you will look better''); and threatening (e.g., ''If you don't do as I say, you will be fat and no one will like you''). The patient is then encouraged to be alert for times when the gremlin voice is dominant, and to begin to question the validity of the voice. In reality, the gremlin voice represents the distorted eating, shape and weight cognitions, whilst the patient's ''healthy'' voice represents the challenging of such negative cognitions and the generation of the alternative, more adaptive belief. We have found that by creating a multifaceted image, patients find it easier to identify the negative cognitions. They also have a rationale for challenging the voice, as they understand that the gremlin is ''fighting for survival.''

This technique is flexible and can be applied to many areas of CBT, including both behavioral experiments and cognitive restructuring. It can be used to consider a life without anorexia. For example, we have patients who put the gremlin in the dustbin, or leave it in a filing cabinet in our offices. It is also helpful

* The concept of externalizing anorexia is not new, and has drawbacks (Vitousek, 2005). However, we stress that the anorexic thinking is part of the patient's own self, being one of a range of personality modes that make up the person as a whole. The gremlin analogy is used to enhance the effectiveness of CBT, adding insight to motivation but without absolving the patient of responsibility for change.

in addressing distorted body image (see Chapter 23). However, this approach is less appropriate for patients detained against their will or those who still perceive an overwhelming benefit to their eating disorder. Labeling a valued aspect of the self in this way may alienate such patients. As with all imagery, this approach needs careful consideration before use with patients with severe abuse histories. For example, it may not be helpful for abused patients who believe they ''deserve'' their anorexia.

## 22.5 Summary

We have outlined the central CBT strategies for addressing the key cognitive component of the eating disorders: overvalued cognitions regarding eating, weight and shape. These apply regardless of diagnosis, though they need to be understood in the context of the individual's formulation. We have stressed the importance of both cognitive restructuring and behavioral experiments, and the need to use them together for more effective modification of these cognitions and associated behaviors. Many of the methods used here appear in the treatment of other elements of the eating disorders (see previous sections), but it is here that the clinician will need to focus in order to deal with the central pathology of these cases.

23

# Body image

While it is often assumed that distorted body image is a key element in the eating disorders, it is not always present. Nor is the nature of body image disturbance invariant. There are three aspects of body image seen in the eating disorders, which are commonly seen together, although not invariably:

- Body image disturbance, in which the patient sees a grossly distorted view of their body.
- Body image dissatisfaction, where the patient may or may not have an accurate perception, but is dissatisfied with what they see.
- An image of the body as being potentially out of control, in which the patient is petrified of becoming overweight (manifesting as an extreme fear of fatness and weight gain).

In the broader context, four important factors need to be considered before starting treatment for this symptom:

- Patients with eating disorders present in all shapes and sizes. They also vary with regard to body dissatisfaction and accuracy of body percept. Therefore, clinicians need to tailor individual interventions for body image.
- Before we begin to work with these patients on their body image, we need to be aware of our own attitudes towards weight and shape, and what explicit or implicit messages we may be conveying. Our experience is that this area in particular requires reflection on the part of the clinician to avoid the dangers of becoming entangled in the patient's dysfunctional evaluation system (e.g., getting caught in the patient's assumption that a body mass index of 26 means that they are "fat").
- The patient's reaction to the clinician needs to be considered. It is highly likely that the patient will evaluate the clinician's body shape and size. We have often been asked questions such as "What is your BMI?" and "How much exercise do you do?"

- It is important to be aware of other health professionals' reactions to our patients. We have experience of other clinicians holding unrealistic or unhelpful attitudes towards such patients, which may be focused on their appearance. Examples of this include encouraging overweight individuals to lose weight when we are requesting weight stability, or praising underweight individuals for their "will power."

While individuals who are obese often experience a drive for thinness and body dissatisfaction similar to the attitudes of patients with eating disorders, they also have valid health reasons for wanting to lose weight (e.g., diabetes, heart disease, etc.). Indeed, these patients may have been instructed by other health professionals to lose weight. Therefore, the following is not designed for those with obesity in the absence of an eating disorder.

## 23.1 What is body image?

Body image is the attitude we have toward our body and our physical perception of it. It is based on the sum of positive and negative attitudes gathered throughout one's life. Those attitudes are strongly influenced by people, beginning with family, then friends and others and places and things around us. We can access these attitudes when we think about how we talk to ourselves about our bodies, how we treat our bodies and how we experience others talking about and treating our bodies.

Modifying body image is a complex issue within the eating disorders, and so it is vital to formulate carefully. Such difficulties are multifaceted, and treatment will depend on identifying the issues that are key for the individual. Any of the following might be relevant:

- misinterpreting difficult emotions as "feeling fat" (e.g., the patient may become more focused on and dissatisfied with their body when a core belief is triggered)
- inaccurate body percept (as demonstrated by the body percept experiment in the assessment – see Chapter 4)
- overevaluation of shape and weight (where the individual cannot accept looking less than perfect, and believes this is the most important focus of their life)
- reinforcement of beliefs by behaviors such as body checking, wearing baggy clothing, and avoidance of certain activities where the body might be exposed

- unrealistic expectations/beliefs (e.g., denying the effects of age and genetics, comparing self with others, idiosyncratic beliefs).

Key to modifying all of these is the development of body acceptance.

## 23.2 The aim of treatment: acceptance rather than satisfaction

Unfortunately, the norm is for women — and increasingly men — to express some dissatisfaction with their bodies. In a culture where a dominant belief is that one can achieve anything if one works hard enough, and where such work can include diet and exercise towards the ''perfect body,'' it is unrealistic for the patient to aim for complete satisfaction with their body. Therefore, the aim of the following interventions is *acceptance* of body shape, rather than *satisfaction* with body shape. In conjunction with the previous chapter, we are working towards lessening the value placed on the ''perfect'' body and the promotion of a more realistic and accepting attitude towards one's own body. In other words, we aim to get the patient to the point where their body is in comparative balance in how they judge themselves (see Chapter 22.3).

The concept of acceptance is applicable to those with comorbid eating disorder and obesity. Whilst the patient may state that they wish to return to a healthy weight band, it is important to be realistic about such goals (whilst remembering that a 10% decrease in weight will have significant health benefits). With such patients acceptance involves an understanding that while they may be obese, this is not a reason for condemnation (as they may believe and have been told by others around them). Equally acceptance involves an understanding that there is not a quick fix weight-loss cure and weight loss is likely to be over a number of years.

One aspect of treatment is to help the patient to see their body as a whole, with all its functions and abilities, rather than as a collection of body parts to be individually judged on an esthetic basis. The specific targets of treatment are to promote:

- acceptance of body shape
- acceptance and understanding of weight stabilization, for normal weight and obese patients
- acceptance and understanding of the need for weight gain, in patients with a BMI less than 20
- reduction of the overevaluation of eating, shape and weight (see previous chapter)
- reduction of rigidity and perfectionism with regard to body image

- understanding that the process of altering body image is likely to be more gradual than other parts of treatment (e.g., changing eating behaviors).

## 23.3 Background to treatment of body image

There is surprisingly little empirical evidence regarding the treatment of body image, with little research indicating what to do, for what patient and at what stage of treatment. However, the need for intervention is supported by the fact that poor body image at the end of treatment is a negative prognostic factor (e.g., Garner & Garfinkel, 1997). Given this lack of evidence, we support the use of CBT principles to devise and shape treatments for individual patients' body image disturbances. A thorough understanding and formulation of the individual's difficulties is essential in selecting appropriate interventions. For some patients, only minimal body image intervention will be required. For others, more in-depth work will be necessary. Broadly speaking the order is to develop a body image formulation, to explore relevant psychoeducation and to identify and challenge inappropriate beliefs in conjunction with the use of behavioral experiments. The main techniques that we use are outlined below.

### 23.3.1 Developing a formulation to understand body image

It is key to incorporate an understanding of the development and role of negative body image into the formulation. Patients will have many unchallenged assumptions about their bodies. It is useful to spend time exploring how and when these were developed, and gently exploring the validity of such beliefs. This can often be usefully done in the form of a time line, linking the development of beliefs with the people around and the events occurring. (e.g., beliefs about the self that arose from comments at the onset of puberty). Importantly, we look for exceptions to the beliefs. The following questions are useful in exploring this issue:

- When did you first begin to focus on your weight and shape?
- When did you first believe you were fat?
- When did you first begin to judge yourself by your weight and/or shape?
- When did you first realize that weight and shape were important?
- What did/do others (e.g., mother, father, partner) say about your shape or weight?
- Was there anybody who did not criticize your weight/appearance?
- Where there any times you felt good about the way that you looked?
- How do you judge other people?
- When did you first begin to diet?

- Was there any teasing about how you looked?
- When did you first associate being thin with success/happiness?
- What does worrying about your shape/weight stop you from doing or help you to do?
- What do you *like* about your appearance?

#### 23.3.1.1 Using imagery to explore the meaning and emotional valence of body image

In order to understand more about the emotional aspects of a patient's individual body image development, we ask them to go through the following steps:

1. close their eyes, and summon the earliest image of themselves
2. describe their physical appearance in detail
3. recall important events or experiences that happened at that time to influence their body image
4. recall which of those incidents made them feel confident or unconfident.

We look particularly for the links or associations between negative emotions and the body, and how they developed. This process can be repeated for other significant ages (e.g., puberty, early relationships).

#### 23.3.1.2 Uncovering beliefs associated with body image

As the clinician and patient begin to explore the patient's body image and its history, the associated beliefs and assumptions become clearer. The next stage is to acknowledge and record those cognitions, which might include:

> I work so hard at trying to be thin. I used to be successful at it . . . it was something I could do . . . I felt like I looked good.

> If I'm fat, then I'm a slob. I can't go out or do things or go on holiday or have a boyfriend until I am thin.

Gaining this understanding of the meaning and assumptions attached to body image/weight enables the clinician and patient collaboratively to challenge these beliefs (see Chapter 23). Since body image disturbance might have been developing since the individual was a child, it can be highly resistant to change.

It is also useful to uncover and explore beliefs about causality in the patient's weight history. Some patients who have previously been at a lower weight/smaller shape hold the belief that they were much happier at that time (e.g., "My relationship was good then – it has gone downhill since I got fatter"). A weight/shape history can be used to explore the veracity of these beliefs, and to put the patient's beliefs about their earlier weight/shape into the context of the multiple factors/experiences that were going on at that time. (As in the

previous chapter, this can challenge the belief that thinness equals being happy or successful.) As the history is discussed in detail, the individual can be encouraged through Socratic questioning to explore a more realistic appraisal. For example, what model best describes the patient's history – weight gain leading to unhappiness; or loneliness leading to binge eating, followed by the weight gain? Was it really their body shape that made them unhappy as a teenager, or was their mood more closely related to examinations or to family stressors? Similarly, for patients with a cyclical history of dieting, bingeing and vomiting, overall changes in weight and shape can be highlighted, alerting the individual to the fact that excessive dieting is not a successful long-term strategy for weight loss and change in body shape. In some cases, it is helpful to build up a picture of family body type and weight history, to stress that genetics might make it impossible to reach the desired size. Asking the patient which parts of the body are inherited from who in the family can make this link easier to communicate, and is more engaging for the patient.

## 23.4 Psychoeducation regarding body image

As with all aspects of CBT for the eating disorders, psychoeducation is extremely important. Once patient and clinician have collaboratively developed the body image aspect of the formulation, including uncovering relevant beliefs, the clinician may introduce the psychoeducation component, tailoring it to the individual. Key elements of psychoeducation include an understanding of the role and function of one's body, the role of physiology in terms of weight change and energy requirements and societal influence on body shape and image.

### 23.4.1 Understanding the functions of the body

Once the patient has an understanding of how their body image has developed, we aim to broaden their attitudes towards their body. Patients are often single-minded in their attitude towards their bodies, perceiving them as objects that need to be controlled and to be made smaller. Therefore, we aim to work with the patient to achieve a more balanced perspective, where they see their body not as an object that needs to be thinner, but as an instrument or being with vital and invaluable skills, functions and abilities. The aim is to encourage the patient to understand and accept that their body tells the story of their life: scars, experiences, choices, relationships and links to family. For example, a patient might be encouraged to explore other understandings, such as: ''My thighs are more muscled than I'd like them to be ideally, but I need to have strong legs to

ride horses properly. If my thighs were thinner, I wouldn't be such a good rider.'' The following questions can initiate discussion of other functions of the body:

| Questions | Possible answers/discussion points |
|---|---|
| • What do you use your body for? | • Communication, to live, to move, to reproduce, to provide affection, to have fun |
| • What is its purpose? | • To help me to be happy |
| • How does it achieve that? | • By remaining healthy, so that I can use it to achieve those things |
| • How has your life shaped your body? | • Operations, scars, pregnancy, tattoos, piercings, age |
| • What ''innate abilities'' does your body have? | • Life-giving; heart, lungs and other vital organs for living; fat to protect these vital organs, to keep me warm; hormones; reproductive system |
| • What could you not do if your body was different? | • Walking; child bearing; sport |
| • How do you use your body with other people? | • To give comfort, to cuddle, sex, breast feed, to communicate emotions, noticing that I share features with family members |
| • How does your body interact with your environment? | • Tells me if the weather is hot, cold, raining, windy; provides a ''sense''; touch |
| • What messages does your body give you? | • Hormones let me know when I am exhilarated, scared, in love, etc. |
| • How does your body change? | • On a day-to-day basis, as I get older |

### 23.4.2 The role of physiology

Once the patient has gained an insight into the development of their own body image, we find it useful to broaden this thinking to include psychoeducation on the role of physiology.

#### 23.4.2.1 Set point model

Set point theory has been discussed in Chapter 15. It is often useful to revisit this theory to reinforce the idea that there is a weight below which your body is ''programmed'' not to fall.

#### 23.4.2.2 The need for body fat tissue for healthy biological functioning

It is important to recognize that the body needs a minimum level of body fat to function optimally, and that body fat levels below this are unhealthy. For females, approximately 25% of body weight should be fat, whereas the figure is 10–15% for males. Levels lower than this, even if weight is within the healthy

range, are likely to lower resistance to disease, cause weakness and irritability, and affect fertility. Body fat levels increase rapidly during adolescence in young women of normal weight (body fat is approximately 16% at the beginning of adolescence, and around 25% by the end), whereas the proportion of body fat decreases during adolescence in young men. This increase in body fat in women is due to an increased accumulation of fat around the breasts, thighs and buttocks, leading to the development of a much more womanly shape, as well as laying down the body fat stores required for optimal outcome of pregnancy. In men, the body fat is more centrally distributed, and there is less of a dramatic change to body shape for the young man to deal with, compared to his female peers. For more information on these issues, refer to the psychoeducation leaflets on fat and body composition (Appendix 2).

### 23.4.3 The role of societal attitudes towards beauty

We find it useful in some cases to discuss with the patient societal perceptions of beauty, and how those perceptions can differ across cultures and time. Historical aspects of beauty may be considered, including earlier practices designed to conform to an ideal (e.g., corsets, foot binding, plucking the forehead) and how these practices are perceived today. In addition, the clinician can discuss current cultural differences in perceived attractiveness, as linked to more recent practices (e.g., dieting, liposuction, breast enlargement, suntanning). We encourage critical analysis of perceived sources of cultural values (e.g., media), asking the patient to consider pertinent issues (e.g., the impact of such societal expectations on today's women; how growing up in such a society might affect anyone's beliefs about their own shape; why might magazines dedicate so much space to contradictory information about diets, appearance and so on). We often recommend that patients read and discuss Brownell's helpful article on the clash between sensible eating and cultural expectations (Brownell, 1991).

## 23.5 Treatment of body image

As we have already said, there is surprisingly little evidence regarding treatment of body image disturbance. In part, this might be due to the assumption that body image will normally self-resolve when other aspects of the psychopathology have been addressed (e.g., Fairburn & Cooper, 1989). However, this is not always the case. We have found that an individualized mix of behavioral experiments, exposure and cognitive restructuring can be helpful (e.g., Farrell *et al.*, 2005). Imagery is also valuable.

### 23.5.1 Cognitive restructuring

There are several cognitive restructuring methods that we find helpful in reducing the strength and impact of body image distortion. These are based on Socratic methods, and frequently lead the patient in the direction of specific behavioral experiments (see previous chapter).

#### 23.5.1.1 Using a pros and cons matrix

Patients will often hold rigid, all-or-nothing beliefs regarding appearance. It can be useful to encourage patients to weigh up the advantages and disadvantages of these beliefs in a pros and cons matrix. As with all such matrices, dividing the costs and benefits into the short and long term can reveal that the patient is undertaking an activity that encourages hopes, but that has serious short- and long-term disadvantages.

| Cons of trying to look perfect | Pros of trying to look perfect |
|---|---|
| • Takes a lot of time which I could be spending with friends | • One day, I *might* look perfect |
| • Expensive | • Might help me to get a job |
| • Stressful | • People might talk to me today |
| • Never happy | |

We then introduce continuum thinking to encourage the patient to incorporate some leeway into their self-evaluation system. For example, we might want to modify the patient's unquestioning assumption that the perfect body image is a useful target. We do this by examining the cost and benefits of having to look perfect or of reaching a healthy weight. This can be used as a starting point to encourage the patient to apply a continuum to looking good – just because an individual wants to make some effort to look attractive, that effort does not have to rule their life.

#### 23.5.1.2 Monitoring body awareness and judgements

The patient can be asked to monitor both events that make them feel conscious of their body and times when they are not aware of their body or when they feel neutral about it. We use this to develop a hierarchy of all the activities or events they avoid due to negative body image. This forms the basis of a series of subsequent surveys and behavioral experiments. For example, we might ask the patient to monitor all the compliments they receive, and habitual methods of dismissing positive comments (e.g., interpreting "You look healthy" as "You look fat"). We encourage the patient to challenge their dismissive cognitive style towards compliments.

We also discuss the concept of *self-serving biases* with our patients. We outline the finding of Jansen *et al.* (2006) that it is normal for women without eating disorders to see their bodies in ways that are idealized in order to enhance their self-esteem. We share this study with patients as a background to asking them to identify and focus on their positive features. We also encourage patients to be more realistic in the way they appraise other people, looking for less attractive features in women who they consider attractive, in order to redress the balance. They are encouraged to consider the statement "No-one is perfect."

#### 23.5.1.3 Mislabeling emotions

When it has become clear that their body image and related behaviors are unproductive for the patient, we encourage them to consider why they hold such strong beliefs. Through use of Socratic questioning, it can become apparent that for some patients, they may be mislabeling difficult emotions as "feeling fat." In other words, "feeling fat" is one way of expressing feelings that can be hard to label, interpret or acknowledge. Monitoring of situations, physical states and emotional states can be used to establish whether it is weight or mood that has changed when the patient finds that they feel they have gained weight or become larger. Using flashcards and diaries, they can be encouraged to think about and explore emotional states that might be triggers to feeling fat.

### 23.5.2 Behavioral experiments

As discussed in Chapter 22, behavioral experiments follow on from cognitive restructuring, with the aim of further modifying the targeted cognition.

Body image disturbance manifests most commonly in three behavioral ways: body checking, body avoidance and comparison. A number of cognitive biases and perceptual distortions contribute to these behaviors. The following section will describe such manifestations and outline behavioral experiments that we find most useful.

#### 23.5.2.1 Body avoidance and checking

Patients often alternate between body avoidance (e.g., covering mirrors, avoiding looking at oneself) and body checking (e.g., repeated checking in mirrors, weighing, trying on different clothes to see which fit). These behaviors may become so automatic that the patient often does not think to mention it unless prompted. The Body Checking Questionnaire (Reas *et al.*, 2002) and Body Checking Cognitions Scale (Mountford *et al.*, 2006) are useful measures to assess this. Patients often have a number of feared consequences associated with ceasing body checking, for example, putting on weight without noticing or losing control of their eating. Once the relevant behaviors and underlying cognitions

have been identified, a behavioral experiment can be designed using the principles outlined in Chapters 21 and 22. We have found experiments that require patients to monitor selected outcomes (e.g., mood, weight) under different conditions (body checking as normal, as little body checking as possible) most effective. Such experiments enable the patient to disconfirm their beliefs regarding the influence of body checking.

Addressing avoidance follows the same principles. Patient and clinician seek to elicit the feared consequence, whether it is emotional, cognitive or behavioral. A graded hierarchy can be developed, for example, from looking in the mirror at home to exposing oneself in a swimsuit at a local swimming pool. Using the framework of the behavioral experiment, the feared consequence can be tested out. For example, a patient who avoided shop changing rooms because they feared others would comment on their size was encouraged to try this out, graduating from a "safe" item (e.g., jumper) at a quiet time, to a riskier item (e.g., bikini) at a busier time and to monitor the reactions of others.

In addressing avoidance it can be useful to investigate self-focused beliefs the patient may hold. Many patients have the assumption that everybody is looking at them and evaluating them. Equally, patients often have the assumption that others are always confident. Such self-focused processes are similar to those seen in individuals with social anxiety.

#### 23.5.2.2 Body comparison

Comparing oneself to others takes many forms. The patient may compare themselves to magazine pictures, selectively focusing on people who are more "perfect" than they are. Equally, they may examine in others the parts that they dislike in themselves, making comparison comments to them (e.g., "You are so lucky to be so thin"). On the other hand, some patients look for broad "defects" in others' bodies in order to feel better about their own perceived defects.

We ask the patient to self-monitor the amount and type of comparing that they are doing. Once the specifics of and the underlying beliefs associated with the behaviors are identified, the patient is asked to spend one day completing the behaviors and one day attempting to refrain from completing the behaviors, in order to test their beliefs about the negative consequences of not comparing (see previous chapter). They are asked to monitor their mood and satisfaction with their body on both days. This exercise can be repeated across several days if necessary. When the patient becomes aware of the unexpected negative impact on mood and body image of such comparisons, they are often willing to consider stopping this behavior. Strategies can then be discussed with the patient on how to broaden their attentional focus. For example, they might practice taking five minutes whilst waiting for a train to look at a range of people passing by,

focusing on an aspect of the people other than their body shapes (their smile, their behavior).

### 23.5.3 Exposure-based methods

Exposure to body image can be used in the same way as exposure to feared objects in other disorders – with the aim of enabling the patient to experience and process the reduction in anxiety as the exposure continues without the feared consequence. However, it is more commonly used within the broader context of behavioral experiments and cognitive challenges (e.g., Norris, 1984). As one might expect from their level of body avoidance, patients find exposure-based methods highly anxiety-provoking. In particular, they report the use of mirrors and other body image exposure methods to be aversive. Consequently, patients are often resistant to this procedure, and the resulting clinician unease means that this technique is often avoided by both the clinician and the patient. However, Key *et al.* (2002) show that the absence of body image exposure makes CBT less effective for body image distortion. They also show that patients who have been treated with this method retrospectively report gaining great benefit from it, even in a group format. Having said that, exposure-based methods might be contraindicated where the patient has a history of trauma resulting in marked body image disturbance and related interpersonal issues.

#### 23.5.3.1 Body image exposure

While the technology may differ substantially (e.g., use of video screens versus mirrors; level of clothing the patient is asked to wear), the principles behind such approaches remain similar. In general, we aim to encourage exposure when body avoidance behavior is occurring (Rosen, 1997). For example, we will ask the patient to observe themselves in a full-length mirror. A hierarchy of body parts is developed, from the most satisfying to the most distressing. Over time the patient works their way through the hierarchy. With repeated exposures, both anxiety and body avoidance decline. This allows us to access strong cognitions about the body, which can then be challenged. Key *et al.* (2002) encourage the patient to start at the top of the head and describe the entire body, thus giving a sense of perspective on their body rather than focusing only on the parts they dislike. Initially, the clinician models this behavior by standing in front of the mirror and describing her or his own body.

Wilson (2004) advocates a mindfulness-based approach to mirror exposure, to promote an environment of non-judgmental acceptance in which to address body shape and image. Our experience is that patients are more accepting of the idea of exposure when set within the context of mindfulness. The patient is asked to describe themselves from head to toe whilst looking in a full-length mirror,

again with the goal of gaining a full perspective on their body rather than focusing on the parts they dislike. Mindfulness training (see Chapter 25) enables them to simply observe their body, describing it in a non-judgmental fashion and staying in the present. This perspective is in stark contrast to the biased information processing, unattainable standards and judgment that normally color the body image of our patients. For further reading, Stewart (2004) is recommended.

### 23.5.4 Imagery and body image

There are several potential uses of imagery in the eating disorders, and these are described elsewhere in this book (see Chapters 24 and 25). Therefore, the focus of this section will be on the application of such techniques specifically to body image disturbances. Imagery can be one of the most powerful techniques in modifying body image, and should therefore be used with care. For patients whose difficulties with their body image stem from abusive experiences, it is particularly important to proceed with caution (if at all), and to allow sufficient time within the session for the patient to process the experience.

#### 23.5.4.1 Using imagery to challenge the anorexic voice

This technique is a variation of the ''anorexic gremlin'' work (Chapter 22). The aim is for the patient to gain a more realistic view of their body. The patient is asked to imagine looking at themselves in the mirror, and to describe what they ''see.'' Usually, they give a highly distorted and critical description. They are then asked to describe the quality and tone of the voice that tells them this opinion. In this way, they are able to determine that it is the anorexic voice (or ''gremlin'') driving the description. We then ask the patient what it felt like to listen to the gremlin describing their body, and then ask them to observe how the gremlin is reacting to their distress (e.g., ''It is smug and satisfied when I describe myself as being so fat'').

Next the patient is asked to make the gremlin stand away from them in the image (e.g., outside the room), and to imagine themselves looking in the mirror again. This time, they are asked to use their own description rather than the gremlin's. The clinician may need to prompt the patient, by asking about non-weight-related factors (e.g., hair) and what the patient likes or dislikes about their appearance. The patient is asked to verbalize both:

- how it feels to listen to their own description
- how the gremlin is reacting.

The gremlin is likely to be smaller and less powerful, or shouting and trying to attract the patient's attention.

Once the image is ended, the two descriptions are compared and contrasted, as they are usually different. The experience can be explored (e.g., why was the

anorexic gremlin so harsh?). As detailed elsewhere, the patient is encouraged to think of the eating pathology as a self-maintaining element of themselves, which will fight the patient in order to survive. The aim is to get the patient to identify that the gremlin is deceiving the patient about their shape, in order to survive. As the patient gets stronger, they are likely to see the gremlin shrink, move further away, sulk, and so on. The more vivid the image that the patient can generate, the more effective this technique is in reducing body image distortion, as the affect has greater meaning. It is important to devote some time to this exercise, particularly in exploring the affect and understanding why the gremlin might be working so hard to distort the patient's perception of themselves. This will need to be repeated over a course of weeks and as homework, because the body image disturbance is often entrenched.

The use of imagery and the anorexic gremlin can be extended in a number of ways:

- Asking the patient to bring in a current photo and a photo from when they were most ill, and asking both patient and gremlin to describe what they see. As the patient can see more clearly how ill they were, the anorexic gremlin's description becomes more shocking and the patient can begin to see the extent of the distortion.
- Ask the patient to draw themselves from their own and from the gremlin's perspective. The drawings can be compared to illustrate the magnitude of the gremlin's deception. For example, patients discover that the gremlin might draw them as twice as large and significantly less attractive than they do themselves.

The patient can then use this understanding of the anorexic gremlin to assist in challenging negative cognitions about their body that they experience outside therapy. For example, Sarah had the belief: ''I'm fat, I'm sure I must have gained so much weight.'' She devised the following challenge: ''My weight has remained highly stable throughout treatment. As I have kept to my eating plan, it is unlikely my weight has changed. This is my anorexic gremlin making me feel bad about myself and distorting my image.'' Sarah's anxiety did not decrease completely but she was able to resist the urge to exercise.

#### 23.5.4.2 Imagery work when beliefs about body image relate to early negative experiences

Sometimes, the individual will have been subject to specific criticism, bullying or teasing about their shape as a child. This experience might be tied up with more general abuse experiences, which have understandable links to body image distortion. Sexual abuse can be particularly relevant in the development of body image disturbance (Waller *et al.*, 1993) and there may also be associations with puberty and changes in the body. Imagery may be particularly appropriate for such distortions (see Chapter 25). Where there has been substantial trauma and the

eating might be serving a function (e.g., reducing sexual attractiveness), it can be useful to use imagery to explore these patients' reactions to becoming a normal weight.

## 23.6 Summary

Body image can be a demanding area to tackle, due in part to the seeming rigidity of patients' beliefs and in part to the lack of clear, effective treatment. Patients differ and fluctuate in their body image disturbance (both percept and satisfaction). As body image is a multifaceted, multisensory phenomenon, clinicians need to incorporate a variety of strategies as suggested by the formulation, keeping in mind that an understanding of the cognitions driving the body image is the first step to effectively targeted interventions.

# Summary

In this section, we have detailed the changes that are necessary in the cognitions of eating-disordered patients if they are to change their thinking, their emotions and their behaviors in a more adaptive way. As we have stressed throughout, this is to address the core pathology of the eating disorders, but many cases have substantial levels of comorbid pathology. In many cases, we find that such comorbid conditions causal links, with patterns of mutual maintenance. For such patients, simply attempting to modify these central eating disorder beliefs will not be sufficient. Therefore, in the next section, we address the means by which we aim to work with patients with substantial comorbidity.

Section V

# When the standard approach to CBT is not enough

In a substantial proportion of patients, standard CBT is not sufficient. This is most commonly the case where there is comorbidity with other psychological disorders. Such comorbidity can range from relatively moderate levels (usually the presence of other Axis I pathology, such as depression and anxiety disorders) to severe (usually the presence of Axis II personality disorder pathology and associated behaviors). It usually has functional links with the eating pathology (e.g., the use of self-harming behaviors or alcohol abuse to deal with the same emotional triggers that drive bingeing and purging). At the less severe end of this spectrum, the comorbid problem can be addressed using additional CBT approaches, delivered in tandem with the CBT for the eating pathology (e.g., treating social phobia with behavioral experiments that include food-related social situations). At the other end of the spectrum of complexity, there is a variety of features that are relatively resistant to such disorder-specific cognitive-behavioral approaches. Those features include very poor self-esteem, severe body image disturbance, extreme perfectionism, dissociative responses to trauma, compulsive pathology and personality pathology (e.g., Fichter *et al.*, 1994; Sansone & Fine, 1992; Waller, 1997). The resilience of these features to change suggests that such cases need to be considered using broader CBT models, which go beyond the disorder-specific approach that we have outlined to date. In working with such patients, we adopt a schema-focused approach to understanding and treating the case, while retaining the appropriate focus on the eating-related features (using the methods outlined in earlier chapters) and other behaviors (see below). However, we also recognize the importance of addressing the emotional factors that can drive the eating problems and other behaviors (e.g., self-harm) that can interfere with the effectiveness of both the disorder-specific and the schema-level CBT.

Figure S5.1 shows a generic schema-focused formulation, illustrating the ways in which early experience drives the development of unconditional core

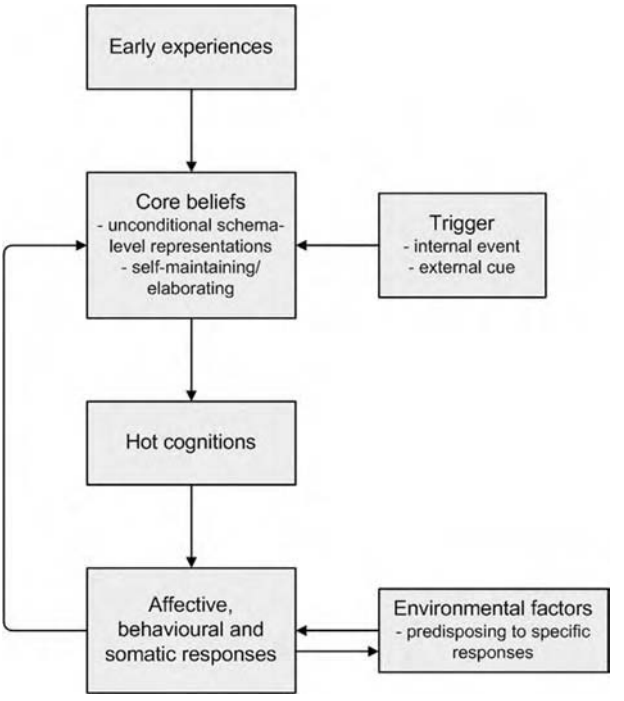



Figure S5.1 Generalized schema-focused cognitive-behavior therapy model of links between experience, different levels of cognition and affective/behavioral responses.

beliefs about the self and the world. Such beliefs drive more immediate thinking ("hot" cognitions; negative automatic thoughts), which drive emotions and behaviors. Such a formulation applies to everybody, with the presence of pathology driven by the nature of the early experiences (e.g., positive and supportive versus negative and critical) and the level of negative core beliefs that develop as a result. In working with the eating disorders, we adapt this model in the way shown in Figure S5.2, to demonstrate the linkage between eating-, weight- and shape-related cognitions and the pathological behaviors. The same model can be used to account for the development of other comorbid conditions, resulting in the specific pathologies being described below. In particular, a common theme that emerges across Axis I comorbidity is the need to understand the role of very poor self-esteem (see formulations in Chapter 24) — a theme that has been identified as being important in symptom-based and transdiagnostic models (e.g., Fairburn *et al.*, 2003; McManus & Waller, 1995).

Of course, it is not always necessary to work with schema-level cognitions and broader emotional factors in order to treat patients, although we find that patients who have been referred to highly specialized services are more likely to have such needs. In many cases, the patient can be treated using methods that address

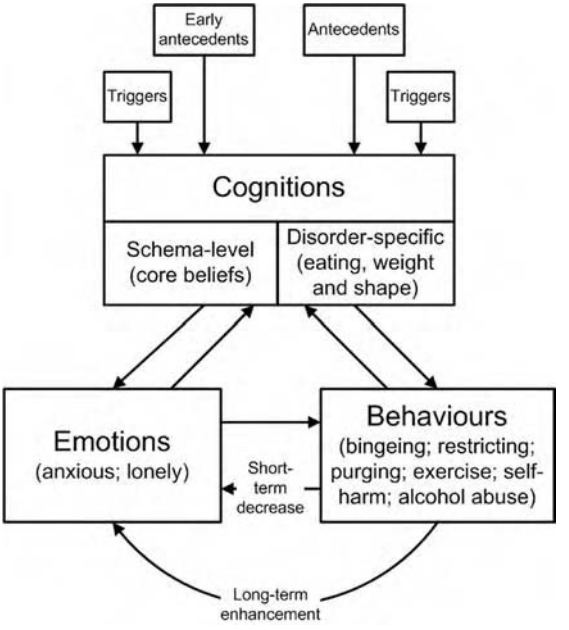



Figure S5.2 Generic formulation of the role of core beliefs in the linkage between cognitions, emotions and behaviors in the eating disorders

cognitions at the level of negative automatic thoughts and conditional assumptions. Where this is possible, it is clearly optimal to work using the well-established, evidence-based CBT methods that we outline in Chapter 24, as this is likely to be an effective approach that can be carried out in a relatively short time. The more complex approaches outlined in Chapter 25 are costly in terms of time and clinician resources, and should therefore be used only when the case formulation indicates it.

Thus, as has been a theme throughout this book, the underlying principle of treatment should be to base the clinical work on the case formulation. In many cases, this will mean that we apply both disorder-specific and schema-level CBT approaches meet the individual's needs. For purposes of clarity about the different approaches, in this section, we first outline CBT methods for addressing specific comorbid Axis I problems (Chapter 24), and then consider the principles and practice of CBT methods for addressing the affect and schema-level cognitions that characterize Axis II personality disorder pathology (Chapter 25). However, it is important to consider how these approaches can be integrated, in keeping with the fact that patients often have both types of pathology underlying their problems (along with the eating pathology itself).

24

# Comorbidity with Axis I pathology

In this chapter, we outline the use of CBT to understand and treat Axis I psychopathologies that are commonly comorbid with the eating disorders. These include mood and self-esteem problems, anxiety-based disorders (obsessive-compulsive disorder, social anxiety, posttraumatic stress disorder), and other impulsive behaviors (including multiimpulsivity). We outline examples of the type of formulation that we find useful when understanding comorbidity between the eating disorders and these other pathologies. However, it is important to stress that these are examples, designed to illustrate the principles involved, and that they will need to be modified to meet the individual's problems and treatment needs.

## 24.1 General principles

We do not treat these comorbid problems as separate disorders that happen to coincide in the same individual. Rather, we find it more helpful to consider the underlying mechanisms that explain why one individual experiences these different symptoms (e.g., use of safety behaviors, blocking emotions) and the developmental and/or maintenance factors that explain the comorbidity. In order to do this, we see it as vital to conduct a comprehensive assessment of the symptoms and their underlying cognitions and behaviors, in order to develop a comprehensive formulation. Such a formulation will be based in the development of the comorbid disorders, and is used to treat the comorbid condition in parallel with the eating disorder.

The following are brief descriptions of how we address each of the Axis I conditions that are most commonly comorbid with the eating disorders. In each case, we have confined ourselves to outlining the principles and practice as they apply to eating-disordered patients who also experience these problems, rather than describing comprehensive treatment for the comorbid disorder itself. We have identified further reading where necessary, to elaborate on this

approach, and measures that we find useful in assessing these disorders and evaluating outcome.

## 24.2 Depression and low self-esteem

Depression is commonly found among eating-disordered patients. For example, Reena is a 34-year-old with a diagnosis of anorexia nervosa, with a body mass index of 15.5. She has a history of low self-esteem that precedes the onset of her eating disorder, but she first showed signs of very low mood when her weight had fallen substantially and then stabilized at a low level. Her current mood fluctuates with her life circumstances. She occasionally has some level of hopelessness, but expresses no suicidal ideation or intent.

### 24.2.1 Assessment

At assessment, we routinely ask patients about a history of depression, as well as their current mood. In cases such as Reena's, we find it useful to use a standardized measure of depression, both at assessment and in evaluating the progress and outcome of treatment. In cases where there are swings in mood, it is important to consider the speed of mood change, as diagnoses of bipolar disorder are often made in error when a diagnosis of borderline personality disorder would be more appropriate (with the more rapid changes in mood).

We find the following psychometric instruments useful when assessing depression and self-esteem in the eating disorders, as well as their underlying cognitions:

- Rosenberg Self-Esteem Scale (Rosenberg, 1965)
- Beck Depression Inventory (Beck & Steer, 1993a)
- Beck Hopelessness Scale (Beck & Steer, 1988)
- Young Schema Questionnaire (short form) (Young, 1998).

However, there are many other measures of self-esteem and depression that are equally clinically useful.

### 24.2.2 Formulation

We consider the possible reasons for the association of eating pathology with depression and low self-esteem when discussing the formulation with the patient. These include:

- Low self-esteem and depression as an antecedent to the eating disorder, where the eating disorder performs the function of improving mood through giving a sense of control. Recurrent developmental experiences contribute to negative core beliefs, leading to what Fairburn *et al.* (2003) have termed "core low self-esteem."

- Low self-esteem and depression as a consequence of having an eating disorder, where the mood change follows the loss of opportunities for positive experiences consequent on the changes in lifestyle.
- Low self-esteem and depression as a consequence of dietary restriction and weight loss (see information about the Minnesota Experiment, Appendix 2, B2). The nutrients that appear to be of specific relevance to depression in the eating disorders are:
  - carbohydrate (low levels can result in low serotonin levels)
  - essential fatty acids, which form an essential part of the brain. These are found in: oily fish (sardines, mackerel, herring, salmon, etc.); walnuts; seeds (e.g., linseed); green vegetables; and salad.

For a more detailed account of the effect of diet on depression and other mental health problems, see van der Weyer (2005).

These reasons are not exclusive of each other. Thus, in formulating with Reena, we identified that the onset of her restrictive eating was a consequence of her poor self-esteem, giving her a sense of control over her life at a time when she felt that she had no control over events and people around her. However, as she gained greater control over her weight, she found that her circle of friends diminished and her performance in school deteriorated (i.e., loss of opportunities for positive experiences). Rather than risk giving up her eating control, she intensified her restriction in the hope that it would continue to enhance her feeling of control over her life, since nothing else was working. As her food intake decreased, her mood deteriorated further, resulting in less and less social activity outside of school. This focus on short-term control resulted in further deterioration in her life situation, and her mood deteriorated until she became depressed. The formulation in Figure 24.1 illustrates the interface between depressed eating pathology and eating symptoms in Reena's case, although it should be remembered that this formulation might be different in other cases (e.g., where the patient has experiences that compound the negative core beliefs that drive the low self-esteem, and where their eating behaviors enhance those negative core beliefs).

### 24.2.3 Treatment

The formulation should be used to decide whether depression should be treated alongside the eating disorder. In many cases, the relief from depression follows in part from the treatment of the eating pathology. For example, in a case such as Reena's, Socratic questioning can be used to enable the patient to consider the potential benefits of regular eating and increasing their carbohydrate intake. It is also important to engage such a patient in behavioral and cognitive change. In many cases, we find it helpful to ask a patient such as Reena to use guided

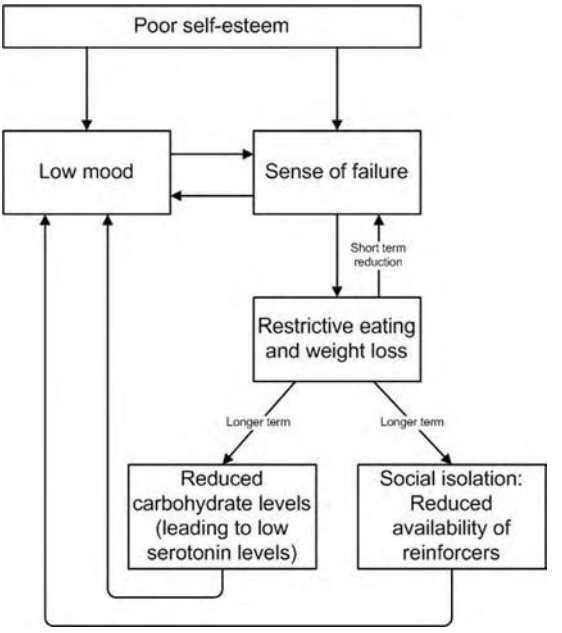



Figure 24.1 Example formulation, showing links between depressed mood and eating pathology.

self-help methods for enhancing self-esteem and improving mood (e.g., Fennell, 1999; Gilbert, 1997) in parallel with CBT for the eating disorder. However, more active intervention is called for in some cases. In particular, antidepressant medication can be a valuable adjunct to such treatment, if it is used to enhance mood long enough to engage the patient in cognitive restructuring and behavioral experiments. Obviously, depression is associated with risk of suicide and self-harm. In the case of suicide risk, it is important to consider the patient's level of hopelessness.

#### 24.2.3.1 Cognitive restructuring

Addressing low self-esteem and depression can require challenges to the individual's cognitions at the levels of negative automatic thoughts, conditional assumptions and core beliefs. Cognitive restructuring is often a necessary antecedent to behavioral activation and behavioral experiments. For example, Reena was encouraged to consider the evidence for her belief that she was unable to socialize after work, and to consider the alternative possibility (''I can only learn if I am able to socialize by trying it out'').

Patients with eating disorders tend to describe the core depressogenic attributional bias – blaming themselves for negative events in their lives, rather than seeing such events as attributable to others or to chance. We find that it is

important to use cognitive restructuring and behavioral experiments to challenge this assumption of personal responsibility for negative events. This requires the use of diaries to identify the attributional bias, then alternative interpretations, and challenging the beliefs through surveys and behavioral experiments.

#### 24.2.3.2 Behavioral activation and experiments

The core element in successful CBT for depression is persuading the individual to undertake behaviors that will increase their chances of having positive experiences, and so challenge the underlying cognitions that are maintaining their depression/low self esteem. We find that the same applies when working with depression among our eating-disordered patients. Eating pathology often results in social isolation and a limited repertoire of potentially reinforcing behaviors. Therefore, efforts to change the depressive thinking pattern need to take place against the background of encouraging the individual to risk making behavioral and lifestyle changes (e.g., accepting invitations to go out with friends; making telephone calls to family).

For example, a depressed eating-disordered patient might have a belief such as: ''There is no point in my trying to meet my friends at the weekend, as I know I will feel like an idiot,'' leading them to defer returning phone calls from their friends about going out with them. An alternative belief could be generated through historical review and Socratic questioning (e.g., ''When I have gone out with them, I have usually enjoyed myself and I have not ended up feeling like an idiot''). While this belief will not be rated as high in probability, it can be compared and contrasted with the more prominent negative automatic thought through a behavioral experiment (e.g., going out for part of the evening with their friends, to see how it leaves them feeling).

## 24.3 Obsessive-compulsive disorder

In clinical groups of patients with eating disorders, a large proportion also have obsessive-compulsive disorder (OCD), obsessive compulsive personality disorder or obsessive-compulsive symptoms. These include patients who present with:

- both OCD and the eating disorder
- obsessive-compulsive symptoms that are part of the eating disorder (e.g., washing hands prior to eating in order to put off eating as long as possible)
- a high level of perfectionism, which manifests as obsessive-compulsive symptoms (e.g., checking material repeatedly to ensure no mistakes are made)
- obsessive compulsive personality traits (e.g., preoccupation with orderliness and symmetry, manifesting as ordering and arranging behavior)

- checking and cleaning behaviors that serve the function of reducing awareness of negative affect.

Therefore, addressing obsessive-compulsive symptoms in the eating disorders can be complex, particularly because it is necessary to determine whether the eating and the obsessive-compulsive symptoms serve similar functions or whether they need to be treated as distinct disorders.

### 24.3.1 Assessment

Obsessive-compulsive symptoms can hold different meanings and functions for each individual. We ask questions such as whether the patient experiences thoughts, mental pictures or impulses that are upsetting and that will not go away, and whether they ever act in a compulsive way. For example, we find that the Vancouver Obsessive Compulsive Inventory (VOCI; Thordarson *et al.*, 2004) and the Symmetry, Ordering and Arranging Questionnaire (SOAQ; Radomsky & Rachman, 2004) give valuable information on relevant symptoms.

### 24.3.2 Formulation

The formulation should enable the clinician to ascertain if there are common cognitions and processes that maintain both disorders or if the disorders have separate cognitive content and maintaining factors. There are clear implications for treatment, since it may be necessary to treat the pathologies as linked or separate, and one disorder might interfere with treatment of the other. For example, Peter was unable to eat a snack at the agreed time, but this was due to his contamination fears, which meant that he needed to clean the kitchen for two hours prior to making the food (and was therefore unable to eat the snack when his body needed the energy). In such a case, it is important to treat the contamination concerns alongside the eating disorder pathology. Figure 24.2 shows an initial formulation for a case where the obsessive-compulsive and eating symptoms have common roots and maintain each other. As before, this formulation is an illustration, and would need to be amended for other individuals.

### 24.3.3 Treatment

Where the formulation indicates that the disorders are functionally linked, we treat obsessive-compulsive symptoms in parallel with the eating disorder. To do so, we access the beliefs that underlie the anxiety, and then work with the patient to develop behavioral experiments to test out those beliefs. However, where the formulation indicates that it is appropriate (i.e., where the behaviors and cognitions do not appear to maintain each other), we will treat the two disorders in sequence rather than in parallel.

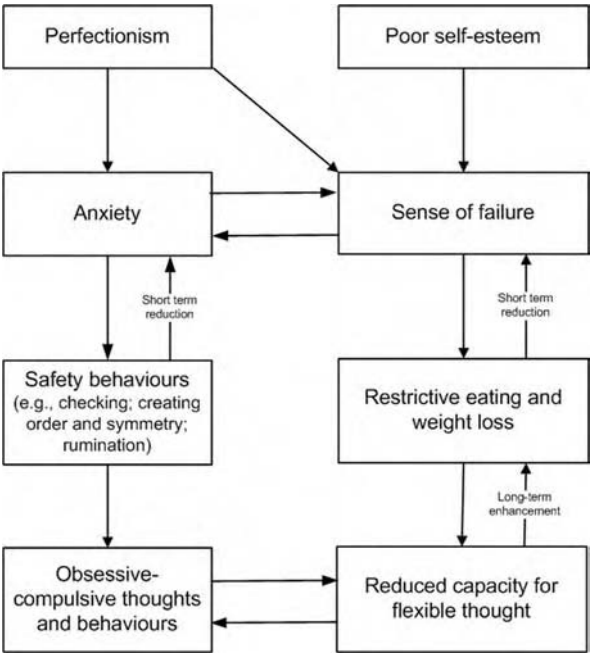



Figure 24.2 Example formulation, showing links between obsessive-compulsive features and eating pathology.

#### 24.3.3.1 Cognitive restructuring

The first stage in cognitive restructuring for the obsessive and compulsive features is to help the patient to identify the cognitions that drive their concerns. The following example illustrates this process with a woman (Vanessa) with fears of contamination (''I will get worms or AIDS'') and disfigurement (''I will become hideous to others. Nobody will want to be near me. People will go out of their way to avoid me'') that are comorbid with her atypical anorexia nervosa (BMI = 18.3). Vanessa tries to reduce the risk of catching these diseases totally (i.e., to 0%). However, the cost to her is high, as she is too scared to leave the house and she risks losing her relationship. The fears of contamination drive her restrictive eating patterns, which in turn make her thinking more rigid.

| | | Aim and principles underlying intervention |
|---|---|---|
| Clinician: | So, Vanessa, you believe if you touch the door handle you will get AIDS or worms and that will lead to no one wanting to know you. | *Establishing the ''current'' belief* |
| Vanessa: | That is pretty much how I feel about it. | |
| C. | If that is what you believe it is no wonder it makes you anxious to think about touching | *Estimate certainty of belief* |

| | | Aim and principles underlying intervention |
|---|---|---|
| | those items we discussed, and I can see why eating would become a concern. I am wondering how much you believe you will get AIDS or worms if you touch food that you have not prepared or if you touch door handles, on the 0 to a 100 scale? | |
| V. | About 75%. | |
| C. | OK — so that is quite a strongly held belief, but there is about 25% of you that does not believe this outcome is possible. | |
| V. | Yes, on some level I know that this is not likely to happen. | |
| C. | So a part of you thinks it is not possible to catch AIDS or worms from touching certain objects. When we were working on the anorexia and there were beliefs that you were not convinced were completely true, such as ''fats are bad for you,'' how did you clarify this? | *Gathering corrective information* (*see Krochmalik* et al. (2001) *for further information on the rationale behind this exercise*) |
| V. | Well I guess initially with the reading material on the role of fats in the body and then by behavioral experiments . . . so I guess I could do a similar thing here? | |
| C. | That sounds good to me. Where do you think you could get that information? | |
| V. | The internet? | |
| C. | Great. What I would like you to do for homework is gather information on how AIDS and worms are transmitted from person to person. Would you be happy to do that? | |
| V. | That would be fine. | |

The information gathered from the internet was discussed in the next session. Vanessa was able to see that it was impossible to get AIDS or worms by touching certain objects. Her beliefs were re-rated, showing a substantial change in the strength of her beliefs, and she reported a slight drop in anxiety. She then describes herself as ''OK'' to move to the next step: behavioral experiments.

#### 24.3.3.2 Behavioral experiments

Vanessa and the clinician developed a set of behavioral experiments to test her beliefs. They consisted of performing a set of actions that she believed gave her a risk of infection. An example was to touch the top of her shoes with both hands, followed by touching her trousers and her face. Her prediction about this experiment was: ''I will catch AIDS or worms'' (strength of belief – 99%), and she contrasted this with the belief that she would not develop any infection (strength of belief – 10%). The result was that there was no evidence of infection. Consequently, she was able to undertake an experiment that she saw as ''riskier,'' and her beliefs began to change and her anxiety began to decline as this process was repeated. Similarly, she was encouraged to touch food items that she was not able to clean beforehand, to test out her beliefs.

Taking a second example, Fiona (who had a full diagnosis of restrictive anorexia nervosa) had the belief that: ''If I do not check my e-mails, I will make mistakes and people will notice, and they will treat me as a sloppy idiot.'' Her safety behaviors were to check her e-mail repeatedly before and after sending. If she found a mistake after sending the e-mail she would e-mail the person and apologize. This pattern of checking was severely impairing her efficiency at work. First, she and the clinician each carried out a survey, to find out whether others were bothered by small mistakes in e-mails, so that she was able to see (at least at an intellectual level) that it was possible for people to make mistakes without there being negative consequences. Following this, the behavioral experiment that she devised with her clinician was to take the risk of sending an e-mail without checking it, in order to test whether her belief (''The recipient will e-mail me and point out lot of mistakes'') was supported, or whether the alternative belief (''The recipient will not notice, and even if they do, they will not care enough to mention it'') more closely fitted the outcome. The outcome was that the recipient did not mention any mistakes. This was developed into a second experiment, testing whether there would be any response to an e-mail into which she had inserted deliberate errors. Again, Fiona received no notification about errors. Her anxiety and her checking behaviors were both reduced.

## 24.4 Social anxiety and social phobia

Social anxiety is a fear of social situations, where individuals perceive themselves to be vulnerable to negative evaluation by others. In its most extreme form, it manifests as social phobia or avoidant personality disorder. All three problems are prominent in the eating disorders (e.g., Brewerton *et al.*, 1993; Bulik *et al.*, 1997;

Halmi *et al.*, 1991; Hinrichsen *et al.*, 2003; Hinrichsen & Waller, 2006), and treating social anxiety is likely to impact on patients' eating pathology.

### 24.4.1 Assessment

Identification of social anxiety problems is often possible through observing the patient's interaction with the clinician and others. There are a number of useful questionnaires that clinicians can use to determine patients' levels of social anxiety. Two of the most useful and best validated are the Fear of Negative Evaluation Scale (Watson & Friend, 1969) and the Social Phobia and Anxiety Inventory (Turner *et al.*, 1989). The Structured Clinical Interview for DSM-IV (First *et al.*, 1997) outlines questions that clinicians can use to determine a diagnosis of social phobia:

- Are there any things that you are afraid to do in front of other people, like speaking, eating or writing?
- What are you afraid will happen when you are in these types of situations?
- Do you think you are more uncomfortable than most people are in these types of situations?
- Do you always feel anxious when you are in that type of situation?
- Do you think you are more afraid of that type of situation than you should be?
- Do you go out of your way to avoid these types of situations?
- How much has this problem interfered with your life?

The first of these questions concerns eating in public. Therefore, it is important to determine whether patients respond positively to this item because they are genuinely socially anxious or because of their eating pathology. Socially anxious patients' primary concern is being judged or humiliated by others for behaving in a certain way. This means that their main concern is about being criticized for how or what they eat. By contrast, the eating pathology is associated with fears of being seen as eating too much and looking overweight, and of being judged on the basis of appearance (rather than on the basis of what they do).

### 24.4.2 Formulation

Clark and colleagues (Clark, 2005; Clark & Wells, 1995) detail four factors that maintain social anxiety and social phobia, and we incorporate these into our formulations of comorbid eating disorders and social anxiety/phobia. Each involves the use of safety behaviors, which reinforce the original problem:

- *Beliefs about the dangerousness of social situations.* Patients with social anxiety have many beliefs that concern their acceptability, their sense of belonging and the consequences of being rejected. Common assumptions are "I must hide my blushing, because the other person will think I'm weak if they see it," "If I get anxious and people notice it they will stop taking me seriously" or "If I babble

and get my words wrong, people will think I'm stupid." Avoidance of these outcomes (the safety behavior) requires the individual to severely limit their actions and social interactions.

- *Self-focused attention.* The patient tends to focus their attention completely on themselves when in a social situation, leading to raised awareness of the physical symptoms of anxiety and an increase in efforts to hide those physical symptoms. This safety behavior comes at the cost of being less able to perform socially.
- *Intrusive negative images that dominate consciousness.* Most socially anxious individuals believe that they look as anxious as they feel, and experience intrusive images to that effect.
- *Use of safety behaviors.* Because socially anxious individuals feel concerned about being judged or humiliated, they often engage in behaviors to help them come across better or to hide their symptoms of anxiety (e.g., avoiding eye-contact; monitoring one's speech; speaking quickly; saying little about oneself; letting the other person do all the talking).

We find that these factors are valuable in formulating cases of comorbid social anxiety and eating disorders. Figure 24.3 illustrates one way in which those factors might interact in the formulation of an individual case, although different factors and interactions between factors will be appropriate in other cases.

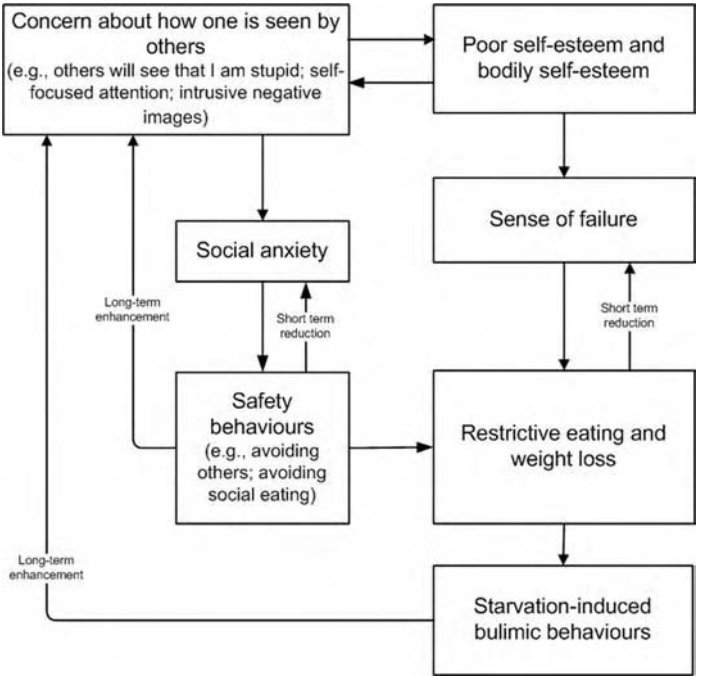



Figure 24.3 Example formulation, showing links between social anxiety/phobia and eating pathology.

### 24.4.3 Treatment

Effective treatment of social anxiety is based on a series of interlinked experiments (Clark & Wells, 1995). Three specific experiments form the core part of treatment, though more individualized treatment-planning might be needed after they are completed or if the patient has a presentation that is more similar to avoidant personality disorder. We find that this sequence of experiments is equally useful in treating comorbid social anxiety in patients with eating disorders. Butler & Hackmann (2004), Clark (2005) and Wells (1997) provide further practical advice on the treatment of social anxiety. With eating-disordered patients, treatment of social anxiety frequently centres on food- and shape-related situations (e.g., avoiding eating with others for fear of being judged to be embarrassing; not letting others see one's body). Thus, the paradigm outlined below can be focused on how others see the patient's body or on how they are perceived (and how they perceive themselves) when using safety behaviors such as eating alone rather than in company.

Clinicians need to be aware that patients with comorbid social anxiety are likely to feel extremely self-conscious while engaging in behavioral experiments, and they may not feel able to tell the clinician that they find the task too difficult, for fear of being judged. It is also important to remember that socially anxious individuals tend to interpret other people's reactions to their anxiety in the light of their narrow code of what is acceptable and what is not, making them susceptible to any signs of rejection or disapproval by others (including the clinician).

#### *Step 1: the safety-behaviors experiment*

In the first experiment, the patient is asked to have two brief conversations with a stooge, which are videotaped. In the first conversation, the patient is asked to use their safety behaviors as they typically would in such a situation. In the second role-play, the patient is asked to drop their safety behaviors, and to focus all their attention on the conversation and the other person (rather than themselves). After each role-play the patient is asked to rate:

- how anxious they felt
- how anxious they thought they appeared
- how well they thought they performed.

Two things can usually be established from this exercise. First, the patient's excessive self-focus and their safety behaviors are usually associated with being *more* anxious, not less. Second, the patient's ratings of how they think they appear and how well they think they performed usually follow their ratings of how anxious and self-focused they felt during the role-plays, thus suggesting that they

are using feelings and other internally generated information to infer how they come across to others.

*Step 2: attention-switching task*

Once it has been established that using safety behaviors can negatively affect how the patient feels in social situations, the second experiment involves the patient trying out ''attention switching'' for homework over the following week. The patient switches safety behaviors and self-focussed attention on and off in different social situations, and observes the impact on how they feel and on their sense of how they are coming across to others. Attention-switching allows the patient to further test the hypothesis that using safety behaviors makes them feel worse in social situations, rather than providing relief. Typically, patients conclude that ''my safety behaviors are not helping me, they are actually part of the problem and they make me feel worse.''

*Step 3: video feedback*

The next step is for the patient to obtain objective information about how they look to other people. In order to determine this, patient and clinician watch the video of the two brief conversations (from step 1). Prior to watching the video, the patient is asked to make detailed predictions of how they think they will come across in the video. In order to maximize the perceived discrepancy between the self-image and the video, they are asked to visualize how they think they will appear before viewing the video and to operationalize exactly what their negative behaviors will look like (e.g., the clinician might ask the patient: ''How much will you shake? Can you please show me for the camera so that we can later compare it with the video''; or ''How red was your blushing when you were talking to the stooge? Could you please pick out a color from the color chart here?''). Finally, the patient is asked to watch themselves in the video as if they were watching a stranger. The clinician might say to the patient: ''Make sure you base your judgement on the visual and auditory information that would be available to anyone watching this. Try to ignore your feelings about how you come across.'' Another helpful strategy is to ask the patient to refer to themselves in the video in the third person: ''How does she look to you? Can you see what she is doing now?'' The patient's ratings are then compared with the actual performance. With the help of this specific cognitive preparation, video feedback usually helps the patient to discover that they come across better than they think, and that their self-impression is misleading (i.e., they do not look as anxious or weird as they thought). Sometimes, patients notice behaviors that they do not like or would like to change. However, further discussion often reveals that these are safety behaviors, which can be dropped.

## 24.5 Posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is diagnosed when the individual develops a response to a traumatic event, involving re-experiencing, avoidance, numbing, symptoms of hyper-arousal, and feelings of intense fear, helplessness or horror. Many patients with eating disorders report traumatic experiences (Fallon & Wonderlich, 1997; Kent *et al.*, 1999; Rorty *et al.*, 1994). Those experiences are sometimes linked to symptoms of PTSD, particularly in the subgroup of patients with bulimic features (Dansky *et al.*, 1997; Kessler *et al.*, 1995).

### 24.5.1 Assessment

While many patients with eating disorders have experienced significant trauma or abuse, most do not go on to develop PTSD. Therefore, a history of trauma alone is not a proxy for a diagnosis of PTSD. There is also considerable diagnostic overlap between PTSD symptoms and other disorders (e.g., the intrusive memories of people with PTSD are similar to those found in people with depression; Reynolds & Brewin, 1999).

In addition to questionnaires such as the Posttraumatic Diagnostic Scale (Foa *et al.*, 1997) and the Impact of Events Scale (Sundin & Horowitz, 2003), we find it useful to ask patients to complete the PostTraumatic Cognitions Inventory (Foa *et al.*, 1999), because this measure identifies the cognitions that need to be addressed in treatment for the PTSD. To make a diagnosis of PTSD, we ask whether the patient has symptoms of:

- re-experiencing (e.g., intrusive thoughts or images; reliving the event)
- avoidance (e.g., not thinking about the event; avoiding people or places associated with the event)
- increased arousal (e.g., trouble sleeping; irritability; poor concentration).

Ehlers and Clark (2000) provide comprehensive information on the cognitive-behavioral assessment of PTSD.

### 24.5.2 Formulation

We find that the most clinically useful cognitive-behavioral model of PTSD is that of Ehlers and Clark (2000). This model proposes that PTSD develops when a person processes a traumatic event and/or its consequences in a way that leads to "a sense of serious current threat." Such processing occurs when the patient has a tendency to interpret specific symptoms of PTSD (e.g., intrusive thoughts and memories) as signs that they are in immediate and serious danger. The patient engages in several cognitive and behavioral strategies that maintain their symptoms, including thought suppression and the avoidance of places, people and/or conversations associated with the trauma. These processes maintain the

person's negative appraisal of the symptoms and consequences of the trauma, and they prevent the person from fully processing the trauma memories.

Ehlers and Clark (2000) distinguish two types of belief that maintain the patient's sense of current threat:

- *Appraisal of the consequences of the trauma.* Patients tend to negatively appraise both their PTSD symptoms (e.g., "Having these symptoms means I'm a weak person") and the consequences of the trauma (e.g., changes in their relationships or circumstances). These appraisals lead to an overgeneralized sense that life has permanently and irreversibly changed, which is associated with further emotional and behavioral reactions (e.g., feelings of depression, social withdrawal).
- *Appraisal of the meaning of the traumatic event.* Traumatic events often take place in the context of the individual having a prior history of negative experiences (e.g., an invalidating childhood environment; Mountford *et al.*, 2007), which has led to the development of negative core beliefs. Thus, the traumatic event that is followed by PTSD symptoms may be more the "tip of the iceberg" than the whole reason for the symptoms, and treatment needs to be carried out with that perspective in mind. The trauma can intensify preexisting negative beliefs that the patient has about the world (e.g., "Men are dangerous"; "Others take advantage of you if you're not on guard") or can shatter positive beliefs (e.g., "Most people are generous and friendly"; "Every person is good at heart"). The resulting black and white perspective on life acts as a mental filter ("I always knew that men are like that"; "Life is totally uncontrollable"; "People are selfish and cannot be trusted"). Furthermore, distorted appraisals that the patient made at the time of the trauma are often consolidated in memory as if they were facts.

Figure 24.4 shows an example of how the comorbidity of PTSD and eating pathology might be formulated for an individual patient, although such formulations are likely to vary widely across cases, not least because the traumatic experience and the relevant moderating factors will differ substantially across individuals.

### 24.5.3 Treatment

Our clinical experience suggests that in many instances the eating disorder can be addressed prior to treating the PTSD. However, there are some cases where PTSD may get in the way of treatment for the patient's eating problems, and where the PTSD will need to be addressed first (e.g., where levels of hyper-arousal make it too difficult for the patient to engage in challenging their beliefs about food-related social situations).

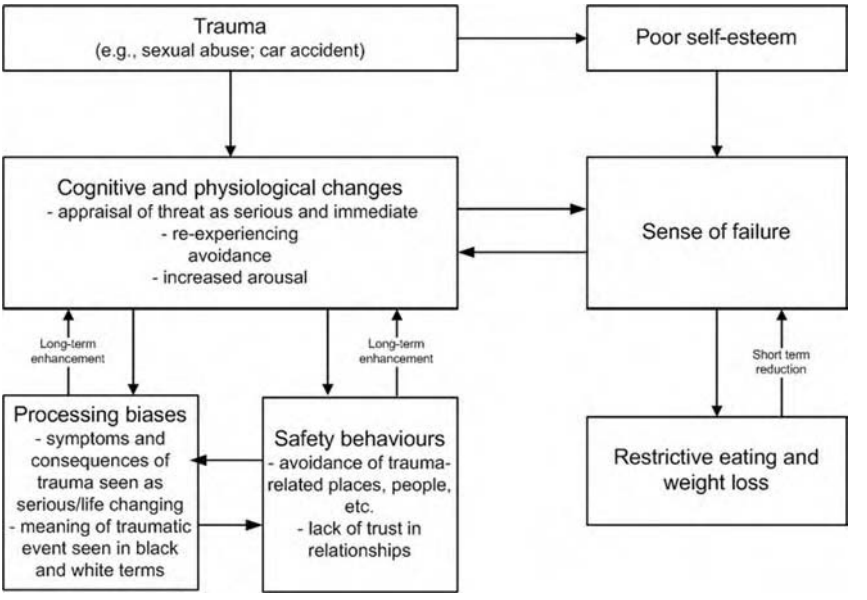



Figure 24.4 Example formulation, showing links between PTSD symptoms and eating pathology.

The rationale of CBT for PTSD can be explained to patients with the help of the "cupboard metaphor" (Ehlers & Clark, 2000). The clinician compares the patient's trauma memory to a cupboard into which various things (e.g., books, clothes, shoes, a tennis racket) have been thrown very quickly. Each badly stored item is comparable to distressing cognitions and feelings. Because all of the items are lying on top of each other (i.e., the thoughts and feelings are not processed appropriately), it is not possible fully to shut the door of the cupboard, and occasionally some of these objects fall out (e.g., intrusive thoughts, unexplained fearful feelings). In order to stop this from happening, the cupboard doors need to be opened fully, and each item needs to be carefully looked at and put where it belongs (i.e., cognitive restructuring). Once this has been done, the cupboard can be closed and it will remain shut (i.e., the thoughts and feelings will no longer be intrusive).

CBT for PTSD has three goals, aiming to help the patient to:

- process the trauma memory fully (leading to a decrease in re-experiencing)
- identify and modify negative appraisals of the trauma symptoms (which maintain their sense of current threat)
- stop using safety behaviors (e.g., thought suppression; experiential avoidance).

In line with Mueller *et al.* (2004), we use four types of behavioral experiments to test patients' beliefs and assumptions. When working with comorbidity with the eating disorders, this paradigm needs to be adapted to address the links to the eating behaviors. For example, it may be necessary to use imagery rescripting

(see below) to address traumatic imagery that has come to be associated with food. This approach can involve overcoming the implicit association of the traumatic event with a particular food-related smell or physical sensation (e.g., patients who feel too anxious to eat when they experience a smell that was present when they were traumatized; patients who report panicky sensations when they eat, which have their root in oral rape). The four types of behavioral experiment are:

- experiments to test the patient's unhelpful appraisals of their trauma symptoms
- experiments to help the patient to re-evaluate their changed (or confirmed) appraisals of themselves and/or the world
- experiments to help the patient to re-evaluate their distorted appraisals at the time of the trauma
- experiments to examine the effects of using safety behaviors, such as thought suppression.

With these goals and methods in mind, CBT for PTSD involves three steps.

*Step 1: reliving with cognitive restructuring*

In imagery rescripting (e.g., Smucker & Niederee, 1995), the patient is asked to "relive" the trauma in imagery. This means that they are asked to imagine the trauma as vividly as possible, and to access their thoughts and feelings during the experience. Their account of the trauma should start just before the event happened and continue until they felt safe, and they should be encouraged to describe what happened in the present tense (e.g., "I can see the person coming towards me now"). In order to ensure that the patient stays with the memory during the reliving, the clinician usually asks questions such as "What can you see right now?", "How do you feel in the memory?" and "What is going to your mind at this point?" In order to identify the most distressing moments in the trauma, the clinician asks the patient to rate their levels of distress at different times during the reliving. Following the reliving exercise, clinician and patient discuss the most problematic aspects of the trauma and consider specific thoughts and beliefs that have been identified. Using standard CBT techniques, these thoughts and beliefs can then be verbally challenged and re-attributed. Once an alternative perspective has been developed together with the clinician, this new knowledge can be integrated into the patient's trauma memory in a subsequent reliving session.

*Step 2: in vivo exposure*

In vivo exposure follows the reliving sessions. It involves deliberate exposure to reminders of the trauma that the patient continues to avoid (e.g., a visit to the

site of the trauma). The aim is to reduce their concerns that the reminders signal immediate danger. Identifying similarities and differences between then and now helps the patient to distinguish between stimuli that are harmless but were part of the scene (e.g., a light shining in at a certain angle, objects in a room), and those that were signaling danger (e.g., voice of the abuser, slamming of the door). A trip to the site of the trauma can also help to provide patient and clinician with new information to help counter some of the patient's distorted beliefs about their own behavior during the trauma (e.g., demonstrating that escape was physically impossible in that location. Overgeneralized beliefs about danger (e.g., ''nowhere is safe''; ''I can be attacked at any time'') can be addressed by setting up behavioral experiments that involve exposure to these activities, and that test the feared outcome and alternatives.

*Step 3: identifying triggers of intrusive memories and emotions*

Cues that are not semantically related to the trauma but that were present at the time the trauma memory was laid down can act as triggers to intrusive images, strong negative affect and severe physical reactions. For example, patients may notice that certain smells or sounds trigger images of the trauma (and strong affect). We ask the patient to pay careful attention to moments when they experience an intrusion, and to identify potential triggers of such intrusions in the environment at that time. Once the patient has a good understanding of the kinds of physical cues that tend to trigger the intrusions, we discuss the similarities and differences between the present and past contexts in which these cues occurred. This allows the patient correctly to identify and re-attribute the reason for the intrusion to a non-threatening source (e.g., ''My intrusive memory of the trauma is being triggered by the smell of petrol, but this doesn't mean that I am in danger right now'').

## 24.6 Impulsive behaviors and multiimpulsivity

Many eating-disordered patients engage in other impulsive behaviors. When they use a range of such behaviors, they are referred to as ''multiimpulsive,'' although this term is not fully defined and it is possible that these patients are experiencing the wider range of problems associated with borderline personality disorder (see Chapter 25). Those behaviors include: compulsive stealing; drug abuse; alcohol abuse; self-harming (including self-cutting, hitting and burning); overdoses/suicidal behavior; compulsive spending; and sexual disinhibition. Their common theme is that the behaviors are used for purposes of emotional regulation, in the same way that many eating behaviors are.

Multiimpulsive patients are more likely to be found in specialist clinics than in more generalized settings (Favaro & Santonastaso, 1998; Lacey, 1993; Welch & Fairburn, 1996), and are more common among those with eating disorders involving bulimic behaviors, particularly those involving purging (bulimia nervosa and anorexia nervosa of the binge/purge subtype) (e.g., Favaro & Santonastaso, 2000; Nagata *et al.*, 2000). Multiimpulsive patients tend to have greater general psychopathology and a less favorable course of illness (Fichter *et al.*, 1994), and are relatively treatment-resistant (Nagata *et al.*, 2000). Therefore, it is important to consider issues of risk and capacity. The key *risk* is that the individual will harm themselves or others, and this must be contained before CBT can be effective. The issue of *capacity* is most important when the individual is using behaviors that mean that they cannot process or respond to the demands of CBT (e.g., those who are abusing alcohol or drugs to an extent that they cannot engage in cognitive challenges). These patients often require a more containing environment (in-patient or day-patient settings), detoxification programs in order to reduce risk or increase capacity, or the use of affect regulation and schema-focused CBT strategies to control and treat the core pathology.

The remainder of this section focuses on the assessment and formulation of these eating-disordered patients. As we explain below, the treatment of such cases is likely to involve skills outlined in Chapter 25. For many patients, the behaviors started at different times, but the primacy of one behavior is likely to be less relevant by the time that the patient seeks treatment. It is necessary to understand which behaviors are more important in maintaining the patient's general level of distress and dysfunction. Therefore, we aim to determine if some of the problems (e.g., alcohol use) are key maintaining factors, and need to be addressed in more appropriate services before we are able to change the eating behaviors. We find that most cases do not have such a single factor, and that we are often able to work with the behaviors in parallel. However, where there is a substantial level of deliberate self-harm, risks can become much higher and more immediate, and we find it useful to set an explicit contract for reduction of this behavior. If the patient is not able to sign up to that contract, we may have to conclude that it is not the time for CBT, as the demands on the patient are likely to be too high. At this point, either a more containing environment (e.g., an in-patient or day-patient setting) or dialectical behavior therapy skills (see next chapter) are likely to be necessary.

### 24.6.1 Assessment

In addition to gathering information about eating behaviors, we ask the patient to note the occurrence of any other impulsive behaviors that they engage in,

the emotions associated with those behaviors and the cognitions linked to the emotions and behaviors. The cognitions linked to specific behaviors are often at the level of negative automatic thoughts and conditional beliefs (e.g., bingeing and purging in order to reduce cravings for food and fears of weight gain; restriction due to overvalued ideas about weight and shape), but the cognitions linked to the affect are more commonly core beliefs (i.e., schema-level, unconditional beliefs – see Chapter 25). This diary is used to build a picture of the functions of the various behaviors (e.g., emotional regulation, such as anger suppression or self-punishment for being "too happy"). However, we also consider why specific behaviors are used across different times (e.g., why does the patient use alcohol in one situation, but self-harm in another?). This is usually understandable as a product of a number of factors, particularly:

- the individual patient's history (e.g., parental use of food to suppress their child's distress; parental modeling of alcohol use to deal with social situations)
- the immediacy of the emotional function required (e.g., self-cutting has a more rapid effect than alcohol use, but alcohol lasts longer)
- availability of the behavior at the time (e.g., binge-eating can be hard to carry out in a social setting, but binge-drinking can be more acceptable)

The patient's history and current environment are used to develop a formulation that allows us to understand their current behavioral profile.

### 24.6.2 Formulation

We aim to make the formulation as simple as possible, while still being useful. However, if we try to incorporate all the behaviors of multiimpulsive cases, we can generate a formulation that is too complex to be easily understood by either the clinician or the patient. Therefore, we find it most productive to return to the principle of linking cognitions, emotions and behaviors in terms of their functions. Figure 24.5 illustrates this process of developing a formulation from one that is simply eating-related to one that involves a range of behaviors. Given the multiplicity of behaviors that can be involved in such cases, this global formulation, such formulations will inevitably differ across individual patients. The final version shows the need to incorporate early experiences and triggers in order to understand (and eventually challenge) core beliefs (see Chapter 25), in a way that is often not needed in more straightforward cases.

### 24.6.3 Treatment

In eating-disordered patients who are using other impulsive behaviors, treating individual behaviors in a disconnected way means that there is a high risk of

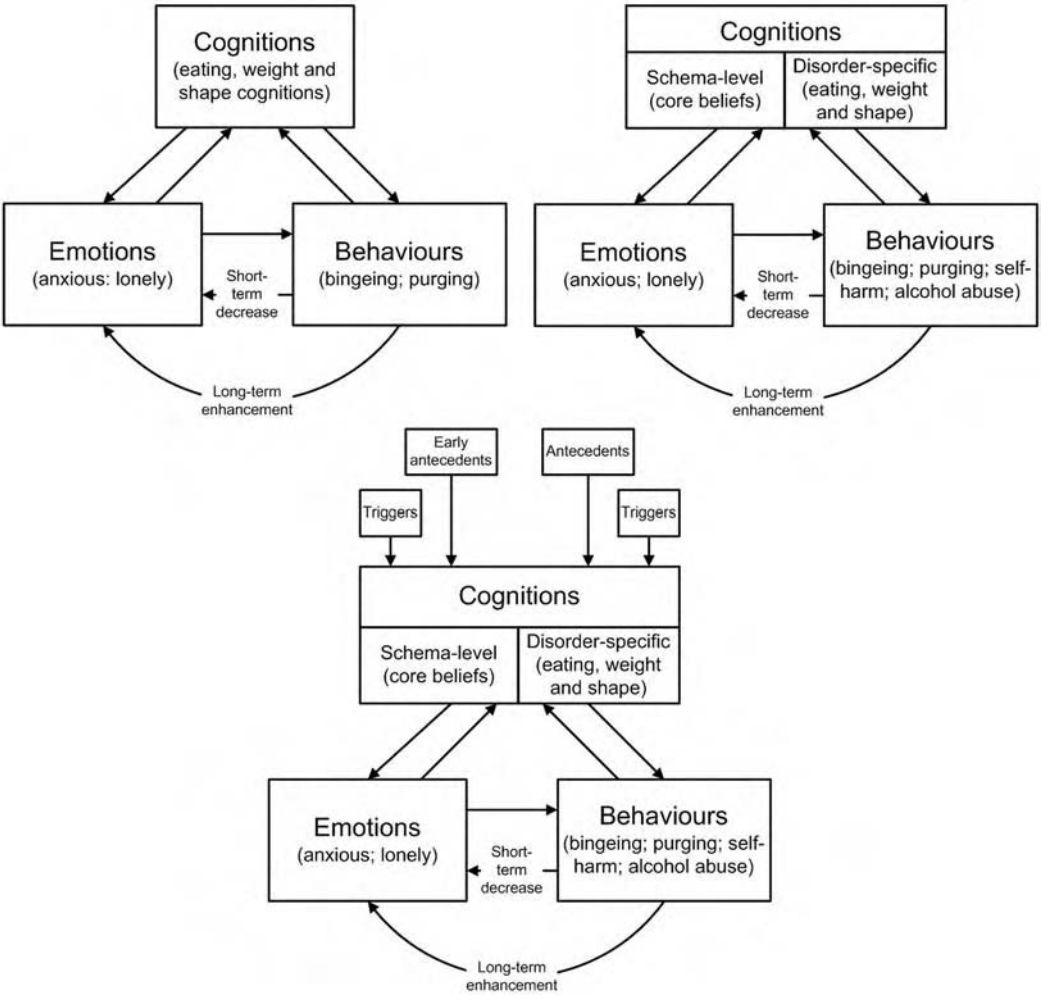



Figure 24.5 Example formulation, showing the development of models from one involving only the eating pathology to a more generalized one that incorporates the fuller range of impulsive behaviors that serve the common function of emotional regulation.

"symptom-switching," such that the patient who self-harms is likely to increase that behavior if the bulimic behaviors are reduced, because the underlying emotional dysregulation problems remain. Therefore, we use the techniques outlined in Chapter 25 to address both emotion dysregulation and the core beliefs that drive those emotions.

25

# Comorbidity with Axis II pathology

Axis II pathology is commonly referred to as the ''personality disorders,'' although many patients find this latter term unhelpful or even antagonistic. Our common experience is that many of our patients can be diagnosed as having the ''cluster C'' personality disorders of obsessive-compulsive personality disorder or avoidant personality disorder. This comorbidity might manifest as a pattern of anxiety-related safety behaviors that share a common root with the eating behaviors. We address the former through the same methods that we use to address obsessive-compulsive disorder, and the latter through similar methods to those used when working with social anxiety (see previous chapter). However, other patients meet criteria for the ''cluster B'' personality disorders – mostly borderline personality disorder, but some of the defensive characteristics of narcissism. These patients often have substantial histories of trauma and emotionally invalidating upbringings, which link to their emotional instability. They are often multiimpulsive, as a result of their emotional fluctuations. We find that their personality difficulties cannot be treated effectively with a simple extension of existing approaches for Axis I disorders.

With such patients, it is important to work at a different level. Emotions are usually the key trigger for their eating behaviors, with eating, shape and weight cognitions being less pivotal (although still present, and playing a role in maintenance). These patients use bingeing and restrictive behaviors to moderate their emotions, because they are unable to tolerate extreme mood states (usually negative moods, but sometimes positive mood). Linehan (1993) describes such individuals as experiencing difficulties in ''distress tolerance,'' while Fairburn *et al.* (2003) describe this as ''mood intolerance.''

In formulating and treating such cases, we find that it is useful to consider the role of emotions and the belief structures that underlie those emotions. We identify three such targets. First, we stress the importance of the techniques from dialectical behavior therapy (DBT; Linehan, 1993) that are used to contain emotions in a more adaptive way, without changing the underlying structures

that cause the emotional distress. This is what Linehan (2001) has described as a "level 1" therapy. She contrasts this with "level 2" therapies, which modify the cognitive structures that underpin those emotions. We use two "level 2" methods, according to the formulation of the individual case. One is to address the cognitions that underlie the emotional avoidance, in order to allow the individual to respond adaptively to emotions rather than maladaptively (cognitive-emotional-behavior therapy). The other is to address the unconditional, schema-level core beliefs that underpin the emotional reactions (schema-focused cognitive-behavior therapy – SFCBT). The remainder of this chapter outlines these three approaches to working with Axis II pathology when it is comorbid with the eating disorders. However, each of these approaches is relatively complex and time consuming relative to conventional CBT for the eating disorders, and hence should be used only in those cases where they are applicable to the formulation. The material here is introductory, and the reader is advised to read more widely (Corstorphine, 2006; Kennerley, 1996; Linehan, 1993; Safer *et al.*, 2001; Waller *et al.*, in press) to develop the level of understanding of these approaches that is necessary in order to apply them flexibly.

In order to introduce such work to our patients, we use the analogy of a Newton's cradle. Most people recognize Newton's cradle as an "executive toy." It is made up of a set of (usually five) steel balls, hung on string so that they are touching in a horizontal line. Lifting and releasing the ball at one end of the line results in the ball at the far end of the line responding. The principle is that all the balls were necessary, but the only apparent action took place in the end balls (which are not in contact. We explain to patients that they often perceive a relationship between a trigger (e.g., mother phones) and a behavior (e.g., exercising, bingeing) that makes no apparent sense. Consequently, the patient assumes that their behavior is senseless, and hence cannot be controlled. In order to reduce this perceived helplessness so that they can learn to change their behavior, we stress that there are meaningful links between the trigger and the behavior (usually core beliefs, dysfunctional assumptions/negative automatic thoughts and emotions), but that these are triggered so rapidly that they are not used to identifying them. Figure 25.1 shows how we illustrate this for the patient, although we would then go on to develop this into a more personalized approach, with diaries to verify the cognitions and emotions involved for the individual patient.

## 25.1 Working with emotional regulation: dialectical behavior therapy methods

DBT has been widely applied in work with self-harm and with the other impulsive behaviors that characterize borderline personality disorder. The central aim is to

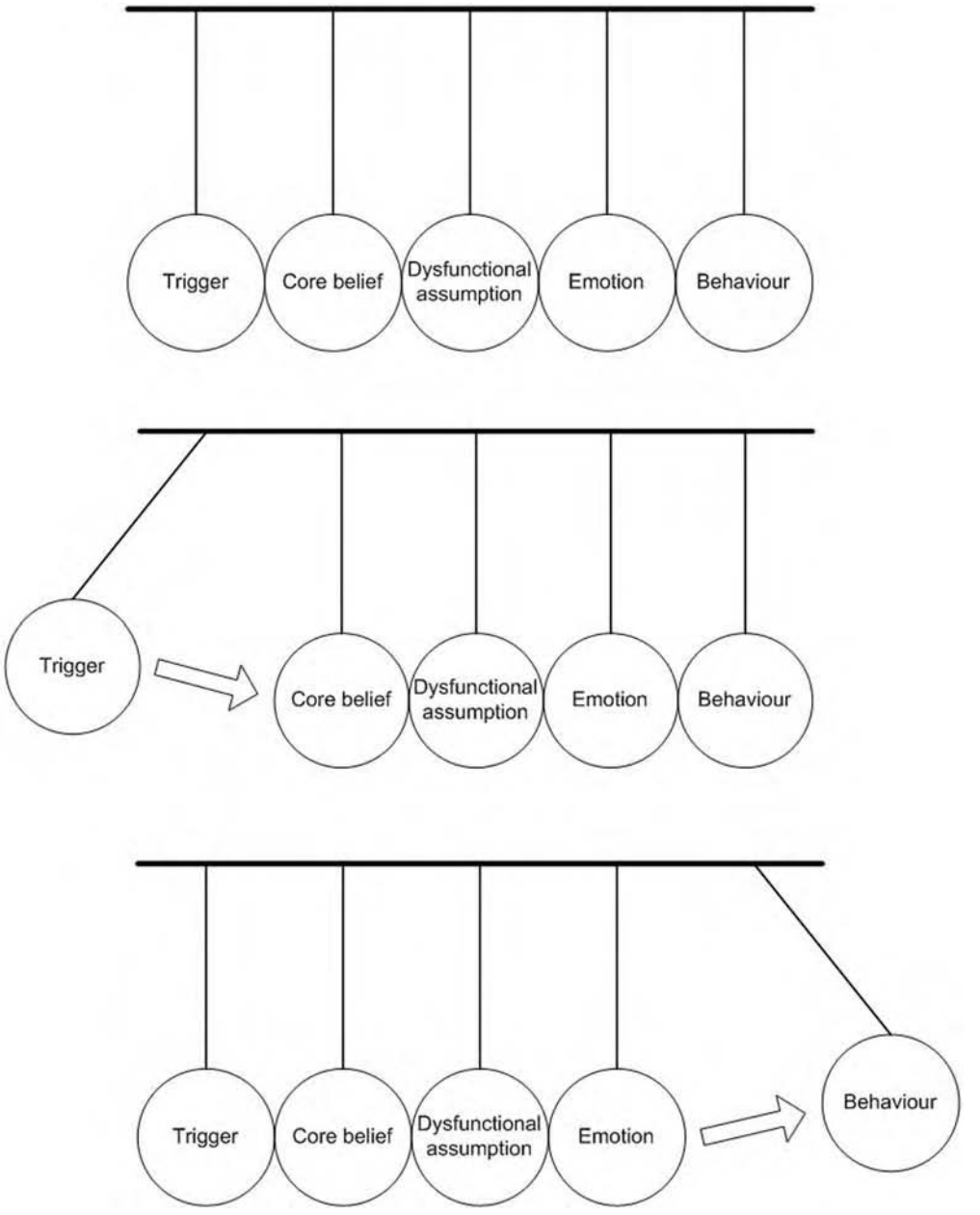



Figure 25.1 The use of the "Newton's cradle" analogy to explain the linkage between triggers and behaviors, mediated by core beliefs, negative automatic thoughts and emotions. This analogy is used to help the patient to identify mechanisms that are not immediately available for conscious report when understanding the visible trigger–behaviors link.

teach the individual ways of identifying and tolerating affect. In order to do this skills training, it is first necessary to engage the patient in change, and then to enhance the individual's awareness of the emotions and the risk that is inherent in existing maladaptive coping mechanisms. The first of these steps requires a technique that Linehan calls "*comprehensive validation*." The clinician needs to create a non-blaming culture within the therapy, where it is clear that the clinician understands the reason why the patient has engaged in the behaviors and does not blame the patient for those behaviors, but where the clinician holds to the principle that the presence of these behaviors in the individual's past does not mean that they have to keep doing them.

The second step is the *reduction of dissociation*, such that the individual does not "zone out" from the emotionally difficult situation by focusing attention elsewhere or by engaging in "blocking" behaviors. An important skill is *grounding*, where the individual learns to identify such a tendency to dissociate and acquires techniques to allow them to focus on the here and now. Kennerley (1996) provides a range of practical techniques that are helpful in reducing dissociation in this way.

The final step is to teach the patient *mindfulness* skills, so that they are able to step back from the emotional distress and consider the situation objectively. This allows them to appraise both the situation and their reactions to it in a way that is unclouded by the tendency to hide from any potential threat or negative emotional state. Individuals learn an awareness of experience that is "in the moment," non-judgmental and single-minded. Mindfulness skills allow individuals to gain more direct contact with their immediate experience while simultaneously achieving some distance from it.

Once these steps have been covered, it becomes possible to enter the stage where the patient can learn new skills of responding to the emotions and to the situations and triggers that evoke those emotions. Such skills might include cognitive methods, such as assessing and discounting the impact of a trigger. However, many of the most effective methods will be behavioral (e.g., developing an alternative behavior that resolves the situation, rather than avoiding it). The key issue is that neither cognitive nor behavioral methods are available to the individual who is dissociating, so that this skill development will be impossible for the individual to acquire for the individual who has not been through the previous stages.

## 25.2 Working with beliefs about emotions: cognitive-emotional-behavioral therapy for the eating disorders

As outlined above, DBT helps the individual to tolerate the affect. As Linehan (1993) indicates, we also find it valuable to address the underlying cognitions in order to allow the individual to develop a more adaptive lifestyle. Such an

approach can modify the beliefs about the acceptability of emotions or it can modify the beliefs that created the unacceptable emotion in the first place. In this section, we address the first of these approaches. We give a brief outline of an intervention aimed at understanding and modifying the cognitions about the acceptability of emotions and the resultant impulsive and compulsive behaviors: cognitive-emotional-behavioral therapy for the eating disorders (CEBT-ED; Corstorphine, 2006).

### 25.2.1 Origins of affect regulation problems

Such cognitions about the acceptability of emotions and the resultant affect regulation difficulties result from growing up in an environment that is perceived to be invalidating – where communication of emotion is ignored or responded to negatively (Linehan, 1993). As a result of growing up in such an environment, the individual develops beliefs that emotions are "bad," "risky" or "dangerous," and so should not be experienced. If the experience of emotion cannot be avoided, it should not be expressed. This concept is similar to Young's (1999) emotional inhibition schema.

These beliefs about the unacceptability of affect are triggered when the individual experiences a *primary emotion*. Primary emotions are appropriate responses to the environment (e.g., feeling angry with someone who has betrayed you; feeling happy that someone you care about is coming to visit), and are adaptive to the situation (e.g., motivating the individual to change the situation). However, the belief that such primary emotions are unacceptable triggers *secondary emotions* (e.g., guilt about feeling angry; anger at feeling upset). Thus, secondary emotions are the result of judging the primary emotions as "bad." For many of our patients, much distress is the result of secondary emotional states, as the initial emotional situation could frequently be tolerated or moderated if the individual could refrain from negative feelings about having the emotion in the first place. In addition to exacerbating distress, secondary emotions can interfere with the individual's ability to attend to the primary emotion, making it impossible to engage in the adaptive response to that primary emotion (e.g., changing the situation). Instead, the individual inhibits their experience and expression of the emotion through their eating and other behaviors.

### 25.2.2 An introduction to CEBT-ED

CEBT-ED is aimed at enabling patients with eating disorders to understand the experience and expression of emotions, so that they can identify and challenge their beliefs and so attend and respond to them. Such skills are needed to reduce the need for maladaptive emotional coping behaviors (i.e., eating behaviors, other impulsive and compulsive behaviors). We find CEBT-ED to be useful with

patients who experience moderate affect regulation difficulties (e.g., those who struggle to recognize and regulate their emotions, but who accept that those emotions are part of their experience). For those with particularly severe affect regulation difficulties (e.g., those who deny or are unable to acknowledge their experienced emotions), interventions that focus on understanding the function of the difficulties tend to be more helpful (e.g., schema-level interventions; Waller *et al.*, in press; Young *et al.*, 2003).

### 25.2.3 Formulation for CEBT-ED

The formulation needs to explain the development and maintenance of the patient's beliefs about the experience and expression of emotions, in order to provide a rationale and framework for the intervention. As a part of the formulation, to normalize the patient's experiences, we discuss the concept of the invalidating environment (Linehan, 1993), and how this can contribute to the beliefs that they now hold about emotions. Figure 25.2 shows both a generic CEBT formulation and an extension of that formulation that is more specific to the eating disorders, linking the emotional processing to the eating symptoms.

### 25.2.4 Intervention

CEBT-ED focuses on emotions, and encourages their experience and expression, and so the content of the session is likely to trigger a range of emotions for the patient (particularly anxiety). Therefore, it is important for both clinician and patient to monitor the emotions that are triggered during the session. Actively identifying and discussing the affective experiences triggered in treatment will provide potent examples to illustrate the formulation.

We begin with an assessment of the patient's understanding of emotions (intellectual versus experiential). We stress that emotions are complex, and that the only way to avoid experiencing emotion is to divert our attention (one of the functions that the patient's eating behavior is currently serving), which does not resolve the problem that the emotions may be alerting us to (e.g., anger may be alerting us to the fact that someone is treating us badly, motivate us to change the way that person is behaving to us). We also outline the potential positive functions of emotions:

- communicating to others (e.g., crying can communicate to others that we need their support)
- influencing others (e.g., anger can influence another to alter their behavior)
- organizing and preparing one for action (e.g., anxiety can motivate you to study for an examination)

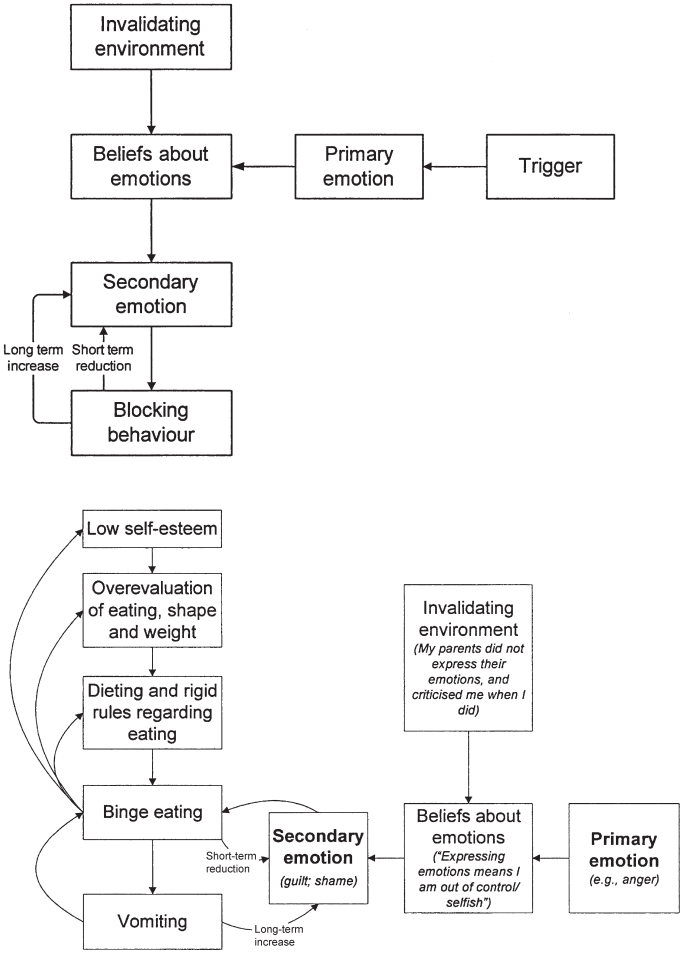



Figure 25.2 Generic and eating-related CEBT models.

- communicating to ourselves (e.g., feeling uncomfortable when in someone's company can indicate to us that it is possibly not in our best interests to spend too much time with this person).

We go on to distinguish emotions that are adaptive responses to the environment and thus serve a function (primary emotions) from emotions that are triggered by beliefs about emotions and intensify distress (secondary emotions).

We then discuss how, in order to serve these functions, emotions need to be expressed in an adaptive and appropriate way. What is appropriate will depend on the context — what we need to achieve and what we need to communicate — and we stress the importance of treating the expression of emotion as lying on a continuum, rather than being black and white. Anger offers a clear example of such

a continuum of expression, with passivity at one end, aggression at the other and appropriate and effective assertiveness lying in the middle.

We use the following strategies to enhance emotional awareness and appraisal:

- Diary monitoring of emotion and its function – enabling the patient to develop the basic mindfulness skills of observing and describing, so that they can become familiar with their emotions.
- List pros and cons of emotion suppression and expression – both long- and short-term consequences, allowing the patient to see that the majority of the advantages of emotion suppression are short term, while the majority of the disadvantages are longer term.
- Experiential exercises (e.g., utilizing drawing and writing) – enabling the patient to bypass their beliefs about the primary emotions, helping them to begin to identify and organize their feelings without the fear of being overwhelmed by the secondary emotions.

This allows us to move on to cognitive restructuring and behavioral experiments to reduce the strength of the patient's maladaptive beliefs, by setting up alternative beliefs that can be tested against the belief that emotions should not be experienced or expressed. Additional work (e.g., continued belief and emotion monitoring; assertiveness training) is necessary to consolidate these new beliefs, and to establish the resulting adaptive emotional coping strategies firmly in the patient's behavioral repertoire.

## 25.3 Working with core beliefs: schema-focused CBT for the eating disorders

In this section, we consider the second mechanism that addresses the cognitions related to affect. We use schema-focused methods to modify the beliefs that created the unacceptable emotion, rather than the beliefs about the acceptability of that belief.

### 25.3.1 Preparing the patient for SFCBT

In SFCBT for the eating disorders, the central task is to identify, challenge and modify the core beliefs that the individual holds, so that the cognitive and emotional triggers to the behaviors are reduced to a manageable level. The challenge in such work is that core beliefs are characterized by being unconditional, such that the individual does not conceive of them as being open to modification. Therefore, the first task is one of explaining the model to the patient, and encouraging them to undertake monitoring and challenges that may seem ridiculous to them. The second issue to raise explicitly with the patient is the fact that their schemas may operate to resist change, by discounting the therapy and

focusing on evidence that supports them. Therefore, it is important to raise this at an early stage, so that potential clashes can be attributed to the schema, rather than being seen as reflecting a lack of motivation or a level of hostility to therapy. Finally, we stress the importance of shifting from the beliefs and behaviors being seen as "mad." Instead, we stress that they made sense when they were laid down (i.e., they were adaptive then), but that they have become maladaptive since then, as the patient's environment and abilities have changed.

### 25.3.2 Assessment

We provide the patient with Young's self-help material on understanding, identifying and modifying core beliefs (Young, 1999; Young & Klosko, 1993). We also ask the patient to complete the short form of the Young Schema Questionnaire (Young, 1998) in order to assess the core beliefs that make useful targets. Educating the patient in this way means that it is possible to discuss the core beliefs that are relevant in their case, and assists the patient to understand that their behavior and emotions are not "mad", by giving them a comparison with others in a similar situation.

In keeping with clinicians such as Malan (1995), we also use the interaction between clinician and patient to identify and demonstrate the presence of specific core beliefs in the individual. For example, where a patient shows excessive concern about the well-being of the clinician, we will hypothesize that this is a demonstration of their self-sacrifice and subjugation schemas in action, making them prioritize others rather than attending to their own needs. We then discuss how this pattern will make it hard to get their own needs met, both in CBT and in the outside world. Similarly, many patients find it hard to attend CBT sessions regularly, and this has often been a recurring feature of previous attempts at therapy. In such cases, we might hypothesize with the patient that this is an example of an abandonment schema, making them expect that others will give up on them, so that they try to push the limits of the therapeutic relationship in order to find out when they will be rejected. We then discuss how this pattern of behaviors might impair the patient's ability to cope with life in a range of settings.

### 25.3.3 SFCBT formulation

Given the diversity of core beliefs that can be associated with the eating disorders and comorbid conditions, it is important to apply the broad principles of SFCBT in order to develop an individual formulation that explains the specific patient's pathology and that directs treatment. The following material is divided accordingly, beginning with the general principles and working up to an example of an individual formulation.

#### 25.3.3.1 General principles

We conceptualize such cases as having both disorder-specific beliefs (overvalued concerns regarding eating, shape and weight) and schema-level beliefs. The latter have a greater impact via the emotional component of the formulation (in keeping with the "Newton's cradle" model, outlined earlier in this chapter). We use diaries to track trigger–schema–emotion–behavior chains in order to support or revise the formulation as necessary over the course of treatment.

##### *Schema-level cognitive content*

We distinguish *central core beliefs* (e.g., defectiveness, abandonment, vulnerability, failure to achieve, emotional deprivation) from the *compensatory core beliefs* that are used to help the individual cope with those central beliefs (e.g., self-sacrifice, unrelenting standards, social isolation). Table 25.1 shows examples of the patterns of linkage between central and compensatory core beliefs that we commonly encounter in eating-disordered patients, and the behavioral manifestations that can demonstrate this cognitive pattern. In such cases, it is important to identify the central core beliefs that drive the problematic behavior, rather than addressing only the behavioral manifestation and its more immediate cognitive driver (the compensatory core belief). For example, a high level of perfectionist behaviors can reflect a compensatory mechanism, designed to help the individual to cope with a central belief of defectiveness or failure. This formulation helps us to target our SFCBT appropriately – on the defectiveness or failure belief, rather than on the perfectionism. To target the perfectionism alone is unlikely to be useful, as this is not the central problem, and the perfectionism is how the patient is keeping their self-esteem intact.

##### *Schema-level cognitive processes*

As well as understanding schema-level cognitive content (the core beliefs), it is important to identify the cognitive processes that allow the schema to "defend" itself against change (e.g., Young, 1999). The strength of these cognitive maintenance mechanisms is highlighted by the way in which patients continue to be affected by childhood experiences (e.g., developing failure beliefs), despite a massive amount of evidence to the contrary in later life (e.g., a successful education, career, relationship, etc.). While there is plentiful evidence that schemas tend to self-perpetuate through preferentially processing information that is consistent with existing beliefs (what Young describes as "schema surrender"), there are two other mechanisms that are important in schema-driven information processing.

The first is the *primary avoidance of processing information/emotion*. Young refers to a similar process as "schema compensation." We identify this process when patients strive to avoid the arousal of intolerable cognitions and associated

**Table 25.1.** Examples of the behaviors that indicate the presence of compensatory core beliefs, and thus the presence of maladaptive core beliefs

| Central core belief | Compensatory core belief | Behavioral manifestation |
|---|---|---|
| Defectiveness/shame | Social isolation | Avoidance of social settings |
| Failure to achieve | Unrelenting standards | Perfectionist behavior; compulsive behaviors |
| Abandonment | Subjugation; self-sacrifice | Efforts to please others; meet their needs rather than one's own |
| | Social isolation | Avoidance of relationships (including commitment to therapy) |
| Emotional deprivation | Emotional inhibition | Emotional distance (secondary alexithymia) |
| Dependence/incompetence | Enmeshment | Overreliance on others; failure to take esponsibility for therapy tasks |

emotional states (e.g., anger, loneliness, happiness). To achieve this, they engage in a number of compensatory core beliefs on a continual basis. For example, a patient might engage in continual obsessional striving to achieve at a perfectionist level, in order to stave off the risk of being seen to be a failure. This can manifest in number of ways, including restrictive eating, compulsive exercise, compulsive self-harm, obsessive-compulsive behaviors, dissociation and secondary alexithymia. This cognitive process is one that we usually find underlying the anorexic/compulsive cluster of behaviors that is present in many of our patients.

The second process is the *secondary avoidance of processing information/emotion* (similar to Young's construct of "schema avoidance"). This process involves the individual using behaviors that "block" the emotion or cognition. As well as bulimic behaviors, the individual will use behaviors such as self-harm, alcohol use, impulsive spending and risky sexual behavior. As described in the previous chapter, each of these behaviors blocks the emotional state, although they differ in:

- their time frames (how long it takes for the effect to take place; how long the blocking effect lasts)
- their availability (e.g., self-harm may be easier to achieve than binge-eating in some settings)
- their social acceptability (e.g., it can be more socially acceptable to drink to deal with emotion than to binge-eat, if one is in company).

Of course, these processes can overlap in the individual. Clinically, we often see patients who strive to restrict, and who then go on to binge-eat. Such a person

may be attempting to avoid the activation of negative emotional states, but then goes on to block the emotions when they are becoming too powerful to deal with in this way. In explaining these two cognitive processes (and their short- and long-term consequences), we find it helpful to use the following analogy:

> When thinking about the way that thoughts and emotions can affect different people, or the same person at different times, I find it can be helpful to think about two gardeners, both of whom like to have a perfect, smooth lawn. Both of them hate moles, which threaten the smoothness of their lawns, but they have very different approaches to dealing with the moles. The person who uses secondary avoidance of emotions and thoughts (or "blocking") is like a gardener who waits for the moles to come to the surface, and then goes and slams the molehill down with a sledgehammer. This keeps the moles in check, but ruins the lawn. The person who uses primary avoidance of emotions or thoughts is like a gardener with a very different approach – he or she simply concretes over the lawn to avoid the moles reaching the surface. Unfortunately, this also ruins the lawn, and the gardener then starts to change over to constantly checking the concrete for any cracks. The key point is that both strategies are actually self-defeating, as the initial point (having a perfect lawn) is lost because of the coping mechanism that is used.

*Discussing the origins of maladaptive schemas*

It is important to include the origins of the core beliefs in the formulation, in order to help the patient to attribute the origins of these thoughts to events and situations that are not necessarily relevant in the here and now (see below). We usually find that the beliefs can be explained through discussion of patterns of parental behaviors and traumatic experiences. For example, discussing a patient's emotional inhibition schema will often reveal that they experienced an emotionally invalidating environment in childhood. In keeping with the concept of comprehensive validation, the aim is to ensure that the patient understands that their beliefs, emotions and behaviors were valid in childhood, because they were adaptive to the environment, but that they are no longer adaptive to life as it now is.

#### 25.3.3.2 Individual case formulation

Clearly, it is important to use these principles to develop a formulation that is specific to the individual case and the behaviors that are present, including the eating behaviors. That formulation should incorporate:

- the experiences that are relevant to the individual's development
- the core beliefs that are specific to the case
- the schema processes (primary and secondary avoidance of cognitions and emotions) that maintain the core beliefs
- the links to the eating behaviors.

Here, we provide two examples of such formulations. The first (Figure 25.3) illustrates an established case with largely restrictive and compulsive behaviors, which have developed over time. The second (Figure 25.4) illustrates an early stage in the development of a more impulsive profile, where the only behavior used to date is bulimia, but where other behaviors (e.g., self-harm) are likely to become established over time.

### 25.3.4 Intervention

This is a summary of SFCBT interventions for the eating disorders, as these approaches are detailed more closely in Waller *et al.* (in press). The key aim is to achieve an attributional shift, such that the individual does not blame themselves for the experiences that determined their core beliefs. This involves using Socratic methods to help them to examine, test and change their cognitions about the experiences. We aim to achieve one or more of the following shifts in attribution:

- internal to external (e.g., "The abuse was my fault" to "It was my father who did it, and it was his responsibility")

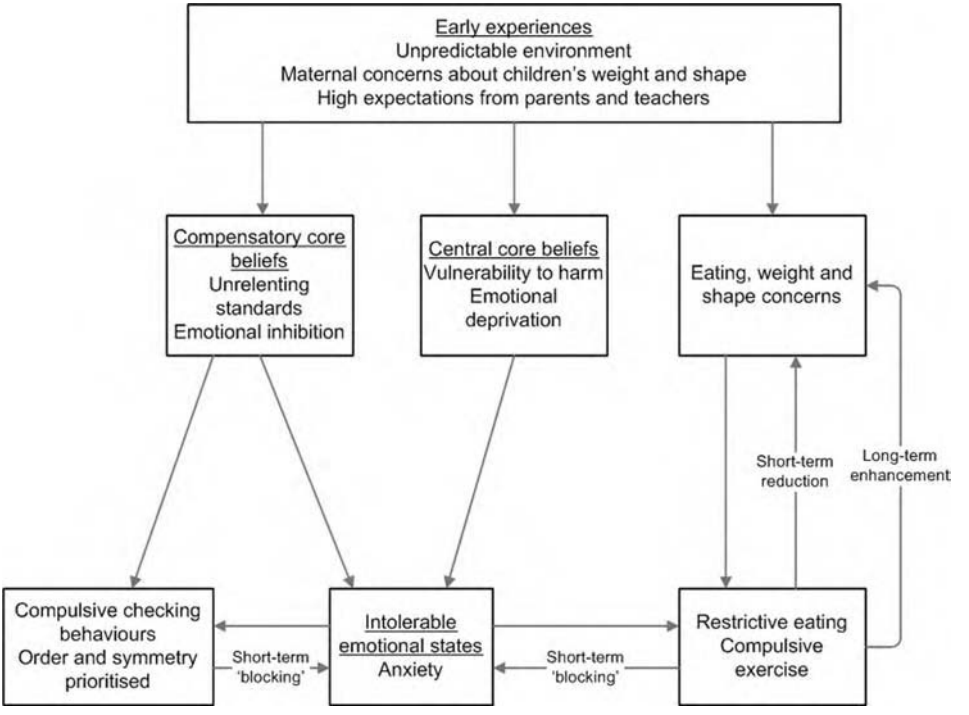



Figure 25.3 Example of individual schema-focused CBT formulation, in a case with largely restrictive/compulsive behaviors.

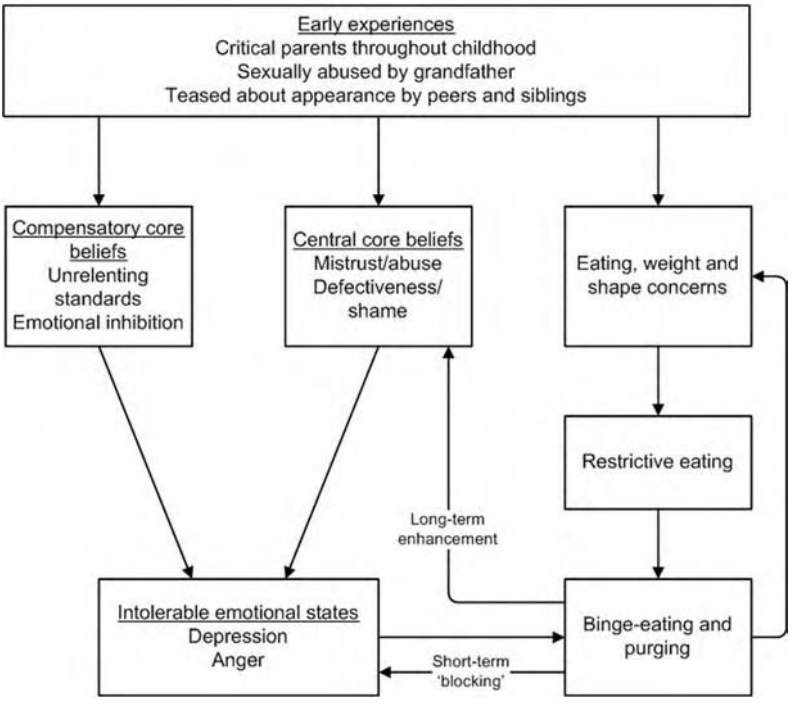



Figure 25.4 Example of individual schema-focused CBT formulation, in a case with largely bulimic/impulsive behaviors.

- stable to unstable (e.g., "I was abused, so I will always be 'damaged goods' " to "The abuse is something that happened and it was painful, but I do not have to assume that the effect on me is inevitably permanent")
- global to specific (e.g., "The abuse affects every aspect of my life" to "The abuse has made it hard for me to trust some men, but that does not have to mean that I can never have a relationship – I just know the type of men I should avoid")

A core skill when working with schema-level beliefs is the ability to move away from black and white thinking, seeing the importance of continuum thinking. While this is common to all CBT, it is a particularly important step in schema work, because continuum thinking is central to the patient's shift away from unconditional thinking. We use a range of other SFCBT tools to assist in the modification of core beliefs, many of which will be familiar from other areas of CBT. As always, they require active participation on the part of the patient as a collaborative therapist. These include the following techniques.

#### 25.3.4.1 Historical review

The patient is asked to generate historical evidence for the accuracy of their beliefs (e.g., what is the evidence that others always desert you?), and is then asked

to generate evidence that the beliefs are inaccurate (e.g., who has stayed with you over time? When people have left you, is that because you pushed them away). The result is usually a short list of evidence for the belief, most of which dates back to childhood, and a longer list of contradictory evidence. The patient is invited to consider this disparity using Socratic questioning, and to develop behavioral experiments that would allow them to test their beliefs more conclusively.

#### 25.3.4.2 Diaries and dysfunctional thought records

Such records allow the patient to learn to identify schema activation. However, they are also valuable because they help us to examine and test the patient's beliefs in vivo, in order to determine whether those beliefs are appropriate to the present. The content reflects the "Newton's cradle" (above), although the columns are in order of ease of identification by the patient, rather than in sequence of activation. The columns are used to identify:

- the planned behavior(s)
- triggers/situations
- emotions
- negative automatic thoughts/"hot" cognitions
- core beliefs.

We encourage the patient to complete the record before undertaking the behavior, to begin to encourage them to see the behavior as a choice rather than an inevitable outcome.

#### 25.3.4.3 Therapy records

Many of these patients have difficulty with dissociation, both between and following sessions, making it hard for them to engage in 168-hour-a-week therapy. To overcome this, we ask the patient to keep a notebook of the proceedings of therapy (e.g., plans that were discussed, decisions taken and homework tasks) to review progress between sessions. In addition, we tape sessions, so that the patient is able to listen to and review the work done in the time between sessions. This is often a valuable exercise for the patient, because they are able to identify their schema activation through being able to observe themselves more objectively.

#### 25.3.4.4 Flashcards

We develop brief summaries of the patient's most prominent schemas, so that the patient is able to identify when they are activated. In the early stages of self-monitoring, the flashcard can be used to demonstrate common links between the individual's core beliefs and their emotional state. We commonly ask the patient to list the emotions that trigger the behaviors (using the diary of cognitive and emotional triggers) and to identify the core beliefs that are particularly pertinent

(using the YSQ and the self-help materials; Young, 1999). As a homework exercise, we then ask the patient to identify which emotions are most commonly associated with which core beliefs, by drawing a line between each pair each time that they cooccur in the everyday life, and gradually thickening the lines as the pairings are identified. Figure 25.5 demonstrates such a flashcard after the individual has spent a week identifying links. This card can then be modified to develop the necessary cognitive challenges, as shown below.

Later, once the core belief–emotion links have been established, the flashcard can be used to provide the patient with a summary of arguments that they have developed to counter the schema. Figure 25.6 gives an example of such a flashcard in the later stage of development. Such a flashcard is used by the patient to support their ability to identify their core beliefs when they are activated and to challenge the unconditionality of those beliefs.

#### 25.3.4.5 Positive data logs

As well as testing beliefs about the likelihood of negative events, it is important to consider whether the patient underplays the role of positive events in their life. We encourage patients to express their beliefs about the low likelihood of positive events, and then to test those beliefs in vivo. For example, a patient might be asked to test their belief that nobody cares about them by predicting how often people will ask how they are over the course of the coming week. We then ask them what it would mean about their belief if they were incorrect (asking them to rate the strength of each belief). We find that the patient always underestimates the

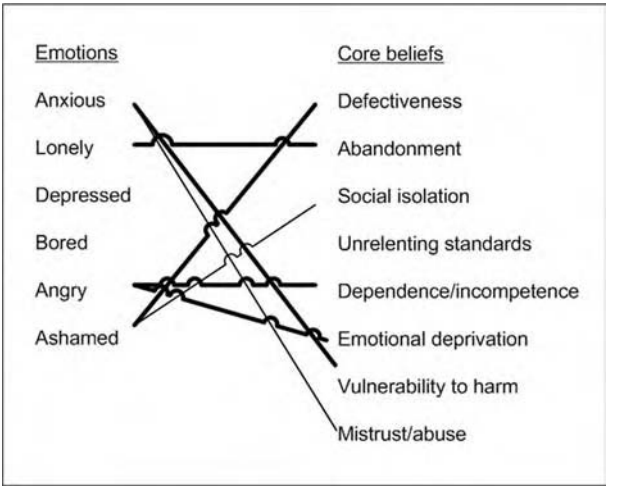



Figure 25.5 Preliminary flashcard demonstrating links between core beliefs and emotional states, as identified during homework. Strength of lines indicates repeated identification of links.

| Emotion | Core belief | Arguments against the schema |
|---|---|---|
| Anxious | Vulnerability to harm; Mistrust/abuse | "I know that I had an unhappy childhood, where I was not kept safe, but I can control the world more now, and it is possible to feel safe." |
| Lonely | Abandonment | "While I was left without anyone I could rely on when I was young, my husband has shown that he is reliable now, and I can trust him." |
| Angry | Dependence/ incompetence; Emotional deprivation | "My anger is a reasonable response to having been treated so poorly when I was young, but it is important to be angry at the right target, and not to let it destroy the good relationships that I have now." |
| Ashamed | Defectiveness; Social isolation | "I know that I was raised to believe that I am fundamentally flawed, but that was about my parents' needs to have someone to attack rather than facing their own relationship problems. If I spend my life avoiding other people, then I will be reinforcing that pattern of belief, and will not be able to escape this way of seeing myself." |

Figure 25.6 Example of a full schema-based flashcard.

likelihood of positive events, enabling them to change their beliefs about the world and other people.

#### 25.3.4.6 Schema dialogue

This technique is used to teach the patient their habitual ways of discounting evidence that is not consistent with their schemas. We ask the patient to adopt the ''persona'' of the schema, and to engage in discussion with the clinician. The clinician uses logical arguments against the belief, and the job of the patient is to ''block'' those arguments in the ways that the schema would. Those ways are likely to include the use of non-sequiteurs, black and white thinking, emotional arousal and aggression towards the clinician. The aim is to teach the patient their habitual ways of discounting evidence. They can then go on to identify similar

patterns in their everyday life, and learn to challenge their avoidance of change in the light of new evidence.

#### 25.3.4.7 Using others as a reference point

A number of patients report that they are not able to identify any errors in their way of thinking. Such a patient frequently describes their home life as idyllic, making it impossible for them to see how their negative core beliefs might be the product of external factors. Therefore, they assume that the schema-level belief must be accurate – their own fault. To overcome this, we ask the patient to act as a therapist for a close relative (e.g., sister, daughter) who has similar problems to herself. For example, we might ask: "If your sister believed that she was worthless, what would you say to her?" or "Would you be happy for your daughter to be raised in the same way that you were?" We find this to be a very powerful tool, helping the patient to see the importance of extrinsic developmental factors (e.g., "cold" parenting) on the individual's behaviors, and helping them to transfer those views to consideration of their own experiences.

#### 25.3.4.8 Imagery rescripting

We find imagery rescripting (e.g., Ohanian, 2002; Smucker & Neiderdee, 1995) to be a very powerful technique for achieving rapid and powerful attributional shifts. This appears to happen because the material was not originally encoded in a verbal form (because it is based on very early experiences), making it hard to shift beliefs through verbally based therapies. The technique is similar to that recommended for PTSD, with the patient developing an alternative ending to the event that is being relived in imagery. This shift allows them to re-appraise the events from an adult (verbally based) perspective, and change attributions so that they do not have to see the events as their own fault.

### 25.3.5 Working on residual eating issues and other behaviors

When the core beliefs have been rendered less powerful, they are less likely to have an impact on the patient's emotion-driven eating behaviors. However, this change will not reduce the role of the disorder-specific beliefs (e.g., overevaluation of eating, shape and weight; low self-esteem; fear of social evaluation), given the maintenance loops that will be in play when the Axis I disorder has been in progress for some time. Therefore, it remains important to re-introduce the more disorder-specific CBT approaches that have been detailed earlier in the book, rather than to assume that addressing the schema-level beliefs will be sufficient.

### 25.3.6 Relapse prevention

Following this period of treatment, it is important to consolidate the positive changes through relapse prevention work. This work will be similar to that

outlined in the final section of this book, but needs to be extended to include identifying the lessons learned about the risks that are inherent in trusting one's schema-level beliefs, rather than considering the broader data that are available in the world. We encourage patients to develop a series of situation-specific flashcards, to be accessed if maladaptive cognitions or emotions start to re-emerge. We also encourage the patient to review the core belief work at regular intervals posttherapy, as they will with the eating-specific work.

# Summary

In this section, we have addressed CBT approaches for working with the complex eating-disordered cases that have comorbid psychological disturbances, making it possible to apply the principles and techniques that were outlined in previous sections. We now consider how CBT can be applied to younger cases, before outlining how to bring treatment to an end point.

## Section VI

# CBT for children and adolescents with eating disorders and their families

So far, we have considered CBT largely as it has been developed with adult and older adolescent populations. However, the eating disorders also affect children and young adolescents. In this section, we will outline ways in which these principles and methods need to be adapted for use with these younger patients. This section should be read in conjunction with the rest of the book, as much of what is outlined here is dependent on understanding the CBT approach as a whole. We will partially reflect the structure of the rest of the book, highlighting those ways in which CBT for children and younger adolescents varies from the approach used with adults. Where we do not address specific points, then we see the best CBT principles and practice as being those that also apply to older cases (as outlined elsewhere in the book).

It is important to note that our experience is based on work in a highly specialized service, providing both in-patient and out-patient services to young patients. This level of specialization is mentioned because it undoubtedly influences the therapeutic work undertaken. The young people concerned are likely to be less motivated and more entrenched in their disorder than many other young people with eating disorders. Despite this level of challenge, we have found techniques that can enhance engagement and motivation and that can aid treatment using CBT. Those techniques are outlined throughout this section.

26

# CBT for children and adolescents with eating disorders and their families

In this chapter, we focus on the ways in which conceptualizing and treating eating difficulties in this age group is different from working with an adult population, given the different developmental phases of the younger people, their social/familial situation and (especially) their position within their families. Children and adolescents are not simply "mini-adults" – childhood and adolescence are developmental phases, with their own discrete tasks and processes. Hence, one cannot simply adjust "adult" techniques into age-appropriate language and then deliver them within therapy. There is a growing body of research to suggest that CBT models and techniques can bring about change in behavioral and emotional difficulties in young people (e.g., Carr, 2000; Graham, 2005a,b), although there is little research to date that could support this view in the eating disorders (Gowers & Bryant-Waugh, 2004). There is evidence for family-based approaches (Eisler *et al.*, 2003; Robin *et al.*, 1998), but (as with most therapies for most disorders) there is a substantial number of patients who do not recover with that approach, and it is necessary to consider the lessons that can be learned from other clinical experience. In addition, it is clear that younger people do not neatly fit the diagnostic criteria that are applied to adults. What is less clear is whether the cognitive content and processes of younger people with eating disorders are similar to those of adults. Our experience leads us to conclude that they are in some ways, and that they are not in others. The implications of these similarities and differences will be addressed throughout this section.

Given these limitations in the knowledge base, in this chapter we will discuss how to work within a CBT framework with children and adolescents with eating disorders, drawing on developmental principles and on our clinical experience of modifying the adult literature for this age group. Issues to be covered reflect those throughout the rest of the book, and include:

- diagnostic categories
- considerations when working with this age group
- assessment

- motivation
- formulation
- interventions
- endings.

## 26.1 Diagnostic categories

Although many patients do not neatly fit a diagnostic category, clinicians continue to try to categorize presenting symptoms into existing categories. Young people with eating problems present at ages that cover all of the developmental stages of childhood and adolescence, but adult criteria and categories are not sensitive to the developmental issues present in children and adolescents (e.g., weight and cognitive functioning), and a strict application of these criteria may result in clinicians overlooking young people with significantly disordered eating. Many of the young people who we see do not neatly fit into the preexisting categories (Nicholls *et al.*, 2000). For example, as many as 50% of young people presenting to a specialist early-onset eating disorders team fail to meet DSM-IV criteria for anorexia nervosa (Nicholls *et al.*, 2000). In response to these issues, clinicians working with children and young people have described more appropriate categories of disordered eating in addition to the adult diagnoses. These include (Bryant-Waugh, 2000):

- food avoidance emotional disorder (FAED)
- selective eating
- functional dysphagia
- pervasive refusal syndrome
- restrictive eating
- food refusal
- vomit phobia
- appetite loss secondary to depression.

The category that young people are assigned to is much less important than establishing a clear individualized formulation and intervention plan. In applying CBT for eating disorders to children and young people, we find it crucial to pay careful and close attention to the cognitions and how they drive the behaviors. For example, a young person who presents with a prominent feature of fear of fatness needs a different clinical approach to a young person who is restricting their eating to a select few food groups based on the fear that other foods will cause an uncontrollable emotional response (panic attack) and that they will die. However, both can result in significant levels of distress and physical compromise. Young people are more likely to have difficulty in describing their internal experiences, and this difficulty can slow the process of determining what

cognitions drive the behaviors. We always take care to assess such cognitions over an extended period.

In summary, a number of the diagnostic groups identified among younger populations do not map onto those found among adults. For a comprehensive consideration of the issues relating to diagnosis with this age group, see Bryant-Waugh (2000) and Nicholls *et al.* (2000). However, the CBT principles remain the same when working with any case. As with adults, we carry out a cognitive-behavioral assessment, in order to formulate the ways in which cognitions and behaviors can be formulated and treated.

## 26.2 Considerations when working with this age group

When working within a CBT model with young people, many of the issues that need to be considered are identical to those encountered by clinicians working with young people in other areas. Those generic issues will be considered briefly, before reviewing issues that are particularly pertinent to the eating disorders.

### 26.2.1 General considerations

As has already been mentioned, young people are not simply mini-adults. It is important to attend to a range of general issues when assessing the patient and planning treatment.

#### 26.2.1.1 Intellectual and emotional capacities

Of course, the linguistic ability and comprehension of the young person is important, but the particular developmental stage that they present in will have an impact on the formulation of the problem, as well as guiding interventions and the choice of measures of outcome. This developmental issue is often most apparent when attempting to get a sense of what the young person understands of feelings (both their own and those of others) and of their cognitive experience. As with adults, individuals differ in their ability to notice and label their emotions, and in their capacity to identify and notice their automatic thoughts. In CBT for young people with any disorder, if they have difficulty in expressing thoughts and feelings verbally, it is important to have other avenues available to help them to do so. Young people often respond well to tasks such as drawing or engaging in games (e.g., as a way in to exploring their inner experiences). Stallard (2002, 2005) and Graham (2005a) address this issue further.

#### 26.2.1.2 Identity formation

A critical task of both early and late adolescence is the process of identity formation. When emotional difficulties have developed alongside this process,

the clinician must take this into account and work with it. In many cases, the emotional difficulties have impaired the developmental task of increased individuation and autonomy. For the younger client, developmental and emotional difficulties unfold across the course of treatment. In such cases, CBT should aim to facilitate the resumption of normal development in all areas.

#### 26.2.1.3 Working with families

A systemic viewpoint can be helpful in any therapeutic approach, as young people cannot be viewed in isolation from the system in which they are functioning. Therefore, working with young people in any therapeutic model means that work with families must also be considered (see Lock *et al.*, 2001). When undertaking CBT with young people, even where the delivery of this therapy is primarily in individual sessions with the child or adolescent, it is usually most helpful if some time is given over to explaining to the caregivers how the problem is being conceptualized and the aims of the intervention. The details that are going to be shared with families and caregivers can be a useful discussion point between the clinician and the young person, and the clinician is likely to adjust what is shared with the family, according to the patient's age, development and risk.

For example, Sophie, a 12-year-old girl diagnosed with anorexia nervosa, was adamant that her parents should not be told her weight at assessment. Her age, the fact that her parents maintained parental responsibility and the team's belief that this information needed to be known by all meant that the team did not comply with her wishes. In order not to remove her autonomy completely, the decision to share this information against Sophie's wishes was discussed with her, and ways were agreed in which this information could be shared with the family. Had Sophie been 16, the outcome might have been different. However, wherever possible, it is important to facilitate a treatment ethos of openness and sharing, thus avoiding the splitting of staff teams and families.

A further benefit to engaging families is that they can be taught to support the concepts and practice of CBT with their child. For example, where a young eating-disordered patient is also suffering from obsessive-compulsive disorder, it can aid the individual therapy if the parents are given explanations of why it is unhelpful to reassure the child about their worrying thoughts, and they can be taught more helpful responses. If this is effective, then the parents can support the CBT during the relapse prevention stage and long after the therapy has ended.

The limited outcome research available to date on what helps young people and their families with eating disorders has concluded that family work is the treatment of choice, particularly when the young person is still living within the family home (e.g., Eisler *et al.*, 2003; Robin *et al.*, 1998). What is less clear from the research evidence to date is how this work is affected by any individual work.

Our experience has taught us that a collaborative model is better for the young person, their family and the clinicians involved.

#### 26.2.1.4 Education

Many of the children and adolescents attending eating disorders services have highly perfectionist personalities. They and their families often express anxiety about not continuing with academic commitments. It is important to consider the education systems that young people are in when one is conceptualizing difficulties and planning interventions. Services working with children and their families frequently make routine contact with schools and colleges, and the information provided (in both directions) is often invaluable. Clearly, consent is sought for this contact to take place. Later on in therapy, the school or college may become a useful venue for carrying out behavioral experiments, and teachers may be needed to support the work being undertaken. A collaborative relationship with the school undoubtedly aids this.

In the case of an eating disorder where physical compromise has prevented school attendance, it is imperative that the establishment is contacted, so that the possibility of continuing with education is considered early on in treatment planning. Returning to school frequently presents the young person with a number of challenges (e.g., eating in front of peers; coping with comments following weight gain), and helping schools to understand some of the dilemmas that they face can aid their transition back to school.

#### 26.2.1.5 Friendships and peers

The patient's friendships must be considered. Not only are peers and social groups important in helping to understand the influences and attitudes that surround the patient (e.g., attitudes to weight and shape), they can also be important in the development and maintenance of difficulties (e.g., a young person experiencing bullying or teasing in their current peer group). Later in treatment, close friends can be used outside of the session (e.g., taking part in surveys of attitudes and beliefs), or can be invited to attend sessions to work on a specific and preagreed issue.

For example, Madeleine, a 15-year-old girl with a diagnosis of vomit phobia, made a promising start after engaging with a CBT program. Following six sessions, her weight for height ratio (Wt/Ht; see below) had steadily risen from 72% to 83%, and her anxiety levels were reducing (according to self-report and questionnaire scores) as she increased her food intake and range of food types eaten. However, as the CBT programme moved to a phase of increasing her eating at school, she began to report increased anxiety that did not reduce over time. On discussion, she talked about feeling misunderstood by peers, believing that they were

inappropriately labeling her as ''anorexic.'' She experienced this as an injustice, and expressed a wish that two of her closest peers should attend a session in order that the clinician could help her to explain the nature of her difficulties. This meeting was arranged with the consent of all parties (including all parents). Madeleine and her clinician spent time planning for the session, and the clinician helped her to think about what it was she wanted to achieve. Her friends were thoughtful and interested and expressed gratitude at the opportunity to ask questions, and in turn helped Madeleine to explain her difficulties to others at school.

Clearly, any such intervention needs to be considered carefully. In this case, the formulation that was guiding the treatment helped the clinician and young person to have an idea about whether inviting friends to attend was an appropriate course of action, or whether other therapeutic tools would be preferable (e.g., role plays).

### 26.2.2 Specific considerations when working with young people with eating disorders

As well as the issues that have been addressed so far, which are important when working with any young person, the following are important considerations when working with young people presenting specifically with eating disorders. While some of these issues are similar to those described when working with adults (as outlined throughout this book), many need to be adapted appropriately for the younger clinical group.

#### 26.2.2.1 Physical issues

Unlike many other disorders of childhood and adolescence, a primary task in the assessment and treatment of any eating disorder must be consideration of the physical state and development of the young person. Regardless of their diagnosis, young people with eating disorders often present in a severely compromised physical state, with associated risks to their physical development. It is essential that a comprehensive physical assessment should be completed by a medical practitioner. Ideally, this professional will be familiar with the complications associated with low weight or failure to develop along a normal growth profile. It is important to remember that weight is considered in relation to the typical growth charts that are based on young people of the same age. The patient may not have been losing body weight, but may have failed to gain weight over a period of time, resulting in a gradual deviation from the normal weight and height profile. For this reason, the use of body mass index is less helpful than ''% weight for height'' scales (Tanner *et al.*, 1966a,b) or BMI centiles when the patient is below 16 years of age.

As stressed in previous sections of this book, the effects of starvation must be considered. Although there is little research to test this, starvation appears to have

substantial effects on cognitive functioning with underweight young people. There are two important considerations here. First, there is enormous variation amongst young people in their apparent ability to think and to engage in conversation whilst at low weight. Some appear to be able to engage in therapeutic exchange, holding onto information from one week to the next, whilst others appear to be unable to do this. Second, there is a noticeable intellectual ''switching on'' of young people as their weight increases. Without exception, even in those situations where a young person has appeared to be alert and cognitively intact, we find that weight restoration improves the young person's ability to engage and hold onto information. This change has implications for the optimum conditions under which to begin a more active phase of CBT.

#### 26.2.2.2 Clinician stance

Given that the young patient may be at best ambivalent about attending, and may be hostile to considering change, the clinician must find a way of working with this. The majority of young people attending have at least a part of them that is frightened by their current situation, and are interested enough in what a service might have to offer that they might agree to engage with. The task for the clinician is to help the young person think about the pros and cons of their eating disorder without an underlying agenda, and to consider change without applying pressure to do so. The therapeutic stance is clearly critical (see Chapter 1).

One of the best tools to aid engagement is to adopt the stance of the ''curious clinician.'' The importance of genuine curiousness (i.e., a real desire to learn from the individual about their experience of her symptoms, rather than trying to fit them into a ''box'') cannot be overstated when it comes to enhancing engagement and increasing the likelihood that they will share information with the clinician. Often, this position enables the patient to become curious about themselves, which in turn enhances the possibility of engaging in contemplating change. The reader is advised to consider the issue of clinician stance (Chapter 1) in depth, since the same issues apply when working with a younger population. Families respond positively to the same approach, since the same principles apply to understanding and working with family systems.

#### 26.2.2.3 Motivation: the young person and their family

As with all therapeutic work undertaken with young people, it is necessary to consider whose motivation is driving the referral and attendance. Rather than seeking help for themselves, the young person is often taken to services by concerned adults who are requesting change, usually because they are concerned and want something to be different in their child. When working with the

eating disorders, the same factors need to be considered, but there is one additional consideration: the young person with an eating disorder may not see their experience as problematic, and may not see that they need to change. While this is the same core motivational issue as that outlined for adults (Chapter 6), there are differences in the domain of consent. Young people with eating problems frequently do not consent to seeking help. More often, they express the view that others are worried, but that they themselves are not, and that they would like to be left alone (an ''anti-contemplative'' stance). The clinician seeing the young person therefore finds that they are working with a (potentially) non-consenting client, and this will undoubtedly impact on the therapeutic stance (see tips to aid engagement, below).

It is never helpful to adopt a confrontational stance with a young person, challenging them on eating behaviors and beliefs about weight and shape. Rather, as with adult clients, it is imperative to adopt a non-judgemental, genuinely curious approach to understanding the young person's position. This conclusion applies equally to working with families. By the time that families reach a specialist service, they often feel blamed by professionals. Even where this is not the case, the family's self-blame is apparent. They are often exhausted, having spent months or years in desperate battles to feed their child, and their motivation to engage in many more months of treatment may be compromised by a sense of hopelessness. In addition, the functional importance of the eating problem must be conceptualized in both systemic and CBT terms. Young people are often still living within the systems in which their difficulties began and continue. The eating disorder may have functional importance within the family, interfering with recovery. In addition, the young person may not be able to contemplate any change while still living in the family setting. These are all important aspects to address and consider.

#### 26.2.2.4 Tips for aiding engagement

Working with children and their families often presents the clinician with challenges around the issue of engagement. As has already been noted in previous sections of this book, such challenges may be more prominent with this population because of issues such as the functional importance of the symptoms to the sufferer. When working with children and adolescents, the issue of who is requesting help makes this issue more complex. Our experience of working with young people with eating disorders suggests that both therapeutic style and practical skills can enhance engagement under these circumstances. As well as the approaches raised in other sections of this book (see Chapters 1 and 6), we find that the tips in Table 26.1 can aid engagement with young people and their families.

**Table 26.1.** Tips to aid engagement with young people with eating disorders and their families

- Get to the young person's level — cognitively, linguistically and emotionally
- Do not make assumptions about the patient/family and their experiences. Stay genuinely curious about who they are and what they have to say.
- Language. Listen very carefully to their language. *Never* use eating disorder terminology or jargon unless they do so first, and if they do then it is essential to ask what such terms mean to them (what is good or bad about it, etc.).
- Acknowledge the lack of power. ''I can hear that you don't want to be here today. It sounds tough, that adults in your life are making you do things you don't want to do. What would you do if you were left to your own devices?''
- Avoid getting drawn into confrontations with the young person, e.g., healthy weight.
- The reasons for and practicalities of non-negotiables (e.g., being weighed) must be explained to the young person.
- Be careful with externalization. Some young people respond well to the idea that their difficulties are separate to them, whilst others appear cross at this suggestion.
- Ask permission to talk about their difficulties (eating). If they refuse, talk about a more comfortable area and return to the issue of eating later on, explaining the importance of hearing their views on this.
- Take a ''one down'' position, particularly initially (e.g., ''Could you help me to understand how things are for you/what that means to you?'')
- Explain what is going to happen when you meet. This minimizes surprises, and allows the young person to feel less out of control.
- Find out if the young person has any questions, and attempt to answer them.
- Ask permission to guess. This can be a useful technique with young people who are reluctant to talk.
- Use the experiences of other young people (e.g., ''Sometimes, other young people who I see here say that . . . Does that sound like the kind of thing that might be true for you/apply to you?''
- Draining. Allow the young person to keep talking about the issues that are on their mind until it seems that they have finished everything they want to say, until they are ''drained.''
- Cope with the young person's direct questions (e.g., ''Do you think I look fat?'') without perpetuating prior patterns (e.g., ignoring the underlying need for reassurance that drives the question).
- Be active in seeking information and engagement, rather than assuming that the patient will strive to engage with you (e.g., do not sit silently throughout the session until the patient talks).

#### 26.2.2.5 Confidentiality

Confidentiality has been included in this section (rather than among the general issues raised above) because, while it is clearly an important consideration in any therapeutic work, it is often an area that presents particular difficulties with this population. Since eating disorder symptoms are often shrouded in shame and secrecy, it is common for families to be unaware of some of the symptoms. It is unlikely that a young person will spontaneously disclose details of symptoms, but when asked directly they often express relief at having spoken about them. It is then necessary to consider which adults need to know this information, and the clinician may be asked not to tell anyone.

It is important to have a detailed conversation at the start of any therapeutic contact about the boundaries of the work and the issues for confidentiality, thus providing a safety net (for the patient, family and clinician) when such a situation occurs. At the very beginning of any assessment with a family and young person, the ''rules'' of the contact are outlined. With the family, this involves a conversation about who makes up the team, what information will be shared among them, what information will be shared with referrers and what (if anything) they would rather not have shared with their child. When assessing the child on their own (see below), we introduce the issue of confidentiality at the start:

> Before we begin, I would like to discuss with you the ''rules'' for our meeting. I know that you have seen professionals before and that these rules may not be new to you, but I think it is important that we spend a minute on them now. This is a private space, a chance for me to hear from you some of your ideas and thoughts about what is going on. It is important that you have the chance to talk about things that it may be difficult to say in front of others. Although it is private and what you talk about can be kept in this room, there are two exceptions [or ''buts,'' depending on the patient's age] to this. First, if you were to tell me something that meant that you were in some kind of danger or at risk, then I would have to tell some other adults about that [clinician may need to explore what risks or danger are, depending on age]. Second, if you were to tell me about another young person who is in danger or risk then the same would apply. I would not do this without telling you, and would probably say something like ''Do you remember when we talked about the things I would have to tell other adults, well that is something.'' We will then be able to talk about who needs to know and how we should tell them. Does that make sense to you? Do you have any questions about any of what I have just said?
>
> OK. At the end of our meeting I will write a report about some of what we have talked about and my ideas. This will be written to you and your family, and copies will be sent to the people who asked us to see you. I tend to write general rather than specific details, but if there is something that comes up as we are talking that you do not want to be in the report, then could you mention it and we can think together about who needs to know the information? Any questions about that?

Outlining the confidentiality issues from the outset provides the clinician with a safe reference point for explaining why confidentiality may need to be broken, and gives the patient a safe framework in which to begin sharing details of her experiences.

For example, Sasha (a 15-year-old female with a diagnosis of anorexia nervosa) disclosed in the assessment session that she had been vomiting into carrier bags and hiding them in her bedroom until she could dispose of them. Her parents were mystified by her failure to gain weight, as they had no knowledge of her vomiting, and Sasha asked if the clinician had to tell them. The clinician discussed with Sasha the seriousness of her low weight and the added risk from vomiting, and explained that she would have to tell Sasha's parents and other members of the treatment team about this behavior to ensure her safety. A lengthy discussion followed about how and when to tell her parents.

#### 26.2.2.6 Comorbidity

As with adult patients, children and adolescents who present with disordered eating frequently describe and present with other difficulties. Research on prevalence and incidence of comorbid problems is limited with this age group, but a significant number of young people who present have concurrent difficulties with other disorders (Cooper *et al.*, 2002). Our experience suggests that these comorbid difficulties may be either primary or secondary to the disordered eating, and management will need to be adjusted accordingly (as is the case for adults — see Chapters 24 and 25).

#### 26.2.2.7 The importance of working within a multidisciplinary team

Our experience of working with young people and their families with eating disorders has highlighted the importance of working within a multidisciplinary team (MDT). The NICE guidelines (National Institute for Clinical Excellence, 2004) state very clearly that such an approach is essential. This approach means that young people and their families have access to the different professionals who are needed to tackle the complex and multifaceted nature of the disorders. In addition, working within an MDT team means that no one professional is left holding the complexity of any case alone (although it is crucial that there is clarity of roles for the different professionals, and that lines of communication are open and clear, in order to limit the possibility for splitting). We find that regular team meetings, shared care plans (drawn up in collaboration with young people and their families) and transparency with families and colleagues help to facilitate the process.

An additional feature of this model of working means that the young person and their family are able to continue working with clinicians in the absence of another.

For example, Chloe (a 14-year-old girl, referred with anorexia nervosa) was approaching her healthy weight range when the clinician who was working with her individually (using a CBT approach) was due to be on leave. The fact that she was engaged with family therapy, the dietician and regular physical monitoring with a psychiatrist meant that there were a number of professionals who could support her over this period. This issue was discussed in a therapy session and then with the team. It was agreed that Chloe would see the psychiatrist, and she and her CBT clinician thought together about what she would find helpful, in terms of the CBT techniques she had been working on so far (with specific regard to the meaning of her approaching healthy weight). This information was handed over to the psychiatrist jointly by Chloe and her clinician, to avoid any confusion or splitting.

## 26.3 Assessment

The principles of assessment with this group are the same as those outlined in Chapter 4. However, when working with children and adolescents, it is necessary to carry out more than just the individual assessment with the identified client. We recommend a broader assessment, including a family assessment, an individual assessment, completion of questionnaires and other psychometric measures, and physical assessment. The team meets to discuss their ideas and feeds back to the family at the end. Such an assessment takes several hours.

The initial assessment meeting involves the whole family and all members of the assessment team. The aims of this part of the assessment are to engage the family and to identify their hopes and fears about the meeting (see Christie *et al.*, 2000). The way in which the patient participates and interacts in the initial part of the assessment can give valuable information about how to proceed in the individual part of the assessment.

For example, Claire was a 14-year-old girl with a two-year history of low weight, food restriction and depression. She was referred to the specialist eating disorders service following failure to gain weight with her local child and adolescent service. In the initial part of the assessment, she sat with her head down, looking increasingly irritated as members of her family talked about their views of why they were at the service and what they wanted. Despite attempts to include her views, Claire remained largely silent, responding with only a few shrugs and ''don't know'' answers. At the start of the individual assessment, the clinician commented:

**Clinician:** I know I have only just met you so I don't know you, but I can't help noticing that you didn't say very much in there, and you seem to me to be cross about something.

I could be wrong, but although you have been quiet so far, I am wondering if there is something that you would really like to say to people in that room?
**Claire:** (pauses) Yes I would. (She smirks)
**Clinician:** Something is amusing you?
**Claire:** Yes. (pauses) Am I allowed to swear?
**Clinician:** (smiling) Would swearing help you to express what you want to say?
**Claire:** Yes. I want to tell them all to f**k off!

This brief example highlights the usefulness of reflecting on the early part of the assessment in the individual session. It allowed humor to be shared between the clinician and client, and freed Claire from her anger and irritation. She was then able to engage in conversation about why she wished to say this to her parents and what she wanted to say that she felt no one was listening to. Ultimately, she was able to acknowledge some of her fears about coming to the assessment and giving up her eating behaviors.

The starting point of the individual assessment is to acknowledge the young person's ambivalence. They may be feeling powerless, and therefore they are more likely to retreat into their eating disorder if they feel challenged to give it up. They have often had the experience of being coerced into giving up their eating disorder, experiencing her parents' attempts to take control of their eating as intrusive. In response, they can get into escalating battles with their parents as their desire to hang onto the eating disorder strengthens. The clinician who demonstrates genuine interest in the young patient's experience (without an agenda) is far more likely to begin an alliance with that patient, providing a useful tool for change later on. Aside from needing to reflect the issue of the patient's enhanced sense of powerlessness, the clinician stance here should mirror that described earlier (Chapter 1).

### 26.3.1 The purpose of assessment

The aims of assessment are fundamentally the same as those outlined for adult cases (see Chapter 4). However, simply to conduct the individual assessment in the absence of the family assessment is to carry out an incomplete assessment. Issues of diagnosis, comorbidity, risk and motivation for the young patient must be considered within the family system. The aim is to gain enough information to be able to make some recommendations about what to do next. However, a number of factors can complicate this process, particularly when planning to implement CBT:

- there is a lack of research evidence to guide clinical decisions
- the patient may have been silent for extended periods
- there can be starvation-induced difficulty in accessing cognitions and feelings (thus making re-feeding the initial goal)
- there might be resistance (by the patient and family) to individual work

- in some cases, there is a need to make a decision to arrange an in-patient admission, with the concomitant impact on engagement and treatment outcome (Gowers *et al.*, 2000).

### 26.3.2 What information do you want?

An essential part of any CBT assessment is to gain enough information to enable the clinician to begin to formulate the person's difficulties and to propose a treatment and intervention plan. However, the factors mentioned above will impact on the clinician's approach to getting this information. As is the case with many adults, the process of assessment is not always straightforward. Nor is it simply a matter of getting the information needed by asking the questions. Our experience suggests that the primary focus of the initial assessment with any young person should be one of engagement (see Table 26.1), focusing on the young person's perspective and agenda during the assessment. This initial approach can resolve the conflict between the perspectives of the clinician (who might have a list of topics to cover) and the young person (who might have come to the assessment with a wish to remain silent or with something specific they want to talk about that does not match the clinician's agenda).

As the engagement with the young person develops, we consider the information in Table 26.2 to be important. We have divided it into information that is similar to that outlined when assessing adult cases (Chapter 4) and information that is more specific to younger patients and their families, although the assessment sessions themselves need to gather this information in a flexible way, rather than in the order presented in Table 26.2.

It is important to note that this is a guideline only. It is extremely unlikely that information will have been gathered on all of the areas by the end of the initial assessment session. In an ideal situation, however, the process of the initial contact will facilitate the young person and clinician forming enough of an alliance to maximize the likelihood of the young person being (more) willing to attend in the future. In addition, the clinician will ideally be in a position to make some initial recommendations about how to proceed with treatment. Ultimately, if the clinician is to know how to proceed, a clear cognitive conceptualization is just as essential as it is with adults.

### 26.3.3 Tips to aid in getting the information required

Although adults with eating disorders are often ambivalent about change and this can get in the way of getting information at assessment, the issues of consent and loss of power make this issue more pertinent in children and adolescents. In our experience, young people often use silence or guarded sharing of information as a means of making them feel more in control and powerful

**Table 26.2.** Areas to include in the assessment of young cases and their families

*Areas that are similar to those addressed with adults (see Chapter 4)*
- Demographic information
- Eating behaviors
- Physical status (Wt/Ht% or BMI)
- Central cognitive elements
- General health
- Comorbid behaviors and disturbances
- Risk assessment
- Treatment history
- Family structure
- Life history
- Additional assessment of cognitions, emotions and behaviors

*Areas that are more specific/relevant to younger patients and their families*
- Motivation and interest in treatment options for both young person and family
- Educational history and current situation
- Highest childhood weight reached
- Peer relationships
- Who is worried?
- Current family situation and relationships (including relationships with food)
- Pubertal stage and psychosexual maturity (ask about aversive experience)
- Developmental stage

over families and clinicians. They may have little choice about attending services, but feel in control about what they share of their internal experiences. Additionally, although not confined to working with children and adolescents with eating disorders, a number of factors (such as developmental stage, cognitive maturity, starvation status and linguistic capacity) may make accessing the internal processes of thoughts, feelings and images more problematic. As well as the tips for engagement (Table 26.1), Table 26.3 outlines some of the strategies that we find helpful in getting the information that is important.

## 26.4 Motivation

Patients who feel compelled to enter treatment (with any diagnosis) are likely to feel coerced, unheard and invalidated. In our experience, this is often the position of the child or young person who is brought along for treatment. Therefore, recognition of this loss of power and control must form the premise for the engagement. When considering motivation, the Stages of Change model (Chapter 6) can be as useful with children, young people and their families

**Table 26.3.** Strategies for getting information more readily from young people and their families

- Find out how the young person experiences their eating problems (e.g., "the voice")
- Use of other agencies: questionnaires, families, schools
- Psychometrics (e.g., EDEQ — Fairburn & Beglin, 1994; BDI — Beck & Steer, 1993a; BAI — Beck & Steer, 1993b)
- Assessment of cognitions, feelings and images: use of imaginal exposure (e.g., to feared situations, such as a plate of a feared food). This can provide access to thoughts and feelings
- Use lifelines: coding times according to feelings such as happiness, or beliefs about shape and weight, popularity, etc.
- Use of toys, pictures, games, etc.

as with adults. We find it useful to represent this model as a diagram for our younger clients, as a way of visualizing the stage they are at and where others would like them to be. It is helpful continually to acknowledge the differences in motivation between families and the young person. Effective models of treatment for the eating disorders in young people have one fundamental difference to those employed with adults: the patient is not invited to take full responsibility for their life and the choices that are made about their treatment. Instead, the adults involved are supported in taking control of their child's food, taking from them the responsibility for choice and control of eating (e.g., Lock *et al.*, 2001). It is not surprising then that many young people report feeling "pushed through" treatment. They return to a normal weight, but sometimes with little or no cognitive change or motivation for long-term behavioral change. Chapter 6 of this book describes a number of ways that such issues can be addressed with adults. In addition to these, we have found techniques that are helpful with our younger clients.

### 26.4.1 Motivational techniques

When working with poor motivation, it is helpful for the clinician to keep in mind that the young person has probably not had many experiences of feeling listened to. It is essential for the clinician to try not to become another person who is "doing to . . . " the young person, and the clinician must work with any (initial) resistance and lack of motivation. We are more likely to facilitate a useful therapeutic relationship if we adopt the therapeutic stance of not being yet another adult who has the sole aim of removing the young person's symptoms. The following list outlines some of the techniques we have found useful when working with motivation. Some of the techniques are the same as those described in Chapter 6 of this book, but need to be adjusted for younger people.

- *Life plans.* This technique can be used in the same way as described in Chapter 6, but with younger patients we find it is helpful to shorten the time boundaries attached. Young people are likely to find looking to the future over many years more difficult than linking the future to specific events, such as going to university, a planned family holiday or the start of a new school term. We have found that it can be helpful to ask the young person to write a piece on how they would like to be remembered in their school year book, in order to help them begin to think about what role they see their eating problems having in their future. The same issue applies when using the "miracle question" (Chapter 6).
- *Friend or foe letters.* As with adult patients, this is a useful technique when working with younger clients. However, children often find the linguistic context of this task challenging, and we have found that a similar task can be to draw pictures that represent "my friend" or "my enemy."
- *Pros and cons lists.* This technique can be used equally well with younger patients. However, the young person is likely to need more help in developing lists than an adult, and the clinician will need to pay careful attention to avoid coercing the child into finding answers that are not their own.
- *Pie charts.* Younger clients like things to be visually represented wherever possible, and consequently we find that they work well with pie charts. Most commonly, the pie chart is used to represent the different areas that a young person considers important in their life and the proportions given over to each. Once this has been constructed, they are asked to create an "ideal" pie chart — one that represents how they would like their life to be. The two can then be used side by side, and the clinician can think with the patient how they could move from one to the other, what would need to happen for this to be possible, and so on. It is important at this point to acknowledge how much of their current identity is taken up by issues to do with eating, weight and shape, and what could replace this element if the patient were to consider change. The pie charts are a useful visual mechanism to consider this and to consider progress through therapy.
- *"Inviting the eating disorder into the room."* Our experience has taught us that patients are relieved to have a way of discussing their internal experiences with someone, using the patient's own language. For example, Isabel (a 13-year-old) talked regularly about how: "anorexia is beating me up for talking to you." She found this a useful way of separating her more functional self from the anorexia (what she called "her"). The clinician can then work with the young person on thinking whether she might like to get some space for herself, away from "her."
- *Use of other patients and families.* This strategy is useful for enhancing motivation with both young people and their families. We ask families and young people who are at later stages of treatment or recovery to be available to

offer support and information. This system often provides a powerful and credible source of tackling hopelessness, and keeping alive a belief about the possibility of change.

- *Control*. It is important to acknowledge the young person's lack of control over decisions and treatment. It can be important to work together to consider other areas of their life that they may have more control over (e.g., caring for pets, schoolwork).
- *Psychoeducation for parents and young people*. This has been covered in more detail in Chapter 13. However, when working with younger patients, information must be given to both the patient and family. We find that giving parents information on long-term health problems and what to expect throughout the recovery process is useful in maintaining parents' motivation to change and assist in CBT. For more information on the process of change with young people, readers are referred to the stages of change model proposed by Lask (2000).
- *Flash cards*. With younger patients, it is useful for them to write down supportive statements to help them to cope at the times when they have identified as the hardest to keep going. For example, Joseph, a 15-year-old boy with anorexia nervosa designed a flash card that he laminated and kept in his pocket at all times. It read: ''DON'T DO IT! YOU WANT YOUR LIFE BACK AND YOU WILL NEVER GET BACK TO FOOTBALL IF YOU CHEAT.''

## 26.5 Case formulation

Clinicians working with patients with eating disorders can feel overwhelmed by the complex nature of the patient's presenting problems, regardless of the age at which they present. All of the issues relating to case formulation that have been covered in Chapter 8 apply when working with a younger population. A formulation is just as crucial an element of CBT when working with younger patients, but there are differences in how this is done to reflect the nature of the patient (developmental level, family position) and the evidence in support of specific models.

At the end of the assessment, we find it is helpful to try to feed back an initial formulation to the young person and then to their family. At this point, this formulation is not linked to a specific theory of the eating disorders, but is related more generally to the principles underlying CBT models, that:

- problems are multifaceted in their nature,
- behaviors have both distal and proximal triggers
- thoughts, feelings, behaviors and the environment are all important factors in both the development and maintenance of presenting problems.

When communicating such ideas to our younger clients, we find that we must pay careful attention to their language, their level of cognitive functioning and their interest in being understood, and we adjust our feedback accordingly. For example, at the end of an initial assessment with a 15-year-old girl called Zoe, the clinician offered the following initial formulation:

**Clinician**: OK Zoe. Well, we have just about come to the end of our time together today, but there are a few things I would like to end with. I wonder — have you done any thinking about some of the reasons that might explain why you are sitting here in a room in front of me in this service?
**Zoe**: Well yes I have, but I don't really understand how it has got this far.
**Clinician**: It sounds as if it might all be a bit confusing to try and make sense of. Would you be interested in hearing some of my ideas based on what we have talked about today?
**Zoe**: Yes, I would.
**Clinician**: Well, it sounds from your description that you struggled as a young child when your youngest sister was born, and that you felt a bit left out of your family. Although you were happy at school for many years, you said that moving house and changing schools when you were 11 was very difficult for you, since you went to a school that none of your closest friends attended. That time, you said, coincided with changes in your body that you found difficult to talk about with your new friends, as you felt you were developing earlier than they were. You said this made you feel very self-conscious and different to the other girls, and you remember first wanting to lose weight at about this time. You also told me that you have always given 100% to your academic work and have felt disappointed when your grades have not been A's. I think you also said that your family also has expectations that you and your siblings should work hard and achieve top marks. Is that right?
**Zoe**: Yes. Only last week, my sister got an A and got taken out for a meal.
**Clinician**: Right, so with all of this going on and the increased pressure from your looming exams, I wonder if it is possible that what started as a diet has developed into you finding a way of coping with your difficult feelings? What I mean is, do you think that following your strict food rules and focusing on food seems a little more straightforward to you than other issues that are going on in your life right now?
**Zoe**: Definitely. I think I feel less stressed when I am concentrating on food than what I want to do with my life and the fact that I might fail my examinations.

It is always useful for the clinician to see how the young person responds to this initial linking of ideas. Once therapy has begun, a more comprehensive formulation can be developed. However, as with adult patients, the timing of this piece of work is crucial. The young person must be motivated, interested and cognitively intact enough to contribute to the formulation, and to take at least some of it on board. As with the above example, when the clinician feels the patient is motivated, this process can be introduced again, using the same style of inviting the young person's interest in her "story."

The formulating of the case can then proceed according to the principles outlined in Chapter 8. Although some young people are able to engage in the process of formulating without too much difficulty, others find it helpful initially to engage with this task by formulating using a fictional person. The young person and the clinician generate basic information about a fictional person (e.g., a 15-year-old girl who is low in weight and worried about her appearance), and then invent information that might explain some of her behaviors. The distance from their own experience can often be a useful way to introduce the ideas and concepts involved in a CBT formulation, and can offer the young person who is less motivated to change a way of engaging with the process of understanding some of the factors that might be important in the development and maintenance of their own problems. The clinician can use the young person's response to the fictional person to guide the delivery of the young person's formulation.

In any area of work with young people, clinicians must proceed with caution and respect when addressing possible family and parental factors. It may be tempting for the clinician to adopt a "parent blaming" approach, but this is ultimately unhelpful. The young people who we work with are very sensitive to this possibility, since it has often been their experience of services to date. This appears to have resulted in the development of "antennas" that are very sensitive to any evidence of their parents being blamed. We have found that the analogy of a "tool kit" can be helpful here:

**Clinician**: As part of thinking about your difficulties, we need to think about the relationships and factors in your family that may be important. If we are going to understand how your problems have developed and what is keeping them going, then we need to spend some time thinking about where you live and who you live with. I want to be really clear that I am *not* saying that this is anybody's fault. We are not trying to find anyone to blame, but the important relationships in your life are important for us to think about. One way of thinking about this could be in relation to a "tool box." Each of us has a tool box, containing different tools to help us cope with everyday life. We inherit some of the tools from our parents, and we collect some along the way through our experiences of life. So, when our parents became parents, they each had different tools in their boxes. As babies and children grow up, they need different tools from their parents to help them along the way. Sometimes there are no difficulties with this — say the baby needs a spanner to fix it, and the parents have one that fits — but at other times they may not have one or have the wrong size. It is not that they don't *want* to help, but their tools are not quite right. This is because they have either not inherited the necessary tools from their own parents, or because life has not allowed them to collect the necessary tools.

The clinician can then proceed and explore the nature of important relationships, using ideas around tools needed and tools available. This analogy can also

be used where the clinician is aware of either past or ongoing abusive relationships, although caution is recommended when doing this. For example, it can be used to think about why a mother continues to use alcohol, given her own experiences of being parented. However, the clinician must keep in mind issues of ongoing risk and safety, especially where the young person continues to live within a potentially abusive context.

## 26.6 Interventions

Regardless of the age of the client, any cognitive-behavioral intervention must be based on an individual case formulation. The problems in diagnosing eating disorders with a younger age group were touched on earlier in this chapter. Such problems highlight the importance of assessing, formulating and intervening on an individual level rather than at a diagnostic level. Before starting any intervention, the clinician must prioritize the physical needs of the young person. Although it is possible to proceed with interventions whilst at a low weight, this must be alongside regular physical checks and dietetic monitoring. Although unsupported by research to date, our experience of working with these young people suggests that they become more cognitively "switched on" at about 85% Wt/Ht. In other words, when approaching a healthy weight, CBT appears to be more possible as a result of some increase in cognitive capacity. Particular features to look for are the following:

- some flexibility in thinking
- more capacity to listen and retain information
- less interference from the "anorexic voice"
- ability to concentrate.

However, this figure of 85% must be considered as an anecdotal guide and an approximation, since all the young people who we see are individuals and respond differently to loss of weight and resulting cognitive deficits.

When working with any young person, the clinician must continually appraise their cognitive functioning and motivation, and adjust the interventions as appropriate. Our experience of working with CBT for children and adolescents with eating disorders has suggested the following phases of treatment, once physical stability and some cognitive flexibility have been established:

- motivational enhancement
- cognitive-behavioral change, including a "real world preparation" phase and addressing any comorbidity
- relapse management
- ending.

It is important to emphasize that these are not discrete phases, with clear start and finish points. Rather the individual will move between them at all stages of the treatment process. However, for the purposes of this chapter, each will be addressed in turn, considering the specific factors relevant to young people and their families.

### 26.6.1 Motivational enhancement

The issues and techniques involved in this element have been covered in Chapter 6 and earlier in this chapter (Section 26.4). In essence, this element underpins all of the work that follows, and the clinician must work continually with the patient's (and family's) fluctuating level of motivation. When working with very unmotivated children and adolescents, there are occasions when the clinician does a time-limited piece of work addressing the young person's motivation and then takes a break before re-assessing their motivation at a later stage. In our experience, it is better to take a break and re-evaluate than to get into the position of "battling" with the young person's resistance. This issue is revisited in Section 26.7.3 of this chapter.

### 26.6.2 Cognitive-behavioral change

CBT can proceed when the child or young person has some motivation (i.e., is interested in the possibility of change) and appears to be functioning cognitively in such a way that they can begin to use it. Many of the techniques we use with this age group are the same as or similar to those described in other sections of this book, but are adjusted for developmental stage and cognitive capacity. The fundamental difference is likely to be in the style of delivery, since individual CBT with this age group is usually delivered alongside family work, providing unique opportunities and challenges for cognitive restructuring and behavioral experiments. For a more comprehensive review of CBT techniques and interventions with younger children, see Stallard (2002). Wilson and Sysko (2006) have made a strong case for applying the Fairburn CBT model when working with bulimia nervosa in adolescents. Therefore, there are many lessons from previous chapters on adult cases that can be applied when treating with such cases. However, the prevalence of full bulimia nervosa cases in this younger age group is lower than in adults, and many suffer only partial syndrome eating disorders. Therefore, it has to be stressed that the transferability of these techniques may be limited unless one adopts a relatively individualized approach.

Below, we consider:

- general issues when intervening with the eating problems of young people
- techniques for working with eating, weight and shape concerns

- techniques for working with eating disorders that do not have eating, weight and shape concerns at their core
- working with patient–clinician relationship issues that arise with younger cases.

#### 26.6.2.1 General considerations

Regardless of the underlying features of the individual's eating disorder, there are a number of factors that we have found helpful when applying CBT principles and theory to this client group.

- *Language*. We discuss cognitive behavioral theory and therapy in language that seems to make most sense to the young person. For example, although many adolescents appear to have the capacity to understand the concept of "core beliefs," many do not. Similarly, younger adolescents and children find this idea difficult. Most commonly, we find that the term "bullies" makes more sense than "core beliefs." The clinician can then talk about these "bullies" fighting to stay alive, having been around for years, and being very difficult to change or get rid of. When discussing schemas and how they influence a young person's view of the world and incoming information, we find it useful to describe this to them as if they have a video camera on their head that has a filter on it that screens out some information and focuses in on others. This idea provides a useful way to help them begin to notice the way in which they "filter" the world.
- *Homework*. This is a key feature of CBT, and a frequently challenging area for the clinician. Young people are notoriously poor at completing homework tasks, particularly diaries (Christie, 2000), and this matches our experience. Unlike the stance taken with adult patients (Chapter 9), non-compliance is unlikely to make us withdraw a session or therapy in the short term. Instead, with a younger population, the clinician needs to focus on tasks being completed within the session and on time-limited tasks that are easy to complete between sessions. However, should it become clear that the key issue is a lack of motivation, such non-compliance might result in termination of treatment in the long term.
- *Food diaries*. Although these are considered just as important as they are with an older population (Chapter 14), the responsibility for collecting the information may not rest with the young person. The clinician needs to consider carefully how this issue is tackled. For all diaries, we find that drawing out an individualized diary is more meaningful. With younger children, we find that using pictures, colors and symbols can be a helpful way of eliciting information for the young person to make sense of.
- *Agenda setting*. Although this is an important part of CBT in general, the younger patient may find it harder to stick to a firm agenda. We recommend

greater flexibility than with adults, since adolescents in particular seem to have pressing issues to talk about that have arisen in their lives, and that were not on the preagreed agenda. Clearly, if a pattern of difficulty sticking to preagreed tasks emerges, that pattern may be indicative of avoidance of the work, and the clinician will need to tackle this directly. However, where this does not appear to be the case, we recommend a space at the beginning of each session to "off-load" any current and pressing issues and feelings.

- *Thinking styles.* Younger people are more likely to describe absolutist thinking. There may be a need for relatively "concrete" behavioral tasks to address this.
- *Weighing.* As with an adult population, weighing is an essential part of CBT with younger patients. Broadly, we address it in the same way as described in Chapter 15. However, it is important to consider how the information will be shared with family and team members and to remember that young people generally have less control over their eating and weight than adult patients.
- *Psychoeducation.* This is as important with young cases as it is with an older population, but families and caregivers must be included more routinely.

#### 26.6.2.2 Techniques for addressing eating, weight and shape concern

When working with children and young people who have the core features of eating, weight and shape concern maintaining their eating disorder, the techniques described in Chapters 16 to 23 can be applied.

In essence, the task inherent in this phase is to help the child or adolescent to develop strategies for surviving life without using food as a way of coping. They need help to establish emotional and cognitive distance from this method of coping, and to begin to consider healthy alternatives. The following represents useful techniques for addressing these issues with a younger population:

- *Cue cards.* Encouraging the patient to fight the eating disorder "voice" (e.g., shouting at the "voice"), and allowing themselves to see that the eating disorder perspective is only one way of viewing the world (e.g., visualizing themselves as standing next to the eating disorder).
- *Letters.* As well as using letters for motivational purposes (Chapter 6), we find that they can be used in a number of other ways. These include the generation of alternative thoughts (e.g., writing a letter as if from a best friend that details the patient's likeable personal qualities; considering the pros and cons of saying "goodbye" to the eating disorder).
- *Visualization.* Young people often respond well to visualization tasks (see Chapter 22). For example, Karen (a 15-year-old with anorexia nervosa) talked at length about the difficulty she experienced getting any mental distance from her anorexic voice. She described it as constantly "shouting" at her,

and that this was worsening the more she challenged her beliefs by eating and gaining weight. Based on Karen's input about what she felt would need to happen to facilitate some "time-out," she and the clinician came up with the image of flushing the anorexia away. To make this image more powerful, Karen and the clinician discussed at length all the sensory elements to the image (smell, sight, sound, feel), and came up with the image of the anorexia pouring off her and down the drain. Karen practiced visualizing this set of images, and reported increasing success at getting distance from her anorexic voice.

- *Diaries.* These are used as with adults (Chapter 14), in order to gain further information on thoughts, feelings and behaviors, in relation to food and eating and other significant factors.
- *Continuum thinking.* As with adult cases (Chapters 19 and 22), we find this to be a vital technique. Younger people seem to be particularly prone to black and white thinking and very high levels of perfectionism. Drawing a continuum with a young person and working with them on issues along that continuum can be a particularly helpful way of highlighting this thinking style. For example, as is the case with many adult patients, many of our younger clients state an initial goal of treatment as: "to be completely happy with my body." We find it useful in such cases to draw a continuum with unhealthy body image at one end and healthy body image at the other. We can then use the continuum to write on information about what would define points along that continuum, including information on what others would say. The continuum can also be used to track points in their history when the person has been at different points along this line, and they and the clinician can consider what have been the influences on such differences. Clinician and patient can consider what would need to happen for them to move along the line.
- *Tasks to highlight the concrete world of the eating disorder.* Young people are often more concrete in their cognitive style than older clients, and we find it important to address this style. Continuum thinking is useful here (see above), but the patient's weight and carbohydrate intake may be limiting factors in the early stages of treatment.
- *Drawings.* Young people often find it easier to express themselves in pictorial form. We encourage the use of whichever medium of expression the young person is most comfortable with, taking time to establish how we as clinicians can understand what is being communicated. For example, some young patients find it easier to demonstrate their feelings about their weight and shape by drawing how they see themselves. Such pictures can be used in a number of creative ways by the clinician to assist the young person to address their eating, weight and shape concerns (e.g., by carrying out a survey with friends in order to determine how they see the patient – see Chapter 22).

- *Diagrams.* Young people are often more able to grasp concepts and ideas if they are presented in a visual format. We often draw diagrams (based on the formulation principles outlined in Chapter 8) in order to link ideas in a visual format for the young person. Wherever possible, tasks for homework are created together with the young person in a visual form (e.g., pie chart, continuum line, drawing, documenting angry feelings on an "anger thermometer," rating feelings of fatness on a scale of varying sizes and noting associated situations and thoughts).
- *Friends.* Where appropriate, it is often useful to involve the friends of our younger clients (see above). That involvement can include engaging them in psychoeducation, surveys and behavioral experiments.
- *Behavioral experiments.* As with older clients, these are the most powerful of our CBT techniques. For example, weekly weighing provides a regular opportunity to test beliefs about the relationship between eating and weight. This allows the patient to engage in manipulating their eating in a planned way in order to discover whether their eating, weight and shape beliefs are accurate or not (e.g., will they put on weight uncontrollably, binge more, be rejected by friends).
- *Cognitive restructuring.* The techniques described in Chapters 18 and 22 apply here. In addition, the use of role play can be helpful to challenge automatic thoughts and core beliefs in younger eating-disordered patients, using dialogue techniques (see Chapter 25). Initially, the young person engages in the role play as themselves, arguing the case for their belief (e.g., "I am fat"; "I am unlikeable"). In the second phase, the clinician and client swap roles. This time, the clinician argues for the core belief and the young person must argue against it. Young people usually respond well to this exercise, often becoming quite animated and engaged in the task. In addition, as a way of identifying unhelpful cognitions and restructuring them, we continually refer to the idea of a video camera with a stuck filter, in order to highlight for the young person how limited their perception of her world is. Other authors (e.g., Eivors & Nesbitt, 2005) have also addressed the issue of how to address issues of eating, weight and shape concern.
- *Using the young person's own visual aids/representations.* Many of the young people we see are very creative, and are able to use their creative skills to aid the therapist in understanding their internal experiences. We have found that it is crucial to work with whatever material is brought to sessions. This stance often includes using material that may not have been discussed and planned ahead of time. The task for the therapist is to find a way of integrating this flexibility with the CBT principles. For example, Gemma (a 15-year-old diagnosed with anorexia nervosa) arrived in one of her early sessions with a

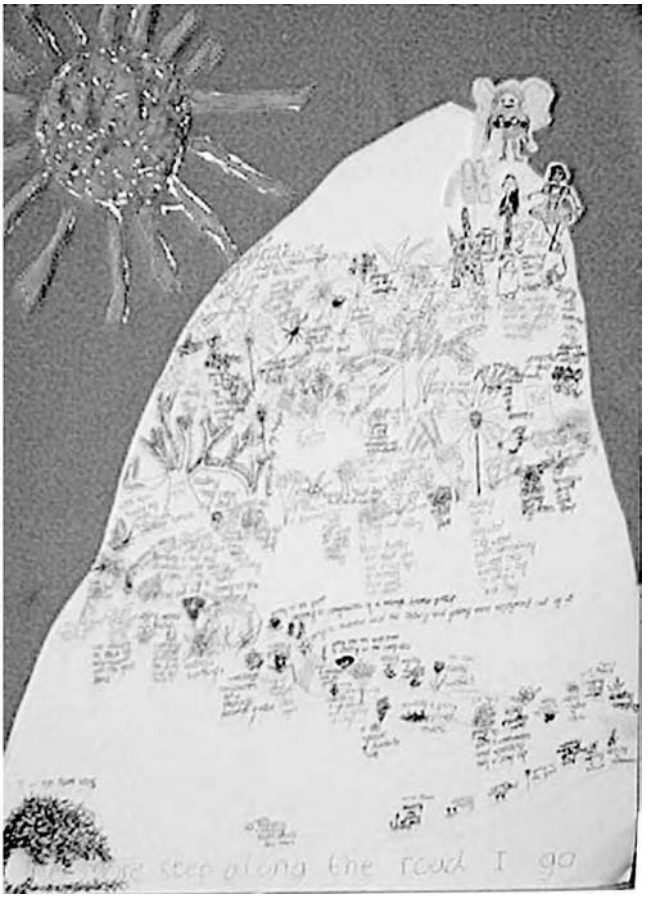


Figure 26.1 Gemma's mountain image.

picture of a mountain that she had drawn (see Figures 26.1 and 26.2*). She was keen to explain to her therapist how this mountain represented her view of recovery, and the steps and goals that she had identified as necessary. She had taken time to draw out this image, using key members of her family within it, rendering it in such a way that made sense to her. The therapist used this image in future sessions, using Gemma's language to explore issues related to taking risks and steps towards recovery. What became apparent immediately in the initial discussion of this picture was Gemma's belief that the therapist might think that she was "silly" or "childish," which gave the therapist the opportunity to tackle Gemma's core beliefs around not being good enough.

*Patient's name changed for purposes of confidentiality, and permission obtained from the patient and her parents to use these drawings.

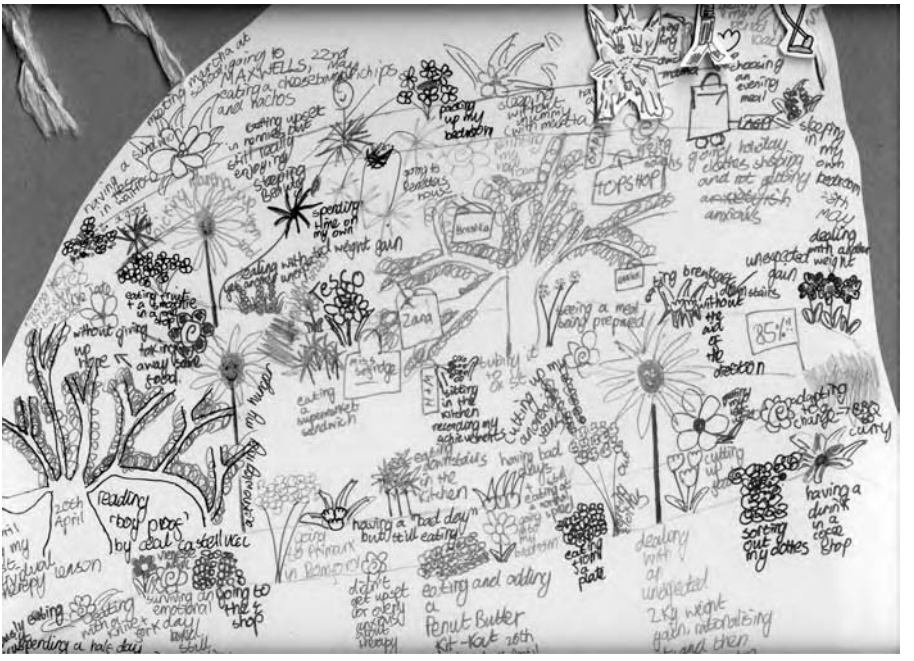



Figure 26.2 Gemma's mountain image – detail.

### 26.6.2.3 Techniques for working with eating disorders that do not have weight and shape concern at their core

Avoidance of a healthy diet and resulting physical compromise can present in the absence of overvalued ideas about weight and shape or a distorted body image. This may be for a number of reasons, as outlined here.

*Cognitions relating to eating, weight and shape are masked*

First, it is possible that the young person is unable to conceptualize and verbalize such beliefs, given their cognitive capacity. The level at which the young person is functioning must be the level at which interventions are targeted. For example, Lisa (an 11-year-old girl, with a seven-month history of dietary restriction and extreme weight loss) denied any concerns about being at a higher weight, explaining her avoidance of fatty foods in terms of making a healthy choice. She said that she would like to weigh more and that she saw herself as too thin, but when she tried to eat more she felt sick, believing her now shrunken stomach to be unable to cope with larger amounts. She described being scared that it might burst, or that she would be sick if she ate too much. The clinician working with her drew pictures of the stomach and, using the idea of a balloon that had deflated, talked with Lisa about how they could help her to re-inflate the balloon. She responded well to this idea, and was able gradually to increase the amounts

of food she was eating. However, the beliefs around health and fat were harder to shift, and over time it became clear that she did hold some views about her own body image and the meaning of being fat, but that she had not been aware of them herself initially. In such cases, where the young person is unable (or unwilling) to share underlying cognitions of weight and shape, the clinician should work at the level of the information that is available.

*The central cognitions do not relate to eating, weight and shape*

In contrast, in other cases we see young people who present in varying stages of emaciation without the associated features of overvalued ideas about weight and shape and body image distortions but with other apparently central cognitions. For example, Meena (a 16-year-old Asian girl) presented with a one-year history of dietary restriction and weight loss. She was referred for a second opinion when her local child and adolescent mental health team (who had diagnosed her with anorexia nervosa on the basis of her physical status and food avoidance, despite the absence of the central cognitions of that disorder) felt stuck. Following assessment, the clinician shared the following initial formulation with her:

**Clinician**: Meena, from what you have told me today, it sounds as if your worry about food began when you were 11 years old. At that time, you had an illness that caused you to feel very unwell and vomit a lot. It took a long time for this to be understood and treated, and you said that ever since, whenever you have felt slightly unwell you get very worried that the same thing is happening again. You told me about a situation last year when you believe you ate too much, and the resulting feeling was similar to when you had been 11. It sounds as if you got very panicky at this time, with lots of sensations in your body, such as sweating, feeling light-headed and your heart was pounding. This worried you for several hours, and eventually you were sick. Since then, it sounds as if you have been in a state of constant alertness, continually scanning your body for signs that something is not right and that you have "that feeling" again. As time has gone on, you have cut out more and more foods that you believe may be responsible for making you feel this way, and your weight has dropped. Does this sound right so far?

**Meena**: Yes. That's it exactly. People keep telling me that I am anorexic but I am not. I know I am too thin. I wish I could put on weight and eat like I used to but I just can't.

Based on this conceptualization, Meena and the clinician began a CBT program based on anxiety management techniques rather than addressing central beliefs about weight gain and body image. She responded well to techniques such as relaxation, began a graded exposure to her feared foods (initially in sessions, and then between sessions) and worked with the clinician on restructuring the underlying belief that she might die if she got unwell. She regained the weight she had lost, and she resumed menstruating. As she improved and resumed all aspects

of her life, passing her exams and moving on to college, the systemic part of the picture became more evident. In later sessions she returned, often tearful, to talk about how difficult family relationships were now that she wanted to have male friends and do more socializing. It appeared that a return to health had facilitated a lot of anxiety within the family system. The clinician speculated that this might present a risk for relapse, and provided details of Asian support groups for Meena and her family.

*The central cognitions are not accessible*

With younger children, the explicit use of cognitive restructuring can be more problematic. This is often because the cognitions are not so easily accessible or because younger children tend to be more concrete in their thinking. For example, Socratic questioning frequently ends up at an "I don't know" response. In such cases, we recommend more of a focus on the behavioral element of CBT.

For example, Joanna (a 13-year-old girl) was referred following a two-year history of food faddiness and low weight. A recent worsening in her food restriction and weight loss behaviors prompted the referral. When she was seen for assessment she became tearful, explaining that she found questions difficult, since she did not know why she found it hard to eat. She said that talking about it made it worse for her. She described other difficulties (such as extreme levels of anxiety prior to car journeys, when she would restrict her eating still further), and stated that her school life and friendships had been significantly affected. Over the course of treatment, it was never possible to get any clarity of the underlying cognitions but there did seem to be something of a phobic element to the food, possibly based on a fear of textures and choking. Despite never having a very specific cognitive conceptualization, a formulation based on learning theory was helpful, considering her need to relearn her relationship with food. Joanna responded well to maintaining shared control over which new foods she would try according to her hierarchy of feared foods, and work proceeded with very small increments in quantity of food. She received positive reinforcement and preagreed rewards for her efforts. However, this work would not have been possible without simultaneous family therapy.

#### 26.6.2.4 Working with the relationship with the clinician

As with older clients, the relationship that the young person develops with the clinician can be a useful tool in itself for addressing eating, weight and shape concerns. In our experience, younger clients are much less inhibited by potential societal rules for commenting on others' weight and shape, and are more likely to ask the clinician outright about their weight, or for their opinion

about their weight. We find it useful to respond to such situations as if they were an experiment – a potential opportunity to challenge a strongly held belief.

For example, Jasmine (a 14-year-old girl with anorexia nervosa) had been working with her clinician for three months, and had gained 7 kg over this time. At the start of her weekly session, after being weighed and gaining 0.6 kg, Jasmine asked the clinician:

**Jasmine:** I have gained a lot this week haven't I? Do you think I look fat?
**Clinician:** Well, let's take a minute to think about that, about what I think. Jasmine, I am interested in what will happen in your head depending on how I answer. So, if for example **I** say "No, I do not think you look fat," what will you say to yourself?
**J:** Well I will probably tell myself that you would say that, because it is your job.
**C:** OK, so it sounds as if you wouldn't believe me?
**J:** Probably not.
**C:** What about if I said the opposite, and replied to your question "Yes, I do think you are fat."
**J:** Well, I would be upset but I would believe you because that is what I think.
**C:** OK, so it would be easy for you to believe me if what I said was the same as what you already think?
**J:** Well, yes, because that would make sense to me.
**C:** It seems as if your head is very good at getting rid of any information that may not fit with what you think, like the filter on the camera we have talked about before. I wonder, what do we need to think about to help you change the filter on that camera?
**J:** I don't know really.
**C:** I wonder how many situations there are where you screen out information that may be challenging to what you believe about yourself? Maybe we could set up an experiment to test this idea further?

A similar style is recommended when the young person asks directly about the clinician's weight. The social contexts of younger people are more likely to involve asking adults for advice on a number of issues (e.g., parents, teachers), and the clinician may come to be another important adult and potential source of information. We recommend a stance of therapeutic openness – one that facilitates the opportunity for asking the clinician questions without ignoring the importance of therapeutic boundaries. For example, at a later date, Jasmine asked a further direct question of her clinician:

**J:** I don't want to be rude, but how do you cope with being a normal weight?
**C:** Jasmine, I wonder, in asking me about how I cope with issues to do with weight, are you wondering how it could be possible for someone to cope with being a healthy weight?
**J:** Yes I am. Other people seem to be able to manage it but I just don't know if I could.
**C:** Well, what do you think might be some of the reasons why someone, perhaps me, might be able to cope with normal weight when the idea is so difficult for you?

The patient and clinician can then move on to consider factors that may make it more likely that someone can cope with healthy weight. The clinician is attempting to use this opportunity to elicit other areas of life that could be important as well as weight and shape, as well as considering why eating, weight and shape concerns are so paramount for the patient.

### 26.6.3 Preparation for the real world

There are many reasons why our patients have withdrawn from the real world. If their weight has previously reached a critically low level, they may have been advised or required to stop school, hobbies and interests that involve physical activity. In addition, features that are prominent in the eating disorders (such as low self-esteem, shame and secrecy) often result in the young person withdrawing from social aspects of their life. As treatment progresses, the need to begin re-integration is paramount. Although not conceptually different to working with adults, the ''time-out'' from real life and the tasks of normal adolescence that require a social context in which to proceed are particularly important to address when re-integration is indicated. Young people frequently report that when they return either to the same social group (or in some cases a new one), they feel behind their peers in terms of psychological and psychosexual development.

This re-integration must be attempted as soon as it is physically safe to do so. This is for two reasons: to minimize disruption to the path of normal adolescent development, and because the social context provides a rich source of information for behavioral experiments and cognitive restructuring. For example, the young person who is restricted to their home or a ward is likely to find it hard to gather information to challenge the belief that they are unlikeable. Additionally, many young people need to have other more enticing aspects of life open to them in order to be able to consider relinquishing their eating difficulties. There needs to be a shift in the balance, so that ideally the patient wants other aspects of life more than she wants to hang on her eating disorder. Techniques and interventions that are useful in this ''real-world'' phase are:

- role-playing conversations focused on explaining time away from school to peers
- practicing eating in front of others, and coping with beliefs about what they are thinking
- collecting evidence to challenge beliefs about what and how much others eat
- testing cognitions around thinness and likeability (e.g., the number of texts received when at different weights).

This phase is crucial with this age group, and the same principles that have already been highlighted apply: the clinician must formulate the young

person's difficulties, and work with them to design experiments and opportunities to challenge the unhelpful cognitions.

### 26.6.4 Recovery and relapse management

Chapters 28 and 29 address issues related to endings, recovery and relapse management with adult patients. In our experience, the issue of recovery is just as complex with children and adolescents. In many cases, it is more complex, since many of our younger clients move on from child and adolescent services over the course of their treatment, making it harder to track the course of an individual's (and their family's) recovery. There is little outcome research to date with children and adolescents with eating disorders, but our experience suggests young people with the following characteristics will do well with CBT (recommended in addition to family therapy):

- Not currently living in invalidating environment
- Parents on-board and able to support the young person (and the CBT)
- The functional importance of the eating disorder becomes less important than other areas of life
- Cognitively "switched on"
- Healthy weight achieved (and maintained)
- Able to internalize and to use CBT concepts between sessions
- Less comorbidity.

#### 26.6.4.1 Relapse management

The issues addressed in Chapter 29 are relevant when working with younger patients. When working on issues of relapse management and prevention, we begin addressing related issues (planning for further change, management of risk, relapse prevention) many weeks before the agreed and planned last session. However, with younger patients, this cannot be carried out only with the individual themselves. We always address such issues within network meetings, family therapy sessions and individual therapy sessions. It may become more important for the clinician to link with significant adults (e.g., parents) at this time, in order to draw up strategies for managing risk and relapse within the family. In addition to the techniques described in Chapter 29, the following strategies are helpful when addressing issues of relapse with younger patients:

- *Individualized relapse prevention questionnaire/checklist.* As with older patients, we focus on issues that have influenced the development and maintenance of the eating disorder, what the patient has learned in treatment, and what they have identified as future risk factors for relapse. In many cases we find it helpful for the clinician and young person to develop a questionnaire or checklist to allow the young person (and where appropriate the family) to test coping in the future,

based on what has been learnt about the individual's risk throughout treatment. For example, Khalid (a 13-year-old boy) had worked hard during an in-patient stay to reduce his excessive and compulsive exercise. He continued with CBT whilst an out-patient, and when planning the ending Khalid and his clinician worked together to develop a questionnaire that he could complete on a regular basis to keep a formal record of the amount of exercise he was engaging in (e.g., number of press-ups undertaken, number of times he ran up and down the stairs at home). In addition, he devised a five-point scale to monitor the compulsive element of his exercising (what he called his ''urges''). He discussed how he would like his parents to support this ongoing work, and decided what scores would mean he needed to engage with further professional help.

- *Weighing*. Again, as with older patients, it is essential that the issue of ongoing monitoring of weight is addressed and planned. For the younger child or adolescent patient, adults are likely to play a more active part in this process. This is often a phase when families need to use family therapy sessions to address feelings of anxiety related to their child's increased wish for autonomy. It can be a tense time, but it is a useful point to test out issues of intra-family trust related to more autonomous eating and influence on weight. Examples might include the patient eating at school, going out for meals with friends or eating at a friend's house. With older adolescent patients, the approach to issues of weighing usually corresponds more to the approach described within the adult section of this book, but will always be guided by the family work that has been done to date and what is appropriate for each family.
- *Imaginary sessions*. After CBT has ended, we ask many of our younger patients to set aside time for themselves to have ''imagined sessions.'' This technique is not intended to allow the younger person to avoid facing the ending of CBT, but rather as a way to help them to take responsibility for the therapy, making time to consider and evaluate how they are managing. For example, they can be encouraged to use the therapeutic relationship by asking themselves questions such as: ''What would X (clinician) suggest I think about to help me in this situation?'' Their ability to answer that question can be enhanced by visualizing sitting in a therapy room with the clinician and imagining the likely conversation. In our experience, many of our young patients form strong bonds with their clinicians, and find it reassuring to discuss how they can keep what has become an important relationship alive in their minds after the formal therapy has ended.
- *Relapse prevention or damage limitation?* When working with this age group (just as with adult patients with eating disorders), not all of the relapse prevention and management work is based on positive outcomes. For many reasons, such as continuing to live in an invalidating environment or a desire to continue with

the eating disorder, relapse management becomes about damage limitation. In such situations, we have found it is crucial to be honest about our predictions for the future, and to address likely relapse in both individual and family sessions. For further consideration of this issue, see Section 26.7.3.

## 26.7 Endings

There are three types of ending that the clinician is likely to need to negotiate with younger clients and their families:

- a planned ending at the preagreed end of the CBT
- a planned ending at the transition between child/adolescent and adult eating disorder services
- ending in sub-optimal circumstances.

Each of these is considered below.

### 26.7.1 A planned ending at the preagreed end of CBT

Techniques for ending CBT sessions with young people with disordered eating are similar to young people with other difficulties. However, we have found techniques that appear to be particularly useful with the eating-disordered population. Because CBT with this patient group is typically of longer duration than with other patients, eating-disordered patients frequently come to view their clinicians as important and valued people in their lives. In some cases, the ending phase of their treatment is painful, bringing up issues related to previous endings and other important relationships. In contrast, with our older patients, it is not uncommon for this to be described as the first ending that our younger patients have encountered. Either way, it is crucial that the ending is handled with care and planning.

Ideally, the ending will have been in sight from the beginning. We do not recommend that CBT is commenced without some preagreed end point, although (in line with the recommendations for work with adults – Chapter 29), there are times when this will need to be altered (e.g., increasing the number of sessions or ending them prematurely where appropriate). We regularly remind our younger clients of the end, either by using language such as "When we are not meeting any more . . . " or "After today, we have X number of sessions left." In doing this, the remainder of the work can be prioritized and the clinician can begin to explore what the patient's emerging feelings about this ending are. By about the third session from the end, we begin to talk to our younger clients about what the last session will look like, and begin to plan for it in some detail.

For example, Ally (a 15-year-old girl with anorexia nervosa) had been working with her CBT clinician for over a year at the point of their planned ending.

Initially based in an in-patient setting, the work continued on an out-patient basis. The sessions were planned to end as a result of her having recovered, although there was a plan for her to be monitored via a transfer back to her local generic child and adolescent mental health service. She had formed a very strong attachment to her CBT clinician, and her grandmother had died during this time, making the ending with the clinician more painful still. Three sessions before the end the clinician approached the subject of the last session in the following way:

**Clinician:** We have talked today about what it might be like for you when we are not meeting anymore, and you have been able to tell me how hard you are finding that idea. It is important that we spend some time now thinking about our last session and how we want to use it. Have you given any thought to this?
**Ally:** No, not really. I don't really like thinking about it.
**C**: I can see that it is hard for you. Would it be helpful for me to give you some ideas about what it might be like and what we could do in that session?
**A:** Yes, OK.
**C:** Well, there seem to be a number of ways people cope with the last session. Some cope by not turning up or by coming late!
**A:** (Laughs)
**C:** Do you think you might go for one of those?
**A:** No. I might feel like it, but I would hate not saying goodbye properly.
**C:** OK. So we will assume you will come. In that case we can think about marking our ending in a number of ways. It is important that we spend some time thinking back over the work we have done together and what you feel you have learned and achieved over that time. There are a number of ways that we could do that. Some people like to sit and talk about these things, others like to review the work in their folder, and others like to write letters.
**A:** What do you mean by letters?
**C:** I mean that you and I would write letters to each other about the time we have been working together, and we would read them in the last session.
**A:** I think I like the sound of that. Can you explain it to me some more?

The clinician and patient then engaged in further conversation about the aim and content of the letters. In our experience, young people respond well to this suggestion and the vast majority express interest in doing this. Without exception, all young people who have agreed to do this turn up to the last session with their letters. Very loosely based on the cognitive analytic therapy idea of the ending letter (Ryle & Kerr, 2002), we write the patient a letter that includes: remembering back to where they were when therapy commenced; what their core beliefs and fundamental struggles have been; where they are now; and something that the clinician will always remember them by. At the beginning of the final session, the clinician guides the timing of sharing of the letters and the resulting discussions.

We have found it useful to ask if there is anything that the young person wants to comment on, or that they do not understand. It is also important to make comments on what the young person has written. In our experience this is not hard, since we are often surprised by how much insight young people can express at this stage and how thoughtful their letters are.

Following the sharing of these letters, it is useful to review the therapeutic work undertaken and to consider the directions that the young person hopes to take in the future, considering issues of relapse prevention and any continuing work. With a few minutes left to go, we find it can be helpful to guide the young person through the last phase of the ending session in the following way:

**C:** In a few minutes we will be at the end of our time together. I think it might be useful for us to think about exactly what we will do when that time is up. I am wondering how you would like to say goodbye?
**A:** I don't know. I don't really want to.
**C:** I can see that this is really hard for you. One option would be to leave the room as fast as possible.
**A:** What else?
**C:** Another option would be for us to shake hands.
**A:** That sounds better.
**C:** And another option could be for us to hug.
**A:** That is what I would really like if that is OK.

Clearly the issue of touch within therapy causes ongoing debate for professionals, and in some circumstances it would be inappropriate for both the patient and clinician. However, managed in a safe and boundaried way, such contact can be appropriate and therapeutic with a younger client group.

### 26.7.2 A planned ending at the transition between child/adolescent and adult eating disorder services

When considered carefully and in detail, this type of ending can be a very positive experience for both the patient and family. We do not simply consider the point at which to move someone into adult services as the point at which they reach a certain chronological age. Nor are we recommending that services should hold onto young patients simply because the transition to adult services (and, symbolically at least, to adulthood) is difficult. Rather, the transition should be related to the appropriate point in the patient's development. Many of the young people we see are emotionally (as well as physically) immature for their age, and are unlikely to be ready for the different focus and style of approach to consent that come with adult services.

In our experience, young people and their families can manage this transition well, whether it is in the circumstances of a patient who is recovering or one

who is struggling, as long as the move is handled sensitively and with considerable forethought and discussion. Regardless, we have found that raising the idea of this transition in advance in review meetings and family sessions allows the patient and their family time to adjust to the idea, as well as giving plenty of time to discuss resulting issues in future family and individual sessions. Depending on the constraints on services, we recommend a period of transition for the clinician and patient. Ideally the clinician will be able to set an end date that will be *after* the patient has transferred to adult services. This timing allows the clinician and patient to meet and hand over to the new clinicians, including offering thoughts on any issues that arise in the early part of the transition. We ask the young person to write their own précis of her time in CBT, in order to hand over in their own words what their experience has been, what they have learned so far and what they feel any future work might need to include. Clearly, this depends on the age and ability of each individual patient, and needs to be read in conjunction with the clinician's account. Aside from this, the final session can be approached as has been described above.

### 26.7.3 Ending in sub-optimal circumstances

As with older patients, not all younger patients achieve full recovery, either with CBT or with family-based approaches (Eisler *et al.*, 2003). The issues for this are likely to be many and complex. Until research is available to guide the clinician on likely predictive factors for outcome, the formulation of a young person's (and their family's) difficulties and the clinician's experience will remain the best way of considering likely outcomes. Clearly, this approach is flawed, and our experience has taught us that surprises are to be expected with this client group. However, as a population, young patients with eating disorders remain a group who are difficult to treat, and the clinician must be prepared to expect either sub-optimal or poor recovery.

Multidisciplinary teams can be extremely useful in such cases. The possibility of engaging with a number of different therapeutic tasks offers more opportunities for the young person and the clinician. For example, Daniel (a 14-year-old boy, with a two-year history of food restriction and low weight) was ultimately unable to engage with CBT. Following some motivational work and considering an initial formulation, Daniel agreed to begin some experiments around testing out new foods and increasing his weight. However, he was never able to try these new foods and his weight maintained at about 78% of normal for his height. Following many discussions and revisiting the formulation, he and his CBT clinician concluded that he was not in a position to consider recovery at the current time. Despite this, he was willing and able to engage with the occupational therapist on the team,

carrying out a piece of work looking at areas of his life that he had withdrawn from and ways in which he could re-integrate them into his life. The possibility of re-engaging with CBT at a later date was openly discussed, and Daniel agreed that it could be something that he could benefit from at a later date. In our experience, it is much more therapeutic to discuss openly why ''now is not the right time,'' and to stop CBT before it becomes a negative experience.

Returning to motivational enhancement techniques and maintaining the same style of therapeutic openness (see above) is crucial when dealing with sub-optimal endings. We find that it can help to minimize the sense of hopelessness and failure for the young person who is not in a position to contemplate full recovery. Additionally (and perhaps of equal importance), it allows the clinician a way to survive the work. It can be all too easy for the clinician to take responsibility for failure — the perfectionist nature of our clients mirrored in clinicians' own perfectionism and desire to help. In our experience, clinicians' perfectionism can be magnified when working with such clients because of their age and because of the clinicians' desire to ''rescue'' them. Clearly, supervision and open team discussion of such issues is crucial.

Returning to the formulation to consider why change is not possible is as important for the clinician as for the young person and their family. The following example highlights some of these issues faced by young people and clinicians, and demonstrates the critical importance of taking a systemic approach when working within any CBT model with young people. Leah was a 15-year-old girl with a three-year history of anorexia nervosa (binge—purge sub-type) and a weight for height ratio of 71%. She was living at home, but eventually agreed to an in-patient admission after months of motivational work. Goals for the admission were to: help her gain some control of her bingeing and purging; to achieve a healthy weight; and to develop other strategies for managing her feelings. After several months, she had achieved the first two of these goals. However, she reported (as she had predicted she would from the outset) that getting in touch with her feelings and memories had caused her to feel worse. Thus, although she had regained some control over bingeing and purging, the emotion regulation function of these behaviors had not diminished. Although the team working with Leah had some idea prior to admission of the difficult issues she faced at home, the course of the admission revealed the true extent of the chaos and lack of appropriate adult nurturing and supervision available in her family. Failing to meet social services thresholds for any support or intervention, the team was faced with either recommending that Leah should remain an in-patient until her 18th birthday or working towards discharge in sub-optimal circumstances. Despite many expressions of the team's concerns about Leah's probable prognosis in the event that her parents were unable to make some of the recommended

changes in order to care for her, neither her parents nor the statutory agencies were able to offer anything different.

When Leah was eventually discharged at a healthy weight, the relapse prevention work (both individual sessions and with her family) was about how to stay as healthy as possible and manage the ongoing risks. The clinician also worked with Leah on formulating why she was unable to make any other changes, and why she needed her eating disorder to help her survive life at this time. This discussion allowed the clinician to build into the formulation the possibility that things could be different in the future. Just like older patients, young people can and do come back to services as a later stage to engage with therapeutic work that they have been unable to do previously. Undoubtedly, a more positive early experience of therapy (regardless of outcome) can aid the patient to believe that therapy at a later date could be successful.

Regardless of the fact that therapy is ending in sub-optimal circumstances, the ending needs to be planned and considered in ways that have been described earlier in this section. The content of the sessions and the reasons for ending sub-optimally (e.g., parents who make it impossible for the child to attend) may differ, but the principles, style and process are likely to remain the same.

# Summary

While not all patients or their families report a positive outcome, we aim to provide all of the young people we see with developmentally appropriate CBT for their eating disorder, as long as it makes sense in terms of their formulation and as long as their physical condition is stabilized. As has been stressed throughout this book, we acknowledge that CBT has a way to go before it can be targeted totally appropriately in younger patients. However, we find that CBT is a useful resource as part of the broad multidisciplinary approach that is needed in such cases. Using the words of one of our young patients, expressed at the end of her CBT, the potential positive effects of CBT can be appreciated: ''When I came here I was only visiting life: now I feel like I am really living it.''

## Section VII

# Endings

This section will discuss the ending of CBT for the eating disorders. First, we consider what to do when CBT is not working in the early stages, with the aim of understanding what alternative approaches might be helpful (if any). We then present criteria for recovery, and describe means of measuring the recovery process. We link the process of recovery to the key themes of CBT, and use the stages of change model to integrate ideas and research findings. The impact of clinician investment on negotiating degree of recovery and ending will be discussed. We will then consider the ending of treatment, and how to prevent relapse.

27

# What to do when CBT is ineffective

A substantial number of patients fail to engage with treatment (e.g., Coker *et al.*, 1993) or drop out of therapy (e.g., Halmi *et al.*, 2005; McKisack & Waller, 1997; Mitchell, 1991; Waller, 1997). However, of those patients who do stay in treatment, many comply poorly with therapy tasks (e.g., homework, behavioral experiments, cognitive restructuring). Such patients are likely to be part of the substantial numbers who fail to benefit from CBT (e.g., Fairburn & Harrison, 2003). We find that the patients who fail to benefit from CBT are often those:

- with substantial comorbid states (both Axis I and Axis II)
- who engage in a range of impulsive behaviors
- with a history of trauma and dissociation
- who persist in perceiving benefit from the eating disorder
- who feel pushed into treatment.

However, there are clear exceptions, with some such patients doing extremely well. These characteristics require substantial attention to matters of motivation (Chapter 6), therapy-interfering behaviors (Chapter 9) and comorbidity (Chapters 24 and 25). We also find that it is important to consider issues of patient confidence in the possibility of change, clinician stance and clinician investment (Chapter 6). The aim must be to ensure that the clinician encourages and allows the patient to focus on the eating behaviors themselves.

It is important to consider ending treatment if these factors are not amenable to change, or to consider that CBT is not the right therapy for this patient at this time. If the patient is not ready to engage in active treatment at all at present, then the prospect of long-term motivational work (while ensuring physical safety) can be considered. Alternatively, other treatment modes might be more appropriate to the individual patient (e.g., Fairburn *et al.*, 1995; Murphy *et al.*, 2005). There is no strong evidence for matching patients to treatments. However, we find that the patients who benefit more from therapies with a strong interpersonal basis are those who have a history of significant separation and loss experiences.

28

# Recovery

In a research setting, outcome is usually measured as a ''snapshot''. In contrast, the clinician working with an individual patient is more concerned with the process of recovery for a particular individual. In addition, whilst empirical studies focus on physical factors, clinicians prioritize psychological factors (Willoughby & Hirani, 2005). What we find useful is to adopt a Socratic approach to defining recovery with the individual patient, so that neither we nor the patient are required to have the right answer regarding what constitutes recovery. Rather, we see the definition of recovery as emanating from a collaborative approach. For example, if the patient concludes that simply stopping the behaviors is an adequate definition, then we can explore with them whether that position is tenable as life stresses trigger their remaining emotional and cognitive vulnerability. Similarly, if we suggest that the patient needs to change both their behaviors and cognitions, they need to be able to raise concerns about whether they will have recovered if they cannot re-engage in normal social interactions or if they remain depressed.

## 28.1 Defining recovery and the recovery process

As yet, there are no definitive and universally agreed criteria for recovery from an eating disorder. Criteria that have been used in research trials include the presence or absence of behaviors, changes in BMI, failure to meet diagnostic criteria for an eating disorder and scores on well-validated eating disorder measures. The Morgan–Russell scales (Morgan & Russell, 1975) were designed to measure such outcomes but are not widely used now, due to their limited nature.

Given the diversity of goals, it is clear that recovery cannot be judged on a single set of criteria. Based on our clinical experience, we use a combination of psychological, physical and social factors in conjunction with clinical judgement and patient opinion. The degree of importance attached to each of these varies from patient to patient. However, all these factors need to be taken into consideration. Many of these criteria focus on moving *away* from something

(e.g., a problem behavior), rather towards something (e.g., a more adaptive behavior). Patients with eating disorders are often rigidly polarized in both their beliefs and behaviors. Recovery involves understanding of moderation and moving from an extreme to a middle ground – for example, understanding that eating a range of foods is more appropriate than sticking rigidly to an extremely "healthy" diet. This is compatible with the ideas of continuation and normalization.

Having said that there are no universal criteria for recovery, there are key indicators that we routinely use in our practice. These are a combination of psychological, physical and social factors, and include:

- absence of behaviors such as restriction, bingeing, vomiting, laxative abuse and excessive exercise
- a stable BMI above the minimum level necessary for menstruation
- absence of preoccupation with food, shape and weight
- stable and euthymic mood.

In keeping with the CBT model, factors have been grouped by cognitive, emotional, behavioral and physical elements. Other aspects deemed crucial for evaluation of recovery include social issues. Such factors are expanded on below.

### 28.1.1 Cognitive factors: overevaluation of eating, shape and weight

The core maintaining mechanism of an eating disorder is the overevaluation of eating, shape and weight. Thus, a reduction of this mechanism is essential for recovery, evidenced by the following:

- the patient judges themselves on a wide range of factors and not just shape and/or weight
- the patient does not have an overwhelming desire to lose weight
- the patient does not have a significant fear of fatness or distortion of body percept and concept
- the patient has an understanding of the healthy weight range for someone of their height.

However, it must be stressed that body dissatisfaction and thoughts of dieting are highly prevalent in many societies, and thus complete eradication of such thoughts is unlikely. The goal, therefore, is for patients to develop a relationship with their body that is similar to that of an individual without an eating disorder. The patient is moving towards the balance demonstrated in their "ideal" higher values pie chart (Chapter 6).

### 28.1.2 Emotional factors

Over the course of effective treatment, the patient will have developed an understanding of the function of their eating disorder. For many patients, one such

function is managing emotions (e.g., blocking affect). Thus, one aspect of recovery is that the patient is able to identify, tolerate and respond or attend to difficult emotions, rather than suppress them through the use of food and eating-disordered related behaviors. It is equally important that the patient has not substituted another behavior for their eating disorder; for example, there is no evidence of self-harm, substance misuse, obsessive-compulsive behaviors or excessive exercise. Whilst some of these behaviors are normal in moderation (e.g., exercise, cleaning), the function is appropriate rather than a means of distress tolerance. Instead, the patient will have developed adaptive skills to assist in managing intolerable affect. Furthermore, the patient should report a stable, euthymic mood (unless factors such as depression or bereavement are prevalent).

### 28.1.3 Behavioral change

In the eating disorders, the reduction in the use of behaviors such as bingeing, vomiting, laxative abuse and excessive exercise are key indicators of progress. We record the number of episodes on a weekly basis, aiming to give a sense of the patient's movement through treatment. Of course, it is likely that such behaviors will change on both a qualitative and a quantitative basis (e.g., bingeing will often shift from objective to subjective episodes). Whilst many patients will have ceased using behaviors completely by the end of treatment, others will need the extra period of time posttreatment to eliminate such behaviors fully (Waller *et al.*, 2005).

In terms of food intake, the patient may not initially be able to trust their internal hunger and satiety signals, but can understand and respond to the need to eat regularly despite not feeling hungry. As time goes on, the patient is able to recognize and respond appropriately to their internal hunger mechanisms. Therefore, an early stage of the recovery process may involve the patient "eating by the clock," including following a highly structured eating plan. Although this looks abnormal to the outside world, it is normal and appropriate to their stage of recovery. As time goes on, it is important that they develop a more flexible approach to eating, but this is likely to continue after therapy has been completed. This theme is expanded in the eating continuum at the beginning of the section on diet and nutritional issues (Chapter 7). Other behavioral criteria for recovery would include:

- the patient does not report any loss of control over eating
- the patient consumes a varied diet that includes a wide range of foods from all food groups, including previously feared foods
- the patient reports that they consume regular meals with regular planned snacks each day
- there is no compensation for consumption of alcohol by reducing food intake.

### 28.1.4 Physical factors

A key physical factor is the return to a stable weight that allows natural menstruation (if the patient is female and at an age where she would be expected to menstruate). This usually equates to a BMI of 20 or above, but if in doubt an ovarian ultrasound will be able to identify if weight is high enough to trigger menstruation. In females who have been underweight since before puberty, one cannot know the weight at which menstruation is likely to occur. Amenorrheic females may need to be stable at a healthy weight for some months before menstruation resumes, and we have found that many patients seem to need to be approximately 3 kg heavier than their preillness weight for resumption. Thus, resumption of menstrual function may occur some time after the end of active treatment. In females who had not lost menstrual function, learning to keep weight stable is the goal. In men, recovery will involve being at a stable weight where BMI equal to 20 or above.

Recovery will involve the reduction in symptoms associated with food restriction or being a low weight. These may include improved bowel function, improved condition of skin and nails, improved concentration, improved tolerance of temperature extremes and lower levels of depression. It is also important to note that while bone and dental health can improve considerably, some damage is likely to be permanent.

### 28.1.5 Social factors

The development of an eating disorder often leaves little mental space or physical energy aside for other areas such as work, study, relationship, friends or hobbies. In severe cases, individuals may be compelled to take leave from study or work due to physical compromise. A sign of recovery is when the patient becomes interested in developing or returning to such activities and begins to make steps towards this. Body dissatisfaction or fear of intimacy may lead some individuals to avoid relationships whilst ill. Equally, some individuals may avoid social occasions due to concerns about foods available or being observed eating. Recovery involves improved relationships with others, as the focus is not so much on food. One patient described feeling that they had recovered when they were able to eat with their family and to have similar foods, rather than ''diet food,'' which led to a reduction in tension around meal times. Again, recovery will involve tentative steps towards building new relationships and getting back in contact with people who patients want to remain in their lives. Many people with a long-standing eating disorder may have a circle of friends that consists mostly of others who suffer from an eating disorder. Starting to develop friendships with people who have a healthier relationship with food is an important sign of recovery.

### 28.1.6 Achieving goals

In addition, since a fundamental factor in CBT is collaborative goal setting, meeting such goals can also be seen as a means of evaluating the recovery process. The most useful goals are those which are behavioral and, therefore, measurable, and would include a combination of short-, medium- and long-term targets. It may be that at the end of treatment, the patient has achieved their short-term goals and can see that they have made steps towards longer-term goals (e.g., has returned to university in order to gain necessary qualifications for a future desired career, or, for a female patient, has reached a weight at which menstruation would be expected, in order to plan for a family).

### 28.1.7 Objective measures

The use of psychometrics is also invaluable in charting progress over the course of treatment and in demonstrating change objectively. Measures that are particularly recommended include:

- Beck Depression Inventory (Beck & Steer, 1993a)
- Beck Anxiety Inventory (Beck & Steer, 1993a)
- Eating Disorder Examination Questionnaire (Fairburn & Beglin, 1994)
- Testable Assumptions Questionnaire (Hinrichsen *et al.*, 2006)
- Young Schema Questionnaire (Young, 1998).

Thus, a combination of the clinician's and patient's perspectives and objective information (such as presence or absence of behaviors, BMI and psychometric outcome) appears to be the most useful way in which to evaluate degree of recovery.

## 28.2 Applying recovery definitions to a heterogeneous population

Patients with eating disorders are a heterogeneous population. For some, guided self-help or a relatively short course of CBT will be sufficient to address their difficulties. Such patients may achieve recovery as defined above after one treatment episode. At a specialist eating disorders clinic (Waller *et al.*, 2005), approximately half of the adult bulimic patients recovered (defined as no longer meeting diagnostic criteria for any eating disorder) after a mean of 19 sessions of CBT, with a further 25% reaching recovery by the end of a six-month follow-up period. Fewer data are available on patients with anorexic disorders, although there is a clinical suggestion that there should be a longer treatment course for such patients (National Institute for Clinical Excellence, 2004). However, for a smaller subgroup of individuals, one treatment episode will be insufficient. Many factors, including low motivation, comorbidity, chronicity or external factors may be relevant.

Fairburn and Harrison (2003) demonstrate how patients move across diagnoses, with many developing EDNOS presentations. Therefore, there can be difficulties in exploring recovery and the recovery process because it involves working with individuals across the spectrum of stage of change. For example, a small step toward recovery for someone may be accepting for themselves that they have an eating disorder rather than attending because of pressure from others, whilst for someone else it may be "full" recovery, meeting the criteria outlined above. Below we consider how to conceptualize such differences in a meaningful clinical manner.

## 28.3 The stages of change model revisited

The transtheoretical model of change (DiClemente & Prochaska, 1998) is a useful model to consider when thinking about the process of recovery. As described in the chapter on motivation (Chapter 6), individuals move through stages of change as they move through the recovery process. It is important to recognize that people do not just go through these stages once: sometimes an individual has to go through the process many times before they can permanently move on from their eating disorder. Some patients may move between stages, yet never hold on to maintenance, whilst others may get stuck at a specific stage for many years, perhaps even permanently.

Keski-Rahkonen and Tozzi (2005) studied the recovery process in eating disorders by examining interactive postings from sufferers on an eating disorders website. They used the stages of change model to categorize the process, adding one further term (pseudo-recovery) and a further stage (transcendence).

### *Precontemplation*

In this stage, individuals do not experience their eating disorder as a problem. As a result, they are likely to defend or even idealize their behaviors or way of life. Many deny that they have an eating disorder; for example, defending their thinness by saying their family is "slim built." Recovery is not an issue in these patients' eyes because they do not feel they have anything to recover from. Hence, the moment when a patient admits to themselves and to others that they have an eating disorder is the first step on the process of recovery.

### *Contemplation*

This is characterized by ambivalent feelings towards recovery and abstract wishes regarding getting better. External motives such as fertility or pressure from loved ones would also belong to this stage since the primary motivation to change does not come from within the patient. Keski-Rahkonen and Tozzi (2005) suggest

that in these early stages, eating disorder sufferers may not be ready to conceptualize recovery as a goal. Thus, whilst it can be tempting to talk about recovery with a patient who has moved from precontemplation to contemplation, it is important to recognize that this may be frightening and alienating for them.

*Preparation*

This is the stage where a patient has decided that recovery is what they want, and actively makes plans to help them achieve this. They may do more reading of psychoeducation literature, make specific plans about extending diet or eliminating purging, ask relatives for support around eating or make plans to avoid situations where they know they would not be able to keep to their goals. This stage often merges with the next one.

*Action/maintenance*

This is where patients put their plans into action and strive to maintain these changes. Keski-Rahkonen and Tozzi (2005) identify that a pervasive theme mentioned by sufferers is the fact that recovery is such hard work. However, they also identify that many people begin to display cautious optimism about the future.

*Relapse*

As well as the obvious signs of relapse such as returning to bingeing and/or vomiting, Keski-Rahkonen and Tozzi (2005) include ''pseudo-recovery'' in this stage. The example they describe is of an individual who ''recovered'' but who was ''still very thin, exercised a lot, and controlled (her) eating,'' but who then went on to develop binge eating. This change exemplifies the finding that individuals can and do move between diagnoses (Fairburn & Harrison, 2003).

*Transcendence*

Keski-Rahkonen and Tozzi (2005) add this stage to those described above, for the individuals who have grown out of their eating disorder and moved on with their lives. These individuals have developed the ability to distance themselves from the illness and what it represents, including cutting off contact with people who continue to live with their eating disorder. Therefore, the step of joining a club that is not focused on eating or obsessive levels of exercise (e.g., a choir or a photography course), or actively moving away from friends who remain entrenched in their eating disorder to develop friendships with non-eating-disordered people is a very encouraging one. It is perhaps important for clinicians who work on a daily basis with patients who are still entrenched in their eating disorder to remember that people do reach this stage but, because of its nature, they do not have contact with our services.

## 28.4 Recovery as a process: using these models in the clinical setting

Echoing our patients, it is easy to fall into applying a dichotomous approach to recovery: patients are *either* sick or recovered, and patients must be completely recovered by the time they leave treatment. Our experience is that it is more helpful for both clinician and patient to view recovery as a process and to accept that recovery involves many separate cycles through these stages (for instance, giving up vomiting may be one cycle, gaining weight to a normal level another), and that these may or may not match treatment episodes. In CBT the central goal is for the patient to become his or her own therapist. Therefore, the journey of recovery will continue after the patient has finished active treatment. For some patients, this journey may take several years – or may never be completed, although they may be further along the path towards recovery than before. The implications of this include clinician acceptance that our patients will not leave us ''perfect'' or ''cured,'' and working with patient anxiety that they will not manage without us. A particularly effective analogy is that of the ''coast of South America'' (as discussed in Chapter 1).

In this way, the path to recovery for patients with a more longstanding form of eating disorder may involve numerous individual cycles. Viewing recovery as a process can encourage us to take a long-term, more flexible and individualized perspective on each patient. Acknowledging that recovery can be a stepped process enables all concerned to validate the patient's achievements. Reflecting on the progress the patient is making can be a great solace for both clinician and patient – for instance, a ''revolving door'' patient who loses weight rapidly and always needs to be detained to allow themselves to receive treatment might show progress by accepting an informal admission before it becomes an emergency. Similarly, an overweight patient who has gone through numerous cycles of extreme weight loss followed by bingeing and weight gain might accept that weight stabilization is a goal worth pursuing.

It is also worth recognizing that there are occasions where patients with a less entrenched eating disorder may take only a very limited number of sessions to give up their eating disorder and move onto maintenance, then transcendence. These patients are more likely to receive treatment in generic services, not specialist services where patients tend to present with much more complex needs.

## 28.5 Agents of change

When thinking about recovery it can be helpful to think about external or internal agents of change, and how these alter during the recovery process. Thinking in this manner can give the clinician insight into the patient's position along the

recovery pathway. That pathway mainly maps onto the latter stages of the transtheoretical model: preparation, action and maintenance. It is possible to think of three phases during treatment:

*Phase 1.* This is at the beginning of therapy, when the patient is likely to be in the contemplative or action stage. Whilst they may be motivated to change, they will not yet have the skills or understanding to facilitate such change. As CBT is a structured therapeutic approach the clinician will direct the process, especially at the start. Therefore, the clinician can be said to be taking the majority of the responsibility for guiding the patient. Examples of this include setting the boundaries of treatment, advising on an appropriate meal plan and advising on why the food diaries are important and how to fill them in. The patient's role is to attend therapy, and to accept the boundaries that CBT involves. Therefore, in this phase, the agent of change is largely external to the patient.

*Phase 2.* As therapy progresses, the responsibility for change becomes much more of a shared one. The patient brings their food and mood diary, whilst the clinician starts to address relevant aspects of their problems. With time, the patient will gain confidence and skills at identifying problem ways of thinking and behaving, but will need the help of the clinician to develop more adaptive ways of coping with life. Here, the agent of change is shifting from being external to the patient to being internal. During this phase, the patient may say that they ''heard your voice'' tell them what to do when they were faced with a difficult situation.

*Phase 3.* Patients in this phase will be moving from an action stage of change to a maintenance stage. Converting and sustaining action to maintenance is key to the process of recovery. Towards the end of an effective phase of treatment, the patient will, to all intents and purposes, have become their own therapist. They have become able not just to identify unhealthy ways of thinking and behaving, but also to identify solutions and put them into practice. By this time, the patient will have moved from hearing you tell them what to do at times of stress, to hearing their own voice and in their own words. They may not have ''fully'' recovered, and some residual thoughts and behaviors may be evident, but they will be at a stage where they can continue to make progress on their own, whilst recognizing when they need further help. The follow-up period of treatment is usually the time when the patient demonstrates whether they have internalized the therapy and have become their own therapist. At this stage in treatment, the therapist acts as more of a support than the active agent of change, since the patient has internalized the ability to identify and change their behaviors.

This way of thinking about recovery works for patients at any point in treatment, be it the bulimic who manages to give up purging and continues to reintroduce excluded foods during the follow-up period to treatment, or the patient with enduring anorexia nervosa who manages to maintain the 2 kg they have gained recently through not trying to match others' expectations of them (such as the request to eat out at new restaurants or drink alcohol that they have not planned), which would previously have led them to later restrict their food intake.

## 28.6 The patient's perspective on the recovery process

We view the patient's perspective on recovery as highly important, and so time is spent exploring how the patient feels about the progress they have made and anxieties they may have about ending treatment. In our experience, some patients are able to determine when treatment is sufficient. These patients may be able to engage in a discussion with the clinician about an appropriate end point and to reflect on their feelings regarding this. Such patients are more likely to be able to acknowledge a mixture of feelings – perhaps hope and anxiety – as they approach the end of treatment. They may be able to think about the process of their recovery and to understand their role in this process. However, some patients may be keen to end treatment quickly (commonly known as a "flight into health"). In such cases, motivation for change may be low and the individual may have felt "pushed" into treatment by others. In these cases, there is often behavioral change in the absence of psychological change. Some patients may have unrealistic expectations of what they can achieve or maintain without support, in which case we will highlight the advantages of completing a treatment course (e.g., consolidating changes; developing a relapse management plan). In contrast, others may want to continue in therapy due to anxiety that they will not manage on their own. Explaining the phases of treatment (described above) and the coast of South America analogy (Chapter 1) are helpful in working through such fears.

In Keski-Rahkonen and Tozzi's (2005) study, thoughts on recovery fell into four main categories: stage of change; emotion; what is helpful/unhelpful; and "other." Views on recovery changed according to stage of change, and recovery was least likely to be mentioned in the precontemplative and relapse stages. The most pervasive theme was that recovery is very hard work. With regard to what individuals found helpful or unhelpful in their recovery, it was noticeable that the value of professional help is conditional on the sufferer's own willingness to change. Finally, recovery evoked intense emotions: including despair, fear, irony, hope, encouragement and gratitude.

## 28.7 What is *not* recovery (including identifying pseudo-recovery)

While we have talked about recovery as a process, there is also an end point to such a process. Sometimes, however, a patient may meet some of the criteria described above, but not others. How do we distinguish those who are making the ''flight into health'' from those who have not used the treatment?

In essence, a patient has yet to recover if they have made either behavioral changes or psychological changes, but not both. Someone who is amenorrheic or oligomenorrheic is an obvious example of this, as is someone who continues to regularly binge and purge. Similarly, there are many cases where a reduction in behaviors does not indicate change in the underlying cognitions. A less obvious example would include women who are menstruating but who have a BMI of less than 18.5, since a body weight below this is less likely to be protective against osteoporosis, and more likely to require a restrictive diet to maintain that weight. Recovery also necessitates being able to hold on to such changes. An example of this is maintaining a stable and healthy weight for a number of months, rather than reaching this weight for the first time. We have found that many patients find it fairly easy to gain better control over the egodystonic symptoms of their eating disorder (i.e., bingeing and purging), but are unable to give up the egosyntonic symptoms (low weight and restriction). This is pseudo-recovery, as described by Keski-Rahkonen and Tozzi (2005). The same is true for a ''flight into health,'' where a patient can appear to stop behaviors or allow their weight to normalize with ease, but who then leaves treatment quickly, avoiding consolidation in the maintenance stage of change.

## 28.8 Weight gain and obesity

With obese patients, there is often a tendency to expect the patient to lose weight during or after treatment. If this does not happen, it can be easy to fall into the trap of thinking that the therapy has failed, and that the patient has not recovered. In fact, the NICE guidelines for treatment of eating-disordered patients highlight the strong evidence that weight does not necessarily drop as a consequence of treatment, and that obesity management needs to be addressed alongside, or after treatment. We expect the patient to stop trying to lose weight during treatment, although we do recognize that for some people weight may drop slowly (possibly around 0.5–1 kg a month) once the bingeing is under control. The importance of and rationale for weight stability is discussed further in Chapter 15. We also recognize that obesity is unfortunately an issue that is likely to need lifelong input from primary, secondary and possibly tertiary (specialist obesity) services. So, for obese patients, rapid, continued weight loss (around 1 kg or more per week)

is *not* a sign of recovery. This is a hard message for many patients and clinicians to accept, as society tells us weight loss is the preferred outcome in obesity. Of course, gradual, maintained weight loss is preferable to remaining at a high weight or gaining even more weight, but in reality patients who lose weight rapidly are extremely likely to regain this weight (and maybe more), especially if they have not made sufficient psychological progress. In patients who binge, weight is likely to continue to increase. Thus, achieving stability is a significant step, and one that may limit possible further physical health problems.

Continued, rapid weight gain (0.5–1.0 kg a week, or more) for more than a couple of consecutive weeks is a matter of concern in any patient, unless of course this is the target that the patient is working towards. The NICE guidelines recommend a weekly weight gain of 0.5 kg in people recovering from anorexia nervosa in an outpatient setting (National Institute of Clinical Excellence, 2004), but in our experience many patients gain weight at a slower rate than this. Unless the patient is on a monitored weight gain diet, weight gain of this degree indicates that eating is out of control, even if the patient is saying it is not. This needs sensitive handling, but it is imperative that space is repeatedly given for the patient to say what they are struggling with in terms of food, even if they are unable to use advice.

## 28.9 The clinician's perspective: knowing when to end treatment

So far we have said that assessment of recovery is multifactorial. While some patients may reach full recovery after their first treatment episode, others may make this journey in a stepped fashion over several treatment episodes. As a result, the clinician may be left uncertain about how to judge whether the patient has recovered, and how long to offer treatment for. This is likely to be an anxious position for the therapist, and therefore one where supervision will be a useful tool. With this in mind, it is important for the clinician to pay attention to where the motivation for treatment is coming from: themselves or the patient. As (Geller, Williams & Srikameswaran, 2001) point out, it is the patient who is responsible for change, not the clinician. If the clinician falls into the trap of thinking that treatment is something that is done to the patient and that they are only doing a good job if they produce "rapid and lasting symptom change" (Geller, Williams & Srikameswaran, 2001), then it is possible that the patient may feel pushed where they do not want to go, and the clinician can "burn out" very quickly. Geller *et al.* advise that "the end goal is always to assist the client to decide what she wants to do about her eating disorder," and that the "quickest way to get from one point to another in treatment is not always what appears to be the most direct path."

This may be particularly relevant for clinicians working in more generalized settings, who may feel less confident in working with eating-disordered patients. Team members who are less involved with the patient may be able to encourage a more objective reflection, whilst those who have known the patient longer may be better able to see the progress they have made.

Understanding recovery as a process is also valuable in that it reminds us that, in some situations, change can be limited by external influences. Remaining in a damaging environment will significantly limit the likelihood or extent of recovery. Obvious examples of this would be continuing to live with domestic violence or sexual abuse, or a young person who is unable to move away from an invalidating family environment. Other people may choose to keep the same function within a relationship instead of moving on or attempting to alter the relationship. All of these will impact on how far towards recovery a person can move. As a clinician, consideration of such external factors can assist in maintaining a realistic perspective, knowing when to end treatment and reducing "burn-out."

## 28.10 Summary

In this chapter, we have attempted to convey both the complexity and subjectivity that surround the issue of recovery. Key issues include an understanding of the multifactorial nature of recovery, so that recovery is not judged on the basis of one factor alone. Recovery may be stepwise over a number of treatment episodes, and it is important to involve the patient in assessment of recovery.

Whilst in the latter part of the chapter, we have focused in greater detail on the more challenging or chronic patients and the long-term process of recovery for these individuals, we do not wish to forget the fact that many patients do recover from their eating disorder. Such patients move on into life, re-engaging in work, relationships and so on, with only the occasional lapse.

29

# Relapse management and ending treatment

In CBT, we start to prepare the patient for the ending from when treatment begins. Treatment is offered as a set number of sessions, with the explicit expectation that the patient will move toward becoming their own therapist across treatment. There will be indicators of CBT coming to an end throughout the treatment (e.g., a review of treatment at session ten indicating the half way point in a 20-session treatment contract; the patient moving from needing to self-monitor every day to just keeping a summary record of meals and snacks across the week). The ongoing analogy of the patient ''trekking around the coast of South America'' is helpful in pointing toward the ending of the formal treatment journey, and in encouraging the patient to continue with the ''trek'' themselves. Patients are also prepared by the spacing out of the later sessions to fortnightly (and then follow-ups at one month, three months and six months). The last few sessions of treatment is usually the point where plans for relapse prevention are addressed, but we also see it as important to address plans for future change, to be carried out by the patient in the role as their own therapist. It is also the time to begin a discussion about the patient's feelings and thoughts about the treatment ending. The last session is spent summarizing and saying a formal ''goodbye'' to the patient.

As treatment progresses, it may become apparent that the ending will need to be renegotiated based on the extended formulation. The extended formulation, developed with the patient, will provide an indicator as to whether further treatment sessions should be offered (e.g., adding sessions to work on core beliefs that emerged as maintaining factors part way through treatment). It is important to use the extended formulation to decide upon further treatment, as it can be tempting to ''hold onto'' patients past the agreed number of sessions. This temptation might be driven by the patient's fears of abandonment and their anxiety about not coping, or by the clinician's irrationally optimistic belief that ''a few more sessions will fix the patient,'' or by both. In managing the patient's anxiety, we encourage them to think about the ongoing ''trek,'' focus on long-term

goals and remind them of the relapse prevention strategies that they have available. To manage the clinician's anxiety, we recommend discussion with a supervisor or colleague about the rationale behind the proposed additional sessions.

## 29.1 Troubleshooting

At times, patients will have trouble with ending. As the clinician thinks about the ending from the beginning of treatment (and continues to highlight it throughout treatment), the hope is that most of the difficulties will be averted. However, this can be problematic, as outlined below.

### 29.1.1 Patients who will not end

Some patients attempt to prolong the ending by canceling sessions, and not attending the final session. If a patient keeps canceling the ending, we write a letter acknowledging the difficulty they are having in coming to say goodbye, but encouraging them to attend. We offer a further appointment, but stipulate that if they do not attend this appointment we will have to discharge them. Following this type of ending, we write a letter outlining and reviewing treatment as it would have been had the final session occurred.

As CBT draws to a close, if a patient is showing evidence of finding termination difficult, in the penultimate session we discuss that one possible outcome is that they might avoid attending the last session. We indicate that this is how some people manage ending, and that we can accept and understand that some people choose to end in this way. If the patient does not attend the final session, we will write a letter acknowledging the ending and summarizing treatment.

### 29.1.2 When treatment has not worked

It may be that the patient comes to the end of the agreed number of sessions and treatment has not worked. Alternatively treatment may have had to be terminated early, as the patient was unable to meet treatment non-negotiables. In these circumstances, we find it helpful to talk about recovery as a process (see Chapter 28), and we again use the coast of South America analogy. This analogy enables the clinician to reflect with the patient that they have begun to make the trek on the path to recovery by engaging in treatment, and to review where they have reached. A discussion is then held on future plans. For example, it may be that the patient postpones the trek for a while, rests at the point so far reached or continues the trek without help from the clinician. If they want to take such a break from meeting with the clinician, we stress that they can be re-referred so that they can re-commence the trek from whatever point they had reached.

## 29.2 Planning for further change

We return to the pie chart (Chapter 6) to highlight changes in the "balance of life" that have taken place across therapy. We then consider what the individual would like the pie chart to look like in the longer term, in order to begin to consider how they might want to achieve those goals. This might involve setting goals such as being more open in relationships, returning to education, changing jobs and having children, but the patient might need help to consider how they might achieve those goals. Again, Socratic questioning is a valuable tool in this task, as the clinician is likely to have a view of the utility of the patient's goals (or the viability of the means they propose to achieve them) that may be more of a hindrance than a help. The patient is encouraged to develop a log of aims, and is encouraged to review them over the coming years.

It may be that further change will require further work (e.g., general psychotherapy). Ending may involve assisting the patient to think about the pros and cons of further treatment, and whether taking a break from treatment might be beneficial.

## 29.3 Understanding, acceptance and management of risk

To demonstrate comprehensive recovery, the patient will also have an understanding of the function that their eating disorder served, and insight into the factors involved in the development and maintenance of the eating disorder. Returning to a key theme of CBT, the individual will own and understand their personal formulation, and recognize the factors relevant for relapse. Perhaps the real test of recovery is when they face a situation that they would normally have used the eating disorder to cope with. Examples of this might be day-to-day situations (such as receiving a comment about physical appearance) or more extreme (such as a relationship breakdown or bereavement). Someone who is well down the path to recovery will be able to accept that their eating disorder might always be an Achilles' heel, and will be attentive to life stressors that put them at risk of dieting, food restriction or binge eating. They will be aware when they are at risk or have slipped, and will be able to implement behavioral and psychological strategies in order to stabilize the situation.

## 29.4 Relapse prevention

When the patient has begun to set goals for the future and has accepted that they need to monitor risky situations (both in the present and in the future), we discuss

means by which they can avoid that risk. We encourage the patient to develop a relapse prevention file, which includes:

- useful tools and exercises that they have undertaken in treatment (e.g., motivational letters, formulation and pie charts from treatment)
- blank food and emotion diaries, in case they need to use them to avoid a problem
- a healthy eating plan that has helped to stabilize their eating across treatment
- useful phone numbers (e.g., the clinic, the local self-help group) and internet addresses
- copies of assessment and treatment outcome letters.

We also ask the patient to prepare summaries of:

- why they developed the eating disorder and what maintained it
- what helped in treatment
- what therapy-interfering behaviors they engaged in, and how to recognize and overcome them.

We then suggest that the patient treats the end of treatment as a start of personally directed follow-up, and ask them to plan "appointment" dates when they will return to the file and review progress (making notes about their progress and any exercises that they repeat).

Finally, we ask the patient to accept that they are likely to need to access the relapse prevention file, and that there is a danger of mislaying it (an example of a therapy-interfering behavior). Therefore, we ask them to ensure that the file is somewhere memorable. This will allow them to find it when experiencing risk or if they need to talk to a clinician.

## 29.5 The final session

The final session is a chance to get an update on the patient's progress, revisiting their goals from the beginning of treatment. We then check on relapse prevention strategies and any further thoughts about future plans the patient may have had since the previous meeting. Over the previous few sessions the patient's feelings and thoughts about treatment ending will have been raised for discussion, and this discussion can be concluded in this session. This session should also include feedback about what the patient liked and disliked about the treatment. Finally, this session provides the clinician with the opportunity to give the patient some feedback about how they have done in treatment, and for the clinician to acknowledge how he or she feels about the ending.

# Summary

In this section, we have addressed how to end CBT as positively as possible, given the range of possible outcomes. As throughout the whole of this book, we have aimed to stress how the best outcomes depend on a clinician stance that is underpinned by a clear understanding of both cognitive-behavioral principles and clinical realities. Even outcomes that are not positive in the short term can be used to improve the likelihood of recovery in the longer term, if the clinician continues to think about the overall target of CBT with the eating disorders.

# Conclusion: cognitive behavioral therapy for the eating disorders

We believe firmly in the importance of a good clinical assessment and formulation in planning and targeting treatment, and in the need to use treatment skills appropriately. However, it cannot be stated too strongly that the key to effective and flexible patient-based treatment is to adopt a coherent philosophy of care, which allows us to adapt our treatment to the individual patient's needs while remaining principle-driven.

In the course of this book, we have identified that CBT for the eating disorders has at its heart a set of techniques designed to help the patient to challenge the beliefs that drive their eating behaviors, and we have outlined methods for undertaking such challenges. However, we have stressed that such techniques take place in a much wider clinical context, and that effective CBT for the eating disorders depends on attending to issues such as motivation, emotional states, physical safety, nutritional status and psychological comorbidity. We have also emphasized the importance of considering the developmental, physical and systemic issues that apply differentially across the age range. It is also important to ensure that there is an appropriate support system in place, in the form of supervision and staff development.

We are grateful to colleagues and patients for the lessons that they have taught us over the years, and which have gone into the development of the ideas that are outlined in this book. We do not pretend that this book represents a definitive position. CBT for the eating disorders has come a long way, but it undoubtedly has further to go if it is to maintain its position as the leading psychological therapy for the eating disorders.

# References


Abraham, S. & Llewellyn-Jones, D. (1992). *Eating Disorders: The Facts*, 3rd edn. Oxford, UK: Oxford University Press.

Adkins, E. C. & Keel, P. K. (2005). Does "excessive" or "compulsive" best describe exercise as a symptom of bulimia nervosa? *International Journal of Eating Disorders*, **38**, 24–29.

Agras, W. S., Crow, S. J., Halmi, K. A., Mitchell, J. E., Wilson, G. T. & Kraemer, H. C. (2000). Outcome predictors for the cognitive behavioral treatment of bulimia nervosa: data from a multisite study. *American Journal of Psychiatry*, **157**, 1302–1308.

Agras, W. S., Telch, C. F., Arnow, B., Eldredge, K. & Marnell, M. (1997). One-year follow-up of cognitive-behavioral therapy for obese individuals with binge eating disorder. *Journal of Consulting and Clinical Psychology*, **65**, 343–347.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn. Washington, DC: American Psychiatric Association.

Arntz, A. & Weertman, A. (1999). Treatment of childhood memories: theory and practice. *Behaviour Research and Therapy*, **37**, 715–740.

Beck, A. T. & Steer, R. A. (1988). *Manual for the Beck Hopelessness Scale*. San Antonio, TX: The Psychological Corporation.

Beck, A. T. & Steer, R. A. (1993a). *Beck Depression Inventory Manual*. San Antonio, TX: The Psychological Corporation.

Beck, A. T. & Steer, R. A. (1993b). *Beck Anxiety Inventory Manual*. San Antonio, TX: The Psychological Corporation.

Beck, A. T., Rush, A. J., Shaw, B. F. & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford.

Beck, A. T., Wright, F. D., Newman, C. F. & Liese, B. S. (1993). *Cognitive Therapy of Substance Abuse*. New York: Guilford.

Beck, J. S. (2005). *Cognitive Therapy for Challenging Problems: What to Do When The Basics Don't Work*. New York: Guilford.

Bennett-Levy, J., Butler, G., Fennell, M., Hackmann, A., Mueller, M. & Westbrook, D. (2004). *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford, UK: Oxford University Press.

Blake, W., Turnbull, S. & Treasure, J. (1997). Stages and processes of change in eating disorders: implications for therapy. *Clinical Psychology and Psychotherapy*, **4**, 186–191.

Bond, F. W. (1998). Utilising case formulations in manual-based treatments. In M. Bruch & F. W. Bond, eds., *Beyond Diagnosis: Case Formulation Approaches in CBT*. Chichester, UK: Wiley, pp. 185–206.

Bremner, J. D., Krystal, J. H., Putnam, F. W., Southwick, S. M., Marmar, C., Charney, D. S. & Mazure, C. M. (1998). Measurement of dissociative states with the Clinician-Administered Dissociative States Scale (CADSS). *Journal of Traumatic Stress*, **11**, 125–136.

Brownell, K. D. (1991). Dieting and the search for the perfect body: where physiology and culture collide. *Behavior Therapy*, **22**, 1–12.

Bryant-Waugh, R. (2000). Overview of the eating disorders. In B. Lask & R. Bryant-Waugh, eds., *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence*, 2nd edn. New York: Psychology Press, pp. 25–40.

Butler, G. (1998). Clinical formulation. In A. S. Bellack & M. Hersen, eds., *Comprehensive Clinical Psychology*, Vol. 6. Oxford, UK: Pergamon, pp. 1–24.

Butler, G. & Hackmann, A. (2004). Social anxiety. In J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller & D. Westbrook, eds., *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford, UK: Oxford University Press, pp. 141–158.

Carlson, E. B. & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation*, **6**, 16–27.

Carr, A. (ed.) (2000). What works with children and adolescents? *A Critical Review of Psychological Interventions with Children, Adolescents and Their Families*. London: Brunner-Routledge.

Christie, D. (2000). Cognitive-behavioural therapeutic techniques for children with eating disorders. In B. Lask & R. Bryant-Waugh, eds., *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence*, 2nd edn. New York: Psychology Press, pp. 205–226.

Christie, D., Watkins, B. & Lask, B. (2000). Assessment. In B. Lask & R. Bryant-Waugh, eds., *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence*, 2nd edn. New York: Psychology Press, pp. 105–126.

Clark, D. M. (2005). A cognitive perspective on social phobia. In W. R. Crozier & L. E. Alden, eds., *The Essential Handbook of Social Anxiety for Clinicians*. Chichester, UK: Wiley, pp. 193–218.

Clark, D. M. & Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, M. Liebowitz, D. A. Hope & F. R. Schneier, eds., *Social Phobia: Diagnosis, Assessment and Treatment*. New York: Guilford, pp. 69–93.

Cockell, S. J., Geller, J. & Linden, W. (2003). Decisional balance in anorexia nervosa: capitalizing on ambivalence. *European Eating Disorders Review*, **11**, 75–89.

Coker, S., Vize, C., Wade, T. & Cooper, P. (1993). Patients with bulimia nervosa who fail to engage in cognitive behaviour therapy. *International Journal of Eating Disorders*, **13**, 35–40.

Cooper, M. (1997). Cognitive theory in anorexia nervosa and bulimia nervosa: a review. *Behavioural and Cognitive Psychotherapy*, **25**, 113–145.

Cooper, M., Cohen-Tovée, E., Todd, G., Wells, A. & Tovée, M. (1997). The Eating Disorder Belief Questionnaire: preliminary development. *Behaviour Research and Therapy*, **35**, 381–388.

Cooper, M. J., Todd, G. & Wells, A. (2000). *Bulimia Nervosa: A Cognitive Therapy Programme for Clients*. London: Jessica Kingsley.

Cooper, M. J., Wells, A. & Todd, G. (2004). A cognitive model of bulimia nervosa. *British Journal of Clinical Psychology*, **43**, 1–16.

Cooper, M. J., Whitehead, L. & Boughton, N. (2004). Eating disorders. In J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller & D. Westbrook, eds., *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford, UK: Oxford University Press, pp. 267–286.

Cooper, P. J., Watkins, B., Bryant-Waugh, R. & Lask, B. (2002). The nosological status of early onset anorexia nervosa. *Psychological Medicine*, **32**, 873–880.

Cordery, H. & Waller, G. (2006). Nutritional knowledge of health care professionals working in the eating disorders. *European Eating Disorders Review*, **14**, 462–467.

Corstorphine, E. (2006). Cognitive-emotional-behavioural therapy for the eating disorders: working with beliefs about emotions. *European Eating Disorders Review*, **14**, 462–467.

Crisp, A. (1980). *Anorexia Nervosa: Let Me Be*. New York: Grune and Stratton.

Department of Health (2004). *At Least Five a Week: Evidence on the Impact of Physical Activity and Its Relationship to Health: A Report from the Chief Medical Officer*. London: Department of Health.

Dansky, B. S., Brewerton, T. D., Kilpatrick, D. G. & O'Neil, P. M. (1997). The National Women's Study: relationship of victimization and posttraumatic stress disorder to bulimia nervosa. *International Journal of Eating Disorders*, **21**, 213–228.

de Shazer, S. (1988). *Clues: Investigating Solutions in Brief Therapy*. San Francisco, CA: Jossey-Bass.

de Zwaan, M., Aslam, Z. & Mitchell, J. E. (2002). Research on energy expenditure in individuals with eating disorders: a review. *International Journal of Eating Disorders*, **32**, 127–134.

DiClemente, C. & Prochaska, J. O. (1998). Towards a comprehensive, transtheorectical model of change. In W. Miller & N. Heather, eds., *Treating Addictive Behaviours*. New York: Plenum Press, pp. 3–24.

Ehlers, A. & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, **38**, 1–27.

Eisler, I., Le Grange, D. & Asen, E. (2003). Family interventions. In J. Treasure, U. Schmidt & E. van Furth, eds., *Handbook of Eating Disorders*. Chichester, UK: Wiley, pp. 291–310.

Eivors, A. & Nesbitt, S. (2005). *Hunger for Understanding: A Workbook for Helping Young People to Understand and Overcome Anorexia Nervosa*. Carlsbad, CA: Gurze.

Elfhag, K. & Rossner, S. (2005). Who succeeds in maintaining weight loss? A conceptual review of factors associated with weight loss maintenance and weight regain. *Obesity Review*, **6**, 67–85.

Fairburn, C. G. (1997). Eating disorders. In D. M. Clark & C. G. Fairburn, eds., *Science and Practice of Cognitive Behaviour Therapy*. Oxford, UK: Oxford University Press, pp. 209–241.

Fairburn, C. G. (2004). *CBT for Eating Disorders: Principles and Procedures*. Workshop presented in Truro, Cornwall, UK, April.

Fairburn, C. G. & Beglin, S. J. (1994). The assessment of eating disorders: interview or self-report questionnaire? *International Journal of Eating Disorders*, **16**, 363–370.

Fairburn, C. G. & Cooper, P. (1989). Eating disorders. In K. Hawton, P. M. Salkovskis, J. Kirk & D. M. Clark, eds., *Cognitive Behaviour Therapy for Psychiatric Problems*. New York: Oxford University Press, pp. 277–314.

Fairburn, C. G., Cooper, Z. & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, **41**, 509–528.

Fairburn, C. G. & Harrison, P. J. (2003). Eating disorders. *Lancet*, **361**, 407–416.

Fairburn, C. G., Norman, P. A., Welch, S. L., O'Connor, M. E., Doll, H. A. & Peveler, R. C. (1995). A prospective outcome study in bulimia nervosa and the long-term effects of three psychological treatments. *Archives of General Psychiatry*, **52**, 304–312.

Fairburn, C. G., Shafran, R. & Cooper, Z. (1999). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy*, **37**, 1–13.

Fallon, P. & Wonderlich, S. A. (1997). Sexual abuse and other forms of trauma. In D. M. Garner & P. E. Garfinkel, eds., *Handbook of Treatment for Eating Disorders*, 2nd edn. New York: Guilford, pp. 394–414.

Farrell, C., Shafran, R., Lee, M. & Fairburn, C. G. (2005). Testing a brief cognitive-behavioural intervention to improve extreme shape concern: a case series. *Behavioural and Cognitive Psychotherapy*, **33**, 189–200.

Favaro, A. & Santonastaso, P. (1998). Impulsive and compulsive self-injurious behaviour in bulimia nervosa: prevalence and psychological correlates. *Journal of Nervous and Mental Disease*, **186**, 157–165.

Favaro, A. & Santonastaso, P. (2000). Self-injurious behavior in anorexia nervosa. *Journal of Nervous and Mental Disease*, **188**, 537–542.

Fennell, M. & Jenkins, H. (2004). Low self-esteem. In J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller & D. Westbrook, eds., *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford, UK: Oxford University Press, pp. 413–430.

Fichter, M., Quadfleig, N. & Reif, W. (1994). Course of multiimpulsive bulimia. *Psychological Medicine*, **24**, 591–604.

First, M. B., Spitzer, R. L., Gibbon, M. & Williams, J. B. W. (1997). *Structured Clinical Interview for DSM-IV Axis I Disorders: Patient Edition* (SCID-I/P, Version 2.0, 4/97 revision). New York: Biometrics Research Department.

Foa, E., Cashman, L. & Jaycox, L. (1997). The validation of a self-report measure of posttraumatic stress disorder, the Posttraumatic Diagnostic Scale. *Psychological Assessment*, **9**, 445–451.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F. & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): development and validation. *Psychological Assessment*, **11**, 303–314.

Foa, E. B. & Rothbaum, B. O. (1998). *Treating the Trauma of Rape: Cognitive-behavior Therapy for PTSD*. New York: Guilford.

Food Standards Agency (2002). *McCance and Widdowson's the Composition of Foods*, 6th summary edn. Cambridge, UK: Royal Society of Chemistry.

Garner, D. M. (1997). Psychoeducational principles in treatment. In D. M. Garner & P. E. Garfinkel, eds., *Handbook of Treatment for Eating Disorders*, 2nd edn. New York: Guilford, pp. 145–187.

Garner, D. M. & Garfinkel, P. E. (1997). *Handbook of Treatment for Eating Disorders*, 2nd edn. New York: Guilford.

Geller, J. (2002a). What a motivational approach is and what a motivational approach isn't: reflections and responses. *European Eating Disorders Review*, **10**, 155–160.

Geller, J. (2002b). Estimating readiness for change in anorexia nervosa: comparing clients, clinicians and research assessors. *International Journal of Eating Disorders*, **31**, 251–260.

Geller, J. (2005). Working relationships: What level of investment is optimal for our clients? Paper presented at the London International Conference on Eating Disorders. London, UK, April.

Geller, J., Cockell, S. J. & Drab, D. (2001). Assessing readiness for change in anorexia nervosa: the psychometric properties of the readiness and motivation for change interview. *Psychological Assessment*, **13**, 189–198.

Geller, J. & Drab, D. L. (1999). The Readiness and Motivation Interview: a symptom specific measure of readiness for change in the eating disorders. *European Eating Disorders Review*, **7**, 259–278.

Geller, J., Williams, K. D. & Srikameswaran, S. (2001). Clinician stance in the treatment of chronic eating disorders. *European Eating Disorders Review*, **9**, 365–373.

Ghaderi, A. (2006). Does individualization matter? A randomized trial of standardized (focused) versus individualized (broad) cognitive behavior therapy for bulimia nervosa. *Behaviour Research and Therapy*, **44**, 273–288.

Gowers, S. & Bryant-Waugh, R. (2004). Management of child and adolescent eating disorders: the current evidence base and future directions. *Journal of Child Psychology and Psychiatry*, **45**, 63–83.

Gowers, S. G., Weetman, J., Shore, A., Hossain, F. & Elvins, R. (2000). Impact of hospitalisation on the outcome of adolescent anorexia nervosa. *British Journal of Psychiatry*, **176**, 138–141.

Graham, P. J. (ed.) (2005a). *Cognitive Behaviour Therapy for Children and Families*, 2nd edn. Cambridge, UK: Cambridge University Press.

Graham, P. J. (2005b). Jack Tizard lecture. Cognitive behaviour therapies for children: passing fashion or here to stay? *Child and Adolescent Mental Health*, **10**, 57–62.

Gray, N., Young, K. & Holmes, E. (2002). Cognitive restructuring within reliving: a treatment for peritraumatic emotional "hotspots" in posttraumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, **30**, 37–56.

Hall, A. (1982). Deciding to stay an anorectic. *Postgraduate Medical Journal*, **58**, 641–647.

Halmi, K., Sunday, S. R., Klump, K. L. *et al.* (2003). Obsessions and compulsions in anorexia nervosa subtypes. *International Journal of Eating Disorders*, **33**, 308–319.

Hart, S., Abraham, S., Luscombe, G. & Russell, J. (2005). Fluid intake in patients with eating disorders. *International Journal of Eating Disorders*, **38**, 55–59.

Heatherton, T. F. & Baumeister, R. F. (1991). Binge-eating as an escape from awareness. *Psychological Bulletin*, **110**, 86–108.

Herrin, M. (2003). *Nutritional Counselling in the Treatment of Eating Disorders*. Hove: Brunner-Routledge.

Hinrichsen, H., Garry, J. & Waller, G. (2006). Development and preliminary validation of the Testable Assumptions Questionnaire – Eating Disorders (TAQ-ED). *Eating Behaviors*, **7**, 275–281.

Hinrichsen, H. & Waller, G. (2006). The treatment of avoidant personality disorder in patients with eating disorders. In R. A. Sansone, & J. L. Levitt (Eds.), *Personality disorders and eating disorders: Exploring the frontier*. New York: Routledge.

Hinrichsen, H., Wright, F., Waller, G. & Meyer, C.(2003). Social anxiety and coping strategies in the eating disorders. *Eating Behaviors*, **4**, 117–126.

Jacob, F. (2001). *Solution Focused Recovery from Eating Distress*. London: BT Press.

Janet, P. (1889). *L'automatisme psychologique (Psychological Automatism)*. Paris: Alcan.

Jansen, A., Smeets, T., Martijn, C., Nederkoorn, C. (2006). I see what you see: the lack of a self-serving body-image bias in eating disorders. *British Journal of Clinical Psychology*, **45**, 123–135.

Kabat-Zinn, J. (1990). *Full Catastrophe Living. How to Cope With Stress, Pain and Illness Using Mindfulness Meditation*. New York: Dell Publishing.

Kaye, W. H., Weltzin, T. E., Hsu, L. K., McConaha, C. W. & Bolton, B. (1993). Amount of calories retained after binge eating and vomiting. *American Journal of Psychiatry*, **150**, 969–971.

Keller, V. F. & Kemp-White, M. (1997). Choices and changes: a new model for influencing patient health behaviour. *Journal of Clinical Outcome Management*, **4**, 33–36.

Kellow, J. & Walton, R. (2006). *The Calorie Carb and Fat Bible*. Peterborough, UK: Weight Loss Resources.

Kennerley, H. (1996). Cognitive therapy of dissociative symptoms associated with trauma. *British Journal of Clinical Psychology*, **35**, 325–340.

Kennerley, H. (2000). *Overcoming Childhood Trauma*. London: Robinson.

Kent, A., Waller, G. & Dagnan, D. (1999). A greater role of emotional than physical or sexual abuse in predicting disordered eating attitudes: the role of mediating variables. *International Journal of Eating Disorders*, **25**, 159–167.

Keski-Rahkonen, A. & Tozzi, F. (2005). The process of recovery in eating disorder sufferers' own words: an internet-based study. *International Journal of Eating Disorders*, **37**, S80–S86.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M. & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, **52**, 1048–1060.

Key, A., George, D., Beattie, K., Stammers, K., Lacey, H. & Waller, G. (2002). Body image treatment within an inpatient program for anorexia nervosa: the role of mirror exposure in the desensitization process. *International Journal of Eating Disorders*, **31**, 185–190.

Keys, A., Brozek, J., Henschel, A., Mickelsen, O. & Taylor, H. L. (1950). *The Biology of Human Starvation*. Minneapolis, MN: University of Minnesota Press.

Kahm, A. (1994). Recovery through nutritional counselling. In B. P. Kinoy, ed., *New Directions in Treatment and Recovery*. New York: Columbia University Press.

Krochmalik, A., Jones, M. K. & Menzies, R. G. (2001). Danger Ideation Reduction Therapy (DIRT) for treatment-resistant compulsive washing. *Behaviour Research and Therapy*, **39**, 897–912.

Lacey, J. H. (1986). Pathogenesis. In L. J. Downey & J. C. Malkin, eds., *Current Approaches: Bulimia Nervosa*. Southampton, UK: Duphar, pp. 17–26.

Lacey, J. H. (1993). Self-damaging and addictive behaviour in bulimia nervosa. A catchment area study. *British Journal of Psychiatry*, **163**, 190–194.

Lara, J. J., Scott, J. A. & Lean, M. E. J. (2004). Intentional mis-reporting of food consumption and its relationship with body mass index and psychological scores in women. *Journal of Human Nutrition and Dietetics*, **33**, 209–218.

Lask, B. (2000). Overview of management. In B. Lask & R. Bryant-Waugh, eds., *Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence*, 2nd edn. New York: Psychology Press, pp. 167–186.

Lask, B. & Bryant-Waugh, R. (eds.) (2000). *Anorexia nervosa and related eating disorders in childhood and adolescence*, 2nd edn. New York: Psychology Press.

Leahy, R. L. (2001). *Overcoming Resistance in Cognitive Therapy*. New York: Guilford.

Leahy, R. L. & Holland, S. J. (2000). *Treatment Plans and Interventions for Depression and Anxiety Disorders*. New York: Guilford.

Linehan, M. (1993). *Cognitive-behavioural Treatment of Borderline Personality Disorders*. New York: Guilford.

Linehan, M. M. (2001). Dialectical behavioural therapy: Data on effectiveness. Paper presented at World Congress of Behavioural and Cognitive Therapies, Vancouver, July.

Linehan, M. M., Dimeff, L. A., Comtois, K. A., Welch, S. S., Heagerty, P. & Kivlahan, D. R. (2002). Dialectical behaviour therapy versus comprehensive validation therapy plus 12-step for the treatment of opiod dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence*, **67**, 13–26.

Lock, J., Le Grange, D., Agras, S. & Dare, C. (2001). *Treatment Manual for Anorexia Nervosa: A Family-Based Approach*. New York: Guilford.

Lockwood, R., Lawson, R. & Waller, G. (2004). Compulsive features in the eating disorders: a role for trauma? *Journal of Nervous and Mental Disease*, **192**, 247–249.

Mahon, J. (2000). Dropping out from psychological treatment for eating disorders: what are the issues? *European Eating Disorders Review*, **8**, 198–216.

Main, T. F. (1957). The ailment. *British Journal of Medical Psychology*, **30**, 129–145.

Malan, D. H. (1995). *Individual Psychotherapy and the Science of Psychodynamics*. London: Butterworth.

Maughan, R. J. & Griffin, J. (2003). Caffeine ingestion and fluid balance: a review. *Journal of Human Nutrition & Dietetics*, **16**, 411–420.

McKay, D., Abramowitz, J. S., Calamari, J. E. *et al.* (2004). A critical evaluation of obsessive-compulsive disorder subtypes: symptoms versus mechanisms. *Clinical Psychology Review*, **24**, 283–313.

McKisack, C. & Waller, G. (1997). Factors influencing the outcome of group psychotherapy for bulimia nervosa. *International Journal of Eating Disorders*, **22**, 1–13.

McManus, F. & Waller, G. (1995). A functional analysis of binge-eating. *Clinical Psychology Review*, **15**, 345–363.

Miller, W. R. (1995). *Motivational Enhancement Therapy Manual: A Clinical Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence. Matching Alcoholism Treatment to Client Heterogeneity*, Monograph Series, 2 (No 94–3723). Rockville. MD: National Insititute on Alcohol Abuse and Alcoholism.

Mitchell, J. E. (1991). A review of the controlled trials of psychotherapy for bulimia nervosa. *Journal of Psychosomatic Research*, **35**, 23–31.

Morgan, H. G. & Russell, G. F. M. (1975). Value of family background and clinical features as predictors of long-term outcome in anorexia nervosa: four-year follow-up study of 41 patients. *Psychological Medicine*, **5**, 355–371.

Mountford, V., Corstorphine, E., Tomlinson, S. & Waller, G. (2007). Development of a measure to assess invalidating childhood environments in the eating disorders. *Eating Behaviors* **8**, 48–58.

Mountford, V., Haase, A. & Waller, G. (2006). Body checking in the eating disorders: associations between cognitions and behaviours. *International Journal of Eating Disorders*, **39**, 708–716.

Mountford, V. & Waller, G. (2006). Using imagery in cognitive behavioural therapy for the eating disorders: Tackling the restrictive mode. *International Journal of Eating Disorders* **39**, 533–543.

Mueller, M., Hackmann, A. & Croft, A. (2004). Posttraumatic stress disorder. In J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller & D. Westbrook, eds., *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford, UK: Oxford University Press, pp. 183–201.

Murphy, S., Russell, L. & Waller, G. (2005). Integrated psychodynamic therapy for bulimia nervosa and binge eating disorder: theory, practice and preliminary findings. *European Eating Disorders Review*, **13**, 383–391.

Nagata, T., Kawarada, Y., Kiriike, N. & Iketani, T. (2000). Multiimpulsivity of Japanese patients with eating disorders: primary and secondary impulsivity. *Psychiatry Research*, **17**, 239–250.

National Institute for Clinical Excellence (2004). *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders* (Clinical Guideline 9). London: National Collaborating Centre for Mental Health.

Nicholls, D., Chater, R. & Lask, B. (2000). Children into DSM don't go: a comparison of classification systems for eating disorders in childhood and early adolescence. *International Journal of Eating Disorders*, **28**, 317–324.

Norring, C. & Palmer, R. (eds.) (2005). *EDNOS: Eating Disorders Not Otherwise Specified*. London: Routledge.

Norris, D. L. (1984). The effects of mirror confrontation on self-estimation of body dimensions in anorexia nervosa, bulimia and two control groups. *Psychological Medicine*, **14**, 835–842.

Ogden, J. (1992). *Fat Chance! The Myth of Dieting Explained*. London: Routledge.

Ohanian, V. (2002). Imagery rescripting within cognitive behaviour therapy for bulimia nervosa: an illustrative case report. *International Journal of Eating Disorders*, **30**, 352–357.

Padesky, C. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy*, **1**, 267–278.

Padesky, C. A. (1996). Developing cognitive therapist competency: teaching and supervision models. In P. M. Salkovskis, ed., *Frontiers of Cognitive Therapy*. New York: Guilford, pp. 266–292.

Persons, J. B. & Thompkins, M. A. (1997). Cognitive-behavioral case formulation. In T. D. Eels , ed., *Handbook of Psychotherapy Case Formulation*. New York: Guilford, pp. 314–339.

Radomsky, A. S. & Rachman, S. (2004). Symmetry, ordering and arranging compulsive behaviour. *Behaviour Research and Therapy*, **42**, 893–913.

Reas, D. L., Whisenhunt, B. L., Netemeyer, R. & Williamson, D. A. (2002). Development of the body checking questionnaire: a self-report measure of body checking behaviours. *International Journal of Eating Disorders*, **31**, 324–333.

Reynolds, M. & Brewin, C. R. (1999). Intrusive memories in depression and posttraumatic stress disorder. *Behaviour Research and Therapy*, **37**, 201–215.

Rieger, E., Touyz, S. W. & Beumont, P. (2002). The Anorexia Nervosa Stages of Change Questionnaire: information regarding its psychometric properties. *International Journal of Eating Disorders*, **32**, 24–38.

Robin, A., Gilroy, M. & Dennis, A. B. (1998). Treatment of eating disorders in children and adolescents. *Clinical Psychology Review*, **18**, 421–446.

Rorty, M., Yager, J. & Rossotto, E. (1994). Childhood sexual, physical, and psychological abuse and their relationship to comorbid psychopathology in bulimia nervosa. *International Journal of Eating Disorders*, **16**, 317–334.

Rosen, J. C. (1997). Cognitive behavioural body image therapy. In D. M. Garner & P. E. Garfinkel, eds., *Handbook of Treatment for Eating Disorders*, 2nd edn. New York: Guilford, pp. 188–201.

Rosenberg, M. (1965). *Society and the Adolescent Self-image*. Princeton, NJ: Princeton University Press.

Rouf, K., Fennell, M., Westbrook, D., Cooper, M. & Bennett-Levy, J. (2004). Devising effective behavioural experiments. In J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller & D. Westbrook, eds., *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford, UK: Oxford University Press, pp. 21–58.

Royal College of Psychiatrists (2005). *Guidelines for the Nutritional Management of Anorexia Nervosa (Council Report CR130)*. London, UK: Royal College of Psychiatrists.

Russell, G. F. M. (1970). Anorexia nervosa: its identity as an illness and its treatment. In J. H. Price, ed., *Modern Trends in Psychological Medicine*. London: Butterworths, pp. 131–164.

Russell, G. F. M. (1979). Bulimia nervosa: an ominous variant of anorexia nervosa. *Psychological Medicine*, **9**, 429–448.

Ryle, A. & Kerr, I. B. (2002). *Introducing Cognitive Analytic Therapy: Principles and Practice*. Chichester, UK: Wiley.

Safer, D. S., Telch, C. F. & Agras, W. S. (2001). Dialectical behaviour therapy adapted for bulimia: a case report. *International Journal of Eating Disorders*, **30**, 101–106.

Sansone, R. A. & Fine, M. A. (1992). Borderline personality disorder as a predictor of outcome in women with eating disorders. *Journal of Personality Disorders*, **6**, 176–186.

Segal, Z. V., Williams, J. M. G. & Teasdale, J. D. (2002). *Mindfulness-based Cognitive Therapy for Depression. A New Approach to Preventing Relapse*. New York: Guilford.

Serpell, L. & Treasure, J. (2002). Bulimia nervosa: friend or foe? The pros and cons of bulimia nervosa. *International Journal of Eating Disorders*, **32**, 164–170.

Serpell, L., Treasure, J., Teasdale, J. & Sullivan, V. (1999). Anorexia nervosa: friend or foe? *International Journal of Eating Disorders*, **25**, 177–186.

Shafran, R., Cooper, Z. & Fairburn, C. (2002). Clinical perfectionism: a cognitive behavioural analysis. *Behaviour Research and Therapy*, **40**, 773–791.

Slade, P. (1982). Towards a functional analysis of anorexia nervosa and bulimia nervosa. *British Journal of Clinical Psychology*, **21**, 167–179.

Smucker, M. R. & Niederee, J. (1995). Treating incest-related PTSD and pathogenic schemas through imaginal exposure and rescripting. *Cognitive and Behavioral Practice*, **2**, 63–93.

Stallard, P. (2002). *Think Good – Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People*. Chichester, UK: Wiley.

Stallard, P. (2005). Cognitive behaviour therapy with prepubertal children. In P. J. Graham, ed., *Cognitive Behaviour Therapy for Children and Families*, 2nd edn. Cambridge, UK: Cambridge University Press.

Stewart, T. M. (2004). Light on body image treatment: acceptance through mindfulness. *Behaviour Modification*, **28**, 783–811.

Sundin, E. C. & Horowitz, M. J. (2003). Horowitz's Impact of Event Scale: evaluation of 20 years of use. *Psychosomatic Medicine*, **65**, 870–876.

Tanner, J. M., Whitehouse, R. M. & Takaishi, M. (1966a). Standards from birth to maturity for height, weight, height velocity, weight velocity: British children, 1965, I. *Archives of Disease in Childhood*, **41**, 454–471.

Tanner, J. M., Whitehouse, R. M. & Takaishi, M. (1966b). Standards from birth to maturity for height, weight, height velocity, weight velocity: British children, 1965, II. *Archives of Disease in Childhood*, **41**, 613–635.

Thordarson, D. S., Radomsky, A. S., Rachman, S., Shafran, R., Sawchuk, C. N. & Ralph Hakstian, A. (2004). The Vancouver Obsessional Compulsive Inventory (VOCI). *Behaviour Research and Therapy*, **42**, 1289–1314.

Tobin, D., Banks, J., Weissberg-Wong, L. & Bowers, W. (2005). I know what you did last summer (and it wasn't CBT). Paper presented at the Eating Disorders Research Society Meeting, Toronto, Canada, September.

Treasure, J. & Bauer, B. (2003). Assessment and motivation. In J. Treasure, U. Schmidt & E. van Furth, eds., *Handbook of Eating Disorders*. Chichester, UK: Wiley.

Treasure, J. & Ramsay, R. (1998). *Hard to Swallow: Compulsory Treatment in Eating Disorders* (Maudsley Discussion Paper No. 3, p. 20). London: Maudsley Hospital.

Turner, S. M., Beidel, D. C., Dancu, C. V. & Stanley, M. A. (1989). An empirically derived inventory to measure social fears and anxiety: the Social Phobia and Anxiety Inventory. *Psychological Assessment*, **1**, 35–40.

van der Weyer, C. (2005). *Changing Diets, Changing Minds: How Food Affects Mental Well-being and Behaviour*. London: Sustain.

Vitousek, K. (2005). Alienating patients from the "anorexic self": Externalization and alternative strategies. Paper presented at the Seventh London International Eating Disorders Conference, London, UK, April.

Vitousek, K., Watson, S. & Wilson, G. T. (1998). Enhancing motivation for change in treatment-resistant eating disorder. *Clinical Psychology Review*, **18**, 391–420.

Waller, G. (1993). Why do we diagnose different types of eating disorder? Arguments for a change in research and clinical practice. *Eating Disorders Review*, **1**, 74–89.

Waller, G. (1997). Drop-out and failure to engage in individual outpatient cognitive-behaviour therapy for bulimic disorders. *International Journal of Eating Disorders*, **22**, 35–41.

Waller, G., Hamilton, K., Rose, N., Sumra, J. & Baldwin, G. (1993). Sexual abuse and body-image distortion in the eating disorders. *British Journal of Clinical Psychology*, **32**, 350–352.

Waller, G., Kennerley, H. & Ohanian, V. (in press). Schema-focused cognitive behaviour therapy with eating disorders. In L. P. Riso, P. T. du Toit & J. E. Young, eds., *Cognitive Schemas and Core Beliefs in Psychiatric Disorders: A Scientist-Practitioner Guide*. New York: American Psychological Association.

Waller, G., Patient, E., Corstorphine, E. Hinrichsen, H., Lawson, R. & Mountford, V. (2005). Cognitive behaviour therapy for bulimic disorders: effectiveness in non-research settings. Paper presented at the Eating Disorders Research Society Meeting, Toronto, Canada, September.

Watson, D. & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology*, **33**, 448–457.

Welch, S. L. & Fairburn, C. G. (1996). Impulsivity or comorbidity in bulimia nervosa. A controlled study of deliberate self-harm and alcohol and drug misuse in a community sample. *British Journal of Psychiatry*, **169**, 451–458.

Wells, A. (1997). *Cognitive Therapy of Anxiety Disorders: A Practice Manual and Conceptual Guide*. Chichester, UK: Wiley, pp. 80–85.

Willoughby, K. & Hirani, V. (2005). Recovery from anorexia nervosa: a question of definition. Paper presented at the Seventh London International Eating Disorders Conference, London, UK, April.

Wilson, G. T. (1999). Cognitive behavioural therapy for eating disorders: progress and problems. *Behaviour Research and Therapy*, **37**, 579–596.

Wilson, G. T. (2004). Acceptance and change in the treatment of eating disorders: the evolution of manual-based cognitive behavioural therapy (CBT). In S. C. Hayes, V. M. Follette & M. Linehan, eds., *Acceptance, Mindfulness and Behaviour Change*. New York: Guilford, pp. 243–260.

Wilson, G. T. & Sysko, R. (2006). Cognitive behavioural therapy for adolescents with bulimia nervosa. *European Eating Disorders Review*, **14**, 8–16.

Wurtman, J. (1989). Carbohydrate therapy for premenstrual syndrome. *American Journal of Obstetrics and Gynaecology*, **161**, 1228–1234.

Young, J. E. (1998). *Young Schema Questionnaire – Short Form (YSQ-S)* (online). New York: Cognitive Therapy Centre (available: http://www.schematherapy.com).

Young, J. E. (1999). *Cognitive Therapy for Personality Disorders: A Schema-focused Approach*, 3rd edn. Sarasota, FL: Professional Resource Press.

Young, J. E. & Klosko, J. S. (1993). *Reinventing Your Life*. New York: Plume Publishers.

Young, J. E., Klosko, J. S. & Weishaar, M. E. (2003). *Schema Therapy: A Practitioner's Guide*. New York: Guilford.

Appendix 1

# Semi-structured interview protocol

# Eating Disorders Service

## Assessment: Clinical data sheet

Please write clearly, and complete each item for every patient. This sheet is designed to ensure that we have good baseline data on everybody at assessment, and not to influence the way that you interview the patient. Therefore, you do not have to work through the items in order. Just make sure that the information is collected by the end of the assessment, whatever the order in which the questions are asked.

**Name of assessor:** _____

**Date of assessment:** ____ / ____ / ____

**Patient's name:** _____

**Gender:** Female / Male
*(delete as necessary)*

**Date of birth:** ____ / ____ / ____

**Age at assessment:** _____ years

**ID number:** _____

**Employment status/job:** _____

**Presentation at interview:**

| |
|---|
| Appearance<br><br>Mood<br><br>Engagement with therapist<br><br>Alone/accompanied? |

## Eating behaviours

**Pattern of eating:**
Give a brief summary of the patient's usual pattern of eating (e.g., routinised; chaotic) and the amounts eaten at different times in the day.

Foods avoided:

Rituals:

**Weight at assessment:** _____ kg **Height at assessment:** _____ m

**BMI at assessment:** _____ **Patient's ideal weight:** _____ kg
(weight [kg] / height [$m^2$])

**Lowest adult weight:** _____ kg **at age(s) :** _____ years

**Highest adult weight:** _____ kg **at age(s) :** _____ years

**Bulimic behaviours:**

| Behaviour | Current frequency/ occurrence | Past frequency/ occurrence | Comments (e.g., when used in past; type/dose of medication) |
|---|---|---|---|
| Bingeing (objective) [1] | _____ per week | _____ per week | |
| Bingeing (subjective) [1] | _____ per week | _____ per week | |
| Vomiting | _____ per week | _____ per week | |
| Laxative abuse | Yes / No * | Yes / No * | |
| Diuretic abuse | Yes / No * | Yes / No * | |
| Excessive exercise [2] | Yes / No * | Yes / No * | |
| Compulsive exercise [3] | Yes / No * | Yes / No * | |
| Diet pills | Yes / No * | Yes / No * | |
| Other purging behaviours | Yes / No * | Yes / No * | |

* *delete as necessary*

**Notes**

[1] Objective binges = excessive amount of food, sense of loss of control.
Subjective binges = small/normal amount of food, sense of loss of control.
Grazing/comfort eating/'mountain eating' = large amount of food, no sense of loss of control.

[2] Excessive exercise = four or more hours per week, with the intent of losing weight.

[3] Compulsive exercise = the activity has a compulsive, routine element (e.g., rigid number of exercises; superstitious thinking), rather than being defined by the number of hours or by the weight loss element.

**Reported triggers to current bulimic behaviours:**

| **Behaviour** | **Hunger/fullness** (tick if reported) | **Social** (tick if reported) | **Emotional states?** (indicate which apply) |
|---|---|---|---|
| Bingeing | | | Anger *; anxiety *; depression *; shame *; boredom *; loneliness * |
| Purging | | | Anger *; anxiety *; depression *; shame *; boredom *; loneliness * |

* *delete as necessary*

**Periods:** absent / present / not applicable *
* *delete as necessary*

**Menarche:** _____ years

**Reaction to onset of periods:** _____

**Periods currently absent for:**_____ months / years

**Currently on pill/pregnant/breast-feeding?:** Yes / No

**Periods absent in the past for:**_____ months / years

**History of pregnancy?:** Yes / No

Details: _____

**History of termination of pregnancy?:** Yes / No

Details _____

**History of sexual relationships:**

**Sexuality:** heterosexual / bisexual / homosexual / unsure
*(delete as necessary)*

**Disturbance of body concept:** present / absent *
*(dislikes own body)* * *delete as necessary*

**Disturbance of body percept:** present / absent *
*(sees self as too fat/thin)* * *delete as necessary*

**Fear of fatness:** present / absent *
* *delete as necessary*

**Eating disorder diagnosis:**

| **DSM-IV diagnosis** | | **Tick** *(one only)* | **Further details** (if diagnosis is unclear or atypical) |
|---|---|---|---|
| Anorexia nervosa restrictive subtype | | | |
| Anorexia nervosa binge/purge subtype | | | |
| Bulimia nervosa purging subtype | | | |
| Bulimia nervosa non-purging subtype | | | |
| EDNOS: *(see column on right)* | Binge-eating disorder | | |
| | Atypical anorexia nervosa | | |
| | Atypical bulimia nervosa | | |
| | Normal weight purging behaviour | | |
| Other *(see column on right)* | | | |

## Treatment experiences to date

**Past treatment:**
(note what is reported as effective and what did not seem to help)

| Physical/medication: | Psychotherapeutic: |
|---|---|
| | |

**Current treatment:**
If already in treatment, warn the patient about the potential need to change medications or to focus on one psychological treatment at a time.

| Physical/medication: | Psychotherapeutic: |
|---|---|
| | |

## Comorbid behaviours, psychological problems and general health

**Current and past impulsive behaviours** (used to influence emotional arousal)**:**

| Behaviour | | Current use (tick if used) | Use in past (tick if used) | Comments (especially when used) |
|---|---|---|---|---|
| Self-cutting | | | | |
| Other impulsive self-harm (e.g., hitting; burning) | | | | |
| Compulsive self-harm (e.g., picking skin; hair pulling) | | | | |
| Overdoses | | | | |
| Suicide attempts | | | | |
| Compulsive spending (not on food) | | | | |
| Compulsive stealing (not food) | | | | |
| Excessive alcohol use | | | | |
| Drug use | Amphetamine | | | |
| | Cocaine | | | |
| | Ecstasy | | | |
| | LSD | | | |
| | Cannabis | | | |
| | Heroin | | | |
| | Others (specify) | | | |
| Risky sexual behaviour (e.g., recurrent one-night stands; unsafe sex; working in sex industry) | | | | |

**Is the patient's eating problem multi-impulsive in nature?** Yes / No

* *delete as necessary*

**General physical health:**

**Other psychological problems causing impairment** (not requiring full diagnostic criteria)**:**

| **Diagnosis/Problem** | **Current** (tick if present) | **Past** (tick if present) | **Comments** |
|---|---|---|---|
| Anxiety disorders | | | |
| Depression/low self-esteem | | | |
| OCD | | | |
| Perfectionism | | | |
| Personality disorders | | | |
| PTSD | | | |
| Dissociative episodes (amnesia, depersonalization, derealization, absorption) | | | |
| Others | | | |

**Psychological risk factors:**

Significant depression? Present / Absent
*(delete as necessary)*

Suicidal ideation: Present / Absent
*(delete as necessary)*

Suicidal intent: Present / Absent
*(delete as necessary)*

**Physical risk factors:**

**Potential risk to others?**

## Family structure

**Important members of family:**
(indicate if deceased, and when died)

| **Member** | **Name** | **Age** | **Occupation** | **Lives with patient?** (tick if in houshold) | **Quality of relationship with patient** | **Psychiatric problems?** (present or past) |
|---|---|---|---|---|---|---|
| Mother | | | | | | |
| Father | | | | | | |
| Siblings | | | | | | |
| | | | | | | |
| | | | | | | |
| Partner/ spouse | | | | Married? Yes/No | | |
| Children | | | | | | |
| | | | | | | |
| Others | | | | | | |
| | | | | | | |

**Family tree:**

**Social network:**
(e.g., friends, supports)

## History

**Timeline of problems**
(and other notes - add a further sheet if necessary)

**Reported history of trauma:**

| Nature of trauma | Age(s) at occurrence | Perpetrator(s) | Further details |
|---|---|---|---|
| Emotional | | | |
| Sexual | | | |
| Physical | | | |
| Neglect | | | |

**Bullying and teasing in childhood (up to the age of 18 years):**

| | Perpetrator | | If yes, youngest age at this experience | Did they disclose to anybody? | Was the reaction positive or negative |
|---|---|---|---|---|---|
| | Family | Peers | | | |
| Verbal bullying | Yes / No * | Yes / No * | _____ yrs | Yes / No * | Positive / negative * |
| Physical bullying | Yes / No * | Yes / No * | _____ yrs | Yes / No * | Positive / negative * |
| Teasing re weight, shape, height, etc | Yes / No * | Yes / No * | _____ yrs | Yes / No * | Positive / negative * |

**Significant separation and loss experiences**

| |
|---|
| |

## Treatment recommendations

**Motivation for treatment:**

**Obstacles to treatment, and can they be resolved?:**
(e.g., employment, distance, child-care)

**Treatment preferences:**
(e.g., gender of therapist, times of day)

**Plan of treatment discussed with the patient:**
(remind patient that this decision will be ratified by the allocation team, and therefore is not final)

**Who needs copies of the report:**
(apart from the referrer and the GP)

# Appendix 2

# Psychoeducation resources

## Psychoeducation topics/handouts

This section gives a comprehensive range of the handouts that we provide to patients as part of the psychoeducation element of CBT for the eating disorders. Not all patients get all the leaflets - the aim is to identify which ones the patient needs depending on their clinical situation. We have separated them into different sections dependant upon what they cover and when they are needed in treatment. These handouts are provided for photocopying for use with patients. However, it is important that they are used in the context of the material presented throughout this book.

## Contents of Appendix 2

### 2A Getting started: practical information about improving food intake

The following leaflets are designed to support the eating plan (see Figure 7.2). Their aim is to help the patient make the necessary changes to their diet for effective CBT.

1. The advantages of regular eating
2. General points to help normalize food intake
3. Hunger
4. How much do we need to drink (non-alcoholic drinks)?
5. Examples of different foods and the food groups to which they belong
6. Grading foods: a chart to identify what foods are easily managed, and what foods are currently avoided.

### 2B Health consequences of unchecked eating disorder behaviors

1. The effects of semi-starvation on behavior and physical health (the Minnesota Experiment)
2. Complications of anorexia nervosa (especially food restriction and low weight)

3. Complications of bulimia nervosa (especially laxative abuse and vomiting)
4. The effects of self-induced vomiting on physical health
5. The effects of laxative abuse on physical health
6. The effects of diuretic abuse on physical health
7. Exercise and activity
8. Bone health and osteoporosis.

**2C Issues that perpetuate the disorders**

1. The effect of purging on calorie absorption
2. Weight control in the short and long term
3. Why diets do not work
4. The effect of premenstrual syndrome (PMS).

**2D Basic nutritional facts and principles**

1. Metabolic rate/energy expenditure (or how the body uses food)
2. Normal eating
3. Proteins – some basic facts
4. Carbohydrates – some basic facts
5. Fats – some basic facts
6. Fruits and vegetables
7. Alcohol.

Appendix 2A

# Getting started: practical information about improving food intake

## 2A1 The advantages of regular eating

To fully recover from an eating disorder you will need to learn to use food to meet your physical needs rather than as a way of coping with emotional difficulties. This involves eating **three balanced meals with 1–3 planned, appropriate snacks each day**.

### Developing a regular/balanced pattern of eating

Eating three meals and regular snacks each day is helpful for the following reasons:

- You don't have to face very large meals.
- The gaps between meals are more manageable.
- It helps avoid the feeling that you may lose control of what you are eating.
- It helps ensure you get the full range of nutrients that you need, as you will naturally tend to eat a wider variety of foods.

### Hunger

People with eating problems often feel they cannot tell when they are physically hungry or physically full. Reasons for this include:

- Current or previous weight loss seems to alter the body's ability to recognize hunger and fullness, even after a normal body weight is achieved. This is temporary but may take several months, if not longer to return to normal.
- How you feel may have a direct effect on hunger and satiety (fullness). For example, anxiety may make you feel more or less hungry than when you are not anxious.

This type of meal plan is more physically satisfying, which helps your body regulate feelings of hunger and fullness to enable them to return to being natural reflexes.

### Prevents overeating/bingeing

- Since you are meeting your body's physical needs, you are less likely to overeat due to hunger.
- If you are not chronically hungry, you are more likely to be able to reflect on how to handle a situation, rather than reaching for food as your first response to a problem.

### Weight/physical issues

- Whether you are at a normal weight or working to gain weight, following an eating plan will minimize short-term weight fluctuations related to body fluid shifts, thus making weight changes more predictable.

- Eating infrequently can lead to an increase in body fat. This is partly because your metabolism slows down slightly, and partly because when you do eat, you are more likely to overeat, meaning that the excess will probably be stored as fat.
- Eating regularly is the most effective method of maintaining a healthy weight over a long period of time.
- A balanced food intake increases the likelihood that your periods will return at a lower rather than a higher weight.

**Metabolic rate (how quickly you use up energy)**

- Chronic undereating can cause weight gain by lowering your metabolic rate (see the point in weight/physical issues, above).
- Regular eating normalizes your metabolic rate, minimizing physical problems such as feeling cold all the time and feeling moody/irritable.

**Concentration and ability to do academic work**

- After a short time of eating regularly you will spend less time thinking about food, bingeing or purging, meaning you have more space to do academic work (e.g., college work, paid work).
- Skipping meals, especially breakfast, can reduce your ability to solve problems rationally, and reduce your academic performance.

## 2A2 General points to help normalize food intake

When you start to change your eating habits, it can be confusing to work out what to do. This handout gives you some basic tips to help, and offers some explanation as to why these points are important.

1. **Leave no more than 3–4 hours between meals and snacks**. This relates to blood sugar control, which is a key player in appetite control. After 3–4 hours your blood sugar will start to drop, as the energy from the last meal or snack has been used up. This drop in blood sugar sends a strong signal to the brain that you need to eat something. If you leave it for longer than this you may find yourself craving sugary and fatty foods, increasing the risk of overeating.
2. **Do not rely on hunger to tell you when to eat.** Eating disorders often cause hunger perceptions to become distorted and unreliable.
3. Make it a priority to eat regularly. **Aim to not skip meals or snacks** as this is likely to increase physical cravings for food later on (see above), and most people find it extremely hard to reintroduce food once it has been cut out.

In the beginning, this pattern may feel like you are eating all the time, but after a while **this pattern helps you worry less about eating** since cravings for food will diminish.

4. Once you have got the basic meal plan of three meals and two to three snacks, **try not to eat more than this**, as your body has all it needs from your eating plan.
5. If you *cannot* stop yourself from eating between planned meals and snacks, get back on track with your eating plan as soon as possible. Do not miss your next meal/snack to compensate – after all, the extra that you have eaten is unlikely to affect your weight dramatically, whereas missing meals/snacks is likely to lead to further uncontrolled eating, which is likely to affect your weight.
6. **Be realistic about goals around eating.** – Think about easiest changes first and build up to more challenging ones later when you feel more confident. Introduce change gradually. Think about your typical day, when you are least chaotic or feel more secure about your eating pattern, and start there.

## 2A3 Hunger

### What is hunger?

Hunger can be defined as physical (physiological) sensations that motivate us to eat. These include:

- A rumbling tummy
- An empty feeling
- Become more preoccupied with food
- Poor concentration
- Irritability if the meal is delayed

} these all occur just prior to a meal/snack

Normally, hunger occurs approximately 3–4 hours since the last meal and increases in severity with time.

### Emotional hunger

As well as physical hunger, we all experience emotional hunger from time to time. This has a different feel from physical hunger, in that it tends to occur in the chest or mouth area, not the stomach. It also can be defined as wanting to eat in response to an emotional issue going on at that time (e.g., comfort eating).

### The effect of eating disorder behaviors on physical hunger awareness

All eating disorder behaviors can (temporarily) make it difficult to recognize physical hunger. For instance, in the weight loss seen in anorexia nervosa, the gut slows down so much that the symptoms of emptiness related to stomach emptying do not occur. In fact, it may be that you feel much fuller than normal. Also, emotions can affect the physical symptoms of hunger. An example of this is that anxiety can slow how quickly your stomach empties, meaning that you feel full for much longer. **However, neither of these factors means that your body does not need energy from food – this is a continuous requirement.**

Common signs of hunger that are seen in eating disorders include the following. Unlike in non-eating-disordered individuals (where hunger occurs just before a meal), hunger signals may be seen for much of the time (waking and possibly when asleep) and are not just before a meal:

- An absence of signals related to movement of food in the bowel (e.g., feeling empty, tummy rumbling, etc.) because the gut has slowed down drastically
- Preoccupation with food for much of the time, including possibly dreaming of food
- Irritability much of the time
- A ravenous hunger that is insatiable, even after a meal
- Dizziness, headaches

- Feeling cold most of the time
- Feeling a need to binge which is uncontrollable.

### Managing hunger more healthily

The most important thing to do is to eat three balanced meals plus two to three planned snacks a day. This will meet your physical requirements for food, meaning that your hunger can return to a more normal level more quickly. But this takes time, and can be a confusing process. The following tips may be of use.

If you feel hungry, ask yourself the following questions:

- When did you last eat?
- Was it less than 3–4 hours ago?
- Have you eaten enough in the last day or two (see above)?
- Is there something to eat that you really want?
- If you are feeling hungry but have eaten in the last 3–4 hours, would occupying your time be a more suitable thing to do?

If you are feeling physically hungry:

- Think about what you want to eat? Hot or cold, sweet or savoury food?
- Prepare what it is you have chosen to eat, take the necessary time out of your day to eat it slowly (preferably at a table even if it is a snack).
- Try to enjoy the experience of eating the food you have chosen. Take time to recognize what it smells like, how it feels in your mouth and what it tastes like.

If you are experiencing emotional hunger:

- Take a few minutes out of your day to think about what is going on for you. Making a hot drink may help you take this time to reflect – but do not hang around the kitchen afterwards!
- Write your feelings down in your diary, and if possible, talk them through with someone you trust.
- Consider what else you could do other than eat – it can be a good idea to write a list of things that might help you keep occupied, such as ringing a friend, painting your nails, going for a short walk.
- If nothing else but eating will help, think carefully about what you want to eat. Something like a yogurt or some fruit may be the best first option. Sit down to eat this and enjoy the food you have chosen.
- After eating, avoid going back into the kitchen, even if you still feel hungry. Wait 20 minutes or so before deciding if you need something more to eat.

## 2A4 How much do we need to drink (non-alcoholic drinks)?

Many people with eating disorders find it difficult to recognize thirst. If this is the case for you, the information in this handout may help you feel more in control of managing your fluid intake.

- You need to drink 1.5–2 liters (around 3–4 pints) per day to be adequately hydrated.
- Sometimes people can routinely drink too much – 3 litres would be considered the upper end of normal.
- Drinks, just like your food, need to be spread out over the whole of your waking day.
- It is a good idea to drink a range of drinks, not just one type. Suitable drinks include water, low-calorie squash, tea, coffee, herbal teas, diet drinks.
- Avoid drinks such as energy drinks, fruit juice or milk over and above that within your prescribed diet.
- Whilst you do not have to avoid caffeine it is wise not to drink just caffeinated drinks (e.g., coffee, tea, diet cola drinks), and you should minimize your intake of very strong examples (e.g., espresso coffee).
- Do not wait until you are thirsty to drink – by the time you feel thirsty you are already dehydrated. In addition, your eating disorder may affect your ability to recognize thirst.
- Remember to drink more when you engage physical activity, if the weather is very hot, if you have an illness where you have a high temperature or if you have diarrhoea.
- ***Alcohol*** lowers your blood sugar (which will make you more hungry) and reduces your ability to remain in control of your impulses. It will also affect your weight if taken in excess. It is therefore important to talk to your clinician about this issue.

## 2A5 Examples of different foods and the food group to which they belong

| | Bread, other cereals and potatoes | Meat, fish and alternatives | Milk and dairy foods | Fruit and vegetables | Fats important for health | Foods containing fat/sugar |
|---|---|---|---|---|---|---|
| What food is included? | Bread and crackers<br>Pasta and couscous<br>Rice<br>Potatoes<br>Breakfast cereals<br>Cracked wheat (bulgar)<br>Oats<br>Plain biscuits (e.g., Digestives) | Meat<br>Fish (white and oily)<br>Poultry<br>Meat products (e.g., sausages)<br>Fish products (e.g., fish fingers)<br>Eggs<br>Lentils and pulses (e.g., kidney beans, baked beans)<br>Vegetarian products (e.g., Quorn, tofu)<br>Nuts and seeds | Milk<br>Cheese<br>Yoghurt<br>Fromage frais<br>Calcium-enriched soya products | Fresh, frozen and canned fruit and vegetables, and dried fruit<br>A glass of fruit juice counts once per day | Margarine<br>Butter<br>Oils<br>Oily salad dressings (mainly from polyunsaturated or monounsaturated sources, not saturated) | Chocolate<br>Crisps<br>Sweets<br>Pastries<br>Cakes<br>Rich puddings<br>Sugar added to foods, etc., etc. |
| Main nutrients they provide | Carbohydrate (starch)<br>Dietary fiber<br>Some calcium and iron<br>B vitamins | Protein<br>Iron<br>B vitamins, especially B12<br>Zinc<br>Magnesium | Calcium<br>Protein<br>Vitamin B12<br>Vitamin A and D | Vitamin C<br>Carotenes (a form of vitamin A)<br>Folate<br>Dietary fiber Some carbohydrate | Fats<br>Vitamins D, E and K<br>Essential fatty acids | Mainly provide fat and sugar, but many contain other nutrients |
| How much to choose | Should be eaten every 3–5 hours, to include a good portion at each meal, plus at some snacks | Most people need 2 portions per day, although some need three | Most people need three portions per day | Five portions per day | Small portion (such as 2–3 teaspoons) at most meals, but especially lunch and dinner | Most "normal eaters" consume between 1 and 3 portions per day |

## 2A6 Grading foods

Use the sheet (Appendix 2A5) describing the different food groups and examples of foods that fit within each group to fill in this chart. Then use the chart to help you decide which foods you want to prioritize working on.

| Food group | Foods I feel safe eating now | Foods I could eat – but with difficulty | Foods I cannot yet eat/feel very unsafe with |
|---|---|---|---|
| **Bread, other cereals and potatoes** | | | |
| **Meat, fish and alternatives** | | | |
| **Milk and dairy foods** | | | |
| **Fruit and vegetables** | | | |
| **Fats important for health** | | | |
| **Foods containing fat/sugar** | | | |

Appendix 2B

# Health consequences of unchecked eating disorder behaviors

## 2B1 Effects of semi-starvation on behavior and physical health

### The Minnesota experiment

There is a remarkable similarity between many of the experiences seen in people who have experienced fairly long periods of semi-starvation and those seen in people with anorexia nervosa or bulimia nervosa. In the 1940s to 1950s, Ancel Keys and his team at the University of Minnesota in the USA studied the effects of starvation on behavior. What they found both surprised and alarmed them.

The experiment involved carefully studying 36 young, healthy, psychologically normal men, both during a period of normal eating, and during a longer period of fairly severe food restriction, and after the food restriction was lifted. During the first three months of the experiment, the subjects ate normally whilst their behavior, personality and eating patterns were studied in detail. Over the next six months, the men were given approximately half the amount of food that they needed to maintain their weight and they lost, on average, 25% of their original body weight. Some participants actually went down to a BMI of 14. Following this, there were three months of rehabilitation during which time the men were re-fed. Although the individual responses to the experiment varied greatly, the men experienced dramatic physical, psychological and social changes as a result of the food restriction. Of note was the fact that for many, these changes persisted even after weight returned to normal after the food restriction period.

### Attitudes and behavior related to food and eating

The men's change in relationship to food was one of the most striking results of the experiment. They found it increasingly difficult to concentrate on more normal things, and became plagued by persistent thoughts of food and eating. Food became a principal topic of conversation, of reading and of daydreams. Many men began reading cookbooks and collecting recipes, whilst others became interested in collecting various kitchen utensils. One man even began rummaging through rubbish bins in the hope of finding something that he might need. This desire to hoard has been seen in both people and animals that are deprived of food. Although food had been of little interest to the men prior to entering the experiment, almost 40% of them mentioned cooking as part of their postexperiment plans. Some actually did change their career to a career focused on food once the experiment was over.

The men's eating habits underwent remarkable changes during the study. Much of the day was now spent planning how they would eat their allocated

food. Plus, in order to prolong their enjoyment of the food eaten, it would take them vastly longer amounts of time to eat a meal. They would eat in silence and would devote their total attention to the consumption of the food.

The subjects of the study were often caught between conflicting desires to gulp down their food ravenously and to consume it so slowly that the taste and smell of each morsel of food would be fully appreciated. By the end of the starvation period of the study, the men would dawdle for almost two hours over a meal that they previously would have consumed over a matter of minutes.

Another common behavior was that they would make unusual concoctions by mixing different foods together. Their use of salt and spices increased dramatically, and the consumption of tea and coffee increased so much that they had to be limited to 9 cups per day. The use of chewing gum also became excessive and also had to be limited.

During the 12 week re-feeding phase of the experiment, most of these abnormal attitudes and behaviors to food persisted. Some of the men had more severe difficulties during the first six weeks of re-feeding. The free choice of ingredients stimulated ''creative'' and ''experimental'' playing with food; for example, licking off plates and very poor table manners persisted.

### Binge eating

During the restrictive phase of the experiment, all of the volunteers reported feeling more hungry. Whilst some appeared able to tolerate this fairly well, for others it created intense concern or even became intolerable. Several of the men failed to stick to their diet and reported episodes of binge eating followed by self-reproach. While working in a grocery store, one man:

> suffered a complete loss of willpower and ate several cookies, a sack of popcorn, and two overripe bananas before he could ''regain control'' of himself. He immediately suffered a severe emotional upset, with nausea, and upon returning to the laboratory he vomited. He was self deprecatory, expressing disgust and self criticism.

After about five months of re-feeding, the majority of the men reported some normalization of their eating patterns, but for some the difficulties in managing their food persisted. After eight months, most men had returned to normal eating patterns, although a few still had abnormal eating patterns. One man still reported consuming around 25% more than he did prior to the weight loss and ''once he started to reduce but got so hungry he could not stand it.''

### Emotional changes

It is important to remember that the subjects were psychologically very healthy prior to the experiment but most experienced significant emotional changes

as a result of semi-starvation. Many experienced periods of depression; some brief whilst others experienced protracted periods of depression. Occasionally elation was observed, but this was inevitably followed by ''low periods.'' The men's tolerance that had prior to starvation been high was replaced by irritability and frequent outbursts of anger. For most subjects, anxiety became more evident; many of the formerly even-tempered men began biting their nails or smoking if they felt nervous. Apathy was a common problem, and some men neglected various aspects of their personal hygiene. Most of the subjects experienced periods during which their emotional distress was quite severe, and all experienced the symptoms of the ''semi-starvation neurosis'' described above.

Both observation and personality testing showed that the individual emotional response to semi-starvation varied considerably. Some of the volunteers seemed to cope very well whilst others displayed extraordinary disturbance following weight loss. As the emotional difficulties did not immediately reverse once food was in ready supply, it may be assumed that the abnormalities were related more to body weight than to short-term calorie intake. So, we can draw the conclusion that many of the psychological disturbances seen in anorexia and bulimia nervosa may be the result of the semi-starvation process itself.

### Social and sexual changes

Most of the volunteers experienced a large shift in their social behaviors. Although originally quite gregarious, the men became progressively more withdrawn and isolated. Humor and a sense of friendship and comradeship diminished markedly amidst growing feelings of social inadequacy.

> Social initiative especially, and sociability in general, underwent a remarkable change. The men became reluctant to plan activities, to make decisions and to participate in group activities . . . they spent more and more time alone. It became ''too much trouble or too tiring'' to have contact with people.

The volunteers' social contacts with women also declined sharply during semi-starvation. Those who continued to see women socially found that the relationships became strained. One man described his difficulties as follows.

> I am one of about 3 or 4 who still go out with girls. I fell in love with a girl during the control period but I see her only occasionally now. It is almost too much trouble to see her even when she visits me in the lab. It requires effort to hold her hand. Entertainment must be tame. If we see a show the most interesting part of it is contained in scenes where people are eating.

One subject graphically stated that he had ''no more sexual feeling than a sick oyster.'' During the rehabilitation period the men's sexual interest was slow to return. Even after three months they judged themselves to be far from normal

in this area. However, after eight months some or virtually all of the men had recovered their interest in sex.

### Cognitive changes

The volunteers reported impaired concentration, alertness, comprehension and judgement during semi-starvation.

### Physical changes

As the six months of semi-starvation progressed, the volunteers exhibited many physical changes including the following: gastrointestinal discomfort, decreased need for sleep, dizziness, headaches, hypersensitivity to noise and light, reduced strength, edema (an excess of fluid causing swelling), hair loss, decreased tolerance of cold temperatures (cold hands and feet) and parasthesia (abnormal tingling or prickling sensations, especially in the hands and feet). There was an overall decrease in metabolism (decreased body temperature, heart rate and respiration). As one volunteer described it, he felt as if his "body flame were burning as low as possible to conserve precious fuel and still maintain life processes."

During rehabilitation, the metabolism speeded up again, especially in those who had the larger increases in food intake. Subjects who gained the most weight described being concerned about their increased sluggishness, general flabbiness and the tendency for the fat to accumulate around the stomach and buttocks.

These complaints are very similar to those that people with bulimia and anorexia describe as they gain weight. However, after approximately a year the men's body fat and muscle levels were back to their preexperiment levels.

### Physical activity

In general, the men responded to semi-starvation by reducing their activity levels. They became tired, weak, listless, apathetic and complained of a lack of energy. Voluntary movements became noticeably slower. However, according to the original report,

> some men exercised deliberately at times. Some of them attempted to lose weight by driving themselves through periods of excessive energy in order to either obtain increased bread rations . . . or to avoid reduction in rations.

This is similar to the practice of many patients, who feel that if they exercise strenuously they can allow themselves a bit more to eat.

### Significance of the study

As all of the volunteers were psychologically and physically healthy prior to the experiment, all of the symptoms experienced by them can be put down to

the period of starvation. It would appear therefore that many of the symptoms faced in anorexia nervosa and bulimia nervosa are a result of the food restriction rather than the illnesses themselves. And it is important to recognize that these symptoms are not just limited to food and weight, but extend to virtually all areas of psychological and social functioning. It is therefore extremely important that a person with an eating disorder returns to a normal weight (if underweight) to allow these symptoms to reduce significantly/completely, and for both the clinician and the patient to become aware of emotional problems that underlie the eating disorder.

It is also important to think about how the men's relationship with food was not normal even after they returned to eating freely available food. In the short term they felt out of control with much of their food intake and were unable to identify when they felt hungry or when they felt full. Many of these symptoms continued after they reached a normal weight and, for some, took several months and years to normalize. It is therefore important for someone recovering from anorexia nervosa or bulimia nervosa to understand that they cannot just expect that their body will return to being able to regulate food intake on its own. We know that consuming a well-balanced and nutritionally complete food intake, spread out over regular points during the day, encourages a return of the body's ability to recognize when it is hungry and when it is full.

*Reference*: Garner, D. M. and Paul E Garfinkel P. E. (eds.) (1997) *Handbook of Treatment for Eating Disorders*, 2nd ed.

**Effects of semi-starvation: a summary**

- *Attitudes and behavior related to eating*
  - Increased preoccupation with food
  - Planning meals
  - Tendency to hoard
  - Change in speed of eating
  - Increased hunger
- *Emotional changes*
  - Depression
  - Anxiety
  - Irritability
  - Apathy
  - Neglected personal hygiene
- *Social and sexual changes*
  - Withdrawal
  - Reduced sense of humor
  - Feelings of social inadequacy
  - Isolation
  - Strained relationships
  - Reduced sexual interest
- *Cognitive changes*
  - Impaired: concentration, alertness, comprehension, judgement
- *Physical changes*
  - Gastro intestinal discomfort
  - Reduced need for sleep
  - Dizziness
  - Headaches
  - Hypersensitivity to noise and light
  - Reduced strength
  - Edema
  - Hair loss
  - Reduced tolerance for cold temperatures
  - Abnormal tingling/pricking sensations in hands and feet
- *Physical activity*
  - Tiredness
  - Weakness
  - Listlessness
  - Apathy.

## 2B2 Complications of anorexia nervosa (food restriction and low weight)

Anorexia nervosa is a potentially life-threatening condition. As well as the relatively high risk of death, it is also associated with many other serious complications. These are basically all associated with the body's attempt to conserve energy, keep warm and find the food it needs.

The vast majority of the effects are not permanent, and are reversed once food intake and weight are normalized.

| Area of the body/system affected | Common symptoms | Why do they occur? |
|---|---|---|
| Gastrointestinal (gut) | • Reduced stomach size/capacity, leading to feeling full on less food than normal<br>• Constipation<br>• Feeling bloated<br>• Abdominal pain | During periods of food restriction and weight loss the gut does not process food as quickly, meaning that food moves through it much more slowly. This may be because the gut muscle is too malnourished to work normally, also to ensure the body gets everything it can from the food |
| Fertility | • Irregular/absent menstrual periods<br>• Reduced fertility or infertility<br>• If pregnancy does occur the fetus is also at risk in both the short and long term if the mother does not eat enough | When food is sparse, the body reduces all processes that need large amounts of energy, such as pregnancy. The body prevents this from happening by temporarily stopping menstruation. A lack of interest in sex is also common, also reducing the likelihood of pregnancy |
| Blood results | | • A low blood sugar caused by a lack of carbohydrate sends a |

| Area of the body/system affected | Common symptoms | Why do they occur? |
|---|---|---|
| | • Low sugar levels, leading to increased risk of bingeing, and poor concentration<br>• Anemia<br>• Increased risk of serious infections<br>• Cholesterol levels increase | powerful signal to the brain to encourage the body to eat the food it needs.<br>• Anemia can be due to low iron intake<br>• White blood cell levels are the front line for protecting against infection. If food is sparse there is not enough energy or protein to make these cells<br>• The cause of high cholesterol is unclear, but it may be due to cholesterol excretion being affected |
| Tolerance to cold | • Reduced sensitivity to extremes of temperatures<br>• Numb/cold peripheries (toes, fingers and nose)<br>• Hair growth on face and back (lanugo) | • Low body fat levels reduce the ability to cope with extremes of temperature<br>• Blood flow to the organs (heart, kidneys, liver, etc.) is prioritized, causing low blood flow to peripheries<br>• Lanugo is one way the body has to keep warm. |
| Cardiovascular/ circulation | • Low blood pressure – leads to dizziness and feeling faint<br>• Slow pulse rate<br>• Irregular heart beat (atrial fibrillation)<br>• Swollen feet and ankles (edema) | • The slowing down of the heart is to conserve energy. Also the heart is a muscle, so will be weakened in cases of extreme weight loss<br>Edema is often an effect of suddenly stopping |

| Area of the body/system affected | Common symptoms | Why do they occur? |
|---|---|---|
| | | laxative abuse or vomiting, a sudden increase in food, or due to low body levels of protein in severe weight loss |
| Bone health | • Thin bones (osteoporosis)<br>• Not reaching optimum peak bone mass in adulthood (increasing the risk of osteoporosis in latere life) | The main cause is low levels of oestrogen in women (when menstrual periods stop) or testosterone in men. This causes bones to lose strength. Peak bone mass is reached as a young adult, exactly the time most people develop anorexia<br>Bone health is one area where effects of anorexia can be permanent, although it can always be improved. |
| Dental health | • Gum problems – gum recession, bleeding and weakness<br>• *Permanent* erosion of teeth | • Weight loss and vitamin and mineral deficiency can cause gum disease<br>• High intake of acidic foods (like fruit, fizzy drinks, condiments like vinegar) can cause dental problems |
| Emotional | • Irritability<br>• Depression<br>• Poor concentration<br>• Feeling isolated<br>• Fatigue and exhaustion<br>• Anxiety | These responses occur for two reasons:<br>1. To conserve energy – we tend to do less when depressed |

| Area of the body/system affected | Common symptoms | Why do they occur? |
|---|---|---|
| | • Thinking about food all the time | 2. Anxiety and thinking about food may increase the likelihood that we go out and find food to eat |
| Bladder function | • Kidney infections<br>• Poor bladder control | The kidney can become less able to concentrate urine, leading to increased urine production. Problems with the nerve supply to the bladder, and muscle loss can lead to infections |
| Muscle function | • Muscle wasting and weakness | If food is very sparse the body breaks down muscle to provide energy (especially carbohydrate) |
| Other | • Poor sleep | Light sleep patterns are a known effect of weight loss |

Additional complications occur if low weight is in combination with vomiting, laxative abuse, diuretic abuse and/or excessive exercise

## 2B3 Complications of bulimia nervosa (especially laxative abuse and vomiting)

Bulimia nervosa is a potentially life-threatening condition. As well as the relatively high risk of death, it is also associated with many other serious complications. These are mainly related to the effects of purging.

| Area of the body/system affected | Common symptoms | Why do they occur? |
|---|---|---|
| Imbalance of body salts (electrolytes – sodium, potassium and chloride) | • Irregular heart beat/ palpitations<br>• Irregular heart beat (cardiac arrhythmia) or cardiac failure<br>• Convulsions<br>• Dehydration (leads to light headedness and fainting) | • Both vomiting and laxative abuse lead to large losses of body salts and water. The salts are vital in maintaining normal electrical impulses in muscle, especially the heart |
| Edema (swelling) in ankles and legs | • Swollen ankles and legs | • The sudden stopping of vomiting and/or laxatives causes the body to re-hydrate (see above)<br>• This usually resolves by day 10<br>• It is important to drink normally during this time |
| Mouth/oral Problems | • Swollen salivary glands (making the face look "fat")<br>• Erosion of tooth enamel and possible the tooth itself<br>• Frequent and widespread dental decay<br>• Increased sensitivity to hot and cold<br>• Sore throat/difficulty swallowing<br>• Acid reflux<br>• Chronic regurgitation | • Stomach acid is vomited up into the mouth, inflaming sensitive tissues in the mouth, tongue and throat.<br>• The acid also attacks all of the teeth, not just one or two that dental decay usually affects |

| Area of the body/system affected | Common symptoms | Why do they occur? |
|---|---|---|
| Gastrointestinal (gut) — upper bowel (stomach and small intestine) | • Esophagus and/or stomach rupture (which is usually fatal)<br>• Bloating and abdominal pain<br>• Distension<br>• Bleeding in the esophagus<br>• Pancreatitis (inflammation of the pancreas) | • Prolonged vomiting often leads to the flap of skin at the top of the stomach becoming weaker, meaning acid escapes very easily<br>• Bleeding is caused by the physical trauma of vomiting and needs medical assessment |
| Gastrointestinal (gut) — lower (large intestine) | • Damaged large bowel<br>• Chronic constipation/ impaction of feces<br>• Piles (including bleeding)<br>• Bowel prolapse | • Chronic use of stimulant laxatives may cause the loss of normal passage of material through the gut (peristalsis), leading to constipation, and possibly piles<br>• Prolapse can occur due to weakness of the pelvic floor |
| Eyes/face | • Eyes can be bloodshot<br>• Small red spots can occur on the face | • The strain of vomiting causes bleeding in the eyes and facial skin, which resolve once vomiting stops |
| Kidney and bladder infections | • Pain on passing urine<br>• Pus/blood in urine | • Dehydration increases the risk of infection<br>• Fecal contamination of urinary tract (common with diarrhea) |
| Lungs | • Lung infections/ pneumonia | • Vomit can pass into the lungs<br>• The acid will burn the lungs<br>• Bacteria can cause an infection |

NB. If you vomit, avoid brushing your teeth immediately after vomiting. This is because it brushes acid into the teeth throughout your mouth, increasing the risk of dental problems. Instead, rinse your mouth out (including under the tongue) with water or fluoridated mouthwash.

Additional complications commonly seen in anorexia nervosa will probably also be experienced, especially if the person is a relatively low weight, has recently lost a lot of weight or is following a very restrictive diet.

## 2B4 The effect of self-induced vomiting on physical health

You may make yourself sick after eating or bingeing in the hope that it will help you control your food intake and your weight. Whilst on the surface it seems a perfect way of eating freely without gaining weight (although it is important to be aware that this is far from true since around 1200 kcals[1] are retained if vomiting occurs after a binge), there are many health risks involved with this behavior.

### Electrolyte (body salts) imbalance

When you vomit you will not only get rid of some of the food you have eaten, but also many essential salts (potassium, sodium and chloride) that keep nerve and muscle function normal. This leads to:

- Irregular heart beat/palpitations
- Fatigue
- Muscle weakness and spasms (made worse by over exercise)
- Irritability
- Convulsions
- Cardiac failure.

### Dehydration

Consistently making yourself sick will lead to dehydration. The effects of chronic dehydration are:

- Feeling thirsty all the time
- Light-headedness
- Feeling weak
- Fainting (especially on standing)
- Frequent urinary tract infections (e.g., cystitis)
- Kidney damage.

Drinking excessive amounts of water will not reduce the dehydration, and may make it worse. This is due to the fact that the essential salts are needed to allow the body to absorb the fluid.

When you stop vomiting there will probably be a temporary weight gain due to rehydration. This can show itself as puffy fingers, but also slight swelling in the ankles and feet. This can cause much alarm, but in fact is only of medical concern if the swelling extends above the knee. At this point it is important to seek medical advice. Otherwise, rest and raise the feet whenever possible and it will resolve in a few days. Diuretics are not necessary, except in severe cases, when your doctor may prescribe them for a short time. Avoid self-medicating with diuretics.

(NB. Both dehydration and electrolyte imbalances are more likely and more dangerous in laxative and/or diuretic abuse.)

### Problems with teeth

Vomiting for more than a few months is likely to cause dental problems. The important thing to note it that, unlike ordinary dental decay, the damage is likely to affect all of your teeth, and can require very expensive dental treatment. In order to limit the problems it is important to avoid brushing your teeth for at least an hour after vomiting (see the material at the end of Appendix 2B3 for more information on dental care following vomiting). The main dental problems seen in chronic vomiting are:

- Erosion of tooth enamel
- Frequent cavities
- Sensitivity to hot and cold food and drinks
- An unsightly smile!

### Stomach problems

Chronic vomiting can cause problems throughout the whole of your gut:

- Swollen salivary glands (leading to a swollen ''chipmunk'' face)
- Sore tongue, mouth and throat, which can lead to a hoarse voice
- Inflamed/bleeding esophagus (also known as the gullet)
- Distension of the stomach and esophagus (ruptures can occur, which can be fatal).

### Problems with eyes

Vomiting can cause eyes to become bloodshot, which whilst harmless, is unsightly.

### Other problems

It is possible for vomit to pass into the lungs, which may cause lung infections and pneumonia.

## 2B5 The effects of laxative abuse on physical health

Laxatives are medications used on a short-term basis to relieve constipation. There are several different types, which have different roles depending on the cause of the constipation. Some are available over the counter from chemists, whilst others are only available on prescription. Many such laxatives are described as ''natural'' or ''herbal,'' which suggests they are safe, and carry no risk. However, this is not the case. The most common type of laxative abused in eating disorders is stimulant laxatives, such as Senokot or Dulcolax.

(NB. Laxatives prescribed under medical supervision are fine, especially since the doctor will usually prescribe a different type of laxative – usually one that is bulk-forming, such as Fybogel or Lactulose.)

You may have started to take laxatives because of a belief that they will help you lose weight, or to compensate for eating more food than you feel comfortable with. Abuse of stimulant laxatives will leave you feeling empty, with a much-desired flat stomach, and convinced that you have not gained weight. However, any weight loss and change in body shape is the result of the dehydrating effect of watery diarrhea and the complete emptying of the large bowel. It is nothing to do with changes in fat, muscle or carbohydrate levels in the body. This is because laxatives work on the large intestine, whereas food is digested and absorbed in the small intestine.

Laxative abuse can have serious side effects on health, many related to low potassium levels (hypokalemia) secondary to watery diarrhea. This can be severe enough to trigger dangerous cardiac problems and other medical problems, whilst the long-term dehydration related to laxative abuse can lead to kidney failure or problems with kidney function. Other problems that can occur include rectal bleeding (probably related to chemical irritation from the laxatives), urinary tract infections, muscle weakness, confusion or convulsions.

Laxative abuse may also cause you problems when you try to stop taking them. The large bowel gets tolerant to the levels of laxatives taken, so you may have found you needed to take more and more to get the same effect. Stopping them suddenly is then likely to cause water retention due to the fact the watery diarrhea has a dehydrating effect. It is possible for weight to increase up to 5 kg or more when laxatives are stopped abruptly, due to the fluid levels returning to normal. The rise in weight is detectable both from the weighing scales (which can reinforce the belief that laxatives lead to weight control), and from seeing differences in your body, such as feeling more bloated, plus possible temporary swelling of the feet and ankles. This swelling is called rebound edema and usually lasts for 10–14 days after stopping laxative abuse,

following which weight drops slightly due to normalization of body water levels.

You may also experience constipation when you stop taking laxatives. However, there are healthy ways to help your body return to normal bowel function, such as making sure you eat a range of foods that contain dietary fiber (wholemeal or granary bread, high-fiber breakfast cereals, brown rice, lentils and beans (e.g., kidney beans), and fruit and vegetables), drinking enough fluids (around 0.5–2 liters a day) and developing a routine for going to the toilet (even if you do not find it easy to pass a bowel motion to start with). Giving up laxatives can be really anxiety provoking so talk to your clinician/doctor/dietitian if you feel you need more support.

## 2B6 The effects of diuretic abuse on physical health

People with eating disorders sometimes take diuretics (also known as water tablets) because they believe that the weight lost is due to loss of fat. In fact, diuretics have no effect whatsoever on calorie absorption, and the weight loss seen is due to water loss. As soon as the diuretics are stopped, rehydration occurs, and weight returns to normal.

### Non-prescription (over the counter) diuretics

Whilst over the counter diuretics rarely cause medical problems, they can contain very high levels of caffeine. This can lead to headaches, trembling and a rapid heart rate. Caffeine can also greatly increase anxiety.

### Prescription diuretics

Abuse of prescription diuretics tends to be more dangerous.

### Dehydration

Consistent abuse of diuretics will lead to dehydration, the chronic effects of which are:

- Feeling thirsty all the time
- Light-headedness
- Feeling weak
- Fainting (especially on standing)
- Frequent urinary tract infections (e.g., cystitis)
- Kidney damage.

### Electrolyte (body salts) imbalance

When you abuse diuretics you will get rid of many essential salts (potassium, sodium and chloride) that keep nerve and muscle function normal. This leads to:

- Irregular heart beat/palpitations
- Weakness
- Muscle weakness and spasms (made worse by overexercise)
- Irritability
- Convulsions
- Cardiac failure.

NB. These effects are likely to be worse if you also abuse laxatives and/or regularly vomit.

### Low levels of magnesium in the blood

This is called hypomagnesemia. It can make the symptoms of low potassium worse, and can result in arrhythmias (abnormal heart rhythms) and even in sudden death.

### Urine problems

Abuse of tablets that stimulate urine production will potentially cause problems with passing urine:

- Polyuria (producing large amounts of urine)
- Blood in urine (hematuria)
- Pyuria (pus in urine).

### Kidney damage

Long-term abuse of diuretics can eventually lead to kidney problems due to the effect of chronic dehydration, and also due to the toxic effect of the diuretics on the kidneys.

### Other problems

Diuretics can cause several other problems, such as:

- Nausea
- Abdominal pain
- Constipation.

## 2B7 Exercise and Activity

We frequently hear about the need to be more active to improve our chances of remaining healthy. Most of the general population need to increase their activity in order to reduce their long-term health risks. However, many people with eating disorders go too far the other way and are too active, which can also have severe health consequences.

### "Excessive" versus "compulsive" exercise

The diagnostic criteria for eating disorders often include the fact the person uses ''excessive'' levels of exercise *for purposes of weight control*. However, it is difficult to define this objectively, and it is now recognized that it is more relevant to consider whether the person feels a *compulsion* to exercise. Therefore, it is important to think both about how much activity you do, but also *why* you are active.

Common difficulties with activity levels seen in people with an eating disorder include:

- Excessive activity. Although it is difficult to define this objectively, doing more than four hours of activity or exercise per week is probably an excessive level, unless you are a competitive athlete. Activity could be anything such as walking, running, exercise classes, extreme forms of yoga, very high levels of housework.
- Compulsive activity. The person has a belief that they must do an exact number of repetitions (e.g., exactly 300 sit-ups) of an exercise, or something bad will happen (e.g., uncontrollable weight gain).

Both excessive and compulsive levels of activity are unhealthy and possibly dangerous, so therefore need to be addressed in eating disorder treatment.

### How much activity is healthy?

The Department of Health recommends the following as a minimum for the general population:

| | |
|---|---|
| *How much?* | 30 minutes a day. |
| *How often?* | At least 5 days of the week. |
| *How intense?* | Moderate – the person should be warm and slightly out of breath during activity, but still be able to hold a conversation. This level will be different for everybody. |
| *What counts?* | Activity can be regular, organized exercise (e.g., a tennis class, aerobics) but also includes activity of daily living (e.g., walking to the bus stop, housework). |
| *The motivation?* | The healthiest reason people exercise is because they enjoy it. They may want to improve their physical health, including toning up, or perhaps even losing a little weight, but this is not the primary motivation to exercise. |

### Risks of excessive exercise

Although the 30 minutes, 5 days a week is a minimum, there are implications of being too active. Excessive exercise can:

- Increase the risk of injury and even permanent damage.
- Lead to dehydration/fluid balance fluctuations (especially if the person is also purging).
- Lead to exhaustion and impaired performance.
- Result in poor concentration.
- Lead to weight gain and a change in body shape, due to higher muscle levels.
- Lead to infrequent or absent menstrual periods, increasing the risk of osteoporosis.

### Signs and symptoms of exercise being out of control

Some people with an eating disorder find it difficult to accept that their activity level is a problem. If other people have said they are concerned about how active you are but you do not share their concern, go through the list below and tick all of those that apply to you. Try to be as honest with yourself as possible. The more you tick, the more likely it is that your exercise is out of control.

- Exercising more than once a day (unless the person is a competitive athlete)
- Weight loss (when not following a weight reducing diet)
- Distress if asked to take a day off
- Resistance to cutting back on exercise, even when medically advised that permanent damage could occur
- Anxiety/irritability if a session is missed
- The person exercises even if ill/exhausted
- Recurrent overuse injuries with no sign of improvement
- Little variety in exercise program
- Failure to change the sport when asked to do an alternative exercise
- Other aspects of life (e.g., relationships, social and academic life) are neglected in favor of the exercise
- Debt incurred from spending on exercise equipment, personal trainers, gym fees, etc.
- Extensive records or logs of workouts are kept
- Denial of a problem, other than the physical symptoms.

***Reference***: Exercise excess: treating patients addicted to fitness. *The Physician and Sports Medicine* (1992) **20**, 193–201.

## 2B8 Bone health and osteoporosis

Osteoporosis is a condition where bones become very fragile and break easily. Since it is impossible to observe bones without a bone scan, many people are unaware that their bones are weak until it is too late. So, it is important to know that anorexia nervosa will strongly increase your long-term risk of osteoporosis. Bulimia nervosa also carries some risk, especially if weight is low.

### Normal bone

Bone has a structure a bit like a honeycomb. Healthy bone is constantly being broken down and then reformed, so that the honeycomb structure stays stable. In eating disorders the breakdown of bone occurs at a faster rate than the rebuilding occurs, leading to the structure becoming a lot weaker. The spine and hipbones are often the bones most affected by osteoporosis, leading to chronic pain, loss of height and curvature of the spine. Minor falls, knocks or just ordinary daily activities can result in fractures of affected bone.

Whilst we know that bone health improves with treatment, bone may not completely return to optimum health, especially if many of the risk factors (see below) have been present for some time.

Achieving and maintaining a healthy weight, where menstruation occurs naturally, is the best way to prevent permanent damage to bone, or minimize current bone damage.

### What causes osteoporosis in eating disorders?

The main risk factors are:

- A lack of menstrual periods, which leads to estrogen deficiency (there is some evidence that the oral contraceptive pill may be protective, but the estrogen the body naturally makes at a healthy weight is the most effective form of estrogen).
- A low weight, even if menstruating naturally – a BMI below 18.5 will not be enough for the body to benefit from weight-bearing activity.
- A history of being at a low weight during teenage years and early adulthood (up to late twenties), even if weight is now within the healthy range. This is because bones become strongest (known as peak bone mass) during this time. If bones do not reach their optimum strength, fractures become a risk at an earlier stage than normal.
- A very low or a very high level of activity, especially weight bearing (like walking).
- A low calcium intake (dairy foods are the best sources, including low-fat versions).
- Poor vitamin D status (Vitamin D is mainly obtained by 15–20 minutes in the sun each day, with face and lower arms exposed, during the summer months).

- An unbalanced diet – all nutrients from all food groups are needed for healthy bones.
- Smoking cigarettes.
- A very high caffeine intake (say, more than 4 mugs of coffee, or 8 mugs of tea a day).
- A high alcohol intake (more than 14 units in women, 21 units in men).

**Important note**

Unfortunately there is currently no treatment for osteoporosis secondary to eating disorders other than to achieve a normal weight and to menstruate naturally. Sometimes a doctor may want to use a treatment more commonly used for osteoporosis seen in postmenopausal women. However, some of these are not licensed for use in women who have yet to reach the menopause. One such treatment is a medication known as bisphosphonate (Fosamax®, Fosamax® once weekly, and Didronel PMO®). It is important to be aware that these drugs may cause harm to unborn babies or increase the risk of cancer, even if they were taken some time ago. Therefore, the decision to prescribe these drugs should be taken on a case-by-case basis by a rheumatologist after careful discussion of the relative risks and benefits with you, the patient.

Appendix 2C

# Issues that perpetuate the disorders

## 2C1 The effect of purging on calorie absorption

Many people with eating disorders eat more than they feel comfortable with, either regularly or occasionally. This can lead to many emotions like panic, anger, guilt and shame, and often results in methods to try and rid the body of the excess calories eaten, thus regaining control – but how effective are these behaviors?

### Self-induced vomiting

How many calories are lost?

- Researchers have found that on average around 1200 kcals are retained after self-induced vomiting, whether the binge was relatively small (around 1500 kcals) or relatively large (around 3500 kcals) (Kaye *et al.*, 1993).
- "Markers" used to judge when all the food has been purged (e.g., eating carrots first so that the orange color in vomit indicates complete gastric emptying) are ineffective because of the fact the stomach mixes food up during and after the eating process.
- Many people who binge and purge report that they gain weight over time, which suggests that the body learns how to retain calories, despite vomiting.

But vomiting helps me gain control – doesn't it?

- After eating, the body produces insulin to mop up the sugar it expects to absorb from the food. Purging gets rid of some of this food but the insulin levels remain as high, and therefore results in a low blood sugar around an hour or two later. A low blood sugar level sends a strong signal to the brain saying "I AM HUNGRY – FEED ME!" resulting in a strong urge to binge again.
  - therefore, instead of purging because you have binged, you are possibly bingeing because you have purged.
- Many people say that once they have decided to purge, they eat more as they expect to get rid of all the food through purging. Since around the equivalent of two normal sized meals are retained regardless of the size of the binge, it could be argued that you are more in control if you eat a normal meal and avoid vomiting afterwards.

### Laxative abuse

How many calories are lost?

- Laxatives work on the large bowel, whereas calories are absorbed in the upper, small bowel. So it is no surprise that Bo-Linn and colleagues (1983) found that laxatives decrease calorie absorption by at most 12% each time they are used, despite 4–6 liters of diarrhea.

But laxatives help me gain control – don't they?

- After laxatives, the empty feeling and flat stomach probably feel very good. However, as soon as you start eating again the effects are lost, and many people feel more full and bloated than if they avoided the laxatives in the first place.
- Long-term abuse of laxatives can result in constipation and bloating when you stop taking them because the bowel has become "lazy" since it has relied on the laxatives for so long.

**Diuretics/water tablets**

How many calories are lost?

- Diuretics have no effect on calorie absorption. Weight loss after taking water tablets results from fluid losses only, and will be regained once the effects of the water tablets have worn off, and fluids are drunk.

All behaviors used to get rid of food have physical side effects – some very dangerous. Read the handouts on these for further information.

## 2C2 Weight control in the short and long term

Weight is a major concern for people with an eating disorder. A strong desire to control body weight often leads to restrictive eating, vomiting and other purging methods.

It is important to understand how the body regulates weight in both the short and long term, and to learn how to recognize the difference between the two.

### Short-term weight changes

- This basically means the alterations seen on a daily basis.
- It relates to the type of food eaten, hormonal changes and changes related to fluid balance over the course of the day, and does not indicate that you have become fat overnight.
- Some women find that they gain weight just before their period, regardless of whether they are on the the contraceptive pill or not, and that they return to the old weight a day or so after the period starts (see the handout on premenstrual syndrome for more information).
- We all will see an increase in weight from the beginning of the day to the end based on the fact that we retain 2–3 lb (1–1.5 kg) of fluid over the course of the day, which gets excreted as urine after laying down overnight.

### Long-term weight changes

- This basically means changes to fat and/or muscle stores.
- It is related to your energy intake over weeks and months, not days.
- If you eat what your body needs in terms of energy over several weeks your weight will remain stable.
- If you eat less than your body needs over several weeks you will lose weight.
- If you eat more than your body needs over several weeks you will gain weight.

### How do long- and short-term weight changes relate?

- In order to be able to see the long-term weight changes (i.e., changes to body fat and muscle content) we need to look beyond the day-to-day fluctuations.
- Being weighed once a week (in therapy) is sufficient to see long-term weight patterns – weighing yourself more frequently than this will probably result in huge anxiety because of the daily weight fluctuations related to changes in body fluid levels.

- Eating disorder behaviors such as purging (vomiting or abusing laxatives), and bingeing/overeating after a period of restriction all lead to fluid loss (dehydration) and then short-term water retention when the behaviors stop. This makes it much more difficult to assess what is really happening with the weight.
- At least four weighings over several weeks are needed to identify trends in ''real'' weight (i.e., those related to fat and muscle changes).

## 2C3 Why diets do not work

It is easy for someone with an eating disorder, especially if they happen to have a weight higher than the recommended level, to feel that dieting is the answer to their problems. However, this is unfortunately not the case. The following text about diets is taken from a book on eating disorders, and starts to explain why they do not work.

### Diets can make you beautiful and acceptable

As marketed, diets promise beauty, acceptance, and a life free of problems. To the obese or eating-disordered individual, they promise control in an out-of-control world. Though they promise to do this only with food, they are often viewed as the key to control over other problems as well. They make decisions for someone who is overwhelmed by decisions. They provide the illusion that there are concrete, simple answers for abstract and complicated problems. The language of dieting, full of words like "good," "bad," "cheat" and "guilt," reinforces the narrow thinking the individual may already have developed. Diets can be an easy focus for feelings of guilt and shame that belong to other issues and emotions, thereby providing a means of avoiding the issues behind the eating problem.

Diets have an extremely low success rate, yet advertisements for diets promise that this time . . . *this* time . . . they will work. When they don't, the consumer is blamed for a lack of will power. Moreover, diets can actually exacerbate depression and low self-esteem. For someone who is already feeling ineffective and powerless, a diet reinforces those feelings.

Nutrition therapy can help the individual who may have come seeking a diet to enhance her self-esteem to explore other avenues for achieving this in a fashion that actually works. Weight may normalize indirectly as food is no longer used or abused as a means of expressing a negative self-image.

*Reference*: Woolsey, M. M. (2002). Eating Disorders – A Clinical Guide to Counselling and Treatment. Chicago, IL: American Dietetic Association, pp. 155–156.

These are some of the ***psychological reasons*** why diets have such a low success rate. It is also worth thinking about some of the more ***physical reasons*** why diets have such a low success rate. Whilst thinking about this it is perhaps worth remembering that the body is still programmed to deal with food shortages and periods of starvation (which on a genetic level are still seen as the major threat to life, even though food is now readily available). Therefore, we are designed to react to a period of food restriction by overeating and storing excess food when it is available.

- Most diets allow far too little food. Anything less than 1500 kcals a day in women or 2000 kcals for men will tip the body into a starvation state, increasing the risk of overeating at a later time. Someone who is obese will actually need more than this figure to prevent this happening.

- Continued rapid weight loss (more than 1 kg a week) is encouraged or expected, which again triggers the starvation state. Although initial weight loss may be rapid (due to fluid losses), long-term weight loss should be up to 0.5—1.0 kg a week (1—2 lb). Many people lose weight at a slower rate than this, and although this feels very slow, research shows that slow weight loss is much more likely to be maintained.
- Fad diets are often very restrictive in the range and type of foods allowed. Many foods are off-limits, which makes them far more tempting, especially if the dieter is very hungry because they are not allowing themselves enough food.
- If a diet is rigid or relies on special foods (e.g., low-carbohydrate cereal bars in the low-carbohydrate/high-protein diets like the Atkins diet), long-term eating behaviors are not altered, leading to a return to old ways (and weight gain) once the diet is dropped.

### Achieving successful weight loss

Successful weight loss involves not just losing weight, but avoiding weight regain. This is more likely to be achieved through the following.

#### Have realistic expectations

- To begin with, aim to lose 5—10% of your initial weight. Even this modest amount will greatly improve your physical health. Aiming to lose more than this from the outset will probably result in disappointment if you do not achieve this, and it is likely that you will overlook what you have achieved (e.g., losing ½ stone/3.5 kg).
- As stated above, aim to lose no more than 0.5—1.0 kg a week. (You may even lose less than this, but at least weight is going in the right direction.) This might feel very slow, but weight gain does not happen overnight, so weight loss is not going to either.

#### Make changes to your diet based on improving health rather than losing weight

- Eat three meals a day (including breakfast), plus regular low-fat snacks.
- Cut down on the amount of fat and added sugar you eat (e.g., fried foods, pastry, cheese, crisps, cakes and biscuits).
- Eat more fruit and vegetables.
- Cut down on the amount of salt you add to food.
- Review how active you are — aim for 30 minutes of moderate activity (where you get out of breath but can still carry on a conversation) on most days a week, then, if you can, build this up to 60 minutes a day (if you are overweight/obese). If your physical health is currently affected by your weight, speak to your GP before starting any new activity.

## FURTHER READING

Brownell, K. (1990). Dieting and the search for the perfect body: where physiology and culture collide. *Behavior Therapy*, **22**, 1–12.

Ogden, J. (1992). *Fat Chance! The Myth of Dieting Explained*. London: Routledge.

## 2C4 The effect of premenstrual syndrome (PMS)

The following information is adapted from: Kahm, A. (1994) Recovery through nutritional counselling. In B. P. Kinoy, ed., *New Directions in Treatment and Recovery*. New York: Columbia University Press.

Premenstrual syndrome (PMS) affects about 40% of today's women, anywhere from ten to a few days before their period. Common symptoms include:

- Feeling bloated and "feeling fat" – often fluid retention can occur (leading to a sudden weight increase).
- Feeling more moody than normal, perhaps becoming more critical of oneself, or feeling hopeless about life. This is probably due to hormonal changes.
- Feeling more tired than normal.
- Getting more headaches than normal, which may be related to hormones, tiredness, hunger or all three of these factors.

### Increased energy needs and PMS

In the time before a period is due there is an increased energy requirement of around 250–300 kcals a day (Wurtman, 1989). This increased energy requirement leads to increased hunger, often manifesting as cravings for sugary foods (commonly, many women feel more hungry for chocolate just before a period). In addition, women often misread the increased bloating as "feeling fat," which leads to an urge to cut down on their food intake. So just at the time when they need more food, they are eating less than normal. The result is that there is an increased risk of bingeing/overeating, especially considering the fact that women may be feeling moody or irritable.

### Weight changes in PMS

As stated above, weight may suddenly increase just before a period. Usually this is in the region of 1–1.5 kg (2–3 lb), but some women report larger weight increases than this. This is due to hormonal changes, which increase fluid retention. Many women also get more constipated just before a period, which will also potentially lead to an increase in weight.

Once the period starts, within a day or two the change in hormone levels leads to a normalization of body fluid levels, and weight returns to its original level.

### Coping with PMS

The first thing to do is to work out whether you are one of the 40% of women who suffer from PMS. For example, many women think they get the premenstrual weight gain, but on examining their weight changes around menstruation, they realize they were mistaken. To work this out it is important to keep a diary of when you menstruate and compare it to your weight chart, as well as your food

and mood diary. Once you have worked out that you do experience PMT, the following may be of help:

- Be aware that it will happen and be prepared for it. Even if menstruation is irregular, remembering what symptoms you experience can help you keep one step ahead.
- Be aware that your body's physical needs will be different just before a period.
- Do not restrict food intake just before a period. In fact, allowing yourself slightly more substantial snacks/meals may help reduce the cravings (e.g., a Greek yoghurt instead of a low-fat one).
- If you fancy chocolate, allow yourself to have one normal sized bar, as this will help you control the urge to overeat.
- Avoid reading too much into your weight changes around the time your period is due.
- Remember that PMS only lasts for a few days, after which things return to normal.
- If you really feel you struggle with PMS, speak to your doctor to see if there is anything else that may help.

*Reference*: Wurtman, J. (1989). Carbohydrate therapy for premenstrual syndrome. *American Journal of Obstetrics and Gynaecology*, **161**, 1228.

Appendix 2D

# Basic nutritional facts and principles

## 2D1 Metabolic rate/energy expenditure (or how the body uses food)

The body needs energy for all of its functions. These can be divided up into three main groups:

- Maintenance of life (e.g., organ function, digestion, keeping warm/cool, repair of damage)
- Voluntary activities (e.g., general activity and exercise)
- Special purposes (e.g., growth, pregnancy and breastfeeding)

The chart below covers the first two of this list, including the proportion of energy needs that each makes up (assuming an average woman needs 2000 kcal a day):

| | Factors that can affect this | Average calories used |
|---|---|---|
| **Physical activity** | Intensity of activity<br>Duration of activity<br>Body weight | 15–30%/300–600 |
| **Digestion/absorption of food** | Amount of food<br>Composition of food<br>Genetics | 10%/200 |
| **Basal metabolic rate (BMR)** | Amount of muscle<br>Amount of body fat<br>Age<br>Gender<br>Genetics | 60–75%/1200–1500 |

*Some important facts about metabolism and energy requirements:*

- Although the liver and brain are only around 2.5 and 2% of body weight, respectively, they each account for about 20% of the basal metabolic rate (that is 250–300 kcal each, per day).
- When asleep overnight, the average person will use up around 400–500 kcal. This is because the heart keeps beating, the lungs keep breathing, the liver and kidneys keep working, and so on.
- Research shows that eating disorder behaviors lead to a reduction in the basal metabolic rate, meaning that the body needs less energy (calories) to maintain weight. Irregular eating may reduce BMR by about 10%, whereas losing large amounts of weight to a very underweight level has been shown to reduce BMR by as much as 20–30%, or more. Symptoms that you might experience that tell you this applies to you include feeling cold all of the time, suffering from constipation, losing your periods, poor skin/hair, feeling

very tired and lethargic, feeling irritable and frequent headaches (see the sheet on the effects of semi-starvation for more information on this). The good news is that metabolic rate returns to normal when weight and food intake return to normal.

## 2D2 Normal eating

These points come from the reference below. They do not represent an agreed definition about what constitutes normal eating, but are more the opinion of that book's author. Therefore, it may be useful to go through these points, decide whether you agree with them, and, if not, think about how you would define normal eating.

Normal eating *IS*:

- Eating something at least three times a day.
- Eating more than you feel you need to eat on some occasions (overeating).
- Eating less than you need on other occasions (undereating).
- Eating more of the foods that you enjoy the taste of, when you choose to.
- Eating less of the foods you like, as you know you can eat them in the future.
- Eating or not eating on occasions because you feel unhappy, "bad," or tense.
- Eating both "good" and "bad" foods, in other words a variety of foods, without feeling guilty.
- Eating in a flexible way so that it does not interfere with our work, study or social life.
- Eating sufficient food and a variety of foods, often enough to prevent a desire to binge-eat.
- Eating, when out socially, in a similar manner to the other people in the group.
- Eating at "fast food" outlets occasionally, as a treat to yourself.
- Being aware that eating is not the most important thing in life but knowing that it is important for good health.

Normal eating is *NOT*:

- Counting calories, weighing food or following a strict diet.
- Always eating low-calorie foods, for example, diet biscuits rather than bread.
- Eating to lose weight, but knowing that you can "watch your weight" if you want to.
- Assuming that you can control the amount and type of food your body needs better than your body can.
- Having to constantly weigh yourself for reassurance.
- Playing games with yourself to prevent eating certain foods, for example, saying to yourself "dairy products make me feel nauseous" or "I've become vegetarian for health reasons" when the real reason is to justify excessive amounts of fruit and vegetables.

*Reference*: Abraham, S. & Llewellyn – Jones, D. (1992). *Eating Disorders – The Facts*, 3rd edn. Oxford: Oxford University Press, p. 127.

## 2D3 Proteins – some basic facts

### Summary of functions of proteins in the body

These are some of the keys things that protein does in the body:

- Serves as a building block for growth and repair of the body
- A major component of skin, tendons, membranes, muscles, organs and bones
- A major part of enzymes, hormones and antibodies
- Integral in the formation of blood clots (to stop bleeding)
- Maintains fluid and electrolyte (body salts) balance
- Maintains acid–base balance (to keep body fluids at the right concentration)
- Provides energy
- Transports nutrients around the body

### How much energy does protein provide?

- 1 g of protein provides 4 kcal.
- An average portion of protein food (e.g., meat, fish, eggs) contains around 15–20 g of protein

### How much protein do we need?

This tends to remain fairly stable, but there are some factors that increase how much protein we need:

- Pregnancy
- Breastfeeding
- Growth in children and adolescents
- Returning to a normal weight from being underweight
- Chronic infections
- When the body needs to repair itself after major physical trauma (e.g., a car accident).

However, the level of protein in the average diet covers all of these needs (unless someone is in hospital with a major health problem, e.g., pneumonia), so it is not necessary to add more if your diet already includes:

- Eating a normal sized portion of a protein food (for example, meat, fish, eggs, nuts and seeds, pulses such as lentil and kidney beans) at each main meal (lunch and dinner).
- Also, having enough dairy-based foods (most people need 3 portions a day – one portion = 1/3 pt/200 ml milk, one carton yoghurt, 1 oz/25 g hard cheese, average portion of milk sauce (e.g., custard, cheese sauce)).

## 2D4 Carbohydrates – some basic facts

### Summary of functions of carbohydrates in the body

These are some of the keys things that carbohydrate does in the body:

- Provides the body's preferred source of energy. It can use other energy sources (e.g., fat, protein and alcohol, but does not work as well on them in either the short or the long term)
- Provides energy for the brain and central nervous system
- Regulates blood sugar levels
- Prevents the use of protein to meet energy needs
- Prevents the formation of dangerous by-products (ketones) when fat is burned for energy
- Provides dietary fiber to protect against heart disease and cancer
- Contributes to feelings of fullness
- Provides fiber to prevent constipation.

### How much energy does carbohydrate provide?

- 1 g of carbohydrate provides 3.75 kcal.
- An average portion of carbohydrate food (e.g., 2 slices bread) contains around 30–35 g of carbohydrate.

### How much carbohydrate do we need?

Carbohydrate should be around half of total the energy we eat each day. For the average female who needs around 2000 cal a day, this works out to be around 250–300 g of carbohydrate.

The majority of this should be from starchy carbohydrates, milk sugars and natural sugars (e.g., in fruit). This means that each main meal and many snacks should be based on starchy carbohydrates (e.g., rice, pasta, breakfast cereal).

Healthy eating guidelines also allow the consumption of small amounts of foods with added sugars (e.g., chocolate, cakes), and foods that are naturally high in sugar (e.g., fruit juice or honey). Generally these kinds of foods (and other treat foods like crisps) can be eaten 1–3 times a day.

## 2D5 Fats – some basic facts

### Summary of functions of fats in the body

These are some of the keys things that fat does in the body:

- Body fat keeps us warm.
- It protects internal organs (e.g. kidneys) from impact, like falls or knocks.
- Dietary fat provides the essential fatty acids linoleic acid and linolenic acid (also known as omega 3 and omega 6 fatty acids). We need to eat these on a daily basis because:
  - they are very important in improving brain function when returning to a normal weight after being a low weight
  - they are essential for brain function, including the brain development of unborn babies
  - they also have a role in preventing heart disease.
- Fats provide the fat-soluble vitamins A, D, E and K, all of which are essential.
- Fats contribute to the structure of blood vessels, and form a major component of the cell wall. A low fat intake will therefore increase the risk of bruising very easily, and affect skin health.
- Fats transports cholesterol around the body. Many people who are a low weight can have a high cholesterol level, which reduces if fat is added to the diet and weight is gained.
- Fat contributes to the structure of hormones, such as estrogen. A lack of estrogen will lead to a lack of periods, which increases the risk of osteoporosis. Therefore, a diet low in fat may delay the return of menstruation, or the body may need to be a higher weight before periods return if a low fat diet is consumed.
- Fats provide a concentrated form of energy, including as an emergency source of energy when food is not available.
- Dietary fat helps increase feelings of fullness, therefore reducing the risk of bingeing.
- Fat gives taste and aroma to food, as well as make it tender.

### How much energy does fat provide?

- 1 g of fat provides 9 kcal.
- An average portion of fat food (e.g., the margarine on 2 slices bread) contains around 10 g of fat.

### How much fat do we need?

Women need to consume between 65 and 77 g of fat per day, whereas men need to have between 83 and 97 g of fat a day to meet basic requirements.

Around half of dietary fat should come from foods naturally high in fat (e.g., cheese, oily fish, meat, nuts, seeds, etc.), and the rest should come from fats added to foods or used in cooking (e.g., oils, butter, margarine).

**What are healthy levels of fat in the body and in the diet?**

A healthy fat level is approximately 20–25% of body weight for females and 10–15% for males. Levels lower than this are likely to lead to reduced resistance to disease, weakness, irritability, increased risk of bingeing and reduced fertility.

## 2D6 Fruits and vegetables

### Why do we need fruit and vegetables?

Fruit and vegetables provide the following nutrients:

- Vitamin C – important for protecting against infection
- Carotenes (plant source of vitamin A) – important for cell development and healthy vision
- Folates – a B vitamin, important for healthy skin and muscle
- Dietary fiber – important for normal bowel function
- Some carbohydrate – a very healthy form of energy.

### How much do we need per day?

Generally, we need to aim for *five portions of fruit and vegetables per day*. As fruit and vegetables can be very filling, but are relatively low in energy, very low-weight people may suffer from bloating and feeling full very quickly if they eat excessive amounts of fruit and vegetables. This also means that it can be difficult to eat other nutritious foods (like starchy carbohydrates and protein foods). Eating too much fruit and vegetables may also lead to diarrhea or constipation depending on your individual situation and other components of your diet. Eating too much fruit (and possibly vegetables) may increase the risk of dental problems, due to the acid and sugar content of fruit.

### What count as fruit and vegetables?

All the following choices count as fruit and vegetables:

- Fresh, frozen and canned fruit and vegetables
- Dried fruit
- Fruit juice (counts as only one portion per day – see below – due to its high sugar and low fiber content).

### What counts as a portion?

| Fruit | Vegetables |
|---|---|
| One average piece of fruit (e.g., apple, orange, banana, pear) | 2–4 heaped tablespoons cooked vegetables (e.g., peas, beans, carrots) |
| Two small pieces of fruit (e.g., clementines, kiwi fruit, plums) | Small bowl (cereal bowl) of salad |
| Half a large piece of fruit (e.g., grapefruit) | ½ large courgette or pepper |
| Small handful grapes (around 10) | 1 medium tomato |
| 3 large pieces dried fruit (e.g., apricots, prunes, dates) | 2-inch piece of cucumber |
| 1 tablespoon small dried fruit (e.g., raisins) | |
| One small glass (100–150 ml) fruit juice | |

## 2D7 Alcohol

Alcohol is not an energy source that the body has a specific need for (unlike carbohydrate, protein or fat). Furthermore, it does not provide any essential nutrients that cannot be supplied by other foods or drinks. Therefore, it is an optional extra, to be taken on top of the basic diet rather than substituting for that diet.

Some people feel they need to avoid alcohol during their recovery. However, if you do not want to go down that route, then this sheet aims to help you drink appropriately and safely, and to provide information regarding its physical effects.

### What is the recommended limit for alcohol consumption?

- Up to 14 units a week for women; 21 units a week for men.
- Avoid binge drinking, have no more than 2–3 units a day if you are female, or no more than 3–4 units a day if you are male.
- If you do drink more than this in one evening you are advised to avoid alcohol for a couple of days following this to give your liver time to recover.

### Managing alcohol during recovery from your eating disorder

- Alcohol is likely to make you feel hungrier (through lowering your blood sugar levels) and at the same time reduces your ability to be in control of your impulses (i.e., it is harder to say no to things). Therefore, it may increase your desire to overeat or binge.
- When you start treatment you may find it best to avoid alcohol until your eating pattern has become more regular and balanced, and you feel you can completely the effect this will have on your weight and appetite. This may take a few weeks or several months, so it is a good idea to talk to your clinician to decide if you are ready to reintroduce alcohol.
- As alcohol is an optional extra, and because it is likely to increase your levels of hunger and inability to manage binge feelings, it is very important not to reduce food intake to compensate for the amount of alcohol drunk. This will be discussed further in treatment.

### The effect of alcohol on weight

- Alcohol taken in moderation will not drastically affect weight, except if higher calorie drinks are usually chosen (e.g., liqueurs).
- If you drink in excess of the recommended levels (see above), then this is much more likely to lead to an increase in your weight, especially if you are also bingeing (with or without vomiting).

Appendix 3

# Food diary

DAY:

DATE:

| Time | Quantity | Food/Drink | Binge? | Vomit? |
|---|---|---|---|---|
| | | | | |

| Thoughts - Feelings – Events |
|---|
| |

Appendix 4

# Behavioral experiment sheet

| **Belief to be tested** (Rate belief 0-100%) | **Behavioural experiment** What will I do to test the belief? When will I do it? | **Prediction** What exactly do I think will happen? How will I know whether it has happened or not? (Rate belief 0-100%) | **Alternative prediction** What else might happen? (Rate belief 0-100%) | **Outcome** What actually happened? Was the original prediction correct? | **Re-rate cognition** On balance, what is my view now? How do I rate the original beliefs in the light of the experiment? | **Plan** What can I do now to further test the belief? |
|---|---|---|---|---|---|---|
| | | | | | | |

# Index

Tables in *Italics*, Figures in **Bold**


abstinence violation, 99, 101, 104
activity. *See* exercise
administrative staff, 5
adolescent cognitive behavioral therapy. *See* child and adolescent cognitive behavioral therapy
agenda
  characteristics, 136–8
  collaboration, 137
  deviation, 138–9
  monitoring mood and eating and, 136
  setting, 9, 137–9
  structure, 136, 137
  troubleshooting, 138
alcohol
  abuse, 37, 156, 262–4, 336, 410
  appropriate levels, 92–3, 430
  calorie content, 70, *93*, 377, 384, 430
  dehydration and, 81
  detoxification programs, 263
  impulse control and, 77, 92, 93, 430
  snacks and, 77 (*see also* snacks)
alexithymia, 132, *276*, 276
amenorrhea. *See* menstruation: amenorrhea
anemia, 90, 394
analogy use in cognitive behavioral therapy
  "anorexic gremlin", 221–3, 236–8
  "concept of prejudice", 200
  "cupboard", 260
  "hub, spoke and rim", **23**
  "inviting the eating disorder into the room", 282, 305
  "itchy jumper", 66–7
  "Newton's cradle", 267, **268**, 275, 280, 303
  "river", 116, 121
  "schema as prejudice", 187
  "supermarket", 157–8
  "trek along the coast of South America, A", 8–9, 341, 343, 347, 348
anorexia nervosa
  binge-eating/purging, *36*
  case formulation, 107–10
  categories, *36*
  complications, 376, 394–7
  DBT treatment, 3
  DSM-IV criteria, *36*
  energy levels, **147**
  pro-anorexia websites and, 143
  *See also* eating disorders; patient(s); treatment of eating disorders
anxiety, 38, 107, 245, 266, 347, 377, 396. *See also* clinician: anxiety; social anxiety
assessment
  aims, 31
  of behaviors, 39
  of chronic risk, 21
  of cognitions, 39
  of comorbidity, 37–9
  extended, 40
  family structure, 38
  interview, 31–4
  life history, 38
  medical, 19, 21, 37
  of motivation and goals, 39
  of problems and goals, 60–1
  of pros and cons of change, 59, 62
  symptom profile, 38
  of therapy-interfering behaviors (*see* therapy-interfering behaviors)
  of trauma history, 38
  of treatment history, 38
  of treatment preferences, 39
  trouble shooting during, 39–41
  *See also* interviews
asthma, 37
avoidant personality disorder, 256
Axis I pathology, 245–6 (*see also* anxiety; depression)
Axis II pathology, 241
  avoidant personality disorder, 266
  cluster B personality disorders, 266
  cluster C personality disorders, 266

Axis II pathology (cont.)
comorbidity with eating disorders, 266
obsessive compulsive disorder (*see* obsessive-compulsive disorders)

beauty, societal attitudes towards, 231
Beck Anxiety Inventory, 39, 338
Beck Depression Inventory, 39, 246, 338
Beck Hopelessness Scale, 246
behavioral
change, 14
experiments (*see* behavioral experiment(s))
therapies, 12
triggers, 280
behavioral experiment(s), 11–12, 167, 170, 172
belief reattribution by, 190
categories, 192–3
cognitive change and, 12, 190
definition of, 190
design, 191
discovery, 191, 192
following case formulation, 112, 190
as homework assignment, 120
purpose, 190
surveys as, 193
bias
cognitive, 155, 233, 236
depressogenic atributional, 248
documenting with diaries, 249
self-serving, 233
binge eating, 69, 99
blood sugar and, 146
DBT treatment for, 3
emotion-driven, 102
food types, 32
frequency, 32
long-term consequences, 100
weight gain with, 151
binge eating disorder (BED), xxiii, 155
bipolar disorder, 246
black and white thinking, 101, 184, 208, 272, 313
bladder function, 397, 399, 403, 405, 406 (*see also* kidney failure)
body
avoidance, 233–4
checking, 34, 99, 106, 225, 233–4, 250
comparison, 234–5
concept, 34
fat functions and requirements, 230–1 (*see also* nutrients: fats)
function understanding, 229–30
image (*see* body image)
percept, 35, *36*, 167, 225
physiology, 230
Body Checking Cognitions Scale, 233
Body Checking Questionnaire, 233
body image
acceptance, 226
behavioral experiments and, 233–5
beliefs associated with, 227–9
case formulations, 227–9
definition, 225–6
dissatisfaction, 224
disturbance, 224, 227
exposure, 235–6
imagery, 228, 236–8
monitoring, 232–3
origins, 227
psychoeducation, 229–31
puberty and, 237
self-control and, 224
treatment for dysfunctional, 225–9, 231–8
bone. *See* osteoporosis
blood pressure, 19
breast
enlargement, 231
feeding, 34, 78, 94
bulimia nervosa
case formulation, 99–105
categories, *36*
cognitive-behavioral models, 98
complications, 377, 398–400
DBT treatment, 3
DSM-IV criteria, *36*
energy levels and, **147**
*See also* eating disorders; patient(s); treatment of eating disorders

calorie(s)
counting, 81
and food planning, 81–2
requirements, 86
cancer, 71, 91
cardiovascular disease, 17, 19, 21, 71, *80*, 152, 395, 398, 401, 403, 405
care plan, 20, 21
case formulation
accuracy, 110–12, *112*
aspirational outcomes, 199
bulimia, 99–105
characteristics, 11, 96–8, 101–6, 111–12, **246–9**
comorbidity in, 11, 98
complex, 110
emotion-regulation function in, 100
examples, **246–9**, **251**, **255**, **260**
feedback, 102
focus, 97, 98, 101
ideal, 97
importance, 11, 96, **200**
improvement, 112–13
individualized, 97
interrelated problems in, 110
meta-cognitive awareness and, 96
models, **265**
overvalued beliefs in, 199–202
in patient's terms and expressions, 98
personal control in, 106
problem list and, 110
in restriction-based cases, schema-focused, 106–10, **278**, **279**, **305**
transdiagnostic, 98–9

CBT. *See* cognitive behavioral therapy
child and adolescent cognitive behavioral therapy
agenda setting, 311
assessment, 300, *303*
behavioral experiments, 314, 320
case formulation, 306–9
clinician stance, 295, 318–20
cognitive behavioral change in, 309, 310, 314, 320
comorbidity in, 299, 301
confidentiality, 298–9
control issues, 306
ending, 323–8
diagnostic categories, 290–1, 301, 316–8
diaries in, 311, 313
drawings and visualization in, *304*, 312–14
DSM-IV criteria, 290
family engagement in, 292–3
flash and cue cards in, 306, 312
homework and, 311
interventions, 306, 309–23
language use in, *297*, 311
motivation and, *297*, 301, 303–6, 310, 327
multidisciplinarity in, 299–300, 326
non-confrontational approach, 296
physical assessment in, 294–5
psychoeducation and, 306, 312
psychometrics in, 304
'real world' re-entry and, 320–1
recovery and relapse management, 321–3
risk and, 301
role-playing, 320
special considerations, 269, 291–300, *304*
stages of change model, 268, 303–6
use of other patients and families in, 305
vs. adult CBT, 289, 290, 294, *303*, 306, 309–23
weighing and, 312
*See also* children
children
educational considerations, 293
friendships and peers, 293–4
identity formation, 291
intellectual and emotional capacities, 267, 291
motivation in, 295–6
perfectionism in, 293–4 (*see also* perfectionism)
starvation effects in, 294 (*see also* starvation)
*See also* child and adolescent cognitive behavioral therapy
cholesterol/lipid levels, 19, 394
clinical practice, 3–11 (*see also* clinician)
clinician
anxiety, 96, 127, 128, 348
balanced working by, 134
"burn out", 345, 346
curious, 4–6, 46, 219
effectiveness, 126, 132–4
empathy, *62*
expectations, 43, 131
food and nutrition knowledge, 68
investment, 46–7
issues with body image, 131
motivation, 131
personal characteristics, 130–1, 134
power differentials and, 131–2
responsibility for change, 9, 11
stance, 4–6, 14, 45–6, 132–3, 295
supervision, 133
tracking of progress, 96
coeliac disease, 94
cognitive behavioral models and theories, 97, 98, 100, 310–11, 339
cognitive behavioral therapy (CBT)
affect regulation and, 33, 45, 253, 263, 267, 270, 271, 290
agenda setting, 9, 137–9
alternatives to, 333
analogy use in (*see* analogy use in cognitive behavioral therapy)
assessment in (*see* assessment)
behavioral experiments in (*see* behavioral experiment(s))
case formulation (*see* case formulation)
for children and adolescents (*see* child and adolescent cognitive behavioral therapy)
cognitive restructuring in, 183
comorbidity and, 245
continuum thinking in (*see* continuum thinking)
day-patient, 15, 249, 263
delivery of, 15
dimensional approaches to, 184–6
effectiveness in eating disorders, 3
elements, 4, 34–5
evidence and, 3–4, 206–8
expectations, 25–6
evaluation, 14
failure, 20, 25, 113, 326–8, 333
flexibility in, 159
formulation in (*see* case formulation)
goal setting in, 10–11
group, 15
homework in, 9, 43, 113
in-patient, 15
motivation and (*see* motivation)
cognitive behavioral therapy: non-negotiables in, 40, 41, 43, 127, 162, 297
patient role in, 4, 9, 44–5 (*see also* patient(s))
preparation for, 16, 48
problems and goals technique, 56
protocols, 13
psychoeducation, 140
schema-focused (SFCBT) (*see* schema-focused cognitive behavioral therapy)
setbacks, 113
Socratic questioning in (*see* Socratic methodology)
stages (*see* stages of cognitive behavioral therapy)

cognitive behavioral therapy (cont.)
supervisory format and, 133
termination, 16, 22–3
thought levels in, 179
transdiagnostic approaches in, 6–7, 101
transparent nature of, 121
treatment (*see* treatment of eating disorders)
trouble-shooting in, 25–6
weighing during (*see* weighing)
cognitive dissonance, 201
cognitive-emotional-behavioral therapy (CEBT), 270–3, **272**, **305**
cognitive levels, 198
cognitive restructuring, 183, 206–13
of body image, 232–3
comorbidity with obsessive-compulsive disorders, 250–2
depression and, 248
evidence evaluation in, 206–8
collaborative working relationships, 5–6, 23. *See also* multidisciplinary working environment
community mental health professionals, 23
comprehensive validation, 46, 49, 277, 290
compulsive behavior. *See* obsessive-compulsive disorders
comorbidity
CBT expectations and, 26
case formulation and, 11, 98
diversity, 13
impulsive behavior, 37
self-harm, 37 (*see also* self-harm)
substantial, 14
*See also* obesity: comorbidity with eating disorders
constipation, 78, 394, 399, 404, 406
continuum thinking, 10, 184, 204, 205, 208, **210**,232, 272, 313
contraception, 34
convulsions, 398, 401, 403
coping mechanisms, 9, 254–7, 260
cystic fibrosis, 94

dehydration, 79, *80*, 398, 401, 405
dental problems, *22*, 337, 398, 402
Department of Health (UK), 91, 407
depression, 38, 124, 246–9, 390
antidepressant medication for, 248
assessment, 246
behavioral experiments for, *36*, 249
case formulation in, 246–7
cognitive restructuring and, 248–9
comorbidity with eating disorders, 246
treatment, 247–8
diabetes, 19, 91, 93, 94
diagnosis
criteria, 7, 36
DSM-IV, 36
of eating disorders, 36
role in CBT, 7
dialectical behavior therapy (DBT), 266–9, 291–300
comprehensive validation, 269
mindfulness skills, 269
reduction of dissociation, 269
diarrhea, 78, 384, 399, 403, 412, 429
diet
Atkins, 141, 417
changes, 83–5
content, 84–5 (*see also* nutrients; nutrition)
fad, 417
failure, 377, 416–17
feelings towards, 416
improvement, 82–5
patient rules and, 99, 101
pills, 33
unbalanced, 410
dietitians, 5, 23, 69, 93, 126, 128
dissociative features, 38
diuretics, 17, 33, 377, 401, 405, 406, 413
domestic violence, 346
downward arrowing, 49, 199
clinician empathy in, 179
definition, 179
procedure for, 180, 183
trouble-shooting in, 182
draining, 49, 101, 107, *297*
drug abuse, 37, 156, 262, 263, 336
dysphagia, 277, 290, 398

eating
continuum of, 159
improvement of, *141*, 276, 376
overevaluation of (*see* overevaluation)
restrictive, 52, 57, 85, 158, 197, 290 (*see also* anorexia nervosa)
eating disorders
chronic history of, 221
cognitive elements of, 11
compensatory behavior in, *36*
diagnosis, 6, 36
ego-syntonic nature of, 44, 50, 61, 128, 129, 198, 222, 344
emotion-regulation function in, 98, 100–1
food role in, 68–9 (*see also* food)
functional avoidance in, 45
health consequences (*see* medical risk factors in eating disorders)
historical approach to, 6
long-term course of, 132
mortality, 16
not otherwise specified (*see* eating disorders not otherwise specified)
obesity and, 88
perpetuating factors, *141*
physical factors, 45, 126–8
positive reinforcement of, 44
pros and cons of change in, 59–60, 62
psychological factors in, 45, 396
relinquishing, 64–6
risk assessment in, 17 (*see also* risk assessment in eating disorder treatment)
services, 325–6, 338, 344
social factors in, 44

treatment (*see* treatment of eating disorders)
triggers, 156 (*see also* behavioral: triggers)
vegetarianism/veganism and, 88–90
*See also* anorexia nervosa; binge eating; bulimia nervosa; eating; restrictive; hunger
Eating Disorder Examination Questionnaire, 39, 338
eating disorders not otherwise specified (EDNOS)
atypical bulimia nervosa, purging subtype, 102
binge eating, 37
classification, 6, 339
DSM-IV criteria for, *37*
normal weight purging behavior, 165
eating patterns
normal, **71**, **74**, **149**,377, 381, 424
regular, 8, 379–80
timing of eating and, 84
electrolytes, 126, 152, 401, 403, 405
emotion
acceptability, 270
anxiety (*see* anxiety)
avoidance of, 100, 132, 275, 276
awareness of, 271, 273
beliefs about, 269
changes due to low weight, 145
mislabeling, 233
monitoring, 273
numbing of, 106, 109, 245, 336
positive functions of, 271–2
primary, 270, 272
regulation, 264, 267–9
secondary, 270–2
enema, *36*
energy graph, 145–50
function of, 145
joint construction with patient, 145
and normal energy supply, 148–50
patient eating patterns and, 148
patient preparation for, 146–8
exercise, 407–8
assessment, 91
classes, 91
compulsive, 91–2, 276, 407
energy requirements, 91
excessive, 33, *36*, 91–2, 156, 336, 407–9
healthy levels of, 91, 377, 407
inadequate, 71, 86
motivation for, 91
recording of, 33
eye problems, 399, 402

families, 292–3. *See also* child and adolescent cognitive behavioral therapy
fasting, *36*, 45, 85
Fear of Negative Evaluation Scale, 254
flashcards, 61, **281**, **282**, **305**
flatulence, 78
'flight into health', 343, 344
fluid intake
excessive, *80*, 401
inadequate, 79, *81*,398, 401, 405
measurement
misconceptions, 80
normal, 79–81, 384, 404
thirst and, 79, 384
food
allergies, 32, 94
'banned', 101
calcium-rich, 77–8
calorie content, 81–2,*83*
composition (*see* nutrition)
dairy, 78, 409
desserts/fun, 70, 79
diaries (*see* food diaries)
in eating disorders, 68–9, 312, 378
eating of previously avoided, 8
fruits and vegetables, 78–9, 377
grading, 386
groups, *72–3*, 385
monitoring, 120
planning, 81–2, 150
portion sizes, 84
preferences, 32
psychoeducation on, 94
rituals, 32
snacks (*see* snacks)
supplement drinks, 87
*See also* meal(s); nutrients
food avoidance emotional disorder (FAED), 290
food diaries
eating disorder treatment and, 25, 32, 154, **156**,342, 350
form, 155–7
limitations, 160–1
monitoring, 159–60
purpose, 154–5, 159
ready made, 155
non-completion of, 157–8
review with patient, 158–9
'supermarket' analogy and, 157–8
termination, 160
formulation. *See* case formulation

gastric
bloating, 78, 402
dilatation, 90, 398
emptying, delayed, 69, 78
glucose
levels, 19, 77
tolerance, 19
*Guide to Medical Risk Assessment for Eating Disorders, A*, 17
guided self-help, 15, 247

heart disease. *See* cardiovascular disease
height measurement, 25, 33–4
HIV/AIDS, 94

homework
assigning, 120
audiotape review as, 121–2
concerns surrounding, 123
guidelines, 122–4
in-session practice for, 123
instructions, 123
non-compliance with, 124–5
purpose, 120, 122–3
self-evaluation pie charts and (*see* self-evaluation pie charts)
success in CBT and, 120
summarizing, 123–4
typical assignments, 120
hospital admissions, 127
hunger
control, 84, 383
eating disorders and, 382
emotional, 68, 69, 382
physical, 68, 69, 382
recognition, 69, 379, 382
Huntingdon's disease, 94
hypertension, 19

Impact of Events Scale, 258
impulsive behaviors, 262–3
inflammatory bowel disorders, 94
in-patient care, 15, 23, 263
interventions
CEBT-ED and, 271
goals of, *62*, 64, 278
matched to patient, 49
psychodynamic, 24
SFCBT, **246–9**, 278–9
interviews
assessment and, 31–4, 50
demographic information and, 32
eating behaviors and, 32–3
semi-structured protocol for, 31, 376

ketoacidosis, 37
kidney failure, 80, 403, 405, 406 (*see also* bladder function)

laxatives
eating disorders and, 33, 101, 156, 377, 398–400, 403–4, 412
calorie absorption and, 100, 412
injurious effects of, 17
mechanism of, 403, 412
weight gain and, 36, 152
lipid levels, 19
liposuction, 231
logs
positive data, 187–9, 280–2
prediction, 217
*See also* food diaries

meal(s), 76
breakfast, *76*, 85
dietetic input on, 93–4
dinner, *76*
structure, *76*, 84
*See also* food; nutrients
medical practitioners, 16, 21, 23, 126
medical risk factors in eating disorders, 17, *22*, *126–8*, 126–8, *141*, 376–7, 387
blood in vomit, 17
dehydration, 17
disruption of eating habits, 17
excessive exercise, 17
inadequate fluid intake, 17
management, 349
monitoring, 17–18, 22–3
esophageal/gastric tears, 17
psychological, 17
rapid weight loss, 17, 19–20
medical safety in cognitive behavioral therapy, 16–21, 127
medical tests
blood counts, 18, 20, 21, 127, 394
blood pressure, 18
electrocardiogram (ECG), 18, 20, 21
electrolytes, 126, 152, 401, 403, 405
erythrocyte sedimentation rate (ESR), 18
liver, 18
phosphate, 18
SUSS, 18
thyroid stimulation hormone (TSH), 18
urea and electrolytes, 18, 85
menopause, 34
menstruation
amenorrhea, *22*, *36*, 394, 408, 409
eating habits and, 145
fertility and, 394
history, 34
premenstrual syndrome (PMS), 377, 419–20
resumption, 337
metabolism and metabolic rate, 86, 91, 152, 171, 172, 377, 380, 391, 422
Minnesota experiment on starvation, 88, 388–92
'miracle' question, 50–6, *52*, 58
Morgan-Russell scales, 334
motivation
assessment, 50–5
CBT expectations and, 26
changes in, 55
collaboration and, 46
diversity/fluctuation in, 13, 50–5, 61
eating and, 68
enhancement, 46, 55–61
friend or foe letters and, 56–7, *57–63*, 278, 305
for homework, 124 (*see also* homework)
learning and, 46
level, 47
passivity and, 46
pros and cons lists, 50–1, 232–3, 279
self-acceptance and, 46
trouble-shooting, 61–7
multidisciplinary working environment
in child and adolescent CBT, 299–300
clinical decisions in, 24

collaborative working relationships, 5–6, 23, 126, 127, 133–4
'hub, spoke and rim' model, 23
multiimpulsivity, 14, 262–3
assessment, 263–4
case formulation for, 264
characteristics, 263
risks, 263
treatment, 264–5
*See also* obsessive-compulsive disorders
multiple sclerosis, 94
muscle
dysfunction, 21, 397, 401, 403, 405
strength testing, 20–1

narcissism, 266
National Institute for Clinical Excellence, 85, 88, 299, 344, 345
negative automatic thoughts, 122, *181*, 183–5, 198, 248, 249, 263, 264, 268, 280, 303–6
neurodegenerative disorders, 94
nurses, 5, 126
nutrients
carbohydrates, *70*, 71, 84, 145, 147, 377, 426
core, *70*
daily requirements, 77, 141, 377
dietary fiber, *70*, 71
fats, *70*, 70, 71, 84, 377, 427–8
fruits and vegetables, 377, 429
health risks and, 71
healthy diet and, 70
minerals, *70*, 90–1
protein, *70*, 84, 377, 425
supplements, 78, 85, 90–1
vitamins, 70, 85, 429
water, *70*
*See also* food; meal(s); nutrition
nutrition, 69–71
Balance of Good Health (UK) and, 70
junk/luxury/fun foods and, 70, 79
misuse, 71
principles, 76
standard meal structure and, 71
therapy, 416
*See also* food; meal(s); nutrients

obesity
comorbidity with eating disorders, 18, 87–8, 226, 344–5
diseases related to, *22*, 71
management, 344
services, 88
weight loss and, 88
obsessive-compulsive disorders (OCDs)
assessment, 250
behavioral experiments, 253
case formulation for, 250
comorbidity with eating disorders, 32, 38, 245, 249–50, 266, 276, 336
services, 344
treatment, 250–3
occupational therapists, 5, 326
osteoporosis, *22*, *344*, 344, *377*, 377, 396, 409–10
ovarian ultrasound, 337
overdose, 37 (*see also* alcohol: abuse; drug abuse)
overevaluation
alerting patient to, 202–5
behavioral experiments for, 205, 213–14, 220, *221*
in case formulation, 199–202
cognitive restructuring for, 205–13
continuum thinking and, 208 (*see also* continuum thinking)
as diagnostic for eating disorders, 197
domain choice and, 203
of eating, 102, 202
self-evaluation pie charts and, 202, **203**, **205** (*see also* homework; self-esteem and self-worth: self-evaluation pie charts and)
of shape and weight, 225
surveys and, 211–13
treatment of, 205–6

patient(s)
anxiety (*see* anxiety)
approval seeking, 132
belief system, 198, 199, 211
body image (*see* body image)
concerns, 35, *36*, 45, 59–60, 347
dietary rules, 101
diversity, 13
emotions (*see* anxiety; emotion)
engagement in treatment, 13, 49, 66–7, 114, 333
expectations, 44–5, *62*, 226, 343
experiences, 45, 46, *62*, 275
future, view, 58–60
investment, 46–7
life plans, 57–8, 272, 305
manipulation by, 130
mood swings, 107
motivation (*see* motivation)
multiple eating disorders in, 6, 49
perceptions, 129 (*see also* body: percept)
personal characteristics, 130–1
potential for change, 55
pregnant, 24, 34, 93, 94
problems and goals, 60–1
relation to clinician, 132
relinquishing eating disorder, 64–6
resources, 49
safety, 40, 172
secrecy, 320
self-directed prejudice in, 200
self-evaluation systems, 232
'special', 130
as therapist, 9, 55, 172, 347
therapy, failure of, 26, 333
treatment preferences, 3
perfectionism, 38, 100, 108, 249, 275, 293–4, 313
personality disorders, xxiii, 14, 38, 126, 246. *See also* Axis II pathology; obsessive-compulsive disorders

physical
disability, 94
exams, 19
monitoring, 20
positive data logs, 187–9
Posttraumatic Cognitions Inventory, 258
Posttraumatic Diagnostic Scale, 258
posttraumatic stress disorder (PTSD)
assessment, 258
behavioral experiments for, 260
case formulation in, 258–9
CBT and, 260
cognitive restructuring and, 261
comorbidity with eating disorders, 38, 258–62, **260**
'cupboard metaphor' and, 260
imagery rescripting for, 260, 261, 283
safety behaviors and, 260
symptoms, 258
traumatic events and, 259, 261
treatment, 259
prediction log, 217
pregnancy, 24, 34, 93, 94
psychoeducation
cognitive behavioral therapy and, 140
description, 140
dietetic, 94
effectiveness, 140, 142–3
examples, 142
history, 140
internet use in, 143, 252
key topics, 143
leaflets, 70, 376
myths and, 150–3
resources, 376
uses for, *141*,142
psychologists, 5, 126 (*see also* clinician)
psychosexual function, 34. *See also* menstruation
psychotherapists, 5
purging, 17, 100, 377, 412–13. *See also* bulimia nervosa

recovery
absence of behaviors and, 335
agents of change in, 341–3
approaches to, 341, 346
categories, 343
criteria, 334, 336, 338–9, 349
emotional factors in, 335–6
goals during, 336, 338
healthy eating plan during, 350
mood during, 335
patient's perspective on, 343
physical factors in, 337
pseudo-, 339, 340, 344
responsibility for change in, 342
social factors in, 337
stable body mass index and, 335
stages of change and, 339
transcendence in, 339, 340
*See also* relapse; treatment of eating disorders
relapse
management, 173, 309, 321–3, 343
prevention, 48, 283–4, 321, 347, 349–50
risk factors, 198, 340, 349–50
tools and exercises, 350
*See also* recovery; treatment of eating disorders
restrictive eating, 52, 57, 85, 158, 197, 290 (*see also* anorexia nervosa)
risk assessment in eating disorder treatment, *22*, 38
baseline test, 18 (*see also* medical tests)
chronic, 21
initial, 18
insight/capacity, 17
medical (*see* medical risk factors in eating disorders)
motivation, 17
psychosocial, 17
risk in eating disorders. *See* medical risk factors in eating disorders
Rosenberg Self-Esteem Scale, 246
Royal College of Psychiatrists (UK), 85

safety, medical, 16–21, 127
schema-focused cognitive behavioral therapy (SFCBT)
assessment, 263, 274
attribution and, 278
case formulation in, 273–8
cognitive content in, 275–7
core beliefs and, 267, 275, 277, 280, 283
diaries and data logs in, 280–2 (*see also* logs)
flashcard use, 280–1
historical review in, 279–80
imagery rescripting, 283
intervention and, 278–9
Newton's cradle analogy and, 267, 275, 280, 303
preparation for, 273–4
relapse prevention, 283–4
residual eating issues and, 283
schema avoidance and, 276
schema compensation and, 275
schema dialogue and, 282
therapy records in, 280
self-esteem and self-worth
assessment, 246
case formulation in, 246–7
cognitive restructuring and, 248–9
comorbidity with eating disorders, 38, 245, 320
dysfunctional, 99, 197, 246–9
self-evaluation pie charts and, 202–5, **203**, **205**, 281, 305, 335, 349 (*see also* homework)
self-harm
burning, 37, 262
cutting, 16, 37, 262
eating disorders and, 126, 248, 276
for emotional regulation, 262
hair pulling, 38
hitting, 37, 262

overdosing, 37 (*see also* alcohol: abuse; drug abuse)
sexual disinhibition, 37, 262
skin picking, 38
spending, compulsive, 37, 262
stealing, 37, 262
suicide, 248
self-evaluation pie charts. *See* overevaluation: self-evaluation pie charts and
sexual abuse, 34, 237, 346
smoking, 19, 410
snacks
forms, 77
use in eating disorders, 76–7, 381
weight gain and, 77
social anxiety
assessment, 254
case formulation for, 254–5
comorbidity with eating disorders, 253–7, 266
negative images and, 255
safety behaviors for, 254–7
self-focused attention and, 255
treatment, 256–7
social isolation, 106, 107, 253–7
Social Phobia and Anxiety Inventory, 254
Socratic methodology, 10, 46, 63, 65, 94, 98, 155, 177, 183, 188, 199–201, 203, 204, 206, 209, 211, 213, 229, 232, 233, 247, 249, 278, 280, 318–20, 334, 349
engagement with, 177
general questions, 177–8
principles, 177
probe questions, 178
reflections, 178
stages of cognitive behavioral therapy
assessment, 13
central targets, 14
comorbidity, 14
description, 13–14
dietary structure, 14
endings, 14, 345–8
engagement, 13
explanation, 13
formulation, 13
ineffectiveness, 14
model (*see* stages of change model)
motivation enhancement, 13
planning, 13, 20, 24 (*see also* care plan)
psychoeducation, 13
relapse prevention, 14
weight gain and stabilization, 14
stages of change model
action, 48, 50, 340, 342
application of, 48, 339–40
contemplation, 48, 66, 339, 342
maintenance, 48
precontemplation, 47–8, 339
preparation, 16, 48, 340
transition between stages in, 48
young persons and, 268, 303
starvation
and anorexia reinforcement, 107
attitudes towards eating and, 144, 393
in children, 294
cognitive function impairment during, 107, 144, 391, 393
Minnesota experiment on, 88, 388–92
muscle breakdown during, 19
physical effects, 69, 126, 144, 376, 388–93
psychological effects, 143–5, 376, 388–93
social withdrawal during, 107, 144, 390–1, 393
steroids, 37
Structured Clinical Interview for DSM-IV, 254
sun tanning, 231
SUSS test, 20–1
Symmetry, Ordering and Arranging Questionnaire (SOAQ), 250

teeth. *See* dental problems
Testable Assumptions Questionnaire, 338
tests, medical. *See* medical tests
therapist. *See* clinician
therapy-interfering behaviors
appointment cancellation, 44, 114, 274
comorbidity and, 119
five minute session and, 117–18, 124
homework non-completion, 44, 114
inclusion in case formulations, 117
late arrival, 44
motivation and, 44
patient groups and, 119
reasons for, 115–16
re-engagement following, 117
responding to, 116–17, 333
'river analogy' in, 116
short-term contracts for, 117
therapy effectiveness and, 40
transdiagnostic cognitive behavior therapy model, 6–7, 101
trauma, 102. *See also* posttraumatic stress disorder; sexual: abuse
treatment of eating disorders
analogy use in (*see* analogy use in cognitive behavioral therapy)
behavioral interference with, 26
barriers to, 66
breaks in, 15
calorie descriptions and, 81
chronicity of, 129
duration, 8–9, 14–15, 227
emotional-behavioral therapy for, 269
ending, 345–50
equipment for, 25
external factors, 9
follow-ups, 347
format, 15
initial response to, 8
mission statement, 46
physical environment for, 25
physical monitoring during, 16
planning, 24
preparation for, 42–3
relapses in (*see* recovery; relapse)

treatment of eating disorders (cont.)
sessions, 14
themes, 7
therapy-interfering behaviors and (*see* therapy-interfering behaviors)
weighing and, 171, 172 (*see also* weighing)
*See also* cognitive behavioral therapy; recovery; relapse

Vancouver Obsessive Compulsive Inventory (VOCI), 250
vegetarianism and veganism, 88–90
vomiting
binge-eating and, 101
bulimia nervosa and, 377, 398–400
calorie loss from, 412
phobia, 271, 290, 293
physical risks, 152
self-induced, 17, 36, 377, 401–2, 412

water. *See* fluid intake
weighing
assessment/interview, 33
children and adolescents, 312
by clinician, 162
guidelines, 33
as a non-negotiable, 41, 43, 127, 162 (*see also* cognitive behavioral therapy: non-negotiables in)
procedure, 165–7
refusal, 40–1
regular, in therapy, 8, 40, 127, 162, 167–70, 322
weight
change, 19–20
communication, 127
extreme control of, 99
fluctuation, 167, 173, 377
gain (*see* weight gain)
genetic basis for, 170–1
graph, 163–4
healthy, 171
history, 228, 229
loss and gain cycles, 88, 414
low, 69
maintenance, *89*
management, 85, 87, 417
measurement (*see* weighing)
misconceptions, 171–2
overevaluation of, 102
PMS and, 419
set-point theory of, 171, 230
stabilization, 8
weight gain, 8, 85–6, 162, 344–5
cycles, *89*
dehydration and, 86
fluid retention and, 86, 128
maintenance, *89*
manipulation, 33
obesity and (*see* obesity)
physical factors, *89*
physiological effects, 86–7, 162
psychological factors, *89*
rapid, 86
targets, 85, 86
vegetarians/vegans and, 90

Young Schema Questionnaire, 39, 246, 274, 281, 338