



Eating Disorders

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*Cutting edge treatments including
CBT-E*

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What does the consumer want?

PLUS
Much more practical clinical information

EDITORIAL

Kaye Horley, PhD
Editor

Welcome to the first edition of ACPARIAN for this year, our President's address resonating with us as we go forward supporting ACPA and its many exciting new initiatives (see the President and Vice-President Reports). As eating disorders (EDs) are commonly encountered in clinical practice, our focus in this edition seeks to highlight some of the issues involved in EDs and provide for some practical help for clinicians.

EDs are characterised by severely disturbed eating behaviour with significant physical, emotional and lifestyle effects. As such, it is argued that they should be given more weight as serious mental disorders (Klump, Bulik, Kaye, Treasure & Tyson, 2009). Notably, the most common mental disorder resulting in hospital treatment in Australia for young women is that of eating disorders (Australian Bureau of Statistics, 2007), and young people with eating disorders are over ten times more likely to die prematurely than their peers without an eating disorder (Birmingham & Su, 2005; Steinhausen, 2009). Eating problems can be associated with the underweight, those within the healthy range and those who are overweight, and because of the complexities involved are challenging to treat.

Problems with the DSM-IV nosology of EDs have led to criticism of its inadequate reflection of the many presentations of eating disorders evident in clinical practice. The resultant effect of the limiting two specific categories of Anorexia Nervosa (AN) and Bulimia Nervosa is that of a significant remaining number falling into the Eating Disorder Not Otherwise Specified category (Fairburn & Cooper, 2011). A critical evaluation of some of the inherent difficulties in DSM-IV leading to the proposed changes in DSM-V is articulated by Stephen Touyz and Sloane Madden.

Enhanced Cognitive Behaviour Therapy (CBT-E) is considered a cutting edge new treatment for EDs. A detail overview of CBT-E as a transdiagnostic treatment targeting the complexities of the EDs is provided by Anthea Fursland and Susan Byrne. They also present some very practical reference guidelines. In the following article, they explore the effectiveness of CBT-E both in a randomised controlled trial and in a community setting.

There are manifest difficulties associated with the treatment of AN. An overview of three particular psychological treatments including CBT-E, The Maudsley Anorexia Nervosa Treatment for Adults and Specialist Supportive Clinical Management, currently being evaluated in an on-going study in three Australian states, is presented

by Susan Byrne and Karina Allen. Referral information is provided. Schema-focused cognitive therapy as a useful adjunct in the treatment of EDs is explored by Rachel Lawson and Glen Waller. Binge eating is a commonly encountered in clinical practice, either as a disorder in itself, or in association with another psychological disorder. Erin Anderson provides an informative personal account of the value of guided self-help in those with such problems.

In focusing upon treatment, it is essential that consumers are involved. Vivienne Lewis and Megan Bishop note the neglect in this area and provide for an Australian perspective in their study. Notably, an individual with a lengthy history of AN reveals the depth of her misery and dilemmas with treatments experienced. Patient perspectives of AN are further explored in the Research Section, particularly in relation to recovery. Coercive treatment of those with AN is a controversial dilemma faced by clinicians. The ethical issues associated with forced treatment are explored in the Ethics and Legal Dilemma's section. Finally, we thank Mcllyton Clever (Associate Editor) for his candid account as a neophyte clinician learning to treat an obese individual with the associated complexities of his condition. Happy reading.

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FROM THE PRESIDENT

Judy Hyde, PhD
ACPA President

2012 promises to be an important year for ACPA. As our membership steadily grows, we can make stronger representation to Government and raise the profile of qualified clinical psychologists with the public. The lack of value given to accredited training in mental health of clinical psychology that has been a serious concern for some time continues to plague our specialty. Obtaining specialist recognition for clinical psychologists with accredited training is a major goal of ACPA for this year. It seems that ACPA is united in this battle across professional bodies and specialties. The Government has employed a company to establish standards for specialisation of the health professions and ACPA plans to be closely involved as stakeholders in the process determining these standards.

ACPA is gaining recognition in Government and with the Opposition as you will be aware from announcements on the Listserve. It is important that those responsible for the mental health of Australians are properly informed of the differential standards of training within the profession and that Australia continues to have the lowest standards in the developed world, despite having the largest workforce of psychologists. These issues, with the facts to support them, are key elements of ACPA's representation to Government and the Opposition.

ACPA's relationship with the College of Psychiatrists continues to develop as we find common ground and agree on mutual lobbying in the best interests of the public. The College has assisted us in opening doors to those in Government and Opposition members responsible for mental health. Their Senate submission put forward the removal of those without accredited qualifications in mental health from the Better Access Initiative.

The reduction of the number of sessions for those obtaining psychological services has won a temporary reprieve, due to the lobbying of many professional bodies (including ACPA), members of the public and the findings of the Senate Inquiry, but this issue is not resolved. The movement of those requiring more substantial psychological treatment to the ATAPS program needs all members in private practice to lobby strongly for a role in the establishment of their Local Health Network (LHN) to ensure that the GPs and others involved understand the difference between psychologists and clinical psychologists and between those clinical psychologists with and without accredited training in clinical psychology. If we see this as an opportunity, not a problem, we can influence the LHNs to properly cater to the public with mental health problems by contracting those with accredited training in the assessment, diagnosis and treatment of mental health problems, rather than those without this training. Should you wish ACPA to send brochures to these LHNs, please inform the ACPA office.

It appears that some Divisions of General Practice have established ATAPS programs with clinical psychologists who appreciate the supportive environment with balanced and consultative approach to treatment of those with mental health problems. The approaches of these practices with high levels of satisfaction will be examined and disseminated to others involved in establishing ATAPS programs in the future. The Board is looking to establish an ATAPS Committee to look into the elements of programs that lead to the satisfaction of clinical psychologists and to disseminate this information as widely as possible to those responsible for establishing the program.

ACPA has settled into a more productive phase after its abortive attempt to establish a more formal basis in its constitution for local representation. The emerging cohesive approach to the functions and operations of ACPA in which those members interested in contributing to the work of ACPA via committees established to develop approaches, policies, procedures and activities for ACPA, has increased productivity and capacity of those managing the organisation. The committees work closely with the Board and constitute the working arm of ACPA. This is constructive and enables ACPA to develop and address the issues that need attention. The Board concentrates on the politics and the decision-making around issues for which it is legally responsible. The Listserve continues to serve members with the sharing of resources and enabling a voice for everyone. The close communication with members via the Listserve has enhanced individual's sense of community and support and has enabled members to bring issues to the attention of the Board that they become aware of that require a response from ACPA to governing bodies and their opposition.

In 2012 the campaign to provide an effective number of sessions for those with mental health problems seeking psychological treatment from those qualified to provide it continues, as does the effort to have those graduating from Registrar programs in WA, which they entered in the belief they would be granted specialist title, actually granted this title on completion of the program. Specialist title for those with accredited post-graduate training in all specialties of psychology is the lynchpin and we will keep you informed of how this progresses and what is needed from members as opportunities emerge to influence this process. The work on all fronts continues and needs your assistance and support. This is the year of recognition! Help us gain it!

ACPA BOARD REPORT

Caroline Hunt, PhD
ACPA Vice-President

The ACPA Board is pleased to announce a number of new initiatives that are being developed, both within the Board and with the help of ACPA committees. A major project, managed by Judy, is the development of a new web site with an on-line interface. This new web site will allow members to check and update their details on-line at any time, to apply to be listed on the Find a Supervisor Directory, or to apply to be listed on the Find a Clinical Psychologist Directory (both available only to full members). The Find a Clinical Psychologist Directory will be easier to search and include an updated list of problem areas and therapies on offer, and will include a capacity to search within a particular radius. The Find a Supervisor Directory will show whether supervision is available by Skype. When ACPA first started, we were unsure how large we would grow, and it was sensible to have a membership application process that was based on paper-and-pencil form and manual data entry. It is therefore very exciting that we have now grown sufficiently to require a more systematic, streamlined and efficient application process. It will be possible to apply for membership, change membership categories, and renew membership on-line. The process of renewal will therefore become more automated, and include a wider range of payment methods to help the members. The Members Only area on the site will be easier to access and will contain resources and a blog. The blog will be able to be used to advertise rooms for rent or for sale, jobs, and to enable debates on ethics issues.

We are also pleased to announce upcoming CPD activities. The Board has approved a submission to run our National Conference in Western Australia this year. The WA Conference Committee has secured rooms at the Tradewinds Hotel in Fremantle, which is sure to be magnificent setting for our 3rd Annual Conference. There will of course be more details to come, but please set aside

the weekend of the 27-28th October for this event. I am certainly looking forward to seeing everyone there.

ACPA will also be hosting a workshop by Associate Professor Jonathan Shedler, an international expert in personality, in Sydney at the University of New South Wales on the 20th May, 2012. This will consist of a presentation by Associate Professor Shedler on the evidence based taxonomy of personality he developed with Drew Westen, and a workshop on personality in which an ACPA member will present a case for supervision by Associate Professor Shedler. Please watch for more details.

The Board would like to report on the activities of a number of its Committees who work for our organisation. For example, our Ethics Committee has been busy developing a grievance process for the organisation, as well as making plans for ethics-related CPD activities for members. Our Mentoring Committee has finalised much of its documentation, including the Memorandum of Understanding between mentors and mentees, Guidelines, and the Application Forms. Recruitment into the pilot programme will commence shortly. In addition, the Constitution, Finance and Membership Committees are all actively working behind the scenes in their respective areas, developing policy recommendations, and keeping the administration of the organisation running. And of course the Publication Committee's excellent work is demonstrated in every edition of the ACPARIAN! We would like to thank all those individuals who work tirelessly to assist in the governance and functioning of the company.

In advocacy, ACPA has become known by key organisations and political figures. Visits by The Hon Tanya Plibersek, Federal Minister for Health, and Shadow Minister for Mental Health, Senator Fierravanti-Wells, to the training clinic at the University of Sydney raised their awareness of the high level of training of clinical psychologists. These visits are being followed up with the gathering of information on the relative distribution of clinical psychologists in rural and remote areas and the role of university training clinics. A follow-up appointment is being organised with The Hon Tanya Plibersek to raise issues relating to the administrative difficulties experienced with Medicare and other issues. A further visit to the University has been planned with Mr Ian Crettenden, Executive Director, Health Workforce Australia (HWA). A key aim of this meeting is to steer HWA away from the push to develop mental health training in the Vocational, Education and Training (VET) Sector and to retain this at universities with the appropriate accreditation. Meanwhile the relationship between ACPA and the Royal Australian and New Zealand College of Psychiatrists continues to strengthen and develop on a basis of mutual respect and support.

The Board of ACPA would like to thank all members for their continued support of ACPA activities.

WILL DSM-V ADEQUATELY ADDRESS THE SHORTCOMINGS OF DIAGNOSTIC CATEGORIES FOR EATING DISORDERS?: FOOD FOR THOUGHT¹

Professor Stephen Touyz, PhD & Sloane Madden, PhD

Professor Stephen Touyz is Professor of Clinical Psychology at The University of Sydney and Co-Director of the Peter Beumont Centre for Eating Disorders. He has published over 200 papers related to eating disorders and is a past President of the Eating Disorder Research Society.

Dr Sloane Madden is a child and adolescent psychiatrist and co-director of the Eating Disorder Service at The Children's Hospital, Westmead. He has published widely in peer-reviewed journals and books. Research focus included the treatment of anorexia nervosa and the neurobiology of eating disorders. He is President-elect of ANZAED.

When DSM V is launched in early 2013 it will be almost two decades since DSM IV was introduced in 1994. In the two decades preceding DSM IV, Bulimia Nervosa had not yet been described, so what great developments in classification have the last two decades spawned? In essence DSM V represents a gradual evolution of the thinking presented in DSM IV rather than the seismic shift some were advocating. So what's new in DSM V?

Binge Eating Disorder

With DSM V now seeing Binge Eating Disorder graduating from the Appendix to the main body of the manual, this will hopefully drag some of the amorphous "NOS" hordes along with it. And surely it is a good thing to clearly recognise that people who have out-of-control binges with associated disgust, embarrassment &/or guilt and distress about this problem have a mental illness and should be treated as such – hopefully more helpfully than via obesity or weight control measures alone.

Anorexia Nervosa

Some small changes in diagnostic criteria should have some significant impact on clinical diagnosis. *Amenorrhea* is gone as an inclusion category. This category was unhelpful in relation to males, prepubescent, menopausal females and women menstruating solely through being on the contraceptive pill. *Amenorrhoea* is simply one of many

markers of malnutrition and in many ways was superfluous given the weight-related criteria incorporated in the diagnosis of AN.

"*Refusal to maintain weight*" is replaced in DSM V by "*Restriction of energy intake relative to requirements*". The term refusal was thought to imply a deliberateness to an individual's action, requiring the clinician to have a clear understanding of a person's motivation to make a diagnosis of AN. As any clinician knows this is not only difficult, but has the capacity to imply blame. The ability to make this judgment on the basis of both behaviour and corroborative history represents a significant move forward and matches the way clinicians use the diagnostic criteria for their patients

Weight Criteria

DSM IV refers to non-"*maintenance of body weight at or above a minimally normal weight for age and height*". It gives examples of "*weight loss.. or failure to make expected weight gain...leading to body weight less than 85% of expected*". DSM V simply states "*weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected*", omitting the example/guideline of 85% bodyweight. In contrast, ICD10 is more specific, requiring body weight in AN to be of at least 15% below the normal or expected weight for age and height. This loosening of weight criteria in DSM V has a number of possible ramifications. It does leave more responsibility on the clinician to make the judgment about how critical the low weight is, which may be a problem for less experienced clinicians, however, greater flexibility does allow criteria such as weight history, body type and physical compromise to be more seriously considered as decision points. This is particularly helpful in children where amount and rate of weight loss predict risk of severe medical complications rather than absolute weight. Similarly it is psychological pathology (abnormal body image and fear of weight gain), which are generally better predictors of severity than weight at presentation. It may have been useful for DSM V to include stage of illness as a factor, to discriminate between conditions of initial onset, recovery, relapse and chronicity. Nevertheless, it is likely that the lack of strict weight criteria will increase the number of people diagnosed with AN in lieu of EDNOS.

Bulimia Nervosa

Frequency of Binging: Binge eating and inappropriate compensatory behaviours need only occur at least *once a week* (DSM V) rather than *twice a week* (DSM IV) over a 3 month period. This adjustment is based on research evidence that people who binge once a week have the same level of eating disorder pathology, the same level of functional impairment, similar rates of psychiatric comorbidity and the same response to treatment as people who binge/purge more often. This criterion will probably increase the numbers of people diagnosed as BN. The

subtyping in DSM IV (Purging vs non-purging) is gone. This should not be of great consequence, as the nonpurging subtype is rarely seen and indeed has received relatively little attention in the literature. If anything the non-purging subtype more closely resembles Binge Eating Disorder.

EDNOS

This category, renamed **Feeding and Eating Conditions Not Elsewhere Classified, (FECNEC)**, has a number of informal subcategories described for possible future inclusion. These include: *Atypical Anorexia Nervosa* (higher weight), *Subthreshold Bulimia Nervosa* (low frequency or limited duration), *Subthreshold Binge Eating Disorder* (low frequency or limited duration), *Purging Disorder* (in the absence of binge eating), *Night Eating Syndrome*, and the even more residual category *Other Feeding or Eating Condition Not Elsewhere Classified*. Many expect and indeed hope that the prevalence of EDNOS/FECNEC will reduce due to the changed criteria in AN, the loosening of binge criteria in BN and the inclusion of BED. However, in contrast, in his recent visit to Australia, Chris Fairburn talked about the large group of “transdiagnostic” individuals who inevitably will vacillate between symptom patterns, and for whom a more specific diagnosis such as AN or BN is neither possible nor helpful.

So what other implications are there of these changes?:

- With changes to diagnostic criteria potentially altering the inclusion and exclusion criteria in research studies, the smallish changes to AN and BN should not make a huge differences while the two year roll-in will allow researchers time to prepare.
- The increased definitions of the old EDNOS category should allow for greater tailoring of treatments, and facilitate the development of approaches for conditions such as purging disorders and night eating syndrome.

What do you think? Have a look at the proposed changes at the APS website

<http://www.dsm5.org/ProposedRevision/Pages/FeedingandEatingDisorders.aspx>, and go to

<http://www.anzaed.org.au/blog.html> and share your opinion.

1Reprinted with permission from ANZAED newsletter Summer 2011-2012 pages 3-4.





FEATURE ARTICLE

ENHANCED COGNITIVE BEHAVIOUR THERAPY (CBT-E): AN OVERVIEW

Anthea Fursland, PhD and Susan M. Byrne, DPhil

Dr. Anthea Fursland is Principal Clinical Psychologist of the Eating Disorders Programme at the Centre for Clinical Interventions (CCI) Western Australia. She obtained her Masters (ClinPsych) in London and PhD at Berkeley, California. She has co-authored several peer-reviewed papers, and created a web-based self-help resource on eating disorders¹. Anthea is President of ANZAED and on the Steering Committee of the National Eating Disorders Collaboration (NEDC). She is active in the international Academy of Eating Disorders (AED) and a member of the Scientific Program Committee of the 2012 AED Conference. In 2011 Anthea was elected FAED.

Associate Professor Byrne completed her Master of Clinical Psychology and PhD at the UWA before travelling to Oxford University to complete a DPhil. In Oxford, Associate Professor Byrne joined a leading international research team in the area of eating and weight disorders, headed by Professor Christopher Fairburn. She is currently Associate Professor in the School of Psychology at the UWA, holds an adjunct position in the Eating Disorder Programme at the Centre for Clinical Interventions, and heads up the Strong Without Anorexia Nervosa (SWAN) Study.

Introduction

Enhanced Cognitive Behaviour Therapy (CBT-E; Fairburn, Cooper, & Shafran, 2003) is designed to be suitable for all

eating diagnoses: anorexia nervosa (AN), bulimia nervosa (BN) and 'eating disorders not otherwise specified'(EDNOS). The treatment targets the core processes believed to maintain eating disorders (EDs): the tendency to evaluate self-worth primarily or entirely in terms of eating, weight and shape or their control (the 'core psychopathology' of EDs); strict dieting, low weight and the associated 'starvation syndrome' that includes social withdrawal, increased obsessiveness, rigidity, and gastrointestinal changes. The treatment also addresses binge eating, purging (e.g., self-induced vomiting) and driven exercise for weight control, when relevant.

There are two versions of CBT-E: a "focused" form that centres exclusively on ED psychopathology, and a "broad" form which, in addition to addressing core psychopathology, contains four additional modules to address additional maintaining mechanisms: mood intolerance, clinical perfectionism, core low self-esteem, and interpersonal difficulties.

The developers of the theory and treatment have written a comprehensive treatment guide (Fairburn, 2008). What follows is an overview of the main components of the four stages of the treatment.

The treatment

Treatment for those with a BMI ≥ 17.5 lasts 20 sessions while those in the anorexic range receive 40 sessions.

STAGE ONE: covers the first seven sessions and focuses on behavioural change.

Psychoeducation. As in most CBT, psychoeducation plays a large role. It can be introduced in the assessment phase when relevant, but certainly early in treatment. The main topics covered are: starvation syndrome; the vicious cycle (overvaluation of control over weight, shape and eating → restriction → hunger → binge eating → purging and/or further restriction); health risks of EDs; the ineffectiveness of purging; normal weight fluctuations and the importance of not weighing frequently; excessive exercise. Handouts on these topics are available on the Centre for Clinical Interventions (CCI) website².

Formulation. In order to develop a shared understanding of the specific factors that maintain a patient's ED, a case formulation is constructed. The formulation follows a basic template informed by evidence-based models, but is personalised with each patient. It is centred on the core psychopathology of EDs - the overvaluation of controlling eating, weight and shape - and incorporates ED thoughts and behaviours such as following strict dietary rules, dichotomous thinking, and binge eating. It highlights the maintaining features and the self-perpetuating nature of the individual's ED, which then forms the focus of treatment.

Self-monitoring. In CBT-E, changing eating patterns, the central goal of Stage One, requires self-monitoring. Patients are given a strong rationale: in order to facilitate change, both the patient and the psychologist need to be fully aware of what / when food is consumed and what / when disordered behaviours occur. Monitoring allows patients to disengage from eating, become aware of eating patterns and learn that what they thought was out of their control (e.g., binge eating) can be understood and changed. They must be encouraged to record honestly and understand that the psychologist is not there to judge but to help them gain control over their ED.

Patients are asked to self-monitor food intake and also associated thoughts and feelings. Monitoring in real time enables them to be aware of occurrences and make changes in the moment. Difficulties in real-time recording are problem-solved in advance (with strategies such as emailing home from work at lunch; texting themselves; carrying a small notepad in their pocket when they are out for coffee).

Patients are given a completed record and instructions to complete their monitoring records. For examples of self-monitoring and instructions see Fairburn (2008) or <http://www.psych.ox.ac.uk/research/researchunits/credo/cbt-and-eating-disorders-fairburn-2008>. These records should be reviewed each session, and in detail during the first few sessions, to ensure real-time recording and the inclusion of feelings and thoughts. Patterns are identified (e.g., binges tend to occur in the evening) in order to facilitate change.

Self-monitoring is challenging, therefore it is imperative that psychologists believe in its critical function and convey this importance to their patients. They must be empathic about their patients' concerns, but at the same time firm, reassuring them that while their preoccupation with eating and food may increase in the short-term, it will then decrease. Seeing how much (or how little) they have really consumed in a day can be helpful in shaping eating into more healthy patterns.

Regular eating. Developing a more regular eating pattern reduces binge eating, addresses erratic eating and challenges the rules held by many concerning when to eat (or not). The rationale for introducing regular eating comes out of the formulation which highlights the chain of events that typically lead to binge eating: attempts to restrict eating and the resulting failure to maintain the restriction.

Eating regularly involves eating every 2-4 hours throughout the day: breakfast, morning tea, lunch, afternoon tea, dinner, and an additional evening snack for those who eat their dinner early, have high energy requirements (e.g., athletes), or need to gain weight.

A clear rationale needs to be given and repeated: that regular eating reduces restriction, binge eating and grazing throughout the day; it maintains steady blood sugar levels (which affects mood) and increases metabolism. Some changes will be gradual, for example introducing a small lunch (if individuals abstain from eating until the afternoon) and then later introducing breakfast. Patients should be encouraged to plan meals and snacks, either the night before or at the start of the day, and, after eating to engage in behaviours incompatible with binge eating (e.g., going for a walk without money, calling a friend, playing soothing music). At this point in treatment, whatever the weight of the patient, the focus is on structuring their eating pattern rather than eating more.

In-session weighing. Weighing is an essential part of CBT-E. Psychologists must understand and believe in the usefulness of in-session weighing and provide a clear rationale: it is vital that both the patient and the psychologist know the weight and discuss it at the time of weighing. In-session weighing allows for the monitoring of changes which may indicate medical problems and the need for a referral to a medical practitioner, such as continued weight loss in underweight patients and precipitous weight loss, even in patients above or within the 'healthy weight range'.

Patients should be weighed at the start of each session, with the weight logged on a graph and calculated as a BMI, since BMI seems to be less emotive for patients than weight. It is helpful to refer to 'the number on the scale' rather than 'your weight', as this helps patients disengage from their identification with their weight.

Many ED patients weigh themselves at home, often several times a day, and are suspicious about once-weekly weighing. They tend to interpret any weight fluctuation as a signal to restrict, to avoid further weight increase if weight has increased, or to advance weight loss if weight has decreased. Since frequent weighing reinforces preoccupation with weight and maintains dietary restriction, at-home weighing is discouraged.

Weight monitoring allows examination of the relationship between eating and weight and the opportunity to challenge the overvaluation of weight and shape. Psychoeducation must be given about normal weight fluctuations and the inability to draw conclusions with fewer than four consecutive weights.

Some ED patients avoid weighing. Since it is typical for them to over-estimate their weight and any weight increases, avoiding weighing becomes problematic as they have no opportunity to disconfirm fears of weight gain. In-session weighing allows them to disconfirm these fears.

STAGE TWO: A review takes place at session eight. Its main purpose is to assess progress with treatment and the status

of ED behaviours such as binge eating, purging or restriction. A second aim is to assess engagement with CBT-E in terms of regular eating patterns, compliance with self-monitoring and cessation of at-home weighing. A third focus is to identify barriers to change, such as depression and low self-esteem. Lastly, the formulation is reviewed and expanded upon, to help plan the remainder of treatment.

STAGE THREE: This stage covers the remainder of treatment apart from the final two to three sessions (i.e., Sessions 9 to 18 in the short version of the treatment and Sessions 9 to 37 in the long version for underweight patients). Its focus is on the maintaining mechanisms of the patient's ED which were identified in the formulation earlier in treatment and expanded in Stage Two. The most common maintaining mechanisms are overvaluation of weight and shape, dietary restraint/rules and mood difficulties. They can be addressed in any order.

Identifying the overvaluation of controlling weight and shape and its consequences. Since the core-maintaining feature of EDs is the overvaluation of control over weight and shape, this will have been identified in the initial formulation. Here the overvaluation is explored in terms of its negative effects on other areas of the patient's life. A useful strategy is the construction of a 'pie chart'. Patients list the domains of their life on which they judge their self-worth (e.g., family, work, weight and shape, friends) and rank them in order of importance. They allocate 'slices' of the 'pie' to reflect the relative importance of each domain. Patients are often surprised or ashamed at the large size of their weight/shape 'slice', since this reflects the undue importance they give to weight/shape over other life domains. This realisation can encourage them to reduce this overvaluation.

Reducing the importance of weight and shape is one of two approaches to addressing concerns about weight and shape in Stage Three. The other is enhancing the importance of other domains for self-evaluation. Patients create a new 'pie' with 'slices' this time representing the distribution of life domains on which they would like to base their self-worth. This new pie chart demonstrates how change might occur: by enlarging certain 'slices' or creating a new 'slice'. This leads to setting specific goals for homework, such as spending more time with the family or becoming a volunteer at a local library.

Shape checking and avoidance. Tackling body checking and avoidance is a powerful way to challenge the importance of weight and shape. One form of body checking, weighing, will have been addressed in Stage One, and patients should have learned that reducing that form of checking reduces their concern. Patients are told that shape checking and avoidance reinforce body dissatisfaction and maintain a focus on weight and shape. They learn that while most people check their bodies to some extent (e.g., looking in the mirror to check make-up, or noting the tightness of

clothes) people with EDs check in unusual ways (e.g., looking in the mirror repeatedly, touching bones, interpreting snugly fitting clothes as evidence of being overweight). Many patients engage in a particular form of checking by comparing themselves to others (usually thinner people) with the result that they feel like failures.

Some ED patients avoid looking at and touching their bodies by wearing baggy clothes and/or covering up mirrors. This, like avoiding weighing, is unhelpful as it does not allow people to disconfirm their fears about their body shape. Other individuals both avoid and check. They may be unaware that they engage in body checking and/or avoidance, and to reduce these behaviours they must become aware. They will need to record incidents of checking and avoidance on their self-monitoring sheets, and work with their psychologist on reducing these behaviours.

'Feeling fat'. Another strategy for reducing the importance attached to weight and shape is addressing the experience of 'feeling fat'. This phenomenon is reported by many people, but individuals with EDs experience it often and particularly strongly, reporting fluctuations from day to day and throughout the day (irrespective of weight change). 'Feeling fat' reinforces body dissatisfaction and ED behaviours since it is associated with being fat. 'Feeling fat' can best be thought of as a mislabeling of difficult emotions or a heightened awareness of the body. To challenge this phenomenon, patients record when they experience 'feeling fat' particularly intensely and identify the context in which they may be mislabelling emotions (such as feeling sad) or bodily sensations (such as feeling bloated after a meal) as 'feeling fat'.

Dietary rules. These will have been identified in Stage One and although the establishment of regular eating often helps patients relax their rules, many will still be under-eating or attempting to restrict. They are reminded about the role of dieting and dietary rules in the vicious cycle of EDs and challenge their rules underlying restriction and their beliefs that shape these rules (e.g., that eating carbohydrates after 7 pm will result in weight gain). The most common rules relate to when to eat (which will have been addressed with regular eating); how much or how little to eat; or what variety of foods to eat. Other rules include eating less than everyone else and having to eat off a particular (often small) plate. Behavioral experiments are conducted to test out beliefs and fears associated with breaking dietary rules and eating avoided foods.

Events and mood-related eating. Some patients experience a worsening of ED symptoms in response to adverse moods or events and use their ED behaviours to control, dampen or distract them from difficult moods. For them mood intolerance is a maintaining mechanism, and this usually becomes apparent during assessment, early in treatment or by the Stage Two review.

Once event-related eating symptoms are identified in self-monitoring records, problem-solving can be helpful to help patients deal with the triggers. Mood-related changes in eating will need to be addressed in certain patients who have difficulty tolerating certain moods and/or experience intense moods, who often have a history of self-harm or substance abuse. These patients benefit from psycho-education regarding the links between emotions, cognitions and behaviour and learn that their reactions to adverse events or moods escalate rapidly but can be changed with practice. They identify triggering events and their cognitive appraisal of those events, any aversive mood changes, cognitive appraisal of those changes and amplification of emotions. They identify dysfunctional or unhelpful behaviours used to modulate their mood, any resulting changes in the mood and cognitive appraisal of that situation. Cognitive challenging addresses unhelpful thinking styles (e.g., dichotomous thinking) and distress tolerance skills (e.g., distraction) provide patients with alternative strategies to cope with intense moods.

Mindsets. Towards the end of treatment, when patients are experiencing days without ED symptoms, but still having days when the ED behaviours and cognitions return (e.g., binge eating, preoccupation with calories), the concept of an 'ED mindset' is introduced. An ED mindset can be thought of as a frame of mind, an overarching belief that one's self-worth is related to controlling eating, shape and weight.

The mind is conceptualised as a DVD player with many DVDs that get played in different contexts of the patient's life. In patients with an ED, the 'ED DVD' gets 'stuck' and plays repeatedly. When symptoms begin remitting the 'ED DVD' gets unlocked for a time and then gets reactivated, causing a recurrence of symptoms. Patients are taught to manipulate their ED mindset as they would a DVD. Monitoring records can be used to examine setbacks and the context in which the 'ED DVD' got reactivated. Patients manage the recurrence of the ED mindset by identifying triggers for its return (the DVD's signature tune). They learn to respond by 'doing the right thing', behaving as if they did not have an ED (ejecting the DVD), or engaging in social and/or fun activities.

STAGE FOUR: This stage comprises two sessions in the 20-session version and 3 sessions in the 40-session version of CBT-E. The focus is on patients ending well and continuing being active in their recovery.

Maintenance plan. Creating a maintenance plan involves looking back over treatment to assess progress and identifying: a) useful strategies that will need to be continued (e.g., regular eating), and b) behaviours that need more practice (e.g., increasing the variety of foods consumed).

Relapse prevention plan. This involves identifying: a) potential triggers for relapse (e.g., a friend losing weight), and b) strategies for dealing with setbacks (e.g., challenging ED cognitions). It is preferable to refer to a 'lapse' or a 'setback' rather than a 'relapse', since many individuals with EDs engage in dichotomous thinking and believe that a single binge signifies a return to an uncontrollable ED. 'Lapses' can be considered challenges to be overcome with the skills learned in treatment.

If feasible, a follow-up or review session approximately 3 months after the end of treatment encourages patients to take over the role of managing their eating and to set goals.

¹http://www.cci.health.wa.gov.au/resources/infopax.cfm?Info_ID=48.

²http://www.cci.health.wa.gov.au/resources/minipax.cfm?mini_ID=19

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Photo by Rebekah Kim

THE RESEARCH-PRACTICE INTERFACE:

MANUALISED ENHANCED COGNITIVE BEHAVIOUR THERAPY (CBT-E) SUCCESSFULLY CONDUCTED IN BOTH A RANDOMISED CONTROL TRIAL AND IN A COMMUNITY SETTING

Anthea Fursland, PhD and Susan M. Byrne, PhD, DPhil¹

Evidence-based Practice

There is much talk about the importance of using evidence-based practice, yet many clinicians are hesitant to utilise therapies that have shown positive results in randomised controlled trials (RCTs). It is possible that clinicians may doubt the relevance of these treatments to their own patients, as they may consider patients involved in RCTs to be less complex and more compliant than the patients they work with in clinical practice. They may also view themselves as different from therapists working in research settings, who may be seen as working in highly skilled stable therapeutic teams, and whose performance is closely monitored by experts in the treatment under investigation (Wilson, Grilo & Vitousek, 2007).

RCTs of eating disorder treatments have increasingly sought to include a wide range of clinically representative patients (e.g., Agras, Walsh, Fairburn, Wilson & Kraemer, 2000; Fairburn et al., 2009). However, few published studies have examined the "transportability" of evidence-based eating disorder treatments. (e.g., Tuschen-Caffier, Pook & Frank, 2001). This lack of effectiveness research may be a contributing factor to the poor dissemination of evidence-based practice in the field of eating disorders (Wilson et al., 2007). Our study (Byrne, Fursland, Allen & Watson, 2011) aimed to add to the small number of effectiveness studies in the eating disorders field by evaluating the generalisability of the newly-devised Enhanced Cognitive Behavioural Treatment (CBT-E) for eating disorders in an open trial.

CBT-E

CBT-E was developed by Fairburn and colleagues (Fairburn, Cooper & Shafran, 2003) from the "transdiagnostic" theory outlining the processes that maintain *all* forms of eating disorder (Fairburn et al., 2003). This theory is based on the observation that Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Specified (EDNOS) share many distinctive clinical features (Turner & Bryant-Waugh, 2004) including the same "core psychopathology" characterised by a marked tendency to evaluate self-worth in terms of controlling eating, shape or weight (Fairburn et al., 2003). The transdiagnostic model extends the existing,

empirically supported cognitive model of BN (CBT-BN; Fairburn et al., 1993) and is designed to be suitable for all eating disorders.

The key maintaining processes include a dysfunctional scheme for self-evaluation, strict dieting, low weight and the associated 'starvation syndrome', binge-eating and compensatory behaviours, and also includes four additional maintaining mechanisms - clinical perfectionism, core low self-esteem, difficulty coping with intense mood states, and interpersonal difficulties - which in some people serve to maintain this psychopathology and stall progress. CBT-E is designed as an individualised form of treatment, in which specific modules may be directed at the particular maintaining mechanisms operating in an individual.

RCT of CBT-E

The only published RCT of CBT-E for eating disorders (Fairburn et al., 2009) involved two sites in the U.K. and included 149 patients with a BMI ≥ 17.5 (38% BN and 62% EDNOS). Patients received twenty 50 minute sessions, preceded by one 90 minute orientation session. 66.4% of those who completed treatment had a good outcome (measured by post-treatment global scores on the Eating Disorder Examination [EDE; Fairburn & Cooper, 1993] less than one standard deviation [SD] above the community norm). Interestingly, there were no significant differences between BN and EDNOS patients in treatment response. At the end of treatment, 38.6% of BN patients reported no episodes of binge eating or purging in the past month. The overall drop-out rate was 22% (14% for BN patients and 27% for EDNOS patients), and intention-to-treat data showed that, overall, 51.3% of patients had post-treatment global EDE scores within one SD of community norms. The gains made during treatment were largely maintained at a 60-week follow-up, when 50% of the overall sample had a global EDE score within community norms.

These data suggest that CBT-E may be more efficacious than the original CBT-BN (Agras et al., 2000). However, this was a single trial and it only involved patients with BN and EDNOS, since a body mass index ≤ 17.5 was a specific exclusion criterion.

Background/Context of the CBT-E Effectiveness Study

In 2005, a new specialist public outpatient eating disorders service opened in Perth, Western Australia, treating youth (aged 16+) and adults. Before then, there was no specialist eating disorders service for those above the age of 15. The programme was set up within an existing specialist service offering evidence-based treatment for mood and anxiety disorders, the Centre for Clinical Interventions (CCI). The eating disorders programme was headed up by the first author (AF), with the second author (SB) as research consultant and two new graduate clinical psychologists as therapists.

Both authors were familiar with CBT-E: SB had encountered CBT-E whilst working on a DPhil at Oxford under Fairburn (while he was directing the RCT for CBT-E) and AF had received training by Fairburn. It was decided to use CBT-E for the following reasons: a) although the results of the RCT had not been published, CBT-E was assumed to be as good as or better than the CBT-BN from which it had been developed; b) it was transdiagnostic, therefore only one treatment needed to be learned by the inexperienced therapists in the team. Thus CBT-E became 'treatment as usual'.

The other therapists involved in this study were trained and supervised by SB and AF. Their training consisted of orientation to the treatment and familiarisation with the treatment guide in their first week of employment at the clinic. The therapists attended weekly individual supervision meetings with AF and a weekly team meeting with AF and SB to discuss cases and adherence to treatment protocol. Meetings included a review of select videotaped sessions to help ensure treatment fidelity.

A decision was made to collect psychometric data and to build a database so that we could evaluate the programme. We created a pre-treatment package in two parts: the first to include demographic data and the second with various psychometric measures, including the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994) and measures of self-esteem, quality of life, depression, anxiety and stress. SB trained the clinicians to conduct the EDE, a structured clinical interview regarded as the 'gold standard' for assessment and diagnosis of eating disorders.

Patients were only excluded from the programme if their current clinical state made it inappropriate for them to receive outpatient eating disorder treatment (i.e., if they were acutely suicidal, psychotic, substance dependent or had a BMI <14) or if they did not give written consent to release their de-identified data for evaluation and research purposes.

The CBT-E Effectiveness Study

Our sample included all consecutive referrals to the CCI Eating Disorders Programme between March 2005 and February 2009, except those who refused consent for the use of their data and those who were assessed but did not enter treatment. The aim of the study was to investigate the effectiveness and feasibility of conducting CBT-E to treat the full range of eating disorders at a public outpatient clinic in the community. Given the claim that CBT-E is also relevant to AN, and the lack of research into evidence-based treatments for this eating disorder, we considered that a study including low weight patients would be of value.

We hypothesised that treatment with CBT-E would be associated with significant post-treatment improvement in both the specific and associated psychopathology of eating disorders, and that the degree of improvement would be

comparable to the RCT of CBT-E which was still underway. This study is the first effectiveness trial of CBT-E and, moreover, the first published study of CBT-E to include patients with a BMI <17.5.

The study involved 125 patients, who attended, on average, 20-40 individual sessions. Of those who entered treatment, 53% completed. Longer waiting time for treatment was significantly associated with drop-out. By the end of treatment full remission (cessation of all key eating disorder behaviours, BMI $\geq 18.5 \text{ kg/m}^2$, not meeting DSM-IV criteria for an eating disorder) or partial remission (meeting at least 2 these criteria) was achieved by two thirds of the patients who completed treatment and 42% of the total sample. The results compared favourably to those reported in the RCT of CBT-E, with one exception being the higher drop-out rate in the current study. See Table 1 for a direct comparison with the RCT for CBT-E.

Overall, the findings indicated that CBT-E results in significant improvements, in both eating and more general psychopathology, in patients with all eating disorders attending an outpatient clinic.

Discussion

This study showed that CBT-E, conducted as "treatment as usual" in a community clinic with relatively inexperienced staff, can yield results comparable to those found in Fairburn's RCT – *in those who completed treatment*. We have noted how length of time on the waiting list significantly predicted drop-out. Another possible reason for high drop-out is the high staff turnover. During the 4 years of the study there was considerable turnover of staff, resulting in a total of 10 therapists being involved. Furthermore, all but one of the therapists (AF) were Clinical Psychology Registrars (i.e., recent graduates from a Masters or PhD level Clinical Psychology program) with little or no experience treating eating disorders previously. Nevertheless, we submit that this evidence-based treatment, CBT-E, is doable without the infrastructure of an RCT and a research team. Our patients included the usual presentations found in community clinics, and were not a self-selected group. Our staff were inexperienced, novice therapists.

We encourage clinicians to use evidence-based treatments where possible, and not to be discouraged or put off by the belief that research facilities are the only places that can conduct good and effective treatments.

¹ See previous article

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Table 1 Comparison of the results from the Byrne et al. (2011) study with results from the Fairburn et al. (2009) RCT on equivalent outcome variables

| | Byrne et al. (2011) | | | Fairburn et al. (2009) |
|---|---------------------|------------|-------------|-------------------------------|
| | Total Sample | BMI ≤ 17.5 | BMI > 17.5 | Total sample (all BMI > 17.5) |
| N | 125 | 40 | 85 | 149 |
| Drop out rate (%) | 40 | 54.3 | 38.3 | 22.1 |
| Good outcome total sample (%) | 42.4 | 45.0 | 41.2 | 53.0 |
| Good outcome completers (%) | 66.7 | 68.8 | 66.0 | 66.4 |
| Cessation of b/p if present at baseline (ITT) (%) | 39.8 | 30.0 | 42.5 | 42.3 |

Note. Good outcome was defined as having a post-treatment Global EDE (for Fairburn et al.) or EDE-Q (for Byrne et al.) score less than one standard deviation above community norms (UK and Australian respectively).

A RANDOMISED CONTROLLED TRIAL OF THREE PSYCHOLOGICAL TREATMENTS FOR ANOREXIA NERVOSA: THE STRONG WITHOUT ANOREXIA NERVOSA (SWAN) STUDY

Susan Byrne¹, PhD, DPhil and Karina Allen, PhD

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Background to anorexia nervosa

Anorexia nervosa is defined in *DSM-IV* as refusal to maintain body weight above a minimally normal weight for height (e.g., a Body Mass Index [BMI; kg/ m²] > 17.5), combined with (i) a fear of gaining weight or becoming fat and (ii) disturbance in how body weight or shape are experienced, denial of the seriousness of low body weight, or evaluation of self-worth primarily or entirely in terms of eating, weight and shape or their control (APA, 2000). In post-menarcheal females, an additional criterion is amenorrhea. When applying this *DSM-IV* definition, 1 - 2% of women meet lifetime criteria for anorexia nervosa (Hudson, Hiripi, Pope, & Kessler, 2007). When the amenorrhea criterion is removed (as is planned in *DSM-V*), this percentage doubles and approximately 4% of Australian women may be expected to meet lifetime criteria for the disorder (Wade, Bergin, Martin, Gillespie, & Fairburn, 2006).

The prevalence of anorexia nervosa is concerning because the disorder carries the highest mortality rate of any psychiatric disorder, equal with substance abuse (Berkman, Lohr, & Bulik, 2007). The standardised mortality rate is 12 times higher than the annual death rate from all causes in 15 to 24-year-old females (Fichter, Quadflieg, & Hedlund, 2006). Anorexia nervosa is also notoriously difficult to treat. On average, one-third of cases achieve a 'good outcome' (i.e., full eating disorder remission) within 10 years of

treatment (Fichter et al., 2006). In 2004, the National Institute for Clinical Excellence (NICE) was not able to provide empirically supported guidelines on how best to treat anorexia nervosa on an outpatient basis in adults.

The Strong Without Anorexia Nervosa (SWAN) Study

The SWAN Study is designed to provide information about the relative efficacy of alternate psychological treatments for anorexia nervosa. It takes the form of a randomised controlled trial of three psychological treatments, each of which has been found to show promise with anorexia nervosa in the past. The Study is funded by a 4-year grant from the National Health and Medical Research Council of Australia and is led by researchers from The University of Western Australia (A/Prof Susan Byrne), Flinders University (Prof Tracey Wade), The University of Western Sydney (Prof Phillipa Hay), and The University of Sydney (Prof Stephen Touyz). International collaborators from Oxford University, Kings College London, and The University of Otago are also involved.

The three treatments being evaluated are Enhanced Cognitive Behaviour Therapy (CBT-E), the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), and Specialist Supportive Clinical Management for anorexia nervosa (SSCM). In each case, treatment is provided on an individual outpatient basis and consists of 25 to 40 free sessions with a Psychologist or Clinical Psychologist over a 10 month period. The study involves men and women aged 18 years and over, who meet criteria for anorexia nervosa or atypical ('partial') anorexia nervosa.

The three treatments

Enhanced Cognitive Behaviour Therapy (CBT-E) was developed by Professor Christopher Fairburn and colleagues at Oxford University (Fairburn, 2008). It stems from the transdiagnostic model of eating disorders and is designed to be suitable for all forms of eating pathology (i.e., anorexia nervosa, bulimia nervosa and 'eating disorders not otherwise specified') (Fairburn, Cooper, & Shafran, 2008). The treatment directly targets the core processes believed to maintain anorexia nervosa and other eating disorders. For anorexia nervosa, these processes include the tendency to evaluate self-worth primarily or entirely in terms of eating, weight and shape or their control (referred to as the 'core psychopathology' of eating disorders); strict dieting; low weight; and the associated 'starvation syndrome' that includes social withdrawal, increased obsessiveness, rigidity, and gastrointestinal changes. The treatment also addresses binge eating, purging (e.g., self-induced vomiting) and driven exercise for weight control, if these are present (Fairburn et al., 2008). Four additional modules are available if marked problems are identified with mood intolerance, clinical perfectionism, core low self-esteem, or interpersonal difficulties.

The Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) was developed by Janet Treasure and Ulrike Schmidt at the Institute of Psychiatry, London (Schmidt & Treasure, 2006). The treatment is based on a cognitive-interpersonal model of anorexia nervosa, and stems from research on the psychological and neurobiological factors associated with the development and maintenance of the disorder. The four key areas addressed in MANTRA are (i) perfectionistic personality traits and cognitive rigidity; (ii) anxious / avoidant traits and difficulties managing emotions; (iii) beliefs about the benefits of self-starvation and anorexia nervosa, including the interpretation of anorexia as 'identity'; and (iv) unhelpful responses from close others when confronted with eating disorder symptoms (Schmidt & Treasure, 2006). The MANTRA framework also makes use of motivational interviewing techniques and maintains a motivational stance throughout treatment.

Specialist Supportive Clinical Management (SSCM) for anorexia nervosa was developed for use in a New Zealand trial of three psychotherapies for anorexia nervosa (McIntosh et al., 2005). In this trial, SSCM had the highest rates of treatment completion and the highest rates of symptom improvement when compared to cognitive behaviour therapy and interpersonal therapy. The treatment is atheoretical and stems from the clinical management and supportive psychotherapeutic approaches to mental health problems (McIntosh et al., 2006). The aims of SSCM are to alleviate the core symptoms of anorexia nervosa by assisting individuals to make changes to their eating, with the eventual goal of weight gain to within the healthy weight range, and to address other relevant life issues that may arise. This is achieved by (i) providing high-quality education, information and advice about anorexia nervosa, eating and weight, and (ii) addressing other issues that may be relevant to the eating disorder as identified by the patient within a supportive psychotherapeutic model (McIntosh et al., 2006).

SWAN Study progress to date

The SWAN Study commenced in April 2010 and 360 enquiries have been received since that time. Over the three study sites (Perth, Adelaide and Sydney), 64 participants have enrolled in treatment and 18 of these individuals have completed treatment. The treatment non-completion rate is currently 27% (n=17/64), which is approximately half of that observed in routine clinical practice for anorexia nervosa (Byrne, Fursland, Allen, & Watson, 2011).

Referral information

The trial is ongoing through to 2014, and referrals are being accepted until early 2013. The Study can provide a fee-free alternative for clients who have exhausted their options

under the Better Access to Mental Health Care scheme. Clients can be referred by a General Practitioner or Psychologist, and are also welcome to contact us directly if they are interested in participating. Treatment is available in Perth, Adelaide and Sydney, for men and women 18 years and over with anorexia nervosa or atypical anorexia nervosa (BMI < 18.5).

¹ See previous article

Additional information regarding the SWAN Study can be found at <http://www.psychology.uwa.edu.au/research/swan-study>. Alternatively, Dr Karina Allen, the SWAN Study Coordinator, can be contacted at treatmenttrial-psy@uwa.edu.au or on (08) 6488 7428.

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BULIMIA NERVOSA AND BINGE EATING: HAVE YOU CONSIDERED A COGNITIVE BEHAVIOURAL GUIDED SELF-HELP APPROACH?

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Erin Anderson is senior clinical psychologist for the Eating Disorder Outreach Service (EDOS) at the Royal Brisbane & Women's Hospital. Her specialisation is the cognitive behavioural understanding and treatment of eating disorders. However, she is also experienced in motivational interviewing, Maudsley family therapy, narrative approaches, supportive meal therapy, and mindfulness-based interventions for eating disorders. She has worked extensively across both inpatient and outpatient eating disorders services. In addition to her clinical work with individuals and families affected by eating disorders, Erin also provides education to health practitioners, consultancy clinical supervision, and engages in applied clinical research.

Uncontrollable binge-eating, as experienced by most eating disorder patients, is characterised by physical and

emotional discomfort, and often shame, depression and guilt. Many patients have described bingeing to me as "self-defeating" and one poignantly reflected that "after a binge I feel like all of my worst nightmares have come true and I've failed again." This feeling of impotence or futility can erode self-efficacy, often leaving sufferers with a sense of worthlessness that perpetuates the destructive sequence. From a Cognitive Behavioural (CBT) perspective, understanding that restrictive eating (and/or a restrictive eating mindset) are priming experiences for loss of control, can help elucidate a shared conceptualisation of the cycle.

CBT is an effective, evidence-based therapy, particularly for those with binge eating as a central feature. Systematic reviews of randomised control trials provide a substantial case for CBT to be endorsed as *the* psychological treatment of choice for bulimia nervosa (Brownley, Berkman, Sedway, Lohr & Bulik, 2007) and binge eating disorder (Shapiro et al. 2007). However, there are limitations to its widespread implementation in requiring 20 sessions over a period of five months (with a recommendation that in the first stage of treatment sessions occur twice-weekly, Fairburn, 2008). The 2006 Cochrane review (Perkins, Murphy, Schmidt & Williams, 2006) concluded that CBT self-help manuals and guided self help (GSH) are viable as first-line interventions for bulimia nervosa and binge eating, with more intense treatments reserved for patients as needed within a stepped care approach (Wilson & Shafran, 2005). Similarly, the National Institute for Clinical Excellence (NICE) guidelines (2004, p. 16) mandate:

"As a possible first step, patients with bulimia nervosa (and binge eating disorder, p.19) should be encouraged to follow an evidence-based self-help programme. Healthcare professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes."

There are several readily available self-help manuals that simplify the core CBT principles, and have practical utility for the majority of patients with recurrent binge eating (Striegel-Moore et al. 2010). Two of those which have been heavily researched are "Overcoming binge eating" by Christopher Fairburn (1995) and Peter Cooper's "Overcoming bulimia and binge-eating: A self-help guide using cognitive behavioural techniques" (1995). Additionally, an excellent and freely available program is accessible on the Centre for Clinical Interventions (CCI) (2007) website. This Australian resource provides 18 downloadable modules under the heading "overcoming disordered eating" divided into pack A and B. Additionally, CCI supplies 32 useful psychoeducation sheets covering such varied topics as: laxative misuse, body checking, and information for carers. Each of these programs could

support your psychological intervention for binge-eating patients.

The salient features of this type of approach are: psychoeducation, self-monitoring, regular eating and meal planning, proactive problem solving, eliminating dieting, and challenging the disordered eating mindset. Of the manuals listed above, the psychoeducation component comprises the first half of each book, detailing such things as the psychological, social and physical complications of eating disorders, and giving the rationale for the CBT model. The second part of each book outlines active intervention steps, summarily described below.

Self-monitoring of dietary intake and the context in which the food was eaten is introduced to encourage awareness about the eating process and the choices therein. This initial step fosters patient's ability to reflect on their eating over a period of time to identify patterns, e.g., perhaps restrictive daytime eating maybe fuelling hunger-driven binges in the evening? Cognitive rigidity and attention to detail have been theorised as fundamental underpinnings of the eating disordered mindset (Roberts, Barthel, Lopez, Tscanturia & Treasure, 2011). This was demonstrated recently to me by a patient describing her strict rules concerning permissible fruits i.e. bananas were *rigidly* not allowed because she had scrutinised the *minute* caloric difference between a banana versus a 'safer choice' such as an apple. Self-monitoring allows the patient an opportunity to 'zoom-out' from the minutia to see the bigger picture of eating across days and weeks and allow patterns to be reviewed objectively.

Regular eating (i.e. eating three meals and two or three snacks daily) is introduced as a non-negotiable step, however, what is included in the meal plan is self-directed. Consistent dietary intake gives structure to eating habits, eliminates fasting (or grazing) and keeps blood sugar levels and metabolism steady which reduces urges to binge. Self-prescribed meal plans allows the client to draw on their own resources in deciding what is appropriate (i.e. what foods s/he is willing to digest and not purge). Planning ahead also aims to take food decisions out of the moment and delineates clear eating times and non-eating times to (initially) curb spontaneous eating, allowing for natural hunger mechanisms to re-regulate. During the early stages of treatment, hunger is an unreliable cue as it has been overridden (in bingeing) or ignored (in restriction) (Fairburn, 2008). Implicit learning also occurs via the patient undertaking a self-contract. Choosing to honour that contract can help to rebuild self-efficacy.

There are several facets to proactive problem solving that involves intervening in the urge to binge (or purge, or restrict) by identifying triggers and alternative activities. Recognising decision-points that activate binges are varied and individual. For example, at meal times: "I noticed myself

eating my dinner very fast and I started to feel frenzied," or while shopping: "the food court is a risky-zone for me" or cooking: "when the whole apartment smelled of baking cookies I felt overwhelmed with temptation." This phase continues to foster objectivity, curiosity and mindfulness about eating patterns and enables the client to rescue him or herself from problem situations. Distraction and diversion activities (e.g. Sudoku puzzles) maybe useful for 'urge surfing' in the moment, but it is also about encouraging the client to consider what areas of their life they would like to invest in more (e.g. friends, family, study or volunteer work). Essentially, as the patient works towards reducing the eating disorder, simultaneously they will be building up other parts of the self. Additionally, this process addresses the often felt feelings of worthlessness by encouraging self-care activities and valuing the whole self (rather than overvaluing shape, weight and appearance).

The next step in eliminating dieting addresses restrictive eating and the dichotomous mindset (good vs. bad foods). The process is akin to devising a fear-hierarchy with a phobic patient. The client groups food items into levels of increasing challenges (e.g. minor, moderate and major to their unique set of rigid food rules and beliefs. The list is self-comprised of foods they 'fear' because of their perceived effect on shape and weight. This encourages self-directed learning towards the realisation that all foods (that are liked) can be incorporated into a healthy eating pattern and learned to be eaten in reasonable quantities in a controlled manner.

In the last phase of the cumulative program, the processes maintaining the eating disorder may have been sufficiently disrupted for patients to have periods when they think quite differently. They are encouraged to reflect on shifts in their mindset between disordered or non-disordered eating thoughts. The manual(s) introduce concepts of metacognition and unhelpful thinking styles (i.e. dichotomous or perfectionistic), to encourage a dialogue questioning the value of shape in weight determining self-worth. Another central aim is to manage lapses, prevent relapse and deal with setbacks. As a therapist within a GSH context, you may consider expanding on this section with more traditional CBT strategies such as behavioural experiments or thought challenging activities to encourage reality-testing, or expand if needed into formal CBT (Fairburn, 2008).

Further, support to trial a GSH approach in your practice may be gleaned from reviewing an Australian study wherein Peter Cooper's (1995) manual was delivered by a non-specialist health professional in a primary care setting, which found GSH compared favourably to specialist psychological treatment (Banasiak, Paxton & Hay, 2007). Qualitative analysis of the program identified several factors perceived

to contribute to treatment effectiveness e.g. practical style of the manual and the specific behavioural strategies¹³. In authentic GSH-CBT style, I now formally encourage you to 'simply have a read of the book, see if it makes sense to you, and if so give it a go.'

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A SCHEMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY WITH THE EATING DISORDERS: A BRIEF OVERVIEW

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Professor Glenn Waller, DPhil**

Rachel Lawson is senior clinical psychologist and Acting Clinical Head of the South Island Eating Disorders Service in New Zealand. She has extensive experience in the treatment of eating disorders in both NZ and the United Kingdom, and has co-authored two books on the treatment of eating disorders. She is the NZ representative on the committee for the ANZAED and also sits on the professional workforce development committee. Over the past two years she has worked as a project leader for the eating disorders for the Werry Centre establishing a national collaborative data base, special interest groups, and working to roll out Maudsley Family Based Therapy across NZ.

Professor Waller is a Consultant Clinical Psychologist with Central and North West London NHS Foundation Trust, and Visiting Professor of Psychology at the Institute of Psychiatry, King's College London. His clinical specialty is cognitive-behavioural therapy for the eating disorders. He has published and presented widely. He is a fellow of the Board of the Academy for Eating Disorders, an Associate Editor of the International Journal of Eating Disorders, and is on the editorial boards of three journals.

Cognitive behavioural therapy (CBT) is a well-established treatment for specific eating disorders, with trials of CBT showing good outcomes for bulimia nervosa and binge eating disorder (Agras et al., 2000; Fairburn et al., 1995; Fairburn & Harrison, 2003) based on maintenance models of the disorders. However, CBT for anorexia nervosa has been shown to be no more effective than other therapies, and there is little evidence as to how to treat the atypical eating disorders (Fairburn & Harrison, 2003; Waller & Kennerley, 2003). A second set of maintenance models has been developed in order to address these shortcomings (e.g. Fairburn, Cooper & Shafran, 2003), and work is underway to evaluate this treatment.

In managing those eating disorders that appear resistant to current treatments, it has been suggested that models

need to take into greater consideration past experiences as causal factors. Cooper (1997) and Waller and Kennerley (2003) have concluded that the schema level of representations (cognitive, emotional, behavioural and somatic) is the most likely to aid in the development of broader CBT models of the eating disorders. They believe that a complex model of functioning is necessary to work with psychological phenomena that are resilient to current treatments, for example, perfectionism, multiple impulsive behaviours, compulsive pathology and personality pathology (e.g., Fichter, Quadfleig & Reif, 1994; Sansone & Fine, 1992; Waller, 1997). Schema-focused treatments may be useful in that they target factors that may underpin these phenomena and may be useful in augmenting existing treatments for the eating disorders, rather than replacing them.

Schema Research

A modest literature exists examining schemas in the eating disorders. Studies to date have looked at the psychometric properties of some schema measures (Waller, Meyer & Ohanian, 2001; Waller, Ohanian, Meyer & Osman, 2000; Cooper, Cohen-Tovée, Todd, Wells, & Tovée, 1997; Luck, Waller, Meyer, & Lacey, 2005); background experiences leading to the development of unhealthy schemas (Hartt & Waller, 2001; Emanuelli, Dennis, Snell, Waller & Lacey, 2003; Sheffield, Waller, Emanuelli, Murray, & Meyer, 2003); schema content and process relevant to the eating disorders (for example, Cooper et al., 1997; Leung, Waller & Thomas, 1999; Shah & Waller, 2000) and schema-focused treatment (Leung et al., 2000; Kennerley, 1997; Ohanian, 2002; Cooper, 2003). The majority of the studies examine cognitive content and process, with fewer studies in the area of treatment.

Drawing firm conclusions from the literature is made difficult by the use of differing definitions for the term "schemas". Some authors have seen "schemas" as consisting of only cognitive content (e.g., Cooper 1997) while others describe both cognitive content and process, drawing upon Young's (1999) conceptualisation of schemas. Young describes "early maladaptive schemas" as pervasive themes in thinking about oneself and one's relationships, beginning in childhood and elaborated upon as we grow, but becoming dysfunctional in the present environment. Such schemas include negative core beliefs (content) and schema processes.

Studies of psychometric properties of schema measures in the eating disorders have established good psychometric properties for the full and short versions of the Young Schema Questionnaire (YSQ) (Waller et al., 2001; Waller, et al., 2000). Good psychometric properties have also been established for measures of schema processes such as the Young-Rygh Avoidance Inventory (YRAI) and Young

Compensatory Inventory (YCI) (Luck et al., 2005). However, subscales that emerge from factor analysis of these scales are not as Young proposed. Cooper et al. (1997) have developed a measure looking at cognitions, including core beliefs, but it does not take into account schema processes.

Negative core beliefs have been found to be useful in the appraisal of cognitive patterns in anorexia nervosa and bulimia (Cooper & Hunt, 1998; Cooper & Turner, 2000; Leung et al., 1999; Waller et al., 2000). Core beliefs found to be central to bulimic disorders include defectiveness/shame, insufficient self-control and failure to achieve (Waller et al., 2000). However, schema content does not differ between groups with different eating disorder diagnoses, although there are more pathological core beliefs among those eating-disordered patients with a multi-impulsive presentation (Lawson, Waller, Corstorphine, Ganis & Luck, 2003). Schema processes appear to differ across bulimic and restrictive pathologies (Luck et al., 2005).

Researchers have hypothesised about such background experiences as the role of trauma (Hartt & Waller, 2001) and unhealthy family functioning (Emanuelli et al, 2003), and the apparent association between these factors and unhealthy core beliefs and schema processes. Several case reports (Kennerley, 1997; Ohanian, 2002) describe treatment using a schema-focused approach. These case reports show positive outcomes of SFCBT for eating disorders.

It is important to note that the literature described above is limited to female adults, consists of cross-sectional or correlational studies, and involves those who mostly meet full diagnostic criteria for an eating disorder rather than those associated with the EDNOS group.

Drawing upon the existing literature, Waller (2004) has developed a preliminary SFCBT model of the eating disorders. This model attempt to explain the range of phenomena in the eating disorders and account for the similarity of cognitive content and discrepancies in cognitive processing across different types of eating disorders. Waller suggests that different schema processes are central to the development of restrictive and bulimic psychopathologies. This model proposes two new constructs to encapsulate the differences that occur in managing affect, and suggests that those constructs distinguish bulimic from restrictive pathology. The constructs are primary and secondary avoidance of affect. *Primary avoidance of affect* is linked to the process of schema compensation. In behavioural and cognitive compensation for a maladaptive schema (e.g., manifestations such as restriction and compulsive behaviours), the maladaptive schema is not triggered. Thus, painful affect is avoided entirely. *Secondary avoidance of affect* is linked to the process of schema avoidance. When a maladaptive schema is triggered, the resulting negative

affect is dealt with by cognitive and behavioural 'blocking' mechanisms (e.g., binge-eating, alcohol use, self-harm). Evidence to date (Luck et al, 2005) supports this model, indicating that bulimia is marked by the cognitive process of secondary avoidance of affect (schema avoidance) and those individuals with restrictive pathology use the cognitive process of primary avoidance of affect (schema compensation).

Summary

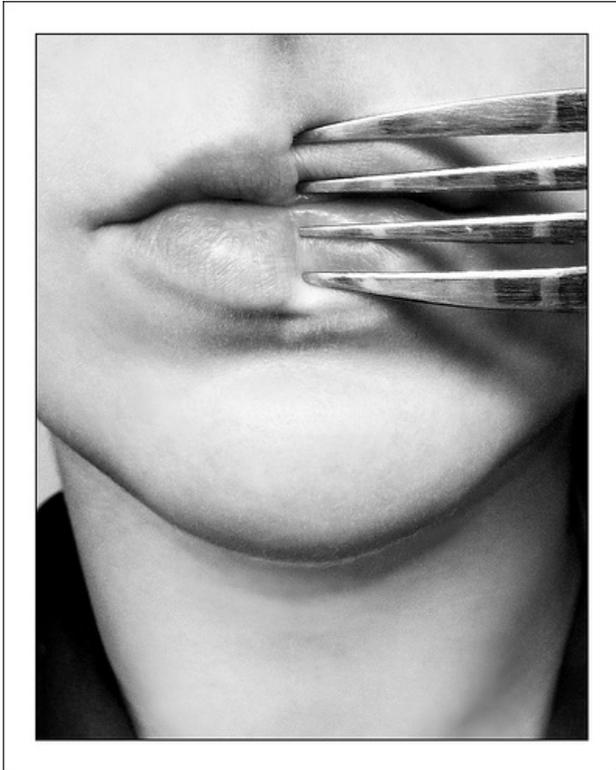
Schema-focused cognitive behaviour therapy is a treatment that may prove a useful adjunct to existing treatments for the eating disorders. A moderate literature base exists that provides support for pathological schemas in the eating disorders, has established psychometric measures designed to evaluate this construct, and provided some case reports supporting its efficacy as a treatment approach. Development of schema-focused models of the eating disorders has begun, although these are waiting to be fully tested.

SFCBT should be used with caution (James, 2001) when working with those with eating disorders. As has been indicated earlier, one of the key gaps in the literature is the lack of systematic research into the effectiveness of SFCBT in treating eating disorders. At present there is one randomised controlled trial underway and only for patients with BED (McIntosh, Jordan, Carter, Latner, & Wallace, 2007). Further, research will need to establish which patients will require this treatment over and above standard CBT. To date we have little evidence of what criteria would be useful in treatment matching.

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EATING DISORDER TREATMENT FROM CONSUMERS' PERSPECTIVES

**Megan Bishop (BSc (Psych) (Hons) and
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Megan Bishop completed her honours in psychology at the University of Canberra in 2010. Under the supervision of Dr Vivienne Lewis, Megan pursued her interest in eating disorders through her fourth year project which focused on the effectiveness of treatment from consumers' perspectives.

Dr Vivienne Lewis is Assistant Professor in Psychology at the University of Canberra and practicing clinical psychologist in the area of body image and eating disorders. She has published a number of papers on body image, is currently writing a self-help book promoting positive body image, and trains Clinical Masters students in working with people with body image and eating issues. She is the previous ACT State Chair of the Australian Psychological Society.

Consumer involvement in the evaluation of treatment for eating disorders has been described in the past as a neglected area of research (Clinton, Björck, Sohlberg, & Norring, 2004). When evaluating the helpfulness of treatment though, it is extremely important to involve consumers, as they can offer insightful views based upon their own experiences and expectations (Rutter, Manley, Weaver, Crawford, & Fulop, 2004). In examining treatment from a consumer's perspective, it is hoped that the strengths and weaknesses of treatment can become more apparent, so that further improvements to the treatment process can be made. The view that consumers should become active participants, rather than just passive recipients of treatment, has shaped government policy worldwide, including the Australian National Standards for Mental Health Services, which state that patients have the right to be involved in the planning, implementation and evaluation of mental health standards (Australian Government, 2010).

To date however, there are only a handful of studies worldwide that have considered the opinions of consumers when assessing the overall quality of eating disorder treatments (Clinton, et al., 2004; de la Rie, Noordenbos, Donker, & van Furth, 2008; Newton, Robinson, & Hartley, 1993; Noordenbos, Jacobs, & Hertzberger, 1998; Noordenbos, Oldenhav, Muschter, & Terpstra, 2002; Rosenvinge & Kuhlefeldt Klusmeier, 2000). This area of research began with Newton, et al. (1993) who studied the treatment experiences of 1638 members from the UK Eating Disorders association. Overall, participants were generally satisfied with the treatment that they had received to date, and found helpful forms of treatment to include counselling, self-help groups, group therapy, inpatient care, and individual psychotherapy. Behaviour therapy and family therapy however, were both seen to be unhelpful forms of treatment by the majority. In order to improve upon treatment for eating disorders, consumers suggested that more specialist services be made available, and that general practitioners be given more training in the area. Furthermore this study revealed a significant delay of 4.5 years between the age of eating disorder onset and the age at which individuals first sought treatment.

De la Rie, et al. (2008) also studied perceptions of the quality of eating disorder treatments in a sample of 158 current patients, 148 former patients, and 73 therapists from specialised eating disorder centres in the Netherlands. This study showed that while therapists believed that it was extremely important to focus on eating disorder symptoms and behavioural change whilst in treatment, patients believed that it was more important to focus on the therapeutic relationship as well as thoughts, feelings and self-esteem. Despite these differences, both therapists and patients valued a number of the same factors, including

'trust in the therapist', 'being respected', 'being taken seriously' and 'being able to talk about eating behaviours'.

The purpose of the current study was to examine consumer's general experiences and expectations of eating disorder treatment within Australia, as no such study has been conducted to date. Due to the varying treatment practices and guidelines within different countries, it is important to conduct such research, so that perceived strengths and weaknesses of eating disorder treatments within Australia may be revealed. The current study involved partial replications of the two previously mentioned studies (de la Rie, et al., 2008; Newton, et al., 1993) in order to explore consumer's first experiences of treatment, the perceived helpfulness of varying treatment types, expectations of treatment, and consumer's suggestions to improve upon treatment.

Method

Participants

The sample consisted of 131 females (97.04%) and 4 males (2.96%) who ranged in age from 18 to 53 years ($M = 27.56$, $SD = 7.82$). With regards to personal experiences of an eating disorder, 62.96% of participants ($N = 85$) reported that they were current sufferers, whilst 34.07% of participants ($N = 46$) reported that they were former sufferers ($N = 4$, missing data scores). Furthermore, 53.33% of participants ($N = 72$) indicated that they had experienced either AN ($N = 54$, 40.00%), BN ($N = 17$, 12.59%) or EDNOS ($N = 1$, .74%), and 46.67% of participants ($N = 63$) indicated that they had experienced a combination of 2 or more of the above eating disorders.

Measure

The survey used in the current study contained 145 open-ended questions and multiple choice items, and comprised 2 main sections. Part A, derived from the work of Newton, et al. (1993), contained questions regarding people's first experiences of treatment and the helpfulness of treatments received. Part B, derived from the Questionnaire for Eating Problems and Treatment (QEPT) (de la Rie, et al., 2008), focused on their expectations of treatment, treatment preferences, and suggestions to improve current treatment practices. Part B of the survey also contained 64 of the 70 criterion found in the original QEPT relating to varying aspects of therapy content, process and outcome. Participants were required to rate each item on a 5-point-Likert scale ranging from 'not important at all' to 'very important', with reference to what determined the quality of treatment for them.

Procedure

The online questionnaire was made available to over 6000 members and contacts of various eating disorder

organisations around Australia. The type of media (email, newsletter or web page) used to inform members about the study, was dependent on the organisation's standard methods of communicating with members. Prior to commencing the questionnaire, individuals were informed that participation was both voluntary and anonymous.

Results

Results showed a 4.65 year gap between the average age at which participants first experienced symptoms of an eating disorder, and the average age at which they reported first seeking help. Participants were most likely to initially approach a professional, a friend, or their mother about their condition, and most (50.38%) regarded this as a positive experience. When asked specifically about their first experiences of treatment however, the majority of participants (58.21%) regarded the experience as negative. When asked the question "overall, how satisfied are you with the treatment that you have received to date?" the majority of participants (63.85%) indicated that they were satisfied.

Table 1 presents the descriptive statistics for the helpfulness of specific treatment types as experienced by participants. Individual therapy was considered to be the most helpful form of treatment with 74.61% of recipients considering it to be either "slightly helpful" (54.61%) or "very helpful" (20.00%). Group therapy, medication, self-help manuals, and inpatient care were also seen to be helpful forms of treatment, in contrast to family therapy which was seen to be unhelpful by the majority of participants (53.13%).

Table 2 presents the 10 most important criterion for high quality eating disorder treatment as indicated by 85.19% of participants ($N = 115$). Participants rated the original 64 criterion on a 5-point-Likert scale (1: Not important at all, to 5: Very important), higher means indicative of more important criterion as perceived by participants. As displayed in Table 2, participants thought that it was most important to be taken seriously whilst in treatment. Participants also thought that it was extremely important to be able to trust their therapist, to be treated by a therapist who was interested in their case, who truly listened to them, and who was honest. Participants also perceived support and respect to be of high importance in treatment, as well as trust from one's therapist, and being able to talk about one's thoughts and feelings.

Table 3 presents the 12 major themes that emerged from a qualitative analysis that was performed on the question "What suggestions or advice do you have to improve treatment for people with eating disorders?" which was answered by 71.11% of participants ($N = 96$). Analysis revealed that (according to patients) more services need to be made available to individuals with eating disorders,

inclusive of more outpatient care or day programs, and that more inpatient care facilities and more treatment for those living in remote areas is needed. Participants also indicated that professionals (notably GPs) should be better trained to deal with eating disorders, and that they should demonstrate more empathy towards sufferers. According to participants, treatment should become more flexible, tailored to the individual, and less standardised. Furthermore, participants suggested that more education on eating disorders is needed within schools and the wider

community, and that more financial assistance be provided to people with eating disorders. Other suggestions to improve upon treatment included the need for therapists to focus less on recovering weight, have greater recognition of the problem, allow for more involvement of consumers in the treatment plan, and provide for more ongoing support, better methods of prevention, and assistance with the transition back to normal life.

Tables

Table 1
Descriptive Statistics for the Helpfulness of Eating Disorder Treatment Types

| Treatment | N | Made the Situation worse | Unhelpful | Slightly Helpful | Very Helpful |
|--------------------|-----|--------------------------|----------------|------------------|----------------|
| Individual therapy | 130 | 4 (3.08%) | 29 (22.31%) | 71 (54.61%) | 26 (20.0%) |
| Group therapy | 76 | 8 (10.53%) | 19 (25.00%) | 28 (36.84%) | 21 (27.63%) |
| Family therapy | 64 | 21 (32.81%) | 13 (20.32%) | 21 (32.81%) | 9 (14.06%) |
| Medication | 108 | 11 (10.18%) | 30 (27.78%) | 47 (43.52%) | 20 (18.52%) |
| Self-help manual | 86 | 10 (11.63%) | 23 (26.74%) | 42 (48.84%) | 11 (12.79%) |
| Inpatient care | 80 | 18 (22.50%) | 11 (13.75%) | 32 (40.00%) | 19 (23.75%) |

Table 2
Descriptive Statistics for the Ten Most Important Treatment Criterion (N = 115)

| Treatment Criterion | Mean | SD |
|-----------------------------------|------|-----|
| Being taken seriously | 4.95 | .22 |
| Trust in therapist | 4.93 | .29 |
| Therapist who is interested | 4.92 | .27 |
| Therapist who truly listens | 4.92 | .27 |
| Therapist who is honest | 4.87 | .43 |
| Feeling supported | 4.86 | .35 |
| Being respected | 4.86 | .40 |
| Trust from your therapist | 4.82 | .53 |
| Being able to talk about thoughts | 4.82 | .49 |
| Being able to talk about feelings | 4.78 | .57 |

Table 3
Descriptive Statistics for Qualitative Responses Regarding Suggestions to Improve Treatment (N = 96)

| Suggestion Themes | Frequency | Percent |
|---|-----------|---------|
| Services | 29 | 30.21% |
| Outpatient care / day programs | 12 | 12.50% |
| Inpatient care | 6 | 6.25% |
| Treatment in remote areas | 6 | 6.25% |
| Professional training | 25 | 26.04% |
| Empathetic professionals | 21 | 21.88% |
| Flexible / individualised treatment options | 21 | 21.88% |
| Education | 13 | 13.54% |
| Financial assistance | 12 | 12.50% |
| Focus less on weight | 9 | 9.38% |
| Ongoing support | 9 | 9.38% |
| Recognition of problem | 9 | 9.38% |
| Prevention and intervention | 7 | 7.29% |
| Consumer involvement | 7 | 7.29% |
| Transition back to normal life | 7 | 7.29% |
| Other | 23 | 23.96% |

Discussion

This study indicated that whilst the majority of consumers are positive about their experiences of individual therapy, group therapy, and self-help methods of treatment, most individuals believe that family therapy is an unhelpful form of treatment for eating disorders. They also revealed a concerning delay of almost 5 years between the age of symptom onset and the age at which individuals first seek help for their condition. These findings are consistent with the previous research of Newton, et al. (1993).

Our findings also highlighted the extreme importance that consumers place on developing a strong therapeutic relationship based upon trust, support, honesty and respect, in line with findings of de la Rie, et al. (2008). In addition, our research highlighted a perceived need for professionals (especially GPs) to be better trained to treat eating disorder patients, which is consistent with the findings of Newton, et al. (1993).

In comparison to previous research (Newton, et al., 1993; Rosenvinge & Kuhlefeldt Klusmeier, 2000), the participants within this study appeared to be more satisfied with their treatment experience overall. This could be attributed to improvements in treatment over time, or to treatment practices specific to Australia. Lastly, this study added to the

area of research by revealing many suggestions to improve upon treatment, including the need for more treatment facilities, more empathy from professionals, more individualised treatment options, more education and more financial assistance.

There are a number of limitations to the current study, however, that should be noted. Firstly, the sample in the current study was considerably smaller than the number of participants in other studies of a similar nature. Secondly, the use of convenience sampling can be seen as a limitation to the current study, as only those in contact with eating disorder foundations in Australia were given the opportunity to participate, and therefore this sample may not be representative of the views of the broader consumer population. Thirdly, it can be said that the male opinion was under-

represented in the study as only 4 males participated. Lastly, although the sole purpose of this research was to collect information regarding consumers' perceptions, individuals with eating disorders are considered as lacking insight into the psychological underpinnings of their condition (Michel, 2002). Therefore, it should be noted that what is perceived to be helpful by the patient, may not necessarily be helpful in terms of treatment outcome.

Despite limitations, the results of this study do suggest a need for more attention to be paid to prevention, detection and early intervention methods, as this may help to decrease the amount of time that it takes sufferers to seek help after they begin to experience symptoms. Previous research has shown that a significant delay in presentation is of particular concern to both patients and treatment providers, as a longer duration of illness is generally associated with a poor long-term outcome (Rosenvinge & Kuhlefeldt Klusmeier, 2000). This research also suggests a need for a closer look at family therapy and how it can become a more positive experience for patients, as although it has been shown to be highly effective in the treatment of anorexia (Lock & le Grange, 2005; Wilson, Grilo, & Vitousek, 2007), it is perceived to be unhelpful by a large number of consumers. Finally, consideration should be given to consumers' suggestions to improve upon treatment (such as the need for more training for professionals, more empathy from professionals, more individualised treatment and more services) as consumers have an implicit right to be active participants in all aspects of their treatment.

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A CLIENT'S PERSPECTIVE

Anna¹, a 36 year old female, presented with subclinical anorexia and associated depression. She was happily married with two young children. As one of five in a family where junk food was prevalent, aged 8 years she was an overweight, shy child who was often teased and hid in her bedroom. At her highest weight of 87 kgs, aged 18 years, she focused on not eating for the first time. Subsequently weight fluctuated. See Table 1 for typical emotions, thoughts and behaviour prior to leaving for a weekend away.

To tell you the truth I'm not sure where to begin. It seems so long ago, yet it's only a number of years since this vulgar monster entered my world; taking over my entire being, changing my world and devastating everyone who cares about me.

It's a strange phenomenon and a disorder with complexities that you cannot even begin to imagine unless you are personally suffering from it. I don't care how many 'experts' (and I have seen the best) think they have the solution, I can tell you now that no-one knows the depth or devastation of this disease. It is like a volcanic eruption; the issues start off simmering below the surface and not even the sufferer knows what is going on. It all seems harmless enough and can stay that way for a long time, but like every problem, if you try and ignore it, it doesn't simply go away, it just gets worse until it eventually reaches crisis point.

And I guess that's what happened to me. Eventually I had to face the reality of the situation and admit that I had a problem. The manipulation created by this particular disease makes it exceptionally hard to face and admit. One day the sufferer can see that they look underweight, but the next day the monster convinces you that you are just fine...that there is no real problem here. It also helps if you avoid looking in the mirror all together and wear the same baggy clothes and dressing gown to disguise your problem and to stop your own eyes from having to deal with it.

It is exhausting, absolutely, unexplainably exhausting. The sufferer is already low on energy from lack of weight and the stress that the whole situation creates just adds to it and basically wipes you out. It is hell on earth...there is no nicer way to describe it and I would not wish it on my worst enemy.

Many sufferers try to restore their weight at home with the help of a nutritionist and psychologist and the success rate of this is hard to determine. The other option that gets thrown around is the fact that the sufferer can enter a 'facility' where they are given a meal plan and strictly

monitored until they gain a sufficient amount of weight. Personally I fought this option for a year as I have two children. I had never spent a day a day away from and couldn't even imagine leaving. But after trying everything at home, I finally succumbed to pressure to enter the hospital. I read up on similar facilities, how they treated patients and also about the meal plans, expectations and positive and negative outcomes of entering treatment. But nothing, and I mean NOTHING, could prepare me for the world I was about to enter. As I kissed my husband goodbye I could barely see straight as my eyes were so swollen from crying and my throat dry from fear.

I could go on for hours about the pain and anxiety felt between the hallow walls of that hospital, but there is no point other than to say that I struggled with every aspect of treatment. But the basic problem was that I was terrified of gaining too much weight and of having no control over the situation.

I left hospital after three and a half weeks, gaining just over two kilos. But as I discovered from the girls who had been re-admitted year after year, it was definitely not a fail-safe plan and slipping back into old habits is easy once the hospital doors shut behind you. What I thought may have been the answer was, in fact, a bandaid solution, just like everything else. The absolute only way to beat anorexia is to want to do it. No one can help you, you have to want to get rid of it, that is the simple, absolute truth.

Experts have numerous theories about why anorexia occurs, but after spending years reading and listening to everyone's thoughts and studies, I have decided to delete all files, pack away all literature relating to the disease, and also the 'health and fitness' books I thought were delivering positive messages and teaching me to eat 'well'. I have decided that no-one actually knows anything for sure. We can all make wild guesses but every case is different and there's no point focussing on it too much anyway. It doesn't make it go away.

At this point I feel as though all of the thinking, talking and over-analysing I have done has merely provided me with more reasons to stay in the hole I have created for myself. Experts give you reasons for being that way, for acting in certain ways and for staying stuck, but I don't want any more reasons or excuses, I just want to remove myself from the whole situation and learn to look at life differently again. The old adage 'what you think, so you become' is true. The more you are told you have a problem, that you are an 'anorexic', the more you believe it. It becomes your identity, how you define yourself, and as a result of this, it makes it all the harder to break free.

For now I have decided to step outside the world of an anorexic and try and find the person I used to be. I have bid the monster farewell in my head and am using the love and

support of my tired, but wonderfully supportive family to see if we can solve problem ourselves. It's early days but I absolutely want to move on from this...I honestly do, BUT in saying that, it is so difficult. The mind plays so many tricks and it is such a tiresome, painful, horrible experience, but there is no other option. I am currently a work in progress and the next few weeks and months should tell us a lot. All I

know is that nothing else has worked and that it is time to put faith in myself again and to stop looking to others to provide the solution. I need to learn to trust myself again, to like myself again...and basically find myself again. It may be a long and painful search but I finally realise that I have so much to gain and look forward to and that makes the search worthwhile.

Table 1. The following is an example of a day from Anna's diary in which she prepares to go away on a weekend trip, and subsequently the day of the trip.

Prior to journey

| Food | Emotion | Cognition | Behaviour |
|---|---|---|---|
| 7:00 poached egg & cheese on toast at table | Fine as no calorie worries. | Constantly worried about what to have for dinner. | Go for a jog (1 hour) to get as low as I can before going away. |
| 12:00 salmon & cheese on toast, nut bar, diet coke at table | Always feel OK when I've eaten healthy. | Just thinking about fact I'm going away for few days & worried that I'll put on weight as others will cook. Eat less for a few days to keep weight down so that I have room to play with. | Trying not to snack in-between. |
| 1700 little KFC | Feel awful. | See how gaunt & thin I look in mirror. So worried about my weight gain after eating weigh self. | Eat a little after seeing self. |

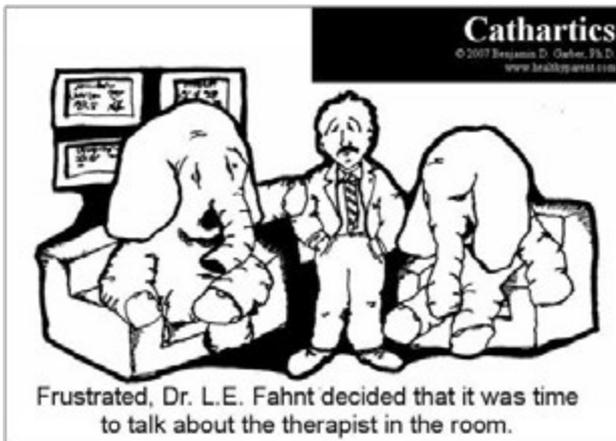
Day of journey

| Food | Emotion | Cognition | Behaviour |
|---|---|---|---|
| 7:30 Poached egg & cheese on toast, apple & pear at table | Felt fine as healthy & light. | Constantly worried about what to have for dinner. Just thinking about fact I'm going away for few days & worried that I'll put on weight as others will cook. | |
| 11:30 Cheese sandwich, apple & pear in park | Felt OK, but kept hoping would not snack in car during long trip. | | Trying not to snack in-between |
| 1430 Lots of lollies in car all afternoon | Anxious. | Keep thinking how can I avoid dinner as I've eaten so many lollies | Manage to avoid eating dinner; not hungry anyway. |

¹Anna is a pseudonym

CALLS FOR CONTRIBUTIONS JULY ISSUE: Personality Disorders

Contributions are invited from those with clinical, psychotherapeutic, research or other expertise in this area, by 30th June 2012. See ACPARIAN Editorial Guidelines for submissions.



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Research Review

RECOVERY OR NOT IN ANOREXIA NERVOSA

Kaye Horley, PhD
Editor

The factors involved in recovery from Anorexia Nervosa (AN) are poorly understood. Variables implicated as predictors in recovery include age of onset, treatment duration and chronicity (Castro, 2004; Saccomani, Savoini, Cirrincione, & Ravena, 1998; Steinhausen, 2002). However, the specificity of such findings have been disputed; for example, Steinhausen's finding of younger age at onset of illness associated with better outcome was in contrast with the opposite finding by Castro, and a non-effect finding by Saccomani et al.

Researchers have explored the difficulties those with AN face in recovering from the condition, either from a clinician's perspective, with emphasis upon objective measures, or from the client's perspective, with emphasis upon subjective complexities. As pointed out by Pettersen and Rosenvinge (2002), an error of clinical judgement may be the assumption that treatment results in recovery and patient resistant factors are implicated in failure to recovery.

Clinical perspectives

Clinical emphasis has been upon objective measures, in particular weight gain and a reduction in AN behaviour, including bingeing and purging (Noordenbos & Seubring, 2006). Discharge, therefore, is often centred on attainment of desired weight. The high rate of relapse indicating that such behaviours may not be predictive of positive long term outcome, suggest that psychological recovery may not parallel physical recovery in that disturbed preoccupation with food and weight may continue (Fenning, Fenning, & Roe, 2002; Castro, Gila, Puig, Rofriguez, & Toro, 2004).

The argument that there is a need for more emphasis upon subjective aspects when assessing recovery has led to an increasing focus upon the subjective experience of the individual recovering from AN (Lamoureux & Bottorf, 2005).

Patient perspectives

Some of these subjective complexities have been explored in studies researching the perspective of women recovering or having recovered from AN. In a study by Jenkins and Ogden (2012), women recovering from AN

described dichotomies between their mind and body, whilst anorexic their body/irrational side dominating their mind/rational side. They described AN as a way of having control over their lives and their body a way of communicating distress. Their perception was that recovery would not be achieved until such competing forces were resolved, described as a sense of becoming "whole" again and without food and weight obsessions. The majority of women also clearly perceived recovery as incorporating both physical and psychological recovery, with the latter not automatically following the former.

The importance of self-acceptance appeared implicit in many studies. AN women appeared to lack a sense of self, resulting in a need to attain a sense of identity. In a study by Lamoureux and Botorff (2005), finding and becoming "the real me", apart from anorexia, was considered central to recovery by the women. Self-change (Jacobson, 2001) associated with self-awareness and schemas of self-acceptance (D'Abundo & Chally, 2004), a cohesive sense of self and feeling worthy (Beresin, Gordon, & Herzog, 1989) and higher self-esteem (Plowman, 2008) were considered explanatory factors in the struggle to recover from eating disorders (ED) with corresponding significant decreases in problematic eating behaviour.

Pettersen and Rosenvinge (2002) implicated seven psychological factors women associated with recovery: i) acceptance of self and body; ii) food not dominating their life or iii) used as a way of solving problems; iv) having a purpose in life; v) fulfilling their potential without unrealistic expectations of self; vi) understanding and expressing their emotions, with decreased anxiety and depression, and vii) social satisfaction. Notably, they made allowance for the continuing experiencing of some ED symptoms. Thus, recovery in their perception was not dependent upon absence of symptoms, but associated more with improved psychological well-being that was both functional and interpersonal.

In many studies, emphasis was placed by the women upon the importance of an empathetic, supportive, non-judgemental therapeutic relationship enabling expression of feelings and perceived as essential to recovery (e.g., D'Abundo & Chally, 2004; Jenkins; Pettersen, & Rosenvinge, 2002). Although those with AN may have the wish or motivation to get better, this is often not translated into change and is particularly challenging for the clinician. Norbo et al. (2012) identified seven motivational factors described by AN patients as mitigating against their wish to recover: i) "perceiving judgements" – exposure to opinions of others; Steinhausen, H. C. (2009). Outcome of eating disorders. *Child Adolescent Psychiatric Clinics of North America*, 18(1):225-42.

(ii) "feeling stuck" – the hopelessness of recovery; (iii) "feeling distressed" – a state of negative emotion; (iv) "denying AN" – lack of acknowledgement of their condition; (v) "eating" – cognitions about food; (vi) "gaining weight" – realisation of increased weight; and (vii) "appreciating the benefits" – increased positive vs. negative effects from AN. It was concluded that the understanding of such psychological factors is important in motivational change treatment.

Conclusion

Knowledge of the psychological factors perceived by women with AN to be implicated in their recovery will facilitate understanding of their ED problems, particularly as research findings indicate that patients perceive the clinical criteria for recovery as underplaying the importance of psychological factors. As outcome may be critically affected by psychological factors, it is necessary for clinicians to take account of both physical and psychological factors, although there are inherent difficulties in assessing the psychological complexities implicit in recovery (Couturier & Lock, 2006).

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Ethics and Legal Dilemmas

SOME POINTS ON THE ETHICS OF THE FORCED TREATMENT OF ANOREXIA NERVOSA

Giles Burch, PhD
Associate Editor

Welcome to the third edition of the Ethics and Legal Dilemma's column of ACPARIAN. Given that the focus of this edition is on eating disorders, this provides us with an ideal opportunity to reflect on some of the key ethical points associated with the treatment of eating disorders that have been discussed in the wider literature.

As with treatments for other mental health problems, there are ethical issues that should be considered carefully by practitioners, and the treatment of eating disorders is no exception. Indeed, *the treatment*, or perhaps rather, the *forced* treatment of anorexia nervosa (AN) is one of the main ethical issues faced by practitioners working with eating disorders. In many ways, some of the issues that are raised in relation to the forced treatment of AN may appear similar to those raised in the last edition of this column "the ethics of suicide", particularly concerning the 'fundamental' right of individuals to refuse treatment versus, what was referred to as, "psychiatric coercion".

Touyz and Carney (2010) have postulated that when it comes to forced treatment in AN, it is medicine and ethics that decide if and when coercion occurs, not the law. Further, they have suggested that there may be greater controversy associated with AN than with general involuntary treatment. However, at this juncture it is necessary to note that it is not just a case of coercion by actual legal means, but also 'perceived coercion', that is, whether the patient feels or believes that they are being coerced through the *threat* of legal orders (see Tan, Stewart, Fitzpatrick, & Hope, 2010). Indeed, Tan et al. (2010) pointed out how perceived coercion may raise another level of issues. For example, while the threat of treatment may avoid some of the negative implications of legal compulsion, patients diagnosed with AN may have less legal

protection when *coerced* outside of a formal process (Tan et al., 2010).

The refusal of treatment by those with AN is common and may occur for a number of reasons, such as the patient's ambivalence towards treatment (e.g., if there are perceived benefits in having AN) and an evaluation that death is unimportant in comparison to having AN (e.g., Tan, Hope, & Stewart, 2003). Given this, forced treatment is something that may need to be considered by practitioners. So what is the critical issue here? The lack of patient cooperation in treatment, even when there is substantial risk to their health, is well documented (e.g., Beumont & Vandereycken, 1998). Often the patient appears 'capable' in making a decision to refuse treatment, yet actually is impaired in their ability to make a 'competent' choice in treatment decisions. Touyz and Carney (2010) stated that the critical ethical point arises when the issue of whether the patient's capability to make "autonomous choice" has been lost or "compromised". They note how AN patients, similar to those diagnosed with schizophrenia or Alzheimer's disease, may experience anosognosia (i.e., an inability to recognize that the problem exists; that there is a threat to life and that treatment is required). Thus, there is a discrepancy between the goals of the patient and caregiver, with the patient refusing treatment in denying that anything is wrong with them (Mitrany & Melamed, 2005). This is the dilemma that clinicians face. As pointed out by Anderson (2008), the four guiding principles of biomedical ethics (1) *respect for autonomy* (in which the informed choice of the patient takes priority), (2) *nonmaleficance* (to do no harm to the patient), (3) *beneficence* (acting in the patient's best interest, with or without consent), and (4) *justice* (balancing costs and risks), conflict with each other in respect to AN. It has been suggested that the reason for this is because of the unique features of AN, listed by Anderson (2008) as:

1. *The intermix of medical starvation signs and symptoms with the mental and behavioral consequences of the overvalued beliefs underlying the disorder;*
2. *The common perception that AN is a voluntary disorder responsive to self-determination, both in development of the illness and in the process of regaining health;*
3. *Moralizing disorders of eating behavior and weight as disorders of personal failure;*
4. *The common stereotype of AN that limits perception of illness to teenage Caucasian girls;*

5. *The multi-factorial concept of etiology that generates competing approaches to treatment; and*
6. *The relatively robust appearance and behavior of many patients, even those with serious AN.*

This presents an ethical challenge for practitioners working with those with AN, a disorder which has a high mortality rate, in that respecting the patient's autonomy may be a factor contributing to the mortality rate (Thiels, 2008). So where does this leave us? Having identified the ethical issues associated with the forced treatment of an individual with AN, it is necessary to examine relevant advice pertinent to this issue. Thiel and Paul (2007; cited in Thiels, 2008, p. 498) have made a number of recommendations aimed at helping practitioners solve this ethical dilemma, including:

- *Coercion should not be used instead of psychotherapy nor does the former preclude the latter.*
- *Applications should be made for guardianship for health and the possibility of detention for 3– 6 months.*
- *As mortality increases when weight decreases below a BMI of 13 kg/m², this is the suggested threshold for considering forced treatment. Suicidality, electrolyte imbalance, cardiac arrhythmia, and other acute mental or physical problems may also necessitate forced treatment.*
- *Use coercion carefully and for the shortest time necessary. The interpersonal relationship and the psychotherapeutic milieu are more relevant for the course of treatment than is force.*
- *As little coercion as possible should be used to ensure feeding. From the beginning patients should be motivated to eat with increasing independence.*

- *Feeding and weight should not be unduly emphasized.*
- *Treat with respect. Protect the dignity and fragile self-esteem of the anorexic patient.*
- *Consider involving the family.*
- *The aim is not a particular weight but the continuation of treatment without coercion.*

The forced treatment of patients diagnosed with AN is a complex ethical issue, and something that we should think about carefully when working with this group. Hopefully, some of the points raised in this column will help to direct our thinking, at least in the first instance. In the meantime, I will leave the final words of this column with Thiels (2008, p. 498), who stated that:

The life of someone who may fully recover is of higher value than autonomy as this has already been compromised by anorexia nervosa.

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Student and Training Matters

STUDENTS' PERSPECTIVE: WORKING WITH OBESE CLIENTS: WHAT STUDENTS OUGHT TO KNOW

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Associate Editor

The current issue of ACPARIAN focuses on one of the most challenging issues for clinicians - eating disorders. These disorders are characterized by marked disturbance in eating behaviour, as well as disturbance in perception of body shape and weight (American Psychiatric Association, 2000). Gabbard (2005) describes eating disorders as conditions of our time, in the context of media coverage of "ideal" body images - particularly the images of slender women considered to "have it all".

The Diagnostic and Statistical Manual (DSM-IV-TR) presents two key diagnostic categories for eating disorders; Anorexia Nervosa (AN) and Bulimia Nervosa (BN). In research literature, anorexia nervosa is identified as a syndrome characterized by three essential criteria. The first is self-induced starvation; the second is a morbid fear of fatness; and third is the presence of medical signs and symptoms resulting from starvation. Bulimia nervosa, on the other hand, shares a similar goal of someone wanting to be thin as in AN, but occurring in individuals less able to sustain prolonged semi-starvation through eating binges accompanied by purges and/or excessive exercise. These definitions touch on the key criteria to be considered by a clinician working with either of these eating disorders.

Obesity, on the other hand, is not a diagnostic category in the DSM-IV-TR. Therefore, is it an eating disorder or a physical illness? The DSM suggests that where evidence of psychological factors are of importance in the aetiology or particular course of obesity, this can be indicated by noting psychological factors affecting medical condition. However, as a result of my experience working with obese clients in a rehabilitation setting, I am inclined to look at obesity as a psychological disorder. One of these psychological factors is ineffectual coping with life stressors, such as the use of food as a comforter. The present article presents a reflection of the author's experience as a clinical intern treating clients who presented with psychological disorders comorbid with obesity and other physical health issues.

Obesity defined

The DSM defines obesity simply as a condition characterized by excessive accumulation of fat in the body. Sadock and Sadock (2007) observe that from a medical perspective, one is considered obese if one's body weight exceeds by 20% the standard weight listed in height-weight tables. The preceding definition identifies medical criteria for obesity, but where then does psychology fit in the scheme of things? This was clarified for me in supervision during clinical internship at a rehabilitation centre in regional Victoria. I present a vignette of one of the cases I encountered during training:

Mr. Z was a 60-year-old male, married with four children, who presented to a rehabilitation outpatients unit for management of depression. Mr. Z had a history of chronic pain from an unsuccessful ankle operation, was on medical watch for a slowing heart, and was morbidly obese. He weighed 142 kilograms, and was 154cm tall. He stated that, pre-morbid, he used to weigh 79kg. As a consequence of his excessive body weight and ankle problem, weight bearing was an issue. Mr. Z reported lack of motivation to do things, a lowered mood, and difficulties with sleep (recent diagnosis of sleep apnea). He also reported recent loss of appetite, describing erratic eating habits. Mr. Z was on antidepressant medication as well as other medications for pain and his heart condition. He expressed concern about his continued weight gain despite irregular eating. He also reported that he had no sexual life as such, resulting in a growing rift between him and his wife. He stated that he no longer felt like a man. One of his goals for seeking help was to return to his pre-morbid self so that he could enjoy his life again.

The vignette is a telegraphic representation of a case that was laden with emotional content and pervasive themes of hopelessness and helplessness. The transference was overwhelming and as an intern I felt out of depth, particularly as to where to start. The presentation was an intricate web of linkages, complex at best, and requiring coordinated intervention (as I realize with the benefit of hindsight).

In rehabilitation settings, similar presentations to that of Mr. Z are commonplace. The challenge is how to help such clients. Analogous to those with BN and AN, body image becomes an integral theme in addition to already existing depressive symptoms. Motivation to do things becomes another casualty with the patient restricting him or herself indoors. Lack of activities perpetuates accumulation of fat, thus exacerbating the obesity dilemma. With that, depressive symptoms escalate becoming the proverbial 'vicious circle'.

Research evidence suggests that obesity is more common in women than in men (Wilson & Fairburn, 2007); and it is six

times more common among women in low socioeconomic status, than in their counterparts in higher socioeconomic status.

Aetiology of obesity

Firstly, there are a number of aetiologic factors that can be used to explain obesity. Current epidemiological evidence suggests that obesity may be the result of biological or genetic factors, thus obesity may be an inherited condition. Lifestyle researchers contend that obesity is a product of decreased activity, particularly in modern affluent societies. Others contend that the use of certain biological treatments e.g., psychotropic medications such as antidepressants or antipsychotics have weight gain as a side-effect, which they do. There is no doubt that psychological factors are crucial to the development of obesity, but the dearth of literature in this area confirms that we are yet to know how and to what extent these factors contribute to the development and/or exacerbation of obesity.

On the experience of transference

During the sessions, Mr. Z presented his issues with a sense of exasperation. He was conflicted in that he loved life, but on the other hand it appeared that his options were dwindling by the day. Attending therapy and having someone independent to talk to was his only hope. He repeatedly reminded me during the sessions of everything that he has tried and how all those strategies were not working.

As he presented his narrative session after session, I felt weighed down by the enormity of the task at hand. For a start, I was a neophyte who was learning the skills of the profession. I felt out of depth and impotent to say the least. How was I going to help this helpless man? As the reader will appreciate, I have not covered any specific details of the content of the transference material or my countertransference reaction. The omission is deliberate on my part. Nonetheless, I believe the descriptions I have proffered above will paint a fair picture of the enormity of the task before me and my general sense of impotence at providing solutions to Mr. Z's issues. Both the transference material and my reaction thereto (countertransference), became grist for the supervision mill; all vital ingredients to my clinical learning.

What I learnt

As I alluded to earlier while discussing transference issues, this was a complex and overwhelming case. Due to the complexity of Mr. Z's presenting issues, my supervisor advised a multi-focused intervention approach. Mr. Z required help in a number of areas – managing depression, pain, sleep, weight management, improving his self-esteem and his relationship. I learnt through the supervision process that Mr. Z required a coordinated approach to his care. I was to focus on management of depressive symptoms and self-esteem issues using Cognitive

Behavioural Therapy strategies. My supervisor also suggested links with other professionals including general practitioner (for physical issues), physiotherapist, dietitian, relationship counsellor, pain specialist and a sleep specialist to assist with the other presenting issues. Whilst at first it was not clear for me why I should liaise with all these professionals, it became apparent as treatment progressed that each professional had an important role to play. In fact I also realized later that what my supervisor advised, that is, including other professionals in providing care for my obese and depressed client, was standard recommended evidence-based practice contained in guidelines for treating eating disorders (see for example, National Institute for Clinical Excellence [NICE], 2004).

At first, this arrangement seemed to be a logistical nightmare for Mr. Z to attend appointments with all these professionals. However, in the end Mr. Z realized how important it was for all these professionals to work with him in a coordinated manner to provide him with the best care needed. At the conclusion of our engagement due to the end of my placement, Mr. Z's mood had improved and he was actively engaging in a few activities with his family.

Conclusion

It was not the intention of this article to argue the case for obesity as a diagnostic category in psychology. The DSM does not present obesity as an eating disorder diagnostic category, but an argument can be made for the impact of psychological factors on obesity. For upcoming practitioners, it is important to recognize that diagnostic categories of mental disorders are social and often political constructions (Carey & Pilgrim, 2010). Thus, irrespective of the current diagnostic status of obesity in psychiatry, it is important to carefully assess individuals and tailor interventions appropriate to their circumstances. In accordance with treatment guidelines for the major eating disorders, a coordinated approach to care, provision of information and support, and involvement of family, are important issues to be considered for successful interventions with obese clients.

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