No Pussyfooting: CBT for Eating Disorders

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Agenda

09:30 – 11:00 Intro to transdiagnostic treatment for eating disorders.
Stages and core elements.
Interactive demonstration of formulation.

11:00 – 11:15 Coffee break

11:15 – 12:15 Interactive demonstration of client and therapist developing self-monitoring and regular eating

12:15 – 13:00 Lunch

13:00 – 14:30 Interactive demonstration of collaborative weighing.
Addressing mood and event-related changes in eating

14:30 – 14:45 Coffee break

14:45 – 15:30 Addressing over-evaluation of weight and shape

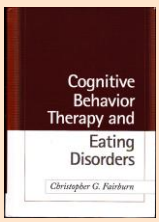
15:30 – 16:00 Should CBT be modified? When and how?

What we're not covering today

Medical management
Working with severely unwell clients
Working with clients with major comorbidities e.g. self harm, suicidal, drugs/alcohol
Initial Assessment
Weight restoration with significantly underweight clients - dietitian
The Broad Version of CBT-E

Introductions

Enhanced CBT for eating disorders "CBT-E"



Fairburn, C. (2008). Guilford

Transdiagnostic theory

	Anorexia	Bulimia	Binge Eating Disorder
Dietary restraint and *hunger			
Compensatory vomiting/laxative abuse			
Binge/compulsive eating			
Body checking/body avoidance			
Preoccupation with thoughts about shape, weight and eating			
Over-evaluation of shape, weight and their control			

	Anorexia	Bulimia	Binge Eating Disorder
Dietary restraint and *hunger	YES		
Compensatory vomiting/laxative abuse	Sometimes		
Binge/compulsive eating	Sometimes		
Body checking/body avoidance	YES		
Preoccupation with thoughts about shape, weight and eating	YES		
Over-evaluation of shape, weight and their control	YES		

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Compensatory vomiting/laxative abuse	Sometimes	YES	Sometimes
Binge/compulsive eating	Sometimes	YES	YES
Body checking/body avoidance	YES	YES	YES
Preoccupation with thoughts about shape, weight and eating	YES	YES	YES
Over-evaluation of shape, weight and their control	YES	YES	YES

	Cognition or behaviour?
Dietary restraint and *hunger	
Compensatory vomiting/laxative abuse	
Binge/compulsive eating	
Body checking/body avoidance	
Preoccupation with thoughts about shape, weight and eating	
Over-evaluation of shape, weight and their control	

	Cognition or behaviour?
Dietary restraint and *hunger	Behaviour
Compensatory vomiting/laxative abuse	Behaviour
Binge/compulsive eating	Behaviour
Body checking/body avoidance	Behaviour
Preoccupation with thoughts about shape, weight and eating	Cognition
Over-evaluation of shape, weight and their control	Cognition

Parsimony

Stages and core elements

Stage One: Starting Well 10 sessions, 2x week
• Assessment • Engagement • Formulation • Regular eating • In-session weighing • Involving significant others

Stages and core elements

Stage One: Starting Well 10 sessions, 2x week	Stage Two: Review 2 sessions, weekly
• Assessment • Engagement • Formulation • Regular eating • In-session weighing • Involving significant others	• Take stock • Identify barriers to change or areas of stage one that need further work before progressing • Reformulate • < 40% Broad version: severe perfectionism, low self esteem or interpersonal problems

Stages and core elements

Stage Three: Addressing main mechanisms maintaining e.d. 8 sessions weekly/Up to 25 sessions for weight restoration
• Mood and event-related changes in eating • Over-evaluation of weight and shape • Dietary restraint • Underweight

Stages and core elements

Stage Three: Addressing main mechanisms maintaining e.d. 8 sessions weekly/Up to 25 sessions for weight restoration	Stage Four: Ending well 3 sessions fortnightly
• Mood and event-related changes in eating • Over-evaluation of weight and shape • Dietary restraint • Underweight	• Future planning • Maintaining helpful changes • Understanding and minimising risks of relapse • Maintenance plan

Formulation

Formulation

is a therapist-client

collaborative activity that occurs at the beginning of therapy whereby a

framework is designed that details the rationale for therapeutic work. Underpinned by a

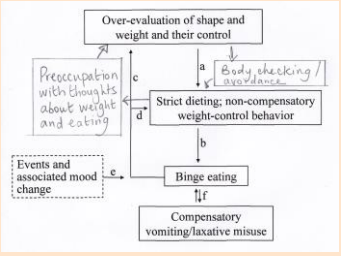
theory that seems reasonable to the therapist and client, formulation links

factors that may underlie or maintain the problem, with

changes the client can make that are likely to resolve or improve it. Formulation remains a

work-in-progress through therapy

An effective formulation enables the client to see for him/herself what next steps s/he might take to help the situation; and gives the client and therapist a solid foundation for understanding the purpose and aims of therapy



Helpful factors:

Resilience narratives

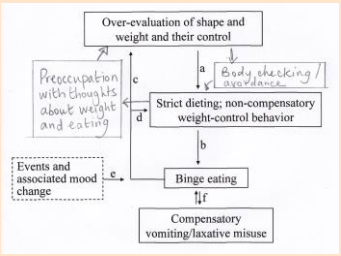
Supportive friends and family

Success in other areas of life

Reasons to recover: e.g. work, parenthood

Faith/hope

Altruism



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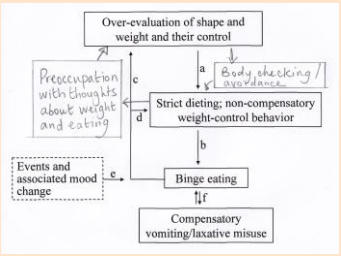

Unhelpful factors:

Social isolation

Identification with the patient role

Institutionalisation

Passive consumer of health care

Stigma – family, social and intrapersonal

Trauma

Negative family factors

Should CBT-E be modified?

Should CBT-E be modified?

- Family issues
- Relational-cultural concerns
- Abuse and humiliation
- Social isolation

Family issues

Adolescence and early adulthood

Family issues

Systemic family therapy
Family psychoeducation
Group family therapy
Family support group
Creative individual therapies
IPT?

Cultural concerns

Eating disorder clients require a therapeutic approach that respects the relational context of human psychological development.

"Individuation does not have the same value in a cultural context in which human nature is defined in terms of 'we' rather than 'I'" (Anderson and Mitchell, 1993, p.62).

Looking at development through a feminist lens, Jean Baker Miller said, "the notion of 'a self' does not appear to fit women's experience" (1984, p.1).

Relational-cultural concerns

A therapy that emphasises the primacy of human relational networks, the inevitability of interdependence, and the psychological injury caused by disconnections (including injustice and inequality), will formulate around these issues. No mainstream therapies, including CBT, explicitly do this (Johnstone and Dallos, 2013).

Relational-cultural concerns

As dynamic inter-relationship with others is essential to human wellbeing and growth, so is sensitive, responsive relationship with oneself (Kaplan et.al. 1991). However, such self-relationship can be thwarted by the culturally mandated virtue of denying oneself essential nutrition. We are immersed in a culture where female identity is framed by pressure to control body size; and where sexuality "is both an optimum value and also a real and present danger" (Brumberg, 1997, p.94). Adolescents whose bodies and sexuality are 'filling out' are exposed to a potentially unbearable sense of self-consciousness and jeopardy in their natural development.

Abuse and humiliation

Eating disordered clients commonly report having experienced degrading interpersonal interactions:

- family jibes
- school-yard bullying or social exclusion
- racial, ethnic or social class discrimination
- workplace manipulation
- domestic violence
- sexual abuse, exploitation or rape

Social isolation

As well as nutrients, oxygen, water, the human brain needs social contact to thrive (Eagleman, 2016).

It has been proposed that social isolation is linked with greater psychological impairment in anorexia (Damiano, et.al. 2015). It is also possible that social isolation compounds impairment by reducing potential exposure to compassionately corrective interaction with others regarding behaviour and cognition. It has been shown that loneliness triggers overeating in women with binge eating disorder (Masheb and Grilo, 2006); and that loneliness increases body dissatisfaction in those with bulimia (Pritchard and Yalch, 2009).

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