No Pussyfooting:
CBT for Eating Disorders

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Contents

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

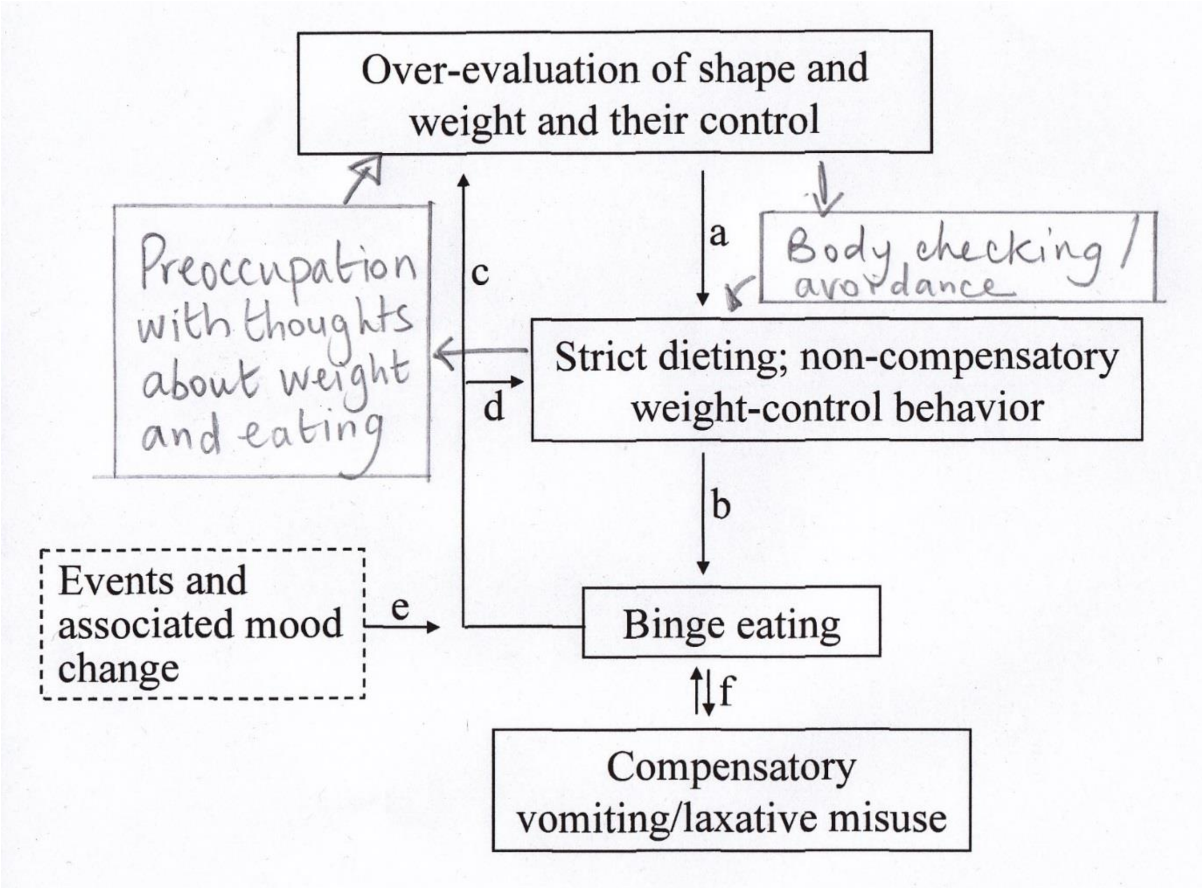
13:00 – 14:30 Interactive demonstration of collaborative weighing; addressing mood and event-
related changes in eating

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?

A basic bulimia formulation diagram



Instructions for self-monitoring

Table 5.2 from Fairburn CG, *Cognitive Behavior Therapy and Eating Disorders*, Guilford Press, New York, 2008.

Instructions for Self-Monitoring

During treatment, it is important that you record everything that you eat or drink, and what is going on at the time. We call this 'self-monitoring'. Its purpose is two-fold: first, it provides a detailed picture of how you eat, thereby bringing to your attention and that of your therapist the exact nature of your eating problem; and second, by making you more aware of what you are doing at the very time that you are doing it, self-monitoring helps you change behavior which may previously have seemed automatic and beyond your control. Accurate "real-time" monitoring is central to treatment. It will help you change.

At first, writing down everything that you eat may be irritating and inconvenient, but soon it will become second nature and of obvious value. We have yet to encounter anyone whose lifestyle made it truly impossible to monitor. Regard it as a challenge.

Look at the sample monitoring record to see how to monitor. A new record (or records) should be started each day.

- The first column is for noting the time when you eat or drink anything, and the second is for recording the nature of the food and drink consumed. Calories should not be recorded: instead, you should write down a simple (non-technical) description of what you ate or drank. Each item should be written down as soon as possible after it was consumed. Recalling what you ate or drank some hours afterwards will not work since it will not help you change your behavior at the time. Obviously, if you are to record in this way, you will need to carry your monitoring sheets with you. It does not matter if your records become messy or if the writing or spelling is not good. The important thing is that you record everything you eat or drink, as soon as possible afterwards.
- Episodes of eating that you view as meals should be identified with brackets. Snacks and other episodes of eating should not be bracketed.
- The third column should specify where the food or drink was consumed. If this was in your home, the room should be specified.
- Asterisks should be placed in the fourth column adjacent to any episodes of eating or drinking that you felt (at the time) were excessive. This is your judgment, regardless of what anyone else might think. It is essential to record all the food that you eat during "binges".
- The fifth column is for recording when you vomit (write 'V') or take laxatives (write 'L' and the number taken) or diuretics (water tablets) (write 'D' and the number taken).
- The last column will be used in various ways during treatment. For the moment it should be used as a diary to record events and feelings that have influenced your eating: for example, if an argument precipitated a binge or led you not to eat, you should note that down. Try to write a brief comment every time you eat, recording your thoughts and feelings about what you ate. You may want to record other important events or circumstances in this column, even if they had no effect on your eating. The last column should also be used to record your weight (and your thoughts about it) each time that you weigh yourself.

Instructions for regular eating

Table 6.1 from Fairburn CG, *Cognitive Behavior Therapy and Eating Disorders*, Guilford Press, New York, 2008.

Patient handout on "Regular Eating"

"Regular Eating"

<u>Pattern of eating</u>

- Breakfast
- (Mid-morning snack)
- Lunch
- Afternoon snack
- Evening meal
- Evening snack

<u>Points to note</u>

- Eat these meals and snacks, but do not eat between them
- Do not skip any meals or snacks
- Do not go more than four hours without eating
- Eat what you like in the meals and snacks, so long as you do not vomit or take laxatives to compensate
- Always know when (and roughly what) you are next going to eat

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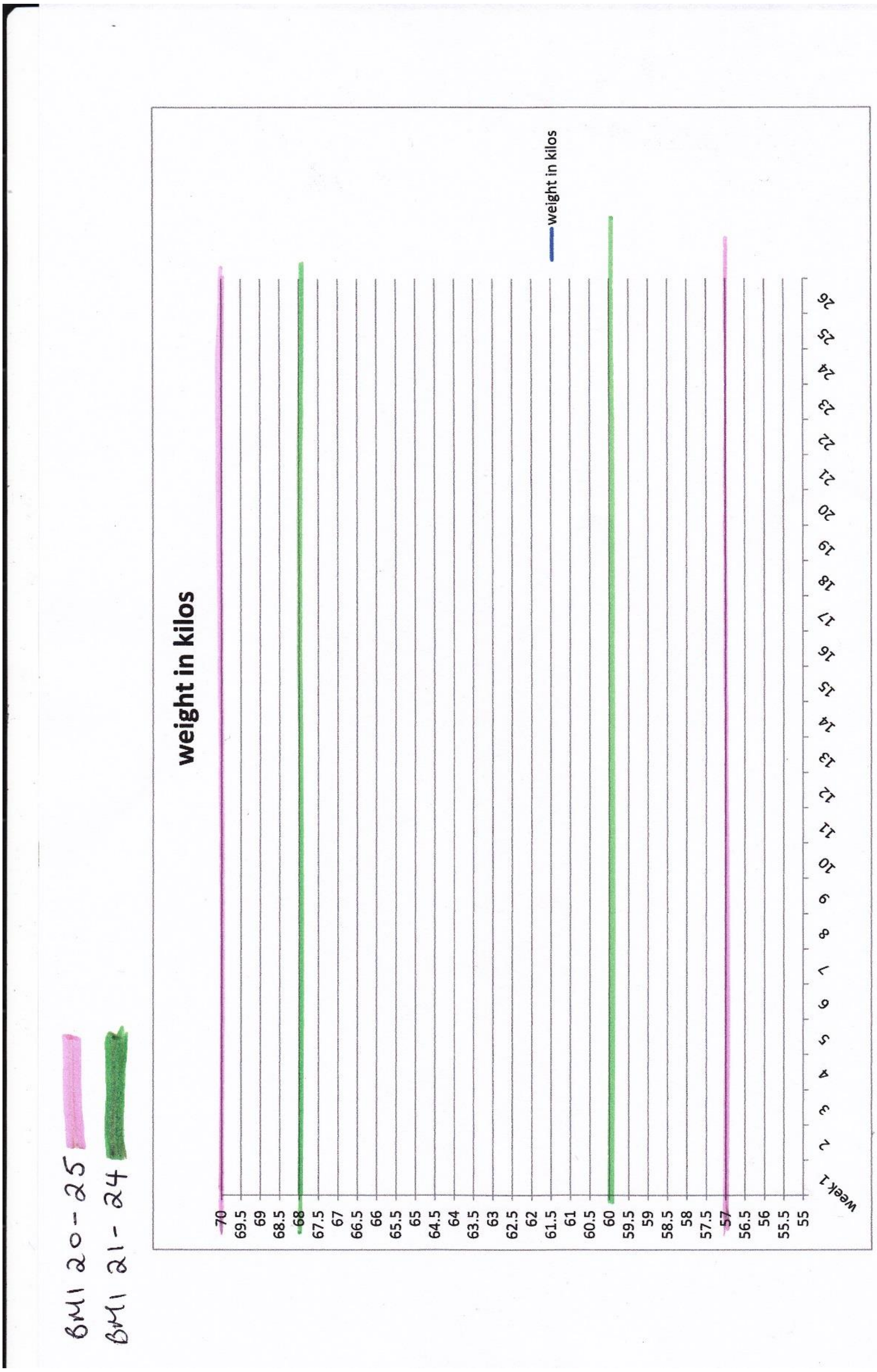
Blank monitoring log page

Time	Food and drink consumed	Place	*	v/l	Context and comments

Personalised weight chart with healthy BMI tram tracks

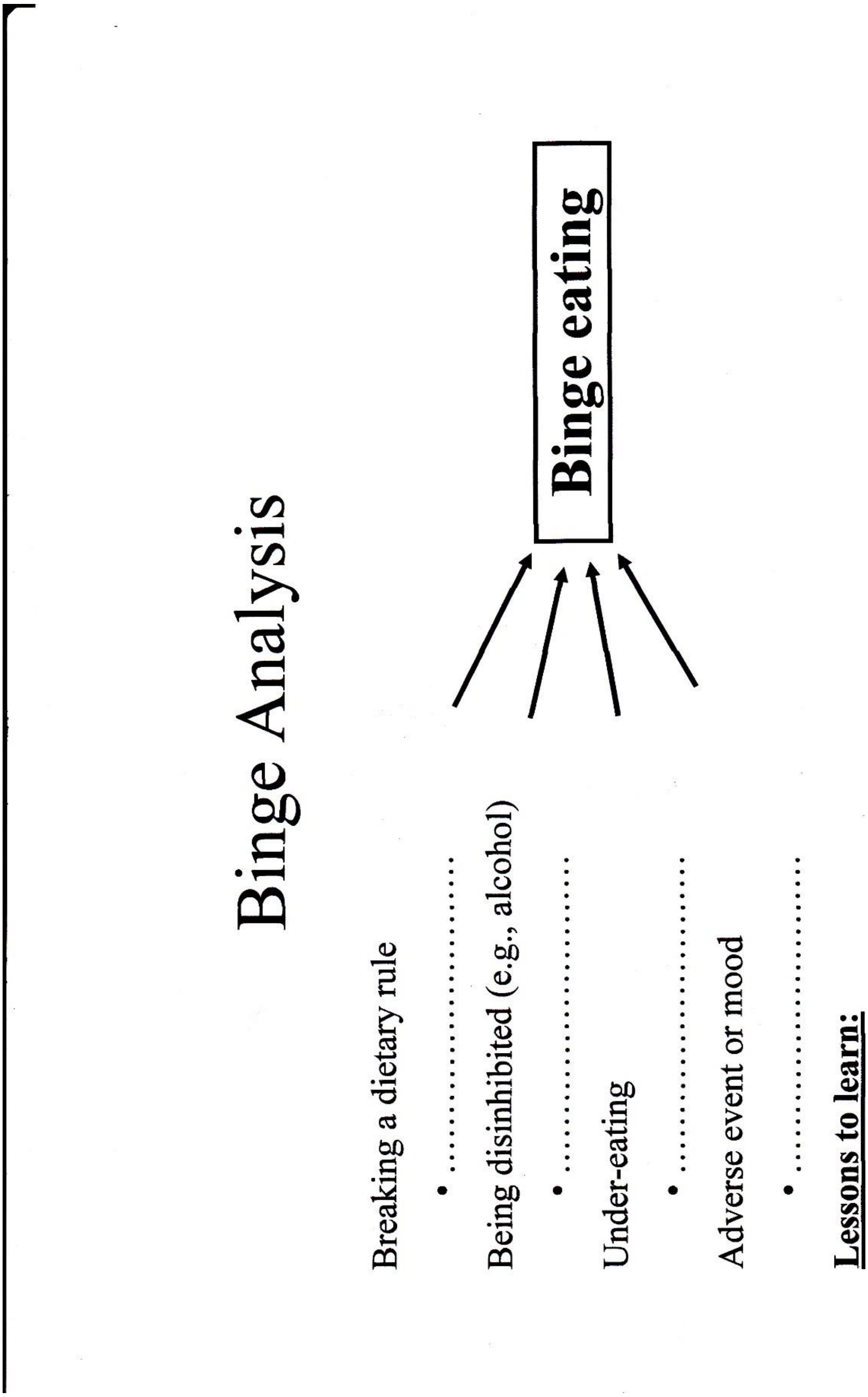


Monitoring page week one

Day Weds. Date 23rd March

Time	Food and drink consumed	Place	*	v/l	Context and comments
7:15	Black coffee	kitchen			
8:30	Black coffee	office			
10:15	Black coffee	office			Stressed Annoyed
1pm	banana	park			
3-5pm	30 celebrations 500ml water	office	*	✓	stupid
6pm	2 glasses white wine	living room			
8-9pm	6 croissants with nutella. 1 pack choc hobnobs 1 tub Ben+Jerry's vanilla		*	✓	Thought about having more wine but stopped myself disgusted but this is less than previous binges GUILT

Binge analysis



Monitoring page week two

Day Weds Date 30th March

Time	Food and drink consumed	Place	*	v/l	Context and comments
7:15	coffee w/ milk banana	Kitchen			okay - surprisingly.
8:30	Iced frappucino. (small)	office			Nice but I feel guilty about the calories
11:30	Yogurt (strawberry)	office			weird afraid people would notice me eating
2pm	Caesar salad mineral water	Prezzi			planned for this - work lunch.
6pm	1 glass wine				didn't need this. Wanted it.
7pm	cous cous w/ roasted veg 1 glass wine	home			Jane over - could not binge

No binge!

Monitoring page week seven

Day ~~Weds~~ Tues Date 26th April

Time	Food and drink consumed	Place	*	v/l	Context and comments
7:15	yogurt banana coffee w/milk	kitchen			
10:20	Coffee w/ milk	office			
1pm	tuna sandwich 2 slices granary bread cucumber + tomato flora spread	office	?		Feel full but won't throw up. 5:30pm Upset after phone call with mum Don't know what to do
8:20	Box of chocolate brownies - 8 Ben + Jerry's Cherry Garcia Whole tub		✱	✓	I can't believe I did this. Horrible

Slowing down, observing and analysing mood changes

Real Time Slowing Down, Observing and Analyzing Mood Changes

As soon as you identify there might be an event or mood that could trigger an unhealthy change in your eating, remove yourself from the situation and write about the following:

What has happened____

How you are judging what has happened____________________________

What you are feeling now____________________________________

How you are judging this feeling ________________________________

Adapted from Fairburn, C.G. (2008), *Cognitive Behavior Therapy and Eating Disorders,* Guilford, p.144.

Pie chart of self-evaluation

The Pie Chart of Self-Evaluation

Client name____________________________ Date______________________

All of us have a system for judging ourselves. If we are meeting our personal standards in areas of our life that we value, we feel reasonably good about ourselves, but if we are not, we feel badly. Typically we judge ourselves according to things such as relationships and roles, work, school, money, pastimes, appearance and more.

Please first consider and list the areas of your life that are important to you.

____

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____

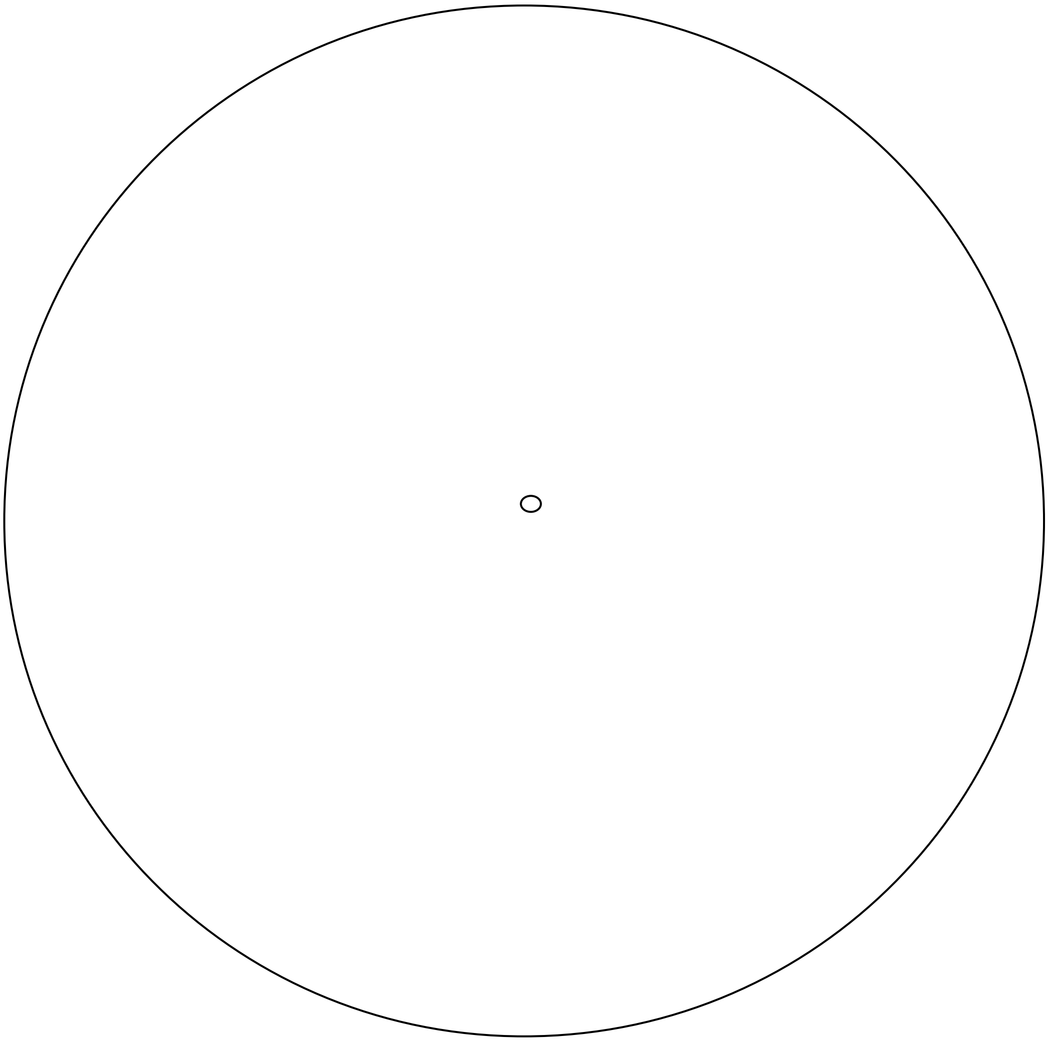
____

____

____

Now choose from this list the areas that have a definite impact on how you judge yourself:

A good way of representing the relative value to you of these areas of your life is to draw a pie chart. Base the size of the slices on how badly you feel when things are not going as well as you hope in that area.



Adapted from Fairburn, C.G. (2008) *Cognitive Behavior Therapy and Eating Disorders*. Guilford. PP. 97-98

Instructions for monitoring body-checking

Please record "in real time" each occasion when you check your body over two whole days. One day will be when you are home, the other when you are out at school, work or elsewhere. The list of possible ways you might check includes (but is not limited to):

- Looking in the mirror
- Looking in reflective surfaces
- Touching body parts
- Looking at body parts
- Measuring body parts with your hand or a tape
- Pinching body parts
- Assessing the tightness of your clothes or accessories
- Checking your muscles
- Comparing your body (or a part of your body) to others, including photos, ads, t.v. actors, celebrities etc

On the monitoring sheets, include a specific description of when and how you checked your body, and how long you spent on it. Also include the thoughts and feelings that occurred during and after checking.

Time of day	Body checking: What was done, time taken	Thoughts and feelings during and after checking

Body checking page

Monday 2nd May

Time of day	Body checking: What was done, time taken	Thoughts and feelings during and after checking
6:50	Shower - looking down at belly to see how much it sticks out - 2 seconds	It's definitly BIGGER I'm a fat cow It has wiggly bits on the side that were not there before.
7:20	Putting on makeup - 15 minutes	
7:40	Get dressed - try on 4 different combinations before settling on one check how big my bum looks in these trousers - ugh.	What is wrong with me? I'm going to be late for work if I don't stop this nonsense
8:50	Walking past shop window - check how fat my ankles look in these sandals	Okay at least my ankles are not too fat - but they are bigger than they used to be :(
9:15	Sat at desk - can feel my belly sticking out over the top of my trousers - check to see how far and how obvious	Yuck! Spare tyre Everyone can notice - self conscious
9:18	Kelly looks great maybe she looks slimmer. Is she thinner than me? Her arms are more toned than mine	I look frumpy compared to Kelly

Topics to cover in assessment

Table 5.1 from Fairburn CG, *Cognitive Behavior Therapy and Eating Disorders*, Guilford Press, New York, 2008.

Topics to cover when assessing the eating problem.

Current state of the eating problem (over the past four weeks and three months)

- Patient's account of the problem and what he/she would like to change
- Eating habits on a typical day (and, if applicable, a "good" and "bad" day)
- Dieting
- Dietary restraint (nature of attempts to restrict food intake): dietary rules; reaction to any breaking of these rules; calorie counting; calorie limits; delayed eating (i.e., postponing eating for as long as possible)
- Dietary restriction (actual under-eating)
- Other weight-control behavior (e.g., self-induced vomiting, laxative or diuretic misuse, over-exercising): frequency; relationship to perceived overeating
- Episodes of overeating (amount eaten and the context; whether or not there was a sense of loss of control at the time): frequency; triggers
- Other eating habits (picking, chewing and spitting, rumination, ritualistic eating)
- Drinking and smoking habits (consumption of water, coffee, tea, carbonated drinks and alcoholic beverages, and smoking habits - and their connection (if any) to the eating problem)
- Social eating: ability to eat with others; eating out
- Concerns about shape and weight
- Views on shape and weight
- Importance of shape and weight in self-evaluation
- Body checking (weighing, mirror use, other forms of checking); body avoidance
- Comparisons with others
- Feeling fat
- Impact of the eating problem on psychological and social functioning
- Effects on mood and concentration
- Effects on work
- Effects on other people (partner, family, friends, acquaintances)
- Effects on activities and interests
- Other effects

Development of the eating problem

- Details of onset and likely triggers
- Subsequent sequence of events (when the key forms of behavior started in relation to each other): evolution of the problem - first six months; subsequently
- Weight history (before and since the eating problem started; true childhood obesity): lowest weight since present height; highest weight since present height

- Prior treatment (for an eating or weight problem): treatment-seeking; treatments offered; treatment experience and attitude to treatment; compliance with treatments and response to them

Personal and family history
- Where born and brought up
- Family during childhood (parents, siblings, atmosphere, disruptions and/or problems) and contact at present
- School, college and occupational history
- Interpersonal history - childhood/adolescent/adult interpersonal functioning
- Family psychiatric history (especially depression and alcohol abuse)
- Family eating disorder and obesity history
- Adverse events (including physical and sexual abuse, bereavements, accidents, bullying and teasing)
- Personal psychiatric history (especially anxiety disorders, depression, perfectionism, low self-esteem, self-harm, substance misuse): onset in relation to the onset of the eating problem; interactions

Current circumstances and functioning
- Living arrangements
- Occupation
- Marital status, children
- Contact with family
- Interpersonal functioning (partner, family, confidantes, friends, gregariousness)
- Past interpersonal functioning (and since eating problem developed)
- Interests and aptitudes
- Past interests and aptitudes (and since the eating disorder developed)

Co-existing psychopathology
- Current psychiatric comorbidity (depression, anxiety disorders, substance misuse, self-harm, suicidal behavior, other)
- Current psychiatric treatment (psychological, pharmacological)

Physical health
- Current physical health (including menstruation)
- General medical history (including timing of puberty in relation to the eating problem)
- Current medication including the contraceptive pill

Attitude to the eating problem and its treatment
- Views on what is keeping the eating problem going
- Attitude to starting treatment
- Concerns about treatment and the prospect of change
- Goals

Anything else?
"Is there anything else that you would like to tell me, or anything else you think I should know?"

Medical risk in eating disorders

Clients with anorexia and bulimia symptoms may run the risk of medical instability for the following reasons:

- Frequent vomiting (e.g. once daily or more) or regular vomiting over prolonged period of time (e.g. 6 months or more)
- Laxative abuse (e.g. taking more than the recommended dose)
- BMI below 17.5 (you must weigh underweight clients and calculate BMI)
- Excessive exercise (e.g. over 2 hours aerobic or weights per day)
- Rapid weight loss over past 4 weeks (e.g. more than 1lb/0.5 kg per week)
- Diet of less than 800 kcals per day over past 4 weeks
- Dehydration

If you have any concerns that your client might be running the risk of medical instability it is imperative that you communicate your concern verbally to the client and in a letter or telephone conversation with client's GP. The client should be aware of the communication. Ask the GP to monitor the client's health. Ask the client to go see the GP in order to do this. Please follow-up with your client to find out what has happened at the GP surgery regarding monitoring his/her health. Document all steps taken.

Sometimes a surgery will ask, "what do you want us to test?" The following tests are recommended:

Full Blood Count (FBCs)

Liver function tests (LFTs)

Albumin

Urea, Creatinine and electrolytes

Thyroid functioning

Glucose levels

Cardiac function

Blood Pressure

For more guidance see Treasure, J. (2009). A guide to the medical risk assessment of eating disorders. Kings College London Institute of Psychiatry. Available at: http://www.kcl.ac.uk/ioppn/depts/pm/research/eatingdisorders/resources/GUIDETOMEDICALRISKASSESSMENT.pdf

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Notes