

# *No Pussyfooting: CBT for Eating Disorders*



*Where change is possible*

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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

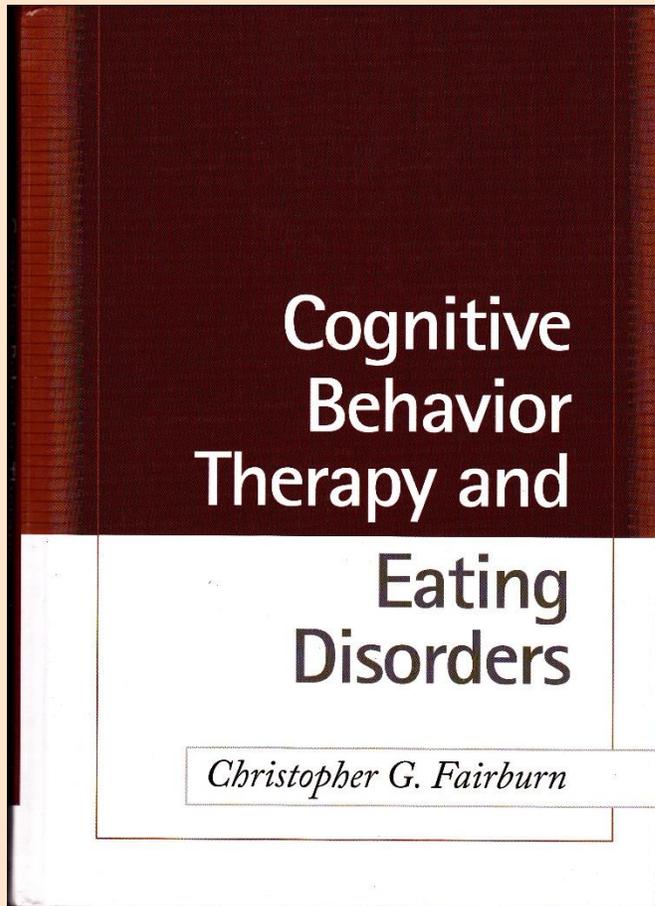
Initial Assessment

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			

	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	



Parsimony

# Stages and core elements

## Stage One: Starting Well

**10 sessions, 2x week**

- Assessment
- Engagement
- **Formulation**
- **Regular eating**
- **In-session weighing**
- Involving significant others

## Stage Two: Review

**2 sessions, weekly**

- 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

**Stage Four: Ending well**

**3 sessions fortnightly**

- Future planning
- Maintaining helpful changes
- Understanding and minimising risks of relapse
- Maintenance plan

## Helpful factors:

Resilience narratives

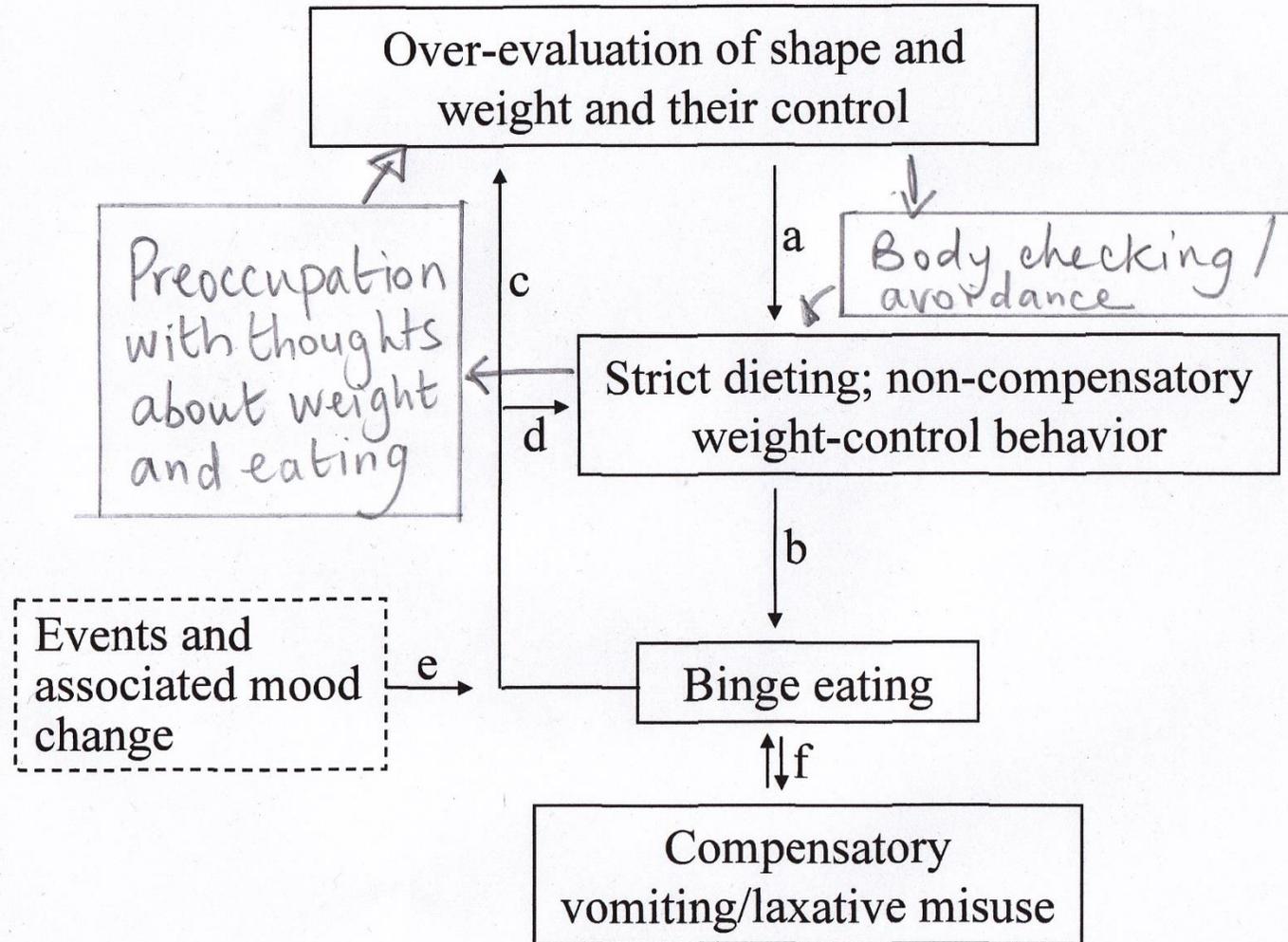
Supportive friends and family

Success in other areas of life

Reasons to recover:  
e.g. work, parenthood

Faith/hope

Altruism



## 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?

- 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).*

# References

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