A Word from the Editor

Creating evidence based guidelines for the treatment of eating disorders may have been the easy part. Dissemination and widespread acceptance of the research based guidelines seem more elusive. How can clinicians adapt and modify their protocols to provide effective, and efficient, treatment to an increasingly complex range of patients with complex clinical symptoms?

Summer 2012 Perspectives addresses the issue of research and treatment manuals. It also includes updates on group therapy, the unique needs of special populations, and assessment tools for monitoring treatment progress. We hope these articles are thought-provoking.

Doug Bunnell, Ph.D.
editor

COGNITIVE-BEHAVIORAL THERAPY FOR THE EATING DISORDERS:
Some principles to help guide us in delivering evidence-based practice

GLEN WALLER, DPHIL, FAED

I have worked with the eating disorders since 1988. My initial training was very much in the radical behaviorist tradition, but I soon decided that my own style was more of a cognitive-behavioral one. At the time, this was almost rebellious, as my boss was very definite that cognitive work was a passing fad and not to be pursued – how many people these days can say that choosing to be a cognitive-behavioral therapist makes them a rebel?

Now, of course, there is a bit of idiocy here. Simply deciding to be a cognitive behavior therapist does not actually make one a cognitive behavior therapist. Labels are no substitute for the real thing – a theme that I shall be returning to…
Over the past quarter of a century, I have been through different patterns of clinical practice and thought. First, I think I was really more of a behavior therapist who called his work CBT. That did not really work very well, so I took up more of a schema-focused, cognitive approach. While that was more challenging intellectually, it did not really work very well. Throughout, I would read material about evidence-based CBT for the eating disorders, and conclude that the patients in the treatment trials were a weirdly easy bunch to work with. Certainly, they could not be as complex as the cases I worked with every day. However, I tend to get a nagging voice in my head when I try to ignore the really, really obvious. So I tried thinking about whether I could get better at what I did. I hooked up with a wonderful supervisor (she knows who she is), started reading what the manuals said, felt like a fool, and started doing more of what the books said. In short, I stopped hiding behind the label of CBT and started doing CBT with my patients. And it worked much better. Even with the complex cases. Just like the books said.

To this day, I retain a strong sense of embarrassment about just how awful a therapist I was back then. I had the opportunity to apologize to a former patient a little while ago. She was very gracious about it. I have decided that the best way of avoiding (or reducing) such embarrassment is to do as good a job as I can, so that I do not end up with too much to apologize for. And to make sure that others do as good a job as they can.

**Who can I upset first…?**

Therein lies an issue – trying to get others to do the best that they can for our patient group. I am aware that a lot of people will not read this article, seeing it as irrelevant to their practice in the eating disorders. I am also pretty certain that others will actively reject what I have to say, snorting at the nonsense that I have come out with.

Many do and will reject the scientist-practitioner model, seeing it as cramping their desire for artistic or intellectual stimulation. I did that myself early in my career, as I have outlined above. While I am aware that I might be expected to name and shame specific therapies here, to do that would simply be silly. I can get far more widely irate than that. Such rejection is not found only among those who practice more psychodynamic treatments, but also among all those who hide behind stances and labels. While that does encompass a lot (not all) of psychodynamic approaches, it also includes those who call themselves cognitive-behavioral therapists while doing nothing that looks like CBT. To sacrifice evidence-based practice for our own intellectual, artistic and emotional satisfaction seems unacceptable to me.

That rejection can be even more powerful when there is a culture that is self-perpetuating, and which resists the implementation of more evidence-based approaches. As a Briton, I am used to the concept of ‘heroic failure,’ but I stand in awe of the experience detailed by Lowe, Bunnell, Neeren, Chernyak & Greberman (2011), who tried to bring some elements of CBT into a much more eclectic therapeutic setting.

My awe is a consequence of knowing just how typical that pattern of institutional resistance is – most of us would be too scared to try what Lowe and colleagues did.

In short, a lot of clinicians express the opinion that using CBT (and evidence-based methods in general) would make them focus on technique and specific benefits for the patient, suppressing their natural inclination to be more of an artist in delivering therapy that has ill-defined (or intangible) benefits.

One even hears: “We cannot measure outcomes, because for our patients to get better means that they have to get worse during treatment.” There comes a point where we have to face the danger that hiding behind an anti-scientific stance is to sacrifice any desire to help patients to get better.

**Delivery of evidence-based CBT for the eating disorders**

All of which brings me to the point of this paper. … just what is needed to be a good cognitive-behavior therapist? What are the principles that I would emphasise, based on my own history of ineptitude? Though many describe CBT as a ‘simplistic’ approach, Wilson (2012) has described CBT as “a complex therapy, with lots of moving parts,” which I think is very apt.

Fairburn (Fairburn & Dalle Grave, 2011) has pointed out that CBT is not one method, but a “family” of methods, only some of which have any evidence base. I am going to focus on evidence-based approaches to CBT for the eating disorders, which do have a lot of moving parts and which require a lot of skill to implement them to best effect.

However, a word of warning. In these days of CBT-E (Fairburn, 2008), I have reached the conclusion that there are many clinicians who practice CBT-H, where the H stands for ‘homeopathy’ – take a remedy, water it down, succeed it, water it down again, until you get to a level where there is effectively none of the active ingredient left, and then expect it to work. Clinicians routinely report ‘watering down’ their use of evidence-based treatments into part of a more ‘ eclectic’ mix, on the basis of their clinical judgement (e.g., Tobin, Banker, Weisberg & Bowers, 2007; Wallace & von Ranson, 2012). In short, remove the hard parts from CBT and it gets easier to do but less effective. We can do better than placebo effects, but...
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Evidence-based CBT is hard work for clinician and patient alike.

Just as problematic, there are clinicians who start off using evidence-based CBT (and those who use other therapies), but who drift off into doing something that is not evidence-based CBT (Waller, 2009). Sometimes that drift appears to be so inexplicable and uncharted that it reminds me of the Marie Celeste – found in the middle of the ocean, with no explanation for how it got there, no crew, and no idea of what had happened to them.

**Principles underlying evidence-based CBT for the eating disorders**

So, here are some principles that I have found to be useful – how to take the basic practice of CBT for the eating disorders and make it work for the patient’s benefit. Most of these principles have been developed through a long process of learning with my patients, my peers, my supervisors, and my supervisees, to all of whom I owe both lots of gratitude (and some heartfelt apologies). Most of these principles are based on my work with adult outpatients, and I leave it to those who work with younger cases and in more intensive settings to determine how to translate them to those groups.

**Principle 1:** **Attend to the evidence base**

The evidence base has gaps, but that is no reason for not knowing about it or using it. There are plentiful reviews, which reach broadly similar conclusions (e.g., Bulik et al., 2007; National Institute for Clinical Excellence, 2004; Shapiro et al., 2007), and there is good evidence that this approach works outside research settings (Ghaderi, 2006). Just because something does not work for everyone (and CBT does not work for everyone), we should not ignore CBT in favour of other therapies where trying CBT would be the most appropriate option. The evidence for treatment matching in adult cases is pretty negligible. Similarly, we should not over-simplify, and assume that we can stop enquiring and developing where there is a treatment that works for some or even most patients. An understanding of the complexities of the eating disorders explains why we need to be able to adapt the therapy to the individual case (Strober & Johnson, 2012).

**Principle 2:** **Read and use the manuals**

There are lots of manuals to guide CBT for the eating disorders (e.g., Fairburn, 2008; Gowers & Green, 2009; Waller, Cordery, Corstorphine, Hinrichsen, Lawson, Mountford & Russell, 2007). Clinicians who use those manuals are more likely to deliver the relevant elements of CBT (Waller, Stringer & Meyer, 2012). This sounds obvious. However, a scarly small number of clinicians use manuals when working with the eating disorders, whatever the therapy that is being delivered (e.g., Tobin et al., 2007; Wallace & von Ranson, in press; Waller, Stringer & Meyer, 2012). Clinical judgement should be combined with the use of manuals, rather than being used to supplant them.

**Principle 3:** **Do the basics**

At heart, CBT is more of a ‘doing therapy’ than a ‘talking therapy.’ The effective elements include helping the patient to eat appropriately, monitoring intake, weighing the patient, using exposure, behavioral experiments, etc. Yet only a minority of CBT clinicians report using these methods on a regular basis (Waller, Stringer & Meyer, 2012). So is everyone focusing on cognitive restructuring? Again, this seems to be a minority activity among clinicians (Waller, Stringer & Meyer, 2012). I often find myself facing the question of what is it that goes on under the label of ‘CBT.’ Then I assess a patient who has been treated using ‘CBT’ several times before, and I ask about what happened in the therapy, and I am none the wiser. Being blunt, it seems to me that the best way of avoiding embarrassment about what we do is to give the patient the most effective therapy possible, so that they never need to go on to a further therapist and demonstrate that they had an incomprehensible treatment before. Do the basics.

**Principle 4:** **Understand the link between the therapeutic alliance and treatment outcome**

While there is a lot of opinion about the importance of the therapeutic alliance in driving positive outcomes, the evidence is relatively weak, especially where the treatment is a relatively structured one (Crits-Christoph, Baranackie, Kurcius, Beck, Carroll, Perry, Luborsky, McLeLlan, Woody, Thompson, Gallagher & Zitrin, 1991). Indeed, in some areas of psychopathology, the evidence is that the link is the other way round. The best predictor of a good therapeutic alliance is a positive change in behaviors and symptoms as treatment progresses (Webb, DeRubeis, Amsterdam, Shelton & Hollon, 2011). Whatever the direction of causality, patients undertaking evidence-based CBT for the eating disorders report a good working alliance with their clinicians early in treatment (Waller, Evans & Stringer, 2012). Always bear in mind the notion of the therapeutic relationship in CBT requiring a “judicious blend of empathy and firmness” (Wilson, Fairburn & Agras, 1997).

**Principle 5:** **Tolerate uncertainty**

I have often reflected that the best CBT clinicians are those who are not afraid to try change, wait for long enough to find if it works, and then plan the next step. In other words, they tolerate uncertainty. If you need to know the answer now, then being a cognitive-behavioral therapist is probably not a good career choice. After all, you have to be calm while the patient does all the worrying – and CBT will not work unless the patient experiences anxiety about change (e.g., eating more, facing body image). Another term for this is “Be boring.” Embrace your boring side, because the patient needs you not to be anxious. When the patient’s weight changes between meetings, stick to your guns and do not get excited, because the patient needs to know that you meant it when you said “This is going to take several weeks…” Remember that anxious CBT clinicians are more likely to be those who avoid using core CBT techniques (Waller, Stringer & Meyer, 2012).
Principle 6: Treat motivational enhancement as an ongoing process

There is (at best) minimal evidence that pre-treatment motivational work is effective in enhancing therapy outcomes (Waller, 2012), and yet over half of CBT clinicians report using this approach (Waller, Stringer & Meyer, 2012). Motivational work can be really valuable, but not when one treats it as a precursor to therapy. CBT clinicians need to avoid being part of the problem, and should not delay starting therapy until the motivational work has worn its (presumed) magic. Early behavioral change (and positive feedback from the clinician and the world) is much more likely to encourage further improvement (see below) and a positive therapeutic alliance (see above).

Principle 7: Review progress (or the lack of it)

CBT is not a ballistic approach to therapy. We cannot simply start it, and then assume that it will continue on its planned course. We need to respond to positive change by being reinforcing (many patients have never before had a successful dose of therapy, and need to learn that success is down to their own efforts). We need to respond to stuckness by being clear about it, and helping the patient to identify ways around it. There is evidence that early behavioral change is a key determinant of later progress in different therapies for the eating disorders (e.g., Agras, Crow, Halmi, Mitchell, Wilson & Kraemer, 2000; Doyle, Le Grange, Loeb, Doyle & Crosby, 2010; Wilson, Loeb, Walsh, Labouvie, Petkova, Liu & Waternaux, 1999), so be firm about the need to change from very early on – give the patient a choice about having the best chance to get well. It is possible that such a review will result in deciding to change therapeutic direction – that is fine, as long as the patient had the best chance of recovery in the first place. In short, if you have been delivering CBT-H, then all that says is ‘try an evidence-based form of CBT.’

Principle 8: Get out of the rut

Even if practiced in the most appropriate way possible, CBT for the eating disorders is not perfect by any means. So we should always be aiming to improve what we deliver by keeping up to date. However, we also need to get ahead of the game. I commonly find that attending general CBT conferences, reading more widely in the field of CBT, and plundering ideas from colleagues who know nothing of the eating disorders means that I find new ideas (well, new to the eating disorders, anyway), which can be invaluable in working with my patient group.

CONCLUSIONS

Earlier, I mentioned the anticipated reactions of different people on reading this article. I missed out one very important group. Some people did not need to read this article – it will have told them nothing new and will not have added one little bit to their practice, because they are already doing all this. Ironically, those are the people who are most likely to have read this far, in case there was something new that they needed to learn. Sorry to disappoint you, but delighted to meet you. I just wish there were more of you.

There are many wonderful clinicians in this field. There are some great treatment approaches – not just CBT. However, most clinicians do not use them, making all the mistakes that I made myself back in those first few years. Within CBT, there is an evidence-practice gap – many CBT clinicians miss the point of what they need to do and why, resulting in scary failures to deliver empirically-supported treatments. The manuals are easy to obtain and can guide us towards better practice (Waller, Stringer & Meyer, 2012), but are not as widely used as they should be (Tobin et al., 2007). This pattern of manual use is not random (Wallace & Von Ranson, in press), meaning that there are clear opportunities for improving uptake. However, simply having the tools is not enough. We need to be able to reflect on why we do what we do when we do it. The aim of this review has been to address that need in just one area of treatment for the eating disorders – identifying therapeutic principles that can help us to keep CBT on target, rather than drifting as cognitive-behavioral therapists. I hope that there have also been ideas that will prove useful to those using other therapies as well. What I would most like to see would be for all clinicians to have a set of principles underlying their use of the best possible practice for their patients, regardless of the therapy concerned. However, that requires us all to be focused on being scientist-practitioners rather than artists.

Speaking of artists, there is a line at the end of the Beatles’ ‘Let It Be’ film where one of the Moptops concludes by saying ‘I’d like to say thank you on behalf of the group and ourselves and I hope we’ve passed the audition,’ I have this horrible idea that I might get to the end of my career and feel that I have failed the audition, but I hope the many clinicians who are better than me will be pushing the envelope of evidence-based practice, and that the principles outlined here will help.

REFERENCES


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In athletics and many forms of competition, “winning” is the dominant culture, where norms supported by every participant, from competitor to spectator, can share in the same ultimate goal—to achieve victory. Whether that competitor is a runner, swimmer, football player, or bodybuilder, it is common to adopt a culture of winning. For individuals competing in these sports, attributes like coordination, speed, and focus are essential to being the best, but in some cases, the sport relies heavily upon an individual’s strength and physique. Sports such as swimming, diving, and wrestling place a larger emphasis on maintaining a specific body type—one that may not be easily attainable through “normal” patterns of eating and exercise. As a result, certain athletes have felt pressure to “make weight” or “slim down” in order to improve their performance at their sport of choice and ultimately align body type with the winning culture.

In instances like this, unfortunately, many athletes will adopt disordered patterns of eating and rigorous exercise patterns, putting them in great danger of developing an eating disorder.

Some research studies have suggested a higher prevalence of eating disorders in athletes versus the general population (Greenleaf, Petrie, Carter & Reel, 2009; Sundgot-Borgen & Tørstveit, 2004). Many of these individuals who are in fact suffering from eating disorders are viewed as determined, disciplined, and dedicated to their sport training, but these may be just masking a pattern of pathological behaviors. Population based studies of eating disorders suggest that less than 1 percent of women meet criteria for anorexia nervosa. One to 2 percent meet criteria for bulimia nervosa and between 3-5 percent meet criteria for eating disorder not otherwise specified (EDNOS; meaning that an individual meets most, but not all of the criteria for anorexia or bulimia). The same study found that the prevalence for an eating disorder in men was between .5 and 2 percent (Hudson, Hiripi, Pope & Kessler, 2007).

In athletes, Sundgot-Borgen and Tørstveit (2004) found 13.5 percent of athletes had an eating disorder diagnosis compared to 4.6 percent in controls.

Although the causes of eating disorders are complex, inferring a direct link between athletics and the etiology of an eating disorder would be impossible. The athletic environment provides a unique context for the expression of eating pathology. Although thin ideal internalization is a robust risk factor for eating disorder pathology (Stice & Shaw, 2002), the athletic context can alter this ideal to reflect a lean but muscular physique. Thus, the sociocultural pressures embedded in many athletic contexts is likely to reflect the idealized body type for that individual sport and may actually insulate against the broader sociocultural norms of thinness and beauty.

Peer pressures in athletic environments are also unique because violation of group norms can carry the added weight of team, coach, or school achievement. When teams or individuals adopt norms that involve extreme dieting, weight control, or fitness standards, vulnerable individuals will find it harder to choose to express these norms in a healthy way. Some of the psychological vulnerabilities to eating disorders may also conform to these peer supported cultural norms. Athletes with traits such as perfectionism, goal directedness, and willingness to tolerate pain, or withhold reward, to achieve victory are often idealized in athletic environments. These same traits affect many with eating disorder pathology.

In athletes, the body type requirements impose certain restrictions that can affect the person’s eating behavior. Research has found that individuals participating in leanness-dependent and weight-dependent sports (i.e., gymnastics or wrestling) have a higher rate of eating disorder pathology compared to those who participate in sports that do not impose weight restrictions (Sundgot-Borgen & Tørstveit, 2004). Further, this drive for thinness is expressed very differently in women and men. For women, the drive for thinness derives from both societal pressure as well as that for their sport. Female athletes tend to report more eating and body shape concerns above and beyond the degree to which it would affect sport or athletic performance. This drive is behaviorally manifested in greater levels of dietary restraint and increased intensity and frequency of exercise. For men, this same drive is more sport and performance specific, but also has deep roots in societal pressure to comply with masculine ideals for physique and strength (Hildebrandt, Shiovitz, Alfano, & Greif, 2008).

Men generally show fewer problematic eating patterns compared to women, but are significantly more likely to use substances to alter their body (Hildebrandt, Langenbucher, Lai, Loeb, & Hollander, 2011). These substances range from over-the-counter substances such as protein supplements to illegal substances such as prohormones, growth hormone, and anabolic steroids. Consistent with this expression of shape and weight control, men are more likely to express a drive for masculinity or bulk, or in many cases an extreme ideal of leanness and muscularity.

**Female Athletes and Eating Disorders**

The Female Athlete Triad is a term used to describe the triangular effect eating disorders have on the female body. The phenomenon is comprised of a series of repercussions from eating disordered behaviors such as low energy due to lack of food consumption, amenorrhea or the loss of menstruation, and low bone density known as osteoporosis (Nattiv et al., 2007). Other chronic and serious effects of eating disorder behaviors (i.e., restrictive...
dieting and/or purging) include nutrient deficiencies, fatigue, frequent infection and illness, iron deficiency, frequent injuries, dehydration, and electrolyte abnormalities. Although seen across all athletes with eating disorders, these effects are most often observed among females participating in sports that emphasize leanness. In the case of female athletes, such complications can result in even more hazardous medical outcomes, as the intense exercise schedule that they impose upon themselves leaves them at increased risk for many poor health outcomes (Deimel & Dunlap, 2012).

As a consequence of their poor nutritional status and overtraining, these female athletes may, in fact, be worsening their athletic performance despite any temporary improvement that occurs from weight loss or fitness changes. The initial improvement often leads to an overinvestment in the association between shape or weight control and athletic performance which may be hard to break if the athlete has achieved any success. Perhaps unique to eating disordered athletes, injuries and poor performance outcomes that result from continued disturbances in eating and weight may not be enough to motivate them to begin healthy eating.

MALE ATHLETES AND EATING DISORDERS

Female athletes are not the only ones to feel the athletic subculture’s pressure to look a certain way to achieve success at sports or athletic trainings. Men also feel that pressure, though sometimes in a very different way. Just as there is a societal “thin ideal” for women, the “muscular ideal” for men has become more apparent (Cafri et al., 2005). In athletic environments, men typically feel the need to attain the lean muscular physique. There is a different ideal in other areas of athletics that can be conflated with the “alpha male” persona or masculine ideal. This persona embodies an aggressive, fearless, and ruthless ideal that drives the athletic culture of winning. These are the same character traits that may predispose men to use appearance or performance enhancing drugs (APEDs) (Irving, Wall, Neumark-Sztainer, & Story, 2002) and which are highly valued in male athletic environments. The medical risks for APED use are in many ways more diverse than those associated with disordered eating and depend largely on the specific substances. Perhaps the most acutely dangerous of these effects originate from the cardiac stress caused by the mixture of heavy weight training, potent stimulants, and anabolic agents that can increase heart size or alter functional markers of cardiac performance (Langenbucher, Hildebrandt, & Carr, 2008).

Gateway Theory To APED Use

The theory known as the ‘gateway hypothesis’ describes a paradigm of drug use which positions the gateway substance as an initial step in the developmental process of more severe drug use. Drug use is started during adolescence and typically progresses from legal substances such as alcohol or cigarettes use to illegal drugs such as marijuana or cocaine. The gateway theory suggest that this initial use (a) often co-occurs with the use of a more dangerous substance; (b) leads to an increased likelihood of future drugs; and, (c) through a range of social or biological mechanisms causes, some individuals to use the more severe drug. Consistent with this theory, the use of serious illicit drugs such as cocaine or heroin rarely occurs without prior experimentation with other illicit and licit substances.

APED use by athletes often has this same progression. Traditionally, many individuals turn to nutritional supplements to increase their capabilities when beginning their athletic career. As a result, it can be hypothesized that nutritional supplements may act as a gateway to anabolic steroid use or other illicit APEDs. There is some evidence to support this progression among college age men and women (Hildebrandt, Harty, & Langenbucher, In press) and implicates a social mechanism whereby supplement use offers social access to individuals who use illicit APEDs. Vulnerable athletes are drawn to supplements as a way to gain a competitive edge and can be seduced by extreme promises of the supplement advertisements or cultural lore, much in the same way that women are seduced by the promises of dietary control. Use of these fitness or nutritional supplements can provide the initial “gateway” to the experience of using more potentate substances (i.e. steroids) to alter appearance. Although social exposure provides one type of contaminant, legal supplements may also provide direct exposure to a range of illicit APEDs. Because supplements are unregulated by the Federal Food and Drug Administration (FDA), the manufacturing practices can become vulnerable to contaminants including illicit APEDs.

Complicating the identification of APED use among athletes is the diversity of body image ideals adopted by athletic subcultures. For instance, the idealized marathon runner will have a very different body than that of the idealized powerlifter. This variation in bodily ideal is well documented among men (Hildebrandt, Alfano, & Langenbucher, 2010), but brings with it a corresponding diversity of substances needed to achieve these ideals. APEDs can include substances used to alter one’s outward appearance or improve physical performance. The polypharmacy that APED users engage in often involves substances from multiple drug classes including supplements, thyroid hormones, beta–agonists, synthetic androgens, aromatase inhibitors, pain killers, and others. With an ever evolving drug marketplace, detection methods are unlikely to ever be fully successful. Furthermore, the knowledge and sophistication of the APED–using community allows interested users to gather information quickly and effectively. Many existing materials such as ‘steroid bibles’ and online forums or web-pages provide interested users with information about what substances to use when and how to manage side effects. The general theme is that these substances are safe and effective, but also must be used appropriately to yield necessary results. It is within many of these communities that the social norms around APEDs originate and in which their use by athletes is adopted and reinforced.

APED Warning Signs and Testing

Many athletes take steroids via injections, transdermal patches, or orally. This, in combination with extensive exercise and weight lifting, enables athletes to develop muscle tissue at a rapid pace, far beyond natural means.
The primary obvious sign of steroid use among athletes involves a drastic increase in overall muscle bulk or bloating. Less obvious psychological signs include a tendency towards increased aggression, impulsivity, irritability, restlessness, trouble breathing, and feelings of grandiosity or imperviousness (to a level approaching mania). Individuals using steroids may also experience more physical symptoms such as an elevated sex drive and increased acne in the back or chest area. As a result, a paradox appears within the athletic community as the reasons that bring athletes to use steroids (i.e., health benefits, appearance, increased athletic ability), also lead to potential health risks, particularly with long-term or problematic use. These prolonged patterns of steroid use in conjunction with disordered patterns of eating exacerbate potential negative side–effects including exaggerated hormonal imbalances, heart arrhythmias, and liver problems. However, these and many of the side effects associated with steroid use have suffered from a poor clinical literature base and absence of well designed research. Nevertheless, these concerns seem to be secondary to the athletes who seek a quick fix for their perceived athletic or muscular insufficiencies.

Among sanctioned organized sports and athletics, most forms of illicit APED use is prohibited, and drug testing for APEDs is an expensive and complex undertaking. The most common procedures to test for whether or not an individual may be using APEDs are through a blood draw, or through hair and urine collection. The most basic analyses include testing for free testosterone or and testosterone/epitestosterone (T/E) ratio. More sophisticated methods are available for identifying specific substances, but there is no test that is impervious to errors. The side effect, however, of the increased focus on testing is the further effort to conceal and deny APED use which can result in APED users not seeking help when his or her use becomes problematic. This avoidance of help seeking is likely to be even greater among APED users with other significant eating pathology because of additional stigma or ambivalence about the disease.

Eating Disorder Prevention and Intervention Among Athletes

The prevention and intervention programs for athletes are best delivered through a system that supports early detection, recovery, and careful reintegration of the eating disordered or APED-using athlete back into its or her athletic career. Recommendations typically include the use of a sports management team comprised of health professionals who are not governed by the athletic system, and who are able to make decisions about psychiatric or physical health in a way that serves the individual over the sport. Unfortunately, these types of systems are rare and/or costly, leading to reliance on existing professionals such as athletic trainers or sport medicine doctors, to identify and often treat affected individuals. In high school athletes, the Athletes Training & Learning to Avoid Steroids (ATLAS) and Athletes Targeting Healthy Exercise & Nutrition Alternatives (ATHENA) award-winning programs target risk factors for eating disorders and APED use through peer engagement and have proven effective in large scale research trials (Goldberg et al., 1996). The same types of programs are still absent for collegiate athletes and no empirically supported programs exist for community based athletics.

Future Thoughts and Considerations

Although there is better recognition of the special needs of eating disordered athletes now than there may have been 10 years ago, there are few, if any, interventions available for APED-users. Although many of the same clinical features are present in both APED users and eating disordered athletes, we have failed to develop specific interventions for this population. The masculine ideal that pervades many athletic contexts is often incompatible with existing treatment models that tries to prevent them from maintaining or reaching this idealized goal. For instance, the masculine norms suggest that men are not to receive help and more masculine men are less likely to need help. Furthermore, the idealized masculine male does not feel weak or need to cheat to achieve his goals. These masculine norms are quite inconsistent with the model of one–on–one therapy centered on emotional expression. However, this forces health professionals with appropriate knowledge or skills to find creative ways to access this population. One potential method is through the use of mental skills or performance based coaching. Sport psychologists, nutritionists, or similar professionals are uniquely positioned to access this population because of the ability to be engaged as just another coach. Unless athletic cultures change, it is likely that this type of position will be essential to the sporting environment to help individuals suffering from eating disorders or APED use.

In summary, eating disorder specialists are well positioned to aid in the identification and treatment of athletes with eating disorders. The role of the specialist, however, may involve participating in screening assessments within an athletic department or as a consultant working with a team or athlete for reasons quite different than eating pathology. Furthermore, the trained specialist should be aware of the sporting culture that may share many extreme norms and behaviors often found among those with an eating disorder. For these reasons, treatment is often better delivered in treatment contexts outside the influence of athletic administration. The unique problem of APED use suffers from the culture of drug testing and being further embedded in masculine ideals that are inconsistent with seeking help for mental or physical health problems. Professionals are encouraged to engage these potential patients in creative ways such as through the role of performance coach or mental skills coach. This type of role may allow for greater access to this vulnerable population.

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**Cognitive Behavioral Therapy-Enhanced: A Tailored Treatment Model for College Women Experiencing EDNOS**

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There is a high prevalence of maladaptive eating practices, weight concerns, and actual eating disorders in college women, with between 25-40 percent of college women experiencing problems that include extreme worries about body image, excessive weight management strategies, and perceived out of control eating episodes (Bishop, Bauer, & Baker, 1998; Schwartz, Rodriguez, Thomas, & Salimi, 2001). While eating-related concerns are also increasingly present in college men, women remain disproportionately affected by these problems (Hudson, Hiripi, Pope, & Kessler, 2007). For the purposes of this article, therefore, only college women’s treatment needs are addressed.

The statistics noting a high prevalence of eating-related problems in the college population are not surprising given current cultural standards regarding the importance of thinness and beauty for young women. In addition, campus environments can serve to magnify pressures for college women to compare themselves with same age peers regarding thinness and attractiveness. They are often involved in social groups in which other women are regularly engaging in excessive dieting, exercising, binging, and purging, thus modeling and normalizing maladaptive eating practices.

Developmentally, many women are at a stage in which their search for identity centers around a tension between a desire for increasing autonomy and a need for connections with family, peers, and romantic relationships. Further, due to cultural messages regarding women’s success,
college women often also place great pressure on themselves to achieve in multiple areas: to excel in academics and secure a successful career, have a perfect appearance, and attract and maintain a romantic relationship (Hinshaw, 2009). In turn, many women cope with these powerful pressures through binge eating or through attempts to control their weight and shape (Choate, 2011).

Although some women are able to resist or challenge these pressures to achieve the thin ideal, many young adult women experience dissatisfaction with their bodies (Cash & Harborsky, 2004). A subset of women with body image dissatisfaction subsequently develop symptoms which meet the criteria for one of the full-syndrome DSM-IV TR eating disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorders Not Otherwise Specified (EDNOS). Of college women who develop eating disorders, the vast majority experience a constellation of symptoms that fall under the EDNOS classification (Fairburn & Bohn, 2005; Schwitzer et al., 2008; Wonderlich, Joiner, Keel, Williamson, & Crosby, 2007). Because EDNOS is the most widely experienced eating disorder among college women, the purpose of this article is to present a summary of CBT-E, a focused treatment model for working with college women experiencing EDNOS.

College Women and EDNOS

Researchers have demonstrated that women with EDNOS frequently have significant impairment, often experiencing similar problems and levels of distress as those with AN or BN (Stice, Killen, Hayward, & Taylor, 1998; Walsh & Garner, 1997). In addition, the majority of clients with eating problems fluctuate frequently between eating disorder diagnoses, so that clients often migrate between AN, BN, and EDNOS (Fairburn, 2008). Further, a recent large-scale study indicates that EDNOS mortality rates are similar to rates for AN, indicating the potential severity of this disorder (Crow, Peterson, Swanson, Raymond, Specker, Eckert, & Mitchel, 2009).

As identified by Schwitzer and colleagues (2001; 2008), college women who experience EDNOS engage in frequent binge eating and high levels of exercise for weight control; however, they do not generally engage in compensatory behaviors like vomiting or laxative use (as in BN) or overly restrictive eating (as in AN). In addition, college women with EDNOS experience significant body dissatisfaction, drive for thinness, overvaluation of appearance, rumination of eating and weight management, unstable self-evaluation, stress, anxiety, depression, perfectionism, fears related to maturity and self-sufficiency, and struggles with functioning autonomously in the adult world (Schwitzer et al., 2001). As is demonstrated from this profile, college women with EDNOS experience significant reductions in their quality of life, and counselors need the knowledge and skills to provide effective treatment for these concerns.

Cognitive Behavioral Therapy-Enhanced Model

CBT has emerged as the gold standard treatment model for understanding and treating eating disorders (APA, 2006; Wilson, Grilo, & Vitousek, 2007) and there is evidence that clients experiencing EDNOS will respond well to an adaptation of CBT (Wilson et al., 2007). The standard CBT treatment was recently reformulated and enhanced by Fairburn (CBT-E; 2008) so that it now takes a transdiagnostic approach to the conceptualization and treatment of eating disorders. While less research has been conducted to date regarding the newer CBT-E version, recent trials indicate its effectiveness (Byrne, Fursland, Allen, & Watson, 2011; Fairburn, Cooper, Doll, O’Connor, Bohn, Hawker, Wales, & Palmer, 2009).

Central to CBT-E is its model for understanding the maintenance of the disordered eating cycle (Fairburn, 2008). According to the model, a client may learn to over-evaluate the importance of weight and shape in determining her sense of self-worth. This belief is reinforced in Western cultures as young women receive cultural messages idealizing an unrealistically thin, attractive appearance. Over time, the client internalizes the thin ideal as the most important determinant of her worth and value as an individual.

In efforts to attain this ideal, she may engage in chronic dieting and attempts to control her weight and shape. Because of the body’s response to dietary restraint, however, restriction is not generally sustainable over a long period of time. Eventually the body will experience a sense of deprivation and loss of control that will result in binge eating. In addition to physiological urges to binge-eat, binges can also serve as a way to regulate emotions or modify negative mood states (Wall et al., 2007). In individuals with BN, binge episodes are followed by attempts to purge the body of unwanted calories, usually through vomiting, laxative, or diuretic abuse. Schwitzer’s and colleagues’ (2001; 2008) research indicates that college women with EDNOS are less likely to engage in these types of behaviors but may turn to excessive exercise as a compensatory mechanism. Regardless of whether or not calories from the binge are purged, the client experiences a sense of failure for losing control and will resolve to work even harder to maintain her diet/exercise routine in the future. Over time, the client feels trapped in a cycle in which she fails in her efforts to reach her ideal weight and shape, so that her attempts for control that were intended to improve her self-esteem contribute to increased feelings of failure (Fairburn, 2008).

CBT-E Tailored Treatment Guidelines

CBT-E is focused on the present and emphasizes the reduction of maladaptive eating behaviors before targeting a change in thoughts or attitudes (Pike, Loeb, & Vitousek, 1996). While the reader is referred to Fairburn (2008) for the entire treatment protocol (see also Choate, 2010 for a summary of CBT treatment for young women experiencing EDNOS), it is beneficial to individualize the CBT-E approach so that it emphasizes treatment components that are most relevant to a particular client’s symptoms and concerns (Ghaderi, 2006). Therefore, while the primary CBT-E treatment components are included here, the summary is tailored to those areas most specific to
the treatment needs of college women experiencing EDNOS. A description of the four phases of treatment is outlined next.

**Phase One**
It is suggested that counselors conduct Phase One sessions twice weekly over a four-week period. Phase One begins with an assessment of the client’s eating-related concerns (see Fairburn, 2008 for recommended assessment instruments and a guide to clinical interviews). In addition, the issues described in the sections below should be addressed during Phase One.

**Motivation and Commitment**
Schwitzer and colleagues (2001) report that college women with EDNOS are often resistant to seeking help and try counseling with several counselors without ever persisting in a counseling relationship. When they do seek counseling, they fear that counselors will pressure them to gain weight (Vitousek, Watson, & Wilson, 1998). The initial goal for counselors then will be twofold: to create a therapeutic alliance in which the client feels validated and safe in disclosing her eating problems, and to enhance motivation and commitment to changing her eating patterns and attitudes (Constantino, Arnow, Blasey, & Agras, 2005).

The counselor can first validate the client’s feelings of anxiety about being forced to gain weight while also helping her to focus on the potential benefits of change. One way to begin this process is to emphasize both the pros and cons of changing her eating-related behaviors and attitudes so that the client can begin to recognize that it is in her best interest to make positive changes in this area (Miller & Rollnick, 1991). As a college student, she is likely to be interested in both shorter- and longer-term goals, so she can be asked to articulate her goals for the future and to examine her personal and professional aspirations. She can then evaluate the likelihood of achieving these goals if she persists with her current behaviors and attitudes. In an atmosphere of support and validation, the client begins to realize that she has a choice in making steps to improve the quality of her life, and she will gradually become more invested in the counseling process.

**Provide Psychoeducation**
To instill confidence in the CBT-E approach, an overview of the treatment should be provided in early sessions. For many college women, the structured treatment approach may be appealing to those who feel out of control and need guidance in establishing boundaries around their eating and in their lives. For others who are learning to exert independence through rebelling against rules and authority, the approach might appear too restrictive. For these women, more time can be spent on motivational issues so that they perceive change as their choice and in their own best interest.

As another part of psychoeducation, the counselor should emphasize the importance of weekly weighing, self-monitoring, and other homework assignments that are crucial to the success of CBT-E (Fairburn, 2008). In addition, the counselor should provide education about the CBT-E model for eating disorders. As the client learns about mechanisms that maintain her disordered eating, it is helpful for the counselor to create a personalized diagram to help her view the cycle in a more objective manner. Further, it is helpful for counselors to provide information about such topics as the consequences of extreme dieting and the ineffectiveness of vomiting in promoting weight loss. To reinforce this information, the book Overcoming Binge Eating (Fairburn, 1995) is also recommended as reading for clients. Further, clients might also benefit from information on nutrition and health (APA, 2006).

**Introduce Regular Eating Patterns**
In Fairburn’s treatment manual (2008), introducing a pattern of regular eating is the most important CBT component. By eating on a regular schedule, the client has more available energy for other tasks, and when she is not experiencing hunger or deprivation, her urges to binge are highly reduced. Further, as she eats regularly (and not according to a restrictive diet), she learns that this does not cause her to gain weight. To normalize eating, clients are instructed to plan and eat three meals per day plus two snacks, with no more than a 4-hour interval allowed between eating. If necessary, counselors can assist clients in planning their eating routine, as many college women with EDNOS may have difficulty in planning meals and snacks that do not involve restricting or bingeing. As many college women live in settings with little structure or time for well-planned meal choices, this aspect may be particularly challenging; the client may benefit from a referral to a nutritionist, if one is available.

During the next several sessions, the client can begin to develop a list of high-risk situations and then create a coping plan for each. Because college women experiencing EDNOS often engage in excessive exercise as a means of compensating for binges (Schwitzer et al., 2001; 2008), counselors can encourage strategies for managing situations that generally lead to excessive exercise. For college women who live in settings in which over-exercising is frequent and highly reinforced, there is a need to refrain from visiting crowded campus fitness centers after meals. Instead a client might benefit from enlisting the help of a supportive friend who can make plans with her for scheduled post-meal activities that do not involve exercise to burn unwanted calories.

**Phase Two**
Phase Two begins after the first four weeks of counseling sessions. This is a transitional stage comprised of two sessions during which the counselor reviews client progress to date, identifies any obstacles, and decides upon the treatment components that need to be addressed in Phase Three. At this stage it is important for the counselor to assess for client improvement, as early response to CBT is a clinically significant predictor of positive treatment outcome (Wilson et al., 2007). If she is not making progress, the counselor may need to spend additional time on the components of Phase One, revisit the client’s commitment to change, or abandon the CBT approach in the hopes that a different treatment will be more effective.
**Phase Three**

Phase Three is generally comprised of eight sessions and begins with a focus on the client’s beliefs and behaviors regarding the over-evaluation of weight and shape. To determine the importance of this area in her life, the client can draw a self-evaluation pie chart. She is asked to think about all areas of her life upon which she judges herself. She can fill in the pie with appropriately proportioned slices (Fairburn, 2008; Waller et al., 2007). As she examines her pie chart, she can better see the need for reducing the proportion that is related to weight and shape and for increasing the proportions in other areas. To reduce the importance of weight and shape, cognitive restructuring is helpful in identifying and changing belief patterns in this area.

To begin developing other life areas, the counselor can encourage the client to identify strengths in multiple life dimensions, including spiritual, intellectual, social, and physical competence (Choate, 2008; Myers & Sweeney, 2005). As the client learns to view her identity as more than just her appearance, she can dedicate her time and energy to more meaningful activities, pursuits, and goals. When she begins to appreciate her strengths, engage in activities beyond the pursuit of the thin ideal, focus on her goals for collegiate life and her career aspirations after college, and accept and value herself, she will be less likely to engage in chaotic eating and bingeing patterns.

Schwitzer and colleagues (2008) report that college women with EDNOS typically experience problems related to perfectionism and an unstable self-evaluation which is overly tied to weight and shape. If a client’s beliefs in these areas appear to be significant obstacles to her progress in treatment, Fairburn (2008) also includes a treatment protocol to address these additional areas of focus that can be included in this stage. If a client is experiencing perfectionism (i.e., over-evaluation of achievement in determining self-worth, rigorous pursuit of personally demanding standards) and/or low self-esteem (i.e., pervasive negative view of self, negative bias in viewing the self and the world, little perceived value as a person) then the counselor can help her view herself in a more realistic, balanced manner, appreciating both her strengths and her areas for growth. She can begin to engage in more performance-free, rewarding, fun activities that she might have missed out on previously due to her focus on achievement, dieting, weight, and shape. She can also examine her beliefs that she has to achieve high standards in all areas in order to have worth and value as a woman, so that she can start to recognize the futility of trying to fulfill all roles at one time (Fairburn, 2008).

Another yet important aspect to address in Phase Three is reducing dietary restraint. Whereas in Phase One the goal was to normalize eating times, a goal in Phase Three is to eliminate dieting by addressing both the type and amount of food eaten. She can first identify any dietary rules she has created, begin a plan to intentionally break each rule, and then determine alternative ways to approach eating. Another step is to create a hierarchy of typically avoided or “forbidden” foods, and progressively incorporate them into meals, beginning with the least threatening and working up the hierarchy towards the consumption of foods perceived as the most anxiety-producing (Wilson et al., 1997). The client is also encouraged to examine the amount of food she eats throughout the day. College women experiencing EDNOS may often limit their food intake during the day, avoiding meals as they rush between classes and/or work schedules, then overeat or binge in the evenings due to feelings of stress, hunger, and deprivation. At this point the counselor can then assist her with planning and eating well-balanced meals and snacks throughout the day that will provide adequate energy for her to function optimally.

The final aspect of Phase Three is addressing the ways in which a client manages stressful events and negative moods, as these often serve as triggers for continued binges. Many clients with disordered eating have poor coping skills for dealing with distress related to the academic demands of college life, relationships with friends, family, or romantic partners, or difficult life transitions. Instead of coping directly with the situation or feelings, they have learned to use eating as a way to avoid or reduce negative emotional states (Waller et al., 2007). Coping skills development will be helpful for the client in managing stressful events instead of turning to her maladaptive eating practices.

**Phase Four**

The fourth and final phase of CBT is to explore termination and to encourage the client to independently use the CBT strategies she has learned. This phase is generally comprised of three sessions, scheduled once every other week. To prepare for termination, a client needs to summarize the progress she has already made in changing her eating- and shape-related attitudes and behaviors and to identify those components she will need to target in order to continue making progress towards her goals (Fairburn, 2008).

**CONCLUSIONS**

The CBT-E approach to treatment for EDNOS can be effective in helping college women to normalize eating and to decrease the over-evaluation of weight and shape. As with any approach, there are several limitations to this model. First, little research has been conducted to examine the differential impact of CBT-E for individuals from diverse racial/ethnic minority backgrounds (Cummins & Lehman, 2007). A second limitation is the relatively low treatment response rate; although no studies have examined the client recovery rate for EDNOS in particular (Fairburn & Bohn, 2005), only 30-50 percent of clients with BN report full recovery at the end of CBT treatment (Wilson et al., 2007). Although it is the most effective approach available, it might not be effective for certain individuals. For women who do not respond to CBT-E, recent research indicates the use of Interpersonal Psychotherapy (IPT) or DBT as effective treatments for eating disorders (APA, 2006; Wilson et al., 2007). For further reading regarding these approaches, refer to the IPT (Wilfley, MacKenzie, Welch, Ayers, & Weissman, 2000) and DBT (Safer, Telch, & Chen 2009) manuals. In summary,
despite these limitations, CBT-E is recommended as a first-line treatment for disordered eating and has the greatest likelihood of treatment success for EDNOS (Wilson et al., 2007). CBT is likely to help college women with EDNOS to improve the quality of their lives as they normalize their eating patterns, reduce binge eating, and begin to change their thinking about the importance of appearance as the primary criterion for judging self-worth.

REFERENCES


This report considers the efficacy of utilizing BIA as a potential technique to evaluate body composition during the weight gain process in restrictive-eating disorder patients. This is important in that improper dietary intake can have profound metabolic effects (Sullivan, 1995; Noordenbox, 2002; Nicholls et al., 2004; Dixon et al., 2007).

BIA is an inexpensive and relatively simple method for measuring body composition, first applied by Hoffer et al., (1969) to measure total body water and then by Luskaski et al. (1985) to determine nutritional status. Basically, the instrument uses electrodes to send a harmless very-low level of electric current through the body. Whereas fatty tissue is low in water content and does not conduct electricity very well, lean body mass (muscle tissue) is more than 70 percent water and does conduct an electric current relatively efficiently. Briefly, BIA measures body fat (FM) (which optimally ranges up to about 25 percent in women and 20 percent in men), as well as lean body mass, the sum of Body Cell Mass (BCM) plus Extracellular Mass (ECM) (Ellis, 2001; Kyle et al., 2004). Lean body mass is also referred to as fat free mass (FFM). In addition, the instrument also measures body mass index (BMI) and intracellular and extracellular water.

In general, aging is associated with a loss of lean body mass and strength and the elderly can sometimes experience replacement of some muscle mass with fat, but with a stable body weight (Gallagher et al., 2000; Song et al., 2004), even though weight gain in the young adult into the mid-life years shows an increase in both fat and muscle mass.

In addition, intra-abdominal visceral fat and waist circumference often increase with age at a faster rate than total body weight (Hughes et al., 2004, Snijder et al., 2006; Fantin et al., 2007); and BMI does not take fat distribution into account (Goodpaster et al., 2005; Ramsay et al., 2006). BIA data can be used to assess actual body composition and thus guide nutritional approaches to metabolic illness. Just as early detection of body composition changes resulting from certain diseases allows for early intervention treatments, it seems clear that the restrictive-eating disorder patient could benefit from the clinician’s ability to empirically evaluate body composition alterations prior to and during therapy, particularly given the metabolic and psychological complexity of anorexia and bulimia.
Studies with BIA

Mika et al. (2004) correctly pointed out that assessing changes in body composition and nutritional status is critical for proper nutritional management during refeeding treatments. Utilizing BIA technology, they evaluated 21 female adolescents with anorexia nervosa (AN) with an initial BMI of 15.5 (15.5 ± 1.1 kg/m²) and 19 normal-weight, age-matched female controls, each four times between weeks 3–15 of refeeding with a hyperenergetic diet. By this method, the researchers concluded that changes observed in the extracellular mass (ECM)/body cell mass (BCM) index were due to an increase in BCM, and that multi-frequency phase-sensitive BIA would be a promising tool for assessment of nutritional status and body composition in AN patients.

An interesting comparison was made by Mattar et al. (2011) between BIA and Dual x-ray absorptiometry (DXA) to measure FFM and FM in 50 female, underweight patients with anorexia nervosa. It was concluded that the best estimates of FFM and FM in the anorexic study group was when the Deurenberg equation, one of several different formulae for computing FFM, was used with BIA, because it took into account height, weight, and age, and it was applicable in adolescents and adults ages 13.4 to 36.9 years-old and for BMI values of 12.8–21.

Ghosh et al. (1997) evaluated an inexpensive hand-held BIA instrument for use at patient bedside. They compared measures of lean body mass in comparison to DXA measures in potentially malnourished patients. Body composition analysis was obtained from 17 patients with eating disorders, 7 with chronic alcoholic pancreatitis, and 18 with inflammatory bowel disease. The results clearly indicated that in thin and non-obese adults, an accurate two compartment (lean body mass and fat mass) measurement could be made in ten minutes using this hand-held BIA machine.

In a study utilizing BIA, anthropometry and DXA to assess body composition, Bruni et al. (2011) found that subjects with eating disorders had a lower BMI and fat mass (measured with both techniques) compared to patients with functional hypothalamic amenorrhea. Leptin levels were positively associated with fat mass and also with body cell mass indexed to height and BIA phase angle parameters (an expression of the active lean body compartment and cellular health). This study certainly accentuated the value of BIA, which was corroborated with DXA. In a separate report using the same subjects, Bruni et al. (2011) demonstrated that a multivariate analysis model confirmed the utility of integrating endocrine data with the study of body composition; and they reported that BIA proved to be a useful clinical alternative to DXA, especially when considering body cell mass and phase angle.

In an interesting study conducted by Vaz et al. (2003) body composition was analyzed in a group of patients fulfilling DSM-IV criteria for bulimia nervosa (BN). Forty three patients with prior AN (BN-AN group) and 61 without this history (BN-nonAN) were evaluated for height and weight, abdominal diameter, body circumferences, skinfold thickness, and BIA parameters. The results showed that more than 40 percent of the BN-AN group showed a BMI of < 20, as well as lower muscle mass, and a higher percent of extracellular water. However, these differences were not evident in the second part of the analysis, when only patients with a normal weight range were compared. This indicated that a large number of BN patients tend to retain some clinical traits of the previous condition, remaining in a “subclinical status.” In other words, they were thinner and had the tendency to remain at a lower weight. Importantly, however, this tendency no longer existed when patients had achieved a normal weight. This raised interesting questions regarding the boundaries between BN and AN and reinforces the importance of monitoring weight and body composition of patients with either disorder.

Rigaud et al. (2000) examined the metabolic expression of extreme starvation in five very malnourished patients (BMI = 9.77 ± .01) on the verge of death vs. 16 less-malnourished AN patients. Resting energy expenditure (REE) was determined by indirect calorimetry, and body composition was measured by anthropometry and BIA. At the start of refeeding, the REE was high in all 5 of the malnourished patients and associated with almost no fat mass, high urinary nitrogen, low serum fatty acids and low to normal catecholamines, insulin, and thyroid hormone values. During the first 2–4 weeks of refeeding of the extremely malnourished patients, REE decreased, whereas fatty acid concentrations increased in the four remaining patients (one having died). REE was low in the AN patients at the start of refeeding and increased thereafter, along with urinary nitrogen output. The reason for the higher REE and protein catabolism was not specifically known, but obviously could have been due to consumption of the final muscle mass and to diseased membranes in those malnourished patients near death.

Many methods of measuring body composition are time-consuming and require equipment that is often unavailable; but BIA is simple and inexpensive and can differentiate between lean and fat tissues. Studying 38 anorexic females with highly variable BMI, Hannan et al. (1991), concluded from the data that the BIA technique compared favorably with other established methods, even in AN patients with a very low BMI. Other studies, however, caution that BIA may have limited utility with some patients with AN (Haas et al., 2012).

Although the various body composition studies that have been presented thus far focus on anorexia, an interesting and recent report by Marra et al. (2009) presented data regarding body composition in underweight ballet dancers and constitutionally lean females. The study utilized phase angle measurements (a bioimpedance variable related to body cell mass) to ascertain whether this parameter differed between the two groups. Thirty AN patients, 10 constitutionally lean individuals, and 15 classic dancers were evaluated by skin fold thickness and BIA. The results...
indicated that the BIA-derived phase angle (an indicator of cellular health and integrity) discriminated between different forms of underweight, and that it is an effective marker to detect qualitative changes in body composition.

In a study by Saladin et al. (2009), which assessed 79 restrictive eating disorder patients receiving a modified Mediterranean-style diet, it was observed that 37 percent gained body cell mass interpreted from BIA as lean body mass, and an additional 39 percent gained lean body mass and fat mass from this diet (p <0.05). Importantly, the BIA data showed that the fat mass acquired by this second group of patients still allowed them to achieve a lean body mass to fat ratio of 80/20 - 75/25. The remaining study group lost lean body mass. Of potential significance, body fluid changes elucidated by BIA appeared to have indicated early onset of Refeeding Syndrome (Kraft et al., 2005) in two of the patients, although this was not definitely ascertained.

Of course it is well-recognized that the issues which lay at the heart of restrictive eating disorder patients are quite complex. This is exemplified by the work of Van Wymbeleke et al. (2004) who studied 87 female AN patients and included BIA to assess body composition. During the treatment period, it was observed that by day eight, resting energy expenditure increased significantly (13.4 percent, p <0.01), based upon an increase in fat-free mass, and that the ratio of REE/FFM remained high thereafter. However, by multivariate analysis, they concluded that the rise in this ratio observed during refeeding was significantly related to energy intake, anxiety, abdominal pain, and depressive mood; and they also noted a significant rise in the REE/FFM ratio with physical activity and cigarette smoking. This rise in REE leveled off after recovery from AN. This strongly suggests that a great many variables affect the results and interpretation of even efficacious BIA data, and that analysis of such data must be careful, thorough, and integrated with as much knowledge about the patient as possible.

**SUMMARY**

The studies presented in this review, along with the vast experience of clinicians and researchers, accentuate the metabolic and psychological complexity of understanding and treating restrictive eating disorder patients. It seems clear that assessing body mass composition in these patients would be an important component of diagnosis and treatment options; and it is suggested here that such an evaluation would ascertain whether or not the acquisition of body mass during refeeding would be metabolically appropriate - ideally achieving an approximate 20/80 percent - 25/75 percent fat/lean body mass ratio.

In addition it is reasonable to suggest that utilizing BIA techniques to achieve this assessment could be efficacious and advantageous in patients with eating disorders. Furthermore, assessing body composition is also important, because weight changes do not necessarily reflect specific changes in body compartments (including fat free mass and fat mass). Of course, many patients with eating disorders have other psychiatric and behavioral comorbidities such as substance abuse and dependence that can confound data obtained for a research study or a treatment regimen. However, by utilizing a technique like BIA, clinicians and researchers have the advantage of using each patient as their own “control” which could potentially allow for a more effective, individualized nutrition regimen according to the body composition changes observed during their treatment period. In addition, BIA can provide information on BMR in anorexic patients and should be explored in evaluating other forms of protein malnutrition. Finally, although it is not yet proven, BIA can measure body fluid changes making it theoretically possible that this diagnostic technique could be used as an additional tool for detecting the early onset of Refeeding Syndrome in patients at risk for this constellation of metabolic disturbances. Therefore, in the hands of a qualified clinician with expertise in instrumentation as well as human metabolism, it appears that BIA could be a very useful modality in the treatment of patients afflicted with restrictive eating disorders.

**REFERENCES**


Emotional and cognitive insight is often insufficient in producing change in eating disorder patients. Group therapy provides a unique opportunity for both emotionally corrective nourishing relationships and behavioral practice of new skills. This article will discuss the clinical challenges in applying evidence based treatment in the real world practice of group psychotherapy. It will also explore some of the common challenges therapists face in managing group dynamics and their own countertransference in their group work with eating disordered patients.

My first experience in leading group therapy for eating disorders was in 1984 as a psychiatric nurse at a private hospital in Beverly Hills, California. I was one of the initial team members charged with designing implementation and facilitation of groups. We worked 12 hour shifts supervising the meals and snacks for anorexics and bulimics, hence I had the experience of seeing first hand the painful desperation and stubborn nature of these illnesses. In 1985, I joined the nursing staff at UCLA Neuropsychiatric Institute working on the adolescent unit. I had the opportunity to lead the eating disorder group supervised by one of my mentors, Dr. Michael Strober.

Completing my post-doctoral fellowship at UCLA, I later assisted in directing UCLA’s outpatient eating disorder program. We used several group therapy formats including process oriented, psychodynamic groups, family groups, and an integrative approach of CBT.

For the last 18 years I have been in private practice on the east coast with a focus on eating disorders. I have found that adding group therapy to my individual sessions greatly facilitates the process of healing. I have been using an integrative approach of CBT, modern analytic understanding, and now DBT informed skills training. My interest and experience in group therapy and treating eating disorders has developed through a process of trial and error. My lab has been my office and following patient progress over the years. I gauge success in the relinquishing of symptoms, and positive progress in their lives outside of treatment.

**Types of Group Therapy**

Many different types of group therapy have been used in the treatment of patients with eating disorders. The following are brief descriptions of the types of group therapies I have found to be most helpful in my work.

- **Cognitive Behavior Therapy** (CBT) (Fairburn, 1995; Agras, et al., 1997) focuses on normalizing eating patterns and challenging overvalued ideas regarding weight and shape.
- **Interpersonal Therapy** (Klerman & Weissman, 1993; Wilfey et al., 2002) focuses on resolving interpersonal difficulties that maintain eating disorder pathology.
- **Self-psychology models the group** as a whole that provides containing and mirroring functions to address self issues, and relational emphatic failures (Schwartzman 1984; Kohut, 1984).
- **Attachment based group therapy** attempts to resolve attachment insecurities and improve reflective functioning (Tasca et al., 2006).
- **Dialectical Behavioral Therapy** (DBT) has been adapted for use with BED and BN in both individual and group formats. DBT is a skills based approach for improving emotional awareness and regulation. Affect regulation models link negative affect and disordered eating (Arnow, Kenardy, & Agras, 1992), and conceptualize eating pathology such as binging, restricting and purging as behavioral attempts to control painful or stressful emotional states (Linehan & Chen, 2005; Wisniewski & Kelly, 2003).
- **Modern analytic psychotherapy** (Spotnitz, 2004), focuses on the patient’s narcissistic defenses and underlying aggression. The modern analytic approach emphasizes the use of therapist’s feelings induced by the group. The therapist works to join with and reflect upon group resistances, rather than challenging them directly. This approach encourages the expression of aggressive drives and therapeutic interventions are intended to provide emotional communications to the patient rather than to promote intellectual insight. Group members and the therapist will elicit feelings of rejection, neglect and envy normally encountered in interpersonal relationships outside of group. The therapy involves training patients “to say anything;” expressing negative thoughts and feelings in the group makes it less likely that they will be acted out in and outside of group.

**Why Group Therapy?**

Obsessive dieting and other eating disorder behaviors often begin as an attempt to adapt to concerns related to identity, competence, and emotion regulation. Research has demonstrated patterns of personality traits in patients with anorexia nervosa including discomfort with change, fear of taking risks, emotional constriction, shyness, and negative self-evaluation (Wonderlich, 2002; Strober & Goldenberg, 1981; Strober, 1991). Consequently, it is not surprising that anorexia usually presents itself during puberty, the quintessential period of emotional and physical change. Bulimia nervosa and other eating disorders may also be associated with perfectionism, impulsivity, low self-esteem, and body dissatisfaction.

**Group Decreases Emotional, Experiential and Relational Avoidance**

Emerging research points to the central role of emotional and experiential avoidance in the etiology and maintenance of eating disorders (Wildes, 2010). Most patients find their symptoms adaptive and a useful mechanism of self-control in the face
of developmental change. Patients are reluctant to relinquish symptoms that have become an important source of self-enhancement and emotion regulation. Group therapy can therefore be the perfect setting for patients who are emotionally avoidant and anxious about interpersonal closeness to safely encounter difficult emotional experiences. Group therapy helps patients to safely enter the uncomfortable and the unknown.

Groups are likely to quickly produce feelings in patients because of the unpredictable range of emotional stimuli and transference targets. Some of our patients are approval seeking and fear, as my teens say, “calling someone out.” Disagreeing or having a differing view is valued in the group by the leader as a form of self-definition. We work on the group norm and encourage individuals to learn how to not hold back, and that being too careful is a missed opportunity. Patients will constantly say “I did not want to say it because I would feel uncomfortable or make others in the group uncomfortable.” The group is trained that we are interested in experiencing unwanted negative feelings in the group. If feelings in the group can be experienced patients will become more resilient, and more likely to not turn to symptoms to avoid the discomfort of these feelings.

Patients are reminded to try in group to “say anything,” to be curious and investigative about thoughts and feelings and less judging. They are told that whatever occurs to them in the group, however small, may trigger something helpful for someone else. There is the constant attention to fears and forms of resistance to using the group. One long term group adolescent anorexic patient said:

“Group helped me more than individual therapy to open up and confront people instead of keeping things in. I also used to worry in the group that my issues were less important and it was wrong to take up the group’s time. I am much more open now in group and I don’t feel guilty about talking or taking up space.”

When dealing with group conflict patients understand that personal attacks are a violation of the group contract. If it does happen, it is an opportunity for feedback and seen as an unsuccessful confrontation, and group learning or a reality check.

The group is also encouraged to share all of their conflicted feelings about recovery and what is underlining the symptoms that they fear giving up. I may say “Mary needs to say everything she can about feeling conflicted about getting better. Maybe then she is less likely to go home after group and binge and purge.” Members are positively reinforced when they risk expressing a negative feeling, especially one directed at the leader.

One adult patient, recovering from anorexia, began group five years ago very reluctant and resistant. She was quiet, “private,” isolated and conflict avoidant. She had few intimate relationships, and feared being criticized. Group has been extremely uncomfortable, especially when there is a change in the group. Once a year she questions how this discomfort is helpful to her, and expresses her conflict about leaving group. She has slowly let go of eating disorder symptoms which functioned as a substitute for intimate relationships. She is socially confident and has now opened her own successful business.

Eating disorder patients also suffer from body dissatisfaction and body image distortion. One other essential value of group therapy is having individuals in various phases of treatment and self-development. Patients that have begun to view their body image more positively and accurately can help other patients by giving feedback. The range of perspectives helps patients to reduce their body checking and avoidance and to safely tune into and explore their own distorted perceptions.

GROUP ELICITS PATTERNS OF SELF-DEFEATING BEHAVIORS

When Sara reached her weight goal the group began to call her Mom, because she stepped in with advice and care-taking. After a few weeks, she described the difficulty of letting go of the eating disorder and watching others holding on. She confided that she wanted to be the perfect recovered patient and was beginning “to crack” under the pressure. She wanted to leave the group. However, her ability to express feelings of envy and competition mobilized other members to discuss the same issue. She overcame her negative feelings and she once again engaged.

Self-defeating interpersonal behaviors surface much more quickly in group than in individual therapy. For example, a socially anxious and needy patient who does not stop talking demonstrates her interpersonal difficulties immediately. The group must avoid the trap of too much interaction with this member and should, instead, look to understand the reason for the excessive talk, and intervene. A solution might be for the leader, as an example, to ask Mary what she makes of Susan’s comment, in order to interject another member and promote interaction and group process. The leader might say, “Everyone expresses their difficulties in different ways, some have to take the risk to listen more, some have to talk more.” The leader can also point out and ask about body language to get the group talking. For example, “what is the leg-shaking saying about what is happening in the group?”

GROUP HELPS PATIENTS SEE HOW OTHERS RESPOND TO THEM AND OFFER THE CHANCE TO PRACTICE NEW BEHAVIOR

Debra, an anorexic patient, joined a long term group at the insistence of her therapist who could not get her to talk in individual therapy. Debra was terrified of change and of any risk taking. She had stayed at the same job for years although she was overqualified and bored. For the first five or six months she said almost nothing in the group. When pressed, she claimed to have no insight, and that no thoughts occurred to her. She was however progressing in recovery and reached her weight goals. What percolated was a vicious circle. Anorexia had long been her main relationship and accomplishment. The fact that anorexia was moving into remission meant others, who were thinner and sicker, were getting more attention. This added to her isolation, fed her insecurities, and steeled her resolve to silence.

Slowly the group nonverbally and verbally expressed frustration with her. They related their own discomfort with opening up and claimed it was not fair that she did not push herself. Additionally, they said it was hard to feel connected to her because she did not share any of her thoughts and feelings and that they knew nothing about her.
As the leader, I too became frustrated at her inability to express herself in the group. In reflection I was experiencing what Lawrence Epstein calls the “bad analyst” feeling (Epstein, 1999), and was internalizing Debra’s and the group’s feelings of ineffectiveness and helplessness.

Upon reflection, I went back to what Anne Alonso (Alonso & Swiller, 1993) calls “neutrallity.” She said, “don’t just do something, sit there.” This allows the group to process and solve problems without interruption. I realized my attempt to bring her out of silence was not working, and that her interpersonal task was simply to tolerate coming to the group. Ironically she desperately wanted human contact and feedback. Her passivity was self-defeating and she was pushing group members away. As she began to talk she faced her fear of change and criticism. Life outside group slowly began to change as well. She went back to school, changed jobs and slowly began to make outside friendships.

Group also allows a patient to see diverse responses to her behavior in the spontaneous reactions from others. In processing the group’s angry feelings toward Debra, one patient suddenly became tearful. She identified with Debra’s isolation and paralysis. Tracy shared:

“When I started group I only had room in my head for thoughts about food and losing weight. My only thought about the other members was to compare my body to theirs. Slowly, I came out of isolation and they became real people that understood me.”

**WHAT ABOUT GROUP THERAPIST?**

For therapists, conducting group therapy presents a number of predictable challenges. Many of these challenges revolve around two main issues:

- How do you convince a patient that the discomfort she may feel in group will be helpful in her recovery, especially when she is conflicted and ambivalent about recovery?
- How do you engage patients in an experience that is more compelling and self satisfying than the symptoms that give them self confidence, emotional safety and a reliable sense of well-being?

Therapists treating eating disorders understand that the best treatment would be one that allows patients to feel and experience the full range of conflicts that have slowed the development of the person and impaired their ability to cope in life. Eating disorder symptoms often leave little room for relationships. Motivation and compliance in treatment when behaviors and symptoms are ego-syntonic is a common problem. Drop out rates are high. Patients are resistant, private, and shameful. Group therapy is like asking them to walk the plank.

When patients team up or are angry with the leader, it is an opportunity to see how they work together and the anger should not be taken away. It is a chance for the leader to model something new by allowing for the safe expression of negative feelings. From an analytic perspective, it is the therapist’s job to metabolize and neutralize negative projections. Patients can air the negative transference anger, frustration, and disappointments that they may avoid expressing in other relationships. One clear sign of countertransference is when the therapist feels frustrated, ineffective, deskilled, and devalued, as I did with Debra above. We have to expect these feelings and attempt to relinquish the self-idealized therapist role and the need to feel helpful and valued.

The challenge when inviting aggression is skilled and measured responses, to use induced aggression to contain the group without acting out.

Group therapists also have to make important choices about how they handle group structure, consistency and motivation.

**Setting boundaries/rules and dealing with “triggers.”** If the group makes its own contract, and is actively involved in developing suggestions and expectations regarding things like attendance, contact outside of the group, and the use of alcohol or drugs, there is less potential for the therapist to be perceived as arbitrary. While the general principle of “say anything” applies, each group must develop their own consensus about topics that could be “triggers,” things that should not be explicitly discussed in group sessions. Patients may be offered the rationale that certain descriptors may provoke competitive feelings or envy, and that negative behaviors will follow. For example, talk about food, weight or body image may keep patients from getting to the deeper issues underlying the eating disorder. I have found it essential that these ‘norms’ be developed by the group members themselves, rather than imposed by the group therapist.

I also find it useful to let patients air their obsessions. Patients will call each other on this and it is much more effective for addressing how the obsessions serve to avoid deeper feelings. If the group drones on about food or weight, we can investigate why and what else is not being said. I may say:

_Susan, are you following this? What do you make of Nancy’s detailed description of the evils of a French fry? I noticed 3 people got up to use the bathroom and three sets of legs are shaking? Does anyone have a theory?

**Maintaining motivation and challenging “stuckness.”** The best approach when encountering lack of motivation or resistance is to invite the group to do the work and resolve them. The therapist might say, “How are we as a group failing to help Kate?” I also may engage a member that had a past shared resistance, for example, “Nicole, you were silent in group for a long time. How did the group help you?”

Motivation is mobilized when patients feel a presence and a sense of importance in their role in the group. When members see changes or a more flexible mode of interpersonal interaction in others they will comment reinforcing individual and group progress.

We want members to show their individual resistances to change and to show us what they do in the real world. Our compliant eating disorder patients will sometimes be cooperative and desirable concealing other feelings and behaviors. Good behavior that is free of conflict gives us less to work with. The therapist needs to identify individual resistances that, unexpressed, become destructive to the group. New members coming into the group, or those terminating, stir up feelings. Patients often leave group when these conflicts, resistances and fears are not explored and when patients cannot express negative feelings about the group or the group leader.

**INTEGRATING TREATMENT APPROACHES**

I have recently started to integrate a skills building component to my group therapy program. Inserting DBT practices into group has been positive for most patients, however some have remarked that they find the didactic...
nature of the skills training uninteresting. Patients find education about the skills helpful during a designated time in the same way cognitive behavioral goal setting is planned for the beginning or the end of the group. They sometimes find it helpful to practice the skills in the moment or spontaneously try to identify what skill is being used by a particular member. Some have been vocal about the structured nature of the skills training interrupting a need to talk about something else or follow up on unfinished business from a previous group. Adolescents have reported that it is boring. The effective group therapist needs to balance efficient use of time and effort in skill development with the vital learning dimensions of the here and now. I have found it important when using CBT, homework goal setting, and DBT skills training to check in with patients regarding their reactions. They will guide me as to how best to use, and how much time to spend on, structured exercises. Ideally, a skills group would be more separate than an integrative process group but that can be logistically difficult in private practice.

SUMMARY

Group therapy is a cost effective treatment that allows for self-expression and the consequent building of competence and confidence. It is not just support but treatment of the isolation of eating disorder illness. The in vivo practice of new skills while facing unwanted emotional discomfort, and unpredictability produces maturation and resilience. It is an opportunity to rehearse for the world. Patients practice self-expression and assertion in giving and receiving feedback. I train my group patients that the discomfort of risk taking will help them to become emotionally resilient and less dependent on their symptoms to cope with stress. We learn quickly about the way our patients behave in their interpersonal world, including issues and behaviors that may not come out or are slow to surface in individual therapy. More witnesses and reaction to the salient self expressions made in group leave a deeper imprint in one’s mind. What our patients experience outside of group inevitably emerges inside the group as well. As these patterns emerge, they can be resolved in the moment.

REFERENCES


Cindy James, Ph.D. started as a group clinician in psychiatric nursing at UCLA Neuropsychiatric Institute and Hospital 30 years ago. She was an assistant clinical professor and co-directed the outpatient eating disorder program at UCLA before moving to Connecticut. She has been in consultation with Dr. Lawrence Epstein learning the modern analytic approach in facilitating group therapy for the past 15 years. She is currently in private practice in Westport, Connecticut.
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