Cognitive Behavioral Therapy for Eating Disorders

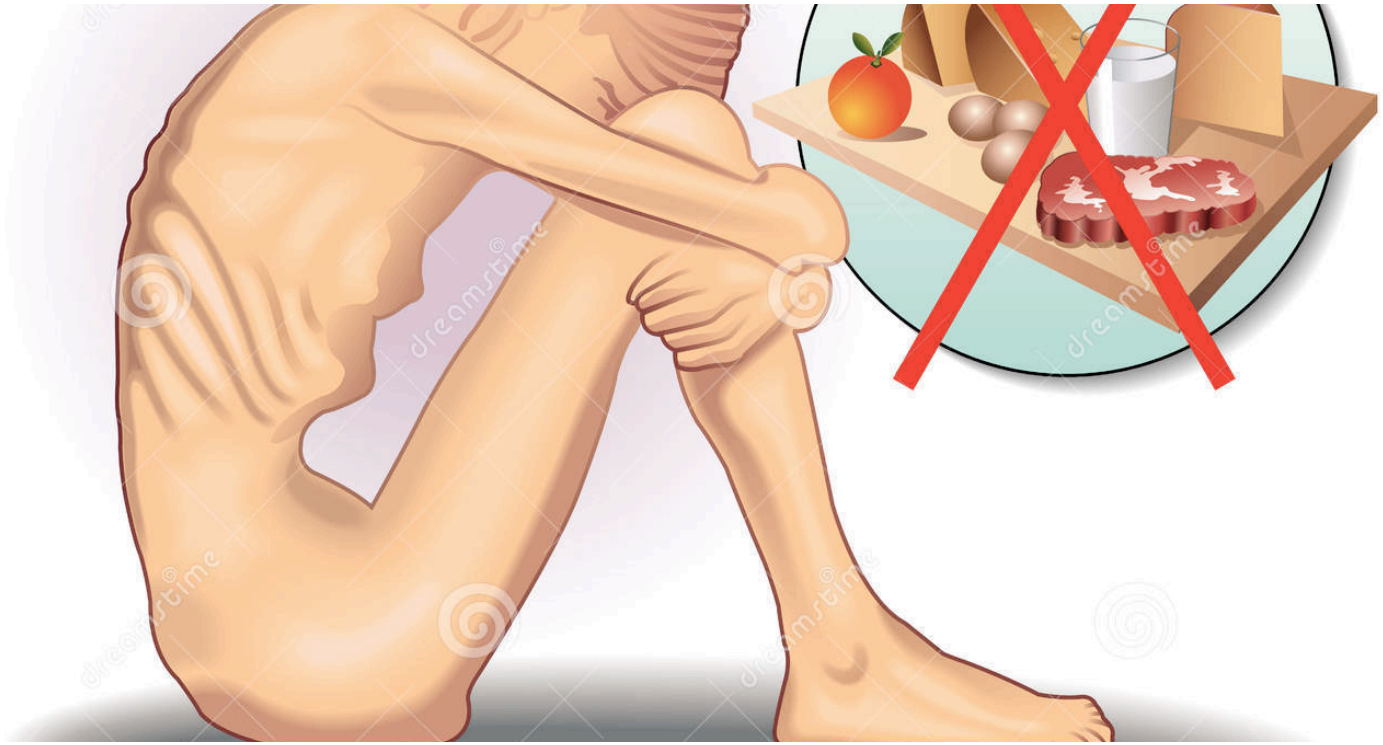
EATING DISORDERS

Anorexia nervosa

Bulimia nervosa

Binge eating disorder

Eating disorder NOS




dreamstime
purposes only.

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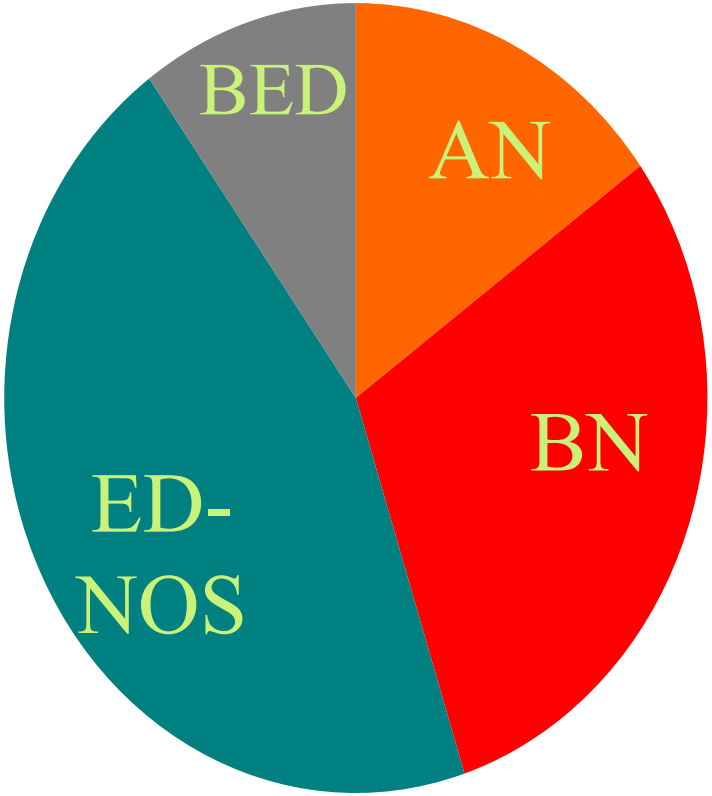
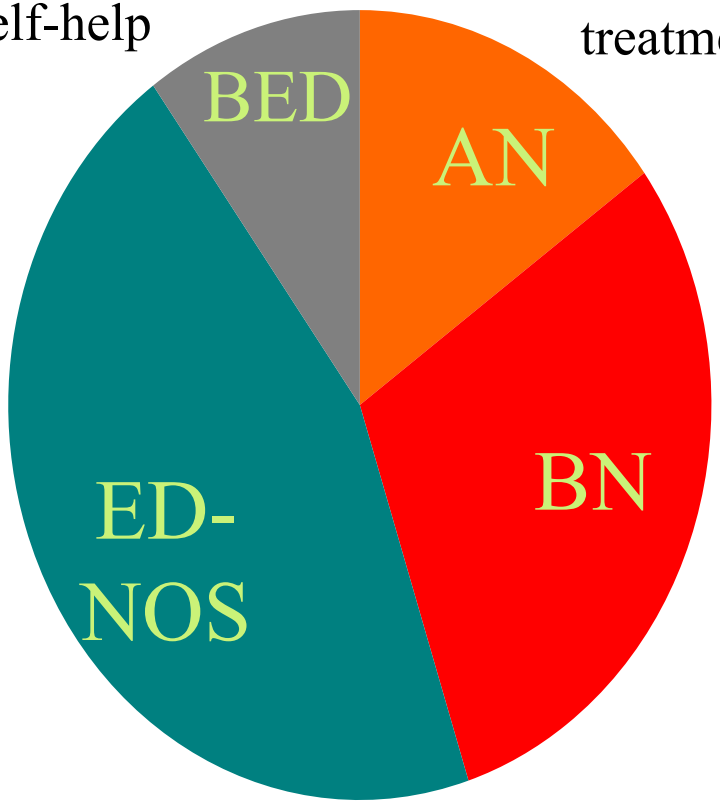

BED
AN
BN
ED-
NOS

Leading treatment is guided CB self-help

No empirically supported treatment



Just one treatment study

CBT leading empirically-supported treatment:

- 40% to 50% of those who complete CBT-BN make a full and lasting recovery

Bulimia Nervosa

- Self-evaluation is unduly influenced by body shape and weight
- Binge eating
- Compensatory behaviors

Bulimia Nervosa

- Self-evaluation is unduly influenced by body shape and weight
  - Almost all BN diet at some point before the onset of the disease
  - Many BN patients used to meet diagnosis of AN

Bulimia Nervosa

- Self-evaluation is unduly influenced by body shape and weight
- Binge eating

Binge Eating

- Eating a greater amount of food in a fixed period of time (e.g., 2 hours) than what most people would eat in the same time period and circumstances

AND

- Accompanied by a sense of lack of control over what and how much one is eating

- May be planned or spontaneous
- Usually done in secret
- Often triggered by unhappy moods
- Often people eat until they are uncomfortably full and feel ashamed

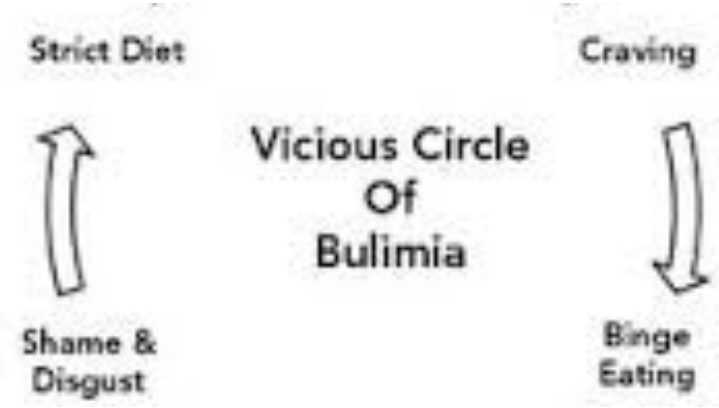
- For example, a binge might involve consuming all of the following in a very rapid amount of time (and in private):
    a. a whole box of cookies
    b. 2 liter bottle of soda
    c. a gallon of ice cream
    d. a large bag of chips

Bulimia Nervosa

- Self-evaluation is unduly influenced by body shape and weight
- Binge eating
- Compensatory behavior

Compensatory behaviors

- For example:
- Vomiting
- Laxatives
- Excessive exercise
- Fasting


Strict Diet
Craving
Vicious Circle
Of
Bulimia
Shame &
Disgust
Binge
Eating

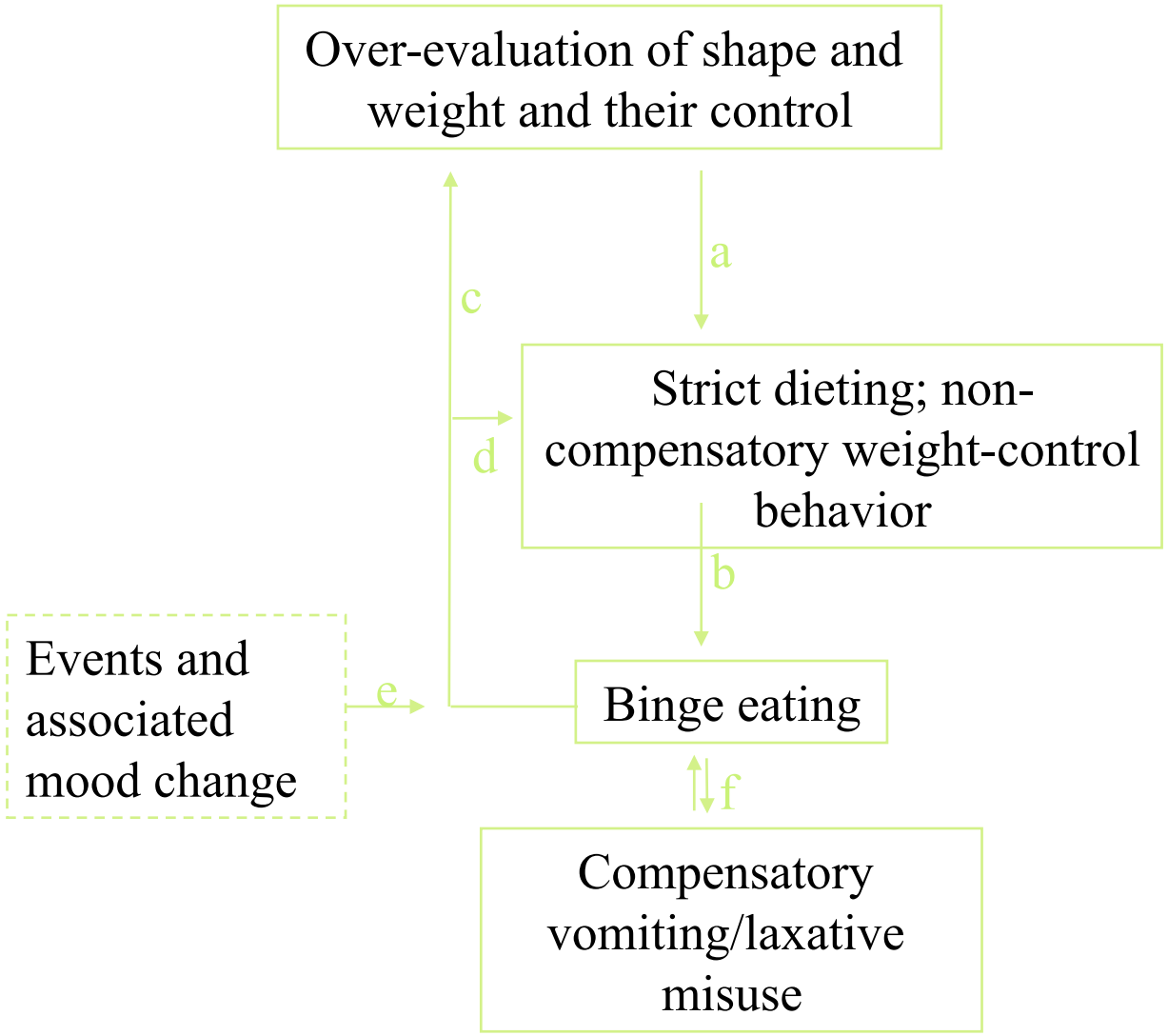
TREATMENT --CBT

What do we do?

- Distinction between causes and treatment?

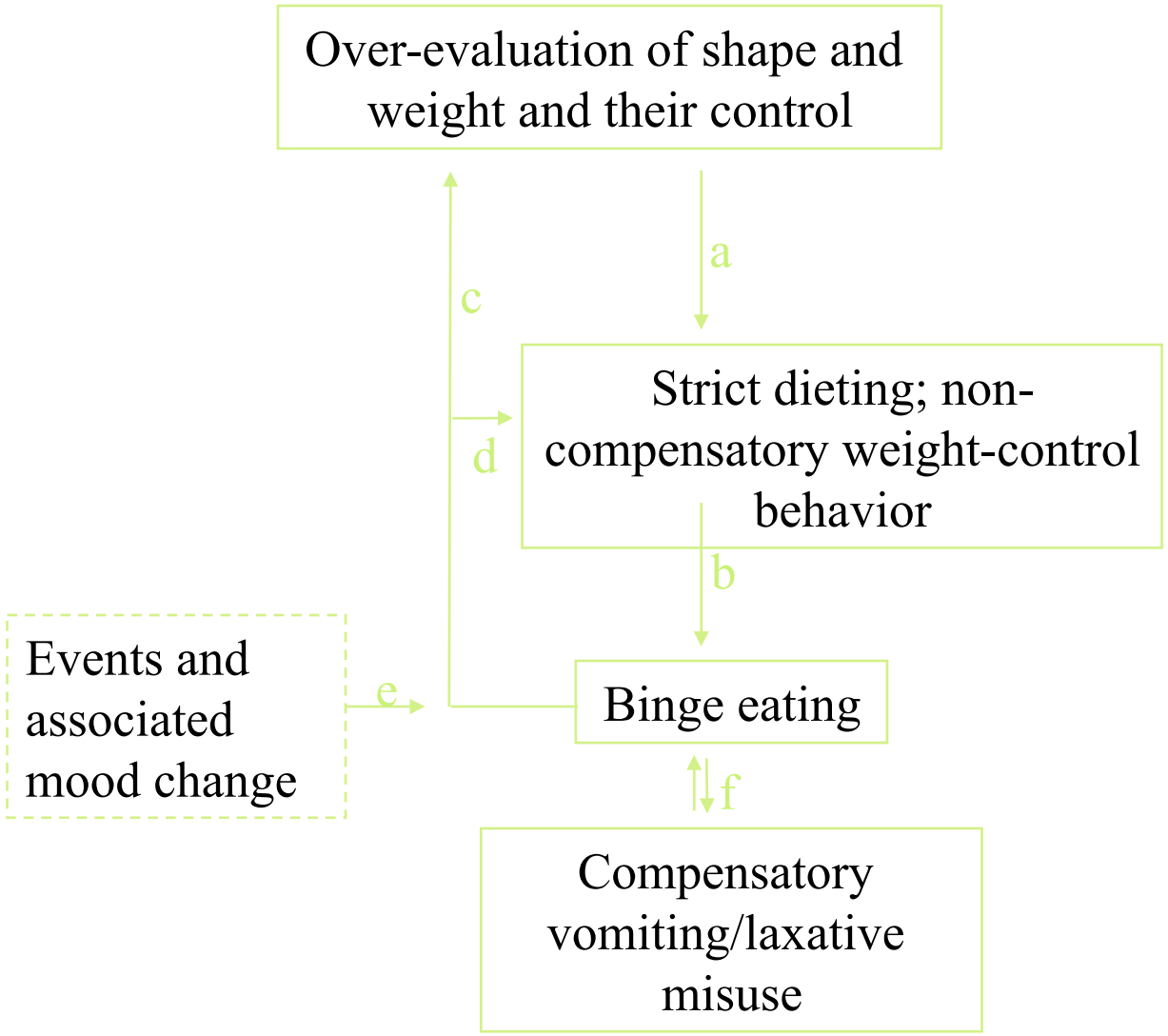
Bulimia Nervosa

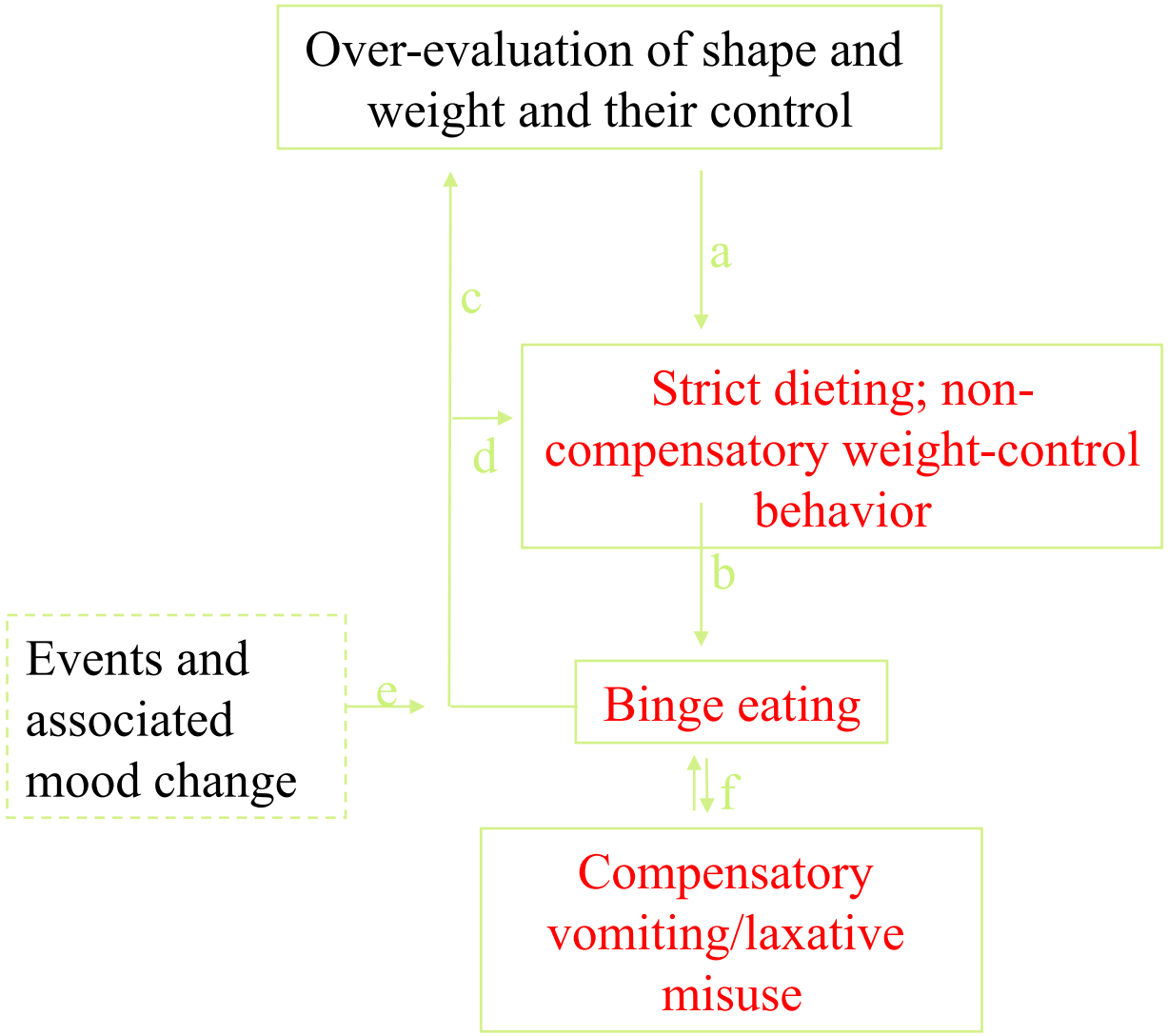
- Distal antecedent:
  - Parents being over-controlling
  - Being teased about appearances
  - Genes
  - …
- Proximal antecedent:
  - Dysfunctional thoughts
  - Dysfunctional behaviors that directly leads to the BN symptoms


Over-evaluation of shape and weight and their control
a
c
Strict dieting; non-compensatory weight-control behavior
d
b
Events and associated mood change
e
Binge eating
f
Compensatory vomiting/laxative misuse

Behavioral Components

BULIMIA NERVOSA

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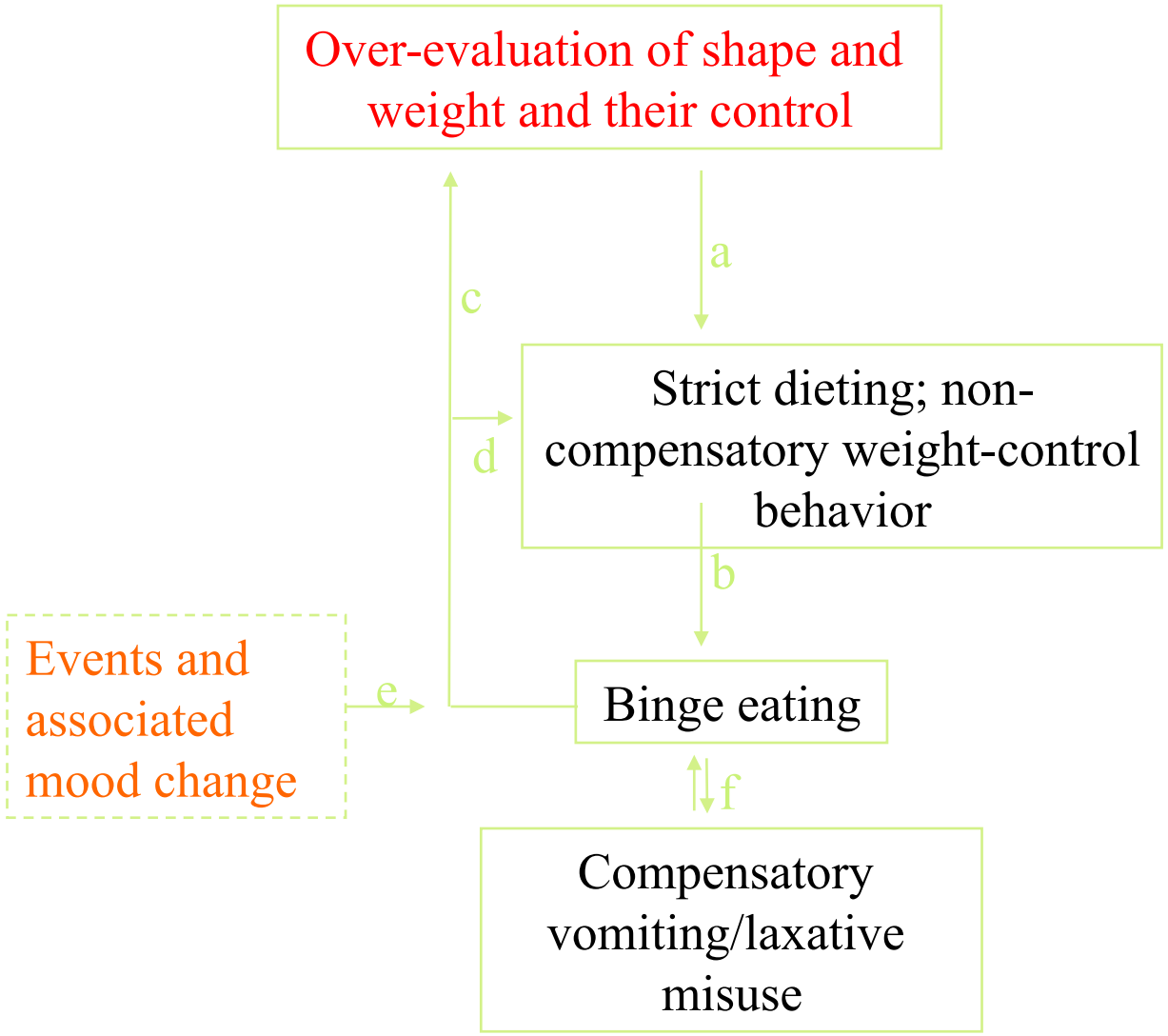
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Treatment of Eating Disorders

- Three parts of CBT for Eating Disorders
  - Part I: Behavioral symptoms related to food and appearance
  - Part II: Cognitive Symptoms related to eating disorders
  - Part III: Relapse Prevention

BEHAVIORS

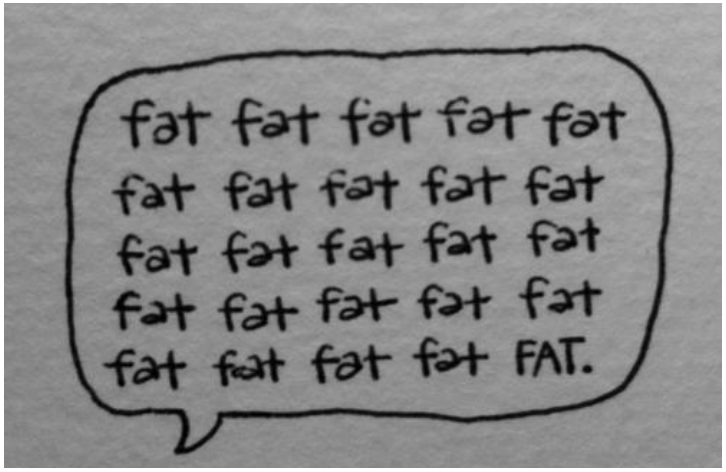
1. Establish real-time self-monitoring
2. Establish a pattern of regular eating
3. Dietary restraint

SELF-MONITORING

Rationale

- Helps patients distance themselves from the processes that are maintaining their eating disorder, and thereby begin to recognise and question them

1. skip a meal
2. avoid people
3. fake a smile
4. cry
5. die a little
6. repeat



ugly. ugly. ugly. ugly. ugly.
ugly. ugly. ugly. ugly. ugly.
ugly. ugly. ugly. ugly. ugly.
ugly. ugly. ugly. ugly. ugly.

Self-monitoring

08:20 am	1 toasted muffin with margarine 1 mug coffee 1 apple	*	Kitchen		Muffin left over from yesterday. Shouldn't have had this.
1:15 Pm	1 can diet cola		High St.		Worked all morning. Skipped lunch. Happy!
3:05 :08 :30 ……	2 Jam doughnuts 3 shortbread biscuits Packet of chocolates 1 can lemonade 2 pieces of cake	* * * * *	Covered market café	V	Bought doughnuts when out shopping – only planned to have one but ate both and thought I may as well carry on. Feel disgusted. When will I learn to control myself ?!
9:30 pm	1 bowl mushroom soup and cup of tea		Living room		
10:10 pm					Weighed myself – 9st 3. Very depressed. Need to get back to my reading for tomorrow.
11:10 pm	Hot chocolate Packet of crisps	*			Can't concentrate – keep reading the same page over and over again. Bored. Fed up.

SELF-MONITORING

Rationale

- Helps patients distance themselves from the processes that are maintaining their eating disorder, and thereby begin to recognise and question them
- Highlights key behaviour, feelings and thoughts, and the context in which they occur
  - **makes experiences that seems automatic and out of control more amenable to change**

COLLABORATIVE WEIGHING

Rationale

- Patients with eating disorders are unusual in their frequency of weighing
  - frequent weighing encourages concern about inconsequential changes in weight, and thereby maintains dieting
  - avoidance of weighing is as problematic
- Knowledge of weight is a necessary part of treatment
  - permits examination of the relationship between eating and weight
  - facilitates change in eating habits
  - necessary for addressing any associated weight problem
  - one aspect of the addressing of the over-evaluation of weight

COLLABORATIVE WEIGHING

Procedure

- No weighing at home (but transfer to at-home weighing late in treatment) but patient and therapist weighing the patient at the beginning of each (weekly) session
  - joint plotting of a weight graph
  - repeated examination of trends over the preceding four readings
  - continual reinforcement of "*One can't interpret a single reading*"

REGULAR EATING

Key intervention for all patients (including underweight ones)

Rationale

- Foundation upon which other changes in eating are built
- Gives structure to the patient's eating habits (and day)
- Provides meals and snacks which can then be modified
- Addresses one form of dieting (skipping meals)
- Displaces binge eating

Procedure

- Help patients eat at regular intervals through the day .....
- ..... without eating in the gaps
- ..... what they eat does not matter at this stage

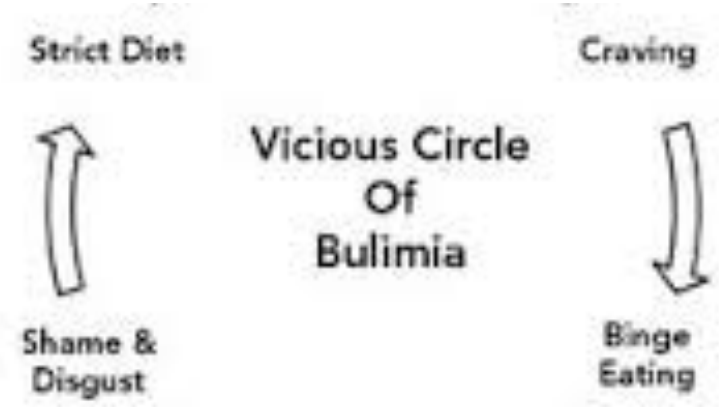
ADDRESSING DIETARY RESTRAINT

"Restraint"

(attempted under-eating)

"Restriction"

(actual under-eating)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ADDRESSING DIETARY RESTRAINT

- Remind patients that (for them) dietary restraint is a problem, not a solution
- Identify the main forms of restraint
  - delayed eating
    - already addressed
  - avoidance of specific foods

ADDRESSING DIETARY RESTRAINT

Food avoidance

- Identify avoided foods
- Categorise them
- Systematically introduce (as behavioural experiments)
- Exposure
  - Food == fat
  - Avoid food
  - Did not get fat
  - Eat food, did not get fat, ➔ food not equal to fat

IDENTIFY AND CHALLENGE DIETARY RULES

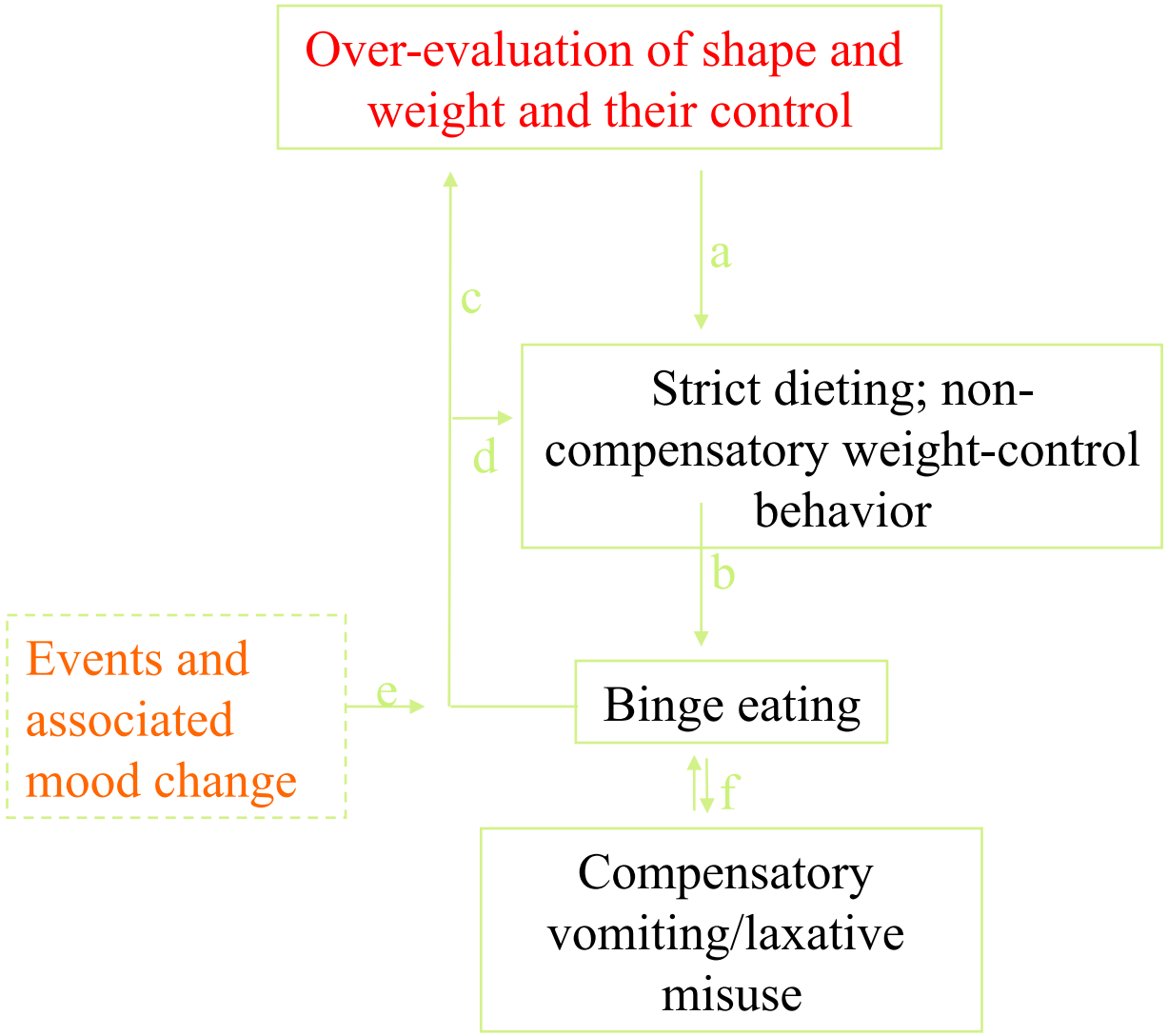
Identify other dietary rules and rituals:

- Not eating more than 600 kcals daily
- Not eating before 6.00 pm
- Not eating in front of others
- Eating less than others present
- Not eating food of unknown composition

COGNITIONS

Whilst continuing with the strategies and procedures introduced in Stage One, address the main maintaining mechanisms operating in the individual patient's case ...

1. Over-evaluation of shape and weight
2. Over-evaluation of control over eating
3. Event-related changes in eating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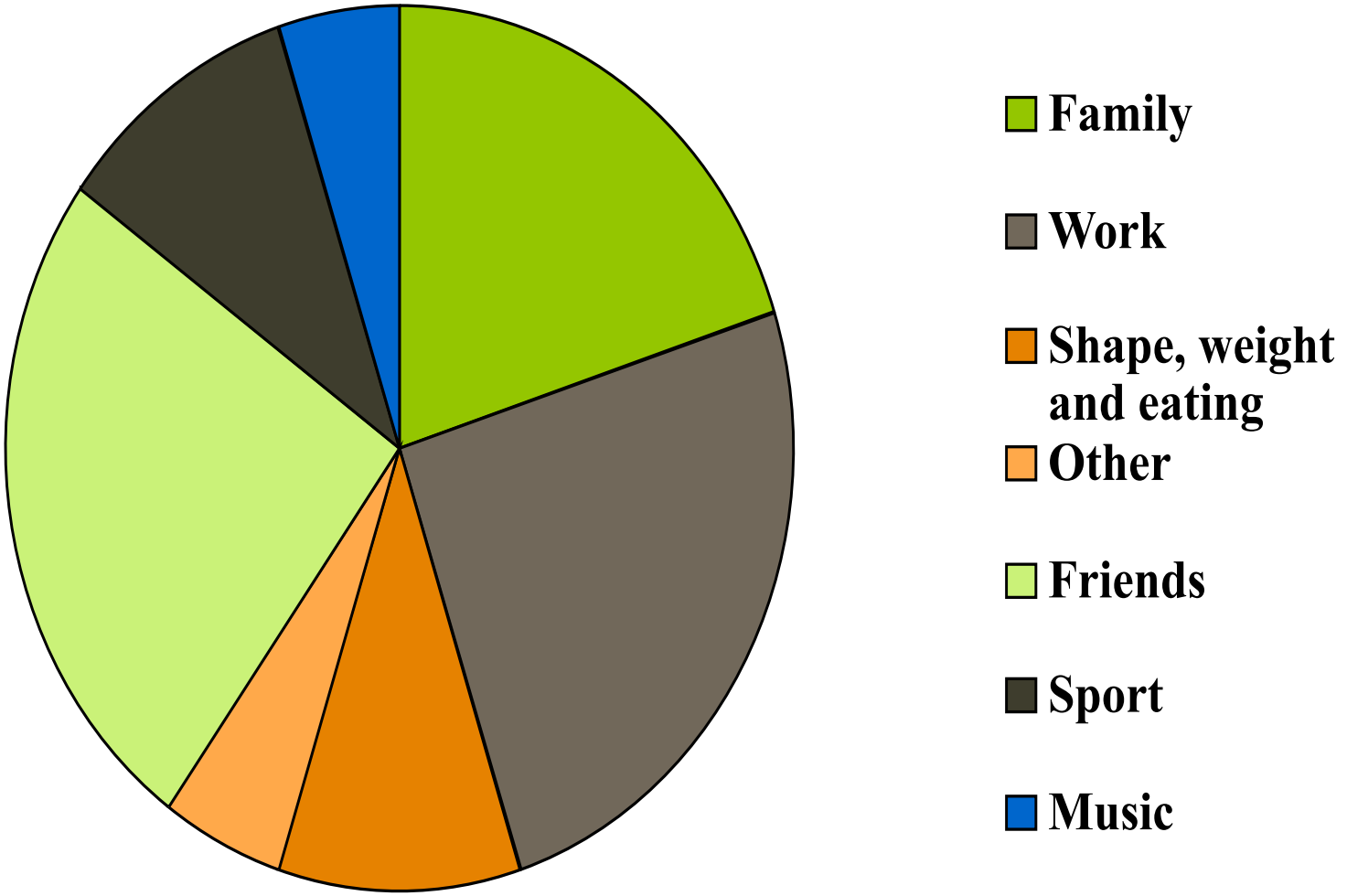
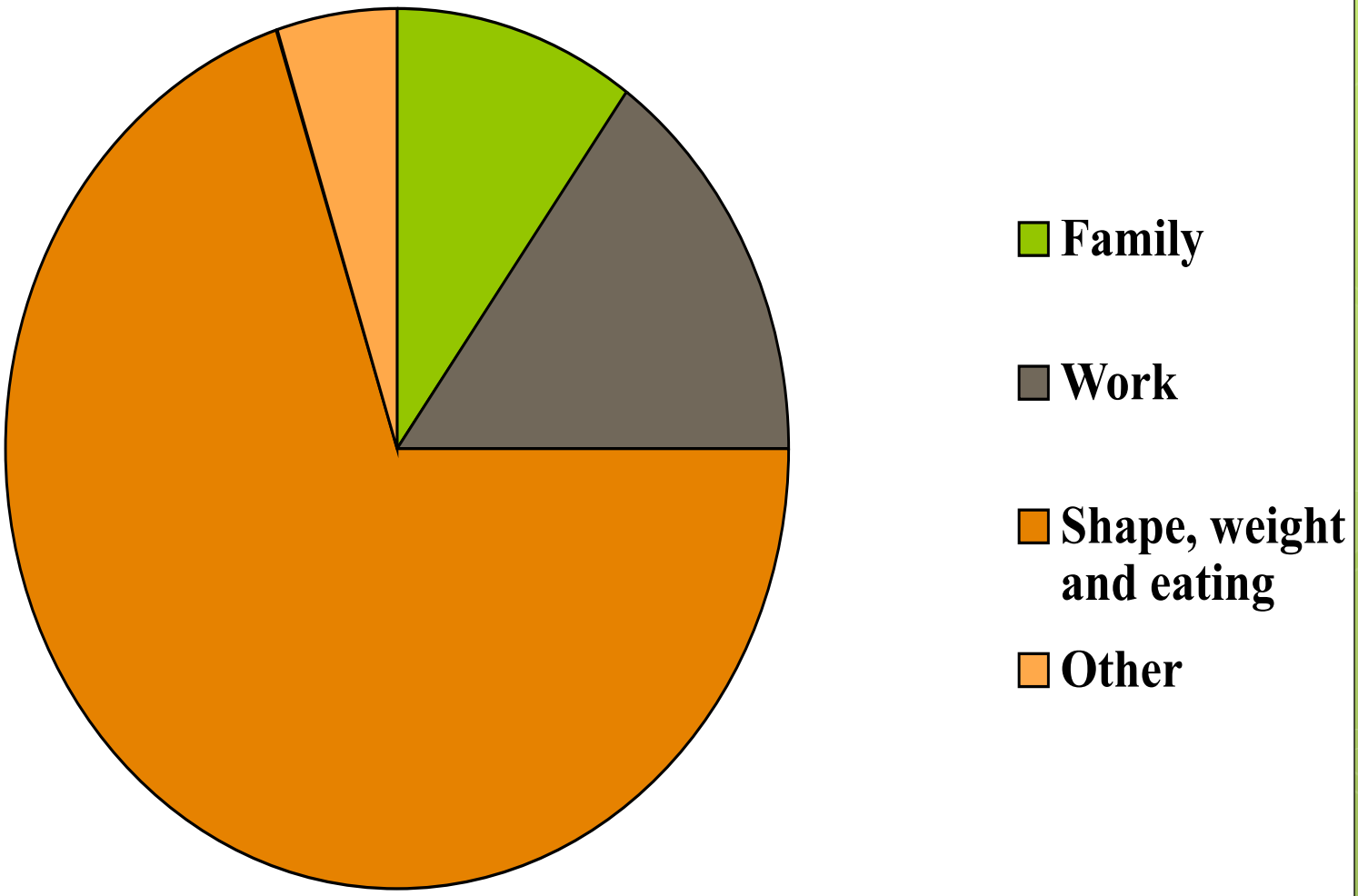
ADDRESSING THE OVER-EVALUATION OF SHAPE OR WEIGHT

The "core psychopathology" of eating disorders is the over-evaluation of shape and weight

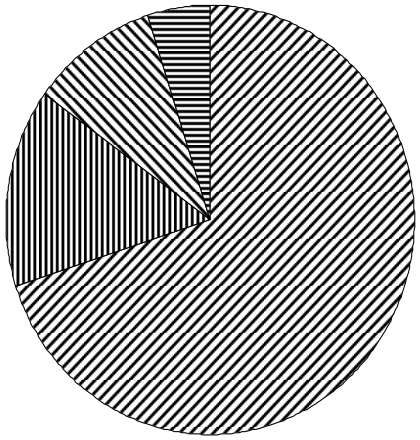
- self-worth is judged largely or exclusively in terms of shape and weight and the ability to control them
- other modes of self-evaluation are marginalised
- most other features appear to be secondary to the core psychopathology
    - dieting
    - repeated body checking and/or body avoidance
    - pronounced "feeling fat"


Family
Work
Shape, weight and eating
Other
Friends
Sport
Music


Family
Work
Shape, weight and eating
Other

EVALUATION OF SHAPE OR WEIGHT (cont)

Expand the formulation



Over-evaluation of shape and weight and their control

- Dietary restraint
- Shape and weight checking and/or avoidance
- Preoccupation with thoughts about shape and weight
- Mislabelling adverse states as "feeling fat"
- Marginalisation of other areas of life

ADDRESSING THE OVER-EVALUATION OF SHAPE OR WEIGHT

2. Address the over-evaluation using two strategies:

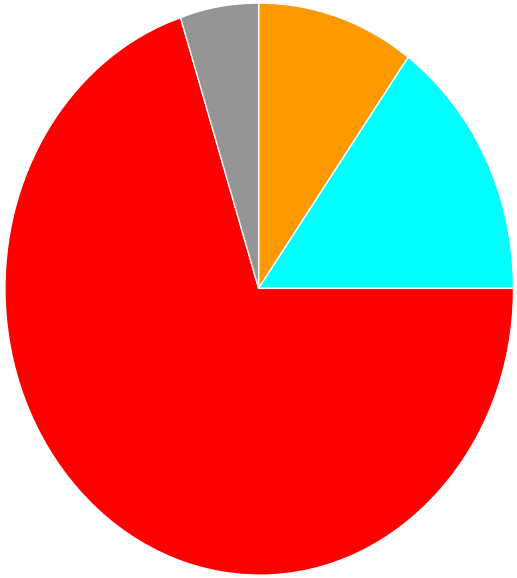
Develop new domains for self-evaluation

Reduce the importance of shape and weight

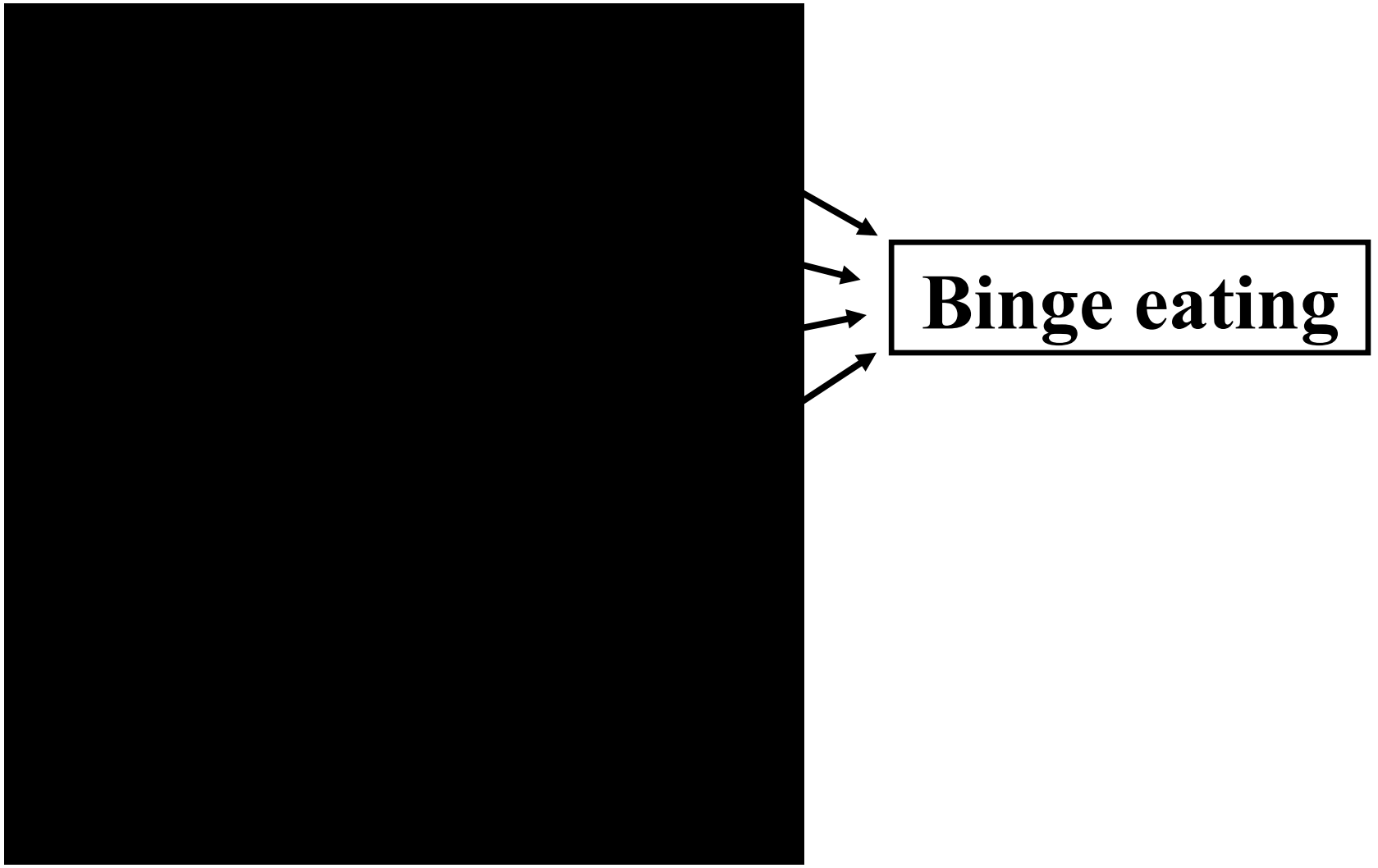
ADDRESSING THE OVER-EVALUATION OF SHAPE OR WEIGHT

Develop new domains for self-evaluation

- encourage patients to identify and engage in (neglected) interests and activities, especially those of a social nature



Binge Analysis



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ENHANCING PROBLEM-SOLVING

Step 1	The problem should be identified and specified as early as possible
Step 2	All possible ways of dealing with the problem should be considered
Step 3	Their likely effectiveness and feasibility should be considered
Step 4	One alternative should be chosen
Step 5	The steps required to carry out the chosen solution should be defined
Step 6	The solution should be acted upon
Step 7	*Subsequently the entire problem-solving process should be evaluated*