A Resource for Counsellors and Psychotherapists Working with Clients Suffering from Eating Disorders

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Foreword

This document is a literature review of research prior to 2009 into the effectiveness of therapeutic approaches for treating eating disorders, intended as a resource for counsellors and psychotherapists. It was written on behalf of the PACFA Research Committee. However, this does not imply that PACFA or its Member Associations endorses any of the particular treatment approaches described.

The PACFA Research Committee recognises that it is important to counsellors and psychotherapists that they have access to recent research evidence that demonstrates the effectiveness of different therapeutic approaches, to assist them in their practice. This document is one of a series of reviews that was commissioned by the PACFA Research Committee to support its Member Associations in their work.

The PACFA Research Committee endorses the American Psychological Association’s definition of evidence-based practice as ‘the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences’, although we would prefer to use the word client or consumer rather than ‘patient’.

The PACFA Research Committee recognises that there is overwhelming research evidence to indicate that, in general, counselling and psychotherapy are effective and that, furthermore, different methods and approaches show broadly equivalent effectiveness. The strength of evidence for effectiveness of any specific counselling and psychotherapy intervention or approach is a function of the number, independence and quality of available effectiveness studies, and the quality of these studies is a function of study design, measurements used and the ecological validity (i.e. its approximation to real life conditions) of the research.

The PACFA Research Committee acknowledges that an absence of evidence for a particular counselling or psychotherapy intervention does not mean that it is ineffective or inappropriate. Rather, the scientific evidence showing equivalence of effect for different counselling and psychotherapy interventions justifies a starting point assumption of effectiveness.

We recognise the need to improve the evidence-base for the effectiveness of various therapeutic approaches. The PACFA Research Committee is committed to supporting our Member Associations and Registrants to develop research protocols that will help the profession to build the evidence-base to support the known effectiveness of counselling and psychotherapy.

We hope that you will find this document useful and would welcome your feedback.

Dr Sally Hunter
Chair of the PACFA Research Committee, 2011
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1. Introduction

This literature review is based on available empirical evidence and has been developed to provide a resource for counsellors and psychotherapists working with clients who have eating disorders. It is not based on a systematic literature review but summarizes current evidence base for therapeutic approaches to working with eating disorders. It has been reviewed by the Research Committee of PACFA, the PACFA Board, and by international eating disorder experts:

- Professor Phillipa Hay, Professor and Foundation Chair of Mental Health, School of Medicine, University of Western Sydney, Sydney;
- Professor Susan Paxton, Head of the School of Psychological Sciences, La Trobe University, Melbourne;

This resource gives an overview of types of eating disorders, prevalence, causes, risk factors and evidence for effective therapy. The review is consistent with current scholarship on the definition of evidence base in psychological practice and mental health areas (e.g., APA Presidential Taskforce on Evidence-Based Practice, 2006). It also provides information about internet links for other therapeutic resources and guidelines.

2. Types of eating disorders

Individuals who suffer from an eating disorder have problems with their eating, weight management practices and body image. These problems often lead to severe, sometimes life-threatening, physiological and psychological consequences. Severe restriction of food intake can result in depression, social withdrawal, preoccupation with food, changes in hormone secretion, amenorrhea (i.e. the absence of at least three consecutive menstrual cycles), decreases in the metabolic rate and binge eating. Eating disorders, particularly anorexia nervosa, have one of the highest mortality rates of any mental disorder, with a death rate of 15.6% (Zipfel, Lowe, Deter, & Herzog, 2000) due to suicide or medical complications (often cardiac arrest secondary to arrhythmias). Therefore it is particularly important, as described in the section about therapeutic interventions, to integrate risk monitoring and management into therapy.

There are three different disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV) which can be captured under the phrase of “eating, weight, and shape-related” disorders: Anorexia nervosa, Bulimia nervosa and Eating Disorder Not Otherwise Specified. Below are the diagnostic criteria for the three eating disorders according to the DSM-IV-TR (American Psychiatric Association, 2000a).
2.1 Diagnostic criteria for Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In post-menarcheal females, amenorrhea (i.e., the absence of the least three consecutive menstrual cycles). A woman is considered to have amenorrhea if her periods occur only following hormone administration.

Table 1: Summary Anorexia Nervosa

<table>
<thead>
<tr>
<th>Anorexia is characterised by:</th>
</tr>
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<tbody>
<tr>
<td>● A severe restriction of food intake</td>
</tr>
<tr>
<td>● A loss of body weight to an unhealthy level</td>
</tr>
<tr>
<td>● A loss of menstrual periods (female)</td>
</tr>
<tr>
<td>● An intense fear of getting “fat”, and/or losing control of eating</td>
</tr>
<tr>
<td>● Body image disturbance: regarding the body as fat despite being underweight.</td>
</tr>
</tbody>
</table>

2.2 Diagnostic criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is larger than most people would eat during a similar period of time and under similar circumstances;
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent, inappropriate compensatory behaviour in order to prevent weight gain such as: self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.
Table 2: Summary Bulimia Nervosa

Bulimia nervosa is characterised by a cycle of binge eating followed by compensatory behaviour such as purging, laxative abuse or over-exercising to get rid of the food.

2.3 Diagnostic Criteria for Eating Disorder Not Otherwise Specified

The Eating Disorder Not Otherwise Specified (EDNOS) category is for disorders of eating that do not meet the criteria for any specific eating disorder. One form of EDNOS can be binge eating disorder.

Diagnostic Criteria for Binge-Eating Disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is larger than most people would eat during a similar period of time and under similar circumstances
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:
   1. Eating much more rapidly than normal
   2. Eating until feeling uncomfortably full
   3. Eating large amounts of food when not feeling physically hungry
   4. Eating alone because of being embarrassed by how much one is eating
   5. Feeling disgusted with oneself, depressed, or very guilty after overeating.

C. Marked distress regarding binge-eating is present.

D. The binge eating occurs, on average, at least 2 days a week for 6 months.

E. The binge eating is not associated with the regular use of inappropriate compensatory behaviours (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

Table 3: Summary Binge Eating Disorder

Binge eating disorder is characterised by periods of binge eating (uncontrolled, impulsive or continuous eating) without compensatory behaviours such as vomiting or excessive exercise.
3. Prevalence

Eating disorders have been reported to be one of the ten leading causes of disability and distress among young women in Australia (Mathers, Vos, Stevenson, & Begg, 2000). The prevalence of specific eating disorders such as anorexia nervosa or bulimia nervosa has been considered relatively low in comparison to other mental disorders such as affective disorders or anxiety disorders (Piran, Levine, & Steiner-Addir, 1999). However, when the prevalence rates of various eating disorders are summed and the higher prevalence rates of sub-clinical eating disorders or eating disorders not otherwise specified are included, it can be stated that many individuals, particularly women, suffer from an eating disorder (Thompson, 2004; Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006).

The accurate prevalence of eating disorders is difficult to assess due to the sometimes secretive nature of the disorder. The prevalence rates given by the American Psychiatric Association (2000a) are approximately 0.5% for anorexia nervosa and between 1% and 3% for bulimia nervosa. Wade and colleagues (2006) reported in an Australian study a lifetime prevalence of 1.9% for anorexia nervosa and an additional 2.4% of women who partially met the criteria for anorexia nervosa (they did not show amenorrhea). Bulimia nervosa was shown by 2.9% of the women and binge eating disorder also by 2.9%; while 5.3% showed an eating disorder not otherwise specified. It is also notable that there has been an increase in disordered eating behaviours in Australia between 1995 and 2005 (Hay, Mond, Buttner, & Darby, 2008).

Eating disorders are much less prevalent in men (Hay, Loukas, & Philpott, 2005; Hoek, 2006; Hoek & Hoeken, 2003) with a ratio of about 10 women to 1 man (Thompson, 2004). In an Australian study (Hay et al., 2005) the prevalence of eating disorders in men was 1.2%. Men showed similar symptoms to women. However, they were less weight concerned or less likely to use self-induced vomiting as compensatory behaviour.

The onset of eating disorders occurs mostly during adolescence or young adulthood. Anorexia nervosa typically begins during adolescence and bulimia nervosa in young adulthood. An eating disorder can, however, also develop in later years and, if untreated, persist into a person’s adult life.

4. Causes and risk factors

Knowledge about causes of, and risk factors for, eating disorders is still limited (Field, 2004; Striegel-Moore & Bulik, 2007) due to the lack of longitudinal studies with large sample sizes. It has been suggested that a complex set of biological, cultural and psychological factors contribute to the risk of developing an eating
disorder. Therefore, the etiology of eating disorders has been described as complex and multifactorial (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Striegel-Moore & Bulik, 2007). Risk factor research has focused on biological processes and factors involved in appetite and weight regulation, and cultural factors that lead to attitudes and behaviours associated with body image and eating. Higher body mass index has not been found to be a risk factor for eating disorders (Jacobi et al., 2004). Table 4 shows a list of risk factors for eating disorders (Pike et al., 2008; RANZCP, 2004; Striegel-Moore & Bulik, 2007). Pike et al. (2008) have shown that negative affectivity, perfectionism, family discord, and high parental demands were risk factors for anorexia nervosa.

Socio-cultural models have focused on the influence of the media and beauty ideals on body image and eating behaviour. The thin body ideal is mostly equated with beauty or success and has been shown to be a strong influencing factor on body dissatisfaction and disordered eating. Body dissatisfaction has been found to be a significant predictor of eating pathology (Stice & Agras, 1998), particularly for bulimic symptoms (Stice, 2002). The research on genetic risk factors in eating disorders is still in its early stages. Results of twin studies suggest that there is a substantial genetic component that contributes to the development of eating disorders (Striegel-Moore & Bulik, 2007). More sophisticated models need to be developed and further investigated. These need to incorporate longitudinal study designs and include the interplay of genes/biological factors and environment.

<table>
<thead>
<tr>
<th>Table 4: Risk Factors for Eating Disorders</th>
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<tbody>
<tr>
<td>• Being female</td>
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<tr>
<td>• Having a parent with an eating disorder</td>
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<tr>
<td>• Body dissatisfaction, focus on appearance and internalization of the thin ideal</td>
</tr>
<tr>
<td>• Low self-esteem</td>
</tr>
<tr>
<td>• Dieting</td>
</tr>
</tbody>
</table>

5. Therapeutic interventions

Many individuals with an eating disorder do not seek or receive appropriate therapy for their eating problems (Mond, Hay, Rodgers & Owen, 2007). Results of an Australian study (Hay, Marley, & Lemar, 1998) indicated that only a minority of individuals with a bulimic disorder sought appropriate therapy. Some key reasons that people do not seek help include fear of stigma, shame, fear of change and costs (Hepworth & Paxton, 2007; Hepworth, Paxton, & Williams, 2007). However, the sooner the disorder is treated, the more likely it is that the disorder can be overcome. Therefore, it is important to make appropriate therapy available and more easily accessible for people with an eating disorder. It is also important to
focus on active engagement of clients in therapy. The following section summarizes recommendations and research results from existing literature and aims to give information about appropriate therapy for anorexia and bulimia. In this literature review, the focus was exclusively on counselling and psychotherapeutic approaches, not on drug treatments.

5.1 Therapeutic alliance

A strong and positive therapeutic alliance, in the form of a collaborative, empathic and accepting bond between client and therapist, is an established predictor of outcome in psychotherapy (Martin, Garske, & Davis, 2000). This is true for psychotherapy in general, and specifically for working with clients suffering from an eating disorder (Constantino, Arnow, Blasey, & Agras, 2005; Brisman, 1994; Geller, 2006; Toman, 2002; Loeb et al., 2005). This is related to the salience of issues of trust and control which are important features of eating disorder conditions (Pyle, 1999). The therapeutic relationship is considered to be the central factor contributing to therapy outcome (APA, 2005).

Both clients and therapists have reported that the therapeutic alliance is an important factor in the quality of the therapy for eating disorders (de la Rie, Noordenbos, Donker, & van Furth, 2008). From the client's perspective, trust in the therapist has been found to be the most important criterion for the quality of the therapy for eating disorders (de al Rie et al., 2008). Gallop, Kennedy and Stern (1994) found that clients in an inpatient unit for eating disorders, who stayed in treatment, reported a stronger therapeutic alliance than clients who left treatment before completion.

However, therapeutic relationships with clients suffering from an eating disorder have been described as challenging (Ardovini, 2002), due to the client's self-harming thoughts and behaviours, the risk of suicide, the influences of cognitions, emotions and activity level caused by starvation or malnutrition, and the client's ambivalence towards recovery and the therapeutic process (Manley & Leichner, 2003). Clients' characteristics which have been shown to be related to the quality of the therapeutic relationship in clients suffering from bulimia nervosa included the severity of symptoms, expected improvement in therapy, and interpersonal problems at the beginning of therapy (Constantino et al., 2005). A further client characteristic that may be related to the quality of the therapeutic relationship is the body mass index of the client (Toman, 2002). Manley and Leichner (2003) describe the challenges counsellors or psychotherapists have to face in the work with clients who suffer from an eating disorder and emphasized the importance of a sound therapeutic relationship. They recommended understanding, empathy and careful listening as key elements to ensure good therapeutic process.
5.2 Therapy for anorexia nervosa

What evidence about the efficacy of therapy of anorexia nervosa do we have?

The evidence base for the efficacy of psychotherapeutic interventions for anorexia nervosa is weak (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Fairburn, 2005; Keel & Haedt, 2008; Steinhausen, 2002; Wilson, Grol, & Vitousek, 2007) and the quality of the studies has been judged to be mostly poor (Keel & Haedt, 2008; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa, 2004; Wilson et al., 2007). This lack of empirical evidence is mostly due to the low prevalence rate and the high morbidity.

Does therapy work?

A review article by Steinhausen (2002), in which 119 studies and 5590 clients have been included, has shown that nearly 50% of people who suffered from anorexia and who completed the treatment recovered, one-third improved and 20% remained chronically ill after treatment. A study about effective treatment of eating disorders in Europe has reported that treatment was successful in 37% of 702 clients with anorexia at 1 year follow-up (Richard, 2005). Vomiting, bulimia, chronicity of the disorder, onset of the disorder in adulthood and coexisting mental disorders were factors which influenced the prognosis negatively. Zipfel et al. (2000) have reported a recovery rate of 50.6% with an additional 20.8% of the clients having intermediate outcome at 21-years follow-up after inpatient treatment. One reason for the low success rates in anorexia is the egosyntonic nature (sufferers do not feel that they have a problem) of this disorder and the fact that individuals with anorexia often do not have a high motivation to overcome it (Pike, Devlin, & Loeb, 2004). Positive influences on the prognosis are prompt therapy after onset of the disorder, a strong motivation to change behaviour and outpatient treatment in less severely disordered people (RANZCP, 2004; Steinhausen, 2002). Furthermore, higher initial body weight and a younger age significantly predicted higher effectiveness of therapy (Richard, 2005). There is only limited empirical evidence available about the effectiveness of group therapy for clients with anorexia (American Psychiatric Association, 2006).

Therapy content and aims: What principles guide therapy for anorexia nervosa?

The following section summarizes recommendations for the therapy of anorexia nervosa (American Psychiatric Association, 2006; American Psychiatric Association, 2000b; National Institute for Clinical Excellence, 2004; RANZCP, 2004). Because of the high mortality rate for this disorder and the challenging nature of treatment, the literature review outlines the broader treatment context and the need for therapists to work collaboratively with other health professionals in relation to the wider medical and dietary aspects of treatment.
Therapy context

- Therapy is provided by a multidisciplinary team including a general practitioner, a dietitian and a mental health specialist.
- Therapy addresses medical, psychological, nutritional and social components of the disorder.
- Therapy includes and/or supports family members and friends where possible.
- Family-based therapy may be offered to children and adolescents suffering from anorexia.
- Outpatient treatment lasts for at least 6 months.
- If the course of therapy does not lead to significant improvements such as weight restoration and changes in dysfunctional thinking and behaviours, more intensive forms of therapy are recommended. Inpatient treatment and the provision of life-preserving care is indicated if the body mass index is less than 14 or the weight of the client is less than 75% of the healthy body weight. Following inpatient treatment, outpatient treatment combined with physical monitoring lasts for at least 12 months.

Aims and important parts of the therapy for anorexia nervosa

- Preventing death by restoring nutrition and regaining weight.
- Fostering more positive eating behaviours and attitudes to weight and shape with encouragement for weight gain and healthy eating.
- Supporting clients to reassess and change dysfunctional thoughts, attitudes, feelings and behaviours.
- Integrating an understanding of the client’s disorders of self-esteem, self-regulation, psychodynamic conflicts, cognitive development, traumas and family relationships.
- Educating and providing information on the nature, course and treatment of anorexia nervosa to the client and carers (where appropriate).
- In most cases, the aims of therapy include helping the client to have an average weight gain of 0.5 kg in an outpatient setting. Controlled weight gain could result from a nutritional rehabilitation program.
- Medical management including the monitoring of weight (weighing once or twice per week), vital signs and dietary intake, to monitor the medical risk and the treatment response but also to avoid the ‘re-feeding syndrome.’ (Re-feeding after recent, rapid weight loss can lead to weakness, peripheral oedema, seizures, coma, visual and auditory hallucinations or sudden death). Detailed information about risk assessment and risk monitoring can be found in Waller et al. (2007) and in a guide to the medical risk assessment for eating disorders by Treasure (2004) which is available on
the internet (see Table 8).

- Addressing comorbid disorders, such as depression or anxiety following best practice for those issues.
- Facilitating psychological and physical recovery and preventing relapse.

**Management of physical risks and complications of anorexia nervosa**

- Physical risk in clients with anorexia nervosa needs to be monitored regularly by a medical specialist throughout treatment. Physical symptoms associated with starvation need to be treated.
- Clients with anorexia and their carers need to be informed about the physical risk.
- Health care professionals treating clients with anorexia nervosa need to be aware of the increased risk of self-harm and suicide, and implement behavioural contracting with clients.

**Monitoring of the process**

- It is important to monitor the level of risk to the client’s mental and physical health during therapy. The physical state of the client needs to be monitored regularly, including weight gain/loss and other specific indicators of increased physical risk.
- Responsibility for the monitoring of progress and of risk needs to be discussed and agreed by all involved health care professionals and the client.

**Inpatient or outpatient treatment?**

The National Institute for Clinical Excellence (NICE, 2004) recommends that the majority of people suffering from anorexia nervosa should be treated in an outpatient setting with psychological treatment provided by a service that is competent in giving specific treatment for this disorder and in assessing the physical risks. Inpatient treatment is necessary if the medical risks for outpatient treatment are too high and rapid weight loss or physical deterioration occurs (Beumont, Hay, & Beumont, 2003). Clients with a weight below 75% of healthy body weight or with rapid and severe weight loss can be too severely compromised to be treated in a weekly outpatient psychotherapy setting and it may be necessary to treat in an intensive outpatient or inpatient setting (American Psychiatric Association, 2000b), where malnutrition can be corrected and regular monitoring of the medical risk can be assured. However, not only weight, but also the client’s overall physical condition, rate of weight loss, cardiac function, psychological condition and the social circumstances should be considered in determining the appropriate level of care (American Psychiatric Association, 2006).
What kind of therapeutic approach?

At this point, no specific psychotherapeutic approach can be considered to be superior to other approaches for the treatment of anorexia nervosa (Hay, Bacaltchuk, Byrnes, Claudino, Ekmejian, & Yong, 2003; PYNICE, 2004; RANZCP, 2004). It has been recommended that dietary advice should be part of the treatment when combined with individual or family psychotherapy (RANZCP, 2004). Psychotherapies used for the treatment of anorexia nervosa include CBT, family therapy, psychodynamic therapy, art therapy and interpersonal therapy. Other therapeutic approaches increasingly used in the treatment of anorexia nervosa are motivational enhancement therapy, dialectical behavioural therapy (Kotler, Boudreau, & Devlin, 2003) and mindfulness and acceptance-based approaches (Baer, Fischer, & Huss, 2005). Yager (2003) has suggested the use of e-mail as an adjunct to outpatient treatment of anorexia nervosa.

Cognitive behavioural therapy

CBT for anorexia nervosa is the individual therapy most often evaluated in research studies. However, CBT has not been shown to be significantly more effective than other psychotherapies (Channon, De Silva, Hemsley & Perkins, 1989; Wilson et al., 2007). Pike, Walsh, Vitousek, Wilson and Bauer (2003) have reported in their randomized controlled trial in which they compared CBT to nutritional counselling that clients who received CBT showed significantly better outcome and were less likely to relapse than clients who received nutritional counselling. Of the clients who had received CBT, 44% had good outcome compared to 7% of the nutritional counselling group. Details about CBT for eating disorders can be found in a comprehensive treatment guide by Waller and colleagues (2007).

Family therapy

Review articles indicate that most research about the efficacy of treatment for anorexia in adolescents has been undertaken on family therapy (Wilson et al., 2007). The evidence base for the Maudsley model of family-based therapy for the treatment of anorexia nervosa in adolescents is strongest (Keel & Haedt, 2008; Wilson et al., 2007). Details about the Maudsley model and the treatment process can be found in the published manual (Lock, le Grange, Agras, & Dare, 2001). Family-based therapy involves 10-20 sessions over 6-12 months with all family members. In the first phase of therapy, the role of the parents is to take complete control over their child’s eating and weight. In later stages of therapy, the client regains autonomy and engages in age-appropriate individuation from the parents which is related to recovery.

Eisler (2005) has given an overview of empirical evidence for family therapy and its effectiveness for the treatment of anorexia nervosa in adolescents and a description of a treatment model. Recovery rates for adolescents have been shown to be slightly higher after family therapy than for individual therapy (Wilson et al.,
Eisler et al. (2000) have shown that after receiving family therapy 38% had a good and 25% had an intermediate outcome. It has also been shown that although outcomes of family therapy were comparable to outcomes after individual therapy (Robin et al., 1999; Robin, Siegel, & Moye, 1995), adolescents who received family therapy recovered faster (Robin et al., 1999).

In a randomized controlled trial by Schmidt et al. (2007) in which family therapy was compared to CBT guided self-care, the two treatment outcomes did not significantly differ from each other after 12 months. Furthermore, there is no supportive evidence for the effectiveness of family therapy in adults and individuals who have suffered from the disorder for a longer period of time. Therefore, family therapy has been shown to be more effective for adolescent clients than for adult individuals (Bulik et al., 2007). It has been suggested that for clients with a late onset of anorexia nervosa, individual therapy could be a better therapeutic intervention than family therapy (Beumont et al., 2003). It can be concluded that children and adolescents with anorexia nervosa should be offered family interventions, as also recommended by the NICE guideline (NICE, 2004).

**Psychodynamic therapy**

Kächele and colleagues (2001) found in their study of the outcome of psychodynamic inpatient treatment of eating disorders in Germany that 33% of the clients who had suffered from anorexia nervosa were free of symptoms at the two and a half year follow-up. In a study about the effectiveness of focal psychoanalytic psychotherapy, cognitive-analytic therapy and family therapy, one third of the clients no longer showed symptoms at the end of therapy (Dare, Eisler, Russell, Treasure, & Dodge, 2001). However, the sample sizes in this study were small. Therefore, reduced power due to small sample sizes made it impossible to differentiate between the three psychotherapy approaches. The effectiveness of psychodynamic therapy for the treatment of anorexia nervosa has only been investigated to a limited extent.

**Interpersonal therapy**

Interpersonal therapy has mostly been investigated with individuals who suffer from bulimia nervosa. Little empirical evidence exists about the efficacy of this therapy for anorexia nervosa. In a study by McIntosh and colleagues (2005), CBT, interpersonal therapy and a treatment combining specialist supportive clinical management (psycho-education and supportive psychotherapy) were compared in clients with anorexia nervosa. The specialist supportive clinical management and CBT were more effective than interpersonal therapy. However, sample sizes were small and overall outcome was low (9% of the clients had a very good outcome and 21% showed improvements).
**Art therapy**

To our knowledge, there is no empirically based study that has investigated the efficacy of art therapy as a therapeutic intervention for eating disorder. However, narrative reports on the use of this approach for the treatment of eating disorders imply positive outcomes (Frisch, Franko, & Herzog, 2006). This therapeutic approach combines non-verbal and verbal elements and is frequently used in combination with other psychotherapeutic approaches (Matto, 1997). Art therapy can help clients to work on cognitive distortions related to their body or their eating patterns, facilitate the expression of emotions or the exploration of conflicts and problems, and can help to develop new coping strategies. Levens (1995) describes treatment of eating disorders through art therapy and how the art therapist can facilitate the client’s treatment process.

**Table 5: Summary therapy for anorexia nervosa**

Based on the currently available research results it can be concluded that psychotherapeutic treatment is significantly more effective than no treatment (Dare et al., 2001) or dietary advice on its own (Pike et al., 2003). Family therapy is the most widely tested and efficient method for adolescents. Furthermore, a multidimensional and multidisciplinary treatment approach including thorough assessment, ongoing risk management, and integration of multiple treatment modalities is recommended.

### 5.3 Therapy for bulimia nervosa

**What evidence about the efficacy of therapy of bulimia nervosa do we have?**

The empirical evidence for psychological treatment of bulimia nervosa is strong (NICE, 2004; Shapiro et al., 2007), particularly for CBT and interpersonal therapy (Wilson et al., 2007). Studies about the efficacy of alternative treatment approaches are rare.

**Does therapy work?**

Review studies about the efficacy of treatment for bulimia nervosa have concluded that a high percentage of clients still suffer from the disorder after treatment (Mitchell, Hoberman, Peterson, Mussell, & Pyle, 1996). Results of a European collaborative study in which treatment outcomes from several European countries have been combined indicated that 40% of the 981 clients with bulimia showed positive outcome at a one year follow-up (Richard, 2005). This success rate was relatively low compared to other studies.

A study of the long term course of bulimia nervosa (Fichter & Quadflieg, 1997) showed that six years after treatment, 60% achieved a good outcome, and 29% an
intermediate outcome. Thompson-Brenner, Glass, and Westen (2003) conducted a meta-analysis of psychotherapy for bulimia nervosa, in which they included 26 clinical trials (N = 1427) of different therapeutic approaches. They found that of the clients who completed therapy, 40.1% were classified as recovered post-treatment (recovery rate for intention-to-treat sample was 32.6%). The recovery rate after treatment for individual CBT was on average 48% for completers. Follow-up data has been available for seven studies. After the average follow-up time of 12.75 months, 43.7% of clients were recovered (across different treatments).

The recovery rate for individual therapies was significantly higher than for group therapies. Frequency of binge eating, age, psychological distress and family relationships were factors that were related to the effectiveness of therapy (Richard, 2005).

**Therapy content and aims: What principles guide therapy for bulimia nervosa?**

In the following section, standards of treatment for bulimia nervosa are summarised (American Psychiatric Association, 2006; American Psychiatric Association, 2000b; NICE, 2004; RANZCP, 2004):

**Therapy context**

- Inpatient treatment should be considered for clients with risk of suicide or risk of severe self-harm only. The majority of clients can be treated in an outpatient setting.
- Therapy addresses the reduction of binge eating and purging behaviour.
- Fluid and electrolyte balance should be monitored throughout treatment, particularly in clients who are vomiting frequently or using large quantities of laxatives.
- Dietary advice in combination with other treatment approaches can be useful to establish healthy eating patterns and reduce eating disorder behaviour such as vomiting.
- Eating disorder symptoms and the client’s medical condition should be assessed and monitored throughout the treatment.
- Family therapy could be considered for adolescents.

**Cognitive-behavioural therapy for bulimia nervosa**

The NICE guideline (NICE, 2004) recommends that adults suffering from bulimia nervosa should be offered CBT for 16 to 20 sessions over 4 to 5 months. Hay, Bacaltchuk and Stefano (2004) found CBT to be an efficacious treatment in their Cochrane review. This therapeutic approach is the most investigated evidence-based treatment with the most evidence of efficacy and has been recommended as the therapy of choice for bulimia nervosa (Pike et al., 2004; Wilson et al., 2007). About 30% to 50% of the clients typically overcome binge eating and purging after
they receive CBT (Anderson & Maloney, 2001; Wilson et al., 2007). Ghaderi (2006) found that a more individualized CBT treatment, instead of a strictly manual-based treatment, was slightly more beneficial particularly in terms of drop-outs. At post-treatment, 62% \((n = 32)\) of the clients did not show binge episodes or compensatory behaviour. The treatment of bulimia nervosa with CBT has been described in Fairburn (2002).

**Interpersonal psychotherapy for bulimia nervosa**

Interpersonal therapy (IPT) is an alternative therapeutic approach recommended by the NICE guideline (2004) for the treatment of bulimia nervosa. However, it usually takes 8-12 months to reach results comparable with CBT. Reviews about IPT (Tantleff-Dunn, Gkee-LaRose, & Peterson, 2004) have provided evidence for the efficacy of interpersonal therapy in the treatment of bulimia. Some studies found CBT was more effective than IPT - in some studies CBT was as effective as IPT and in others CBT was more effective at the end of therapy. However both therapeutic interventions showed comparable outcomes at follow-up (Tantleff-Dunn et al., 2004).

**Psychodynamic therapy for bulimia nervosa**

There is little empirical evidence for the effectiveness of psychodynamic treatments for bulimia nervosa. Murphy, Russell and Waller (2005) have shown in their study that after psychodynamic treatment 50% of the sample \((N = 14)\) was symptom-free at three and six month follow-ups.

**Guided self-help and self-help for the treatment of bulimia nervosa**

Guided self-help (GSH) has been recommended as a valuable and effective first step in the treatment process of bulimia (NICE, 2004). In guided self-help, a self-help manual based on CBT is introduced to the client by the therapist. The client works through the manual independently, learns about the disorder, how to change behaviour and cognitions and about new skills and problem solving techniques. In the sessions with the therapist, the client gets support, encouragement and assistance in working through the manual. GSH has been found to be an effective treatment approach for the treatment of bulimia nervosa. It has been evaluated in comparison with waiting list controls, CBT, family therapy and pure self-help treatment (Grilo, 2000; Mitchell, Agras, & Wonderlich, 2007; Shapiro et al., 2007; Stefano, Bacaltchuk, Blay, & Hay, 2006). An Australian study (Banasiak, Paxton, & Hay, 2005) found that 28% of the GSH group compared to 11% of the delayed treatment group showed absolute remission from binge eating and all compensatory behaviours. An overview of guided self-help manuals has been given in Paxton, Knauss and Shelton (in press).

A CD-ROM-based CBT self-help intervention has also been described as a valuable first step in treatment for clients who have no access to face-to-face treatment (Bara-Carril et al., 2004).
Table 6: Summary therapy for bulimia nervosa

Based on current available research, CBT can be considered as the treatment of choice for the treatment of bulimia nervosa, with interpersonal therapy as an alternative approach for clients who do not respond to CBT. CBT currently has stronger and more consistent empirical support than interpersonal therapy and results in more rapid alleviation of symptoms. To increase global outcome it may be helpful to use CBT in combination with other psychotherapies. Family therapy should be considered for adolescents. Guided self-help is an effective approach as a first step in the treatment process and may be an effective treatment in some cases.

There is a lack of clinical trials which include therapeutic approaches other than CBT or interpersonal therapy (Thompson-Brenner et al., 2003). Cognitive-behavioural therapy is currently the treatment of choice for bulimia nervosa, but further studies that include different therapeutic approaches are necessary to be able to draw a more precise conclusion about the efficacy of other treatment approaches.

5.4 Therapy for eating disorder not otherwise specified

A high percentage of clients with eating disorders do not fully meet the diagnostic criteria for anorexia nervosa or bulimia nervosa but clearly suffer from disordered eating. This group of clients fall under the DSM-IV-TR category eating disorders not otherwise specified (EDNOS). The required therapeutic intervention depends on symptoms and severity of impairment (APA, 2000b). Treatment strategies for the reported problems such as binge eating, unhealthy dieting behaviour and body dissatisfaction can be nutritional counselling and dietary management combined with cognitive-behavioural, interpersonal or psychodynamic psychotherapy (APA, 2000b). The APA (2006) also recommends dialectical behavioural therapy for the treatment of binge eating disorders.

In a review article about the effectiveness of the treatment of binge eating disorders it has been concluded that evidence of the efficacy of treatments for binge eating disorders is still limited (Brownely, Berkman, Sedway, Lohr, & Bulik, 2007). It can be helpful to use a ‘non-diet’ approach with a focus on self- and body acceptance, exercise and improvement of nutrition and health. Guided self-help can be a valuable treatment approach particularly for binge eating disorders (Paxton, Knauss, & Shelton, in press). For overweight clients with binge eating disorder, CBT and behaviour weight loss therapy have both been found effective (Munsch, Biedert, Meyer, Michael, Schlup, Tuch, & Margraf, 2007). A guided self-help manual for the treatment of disordered eating is accessible on the internet (Fursland, Byrne, & Nathan, 2007; see Table 8).
6. Summary and conclusion

The success rate of treatment of anorexia nervosa is still low. Available and empirically evaluated therapeutic approaches have not shown to be as effective as one would wish. Risk monitoring and management is an important part of the therapeutic process. Important aims of therapy are weight gain, change of eating behaviour, of attitudes to weight and shape and of dysfunctional thoughts and feelings.

There is a strong evidence-base for the treatment of bulimia nervosa showing that CBT is the most effective treatment approach and that interpersonal therapy can be considered as an alternative approach. Guided self-help which is based on CBT can be recommended as a first step in the treatment process for bulimia nervosa and can also be considered as helpful in the treatment of binge eating disorders.

For the treatment of EDNOS and binge eating disorders nutritional counselling, exercise and dietary management combined with psychotherapy can be recommended. Guided self-help can also be a valuable treatment approach for binge eating disorders.

**Table 7: Internet Resources**


References


