

EATING DISORDERS:

Best Practices in Prevention and Intervention

**Mental Health and Spiritual Health Care
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Introduction

BACKGROUND

The Eating Disorders Continuum

Eating disorders can be viewed as occurring along a continuous line, with normal eating at one end and clinically diagnosed and treated eating disorders at the other. The idea is useful in highlighting how body image, weight and eating problems are related. It also acknowledges the differences in the seriousness of the problems.

While there are variations on the linear idea, they all illustrate the idea that eating disorders are related to their life situations, stressors and social contexts.

Eating disorders don't always develop in a linear fashion, though. There are various ways they develop. The British Columbia Eating Disorders Program has developed the following chart to illustrate the range of behaviours on the disordered eating continuum.

TABLE 1: THE CONTINUUM OF DISORDERED EATING		
Wellness	Unhealthy Eating Behaviours	Eating Disorders
<p>Occurring most of the time:</p> <ul style="list-style-type: none"> • realistic, positive body image • eating and drinking only when hungry or thirsty • positive attitude and balanced approach to food choices • positive attitude and balanced approach to physical activity choices 	<p>Unhealthy eating behaviours and attitudes increase in frequency and intensity:</p> <ul style="list-style-type: none"> • feeling fat, worried about appearance, size, shape • preoccupied with food, weight, exercise, looks • not using food in response to body signals, but eating for comfort or as a response to depression, boredom • not eating due to depression or self-punishment • postponing or cancelling activities (ex: beach) due to weight, size, appearance • dieting, restricting, fasting, bingeing, purging, compulsive eating • compulsive exercising <p>Usually, as more energy is spent on unhealthy behaviours and attitudes, less energy is available for life's activities (ex: school, work, family, friends, hobbies).</p>	<p>Unhealthy eating behaviours are labelled as eating disorders once they have reached a point where they can be formally diagnosed.</p> <p>Traditionally, eating disorders are separated into categories:</p> <ul style="list-style-type: none"> • anorexia nervosa • bulimia nervosa • compulsive or binge eating

Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder

Anorexia nervosa and bulimia nervosa are both characterized by a preoccupation with weight and a desire to be thinner. They are not mutually exclusive in that 50 per cent of anorexic patients will also have bulimia. The disorders are diagnosed using recognized criteria.

Anorexia Nervosa

Individuals with anorexia nervosa have a markedly restricted caloric intake, strange dietary rules and may exercise compulsively. The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) provides the following diagnostic criteria for anorexia nervosa:

- an intense fear of gaining weight
- a refusal to maintain adequate nutrition, often associated with an erroneous image of the self as fat

- loss of original body weight to 85 per cent or less of what is expected for normal height and weight
- disturbance of body image and negative self-evaluation
- absence of at least three consecutive menstrual periods in females who have started menstruating

Anorexia nervosa is also defined as restricting type, during which no bingeing or purging behaviour occurs, or as binge-eating/purging type characterized by binge eating, self-induced vomiting or misuse of laxatives, diuretics or enemas.

Bulimia Nervosa

According to the DSM-IV, bulimia nervosa is characterized by:

- frequent binge eating episodes accompanied by a sense of loss of control
- recurrent inappropriate behaviour (ex: vomiting, use of laxatives, fasting, excessive exercise) intended to prevent weight gain
- both of the above behaviours occur at least twice a week, on average, for three months
- self-evaluation is excessively influenced by body shape and weight

Bulimia is divided into purging type and non-purging type with the latter characterized by obsessive exercising.

Binge Eating Disorder

The DSM-IV classifies binge eating disorder as an eating disorder not otherwise specified, which is a category containing significant eating disorders that do not fit clearly into anorexia nervosa or bulimia nervosa. The DSM-IV defines binge-eating disorder as:

- binge eating episodes accompanied by a sense of loss of control
- no inappropriate behaviour to prevent weight gain
- the behaviour occurs at least twice a week, on average, for three months

In order to be diagnosed as binge eating disorder, the binge-eating episodes must have three or more of the following characteristics

- eating more rapidly than normal
- eating until feeling uncomfortably full
- eating large amounts of food when not hungry

- eating alone because they are embarrassed by how much they are eating
- feeling disgusted with themselves, depressed or very guilty after overeating

Co-Morbidity

Sources point to the high incidence of co-morbid psychiatric conditions among individuals with anorexia nervosa, bulimia nervosa and binge eating disorder (Spindler et al, 2004; Kotwal et al, 2004; Grilo et al, 2003; Woodside et al, 2001; APA, 2000). Findings by the American Psychiatric Association Work Group on Eating Disorders (2000) found that:

- 50 to 70 per cent of the clients experienced mild to severe depression
- four to six per cent had bipolar disorder
- 25 per cent had obsessive compulsive symptoms
- 42 to 75 per cent had a personality disorder
- 20 to 50 per cent had been sexually abused

In an Ontario study (Woodside et al, 2001) which compared males and females with eating disorders, there were marked similarities in terms of co-morbid psychiatric diagnoses, with the exception of sexual abuse, which was higher for women.

Complexity/Multifactor Nature of Causality

While there is a substantial body of research establishing the complex interplay of socio-cultural, developmental, psychological, familial, and biological factors, there remains a lack of consensus as to the etiology of anorexia and bulimia (Steiger, 2004). Kreipe & Birndorf (2000) suggest that this complexity might be addressed by viewing eating disorders as "a final common pathway having multiple determinants" (p.1030).

The following section provides a brief review of resiliency theory and risk and protective factors that assist in understanding possible contributing factors to disordered eating and eating disorders.

Risk Factors

Similar to addictions research, while there is a general consensus as to the complexity of contributing factors, few have been empirically validated as direct causal risk factors. (Abraham, 2003; Barr Taylor et al, 2003; Pritts & Susman, 2003; Mitan, 2002; Johnson et al, 2002; AMA, 2002; Strieger-Moore et al, 2002;

Rohwer & Massey-Stokes, 2001; ADA, 2001; Piran, 2001; Kriepe & Birndorf, 2000; Mussell et al, 2000; Wilhelm & Clarke, 1998).

Of all direct risk factors, the most significant risk factor for the development of an eating disorder is dieting behaviour (McVey et al, 2004; AMA, 2002; Tozzi et al, 2002; Rohwer & Massey-Stokes, as cited in Peters, 2003; Gilchrist et al, 1998). A recent Canadian study found that unhealthy dieting

behaviour is reported in girls as young as 10 years (McVey et al, 2004).

Those involved in the field of eating disorders prevention are concerned that the current focus on reducing obesity in children, although well-intentioned, may inadvertently increase disordered eating behaviours because “overweight, perceived overweight and weight concerns are known to precede dieting, hazardous weight loss behaviour and eating disturbances” (O’Dea, 2002, p.91).

TABLE 2: SUMMARY OF POSSIBLE RISK FACTORS FOR THE DEVELOPMENT OF EATING DISORDERS		
	Eating Specific Factors (Direct Risk Factors)	Generalized Factors (Indirect Risk Factors)
Biological Factors	<ul style="list-style-type: none"> • Eating disorder – specific genetic risk • Body weight • Appetite regulation • Energy metabolism • Gender 	<ul style="list-style-type: none"> • Genetic risk for associated mental health disturbance • Temperament / Impulsivity • Neurobiology mechanisms • Gender
Psychological Factors	<ul style="list-style-type: none"> • Poor body image • Maladaptive eating attitudes • Maladaptive weight beliefs • Specific values or meanings assigned to food or body • Overvaluation of appearance 	<ul style="list-style-type: none"> • Poor self-image • Inadequate coping mechanisms • Self-regulation problems • Unresolved conflicts, deficits, posttraumatic reactions • Identity and autonomy issues
Developmental Factors	<ul style="list-style-type: none"> • Identifications with body-concerned relatives or peers • Aversive mealtime experiences • Trauma affecting bodily experience 	<ul style="list-style-type: none"> • Overprotection • Neglect • Felt rejection, criticism • Traumata • Interpersonal experience
Social and Cultural Factors	<ul style="list-style-type: none"> • Maladaptive family attitudes to eating, weight • Peer-group weight concerns • Pressures to be thin • Body-relevant insults, teasing • Specific pressures to control weight (ex: ballet, sports) • Maladaptive cultural values assigned to body 	<ul style="list-style-type: none"> • Family dysfunction • Negative peer experiences • Social values detrimental to stable positive self-image • Destabilizing social change • Values assigned to gender • Social isolation • Poor support network • Impediments to means of self-definition

Source: Health Canada. (2002). A Report on Mental Illnesses in Canada, p. 83

Protective Factors

Protective factors decrease the likelihood that a problem will develop. A protective factor is not simply the absence of a risk factor, however protective factors may emerge in response to risk factors — for example, when healthy adaptation or coping result

as a response to trauma. Table 3 provides a list of protective factors that are specific to eating disorders and a list of those generally associated with mental health.

TABLE 3: PROTECTIVE FACTORS DIRECT AND INDIRECT	
Specific to Eating Disorders	General for Overall Mental Health
<ul style="list-style-type: none"> • Positive body experience, including an understanding of normal pubertal changes • Healthy eating and exercise habits • An understanding of normal nutrition • Understanding that food is neither good nor bad and that eating is an enjoyable, normal behaviour • Lack of pressure to conform or be praised based on weight and shape • Community definitions of beauty that focus on self-respect, assertiveness and generosity of spirit • Competent adult role models of all shapes and sizes who are praised for their accomplishments 	<ul style="list-style-type: none"> • High self-esteem, confidence and self-respect • Confidence in expressing one's needs and emotions • Optimism • Self-awareness about own feelings • Healthy stress management, coping, problem-solving skills and assertiveness • Social competency • Supportive relationships • Family stability and cohesiveness, healthy conflict resolution • Encouragements of self-expression • Mentoring by adults outside the nuclear family • Clear and positive social norms at the community level and clear and fair rules • Strong communal coping and local community traditions of inclusion • Inter-generational communication and involvement • Respect for children and youth – their inclusion and participation as members of society in their own right • Respect for cultural diversity

Source: The Eating Disorder Resource Centre of British Columbia. (2001). Preventing Disordered Eating: A Manual to Promote Best Practices for Working with Children, Youth, Families and Communities, pp.16-17.

Best/Promising Practices In Prevention

Research on the prevention of disordered eating is very new and far from definitive. Wener's 2003 review of prevention literature concluded that there is not enough evidence to allow for clear statements about what is best practice. The Eating Disorders Program of British Columbia states in its eating disorders prevention manual that this will change over time and that "as the number of prevention programs and body of research expands, knowledge of, and confidence in best practice strategies will grow." (2001, p.6)

MODELS OF PREVENTION

Levine & Piran (2001) provide a useful context for examining different prevention approaches in their review of the Disease-Specific Pathway (DSP) model, the Non-Specific Vulnerability Stressor (NSVS) model and the Ecological model. Prevention programs tend to contain elements from both the DSP and NSVS models, and, to a lesser extent, the ecological model (see Table 4).

TABLE 4 – PREVENTION MODELS

Disease Specific Pathway (DSP) Model	Non-Specific Vulnerability Stressor (NSVS) Model	Ecological Model
<ul style="list-style-type: none"> • Nutrition and exercise for healthy weight control • Nature and danger of calorie-restrictive dieting • Individual strategies for analyzing and resisting unchanging cultural factors • Nature and dangers of eating disorders • Developmental factors such as weight gain during puberty. 	<ul style="list-style-type: none"> • Nutrition and exercise as part of a healthy lifestyle • Life skills (assertiveness, relaxation) • Improvement of general self-esteem and sense of competence • Development of social support • Critical thinking about gender 	<ul style="list-style-type: none"> • Changing attitudes and behaviours (parents, teachers and other significant adults) • Creating healthier values and norms (peers and community) • Collective efforts to transform socio-cultural influences (media)

Source: Levine, M. & Piran, N. (2001). The prevention of eating disorders: Toward a participatory ecology of Knowledge, action and advocacy. In Striegel-Moore & Smolak (eds.) Eating Disorders: Innovative directions in research and practice. Washington, DC: APA.

ELEMENTS OF BEST PRACTICE

Current knowledge about prevention provides cautions around some components of the DSP model and emphasizes the merits of elements from the NSVS and Ecological models (as described in Table 4).

Do No Harm

There are cautions provided by a number of sources (O'Dea, 2002; Russell & Ryder, 2001; Crago et al, 2001, as cited in Peters, 2003) that prevention programs containing symptom-specific education may, inadvertently, be more of a risk than a benefit because they provide information about behaviours such as vomiting or laxative use. Russell & Ryder (2001) address this concern and recommend that prevention materials and education:

- not address eating disorders without placing them within the entire context of the continuum
- place the emphasis on positive body image and the dangers of dieting – not on specific eating disorders or their causes
- never address how to be eating disordered (ex: vomiting, laxative use, etc.)

Enhancing Self Esteem

Enhancing self-esteem is viewed as integral to successful eating disorders prevention because it has been identified as both a risk and protective factor for the development of a negative body image and eating problems. (McVey, 2003; Peters, 2003; Piran, 2001; O'Dea & Maloney, 2000). For example:

- children with high self-esteem are better able to cope with teasing, criticism, stress and anxiety – all of which are associated with eating problems.
- developing self-esteem helps children to recognize and value their strengths, be more self-accepting and less likely to obsess about being perfect. Perfectionism is strongly linked with body image issues and eating disorders.

Of particular merit is programming that increases self-identity and a sense of self-worth by focusing on the multi-faceted aspects of self, the value of diversity and moves students away from an over-emphasis on appearance and focus on weight, food and dieting (Abraham, 2003; O’Dea, 2002).

Facilitate Media Literacy

Western culture equates beauty and happiness with an extremely thin body shape, and this message is promoted relentlessly by our media. Canadian, American, Australian and British sources all note that children are exposed to this message from an early age and without media literacy skills, they are unlikely to question its validity (AMA, 2002; Friedman, 2000; McVey, 2003). Smolak (1999) demonstrates how unreachable the current cultural ideal is for women:

- the average woman in the United States is 5’4” , weighs 144 lbs. and wears a size 12 or 14.
- the average American model is 5’11, weight 117 and represents two per cent of the population.
- media images of women represent only five per cent of the female population. Ninety-five per cent do not match the cultural ideal.

Media literacy training provides children and adolescents with the knowledge and skills needed to question what they see in the media and to understand, in very specific ways, how it does not reflect reality [ex: that a magazine cover model has been digitally altered and airbrushed] (Friedman, 2002; Cavanaugh & Lemberg, 1999; Gordon, 2000; Jambor, 2001). A study by Wade and colleagues (2003) found that students involved in media literacy groups demonstrated less internalization of society’s thin ideal than participants in control groups.

Facilitate Peer Support

Peers and friendship groups contribute significantly to the development of perceptions around body image and related behaviours. In their manual, the Eating Disorders Resource Centre of British Columbia (EDRC of BC) notes the tendency to focus on negative aspects of peer relationships (ex: peer pressure) rather than recognizing and capitalizing on the supportive nature of friendships (EDRC, 2001). The manual suggests that effective prevention programming needs to recognize the positive aspects of peer groups and friendship networks as a mechanism for:

- working together to explore healthy approaches to eating and being active
- building skills (ex: responding effectively to bullying or teasing about shape and weight)

In addition, age appropriate training in basic helping skills (ex: communication skills, problem solving, conflict resolution), ethics, confidentiality and referral processes, capitalizes on existing peer influences and provides peers with the skills to help one another. Older peers can also act as mentors for younger peers. (EDRC, 2001)

Include Boys and Girls

While most prevention programming has been focused on girls, recent studies have identified an increase in body image issues and eating problems in boys and young men. O’Dea notes that “young male adolescents are known to be concerned about their body image and size, and engage in dieting and steroid abuse.” (2002, p. 89)

McVey (2003) describes the following benefits associated with educating boys about body image issues:

- helping them to deal with their own body image issues and unhealthy practices related to eating and exercise
- facilitating an awareness about the intense pressure faced by female students
- helping boys, as well as girls, to understand why school policies are put in place about harassment and teasing about weight and shape

Building Capacity in Key Stakeholders

Parents

Parents are children's first teachers and role models. They continue to be a significant influence throughout childhood and adolescence. They are critical to effective prevention. Russell & Ryder (2001) point out that because parents have been exposed to societal norms and messages about shape, weight and food, it should not be assumed that they have the understanding and skills to help their child to develop a positive body image. Many parents will require information and skill building that will allow them to:

- understand how societal attitudes and prejudices have influenced their own beliefs, attitudes and behaviours about their bodies and the bodies of others, their reasons for exercising, the way they label foods as bad, safe, dangerous, and fattening
- teach their children about different body types and the importance of who a person is, not what they look like
- send clear messages to children that they are valued and accepted for qualities other than how they look
- discuss with their children:
 - the dangers of trying to change one's body through dieting or other body altering behaviours [ex: steroids]
 - the benefits of being active
 - the importance of eating a variety of foods (avoid labelling foods as good, bad, etc.)
- be role models for sensible eating, emphasizing through words and behaviour that healthy eating is an essential part of normal daily living and good quality food is needed as fuel for our bodies
- talk about the importance of self-acceptance and encourage children to practice being their own best friend and to control self-talk by replacing negative with positive messages. (Russell & Ryder, 2001)

Piran (2001) points out that current eating disorders prevention packages in many schools focus mainly on

children and do not always provide reading materials for parents.

Teachers and Other School Staff

Because children spend so much of their time at school, school personnel are also key influences. Teachers, coaches and administrators need to be aware of their attitudes and behaviours concerning shape, weight and food. They need to be aware of the messages they are sending. School personnel are likely to require additional training to be able to encourage a body friendly environment (Friedman, 2003; EDRC of BC, 2001; Smolak, as cited in Peters, 2003) where teachers and other school staff:

- place an emphasis on building self-esteem, self-assertion, critical thinking and communication skills
- model positive attitudes and practices around shape, weight and food
- put in effect policy or administrative procedures to deal with sexual harassment and teasing based upon weight and shape
- realize that some standard practices (ex: weight categories in sports) may have negative effects on vulnerable students and use discretion in changing those practices to accommodate individual needs

McVey et al (2004) report that formal training of educators about body image issues, and eating disorders prevention is underway in Ontario at the present time.

Coaches

Adolescents and young adults involved in ballet, gymnastics and competitive sports may be particularly high risk due to longstanding requirements and expectations around body shape and weight. Sources (Vaughan et al, 2004; Piran, 2001) stress that instructors and coaches need to be well informed and unbiased while openly encouraging adolescents to make healthy choices.

Pediatricians and General Practitioners

Pediatricians and General Practitioners (GPs) are frequently the first points of contact for individuals with an eating disorder. As such, they are in a key position to increase public awareness about the risks of restrictive dieting (AMA, 2003; APA, 2003). This can be done in a number of ways, including the promotion of healthier attitudes towards weight and shape, and provision of sound nutritional advice. Abraham (2003) recommends that all practitioners:

- engage in continuing education regarding healthy attitudes, practices and beliefs about food, eating, exercise and body weight for young people
- when talking with adolescents, be aware of possible risk, trigger and perpetuating factors associated with eating and exercise problems

Since childhood overweight has been identified as a pressing problem, unintended consequences have become a key concern. The Canadian Pediatric Society (CPS) addressed this issue with the publication of their 2004 best practice guidelines which cautions pediatricians and recommends that they:

- discourage fad diets, fasting, skipping meals and dietary supplements to achieve weight loss
- advise teenagers to be wary of any weight loss scheme that tries to sell them anything, such as pills, vitamin shots or meal replacements.

The guidelines also state that, given the high prevalence of dieting behaviour in adolescent girls, screening for disordered eating should be a part of routine health care (for full guidelines see www.cps.ca/english/statements/AM/AH04-01.htm)

Both the American Academy of Pediatrics (2003) and the Australian Medical Association (2002) recommend that medical practitioners examine their own beliefs and prejudices around weight and shape, as these may inadvertently add to stress and unhealthy choices. The AAP recommends practitioners advise against the use of strict diets for weight loss and that pediatricians be aware of the careful balance that needs to be in place to decrease the growing prevalence of eating disorders in children and adolescents. When counselling children on the risk of obesity and healthy eating, care needs to be taken not to foster overaggressive dieting and to help children and adolescents build self-esteem while still addressing weight concerns (AAP, 2003).

Best/Promising Practices In Identification

Early detection and treatment of eating disorders is strongly correlated with better outcomes (Abraham, 2003, Marks et al, 2003; Rome et al, 2003; Mitan, 2002). The literature reviewed consistently stresses the need to increase capacity to identify and intervene early. While acknowledging the secrecy that characterizes eating disorders makes this challenging, sources reviewed point to a number of relatively straightforward ways to work toward this goal.

MECHANISMS FOR IDENTIFICATION

The work that has been done on identifying high risk groups of individuals provides a solid foundation for strategy development in improving rates of early identification. Research has highlighted the following groups as being more high risk:

- pre-teen and adolescent girls
- girls and women involved in competitive sports, modeling and ballet
- females and males in competitive sport (running, gymnastics) and other activities (modeling, ballet) that place strong emphasis on body shape and weight

Pre-Teen and Adolescent Girls

The number of people involved in the lives of pre-teen and adolescent girls is generally larger than for any other group. It includes parents, pediatricians, general practitioners, gym teachers and school counsellors. This reality provides numerous opportunities to employ effective formal and informal mechanisms for identifying disordered eating and eating disorders.

Parents: As with prevention, parents are central to any plan to ensure early identification of children and adolescents with disordered eating patterns. Parents' ability to identify eating disorders early is dependent upon possessing the requisite information. In addition, they require access to information about available resources for their child and the family as a whole.

School Personnel: Teachers, coaches, counsellors and other school staff spend a great deal of time with pre-teen and adolescent girls. Given adequate information about eating disorders and available resources, school staff are in an

excellent position to identify at risk behaviour and respond effectively.

Health Care Practitioners: The capacity of health care practitioners to identify eating disorders in pre-teens and adolescents is yet to be realized. Existing guidelines and literature concur that simple screening questions about eating patterns and satisfaction with body appearance should be routinely asked of all pre-teens and adolescents (NICE, 2004; AAP, 2003; EDAQ, 2000; Russell & Carr, 2003; Marks et al, 2003; Rome et al, 2003; Pritts & Susman, 2003).

The Canadian Pediatric Society (2004) and the American Academy of Pediatrics (2003) both emphasize that health care professionals need to take the developmental process of adolescence into account, and that a strict reliance on DSM-IV diagnostic criteria is inadequate because of the nature of physical and psychosocial development. The CPS (2004) guidelines state:

... the use of strict criteria may preclude the recognition of eating disorders in their early stages and sub-clinical form and ... may exclude some adolescents with significantly abnormal eating attitudes and behaviours. Finally, abnormal eating habits may result in significant impairment in health, even in the absence of fulfillment of formal criteria for an eating disorder. For all of these reasons, it is essential to diagnose eating disorders in adolescents in the context of the multiple and varied aspects of normal growth during puberty, adolescent development, and the eventual attainment of a healthy adulthood, rather than by merely applying formalized criteria (2004, p.190).

As with other stakeholder groups, there is a need to ensure that practitioners possess the requisite information in order to optimize the effective implementation of guidelines and research findings.

Adolescents with Type 1 Diabetes

Jones and colleagues (2000) found that DSM-IV and sub-threshold eating disorders were twice as common in adolescents with Type 1 diabetes.

Young women with Type 1 diabetes mellitus are cited as being particularly at risk for developing eating disorders because insulin omission is a common weight loss practice among women with Type 1 diabetes mellitus.

Meltzer et al (2001) point to studies showing that 15 to 40 per cent of young women with Type 1 diabetes engage in insulin omission or reduction, which results in calorie purging and rapid weight loss. Under-dosing on insulin has the potential for serious side effects including microvascular (ex: retinopathy) and metabolic complications (Pritt & Susman, 2003; Walsh et al, 2000).

Family members, school personnel and health care practitioners can all be effective in identifying at risk behaviour in this sub-group of adolescent girls.

Adult Women

Research has found that, during the five years preceding the diagnosis of an eating disorder, women go to medical practitioners markedly more often than women without eating disorders. Sources (Marks et al, 2003; Hay, 2003; Mehler, 2001; Wilhelm & Clarke, 1998) note that while individuals are often reluctant to go to a physician with an eating disorder they may present with symptoms, like low BMI, amenorrhea or gastrointestinal complaints, all of which may appear unrelated. These sources assert that health care practitioners should suspect eating disorders in women who present with:

- low body mass index (BMI) compared with age norms
- weight concerns when they are not overweight
- menstrual disturbances or amenorrhea
- gastrointestinal symptoms
- physical signs of starvation or repeated vomiting
- Type 1 diabetes and poor treatment adherence
- co-morbid concerns such as depression, anxiety and substance abuse

Also, it is recommended that questions about poor body image and dieting be part of a systematic lifestyle risk assessment when taking a medical history (Luck et al, 2002; AMA, 2003).

Again, a sufficient knowledge of eating disorders is a requirement for this to be an effective mechanism.

Individuals in High Risk Occupations and Activities

There are also higher rates of eating disorders in female and male competitive athletes. Studies show that young female athletes who are high risk for developing disordered eating patterns and eating disorders are those who are involved in sports that emphasize leanness such as gymnastics, track and field, figure skating, cross-country and swimming (Black et al, 2003; Smolak et al, 2000). Black and colleagues' 2003 study of college and university athletes found prevalence rates of eating disorders in 33 per cent of cheerleaders, and disordered eating in 50 per cent of gymnasts, 45 per cent of modern dancers and 45 per cent of cross-country athletes.

Coaches and instructors: Coaches and instructors who work with adolescents and young adults in competitive sports, ballet, gymnastics, weightlifting and wrestling are in an excellent position to identify individuals who appear at high risk for developing an eating disorder.

Vaughan et al (2004) focus on post-secondary institutions and make the following recommendations for supporting coaches and instructors to develop the capacity for identification:

- Post-secondary institutions should have eating disorders policies and procedures, as there is evidence that these increase the knowledge of coaches and instructors, and increase their capacity to identify and respond to athletes with eating disorders.
- Education and training should be provided by universities and be made available to athletic trainers, coaches and athletes.
- There should be referral mechanisms in place for dietitians, counsellors and psychologists with expertise in eating disorders.

This study found that female coaches possess more knowledge of eating disorders and are more confident about approaching an athlete having difficulties. Given this, there is a recommendation that male coaches be targeted for additional training and education.

Healthcare practitioners: As with other high risk populations, the regular use of screening questions would help in alerting health care practitioners to disordered eating and eating disorders.

Best/Promising Practice – Intervention

While the evidence base related to effective treatment of eating disorders is expanding rapidly, there is still a lack of definitive research findings and there are still major gaps in knowledge (NICE, 2004; Bergh et al, 2002). As with prevention and identification, best practices in intervention are based on the most recent information available and will continue to evolve.

This section presents best practice themes derived from a number of guidelines, recommendations, and other best practices literature from Canada, the United States, Australia and Britain. The most recently compiled guidelines were published in January of 2004 by the National Institute for Clinical Excellence (NICE) in Britain. Other recent guidelines reviewed include those from the Canadian Pediatric Society (1998, reaffirmed in February 2004), the American Psychiatric Association (2000), American Academy of Pediatrics (2003), Australia Medical Association (2002) and American Dietetic Association (2001).

ELEMENTS OF INTERVENTION FOR ALL EATING DISORDERS

There is a significant consensus on key elements of successful eating disorder intervention that apply across diagnoses. These elements are also reflective of the principles of mental health renewal in Manitoba.

Early Identification and Intervention

It is widely accepted that early identification and intervention are strongly linked to positive results. To achieve this requires proactive measures such as routine screening of high risk groups.

Community Based

Interventions for individuals should be community-based wherever possible. Clinical research and guidelines reviewed concur that nearly all individuals can be successfully treated in community settings. Hospitalization should be considered only when an individual is severely medically compromised or at risk of serious self-harm.

Access to Services and Supports across the Continuum

Individuals should have timely access to appropriate services and supports that are responsive to their needs, generally progressing from less intrusive to more intensive, and include follow-up/relapse prevention.

Multidisciplinary/Interdisciplinary

A multidisciplinary/interdisciplinary team should be involved during the assessment and ongoing treatment of eating disorders (ex: medical, nursing, nutritional, and mental health disciplines). Psychological treatment provided should focus on eating behaviour, attitudes to weight/shape and wider psychosocial issues.

Age Appropriate

Eating disorders treatment for children and adolescents should be appropriate to their physical and psychological developmental stage, should involve family members and should balance treatment needs with social and educational needs wherever possible.

Involvement of Natural Supports

Family and other natural supports should be offered education and information on eating disorders and be linked to resources including self-help and support groups.

Consumer Involvement

Consumers should have an active role in the treatment process, with individual needs, goals and preferences being considered during the development and implementation of a treatment plan.

KEY COMPONENTS OF A SUCCESSFUL THERAPEUTIC RELATIONSHIP

Literature reviewed highlights the importance of a positive therapeutic relationship, and identifies components of the therapeutic approach that has been found to be most effective in working with individuals with eating disorders (NICE, 2004; Vitousek & Watson, 1998; Clinton, 1996). These are outlined below.

Collaboration

The best possible results are realized when the therapeutic approach is based on a collaborative partnership between the individual and therapist, rather than being didactic and expert-driven.

Respect for individuality

While there are commonalities in eating disorders symptoms, their complexity and multi-faceted nature require an acceptance of, respect for and responsiveness to, the unique situation of each individual.

Honesty

There is irrefutable evidence pointing to the dangers of eating disorders. This information must be provided, but in a style that respects contrary beliefs and encourages testing both sets of beliefs through individual experience.

Patience and Curiosity

Given the tendency toward uneven progress and periods of relapse, the most effective therapeutic approach encompasses patience and curiosity, and a curiosity about what happened, rather than impatience or recrimination.

An Emphasis on Experimentation

Individuals respond more positively to approaches that acknowledge the tentative and experimental nature of the therapeutic process (ex: for each suggested step, taking a "let's test this out and see what happens" approach). In this approach, an evaluation of results is based on client's experience rather than a therapist's opinions.

Focus on Functionality of Beliefs

Given the strong beliefs often held, it works against the relationship to focus on belief system correctness. Working to understand the purpose of a belief system makes possible a level of discussion that does not occur when the focus is on right or wrong. The use of an approach that examines positive and negative aspects of beliefs and behaviours has proven useful, particularly with anorexia nervosa.

Systematic / Outcome-focus

Asking, rather than telling, is important to keeping a systematic outcome orientation, in which insights gained during therapy can be summarized and applied to everyday life. (Vitousek & Watson, 1998)

THERAPEUTIC MODELS/ APPROACHES

There are many therapeutic models/approaches for treating eating disorders, each with its own strengths and limitations. Treatment may involve

any number of therapies (ex: cognitive behavioural, psychodynamic, family, experiential) provided in various formats. For less complex cases, one or two therapies may be offered in a time-limited, less intense format. However, for more complex cases, therapists tend to use an eclectic approach, including parts of different models and varying, depending on individual needs. (Becker, 2003)

While not definitive, there is evidence supporting particular therapies as treatments of choice, depending upon the specific eating disorder and the age of the individual.

However, as emphasized in the 2004 National Institute of Clinical Excellence (NICE) guidelines: the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness. (p.9)

Wherever possible, practice in eating disorders intervention is guided by clinical research (randomized controlled trials and well conducted clinical studies). It is important to recognize that:

- certain therapies have been the subject of extensive clinical studies (ex: cognitive behavioural therapy and pharmacotherapy)
- other therapies have only recently been adapted for eating disorders (ex: motivation enhancement and dialectical behavioural therapy)
- some therapies have not tended to be subjects of controlled studies (ex: experiential therapies, feminist therapy)

At this time, a great deal of practice draws from expert opinion and well documented clinical experience (NICE, 2004, APA, 2000). This can be attributed to the lack of reliable clinical research and the relative newness of some treatments. It can also be attributed to the complexity of eating disorders and the need to individualize treatment by using a mix of therapies. Gowers (2004) notes that, because of this reality, established practice guidelines may be based on best researched rather than best practice research (p.6).

The following subsections present a brief summary of best practice themes that emerge in the literature reporting on, or reviewing, clinical research and practice (Appendix 4 provides a brief description of the therapeutic approaches).

Anorexia Nervosa

Appropriate treatment for anorexia nervosa (AN) continues to be the subject of debate. There remains a lack of definitive evidence pointing to effective

interventions (NICE, 2004; Gowers, 2004; Tozzi et al, 2004).

Treatment for anorexia is generally divided into three phases:

- Restoring weight lost due to severe dieting and purging — there is a strong consensus in the literature reviewed supporting restoration of weight in medically fragile individuals before the therapeutic process begins. Because malnutrition has an impact on psychological functioning and cognitive ability, it is argued that individuals need to be stabilized before psychotherapy is likely to be effective (NICE, 2004; Becker, 2003; Connors, 2001; APA, 2001).
- Treating psychological disturbances such as distortion of body image, low self-esteem and interpersonal conflicts — once malnutrition has been addressed and some level of weight restoration achieved, treatment usually involves one or more psychotherapies, selected according to individual needs.
- Achieving long-term remission and rehabilitation or full recovery — this phase involves provision of the supports needed to remain well.

The most recent guidelines indicate that anorexia nervosa can nearly always be treated in the community on a longer-term outpatient basis. These guidelines also state that, should individuals with anorexia nervosa require inpatient treatment, they should be provided with relevant psychological interventions (NICE, 2004).

What follows is an overview of guidelines and research related to specific therapies used in the treatment of AN.

Cognitive Behavioural Therapy

Cognitive behavioural therapy (CBT) is not recommended in the treatment of anorexia nervosa until weight has been stabilized. The most recent set of clinical guidelines indicates that rigid behaviour modification should not be used during inpatient treatment of anorexia nervosa (NICE, 2004).

There are findings supporting the use of CBT after weight stabilization. A recent study (Pike et al, 2003) yielded positive findings for CBT in post-hospitalization treatment of adults with anorexia nervosa. In this study, the group receiving CBT had lower dropout and relapse rates and better overall clinical outcomes than the comparison group receiving nutritional counselling and medical monitoring.

Family Based Therapy

It is generally agreed that family based therapy is particularly useful for adolescents (NICE, 2004; Dare & Eisler, 2002; APA, 2000), and that adolescents improve more with family treatment than individual treatment.

Benefits cited in family based treatment include:

- enhancing understanding about the eating disorder and the family member's experiences
- maintaining positive relationships within families and addressing family issues that emerge during treatment
- increasing family capacity to provide the necessary support to the individual with an eating disorder

NICE (2004) recommends that therapeutic involvement of siblings and other family members should be considered in all cases because anorexia nervosa can affect all family members. The guidelines recommend that children and adolescents be offered family interventions that directly address the eating disorder. However, it is also recommended that children and adolescents be offered individual appointments in addition to family therapy.

Family therapy may also be beneficial for adults who have difficult family relationships that contribute to the perpetuation of an eating disorder.

Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) views eating disorders as an expression of interpersonal difficulties. It is a non-interpretive, non-directive, short-term focal psychotherapy that focuses on the interpersonal issues, and does not deal directly with weight, food or body image.

There are no controlled studies on the use of IPT in anorexia. Sources (Becker, 2003; McIntosh et al., 2000; Apple 1999) note the usefulness of IPT in addressing underlying issues that trigger and perpetuate disordered eating behaviours. NICE guidelines (2004) indicate that IPT may be offered to adults with anorexia nervosa.

Psycho-Education

Individuals with eating disorders generally have a lot of information and misinformation about diet and weight (Vitousek & Watson, 1998). Specific types of factual information identified as beneficial for individuals with anorexia nervosa (as with all eating disorders) includes:

- physical and psychological consequences of restrictive eating, bingeing, purging and low weight status
- a balanced diet, and the determinants of appetite and energy expenditure
- genetic influences on body weight, fat distribution and metabolism
- exercise physiology and mythology
- coping techniques, distress tolerance, communication and conflict resolution
- identification and celebration of strengths
- life and relationship skills

Motivational Enhancement Therapy

There has been growing interest in Motivational Enhancement Therapy (MET) in the treatment of anorexia nervosa. The therapy recognizes resistance to treatment, identifies an individual's stage of change and begins the treatment at that stage. MET works to help individuals identify their stage of change and ease their movement through the stages. MET understands motivation as the product of a successful interpersonal process, rather than as a pre-existing individual trait (Kaplan, 2002 as cited in Wener, 2003).

In the initial pre-contemplation stage, the behaviour is seen as having many rewards and no costs. The contemplation stage involves recognition of the costs associated with behaviour along with recognition of the rewards, but the individual remains uncertain about whether to change the behaviour. During the determination and action stage, the individual resolves the conflict in favour of the benefits associated with change. Of course, it is rarely a linear process.

A review of MET for anorexia nervosa found that, while researchers and clinicians are optimistic, at the time, no randomized controlled trials had been undertaken (Wener, 2003).

Experiential Therapies

Kaplan (2002) notes that, while there is a significant body of literature on the use of experiential therapies, such as dance-movement therapy and expressive art therapy, there are no controlled trials examining their effectiveness with anorexia nervosa.

Many eating disorders programs have an experiential therapy component and therapists report it useful in providing another avenue for accessing internal processes. Diamond-Raab & Orrell-Valente (2002)

point to findings supporting a group therapy approach that integrates art therapy, psychodrama and verbal therapy for adolescents with anorexia nervosa who may be reticent to engage in more traditional group therapy.

Psychodynamic Therapy

Pike (1998) notes that evidence supports the usefulness of psychodynamic therapy in outpatient treatment of anorexia nervosa. Again, psychodynamic therapy is generally one component of a more comprehensive treatment strategy (ex: with behavioural components such as self-monitoring, cognitive restructuring, relaxation and assertiveness training). For example, Conners (2001) points to the benefits of approaches that integrate cognitive behavioural components into a psychodynamic framework. Zerbe (1996) describes the benefits of an approach that combines psychodynamic and feminist components.

Feminist Therapy

Therapy that incorporates a feminist perspective has been identified as useful in working toward empowerment, celebrating diversity, consciousness raising, social and gender role analysis, resocialization and social activism (Peters, 2003). Feminist therapy helps women take control of their lives in less destructive ways than through eating disordered behaviour.

Many practitioners use some of these components in eating disorders treatment with women. However, empirical research on feminist practice is in its infancy (Peters, 2003).

Pharmacotherapy

There is limited evidence in support of pharmacological treatment of anorexia nervosa, and pharmacotherapy is not recommended as the sole or primary treatment for anorexia nervosa (NICE, 2004; Milan 2002; APA 2000; Attia et al, 1998; Gilchrist et al, 1998).

Guidelines (NICE, 2004, APA, 2000) also recommend that psychotropic medication not be considered until after weight gain as the weight gain itself may resolve co-morbid conditions such as depressive or obsessive compulsive features. At that point, a more reliable assessment of co-morbid conditions can occur. Certain serotonin reuptake inhibitors (SSRIs) may be helpful for weight maintenance and for resolving mood and anxiety symptoms associated with anorexia, or when depression precedes its onset (Zhu & Walsh, 2002; Wilhelm & Clarke, 1998).

Practitioners are urged to be cautious in prescribing medications with side effects that include weight gain, and to prescribe these only after consultation with the individual (Becker, 2003).

Likewise, careful consideration and caution should be used before prescribing medications that have cardiac side effects because of the compromised cardiovascular function of many people with anorexia nervosa. If a decision is made to use one of these medications, ECG monitoring should be undertaken (NICE 2004).

Follow-Up/Relapse Prevention

Themes in the literature reviewed are the importance of follow-up and relapse prevention measures that are of long enough duration. For example, Bergh and colleagues (2002) cite findings pointing to the high risk of relapse within the first year of remission and recommend longer-term follow-up.

NICE guidelines (2004) recommend that the length of outpatient psychological treatment following inpatient weight restoration be a minimum of twelve months in duration.

Other findings include:

- A study by Pike (1998) showed that individuals receiving CBT during a year of relapse-prevention programming retained significant improvements in weight restoration, eating behaviour, body shape and weight concerns, associated pathology and social functioning.
- Zhu & Walsh's review (2002) of recent studies found that pharmacological interventions oriented at reducing relapse show promise.

Shortcomings in Anorexia Nervosa Treatment Research

The most recent guidelines reviewed (NICE, 2004) highlight the following shortcomings in research specific to anorexia nervosa:

- There is a need to define specifically the effects of various treatments as opposed to effects of other variables such as the experience of the therapist, duration of treatment and concurrent treatment.
- There is a need to distinguish between therapies delivered at different stages of treatment.
- There is a need for further exploration of relapse prevention models that incorporate pharmacological interventions.

- There is a marked need for additional research into user satisfaction, since it is a key contributor to positive results.

Bulimia Nervosa

Compared to anorexia nervosa, there are more definitive findings regarding bulimia nervosa. These are outlined below.

Cognitive Behavioural Therapy for Bulimia Nervosa

Cognitive behavioural therapy (CBT) has been studied the most and is widely cited as an effective treatment for adults with binge/purge symptoms — with positive results cited for both individual and group therapy (NICE, 2004; Lilly, 2003; Hay, 2003; ADA, 2001; EDAQ, 2000; APA, 1996; Hay & Bacaltchuk, 2003; Mitchell et al, 2001).

NICE (2004) guidelines reflect this, specifically stating that group or individual CBT should be offered to adults with bulimia nervosa, providing 16 to 20 sessions over 4 to 5 months.

Preliminary studies of CBT modified for use with adolescents, while promising, need to be tested further (Gowers, 2004; Lock, 2002). Lock (2002) emphasizes the need to involve and support family members.

NICE (2004) guidelines specify that more research is needed to identify how to address the needs of the 50 per cent of people with bulimia who do not succeed with CBT.

Guided Self-Help

CBT has been touted as a therapy that can be simplified for use in non-specialist settings. Guided self-help, largely informed by CBT, is increasingly being identified as useful in treating eating disorders. Benefits cited for guided self-help treatment include that it:

- is relatively brief;
- does not require travel
- is inexpensive
- does not require specialist time
- is simple to disseminate
- is non-stigmatizing, which may benefit those reluctant to request treatment from specialists

- is potentially empowering, and may serve as a first step in seeking more comprehensive treatment, if needed

Self-help formats (manuals, CD-ROMs), along with limited guidance from a therapist or other healthcare practitioner, have been the recent focus of interest and research (Bailer et al, 2004; Bara-Carril et al, 2004; Ghaderi & Scott, 2003; Carter et al, 2003; Durand & King, 2003; Thiels et al, 2003; Palmer et al, 2002). While preliminary, findings have been generally positive, with reductions in bingeing and purging experienced during therapy being retained at follow-up.

Researchers are still gathering information about who might benefit from self-help intervention, and at what point in the course of a disorder should seeking self help be encouraged (Garvin et al, 2001).

The 2004 guidelines by NICE consider guided self-help a viable treatment and recommend it is considered as a first step in treating uncomplicated bulimia nervosa in adults (NICE, 2004).

Interpersonal Psychotherapy

Sources (NICE, 2004; Becker, 2003; Wilson et al, 2002; Hay & Bacaltchuk, 2001; Agras et al, 2000) note that IPT takes longer than CBT to achieve results. However, the retention of benefits is similar for both therapies.

NICE guidelines (2004) recommend that IPT be offered as an option for individuals with bulimia nervosa who have not responded to CBT, or who wish to be involved in an alternative treatment. However, the guidelines state that individuals should be informed that it takes 8 to 12 months to achieve results, which is a longer period of time than for CBT.

Pharmacotherapy

Results indicate that antidepressant medication can reduce the frequency of binge eating and purging, particularly when used with psychotherapy such as CBT or IPT (Sloan et al, 2004; Bacaltchuk et al, 2003; Mitan, 2002; Whittal et al, 1999; Walsh et al, 2000). Selective Serotonin Reuptake Inhibitors (SSRIs), particularly Fluoxetine, have been found most effective, primarily because they have fewer side effects than other medications (NICE, 2004; APA, 2000), and are approved by the United States Food and Drug Administration (FDA) for the treatment of bulimia nervosa in adults (Zhu & Walsh, 2002).

Other medications have been studied, but only antidepressants are currently recommended for

treatment of bulimia nervosa (NICE, 2004; APA, 2000).

Dialectical Behaviour Therapy (DBT)

A 2001 randomized controlled study by Safer and colleagues showed that binge and purge rates decreased significantly after DBT treatment focused on teaching adaptive emotion regulation skills.

Although preliminary results are promising (Palmer et al, 2003; Safer et al, 2001), more research is required to determine who would best benefit from DBT, and the length and intensity of treatment required.

Exposure and Response Prevention

Research to date indicates that, when used alone, Exposure and Response Prevention (ERP) does not appear to be of any benefit and that when used in concert with CBT, ERP does not appear to affect results (Hay & Bacaltchuk, 2003; Carter et al, 2002).

Psychodynamic Therapy

The benefits of psychodynamic therapy for bulimia nervosa are the same as for anorexia nervosa. Becker (2003) suggests that an insight-oriented therapy aimed at identifying the underpinnings of eating disordered behaviour may be most useful when paired with strategies that increase self-observation and an understanding of the role that the behaviour plays (Becker, 2003).

Feminist Therapy

As it is with anorexia nervosa, feminist therapy is viewed as a useful component of therapy because it can provide a framework for understanding societal pressures and it can help with recovery (Connors, 2001).

Experiential Therapy

Experiential therapy components such as art, psychodrama and creative movement, are parts of many treatment approaches for bulimia nervosa. As in anorexia nervosa treatment, they are cited as useful in augmenting the effectiveness of verbal therapy (Diamond-Raab & Orrell-Valente, 2002; McComb & Clopton, 2003).

Follow-Up/ Relapse Prevention

The importance of proactive, planned relapse prevention is highlighted in a study by Mitchell and colleagues (2004), which found that simply telling individuals with bulimia nervosa to come back if they

have problems is not an effective relapse prevention technique (p.549). The authors recommend return visits that are planned in advance, or follow-up phone calls.

The following are also identified as useful components in proactive follow-up/relapse prevention:

- aftercare plans that involve the general practitioner, school staff, friends, family and the person with the eating disorder
- referral to a self-help consumer-based organization can be extremely helpful and a source of ongoing information, support and assistance
- for women who are mothers, interventions aimed at assessing and responding to the needs of family members
- education, support and therapy that helps family and friends understand and help with recovery (EDAQ, 2000)

Binge Eating Disorder

Binge eating disorder is the most recently identified eating disorder and research into effective treatments is still very preliminary. Levine and colleagues (2003) indicate that a number of the treatments are similar to those for bulimia nervosa, with some adaptations.

Cognitive Behaviour Therapy for Binge Eating Disorder

As with bulimia nervosa, clinical evidence supports the use of CBT for treating binge eating disorder. Levine et al (2003) cite some notable differences between CBT for binge eating disorder and bulimia nervosa, specifically that:

- Despite early cautions around reducing calories, evidence to date suggests that decreasing caloric intake and increasing dietary restraint in a weight control program does not exacerbate binge eating.
- Cognitions related to having a large body size can be directly targeted in treatment. Individuals can be encouraged to work toward acceptance of a larger body size and to restructure maladaptive thoughts about a realistic level of weight loss.

A recent study by Wilfley and colleagues (2002) indicated that, for individuals who received CBT, binge eating remained significantly below baseline at the six-month and one-year follow up periods.

The NICE guidelines (2004) recommend that cognitive behaviour therapy adapted for binge eating disorder should be offered to adults with binge eating disorder.

Guided Self-Help

Guided self-help is increasingly being considered as a treatment of choice for uncomplicated binge eating disorder, particularly in situations where therapists are not easily available or associated costs such as travel are prohibitive (Palmer, 2002; Loeb et al, 2002; Peterson et al, 2001; Kotwal, 2004).

Positive results have been cited for both guided and unguided self-help, including:

- improved eating behaviour
- elimination of inappropriate compensatory behaviours
- reduction in shape and weight concerns and other symptoms of psychopathology
- improved general physiology

The NICE guidelines (2004) suggest that CBT for binge eating disorder in a self-help format be considered as a possible first treatment, along with direct encouragement and support provided by health care professionals.

Interpersonal Psychotherapy (IPT)

Clinical research and experience supports the use of IPT in the treatment of binge eating disorder. Studies (Kotwal et al, 2004; Levine et al, 2003; Wonderlich et al, 2003; Hay & Bacaltchuk, 2001; Wilfley et al, 2002; Wilfley et al, 1997) indicate that, for individuals who received group interpersonal psychotherapy, binge eating remained significantly below baseline at the six-month and one-year follow up periods.

Pharmacotherapy

As with bulimia nervosa, pharmacological treatment for binge eating disorder may be a useful adjunct to psychological therapies. SSRIs have been studied most extensively and there is some evidence that Bupropion may be useful in addressing depression in individuals with binge eating disorder, and that anticonvulsants may be useful for treating co-occurring bi-polar disorder.

Zhu & Walsh (2002) note the benefit of combining medication with psychotherapy. They also note that sole reliance on medication may prevent

development of the psychological tools needed to deal successfully with binge eating disorder in the long term.

Experience to date shows that a combination of CBT and antidepressant therapy can reduce binge frequency. However, this approach remains unproven in controlled trials (Kotwal et al, 2004).

Dialectical Behaviour Therapy

A modified version of dialectical behaviour therapy (DBT) also appears promising in treating binge eating disorder. Telch and colleagues (as cited in Levine, 2003) adapted and tested a group-based version of DBT and found it to be effective in reducing binge eating behaviour and decreasing maladaptive attitudes about eating, shape and weight. Other studies (Safer et al, 2001; Palmer, 2002) have also yielded promising results.

More research is needed on length, intensity and the identification of which individuals would benefit most from DBT. The NICE guidelines (2004) recommend that modified DBT be offered to adults with persistent binge eating disorder.

Psychodynamic Therapy

The literature reviewed was silent on psychodynamic therapy for binge eating disorder.

Feminist Therapy

Literature reviewed on binge eating disorder did not address the use of feminist therapy. However, as with anorexia nervosa and bulimia nervosa, feminist therapy would have the capacity to provide a relevant framework within which women can empower themselves and work toward recovery.

Experiential Therapy

As in anorexia nervosa and bulimia nervosa treatment, experiential therapies provide an additional mechanism for self-discovery and the identification of issues that need to be addressed before recovery can begin (Riva et al, 2003).

Follow-up/Relapse Prevention

As with all eating disorders, a proactive plan for relapse prevention is an essential part of treatment. NICE guidelines (2004) recommend that, following intensive treatment, active relapse prevention planning should be a minimum of 12 months in duration.

TYPE OF TREATMENT	AIMS OF INTERVENTION
Nutritional Rehabilitation	Restore weight (AN); reduce binge eating and purging (BN); normalize eating patterns; achieve normal perceptions of hunger and satiety; correct biological and psychological complications of malnutrition.
Psychosocial treatments	Enhance motivation; increase self-esteem; teach assertion skills and anxiety management techniques; improve interpersonal and social functioning; treat co-morbid conditions/clinical features associated with eating disorders.
Cognitive-Behavioural Therapy (CBT)	Reduce binge-eating and purging behaviours (BN); improve attitudes related to eating disorders; minimize food restriction; increase variety of foods eaten; encourage healthy but not excessive patterns; address body image concerns, self-esteem; affect regulation, coping styles and problem solving.
Family Therapy	Teach families how to express emotion, set limits, resolve arguments and solve problems effectively; increase parents' understanding of the difficulties of the affected child; avoid a view of the world where success or failure is measured in terms of weight, food and self-control.
Feminist therapies	Address role conflicts, identity confusion, sexual abuse and other forms of victimization in the development, maintenance and treatment of eating disorders; emphasize the importance of women's interpersonal relationships.
Interpersonal Psychotherapy (IPT)	Help to identify and modify current interpersonal problems; identify and improve underlying difficulties for which eating disorders constitute a maladaptive solution; improve insight into interpersonal difficulties and motivation.
Interpersonal Psychotherapy (IPT)	As above for CBT, IPT and feminist therapy, depending on approach taken; provide information, support and help for individuals to more effectively deal with the shame surrounding their problem, as well as provide additional peer-based feedback and support.
Group Therapy	As for CBT (BN): improve eating, reduce bingeing and inappropriate compensatory behaviours, reduce shape and weight concerns, and improve general psychological outlook which can be a valuable adjunct to most forms of treatment.
Self-Help and Guided Self-Help	As for CBT (BN): improve eating, reduce bingeing and inappropriate compensatory behaviours, reduce shape and weight concerns, and improve general psychological outlook which can be a valuable adjunct to most forms of treatment.
Medications	Treat other psychiatric problems associated with the eating disorders — after weight restoration (AN), or in combination with psychological approaches (BN) such as depression.

Therapeutic Approaches to Treating Eating Disorders

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