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Treatment Plans and Interventions for Bulimia and Binge-Eating Disorder. By Rene D. Zweig and Robert L. Leahy.
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CHAPTER 1

Introduction

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Approximately 5 million Americans meet diagnostic criteria for an eating disorder every year (Becker, Grinspoon, Klibanski, & Herzog, 1999; Hudson, Hiripi, Pope, & Kessler, 2007). The eating disorders, which include bulimia nervosa (BN), anorexia nervosa (AN), and eating disorder not otherwise specified (EDNOS), are all serious psychological disorders.* The purpose of this book is to provide therapists and other health care practitioners with a comprehensive treatment model and empirically supported interventions for BN. Information is also provided to allow practitioners to adapt this treatment for patients with EDNOS, including binge-eating disorder (BED), purging disorder, and subthreshold BN.

Although eating disorders are relatively uncommon psychiatric illnesses, they warrant careful study and efficacious treatment because of their chronic, severe nature. Lifetime prevalence estimates of AN, BN, and BED are 0.9%, 1.5%, and 3.5% among women, respectively, and 0.3%, 0.5%, and 2.0% among men, respectively (Hudson et al., 2007). Individuals may meet diagnostic criteria for more than one eating disorder over their lifetime, and relapse following treatment is not uncommon. Regardless of the specific diagnosis, individuals with an eating disorder are more likely than those without an eating disorder to have a comorbid Axis I diagnosis, particularly major depression, obsessive–compulsive disorder, or a substance use disorder (Kaye, Bulik, et al., 2004). Suicidality, poor body image, perfectionism, and low self-image also commonly co-occur with BN (Fink, Smith, Gordon, Holm-Denoma, & Joiner, 2009; Wade, 2007). Like the other eating disorders, BN is associated with an elevated mortality risk, health complications, dental erosion, disrupted interpersonal relationships, and impairment in educational/employment pursuits. Effective treatment can reverse the course of BN and improve the patient's functioning across all domains. Without treatment, BN, like all the eating disorders, is chronic (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000).

BN was first described as a distinct disorder in 1979 (Russell, 1979). Since that time, a significant amount of progress has been made in understanding BN and in developing effective treatments (Mitchell, Agras, & Wonderlich, 2007; Steinhausen & Weber, 2009). BN is more common than once thought, afflicting approximately 1.5% of women and 0.5% of men in their

*The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) recognizes anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified as distinct disorders, and also lists binge-eating disorder separately as a provisional disorder requiring further study (see Table 1.1).

TABLE 1.1. Diagnostic Criteria for the Eating Disorders

	Bulimia nervosa	Anorexia nervosa	Eating disorder not otherwise specified
DSM-IV-TR diagnostic code	307.51	307.1	307.50
Prevalence	Females, 1.5% lifetime Males, 0.5% lifetime	Females, 0.9% lifetime Males, 0.3% lifetime	For BED: Females, 3.5% Males, 2.0%
Symptoms	1. At least twice-weekly episodes of binge eating that include loss of control and consumption of an objectively large quantity of food during a 2-hour period. 2. Use of compensatory behaviors at least twice weekly to avoid weight gain. 3. Bingeing and purging has occurred for at least 3 months. 4. Self-worth largely determined by perceived shape/weight.	1. Body weight below 85% of expected normal for age and height. 2. Extreme fear of weight gain. 3. Distorted body image, self-worth based largely on body weight, and minimizing of the seriousness of low body weight. 4. Amenorrhea.	Disorders of eating that are clinically significant, cause distress, and/or impair functioning that do not meet the criteria for AN or BN. May include BED, purging disorder, mixed eating disorder symptoms, subthreshhold BN, and subthreshhold AN.

Note. Data from American Psychiatric Association (2000) and Hudson, Hiripi, Pope, and Kessler (2007).

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lifetimes (Hudson et al., 2007). In addition to its direct effect on health, BN often negatively affects work, school, social, and familial responsibilities (Hudson et al., 2007). Patients with BN also have elevated rates of suicide attempts, self-injurious behavior, major depression and other Axis I disorders, Axis II disorders, and substance abuse. Purging and other symptoms of BN can cause irreversible dental and medical consequences. Despite the severity of the disorder and the availability of efficacious psychological treatments, most patients with BN remain undertreated (Wells & Sadowski, 2001). Fewer than 50% of patients with BN seek treatment specifically for their eating disorder, and physicians typically do not screen their patients for symptoms of BN (Hudson et al., 2007).

Although this book focuses primarily on the cognitive-behavioral treatment of BN, there is considerable overlap in both the symptoms and treatment of all the eating disorders. AN, BN, and EDNOS, which includes subthreshold eating disorders, BED, and purging disorder, are recognized as separate disorders in the American Psychiatric Association's current diagnostic manu-

al.* Yet all the eating disorders share several common core features: a preoccupation with shape, weight, and food intake; a strong desire to be thin; use of extreme measures to try to achieve a desirable shape; distorted body image; unrealistic expectations about body shape and composition; perfectionism; discomfort eating in the presence of others; and a lack of healthy emotional coping skills. Additional information about the current diagnostic system and the "transdiagnosis" of eating disorders can be found in Appendix A. In recognition of the overlap in symptoms across eating disorder diagnoses, this book provides information for clinicians to adapt treatment for patients with BED, purging disorder, subthreshold BN, and other variations of EDNOS.

RATIONALE FOR COGNITIVE–BEHAVIORAL TREATMENT

BN was first recognized by the DSM in 1980, and effective psychological treatments have since been developed. Of all the psychological treatments in use for the eating disorders, cognitive-behavioral therapy (CBT) is considered to be most efficacious for BN (Fairburn & Harrison, 2003; Wilson & Fairburn, 2002). Interpersonal psychotherapy (IPT) may be as effective as CBT in the treatment of BN, although patients treated with IPT recovered significantly more slowly than with those treated with CBT (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). IPT is a manualized, short-term, nondirective treatment that was originally developed for depression and has since been adapted to treat BN. IPT treatment sessions focus on identifying and changing the maladaptive interpersonal context in which the eating disorder developed and is maintained, and the eating disorder is not discussed directly in these sessions. Some early evidence supports the use of dialectical behavior therapy (DBT) for the treatment of BN (Safer, Telch, & Agras, 2001). DBT has been used as a stand-alone treatment for BN and also in conjunction with CBT protocols. DBT effectively targets the link between binge eating and negative affect by teaching patients emotion regulation skills. Additional research is needed, however, to determine whether DBT is as effective as CBT in the treatment of BN or whether it is particularly useful with a specific subset of patients.

CBT for BN was given an "A" evidence grade by the United Kingdom's National Institute for Clinical Excellence (2004) guidelines, which indicates that CBT is an evidence-based treatment supported by multiple randomized control trials. Nearly half of patients make a full recovery after receiving CBT for BN, and many more experience a significant reduction in their bingeing, purging, and dietary restriction (Agras, Walsh, et al., 2000). Following treatment, a significant proportion of patients remain in full or partial remission (Fairburn et al., 1995; Keel, Mitchell, Miller, Davis, & Crow, 1999).

Eating disorders have been incorrectly described as an exaggerated form of body dissatis-

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*As a result of recognized problems with the current diagnostic criteria for eating disorders, including the elevated prevalence of EDNOS diagnoses, several changes to the diagnostic criteria have been proposed by the Eating Disorders Work Group that are likely to be included the next revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; Eating Disorders Work Group, American Psychiatric Association, 2010). DSM-5 is due to be published in May 2013. The proposed changes for DSM-5 include recognizing BED as a distinct diagnostic category no longer subsumed under EDNOS, removing amenorrhea from the diagnostic criteria for AN, and delineating several conditions that will fall under the EDNOS diagnostic category: atypical AN; subthreshold BN; subthreshold BED; purging disorder; night-eating syndrome; and other feeding or eating condition not otherwise classified.

faction. Among females in America, Europe, and many other areas, body dissatisfaction is so prevalent that it has been coined "normative discontent" (Rodin, Silberstein, & Striegel-Moore, 1984). Body image dissatisfaction and thin weight ideals are more common in women from wealthier nations and in the Americas than other areas of the world (Swami et al., 2010). More than one-half of American women of all ages report feeling dissatisfied with their bodies (Cash & Henry, 1995; Frederick, Peplau, & Lever, 2006). This dissatisfaction is typically focused on one's body weight, the shape of the lower body, and the shape of the torso (waist). However, normative discontent is substantially different from and is not synonymous with eating disorder symptomatology. Individuals can dislike aspects of their bodies without engaging in extreme measures to maintain thinness, without threatening their physical and mental well-being, without basing their self-worth on body weight alone, and without interfering with their daily functioning. Eating disorders, in contrast, are chronic, are severe, and do warrant evidence-based intervention.

LEVEL-OF-CARE DECISION MAKING

Although this book focuses on cognitive-behavioral treatment for eating disorders in individual and outpatient settings, treatment is available in multiple settings with varying intensities. Treatment for BN can occur in outpatient, intensive outpatient, inpatient, or long-term residential settings. Treatment may take place in a medical center, psychiatric hospital, community clinic, specialty clinic, or private practice. Treatment can be provided by any qualified professional, including, but not limited to, psychologists, psychiatrists, social workers, mental health counselors, nutritionists, internists, and nurse practitioners (hereafter referred to as "the therapist"). The therapist may utilize individual sessions, group therapy, guided self-help, teleconferencing or videoconferencing, or any combination of these. Severity of presenting symptoms, duration of illness, comorbidity, and availability of treatment are all factors that may affect the setting in which treatment is provided.

The American Psychiatric Association (2006) recommends a stepped-care model to determine the appropriate level of treatment, meaning that the lowest reasonable level of treatment should first be utilized with any given patient. From there, the level of care can be stepped up (or down) as necessary. This approach has the advantage of balancing the least disruptive level of care with one that is maximally effective for the patient. The stepped-care model means that the majority of patients, including those with severe symptoms and a long eating disorder history, can receive cognitive-behavioral treatment in an outpatient setting. In fact, intensive outpatient and inpatient treatments, although more time intensive and costly, are not automatically more effective than outpatient cognitive-behavioral treatment (Meads, Gold, & Burls, 2001). Most patients with BN are treated in an outpatient setting, with only 13% receiving hospitalization (Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 2000). A subset of patients with BN remit without formal treatment, either on their own or by using a self-help workbook (Carter et al., 2003).

Treatment decisions are best made after a comprehensive psychological and medical assessment of the patient (see Appendix B). This assessment may include the patient's presenting symptoms, body weight, current food intake, frequency of purging behaviors, vital signs, electrolyte levels, concurrent medical consequences, psychiatric comorbidity, past or present suicidality,

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past treatment episodes, ability to meet daily responsibilities, and motivation for treatment. In addition, practical concerns such as availability of and proximity to treatment as well as health insurance coverage may factor into level-of-care decisions.

In instances where medical or psychological stabilization is required, inpatient treatment should be recommended to patients. Hospitalization is more common among patients with AN than those with BN or EDNOS, but it may be warranted in severe forms of these eating disorders. The *Practice Guideline for the Treatment of Patients with Eating Disorders* (American Psychiatric Association, 2006) suggests several circumstances under which inpatient treatment or medical hospitalization should be considered by the therapist and recommended to patients (see Table 1.2). A body mass index (BMI) below 18.5 is considered underweight and is a defining symptom of AN. Patients are often immediately hospitalized if their BMI is below 18.0 because this index suggests the need for medical stabilization and monitored refeeding. BMI is a standardized reference for body weight that takes height into account, and it is most often used to categorize patients as underweight, normal weight, or overweight (see Appendix B for more information). No single criterion mandates inpatient treatment, although an immediate referral is warranted if there is any symptom that represents imminent harm to patients (e.g., suicidality, dangerously low body weight, refusal to eat, electrolyte abnormalities). In that case, a referral should be made to an inpatient treatment setting that can provide constant supervision and/or refeeding. In addition, lack of progress in outpatient or intensive outpatient treatment or the intensification of symptoms while in a lower level of care also suggests the need for a more structured, more intensive treatment environment.

Intensive outpatient treatment is often utilized as an alternative to weekly outpatient treat-

TABLE 1.2. Circumstances That Warrant Inpatient Hospitalization

Hospitalization should be considered when the patient displays any one or more of the following symptoms:

- Below 85% of expected body weight *or* BMI below 18.0.
- Severe resistance to and/or low motivation for change.
- Long duration of eating disorder.
- Purging multiple times daily.
- Lack of access to outpatient treatment.
- Low familial and social support for change.
- Amenorrhea.
- Acute or multiple comorbid psychiatric disorders.
- Concurrent alcohol or substance abuse.
- Strong risk or intent for suicide.
- Serious concurrent medical problems.
- Electrolyte imbalance.
- Abnormal vital signs such as pulse, blood pressure, or body temperature.
- Rapid rate of weight loss.

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ment when more structure and stability would benefit the patient. This is often recommended when a patient is unemployed, severely depressed, or experiencing very chaotic eating and bingeing patterns. Intensive outpatient treatment typically includes a combination of individual and group therapy sessions held for several hours daily. The patient typically attends these programs for 3 or more days per week, either during the daytime or in the evenings. This level of treatment is often used as a step-down from successful inpatient treatment, although it also can be utilized as a first-line treatment or a step-up if a patient is not improving through outpatient treatment.

In the absence of severe psychiatric comorbidity or life-threatening medical consequences from the eating disorder, outpatient treatment can often be recommended as the first-line treatment. This treatment, described throughout this manual, can be provided through once- or twice-weekly individual psychotherapy sessions. At the outset of treatment, the therapist and patient can draft a treatment contract to stipulate that, although weekly outpatient treatment will first be utilized, the patient will be transferred to a higher level of care if substantial improvement is not made within 6 weeks. Treatment providers will then need to routinely assess which level of care and setting are appropriate for any given patient. Assessment is an ongoing process that should occur throughout treatment, not simply at the outset, because a patient may experience significant improvements, setbacks, or an onset of comorbid conditions that will affect the appropriate level of care.

Regardless of the level of care recommended, it is important that empirically supported treatments are utilized to maximize the potential for treatment response. For adults, CBT is widely considered to be the recommended first-line treatment for BN. For adolescents and children, both CBT and family-based treatment, also known as the Maudsley approach, have been shown to be efficacious (le Grange & Lock, 2009; Schmidt et al., 2007).

USING THIS TREATMENT PLANNER

This book is intended to be a comprehensive guide for clinicians who wish to provide CBT for BN. Included in this treatment planner are diagnostic criteria for the eating disorders, background information on the conceptualization and treatment of BN, assessment tools, a session-by-session protocol for the cognitive-behavioral treatment of BN, patient handouts and worksheets, and an extensive case example. Using these materials, the reader will be equipped to assess, diagnose, conceptualize, and treat a patient with BN. Suggestions are also provided for adapting this treatment for BED, purging disorder, subthreshold BN, and other variations of EDNOS. The included treatment planning materials are a synthesis of the original empirically supported treatment for BN, the transdiagnostic treatment for eating disorders, and current eating disorders treatment research (Fairburn et al., 2009; Fairburn, Marcus, & Wilson, 1993).

In this chapter we have discussed the symptoms of eating disorders, their diagnosis, treatment outcome research, common comorbid psychopathology, and level-of-care decision making as well as basic information about CBT and its application to BN. In Chapter 2 we go into more detail about BN and offer a cognitive-behavioral model for understanding it. From there, we provide descriptions of the common comorbid medical and psychiatric problems as well as information about the efficacy of psychotropic medications most often prescribed for BN. Collaboration

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with a full treatment team, including an internist, a psychiatrist, and a nutritionist, is strongly encouraged.

Chapter 3 consists of detailed information to assist any therapist with assessment and case conceptualization of a patient with an eating disorder.

The treatment plan is included in Chapter 4. We present session-by-session suggestions for the treatment of BN, including thorough descriptions of interventions, in-session worksheets, patient handouts, and suggestions for between-session homework. This 20-session treatment plan is appropriate for adult and adolescent patients seeking outpatient treatment for BN, and it can be readily adapted for patients with EDNOS. A section on handling "roadblocks" and managing treatment resistance is provided at the end of Chapter 4 to assist the therapist with effective treatment implementation.

To illustrate the treatment plan in action, Chapter 5 offers a case example that parallels the session-by-session treatment planner. For each of the patient worksheets suggested in Chapter 4, a completed sample is shown with the case example in Chapter 5. Before providing this treatment, the therapist should become familiar with the entire treatment protocol. In addition, consistent with the ethical guidelines for clinical conduct, clinical supervision should be sought prior to treating an individual when the presenting problems are outside the bounds of the therapist's expertise.

Many patients presenting for treatment for BN will be utilizing their health insurance to cover or offset the cost of treatment. In this era of managed health care, the patient's health care provider often requires the therapist to provide initial diagnostic reports, updates on treatment progress, and requests for additional sessions in order to cover the patient's treatment costs. Chapter 6 discusses how to communicate effectively with the managed care organization. This chapter includes information on eating disorder diagnoses, a sample treatment report, lists of symptoms and interventions to be included in treatment reports, and guidelines for requesting additional sessions.

Appendix A provides additional information about the transdiagnostic theory and updated research on the eating disorders. Appendix B includes several assessment instruments that will help clinicians conduct proper evaluations at intake and throughout treatment. Appendix C offers suggestions for background reading in CBT for those clinicians who wish to better understand this treatment modality. Patients and their families often benefit from reading as an adjunct to their treatment, both for psychoeducation and to reinforce concepts discussed in treatment sessions; suggested reading materials for patients and their families also are provided in Appendix C.

Experienced clinicians, new professionals, and graduate students should all find useful information within this planner to guide their treatment of eating disorders. Although no prior training in CBT is required for use of this treatment planner, a basic knowledge of the key concepts will be useful for any practitioner.

The confines of this treatment planner are as important to mention as its contents. The cognitive-behavioral interventions are intended to be a stand-alone treatment for adults and adolescents with BN, and not to be used piecemeal or in an adjunctive manner. Instead, this treatment has been shown to be effective when its interventions are utilized all together and as part of a cognitive-behavioral case conceptualization (see Chapter 3). Although the treat-

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ment interventions should be utilized largely as described, we expect you will adapt treatment to fit each patient's unique symptom and cognitive profile. Likewise, the interventions described herein can be adapted for use with patients with subthreshold BN and with EDNOS. CBT for BED, for example, is quite similar to the treatment described in Chapter 4, although there is no need to focus on purging. This treatment plan also may be adapted for adolescents with BN. The current research literature suggests that family-based treatment is most effective for adolescents with AN, although results are less clear for adolescents with BN (Eisler et al., 1997; le Grange, Crosby, Rathouz, & Leventhal, 2007). Either CBT or family-based treatment may be efficacious for adolescents with BN (Schmidt et al., 2007).

Although this treatment planner may be useful for patients with various forms of an eating disorder, this treatment should not be utilized concurrently with weight reduction efforts. Dieting has been shown to exacerbate and maintain disordered eating regardless of diagnosis. Specifically, dietary restriction often precedes the onset of bingeing. Strict dietary rules, whether or not they are adhered to, are considered maintaining factors in BN, BED, and AN. Throughout this CBT for BN, there is an emphasis on reducing food rules and dietary restriction. Thus, active dieting is contraindicated for improvement in this treatment. Weight loss, where indicated, can be set as a treatment goal only once patients are abstinent from bingeing.

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