Guidelines for the Treatment of Children and Youth with Eating Disorders
by
Sarah Dunnill

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St. Lawrence College
Kingston, Ontario
Canada
Dedication

This thesis is dedicated to my father. The unconditional support you gave me will always be cherished and your memory will give me strength. I hope that I will make you proud.

I would also like to dedicate this thesis Dylan Simpson. You have given me so much support and kept me going even when I thought I couldn’t take anymore. You listened to whatever I had to say and made me feel like it will all be okay.

Lastly, I would like to dedicate my thesis to my mom and my sister. We have gone through a hard time, but we will have strength. Dad will be watching over us.

You all have my unconditional love and support that you have given me.
Abstract

Eating disorders are a serious and persistent mental health disorder which often develop in youth and adolescents. Untreated eating disorders can have an impact on individuals’ lives as a result of heightened risk of health-related issues as well as chronicity and comorbidity. The purpose of the present thesis was to create treatment guidelines for clinicians treating youth and adolescents with eating disorders that include recommendations for empirically supported treatments. The literature supporting the use of dialectical behaviour therapy, cognitive behaviour therapy, cognitive remediation therapy, interpersonal therapy, and motivational interventions for the treatment of anorexia nervosa, bulimia nervosa, avoidant restrictive food intake disorder and other specified eating disorders is reviewed within the guidelines. Recommendations are made regarding which treatment option might be most beneficial depending on the clients’ specific circumstances. The guidelines were developed for use by therapists working within a multidisciplinary team in a clinical setting. It is hoped that these treatment guidelines could be adopted in other clinical settings to improve treatment of youth and adolescents with eating disorders. Although the hospital guidelines include model treatment sessions, due to copyright and privacy issues these were not included in the present thesis but can be obtained through the hospital. Limitations to the present thesis include a lack of implementation data supporting the efficacy of the treatment guidelines in ensuring better treatment integrity. Future research should include the implementation of the treatment guidelines in a clinical setting evaluating the therapist adherence, the efficacy of the treatment plan, and ease of implementation.
# Table of Contents

**Dedication** ............................................................................................................. ii  
**Abstract** ................................................................................................................ iii  
**Acknowledgements** ............................................................................................... v  

**Chapter I: Introduction** ......................................................................................... 1  
  Purpose of the Project .......................................................................................... 2  

**Chapter II: Literature Review** ............................................................................... 4  
  Cognitive Remediation Therapy ........................................................................... 4  
  Dialectical Behaviour Therapy .............................................................................. 5  
  Cognitive Behaviour Therapy ............................................................................... 7  
  Interpersonal Therapy ......................................................................................... 10  
  Motivational Interviewing ................................................................................. 10  
  Summary .............................................................................................................. 10  

**Chapter III: Method** .............................................................................................. 12  
**Chapter IV: Results** .............................................................................................. 14  
**Discussion** ........................................................................................................... 15  
**References** ........................................................................................................... 18  
**Appendix A** ........................................................................................................ 1
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Project Report

Chapter I: Introduction

Eating disorders are among the three most prevalent chronic mental illnesses in children 14 years old to 20 years old (Chamay-Weber, Narring, & Michaud, 2005). The prevalence of eating disorders is 13.1%, which is a strikingly high percentage among children and youth under the age of 20 (Dooley-Hash, Banker, Walton, Ginsburg & Cunningham, 2012). Eating disorders are a complex disorder to treat because of their chronic nature which makes the children and youth resistant to treatment (Noordenbos, Oldenhave, Muschter, & Terpstra, 2002). Noordenbos, Oldenhave, Muschter, and Terpstra (2002) define chronicity as a disorder lasting 10 years and over. They state that 1 in 5 individuals with anorexia nervosa or bulimia nervosa will have a chronic eating disorder lasting over a decade.

Eating disorders in children and youth often persist into adulthood leading to further issues with the individual’s health (Herpertz-Dahlmann, Dempfle, Konrad, Klasen & Ravens-Sieberer, 2015). Herpertz-Dahlmann et al. (2015) found that those who had eating disorders with comorbid depression or anxiety at a young age were at an increased risk of being obese or having an extremely low body weight in adulthood. Baiano et al. (2014) report that those with long term eating disorders have a lower health related quality of life than those of the general population. They also found that treatment of eating disorders leads to an increased health related quality of life; however, they questioned whether the increase was due to components of treatment themselves, or the implied care from the therapists treating the individuals. This question is important to the use of guidelines in the treatment of eating disorders it would ensure that the treatments are consistent across the clients. If treatment efficacy was studied after the introduction of the guidelines for treatment of youth eating disorders, then it would provide evidence indicating whether the consistency of the treatments is increasing the client’s quality of life.

It was found that eating disorders have a high comorbidity with major depressive disorder, anxiety disorders in youth, and alcohol and substance use disorders later in life (Baiano et al., 2014; Herpertz-Dahlmann, 2001). Herpertz-Dahlmann et al. (2001) found that comorbid disorders are very common among those with chronic eating disorders. In their study, they found that 97% of individuals with chronic eating disorders were also diagnosed a comorbid disorder; however, the likelihood of having a comorbid disorder decreased to 51% among non-chronic cases. Comorbidity has been linked to an increased severity of the individuals’ eating disorders (Herpertz-Dahlmann et al. 2001) and it has also been established to decrease their quality of life (Baiano et al. 2014). Baiano et al. (2014) reports that relapse and hospitalizations have a negative effect on the treatment of the individuals’ comorbid disorder leading to an increased risk of eating disorder chronicity. According to Mayes et al. (2014), suicidal ideation and suicide attempts have a high prevalence among children and youth who have eating disorders, especially in those diagnosed with bulimia nervosa (BN). They also found that there was an increased risk for suicide attempts in chronic cases of eating disorders persisting into young adulthood. They attribute the increase to the length of illness, age and switching eating
disorder symptoms and found that those who had suicidal ideation or suicide attempts had a comorbid diagnosis of anxiety or depression. Compared to the general population below the age of 20, mortality related to eating disorders is increased due to the associated issues with health and comorbid diagnoses (Fichter & Quadflieg, 2016). According to Herpertz-Dahlmann (2001), the mortality rates increase from childhood to adulthood in individuals with eating disorders. This demonstrates the importance of having an efficient and effective treatment so that the children and youth’s eating disorders do not become chronic and persist into adulthood.

While clients often seem as though they desire a change from their treatment, they often do not experience changes from their treatments (Abbate-Daga, Amianto, Delsedime, De-Bacco & Fassino, 2013). It is suggested by Abbate-Daga et al. (2013), that they may be both consciously and unconsciously resistant to treatment because of feelings of distress triggered by change. Carter and Kelly (2015) wrote that despite clients’ motivation for change, motivation was not sufficient to decrease their eating restrictions. If the clients cannot recover from their eating disorder by motivation alone, then it is important to have an effective treatment support these clients while attempting to recover from their eating disorder (Carter & Kelly, 2015). It is also important to have an effective treatment because clients with multiple treatment failures may begin to see themselves as untreatable and will become less likely to seek treatment in the future (Noordenbos et al., 2002). The resistance to treatment, or refusal to seek treatment is often dangerous to clients as their body is affected by their lack of nutrition in ways that can be permanent (i.e. osteoporosis) and fatal to the client (i.e. heart attack) (Noordenbos et al., 2002). Wonderlich et al. (2012) write that due to the difficulty and length of treatment required to treat individuals with eating disorders, clinicians tend to stray from empirically based treatments. Clinicians may rely on a mix of treatments, single treatment strategies, or supportive counselling resulting in an ineffective treatment (Wonderlich et al., 2012). Furthermore, the deviations from empirically based practices often result in outcomes that are difficult to interpret, and success of treatment cannot be objectively assessed (Wonderlich et al., 2012). Wonderlich et al. (2012) suggest that clients with eating disorders are treated by a multidisciplinary treatment team including a mental health worker, nurse, and a dietitian with a structured plan for treatment. They state that the plan should be followed with clear goals for the clients to reach and any alterations to the plan should be discussed with the treatment team. They further these suggestions by recommending that the treatment team follow treatment guidelines for treatment status and any changes that might be required in treatment.

**Purpose of the Project**

An effective and efficient treatment is important when the clients are first diagnosed with an eating disorder in order to reduce the risk that the disorders will become chronic which carries added risk to the clients. Eating disorders typically emerge in youth and during adolescents and the eating disorder team at the agency has the advantage of treating the clients in this critical time period. The treatment guidelines for eating disorders in children and youth are being developed in order to give support to the therapists working with the clients and provide recommendations for any new staff that may be introduced to the treatment team. Implementation of the guidelines will also provide the hospital with a standardized treatment plan which may be further assessed for
its efficacy in treating a range of clients, rather than relying on assessing the efficacy
given single cases through the clinicians’ experience. The agency suggested the treatment
guidelines as a means to study their effect in treatment, and as a training resource for
staff. The guidelines may also be published to add to the literature surrounding the
treatment of eating disorders in children and youth. If the guidelines are published, then
they may be able to help other clinicians or agencies to develop an effective treatment
plan or add to an already established treatment plan for the treatment of eating disorders.
Chapter II: Literature Review

Eating disorders are one of the most prevalent mental health disorders in youth and childhood (Dooley-Hash et al., 2012). They are associated with high mortality due to health complications, suicide, and an overall decreased wellbeing (Mayes et al., 2014). Eating disorders often have a lasting impact on the individuals’ adult life because of an increased risk of comorbidity, obesity and chronicity (Baiano et al., 2014; Herpertz-Dahlmann et al., 2015; Noordenbos et al., 2002). Smink, van Hoeken, Oldehinkel and Hoek (2014) conducted a community cohort study to determine the prevalence of eating disorders according to the criteria in the DSM 5. They found that the prevalence rates of EDs in the female portion of the sample were 1.7% for anorexia nervosa (AN), 0.8% for bulimia nervosa (BN), 0.6% for other specified eating disorders (OSFED), and 0.2% for unspecified eating disorders. The prevalence rate was low for males in all other eating disorders (ED) except for binge eating disorder (BED) (Smink et al., 2014). Treatments vary across the different classifications of eating disorder and given their prevalence and severity it is important to determine the most effective treatments for eating disorders. The American Psychology Association’s (APA) guidelines for eating disorder treatment recommends the best available treatment for all eating disorders excluding AN (APA, 2006; Lynch et al, 2013). There is a scarcity of empirical support for most treatments for AN; although, cognitive remediation therapy (CRT) and dialectical behaviour therapy (DBT) have shown promise in the treatment of AN (Lynch et al., 2013). Furthermore, DBT and preliminary studies of family DBT have shown promising results in the treatment of other eating disorders such as BN, BED, OSFED and other unspecified eating disorders (Lynch et al., 2013). The treatment recommendations from the APA (2006) highlight cognitive behaviour therapy (CBT) as well as interpersonal therapy (IPT) for OSFED (Lynch et al., 2013). MI has mixed empirical support as a standalone intervention but paired with other treatment it shows promise (MacDonald, Hibbs, Corfield & Treasure 2012). Mixed findings for MI are commonly associated with the difficulty in separating the strategies from MI and the therapies that are used in conjunction (MacDonald et al., 2012). Aside from MI, each of these therapies use a manualized format.

Cognitive Remediation Therapy

Cognitive remediation therapy (CRT) is a treatment used to develop cognitive flexibility in clients with anorexia nervosa (AN) to combat rigid thinking patterns that are associated with difficulties with set-shifting and central coherence in clients with AN (Danner et al., 2012). Central coherence is the ability to see events from a broader perspective and set shifting is the ability to shift thinking between tasks (Danner et al., 2012). Clients with rigid thinking patterns may exhibit preoccupations with their weight and appearance, perform ritualized behaviours, and/or be willing or unable to change their eating or exercise routines (Brockmeyer et al., 2014). CRT is often used to prepare clients for therapies in which cognitive flexibility is important, such as cognitive behaviour therapy (CBT) or dialectical behaviour therapy (DBT) which require that the clients are able to change their behaviour, or thinking patterns (Dingemans et al., 2013). CRT was effective in improving clients’ neurofunctioning and improving the results of treatment as usual after CRT with clients living with anorexia nervosa. For example,
Brockmeyer et al., (2014) found that clients with anorexia who participated in CRT also demonstrated improvements in their cognitive flexibility and significant improvements in their set shifting as they advanced through the activities that are used in the CRT condition. Furthermore, Dahlgren, Lask, Landro, and Ro (2013) reported a significant increase in their clients’ visuo-spatial memory, and verbal fluency at the end of treatment; however, there was no change in their clients’ mental flexibility or planning. In addition, they stated that some aspects of central coherence had improved by the end of treatment. Dingemans et al., (2013) examined whether CRT would be a beneficial add-on to treatments for individuals with severe and enduring eating disorders by comparing treatment as usual (TAU) with CRT, and TAU alone as a control group. TAU, in this case, referred to a mix of therapies including normalization of eating behaviours, art therapy, social skills training and CBT (Dingemans et al., 2013). Their participants displayed a larger reduction in their eating disorder psychopathology at the end of treatment than the control group. The authors also found high treatment acceptability in their study with low attrition rates (Dahlgren et al., 2013 Dingemans et al., 2013) and high acceptability assessments (Brockmeyer, 2014).

Dialectical Behaviour Therapy

Dialectical behaviour therapy (DBT) is a treatment used to increase emotional regulation among clients with eating disorders (Lynch et al., 2013). DBT focuses on increasing emotional regulation through mindfulness, validation, interpersonal effectiveness, emotional regulation, and distress tolerance (Lynch et al., 2013). It has been shown that clients with anorexia nervosa (AN) often display problems with emotional identification, avoidance and overcontrol which leads to serious and enduring eating disorders (Lynch et al., 2013; Salbach-Andrae et al., 2008). DBT is used to help clients identify their emotions, and become aware of how their emotions affect their behaviour so they may find more adaptive ways to cope with strong and unpredictable emotions (Salbach-Andrae et al., 2008). There are a number of studies which supported the effectiveness of DBT among clients with eating disorders. For example, Lynch et al. (2013) found that after receiving radically open DBT, 20.5% of their clients reached full remission and 41% of their clients had reached partial remission from their symptoms of AN. Lynch et al., explains that the main difference between regular DBT and radically open DBT is that radically open DBT focuses on emotional overcontrol rather than under control; however, all other components of DBT remain the same. Salbach-Andrae et al. (2008) reported that out of six clients, four clients with AN restricting type, and one client with AN binge/purge type had reached full remission by the end of a course of DBT. Similarly, in the study of Federici and Wisniewski (2013), five out of the six participants endorsed fewer eating restrictions by the end of treatment. Of the clients with AN who reported binge eating, three of the participants stated that there were no occurrences of binge eating by the end of treatment (Federici & Wisniewski, 2013). Six of the participants who endorsed purging at the beginning of treatment no longer purged at the end of treatment (Federici & Wisniewski, 2013). Lastly, there was a decrease in excessive exercise in the participants who reported it at the beginning of treatment (Federici & Wisniewski, 2013). The studies by Lynch et al. (2013) and Federici and Wisniewski (2013) also showed improvements in their clients’ weight. According to Lynch et al. (2013) participants had significant increases in their BMI and significant
decreases in their eating disorder symptoms by the end of treatment. Additionally, Federici and Wisniewski (2013) reported that all participants who were considered underweight had gained weight by the end of treatment. Increases in quality of life and wellbeing were also reported by the participants in the studies. Lynch et al. (2013), stated that participants reported an increase in quality of life and reductions in distress in pre and post- questionnaires. Federici and Wisniewski (2013) measured self-injurious and suicidal behaviour and found that self-injury decreased in four of six participants. Furthermore, upon entry, each of the participants had medically comorbid disorders resulting from their eating disorders and by the end of the treatment, all participants had been medically stabilized except for one participant who needed hospitalization (Federici & Wisniewski, 2013). Lastly, participants reported positive associations with the therapeutic techniques used in treatment, and increased motivation to change (Federici & Wisniewski, 2013). Clinicians delivering the treatment also endorsed positive associations with the treatment, and decreased burn out (Federici & Wisniewski, 2013).

Another disorder in which DBT is used as treatment is BN. It is used to increase emotional regulation among clients with BN. It has been shown that clients with BN attempt to suppress negative emotions, and distress through a binge/purge cycle, often leading to increased maladaptive cognitions and distress with short term relief through binging/purging (Hill, Craighead & Safe, 2011). Hill, Craighead and Safer (2011) used an appetite focused form of DBT (DBT-AF) in order to treat clients with BN. They found that DBT-AF was effective in treating clients with BN. They reported that the symptoms of the clients experiencing BN were quick to decrease after the start of treatment. According to Hill et al. (2011), 61.5% of their clients no longer met criteria for BN and 26.9% of clients were abstinent from binge/purging behaviours at post treatment. A study by Chen, Matthews, Allen, Kuo and Linehan (2008) also demonstrated improvements in their clients’ symptoms of BN. They found that three out of six of their clients were abstinent from objective binging episodes prior to the 6-month follow up, while two clients reported purging until post-treatment, and one reporting purging until the 6-month follow-up. One had disclosed diuretic abuse at the start of treatment but was abstaining by post-treatment (Chen et al., 2008). According to Fischer and Peterson (2015) there were significant improvements in all their clients’ eating disorder symptoms by the end of the study, and decreased occurrences of binge eating, purging, and eating disorder related cognitions. They reported that three out of seven participants had reached the criteria for full-remission by the end of treatment. DBT was also effective in improving clients’ wellbeing by the end of the studies by Hill et al. (2001), Chen et al. (2008), and Fischer and Peterson (2015). In the study by Hill et al. (2001), clients were able to decrease their dietary restrictions without increasing their distress regarding eating. Their clients reported an increase in their awareness of their emotions, awareness of their emotional eating, self-efficacy and negative affect at follow-up. Hill et al. (2001) also found that comorbid depression had decreased to minimal or no depression at follow-up. Chen et al. (2008), found that DBT was successful in treating the clients’ suicidal and self-injurious behaviours, objective binge eating, and improving eating disorder related scores on the assessments administered to the clients. Chen et al. (2008), and Fischer and Peterson (2015), both reported decreasing the frequency of suicidal and self-injurious behaviours during the treatments; however, both authors also reported one serious suicide attempt during the treatments.
Dialectical behaviour therapy has also been used effectively with other feeding/eating issues (Telch, Agras & Linehan, 2000). Other feeding/eating issues encompasses a number of different eating disorder classifications; however, the only eating disorder that has been well researched is binge eating disorder (BED). Similar to AN and BN, the focus of DBT in the treatment of BED is to target dysregulated emotions which often results in binge eating as a maladaptive form of emotional management (Telch, Agras & Linehan, 2001). DBT is used to provide clients with adaptive methods of regulating their emotions in order to treat BED (Telch, et al., 2001). Telch, Agras and Linehan (2000) found that 82% of participants in the study were abstaining from binge eating by the end of treatment. Abstinence was also maintained at the post-treatment. A second study by Telch and colleagues (2001), found that 88% of participants had abstained from binge eating four weeks prior to the termination of treatment. They noted that abstinence had reduced at the 6-month follow up for 56% of participants. Lastly, binge eating was reduced among 52% of participants through the treatment course (Telch et al., 2001). The first study by Telch et al. (2000), also reported increases in their clients’ wellbeing. There were overall improvements in the eating disorder related assessments delivered during pre- and post-treatment for eating, shape and weight concerns (Telch et al, 2000). According to Telch, et al. (2001), clients reported greater self-efficacy regarding their ability to change their negative affects by the end of treatment. They also reported an increased control over their urge to eat when feeling anxious or angry, but not when feeling depressed.

Family dialectical behaviour therapy (F-DBT) is a separate treatment from individual DBT which uses components of family-based treatment (FBT) and dialectical therapy in order to treat clients with eating disorders and their families (Murray et al., 2015). This treatment provides the family with psychoeducation in relation to their loved one as well as treatment (Murray et al., 2015). There is a dearth of research surrounding F-DBT as the conceptualization is fairly new (Murray et al., 2015). Murray et al. (2015) conducted a study which evaluated the efficacy of a combined DBT and FBT approach to examine whether the effects of treatment would be augmented when treating clients with BN. They found that the combination of approaches was effective in reducing the symptoms of BN and clients’ ability to regulate their emotions. The clients’ parents also endorsed higher self-efficacy in helping their loved one by the end of treatment (Murray et al., 2015). Murray et al. (2015) suggest that the findings in this preliminary study support the use of the combination of family-based therapy and dialectical behaviour therapy. They suggest further research is needed to further substantiate the use of family-based therapy a dialectical behaviour therapy and evaluate the treatment components.

Cognitive Behaviour Therapy

Cognitive behaviour therapy (CBT) is a treatment used to help clients change their maladaptive thought patterns (Anderson & Maloney, 2001). It is believed that maladaptive thought patterns affect the behaviour of those who experience bulimia nervosa. CBT uses relaxation techniques, cognitive restructuring, and relapse prevention strategies to help individuals with eating disorders recover (Anderson & Maloney, 2001). Those with BN are noted to struggle with low self-esteem, and often evaluate their worth based on the interpretation of their weight or shape (Anderson & Maloney, 2001). CBT uses a structured and directive approach to treating clients with BN (Anderson &
Homework is generally used in CBT to help give the client and clinician insight into the clients’ maladaptive thinking patterns (Anderson & Maloney, 2001). CBT has been shown to be an effective treatment for clients who are experiencing BN. Anderson and Maloney (2001) conducted a meta-analysis which showed that CBT was effective in significantly reducing both binging and purging behaviours among individuals with BN, although reductions in binging and purging were variable among studies. A study by Waller et al. (1996) found that CBT was effective in treating clients with BN in a primary care setting. There were 11 participants in the study, six of whom had a positive outcome after treatment. Waller et al. (1996) assert that negative outcomes were associated with external stressors, comorbid diagnoses and the presence of obesity. Another meta-analysis by Linardon, Wade, de la Piedad Garcia, and Brennan (2017) found that CBT was effective in treating clients with BN for both physical and cognitive symptoms. It was found that CBT participants were able to maintain changes in follow-up conditions. The most beneficial form of CBT for BN was a therapist led, manualized form of CBT which was enhanced or specific to BN (Linardon et al., 2017). Linardon et al., (2017) found that CBT is equally effective in treating BN as other behavioural therapies. They also found that pharmacological treatments in conjunction with CBT was found to be equally effective in treating BN and binge eating disorder (BED), but only provided short term positive results. Linardon et al., (2017) suggested that CBT was more effective in treating eating disorders than interpersonal therapy but less or equally as effective as other non-specific treatments. Two studies found that CBT was effective in increasing the wellbeing of their clients (Waller et al., 1996; Linardon et al., 2017). Anderson and Maloney (2001) asserted that few studies in the meta-analysis evaluated self-esteem; however, the studies that did measure self-esteem showed significant increases in the clients’ self-esteem by the end of treatment. Waller et al. (1996) reported that participants in their study endorsed an improvement in their eating habits and mood, and a decrease in their negative evaluation of their weight and shape. In contrast, however, Anderson and Maloney (2001) state that among the studies evaluated in their meta-analysis, CBT was ineffective at changing shape or weight concerns. They also found that no conclusions could be drawn regarding eating restrictions as there were few studies that included measures which evaluated eating restrictions.

Avoidant/restrictive food intake disorder is a new classification introduced by the DSM 5, as a result there is a limited number of studies evaluating treatment of clients with ARFID (Bryant-Wraught, 2013). There is some question as to whether ARFID has more in common with AN or anxiety disorders, which affects the treatment course of this disorder (Murphy & Zlomke, 2016). ARFID is more common in males and manifests at a younger age than AN or BN (Murphy & Zlomke, 2016). The literature surrounding ARFID is limited to preliminary studies assessing the viability of treatments used for this disorder. Bryant-Waught (2013) conducted a single case study in which they treated a client with ARFID with cognitive behavioural therapy. The treatment consisted of cognitive restructuring self-monitoring, goal setting, and psychoeducation. The client was capable of identifying the need to change and the negative outcomes associated with his restrictive eating (Bryant-Waught, 2013). Bryant-Waught (2013) identified that the client had issues with anxiety which were interfering with the client’s motivation to eat. The client had succeeded in increasing his intake through supplements and yoghurt but did not widen his food selection at the end of treatment. As a result of the increased
nutrition, the client’s physical development had improved over time (Bryant-Waught, 2013). In comparison, Murphy and Zlomke (2016) used behavioural parent training in order to treat a client with ARFID. They used an exposure-based approach using differential reinforcement with attention as the reinforcer in order to increase the amount of food consumption and the amount of food that the participant would accept. Murphy and Zlomke (2016) also used modelling and food diary cards in order to track the client’s progress. At the end of treatment, the participant was accepting significantly more foods, and there was a reduction in disruptive behaviours related to eating. The improvements that the participant gained through the intervention also generalized outside of the home setting (Murphy and Zlomke, 2016). The participant’s mother reported increases in her confidence and skills regarding meal time with the participant. However, generalizability and single case design were both limitations in this study (Murphy and Zlomke, 2016).

As demonstrated above, treatment for ARFID is still being developed. Comparing the treatment from Murphy and Zlomke (2016), and Bryant-Wraught (2013), it appears that behavioural treatments and exposure had better results in terms of improvements in the clients’ eating behaviours. Murphy and Zlomke (2016) did not address the acceptability of the treatment from the client’s perspective, therefore it is hard to determine which treatment produced a better outcome on the clients’ cognitions about eating.

Cognitive behaviour therapy is also used to treat clients with other feeding/eating issues, and has been shown to be an effective treatment (Fishcer et al., 2014). The focus of CBT in the treatment of BED is to target maladaptive cognitions which often influences client’s behaviours and increases the likelihood of binge eating (Fishcer et al., 2014). They assert that CBT is used to help clients learn new coping methods and ways of thinking which will influence positive behaviour changes in the clients. Fischer et al. (2014) found that CBT was effective in reducing binging episodes by 30% and BED symptoms during treatment and at follow-up. The effect of treatment on binging episodes had further improved by 67% and BED symptoms had continued to improve at a slower rate over the follow up period (Fishcer et al., 2014). Another study by Grilo et al., (2012) found no significant difference between treatments using CBT with fluoxetine or CBT with a placebo pill at any time during treatment; however, both interventions were more effective than using fluoxetine alone. They reported that 26.9% of participants in the treatment group receiving CBT and fluoxetine, 35.7% of the treatment group receiving CBT and a placebo pill, and 3.7% of the treatment group receiving fluoxetine only were in remission at the follow up. A study by Agüera et al. (2013), also found that 47% of participants with BED were in remission, compared to 30% remission for BN non-purging type and 27.2% remission for BN purging type by the end of CBT. Studies by Fischer et al. (2014), Grilo et al. (2012), and Agüera et al. (2013), each reported that BMI was unchanged through the treatment trials; however, Fischer et al., state that improvement in BMI gradually increased over the 4-year follow-up period in their study. One drawback to CBT found by Fischer et al. (2014), was that restrictive behaviours had developed in their clients with BED over the course of treatment to varying degrees; some of the clients were restricting to maintain a healthy weight after weight loss from treatment, while others were restricting to a level which suggested other eating disorder symptoms.
Interpersonal Therapy

Interpersonal therapy (IPT) has also been successfully used in the treatment of eating disorders with results similar to CBT. IPT examines the clients’ relationships for factors that would maintain their eating disorder (Wilfley & Agras, 1993). It is a client centred approach which helps clients build or maintain healthy relationships and reconcile differences that may have influenced the clients’ eating disorder related behaviours (Fairburn et al., 2015). IPT focuses on the premise that the clients’ eating disorder is related to grief, role transitions, relational disputes, or poor social skills (Fairburn et al., 2015). This is demonstrated in a study by Wilfley and Agras (1993), who found that clients who were experiencing BED and receiving IPT had decreased their occurrences of binging by 71%, and 44% of clients were abstaining from binging by follow-up. Additionally, Fairburn et al.’s (2015) study found that 33% of clients receiving IPT were in remission by the end of treatment. The effects of treatment improved in IPT to 49% of clients in remission. However, both sets of researchers (i.e., Wilfley & Agras, 1993; Fairburn et al., 2015) noted that IPT is slow to reach its maximum result. Therefore, studies evaluating IPT require a follow-up period to accurately measure the effects of the treatment.

Motivational Interviewing

Motivational interviewing (MI) is often used as a strategy to enhance treatment for clients with eating disorders (MacDonald et al., 2012). It has not been found to be an effective standalone treatment for eating disorders; however, components of MI can be used to enhance other treatments. MI is used to build the clients’ motivation for change by promoting change talk and eventually guiding the client towards change (MacDonald et al., 2012). For example, MacDonald et al. (2012) conducted a systematic review of the literature and found that MI was successful in decreasing eating disorder symptoms. Three studies reported readiness for change among their participants. Among the studies that did not use control groups, there were four studies which reported a high readiness for change among their participants (MacDonald et al., 2012). Mixed findings regarding the efficacy of MI for eating disorders is largely due to difficulties in evaluating the effects of MI specifically when it is combined with other treatments (MacDonald et al., 2012). There is also a dearth of research available which studies the effect of MI when added to other treatments (MacDonald et al., 2012). MI has been shown to have little effect as a standalone treatment however, the study by MacDonald et al. suggests that there are some benefits in using MI specifically in order to increase the clients’ readiness for change.

Summary

Resistance to treatment is a common barrier confronted by clinicians treating eating disorders. Often clients with eating disorders have difficulty accepting their illness or are ambivalent about recovery (Carter & Kelly, 2015). Clients are often unmotivated and not engaged in treatment (Carter & Kelly, 2015). Wonderlich et al. (2012) suggests that clients with eating disorders in an outpatient setting be treated using a multidisciplinary team which employs proper goal setting and a structured treatment.
Wobrock, Weinmann, Falkai, Gaebel (2009) assert that guidelines increase quality of care in mental health by decreasing the use of non-evidence-based practices which may be ineffective or harmful to the clients. They state that guidelines are particularly useful for interventions with clients with more severe mental illnesses. Treatment guidelines encourage therapists to use empirically based treatments with their clients (American Psychological Association, 2002). The American Psychological Association (APA; 2002) state that treatment guidelines should be client focused and centered on the condition that the guidelines are intended to treat. The APA assert that guidelines that effectively communicate the necessary information needed to implement the treatments can be very effective in ensuring therapists integrate empirical knowledge into practical application. It is suggested by the APA (2002) that treatment choices are flexible in order to support efficacy, variety and ease of implementing treatment into a clinical setting. The APA notes that clinicians will need sufficient knowledge and experience to adapt the treatments to their clients’ individual needs. Guidelines should also provide the clinician with flexible options for treating clients so that they may be able to address clients’ unique circumstances if required (APA, 2002). They assert that standardization of practice is important; however, a certain amount of flexibility is also important to improve treatments and meet a range of clients’ needs. Additionally, building a strong rapport with clients as well as an expectation and pursuit of improvement in treatment is crucial to integrating the standards suggested by the treatment guidelines (APA, 2002). Finally, the benefit of guidelines is dependent on the quality of the guidelines and the method in which they are implemented in a clinical setting. According to APA (2002), guidelines should be evaluated based on treatment efficacy and clinical utility.

The focus of the present thesis is to provide the eating disorder team at an outpatient eating disorders clinic within a hospital with a set of guidelines that promote a treatment structure which can be used by the current and future behavioural therapists. It is important to have treatments which are empirically supported as guidelines are often used to create a standard of care (Wobrock, et al., 2009).
Chapter III: Method

The guidelines are designed to provide a consistent and structured resource for therapists working in an outpatient clinic at a hospital in Kingston, Ontario with children and youth who have been diagnosed with any of the classifications of eating disorders in the DSM 5 (including other specified feeding and eating disorders (OSFED)). The primary intended consumers of the resource manual are behavioural therapists who are trained in using DBT or CBT. The guidelines are part of a larger set of guidelines developed by the eating disorder team at this hospital. Separate sections will be written based on area of expertise by the nurse practitioner, registered dietitian, and social worker. The full guidelines are to be used by an interdisciplinary team of professionals, such as a nurse to monitor the client’s health, registered dietician to work with the client’s diet, social worker to work with the client’s family, and behavioural therapist to conduct individual counselling. The section of the guidelines created for this thesis project include a thorough description of the role of the behavioural therapist on the eating disorder team. The policy section outlines the expectations for behavioural therapists involved in the program to collaborate with the team through the intake, diagnoses of the clients, and assessments of the client before and after treatment. The behavioural therapists work with the clients in individual sessions and tailor their therapy to suit the needs of the clients using the identified empirically supported interventions. DBT, CBT, CRT, IPT and MI. The intervention chosen is dependent on client needs. The behavioural therapists’ role includes determining which therapy would be the most beneficial to the client during the intake and the first individual session with the client. Participants were not part of this project.

Procedure.

The information included in the guidelines was gathered from empirical journals, the behavioural therapist’s (BT) experiences, and relevant diagnoses from the DSM 5. The BT at the agency recommended which therapies and diagnoses to include in the guidelines and provided feedback on each section of the guidelines and the guidelines as a whole. Articles were obtained from EBSCOhost. The databases used in the research for the guidelines are PsycINFO, PsycARTICLES, CINAHL Plus and Full Text, Food Science Source, Academic Search Complete, and ERIC. Some of the search terms used were eating disorders, treatment, DBT, Motivational Interviewing, CBT, CRT, IPT, Children, Youth, Anorexia, Bulimia, Binge Eating Disorder, mortality, resistance, prevalence, EDI-3, Beck Youth Inventory II.

The guidelines begin by describing the goal of the guidelines, client intake process and the assessment procedures. The next section describes the different diagnostic classifications of eating disorders according to the DSM 5. After the classifications, there is a section which describes each of the treatment approaches that the behavioural therapist may use with the clients. The next section provides diagrams demonstrating the treatment plans for AN, BN, ARFID, and OSFED. The diagrams are each explained, and information is provided on which treatment option to use depending on what is observed by the behavioural therapist relating to the client and their experiences. Lastly, there is a section with samples of model sessions that the behavioural therapist could use in individual sessions with the clients. These will provide users with examples of how sessions should look when they are working with their
clients so that there will be the most benefit attained from the therapy.

The full guidelines will be available online for use in the eating disorders clinic at the hospital. The guidelines may also be published for use by professionals in the field. The only materials required are a laptop and/or computer for research and paper for printing.
Chapter IV: Results

Product

The treatment guidelines that have been developed for youth and adolescents with eating disorders can be found in appendix A. The guidelines begin with a preamble, which provides an overview of the purpose of the treatment guidelines. The purpose of the guidelines, as described in the preamble, is to help clinicians make the most appropriate choice of treatment for children and youth with eating disorders. The guidelines describe the intake assessment process at the agency, which provides information relevant to the first meeting between the eating disorder team, client and family/caregiver. Expectations of the client and family, such as bringing the client’s medication to the appointment, waiting in the waiting room or perhaps filling out assessments, are outlined. The guidelines also describe expectations of the clinicians during the first meeting, such as retrieving the client and their family from the waiting room, measuring the client’s weight, or administering the assessments. The assessment procedures section gives a brief description of appropriate tools including the Beck Youth Inventory-2 and Eating Disorder Inventory-3 which are used with the clients before and after treatment. The guidelines summarize the diagnostic criteria for each category of eating disorders based on the DSM 5 criteria. The eating disorder classifications that are described in the guidelines are pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge-eating disorder, and other specified feeding or eating disorders. The next section describes the treatment options. Treatments were selected based on existing empirical support. The treatments included in the guidelines are cognitive remediation therapy, dialectical behaviour therapy, cognitive behaviour therapy, interpersonal therapy and motivational interviewing. There is a brief description of the goals and strategies used in each of the treatments. Finally, the guidelines include decision trees which guide the clinician in determining the most appropriate treatment options based on the client’s diagnosis. Further the guidelines offer insight into what a clinician may observe in their clients to guide their treatment choices. Due to issues with privacy and copyright, session models are not included in the appendices of this thesis.
Discussion

Summary

Treatment guidelines for children and youth with eating disorders were developed to provide behavioural therapists with recommendations for treatments to be used with anorexia nervosa (AN), bulimia nervosa (BN), avoidant/restricting food intake disorder (ARFID), and other specified eating disorders (OSFED). The treatments outlined in the treatment guidelines were cognitive remediation therapy (CRT), dialectical behaviour therapy (DBT), cognitive behaviour therapy (CBT), interpersonal therapy (IPT) and motivational interviewing (MI). These treatments have been shown to be effective for treating eating disorders. It is hoped that if these treatments are used with children and youth then the disorders can be treated before they become chronic and continue into adulthood, which can increase the risk of health-related problems, comorbidity and mortality.

Strengths

Treatment guidelines are often used to help clinicians determine treatment strategies that are best used when treating specific disorders; however, to date there are no guidelines which recommend a specific treatment for AN (Lynch et al., 2013). Research for treatment guidelines have often focused on CBT or IPT as the treatments of choice for AN but there is no definitive conclusion regarding effectiveness or recommendations for one or the other as a primary treatment for AN (Lynch et al., 2013). The present treatment guidelines for children and youth with eating disorders attempted to fill this gap by recommending that AN should be treated using CRT and DBT or DBT only as they have been shown to be effective in the treatment of AN. CRT has been shown to increase cognitive functioning by improving client’s set shifting and central coherence which is crucial for client’s to be effective in other treatments such as DBT. Therefore, the present treatment guidelines recommend this approach if rigid thinking patterns are observed by the clinician. The treatment guidelines explain that rigid thinking patterns can be observed as a difficulty in expressing thoughts or emotions and/or being incapable or unwilling to change a routine. If rigid thinking patterns are not observed in the client, then it is suggested that clinicians use DBT alone, which is further described in the treatment plan section of the guidelines. Often individuals with AN have difficulties with emotional regulation which are targeted when being treated with DBT. DBT has been shown to help clients with AN reach full or partial remission, increase weight, decrease eating restrictions and increase clients’ quality of life.

Dialectical behaviour therapy has also been shown to be effective with other eating disorders; however, it has not been recommended in other treatment guidelines despite showing equally or more effective results to CBT, which is currently the most commonly used treatment for eating disorders. The present treatment guidelines provide the choice of treatments using CBT or DBT as they have both been shown to be effective. The choice between therapies is important given that flexibility in treatment guidelines have been identified as a problem among the previously available treatment guidelines. Limited clinical choices and inflexibility may lead to clinicians to choose not to use the guidelines available (American Psychology Association; APA, 2002). According to the APA (2002), guidelines should provide clinicians with choices regarding treatment to help clinicians adapt treatments based on the individuals’ circumstances and promote
efficacy, variety and ease of guideline implementation. As such, the present treatment
guidelines for children and youth with eating disorders provide clinicians with
information on how clinicians can choose which therapy is best suited to their clients. It
is hoped that if this approach is effective the treatment guidelines may be adopted by
other agencies to promote more effective treatments across settings.

Limitations

There are two limitations to the present thesis. The first limitation is that the model
sessions could not be included in the attached treatment guidelines due to copyright and
privacy issues. The model sessions would have provided insight into how clinicians may
implement the treatments into sessions with clients. However, each therapy included in
the attached guidelines follows a manualized format which is described for each therapy
in detail and provides session by session guides. The second limitation is the lack of
implementation data. This could have further supported the use of the treatment
guidelines in a treatment setting. Data on implementation could have also given insight
into the ease of implementation of the treatment guidelines, which is important as the
ease of implementation often indicates whether the treatment guidelines will be used by
clinicians.

Multilevel Challenges

From the multilevel perspective some challenges that may be faced are through
implementation of the manual at the client level. Eating disorders are difficult to treat and
often individuals are resistant to treatment. The therapies outlined in the treatment
guidelines require that the clients complete the homework and practice the tools in each
session and out of the sessions. If these are not practiced by the client, there is a
decreased likelihood of remission following treatment. A challenge at the program level
is training in each therapy. Therapists will be required to have training in the treatments
described in the treatment guidelines in order to properly treat the clients. Therapists may
be specialized in one treatment, which may result in the therapist favoring the use of the
treatment modality they feel familiar with. It is intended that clinicians have the choice
between therapies so that they may tailor their treatments to the needs of the client; however, this may require further training to ensure fluency in each of the therapies
outlined in the guidelines. Similarly, an organizational level challenge that could emerge
is if an organization has a focus on one type of therapy, such as a CBT focus. This could
impact support and implementation of the treatment guidelines into a clinical setting. A
societal level challenge of implementing the guidelines is the availability of the
guidelines. In order for the guidelines to be shared on a societal level, it must be shown to
be effective through the implementation of the manual across settings.

Contributions to Field of Behavioural Psychology and Future Research

Eating disorders are one of the most difficult disorders to treat as some of the well-
known eating disorders such as AN do not have an empirically established treatment
plan. If successful when implemented, then the treatment plan suggested by this thesis
would further research into the field of behavioural psychology perhaps by eliciting
further research into new treatments for eating disorders or by improving on the empirical
base of therapies already being used. The addition of DBT into the recommended research for eating disorders may provide a much-needed change in direction in the treatment of eating disorders, specifically for AN. If DBT continues to be successful as a treatment for eating disorders, then this may bring attention to the importance of emotion in the development of eating disorders and could invite more research into the causes and maintenance of eating disorders. DBT would also be beneficial to add to the recommended treatments by the American Psychological Association as they are influential in the field of psychology and have already made treatment suggestions for eating disorders.

Further research should investigate the implementation of the guidelines in the clinical setting. This should include studies on the efficacy of the guidelines, the ease of implementation and therapist adherence to the guidelines. Further research into treatment for ARFID and a family based DBT would also be beneficial as the research is limited causing difficulty with suggesting an empirically effective treatment plan.
References


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Appendix A

BEHAVIOURAL THERAPY TREATMENT GUIDELINES FOR YOUTH AND ADOLESCENT WITH EATING DISORDERS


Created by: Sarah Dunnill

CAUTION
This report was completed as part of a supervised student placement. It should not be placed on any official file, nor would it be appropriate to discuss its findings in official agency reports.

In partnership with:

St. Lawrence College
Table of Contents

**Preamble** ........................................................................................................................................................................ 1

**Intake Appointment** ............................................................................................................................................................. 1

**Assessment Procedures** .......................................................................................................................................................... 1
  Beck Youth Inventory - 2 ............................................................................................................................................................... 1
  Eating Disorder Inventory – 3 .......................................................................................................................................................... 1

**Eating Disorder Diagnostic Criteria** ....................................................................................................................................... 2
  Avoidant/Restrictive Food Intake Disorder ........................................................................................................................................... 2
  Anorexia Nervosa ................................................................................................................................................................................ 2
  Bulimia Nervosa ................................................................................................................................................................................... 3
  Binge-Eating Disorder .......................................................................................................................................................................... 4
  Other Specified Feeding or Eating Disorder ......................................................................................................................................... 5

**Eating Disorder Treatment** ......................................................................................................................................................... 6
  Dialectical Behavioural Therapy .......................................................................................................................................................... 6
  Cognitive Remediation Therapy ............................................................................................................................................................. 7
  Cognitive Behavioural Therapy .............................................................................................................................................................. 7
  Interpersonal Therapy .............................................................................................................................................................................. 8
  Motivational Interviewing ..................................................................................................................................................................... 9

**Treatment Plan** ........................................................................................................................................................................... 11

**Phase One: Individual Counselling** .......................................................................................................................................... 11
  Anorexia Nervosa Treatment Plan .................................................................................................................................................. 11
  Bulimia Nervosa Treatment Plan .................................................................................................................................................... 13
  Avoidant/Restrictive Food Intake Disorder Treatment Plan .............................................................................................................. 14
  Other Feeding/Eating Issues Treatment Plan ........................................................................................................................................ 15
  Motivational Interviewing ................................................................................................................................................................... 16

**Phase 2: Family Counselling** ..................................................................................................................................................... 17
  Family Dialectical Behaviour Therapy Treatment Plan ..................................................................................................................... 17

**References** .............................................................................................................................................................................. 18
Preamble

The purpose of this practice guideline is to guide behaviour therapists in the outpatient treatment of clients under the age of 18 who have been diagnosed with an eating or feeding disorder. It is written to give guidance to behavioural therapists who are new to working in this field or further developing their skill in this field. The goal of this policy manual is to guide behavioural therapists through the treatment of eating disorders among children and youth.

Intake Appointment

It is expected that the parents and/or caregivers accompany the patient to the intake appointment which may last up to 4 hours. The parents and/or caregiver should be informed that all members of the eating disorder team will be present during the intake session. In addition, over the counter and prescribed medications should be brought to the intake appointment. The clients, parents and/or caregiver are expected to arrive fifteen minutes early to the intake appointment to complete administrative documents. The patient and parents and/or caregiver will wait in the waiting room until one of the professionals in the Eating Disorder Team escorts them to the room where the intake appointment is held. Psychometric tests, such as the Beck Youth Inventory and Eating Disorders Inventory – 3 will be given to the clients to be completed before or after the intake session. There will be a history and physical examination of patient completed by the nurse practitioner. Body Mass Index (BMI), ideal body weight and ideal body weight percentiles will be calculated by the nurse practitioner. After the intake the clients and their parents and/or caregiver will be presented a treatment plan and will be given the opportunity to accept or reject the treatment plan. The intake will be separately documented by each member of the team in the Patient Charting System (PCS).

Assessment Procedures

Beck Youth Inventory -2.

The Beck Youth Inventory-2 (BYI-2) is a psychometric assessment which uses inventories to assess youths’ anxiety, depression, anger, disruptive behaviour and self-concepts for children and youth (Pearson, n.d.). Each inventory consists of 20 statements that reflect criteria in the Diagnostic and Statistical Manual of Mental Disorders [4th ed.] (DSM-IV; American Psychiatric Association, 1996) addressing anxiety, depression, and individuals’ feelings about being mistreated, negative thoughts about others and physiological arousal (Pearson, n.d.).

Eating Disorder Inventory – 3.

The Eating Disorder Inventory-3 (EDI-3; Garner, 2004) is used by the eating disorder team to evaluate the differences in their self-assessments before and after treatment. The EDI-3 consists of 91 statements related to eating disorders that are rated on a 6-point Likert scale (Garner, 2004). According to Garner (2004), the EDI-3 assesses
a 12 factor subscales which assess the clients’ Drive for Thinness, Bulimia, Body Dissatisfaction, Eating Disorder Risk Composite, Low Self-Esteem, Personal Alienation, Interpersonal Insecurity, Interpersonal Alienation, Interoceptive Deficits, Emotional Dysregulation, Perfectionism, Asceticism, Maturity Fears, Ineffectiveness, Interpersonal Problems, Affective Problems, Overcontrol, and General Psychological Maladjustment. There are 6 scores that use data from the 12 subscales to determine the results from the EDI-3 (Dadgostar et al., 2017). There are also 3 scores which examine the validity of the clients’ answers (Dadgostar et al., 2017). Improvements in low answers would reflect positive outcomes from treatment when the clients are being discharged.

**Eating Disorder Diagnostic Criteria**

**Avoidant/Restrictive Food Intake Disorder**

Avoidant/restrictive food intake disorder (ARFID) is diagnosed when individuals avoids or restricts eating food, which leads to significant weight loss, a lack of required nutrients, a dependence on food supplements, and/or inhibited psychosocial functioning (American Psychiatric Association, 2013). The American Psychiatric Association state that ARFID will be diagnosed if there is suitable food available to the individuals and there are no cultural or religious practices which would explain the behaviour. They explained that the individuals’ lack of eating must not solely occur in the presence of another eating disorder and has no association with body image or weight loss. The individuals’ food avoidance must not be associated with any other mental disorder or medical condition that would more accurately explain the behaviour (American Psychiatric Association, 2013). They explained that, if the food avoidance is associated with another condition or disorder then it will be diagnosed if the avoidance is greater than what is expected with the condition or disorder and it also requires attention from a clinician. If the clients are in remission then these behaviours will be absent for a sufficient amount of time (American Psychiatric Association, 2013).

**Anorexia Nervosa**

Anorexia Nervosa (AN) is diagnosed when the individuals is restricting energy intake below what is required by the body to a degree that the individuals has a significantly low body weight given their age, sex, developmental trajectory and their physical health (American Psychiatric Association, 2013). The American Psychiatric Association (2013) explain that significantly low body weight in children and youth is defined as having a lower weight than what is minimally expected. They state that a diagnosis for AN requires that the individuals has an extreme fear of gaining weight or being fat. The individuals use restricting behaviours in order to hinder their ability to gain weight despite an already low weight (American Psychiatric Association, 2013). The American Psychiatric Association adds that the individuals experience discrepancies in the evaluation of their body or shape and their actual appearance. The individuals place excessive importance on their weight, or shape (American Psychiatric Association, 2013). Lastly, the individuals have difficulty understanding the implications of the individuals’ low body weight (American Psychiatric Association, 2013).

**Restricting type.** Restricting type AN is diagnosed when the individuals does not engage in repeated binging or purging behaviours in the last 3 months (American
According to the American Psychiatric Association (2013), fasting, dieting, and/or excessive exercise is used as the primary method of losing weight.

**Binge-eating/Purging type.** Binge-eating/purging type AN is diagnosed if the individuals has repeated occurrences of binge-eating or purging behaviours in the last 3 months (American Psychiatric Association, 2013). For further descriptions of binge-eating and/or purging, please review sections for binge eating disorder, and purging disorder.

**Remission.**

*Partial Remission.* The clients is considered to be in partial remission if their body weight has been restored for a sufficient amount of time; however, they are still experiencing an extreme fear of gaining weight or discrepancies between the evaluation of their body or shape and their actual appearance (American Psychiatric Association, 2013).

*Full Remission.* The clients is considered to be in full remission if all the criteria the individuals was experiencing have not been occurring for a sufficient amount of time (American Psychiatric Association, 2013).

**Severity.** The American Psychiatric Association recommends assessing the severity of the diagnoses of AN. For children and youth, the severity is assessed based on the BMI percentile given their gender, height and age (American Psychiatric Association, 2013). The American Psychiatric Association (2013) outlines the severity as follows:

- Mild: BMI > 17 kg/m²
- Moderate: BMI 16-16.99 kg/m²
- Severe: BMI 15-15.99 kg/m²
- Extreme: BMI < 15 kg/m² (p. 339).

**Bulimia Nervosa**

Bulimia nervosa is diagnosed with repeated occurrences of binge eating (American Psychiatric Association, 2013). Binge eating is defined as individuals consuming an undeniably larger amount of food than what most individuals would eat in a similar period of time, and circumstances (American Psychiatric Association, 2013). The American Psychiatric Association state that the individuals may be diagnosed if they feel that they are not in control of their eating during these occurrences. According to the American Psychiatric Association (2013), bulimia nervosa will be diagnosed if there is repeated use of compensatory behaviours to inhibit weight gain. Some examples of maladaptive compensatory behaviours provided by the American Psychiatric Association are “self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise” (p. 345). On average, the bingeing and inappropriate compensatory behaviours must occur once a week for 3 months at minimum (American Psychiatric Association, 2013). The American Psychiatric Association explains that individuals’ evaluations of themselves are significantly altered based on their interpretation of their body shape and weight. Lastly, bulimia nervosa will be diagnosed if the disturbance is
not solely occurring in the presence of anorexia nervosa (American Psychiatric Association, 2013).

**Remission.**

**Partial Remission.** The clients are considered to be in partial remission if some of the criteria that was previously occurring no longer occurring for a sufficient amount of time (American Psychiatric Association, 2013).

**Full Remission.** The clients are considered to be in full remission if all the criteria the individuals were experiencing have not been occurring for a sufficient amount of time (American Psychiatric Association, 2013).

**Severity.** The severity of bulimia nervosa is determined by the number of occurrences of the compensatory behaviours (American Psychiatric Association, 2013). The American Psychiatric Association further explains that the level of severity may be altered by the individuals’ experience of the symptoms and functional disability. The level of severity is outlined as follows:

- **Mild:** An average of 1-3 episodes of inappropriate compensatory behaviors per week.
- **Moderate:** An average of 4-7 episodes of inappropriate compensatory behaviors per week.
- **Severe:** An average of 8-13 episodes of inappropriate compensatory behaviors per week.
- **Extreme:** An average of 14 or more episodes of inappropriate compensatory behaviors per week (American Psychiatric Association, 2013, p. 345).

**Binge-Eating Disorder**

Binge-eating disorder will be diagnosed if the individuals experience repeated occurrences of binge eating (American Psychiatric Association, 2013). Binge-eating is defined as individuals consuming a larger amount of food than what most individuals would eat in a similar period of time and circumstances (American Psychiatric Association, 2013). According to the American Psychiatric Association (2013), when individuals are binge eating they will eat much quicker than the average individuals; eat until they feel uncomfortably fully; eat when they are not feeling physically hungry; eat alone for fear of judgement of their eating; a later feeling of disgust, depression or guilt associated with the binge. The individuals feel distress about their binge eating (American Psychiatric Association, 2013). The occurrences of binge eating must average once a week for three months at minimum. Lastly the American Psychiatric Association assert that binge-eating disorder will be diagnosed if there are no compensatory behaviours present and binge-eating is not solely occurring in the presence of anorexia nervosa and/or bulimia nervosa.

**Partial Remission.** The clients are considered to be in partial remission if the occurrences of binge-eating are decreased to an average of once a week for a sufficient amount of time (American Psychiatric Association, 2013).

**Full Remission.** The clients are considered to be in full remission if all the criteria the individuals was experiencing have not been occurring for a sufficient amount of time
Severity. The level of severity is determined by the number of occurrences of binge-eating (American Psychiatric Association, 2013). The American Psychiatric Association further explains that the level of severity may be altered by the individuals’ experience of the symptoms and functional disability. The level of severity is outlined as follows:

**Mild:** 1-3 occurrences of binge-eating per week.

**Moderate:** 4-7 occurrences of binge-eating per week.

**Severe:** 8-13 occurrences of binge-eating per week.

**Extreme:** 14 occurrences of binge-eating per week. (American Psychiatric Association, 2013, p. 350).

**Other Specified Feeding or Eating Disorder**

Other specified feeding or eating disorders are classifications for feeding or eating disorders that cause distress or impairment in social, occupational functioning and are diagnosed when individuals’ behaviours do not meet the criteria for other eating or feeding disorders (American Psychiatric Association, 2013). The American Psychiatric Association explains that if the clinician wishes to specify the reason that the individuals do not meet criteria for an eating disorder then the reasons may also be addressed in the other specified feeding or eating disorder classifications.

**Atypical Anorexia Nervosa.** Atypical anorexia nervosa will be diagnosed if the individuals met all the criteria for anorexia nervosa and the individuals’ weight is above average or average range despite a significant weight loss (American Psychiatric Association, 2013).

**Low Frequency or Duration Bulimia Nervosa.** Low frequency or duration bulimia nervosa is diagnosed when all the criteria of bulimia nervosa are met; however, the average frequency of compensatory behaviours is less than once per week, and/or less than 3 months (American Psychiatric Association, 2013).

**Low Frequency or Duration Binge-Eating Disorder.** Low frequency or duration binge-eating disorder diagnosed when all the criteria of binge-eating disorder are met; however, the average frequency of binge eating is less than once per week, and/or less than 3 months (American Psychiatric Association, 2013).

**Purging Disorder.** Purging disorder is diagnosed there is repeated use of purging behaviours to alter the individuals’ weight or shape without occurrences of binge eating (American Psychiatric Association, 2013). According to the American Psychiatric Association some examples of purging behaviour are self-induced vomiting: misuse of laxatives, diuretics, or other medications.
Eating Disorder Treatment

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) was developed for treatment of Borderline Personality disorder but it has since been applied successively with eating disorders (Linehan, 2014). DBT has been established to be an effective treatment of eating disorders with empirical support (Federici & Wisniewski, 2013). The focus of DBT is to regulate the clients’ intense emotions and teach skills so individuals who are living with eating disorders are able to cope with difficult circumstances that will arise during and after recovery (Anderson et al., 2015).

One of the core beliefs outlined in DBT is called dialectics which means that every truth has contradicting factors that can coexists in any situation (Linehan, 2014). According to Linehan (2014), dialectics are used in the treatment of intense emotions by considering the clients’ emotions and those of all involved when dealing with either intrapersonal or interpersonal conflict. She stated that in DBT, dialectics are applied to dichotomous thinking which means that clients perceive situations at the extreme ends of the spectrum of emotions. One of the roles of the counsellors is to help the clients analyze both sides of the spectrum in order to guide the clients to analyze their perspectives (Linehan, 2014). Additionally, Linehan asserts that DBT addresses the need for clients to accept themselves as they are, while being aware of the need to change. Linehan discussed that DBT targets maladaptive behaviours that are being used as a coping mechanism and teaches clients to use alternative skills serving the same purpose. Some of the skills that are taught through DBT are mindfulness, interpersonal effectiveness skills, emotional regulation skills, adaptive distress tolerance skills (Linehan, 2014).

The goal of mindfulness skills is to teach the clients to be aware of how things (emotions, actions, reactions, events, etc.) are in the moment and allowing them to be as they are in that moment without any judgments (Linehan, 2014). According to Linehan (2014), this skill is beneficial as it allows the clients to distinguish and communicate their emotions that result from events in their lives. Linehan states that mindfulness allows the clients to observe the consequences of their actions and the actions from others to learn from them.

Linehan (2014) lists three aspects of interpersonal effectiveness skills. She discusses that the first aspect is for clients to reach their goals while maintaining their interpersonal relationships and self-respect. She states that the second aspect is to help the clients build healthy relationships with others if they require assistance; the therapists should aim to help the clients build support systems through proper communication and sensitivity. The third aspect that she suggested is accepting healthy relationships as they are while also allowing for changes in the relationship.

Emotion regulation skills are difficult to teach because secondary emotions often alter the clients’ primary emotions to become more intense and inappropriate the circumstances; however, the clients’ primary emotions are usually appropriate to the circumstances which triggered the emotions (Linehan, 2014). Linehan (2014) stated that as a result, those who have difficulties regulating their emotions have been repeatedly
told that their emotions are not warranted of the circumstances. She asserted that when this occurs, the clients begin to also invalidate their own emotions affecting their entire self-concept as a result. According to Linehan, emotional regulation skills focus on validation and teaching clients’ self-validation of their emotions. This requires that clients are mindful, so they can identify their emotions and learn to validate themselves to begin making changes (Linehan, 2014).

Lastly, distress tolerance skills focus on helping clients build acceptance for distress, understand why they are feeling distress and tolerate distress (Linehan, 2014). Linehan (2014) stated pain is an unavoidable part of life which is why it is important to teach skills to help clients learn how to cope with distress adaptively. Linehan believes that it is unrealistic for the main goal of therapy to be the removal emotional distress as it will eventually cause an increase in suffering. Becoming tolerant of distress will allow clients to exist in their emotional state and environment instead of continuously striving for an unattainable ideal (Linehan, 2014).

**Cognitive Remediation Therapy**

Cognitive remediation therapy (CRT) is a treatment that was first used to treat patients with schizophrenia but has been adapted for treating eating disorders by focusing on the psychological and cognitive processing in adults (Davies, & Tchanturia, 2005). Abbate-Daga, Buzzichill, Marzola, Amianto, and Fassino (2012) suggest that individuals with eating disorders have diminished neuropsychological functioning due to difficulties in set shifting and central coherence. Abbate-Daga et al. state that the goal of CRT is to improve client’s mental flexibility and functioning which often causes rigidity in the clients’ thoughts and in their verbal and non-verbal functioning. Increase in neurological functioning allows for more adaptation to the clients’ rigidity and allows for the alternative thinking which may be crucial to further treatment (Abbate-Dage et al., 2012).

CRT is developed to be engaging for clients with eating disorder through activities that are enjoyable and interesting for clients (Neil et al., 2016). Neil et al. (2016) suggested that eating disorder clients tend to be resistant to treatment and have a high attrition rate. Neil et al. (2016) asserted that having engaging activities to make improvements in the clients’ cognitive functioning is essential to treatment made to prepare clients for more intensive treatment. They discuss that the therapy does not focus on the eating disorder itself, as in weight restoration, reducing compensatory behaviours, or addressing eating behaviours, instead it focuses on redeveloping the neurological processes. They state that, this is done by encouraging the clients to focus on meta cognition, which means that the clients think about thinking. When the clients are exploring their metacognition, Neil et al. suggests that they focus on alternative ways of thinking which exercises their ability to think flexibly and to think of the whole picture which exercising.

**Cognitive Behavioural Therapy**

Cognitive Behaviour Therapy (CBT) is an evidence-based approach which is used in the treatment of eating disorders (Wright, Basco & Thase, 2005). According to Wright et al. (2005), CBT works primarily with clients who are experiencing BN and BED;
however, it has not been equally established in the treatment of AN. They state that CBT focuses on the clients’ maladaptive thoughts about being thin, their body shape and weight. It examines the clients’ motivation for their eating behavior and maladaptive compensatory behaviours (Wright et al., 2005). Wright et al. believes that the maladaptive behaviours are largely affected by cultural influences emphasizing shape and weight.

CBT often uses psychoeducation, self-monitoring, cognitive restructuring and response prevention in the treatment of eating disorders (Wright et al., 2005). Wright et al. states that self-monitoring requires that the clients monitors their food intake, time that they eat, any compensatory behaviour, and triggers in the environment. They suggest that clients will learn strategies in order to avoid triggering situations. Wright et al. asserts that clients will learn how to prolong the time before they use compensatory behaviours so that they may become comfortable without their use. Cognitive restructuring is used to change maladaptive thoughts associated with each individuals’ eating disorder so that they may challenge the thoughts that are maintaining their behaviours (Wright et al., 2005). Wright et al. recommends that the therapists and clients work collaboratively to find an optimal weight to reach during treatment. They also suggest that the clients and therapists work together to establish a meal plan. They state that there should be a consistent method of measuring the clients’ weekly weight.

It is important to note that the effects of CBT are diminished in clients who have reached starvation as a result of their eating disorder, especially in those with AN (Wright et al., 2005). According to Wright et al., starvation can cause the clients to have reduced cognitive abilities which interfere with the cognitive base of CBT. To address this issue, Cognitive Remediation Therapy is used to reestablish cognitive functioning so that those with eating disorder can benefit from the use of CBT (Wright et al., 2005).

**Interpersonal Therapy**

Interpersonal therapy (IPT) was developed for use in the treatment of depression but has been applied for use with clients with eating disorders (Murphy, Straebler, Basden, Cooper & Fairburn, 2012). According to Murphy et al. (2012), IPT analyzes the interpersonal relationships in the clients’ lives as it is found that interpersonal difficulties can maintain clients’ eating disorders. They add that IPT analyzes interpersonal relationships to find the cause of the symptoms that the clients are experiencing. IPT is broken down into in three phases of treatment and has clear distinction between the phases (Murphy et al., 2012).

The first phase of IPT is to introduce the treatment and explain its how it can be effective in treating eating disorders (Murphy et al., 2012). Murphy et al. (2012), suggests that the therapists explain to the clients that the style of therapy is going to change during each phase of the treatment. According to Murphy et al., the therapists will identify the current interpersonal problems that are distressing the clients by asking about their interpersonal history in relation to the onset and development of their eating disorders. They state that the therapists and clients will choose the focus of the therapy based on the current interpersonal problems, life circumstances and the clients’ interpersonal functioning. In the first phase, the therapists will be asking if the clients’ symptoms have
changed since the last session and if there were changes in their interpersonal lives which led to change in symptoms (Murphy et al., 2012). According to Murphy et al., The problem areas that are usually identified in the first phase of IPT are lack of intimacy and interpersonal deficits, interpersonal role disputes, role transitions, grief, and life goals.

Murphy et al (2012) state that the second phase of IPT is patient-led. Murphy et al., suggests that the therapists help guide the clients to meet their goals while focusing on the use of nondirective strategies. In the beginning of phase two, information will be gathered to further describe the clients’ key interpersonal issue (Murphy et al., 2012). According to Murphy et al., the clients should naturally move on to ways of changing their interpersonal behaviour after several sessions. When this occurs, they suggest that the therapists will help the clients think of options for changing and develop a plan of action. They add that the need to change should be expressed at regular intervals to urge the clients towards making interpersonal changes; however, it should be expressed in a general way rather than pressing for a specific change in behaviour.

The third phase of IPT is the ending phase of treatment (Murphy et al., 2012). Murphy et al. (2012), suggests that the sessions are changed to two-week intervals to begin fading out treatment, and increasing the clients’ autonomy. They state that phase three of IPT focuses on reaching two goals. They explain that the first goal is for the therapists to ensure that the clients will maintain their progress in their interpersonal lives after completion of therapy and the second goal is to reduce the chances of relapse after treatment. According to Murphy et al., the clients’ eating will be assessed; however, it is important to note that changes to the clients’ eating behaviour tend to reach the full effect 4 to 8 months after treatment if the progress is maintained. They suggest that the therapists should emphasize the importance for the clients to monitor for maladaptive eating behaviours in order to indicate the need to review and manage their interpersonal lives. Lastly, the therapist should ask the clients how they feel about the termination of therapy (Murphy et al., 2012).

According to Murphy et al. (2012), IPT focuses on the clients leading therapy in order to set goals, develop a plan to change, and execute the plan. They state that during phases two and three, the therapist is instructed to avoid taking a directive approach so that the clients can be autonomous in creating changes. Recovery from an eating disorder is slower when using IPT as a large part of the improvement is gained after treatment as the clients learn to make changes to their interpersonal functioning independently (Murphy et al., 2012).

Motivational Interviewing

Motivational interviewing (MI) is a treatment that was developed for clients with substance use disorders, but it is often applied to populations who are ambivalent to change (Knowles, Anokhina & Serpell, 2013). According to Knowles, Anokhina and Serpell (2013), clients with eating disorders are often resistant to changing their behaviours and recovery because of this the use MI as a treatment was tested. Knowles et al. asserts that MI is often used in collaboration with other therapies as enhancement sessions, or techniques to increase clients’ motivation to change and recover from their
eating disorders. Knowles et al. state that when treating clients with eating disorders using MI, the counselor considers the clients’ readiness, willingness and ability to change their behaviors in favor of recovery. According to Knowles et al., MI is a client centered non-confrontational treatment which uses active listening, open ended questions, and summarization to guide the clients rather than instructing the clients to make behavioural changes. The MI therapist will be expected to ‘roll with resistance’, this means that they will be understanding of the reasons why the clients is not ready to make changes and use techniques to tactfully neutralize the resistance (Knowles et al., 2013).

MI operates on the assumption of harm reduction, meaning that it is not expected that the clients will not immediately change their behaviour, instead they will make smaller changes to reach their ultimate goal (Wilson & Schlam, 2004). When using MI, Wilson and Schlam (2004) state that the role of the therapist is to guide the clients into willingness to change; this can be done through reinforcing ‘change talk’ or acknowledging discrepancies in the clients’ beliefs about their eating disorder. Change talk is when clients begin to actively question their motivation for maintaining their eating disorder, it usually signifies that the clients is in or entering the pre-contemplation stage of the ‘stages of change’ theory (Wilson & Schlam, 2004). Wilson and Schlam discuss that the stages of change is a theory that clients who are trying to make behavioural changes will progress through stages of pre-contemplation, contemplation, planning, action, and maintenance while working towards recovery from their eating disorder. Wilson and Schlam explain that when clients are in the stage of pre-contemplation, their motivation for change is very low as they do not feel any need to change their behaviours. The pre-contemplation stage is when a majority of the techniques in MI are generally used in order to help the clients move from this stage to contemplation so that they may begin making changes to lead them into recovery (Wilson & Schlam, 2004). They state that the contemplation stage is when the clients can see that they need to change their behavior but they are not actively trying to make the changes. According to Wilson and Schlam, when the clients are in the contemplation stage, the counsellor will continue to reinforce change talk, and eventually guide the clients into preparing a plan for changing their behavior. The planning stage is when the clients have accepted the need for change and begins to create a plan to change their behaviours (Wilson & Schlam, 2004). They explain that the therapist will often assist the clients through the planning stage by collaborating with the clients to create a realistic plan to change their behaviour. The action stage is when the clients are actively implementing the plan in order to change their behaviour (Wilson & Schlam, 2004). Lastly, they assert that maintenance is when the clients are successful in making behavioural changes and continuing with the change. Wilson and Schlam note that the stages of change are rarely linear, and the clients may regress to previous stages.

MI is not a skill-based approach; MI uses therapeutic techniques and the clients’ preexisting skills to elicit the clients’ motivation for change (Knowles et al., 2013). Knowles et al. (2013) state that for this reason, using MI collaboratively with a skills-based treatment can be effective in leading the clients into recovery.
Treatment Plan

The clients will begin attending weekly counselling sessions with the behaviour therapist upon completion of the intake process. There are two phases that are involved in the treatment of eating disorders; the first phase of treatment is individual counselling sessions and the second phase of treatment is family therapy. The individual session treatment plan will be assessed during intake, or the first counselling session with the clients. The treatment plan will be assessed by the clients’ diagnosis and their current circumstances. The behavioural therapist and client will collaborate to determine which goals would be beneficial to their treatment depending on the therapy selected, and each client’s particular needs. This section of the guidelines will review the decision-making process when prescribing a treatment to a client.

Phase One: Individual Counselling

Anorexia Nervosa Treatment Plan

![Diagram of Anorexia Nervosa Treatment Plan]

Figure 1. Treatment plan options for clients who have been diagnosed with anorexia nervosa.

Anorexia Nervosa

When clients are diagnosed with anorexia nervosa (AN), treatment typically follows two options (Figure 1). The first option demonstrated in Figure 1 for the clients to begin cognitive remediation therapy (CRT) then continue into dialectical behaviour therapy (DBT) upon completion. The second treatment plan is for the clients to begin with DBT. The decision-making process should be determined by the clients’
neuropsychological performance. The clients may present with rigid thinking patterns which can affect the efficacy of DBT. Rigidly may be observed by the clients’ inflexibility in their expression of their thoughts and ability to change their routine (Danner et al., 2012). Danner et al. (2012) state clients with rigid thinking patterns may be preoccupied with thoughts about food, exercise and their body weight. According to Danner et al., those with rigid thinking also present with inflexible cognitions and difficulties with central coherence and metacognition. Another factor is that the clients may be resistant to treatment which increases the risk of drop out from treatments. If these traits are observed in the clients then it is recommended that the clients begin their individual sessions with a focus on CRT. Clients’ who have completed CRT or who do not present rigid thinking patterns will begin sessions of DBT.

Clients with AN often present with difficulties regulating their emotions as a maintaining factor for their eating disorders (Racine & Wildes, 2014). Racine and Wildes (2014) assert that emotional regulation difficulties in clients often leads to the creation of a relationship between intense emotions and the resulting behaviours of AN. According to Racine and Wildes, issues with regulating emotions presents as clients’ difficulty recognizing and understanding their emotions and the emotions of others. They state that this results in the clients’ inability or decreased ability to observe and control their emotion effectively. They also believe that the clients may suppress and invalidate their emotions because of a maladaptive core belief regarding importance of experiencing the range of their emotions. The effect of the suppression and invalidation of their emotions leads to the strong emotional responses elicited by the clients’ eating disorder and their daily lives (Racine & Wildes, 2014). DBT is the primary treatment for AN as it focuses on teaching clients’ skills to validate and regulate their emotions and has been empirically supported to create behaviour change, and facilitate recovery.
Bulimia Nervosa Treatment Plan

Figure 2. Treatment plan options for clients who have been diagnosed with bulimia nervosa.

Bulimia Nervosa

When clients are diagnosed with bulimia nervosa (BN), treatment typically follows two options (Figure 2). The first option demonstrated in Figure 2 for the clients to begin cognitive behaviour therapy and the second treatment plan option is for the clients to begin with DBT. The treatment options will be determined by the clients’ current cognitive and emotional circumstances.

Clients with BN may present with maladaptive thinking patterns which are maintaining their eating disorder (Glasofer & Devlin, 2013). According to Glasofer and Devlin (2013), these thinking patterns maintain the eating disorder by creating the behavioural disturbances associated with BN to cope with their maladaptive thinking patterns. They assert that the clients will often use control (e.g. control over eating and weight) as a means to determine their self-worth. They state that binge/purge cycle results in lowered self-esteem and reinforcement of the cognitive disturbances by the clients. Clients’ whose primary issue is their maladaptive thinking patterns will benefit from treatment using CBT.

BN often presents with difficulties regulating their emotions which may also be a maintaining factor for their eating disorder (Hayaki, 2009). According to Hayaki (2009), clients with BN have been found to experience Alexithymia which is a difficulty with discerning between feelings and physical sensations. He states that this is associated with an inability to identify and describe their emotions. BN is also associated with avoidance of feeling unpleasant emotions leading to negative reinforcement of the binge/purge cycle (Hayaki, 2009). If the clients’ primary difficulty is emotional regulation, then it is recommended that clients begin treatment using DBT.
Avoidant/Restrictive Food Intake Disorder Treatment Plan

Avoidant/Restrictive Food Intake Disorder

Cognitive Behaviour Therapy

Exposure

Figure 3. Treatment plan for clients who have been diagnosed with avoidant/restrictive food intake disorder.

Avoidant/Restrictive Food Intake Disorder

When clients are diagnosed with avoidant/restrictive food intake disorder (ARFID), treatment typically follows one treatment plan (Figure 3). The treatment plan demonstrated in Figure 3 is for the clients to begin cognitive behaviour therapy which continues into exposure therapy.

Avoidant/restrictive food intake disorder is often associated with common cognitions experienced by individuals with anxiety disorders (King, Urbach & Stewart, 2015). King, Urbach and Stewart (2015) believe that ARFID is likely to be created through classical conditioning, such as eating being paired with a negative sensation, or operant conditions, such as negative reinforcement through escape of anxiety results in refusal to eat. CBT is used to treat clients with ARFID due to its similarities with anxiety disorders. Exposure is also used in the treatment of ARFID to counter condition the negative experience associated with eating. Exposure is also used to normalize the process of eating and increase the variety of foods that the clients will eat.
Other Feeding/Eating Issues Treatment Plan

![Diagram showing the treatment plan for clients with other feeding/eating issues.]

**Figure 4.** Treatment plan for clients who have been diagnosed with other feeding/eating issues.

**Other Feeding/Eating Issues**

When clients are diagnosed with other feeding/eating issues, treatment typically follows three options (**Figure 4**). The first option demonstrated in **Figure 4** for the clients to begin CBT, the second treatment plan option is for the clients to begin with DBT, and the third option is to begin interpersonal therapy (IPT). The treatment options will be determined by the clients’ current cognitive, emotional, or social circumstances.

Individuals with difficulties regulating their emotions may present with increased impulsivity, detachment, hostility and negative affectivity (Pollock, McCabe, Southard, & Zeigler-Hill, 2016). Pollock et al. (2016) found that emotional dysregulation often leads to an increased reactivity to interpersonal experiences in the clients’ daily lives resulting in difficulties with interpersonal relationships. Emotional dysregulation has also been linked to an increase in self-harming behaviours due to heightened emotional sensitivity, emotional intensity and longer lasting emotions (Neece, Berk, & Combs-Ronto, 2013). If these traits are observed in the clients, then it is recommended that they receive DBT as their primary treatment approach.

Individuals with maladaptive cognitions may present with mood disturbances, poor self-esteem, feelings of ineffectiveness and self-worth dependent on weight or restriction (Gowers, 2006). Clients may also present with comorbid anxiety, depression which increases the severity of eating disorders (Turner, Marshall, Wood, Stopa, & Waller, 2016). If these traits are observed to be the primary difficulties the clients are experiencing, then it is suggested that CBT is the primary treatment approach. In the case of binge eating disorder (BED), it has been noted that in some cases CBT has only been effective in reaching partial remission as it decreased binging episodes, but not decreasing maladaptive cognitions, which may lead to relapse into full BED (Linardon,
Clients may present with interpersonal issues which maintain the eating disorders (Tanosky-Kraff, Shomaker, Young, & Wilfley, 2016). Clients may isolate themselves from their peers which allows for the cognitions and behaviours associated with the eating disorder continue unchallenged. Negative interpersonal factors may trigger bingeing and restricting episodes due to negative feelings, and the effort to cope with these feelings (Tanosky-Kraff et al., 2016; Murphy, Straebler, Basden, Cooper, & Fairburn, 2012). According to Murphy et al. (2012), interpersonal factors may also lead to increased issues with self-esteem leading to an increase in the eating disorder symptoms. If interpersonal issues are the primary issues that are affecting the clients then it is suggested to begin using IPT in order to evaluated interpersonal experiences and build the clients’ interpersonal support.

**Motivational Interviewing**

Motivational Interviewing (MI) may be used in conjunction with any of the therapies listed (Knowles, Anokhina, & Serpell, 2013). Knowles et al. (2013), it is generally used when clients are ambivalent to change or not engaging in therapy.

Individuals may present as unwilling to make efforts towards change or understanding the need to change (Carter & Kelly, 2015). According to Carter and Kelly (2015), clients may also present with a lack of engagement in treatment sessions. This is known in MI as the contemplation stage of change. They state that another presentation which MI may be useful is when clients were engaged and making changes in the past but have relapse back into the contemplation stage. These circumstances are when MI booster sessions may appropriate to use if other treatments alone are insufficient to elicit motivation for clients. MI strategies may also be integrated into the treatment methods in other to elicit motivation to change throughout therapy.
Phase 2: Family Counselling

Family Dialectical Behaviour Therapy Treatment Plan

Family Dialectical Behaviour Therapy

If clients have completed the individual phase of therapy without recovery from their eating disorder, then the individual therapy may be combined with family therapy in which the behavioural therapist and social worker will collaborate to deliver DBT to the clients and their families (Figure 5). Both professionals will remain connected with their clients and will assist in communication between all members involved in therapy. It may occur that the clients have already taken part in DBT, if this is the case then the parents will be learning the skills for their own benefit, and to help the clients practice and become consistent in using the skill. If both parties have not taken part in DBT then it is an opportunity to learn the skills, while assisting each other in practice.

The role of the behaviour therapist in Phase 2 is to assist with the delivery of DBT to the family. If the clients have already taken part in DBT then the behavioural therapist may share the clients’ experiences with the skills being taught in DBT; however, this will be restricted to the bounds of confidentiality and the behaviour therapist should only share experiences that the clients are comfortable sharing. The role of the behavioural therapist will be altered by the family dynamics. For example, the behavioural therapist may advocate for the clients with their family if needed. Conversely, the behaviour therapist may be required to moderate any disagreements involving the clients and their family.
References


