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An evaluation of “Positive Bodies: Loving the Skin You’re In” -
A Cognitive Behavioural Therapeutic based group program aimed at improving body image.

Carolina L. Casetta and Dr Vivienne Lewis
University of Canberra, Australia
Abstract

This study aimed to evaluate a brief Cognitive Behavioural Therapy (CBT) group intervention program aimed at improving body image in women called “Positive Bodies: Loving the Skin You’re In”. A sample of 20 women aged 17 to 54 years, who volunteered to participate in this program, completed a questionnaire at the commencement and cessation of the intervention. The questionnaires, which aimed to monitor self-esteem and body image, consisted of the Rosenberg Self-Esteem Scale, the Body Areas Satisfaction Scale, the body shame and self-surveillance subscales from the Objectified Body Consciousness Scale and the Body Image Quality of Life Inventory. Paired samples t-tests, along with its non-parametric equivalent, were conducted in order to determine whether levels of self-esteem and body image variables improved from treatment commencement to cessation, as hypothesised. Results indicated that participants experienced a significant increase in self-esteem, body satisfaction and satisfaction with many specific body parts, along with a significant decrease in self-surveillance and body shame. In addition, a participant’s body image had a more positive effect on quality of life at treatment cessation in comparison to that at treatment commencement. Qualitative analyses also indicated that the program was well received by participants. Although analyses indicate that “Positive Bodies” might be associated with improved body image and self-esteem, limitations of the study must be considered when interpreting these results.
An evaluation of “Positive Bodies: Loving the Skin You’re In”-

A Cognitive Behavioural Therapeutic based group program aimed at improving body image.

Body image encompasses how an individual perceives and feels about their body, in addition to the degree to which they desire a body different to their own. People with negative body image experience strong negative affect and thoughts related to their bodies and may perceive their bodies in a distorted manner (Caddy & Richardson, 2012; Cash & Hrabosky, 2003; Peltzer & Pengpid, 2012). Furthermore, many use maladaptive behaviours to either minimize a discrepancy between their body and an ideal body or to minimize the distress experienced as a result of evaluating their bodies. Such experiences categorize negative body image (Dworkin & Kerr, 1987; Wade, George & Atkinson, 2009).

Negative body image is observed frequently in women, and is observed to such a great extent that it is often considered a “normal” female trait. For example, Tiggeman and Pennington (1991; cited in Moulding, 2007) found that over half of a sample of Australian women was dissatisfied with their bodies. Although body image disturbance is most prevalent in adolescence and early adulthood (Matusek, Wendt & Wiseman, 2004), body image disturbance is also widespread amongst women of different ages (Teixeira et al., 2006).

Western society and the media regularly endorse an unrealistic body ideal for women, which encourages women to have low body fat, particularly in the mid-section (Foster, Wadden & Vogt, 1997; Mautner, Owen & Furnham, 1999). It is not surprising, therefore, that many women feel the need to adhere to such an ideal and experience distress when their bodies differ from the ideal (Fursland et al., 2012; Hausenblas & Fallon, 2006; Moulding, 2007). Although body dissatisfaction can be partly attributed to the internalisation of these socio-cultural ideals that society and media endorse (Chen, Fox, Haase & Ku, 2010), the
development of negative body image is complex. Parental weight concern, being teased as a child or as an adult for one’s appearance (Grilo & Masheb, 2005; Richardson & Paxton, 2010), engaging in frequent conversations about appearance and comparing one’s body with another (Mautner et al., 1999; Richardson & Paxton) and certain personality characteristics (Fursland et al.) are just some of the risk factors of negative body image that have been identified (Grilo & Masheb; Zabinski, Wilfley, Calfas, Winzelberg & Taylor., 2004). These risk factors are sometimes addressed in preventative or intervention measures for body image (Richardson & Paxton).

In addition to the risk factors mentioned, self-esteem is of particular importance as it has been identified as a contributor to as well as a result of negative body image (Foster, Wadden & Vogt, 1997; Hawks, Madanat, Smith & de la Cruz, 2008; Mendelson, McLaren, Gauvin & Steiger, 2002). Aiming to improve and monitor self-esteem is particularly important for negative body image sufferers, as it has a large impact on the mental and physical health of an individual, has been found to be a greater predictor of eating disorders than dieting (Schmidt, 2001 cited in Karpowicz, Skarsater & Nevonen; 2009), and accounts for a large percentage of variance in body image dissatisfaction (Grilo & Masheb, 2005). Body image has even been shown to be improved through activities aimed at improving self-esteem (O’Dea & Abraham, 1999; Norwood, Murray, Nolan & Bowker, 2011) and conversely, self-esteem has been shown to be improved through activities and programs aimed at improving body image (Karpowicz et al.; Richardson & Paxton, 2010; Rosen, Reiter & Orosan, 1995). However, as the relationship between body dissatisfaction and self-esteem is bi-directional, negative body image also has a devastating effect on self-esteem (Dworkin & Kerr, 1987). Therefore, building self-esteem is often focused upon in body image improvement programs (Guinn, Semper, Jorgensen & Skaggs, 1997; Norwood et al.).
In addition to low self-esteem, negative body image has also been found to contribute towards a number of other serious psychological and physical consequences (Grogan, Hartley, Connor, Fry & Gough, 2010). There is evidence to suggest that negative body image has been linked to development of depression, social anxiety (Stice, Hayward, Cameron, Killen, Taylor, 1999) smoking, low self-esteem and there has been speculation that negative body image even delays women’s psychosocial development (Grogan et al.; Harris, 1995; Mendelson et al., 2002). Furthermore, longitudinal studies have indicated that having a negative body image predisposes individuals to employing negative eating patterns such as calorie restriction, binge eating, purging or even subsequent eating disorders (Da Cunha Feio Costa, de Assis Guedes de Vasconcelos & Peres, 2010). These consequences indicate the serious impact that negative body image can have on the quality of life of an individual.

The potential negative outcomes of body image disturbance highlight the importance of appropriate prevention and treatment for negative body image (Cash & Hrabosky, 2003). While only a small percentage of women develop eating disorders, a large percentage of women experience negative body image and are therefore at risk for negative mental and physical health outcomes (Tiggeman and Pennington, 1991 cited in Moulding, 2007). It is therefore important that body image interventions are not only designed for individuals suffering from eating disorders, but also for women with general body image problems (Gollings & Paxton, 2006; Moulding).

The group program evaluated in the current study, “Positive Bodies: Loving the Skin You’re In” is a program based on Cognitive Behavioural Therapy (CBT) developed for women over the age of 16 with negative body image (see Lewis, 2012 for latest version of program in the form of a self help manual). CBT-based interventions are a popular choice for body image problems and have been proven to be effective in individual, group and
computer-based or online formats (Cash & Hrabosky, 2003; Gollings & Paxton, 2006; Winzelberg, Taylor, Sharpe, Eldredge & Constantinou, 1997; Zabinski et al., 2004).

The main aim of CBT is to teach individuals the relationships between their thoughts, behaviours and emotions and to modify maladaptive thoughts, behaviours and emotions which precipitate and maintain psychological issues (Rosen et al., 1995; Smith, Wolfe & Laframboise, 2001). Examples of CBT interventions have been successfully applied to individuals with body dysmorphic disorder (Rosen et al.), binge eating symptoms (Binford et al., 2005; Shelley-Ummenhofer & MacMillan, 2007), individuals with weight management issues (Rapoport, Clark & Wardle, 2000; Shelley-Ummenhofer & MacMillan) and individuals identified at risk of developing an eating disorder (Zabinski et al., 2004).

Specifically, a CBT online course by Cash and Hrabosky (2003), which covers similar topics to “Positive Bodies”, reported improved self-esteem, decreased social anxiety and improved eating attitudes. The authors recommended that greater facilitator-client contact, as provided in “Positive Bodies”, could have encouraged clients to be more compliant with their program. Another individual CBT course aimed at improving body image over six weeks resulted in improved self-esteem, weakened maladaptive body image thoughts, improved affective body image, and clients judging their body size to be smaller and closer to the norm (Butters & Cash, 1987). Similarly, a CBT course of a psycho-educational nature run both online and in a group format, resulted in improved body image and unexpectedly resulted in improvements in anxiety and depression (Gollings & Paxton, 2006).

Within a CBT framework, “Positive Bodies” aims to improve body image by covering a range of topics related to body image and wellbeing. For example, similar to other effective body image improvement programs and as recommended through literature, “Positive Bodies” aims to help clients reduce their thin-ideal internalization (Matusek et al.,
2004; Robinson & Bacon, 1996; Stice, Marti, Spoor, Presnell, Shaw, 2008), gain acceptance of their bodies (Wade et al., 2009), identify contributors to their negative body image (Cash & Hrabosky, 2003; Richardson & Paxton), reduce their perceived pressure to be thin (Bucholz et al., 2008; Hawks et al., 2008), use relaxation techniques when experiencing anxiety of any kind (Caddy & Richardson, 2012) and improve their general health by improving their nutrition and increasing physical activity (Graff Low et al., 2006; Hausenblas & Fallon, 2006; Lock & Grange, 2005; Robinson & Bacon; Stice et al.). Furthermore, “Positive Bodies” aims to help clients build their self-esteem (Wolchik, Weiss & Katzman, 1986), become assertive in relation to appearance teasing and taking compliments (McVey, Davis, Tweed & Shaw, 2003; Robinson & Bacon) and develop adequate social support networks either through support from their peers in group interventions or from family and friends (Celio et al., 2000; Binford et al., 2005). Some of the programs which utilize these methods are based upon the CBT framework while others are based on different theoretical perspectives. A more detailed description of “Positive Bodies” and the activities it contains can be found within the method section.

Although CBT strategies have been demonstrated to be effective with body image issues, and many of the specific strategies in “Positive Bodies” have been used in other efficacious programs, it is still imperative to evaluate the program. If “Positive Bodies” has the desired effect, participants should experience improvements in body image and self-esteem. As body image is multidimensional, a number of measures were assessed, including body surveillance; which measures how often a participant thinks about their body, body shame; which measures feelings of shame toward personal appearance, quality of life (QOL); which measures the impact that participants’ body image have on their quality of life, and body satisfaction.
In addition, the current study will monitor self-esteem throughout the duration of the intervention. As in other body image programs, self-esteem activities have been incorporated into the “Positive Bodies” program due to the close relationship between body image and self-esteem discussed (Mendelson et al., 2002; Wolchick, Weiss & Katzman, 1986; Zabinski et al., 2004). In addition, prior studies demonstrated that CBT strategies have a positive effect on self-esteem in women with body image issues (Shelley-Ummenhofer & MacMillan, 2007), and evaluations of other body image-related programs have yielded concurrent improvements in body image and self-esteem (Cash & Hrabosky, 2003; Hawks et al., 2008; Karpowicz et al., 2009; McVey et al., 2003). Therefore, an improvement in self-esteem from baseline to post-treatment could therefore indicate “Positive Bodies” clients have responded well to self-esteem activities within the program or to other activities aimed at improving body image and general wellbeing.

The aim of this study was to investigate whether participants reported improvements in self-esteem and body image in general from pre-treatment to post-treatment. It was hypothesized that an increase in self-esteem, body satisfaction and QOL would be observed, while a decrease in body surveillance and body shame was expected. It was also hypothesised, that due to “Positive Bodies” aiming to improve overall body image, participants’ satisfaction with different body parts would increase. A short qualitative analysis was conducted to explore participants’ perceptions of the program.
Method

Participants

The sample consisted of 20 women between the ages of 17 and 54 years ($M=31.0, \text{S.D} =10.72$) who volunteered to participate in the “Positive Bodies: Loving the Skin You’re In” program between 2008 and 2011. These women were a community self-referred sample.

Measures

The questionnaires in the current study consisted of a variety of scales to measure body image related constructs and self-esteem (Appendix A and B). In order to match pre- and post-questionnaires while maintaining participants’ survey responses confidential, participants were asked to create a unique re-identifying code. This code consisted of the first three letters of their first pet’s name and the last 3 numbers of their phone number.

Demographics

Participants were asked for general information, including their gender, age and reason for participating in the “Positive Bodies” group.

The Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965) was used, which measures global self-esteem in people of a variety of ages and cultures (Schmitt & Allik, 2005). This scale consists of 10 items, with four response categories (“Strongly Disagree” (1) to “Strongly Agree” (4)). A higher score is indicative of higher levels of self-esteem and an example of an item includes “On the whole I am satisfied with myself”. The internal consistency of the self-esteem scale in the current study was high (.92 and .87) and similar to that found in earlier studies (.92; Rosenberg, 1979). Rosenberg (1979) has also reported the RSES as having excellent test-retest reliability over a period of 2 weeks (.85 and .88) and Sinclair et al., (2010) reported appropriate convergent validity and discriminate validity. Many studies have indicated that this scale is bi-dimensional, although a meta-analysis (Huang & Dong, 2012) has indicated that these factors are most likely a result of negative and positive wording and do not measure different constructs. Therefore, in accordance
with the recommendations made by Huang and Dong, self-esteem will be treated as having one factor in the current study.

The Body Areas Satisfaction Scale (BASS) was taken from the Multidimensional Body-Self Relations Questionnaire (Cash, 2000) and was used to measure body satisfaction. This scale requires the respondent to indicate how satisfied or dissatisfied they are with nine aspects of their appearance; for example, “face”, or “mid torso”, on a five point scale (“Very dissatisfied” (1) to “Very satisfied” (5)). A higher score is indicative of greater satisfaction with more areas of the body. Cash (1994) reported the BAS has adequate test-retest reliability (.86) and internal consistency of .77. In the current study, internal consistency was high (.93 and .85).

The Objectified Body Consciousness Scale (McKinley & Hyde, 1996) consists of three subscales, two of which were selected for the current study; self-surveillance (8 items) and body shame (7 items). The self-surveillance scale measures how often a participant thinks about their body appearance, while body shame measures feelings of shame toward personal appearance. An example of an item in the self-surveillance and body shame scales are “I rarely think about how I look” and “I feel like I must be a bad person when I don’t look as good as I could” respectively. McKinley & Hyde reported adequate internal consistencies for the Surveillance Scale, .79 and .76 and for the Body Shame Scale, .84 and .70 for undergraduates and middle-aged women respectively. In the current study, the internal consistency of body surveillance was adequate (.81 and .88) while internal consistency for body shame was not. After deleting one item, the internal consistency rose (.88 and .83). These scales have been found to have convergent validity by having strong relationships with body-esteem and other measures of body image, and accounting for significant variance in dieting and restricting eating (McKinley & Hyde, 2006). Furthermore, body shame has also been validated as a measure of internalisation.

The Body Image Quality of Life Inventory (Cash, 2002) was used in order to measure the impact that a participant’s body image has on their quality of life. This scale consists of nineteen
items, with seven response categories (‘Very Negative Effect’ (-3) to ‘Very Positive Effect’ (+3)). The respondent is required to indicate what effect their body image has in different situations, such as, ‘My experiences when I meet new people’. A higher score on this scale indicates a participant’s body image has more of a positive impact. Cash and Fleming (2002) demonstrated that the scale had adequate test-retest reliability for a two to three week period (.79). In addition, Cash and Fleming also found adequate convergent validity, finding that scores were associated with higher body satisfaction, less body shame, lower body surveillance and less strongly internalized cultural beauty standards. The internal consistency for this sample was high (.914 and .948).

**Open Ended Questions** were asked in the last section, in order to investigate whether participants believed they benefited from “Positive Bodies”, whether the program met their expectations and what they believed was the most useful aspect of the program. These responses were grouped and coded accordingly for analyses.

**Procedure:** The current study is based on secondary data obtained from an unpublished dissertation conducted by Patrick (2011). The use of this secondary data was also approved by the University of Canberra’s Human Research Ethics Committee (HREC) in early 2012. This procedure section outlines the research method used in their studies.

The body image program was advertised at the University of Canberra and local community websites for women who had concerns about their appearance (Advert found at Appendix C). Individuals interested in participating contacted the group facilitators via phone or email to register. Throughout this contact, group facilitators ensured participants were aware that a research project was being conducted to evaluate the program and that participation in this project was completely voluntary. The researchers attended the first session of the program to explain the study, what participation would involve and that a participant’s decision to refuse participation or withdraw from the study would not impact upon their group therapy or their relationship with their group
facilitator. Once informed consent was obtained, questionnaires were administered to the participants. Participants were allowed time to complete the questionnaires, and all questionnaires; either complete or incomplete, were provided to the researcher in a sealed envelope. During the last session (Session 6), the researcher administered the post treatment questionnaire in a similar manner described for the pre-treatment questionnaire.

The group facilitators were a number of Clinical Masters Students and were frequently supervised by the creator of the program, Dr Vivienne Lewis, to ensure the group was facilitated in an ethical manner and that the program manual was adhered to.

**Intervention:** The intervention evaluated in the current study consisted of six 1.5 hour group sessions, over six weeks. “Positive Bodies: Loving the Skin You’re In” was designed by body image expert, Dr Vivienne Lewis (see Lewis 2012 for self help manual converted from program), and is based on Australian and International research on effective intervention techniques for body image concerns. Importantly, that the manual outlining “Positive Bodies” was published in 2012, but the program itself was developed before the study began in 2008. Through group discussion, the course covers the development of body image, eating disorders and risky behaviours, healthy eating and behaviours, methods to challenge negative thoughts about one’s body, using relaxation and body awareness to increase positive thoughts about one’s body, and how to increase self-esteem. The course also discusses how to detect and act upon negative body image in children. A general outline of the “Positive Bodies” program which was utilised in the current study is provided below.

**Session 1:** Group members create group rules and personal goals for the therapy. The meaning of body image and examples of the cognitive, emotional, physical and attitudinal aspects of body image are discussed. Furthermore, participants are encouraged to discuss the many negative consequences of body image. These discussions commonly cover how negative body esteem
compromises self-esteem, gender identity and sexual fulfilment, while contributing to interpersonal anxiety, depression and eating disturbances.

**Session 2:** Risk and maintenance factors for negative body image are discussed. For example, participants are asked to identify some cultural (e.g. media and society), interpersonal (e.g. teasing and relationships with others), and personality (e.g. perfectionism) influences that have and are contributing to maintenance of their negative body image. Group facilitators then explain how negative thinking also contributes to the maintenance of negative body image using the ABC theory. This theory explains a specific situation (A) triggers certain thoughts or beliefs about your body (B) resulting in an emotional or behavioural consequence (C).

**Session 3:** The impact of having common appearance assumptions and body image distortions are discussed and demonstrated by the facilitators, with an example of a story of female twins that have different body image. Following on from this story, participants identify which common appearance assumptions they possess and the common body image distortions they experience. Group facilitators explain how group members can dispute associated negative automatic thoughts about their bodies, by adding two additional steps (Disputing and Effects of Disputing automatic thoughts) to the ABC method described above. Group members are taught the importance of having positive body affirmations and are given the opportunity to write some affirmations and say them aloud.

**Session 4:** Eating disorders and maladaptive eating patterns are discussed. For example, facilitators explain how common maladaptive methods; such as laxative use and purging, are not only damaging to the human body, but also do not necessarily prevent weight gain. Group members discuss how to improve their nutrition and exercise patterns. Facilitators teach methods to decrease the use of body image rituals, such as checking, pinching and re-dressing, and the use of such methods are planned for homework.
**Session 5:** This session focuses on managing stress and building self esteem. Participants are encouraged to think of practical ways they could improve their self-esteem and plan to use such methods outside of the group intervention. In addition, group members discuss the benefits of relaxation and mindfulness and how they can incorporate these methods into their lives. Participants are also encouraged to participate in grounding, breathing, meditation and mindfulness exercises in-session in order to identify which method they like and are likely to use outside of the sessions.

**Session 6:** Group members discuss how to be assertive and how to respond to inattentive (people who do not provide the compliments wanted), insensitive (people who provide criticism of one’s appearance) and intimidating (looks are perceived as intimidating) people. Group members then review the content of the workshop and set specific, measurable, attractive, realistic and timed (SMART) goals for the future. Participants conclude their workshop by writing a letter to their body, which is a powerful exercise. This activity allows participants to apologise to their bodies for the way they have mistreated it in the past, thank their body for all that it has given them, and to promise their bodies that they will attempt to treat them better in the future.

**Results**

All statistical analyses used a critical alpha level of .05, using SPSS 17.0. In order to deal with missing cases, list-wise deletion was used throughout analyses.

**Descriptives of Self-Esteem and Body Image Variables**

Descriptive statistics for all variables included in analyses can be found in Table 1 and 2. Inspection of the mean scores at pre-treatment revealed that the sample’s average responses on self-esteem items were neutral (between mostly disagree and mostly agree), and that the average response to the body satisfaction items were in the “neither satisfied nor dissatisfied” range. Furthermore, the average response on the self-surveillance and shame items were in the “somewhat
agree” range, indicating participants were experiencing some body shame and were engaging in some self-surveillance. The QOL mean indicated that body image, on average, was having at least a slight negative effect on the quality of life of participants.

These average responses were different post-treatment, with the average response on the self-esteem items in the “mostly agree” range, demonstrating participants were experiencing higher levels of self-esteem post-treatment. Post-treatment, average responses on self-surveillance were in the “neither disagree nor agree” range, and for body shame in the “slightly disagree range”, which indicated decreases in body shame and self-surveillance. The QOL mean post-treatment indicated that participants’ body image had a slight positive effect on quality of life post-treatment.

Participants pre-treatment were found to be dissatisfied with their lower-torso, mid-torso, muscle tone and weight, whereas post-treatment participants were only dissatisfied with their weight. While participants were only satisfied with height at pre-treatment, at post-treatment participants were also satisfied with their face, hair and overall appearance.

Although the mean scores demonstrate improvements in all variables, inspection of the range of scores reveal some concerning scores not only at pre-treatment, but also at post-treatment. For example, minimum scores indicated that there were participants that endorsed “Strongly Disagree” on nearly all items of self-esteem at pre-treatment, and “Mostly Disagree” on nearly all items at post-treatment. Similarly, there were participants who on average responded, “Very Dissatisfied” on items measuring satisfaction with different aspects of their appearance at pre-treatment and “Mostly Dissatisfied” at post-treatment on the same scale. In regards to shame, there was participants that on average responded “Strongly Agreed” to shame items at pre-treatment, and responded on average, “Somewhat Agreed” to body shame items at post-treatment. Of additional concern, QOL revealed that at pre-treatment body image was having a “Very Negative Effect” on the quality of life of a participant and still was having a negative effect on a participants’ quality of life at post-treatment.
Table 1

*Descriptives of Body Image and Self-Esteem variables*

<table>
<thead>
<tr>
<th>Scale</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
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<td>11.00</td>
<td>37.00</td>
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<tr>
<td>Post Self-Esteem</td>
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<td>20.00</td>
<td>38.00</td>
<td>29.95</td>
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<tr>
<td>Pre Body Satisfaction</td>
<td>20</td>
<td>9.00</td>
<td>39.00</td>
<td>24.30</td>
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<td>Post Body Satisfaction</td>
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<td>17.00</td>
<td>43.00</td>
<td>29.25</td>
<td>5.57</td>
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<td>Pre Self-surveillance</td>
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<td>18.00</td>
<td>56.00</td>
<td>39.10</td>
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<td>Post Self-surveillance</td>
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<td>14.00</td>
<td>44.00</td>
<td>31.60</td>
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<tr>
<td>Pre Body shame</td>
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<td>41.00</td>
<td>27.60</td>
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<td>Pre Quality of Life</td>
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<td>26.82</td>
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<td>Post Quality of Life</td>
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<td>-30.00</td>
<td>35.00</td>
<td>4.60</td>
<td>20.49</td>
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*Pre = Pre-treatment, Post = Post-treatment*
Table 2

*Descriptives of Items on the Body Areas Satisfaction Scale*

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<th>Std. Deviation</th>
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<td>1.00</td>
<td>5.00</td>
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<td>Post Satisfaction Face</td>
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<td>2.00</td>
<td>5.00</td>
<td>3.85</td>
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<td>Pre Satisfaction Hair</td>
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<td>1.00</td>
<td>5.00</td>
<td>3.30</td>
<td>1.30</td>
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<td>Post Satisfaction Hair</td>
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<td>Pre Satisfaction Mid Torso</td>
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<td>0.94</td>
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<td>4.00</td>
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</tr>
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<td>5.00</td>
<td>3.30</td>
<td>0.86</td>
</tr>
<tr>
<td>Pre Satisfaction Muscle tone</td>
<td>20</td>
<td>1.00</td>
<td>4.00</td>
<td>2.15</td>
<td>1.04</td>
</tr>
<tr>
<td>Post Muscle tone</td>
<td>20</td>
<td>1.00</td>
<td>5.00</td>
<td>3.15</td>
<td>0.99</td>
</tr>
<tr>
<td>Pre Satisfaction Weight</td>
<td>20</td>
<td>1.00</td>
<td>4.00</td>
<td>2.20</td>
<td>1.24</td>
</tr>
<tr>
<td>Post Satisfaction Weight</td>
<td>20</td>
<td>1.00</td>
<td>4.00</td>
<td>2.45</td>
<td>1.09</td>
</tr>
<tr>
<td>Pre Satisfaction Height</td>
<td>20</td>
<td>1.00</td>
<td>5.00</td>
<td>3.80</td>
<td>1.16</td>
</tr>
<tr>
<td>Post Satisfaction Height</td>
<td>20</td>
<td>3.00</td>
<td>5.00</td>
<td>4.10</td>
<td>0.64</td>
</tr>
<tr>
<td>Pre Satisfaction Overall Appearance</td>
<td>20</td>
<td>1.00</td>
<td>4.00</td>
<td>2.68</td>
<td>1.15</td>
</tr>
<tr>
<td>Post Satisfaction Overall Appearance</td>
<td>20</td>
<td>1.00</td>
<td>5.00</td>
<td>3.55</td>
<td>0.94</td>
</tr>
</tbody>
</table>

*Pre = Pre-treatment, Post = Post-treatment*
Change in Body Image and Self-Esteem from Pre-treatment to Post-treatment

A number of Paired Samples T tests were planned in order to investigate whether participants’ body image and self-esteem improved from pre-treatment to post-treatment. During assumption testing however, QOL, body satisfaction and satisfaction with certain body parts were found to have non-normal distributions, which violated the assumptions of these tests. Normally, t-tests are robust to violations of normality with samples over thirty. However, as the sample size was small a decision was made to use Wilcoxon Signed Rank Tests, the non-parametric equivalent of a paired samples t test, with variables with non-normal distributions.

Changes in Body Image and Self-Esteem

Three paired samples t-tests were conducted to determine whether participants’ self-esteem increased, and participants’ body shame and body surveillance decreased from pretreatment to post-treatment. As expected, there was a significant increase in self-esteem from pretreatment ($M = 25.10, SD = 6.46$) to post-treatment ($M = 29.95, SD = 4.88$), $t(19) = 4.66, p < .001$. The eta squared statistic (.53) indicated a large effect size.

In addition, as hypothesised, there was a significant decrease in self-surveillance from pre-treatment ($M = 39.10, SD = 9.34$) to post-treatment ($M = 31.60, SD = 8.04$), $t(19) = 3.749, p = .001$ and in body shame from pre-treatment ($M = 27.60, SD = 9.05$) to post-treatment ($M = 20.70, SD = 6.77$), $t(19) = 4.191, p < .001$. These eta statistics for both these analyses indicated large effect sizes (.425 and .48 respectively).

Two Wilcoxon signed rank tests were conducted in order to investigate whether participants’ body satisfaction and QOL increased from pre-treatment to post-treatment. These tests revealed a significant increase in body satisfaction following participation in “Positive Bodies”, $z = -3.34, p = .001$, with a large effect size ($r = .53$). The median score on the BSAS increased from pre-program
An increase in QOL was also observed, $z = 3.44$, $p = .001$, with a large effect size ($r = .54$).

These tests indicate a favourable outcome from pre-treatment to post-treatment in increases in self-esteem, body satisfaction and the extent to which body image has a positive impact on participants’ QOL, while experiencing decreases in body shame and body surveillance.

**Changes in Satisfaction with Body Parts**

For individual parts, paired samples t tests indicated that there was a significant increase in participants’ satisfaction with their face from pre-treatment ($M = 3.20$, $SD = 1.01$) to post-treatment ($M = 3.85$, $SD = 0.67$), $t(19) = 3.32$, $p = .004$ and with their muscle tone from pre-treatment ($M = 2.15$, $SD = 1.04$) to post-treatment ($M = 3.15$, $SD = 0.99$), $t(19) = 4.359$, $p < .001$. Eta squared statistics indicated a large (.367) and moderate (.096) effect size respectively. No significant difference in satisfaction with mid-torso from pre-treatment ($M = 2.15$, $SD = 1.04$) to post-treatment ($M = 2.40$, $SD = 0.94$), $t(19) = 1.422$, $p = .171$, was observed.

Wilcoxon Signed Rank Tests were conducted with the variables which violated the assumption of normality (See Table 3). These tests indicated that participants’ satisfaction with their hair, lower torso, upper torso and overall appearance significantly increased from pre-treatment to post-treatment. No significant differences were found for satisfaction with weight and height.
Table 3

Z scores, P values, Effect Sizes and Median Scores for Items on the Body Areas Satisfaction Scale

<table>
<thead>
<tr>
<th>Variable</th>
<th>Z score</th>
<th>P value</th>
<th>R (effect size)</th>
<th>Median score T1</th>
<th>Median score T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hair</td>
<td>-2.308</td>
<td>.021</td>
<td>0.364, medium</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Lower Torso</td>
<td>-2.124</td>
<td>.034</td>
<td>0.394, medium</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Upper Torso</td>
<td>-3.095</td>
<td>.002</td>
<td>0.489, medium</td>
<td>2.50</td>
<td>3.00</td>
</tr>
<tr>
<td>Weight</td>
<td>-1.008</td>
<td>.313</td>
<td>0.159, small</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Height</td>
<td>-0.966</td>
<td>.334</td>
<td>0.159, small</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Overall Appearance</td>
<td>-2.953</td>
<td>.003</td>
<td>0.467, medium</td>
<td>3.00</td>
<td>4.00</td>
</tr>
</tbody>
</table>

Participants’ perceptions of the body image course

Qualitative analyses were also conducted in order to assess which aspects of “Positive Bodies” the participants deemed useful and whether “Positive Bodies” met their expectations. A previous researcher coded participants’ responses to two separate questions “Please comment on whether the program met your expectations” and “What was the most useful aspect of the program?”. These responses were then grouped by code and frequencies were conducted.

Nine participants (45%) said that program met expectations, while 50% indicated the program exceeded expectations (50%). Twenty per cent reported the group discussions and sharing the experiences were the most useful aspects, while 80% indicated that strategies learnt throughout the intervention were the most useful aspects.
Discussion

A sample of twenty women completed two questionnaires as part of an evaluation of the “Positive Bodies: Loving the Skin You’re In” program, which is a CBT based program aimed at improving body image (Lewis, 2012). These questionnaires were administered to investigate whether the participants experienced improvements in body image and self-esteem from the commencement to the cessation of the program.

In order to investigate whether participants’ satisfaction with specific parts of their bodies improved from pre-treatment to post-treatment, participants’ responses on the BAS were compared over time. In line with the hypotheses and the aims of the program, participants became increasingly satisfied with a number of body features; including their face, muscle-tone, hair, lower torso, upper torso and overall appearance from baseline to post-treatment. This is a favourable outcome, as it could indicate that the strategies taught in “Positive Bodies” generalize to most body features and overall appearance. This is in line with research that has indicated that CBT-based strategies are applicable to people dissatisfied with a range of different body areas (Butters & Cash, 1987).

In contrast, participants were not observed to become more satisfied with their mid-torso, weight or height. The lack of improvement in satisfaction with height is not of concern, as participants indicated they were satisfied with their height at pre-treatment and this level of satisfaction was maintained at post-treatment. The results revealing that satisfaction with weight and mid-torso are concerning however, and may indicate that “Positive Bodies” should incorporate more activities aimed at improving satisfaction with these specific body areas. This result may have been obtained because the ideal body frequently endorsed by Society and the media, encourages women to have minimum body fat especially around the mid-torso. This social ideal may have resulted in dissatisfaction in weight and mid-torso
becoming more ingrained in comparison to other body areas, and therefore more difficult to improve in interventions.

As hypothesised, from pre-treatment to post-treatment, participants’ self-esteem also significantly improved, with a large effect size. This is a very encouraging result as it may indicate that individuals are experiencing improvements in self-esteem either as a direct result of the self-esteem activities or indirectly through activities aiming to improve body image or general wellbeing. This is an important outcome, particularly because people with higher self-esteem fare better physically and mentally than those with lower-self-esteem (O’Dea & Abraham, 1999). This is in line with previous research which indicates that CBT strategies were successful in increasing self-esteem in women with body image problems (Dworkin & Kerr, 1987) and that concurrent improvements were observed for self-esteem and body image throughout body image interventions (Cash & Hrabosky, 2003; Hawks et al., 2008; Karpowicz et al., 2009; McVey et al., 2003).

The main aim of “Positive Bodies” was to improve participants’ body image. Various measures of body image were administered in order to monitor the overall body image of the participants through treatment. Participants’ ratings on all body image measures improved largely and significantly from pre-treatment to post-treatment. Therefore, participants’ reported thinking less about their bodies, experiencing less shame towards their physical appearance, experiencing greater body satisfaction and reported experiencing a slight positive effect of body image on QOL at post-treatment. These results coincide with the hypotheses and previous research which indicate that CBT-based interventions are effective in improving body image by reducing maladaptive body image thoughts, affect and behaviours and by teaching individuals to perceive their bodies in a more objective manner (Rosen et al., 1995; Smith et al., 2001). Of particular importance, body image had a slight positive effect on
participant’s QOL at post-treatment. This could indicate that for the overall sample, body
image problems no longer impacted negatively on other aspects of participants’ lives; such as
their relationships with others, daily activities, sexuality and satisfaction with life in general.
It should be noted, however, that post-treatment levels in body image variables are still not
ideal, and therefore, “Positive Bodies” may need to be amended in order to produce greater
changes in body image.

Participants’ ratings on popular measures of body image and wellbeing might be
important, but their perceptions of the program can provide equally important information
about the utility of the program (Banasiak, Paxton & Hay, 2007). Qualitative analyses
indicated that participant’s had a positive perception of the program, as 95% said “Positive
Bodies” met or exceeded their expectations. In addition, 80% indicated that the strategies
taught were the most useful aspects of “Positive Bodies”. This is in line with research
indicating that CBT strategies are relevant for body image issues (Cash & Hrabosky, 2003;
Gollings & Paxton, 2006; Winzelberg et al., 1997; Zabinski et al., 2004) and that clients
appreciate learning strategies to combat negative body image as simply providing
information regarding body image and eating disorders is not sufficient for change (Banasiak
et al.; Cash & Hrabosky). In addition, 20% of the sample indicated group discussions and
sharing experiences were the most useful aspects of the program. This is in accordance with
research which indicates that group interventions are practical because individuals can feel a
strong sense of support from other individuals experiencing negative body image (Rosen et
al.1995; Zabinski, 2004) and can demonstrate their understanding of principles via discussion
with group members, which also increases adherence to intervention procedures (Wade et al.,
2009).
Although a number of important outcomes have resulted from this study, the limitations of the study need to be considered when interpreting the results. Firstly the sample size is rather small and therefore, the results cannot be generalized to greater populations. Furthermore, the improvements in body image and self-esteem cannot be directly attributed to the program as there was no control or comparison group. Therefore, the improvements in self-esteem and body image could have been influenced by another unidentified confounding variable. It is therefore recommended that further research into the evaluation of “Positive Bodies” is conducted ideally using a control group and a comparison group receiving another intervention. In addition, future studies should also examine whether improvements in self-esteem and body image are maintained after treatment cessation. Results demonstrated that although improvements were observed from pre-treatment to post-treatment, the ratings on the scales at post-treatment were still not in the desired range.

Despite the limitations, this study has indicated that “Positive Bodies” may produce improvements in self-esteem and body image, and is perceived positively by participants. In addition, as the sample consisted of women of a variety of ages, “Positive Bodies” may be applicable to women in different stages of their life. Therefore, this study has provided further support for CBT interventions and the group intervention format for body image issues.
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Is It Worth Trying to Improve Clients’ Motivation to Recover from an Eating Disorder?

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Paper Presented at the  
Australian & New Zealand Eating Disorders and Obesity Conference  
Surfers Paradise, Gold Coast (QLD), 18-19 May 2015.
ABSTRACT: The current paper reviews the literature on motivational approaches in the treatment of eating disorders and makes recommendations for clinical practice. Despite the availability of evidence-based practice guidelines, eating disorders to have poor response rates, high attrition, and high recidivism. Clients’ lack of motivation is multifaceted and there are no known predictors of spontaneous recovery from eating disorders. Motivational Interviewing (MI) is a client-centered approach to treatment that uses directive techniques and that emphasizes maintaining a strong therapeutic rapport, conveying a non-judgmental stance, developing empathy, and rolling with resistance. There is little evidence that motivationally-focused interventions improve eating disorder symptoms on their own. On the other hand, MI approaches prior to commencing established treatments appear to be helpful at improving motivation and treatment retention. Previous research reveals that support is strongest for using MI with treatment for binge eating. It is important for clients to stay engaged in treatment for disordered eating, because the research shows that they do not often get better on their own. MI pre-treatment appears to increase engagement in subsequent therapy (probably better than non-MI approaches) and it may do so primarily through its beneficial effects on the therapeutic alliance.

Keywords: eating disorders; motivational interviewing; therapeutic alliance

Introduction

In a clinical context, motivation to change refers to a person’s readiness, willingness, and ability to change their problematic behaviour. The current paper provides an overview of the role of motivation in the treatment of eating disorders and aims to provide some clarity around whether it is worth trying to improve clients’ motivation to recover from an eating disorder. In this paper the general term of “eating disorder” will be used, in part because space does not allow for separate literature reviews relating to motivation and the main DSM eating disorder diagnoses (i.e., anorexia nervosa, bulimia nervosa, eating disorder not otherwise specified, binge eating disorder). Moreover though, there are well-established commonalities among the psychopathologies underlying the eating disorders. Some of these similarities are especially relevant when discussing motivation and/or ambivalence toward behaviour change. For example, the over-evaluation of eating, shape, and weight is considered to be a core psychopathology of the eating disorders (Fairburn, Cooper, and Shafran, 2003). This trait typically results in an intense fear of gaining weight during treatment, which is often cited by clients as an obstacle to them pursuing or completing treatment for their eating disorder.
The development and evaluation of eating disorder treatments have progressed significantly within the past two decades. Health practitioners now have evidence-based practice guidelines for the treatment of eating disorders. Among the most methodologically rigorous in their criteria are the guidelines published by the UK’s National Institute for Clinical Excellence (Wilson and Shafran, 2005). Psychological and/or psychiatric associations in Australia, Canada, and America have also published practice guidelines for the treatment of eating disorders. The conclusions across sources are consistent: the evidence to date reveals that cognitive-behavioural therapy (CBT) is the most well-researched, empirically supported treatment for eating disorders. Other evidence-based treatments, such as family-based therapy, also show promise as effective psychological interventions for eating disorders. But the fact remains that eating disorders, even when treated with manual-based CBT, have relatively poor response rates, especially for underweight patients (Weiss, Mills, Westra, and Carter, 2013). Among individuals with bulimia nervosa, CBT typically eliminates binge eating and purging in roughly 30% to 50% of all cases (Wilson, Grilo, and Vitousek, 2007). Hospital and clinic-based eating disorder treatment programs have high rates of attrition. Clients drop out for various reasons, but often because they are unwilling or unable to gain weight or to normalize their eating. Even when treatment gains are achieved by clients, they often do not last; relapse is a common occurrence.

Adding to the challenge of delivering an effective psychological intervention for eating disorders is the fact that some therapists are more effective than others. This is not usually the focus of clinical trials, but therapist differences almost certainly exist. Some therapists connect with their clients better than others. We do not know yet precisely which therapist qualities predict better actual treatment outcome in the eating disorders, but both common sense and emerging evidence point toward therapist characteristics that are likely to be associated with better treatment outcome. For example, clients with an eating disorder have been found to prefer therapists who are warm, supportive, understanding, nonjudgmental, trustworthy, and validating (Gulliksen, Espeset, Nordbo, Skarderud, Geller, and Holte, 2012). More research is needed to examine whether therapist characteristics moderate, to a significant degree, the effectiveness of different therapy modalities.

Of course, not all therapists choose to embrace evidence-based interventions when treating individuals with an eating disorder (Wilson et al, 2007). This is probably especially true in individual therapy and private practice, where standardized treatments are not required.
and where therapists may prefer a more flexible or eclectic approach to their sessions. Therapists may feel that CBT is too rigid or repetitive, that it does not address their clients’ needs, or more generally that CBT does not work all that well (or as well as something else they think works). Unfortunately, many therapists lack adequate training in evidence-based interventions for eating disorders (von Ranson and Robinson, 2006). It is not an aim of this paper to criticize therapists who do not use empirically-supported treatments for eating disorders. Having said that, there are common cognitive impediments to accurately evaluating improvement in psychotherapy (Lilienfeld, Ritschel, Lynn, Cautin, and Latzman, 2014) and in general, therapists are not good judges of whether or not what they are doing is working. In addressing the goal of this paper – to clarify whether it is worth trying to improve our clients’ motivation to recover from an eating disorder – the use of evidence-based treatments is the baseline from which the added value motivational approaches will be considered. We want to motivate our clients to do things that are likely to work. To motivate clients to do things that are not likely to help them is counterproductive.

In sum, we have reasonably effective treatments for eating disorders. But despite the availability of evidence-based practice guidelines, eating disorders continue to have generally poor response rates, high attrition, and high recidivism. In particular, many clients have a very difficult time gaining the behavioural and cognitive control over their symptoms that is required in order to normalize one’s eating. Client noncompliance is a major obstacle to treatment success and diminishes the effectiveness of cognitive and behavioural interventions in general (Antony, Roth Ledley, and Heimberg, 2005). In the treatment of eating disorders, it has been the current author’s experience that clients frequently revert to disordered eating (e.g., restriction, bingeing, purging) outside the hours of an intensive treatment program or, in the case of individual outpatient care, that there was never very much behaviour change between therapy appointments to begin with. Individuals with an eating disorder need to do considerable work on their own time in order to recover and to maintain treatment gains. This is where a client’s level of motivation becomes extremely important.

*Understanding a Lack of Motivation among Individuals with an Eating Disorder*

Ambivalence toward change is a common feature of eating disorders, particularly anorexia nervosa. There are a number of potential psychological obstacles to behaviour change among individuals with an eating disorder, including denial that the eating disordered behaviours are a problem, ambivalence about engaging in treatment, ambivalence about eliminating
symptoms and their protective functions, and a fear of gaining weight (Dray and Wade, 2012). Ambivalence toward change as it relates to unhealthy behaviours is the focus of Prochaska and DiClemente’s (1983) Transtheoretical model (also known as the Stages of Change model). This model is often applied in discussions of the role of motivation in the eating disorders, despite a lack of strong empirical support for its applicability to treatment outcome in eating disorders (Dray and Wade, 2012). Originally developed as a model of motivation during smoking cessation, the Stages of Change model seeks to explain various clinical issues and targets, depending on the patient’s stage of readiness, ranging from pre-contemplation to action. This model and its subsequent revisions have been useful for both informing clinical research and practice, and for increasing awareness of the challenges of treating various problematic behaviours, including addictions and eating disorders. However, the theory has several weaknesses. It tends to oversimplify the stages of behaviour change. For instance, it is not uncommon for an individual with an eating disorder who is attending intensive treatment to be planning her relapse once she is out of the hospital. According to the model, should such a patient be considered to be in the action stage, as her admission and current behaviour would suggest, or is she is the contemplation stage? Or, is she already relapsing, in a sense? Motivation rarely fits into discrete stages and is constantly in flux. In 2001, Freeman and Dolan proposed a revised Stages of Change model. Their expanded model includes additional stages of change with greater specificity that reflect common experiences of clients and therapists (e.g., anti-contemplation, prelapse) (Freeman and Dolan, 2001). Although more research is warranted, the Freeman and Dolan model appears to be a good theoretical framework from which to understand the apparent lack of motivation associated with recovery from an eating disorder.

In determining whether it is worth trying to improve clients’ motivation to recover from an eating disorder, it is important to emphasize that there are no known predictors of spontaneous recovery from an eating disorder. A recent study examined the natural course of eating pathology among female undergraduate students during their university years. It was concluded that there was little evidence of spontaneous improvement in untreated eating pathology across time and that eating pathology appears to be a particularly stubborn form of psychopathology (Mills, Polivy, McFarlane, and Crosby, 2012). This is relevant to the topic of motivation for two reasons. First, it is important for clients to stay engaged in eating disorder treatment because they are unlikely to get better on their own. Second, because eating pathology tends to be relatively stable across time, clients often have unrelenting patterns of symptoms. Some individuals with bulimia nervosa have binged and purged
multiple times per day, every single day, for several years. They report that they cannot imagine not doing it. Given these individual’s past experiences, confidence that they will be able to get control over their eating disorder symptoms could be considered irrational. Having an eating disorder can be incredibly demoralizing, which undoubtedly affects clients’ level of motivation. Part of the lack of motivation so often seen in individuals with an eating disorder can be explained by a reluctance to give up a symptom that is ego syntonic or one that helps someone cope with overwhelming anxiety and distress. But another part of that apparent lack of motivation may be due to the fact that eating disorders are stubborn, pernicious disorders that are difficult to overcome. Therapists should not underestimate the feelings of helplessness and hopelessness that often accompany an eating disorder. It is hard to feel motivated if you do not feel confident that you can ever recover from an eating disorder. This presents a challenge to therapists; it is important for a clinician to present effective, feasible solutions and strategies for overcoming an eating disorder, but to not instil false hope that the treatment on offer will be quick or easy.

The most effective treatments require active work on the part of the client. In CBT, clients are usually asked to monitor their eating by keeping a food diary. However, thorough self-monitoring is a difficult task to accomplish even with banal behaviours, much less with eating disorder symptoms. Research suggests that ambivalence toward change is intensified when patients receive a directive approach to treatment, like CBT (Beutler, Harwood, Michelson, Song, and Holman, 2011). So, while CBT is, in most cases, the best choice of treatment for an eating disorder, therapists need to be cognizant of the fact that because of its very nature – being an action-oriented, directive, structured intervention – CBT can elicit resistance from clients.

As reviewed above, eating disorder clients’ lack of motivation is multifaceted. There is often ambivalence toward behaviour change, especially in cases of anorexia nervosa. This lack of motivation can be conceptualized as a reluctance to give up aspects of the disorder from which the individual derives comfort, satisfaction, and/or self-worth, such as the quest for thinness. In addition, there is often a lack of motivation to fully comply with the treatment on offer. This can manifest as an unwillingness to comply with specific tasks that are recommended by the therapist – for example, to monitor one’s food intake in diary form or to eat “forbidden foods” in moderation and without compensation as a behavioural experiment. These two related but distinct aspects of clients’ motivation to recover from an eating disorder – desire and willingness – are sometimes confounded. It is recommended here that therapists identify and target the source of treatment noncompliance with precision.
There may be many individuals with an eating disorder who very much want to recover, feel ready to do so, but just don’t want to do it the way we tell them to. An ensuing lack of progress might then attributed to the ambivalence “inherent” in eating disorders when, really, the fact is that our best available treatments for eating disorders involve tasks that people generally find very hard to do.

What Do Motivational Approaches to Eating Disorder Treatment Accomplish?

The most well-researched psychotherapeutic approach to increasing motivation is Motivational Interviewing (MI). MI is a client-centered approach to treatment that uses directive techniques and that emphasizes maintaining a strong therapeutic rapport, conveying a non-judgmental stance, developing empathy, and rolling with resistance. In general, MI seeks to explore and resolve a client’s ambivalence toward change by acknowledging both the pros and cons of changing behavior, by normalizing the experience of ambivalence, and by helping the client situate his/her behavior within the context of his/her values and goals (Miller and Rollnick, 2012). The idea is that MI provides a safe and supportive therapeutic environment in which clients can express and resolve ambivalence toward change. In the integrative treatment of eating disorders, Geller and Dunn (2011) have described ways of using MI to tailor CBT to a patient’s readiness for change. MI is often offered as an adjunct to a traditional treatment plan in the form of a brief “pre-treatment.” Several studies from the past decade have looked at the impact of incorporating MI with eating disorder treatment in various ways and have produced some converging results. Two such studies are described next in detail.

Given the high attrition rate from intensive eating disorder treatment programs, Weiss and colleagues sought to determine whether motivational interviewing as a brief, pre-treatment intervention would be associated with higher completion rates in subsequent intensive treatment for an eating disorder (Weiss, Mills, Westra, and Carter, 2013). Participants were recruited from the waiting lists for the inpatient and day hospital units of the Toronto General Hospital. The only eligibility exclusion was a BMI of less than 14. The mean age off participants was 28 years old; the mean age of eating disorder onset was 17.3 years and a mean duration of illness of 10.7 years, which are fairly typical participant characteristics in eating disorder treatment trials. Participants were randomized into either the MI pre-treatment condition or a waitlist control condition. Treatment staff in the subsequent intensive treatment program were blind to participants’ group assignment. The
MI condition received four, weekly 50-minute sessions of MI with an individual therapist over consecutive weeks. That treatment followed the principles and techniques covered in Miller and Rollnick’s MI manual (Miller and Rollnick, 2012). The MI intervention was considered “brief” only in comparison to the typical length of treatment for an eating disorder. MI as an adjunct to other treatment is typically delivered in 1-2 one-hour sessions. At the conclusion of the study, it was noted that the third and fourth sessions tended to be repetitive in terms of content, and that one or two sessions of MI would have probably been a sufficient dose of MI. Participants in the control condition did not receive any MI treatment, but remained on the waiting list. All participants received eating disorder treatment as usual. The results revealed that participants in the MI condition were significantly more likely than those in the control condition to complete the subsequent treatment program (69% versus 31%). But, contrary to the researchers’ predictions, there were no significant differences between groups on self-reported motivation, as measured by motivation rulers – 10-point Likert measures of motivation, confidence, or readiness. There were few clues from the findings as to what might have led to the observed group differences in treatment completion. Those results stand in contrast to others’ findings, where MI-based treatments have been associated with increases in motivation and readiness to change in individuals with anorexia nervosa (Feld, Woodside, Kaplan, Olmsted, and Carter, 2001; Wade, Frayne, Edwards, Robertson, and Gilchrist, 2009). Yet there was the objective result of resultant improvements in treatment completion. One possibility is that the participants in the MI condition had formed a more positive impression of the program, given the individualized attention they received prior to starting intensive treatment. It could be that the therapeutic relationship itself was a mechanism for positive change and improved the clients’ willingness to comply with the treatment program and persistence at attending the program. By adopting an MI approach, the therapist was embodying the characteristics preferred by eating disordered clients (i.e., warm, supportive, understanding, nonjudgmental, trustworthy, validating).

While the precise mechanism of therapeutic change in that study is only speculative, the individual sessions of MI would appear to be worth the investment of time and resources. By staying in treatment until they are fully symptom-free and have reached a minimally healthy body weight (usually defined as a BMI of 20), clients reduce their odds of relapse (Carter, Blackmore, Sutandar-Pinock, and Woodside, 2004). Therefore, identifying ways in which to increase clients’ completion of treatment – the ‘willingness’ facet of motivation or the ability to comply with the requirements of the treatment plan – is an important goal for future research and clinical practice.
In another study of MI and eating disorders, researchers examined how MI compares to an active therapy control for women who binge eat (Vella-Zarb, Mills, Westra, Carter, and Keating, 2015). Evidence shows that MI is most effective as an adjunct treatment for binge eating. However, there are very few treatment outcome studies of MI that use an active therapy control group and this is an important research gap to fill in the literature. Because MI differs from CBT in both the spirit of the therapy and the techniques employed, it is important to determine the source of any benefit of motivational approaches. Pre-treatments involve spending additional time with the client, which could itself, enhance therapeutic alliance and/or treatment outcome. In this study, women with either binge eating disorder or non-purging bulimia nervosa were recruited from a university and surrounding community. Participants either received one, one-hour session of MI followed by a self-help manual, or one, one-hour session of psychoeducation followed by a self-help manual for binge eating. The manual was Christopher Fairburn’s (1995) “Overcoming Binge Eating,” which is an empirically supported self-help CBT manual. Participants were told that they would receive one of two types of “orientation” sessions, but were blind to condition. The psychoeducation session was informational only, delivered by an individual therapist, with no discussion of motivation, but matched in terms of time spent with participant. The MI session was conducted by the same therapist, trained and supervised in MI. Standardized, well-established measures of motivation were administered. Both groups improved between baseline and one month and again between baseline and 4 months in terms of overall eating disorder symptoms (EDE-Q global scores). In terms of pre-post differences for each type of session (psychoeducation versus MI), the MI participants showed a significant increase in readiness and self-efficacy, whereas the psychoeducation group did not. These results are consistent with the conclusions of others (Dray and Wade, 2012; Knowles, Anokhina, and Serpell, 2013) in that MI approaches appear to increase motivation among clients, but that they do not necessarily improve treatment outcome. To summarize, this second study suggests that MI is more effective than other types of psychological interventions at increasing readiness to change and self-efficacy. However, MI as an adjunct to self-help does not appear to offer any unique benefit for reducing binge eating symptoms.

Based on clinical observations and emerging research evidence, it is argued here that therapists who follow the spirit of MI probably do a better job than average at fostering an effective therapeutic alliance. This alliance probably improves clients’ engagement in treatment but may not lead directly to symptom change. Therapeutic process research on MI in other psychiatric populations suggests that it is the relationship itself that is predictive of
therapeutic engagement and points to the therapeutic alliance as a facilitator of behaviour change. In one study of individuals with anxiety (Marcus, Westra, Angus, and Kertes, 2011), participants who received CBT alone for generalized anxiety disorder, with no MI pre-treatment, described the same therapists as directive and described themselves as playing a more passive role in therapy, as compared to those who received MI as a pre-treatment to CBT. The findings of this qualitative study converge with other quantitative studies that support the idea that MI pre-treatment leads to increased engagement in subsequent therapy.

Does previous research show that MI approaches improve compliance with evidence-based treatments for eating disorders? That specific research question has not been tested and would be a very valuable addition to the eating disorder treatment literature. As reviewed above, noncompliance is a major stumbling block for many clients. MI may provide benefit in terms of enhancing clients’ willingness to comply with homework and their persistence at actively participating in treatment. In those cases, the treatment is optimized and the client’s likelihood of success is maximized.

The Best Use of Motivational Approaches with Eating Disorder Clients

How do you incorporate discussions around motivation with clients and maximize their therapeutic benefit? Generally, be realistic about what using a motivational approach is going to achieve. There is no evidence that motivational approaches are good stand-alone treatments. There is also little evidence that motivational interventions actually improve outcomes. On the other hand, motivational approaches delivered prior to commencing treatment appear to be helpful in predicting treatment response. Start by identifying any psychological barriers to behaviour change. If there is resistance from the client to either changing problematic behaviours or complying with the best course of treatment, MI can be a low-cost investment in terms of time and energy. Adopt the spirit of MI with your clients: be genuine, empathic, curious, warm, and non-judgmental. When therapists do this, they are probably improving the likelihood of their clients engaging well with treatment. The idea that the therapeutic relationship is the cornerstone of therapy is not new. Client-centred approaches to psychotherapy are based on this premise. Dialectical behaviour therapy (which, incidentally, has been shown to have therapeutic benefit for individuals with an eating disorder) advocates for a close and authentic therapist-client relationship. Being an engaging therapist will maximize the effectiveness of the treatment and will, in turn, optimize
clients’ progress. It is worth emphasizing again the importance of using a treatment that works – motivating patients to adhere to an unhelpful regime could make things worse.

Glen Waller (2012) cautions of a problem he describes as “motivation as manifesto.” Expressed motivation from the client is a verbal statement of intent, but without the behavioural change to back it up. Clients can say a lot of things to convince themselves and others that they are ready and willing to change. As Waller explains, the best case scenario is a patient who says “I plan to get well and I know that it will be hard work.” This scenario probably happens infrequently in the real world. Arguably, one of the main reasons for this disconnect is the distinction between a client wanting to recover and a client being willing to do and to persist at the things that the therapist asks them to do in order to recover. Talking about motivation can distract from the difficult, tedious, and repetitive work that is most likely to lead to behaviour change and better symptom control. It can quickly use up precious individual therapy time. Just talking about motivation (or lack thereof) does not improve patients’ motivation. Therefore, discussion around motivation should be targeted at resolving ambivalence about giving up the eating disorder, if needed. But as importantly, it should be aimed at resolving a lack of trust in and/or willingness to comply or persist with evidence-based treatment approaches.

How, as a therapist, does one know when he or she is improving a client’s motivation? Therapists are not reliable judges of their clients’ motivation. The best judge of the patient’s motivation is someone who is not invested in the outcome of therapy (Geller, 2002). Observers’ judgments are most predictive of treatment outcome and clinicians’ are the least predictive, with clients’ judgments somewhere in the middle. In practice, an impartial observer is difficult to arrange. Most research studies use clients’ judgments of motivation. In practice, most therapists use their own judgments of how motivated their clients are feeling. The issue of how to measure motivation is important and the reliance on therapist judgments is a limitation of which to be aware. Ideally, motivation should be assessed through client’s self-reported ratings of the different facets of motivation using standardized measures like the URICA and the WEL, as well as clients’ qualitative narratives (Marcus et al, 2011).

Conclusions

Despite a lack of reliable evidence showing that motivational approaches such as MI improve eating disorder treatment outcome, there is evidence that motivational approaches
improve certain aspects of clients’ motivation and their engagement and/or retention in treatment. It is vital that clients stay engaged in treatment for disordered eating, because the available research shows that they do not often get better on their own. Clients are more likely to get better using evidence-based treatments if they comply fully with the treatment, but eating disorder treatment can be difficult and lengthy. MI pre-treatment has been shown to improve engagement in subsequent therapy (probably better than non-MI approaches) and it is suggested here that it does so primarily through its beneficial effects on the therapeutic alliance. Adopting the spirit of MI when delivering evidence-based treatment for an eating disorder is a useful approach for therapists to take.
References


Eating Disorders: The Influence of Attachment Style and Childhood Emotional Invalidation

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Paper Presented at the Australian and New Zealand Eating Disorders and Obesity Conference
Surfers Paradise, Gold Coast (QLD), 18-19 May, 2015
Eating Disorders: The Influence of Attachment Style and Childhood Emotional Invalidation

ABSTRACT: The current study explored how attachment style and emotional invalidation by mothers and fathers in childhood and adolescence were associated with the emergence of various eating disorders. The sample involved 144 adult females, aged 18-45 (M= 23 years), who completed the Experiences in Close Relationships Scale, the EAT 26, and the Invalidating Childhood Experiences Scale. A cluster analysis revealed six distinct profiles amongst participants including excessive exercise/diet pill consumption, binge eating disorder, anorexia, bulimia, extreme anorexia/bulimia and a large normal group. The results identified insecure attachment style was frequently endorsed by those with varying ED profiles as was a history of parental emotional invalidation. Emotional invalidation by fathers was more extreme and appeared to exert greater influence on the development of severe anorexic/bulimic pathology, with a highly fearful attachment style being typical. Less extreme emotional invalidation by both mothers and fathers was influential for bulimic and exercise/diuretic groups, with the bulimic group characterised by anxious attachment. Surprisingly anorexia was not associated with emotional invalidation, but was associated with a moderately fearful attachment style. Results for this anorexic group were interpreted as reflecting emotional constriction while those in the bulimic and extreme anorexic/bulimic group were characterised
by emotional overwhelm. The results highlight the influence that insecure attachment styles and parental emotional mismanagement in childhood and adolescence have on the development of various EDs in adulthood.

**Keywords:** Anorexia, bulimia, binge eating disorder, attachment style, emotional invalidation.

Eating disorders (EDs) are complex processes involving genetic and environmental factors (Bulik, 2005; Espeset et al., 2012; Fairburn & Harrison, 2003; Fox, 2009). More contemporary research is beginning to examine how emotional socialisation within the family may underpin ED development.

There are numerous EDs described in the DSM-V, with bulimia nervosa (BN), anorexia nervosa (AN) and binge eating disorder (BED) the most extensively researched. Anorexia includes an inability to maintain a minimal normal weight, excessive fears concerning weight gain or becoming overweight, self opinion derived from body weight or size and refuting the health dangers low body weight presents (American Psychiatric Association (APA), 2013). Bulimia involves the uncontrollable ingestion of food quantities larger than the majority would consume in a similar timeframe and context. Weight gain prevention behaviours including vomiting, abusing laxatives, diuretics, or similar medications, extensive exercise and fasting are consequently performed. Self worth is heavily
influenced by body weight and perceived shape (APA). In BED, a comparatively larger quantity of food is uncontrollably ingested while simultaneously experiencing distress involving guilt, shame and disgust. A binge often occurs alone and regardless of resting appetite and typically once each week for three months (APA).

Attachment Theory

There has been recent interest in how relational factors underpin EDs. One common paradigm used to explain relational styles is attachment theory. Originally proposed by Bowlby (1982) and extended by Ainsworth et al. (1978, as cited in Bowlby) attachment theory involves the representation of self and other in the context of relationships (Mikulincer & Shaver, 2010). Initially attachment experiences transpire between parent and child, with characteristic experiences forming internalised templates about the self and other that are activated during attachment experiences in future relationships (Sroufe et al., 1999). Secure attachment unfolds following emotionally sensitive and sustained care and protection, with such individuals viewing themselves as worthwhile and others as supportive and responsive, generating an enjoyment of relationships, an ability to engage in emotional intimacy while remaining autonomous, and the capacity for thoughtful reflections on relationships (Bartholomew & Horowitz, 1991; Mikulincer & Shaver).
In the absence of secure attachment, a number of insecure attachment styles may unfold. Anxious attachment evolves following unreliable care, leading to the disruption of self-efficacy, self-worth and autonomy and a pervasive sense of hurt, disappointment and chronic anger and abandonment fears (Cassidy & Shaver, 1999; Obegi & Berant, 2009). Such individuals hold unfavourable self views, and desire intensive support and care from idealised others. Their prototypical emotional lability, excessive emotional disclosure, and low self-confidence predisposes them to enmeshed relationships and coercive relational strategies that may culminate in feared rejection and abandonment (Allen et al., 2005; Bartholomew & Horowitz, 1991).

Avoidant attachment arises in response to inattentive, punitive and disapproving caregivers who typically encourage independence, self-reliance and suppression of vulnerable feelings and needs (Mikulincer & Shaver, 2010; Obegi & Berant, 2009). Those with avoidant attachment hold a positive self perception while regarding others unfavourably and maintain distance by sidestepping close bonds, displaying interpersonal hostility, and emphasising independence and invulnerability. They prefer to remain aloof, self-confident and independent and rarely share detailed inner experiences (Bartholomew & Horowitz, 1991).

In extreme environments, disorganised attachment featuring chaotic and contradictory behaviours reflecting the presence of both intense anxiety
and intense avoidance (Sroufe et al., 1999) emerges when caregivers are both a source of danger and fear, and a safe haven. Accordingly caregivers may be abusive, highly neglectful, display frequent uncontrollable rage outbursts or become highly distressed by their child’s feelings or behaviours (Main & Solomon, 1986). Disorganised individuals view self and other negatively, leading to avoidance of intimacy, rejection fears, submissive interpersonal behaviour and poor self confidence (Bartholomew & Horowitz, 1991).

**Attachment Theory and Eating Disorders**

There is strong evidence linking ED symptoms with attachment difficulties (Broberg et al., 2001; Hochdorf et al., 2005; Latzer et al., 2002; Suldo & Sanberg, 2000). Avoidant attachment tends to be cited more than anxious/ambivalent and disorganised attachment in clinical populations regardless of ED subtype. Ward et al. (2001) found 95% of their anorexic participants were avoidant, while Hochdorf et al. found their anorexic and bulimic participants more frequently endorsed avoidant attachment than anxious or secure patterns, with insecure attachment identified as a significant predictor of EDs. Similarly, Latzer et al. found in 58 women with clinical AN or BN, avoidant attachment was reported more frequently than secure or ambivalent attachment, regardless of ED subtype. Barone and Guiducci (2009) also noted that avoidant attachment was the most prominent style amongst anorexic, bulimic and BED participants.
Further studies have identified the existence of disorganised attachment styles in those with clinical EDs. Troisi et al. (2005) noted both anxious and avoidant features were prominent in their anorexic and bulimic participants, regardless of ED type while Ringer and Crittenden (2007) found that 50% of their anorexic subjects and 35% of their bulimic subjects endorsed anxious and avoidant relational strategies. Exploring disorganised attachment more specifically, Barone and Guiducci (2009) classified 40% of bulimic and 30% of BED participants as disorganised while Ward et al. (2001) found 50% of their small anorexic sample demonstrated disorganised features.

While avoidant attachment is more common in clinical populations, the trend in non-clinical samples is less clear. A number of community studies have observed sub-threshold anorexic and bulimic patterns occurring in those with anxious attachment styles (Salzman, 1997; Suldo & Sanberg, 2000). A smaller body of research exploring BED has also noted high rates of anxious attachment in community samples (Pace et al., 2012). While some studies with community groups have identified greater endorsement of avoidant patterns, these studies specifically examined attachment styles in bulimiics (Cole-Dedtke & Kobak, 1996; Evans & Wertheim, 2005).

*Eating disorders and experiences within the family and parental relationships*
Current research indicates those with ED symptoms report early family difficulties reflecting two broad themes. The first involves excessive constraints on thoughts, self-expression and emotional experience (Fox, 2009; Gillet et al., 2009) and prioritising external concrete objects including food, weight, success and achievement (Laliberte et al., 1999; Schneer, 2002). The second involves environments featuring chaos, unclear communication, conflict, fleeting emotional warmth and comfort and difficulty individuating (Dallos & Denford, 2008; Fox, 2009). The latter chaotic environment has been associated with clinical AN and BN (Fox; Vidovic et al., 2005) with the highly constraining environment more typical for anorexics (Fox; Vidovic et al.).

It is also evident that individuals with EDs experience problematic parental relationships, encompassing controlling and intrusive parenting styles (Fosse & Holen, 2006; Jones et al., 2006; Yamaguchi et al., 2000) low levels of verbal and physical love and care (Deas et al., 2001; Latzer et al., 2002) and frequent rejection (Tereno et al., 2008). These results suggest that anorexia and bulimia may evolve when individuals feel deprived of parental love and acceptance.

In accordance with the prevalence of insecure attachment, problematic family functioning and maladaptive parenting styles in ED populations, typical parental reactions to emotions expressed by their children has attracted increasing interest. One response category involves
emotional invalidation (EI), a subtle process involving the rejection of or aversion to another’s expressed emotions. Linehan (1993) claims EI involves unpredictable, improper and extreme responses from others to the expression of private internal experiences, including minimisation or punishment which conveys that communicating inner emotional experiences is wrong and socially unacceptable. Such experiences leave children doubting their perceptions and emotions, fostering emotion dysregulation and poor distress tolerance as the child never learns how to manage intense feelings with their caregivers.

Leahy et al. (2011) argue validation is essential to developing secure attachments as caregiver responses convey that inner feelings can be soothed, understood, and symbolically represented. These experiences are gradually internalised leaving the secure individual confident of acquiring support and able to manage their emotions. Conversely, insecure individuals would be less optimistic and even wary about receiving validation, and when parents have ignored or criticised emotional expression, an insecure individual feels their needs are excessive, inconvenient and shameful. When their feelings are repeatedly ignored, denied or lead to withdrawal of love, children may learn to habitually suppress their experience and expression of emotions (Corstorphine, 2006; Gaertner et al., 2010), which is reminiscent of avoidant attachment. More extreme responses including shame, punishment and physical or verbal aggression leaves children with
substantial un-metabolised affect, feeling their emotions and needs are excessive and wrong, and with limited frustration capacities, fostering social incompetence, rejection and exclusion (Fonagy, 2004; Fosha, 2000). This may culminate in either an anxious attachment pattern whereby children hyper-activate their emotions and need for care so parents begrudgingly attend to them, or a fearful attachment pattern whereby children oscillate between suppressing and augmenting their feelings which is often associated with extreme emotional outbursts (Mikulincer & Shaver, 2010).

Initial empirical exploration of how EI may contribute to emotional difficulties and relate to EDs has begun. One small study found bulimics recorded the highest invalidation scores, especially with their fathers, amongst AN and BN participants. Paternal invalidation was associated with bulimic symptoms including vomiting and excessive exercises. Interestingly participants who reported a history of bingeing had fewer invalidating experiences with their mother (Haslam et al., 2008). While Ford et al., (2011) observed childhood EI generated negative self-beliefs in adults with EDs, further community based research by Haslam et al. (2012), identified eating related concerns were associated with childhood EI. Perceiving emotional expression as an indication of weakness was responsible for the association between childhood maternal EI and ED symptoms. While initial evidence indicates an association between childhood EI and adulthood EDs,
Ford et al. and Haslam et al. (2012) did not explore whether there is a differential effect on anorexic or bulimic symptoms.

The early family life and parenting experiences often reported by individuals with problematic eating appear to involve either behavioural and emotional rigidity or a chaotic and enmeshed style of relating and functioning, with maladaptive parental responses to expressed emotion. Accordingly, EDs may facilitate both the over-activation and under-activation of the attachment system to manage difficult feeling states. Some argue EDs distract youngsters from unavailable, harsh or rejecting caregivers, to instead focus on tangible objects including food, weight and shape. This permits conflict avoidance and distress alleviation, yet their external focus may leave their self worth resting on achieving sociocultural ideals (Cole-Detke & Kobak, 1996).

Alternatively, ED symptoms may promote caregiver proximity whereby dysfunctional behaviours enhance and sustain caregiver interest in an attempt to complete a disturbed separation/individuation process (Orzolek-Kronner, 2002). However it is unknown how early experiences of EI may influence over-activation or under-activation the attachment in specific ED profiles.

The current study explored retrospectively the effect of pre-adolescent and adolescent experiences of EI on the association between
insecure attachment, EI and ED onset. More specifically, the aim was to further delineate the relationship between ED sub-type and insecure attachment sub-type and explore how the experience of childhood invalidation by mothers and fathers relates to the emergence of different EDs. Specifically it was hypothesised that greater levels of attachment anxiety would be associated with bulimia and greater levels of attachment avoidance would be associated with anorexia. While parental invalidation was predicted to be associated with bulimia, anorexia and BED, no specific predictions were made regarding relative severity.

Method

Participants

The sample comprised 144 female participants aged 18-45 ($M = 23.30$, $SD = 6.02$) involving undergraduate students and their associates. Participants completed the following measures:

*Experiences in Close Relationships Revised (ECR-R) scale (Fraley et al., 2000).*

This 36 item questionnaire explores the experience of emotionally intimate relationships, with 18 items measuring attachment anxiety (e.g., “My romantic partner makes me doubt myself”) and 18 items measuring attachment avoidance (e.g. “I prefer not to show a partner how I feel deep
down). Items are rated on a seven point scale (1 = strongly disagree, 7 = strongly agree), and the scale has been demonstrated to psychometrically sound (Brennan et al., 1998).

*Eating Attitudes Test (EAT-26) (Garner et al., 1982).*

This 26 item self-report measure involves participants computing body mass index (BMI) and then answering questions exploring attitudes to eating that reflect three subscales (diet, bulimia/food pre-occupation and oral control). Items are rated on a six point Likert scale (1 = never; 6 = always), with scores of 20 or above indicative of a substantial concern around diet, weight and problematic eating patterns (Garner et al.). A further five items concerning the presence of eating disordered behaviours (such as extreme weight loss and vomiting) over the past six months are also rated on a six point Likert scale (1 = never; 3 = 2-3 times per month, 6 = once or more per day) are also included. The EAT-26 is a widely used screening tool for ED symptoms (insert refs)

*The Invalidating Childhood Experiences Scale (ICES) (Mountford et al., 2007)*

This 18 item measure exploring experiences of EI with each parent prior to age 18. Only the first 14 items were included as the final four relate to family functioning styles and are not directly relevant to the current
study. Each item was rated on a five point scale (1 = never; 5 = all of the time).

**Results**

*Assignment to eating disorder/normal groups using cluster analysis*

A cluster analysis was performed to establish groups that presented different levels and styles of ED symptoms. The variables used included BMI, the EAT26 Diet subscale, the EAT26 Bulimia subscale, the EAT26 Oral subscale, the five supplementary questions of the EAT 26 scale pertaining to eating binges, intentional vomiting, pill consumption (laxatives, diuretics, diet), exercising more than 60 minutes per day and having lost more than 20 pounds in the prior six months. Prior to conducting the cluster analysis, each variable was standardised using Z scores to ensure that the different scales used to assess these variables did not bias the clustering process.

A two-step clustering procedure was used, with the initial exploratory hierarchical cluster analysis performed using Ward’s Method, and the squared Euclidean distance to find the most appropriate number of clusters and to define the initial cluster centres (Hair et al, 2006). The dendogram and agglomeration schedule indicated that the six cluster solution was the best, as it produced six distinct groups with clear differences in their specific ED symptoms and patterns. The analysis was
refined through using the centres of each of these clusters as starting points of a simple K means cluster analysis, permitting individual cases to be reassigned to the nearest cluster centre. A 92% correspondence rate was observed when moving from a hierarchical to a K means cluster solution, indicating stability amongst the groups. The standardised ED symptom variables associated with each group are presented in Figure 1. Cluster distinctiveness was explored by comparing the six groups on the clustering variables and EAT-26 total scores with means and standard deviations presented in Table 1. A series of one way ANOVAs explored whether the groups differed significantly on these variables.

The six groups produced present unique profiles of ED symptoms and behaviour as evident in Table 1 and Figure 1. The largest group was Group 1 (n=69) termed the Norm group which showed very low levels of ED symptoms and behaviours, with few participants demonstrating clinical symptoms (EAT26 score ≥ 20), although 10% did fall in the range of pathology. Group 2, termed the Exerciser/Diuretics (E/D) demonstrated a tendency to engage in frequent prolonged exercise and diuretic consumption while reporting relatively normal eating habits. More participants in this group (20%) recorded clinically significant scores on the EAT-26 compared to the norm group, although the majority did not demonstrated disordered eating. Group 3 (N = 26) were identified as Binge Eaters (BED) featuring
Figure 1: Standardised values of eating disorder symptoms across groups

Table 1

*Means and standard deviations for EAT 26 subscales, EAT 26 total scores and BMI*

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<td>15.58b</td>
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<td>22.40a</td>
<td>22.89a</td>
<td>32.36b</td>
<td>20.07a</td>
<td>24.15a</td>
<td>20.99a</td>
<td>27.61</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>(SD)</td>
<td>(3.39)</td>
<td>(2.30)</td>
<td>(6.91)</td>
<td>(1.67)</td>
<td>(3.87)</td>
<td>(1.25)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
higher BMI’s and frequent bingeing, lower oral control and a tendency towards dieting and bulimia. The majority of participants (81%) had EAT-26 scores indicative of a clinical ED. Group 4 (N=14), the Anorexic group (AN) exhibited high dieting and oral control scores and low BMI levels, reflecting anorexia nervosa, with 100% of participants obtaining clinical levels of ED symptoms on the EAT 26. Group 5 (N=11), the Bulimic (BN) group involved higher scores on dieting, bulimia, binges and weight loss and noticeably higher occurrences of vomiting and pill consumption, characteristic of bulimia. All participants obtained EAT-26 scores indicative of a clinical ED. Group 6 (N=4), the extreme Anorexic/Bulimic (AN/BN) group featured participants with extremely high scores on all EAT-26 variables, particularly for weight loss and bulimia and noticeably low scores on BMI. This group was thought to incorporate females experiencing extreme mixed anorexia/bulimia and all obtained EAT-26 scores in the clinical range.

Attachment and maternal and paternal invalidation

Following the cluster analysis a MANOVA, with group membership as the fixed factor and attachment style (anxiety, avoidance) and maternal and paternal ICES score as the dependent variables, was carried out to ascertain differences between groups on attachment and invalidation experiences. Multivariate testing highlighted specific between group differences on these variables (Pillai’s Trace = .358, $F (20,552) = 2.72$, $p <$
Further, follow up univariate ANOVAs and simple planned contrasts were performed to ascertain differences between the Norm and ED groups. The mean and standard deviations for each group and results of these tests are shown in Table 2.

As evident in Table 2, there were a number of differences between insecure attachment and experiences of invalidation amongst the six groups. The E/Ds did not seem troubled by either attachment anxiety or attachment avoidance, although they experienced greater levels of maternal and paternal invalidation compared to the Norm group. The BED group experienced significantly greater attachment anxiety than the Norm group, yet did not experience difficulties with attachment avoidance or report high levels of maternal or paternal invalidation. The AN participants however were both significantly higher on both attachment anxiety and attachment avoidance, and although showing a trend to score higher on maternal and paternal invalidation than the Norm group, the differences were not significant. The BN participants scored significantly higher on attachment anxiety with a non-significant trend to be higher on attachment avoidance than the Norm group. In contrast to the AN group, they had significantly higher scores on both maternal and paternal invalidation compared to the Norm group. Finally, the extreme AN/BN group reported higher scores on both attachment anxiety and avoidance than the Norm group and also
### Table 2

*Means and standard deviations for attachment anxiety, attachment avoidance, maternal ICES and paternal ICES*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1. Norm</th>
<th>2. E/D</th>
<th>3. BED</th>
<th>4. AN</th>
<th>5. BN</th>
<th>6. AN/BN</th>
<th>F (5,138)</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attachment</strong></td>
<td>$M$</td>
<td>58.87</td>
<td>60.90</td>
<td>70.65*</td>
<td>72.21*</td>
<td>74.72*</td>
<td>89.5***</td>
<td>3.20</td>
</tr>
<tr>
<td></td>
<td>(SD)</td>
<td>(19.73)</td>
<td>(23.22)</td>
<td>(24.83)</td>
<td>(25.47)</td>
<td>(26.96)</td>
<td>(23.06)</td>
<td>.104</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td>$M$</td>
<td>50.68</td>
<td>52.75</td>
<td>58.92</td>
<td>63.57*</td>
<td>61.27</td>
<td>80.25**</td>
<td>2.53</td>
</tr>
<tr>
<td></td>
<td>(SD)</td>
<td>(20.55)</td>
<td>(17.78)</td>
<td>(23.45)</td>
<td>(23.49)</td>
<td>(24.50)</td>
<td>(21.94)</td>
<td>.084</td>
</tr>
<tr>
<td><strong>Attachment</strong></td>
<td>$M$</td>
<td>28.52</td>
<td>38.00**</td>
<td>28.85</td>
<td>34.78</td>
<td>37.45*</td>
<td>30.52</td>
<td>2.98</td>
</tr>
<tr>
<td></td>
<td>(SD)</td>
<td>(11.76)</td>
<td>(12.27)</td>
<td>(10.79)</td>
<td>(12.87)</td>
<td>(13.92)</td>
<td>(17.45)</td>
<td>.097</td>
</tr>
<tr>
<td><strong>Maternal ICES</strong></td>
<td>$M$</td>
<td>27.39</td>
<td>35.85*</td>
<td>31.54</td>
<td>31.79</td>
<td>40.82***</td>
<td>54.50***</td>
<td>6.08</td>
</tr>
<tr>
<td></td>
<td>(SD)</td>
<td>(12.02)</td>
<td>(12.14)</td>
<td>(9.84)</td>
<td>(15.95)</td>
<td>(13.88)</td>
<td>(14.84)</td>
<td>.181</td>
</tr>
</tbody>
</table>

* = $p < 0.05$; ** = $p < 0.01$; *** = $p < 0.001$
endorsed significantly greater levels of paternal invalidation than the norm group.

**Discussion**

Overall, results generally confirmed hypotheses that attachment insecurity would differentiate the ED groups from the normal non-ED group. As anticipated, compared to the norm group, bulimia was associated with higher attachment anxiety, as was binge eating. Anorexics experienced significantly greater attachment anxiety and avoidance than normal individuals. However the difference in avoidant scores between anorexics and bulimics was minimal, therefore generating weak support for the hypothesis that anorexics would demonstrate higher avoidance. The small group featuring anorexic and bulimic symptoms were the most extreme and scored more highly on both attachment anxiety and avoidance compared to the norm group. There was strong support for the hypotheses that parental invalidation would be associated with EDs. Bulimics reported significantly greater levels of both maternal and paternal invalidation than normal individuals. Conversely, anorexics did not vary from the normal group on parental invalidation. In the extreme AN/BN group however, high levels of paternal invalidation were evident although maternal invalidation did not differ from the norm group. An unexpected finding was the high levels of parental invalidation in those who engaged in excessive exercise and diuretic use but who did not qualify for anorexia.

*Attachment Anxiety and Attachment Avoidance*

As hypothesised, bulimia was associated with greater attachment anxiety than attachment avoidance, which corresponds with prior researching findings (Salzman, 1997; Suldo & Sandberg, 2000; Troisi et al., 2005). The BED group also experienced greater attachment anxiety in accordance with Pace et al. (2012). The dominance of attachment
anxiety supports existing ideas that bulimia and binge eating emerge in females who have experienced inconsistent caregiver reactions, occasionally feeling understood, attended to and heard yet often feeling ignored and rejected. Such frustrations and dissatisfaction continue in adult relationships (Bartholomew & Horowitz, 1991), culminating in a dependent and coercive interpersonal style (Allen et al., 2005). Therefore EDs may serve to maintain proximity to an attachment figure, and possibly reflect unresolved separation/individuation conflicts (Orzolek-Kronner, 2002). Bulimia and binge eating may help manage intense negative affect (Anestis et al., 2007), concerning sadness, fear and abandonment (Mikulincer & Shaver, 2010) and anger and frustration with inadequate responses from others when more sophisticated ER strategies acquired in a secure dyad have not developed (Allen et al.; 2005, 2008).

While there was partial support for the hypothesis that anorexia would be associated with attachment avoidance, it was also linked with attachment anxiety. The significant relationship between anorexia and attachment avoidance corroborates prior findings (Hochdorf et al., 2005; Latzer et al., 2002; Ward et al., 2001), yet the simultaneous endorsement of attachment anxiety suggests this group was characterised by fearful avoidant attachment. Although an extreme anorexia/bulimia group was not foreseen, they also reported attachment patterns more strongly reminiscent of fearful avoidance. The presence of high attachment anxiety and avoidance in both anorexic and extreme anorexia/bulimia populations is consistent with Troisi et al. (2005), Ringer and Crittenden (2007) Ward et al. and Barone and Guiducci (2009). A coherent strategy for managing affect fails to unfold in fearful avoidant populations consequent to primary attachment figures being a source of safety and danger, leaving individuals immobilised in times of distress. Anorexics often manage and avoid uncomfortable internal states and feelings by restricting food intake (Harrison et al., 2009; Overton et al., 2005), echoing an avoidant attachment style whereby individuals strive
to suppress vulnerable emotions, are fiercely independent and view relationships as unimportant following bids for attachment being consistently met with punishment, rejection and indifference (Bartholomew & Horowitz, 1991). High anxiety and avoidance in anorexics and extreme anorexic/bulimics suggests they have possibly experienced harsh and traumatic parental encounters, highly unstable and contradictory parenting, or carry an important unresolved loss potentially concerning abuse or trauma. The absence of a coherent attachment style may lead to individuals switching between using a deactivating (avoidant) and a hyperactivating (anxious) strategy depending on the availability of attachment figures and the level of conscious distress (Allen et al., 2005). Overall, findings indicate insecure attachment styles as frequently co-occurring with ED symptoms, with greater disease severity associated with more extreme attachment insecurity, culminating in the presentation of a fearful avoidant pattern encompassing anxiety and avoidance.

Paternal and Maternal Invalidation

As hypothesised, bulimic symptoms were associated with higher levels of maternal and paternal EI during childhood and adolescence. This partially supports the findings of Haslam et al. (2008), who noted invalidation was associated with excessive exercise in bulimic but not anorexic or binge eating participants. While Haslam et al. only found evidence of paternal invalidation in bulimics, the current study demonstrated bulimics experiencing both maternal and paternal EI. Although Haslam et al. (2012) observed a relationship between childhood maternal EI and ED symptoms, specific ED profiles were not explored. However, maternal and paternal rejection, which is arguably synonymous with EI, has been observed in bulimic populations (Tereno et al., 2008).

Similar to Haslam et al. (2008), the current study observed BED and anorexia were not associated with parental invalidation, however extreme anorexic/bulimics reported high
levels of paternal invalidation. It appears EI specifically influences the development of bulimia, particularly when transpiring between fathers and daughters (Haslam et al.), and may lead daughters to experience anxiety about their level of acceptance, worth and desirability by the opposite sex which is a natural concern during adolescence. Bulimia may help manage relational anxiety, shame and intense affect and neediness emerging from invalidating experiences particularly when adolescents are adjusting to their sexuality and an emerging sexual body (Leahy et al., 2011; Wiederman et al., 1996).

The E/D group typified by frequent exercise and diuretic consumption was an unexpected discovery. Individuals in this group did not endorse attachment insecurity but did endorse frequent paternal and maternal invalidation. This suggests that damaging EI may occur within a secure parental bond and may reflect warm caregivers who are sporadically critical and demanding in the standards expected of their daughters, reminiscent of the perfect family environment proposed by Linehan (1993). Interestingly, this group recorded the highest level of maternal invalidation, suggesting the mother imposes high standard for her daughter who in turn may use exercise and diuretics to attain maternally sanctioned expectations concerning appearance (Francis & Birch, 2005).

However, parental EI during childhood and adolescence appeared unrelated to anorexia. This possibly relates to anorexics frequently utilising emotional inhibition strategies. The absence of parental emotional support, implied by the insecure attachment styles this group endorsed, can foster emotional inhibition (Coggins & Fox, 2009), whereby conscious efforts arise to suppress psychological and physical awareness of emotional experiences and prohibit emotional disclosure. This has been repeatedly identified in anorexic groups (Espeset et al., 2012; Fox, 2009). One who relies on emotional inhibition in childhood and adolescence may experience far less EI because they rarely contemplate, or communicate directly about, their own feelings. This propensity also reflects an avoidant attachment style
whereby emotions remain undiscussed, and the repeated observations of alexithymia in anorexic individuals (Quinton & Wagner, 2005; Sperenza et al., 2005).

The anorexic/bulimic group recorded high levels of paternal invalidation, which in corroboration with the observed elevations in attachment anxiety and avoidance, suggest such individuals have grown up in a chaotic and unpredictable family environment comprising an overbearing, controlling and possibly violent or abusive male figure. While the current study did not specifically explore emotional abuse, Waller et al. (2007) contend EI, which is a fundamental aspect of emotional abuse, is critical in the development of EDs, which results of the current study seem to partially verify. If Waller et al.’s assertions are correct, then the current study provides further support for Kennedy et al. (2007) and Kugu et al. (2006) who both cited a high prevalence of emotional abuse in their ED participants, which supports Kent et al.’s (1999) claim that emotional abuse is an important predictor of EDs. Furthermore trends pertaining to invalidation in the current study are consistent with Bardone-Cone et al. (2008) who found a strong history of both emotional abuse and neglect amongst anorexic/bulimics.

The current findings offer useful clinical information in working with specific ED populations. Anorexics appear prone to chronic emotional suppression typical of those with avoidant attachment styles given their lack of early EI with their parents. These individuals require assistance in relaxing defenses to encounter and express affects that may have generated parental rejection, punishment or alienation (Slade, 1999) so as to facilitate greater emotional intimacy (Teyber & Holmes-McClure, 2011). Conversely bulimics who typically experience relational anxiety require assistance managing and learning to symbolise intense affect in context of a firm yet empathic therapeutic alliance (Daly & Mallinckrodt, 2009; Slade; Wallin, 2007). Finally anorexia/bulimia seemingly emerges following traumatic and frightening caregiver experiences and they hence require a carefully constructed therapeutic
alliance, assistance in remedying defences causing relational instability including splitting and dissociation (Liotti, 2004) and promoting affect regulation, reflective functioning and resolving trauma narratives (Slade). More broadly, it appears troubled father-daughter relationships are an important feature in females with more extreme EDs, although maternal EI was strongly implicated in bulimia and E/D. Thus educating parents, particularly fathers, about effective communication and emotional management skills is warranted with child and adolescent ED clients (Haslam et al., 2008; Jones et al., 2006).

While the current findings indicate differential patterns of EI and attachment anxiety and avoidance are associated with various types of EDs, findings are qualified given the five ED groups had small numbers, limiting the reliability and certainty of the pattern of results obtained. As EDs often co-exist with other psychopathology including depression (Corcos et al., 2000), anxiety (Swinbourne & Touyz, 2007) and borderline personality disorder (Lieb et al., 2004), these factors need to be controlled in future replications. Future studies also need to confirm the group categorisation of EDs with individual interviews by a qualified clinician. Attachment styles and parental EI may also be corroborated through AAI interviews with a subsample of participants from each ED profile. Given the apparent differential influence of paternal EI on the emergence of more extreme AN/BN patterns and the impact of paternal and maternal EI for BN and E/D, and the lack of association between AN and EI, more detailed parental interviews concerning emotion management are warranted.

In conclusion, bulimia and BED relate to more anxious attachment while anorexia and particularly anorexia/bulimia reflect fearful attachment styles. Differential patterns of EI highlight the role of paternal EI in more extreme AN/BN and the role of paternal and maternal EI in the development of BN and excessive exercise and diuretic use. Overall, findings emphasise that early emotional experiences and detrimental emotional management
by parents during childhood and adolescence generates an increased likelihood of EDs emerging in adulthood.

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Understanding the Root Cause of Eating Disorders and Applying the Principles of Functional Behaviour Assessment in a Clinical Setting

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Paper presented at the

Australian & New Zealand Eating Disorders and Obesity Conference

Surfers Paradise, Gold Coast (QLD, Australia), 18-19 May 2015
Understanding the Root Cause of Eating Disorders and Applying the Principles of Functional Behaviour Assessment in a Clinical Setting

**ABSTRACT:** Treatment of any unwanted behaviour, in particular, those behaviours related to eating disorders such as anorexia, bulimia and obesity is frequently based on a model of attempting to change behaviour, without first understanding the root cause for the behaviour. With this approach, the treatment offered is intermittently successful, appearing to work for some and not others, with relapse occurring frequently. This paper introduces the application of foundational principles of Functional Behaviour Assessment as a means of practically assessing the reasons for a person’s behaviour. From this perspective, we are able to gain an in-depth understanding of ‘why the unwanted behaviours are being used’ and base the treatment plan on the outcomes of this assessment. Tanya Curtis from Fabic has taken the previous complex and thus often inaccessible principles of Functional Behaviour Assessment and created three simple practical steps that when applied create a template for understanding and changing behaviour. When applied in the clinical setting, these principles are resulting in long-term behaviour change for clients using any unwanted behaviours including those exhibiting unwanted and harmful eating patterns, thus meeting the criteria for eating disorders such as anorexia, bulimia and/or obesity.

**Keywords:** eating disorders; Functional Behaviour Assessment; anorexia; bulimia; obesity

**Introduction**

Despite eating disorders including anorexia, bulimia and obesity being prevalent for many hundreds of years, with research and funding consistently increasing in the areas of treating eating disorders, it is difficult to make sense of the fact that the number of people with eating disorders is consistently increasing. This paper explores introducing Functional Behaviour Assessment as a way of assessing and then treating unwanted behaviour based on first understanding the reason for the unwanted behaviours and then changing behaviour based on a skills building approach. Senior Behaviour Specialist, Tanya Curtis, bases this approach on the Fabic Three-3-Step Process to Behaviour Change that she has developed and derived from the principles of Functional Behaviour Assessment. These three steps of (1) Body, (2) Life and (3) Skills are used at Fabic Multi-Disciplinary Behaviour Specialist Clinic (Gold Coast, Australia) with clients who use unwanted behaviours of a high or low intensity.
and whom may have received formal diagnosis including anorexia nervosa, bulimia and/or obesity.

**About Functional Behaviour Assessment**

Functional Behaviour Assessment was first discussed in the literature by B.F. Skinner in the 1950’s (Skinner, 1953) and has since been referred to by numerous authors in various ways (Carr & Durand, 1985; Iwata, 1994; Repp & Horner, 1999; Bullock & Gable, 1999; Edwards, Magee, & Ellis 2002). Functional Behaviour Assessment is the process used to identify the events that reliably predict and maintain a target behaviour (March & Horner, 2002). Functional Behaviour Assessment is also known as *Functional Assessment* and incorrectly referred to as *Functional Analysis*, however it is important to note that theoretically Functional Behaviour Assessment is a preliminary step of the more comprehensive and clinical Functional Analysis (Bullock & Gable, 1999). Traditionally, Functional Behaviour Assessments have been used with high-intensity unwanted behaviours and more frequently used for those with a diagnosed developmental delay or behavioural disorder such as intellectual impairments or autism spectrum disorder. Minimal literature is found discussing the use of Functional Behaviour Assessment with eating disorders, however Farmer and Latner discuss eating disorders in the book *Functional Analysis in Clinical Treatment* (p. 379 to 402, 2007). Although an in-depth traditional Functional Behaviour Assessment, when conducted is very effective, is also time consuming and thus often inaccessible to be used universally.

The Fabic 3-Step Process to Behaviour Change (i.e., Step 1: Body; Step 2: Life and Step 3: Skills) simplifies the complex steps of Functional Assessment to make accessible the principles of this assessment to all, yet are still based on the founding principle of knowing that every unwanted behaviour is happening for a reason. The Fabic 3-Step Process is based on the premise that what the behaviour looks like (i.e., the form of the behaviour) is not important, however, what is fundamental is identifying the reason for the behaviour (i.e., the function). The Fabic 3-Step Process to Behaviour Change will be discussed in more detail in this paper, yet first a person-centred process must be introduced as a means of communicating and building rapport with the client and addressing their needs.
Client communication: meeting clients for who they are and not what they do

Behaviour is not who you are, it is what you do

Too frequently in today’s society, people who have a diagnosis and/or use unwanted behaviours, become identified by, or are identified by their label or behaviours. This identification stems from a basis of judgment where a label or behaviour is judged to be less than another, wrong, inferior or negative in some way. Judgment and understanding cannot exist together! As soon as one judges any person’s label or behaviour to be negative, they simply close the door on understanding the root cause of the unwanted behaviours. It is imperative to understand that judgment of self or another negatively impacts one’s self-esteem, psychological wellbeing and mental health status.

In fact, all behaviours (wanted or unwanted) are simply a form of communication. Communication is not limited to the words that do or do not come from a person’s mouth, yet all behaviours used send a message. The Fabric process of gaining an understanding of the reason for that unwanted behaviour is to never judge any behaviour to be wrong, yet simply ask “I wonder why that behaviour is happening”?

People are not their labels and are not their behaviours

That said, diagnosis that come with a label could serve a purpose. Labels can provide: a description of the behaviours a person is using; a description of certain characteristics; access to a level of understanding and in some situations labels provide access to funding and certain treatment options that will support the individual’s ongoing development. However, a label in of itself will never change a person’s behaviour. A label is simply a description of behaviours and characteristics but does not define who a person is! Labels are often misinterpreted and frequently judged! With judgment we can lose sight of the person behind the label as we simply judge certain behaviours to be wrong. Thus, treatment is often based on the premise that that behaviour is wrong and must simply be changed to a replacement behaviour that is considered right, desired or wanted.

The Fabric methodology is based on the fundamental principle that a person is not their behaviour and not their label. Image 1 below shows a chart used by Fabric clinicians as a means of communicating with their clients. Sometimes the chart is used visually with their clients and other times the language is simply introduced to clients.
The language of the chart in Image 1 is based on first knowing that at the core of every individual is an awesome, amazing and loveable being. Using this language in the clinical setting draws attention to the fact that we are all ‘human beings’ and not ‘human doings’, thus our being and our doing are two separate factors. Our being is our essence and that has, is and will always be the same no matter what behaviours we actually ‘do’! Our essence, at the core is one of an awesome, amazing, loveable being no matter how unwanted and inexcusable the behaviours are that we choose! This language lays a foundation of building rapport and trust as it allows the clients to feel seen for who they are and not what they do. The language extends to sharing with clients that ‘what they do’ will never be judged, rather, it is understood that these behaviours are simply a coping strategy that they have used in response to an aspect of life they do not feel completely equipped to respond to, albeit a behaviour that is considered unwanted and self-harming. Clients with anorexia, bulimia or obesity are taught that their eating behaviours maybe unwanted but these behaviours are not to be judged rather understood. Clients are taught that presently their behaviours associated with anorexia, bulimia and obesity are the existing skills they have in their repertoire to respond to the challenges life has presented to them. Clients are reminded that this language is not to excuse the unwanted behaviours, rather provides opportunity for understanding as to why these behaviours have been in their repertoire without judging their behaviours negatively.
The language accompanying Image 1, when used in depth, highlights that in today’s society many people become identified by or are identified by what they do. That is, we judge the ‘doing’ as we have lost site of the ‘being’. This is extremely harmful to society as a whole. For example, we have people identified by perceived unwanted behaviours that are associated with an eating disorder and thus are identified/labeled as ‘the person with anorexia, bulimia or obesity’. We stop seeing people for who they are at their essence and see them through the eyes of their eating disorder. The truth is, at the core of every person, there is an awesome amazing, loveable being, who has lost site of their being and thus the identification becomes about by what they do (or have done). Another example is a person who is called an alcoholic, a person who at the core has a beautiful essence yet is so deeply hurt and has not yet developed the skills to truly heal their hurts and thus engages in the doing of ‘drinking’ to mask their hurt. Some theories suggest that the act of drinking is an illness and a person will never recover, and thus, will always be an alcoholic. The author of this paper has met people in the clinical setting who attend support groups for alcoholics and stand up at the meeting and say ‘my name is XXXX. I am an alcoholic and I am 24 years sober’. This is a person who has and is identified by their ‘doing’ and lost sight of their ‘being’. In truth, there is in awesome amazing, loveable being who used to drink, but now no longer drinks, not a person who needs to carry a life-time sentence of this label which comes with the judgment based on what they used to do! The examples of unwanted behaviours and labels that society judge without understanding is endless, some examples include: ‘the naughty child’; ‘the bad parent,’ ‘the slack employee’; ‘the thief’; ‘the person with Asperger’s and ADHD’, ‘the angry, rude, aggressive, depressed, anxious, sad person’. The fact is, these are all simply a description of the person’s doing and is excluding awareness of the beautiful being, thus creating a deep hurt triggered by rejection.

The examples above share the harm that is associated with becoming identified by ‘unwanted behaviours’. However equally, if not more harming is when we become identified by the desired behaviours shown in Image 1. Examples include when people are identified as playing a particular role very well. For example playing the role of a: ‘straight-A student’; ‘good mother’, ‘perfect person’, ‘beautiful-looking woman’, ‘good provider’, ‘popular student’, ‘likeable person’, ‘person who has it all together’ etcetera. This possible list is endless, yet extremely harming when identifying people or self by any of these roles. For example, what happens to a person’s anxiety levels when they are identified by being a straight A student and then they get a B grade, or to the parent who is identified by being a ‘good parent and their child has a tantrum in public, or the person who is identified as being
the ‘perfect person’ and something about them is exposed for not being perfect? Answer: their anxiety levels increase and thus use of unwanted behaviours are escalated.

Image 1 simply introduces a language that is firstly sharing that at the core we are all already amazing and this is not founded in anyway based on what we do, have done or will do in the future. Sometimes people will use behaviours that are wanted and other times they will use behaviours that are unwanted. We will do this because we are human and humans are not perfect in their doing, but rather we are perfect in our being. At Fabic, clients are further introduced to the concept that their core essence can never change no matter what they do, but what they do, the behaviours used, can be changed when a person chooses to learn how. This language removes judgment, increases acceptance and allows a person to be ready to explore and take responsibility for the Fabic 3-Step Process to Behaviour Change.

Fabric 3-Step Process to Behaviour Change - (1) Body, (2) Life, (3) Skills

The steps of Functional Behaviour Assessment are often complex, time-consuming and thus not practical to use on a daily basis. The Fabic 3-Step Process to Behaviour Change as developed by the author and based on Step 1: Body, Step 2: Life and Step 3: Skills, simplifies the process of Functional Behaviour Assessment to make practical and thus accessible the principles of Functional Behaviour Assessment in a clinical setting. The crucial element drawn from Functional Behaviour Assessment is that we must understand the root cause of behaviour prior to developing and implementing behaviour change strategies. This 3-step model to behaviour change is based on: firstly knowing that all behaviour is a form of communication and must not be judged rather understood; secondly on identifying the reason for the unwanted behaviour, and thirdly developing skills building behavioural strategies resulting in lasting behavioural change.

Too frequently in today’s society, we hold the belief that unwanted behaviours must simply be changed. When we approach behaviour change from this perspective, behaviour change will only ever be short-lived. However, if we apply the understanding that all unwanted behaviour is preceded by anxiety, we will come to understand that we must develop a relationship with understanding anxiety and how it is experienced by any person who is ready to change their own unwanted behaviour patterns.

At Fabic, anxiety is understood to occur when a person is presented with any aspect of life they perceive they do not have the required skills to respond to. This could be that
they find an aspect of life difficult, challenging, uncomfortable, unwanted or disliked in some aspect. The words, *they do not perceive they have the skills to respond to*, is important to highlight here. We all have natural strengths, weaknesses and perceptions of life. When attempting to understand how one person is experiencing life, we must be open to understanding that their perception of *how they are perceiving life* in comparison to *the way we think they are experiencing life* maybe very different. To gain a true understanding of the reasons for unwanted behaviour we are interested in how the client themselves perceive their experience of life. For example: if the client perceives their experience of life to be one they feel equipped to respond to it is likely their wanted behaviours will be predominant, whereas if they perceive their experience of life to be one they do not feel equipped to respond to, there will be an increase in use of unwanted behaviours.

Unwanted behaviours (*Step 1: Body*) occur when the client is presented with an aspect of life (*Step 2*) that they do not perceive they have the required skills (*Step 3*) to respond to. Therefore, changing our unwanted behaviours (*Step 1: Body*) requires developing new wanted skills (*Step 3*) to respond to whatever life (*Step 2*) presents. The outcome being, clients develop self-responsibility to self-master aspects of life that have previously triggered the unwanted behaviour and thus are self-empowered to heal themselves. The following text will explore these three steps in more detail.

*Step 1: Body*

From our body come all of all our behaviours; this includes our wanted behaviours, low-intensity unwanted behaviours and our high-intensity unwanted behaviours. Simply put, everything we do, think, say and feel comes from our body. Our body is a form of communication, telling us how we are experiencing life. When our body is using wanted behaviours, it is understood that we are experiencing life in a way that we feel equipped to respond to. When we are using any form of unwanted behaviours (i.e., low, medium or high intensity unwanted behaviours including the smallest of reactions), it is understood there is an aspect of life presented that we do not feel equipped to respond to. What comes from our body including ALL unwanted behaviours and reactions must not be judged, rather needs to be understood. Those with an eating disorder including anorexia, bulimia or obesity are using a selection of unwanted behaviours associated with this disorder (e.g., refusing to eat, over-eating, over-exercising, under-exercising, obsessing over calorie intake and outtake, purging after eating etc.).
Any unwanted behaviour is simply a person’s way of communicating that they are experiencing life to be negative, uncomfortable and/or challenging in some way. Our question to ask when unwanted behaviours are being used is “I wonder what aspect of life that that person is finding negative?” As supporters of any person using an unwanted behaviour, including one experiencing an eating disorder, it is important to approach the unwanted behaviour not from a perspective of “that behaviour must change” rather from a perspective of “let me understand why that behaviour is happening”. As discussed previously, unwanted behaviours are simply communicating that a person is experiencing a form of anxiety as a result of being presented with an aspect of life (Step 2) that they do not feel like they have the required skills (Step 3) to respond to. Our only question need be “what is the part of life that person is perceiving some loss of control over?”

Step 2: Life

Life is happening around us all day, every day. People are always participating in life and we can never be absent of being in life while we are alive. A person may be hiding in a secluded cave and appearing not to be part of society, however despite this, they are still experiencing life whilst away from society! The fact is, we are never not experiencing life. We have a life that has happened before now (our past) and life that is now (our present) and life in front of us (our future). Sometimes we feel like we have the required skills to respond to what life has or will be presented to us and other times we do not feel equipped to respond to life.

Throughout our life we experience many hurts. Our hurts may include: feeling rejected by parents, grandparents, siblings, family members, friends, teachers, others; not being seen for the awesome, amazing, loveable being that we innately are; being judged for any of our behaviour choices; not feeling good enough or worthy; knowing our parents or loved one argue and are not loving towards each other; loss of a loved one be that relative, friend, celebrity or pet; not feeling included in a certain group etc. The simplicity is that our hurts are experienced any time we have created a picture about the way life (including ourselves and other people) should be and that picture does not happen according the image we had created. Our pictures are easily defined as our shoulds, wants, expectations and our needs of the way we anticipate life will be. When any of these pictures do not occur according to our image we have what we call a ‘smashed picture’. These smashed pictures are life’s triggers to our hurts and precede the use of any unwanted behaviours (Step 1). Examples of smashed pictures include: family members arguing; friends being mean to each
other; making mistakes or receiving corrections; not getting the anticipated grades; a teacher responding negatively to their student; relationship tension or breakdown; another person not doing what I expected them to do; death of a loved one etc. The reality is the list of possible smashed pictures is unique and potentially endless for each individual. Each smashed picture is another hurt and/or challenge experienced by a person in life. It is these hurts and aspects of life that people do not often feel like they have the skills to respond to and thus predict the use of unwanted behaviours. The unwanted behaviours are frequently used in an attempt to control life to be according to the way the client perceives life should be – according to their created picture! These controlling and unwanted behaviours are simply the person’s coping strategies to respond to what life has presented. Thus, changing unwanted behaviours is simply about teaching a person new skills (i.e., wanted replacement behaviours) based on understanding the root cause of the behaviour that is unique to each user.

*Step 3 - Skills*

As taught at Fabic, embracing self-responsibility is the only way to change our experience of life to be one that we perceive as a more positive experience for ourselves, and thus others. Self-responsibility is based on knowing that the only way to change our experience of life is to learn new skills (wanted behaviours) to respond to whatever life is presenting. However, society is failing many, as we live in a way expecting people to have self-mastered many aspects of life, yet we don’t embrace that skills need to be taught and not expected. When an unwanted behaviour is observed, it is often observed with judgment of they should not be using that behaviour, rather than the antidote of “I wonder what new skills are required here?” Our school curriculum supports skills development in many areas, yet it is does not teach us to deal with other aspects of life such as rejection, death, loss, imperfection, conflict, social challenges, raised voices, losing, making mistakes, feedback from others, judgment and jealousy from others, any unwanted behaviours used by other people etc. Note: this is not to assert that schools should be teaching this, but a statement that many life-skills are expected to be gained automatically, rather than embracing the concept that skills to respond to life and to our smashed pictures need to be taught and not expected.

It is commonly understood at Fabic that once a person has learnt the required skills (wanted behaviours) to respond to life, they then have a choice as to which behaviour they will choose (i.e., their old unwanted behaviour or their new wanted behaviour). However, without being taught the required skill, there is minimal choice as the client only has the behaviours prevalent in their existing behavioural repertoire (i.e., often the unwanted
behaviours) to use when life presents any challenges. This is not an excuse or judgment by any means, but rather offering a deeper understanding of the client and their behaviours. When a client chooses to take responsibility for learning the skills to respond to life, then they will change their own experience of life to be one they feel more equipped to respond to.

**Summary**

Our societal roles have the potential to be all the same. We all have the potential to be constant ‘students of life’ and constant ‘teachers of life’. Life will continue to happen to us all; this we cannot escape. When any human being is observed to be using any unwanted behaviours rather than judging that behaviour to be wrong, we could simply state:

1. **Body**
   This unwanted behaviour is a form of communication. What is this person attempting to communicate?

2. **Life**
   I wonder what is challenging for that person in their life (past, present or anticipating their future) that is resulting in them using this unwanted behaviour? I wonder what part of life they do not feel like they have the skills to respond to?

3. **Skills**
   What skills (wanted behaviours) if taught would provide that person with the opportunity to develop the required skills to respond to life in a way that results in a positive experience for them?

When applied, these three simple steps have the potential to change any person’s unwanted behaviours. These steps have been used to successfully teach clients with varying labels, including but not limited to, anorexia, bulimia and obesity to change their own experience of life including ridding themselves of the unwanted behaviours associated with eating disorders.
REFERENCE LIST


Managing Complexity and Comorbidity in Group Therapy: Observations from RPAH Eating Disorders Day Program

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Paper Presented at the Australian & New Zealand Eating Disorders and Obesity Conference
Surfers Paradise, Gold Coast (QLD), 18-19 May 2015.

Acknowledgements: The writers of this paper thank the contributions of those who have established the Peter Beumont Day Program and set up the research processes including: Dr Susan Hart, Ms Sarah Horsfield, Dr Janice Russell, Mr Chris Thornton, Dr Sarah Maguire, Ms Brooke Donnelly, Ms Angela Thomas, Ms Caitlin McMaster, and Ms Jessica Wheatley.
Managing Complexity and Comorbidity in Group Therapy: Observations from RPAH Eating Disorders Day Program

ABSTRACT: Royal Prince Alfred Hospital’s Peter Beumont Eating Disorders Day Program opened its doors to patients in 2010 as a pilot program. It has now operated for 5 years and seen 157 patients (29 of these having more than one admission). Patients have mixed presentations of anorexia, bulimia and binge eating disorder, so that in the same therapy group there may be someone very underweight and someone very overweight. Some have trauma histories, chaotic lives and features of borderline personality disorder, while others present with clinical perfectionism, rigidity and obsessive compulsive behaviour. They have individually tailored programs and different treatment targets, yet they are treated as a group. This presentation provides an overview of service provision, including an outline of how therapy is provided and preliminary outcome data both at discharge and 6 and 12 month follow up. Observations are made about ways to sensitively and effectively address the challenges implicit in providing an eating disorder recovery program in a group context when patients’ symptoms and needs may be very different. The use of non negotiables, treatment contracts and specific techniques and case examples from DBT and CBT-E are presented.

Keywords: Eating disorders, day program treatment, group therapy, comorbidity, trauma

Introduction

The treating team at the Peter Beumont Eating Disorders Day Program (PBDP) of Royal Prince Alfred Hospital have provided an intensive outpatient recovery program to more than 157 individuals suffering from anorexia (AN), bulimia (BN) and other specified feeding and eating disorders (OSFED) over the last 5 years. It is an effective, evidence-based program leading to significant reduction of eating disorder (ED) symptoms in patients. Research and data collection within the program has focused on documentation of ED symptoms over the period of admission, discharge, and follow up.

Anecdotally, it would seem that many program patients had some form of trauma or abuse in their past, had other axis I disorders such as anxiety and depression, and very many engaged, or had in the past engaged, in a range of self- harming behaviour apart from ED symptoms. In team discussions and supervision, the question of whether the ED was the patient’s primary problem became important to treatment planning. Whilst the same treatment package is offered to all, patient diversity requires a tailored approach, where different emphases are placed depending on symptomatology, non-ED features, and one’s stage in recovery.
This paper begins by describing treatment provision at PBDP, and highlighting recent research findings on EDs, childhood trauma and comorbid problems. It will then outline outcome data from patients having attended the PBDP, and go on to describe a treatment approach taken at PBDP based on collaborative case formulation and tailoring treatment to individuals within a group therapy context.

**The Peter Beumont Day Program (PBDP)**

The PBDP is a recovery program for up to 8 patients run by a multidisciplinary team, consisting of dietitians, psychologists, occupational therapists and a research assistant. It is designed for individuals who are motivated to recover and in need of more support than weekly psychotherapy. It provides three supervised meals a day over four days per week.

The majority of therapy is provided in a group context. The anchor of therapy is support around behaviour change and eating to a tailored meal plan. Therapy is based on Fairburn’s Cognitive Behaviour Therapy- Enhanced (CBT-E) (2008) and on Linehans’s Dialectical Behaviour Therapy (DBT) (1993) with an emphasis on challenging the over-evaluation of weight and shape, planning and debriefing meal experiences, distress tolerance, mindfulness and emotion regulation.

Patients collaborate with the treatment team to develop and sign a treatment agreement, and this includes agreeing to the implementation of ‘treatment non negotiables’ around not losing weight, complying with the meal plan, and working within the group context. There are consequences of non-compliance to the treatment agreement, in the way of ‘red flags’ and a brief step out period. Vanderlinden and Vanderereycken (1997), who are well known for the treatment of eating disorders comorbid with trauma, indicate that symptom reduction and stabilisation should always be the first point of focus. In parallel to this, at the PBDP goals are mostly set around weight management and symptom reduction, with a view to trauma work taking place with the patient’s individual therapist as and if appropriate at a later point in time.
Eating Disorders and Comorbidity

The literature suggests that comorbid problems including mood, anxiety, personality and substance use disorders are highly prevalent across EDs (Blinder, B.J et al, 2006), and that higher levels of comorbidity tend to be associated with trauma experiences among sufferers (Brewerton, T.D, 2007).

According to Anderson (2013:183), “identification and treatment of PTSD is a package deal in treating patients with EDs”. Trauma and comorbid problems are widely documented in ED treatment, and varied prevalence statistics show that 18-85% of individuals suffering from EDs also present with trauma (Ackard and Brewerton, 2010; Brewerton 2005; Briere, J & Scott, C, 2007; Connors, 2001; Corstorphine et al, 2007; Vanderlinden & Vanderereycken, 1997; Wonderlich et al. 1997).

A recent study (Tagay, S et al, 2014) of 103 patients with AN and BN found that 23.1% of AN and 25.5% of BN patients met criteria for Post-Traumatic Stress Disorder (PTSD). Cumulative traumatization led to more severe symptomatology. A study of 135 women by Eunice Chen (2009) found a significant co-occurrence of Borderline Personality Disorder (BPD) with EDs. BN symptoms were associated with a significantly greater risk of recurrent suicidality while AN was associated with increased risk of recurrent non-suicidal self-injury. BPD with AN or Binge Eating Disorder (BED) was associated with a higher number of non-ED Axis I disorders. Another study comparing treatment experiences of individuals with an ED and comorbid BPD to those with an ED and no comorbid BPD (Ben Porath et al, 2009) found that those comorbidly diagnosed presented with higher levels of distress and psychological disturbance. With respect to affect regulation, results indicated that at the beginning of treatment, eating disordered individuals who carried a comorbid diagnosis of BPD were significantly less able to regulate affect than patients without a comorbid borderline diagnosis. When treated using an approach informed by DBT there was no statistically significant difference in affect regulation between the two groups at the end of treatment.

Research findings suggest that different symptom profiles correlate with different traumatic experiences. For example in a study by Jaite (2011), a link was found between reported childhood emotional abuse and ED symptoms, but only with AN Binge/Purge (B/P) subtype and not with AN Restricting (R) subtype. A study by Bardone-Cone (2008) found those individuals with BN and a history of AN reported higher incidences of childhood
maltreatment and neglect as well as greater severity of purging and restriction symptoms. Further, a study by Allison et al (2007) found higher rates of childhood abuse and neglect amongst sufferers of BED and Night Eating Syndrome (NES) compared with overweight/obese individuals. A study of 2436 inpatients over 5 years (Blinder et al, 2006), found extremely high comorbidity regardless of ED, ubiquitous depression across all EDs, no difference in overall rate of anxiety disorders across EDs, greater PTSD in B/P AN, more psychotic diagnoses in AN, more obsessive-compulsive disorder in AN; more substance use in BN; and a replicated comorbidity rank-ordering for ED patients: mood, anxiety, and substance use disorders, respectively.

A full review of the complexity of ED presentations is beyond the scope of this paper. Suffice to say that EDs are multifaceted problems, and are often the ‘tip of the iceberg’ of the patients’ experience. While the prevalence data suggests that therapists are likely to experience traumatised ED patients at a high rate, there is also a considerable range in prevalence data, suggesting that is important not to assume, or presume the likelihood of abuse or traumatic experiences is all individuals with EDs. These findings indicate the need to adopt a tailored approach when considering treatment.

Description of Program and Patients

The PBDP received 157 admissions from its inception in 2010 until the end of 2014. Across this span of time, there were 116 different cases, with 29 experiencing more than one admission. All but one of these cases has been female. The average age at admission was 25 (SD=6.34), and the patients ages ranged from 17 to 57.

The minimum recommended length of stay in the program is four weeks of four-day treatment, which measures to 3.43 numerical weeks. The average length of stay across these patients was 6.19 weeks, with stays ranging from 0 (those who dropped out immediately) to 34.86 weeks.

The PBDP deals with a range of EDs, however given that the criteria for admission requires patients to demonstrate a BMI of 16 or above, this limits the presentation of acute AN. The table below represents the average weight and BMI at admission according to DSM IV diagnoses.
As discussed, a range of comorbidities are dealt with throughout the program including anxiety disorders, depression and other mood issues, substance addictions, and personality disorders. These comorbidities are identified through a clinical interview, in collaboration with external treatment professionals, and observed throughout treatment.

Whilst data on Borderline Personality tendencies is now being collected using the McClean Screening Instrument for Borderline Personality Disorder (MSI-BPD; Zanarini, Vujanovic, Parachini, Boulander, Frankenburg, & Hennen, 2003), previously no specific instrument was used to yield data. From the process of clinical judgement described above, it was estimated that 44 of the 116 cases (37.93%) that have come through the program present with borderline personality tendencies such as debilitating impulsivity, frequent self-harm or suicidality, and a sense of identity disturbance.

To this point, we have forgone the use of a specific trauma measure. This makes it hard to quantify trauma presentation at the PBDP, and in future it may be worth exploring the use of a screening tool that does not upset or interfere with the main treatment emphasis.

### Investigating the Effectiveness of the Program

**Methods and Measures**

Consenting patients at the PBDP complete an online battery of questionnaires at admission and discharge, and at 6, 12, and 24 months following discharge. While height and weight data is collected by a clinician whilst in the program, this data is self-reported throughout the follow ups.

PBDP patients are categorised according to their most significant presenting symptom, i.e. ‘Restricting (R)’, or ‘Bingeing/Purging (B/P)’. On this basis they complete
either the Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger et al., 2002) or the B/P equivalent, the Bulimia Nervosa Stages of Change Questionnaire (BNSOCQ; Martinez et al., 2007). Additional data that is currently being collected from all patients include: the Eating Disorders Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008), the Eating Attitudes Test (EAT-26; Garner et al., 1982), and the Eating Disorders Quality of Life scale (EDQOL; Engel et al., 2006).

When investigating the effectiveness of the PBDP, exclusion criteria was applied if patients had not consented to participating in research, if they had intellectual disabilities preventing them from engaging with the research process, if they had completed questionnaires at one time point only, if they were in their second or third trimester of pregnancy, and if patients had terminated treatment prematurely or for some other reason not been able to attend four weeks of 4-day treatment. This left 88 valid admissions (56.05%) across 63 different cases, with 16 individuals experiencing more than one admission.

Of this group, we have follow up data on 34 of the 63 individuals (53.97%). Attrition resulted for several reasons including: genuine drop-out where patients indicated they no longer want to participate in the study, passive drop out where patients no longer responded to email invites to complete the follow up survey, and ongoing data collection where some time points have not yet been reached or patients were readmitted before a follow up point was reached.

Weight and Behaviour Statistics

Weight management is vital for those in the PBDP who present as ‘restrictive’ (N=53) and the average BMI according to timepoint is presented in the Table 2. From the data collected on this group, we can see that there is an increase in BMI from admission to discharge. When investigating these differences through a general linear model (GLM), we can see that when including all timepoints, the overall model is not significant (F=1.786, p=.135), however a contrast between admission and discharge timepoints does show a significant increase of BMI (p=.016).

We can conclude from this that whilst patients approach a normal weight when attending the program, this does not change significantly in follow up. However conclusions from follow up data should be treated with caution due to smaller sample sizes, and self-reported weights.
Table 2. Restricting patients (N=53) average BMI at research timepoints.

Timepoint | Mean BMI | N  | SD  \\
--- | --- | --- | ---
Admission  | 18.96 | 53  | 2.20  \\
Discharge  | 19.93 | 52  | 1.92  \\
6 months   | 19.37 | 22  | 1.39  \\
12 months  | 18.87 | 14  | 2.73  \\
24 months  | 19.79 | 6   | 1.67  \\

Of those who were categorised as presenting with B/P (N=35), there is an improvement in ED behaviours such as bingeing (Table 3) and purging (Table 4). According to data from the EDE-Q (Fairburn & Beglin, 2008) the mean number of reported monthly objective binges reduced from 17.34 at admission to 5.37 at discharge. When investigating this change through a GLM, we can see that this change is significant when comparing admission data to each other timepoint (F=12.762, p=.001), but when investigating further changes in follow up through a difference contrast (e.g. 6 month follow up vs. Treatment average, 12 month follow up vs. previous timepoint averages, etc.) this does not yield a significant result. We can therefore make the conclusion that improvement is mostly seen whilst attending the program, and this change does not significantly differ at follow up points.

Table 3. Reported monthly objective binges according to the EDE-Q (Fairburn & Beglin, 2008) in bingeing/purging patients (N=35).

Timepoint | Objective Monthly Binges | N  | SD  \\
--- | --- | --- | ---
Admission  | 17.34 | 35  | 14.14  \\
Discharge  | 5.37  | 35  | 7.72  \\
6 months   | 13.85 | 13  | 13.91  \\
12 months  | 7.17  | 6   | 7.96  \\
24 months  | 2.50  | 4   | 5.00  \\

We can also see improvement in this group in regards to frequency of monthly purging. At admission, patients reported purging an average 24.12 times per month, which reduced to 8.03 at discharge. When investigating this change in a GLM, the overall model was significant (F=3.014, p=.02) and contrasting discharge to admission was significant (p=.022). Significant differences are not seen in follow up. We can therefore conclude we see the best improvement throughout treatment, however these improvements are not held across follow up. It would, however, be beneficial to investigate these results further whilst controlling for outliers (in follow up a few patients reported purging 100-200 times in one month), and having more follow up results to even out the sample size across timepoints.
Timepoint | Monthly Purging | N  | SD   \\
---|----------------|----|------
Admission | 24.12          | 34 | 28.04
Discharge | 8.03           | 35 | 10.41
6 months  | 23.69          | 13 | 30.48
12 months | 43.50          | 6  | 78.29
24 months | 3.50           | 4  | 4.73

Table 4. Reported monthly purging according to the EDE-Q (Fairburn & Beglin, 2008) in bingeing/purging patients (N=35).

Eating Disorder and Wellness Statistics

When evaluating patient ambivalence and motivation to change, the following improvements throughout treatment were seen. On average, according to the ANSOCQ (Rieger et al., 2002), patients entered the program with a score of 2.9 (SD=.70) and were discharged with a score of 3.5 (SD=.75). This means they moved from the preparation stage to the action stage.

According to the BNSOCQ (Martinez et al., 2007), on average patients entered the program with a score of 3.1 (SD=.61) and were discharged with a score of 3.7 (SD=.67). This again reflects that during treatment the patients had moved from preparation to action. For both groups, and including all timepoints, this yielded a significant GLM model (ANSOCQ, F=4.823, p=.030; BNSOCQ, F=5.235, p=.025).

<table>
<thead>
<tr>
<th>Timepoint</th>
<th>N</th>
<th>ANSOCQ Average</th>
<th>ANSOCQ Stage</th>
<th>N</th>
<th>BNSOCQ Average</th>
<th>BNSOCQ Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>51</td>
<td>2.9 (SD=0.70)</td>
<td>Preparation</td>
<td>34</td>
<td>3.1 (SD=0.62)</td>
<td>Preparation</td>
</tr>
<tr>
<td>Discharge</td>
<td>47</td>
<td>3.5 (SD=0.75)</td>
<td>Action</td>
<td>35</td>
<td>3.9 (SD=0.68)</td>
<td>Action</td>
</tr>
<tr>
<td>6 months</td>
<td>21</td>
<td>3.3 (SD=1.00)</td>
<td>Preparation</td>
<td>14</td>
<td>3.0 (SD=1.01)</td>
<td>Preparation</td>
</tr>
<tr>
<td>12 months</td>
<td>17</td>
<td>2.8 (SD=1.10)</td>
<td>Preparation</td>
<td>5</td>
<td>3.5 (SD=3.51)</td>
<td>Action</td>
</tr>
<tr>
<td>24 months</td>
<td>6</td>
<td>3.5 (SD=1.17)</td>
<td>Action</td>
<td>4</td>
<td>3.9 (SD=1.22)</td>
<td>Action</td>
</tr>
</tbody>
</table>

Table 5. Reported average stage of change according to ANSOCQ (Rieger et al., 2002) and BNSOCQ (Martinez et al. 2007).

Improvements in global ED measures were also seen across treatment and follow up. These results are described in the table below, through a GLM analysis, all significant at the <.001 level. Of interest, a difference contrast data from the EDQOL (Engel et al., 2006) indicates that not only had quality of life improved at discharge, but these improvements continued to be noted when comparing 6-month follow up data to the averaged treatment timepoints (p=.037), and when comparing 24-month follow up data to all previous timepoints (p=.001).
<table>
<thead>
<tr>
<th>Timepoint</th>
<th>N</th>
<th>EDEQ Global (SD)</th>
<th>EAT26 Total (SD)</th>
<th>EDQOL Total (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>87</td>
<td>3.84 (1.44)</td>
<td>36.72 (15.80)</td>
<td>2.05 (0.68)</td>
</tr>
<tr>
<td>Discharge</td>
<td>84</td>
<td>2.75 (1.45)</td>
<td>21.87 (15.94)</td>
<td>1.54 (0.74)</td>
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<tr>
<td>6 months</td>
<td>36</td>
<td>2.95 (1.71)</td>
<td>25.44 (18.71)</td>
<td>1.51 (0.86)</td>
</tr>
<tr>
<td>12 months</td>
<td>23</td>
<td>3.13 (1.65)</td>
<td>27.39 (19.02)</td>
<td>1.59 (0.84)</td>
</tr>
<tr>
<td>24 months</td>
<td>10</td>
<td>1.97 (1.59)</td>
<td>11.40 (15.22)</td>
<td>0.82 (0.77)</td>
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<tr>
<td>Overall model</td>
<td></td>
<td>F=7.577, p=.000</td>
<td>F=11.573, p=.000</td>
<td>F=9.779, p=.000</td>
</tr>
</tbody>
</table>

Table 6. Means and results of EDE-Q (Fairburn & Beglin, 2008) Global Score, EAT-26 (Garner et al., 1982) Total Score, and EDQOL (Engel et al., 2006) Total Score.

Summary of Outcome Results

The outcome data suggests that significant reduction in restriction, bingeing and purging is achieved by patients of the PBDP during treatment. Significant reduction in eating disorder pathology as measured by the EDEQ (Fairburn & Beglin, 2008), EAT26 (Garner et al., 1982) and EDQOL (Engel et al., 2006) is also achieved during treatment, and maintained throughout follow up periods. While a reduction in bingeing appears to be maintained during follow up periods, this is not clear for purging and restriction, due to a high attrition rate at follow up and a small sample size in these groups.

Approaching Complexity: Collaborative Case Formulation

Assessment and Treatment Contract

A collaborative case formulation approach takes on board a consideration of what needs to be addressed first, and whether other symptoms might emerge when ED symptoms are addressed. This process begins at triage. The patient is asked about comorbid difficulties including alcohol and substance use, mood, suicidal and parasuicidal behaviour. Before beginning treatment, the patient meets with the program coordinator. Details of the presenting problems are gathered, and a frank discussion is held around whether the ED is the person’s biggest problem right now. The possibility of a more unmanageable problem emerging upon addressing ED symptoms is discussed, as well as ways to mitigate this. The patient and therapist develop a plan to manage any emergent comorbid problems. Much consideration is given to how and whether this will work, and treatment of the ED is made a priority for the time that the patient commits to the program. Consideration is also given to the appropriate length of treatment given the presence of comorbid concerns.
Before beginning treatment, the patient signs a contract containing an agreement not to engage in any self harming behaviour, substance abuse, or any other behaviour that could interfere with her adherence to treatment, and to maintain appointments with outpatient specialists assisting with comorbid axis I diagnoses. A clinical interview is conducted with the patient to begin a process of understanding how the ED emerged, what preceded it, the context in which it emerged, and the function of the ED. This is a collaboration, in which a discussion is held between the therapist and the program patient around the function of the ED. Questions such as “how do you think the ED helps you?” and “what is the ED trying to stop you from feeling?” and “how do you think the ED and other problems like depression affect each other?” are asked.

“Your Body, Your Life, Your Choice”: Autonomy and Therapeutic Relationship

The importance of the patient’s autonomy is emphasised repeatedly throughout treatment. Someone with a trauma history may feel like a passive recipient of treatment. Treatment can seem like something ‘being done to’ the patient because of its highly structured approach, with treatment non negotiables and clear consequences of non compliance to the treatment agreement. The team remind them frequently that they are in charge of their journey. While the team makes recommendations and provides advice, it is the choice of the patient at all times to accept or discard these without any disadvantage to them. Recent research has emphasised the importance of the therapeutic alliance to treatment outcomes for AN in particular (Sly et al, 2014). A warm, respectful and supportive therapeutic relationship is developed between the team and the patients from the first moment of contact through to discharge. Having the patient feel in control of processes and decisions about treatment, and active in the program is a key feature of this approach.

Monitoring Symptoms and Emotions

Patients may not always have the insight to report accurately on the function of their ED, or its aetiology, and they may not remember trauma from childhood. This may especially be the case for individuals with a short duration of illness and little treatment of their ED. Thus a clear understanding of the ED and its function may only emerge over the process of treatment.

The speed of symptom remission can signal how primary or secondary the ED is to the person’s formulation. For instance if someone with restriction is able to quickly and
readily comply to the meal plan, this could signal that weight and shape concerns are less important to this person than some other function of the ED, and is worth exploring. For instance, the ED may be a symptom of another axis I disorder like anxiety, depression or PTSD, and treatment may need to shift focus to address this problem. It may also highlight schemas and difficulties underlying the ED. For example someone with perfectionism and unrelenting standards may be complying with ED treatment only to please the treating team, with little internal motivation. It would be counter productive in this instance to focus solely on symptom reduction. Instead, switching focus for a time to the therapeutic relationship and moving towards a deeper understanding may be more productive and powerful.

Watching the person’s range of emotional expression or inhibition also provides important information about the function of their ED. PBDP therapists are in a unique position in the person’s life to be able to respond to the expression or restriction of emotion after meal completion. The therapist might reflect that “what you are feeling right now is just what the ED does not want you to feel,” and hence help the person begin a journey inwards towards synthesis.

A strong CBT Foundation, with a heavy DBT influence

The first line of treatment for individuals with an ED is CBT, and the PBDP’s primary emphasis is on normalising eating through compliance to a meal plan, meal supervision, weighing, homework, behavioural experiments, cognitive challenging around body image distortion, monitoring of medical stability and symptom reduction. A heavy DBT influence emphasises both acceptance and the need for change, eg “I understand where you are at. The ED is here for a reason and you have needed it up until now, and you also can’t stand living like this any more.” Patients agree to ‘close the door’ on an ED way of dealing with problems and emotions, and use distress tolerance skills to ride out urges. Chain analysis and pros and cons worksheets are used for working through urges. Mindfulness activities are practised regularly, and the skills of radical acceptance, wise mind and opposite action are emphasised in treatment. Emotion regulation has a heavy emphasis, with patients receiving extensive coaching on identifying, labelling and observing emotions, as well as understanding their function and action urge. Objectivity and non-judgment is emphasised at all times when patients report around meal plan compliance.
A tailored approach within a group context

The therapist may be running a group where some people have agreed to exercise and eat less as part of their treatment plan, while others have been asked not to exercise and eat more. The therapist needs to be able to give a general message to the whole group about symptom reduction, while tailoring this to individuals. This can be difficult when group members are at different stages of recovery, with different symptom profiles, and different underlying levels of motivation to recover. Patients report tendencies to compare with each other, and may find it distressing that some others are eating less or exercising more. Briefly, some principles that are used are as follows:

a) A Socratic approach, in which questions are asked and each patient is viewed as the expert in their recovery journey. When reporting on eating and symptoms, the therapist can ask “Was your choice to exercise last night driven by you, or by your ED?” The therapist helps to tease this apart in patients with less insight.

b) Focus on common threads: The therapist points out that the ED is the same on the inside for each group member. That is, for all patients, it has been a way to cope with difficult emotions. When patients report on symptoms, the therapist can ask each the same question about what difficult emotion the symptom was trying to protect them from.

Similarly, even if group members do not share symptoms, they have probably shared the same emotional experience, and can be called upon to support each other with helpful ways to deal with difficult and triggering situations. While the ED may manifest in different symptoms, it has the same core internal features. The therapist can ask some unifying questions to elicit shared response from the group, for example “How many of you drive yourself relentlessly, or avoid things in case you might fail?” and “how many of you feel your life has been dominated by this ED?” and “how many of you are scared of putting on weight?”

c) Be congruent about differences: It is important to be matter of fact about differences between group members. People with BED may feel intense shame about reporting a binge, especially if others in the group do not share this symptom. It is important for the therapist not to inadvertently reinforce feelings of shame by avoiding asking about binging, and also to tackle this sensitively. When patients debrief about meal plan compliance, the therapist can ask “did you eat less/ more than the prescribed meal plan?” Remind patients regularly that they each have a different treatment plan, with
different emphases, and they are working on different things. Some people are incorporating planned, healthy exercise into their routine, while others need to move away from being overly reliant on exercise as a way of coping with emotions.

d) Be clear with the group about what true recovery involves, and ask group members to consider what they are ready and willing to work on. Highlight that for some group members, it is appropriate right now to work on symptom relief and containment. Others, however, may be ready to immerse themselves fully in ED treatment until fully recovered. Emphasise that neither is right or wrong, because everyone is different and in different circumstances. Ask group members to check in with their own wisdom around what they are ready to challenge.

e) Team Review and individual care coordination: The treatment team meet with each patient individually on a weekly basis to clarify individual treatment goals and address any concerns that patients might have. Weekly individual care coordination sessions also give patients the opportunity to work on tailored treatment goals.

Conclusion

The PBDP is an effective program in which individuals committed to recovery from an ED appear to achieve significant symptom relief. It is able to accommodate diverse groups with a range of comorbid problems and trauma histories by cultivating warm therapeutic relationships, using a structured CBT framework, strong DBT content and a respectful, collaborative case formulation approach. In future it would be worthwhile for the PBDP to incorporate measures of affect regulation into data collection, and perhaps to consider an appropriate way to more formally measure the presence of axis I disorders and trauma history, in the interests of learning more about the differences and similarities within this complex group.
References


