Paper read at Eating Disorders Alpbach 2013,  
The 21st International Conference,  
October 17-19, 2013
New Evidence and Approaches in the Psychological Treatment of Severe and Enduring Anorexia Nervosa

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Acknowledgements

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Daniel Le Grange, PhD
Hubert Lacey, MD
Outline of Presentation

The Evidence

- Introduction and overview
- Systematic review of treatments in severe and enduring anorexia nervosa (SE-AN)
- A randomised controlled trial (RCT) of two psychological therapies

The Therapies

- Cognitive behaviour therapy – SE AN
- Specialist supportive clinical management-SE AN

Interactive discussion of clinical cases -all
Core reading

• Hay et al. (2012) Treatment of severe and enduring anorexia nervosa: A systematic review. *ANZJPsiychiatry* 46 (2) 1136-1144

• Touyz et al. (2013 online May) Treating Severe and Enduring Anorexia Nervosa: A Randomized Control Trial *Psychological Medicine*


• If you would like a copy email p.hay@uws.edu.au for an electronic copy
SYSTEMATIC REVIEW OF TREATMENTS FOR SEVERE AND ENDURING ANOREXIA NERVOSA

Hay et al. (2012) Treatment of severe and enduring anorexia nervosa: A systematic review ANZJ Psychiatry 46 (2) 1136-1144
What is “Long-standing” (L-AN), Chronic, or Severe and Enduring Anorexia Nervosa (SE-AN)?

- There is no generally accepted definition of what constitutes ‘chronicity’ in AN (Tierney & Fox, 2009).
  - Robinson suggests that after 6-7 years of an ED, the likelihood of people recovering reaches a plateau and fails to reach zero,
  - although some evidence suggests that such a plateau does not appear until 10-20 years after the onset of the disorder (Steinhausen).
Background: Longstanding anorexia nervosa (L-AN)

• Associated with poor quality of life (co-morbid conditions, social isolation)
• Highly resistant to treatment, often having repeated treatment failures
• Intensive/frequent use of GP and health services as well as the welfare system
• Poses a significant burden to parents, carers and the community
• L-AN has the highest mortality rate of all mental illnesses
  – 20% after 20 yrs (Steinhausen et al., 2000)
• Direct inpatient costs exceed that of schizophrenia (Rieger et al., 2000)
Reasons why patients with AN often refuse treatment

Adapted from Anderson & Stewart ‘83 and Goldner ‘89

• AN patients often have a strong sense of self-determination which is characterised by perfectionism and rigid inflexibility, associated with a marked sense of vulnerability to an outsider’s perceived reality, skills, and value judgments, and a strong feeling they should be able to address their own difficulties.

• They often have a mistrust of interpersonal relationships and interpersonal deficits.

• They are extremely apprehensive about a perceived loss of control and constantly strive to overcome a pervasive feeling of ineffectiveness.

• They often have distortions in their thinking which have an adverse impact on their conceptual, perceptual and decision-making abilities.

• AN patients often report a mood disturbance that may be exacerbated by the physiological and metabolic disturbances that accompany starvation and malnutrition.

• They may be adversely influenced by the often less than optimistic view regarding the long-term outcome of the disorder.
In absence of guidance or evidence…. 

“Clinicians often modify treatment, target co-morbid complicating disorders, switch to intermittent supportive treatments, or intensify treatments with higher levels of care, all of which are based on clinical decision making with a minimal of scientific guidance” (p. 467). 

Minimizing and treating chronicity in the eating disorders (Wonderlich et al., 2012).
Systematic review search date to 08/11

Aims:
1. conduct a systematic review of randomised controlled trials (RCTs) of treatment for chronic anorexia nervosa participants, and
2. identify research informing novel therapeutic approaches for this group that address relevant clinical aspects of L-AN.

Methods: see paper for details but included contacting authors of papers that had mean illness duration >3 years as per Russell et al. trial of family therapy
Results

- 11 studies identified that included participants with illness duration >3 years
- 4 had majority participants with illness duration >3 years
- Key findings:
  - Olanzapine ‘promising’ regards weight gain and reduced ED symptoms
  - Advantage probably for specialist vs non-specialist care
  - CBT-AN may reduce relapse – 1 study
  - Residronate may improve bone density
  - All require replication
  - No RCT specifically for treatment of people with L-AN
Factors in L-AN addressed by identified psychological treatments:

- Mood intolerance, affective disorder
- Impaired Social and interpersonal status
- Personality vulnerability/Disorder
- Contemplative or earlier stage of change
- Modifications of Rx Goals
- *Note:* All aimed to ensure Medical Safety and encourage if not mandate Weight Gain
<table>
<thead>
<tr>
<th>THERAPY AFFECT/MOOD</th>
<th>SOCIAL/INTER-PERSONAL</th>
<th>PERSONALITY</th>
<th>MOTIVATION TO CHANGE</th>
<th>RX GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SSCM-SE</strong></td>
<td>Symptom management</td>
<td>Supportive therapy</td>
<td>n.a.</td>
<td>Decisional analysis reflection</td>
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<tr>
<td><strong>CBT-SE</strong></td>
<td>Schema section includes emotion regulation skills</td>
<td>Schema section includes interpersonal effectiveness</td>
<td>Schema therapy addressing sense of self and environment</td>
<td>Motivational interviewing key feature</td>
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<tr>
<td><strong>CBT-E</strong></td>
<td>Mood intolerance core module</td>
<td>Inter-personal Rχ module (optional)</td>
<td>Low self-esteem &amp; Clinical perfectionism (optional modules)</td>
<td>Decisional analysis task</td>
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<tr>
<td><strong>COPP</strong></td>
<td>Emotion counselling skills development</td>
<td>Build a support system less dependent on health care providers</td>
<td>Positive self-esteem and autonomy are fostered</td>
<td>Motivational Treatment tailored to the patient’s SoC</td>
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<tr>
<td><strong>MANTRA</strong></td>
<td>Emotion skills training</td>
<td>Addresses social integration and rigidity</td>
<td>Cognitive remediation addressing inflexibility</td>
<td>Motivational interviewing core</td>
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<tr>
<td><strong>Strober</strong></td>
<td>Supportive therapy</td>
<td>Supportive therapy</td>
<td>Establishment of sound therapeutic relationship</td>
<td>Not specific but collaborative approach &amp; Lengthy initial consultative phase</td>
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<td></td>
<td>Social routines</td>
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<td></td>
<td>Regular family meetings</td>
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<td></td>
<td>Hobbies etc encouraged</td>
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TREATING SEVERE AND ENDURING ANOREXIA NERVOSA: A RANDOMIZED CONTROL TRIAL

Touyz et al. (2013 online May) 
*Psychological Medicine*
A multi-center comparison of CBT and SSCM for chronic AN

Australian New Zealand Clinical Trials Registry (ANZCTR)
Registration number: ACTRN12607000440426

Funding: NHMRC (Australia) (Touyz, Le Grange, Lacey & Hay), St. Georges Medical School (Lacey), Butterfly Foundation (Touyz), University of Western Sydney (Hay)
Aims of this RCT:

To establish the first effective outpatient treatment for L-AN by:

- comparing the capacity of CBT and SSCM to
- improve quality of life and to reduce depression and social isolation
- reduce core eating-disorder pathology

and to investigate whether the reduction in chronicity translates to a reduced burden on medical services.
Hypothesis and outcomes

- CBT > SSCM in demonstrating improvements on primary outcome measures.
- Primary Outcome: mental health related QoL, mood disorder symptoms, and social adjustment.
- Secondary Outcome: weight, eating disorder symptoms, motivation for change, and health care burden.
- Randomized: 63 medically stable adults AN (excluding amenorrhea criteria) to CBT or SSCM; 2 months on stable meds dose & still meeting entry criteria
International team

Treatment site 1: Sydney
Stephen Touyz (site supervisor); Rebecca Smith (project coordinator); Carla Evans (therapist); Monica Ward (therapist); Liz Rieger (supervisor); Phillipa Hay (medical consultant)

Treatment site 2: London
Hubert Lacey (site supervisor); Bryony Bamford (therapist); Vicki Mountford (supervisor); Amy Brown (research assistant); Sam Scholtz (medical consultant)

Data management site: Chicago
Daniel le Grange (site supervisor)
Colleen Stiles-Shields (data management)
8 months (27.5 contact hrs) of treatment (33 50min sessions in both modalities)

Independent assessments at Baseline (BL), end-of treatment (EOT), 6 and 12 month follow-up
# Participant Timeline

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<th>Screening Period</th>
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- **Mid-Treatment**
- **End of Treatment**
- **6 month follow-up**
- **12 month follow-up**
159 Assessed

86 Excluded

63 Randomized

- **CBT (n=30)**
  - Received intervention (n=28)
  - Terminated Prematurely (n=2)
  - EOT = 25
  - 6 Mo FU = 22
  - 12 Mo FU = 23
  - ITT MEM
    - N = 30

- **SSCM (n=33)**
  - Received intervention (n=30)
  - Terminated Prematurely (n=3)
  - EOT = 30
  - 6 Mo FU = 22
  - 12 Mo FU = 27
  - ITT MEM
    - N = 33
<table>
<thead>
<tr>
<th>Patient Baseline Characteristics</th>
<th>Sydney (n=29)</th>
<th>London (n=34)</th>
<th>TOTAL (N=63)</th>
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<tr>
<td></td>
<td>CBT</td>
<td>SSCM</td>
<td>CBT</td>
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<tr>
<td>Age(^1)</td>
<td>34.3 (11.3)</td>
<td>32.3 (12.1)</td>
<td>34.9 (7.0)</td>
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<td>Weight (BMI)(^1)</td>
<td>16.2 (1.8)</td>
<td>16.1 (1.5)</td>
<td>16.4 (0.9)</td>
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<td>Duration illness (yrs)(^1)</td>
<td>15.9 (7.1)</td>
<td>16.4 (11.4)</td>
<td>19.1 (7.7)</td>
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<td>AN Restricting (n,%</td>
<td>12 (85.7)</td>
<td>11 (73.3)</td>
<td>11 (64.7)</td>
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<td>Never partnered (n,%</td>
<td>8 (57.1)</td>
<td>8 (53.3)</td>
<td>7 (41.2)</td>
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<td>Employed (n,%)</td>
<td>4 (28.6)</td>
<td>4 (26.7)</td>
<td>8 (47.1)</td>
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<td>College degree (n,%</td>
<td>10 (71.4)</td>
<td>9 (60.0)</td>
<td>15 (88.2)</td>
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<td>Medical concerns (n,%</td>
<td>13 (92.9)</td>
<td>12 (80.0)</td>
<td>15 (88.2)</td>
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<td>Current meds (n,%</td>
<td>4 (28.6)</td>
<td>7 (46.7)</td>
<td>8 (47.1)</td>
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<td>Sample Size</td>
<td>14</td>
<td>15</td>
<td>17</td>
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## Within Group Changes Standardised ES

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<thead>
<tr>
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<th>End of Treatment</th>
<th>6-Mo Follow-up</th>
<th>12-Mo Follow-up</th>
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<tr>
<td><strong>Primary Outcomes</strong></td>
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<tr>
<td>EDQoL Total</td>
<td>0.733***</td>
<td>0.92***</td>
<td>0.88***</td>
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<tr>
<td></td>
<td>0.92***</td>
<td>0.98***</td>
<td>0.84***</td>
</tr>
<tr>
<td>SF-12 MCS</td>
<td>0.46*</td>
<td>0.85***</td>
<td>0.43*</td>
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<tr>
<td></td>
<td>0.85***</td>
<td>0.76***</td>
<td>0.28</td>
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<tr>
<td>SF-12 PCS</td>
<td>-0.32</td>
<td>0.09</td>
<td>0.09</td>
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<td></td>
<td>0.09</td>
<td>0.13</td>
<td>0.01</td>
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<tr>
<td>BDI Total</td>
<td>0.62**</td>
<td>0.98***</td>
<td>0.70***</td>
</tr>
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<td></td>
<td>0.98***</td>
<td>0.86***</td>
<td>0.56**</td>
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<tr>
<td>WSAS Total</td>
<td>0.34</td>
<td>0.68***</td>
<td>0.64***</td>
</tr>
<tr>
<td></td>
<td>0.68***</td>
<td>0.75***</td>
<td>0.41*</td>
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<tr>
<td><strong>Secondary Outcomes</strong></td>
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<tr>
<td>BMI</td>
<td>0.42*</td>
<td>0.49*</td>
<td>0.24</td>
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<tr>
<td></td>
<td>0.49*</td>
<td>0.50*</td>
<td>0.50*</td>
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<tr>
<td>EDE Global</td>
<td>0.85***</td>
<td>0.62***</td>
<td>0.84***</td>
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<tr>
<td></td>
<td>0.62***</td>
<td>0.64***</td>
<td>1.04***</td>
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<tr>
<td>ANSOCQ Total</td>
<td>1.09***</td>
<td>1.46***</td>
<td>1.03***</td>
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<td>1.46***</td>
<td>1.11***</td>
<td>1.52***</td>
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*P* < .05, **P** < .01, ***P*** < .001
## Treatment Outcome by Group

<table>
<thead>
<tr>
<th>Primary Outcomes</th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
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<tbody>
<tr>
<td>EDQoL Total</td>
<td>1.2 (0.8)</td>
<td>1.4 (0.6)</td>
<td>1.1 (0.5)</td>
<td>1.4 (0.6)</td>
<td>1.2 (0.7)</td>
<td>1.3 (0.7)</td>
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<tr>
<td>SF-12 MCS</td>
<td>40.2 (11.1)</td>
<td>38.9 (8.9)</td>
<td>39.9 (8.7)</td>
<td>37.9 (9.8)</td>
<td>37.8 (9.8)</td>
<td>36.8 (11.0)</td>
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<tr>
<td>SF-12 PCS</td>
<td>48.3 (8.4)</td>
<td>48.0 (10.7)</td>
<td>51.6 (5.7)</td>
<td>48.4 (7.8)</td>
<td>51.0 (6.9)</td>
<td>48.2 (8.1)</td>
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<td>BDI Total</td>
<td>14.1 (12.2)</td>
<td>17.2 (12.9)</td>
<td>13.1 (7.0)</td>
<td>18.7 (2.9)</td>
<td>14.9 (11.3)</td>
<td>18.4 (13.7)</td>
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<td>WSAS Total</td>
<td>12.4 (9.9)</td>
<td>14.4 (9.2)</td>
<td>9.3 (4.9)</td>
<td>13.8 (8.4)</td>
<td>11.7 (7.4)</td>
<td>16.3 (10.5)</td>
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### Secondary Outcomes

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<thead>
<tr>
<th></th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
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<tbody>
<tr>
<td>BMI</td>
<td>16.8 (1.5)</td>
<td>16.8 (2.0)</td>
<td>16.6 (1.4)</td>
<td>16.8 (1.7)</td>
<td>17.0 (1.7)</td>
<td>16.8 (1.8)</td>
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<tr>
<td>EDE Global</td>
<td>1.7 (1.1)</td>
<td>2.2 (1.4)</td>
<td>1.7 (1.1)</td>
<td>2.2 (1.3)</td>
<td>1.5 (1.1)</td>
<td>2.2 (1.3)</td>
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<tr>
<td>ANSOCQ Total</td>
<td>3.2 (0.8)</td>
<td>3.4 (0.6)</td>
<td>3.2 (0.8)</td>
<td>3.2 (0.6)</td>
<td>3.5 (0.7)</td>
<td>3.1 (0.8)</td>
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### Healthcare utilization

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<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
<th>CBT (n=31)</th>
<th>SSCM (n=32)</th>
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<tr>
<td>PCP visits</td>
<td>3.0 (1.9)</td>
<td>3.3 (3.4)</td>
<td>3.1 (3.7)</td>
<td>4.6 (4.1)</td>
<td>2.8 (2.7)</td>
<td>3.2 (3.6)</td>
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Strengths

- Two treatment sites increase generalisability
- Manualised treatments, experienced therapists trained to competence, supervised weekly
- MEM conserves data and limits assumptions of LOCF
- Low attrition and state of the art measures
- Appropriate outcome measures
Limitations

- Modest sample size (power)
- Participants treated in two University based clinical settings
- Homogenous sample compromising generalisability
- Expert medical consultation provided
- Results are at 12 month follow-up only
Findings

- Retention rate at 12-month follow-up was 85%.
- At EOT and follow-up, both groups improved significantly on the majority of outcome measures.
- There were no differences between treatment groups at EOT.
Findings (continue)

- At 12-month CBT reported lower EDE global score ($p = .004$), and higher readiness for recovery ($p = .013$) to SSCM.
Implications

- Patients with severe and enduring anorexia nervosa can make significant and meaningful improvements with therapy.
- CBT showed small advantage at follow-up over SSCM in terms of core eating pathology and readiness for change over time.
- But no significant differences in health related quality of life or health care utilisation.
Adapted for severe and enduring illness:

- CBT-SE
- SSCM-SE
Principles of CBT-AN

The central goal of CBT in anorexia nervosa is the normalization of eating behaviour to ensure consistent weight gain and medical stability to achieve a healthy weight with specific focus on the interaction between the thoughts, emotions and behaviours that are the core psychopathology of anorexia nervosa.

Garner, Vitousek, and Pike (1997) proposed the following principles of CBT in AN:

(i) acceptance of conscious experience rather than unconscious phenomena;

(ii) focus upon belief, assumptions, schematic processing and meaning systems as mediating variables for maladaptive behaviours and emotions;

(iii) the employment of questioning as a prominent therapeutic strategy;

(iv) active participation by the therapist in treatment;

(v) the essential contribution of homework sessions including self-monitoring.
mCBT-AN: Overview

Section I (sessions 3 - 6 approx):

Orienting and Engaging Individuals in Treatment and Enhancing Motivation for Recovery

- The therapeutic relationship
- Rationale and focus of mCBT-AN
- Role & Function of AN
- Weight Monitoring
- Homework
- Self-Monitoring
- Motivation for Change
mCBT-AN: Overview

Section II (from session 7)

• Core Cognitive and Behavioral Interventions for AN
  • Weight gain protocol
  • Behavioral interventions and experimentations
  • Cognitive distortions
  • Dysfunctional thought record
• Additional Modules
mCBT-AN: Overview

Section III (from session in early to mid 20’s):

- Schema-based CBT
  - Emotive techniques
  - Interpersonal techniques
- Affect regulation & Interpersonal effectiveness skills
- Additional Modules
mCBT-AN: Overview

Section IV (last few sessions – approx 32-34):

• Ending Treatment and Relapse Prevention
  – Balance between promoting change and encouraging acceptance
  – Personalized Plan for Maintenance
    • Relapse prevention entails reviewing gains
    • Personalized plans for future maintenance
    • Explicit strategies for addressing lapses to avert full relapse
    • Knowledge of cognitions and behaviors as cues for relapse
CBT-SE (L-AN RCT)

- Modified to have improved quality of life as the primary goal
- Motivational interviewing a key feature,
- Schema section includes emotion regulation skills, interpersonal effectiveness
Motivational Interviewing

- Where patients are at a pre-contemplative or contemplative stage of change (as is most common), motivational enhancement strategies are employed.
- The aim of MES is to help patients move from earlier stages into 'action' utilising cognitive and emotional strategies. For example with pre-contemplators, the therapist explores perceived positive and negative aspects of use.
- Open-ended questions are used to elicit client expression, and reflective paraphrase is used to reinforce key points of motivation. During a session following structured assessment, most of the time is devoted to explaining feedback to the client.
- Later in MES, attention is devoted to developing and consolidating a change plan.
ROLE OF THE EATING DISORDER

1. What role/function does the eating disorder serve for you?

2. What role/function does the eating disorder serve in your family and other relationships?
### PROS AND CONS OF HAVING AN EATING DISORDER

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<th>CONS</th>
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Decision analysis
Positive and negatives of:
If I (gain weight)
Short term consequences.............
Long term consequences.............

If I (Lose weight)
Short term consequences.............
Long term consequences.............
Life without an eating disorder

• Find a quiet place where you can sit/lie comfortably and undisturbed. Close your eyes and spend a few minutes focusing on your breathing. Try to take slow deep breaths in and out. With each breath out try to clear your mind of all thoughts, concerns and worries. Image yourself waking up and realizing that miraculously you no longer have an eating disorder. Imagine yourself going through the day including having meals, going to work/school, having relationships, participating in leisure activities, etc.

• Questions....
Questions

• What immediate reaction did you have to considering life without an eating disorder?

• In considering life without an eating disorder, write down your thoughts and feelings in regard to ...
  – your body
  – your eating
  – your relationships
  – your job/school
  – your leisure/free time
  – were there other areas of your life that you found yourself thinking of?
Schema-Based Work for Relapse Prevention

- Schema-based work focuses on the organizing themes that an individual holds about herself.
- AN maladaptive self-schema = I am anorexic and must stay this way because it brings me control, mastery, and somehow makes me special.
- Global maladaptive self-schemata are common (e.g., I am selfish and unlovable).
- Generally maladaptive self-schemata are not fully articulated or conscious.
Expansion of Self-Schema

Sister

Art

Friend

Volunteer

Horseback Riding

Student

Daughter
# Building Problem Solving and Coping Strategies

<table>
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<tr>
<th>SITUATION</th>
<th>FEELINGS</th>
<th>THOUGHT(S)</th>
<th>COPING STRATEGY</th>
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<tbody>
<tr>
<td>Describe actual event or specific problem</td>
<td>Specify the feelings that you were aware of at this time</td>
<td>Specify the thought(s) that are associated with the event or problem</td>
<td>Outline specific thoughts, plans, and activities that will help</td>
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SSCM-SE Aims

- To achieve relief of the core symptoms of anorexia nervosa
- To encourage more normal eating
- To facilitate some weight gain
- To reduce the impact of the patients anorexia on their quality of life
- To foster and maintain a therapeutic relationship between patient and clinician that facilitates the establishment of normal eating
Core elements of SSCM

• Therapy consists of two strands that run simultaneously throughout therapy sessions
  • gradual resumption of normal eating in order to bring about restoration of normal weight
  • attending to other life issues which may relate directly or indirectly to restrictive eating and low weight, or may be unrelated
• The therapist’s role is to support and encourage the patient as she makes changes in her eating and in other areas. The therapist will also give good quality information about food, eating, body shape, weight and anorexia nervosa, and advice about strategies that may be helpful.
  – Establishing and reviewing target symptoms
  – Nutritional education and advice
  – Monitoring physical state – plan goal weight
  – Support around life issues or problems
What SSCM is:

- Flexible
- Treatment tailored to the individual patient
- Treatment tailored to specific needs & goals
- A collaborative ‘goal setting’ treatment
- Focus on symptoms must be maintained throughout
- Active strategies can be suggested but not enforced
Motivation is enhanced through

• the use of support and encouragement

• the provision of psycho-educational materials

• understanding of factors likely to impede change.
Assessment

• confirms the diagnosis
• reassures the patient that the problems are understood by the therapist
• it establishes the symptom focus as an essential part of therapy
• allows the establishment of an individualized TargetSymptom Checklist
Assessment

• Acknowledge frustrations of ‘starting again’
  – Use a timeline to develop formulation rather than many questions
  – Develop formulation from their treatment priorities
• Determine QoL goals based on current & past history
• Reasons for previous treatment failures (barriers to treatment) incorporated into formulation
• Strengths or resiliencies MUST be incorporated into assessment
Psychoeducational modules

- What Is Anorexia Nervosa?
  - Incidence
  - Causes
- Effects of Dieting & Problems related to dieting
- The Cycle of Disordered Eating
- Effects of Starvation (Keys etc)
- Exercise as Weight-Control
- Socio-cultural Influences on Eating Disorders
- Theories of Biological and Genetic Contribution to Weight Status and Body Shape (Set Point Theory)
- Medical Consequences of Eating Disorders
- What are the Scales Really Telling You? (weight fluctuations etc)
- Nutrition and recovery from anorexia nervosa
The Model of Anorexia Nervosa

**Risk Factors: Family**
- Family history of depression
- Family history of alcoholism
- Family conflict or trauma
- Parental deprivation
- Sexual abuse
- Physical abuse
- Emotional abuse

**Risk Factors: Society**
- Social pressures on women
- Emphasis on thinness
- Role confusion
- Mixed messages for women

**Risk Factors: Personal**
- Poor problem-solving skills
- Low self-esteem
- Low mood, depression
- High anxiety, nervousness
- Perfectionism
- Self-criticism
- Impulsivity
- Fears about sexuality
- Relationship problems
- Weight loss from physical illness

**Initial Dieting & Weight Loss**
- Secrecy & lying about dieting
- Continued weight loss
- Hunger

**Beginning of Anorexia Nervosa**
- Extreme fear of weight gain
- Total preoccupation with food & weight
- Loss of hunger
- Harder to lose weight

**Anorexia Nervosa Takes Over**
- Cold intolerance
- Electrolyte disturbances
- Low blood sugar
- Dizziness
- Tiredness
- Lack of energy
- Lowered metabolic rate
- Lowered (or irregular) heart rate
- Muscle loss
- Moodiness
- Irritability
- Dry, pasty skin
- Headaches
- Visual problems
- Poor sleep
- Water retention
- Gastrointestinal problems
- Irregular or absent periods

**Symptoms of Starvation**
- Family relationships
- Intimate relationships
- Friendships
- Work (job/education)
- Leisure/interests
- Social activities
- Financial
Setting goals
Initial Phase of Treatment
Sessions 1 – 5

- Two to Five Goals
- Patient always works to these goals
- Never less than two goals
- At least one must be symptomatic and at least one be a quality of life goal
- Patient can develop mini-goals on route to a goal
Target Symptoms

The Target Symptom Checklist is designed to:

• provide structure

• ensure that the primary focus on symptoms of anorexia nervosa remains
NSCM Target Symptom Checklist

NAME ___________________________ SESSION # ___________________________ Date

Changes since last session:
Note frequency/severity where appropriate.

Weight: _____ kgs          Change since last session: _____ kgs

No of meals eaten per day

No of days of regular eating

Exercise

Vomiting

Laxatives

Other Compensatory Behaviors

Menstruation Y/N

Other target symptoms.

___________________________

___________________________

___________________________

___________________________

___________________________

___________________________

___________________________
Quality of Life

- Family relationships
- Intimate relationships
- Friendships
- Work (job / education)
- Leisure / interests
- Social activities
- Financial stability
Middle phase (sessions 5 – 27)

Review patient's general progress
Monitor target symptoms
Use Target Symptom Checklist
Review patient's general progress (how are things going?)
Acknowledge and praise ANY attempts at changes
Review the patient's eating patterns through dietary recall or dietary diary
Support and encourage regular eating
Weighing
Final Phase (sessions 27 – 30)

• Termination issues
  – Explore and normalise ending issues
  – Use reassurance regarding patients knowledge and skills

• Future Focus
  – Review changes and progress
  – Review future goals
  – Facilitate future goals
Main SSCM adaptations for longstanding anorexia nervosa

• Focus is on quality of life rather than weight restoration
• Goals are smaller (improvement rather than cure) but you must have them
• Motivation throughout therapy
• Symptom (clinical) management
• Increased focus on reassurance, consistency, encouragement, psycho-education and supportive advice
When patients feel treatment isn’t working:

• highlight to the patient what (small) changes and achievements have been made to date.

• revisit and perhaps modify treatment goals to match the patient’s current level of motivation and capacity for change.

• set small, achievable, but meaningful, weekly goals to increase patients’ sense of self-efficacy and belief in treatment.
# Differences between treatments

<table>
<thead>
<tr>
<th>CBT</th>
<th>SSCM</th>
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<td>Patients receive Motivational Enhancement Therapy strategies to improve motivation/readiness for change.</td>
<td>Psychoeducational material is given and discussed to increase patient motivation.</td>
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<td>Treatment and sessions are highly structured and largely therapist directed.</td>
<td>Treatment and sessions are less structured and are based on what the patient brings to the session.</td>
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<tr>
<td>Eating behaviours are directly challenged through use of behavioural experiments and cognitive strategies.</td>
<td>Changes to eating behaviours are encouraged using advice and education around nutrition rather than specific strategies.</td>
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<td>Patients are given homework in each session which relates to session content and is <em>always</em> followed up in the next session.</td>
<td>No homework is ever given. Patients may be sent away with educational material, but it is not necessarily raised in the next session.</td>
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Features of psychological approaches that address barriers to change and/or symptom maintenance in chronic AN Strober 2010:

- Supportive therapy encouraged, social routines established, regular family meetings, hobbies and the like encouraged
- Establishment of sound therapeutic relationship, collaborative approach & lengthy initial consultative phase,
- Weight gain encouraged but not mandatory,
- Goals in very small steps, medical safety is ensured
COPP (Williams et al., 2010)

- Emotion counselling skills development
- Build a support system less dependent on health care providers
- Positive self-esteem and autonomy are fostered
- Motivational interviewing treatment tailored to the patient’s stage of change
- Goals are set by client
- Medical safety non-negotiable
- Primary goal to improve quality of life
Thank you!
& If you would like a copy of the handouts email p.hay@uws.edu.au for an electronic copy

Next: Discussion
Questions and clarifications?
Your cases