

CHAPTER 17

Eating Disorders *A Transdiagnostic Protocol*

Zafra Cooper
Suzanne Bailey-Straebl
Rebecca Murphy

Eating disorders have been prevalent, perplexing, and difficult to treat for decades. The authors of this chapter are among the originators of the most successful treatment ever developed for these disorders. Their transdiagnostic unified theory and treatment protocol are applicable to all eating disorders, and in this chapter they clearly and succinctly describe their state-of-the-art treatment approach. In doing so, they describe how the central problem is not necessarily dieting, low weight, bingeing, or purging, but rather culturally reinforced attitudes and beliefs regarding shape and weight. The recommendations for applying various treatment components in a modular fashion speak to the art of administering this treatment, as nicely illustrated in the case of “Avery.” The detailed explication of this approach as applied across the full range of eating disorders will be extremely useful to all clinicians seeking to effectively treat eating disorders.

—D. H. B. & M. K. N.

Feeding and eating disorders are serious conditions characterized by persistent disturbances of eating or eating-related behavior and may also be accompanied by altered consumption and absorption of food.¹ The three specific and individually defined eating disorders recognized by the fifth, text revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022) are anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED). DSM-5-TR also describes a range of variants under the umbrella term other specified feeding or eating disorders (OSFED) that do not meet the threshold for the specific individually defined disorders or contain a mix of their features.

These eating disorders are the cause of substantial physical and psychosocial morbidity, including significant impairment in quality of life. They typically

emerge during adolescence or early adulthood (Solmi et al., 2022), although they can also occur in middle-aged and older adults, this being especially true for BED and OSFED (Hay et al., 2023). Once established, they are difficult to treat, with longer duration predicting worse outcomes (Vall & Wade, 2015). They are less common among men than women, although more men are affected than previously thought (Mangweth-Matzek & Hoek, 2017). There is limited evidence concerning transgender and gender-diverse individuals, although recent research suggests a higher prevalence in LGBTQI+ individuals (Hay et al., 2023; Rasmussen et al., 2023). In a systematic review, Galmiche, Déchelette, Lambert, and Tavoracci (2019) concluded that eating disorders are not confined to developed Western countries, with a high prevalence of these disorders in Asia and developing Middle Eastern countries. Eating

disorders are a significant source of morbidity particularly among adolescent girls and young women. (Hoek, 2017). AN, BN, and BED are all associated with increased mortality (Smink, Van Hoeken, & Hoek, 2013; Giel et al., 2022).

Despite the existence of evidence-supported specialist interventions for eating disorders (Cooper & Bailey-Straebl, 2015; Kazdin, Fitzsimmons-Craft, & Wilfley, 2017), there is a well-documented unmet need for treatment. The majority of those with diagnosable disorders do not receive appropriate treatment, with even fewer receiving treatments that are recommended and evidence-based (Waller, 2016). This chapter focuses on the eating disorders mentioned earlier (AN, BN, BED, OSFED) and describes their core features and the mechanisms involved in their persistence. We then describe a transdiagnostic cognitive-behavioral treatment designed to address these maintaining mechanisms. Avoidant/restrictive food intake disorder, pica, and rumination disorder do not share the distinctive core features of the other eating disorders and are beyond the scope of this chapter.

CLASSIFICATION AND DIAGNOSIS

The DSM-5-TR scheme for classifying and diagnosing eating disorders recognizes three individually specified disorders: AN, BN, and BED. Clear inclusionary and exclusionary criteria are provided for establishing the presence of these disorders and distinguishing them from each other. In addition, there are “other eating disorders” that DSM-5-TR has grouped in two residual categories termed *other specified feeding or eating disorder* (OSFED) and *unspecified feeding or eating disorder* (UFED), respectively (American Psychiatric Association, 2022). No specific diagnostic criteria are specified for the two residual eating disorder diagnoses in DSM-5-TR, but examples of the “other specified” presentations are listed.

CLINICAL FEATURES

Both the DSM-defined specific eating disorders and the other specified disorders share a variety of distinctive features. Most share the “core feature” of an overevaluation of shape and weight and their control. This feature is required for a DSM diagnosis of AN

and BN but is also present in the majority of those with DSM-defined BED (Grilo, 2013) and most but not all OSFED presentations. This core feature is similar across all genders and occurs in both adults and adolescents. Whereas most people evaluate themselves based on their perceived performance in a variety of life domains (e.g., the quality of their relationships, their work performance, their sporting prowess), people with eating disorders base their judgments of self-worth largely, or even exclusively, on their shape and weight, and their ability to control them. This core feature is distinctive of the eating disorders and is less frequently seen in the general population. It should be distinguished from “body shape dissatisfaction,” which refers to a dislike of aspects of one’s appearance. Some degree of body shape dissatisfaction tends to be widespread, and its presence has sometimes been referred to as “normative discontent” (Rodin, Silberstein, & Striegel-Moore, 1984). Both body shape dissatisfaction and the more distinctive overevaluation of shape and weight seen in the eating disorders are strongly reinforced by a prevailing culture that preferentially values certain body shapes, promoting their achievement predominantly through dieting. Weight stigma directed at those not achieving these ideals, together with its frequent internalization by patients, is often a further factor in strengthening overevaluation.

The overevaluation of shape and weight results in the pursuit of weight loss and/or shape change, and an intense fear of weight gain and any accompanying shape change. Most other features of these disorders are secondary to this core feature and its consequences (e.g., dieting, driven exercising, losing weight and becoming underweight). In some presentations, classified in DSM as AN or within OSFED as atypical anorexia nervosa (AAN), there is a sustained period of undereating that results in patients losing significant amounts of weight or becoming underweight. In others, equivalent attempts to restrict food intake are disrupted by repeated episodes of loss-of-control overeating (binge eating), which may or may not be combined with regular extreme methods of compensation for these episodes (generally classified as BN or BED in DSM depending on the presence of regular compensatory behavior). Although DSM-defined BED occurs across the weight range, it is associated with higher weights (and what has been termed *clinical obesity*; Rubino et al., 2025) in those who seek treatment (Kessler et al., 2013; Udo & Grilo, 2018).

Many patients mislabel adverse physical and emotional states, and as a result, experience intense spikes in body image concern, which they often equate with changes in body shape/weight. In addition, many repeatedly scrutinize their bodies, focusing on parts that they dislike, which contributes to further dissatisfaction and the intensification of their concerns. Others actively avoid seeing their bodies, assuming that their weight, shape, or size is unacceptable. Equivalent behavior is seen with respect to weighing with many patients weighing themselves frequently. This may result in patients becoming preoccupied with relatively small, and to be expected, day-to-day fluctuations in weight. Others actively avoid knowing their weight, and with no information to evaluate their fears about potential weight changes, remain highly concerned about it.

Depression and anxiety are frequently present in the three DSM-5-TR-defined disorders, and there is a subgroup within each of these disorders that also engages in self-injury or substance use, or both (Keski-Rahkonen & Mustelin, 2016; Hilbert et al., 2019; Guerdjikova, Mori, Casuto, & McElroy, 2019; Kirkpatrick, Breton, Biorac, Munoz, & Booi, 2024). In those who are low weight, impaired concentration, loss of sexual interest, and obsessional features are also frequently present, as well as loss of interest in the outside world, social withdrawal, and isolation. Typically, these features are exacerbated by weight loss and diminish with weight regain.

As discussed earlier, the core features of the other eating disorders, especially those listed as “specified” in DSM-5-TR, closely resemble those seen in the DSM-5-TR-defined AN, BN, and BED. These other eating disorders are generally of comparable severity and result in similar levels of impairment (Dang et al., 2024; Nutter, DaSilva, & Saunders, 2025).

THE “TRANSDIAGNOSTIC” PERSPECTIVE

The DSM-5-TR scheme, with its proliferation of eating disorder diagnoses, encourages the view that AN, BN, and BED and, to a lesser extent perhaps, the various suggested OSFED categories are distinct clinical states, each requiring its own form of treatment. This obscures the important fact that the eating disorders including the other specified and unspecified eating disorders have much in common. In fact, a consideration of their clinical features indicates that the eating

disorders share a distinctive core psychopathology not seen in other psychiatric disorders. As described earlier, this is the overevaluation of shape and weight and their control, which refers to patients’ tendency to judge their self-worth largely, or even exclusively, in terms of weight and shape, and their ability to control them. The transdiagnostic cognitive-behavioral theory proposes that it is this distinctive scheme for deriving self-esteem that is of central importance in maintaining the eating disorders. Other clinical features can be understood as stemming directly from this feature, albeit at somewhat varying frequencies or in different combinations as described earlier.

Further support for the transdiagnostic perspective comes from studies comparing OSFED categories with the three DSM-5-TR-defined diagnoses. Despite changes designed to eliminate the large residual category of EDNOS in the earlier DSM-IV (American Psychiatric Association, 1994), OSFED diagnoses remain prevalent, exhibiting eating disorder psychopathology very similar to those of the DSM-defined disorders (Dang et al., 2024). A particular notable example is studies showing few, if any, differences between DSM-defined AN and the OSFED category of AAN (Nutter et al., 2025). Furthermore, studies of the course of the various eating disorders suggest that, over time, patients move between the various diagnostic categories. When classified using the earlier DSM-IV scheme, one-third of those who initially received a diagnosis of AN subsequently met diagnostic criteria for BN (Eddy et al., 2008) and a substantial minority of those who were in the residual “not otherwise specified disorders” had met criteria for AN or BN in the past (Fairburn et al., 2007). A review of studies of the course and outcome of AN and BN indicated that no significant differences exist whether DSM-IV or DSM-5 definitions are used, while noting that much less was known about the course and outcome of BED (Smink et al., 2013). Although some changes might be expected in the detailed proportions of those who move within DSM categories, given the relatively small changes made in the new system, it seems likely that further research will continue to show a similar pattern of movement as shown in a more recent study (Forbush et al., 2018). If this temporal movement continues to be the norm in the case of the eating disorders, it does call into question the claim that these various forms of disorder are indeed separate and distinct states. In summary, the shared but distinct core psychopathology of the eating

disorders, together with other shared clinical features and the phenomenon of temporal movement between the diagnostic categories, suggests that transdiagnostic mechanisms may be responsible for maintaining these disorders (Fairburn, Cooper, & Shafran, 2003). If correct, this implies that treatments capable of successfully addressing these maintaining mechanisms should be effective for all forms of eating disorder and the DSM scheme of classification as outlined may be of limited use in determining treatment.

**TRANSDIAGNOSTIC
COGNITIVE-BEHAVIORAL THEORY**

In common with most evidence-based cognitive-behavioral treatments, the theory that underpins enhanced cognitive-behavioral therapy (CBT-E) is primarily concerned with the processes that maintain the disorder rather than those responsible for its development. According to the theory, it is the unhelpful scheme for self-evaluation mentioned earlier that is central to the maintenance of these disorders. Whereas

most people derive their evaluations of themselves based on their perceived performance in a variety of life domains, people with eating disorders make these judgments based largely on their shape, weight and eating, and their ability to control them. Consequently, their lives become focused on shape, weight, and eating, with dietary control, thinness, and weight loss being actively pursued, while perceived overeating, weight gain, and any consequent shape change are assiduously avoided. Most of the other features of eating disorders can be understood as stemming directly from this core system of self-evaluation, including weight control behaviors, and the various forms of body checking and avoidance.

Figure 17.1 shows a composite transdiagnostic formulation. In our experience, this composite formulation represents the core cognitive, behavioral, and emotional processes that maintain any eating disorder, whatever its exact form. The specific processes operating for any individual depend on the exact nature of the eating disorder presentation. As described below, in some cases, only a limited number of these processes are active, whereas in other cases, most of the processes are operating. This transdiagnostic account highlights the

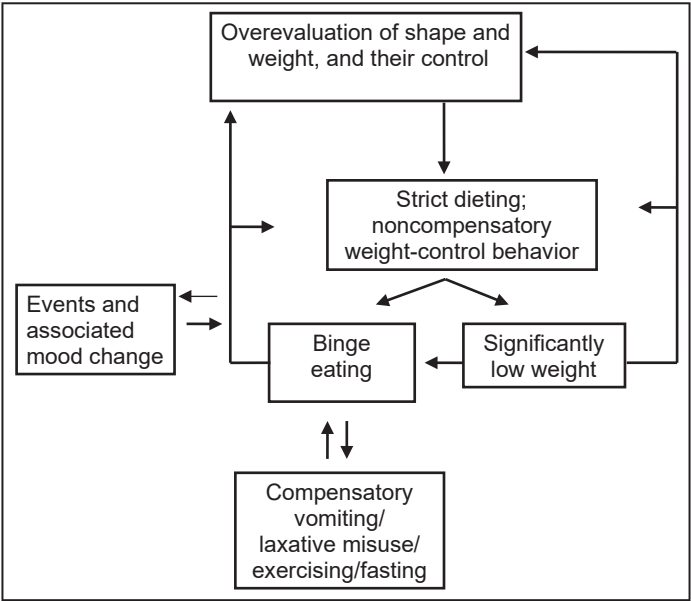


FIGURE 17.1. Composite Transdiagnostic Formulation. From Fairburn (2008, p. 19). Copyright © 2008 The Guilford Press. Reprinted by permission. This figure may be downloaded from www.credo-oxford.com.

processes that need to be addressed in treatment, thereby helping the clinician design a bespoke treatment to fit the individual patient's problems.

Those with a low-weight form of eating disorder (often, but not necessarily, with a DSM-5-TR diagnosis of AN) restrict their food intake to achieve and maintain a body weight that is extremely low. This restriction is accompanied by the well-documented features of starvation (Keys, 1946), such as pronounced social withdrawal and narrowing of interests, which in turn contribute to the maintenance of the disorder by isolating them from external influences that might diminish their concerns with controlling shape, weight, and eating. Some also experience a sense of achievement from their perceived control over these areas. This pathway is shown in Figure 17.2 and describes what is often referred to as the “restricting” form of AN.

One feature of some eating disorder presentations that is obviously not a direct expression of the core self-evaluation is binge eating. The cognitive-behavioral theory proposes that binge eating is largely a product of the way that those with these disorders *attempt* to restrict their eating (i.e., the form of dietary restraint),

irrespective of whether they actually undereat. Rather than adopting general guidelines about how to eat, many individuals with eating disorders try to adhere to multiple, extreme, and highly specific, dietary rules. An accompanying tendency—one that involves reacting in an extreme and negative fashion to the frequent and almost inevitable breaking of these rules—leads to interpreting even minor deviations from the self-imposed rules as evidence of failure or a lack of self-control. This results in their temporarily abandoning attempts to restrict eating and responding to the inevitable urge to eat that is experienced. This process produces a pattern of eating in which attempts to restrict eating are repeatedly interrupted by episodes of binge eating. The binge eating intensifies concerns about the ability to control eating, shape, and weight, and encourages yet greater dietary restraint, thereby increasing the risk of further episodes of binge eating.

It should be noted that episodes of loss of control over eating and binge eating do not come out of the blue; rather, they are particularly likely to occur in response to life difficulties and any associated mood change, in part because, for some, binge eating temporarily ame-

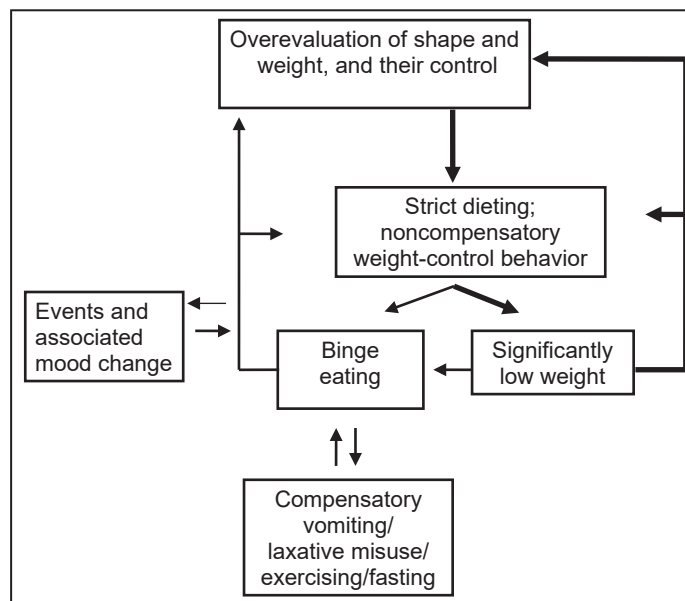


FIGURE 17.2. Composite Transdiagnostic Formulation showing core AN features. From Fairburn (2008, p. 21). Copyright © 2008 The Guilford Press. Reprinted by permission. This figure may be downloaded from www.credo-oxford.com.

liorates negative mood states, and in part because it distracts from thinking about their difficulties.

A further process that maintains binge eating in those who also use “purging” (e.g., self-induced vomiting or laxative use) to compensate for perceived overeating is the mistaken belief in the effectiveness of purging in preventing energy absorption. Not realizing that vomiting only retrieves part of what has been eaten, and that laxatives have little or no effect on energy absorption (Fairburn, 2013), may partially undermine a deterrent to binge eating. This pathway describes a form of eating disorder, generally classified in DSM-5-TR as BN (shown in Figure 17.3).

It is important to note that the presence of loss-of-control eating or binge eating does not distinguish the two forms of disorder described, because there is a subgroup of patients/people with low weight (who would receive a DSM-5-TR diagnosis of AN) who experience loss-of-control eating or binge eating (with or without compensatory purging). The major difference between the two forms of disorder lies in the relative balance of the undereating and overeating, and whether or not low weight is a prominent feature.

Similarly, in yet a different presentation characterized by loss-of-control eating/binge eating, which is generally classified within DSM-5-TR as BED, there are no accompanying compensatory extreme weight control measures nor is there extremely low weight (shown in Figure 17.4). All or some of the other maintaining mechanisms illustrated in Figure 17.1 may apply.

The processes outlined earlier and in Figure 17.1 also appear to maintain the other eating disorders (DSM-5-TR other specified and unspecified eating disorders) with different processes or combination of processes occurring in individual presentations (e.g., restrictive eating and weight loss with many of the accompanying consequences of weight loss as seen in DSM-defined AN, but no significantly low weight, currently classified as AAN within OSFED and purging behavior without objective binge-eating episodes, currently classified as purging disorder within OSFED). Importantly, this transdiagnostic account highlights the processes operating in the individual case that need to be addressed in treatment, whatever the DSM diagnosis. Treatment can therefore be individualized by the clinician to fit the eating disorder presentation.

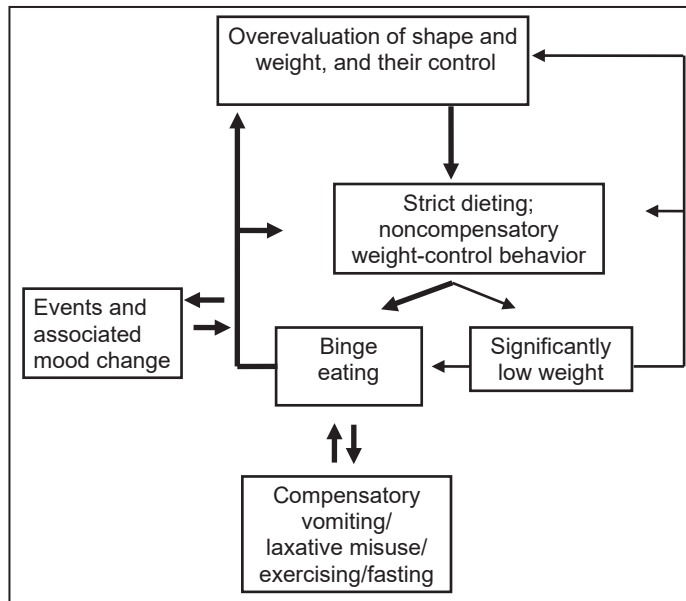


FIGURE 17.3. Composite Transdiagnostic Formulation—Showing Core BN Features. From Fairburn (2008, p. 21). Copyright © 2008 The Guilford Press. Reprinted by permission. This figure may be downloaded from www.credo-oxford.com.

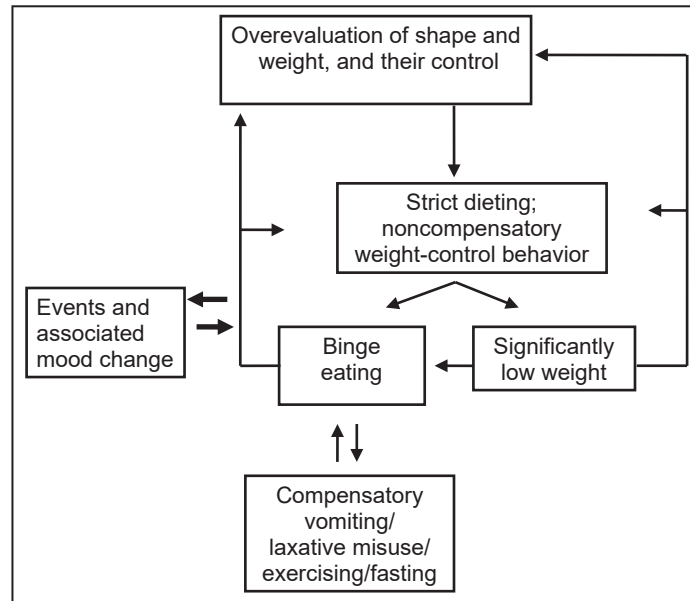


FIGURE 17.4. Composite Transdiagnostic Formulation showing core BED features. From Fairburn (2008, p. 21). Copyright © 2008 The Guilford Press. Reprinted by permission.

TRANSDIAGNOSTIC COGNITIVE-BEHAVIORAL TREATMENT

Enhanced cognitive behavior therapy, based on the transdiagnostic theory outlined above, was designed for the full range of clinical eating disorders seen in adults, including other specified eating disorders (Fairburn, 2008; Fairburn et al., 2003). The treatment is described as “enhanced” because it uses a variety of new strategies and procedures intended to improve treatment adherence and outcome. In addition, it has modules designed to address certain obstacles to change that are “external” to the core eating disorder, namely, clinical perfectionism, low self-esteem, and interpersonal difficulties. Thus, there are two forms of CBT-E, a focused form that focuses exclusively on the core eating disorder features and a broad form that also addresses the three identified external obstacles to change. The treatment also exists in two lengths, a 20-week version for patients who are not significantly underweight or do not need to restore weight, and a version that can be up to double this length for patients who need to restore their weight as part of the recovery process.

CBT-E, as originally developed is primarily an outpatient treatment, designed to be delivered on an individual rather than a group basis, although intensive outpatient, day patient, and inpatient versions have been developed (Dalle Grave, 2012a, 2012b; Dalle Grave et al., 2022) and also a recent group version (Bailey-Straebl & Sproch, 2025). The treatment of young people with CBT-E has been described in a dedicated treatment guide (Dalle Grave & Calugi, 2020).

The Research on CBT and Enhanced CBT

Consistent with the current way of classifying eating disorders, much of the research on their psychological treatment has focused on the specific disorders defined by DSM-5-TR in isolation. Over the past two decades, significant progress has been made in developing treatments for eating disorders, and evidence for their efficacy has been documented in both narrative and systematic reviews. In particular, CBT, a guided self-help form of CBT (GSH), enhanced cognitive behavioral treatment (CBT-E), and interpersonal psychotherapy (IPT) are recommended for the treatment of forms of

disorder likely to be diagnosed as BN or BED and to a lesser extent (due to less robust evidence) the other eating disorders (Brownley, Berkman, Sedway, Lohr, & Bulik, 2007; Hay, 2013; Kass, Kolko, & Wilfley, 2013; National Institute for Health and Care Excellence [NICE], 2017; Peat et al., 2017; Shapiro et al., 2007) with further support for CBT-E from two more recently published studies comparing CBT-E to active comparison treatments. In samples that did not include those who were significantly low weight, CBT-E was superior to both psychoanalytic psychotherapy (Poulsen et al., 2014) and IPT (Fairburn et al., 2015; Poulsen et al., 2014). In addition, recently published meta-analyses and systematic reviews have confirmed support for manual-based CBT (the earlier form of CBT-E, CBT BN) and CBT-E as superior to both alternative active psychological treatments and third-wave behavioral treatments (Linardon, Fairburn, et al., 2017; Linardon, Wade, et al., 2017). A recent systematic review and meta-analysis has supported the view that the benefits seen in research studies for cognitive-behavioral therapy for eating disorders (CBT-ED) translate into routine clinical care (Öst et al., 2024). Many of these studies in routine care used CBT-E. For adults with low weight (likely to have a DSM diagnosis of AN), CBT is less well supported (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Hay, 2013; Kass et al., 2013; Watson & Bulik, 2013), although the evidence base is improving (Brockmeyer, Friederich, & Schmidt, 2018). Currently three main approaches for AN are recommended (NICE, 2017): CBT-E (Fairburn et al., 2013) and other forms of evidence-based CBT-ED; specialist supportive clinical management (SSCM; Carter et al., 2011; McIntosh et al., 2006; Touyz et al., 2013); and the Maudsley model AN treatment for adults (MANTRA; Schmidt et al., 2015), with eating-disorder-focused focal psychodynamic therapy (FPT; Zipfel et al., 2014) as a subsequent consideration. To date, no single specialist treatment has emerged as clearly superior to the others (Kaidesoja, Cooper, & Fordham, 2023), with studies comparing a variant of CBT-E with FPT (Zipfel et al., 2014) and a study comparing CBT-E with SSCM and MANTRA (Byrne et al., 2017) being broadly consistent with this conclusion.

For adolescents with low weight, family-based treatment (FBT) has received the most support (Agras et al., 2014; Couturier, Kimber, & Szatmari, 2013; Lock, 2018; NICE, 2017) with some support for CBT-E, although not derived from controlled studies (Dalle Grave, El Ghoch, Sartirana, & Calugi, 2016; Le Grange et al., 2020). In a nonrandomized effectiveness

study of FBT and CBT-E for adolescents, both treatments achieved similar effects, although FBT achieved more rapid weight regain in underweight adolescents (Le Grange et al., 2020).

Four meta-analyses and systematic reviews that have included both controlled and uncontrolled trials have provided robust support specifically for CBT-E in transdiagnostic samples (Atwood & Friedman, 2020; Dahlenburg, Gleaves, & Hutchinson, 2019; de Jong, Schoorl, & Hoek, 2018; Groff, 2015) with the latest and most comprehensive review (Atwood & Friedman, 2020) concluding that there was support for the efficacy and effectiveness of CBT-E for the full spectrum of eating disorders, with respect to reducing eating disorder behaviors and core psychopathology and increasing body mass index (BMI) in individuals with AN. Consistent with these findings, a more recent synthesis of the systematic review evidence base found support for the effectiveness of CBT-E (Kaidesoja et al., 2023) rather than adapted forms of CBT. Despite this, the review noted that superiority over comparison treatments, especially in the longer term, has not been conclusively demonstrated (Kaidesoja et al., 2023).

Two main points emerge from the research on CBT-E to date:

1. CBT-E can be used to treat all forms of eating disorder in adults and adolescents. Thus, CBT-E is transdiagnostic in its scope.
2. There are good data on the use of CBT-E to treat adults and older adolescents, including those with low weight. For these patients, the availability of CBT-E may make the need to learn a variety of different treatments for each of the eating disorders (Fairburn & Wilson, 2013) redundant.

The remainder of this chapter is devoted to a description of the focused version of CBT-E in its most recent form. This is the core version of the treatment, and it forms the basis of the variants of CBT-E. It is the version recommended for treating the great majority of adults with an eating disorder provided that they can be managed on an outpatient basis. A description of the focused treatment is available in the original treatment guide (Fairburn, 2008; Fairburn, Cooper, Shafran, Bohn, Hawker, Murphy, et al., 2008), together with details of the broad version (Fairburn, Cooper, Shafran, Bohn, et al., 2008). While the treatment described here is essentially similar in content to that in the original guide, it should be noted that there are some updates and changes of emphasis from the version published in 2008.

THE CONTEXT OF TREATMENT

Patients

CBT-E is a treatment for patients with an eating disorder of clinical severity, that is the eating disorder is persistent and significantly interferes with the patient's psychosocial functioning or physical health. It was originally designed for patients age 18 years or more, and it is suitable for all genders. When delivered as an outpatient-based treatment, it is essential that it be safe for the patient to receive this level of care. In practice, this means that the patient's physical state must be stable and that any risk of self-harm or suicide can be appropriately managed in this context. The treatment was originally evaluated for patients with a BMI between 15 and 40. Subsequent advances in knowledge and clinical experience have indicated that relying on BMI guidelines as a measure of individual health, and to determine who might benefit from treatment, is not appropriate and that many more people, especially those living in larger bodies, may benefit from the treatment.

Therapists

There are no specific professional qualifications needed to practice CBT-E, and clinicians from a variety of clinical backgrounds can learn to be competent therapists. Certain background knowledge and experience are desirable. First, ideally, the therapist should be well informed about eating disorders in general, and they should have experience working with patients with eating disorders. Second, therapists should also be aware of the medical complications of eating disorders and be able to manage them appropriately (Fairburn, Cooper, Shafran, Bohn, & Hawker, 2008; Hambleton et al., 2022). Third, therapists should be comfortable implementing a short-term treatment focused primarily on maintaining factors and, preferably, should have some experience working in this way.

ASSESSING PATIENTS AND PREPARING THEM FOR TREATMENT

The Initial Evaluation Interview(s)

The initial assessment interview has three interrelated goals. The first is to begin to forge a positive therapeutic relationship and better understand the individual's needs and goals. This is important for several reasons: Many patients with an eating disorder are highly ambivalent about treatment because of the "ego-syntonic" na-

ture of their overevaluation of eating weight and shape; many may experience shame about their eating disorder, and they may have had adverse treatment experiences in the past. The assessing clinician needs to be sensitive to the patient's attitude to the assessment interview and ask directly about it. The aim is that it be a collaborative enterprise ending with the clinician being able to give patients an expert opinion as to the nature of their problems and, if indicated, the treatment options.

The second goal is to establish that an eating disorder is indeed present. An apparent eating disorder may, for example, turn out to be an anxiety disorder (e.g., difficulty eating with others due to a social phobia), or a mood disorder (e.g., severe weight loss resulting from a clinical depression), among others. It is therefore critical to establish the nature of the problem or problems, and, if there are coexisting conditions, evaluate their severity to decide on the most appropriate next step.

The third goal is to ensure that the patient is safe to receive outpatient care. This requires checking that there are no reasons to be unduly concerned about the patient's physical health or the risk of suicide. Guidance for doing so is provided in the original treatment guide (Fairburn, Cooper, & Waller, 2008a, 2008b).

Patients are invited to bring others to the appointment if they wish. They may simply provide moral support (and stay in the waiting area) or also serve as an additional source of information provided the patient is willing for them to do so. A significant other's viewpoint is of interest, since it can provide a different perspective on the patient's difficulties. Problems may be described that were not mentioned by the patient (e.g., that the patient takes an inordinate amount of time to eat meals or has extremely small portions). However, it is not appropriate to insist that significant others attend given that some adult patients will have kept their eating problem hidden from others and would not attend if such disclosure were required. The situation is different with younger patients, when involvement of the parents is generally essential.

Toward the end of the first interview, we weigh patients and measure their height. This is an extremely sensitive matter for most patients, and some are resistant to it. We explain that weighing is necessary to complete the assessment. We do not think it is generally appropriate to rely on patients' self-reported weight or height, as these can be inaccurate. In our experience, patients typically expect their weight to be measured, although many may prefer that this not happen. At this early stage, we do not insist on patients knowing their weight if they prefer not to do so.

We are in favor of seeing patients for assessment on two occasions a week or two apart. This avoids an overly lengthy first appointment, which can be exhausting for the patient and has the benefit of often adding new information of value. On the second occasion, patients are usually more relaxed; they sometimes add further information not previously shared, and there is an opportunity to discuss issues that require particularly careful exploration (e.g., the nature and extent of any coexisting depressive features). The second appointment is also a good time to discuss treatment options.

We recommend routinely asking patients to complete certain questionnaires prior to the initial appointment. This is useful, since it gives us standardized information on the nature and severity of patients' eating problems. The two questionnaires we recommend are the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008) and the Clinical Impairment Assessment (CIA; Bohn & Fairburn, 2008). The EDE-Q provides a measure of the severity of current eating disorder features, and the CIA assesses the impact of these on psychosocial functioning. Both questionnaires are short and easy to complete, and both focus on the previous 28 days and are sensitive to change. In addition, we include one of the well-established measures of general psychiatric features. By the end of the second appointment, it should be possible to discuss with the patient whether to recommend CBT-E.

If patients have not benefited from CBT for their eating disorder in the past, whether it is appropriate to offer them the same treatment a second time merits thought. On the other hand, it is possible that a patient's circumstances may now be more conducive to a good outcome or the patient's attitude toward treatment and recovery may have changed. While patients may report having had CBT before, it often emerges that it was different in character from CBT-E. It is always worth finding out exactly what the prior treatment involved.

Contraindications to Starting CBT-E Immediately

There are certain contraindications to embarking upon CBT-E immediately. Most of these apply to any psychological treatment for an eating disorder. The main contraindications follow.

Coexisting Clinical Depression

Most patients with an eating disorder have some secondary depressive features, but a sizable subgroup has

an independent, but interacting, clinical depression. The identification and management of clinical depression in patients with eating disorders is discussed in detail in the original treatment guide (Fairburn et al., 2008a). The presence of a clinical depression may interfere with psychological treatment in several ways. Depressive thinking results in patients being unduly negative about the possibility of change, and the often accompanying reduction in drive may have similar effects. Concentration impairment may also be a problem, as information may not be retained well. In such situations, we find it best to treat the depression first and then start CBT-E, thereby allowing the patient to make the best possible use of the treatment.

Other, co-occurring conditions, such as anxiety disorders or personality disorders, are not necessarily contraindications to CBT-E. To date, there is relatively little research to guide how best to address coexisting psychological conditions and physical conditions in patients with eating disorders (NICE, 2017; Wade, Shafaran, & Cooper, 2024). It is also worth noting that the pervasive impact of the eating disorder on mood, behavior, and relationships means that it is often difficult to determine whether there is indeed a coexisting other disorder, especially a personality disorder.

Significant Substance Use

Sessions attended while intoxicated cannot provide therapeutic benefit, and persistent substance use outside sessions can severely undermine the patient's ability to utilize CBT-E. Again, we recommend addressing substance use first, with ongoing support, to allow the patient to engage in CBT-E. Social use of alcohol or other substances is relatively common among patients with eating disorders and does not in itself preclude effective engagement in CBT-E.

Major Life Difficulties or Crises

These are distractions that may, understandably, interfere with treatment. It is often best to delay treatment until the crisis has passed.

Inability to Attend Regularly

A central feature of CBT-E is establishing and maintaining "therapeutic momentum." This requires that appointments be regular and frequent (especially in the early stages). We ask patients to ensure, as far as possible, that there will be no breaks in their attendance in

the first 6 weeks and no breaks of longer than 2 consecutive weeks throughout the rest of treatment. In some cases, when someone cannot attend regularly, it may be best to defer starting treatment. Patients generally understand the rationale for this, as they can see that we are taking their treatment seriously and do not want them to start in a way that is unhelpful.

Therapist Absence

The need to establish and maintain therapeutic momentum also places an obligation on the therapist. If the therapist is going to be away in the first 6 weeks of treatment, it may well be best to delay its start. Possible ways of minimizing the impact of therapist absence are discussed in the original treatment guide (Fairburn, Cooper, Shafran, Bohn, Hawker, Murphy, et al., 2008).

Describing CBT-E to the Patient

If CBT-E is recommended, it is important that it be accurately described to patients. The therapist's description may be supplemented by providing an information sheet about CBT-E (obtainable, along with other resources, from www.cbte.colfor-professionals/cbt-e-resources-and-handouts). Once patients have had an opportunity to ask questions, it is our practice to ask them to think over what has been proposed and let us know within a week what they have decided. In our experience, virtually all decide they would like to proceed with the treatment.

CLINICAL ILLUSTRATION: ASSESSING PATIENTS AND PREPARING THEM FOR TREATMENT

Avery was a 22-year-old college student referred by their primary care provider for the treatment of an eating disorder. They attended the initial assessment on their own and reported that their family were unaware of their problems and that they would like that to remain the case. They gave a clear account of their eating difficulties and their development. Assessment indicated that they were suffering from an eating disorder characterized by dietary restraint, regular binge eating and compensatory self-induced vomiting (meeting DSM-5-TR diagnostic criteria for BN). They had been dissatisfied with their weight since early adolescence and began dieting to lose weight during their final year at high school. Initially, they lost about 15 to 16 pounds

(lb; 7 kilograms [kg]) but then found it more difficult to stick to their diet and began binge eating and subsequently inducing vomiting. They described their daily food intake as consisting of a very small bowl of cereal for breakfast with non-fat milk and a small salad for lunch. They often tried to delay these meals as long as possible and sometimes skipped them entirely. They reported large episodes of binge eating every night (typical binge episodes including some combination of a loaf of bread, a large family size bag of chips, a package of cookies, a large tub of ice cream). Occasionally, they also took more than the recommended dose of a laxative to further compensate for the binge eating. During the evening, they would vomit up to four times. Avery described a range of rigid dietary rules about how much they should eat at each meal, and they reported avoiding many foods that they regarded as fattening and likely to trigger binges.

Avery described their body in their own words as “repulsive” and had avoided weighing themselves for the past 6 months. They did not know their weight but believed it to be unacceptably high. They frequently checked their body (to see “how big” they were) and had missed important lectures because of their ensuing low mood. At assessment, they weighed 140 lb (63.5 kg), having regained most of the initial weight lost. Although they were reluctant to be weighed, they understood that it was needed to complete the assessment and agreed to be weighed only if they were not told their weight. At the time they were first assessed, they had several work deadlines to meet, and their mood appeared low. They were also drinking a bottle or more of wine each night.

Aside from the eating difficulties, two issues were of concern and were possible contraindications to immediately beginning CBT-E: their apparently persistently low mood, together with a range of features suggestive of a coexisting depression (reduced interest and socializing, negative thinking, hopelessness) and their alcohol intake. Their scores on the EDE-Q and the CIA were consistent with their account of their eating difficulties and resultant impairment, and standardized assessment of general psychiatric features confirmed the concern about their depressed mood. The assessing clinician explained how these two issues might interfere with treatment. The patient responded by acknowledging that they were drinking too much and saying that they would like to reduce it. They added that they wished to overcome their eating disorder but feared weight gain. They had a few work deadlines in the following 2 weeks, and so a second appointment was arranged after these, and it was agreed that they would attempt to re-

duce their alcohol intake. At their second appointment, Avery was more relaxed, having completed their work. Their mood seemed considerably improved, and they were no longer reporting other depressive symptoms. They had greatly reduced their alcohol intake, confining their drinking to no more than two glasses of wine on weekday evenings and up to three on weekend evenings. It was agreed that CBT-E would begin.

OVERVIEW OF THE TREATMENT

Length of Treatment

CBT-E is a short-term, time-limited, individualized psychological treatment best delivered on a one-to-one basis. For patients who do not need to regain significant amounts of weight as part of recovery and are safe to be treated as outpatients, an initial assessment appointment (in addition to the assessment interviews discussed earlier) followed by 20 fifty-minute treatment sessions over 20 weeks is generally sufficient, although some may require fewer sessions. For patients who need to regain weight as part of the recovery process, treatment may need to be longer, often involving closer to 40 sessions over 40 weeks. In this chapter, we describe the 20-week treatment and then adaptations needed for patients who need to regain weight. The fact that CBT-E is usually time-limited might be thought not to be entirely consistent with the claim that it is individualized. Our experience is that the recommended number of treatment sessions is sufficient, but not excessive, for most patients. There are advantages to working within a fixed time, the major one being that it concentrates the minds of both patient and therapist. It both encourages the establishment of therapeutic momentum and helps to ensure that therapist and patient keep working hard to achieve change. It also makes it much more likely that treatment will have a formal ending rather than fizzling out, as sometimes happens when treatment is open-ended. Having a definite endpoint is important, as it ensures that important future-oriented topics (e.g., how to minimize the risk of relapse) are covered in the final part of treatment.

There are circumstances under which it is appropriate to adjust the length of treatment. It rarely needs to be shortened, although this does apply in occasional cases in which change is profound and rapid. Somewhat more often, there is a case for extending treatment. The indications for doing this are described briefly toward the end of the chapter.

Structure of the Treatment

The 20-week version of the treatment has four stages. These are illustrated in the treatment map (see Figure 17.5):

- *Stage 1.* The aims are to engage the patient in treatment and change, jointly create a formulation of the processes maintaining the eating disorder, provide education, address weight concerns, and introduce a pattern of regular eating. Following the initial preparatory session, it is recommended that the appointments are twice weekly for 4 weeks.
- *Stage 2.* The aims are to review progress, identify barriers to change, modify the formulation as needed, and collaboratively plan Stage 3. This stage generally comprises two appointments, each a week apart.
- *Stage 3.* This is the main body of treatment. The aim is to address the key mechanisms that are maintaining the patient's eating disorder. There are generally eight weekly appointments.
- *Stage 4.* This is the final stage of treatment, and the focus is on the future. There are two aims: The first is to ensure that the changes made in treatment are maintained over the following months, and the second is to minimize the risk of, relapse in the long term. Typically, there are three appointments, each 2 weeks apart.

In addition, we recommend a single review appointment 20 weeks after treatment has finished.

The Implementation of CBT-E

CBT-E is designed to be a complete treatment. In our view, it should generally not be combined with other forms of therapy or take place simultaneously with them. The risk is that both can detract from treatment: combining with other treatments risks the patient not receiving an evidence-supported intervention, and participating in two treatments at once risks overburdening the patient, as well as possible inconsistencies between the two (Wade et al., 2024).

In our view, it is best if CBT-E sessions remain focused on the eating disorder. If the patient experiences a crisis during treatment that needs addressing immediately, we arrange one or more “crisis sessions” in addition to the CBT-E sessions to address the problem in question. Occasionally, we suspend CBT-E for a few

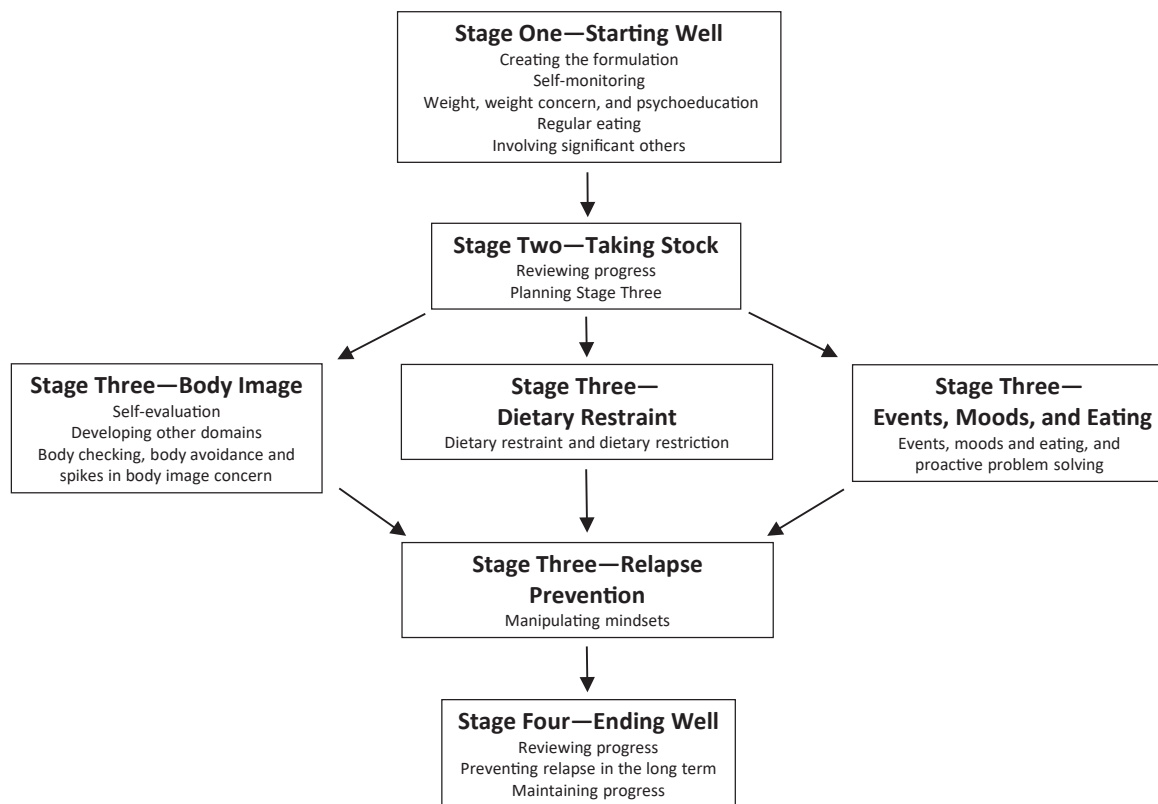


FIGURE 17.5. CBT-E Treatment Map. From CREDO (2017). Copyright © 2017 CREDO. Reprinted with permission.

weeks if continuing seems inappropriate (e.g., if there is a new onset of a clinical depression).

Some therapists may be tempted to change therapeutic focus if progress is slow or difficult. Although this might be tempting, we recommend that the therapist continues to work within the framework of CBT-E while using the formulation of the patient's difficulties (see below), to try to understand the barriers they may be encountering.

THE TREATMENT PROTOCOL

Stage 1: Starting Well

This is the initial intensive stage of treatment. There are several interrelated goals, all of which apply, regardless of the exact nature of the patient's eating problem.

The Initial Preparatory Session

The initial session is typically up to two hours long and has four major goals.

ENGAGING THE PATIENT IN TREATMENT AND THE PROSPECT OF CHANGE

A particular challenge in working with patients with eating disorders is engaging them in treatment. Many come to treatment with misgivings and varying degrees of reluctance. It is essential that the therapist understand this and be sensitive to the patient's likely ambivalence.

The initial session is especially important in this regard. The patient is evaluating the therapist just as much as the therapist is evaluating the patient. Some clinicians advocate an initial phase of "motivational enhancement." We agree that engagement in treatment,

and more especially, in change, is crucial, but suggest that well administered CBT-E enhances motivation for change and overlaps significantly with the strategies of motivational interviewing (Wilson & Schlam, 2004). We have not found that that special non-CBT procedures are required.

Integral to engaging patients is explaining what treatment will involve. Various topics need to be covered:

1. *The nature and style of the treatment.* It is helpful for patients to be told the name, nature, and style of the treatment.

2. *Treatment practicalities.* They should also be told the initially planned number, duration, and frequency of the treatment sessions.

3. *In-session weighing.* Patients need to be forewarned about the in-session weighing that is an element of treatment from Sessions 1 or 2 onward. The rationale needs to be explained (see “Establishing Collaborative Weighing”). We are often asked whether patients ever refuse to be weighed even after this rationale is given and once an opportunity to discuss this further has been provided. When patients are reluctant, we devote additional time to understanding their concerns during the initial assessment and collaboratively considering the impact of not engaging in the intervention during treatment.

4. *Instillation of “ownership,” enthusiasm, and hope.* The notion that it is the patient’s treatment, not the therapist’s, also needs to be stated. Throughout treatment, patients should feel clear about what is happening and why. While many patients are keen to overcome their eating problem and eager for treatment to start, not all are and embarking on treatment can be overwhelming. Maximizing enthusiasm and hope is essential. Part of this involves conveying that the therapist is knowledgeable about eating disorders, understands the individual’s problems and believes that recovery is possible. Equally, it is vital to acknowledge the patient’s lived experience and convey that the therapeutic process will be a collaborative partnership with patient and therapist working together toward recovery.

We have come across patients who have been told that they will never overcome their eating disorder. Rarely have we felt that such a statement was warranted. Saying something like this may set up a self-fulfilling prophecy by undermining any hope of recovery that the patient might have. Research to date has not generated reliable predictors of treatment outcome, and our experience

over the years has taught us not to entirely trust our clinical judgment in this regard. We have all been surprised by remarkable responses even after years of a severe eating disorder.

ASSESSING THE NATURE AND SEVERITY OF THE PSYCHOPATHOLOGY PRESENT

Depending on the context within which one works, the person who conducts the initial evaluation interview(s) may or may not be the person who subsequently treats the patient. If the therapist is seeing the patient for the first time, it is helpful to conduct a second assessment of the eating disorder, so the therapist hears the patient’s concerns firsthand. Inevitably, this assessment overlaps to an extent with the initial one, but it is important and can be highly engaging and helpful in establishing a collaborative relationship.

We recommend that this further assessment is treatment-oriented rather than diagnostic, so it differs somewhat from the one conducted when the patient was first seen. While a broad range of topics is covered, the main focus should be on the patient’s present state. Therapists are encouraged to consider each person’s specific circumstances, including factors such as a developmental stage, co-occurring mental or physical health conditions, cultural background, other individual characteristics and life circumstances. Knowledge of these factors will help the therapist implement treatment in an individualized way.

JOINTLY CREATING THE FORMULATION

The next step is the creation of the *formulation*, that is, a personalized visual representation (i.e., a diagram) of the processes that appear to be maintaining the patient’s eating problem. This is ideally done in the initial session unless the patient is significantly underweight (see below) or the eating disorder is unusual and difficult to understand, in which case it is best delayed until the next session, so that the therapist has ample time to think over its likely form.

The creation of the formulation has a number of purposes: it helps to engage the patient in treatment; it involves “decentering,” which is central to helping patients change; it conveys the notion that eating problems are understandable and maintained by a variety of interacting self-perpetuating mechanisms; and by highlighting the maintaining mechanisms, it provides a guide to what needs to be targeted in treatment.

A composite transdiagnostic formulation was shown in Figure 17.1. This should be used by the therapist as a template from which the personalized formulation can be derived, one that matches the individual difficulties of the patient elicited and discussed during the assessment. The more familiar the therapist becomes with the template formulation, the easier it is to create an individualized one.

The formulation should focus on the main mechanisms that appear likely to be maintaining the patient's eating problem. It does not need to be comprehensive (as this risks the formulation being overdetalled and confusing), and it is not concerned with the origins of the problem.

The formulation, referred to as a *diagram* or *picture* (or whatever words seem most suitable for the patient) should be drawn out, step by step, in an unhurried manner, with the therapist taking the lead but with the patient's active involvement. It is best to start with something that the patient wants to change (e.g., binge eating/out-of-control eating) or something that is clearly agreed to be a problem by the patient (e.g., preoccupation/always feeling cold). The patient's own words should be used in the formulation and not the terms used in the template. Since the formulation is based on information only just obtained, the therapist should make clear that it is provisional and will be modified as needed during treatment. It is important that patients see the formulation as a credible explanation of their eating problem and its persistence.

Once the formulation has been created, the therapist should discuss its implications for treatment. The points to be made are that to overcome the eating disorder, the patient will need to address not only the things that they would like to change (e.g., loss of control over eating) but also the mechanisms responsible for maintaining them (the "vicious circles"). Thus, for example, with patients who binge-eat, treatment commonly needs to focus on more than simply stopping binge eating; instead, it may also need to address the patients' various forms of dieting, their ability to deal with adverse events and moods without binge eating, and their concerns about shape and weight. Not addressing the range of maintaining processes markedly increases the likelihood of relapse.

ESTABLISHING REAL-TIME SELF-MONITORING

The final task in the initial session is to establish real-time self-monitoring. This is the ongoing, "in-the-

moment" recording of relevant behavior, thoughts, feelings, and events. It needs to be initiated from the outset of treatment and fine-tuned in Session 1. It continues throughout treatment and is central to it. It has two main purposes: First, it helps the patient identify precisely what is happening on a day-to-day basis; second, by gaining such awareness of their thoughts, feelings, and behavior at the time it happens, patients learn that they have choices, and that many things they thought were automatic and beyond their control can be changed.

The monitoring record that we use is designed to be straightforward for patients to complete and to use. Exactly what is recorded evolves during treatment. At the beginning, the emphasis is largely on the patient's eating patterns.

When describing how to monitor eating habits, it is our practice to go over an example (created for this purpose) that roughly matches in form the eating habits of the patient in question. Table 17.1 shows our instructions for monitoring, and Figure 17.6 shows a completed monitoring record. These records are often mistakenly referred to as food logs or food diaries. We do not use this term and call them "records" or "monitoring records" to avoid conveying the incorrect impression that they are simply a retrospective record of dietary intake.

Fundamental to establishing accurate real-time recording is discussing the patient's records in detail, especially in Session 1, when the patient brings them back for the first time. Reviewing the records should be a joint process, with the patient taking the therapist through each day's record. There are two aspects to the review in Session 1: assessing the quality and process of monitoring (e.g., was it "in the moment"?) and assessing the information gained about the patient's eating habits (e.g., when was their first meal). In subsequent sessions, the focus is largely on what has been recorded, although the therapist should intermittently ask the patient about the process of recording and the accuracy of the records. A brief video demonstration of addressing difficulties with self-monitoring is available at www.guilford.com/barlow2-materials. In these subsequent sessions the review of the records generally takes no longer than 10 minutes. It is best if therapists develop a strategy of acknowledging identified problems and putting them on the session agenda rather than addressing them as they come up in the records. This helps to plan and structure session time

TABLE 17.1. Instructions for Self-Monitoring

During treatment, it is important that you record *everything* that you eat or drink, and what is going on at the time. We call this “self-monitoring.” Its purpose is twofold: (1) It provides a detailed picture of how you eat, thereby bringing to your attention and that of your therapist the exact nature of your eating problem; and (2) by making you more aware of what you are doing at the very time that you are doing it, self-monitoring helps you change behavior which previously seemed automatic and beyond your control. Accurate “real-time” monitoring is central to treatment. It will help you change.

At first, writing down everything that you eat may be irritating and inconvenient, but soon it will become second nature and of obvious value. We have yet to encounter anyone whose lifestyle makes it truly impossible to monitor. Regard it as a challenge.

Look at the sample monitoring sheet to see how to monitor. A new sheet (or records) should be started each day.

- The first column is for noting the time when you eat or drink anything, and the second is for recording the nature of the food and drink consumed. Calories should not be recorded; instead, you should write down a simple (nontechnical) description of what you ate or drank. Each item should be written down as soon as possible after it was consumed. Recalling what you ate or drank some hours afterwards will not work since it will not help you change your behavior at the time. Obviously, if you are to record in the way that you are being asked, you will have to carry your monitoring sheets with you. It does not matter if your sheets become messy or if the writing or spelling is not good. The important thing is that you record *everything* you eat or drink, as soon as possible afterwards.
- Episodes of eating that you view as meals should be identified with brackets. Snacks and other episodes of eating should not be bracketed.
- The third column should specify where the food or drink was consumed. If this was in your home, the room should be specified.
- Asterisks should be placed in the fourth column adjacent to any episodes of eating or drinking that you felt (at the time) were excessive. This is your judgment, regardless of what anyone else might think. It is essential to record all the food that you eat during “binges.”
- The fifth column is for recording when you vomit (write “V”) or take laxatives (write “L” and the number taken) or diuretics (water tablets) (write “D” and the number taken).
- The last column is used in various ways during treatment. For the moment, it should be used as a diary to record events and feelings that have influenced your eating (e.g., if an argument precipitated a binge or led you not to eat, you should note that down). Try to write a brief comment every time you eat, recording your thoughts and feelings about what you ate. You may wish to record other important events or circumstances in this column, even if they had no effect on your eating. The last column should also be used to record your weight (and your thoughts about it) each time that you weigh yourself.

Every treatment session will include a review of your latest monitoring sheets. You must therefore remember to bring them with you!

Note: From Fairburn (2008, p. 61). Copyright © 2008 The Guilford Press. Reprinted with permission.

Stage 1: Achieving Early Change

Following the initial preparatory session, there are ideally eight twice-weekly appointments. We find that twice-weekly appointments are helpful in building therapeutic momentum. If twice-weekly sessions are not feasible for whatever reason, we suggest trying to approximate this schedule as closely as possible by, for example, combining one in-person session early in the week with an online or telephone session (shorter if nec-

essary) later in the week. This adaptation has not been formally evaluated, but it may help maintain therapeutic momentum and provide additional support during the critical early phase of treatment.

Establishing Collaborative Weighing

Collaborative weighing involves the therapist and patient together obtaining the patient’s weight at the start of the session. This is done once a week (for patients

Day Saturday..... Date March 19th

Time	Food and drink consumed	Place	*	v/l	Context and comments
6.30	Glass water	Kitchen			Feeling really sad that I binged last night.
10:10	2 kiwis Black coffee }	Cafe			Low calorie and high fiber breakfast - will not binge today!
12:45	Smoked turkey on wheat bread Light mayo Black coffee }	Cafe			Usual lunch
5.40 to 7.30	Piece of carrot cake 1/2 pint of ice cream 4 slices of toast with peanut butter Seltzer Raisin bagel 2 slices of toast with peanut butter Seltzer Peanut butter from jar Raisin bagel 3/2 pint ice cream Herbal tea - large	Kitchen	* * * * * * * *	 V V	Help - I can't stop eating. I'm completely out of control. I hate myself. I am disgusting. What is wrong with me?? I am never going to be able to stop. I've ruined another day.
9:00	Rice cake with fat-free cottage cheese Seltzer	Kitchen			Why am I eating again?? Really lonely. Feel horrible. Feel like giving up.

Note. Blank monitoring records, as well at other treatment materials, can be found at www.cbte.co. Monitoring record adapted from Fairburn (2008).

FIGURE 17.6. A completed Monitoring Record. Note: Blank Monitoring Records as well at other treatment materials can be found at www.cbte.co. Monitoring record adapted from Fairburn 2008. Reprinted with permission.

who require weight regain, it may be done more frequently; see below). The latest weight data point is then plotted on an individualized weight graph that is jointly interpreted with particular emphasis on trends over a period of at least 4 weeks. A crucial element of the intervention is that patients do not weigh themselves outside these times.

Collaborative weighing has several purposes. First, as patients' eating habits will be changing in treatment, they are likely to be anxious about any resulting change in their weight. In-session weighing provides week-by-week data on "the number on the scales" that will help patients make informed conclusions about the effect of treatment on their weight. Second, regular in-session weighing provides an opportunity for the therapist to help patients interpret the numbers on the scale, which they may otherwise be prone to misinterpret. Patients may otherwise be overly concerned about expected and inconsequential weight fluctuations often related to hydration status. Third, collaborative weighing addresses one form of body checking, namely, weight checking. Many patients with eating disorders weigh themselves at frequent intervals, sometimes many times a day. As a result, they can become concerned with day-to-day weight fluctuations that would otherwise pass unnoticed. Others actively avoid knowing their weight but remain highly concerned about it. Avoidance of weighing is as problematic as frequent weighing, since it results in patients having no data on which to base their conclusions about the presence or absence of weight change.

Patients often need guidance about how to assess and interpret their weight. They should be informed that body weight fluctuates throughout the day and from day to day according to their state of hydration and a variety of other physiological factors. Frequent weighing results in preoccupation with inconsequential weight fluctuations that tend to be misinterpreted. This may lead patients to restrict their eating, whatever the reading on the scales. This important maintaining process is disrupted by collaborative weighing.

Almost all patients are anxious about the effects of treatment on their weight, and therapists need to acknowledge this and be sensitive to it. Patients are advised against having an exact desired weight, since this does not allow for natural, day-to-day fluctuations. Instead, they are advised to accept a weight range of approximately 6 lb (or 3 kg) in magnitude. It is best that patients postpone deciding upon this weight range until near the end of treatment, when their eating hab-

its should have stabilized and they should be less concerned about controlling their weight and shape. They are also strongly advised against having a goal weight range that results in physical or psychological impairment and maintains the eating disorder. Patients should be encouraged to see that one of the major aims of treatment is to help them judge themselves more broadly rather than solely or largely in terms of their control of their weight, shape, and eating, and that accepting a weight that they can maintain without having an eating disorder or major impairment is part of achieving this goal. This is discussed further below.

Educating Patients about Eating Problems

To ensure that patients have a reliable source of information, we recommend that they read one of the authoritative books on eating disorders.

Establishing Regular Eating

Regular eating is fundamental to successful treatment, whatever the form of the eating disorder. It reliably results in a rapid decrease in the frequency of binge eating (if present) and, it addresses an important type of dieting, "delayed eating" (i.e., putting off eating during the day). For patients who need to regain weight, it introduces regular meals and snacks that can be subsequently increased in size (see below).

Regular eating is introduced around Session 3. It is the first time that patients are asked to change the way that they eat. There are two aspects to the intervention: First, the patient should eat at regular intervals through the day (usually three planned meals each day, plus two to three planned snacks); second, patients' eating should be confined to these meals and snacks. Several points need to be stressed:

1. Patients should be encouraged to choose what they eat in their planned meals and snacks. The only condition is that the meals and snacks must not be followed by vomiting, laxative misuse, or any other compensatory behavior.
2. Patients should not be put under pressure to change what, or how much, they eat at this point in treatment. Doing so, tends to be an obstacle to adopting regular eating.
3. If patients seek advice on what to eat, they should be told that the priority is their pattern of eating and not what they eat. Nevertheless, if patients

want guidance, they should be told that it would be ideal if they adopted a varied diet with the minimum number of avoided foods.

4. While the new eating pattern should be adhered to whatever the patients' circumstances or appetite, it should be adjusted to suit patients' day-to-day commitments.
5. Patients should plan ahead. They should always know when they are going to have their next meal or snack, and there should rarely be more than a 4-hour interval between the meals and snacks. If the day is going to be unpredictable, they should plan as far as possible and identify a time when they can take stock and, if necessary, replan the rest of the day.
6. Patients whose eating habits are chaotic or highly restrictive may need to introduce this pattern in stages.
7. Patients should be told that their sensations of appetite, hunger, and fullness are all likely to be unreliable at present and for the time being should not be used to determine what they eat. Instead, they should adhere to the agreed pattern of eating.

Two rather different strategies may help patients resist eating between the planned meals and snacks. The first is to help them identify activities that are incompatible with eating or make it less likely. They should try to predict when difficulties are likely to arise and intervene early by arranging distracting activities that help them adhere to the regular eating. Another different strategy involves suggesting that urges to engage in an eating disorder behavior (e.g., binge eating, vomiting) are temporary phenomena, on which they do not necessarily need to act. Patients can learn to decenter from these urges and simply observe them rather than try to eliminate them. They will find that these urges dissipate over time. This latter strategy is difficult for most patients, especially in the early stages of treatment, and may be best left until later in treatment, when urges to engage in eating disorder behaviors have started to decrease.

Involving Significant Others

CBT-E was developed as an individual treatment for adults; hence, the involvement of others is not an essential part of the treatment in this form. Despite this, it is our practice to see "significant others" if this is likely to facilitate treatment and the patient is willing for this to

happen. We do this with the aim of creating the optimum environment for the patient to change. There are two specific indications for involving others:

1. If others can be of help to the patient in making changes.
2. If others are making it difficult for patients to change, for example, by commenting negatively on their appearance or eating.

If patients agree to such sessions, we carefully plan the content of these sessions with the patient prior to their taking place.

Typically, the sessions with others last about 45 minutes and take place immediately after a routine session. We hold up to three such session (with patients who require weight regain there may be more such sessions, as we discuss below). Topics other than the eating disorder are not usually addressed. With adolescent patients, there is of necessity far greater involvement of others (Cooper & Stewart, 2008; Dalle Grave & Calugi, 2020).

CLINICAL ILLUSTRATION: PROGRESS THROUGH STAGE 1

Avery was initially very quiet during treatment sessions and appeared to simply agree to everything the therapist suggested. To engage them collaboratively in treatment, the therapist actively encouraged them to ask questions and express any doubts they had. They responded positively to the (formulation) "diagram" as they felt it "explained" their eating disorder, but they were surprised and somewhat skeptical that their attempts to diet during the day were leading to binge eating in the evening. They were able to complete real-time monitoring records and responded well to the educational material.

Two difficulties were encountered at this stage: Avery was very reluctant to be weighed, saying that they would only become more preoccupied with their weight; and they did not think that they would be able to eat regular meals and snacks, because they had never eaten in this way before and it would certainly lead to weight gain. Once the therapist explained the rationale for weekly weighing in more detail emphasizing that it would help them to gain accurate information over time, they agreed to be weighed but were nevertheless very anxious about the "number on the scales." However, they agreed to continue weighing and discovered that knowing

their weight regularly and learning to interpret weekly changes with their therapist's help led them over time to be much less concerned about weighing and weight fluctuations. They also came to realize that their preoccupation had not increased. Regarding regular eating, the therapist explained, with reference to the formulation, that adopting this pattern of eating would help to protect them from binge eating and hence to begin to overcome their eating problem. Their reluctance to eat meals and snacks for fear of weight gain was tackled by reassuring them that at this stage, the change they were being asked to make was about the timing and regularity of eating rather than a change in the amount or type of food eaten. Also, it was pointed out that regular eating results in a decrease in the frequency of binge eating; therefore, overall, it would be unlikely that they would be eating more. They were willing to experiment with eating regularly, albeit in a very controlled and restrained way, and began to experience a reduction in the frequency of their binge eating.

Stage 2: Taking Stock

Stage 2 is a transitional stage in treatment. It has three aims:

1. To conduct a joint review of progress.
2. To revise the formulation, if need be.
3. To design Stage 3.

Sessions are held once a week. While reviewing progress, the therapist should continue to work with the patient to implement the procedures introduced in Stage 1.

The reason for conducting this formal review of progress is that there is strong evidence across all eating disorders that the degree of change during the first few weeks of treatment is a potent predictor of outcome (Linardon, Wade, et al., 2017). If progress is limited, this needs to be recognized early on, and its explanation sought, so that treatment can be adjusted as needed.

Conducting a Joint Review of Progress

The review of progress is best done systematically, with the patient once again completing the EDE-Q, the CIA, and the measure of general psychiatric features. Reviewing the patient's monitoring records can also be helpful. In addition, patient and therapist should consider the degree to which the patient has been able to comply with the various elements of treatment.

Generally, patients' views concerning their progress tend to be unduly negative. An important task for the therapist is to help the patient arrive at a balanced appraisal of what has changed and what has not. Typically, there will have been a decrease in the frequency of binge eating and compensatory purging (if present), and an improvement in the pattern of eating, whereas concerns about shape will not have decreased much, if at all (to a large extent because they have not been addressed).

One important, and sometimes overlooked, reason for progress not being as good as might be expected is the presence of clinical depression. Ideally, clinical depression should be detected and treated before treatment but, inevitably, it is sometimes missed or develops during treatment. If the patient has a clinical depression, it is best to consider suspending CBT and treat the depression, resuming CBT-E once there has been a response. Our practice has been to treat clinical depression with antidepressant medication (Fairburn et al., 2008a).

Revising the Formulation

It is important to review the formulation and consider what has been learned during Stage 1. Often, no change is indicated, but sometimes problems and processes are detected that were not obvious when the formulation was originally created. For example, it may have emerged that overexercising is a far greater problem than had been thought. If so, the formulation may need to be revised. Also, this is the point in treatment when we recommend assessing whether it may be advisable to use the "broad" form of CBT-E. The contribution of clinical perfectionism, core low self-esteem, and interpersonal difficulties as obstacles to treatment progress should be considered and, if appropriate, one of these modules should be incorporated into treatment (for further details please see Fairburn, Cooper, Shafran, Bohn, & Hawker, 2008, and www.cbte.co/for-professionals/web-based-training).

Designing Stage 3

Last, Stage 2 is the time when Stage 3 should be designed. At this stage, the treatment becomes highly individualized. The therapist, in collaboration with the patient, should decide which elements of Stage 3 will be of most relevance to the patient and in what order they should be implemented (see below).

CLINICAL ILLUSTRATION: PROGRESS THROUGH STAGE 2

A review of progress conducted in Stage 2 with Avery revealed that they were making good use of the treatment procedures and were completing agreed “next steps” between sessions. They were keeping records as agreed, eating regular meals and snacks most of the time, and they were no longer extremely anxious about collaborative weighing; nor had they become more preoccupied with their weight as they had thought. There was a marked reduction in the frequency of their binge eating and vomiting, although they still experienced episodes of binge eating and vomiting once or twice a week. Problems that still needed addressing in Stage 3 included their dieting, stress-related binge eating, and their overevaluation of the importance of weight and shape. It was decided that there was no need for the broad form of CBT-E.

Stage 3: Addressing the Key Maintaining Mechanisms

This is the main part of treatment. The focus is on addressing the key mechanisms that are maintaining the patient’s eating problem. These may be categorized under six headings:

1. Overevaluation of shape and weight
2. Overevaluation of control over eating
3. Dietary restraint
4. Event- and mood-related changes in eating
5. Dietary restriction
6. Being underweight

The relative contributions of these mechanisms vary from individual to individual. The first four are considered here. Dietary restriction when linked to being a significantly low weight and/or needing to regain weight to recover are addressed separately, when we discuss the adaptations required for those who are underweight. The order in which these mechanisms are addressed depends on their relative importance in maintaining the patient’s disorder and the length of time it takes to address them. Generally, it is best to start by addressing concerns about shape and weight, because they are the most complex of the maintaining features with links to most other features, and it takes the longest for these concerns to change.

At the same time, the therapist needs to continue implementing the procedures introduced in Stage 1. If

the patient is receiving the broad form of CBT-E, one or more of the additional treatment modules will also be employed, as described in the guide and the web-based training program (Fairburn, Cooper, Shafran, Bohn, Hawker, Murphy, et al., 2008; www.cbte.co/for-professionals/web-based-training).

Addressing the Overevaluation of Shape and Weight

At the heart of most eating disorders is the distinctive overevaluation of shape and weight, with self-esteem derived largely, or even exclusively, from shape and weight, and the ability to control them. As described earlier, most of the other features of these disorders are secondary to this distinctive feature and its consequences. This overevaluation occupies a central place in most patients’ formulation and is a major target of treatment. Clinical experience and research evidence suggest that unless this feature is successfully addressed, patients are at substantial risk of relapse. There are five aspects to this process:

1. Identifying the overevaluation and its consequences
2. Developing marginalized domains of self-evaluation
3. Addressing body checking
4. Addressing body avoidance
5. Addressing spikes in body image concern

While identifying the overevaluation and its consequences necessarily precedes the other aspects listed here, these other aspects do not need to be addressed in the order listed here. Toward the end of Stage 3, it is important to also begin to help patients develop skills for dealing with setbacks.

Identifying the Overevaluation and Its Consequences

The starting point is educating patients about the notion of self-evaluation and helping them to identify their schemes for self-evaluation. The implications of such schemes are discussed and plans for addressing the expressions of the overevaluation are devised.

Briefly, we recommend that the therapist start by explaining that most people tend to judge themselves on the basis of meeting personal standards in the areas of life they value. They derive their views about their self-worth (self-esteem) based on their perceived suc-

cess or otherwise in these valued areas. Patients are then encouraged to generate a list of areas in their lives from which they derive self-worth. Almost invariably this will include body shape and weight, and perhaps also controlling eating. The therapist explores the relative importance of these domains of self-evaluation; the clue to their relative importance is the magnitude of patients' responses when things go well or badly in these areas. The various areas of life listed can then be ranked and represented visually using a pie chart, which the therapist and patient draw together. This is intended to help make a potentially highly abstract discussion more concrete (given this, any visual representation that resonates for the patient would be acceptable here). The pie chart of someone without an eating disorder is shown in Figure 17.7 and this may be contrasted with one typical of someone with an eating problem (Figure 17.8), in which there is a large "slice" representing the overevaluation of shape and weight.

It is useful for patients to review their initially constructed pie charts on several occasions before their next session, so that it can be discussed further and adjusted as needed. Often revisions take the form of expanding the size of the slice representing the importance of shape and weight.

Patients are asked to consider the implications of their scheme for deriving self-worth (as represented by the pie chart) and to reflect on whether there might be any problems inherent in such a scheme. Discussion generally leads to the identification of three main problems:

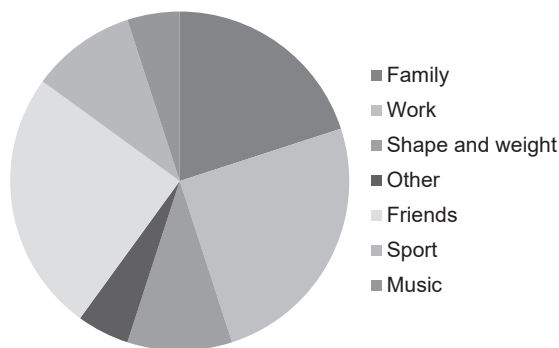


FIGURE 17.7. Pie chart of person without an eating disorder. From Fairburn (2008, p. 99). Copyright © 2008 The Guilford Press. Reprinted by permission.

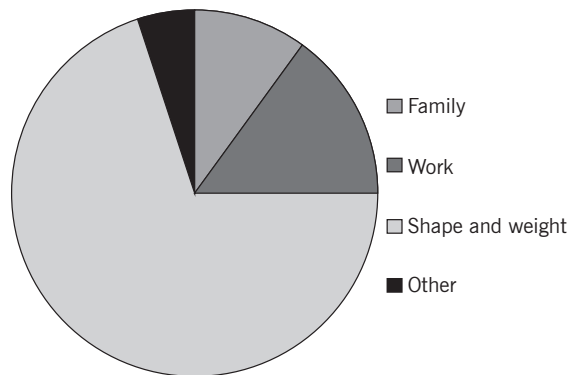


FIGURE 17.8. Pie chart of person with an eating disorder. From Fairburn (2008, p. 98). Copyright © 2008 The Guilford Press. Reprinted by permission.

1. Having a pie chart with a dominant slice is "risky." A dominant slice makes people particularly vulnerable should anything threaten their ability to meet their personal standards in the area concerned.

2. Judging oneself largely based on appearance and particularly on weight and shape is problematic, because these features are only controllable to a limited extent. The therapist should discuss what has been termed *diet culture*, the false equation of thinness/fitness and specific body shapes with health, self-control, and superiority, and explain that this places undue pressure on all, especially those living in larger bodies. This, together with the incorrect belief that weight loss is inherently good and that anyone can achieve a desired body size with enough determination and willpower, can lead people to strive for narrowly defined, unrealistic goals which are both unattainable and harmful. It also results in prevalent weight stigma within society, which may also be internalised by individuals. Instead, it is important to convey that, contrary to these harmful societal narratives, body weight and shape are under strong genetic and physiological control. Patients should be encouraged to evaluate such "health" and weight loss advice, and recognize that much of this is driven by industries that stand to make enormous financial gains by encouraging and promoting body dissatisfaction. Furthermore, it is helpful for patients to consider that unrealistic beauty and body image standards are reinforced by digital manipulation

of media images (see further discussion below in the section addressing body image).

3. Placing great importance on shape and weight drives people to pursue unhelpful behavior such as dieting, purging, driven exercising and body checking, among others, and these behaviors maintain eating problems.

Such a discussion naturally leads to the final step in the examination of self-evaluation, namely, the creation of a formulation that includes the consequences of the overevaluation (the “extended formulation”). A discussion of what the patient experiences and does, because of the importance placed on shape and appearance, leads to a diagram resembling that in Figure 17.9. The therapist needs to also discuss with the patient the ways in which these consequences (e.g., body checking) also serve to maintain the overevaluation. In collaboration with the patient, the therapist should add the upward feedback arrows.

The next step involves the therapist and patient devising a plan to address the concerns about shape and weight. There are two major overarching and complementary strategies:

1. To develop new domains for self-worth.
2. To reduce the importance attached to shape and weight.

Developing Marginalized Domains for Self-Evaluation

While tackling expressions of the overevaluation of shape and weight (see below) reduces the extent of the

overevaluation and the shape and weight-related “slice” of the pie chart begins to shrink, it is also necessary to increase the number and importance of other domains for self-evaluation. To achieve this, patients need help to begin to become actively involved with other aspects of life. There are five steps to this process that should continue to be on the agenda throughout the rest of the treatment:

1. Explaining the rationale for developing new domains for self-worth.
2. Helping the patient identify new activities that might be engaging and would be a potential source of self-worth.
3. Agreeing on one, or possibly two, activities that the patient can try.
4. Ensuring that the patient actually tries the activity identified, often using a problem-solving approach (described later in the chapter).
5. Reviewing progress each week, with the therapist being encouraging and facilitative.

Simultaneously, the patient’s overevaluation of shape and weight should be directly targeted, usually starting with body checking, which is often of central importance in maintaining the patient’s concerns.

Addressing Body Checking and Avoidance

Patients often do not describe this behavior, unless asked about it, and many are not fully aware of it.

The first step involves providing information about body checking, body avoidance, and their consequences, stressing the following two points:

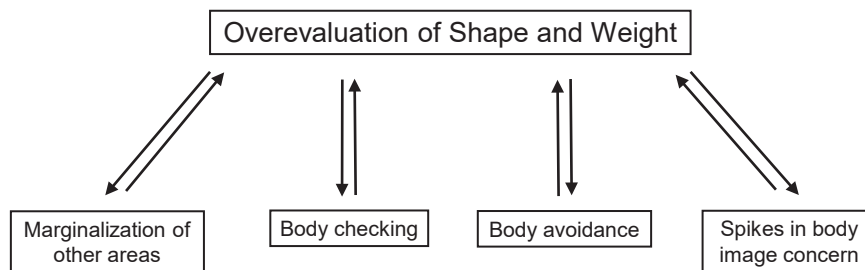


FIGURE 17.9. Extended Formulation. From Fairburn (2008, p. 101). Copyright © 2008 The Guilford Press. Reprinted by permission. This figure may be downloaded from www.credo-oxford.com.

1. Most people assess their body (e.g., check weight, assess shape in the mirror) to some extent but many people with eating problems repeatedly check their bodies. Such checking can become “second nature,” so that patients may not be aware that they are doing it. Frequent checking can increase and maintain dissatisfaction with their appearance.

2. Some people with eating problems avoid seeing their bodies and dislike other people seeing them, too. Often, these people engaged in body checking in the past but switched to avoidance because the repeated checking became intolerable. Body avoidance is problematic, because it allows concerns and fears about shape and appearance to persist in the absence of any accurate information and, in most such cases, needs to be addressed.

The therapist and patient first need to identify any checking and avoidance that is present. A specific monitoring record may be used for this purpose (www.cbte.col/download/my-monitoring-record-for-shape-checking). Since recording body checking can be highly distressing for some patients, we recommend asking patients to only do it for two 24-hour periods. It is almost certainly useful to forewarn patients that it might be distressing, but that it will yield information that is helpful in overcoming their eating disorder. It is common for patients to be greatly surprised by how often they check their shape.

Once various forms of body checking have been identified, it is helpful to discuss two general points:

1. Body checking generally involves focusing on aspects of one's body shape that one dislikes. When doing this, apparent flaws that would normally go largely unnoticed become more salient. Furthermore, intense focus and scrutiny often lead to apparent defects being magnified. These processes are likely to contribute to body checking having adverse effects.

2. Stopping or modifying unhelpful forms of body checking is, with time, generally experienced as a relief.

ADDRESSING BODY CHECKING

Body checking can be problematic in a variety of ways: the way that it is done; its frequency; and patients' interpretations of their findings. We recommend that patients consider the following questions each time that they are about to check themselves:

- What are they trying to find out?
- Can checking in this way produce the information they are seeking?
- Might there be adverse effects from such checking, the frequency of this checking or the way they are checking?
- Is there a better alternative to obtain the information they seek or is such information simply not helpful or likely to have adverse effects?

Mirror use and other reflection checking, including digital formats (e.g., selfies, self-view mode in virtual meetings), deserves particular attention, because mirror images and/or reflections can provide credible yet highly misleading information and therefore play an important role in maintaining many patients' body dissatisfaction and concerns. We recommend helping patients to question their reflection checking and to be mindful of how they use mirrors, self-view, and any other similar methods of body checking. Mirrors, for example, are generally useful for applying makeup, brushing and styling hair, shaving, and so forth. Full-length mirrors can be helpful for ensuring clothing is tucked in appropriately or for checking overall presentation. Self-view allows checking that one can be seen properly by others. Patients are asked to consider whether it is helpful or informative to scrutinize their body several times a day to find out if they have gained weight or to look only at a particular aspect of their body that they dislike many times each day, or to look at themselves naked in a full-length mirror. Any of these forms of checking are likely to risk increasing their dislike of their shape through the magnification process mentioned earlier. It should be stressed that we are not recommending total avoidance of reflection checking but rather that patients consider carefully how to do so appropriately (e.g., as outlined earlier) and avoid ways of checking that have adverse effects.

Another form of body checking that may actively maintain dissatisfaction with shape involves comparing one's body, with other people (in person, virtual, or photographic comparisons). The way these comparisons tend to be made usually results in patients concluding that their bodies are unattractive relative to those of others. As noted earlier, individuals' appraisals of their bodies often involve intense scrutiny and selective attention to body parts they dislike, viewed from particular and sometimes unusual perspectives—including angles that could not easily be used to look at others (e.g., looking down at one's thighs). The scru-

tiny is liable to result in the magnification of perceived defects, and the selective attention increases overall dissatisfaction with shape. In contrast, patients' assessment of others is often very different. They tend to use different standards of judgment, usually making more holistic and often less critical judgments about other people. Furthermore, when making these comparisons, they tend to choose a biased reference group, generally people who they believe are thinner or more muscular or more attractive than they believe themselves to be. Increasingly, they also may be comparing themselves to manipulated and edited digital snapshot images that bear little resemblance to real people.

The steps involved in addressing comparison making are as follows:

1. Helping patients identify when and how they make comparisons.
2. Encouraging patients to consider whether their comparisons were inherently biased—in terms of the object of the comparison, as well as how the comparison was made. We recommend highlighting:
 - Body checking provides patients with a perspective on their bodies that is difficult, if not impossible, to get on someone else's body. For example, what they see when looking at themselves in the mirror is quite unlike what they see when looking at someone else.
 - Comparing themselves with people portrayed in either traditional or social media (models, film stars, celebrities or friends' and acquaintances' social media profiles) is problematic since they may have chosen an unrepresentative subgroup and, in any event, images have almost certainly been carefully selected and manipulated or both.
3. Certain homework tasks could usefully complement these discussions. For example, patients may be asked to experiment with being less selective when choosing targets for comparison or, rather than trying to stop comparing, which can be difficult, they can be encouraged to choose something neutral for their comparison making (e.g., eye color, hair style, shoes). Patients should also be encouraged to reflect on whether they judge others who are seen as “more attractive” using the same standards of scrutiny they apply to themselves. After completing such exercises, it is important to help patients reflect on what they have learned and what they may wish to do differently in the future.

4. While it is helpful to discuss biased comparison making and its implications as outlined earlier, it is also essential to discuss societal pressures. Narratives about dieting and weight loss promote unrealistic and unattainable goals for body weight and shape, often reinforced by edited and manipulated digital images, and suggest that not attaining these goals is a matter of personal failure. Patients should be supported in devising ways to distance and insulate themselves from these extremely unhelpful pressures as far as possible.

ADDRESSING BODY AVOIDANCE

It is helpful for patients to gradually reverse their body avoidance and begin to feel more comfortable seeing and feeling their bodies. In addition, it is helpful to make gradual progress toward allowing others to see their bodies. Examples of behaviors to gradually phase out might include dressing and undressing in the dark and wearing baggy, body-disguising clothes (if the reason for doing so is body avoidance rather than aesthetic preference or conformity with religious or cultural norms). Participation in activities that involve some body exposure can be helpful if they are activities the person would otherwise wish to undertake (e.g., swimming, taking part in sports activities, allowing themselves to be photographed). Depending on the extent of the problem, tackling body avoidance may take many successive sessions. As there is sometimes a risk of patients returning to repeated body checking, the therapist should inquire about any checking and help patients ensure that it is not unhelpful or risky.

Spikes in Body Image Concern

Marked increases in body image concerns, sometimes referred to by patients as “feeling fat,” are not only an expression of overconcern with weight and shape and their control but also maintain it. These fluctuating episodic increases are often mistakenly equated with actual changes in body shape or weight that patients believe should be acted on by, for example, renewed efforts to restrict eating or to increase exercising or purging. Hence these episodes of increased concern are an important target of treatment.

Unlike other aspects of the eating disorder, which remain relatively stable, the occurrence of these episodes tends to fluctuate markedly from day to day and even within a single day. It is our impression that in patients with eating disorders certain, usually negative,

emotions and bodily experiences come to be labeled as intense body dissatisfaction or spikes in body image concern. As these episodes tend to increase overall body image concern and maintain the disorder, it is important to understand and address them in treatment.

There are five steps in addressing episodes of increased body image concerns:

1. **Psychoeducation and reframing.** The therapist should first explain that these episodes or spikes occur over a short period of time and, as such, are unlikely to reflect true changes in body shape or size. Instead, they may be indicative of emotions or physical sensations (e.g., anxiety, shame, boredom, or physical discomfort) or be due to body checking or comparison making.

2. **Monitoring and awareness.** Patients should be asked to record times when they have particularly intense increases in body image concerns. This can be done as part of the normal recording process, using the right-hand column of the recording sheet. This requires accurate real-time recording. When patients record “spikes,” they should also think about (and record) what else they are feeling at the time—in terms of emotions or physical sensations and/or anything else that has just happened (e.g., an event such as body checking or comparison making).

3. **Developing insight into triggers.** Once patients have monitored these episodes, they should ask themselves two questions each time they experience them:

- What has happened in the last hour that might have triggered this feeling?
- What else am I *feeling* just now?

4. **Identifying common triggers.** It usually emerges that the patient's experiences of intense increases in body image concerns are triggered by either the occurrence of certain negative mood states or by physical sensations that heighten body awareness. Examples of these two types of stimuli include the following:

- Feeling bored, depressed, lonely, or tired.
- Feeling full, feeling worried after eating an avoided food, bloated, or sweaty; feeling of thighs rubbing together; clothing that feels tight.

5. **Addressing triggers and reinterpreting these spikes.** Over subsequent weeks, patients should continue to do this whenever they have strong increases in body image concerns. In addition, they should ad-

dress any masked problem (e.g., feeling bored) using the problem-solving approach (described later in this chapter). In some patients, problem solving will already have been taught in the context of addressing event-triggered changes in eating. In others, the approach needs to be introduced at this point. When tackling patients' response to heightened body awareness, therapists should help them appreciate that the problem is their negative interpretation of these sensations rather than the sensations themselves. The sensations can be considered markers or warnings that something else is happening that needs attention.

Addressing episodes of increased body image concerns typically takes many weeks and will be a recurring item on the session agenda. Generally, the frequency and intensity of these episodes progressively decline and patients' “relationship” to the experience changes, such that it is no longer equated with changes in body shape or size. Once such a metacognitive change takes place, these episodes of intense concern no longer have the power to reinforce ongoing body image problems and eating disorder behaviors.

Addressing Dietary Restraint and Food Avoidance

Dieting is one of the most prominent features of patients with eating disorders. A major goal of treatment is to reduce or, if possible, eliminate dieting. As noted earlier, attempts to restrict eating (“dietary restraint”) may not result in undereating in physiological terms (“dietary restriction”) and hence weight loss. In this section we focus on addressing dietary restraint and dietary rules. Addressing dietary restriction is discussed in a later section on treatment of those who are a low weight. Many patients with eating disorders practise a form of dietary restraint that is both extreme in intensity and rigid in form. Patients set themselves multiple demanding dietary rules. These rules are harmful and contribute to the persistence of the eating disorder. The rules may concern when patients eat (e.g., not before 6:00 P.M.), how much they should eat (e.g., less than 600 kcal per day) and, most especially, what they should eat, with most patients having many foods that they are attempting to avoid (“food avoidance”). Many have all three types of dietary rule. As a result of these rules, patients' eating is inflexible and restricted in nature. Dietary restraint is valued, and patients tend not to be aware of its adverse effects.

When addressing dietary restraint, an important first step is for the therapist to help patients see that their dieting and the rules to which they attempt to adhere are a problem. This can be done with reference to their formulation, which in most cases shows that dieting plays a central role in the maintenance of their eating problem. If this is the case, it will need to be addressed to overcome the problem. Also, dieting may well have many adverse effects on their day-to-day life. These may be clear from the CIA (Bohn & Fairburn, 2008); for example, it may preclude eating out; it may result in tension at mealtimes; and it may cause preoccupation with thoughts about food and eating. During this discussion, earlier information about the harmful effects of the value placed on dieting and achieving a socially sanctioned ideal body shape in our society may need to be revisited.

Once it has been agreed that having many extreme and inflexible dietary rules is a problem, therapist and patient need to identify the various dietary rules present. Many will be evident by this stage in treatment. Addressing these rules involves:

1. Identifying specific rules and their motivation.
2. Exploring the likely consequences of breaking the rule. The patient may believe that breaking the rule will lead to weight gain or invariably result in binge eating.
3. Devising and implementing a plan to break rules to explore the consequences of doing so.
4. Analyzing the implications of planned rule breaking.
5. Planning further breaking of rules until they cease to have significance.

Food avoidance may be particularly important for patients who binge-eat, because eating an avoided food may be the immediate trigger of an episode of binge eating. Nevertheless, food avoidance should be addressed for all patients when it has a role in maintaining the eating disorder. First, avoided foods should be identified. A good way of doing this is to ask patients to visit a local supermarket and note all foods they believe they should not eat and/or would be reluctant to eat because of their possible effect on their shape or weight, or because they think that they might trigger an episode of binge eating. These avoided foods are sometimes referred to as *feared foods*. We prefer not to use this term, as we do not believe that what is involved in food avoidance is essentially an anxiety reaction; rather,

it is a belief that the consequences of eating these foods, which are liked, will be unacceptable. The patient and therapist should categorize these avoided foods according to the difficulty the patient would experience eating them. Patients should then be encouraged to introduce these foods progressively into their diet, starting with the easiest and gradually moving on to the most difficult. Often this requires detailed planning to ensure that the introduction of an avoided food does not lead to overeating or binge eating as sometimes predicted. The amount eaten should be determined by the patient, with the eventual goal being that the patient should be capable of eating more typical quantities without difficulty. The systematic introduction of avoided foods should continue until patients are able to eat them without difficulty. Often this will take the remainder of treatment and sometime beyond it.

Other dietary rules should be tackled in a similar fashion, with a focus on both the belief that is maintaining the rule and breaking the rule itself. It is especially important to address rules that interfere with social eating as these tends to be associated with impairment in everyday functioning.

Addressing Event and Mood-Related Changes in Eating

In patients with eating disorders, eating habits may change in response to outside events and moods. The following are common:

- Binge eating or vomiting, or both, to cope with negative events or adverse moods. Binge eating has two relevant properties: It may be distracting and take the patient's mind off aversive thoughts, and it may have a direct modulating effect on mood, in that it dampens strong mood states. The latter property may also be true of vomiting and intense exercising.
- Eating less or avoiding eating to gain a sense of personal control when external events feel outside the patient's control. This is seen most often in low-weight patients.
- Eating less to influence others; for example, it may be a way of exhibiting feelings of distress or anger.

In Stage 3, if events and moods appear to contribute to the maintenance of the eating disorder, their contribution needs to be assessed and addressed, with the goal of helping patients deal with events and moods directly

and effectively. With most patients, the first step is to identify such changes in eating through real-time recording, and in subsequent sessions examine in detail particular examples to identify the triggers involved. Then, patients should be introduced to a variant of the standard cognitive-behavioral technique of problem solving, termed *proactive problem solving*. The distinctive feature of this approach is its emphasis on spotting problems early. It is described in detail in the original treatment guide. The approach is remarkably effective in most cases.

One exception to its effectiveness is for those patients who have difficulty tolerating mood states that involve intense emotional dysregulation. These patients have what we have termed *mood intolerance*. Sometimes these patients may have been diagnosed with a borderline personality disorder, although this is often unwarranted, as noted earlier. While patients who struggle to tolerate intense mood states may benefit from proactive problem solving, they may also need more direct help coping with their moods. It is worth noting that it is not always possible to distinguish between a heightened *sensitivity* to emotional states and the *experience* of especially intense emotions. We use an approach that overlaps with elements of dialectical behavior therapy (Linehan, 1993) and is described in more detail in the original treatment guide.

Setbacks and Mindsets

The core psychopathology of eating disorders may be viewed as a *mindset*, or frame of mind. While normally one's "mind-in-place" varies with changing circumstances, in people with eating disorders, it tends to get locked in, and patients' thinking becomes persistently dominated by eating disorder thoughts. It leads patients to filter both internal and external stimuli in a distinctive way; it directly results in the behaviors characteristic of eating disorders; and it may result in the mislabeling of various physical and emotional experiences as marked increases in body concerns.

The cognitive-behavioral strategies used in CBT-E are designed to address both the key features of the eating disorders and, most importantly, the processes that are maintaining them. In patients who are making good progress, these mechanisms gradually erode during Stage 3, with the result that healthier and situationally more appropriate mindsets start to move into place, albeit temporarily at first. Such shifts in mindset usually become evident toward the end of treatment.

They are often reported by patients with surprise, noting that they suddenly realized for a period of time they had not had their usual eating disorder thoughts. At first, the eating disorder mindset is prone to come back into place very easily (e.g., a friend discussing a diet). Such "setbacks" can readily escalate into a full-blown relapse unless they are addressed as quickly as possible. It is therefore important to raise the topic of mindsets at this stage in treatment so that patients can learn to identify their eating disorder mindset coming into place by being aware of characteristic early changes in their behavior. Once patients can detect these early behavior changes, they can learn how to modify the mindset, thereby preventing the setback from becoming established. Practice in becoming aware of the mindset returning and dealing with it effectively is of great value, as this skill—intervening very early at the beginnings of a setback—may account for the low relapse rates following CBT-E. Experiencing occasional setbacks later in treatment can actually be helpful, because it gives patients an opportunity to utilize and practice the strategies and procedures for controlling mindsets while still in treatment. Full details of how to help patients manipulate their mindset and address setbacks are provided in the original treatment guide.

CLINICAL ILLUSTRATION: PROGRESS THROUGH STAGE 3

The first issue tackled in Stage 3 was Avery's over-evaluation of weight and shape. When they and the therapist completed a pie chart, Avery was distressed to see that controlling eating, weight, and shape filled three quarters of their chart. They were also able to see, after discussion, that other areas in their life had become marginalized, largely because of their shape and weight concerns. As a first step toward "increasing" the domains in their pie chart, they agreed to pursue their previous interest in drawing and to investigate and subsequently join an art class. In discussion with the therapist, Avery was able to recognize that their body checking and the frequent surges of body image concerns that they described as "feeling fat," were an expression of their shape and weight concerns. They also understood, with the help of the extended formulation, how these expressions were maintaining their concerns. They were much less convinced by the therapist's suggestion that dieting was also playing a role in the maintenance of their disorder. Thus, while Avery was able

to reduce their body checking (and remove all but one of the six mirrors in their room) and relabel “feeling fat,” they were very reluctant to tackle their dieting, which consisted of numerous rules about eating and a long list of avoided foods. They did not see dieting as a problem and thought that they would feel better about themselves if they were to lose weight. They also thought that strictly avoiding foods that they usually ate during their binge-eating episodes was the best strategy to prevent these episodes occurring. The therapist addressed this difficulty in treatment by returning to the formulation and explaining how this form of dieting maintained their binge eating in the same way as their delayed eating at the beginning of treatment had also done. In addition, the therapist initiated a discussion about the major adverse effects of such dieting, stressing preoccupation with food and eating, anxiety about eating generally, and an inflexible eating pattern that often prevents people from eating socially. Avery was eventually able to begin to break some of their dietary rules and to start eating previously avoided foods without experiencing the predicted consequences of weight gain and more binge eating. With encouragement from the therapist, they were also able to reconsider the advantages and disadvantages of losing weight. They were even able to consider that accepting a small increase in their weight might make it easier for them to eat more freely and to no longer have to spend so much time dieting and avoiding social occasions.

By this stage Avery had almost stopped binge eating, but an analysis of remaining residual binge-eating episodes revealed that they were more likely to happen if they had been drinking alcohol. As a result, they decided to further reduce their alcohol consumption.

Toward the end of this stage in treatment, Avery could see that the eating problem was beginning to resolve and that they were at times able to distance themselves from it and the eating disorder “mindset.” Minor setbacks during treatment had helped them identify that delaying eating, skipping snacks, and going back to certain diet foods were likely early warning signs of the return of their eating disorder mindset. They were able to accept that an increase in their weight had contributed to making this possible and they were prepared to accept this given the progress they had made.

Stage 4: Ending Well

This is the final stage in treatment. With patients who are receiving 20 sessions of treatment, it comprises

three sessions over 5 weeks (i.e., the sessions are 2 weeks apart). It has two broad aims:

1. To ensure that the changes made in treatment are maintained and built upon
2. To minimize the risk of relapse in the future

At the same time, patients discontinue self-monitoring and transfer from in-session weighing to weighing themselves at home.

Ensuring That the Changes Made in Treatment Are Maintained

The first step in ensuring the maintenance of changes made in treatment is to review patients’ progress and identify remaining problems. This can be done in much the same way as in Stage 2, using the EDE-Q and CIA as a guide. Based on this review, therapist and patient jointly devise a specific short-term plan for the patient to follow until the posttreatment review appointment in 5 months’ time. Typically, this includes further work on body checking and food avoidance, as well as encouraging the patient to maintain efforts to develop new interests and activities.

Minimizing the Risk of Relapse in the Future

Relapses are not all-or-nothing phenomena. They occur in degrees and may start as a “slip” or setback that then becomes established. Commonly, the slip comprises the resumption of dietary restraint, often triggered by an adverse, shape-related event (e.g., a critical comment, or clothes feeling tighter than usual). In patients who were previously binge eating, this return of dietary restraint may lead to an episode of binge eating through the mechanisms described earlier, which in turn encourages yet greater dietary restraint, thereby increasing the risk of further episodes of binge eating. Within days, most aspects of the eating disorder may have returned. The patient’s reaction to this sequence of events is crucial in determining what happens. If it is detected early on, as discussed earlier, it is relatively easy to intervene, but if it is not, it becomes progressively more difficult to deal with the setback.

To minimize the risk of relapse in the long term, the therapist needs to do the following:

1. *Discuss the risk of relapse with the patient, highlighting common triggers and the likely sequence of events for*

them. Some patients hope that they will never have any eating difficulties again. Without being discouraging or making patients' hopes for the future unduly negative, therapists need to ensure that patients' expectations are realistic; otherwise, there is a risk that they will be vulnerable to react negatively to any emerging setback. Patients should learn to view their eating disorder as their particular vulnerability, that is, their likely response to stress in general, as well as to certain triggers.

2. *Stress the importance of detecting problems early, before they become entrenched.* Both therapist and patient should identify likely early warning signs of an impending relapse. For patients who are prone to binge or purge, these forms of behavior often occur early during any setback and are readily noticeable. Patients whose eating disorder is primarily characterized by dietary restriction may need help to spot signs of the return of the eating disorder mindset.

3. *Construct with the patient a plan of action (a written personalized "long-term maintenance plan") for use in the future should problems arise.* There are two important elements: focusing on a possible reemergence of the eating problem, and reversing it and addressing the triggers of the setback. In general, the former is achieved by doing what was learned in treatment, while the latter is achieved using problem solving.

4. *Discuss when the patient should seek further help.* It is important that patients seek further help if it is needed. If patients are unable to get back on track within a few weeks using what they learned in treatment and their maintenance plan, we suggest that the patient should seek help.

Ending or Extending Treatment

It is unusual not to end CBT-E as planned. If patients have reached the point where the central maintaining mechanisms have been disrupted, treatment can and should finish. Otherwise, patients (and therapists) are at risk of ascribing continued improvement to the ongoing therapy rather than the resolution of the eating disorder. In practice, this means that it is acceptable to end treatment with patients who are still dieting to an extent, perhaps binge eating and vomiting occasionally, and those who have residual concerns about shape and weight.

At times there are grounds for extending treatment. In our view, the main indication for doing this is the presence of eating disorder features that continue to in-

terfere significantly with the patient's functioning and are unlikely to resolve of their own accord but may resolve with further CBT-E treatment. Another reason to extend treatment is to compensate for the impact of disruptions to treatment, generally due to the emergence of a clinical depression or the occurrence of a life crisis.

The occasional patient benefits little from CBT-E. It is our practice to refer such patients for a different, and perhaps more intensive treatment rather than to extend outpatient CBT-E.

CLINICAL ILLUSTRATION: PROGRESS THROUGH STAGE 4

Avery was able to end treatment on time. By the end of treatment, they were eating regularly and were no longer binge eating and vomiting. To their surprise their weight had largely remained unchanged during treatment, although toward the end of treatment they had decided that they were prepared for it to increase slightly, so that they would not have to try to adhere to so many rules and would be able to eat more freely. They identified regular eating, not avoiding certain foods and taking up new activities, as the most helpful aspects of treatment and planned to work on maintaining these changes until the post treatment review. To prevent further problems, they identified two early warning signs that were important: dieting (skipping meals or snacks and avoiding certain foods) and increasing their alcohol intake. Although they were still somewhat dissatisfied with their shape, they were resolved that trying to diet as they had done before was not helpful. They also agreed that their acceptance of their increased weight helped them to no longer feel the need to diet so strictly. They planned to continue to find other ways of accepting and valuing themselves.

The Posttreatment Review Appointment

We routinely hold a posttreatment review appointment about 20 weeks after the completion of treatment. During the intervening period, patients do not receive any further therapeutic input. The review session has several purposes:

1. *To reassess the patient's state and need for further treatment.* If residual eating disorder features are significantly interfering with the patient's functioning, then further treatment should be considered. If there

has been a setback, a few brief sessions may be needed to get the patient back on track.

2. *To review the patient's implementation of the short-term maintenance plan.* The therapist should review the plan with the aim of identifying residual eating disorder features that the patient needs to continue to address.

3. *To discuss how any setbacks have been handled.* The patient's ability to detect and address setbacks should be reviewed in detail.

4. To review and amend the long-term maintenance plan if necessary.

CLINICAL ILLUSTRATION: PROGRESS AT THE POSTTREATMENT REVIEW APPOINTMENT

At the review appointment, Avery described several occasions when, under stress, they had experienced a "lapse." On these occasions, they were able to implement the strategies they had learned in treatment to prevent a "relapse." They described their acceptance of their higher weight as helpful in that they were no longer under such pressure to restrict their food intake. Continuing to find other ways to derive self-esteem and to value themselves was helpful in shifting their focus away from relying almost entirely on weight and shape. They thought this was something that needed continued work.

CBT-E FOR UNDERWEIGHT PATIENTS

The great majority of patients with an eating disorder undereat at some stage and many may become underweight or achieve a weight that is unsustainable for them without adverse physical and psychological consequences, at least for a period of time. Generally, this does not last, and they regain the weight they lost, but a minority sustain significant undereating and remain underweight or at an unsustainable weight. The considerations and modifications described here are suitable for such patients, often those given a DSM diagnosis of AN or AAN, but not exclusively.

CBT-E for underweight patients and those requiring weight restoration as part of recovery does not require major modifications, because as we have seen earlier, the core psychopathology and behaviors are shared across the various eating disorder presentations. It does

need to be adjusted to accommodate three often prominent issues for those who are low weight or have lost a significant amount of weight.

1. Limited motivation to restore weight
2. Being underweight/having lost a significant amount of weight
3. Undereating ("dietary restriction")

To do this, CBT-E needs to be extended in length, because it generally takes time to engender motivation to change and agree that weight restoration is required for recovery, and even more time to regain weight. Hence, as mentioned earlier, for those who require substantial weight regain, treatment generally takes up to 40 weeks, with sessions held twice weekly until the patient is consistently regaining weight. Once this is happening, sessions are weekly; then, toward the end of treatment, they are every 2–3 weeks.

Patients' health and safety are always of paramount importance, and this is especially true of patients who are underweight and/or have lost significant amounts of weight because their physical health is invariably compromised. Therapists need to be aware of potential physical complications, and those who are not medically qualified should have good access to a physician who can advise on the management of medical problems.

Overview

The four stages of the 20-week version of CBT-E do not neatly map onto the version for underweight patients. Treatment for these patients may be thought of as having three steps (see Figure 17.10 showing these steps and their relation to the four stages of the 20-week treatment):

- *Step I.* This lasts up to 8 weeks, and the focus is on engaging patients, helping them make an informed decision to change and to decide that they need to regain weight.
- *Step II.* This is the weight-regain step. The goal is that patients regain weight at the rate of about 1–2 lbs (0.5–1 kg) per week. The length of this phase is determined by the amount of weight to be regained. Importantly, during this phase, the patient's other eating disorder psychopathology is also addressed.
- *Step III.* This is the weight-maintenance phase, in which patients practice maintaining their new

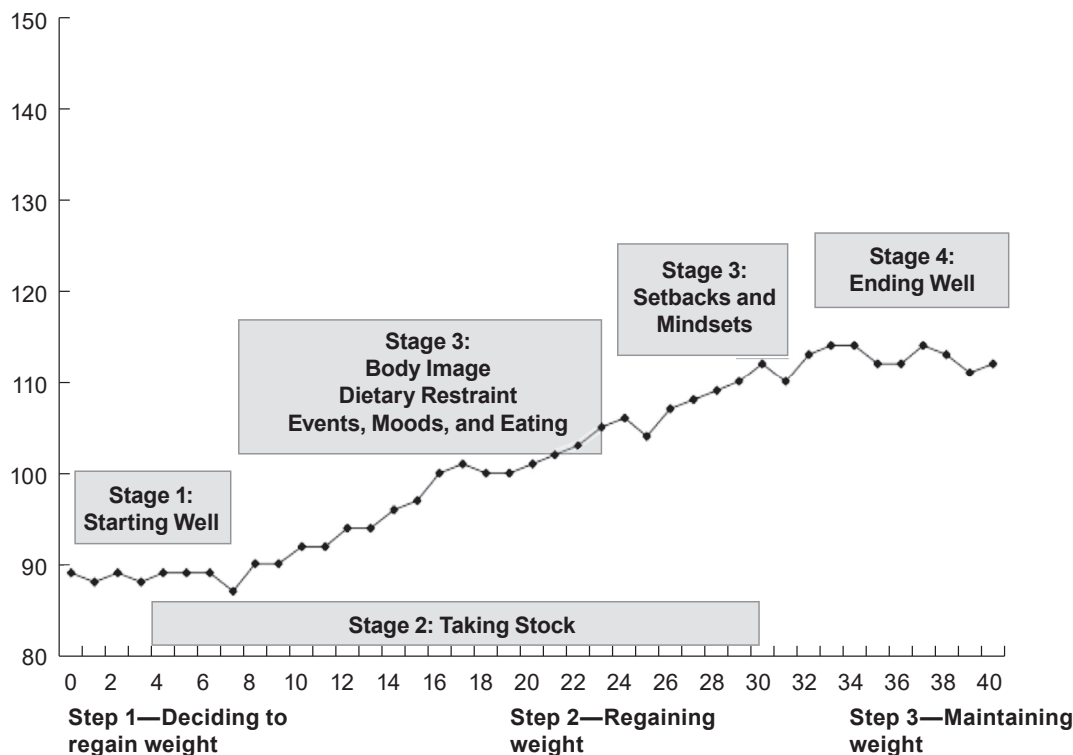


FIGURE 17.10. Three steps of low weight treatment. From CREDO (2017). Copyright © 2017 CREDO. Reprinted with permission.

weight range, one that does not result in impairment or maintain their eating disorder. It lasts about 8 weeks.

Step 1

The first two treatment sessions are similar to those of the 20-week treatment, although there are certain modifications to accommodate education about the effects of being significantly underweight and/or having lost significant amounts of weight and to incorporate this information into the formulation. In practice this involves the following:

- *Inquiring carefully in the initial assessment about the features that are likely linked to being underweight or to significant weight loss.* This inquiry should be embedded within the usual assessment.
- *Providing personalized education about the effects*

of being underweight or of significant weight loss before jointly creating the formulation. This involves delaying the formulation to the second treatment session rather than creating it in the initial session as in the 20-week version.

- *Jointly creating a formulation that highlights the likely contribution of being underweight or of weight loss to the maintenance of the patient's eating problem (e.g., preoccupation with food and eating, increased need for routine and predictability, indecisiveness, heightened feelings of fullness, low mood, social withdrawal).*

- *Discussing the implications of the formulation for treatment.* The major point is that many features will resolve if the patient regains weight, and at the same time, patients discover their true personality that has been masked by being underweight or by the weight loss. Simultaneously, it is emphasized that treatment will involve much more than mere weight regain.

• *Helping patients decide to change.* The goal is that patients make this decision themselves rather than having the decision imposed on them. The aim is to interest the patient in the benefits of change and the possibility of a “fresh start.” There are five steps in this process:

1. Creating a “Current Pros and Cons of Change” table.
2. Creating a “Future Pros and Cons of Change” table. A brief video demonstration discussing change and the future is available at www.guilford.com/barlow2-materials.
3. Creating a “Conclusions” table. An example is shown in Table 17.2.
4. Helping the patient identify and accept the implications of these conclusions.
5. Helping the patient decide to act and “take the plunge.”

TABLE 17.2. “Conclusions” Table

I want to get better and regain weight because . . .

- I will be able to have a fill life, not one that is just about eating and weight.
- I will be healthier: My bones and heart will be stronger; I won’t be cold and faint and will be able to sleep properly; I won’t be ill!
- I will be able to have good relationships with other people and hopefully a partner and children who I can be a good role model to.
- I will be able to enjoy my job and be successful at it.
- My eating problem stops me from being able to do things well. When I am better, I won’t need an excuse.
- Getting better won’t be giving in. Not getting better would be giving in. Getting better is about choosing to give myself a life.
- I want to show how strong I can be by eating; not eating is the easy thing.
- Eating enough food for my body to function optimally is not greedy.
- Being higher in weight will help to give me true control over my eating. I will be able to make choices about what I eat. At the moment the eating problem has control over me.
- Being well will enable me to develop my talents as a person and to discover my true self.
- Getting better will give me choices in life. The eating problem has been holding me back.

Note. Adapted from Fairburn (2008).

At the same time, collaborative weighing and regular eating are also introduced, much as in the 20-week treatment. One difference is that weighing takes place every session, because patients’ weight is a significant health problem and a major target of treatment. Another is that the pattern of regular eating should include three meals and three snacks; that is, patients should routinely have six episodes of eating rather than the recommended five or six as in the 20-week treatment.

If the patient decides to regain weight, then Step II begins. If, however, the patient does not agree despite extensive exploration of the topic (over at least 8 weeks), then CBT-E has failed, and other treatment options should be considered.

Step II

In Step II, the focus is on weight regain, while at the same time addressing the patient’s eating disorder psychopathology in much the same way as described earlier. Thus, there is an emphasis on modifying the overvaluation of shape and weight, dietary restraint, and event- and mood-related changes in eating.

Weight regain is understandably very difficult for patients. It is a long and laborious process. It requires that patients maintain an energy surplus each day of about 500 kcal if they are to regain weight at a rate of about 1–2 lbs (0.5–1.0 kg) per week. We recommend an individualized approach to determining the patient’s weight goal range aiming for a sustainable and functional weight range on a case-by-case basis, guided by two core criteria:

1. It does not contribute to the maintenance of the eating disorder: The weight range can be sustained without reinforcing or contributing to the maintenance of the eating disorder. Recovery is unlikely if disordered behaviors (e.g., restrictive eating or compensatory practices) are required to maintain a specific weight, or if the weight itself functions as a maintaining mechanism.
2. It does not cause impairment. The weight range is not associated with significant impairment in functioning in physical (e.g., effects of starvation syndrome or other complications related to low weight/weight loss), psychological (e.g., preoccupation with food and eating), or social (e.g., avoidance of eating with others) functioning.

It should be noted that, previously, we placed much more emphasis on body mass index (BMI) as the prima-

ry indicator of a return to health. However, with large individual differences between patients, we recognize that a uniform indicator of health can be problematic. Instead, we have put much greater emphasis on an individualized approach to determining goal weight range using the two criteria described above.

Step III

The goal of this phase is to help patients maintain their individually determined weight range. While patients are concerned that their weight will continue to rise, therapists worry that it will fall. The risks and dangers of weight loss should be discussed openly with patients.

Therapists should encourage patients to live life fully now that they are free from the debilitating effects of being underweight. Patients should be helped to flourish, take risks, and enjoy themselves, while not forgetting the importance of maintaining their new weight range.

The final few sessions need to cover the same topics as those covered in the 20-week version. Thus, they address the following:

1. Mindsets and setbacks.
2. Ensuring that changes achieved are maintained.
3. Procedures for minimizing the risk of relapse in the future.

CONCLUDING REMARKS

One of the advantages of CBT-E is that treatment is guided by a highly individualized formulation based on patients' eating disorder presentation, not their diagnosis. Moreover, this formulation can be, and is, modified and further personalized as treatment progresses. The formulation helps therapists and patients maintain a consistent focus on the processes most directly responsible for perpetuating the disorder, while allowing for flexibility. This capacity for flexibility within a structured framework—sometimes referred to as “flexibility within fidelity”—allows CBT-E to take account of a variety of individual characteristics, personal circumstances, and cultural contexts (Kendall, Gosch, Furr, & Sood, 2008; Murphy, Bailey-Straebl, et al., 2025).

CBT-E is a principle-driven treatment. Although the treatment is organized into four structured and sequential stages, the specific procedures, their content, and the order in which they are implemented are tailored to

the individual's formulation and evolving needs. The flexibility of CBT-E is particularly apparent in Stage 3, where it employs a modular approach, allowing clinicians to select modules and their procedures based on individual needs. The model can also accommodate several factors external to the eating disorder (clinical perfectionism, low self-esteem and interpersonal difficulties) that are sometimes encountered as further maintaining mechanisms. This approach not only allows for tailored treatment paths but also promotes additional innovation in CBT-E, as new modules can be developed (e.g., for co-occurring trauma) and, if evidence supported, integrated into CBT-E (Murphy, Bailey-Straebl, et al., 2025).

Despite its successes and broad applicability, CBT-E does not help everyone. There is an urgent need to identify predictors and moderators of treatment response to understand for whom, and under what conditions, the treatment is likely to be helpful. A better understanding of how the treatment works is likely to contribute to this goal. Greater knowledge of the mechanisms of change would provide the basis for further enhancing the active components of treatment and omitting redundant ones. It might also suggest ways to simplify treatment, generally, or in particular cases.

Another urgent challenge concerns the dissemination and implementation of CBT-E. Despite empirical support, few patients with eating disorders are receiving it. In part, this is due to individuals not seeking treatment or to eating problems not being correctly detected in primary care. However, even when treatment is sought and offered, many do not receive empirically supported interventions. The barriers to wider dissemination and implementation include clinician attitudes toward such treatment and the lack of sufficient numbers of suitably trained therapists. One way to begin to address this is to use a highly scalable method of training large numbers of geographically dispersed therapists simultaneously. A web-based training program for CBT-E was developed for this purpose and to date has trained over 6,000 therapists worldwide (Centre for Research on Eating Disorders at Oxford [CREDO], 2017, available at www.cbte.co/training). The evaluation of this program has revealed it to be popular and effective (Cooper et al., 2017; Fairburn et al., 2017; O'Connor, Morgan, Bailey-Straebl, Fairburn, & Cooper, 2018).

Despite such training, it is still unlikely that there will ever be enough therapists to meet the need for treatment. Direct-to-user treatments, which are wholly program-led, are urgently needed to increase the reach

of CBT-E. A program-led digital version of CBT-E has been developed, and an initial pilot evaluation has produced promising results (Murphy, Khera, & Osborne, 2025; www.cbte.co/self-help-programmes/digital-cbte).

NOTE

1. Please note that the authors use the singular “they/them/their” when referring to an individual.

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The website www.cbte.co provides up-to-date information on the empirical status of CBT-E and opportunities to obtain training. All the materials needed to implement CBT-E may be downloaded free of charge from this website.

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