General Introduction

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An increasing number of diverse approaches to treating eating disorders have obtained empirical support for their efficacy in recent years. The patients who benefit from these treatments are increasingly diverse as well, in terms of their eating disorder symptoms, the other problems with which they struggle, and the details of their life histories and circumstances.

The idea for this casebook emerged from the observation that clinicians and patients would like to see how therapy actually works—what happens in the therapy sessions. Readers of treatment manuals and research articles may understand the concepts and still find it difficult to imagine the actual conversations between clinician and patient in which those concepts are used. Clinicians remain uncertain of exactly "what to say" or "how to do it," and patients enter treatment with little concrete information about the nature of their chosen therapeutic approach or other available options. The cases in this book include many excerpts of dialogue between patients and therapists drawn or adapted from real psychotherapy interactions, disguised to protect patient confidentiality.

The cases in this book are "evidence based" in at least two important ways. First, these cases all emerged from clinical research that aimed to demonstrate that a defined method of treating eating disorders was actually beneficial to patients, relative to no treatment or relative to alternative treatment approaches. Second, the individual cases are presented with demonstrations of symptom change, including the results of research assessment interviews, self-report questionnaires, the clinicians' observations, and the patient's own words. Evidence from at least two time points—the beginning and end of treatment—is included in every case, and some cases include midtreatment or follow-up data.

The chapters were written by expert treatment–outcome researchers. Many of the cases were drawn from randomized clinical trials. The patients included in the book provided their initial consent to participate in the clinical research—including audio or video recording of sessions in some cases—and then later provided explicit consent for their individual psychotherapy material to be included in this book. In three cases (adolescent-focused therapy, cognitive-behavioral therapy for night eating syndrome, and emotion acceptance behavior therapy) the patient or his/her family either was not recorded or did not wish to provide full consent for the therapy interactions to be published; therefore, the psychotherapy material is less detailed and more thoroughly altered. Throughout the book, those cases based on a single patient who provided explicit consent to publish this material are noted, and those cases that represent composite patients and include altered therapy dialogue are also noted.

To provide perspective on the diversity and distinctiveness of treatment approaches, the cases have been grouped into five sections: "Behavioral Approaches" (exposure and response prevention and family-based treatment), "Cognitive Approaches" (motivational interviewing and cognitive remediation therapy), "Affect-Based Approaches" (psychoanalytic psychotherapy and emotion acceptance behavior therapy), "Relational Approaches" (interpersonal psychotherapy and couple therapy), and "Integrative Approaches" (cognitive-behavioral therapy, enhanced broad cognitive-behavioral therapy, dialectical behavior therapy, and adolescent-focused therapy). Though different approaches frequently overlap in their effect—for example, in a behaviorally focused therapy, changes in cognition and affect are evident as well—we have separated them to facilitate appreciation of the distinctive nature of certain interventions and the intended mechanisms of treatment. However, the inclusion of session process dialogue is intended to allow the reader to perceive the complex, multifaceted processes taking place. The introductions to each section provide theoretical and historical context to the approaches that are described.

OVERVIEW OF EATING DISORDER DIAGNOSES

To avoid repetition, we present here the key criteria of the major eating disorder diagnoses. At the time that the diagnoses in these case reports were made, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) had not yet been published. In some cases, however, the authors indicate what diagnosis would be applicable in DSM-5, as well as the diagnosis that was made at the time. Given that the focus of the book is not classification, we will here present only the main criteria and definition for each disorder, as well as a few crucial treatment and research considerations.

Anorexia nervosa is characterized by distorted body image and excessive dieting, severe weight loss, and a pathological fear of becoming fat. Individuals with anorexia nervosa are underweight for their height, and may maintain their underweight status by exercising and purging as well as caloric restriction. Females with anorexia nervosa may have amenorrhea (lack of menstruation), and anorexia nervosa has many potentially serious physical effects. Anorexia nervosa among females typically manifests in adolescence or early adulthood, although it can affect females and males of all ages. Recommendations for appropriate treatment vary widely according to culture. In the United States, for example, inpatient or residential psychotherapy for low-weight patients is somewhat more commonly recommended than in other countries; in Europe, for example, outpatient psychotherapy is more common for patients at lower weights. Outpatient clinical trials for adult anorexia nervosa are not considered to have been particularly successful to date, with high observed dropout rates and low rates of recovery (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007).

Bulimia nervosa is characterized by frequent and recurrent episodes of binge eating, which is eating characterized by the subjective "loss of control" over eating. Binge episodes are followed by behavior that compensates for the binge episode, such as purging (e.g., vomiting, excessive use of laxatives or diuretics), fasting and/or excessive exercise. Individuals with bulimia nervosa may be within or above the healthy weight range, and show dysfunctional levels of concern with their shape, weight, or eating. The frequency of binge–purge behaviors necessary for a bulimia nervosa diagnosis was reduced from twice per week to once per week in DSM-5. There are a large number of published outpatient clinical trials for outpatient psychosocial treatments of bulimia nervosa, with good outcomes observed among 40–70% of patients (depending on the definition of good outcome) in the best available treatments (Keel & Brown, 2010).

Binge-eating disorder is characterized by frequent and recurrent episodes of binge eating without specific compensatory behaviors. Individuals with binge-eating disorder may or may not exhibit overly high levels of concern with shape or weight, or distorted body image, which are not necessary to the diagnosis. Individuals with binge-eating disorder may be normal weight or overweight, though the diagnosis shows associations with overweight and obesity. Though binge-eating disorder was relatively recently defined, clinical interventions tend to show relatively good outcomes (and more placebo effects), with good outcomes regularly observed for 70% of participants in many clinical trials (Keel & Brown, 2010). Purely psychological interventions (as opposed to those with a specific weight loss component) are associated with good psychological outcomes, but low levels of overall weight loss (Wilson, 2011).

Eating disorder not otherwise specified was frequently diagnosed under the criteria included in DSM-IV, due to high thresholds for full

criteria diagnoses (which have been lowered in DSM-5), and due to the highly variable nature of eating disorders, which may manifest with or without insight into the nature of cognitive concerns, varying degrees of weight loss, and with or without the full complement of a wide range of unhealthy or unusual weight-control and eating behaviors (e.g., chewing and spitting, eating non-nutritive substances, night eating).

Patients with eating disorders are observed to show a wide degree of heterogeneity within diagnostic categories as well. For example, patients with severe malnutrition, major depression, or personality pathology may differ from other patients with the same eating disorder diagnosis without these co-occurring conditions, and may require different treatment approaches (e.g., Grilo, Masheb, & Wilson, 2001; Thompson-Brenner & Westen, 2005). Patients with severe malnutrition may require intensive interventions for medical or psychiatric reasons as well.

OVERVIEW OF CLINICAL ASSESSMENT

Another purpose of this casebook is to introduce clinicians to the assessment instruments—interviews and questionnaires—that are commonly used in research studies to provide relatively objective measures of pathology, improvement, and outcome. Increasingly, clinicians appreciate the utility of objective measures in clinical practice to inform themselves and their patients.

Common Research Instruments and Domains

The most commonly used structured clinical interview for eating disorder pathology is the Eating Disorder Examination (EDE; Fairburn, 2008; Fairburn & Cooper, 1993). The EDE is a structured interview that assesses the behavioral and cognitive symptoms of eating disorders (e.g., binge eating, compensatory behaviors, food restriction, body dissatisfaction, dietary restraint), as well as specific subscales for shape concerns, weight concerns, eating concerns, and dietary restraint, and a global score that is the mean of the four subscale scores. The EDE assesses the frequency and severity of symptoms over the past 28 days. Norms for the EDE in nonclinical and clinical samples, as well as benchmarks for significant improvements in EDE scores over short- and long-term treatment, have been well established. Most published clinical trials include the EDE as the gold-standard interview instrument with the best psychometrics and highest level of validity, when administered by reliable assessors who are blind to treatment condition.

Various other assessments were used depending on the treatment focus and research questions; all the relevant assessment instruments are described

in the individual case descriptions. Self-report instruments of current and recent eating symptoms, such as the Eating Disorders Examination—Questionnaire version, the Eating Disorders Inventory, or shorter measures of binge–purge symptoms, are commonly utilized to observe week-to-week symptom levels and changes (see chapters for specific instruments and citations). Co-occurring psychopathology, such as Axis I mood and anxiety disorders, or personality disorders, are commonly assessed at baseline and outcome time points using structured interviews with established reliability, and specific related symptom domains (depression level, social functioning) may be assessed using brief questionnaire instruments on the same schedule or more frequently.

Rationale for Research Assessment in a Clinical Scientist Model of Treatment

The importance of an evidence base for psychotherapy practice does not only apply to testing models of treatment in large-scale research studies, but also to the use of reliable and valid assessment instruments within individual courses of treatment. The rationales for collecting empirical evidence of treatment effects apply across treatment approaches. For example, research assessments can help clinicians safeguard against their own erroneous assumptions, which psychological research suggests are all too easy for us to make. Human beings are extremely likely to maintain their beliefs even when erroneous through their ways of collecting and processing information, and therapists and clients are *both* subject to these processes (Lilenfeld & O'Donohue, 2006). A large body of research indicates that clinicians regularly make errors or display biases in judgment in accordance with their own beliefs about treatment, psychology, and psychopathology (Kazdin, 1993; Persons, 2005).

As a simple but general example, a therapist may believe that a particular set of psychotherapy interventions are having a positive effect for his/her client despite the client's subjective experience of the contrary. Regular standardized assessments, in domains pertaining directly to the goals of treatment, allow the therapist and client to observe the same data—possibly more objective data, and certainly more uniform data than each would collect separately by independent observation—measured over time. Additionally, therapists and clients are both subject to make errors regarding *causation* and *expectancy*—that is, to believe that certain correlated events cause one another and that certain behaviors will bring about certain outcomes (Kazdin, 1993; Lilenfeld & O'Donohue, 2006). For example, a client may believe that because he becomes anxious when he socializes, social contact causes anxiety, and that increased social contact will lead to increased anxiety. In the context of an efficacious cognitive-behavioral treatment,

the client may be asked to test these beliefs through a series of behavioral experiments involving social interaction, coupled with frequent assessment of his anxiety levels. The evidence that his anxiety has reduced within one single extended social interaction, and that his anxiety is much reduced after exposure to frequent social contact, helps to disprove these beliefs and thereby promote flexibility in behavior and recovery from social anxiety.

The use of clinical assessment not only to be more "accurate" but also to augment the effect of individual patients' treatment is now well documented and well discussed elsewhere (see Kazdin, 1993; Persons, 2005). It is our hope that the benefits of formal assessments in the treatment of eating disorders in the following cases will be apparent to the readers.

What to Consider When Reading These Cases

Finally, here we present a few ideas for the reader regarding questions to hold in mind while reading the cases. In addition to the evident contrast between the different approaches, you might note also what is common across these generally successful cases. What is necessary, but not mentioned, to having the therapy progress so well? What are the personal qualities of certain individuals with eating disorders that might make a particular form of therapy a good or poor fit? Similarly, are there qualities of therapists that might make them more or less suited to using certain approaches? What would be similar or different if these forms of psychotherapy were used with other emotional issues besides eating disorders? What do you think the influence might have been of the research context to the psychotherapy, as opposed to if the treatment was implemented in a less structured community setting? If you could implement these treatments without such strict guidelines, what changes might you make?

Furthermore, it is fascinating to consider the skill of the therapists—their "art" as well as their science. All cases have difficult moments, when the therapist has an idea of what would be helpful that pushes up against the patient's customary way of behaving, thinking, or feeling. We hope you find it interesting to see how these expert therapists present new, challenging ideas about growth and change without losing their empathic connection to their patients in distress.

In general, we hope that this book will help clinicians (and their patients) to understand and appreciate evidence-based treatments for eating disorders. We hope the collection of different approaches, presented with therapy process material, will facilitate readers' understanding both of the important distinctions among treatment approaches, as well as key common factors across beneficial treatments.

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