The Treatment of Anorexia Nervosa in Adult Women:

Time To Consider A Novel Approach?

by

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Abstract

Anorexia Nervosa (AN) is a life-threatening illness, with a suicide rate that is 200 times that of the general population, associated with high levels of disability, psychological and physical comorbidity. It has the highest mortality rate of any mental illness. AN in adulthood is particularly resistant to treatment, and few therapeutic approaches have proven effectiveness. It is critical that awareness is brought to this lack, and that research continues to expand and improve upon existing approaches. This thesis has two main purposes: (1) to contribute to the conversation surrounding the difficulties in treating Anorexia Nervosa in adult populations by providing a critical analysis of four outpatient therapeutic approaches to treating adulthood Anorexia Nervosa, and (2) to address the flaws in treatment approaches that focus too heavily on weight restoration and food related concerns, and to highlight the benefits of utilizing an approach that does not place these issues at the core of treatment. This manuscript-style thesis begins by presenting an introduction to AN including important statistics on the illness. The introductory chapter orients the reader to the purpose and significance of this thesis, describes how the research was conducted, provides a definition of key terms, outlines scope and limitations, and situates the author, including stated biases. Following this, four treatment approaches for adulthood AN are discussed: Cognitive Behavioural Therapy (CBT), Enhanced Cognitive Behavioural Therapy (CBT-E), the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), and Acceptance and Commitment Therapy (ACT). The thesis concludes with a discussion, personal reflections, limitations, and suggestions for future research.

Keywords: Anorexia Nervosa, Cognitive Behavioural Therapy, the Maudsley Model of Anorexia Nervosa Treatment for Adults, Acceptance and Commitment Therapy, Counselling, Psychotherapy

Acknowledgments

To all individuals, women and men, who are living with Anorexia Nervosa. Always know that you are loved, you are stronger than you believe, and you are never alone. May this thesis provide you with hope for your recovery.

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A huge thank you goes out to all the wonderful individuals who engaged in meaningful discussion with me over the past 9 months. Your insights and experiences kept me moving forward, and provided me with the depth and inspiration to write this thesis. Knowing that I was not alone in my experiences and opinions on the therapeutic treatment of Anorexia Nervosa was deeply moving, and has given me the push to keep advocating for this population.

To all the wonderful friends I have in my life, both on the East coast and on the West Coast, and overseas. Thank you for always listening to me, providing me with endless support, and forcing me to go out and have fun instead of stressing over writing.

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CHAPTER 1: INTRODUCTION

"Most people are like dandelions; robust, resilient, and able to thrive even under poor growing conditions. People with Anorexia Nervosa are more like orchids, they are delicate and wilt easily and need the right growing conditions to thrive, but if they get these conditions, they blossom in a spectacular fashion." (Schmidt, Wade, & Treasure, 2014, p. 54).

Anorexia nervosa (AN) is one of the earliest psychiatric conditions that was identified, with definitive accounts made in the 19th century by Gull (1874) and Lasegue (1873), (Hay, Touyz, & Sud, 2012). It is a life threatening illness, with a suicide rate that is 200 times that of the general population, and causes high levels of disability, psychological and physical comorbidity (Schmidt, Wade, & Treasure, 2014). According to Hesse-Biber, Leavy, Quinn, & Zoino (2006) it has the highest mortality rate of any mental illness. Once the illness has become well established, approximately three years after onset, treatment response tends to be poor and treatment dropout is high (Schmidt, Wade, & Treasure, 2014). It is my view that one of the main the reasons we do not see efficacy amongst these individuals is because the emphasis of some treatment approaches tend to miss the mark by placing too strong of a focus on food and weight restoration. Longitudinal research has suggested that fewer than 50% of individuals diagnosed with AN recover fully; 20-30% continue to experience residual symptoms, 10-20% remain significantly ill, and 5-10% die from their illness (Steinhausen, 2002). Given the potentially hazardous health risks associated with AN, the obvious target of treatment has been restoration of weight. However, weight gain alone is insufficient for long-term, meaningful recovery (Orsillo & Batten, 2002). Despite this, many treatment approaches are centred on food and

weight related concerns, automatically placing other potentially important factors in second place (Orsillo & Batten, 2002).

Over the years, research into the treatment of eating disorders, such as Bulimia Nervosa and Binge Eating Disorder has been comprehensive and has resulted in major success in identifying treatment approaches with improved rates of recovery (Draxler & Hiltunen, 2012). Despite these strides forward for eating disorder diagnoses in general, progress has been much slower for AN (Draxler & Hiltunen, 2012). This struggle is not a recent one; over the past 50 years "no improvements in terms of numbers of diagnosis and treatments have been successfully proven" (Steinhausen, as cited in Draxler & Hiltunen, 2012, p. 201). Substantial pessimism surrounds the usefulness of outpatient therapy where it has been suggested that "outpatient psychotherapy has been largely unsuccessful in assisting adults to achieve weight restoration" (Attia & Walsh, as cited in Wade et al., 2011). Despite the devastating consequences of AN, research has yet to identify a "gold standard" therapeutic treatment to assist individuals in recovering fully from AN.

This first chapter highlights the purpose of this thesis, the significance of this study, the theoretical framework within which this thesis was inspired, how the review was performed, definitions of key terms to guide the reader throughout the following chapters, limitations and scope of the document, and situating the author in the research.

As a courageous participant in Rance, Moller, and Clarke (2015) shared,

> [I] perceived the treatment system as overly focused on food and weight. In contrast, they felt that 'eating disorders are not about food, they're about life' and that a key part of treatment is being seen, and treated, as a 'whole person.' (p. 586)

I share this perspective, and deeply believe that treatment for longstanding AN should not place food and weight concerns as the primary focus of treatment, as this has the potential to encourage women to remain in their eating disorder (ED) (Rance et al., 2015).

Thesis Statement

It is my contention that although AN appears to be resistant to treatment, perhaps this is an indication of the treatment approaches and not of sufferers' characteristics. It is my view that the reason we do not see treatment efficacy amongst these individuals is because the emphasis of some treatment approaches tend to miss the mark by placing too strong of a focus on food and weight restoration. I believe that existing therapeutic interventions for AN tend to fail to see AN from a whole-person approach, and they fail to give individuals a sense of agency in their recovery.

Purpose

This thesis has two main purposes: (1) to contribute to the conversation surrounding the difficulties in treating Anorexia Nervosa in adult populations by providing a critical analysis of four outpatient therapeutic approaches to treating adulthood Anorexia Nervosa, and (2) to address the flaws in treatment approaches that focus too heavily on weight restoration and food related concerns, and to highlight the benefits of utilizing an approach that does not place these issues at the core of treatment.

In addition, I myself want to learn more about the treatment of AN, as I hope to work with individuals who have AN after the completion of my Master of Counselling degree. This thesis is the beginning of what I imagine will be a lifelong journey into the pros and cons of various aspects of outpatient treatment.

Significance

This thesis presents important information on the general background of different treatment approaches, a brief overview of each therapeutic process, the effectiveness, and limitations of different treatment approaches in a population that is notoriously 'difficult to treat'. This thesis contributes to the longstanding discussion on the treatment of adulthood AN, and proposes that further research is not only warranted, but is of the utmost importance.

Despite the fact that this illness appears to be resistant to treatment, perhaps this is more an indication of the treatment approaches used than sufferers' characteristics. Many researchers have pointed to the difficult 'ego-syntonic nature' of the individuals struggling with this illness (Bamford & Mountford, 2010), as reasons for treatment ineffectiveness. In relation to AN, ego-syntonic refers to the value that individuals place on their disorder, and that this importance can hinder motivation for recovery and engagement with treatment (Gregertsen, Mandy, & Serpell, 2017). Although this is merely one example, I came across this sentiment repeatedly whilst conducting research for this thesis. This thesis is significant in that it presents research that directly challenges this harmful picture that is painted in the research of individuals who are struggling with AN.

This thesis contributes to the counselling profession because it suggests an alternative view for treatment, whereby we focus on the values and emotional wants of the client themselves, and not the goals set out by a specific therapeutic approach. It promotes a collaborative approach to the treatment of eating disorders, which attempts to disregard a hierarchical approach whereby the therapist is viewed as the expert, and the client is viewed as the individual who is coming into the room with "*her* problem". This eliminates the assumption that the therapist is the all-knowing expert.

Additionally, through personal communication with a variety of individuals in the counselling profession, it is my understanding that there are not enough trained practitioners to meet the high demand for the treatment of AN. This thesis hopes to inspire readers to perhaps take on additional learning regarding the treatment of this largely misunderstood population, who is in desperate need of compassionate, loving, trained, and engaged practitioners.

Method

The methodology used in this thesis was to undertake a comprehensive review of the existing literature concerning the therapeutic outpatient treatment of AN in adult (18 years ≥) females, and to conduct a critical analysis of the presented therapeutic models. Only literature concerning outpatient treatment for Anorexia Nervosa in adult females was included in this review. Any research concerning the following was excluded from analysis: childhood or adolescent AN (18 years ≤), males, inpatient treatment, treatment facilities, hospital settings, other eating disorders (Bulimia Nervosa, Binge-Eating Disorder, EDNOS, Avoidant/Restrictive Food Intake Disorder), and therapeutic frameworks aside from CBT, CBT-E, MANTRA, and ACT. As there exists an abundance of therapeutic approaches to the treatment of AN, and due to the space limitations of this thesis, the four therapeutic approaches that have received the most research attention were included; Cognitive Behavioural Therapy (CBT), Enhanced Cognitive Behavioural Therapy (CBT-E), Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), and Acceptance and Commitment Therapy (ACT).

This thesis is presented in a manuscript-style format, such that the second, third, and fourth chapters may be read as individual papers. This was done with the understanding that each potential reader has their own individual interests, and thus may only wish to read a chapter that is specific to their interests and intentions.

Definition of Terms

The definitions for each of the treatment approaches discussed in this thesis are presented at the beginning of each chapter. Chapter 2 addresses Cognitive Behavioural Therapy, as well as Enhanced Cognitive Behavioural Therapy. Chapter 3 discusses the Maudsley Model of Anorexia Nervosa Treatment for Adults and Chapter 4 looks at Acceptance and Commitment Therapy.

Anorexia Nervosa

Anorexia Nervosa is characterised by intense fears of weight gain and eating, and a distorted body image, which serves to motivate severe dietary restraints or other behaviours targeted at weight loss, including purging or excessive physical activity (Zipfel, Giel, Bulik, Hay, & Schmidt, 2015). Key symptoms include the relentless pursuit of thinness and over-evaluation of emaciation, and the individual is driven by an extreme dread of food, eating, and normal body weight (Schmidt, Wade, & Treasure, 2014). The individual may become distressed and angry when asked to eat.

In order to be diagnosed with Anorexia Nervosa, the following conditions must be present: restriction of energy intake relative to requirements which leads to a significantly low bodyweight in the context of age, sex, developmental trajectory, and physical health; intense fear of gaining weight or of becoming overweight, or persistent behaviour that interferes with weight gain, even though at a significantly low weight; disturbance in the way one's bodyweight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight (American Psychological Association, 2013, p. 338-340).

Body Mass Index (BMI)

A low body-mass index (BMI) is the central feature of Anorexia Nervosa. The definition of Body Mass Index is taken from the Centers for Disease Control and Prevention (CDC) website: "Body Mass Index (BMI) is a person's weight in kilograms divided by the square of height in meters," (CDC, n.d., para. 1)

Limitations and Scope

This thesis has several limitations. Firstly, the intent herein is not to propose a novel approach for outpatient therapeutic treatment of adulthood AN. Rather, I hope to encourage readers to question certain aspects inherent in existing approaches, mainly the focus placed on food and weight restoration. I am not suggesting that this aspect of treatment should be completely eliminated, especially when an individual's life is at risk. Instead, I suggest that it may be worth questioning the utility of placing such concerns at the centre of treatment. My bias against approaches that focus primarily on food and weight/shape related cognitions should be kept in mind whilst reading this document.

This thesis presents four different treatment approaches to the therapeutic outpatient treatment of adulthood AN. It is important to note that the four approaches discussed within this thesis are merely the tip of the iceberg when it comes to theoretical frameworks, but it is beyond the scope of this thesis to discuss more. It is also beyond the scope of this thesis to discuss the factors that contribute to the development of AN, otherwise known as maintaining factors. If this is of interest to you, please refer to the section titled recommended reading.

Situating the Author

First and foremost, I am not an expert on the subject, nor have I worked therapeutically with adults struggling with AN. The thoughts and opinions presented in this thesis are formed

through a variety of personal interactions, volunteer experiences, my Master of Counselling educational journey thus far, copious amounts of research, workshops and lived experience with an eating disorder.

My personal experience with an eating disorder allowed me to write this thesis from a deeply heartfelt space, and certain critiques come from this personal approach rather than from the research literature. Although I am fully recovered, and have been for over five years, I have a bias toward approaches that focus on the desires of the individual. This bias is based on my personal positive therapeutic experience, which continues to date. It is important to note that I was never engaged in an outpatient treatment that was focused heavily on food and weight related concerns, so I cannot speak to that on a personal level. However, I can attest to the fact that my outpatient treatment, which was focused on tackling the factors that contributed to my eating disorder in the first place, along with emotional factors that were maintaining my disorder, positively contributed to my recovery, and allowed me to feel safe in my therapeutic journey. Due to my lived experience, I found some of the wording used in the literature to be very problematic, for example, referring to individuals as “patients” and referring to individuals with AN as being “obsessive” and having a desire for “control”. I attempt to alter this language whenever possible, however, at times was unsuccessful as I also believe in maintaining the integrity of the research in the field. It is not my intent, nor my job, to alter words. I can merely provide an argument as to why that language is damaging.

It is my opinion that the toxic societal influences that directly contribute to struggles with food, weight, and body image cannot be disregarded prior to this discussion. Placing too heavy of a focus on food and weight related concerns during therapeutic interventions completely disregard the environment in which the eating disorder developed in the first place. It is

unrealistic to assume that one can just tackle the thoughts surrounding food and weight, without addressing the societal influences and discourses that contributed to this development in the first place. Additionally, focusing so intently on food and weight is likely what led to the development of the eating disorder in the first place. For one reason or another, the individual developed an "obsession" with food and weight; it became all consuming, the individual began to organize her life around when she could eat, when not, established rules surrounding caloric intake, and the list goes on. Treating the individual from a therapeutic standpoint that continues to emphasize this excessive emphasis on food and weight seems highly problematic and serves to support societal messages that food and weight is the end all and be all. Discussing with the client how the present sociocultural climate has influenced her cognitions surrounding food and weight may be more beneficial. This notion is elegantly written in Hesse-Biber et al. (2006): "Eating disorders and disorderly eating are also culturally-inducted diseases promoted partly by economic and social institutions that profit from the 'cult of thinness; promoted by the mass media," (p. 208). Many theorists highlight the causes of AN as entirely internal, which is factual to a certain extent, yet entirely disregards the problematic societal influences that contribute to the development and maintenance of the disorder.

The next chapter will present Cognitive Behavioural Therapy (CBT) and Enhanced Cognitive Behavioural Therapy (CBT-E). Chapter three will address the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA). Chapter four will examine Acceptance and Commitment Therapy (ACT). Chapter five will be the discussion and conclusion to this thesis and in this final chapter I suggest directions for future research.

CHAPTER 2:

COGNITIVE BEHAVIOURAL THERAPY & ENHANCED COGNITIVE BEHAVIOURAL THERAPY

I believe that North Americans exist in a sociocultural climate that is so obsessed with weight and body image. The ways in which society is deeply entrenched in diet culture is made evident by the copious amounts of billboards, magazines, advertisements, celebrities, and social media advertisements that seem to highlight the importance of having 'a perfect body' (Dooner, 2019). In addition to this, there exists a widespread culture of body shaming, evident in the never-ending efforts to "help you lose those last 10 pounds", and ever-present commentary on what should be done about our "weight epidemic" (Dooner, 2019). We exist in an environment that constantly sends us messages promoting a thin body ideal. It is no wonder that the myth that anyone can, and everyone should, achieve the "ideal body" exists (Kater, 2010). For some, these messages contribute to the creation of disordered thoughts surrounding food and weight, so it seems counter-productive to utilize an approach that focuses on something that likely contributed to the development of AN in the first place.

The focus of this chapter is on the use of Cognitive Behavioural Therapy and Enhanced Cognitive Behavioural Therapy for the treatment of AN amongst female adults in outpatient environments. This chapter will be split into two sections: the first will cover Cognitive Behavioural Therapy, beginning with a brief overview, then will outline the utilization of CBT in the treatment of AN. The therapeutic process, a brief literature review, critiques, and benefits will be outlined. The second section will review Enhanced Cognitive Behavioural Therapy and will follow the same format as the preceding section.

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is an integration of two theoretical approaches to understanding psychological distress: the cognitive approach, and the behavioural approach (Crisis & Trauma Resource Institute, 2019). The cognitive behavioural approach is based on the idea that our thoughts have a significant impact on our emotions and our behaviours while the behavioural approach states that our actions have a strong influence on our thought patterns and emotions (Crisis & Trauma Resource Institute, 2019). From a cognitive-behavioural lens, the meaning that we attach to events is what influences our emotional responses to certain situations. This cognitive appraisal can lead to emotional, physiological, and behavioural responses. Simply put, our thoughts about a situation influence what we notice about the interaction, and in turn, directly influence our behavioural response.

Although it is beyond the scope of this thesis to include a complete historical overview of CBT, a brief discussion of the founders and central tenets is warranted to credit the original founders. Originally developed as an original approach to mood transformation, the origins of CBT go back to the mid-1950s and the early 1960s with the innovative work of Albert Ellis and Aaron T. Beck (Burns, 1999). Originally referred to as Cognitive Therapy, the following excerpt is taken from Aaron T. Beck:

> cognitive therapy may be defined in two ways: In a broad sense, any technique whose major mode of action is the modification of faulty patterns of thinking can be regarded as cognitive therapy… An individual's distorted views of himself and his world, for example, may be corrected through insight into the historical antecedents of his misinterpretations (as in dynamic psychotherapy), through greater congruence between the concept of the self and the ideal (as in Rogerian therapy), and through increasingly

> sharp recognition of the unreality of fears (as in systematic desensitization). (Beck, 1970, p. 347)

Cognitive therapy arose out of the observation that behaviour therapy, which was the dominant therapeutic approach to mental ailments at the time, was missing a key piece- the individuals private internal experience (Beck, 1970). Beck believed that an individual's belief system could be contradictory, in that they may attach credence to realistic and unrealistic perceptions of the same situation or thought (Beck, 1970). It is this inconsistency that may provide understanding as to why an individual may react to an unthreatening situation or stimulus with fear, even though they may simultaneously acknowledge that this is not realistic (Beck, 1970). Cognitive therapy was developed to modify individuals' maladaptive cognitions by delineating their specific misconceptions, distortions, and non-adaptive assumptions by testing their validity (Beck, 1970). It is assumed that by loosening the bond between the individual and their pervasive, distorted cognitions, that the client will be able to formulate their private and public experiences in a more realistic manner (Beck, 1970).[1]

CBT is a structured, short-term, and problem-oriented approach, and was created to be practical, as well as goal-oriented, while providing individuals with long-term skills to keep them happy (Crisis & Trauma Resource Institute, 2019). This includes identifying behaviours that are beneficial and eliminating maladaptive ones through a variety of strategies. It assists clients in overcoming their difficulties by identifying and shifting their dysfunctional thinking, behaviours, and emotional responses (Galsworthy-France & Allan, 2013). CBT has been effectively applied to a wide variety of troubles, many of which are experienced by adults who are struggling with Anorexia Nervosa (AN). These can include depression, anxiety, low self-esteem, and obsessive

[1] For further reading on the origins of Cognitive Behavioural Therapy, please refer to the "further reading" section of this thesis.

thinking patterns and behaviours (Galsworthy-France & Allan, 2013). A Cognitive-Behavioural approach to the treatment of AN will be explored herein.

Cognitive Behavioural Therapy (CBT) and Anorexia Nervosa

Some researchers believe that eating disorders are well suited for treatment with Cognitive Behavioural Therapy (CBT), due to the fact that the core psychopathology of eating disorders is cognitive (Murphy, Straebler, Cooper, & Fairburn, 2010). CBT is regarded as the 'treatment of choice' for many eating disorders, and appears in many treatment guidelines as a recommended treatment approach (e.g., American Psychiatric Association, 2006; National Institute for Health and Clinical Excellence, 2004; Royal Australian and New Zealand College of Psychiatrists, 2004), (Bamford & Mountford, 2010). CBT was originally developed for the treatment of depression (Burns, 1999), and Garner and Bemis were the first to apply this approach to AN in 1982 (Grave, El Ghoch, Sartirana, & Calugi, 2016). The CBT approach to treating Anorexia Nervosa is centred on the idea that the key maintaining features of this disorder are specific beliefs and values that are dysfunctional surrounding body shape and weight (Cooper & Fairburn, 1984). Since cognitive and attentional biases toward food, eating, and shape-related stimuli are common in eating disorder presentations, CBT would naturally be a logical choice for treatment, as it is centred on shifting dysfunctional thinking, behaviours, and emotional responses (Galsworthy-France & Allan, 2013). Another aspect of CBT that seems to suggest that it would be an ideal match for AN treatment is the stylistic features of treatment; it is structured, time-limited, directive, and focused on the present (Galsworthy-France & Allan, 2013). Freeman (2002) suggested that these features would be suited to treating individuals with AN, as they are typically seen as comfortable with order and control, and as unwilling to dive into the past. Although this seems logical, I struggle to see how working with an individual from

a stance that has likely contributed to the development of their eating disorder in the first place would be beneficial. If an individual's preference for order and control has led to their development of AN, as is theorized in abundant amounts of literature, how would supporting this perspective assist them in recovering? In addition, I find attempts to "shift dysfunctional thinking" to be highly problematic. Using the word "dysfunctional" to describe an individual's thinking pattern comes across as very belittling, demeaning, and downright disrespectful. Additionally, the use of this language sets up the therapeutic relationship to be a hierarchical one, whereby the therapist has a superior position over the client; the individual has entered treatment with "dysfunctional" thinking patterns, and the therapist is the all-knowing expert who will direct the client to a more "functional" thinking style. I also agree with the point raised by Bamford and Mountford (2010), in that "the ego-syntonic nature of anorexia can mean attempts to challenge eating disordered behaviours and cognitions may be unwelcome, and highly distressing" (Bamford & Mountford, p.49, 2010).

Therapeutic Process

Prior to a brief discussion on the therapeutic techniques utilized in treating this population from a CBT lens, it is important to note that I had difficulty locating treatment manuals outlining the structured CBT approach for this population. This is largely due to the fact that CBT is a manualized approach. However, further details on the therapeutic process for AN will be explored in the below section on CBT-E, as these manuals were readily accessible. Please refer to Table 1 for an overview of the therapeutic techniques used in CBT.

CBT aims to change the disturbed eating habits and so-called "abnormal beliefs and values" that individuals hold (Cooper & Fairburn, 1984). Treatment is seen as a discrete episode, with significant improvement expected (Bamford & Mountford, 2010). The role of the therapist

in CBT is to assist clients in determining what may be helpful to meet their needs, and to assist them in becoming active participants in their life (Crisis & Trauma Resource Institute, 2019). A variety of techniques are used in the therapy room, such as behavioural approaches, including stimulus-control measures.

From a traditional CBT approach to AN, the goals of treatment are to restore weight to a healthy range, to normalize eating patterns by introducing a healthy meal plan of three meals and 2-3 snacks per day, to support the person in gradually becoming their own therapist through the assignment of homework by collaboratively developing behavioural experiments, encouraging the client to identify, challenge, and modify their unrealistic cognitions in regard to eating, shape and weight, and to focus on issues such as self-esteem and preventing relapse (Fairburn, 2008). Specific skills that the client learns include how to keep a food diary, thought monitoring, and homework tasks (Bamford & Mountford, 2010). Other strategies present in traditional CBT approaches to AN include pros and cons lists, focusing on ‘life goals’, considering the physical complications of AN (for example, osteoporosis and bradycardia) to increase motivation. I concur with the point raised by Bamford and Mountford (2010), that using losses as a way to increase motivation can have negative consequences, namely that these may be perceived by clients as big losses, which may bring rise to feelings of grief and anger.

Purpose of therapy	Treatment seen as discrete episode with expectation of significant improvement
Stance	Collaborative and Socratic
Engagement	Initial focus and remains central throughout
Pace of therapy	Matched to patient level with focused direction from clinician
Motivation	Motivation enhanced through use of specific strategies, e.g. pros and cons, friend and foe letters
Goals	Goal setting core part of treatment
Medical risk	Primary. Clinician alert to rapid weight loss and low BMI
Practical issues	Patient primarily responsible for attending sessions and completing mutually agreed tasks
Agenda setting	Expected and adhered to
Psycho-education	Essential part of therapy
Weighing	Core part of treatment, weighed weekly in session
Diaries	Core part of treatment. Initiated early on in treatment
Behavioural experiments	Expectation of greater ability to tolerate anxiety therefore behavioural experiments should have a greater degree of challenge
Homework	Essential. Expected weekly and from the beginning
Tolerating distress	Part of therapy if indicated
Body Image	More focused on cognitive and behavioural aspects of body image disturbance
Length of therapy	Typically 20–40 sessions. Can be reviewed and recontracted every 10 sessions depending on effectiveness
Ending	Relapse prevention plan developed. Impact of ending acknowledged and prepared for

Table 1 (Bamford & Mountford, 2010, p. 52).

Review of Studies

Despite being dated, the article by Cooper and Fairburn (1984) is included in this discussion as it was the first clinical report on the use of CBT techniques to treat AN. In their research, Cooper and Fairburn adapted a CBT treatment that was initially used for the treatment of Bulimia Nervosa to treat five females over the age of 18, diagnosed with AN. Two modifications were necessary as the etiology of these illnesses is very different: (1) the poor treatment engagement of AN individuals, and (2) the necessity of weight gain (Cooper& Fairburn, 1984). In Cooper and Fairburn's study, the need for weight gain was not promoted as the end goal of treatment, rather, as an important first step in therapy. This distinction between an initial first step in therapy and an end-goal of treatment is important, as it does not neglect the importance of weight restoration for survival, and it acknowledges that weight-restoration need not be the sole focus of treatment. Additionally, participants were informed of an appropriate weight goal, and asked to follow a pattern of regular eating consisting of pre-set meals, and they were provided with precise instructions on what they could and could not eat (Cooper & Fairburn, 1984). Weight gain was part of the first stage of therapy, and the second phase began only after significant weight gain had been achieved.

Included in the second phase of therapy was an emphasis on measures to reduce dietary restraint and psychoeducation surrounding the nature of the illness (Cooper & Fairburn, 1984). I understand the necessity of weight gain, as this not only saves the individuals life, it also provides them with the cognitive strength to engage in treatment effectively. However, having an initial phase that is solely focused on weight gain, combined with the restoration of strictly regulated eating patterns seems to me that it would be too overwhelming for clients. The final phase was intended to ensure that progress was maintained. The findings were mixed: two

participants did well, one displayed some improvement, and two did not benefit whatsoever. The authors concluded that despite the numerous and frequent treatment sessions, only modest successes were observed. Worth noting is the small sample size of five participants in Cooper and Fairburn's study (1984). Therefore, the generalizability of the results is not possible.

Premature therapy termination is a common issue that researchers have observed among individuals with eating disorders (Schnicker, Hiller, & Legenbauer, 2013). Randomized control trials with adults who are suffering from AN report varying drop-out rates. In CBT, termination rates of up to 57% have been reported (Halmi et al., 2005). In an outpatient treatment setting, Pike et al. (2003) found a drop-out rate of 20% in persons with AN who were receiving CBT. Schnicker, Hiller, and Legenbauer (2013) conducted drop-out analyses for a manual based CBT treatment protocol for 104 females with Anorexia Nervosa, as well as Bulimia Nervosa. There were three main research aims: (1) discovering which proportion of participants prematurely terminated participation in a naturalistic, outpatient environment, (2) determine differences between those who prematurely terminated therapy and those who participated to completion, and (3) determine the effect of CBT on those who dropped out, and those who completed (Schnicker, Hiller, & Legenbauer, 2013). As the focus of this thesis is on AN, the results of those participants will be included herein. Out of the 104 participants, 35 were assigned to the AN group (Schnicker, Hiller, & Legenbauer, 2013). Premature treatment ending was defined as when the number of therapy sessions scheduled at the start of therapy was not completed. Treatment utilized followed the "Manual of Cognitive-Behavioral Therapy for Anorexia and Bulimia,"(Legenbauer & Vocks, 2006). The authors found drop-out rates of 22.9% among AN participants. The authors found no differences between completers and drop-outs in regard to BMI, age, or comorbid disorders. Although the results are promising, the authors identify a

strong limitation; that the sample size of individuals with AN was very small, therefore generalizations are limited (Schnicker, Hiller, & Legenbauer, 2013).

Galsworthy-Francis and Allan (2013) conducted a systematic review of the use of CBT for AN in response to the lack of systematic reviews at the time of publication that focused solely on CBT effectiveness in this treatment population. They reviewed 16 studies, five of which were Randomized-Control Trials, two non-randomized, and nine individual clinical trials (Galsworthy-Francis & Allan, 2013). All of the CBT programmes were conducted in an outpatient setting, utilizing a manualized approach. In the studies reviewed where CBT was compared to other treatments, no superiority was found. Overall, through their review, the authors found that CBT may be more acceptable than other therapies, and it was not found to be worse than other approaches with respect to treatment acceptance and adherence. In general, CBT was found to be an accepted and effective treatment for AN based on several outcomes. However, the authors did not feel that it is the 'treatment of choice' for AN. Despite this, the authors found that CBT demonstrated positive results on the physical, eating disorder-specific cognitions, wider psychological outcomes, and for relapse prevention (Galsworthy-Francis & Allan, 2013).

The authors highlight that although their study provided important insights, the measures of outcome were entirely quantitative, meaning that they were not based on participants' lived experience. The downfall with purely quantitative research is that it is not able to highlight differences between professional's and person's views of what is important in recovery. As the professionals are not the ones working through the disorder, despite their many years of experience, they can never say with certainty which factors contribute to recovery, and which do not. All they can do is share their experiences and opinions based on these observations.

Touyz et al. (2013) sought to evaluate the efficacy of CBT and Specialist Supported Clinical Management (SSCM), two highly researched and applied therapeutic approaches, for adults with severe and enduring AN. Sixty-three individuals with an AN diagnosis, all over the age of 18, and with a minimum of a seven year illness history, were included in the study. Thirty outpatient visits were conducted over eight months, and participants either received CBT for AN, or SSCM. Each of the therapeutic approaches were modified to be used with individuals who had severe and enduring AN. Each participant was assessed at baseline, the end of treatment, and at six and 12-month follow ups. The main outcome measures were quality of life, mood disorder symptoms, and social adjustment. Second outcome measures were weight, eating disorder psychopathology, motivation for change, and health-care burden. This study is unique and is included in this thesis as the outcome measures were modified to prioritize quality of life over weight gain; that is, the treatment was not focused on food and weight concerns, but rather, on how the individual was doing in life in general. The focus of treatment was communicated clearly to the participants, and the client and therapist worked collaboratively to determine what the client's goals were at the outset of treatment. My belief is that this is a really important feature in treating AN. Based on personal communication with past clients, I have been told countless times how infuriating it can be to have someone dictate your treatment aims, for example, having a professional tell you that you "have to gain x amount of weight". Prioritizing quality of life helps the client to understand that the clinician only wants what is best for them and may allow them to ease into the treatment. This was the first randomized Control Trial to examine the effectiveness of two manualized treatment approaches that were specifically altered to treat severe and enduring AN. Both treatment groups experienced significant improvements on all primary and secondary outcome measures at all assessment time points and in domains

outside the traditional core psychopathology. No significant differences between the two groups at the end of treatment were observed. However, at six- and 12-month follow-up, some individuals showed better social adjustment, lower ED symptoms, and improved readiness to change. Additionally, this study had an 85% retention rate (Touyz et al., 2013). At the time of publication, this was the highest rate of any published study looking at adult AN. In comparison to previous CBT studies that found, on average, a retention rate between 65-78%, this 85% rate was significant (Touyz et al., 2013). Low dropout rates in this study may be attributed to the fact that the therapists worked on areas that the *client* deemed important. Based on the study findings, the authors argue that individuals with severe and enduring AN can make significant strides in terms of achieving a higher quality of life along with a reduction in ED pathology. By widening the treatment goals, focusing on quality of life, and lessening the pressure to achieve weight gain, the researchers were able to engage with individuals who had severe and enduring AN in treatment, reduce the usual high drop-out rates, achieve significant progress, and allowed participants to achieve meaningful, positive change in their lives. The fact that at the time of publication, this was the only randomized control trial to assess individuals with such severe and enduring AN is astounding. The researchers took two rather popular approaches to adulthood AN, CBT and SSCM, and modified them slightly so that weight gain and recovery from core features of ED were not treatment priorities. Weight gain was encouraged but not identified as a primary goal or focus of the therapy. My working hypothesis is that removing the foci from weight gain and recovery and allowing the client to play an active role in their therapy by working collaboratively with the therapist on treatment goals in this case drastically improved the retention rates. By widening the treatment goals, focusing on quality of life, and lessening the pressure to achieve weight gain, they engaged with individuals who had severe and enduring

AN in treatment, reduce the usual high drop-out rates, and achieve significant progress, allowing participants to achieve meaningful, positive change in their lives. Although the sample size used was rather small, I feel that this study holds extremely important information that can help to guide the future of treatment for individuals who have been struggling with this debilitating illness for years. Although "recovery" is a long, and often painful process, it is possible. Despite the prevailing pessimism in the published literature of retaining such clients in treatment and follow-up, a retention rate of 85% at follow-up was achieved in this study.

Benefits of Cognitive Behavioural Therapy

A brief outline of my perceived benefits of utilizing CBT for the treatment of adulthood AN will be included herein: these benefits include the use of homework and the strict therapeutic timeline.

Homework in the therapeutic approach provides the client with a tactile reminder of goals, progress, and steps to recovery once she leaves the therapeutic space. Having homework extends the therapeutic engagement and gives clients a way to work on therapeutic aims in their own space, and at their own pace. This homework serves as an important step for recovery, as the clients are learning different tools that they can embed into their identity, long after the therapeutic relationship has come to an end. The more tools the client has at her disposal, the more likely she is to maintain recovery over the long-term.

The strict guidelines surrounding treatment length may improve treatment engagement and can help both the client and therapist remain focused throughout the entire course of treatment.

Critiques of Cognitive Behavioural Therapy

There is an abundance of literature attesting to the importance of client stance during treatment- specifically about their motivation to change (Geller, Williams, & Srikameswaran, 2001a). As in all therapies, the motivational stage of the client is especially important in the treatment of longstanding AN. As such, it may be extraordinarily difficult for them to imagine their life without their food and weight related thoughts and behaviours, and treatment effectiveness will be directly related to how motivated they are to part ways with their AN. This entrenched psychopathology and ambivalence to change may not be a good fit for the active stance of traditional CBT approaches as discussed above, which can leave the client and therapist with feelings of being stuck, frustrated, and hopeless (Bamford & Mountford, 2010).

Although the benefit of having an approach that hones in on weight restoration and physical manifestations of the illness has been highlighted above, this pro also has a cost. Many clients seek treatment not only due to the physical presentation of their suffering. Often, the reason an individual presents for treatment is because her quality of life has been deeply affected, her relationships are suffering, and she is no longer engaged in activities she once found joy in (Rance, Moller, & Clarke, 2015). As such, it would seem logical to focus on improving quality of life as the primary intervention goal, rather than on physical manifestations of the illness (Bamford & Mountford, 2010). However, this is not to disregard the importance of ensuring the individual's life is not at risk.

Similarly, although the utilization of homework has benefits, many persons with AN may find this facet of CBT anxiety-provoking, thereby impeding treatment and recovery (Bamford & Mountford, 2010). This may be observed due to the high levels of perfectionism that are often

seen in this population, and this may negatively impact their ability to engage in homework assignments.

This approach misses many important factors when it comes to working with individuals who have been living with AN for a large portion of their life, as is often the case with adult sufferers. Components of traditional CBT, as discussed above, require a certain cognitive capacity (Draxler & Hiltunen, 2012). A person who has been starved, regardless of the length of time, will have restricted capabilities in the cognitive domain, which may make treatment engagement difficult, and could further explain limited treatment effectiveness (Draxler & Hiltunen, 2012).

Enhanced Cognitive-Behavioural Therapy (CBT-E)

CBT-E is derived from CBT applied to individuals with Bulimia Nervosa (BN). It is an approach that is designed to treat eating disorder psychopathology generally, rather than a specific diagnosis (Murphy et al., 2010). Thus, the approach differs on a case-by-case basis as the therapist will create an individualized formulation of the individuals maintaining processes. It is designed for adults, in an outpatient setting, with any type of eating disorder (Murphy et al., 2010).

Although to date there has been no specific approach that has shown superiority for AN treatment in adults, the latest enhanced version of Cognitive Behavioural therapy (CBT-E) has shown promise for AN in adults and adolescents in outpatient settings (Byrne, Fursland, Allen, & Watson, 2011). In 2003, Fairburn, Cooper, and Shafran came together after they had all observed in their clinical practice that eating disorders share many common features, and that studies often found a migration from one eating disorder diagnostic category to the next (Dalle Grave, El Ghoch, Sartirana, & Calugi, 2016). This observation led to the development of CBT-E.

It was designed for the treatment of all eating disorders (Byrne et al.,). CBT-E focuses on the key processes maintaining eating disorder psychopathology. CBT-E is a treatment approach that views eating disorders as transdiagnostic in nature, based on the opinion that the over evaluation and control of shape and weight is central to maintaining all eating disorders (Murphy et al., 2010). Clinical features that are seen in Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, and Eating Disorder Otherwise Not Specified can be understood as stemming directly from this psychopathology (Murphy et al., 2010). It was derived from the Cognitive Behavioural Approach to Bulimia Nervosa, yet adapted to focus specifically on eating disorder psychopathology, rather than DSM diagnoses (Dalle Grave et al., 2016).

Therapeutic Process

CBT-E uses specified strategies, as well as an adaptable series of sequenced therapeutic steps to achieve cognitive, as well as behavioural changes (Murphy et al., 2010). CBT-E differs from certain forms of CBT: it does not use conventional thought records, does not make much use of cognitive restructuring, and there is no reference to widely used CBT concepts such as automatic thoughts, assumptions, core beliefs, and schemas (Fairburn, C.G., 2008). CBT-E therapists favour the use of strategic changes in behaviour in order to modify thinking, versus direct cognitive restructuring that is typical of traditional CBT (Murphy et al., 2010). It is essential that persons learn to de-centre from their eating problem, to become interested in it, understand how it works and why it is self-maintaining (Fairburn, C.G., 2008). I can see how giving the client the power to understand the eating disorder, how it works, and why it self-maintains could be incredibly empowering.

There are two forms of CBT-E: (1) the “focused” form, which focuses solely on eating disorder psychopathology and (2) a broad form of treatment which addresses external obstacles

to change, in combination with eating disorder psychopathology (Murphy et al., 2010). The second, broader form of CBT-E is considered to be the more complex of the two approaches, and is to be reserved for those in which clinical perfectionism, low self-esteem, or interpersonal difficulties are predominant, and are serving to maintain the eating disorder (Murphy et al., 2010).

In addition to the two forms of treatment modalities, there are two intensities: persons who are not significantly underweight (i.e. those with a BMI above 17.5), there are 20 sessions over 20 weeks, which is believed to be suitable for a great majority of outpatient settings and for adults (Murphy et al., 2010). In individuals with a BMI below 17.5, treatment consists of 40 sessions over 40 weeks. To put this into perspective, those who have a BMI above 17.5 are given treatment for roughly 4.5 months, and those with a BMI of 17.5 or lower receive treatment for roughly nine months. CBT-E was specifically designed for adults with Anorexia Nervosa, a population that tends to have a longer illness duration compared to younger sufferers. I find it hard to believe that such a short time period can be effective when treating individuals who have been struggling with their eating disorder for several years. To paint a picture of just how long an individual can be living with AN, Rance, Moller, and Clarke (2017) elicited the views on treatment approaches of 12 women who were either recovered, or in recovery, from AN. Although the sample size in this study was small, their average illness duration was ***13 years***. If we are to take the average length of illness duration from Rance et al's. (2017) study, and examine this realistically, it seems quite impossible to assume that an individual who has been suffering for 13 years would be able to sustain long-term recovery after only nine months. Additionally, this focus on BMI as a determinant of who gets more "intensive" treatment is problematic for a variety of reasons. Rance et al. (2017) utilize client perspectives to highlight

the pitfalls of using an approach that is focused too heavily on BMI as an indicator of treatment necessity. One downfall of using BMI as an indicator for treatment intensity is that this directly excludes those with higher BMI's, and whether intentional or not, suggests that these individuals are not 'sick' enough to access care. For example, one participant in the study said, "unless I'm a BMI of 10 I'm not going to get any help", (Rance et al., 2017, p. 587). In the same study, participants noted that even when they had been granted access to care, their on-going help was not guaranteed, especially when this treatment was heavily focused on their BMI; as is the case in CBT-E.

CBT-E has four defined stages, and each will be briefly outlined below. It is beyond the scope of this paper to discuss each of the four stages in detail. Prior to starting treatment, an evaluation interview takes place whereby the client's 'psychiatric' problems are identified and is designed to put the client at ease and emphasize the collaborative nature of therapy (Murphy et al., 2010). One focal point of this assessment is to determine whether CBT-E is the right approach for the individual in question. This is a beneficial step to include in the assessment process, as therapy is not a "one size fits all approach," and acknowledging that this approach may not be of most benefit to everyone is an important factor to recognize.

Stage one. It is of utmost importance that treatment starts well, which is supported by various studies that highlight that the magnitude of change achieved early on is a good predictor of treatment outcome (Fairburn, Agras, & Walsh, 2004; Agras, Crow, & Halmi, 2000). This first stage is designed to achieve initial therapeutic momentum and is the most intensive of all stages. It is conducted over eight sessions that are held twice a week over four weeks. The goal of this stage is to engage the client in treatment and change, to develop a formulation that is personalized, to provide psychoeducation surrounding the disorder, and to introduce and

implement two important parts of CBT-E (Murphy et al., 2010). The first is weekly weighing, and the second is regular eating. The six steps in stage one are outlined below.

Engaging the Client in Treatment & Change. As mentioned earlier, individuals with eating disorders tend to be ambivalent towards treatment and change. Due to this reluctance, getting individuals "on board" with therapy is a first step. Engagement can be improved upon by conducting the initial assessment and by encouraging them to take ownership of their therapeutic journey (Murphy et al., 2010).

Collaboratively Creating Formulation. A visual representation is created, which is personalized to the individual processes that are maintaining the eating disorder, utilizing the individual's own experiences and language. This diagram serves to guide the client and therapist toward what needs to be targeted in treatment if the individual is to achieve a full and lasting recovery (Murphy et al., 2010).

Real-Time Self-Monitoring. This is the "in-the-moment" logging of eating and other behaviours, thoughts, feelings, and events that are relevant to the eating disorder. This step occupies an essential role throughout the rest of therapy (Murphy et al., 2010). CBT-E provides two reasons for the central role of this self-monitoring: (1) it assists individuals to further understand their eating problem and can help to highlight progress, and (2) it helps clients to be more aware of what is happening in the moment, and they can begin to make alterations to behaviour that may have previously seemed automatic or beyond their control (Murphy et al., 2010). Records are reviewed each time therapist and client meet, and difficulties, if any, are discussed.

Providing Psychoeducation. This education is centred on weight and eating. Main topics include: characteristic features of eating disorders with their accompanying physical and

psychosocial effects, body weight regulation, BMI and how it is interpreted, natural weight fluctuations, effects of treatment on weight, ineffectiveness of vomiting, laxatives, diuretics as means to control weight, adverse effects of dieting, and dietary rules vs. dietary guidelines (Murphy et al., 2010).

Establishing Weekly Weighing & Regular Eating. Client and therapist check weight once a week and plot the numbers on an individualized graph, and clients are encouraged not to weigh themselves outside of session (Murphy et al., 2010). There are three reasons identified for conducting weekly weigh-ins: (1) provides opening for therapist to educate individuals about body weight, and to help them interpret the numbers, (2) provides individuals with accurate information about their weight during a time when their eating habits are shifting, and (3) it addresses the maintaining process of excessive body weight checking/it's avoidance.

Establishing a pattern of regular eating is central to successful treatment (Murphy et al., 2010). Clients are asked to eat three planned meals every day, and two to three planned snacks, with intervals between eating not exceeding four hours.

Involving Significant Others. Although this is a treatment for adults, significant others are involved in the therapeutic process when this is determined as helpful in treatment facilitation (Murphy et al., 2010).

Stage two. This is a brief, yet crucial transitional stage that consists of two appointments, one week apart. Whilst maintaining procedures discussed above, the therapist and client review progress together, with the goal being to highlight problems that still needed to be addressed (Murphy et al., 2010). Additionally, any barriers to change that may have emerged are reviewed; revision of the formulation may take place and designing of stage three. It is at this stage where

the therapist assesses whether the broad version of the treatment is required, which addresses the authors previously outlined concerns.

Stage three. The main body of treatment typically is comprised of eight weekly appointments. The aim of this stage is to target the processes that maintain the eating disorder (Murphy et al., 2010). Each feature of this stage is briefly highlighted below. It is beyond the scope of this document to go into further detail.

Addressing the Over evaluation of Shape & Weight. The therapist explains the concept of self-evaluation and helps the client to identify the ways in which they evaluate themselves. Please refer to Figure 2 for a visual of the way in which this may be done.

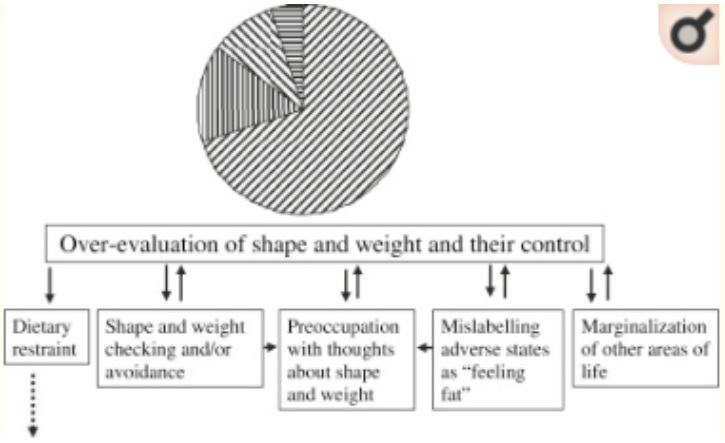


Figure 3 (Fairburn, 2008).

Together, therapist and client identify issues embedded in this scheme for self-evaluation, looking at three intertwined problems: (1) self-evaluation relies heavily on performance in one area of life, which in turn marginalizes areas other than shape and weight, (2) controlling shape and weight is an area in which success is elusive, and (3) this over evaluation is directly responsible for the behaviour that characterizes the eating disorder. One way that this over evaluation of body shape and weight is challenged is by assisting clients in increasing the number and significance of other domains for self-evaluation (Murphy et al., 2010). An example of this would be engaging in other areas of life that may have been temporarily sidelined when

the eating disorder took over and assisting the client in viewing these as important areas for their self-schema (Murphy et al., 2010). In addition, body checking and avoidance, and "feeling fat" emotions are addressed (for those persons who have a distorted body image).

Addressing Dietary Rules. The therapist assists clients in understanding that their extreme and rigid dietary rules impair their quality of life and are a key feature in their eating disorder (Murphy et al., 2010). A major goal here is to eliminate dieting altogether. Various dietary rules are identified, combined with the beliefs that fuel them.

When Utilizing the Broad Version. If in stage two, the therapist has noticed that clinical perfectionism, core low self-esteem, or significant interpersonal problems are evident and are contributing to the eating disorder, these areas are addressed as well (Murphy et al., 2010). Due to space limitations, the details of each step will not be discussed in this document. If readers wish to review a detailed account, please refer to Fairburn C.G. (editor). Cognitive behavior therapy and eating disorders. Guilford Press; New York: 2008.

Toward the end of this stage, it is often important to explore the origins of the client's foci on shape, weight, and eating (Murphy et al., 2010).

Stage four. This is the final stage, and the main foci are ending treatment on a positive note, maintaining progress that has already been made, and reducing the chance of relapse (Murphy et al., 2010). This stage usually takes place over three appointments, separated by two weeks each. In this stage, clients begin weighing themselves weekly at home. Together, therapist and client create a plan for the next few months until the client attends a post-treatment review appointment, which is usually held 20 weeks after treatment completion.

When clients' weight is a concern, additional steps need to be completed in order to address certain characteristics. The priority here is to address motivation, as oftentimes,

underweight individuals do not view undereating or being underweight as problematic (Murphy et al., 2010). The client is then assisted in thinking about the different advantages and disadvantages of change. An important factor here is the therapist's stance, showing deep interest in the client as a human being *beyond* the eating disorder, and assisting her in reflecting on the state of different facets of their life (Murphy et al., 2010). This aspect of CBT-E brings about quite a bit of confusion; are these not factors that should be addressed very early on in treatment, regardless of whether an individual is "underweight"? I am aware that this therapeutic approach takes a transdiagnostic perspective, meaning that it treats all eating disorders from the same lens. However, in Anorexic individuals (something I can only assume would be determined early on in treatment), these types of discussions seem to be especially important to discuss between therapist and client very early on.

The article by Murphy et al. (2010) has informed the aforementioned therapeutic process overview and is an important contribution to the literature on the treatment of eating disorders. Although CBT-E is the only treatment reviewed in this document that does not focus solely on AN, it is still important to include in this thesis as it provides important insights into the treatment of AN and is still utilized frequently amongst this population. The authors do highlight, however, that treatment outcome must be further improved upon, especially in individuals who are significantly underweight. A brief literature review on the use of CBT-E for AN will be presented herein.

Review of CBT-E Literature

Frostad et al. (2018) conducted a quality assessment project of CBT-E for AN in an outpatient hospital setting, to measure pre and post BMI changes in a sample of adults in Norway. Their assessment included 44 adults with AN. Of these 44 participants, only half

completed treatment. This study contributed two main findings to the literature on CBT-E for adult AN: (1) more than 2/3 of the clients who were treatment completers achieved a normal weight after 12 months, and (2) the half of clients who prematurely terminated therapy never recovered to the same level as the completers. In addition, a relatively large effect on BMI was observed in this group of individuals with severe AN. The researchers found that CBT-E for AN was relatively easy to implement in the outpatient setting, and the results of the assessment were promising, and in line with existing clinical trials which have assessed CBT-E efficacy. Despite these positive results, client retention was low, with only half of the participants completing the entire protocol.

Preliminary findings were reported from a three-site study on the use of CBT-E to treat outpatients with AN (Fairburn, 2009). At the time of publication, this was the largest study on the treatment of AN to date. It was found that CBT-E could be used to treat roughly 60% of outpatients with the disorder, who all had a positive treatment outcome. Relapse rates also appeared to be low.

Recent studies evaluating the efficacy of CBT-E in the treatment of individuals with AN have found that roughly 30% of those entering treatment recover at the end of their outpatient therapy (Waller, 2016). Watson, Allen, Fursland, Byrne, & Nathan (2012) sought to examine Quality of Life (QOL) amongst those who were treated under a CBT-E approach. QOL is "the degree of enjoyment and satisfaction experienced in life, and embraces emotional well-being, physical health, economic and living circumstances, and work satisfaction," (Watson et al., 2012, p. 393). QOL is an important measure and is relevant to the evaluation of any treatment because it reflects holistic and fundamentally important aspects of health that cannot be captured merely in symptoms. This is especially important to measure in those with EDs, as these individuals

tend to have poorer QOL compared with healthy controls. In their research, Watson et al. (2012) sought to consider QOL before and after treatment amongst those with EDs who engaged in CBT-E treatment, with the prediction that CBT-E would result in improved QOL. 34 of the participants in this study had AN, and all participants were over the age of 16. QOL was determined throughout using the Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form. This study did not separate results based on diagnosis (Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Otherwise Not Specified), however, QOL is an important aspect of treatment that is not highlighted in many studies, therefore the results were determined to be relevant for the purposes of this thesis. The study by Watson et al. (2012) found that QOL improved with CBT-E across the sample, and 85% of those who completed treatment has post-QOL in a "normal" range. An additional finding concerned QOL across all diagnostic groups; QOL measurements showed no difference across eating disorder diagnosis, and pre-treatment QOL was significantly impaired compared to the general population. Higher QOL at post-treatment was correlated with higher QOL at baseline, and improvement in depressive symptoms and self-esteem with CBT-E treatment. The authors suggest that CBT-E may be effective at improving QOL because it directly targets eating pathology and low self-esteem.

Byrne et al., (2011) sought to examine the effectiveness and feasibility of utilizing CBT-E for all eating disorders at a public outpatient clinic, using an open trial for adults with any of the eating disorders recruited from the community. For the purposes of this thesis, only the results of those with AN will be highlighted. At the time of publication, the only published RCT examining CBT-E for eating disorders was conducted in 2009 by Fairburn et al., and this study did not examine the use of CBT-E amongst those with AN. This study included 34 AN individuals and only 12 of these completed treatment. Out of the 12 who made it to the end of the

treatment, six experienced full remission, which the authors defined as no ED symptoms over 28 days. The other six experienced full/partial remission. This was the first published trial utilizing CBT-E in persons with a BMI lower than 17.5. The results showed that CBT-E resulted in significant improvements in general eating and psychopathology (i.e., not only among those with AN). The dropout rate amongst those who were among the AN sample was 54.3%, compared to 38.3% for the non-AN sample. Overall, the authors suggested that their observed results appeared to indicate that CBT-E may be less effective for treating AN than the other eating disorders.

Fairburn et al. (2013) studied the effects of CBT-E in two representative, and severely affected samples of persons with AN. The research assessed four key clinical questions: (1) in adults with severe AN, what proportion can complete outpatient treatment? (2) among those who complete treatment, what is the outcome? (3) are the changes, if any, sustained? and (4) are there any baseline variables that predict successful completion of therapy? Two samples of participants were recruited, 50 individuals from the United Kingdom, and 49 from Italy. Study participants were female participants in their mid 20s, with the average length of AN of three years. In both the samples, 2/3 of the individuals completed the full treatment (40 weeks). Amongst those who completed treatment, there was a significant positive response in both samples. The average weight gain was 7.47 kg, and over 60% achieved a BMI of 18.5 or above. There were substantial improvements in eating disorder psychopathology and general psychiatric features. The changes that were achieved during treatment were well maintained, however, there was a slight deterioration in average weight and BMI among participants. Regarding the fourth research question, the authors found that treatment completion was significantly associated with eating disorder severity, whereby those with greater psychopathology were less likely to finish

therapy. The researchers stated that the findings were sufficiently promising in order to justify the evaluation of CBT-E in RCTs, due to the fact that not only did 2/3 of participants complete treatment with substantial improvements in weight and eating disorder features, but these improvements were well-maintained across two different sample groups.

Therapeutic Benefits of CBT-E

There is an abundance of literature on the use of CBT-E with adults who are attempting to overcome AN. As such, it was easy to find a variety of studies, utilizing different research approaches, assessing many different populations from a wide variety of backgrounds. It appears that CBT-E is an effective approach that can be applied to a wide variety of clients, as the original founders intended. Studies conducted with participants in America, Norway, Italy, the United Kingdom, Canada, Australia, New Zealand, and several more exist. With such a vast array of countries, it can be said that CBT-E as an approach also may be applicable to a multicultural population.

Another benefit of CBT-E is seen during the stage of therapy where the client is taught "real time self-monitoring". The client is taught how to notice their thoughts, behaviours, and feelings and reactions to specific food and weight related events, and to subsequently shift these dysfunctional patterns. This step may help clients to increase their awareness to what is happening in the present moment, which is a mindfulness approach referred to as "present-moment focus" (details of which will be discussed in Chapter 4, Acceptance and Commitment Therapy). This noticing and altering the dysfunctional response patterns allows individuals to take initiative in their recovery and gives them the agency to individually select how they wish to respond to these cognitions and behaviours.

An additional benefit of CBT-E appears in the final stage of treatment, where reducing the risk of future relapse is prioritized. One of the methods that is used in this phase, as discussed above (refer to ***stage four***), is assisting clients in creating realistic expectations for their future. This is an important step to any treatment, especially in those who have been struggling with AN for several years, as is often the case with adults. Preparing for the potential relapse and envisioning how the individual will respond and utilize their resources when/if this does happen, is a very beneficial part of treatment. This can help the client increase her self-esteem and provide her with a sense of security about the future knowing that should she relapse; she can re-achieve her hard earned progress.

Critiques of CBT-E

The main critique that I have regarding CBT-E for the treatment of AN concerns the immense focus that is placed on weight and food troubles. Much of my sentiment surrounding this is supported by the experiences of 12 women who shared their perspectives on AN treatment in Rance et al., (2017), and much of their stories will be utilized to support the critiques herein. This literature is important as, at the time of publication, it was one of the only studies that highlighted *participant* experiences of treatment for enduring AN.

My first critique begins with the overall goal that CBT-E identifies in treatment, and that is that the therapist and client work together, as a team, to help the client *overcome her eating problems*. Although the collaborative nature of this is celebrated, and the fact that eating difficulties are a key aspect of AN, having this be the sole focus of treatment is highly problematic, as it misses many of the psychosocial consequences for the individual living with the eating disorder. Having a treatment that is heavily focused on the individual overcoming the eating problems might miss the way in which this eating disorder developed in the first place. To

quote one of the participants in Rance et al., (2017), "perceived the treatment system as overly focused on food and weight. In contrast, they felt that 'eating disorders are not about food, they're about life' and that a key part of treatment is being seen, and treated, as a 'whole person'," (p. 586).

The focus on weighing of clients at various different stages of the therapeutic process is worrisome. First of all, having a treatment system that is heavily based on BMI is problematic in that it excludes individuals who may be in desperate need of treatment, but will not be able to access such care if their BMI is not deemed 'low enough'. In a society where treatment is already difficult enough to obtain, having treatment cut-offs based on BMI sends the message that "if your BMI is about *x,* then you are not 'sick enough' to enter treatment". What kind of message does that send to individuals? Even when the individual is deemed 'sick enough' to enter treatment, in CBT-E, her weight is continually monitored throughout treatment. I understand this methodology from a health and safety approach; the individual's life comes first and foremost, and if she has a life-threatening weight, then that needs to be determined and tackled immediately. However, a common feature of AN is an obsessive focus on weight, numbers, and shape, which often interferes with all other areas of life. Weighing an individual in treatment seems to reinforce the very thing that brought them in the door in the first place. In CBT-E, the weigh-ins occur weekly in session, yet the client is strongly encouraged to not weigh themselves at other times outside of the therapeutic space. How is this enforced? From personal experience, I know that oftentimes in AN, individuals tend to weight themselves up to three times a day, and sometimes cannot even fall asleep at night if their weight is 'too high'. It seems highly unrealistic to expect that someone who is seeking treatment for an illness that is so centred on weight, would simply relinquish control to the therapist regarding weigh-ins. Then, as a part of

the ending of therapy in stage four, clients are *encouraged to weigh themselves at home as a way to monitor progress.* It strikes me as highly problematic that clients are encouraged to continue to closely monitor their rigid thoughts, which they likely had at the outset of therapy. The experiences of the women in Rance et al., (2017) further supports this notion, where "treatment systems and therapy which focus almost exclusively on weight and food might have negative behavioural side effects, and encourage ED behaviours," (p. 590).

In conjunction with the heavy focus that is placed on weight, and weight monitoring in CBT-E, food and dietary patterns are also given excess attention. Real time self-monitoring includes providing clients with strict eating rules (three times a day, two snacks, refer to ***therapeutic process)***, which seems to reinforce the already present rigid rules surrounding food. The reasoning for addressing dietary rigidity is described as allowing the individual to see how their extreme and rigid rules are negatively impacting them. This is certainly sensible and providing the client with the opportunity to explore the ways in which their rules are harming them has great utility. However, by providing them with another diet to follow, CBT-E simply replaces one behaviour with one that is "healthier". The removal of one rigid behaviour and the replacement of such with another seems contradictory. Should therapists not be encouraging an absence of dieting in the first place? The experiences expressed in Rance et al., (2017) again support this notion, insofar as "it appeared that therapy which focused narrowly on food and weight had the potential to encourage the women to remain in, rather than relinquish, their ED," (p. 587). An example is provided by Lucy*:

> "[I] spent two years with them [local ED service]… to get to the point where I realised that focusing on food and maintaining restoring weight doesn't work for me, because all

it does is push me further into depression… which I don't handle very well… it makes me suicidal".

Although the above is just one possible scenario, it paints a clear picture of how the extreme focus on weight and food in therapy can have detrimental side effects. The next chapter will present the literature on The Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA).

CHAPTER 3: MANTRA

Adults with Anorexia Nervosa (AN) are a notoriously difficult population to treat with high rates of treatment resistance, high rates of relapse and low rates of recovery (Fairburn, 2005). As an adult has often lived and engaged in the world with an eating disorder for a lengthy amount of time, the person can begin to see the eating disorder as a part of who she is, which can make treatment engagement challenging (Schmidt et al., 2013). There is little evidence to suggest that any psychological treatment consistently produces good outcomes for adults with AN (Byrne et al., 2017). Over the past 10 years, several new approaches have appeared in the literature on adult anorexia nervosa, however, for the purpose of this thesis I will focus on the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA). I chose to focus on this model as in 2017, the National Institute for Health and Care Excellence (NICE) recommended MANTRA as a first line treatment for adults with anorexia nervosa.

The focus of this chapter is on the use of The Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) amongst female adults in outpatient environments. The following topics will be addressed: (1) the background of the approach, (2) the therapeutic process, (3) the therapeutic style, (4) what the studies show, (5) when applicable, what the therapist and client experiences of MANTRA are, and (6) critiques of MANTRA. Additionally, I will evaluate how client centred the approach is, based on the definitions and discussion presented in the first chapter of this thesis.

Background

MANTRA was founded by Ulrike Schmidt, Tracey D. Wade, and Janet Treasure (2006). This model of treatment was developed using the U.K. Medical Research Council's framework for the development of complex interventions and involved an iterative translational process

between basic research and model/treatment development (Schmidt, Wade, & Treasure, 2014, p. 50). MANTRA was developed in response to the lack of an effective treatment approach for adults with Anorexia Nervosa (Schmidt et al., 2013). The developers felt that one of the reasons that there was a relative lack of effective treatments for this population is that current approaches have been adapted from those for other disorders, and these are not tailored sufficiently to the characteristics and needs of those with AN (Schmidt et al., 2013). Additionally, none of the psychotherapeutic approaches focus on how the eating disorder is maintained.

MANTRA is an approach to the treatment of AN that was designed specifically for adults, who are often long-time sufferers. The central tenets of the approach draw on neuropsychological, social cognitive, and personality trait research (Schmidt et al., 2012). It was developed out of the belief that in adults with AN, certain personality traits are more common, namely sensitive/anxious and perfectionist/obsessional traits, and that these qualities may negatively impact treatment outcome (Schmidt et al., 2012; 2014), suggesting that the outlined personality traits existed prior to the development and progression of AN. MANTRA was developed with the belief that there are four broad factors that are core to the maintenance of AN: (1) cognitive rigidity and attention to detail, (2) socio-emotional impairments (for example, avoidance of experience and expression of emotion), and starvation exacerbates these issues, (3) sufferers hold strong beliefs about the utility of AN in their lives (for example, AN keeps me safe, AN numbs my emotions), and (4) parents and/or loved ones may unintentionally maintain the disorder through high levels of expressed emotion, or through enabling behaviours (Schmidt et al., 2012).

I feel that some of the wording that is utilized by the MANTRA approach to address sufferers and their families is belittling. For example, I feel that referring to parents and loved

ones as having “high levels of expressed emotion,” and “enabling behaviours,” disregards the difficulty inherent in having a loved one struggling with a life-threatening disorder. Viewing family members under such a damning light may discourage them from participating in treatment. MANTRA proposes that it is crucial that all four of the maintaining factors are addressed in treatment, with the hope that alterations in the four mediating factors will improve clinical outcomes (Schmidt et al., 2013). It was designed as a radical departure from the classic CBT treatment approaches, which placed a (from their perspective) unnecessary amount of importance on weight and shape concerns as the central psychopathology of AN (Schmidt, Wade, & Treasure, 2014). Under the MANTRA approach to AN treatment, therapists understand that client worries rarely concern strictly eating disorder related themes (for example, fears of weight gain). Research has found that eating disorder related themes are only related to 1% of worries in clients (Sternheim, Startup, Saedi, et al., 2012). Instead, the most prevalent worries discovered were interpersonal difficulties (42%), consisting mainly of rejection and abandonment, negative perception of self (22%), and the experience of negative emotions (20%) (Sternheim, et al., 2012).

MANTRA results in a treatment that is targeted to AN, that is matched to each client’s clinical symptoms, her personality traits, and her individual psychological profiles (Wade, Treasure, & Schmidt, 2011).

Therapeutic Style

The therapeutic style is influenced by motivational interviewing (Schmidt et al., 2012), in addition to giving importance to eating and weight gain in recovery (Wade et al., 2011). The MANTRA style of therapy was developed as a way to present the client with an experience that is different from what they may be used to experiencing (Schmidt et al., 2014). More

specifically, many anorexic clients may be used to others consistently worrying about their health, which may be expressed as warning, lecturing, or in some unfortunate circumstances, threatening them on the health risks associated with being anorexic. This experience is all too common and may cause clients to become defensive of their condition (Schmidt et al., 2014). From this lens, it is clear to see that in order to assist clients in moving past a defensive stance, the therapist must avoid warning, lecturing, or threatening of any kind. The therapist creates an environment that is highly warm and empathic; therapists are reflective, responsive, and collaborative (Schmidt, Wade, & Treasure, 2014). Each session is also highly strategic, as the therapist must maintain the momentum in order to positively encourage the client in a direction of change (Schmidt, Wade, & Treasure, 2014).

Therapeutic Process

MANTRA is a combination of a top-down, and bottom-up approach; it is both theory-led and data driven, as well as driven by the client and clinician (Schmidt, Wade, & Treasure, 2014), and was designed for use in outpatient settings. The therapeutic relationship involves 20-40 weekly sessions, depending on how severe the therapist deems the illness to be, in addition to four or five follow-up meetings, which are usually scheduled once a month (Schmidt et al., 2014). From a MANTRA perspective, positive change occurs once the client makes steps in the direction of healthy eating and gaining weight (Schmidt, Wade, & Treasure, 2014). MANTRA is a formulation-based treatment, individually tailored to match the clinical symptoms, the personality traits, and the neuropsychological profile of each client that is accompanied by a workbook (Byrne et al., 2017). Treatment is centred on the clients' workbook, and it is through collaboration between the therapist and client that important parts are deemed relevant (Schmidt et al., 2012).

The therapist moves through four treatment phases with the client, which will be briefly outlined herein. All information on the phases of treatment is taken from Schmidt et al. (2012).

Early phase. This phase takes place in sessions 1-4, although this may be extended dependent on illness severity. This stage is meant to be a way for the therapist and client to explore the client's history, where she is heading in life, how AN helps and how it hinders her. It is in this phase that pro-anorexic beliefs (e.g., How AN helps them) are explored, and this is how the therapist discovers the unique meaning that AN holds for the client. Examples of pro-anorexic beliefs include "AN makes me safe," "AN numbs my emotions," "AN helps me to cope with my stress". This step is strongly emphasized because a reduction in such beliefs predicts positive treatment outcomes, whereas increasing anti-AN beliefs does not show the same positive outcome. The central mechanism through which these beliefs are reduced is by building motivation for change. Exercises are adapted from literature on motivational interviewing (ref), and include motivational readiness rulers (ref), therapeutic writing exercises (ref) that explore and question the value of AN to the individual, letters to AN as a friend or as an enemy, and casting one's mind backward to their life before AN took hold. The goal of such exercises is to help the individual identify the function of AN in their life. Another approach taken is value-driven, whereby the therapist encourages the client to examine what her values were prior to AN, as these tend to shift as thinness and weight gain become prioritized. Exercises are also used whereby AN is externalized, with the hope that the individual will work toward separating AN from her identity. Information about nutritional/physical risk, neuropsychological test results, and various assessment measures are also used to build motivation to change.

In sessions 1-4, the notion that support from outside others is important is introduced, as Anorexia can be very isolating, causing the sufferer to socially withdraw. Who is included in

support is up to the client, and this is done by having the individual complete a support questionnaire that helps them to think of those in their social support network that may be the most helpful in beating AN. The general rule for this aspect of the early treatment phase is that "close others are invited to participate flexibly in sessions as necessary, with greater involvement the iller the patient," (Schmidt et al., 2012, pp. 56). Working on nutrition and the educational component, two aspects of sessions 1-4 are briefly outlined below.

Working on nutrition. As healthy weight gain and nutrition are key aims of MANTRA, nutritional work is flexibly intertwined with therapy, dependent on how ready the client is to tackle this aspect of treatment. A medical risk assessment is conducted using the Maudsley Body Mass Index Chart and Risk Assessment in Anorexia Nervosa, and based on the results, the individual is asked to reflect and rate how competent they believe themselves to be to care for their own nutritional needs, and how dependent/independent they are in terms of their nutritional safety. Under a MANTRA approach, I appreciate the way that BMI is used solely as an assessor of the client's safety, unlike in CBT and CBT-E, where it can be used as a barrier to treatment (please refer to Chapter 2 for a discussion of the use of BMI from a CBT lens). Clients also rate what they feel that their support system and therapist would say about their competency, and if there is a big discrepancy between these results then this is discussed with the client. Individuals are weighed at the beginning of each session, with the rationale being 1) it is important to continuously monitor the clients' health risk and ensure that the therapy proceeds safely, 2) weight gain or absence of is one of the key measures of judging how well therapy is going, and 3) if the client has fears of rapid weight gain in an out-of-control manner, then these regular weigh-ins can serve to manage these fears. Clients are encouraged not to weigh themselves between sessions, as this would be counter-productive to therapeutic aims. In contrast to CBT for

eating disorders, clients are not encouraged to maintain a food diary, as this enforces detail-focused thinking styles which can be a maintaining factor in AN.

As has been mentioned several times throughout this thesis, I not only understand, but I agree with the utility of weight monitoring when it is done from a stance of saving the individual's life. Other than that, I see minimal purpose of weight monitoring in outpatient therapy. Under the MANTRA approach, I feel that the justifications for weight monitoring are harmful to the client and may hinder progress. Even worse, this may lead to drop out in individuals who deeply fear being weighed altogether. Firstly, I believe that therapy progress can be assessed through a variety of other means aside from weight gain or absence of such, for example, looking at whether the individual is engaging in activities that bring her joy (Geller, 2006). Additionally, weighing the individual in every session, yet encouraging them to not weigh themselves outside session not only indicates a lack of trust, but may send the client ambiguous messages on the importance of weight.

Education aspect. Each client receives education on daily energy needs for maintaining weight, for gaining weight, and on the consequences of starvation. Individuals are also provided with information on what to eat on a day-by-day basis and what "healthy" eating is. The goal of the educational component is to help the client think about the bigger picture of improved health that will allow them to have a healthier life in line with their personal values and goals. Clients are also provided with feedback on their neuropsychological tests conducted in the initial stages, and how their results compare to age and sex matched healthy controls to monitor progress.

Formulation and treatment planning. This takes place during sessions 5-8. The central therapeutic task of this stage is to build a collaborative case formulation, and to develop a treatment plan with goals for the therapeutic journey. This involves the following 5 steps: (1)

developing a good understanding of the individuals' current difficulties in light of their earlier life experiences and current environment; (2) understand what the key maintaining factors are, and sharing this with the client, as well as their family if deemed appropriate; (3) develop a collaborative diagrammatic case formulation; (4) supplement this with a formulation letter, and (5) the therapist and client agree on treatment goals and plans for future change. In regard to developing goals, many individuals with AN can find this step to be rather difficult, in part because they may not be ready to set goals around weight gain and nutrition. Many individuals may have a past of setting too many goals that are unattainable, and they may easily be discouraged. The therapist will work with the client to help them identify areas of difficulty and think about their aspirations in this area, which is usually followed by the development of SMART (specific, measurable, achievable, realistic, tangible) goals.

Working for change. This takes place in sessions 9-18. Throughout this phase, the therapist and client work towards long-term change through an ongoing focus on nutrition and the manual to work on the identified problem areas. In this stage, the therapist asks the individual to reflect on her thought processes versus the content of the thinking. Additionally, the client is asked to reflect on how her thinking style impacts her life. The neuropsychological assessment that was mentioned above is revisited, and these results are supplemented with various workbook exercises to get individuals to reflect on their thinking style, how their thinking style may have shifted as a result of AN, and how this affects their life. The individual is often invited to reflect on the impact that her thinking style has had on behavioural aspects, for example, feeling the need to get things right every time and to avoid mistakes. Using this example, the person can reflect on the trade-off between speed and accuracy or effort in tasks they perform, further

leading to discussions on the standards the person has set for themselves, and whether these are attainable or not.

Discussions are about unhelpful and rigid rules about food, calorie counting, weighing of foods, and AN rules regarding the types of food that the person is “allowed” to eat. This rigid style of thinking is often extrapolated into the interpersonal domain, and the therapist explores this with the client as well. The client is encouraged to explore these rules, and to disentangle the helpful rules from the ones that are not so helpful.

Emotional education is another aspect of this phase that is important. The therapist teaches the client about the function of emotions from an evolutionary perspective; what emotions are, and why we have them. The individual is also invited to look at her emotional rulebook, which are rules that a person may have surrounding emotional expression. For example, some people may think that it is bad to express emotions and turn to AN to numb these emotions. Clients are also taught how to manage extreme and overwhelming emotions, and to see the world from another’s perspective so that they gain a more balanced picture of interpersonal and emotionally distressing situations.

Clients are introduced to the concept of self-compassion, which is a way of positively relating to oneself that does not involve self-evaluations or social comparisons. As people try to make changes in the different areas outlined in therapy, oftentimes their inner critic will turn on, and their fear of criticism, negative evaluation, and rejection will also ignite. This can extend into other areas, attacking the many small changes the person is trying to make. Clients are taught to recognize their inner critic and are encouraged to challenge the belief that harsh self-criticism is necessary for survival. To contrast this harsh inner critic, clients are taught to become more aware of the pure intentions of others, and to become more self-compassionate.

Ending, relapse prevention, and follow-up. This takes place in sessions 19-24, with the focus on ending the therapeutic process and implications this has for the client. The therapist discusses relapse prevention strategies with the client, and they exchange good-bye letters to reflect on what has been learned in treatment, what goals have been achieved, and what the remaining areas of work are. Follow-up sessions are meant to review with the client all the helpful changes that have been achieved, which can include building a new identity that is separate from AN.

The Manual

The manual was designed to be user-friendly and consists of images, stories, diagrams, and checklists. The below image displays the content of the MANTRA manual (Schmidt et al., 2014, p. 50).

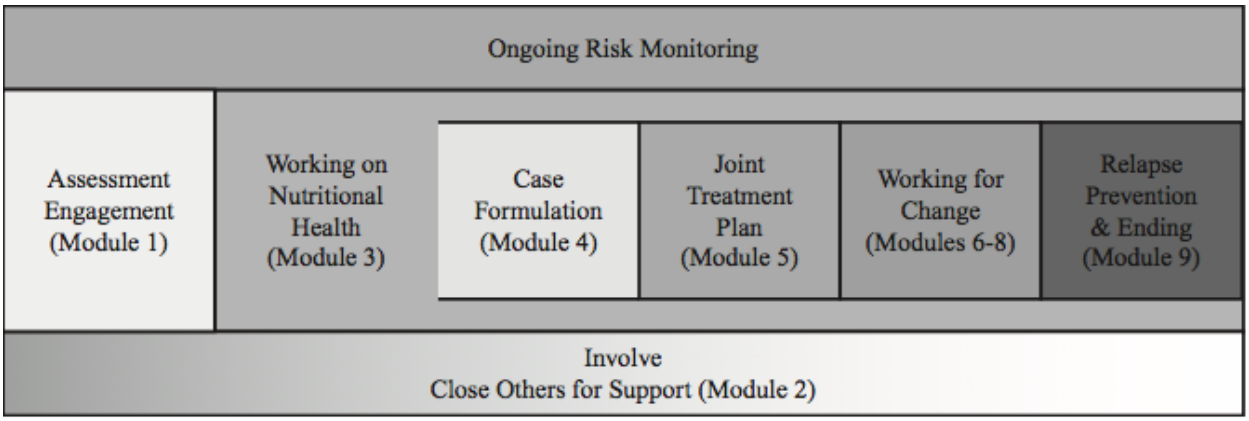


FIGURE 1. Treatment phases of MANTRA.

It is beyond the scope of this thesis to present the details of the MANTRA workbook. However, content will be briefly summarized below, and is taken from Schmidt et al., 2014.

Module 1: Getting started with treatment, including exploration of motivation to change, identification of pro-AN beliefs, assessing the function of AN in the person's life, exploration of AN impacts on personal values, etc.

Module 2: Identification of potential support networks, identification of helpful and unhelpful interactions, plans for involving others in recovery.

Module 3: Assessing medical risk, daily caloric needs for maintaining and gaining weight, education surrounding negative effects of starvation, nutritional change plan.

Module 4: Allows the client to build a conceptualization of how their AN developed, and how it is being maintained.

Module 5: Identification of areas of concern/difficulty, aspirations, education on setting specific, measurable, achievable, realistic, and tangible goals, and use of behavioural experiments to achieve outlined goals.

Module 6: Exploration into thinking styles; may involve questions such as "am I overly focused on detail?", "am I finding it hard to be flexible and switch between different perspectives?", "What is the impact of my thinking style on my life?".

Module 7: Understanding the emotional and social mind. How to listen to your emotions, identify your beliefs about emotions, and learning how to appropriately express emotions and needs. Learning to manage extreme and overwhelming feelings, and development of self-compassion.

Module 8: How to develop an identity beyond AN.

Module 9: Reflection on how to maintain therapeutic gains, imagining what could get in the way of recovery, tool kits for keeping well, and development of mottos for living a bigger life.

What the Studies Show

Being one of the newer treatment approaches that shows promise, several studies assessing MANTRA as a treatment option have been conducted. All studies involved adults who met the diagnostic criteria for AN.

Wade et al. (2011) conducted a study to examine the new kid on the block in the world of psychotherapeutic approaches to the treatment of AN in adults; in other words, MANTRA. At the time of publishing, there had been many attempts at proposing effective treatment approaches for this population, to no avail. The central aim of their study was to determine whether MANTRA was worthy of conducting further time-consuming, and costly trials. In their research, Wade et al. (2011) used a case series design, and hypothesized that as a result of MANTRA, fewer participants would drop out of treatment in comparison to previous outpatient trials, and that large effect sizes would be observed in changes in BMI, eating pathology, and motivation. The authors also theorized that the emphasis on Motivational Interviewing would be the mechanism by which these effects were observed. After an initial assessment session, therapy was delivered in 25, 60-minute sessions, over a period of 10 months. Twenty of these were weekly sessions, and five were monthly. Participants completed a self-report questionnaire at the first session, were given the Eating Disorder Examination (EDE) at second session, and were re-interviewed with EDE at the fifth, tenth, and last session (Wade et al., 2011). The EDE provides a measure that practitioners can use to assess the range and severity of eating disorder features (Fairburn and Beglin, 1994). EDE was also administered at 3-month and 12-month follow-up. Thirty-three people participated in the study (Wade et al., 2011). The results supported the first hypothesis, whereby the dropout rate was 17.9% compared to similar trials, in which dropout rates ranged from 31-64% (Dare et al., 2001; Halmi et al., 2005; McIntosh et al., 2005 as cited in

Wade et al., 2011). An Italian research team who conducted a similar approach assessing Cognitive Behavioural Therapy (Ricca et al., 2010, as cited in Wade et al., 2011) reported dropout rates of 19%, similar to the dropout rate reported in the current study. The second hypothesis was also supported, whereby good outcomes were found in 30% of participants at post-treatment, dropping to 26% at 12-month follow-up (Wade et al., 2011). Important to note is that lower reports of self-esteem, and high levels of reported ineffectiveness at baseline seemed to differentiate those with poor outcomes and those with moderate/good outcomes (Wade et al., 2011). This is more than other approaches have reported, for example, 18% for focal psychotherapy and cognitive-analytic therapy (Dare et al., 2001 as cited in Wade et al., 2011), and 0% in interpersonal psychotherapy (McIntosh et al., 2005, as cited in Wade et al., 2011). Although this number is promising, it is lower than what was observed in similar trials for CBT (Ricca et al., as cited in Wade et al., 2011) and SSCM (McIntosh et al., as cited in Wade et al., 2011). Additionally, large effect sizes were found in improvements surrounding motivation to change [see 'definitions' section of this document for specific stages] (Wade et al., 2011). In conclusion, the study by Wade et al. (2011) seemed to suggest that MANTRA is a therapy that is worthy of future investigation using more robust designs, for example, randomized control trials (RCTs). Additionally, these results suggested that MANTRA has the potential to be a powerful therapy with weight-restored clients in order to prevent relapse, and perhaps may not have as much utility in those who have not yet achieved weight restoration (Wade et al., 2011). The influence on outcomes of low self-esteem and high ineffectiveness may point to a promising avenue of treatment, whereby addressing these features early in treatment may have positive effects on AN outcome (Wade et al., 2011).

The first pilot study of MANTRA assessed treatment uptake, retention, and outcomes in 28 adults, and found good results for all three Schmidt et al., 2012). Schmidt et al (2012) sought to test the efficacy and acceptability of MANTRA compared to Specialist Supportive Clinical Management (SSCM) in adults with anorexia nervosa in an outpatient setting. The authors hypothesized that MANTRA would be more effective at the end of treatment, and at follow-up in regard to weight gain and reduction in symptoms. They also proposed that participants who had received MANTRA would show improvements in neuropsychological tasks that assessed cognitive rigidity (Schmidt et al., 2012). Each client was assigned to a treatment condition, and they received 20 once-weekly individual sessions of therapy, and four monthly follow-ups (Schmidt et al., 2012). The authors observed no significant differences between the two treatment groups, both had good retention, comparable adherence, similar treatment expectations, and similar levels of satisfaction (Schmidt et al., 2012).

In 2013, Schmidt et al. began the first large-scale evaluation of MANTRA to compare the efficacy and acceptability of MANTRA compared to SSCM in adult outpatients with AN. It was hypothesized that MANTRA would be superior in producing weight gain, greater improvements in eating disorder-related psychopathology at six and 12 month follow ups, and that MANTRA would be more cost-effective, showing lower costs at follow up (Schmidt et al., 2013). Cost-effectiveness would be determined by the number of hospitalizations during treatment and follow-up. The study included 142 participants who were randomly assigned to receive 20 to 30 once-weekly sessions of MANTRA or SSCM, with outcomes measured at pre-randomization, and at six and 12-month follow-ups. Mean participant age was 26.7 years, and participants had a clinical diagnosis of AN or Eating Disorder Not Otherwise Specified (EDNOS) (Schmidt et al., 2015). The post-treatment outcomes were analyzed by researchers who had not been involved in

the treatment process (Schmidt et al., 2013; Schmidt et al., 2015). Recovery was determined through use of BMI and Eating Disorder Examination. The results showed that participants in both groups experienced significant improvements in their BMI, eating disorder psychopathology (as measured by the EDE), affective symptoms, and psychosocial impairments at follow-up (Schmidt et al., 2015). It was found that attendance, acceptability, and credibility of MANTRA surpassed that of SSCM. Additionally, trends were observed that suggested that MANTRA produced better BMI outcomes in participants who were severely ill upon entering the trial (Schmidt et al., 2015). Of the original 142 participants, 104 provided data for the follow-up (Schmidt et al., 2015). Upon analyzing the data, the hypothesis was not confirmed. Despite this, it is worth noting that for both the treatment groups, improvements that were observed at 12-month follow up were either maintained or had increased at the 24-month follow-up (Schmidt et al., 2015). In both conditions, 83% of the participants did not need intensive treatment outside of the trial.

Although the aforementioned results showed promise for MANTRA as a first-line treatment for AN, there is no information on the long-term outcomes. To address this lack of information, Schmidt et al. (2016) conducted an assessment on the long-term outcomes of MANTRA and SSCM. It was hypothesized that at 24-month follow-up, those who had received MANTRA would exhibit greater weight gain, and more improvements in eating-disorder related and other psychopathology than those who had received SSCM.

One study sought to compare the efficacy of SSCM, MANTRA, and Enhanced Cognitive Behavioural Therapy (CBT-E) in the treatment of adults with Anorexia Nervosa, hypothesizing that CBT-E and MANTRA would be superior to SSCM in regard to eating disorder psychopathology and weight gain (Byrne et al. 2017). Eating disorder psychopathology was

assessed using the Global Subscale of the Eating Disorder Examination (EDE), with the average age of participants being 26.19 years. It was found that all three treatments were associated with a significant reduction in general psychopathology, and psychosocial impairment (Byrne et al., 2017). In response to the findings, Byrne et al. (2017) suggested that since weekly in-session weigh-ins were common factors across the three approaches, that this may be a main driver of change for adults with anorexia nervosa.

Therapist/Client Experiences

In the largest evaluation of MANTRA to date comparing MANTRA to SSCM, Schmidt et al. (2015) found that individuals who received MANTRA had better attendance than those who received SSCM treatment. In the same study, the authors looked at client self-reports of treatment acceptability and credibility, finding that MANTRA was rated as significantly more favorable on both dimensions at 12-month follow up. In addition, MANTRA participants provided significantly more positive feedback compared to SSCM participants (Schmidt et al., 2015). These findings are important, as greater acceptability of MANTRA may translate into increased willingness to engage in additional treatment if needed, or may suggest improved long-term outcomes (Schmidt et al., 2015). These positive client experiences were found at 24-month follow-up (Schmidt et al., 2016).

Lose, Davies, Renwick, Kenyon, Treasure, and Schmidt (2014) conducted a study that sought to understand the client experiences of MANTRA and SSCM in the study by Schmidt et al. (year), discussed earlier in this document. The authors recruited 17 participants from the study, using purposive sampling to ensure that the participants represented different age groups, illness severity, diagnostic subtypes, and included those with and without previous treatment experience. A semi-structured, in person interview that lasted approximately 30 minutes was

conducted to obtain results from 11 MANTRA participants and six SSCM participants (Lose et al., 2014). For the purpose of this thesis, the MANTRA experiences will be discussed herein. Five main themes emerged from the clients' descriptions: (1) positive and helpful aspects, (2) beneficial outcomes, (3) less helpful aspects, (4) possible improvements, and (5) therapeutic and external environment. These themes will be used to discuss the client experiences.

Positive and helpful aspects. Eight of the 11 MANTRA clients felt that the treatment was structured well, was flexible, and tailored to their needs (Lose et al., 2014). The clients felt that the structure of the therapy helped orient them to treatment, facilitated engagement and change, and provided them with a sense of progress throughout treatment. Seven participants found that the manual was helpful, and referred to it as a guide that helped them organize their thoughts, provided them with a fresh way to look at their difficulties, and as something to refer to outside of session. Ten of those interviewed found other aspects of the treatment useful; for example, developing a psychological understanding of their problem, reflection on thoughts, feelings, experiences, goals, and aspirations, and being provided with relevant information and tools for change (Lose et al., 2014). One aspect that was well received across all participants was the formulation of goodbye letters between therapist and client. These were viewed as very personal and providing a helpful summary of the treatment. The involvement of significant others was considered useful, and for some participants it meant that their significant others became more supportive (Lose at al., 2014).

Beneficial outcomes. Six of the 11 clients who received MANTRA thought that the therapeutic process helped them gain insight into and perspective on their difficulties (Lose et al., 2014). This allowed clients to be less affected by their thought processes and feelings, they felt more empowered to make changes, and they felt that they were able to be more flexible and

express their feelings, as well as their needs. Six of the individuals believed that during treatment, they developed the skills to be able to communicate more openly, and with more confidence. These results extended to general life aside from their eating disorder (Lose et al., 2014). Seven clients reported improved quality of work, and quality of social life (Lose et al., 2014).

Less helpful aspects. Nine clients expressed dislike of various aspects of the manual or treatment approach. For example, one client expressed that "some of the ones like writing a letter to your anorexic friend and then… which I always found a bit… uncomfortable," (Lose et al., 2014, pp. 134).

Possible Improvements. Six of the participants suggested some changes to the treatment and the manual. Examples of such proposed changes included adding more 'open talking', additional reading, having a separate manual for those who met AN criteria except for the BMI component (also referred to as EDNOS), and having group sessions with other AN clients. Three individuals felt that treatment would have been better if more practical advice was involved or if there had been a therapist who was more prescriptive (Lose et al., 2014).

Therapeutic and external environment. Eight participants between MANTRA and SSCM emphasised the importance of a good match between client and therapist.

Overall, the perceptions of MANTRA focused on the clear structure of the approach, and the flexibility and tailored use of the manual as this was felt as personalizing treatment. Clients also felt that MANTRA helped them gain insight, alter their thinking styles, and improve their quality of life overall, which is in line with what the therapy sets out to achieve (Lose et al., 2014).

Critiques

Some persons may become overwhelmed by the large amounts of material available and may be intimidated by the role of homework in treatment (Schmidt, Wade, & Treasure, 2014). In addition, homework may be counterproductive for those who exhibit perfectionist tendencies, as they may place excess worry on getting the "right" answer, which would counteract therapeutic benefits (Schmidt, Wade, & Treasure, 2014). Others have suggested that the client may become over reliant on the therapist in the proper use of the manual (Schmidt, Wade, & Treasure, 2014).

Another point of critique I want to put forth is that due to the fact that MANTRA is a rather new approach, it was quite difficult to find literature assessing treatment effectiveness. In addition, much of the existing literature and studies came from the founders of the theory. Researching one's own theory and/or methods may be subject to bias. However, in the literature, the authors did offer a solid explanation of the limitations and critiques of the approach. Although the results found thus far have been promising, it is difficult to generalize these findings as the numbers of participants were small. Additionally, no research on North American populations was discovered in my search. However, the literature was based mainly in the United Kingdom and Australia, similar contexts to North American contexts.

An additional critique I have concerns the use of comparisons in the early phase of treatment. Although I am no expert on the matter, the fact that clients are provided with information on how the results of their neuropsychological tests compare to age and sex matched health controls seems rather suspect. This is a population that tends to exhibit anxious, obsessional, and perfectionist qualities, and placing them in a situation whereby they are comparing themselves to others seems like it may be a slippery slope. Doing so, they may strive to improve their test results, not because they wish to get healthy, but because they want to do

better than their peers. Some information on the dialogue that is used during this phase of treatment would be helpful to understand the level of support that is provided to individuals whilst making this comparison.

Despite the increased interest in effective treatments for adults with anorexia nervosa, the need to continue to study approaches in well-conducted, adequately powered studies remains pressing (Schmidt et al., 2012).

CHAPTER 4: ACCEPTANCE AND COMMITMENT THERAPY

Throughout my research, one theme has been consistent: the pressing need for efficacious interventions for the treatment of Anorexia Nervosa (AN) (Fairburn, 2005). An important factor worth noting are the ethical concerns that exist when attempting to conduct research alongside this group of individuals, which may explain in part the lack of effective trials of psychological treatments that exist in the research (Fairburn, 2005). The nuances that exist within researching therapeutic approaches to AN have been so challenging that at one point, it was suggested that randomized control trials should be temporarily halted until more preliminary research identified new and promising treatments (Fairburn, 2005).

This chapter will focus on Acceptance and Commitment Therapy (ACT) which is a novel approach that aligns with the author's view's on how clients should be treated in session. What makes this approach novel is that it assists clients in accepting the emergence of their thoughts, feelings, and sensations, and encourages the understanding that these are not in our power to control (Kater, 2010). Rather, it is how we relate to these mental events that has the power to transform our minds, bodies, and souls (Kater, 2010). For practitioners, ACT offers a new way to stand alongside our clients who have consuming and constricting thoughts and fears, which are maddeningly encouraged by wider culture (Kater, 2010). Therapists can help clients in accepting this difficult reality and encourage them to take the steps that are needed to live a life that is inspired by their most deeply held values and preferences for how they wish to live (Kater, 2010).

Although research on ACT for the treatment of AN in adults is limited, I believe that it holds promise in the treatment of this disorder. This chapter will present a brief introduction to ACT as a general approach and discuss the six core psychological processes that make up the

theory. Then, ACT as applied to AN will be presented, followed by a brief literature review, benefits, and critiques of ACT as an approach to treating AN.

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) is a relatively new psychotherapeutic approach, which has been outlined as a third wave cognitive behavioural psychotherapy (Berman et al., 2009). It integrates a theory informed by basic science, learning and behaviour perspectives, with an emphasis on mindfulness and acceptance of situations that cannot be changed (Berman et al., 2009). The overarching goal of ACT is to increase clients' awareness of their own personal experiences and contingencies present in their lived environment, while assisting them in acting in tandem with their identified goals and values (Berman et al., 2009). This is done through increasing the clients' psychological flexibility. An ACT approach to treatment is summarized in the acronym; **A**ccept and defuse from private internal events, **C**hoose a direction that is of value, and **T**ake action to move toward that valued direction (Hayes & Pankey, 2002). Those who work from an ACT lens oppose the myth of healthy normality that is present in western culture, where happiness is commonly seen as the absence of negative experiences, thoughts, and emotions (Manlick et al., 2013). From an ACT perspective, intolerance of negative affect is viewed as a key source of human suffering (Manlick et al., 2013). Experiential avoidance is the method by which humans attempt to control these negative internal experiences and this can manifest in one of the following ways: behavioural avoidance, distraction, numbing of experience, and attempts to change private internal experiences (Manlick et al., 2013). The attempts at control that individuals make are challenged, with the hope that they will come to understand that the control they are trying to exert is creating their presenting concerns, instead of solving them (Manlick et al., 2013). The goal of this is that the client comes

to an understanding of what the costs of these attempts at control are (Manlick et al., 2013). Ideally, the relationship between negative internal events and the resulting hindering behaviours will be changed. The ACT therapist neither responds to the person in the room as if their thoughts are wrong, nor do they attempt to convince the individual to "not think" or "not feel" as they do (Kater, 2010). What separates ACT from other forms of cognitive-behavioural approaches is the emphasis it places on the *context* in which clients' distressing events and psychopathology occur, instead of the specific content of the distressing cognitions and/or behaviours (Berman et al., 2009). The "ideal" outcome of an ACT therapeutic relationship is an individual who can identify and mindfully observe her feelings, without responding to them behaviourally or accepting them as a literal truth (Berman et al., 2009). The goal of ACT is to increase psychological flexibility by applying six core processes: 1) defusion, 2) acceptance, 3) contact with the present moment, 4) values, 5) committed action, and 6) self-as context (Hayes et al., 2006). A brief description of each will be provided below.

Psychological Flexibility, The Six Core Processes, and Mechanism of Change

ACT is "a psychological intervention based on modern behavioural psychology, that applies mindfulness and acceptance processes, and commitment and behaviour change processes, to the creation of psychological flexibility" (Powers, Zum Vörde Sive Vording, & Emmelkamp, 2009, p. 73). Psychological flexibility involves the ability to be in touch with the present moment as a fully conscious human being, and to alter or persist in behaviours according to personally valued life goals (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). The main goal of ACT is to decrease psychological inflexibility by using six core processes to help clients learn to accept negative emotions instead of engaging in avoidance behaviors (Blackledge & Hayes, 2001). Each of the six processes is a psychological skill and not meant to follow any specific order

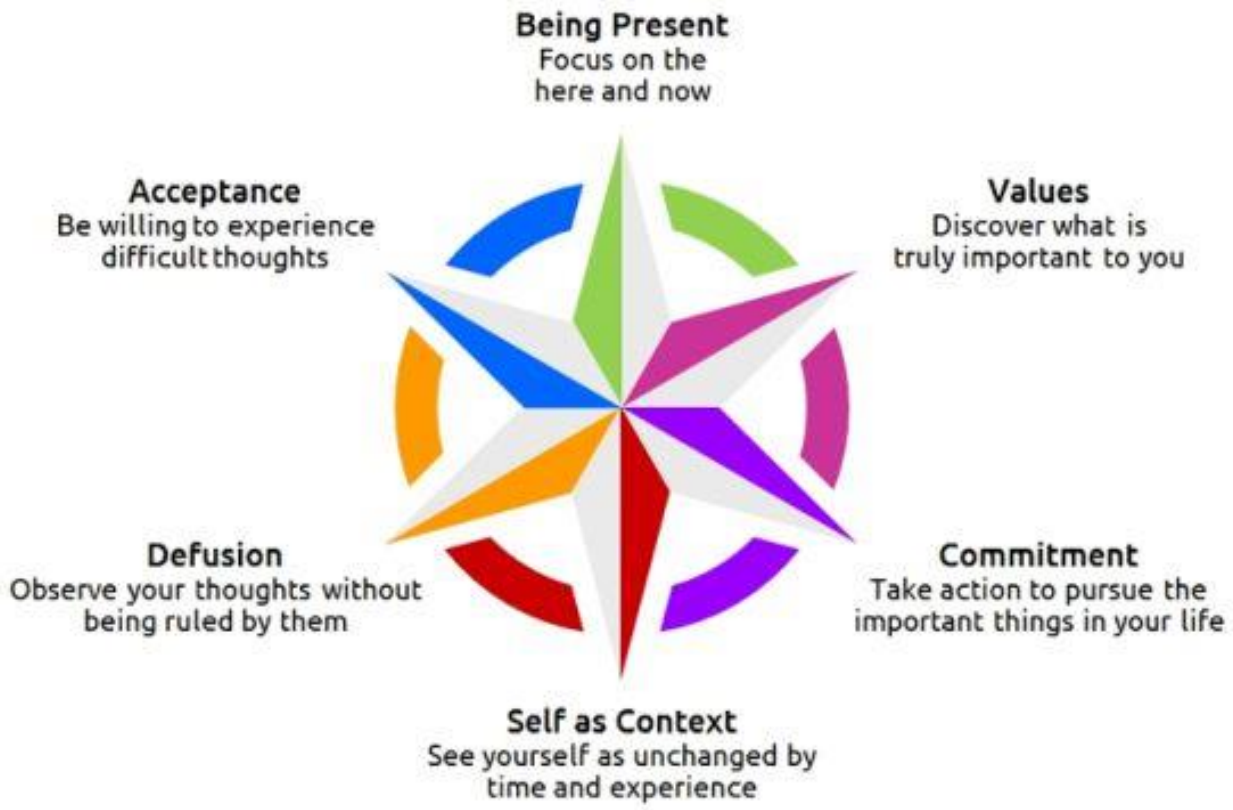
(Cullen, 2008). Rather, each skill is designed to help a client move towards living a more valued and fulfilling life, where her negative emotions no longer impinge on cherished goals (Blackledge & Hayes, 2001).

The six core processes are outlined below. 1.) Acceptance: increase the willingness of the client to acknowledge her inner events without engaging in attempts to control or change them; 2.) Defusion: assist clients in recognizing that their thoughts are not facts by decreasing their literal meaning, thereby helping the client to understand that they possess the ability to separate themselves from their negative inner experiences; 3.) Self-as-context: take an observer view of the self by learning to see the self simply as the context where the inner experiences occur, not as one who is defined by their private events; 4.) Present Moment Awareness: help the client to attend to internal and external experiences as they occur, instead of ruminating over the past or hypothetical future events; 5.) Values: have the client identify important life principles that can serve to motivate behavioral change, and 6.) Committed Action: the gradual process of building patterns of behavior that are organized around the personal values identified by the client (Woidneck et. al, 2012; Cullen, 2008).

The above six processes when applied as skills help clients learn that their unpleasant emotions do not need to determine behaviour, and that they can fully experience their negative cognitions without these impeding on their personally valued goals (Blackledge & Hayes, 2001). Psychological problems are resolved once the client learns to accept aversive emotions and cognitions without judgment or the need to control, and can utilize these feelings in a constructive way while working towards valued goals (Blackledge & Hayes, 2001). Change occurs once clients accept their reactions, are aware of their inner experiences, can choose a valued direction, and take action in pursuing their goals (Powers et. al, 2009). The basic

proponents of ACT highlight the importance of human agency. Once the individual realizes that she can change the course of her life, and that she does not need to be controlled by negative private events, she can live a meaningful life in pursuit of valued goals.

Figure 1: A Visual Representation of the Six Core Processes



Cognitive Defusion

On the other side of cognitive defusion lies cognitive fusion, whereby cognitions dictate behaviour at the expense of other external variables (Manlick et al., 2013). In order to defuse the relationship between thoughts, feelings, and behaviours, control strategies that may be at play are drawn out and explored, with the hope being that the client will come to understand that their efforts at controlling their negative affective experiences are not successful or productive (Hayes

et al., 1999). The alternative to control and avoidance is mindfulness, where clients learn to observe their mind rather than *be* their mind; it is still entirely possible to have negative thoughts, but to disentangle these from your sense of self (Manlick et al., 2013).

Research shows that ACT may be effective for a variety of presenting concerns, such as depression (Zettle & Rains, 1989), chronic pain (Dahl, Wilson, & Nilsson, 2004), and psychosis (Bach & Hayes, 2002). Although ACT can be applied to a variety of different presenting concerns, who would benefit the most from this type of approach? Kater (2010) suggests that those who have struggled long enough to recognize the time, energy, money, relationships, and live experiences that have been lost to their internal and external struggles. The struggles, losses, and energy given to AN have long been documented, and these losses seem to be amplified in adult sufferers, as they may have spent most of their life living alongside AN. This fact, partnered with the unique approach of undermining ineffective control strategies and the avoidance of adverse thoughts and feelings seems to suggest that theoretically, ACT is an ideal treatment for AN (Heffner et al., 2002). I can see how this approach would be especially beneficial for those with AN, as it would provide them with the skills to confront distressing experiences that inevitably occur, whilst providing them with the option for recovery that encourages them to pursue the values they hold close to their heart.

ACT, at the core of the approach, moves away from attempts to change maladaptive cognitions and behaviours, and shifts toward placing the control back in the clients' hands through allowing them to select how they want to respond to their thoughts. ACT teaches clients to recognize their thoughts and understand that they can still live a meaningful life in the face of challenging cognitions, and subsequent behaviours. This is taken a step further by constructing an environment in which the client is encouraged to pursue wellness and change through the

pursuit of their chosen values. Due to the aforementioned, I believe that the utilization of ACT for adult women with AN is deserving of additional research. Individuals amongst this population have often lived with AN for many years (Rance, Moller, & Clarke, 2015), and can be quite resistant to treatment (Fairborn, 2005). When considering the fact that oftentimes the individual has lived with their disorder for several years, one can begin to comprehend the observed resistance to treatment amongst this population. In addition, other approaches that have been included in this thesis do not place the focus of treatment on the pursuit of the individual's values; rather, the goal of treatment is often weight restoration and regular food scheduling (please refer to Chapters 2 and 3 for relevant literature). ACT is an approach that presents a new perspective that one can take to the therapeutic treatment of AN.

ACT is an approach that seems promising in beginning to place this control over treatment back in the individual's hands. Clients choose the direction that their treatment goes by discussing their values with the therapist, and collaboratively the therapist and client work to establish a commitment to change in pursuit of these identified values. There is an ever-growing body of research that suggests that the core constructs that ACT targets are central in the development and maintenance of eating disorders (Jurascio, Shaw, Forman, Timko, Herbert, Butryn, Bunnell, Matteucci, and Lowe, 2013). In line with Orsillo and Batten (2002), I believe that using ACT as an approach to AN has the potential to address limitations inherent in other approaches and may result in clinically relevant and meaningful change. ACT as a treatment approach to adulthood Anorexia Nervosa, and this promising avenue for future research will be explored next.

An ACT Approach to Adulthood Anorexia Nervosa

ACT is client-centred, relying on the client's values to guide treatment (Wilson & Roberts, 2002). It requires the therapist to have a deep understanding of clients' experience and their hardships to provide content for intervention, and it also relies on the client's commitment to growth and development (Wilson & Roberts). A therapist working from an ACT approach will consistently work to undermine the notion that the therapist has the power to 'change' the client, and places emphasis on clients' contributions to their progress (Wilson & Roberts).

Martinez and Craighead (2015) acknowledge the longstanding search for a "gold standard" treatment for persistent AN. They propose that perhaps the reason this dilemma exists may be in part due to a subpar consideration of individual differences, primarily personality and neurocognitive traits (Martinez & Craighead, 2015). This line of thinking opens a new door for research into the treatment of AN, and is a very important path to be exploring, especially in the realm of persistent AN. When looking at the research surrounding treatment from this lens, one can begin to understand *why* it is so difficult to recover; perhaps the woman has incorporated AN into her identity. Taking this into consideration, an important question to ask is "what function does AN serve for this individual?". It has been suggested that AN serves as a way in which an individual can control, and/or avoid negative internal and external experiences (Martinez & Craighead, 2015; Kater, 2010; among others). ACT is supported by a rich body of literature that dates back roughly 25 years, documenting effectiveness for disorders of experiential avoidance, which are driven by a compelling urge to avoid or control undesirable internal experiences (Kater, 2010). ACT has been considered a promising line of therapeutic work for AN as it specifically works with ineffective efforts at control, and the maladaptive unwillingness to sit with negative thoughts and emotions, features considered to be maintaining factors in AN.

ACT takes this a step further by working with the individual and her values, and slowly working with her to tease apart the self and AN. Additionally, allowing the individual to choose how she wishes to recover by selecting her valued direction, is unbelievably empowering and respectful. It is not an objective party that is making the choice for them, saying "you need to recover because you are too thin, and this is unhealthy". Progress is determined by clients' steps towards acceptance of the thoughts that drive their disorder, and the recognition that these are merely mental constructions that are created by associations between events that have come to be triggered reflexively (Kater, 2010). In addition, the individual comes to the understanding that she can choose how to respond to these automatic responses (Kater, 2010).

The six core principles outlined in ACT target the emotional, cognitive, and behavioural manifestations of AN (Manlick et al., 2013). The following will present an expanded discussion on the six core principles mentioned earlier, with specific applications to AN. It is important to make the reader aware that many of the ACT interventions are metaphorical in nature, and do not involve concrete steps for the therapeutic process (Heffner et al., 2002). In order to increase the effectiveness of the use of metaphor, the authors suggest incorporating visual, auditory, and tactile components. How each core principle is applied to the treatment of AN will be described in as much detail as possible keeping this consideration in mind.

Cognitive Defusion

In AN, judgments about size, fear of fatness, and overwhelming impulses to restrict food intake often control a person's thinking (Kater, 2010). From an ACT lens, these sorts of thoughts become fused to the person, and until persons learn to de-fuse themselves from this thinking, they will remain distressed by the content. In order to allow individuals to de-fuse from their thoughts, mindfulness as a skill is taught. The goal of using mindfulness to achieve cognitive

defusion is to assist the individual in watching what the mind says and does, rather than remaining captive to destructive and often self-limiting concepts and rules (Kater, 2010). For example, a client may have the thought "I can't stand to feel full. It makes me feel like I will blow up!" In my volunteer work over the years with this population, I can attest to the fact that this is a common thought, and I have seen the distress this thought can cause. Naturally, this thought would cause anguish, as the individual believes that eating until full is akin to destruction (Kater, 2010). In this case, ACT would propose de-fusing the person from their cognition through mindfulness, by helping them to *observe* the thought instead of becoming *fused* with it. The first step to this process is helping the person to question the literality of the thoughts (Kater, 2010). This creates a shift from "if I eat until I am full, I will blow up!" to "I am having the thought that if I feel full, I will explode," (Kater, 2010). The more this is practiced, the more the individual will be able to de-fuse this thought from her sense of self. I feel that this is a very gentle and compassionate approach to working with individuals who have enduring AN. When compared to more cognitive approaches, which challenge and attempt to change disordered thinking, the skill of cognitive defusion assists individuals to take a step back from their thoughts and see them for what they are… just thoughts.

Another aspect of cognitive defusion that I believe would be fruitful in working with long-lasting AN is the understanding that this skill provides the therapist. When viewing AN thoughts from a lens of fusion, the lack of behavioural and emotional flexibility suddenly becomes more understandable (Kater, 2010). Why would *anyone* eat until they were full if they truly believed they would blow up? In this view, the client's response is actually quite rational; she is responding to the world as she truly experiences it (Kater, 2010). From a therapist's perspective, having this knowledge allows us to be more compassionate, empathic, and patient.

From a client's perspective, I can imagine that interacting with a therapist who was compassionate, empathic, and patient would be exceptionally beneficial and healing.

Being Present

Many individuals who struggle with disordered eating behaviours have difficulty with living in the present moment (Sandoz et al., 2011). Being present involves working with clients and assisting them in developing mindfulness skills as a means to address poor set-shifting, rule-boundness, and excessive supervisory cognitive control that all contribute to the cognitive rigidity that is often seen in AN sufferers (Wisniewski, Bishop, & Killeen, 2014). Being present is an essential skill to develop as it is necessary in learning the other core ACT skills (Sandoz et al., 2011). Those who are seeking to recover from AN will benefit from mindfulness practices, such as being present, as they often show a strong fusion with their thoughts [which will be discussed further below] and can have difficulty taking other perspectives. An example of how an individual with AN may struggle to shift to present-moment focus can show up when sensations of fullness are present (Sandoz et al., 2011). When these feelings exist, individuals may enter a cognitive spiral where they project into the future and ruminate on the ways in which they are going to "make up" for the food consumed, or how they can avoid this feeling in the future. In order to get rid of this feeling, they may engage in excessive exercise, losing the ability to be present, causing them to become unaware of their fatigued muscles and their body's hunger signals (Sandoz et al., 2011). Working to facilitate present moment focus with this population involves focusing on primarily sensory experiences, for example, experiences in any of the five senses (Sandoz et al., 2011). At advanced stages of present-moment focus, the client can contact and describe her experience as it occurs in the present (Sandoz et al., 2011).

Self as Context

ACT aims to develop a context where various perspectives of the self can be experienced by the client, with the end goal being the discrimination of the aspect of self that is common in all experiences (Sandoz et al., 2011). Self-as-context is a mindfulness-based process that attempts to create a distinction between the individual, referred to as "self" and the individual's ability to watch her thoughts, called the "observing self" (Wisniewski, Bishop, & Killeen, 2014). Whilst teaching this psychological skill, the client begins to discriminate between herself and the problem behaviour (Heffner et al., 2002). This step provides the context where avoidance is unnecessary, and acceptance is possible. In order to determine the clients' ability to separate the self, the therapist may intentionally create a context where self-awareness is to be expected as more or less likely (Sandoz et al., 2011). For example, is the client able to recognize herself as separate from the experience of food restriction? The client may associate her sense of self with her psychological experience (Sandoz et al., 2011). An example of this that is often seen in AN populations is an individual experiencing herself as "good" when she has successfully restricted, and she may have minimal awareness of a sense of self that is *separate* from her eating (Sandoz et al., 2011). Most of this work is done through the use of various metaphors to assist the individual in seeing that their sense of self exists in a variety of contexts. One example of such an exercise is the observer exercise, where the client is directed to experience a transcendent sense of self that is separate from her memories, roles, body, thoughts, and feelings (Orsillo & Batten, 2002).

Acceptance

Experiential avoidance occurs when an individual repeats actions or behaviours for the purpose of avoiding difficult thoughts and/or feelings (Kater, 2010). A common feature in AN is

the avoidance of thoughts and/or feelings that are related to weight and body image (Heffner, Sperry, Eifert, & Detweiler, 2002). This was supported by a study by Meyer, Waller, and Watson (2000), who found that experiential avoidance may play a role in eating disorders, with food restriction as an attempt to avoid or reduce negative weight and body image thoughts. ACT makes no attempt to change or eliminate an individuals' avoidance tactics. Rather, an ACT therapist will encourage the acceptance of distressing thoughts and feelings (Heffner et al., 2002). In order to do so, the therapist will facilitate contact with direct contingencies by encouraging the individual to deliberately experience the previously avoided thoughts and feelings (Heffner et al., 2002). One metaphor used in therapy is the Chinese Finger Trap metaphor. The therapist will explain to the client how a Chinese finger trap works, that after inserting fingers, if the fingers pull out the tube catches and tightens (Heffner et al., 2002). The only way to remove fingers is to push them in, then slide them out; we must first surrender our fingers to the trap (Heffner et al., 2002). This metaphor is used to highlight the idea that attempts to control an event that is uncontrollable are fruitless, whereas efforts to lean in and accept the nature of our events are more beneficial. [For further examples of metaphors used in ACT, please refer to Heffner, Sperry, Eifert, and Detweiler, 2002]. The example provided by Heffner et al. (2002) uses body weight as the uncontrollable event, and how accepting one's body as is can be more beneficial than attempts to fight against this. This can be used as a platform for a discussion around how restricting agendas are counterproductive, as they may cause feelings of being tired, hungry, cold, and irritable whilst still not being satisfied with the body.

The goal of teaching acceptance is for the client to come to the understanding that negative emotions and thoughts are not obstacles to recovery, rather, these are to be expected (Heffner et al., 2002). From this perspective, clients can begin to learn to be comfortable with

aversive thoughts and feelings, while still moving towards their valued goals (*the identification of valued life goals will be discussed below).* Acceptance will ultimately look different for each client as the presenting thoughts, feelings, and values will be different for each individual. However, once a client has moved towards acceptance, she will be able to experience her symptoms without avoiding them (i.e., without engaging in restricting behaviours) (Heffner et al., 2002).

Values and Committed Action

A central component of ACT is the need for clients to connect with what is of greatest importance to them, what they want their life to stand for, and using this as a driver of change (Kater, 2010). The idea behind this is that recovery is not linear, and in times when disordered behaviours may be tempting, individuals can draw on their personally identified values and goals as a reminder as to *why* they have chosen the path of recovery. Specific to those with AN, different exercises are undertaken with the intention of helping clients connect to their deepest desires, and help them to envision what they would want their life to look like if their AN thoughts and impulses were no longer controlling their actions (Kater, 2010). An example of a prompting question is "in a world where you could choose to have your life be about something, what would you choose?" (Kater, 2010). Although there are phases where value exploration is the focus, values should be touched upon in every session (Wilson & Roberts, 2002). In my opinion, commitment to valued action is the most beneficial aspect of ACT for AN. When individuals seek out our services in hopes of recovery, they are essentially facing their darkest, deepest demons. This facing of internal pain may be akin to skydiving; it is risky, unpredictable, and intimidating. When we invite clients to do this, immense courage is required. The foundation for this courage has to come from something that truly matters to them. Additionally, allowing

the client to select a valued path to guide their recovery places their journey back in their hands. When they take a few steps back in their process, they will have the ability to reflect upon the reasons they chose to recover in the first place. This has additional benefits, in that with repeated practice, the client will no longer have to rely on the therapist to support them in their recovery; instead, they can re-connect to their dreams and values. The following example has been adapted from Kater (2010). Imagine a mother who has been struggling with AN for her children's entire life. The therapist may begin exploring the woman's value system with her, and it may arise that she places extreme importance on being a good mother. The therapist may begin to inquire about this value a bit further, "what does it mean to you to be a good mother?" "What might it look like if you were living in accordance with this value?" The client may, on *her own terms,* outline that if she were to live in accordance with her value, she would be able to sit and have meals with her children at the end of the day. Or perhaps, she may want to slowly begin incorporating regular eating habits into her life, so that she could have the energy to play with her children.

Review of the Literature

Prior to beginning a discussion of the existing literature on the application of ACT to adulthood AN, it is important to note that difficulty arose when attempting to locate randomly controlled trials, and studies in general. Thus, it is not possible to assess the efficacy of ACT relative to other forms of treatment. Perhaps this lack of research is due to the relative novelty of ACT as an approach as a whole, and even more novel in the treatment of AN. However, ACT has been used in many clinical settings, and has been studied under various conditions. The following will outline several studies examining the effectiveness of ACT for the treatment of adulthood AN in an outpatient setting.

Berman et al. (2009) sought to evaluate the effectiveness of ACT for the treatment of AN, utilizing a case series method with individuals who had been treated for AN before. Inclusion criteria for the study were as follows: adults, on a stable medication regimen, and to meet all criteria for AN except for the weight and menstruation requirements. I feel that the authors in this study are moving AN research in a positive direction by not paying mind to the weight and menstruation requirement. BMI and menstruation should not be considered markers that an individual does not need treatment. Three individuals were involved in the study, and they had been involved in intensive treatment of AN for one to 20 years. The authors highlight that although the number of individuals included was small, they were representative of a group that is resistant to treatment, and a group that can be difficult to research due to ethical constraints. Each participant was seen for 17-19 weekly sessions of ACT, with symptoms assessed at baseline, post-treatment, and at a one year follow up. Through their work, Berman et al. (2009) found four results: (a) two of the three participants experienced substantial improvement; the third participant improved as well, however, in a more modest way, and all participants experienced gains in their quality of life, and in the pursuit of their valued goals; (b) improvements were made both during and at the one-year follow-up; (c) the two individuals who were considered the most "severely ill" at the beginning of treatment experienced the most improvement; (d) although few, all participants completed the entire protocol, something that is worth noting in a population that has high treatment drop-out rates. Participant improvement was determined by assessing clients post-trial, and at a one-year follow-up, using a variety of self-report measures, a semi-structured clinical interview, and blind weight and height measures (Berman et al., 2009). As there was no control condition in the case series, no causal claims regarding the efficacy of ACT can be made (Berman et al., 2009). However, this tends to support

the suggestion that ACT is a safe and feasible treatment for AN, and points to the necessity of further studies examining effectiveness.

Research by Hartmann, Thomas, Greenberg, Rosenfield, and Wilhelm (2014) tested an acceptance/mindfulness, cognitive restructuring, and distraction strategy on short-term effectiveness of reducing frequency of thought or occurrence in participants with AN, BDD, and healthy controls. For the purpose of this thesis, the results in regard to acceptance/mindfulness and AN will be presented. The authors found that CBT was less effective in the AN group than the BDD group, supporting the suggestion that CBT is not effective for AN that has been discussed throughout this paper. In addition, their research is in accordance with support for ACT similar to those found in Berman et al., (2009).

Heffner et al., (2002) presented a case example of a 15-year-old Caucasian female. Although this thesis is discussing treatment approaches to Anorexia Nervosa in adults, this case example is still beneficial in highlighting the use of ACT for treating Anorexia Nervosa. In their case presentation, they moved through an ACT treatment plan that highlighted the different treatment steps used, including metaphors, and commitments to valued directions. Rather than making attempts to control her weight, the therapist encouraged the client to accept her body by engaging in several exercises (Heffner et al., 2002). Through treatment, her symptoms began to diminish within 10 sessions, and her treatment successes were maintained at monthly follow-up sessions (Heffner et al., 2002). In addition, her desire for thinness and feelings of ineffectiveness decreased, and her weight restored to a healthy level for her age, in addition to the resumption of her menstrual cycle. The authors report that although their client felt no desire to attend treatment initially, by the end of treatment, she began to recognize the benefits. Despite the successful treatment results reported, it is important to note that this does not point to the efficacy of solely

ACT techniques, as the authors utilized other techniques such as parental support, rapport, and other CBT methods (Heffner et al., 2002). When working with adults who have lived with unremitting AN, parental support and other CBT methods may not be accessible, leaving the question as to whether ACT is as efficacious as was seen by Heffner et al. (2002).

Benefits of ACT for AN

I have attempted to thread the perceived benefits of ACT for AN throughout this chapter. However, they will be briefly summarized herein. ACT places significant emphasis on empowerment, encouragement of the client to take charge of their change through the pursuit of a valued direction, is significantly less pathologizing compared to other approaches to AN, provides the individual with a sense of agency (they are selecting their valued direction of recovery), and the foci is off of weight restoration and food.

In opposition to the cognitive models of treatment, where the focus is on extracting maladaptive thoughts and/or beliefs for change, ACT at the core is fundamentally less pathologizing (Manlick et al., 2013). The less pathologizing nature of ACT begins the second the individual walks through the door to the therapy office. A therapist working with AN from an ACT lens may also suffer from a busy mind and will work with the woman instead of picking apart her maladaptive cognitions (Manlick et al., 2013).

Another benefit of utilizing an ACT approach in the treatment of AN is that it successfully navigates the ego syntonic nature of eating disorders more generally (Manlick et al., 2013). This is done through directing the client's focus to their personal values as a means to illustrate the inhibiting effects of AN on the individuals prized life values (Manlick et al., 2013). For example, if a woman places value on being a good student, yet is unable to focus due to her AN, the therapist may unpack the value that she places on being a good student by exploring

what this means to her, what she hopes to accomplish, what her favourite class is, and other important values. Eventually, the hope would be that the individual would choose to recover in pursuit of her values. This is especially beneficial for those who do not want the goal of their treatment to be weight gain (Manlick et al., 2013). This aspect of ACT is, I believe, of the utmost importance to consider in future research on AN treatment for adults. Working with individuals to pursue the innermost workings of their heart and soul provides them with a tremendous amount of agency in their recovery. They have *chosen* to recover, not solely because their health was at risk, but they have done so in pursuit of something that makes their eyes sparkle, and their heart skip a beat. I would imagine that in the face of a relapse, having the ability to reflect on the reason you chose to recover could serve to empower the individual to keep moving forward in their recovery.

Critiques

Caution must be exercised on the part of the therapist to avoid inadvertently giving the individual one more control or change agenda; she or he must be cautious as to not provide the golden way out (Hayes & Pankey, 2013). The reason for this is that those who have a tendency to exercise deliberate control over their bodies and rule-governed strategies may be quick to jump at the idea of another way to control negative thoughts and feelings.

As the overarching goal of ACT is to increase psychological flexibility, this requires quite a bit of cognitive awareness. Amongst a population where one of the main diagnostic factors is starvation and low body weight, it may be possible that their cognitive functioning has been temporarily depleted. I question whether or not an individual who has been living with AN for a long period of time would be able to engage in the abstract features of this approach until they have been weight restored.

Much of the research I reviewed had small sample sizes. This may be in part due to the novelty of the approach, and the ethical constraints of studying this population. However, these findings should be approached with caution as they may not be generalizable due to the number of participants.

Conclusion

ACT works with individuals to accept their cognitions, while teaching them that although they exist, they are not absolute truth versus attempts at ridding the individual of all negative/uncomfortable thoughts. I feel that this approach would ease the individual into considering what recovery might look like, and does not place immediacy on ridding the individual of their identity with AN. In addition to this gentle easing of the individual into the possibility of a life without AN, this approach is significantly less pathologizing than the three other approaches discussed in this thesis.

CHAPTER 5: DISCUSSION

Aim of Thesis

The central aim of this thesis was to add to the discussion of the difficulties in treating Anorexia Nervosa in adult populations through providing a critical analysis of four outpatient therapeutic approaches. I addressed the flaws in treatment approaches that place weight restoration and food related concerns as the cornerstone of therapy and attempted to highlight the benefits of utilizing treatment approaches that do not place these concerns at the core of treatment. Another important goal was to highlight the importance of continued research into effective outpatient approaches for this population, as inpatient experiences can be deeply traumatizing.

Throughout this thesis, the intention has not been to discredit the existing literature. However, the tone of much of the research can be described in one word: disheartened. Many authors pointed to the discouraging statistics amongst this population and questioned the effectiveness of many of the approaches that clients commonly seek. It is important to note that all the approaches included in this thesis *have* found some positive results with participants. Although the positive results do not go ignored, after reviewing the research, I believe that continued research into this population is of the utmost importance, especially when the recovery statistics are taken into account. Longitudinal research has suggested that fewer than 50% of individuals diagnosed with AN recover fully; 20-30% continue to experience residual symptoms, 10-20% remain significantly ill, and 5-10% die from their illness (Steinhausen, 2002). In addition, the suicide rate is 200 times that of the general population, causes high levels of disability, psychological and physical comorbidity (Schmidt, Wade, & Treasure, 2014), and has the highest mortality rate of any mental illness (Hesse-Biber, Leavy, Quinn, & Zoino, 2006).

These statistics are frightening, and I felt a sense of urgency to highlight alternative approaches that have the potential to provide individuals with an improved sense of hope and agency in their recovery. If the tone of the research is disheartening, then what must the client feel whilst engaged in treatment?

This thesis examined four different therapeutic approaches to the outpatient treatment of female adults with AN. It is important to note that while an in-depth discussion was presented for each of the therapies, these are only four methods out of many. Some other common treatment approaches for Anorexia Nervosa include, but are not limited to, Dialectical Behavioural Therapy, Interpersonal Psychotherapy, Family Therapy, Medical Nutrition Therapy, Specialist Supportive Clinical Management, Motivational Interviewing, Art Therapy, and Cognitive Remediation Therapy.

Summary of Chapters

This thesis was presented in a manuscript-style format, where the first chapter presented an introduction to the thesis, including the purpose, significance of the research, the method in which the thesis was conducted, definition of key terms, limitations and scope, and situating the author.

Chapter two presented two different, yet related, therapeutic approaches: Cognitive Behavioural Therapy (CBT) and Enhanced Cognitive Behavioural Therapy (CBT-E). The chapter was split into two sections, with the first reviewing CBT and the second CBT-E. The first part of chapter two presented a brief overview of CBT in general, and then CBT as applied to the treatment of AN. Then, an exploration of the therapeutic process, a brief literature review, critiques, and benefits were presented. I concluded with a reflection on the chapter, where I believed that the approach missed several important factors when it comes to working with those

who have been living with AN for many years, as is often the case with adult clients. An important consideration in treatment of AN is that those who have been starved, regardless of the length of time, have restricted cognitive capabilities which can make treatment engagement difficult (Draxler & Hiltunen, 2012). The second part of chapter two presented a brief overview of CBT-E, the therapeutic process, a brief literature review, critiques, and benefits of the approach. I presented an important therapeutic benefit of CBT-E; the client is taught "real time self-monitoring", with the goal that the client increases her awareness of what is happening in the present moment, allowing her to notice certain reactions to food and weight related concerns. The noticing and choosing a different response provide the individual with an opportunity to take initiative in her recovery. However, despite this highlighted benefit, the approach overall was heavily focused on food and weight related concerns, which I presented in my critique of the approach. I concluded the chapter with a client experience taken from Rance et al., (2017) that summed up the detrimental effects that focus on food and weight in therapy can have on clients.

Chapter 3 presented The Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), an approach that was recommended as a first line treatment for adults with AN in the National Institute for Health and Care Excellence (NICE). The chapter addressed the background of the approach, the therapeutic process, the therapeutic style, a brief literature review, therapist and client experiences of the approach, and critiques of the approach. I reviewed the client experiences of MANTRA, something that I believe is important when assessing any therapeutic approach. The clients felt that the approach was clear and structured, and that they viewed the flexibility and tailored nature of the manual as positive, as the treatment felt individualized. They also felt that MANTRA helped them to gain insight, altered their thinking styles, and improve their quality of life overall (Lose et al., 2014). Although important

therapeutic benefits were outlined, Chapter 3 concluded with important considerations and critiques.

Chapter 4 presented Acceptance and Commitment Therapy (ACT), which is an approach that assists clients in accepting the emergence of their thoughts, feelings, and sensations, and encourages the understanding that these are not in our power to control (Kater, 2010). ACT aims to help clients come to the realization that it is how they relate to their mental events that has the power to transform their minds, bodies, and souls (Kater, 2010). The chapter began with a brief introduction to ACT as an approach in general, then presented the six core psychological processes that make up the theory, the application of ACT to AN, a brief literature review, benefits, and concluded with critiques of ACT. An ACT approach to AN aligns very closely with my beliefs on how clients should be regarded in the therapeutic space. ACT places significant emphasis on empowerment, encouragement of the client to take charge of their personal change through the pursuit of a valued direction, an embracing of emotion, is significantly less pathologizing compared to other approaches, provides the individual with a sense of agency, and removes the focus on weight restoration and food. Despite the many benefits, the chapter concludes with some critiques of an ACT approach to AN.

Personal Reflection

Prior to beginning this thesis, I knew that I would come across some content that was emotionally charged, and that my biases would surface. While preparing this thesis, I did my absolute best to include all perspectives on the therapeutic treatment of adulthood AN, however, it was beyond the scope of this paper to conduct an in-depth analysis beyond the four approaches I selected. Throughout this process, I learnt many things about myself, the counselling

profession, Anorexia Nervosa in adulthood, and the different aspects to treatment in a treatment resistant population.

I will begin by addressing the obvious—much of the content I came across was emotional, and I found certain aspects to be quite difficult to read. While researching I did my absolute best to read about as many client experiences as I could, and the ways in which some of these individuals had been treated in therapy was shocking. I read stories of individuals who were not treated as human, who felt that they had no access to care unless their BMI was "low enough", and who felt that they had absolutely no control in their recovery. I was quite surprised to learn that many clients had not even been *asked* if they wanted to recover. This part was especially shocking to me: how could therapists expect their clients to improve if they did not even want to recover in the first place? This leads to my first personal reflection; that a sense of agency and motivation appeared to be missing from much of the client experience. Perhaps if the individual was given the opportunity to recover in the pursuit of a valued life goal, this would increase their odds.

A second personal reflection concerned the use of language in much of the research. A word that I came across very often when researching was "dysfunctional" as a way to describe the client's thoughts and behaviours. Using the word "dysfunctional" to describe an individual's thinking pattern comes across as very belittling, demeaning, and disrespectful. Additionally, the use of this language sets up the therapeutic relationship to be a hierarchical one, whereby the therapist has a superior position over the client; the individual has entered treatment with "dysfunctional" thinking patterns, and the therapist is the all-knowing expert who will direct the client to a more "functional" thinking style.

A third personal reflection is in regard to the bias I held prior to beginning my research. Due to personal experience with an eating disorder, personal communication with sufferers and therapists in the field, and my own research for personal interest, I have always felt that many approaches were too focused on food and weight restoration. In this, I felt many individual characteristics were missed—the focus was never on what the *client* wanted from recovery, and if she even wanted to recover in the first place. Once I began researching for this thesis, all the approaches I studied, except for one (ACT), viewed food and weight restoration as a very important step, if not *the* most important step in recovery. Although researchers had studied many individuals from these approaches, there was still a lack of a clear consensus of an effective approach that resulted in long-term recovery for sufferers. As Orsillo and Batten (2002) highlighted, weight gain alone is not sufficient to produce long-term, meaningful recovery from anorexia. I noticed that a lot of the research I came across supported my initial bias—that food and weight restoration, when placed at the centre of treatment aims, do not necessarily lead to better outcomes. Although I did come across literature that supported this view, I was surprised to discover that this was outweighed by literature that countered my perspective.

I will conclude this section with something I learnt about myself and my clinical practice. In my clinical work as an intern counsellor, Cognitive Behavioural Therapy (CBT) is an approach that I have found to be extremely effective when working with many different populations. It is an approach I have been interested in for quite some time, which led me to seek out further learning through the Crisis and Trauma Resource Institute. Due to my previous positive experiences with CBT I expected to feel a similar sentiment when learning how it has been applied to the treatment of AN, however, I experienced the opposite reaction. The reader will notice that throughout this thesis, my critiques are evidently strongest in the second

chapter—the portion of this thesis that reviewed CBT for AN. Learning how to critique a theory that I once stood strongly by was an important opportunity for growth, and is a lesson I take forward into my future clinical practice.

Limitations

A detailed review of the limitations and scope of this thesis was presented in chapter one. However, a brief summary will be provided in this concluding chapter.

This thesis presented four different therapeutic outpatient treatment approaches for adulthood AN, and these are merely four out of many theoretical approaches. It was beyond the scope of this document to present literature beyond the four approaches chosen. If the reader has an interest in learning about other theories after reading this thesis, please refer to Recommended Reading. Additionally, due to space restrictions, the author was unable to discuss maintaining factors in AN. Further reading on such can also be located in Recommended Reading.

When I began writing, my initial plan was to review the four treatment approaches, and analyze how client-centred each approach was, and suggest an alternative approach whereby motivational interviewing was weaved into each therapy. However, I quickly realized that this was beyond the scope of the thesis. The use of motivational interviewing in the treatment of Anorexia Nervosa in adulthood will be briefly discussed in the section “Recommendations for Future Research”.

Recommendations for Future Research

I feel that this thesis has provided a greater awareness of the difficulties in treating Anorexia Nervosa in adulthood, but there is a need to continue the quest for effective treatment approaches that provide the individual with a sense of agency and hope.

As mentioned in the preceding paragraph, there were certain theories I had initially set out to review (Motivational Interviewing), yet I was bound by space and time restrictions. I feel that the work by Josie Geller on the use of Motivational Interviewing (MI) and assessing client readiness for change is deserving of future research, and I feel that this work is progressive in the treatment of adulthood AN. In her work, she highlights that a common complaint in working with eating disorder clients that present as ambivalent about change is that they have been told to 'just eat', (Geller, 2006). In her research, Geller points to the widespread phenomena that have been discussed in this thesis—treatment refusal, drop-out, and relapse. In the face of such, she believes that understanding the client's readiness for change and the incorporation of this information into a treatment plan may improve relationships with clients, and ultimately result in more meaningful and efficient service (Geller, 2006). In her work, Geller has found that pre-treatment readiness for change has been the only consistent predictor of short and long-term clinical outcomes in the programs she has conducted (Geller, 2006). I feel that this finding alone holds more promise than any of the results I reviewed throughout this entire thesis. I am aware of the boldness of this statement; however, the reader should interpret this as my strong belief in the necessity of future research into this approach. For further reading on Josie Geller and the readiness for change, please refer to Appendix A.

Future research into therapeutic treatment for Adulthood AN should include more client experiences. I understand that there are ethical nuances in including such perspectives, however, this was something I felt was missing from much of the research I came across. I believe that including client insights into each approach can point toward important next directions for research and may include insight into what it might feel like to be in the throes of the disorder. For example, Rance et al., (2017) included the perspectives of 12 women who had recovered or

were in recovery for Anorexia Nervosa and had received psychological treatment. Their analysis revealed that the women they studied, although the sample size was small, had a high degree of dissatisfaction with the treatment that they had received. Additionally, they felt that the treatment systems they had engaged with were too focused on, and driven by, food and weight (Rance et al., 2017). This study provided a unique take on research and was the only one of its kind that I came across in my research. I feel that qualitative research akin to the work by Rance et al. (2017) is an important direction for future research.

Overall, I feel that future research should concern the development and assessment of treatment approaches that take the focus off food and weight related concerns, and instead focus on approaches that do not place these issues at the core of treatment. I came across the beginnings of such research while writing this thesis, and I personally believe that much promise exists in such approaches.

Final Concluding Remarks

Overall, I deeply believe that treatment for longstanding AN should not place food and weight concerns as the primary focus of treatment. Throughout this thesis, my hope was to contribute to the conversation on the difficulties in treating AN amongst adults through providing a critical analysis of four approaches, and to address the flaws and benefits inherent in each approach. I feel that this thesis has contributed in important ways to the counselling profession, as it has supported an alternative view of treatment. My hope was to instill hope in the reader, whether they are a sufferer themselves, or in the counselling profession looking to further their knowledge.

Writing this thesis was a way for me to learn more about different therapeutic approaches for the treatment of AN in adult populations, as this is a group of individuals that I hope to have

the opportunity to work with one day in my career. The knowledge I gained from writing this thesis is paramount and has sparked a deeper passion within me for working toward finding an effective therapeutic treatment approach for this population. I believe that recovery from Anorexia Nervosa is possible, regardless of what stage of the journey the individual is in.

"*And I said to my body, softly: 'I want to be your friend'. It took a long breath and replied: 'I have been waiting my whole life for this*'." Nayyirah Waheed

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