# 1

# A Treatment Field in Transition: Where We've Been and Where We're Going

*If we do not change our direction, we are likely to end up where we are headed.*

—Chinese proverb

Within a 2-day period, I received two calls from mothers of teenagers with anorexia. The first had taken her daughter, who had lost a great deal of weight precipitously, to her pediatrician, who declared the girl to be "fine" because her weight was still on the growth charts. She instructed this mother "not to worry," that there was "no problem to speak of . . . aside from amenorrhea," and referred the client to a gynecologist. This physician declared that it is normal for girls not to have regular periods until age 21 and not to be concerned. She prescribed birth control pills to replace the estrogen necessary to restore and maintain her bone density, despite research that shows hormone replacement therapy to be ineffective in treating anorexic women (Seidenfeld & Rickert, 2001). The girl's father did not "believe in therapy" and felt that if there were to be any medical implications at all, she clearly needed to be in the hands of a medical doctor, not a psychotherapist. "I am calling you now," this mother told me in our first phone contact, "Because I can't bear the thought of going to still another doctor who will ignore or misunderstand P's situation. I can't risk it," she said, "in terms of her health, and for my own sanity."

The second call was from a mother who had asked her pediatrician what she should do to support her daughter, for whom the alarm bells were sounded by her boarding school headmistress when she requested that the girl return home to

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recover and to avoid setting a poor example in the dining hall for peers. “What do I do now?” this mother asked. “How can I help her in the face of her disbelief that anything is wrong?” “Just support her. . . . *You're* the mother . . . *you'll* know what to do” was as much advice as this doctor could offer. But simply loving a child is not enough for a parent seeking to support recovery from an eating disorder. Parents and families need guidance; it is for health care professionals to provide it.

From the perspective of close to 40 years in my therapist's chair, I have been unintentionally rendered a virtual fly on other professionals' office walls listening to clients' war stories of their past therapy encounters. Physicians are not alone in failing to comprehend fully the implications of eating disorders, which are shrouded in myths and misconceptions. They are joined by some of the best and brightest mental health professionals who participate in eating disorder treatment teams, along with the parents of child clients, who have the most powerful investment of all.

Suffering from her own misguided beliefs, the first caller spoke of “plea bargaining” with God: “So if she could just gain two or three more pounds—it would be OK if she has some compulsions, if her coping might be a bit off. We could *live* with that.” This mother was wrong: I made it clear to her that this youngster, and this family, really could *not* afford to live with anything less than a life without an eating disorder. This young woman needed and deserved to achieve a full recovery, to nourish and care for herself physically and emotionally through free choice and without fear, not only with regard to food and eating, but in all life functions. She needed to develop a healthy relationship with food to fuel her body, to live a balanced and quality existence, and to menstruate naturally if she wished to become a parent herself one day.

In this chapter, I define the problems professionals face in treating eating disorders in preparation to propose solutions in the chapters that follow. I describe some of the most salient issues in the field of eating disorder treatment, including the misunderstood role of food and weight, the pervasiveness of risk factors, inadequate professional education, insufficient treatment resources, and insurance coverage for eating disorder treatment. Finally, I review the research–practice divide and summarize the field's best practices as they are currently understood.

## STATE OF THE FIELD

Eating disorders do not come with instructions, either for victims or therapists. Because of symptom variability and inconsistency as seen through the majority of cases that fall into the eating disorders not otherwise specified category of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Rev.; American Psychiatric Association, 2000) and because “eating disorders often coexist with other mental health disorders, these disorders often go undiagnosed and untreated” (Hudson, Hiripi, Pope, & Kessler, 2007, p. xxx). A low number of sufferers obtain treatment for their eating disorder. Although early detection is important for successful outcomes, practitioners typically fail to make an early diagnosis and establish a relevant course of treatment (Hudson et al., 2007).

Compounding the problem, many health professionals treating eating disorders fail to recognize both *that* they do not know and *what* they do not know, thereby losing sight of what they need to learn—about themselves, their clients, the disorders, and the obstacles that could impede sound and effective treatment. Because of this failure, they often practice what they know by default, doing what is familiar and comfortable and relying on generic practice principles. Many professionals acknowledge that treating eating disorders is a separate field in itself about which they know little or nothing, yet they offer treatment just the same in the assumption that lethal behaviors can be ameliorated sufficiently through treating the emotions underlying and driving them. The following sections describe factors contributing to the current state of the field.

## *Misunderstood Role of Food and Weight*

The greatest impediment to diagnosis and treatment is that eating disorders are not what they appear to be, surrounded as they are by the smokescreens of food and weight. We have heard it before and we know it well: Eating disorders are not about food. Yet food and weight issues confuse and confound clinicians throughout the treatment labyrinth. Food- and weight-related behaviors are useful diagnostic mechanisms, offering access to pivotal underlying emotions and providing invaluable opportunities to access and integrate healing behavioral changes. At the same time, eating and weight issues can distract and deter practitioners from the need for constant vigilance of the deeper issues and comorbidities that underlie and drive these disorders. How easy it is to lose track of the reality that though the issue of weight in diagnosis and treatment is of consequence, by itself it is by no means indicative of recovery from an eating disorder.

Though weighing in is an important accountability tool, it is counterproductive for clinicians to seek an "ideal weight" or to offer anorexic patients the "carrot" of reaching a specific "target weight" as their goal. No one . . . not a nutritionist, not the patient, nor a physician . . . can set a goal weight arbitrarily and expect it to lead to recovery. When a nutritionist or doctor says, "It is important for you to gain another five pounds" (to reach the low end of normal on the charts), the patient hears, "Five pounds is all I need to gain in order to get everybody off my back; five pounds will let me stay skinny without being considered 'sick.'"

*The body itself* is the only accurate determiner of appropriate weight; an attachment to any weight less than the body's set point weight is a distraction to complete recovery. Each person has a set point weight to which the person naturally gravitates; bodily fluctuation may span from 5 to 10 pounds, but the fit body at its set point weight will rarely gain beyond its natural range. Attaining one's set point weight marks full weight restoration, a normalized internal function of brain and body, and the reversal of amenorrhea. The set point concept counteracts the commonly held misconception that the more one eats, the more weight one gains; that food is fattening; and that when it comes to food, less is more. I think of the set point weight as being like an ocean's tide. When the moon is new, gravitational forces may not pull the body of water as high as it comes in when the moon is full. The rising tide, be it slightly higher or lower, always approaches, (but does not exceed), a certain point on the shore, with the exception of hurricanes or other natural forces. So is the set point equally consistent, expected to fluctuate ever so slightly, but always hovering close to the water line.

By failing to remember that food and weight are but two of many significant elements of these diseases, practitioners may inadvertently enable disease. For example, an internist highly experienced in the treatment of eating disorders saw a client of mine and remarked that her motivation to renew her recovery effort now "could surely not be the result of any physical problems," as her weight was "fine" and her lab tests "excellent." He directed these remarks to a woman who purged every morsel of food, multiple times a day, with the exception of breakfast. She chose never to return to the internist's care (as he failed to demonstrate an understanding of eating disorders and the severity of her condition. By applauding her weight, he reinforced her distortion that eating disorders are defined by weight and that she would need to lose more weight to maintain her anorexic status). It took extensive therapeutic work to repair the emotional damage done.

Routine physical exams or lab tests provide "evidence" of an eating disorder only in the direst stages of the disorder. The therapist's reliance on body mass index (BMI) to determine the existence of an eating disorder can act as a diagnostic decoy. BMI is a measure of body fat based on height and weight. Normal weight is at 18.5 to 24.9; overweight is at 25 to 29.9; obesity is at 30 or greater. Waiting until a BMI becomes low enough to warrant a diagnosis of anorexia may seriously threaten opportunities for early intervention. BMI offers only an approximation of a diagnostic standard and does not take into account natural variations in physique among ethnic groups, bone structure, fat–muscle ratios, or genetic components.

### *Pervasiveness of Risk Factors*

Myths and misconceptions about eating disorders are rampant in a society where dieting and exercise have become a norm and even obsession. Many people consider food restriction to be normal or even a healthy sign of enviable self-discipline. Considering themselves experts on food and eating simply because of their own personal life experiences, some practitioners subscribe to subjectively based truths about healthy eating and weight management. Everyone eats; everyone knows what he or she considers to be healthy and normal behaviors with regard to eating and weight control.

But in the face of ever-changing dietary trends that arouse attention and fear, "normal" eating in today's world is no longer necessarily "healthy" eating. It becomes increasingly difficult for clients and professionals to recognize pathology in the face of a myriad of contradictory theories about how to become and remain fit and thin. Adding to the confusion, those with clinical disorders appear to be doing precisely what everybody else is doing [by]—skipping meals, having coffee and a doughnut and calling it breakfast, or grabbing a soda or protein bar for lunch on the run.

A recovering anorexic high school student spoke of her frustration at having to fulfill the requirements of her food plan: "*None* of my friends eat breakfast; *nobody* eats seven grains a day, three dairy exchanges! Why do *I* have to? It's not normal. I *see* what's normal, all around me, observing my friends in the cafeteria!" Unfortunately, she is not far off the mark. Eating healthfully becomes a hard pill to swallow, particularly in the face of irrational fears evoked by a fat-phobic society.

An adult client with anorexia described her childhood eating habits as being "unhealthy." When I asked what she meant by unhealthy, she replied, "You know. . . . My mother had me eating things like red meat, dairy products. . . ."

Professionals, like all human beings, tend to become increasingly bodily aware and health conscious as they experience the effects of aging, pregnancy, injuries, and the insults of daily life. People need not be eating disordered to restrict or abuse food at times or to eat in response to emotional cues such as stress, sadness, or boredom. Over the years, in conducting many informal surveys about what constitutes healthy eating, I have observed that the majority of those questioned, young and old, lay and professional, believe that healthy eating is fat-free and sugar-free eating and that dieting is the best and only way to lose weight and keep it off. In seeking data about what triggered clinical disease in my clients, invariably the trigger to disease onset is "I started an innocent diet; then, I just kept on eating 'healthier and healthier.'"

It becomes increasingly difficult to consider eating disordered behaviors pathological in light of their prevalence. Misconceptions leading to dysfunctional eating run deep and know no age barrier. Fully 40 percent to 50 percent of girls on American college campuses skip meals, diet, and binge eat in an attempt to become healthier and more fit. Many of them are at risk of developing anorexia or bulimia (Ann, 2007). One of my college-age clients insisted that this statistic is vastly underestimated: "Seeing what girls eat and don't eat in my sorority house, I'd say 70 percent is more like it." Box 1.1 lists statistics that indicate how widespread disordered eating is in the United States.

It is up to the practitioner to remind clients that they have a life-threatening disease that, at least temporarily, sets them apart from the freedom that others have to abuse food [or engage in disordered eating]. Just as a glass of red wine can be healthful and relaxing for most, that same glass of wine for the person recovering from an addiction to alcohol can mark the beginning of a downward spiral into recurring alcohol abuse.

## *Inadequate Professional Education*

Eating disorder professionals come by their lack of treatment preparedness honestly. For those of us schooled before eating disorders became a field in itself in the 1970s, there was virtually no information available to be taught. Now, some 40 years later, despite the increasing accessibility of scientific research about eating disorders, treatment of these diseases continues to fall between the cracks of formal education. Opportunities for training are few, and there is a lack of clarity within the health professions about what constitutes adequate preparation to treat eating disorders. A survey showed that "researchers and clinicians both felt that they had received inadequate training [in eating disorders] to engage in integrated clinical-research activities" (Banker & Klump, 2007, p. 3). Graduate social

## BOX 1.1

## Eating Disorder Statistics

- 42 percent of first- through third-grade girls want to be thinner.
- 81 percent of 10-year-olds are afraid of being fat.
- 46 percent of 9- to 11-year-olds are "sometimes" or "very often" on diets, and 82 percent of their families are "sometimes" or "very often" on diets.
- Over half of teenage girls and nearly one third of teenage boys use unhealthy weight control behaviors such as skipping meals, fasting, smoking cigarettes, vomiting, and taking laxatives.
- 91 percent of women recently surveyed on a college campus had attempted to control their weight through dieting; 22 percent dieted "often" or "always."
- 25 percent of American men and 45 percent of American women are on a diet on any given day.
- 35 percent of "normal dieters" progress to pathological dieting. Of those, 20 percent to 25 percent progress to partial- or full-syndrome eating disorders.
- Girls who diet frequently are 12 times as likely to binge as girls who don't diet.

*Source.* Reprinted with permission from the National Eating Disorders Association (n.d.).

work programs in the United States tend to be oriented towards social welfare rather than clinical practice, and clinical curricula all too typically overlook the unique treatment requirements of eating disorder care in not offering specialty courses. A survey showed that 42.3 percent of practitioners received formal education in the context of graduate training; the most common training in eating disorders treatment consisted of workshops or seminars (71.2 percent), followed by self-education/reading (53.8 percent), and informal supervision (57.7 percent) (von Ranson & Robinson, 2006).

A student recently trained at one of the most highly reputed graduate schools of social work inquired why there were no courses dedicated to the treatment of eating disorders. She was informed that specialty training for eating disorders is "unnecessary and redundant" based on the proliferation of more generic courses that address the issues underlying these disorders, such as human development, self-esteem, mood disorders, and issues of control and identity. This response reflects the misconception that an eating disorder is not a disease in itself but merely a symptom of deeper issues. In fact, successful eating disorder treatment requires highly specific and clearly intentional protocols.

In this attitude, graduate schools of mental health are not alone. My colleague, a highly skilled nutritionist, described the advice she received from her graduate school advisor, who discouraged her from working with eating disorders. Her mentor made the case that "the work is tough, the clients resistant, the changes minimal, and the liability risks enormous. . . . People die from these disorders!" The advisor went on to caution her about the high rate of professional burnout in the field of eating disorder treatment, which in fact is more likely to be directly correlated with the failure of clinicians to understand the requirements of eating disorder treatment and the failure of clients with eating disorders to thrive with inadequate treatment.

Partly in response to pressure from organizations that fund research that demands legitimized, quantifiable, and predictable outcomes, as well as from insurance companies and legislators, the field is faced with a demand for an increasing commitment to evidence-based therapy approaches over the harder-to-measure relationship capacities of the therapist. The training that does exist for clinical practice traditionally prepares therapists to function as autonomous, self-directed professionals, leaving them unprepared (and often unwilling) to commit to the logistics, time, and effort it takes to accomplish the ongoing demands of team collaboration. Improvements are needed in the education of professionals who will treat eating disorders to ensure that this vulnerable population receives adequate treatment.

On a positive note, the very best resource of all for education about eating disorder treatment exists right under our noses. The Academy for Eating Disorders is a worldwide community of 1,400 inspired, dedicated, and energetic experts whose work and contributions comprise the heart and soul of research and treatment advances in this field. Members participate in animated and impassioned dialogue, sharing rich personal and professional experiences as a form of peer consultation through a membership listserv and through annual conferences that integrate the best and brightest minds in the field. The Academy for Eating Disorders is at the cutting edge of treatment change and progress in both clinical practice and scientific research. I urge all practitioners who treat clients with eating disorders or who wish to learn to treat these disorders or contribute to the growth of eating disorder research and clinical practice to become active participants in the resources provided by this and other national eating disorder organizations as a best practice for learning.

### *Insufficient Treatment Resources*

With tongue in cheek, a colleague observed, "Of 500 psychotherapists in any given area, about 490 would claim competence in treating eating disorders." The treatment requirements of eating disorders, however, are far more rigorous than most clinicians recognize. In light of the voids in formal and informal education, it is hardly surprising that the majority of people with these disorders do not receive any form of treatment (Hudson et al., 2007), and research shows a substantial client and doctor delay in seeking and finding treatment (de la Rie, Noordenbos, Donker, & van Furth, 2006). In addition, clients do not obtain the quality of treatment they deserve in locations where there are simply not enough adequately trained specialists available to meet client numbers and demands.

A survey found that the majority of people with eating disorders are not receiving the recommended level of care and that 55 percent of those with the conditions were not treated by a specialist. For some, the nearest appropriate specialist service could be up to 150 miles away. Only 14 percent of clients, caregivers, and professionals in one survey had found eating disorder treatment close to home, and only 17 percent of young people had been treated in settings that were age appropriate (BBC News, 2005b). In the United States, it is reported that only one third of people with anorexia nervosa receive mental health care, only 6 percent of people with bulimia receive mental health care, and the majority of people with severe eating disorders do not receive adequate care (National Eating Disorders Association, n.d.).

The source of the misconception that eating disorders are not curable may be that, to date, too few professionals have been adequately trained to treat and heal them. Eating disorders *are* curable, however. Studies conservatively indicate that "50 percent of clients with anorexia remit within one to three years and never require inpatient care. Of the remaining 50 percent who require inpatient care, an additional 50 percent to 70 percent will recover, depending on the duration of follow-up. Thus, an estimated 75 percent to 85 percent of clients with anorexia completely recover. If clients who experience significant improvement are included, the rate of positive outcome rises to over 90 percent" (Johnson, Lund, & Yates, 2003).

I believe that when clients suffer for decades from an eating disorder, it is not about the tenacity of the disease, or even about the resistance of the clients. It's about us—the treating professionals—and it is an indicator of how imperative it is that we upgrade the quality of our understanding and caregiving. Our first job is to educate ourselves.

### *Insurance Coverage for Eating Disorder Treatment*

In December 2006, a landmark statement by the Academy for Eating Disorders affirmed that "eating disorders (anorexia and bulimia nervosa) are biologically based mental illnesses" involving a "neurobiological disorder of the brain . . . that significantly impairs cognitive function, judgment, and emotional stability and limits the life activities of the person with the illness." Researchers who are working to redefine how diseases are classified are now looking less at symptoms or physiological measurements and more at their genetic underpinnings (Bulik et al., 2003; Kaye et al., 2000). According to Bryan Lask, an expert researcher in the field of anorexia,

> "The biological cause has been underemphasized and the sociocultural pressures have been overemphasized. There has to be a biological contribution; otherwise, everyone would be anorexic given the sociocultural pressures in our society." (cited in Laurance, 2005, p. 22)

Finding disease origins in biology and genetics lends credence to eating disorders as legitimate diseases that are coverable by insurance companies. In a 2006 press release, the Academy for Eating Disorders' president, Eric van Furth, issued the position statement that "Eating disorders clearly fit the criteria for biologically based mental illness. Parity for coverage should occur throughout the U.S. health system" (Academy for Eating Disorders, 2006). The struggle for parity in insurance coverage for mental health disorders, and especially for eating disorders, has been a sore spot in the profession for years. A lobbyist for insurance coverage for individuals with eating disorders and their families spoke of the biased attitudes she regularly encounters among federal and state legislators, who typically do not consider eating disorders to be "real diseases" at all, but rather "healthy eating gone wild" or unique forms of dieting at the discretion of the individual. Considered to be conditions of volition and intention, eating disorders have been denied disease status.

Until recently, insurance coverage was restricted to situations where medical or physiological complications required hospitalization, irrespective of whether there might also be a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Rev.; American Psychiatric Association, 2000), even if services were delivered in a psychiatric setting. The average recovery time required for a hospitalized individual with anorexia is seven years; the average length of stay anorexics need to fully restore weight and provide relapse-prevention treatment is 90 to 120 days; the average number of inpatient treatment days covered by insurance plans is 31 days for anorexic clients and 14 days for bulimic clients. In countless instances, families have depleted their retirement accounts and life savings or have been forced to take out second mortgages on their homes because insurance companies refuse to cover a child's eating disorder treatment.

In October 2008, Congress succeeded in eliminating discrimination in health care coverage against people who have mental disorders, with House and Senate coming together to pass mental health parity (see Emergency Economic Stabilization Act of 2008). According to the Eating Disorders Coalition for Research, Policy & Action (2008),

> This bill requires group health plans that currently offer coverage for mental health and substance-use disorders to provide those benefits in the same manner as benefits provided to all other medical and surgical procedures covered under the plan. It also prohibits group health plans from imposing discriminatory annual/lifetime dollar limits, co-pays and deductibles, or day and visit limits unless similar limitations or requirements are imposed for other medical and surgical benefits.

"Every day we get calls from parents whose kids are on the verge of death due to an eating disorder, yet they cannot get their health insurance companies to pay for this life-saving treatment," said Jeanine Cogan, policy director of the Coalition. "This law will change that" (Eating Disorders Coalition for Research, Policy & Action, 2008).

The parity legislation passed in 2008 will not take effect till January 1, 2010. The Federal parity law was written in such a way that it honors already existing state laws that are stronger. For states where eating disorders are not defined as mental illness, the federal parity law will not remedy that, but there is still a possibility that eating disorders will be treated, as the law leaves it up to the plans to decide what mental illnesses are covered.

A number of organizations are continuing the fight to expand insurance for eating disorder treatment (see Box 1.2 for a list of these organizations). As a result

### BOX 1.2

### Eating Disorder Organizations

- Families Empowering and Supporting Treatment of Eating Disorders (F.E.A.S.T.) is an organization of and for parents and caregivers to help loved ones recover from eating disorders by providing information and mutual support, promoting evidence-based treatment, and advocating for research and education to reduce the suffering associated with eating disorders.
- The National Association of Anorexia Nervosa and Associated Disorders (ANAD) is the oldest association aimed at fighting eating disorders in the United States. ANAD assists people with eating disorders such as anorexia nervosa and bulimia and also assists their families. Headquartered in Highland Park, Illinois, ANAD is a nonprofit organization working in the areas of advocacy, family support, therapist referrals, research, education, prevention, and hotline help for those with anorexia and bulimia.
- Family Resources for Education on Eating Disorders (FREED) is a parent-founded nonprofit organization committed to educating the community about the serious nature and growing prevalence of anorexia, bulimia, and binge eating disorder (http://home.comcast.net/).
- The National Eating Disorders Association (NEDA) STAR (States for Treatment Access and Research). This program promotes awareness among local legislators about the challenges in accessing adequate medical care to battle an eating disorder because of unfair practices by insurance companies and seeks to change state law to address those inequities (http://www.nationaleatingdisorders.org).
- The Academy for Eating Disorders (AED) is an international, transdisciplinary professional organization. The AED promotes excellence in research, treatment and the prevention of ED and provides education, training, and a forum for collaboration and professional dialogue (http://www.aedweb.org).
- The Eating Disorder Referral and Information Center provides information and advocacy for the uninsured and underinsured seeking health insurance coverage (http://www.EDReferral.com).
- The CoverMe Foundation [makes] available a resource database and corporate partners to inform and assist the uninsured with low-cost and no-cost options available in and around users' communities (http://www.covermefoundation.org).

of their efforts, for example, on October 9, 2008, President George W. Bush signed Michelle's Law (H.R. 2851), designed to ensure that dependent college students who take a medically necessary leave of absence do not lose health insurance coverage. Box 1.3 lists some strategies for procuring health insurance coverage for eating disorder treatment.

For clients without health insurance, some residential care facilities offer scholarships, and occasionally government-sponsored programs offer financial support for participation in research projects that pair clients with resources. In communities where there are research hospitals and universities, clinical studies may be available that provide opportunities to participate in low-cost, high-quality treatment. Nonprofit organizations, such as the National Association of Anorexia

### BOX 1.3

### Strategies for Procuring Insurance Coverage for Eating Disorder Treatment

- Speak directly with an appeals specialist at the insurance company.
- List medical complications. In procuring insurance coverage for eating disorder care, the International Classification of Diseases codes for bradycardia, hypotension, malnutrition, and severe malnourishment may be used additionally where there is evidence of anorexic brain imbalances.
- With employer-provided health insurance, human resources departments can sometimes become successful insurance advocates.
- Focus on cost–benefit analysis. Relate the successes the client has known.
- Be aware that "benefit substitutes" may be a possibility in certain situations when benefits are running out. As an example, you might check to see if outpatient days may be swapped for available inpatient days, or vice versa, to allow for a more extended tenure in either of the milieus.

Nervosa and Related Disorders or the National Eating Disorders Association, as well as individual psychotherapists, can be instrumental in connecting people with viable treatment sources.

## BEYOND THE RESEARCH–PRACTICE DIVIDE: CURRENT BEST PRACTICE

Central to the failure of current efforts to properly educate clinicians treating eating disorders is the unworkable disconnect between eating disorder research and its application to clinical practice. Academics and scientists, who make the most significant contributions to the clinical literature, typically have had limited access to the treatment venue. The focus on scientific evidence typically leaves the research inaccessible, and in many cases irrelevant, to the more intuitive style of practitioners on the front lines of treatment. In addition, the eating disorder professional literature tends to focus on disparate and nonintegrative elements of care in the face of highly complex, systematic, multifaceted disorders that demand a fully integrative basis of care.

According to a 2007 survey, eating disorder clinicians revealed that they considered research findings to be largely irrelevant to the realities of clinical practice and cited the need for empirical guidelines for adapting empirically supported treatments to 'real-life' treatment and for changing course when they are ineffective (Banker & Klump, 2007). The author of the survey report highlighted "the need for researchers to study what clinicians do in their treatments rather than simply expecting clinicians to do what researchers study" (Banker & Klump, 2007, p. 4).

There is much that is compelling about the certainty of statistics and hard evidence that arise out of pure science. Although evidence-based research in the field clearly points to better efficacy with cognitive–behavioral therapy (CBT) than with less-specified approaches, exclusive CBT practice and a rigorous adherence to a single method are considered inadequate to produce optimal outcomes. As humanistic psychologist Abraham Maslow noted, “If you only have a hammer, you tend to see every problem as a nail” (cited in Germer, Siegel, & Fulton, 2005, p. 69). “The danger of excess loyalty to one method of treatment is summarized in the concept of ‘theory countertransference,’ in which the therapist imposes his or her theoretical predispositions on the client. The result is therapy that confirms the therapist’s assumptions, and where ‘stalled treatment tends to be chalked up as client resistance’ ” (Germer et al. 2005, p. 69).

Evidence-based guidelines alone do not necessarily motivate change in the client or the practitioner’s creative process in seeking ways to liberate the client’s tyrannized soul. Consistent with evidence-based psychological therapy for other clinical disorders, it has been shown that evidence-based treatment is relatively rarely implemented in routine clinical practice (for eating disorders) (Wilson, 2005).

If CBT and evidence-based practice alone are not sufficient to cure an eating disorder, however, neither are random or purely intuitive approaches, including psychodynamic psychotherapy. It is increasingly evident that eating disorders, with their diverse and systemic etiology, symptom presentation, treatment systems, protocols, modes, and milieus, defy scientific reductionism and compartmentalization. Psychiatrist David Brendel spoke of the “myth of psychiatric scientism” in arguing that “psychiatry needs to adopt a wider view of evidence, one more akin to the ideas of quantum physics. Physicists have moved beyond a mechanistic Newtonian view of the world,” he observed. “They talk about chaos and uncertainty and about the effect that the observer has on what is being observed” (cited in Pettus, 2006, p. 38).

Eclecticism and inclusion are key to achieving positive outcomes in treating eating disorders. When and how to combine methodologies become decisions of nuance and accrued skill sets. The authors of one research study concluded that therapists need “to show flexibility and breadth of understanding in adapting symptom-management techniques to the unique constellation of transference themes that exist with each patient” (Johnson, Connors, & Tobin, 1987, p. 675).

Since the 1990s, which has been called the decade of the brain, the greatest single factor influencing the treatment of eating disorders is evidence-based research proving that biologically and genetically based eating disorders affect, and are affected by, brain and genetic structure and function. Ironically, the science of the brain is increasingly lending legitimacy and credence to the importance of the “art” of human connection in therapeutic healing. The field of psychoneurobiology has proved that healthy therapeutic connections result in structural and functional brain changes that can influence and even change gene structure. The implications of these findings for eating disorder treatment are vast and yet to be plumbed, but the discoveries support the importance of the human relationship, along with practicable, eclectic, and proven treatment skills, in healing eating disorders. So the art of human connection turns out to be scientific after all, and a bridge to help clinicians breach the chasm between research and practice appears to be enticingly within reach. This research is discussed in greater detail in Chapter 11.

Combining the positive effects of empirical and anecdotal data promises to optimize treatment efficacy. New clinical trends include the growing popularity of mindful practice and of somatic–sensory, synergistic, mind–body approaches; these trends are derived from research on brain plasticity demonstrating that the human brain is capable of changing throughout life (Doidge, 2007, p. 43). Combining elements of science and humanity makes treatment more palatable for professional consumption and outcomes more potent for clients with eating disorders.

Therapists do not cure eating disorders or their clients; clients cure themselves through recovery assets that congeal and accrue from within. It is through the healing relationship, nourished by the unique and versatile use of the self, that practitioners provide the means and incentive for the client to heal herself. It is for the therapist to inspire the client to learn and to motivate the individual to take in and take charge of new information, to become transformed by it, and to use it to further discover and enrich herself. The eating disorder therapist, through the healing connection, becomes the medium to the client's return to the exiled core self.

It has been my observation throughout the four decades of my own practice, that the therapist's versatile use of self is the most critical took in his or her arsenal. There is no such thing as a good idea that has not been thought of before. The uniqueness of the therapist's use of self in relationship with clients with eating disorders has been corroborated in research about the efficacy of mindful psychotherapy that took place during the mid-1990s, which we consider in Chapter 13. I believe that the 2,500-year-old practice of mindful awareness is rapidly on its way to becoming the heart of combining CBT and psychodynamic treatments. An in-depth discussion of the integration of mindfulness in psychotherapy, CBT techniques, and healing aspects of the therapeutic relationship is found in Chapter 8.

## CONCLUSION

The field of eating disorder treatment is still in its adolescence, as are so many of its clients. As treatment techniques continue to evolve, practitioners struggle to stay abreast of best practices and how to apply them. In the face of the treatment field's crisis of identity, clinicians find themselves very much on their own, seeking to find their own way as definitive training mechanisms continue to elude them. The field is at once enriched and compromised by the divergent viewpoints of clinicians and researchers and by a sense of benign chaos that arises out of a diffuse diversity of approaches, limited resources, and in some cases, personal biases and misunderstanding regarding eating disorders and their unique requirements for treatment.

Eating disorder treatment depends on rules and protocols, but with a clear overlay of intention and action, humanity and instinct, integrative skills and a creative and knowledgeable use of the practitioner's self in seeking life-saving changes. In psychotherapeutic treatment, and perhaps especially in the treatment of eating disorders, therapists need to learn how best to access their most valuable personal resource of all—themselves—in developing the optimal treatment relationship.