Action research on eating disorders

In an article in the February 2001 AUCC Journal, **Vicky Groves** and **Julie Devlin** outlined an action research study in progress at Cardiff University for working with students with eating difficulties. Here they present the findings of the completed study, showing the success of the approaches used by the therapists, and describe the influences of the study on their current counselling approach at Cardiff.

Eating difficulties have been noted to be on the increase and undoubtedly have an influence on students in higher education. Dysfunctional eating patterns frequently affect an individual's ability to concentrate on academic study, can interrupt relationship development and lead to increasing isolation (Royal College of Psychiatrists, 2003)[1]. This can further reduce an already low self-esteem and along with high anxiety, depression symptoms, and perfectionist thinking, spiral the individual into further dysfunctional eating patterns as compensation.

Every year 10 to 17 per cent of students requesting counselling from our service present with an eating difficulty. The project, run over two academic years, aimed to explore and develop counselling practice, with the objective of providing a research based multi-faceted service. The aimed outcome would be a comprehensive specialist service available to students with eating disorders.

We spent the first year of the project researching literature, visiting specialist centres and other universities, and undertaking a variety of training courses. These included cognitive analytical therapy (CAT) for eating disorders, interpersonal therapy and motivational interviewing training. As there are no specialist centres in Wales we formed links with the community mental health teams, the Eating Disorder Association, and other interested specialists including the community dietician.

For the action research part of the project we used clients' perception of their own motivation as one indicator for appropriateness and choice of treatment. We formulated a 'stepped care decision tree' based on motivation scores and diagnosis. This acted as a map guiding us to particular choices of self-help books and therapy. Within the 'stepped care decision tree' cognitive behavioural therapy and the use of guided self-help was prominent. Guided self-help would appear to be relevant and empowering as students can continue work at their own pace during recess holidays and consequent breaks in therapy.

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At the time there were no specific therapeutic approaches recommended for anorexia nervosa. Only those approaches that had been researched as helpful and supportive to eating disordered clients were utilised. Joint supervision for the counsellors was key in order to maintain a safe, ethical environment for clients.

Assessments

Monitoring closely throughout the process included the clients' use of formal self-reporting assessment tools. These questionnaires were completed at the first session, during therapy, and at closure.

Self-reporting questionnaires:

The EDEQ (Fairburn and Beglin, 1994)[2] is a self-reporting questionnaire that gives a specific assessment of the psychopathology of the eating disorder. A global score gives the overall severity, plus sub-scales of restraint, eating, shape and weight concerns. This scale also monitors methods of weight control including laxative and diuretic misuse, vomiting and excessive exercising.

As depression and anxiety are commonly associated with eating disorders, we used the Hospital Anxiety and Depression Scale (HAD) (Zigmond and Snaith, 1983)[3]. This scale was selected primarily because it is simple to use, and because it focuses on the core depressive concept of anhedonia (total loss of pleasure) and includes no somatic symptoms. The questionnaire is self-reporting and designed for use in general medical patients. It is also useful as a gauge to patient progress as the test can be repeated over the course of therapy. A score of more than eight in either subscale is regarded as significant.

During the initial assessment, questions relating to substance use, self injury, and types of previous help sought were discussed and DSM IV (1994)[4] was used to determine the client's diagnosis. Questions relating to the stages of change were also given, and from the responses, the client's current motivation was expressed as a figure (0-10), which we utilised

along with the presenting difficulty to guide us to specific self-help books.

Medical care

With clients' permission, letters and an information leaflet were sent to GPs requesting that they monitor their patients. If clients were willing they were weighed within the university health centre and the results reported to the counsellors. This was felt to give the opportunity for anxieties about weight changes to be explored within the therapeutic environment.

Low-weight, anorexic clients raise many 'duty of care' issues for us as counsellors and for the university. Ethical and boundary issues included the safety of individuals, and of clients being emotionally and physically well enough to be in a therapeutic relationship. However, as previously discussed there is an absence of specialists for adults in Cardiff, and Wales in general. We found ourselves frequently being asked to continue working with vulnerable, dangerously-ill clientele.

In order to help us with this dilemma, and to protect clients, counsellors and the university we developed a working policy for specific situations. For individuals who are low weight (BMI 17 or under) or with the presence of physical symptoms or medical complications, we support these clients emotionally while urgently requesting appropriate alternate care from a GP or local community mental health team (CMHT). This policy has led to us working collaboratively with members of the local CMHT, a move that has recently been suggested by the Royal College of Psychiatrists (2003)[1].

Methodology

All clients who presented with, or reported, an eating disorder were assessed by using the EDEQ and the HAD questionnaires. A consent form was obtained giving permission for the data to be used anonymously, and the questionnaires were subsequently repeated at four-weekly intervals. Data extracted from the questionnaires was analysed using descriptive statistics and one-tailed t tests using the SPSS computer programme.

A diagnosis of an individual's eating disorder was made using DSM-IV categories: these included anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorder not otherwise specified (EDNOS).

Therapy included psycho-education and dietary advice (a dietician was available for consultation) and utilised the stepped care decision tree, according to the client's diagnosis and stage of motivation (Treasure and Schmidt, 1993)[5]. While the 'stepped care decision tree' and the self-help books provided a framework, they also allowed the counsellors to continue working within their own individual therapeutic approach.

Within the stepped care decision tree, adapted from Garner and Needleman (1997)[6], the use of guided self-help was prominent. To establish which self-help book to offer, we applied the client's current motivation, diagnosis and presenting difficulty as a path-finder to particular self-help books. For clients with significant interpersonal difficulties, interpersonal therapy was offered.

Anorexia nervosa: offered individual long-term therapy alongside self-help books (see table below). Clients with special issues for consideration, such as low weight or medical complications, were referred to their GP and/or CMHT.

Bulimia nervosa, binge eating and EDNOS: Clients highly motivated for change were offered the self-help book *Overcoming binge eating*. Less motivated clients were offered *Getting better bit(e) by bite(e).* Poorly motivated clients were offered four sessions (in an attempt to improve motivation) and then reassessed.

Self-help books

Fairburn C. Overcoming Binge Eating. New York: Guilford Publications; 1995.

Schmidt U, Treasure J. Getting better bit(e) by bit(e) London: Psychology Press; 1993.

Treasure J. Anorexia nervosa: a survival guide for families, friends and sufferers. London: Psychology Press; 1997, reprinted 1999.

Crisp, Joughin, Halek, Bowyer. Anorexia nervosa: the wish to change. London: Psychology Press; 1996.

Results of quantitative data analysis

Thirty-one clients agreed to take part in the project: 30 female, one male. According to DSM-IV diagnosis, nine (29 per cent) had anorexia nervosa, five (16 per cent) had bulimia nervosa, five (16 per cent) had binge eating disorder, and 12 (39 per cent) were placed in the 'eating disorder not otherwise specified' category. The drop out rate was 19 per cent, that is, six clients stopped attending following two counselling sessions or fewer. One client had severe medical symptoms and a low body weight (BMI <14) and was referred elsewhere.

Of the 31 participants, 10 (32 per cent) were currently self-injuring (cutting) alongside their eating disorder; five (16 per cent) were abusing non-prescribed drugs including street drugs, diuretics, laxatives and 'slimming' pills; and three (9.7 per cent) felt that their alcohol intake was a problem. Either at the start of, or commencing during therapy, 11 clients (35.5 per cent) were taking antidepressant medication prescribed by their GP.

Perfectionist traits, interpersonal difficulties and childhood abuse have previously been well documented as accompanying eating disorders. We recorded their frequency of occurrence: 15 (48 per cent) clients revealed perfectionist traits; 13 (42 per cent) described interpersonal difficulties; and two (six per cent) disclosed childhood sexual abuse.

Nine (29 per cent) clients needed to be referred to their GP for medical treatment and two (six per cent) clients were referred to the CMHT for assessment and co-treatment.

On the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983)[3], 13 clients reported relatively low levels of depression, with only four clients at assessment scoring in the severe category. Mean depression scale scores at assessment were eight, and mean depression scale scores at closure were 5.4. A large number of clients (14) presented without symptoms of depression. However, the anxiety scores were much higher, with 29 clients reporting anxiety symptoms at assessment, 17 of which scored in the severe category. Mean anxiety at assessment was 14.8, and mean anxiety at closure was 9.8. Only two clients presented without symptoms of anxiety.

The majority of clients with a diagnosis of anorexia utilised Crisp et al for self-help, and the majority of bulimic/ binge eating disorder clients used Professor Fairburn's manual.

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Discussion

Significant positive differences in the T tests were found in the bulimia, binge eating disorder, and EDNOS client groups, allowing us to conclude that our approach had been effective. With the anorexia client group, the T test did not show significant differences between the means. However, individually, three clients showed significant improvements, and one global score showed marginal improvement, with two remaining unchanged.

So far, research has not revealed one therapy that is effective in anorexia. It is also accepted that anorexia requires long-term therapy. This study was completed over one academic year and the majority of clients seen in eight to12 sessions. Therefore, we feel the study would have to be extended for these specific results to have an unbiased comparison.

Eating disorder examination questionnaire *(Fairburn and Beglin, 1994)*[2]

Variable	No	Mean	SD	Mean diff	2 tail sig (p value)	95% CL
Total participants						
Global assessment score	24	4.05	1.31	1.60	.000	.965-2.23
Global closure score	24	2.44	1.66			
Anorexia						
Global assessment score	6	4.58	1.62	1.16	.140	-.54-2.87
Global closure score	6	3.41	2.17			
Bulimia						
Global assessment score	4	4.62	.298	3.20	.005	1.85-4.54
Global closure score	4	1.42	.793			
Binge eating disorder						
Global assessment score	3	3.30	.346	2.23	.041	.225-4.24
Global closure score	3	1.06	.461			
ED NOS						
Global assessment score	11	3.74	1.41	1.09	.029	.133-2.04
Global closure score	11	2.66	1.47			
P< 0.05 Confidence limits						

Depression

'A very high percentage of treatment-seeking patients with eating disorders report a life-time history of unipolar depression' (Am J Psychiatry 2000). This was not the case in our client group where 14 clients (45 per cent) did not have any symptoms of depression on the HAD scale. Thirteen clients (42 per cent) had mild to moderate symptoms, and only four (13 per cent) had severe symptoms. This is an unusual finding that cannot be explained.

Anxiety

Our study revealed very high levels of anxiety with 29 clients (94 per cent) revealing symptoms of anxiety at assessment (HAD score more than eight) – 12 (39 per cent) had mild to moderate symptoms and 17 (55 per cent) had severe symptoms. Bulik (1995)[9] reviewed studies exploring the relationship between anxiety and eating disorders and stated that anxiety may not be part of the clinical picture, but that 'a significant proportion of women with bulimia nervosa and anorexia show co-morbid anxiety', which started prior to the eating disorder. This finding is supported by a more recent article in the American Journal of Psychiatry (2000)[8] stating that 'life time prevalence rates for anxiety disorders also appear to be higher for patients with both anorexia nervosa and bulimia nervosa, but rates for specific disorders vary'.

Perfectionism

In a large international multi-centre study (322 anorexic participants), perfectionism has been found to be phenotypic, that is a 'robust discriminating characteristic of anorexia nervosa' (Halmi et al, 2000)[9]. We did not use a formal scale to measure perfectionism. However, subjective reports revealed high levels (48 per cent) of perfectionist traits across all eating disorder types.

Conclusion

The results appear to show that the approaches used by the therapists have been successful and therefore we continue to offer guided self-help alongside individual therapists' approaches.

Our project revealed a relatively high percentage of students coming for counselling with anorexia (29 per cent compared to the general population 0.5-1 per cent). This is not altogether an unexpected finding – as the common age range for eating disorders is 11-35 years old, universities would undoubtedly have a skewed number. Whitaker and Davis (1989)[10] validate this: 'severe eating disorders and less extreme manifestations of self-induced vomiting, laxative abuse and binge eating are relatively common among college women'. However we also note that included within the EDNOS category were five clients (16 per cent) who fitted an anorexia nervosa diagnosis in all but one category. It will be interesting to observe future changes in the diagnosis of eating disorders, particularly anorexia, which may influence our findings.

We measured generalised symptoms of anxiety and found high levels but did not categorise types of anxiety. We also subjectively reported perfectionist traits, revealing high levels across all eating disorder types; the utilisation of a formal scale for perfectionism might have revealed different results. We therefore feel that a further study would be useful to compare anxiety, anxiety sub types, and perfectionism within the general student population and eating disorder clients, which may prove beneficial in directing us to appropriate therapeutic approaches and treatments for these specific difficulties.

The best bibliotherapy books can produce results comparable to those of drug therapy or psychotherapy

Prior to the study, students had to borrow self-help books from main university libraries and reported that they felt too self-conscious, ashamed or embarrassed to do so. We therefore opened a small library of our own, which has proven to be a huge success. This is in line with a new initiative in Cardiff, the 'Mental Health Primary Care Resource Project', a book prescription scheme developed by Cardiff and the Vale NHS Trust, in collaboration with Cardiff county library services. This initiative allows primary care workers, GPs, counsellors and CPNs to prescribe bibliotherapy for all mild to moderate difficulties.

The AUCC (October 2003)[11] discusses how meeting government targets has 'led to more students seeking counselling support'. Offering bibliotherapy may be a solution for some and a starting point for others. This is supported by Frude (2003)[12], who claims that 'studies have demonstrated that the best bibliotherapy books can produce results comparable to those of drug therapy or psychotherapy'.

As a counselling service we are moving to offer widening choices to students including a variety of groups: for example, *Stresspac*, a group psycho-educational approach using brief CBT (White, 2002)[13,14], building self-confidence, yoga, and an eating disorder psycho-educational and therapeutic group. It will be interesting to note in the future how many of the clientele with eating disorders choose to make use of the full range of diverse choices available.

Vicky Groves, the project leader, is a full-time student counsellor at Cardiff University, has an MA in Cognitive Behavioural Therapy and is a Registered General Nurse. Julie Devlin is an integrative psychotherapist and worked part time in student counselling for several years.

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