

APPENDIX 1

EATING DISORDER RATING SCALE

1. How distressing/disabling has your eating disorder been in the last week?

0	1	2	3	4	5	6	7	8
Not at all			Moderately			Extremely The worst I have ever been		

2. How often in the past week have you tried to diet or restrict your food intake?

0	1	2	3	4	5	6	7	8
Not at all			About half the time			All the time		

3. How often in the past week have you binged?

0	1	2	3	4	5	6	7	8
Not at all			About half the time			All the time		

4. How often in the past week have you vomited to lose weight or prevent weight gain?

0	1	2	3	4	5	6	7	8
Not at all			About half the time			All the time		

5. How often in the past week have you taken laxatives to lose weight or prevent weight gain?

0	1	2	3	4	5	6	7	8
Not at all			About half the time			All the time		

From *Treating Bulimia Nervosa and Binge Eating* by Myra Cooper,
Gillian Todd and Adrian Wells – published by Routledge

6. How often in the past week have you taken exercise to lose weight or prevent weight gain?

0	1	2	3	4	5	6	7	8
Not at all			About half the time			All the time		

7. Below are a number of the thoughts that you may have, at times, about eating, weight and shape and about yourself. Indicate how much you believe each thought by placing a number from the scale in the box next to each item.

0	10	20	30	40	50	60	70	80	90	100
I do not believe this thought is true						I am completely convinced that the thought is true				

Negative beliefs – uncontrollability

- Once I've started bingeing I can't stop
- I have no control over my weight concerns
- I can't ignore my worrying thoughts about my shape
- I can't stop myself thinking about food

Negative beliefs – negative consequences

- Eating will make me fat
- Eating fat will make me fat
- If I get fat or gain weight people will reject me
- If I eat normally I'll gain weight and become obese

Positive beliefs – bingeing

- Bingeing will make me feel better
- Bingeing will stop my painful feelings
- Bingeing will take my mind off my problems
- Bingeing helps me control my thoughts

Positive beliefs – covert behaviours

- Concentrating on my shape stops me getting fat
- Worrying about my shape stops me getting fat
- Checking my appearance stops me getting fat
- Paying close attention to what I eat stops me getting fat

Positive beliefs – vomiting and purging

- Being sick stops me gaining weight
- Being sick stops me worrying about myself
- Being sick calms me down
- Being sick makes me feel better

Self beliefs

- I'm stupid
- I'm no good
- I'm all alone
- I'm unlovable

APPENDIX 2

WEEKLY EVALUATION SHEET

Date:

What have I achieved this week?

What have I learned?

What has been difficult for me?

What areas do I need to work on over the next week?

What realistic, achievable goals can I set myself?

What problems am I likely to have?

How might I overcome these?

What do I want to work on in therapy this week?

Comments:

From *Treating Bulimia Nervosa and Binge Eating* by Myra Cooper,
Gillian Todd and Adrian Wells – published by Routledge

APPENDIX 3

A CLIENT'S GUIDE TO COGNITIVE THERAPY FOR BULIMIA NERVOSA

Introduction

This Guide will provide you with information about cognitive therapy (CT) for bulimia nervosa (BN) and what it involves, using a question and answer format. Your therapist is interested in your views and reactions to the Guide. If you have any questions or comments then please feel free to mention them. You may wish to underline key sentences, or write notes on the Guide, to remind yourself of points you would like to comment on or discuss in more detail.

What is cognitive therapy for BN?

Cognitive therapy is a psychological treatment that has been found to be effective in treating a range of problems including bulimia nervosa.

After conducting a detailed assessment of your eating problems, your therapist will help you to understand your BN, particularly what keeps it going and why it might have developed. You will then be in a better position to make some changes and to overcome bulimia nervosa.

Treatment will help you address uncertainty and anxiety about changing your problem. You will learn a range of strategies and techniques that will help you to stop binge eating. These involve questioning negative and positive beliefs about eating, and challenging unhelpful behaviours. Finally a 'blueprint' or plan will be developed that will help you to prevent slipping back into bulimic behaviours.

What are the aims of CT for BN?

The main goal of treatment is to teach you strategies and techniques that you can apply by yourself, at home, to overcome your problems. You will learn strategies that will continue to be useful once treatment is over for some time to come. Overall, cognitive therapy aims to provide you with the skills to be your own therapist

What does it involve?

Treatment is usually short term (normally up to 16 sessions) and structured.

Each session lasts approximately 50 minutes, and the discussion will focus on specific aspects of your BN, and how these might be addressed.

More specifically it involves the following:

Agenda setting

Sessions will be structured round an agenda in order to make the best use of the time available. The agenda will be drawn up at the beginning of the session. Priority items will be identified and time budgeted so that these are dealt with first. Your therapist will select items for discussion but will also expect you to bring items, particularly in the later stages of treatment. An agenda ensures that items that are important to you, as well as items that your therapist believes to be important, are covered. It also helps to avoid an 'end of session rush', a tendency to deal with important items in the last few minutes of the session. It is important to be realistic about the number of items that can be tackled comfortably in one session. Try to avoid the temptation to cover too many items. Patients also find that it is usually most helpful to deal with items one at a time rather than jump from item to item. You will gain a sense of achievement and closure by settling issues one at a time.

Feedback

Your therapist will encourage you to contribute your own ideas and suggestions and will welcome questions. During sessions you will be encouraged to provide mini summaries of what you have learned, and to give feedback on your progress with trying out the strategies and techniques discussed and agreed upon in sessions.

Working as a team

Cognitive therapy involves working together with your therapist to make changes and overcome your eating problem. The goals of treatment, understanding of your problem, the skills you learn, the strategies and techniques you employ will all be developed and agreed jointly with your therapist.

Evaluation

To give you the best chance of getting better, your therapist will be evaluating your progress in treatment very carefully. It is very important to know whether or not this approach helps you.

Diaries and questionnaires

You have probably already filled in some questionnaires to help your therapist assess your current problems. At the beginning of each session you will be asked to complete one brief questionnaire. This will help your therapist to assess how you have been in the past week. At the end of treatment you will be asked to fill in the initial questionnaires again. These questionnaires will enable your therapist to see what progress you have made at the end of treatment. There will be additional questionnaires to be completed in some sessions, or for homework. These will give your therapist more information about specific problems that you may have. They will help identify problems that may need to be worked on in treatment.

Homework

Discussion of your problems is likely to be helpful but will not usually be enough, by itself, to help you overcome them. Putting ideas into practice in everyday settings is essential. To help you do this, you will be expected to carry out weekly homework. Homework assignments will be agreed in collaboration with your therapist. They will be designed to try out strategies and test ideas discussed in sessions. If you are unable to complete any of the assignments agreed, for whatever reason, then it is important that you let your therapist know this at your next meeting. Your therapist will then be able to help you resolve any difficulties.

What will I have to do?

Therapy involves a number of things. For example, it might involve completing diaries and record sheets, reading information about BN, taking part in exercises in the session and planning and carrying out a range of different tasks, both in sessions and on your own at home.

You will have to make a commitment to treatment. A full course of treatment is likely to be of most help to you. If you do stop treatment

before the end, you may well lose out on any progress you have made. You may also miss out on the chance to get better and stay better. If you are thinking of stopping treatment please discuss this with your therapist before you come to a decision.

You will have to set aside time, not only to attend sessions, but also to complete homework assignments. Treatment is also likely to require effort, hard work and persistence. For treatment to stand a good chance of success you will have to give it a high priority. However, if you are willing to invest the time and effort then the payoff, overcoming your eating problem, is likely to be considerable.

What happens after treatment?

Depending on your progress and the resources available locally, your therapist may arrange one or more follow-up or booster sessions after the end of treatment.

I have lots more questions; what should I do?

It is not unusual to have lots of questions about eating disorders and therapy particularly when first starting treatment. Your therapist will not be at all surprised if you do have concerns and questions, and will always be willing to discuss these with you. As a first step, if you have questions and concerns right now, then make a note of them, and take them with you to your next session. Your therapist will be pleased to discuss them with you.

Recommended reading

Cooper, M.J., Todd, G. and Wells, A. (2000). *Bulimia Nervosa: A Cognitive Therapy Programme for Clients*. London: Jessica Kingsley.

APPENDIX 4

EXAMPLE ASSESSMENT LETTER

Dear Alice

Thank you for attending the outpatient clinic for an assessment on 27 November 2006, it was a pleasure to meet you. This letter attempts to provide a summary of the assessment. If there is anything in this letter that is factually incorrect or is expressed in a way that does not reflect what you told me, then please do not hesitate to contact me and I will make the necessary changes.

As you know you were referred by your GP Dr Smith for an assessment of your eating problems. You told me that your main problem was binge eating, which you felt was uncontrollable. You described having large binges that involve eating up to 6000 calories, after which you induce vomiting. In the last 28 days you binged on 26 days. On 16 of those days you binged three times a day, and on the remaining 10 you binged daily, which makes a total of 58 binges over 28 days. You said that when you are not bingeing you try to restrict your food intake and will often try and follow a specific diet, for example the South Beech diet. While bingeing you described feeling a sense of being out of control and find it difficult to stop eating. You feel compelled to eat the whole cake, tub of ice cream or the whole loaf of bread and will not be able to put your mind at rest until all the food has gone. You told me that you are spending in excess of £200 a week on food and feel worried that you are getting into debt. On occasions you have taken food from friends' cupboards and feel extremely guilty about this and worry this behaviour might cost you friendships if they find out.

We discussed triggers for bingeing, which tend to be when you are feeling stressed and anxious or low in mood. This usually occurs when you are sleep deprived because of worrying about your course work and thinking about not being liked by your friends. A further trigger you observed is when you feel fat or worried about your figure. There are also occasions when you will binge when feeling bored. On reflection, you noticed that bingeing was a way of coping with negative critical thoughts you have about yourself, and in the short term eating provides a sense of relief from your distress only to be followed by greater distress, which makes you want to eat again.

As a way of compensating for binge eating, you induce vomiting 100 per cent of the time, and to compensate for the calories absorbed during a

binge you exercise hard at the gym on a daily basis. Your regime usually includes attending 2-3 studio classes, for example yesterday you did a 45 minute cardio-cycle class followed by a 1 hour pump class after which you did 30 minutes of weight lifting, and ended with a 1 hour step aerobic class. You told me that you would feel guilty if you do not exercise and will not allow yourself a day off. After bingeing you described having a bloated and painful stomach and on 1-2 occasions a week you will take laxatives in normal amounts to reduce the bloating. You were very clear that your use of laxatives was not as a weight control strategy.

You described a typical day for eating as yesterday. You got up at 7.30 a.m. feeling starving hungry and binged. The binge initially started with healthy food that included two bowls of porridge with banana and a fruit smoothy, which degraded into eating junk food. After bingeing you went back to sleep until 11.00 a.m. Between the hours of 11 and 1 p.m. you binged for the second time on doughnuts, bread and chocolate. The next time you ate was 8.30 p.m. at a friend's house, and then at 11.00 p.m. you binged for a third time on crisps, cake and chocolate.

You told me that you were concerned about the effect of binge eating on your physical health. You suffer with heartburn and tend to have pain in your stomach following bingeing for which you take milk of magnesia. You feel exhausted most of the time and have no energy. You have regular sore throats and mouth ulcers and said that your voice is so husky it sounds as though you smoke 40 a day. You have been taking fluoxetine 60mg a day for the past 9 months, which has had no impact on reducing bulimic behaviours.

You described being extremely concerned about your weight and shape. You said that your shape is more important than your weight and worry that your thighs, hips and stomach are disproportionate to the rest of your body. You are worried that your breasts are too small and would ideally like a flat stomach. In the company of other young females you often compare yourself negatively to those who you perceive as beautiful and better looking than you, which causes distress. You say to yourself, 'I'm so ugly, no one would want to take notice of me'. You told me that your weight fluctuates a lot within a 3 stone range, which is noticeable to other people, which you find humiliating and leaves you feeling concerned about what other people think of you.

You told me that during phases of excessive bingeing you gain weight rapidly, between 8 and 12kg at a time. The first 8kg goes on over 3-4 weeks and the remaining 6kg more slowly. When your weight gets too high you will then try and lose weight through exercising excessively and through restricting your food. You said that you tend to lose weight quite

quickly and that your most typical weight is 68kg (BMI – 20.9). Your highest weight was 82kg (BMI – 25.3) in June 2004, and your lowest weight was 59kg (BMI – 18.2) in August 2005. Your weight in the Clinic today was 64kg, with a height of 1.8m. I calculated your current Body Mass Index at 19.7, which is at the bottom end of a normal healthy weight range. You told me that you do not weigh yourself and feel scared to have scales around you because in the past you have compulsively checked your weight several times a day.

You described feeling preoccupied with food to the point where it makes it difficult to concentrate. Your college work had been badly affected and your exam result at the end of your second year was lower than predicted. This has been very upsetting for you, which has made you determined to do something about your eating disorder.

You described feeling stupid and compare yourself negatively to other people and think, ‘They cope and do well, why can’t I?’ This makes you feel angry and critical of yourself. You said you associate pain with feeling happy and that eating to the point of distension is painful and serves as a punishment. You also felt that one side of you wanted to make yourself fat and ugly as a way of pushing people away and protecting yourself from getting hurt.

We discussed some of the reasons why you felt the need to punish yourself. You told me that you were sexually abused as a child until the age of 16 and one way of coping with the abuse was to binge eat because the pain took away the painful thoughts and made you feel happy. You felt that after a period of counselling that one side of you has come to terms with the abuse yet currently find that any negative emotion is intolerable and use binge eating as a way of coping. As a child you wanted to make yourself fat as a way of trying to protect yourself from being hurt. However, the abuse continued and you were teased and bullied at school because of your weight. During this time you had few friends and felt lonely and isolated. In your later teenage years you desperately wanted to lose weight so would starve yourself and exercise; you also continued to binge eat and found that inducing vomiting helped to keep your weight down.

You were brought up in a large Catholic family in Northern Italy. You described your upbringing as very strict and restrictive. Your father is 60 and works as a physician. Your mother is 55 and is a housewife. You have six siblings, two sisters and four brothers, two of whom are identical twins. You are the youngest in the family. You said that you get on well with everybody and feel particularly close to your second eldest sister, Gabriella. You described your family as not being very open emotionally

although supportive in a practical sense. You enjoyed junior school and made friends. At secondary school you excelled academically and were picked on by your peer group and teased about your weight. In hindsight you recognise that the bullying was probably unrelated to your size and probably about other factors such as showing vulnerability. You came to University in London to read Veterinary Science.

It was our impression that you have bulimia nervosa, purging subtype. We discussed how cognitive therapy is the treatment of choice and that many people manage to make a full recovery. We think that you would greatly benefit from this therapy and will place you on our waiting list. It is likely to be 4–6 months before a place becomes available and would recommend that in the meantime you read and work through some self-help material. I suggest that you read *Bulimia Nervosa: A Cognitive Therapy Programme for Clients* by Myra Cooper, Gillian Todd and Adrian Wells (Jessica Kingsley).

We will write to you once a place for individual therapy becomes available.

Yours sincerely

APPENDIX 5

EATING BEHAVIOUR QUESTIONNAIRE

Name:		Date:	
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Instructions

Listed below are some statements about different behaviours. They all describe ways in which people sometimes behave. Please read each statement carefully and decide how often you find yourself behaving in the way described. Use the rating scale to describe how often you engage in each behaviour. Write the number in the box before the statement.

Rating scale

0 10 20 30 40 50 60 70 80 90 100

Never

Always

- 1 Diet to lose weight or prevent weight gain
- 2 Eat large amounts of food only when you're on your own
- 3 Wear baggy clothes that hide your shape from others
- 4 Collect recipes
- 5 Visit food shops or supermarkets primarily to look at food rather than to make a purchase
- 6 Put only small amounts of food onto your fork or spoon at a time
- 7 Talk about food
- 8 Fill up on lots of low calorie food
- 9 Avoid weighing yourself
- 10 Chew food and spit it out without swallowing
- 11 Avoid communal changing rooms
- 12 Cook elaborate meals
- 13 Eat more than you intended
- 14 Buy lots of food that is high in fat, sugar and carbohydrate
- 15 Eat only 'safe' foods (i.e. low calorie or familiar foods)

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- 16 Hoard food
- 17 Eat slowly
- 18 Read cookery books and cookery magazines
- 19 Check your weight with average weights in books and magazines
- 20 Wear loose clothes
- 21 Watch food programmes on television
- 22 Eat diet foods
- 23 Visit shops to look at cooking utensils rather than to make a purchase
- 24 Eat large quantities of high calorie food
- 25 Go on eating binges in which you lose control of your eating
- 26 Take only small mouthfuls of food at a time when eating
- 27 Avoid drawing attention to your weight and shape
- 28 Spend hours preparing a meal
- 29 Eat until you feel sick
- 30 Avoid wearing tight fitting clothes
- 31 Eat only when you're by yourself
- 32 Buy unusual cooking utensils that you are unlikely to use a great deal
- 33 Avoid looking at your body when taking a bath or shower
- 34 Eat more than others would eat in similar circumstances
- 35 Make rules about what you should or shouldn't eat
- 36 Wear large chunky jumpers
- 37 Avoid food if you don't know how many calories are in it
- 38 Chew your food for a long time before swallowing
- 39 Spend a long time searching for ingredients that are hard to find
- 40 Set yourself a strict calorie limit for each day
- 41 Eat little in front of other people but eat large amounts when they have gone
- 42 Visit specialist food shops
- 43 Avoid looking at your body in the mirror
- 44 Check the calorie content of food before you buy it
- 45 Eat food, when you're on your own, that has been thrown away
- 46 Wear clothes that are a size or more too big
- 47 Go to several shops, hoping you won't be noticed, buying small quantities of food in each shop

Eating Behaviour Questionnaire Scoring

Add up the scores for each item on each subscale and divide by the number of items in the subscale.

Weight and shape (10 items): 3, 9, 11, 20, 27, 30, 33, 36, 43, 46.

Bingeing (10 items): 2, 5, 10, 16, 25, 29, 31, 41, 45, 47.

Dieting (9 items): 1, 8, 15, 19, 22, 35, 37, 40, 44.

Food (10 items): 4, 7, 12, 18, 21, 23, 28, 32, 39, 42.

Eating (4 items): 6, 17, 26, 38.

Overeating (4 items): 13, 14, 24, 34.

APPENDIX 6

EATING DISORDER BELIEF QUESTIONNAIRE

Name:		Date:	
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Instructions

Listed below are different attitudes and beliefs which people sometimes hold. Please read each statement carefully and decide how much you agree or disagree with the statement. Base your answer on what you emotionally believe or feel, not on what you rationally believe to be true. Choose the rating which best describes what you usually believe or what you believe most of the time rather than how you feel right now. Write the number in the box before the statement.

Rating scale

0 10 20 30 40 50 60 70 80 90 100

I do not
usually
believe
this at all

I am usually
completely
convinced
that this
is true

- 1 I'm unlovable
- 2 If my flesh is firm I'm more attractive
- 3 I'm ugly
- 4 I'm useless
- 5 I'm a failure
- 6 If I eat a forbidden food I won't be able to stop
- 7 If my stomach is flat I'll be more desirable
- 8 If I lose weight I'll count more in the world
- 9 If I eat desserts or puddings I'll get fat
- 10 If I stay hungry I can guard against losing control and getting fat
- 11 I'm all alone
- 12 If I eat bad foods such as fats, sweets, bread and cereals they will turn into fat

- 13 I'm no good
- 14 If I eat normally I'll gain weight
- 15 If I eat three meals a day like other people I'll gain weight
- 16 If I've eaten something I have to get rid of it as soon as possible
- 17 I'm not a likeable person
- 18 If my hips are thin people will approve of me
- 19 If I lose weight people will be friendly and want to get to know me
- 20 If I gain weight it means I'm a bad person
- 21 If my thighs are firm it means I'm a better person
- 22 I don't like myself very much
- 23 If I gain weight I'm nothing
- 24 If my hips are narrow it means I'm successful
- 25 If I lose weight people will care about me
- 26 If my body shape is in proportion people will love me
- 27 I'm dull
- 28 If I binge and vomit I can stay in control
- 29 I'm stupid
- 30 If my body is lean I can feel good about myself
- 31 If my bottom is small people will take me seriously
- 32 Body fat/flabbiness is disgusting

Eating Disorder Beliefs Questionnaire Scoring

Add up the scores for each item on each subscale and divide by the number of items in the subscale.

Negative self beliefs (10 items): 1, 3, 4, 5, 11, 13, 17, 22, 27, 29.

Acceptance by others (10 items): 8, 18, 19, 20, 21, 23, 24, 25, 26, 31.

Self acceptance (6 items): 2, 7, 9, 12, 30, 32.

Control over eating (6 items): 6, 10, 14, 15, 16, 28.

APPENDIX 7

EATING DISORDER THOUGHTS QUESTIONNAIRE

Name:		Date:	
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Instructions

Listed below are some thoughts which people sometimes have when eating. Please read each thought carefully and decide how much you believe each thought to be true. Choose the rating which best describes how you usually feel rather than how you feel right now. Write the number in the box before the thought.

Rating scale

0 10 20 30 40 50 60 70 80 90 100

I do not
usually
believe
this at all

I am usually
completely
convinced
that this
is true

- 1 I'll get fat
- 2 If I don't eat I'll lose control
- 3 My clothes won't fit any more
- 4 It doesn't matter if I keep eating
- 5 If I eat it will stop the pain
- 6 It's not me doing this
- 7 I'm going to go on getting heavier and heavier
- 8 I deserve something nice
- 9 If I eat it will take away the 'all alone' feeling
- 10 I'll just have a little bit more
- 11 The urge to binge is stronger than my willpower
- 12 I've nothing apart from eating/bingeing in my life
- 13 I'll gain weight

- 14 I've no self control
- 15 If I eat it will comfort me, it's a way of being nice to myself
- 16 I'll hate myself after eating so much
- 17 If I eat it will stop me feeling frightened
- 18 Go on, eat more to punish yourself
- 19 One more bite won't hurt
- 20 I'll have to vomit (exercise, take laxatives)
- 21 If I don't eat then I'll be overwhelmed with distressing thoughts and feelings
- 22 I'll have to go on a strict diet
- 23 If I eat it will all hurt less inside
- 24 If I eat it will stop me feeling bored
- 25 I'll look a mess after eating so much – fat and disgusting
- 26 If I eat it means I don't have to think about unpleasant things

Eating Disorder Thoughts Questionnaire Scoring

Add up the scores for each item on each subscale and divide by the number of items in the subscale.

Negative thoughts (10 items): 1, 3, 7, 11, 13, 14, 16, 20, 22, 25.

Positive thoughts (10 items): 2, 5, 6, 9, 12, 17, 18, 21, 23, 26.

Permissive thoughts (6 items): 4, 8, 10, 15, 19, 24.

APPENDIX 8

CONSEQUENCES AND DANGERS OF THE SYMPTOMS OF BULIMIA NERVOSA

Impact of specific symptoms

Bingeing

Bingeing leads to fullness in the stomach, bloating and abdominal discomfort. It may also lead to more general digestive problems including stomach cramps, wind, constipation and diarrhoea.

Vomiting

Vomiting is not an effective means of weight control. Research suggests that self-induced vomiting results in the retrieval of less than half the calories consumed in a typical binge. Since binges usually consist of large quantities of food, this means that a large number of calories are likely to be retained. This explains why people who vomit every time they eat are not necessarily underweight. Vomiting also encourages overeating. The thought that follows bingeing, e.g. the thought 'I'll get fat', and that you may identify later on with your therapist, maintains vomiting, and is likely to be less distressing and less likely to act as a deterrent to bingeing if you believe that vomiting removes most of the calories consumed in a binge.

If vomiting is frequent, and has been occurring for some time, then there may be a variety of physical and physiological effects.

- ⊙ *Teeth damage can occur.* Exposure to acid from the stomach, which occurs during vomiting, will erode dental enamel. Brushing the teeth after vomiting makes the erosion worse: acid in the mouth remaining after vomiting then scours the teeth. Although the damage is irreversible, erosion will stop once vomiting stops.
- ⊙ *Swelling of salivary glands.* Glands around the mouth that produce saliva will swell gradually in some people who induce vomiting. The swelling is painless but may lead to increased production of saliva. The parotid gland (the gland commonly affected most in mumps) often swells the most. As a result the face may take on a round, chubby appearance. This may be particularly distressing as the face may then appear 'fat'. The swelling is reversible and will gradually diminish as eating habits improve.

- ⊙ *Throat damage.* Most people induce vomiting by manually stimulating the gag reflex. This requires force and may result in superficial injuries to the back of the throat. These injuries may get infected. Recurrent sore throats and hoarseness are also common.
- ⊙ *Oesophagus.* Rarely, violent vomiting can lead to tearing and bleeding of the wall of the oesophagus, the tube leading from the mouth to the stomach. If this happens, medical advice should be sought. Vomiting repeatedly over several years can weaken the oesophageal sphincter, the set of muscles at the top of the stomach. If this happens the contents of the stomach may return spontaneously into the mouth, a distressing and uncomfortable experience.
- ⊙ *Hands.* If fingers are used to stimulate the gag reflex then damage can occur to the knuckles on the hand used. Abrasions may appear, then scars form. This injury is commonly known as 'Russell's sign'.
- ⊙ *Electrolyte balance.* Body fluids and electrolytes can be disturbed in a number of different ways. The most concerning is a low potassium level (hypokalaemia) which can result in heartbeat irregularities. Symptoms of fluid or electrolyte disturbance include extreme thirst, dizziness, fluid retention (swelling of legs and arms), weakness and lethargy, muscle twitches and spasms. Up to half of those with bulimia nervosa have some fluid and electrolyte disturbance but fortunately most have none of these symptoms and in most cases the electrolyte disturbance is only mild. The effects are reversible and disappear once vomiting stops. Chemically inducing vomiting, for example, by using Ipecac or salt water, can also be another cause of electrolyte disturbance.

Laxatives and diuretics

Laxatives have little effect on calorie absorption. It is common for people with bulimia nervosa who take laxatives to find that they become dependent on them, needing to take more and more for the same effect. Taking laxatives can also lead to electrolyte disturbances. People taking laxatives in addition to vomiting regularly are particularly at risk. Fortunately, the effects of taking laxatives are usually reversible. However, stopping laxatives suddenly may lead to rebound water retention and, thus, a temporary increase in weight.

Diuretics

Diuretics or water pills have no effect on calorie absorption. In large quantities diuretics also lead to fluid and electrolyte disturbances. Again, the effects are typically reversible, but stopping them suddenly may lead

to rebound water retention and, as with stopping laxatives suddenly, a temporary increase in weight.

Diet pills

There is no evidence that diet pills are helpful in bulimia nervosa. They may have unwanted side effects.

Over-exercising

Excessive exercise can be harmful. It can lead to injury and in extreme cases compulsion to exercise strenuously may mean that injuries are not given adequate time and rest to heal.

Dieting

- ⊙ *Effect on hormones.* Dieting, with or without weight loss, can affect hormones, resulting in irregular or absent menstruation. The body needs a certain amount of body fat for menstruation to occur. This may be why menstruation is affected when there is weight loss. However, the reason why menstruation may be affected, even when body fat is adequate, is not yet understood. Dieting is also associated with high levels of the hormone cortisol, which in turn is associated with stress, a known trigger for binge eating.
- ⊙ *Appetite control.* Dieting can disturb certain physiological mechanisms that control eating. The nutritional content of food, particularly the amount of carbohydrate, fat and protein, affects the mechanisms controlling appetite. An unbalanced diet can thus affect hunger, and encourage overeating.
- ⊙ *Serotonin levels.* Dieting affects certain chemical neurotransmitters in the brain, particularly serotonin. The effect is more pronounced in women than in men. Serotonin is thought to play a role in normal eating and in food selection, thus dieting, by affecting serotonin levels, may exaggerate and increase the risk of developing bulimia nervosa.

Impact of related behaviours

Illicit drugs

These can be very unhelpful. Some encourage overeating, either directly or indirectly by lowering normal psychological resistance to bingeing.

Alcohol

Some people with bulimia nervosa find that they are much more likely to binge when they have been drinking large amounts of alcohol. In some cases heavy drinking can also induce a relapse and a binge after some time without binge eating.

Checking and avoidance behaviour

People with bulimia nervosa frequently engage in a variety of behaviours connected with their weight and shape. For example, they may weigh themselves frequently, avoid changing in communal changing rooms, avoid swimming, avoid wearing tight clothes, check or measure body parts, or engage in extreme dieting. These behaviours are self-defeating; they serve only to increase rumination, i.e. preoccupation and concern with weight and shape. It is easy to see how focusing on weight and shape might increase rumination about these issues. However, the opposite, deliberately trying to avoid focusing on weight and shape, is just as likely to increase preoccupation: try hard not to think about a white bear for a few moments and notice what happens!

General impact of bulimia nervosa

Decreased quality of life

Overall, bulimia nervosa can lead to depression and demoralisation. It can also be a very lonely disorder; the secrecy, guilt and shame felt about it may lead to isolation from other people. Sufferers quite often report feeling lonely and isolated. It often affects many aspects of life and reduces overall quality of life. There may be a tendency to avoid social contact and social occasions, particularly when food is involved. This can be upsetting and puzzling to friends and family. With time, relationships may suffer, either because the eating disorder takes up time and attention or because of the need to hide essential details of the problem from other people. Children may be affected; there may be attempts to restrict their food intake as well or simply a lack of food available for them because of attempts to avoid bingeing by keeping very little food in the house. Some sufferers find themselves unable to meet their child's emotional needs except through food, including by over and inappropriate feeding. Daughters, in particular, may suffer as they get older and may feel under

pressure to join in a mother's dieting. There may also be financial difficulties; bingeing can be an expensive burden.

Impaired fertility

Dieting and weight loss can impair fertility, although the effects are typically reversible. Little is known about the effect of bingeing on fertility and pregnancy. The use of vomiting, laxatives and diuretics is more likely to be harmful. Some pregnant women with bulimia nervosa may be at risk of gaining too little weight and of giving birth to underweight babies. Preliminary work, which needs to be confirmed, suggests that the miscarriage rate may be higher in those with bulimia nervosa than in women without eating problems.

APPENDIX 9

STEPS IN THE PETS FRAMEWORK

Prepare

Identify target thought (e.g. 'I'll lose control')

Rate belief in thought

Identify problematic situation

Operationalise target thought as an observable prediction with a 'test strategy'

Clarify the rationale for the experiment

Expose

Expose to the problematic/trigger situation (e.g. eating biscuits)

Test

Test prediction by performing a disconfirmatory manoeuvre, that is, behaviour or actions that will provide a rigorous or 'extreme' test of the prediction (e.g. eat two biscuits then stop)

Summarise

Review outcome – 'What did you discover?'

Re-rate belief in target thought

Refine experiment and repeat

Source: Adapted from Wells (1997).

APPENDIX 10

MYTHS ABOUT BULIMIA NERVOSA AND COGNITIVE THERAPY

There are some myths about bulimia nervosa (BN), eating and food, and cognitive therapy (CT) that are not founded in fact. Below we identify some common ‘myths’ and discuss whether or not there is any truth in each of them.

Bulimia nervosa

It's not a real illness

BN varies in severity like many other illnesses and problems, but it is a recognised mental health problem. BN (like other eating disorders) is just as much a ‘real’ illness as any other disorder or disease.

Only adolescents and young women get BN

BN is more common in adolescents and young women, but not all people with BN are adolescents or young women. Other people, including older women and men, can suffer from BN.

It's just dieting a bit too much

There is much more to BN than dieting a bit too much. Many people diet but do not develop BN or any other eating disorder; dieting is not the same thing as BN.

The best thing to do is to ‘pull myself together’ and try harder to lose weight

BN does not respond to attempts to ‘pull yourself together’, either trying harder to control your eating or trying harder to lose weight. It is about what you do just as much as how much effort you put in and therapy will help you to focus your efforts in the most helpful way.

It's a sign of weakness or serious character flaw

BN has nothing to do with weakness or character flaws. It is easy to blame or criticise yourself for your illness, but this rarely helps.

No one else can possibly understand what it's like

While no one else can have exactly the same experiences as you, not even someone with BN, you may be surprised when you do start to share your experiences with others that you are not alone, and that others have had very similar experiences. Very often this leads to a feeling that others do understand how you feel quite well.

Mothers are to blame for eating disorders

It is never helpful to blame others for your eating disorder; life is never so straightforward or simple that a single person can be 'blamed'. A huge number of factors will have created the circumstances in which your eating disorder has developed – therapy will help you to understand what some of these are, and how they may have worked together.

The media are to blame for eating disorders

It is very fashionable to promote thinness, including extreme thinness (e.g. Size 0), and there is no doubt that images of perfection in appearance do have a very negative impact on how women feel about their own bodies and appearance. Such images also seem to encourage dieting, which is a known risk factor for bulimia nervosa. However, no researchers or clinicians believe that these are the only factor involved. Personal circumstances and individual factors are likely to be equally, if not more, important.

Purging is a good way to lose weight or prevent weight gain

Research indicates that purging, whether vomiting, using laxatives or some other means, will not get rid of all the food that you have eaten, and that, as a weight loss strategy, it is relatively ineffective.

Eating disorder related behaviours are generally harmless

Some people with BN experience medical complications as a result of their eating disorder behaviour, and may need medical management. Fortunately, serious medical complications are rare and most problems that people experience as a result of their BN behaviours are reversible with recovery.

Eating and food

Some foods (e.g. chocolate, butter, sugar) are just 'bad' and you should never eat them

Banning some foods from your diet completely is unlikely to be helpful – there is nothing inherently or morally 'bad' about certain foods, even if you feel that this is the case.

A healthy diet shouldn't include carbohydrates, fat or sugar, and healthy eating means only salad and low calorie food

Healthy eating means a balanced diet, not one that excludes whole groups or categories of food, or that involves eating excessive amounts of one particular type.

Some foods automatically lead to weight gain – it's what you eat, not how much, that matters

There is nothing inherently weight inducing about specific foods – it's how much you eat and how much energy you then expend that matters.

The only way to lose weight is to give up eating all the foods I really like

This is rarely useful or helpful – a balanced diet that involves eating fewer calories is the best way to lose weight.

Cognitive therapy

Talking won't help: people with psychological problems need medication

Some people with BN are helped by medication, and it may be worth considering this in certain circumstances, but the evidence is that many more people are helped by 'talking' treatments such as cognitive therapy.

It's too simple or basic to work

This can be an initial reaction, especially when the treatment is explained or described briefly or by someone who isn't an expert in it. The basic principles are simple (like all good scientific theories) but the practice, as you will find, is more complex.

Everyone with BN needs lengthy psychotherapy, not a short-term treatment

The evidence does not support this – many patients can recover significantly with short-term psychological treatment.

Someone who hasn't had BN (e.g. a therapist) can't possibly understand or help me

It can be very useful to talk to other people who have or who have had BN, but therapists who have no personal experience of BN can be very effective therapists. Would you request that your doctor had exactly the same symptoms or illness before accepting treatment?

The therapist will want to make me eat more, gain weight or get fat

Good therapists have no interest in making patients with BN eat more or gain weight, unless of course the patient is so seriously or dangerously underweight that their health is compromised. Equally, they have no interest in patients becoming fat. Weight gain or eating more is not the principal or even an aim at all in the vast majority of cases, and is certainly not an aim of the treatment presented here.

CT won't deal with how bad I feel inside (especially if it is all about cognition or thoughts)

The word cognitive refers to the means by which change in emotional experience is achieved. Emotional experience is an important topic and focus of attention in CT; as well as becoming less preoccupied or thinking less about eating, food, weight and shape, CT aims to help you feel better.

APPENDIX 11

MEDICAL ASPECTS OF BULIMIA NERVOSA FOR FAMILY PHYSICIANS

With increasing evidence for the effectiveness of psychotherapy for BN, patients are more likely than ever before to be seen and treated by therapists whose professional training is in psychological therapy, and who have little or minimal medical training. This is particularly true with the trend towards treatment of less severe mental health issues, including less severe eating disorders, in primary and secondary care settings. In such cases general practitioners (GPs) have an important role in the treatment of BN. Indeed, apart from patients who are being treated in hospital, the family physician is frequently at the centre of medically managing the patient. It is important that the patient's physical health as well as mental health is appropriately monitored and, at various points based on the physician's medical assessment, referral or advice from specialist medical services might be sought. This is equally true of men with BN as it is of women with the disorder.

Bulimia nervosa can be associated with a range of physical problems, some of which are potentially serious if left untreated. It may also be appropriate to prescribe some psychotropic medication. If this is indicated, and when specialist eating disorder services are not involved, the decision about this and its monitoring often rests with the physician.

Some detailed texts and guidelines have been written about the medical management and risks associated with BN. Our aim is not to replace these; rather we aim to address some of the common issues and questions that GPs experience as the primary medical practitioner for a patient with BN who is also receiving psychological treatment.

Baseline assessment

It is recommended that the physician check height and weight and calculate Body Mass Index (BMI), provided of course that the patient is willing to agree to this. If the patient has a low BMI it can be helpful to check core temperature and carry out a squat test (see below). The physician would normally ask about general health and well-being, menstruation, nutritional intake and physical activity. Blood pressure and pulse rate should be taken, as part of a full physical examination, looking particularly for signs of nutritional deficiency, such as muscle weakness or

yellowing skin and sclera. If the patient is engaging in purging behaviours, an assessment of any symptoms associated with the purging needs to be made. However, it is always important to remember that it is usually helpful to strike a balance between using further tests and investigations appropriately and over-medicalising the disorder. Based on the history and frequency of symptoms it might be useful to check the patient's blood chemistry. In particular, full blood count (FBC), erythrocyte sedimentation rate (ESR), urea and electrolytes (U&E), creatinine (Cr), creatine kinase (CK), glucose (Gluc) and liver function (LFTs) may need to be tested. Tests for any other physical problems should also be carried out, if appropriate. Patients who are taking drugs, for example tricyclic antidepressants, that may affect the QT interval should receive an electrocardiogram (ECG). A useful table for indicators of levels and measures that should cause concern, and for which medical intervention (including guidance on type of intervention, for example, the need and appropriateness of dietary supplements) may be necessary, has been produced by King's College, South London and Maudsley NHS and can be accessed online at their Trust website. It is reproduced at the end of this Appendix with kind permission from Professor Janet Treasure.

Regular monitoring

If the parameters of the measures listed above are in the normal ranges then, at the discretion of the physician, regular review and monitoring of these may be all that is currently required.

Additional testing

It is important that the physician is alert to any changes in the patient's BN that may indicate increased risk (e.g. reports of blood in vomiting, increases in vomiting or purging, addition of new methods of purging) or of any illness or other behaviours that may increase medical risk (e.g. illness that results in dehydration, binge drinking, use of illegal substances, misuse or abuse of over-the-counter medication). Weight, and marked increases in food restriction, must also be monitored regularly. Some patients may move into anorexia nervosa and this can markedly increase medical risk. If such changes occur then it is vital to repeat previous tests as soon as possible.

Medication

Selective serotonin reuptake inhibitors (SSRIs), as well as some other classes of antidepressants, have been shown to reduce bingeing and vomiting. Fluoxetine hydrochloride (Prozac) is perhaps most often prescribed for BN. The recommended dose is 60mg/day (the patient would typically start on a lower dose and, as side effects are tolerated, the dose would be gradually increased to 60mg). This is rather greater than that often prescribed for other psychiatric disorders. It is important to be aware that antidepressants have a range of side effects, some of which may increase a patient's medical risk. The relatively low risk of side effects with fluoxetine makes it the drug of choice if medication is deemed necessary, and it is the drug endorsed as most helpful in BN by the NICE guidelines for eating disorder (NICE 2004). However, it is also useful to be aware that no consistent predictors of positive response to antidepressants have been identified, and that there is little research investigating impact on features other than bingeing and vomiting. The mechanisms by which they may work are also largely unknown.

Pregnancy

It is advisable to monitor patients with BN who become pregnant particularly carefully and regularly. Their pregnancy should be regarded as high risk, and they need to be referred to an obstetrician for specialist care at an early stage. Any medication they are receiving should be reviewed and stopped if possible, particularly if it is known to be or likely to be problematic during pregnancy. Women with BN who are pregnant may also require advice about safe limits for exercising, especially if this is a key compensatory strategy following binge eating. They are likely to be very concerned about the potential impact of their BN on their unborn child, a concern that may continue postpartum as they worry about feeding their child appropriately. They may value and be helped by a referral to a dietician, both for themselves and later on when beginning to feed their baby.

General medical problems

Many patients with psychiatric illnesses suffer from inadequate general medical care, either because they are reluctant to consult their physician,

or because their symptoms are mistakenly attributed to their mental health problems, including by themselves and other professionals. A useful source to consult on this topic is Dean et al. (2001). In general, it is important to ensure that physical symptoms are carefully identified and, if necessary, appropriately investigated. As well as asking about psychological state, physicians have an important role in routinely asking patients with BN about their physical health, including when this may not be the primary focus of the consultation.

Reference

Dean, J., Todd, G., Morrow, H. and Sheldon, K. (2001). Mum I used to be good looking . . . look at me now: The physical health needs of adults with mental health problems: The perspectives of users, carers and front-line staff. *International Journal of Mental Health Promotion*, 3, 16-24.

A rough guide to a summary measure of risk

Written by Professor Janet Treasure

Kings College London, South London and Maudsley NHS Trust, reproduced with kind permission of Professor Janet Treasure.

1. No table scores

Stable. Regular review and monitoring of above parameters with routine referral to eating disorders unit or secondary services depending on local resources.

Unstable. If weight is falling ask the person with anorexia nervosa to come up with a plan to ensure that nutritional state does not fall into the risk areas. Regularly review the implementation of this plan.

2. Score/s in the Concern area

Regular review of parameters (approximately weekly) and assessment of capacity with urgent referral to eating disorders and appropriate medical intervention if needed. As this signifies medical risk this should also be shared with the carer.

3. Score/s in the Alert area

Immediate contact and referral to eating disorders unit and physicians if outpatient with assessment of capacity. The patient will need urgent specialist and medical assessment. If inpatient – immediate contact with on-call physicians.

Table A.1 gives values of concern for each part of the assessment and is followed by a management protocol based on risk.

Table A.1 A rough guide to a summary measure of risk

System	Test* or Investigation	Concern	Alert
Nutrition	BMI	<14	<12
	Weight loss/week	>0.5kg	>1.0kg
	Skin breakdown	<0.1cm	>0.2cm
	Purpuric rash		+
Circulation	Systolic BP	<90	<80
	Diastolic BP	<70	<60
	Postural drop (sit-stand)	>10	>20
	Pulse rate	<50	<40
Musculo-skeletal (squat test and sit-up test)	Unable to get up without using arms for balance (yellow)	+	
	Unable to get up without using arms as leverage (red)		+
	Unable to sit up without using arms as leverage	+	
	Unable to sit up at all		+
Temperature		<35	<34.5C
		98.0F	<97.0F
Bone marrow	WCC	<4.0	<2.0
	Neutrophil count	<1.5	<1.0
	Hb	<11	<9.0
	Acute Hb drop (MCV and MCH raised – no acute risk)		+
	Platelets	<130	<110

continues

From Treating Bulimia Nervosa and Binge Eating by Myra Cooper,
Gillian Todd and Adrian Wells – published by Routledge

Table A.1 (continued)

System	Test or Investigation	Concern	Alert
Salt/water balance	1. K+	<3.5	<3.0
	2. Na+	<135	<130
	3. Mg++	0.5–0.7	<0.5
	4. PO4--	0.5–0.8	<0.5
	5. Urea	>7	>10
Liver	Bilirubin	>20	>40
	Alkpase	>110	>200
	AsT	>40	>80
	ALT	>45	>90
	GGT	>45	>90
Nutrition	Albumin	<35	<32
	Creatinine kinase	>170	>250
	Glucose	<3.5	<2.5
Differential diagnosis	TFT, ESR		
ECG	Pulse rate	<50	<40
	Corrected QT interval (QTC)		>450msec
	Arrythmias		+

Note: * The baselines for these tests vary between labs. Any abnormal result is an indication for concern and monitoring.

APPENDIX 12

MEDICAL ASPECT OF BULIMIA NERVOSA FOR NON-MEDICAL PRACTITIONERS

Physicians must be kept regularly informed about a BN patient's therapy by those who are non-medical practitioners. It is also important to alert the physician if there is any significant change in the patient's physical symptoms, an increase in the frequency, intensity or methods of purging, or significant weight loss, so that appropriate physical tests, and any relevant treatment, can be initiated.

Medical risk can be increased by a range of BN-related behaviours, and it is important that the physician is alerted to these if new behaviours and information emerge that the patient has not previously discussed with the physician. Such behaviours include excessive fluid loading, vomiting blood, misuse of prescribed medications such as insulin or adrenalin (many patients purchase normally prescribed medications over the internet), use of illegal substances, excessive or binge drinking, and misuse or abuse of over-the-counter medications such as anti-decongestants, diet pills, caffeine tablets. Symptoms that may need further investigation by the physician, if not already known and investigated, include cardiovascular and respiratory symptoms such as shortness of breath, palpitations and chest pain. Any neurological symptoms, particularly significant dizziness or marked changes in concentration or memory, should also be reported. Severe reflux should also be discussed by the patient with their physician. Severe abdominal pain on bingeing should be investigated immediately; in a small number of cases this can indicate rupture of the stomach. Patients should also be advised to attend a dental checkup, if this has not been done recently, particularly if they are vomiting regularly, as this can cause significant tooth and gum damage. The patient who is pregnant will need particularly careful medical care; it is important that patients who are or who become pregnant consult with their physician at the earliest possible opportunity. They should be referred on for specialist prenatal care at an early stage, and generally considered to be at high risk of complications.

APPENDIX 13

USEFUL WEBSITE ADDRESSES

www.edr.org.uk Lucy Serpell's eating disorder resources for health professionals
www.rcpsych.ac.uk Royal College of Psychiatrists – mental health information with leaflets downloadable in a pdf format
www.nice.org.uk NICE guidelines
www.babcp.com British Association of Behavioural and Cognitive Psychotherapists – information and downloadable leaflets
www.b-eat.co.uk Beating Eating Disorders – information for patients and carers and professionals
www.aedweb.org Academy of Eating Disorders – international organisation that promotes awareness, research and developments in the treatment of eating disorders
www.iop.kcl.ac.uk Institute of Psychiatry Eating Disorders – information for health professionals
www.bbc.co.uk/health BBC health website – information on eating disorders
www.something-fish.org Pro-recovery website on eating disorders
www.mirror-mirror.org Information for patients with eating disorders
www.mct-institute.com

APPENDIX 14

POSITIVE CORE BELIEFS QUESTIONNAIRE

Name:		Date:	
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Instructions

Listed below are different attitudes and beliefs which people sometimes hold. Please read each statement carefully and decide how much you agree or disagree with the statement. Base your answer on what you really feel or believe, and not on what you think you should believe. Choose a rating out of 100 which best describes what you usually believe, rather than how you feel right now. Write the number in the box before the statement.

Rating scale

0 10 20 30 40 50 60 70 80 90 100

I do not
believe this
thought
at all

I am
completely
sure that
this thought
is true

- 1 I am a strong person
- 2 I am lovable
- 3 I am competent
- 4 I am resilient
- 5 I am likeable
- 6 I have value as a person
- 7 I am an achiever
- 8 I have a role
- 9 I am interesting
- 10 I have something to contribute
- 11 I am important
- 12 I am successful
- 13 I am an independent person

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- 14 I am a capable person
- 15 I fit into a group
- 16 I am ambitious
- 17 I am in control of my life
- 18 I am adventurous
- 19 I am lucky
- 20 I am a good person
- 21 I am a positive thinking person
- 22 I am confident
- 23 I am a responsible person
- 24 I am a friendly person
- 25 I am trustworthy
- 26 I am a sociable person
- 27 I am a fun person

Positive Core Beliefs Questionnaire Scoring

Add up the scores for each item and divide by the total number of items (i.e. 27).

Normative scores (from Noad, Stewart-Brown and Cooper, unpublished).

Positive Core Beliefs Questionnaire	N=224 Mean age =21.6 (SD=5.9) Female=69%	Mean=72.37	Standard deviation =13.23	Range=4–96
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APPENDIX 15

A COST-BENEFIT SHEET

Advantages of change	Disadvantages of change
Conclusion	

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THE BINGEING VICIOUS CIRCLE

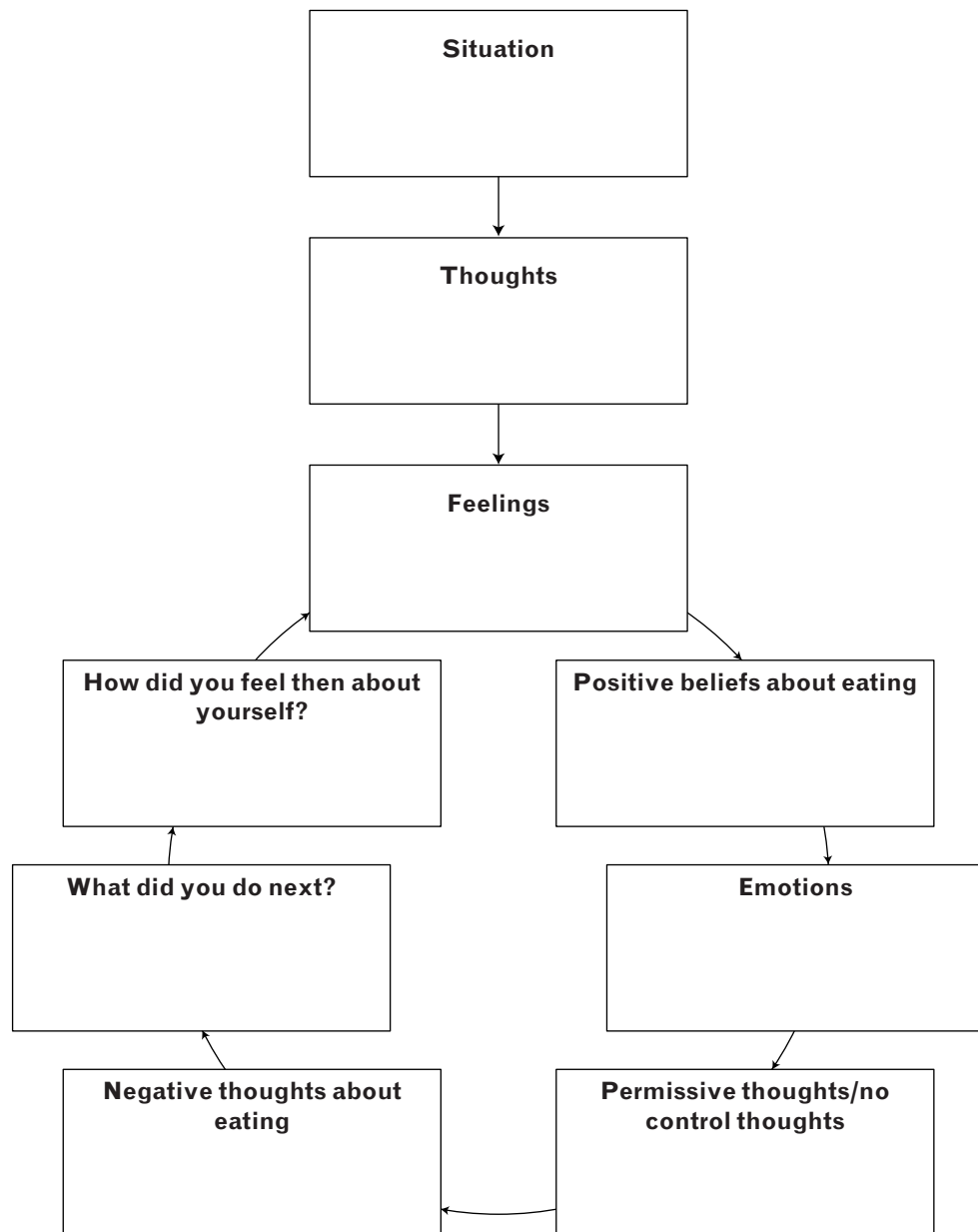


Figure A.1 The bingeing vicious circle

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WORKSHEET TO ELICIT FORMULATION

**What thoughts were running through your mind?
What were you thinking to yourself?**

What did that mean or say about you?

Did you start eating?

How did you think that would help?

What did you think would happen if you didn't eat?

What thoughts made it easy to keep eating?

How did you feel about your sense of control?

What did you do next?

How did you feel then about yourself?

A MODIFIED DYSFUNCTIONAL THOUGHT RECORD FORM TO RECORD UNCONTROLLABILITY BELIEFS ABOUT EATING

Situation	Feelings (0–100)	Beliefs (0–100)	Behaviour
Where was I? What was I doing? What was I thinking? What was I worrying about?	How did I feel?	What was running through my mind while I was bingeing/ contemplating bingeing? How much did I believe I could control my bingeing?	What evidence do I have against my belief? What evidence do I have that I can control my bingeing?

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A BEHAVIOURAL EXPERIMENTS WORKSHEET

Thought I want to test (Belief 0–100)	Situation in which I'll test it	Test strategy (what I will do)	Outcome (Belief 0–100)

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MODIFIED DYSFUNCTIONAL THOUGHT RECORD FOR IDENTIFYING NEGATIVE BELIEFS ABOUT CONSEQUENCES

Situation	Feelings (0-100)	Beliefs (0-100)	Response to beliefs (0-100)

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A DYSFUNCTIONAL THOUGHT RECORD SHEET FOR A POSITIVE BELIEF ABOUT EATING

Situation	Feelings / sensations	Beliefs	Behaviour

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AN ADVANTAGES AND DISADVANTAGES ANALYSIS FOR A POSITIVE BELIEF

Positive belief		
Advantages	Disadvantages	Evaluation of advantages
Conclusion		

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KEY POSITIVE BELIEF ABOUT EATING, AND THE EVIDENCE FOR IT

Situation	Feelings (0-100)	Beliefs (0-100)	Counter-evidence
Conclusion			

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A BEHAVIOURAL EXPERIMENTS WORKSHEET FOR A POSITIVE BELIEF

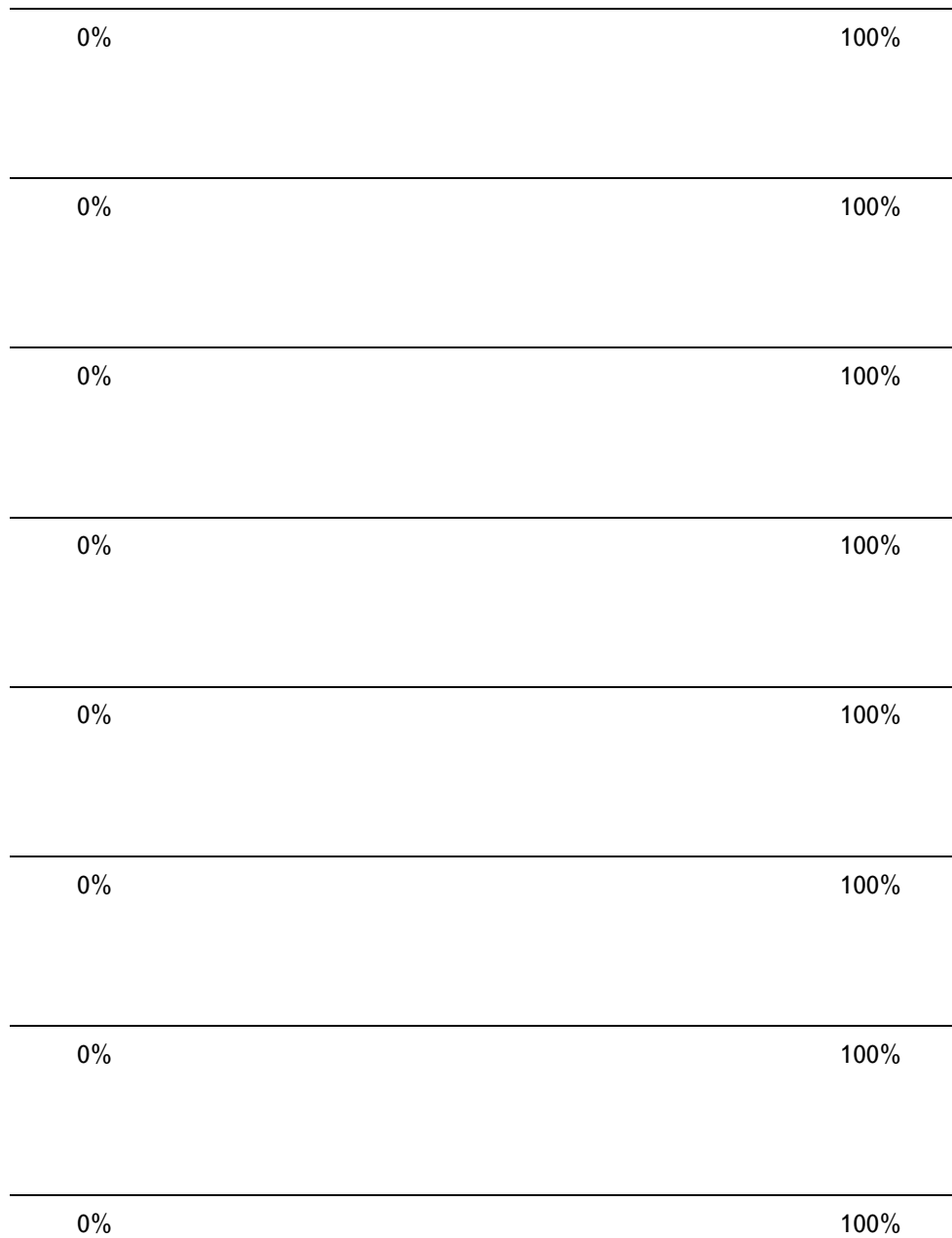
Thought I want to test (Belief 0–100)	Situation in which I'll test it	Test strategy (what I will do)	Outcome (Belief 0–100)

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A CORE BELIEF WORKSHEET

Old core belief	New core belief
What is the most you've believed this belief this week (intellectually and emotionally 0–100%?)	What is the most you've believed this belief this week (intellectually and emotionally 0–100%?)
Intellectually Emotionally	Intellectually Emotionally
What is the least you've believed it this week (intellectually and emotionally 0–100%?)	What is the least you've believed it this week (intellectually and emotionally 0–100%?)
Intellectually Emotionally	Intellectually Emotionally
Meaning of the old belief (ask patient to operationalise the belief)	Meaning of the new belief
Evidence against old belief (in the last month)	Evidence to support new belief (in the last month)

A COGNITIVE CONTINUUM



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SAMPLE FLASHCARD TEMPLATE

When my core belief (e.g. _____) is triggered I start to think . . . (e.g. _____)

This makes me feel . . . (e.g. _____)

When I'm thinking and feeling like this, my way of coping is to binge eat . . .

However, while binge eating helps in the short term, in the long term I feel . . . (e.g. _____)

List all the evidence against the core belief (e.g. _____)

Right now, what I need to do is (for example):

- ⊙
- ⊙
- ⊙
- ⊙
- ⊙
- ⊙
- ⊙
- ⊙

WORKSHEET FOR THE BLUEPRINT

General questions

What have you learnt in our therapy over the last few months?

What have you found useful or helpful?

What cognitive therapy skills have you developed?

What has been difficult?

What problems are remaining?

How might you work on these? Develop a plan.

Specific questions

The cognitive model: understanding what keeps the problem going

What beliefs and thoughts are important in maintaining binge eating?

How do these beliefs and thoughts play a role in maintaining BN symptoms?

What beliefs make you vulnerable to BN?

Detached mindfulness

What is the aim of detached mindfulness?

What specific DM strategies did you find most helpful?

Fears associated with change

What fears did you have about changing?

How did you overcome these?

What was most helpful here?

Challenging negative and positive beliefs about eating

What helped you overcome your negative beliefs about eating?

What was most helpful here?

What helped you overcome your positive beliefs about eating?

What was most helpful here?

Challenging other problem behaviours

What helped you to decrease any other problem eating-related behaviours?

What was most helpful here?

Negative self beliefs

How did you challenge your negative self beliefs?

What strategies were most helpful?