TRAINING-THE-TRAINER FOR LONG-TERM SUSTAINABILITY: IMPLEMENTATION OF COGNITIVE BEHAVIORAL GUIDED SELF-HELP FOR RECURRENT BINGE EATING IN A UNIVERSITY COUNSELING CENTER

By

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A Dissertation submitted to the

Graduate School-New Brunswick

Rutgers, The State University of New Jersey

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Graduate Program in Psychology

written under the direction of

G. Terence, Wilson, Ph.D.

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New Brunswick, New Jersey

October, 2014

ABSTRACT OF THE DISSERTATION

Training-the-Trainer for Long-term Sustainability: Implementation of Cognitive Behavioral Guided Self-Help for Recurrent Binge Eating in a University Counseling Center

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Research investigating feasible, evidence-based strategies for transferring empirically-validated treatments into routine clinical settings is needed to bridge the implementation gap. This study evaluated the implementation of cognitive behavioral guided self-help (CBTgsh) for recurrent binge eating in a university counseling center, using a train-the-trainer (TTT) model situated within the Core Implementation Components framework (Fixsen, Blase, Naoom, & Wallace, 2009). An organizational stakeholder served as "trainer" and staff therapists as "trainees." This study also served to 1) test the bounds of effectiveness of both CBTgsh and the second cascade of the TTT model and 2) respond to a service request by university community partners for assistance in instituting a sustainable program of CBTgsh within a counseling center after the Zandberg and Wilson (2012) trial. After receiving expert-led training in CBTgsh, the designated trainer subsequently trained and supervised interested staff therapists (n = 7) to implement the treatment. Consultation was provided to the trainer throughout the two years of study implementation. Clients were 12 students (83.3% female) presenting with recurrent binge

eating at a university counseling center; diagnoses included binge eating disorder (50%), eating disorder not otherwise specified, and one case of bulimia nervosa. Given study limitations, results should be considered pilot data. Consistent with hypotheses, study therapists implemented treatment with a high level of fidelity to the protocol by the end of Year 2; additionally, study therapists expressed positive attitudes toward manualized treatments, which were unchanged from pre- to post-training. Last observation carried forward intent-to-treat (ITT) analyses indicated statistically significant reductions in recurrent binge eating and depressive symptoms from baseline to post-treatment using weekly-administered assessments of binge eating frequency and depression. Indicators of program sustainability and implementation success evident by study conclusion included embedded twice-yearly CBTgsh trainings at the counseling center as well as the creation of a CBTgsh minor rotation within the predoctoral internship program at the center. Limitations were considerable, and notably included low recruitment and small sample size, low retention (41.7% completers), and low post-treatment assessment completion. Suggestions for guiding future implementation of CBTgsh within similar settings are discussed.

Acknowledgement

I am honored to acknowledge the many individuals who provided guidance and assistance regarding the design and implementation of this project. I would like to thank my advisor, G. Terence Wilson, Ph.D., for his direction, support, and encouragement throughout the development and implementation of this project and throughout my graduate training in both research and clinical settings. Terry, thank you for your time, wisdom, and mentorship in the truest sense of the word. I would also like to thank the other members of my dissertation committee for their time and assistance: Thomas Hildebrandt, Psy.D., Robert Karlin, Ph.D., and Diana T. Sanchez, Ph.D. I want to extend a heartfelt thanks to Dr. Patricia Woodin-Weaver, Ed.D., for her willingness to give so much of her time and herself to the successful implementation of this project over the past two years. Tricia, I am inspired by your commitment to your work and have learned so much from our collaboration. Similarly, I would like to thank the study therapists, staff, and leadership of Rutgers Counseling, ADAP, and Psychiatric Services for their invaluable collaboration in the initiation of this study and their demonstrated commitment to its implementation. I am grateful to Laurie J. Zandberg for the idea for this project, assistance in training, and development of training materials, as well as her initial collaboration which made this study possible. I would also like to thank Jessica Yu for her assistance in developing training materials. I am forever grateful to my family, whose fierce love and boundless encouragement sustains me and is my greatest asset always. Lastly, but far from least, I would like to thank my husband Paul, without whose support this document would have never reached fruition, but more importantly, without whom my days would involve far less laughter and love without condition.

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Introduction

The so-called "implementation gap" between psychological research and practice refers to the discrepancy between treatments offered in routine clinical settings and treatments demonstrated to be efficacious through controlled, often university-based efficacy research. Decades of efficacy research have demonstrated a catalog of "treatments that work" for various psychological disorders, but evidence suggests that such treatments are not adopted nor reliably implemented in "real world" clinical settings in a timely fashion, if at all (President's New Freedom Commission on Mental Health, 2004; U.S. Department of Health and Human Services, 2006). Taken together, the growing consensus that treatment efficacy research has far surpassed evidence-based guidelines on how to implement such treatments in routine clinical settings combined with the increasing push for evidence-based services by third-party payers and individual consumers, makes identifying effective methods of implementation to increase the uptake of evidence-based treatments a high priority among a growing number of researchers as well as the National Institutes of Mental Health (NIMH).

Treatment outcome research for eating disorders, the majority of which is comprised of controlled efficacy studies, is no exception to the implementation gap (Agras & Robinson, 2008; Mussell, Crosby, Crow, Knopke, Peterson, Wonderlich, et al. 2000; Wilson, Grilo, & Vitousek, 2007). Some researchers have suggested that evidence for the generalizability of efficacious treatments for eating disorders to routine clinical settings is lacking relative to the progress that has been made for other psychiatric problems, such as mood and anxiety disorders (Wilson, Grilo, & Vitousek, 2007). For instance, multiple efficacy trials have demonstrated cognitive behavior therapy (CBT) to

be the "gold standard" treatment for eating disorders characterized by recurrent binge eating (bulimia nervosa and binge eating disorder (BED)) (NICE, 2004; Wilson, Grilo, & Vitousek, 2007). Despite these findings, research indicates that routine clinical settings—the same settings which serve the majority of individuals seeking treatment—do not typically deliver CBT to patients presenting with eating disorders (Hart, Granillo, Jorm, & Paxton, 2011; Mussell et al., 2000; Shafran, Clark, Fairburn, Arntz, Barlow, et al., 2009; von Ranson & Robinson, 2006; Wallace & von Ranson, 2012). For instance, Crow, Mussell, Peterson, Knopke, and Mitchell (1999) report that only 6.9% of individuals presenting with bulimia nervosa (BN) at a treatment center received CBT. Furthermore, even when clinicians report that they deliver CBT to treat eating disorders, research examining treatment content indicates that core cognitive-behavioral intervention components are used far less frequently than recommended by treatment protocols (von Ranson, Wallace, & Stevenson, 2013; Waller, Stringer, & Meyer, 2012).

Challenges to bridging the implementation gap include attitudinal barriers to community clinicians' adoption of evidence-based treatment protocols, such as beliefs about the unhelpfulness of manualized protocols, the lack of relevance of research trials to clinical practice, and the belief in the superior importance of the therapeutic alliance over specific treatment components (Lilienfeld, Ritschel, Lynn, Brown, Cautin, & Latzman, 2013; Shafran et al., 2009). Beyond clinician attitudes however, two significant barriers exist to bridging the gap between research and practice in the field of eating disorders and more generally, namely 1) the lack of evidence-based practices to guide the implementation process within the field of psychological treatments, and 2) the dearth of feasible, evidence-based training models which impacts the availability of training in

evidence-based treatments for community clinicians (Shafran et al. 2009; von Ranson & Robinson 2006; von Ranson, Wallace, & Stevenson, 2013). Indeed, 82.7% of community clinicians treating eating disorders who responded to a survey conducted by von Ranson and Robinson (2006) indicated that they would like to receive training in manualized CBT for eating disorders if it were readily available.

Implementation

Proctor, Landsverk, Aarons, Chambers, Glisson, and Mittman (2009) have argued that research into evidence-based implementation strategies, or best practices for transferring evidence-based treatments into routine clinical settings, is required for long-term sustainability of implementation efforts and a true end to the research/practice gap. Given that the field of implementation research, particularly as it relates to mental health services, is in its infancy (Proctor et al. 2009), it is beset by a myriad of challenges common to newly emerging fields, including fluid constructs, inconsistent definitions of terms across studies, poorly defined strategies, lack of evidence-based frameworks or conceptual models, and flawed methodologies that often prevent generalization (2009). NIH program announcements define implementation as "the use of strategies to introduce or change evidence-based health interventions within specific settings." Investigators have advocated the use of conceptual frameworks to guide implementation, namely the *what*, *who*, and *how* of implementation, for the advancement of the field as a whole (Fixsen, Blase, Naoom, & Wallace 2009; Proctor et al. 2009).

Fixsen and colleagues (2009) outline a theoretical framework that can answer the "*what*" of implementation efforts—the Core Components of Implementation framework—based on commonalities among successful programs. These core

components are 1) staff selection, 2) preservice and in-service training, 3) ongoing coaching and consultation, 4) staff evaluation, 5) decision support data systems, 6) facilitative administrative support, and 7) systems interventions. Together, the core components "work together to implement and sustain the effective use of human service innovations such as evidence-based programs" (2009, p. 534), thereby facilitating one of the major goals of mental health service implementation.

Recent conceptual reviews of implementation science also provide suggestions about "*who*" should conduct implementation research. Fixsen and colleagues (2009) suggest that "purveyors" of implementation should be individuals with expertise in a given program or practice, who work as consultants to organizations to implement a given program with fidelity. Proctor and colleagues (2009) suggest that such purveyors should partner with community organizational stakeholders in order to facilitate administrative support and promote program sustainability.

The necessity of partnerships between research purveyors and practitioners in implementation implicates a particular approach to the "*how*" of conducting such research. Proctor et al. (2009) note the "inherently collaborative form of inquiry" unique to implementation research in which "researchers, practitioners, and consumers must leverage their different perspectives and competencies to produce new knowledge about a complex process" (p. 31). Many researchers suggest that implementation research is best facilitated by a community-based participatory approach (Fixsen et al. 2009; Proctor et al. 2009), one in which power and decision making (such as in research design and specific program goals) are shared between researchers and community stakeholders in truly

collaborative partnerships (Becker, Stice, Shaw, & Woda, 2009; Israel, Eng, Schulz, & Parker, 2005).

Implementation researchers also highlight the need for studies to assess so-called "implementation outcomes" separate from clinical treatment outcomes typically prioritized in treatment studies (Fixsen et al. 2005; Proctor et al. 2009). Assessing implementation outcomes can help to determine barriers to success when efforts may fail (i.e. did an intervention fail upon transition to a new setting, or was a successful intervention deployed incorrectly implicating a failure of implementation) (Proctor, Silmere, Raghavan, Hovman, Aarons, Bunger, et al., 2011). To that end, Proctor et al. (2011) suggest that treatment implementation studies should measure treatment acceptability, adoption, appropriateness, feasibility, fidelity, and long-term sustainability, in addition to assessing client symptom improvement as outcome measures.

Therapist training and implementation of psychological treatments

In addition to the lack of evidence-based implementation frameworks, the relative lack of feasible therapist training strategies for translation of evidence-based treatments into routine clinical settings creates a significant problem in bridging the implementation gap in mental health services. Namely, how will therapists in real-world settings become trained to implement these evidence-based treatments? Indeed, some researchers have suggested that therapists' lack of access to such training is the most significant barrier to therapist adoption of empirically-validated treatments (Cook, Biyanova, & Coyne, 2009; Insel, 2009; Waller, Stringer, & Meyer, 2012). Two necessary components of a training procedure as it relates to implementation are: 1) Does the training bring therapists to an acceptable level of treatment fidelity and competence, and 2) Is the training procedure

feasible? (including cost, time resources, organizational support, etc.) A growing body of research suggests that the typical training approach—namely, self-directed review of a treatment manual and an expert-led workshop—does not result in improving therapists' skill or competence in delivering the treatment, though it does increase therapists' declarative knowledge and self-reported proficiency (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & David, 2010). Therefore, this "training as usual" technique does not satisfy the "training to competence" criteria mentioned above. Some research has demonstrated that expert-led workshops that also included observation, feedback, consultation or coaching after the workshop can improve therapists' skill proficiency (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004) and adoption of the treatment (Kelly, Heckman, Stevenson, Williams, Ertl, Hays, et al., 2000) relative to a workshop alone. Indeed, most randomized controlled trials and treatment efficacy studies utilize a "gold-standard" intensive training (i.e. expert-led workshop, training cases with supervision) and supervision (continual clinical supervision informed by expert review of recorded sessions) paradigm. However, such methods are expensive, time-consuming, and reliant on a small number of treatment experts as trainers (Herschell et al. 2010; Wilson, Wilfley, Agras, & Bryson, 2010), making these methods impractical and unfeasible for training purposes in routine clinical settings (Roth, Pilling, & Turner, 2010). In fact, evidence-based guidelines for "necessary and sufficient" components of training in evidence-based psychological treatments, which could help settings navigate a solution to both the competence and feasibility requirements, have not yet been developed (Chu, 2008).

Train-the-Trainer. One promising alternative which addresses the above impracticalities of the "gold standard" training method is the Train-the-Trainer (TTT) model. In TTT, an expert in a given treatment trains a designated individual ("designated trainer") to deliver an evidence-based treatment and to train others in how to deliver the treatment. This new trainer then becomes the trainer and supervisor of individuals implementing said treatment in his/her organization. This pyramid model or "cascading" design theoretically results in more trainers and treatment implementers and less contact with the original treatment expert. The TTT model has received preliminary support, though empirical tests of the model within the field of mental health are still in an early stage (Herschell et al., 2010).

In a sample of community practitioners learning motivational interviewing for substance abuse, Martino, Ball, Nich, Canning-Ball, Rounsaville, and Carroll (2011) compared the effectiveness of TTT to both expert-led training and self-directed training. Measures of subsequent therapist competence demonstrated that TTT was comparable to expert-led training, and that both were superior to self-directed training. In the treatment of panic disorder and major depression in community clinics, two studies demonstrated that a TTT model (in which a single staff member was trained by experts in CBT to then train other staff members) produced outcomes comparable to those in CBT efficacy trials (Merrill, Tolbert, & Wade, 2003; Wade, Treat, & Stuart, 1998). Segre, Brock, O'Hara, Gorman and Engeldinger (2011) used TTT to train health care agency staff in perinatal depression screening, and benchmarked their screening rates against those of Healthy Start (a screening program which used an intensive training model). Screening rates in

62.5% of agencies trained in the TTT model were comparable to those in the Healthy Start programs, offering promising results for TTT.

Within the field of eating disorders, only two studies have examined the effectiveness of TTT to date, and both lend preliminary support to the training model. As part of a larger program of eating disorder prevention research (*Reflections*: *A Sorority Body Image Improvement Program)*, Perez, Becker, & Ramirez (2010) demonstrated that a dissonance-based eating disorders prevention program could be successfully and reliably implemented within sororities when endogenous facilitators (peer sorority members) were trained to subsequently train other peers in facilitation of the intervention.

More recently, Zandberg and Wilson (2012) demonstrated "proof of concept" for the TTT model in implementing cognitive behavioral guided self-help (CBTgsh)—a short-term, evidence-based treatment for patients with recurrent binge eating. In this study, an advanced doctoral student received expert-led training in CBTgsh, and subsequently trained and supervised more novice doctoral students in treatment implementation with eligible patients referred by providers at Rutgers Counseling, ADAP, and Psychiatric Services (CAPS). Benchmarking findings suggest that clinical outcomes from this study were comparable, or slightly superior, to two of the largest and best-controlled studies of CBTgsh which employed expert-led training models (Grilo & Masheb, 2005; Mitchell, Agras, Crow, Halmi, Fairburn, Bryson, et al., 2011).

Within the context of TTT, Zandberg and Wilson (2012) employed an "active learning" model to guide training and supervision, using recommendations from therapist training literature (Beidas & Kendall, 2010). In fact, a recent review of cross-discipline TTT programs in the health and social care fields (Pearce, Mann, Jones, Buschbach, Olff,

& Bisson, 2012) identified common curriculum components of effective TTT packages which are consistent with recommendations made by therapist training literature. This research suggests inclusion of 1) both didactic (passive) *and* active learning strategies, such as incorporation of behavioral role-plays (Beidas & Kendall, 2010; Cross, Matthieu, Cerel, & Knox, 2007; Herschell et al. 2010), and 2) "blended learning" techniques which use multiple information delivery methods to convey a set of skills (Cucciare, Weingardt, & VillaFranca, 2008) may be more likely to result in clinician behavior change (Pearce et al. 2012).

Zandberg and Wilson (2012) also demonstrated that CBTgsh is readily disseminable treatment for use with a TTT model in community settings, given that it is a short-term, cost-effective, evidence-based treatment for BN, BED, and eating disorder not otherwise specified (EDNOS) (Lynch, Striegel-Moore, Dickerson, Perrin, DeBar, Wilson, et al., 2010). Controlled outcome research has demonstrated CBTgsh to be superior to waitlist control conditions across diagnostic categories (Carrard, Crepin, Rouget, Lam, Golay & Van der Linden, 2011; Ljotsson, Lundin, Mitsell, Carlbring, Ramklint, & Ghaderi, 2007; Sysko & Walsh, 2008; Wilson & Zandberg, 2012), and comparable with other specialty longer-term therapies for eating disorders including interpersonal psychotherapy for BED (Wilson et al., 2010) and family therapy for adolescents with BN (Schmidt, Lee, Beecham, Perkins, Treasure, Yi et al., 2007). Previous trials have demonstrated that CBTgsh can be successfully implemented by a range of service providers, including graduate students (Wilson et al., 2010), general practitioners (Banasiak, Paxton, & Hay, 2005), and masters-level and doctoral-level therapists (Grilo & Masheb, 2005; Striegel-Moore, Wilson, DeBar, Perrin, Lynch,

Rosselli, et al., 2010). Highlighting Patel's (2009) note of the discrepancy between the supply of professional psychologists and the demand for treatment services, Zandberg and Wilson (2012) argue that "the potential for implementation by non-specialist practitioners is perhaps the most significant advantage conferred by CBTgsh in addressing the research-practice divide." While Zandberg and Wilson (2012) provide preliminary evidence that CBTgsh can be implemented using a TTT model in a psychological training clinic with doctoral students as trainer and trainees, no study to date has evaluated the implementation of CBTgsh in a community setting using a TTT model guided by a larger implementation framework.

The Present Study. With regard to implementing an evidence-based psychological treatment, research suggests that an empirically-validated and readily disseminable treatment should be implemented using a feasible, yet effective training model within the context of a larger implementation framework in a routine clinical setting with organizational stakeholders (Fixsen, et al., 2009; Herschell et al., 2010; Proctor et al., 2009). The present study aimed to fulfill the above charge by using a TTT model situated within a larger implementation framework (Core Implementation Components; Fixsen et al., 2009) to guide implementation of CBTgsh for recurrent binge eating in a university counseling center using an organizational stakeholder as the trainer and staff therapists as "trainees."

Zandberg and Wilson (2012) suggest that university or college counseling centers present as ideal settings for such implementation work, given these centers' high degree of accessibility to a student population. Indeed, university counseling centers are particularly well suited to eating disorder implementation research given the high

prevalence of eating disorder symptoms in university settings (Eisenberg, Nicklett, Roeder, & Kirz, 2011), which corresponds to the late adolescent or young adulthood developmental stages at which symptom onset is most common (Hudson, Hiripi, Pope, & Kessler, 2007). Some estimates suggest that eating disorders are among the most common presenting problems at university-based counseling centers (Zivin, Eisenberg, Gollust, & Golberstein, 2009). However, despite these findings, no study to date has examined the implementation of an evidence-based eating disorder treatment within a university counseling center. The lack of such investigations provides a particularly salient example of the research-practice gap – at the same universities where such evidence-based treatments are developed and tested, students seeking treatment through university-funded counseling services often do not have access to such treatments!

Rutgers Counseling, ADAP, and Psychiatry services (CAPS)—the implementation setting for the present study—has been no exception to the aforementioned statistics or gap. Given their role as referral sources in the Zandberg and Wilson (2012) study, CAPS staff became acquainted with the favorable outcomes associated with CBTgsh, potentially strengthening their "buy-in" regarding this evidence-based treatment to address recurrent binge eating. Such buy-in was operationalized by Zandberg and Wilson (2012) as the high number of eligible CAPS clinicians who made referrals for CBTgsh during the study period, as well as clinician self-reported satisfaction with the program. Additionally, following the conclusion of Zandberg and Wilson (2012), members of the CAPS Eating Disorder Team expressed personal interest in receiving training in the intervention to foster sustainability of CBTgsh within the CAPS system.

The present study, therefore, aimed to both respond to a service need expressed by community members within Rutgers University CAPS, and to guide the sustainable implementation of CBTgsh for recurrent binge eating within CAPS, with guidance from both therapist training literature and implementation science. The conditions in the present study were necessarily less controlled than in an efficacy trial, particularly given the recommended community participatory approach in addition to considerations for generalizability and sustainability. The study was a first step in "testing the bounds of flexibility before effectiveness is compromised" (Proctor et al., 2011 p. 27) both of CBTgsh and the TTT training model, as the hypothetical "second cascade" of the pyramid model of training, in which expert contact is further reduced.

Specific aims and hypotheses. The present study, conducted over two years, had several specific aims. The first and guiding aim, as mentioned above, was to respond to a service need expressed by our community partners at the university, for training and assistance in developing a sustainable program of evidence-based treatment delivery for students seeking treatment for recurrent binge eating. Another primary aim was to assess the effectiveness and feasibility of a TTT model to implement a sustainable program of CBTgsh service provision in a university counseling center using an organizational stakeholder as the designated trainer, and staff therapists as "trainees." It was hypothesized that the TTT model would result in an acceptable level of fidelity and competence in administering CBTgsh, and that client symptom outcomes would demonstrate statistically significant improvement from baseline to post-treatment. Additionally, given both the lack of research on implementation in university counseling centers and CAPS' request for assistance in setting up a sustainable program of treatment

delivery, a third aim was included to measure preliminary implementation success, and to provide a "roadmap" of implementation strategies for future studies seeking to implement evidence-based treatment programs in this unique setting. Therefore, therapist factors (such as background, and attitudes toward evidence-based treatment), therapist and client pretreatment expectancy as a proxy for treatment acceptability, therapist and client ratings of treatment satisfaction, and organizational factors (i.e., treatment adoption, therapist willingness to use the treatment in the future, program penetration) were also assessed. Given the enthusiasm of CAPS treatment staff for this training opportunity, as well as the self-selection of interested therapists, it was hypothesized that therapist attitudes would be positive, or at least improve over the course of the study. Additionally, given Zandberg and Wilson's finding of high client and therapist satisfaction with CBTgsh, it was also hypothesized that therapists and clients would report high rates of treatment satisfaction. Due to the emerging nature of implementation research, organizational indicators of implementation success were considered crucial, yet exploratory hypotheses.

Method

Participants and Recruitment

Client participants were treatment-seeking undergraduate or graduate students enrolled at Rutgers University who presented for treatment at Rutgers Counseling, ADAP, and Psychiatric Center (CAPS) endorsing recurrent binge eating, operationalized as a minimum average of one objective binge episode a week during the preceding month, with no gap of 2 or more weeks between binge eating episodes. Potential client participants were screened initially upon presentation to CAPS via routine clinical

practice for this organization which includes two initial steps outside of CBTgsh implementation, namely: 1) triage phone screen, and 2) assignment to a CAPS provider for an "extended appointment" or initial/diagnostic evaluation session at which time a treatment plan is generated by the provider and referrals for any concurrent services are made. Participants who presented at either of aforementioned stages with recurrent binge eating were eligible to be sent to the Designated Onsite Trainer (DOT) to be screened for eligibility in the present study using the following inclusion criteria: 1) adult (≥18 years) Rutgers University student, 2) English-speaking, 3) Body Mass Index was 19≤ BMI≥ 40, and 4) agreement to complete blood work at Hurtado Medical Center given any reported purging behavior. Participant exclusion criteria included, 1) brain injury or impairment (e.g., mental retardation) affecting recall or ability to complete assessments, 2) severe current substance abuse, 3) suicidal intent (defined according to standard CAPS procedures for suicide assessment), and 4) DSM-IV diagnosis of a psychotic disorder. Notably, in order to facilitate the generalizability of this effectiveness trial, concurrent psychopharmacological or psychological treatments did not preclude participation.

Therapists (Core Component 1: Staff Selection)

Designated onsite trainer (DOT). The designated onsite trainer (DOT) in the present study was an organizational stakeholder within the CAPS system. The DOT has a doctorate of education (Ed.D.) in counseling psychology, and has been employed by CAPS in varying clinical service positions since 2001, and has held her current title of *NJ Licensed Practicing Psychologist* at CAPS since 2009. Prior to becoming a psychologist, she worked as teacher and an independent consultant and trainer for residential childcare

workers and educators specializing in contingency management and behavior modification therapeutic milieu treatments in educational settings for over 20 years.

The DOT has had approximately 10 years of experience in treating eating disorders in both group and individual treatment modalities. She has served as the CAPS Eating Disorder Team Leader and as the Co-Chair of the Professional Development Committee of Rutgers Health Services (RHS), which seeks to develop annual training opportunities for multidisciplinary providers of RHS. Additionally, she has served as a member of multiple other organizational committees at CAPS including the CAPS training committee (for predoctoral internship program), the quality assurance committee, and a CAPS program review committee.

She has identified her primary theoretical approach as *integrative,* with influences from both a cognitive behavioral and psychodynamic orientation, as well as from object relations theory. She has managed an average weekly caseload of 20 clients at CAPS. Notably, prior to the commencement of study training, the DOT noted only limited coursework training in CBT, a limited number of clinical cases treated exclusively with CBT, and no previous training in the use of treatment manuals. Given her close contact with research investigators in the Zandberg and Wilson (2012) trial in which CAPS staff served as referral sources, the DOT had early "buy-in" regarding the efficacy of CBTgsh for recurrent binge eating and volunteered to serve as the onsite trainer for the present study to help facilitate CAPS staff training in this evidence-based treatment.

Study therapists. Study therapists were self-selected CAPS staff therapists recruited by the DOT via announcements in CAPS Eating Disorder Team meetings and via email contact to other CAPS therapists. Notably, no specific therapist qualifications

were required for participation—therefore, study therapists were expected to vary in background, approach to therapy, amount of therapy experience in general and eating disorder treatment experience specifically, to facilitate wider generalizability of the present findings on training and implementation outcomes with non-specialist providers.

Training (Component 2: Preservice & In-service Training)

Training the Trainer. The DOT was trained by West, Zandberg, and Wilson to implement CBTgsh. She was given *Overcoming Binge Eating* (the companion book to the CBTgsh program), the CBTgsh therapist manual (Carter & Fairburn, 1998), and the CBTgsh "therapist checklist" (created by Zandberg & Wilson, 2012; Appendix A) for independent review prior to attending two, two-hour workshops facilitated by West and Zandberg entailing the background, empirical support, and application of CBTgsh. These workshops included review of sample treatment materials (i.e. dummy self-monitoring records), in addition to clinical vignettes and several behavioral role-play scenarios relevant to common treatment situations in CBTgsh. These training features were incorporated to reflect research that suggests the combination of both didactic (passive) *and* active (i.e., behavioral role-plays) learning strategies vs. passive learning alone may be more likely to result in clinician behavior change (Beidas & Kendall, 2010; Cross et al. 2007; Herschell et al. 2010; Pearce et al. 2012). The DOT then completed one CBTgsh training case during which a treatment expert (Wilson) reviewed session audio recordings and provided weekly individual supervision. She was provided with all utilized training materials (i.e. workshop slides, sample clinical vignettes, therapist checklist, etc.) for training CAPS study therapists.

On site outreach. Prior to the commencement of study therapist training at CAPS, the PI attended several staff meetings, was introduced to the study team as a whole at the conclusion of one of the initial training workshops, and was introduced to multiple staff members at the center as a means of promoting a collaborative relationship (consistent with a community participatory approach) to facilitate both the research study and long term CBTgsh program sustainability. Additionally, the PI maintained a presence at CAPS through regular visits to consult with the DOT, monitor audio recordings, and transfer assessment measures.

Study Therapist Training. The CAPS DOT trained study therapists in a manner similar to the above description. Study therapists were provided with *Overcoming Binge Eating* and the CBTgsh therapist manual (Carter & Fairburn, 1998) for independent review before attending 2, 2-hour training workshops, no more than 3 weeks apart, in which the DOT presented the CBTgsh training materials (PowerPoint slides, vignettes, and therapist checklists, and facilitated role-plays).

The DOT, in collaboration with the PI, also trained study therapists in research procedures including use of digital recorders, timing of assessments, and manner of transfer of completed assessments and digital session recordings for review by the PI. The PI took several steps to reduce burden on study therapists regarding research procedures, including making "patient folders" with all necessary measures separated by session and stepwise instructions for administration and storage. The research procedures were outlined in a "checklist" (Appendix B) and reviewed with study therapists at the second CBTgsh training workshop.

Intervention. Treatment took place in a 12-week model, and consisted of 10 sessions (sessions 1-8 weekly, sessions 9-10 at two week intervals) of Cognitive Behavioral Guided Self-help (CBTgsh) for binge eating. Following an initial 45-60 minute treatment session, all subsequent CBTgsh treatment sessions were 20-30 minutes in length. The treatment utilized a companion text, *Overcoming Binge Eating* (Fairburn, 1995), which is comprised of two sections—the first contained psychoeducation about eating disorders, while the second section outlined the six steps of the self-help program around which treatment was structured.

Each step of the CBTgsh program included specific between-session tasks (i.e., self-monitoring, regular eating, problem solving) and review check-lists that facilitated patient monitoring of her/his own progress throughout treatment. Each treatment session reviewed the client's progress on the previous week's tasks, and all sessions aimed to facilitate client adherence to the self-help program. The therapist's role in CBTgsh involved: 1) trouble shooting problems and enhancing client motivation, 2) determining treatment pace (length of time spent on each step), 3) helping to increase client knowledge and skills practice by referring client to the self-help book, 4) monitoring client symptoms that may interfere with CBTgsh (i.e. depression, suicidality), and conducting crisis management and triage to additional services if necessary.

Supervision / Consultation (Component 3: Ongoing Coaching & Consultation)

Supervision. The DOT held 1 hour supervision meetings with study therapists three times per month for the duration of the study. Several supervision techniques were recommended for use by the DOT, modeled after the supervision used in the Zandberg and Wilson (2012) trial. Suggestions made by the PI and expert trainer for DOT-led

supervision in the present study included mirroring supervision meetings after CBTgsh treatment sessions, with reference or consultation to the book (*Overcoming Binge Eating*), workshop materials or therapist manual to address problems, concerns, or questions raised by therapists as they administered the treatment. In the present study, DOT review of audio recorded sessions prior to supervision meetings was impractical due to time constraints; therefore, study therapists recounted their session progress verbally and received coaching and feedback from the DOT.

Although originally conceptualized as supervision, the DOT remodeled the thrice-monthly meetings to be more similar to *consultation* and discussion among CAPS CBTgsh team members. This *consultation group,* during the first year of study implementation, appeared to be more similar to a DBT consultation group, rather than feedback-based supervision as originally suggested by the first cascade in the TTT model.

Consultation. The PI acted as a consultant to the DOT throughout the study regarding training and supervision of the study therapists, which was augmented by the PI's review of study therapists' session recordings. Monthly in-person consultation meetings were held for the first academic year of the study, with an option for immediate consultation available by phone. During the first semester of implementation, consultation topics consisted primarily of 1) trouble-shooting research procedures, 2) report on enrollment and specific client progress/session number, and 3) questions regarding specific training topics encountered during the workshop and in subsequent group supervision, with impromptu phone contact occurring approximately 1-2 times per month. Consultation calls throughout the second semester revolved primarily around

challenges that arose during the first and second semesters of implementation (i.e. low enrollment and retention) and ways to address such challenges during the second year of implementation. Beginning in June 2013, in-person consultation meetings were replaced by monthly remote (phone) consultation, again with an option for immediate consultation between scheduled calls if necessary. Consultation calls throughout the second year of implementation consisted of client updates, review and feedback regarding newly implemented training materials and protocols to enhance enrollment and retention, and updates on program penetration into the CAPS organization. A more thorough discussion of consultation topics throughout the two years of implementation can be found in Appendix C.

Fidelity Monitoring (Component 4: Staff Performance Assessment)

The PI audited approximately 20% of all recorded sessions from study therapists in an ongoing manner throughout the study. Digital recordings of sessions were randomly selected to be monitored to assess therapist adherence to the treatment protocol, which in addition to informing the content of ongoing consultation via aggregate feedback, also served as an indirect measure of training success. Recordings were rated on a CBTgsh fidelity rating scale modeled after the scale used by Fairburn and colleagues (unpublished) at the Centre for Research on Eating Disorders at Oxford. The fidelity rating scale (Appendix D) consists of 9 questions, assessing major CBTgsh themes common to all treatment sessions including degree of orientation to session, review of self-monitoring records, reference to the companion book to address concerns or questions, specific session focus on the eating disorder, therapist collaboration, manner of addressing noncompliance, etc., each rated on a 0-2 (three-point) scales. Scores on each

item were then summed for an overall fidelity rating for each session, and could range from 0-18. Therefore, scores greater than 12 represented at least 66.7% adherence to the manual, and scores greater than 14 represented at least 75% adherence to the manual, etc. Mean fidelity ratings for each therapist were calculated by averaging the summed fidelity scores across all randomly audited sessions for each therapist.

Implementation Component 5: Decision Support Data Systems

Taken together, the PI's consultation to the DOT (informed by fidelity monitoring) and measures of client enrollment and retention, established a feedback loop, or a *decision support data system,* (Fixsen et al., 2009) through which problems that arose during the process of implementation could be addressed.

The feedback loop between the DOT (acting as both trainer and liaison for the CAPS study therapists) and the study PI revealed several challenges that arose during Year 1 of implementation. These challenges centered on ways to improve fidelity to the CBTgsh treatment model, and address low client enrollment and poor client retention.

Year 1 challenge: Fidelity. Several themes emerged during audio recording review which decreased fidelity to the CBTgsh treatment model during Year 1 of implementation, and which required additional attention to facilitate necessary improvements outside of routine consultation meetings. Examples of problem areas included maintaining session focus on the eating disorder, therapist handling of ambivalence, and session organization. To address these issues, the PI and DOT instituted a "training refresher" to occur at the end of the first academic year of implementation, with the idea of enhancing training on specific aspects of CBTgsh. In addition to the original training materials used in the Fall 2012 workshops, the PI created

several additional training guides to be used in the "training refresher" (Year 2 Training Refresher Guide found in Appendix E). These included: 1) specific examples or templates demonstrating how to effectively use the previously provided Therapist Checklist to structure the sessions; 2) a Session One agenda in detail (Appendix F); 3) special notes on in-session presentation and review of self-monitoring records (Appendix G); and 4) more explicit guidelines on how to address non-compliance including step-by-step instructions on when to use non-compliance procedures.

In addition to the aforementioned materials, the PI along with a fellow graduate student who had experience in CBTgsh, created an "audio library" of recorded role play scenarios from each step of CBTgsh to serve as models. The audio library was distributed to the DOT and all study therapists to provide opportunities for self-directed learning and to guide supervision of study therapists by the DOT. Specifically, therapist treatment sessions on a given program step could be compared against the corresponding audio library role-play. Transcripts of the audio library role-play recordings can be found in Appendix H.

Additionally, Year 2 changes included suggested modifications of supervision meetings, specifically to incorporate more active learning and behavioral rehearsal (role-plays) of common treatment scenarios (Beidas & Kendall, 2010) focused on the CBTgsh manual, rather than solely consultation-type discussion among team members. Use of the audio library role-plays and the more comprehensive training materials provided as part of the refresher facilitated the change from consultation to coaching by the DOT.

Year 1 Challenge: Enrollment and retention. Prior to Year 2, the DOT scheduled additional announcements within CAPS, at staff meetings and "brown bags" to

promote the service and improve enrollment. Regarding client retention, changes were made to both the intake procedure and follow-up protocol to be activated upon a missed session. The intake procedure was modified to include planning for additional CAPS services to manage client issues that may interfere with a CBTgsh session focus on the eating disorder. Since such services were arranged in the initial consenting appointment, CAPS study therapists were instructed to refer the client to their additional treatment providers to manage crises that arose unrelated to the eating disorder during CBTgsh treatment. Additionally, motivational interviewing-inspired commitment strategies were used by the DOT in the initial consenting appointment to promote client retention from initial contact.

Regarding follow-up after a missed client session, a more immediate procedure was implemented than routine CAPS practice; specifically, upon a client "no-showing" a session, the study therapist was instructed to be in touch with the client by email or phone during the scheduled session time (already blocked on the therapist's schedule so additional time was not required). Therapists were also encouraged to reschedule missed sessions as quickly as possible. To address any scheduling issues arising from study therapists' weekly caseload, the DOT volunteered to serve as an "understudy" for study therapists who were unable to reschedule a client appointment in a timely fashion, to facilitate treatment progress. As a final measure to improve retention, study therapists were instructed to preemptively address clients' waning motivation in treatment (indicated by missed homework over several sessions) as a warning sign of potential to drop out. All Year 2 changes were synthesized for study therapists in a handout to keep them informed of the research agenda (Appendix E)

Measures

Additionally in line with both recommendations from Proctor et al. (2009) and community participatory research, chosen measures were "brief and feasible" and the DOT provided crucial input regarding assessment and measure selection, particularly regarding expected acceptability and feasibility of such measures. For example, the DOT suggested use of the PHQ-9 over the BDI given both the former's brevity, and its more frequent use in routine CAPS practice. In addition, the DOT digitized and synchronized study measures into the existing electronic record keeping system already in place at CAPS, thereby reducing the burden on individual study therapists during the course of research. Weekly assessments completed by CBTgsh clients, namely the PHQ-9 and self-reported binges and purges, could be calculated and entered into existing clinical documentation in under 2 minutes. The aforementioned steps were taken to facilitate sustainable use of routine outcome monitoring during implementation of CBTgsh at CAPS even beyond the present two year study.

Demographic questionnaire. The "Client Demographic Form" assessed client age, year at Rutgers, ethnicity, current psychotropic medication use, and information regarding any current psychological treatment as well as past treatment for an eating disorder. The "Therapist Background Questionnaire" (TBQ) assessed therapist age, gender, ethnicity, information regarding their training (i.e. degrees earned, previous psychotherapy experience, prior training in CBT, etc.) and their approach to therapy (i.e. primary theoretical orientation, theoretical approach to eating disorder treatment, etc.).

Therapist attitudes. The 17-item Attitudes Toward Psychotherapy Treatment Manuals scale (Addis & Krasnow, 2000) was used to assess study therapists' attitudes

toward manual-based treatments (like CBTgsh) before training, and again after the first year of study implementation. The scale measures two factors—Negative Process (which indicates extent of therapists' dislike of manuals' impact on therapy practice) and Positive Outcome (indicates therapists' agreement that manual use results in better outcome). Items are rated on a 1-5 Likert scale with 10 Negative Process items such as "Treatment manuals ignore the unique contributions of individual therapists," summed to form a "negative process" subscore which has a maximum score of 50, where higher scores indicate more negative attitudes toward treatment manuals. Additionally, 7 Positive Outcome items like "Treatment manuals keep therapists on track during therapy" are summed to form the "positive outcomes" subscore, with a maximum score of 35, where higher scores indicate more positive attitudes toward treatment manuals). Both factors have demonstrated good internal consistency (Addis & Krasnow, 2000).

Eating pathology. The Eating Disorder Examination Questionnaire Sixth Edition (EDE-Q; Fairburn & Beglin, 2008) is the self-report questionnaire version of the gold-standard, semi-structured interview for eating disorders (Eating Disorder Examination; EDE). The EDE-Q consists of 36 items measured on a 7-point scale, and assesses binge eating and compensatory behaviors over the 28 days prior to administration, in addition to measuring four constructs (subscales taken from the EDE) including, a) Eating Concern, b) Shape Concern, c) Weight Concern, and d) Dietary Restraint. Recent reliability data for the EDE-Q demonstrates good internal consistency ($\alpha > .90$; Peterson, Mitchell, Crow, Crosby, & Wonderlich, 2009 with the EDE-Q 5.0).

Additionally, clients reported their binge/purge frequency during the week prior to each treatment session, as a way of tracking symptoms throughout treatment.

Negative affect. The Patient Health Questionnaire (PHQ-9) is a self-report questionnaire version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the nine item depression scale of the PHQ based directly on the diagnostic criteria for major depressive disorder listed in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). The PHQ-9 assesses the frequency of the nine criteria for major depression over the previous two weeks on a 0-3 scale ("0" (not at all) to "3" (nearly every day)). Scores can range from 0-27, with scores of 5, 10, 15, and 20 representing mild, moderate, moderately severe, and severe depression, respectively. A study involving two different patient populations demonstrated that the PHQ-9 has good internal consistency, ($\alpha \approx 0.88$; Kroenke, Spitzer, & Williams, 2001). In addition to an overall symptom severity score, the PHQ-9 also assesses degree of functional impairment (i.e. "How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?"). Use of the PHQ-9 is consistent with routine clinical care already in place at Rutgers CAPS. The PHQ-9 was administered before each session to measure depressive symptoms throughout treatment.

Expectancy. The Credibility and Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000) was used to measure both therapist and client pre-treatment expectancy and was administered after the first session. Expectancy measures were included as an indirect measure of treatment acceptability within the CAPS setting, by both providers and consumers. The present study used the credibility factor of the CEQ, which includes 3 items measured on a 9-point scale (total scores can range from 3 to 27, with higher scores indicating more positive expectancy), measuring clients' perception of how logical treatment seems, how successful the client thinks the treatment will be in helping them to

reduce symptoms, and the client's level of confidence in recommending the treatment to a friend with similar symptoms. The credibility factor of the CEQ has demonstrated high internal consistency (standardized alphas ranging from .81 to .86 across two studies) and good test-retest reliability (r = .75 in one study) (Devilly & Borkovec, 2000). The present study's expectancy measure included an additional item from the full CEQ, ("By the end of treatment, how much improvement in your symptoms do you think will occur") which is measured on an 11-point scale from 0% to 100% in 10-point increments. This item has been used as a measure of outcome expectancy on its own (Borkovec, Newman, Pincus, & Lytle, 2002), possesses good face validity, and has also been shown to predict treatment outcomes (Price, Anderson, Henrich, & Rothbaum, 2008). Therapists completed a therapist version of the CEQ, with item wording changed to reflect the therapist's expectancy for the client, (i.e. "At this point, how successful do you think this treatment will be in reducing your client's symptoms?"). All four items were included in this therapist version, with appropriate wording changes.

Treatment satisfaction. Client satisfaction with CBTgsh as delivered at CAPS was assessed via a post-treatment satisfaction questionnaire assessing overall level of satisfaction with CBTgsh, the treatment modules, quality of contact with their therapist, and treatment outcome (5 items rated on a 1-7 Likert scale, with a maximum score of 35 and higher scores indicating a greater degree of satisfaction). In addition, the questionnaire assessed client psychotropic medication use at post-treatment, and any psychological services they may have received concurrent to CBTgsh. Similar to the client satisfaction questionnaire, the therapist version of the treatment satisfaction questionnaire included 5, Likert-type (1-7 scale) questions assessing therapists' overall

satisfaction with the program, treatment modules, quality of contact with client, and treatment outcome (maximum score of 35 with higher scores indicating greater satisfaction). In addition, the questionnaire included a single question assessing therapist likelihood of using CBTgsh with similar clients in the future (outside of the current study) on a 1-7 Likert scale (with 7 indicating highest likelihood of future use) as a measure of institutional uptake and program penetration in the organization.

Data Analysis

There were three primary outcome variables in the present study: therapist adherence to the treatment protocol (fidelity), therapist attitudes and expectancy, and client symptom improvement. Therapist fidelity is reported using descriptive statistics and percent adherence to the protocol to illustrate each therapist's mean fidelity rating in both years of the study. Given the small sample size for both therapists and clients in the present study, data from all variables was first tested for skewness and kurtosis ($Z_{skewness}$ and $Z_{kurtosis}$ statistics were calculated by dividing skewness and kurtosis statistics for each variable by that variable's standard error value to determine if the Z was less than 3.2, which would indicate acceptable normality (Tabachnik & Fidell, 2013)). Tests revealed that the data from all variables adequately satisfied the assumption of normality. Therapist attitudinal data were analyzed using paired sample *t*-tests to compare pre- and post-Year 1 attitudes toward manual based treatment. Additionally, Pearson product-moment correlation coefficients were computed to assess the relationship between pre-treatment expectancy ratings and client symptoms at post-treatment. Client symptom measures (binge frequencies, levels of negative affect) were analyzed using both baseline-observation-carried-forward (BOCF) and last-observation-carried-forward

(LOCF) intent-to-treat (ITT) paired sample *t*-tests to compare pretreatment and post-treatment outcomes. BOCF and LOCF ITT analyses were used to demonstrate both a more conservative data imputation method for missing variables due to premature dropout (BOCF), and an imputation method which would decrease the likelihood of a Type II error (LOCF) given the small sample size, low rate of treatment completion, and existing evidence which suggests early response to CBT in eating disorders (Grilo, Masheb, & Wilson, 2006). All tests were two-tailed and *p*-value of .05 was used to indicate statistical significance. Cohen's *d* effect sizes (Cohen, 1988) were calculated and corrected for dependence between means using Morris and DeShon's (2002) equation 8 for all significant *t*-test comparisons. Effect sizes were defined as 0.20 = small effect, 0.50 = medium effect, and 0.80 = large effect. R-squared was calculated as a measure of effect size for significant correlations. Secondary outcome measures included more qualitative *implementation outcomes*, such as program penetration into the CAPS system, level of intervention uptake, and reported therapist and client satisfaction ratings. All implementation outcomes were reported descriptively. Given the low sample size in the present study, results should be conceptualized as preliminary pilot data and interpreted with caution; the conventional statistical analyses used above were performed for illustrative purposes and with knowledge regarding the limited conclusions which can be drawn from such a small sample.

Results

Participants

Therapists. Eight female CAPS staff therapists participated in the present study. Seven were initially consented and trained in Fall 2012, and one additional therapist

joined the team in Spring 2013 after staff turnover. Study therapists were 87.5% Caucasian (*n = 7)* and ranged in age from 27 to 71, with a mean age of 42.33 (*SD = 16.10).* Seven of the eight therapists possessed a doctorate in psychology (*n=6* PsyD, *n=1* PhD), and the remaining therapist held an MSW and LCSW. Therapists' years of experience (post-degree) ranged from 1 to 24, with a mean of 10.87 years (*SD= 8.98),* and study therapists maintained an average caseload within CAPS ranging from 15-27 clients per week, with a mean of 18.4 *(SD=5.27).* Study therapists identified their primary theoretical orientation as psychodynamic (*n=4),* cognitive behavioral (*n=2),* and "other" (integrative, *n=1*; interpersonal, *n=1*). Six of the eight therapists noted using CBT as part of their routine clinical practice, even when this orientation was not identified as primary. All study therapists (*n=8*) endorsed having had prior training in CBT (with amount of prior training ranging from "informal," to several didactic courses, to workshops and individualized training and supervised clinical experiences in CBT), and 62.5% (*n=5*) noted prior training in a manual-based treatment/use of a treatment manual. Five study therapists noted prior training in treating eating disorders; therapist self-reported mean baseline level of confidence in treating eating disorders (measured on 0-10 Likert-type scale, with 10 meaning "*extremely confident*") was 5.69 (*SD=2.40),* with scores ranging from 2 to 9. Therapist characteristics are outlined in Table 1.

One therapist withdrew in Fall 2012 after completing initial consents and measures, but prior to training, due to increased work demands within the organization and involvement in another study. Two study therapists retired and left the university (one in December 2012 after completing initial training but before treating any CBTgsh clients; one in September 2013 after completing both trainings and treating one case).

After turnover and with the addition of the therapist who joined the study team in Spring 2013, the total number of CAPS study therapists (excluding the DOT) at the conclusion of the study was 5. Therapist flow throughout the two year study and number of clients treated can be found in Table 2.

Clients. Figure 1 shows participant flow and recruitment throughout the study. Between September 2012 and March 2014, 21 clients were triaged to the DOT for assessment and possible inclusion. Seven clients were assessed by the DOT but were not assigned to a CBTgsh therapist. Five of these clients were deemed ineligible following baseline assessment; reasons for ineligibility included lack of any binge eating episodes (*n = 3*), and lack of required amount of binge eating episodes specified by inclusion criteria (*n* = 2). The two clients who exhibited binge eating behaviors at levels less than that specified by inclusion criteria were treated with CBTgsh by the DOT, but were not included as part of the study and did not complete assessments. An additional two clients triaged to the DOT for assessment were deemed eligible to participate, but were not interested in the treatment (*n* = 1) or declined eating disorder treatment *(n* = 1) at the time. After completing baseline assessments, one client was lost to follow-up before attending even one CBTgsh session, and an additional client was still undergoing treatment at the time of analyses. Therefore, these clients were excluded from subsequent data analyses, which were conducted on the remainder of the sample (*n* = 12).

Participants were 10 female and 2 male students (50.0% Caucasian, 16.7% Latina, 16.7% Asian, 8.3% South Asian, and 8.3% biracial) with a mean age of 20.42 years (*SD* = 1.78) and mean BMI of 28.24 (*SD* = 4.90). Table 4 details participant characteristics at baseline. Six of the participants (50%) met DSM-IV diagnostic criteria for BED, 5

(41.6%) were classified as EDNOS because of subthreshold binge frequency (i.e. fewer than two binge episodes per week), and 1 (8.3%) met diagnostic criteria for BN. The average number of binge eating episodes over the preceding month was 15.25 (*SD* = 11.57). Two participants (16.6%) endorsed compensatory vomiting over the preceding month at baseline, and 1 (8.3%) reported use of laxatives. The baseline mean score on the PHQ-9 was 14.58 (*SD* = 6.10), indicating moderate to moderately-severe depression (Kroenke et al., 2001). The mean pretreatment scores on EDE-Q subscales were: weight concern, *M* = 4.35(*SD* = 1.46); shape concern, *M* = 4.51(*SD* = 1.65); eating concern *M* = 3.75(*SD* = 1.43); and dietary restraint, *M* = 2.43(*SD* = 1.84). A history of past eating disorder treatment (including inpatient hospitalization and outpatient therapy) was reported by 8.3% (*n* = 1) of the sample. Concurrent treatment with psychotropic medication was endorsed by 41.7% (*n* = 5) of the sample, and 49.9% (*n* = 6) reported attending one or more concurrent sessions of psychological treatment (either group or individual therapy) at CAPS or a non-Rutgers affiliated mental health setting while participating in CAPSgsh treatment.

Treatment Attendance

Treatment completion for the present study was defined as completion of at least 8 of the 10 sessions, given both the well-documented phenomenon of early treatment response (*i.e. in the first 4 sessions*) to CBT for BN (Grilo, Masheb, & Wilson, 2006) and prior research investigating guided self-help protocols for BN which have used between 4-8 treatment sessions (Mitchell et al. 2011; Steele & Wade, 2008; Ghaderi, 2006; Walsh et al. 2004; Ghaderi & Scott, 2003; Palmer, Birchall, McGrain, & Sullivan, 2002). Treatment retention in the present study was relatively low, with only 41.7% of the

sample completing at least 8 sessions. Four participants (33.3%) completed 5 sessions before dropping out of treatment, and 25% (*n* = 3) completed 4 or fewer sessions before dropping out of treatment. The mean number of treatment sessions attended across the sample was six. Of the treatment completers, only 60% (*n* = 3) completed post-treatment assessments (EDE-Q and satisfaction measures). Sample size precluded meaningful analyses of baseline differences in demographics, eating pathology, or depressive symptoms between treatment completers, clients who dropped out at mid-treatment, and clients who dropped out prior to mid-treatment. Reasons for drop-out included medical reasons (*n* = 3), legal difficulties that interfered with continued treatment (*n* =1), and decreased motivation to continue treatment given marked reduction in binge eating over the course of sessions attended combined with scheduling constraints (*n* = 3).

Primary Outcomes

Therapist fidelity. Fidelity scores were calculated only for therapists who treated at least one client during the study (*n = 6*; see Table 2). Three therapists treated clients during the first year, but did not treat clients during the second year of the study. The remaining therapists (*n = 3*) treated clients in both the first and second years of the study (pre- and post-"training refresher"). Therapist fidelity ratings are presented for both Year 1 and Year 2 (post-training refresher) separately to provide comparison before and after the adjunctive training can be found in Table 3.

Therapists' (*n* = 6) mean fidelity scores in Year 1 ranged from 10.33 to 15, with an overall mean of 11.44 (*SD = 1.31*). This overall mean represents a 63.56% fidelity to the CBTgsh protocol in Year 1. When separated by therapist, Year 1 fidelity percentages ranged from 57.4% to 83.3% fidelity to the protocol; 4 therapists reached a mean fidelity

rating above 60% (see Table 3), while 2 therapists nearly achieved 60% fidelity (57.4% and 59.3%).

Overall, fidelity to the treatment manual improved from first to second year of study implementation. Fidelity rating for therapists who treated clients in the second year (*n = 3*), ranged from 17.57 to 18, with an overall mean of 17.64 (*SD = .50)*, which represents 98% fidelity to the protocol. When separated by therapist, Year 2 fidelity percentages indicate that all therapists who treated clients in Year 2 of the study (*n= 3*) achieved higher than 95% fidelity to the protocol (see Table 3 for mean, SD, and percentages).

Therapist attitudes. Two of the original therapists retired (*n = 1*) or withdrew from participation in the study given time constraints (*n* = 1) prior to the second administration of the attitude measure. Therefore, analyses were conducted on the remaining 6 therapists. Therapists' baseline (pre-training) mean negative process score was 20.83 (*SD* = 4.53) (maximum possible score of 50) and mean positive outcome score was 25.83 (*SD* = 4.71) (maximum possible score was 35), indicating fairly low negative attitudes and relatively positive attitudes toward treatment manuals. At Time 2 (post-Year 1 of implementation), therapists' mean negative process and positive outcome scores were similar to baseline, with means of 23.00 (*SD* = 4.29) and 25.50 (*SD* = 5.13), respectively. Paired sample *t*-tests revealed no difference in either therapists' *negative process* attitudes from time 1 to time 2 ($t = -1.41$, $p = .218$), nor therapists' *positive outcome* attitudes from time 1 to time 2 ($t = 0.30$, $p = .777$.

Client symptom improvement. Given the low rate (*n* = 3) of completion of post-treatment assessments (including the EDE-Q and client/therapist post-treatment

questionnaires including satisfaction measures), rates of diagnostic remission or reported binge abstinence over the preceding 28 days could not be calculated for the majority of the sample. Therefore, analyses of client symptom improvement regarding binge and purge frequency, were calculated using the weekly self-reported binge and purge frequencies, with post-treatment defined as binge/purge frequency reported at Session 10. As planned, change in depression scores from pre to post-treatment was determined by analyzing PHQ-9 scores across sessions, with post-treatment defined as Session 10 PHQ-9 score.

Using *last observation carried forward (LOCF)* intent-to-treat (ITT) analyses (n = 12), paired sample t-tests revealed statistically significant reductions in weekly binge episodes from pre- (M = 7.00, SD = 5.19) to post-treatment (M = 1.92, SD = 1.73), t = 3.497, $p < .005$, Cohen's d = 1.20. No statistically significant reduction in purging episodes was observed from pre- (M = 0.17, SD = .58) to post-treatment (M = 0.33, SD = 1.15), t = -1.00, p = .339, likely due to the low baseline frequency of purging. A statistically significant reduction in depression scores (PHQ-9) was observed from pre- (M = 14.58, SD = 6.10) to post-treatment (M = 8.83, SD = 5.75), t = 3.415, $p < .006$, Cohen's d = 0.99.

Using the more conservative data imputation method of *baseline observation carried forward (BOCF)* analyses (n = 12), paired sample t-tests revealed reductions in weekly binge episodes and negative affect that failed to meet significance at conventional levels, though reduction trends approached significance, from pre- (M = 7.00, SD = 5.19) to post-treatment (M = 4.42, SD = 4.36), t = 2.025, p = .068 for binge frequency and pre- (M =14.58, SD = 6.10) to post-treatment (M = 11.50, SD = 7.76), t = 2.152, p = .054 for

depression (PHQ-9 scores). As with the above-reported LOCF analyses, no reduction in purging episodes was observed from pre- to post-treatment, again likely due to the low baseline frequency of purging.

Therapy expectancy. Overall, both therapists and clients reported positive treatment expectancies at baseline, with mean rates of expected improvement over the course of treatment at 75% regarding the single factor item (0-100% of expected improvement) for both study therapists and clients. Additionally, therapist pretreatment expectancy scores as measured by the 3-item CEQ were fairly high, with a mean of 23.9 (*SD* = 2.69) out of a possible 27. Similarly, client pretreatment expectancy scores on the 3-item CEQ were high, with a mean of 23.4 (*SD* = 2.06) out of 27.

Implementation Outcomes

Satisfaction ratings. The low rate (*n* = 3) of completion of post-treatment assessments, (including therapist and client satisfaction ratings), precluded meaningful analysis of post-treatment therapist and client satisfaction with CBTgsh. Clients who completed post-treatment satisfaction ratings reported high satisfaction with CBTgsh, with a mean satisfaction score of 33.00 (*SD* = 1.73), and all clients indicated that they had felt treatment with CBTgsh had been worthwhile and that they would recommend this treatment to a friend with a similar problem. Similarly, therapist post-treatment satisfaction scores were high (*M* = 31.67, *SD* = 1.53), and all therapists indicated a very high likelihood (7/7) of using CBTgsh with similar clients in the future outside of the present study.

Penetration and sustainability. By the conclusion of the study, several proximal indicators suggest that CBTgsh developed sustainability within the CAPS system. The

DOT has arranged for the "Year 2 Training Refresher" to become an annual "spring CBTgsh training" at CAPS, both to prevent therapist drift for previously trained CBTgsh therapists and to engage additional therapists who may express interest in becoming trained over the course of an academic year or who are unable to attend the Fall training. Therefore, this "Year 2" study change resulted in the institution of twice-yearly CBTgsh trainings at CAPS, with plans for sustainability after the conclusion of the present study. Similarly, the DOT has made arrangements for annual announcement of the CBTgsh service to be made at the large initial Fall and Spring CAPS staff meetings (topics of which are usually "booked" far in advance) to promote enrollment early academic semester. Perhaps most interestingly, given the DOT's role in the CAPS pre-doctoral internship training program, the CAPS internship training director has agreed to create a CBTgsh "minor rotation" optional experience for CAPS pre-doctoral interns, with the current study's DOT leading training and supervision. These implementation outcomes and proximal indicators of treatment penetration and program sustainability in the CAPS organization are crucial to implementation research (Proctor et al., 2011).

Discussion

The present study aimed to provide a preliminary evaluation of a TTT model situated within a larger framework (Core Implementation Components; Fixsen et al. 2009) to guide implementation of CBTgsh for recurrent binge eating in a university counseling center using an organizational stakeholder as the trainer and staff members "trainees", with consultation provided by an advanced doctoral student. The study was designed to test the limits of the model's flexibility, as it is the hypothetical "second cascade" of a pyramid model of training, in which contact with the original treatment

expert is further reduced. In addition, the study aimed to establish a sustainable program of CBTgsh service delivery within the CAPS system.

We hypothesized that a TTT model would result in an acceptable level of fidelity and competence in administering CBTgsh and that client symptoms would demonstrate statistically significant improvements from baseline to post-treatment. Consistent with hypotheses, mean ratings for therapists who treated clients in the first year of the study (n = 6) indicated an overall mean of 63.6% fidelity to the protocol. These Year 1 fidelity ratings indicated an overall minimum acceptable fidelity to the protocol (60%), a percentage which has been used in other research examining fidelity to evidence-based treatments (Lu, Yanos, Gottlieb, Marcello, Silverstein, Xie et al., 2012). There was a marked improvement in fidelity ratings demonstrated by therapists who treated clients in both years of study implementation (n = 3), with an overall mean rating of 17.64, or 98% to the treatment protocol by the second year of the study. Consistent with hypotheses and previous research demonstrating the efficacy of CBTgsh for reduction in recurrent binge eating, last-observation-carried-forward intent-to-treat analyses indicated a significant reduction in binge eating episodes from baseline to post-treatment, as measured using weekly reported binge frequencies, t = 3.497, p < .005, an outcome which showed a large effect size (d = 1.20). Similarly, client's depressive symptoms as measured by the PHQ-9 showed a significant reduction from baseline to post-treatment, t = 3.415, p < .006, and a large effect size (d = .99). The more conservative imputation method of baseline-observation-carried-forward analyses revealed similar trends for reduction in both binge eating and depressive symptoms from baseline to post-treatment but these reductions failed to meet conventional levels of significance, likely due to the high rate of premature

drop-out in the present study, which may have skewed post-treatment results due to the small sample size, therefore obscuring week to week reductions in binge frequency and depressive symptoms.

It was also hypothesized that therapist attitudes toward manual-based treatments would be positive and may improve over the course of Year 1 of implementation. Consistent with hypotheses, therapist attitudes toward manual based treatments were very positive (low negative process and high positive outcome scores), at both baseline and post-Year 1. No significant changes in either negative or positive attitudes toward manuals were seen from baseline to post-Year 1, likely due to a ceiling effect at baseline. Interestingly, one sample *t*-tests revealed that therapists' *negative process* scores at Time 2 (23.00) did not significantly differ from the *negative process* scores of a large national sample (n = 415) of CBT-oriented, APA-member clinicians (M = 26.94), (Addis & Krasnow, 2000), t = -2.25, p = .074, though the present study therapists' mean scores trended lower (less negative) than the national mean. This pattern was replicated with *positive outcome* scores at Time 2 (25.50) compared to the large national sample of self-identified CBT oriented clinicians (M = 22.39), t = 0.59, p = .575. More positive attitudes toward treatment manuals are expected from clinicians who identify with a CBT orientation, as the majority of available treatment manuals exist for CBT-oriented therapies (Addis & Krasnow, 2000). An additional one-sample *t*-test demonstrated that the present study therapists' *negative process* scores at Time 2 were significantly lower than mean *negative process* scores obtained from therapists who rated their first experience with a treatment manual as "negative," (Addis and Krasnow, 2000), (M = 36.26), t = -7.57, p < .001. These comparative findings add support to the assertion that

staff therapists in this study held positive attitudes toward the use of treatment manuals, a finding which is noteworthy given that only two of the study therapists in the present trial identified primarily with a cognitive-behavioral orientation.

Additionally, it was hypothesized that therapist and client pretreatment expectancy ratings of CBTgsh would be high. This study utilized therapist attitudes and therapist and client pretreatment expectancy as proximal measures of CBTgsh *acceptability,* which Proctor and colleagues (2011) characterize as the perception on the part of various implementation stakeholders, such as providers and consumers, that a given treatment or service is palatable and agreeable (Proctor et al., 2011). Both therapist and client baseline expectancy ratings for treatment success were high, with therapist mean baseline expectancy rating of 23.9/27 (with higher scores indicating a more positive expectancy) and a mean expected rate of client symptom improvement over the course of treatment of 75-80%. Client mean baseline expectancy was similarly high, with 23.4/27, and an expected reduction in symptoms of 75%.

Sustainability within CAPS

The guiding aim for the current study was to respond to a request for training in CBTgsh expressed by our community partners at CAPS as well as for assistance in establishing a sustainable program of CBTgsh treatment delivery in their setting after the conclusion of the Zandberg and Wilson (2012) study. At the conclusion of the present study, 6 providers (including the DOT) at CAPS have been trained to implement the treatment within the CAPS setting, twice yearly (fall and spring) CBTgsh trainings as well as Fall and Spring staff meeting announcements to remind CAPS providers of the CBTgsh service have been embedded into the organizational calendar, and the CAPS

predoctoral internship program has created a CBTgsh optional minor rotation. Satisfaction rates were high on the small number of completed post-treatment assessments, and though a more meaningful analysis of satisfaction questionnaires was precluded, qualitative comments relayed by the study therapists to the DOT indicated both a high level of satisfaction with the program, and a high degree of likelihood of continued use after the study. It is notable that the DOT and study therapists maintained these attitudes despite the low number of recruited patients and the relatively high number of treatment non-completers. This exploratory anecdotal finding is supported by study therapists' positive attitudes toward treatment manuals, which was maintained over the course of study implementation, as well as by high positive baseline treatment expectancy ratings made by both clients and therapists. It is likely that program satisfaction was enhanced by the previous relationships formed between Zandberg and Wilson with key CAPS stakeholders during the 2012 trial where CAPS therapists served as referral sources, as well as by the PI's own collaborative relationship building for the present study. The PI's attendance at several staff meetings served multiple purposes beyond promotion of the study, including "giving a face" to the researchers on site, building a solid working relationship between researchers and CAPS practitioners, and demonstrating that CAPS treatment priorities were of utmost importance to the research agenda.

Limitations

As aforementioned, all of the above results can be best characterized as initial pilot data and should be interpreted with caution due to various limitations, the most notable of which include the small sample size (n = 6 therapists who treated at least one

client, and *n* = 12 clients), the relatively low rate of client retention (41.7% of clients completed at least 8 sessions), and the subsequently low rate of post-treatment assessment completion (*n* = 3) which precluded analyses using the EDE-Q as well as more meaningful analysis of post-treatment satisfaction. Furthermore, scheduling constraints and study therapists' weekly caseload resulted in unequal assignment of treatment cases across therapists, which may have biased results. The aforementioned limitations are discussed in detail below, as they posed the most significant challenges in the present study, with recommendations for amelioration in future research. Other limitations of the present study, which are more typical in effective studies and implementation research include lack of a control condition, which allows for the possibility that factors independent of CBTgsh treatment were responsible for observed clinical improvements, even though evidence suggests that eating disorders are usually non-responsive to standard waitlist control conditions (Carrard et al., 2011; Fairburn et al. 2009). Additionally, the present study had relatively few exclusion criteria, and permitted client participants access to concurrent psychological and psychiatric treatment to address comorbid issues. While exclusion criteria were minimized intentionally, both to facilitate the generalizability of the present findings to other real-world clinical settings and conditions and to remain faithful to a true community participatory approach to the present research, such concurrent treatments have the potential to confound results.

Enrollment and Retention

The low number of client referrals (*n* = 21) proved to be a major challenge in the present study. While researchers agree that implementation efforts are plagued by a "small n" problem (Proctor et al., 2009), the present study had expected to recruit more

clients over the two year study period. The low recruitment rate is even more difficult to explain given both Zandberg and Wilson's (2012) 44 referrals from Rutgers CAPS of a nearly identical demographic over a similar time frame, as well as by research identifying eating disorders as among the most common presenting problems at university counseling centers (Zivin et al. 2009). It is possible that a change in the demand for this particular service at CAPS occurred between the closing of enrollment in the Zandberg and Wilson trial in March 2012, and the opening of enrollment in the present trial in September 2012. In other words, the high number of patients treated with CBTgsh over the two years preceding the current study may have decreased the referral pool.

Another possible explanation for low client recruitment in the present study was the CAPS center-wide triage protocol for new clients. This process involves an initial phone screen and assignment to a CAPS provider for an "extended appointment" (EA), which includes an initial evaluation and generation of a treatment plan, which typically involves some type of individual therapy follow-up with the provider who conducted the EA and may also include referrals for concurrent services (such as psychiatry, seeing a medical provider at university health, or for group therapies available at CAPS). Both triage screeners and providers conducting EAs were encouraged to refer students presenting with recurrent binge eating (at either the triage or EA stage) to the DOT for assessment. However, given that recurrent binge eating is frequently comorbid with other psychiatric disorders, such as mood or anxiety disorders, it may be that CAPS providers conducting the EAs conceptualized cases in the context of different presenting problems, and saw recurrent binge eating as relatively low on the priority list for treatment. Concurrent psychological treatment to address comorbidities, such as depression, during

treatment for recurrent binge eating is not contra-indicated (42.1% of patients in Zandberg and Wilson study received concurrent psychological treatment while being treated with CBTgsh), and students seeking treatment at CAPS frequently utilize concurrent services (i.e. individual therapy and psychiatric medication management or individual therapy and group therapy). However, though this use of services is possible, it is not standard practice at CAPS for students to be referred for concurrent individual treatment by two separate staff therapists. This issue may have reduced referrals to the in-house CBTgsh program by providers conducting EAs in the present study, and was not an issue in the Zandberg and Wilson trial which provided CBTgsh as an adjunctive service at a different clinic.

Of note, the low referral rate represented more of a problem to the research team than to the DOT or study therapists, for whom treating a specific number of patients with CBTgsh within a given time frame was less crucial than becoming trained in provision of this treatment with the long-term goal of establishing this service as sustainable within CAPS.

In addition to low recruitment, treatment retention in the present study was low, with only 41.7% of clients completing at least 8 treatment sessions, with a subsequently low completion rate of post-treatment assessments including the EDE-Q and satisfaction questionnaires. This treatment completion rate compares unfavorably with the 76.3% retention rate in Zandberg and Wilson (2012). Changes initially implemented to increase treatment retention were designed to address client ambivalence over the course of treatment and improve the follow-up procedure after a missed session. Subsequent Year 2 changes included specific training strategies for recognizing and addressing client

ambivalence during treatment within the training refresher (see Appendix E, "motivation"), as well as the establishment of a more immeidate follow-up protocol than is standard CAPS practice after a missed session (see Appendix E, "Follow-up Protocol/Drop-Out Prevention"). Study therapists were also encouraged to reschedule missed sessions as quickly as possible, and the DOT enacted an "understudy" system whereby the DOT would conduct the missed session if a study therapist was unable to reschedule in timely fashion. Though retention did improve over Year 2 (4 of the 5 treatment completers finished treatment subsequent to the implementation of Year 2 changes), the exact contribution of these changes to the improved retention rate is precluded by study design and confounds.

It is also possible that the low retention rate reflected a difference in sample from the Zandberg and Wilson (2012) study. Clients who participated in the Zandberg and Wilson study first presented and were assessed at CAPS, were then referred to the off-site study, and attended an additional off-site assessment interview with one of the authors (L.J.Z) to determine eligibility before being assigned to a CBTgsh doctoral student therapist and beginning treatment at an offsite location (GSAPP psychological clinic). It is possible that motivation for and investment in treatment was higher for this sample, given the more burdensome nature of the process, compared to the present study's sample who received all treatment at CAPS. In 2011, DeBar and colleagues noted a similar possibility when attempting to explain lower rates of binge abstinence and session attendance in an extension and replication of CBTgsh for binge eating in a more real-world setting (large, west coasted-based HMO) compared to their previously conducted randomized controlled trial.

Given that the mean number of CBTgsh sessions attended in the present study was 6, it is also possible that a 10 session model of CBTgsh over 12 weeks had low feasibility and/or acceptability by clients in the present trial. Indeed, the 10 session model over 12 weeks was challenging to accommodate in an academic semester schedule at CAPS, which could have affected both retention and enrollment. Zandberg and Wilson (2012) noted the feasibility of this model within the confines of an academic semester. However, several notable differences in the present study posed challenges that were not encountered in the 2012 trial, namely the difference between schedule availability of full-time employee staff therapists at CAPS compared to the wider schedule availability of doctoral students. These differences in availability are particularly important with regard to rescheduling missed appointments, and working with a student's schedule around busy times of an academic semester (i.e., midterms, finals, breaks, etc.). Taken together, time needed for triage, assessment, assignment to a therapist, and potential scheduling conflicts over the course of the treatment, may indicate that a 10 session model of CBTgsh over 12 weeks is not practical within the confines of an academic semester (typically 14-16 weeks) within a university counseling center. Prior research investigating guided self-help for recurrent binge eating has demonstrated that protocols using fewer than 10 sessions have nonetheless been effective in reducing symptoms—Mitchell et al. (2011) used 8, 20-minute sessions over 18 weeks; Ghaderi (2006) and Ghaderi and Scott (2003) used 6, 25-minute sessions over 12 weeks. Given these findings, as well as the mean number of sessions attended in the present study (if used as a proxy for an acceptable number of sessions by client consumers), a 6-8 session model may be more feasible and acceptable in this setting. Alternatively, modifying CBTgsh to

be conducted in group format may be an interesting option, particularly within CAPS, where many types of group treatments are offered, frequently concurrent with individual therapy. In 2009, Peterson and colleagues demonstrated the effectiveness of a group cognitive-behavioral therapy (both therapist-led and self-help) in the reduction of binge eating, with results that were maintained through 6 month follow-up. In the CAPS setting, group treatment might address some of the aforementioned challenges, such as with academic calendar scheduling (group may have period of open enrollment and then close for remainder of the semester), and would represent a cost-effective alternative given the need for fewer providers reaching more clients simultaneously.

Fidelity, Training, and Supervision

The low enrollment and retention resulted in a low number of overall treatment sessions in the present study and affected the sample of recordings rated for fidelity to the treatment model. A larger sample of treatment sessions may have contributed to more accurate estimations of therapist's fidelity to the manual. Ratings of fidelity are common in treatment outcome research, and are also supported and recommended by implementation science (Fixsen et al. 2009) as a way to assess the use and outcome of skills taught in training and reinforced through ongoing coaching and as indicators of implementation progress. Although the present study resulted in a relatively acceptable level of fidelity (63.6%) during Year 1 of implementation, examination of ratings in the specific domains assessed by the fidelity measure indicated consistent difficulty with several areas which are obscured by the overall fidelity mean scores. These areas included difficulty in maintaining session focus on the eating disorder, addressing client ambivalence, overall session organization, and guided review of self-monitoring records

pursuant with the given program step. These issues, as well as individual therapist feedback, prompted the institution of the training refresher (Appendix E) prior to the start of Year 2 which included specifically targeted training materials to enhance treatment fidelity, particularly in areas noted to be problematic in Year 1 session review (Appendices E – G). Additional training materials also included the "audio library" which provided recorded role play scenarios of treatment challenges at each program step (Appendix H).

The audio library was met with very positive feedback from study therapists and the DOT and is in line with recommendations from Pearce et al. (2012) regarding the success of "blended learning" techniques in effective TTT models. Although the treatment design does not permit determination of the exact contribution of the training refresher on improving therapist fidelity scores due to confounds of time and experience, it is possible that provision of such training materials improved therapist ability to achieve higher levels of fidelity to the protocol. It may be that more specific and detailed training materials (such as an audio library and precise instructions on dealing with treatment challenges in a manner consistent with the protocol) become increasingly important with each subsequent cascade in the TTT or pyramid model of training. That is, as contact with the original treatment expert is reduced, expert-verified specific training materials can serve as a proxy for expert consultation and involvement in service provision.

Supervision is an additional training tool within the context of a TTT model, which provides necessary support and targeted feedback to assist in proper administration of the desired intervention with the potential to impact therapist fidelity to the treatment

manual. Referred to as “ongoing coaching and consultation” within the Core Implementation Components framework, ongoing supervision is seen as necessary in promoting behavior change in human service implementation (Fixsen et al., 2009), a fact that is also supported by therapist training literature which points to the superiority of training models that incorporate ongoing supervision after initial workshops or training (McHugh & Barlow, 2010; Miller et al., 2004; Cucciare et al., 2008). The PI and expert trainer recommended that the structure and style of supervision in the present study mirror actual CBTgsh treatment sessions, with agenda setting, and references to the companion book, workshop materials, and treatment manual to address problems, concerns, or questions raised by study therapists. These recommendations were consistent with the style of supervision used in the Zandberg and Wilson (2012) trial, with one notable difference—DOT review of audio recorded sessions to guide supervision meetings was not feasible due to time constraints in this setting. Without session recordings to supplement supervision meetings—instead replaced by the PI’s random review of session recordings used to generate aggregate feedback for consultation meetings—it is likely that valuable opportunities for coaching study therapists on administration of CBTgsh were lost. During Year 1, thrice-monthly supervision meetings were more similar to *consultation* and discussion among CAPS CBTgsh team members rather than feedback-based supervision as originally suggested by the first cascade in the TTT model used in Zandberg and Wilson (2012). The style into which CAPS CBTgsh supervision meetings evolved is consistent with multiple other consultation groups held at CAPS by varying providers addressing specific issues. This evolution may have occurred because CAPS study therapists are more familiar with seeking consultation,

rather than feedback-based supervision, at their current level of practice in CAPS (study therapists were not "trainees" outside of CBTgsh and were all licensed practitioners).

Changes instituted prior to Year 2 included modification of supervision meetings to re-focus on skills practice and session feedback guided by the CBTgsh protocol. Audio library recordings and role play scripts were used to structure supervision meetings around relevant treatment interventions and skills—a task facilitated by the stepwise nature of CBTgsh (i.e. supervision meeting focused on Step 3 of the program, when one of the study therapists was preparing for a Step 3 session). The DOT asked study therapists to listen to a specific audio role play from the library before meetings, so that the clip could be discussed and behavioral rehearsals practiced during supervision. Additionally, study therapists were encouraged to use the library of role-plays as examples of how to administer the treatment in a manner consistent with the protocol and as standards for comparison of their own CBTgsh sessions. Using standardized treatment scenario role-plays in this manner may be a potential solution to the challenge posed by the inability to review session recordings given time and setting constraints. These Year 2 supervision changes were consistent with the approach suggested by Fixsen et al. (2009), where the supervisor/trainer acts as coach, providing trainees with advice, encouragement, and opportunities to practice specific skills (2009). This recommendation corresponds well with both the role of the CBTgsh therapist in the therapeutic relationship, as well as with literature on training and supervision methods that encourage active learning and experiential/behavioral rehearsal (Beidas and Kendall, 2010).

Future implementation efforts using the TTT model should give early priority to training the trainer on how to *supervise* (not just train) trainees in a given treatment, and

should consult with the trainer to ensure that such supervision is acceptable in the setting and with staff. Indeed, research has suggested that specific training in how to supervise the delivery of an evidence-based treatment is required for successful implementation, even for trainers who have experience in supervision of other treatments (Rapp et al., 2010; Bruns et al., 2008). It is possible that the present study's "supervision training" of the DOT could have been enhanced with audio library supplements as additional tools to aid evaluation of treatment sessions. Alternatively, initial DOT training could include a "mock supervision" meeting to serve as a model, where a treatment expert might facilitate supervision of a CBTgsh session. Clearly, more research is needed into the exact content, style, and dosage of supervision necessary for effective implementation. The use of standardized patient scenarios or role plays as assessment tools to evaluate therapists' fidelity to the protocol and competence in administering the treatment may facilitate future determination of training success, even when few patients are treated. Such evaluations are common in medical education and are gaining increasing attention for use in therapist training (Fairburn & Cooper, 2011).

Future Considerations

Despite the present study's limitations, Fixsen and colleagues (2009) note that "each attempted implementation of a program reveals barriers that need to be overcome and their (eventual) solutions" such that unforeseen issues that arise at various stages of implementation may be found to have been "preventable with different actions earlier in the implementation process" (p. 537). The final aim of the study was to provide a preliminary "roadmap" to guide future implementation efforts in university counseling centers, particularly with use of CBTgsh within a TTT model. The importance of using a

guiding implementation framework cannot be overstated (Fixsen et al., 2009; Proctor et al., 2009). Though all facets of the Core Implementation Components framework are crucial to implementation, the present study demonstrated the paramount importance of *decision support data systems*, or rather, the feedback loop between the onsite trainer and the research/implementation purveyor. That feedback loop between the PI and the DOT was comprised of ongoing fidelity monitoring which informed ongoing consultation. The reduction in frequency of consultation over the course of the two year study lends support to the idea that early stages of implementation require more intensive consultation on the part of the program expert and implementation purveyor (in this study, the PI) (Fixsen et al., 2009).

The feedback loop also highlighted the need for, and spurred creation of the "training refresher" as well as the "Year 2 Implementation Guide" to address challenges which arose during year one. The creation of these adjunctive training materials (appendices D-F) as well as the generated CBTgsh audio library (Appendix H) to supplement the original training workshop and materials is perhaps this study's most significant contribution. Indeed, challenges observed in Year 1 highlight the potential need for more specific and intensive training materials in later cascades of the TTT or pyramid model of training, as well as the need for more explicit focus on supervision training in the context of evidence-based treatments, perhaps in the form of disseminable materials (i.e. standardized recordings) to guide supervision in the absence of audio recorded session review by onsite trainers and supervisors. The feedback loop also highlighted challenges that may be encountered in future research in a university counseling center setting or similar settings, including 1) specific triage and assessment

protocols that may affect enrollment numbers in a research trial, 2) scheduling constraints on the part of both client and full-time counseling center staff therapists who manage large weekly caseloads, and 3) the difficulties posed by an academic semester schedule, particularly in research studies requiring a certain number of sessions with specific spacing protocols.

Future implementation research in university counseling centers should consider using brief treatment protocols (such as the aforementioned 6-8 session CBTgsh) or differing formats (i.e. group treatments) to better accommodate semester scheduling and potentially improve treatment retention. Additionally, future studies should investigate center-wide initial screening, triage, and therapist-assignment protocols in advance of formalizing research study design, given the possible implications for low recruitment and enrollment. Training in specific assessment procedures at varying levels of the organization, perhaps even outside of specific study therapists, may be indicated to ensure that an adequate sample is identified for treatment. In addition, organization-wide advertisement of a program should begin far in advance of the opening of study enrollment. Finally, future implementation efforts should be approached using a community participatory research model facilitated by an organizational stakeholder. The research study and PI's presence at CAPS was facilitated by the DOT, demonstrating the close collaboration between the implementation/training consultant and the onsite trainer. This likely allowed the research agenda to "piggyback" on the existing organizational trust in and respect for the DOT and is likely one of the reasons why choosing an organizational stakeholder as the onsite purveyor of a new program is key in promoting implementation in new settings (Proctor et al. 2009).

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Table 1

Therapist Characteristics

Therapist ID	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*
Age (years)	29	--	71	48	27	42	--	37
Degree	PsyD	PhD	PsyD	PsyD	MSW/LCSW	PsyD	PsyD	PsyD
Years of Psychotherapy Experience	1	22	8	15	4	12	15	15
Avg. Weekly Caseload	20	27	--	15	--	--	15	15
Orientation (primary)	CBT	dyn.	dyn	other	CBT	dyn.	dyn	other
Prior training in manual-based tx?	Yes	Yes	No	Yes	Yes	Yes	No	No
Prior training in Eating disorder tx?	Yes	Yes	Yes	No	Yes	No	Yes	No
Confidence in Treating Eating Disorders (0-10, 10 “extremely confident”)	9	6.5	5	5	7	2	8	3

Note. Years of experience in psychotherapy indicates years of experience in conducting psychotherapy since terminal degree. Psychodynamic orientation is abbreviated as “dyn”.

Table 2

Therapist Flow and Number of Clients Treated

Therapist ID	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*
Completed Training 1?	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes*
Completed Training 2?	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Number of cases treated**	4	2	1	1	4	0	0	1

Note. Therapist 17 audited initial training sessions in September 2012, but was not formally consented as a study therapist until Spring 2013 after staff turnover, due to semi-permanent status in CAPS organization. "Cases treated" refers to the number of cases a therapist treated for at least one session.

Table 3

Therapist Fidelity Ratings

Therapist ID	*10*	*11*	*12*	*13*	*14*	*17*
Year 1: Fidelity *M* (SD)	*11.75*(.96)	*10.33*(.58)	*11*(.00)	*15*(.00)	*12*(1.00)	*10.67*(.58)
Percent Fidelity	65.3%	57.4%	61.1%	83.3%	66.7%	59.3%
Year 2: Fidelity *M* (SD)	*17.60*(.56)	*18.00*(.00)	--	--	*17.57*(.53)	--
Percent Fidelity	97.8%	100%	--	--	97.6%	--

Note. Therapists 12, 13, and 17 did not treat a CBTgsh client in Year 2 of study implementation, and therefore Year 2 fidelity scores were not able to be calculated.

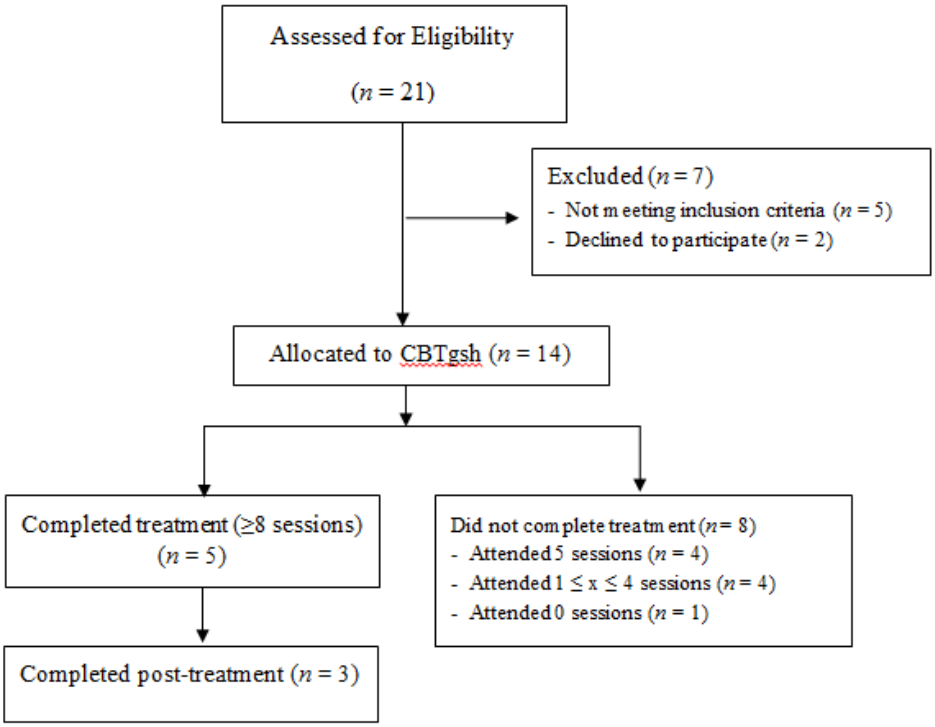
Table 4

Baseline Participant Characteristics

Characteristic	Patients (N = 12)	
	N	%
Female	10	83.3
Ethnicity		
Caucasian	6	50.0
Latina	2	16.7
Asian	2	16.7
South Asian	1	8.3
Biracial	1	8.3
Education		
First year	2	16.7
Sophomore	1	8.3
Junior	5	41.7
Senior	3	25.0
Graduate student	1	8.3
Prior eating disorder treatment (inpatient or outpatient)	1	8.3
Concurrent psychotropic medication	5	41.7
Concurrent psychological treatment	6	50.0
	Mean	*SD*
Age	20.42	*1.78*
Body Mass Index	28.24	*4.90*
PHQ-9	14.58	*6.10*
EDE-Q Binge Frequency (preceding 28 days)	15.25	*11.57*
EDE-Q Weight Concern	4.35	*1.46*
EDE-Q Shape Concern	4.51	*1.65*
EDE-Q Eating Concern	3.75	*1.43*
EDE-Q Dietary Restraint	3.08	*1.37*

Note. Body Mass Index was calculated using the following equation: [(weight lbs) / (height inches)^2] * 703. PHQ-9 is the Patient Health Questionnaire which measures depressive symptoms (Kroenke, Spitzer, & Williams, 2001). EDE-Q is the Eating Disorder Examination Questionnaire (Fairburn & Beglin, 2008), a self-report assessment of eating pathology. EDE-Q Weight Concern, Shape Concern, Eating Concern, and Dietary Restraint entries represent subscores produced by the overall EDE-Q.

Figure 1. Schematic presentation of referral, enrollment, attrition, and assessment completion



Appendix A

CBTgsh Therapist's Checklist

(Developed by L.J. Zandberg for use in Zandberg and Wilson, 2012)

STARTING WELL

Did you…

- State the session number and remaining number of sessions?
- Briefly (< 5 minutes) assess Ct's progress on assigned targets from the previous week?
- Summarize Ct feedback and note any areas of non-compliance as important to address later in the session?

THE WORK

- Review two monitoring forms (good day, bad day)?
- Highlight all marks of adherence? Can you enhance your attention to and reinforcement of Ct compliance and progress?
- Guide the Ct to notice patterns and departures from program guidelines? E.g. "What might you have done to make this more consistent with (Step _)?"
- Address questions and non-compliance with reference to the book (i.e., "what does the book say about that?"). Did you highlight rationale and encourage a temporary experiment (e.g. "would you be willing to try this week and really test this out")?

ENDING WELL

- *If moving on:* Provide brief orientation to next step and agree upon when Ct will start?
- Ask Ct to summarize/set targets based on your conversation (and enhance the specifics, if necessary)?

STYLE

Did you….

- Remain supportive and instill hope?
- Validate and normalize Ct concerns/problems (before addressing them)?
- Take non-compliance seriously, by noting it and non-judgmentally assessing 1) what got in the way, and 2) how it can be changed?
- Show expertise by referring as appropriate to the literature, research, or clinical experience (as detailed in the book)?

Appendix B

Guided Self-Help for Binge Eating at CAPS Research Procedures

Patient Folders:

Pre-assembled patient folders will be stored on top of the electronic safe.

a. All of the necessary materials for a Guided Self-Help patient can be found in the patient folder. Each therapist should take patient folder for each of their Guided Self-Help patients.

b. Each patient folder is labeled with a number—this will serve as the Client ID. The Client ID is to be used *instead of* the client's name on all research measures.

c. Each patient folder contains labeled tabs to facilitate administration of measures to both patients and therapists at the appropriate time points.

(Before) Session 1:

1. Before session 1, administer the

    a. **TPQ/PHQ-9 (all one form)**

    b. **the Patient Demographic Form**

        i. Can be found in the "Session 1" folder (labeled "pre-session)

        ii. *Make sure to label each measure with your Therapist ID, the Client ID, the Date, and "GSH Session 1" in the appropriate places on the top of the form* (*this should be done for each measure that you and your patient complete*).

2. Audio record the session

a. Before you begin the session, say the session number, date, and the therapist and client IDs into the recorder. (i.e. This is GSH session 2, on 9/15/12, with Therapist 11 and Client 010).

b. Make sure to record each patient's GSH sessions in the same file (either A, B, C, or D) in your digital recorder.

c. Make sure to have back-up batteries on hand for your digital recorder!

3. Client takes home:

    a. Monitoring records and Instructions for monitoring (paper-clipped and labeled "Client Take-Home" in Session 1 folder)

4. After session 1, administer the

    a. **Client Pre-treatment Expectancy Questionnaire** (labeled "Post-Client")

5. After session 1, you *the therapist* must fill out the

    a. **Therapist version of the Pre-treatment Expectancy Questionnaire (**labeled "Therapist Post"

Self-monitoring records…

…can be found in each Session folder within a complete Patient folder

- Remember your client 7 self-monitoring records at each session 1-7. (There are extra in the back of each patient folder).

- At Sessions 8 and 9, your client gets 14 records, as these sessions occur bi-weekly.

(Before) Sessions 2-10:

1. Before the session administer to the client the:

    a. **TPQ/PHQ-9**

i. These forms can be found in each session folder within a larger patient folder (i.e. Session 2, Session 3, etc.)

2. **BEFORE SESSION 5:**

    a. Note that in the patient folder tab, "Session" there are Client and Therapist versions of a Mid-treatment Expectancy Questionnaire (in addition to the regular TPQ and PHQ-9) to be filled out AFTER Session 5.

3. **BEFORE SESSIONS 9 AND 10:**

    a. Make sure your patient completes two TPQs (only one PHQ-9 is necessary)for each of these sessions (as they are held bi-weekly)

After each GSH session:

1. Return completed and labeled questionnaires to the CAPS ED electronic safe, located in the therapist mail room. Combination: _____

    a. All measures can be put in the same folder once in the safe, but please make sure that each measure is labeled with both Client ID and Therapist ID, date, and session #.

2. Before each Wednesday evening (at approx 5:30 pm), please deposit your GSH digital recorder in the CAPS ED safe. You may pick it up in on Thursday morning.

After GSH Session 10:

1. After the session, give the patient:

    a. **The Eating Disorder Examination Questionnaire (EDE-Q)**

    b. **Patient Treatment Satisfaction Questionnaire**

2. After the session, *you the therapist* must complete the:

a. **Therapist Treatment Satisfaction Questionnaire**

Confused about what to administer when?

1. Refer to each Patient Folder
    a. There will be a tab for each GSH Session 1-10 that includes all the measures to be administered (to both patient and therapist) for that session.
2. Ask Tricia or Julia to clarify

Appendix C

Consultation Themes

First Semester of Implementation (Fall 2012):

1) Trouble-shooting research procedures

2) Logistical considerations regarding transfer of files and assessments

3) Report on enrollment and specific client progress/session number

4) Questions regarding specific training topics encountered during the workshop and in subsequent group supervision.

Consultation meetings as well as impromptu phone contact (occurred approximately 1-2 times per month) allowed for close collaboration between the study PI and DOT regarding challenges to implementation and issues that arose with training and treatment delivery.

Second Semester of Implementation (Spring 2013):

1) Troubleshooting low client enrollment and retention (issues that had become evident throughout the Fall 2012 semester)
2) Focusing on way to improve the fidelity of treatment sessions to the CBTgsh protocol
    a. i.e. implementation of strategies to enhance client motivation and resolve ambivalence
    b. how to manage/address crises that arose during CBTgsh treatment that were unrelated to eating disorder
    c. challenges to maintaining weekly appointments directed by protocol in the context of an academic semester.

Consultation throughout the Spring 2013 semester revolved primarily around challenges that arose during the first and second semesters of implementation with the goal of addressing such challenges during the second year of implementation. The product of Spring 2013 consultation meetings are the aforementioned CAPS CBTgsh Year 2 Guide and the CAPS GSH TTT Training Refresher.

Second Year of Implementation (Summer 2013 – Spring 2014)

1) Update regarding enrollment and advertisement of the study within CAPS

2) Updates on progress of study clients and appropriateness of clients to begin treatment or continue treatment

3) Review and feedback regarding Year 2 training materials and new follow-up protocols to enhance retention

4) issues regarding scheduling and subsequent "understudy" system

5) updates on program penetration in the CAPS organization and organizational indicators of sustainability after study conclusion.

In June 2013, in-person consultation meetings transitioned to monthly consultation phone calls.

Appendix D

CBT-GSH Fidelity Rating Form

Therapist ID: **Client ID:** **Session #**

Date:

1. **Did therapist orient the patient to the session?** [Therapist notes which session it is (e.g. "*today is our third session, we have five more sessions left" or "after today, we will be meeting every other week," "today is our last session…"); if first session, therapist explains how the first session will work*]

   0 ____Did not orient

   1 ____Some orientation, or started session first then went back to orient

   2 ____Oriented patient at beginning of session; nearly complete / complete orientation

2. **Did therapist introduce (if first session) or review (if later sessions) the self-monitoring forms?**

   0 _____Did not introduce/review monitors

   1 _____Introduced/reviewed monitors not focused on current step; therapist directed vs. collaborative

   2 _____Introduced/reviewed monitors focused on current program step; collaborative review

3. **Did therapist introduce (if first session), or discuss/review (if later sessions), the checklist?**

   0 _____Therapist did not review checklist

   1 _____Therapist asked about but did not assess complete review of checklist

   2 _____Therapist reviewed entire checklist with patient

4. **Did therapist introduce the next program step appropriately (according to the book) or, if applicable, discuss deferring the next step?**

   0 _____Therapist did not discuss next step/step deferment with patient

   1 _____Therapist did introduce next program step/deferment, but did so incompletely and/or uncollaboratively

2 _____Therapist introduced next step/deferment completely and collaboratively

5. **Did therapist praise the patient for attempts at implementing the self-help program?**

0 _____Therapist did not praise patient for attempts at program compliance

1 _____Therapist occasionally praised patient for attempts at program compliance

2 _____At almost every instance of compliance with program, therapist praised patient

6. **Did therapist encourage patient to use the book as a form of self-help? ("what does the book say?")**

0 _____Therapist did not encourage patient to refer to book; gave own advice contrary to book's stance, etc.

1 _____Therapist sometimes referred patient to book; asked what they thought they should do based on own advice

2 _____At almost every opportunity, therapist asked patient "what does book say about this?"

7. **Did therapist maintain a specific focus on the eating disorder throughout the session?**

0 _____Therapist allowed session to go off-track; non ED focus; asked non-ED related questions of patient

1 _____Therapist allowed non-ED discussion for part of session but eventually redirected to ED)

2 _____Therapist maintained session focus on ED; re-directed patient when necessary

8. **Did therapist address non-compliance, and in the manner outlined in the manual? (assess, validate/normalize, troubleshoot, generate solutions, pros/cons when necessary?)**

0 _____Therapist did not address non-compliance; or did so offhandedly or judgmentally

1 _____Therapist addressed non-compliance but didn't validate or help client generate solution

2 _____Therapist addressed non-compliance completely and in manner described in manual

9. **Did therapist maintain collaborative style?**

0 _____Therapist did not maintain collaborative style with patient in session at all

1 _____Some of session was collaborative with clear instances of non-collaboration

2 _____Therapist was collaborative at nearly every opportunity

Appendix E

CAPS CBTgsh TTT Project - Year 2 Guide and Training Refresher

Turbo-charging all cylinders to improve retention and outcome. Keep up the great work!

1. TRAINING
    a. Refresher course (one in June; additional training in September)
    b. Audio library
        i. Will be available to all study therapists through shared folder (copyright Julia West)
        ii. Idea is to enhance training on specific aspects of treatment
2. SUPERVISION / CONSULTATION
        i. Consultation meetings with study therapists will now utilize clips of GSH sessions from study therapists – assessing what went well, how on-protocol it is, what might be improved, any questions therapists might have
            1. Supervision/guidance of study therapists can be composed of comparing given session/section to the corresponding audio library entry.
3. INTAKE PROCEDURE
    a. Offer of concurrent services will be more formalized in intake
        i. Idea is to facilitate study therapist's reference back to concurrent therapy if crisis comes up
    b. Continued use of commitment strategies
4. FOLLOW-UP PROTOCOL / DROP-OUT PREVENTION
    a. Importance of making each and every session should be conveyed early (Session 1). (*see handout on sample 1 plan for specifics)*

b. In event of a missed session – GSH therapist contacts the client immediately (within scheduled session time) to follow-up with them regarding the missed session. This contact should include: 1) a phone call with a voicemail, and 2) an email. Note/ email should also be sent to Tricia to alert her to missed session…
    i. These contacts should be nonjudgmental and upbeat, i.e. "I didn't see you for session today and wanted to check in to see what had happened. I am really looking forward to hearing from you so we can reschedule very soon and stay on track!"
    ii. If no response from client within 3 days, then therapist should call / email again.
    iii. If no response within 2 days, Tricia needs to call /email.
c. Regarding anticipating drop-out
    i. **Near beginning of each GSH session – ask client:

    "How helpful are you finding this treatment to be? (0 – 5)"

        1. This is meant to assess the client's engagement in treatment.
        2. Note the score in the client note –
            a. **Any big change in the score in the negative direction should be addressed in that session to determine if client is at risk of dropping out.

CAPS GSH TTT TRAINER REFRESHER – SPRING 2013

1. Therapist Checklist (Starting Well, specifically)
    a. Role play (Client Re-direction during brief check in)
    b. Refer back to slides from Part II of Training (attachment)
        i. Starting well – 5 min
            1. How was your week (overall)? – this is a tricky one to use, particularly with a client who is talkative or has been in past sessions. You don't necessarily want to *not* include this question, as it could illuminate any broad stroke issue that you wouldn't want to miss, but don't get too caught up in the client's response to this question – lead by example (attention is aimed at eating disorder)
            2. Tell me about your program targets from the past week
                a. How did _(insert program target here)__ go?
                    i. GET SPECIFICS!! How many days did client adhere to Step or target as book prescribes
            3. *Check in briefly about recurrent tasks (i.e. review check-list, weekly weighing)*
            4. Summary statement and transition to "good day / bad day"
    c. Maintain focus on the CHECK-IN, providing brief areas of reinforcement for progress and "tabbing" areas of difficulty for later…

i. Ex: *"Five days of by-the-book regular eating? What great progress! I can't wait to see that in action on your monitoring. How about weekly weighing…"*

ii. Ex: *"Hmm, so it sounds like several factors got in the way of your planned snacks this week. This can be a tricky step to get started on, so let's definitely make time today to talk about how to improve your regular eating. What about weekly weighing, how did that go?"*

iii. In the face of questions, comments, or other diversions during the check – in, Acknowledge that they have questions, but ask client if s/he is willing to allow you to take a snapshot of the week for big picture purpose before jumping in and problem-solving issues that have come up.

1. It's all about orienting the client to how you do things—once you have established this, it will become easier to implement, even with a talkative client

iv. Monitoring review / addressing problems – 15 min

v. Ending well – 5 min

1. **Re-orient patient to structure of patient if necessary even after initial orientation at outset of Session 2

d. Practice "tabbing" issues for later

2. Session 1 agenda in detail (handout)

a. If therapist and client are concerned about all of the Step 1 tasks getting done, therapist may prioritize the tasks AS LONG AS monitoring and weighing are established…

b. FIRST SESSION should ABSOUTELY include the phrase – "This treatment is one in which the more you put into to it, the more you get out of it...You are the driver of this program – it is up to you how far this treatment takes us."

3. Special Notes on *Self-Monitoring:*

a. Therapist should NOT set up expectation that the work for this program is overwhelming. Rather, elicit from client how confident they feel about the work involved, troubleshoot if necessary (you can validate in that "many people find that although the monitoring may seem a bit taxing at first, it gets much easier within a couple weeks".

b. Remember, Monitoring is the most important homework assignment in Step 1 – make sure that it is presented as such!!

c. Instructions for monitoring (Fairburn Handout)--REVIEW

d. Guidelines for in-session review of monitoring records (handout)

i. This should help guide you as to how to structure the good day / bad day review of monitoring records in an organized way during the session, while maintaining focus on the program step.

4. Addressing non-compliance

a. Assessment (brief) – validation/normalization – highlight RATIONALE (what does book say), expectations about treatment (i.e. we have seen this program be

effective for many people with your problem) and communicate confidence (we have every reason to expect it will be helpful to you, particularly if you give it your all) – address motivation (worth trying out? Pros/cons) AND/OR troubleshooting (what can be done?)

i. Set short-term goals (this week vs. the next 12 weeks)

ii. Focus on *specific behavioral changes*

iii. Ask patient to complete "why change" assignment (pp. 132-135)

5. Motivation

a. Increased use of in-session Pros / Cons of changing

i. WHEN TO USE IT?

1. Non-compliance on same task over multiple weeks (start on second week of not getting compliance on a given task)

2. Non-compliance across several tasks in a single week

a. Remember, priorities are LIFE, MOTIVATION, then PROGRAM STEPS

b. Setting up a pros / cons in session and assigning rest for homework (would audio role play help?)

i. Pro of maintaining status quo, con of maintaining status quo, con of changing, PRO OF CHANGING (END WITH THIS ONE)

1. This is done with a functional focus – what are the implications (consequences) of engaging in a particular behavior (e.g., dieting) or holding a particular belief (e.g., I must be thin)?

2. This pros/cons exercise can be done specifically (i.e. for a given step) or more generally (sticking with the program)

c. Anticipating a potential drop-out (sustained non-compliance on one thing or many tasks not done in a given week), attendance issue,

i. Better to do a pros/cons (remember, this is an exercise where the PATIENT articulates and makes arguments for and against, not the THERAPIST) to help address the motivational issue before a drop-out. This is a nice, non-confrontational way in which to do so.

1. *Remember, a pros and cons list can be started in a GSH session and assigned to finish for homework

6. Ways to increase collaboration

a. Have client say hw tasks back to therapist at end of each session

b. Ask client if they notice patterns ONLY IF YOU AS THERAPIST NOTICE THEM ON RECORDS

c. When a problem arises, ask clients for possible solutions before you the therapist bring them up—collaborative, can save time, and more likely to work since client is generating them.

7. Refresher of the Fairburn Manual for GSH (pdf version of Fairburn manual)

a. When NOT to move forward with program step

8. Misc. book issues

    a. i.e. What book says re: Meals vs. Snacks

        i. *If book doesn't address it, it is likely that this should not be a major focus.* i.e. (Especially in Step 2 – book doesn't say much about difference between meals and snacks. We say, "We use different words for meals and snacks, so they should look different" (at least in terms of quantity, i.e. a meal should be larger than a snack). We also typically engage the client who is having trouble deciding what is a proper meal or snack in some behavioral homework (i.e. what do friends/others eat for lunch/snack/dinner/etc.?) Otherwise, we refrain from giving advice about what to eat when, or what should compose a given meal or snack. The book specifically doesn't go into this because this type of nutritional counseling is typically outside the wheelhouse of most GSH providers, and is typically unnecessary to produce behavioral changes (i.e. cessation of binges/purges). For a client who is having a particularly hard time in this area (and who doesn't respond to the above suggestions), we would, in rare cases, refer them to the following pdf that gives general nutritional advice from an approved governmental website http://www.choosemyplate.gov/downloads/mini_poster_English_final.pdf

        Any advice on specific content of meals and snacks is usually beyond the scope of GSH. Consult with the study trainer in these cases as to how this particular issue might be dealt with in a manner that is consistent with the protocol.

Appendix F

CBTgsh Session 1 Agenda in Detail

I'm going to give you an idea of what today's session will cover—and this is something I'll always do in our sessions, I'll always let you know what our plan will be.

Today's plan is to:

Orient you to tx and let you know what it will be like

20-25 min

That means start on time, focused on ED, you do bulk of work outside session

Tell you **what you can expect from me and the tx**, and **what I will expect from you**

Driver's seat (read and do best at tasks),

I'm in passenger seat to help with roadblocks/problems

This tx makes you your own therapist

We'll check in re: **what's been going on with your eating** and I'll get some info on that

End this with how it interferes/how life would be diff without it/goals

Then I'm going to **get you started on things** you can do this week to get going with tx—

Reading part 1

Reading part 2 intro and Step 1

Monitoring

One time weighing

Summary Sheet

Review Check-in

med appt check with Cheryl?

We're hitting the ground running, and not wasting any time! Sound good?

Also, I'm going to be talking a lot more than I usually will be, and giving you a lot of info today, so if you have questions or concerns at any point, please let me know!

Orienting to tx (5-10 min)

This is Session 1, we have 9 more sessions together.

Today we'll meet for about 45 min. But, for all the other sessions, we're going to meet for 20-25 minutes, which can go by quickly. So that means a few things:

1. We both need to make a real effort to be here on time, so we can start on time and have the full 25 min together.

2. We're going to be entirely focused on your eating disorder. We find that when we're really focused on the eating, it's the best way to make the most progress, and also, you might find that getting your eating disorder under control may put you in a better position to handle other things that may be bothering you.

3. Another thing that our 20-25 min sessions together mean is that:

    a. You're going to be doing the bulk of the work in this tx outside of the session, during the week. This is a guided self-help program, so most of the work is done by you, outside of the sessions, in your life.

You are really in control of this program, you're in the driver's seat, so to speak. Your role is going to be to read the sections we discuss here, and to be working your very hardest to carry out the tasks in each section.

My role is to be here to support you, troubleshoot any problems that come up along the way, help with your motivation or any stumbling blocks. I am in the passenger seat, so to speak.

So because you're driving, how far this treatment takes you is up to you—the more you put into it, the more you'll get out of it—how does this sound?

That's an overall picture of this treatment. The best part about doing treatment this way is that it's going to make you your own therapist, and set you up with the skills you need to keep this going indefinitely so you can live your life with an eating disorder.

At the end of today, I'm going give you the book and explain it and lay out exactly what you'll do this week to get started.

INFO GATHERING (10-15 min)

Why don't you give me an idea about what prompted you to start tx here and what's been going on with your eating?

Do some brief assessment of client's issues—what are the exact characteristics of their ED?

Why don't you give me an idea about what prompted you to start treatment here and what's been going on

with your eating?

How many times are you bingeing/purging per week? (Are binges both objective and subjective)

Any use of laxatives, diuretics, diet pills?

Any food rules? (calorie limit per day, foods you avoid completely or usually, dieting now?, shooting for weight loss now?)

Body checking/body avoidance behaviors?

Assess: frequency of each, types of purging, etc. Remember this is BRIEF—we have a lot of information from the assessment session already.

End the assessment phase with the questions below:

1. How is all of this getting in the way for you? Does it affect your relationships at all? School? Work? Etc.

   How do you think your life might be different if you get over this problem?

2. Elicit client's goals while in this treatment?

EMPHASIZE FOR CLIENT:

   a. You're in the right place!

   b. Progress isn't straight line…knowing yourself, will you be tempted to drop out? Commit to 10 sessions?

PART II: Introduce book: (20-25 min)

Give book:

Yours to keep! The GPS for the car you're driving in this treatment. I'll have mine every week, and it's a good idea for you to bring yours with you every week.

Part 1: Introduction and background info that will make you expert on your eating problem and the treatment of it. 130 pages long (p. 3-127) —I'd like you to read through it this week—knowing your workload, is that possible?

Part 2: Self-help portion of book:

Intro—talks about why to change (short but important to read)

6 steps that are the steps of the tx program

So this is the hit the ground running part—it's really important that you read the Why Change? Section and Step 1 as soon as you can—do you have time today to read that?

Each step involves tasks that you need to do—the 2 tasks for this week in Step 1 are to **self-monitor your eating** and start **weighing yourself** once and only once per week.

1. Self-monitoring—REALLY important—foundation of the tx—the gas in the car you're driving! The book outlines how to monitor in great detail and I also have an instruction sheet for you on how to do it. I'm going to briefly go through it with you right now as well.

   Real time, write everything down, explain columns

   Questions?

   Do you feel you'll do this everyday?

2. Weighing once per week

   a. Same day/around same time

      i. On board with this?

   b. Do you have a scale? Do you feel you'll be able to do this?

Ok, so those are the tasks for Step 1

I know this is a lot of info and that I'm doing a lot of talking—please let me know if you're lost or confused or have questions!!!

There are 2 things about all of the 6 steps that are the same:

Summary sheet—p. 154. Fill it out each week, explain columns

What is good day? (p. 155)

What is G/D for this week? (monitored, weighed if day to weigh)

Review check-in (p. 151)

Helps train you to be your own therapist

Schedule a time between sessions to sit down and go over checklist to see how

you're progressing in program…make sense?

WHEW! I know that was a lot!!! Let's make sure we're on the same page for what your tasks are for this week, so we don't waste any time!

Tasks for this week:

Reading part 1

Reading part 2 intro and Step 1

Monitoring

One time weighing

Summary Sheet

Review Check-in

Appendix G

CBTgsh for Binge Eating Guidelines for In-Session Review of Self-Monitoring Records

The overall goal is to form hypotheses on what factors contributed to binges on that day (using the program formulation to guide you), and how to correct those factors to prevent and eliminate binges/how to make a given day more compliant with the goals for that step of the program. A good review of self-monitoring records uses focused questions to prompt the patient to "prove the model" to herself/himself, based on her/his own monitoring forms.

General "How-to" Principles:

1. Review good day/bad day monitors in an organized fashion, for example by asking client to "walk you through" the day of eating.
    a. If client is very talkative or digressive — focus instead on guiding client with specific questions.

2. Begin review of good day/bad day self-monitors through the lens of the step the client is currently on. In other words, the step the client is on will dictate what you're looking for on any given monitor. See below for guidelines to help you review monitors on each step.

3. However, remember the program is cumulative! As you move on, you can use earlier steps to assist in the good day/bad day review.

    a. For instance, if the client is on Step 3, initial questions will inquire about alternative activities, but therapist should also ask questions about client's

regular eating on that day (and either praise compliance, or trouble-shoot what went wrong).

4. Do not be distracted by the Comments section—particularly in earlier steps (i.e. regular eating). Comments section can provide valuable information (particularly in Steps 3 and 4), but can also include material that may get you off-track in your review of records. Remember, review records through the lens of the step and the program model (review "overall goal" stated above). You do not need to address each comment written.

5. Avoid making the same point across monitoring records. Do it well once, and avoid repetition.

6. *If* you notice a clear difference between a client's Good Day and Bad Day that is in line with the model, ask the client questions to guide them to see the pattern—i.e. "Do you notice any differences in your eating on the Good Day vs. the Bad Day?"

Remember, whenever you review Good Day/Bad Day monitors, make sure to highlight any signs of adherence/compliance with program guidelines for that step!

**NOTE: When it's likely that a client knows a step well (spent a few weeks on the same step, or closer to the end of the program), allow the client to direct review of a Good Day/Bad Day, with questions like, "Looking at this day and knowing what you know from the book, what do you think may have contributed to your binge?" or "What could you change about this day to make it more compliant with the program guidelines?"

Remember, the goal is to make the client her/his own therapist, and to train them to identify patterns that set them up for a binge.

Ask yourself the questions listed below to help you process the client's records during in-session review of Good Day/Bad Day. Look at the records through the lens of the step the client is on, meaning, ask yourself the questions from the particular step first, but remember, the program is cumulative, so guidelines from earlier steps are fair game!

Bolded questions are sample questions to ask client.

Step 1: Self-Monitoring

Ask yourself the following questions while looking at client's records to guide processing:

Did client write down everything s/he ate?

Anything eaten that wasn't written down?

How soon after s/he ate it did s/he record it?

(We are looking for as near to real time as possible)

Did client fill out some context in the Comments section?

*Did client write * indicating binges, 's' indicating subjective binges, 'v' for vomiting?*

Did client put brackets around meals?

Praise signs of adherence, compliance with monitoring. Suggest ways to improve monitoring based on above guidelines.

Step 2: Regular Eating

Did client eat 3 meals, 2-3 planned snacks per day?

No skipping of meals/snacks

Did client have no more than 4 hrs without eating?

Remember to ask, **"When did you wake up/When did you go to sleep"**, *to make sure the 4 hr rule for regular eating has been followed*

Did client refrain from eating outside of planned meals/snacks?

If client got off track, did s/he get back on ASAP?

Did client adjust timing of meals/snacks to accommodate special situations? **"Did you revise the plan during the day, when necessary?"**

More sample questions to ask client:

"**Based on what you know about regular eating the way the book talks about, how did this day go?**"

"**Do you see any problematic gaps in time between meals and snacks?"**

To make the point about getting back on track to regular eating plan ASAP:

"Do you remember what the books says about what to do after a binge, or after straying from the regular eating plan?"

**Have these questions in your back pocket, as a way to suggest improvements to regular eating:

Did you plan your meals/snacks ahead of time (night before, or morning of?)

Did you plan the times?

Did you plan the content?

NOTE ON STEP 2:

**Though this step is about establishing the pattern (when) of eating,

and not necessarily the "what" of eating, have in mind, that overly restrictive meals/snacks will keep person physiologically vulnerable to binge eating. We like to say, **"We use different words for meals and snacks—they should look different!"**

In other words, you CAN address the size of meals/snacks at Step 2, if overly restrictive meals/snacks are interfering with person adhering to a pattern of regular eating.

For instance, when meals/snacks are frequently turning into binges, it is likely because meals/snacks are too small

With particular trouble adhering to regular eating plan (not eating outside of it, etc.), refer to pp. 163-165 in book, "Advice on Meals" and "Advice on Cooking and Shopping" to help with the problems.

Step 3: Alternatives to Binge Eating

Did client record urges to binge (eat between meals, purge) in column 6?

(If binges are present, should have urge recorded)

Did client use list of alternative activities?

How did intervening go? "**How did using your alternative activities go?"**

Did client note urge/intervene early enough?

"**When did you first notice your urge to binge?"**

"Did you note the urge right then?"

"Did you get out your list to use it as soon as you noticed?"

Did client use activities? (more than one if necessary, until urge went away?)

"What / how many activities did you use? Did you use activities until urge went away?"

Did activities work?

If not, could the list be improved/modified?

"**Are there activities that you may want to add to or remove from the list? What activities worked/didn't work?"**

Did client use list of alternatives to deal with urges to purge?

"**Did you practice using alternative activities to deal with your urges to purge?"**

<u>Step 4: Problem-Solving</u>

Is client problem-solving frequently enough? (Must practice skill!)

This might mean asking client is there may have been an opportunity for problem-solving (if you see one) that they didn't notice on a particular day

Is client catching problems early enough?

When client is problem-solving, is s/he doing it well? (writing out 6 steps on back of monitor)

Is client reviewing problem-solving next day, to see where s/he could improve / what s/he did well?

<u>Step 5: Tackling Dieting and Food-related Avoidance</u>

Is client eating at regular intervals?

Is client eating normal quantities vs. restricting?

Is client incorporating foods from her/his avoided foods list?

In hierarchical format? (easier to harder?—not skipping around on list!)

Doing this on days where:

Client has stuck to regular eating?

Planned to incorporate this food?

"Did you plan to incorporate this food on this day?"

Has alternative activities set-up to deal with possible urge to binge?

Has problem-solved issues that may leave her/him vulnerable on that day?

"How might you have set-up this day, the way the book describes, to make it ideal for incorporating an avoided food, and preventing a binge?"

Is client tackling other forms of avoidance?

Additional Shape and Weight module:

Has client recorded/monitoring body-checking and/or avoidance behaviors?

Is client working on reducing, then eliminating these behaviors?

Appendix H

CBT Guided Self-Help for Recurrent Binge Eating: Audio Library Catalog and Role-play Transcriptions

1. 'Starting Well' (no digression)—Check in for a GSH session 2

2. 'Starting Well' (with redirect of inquisitive client)—Check in for a GSH session 3

3. Introducing book and assigning Step 1 targets in a GSH session 1

**note: This role play acknowledges that there are a lot of homework targets, but does not set up an expectation that completing them is too difficult or not do-able. THIS STRATEGY SHOULD BE MODELED EXACTLY! We want first and foremost, to set up the expectation that the client can accomplish these things and that others have been able to. The importance of "hitting the ground running" should not be undersold to the patient in this (or any) treatment, as early response is a robust finding documented in CBT (and CBT for eating disorders!) Where necessary, the therapist can validate that there are a lot of targets, and in some cases, the therapist can help the client prioritize what absolutely needs to be done. In this case, SELF-MONITORING should take precedence over other tasks in Step 1 (remember, to do this, the patient must read at least Step 1 in the book). This strategy should not be the default or most common strategy, but rather a fall-back position if the client is very uncertain about their ability to complete all of the Step 1 tasks. The most common Step 1 task to be broken down to a more manageable chunk is the reading of Part 1 of the book--it is fine for the client to read half of Part 1 (background section) for the first week if they need to given their schedule.*

This role play can also serve as a model on the foundation of "Ending Well" which involves having the client review the weekly targets and enhancing specifics if necessary. Step

1 involves the most amount of weekly targets in the entire program, so making sure the client and GSH therapist are on the same page regarding homework targets is crucial (as it is for other steps as well).

4. Noncompliance flow chart for weekly weighing in a GSH session 2

**note: Molly has a BMI of 25, hasn't weighed herself in over a year, requested a blind weighing at her medical appointments, and has a history of weighing up to 20x/day as a teenager. She returns for Session 2 and has not weighed herself as planned…This recording takes place in the middle of the session, after the 'Starting Well' check-in (where the therapist identified that Molly hadn't weighed) and after the Good Day/Bad Day monitoring review has taken place.*

5. Client has co-occurring problem (outside of ED) assessed during check-in in a GSH session 5

**note: If a client's demeanor in session is markedly different (in a negative way) than prior sessions and such demeanor is affecting the session, the savvy GSH therapist can check in on what is happening for the client. The weekly-administered PHQ-9 can assist with this, as the GSH therapist who spots a change in score on the suicidal ideation question (9) on the PHQ-9 should indeed check in with the client to determine client's safety. Remember priorities, 1) Life, 2) Motivation to continue with program, 3) GSH program step. Sometimes, though, as in this case with the role play, the client's demeanor will provide the most noticeable clue. In this case, the therapist validates client's distress and puts the decision back to the client whether or not to continue with the session focused on her ED or to reschedule the session. For certain types of issues that crop up for clients, as in this case, it is often appropriate for the therapist to gently remind the client that to the extent that she can get her eating under control, she may be in a better place to deal with other problems.*

6. Dealing with noncompliance and a full pros/cons exercise in a GSH session 3 (dieting vs. beginning regular eating).

**note (Background): Patient is a 29 year old female (BMI 26) presenting with binge episodes one to two times per week. She denies any form of compensatory behavior. Patient reported a history of significant weight fluctuations and stated that she purposely avoided weighing herself. Patient was seen for an assessment and two treatment sessions. She completed self-monitoring records and (reluctantly) weighed herself once a week. However, she repeatedly stated concerns about her weight ("I feel gross") and concerns about implementing a regular pattern of eating ("I feel like I'm eating too much"). At the outset of session 3, the patient comments that she thinks that the treatment "isn't right for her," because it would make her "gain a lot of weight," and that she was "thinking too much about food."*

***additional note: Pros/Cons can be simply started in session and then sent home with a client to complete as homework if a motivational issue is discovered later in session. HOWEVER, if client presents at beginning of session with any variation of "I don't think this treatment is for me" the session agenda should shift immediately to motivation (assessment, validation, rationale/referring back to goals, and pros/cons list). This takes precedence over a program step. The GSH therapist should strive to identify any possible motivational issues as early as possible in the session, in order that s/he may address it and give it the importance it deserves. There are several ways the CAPS GSH Year 2 protocol seeks to address this: 1) adding the additional question regarding client engagement in the program to the "check in", and 2) emphasizing more precise mirroring of the 'Starting Well' check-in set forth by Zandberg. The quicker the GSH therapist can determine what was done vs. not done the prior week, the quicker s/he may determine if a pros/cons exercise might be necessary. A good rule of thumb: Pros/Cons exercise is warranted when 1) client has noncompliance on same task over multiple weeks, 2) client has noncompliance on many tasks within the same week,*

AND/OR 3) the "dealing with noncompliance" flow chart demonstrates a motivational issue (i.e. fear, uncertainty) vs. a logistical one (not sure how to do something).It is session 7, and Kayla is coming back after working on Step 4. Session check-in revealed that Kayla has maintained regular eating, monitoring, and once-weekly weighing, has successfully used alternative activities a number of times over the course of the week, but has "not had any opportunities to use problem-solving." She verbalizes understanding this step, but did not put it into practice this week. Kayla has had 2 binges over the past week.

7. Step 3 - Makes list and tries it; needs work on noting urge earlier, and trying multiple activities in a row.

VIGNETTE: Brittany is a 23 year old undergraduate (BMI 24), presenting with binge eating episodes about 7 times a week. Brittany has long endorsed high shape and weight concerns, has been binging sporadically since she was 16. Brittany often gets down on herself for continuing to binge and not being "able to kick this thing for good!" It is Session 5, and Brittany has returned from her first week spent implementing alternative activities to binge eating.

Note: The highlighted portion of this role play (near the end) represents a "best case scenario" where the GSH client is able to recite (from memory) the entire 3-part rationale behind alternative activities. In actual clinical practice, the client might well benefit from referring back to their book (in session) to be able to answer the question "Do you remember what the book says about the three things that must happen for you to deal with an urge successfully?"** This question is an excellent one to ask to help the client assess the utility of their listed alternative activities – in Brittany's case, it was suggested that she augment her list to include activities that will get her out of her room and away from extra food.*

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8. Step 4 – Problem-solving review

VIGNETTE: *It is session 7, and Kayla is coming back after working on Step 4. Session check-in revealed that Kayla has maintained regular eating, monitoring, and once-weekly weighing, has successfully used alternative activities a number of times over the course of the week, but has "not had any opportunities to use problem-solving." She verbalizes understanding this step, but did not put it into practice this week. Kayla has had 2 binges over the past week.*

** a patient presents with having had "no opportunities for problem-solving" but still has binges, chances are, you might have to point out a problem they didn't notice.*

**Session-saving tip: When introducing Step 4, have patient generate one or two problems to solve over the coming week, in order to get them thinking about how they might practice this step in advance.*

NOTES:

a. *A brief disclaimer: After only one week on step 4, Kayla knows problem-solving really well – you might find that this is not always the case with actual patients! If you encounter a patient who has not practiced problem-solving (like Kayla), and who is not able to work through the steps with you in session, you should encourage the patient to return to the book in session as you work through the problem-solving steps with an example problem. A good rule of thumb – if a patient has not practiced problem-solving during the week, and there appear to be missed opportunities for problem-solving*
b. *(particularly on days where the patient also binged) it is probably a good idea to push for another week on this step (and ensure, before the patient leaves, that*

they understand the steps of problem-solving and also have some ideas for problems that are likely to come up during the next week)

i. *If I were Kayla's therapist, I might push for another week on problem-solving, even though she knows the steps of problem-solving quite well without looking in the book. Here's why – there were opportunities during the week where Kayla could have practiced problem-solving, but did not. These days also included binges. Where clear examples like this are present, there is a strong case for remaining on this step. However, one should also take into account how far along in the 10 allotted sessions a patient is before making this determination. Given Kayla's knowledge of the steps (even though she did not practice), if Kayla were on Session 8 (therefore, the next session was 2 weeks away), I might encourage her to practice problem-solving again, while also introducing Step 5.*

    1. *Problem-solving need not be a step at which someone is fully excelling before they are moved forward, as this is a generalizable skill to practice over time. All that is necessary to move them forward is some evidence that they understand the steps of problem-solving, are spotting problems, and beginning to put the steps into practice.*

c. *A lot of times patients get hung up on this step because they don't view feeling certain emotions or something like "unstructured time" (even though such emotions/situations might trigger binges), as problems to be solved. In Kayla's case, "feeling stressed" was very connected to a concrete issue – a school project. In some cases, "feeling tired," "feeling sad," or "feeling stressed" may*

not be so overtly connected to an external problem for problem-solving. This is an opportunity within the GSH protocol to help clients develop good habits for dealing with a number of issues that might make them more vulnerable to binge eating – it is a brief opportunity to introduce some behavioral concepts that might be useful to them in reducing their binge likelihood. Simple behavioral activation, emotion regulation (self-soothing), and practice with spotting trouble early and taking the time to problem-solve, can be very useful here. REMEMBER, there is not time within this treatment to conduct a full treatment course on any of these topics. Keep it brief (i.e. "sometimes people find that getting active helps them cope with feeling sad – what do you think you could do"), keep it focused on 1) getting skilled at spotting problems that may leave them more vulnerable to binge eating early, and 2) coming up with solutions to those issues and trying them out. In true GSH style, allow the patient to help generate potential solutions and then practice on their own. You may find that many patients "take the ball and run with it," applying problem-solving to other areas of their life, but keep in mind that this is not the main treatment focus in GSH.

d. *This is a direct quote from the role play, and is very useful in explaining the relationship between problem-solving and alternative activities. "Problem-solving is something to deal with problems BEFORE they become urges to binge. Alternative activities are something to do once you notice an urge to binge."*

9. Step 5 – Dealing with avoided foods

VIGNETTE: Joy is a 20 year old undergraduate (BMI 21), presenting with binge eating episodes about 3 times a week. She reports vomiting after each binge episode. Joy reports

having engaged in binging and purging for approximately 2 years, and endorses high shape and weight concerns, as well as a prior history of yo-yo dieting and weight fluctuation. Joy has done well in CBT-GSH, and reports enjoying the program. She spent 3 weeks on Step 2 (regular eating), which was tough for her to implement, but mastered the step and has progressed well through steps 3 and 4. She just reported to her therapist about her first week implementing Step 5, Dieting and related forms of Avoidance. Session check-in revealed that implementing Step 5, "went horribly." Joy reports that she binged after she incorporated the first two avoided foods she tried. After that, she "didn't try anymore foods on her list" the rest of the week. Below, Joy and her therapist review a good day/bad day.

**Note: Keep in mind – if any of the foundational GSH program steps have faltered, this might be the reason behind "break-through" binges, particularly when patients report bingeing after incorporating forbidden foods. Be on the look-out for any apparent degradation of regular eating across a week, even when a patient has moved beyond Step 2 in the program.*

GSH Role-Play Transcriptions

Entry 1: Starting well – no digression

Hi Jessica! It's good to see you again. This is guided self-help session 2 which means we have 8 sessions left together.

Hi! Nice to see you too.

Before we get started today I would just like to remind you a little bit about how the sessions are going to go from here on out—since I gave you so much information last week it's always helpful to do a little refresher. Each of our sessions from now on are going to be between 20 and 25 min. and we will start out each session with us reviewing the targets that you worked on the previous week, then we will review your monitoring records and look for patterns in these records and identify and work with any problems that you might have had in doing the targets from the previous week, and then we'll get you set up for the coming week. How does that sound?

That sounds good.

Great. So first, I'd like to do a brief check in with you to get a snapshot of how your week has been with your targets for step 1. How did you do with Step 1 this week?

Um, I think I did ok – there was a lot of stuff to do, for sure, but I think I did pretty good.

I'm glad to hear it. Did you monitor like the book describes?

Uh, yeah I think so

Awesome! How many days did you monitor in that way?

Everyday—well, 6.5 days, because I started halfway into the day after our session last week.

Wow! Everyday is amazing and such a great way to start this program! I can't wait to see your records – they will be so helpful to us in doing this treatment to overcome your eating problem. How about the once weekly weighing?

Um, well I did weigh myself.

Once and only once?

Well, I started out that way, but near the end of the week I ended up weighing myself a few more times.

I'm glad to hear you gave it a try this week, especially considering your reluctance last week when we talked about this target. Let's, definitely make time to talk about that later in the session. How about the review check-in and summary sheet?

I did the review check-in, but I am kinda confused about when to do that summary sheet – are we supposed to do it in the book and like during the check-in?

Awesome job remembering the review check-in—that can get lost in shuffle sometimes and I'm happy you did it! Let's make sure we clarify any of your questions about the summary sheet later on in our session today as well. I will keep a list of things we want to make sure we address before you leave. How did the reading go?

I did the reading—you were right, it went fast. I almost felt like he had written it for me, so much of it applied and I was like, "omg, I do this!" like the whole time.

Wonderful! I'm glad you read that and that you felt it was relevant to you. All in all, Jessica, it sounds like you had a pretty good week 1 and a good start to this program—you monitored (yay!) on all days, did the reading and review check-in. We've also identified a couple areas that we should trouble-shoot today in our session—the once weekly weighing and the summary sheet. Are you ready to jump in with a good day/bad day on the monitors? I can't wait to see them!

Yeah, lemme see which ones I want to pick…

Entry 2: Starting well – re-directing digressive client (or client who asks questions a lot in the beginning)

Hi Courtney, good to see you again. This is GSH Session number 3, which means we have 7 sessions to go after today. How was your week?

It was ok, swamped with classes and everything.

I can imagine at this point in the semester. How did you do with regular eating?

I have a lot of questions about regular eating. On Saturday, I went out with friends to a party, and there were snacks everywhere. This has always been a big issue for me—for one, I often feel very anxious at parties, and so eating feels like the best thing to do to act normal, and of course there is food out and available, a total trigger. So I tried to stick to the plan but ended up binging instead.

Hmm, okay, so it sounds like parties present a challenge to regular eating that we will want to dig into a bit later [TABBING FOR LATER TECHNIQUE]. Let me see if I can get a snap shot of how your week went in terms of the program, and then we can jump into specifics [RE-ORIENTING TO CHECK-IN]. How many days out of the past seven would you say that you ate three meals and 2-3 planned snacks, like the book describe? [ASSESSING SPECIFIC ADHERENCE]

I don't know, maybe four. But not for want of trying! I mean, it just feels incredibly hard to resist eating in between, especially when I'm stressed out with work and all…

Four out of seven is a very nice start. That's great to hear. [REINFORCING AND MOVING FORWARD TO NEXT ITEM] How about the weekly weighing, how did that go?

…I did it.

Great! Once and only once? [ASSESSING SPECIFIC ADHERENCE]

Yeah…it was really hard to resist doing it more, but I put it away and asked my roommate to hide it!

Awesome job—and a very clever solution to a tricky problem! Review checklist?

I did that.

Great. And the summary sheet?

Yep. That stuff is the easy part.

Excellent! Alright, Courtney, so I'd say you made a nice dent in regular eating, but I can see that you have some specific questions and concerns about how to make this fit into your life better, is that right? [REINFORCING AND SUMMARIZING]

Yeah, definitely. I am pretty worried this won't work for me.

Well that is exactly what we are here for! Regular eating usually takes some practice and special attention [NORMALIZING DIFFICULTY]. Are you willing to give this a look today and see if we can address some of the challenges you faced?

Yes, I want so badly to get this right.

Ok, let's jump in by taking a look at a good day and bad day, and if you'd like to use Saturday, the day you mentioned, we can look at that more carefully now. How does that sound? [TRANSITION TO GOOD DAY/BAD DAY].

Entry 3: Introducing book and assigning Step 1 targets in a GSH session 1

See second half of Appendix F (beginning with "Part II: Introduce book")

Entry 4: Noncompliance for weekly weighing in a GSH session 2

Hi Molly! It's good to see you again. This is guided self-help session 2 which means we have 8 sessions left together.

Hi.

Before we get started today I would just like to remind you a little bit about how the sessions are going to go from here on out—since I gave you so much information last week it's always helpful to do a little refresher. Each of our sessions from now on are going to be between 20 and 25 min. and we will start out each session with us reviewing the targets that you worked on the previous week, then we will review your monitoring records and look for patterns in these records and identify and work with any problems that you might have had in doing the targets from the previous week, and then we'll get you set up for the coming week. How does that sound?

That sounds good.

Great. So first, I'd like to do a brief check in with you to get a snapshot of how your week has been with your targets for step 1. How did you do with Step 1 this week?

I did good with most of it—I just absolutely cannot do the weighing, though.

Ok – let's definitely talk about the weighing today. For right now, though I'd like to check in on the other homework tasks from Step 1. Is that alright?

Uh-huh.

Ok, great – how did you do with monitoring?

I did it.

Awesome! I'm so glad to hear it! How many days did you monitor like the book describes?

Everyday.

Wow! Everyday is amazing and such a great way to start this program! I can't wait to see your records – they will be so helpful to us in doing this treatment to overcome your eating problem. How about the review check-in and the summary sheet?

I did those, too.

Awesome job remembering those. They can get lost in the shuffle sometimes and I'm happy you did it! How did the reading go?

I read most of the first half of the book – I have a bit more to go, but not much.

Awesome! Good job with that. All in all, it sounds like you had a pretty good week 1 and a good start to this program—you monitored (yay!) on all days, did the reading and review check-in and summary sheet. Are you ready to jump in with a good day/bad day on the monitors before we discuss weighing?

Sure….

After monitoring records review…

Ok, Molly, so let's touch base about the weekly weighing. What got in the way of you doing that?

I mean, I just can't do it. It's been so long since I've known my weight. I used to be totally obsessed with weighing and it made me miserable. I would literally get on a scale like 20 times a day.

I can understand, given your history, why you would be reluctant to weigh yourself.

Yeah, I mean, it's just terrifying. I can't go back to that.

You know, lots of people that have similar problems to you and use this program can feel this way about weighing at first.

Really? I mean, then why do we have to do it? It doesn't make sense.

I'm glad you asked that – that's a great question. Do you remember what the book says about why it's important for you to weigh yourself once and only once a week?

Not really, to be honest.

Well, it makes total sense to me that you wouldn't have done something that is scary for you if you don't know why we're asking you to do it! Let's look at p. 150 in the book together…What does the book say about why it's important to weigh yourself?

Because I have to know what's happening to my weight because we're going to make changes to my eating.

Exactly right.

I mean, I guess I get that part. I don't understand why you can't just do it then, and not tell me? That's what they do at my doctor.

That's another common question that people ask. Let's look at p. 153 in the book. What does it say?

That I shouldn't keep my head in the sand and fear the worst.

EXACTLY. If I were to weigh you here and not tell you your weight, you wouldn't have any knowledge about what your weight was doing as you went through the steps where we change your eating. It can be difficult to make those changes, especially when you're

fearing the worst about your weight and you don't really know what it's doing. Also, do you remember when we talked last week about this program setting you up to be your own therapist?

Yeah.

Part of this program's goal is to give you all the tools you need to continue implementing this program and being in control of your eating on your own—and not needing a therapist for that. I remember last week that you were jazzed about that prospect. Is that still the case?

Yeah, I mean, I guess. I'm just so afraid that if I weigh myself once, I won't be able to stop.

Let's problem-solve that a bit. Do you have access to a scale?

My roommate has one, and she keeps it in our bathroom.

Ok—do you remember what the book says about when you should weigh?

I mean, only that you should pick like the same time each week?

Right—pick a preset morning of your choice and make that your weighing morning and then ONLY weigh on that day.

Ok. But what about after, if I want to weigh again and again?

What do you think you could do to prevent that?

I mean, I guess if I didn't have a scale I couldn't do that. Maybe I could ask my roommate to hide it?

That sounds like a great idea—does your roommate know you're doing this program? Do you think she would be supportive in this way?

Yeah, we're close, actually. She would totally do that if I asked her.

That is a really great idea, Molly. Is this sounding more do-able for this coming week?

I guess so, but I'm still worried about how I'll feel when I see my weight.

Well, you could choose your preset morning to be the morning of our sessions, so that after you weigh, you'll know that you're coming to see me not too long afterward and we can problem-solve any trouble after that.

Oh, that sounds better.

I'm glad to hear it. Are you willing to give this plan for weighing a try this week?

Yeah, I can try.

Excellent!

Entry 5: Co-occurring problem (outside of ED) assessed during a GSH session 5 check-in

Really nice to see you again, Jessica! This is guided self-help session 5, which means, if you can believe it, we are halfway through the program and have 5 sessions to go.

Wow – ugh, I wish I'd had a better week.

Well, let's check in about that. How did your week go with Step 3?

I mean, I guess it was ok – I'm not sure this step has helped, but…

Ok, well I will definitely want to get into specifics with you about how we can make this step more helpful, but first it would help me to get a snapshot of the week. Did you make your list of alternative activities?

Yeah, I made the list…I just…ugh (*client gets quiet*).

Jessica, I'm getting the sense that you're upset – is everything alright?

(Client says tearfully): Actually, no. I've had a horrible week. A couple days after our last session, I found out that my boyfriend of like, 3 years, has been cheating on me. I confronted him about it and we had a huge fight, and broke up. It's super hard, because I miss him so much and we have so many mutual friends. To top that off, I've been so heartbroken over the breakup that I couldn't concentrate to do my homework and I ended up missing a class assignment and lost points for it. I don't see how this week could have been any worse.

Wow, Jessica, I'm sorry – it really does sound like you've had a terrible week.

I really have! I just miss him a lot and I feel really betrayed.

I'm sure. I can imagine you're feeling a lot of things right now, and I can see why you're upset. It's remarkable that even during such tough week, you made your alternative activities list for this program – that is dedication! Given how important it is for us to

focus on your eating problem when we're together, I'm wondering what you think you're up for today. Do you feel like you are able to focus on the eating disorder today with me, or would it be better for us to reschedule this session?

I'm not sure – I'm sorry…

That's alright - there is nothing to apologize for! I'm just trying to figure out what you're up for today. You've made a lot of progress with your bingeing so far, and you've been working so hard – even when things have been tough.

I think maybe I can try to focus on the eating disorder today.

Ok – it might actually be a productive distraction for you.

Yeah.

Remember what we talked about early on – if getting your eating under control makes other things easier in your life, maybe it would be good to focus on this today.

Yeah exactly – the last thing I want is to have him cheat on me and then get in the way of my progress, too! I don't want to give him that satisfaction!

Alright – I'll take it! Let's keep going, then! You mentioned that you had made your alternatives list. That's awesome.

Yeah, I made sure to pick a variety of activities like you said.

Nice work! We will definitely want to take a look at the list later on. Did you record your urges to binge or eat between meals on your monitors?

I did, yeah, but sometimes I still ended up bingeing.

Ok – I'm glad to hear you recorded. Let's make sure to look at least one example later on today to see where we can help your use of activities improve. Did you use your list at any point when you noticed your urges?

Yeah – I used it a few times and it worked, actually. Then there were times when it didn't.

Wow! I'm so happy to hear this! It's great that on your first week with this step—even with things being so hard otherwise!—you made the list, used it, and it worked! It will be helpful today to look at the times when the list didn't work, to see how we can troubleshoot to help fix that. We will definitely want to look at one of those times—maybe that can be the bad day we review.

Yeah, I could use some help on that one.

Well, that's what I'm here for! You know, I have to check in on regular eating as well – how did that go this week?

I think I did it really well on like 5 or 6 days, and then on the day when we broke up, I didn't. Actually, that was also a day when my list wasn't working.

Great job! That is really awesome—good for you. We will definitely want to look at the day when the your regular eating and list use broke down a bit later on. How about the other hw tasks that you've gotten down pat by now – monitoring, weighing, and review check in?

Yeah, I did all those.

Ok, Jessica. I have to say, I am so proud of you. In spite of a really tough week, you followed the program SO well and you made the choice to stay today and focus on the ED. What a testament to your dedication to getting better – awesome. Let's dive in to your good day / bad day and troubleshoot some of the areas that gave you trouble this week.

Entry 6: Dealing with noncompliance and full pros/cons exercise in a GSH session 3

Hi Katie—great to see you today.

Hi.

This is GSH session 3, which means that we have 7 sessions left. How did your week go with Step 2?

Actually, not too good—er, well, I mean, I'm really thinking that this treatment might not be right for me. I feel like it's going to make me gain a lot of weight, which I absolutely don't want to do, and I feel like I'm actually thinking about food more now than I was when I started.

Katie, I am happy you shared this with me, and I would really like to talk about these concerns you have about the treatment.

Ok. I'm sorry, I don't mean to be difficult, I'm just not sure this program is right for me.

You're not being difficult at all. I really appreciate you coming in today to talk about this, and I want to make sure we give this our full attention today, so I can understand you concerns and what's changed for you regarding the program. Is that ok?

Yeah, that's fine.

I want to make sure I understand exactly what your concerns are—I heard what sounded like 2 separate issues. One is that you're worried this program is going to make you gain a lot of weight, and the other is that you feel like you're thinking too much about food—is that right? Am I leaving anything out?

No, that's pretty much it. It's so frustrating.

I can understand your frustration. Let's try to tackle these issues one at a time. Let's talk about you thinking about food a lot. Can you explain this a bit more to me?

I feel like I'm more focused on food now than I was before the program! I definitely think about it more now than I did before, and I feel like it takes up a lot my time—from the monitoring and planning meals to timing for regular eating.

I can understand that feeling. Do you remember what the book said about feeling preoccupied about food early on in treatment?

Hmm, not really.

Let's go back and look together. The book actually mentions in the section about self-monitoring, it's on p. 146…what do you see down at the last bullet point there?

It says that you may feel that monitoring will make you even more preoccupied with your eating and that this might be true, but that the preoccupation will be more constructive because it will be focused on how to overcome the eating problem.

Exactly.

Hmm, I guess I hadn't thought about it like that.

Have there been other times you've been really preoccupied with food and eating when you haven't been in this program?

Yeah, actually, a lot. It kind of comes and goes—the preoccupation, that is. I definitely feel that way after binges and like right before them too. There are times when I don't think about it as much, but I definitely always go back to it.

Right, that's pretty common for people who have binge eating. It might be that you are more preoccupied with food right now than before you started the program, but your preoccupation is more focused and more productive. Another thing that I'd like you to remember is that you're still new to the program and doing the steps and creating new habits. Any time you're new to a behavior, it's going to take more thought and planning to get started with it than it will after you've got it down.

I think I remember you saying that when I said I thought the monitoring would be tough.

Right—I'm wondering, did the monitoring feel as burdensome this week than the first day you tried it?

Actually, no. It's still not my favorite task, don't get me wrong, but it was definitely a bit easier this week since I had the hang of it.

I wondering if you feel like it's worth a shot to keep going with the program and see what happens to your preoccupation with food. For other people with this problem, the preoccupation has gone down. I see no reason why it wouldn't be the same for you. Are you willing to give this a try?

Yeah, actually, I feel better about that, but this still doesn't solve my problem about this program making me gain weight.

Right, let's talk about that—do you remember what the book says about what will happen to your weight?

Yeah, it said that for most people it doesn't change. It's still so so scary though.

I know that it's scary and many people feel the same way. This is part of the reason why we keep track of your weight—we will see what happens to your weight as we make changes to your eating. We're not just closing our eyes and not watching.

I'm just really afraid though. This regular eating thing just seems like too much food. I really feel gross and like I'm eating too much and too often. I'm just not sure this will work.

Regular eating can be a tough step for people in this program—it's asking you to make a big change in your habits. Do you remember what the book says about why regular eating is so important in overcoming binge eating?

Doesn't it like, break up binges because you're not so hungry or something?

That's exactly it—great memory! This pattern of eating is going to break up the cycle of bingeing and then restricting, which sets you up for another binge. You'll be less vulnerable to binge eating this way.

I get it, it's just so hard to do.

Did you attempt regular eating this week?

Yeah, I mean, I did it on 3 days, but like, it's so scary and it really feels like too much.

First of all, it's great that you did it on 3 days—that's good work! I understand that it's hard—many people have to spend a few weeks on this step before they can move on. In terms of it feeling like its too much, do you mean that you feel too full?

No, not really, it's more that it just feels like too much to eat! I know I'm going to gain weight.

Katie, I hear that trying out this regular eating seems really scary to you and that you're not sure about it, especially because you're afraid to gain weight. I think it might be helpful for you to do an exercise right now to help you figure out if it might be worth it for you to try this out, even for a preset period of time, knowing that you could always go back to eating the way you are now. Are you willing to try this exercise with me?

Ok.

I'd like us to start a pros and cons list of trying regular eating vs. continuing your dieting like you are now so we can really figure out if it's worth it for you to give this a try. Let's

start it here together, and then we'll see where we are at the end of it—you can take it home to finish it and add to it on your own to help with you decision. What do you say?

That sounds good.

Let's start with the pros for continuing to diet the way you are now—what are the pros?

Um, I guess I don't have to worry about feeling like I'm eating too much during the day, I won't gain weight…

I'm wondering how you having gained and lost weight in the past, before starting this program, fits in here…

Hmm, I guess it's not a definite that I won't gain weight, even if I don't do the regular eating.

What else might be a pro?

Well, it's easier just to keep doing what I'm doing, it takes less time.

OK, what are some of the cons of continuing dieting the way you are now?

Hmm, well, I'm hungry a lot of the time and that like makes me have a short temper.

Ok. What else?

I will probably keep yo-yoing with my weight, like I have been…

Ok, anything else?

Hmm, not sure…

What do you think will happen to your bingeing if you continue dieting like you are?

I guess I will probably keep bingeing—I mean, I've tried stopping before but it doesn't work.

That's probably true. What are some of the cons of beginning regular eating like the book describes?

I mean, I might gain weight, it's hard, I feel like it's too much food, it takes time to plan out.

Ok, anything else?

Hmm…I don't think so.

Ok, what are the pros of beginning regular eating?

Well, I won't be hungry all the time…it will help me stop bingeing….maybe the planning will help me feel in control…I can feel accomplished for doing something new.

You can always take this home to add to it, but I would like you to look at something on here now. In terms of your fear about gaining weight—what do you see about your weight on this pros/cons chart?

Hmm…I guess my weight isn't guaranteed to stay the same or go down in any of the columns, actually, no matter if I stay with dieting or start regular eating.

Interesting.

Yeah, I guess I hadn't thought that before.

What about your binge eating? What does this chart say about that?

I mean, if I do regular eating, it will go down, but it will probably stay the same if I do nothing.

That is probably true. What are you thinking at this point?

I'm thinking it might be worth it for me to try regular eating—even though it's hard.

Remember, you can always go back to the way you do things now. But right now, you have this amazing opportunity while you're in this program to really throw yourself into it and try your best with regular eating. What do you think?

I think so—I will try my best.

That's great—I think you've made a sound decision, Katie. How do you feel about moving forward with regular eating this week? Or would you like some more time to think about your decision.

No, I feel nervous but better, for sure. I don't think I need more time.

Good. I'll tell you what--I'd like you to take this list home and add to it over the next day or so if you need to. If you feel yourself needing some motivation, you can take this chart out and look at it as a reminder.

I can definitely do that.

You know, we actually have some time left today, so I'm wondering if we can briefly look at a day or two of regular eating or a good day / bad day from this past week to see any problems and help set you up for success this week. How does that sound?

Yeah, hold on—let me pick them….

Entry 7: GSH step 3 alternative activities list

Hi Brittany – great to see you today.

Hi!

This is guided self-help session 5, which means we are halfway through! Can you believe it?

Wow , yeah.

I know last time you mentioned you thought the next step in the program made a lot of sense to you – so I'm curious -How did you do with Step 3 this past week?

Well, um, I feel like I did ok, I guess. Maybe I thought it would be easier to do than it actually is, though?

Hmm, well, let's see about some specifics here. Did you record your urges to binge on your monitors?

Yeah, I did.

Excellent – nice work. Did you make your list of alternative activities?

Yep, it's right here.

Nice! Did you try using your alternative activities this week, when you felt an urge to binge?

Actually, yeah, - I tried it a few times.

How did that go for you?

Well, it didn't really work.

Ok, then, today we'll definitely touch base on how we can help figure out how to make this work for ya. Don't despair – we'll figure this out together! Before we jump to a good day/bad day, though, you know I have to ask about a few more things, right? How did you do with regular eating this week?

Um, I think pretty well – probably 6 days, maybe 6.5? There was one day that was crazy with my work schedule after class, but I figured it out and got back on track the next day.

Brittany, that's amazing! Way to keep up the good work with regular eating, and also get back on track after a small setback – nice job!

Thanks! I was actually pretty happy about it too.

And how about monitoring and once weekly weighing, and your check-in

Check, check, and check – that stuff is easy.

Alright! It wasn't always easy for you, remember? But you're a pro at it now- keep that in mind when these steps seem hard at first, ok?

Haha, ok – good point.

Alright, it sounds like you've been holding the line steady with the older steps this week – with regular eating, and monitoring and weighing, which is awesome. With Step 3, you've recorded your urges to binge on your records, made your list, and started out trying your activities this week – that's a great start! Let's look and see what we can do to make this step work for you. Sound good?

Yup – sounds like a plan.

Alright – let's look at a good day/bad day.

Ok, um, let me see – can we look at this day? This is a bad day here.

Ok, so let's take a look here. I see you noted an urge to binge around 10 am.

Yeah, I had breakfast at about 8 with my friends – early Sunday breakfast in the caf.

How soon after you noticed your urge to binge did you write it down?

Um, well, actually, I noted it down like a bit after – pretty much like, just before I did my activity.

So, it sounds like you noticed that you felt like bingeing a bit earlier?

Yeah, I actually felt like bingeing as soon as I got back from breakfast…but it was weird, it didn't come on all strong, so it wasn't like some urges sometimes where it happens all fast, this one seemed like it had a longer build-up.

Hmm, so when you first noticed the build-up, what did you do?

I guess, nothing. I was working, so I tried to ignore it.

Ok, so when did you decide to note it down?

I guess when it started getting worse. I noted it down, and got out my list, and tried to play one of my cell-phone games. But before I knew it, I had gotten out my granola bars, that I keep for my snacks, and eaten like 7 of them. Ugh. And then the whole day went out of control and I ended up bingeing like 2 other times. This day was a total disaster.

I can see that this was a tough day for ya – let's focus just on this first binge urge first. I'm wondering – given what you read about in step 3, what do you think could have helped this turn out differently?

I'm not sure…

Well, what if you had recorded your urge to binge as soon as you noticed it – before it was really really strong, while it was still "building up"?

Yeah, I mean, I guess that might have helped a bit. I mean, maybe I could have stopped it before it got hard to deal with?

I think you're right. Remember the two goals of this step – spot urges as soon as you can, and become good at dealing with them. If you could spotted and recorded this urge right away, then you could go right to your card and start the activities.

Yeah, that's true. I will try that.

I think that might be helpful for you. Now, let's say you spotted that urge and noted it early, and turned to your activity card. I see that you didn't binge while you were playing the game on your phone. Did you try any other activities afterward?

No, I pretty much played one game and then I couldn't handle it anymore and then I binged.

Hmm – so I think there might be two things going on here – one is, by the time you got out your activity card, you were already really struggling with the urge to binge – and we talked about how noting it earlier and trying activities earlier might help. The next thing is, you might need to try *more than one activity* to deal with an urge successfully.

Hmm, I guess that makes sense.

Do you remember what the book says about the three things that must happen for you to deal with an urge successfully?

Um, I think time has to go by, you have to make it hard to binge, and you have to do something else.

You got it- that's it exactly. So knowing those things, what do you think you could have done differently?

I guess, I could have noted it earlier, like you said, and tried activities earlier. Then, I guess I could have done more than one thing, to let time go by? Also, I probably should have picked something that got me out of my room, so it would have been harder for me to binge?

Brittany, that's an excellent plan! Way to think that through – nice work. It sounds like you might want to look at the activities on your list and make sure that some of them involve active things that will get you away from the food, so it makes it harder for you to binge. Now, just extending it a bit, how might you have dealt with urges to binge later in this day?

Well, after I messed up, I guess I just stopped recording my urge and using my activities. So I guess I could have just repeated the whole process for each time I had an urge to binge?

Right on – now you got it down. Just like with regular eating, it's really important to get right back on track with this step as soon as you can after a setback.

Entry 8: Problem-solving review

Ok, Kayla, let's take a look at a good day/ bad day.

Ok, let's look at this day – this is the only day I binged the whole week.

Ooh, ok, let's take a look here and see what we can learn…Ok, so walk me through this day here…

Well, I don't understand – I did all my regular eating like I've been doing. I noted the urge to binge pretty late, but I didn't really realize I had the urge until I was just so, ugh, I dunno. I was really stressed out, I had a really stressful week. I mean, I tried to use my activities, but by then, it was like really tough, and I was in the for the night, so I couldn't get away from the food. I dunno, everything fell apart like right before dinner, and then again after dinner.

Ok, I can tell this was a tough day for you – it sounds like your week was stressful. Just to point out, you did REALLY well for a stressful week – let's see what we can learn from this day, so we can make it count. I notice that in your "comments" section in the morning, you have "really stressed – presentation hanging over my head."

Yeah, I woke up feeling anxious about it – I've been procrastinating working on this presentation, it's a group project, and I can't get the other group members pinned down to work on it. So I was kind of on edge about it, and the due date was coming up, and, ugh. I dunno.

Wow, I can hear even now in your voice how stressful that was! I also remember you mentioning that you notice you are more likely to binge when you're feeling stressed – did I remember that right?

Oh yeah, totally.

Hmm, Kayla, this seems like it was a problem on this day.

Oh, definitely!

Do you think you might have been able to use problem-solving effectively here?

Hmm – I mean, now that you mention it, probably, yeah. I guess I didn't think of just "feeling stressed" as a problem. But it def. makes it more likely that I'll binge.

So, maybe when you notice you're recording "feeling stressed" in the comments section, a red light should go "ding ding ding!" in your head, and you should think – PROBLEM!

Hahah, yeah, maybe.

So, how might you have problem-solved this on this day? You got a jump on step one of problem-solving because you identified the problem early, right?

Well, so I guess – although I probably could have done this a few days earlier, right when I hadn't heard back from two of the group members.

Good call – see, you're getting this! Ok, so next?

I clearly state the problem – stressed over getting this group project done.

Right – so the real issue with that is…

I mean, Completing a project when I can't get in touch with some of the members!

Right, great job. Next?

I have to list solutions. So, I mean, I could…..hmm…..

This step is a little tricky, huh?

I mean, I guess I could do it myself

Right

I could meet with the one group member who responded and we could do it together.

Good.

I could send out an email saying that's our plan to the whole group, and that we can't wait anymore before deadline.

Ok, that sounds good.

I could not work on it at all, and stay worried, I guess, haha

Ok, at this point, we're just brainstorming, right? So, now, you think through each solution.

Hmm, so I don't want to just do nothing, that will make me feel worse and get a bad grade. I don't really want to just do it alone, that's not fair. I guess me and the other girl who answered could email the whole group saying that we need to work on this now bc we can't wait anymore, and this is where they should meet us? That would get some work done and I'd also have help?

I like it – that's probably what I would choose in your shoes.

Then, I would do it, and then review the steps?

Sheesh, Kayla, for not having practiced the steps this week, I can tell you read! That was excellent! Now, how do you think this day might have been different if you had done this right when you noted that you were "stress out over the presentation" in the morning and saw it as a problem?

Oh, I would have felt A LOT better, and maybe not having binged?

That's my guess. Here's a tip – problem-solving is something to deal with problems BEFORE they become urges to binge. Alternative activities are something to do with urges to binge. How might you have improved your alternative activities usage this day?

I probably should have just changed my plan and gotten out of my room right when I noticed the urge – or noticed it earlier. Though on this day, I think the problem was the big issue.

Entry 9: Dealing with avoided foods

Ok, Joy, let's dive in to a good day/bad day and see what we can see.

Alright – I mean, it really went badly. I'm not sure this step is going to work for me...ok, this day here. I ended up trying potato chips – it didn't go well.

Ok, so let's take a look here. If you remember from the book and from what we talked about last time, there are some things that make it more likely that incorporating these new foods will go "well" as you say. Let's see how this day shapes up. So, first of all, was potato chips near the bottom of your list – in terms of easier to harder?

Yeah, it's the first one.

Ok, good. Did you plan on incorporating potato chips on this day?

Yeah, I did. My sister had sent me a care package with some chips in it and other stuff for school.

Ok, so you planned it as well. So far, so good. Now, how about regular eating – how did this day shape up there? Let's see…

Hmm….i guess not super great.

Where did you go off the track on that?

Well, I skipped lunch. I had a bunch of errands to do, and I missed lunch. Anyways, I was freaked out about the chips anyway – I've NEVER been able to eat chips without binging.

And when had you planned on eating the chips?

Well, I hadn't really planned on a time to eat them. They were just there, so I figured when I got home, I might as well try them.

Hmm, ok, this is beginning to make more sense to me. I can see how this ended up not going so well. Do you remember about what the book says about what's really important to do on days where you plan on incorporating avoided foods?

Hmm, I guess regular eating. I didn't really think it through I guess.

Yeah – regular eating MUST be there – that's like the foundation, and incorporating avoided foods is like you building up the house on the foundation. If the foundation isn't there and you try to build…

The house crumbles?

Yup. So how might you have tackled this differently?

Maybe, I guess I could have gotten lunch out, or remembered something for my purse, or eaten lunch as soon as I had returned.

Yes, those are good ideas. Another tip would be to plan out not just what day, but *when* you'll incorporate your new food – that way, you'll be prepared with a plan and not flying by the seat of your pants. Can you think of the other things that you would need to make this avoided food incorporation more likely to be successful?

Hmm, maybe, like, have a plan to deal with the urge to binge, just in case?

Yes! You got it! So how might you have done that?

Well, I guess not having a lot of the chips around – like making it harder to binge. And then having my activities ready to go.

That is really smart – those things, combined with planning out your food incorporation, and having that regular eating foundation are really important and set the stage for success. What about the other day you tried to incorporate the food? Knowing what you know now, try to be the detective here…where do you think you could have improved things?

Hmm, well I definitely could have planned when to eat the food, and I could have had my alternative activities ready to go just in case. I did do regular eating on this day, so that part is good.

Ok, that sounds like a good start. Where was this food on your list?

Actually, that was a few steps up – cupcakes are harder for me

This is a great point – you arranged this list from easier to harder for a reason! Don't be tempted to skip around, not just yet.

Yeah, I guess the cupcakes were just there, in a friend's room, and I just decided, "why not?" Probably not the most well-planned out experiment!

Probably not – but it's great that we're figuring out what went wrong instead of not knowing, right? You notice anything else about this day that might have made it not so great for trying out an avoided food?

Hmm, not really….

I'm looking at the comment you mention early on, "I'm soo tired."

Oh, yeah. I had been up late the night before. I was exhausted.

I think I remember you saying that being tired was one of the triggers you had for bingeing- is that right?

Oh yeah, actually. It is. I am way more likely to binge when I'm tired.

Sounds like an opportunity for problem-solving to me!

Good point.

That's actually a really important tip for trying out new foods – make sure you've problem-solved any issues on your planned day that might make you vulnerable to binge.

Oh, that's right. I guess it seems clearer to me now.

Let's review, to make sure you're on the right track for this coming week. What are the "ingredients" you need to make trying out avoided foods a success?

Well, regular eating on that day for sure.

Right! The foundation – gotta have it.

And then, I guess, plan out when to have the food and make sure the food is the next step on the list, not skipping around.

Good. Anything else?

I guess, have a plan to deal with the urge to binge just in case – like alternative activities, and limiting how much of the food is there. And then problem-solving any issues on that day to make sure you're not extra vulnerable to bingeing?

Excellent! Great work – you got this down, girl! You might want to think about making that list on the back of your monitors and going through it when you pick your days/foods to try this coming week. I love a good checklist

Oh that's a good idea.
