

SOLUTION-FOCUSED THERAPY INTEGRATED WITH COGNITIVE BEHAVIOR THERAPY TREATING EATING DISORDERED ATHLETES

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Eating disorders afflict a noteworthy minority of athletes, especially in aesthetically-judged and weight-category sports. This paper summarizes a Masters thesis on the author's use of solution-focused principles in a cognitive behavior therapy framework in treating these athletes. It also discusses the relative advantages of solution-focused and cognitive behavioral strategies in dealing with this population.

Overview. This paper is a brief summary of the key features of treatment identified in the Masters thesis of Nicolas Allen, M.A., completed in 2008, at City University, Alberta Campus. In approaching this topic, Mr. Allen was attracted by the solution-focused therapy model, and by extensive experience in sport at many levels. In narrowing the topic of his research, he decided to study the treatment of athletes with eating disorders (EAD), and thought that a solution-focus (SFT) would lend itself well to the treatment of these disorders. While aware that best practices in the treatment of eating disorders indicated a preponderance of efficacy for family therapy in helping children and early adolescents, and Cognitive Behavior Therapy (CBT) for late teens and adults (Kohn & Golden, 2001; Williams, Goodie & Motsinger, 2008), Mr. Allen was still enthusiastic that SFT could have great potential. He set about trying to find subjects for a qualitative study to investigate this hypothesis. He was soon frustrated in finding no eating-disordered athletes who had been treated with this modality. Further, he found only one therapist in Western Canada who purported to use SFT with this population. With the permission of his thesis supervisor he was permitted to narrow the research to a qualitative single-subject design, interviewing the author extensively over three sessions. This summary paper highlights the main findings garnered from repeated and elaborated themes and trends in these interview sessions.

Methodology. In contrast to descriptive or empirical studies emphasizing quantitative data analysis, qualitative research analyzes subjective and qualitative data in terms of recurrent and elaborated themes and schemata that arise from intensive interviews with a relatively small group of experimental subjects or interviewees. In this study, the researcher used a modified case

study approach in interviewing the author. (Stake, 1995; George & Bennett, 2005; Gerring, 2007). Also, in keeping with the post-modern philosophy on which this research is based, the interviewer him(her)self is included as a key interactive variable, potentially influencing both the course of the interviews and conclusions derived therefrom. Accordingly, especially if a paper is an academic thesis, considerable time and effort is involved in describing the methodology. Thankfully, in the clinical interests of the present paper, the methodology aspects can be left out in favor of focus on the treatment findings.

Incidence and Reporting. As most of you readers know, eating disorders encompass not only compulsive binge-eating, but also the major disturbances such as Anorexia Nervosa (AN), a condition of significant underweight by severe dietary restriction, and Bulimia

Nervosa (BN, binge-eating and purging by self-induced vomiting and other behaviors). There are a number of other more obscure eating disorders, including anorexia athletica (underweight caused by excessive exercise) (Kirk et al., 2001), that nevertheless can have significant negative health consequences. While most of these disorders can be reversed through individual effort or clinical treatment, they can cause considerable damage and even death, so they are far from trivial. As Allen notes in his literature review:

Conservative research shows that more than 13% of female collegiate athletes surveyed have clinically significant EDs (Sherman, Thompson, Dehass, & Wilfert, 2005). This rate is even higher in exhibition or weight-classified sports such as gymnastics, figure skating, boxing, and wrestling (Sherman et al.). Sherman et al. proposed that aspects of the sport environment, such as sport-specific body stereotypes, the belief that thinness or leanness enhances performance, and the presumption that good performance implies good health, could complicate the identification of disordered eating in athletes. - (Allen, 2008, p.11).

While they occur predominantly in females, approximately 5% of cases occur in males, a largely overlooked statistic. There could also be the factor of underreporting, especially in males in weight category sports (horse jockeys, wrestlers, judoka), and aesthetic sports (gymnasts, divers, figure skaters, ballet dancers) (Baum 2006). Shame and social stereotyping and stigmatizing has the capacity of driving most cases underground (Bertolino & O'Hanlon, 2002) beneath detection for years, but perhaps even more so for males. While overtly proud of athletic prowess, males are more reluctant to admit to vanity over physical appearance (exception: body builders) and eating disorders to limit percentage of body fat for aesthetic appearance. In sport among females, eating disorders are especially prevalent in aesthetically-judged sports, especially gymnastics, synchronized swimming, diving, figure skating, and dancing, particularly ballet (Murphy, 2005). Although coaching and sport official awareness has improved in the past twenty years, the stigma of eating disorders keeps many of these conditions denied or underreported (McCourt & Waller, 1995; Sherman & Thompson, 2001). Even when they refer

their athletes for treatment, many coaches hope their protégés do not gain weight or change body shape as a function of their treatment or recovery (Weinberg & Gould, 1995).

Multidimensional Nature. Eating disorders are inherently multidimensional. That is, they have biological, psychological, familial, social, and societal factors in their development, structure, function, etiology, and prognosis for recovery. Because of this, an adequate treatment must address each of these dimensions in order to be thoroughly effective. While treatment perhaps cannot change media messages glorifying thinness and physical beauty, it can help clients cope with and counteract many of these messages that permeate our culture. Similarly, multidimensional treatment can address familial factors of enmeshment, control, and the emphasis on popularity, achievement, and success. On a psychological level, such treatment dissolves and deconstructs cognitive rigidity, black-white thinking, perfectionism, obsessive overcontrol, and other ineffectual attempts to deal with overpowering emotions. On the biological level, such treatment deals with nutrition, exercise, energy, physical performance, biomechanics, body function, and body image. Psychoeducation is also needed to counteract popular but erroneous misconceptions about food, digestion, metabolic rate, sensuality, satiation, biological set-point, starvation syndrome, and the ineffectiveness of purging to control weight. CBT has a basis in research, education, and personal effectiveness skills training, so it is a natural fit to incorporate psychoeducation into this model. Because it addresses cognition, affect, and behavior, CBT has the breadth and comprehensiveness to easily integrate the multidimensional elements needed for effective treatment of eating disorders. Although other treatment models can include multidimensional factors, it may be more awkward to shift into these topics in a less didactic model of psychotherapy.

Treatment options, CBT and SFT. While CBT is regarded as the treatment of choice for eating disorders, Allen's research review found three books and one research article discussing the potential of SFT with eating disorders (Jacob, 2001; McFarland, 1995; Nardone et al., 2005; O'Halloran, 1999). An approach featuring client strengths and a future orientation around solutions might have considerable applicability in the treatment of AEDs; hence Allen's interest in pursuing this potential further. In particular, he wanted to identify Dr. Young's use of SFT principles with his AED clients within his integrative CBT approach, especially when and how SFT principles might be even more effective than other interventions.

Allen presents a brief description of SFT as follows:

Steve DeShazer, Insoo Kim Berg, and their colleagues at the Brief Therapy Center developed the client-centered approach of SFT during the mid 1970s and 1980s (DeJong & Berg, 2002; Jacob, 2001). DeShazer developed the approach by observing individual therapy sessions and by paying attention to what interventions were most useful (DeJong & Berg). SFT is a therapy in which both the psychologist and client(s) construct the problem and the solution (Jacob).

SFT psychologists also ask exception questions that direct clients to times in their lives when the problem did not exist (Corey, 2001). Sources for exception questions exist in the client's story, in the miracle day description, and through direct questions (e.g. "Are there times the problem is less intrusive?") (Jacob, 2001). Problem exploration reminds clients that problems are not all-powerful and have not existed forever. Exception questions provide a field of opportunity for evoking resources, engaging strengths, and positing possible solutions. Psychologists focus on small, achievable changes that may lead to additional positive outcomes. Psychologist language matches the client's language by using similar words, phrases, pacing, and tone (Corey). The questions asked presuppose change and remain goal-directed and future-oriented (McFarland, 1995). (Allen 2008, pp. 15-16).

About Dr. Young. Frank D. Young, Ph.D., is a registered psychologist in private practice in Calgary, Alberta, Canada. Formerly Senior Clinical Psychologist, Holy Cross Hospital, Calgary, Alberta. Instructor, Canadian Federation of Clinical Hypnosis. Sport Psychologist, National Coaching Certification Program. Founding Editorial Advisory Board Member, Journal of Systemic Therapies. Clinical Member, American Association for Marriage and Family Therapy. Dr. Young has published articles, presented numerous workshops, and produced audio files on such topics as Ericksonian approaches in hypnosis and therapy, humorous approaches in strategic therapy, anorexia and bulimia, imagery training, lucid dreaming, creativity and Mind State Management, and performance enhancement. Over the past 20 years he has been increasingly involved with sport psychology at provincial, national, and international levels, both with individual athletes and as consultant to several of Canada's national teams. Many of his principles of meditation and problem resolution derive from the philosophy of judo and the psychology of optimal performance.

In addition to a general profile about Dr. Young, it is important for this paper to note that he was the founder and coordinator of the Bulimia and Anorexia Program, Holy Cross Hospital, a centre training therapists and interns in the treatment of eating disorders for the catchment area of southern Alberta. Spanning his 30-year career, Dr. Young has treated or consulted to close to a thousand cases of eating disorders, and also several hundred athletes. Looking at the more narrow range of overlap of these populations, Dr. Young has been involved in the treatment of an estimated over a hundred cases of athletes with eating disorders. Many of these cases featured treatments incorporating aspects of SFT, although the primary framework was CBT.

RESULTS: MAJOR THEMES IN TREATMENT

The researcher, Nicholas Allen, analyzed the content of two interviews and editorial revisions to identify major themes in Dr. Young's treatment approach to athletes with eating disorders. Allen was especially interested in how and where SFT interventions were integrated in Young's multidimensional CBT approach. These are the major themes identified:

1. **Assessment.** In contrast to a pure SFT approach, which often bypasses diagnoses, labels, and pathology, Young conducts a more structured and traditional assessment. Topics include personal history, history of problem, scope of problem and impairment, diagnostic status, and contextual issues. The aim is to provide a comprehensive formulation of the predisposing, precipitating, and perpetuating factors that led to the etiology of the disorder. Biological, psychological, family, and social factors are included in the formulation, guiding the subsequent treatment plan. Part of this approach is congruent with Young's training and his professional requirements as a psychologist, but the main impetus is the thoroughness inherent in a comprehensive CBT plan. Also, as in SFT, there is an emphasis on building on personal strengths and resources, utilizing the support network, and learning from previously attempted solutions.
2. **Multidimensional model.** With AEDs there is an even greater emphasis on biological factors such as interaction effects of diet, nutrition, and training regimes on energy, mood regulation, emotional control, biomechanical performance, and overall competitiveness in sport. Psychological factors working in the sport and social environment play a prominent role in the maintenance of the disorder, and thus its path of treatment and recovery. Family and societal factors, while included, have less prominence in this therapy. In contrast, a pure SFT approach might focus on areas primarily dictated by client concerns and narratives, possibly missing underlying biological factors, such as the effects of the starvation syndrome upon mental functioning and physical performance. That is, symptoms of starvation can masquerade as if they were neurotically based, e.g., depression, anxiety, mood swings, irritability, restless lassitude, social withdrawal, sleep disorders, obsessional and rigid thinking can be a factor of starvation or malnutrition entirely, rather than a pre-existing neurotic condition..
3. **Educational and research orientation.** A CBT approach integrates research on best practices, and psychoeducation to counteract rigid biases and narrow paradigms evident in eating disordered black-white thinking. In contrast, a pure SFT eschews didactic or

academic information sessions, preferring clients to discover for themselves alternative information and possibilities. As athletes are typically looking for "the winning edge" they are apt to be more eager to absorb direct information derived from leading research on their situation. Thus a direct approach may be more effective, and certainly more efficient, than a more indirect SFT approach to disseminating relevant information.

4. **Constraints and skill training.** A pure SFT approach assumes that clients have within themselves all the resources and skills they need to find the solutions to their problems, Clients are prevented from gaining access to these resources and strengths by constraints or limiting assumptions. These are similar to "underlying schemas" or assumptions and rule structures that are unveiled and challenged in CBT interventions. Both therapies gently unhook the client from the grip of maladaptive thinking patterns. However, CBT also goes beyond a constraint model by sometimes providing direct skill training in a client deemed to be skill deficient. Skills can be taught, modeled, drilled in role plays and simulations, and finally transferred into the real life of the client. Again, the concept of skill learning and practice is congruent with the mindset of athletes, whose lives are largely devoted to skill acquisition and mastery.

5. **Motivational interviewing.** Eating disorders often have the properties of addictions which the client may be reluctant to surrender. Thus CBT often uses elements of motivational interviewing to assess client readiness for change (Weeks & L'Abate, 2003) to cement client motivation and prevent false starts and sudden collapses. Typically the therapist employs restraint, skepticism, and doubt, as well as therapeutic challenges "I'm not sure if you are really ready for change yet. Let's go slow and assess this further." In contrast, a typical SFT approach is to promote change from the outset in a flurry of hope and activity. With AEDs there is often a delicate interplay of enthusiasm and caution in embarking on the therapeutic journey and setting the glue of the therapeutic alliance.

6. **Utilization of client strengths and resources.** Both SFT and CBT utilize client strengths and resources. Both have a positive orientation to clients and their inherent potential. A prominent example of a strength in all experienced athletes is an ethos of using best known practices for training based on current research. The academic orientation of CBT places it in a leadership position in a therapy oriented towards athletes and their view of the world.

7. **Empathy and a bond of mutual respect.** Both therapies, as all therapies, emphasize empathy and mutual respect as their basis. While this aspect does not differentiate the

relative advantage of either therapy, it was noted in Mr. Allen's research as a prominent theme in Young's therapy of AEDs.

- 8. Externalization of the problem and the reciprocal nature of perceived control.** Both CBT and SFT use externalization of the problem, so that therapist and client can join in the therapeutic alliance to limit the sphere of influence of the problem, and increase the sphere of freedom from the problem. SFT promotes this idea even more with scaling or questioning the client about these changes in relative influence as therapy progresses. This element can be especially important in the reciprocal nature of perceived control in eating disorders. That is, there is a paradoxical effect of an eating disorder developed to counteract the client's perceived lack of control over her (his) world, then becoming a rampant element largely controlling the life of the client.
- 9. Use of metaphors.** Metaphorical stories are a large part of Young's therapy, largely owing to the traditions of SFT and Narrative Therapy models, and Young's significant use of Ericksonian hypnosis-derived patterns of communication. For example, a frequent metaphor in SFT management by exception is the story of islands of security in a sea of chaos after a flood. Gradually more and more islands of resources appear and become connected, and thus the seas of chaos and insecurity recede as treatment progresses. Another metaphor is how an eating disorder saps your ability to deal with real-life stressors, just like a computer virus that obstructs and consumes RAM to grossly slow down the computer's ability to handle complexity. While metaphors are used in CBT, they are not central to that approach, compared to the relative emphasis of metaphors in SFT, and the attunement to utilizing client language and personal stories as metaphors for internal resources.
- 10. Future orientation and the use of imagery.** In the early phases of treatment with AEDs, Young typically installs hope by having his clients go through an imaginary mirror that is permeable, thereby stepping into a future six months from now when their eating disorder is in their past. They also visit imagined key turning points in the process of their recovery, including resiliency to overcome challenges and setbacks. This future-paced guided imagery journey is typical of CBT, and also parallels SFT use of the Miracle Question, asking the client to imagine what life would be like if a miracle happened and their eating disorder were now cured. Imprinting such an image becomes a blueprint for the self-fulfilling prophesy of future client recovery. Of course, imagery practice is a frequent exercise of high performance athletes, so it is an almost automatic fit for the mindset of AEDs.

11. **Discipline and delay of gratification.** Another prominent theme in the treatment of AEDs is therapist utilization of the athlete's ability to be disciplined in the pursuit of a long-range goal. Of course, this asset can lead to self-destructive rigidity and perfectionistic overcontrol in the cases of anorexia. In cases of bulimia nervosa, overcontrol can alternate with impulsive behavior, especially in dealing with competitive pressures and self-comfort rituals after disappointments and poor athletic performances. CBT is aimed at helping athletes deal with strong emotion within a framework of containment but thorough examination and acceptance of occasional emotional turmoil.

12. **Process orientation.** Once treatment goals have been established and agreed upon, therapy can proceed with a high degree of orientation to process, small and segmented steps toward larger end goals. Again, this method is common to both CBT and SFT, expanding the range of positive influence patterns in our lives. For athletes in particular, this graduated attainment is a method of steady discipline quite familiar to them. An emphasis on the love of process, being in the Now, and focusing on the positive feelings generated by smooth performance, is a focus cherished by experienced athletes.

13. **Use of external support networks.** Most addicted people, including AEDs, participate at least partially in the myth of independence. That is, they believe that their life generally works well for them; they just have this little secret problem that they will be able to overcome by themselves without external support or help. The trouble is that the little problem never goes away, and gradually becomes worse and more consuming of precious personal resources. In the early to middle phases of treatment, Young helps the AED deal with issues of shame and dependency by desensitizing the fear of asking for help and relying on a support net of 9-12 people when dealing with strong impulses or emotions that could derail recovery. For AEDs this support net often includes both people in the sport community and relatives and friends outside it. Both CBT and Narrative approaches use support networks; they are a prominent component of recovery programs in general.

14. **Challenges to continuity of therapy.** AEDs are challenging to treat partly because of the constant demands of rigorous training schedules that make serious time and energy demands of athletes, not to mention intense competitive pressures. Added to this difficulty are training camps, tours, and competitions that require athletes to be on location in Europe or Asia for weeks and sometimes months away from therapy and other supports to their recovery. During those times, they may have one or two confidants in the sport environment, and perhaps long distance calls, emails, and Skype sessions with their therapist in rare unscheduled moments away from the team and its schedule. Still, the challenges to recovery for AEDs and their treatment are formidable for elite athletes, requiring flexibility and dedication for the client as well as the therapist.

15. **Life development and identity perspective.** The best competitors are those who have a balanced perspective and role diversity, so that their entire self-esteem is not totally dependent on athletic performance. This breadth of perspective is also crucial in helping AEDs, whose identity horizons and sources of self-esteem are further ravaged by the secrecy and shame issues generated by eating disorders. Both CBT and SFT aim to widen the perspectives and paradigms of their clients to put athletic performance in its proper perspective.

16. **Spirituality and mindfulness elements.** Although not central to CBT and SFT, Young emphasizes several aspects of mindfulness derived from his martial arts background. Zen and Taoist concepts of observation and witnessing, detachment, passion, focus, and compassionate acceptance allow athletes to contact their Inner Warrior, rather than their inner worrier. Compassion and acceptance allow AEDs to go beyond judgmental and rigid paradigms of thinking that trap them in their disorder.

17. **Relapse prevention.** SFT typically focuses on getting the client “unstuck” from their problems, assuming they will be then free to use their own internal resources to avoid future difficulties. In contrast, CBT approaches to AEDs often focus carefully on relapse prevention in the latter phases of therapy. Relapses, a frequent phenomenon in eating disorders, are most likely to occur at times of high stress or crushing disappointments, a common occurrence in the lives of athletes. Therefore, there is a strong emphasis on homework assignments, challenges, and simulations to test the resiliency of the recovery. Only when the AED has completed these assignments successfully can termination of treatment occur, and even then there is a commitment to internal and external monitoring and follow-up for up to a year post-treatment.

DISCUSSION AND CONCLUSION

In 2008 a graduate student based in Edmonton, Alberta, used a modified single subject discursive analysis design for his master's thesis in applied psychology. Nicholas Allen wanted to test his hypothesis that Solution-Focused Therapy (SFT) would be an excellent treatment of choice for athletes with eating disorders (AEDs). His interviewee, Frank D. Young Ph.D. R. Psych. is a practicing therapist with over 25 years' experience in treating both eating disorders and athletes with eating disorders. From a literature review, as well as extensive and thorough interviews with

Dr. Young, Allen came to know why Cognitive Behavior Therapy (CBT) is identified as the treatment of choice for eating disorders and AEDs in particular. Dr. Young uses specific techniques and an ideological slant derived from SFT and narrative approaches in the wide-ranging and thorough framework of CBT. Mr. Allen's paper features the highlights of themes that occur in Dr. Young's blend, including mindfulness and spiritual elements not commonly associated with either model, but a helpful adjunct to both athletes and people afflicted with eating disorders, especially where these populations overlap in AEDs.

While Allen's thesis describes these themes at length, the current paper condenses the main themes. The author's conclusion is that, for both eating disorders and athletes, but especially AEDs, a CBT model provides the required multidimensional framework necessary for a thorough and comprehensive treatment. SFT, while an inspired model, is not sufficient in most of these cases to address the depth and width of comprehension and administration of treatment necessary to assure prevention of relapse and possible subsequent treatment failure. Nevertheless, many interventions and attributional sets from SFT can be constructively and seamlessly integrated into CBT to amplify its effectiveness and enjoyment for both therapist and client.

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