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TRANSDIAGNOSTIC MODELS OF EATING DISORDERS AND THERAPEUTIC METHODS: THE EXAMPLE OF FAIRBURN'S COGNITIVE BEHAVIOR THERAPY AND ACCEPTANCE AND COMMITMENT THERAPY

The present article aims to present a transdiagnostic approach to eating disorders (anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified) using the example of two relatively new types of therapy: Cognitive Behavior Therapy (CBT), based on Fairburn's model, and Acceptance and Commitment Therapy (ACT). Theoretical frameworks, psychopathology, proposed change mechanisms, as well as objectives and selected therapeutic techniques are discussed for both approaches. Directions for further research comparing the efficacy of the two approaches, the factors that moderate their outcomes, and the possibilities of integrating the two models are also suggested.

Keywords: eating disorders, Cognitive Behavior Therapy, Acceptance and Commitment Therapy, transdiagnostic approach.

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INTRODUCTION

Eating disorders listed in DSM-IV-TR include Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Specified (EDNOS). This last category includes Binge Eating Disorder (BED, American Psychiatric Association, 2000).

The number of people affected by eating disorders has been climbing steadily in the last few decades (Currin, Schmidt, Treasure, & Jick, 2005), both in the Western countries and in Poland (Pilecki, Nowak, & Zdenkowska-Pilecka, 2004). With the life-threatening potential of these disorders and the harmful effects they have for physical and mental health, the importance of developing effective treatments can hardly be overestimated.

The purpose of the present paper is to present two relatively new types of eating disorder therapy (under development since the 1980s) based on the transdiagnostic approach to a wide spectrum of clinical issues associated with eating: Fairburn's transdiagnostic model of Cognitive Behavior Therapy and the Acceptance and Commitment Therapy (ACT). Potential directions for further research aimed at optimizing treatment efficacy will also be suggested.

Fairburn's transdiagnostic approach, developed from traditional Cognitive Behavior Therapy, proceeds from the notion that all eating disorders have similar characteristics (Favaro, Ferrara, & Santonastaso, 2003) and underlying psychopathology reflected in analogous attitudes and behaviors (Fairburn, Cooper, & Shafran, 2003). In a number of clinical cases the diagnosis migrates from anorexia to bulimia or from bulimia to EDNOS (Milos, Spindler, Schnyder, & Fairburn, 2005). The majority of eating disorder sufferers (over 50%) are originally diagnosed with EDNOS, which, before the development of the transdiagnostic model, was not covered in studies assessing the efficacy of eating disorder treatments. As a result, there were no specific recommendations for the management of people with EDNOS diagnosed (Fairburn & Harrison, 2003; Fairburn & Bohn, 2005).

Cognitive Behavior Therapy (Fairburn's Transdiagnostic Model)

In Fairburn's transdiagnostic approach, eating disorders are understood as cognitive problems (Fairburn, Cooper, & Shafran, 2013). According to this model, the underlying cause of all eating disorders is the same set of dysfunctional self-worth beliefs, referred to by Fairburn as "core psychopathology." It involves

the overestimation of body weight,[1] appearance, and their control (Fairburn et al., 2003). Unlike in people whose self-worth is based on their achievements in various spheres of life, in eating disorder patients the sense of self-esteem of is primarily determined by their weight, figure, and the ability to control them. Consequently, they engage in behaviors that reinforce core psychopathology. These patients attempt to follow various dieting regimes, often extremely restrictive or irrational, such as complete avoidance of carbohydrates or eating 800 kcal a day. Breaking any of these rules, virtually unavoidable due to their restrictiveness, usually prompts a binge eating episode. The patient temporarily suspends all restrictions on food intake, thinking: "Since I have broken a rule anyway, I can eat as much as I want to." A few days later this leads to even stricter dietary restrictions, often accompanied by a sense of guilt. In some people a binge eating episode is followed by compensatory behavior (e.g., induced vomiting, strenuous physical exercise, or intake of laxatives), which in turn increases the risk of another binge through a dysfunctional belief that compensatory behavior helps control weight. Some patients use binging to cope with stressful life events and negative emotions, or as a diversion or mood regulator.

In individuals who rarely or never engage in binge eating, dietary restrictions cause gradual loss of body mass, leaving them underweight. The consequences of low weight and malnourishment include problems with focusing and decision-making, a general decline in cognitive processes, obsessive thoughts about food, and gradual social withdrawal. Prolonged restrictive dieting causes a premature sense of fullness during a meal. All the above consequences of being underweight and malnourished are secondary contributors to core psychopathology (Fairburn et al., 2013).

As part of "extended theory," Fairburn identified other mechanisms that maintain core psychopathology, such as: shape and weight checking (weighing oneself on a daily basis, examining oneself for hours in the mirror, using measuring tape, comparing oneself with others) and/or shape and weight avoidance (avoiding mirrors, swimming pools, and trying on clothes; never weighing oneself), interpreting each sensation or discomfort as "a sense of being fat," marginalization of activity in other life domains (social withdrawal), as well as preoccupation with thoughts about food, weight, and appearance.

In addition, some patients display maintenance mechanisms typical of general psychopathology and not unique to eating disorders. These are: clinical perfectionism, low self-esteem, and interpersonal difficulties (Fairburn et al., 2003).

[1] The Authors intentionally use the colloquial term "weight" instead of the correct term "body mass" in order to make the text more accessible.

These mechanisms do not necessarily occur in every patient and they do not always coincide in time with core psychopathology. The presence of these mechanisms does not automatically lead to eating disorders. The sine qua non condition is that the individual harbors a set of dysfunctional convictions regarding the significance of weight and shape, and the importance of having them under control (Hoiles, Egan, & Kane, 2012).

The main goal of Cognitive Behavior Therapy in the transdiagnostic model is to improve patients' quality of life by achieving a resolution of symptoms. Since according to Cognitive Behavior Therapy (Dimidjian & Dobson, 2005) behavioral change alone is not sufficient to ensure lasting improvement, the primary objective can be achieved by modifying maladaptive convictions about the importance of weight, shape, and having them under control. Beliefs can be modified directly, by replacing an earlier way of thinking with a new, more adaptive one (i.e., by cognitive restructuring) or indirectly, by disrupting the mechanisms that maintain maladaptive thinking (Gelder, 2006). The latter cognitive change mechanism plays a key role in the transdiagnostic theory (Fairburn et al., 2013). Maintenance mechanisms are disrupted through the achievement of specific objectives, such as normalisation of eating habits, a reduction of dietary restraint, elimination of the number of binge eating episodes and compensatory behavior, giving up on weight and shape checking/avoidance, learning to deal with emotions in other ways than by eating, and becoming more active in other areas of life (Fairburn et al., 2013).

The transdiagnostic therapy protocol was developed on the basis of 30 years of experience, observation, and revision of the traditional cognitive behavioral approach by trial and error. CBT-E (Cognitive Behavior Therapy-Enhanced) was designed as individualized intervention involving modules selected and ordered according to a specific problem conceptualization developed together with the patient (Fairburn, Cooper, Shafran, & Bohn et al., 2013).

Intervention makes limited use of traditional cognitive methods, such as thought record, identifying and challenging core beliefs (or Socratic questioning), because observation does not confirm their efficacy in the treatment of eating disorders. There are two rules for selecting therapeutic techniques. One is concerned with effectiveness (choosing methods that work) and the other with simplicity (if desirable changes can be achieved using a simpler technique, more complex ones are not to be employed). The main strategy in Fairburn's approach is psychoeducation. During the course of therapy, patients learn to monitor their eating disorder and its mechanism. They are encouraged to try new behaviors and observe their consequences. Purely cognitive techniques are used in this

framework to identify and cope with cognitive distortions associated with eating disorders (in particular, black-and-white thinking and selective attention). Traditional tools, such as self-monitoring, pie charts, problem solving, or pros and cons, are also employed (Fairburn, Cooper, Shafran, & Bohn et al., 2013).

CBT-E is an evolution of cognitive behavioral approach to bulimia nervosa with documented efficacy (Wilson & Shafran, 2005). The results of the first randomized controlled trial (RCT) evaluating CBT-E in participants diagnosed with EDNOS and bulimia nervosa confirmed relatively high efficacy of both the focused version of therapy (targeting eating disorder maintenance mechanisms exclusively) and its extended variant which also deals with additional maintenance mechanisms of clinical perfectionism, low self-esteem and interpersonal difficulties. Sixty weeks post treatment, improvement was maintained in 51.3% of participants (Fairburn et al., 2009). Another RCT study confirmed the effectiveness of CBT-E in patients with BMI under 17.5 – that is, those meeting the diagnostic criterion for anorexia nervosa. The study reported 40% effectiveness, with two thirds of patients who completed treatment (53%) experiencing improvement (Byrne, Fursland, Allen, & Watson, 2011).

Overall, research findings have been promising so far, especially that CBT-E was shown to be effective in individuals with BMI under 17.5 (for whom the effectiveness of Cognitive Behavior Therapy is yet to be empirically established) as well as in patients diagnosed with EDNOS. Nevertheless, authors have noted that future research should include an analysis of the mediators of change (i.e., the factors whose change in the course treatment is responsible for its effects) and the moderators of change (the factors that facilitate or impede positive outcomes) (Murphy, Cooper, Hollon, & Fairburn, 2009), stressing the need for continued improvement of intervention methods to minimize the percentage of patients who terminate therapy prematurely.

Acceptance and Commitment Therapy (ACT)

Similarly to Fairburn's model, ACT follows the transdiagnostic approach, but the health and illness model it proposes is applicable to a much wider range of psychological disorders than merely eating problems. Philosophically, it is founded on functional contextualism, while its theoretical foundations are in the Relational Frame Theory (RFT), a comprehensive theory of human language and cognition (Hayes, Strosahl, & Wilson, 2013). ACT has been shown to be effective in such problems as chronic pain, depression, psychosis, anxiety disorders,

obsessive-compulsive disorders, and many more (Ruiz, 2010). As ACT is less known in Poland, it will be discussed in greater detail.

Drawing on one of the assertions of functional contextualism, namely the so-called pragmatic theory of truth (that which is useful and functional is true), the founders of ACT assume that therapeutic objectives are not imposed by some arbitrary, external criterion but rather follow from values important for a given individual. Thus, in contrast to the traditional approach, ACT does not insist on an arbitrary definition of "norm"; mental health is construed as the ability to achieve objectives and values important for a given person rather than as the absence of symptoms (Gifford, Hayes, 1999; Hayes et al., 2013).

The ACT approach to mental health differs from the traditional theory in yet another significant way. Taking RFT and findings from empirical research on that model as their point of departure, Hayes et al. (2013) have postulated that psychological suffering (or pain) is an inevitable part of the human experience due to the way human language operates. Pain cannot be avoided because, unlike animals, we cannot escape such suffering in a physical and situational sense. For example, we cannot elude the pain of losing a loved one or a memory of past injustice. The human being has always been accompanied by his or her mind, whose creations (thoughts) provoke the same responses as actual physical events. This phenomenon is known as cognitive fusion. It occurs when verbally established[2] stimulus functions marginalize their other roles, for example when the evaluation of a given stimulus (value, beauty, etc.) eclipses its other aspects, gaining total control over our responses to that stimulus. Fusion causes human behavior to be governed by verbal rules[3] to a greater extent than by direct experience. Admittedly, the control of behavior by verbal rules is not without its advantages (e.g., they facilitate the assessment of situation as well as enable us to predict consequences and plan our actions). On the other hand, the same rules

[2] Verbal transformation of stimulus function is understood in RFT as expansion of non-arbitrary functions of a given stimulus by other functions through its inclusion in so-called relational frames with other stimuli. For a more detailed and systematic account of Relational Frame Theory and its practical implications, see Torneke (2010) or Ostaszewski and Malicki (2013, in Polish).

[3] Modern behavioral psychology maintains that, in contrast to that of nonverbal organisms, human behavior is controlled not only by direct causative relationships. According to RFT, by using relational frames and deriving relations between them, humans are able to establish rules governing behavior and learn new behaviors without the need for direct conditioning. These rules are formulated on the basis of the same behavioral mechanisms that underlie language acquisition and, in this sense, are referred to in RT as "verbal rules." One of the key attributes of rule-governed behavior is its resistance to modification by direct consequences. This has some undeniable advantages, but in the case of clinically problematic behaviors it makes the therapeutic process particularly challenging. For a comprehensive discussion of verbal regulation, see Torneke (2010).

applied to internal experience may can often cause pain, leading to the depletion of individual behavioral repertoire and its diminished flexibility, thereby hampering progress towards goals and values important for the individual (Hayes et al., 2013). According to RTF, these processes are a natural consequence of human language and "by-products" of typical human cognitive mechanisms (Torneke, 2010; Ostaszewski & Malicki, 2013).

The originators of ACT claim that mental problems are not directly caused by painful thoughts or negative emotions, but result from attempts to avoid and control them at all costs. These attempts are doomed to failure anyway, since we cannot control our internal experience (feelings, memories, thoughts, sensations) the way we control external threats. Attempts to control, alter, or avoid our own experiences (thoughts, emotions, memories, physical sensations) are referred to as experiential avoidance. Experiential avoidance results in the opposite of what it seeks to achieve, reinforcing the importance, intensity, and frequency of unwanted internal experiences (Luoma, Hayes, & Walser, 2007). Furthermore, experiential avoidance is energy- and time-consuming, gradually undermining behavioral flexibility and depleting behavioral repertoire, causing individuals to lose touch with the goals and values they find important. Every day becomes a struggle for a short-term relief offered by escaping one's experience. Fleeing from experience supersedes the pursuit of that which is truly important and could bring happiness and a sense of purpose (Sandoz, Wilson, & DuFrene, 2010; Hayes et al., 2013). Experiential avoidance leads to so-called secondary suffering – the pain of living without purpose, goals, or values. Cognitive fusion and experiential avoidance foster psychological inflexibility, which ACT recognizes as the primary source of psychopathology. It is defined as the inability to prevent, initiate or continue a behavior even if it is necessary to achieve goals compatible with individual values (Luoma et al., 2007).

According to ACT, the basis for mental health and therapeutic change is psychological flexibility: being here and now, with all of our thoughts and emotions, and the ability to make choices and guide our behavior according to our personal values (Ciarrochi, Billich, & Godsell, 2010; Hayes et al., 2013). Psychological flexibility is comprised of six functionally defined behavioral components, whose development is the strategic aim of ACT. These are: defusion, acceptance, being present, self-as-context, values, and committed action. They are discussed in more detail below.

Defusion is a therapeutic process involving the creation of a context in which thinking becomes experienced as an internal, observable process, and thoughts are no longer reified, thus losing their influence on emotions and behavior. We

can say that, as a result of defusion, people learn to recognize symbols (including thoughts and memories) for what they are, instead of for what they symbolize. Acceptance means conscious agreement to experience reality as it is. It is a choice to fully experience difficult emotions, thoughts, memories, and physical sensations, without defending against our own experience when such defense would interfere with the pursuit of goals compatible with our personal values. Being present is tantamount to being attentive and aware of what one experiences at any given moment, while self-as-context means assuming the observer's perspective, particularly with respect to the contents of one's consciousness (such as thoughts, emotions, or memories). These processes help establish which values are important for a given person and act in a way that is compatible with those values (Hayes et al., 2013).

In ACT (unlike in Cognitive Behavior Therapy), eating disorders are defined by the role they play in the life of an individual and in the context from which they emerge (Sandoz et al., 2010). Eating disorders and their symptoms require treatment not because they are abnormal, have negative effects on the body, or cause stress, but because they prevent individuals from acting in accordance with their goals and values. Individual symptoms can be interpreted as means of escaping difficult thoughts, unpleasant emotions or physical sensations, both on a more general level (e.g., fixation on food and weight diverts attention from life problems, the sense of loneliness, or the inevitability of death) and on the level of individual behaviors and internal experiences (for example, binge eating is a way to escape sadness) (Pearson, Heffner, & Follete, 2010). It should be noted that, with the constantly shifting context, perceived behaviors – both those more fleeting (feelings, thoughts) and those more easily observable (dietary constraints, eating binges, compensatory behavior) – may serve different functions in different people and should be analyzed on an individual basis (Sandoz et al., 2010).

Apart from the present context informing individual symptoms, what is of no small significance is the historical context: a unique set of personal experiences that shapes the individual's attitude towards weight and appearance, food, and their own internal experiences. In the course of their lives, people with eating disorders learn that beauty is associated with being thin and that this is the way to win social approval, which is an important positive reinforcement for any person. They also learn that eating is more than satisfying a biological need – it has other functions as well. It can be used to obtain positive social reinforcement, such as mother's approval at the sight of a meal finished by her child. Furthermore, it plays a significant role in culture and celebration of holidays and other

functions. For example, a wedding or a Christmas Eve dinner are inconceivable without food. It is also a way to show other people affection – for some, the only kind they have experienced. Eating is also an acceptable and easily available form of experiencing pleasure or finding relief from painful emotional states. In addition, some people are told from early childhood that bad moods and negative thinking are signs of abnormality and evidence of a problem that must be solved. They also learn that positive emotions gain social approval. As a consequence, they attempt to avoid undesirable internal experiences, for example by overeating or drastically limiting their food intake.

Eating disorders develop when, due to a series of experiences (learning process), body and food assume aversive control over a given person's behavior. With time, that person's attention becomes increasingly fixated on the body, itself reduced to the "fat-thin" dimension, pushing other aspects of life to the background. Food becomes a "punisher," and interactions with it are dominated by avoidance. The individual's behavioral repertoire is gradually depleted, and his or her thoughts, feelings, and attention are increasingly centered on the body and body image avoidance.[4] Behaviors aimed at controlling weight and appearance become more important than education, relationships with loved ones, and hobbies. The individual loses the ability to do what they considered truly important – to pursue their goals and aspirations. Thoughts of food, weight and appearance divert attention from the present moment, making it impossible to experience reality to the full extent. Dietary restrictions, binge eating, and body image avoidance all serve to get away from unwanted internal experiences. The sense of self becomes restricted to the dimensions of weight, food, or eating disorder ("I am a glutton," "I am anorexic"). As the patient loses touch with the long-term consequences of his or her actions, his/her set of values becomes increasingly restricted. Work, family, close relationships, socializing, and the pursuit of passions and dreams all become of secondary importance as the life of the affected person focuses on food, weight, and appearance. Behavior falls under the control of verbal rules associated with externally imposed values and the need to win social approval (e.g., "I will not be happy until I lose weight"). This pattern of behavior persists despite negative consequences and inconsistency with personal objectives and values (Sandoz et al., 2010). It is worth noting that in this approach it is not the diagnosis (differentiating between anorexia nervosa, bulimia,

[4] Body image avoidance is a broad term that covers shape and weight checking, as well as avoiding mirrors, concealing one's actual body shape by wearing loose-fitting clothes and other behaviors (which Fairburn termed shape checking and avoidance).

and EDNOS), but the conceptualization unique for a given person that dictates the course of treatment (as in Fairburn's transdiagnostic model).

The primary goal of therapy is to restore the client's ability to lead a life consistent with their values. This is achieved by enhancing psychological flexibility (developing its individual behavioral components) to improve the client's chances of leading a rewarding life. With this purpose in mind, ACT does not concentrate on the alleviation of eating disorder symptoms but on expanding the patient's behavioral repertoire and changing its dominant functions (Sandoz et al., 2010). The authors insist that in the course of therapy it is vital to see the client not as a problem to solve but as a human being, with all of his/her struggles, values, aspirations, experiences, and pain.

During therapy, the therapist observes rigidity in the course of a session with respect to individual behavioral components and supplies experiences to increase the chance of restoring psychological flexibility. This strategy aims to enhance the client's awareness of the sources of behavioral control alternative to verbal rules, to bolster his/her autonomy and ability to make choices, and to promote new, effective behaviors compatible with the individual's goals and values. The originators of ACT suggest that there is no single correct treatment protocol and encourage therapists to develop custom protocols (Sandoz et al., 2010).

The choice of techniques used in ACT is based on their functional rather than formal qualities. This means that ACT allows any method to be used as long as it fulfills its function (Hayes et al., 2013). An ACT practitioner uses a variety of techniques employed in other therapeutic approaches, selecting them so that they affect specific processes that together make up psychological flexibility. The choice is justified by referring to the propositions of the Relational Frame Theory and findings from related research (Blackledge & Drake, 2013).

In contrast to traditional Cognitive Behavior Therapy (but similarly to Fairburn's transdiagnostic model), the therapist does not aim to modify the content of thoughts or beliefs, as that would only serve to reinforce their importance and frequency. Instead, he/she tries to change the function of thoughts and beliefs in the client's life. The therapist modifies the psychological function of problematic experience, facilitating progress towards objectives and values by providing appropriate therapeutic context, using imagery, mindfulness, metaphors (including those that involve the nonverbal system, e.g., rope pulling), change of perspective tasks (e.g., What would the five years older you say to the present you?), exercises in value clarification and goal setting. Since ACT stems from behaviorism, it also uses techniques such as monitoring, exposure, and behavioral experiment (Blackledge & Barnes-Holmes, 2009; Hayes et al., 2013).

The results from a handful of studies evaluating ACT in eating disorders are encouraging. The first case study describing the application of ACT in the treatment of eating disorders involved anorexia (Heffner, Sperry, Eifert, & Detweiler, 2002). Several RCT studies have confirmed the effectiveness of ACT in people with disordered eating; however, none of them were conducted on a clinical population (patients diagnosed with eating disorders). The following groups have been studied so far: students with eating problems accompanied by other mental disorders (Juarascio, Forman, & Herbert, 2010), bariatric surgery patients (Weineland, Arvidsson, Kakoulidis, & Dahl, 2011) and people with body image dissatisfaction (Pearson, Follette, & Hayes, 2012). Researchers have stressed the need for empirical studies on a population of patients diagnosed with eating disorders and for further development of this model (Sandoz et al., 2010).

CONCLUSIONS

Although the approaches described in the present article differ in terms of theoretical background, proposed change mechanisms, and psychopathology models, they have a number of features in common. Both put emphasis on empiricism and empirical validation of treatment effects in clinical trials. Both share a transdiagnostic view of eating disorders (despite different models of psychopathology) and look to adapt their approaches to individual conceptualization of each particular case.

At present, CBT-E is supported by a more substantial body or empirical data. Its major strength is the specific and clearly scheduled protocol and swift implementation of changes in unhealthy behavior (e.g., elimination of compensatory behavior). On the other hand, therapy is focused on symptoms and requires a highly motivated patient, who also has to consent to regular weight measurements and food intake monitoring from treatment start. The mechanisms underlying improvement have not been uncovered and empirically confirmed, either. Despite optimistic data on CBT-E, we need to answer the theoretical question about the expected durability of treatment effects. Our present empirical knowledge on learning processes suggests that behavior modification usually consists in learning a new behavior, rather than eradicating previous, maladaptive behaviors from the individual's repertoire. Phenomena such as spontaneous recovery in classical conditioning or resurgence of old responses in operant conditioning suggest that a change of behavior does not eliminate its previous patterns (Bouton, 2002; Bouton & Swartzentruber, 1991). Rather, they are suppressed, but not

"erased" and remain in the individual's repertoire of potential behaviors. If, however, new behaviors at some point stop being maintained by social reinforcements (which is a distinct possibility in eating disorders, since the patient's sociocultural environment may endorse behavior aimed at maintaining a slim figure), a reemergence of previous patterns of behavior is to be expected. Although this prediction is formulated on the grounds of behaviorism, it is consistent with the cognitive schema activation-inactivation model (Hollon, Evans, & DeRubeis, 1988). According to this model, instead of being transformed, dysfunctional cognitive schemata are inactivated, while new, more functional schemata replace them as active behavior regulators. It can therefore be expected that in unfavorable circumstances the process is reversed and old schemata are activated, overriding new ones. Consequently, the CBT-E model seems to fail to equip patients with more general skills for coping with situations where previous patterns of behavior are reactivated. Perhaps Acceptance and Commitment Therapy is a better answer to the environmental and cultural factors that maintain the psychopathology of eating disorders.

ACT is focused on the individual and his or her goals and values, treating symptoms as ineffective, learned adaptive behaviors hampering their achievement. This approach could make it easier to start treatment and lessen the discomfort associated with the introduction of changes as well as relieve fixation on food, weight, and appearance, particularly in people with a long history of disorder and comorbid problems. It provides patients with a set of skills enabling them to cope in a situation where, for example, painful thoughts or emotions internalized in the past threaten to trigger earlier behavior patterns. Consequently, the risk of patients reverting to the behavior that prompted them to see a therapist should be reduced in the first place. Moreover, patients learn new behaviors that are consistent with their personal values and goals and provide them with a steadily increasing amount of positive reinforcement, which further lowers the risk of returning to problematic behavior patterns.

Future research should conduct a direct comparison of the efficacy of the two approaches in the treatment of eating disorders, with particular emphasis on treatment outcome duration. The characteristics of patients who are more likely to benefit from one or the other model are also worth investigating. Hypothetical differentiating factors could include motivation level, treatment history (duration of disorder, other concurrent mental problems, number and types of previous therapies), and the significance attributed to the disease. Another promising direction for research would be to consider integrating the two approaches to the

treatment of eating disorders in order to use the strengths of either model and maximize the efficacy of therapeutic interventions.

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