Understanding and Working with Disordered Eating in Psychotherapy

THE TALKING THERAPIES UK PRACTITIONER SERIES



Understanding and Working with Disordered Eating in Psychotherapy

A Clinical Guide for Counsellors and Psychotherapists

Practitioner level · 6 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Understanding and Working with Disordered Eating in Psychotherapy course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 2. This printing was set on 2 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Understanding and Working with Disordered Eating in Psychotherapy – A Clinical Guide for Counsellors and Psychotherapists offers a rigorous, intermediate-level exploration of the complex presentation of disordered eating within a CBT framework. Over six CPD hours, participants will be guided through four interlinked modules that together build a comprehensive skill set for safe, evidence-informed practice in both private and NHS settings.

The first module, Foundations and Clinical Conceptualisation, invites learners to map the full spectrum of disordered eating, from sub-clinical concerns to formally diagnosed eating disorders. By examining current NICE diagnostic criteria and the latest revisions of the DSM-5, participants will develop a nuanced understanding of how cognitive distortions, affect regulation difficulties, and interpersonal maintenance factors intertwine to sustain maladaptive eating patterns. Practical case formulation exercises will enable clinicians to integrate formulation with assessment tools such as the PHQ-9 and GAD-7, ensuring that each client's unique psychological landscape is accurately captured.

Risk Assessment and Ethical Practice, the second module, equips practitioners with a systematic protocol for evaluating both physical and psychological risk. Learners will acquire competence in interpreting medical indicators, recognising signs of electrolyte imbalance, and applying tiered safety planning that aligns with NHS safeguarding standards and private practice ethical guidelines. The module also addresses consent, confidentiality, and the delicate balance of autonomy and protection when working with clients whose insight may be compromised.

In Evidence-Based Therapeutic Interventions, participants will master core CBT-ED techniques, including regular eating, exposure to feared foods, and cognitive restructuring of weight- and shape-related thoughts. Complementary Compassion-Focused Therapy (CFT) strategies are introduced to foster self-compassion, reduce shame, and counteract the harsh self-criticism that often fuels relapse. Role-play and

video-demonstrations provide hands-on experience in pacing interventions, monitoring progress with validated outcome measures, and adapting protocols for comorbid mood or anxiety disorders.

The final module, The Therapeutic Relationship and Multi-Disciplinary Working, explores relational dynamics that can either impede or enhance recovery. Learners will examine transference, counter-transference, and the therapeutic alliance within the context of eating disorder work, and will develop collaborative skills for engaging dietitians, physicians, and community services. By the end of the course, participants will leave with a robust, ethically grounded toolkit that enables them to deliver compassionate, effective psychotherapy for disordered eating, confident in their ability to assess risk, formulate cases, implement CBT-ED and CFT interventions, and work seamlessly within a broader clinical network.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 6 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Differentiate between various clinical presentations of disordered eating and eating disorders using current diagnostic frameworks.
- Assess physical and psychological risk effectively, implementing robust safeguarding and referral protocols.
- Integrate evidence-based therapeutic interventions, such as CBT-ED and CFT, into clinical practice.
- Navigate complex therapeutic dynamics, including ambivalence, resistance, and countertransference.
- Apply ethical and legal principles regarding client autonomy, capacity, and multi-disciplinary collaboration.

PART 1

Foundations and Clinical Conceptualisation

Explore the spectrum of disordered eating, diagnostic criteria, and the underlying psychological maintenance factors.

CHAPTER 1

Mapping the Spectrum of Disordered Eating

In the contemporary landscape of psychological practice, the distinction between normative cultural pressures regarding weight and shape, and clinical disordered eating, has become increasingly blurred. For the counsellor or psychotherapist, this ambiguity presents a significant diagnostic and therapeutic challenge. It is no longer sufficient to view eating disorders as binary categories of 'present' or 'absent'; rather, we must conceptualise them as existing on a spectrum. This lesson invites you to examine this continuum, moving from the pervasive influence of diet culture to sub-threshold presentations that often fall outside the rigid boundaries of the International Classification of Diseases (ICD-11) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Understanding this spectrum is foundational because it determines the intensity of intervention, the urgency of medical referral, and the specific therapeutic focus required in the room.

To begin, we must acknowledge the environmental context in which our clients exist. Modern Western culture, particularly in the UK, is saturated with pro-anorexia and pro-diet messaging. Social media algorithms frequently reinforce thinness ideals, creating a pervasive 'weight stigma' that normalises body dissatisfaction. Many clients present with what might be termed 'orthorexia' or rigid dietary rules, which, while not a formal diagnosis, can cause significant distress and functional impairment. The clinician's task is to differentiate between these normative, albeit unhealthy, cultural adaptations and clinical pathology. This differentiation is not merely semantic; it has profound implications for the therapeutic alliance. If a therapist pathologises a client's attempt to manage their weight in a culturally sanctioned way, they risk alienating the client. Conversely, if a therapist minimises a severe eating disorder as merely 'dieting,' they risk missing a life-threatening condition. Therefore, the initial assessment must be nuanced, exploring the degree of control, the presence of compensatory behaviours, and the impact on daily functioning.

The clinical spectrum is often described as ranging from ‘at-risk’ populations to full-blown eating disorders. At the lower end of the clinical spectrum, we find ‘Other Specified Feeding or Eating Disorder’ (OSFED) in the DSM-5-TR, or ‘Other Eating Disorders’ in the ICD-11. These are not ‘mild’ versions of anorexia nervosa or bulimia nervosa. Research consistently demonstrates that OSFED presentations carry a comparable level of psychopathology, comorbidity, and functional impairment to their more severe counterparts. A common misconception is that because a client does not meet the strict weight criteria for anorexia nervosa, their suffering is less significant. This is clinically inaccurate. A client with OSFED may present with binge eating without regular compensatory purging, or with restrictive eating that does not result in significantly low weight. These presentations are often under-recognised and under-treated, leading to chronic suffering and a higher risk of developing a full syndrome over time. As practitioners, we must be vigilant for these sub-threshold presentations, recognising that the absence of a specific label does not equate to the absence of clinical need.

Consider the following worked clinical example to illustrate this conceptualisation. Sarah, a 24-year-old university student, presents to your practice reporting ‘stress eating.’ She describes episodes of consuming large quantities of food in a short period, followed by intense shame and guilt. However, she does not engage in self-induced vomiting, misuse of laxatives, or excessive exercise. Her weight is within the normal range, and she has never been underweight. A novice clinician might dismiss this as a ‘bad habit’ or a lack of self-control, perhaps suggesting a diet plan or mindfulness app. However, a deeper exploration reveals that Sarah’s eating is driven by a rigid set of rules: if she eats ‘forbidden’ foods, she must ‘undo’ the behaviour through mental distress or by restricting the next meal. She has developed a profound fear of weight gain, which, while not currently manifesting in low weight, is distorting her self-worth. This presentation aligns with OSFED, specifically binge-eating type without purging. The clinical conceptualisation here is that Sarah is suffering from a significant eating disorder, not a behavioural quirk. The therapeutic focus must address the underlying anxiety and the rigid cognitive structures, rather than simply targeting the eating behaviour. If we fail to recognise this as a clinical condition, we miss the opportunity to intervene before the disorder escalates or becomes entrenched.

Furthermore, the spectrum is not static. Clients can move along the

continuum, often in response to life stressors, changes in body image, or the effectiveness of treatment. A client with bulimia nervosa may, through treatment, reduce the frequency of purging but continue to experience significant body dissatisfaction and dietary restriction. This transition does not signify 'recovery' in the holistic sense, but rather a shift in the presentation. The therapist must remain flexible, adjusting the conceptualisation as the client's presentation evolves. This dynamic view of disordered eating is crucial for long-term care. It acknowledges that eating disorders are complex, multi-dimensional conditions that interact with other psychological factors, such as depression, anxiety, and trauma.

In mapping this spectrum, we must also consider the role of comorbidity. It is rare for an eating disorder to exist in isolation. Clients often present with co-occurring conditions, such as obsessive-compulsive disorder, post-traumatic stress disorder, or personality disorders. These comorbidities can mask the eating disorder or complicate its treatment. For instance, a client with anorexia nervosa and obsessive-compulsive traits may exhibit extreme rigidity in their eating, which is difficult to distinguish from the restrictive nature of the eating disorder itself. The therapist must be skilled in disentangling these presentations to formulate an accurate treatment plan. This requires a comprehensive assessment that goes beyond the eating behaviours to explore the client's broader psychological history and current functioning.

The implications for practice are significant. First, we must adopt a non-judgmental, curious stance when exploring a client's relationship with food and body. We must avoid imposing our own values about health or weight, recognising that the client's experience is valid regardless of their BMI. Second, we must be prepared to work with a wide range of presentations, from those with severe medical risk to those with sub-threshold symptoms. This requires a broad skill set, including the ability to assess risk, provide psychoeducation, and deliver evidence-based interventions such as Cognitive Behavioural Therapy for Eating Disorders (CBT-ED) or Family-Based Treatment (FBT) for younger clients. Third, we must be aware of the limitations of our role. While we can provide psychological support and therapy, we are not medical professionals. We must know when to refer to a GP or a specialist eating disorder team for medical monitoring. This collaborative approach ensures that the client receives comprehensive care that addresses both the psychological and

physical aspects of their condition.

Finally, it is essential to recognise the impact of disordered eating on the therapist. Working with clients who have eating disorders can be emotionally demanding. The therapist may experience countertransference reactions, such as anxiety about the client's weight, frustration with the client's resistance, or a desire to 'fix' the problem. These reactions are normal and can be used therapeutically if explored in supervision. By understanding the spectrum of disordered eating, we can better manage our own responses and provide more effective care. We must remember that our goal is not to change the client's body, but to help them develop a healthier relationship with food and themselves. This requires patience, compassion, and a deep understanding of the complex factors that maintain disordered eating.

In conclusion, mapping the spectrum of disordered eating is a critical skill for the modern psychotherapist. It requires us to move beyond rigid diagnostic categories and embrace a nuanced, dynamic view of these conditions. By recognising the continuum from normative dieting to clinical pathology, we can provide more accurate assessments, more effective treatments, and more compassionate care. As we proceed through this course, we will explore the aetiology, maintenance, and treatment of these conditions in greater depth. However, the foundation laid in this lesson is essential for all subsequent work. It is the lens through which we view our clients, the framework within which we operate, and the basis for our clinical decisions. Let us approach this work with humility, curiosity, and a commitment to evidence-based practice.

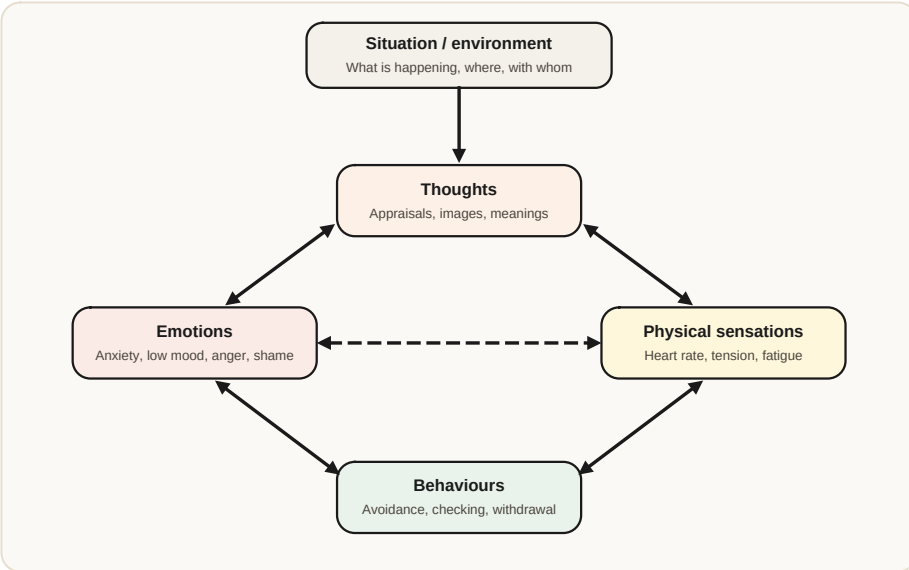


FIGURE 1.1 The five areas model

Greenberger and Padesky's five areas ("hot cross bun") model: a situation is processed through thoughts, emotions, physical sensations and behaviours, and every element influences every other. Change introduced at any point, most often at thoughts or behaviours, alters the whole system.

Points worth keeping

- The distinction between normative diet culture and clinical disordered eating is increasingly blurred, requiring nuanced assessment.
- Sub-threshold presentations, such as OSFED, carry significant psychopathology and functional impairment comparable to full syndromes.
- The clinical spectrum is dynamic, with clients moving along the continuum in response to stressors and treatment.
- Comorbidity is common and can mask or complicate the presentation of eating disorders, requiring comprehensive assessment.
- Therapists must adopt a non-judgmental stance and be aware of their own countertransference reactions when working with this population.
- Collaboration with medical professionals is essential for comprehensive care, particularly for clients with significant physical risk.

PRACTICE TASK

Review your current caseload and identify any clients who may be presenting with sub-threshold eating disorder symptoms (e.g., rigid dietary rules, body dissatisfaction without low weight, or binge eating without purging). Reflect on how you conceptualised these presentations in your initial assessment. Consider whether you might have missed a clinical diagnosis or underestimated the severity of the condition. Discuss your reflections in your next supervision session, focusing on how you can improve your assessment of the eating disorder spectrum in future cases.

CHAPTER 2

Aetiology and Psychological Maintenance

Disordered eating is a complex phenomenon that emerges from the interaction of biological, psychological and social factors. In clinical practice it is essential to recognise that no single factor is sufficient to explain the onset or persistence of an eating disorder; rather, a constellation of influences shapes the individual's experience and behaviour.

Biological contributors are often subtle but can set the stage for vulnerability. Genetic studies demonstrate a moderate heritability for anorexia nervosa, bulimia nervosa and binge-eating disorder, suggesting that inherited traits such as neurobiological sensitivity to reward, anxiety and impulsivity may predispose individuals to develop disordered eating patterns. Neurochemical imbalances, particularly in serotonin and dopamine pathways, have been implicated in appetite regulation, mood and reward processing. For example, altered serotonergic transmission can heighten anxiety and compulsive behaviours, while dopamine dysregulation may influence the reinforcing properties of food and shape the pursuit of control. These biological vulnerabilities are rarely sufficient on their own; they interact with psychological and environmental stressors to produce the full clinical picture.

Psychological factors encompass a range of cognitive, emotional and behavioural processes. Cognitive distortions such as all-or-nothing thinking, catastrophising and over-generalisation are common in eating disorders and serve to maintain maladaptive beliefs about body image, self-worth and control. Perfectionism, a trait characterised by excessively high standards and self-criticism, is strongly associated with anorexia nervosa and bulimia nervosa. Individuals with high perfectionism often use restrictive eating or purging as a means of achieving an unattainable ideal, and the resulting success reinforces the behaviour. Emotional regulation deficits also play a key role; many clients report using food or disordered eating behaviours as a way to cope with negative affect, thereby creating a negative reinforcement loop.

Attachment and early relational experiences shape the internal working

models that guide emotion regulation and self-concept. A history of inconsistent caregiving, emotional neglect or abuse can foster a sense of unworthiness and a belief that one must control external circumstances to feel safe. These beliefs often manifest in rigid eating patterns and a preoccupation with weight and shape. Moreover, comorbid psychiatric conditions such as anxiety disorders, depression and obsessive-compulsive disorder frequently co-occur with eating disorders, further complicating the clinical picture and reinforcing maladaptive behaviours.

Social and cultural influences are equally critical. The pervasive idealisation of thinness in media, coupled with social comparison processes, can trigger body dissatisfaction and drive disordered eating. Societal pressures to achieve a certain body type, coupled with the increasing prevalence of social media platforms that reward curated, idealised images, amplify the risk of developing disordered eating. Family dynamics also contribute; over-protective or controlling parenting styles, as well as family emphasis on appearance or weight, can reinforce maladaptive beliefs about food and body. Peer pressure and the desire for social acceptance can further entrench disordered behaviours, especially during adolescence when identity formation is at its peak.

The maintenance of disordered eating is often perpetuated by a series of safety behaviours and cognitive biases that provide short-term relief but reinforce the disorder in the long term. Safety behaviours include restrictive eating, compensatory exercise, purging, and the use of diet pills or laxatives. These behaviours temporarily reduce anxiety or improve self-esteem, thereby reinforcing the belief that they are necessary for survival. Cognitive biases such as confirmation bias and selective attention to body-related information serve to reinforce the core beliefs of the disorder. The interaction of these factors creates a self-fulfilling cycle: the more the individual engages in safety behaviours, the more they feel compelled to continue, which in turn strengthens the underlying beliefs.

A worked clinical example illustrates how these factors interact. Consider a 23-year-old woman, Emma, who presents with a BMI of 16.5 and a history of restrictive eating and occasional purging. Her family history includes a mother with a history of anorexia nervosa and a father who was emotionally distant. Emma reports that she began restricting food at age 13 after receiving criticism about her weight from a teacher. She describes herself as

a “perfectionist” and reports that she feels “incomplete” when she deviates from her strict meal plan. In therapy, Emma’s cognitive distortions are evident: she believes that if she does not adhere to her diet, she will be judged as a failure. She also reports using exercise as a way to “earn” food and to cope with anxiety about social situations.

In conceptualising Emma’s case, the therapist would recognise the interplay of genetic predisposition (family history of anorexia), neurobiological vulnerability (possible serotonergic dysregulation contributing to anxiety), psychological factors (perfectionism, cognitive distortions, emotional regulation deficits), and social influences (critical teacher, media pressure, family dynamics). The maintenance of her disorder is reinforced by safety behaviours (restrictive eating, purging, compulsive exercise) and cognitive biases (confirmation bias, selective attention to body image). The therapist would use this conceptualisation to target specific mechanisms: for example, cognitive restructuring to challenge perfectionistic beliefs, exposure to feared foods to reduce avoidance, and emotion-regulation skills to replace disordered eating with healthier coping strategies.

Clinical assessment should therefore adopt a biopsychosocial framework. A structured interview that probes genetic history, medical comorbidities, early relational experiences, current stressors, and media exposure provides a comprehensive picture. Standardised tools such as the Eating Disorder Examination Questionnaire (EDE-Q) or the Eating Disorder Inventory (EDI) can quantify symptom severity, while measures of anxiety, depression, and perfectionism (e.g., the Frost Multidimensional Perfectionism Scale) can elucidate comorbid psychological factors. Observational data, such as the frequency of safety behaviours and the context in which they occur, help to identify maintenance mechanisms.

Once the assessment is complete, the therapist can formulate a treatment plan that addresses both the underlying vulnerabilities and the maintaining factors. Evidence-based interventions such as CBT-ED, which targets cognitive distortions, safety behaviours and emotional regulation, are effective across the spectrum of eating disorders. In addition, family-based therapy may be appropriate for adolescents, while dialectical behaviour therapy (DBT) skills can be useful for clients with high emotional dysregulation. Integrating these approaches with a clear understanding of the biopsychosocial model ensures that treatment is tailored to the

individual's unique constellation of risk factors.

In practice, it is also important to consider the role of the therapeutic alliance. Clients with eating disorders often experience shame and guilt, which can impede disclosure. A therapist who demonstrates empathy, normalises the client's experience, and collaboratively explores the functions of disordered eating can foster a safe environment for change. The therapist should also be vigilant for countertransference, as the client's intense emotions and the therapist's own beliefs about food and body can influence the therapeutic process.

In summary, disordered eating arises from the dynamic interaction of biological, psychological and social factors. The maintenance of the disorder is driven by safety behaviours and cognitive biases that provide short-term relief but reinforce maladaptive beliefs. A comprehensive assessment that incorporates genetic, neurobiological, psychological and social domains allows the therapist to formulate a precise conceptualisation. This, in turn, informs a targeted, evidence-based intervention that addresses both vulnerability and maintenance mechanisms, ultimately supporting the client's recovery.

Key points

- Eating disorders result from the interaction of genetic, neurobiological, psychological and social factors.
- Cognitive distortions, perfectionism and emotional regulation deficits are core psychological mechanisms that maintain disordered eating.
- Safety behaviours such as restriction, purging and compulsive exercise provide short-term relief but reinforce the disorder.
- A biopsychosocial assessment, using structured interviews and validated questionnaires, is essential for accurate conceptualisation.
- Evidence-based treatments (CBT-ED, family-based therapy, DBT) should be tailored to the individual's unique risk profile.

Practice task

This week, conduct a biopsychosocial assessment of a client presenting with disordered eating. Identify at least one biological, one psychological and one social factor that may be contributing to the disorder. Write a brief conceptualisation (200-300 words) that links these factors to the client's current maintenance behaviours, and outline one evidence-based

intervention that targets a specific mechanism identified in your assessment.

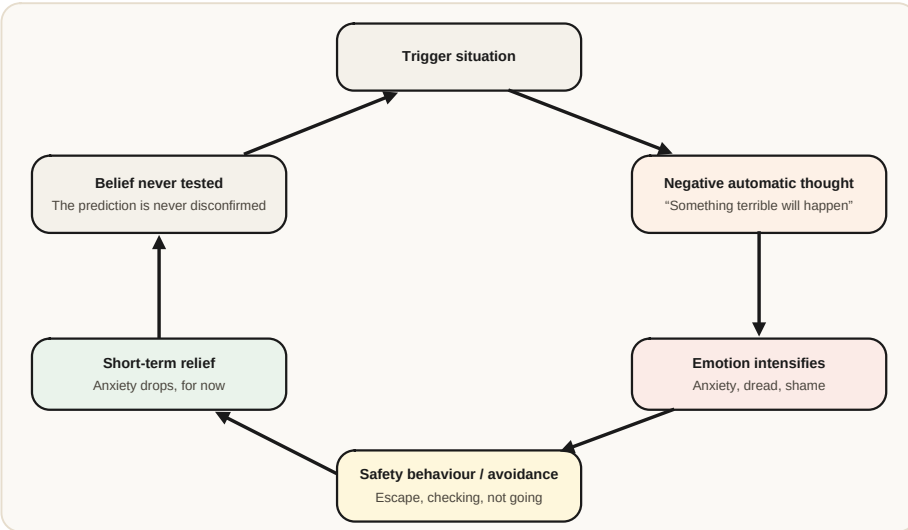


FIGURE 2.1 A maintenance (vicious) cycle

How problems keep themselves alive: a trigger activates a negative automatic thought, the emotion rises, a safety behaviour or avoidance brings short-term relief, and because the feared prediction is never tested, the underlying belief survives to fire again. Treatment interrupts the loop, usually at the behaviour.