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GOOD PRACTICE GUIDELINES

Trainee clinical psychologists and qualified clinical psychologists working with people with eating disorders

For UK Clinical Psychology Training Providers

September 2021

Division of Clinical Psychology
Faculty for Eating Disorders

CONTENTS

ISBN: 978-1-85433-802-0

‘Eating disorders is an awesome specialism to work in as a clinical psychologist and extremely rewarding. I would urge every trainee to consider it, even if they have not done so before. It draws on all aspects of you as a person and a professional. You are privileged to stand alongside individuals and families as they work through some of the hardest challenges they will face. It is so diverse as a specialism. You need always to think about the bio, psycho and social. You also will be from the outset so much more than a therapist, working indirectly and as a team, developing services and the knowledge base. There will also be tremendous variety in the severity and nature of the problems you work with – eating disorder defines the population but is not the sole focus of your work.’
Dr Nick Hawkes, Consultant Clinical Psychologist

‘[My clinical psychologist] came into my life when I was at a very low ebb. He listened to me, he was never critical, shocked or judgmental. Over the weeks he has taught me the tools to help deal with my difficulties, shown me that my problems weren’t with food but with my emotions plus much more. He persevered constantly when I tried to prove to him what a worthless person I was. The difference he has made to my life is nothing short of exemplary. Close family and friends have even seen the difference in me. I am feeling stronger, more confident and able to view food as fuel and not as my enemy.’
Linda

‘There is no doubt that the enormous amount of trust that has built up with my psychologist is finally enabling me to challenge the issues underpinning my anorexia.’
Alan Clarke

‘Eating disorders has been my main area of professional interest since prior to undertaking my clinical training, and this has often been met by shock or disbelief from other professionals. I think this reaction may stem from the myths which surround eating disorders, most notably the idea that recovery is unlikely. This is far removed from my clinical experience. Whilst the work is challenging and often emotive, the rewards are immense. Supporting individuals and their families to achieve valued goals and improve their psychological wellbeing (often making changes that they themselves thought were not possible) is a powerful and truly rewarding experience, and a true testament to the strength, resilience and dedication, which in my experience encapsulates this client group.’
Amy Gulliver-Terry, Trainee Clinical Psychologist

‘Though it’s been several years since I was in treatment, I am still grateful every day for the psychological help I received for my psychological illness. I owe my life to my clinical psychologist, and without her intervention, you would not be reading these words.’
Caroline Crandell

‘My placement in a specialist eating disorders (ED) team has provided a real range of different experiences, and insight into those aspects of work as a psychologist that are unique to this particular client group. For anyone considering undertaking such a placement, I’d highly recommend it. Personally, I’ve really valued being part of a highly skilled and experienced MDT [multidicsiplinary team], and have learnt a great deal from working jointly with colleagues from other professions. Whilst other placements have offered opportunities for joint working, in the ED team this is standard practice and fosters such a good environment for learning. I’ve also found the dynamic between physical and mental health a key area

of learning, in particular in relation to assessing risk and planning interventions. Finally, for anyone with an interest in working with the system around a young person, this is central to the work of a children and young people's mental health service ED team, and there are plenty of opportunities to observe, join and consider systemic ways of working.'
Hannah Little, Trainee Clinical Psychologist

'When I first started seeing my psychologist I felt like a shell of a person, with nothing to live for. Through our work, I've learned how to listen to the parts of me I've ignored, and how to really take care of myself. It's not been easy but it's been worth it. I feel like my world has turned from greyscale to colour.'
Ellen

'This is a field I feel very privileged to work within as a clinical psychologist. The work involves opportunities to work on a variety of levels (individual therapy, family based interventions, group work, across organisations/systems and in a consultancy capacity) and with a variety of presentations. Recovery from an eating disorder is very challenging; in my role I meet brave individuals every day and when our work together facilitates them to take steps towards treating themselves with the respect they deserve, the satisfaction is immeasurable.'
Dr Amy Wicksteed, Lead Clinical Psychologist

PURPOSE AND STATUS OF THIS DOCUMENT

This paper has been prepared on behalf of and through consultation with the British Psychological Society Faculty for Eating Disorders (FED). It has been co-produced by a working group inclusive of experts by experience and relevant partnership organisations including Beat, and Diabetics with Eating Disorders (DWED). An expert by experience focus group subsequently kindly provided further consultation and feedback on a working draft of the paper prior to its finalisation. This central involvement of people with lived experience of eating disorders in developing this paper was crucial in enabling us to meet our core aim. This core aim was to ensure that all trainees and qualified clinical psychologists have clear guidance for providing treatment for eating disorders that is person-centred, as well as evidence based. In line with this, our purpose is to enable clinical psychology, in conjunction with our mult-disciplinary colleagues, to deliver the best possible treatment outcomes and quality of life improvements for people with eating disorders.

The current paper builds on the previous FED paper *Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to People with Eating Disorders* (2008). The current revision also retains the key purpose of the 2008 paper in providing guidance to training providers and members of the profession in ensuring trainee clinical psychologists, upon qualifying, are equipped to work effectively within the field of eating disorders. The current paper additionally aims to provide post qualification competencies for clinical psychologists choosing to specialise in eating disorders; this is, with a view to guiding such qualified clinical psychologists in their continuing professional development. Concomitantly, the paper provides relevant guidance for Health Education England to assist with current workforce planning initiatives.

The Faculty highlights that in line with the current standards for the accreditation of doctoral programmes in clinical psychology (British Psychological Society; BPS, 2015), it is the responsibility of individual training courses and placement supervisors to refer to and uphold the good practice outlined in this paper.

Important recommendation is also made that this paper is read in conjunction with the overarching standards for clinical psychology training. These standards are comprehensively outlined in the BPS paper *Standards for the accreditation of Doctoral programmes in clinical psychology* (BPS, 2019). The current paper does not provide the detail of all the core competencies required for clinical psychology training. Rather, this paper focuses on the application of the direct clinical competencies, as these are required for work in the field of eating disorders.

The Division of Clinical Psychology Professional Standards Unit (PSU), the Committee on Training in Clinical Psychology (CTCP, and the Group of Trainers in Clinical Psychology (GTiCP) were consulted in the development and publication of this document.

Minor additions to the paper have further been made due to treatment developments and accelerations in response to the Covid-19 pandemic.

RECOMMENDATIONS

It is recommended that this paper is circulated to BPS approved clinical psychology doctoral training programmes in the UK. Additionally, that circulation is extended to those qualified clinical psychologists currently practising in the field of eating disorders.

INTRODUCTION

CLINICAL CONTEXT

It is widely recognised that eating disorders have high levels of morbidity and mortality relative to other psychiatric disorders (e.g. Arcelus et al., 2011; Steinhausen, 2002). Eating disorders are additionally associated with poor quality of life (De La Rie et al., 2007; Pohjolainen et al., 2010), carry considerable economic and social costs (Price Waterhouse Coopers, 2015, and are associated with negative as well as positive experiences of care giving (Dimitropoulos et al., 2008; Graap et al., 2008). It is further established that where there is the provision of specialist services for adults, young people and children with these difficulties, prognosis is improved and mortality rates are reduced (e.g. Dare et al., 2001; Lindblad et al., 2006). It is also pertinent that the revised National Institute for Health and Care Excellence (NICE) guidelines (NICE, 2017) point to the use of evidence-based interventions provided by competent health professionals to optimise treatment efficacy. The new guidance for commissioners and providers of adult eating disorder services (NHS England, 2019) goes further in stipulating a specific role for psychologists in undertaking assessments, formulations and delivering evidence based psychological interventions for eating disorders and co-existing problems. In these respects, there remains a clear and significant role for clinical psychologists in working with people with eating disorders. There is also a clear requirement for a good practice approach to training and to continuing professional development for psychologists, to ensure effective clinical governance within the specialism.

VALUES AND MYTHS

As a specialist field of clinical psychology, eating disorders is believed to be attractive, especially to people with direct or indirect personal experience of eating problems or pre-training experience. It may not feature on the radars of all clinical psychologists or trainees, and sometimes it can be difficult to recruit to the specialism (Parliamentary and Health Service Ombudsman; PHSO, 2017). This is with resulting serious shortage of training in eating disorders among psychologists in certain areas, such as Northern Ireland.

Before training, the nature of work in the field of eating disorders may be subject to negative myths. Objectives of training can be operationalised as knowledge, skills and attitudes (KSA). Whilst for the most part this document will be concerned with knowledge and skills, we recommend that doctoral training courses also make it a mission to develop an attitude of enthusiasm among trainees for the specialism. This enthusiasm can be cultivated by increasing awareness of eating disorders, and confidence in the potential to support both meaningful recovery and quality of life improvements. This would be to the benefit of people suffering from eating disorders, as well as to the benefit of trainees and clinical psychologists who might otherwise miss out on the valuable opportunities the field affords. Unpublished qualitative data suggest that targeted training can shift perceptions of eating disorders and their treatment from ‘mysterious’, ‘difficult’ and ‘stressful’ to ‘interesting’ and ‘doable’. This is with the potential to make a difference, and with corresponding measurable increases in the motivational dimensions of ‘readiness’, ‘willingness’ and ‘ability’ to work with people with eating problems.

Relatedly, NHS Education for Scotland, Health Education and Improvement Wales and Health Education England can support recruitment and retention of staff in the specialism with opportunities to progress. This progression should be supported by training, right up to the role of clinical team lead. This is, as is envisaged by the access and waiting times recommendations for staffing structures for specialist eating disorder services (NHS England, 2015), and the Parliamentary Ombudsman recommendations (PHSO, 2017).

NATIONAL DRIVERS

At present there are several national drivers promoting good quality of services in the field of eating disorders. These drivers either directly point to the need for competency based professional development, or provide inference of this requirement through the emphasis that is placed on evidence based interventions and the need for appropriately skilled multidisciplinary teams. These drivers include Health Education England, Quality Network for Eating Disorders (QED, 2017, 2019), the Clinical Reference Group for Specialised Mental Health, the recently revised NICE guidance *Eating Disorders: Recognition and treatment* (NICE, 2017), the *Access and Waiting Time Standard for Children and Young People with an Eating Disorder: Commissioning guide* (NHS England, 2015), the *NHS Long Term Plan* (NHS England, 2019) and The Mental Health Strategy 2017–2027 (The Scottish Government, 2017). Additionally, the *NHS Mental Health Implementation Plan 2019/20–2023/24* (NHS England, 2019) identifies specifically the need to focus severe mental illness (SMI) investment on improving community care for adults with eating disorders; this will require high quality training contributing to recruitment and retention.

The PHSO report *Ignoring the Alarms: How NHS eating disorder services are failing patients* (PHSO, 2017) has also poignantly highlighted the importance of adult eating disorder services achieving parity with those services provided for children and young people. The Parliamentary Ombudsman called for a review of existing adult eating disorder services, and asked NHS England and the Department of Health to consider producing relevant benchmarking guidance for service provision. Moreover, the PACAC report Ignoring the *Alarms Follow-up: Too many avoidable deaths from eating disorders* (PACAC, 2019) found a serious lack of training for doctors about eating disorders, and more generally emphasised the need for more specialist education and training to increase the provision of specialists who can work in the eating disorders field. NHS England with NICE and the National Collaborating Centre for Mental Health has been responsive in preparing the afore mentioned new guidance for commissioners and providers of adult eating disorder services (NHS England, 2019). This guidance is fundamental and is paving the way for the improved provision and standardisation of treatment nationally. For example, with the introduction of HEE sponsored Eating Disorders Services for Adults (EDSA) Whole Team Training. The current document aims to support improvements in the quality and consistency of baseline eating disorders training for practitioner psychologists.

The direct initiative for the current revision of the Faculty's good practice guidance arose when Health Education England specifically tasked a workforce working group to 'ensure the competency, developmental needs and capability of the workforce to deliver the quality of service as set out in the national service specifications and policy for each specialised mental health service' (NHS England, 2014). In contributing to this working group the then Clinical Reference Group for Specialist Eating Disorders tasked all relevant health professions within the field of eating disorders with producing profession specific core competencies for the training and consolidation of clinical practice. The Clinical Reference Group further advocated that in developing these clinical competencies these should be in line with its Charter for service provision which specifies:

'All care should be delivered through patient and family-centred, integrated care pathways that bridge transitions, are evidence-based, support early intervention, cover all treatment settings and are delivered by (skilled) multidisciplinary teams. The care pathways should also adhere to recognised quality standards in the field of eating disorders (2014).'

In developing the clinical psychology specific core competencies, the FED has sought to come in line with other BPS Division of Clinical Psychology (DCP) publications in marketing our recommendations as good practice guidelines.

This also serves to clarify the lineage with the Faculty's previous paper *Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to People with Eating Disorders* (2008), and the requirement to read the current revision in conjunction with the DCP paper *Standards for the accreditation of Doctoral programmes in clinical psychology* (2019) .

1. CORE COMPETENCY REQUIREMENTS FOR TRAINING IN CLINICAL PSYCHOLOGY

Accredited doctoral training programmes in clinical psychology provide quality assurances for competency based training to the point of qualification. This is with these quality assurances achieved through adherence to the criteria for accreditation as specified in *Standards for the accreditation of Doctoral programmes in clinical psychology* (BPS, 2019). Doctoral training programmes also require the approval of the Health and Care Professions Council (HCPC) to ensure the programmes meet the HCPC's *Standard of Education and Training (SETs 4 and 6)*. Graduates from those programmes which meet the required HCPC standards, upon qualifying, are deemed to meet the minimum requirements to register with the HCPC and practice as applied psychologists; this is a legal requirement for anyone planning to practise using a title protected by the Health Professions Order (2001) and is inclusive of using the title clinical psychologist.

Standards for the accreditation of Doctoral programmes in clinical psychology additionally specify that: 'Programmes should refer to the standards and guidelines which are identified and revised from time to time by the Division of Clinical Psychology's Faculties for guidance in relation to the knowledge and skills required for work with specific populations and groups' (BPS, 2019).

In line with this recommendation the FED advises that training programmes work in conjunction with local special interest groups and supervisors using this updated guidance to meet the specific knowledge and skills requirements for working in the field of eating disorders.

2. EATING DISORDER PLACEMENT SPECIFIC CORE COMPETENCY REQUIREMENTS FOR CLINICAL PSYCHOLOGY TRAINING

The FED core competency framework outlines the eating disorder specific clinical requirements for trainees undertaking a placement in eating disorders. As afore mentioned though, the Faculty framework is to be viewed in conjunction with the overarching standards for clinical psychology training as are comprehensively outlined in the BPS paper *Standards for the accreditation of Doctoral programmes in clinical psychology* (BPS, 2019). The 2019 paper provides nine core competencies (generalisable meta-competencies, psychological assessment, psychological formulation, psychological intervention, evaluation, research, personal and professional skills and values, communication and teaching, organisational and systemic influence and leadership) that are required to meet clinical psychology doctoral training standards. The FED core competency framework closely aligns with the nine core competencies outlined in the 2019 BPS paper, but additionally further separates out competencies in working with families, carers and partnership organisations, and the emphasis that is given within the field to collaborative care. The also FED stipulates for those trainees wishing to specialise in eating disorders post-qualification it is advisable that they undertake a specialist eating disorders placement during training. This recommendation is with a view to meeting the direct clinical core competencies as they apply to eating disorders as specified in this paper. This is while also ensuring trainees fully fulfil all nine generalisable competencies as they are specified in the 2019 BPS paper.

The eating disorder specific clinical core competency requirements detailed below are to be considered 'essential' unless they are specifically marked as 'desirable'. There is also an expectation for parity in training across all the eating disorder settings (outpatient, day care and inpatients), where this is available, and between the training opportunities provided by adult and children and young people's eating disorder services.

2.1 META-COMPETENCIES

1. Drawing on psychological knowledge of the impact of starvation and other disordered eating behaviours on cognitive, emotional, physical and behavioural functioning to facilitate motivation to change in individuals with eating disorders. Also, drawing on such knowledge to facilitate improved carer and family understanding and support.
2. Drawing on psychological knowledge of the effects of illness duration, neuro-progression, missed developmental opportunities and loss of social capital to promote early intervention, the targeting of intervention to stage of illness (e.g. FREED Service Delivery Model) and to facilitate improved commitment to treatment where applicable.
3. Drawing on understanding of the interface between the physical and psychological effects of an eating disorder to facilitate early behavioural change for the purposes of improving cognitive flexibility and emotional resilience to promote recovery. This includes a requirement for basic nutritional knowledge in relation to the needs of people with eating disorders.
4. Working with ambivalence about change and with complex motivational considerations.
5. Deciding using current evidence and knowledge, and with awareness of gaps in the eating disorders knowledge base, how to formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to work effectively whilst holding in mind alternative, competing explanations, and critiques of the application of quality criteria and standards of evidence within guidelines, such as those provided by NICE.
6. Being familiar with theoretical frameworks, the evidence base and practice guidelines for the treatment of eating disorders. Practice guidelines include *Eating Disorders: Recognition and treatment* (NICE, 2017), *Adult Eating Disorders: Community, inpatient and intensive day patient care. Guidance for Commissioners and Providers* (NHS England, 2019), *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa* (2nd edn) (Royal College of Psychiatrists, 2014), *Junior MARSIPAN: Management of Really Sick Patients Under 18 with Anorexia Nervosa* (Royal College of Psychiatrists, 2012), *Severe and Enduring Eating Disorder (SEED): Management of complex presentations of anorexia and bulimia nervosa* (Robinson, 2009), *A Guide to the Medical Risk Assessment for Eating Disorders* (Treasure, 2009), *Access and Waiting Time Standard for Children and Young People with an Eating Disorder* (NHS England, 2015), relevant sections of the *Diagnostic and Statistical Manual of Mental Disorders* (5th edn) (American Psychiatric Association, 2013), *International Statistical Classification of Diseases and Related Health Problems* (11th rev.; World Health Organization, 2018), the *NHS Long Term Plan* (NHS, 2019) and local transitions protocols.
7. Drawing on psychological knowledge of the effects of transitions (including life stage – e.g. going to university and service transitions) to facilitate treatment engagement and timely intervention.
8. Developing an understanding of the overlapping and different roles of disciplines working in the field of eating disorders including psychiatry, nursing, dietetics and occupational therapy.

2.2 PSYCHOLOGICAL AND PHYSICAL ASSESSMENT

1. Developing specialist skills in the psychological assessment of presentations that would be given a diagnosis of anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder (ARFID), other specified feeding or eating disorder (OSFED), and unspecified feeding or eating disorder (UFED) (American Psychiatric Association, 2013). This includes a requirement for knowledge of the range of non-compensatory and compensatory behaviours used for weight control purposes across the spectrum of eating disorders.

2. Transferring and adapting the specialist skills developed to undertake the psychological assessment of eating disorders via telehealth. This has been required in response to the Covid-19 pandemic, and is important to ensure improved parity for people in accessing eating disorders assessment and treatment moving forwards.

3. Developing awareness of and basic skills for assessing the physical consequences and risks associated with eating disorders. Also, awareness of additional risk factors associated with pregnancy in eating disorders and relevant physical co-morbidities, especially diabetes. This includes developing understanding of the specific risk considerations associated with Type 1 diabetes, awareness of the medication and differing dietary requirements, and the importance of liaising with local diabetes services as part of the assessment processes.

4. Developing awareness of the gender difference in BMI equivalence, and using this to inform both risk assessment and subsequent treatment planning.

5. Developing awareness that there can also be within gender differences in BMI due to differences in body composition (e.g. female athletes).

6. Developing knowledge of and effective use of local service medical risk management procedures, including appropriate liaison with medical staff when required.

7. Developing knowledge and skills in psychological risk management both generic, and in relation to how this relates to the morbidity and mortality rates associated with eating disorders, especially anorexia nervosa.

8. Developing skills in the assessment of suicide risk given the mortality rates associated with, in particular, anorexia nervosa.

9. Developing skills in the psychological assessment of frequently co-existing mental health difficulties, including depression, social anxiety, obsessive compulsive disorder, body dysmorphic disorder, post-traumatic stress disorder, somatic symptom disorder, low self-esteem and dissociative processes including, as desirable, dissociative disorders.

10. Developing psychological knowledge in the assessment of the most common co-morbid difficulties meeting criteria for diagnoses of borderline personality disorder, obsessive compulsive personality disorder, avoidant personality disorder and dependent personality disorder. This is less pertinent (but nevertheless still relevant) for working with young people where the conceptualisation would provide a more descriptive summary of relevant personality traits.

11. Developing psychological knowledge in the assessment of personality traits that have been found to be highly correlated with eating disorder symptom severity and poorer treatment outcomes including perfectionism, impulsivity and affective instability, compulsivity and avoidance.

12. Developing psychological knowledge in the assessment and understanding of relevant pervasive developmental disorders; this is especially as this applies to autistic spectrum disorder (ASD). Here it is important to also recognise the overlap which exists between the features of ASD and those of anorexia nervosa and starvation. This means that the diagnosis of ASD can be particularly difficult in people with anorexia nervosa, and should generally be avoided while someone remains underweight. It is also important to note that ASD is often less obvious in women/girls, and is therefore likely to be missed in those with eating disorders.

13. Developing and demonstrating competence in the use of eating disorder specific patient rated outcome measures (PROMs) (e.g. Eating Disorders Examination – Questionnaire (EDE-Q; Fairburn & Beglin, 1994, 2008), Clinical Impairment Assessment (CIA; Bohn & Fairburn, 2008), Eating Disorders Inventory – 3 (EDI-3; Garner, 2004) and the Eating Disorders Quality of Life Scale (EDQLS; Adair et al., 2007).

14. Competence in the use of PROMS also requires age appropriate measure selection. For those undertaking training or work in children and young people's eating disorders services, reference should be made to the national consensus guidance on the use of PROMS with young people at www.corc.uk.net/outcome-experience-measures. The core eating disorder specific PROM for young people remains the EDE-Q, however alternative administration practices and norms for young people are considered on this site. Generic measures PROMS might also have some value, provided there is sufficient consideration of their interpretation with regards to eating disorders. In this context, the self-rated, parent-rated and clinician-rated Health of the Nation Outcome Scales Child and Adolescent Mental Health questionnaires (HoNOSCA; Gowers et al., 1999) might be considered as a measure of general functioning.

15. Developing and demonstrating competence in assessing and understanding the influences of diversity in the development and maintenance of eating disorders. Diversity includes, but is not limited to, religion or belief, culture (including effects of the digital age such as the use of social media), sexual orientation, gender identity (including people who are transgender and those who identify themselves as non-binary), race, disability, age, relationships, socioeconomic status, pregnancy and parenting. The requirement here is to explore the individual meaning to each person of their personal characteristics and to consider, if and how, these might relate to their eating problems. It is also important to be able to consider in what ways the individual's diversity might provide personal strengths which could contribute towards their recovery.

16. Developing and demonstrating knowledge of the limitations of existing PROMS when working with diversity. For example, standard PROMS may have less internal reliability for males, and have been shown to produce lower alpha levels for male samples (e.g Darcy, 2012; D'Emden, 2012), which places greater emphasis on the clinical assessment. Knowledge of population specific PROMS is therefore also important and there are, for instance, male specific PROMS. Some of these measures require further standardisation but can already provide greater face validity for men with eating disorders, and promote improved

understanding of their frequently differing weight and shape concerns. Examples of male specific PROMS include the Eating Disorder Assessment for Men (EDAM; Stanford & Lemberg, 2012) and the Drive for Muscularity Scale (DMS; McCreary, 2007). There are also age adapted scales for use with adolescent males such as The Male Body Image Concerns Scale (MBICS; Weisman et al., 2012). Additionally, there are diabetes specific measures which have been validated in both young people and adults (e.g. the Diabetes Eating Problem Survey; Markowitz et al., 2010), which may be more appropriate for those with co-existing type 1 diabetes.

17. Developing understanding that eating disorders may also present differently when working with diversity. For example, men may present with a preoccupation with muscularity rather than thinness.

18. Developing competence in the use of patient defined goals-based outcomes and patient-rated experience measures (PREMs).

19. Developing knowledge in the assessment of capacity and application of the Mental Health and Mental Capacity Acts as they relate to the field of eating disorders. Also, competent knowledge of issues relating to consent and understanding of Gillick competence for those under 16 years of age.

20. Developing awareness and understanding of re-feeding syndrome. There is also a requirement for awareness of the additional risk factors that can be associated with re-feeding in patients with type 1 diabetes.

21. Recognising at assessment that a first pregnancy especially may present an opportunity to engage women in treatment as their motivation to address their eating difficulties may be higher. However, also assessing and collaboratively considering whether stabilisation goals might be most manageable/realistic in the first instance; that is, if the prospect of full recovery feels overwhelming when accompanied by all the physical and emotional changes associated with pregnancy.

22. Developing awareness of both generic and eating disorders specific safeguarding concerns, and clear understanding of the mandate to follow due safeguarding processes.

23. Developing awareness and understanding of both psychological and physical assessment considerations for individuals who are either pre- or post-bariatric surgery. Understanding of post-bariatric surgery considerations is deemed important as this will have potential application for all eating disorder services. (Desirable: Pre-bariatric surgery assessment is more specialised and the opportunity to develop such skills is likely to depend on the service specification of the eating disorders facility offering the training placement.)

24. Desirable: Developing and demonstrating competence in the use of neuropsychology assessments to evaluate the potential effects of neuro-progression and/or the impact of starvation on cognitive function with a view to treatment planning.

25. Desirable: Developing awareness and understanding of the assessment of food phobia, emetophobia and needle phobia. With regards to needle phobia, this is as this applies to general risk management with the requirement for blood tests, but also as needle phobia can be a maintenance factor associated with eating problems in those with type 1 diabetes.

2.3 PSYCHOLOGICAL FORMULATION

1. Developing formulation skills which are informed by theory and evidence specific to the field of eating disorders. Using conceptual integration in turn to aid in the selection of protocol based and principle driven interventions with established treatment efficacy. This includes, and places specific emphasis upon, the development of CBT-ED and MANTRA specific formulation skills, and in the case of children and young people's placements formulations utilising the principles of FT-AN and FT-BN.

2. Ensuring in formulating presentations of anorexia nervosa, restricting type that the central maintenance cycle is clearly delineated. This is whereby the over-evaluation of shape and weight, and their control, drives strict dieting and non-compensatory weight control behaviour. How with the progressive effects that the resulting starvation has on cognitions, emotions, physiology and behaviour, that this then further reinforces the preoccupation with eating, shape and weight, and the perceived requirement to intensify the drive for thinness. Additionally, ensuring that these formulations are personally tailored to incorporate individual differences in presentation, and additional precipitant and maintenance factors as needed.

3. Ensuring in formulating presentations of anorexia nervosa, binge eating/purging type and bulimia nervosa that the central role of the over-evaluation of shape and weight, and their control, is again clearly depicted. However, with additional clear emphasis given to the perceived intermittent loss of control over dietary intake. This is with the recognition that this perceived loss of control will vary across presentation, and often across time. This is with the violation of very rigid dietary rules/subjective binges at one end of the continuum, and recurrent objective binge episodes at the other. This means there will need to be accompanying recognition of the varying effects of these eating behaviours on cognitions, emotions, physiology and ongoing behaviours. Irrespective though of the subjective/objective nature of this binge eating, formulations are required to clearly and collaboratively map out the ways in which compensatory weight control behaviour is in turn then used to neutralise the perceived fears of weight escalation. This is with this compensatory weight control behaviour including, but not necessarily limited to, self-induced vomiting, laxative misuse, diuretics, diet pills, enemas, fasting or excessive exercise. The concomitant effect being to again strengthen the over-evaluation of shape and weight, and the perceived need to more rigorously pursue weight control through dieting. The requirement also remains to ensure that formulations are personally tailored to incorporate individual differences in presentation, and additional precipitant and maintenance factors as needed.

4. Developing formulations collaboratively with people with Anorexia Nervosa that are cognisant of the individual meaning that maintains their core drive for thinness.

5. Ensuring in formulating presentations of Binge Eating Disorder that the central role of binge eating typically for mood regulation and/or emotional blocking, and/or self-harming purposes is fully delineated. This is alongside the cognitive, emotional, physical and behavioural effects of this loss of control over eating, and together with other individual precipitant and maintenance factors as required.

6. Ensuring in formulating ARFID, OSFED and UFED presentations that the conceptualisations are individually tailored and, where applicable, clearly map out the central maintenance cycles

that are consistent with the other major eating disorder diagnostic categories.

7. Constructing formulations that are individually and sensitively tailored with awareness of diversity in eating disorders; especially gender (including people who are transgender and non-binary), sexual identity, religious, and cultural differences in presentation. This includes respectful understanding that self-control around food is a quality valued in many cultures and religions. However, that most religions state that fasting can be broken or abstained from, sometimes with alternative observances identified, in the event of significant health concerns. Trainees are further required to develop the understanding that interactions between eating problems and diversity often involve many factors that go beyond the direct relationship with food.

8. Constructing formulations that incorporate knowledge, theory and meaning relating to co-existing and potentially interlinked physical health difficulties (e.g. diabetes, gastro-intestinal problems and obesity).

9. Developing skills in formulating systemic factors particularly for children and young persons with eating disorders, and in the maintenance of severe and longer term eating disorder presentations.

10. Developing skills in the formulation of presentations where the disordered eating behaviours are associated with other co-morbidities (e.g. depression, social anxiety, obsessive compulsive disorder, body dysmorphic disorder, post-traumatic stress disorder, somatic symptom disorder, and dissociative processes including dissociative disorder) or other psychological processes causing significant distress or dysfunction (e.g. low self-esteem, trauma, attachment difficulties and complex grief).

11. Working dynamically to re-formulate, as might be required. This is with the potential for transdiagnostic shifts across eating disorder presentations, and the potential for behavioural substitution to other impulsive and compulsive problems. Also, given the potential for the development of secondary co-morbidities (e.g. the development of depression as secondary to an eating disorder).

12. Developing awareness of additional therapeutic approaches where evidence for treatment efficacy is emerging, weaker or lacking, or where certain therapies have not been demonstrated to be superior to other approaches. This wider range of therapy approaches includes interpersonal psychotherapy (IPT), dialectical behaviour therapy (DBT), radically open dialectical behaviour therapy (RO-DBT), schema therapy and cognitive analytic therapy (CAT).

It is emphasised that awareness of and the ability to formulate co-occurring disorders is important for overarching care planning, signposting and effective risk management. Also, that formulation is important in terms of the opportunities this presents for further progressing research and understanding in the field.

With regards to personality disorder co-morbidity, cautionary note is also added that at low BMIs conclusive personality disorder diagnoses cannot be made. In some instances, what initially appears to be personality disorder co-morbidity abates with weight improvement and evidence based eating disorders treatment.

2.4 PSYCHOLOGICAL INTERVENTION

1. Developing understanding of NICE recommended therapy models for the treatment of eating disorders as applicable to children and young people and adults.

2. Developing understanding of stage and severity of illness and treatment setting. This includes knowledge about the impact of length of illness on brain function and prognosis.
Also, knowledge of service delivery

models such as FREED (First Episode and Rapid Early Intervention for Eating Disorders), which has been demonstrated to reduce drop-out rates and to expedite recovery. Additionally, understanding and knowledge of the differing treatment emphases depending on stage of recovery. For example, for those with anorexia nervosa, the mirror exposure component of body image work should be saved until there is weight restoration.

3. Developing understanding that factors determining prognosis remain unclear. This means that the understanding of stage and severity of illness should be held alongside the recognition that eating disorder presentations can and, where appropriate, should be worked with irrespective of illness duration (NHS England, 2019).

4. Developing skills in providing psychoeducation for eating disorders regarding starvation, and the risks associated with non-compensatory and compensatory forms of weight control.

5. Developing understanding and basic skills in nutrition, and psychoeducation regarding the importance of regular and balanced eating. Also, psychoeducation around weight fluctuations and the effects of hydration as is integral to psychological therapy for eating disorders.

6. Ensuring understanding that, while initial motivation helps to predict treatment outcomes, motivational enhancement therapy (MET) in isolation does not further improve recovery rates. This means motivational enhancement exercises should only be incorporated where these are specifically indicated in evidence-based models of psychological therapy (e.g. MANTRA).

7. Developing knowledge of the importance of early behavioural change in psychological therapy as a marker for readiness to change. Understanding, therefore, that it is important to be encouraging behavioural change early in treatment, and recognising the importance of not continuing with therapy when this is proving ineffective.

8. Developing the ability to implement at least one NICE (2017) recommended evidence-based model of formal psychological therapy for eating disorders. Current first line treatments for adults with anorexia nervosa include eating disorder focused cognitive behavioural therapy (CBT-ED), maudsley anorexia nervosa treatment for adults (MANTRA) and specialist supportive clinical management (SSCM). If CBT-ED, MANTRA and SSCM have proven to be ineffective or are unsuitable then eating disorder focused focal psychodynamic therapy (FPT) is considered a viable second line treatment approach. For children and young people with anorexia nervosa it is recommended that consideration is given to anorexia-nervosa-focused family therapy (FT-AN) provided as single-family therapy or an integration of single and multi-family therapy. Alternative second line treatment options for children and young people with Anorexia Nervosa include CBT-ED or adolescent focused psychotherapy for anorexia nervosa (AFP-AN). The primary evidence based psychological therapy for bulimia nervosa remains CBT-ED for adults (to be offered if guided self-help is not suitable or has not proven to be effective). However, for children and young people with bulimic presentations bulimia nervosa-focused family therapy focused (FT-BN) is now the recommended first line of treatment; this is with CBT-ED recommended as a second line intervention. Conversely, for those with binge eating disorder, if guided self-help has not proven effective, it is recommended that CBT-ED is provided in a group format before considering individual CBT-ED. This clear

recommendation for group therapy for people with binge eating disorder has the potential to provide trainees with valuable group facilitation experience.

9. Developing knowledge of the adaptations to the online provision of psychological therapy for eating disorders which have been published in response to the Covid-19 pandemic (e.g. Murphy et al., 2020; Waller et al., 2020). This is, to optimise treatment effectiveness when delivered via teletherapy. This is in recognition that remote technology has the scope to further improve step-down from inpatient eating disorder admissions. Similarly, as telehealth offers new opportunities for people to access outpatient and day care eating disorders treatment; this is, when travel and geography have previously posed barriers to treatment attendance (Collins et al., 2020).

10. Developing skills in critiquing the evidence base for the broad range of psychological therapies used in the treatment of eating disorders. This includes understanding that recovery rates for even the NICE recommended treatment approaches require further considerable improvement.

11. Developing awareness of developments which are in line with the NICE recommendation that, due to the high number of sessions which the currently recommended psychological interventions require, less intensive therapies building on the existing evidence base should be trialled (e.g. as an emerging treatment, CBT-T) (*Ten Sessions: Brief cognitive behavioural therapy for non-underweight patients*).

12. Developing awareness of additional therapeutic approaches where evidence for treatment efficacy is emerging, weaker or lacking, or where certain therapies have not been demonstrated to be superior to other approaches. This wider range of therapy approaches includes interpersonal psychotherapy (IPT), dialectical behaviour therapy (DBT), radically open dialectical behaviour therapy (RO-DBT), schema therapy, and cognitive analytic therapy (CAT).

13. Recognising, in considering those psychological therapy approaches not currently included in the NICE guidance, that there should be clear clinical rationale based on empirically grounded psychological processes, and evidence for the application of the approach in the formulation. As part of ensuring informed treatment consent the effectiveness of past courses of therapy (especially the outcome of previously completed NICE recommended treatments) should be considered, and the patient's views and treatment preferences should be taken into consideration.

14. Developing understanding that considerable further research is required to substantiate the evidence base for effective eating disorders treatment. As such, that the monitoring of progress throughout treatment is paramount irrespective of the approach taken.

15. Developing awareness that the evidence base for the treatment of ARFID is particularly weak, and requires further research and understanding.

16. Recognising that cognitive remediation therapy (CRT) was devised as an adjunct to evidence-based therapies for eating disorders, and not as a standalone treatment.

17. Developing knowledge of the key components of all stages of treatment, including an emphasis on endings and gains maintenance. For those people with a history of anorexia nervosa who have achieved a healthy weight this should include support with weight stabilisation.

For all eating disorder presentations this should include the consolidation of individual psychosocial goals.

18. Recognising that body image mirror work should be saved until weight restoration has been achieved. Behavioural experiments, psychoeducation and surveys can be introduced earlier in treatment as per the evidence based therapy models.

19. Developing understanding and skills in the provision of psychological therapy for individuals whose illnesses are of long duration or which are severe. This will include the repeat delivery of evidence based therapy approaches, particularly where there is some indication of improved readiness for treatment. It is important to note here that behavioural change can provide helpful concrete indication of improvement in motivational intent to work towards recovery.

20. Developing knowledge that we do not currently have a good understanding of which patients with long-term eating disorders will work towards recovery over time. Learning that this lack of prognostic indicators creates a requirement for balancing acceptance with hope. There is, as such, a role for clinical psychologists in supporting discrete goals aimed at improving quality of life, including avoiding or reducing admission, or risk of death. Additionally, a role for the profession in doing so without negating ongoing hope for partial and / or full eating disorder symptom recovery for all patients, irrespective of illness duration.

21. Developing understanding that the term SEEDS (severe and enduring eating disorders), which is sometimes referenced in the eating disorders literature, remains controversial in its use and has not been reliably established as a meaningful construct. However, also understanding that for some patients, although not others, this term is one that they relate to, and sometimes find helpful in framing their here and now medical management. The main ethos therefore remains one of individually tailored patient care.

22. Developing skills in the treatment and management of suicide risk. Typically, this would be in conjunction with joint working with the community mental health recovery services, or the local equivalent of this.

23. Developing awareness that while disordered eating symptoms for some women may remit during pregnancy, there can be many challenges during pregnancy and the post-natal period. Treatment should be adapted to cover the post-natal period as well, and tailored to meet the individual needs of the patient and her family.

24. Developing understanding and skills in skills training for carers (the New Maudsley Approach).

25. Developing understanding of NICE recommended treatments for relevant co-morbidities such as personality disorders. Also, recognising that effective eating disorders treatment sometimes similarly results in good outcomes for both the eating disorder and the associated co-morbidity.

26. Recognising the importance of clinical governance in facilitating good treatment outcomes. This includes the monitoring of progress throughout treatment, in addition to outcomes monitoring. Also, the use of supervision to monitor adherence to the therapy model; this would include factors that influence therapy, including adopting a reflexive approach to considering the therapist's own beliefs and emotions.

2.5 WORKING WITH FAMILIES AND CARERS AND PARTNERSHIP ORGANISATIONS

1. Developing awareness of the important role that families and carers can potentially have in supporting recovery from an eating disorder.
2. Developing awareness of the significant impact that eating disorders can have on relationship dynamics within surrounding family and carer relationships.
3. Developing understanding of the common ways in which families and carers may inadvertently be drawn into enabling eating disorder behaviours.
4. Developing understanding of how responses which involve conflict and high expressed emotion can impede recovery.
5. Developing knowledge and understanding of carers' assessments and of the triangle of care (Carers Trust, 2013).
6. Developing knowledge and skills in supporting and enabling families and carers to foster open, non-judgemental, and boundaried responses to eating disordered behaviours; again, this includes training in the New Maudsley approach.
7. For those trainees on placement in a children and young people's eating disorders service, working with families and carers would need to be an integral part of the work and would likely be the main intervention focus (e.g. FT-AN & FT-BN).
8. Developing an awareness of the key roles played by relevant partnership organisations in providing direct support to people with eating disorders, and in promoting public awareness of these difficulties. Also, recognition of the expertise of these partnership organisations in the specific groups they represent, and the valuable roles they therefore additionally play in disseminating knowledge and training to professionals and lay people alike. Key partnership organisations currently include Beat, DWED (diabetics with eating disorders), MaleVoicED and FEAST (for parents of those with eating disorders). Organisations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) may also be of benefit to those with co-existing substance difficulties.

2.6 EVALUATION AND RESEARCH

1. Developing an awareness of outcome measures used in routine practice in eating disorder services (outlined in sections 2.2.12, 2.2.13, 2.2.15, and 2.2.17) whilst also developing an understanding as to how these measures can be used to evaluate treatment progress and outcomes.
2. Desirable: Contributing to research or service evaluations in line with the doctoral training requirements while trainees are completing eating disorder placements is of course encouraged and desired. This might, for example, include the completion of a service related research project if appropriate to the individual training programme requirements. Alternatively, those interested in specialising in the field post qualification might wish to tailor their major research projects to contribute to the further advancement of our understanding of eating disorders and their treatment.

2.7 COLLABORATIVE CARE

1. With its multifactorial complexity, care of people with eating disorders involves multiple professionals, agencies and other supporters. Coordination of care is identified as critical to safety and efficacy (PHSO, 2017), and, as recommended, has now been formalised as a NICE Quality Standard (https://www.nice.org.uk/guidance/qs175). In preparation for qualification, trainee clinical psychologists need to be trained to be ready to participate in and lead coordinated care both as care coordinators or lead professionals. They also need to bring the competencies

outlined above to coordinated care, such as recommending appropriate psychological intervention or using psychological formulation to illuminate and to address obstacles to effective collaboration.

2. Collaborative care is of especial importance where there is co-existing type 1 diabetes, and associated physical health problems. Close liaison with the diabetes clinic is paramount where the diabetes is poorly managed and/or strongly linked to the eating disorder.

3. Joint working with the community mental health teams is similarly of importance where there is a strong suicide risk and/or significant severe personality co-morbidities.

4. For women with eating disorders who are pregnant, liaison should take place with the obstetric team, perinatal mental health team, mid-wives and/or health visitors as needed. This liaison is again most important in complex cases where low weight and/or electrolyte imbalances are a potential concern.

5. To contribute effectively to collaborative care, understanding and training regarding the legal framework for compulsory treatment is similarly required. This means understanding of the Mental Health Act (DH, 1983, amended 2007) and the Mental Capacity Act (DH, 2005) especially as these apply to people with eating disorders is needed.

6. An ability to work within a multidisciplinary team, often with several different disciplines, is also a core skill, as is an understanding of team dynamics and the ways they may be affected by the patient (e.g. potential for splitting).

2.8 PERSONAL AND PROFESSIONAL SKILLS AND VALUES

In addition to the personal and professional skills and values which are outlined in the BPS paper *Standards for the accreditation of Doctoral programmes in clinical psychology* (BPS, 2019) we additionally highlight the following specific requirement for eating disorders placements:

1. Demonstrating self-awareness and working as a reflective practitioner in considering personal relationships with food, exercise and body image, and the potential impact of these influences on the therapeutic relationship.

2. Demonstrating self-awareness and working as a reflective practitioner in considering personal experiences of perceived loss of control and/or personal predispositions towards over-control; this is to improve empathic attunement with individuals with eating disorders, and awareness of the potential impact of these personal experiences on the therapeutic relationship.

3. Demonstrating the importance of being able to reflect on one's emotional responses to the patient, both positive and negative.

2.9 COMMUNICATION, TEACHING, ORGANISATIONAL AND SYSTEMIC INFLUENCE, AND LEADERSHIP

1. The competencies required in these domains are likely to be akin to those required across specialities to a large extent. Trainees should be prepared to communicate, supervise and teach the competencies outlined in this document once qualified, and to lead specialist eating disorder services (NHS England, 2015).

2. Complicated and intense dynamics can be associated with clinicians and systems, teams and organisations responses to eating disorder distress. These dynamics can be related to the valued nature of aspects of eating disorders to sufferers, the intensity of affect, severity of symptoms, level of risk, and difficulties in recognition and expression of emotion, and problems with interpersonal communication. There is therefore a competence requirement to bring psychological theory and data to indirect roles (e.g. consultation and supervision) and to service development and leadership in readiness for working as an eating disorder specialist clinical psychologist.

3. CONTRACTING OF EATING DISORDER PLACEMENTS AND SUPERVISION REQUIREMENTS

Specialist eating disorder placements may be undertaken in a variety of settings including specialist outpatient eating disorder services, a day care programme or within a specialist inpatient ward. The range of settings will depend on local availability, but where possible experience across different settings within the specialism is highly desirable. Placements may focus on providing care for working age adults, children, or may be within an ageless service that spans both child and adult client groups. Placements should also include a range of treatment modalities: individual, group, family or multi-family group work. The emphasis placed on different treatment modalities will be as appropriate to the setting and life stage. For example, there is the expectation evidence based family work (e.g. AN-FT) would be a requirement of a child and young persons eating disorders placement. Placement providers are additionally required to ensure that trainee clinical psychologists can meet the competencies highlighted in this document. Placement providers are also expected to provide appropriate supervision (two hours per week), and observational opportunities, as needed, to facilitate this learning process.

Eating disorder placements have traditionally taken place in the final year of training as people with eating disorders often have complex multiple problems and diagnoses, and have the highest mortality rate across all psychiatric diagnoses. Undertaking an eating disorder placement in the final year of training will increase the likelihood that trainees will already have had the opportunity to have established some core generic skills. These core generic skills can then be built upon during their eating disorders placement. However, eating disorders training and placement experiences can be a feature during each year of training with the placement tailored to the trainee's stage of development. For example, in the first year of training there would potentially be more emphasis on group work with a qualified clinician, more straightforward cases and more joint working with the clinical supervisor. In these instances, an adult eating disorders placement might form part of a working age adult placement (e.g. a split placement in conjunction with a community mental health recovery service). A child and young persons eating disorders placement might also be considered as suitable as part of a core child and adolescent placement. The clinical supervisor then has the responsibility for modifying the placement to ensure patient needs are competently and effectively met, that the agreed requirements of the placement as negotiated with the training programme are fulfilled, and that the placement is appropriate to the level of the trainee's experience. It must also be noted that an eating disorders placement is unlikely to be able to provide all the opportunities required for a supervisor to sign-off a trainee as fully competent in the wider area of a core placement (e.g. adult mental health), and this needs to be considered by the allocating course.

It is a requirement that any eating disorders placement is supervised by a qualified clinical psychologist who meets the BPS supervision requirements, is HCPC registered, and is themselves competent in all the above outlined eating disorder specific clinical competencies. The Faculty further recommends supervisors meet, or can evidence proactively working towards achieving the Faculty's additional competency requirements for qualified clinical psychologists specialising in the field of eating disorders.

For clinical psychologists planning to work in the field of eating disorders post qualification, the completion of a specialist eating disorders placement during training is highly desirable but not mandatory. Section 5 of this paper provides clarification about the post qualification requirements for clinical psychologists who have not completed an eating disorders placement during training, and who wish to transition to work in the field.

4. EATING DISORDER TRAINING REQUIREMENTS FOR CLINICAL PSYCHOLOGY TRAINING PROGRAMMES (ACADEMIC TEACHING)

There is an expectation that all clinical psychology trainees should develop an understanding and knowledge of the main presenting problems found in the speciality including anorexia nervosa, bulimia nervosa, binge eating disorder and avoidant/restrictive food intake disorder (ARFID) other specified feeding or eating disorder (OSFED), and unspecified feeding or eating disorder (UFED). As such, doctoral training courses should include the following eating disorders specific training as part of their academic programmes:

1. Identification of people with eating disorders, preferably in the first year. This should include the range of diagnoses across the lifespan including current theories on epidemiology, incidence, prevalence, natural history, co-morbidity and outcome. Also, understanding of the role of trauma and personality traits such as perfectionism in eating psychopathology.
2. Psychological models of eating disorders and further teaching should also be presented, although not necessarily in the first year.
3. Teaching should additionally include the psychological assessment of eating disorders (including the use of eating disorder specific PROMS), understanding of the physical health risks associated with eating disorders (including an awareness of re-feeding syndrome and the specific risk factors associated with pregnancy and type 1 diabetes), and NICE guidance on treatment approaches and current research.
4. There should be specific recognition of the different approaches required for younger people, including reference to complex consent and confidentiality issues.
5. Teaching should further highlight the importance of early intervention and knowledge about the impact of length of illness on brain function and prognosis.
6. Teaching on patients whose illness is of long duration and/or severe should be included.
7. There should also be teaching around the significant impact that eating disorders can have on relationship dynamics within surrounding family and carer relationships. Also, learning in relation to the important role that families and carers can potentially have in supporting recovery from an eating disorder.
8. Teaching should also provide knowledge about the use of different treatment settings (outpatient, day care and inpatients) and understanding about the importance of well-planned and coordinated transitions. This is with recognition of the risks inherent in transitions across eating disorder settings, and for those who are in different places at different times (e.g. students going to university and some travelling communities).
9. In line with section 2.8.2 the competency to bring psychological theory and data to indirect roles such as consultation and supervision, and to service development and leadership is key to readiness to work as an eating disorder specialist clinical psychologist. It would therefore be helpful for courses to consider bringing eating disorder related content or eating disorder specialist teachers into the delivery of these parts of the curriculum.
10. Reflection on the recognition of diversity in eating disorders is also important and should usefully include, but not be limited to, religion or belief, culture (including effects of the digital age such as the use of social media), sexual orientation, gender identity (including people who are transgender and non-binary), race, disability, age, relationships, socioeconomic status, pregnancy and parenting.

11. Experiential learning exercises in relation to body image, perceived loss of control and propensities towards over-control are additionally desirable; this is to aid the development of reflective practice, and the required empathic attunement with those with eating disorders.

12. Teaching should include presentations from those with lived experience to improve relatability, understanding of individual differences, and therapy process considerations. For example, explanation of the emotional experiences associated with weight restoration and reductions in binge eating and purging might be helpful. Similarly, the lived experience perspective in relation to concerns about treatment ending and the importance of, where possible, collaborative and thorough discharge planning could be appropriately thought provoking.

5. GENERIC PLACEMENTS AND SUPERVISION

Eating disorders are treated in a variety of settings in the health service and all trainee clinical psychologists may be expected to have some experience of treating eating disorders at least on an outpatient basis. The Faculty recognises that trainees may be able to acquire at least some of the competencies outlined above in a range of service contexts, and with a range of client groups. However, as is explained above, for trainees who wish to specialise in the field of eating disorders post qualification it is desirable that, where possible, they undertake a placement in a specialist eating disorders service during their training.

6. COMPETENCY REQUIREMENTS FOR QUALIFIED CLINICAL PSYCHOLOGISTS SPECIALISING IN THE FIELD OF EATING DISORDERS

There is an expectation that post qualification competency requirements for clinical psychologists specialising in eating disorders will be consistent with the KSF requirements (Department of Health, 2004) related to the banding of each post. However, the Faculty additionally recommends that to meet the direct clinical competencies needed for specialism in the field of eating disorders qualified clinical psychologists will need to undertake the following (competency requirements are again to be considered 'essential' unless they are specifically marked as 'desirable'/'highly desirable'):

1. Post qualification training in evidence based models of formal psychological therapy for eating disorders to ensure high level of clinical skills and model adherence as recommended by NICE. This currently specifically includes training in CBT-ED, MANTRA and SSCM for clinical psychologists working with adults with eating disorders and FT- AN, FT-BN and CBT-ED for those working with children and young people with eating disorders. Also, training in evidence based skills training for carers such as the new Maudsley approach.

2. Desirable: Further research into those treatments where the evidence base is emerging, weaker or lacking, or where certain therapies have not been demonstrated to be superior to other approaches. This wider range of therapy approaches includes CBT-T, interpersonal psychotherapy (IPT), dialectical behaviour therapy (DBT), radically open dialectical behaviour therapy (RO-DBT), schema therapy, and cognitive analytic therapy (CAT). This is with the recognition that there is still much work to be done to improve clinical outcomes in the field.

3. Desirable: Post qualification training in evidence-based models of formal psychological therapy for relevant co-morbidities, including personality disorders, is also recommended. This is particularly to inform treatment planning where co-morbidities might require treatment in parallel with the eating disorder, or consecutively as part of a stepped care approach.

4. Highly desirable: Practitioner accreditation in the use of evidence based therapies where these accreditations exist (e.g. BABCP accreditation).

5. Regular clinical supervision from a clinical psychologist with significant experience in the field of eating disorders. All clinical psychologists working within the specialism need to ensure they are receiving supervision in line with the DCP supervision guidelines and the HCPC supervision requirements. However, it is recognised that very senior clinical psychologists within the field will not necessarily have local access to supervision from another clinical psychologist with very significant experience in the specialism. In such instances, there is increased onus on the individual clinician to be ensuring that they are following the formal DCP guidelines for supervision, and the HCPC supervision requirements. Very senior clinical psychologists are also strongly advised to ensure that they continue to receive peer support and learning via networks, such as that provided by the Faculty.

6. Reflective practice and peer evaluation through the observation of therapy for quality assurance purposes (e.g. live observation) or through the audio or video recordings of sessions with the relevant required consents.

7. Regular attendance at and participation in professional networking and peer learning events. In this respect, attendance at BPS FED CPD events and training courses is encouraged. The Faculty selects keynote speakers of standing within the field, and aims to provide CPD events in both the south and north of the UK. Similarly, BrEDS (British Eating Disorders Society) is a useful multidisciplinary forum for clinical psychologists working with eating disorders to undertake important networking, and peer-learning. The charity Beat also runs biannual conferences which often feature international speakers and key research updates.

8. Development of understanding of commissioning of eating disorders care pathways.

9. Maintenance of up to date knowledge of developments in the field of eating disorders as these relate to the consultation and supervision of staff and the formulation of teams, as well as to direct clinical work.

10. Maintenance of up to date awareness of and ability to critically appraise the evidence base for the treatment of eating disorders, particularly as this relates to the NICE guidelines and ongoing emerging research in the field.

11. Promotion of service user and carer and partnership organisation involvement as an integral part of service development.

12. Learning from experts through experience and through experiential learning to foster ongoing reflective practice, to maintain positivity and to facilitate career long learning.

It is emphasised that the nine overarching core competencies (BPS, 2014) developed during clinical psychology training (generalisable meta-competencies, psychological assessment, psychological formulation, psychological intervention, evaluation, research, personal and

professional skills and values, communication and teaching, organisational and systemic influence and leadership) which interact to create the knowledge and transferable skills of our profession provide the main basis for clinical psychologists' post-qualification expertise across all areas including eating disorders. However, that in this field the post-qualification further development of skills in the use of evidence-based psychological therapy models for eating disorders is important; this is for the model adherent application of protocol and principle driven evidence based therapies. Also, where required, to optimise the application of the generalisable meta-competencies for which clinical psychology is known.

For clinical psychologists specialising in the field, post qualification training in evidence-based psychological therapy models for eating disorders also facilitates the application of relevant psychological theories trans-diagnostically across models where needed. This allows integrative consideration to be given, where applicable, to co-morbidities, lifespan, organic, psychological and social/systemic domains to promote recovery. In turn, this skills-set facilitates the development of formulations that derive testable hypotheses promoting the evaluation of change, both generic and tailored to specific individual goals. By extension, these competencies additionally support formulation driven work from knowledge of empirically grounded psychological basic processes where there are gaps in the presently established treatment evidence base. In the field of eating disorders this is particularly key as there is clear role for clinical psychologists in applying such knowledge to progress relevant research, and therefore treatment advances. This is to support both early intervention/acute presentations and treatment at the complex, severe and more longstanding end of the eating disorders spectrum.

The Faculty additionally specifies that for qualified clinical psychologists who have been working in other fields (and who potentially will not have completed a specialist eating disorder placement during training) a defined induction, transition and mentoring period is required for effective transition to working in the field of eating disorders. It is highly recommended that this induction, transition and mentoring period should be implemented under the supervision of a clinical psychologist with current specialism in the field. CPD goals should also be tailored to meet the identified learning needs and should be clearly documented in the clinical psychologist's appraisal. This good practice paper should then be used as a reference guide to ensure that, irrespective of length of qualification, clinical psychologists moving into the field can fully develop the specialist placement competencies outlined by the Faculty.

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WITH ACKNOWLEDGEMENTS FOR THEIR KEY CONTRIBUTIONS TO THE 2008 PAPER:

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ACKNOWLEDGEMENTS

This paper is the result of collaborative working and consultation with experts through experience, partnership organisations and four nations representatives. Appreciation, thanks and recognition is especially given to the main authors and contributors who are listed in alphabetical order above. Sincere thanks are additionally extended to the experts by experience, trainee clinical psychologists and qualified clinical psychologists who contributed to the quotes at the beginning and end of the document. The Faculty believes that these contributions importantly serve to capture and enliven the meaning of what it is to work with people with eating disorders.

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‘It was vital for my recovery that my psychologist let me be angry at the world for the disease I was fighting and that she didn’t pretend to know how that felt. The honesty that some days things were going to be difficult, coupled with the reassurance and support that I would overcome those days prepared me for the challenge ahead of me. But most importantly never forget to be patient.’

Harriet

‘Working with a clinical psychologist saved my life. They saw me as more than numbers on a scale or the amount of calories consumed. It was the first time anyone ever addressed what was going on inside my head and helped me realise I could recover from this and that an eating disorder free future was possible. Now I am living that future, I am so grateful for the support I received and how they never gave up on me, even when I didn’t always believe in myself.’

Chloe

‘Much of my anorexia nervosa is driven from feeling unsafe and I have felt the most understood, and “safe”, when working with a clinical psychologist.

Not only have they helped me progress psychologically, they have enabled me to actually change my behaviour. They taught me techniques to manage the anxiety that arose from making these changes. By taking the risk to do things differently and avoid engaging in my familiar but unhealthy behaviours, I have gained precious freedom from my rigid and lethal illness.

I am also extremely grateful for the well-supported “Exposure” work clinical psychologists have done with me. Without this highly challenging, yet invaluable work, I would not have been able to make the progress towards Recovery that I have!!’

Lara Tosunlar

‘The clinical psychologist who worked with my daughter tailored her treatment to her specific needs. That is why the treatment worked, and why three years later she is still using the tools she gave her to keep well.’

Margaret

‘My eating disorder was a tremendously powerful force, which took all the strength I had and more to tackle. The support of my clinical psychologist helped me realise that I didn’t have to go through recovery alone, and that the transformative power of therapeutic relationships can match the power of entrenched eating problems.

More than anything, the relationships I made in my treatment were the vehicles through which I managed to change. My clinical psychologist viewed me as a whole person, not just through the lens of weight and eating disorder symptoms, and that helped me to realise there was more to me than illness.

I appreciated the way my clinical psychologist would help me understand my situation in the round, not seeing me as a problem to be fixed but respecting that there many, complicated reasons that I was unwell.

During my experience of an eating disorder, I felt overlooked as a person, and just seen through the lens of medical risk. Having a psychologist meant I could finally explore the psychological components of my eating disorder too. This was key in starting the journey towards recovery.’

James Downs

'Working in this field has been both a rewarding and varied experience that I have valued in my assistant psychologist roles both within children's eating disrders service (EDS) and adult EDS. I have learnt a considerable amount from working alongside the highly skilled multidisciplinary team, and delivering a variety of interventions and group work. It has been a privilege to support clients through challenges in order to improve their wellbeing and quality of life.'

Catherine Rowland, Assistant Psychologist

'In supporting people with eating disorders, it is important to work with an acceptance of where someone is to help them to create a platform for change. Once someone (and the sooner the better) takes the leap of courage that treatment requires, the scope to support them to build a better quality of life is often considerable. People with eating disorders are typically resourceful and determined individuals. So to see the drive that has previously maintained an eating disorder redirected to create a skilful, and change focused, energy for recovery (a new solution to that person's problems) is immensely satisfying and rewarding.'

Dr Caroline Foster, Consultant Clinical Psychologist

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REP147/09.2021