

Chapter 5.

Evidence-Based Practice for Treatment of Eating Disorders

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SUMMARY. The purpose of this chapter is to review the status of evidence-based practice (EBP) for the treatment of students with eating disorders in university and college counseling centers. Several issues affecting the application of the research findings to service delivery for eating disordered students will be addressed. These include discussion of EBP research paradigms, populations studied, treatment interventions selected, other salient variables examined, utilization of appropriate assessment indices and meaningful outcome measures, and multicultural considerations. EBP relevant guidelines, implications and suggestions for future directions in college mental health are presented. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]

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The purpose of this chapter is to provide an overview of the current status of evidence-based practice (EBP) for the treatment of students with eating disorders in university and college counseling centers. EBP paradigms can be made useful for campus-based practice. The EBP movement is driven by scientific inquiry, the search for best practices and the consideration of stakeholders' interests, including clients, health care providers, and institutional or other third party payers. At best, EBP involves a focus on accountability, with principal goals to demonstrate that psychotherapy effectiveness stands up to empirical scrutiny and that practice is informed by scientific findings. At worst, EBP elicits concerns about the misuse of EBP data by Managed Care and other third party payers in ways that would limit or hurt health care service delivery. The roots of the EBP movement stem from the medical model calling for empirically validated treatments with controlled clinical trials, carefully monitored interventions, and dosage effects testing for specific diagnoses.

In the application of empirically validated treatments to the realm of counseling and psychotherapy, however, significant questions arise as to what constitutes replicable interventions, reliable evidence, and appropriate measures to evaluate the efficacy of treatments. Perhaps as one consequence of this uncertainty, the framework of what should be included is ever broadening. The language used reflects this evolution, moving from empirically validated treatment (EVT) to empirically based treatment (EBT) to empirically supported interventions (ESI) and empirically supported relationships (ESR) and now to evidence-based practice (EBP), evidence informed practice (EIP), and evidence informed interventions (EII) (Barlow, 2000; Chambless & Hollon, 1998; Norcross, 2001; Wampold, Lichtenberg & Waehler, 2002). For purposes of this chapter, the term evidence-based practice (EBP) will be used as an umbrella reference for all of these terms. Later in this chapter, unique aspects of college counseling centers will be elucidated as they differ from the practice sites where most EBP research has taken place.

EATING DISORDERS

Most counselors in university and college counseling centers deal with at least some clients with a diagnosis of mild, moderate, or severe eating disorders as large numbers of female students (and a much smaller number of males) present with such concerns. Eating disorders are characterized by severe disturbances in eating behavior, with defini-

tions typically based on the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association, 2000): Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorder Not Otherwise Specified (EDNOS) are the three major subtypes with Binge Eating Disorder (BED) representing a newer category being investigated. The treatment of obesity is not addressed in this article, since obesity is considered by the *DSM-IV-TR* (American Psychiatric Association, 2000) to be a medical disorder not consistently associated with psychological syndrome or behavior; however, obesity may be co-morbid with BED.

The findings of EBP studies regarding eating disorders vary by specific diagnosis. Eating disorders were first included in the *DSM-III* (American Psychiatric Association, 1980). The revised editions contain different criteria for eating disorders with increasing levels of severity and greater specificity required for diagnosis. Many clients presenting to university and college counseling centers may not meet the strict criteria for AN or BN and more frequently fit the EDNOS classification, which is not surprising, since eating disorders are often thought to exist along a continuum, varying in severity rather than occurring in discrete categories (Herzog & Delinsky, 2002). Eating disorders affect approximately 10% of adolescent girls and women, making them some of the most gendered diagnoses in the *DSM* (Smolak & Murnen, 2002). It should be noted that regardless of the eating disorder diagnosis, little EBP research has actually been conducted in college counseling center settings.

Anorexia Nervosa

AN is characterized in the *DSM-IV-TR* (American Psychiatric Association, 2000) by refusal to maintain minimally normal body weight, intense fear of becoming fat, distorted perception of body size or shape, with amenorrhea in postmenarcheal females. Two AN subtypes are noted: Restricting and Bingeing/Purging. There is little research on outcomes for treatment, especially in outpatient settings such as university mental health services. Wilson and Fairburn (2002) suggest that this lack of studies in outpatient contexts may be due to the low incidence of the disorder, the clinical and methodological difficulties inherent in studying AN (including small potential samples and difficulty to engage in treatment), and the severity of these problems, which may require hospitalization.

Stein, Saelens, Douchis, Lewczk, Swenson and Wilfley (2001) describe a small number of controlled studies based of AN on Euro-American females in their mid to late teens. Primary favorable outcomes include weight gain and resumed menstruation. They also reported a few studies involving family therapy that have demonstrated some effectiveness, although it is difficult to draw conclusions from such a small number of investigations. The applicability of a family therapy model in a college or university counseling center is limited, since students are often geographically separated from family. Cognitive-behavioral therapy (CBT) has recently been studied for AN with promising but limited findings (Wilson, 1999). Studies to date have not clearly established a role for pharmacotherapy (Wilson & Fairburn, 2002). Due to the complex medical consequences of AN, including a significant mortality rate, college counseling center practitioners should work closely with physicians and nutritionists in providing outpatient treatment, an essential collaboration which nevertheless complicates evaluating treatment within the EBP paradigm. It is difficult to generalize or identify effective treatments for AN because of these multiple research constraints.

Bulimia Nervosa

The *DSM-IV-TR* (American Psychiatric Association, 2000) describes the essential features of BN as binge eating, inappropriate compensatory methods to prevent weight gain (bingeing and purging or using other compensatory behaviors such as laxative abuse, excessive exercise or fasting at least twice a week for 3 months), and self-evaluation excessively influenced by body shape and weight. Two BN subtypes are noted: Purging and Nonpurging. BN is the most studied among the eating disorders (Wilson & Fairburn, 2002) though again, relatively few EBP investigations have taken place in university mental health services contexts. Primary outcome measures are frequency of bingeing and purging or other compensatory behaviors. Study samples remain predominantly Euro-American females in their early 20's presenting without co-morbidity (Stein et al., 2001).

The most intensely studied BN treatment is CBT that addresses the presenting behaviors of bingeing and purging as well the extreme dietary restraint and dysfunctional thoughts and attitudes about idealized body shape and weight (Wilson, 1997). The cognitive model suggests that treatment may also need to address negative self-evaluation, perfectionism and dichotomous thinking, and perhaps also the ability to

tolerate negative affect. The cognitive conceptual framework posits that vulnerable women, often college students, idealize thinness and unrealistically restrict their food in pursuit of this goal leading to periodic loss of control over eating (bingeing) and then purging as an attempt to compensate and reduce anxiety. A vicious cycle of distress and lower self-esteem leads to increased reliance on the drive to be thinner, even more restrictive eating, and another binge/purge cycle.

Manual based CBT uses an integrated sequence of cognitive and behavioral interventions that typically begin with psychoeducational and behavioral interventions, then move to cognitive interventions, and finally conclude with interventions aimed at maintenance of change over time. Reviewing a number of well designed studies with over 20 controlled trials for CBT showing some efficacy, Wilson and Fairburn (2002) conclude that manual-based CBT is first line treatment of choice for BN (with about half ceasing binge and purge behaviors). They note that CBT is well accepted by the majority of patients, is effective in eliminating core features, and often improves co-morbid problems such as low self-esteem and depression; and long-term positive effects seem reasonably stable.

Wilson and Fairburn (2002) note that CBT may be more effective in treatment of specific bulimic symptoms but not more effective than alternative treatments in dealing with associated aspects of BN such as personal well-being or relational effectiveness. Interpersonal Psychotherapy (IPT) is the alternative intervention most often studied. IPT helps clients identify and modify current interpersonal problems, and identifies their link to eating behavior (Stein et al., 2001). The treatment phases include: (1) identification of the most significant interpersonal problems areas; (2) changing functioning in those areas; and (3) a termination phase consolidating therapeutic work and preparing client for further independent work. IPT treatment typically spans 15-20 sessions.

A treatment approach that takes into account a more complex model is proposed by Wonderlich, Mitchell, Peterson, and Crow (2002) and is referred to as Integrative Cognitive Therapy (ICT). ICT may be highly suitable for work with college clients. ICT looks at emotional states as proximal antecedents for binge eating and with bulimic behavior as an effort to regulate or escape from negative affect. ICT is an extension of CBT that incorporates affective, cultural and biological factors. It takes into account that BN clients are more likely to have events that threaten the attachment process such as more physical and sexual abuse in childhood, parental histories of psychopathology, and conflictual, disengaged and non-nurturant families of origin. Four treatment phases are

delineated in ICT: (1) education using a workbook; (2) normalization of eating and associated coping skills; (3) exploration of interpersonal patterns and schemas; and, (4) relapse prevention and lifestyle management. Again, approximately 20 sessions are employed in the manualized version of this intervention. The ICT model is promising, especially for the treatment of college students with BN, but it is still in its early stage of development and requires further testing.

A few studies have examined a Stepped-Care approach to BN, which sequences interventions based on intensity, cost and efficacy, progressing from self-help to therapist intervention; clients begin with the least intense and expensive treatment, and move up steps as needed (Stein et al., 2001; Wilson, Vitiusek & Loeb, 2000). Initial investigations of the Stepped-Care approach have suggested some positive outcomes but further studies are required before conclusions can be drawn.

Wilson and Fairburn (2002) reviewed the literature that examined the effect of antidepressant medication for BN, with and without other psychotherapy. Several classes of antidepressant drugs produced greater reductions in bingeing and purging in the short term in BN than placebo; however, the long term results remain mostly untested and the effects when combined with psychotherapeutic interventions are mixed. Comparisons of CBT and antidepressant drugs indicate that CBT is more acceptable to patients than medication, the dropout rate is lower, and the treatment is superior to drugs alone; combining CBT with medication is more effective than medication alone but produces few consistent benefits over CBT alone, although combining might aid in reducing co-morbid anxiety and depression (Wilson & Fairburn, 2002, p. 565).

The severity and complexity involved in BN and its treatment pose a challenge when examining the utility of EBP findings, both for the general population and for the college student client population. Clearly CBT and IPT provide some positive results, with CBT found to be equal or superior to all treatments to which it has been compared (Wilson, 1997). Nevertheless, success here still means that up to 50 percent do not see a reduction in binge/purge behaviors. Thus, for the clients who derive little or no benefit from those interventions, other treatment strategies must be considered. Few clinical treatment studies examine more integrative orientations such as ICT or consider different interventions for stages of treatment. For example, group therapy as a primary or adjunctive treatment modality for those at the action stage of change has not been well studied.

Eating Disorder Not Otherwise Specified

The EDNOS category refers to eating disorders that do not meet criteria for AN or BN. For example, EDNOS includes someone who meets all the criteria for BN but at a sub-morbid frequency. In actual practice, many students present at college counseling centers with an eating disorder that takes an “atypical” form. Herzog and Delinsky (2002) note that contrary to being atypical, the EDNOS diagnosis is common, given to from 25 percent to 50 percent of clients who present with disordered eating. Unfortunately, most EBP studies exclude subjects who do not present with pure *DSM-IV-TR* diagnosis for AN or BN, so little can be said about interventions for EDNOS. The one exception is Binge Eating Disorder (BED), introduced in 1994 as a provisional category requiring further study, and currently classified as EDNOS in the *DSM-IV-TR* (American Psychiatric Association, 2000).

Binge Eating Disorder

According to the *DSM-IV-TR*, research criteria for the provisional BED diagnosis include recurrent episodes of binge eating with impaired control and significant distress over bingeing, and the absence of purging or other inappropriate compensatory behaviors at least twice a week for at least six months (American Psychiatric Association, 2000). Prevalence is 0.7 percent to 4 percent of the general population, with 30 percent in weight control programs. Onset is typically in late adolescence. BED is 1.5 times more likely for women than men and may be co-morbid with obesity.

Treatment of BED has focused on management of weight and eating behavior. Studies have looked at CBT, IPT, pharmacological, behavioral weight loss (BWL), and Stepped-Care programs. Studies report problems with adherence, drop out, and relapse rates with all five of the above programs. Most investigations were conducted outside of campus-based practice settings. At this juncture, no treatment has proved differentially effective with small sample sizes and the focus on very short term results limiting current findings (Wilson & Fairburn, 2002; Stein et al., 2001).

ISSUES IN EBP RESEARCH

Critiques of the application of EBP to eating disorders have noted the limitations based on constraints of randomized controlled trials (RCTs)

and other research design restrictions. The relevance to actual practice has been questioned based on study selection decisions regarding sample population, interventions, salient factors, and outcome measures, and also, the failure to address multicultural counseling issues. Each of these issues is very important in the college context.

Research Subject Selection

In order to comply with the research methodology, treatment populations used in an AN or BN research study have been artificially restricted and the resulting sample selection no longer represents the population that would present in university health services for eating disorders. The EDNOS clients routinely get excluded, as do the many co-morbid clients who present with other problems along with the eating disorder. Seligman (1995), among others, has criticized this aspect of RCTs because they select for only one diagnosis using a large number of exclusion criteria while, in actual practice settings, including college student psychotherapy, most clients have multiple problems, especially clients toward the more severe end of the symptom spectrum.

Westen, Novotny, and Thompson-Brenner (2004) identified several problematic methodological issues including the empirical and pragmatic limitations imposed by reliance on *DSM-IV* diagnosis and the problem of co-morbidity. Their review also noted the limits of generalizability due to the way that researchers versus clinicians assess for co-morbidity. They observe that researchers advertise for one disorder, while in actual practice, the initial client presentation may not remain as the primary diagnosis. Westen et al. estimate that from 1/3 to 1/2 of all those presenting for treatment might be excluded as subjects for any given study.

Treatment Interventions and Other Factors

EBP studies have focused principally on the examination of type of therapeutic intervention. Specific treatments have been subject to testing and compared to purposely contrasting treatments, leading to the study of artificially rigid interventions. The appeal of manualized treatment is that therapists can adhere to a particular set of interventions that are allegedly more likely to lead to positive treatment outcomes. Westen et al. (2004) call for a change “from providing clinicians with step-by-step instructions for treating decontextualized symptoms or syndromes to offering them empirically supported theories of change that

they can integrate into empirically informed treatments” (p. 658). They question why the CBT manual is limited to its current form and ask about adding affect regulation or addressing interpersonal problems components or changing the order or number of treatment sessions. Their point is that, at present, it is unlikely that any of these variables would be tested, even though they could be justified by theory for inclusion and could favor more efficacious choice of the treatment. They note that selecting what treatment to test is often “pre-scientific” in itself and thus can lead to scientifically invalid conclusions.

Conceptual frameworks regarding the etiology of eating disorders affect directions in devising treatment strategies. Nearly 20 years ago, Johnson and Connors (1987) described a biopsychosocial conceptualization of the etiology of bulimia, including bioenergetic, familial, and sociocultural factors. Such a biopsychosocial model seems to fit many of the students with eating disorders seeking our services. Striegel-Moore and Cachelin (2001) cited several theoretical models in their review of the etiology of eating disorders, all of which are multifactorial, albeit differing in emphasis placed on various risk factors (sociocultural, familial and interpersonal, personal vulnerability factors, and traumatic life events). They called for future research which considers various risk factors within an integrative framework that can assist in development of therapeutic interventions. Tylka and Subich (2004) conducted research on college women testing a multidimensional model that included sociocultural, personal and relational correlates ranging along a continuum of degree from no symptoms to clinical disorder. They found that the context of personal and relational variables may mediate or moderate the symptomology and suggest that treatment programs simultaneously address the different factors implicated in the multidimensional model.

In general, the EBP paradigm tests various treatments with the underlying assumption that the treatment intervention is the most salient factor. However, psychotherapy research has indicated that this is a mistaken notion, since the type of therapy used accounts for only a small portion of client outcome (Norcross, 2002). Other factors known to contribute include therapist and client characteristics and the qualities of the therapeutic relationship. Wampold (2001) observes that variability among providers delivering the same intervention is much greater than variability among types of interventions themselves, so it is grossly misleading to identify efficacious interventions while ignoring provider differences. Norcross (2001) reported extensive work to identify empir-

ically supported therapy relationships and to determine ways to customize therapy to individual clients.

Similarly, Henry (1998) has regarded the narrowly construed EBP research as potentially damaging “pseudo-science” and calls for psychotherapy research designs that focus on central therapeutic processes. Albon and Marci (2004) note that the focus on evidence-based manualized treatments misses important information about what is efficacious about a given treatment and minimizes the importance of the clinical encounter within the therapeutic relationship. They also call for a shift in focus to a study of the change process rather than of the treatment type, and for bridging the gap between efficacy and effectiveness, studying therapy as it occurs in naturalistic settings, and attending more to patient contributions and to patient-therapist transactions. Given that many clients in university settings have a greater than average level of positive precursors for change (Hanna, 2004), therapeutic alliance and other common factors may be even more important.

Outcomes

EBP outcomes, whether or not collected in college setting, tend to focus on symptom reduction rather than more global assessments of functioning. Even if looking at symptoms, it is unclear whether this means simply reduction or percentage of clients improved or recovered? Issues of statistical significance may be assumed to outweigh the more important goal of clinically significant change. For researchers looking at factors other than primary symptoms, decisions must be made about what other variables to include, how to assess them, and at what points to measure them. Outcome follow-up is often done upon completion of treatment, and the relapse issue, which is of great concern in eating disorders, is rarely addressed.

RCTs yield efficacy studies. Effectiveness studies are also needed to evaluate efficacy as applied to diverse settings by therapists with varying experience and expertise and with heterogeneous client groups. Before drawing conclusions about outcomes, clarity about how many subjects and how diverse a sample is needed is required in order to generalize the findings.

Multicultural Concerns

In line with the above, EBP has been criticized for using homogeneous samples, and culture bound research methods, conceptualizations

and treatment paradigms (Sue, 1999). Atkinson, Bui and Mori (2001) describe the EBP and the Multicultural Counseling movements as being on a collision course, both representing important developments in professional psychology that have rarely intersected. They list a number of issues that need to be addressed by EBP researchers from a multicultural perspective: subjects, symptom manifestations, acculturation, counselor multicultural competence, and relationship characteristics. The latter include variables such as linguistic similarity, racial/ethnic similarity, racial/ethnic identity development compatibility, and compatibility about causes and cures for psychological problems.

Similarly, Root (2001) states that more attention must be paid to cultural variations in the etiology, assessment and treatment of eating disorders. She underlines the need to test what has been considered “universal” on groups other than white Euro-American women, calling for studies on samples of Asian American, African American, Latina, and American Indians to determine whether ethnic group differences may influence eating disorder symptoms and suitability of treatments. Research reliance on patient samples inadvertently excluding ethnic minority groups may have created sampling bias that contributes to the perception that eating disorders mainly affect Euro-American populations (Striegel-Moore & Cachelin, 2001). Smolak and Striegel-Moore (2002) identify acculturation and discrimination specifically as issues faced by ethnic minorities that might impact the development of eating disorders. The relative lack of feminist and multicultural counseling formulations in devising EBP designs is especially troubling given the disparity in occurrence of eating disorders in women versus men and the acknowledged importance of cultural competence in evaluating usefulness of treatments (American Psychological Association, 2003; D.W. Sue & Sue, 2003).

GUIDING PRINCIPLES AND NEW MODELS FOR EVIDENCE-BASED PRACTICE

Taking into account some of the limitations of EBP research, Wampold, Lichtenberg, and Waehler (2002) have provided some guiding principles regarding what they term empirically-supported interventions that are useful guidelines for campus-based future studies in this area: (1) Consider intervention level of specificity (e.g., moving from a most general level “psychotherapy” to more specific levels, such as “CBT,” “CBT for BN,” “CBT for BN with college women”; (2) Recog-

nize the importance of other client variables (e.g., ethnicity, gender, attitudes and values, preferences for type of treatment); (3) Base conclusions on aggregate evidence, using meta-analysis methods; (4) Present evidence for absolute and relative efficacy (e.g., treatment better than nothing, treatment A better than B, and factors such as cost); (5) Make causal attributions for specific ingredients only if evidence is persuasive (e.g., legitimacy of the common factor models as opposed to the specific ingredient models); (6) Broaden assessment outcomes beyond symptom reduction to include general life functioning, perspective and cost/benefits from multiple perspectives (client, provider, third party payer); and (7) Assess outcomes at the local level and recognize freedom of choice. These seven principles have been endorsed by the Society of Counseling Psychology, American Psychological Association Division 17. They reflect the scientist-practitioner model where interventions follow from a scientific base and scientists conducting research are informed by those in practice. Counselors practicing in college mental health contexts would find these seven principles could serve as useful guides for investigations they might conduct.

IMPLICATIONS AND CONCLUSIONS

Campus-based clinicians need to consider a number of issues in applying findings of EBP research to counseling center settings. Flexibility is required, since the faithful following of 15-20 session protocols for specific diagnoses may be difficult to implement. Specifically, the majority of college counseling centers use very brief therapy models (Archer & Cooper, 1998) and it is clear that the average number of counseling center sessions per client is far fewer than those called for in EBP protocols. Additionally, some students interrupt counseling due to breaks in the academic calendar and others may face session limit policies. Since many clients with eating disorders present with more than one problem, conceptualization and decisions about what to treat become important factors. Do you provide treatment for only one problem or do you address issues in a more integrated manner? Would the latter be sequential EBP protocols or a simultaneous incorporation of a variety of strategies based on EBP, clinical judgment and client characteristics? What if underlying issues, such as past childhood sexual abuse, are more significant in terms of treatment needs? Interdisciplinary interventions involving physicians, psychologists, and nutritionists are often the best practice with eating disorders (Hotelling, 2001), but such col-

laboration is rarely discussed in the EBP literature. Likewise, consideration of group counseling as a primary intervention or adjunct to individual therapy may be a preferred college counseling center practice (Archer & Cooper, 1998) yet is rarely mentioned.

Several other forces run counter to using current forms of EBP interventions in the college mental health context. Therapists working with college students typically use a multidimensional model of eating disorders that ranges along a continuum from a few symptoms to full-blown clinical disorder. Most students present as EDNOS, although this category is poorly defined and least studied (Striegel-Moore & Smolak, 2002). University and college counseling centers are committed to providing multiculturally sensitive counseling, which means recognition of group as well as individual and universal factors to inform assessment and treatment intervention, and therapist multicultural competence as it impacts treatment outcome. However, EBP research has not studied the role that these variables play. To address this shortcoming, the "Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists" (American Psychological Association, 2003) must be incorporated into future EBP research paradigms. In light of these issues, few of the EBP interventions can be adopted "as is" at university and college counseling centers.

At this juncture, it would be premature to recommend exclusive use of only validated treatments and to withhold treatments for which there is not scientific evidence. The progress of scientific study of therapy in naturalistic settings is not sufficiently comprehensive to warrant such a position. Further, empirically unvalidated and empirically invalidated are not the same. It would be a wrong approach to dismiss the many interventions that have not been subjected to testing. Stein et al. (2001) cite several alternative treatments that need testing, such as feminist, stress-reduction, and Gestalt therapies. Garvin, Striegel-Moore, Kaplan, and Wonderlich (2002) call for further research on professionally designed self-help programs as potentially inexpensive and readily disseminated interventions and/or as adjuncts to other treatments, a strategy that could be readily employed in counseling centers should studies show support. Wampold et al. (2002) note that particular treatments deserve exclusive use if and only if the evidence of their superiority compared to other interventions is clear and persuasive.

Compelling evidence shows that studies of psychotherapy effectiveness must take into account client, counselor, and relationship characteristics (Atkinson et al., 2001; Norcross, 2002; Wampold, 2001). The

American Psychological Association president-elect (Levant, 2004) has set up a task force to produce a report recommending action with targeted messages for health care decision makers, payers, and psychologists. EBP is based on the Institute of Medicine (IOM) definition, with three equally valued components: (1) Best research evidence; (2) Clinical expertise; and (3) Patient values (Sackett, Strauss, Richardson, & Rosenberg, 2000). Evidence is broadly construed and therapist clinical judgment and therapeutic relationship are considered along with contextual and group factors. It is challenging to try to resolve the tension between conceptualizing the presenting problem in a way that addresses complexity and allows for flexibility in intervention while at the same time finds enough consistency in the treatment protocol to allow it to be evaluated and replicated. Meaningful evaluation measures are needed to go beyond symptom reduction and deal with broader as well as longer term outcomes. Such a multi-component perspective best fits college students with various eating disorder diagnoses.

Eating disorder studies reflect both advances in the EBP field and the limitations of studies to date. Nowhere is this contrast more evident than in the treatment of university students with ED diagnoses. As noted by Wampold et al. (2002), the current situation calls for a closer alliance between practitioners and scientists, so that each can inform the other and develop consensus on meaningful and valid interventions for complex presenting problems. University settings, with the proximity of academic departments to counseling service units, provide opportunities for such collaborations. As these application issues are resolved, EBP will be increasingly embraced in college settings, informing development of brief therapy treatment plans. Putting time and energy into this exploration makes very good sense in a setting where resources are scarce and accountability highly valued.

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