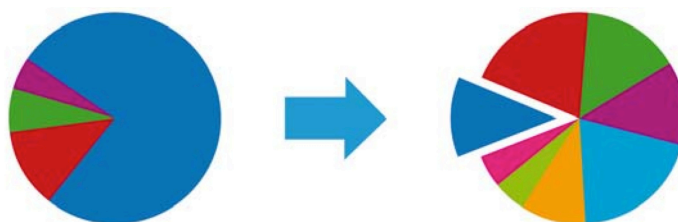


## Inpatient Treatment For Eating Disorders Information for Patients



### Introduction

This pamphlet describes the inpatient enhanced cognitive behavioural therapy or CBT-E for eating problems.

Please read each part of this pamphlet carefully, and underline all the parts that are not clear to you or that you wish to discuss with your therapist. Acquiring detailed knowledge of the general organization of the program and the applied procedures is an essential requirement before deciding to be included on the waiting list for the inpatient treatment.

### The unit

The treatment is provided in a specialized unit for the treatment of eating problems that accommodates 28 patients (16 inpatients and 12 day-patients). The atmosphere in the unit is not medical since it is furnished with typically home-style furniture. The rooms are double or triple and are equipped with private bathroom, wardrobes and desks. You are allowed, as in a college, to decorate your room with posters, personal items and photos. In the unit there is a dining room, a recreation room - where there is also a kitchen for the cooking group - an Internet point room and a lounge with digital TV, DVD and a bookcase. During the day you may have access to other areas of the department, such as the gym, and rooms for individual and group therapy.

The *unit is open*, and you will be free to go outside of it if you are in a stable medical condition.

Similarly, your significant others will be free to visit

you at any time other than mealtimes and when treatment sessions are in progress. Key elements of the treatment are developing a trusting and collaborative relationship with your therapists and playing an active role in the treatment. An open unit has the main advantage of helping to expose you to some important environmental triggers of your eating problem during the inpatient treatment: a strategy that seems to reduce the rate of setbacks after discharge and to prevent the development of dependence on treatment, two problems often observed in traditional closed units.

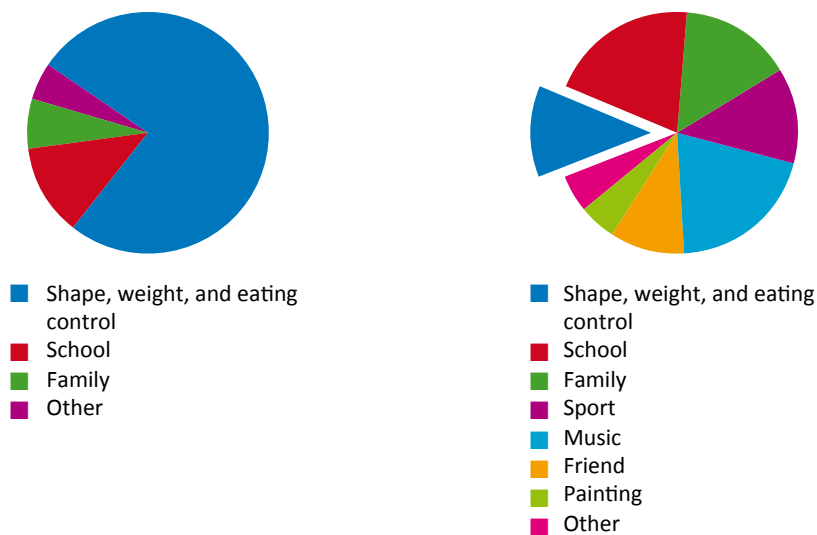
The unit is 'open', and you will be free to go outside of it if you are in a stable medical condition.

## The cognitive behavioral theory

The treatment (called inpatient CBT-E) is derived from the transdiagnostic cognitive behavioral theory and therapy developed at the Centre for Research on Eating Disorders Oxford (CREDO). *Transdiagnostic* means that the theory (and the therapy derived from it) is applicable with minor changes to all the eating problems (e.g. anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified). *Cognitive behavioral* means that the theory mainly analyzes the thoughts (cognitive) and behavior (behavioral) involved in the maintenance of eating problems.

According to the theory, central to the maintenance of eating problems is the *overvaluation of shape, weight and eating control*. While people without eating problems generally judge themselves on the basis of their perceived performance in a variety of domains in life (e.g. quality of their relationships, work, parenting, sporting ability, etc.), those with eating problems judge themselves largely, or even exclusively, in terms of their eating habits, shape or weight (and often all three) and their ability to control them (see Figure 1). This method of self-evaluation is dysfunctional because it marginalizes other important areas of life that are fundamental to developing a stable and good level of self-esteem (e.g., work, interpersonal relationships).

The overvaluation of shape, weight and eating control is the core maintaining mechanism of eating problems



**Figure 1.** Self-evaluation schema (illustrated via a pie chart) of young women with (on the left) and without (on the right) an eating problem.

According to the theory, most of the other clinical features of eating problems can be understood as stemming directly from it, including extreme weight-control behavior (e.g. strict dieting, self-induced vomiting, misuse of laxatives and diuretics, and excessive and compulsive exercising), the various forms of body checking and avoidance and the preoccupation with thoughts about eating, shape and weight.

Extreme weight control behaviour stems directly from the overvaluation of shape and weight and eating control score

The only feature that is not a direct expression of the overvaluation of shape, weight and eating control is binge eating (i.e. episodes of uncontrolled overeating). However, this behavior is usually triggered by the breaking of extreme and rigid dietary rules (some people with eating problems tend to react negatively to the breaking of dietary rules temporarily abandoning their control of eating) or by adverse day-to-day events and negative emotions. A further process maintaining binge eating occur if one practices compensatory purging (i.e. vomiting or taking laxatives in response to binge eating). In this case the belief that purging may prevent weight gain by eliminating the calories introduced tends to relax the control over eating, fostering the onset of new bulimic episodes. In reality, vomiting only retrieves part of what has been eaten and laxatives have little or no effect.

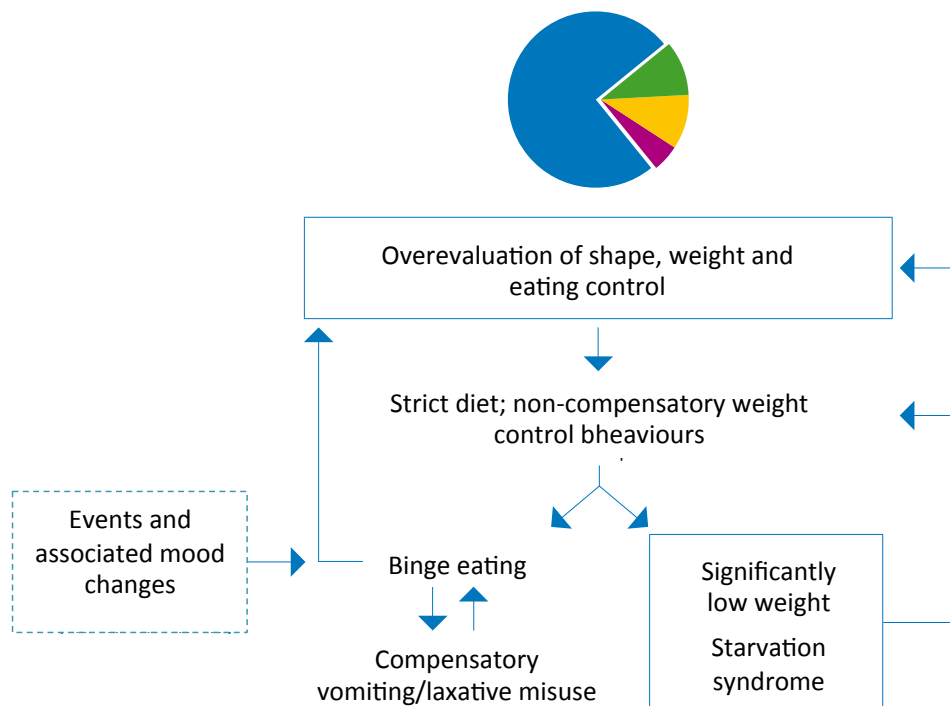
Binge eating is largely a product of attempt to restrict eating (dietary restraint)

Some individuals are more successful in their attempts to restrict diet and reach a condition of underweight. This condition is very problematic because it is associated with several impairing symptoms (e.g. preoccupation with thoughts about food and eating, impairment of concentration capacity, depression, mood swings, irritation, anxiety, social withdrawal, personality changes, loss of sexual appetite, gastrointestinal discomfort, intolerance to cold, reduction of basal metabolism, amenorrhea, etc.) that serve to maintain undereating, thereby locking them into a self-perpetuating cycle.

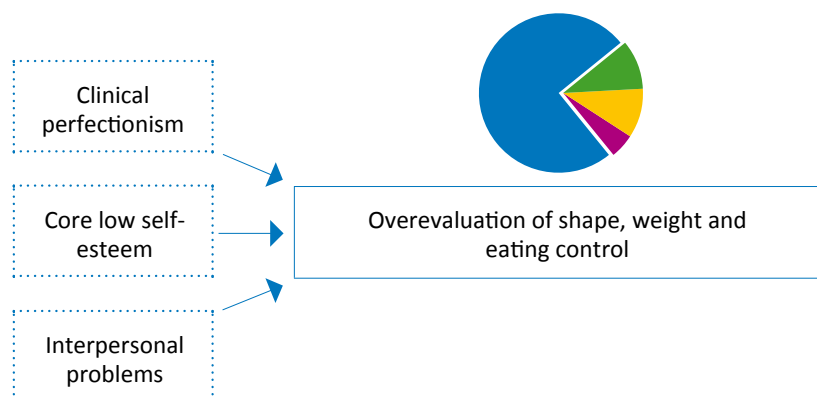
Underweight is associated with severe symptoms (starvation syndrome) that serve to maintain the eating problem.

Figure 2 provides a schematic representation of the main processes involved in the maintenance of eating problems.

The theory proposes that in certain individuals one or more of three external maintaining processes interact with the core eating problem maintaining mechanisms and that when this occurs it is an obstacle to change. The first of these external maintaining mechanisms concerns the influence of severe perfectionism ('clinical perfectionism'); the second concerns the impact of unconditional and pervasive low self-esteem ('core low self-esteem'); the third is interpersonal and developmental in character ("interpersonal difficulties") (see Figure 3).



**Figure 2.** The main maintaining mechanisms operating in eating problems



**Figure 3.** The three external maintaining mechanisms operating in some people with eating problems

## The treatment

### Indications

The indication for inpatient CBT-E is discussed with your therapist during the evaluation interview. In general, inpatient CBT-E is recommended if you have an eating problem that has not improved with outpatient treatments or if you have some medical condition that prevents you from safely undergoing outpatient therapy. Typical conditions include a very low BMI (< 15.0), rapid weight loss (< 1kg per week) for several weeks, marked medical complications (e.g. pronounced edema, severe electrolyte disturbances, electrocardiogram alterations, hypoglycaemia). Other indications include high frequency and intensity of binge eating and vomiting or excessive and compulsive exercising, and severe interpersonal problems.

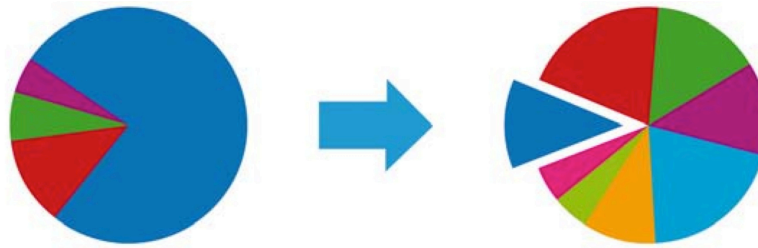
The treatment is indicated for people who did not improve their eating problem with outpatient therapy or that have a physical condition that does not permit to make an outpatient therapy safely.

The treatment is not suitable if you are not willing to play an active role in the treatment and if you are not motivated to change. However, the door to treatment is open to you in the future if you develop the motivation to address your eating problem. The treatment is also not suitable if you practice daily substance misuse or suffer from an acute psychotic state. In these cases you will be referred to specialists who can help you to overcome these problems, and once resolved you may be admitted to the eating disorder unit.

### Goals

The goal of treatment is to help you to develop a more functional and articulate way of evaluating yourself not based predominantly on the control of shape, weight, and eating (see Figure A.4). To achieve this goal, the treatment adopts two main strategies:

1. *Strategies aimed at reducing the importance you attribute to the control of shape, weight and eating* (i.e. reducing the size of the shape, weight, and eating slice of the pie graph). You will be helped to identify (via the building of your *Personal Formulation*), and then to address, the principal maintaining mechanisms of your eating problem. Typical mechanisms addressed by the treatment include: underweight, dietary restriction, binge eating and vomiting, excessive and compulsive exercising, body checking and avoidance and feeling fat.
2. *Strategies aimed at increasing the number and the importance of other interests in your life* (i.e. increasing the number of slices in your pie chart).



**Figure 4.** The aim of the treatment

### **Distinctive characteristics of the treatment**

The treatment has several distinctive characteristics that distinguish it from traditional inpatient treatment for eating disorders:

1. It is based on a theory sustained by considerable scientific evidence.
2. It is designed to be suitable for all forms of clinical eating problems so long as inpatient management is appropriate.
3. It is tailored to your specific problems, adopting an individual approach supported by some of the procedures delivered in groups.
4. It primarily focuses on what is keeping your eating problem going. It is therefore mainly concerned with the present and future. It addresses the origins of your problem as needed.
5. It is an 'immersion' in psychotherapy aimed at overcome your eating problems. It is not an institutional and medical treatment.
6. It is organized in an open unit to facilitate your exposure to the environmental triggers of eating problem.
7. It is designed to actively involve you in all phases of treatment, from the decision to be hospitalized to the choice of the maintaining mechanisms of your eating problem to be addressed.
8. It is concerned with your functioning in its entirety (psychological, physical, social), not just with your eating and weight, and it is designed to enhance the control over your eating and your life.
9. It has two main versions. The 'focused' version exclusively addresses the eating disorder problems. The 'broad' version also addresses one or more of the external psychological problems that contribute to the maintenance of eating problem (e.g. clinical perfectionism, core low self-esteem, interpersonal problems).

The treatment has several distinctive characteristics that distinguish it from traditional inpatient treatment for eating disorders

### **The preparation**

Admission to the treatment is voluntary and requires your willingness to change, and to play an active role in the treatment, which should effectively become a priority in your life. For these reasons the preparation for the treatment is a fundamental stage that precedes the treatment. The preparation for intensive CBT-E usually occupies three sessions, and has the following aims:

1. To assess if you have an eating problem of clinical severity.
2. To evaluate if you are suitable for the treatment.
3. To inform you about your eating problem and the treatment.

Admission is voluntary and requires your willingness to change

4. To help you to evaluate the pros and cons of initiating the treatment. In this evaluation you should reflect on the short- and long-term effects of your eating problem on your health, psychological functioning, relationships, and school or work performance, and whether your eating problem provides you with something positive that you are afraid to lose.

If you arrive at the conclusion that the inpatient treatment is a good opportunity for you to change, you are placed in a waiting list that usually last six weeks. One week before admission, which is usually planned on Monday, you have another session to review the treatment procedures in detail and to re-evaluate your motivation to change.

Should you be very ambivalent about the decision to start the treatment some adjunctive sessions may be necessary to evaluate you motivation to change.

### Attitudes and commitment required

The treatment should be seen as an opportunity to make a 'fresh start' and to build a 'new life' that is no longer conditioned by your eating problem. Like with any change there are risks, but the benefits that you could achieve are enormous and include:

The treatment should be seen as an opportunity to make a "fresh start."

1. Improvement in your physical health.
2. Ability to think more freely without being continuously oppressed by obsessions about eating, shape and weight.
3. Becoming happier, less irritated and rigid.
4. Developing a mind with a broader perspective.

*You should consider the treatment as an 'experiment'* to test your belief about the impact of reducing the importance you attribute to the control of shape, weight, and eating on your life. If you are dissatisfied with the outcome of the experiment you can always revert to the control of eating, shape and weight imposed by your eating problem.

*You should see the treatment as a 'priority'*, and shift your efforts from the control of eating, shape and weight toward change. To overcome your eating problem you will need to work hard but it will be worth it. The more you put in, the more you will get out.

*You should try to do your best to 'start the treatment well'*; the more you change in the first four weeks of the treatment, the more chance you will have to overcome your eating problem. Positive changes produce a momentum, thanks to which you can work from day to day to overcome your eating problem.

It is important that every appointment (individual sessions, groups, assisted meals, review meetings) starts and ends on time. Your therapists will make sure they are ready at the due time and we request that you do the same. It is a very good idea to arrive a little in advance - say 10 to 15 minutes beforehand. This will give you an opportunity to settle down and think over things.

*You and your therapists should work together as a team* to help you overcome your eating problem. You will both agree upon specific tasks (or 'next steps') for you to undertake between each session. These tasks are very important and will need to be given priority. It is what you do between sessions that will govern to a large extent how much you benefit from treatment.

You should take the responsibility to adopt behavior that does not negatively influence other patients. As your behavior may have a positive or negative influence on other patients, it is important that only constructive criticism is made of the program, but you should make it directly to your therapists and not in front of other patients. You are also not allowed to bring psychoactive substances into the unit or speak with other patients about unhealthy weight loss behavior.

You should take the responsibility to adopt behavior that does not negatively influence other patients

## The clinical team

A multidisciplinary team, fully trained in cognitive behavioral therapy, delivers the treatment. You will be assigned to five main therapists: dietician, psychologist, physician, psychiatrist, and nurse and each of them has a specific role in the treatment.

The dietician is primarily focused on helping you to change your eating habits and weight. The psychologist addresses your overvaluation of shape, weight and eating control. The physician is responsible for your physical health. The psychiatrist assesses and eventually treats co-existing psychiatric problems (e.g. clinical depression). The nurse has the usual tasks of overseeing the administering of medications and assists you in weighing yourself. Should a therapist be absent, you will temporarily be assigned to a substitute therapist.

A multidisciplinary team, fully trained in cognitive behavioural therapy for eating disorders, delivers the treatment

Other professionals also operate in the unit, such as educators who help young patients do school homework and physiotherapists who run the physical exercise sessions.

## Stages and general organization of the treatment

The treatment lasts 20 weeks, 13 weeks of which are spent in inpatient followed by seven weeks of day-hospital. In the day-hospital stage you sleep in your own home or, if you live too far from the hospital, in an apartment close to the unit.

The treatment is divided in the following four stages:

- Stage One (weeks 1 to 4) - The focus of this stage is to engage and to educate you on your eating problem, and to build your Personalized Formulation of the main mechanisms that maintain your eating problem. At this stage you will be encouraged to achieve a maximum change in behavior, including, if you are underweight, the initiation of weight regain.
- Stage Two (weeks 5 and 6) – At this stage you will carry out a detailed review of your progress and of barriers to change within the individual sessions. In addition, you will assess if some external psychological problems (e.g. clinical perfectionism, core low self-esteem and interpersonal problems) might be contributing to the maintenance of your eating problem.
- Stage Three (weeks 7 to 17) - The precise content of this stage is dictated by your problem and the treatment become very individualized. You will address the overvaluation of shape and weight together with food avoidance and other dietary rules. In this stage you might also address one or more of external psychological problems in specific ‘broad’ CBT-E modules. During this stage if you are underweight you will reach your target BMI range and you will start to practice weight maintenance.
- Stage Four (week 18 to 20) - The focus of this final stage of treatment is on helping you to prepare the transition to outpatient therapy.

The treatment also includes a CBT oriented family module (see below) if are under 18 years of age.

Figure 4 shows the general organization of inpatient CBT-E.

Place	Inpatient												Day-hospital							
Stage	One				Two		Three										Four			
Weeks	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
CBT-F	CBT-E individual sessions (twice a week in the first four weeks and then once a week)																			
	Weekly review meeting (patient, dietician, psychologist, physician, nurse)																			
	Assisted eating						Non-assisted eating (if BMI ≥ 18.5)													
	Group treatment sessions (four times a week)																			
	Physical exercise sessions																			
CBT-B <i>(If additional 'external' maintaining mechanisms have emerged)</i>													Clinical perfectionism module							
													Core low self-esteem module							
													Interpersonal problems module							
													CBT-oriented family module (if < 18 years of age)							

**Figure 4.** The general organization of the treatment.  
CBT= Cognitive Behavioral Therapy.

### Admission

On arrival at the unit you will be welcomed by your dietician who will illustrate the organization of the program, the strategies to adopt during assisted meals and fix the first appointment with your psychologist (usually the day after admission). The dietician will also explain and give you the handout on weight regain guidelines, if you are underweight, or the weight maintenance guidelines if you are not underweight. You will use these guidelines to decide on the change to your diet during the weekly review meeting (see below).

You will then meet your nurse who will show you your room and describe the general rules of the unit. On the same day you will meet your physician to assess the condition of your health.

### The assessment

The assessment has the aim of accurately evaluating your physical and psychosocial status and it includes:

- *Physical Examination.* Your physician carries out the examination, with an assessment of the physical complications associated with eating problems.
- *Dietary history.* Your dietician will take note of the history of your eating habits.
- *Laboratory tests and instrumental examinations.* The assessment includes routine laboratory tests, an electrocardiogram, and if you are underweight, also an evaluation of your bone mineral density with a dual energy X-ray absorptiometry.
- *Weight and height assessment.* This is to assess your body mass index (BMI), which is your weight (in kg) divided by your height squared (in m.).
- *Energy expenditure and physical activity assessment.* Energy expenditure is assessed with an indirect calorimeter, while the level of your physical activity is assessed with an instrument called an accelerometer.

Your eating problem will be assessed with international gold standard measurements



- *Eating problem evaluation.* At admission and in the last week of the treatment a clinician will interview you using the Eating Disorder Examination, an interview lasting about one hour that assesses your eating problem in detail. You also have to fill in at admission, after four weeks and at the end of the treatment the Eating Disorder Questionnaire, a measure of the eating disorder features, in the last 28 days, and the Clinical Impairment Assessment, a measure of the influence of your eating problem on your psychological functioning in the last 28 days.
- *Psychiatric problem evaluation.* The evaluation is made by a psychiatrist and aims to assess if other co-existing problems (e.g., clinical depression) might hinder the treatment of your eating problem.

## Treatment core procedures

### Personal Formulation

In the individual sessions with you psychologist, you will work together to build the *Personal Formulation* of your eating problem. The formulation is similar to those described in Figure A.2, but it is personalized, and will include the key maintaining mechanisms of your eating problem. The formulation will be used by you and by all team members to identify features to be addressed in the treatment. An initial personal formulation will be built in the first week of the treatment, but then it will be revised during the course of the treatment. The aim is to create a tailor-made treatment that fits your problem.

### Monitoring of weight, eating habits, and exercising

You will measure your body weight once a week on the unit's private scales with the assistance of the nurse during the period of assisted eating. You will have to plot the number of your body weight on the *Weight Graph* and in the last column of your *Monitor Record* with your interpretation of the weight change. After the weigh-in, you will fill out the *Eating Problem Checklist* in which you will have to report the frequency of binge eating, weight control behavior (e.g. dietary restraint, self-induced vomiting, misuse of laxatives and diuretics, driven exercising), body checking and avoidance, and the concerns about shape, weight and eating control, in the last seven days. The weight data and the Eating Problem Checklist are inserted by the nurse into a database and discussed the same morning at the review meeting (see below).

You are actively involved in monitoring and evaluating you weight and eating problem changes.

During the non-assisted eating you initially check your weight once a week in the unit without the assistance of the nurse and in the last four weeks of day treatment on your own scales at home or where you are living.

### Weekly review meeting

Once a week, on the same morning as the weight monitoring you will participate a the weekly review meeting in which all your therapists (i.e. physician, psychologist, dietician and nurse) will meet around a round table to discuss the various elements of the treatment and their relationship to one another. The review meeting starts by analyzing your interpretation of the Weight Graph. Then you will suggest the changes to your diet following the indications of the unit's weight regain or weight maintenance guidelines. Finally, you will discuss the state of your Personal Formulation, also analyzing the Eating Problem Checklist scores, and the maintaining mechanisms to focus on during the week.

Once week you meet all your therapists around a round table to discuss the various elements of the treatment and their relationship to one another

### **Assisted eating**

The main reason for hospitalization is being unable to address weight regain or interrupt binge eating and vomiting with outpatient treatments. This may depend on various reasons including the intensity of preoccupation with thoughts about food and eating, the fear of losing control over eating and weight, the presence of extreme rituals affecting eating, and the ambivalence about change. Assisted eating has been designed to help you to overcome all these problems.

Assisted eating typically takes place over the first six weeks or until you reach a BMI of 18.5. In this stage of the treatment you will consume four meals a day (breakfast, lunch, snack, and dinner) in the dining room with other patients and with the assistance of a dietician or nurse who uses psychological procedures to help the eat. You will be encouraged to view food like a 'medication', and to eat mechanically for the meantime. This type of eating will be continued until you eat autonomously and appropriately. The dietician will support you and help you to eat without being influenced by your thoughts on eating. In some cases the dietician will help you to address some eating rituals (e.g. eating too slowly or cutting food into small pieces). During the phase of assisted eating you will stay in a dedicated room for one hour after eating and you will not have access to a bathroom so as to address the urge to vomit after eating.

The dietician or the nurse will help you to address eating using specific psychological procedures.

One of the principal aims of treatment is to help you to feel in control during all the phases of weight regain. You will therefore be an active participant in deciding your goal BMI range (which is generally between a BMI of 19.0 and 20.0) and the nature of your diet following the unit's weight regain guidelines). Generally, in the first week of treatment, energy intake is set at 1,500 kcal per day, and it is then increased to 2,000 kcal per day in the second week, and to 2,500 kcal per day in the third week. Subsequently, energy intake is adjusted collaboratively on the basis of your rate of weight regain, the goal being a gain of 1.0kg to 1.5kg per week. If you need an intake of over 2,500 kcal per day to achieve this, you are given the option of doing so using normal food alone or with the addition of high-energy supplementary drinks. Note that the calorie content of the diet is a weekly mean, and that the calorie content of the diet may change slightly from one day to the next. Once your weight nears a BMI of 18.5, energy intake is gradually reduced in order to reach and maintain your body weight within the goal BMI range. Since the treatment is voluntary, nasogastric tube feeding or parenteral nutrition are not used to address undereating and underweight. If you are not able to eat the meals with our assistance you will need another form of treatment.

One of the principal aims of treatment is to help you to feel in control during all the phases of weight regain.

If you are admitted because of binge eating and purging that has proved impossible to control on an outpatient basis, assisted eating is designed to show you that you can eat a normo-caloric diet comprising three meals and a snack without gaining weight and that you can eat these meals without binge eating or purging.

### **Non-assisted eating**

When the period of assisted eating is over, you will start to eat without assistance. In this phase you will learn to identify and address your residual dietary rules and to maintain your weight following an elastic and healthy diet based on National Dietary Guidelines.

During non-assisted eating in the unit you will choose food as if you were in a self-service restaurant, and you will have free access to the bathroom. From week 14 you will live outside the hospital and progressively consume more meals outside too. In this phase you will be encouraged to eat at

During non-assisted eating you will learn to identify and address your residual dietary rules

restaurants, fast food and self-service establishments, pizzerias and bars and with other patients as well as with significant others.

### **Individual sessions with a psychologist**

The sessions are twice weekly for the first four weeks and thereafter weekly. In these sessions you and your psychologist will work together on the following issues:

- Increasing engagement in the treatment.
- Developing the Personal Formulation of the mechanisms maintaining your eating problem.
- Using the Monitor Record in the best way in real time.
- Accepting the changes in eating and weight.
- Dealing with events and moods.
- Reducing the overvaluation of shape and weight.
- Addressing, as necessary, clinical perfectionism, core low self-esteem or interpersonal difficulties.
- Preparing a post-discharge treatment plan in order to achieve a smooth transition from inpatient to outpatient treatment.

Individual sessions are the twice a week for the first four weeks and thereafter weekly

### **Group treatment sessions**

You will participate in group treatment sessions, which are used to supplement the individual ones. The groups encourage self-revelation, mutual support and learning from patients who are addressing their eating problem successfully. In some patients, they also help to overcome the shame of having a disorder and to develop positive personal relationships. Two types of group are held, psycho-educational and CBT-E focused (see Table 2).

**Table 2.** The group treatment sessions

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#### **Psycho-educational groups**

- Three times a week.
- Interactive, and patients are encouraged to ask questions, but not disclose personal information.
- Provide scientific and updated information on eating problems and on the most modern strategies and procedures to address them.

#### **CBT-E groups**

- Once a week in Stage One, then twice a week.
  - Interactive, and use the most modern cognitive behavioral strategies and procedures to address the eating problems.
  - Support the individual psychotherapy sessions in helping patients to:
    - Deal with events and mood changes.
    - Address dietary rules and dietary restraint.
    - Address the overvaluation of shape and weight.
-

### Physical exercise sessions

You will participate in physical exercise sessions twice a week, if your medical condition so permits. These sessions, lead by a physiotherapist, have the following main aims:

- To improve the restoration of muscle mass.
- To improve physical fitness.
- To help you to accept the changes in your shape
- To learn to exercise without thinking about shape, weight and calorie consumption.

### Involvement of significant others

If you are over 18 years of age, significant others are seen if you are willing and if doing so is likely to facilitate treatment. The significant others are people who have a major influence on your eating. Typically, they attend three times during the course of treatment and the aim is to encourage them to create a positive home environment that is likely to support your efforts to change.

### Adolescents' module

If you are under 18 years of age, you will be accommodated in rooms separated from adults and during outings from the unit, if authorized by your parents, an adult should always accompany you. During day treatment, if you do not live at home, you should stay in private rooms or an apartment with at least one parent or an adult nominated by your parents.

The adolescents' module includes family therapy, adolescent groups, and the 'school in the hospital' scheme

The Adolescents' Module, in addition to the core procedures described above with the exception of CBT-E groups, includes three additional procedures:

1. *Family therapy*. This consists of six family sessions with the psychologist to create an optimum family environment; two family meals in the unit where you will consume meals with your parents; and two sessions with the dietician to plan meals at home.
1. *Adolescent group*. The group, delivered by a psychologist, addresses the various adolescent problems associated with eating problems, such as the construction of a sense of identity, the acquisition of a greater degree of autonomy, the development of better relational abilities and adaptation to changes resulting from puberty. In the group patients also learn specific skills to improve social communication, assertiveness, and to resolve conflicts.
2. *School in the hospital*. At Villa Garda a project called 'School in the Hospital' is implemented. It was developed by the Italian Minister of Education, University and Research (MIUR) (<http://pso.istruzione.it/>) giving you the possibility to continue your school curriculum. The scheme includes both face-to-face lessons using legally recognized textbooks with a teacher and lessons via web using Skype technology. Regular meetings between the team members and teachers are organized to evaluate and address the various obstacles that have emerged both during the treatment and the school lessons.

The project "School in the Hospital" will permit you to continue your study curriculum

### Management of day-to-day difficulties

You will learn many effective strategies to cope with events and mood changes during individual and group sessions. However, in case of difficulty you may ask for help from your nurse, who has the skills to help you to overcome these problematic moments.

### **Maintenance of change after discharge**

The treatment pays great attention to the problem of setbacks after discharge and has introduced the following elements to maximize the chances that the changes achieved in treatment will also be maintained at home:

- The unit is open and you will be exposed from the beginning of the treatment to many environmental triggers of your eating problem.
- There is a day treatment phase near the end of your stay when you will face some of the difficulties that you will encounter after discharge (e.g. socializing with others, cooking) while still having the support of the team.
- During the final few weeks of treatment you will spend weekends and several weekdays at home, again while still having the support of the team.
- Significant others are involved in treatment and are helped to create a positive home environment for you.

In addition, towards the end of treatment considerable effort is dedicated into arranging post-discharge outpatient treatment for you, consistent with the approach you followed in the unit.

### **A note on drugs**

The treatment makes parsimonious use of psychotropic drugs, since they do not help to reduce your overvaluation of shape, weight and eating control. An exception is the use of antidepressants if you have a co-existing clinical depression, since its presence interferes significantly with the treatment of your eating disorder. This eventuality is evaluated with your psychiatrist and you will be actively involved in this decision.

Your physician may prescribe vitamins for you if you are underweight, or calcium if you have osteopenia or osteoporosis, or potassium if your potassium serum is low.

The nurse will administer all the drugs, and for the entire period of your stay in the unit you will not be allowed to have any drugs, including alcohol or other substances, with you.

### **Treatment outcome**

The Villa Garda – Oxford trial indicates that about ninety percent of patients complete the inpatient treatment and that a large group makes a complete recovery from the eating problem at one-year follow-up. There is no reason why you should not be in this group so long as you throw yourself into treatment and make it your priority.

## **Practical information**

### **Visiting by significant others**

Visits from family and friends during the week are permitted outside the treatment activity times. Significant others, if you consent, may be given information on the course of your health by calling your physician at fixed times of the week.

### **Money**

We advise you to make deposit money at the administration desk and not to carry a large amount of money with you to avoid theft, a fact that is common where many people live together. For weekly money needs (newspaper, etc.), you may withdraw your money at the administration desk from Monday to Friday, 10.30am to 11.30am.

### **Clothes**

The unit is not a medical unit in the classic sense, so you should bring with you casual clothing, possibly one or outfits with shoes and gym clothes. During the day you should not wear pajamas or

a nightgown. In the winter, as it can get quite cold, you need to bring heavy garments with you (coats, anoraks, etc.). For servicing of clothes you may use a laundry service outside the hospital. Periodically you can make a list of things you need from home (i.e. clothes, books, records and other objects, but not food) that your significant others may bring or send to you.

#### **Bureaucratic and administrative problems**

Administration staffs are available from Monday to Friday, from 10.30am to 11.30am, to help with any bureaucratic problems.

### **References**

Dalle Grave, R., Bohn, K., Hawker, D., Fairburn, C.G. (2008). Inpatient, Day Patient and Two Forms of Outpatient CBT-E. In Fairburn C.G. (Eds.). *Cognitive Behavior Therapy and Eating Disorders*. New York, Guilford Press.

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Dalle Grave, R. (2013). *Multistep Cognitive Behavioral Therapy for Eating Disorders: Theory, Practice, and Clinical Case*. Lanham: Jason Arosen.

Fairburn C.G. (2008). *Cognitive Behavior Therapy and Eating Disorders*. New York, Guilford Press.