CONCEPTUALIZING COUNSELLOR COMPETENCE IN THE TREATMENT OF EATING DISORDERS: A DELPHI STUDY

by

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Abstract

Counsellors are ethically obligated to provide only those services that are within the bounds of their professional competence (American Counseling Association [ACA], 1988; Canadian Counselling Association [CCA], 1999; Canadian Psychological Association [CPA], 1991). Counsellors who provide services to individuals with eating disorders (EDs) must be competent to do so, and must recognize the boundaries of that competence. The purpose of the study was to begin to identify the competencies associated specifically with psychotherapy for EDs. A three round Delphi procedure was employed to answer the following research question: according to experts in the treatment of EDs in British Columbia, what competencies are essential for basic, independent therapeutic practice with clients who have EDs?

A panel of 29 expert participants from a variety of disciplines reached a consensus on 188 competencies thought to be “essential” to this work, and on 21 competencies thought to be “useful but not necessary”. Based on an informal categorization of items, several topic areas were identified as having potential importance for competent practice: (1) aspects of the ED therapist’s role may overlap with the activities of other health professionals involved in the treatment of EDs; (2) an interdisciplinary approach is key for client care; (3) the strength and quality of the therapeutic relationship can help or hinder a client’s recovery from an ED; (4) empirically supported treatments for EDs were not considered “essential”; and (5) the therapist’s resolution of his/her own experience of body dissatisfaction/disordered eating/an ED requires consideration.
The list may help counsellors and counsellors-in-training who wish to work in the field of EDs to identify the competencies they possess and those they would like to develop in their education, continuing education, and training. Thus, the list could help them take steps in their responsibility to assess their competence to work with clients who have EDs.
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Chapter 1 - Introduction

Eating disorders (EDs), which cause great pain and suffering to those who experience them, are psychiatric disorders as defined in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) (American Psychiatric Association [APA], 1994). Three EDs are listed in the DSM-IV: Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorder Not Otherwise Specified (EDNOS), with the criteria for one EDNOS (Binge Eating Disorder [BED]) highlighted for further study. Estimates of the prevalence of EDs vary depending on sampling and assessment methods (APA, 2000). Reported lifetime prevalence rates for AN among women range from 0.5% to 3.7% (Garfinkel, et al., 1996; Walters & Kendler, 1995) and, for BN from 1.1% to 4.2% (Garfinkel, et al, 1995; Kendler, McLean, Neal, Kessler, Heath, & Eaves, 1991).

Epidemiological studies of BED have yielded prevalence rates ranging from 1.0% to 3.3% (e.g., Bruce & Agras, 1992; Hay, 1998; Spitzer et al., 1992). Eating disorders are more commonly seen among females, with estimates of the male-female prevalence ratio ranging from 1:6 to 1:10 (APA, 2000).

Individuals who struggle with EDs can face a severely diminished quality of life in the personal, interpersonal, and financial realms (Kashubeck-West & Mintz, 2001; Piran, Levine, & Adair, 1999). Individuals with EDs often experience feelings of intense shame and guilt (Thurstin, 1999). In addition, the majority of persons with EDs have additional psychiatric diagnoses (Braun, Sunday, & Halmi, 1994; Milos, Spindler, Buddeberg, & Cramer, 2003), which are thought to be an aggravating factor in the course of EDs (Herpertz-Dahlmann, Wewetzer, Schulz, & Remschmidt, 1996; Herpertz-Dahlmann et al., 2001; Herzog, Nussbaum, & Marmor, 1996; Saccomani, Savoini,
Cirrincione, Vercellino, & Ravera, 1998). At their most extreme, EDs can result in death due to suicide or physiological complications such as cardiac arrest secondary to arrhythmias (APA, 2000; Herzog et al., 2000; Ressler, 1998; Sansone & Levitt, 2002). Mortality rates have been found to be as high as 18%, one of the highest of all the psychiatric illnesses (Kaplan & Garfinkel, 1993; Neumaerker, 2000). The high mortality, high morbidity and psychological pain associated with EDs indicate the seriousness of these complex disorders (Kashubeck-West & Mintz, 2001). The treatment of EDs requires expertise and the APA (2000) states that interdisciplinary interventions are indicated including psychological, medical, psychiatric, nutritional, and dental evaluation and monitoring. Clinical decisions must be made as to whether such interventions should take place in an inpatient or outpatient setting (APA, 2000).

Single-factor causal theories of EDs have been replaced by the view that EDs are “multidetermined” (Garner, 1997). This has led to the acceptance of a biopsychosocial model that includes individual, psychological, biological, familial and cultural factors (Attie, Brooks-Gunn, & Petersen, 1990; Garner, 1997). From a therapeutic standpoint, the complex etiology of EDs is thought to require complex psychological intervention (Holt & Espelage, 2002). Historically, psychological treatment for EDs has drawn from a wide range of therapeutic approaches including interpersonal models, family-based counselling, and cognitive-behavioral therapy (CBT) (Robin, Gilroy, & Dennis, 1998; Wilson & Fairburn, 1993). CBT has been the most intensively studied intervention and it has demonstrated the most evidence of efficacy for treating adults with BN. Interpersonal therapy (IPT) has also been shown to be helpful for BN (APA, 2000), and there is preliminary support that CBT and IPT are effective for treating adults with BED.
(e.g., Wilson & Fairburn, 2000; Wilson, Fairburn, & Agras, 1997). AN remains a relatively treatment-resistant and chronic illness for most clients, and little empirical evidence exists on which to base psychological interventions. However, new approaches based on relapse prevention and motivational enhancement are currently being researched (Kaplan, 2002).

It is likely that most counselling practitioners will encounter clients with EDs at some point in their careers (Kalodner, 1998). Empirical literature on the treatment of EDs has been accumulating at a tremendous rate over the last 15 years. This research has been published primarily in the clinical psychology, psychiatry and ED specialty journals, whereas its presence has been less apparent in the core journals of counselling psychology (Hotelling, 2001; Kashubeck-West & Mintz, 2001). Some scholars argue that this may have made it more challenging for counselling professionals who are interested in the treatment of EDs to remain abreast of current developments (Hotelling, 2001; Kashubeck-West & Mintz, 2001).

Counselling professionals may also encounter clients who present with subclinical disordered eating symptomology. Despite failure to meet the DSM-IV criteria, disordered eating represents a serious risk to health and well-being (Rome & Ammerman, 2003). For some individuals, disordered eating may be relatively static and non-progressing. For others, it is the early presentation of what will become a full-blown eating disorder. For example, extreme dieting has been found to be a sensitive predictor of adolescents who later develop EDs (Patton, Selzer, Coffey, Carlin, & Wolfe, 1999). Rome and Ammerman (2003) emphasize that health professionals should offer early and
comprehensive intervention to individuals who present with subclinical disordered eating symptomology.

Taken together, the factors described above – the seriousness and complexity of EDs, the shortage of counselling psychology literature related specifically to EDs, and the likelihood of professional contact with clients who have clinical or subclinical EDs – suggest that some counsellors may be working with this challenging, high risk client population but may have little background preparation and few resources to support such work. This could be a particularly significant problem at the Master’s level of counselling, where opportunities for students to develop competence in a more focused area (e.g., EDs, anxiety disorders, grief counselling, etc.) may be limited. For example, in CACREP-accredited programs, community counselling is a general, non-specialty, entry-level program that may or may not have a specific emphasis (Davis, 1997). Corey, Corey and Callanan (1993) note that EDs (along with sexual abuse, substance abuse, and AIDS) present challenges that demand continuing education.

Individuals who complete a generalist Master’s degree in counselling and who wish to extend their scope of practice to include EDs will be responsible for evaluating, developing and maintaining their competence in that area. Currently, in the Lower Mainland area of British Columbia, there are at least 50 practitioners holding a Master’s degree or less who are known to provide therapy to individuals with EDs/disordered eating (Eating Disorder Resource Centre of B.C., 2003). Currently, there exist no criteria against which these practitioners might measure their competence to provide services to this population. Indeed, there may be some debate as to whether counselling individuals with EDs is an activity commensurate with Master’s level counsellor education given
ongoing disputes about the level of education required to provide psychological services in general (e.g., McPherson, Pisecco, Elman, Crosbie-Burnett, & Sayger, 2000).

Interest in competence has been increasing in the specialty areas of counselling where efforts have been made to identify, describe, investigate and promote specific counsellor competencies. This has been most evident in the multicultural counselling field (e.g., Arredondo, 1999; Arthur & Achenbach, 2002; Liu & Clay, 2002; Pope-Davis & Ottavi, 1994; Sue, Arredondo, & McDavis, 1992) in response to the increased diversity of counselling consumers (Arthur & Januszkowski, 2001). Competencies in addictions counselling are also beginning to be identified and promoted (Addiction Technology Transfer Centres National Curriculum Committee, 1998; Page & Bailey, 1995) in response to the increased awareness of drug and alcohol abuse in North America (Doweiko, 1993). Other specialty areas of counselling such as career (e.g., Engels & Minor, 1995; Evans & Larabee, 2002; Mariani, 1998), gerontology (e.g., Meyers, 1992), and school (e.g., Housley & McDaniel, 1999; Paisley & Borders, 1995) have outlined competencies for counselling practice.

The professional organizations of counselling do not recognize EDs counselling as a specialty area. Therefore, practice standards or guidelines for the provision of counselling services to clients with EDs have not been developed, whereas such documents have emerged in the professions of psychiatry and social work (American Board of Examiners in Clinical Social Work [ABECSW], n.d.; APA, 1993, 2000).

Rationale for the Study

The trend to develop competency profiles and/or guidelines for the treatment of special populations has been a source of inspiration for the present study. The
development of a list of criteria that delineates the knowledge, skills and other therapist characteristics required for working with clients who have EDs could potentially assist counselling professionals in gauging their competence to provide services to clients with EDs and/or in helping them to confirm, expand, or redefine their scope of practice in relation to this population.

Several considerations were relevant to this endeavour. First, counselling professionals should provide services that are within the bounds of their professional competence (American Counseling Association [ACA], 1988; Canadian Counselling Association [CCA], 1999; Canadian Psychological Association [CPA], 1991). Counsellors who provide services to individuals with EDs must be competent to do so and must recognize when it is necessary to refer a client to other professionals (e.g., hospital-based programs, family physicians, nutritionists, etc.). In addition, the likelihood of professional contact with clients who have clinical or subclinical EDs may tempt some counsellors to practice outside their competence for a variety of reasons including (but not limited to) a lack of awareness regarding what constitutes competent practice with this population. Moreover, other professions such as psychiatry and social work have deemed EDs a unique problem that deserves special attention and have developed practice guidelines and standards in order to improve client care. Counsellor education programs might also benefit from the conceptualization of counsellor competence with respect to the treatment of EDs from the perspectives of curriculum development, and training and supervision. These considerations figured strongly in the rationale for the present study.
Purpose of the Study

The problem identified for investigation was that counselling practitioners do not have identifiable criteria to help them ascertain whether they are competent to provide services to individuals with EDs. The purpose of the study was to begin to identify the competencies associated specifically with psychotherapy for EDs. This list of competencies could then be used by counselling practitioners to inform their practice with clients who have EDs. The study was designed to be preliminary in nature and of relatively small scope.

Research Question

To address the study's purpose, the following research question was developed: according to experts in the treatment of EDs in British Columbia, what competencies are essential for basic, independent therapeutic practice with clients who have EDs?

Assumptions

The assumptions underlying this study were that (1) the provision of therapeutic services to clients with EDs requires competencies that go beyond those of the generalist counsellor; and (2) the qualified, knowledgeable and experienced individuals in the EDs treatment field in B.C. were the most appropriate “experts” to consult in order to answer the research question.

Definition of Terms

Competence

There is wide variability in the literature concerning the definition of professional competence, although knowledge and skills are typically cited (e.g., Hager & Conzci, 1991; Kim, Boo, & Wheeler, 1979; Kitchener, 2000; Welfel, 2002). The definition
selected for this study was based on a combination of sources that identified knowledge, skills, and other individual characteristics as key aspects of competence (Bemis, Belenky, & Soder, 1983; Ghorpade, 1988; Kitchener, 2000). Specifically, competence was defined in this study as being comprised of knowledge; skills; training, supervision, and continuing education activities; and other therapist characteristics.

**Competencies**

Using the literature reviewed for this project, the following definition of competencies was developed for the purposes of this study: the specific skills, areas of knowledge, and elements of training, supervision and continuing education needed to perform the tasks of therapy competently, but also any other specific therapist characteristics deemed important for the provision of competent psychotherapy services. (See section on Defining Competencies for a full discussion.)

**Delphi**

Delphi is an empirical research method that consists of systematic polling of the opinions of a panel of experts who are knowledgeable about a given topic. A multi-phased questionnaire approach is employed, with the goal of reaching group consensus on the research question.

**Expert**

In a Delphi study, an expert is an individual who is knowledgeable about and/or experienced with the topic under investigation (Dalkey, 1967). Experts are selected to participate in the study as part of a “panel.” The investigator creates a set of criteria prior to panel selection to ensure that panelists possess an adequate level of expertise. In this study, the expert criteria were developed based on a review of the Delphi literature on
competencies and on feedback from members of the Eating Disorders Advisory Committee of British Columbia. Panelists were required to meet at least one of the following:

1. Has practised in EDs treatment for at least 5 years and completed a practicum and/or internship in a related area;
2. Has supervised therapists-in-training in an EDs treatment setting;
3. Has published scholarly work on the topic EDs treatment, ethics, and/or professional competence between 1995 and 2003 (first, second or third author);
4. Has taught about EDs treatment at the graduate level;
5. Has presented one or more refereed national conference presentations on EDs treatment, ethics, and/or professional competence.

Round

A round is a completed Delphi questionnaire cycle: from the investigator to the panel, and back to the investigator (Dalkey, 1969).

Consensus

Consensus refers to the degree of agreement among the panel of experts in a Delphi study and is determined by the investigator who chooses an appropriate range or cut-off point (Page-McCuiston, 1997). In this study, the definition of consensus selected was an 85% or greater level of agreement among participants on the rating of a competency item (a rating of 3 equals “essential,” 2 equals “useful but not essential,” and 1 equals “not necessary”).
Chapter 2 – Literature Review

The following chapter provides a review of a range of literature that underlies the proposed investigation, which aims to identify and evaluate the essential competencies for basic, independent therapeutic practice with clients who have EDs. Although there is extant literature that addresses the therapist’s activities with respect to ED clients, little research has focused on this topic from the perspective of ethics and competence. Therefore, the literature review for this study may be somewhat unconventional in its presentation of various topics relevant to ethics, competence, and eating disorders. The review is divided into two main sections. The first provides a general review of professional ethics, followed by a more detailed review of professional competence and competencies. The second section is focused specifically on EDs, the ethical considerations involved in treatment, and the literature that provides guidance on preferred treatment practices, and the preferred characteristics of the EDs therapist.

*Ethics Codes and Ethical Decision-Making*

The root of the word “ethics” is the Greek work “ethos” meaning “character.” According to Sieber (1992), ethics “is the systematic study of value concepts – ‘good’, ‘bad’, ‘right’, ‘wrong’ – and the general principles that justify applying these concepts” (p.3). Huber and Baruth (1987) write, “ethics is concerned with the conduct of human beings as they make moral decisions” (p.3). Historically, ethics were first applied at the level of individual, moral decision-making and only later became written rules for groups. Two factors influenced this shift: the accepted mores and moral principles of Western civilization and the deliberations of individuals affiliated with the societal subgroups known as “professional associations.” The results of these deliberations have
been incorporated into formal written ethics codes and institutionalized into “guild customs” (Swensen, 1997).

One of the hallmarks of a profession (e.g., law, medicine, counselling, etc.) is that its members define their own scope of practice. The privilege to work autonomously requires that professionals limit themselves to practicing within their areas of competence (Shimberg, 1991). Society recognizes this privilege, along with the powerful nature of professionals’ influence on the lives of consumers and the enormous responsibility inherent in this power. Accordingly, society requires that the professions develop codes of ethics to which their members agree to be held accountable (Pope & Vasquez, 2001). Welfel (2002) states that ethical codes are intended to identify the ethical goals of the profession and guide the professional through the most common pitfalls of practice. The codes articulate both prescribed and prohibited activities, describe conditions for other permissible behaviours (e.g., bartering), and include aspirational statements that clarify the fundamental ethical values of the profession (Welfel, 2002). Pope and Vasquez (2001) write that the task of ethics is to help professionals by “acknowledging the reality and importance of the individuals whose lives we affect by our professional actions...understanding the nature of the professional relationship and professional interventions [and] affirming accountability for our behavior” (p. 12).

There are several benefits and limitations associated with ethical codes as described by Welfel (2002). Benefits include the support a code can provide to the professional who is faced with an ethical quandary; the enhancement of the profession’s reputation and the minimization of harm done by irresponsible practitioners; the continued revision of the code, which involves the solicitation of input from, and
education of, practitioners; and the inclusion of statements that define the ethical ideal. Limitations include the fact that some parts of a code may become obsolete by the time it is published; the self-interest of professional associations whereby compromises may be made regarding the extent to which ethical ideals are a focus; and the codes' broadly written nature (although their ability to be applied to a variety of professional settings, activities and client populations could also be argued as a benefit) (Welfel, 2002). Other criticisms of professional ethical codes include their lack of comprehensiveness (Green & Hansen, 1986) and inherent ambiguity (Daniluk & Haverkamp, 1993). In addition, concrete definitions of some concepts (e.g., "competence") are often lacking in the codes.

According to Kitchener (2002), ethical codes comprise only one part of ethical decision-making, and they are most effective when practitioners also cultivate a reliable "ordinary moral sense" (p.19) in response to ethical situations. She suggests that the counselling profession should move away from ethics that are rule-bound to ethics that focus on identifying foundational ethical principles that can be applied to even the most difficult ethical dilemmas (Kitchener, 1984a, 2002). Five principles provide the primary rationale and framework for the contents of the helping professions' codes of ethics. These are: autonomy, nonmaleficence (avoiding harm), beneficence (doing good), justice (fairness), and fidelity (promise keeping). The value of these principles is that they allow practitioners to frame ethical problems in a common vocabulary and to think carefully about issues that may not appear in ethics codes. In psychology, Kitchener (2000) argues, practitioners must identify sound reasons for how the principles should be balanced and/or overturned. She emphasizes that any decision made by the practitioner
must be “ethically defensible given the circumstances, and provide the best possible balance of ethical harms and benefits while protecting individual rights” (p.41).

*Ethics Codes of Psychology and Counselling*

The professional ethical codes of psychology and counselling have been described as being reflective of the meta-ethical principles noted above (Kitchener, 1984a, 1984b, 2000). In the U.S., the first ethics code pertaining to therapeutic practice was published in 1953 by the American Psychological Association (APA). This code was revised and consolidated in 1959 and subsequent revisions have been undertaken by committee work (Kitchener, 2002). It has since been used as the model for the development of many other associations’ codes (Holtzman, 1979).

There are numerous ethics codes published by the professional associations of counselling. Broadly speaking, the counselling professional is responsible for providing competent and ethical services for the benefit of the client that extends beyond simply doing no harm or avoiding negligence or misconduct (Pettifor, 1996). In Canada, both the Canadian Counselling Association ([CCA], 1999) and the Canadian Psychological Association ([CPA], 1991) have published codes of ethics. These codes provide guidance for ethical situations that can arise in all types of counselling and have been designed to protect both the client and the counsellor. In addition, they help protect the profession from the questionable conduct of its own membership and unwarranted attacks by members of the public (Swensen, 1997). Reflected in these codes are counsellor responsibilities associated with the making of careful, informed, professional judgments (which are often related to issues of immense complexity) without the reassurance of a “one-size-fits-all” guide for responding to a client’s needs. Counsellors must be vigilant
in identifying, examining, and attempting to address the ethical challenges of counselling work, despite the human susceptibility to avoiding this process (Pope & Vasquez, 2001).

Professional Competence

Codes of ethics typically include a set of standards concerning professional competence. According to Martin (1988), competence cannot be separated from ethical conduct. In the counselling profession, the competence requirement has been established in the ethical, legal and professional standards governing its practice (Pope & Vasquez, 2001). From a legal perspective, society’s expectation of professional competence is upheld through licensing boards and the courts. A counsellor who does harm to a client could be sued for malpractice and held legally responsible in a court of law (Remley & Herlihy, 2001). McAvoy and Reid (1996) note that questions around what constitutes “good counselling” and “good counsellor” are now being considered not only by the counselling profession, but also by judges and juries.

Various codes provide comparable guidelines concerning competence. For example, the Canadian Psychological Association’s (CPA) Code of Ethics (1991) states that, psychologists should “offer to carry out...only those activities for which they have established their competence to carry out for the benefit of others” (pg. 224). Similarly, the Canadian Counselling Association’s (CCA) Code of Ethics (1999) states that counsellors should “limit their counselling services and practices to those which are within their professional competence...” (pg. 3). The American Counseling Association’s (ACA) Code of Ethics and Standards of Practice (1995) states that, “counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials,
and appropriate professional experience” (p. 4). These standards make it clear that professionals who deliver services without the requisite competence may be engaging in unethical and potentially harmful behaviour.

The term “competence,” however, is not explicitly defined in the CPA or CCA codes, although terms such as “education,” “professional experience” (Standard A.3, CCA), “relevant knowledge,” “techniques,” and “continuing education activities” (Standard II.9, CPA) have been included in standards relating to professional responsibility and responsible caring. Because these terms are not operationalized fully, counsellors may be defining competence for themselves, particularly after they complete their formal training. Remley and Herlihy (2001) emphasize that the responsibility for determining competence during formal training lies primarily with trainers and supervisors, but shifts onto the counsellors themselves after training has concluded. Given that the codes tend to be written broadly, they preclude the inclusion of detailed guidelines for specific client issues (e.g., anxiety, depression, addictions, grief, EDs, etc.). Thus, particularly after formal training has been completed, the onus rests largely on counsellors themselves to determine not only their own general but also issue-specific competence level. This may be a challenging endeavour given the complexity of professional competence as a construct. Indeed, the difficulty in establishing criteria for determining professional competence can be partially attributed to the multidimensional and complex nature of “professional competency” as a concept (Davis, 1997). Kitchener (2000) adds that competence can be an overwhelming topic because its relative aspects make it “difficult to pin down” (p.184).
A variety of conceptualizations of competence have been put forth in the literature. According to some scholars, competence encompasses knowledge, skills and abilities (Hager & Conczi, 1991; Kim et al., 1979, Kitchener, 2000), including the ability to recognize inadequacies or impairment in these areas (Kitchener, 2000). Welfel (2002) defines competence as knowledge, skills, and diligence (i.e., attentiveness to the client's needs over all else). Other writers have identified a range of behaviours and attitudes including interpersonal skills, motivation, professional judgment (Cervero, et al., 1990), values, beliefs, and attitudes (Nelson, 1988). Discussing the competence of lawyers, Cramton (1981) distinguishes between ability and performance, noting the difference between “the ability to perform a task at an acceptable level” and “the reality of actually doing so in a particular situation” (p.161). In his opinion, competence exists on a continuum of professional expertise with gross negligence and maximum effectiveness at either extreme. Martin (1988) defines therapist competence in terms of ethical actions as well as having the knowledge and skills needed to perform therapeutic tasks. As illustrated above, there appears to be some agreement that competence includes knowledge and skills; however, there is greater variability among the other proposed attributes.

Closely linked to the issue of competence is the counsellor's “scope of practice,” the limits of which individual counsellors are responsible for determining. Counselling is an exceptionally broad profession (Remley & Herlihy, 2001). Defining a scope of practice entails outlining the areas in which one judges oneself to be competent to deliver services and the boundaries of those areas. Once a scope of practice has been determined, the counsellor then faces the ethical problem of determining whether his or
her own level and scope of professional competence justifies taking on a particular case
(Biggs & Blocher, 1987). Corey et al. (1993) state that it is crucial for counselling
professionals to know the boundaries of their own competence, and to know when to
consult with another professional or refer the client elsewhere.

However, adhering to the limits of one's scope of practice can be deceptively
challenging. According to Coate (2001), going beyond one's scope of practice can
"creep up silently and insidiously in the unfolding of a particular piece of work...[or] a
more general complacency accompanied by a degree of omnipotence can set in –
sometimes in very experienced practitioners" (p.181). Another obstacle to recognizing
the limits of competence can be the therapist's personal needs, a situation potentially
aggravated by inexperience. As noted by Steere (1984), the more inexperienced a
therapist is, the more inadequate and insecure he or she may feel in the role. Therefore,
he or she may be less willing to admit limitations. Thus, the least competent therapists
may also be the least likely to recognize their limitations.

In a review of the ethical guidelines and standards of various professional mental
health associations, Corey et al. (1993) noted that important questions concerning
competence and scope of practice remain unanswered. These include, "What are the
boundaries of one's competence, and how do professionals know when they have
exceeded them?" and "How can [professionals] determine whether they should accept a
client if they lack the experience or training they would like to have?" (p.173). Other
questions related to competence include, "Competent in relation to whom? Competent
by what standards? What exactly is a reasonable standard? How up-to-date should a
professional's knowledge be?" (Kitchener, 2000, p.184). These concerns become even
more complex when criteria for evaluating competence are considered. For example, completing a doctoral degree does not guarantee skills or knowledge acquisition in all therapeutic tasks (Corey, Corey & Callanan, 1998). Biggs and Blocher (1987) state that defining a scope of professional practice is “perhaps the most difficult and compelling issue for counselors that relates to the issue of professional competence” (p.71).

The literature provides remarkably few clues about how counsellors can determine their competence and/or scope of practice. Peterson (1996) developed a document designed to help psychologists self-evaluate their current level of competence/scope of practice and suggested that practitioners consult other standards that address specialty areas of practice, if they exist (Pettifor, 1996; Pettifor, Bultz, Samules, Griffin, & Lucki, 1990).

**Defining Competencies**

There has been much interest in the definition of competencies, not only in ethics and counselling psychology but also in other domains. In the training field, it has been defined as an underlying characteristic of a person that results in effective and/or superior performance in a job, and can be a motive, trait, skill, or body of knowledge (Klemp, 1980). A relatively consistent definition appears in industrial psychology where it has typically been defined as knowledge, skills, abilities and other characteristics required to perform a job (Bemis et al., 1983; Ghorpade, 1988).

Other definitions exist that take into account many other factors. In a Delphi study of chef's competencies, Birdir and Pearson (2000) cite skills, judgements, attitudes, values, entry skills, knowledge, ability and capacity as competencies. The “iceberg model” of competencies has also been developed to illustrate the more and less
observable elements of competency where knowledge and skills are at the tip, and the
less-visible elements that control these surface factors are social role, self-image, traits
and motives (Garavan & McGuire, 2001). Derouen and Kleiner (1994) note that, if
competence is to be a holistic concept, it must include, among other characteristics,
values and attitudes. Garavan and McGuire (2001) comment that multi-dimensional
definitions have been used to good effect in several research studies.

**Multicultural and Addictions Competencies**

In counselling, the term “competencies” has been used extensively in the
multicultural and addictions fields. In a seminal article, Sue et al. (1992) presented a
rationale and conceptual framework for a multicultural perspective in counselling. This
framework included (1) competency areas: (a) counsellor awareness of own assumptions,
values and biases, (b) understanding the worldview of the culturally different client and
(c) developing appropriate intervention strategies and techniques; and (2) dimensions of
competence: (a) beliefs and attitudes, (b) knowledge and (c) skills. Within this
framework, a total of 31 separate multicultural counselling competencies (MCCs) were
identified (e.g., “Culturally skilled counsellors are aware of institutional barriers that
prevent minorities from using mental health services,” p.482). The term “awareness” or
“self-awareness” has since arisen in MCC terminology (Arthur & Januszkowski, 2001) in
lieu of beliefs and attitudes.

In the addictions counselling literature, competencies have been defined as
knowledge, skills and core tasks (Page & Bailey, 1995) and as knowledge, skills and
attitudes (Addiction Technology Transfer Centres National Curriculum Committee,
1998). In the latter document, sections were included on the knowledge, skills and
attitudes required for screening, implementing treatment plans, and various aspects of individual, couples, and family counselling. Under “Individual Counseling,” for example, a skills competency associated with facilitating the client’s engagement in the treatment and recovery process was, “assessing client readiness for change” (p.68).

In summary, although the ethics codes of psychology and counselling include guidelines concerning professional competence, there is a lack of clarity around its definition. In the broader literature, knowledge and skills are typically cited as key components of competence (e.g., Hager & Conczi, 1991; Kim et al., 1979, Kitchener, 2000, Welfel, 2002). With respect to specific competencies, the multicultural and addictions counselling fields have been the first to attempt to define the particular knowledge, skills, and attitudes required for competent practice with special populations (e.g., Addiction Technology Transfer Centres National Curriculum Committee, 1998; Sue et al., 1992). One organization in the U.S. has developed a list of competencies for working with clients who have EDs from the perspective of clinical social work (American Board of Examiners in Clinical Social Work [ABECSW], n.d.), and document will be discussed in detail in a later section. However, to provide further context for the research question, I will first provide some information about ethics as they pertain to the treatment of EDs.

*Ethics and Eating Disorders*

The treatment of EDs can be complex and challenging because the wishes of the client are often in conflict with the goals of treatment. This can have implications for the client’s autonomy (e.g., what does the therapist do when the client is severely ill but not wanting treatment). Individuals with EDs may deny having being ill or feel ambivalent
about recovery. Because the disorder may have provided a solution or type of protection, recovery can be a frightening prospect. Thus, clients may attempt to impede the help of family members and clinicians (Bentovim, 2000). For the individual who struggles chronically with AN, the disorder can become an integral and even desirable part of her identity. As such, she may experience therapy and the therapist’s attempts to help as threats to her sense of self (Bulik & Kendler, 2000). This latter issue can have implications for the principles of beneficence (e.g., how can the therapist best help the client given the ego-syntonic nature of the disorder) and nonmaleficence (e.g., when is it appropriate for the therapist to begin challenging the client to consider that “she is not the ED”).

Several types of ethical dilemmas that can arise in the treatment of EDs have been discussed in the EDs literature. For example, in the adult population, the ethics of treatment refusal have been discussed at length, particularly with respect to determining the client’s competence to consent to treatment (e.g., Goldner, 1989; Goldner, Birmingham, & Smye, 1997). Tiller, Schmidt, and Treasure (1993) discussed whether there are times when compulsory treatment may be necessary to offset the effects of starvation, which can distort the client’s ability to make a treatment decision. Decisions are required of the practitioner that involve the ethical principles of autonomy (e.g., how does the therapist determine whether the client is so starved that her cognitive functioning has been impaired), beneficence (e.g., how does the therapist best support the client who has been told she will be committed to a hospital due to low body weight), nonmaleficence (e.g., how does the therapist weigh the potential trauma of forced treatment against the necessity to medically stabilize a client), and fidelity (e.g., does the
therapist set up certain non-negotiables concerning body weight at the onset of therapy in order to minimize the client’s feelings of betrayal if and when compulsory treatment becomes an issue). Critics of compulsory treatment have argued against its use and cite concerns about the infringement of the individual’s rights and autonomy (Strasser & Giles, 1998).

Relatively little literature has discussed ethical concerns pertaining specifically to the adolescent population with EDs. However, one notable contribution has been the presentation of a framework for ethical decision-making with child and adolescent populations. Manley, Smye, and Srikameswaran (2001) state that there are unique factors to consider when treating children and adolescents with EDs. For example, younger clients can deteriorate physically much more quickly than adults. This issue certainly has implications for the private practitioner, who would likely want to ensure that the client was receiving ongoing medical monitoring. In addition, broader developmental factors must be taken into consideration (e.g., to what extent can the therapist engage the youth in formal operations). These issues certainly have implications for autonomy when compulsory treatment is being considered (Manley et al., 2001).

Substantial attention has been devoted to the personal feelings and attitudes that can arise in clinicians when working with individuals who have EDs (e.g., Burket & Schramm, 1995; Piran & Jasper, 1993; Wooley, 1991). Because EDs are not easily ameliorated in the short term, clinicians’ reactions to clients with EDs can include feelings of demoralization, boredom, anger, helplessness, mistrust, and the desire to solve the problem or rescue the client (APA, 2000; Beumont & Vandereycken, 1998; Zerbe,
1998). Such reactions have implications for the principles of beneficence and nonmaleficence (e.g., how and with whom does the therapist process these feelings so that they do not result in poor therapeutic services). Garner (1985) suggests that these negative reactions are one of the most critical factors contributing to iatrogenesis in therapy for EDs.

With respect to professional competence for working with EDs, some scholars have stated that the knowledge base and skills required to treat EDs are extensive (Buhl, 1993; Sargent, 1992; Yager & Edelstein, 1987) and that there is considerable risk of therapist error and causing harm to the client (Garner, 1985; Thompson & Sherman, 1989). Given the unique clinical needs of clients with EDs, the counsellor who practices beyond his or her level of competence may do so to the physical, mental and emotional detriment of the client. The seriousness of these disorders suggests that counsellor incompetence could, in some cases, be life threatening for the client.

*Empirically Supported Treatments for EDs*

Empirically supported treatments (ESTs) have been discussed in the EDs literature for well over a decade (e.g., Fairburn, Agras, & Wilson, 1992; Mussell et al., 2000). Some scholars have suggested that the use of ESTs is an ethical issue (e.g., Arnow, 1999; Ollendick & Davis, 2004; Persons & Silberschatz, 1998) because the principles of beneficence and nonmaleficence are inherent in the therapist’s choice of intervention (e.g., if a treatment is known to be efficacious, clients may benefit from receiving it; how can therapists be certain that non-validated are not harmful) (Persons & Silberschatz, 1998).
Unfortunately, there exists remarkably little empirical evidence for the effective treatment of AN. Kaplan (2002) reviewed the available randomized control trials (RCTs) studies on the treatment of AN and concluded that there was a “desperate need for further research in the area” (p. 235). He noted that promising new approaches that conceptualize resistance and ambivalence to change as primary symptoms (e.g., Motivational Enhancement Therapy) are being investigated, as are experiential therapies for body image disturbance. He recommended that mindfulness-based cognitive therapy be studied for its potential use in relapse in AN, based on preliminary results on relapse prevention in depression (Kaplan, 2002).

For BN, CBT has been promoted as the treatment of choice because, to date, it has shown the most evidence of efficacy in studies that used RCTs (APA 2000). In fact, one published guideline on the treatment and management of EDs specifically recommends that an adapted form of CBT for BN be offered to adults and adolescents with BN for 16-20 sessions over 4-5 months ([CBT-BN], Wilson et al., 1997) (National Collaborating Centre for Mental Health [NCCMH], 2004). Many studies have provided evidence that CBT for BN is effective, even in the long term (e.g., Agras et al., 1994; Fairburn, Jones, Peveler, Hope, & O'Connor, 1993; Wilson, Eldredge, Smith, & Niles, 1991). However, a recent review of ESTs suggests that CBT for BN may be less effective in the long-term than previously thought. Westen, Novotny, and Thompson-Brenner (2004) reported that 60% clients who had completed a CBT treatment protocol for BN remained symptomatic (despite a marked reduction in symptoms, in some cases), sought further treatment, and/or relapsed 1-2 years after receiving manualized CBT interventions.
Evidence has also emerged from RCTs of the efficacy of IPT for treating BN (APA, 2000). There is some interesting background as to how IPT came to be viewed as an EST for BN. When Fairburn (1997) wanted to test CBT against a comparison treatment that had some credibility, he chose IPT. The most currently published IPT manual still advises against discussing BN symptoms because this was key in distinguishing the two experimental conditions (CBT does focus on symptoms). They note that when IPT proved to be helpful “by accident,” the intervention was placed on the list of ESTs despite any evidence for one of its key components: the counterintuitive practice of not discussing one of the main concerns (BN) for which the client has presumably sought therapy (Westen et al., 2004).

Therapists who provide services to clients with BN have been reported to underutilize ESTs (Arnow, 1999; Haas & Clopton, 2003; Mussell et al., 2000; Wilson, 1998). Many explanations have been offered regarding this phenomenon. Arnow discussed practitioner objections to ESTs as one possible reason, including objections related to the relevance of outcome data from RCTs to clinical practice and perceptions that manualized versions of therapies are too constraining. He also cited the lack of opportunities for training in ESTs as a potential factor, a concern echoed a year later by Mussell and colleagues. Others have suggested that the poor dissemination of knowledge regarding ESTs has been to blame (Crow, Mussell, Peterson, Knopke, & Mitchell, 1999). Haas and Clopton argued that BN treatment outcome studies need to address comorbidity issues if practitioners are to embrace ESTs for BN.

As noted above, an EST for BN (CBT-BN) has been actively promoted in one practice guideline for the treatment and management of EDs (NCCMH, 2004). However,
not all guidelines and standards documents have made such specific recommendations, but instead have simply listed therapies for which there is evidence of efficacy (e.g., APA, 2000; ABECSW, n.d.). The ABECSW's position is that a clinical social worker with expertise in treating EDs would likely possess the flexibility and good judgment to make use of any approach that would be effective (B. Booth, ABECSW, personal communication, October 26, 2004).

**Extant Guidelines, Standards, and Certification for the Treatment of EDs**

In the course of the literature reviewed for the present study, three documents were found that describe best or preferred practices in the treatment of EDs. These included: (1) the *Practice Guideline for the Treatment of Patients with Eating Disorders* ([APA], 2000); (2) the *Draft Position Statement on the Advanced Practice of Clinical Social Work in Treating Those with Eating Disorders* ([ABECSW] n.d.); and (3) *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders* (NCCMH, 2004). In addition, The International Association of Eating Disorders Professionals Foundation (IAEDP), a U.S.-based organization offering certification to professionals who work in the EDs field, developed a Certification Manual that outlines the minimum education levels and baseline knowledge required of professionals (e.g., physicians, therapists, counsellors, dietitians, etc.) who wish to treat EDs. The following sections describe the development and content of these documents in more detail.

**APA Practice Guideline**

The American Psychiatric Association’s *Practice Guideline for the Treatment of Patients with Eating Disorders* ([APA] 1993, 2000) was the first best practices document
published on the treatment of EDs. The document was developed initially as a "set of patient care strategies...to assist physicians in clinical decision-making" (APA, 1993, 2000). The guidelines have also been described as a tool for educating health professionals and the general public about appropriate and inappropriate treatments (Zarin, Seigel, Pincus, & McIntyre, 1993). Yager (2001) adds:

The purpose of practice guidelines is to put into the hands of clinicians, insurance companies, managed care companies, and the public a set of guidelines that incorporate the best current practice information derived from 'evidence tables' based on a careful sifting through available scientific literature, blended with informed, judicious, and peer-reviewed opinions based on the clinical experiences of experts (p. 187).

The Guideline was developed by a "Work Group on Eating Disorders" consisting of 9 psychiatrists with expertise in the EDs field. Before receiving formal APA approval, a series of 11 steps was undertaken in the development process. These included a comprehensive literature review, the solicitation of ongoing comments and review by APA committees and approximately 100 external and internal reviewers, and the production of 4 draft documents. Each study or document reviewed was assigned a code that indicated the nature of the evidence presented (e.g., randomized clinical trial, cohort or longitudinal study, review, expert opinion, etc.). Based on the evidence, recommendations were developed and assigned a code that indicated the Work Group's level of clinical confidence in the recommendation ("recommended with substantial clinical confidence," recommended with moderate clinical confidence," or "may be recommended on the basis of individual circumstances"). The document was published
initially in 1993 in the *American Journal of Psychiatry* and has since been revised in order to take into account new evidence (APA, 2000).

The *Guideline* includes information about the clinical features, natural history, course, and epidemiology of EDs; treatment principles for AN and BN (nutritional rehabilitation, psychosocial treatments, and medications); other clinical and environmental factors that influence treatment; and future research directions. The requisite knowledge base and skills pertaining to psychosocial interventions for AN are described. For example, it is recommended that the practitioner understand psychodynamic conflicts, cognitive development, psychological defenses, the complexity of family relationships, and the presence of other psychiatric disorders. For BN, it is recommended that CBT or IPT be utilized, since the most evidence of efficacy has been accumulated for these modalities. Other issues recommended to be addressed in the psychosocial treatment of BN include “identity formation, body image concerns, sexual and aggressive difficulties, affect regulation, gender role expectations, interpersonal conflicts, family dysfunction, coping styles and problem solving” (p. 645).

Wilson and Agras (2001) have criticized a number of aspects of the *Guideline*. For example, they state that the coding system used to establish clinical confidence in the treatment recommendations “does not spell out the criteria for making these categorical evaluations” (p.221). In addition, they argue that the document is overinclusive. For example, some recommendations are not given a level of confidence code (e.g., “family therapy should be considered whenever possible” [p.666]). This omission is interpreted by the authors as the “tempting tendency” (p.222) to rely on expert, yet still subjective, clinical judgment. They argue that an emphasis on clinical judgment is inconsistent with
the move towards evidence-based treatment. A final critique they make of the Guideline is that it does not specifically endorse and promote the use of CBT for BN despite its acknowledgment that CBT is presently the treatment for which there is the most evidence of efficacy.

**ABECSW Draft Position Statement**

The American Board of Examiners in Clinical Social Work (ABECSW) has also developed a set of practice guidelines for EDs. Based in the U.S., the ABECSW describes itself as a professional standard-setting and credentialing organization for the clinical social work profession. The Draft Position Statement on the Advanced Practice of Clinical Social Work in Treating Those with Eating Disorders appeared on the ABECSW website in support of a proposed specialty credential in the treatment of EDs. The organization argues that a specialty credential in the treatment of EDs for clinical social workers is warranted because individuals with EDs constitute a population with specifically defined psychological, behavioural, and psychiatric problems as defined by the DSM-IV (ABECSW, 2003).

The Draft Position Statement was developed by a Task Group selected by the ABECSW in conjunction with a hired consultant. The Task Group consisted of two groups: generalist clinical social work practitioners who worked with clients with EDs and scholars who specialized in the study of the treatment of EDs. The consultant wrote the document based on recommendations made by the Task Group. Approximately 40 individuals (e.g., clinical social workers, government representatives) and EDs programs (e.g., Renfrew Centre) reviewed and rated the document based on the validity of its content, presentation style, and the appropriateness of the references. The document has
since been removed from the website for further revisions (to the competencies section in particular) and the organization is now taking steps to create a speciality certification in EDs for clinical social workers (B. Booth, ABECSW, personal communication, October 26, 2004).

The document is comprised of several sections, beginning with an introduction to the ABECSW and the rationale for creating the document. The next section presents a proposed knowledge base for EDs practice, including information on prevalence, assessment, medical complications, sequencing and integration of treatments, and major treatment modalities (psychoeducation, CBT, IPT, psychodynamic, feminist, and body image approaches, and pharmacological treatment). The third section presents proposed professional competencies for a clinical social work specialty in EDs (categorized into values, professional knowledge, professional use of self, disciplined approach to the practice environment, and practice competencies). Finally, standards for certification in an EDs specialty are presented, including level of education required, continuing education, clinical supervision and consultation, and evaluation.

*NCCMH Core Interventions Guideline*

This document is commonly referred to as the “NICE” Guideline, named after the commissioning body, the National Institute for Clinical Excellence [NICE]) (Academy for Eating Disorders members, listserv communication, 2004). The aims of the Guideline were to (1) evaluate psychological interventions, medications, service delivery systems, service-level interventions, and physical management practices in the treatment and management of EDs; and (2) integrate these interventions with a view to promoting best practices in caring for individuals with EDs in England and Wales.
The document was developed in the U.K. by a Guideline Development Group (GDG) convened by the National Collaborating Centre for Mental Health (NCCMH). The GDG included members from the following groups: psychiatry, clinical psychology, nursing, family therapy, social work, and general practice. A representative from a community organization and one consumer also participated. The GDG met 23 times during the guideline development process. Topic sub-groups, led by national experts in the field, were formed to identify and analyze evidence and treatment approaches. Focus groups were held with family members and friends of those with EDs, and special advisors with specific expertise on aspects of the treatment and management of EDs were consulted. Prior to being finalized and published, the draft document was reviewed by numerous stakeholders and special advisors, and other individuals identified by NICE.

The NICE Guideline contains detailed descriptions of AN, BN and EDNOS (including BED) and provides detailed information about incidence and prevalence; etiology; symptoms, presentation, and course of illness; diagnosis; physical and social consequences; prognosis; impairment and disability; information specifically on children and adolescents. The use of various health resources (e.g., tertiary care) by these populations is also discussed. Information pertaining to the treatment and management of EDs in England and Wales is also presented, including sections on assessment; engagement, consent, and the therapeutic alliance; the patient’s experience of having and ED; the involvement of family members/carers in treatment; and the stigma experienced by individuals with EDs. More than 100 recommendations for the treatment and management of EDs appear in the document, from treatment setting (e.g., most adults with AN should be seen in an outpatient setting) to which psychotherapies should be
considered for use with each ED (e.g., the use of an evidence-based self-help program encouraged should be considered as a first step for BN).

IAEDP Certification

The International Association of Eating Disorders Professionals Foundation (IAEDP) is a U.S.-based organization that offers certification to professionals who work in the EDs field. IAEDP has developed a set of criteria in the form of a Certification Manual (IAEDP, 2003) that outlines the minimum education levels and baseline knowledge required of professionals (e.g., physicians, therapists, counsellors, dietitians, etc.) who wish to treat EDs. Individuals may be certified as either a “Certified Eating Disorders Specialist” (CEDS) or a “Certified Eating Disorders Associate” (CEDA) and renew their credentials by participating in IAEDP-approved continuing education. One of the stated purposes of the IAEDP (2003) is to “establish and promote a uniform curriculum to serve as the minimum recommended knowledge base to enable a health care professional to provide competent, appropriate and effective services to persons suffering from eating disorders” (p.2). In addition, the organization has adopted the American Psychological Association’s ethics code (1992) in order to promote high standards of professional conduct.

Much of the Certification Manual is comprised of application forms and the Ethical Principles of and Code of Conduct (American Psychological Association, 1992). A 1-page recommended reading list is also included. The other substantial section of the Manual describes the requirements for obtaining certification (as either CEDS or CEDA). A 48-credit (for CEDS) or 36-credit (for CEDA) master’s or doctoral degree from a behavioural science program is required. The applicant must provide a typed case study
(including presenting problems, DSM-IV diagnoses, course of treatment implemented, modalities of treatment, principal obstacles encountered, outcome, and follow-up), write a certification examination based on a recommended reading list, and complete IAEDP curriculum courses including an introduction to EDs, treatment modalities, medical/physiological aspects, and nutrition and weight control. They must also show evidence of a minimum of 3000 (CEDS) or 1500 (CEDA) direct patient/client service hours under an IAEDP-approved supervisor. Applicants must submit a typed statement explaining reasons for seeking certification, and sign a statement of ethical practice principles. Finally, applicants must complete one IAEDP symposium two years prior to the certification test date.

Summary

The extant guidelines and standards documents described above provide a wealth of information about preferred/best practices in the treatment of EDs. Each document has a unique emphasis that is related to its aim and the discipline(s) primarily responsible for sponsoring it. For example, the Draft Position Statement is clearly focused on the practice of clinical social work with EDs rather than on the principles associated with multiple aspects of treatment (e.g., nutritional rehabilitation, medical monitoring, pharmacology, etc.) that appear in the APA and NICE Guidelines. The description of specific competencies in the ABECSW's Draft Position Statement is particularly germane to the present study. In contrast to both the APA Guideline and the ABECSW Draft Position Statement, the NICE Guideline discusses at greater length EDNOS (including BED), provides substantially more information on (and recommendations concerning) EDs in child and adolescent populations, makes clear recommendations
about the use of certain evidence-based psychotherapies (e.g., CBT for BN), and presents the methodology for the review process and the creation of the document in minute detail. Finally, the IAEDP Certification Manual provides useful suggestions for the level of education and amount of clinical supervision required to specialize in the treatment of EDs

*Features of the “Ideal” EDs Psychotherapist*

The EDs research literature contains many articles that describe what therapists should be doing with clients who have EDs. Topics range from what is recommended for establishing the therapeutic alliance (e.g., Freedman & Leichner, 2001), to what stance therapists should adopt (e.g., Vitousek & Watson, 1998), to the type of therapy that should be conducted (Wilson & Agras, 2001). However, only one article was found that addressed specifically the qualities or characteristics ideally possessed by an EDs therapist (Andersen & Corson, 2001). Dr. Arnold Andersen is a much published psychiatrist in the field of EDs who was responsible for co-authorship of the APA’s *Practice Guideline for the Treatment of Patient with Eating Disorders* (2000). A PsychInfo search revealed that Dr. Andersen has published at least 8 articles since 2001 on the topic of EDs treatment. Dr. Patricia Westmoreland Corson is a psychiatrist and colleague of Dr. Andersen’s at the Eating Disorders Services at the University of Iowa. The authors provided their opinions on four areas that they deem essential for the ED therapist: a body of knowledge; personality qualities and attitudes; training in evidence-based, scientific psychotherapies; and experience and continual review. These are described in detail, below.
The essential knowledge included: understanding the physiological and psychological consequences of starvation; awareness of culture-bound disorders, sociocultural norms, gender, race, ethnicity, and sexual orientation issues as related to EDs; the role and effects of medications; knowledge of when to refer; knowledge and encouragement of normal, age-appropriate social skills, attitudes and behaviours in the client; an understanding of the role of nutritional rehabilitation; an understanding of transference, countertransference, boundaries of psychotherapy; knowledge of development, and how it pertains to the functioning style of the family; and possession of an overall organizing concept of the causes, progression and maintenance of EDs.

Abilities included: the ability to make a central dynamic formulation; to diagnose accurately; to critically evaluate the EDs research literature; to use both standardized tests and qualitative descriptions of symptoms; to work as part of an interdisciplinary team; to modify treatment based on comorbidity; and to remain abreast of the literature.

Training included: specific training in CBT or IPT at minimum, with knowledge of supportive, educational and dynamic techniques; and supervision (including of assessment) after training of at least 12 cases.

Suggestions were also made regarding the personal qualities and characteristics that would contribute to being an EDs ideal therapist: nonpossessive warmth; caring; empathy; has perspective; technical competence; avoidance of narcissism, needs for obsessive control, and competition with the client; not easily frustrated; never gives up; does not achieve 100% success and accepts this; and high self-nurturance. Other therapist characteristics are also discussed including: the therapist's discipline (no specific discipline is preferable; however, more severe cases require more extensive
training and experience – degrees below the Master’s level seldom include the requisite training); the therapist’s gender (has little impact on treatment efficacy, but a client’s request for a therapist of a particular gender should be accommodated if possible); weight of the therapist (should be frankly discussed if it is a concern to the client); whether the therapist has had an ED (an active ED would be problematic, whereas a past ED could enhance therapy); and the role of computers, online support, and self-help books in treatment.

To the authors, “ideal” was conceptualized as “completely adequate, not perfect” (p.357). They state that the minimum requirements for providing therapy to clients who have EDs are “knowledge, skills, training with supervision, continuing education, and interpersonal support” (p.357).

While the attributes referred to in the article described above are not explicitly conceptualized as “competencies,” they could arguably be conceptualized as such. Along with the three treatment guidelines described above, this article was used as a source document for the questionnaire items in this study.

Summary

In this chapter, I have reviewed a range of literature that has informed the present investigation. Two main areas of literature were reviewed: (1) issues related to professional ethics, competence, and competencies, and (2) issues related to ethics and EDs (including the use of ESTs), preferred treatment practices, and the preferred characteristics of the EDs therapist.

To summarize, the codes of ethics developed in the fields of psychology and counselling have included guidelines concerning professional competence. However,
competence is not defined specifically in these documents nor is there a consensus on its
definition in the broader ethics literature, although knowledge and skills are typically
cited as key (e.g., Hager & Conczi, 1991; Kim et al., 1979, Kitchener, 2000, Welfel, 2002). Defining a scope of practice is an important aspect of competence and entails an
understanding of the boundaries of one's competence, including when to consult or refer
(Corey et al., 1993). Obviously, these considerations apply to all counselling
practitioners. However, the high mortality rate and the complex psychological needs and
physiological complications of clients with EDs, the extensive knowledge base and skills
required (Buhl, 1993; Sargent, 1992; Yager & Edelstein, 1987), and the risks of
iatrogenesis or therapist error (Garner, 1985; Thompson & Sherman, 1989) may be
additional considerations for counsellors who wish to provide their services to clients
with EDs.

Ethical concerns have been discussed in the EDs literature on a variety of topics
including compulsory treatment, ethical decision-making in the treatment of adolescents,
and clinicians' reactions to clients with EDs. The use of empirically supported treatments
(ESTs) has been described as being relevant to discussions on professional ethics (e.g.,
Persons & Silberschatz, 1998). However, the promotion of ESTs and the basis on which
they are determined as been the focus of much debate (e.g., Waehler, Kalodner,
Wampold, & Lichtenberg, 2000). In the EDs field, two ESTs have been identified for the
treatment of BN: CBT and IPT. However, there is evidence that these ESTs are
underutilized and a variety of factors have been presented to attempt to explain this
phenomenon (e.g., Arnow, 1999; Haas & Clopton, 2003; Wilson, 1998; Mussell et al.,
2000).
Extant treatment and practice guidelines for EDs provide valuable information about what an EDs therapist should know and be able to do (ABECSW, n.d.; APA, 1993; 2000; NCCMH, 2004). Other literature (e.g., the “ideal” EDs therapist [Andersen & Corson, 2001], the IAEDP Certification Manual [IAEDP, 2003]) has added to our understanding of the education level and other personal characteristics that might be helpful for an EDs therapist to possess. Other than the Draft Position Statement published by the ABECSW, the information contained in this literature has not been conceptualized specifically in terms of competence/competencies, nor has a determination been made about which aspects of practice would be essential for therapeutic practice with clients who have EDs. The present study was a preliminary investigation designed to explore these very ideas. With the “essential competencies” identified, counselling practitioners would have a reference point for assessing their competence to provide services to this population.
Chapter 3 – Method

In this chapter, I describe the methodology and design of the study, and I present my biases that are germane to the investigation. I address: the selection of the method (Delphi), its advantages and limitations, its reliability and validity, and additional factors that must be considered when using it. These are followed by sections on participants, the study design (including questionnaire development and recruitment procedures), researcher bias, data collection procedures, and data analysis.

Method Selection

As the purpose of the study was to identify the competencies considered essential for basic, independent therapeutic practice with clients who have EDs, the use of the Delphi technique (hereafter referred to as “Delphi” or “the Delphi”) was particularly appropriate. Delphi was developed in the 1950s by Olaf Helmer and Norman Dalkey for the RAND Corporation and was originally used for technological forecasting. It employs a series of iterative questionnaires in order to poll and organize the opinions of a sample of experts, with the aim of achieving a group consensus (Dalkey, Rourke, Lewis, & Snyder, 1972). Thus, a group process concerning a complex topic can occur among experts who otherwise might not be able to come together geographically (Fish & Busby, 1996; Linstone & Turoff, 1975). Delphi has been found useful for investigating areas that have not been articulated clearly or explored widely (Cookson, 1986; Weatherman & Swenson, 1974), and Stewart (2001) states, “[Delphi’s] capacity to capture those areas of collective knowledge that are held within professions but not often verbalized makes it enormously useful in the field of professional education” (p.922).
Delphi was selected as the method of choice for this investigation for several reasons. First, while there was considerable information about what therapists should know and be doing with ED clients in the EDs literature, the conceptualization of this information from the perspective of professional competence had not been explored explicitly. Second, it has been suggested that expertise is needed to treat EDs (e.g., APA, 1993, 2000) and Delphi features the solicitation of expert opinion. Third, experts in the treatment of EDs in British Columbia were geographically widespread and face-to-face individual and/or group meetings would require considerable resources. Delphi circumvented this concern by permitting experts to communicate and work toward group consensus without face-to-face meetings (Fish & Busby, 1996).

It is worthwhile to note that Delphi has been used to determine the competencies required for cross-cultural school psychologists (Lopez & Rogers, 2001; Rogers & Lopez, 2002), public health agency staff (Gebbie, Merrill, Hwang, Gupta, Btoush, & Wagner, 2002), and effective supervision in rehabilitation counselling (Thielsen & Leahy, 2001).

Advantages and Limitations of Delphi

Rogers and Lopez (2001) have stated that Delphi "lends itself specifically to the process of identifying competencies because it relies on the collective opinions of experts to explore the skills needed within specific areas of specialization" (p.276). Delphi requires less time of participants than traditional methods of pooling opinions (e.g., committee work), is relatively inexpensive, and is well-suited for bridging the gap between research and practice (Fish & Busby, 1996). The fact that participants are typically unaware of each others' identities helps to avoid the pitfalls of public group
discussion (e.g., focus groups) such as group pressures, the unwillingness to abandon publicly stated opinions, and the effects that individuals have on groups (Dalkey et al., 1972; Helmer, 1966; Pyke, 1970). Participants are not required to convene physically, thus potentially enabling the participation of more panelists (Boberg & Morris-Khoo, 1992). Finally, Delphi provides researchers with a systematic way to build constructs and organize ideas that can be validated later and organized further into models or theories (Linstone and Turoff, 1975).

In terms of limitations, Delphi can take weeks or months to complete and can be difficult to coordinate (Preble, 1983). The time the researcher takes between phases to compile and prepare the responses must be minimized to maintain panelist interest and involvement (Mamalakis, 2001). The process can also be time-consuming for both the panelists and researcher because the questionnaires can be lengthy. Multiple rounds increase the time commitment for all involved (Preble, 1983). Proper coordination of a Delphi project includes repeated mail-outs, the tabulation of large amounts of data, and extensive record keeping (Boberg & Morris-Khoo, 1992).

Another disadvantage of Delphi is the reduction of unique or extreme opinions due to the focus on consensus-building (Lindstone & Turoff, 1975; Sackman, 1975). In addition, Dalkey and colleagues (1972) note that opinions are value laden and are more directly tied to emotions rather than factual statements. Value judgments are neither "right" nor "wrong." Therefore, a consensus of value judgments does not represent an objective measure of truth or behaviour. However, Fish and Busby (1996) argue that "the view that truth is relative underlies the attempt to gather myriad opinions on a particular topic" (p.470). Indeed, the present study has not sought "the facts" or "the truth" about
ED practitioner competencies. Instead, its aim has been to establish a preliminary consensus among a group of provincial ED treatment experts on the essential competencies for basic, independent therapeutic practice with clients who have EDs.

Validity and Reliability

Delphi has been criticized for its lack of rigor compared to other social science research methods in terms of its lack of validity and reliability testing (Boberg & Morris-Khoo, 1992). Theoretically, the same process conducted with two or more panels could yield different results. With respect to validity, a Delphi study does not base its validity on random selection; rather, the validity of the results relies on the expertise of panel members in the area under investigation (Dalkey, 1969; Fish, 1989; Speight, Thomas, Kennel, & Anderson, 1995; Stahl & Stahl, 1991). Delphi is based on the assumption that several people are less likely to arrive at a wrong decision than a single individual. Pressures to converge on consensus may threaten validity (Hill & Fowles, 1975). However, the use of knowledgeable and interested participants may help increase the content validity (Goodman, 1987) and the successive rounds may help increase the construct validity. Ultimately, the validity of results is affected by the response rates for each round (Hasson, Keeney, & McKenna, 2000).

Categorizing Delphi

As Stewart (2001) has noted, it has been debated whether Delphi is a method or a methodology, and whether it is quantitative or qualitative. She suggests that Delphi is a strange case because of its myriad purposes and modifications. Epistemologically, Delphi could be viewed as deriving from objectivism where the expert-generated items are considered as facts and objective truths. However, as previously noted, opinions are
value-laden judgments. A consensus of opinions does not represent an objective measure of truth or behaviour (Dalkey et al., 1972). Thus, Delphi could be seen to derive from constructivism, where the findings represent a shared meaning that is developed from an interactive process. Stewart argues that, ultimately, although an interpretive analysis of data occurs in the first phase, Delphi is fundamentally reductionist in nature because its aim is to “gain a generalized opinion from a group that ignores contexts and multiple realities” (p.922). Panelists may generate similar statements that do not necessarily mean the same thing. The investigator “does not explore these meanings but instead reduces them to amalgamate ‘alike’ statements...the researcher employs a standardized, ‘objectified’ technique to interact with the participants” (p.922). According to Stewart, these definitions indicate that Delphi represents quantitative research.

Fish and Busby (1996) classify Delphi as a mixed method. They argue, however, that the philosophical assumptions underlying Delphi’s use are more important than how it is designed and implemented, and that attempts to collect various opinions on a topic rests on the view that the truth is relative. They emphasize that the philosophical underpinnings of Delphi relate more to the application of useful knowledge than with the attempt to define the truth. For the purposes of this study, I have classified Delphi as a mixed method based on my intent to use it to fulfill the goals of accessing multiple individual (and individually constructed) perspectives and enriching understanding of the topic at hand, while enabling a summarization of this data into a format that facilitates numerical evaluation and group consensus (Tashakkori & Teddlie, 1998).
Consensus

It is important to consider the definition of “consensus” when using Delphi (Williams & Webb, 1994a). There are a variety of opinions in the Delphi literature regarding what constitutes consensus. There is no universally agreed-upon cut-off, as the level employed depends upon sample numbers, aim of the research, and available resources (Hasson et al., 2000). McKenna (1994) suggested that consensus should be equated with 51% agreement amongst respondents, whereas Sumson (1998) recommended 70%, and Green, Jones, Hughes, and Williams (1999) opted for 80%. At the extreme end of the continuum, Williams and Webb (1994a) chose 100% agreement as the appropriate level for their study of activities that help students to learn in the clinical environment. Response stability over rounds has also been suggested as method for determining consensus (Crisp et al., 1997). Williams and Webb (1994a) comment that many researchers wait until after analyzing the data to set a consensus level which, they argue, can make the concept of consensus arbitrary and may introduce more researcher bias.

The definition of consensus for this study was originally proposed to be a 65% or greater level of agreement among participants on the rating of a competency item (a rating of 3 equals “essential,” 2 equals “useful but not essential,” and 1 equals “not necessary”). However, when the study was modified to include questionnaire items from established guidelines for the treatment of EDs, a higher level was considered. After Round 1, it became clear that 65% would not offer a particularly sensitive gauge with which to discriminate the relative importance of items (at 65%, nearly all Questionnaire 1
items would have reached consensus). Therefore, an 85% or greater level agreement was selected.

Participants

In a Delphi study, participants are selected on the basis of their expertise on the topic under investigation. The term "expert" and also the process of identifying experts have been debated in the Delphi literature (e.g., Strauss & Zeigler, 1975). It has been argued that the idea that one group can represent "valid expert opinion" is scientifically untenable and overstated (Strauss & Zeigler, 1975). For example, the panelists who commit to a lengthy Delphi process are likely to do so because of their interest in the research topic. Other prospective panelists, despite possessing expertise and having valid opinions, may choose not to participate due to their lack of interest in the research topic. Opting for a more inclusive definition of "expert," Fish and Busby (1996) state that Delphi could be used to survey, for example, expert clients, referral sources, or any other group of individuals whose opinions are important. Nevertheless, the selection of an appropriate panel is the most significant assurance of quality outcome in a Delphi study (Dalkey, 1969). An aim of the selection process is to obtain a panel of experts with as much diversity as possible (Delbecq, Van de Ven, & Gustafson, 1975; Mamalakis, 2000; Powell, 2002). Ultimately, each participant must be justifiable as an "expert" on the topic being investigated (Jones & Hunter, 1995).

In this study, the expert criteria were developed based on a review of the Delphi literature on competencies and on feedback from members of the Eating Disorders Advisory Committee of British Columbia. Panelists were required to meet at least one of the following criteria:
1. Has practised in EDs treatment for at least 5 years and completed a practicum and/or internship in a related area;

2. Has supervised therapists-in-training in an EDs treatment setting;

3. Has published scholarly work on the topic EDs treatment, ethics, and/or professional competence between 1995 and 2003 (first, second or third author);

4. Has taught about EDs treatment at the graduate level;

5. Has presented one or more refereed national conference presentations on EDs treatment, ethics, and/or professional competence.

Design

Overview

Delphi polls the opinions of a panel of experts who are knowledgeable on a given topic via a series of iterative questionnaires, referred to as “rounds” (Dalkey et al., 1972). In a classic Delphi study, the first round consists of each panelist responding, in as much detail as they wish, to one or more open-ended questions. The researcher then compiles the Round 1 responses and extracts statements (preferably verbatim) from the data that will become the content items for the next questionnaire. In subsequent rounds, panelists are asked to rate the items on some dimension determined by the researcher (e.g., level of importance, panelists' level of agreement, etc.), usually using a Likert-format scale (Likert, 1932). After receiving participants' completed questionnaires, the researcher calculates summary statistics for each item (e.g., mean, median, interquartile range, and/or standard deviation) and, in the next round, sends this information out to each panelist. The panelists are then asked to reevaluate their rankings for each item taking into consideration the group’s response.
Some studies (e.g., Duffield, 1993; Jerkins & Smith, 1994) have modified the classic Delphi by providing pre-existing information (i.e., from the literature) in Round 1. Uhl (1971) noted that it is unwise to ignore prior work on a topic in the hopes that the panel will reconstruct it in the process of clarifying related issues. Because at least three sets of practice guidelines and standards documents existed for the treatment of EDs, this study included questionnaire items drawn from these sources and one other relevant article in Round 1 – there was no point in asking participants to “reinvent the wheel.” However, given the possibility that participants could provide novel and useful competencies that were not reflected in these sources, they were given the opportunity to generate their own competency items on Questionnaire 1.

Not including the participant comments generated each item in subsequent questionnaire rounds is another acceptable modification to the Delphi process. Uhl (1971) contended that too much detailed feedback could be inhibiting to panel members, thus having the same effect as a dominant personality in the group. In addition, reviewing one or more comments per item in addition to the item statistics could be overwhelming for participants who complete multiple and often lengthy questionnaires (Hasson et al., 2000). For these reasons, this study did not include the participants’ comments on subsequent questionnaires.

Classic Delphi studies use four rounds, but various modifications to the procedure are acceptable (Young & Hogben, 1978). For example, the number of rounds can be determined by the investigator who considers the design of the study, response stabilization, point of diminishing returns, and “sample fatigue” (Dalkey et al., 1972; Fish & Busby, 1996; Hasson et al., 2000). More recent evidence indicates that two or three
rounds are preferred (Beech, 1997; Green, Jones, Hughes, & Williams, 1999; Proctor & Hunt, 1994).

The present study was designed to be three rounds, with the option of concluding the study after two rounds if consensus had been reached on all items. This design helped ensure that there was adequate opportunity for participants to provide their opinions, generate additional items, and participate in a consensus process within a realistic and reasonable time frame. In making this decision, the Delphi literature on competencies was reviewed and the following factors were considered: the inclusion of items drawn from the EDs literature on the Round 1 questionnaire, the limited monetary resources available to conduct the study, and the potential of sample fatigue and diminishing returns due to potentially lengthy questionnaires. A final consideration was the university ethics process, which was unsupportive of open-ended timeframes or commitments for participants (i.e., I could not state that rounds would continue until there was complete consensus, as this could take any number of rounds. Rather, I was required to stipulate a maximum number of rounds to show that I would not be forcing participants into an unknown, and possibly exploitive, commitment). It is worthwhile to note that Delphi studies employing more than three rounds are rare in the published literature reviewed for this study, and two rounds are typical.

**Questionnaire Development**

The Round 1 questionnaire was developed using four sources: (1) *Practice Guideline for the Treatment of Patients with Eating Disorders* (APA, 1993; 2000); (2) *Draft Position Statement on the Advanced Practice of Clinical Social Work in Treating Those with Eating Disorders* (ABECrSW, n.d.); (3) *Eating Disorders: Core Interventions*
Each of these sources was reviewed in detail and questionnaire items were created by extracting sentences and phrases from the text (verbatim, wherever possible) that applied to various aspects of psychotherapeutic treatment with individuals who have EDs. This process resulted in a total of 325 potential items for inclusion on the first questionnaire (75 from APA, 180 from ABECESW, 24 from NCCMH, and 46 from the article). I then reviewed the 325 items in order to identify: (1) duplicates; (2) items that were not specific to therapy for EDs (e.g., “Recognizes and respects client boundaries”); (3) items that were too general, vague, or broad (e.g., “Possesses a knowledge base specific to eating disorders”); and (4) items that did not reflect a competency (e.g., were outside the realm of competence, such as “Is recognized as an expert by peers/professional community,” or were suggestive of expertise, such as “Has sufficient knowledge to conduct, supervise, and teach specialized practice area”). I then drew up a list of these items as well as a draft Questionnaire 1 that retained only the items that were not earmarked for potential removal. These documents were distributed to two members of the thesis committee who reviewed them and provided suggestions regarding (a) amendments to the questionnaire, and (b) retaining some items that had been removed.

After making the suggested changes, I piloted Questionnaire 1 with two colleagues. One had been a therapist practising in the area of EDs for more than 15 years and the other was a Counselling Psychology student who had no familiarity with EDs. As a result of their comments, several items were split into two because they contained more
than one competency and the Likert scale initially selected for the questionnaires was exchanged for another. The initial scale had been based on scales seen in the Delphi competencies literature (1-5, “Very Unimportant” to “Very Important”). The feedback indicated that scale did not adequately reflect dimensions of “essentiality.”

In consultation with a professor in the Measurement, Evaluation and Research Methodology in the Faculty of Education, a more useful and appropriate scale was researched and selected. The scale was drawn from literature that addressed content validity of tests and questionnaires (Lawshe, 1975; Veneziano & Hooper, 1997). The scale anchors were “essential,” “useful but not essential,” and “not necessary.” These were used for the purposes of the present study to create a scale that participants would use to rate potential competency items based on how essential they were for basic, independent therapeutic practice with individuals who have EDs. The scale was developed as follows: 3 equals “essential,” 2 equals “useful but not essential,” and 1 equals “not necessary.”

The final version of Questionnaire 1 contained a total of 187 items that were organized into the following categories: Specialized Knowledge Base, Specialized Skills, Training, Supervision & Continuing Education, and Therapist Characteristics. In addition, demographic questions were included in the first section of the questionnaire. Questionnaires 2 and 3 were developed during the data collection phase, and included only new participant-generated items, and items for which consensus had not been reached in previous rounds. Roberts-Davis and Read (2001) state that it is permissible for the researcher to exclude items for which consensus has been reached from future
questionnaires if a level of consensus has been established. The questionnaires appear in Appendices F, H, and J.

Recruitment of Participants

Based on recommendations I received from my thesis committee at the proposal defense concerning participant attrition, and for reasons pertaining to data management (i.e., limiting the size of a potentially enormous data set), the desired sample size was determined (a priori) to be 30 participants.

The selection of an appropriate panel is the most significant assurance of a credible outcome in a Delphi study (Dalkey, 1969). One aim of the selection process is to choose a panel of experts that represents as much diversity as possible (Delbecq et al., 1975; Mamalakis, 2000; Powell, 2002). Therefore, considerable detail will be provided with respect to the recruitment and selection of the study’s participants.

A list of professionals involved in the treatment of EDs in British Columbia was developed using the following sources: Eating Disorder Resource Centre of B.C. Referral and Program Lists; the Internet (e.g., websites for B.C. Psychological Association, Vancouver Island Association for Ending Disordered Eating); published lists of conference participants (e.g., from conferences sponsored by ANAD, St. Paul’s Hospital Eating Disorders Program); listserves (e.g., B.C. Association of Clinical Counsellors); and an author search for UBC dissertations and theses on the topic of EDs.

Delphi studies use purposive sampling to obtain a diverse panel of experts, which helps ensure that a variety of opinions on the topic will be represented. In this study, quotas for participant recruitment, based on a number of dimensions thought to be relevant, were established prior to commencing the recruitment process. The intent was
not to adhere to the quotas rigidly, but rather to use them as guidelines to help ensure a reasonable degree of diversity among the 30 participants selected. The quotas were developed taking into consideration the following three dimensions and associated assumptions:

1) Profession: Matching the proportions of the various professions represented in the sample to the estimated proportions of various professions working in ED programs and private practice in B.C. was judged to be a defensible manner of selecting a number of participants from each profession. Thus, the composition of tertiary care treatment teams for EDs and the estimated number of counsellors providing services to clients with EDs in B.C. (approximately 50, Eating Disorder Resource Centre of B.C. [2003]) were utilized as a basis for this dimension;

2) Setting: experts were found working in tertiary care and community ED programs, but also in private practice;

3) Geographical Location: experts were found in both rural and urban communities, but a greater proportion would be found in urban settings (based on population distribution and the fact that all tertiary care facilities are located in Vancouver).

Recruitment was undertaken via two means (see Appendices B and C for the letters and advertisements used). Letters of introduction about the project were sent to 292 individuals. Twenty-two letters were returned as undeliverable. An advertisement was also sent out on the B.C. Association of Clinical Counsellors (BCACC) listserve. A toll-free number was set up to facilitate the responses of prospective participants who
lived outside of Vancouver’s Lower Mainland. Over a period of 6 weeks, 55 individuals offered to participate in the study. In some cases, follow-up questions were asked of these respondents in order to clarify their eligibility (e.g., "In what setting/area of practice did you complete your practicum/internship?"). As a result, 53 respondents met the inclusion/expert criteria. At the beginning of the recruitment process, participants were selected on a "first-come, first served" basis, provided they met the expert criteria. Occasionally, decisions were made to include more individuals in a category than originally planned, based on trends in respondents (e.g., when it became clear that no Family and Youth Workers were responding, two more counsellors were added). As the recruitment process drew to a close, the last 3 participants were selected in order to increase the representation of individuals who worked in rural areas. The list of 30 participants selected represented a relatively diverse group of individuals working in the treatment of EDs in B.C. The recruitment quotas are presented in Table 1 along with the actual numbers and percentages of selected participants represented by each guideline.
Table 1

*Recruitment Quotas and Number of Participants Selected*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Guideline</th>
<th>Quota</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td><strong>Familiarity with psychotherapy for EDs</strong></td>
<td>Provides/provided psychotherapy</td>
<td>20</td>
<td>66.7</td>
</tr>
<tr>
<td></td>
<td>Does/did not provide psychotherapy</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>30</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Private practice</td>
<td>15</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td>ED treatment centre</td>
<td>15</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td>Both private practice &amp; ED treatment centre</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>University</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>30</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Community size</strong></td>
<td>Rural</td>
<td>13</td>
<td>43.3</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>17</td>
<td>56.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>30</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Profession</strong></td>
<td>Psychiatry</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Clinical psychology</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Social work</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>Counselling psychology</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Family &amp; youth worker</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Nursing</td>
<td>3</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Medicine</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Dietetics</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Other (e.g., admin, rec therapist, occupational therapist, professor, etc.)</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>30</td>
<td>100.1</td>
</tr>
</tbody>
</table>

54
High participant motivation is thought to be essential to a successful Delphi study due to the amount of time spent responding to potentially long and complicated questionnaires (Beretta, 1996). Therefore, participants were offered an incentive of a $15.00 gift certificate to a major book retailer for each of the three questionnaires completed (for a total of $45.00). These certificates could be redeemed at a retail outlet or online. This was felt to be a minimal but reasonable incentive to secure and maintain the participation of experts in the EDs field who were potentially very busy individuals.

Researcher Bias

Whether Delphi is a qualitative, quantitative, or mixed method, it cannot be said that the researcher’s agenda is completely absent. The current research topic arose from my desire to determine my own competence as a counsellor who wishes to provide services to clients with EDs. While conducting this research, I consistently and conscientiously challenged myself to maintain an awareness of, and minimize, my biases. This was of particular importance during the panel selection and the selection of items used on the first questionnaire. Towards the end of the recruitment process, when I began selecting participants more purposefully to increase the representation of participants from rural areas, I tried to be cognizant of whom I was tempted to select or not select. Obviously, alternative views could not be presented if those holding different opinions were not included. Therefore, the setting of participant quotas prior commencing recruitment and the selection of participants on a “first come, first served” basis at the beginning of the process were attempts to minimize this potential problem. Only the last 3 participants were chosen more purposefully in an attempt to boost the number of participants from rural areas.
As a further precaution, I have attempted to explicitly acknowledge my biases, including the cognitive processes (e.g., expectations, assumptions) and aspects of lived experience that may have influenced my understanding of the phenomenon I investigated (Elliot, Fischer, & Rennie, 1999; Stiles, 1993). Below, I have discussed my role in the present study using the framework of Guba and Lincoln’s (1994) basic beliefs of alternate inquiry paradigms.

Philosophically, I align myself with the constructivist worldview and am inspired by the contributions of critical theory, particularly feminist theory. I ascribe to the idea of a “reality” underlying all phenomena; however, I believe that this reality is individually construed and constructed through emotion, cognition and behaviour. Moreover, consistent with both constructivism and critical theory, I believe that this reality is changeable and socially constructed. My epistemological stance is aligned with critical theory in terms of my beliefs in the value-mediated, interactive linking of researcher and “other,” which, as noted by Guba and Lincoln, influences what, in fact, can be known about any given phenomenon (hence the “fusion” of ontology and epistemology). My methodological preferences typically lean toward a reflexivity between researcher and researched, and the inclusion of participant “voice,” although I would agree that participant voice was not a focus of this study despite there being some opportunity for participants to provide brief comments. Indeed, participant “voice” was represented mainly through the provision of their opinions via numerical ratings.

Rather than seeking “the truth” about competence in EDs counselling, the research aimed to establish a preliminary consensus on the issue by identifying those areas of competence for EDs counselling that current experts in the field could agree on.
(Mamalakis, 2000). There may be future opportunities to validate the results of the research, or perhaps organize it further in some way (Linstone and Turoff, 1975).

Finally, my interest in the topic of EDs counselling competence arises both from my own experience, more than a decade ago, of having been a client who sought counselling while recovering from an ED and from my more recent professional interest in developing a counselling specialization in disordered eating issues. When I proposed this study in November of 2003, my assumptions regarding the competence for working with clients who have EDs were as follows: (1) the counsellor should understand the extant etiological models of EDs; (2) the counsellor should incorporate empirically validated treatments into his/her primary orientation; (3) the counsellor should be aware of his or her judgments, biases and triggers around different body shapes and sizes, and towards different eating problems; (4) the counsellor should have an awareness and analysis of his or her own disordered eating patterns and body image concerns (past or present); (5) the counsellor should maintain a therapeutic stance that views a strong counselling relationship as key to treatment success; (6) the counsellor should have specific training and experience in working with this clientele (clinic, practicum and/or work experience); and, (7) the counsellor should have received supervision from a qualified practitioner with demonstrated competence in EDs issues. By surfacing these preconceptions prior to the beginning of the study, I was attempting to minimize the risk of allowing them to bias the sample selection and inclusion or exclusion of items from the rounds.

As I review these assumptions a year later, I am struck by how little they have changed, except that I would now amend point (2) to read: the counsellor should strive to
incorporate empirically informed interventions into therapy for clients with EDs. I believe this change has resulted from my practicum and supervision experiences at B.C. Children’s Hospital Eating Disorder Program and the development of what I think is a more nuanced understanding of the complex debate around empirically supported therapies (ESTs). To illustrate, I used to think that counsellors were being potentially unethical if they did not provide ESTs for EDs (e.g., CBT or IPT for BN). However, my experiences over the last year of counselling adolescent girls who have EDs have prompted me to think more flexibly about what interventions might or might not be effective with various clients.

Procedure

Round 1

The Round 1 questionnaire packets were sent to the 30 participants selected. These packets contained: a simple cover sheet with general instructions, 3 participation consent forms (two consent forms to participate in the study [Appendix D], one that was attached to the questionnaire [see Appendix E]), Questionnaire 1, and a pre-addressed stamped return envelope (see Appendix F for Round 1 materials). Participants were asked to complete the demographics section of the questionnaire and then rate each potential competency item using the scale where 3 equals “essential,” 2 equals “useful but not essential,” and “1 equals not necessary.” In the instructions, it was stated that the items pertained specifically to individual psychotherapy with clients who have EDs. As a “no response” option is considered essential because it may help reduce the likelihood of an artificial consensus (M. Turoff, personal communication, July 19, 1998, cited in Cabaniss, 2001), participants were given the option of circling “Don’t Know” in the
event that they were unfamiliar with or unclear about an item, or if they had no opinion. They were also provided space to write a very brief comment about any item, although comments were not required. In the final section of Questionnaire 1, participants were invited to provide up to 10 additional competency items that they thought were essential but that they perceived had not been represented in the list of 187 items. They were requested to construct the items to be as succinct and specific as possible.

Participants were asked to complete and return the questionnaire and one consent for participation form within 2.5 weeks (they were to keep the other consent form for their own records). The due date permitted several participants who were going on holidays at the end of the summer to have adequate time to complete the questionnaire. Reminder postcards were mailed out approximately 2 weeks after the initial packet (see Appendix G). Twenty-nine completed questionnaires and consent forms were returned. Two weeks after the due date for Questionnaire 1, one participant informed me that they wished to drop out of the study.

The data from Questionnaire 1 (demographics and competency items) were entered into SPSS. Group means, standard deviations and medians were calculated for each competency item. In addition, frequency tables were produced in order to determine which items had achieved an 85% or greater level of agreement (i.e., consensus). Any comments were typed into a word processing document.

Round 2

On Questionnaire 2, a decision was made to include only those items for which consensus had not been reached in Round 1 in addition to the new items that had been generated by participants in Round 1. It is permissible for the researcher to exclude items
for which consensus has been reached from future questionnaires if a level of consensus has been established (Roberts-Davis & Read, 2001). In a Delphi study, the inclusion of an overwhelming number of items can cloud consensus (Hasson et al., 2000); removing consensus items had the distinct advantage of reducing the number of items that participants were required to review and re-rate.

Regarding the literature-derived items for which consensus had not yet been reached, participants were instructed to consider the statistics presented for each item (group mean, SD, and median), and invited to re-rate the items to match the group’s median response (if, in fact, their previous rating was different from the median response). If they decided not to change their rating to the group median, they were requested to provide a brief explanatory comment. In order to avoid artificial consensus, the instructions were worded to minimize the pressure on participants to change their response to the group response or to rate items about which they were unsure (M. Turoff, personal communication, July 19, 1998, cited in Cabaniss, 2001).

Participants had been asked to make their suggested items as succinct and specific as possible. Hasson et al. (2000) have suggested that such items should appear in the wording used by participants so as to reduce the inappropriate intervention of the researcher. They state, “Participants themselves should judge items in terms of quality, not the researchers” (p.1012). Echoing this, Burns, Fiander and Audini (2000) note that the investigator should not edit the participants’ suggestions (except for removing exact duplicates) so that the results reflect the experts’ (not the researchers’) views. Therefore, in this study, the items generated by participants were transferred to Questionnaire 2 either verbatim or edited in a very minor manner so as to complete the sentence stem:
"For basic, independent practice with clients who have eating disorders, the therapist should..." Participants were asked to assign an initial rating to these participant-generated items. They were also asked to note the amount of time they had taken to complete the questionnaire.

Prior to distributing Questionnaire 2, I asked a colleague to review it in order to ensure that the instructions were as simple and clear possible. Several amendments were made based on his feedback. Included in the second questionnaire packet were: a simple cover sheet containing instructions, Questionnaire 2 and its consent form, the first gift certificate in the amount of $15.00, and a list of the items for which consensus had been reached in Round 1. Participants were asked to complete and return Questionnaire 2 within 10 days (see Appendix H for Round 2 materials). Reminder postcards were mailed out approximately 1 week after the questionnaire packet, and again 1 week after the return date (see Appendix I). All 29 questionnaires were completed and returned.

The data from Questionnaire 2 were entered into SPSS. Group means, standard deviations and medians were calculated for each item. Again, frequency tables were produced in order to determine which items had achieved an 85% or greater level of agreement (i.e., consensus). Comments were typed into a word processing document.

**Round 3**

In consultation with my supervisor, I made the decision to include on Questionnaire 3 only those items that had been generated by participants for which consensus had not been reached (rather than also including any remaining literature-derived items for which consensus had not been reached after 2 rounds). This decision was made for two reasons. The first was that I was concerned about sample fatigue and
its effects on the response rate, based on the length of the first two questionnaires and on receipt of some comments (which could be described as "terse") that had appeared in Round 2 about the re-rating of items. I had also noted that a few participants (n = 5) had taken more than 1 hour to fill out Questionnaire 2, and I was concerned about the ethics of participants devoting more than 60 minutes to the task when they had committed to completing questionnaires that I had stated should take no more than 1 hour to complete. As an important aspect of a Delphi study's validity is a consistently strong response rate across all rounds, I reasoned that reducing the length of Questionnaire 3 would facilitate a strong response in Round 3. The second reason for the decision was that it permitted an equal number of rounds (and therefore an equal opportunity for consensus-building) for each of the two item types: literature-derived and participant-generated.

Therefore, on Questionnaire 3, participants were instructed to consider the statistics presented for each participant-generated item (group mean, SD, and median), and invited to re-rate these items to match the group's median response (if, in fact, their previous rating was different from the median response). If they decided not to change their rating to the group median, they were requested to provide a brief explanatory comment. Participants were also asked to comment on whether and how participating in the study had led them to reflect on their own practice(s) with clients/patients who had EDs.

Included in the third questionnaire packet were: a simple cover sheet containing instructions, Questionnaire 3 and its consent form, the second gift certificate in the amount of $15.00, and a list of the participant-generated items for which consensus had been reached in Round 2. Participants were asked to complete and return Questionnaire
3 within 10 days (see Appendix J for Round 3 materials). Reminder postcards were mailed out approximately 1 week after the questionnaire packet, and again 1 week after the return date (Appendix K). In this last round, 29 questionnaires were completed and returned.

The data from Questionnaire 3 were entered into SPSS. Group means, standard deviations and medians were calculated for each item. Again, frequency tables were produced in order to determine which items had achieved an 85% or greater level of agreement (i.e., consensus). Comments were typed into a word processing document.

Following receipt of their completed Questionnaire 3, participants were sent a letter thanking them for their participation in the study along with their third and final gift certificate for $15.00.

**Data Analysis**

In this study, as per Delphi methodology, analysis of the data was completed throughout the data collection period (i.e., means, standard deviations, medians, and levels of agreement were calculated after each round as a necessary precursors to commencing the next round). However, it was important to consider the types of item statistics presented to the participants because this information allowed them to judge where their response stood in relation to the larger group response (Hasson et al., 2000).

Gordon (1994) has suggested that the median is preferable to the mean for reporting group responses for feedback. The median represents the mid-point of the response distribution and divides the distribution into two equal parts if the distribution is a normal bell curve. When the distribution of responses is skewed toward the high or low
ends of a scale (as is common in Delphi studies, and was certainly evident in the present study), the median is often close to the highest or lowest possible score.

The dispersion of the responses (or “spread”) can be represented by the interquartile range (IQR), which contains the middle 50% of the individual responses. The IQR indicates the degree to which panelists have reached a consensus on an item by providing information about the range of scores that lie in the middle 50% of the cases and provides information about the variability in the data without being affected by extreme scores (Fish & Busby, 1996). It should be noted that most of the recent Delphi studies on competencies that were reviewed for this proposal used the mean and standard deviation (e.g., Lopez & Rogers, 2001; Rogers & Lopez, 2002; Scheffler & Logan, 1999; Thielson & Leahy, 2001; Wakou, Keim, & Williams, 2003), although no rationale for doing so was provided.

In this study, the median, mean, and standard deviation were presented to the panelists for several reasons. First, the median was felt to be a requirement because asking participants to re-rate an item to match a mean (e.g., of 2.89) could not be captured on the Likert-scale employed in the study, which contained only whole numbers (1, 2, or 3). Secondly, the IQR did not seem to provide particularly useful information about the dispersion of group ratings when the rating scale had only three points. The standard deviation was chosen because, with a 3-point scale, it seemed to provide a more sensitive measure of variation in the ratings than the IQR. Thirdly, the mean was calculated and presented for each item in order to contextualize the standard deviation. The presentation of the mean has also been identified as useful because it permits a more useful ranking of items than the median, which could be helpful information for
participants. Arguably, the use of the mean and standard deviation in the study could be seen as problematic because they may be misleading when used with nominal or ordinal data (A. Hubley, class lecture, September 10, 2003). However, Greatorex and Dexter (2000) state that the rating scale used in a Delphi study can be assumed to be an interval scale. In this study, given the alternatives, the item statistics selected seemed to be the best choice for use with the scale employed.
Chapter 4 – Results

In this chapter, I will present the results of the investigation, which aimed to identify the essential competencies for basic, independent therapeutic practice with clients who have EDs. The chapter is divided into three major sections: (a) results of a descriptive analysis of the participants (panel of experts); (b) results pertaining to the consensus process of the questionnaire rounds; and (c) presentation of the consensus items and non-consensus items.

Overview

The intent of the study was to generate a consensus of expert opinion about the competencies that are essential for basic, independent therapeutic practice with clients who have EDs. To this end, a panel of experts from the EDs treatment field in British Columbia participated in a three-round Delphi study. Thirty experts from a variety of professions were selected to participate in the study and 29 of these completed all three Delphi rounds. The study took place in three phases: (1) Questionnaire 1 asked panelists to (a) provide demographic information, (b) rate potential competency items (drawn from the EDs literature) on the basis of whether they were essential for basic, independent therapeutic practice with clients who have EDs (the focus was on individual therapy), and (c) generate new items not represented on this initial list; (2) Questionnaire 2 asked panelists to (a) take into consideration group statistical information for each item and then re-rate items from Round 1 for which consensus (defined as 85% agreement among participants about the rating of an item) had not been reached, and (b) rate the new items generated by participants in Round 1; (3) Questionnaire 3 asked participants to (a) take into consideration group statistical information for each item and then re-rate any
participant-generated items for which consensus had not been reached in Round 2, and (b) provide general comments about their participation in the project. An analysis of these results is presented in the following sections of this chapter.

Response Rates

In a Delphi study, the validity of results is affected by the response rates for each round (Hasson et al., 2000). In this study, the response rate remained very strong across all rounds. The initial questionnaire packet was mailed to 30 participants. Of these, 29 completed Questionnaire 1 (96.7%), 29 completed Questionnaire 2 (100%), and 29 (100%) completed Questionnaire 3. Thus, 96.7% of the participants who initially agreed to participate in the study completed all three rounds.

Panel of Experts

The selection of an appropriate panel helps to ensure a credible outcome for a Delphi study (Dalkey, 1969). One aim of the selection process was to choose a panel of experts that represented as much diversity as possible (Delbecq et al., 1975; Mamalakis, 2000; Powell, 2002). Therefore, considerable detail will be provided concerning the demographics of the panelists who participated in the present study. As is typical when reporting the results of a Delphi study, demographic analysis was completed on the group of participants who completed all questionnaire rounds (29 participants).

Expert Criteria

The numbers and percentages of participants who met the various expert criteria are presented in Table 2.
Table 2

*Numbers and Percentages of Expert Criteria Met by Participants*

<table>
<thead>
<tr>
<th>Criterion</th>
<th>N</th>
<th>% of panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had practiced in EDs treatment for at least 5 years and completed a practicum and/or internship in a related area</td>
<td>26</td>
<td>89.7</td>
</tr>
<tr>
<td>Had supervised therapist-in-training in an EDs treatment setting</td>
<td>17</td>
<td>58.6</td>
</tr>
<tr>
<td>Had published scholarly work on the topic of EDs treatment ethics, and/or professional competence between 1995 and 2003 (first, second or third author)</td>
<td>9</td>
<td>31.0</td>
</tr>
<tr>
<td>Had taught about EDs treatment at the graduate level</td>
<td>10</td>
<td>34.5</td>
</tr>
<tr>
<td>Had presented at least one refereed national conference presentation on EDs treatment, ethics, and/or professional competence</td>
<td>16</td>
<td>55.2</td>
</tr>
</tbody>
</table>

Although participants were required to meet just one of the five expert criteria to be eligible for the study, many participants met more than one. The numbers and percentages of participants who met one criterion, two, three, four, or all five criteria are presented in Table 3.
Table 3

Number Out of Five Criteria Met by Participants

<table>
<thead>
<tr>
<th>Number of Criteria Met</th>
<th>N</th>
<th>% of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>One out of five</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Two out of five</td>
<td>11</td>
<td>37.9</td>
</tr>
<tr>
<td>Three out of five</td>
<td>7</td>
<td>24.1</td>
</tr>
<tr>
<td>Four out of five</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Five out of five</td>
<td>3</td>
<td>10.3</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>99.9</td>
</tr>
</tbody>
</table>

Thus, 86.2% of the panel exceeded the minimum inclusion criteria for the study by meeting two or more of the expert criteria.

Sex, Ethnicity, and Level of Education

The panel that completed all three rounds was comprised of 25 (86.2%) females and 4 (13.8%) males. In terms of ethnicity, the majority (89.7%) described themselves as Caucasian/European, followed by Asian (6.9%), and Jewish (3.4%).

With respect to highest level of education attained, 31.0% had completed a PhD, MD or equivalent doctoral degree, 51.7% had completed a master’s degree, 13.8% had completed a bachelor’s degree, and 3.4% had completed a diploma program. Participants whose highest level of education consisted of either a bachelor’s degree or a diploma program were dietitians (n=2) or nurses (n=3). All other participants (82.8%) possessed at least a master’s degree.
Panel members described themselves as being from the following professional groups: counsellors (31.0%), counselling psychologists (13.8%), nurses (RNs or RPNs) (13.8%), social workers (10.3%) clinical psychologists (6.9%), dietitians (6.9%), physicians (6.9%), psychiatrists (3.4%), recreational therapists (3.4%), and professors (3.4%). At least two panelists other than the professor held associate faculty positions at a university. The numbers and percentages of participants’ professional affiliations are presented in Table 4.

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>9</td>
<td>31.0</td>
</tr>
<tr>
<td>Counselling Psychology</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Nursing</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Social Work</td>
<td>3</td>
<td>10.3</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>2</td>
<td>6.9</td>
</tr>
<tr>
<td>Dietetics</td>
<td>2</td>
<td>6.9</td>
</tr>
<tr>
<td>Medicine</td>
<td>2</td>
<td>6.9</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Recreation Therapy</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Professor</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29</td>
<td>99.8</td>
</tr>
</tbody>
</table>
With respect to work context, 37.9% worked in an EDs program, 31.0% worked in private practice, 20.7% worked in both an EDs program and private practice, 6.9% worked in a university setting, and 3.4% worked in a government setting.

Geographically speaking, 20.7% of the panel worked in a community with a population of 100,000 or less (defined as a “rural” community in this study) and 79.3% worked in a community with a population of 100,001 or more (defined as “urban”).

*Years of Experience in the Treatment of EDs*

The years of experience participants had working in the EDs field ranged from 5 to 25 years and averaged 11.8 years ($SD = 5.62; Mdn = 10.0$). Table 5 presents participants’ years of experience in numbers and percentages, by five-year increments.

**Table 5**

*Participants’ Years of Experience in the Treatment of EDs*

<table>
<thead>
<tr>
<th>Years</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>12</td>
<td>41.4</td>
</tr>
<tr>
<td>10-14</td>
<td>12</td>
<td>41.4</td>
</tr>
<tr>
<td>15-19</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>20-24</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>25</td>
<td>3</td>
<td>10.3</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>99.9</td>
</tr>
</tbody>
</table>

*Provision of Therapy and Orientation/Approach*

When asked if they provided psychotherapy as part of their work in the treatment of EDs, 24 (82.8%) of the participants indicated that they did. In addition, 28 out of 29
panel members (96.6%) reported using a primary approach or theory that oriented their work. These primary approaches/orientations are detailed in Table 6.

Table 6

*Primary Approach/Orientation of Participants to EDs Treatment*

<table>
<thead>
<tr>
<th>Approach/Orientation</th>
<th>Provides Psychotherapy</th>
<th>Does not Provide Psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% of panel</td>
</tr>
<tr>
<td>Integrated/eclectic</td>
<td>8</td>
<td>27.6</td>
</tr>
<tr>
<td>Readiness &amp; motivation/motivational enhancement</td>
<td>4</td>
<td>13.8</td>
</tr>
<tr>
<td>Person/client-centred/Rogerian</td>
<td>2</td>
<td>6.9</td>
</tr>
<tr>
<td>Cognitive-behavioural/CBT</td>
<td>3</td>
<td>10.3</td>
</tr>
<tr>
<td>Behavioural/behaviour change</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bio-psycho-social-spiritual</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Constructivist</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Contemplative</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Insight-oriented</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Family systems</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Medical</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Narrative</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>Did not identify an approach/orientation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>82.8</td>
</tr>
</tbody>
</table>

The 8 participants who reported that they provided therapy and who described their approach/orientation as "integrated" or "eclectic" identified a wide range of theories
and approaches that informed their work. Five of these participants reported that they used 2 approaches, 2 participants reported drawing from 4 different approaches, and 1 participant reported drawing from 7 different approaches.

The approaches mentioned by these 8 participants were: CBT (4 mentions), client/person centred (3 mentions), psychodynamic (4 mentions), Jungian (2 mentions), narrative (2 mentions), family systems (1 mention), transpersonal/spiritual (1 mention), dance/drama therapy (1 mention), cognitive self-regulation (1 mention), interpersonal (1 mention), relational (1 mention), solution-focused (1 mention), psycho-synthesis (1 mention), bioenergetic (1 mention) and dialectical behaviour therapy (DBT) (1 mention). The one participant who indicated an eclectic/integrated approach but who did not deliver psychotherapy as part of their work with ED clients indicated that they used CBT and readiness and motivation/motivational enhancement principles.

Questionnaire Results

In a Delphi study, the results typically focus on the last round of data collected because this represents the most advanced point in the consensus process (e.g., Cabaniss, 2001). However, round-by-round information can also be presented in order to illustrate the movement of the consensus process itself. In this study, consensus was defined as an 85% level of agreement or higher about an item’s rating. Therefore, there could be consensus that an item was “essential,” “useful but not essential,” or “not necessary.” While the question being investigated in this study focused on the identification of the “essential” items, I will also present the items that reached consensus as being “useful but not essential” and the items that did not reach consensus because they provide useful collateral information.
Consensus Process Results

After Round 1, there was consensus that 78 of the 187 literature-derived items on Questionnaire 1 were “essential” for basic, independent therapeutic practice with individuals who have EDs. In this round, no items reached consensus as being “useful but not essential” or “not necessary.”

After Round 1, one item was removed from the participant-generated items because it duplicated another participant-generated item that referred to distress tolerance. Three additional participant-generated items were removed because they referred specifically to skills-based competencies used in family therapy (the focus of the questionnaires had been stated to be individual therapy). The items were: (1) “In family therapy, be comfortable not letting the patient hold the others hostage by threats, particularly that of telling them they can’t participate;” (2) “In family therapy, be comfortable discussing how and why you won’t hold secrets of [a] family member;” and (3) Assess and work with parents’ inability to tolerate painful affect.”

After Round 2, consensus had been reached on an additional 112 items, bringing the total number of consensus items after Round 2 to 190. Of the 112 Round 2 consensus items, 88 were from the original 187 literature-derived items and 24 were from the 51 (55 minus duplicate and family therapy items) items generated by participants. Of the 112 items, 95 were thought to be “essential” (71 literature-derived and 24 participant-generated) and 17 “useful but not essential” (17 literature-derived). Again, no items achieved consensus as being “not necessary.”

As described fully in the Procedure section, on the Round 3 questionnaire, I made the decision to include only those participant-generated items for which consensus had
not yet been reached. After Round 3, consensus had been reached on another 19 of the participant-generated items (15 “essential” and 4 “useful but not essential”), bringing the total number of consensus items after three rounds to 209. Of these 209 items, 188 items were deemed “essential,” and 21 were thought to be “useful but not essential.” After three rounds, no items had been determined to be “not necessary” by the panel. Consensus was not achieved for 29 items. For a complete table of items, see Appendix L.

In summary, consensus was reached on 209 of the 238 total items (total items does not include the 4 items removed, as noted above) that appeared on the questionnaires. A summary of the number of items for which consensus was reached by round is presented in Table 7.

Table 7

<table>
<thead>
<tr>
<th>Item Status</th>
<th>Round 1 LD</th>
<th>Round 1 PG</th>
<th>Round 2 LD</th>
<th>Round 2 PG</th>
<th>Round 3 LD</th>
<th>Round 3 PG</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Essential”</td>
<td>78</td>
<td>-</td>
<td>71</td>
<td>24</td>
<td>-</td>
<td>15</td>
<td>188</td>
</tr>
<tr>
<td>“Useful but not Essential”</td>
<td>-</td>
<td>-</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>“Not Useful”</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>112</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cumulative Total

| Cumulative Total | 78 | 190 | 209 |

Note. LD = Literature-Derived. PG = Participant-Generated.
Consensus and Non-Consensus Items

The task of the panel was to move toward a consensus regarding the competencies that were thought to be essential for basic, independent, therapeutic practice with individuals who have EDs. Using a scale where 3 equals "essential," 2 equals "useful but not essential," and 1 equals "not necessary (DK equals "Don’t Know"), participants assigned all 238 items an initial rating. Subsequently, the items for which consensus was not reached were re-rated. The following two sub-sections present the results of the consensus process in terms of the items that were considered to be "Essential" or "Useful But Not Essential" for basic, independent therapeutic practice with individuals who have EDs. The third sub-section presents the list of competencies for which consensus was not reached.

In order to facilitate a more organized presentation of these items (particularly the list of "essential" items, which is extensive), the items have been ordered according to a categorization scheme of potential competency areas. I was not able to find in either the guidelines for EDs treatment or the other competence literature a useful categorization scheme to help me organize the items. Therefore, using an inductive categorization process, I developed the present scheme by expanding the on the content areas (i.e., specialized knowledge base, specialized skills, and therapist characteristics) used on the study’s questionnaires. It should be emphasized that the categories are provided simply to organize the results coherently; they should not in any way be considered definitive or representative of the participants’ opinions.
"Essential" Competency Items

Table 8 and Table 9 present the 188 items for which there was a consensus on their being "essential" for basic, independent practice with clients who have EDs. For these items, panelists reached an 85% level of agreement or greater that the rating was "3."

Table 8 presents the 102 "essential" items for which consensus was reached after their first rating. For literature-derived items, this was in Round 1; for participant-generated items, this was in Round 2. Table 9 presents the 86 "essential" items for which consensus was reached after a second rating. For literature-derived items, this was in Round 2; for participant-generated items, this was in Round 3. The items have been organized into the following five categories: Specialized Knowledge Base, Specialized Skills, Professional Responsibility, Therapist Characteristics, and Other. Most of the categories contain sub-categories (e.g., Assessment, Treatment Planning, etc.) as a further organizational aid. The table also contains data indicating the number of rounds that were required for the item to reach consensus, the number of participants who provided an opinion on the item in the consensus round (valid n), and the source of the item (EDs literature or a participant). On each table, the items are ordered within the sub-categories such that the literature-derived items appear first, followed by the participant-generated items.
Table 8

"Essential" Items: Consensus After First Rating

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Number of Rounds to Reach Consensus</th>
<th>N</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specialized Knowledge Base</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For basic, independent practice with clients who have EDs, the therapist should:</td>
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<td></td>
<td><strong>Definitions, Epidemiology, Etiology, &amp; Organizing Theory</strong></td>
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<tr>
<td>1</td>
<td>8. Have an overall organizing concept of the causes and progression of EDs.</td>
<td>1</td>
<td>28</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Therapeutic Relationship</strong></td>
<td></td>
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<tr>
<td>3</td>
<td>37. Have an understanding of the biopsychosocial experience of an eating disorder because, in order to gain rapport/a therapeutic alliance, the client needs to have a sense of being understood from the inner experience of conflicting feelings, thoughts, behaviours.</td>
<td>1</td>
<td>27</td>
<td>Participant</td>
</tr>
<tr>
<td></td>
<td><strong>Treatment Planning</strong></td>
<td></td>
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<tr>
<td>3</td>
<td>29. Recognize that programs that focus exclusively on abstinence (e.g., 12-step) are not recommended as the sole initial treatment approach.</td>
<td>1</td>
<td>26</td>
<td>APA</td>
</tr>
<tr>
<td>4</td>
<td>35. Recognize that avoiding food issues in therapy is not adequate or ethical</td>
<td>1</td>
<td>28</td>
<td>ABEC SW</td>
</tr>
<tr>
<td>5</td>
<td>12. Acknowledge that many people with EDs are ambivalent about treatment, and recognize the consequent demands and challenges this presents.</td>
<td>1</td>
<td>29</td>
<td>NICE</td>
</tr>
<tr>
<td>6</td>
<td>13. Be knowledgeable about the implications of comorbid disorders.</td>
<td>1</td>
<td>28</td>
<td>Ideal Th.</td>
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<tr>
<td>7</td>
<td>32. Recognize that psychotherapy alone is not sufficient to treat severely malnourished patients with AN.</td>
<td>1</td>
<td>29</td>
<td>APA</td>
</tr>
<tr>
<td>8</td>
<td>15. Demonstrate knowledge of range of treatment programs/resources relevant to client needs.</td>
<td>1</td>
<td>29</td>
<td>ABEC SW</td>
</tr>
<tr>
<td>9</td>
<td>9. Understand the rationale for sequencing and integrating treatments.</td>
<td>1</td>
<td>29</td>
<td>ABEC SW</td>
</tr>
<tr>
<td>10</td>
<td>35. Be aware of the AN/BN “voice,” what it hears, thinks, sees, filters.</td>
<td>1</td>
<td>29</td>
<td>Participant</td>
</tr>
<tr>
<td>11</td>
<td>34. Realize how truly terrifying changing eating disorder behaviour can be.</td>
<td>1</td>
<td>29</td>
<td>Participant</td>
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<tr>
<td></td>
<td><strong>Knowledge of Other Treatment Components</strong></td>
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<tr>
<td>12</td>
<td>34. Understand the role of nutritional rehabilitation.</td>
<td>1</td>
<td>29</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>13</td>
<td>30. Understand the physiological and psychological consequences of starvation.</td>
<td>1</td>
<td>29</td>
<td>Ideal Th.</td>
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</tbody>
</table>
14 31. Recognize that attempts to conduct formal psychotherapy with starving patients may be ineffective.

15 43. Have knowledge of physical issues related to EDs (e.g., dental, pregnancy, osteoporosis, EDs & diabetes, etc.).

Comorbidity
16 43. Be knowledgeable enough about separate comorbid diagnoses to refer accordingly.

17 1. Have an awareness of substance abuse issues.

Other
18 32. Consider the passive suicidality or longing for death masked by anorexia in some cases.

<table>
<thead>
<tr>
<th>Specialized Skills</th>
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<tbody>
<tr>
<td>Therapeutic Relationship</td>
</tr>
<tr>
<td>19 87. Establish a strong therapeutic alliance characterized by acceptance, honesty, and reassurance throughout the therapeutic process.</td>
</tr>
<tr>
<td>20 88. Build trust, establish mutual respect, and develop a therapeutic relationship with the patient that will serve as the basis for ongoing exploration and treatment of the problems associated with the ED.</td>
</tr>
<tr>
<td>21 89. Monitor the quality of the therapeutic relationship.</td>
</tr>
<tr>
<td>22 92. Be able to discuss frankly with the patient any concerns the patient has in relation to the therapist's weight or shape.</td>
</tr>
<tr>
<td>23 94. Avoid competition with the patient (e.g., concerning body size).</td>
</tr>
<tr>
<td>24 8. Be skilled in building a therapeutic alliance.</td>
</tr>
<tr>
<td>25 9. Be competent in managing, in a genuine and caring way, the challenges that arise in the therapist-client relationship.</td>
</tr>
<tr>
<td>26 29. Have ability to create a space of safety and trust.</td>
</tr>
<tr>
<td>27 10. Provide a therapeutic relationship that will impact on client's self development and other relationships.</td>
</tr>
<tr>
<td>28 45. Be able to discuss frankly with the client any concerns the client has in relation to the therapist’s weight or shape, but only if client expresses this as an issue.</td>
</tr>
<tr>
<td>29 46. If client names it, address competition (e.g., concerning body size) at a level the therapeutic bond can handle.</td>
</tr>
</tbody>
</table>

| Assessment |
| 30 57. Ensure that the client receives an adequate assessment based on face-to-face contact of sufficient duration to gather information about the client's biological, psychological, environmental, and cultural qualities and conditions. |
| 31 55. Utilize bio-psycho-social theories when assessing clients. |
| 32 65. Conduct careful assessment of patient's level of motivation for change. |

| 79 |
67. Accurately assess client’s risk to self.
66. Accurately assess client’s physical risk.
64. Evaluate trauma history in clients presenting with an ED.
72. With children and adolescents, be alert to indicators of abuse throughout treatment.
71. Make clinically responsible diagnoses.
7. Avoid pathologizing and distancing via labelling and/or categorizing
18. Assess client’s ability to tolerate distress and pay attention to this when evoking emotion.

Treatment Planning
73. Apply ED theories creatively and flexibly to develop multiple treatment strategies.
82. Determine whether comorbid disorders should be treated prior to or simultaneously with ED interventions.
10. Consider client risk in treatment planning.
11. Integrate ethical principles and legal requirements (e.g., client autonomy, informed consent) in treatment planning
39. Have, as an aim of psychological treatment, psychological and physical recovery.
40. Have, as an aim of psychological treatment, the reduction of risk to the client.
37. Have, as a general treatment goal, the identification of the relationship between eating and pertinent issues.
38. Have, as a general treatment goal, the client’s mastering of conflicts directly, rather than through the use or avoidance of food.
83. Incorporate comorbidity information when making a decision about medication referral for the client.
109. Consider more intensive forms (or combinations of) of treatment if there is significant deterioration or no significant improvement during psychological treatment.

Treatment Approach & Interventions
76. Discuss the sequencing and integrating of treatments with clients to increase client participation in the therapy plan.
79. Implement treatment interventions based on accurate assessment and evaluation process.
78. Listen to and discuss the patient’s concerns about the proposed treatment in a supportive fashion.
90. Use a collaborative approach (e.g., actively involve client in planning, goal development, etc.) to maximize client participation in the treatment process.
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<tbody>
<tr>
<td>55</td>
<td>160. Take into account both formal and informal feedback from clients (e.g., about intervention strategies, when evaluating clinical efficacy).</td>
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<td>ABECSW</td>
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<tr>
<td>56</td>
<td>96. Adopt a style of empathic engagement versus a forceful approach.</td>
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<td>57</td>
<td>140. Use an approach that addresses problem solving.</td>
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<tr>
<td>58</td>
<td>137. Use an approach that addresses interpersonal conflicts.</td>
<td></td>
<td>1</td>
<td>28</td>
<td>APA</td>
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<tr>
<td>59</td>
<td>139. Use an approach that addresses coping styles.</td>
<td></td>
<td>1</td>
<td>28</td>
<td>APA</td>
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<tr>
<td>60</td>
<td>122. Use psychotherapy to help patients understand how to avoid or minimize risks of relapse.</td>
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<td>APA</td>
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<tr>
<td>61</td>
<td>123. Use psychotherapy to help patients understand how to better deal with salient developmental and other important life issues in the future.</td>
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<td>APA</td>
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<tr>
<td>62</td>
<td>84. Use interventions that incorporate an understanding of comorbid disorders.</td>
<td></td>
<td>1</td>
<td>27</td>
<td>ABECSW, Ideal Th., APA</td>
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<tr>
<td>63</td>
<td>131. Use interventions that incorporate an understanding of the complexity of family relationships.</td>
<td></td>
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<td>28</td>
<td>APA</td>
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<tr>
<td>64</td>
<td>91. Communicate an awareness of the ambivalence about treatment that many clients with EDs experience.</td>
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<td>ABECSW</td>
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<tr>
<td>65</td>
<td>119. Give carers (e.g., family, friends) the opportunity to ask about EDs (e.g., general information, specific risks in involved, best ways to help, etc.).</td>
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<tr>
<td>66</td>
<td>127. Be sensitive to and inquire about how weight and shape concerns are experienced by patients who are minorities from non-Western or other cultural backgrounds, or who are transitioning and assimilating into Western societies.</td>
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<tr>
<td>67</td>
<td>49. Recommend carers seek support for themselves.</td>
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<td>Participant</td>
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<tr>
<td>68</td>
<td>19. Balance evoking emotion with containment.</td>
<td></td>
<td>1</td>
<td>26</td>
<td>Participant</td>
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<tr>
<td>69</td>
<td>28. Have the ability to recognize client’s strengths.</td>
<td></td>
<td>1</td>
<td>29</td>
<td>Participant</td>
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<tr>
<td>70</td>
<td>50. Re: inappropriate treatment modalities, help clients explore options they’re interested in and encourage them to make informed decisions (but it is not the counsellor’s place to make the decision for the client).</td>
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<td>29</td>
<td>Participant</td>
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<tr>
<td>71</td>
<td>31. Be able to address the total lack of self-worth.</td>
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<td>Participant</td>
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<tr>
<td>72</td>
<td>36. Have strategies to deal with the AN/BN “voice,” what it hears, thinks, sees, filters.</td>
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<td>28</td>
<td>Participant</td>
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</tbody>
</table>

**Interdisciplinary Collaboration**

|73 | 150. Collaborate on recommendations/treatment with professionals from other disciplines (e.g., nutritionists, physicians, etc.). |   | 1 | 29 | ABECSW |
|74 | 149. Develop and appropriately make use of a referral base of other specialized health care professionals. |   | 1 | 29 | ABECSW |
|75 | 148. Assemble a team of professionals to provide the best care for clients with EDs. |   | 1 | 29 | ABECSW, Ideal Th. |
|76 | 51. Be aware/careful of client’s “splitting” of health care providers. |   | 1 | 28 | Participant |
### Professional Responsibility

#### Scope of Practice

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
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<tbody>
<tr>
<td>77</td>
<td>162. Practice within the limits of his/her competence.</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>78</td>
<td>54. Recognize boundaries of her/his competence when working with EDs clients.</td>
<td>1</td>
<td>28 ABECBW</td>
</tr>
<tr>
<td>79</td>
<td>168. Possess training and experience commensurate with the severity of the cases seen.</td>
<td>1</td>
<td>28 Ideal Th.</td>
</tr>
<tr>
<td>80</td>
<td>173. Monitor own practice and identify own strengths and limitations and address same.</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>81</td>
<td>163. Monitor own practice, identify own problem areas, and initiate intervention strategies, including referral, when indicated.</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>82</td>
<td>44. Know when and how to refer to a physician for medical intervention.</td>
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<td>29 Ideal Th.</td>
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#### Informed Consent

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<tbody>
<tr>
<td>83</td>
<td>75. Provide clients with information regarding treatment choice.</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>84</td>
<td>77. Provide clients with a rationale for level and type of care.</td>
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<td>29 ABECBW</td>
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#### Ethical Dilemmas

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<tbody>
<tr>
<td>85</td>
<td>164. Effectively resolve ethical dilemmas (e.g., in assessment, diagnosis and/or treatment).</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>86</td>
<td>165. Evaluate resolution of ethical dilemmas to see if they adhere to generally accepted professional values.</td>
<td>1</td>
<td>29 ABECBW</td>
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#### Supervision & Consultation

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<tbody>
<tr>
<td>87</td>
<td>172. Understand own knowledge deficits and seek out appropriate regular supervision/consultation with more experienced practitioners.</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>88</td>
<td>179. Seek consultation in difficult cases in order to decrease client risk.</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>89</td>
<td>161. Actively evaluate and process transference/countertransference issues as they arise (e.g., via supervisor or consultant).</td>
<td>1</td>
<td>28 ABECBW, APA, Ideal Th.</td>
</tr>
<tr>
<td>90</td>
<td>178. If a beginning practitioner, receive supervision from an experienced practitioner in the area of EDs who is a member of a professional EDs organization.</td>
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<td>28 ABECBW</td>
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#### Continuing Education

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<tbody>
<tr>
<td>91</td>
<td>174. Accept responsibility for updating clinical skills and seek training where learning is needed to stay current in field.</td>
<td>1</td>
<td>29 ABECBW</td>
</tr>
<tr>
<td>92</td>
<td>175. Actively pursue continuing education to keep abreast of the literature, latest developments, and knowledge in the EDs field.</td>
<td>1</td>
<td>28 ABECBW</td>
</tr>
<tr>
<td>93</td>
<td>177. If an advanced practitioner, take responsibility for his/her own professional development (e.g., updating clinical skills, seeking training), and seek consultation and supervision as needed.</td>
<td>1</td>
<td>28 ABECBW</td>
</tr>
</tbody>
</table>
94 176. Continuously integrate current knowledge in field into clinical practice.

Integrity in Relationships
95 53. Understand the boundaries of psychotherapy
96 187. Accurately represent level of competence, education, training and experience.

Therapist Characteristics

Self-Awareness
97 185. Have sufficient professional sense of self (e.g., concerning his/her own food, eating, and body attitudes, as well as other personal issues), to avoid projection of personal & cultural issues interfering with assessment, diagnosis, treatment planning and intervention process.
98 5. Have awareness of personal assumptions re: body shape to avoid countertransference or collusion with client.
99 15. Have addressed one's own issues food/body to a high level of resolution.

Other Personal Qualities
100 184. Not be personally experiencing active ED symptoms.
101 182. Not be frustrated easily by the long-range nature of EDs.
102 183. Have high self-nurturance.

Table 9

"Essential" Items: Consensus After Second Rating

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Number of Rounds to Reach Consensus</th>
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<th>Source</th>
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<tbody>
<tr>
<td></td>
<td><strong>Specialized Knowledge Base</strong></td>
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<td></td>
<td><em>For basic, independent practice with clients who have EDs, the therapist should:</em></td>
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<td></td>
<td><strong>Definitions, Epidemiology, Etiology, &amp; Organizing Theory</strong></td>
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<tr>
<td>103</td>
<td>1. Know the diagnostic criteria for AN, BN and EDNOS.</td>
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<td>27</td>
<td>APA</td>
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<tr>
<td>104</td>
<td>54. Know the outcome statistics regarding recovery vs. partial/ incomplete recovery vs. chronicity, and how this is evaluated.</td>
<td>2</td>
<td>28</td>
<td>Participant</td>
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<tr>
<td></td>
<td><strong>Assessment</strong></td>
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<tr>
<td>105</td>
<td>5. Recognize that, when doing assessment, theories other than bio-psycho-social are incomplete.</td>
<td>2</td>
<td>27</td>
<td>ABECSW</td>
</tr>
<tr>
<td>106</td>
<td>4. Keep up with changes in diagnostic assessment.</td>
<td>2</td>
<td>29</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>107</td>
<td>6. View assessment as a process that takes place over several sessions.</td>
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<td>29</td>
<td>ABECSW</td>
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<tr>
<td>108</td>
<td>7. View assessment as a process that focuses on gathering specific information (e.g., current weight, weight history, and degree of body image disturbance, weight control measures).</td>
<td>2</td>
<td>29</td>
<td>ABECSW</td>
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<tr>
<td>109</td>
<td>14. Know how to rate EDs and comorbid symptoms qualitatively.</td>
<td>2</td>
<td>28</td>
<td>Ideal Th.</td>
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<td></td>
<td><strong>Treatment Planning</strong></td>
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<tr>
<td>110</td>
<td>141. With clients who have AN, be prepared to provide ongoing treatment with individual psychotherapeutic interventions for at least one year and perhaps up to 5-6 years.</td>
<td>2</td>
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<td>APA</td>
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<tr>
<td>111</td>
<td>12. Have knowledge of effective bridging between inpatient and outpatient services.</td>
<td>2</td>
<td>29</td>
<td>Participant</td>
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<tr>
<td></td>
<td><strong>Treatment Approaches and Interventions</strong></td>
<td></td>
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<tr>
<td>112</td>
<td>24. Recognize that psychoeducation alone can help clients with mild symptoms.</td>
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<td>28</td>
<td>ABECSW</td>
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<tr>
<td>113</td>
<td>17. Be knowledgeable about evidence-based therapies for EDs treatment.</td>
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<td>APA</td>
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<tr>
<td>114</td>
<td>21. Have knowledge of other clinically useful treatment modalities (e.g., self-help, feminist therapies, body image therapy, dialectical behaviour therapy, 12-step approaches).</td>
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<td>ABECSW</td>
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<tr>
<td>115</td>
<td>25. Be aware of self-help resources.</td>
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<td>ABECSW</td>
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<tr>
<td>116</td>
<td>20. Be knowledgeable about behavioural techniques (e.g., planned meals, self-monitoring).</td>
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<td>APA</td>
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</table>
26. Recognize that support groups may be helpful adjuncts to treatment.

45. Consider family therapy as an important adjunct to individual therapy with adult clients, especially when family conflicts are a major issue and when individuation/autonomy issues are still clinically relevant.

28. Recognize that support groups are not recommended as the sole initial treatment.

46. Be aware of both the benefits and drawbacks of group therapy.

Knowledge of Other Treatment Components

33. Have basic knowledge of nutritional principles in order to reinforce them in therapy.

42. Understand the role of medications in treatment.

Special Populations

49. Be knowledgeable about issues related to age and EDs (e.g., age of onset, EDs and the elderly).

48. Be knowledgeable about issues specific to EDs in athletes.

47. Be knowledgeable about issues specific to males with EDs.

Socio-Cultural Factors

50. Be knowledgeable about cultural factors concerning weight and shape.

51. Have an understanding of culture-bounded disorders and sociocultural norms (e.g., gender-specific pressure for thinness and shape change, differences within different demographic, ethnic, and racial groups, and within sexual orientations).

Other

27. Understand patience is a virtue generally but not always (i.e., weight gain needs to happen. All talk and no gain needs to be addressed.)

30. Recognize the sense of “difference”/”specialness” these clients often feel and the high degree of “intuition” that this may signal, and help them “ground”.

Specialized Skills

Assessment

62. With younger clients, assess dynamic issues of lack of autonomy, incomplete individuation, and failure to tolerate painful affect.

56. Use a multimodal assessment process (e.g., client/family/ peripheral sources).

63. With older clients, assess issues of living independently.

60. In assessment, identify appropriate candidates for a given approach and format (e.g., individual vs. group therapy).
134 59. Include, in assessment, an examination of psychodynamic factors which may be the underlying cause, or sustaining factors, of the ED.

135 61. Include family psychiatric history in assessment.

136 85. Master the integration of assessment and differential diagnostic skills relevant to EDs field.

137 80. Be able to accurately diagnose separate comorbid diagnoses.

138 81. Be able to determine whether comorbidities are preexisting or secondary to ED symptomology.

139 69. Screen for dangerous, but not always evident, medical problems associated with EDs.

**Treatment Planning**

140 74. Demonstrate expertise in sequencing and integration of treatment planning.

141 86. Determine most appropriate level of care, which is assessment driven.

142 36. Have, as a general treatment goal, the stabilization of eating patterns.

143 151. Incorporate nutritional prescription from a physician or a nutritionist into treatment.

**Treatment Approach & Interventions**

144 97. Be skilled in evidence-based therapies for the treatment of EDs.

145 98. Demonstrate mastery of multiple treatment modalities.

146 105. Not use rigid behaviour modification programs with clients with BN.

147 134. Use an approach that addresses body image concerns.

148 136. Use an approach that addresses gender role expectations.

149 138. Use an approach that addresses family dysfunction.

150 132. Use an approach that addresses developmental issues.

151 133. Use an approach that addresses identity formation.

152 135. Use an approach that addresses sexual difficulties.

153 143. With clients who have BN, use an approach that addresses affect regulation.

154 41. Encourage weight gain as an aim of psychological treatment for AN.

155 108. Use psychological treatment for AN that focuses on eating behaviour, attitudes to weight and shape, and wider psychosocial issues.

156 124. Use psychotherapy to help patients understand the developmental, familial, and cultural antecedents of their illness.

86
125. Use psychotherapy to help patients understand how their illness may have been a maladaptive attempt to cope and emotionally self-regulate.

130. Use interventions that incorporate an understanding of psychological defenses.

128. Use interventions that incorporate an understanding of cognitive development.

129. Use interventions that incorporate an understanding of psychodynamic conflicts.

95. Employ motivational enhancement techniques with patients who initially lack motivation.

120. Consider the needs of carers (e.g., family, friends).

155. Be prepared to discuss information and ideas that patients and their families have gathered via electronic means, and from alternative and complementary sources.

147. Provide (or make a referral to) family therapy whenever possible, especially for adolescents still living with parents or older patients with ongoing conflicted interactions with parents.

117. Appropriately refer individuals and/or families to support groups.

153. Offer particular help to EDs patients who are themselves parents by paying attention to their parenting skills, and assessing and, if necessary, aiding their children.


156. Carefully monitor patients’ experiences with OA and similar groups.

126. Engage women patients in informed and sensitive discussions regarding their struggles and personal experiences about what it means to be feminine and what it means to be “perfect” in the modern world.

48. Refer carers to written materials or other information.

6. Assume that the client has resources as it is therapeutic and engages them in the process.

41. Insist that a patient have medical monitoring

47. Consider using a more forceful approach if useful or necessary with, for example, very medically compromised patients.

11. Use DBT skills – mindfulness, distress tolerance, affect regulation, and interpersonal skills.

13. Use expressive skills with AN clients, so as to enable them to identify feelings and feel less restrained expressing themselves in the world.

33. Role play in a safe way to encourage self-assertion/protection – especially for those abused.

Work collaboratively with qualified nutritionist.
178 40. Help client get an MD and/or psychiatrist if they don’t already have one.

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<td></td>
<td>2</td>
<td>29</td>
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</tbody>
</table>

**Professional Responsibility**

<table>
<thead>
<tr>
<th>Scope of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>179 180. Have at least one-third of his/her practice comprised of patients with EDs (i.e., does not treat EDs only occasionally)</td>
</tr>
<tr>
<td>2</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Education &amp; Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>180 181. Possess at least a Master’s degree.</td>
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<tr>
<td>2</td>
</tr>
<tr>
<td>181 171. Have training in evaluating the soundness of the many publications in the field of EDs, including what makes an evidence-based scientific study versus anecdotes or fads.</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>182 166. Have received supervision, after training, of several cases.</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>183 24. Have a colleague in the field you feel totally comfortable with to share mistakes/blunders and counter-transference issues.</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation</th>
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</thead>
<tbody>
<tr>
<td>184 70. Use qualitative descriptions of key ED symptoms so that documentation of therapeutic responses may be made.</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

**Therapist Characteristics**

<table>
<thead>
<tr>
<th>Other Personal Qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>185 53. Not be personally experiencing even disordered eating/body image dissatisfaction.</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>186 157. Be able to evaluate and determine integrity/quality of other ED treatment providers and programs.</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>187 144. Advocate against the use of inappropriate treatment modalities</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>188 158. Attempt to influence decision-making at multiple levels to implement program development and policies beneficial to ED clients.</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>


The vast majority (n = 149, 79.3%) of the total number of “essential” items (n = 188) had originally been drawn from extant ED treatment guidelines and they encompassed a broad range of issues. “Essential” items that had been extracted from the APA and NICE
Guidelines and the ABECSW Draft Position Statement tended to be associated with the domains of knowledge and skills. Items that referenced the domains of professional responsibility and therapist characteristics tended to have been drawn from the ABECSW Draft Position Statement and the Andersen and Corson (2001) article on the qualities of the ideal EDs therapist. The remaining 39 “essential” items (20.7% of “essential” list) were generated by participants, and tended to be associated with knowledge and skills. The majority of these items appeared in two sub-categories of the “Skills” category: Therapeutic Relationship (n = 6 items) and Approach & Interventions (n = 13 items). A few participant items on the “essential” list were slight variations of literature-derived items. For example, the item “Be able to discuss frankly with the client any concerns the client has in relation to the therapist’s weight or shape, but only if client expresses this as an issue” (PI450) was generated in response to “Be able to discuss frankly with the patient any concerns the patient has in relation to the therapist’s weight or shape (I92) (source: Ideal Therapist article).

After one round of rating, approximately 42% of the total items that had been drawn from the literature and approximately 47% of the total items suggested by participants had achieved “essential” status. After two rounds of rating, approximately 80% of the total literature-derived items and approximately 76% of the total participant-generated items had reached the “essential” level. The Round 2 proportions will be discussed in detail in a later section because I believe they hold implications for the trustworthiness of the Round 2 data (see “Limitations and Delimitations” section).
“Useful But Not Essential” Competency Items

Table 10 presents the 21 items for which there was consensus on their being “useful but not essential” for basic, independent therapeutic practice with individuals who have EDs (i.e., items for which there was 85% agreement or greater that the rating was “2”). In addition, the number of rounds required to reach consensus, the number of participants who provided an opinion on the item in the consensus round (valid n), and the item’s source are presented. Again, the items have been organized into inductive categories.
Table 10

Consensus Items: “Useful But Not Essential”

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Number of Rounds to Reach Consensus</th>
<th>N</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specialized Knowledge Base</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For basic, independent practice with clients who have EDs, the therapist should:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Knowledge of Other Treatment Components</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>23. Recognize utility of occupational therapy programs at various stages of recovery.</td>
<td>2</td>
<td>27</td>
<td>APA</td>
</tr>
<tr>
<td></td>
<td><strong>Specialized Skills</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>58. Use standardized self-report instruments (e.g., EAT, EDI) to obtain information in addition to the clinical interview.</td>
<td>2</td>
<td>27</td>
<td>ABECSW</td>
</tr>
<tr>
<td></td>
<td>Treatment Approach &amp; Interventions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>106. Use psychodynamic therapy, especially if CBT or IPT are ineffective</td>
<td>2</td>
<td>26</td>
<td>ABECSW</td>
</tr>
<tr>
<td>4</td>
<td>110. Use psychodynamic and psychoanalytic approaches in individual or group format once bingeing and purging are improving.</td>
<td>2</td>
<td>27</td>
<td>APA</td>
</tr>
<tr>
<td>5</td>
<td>142. With clients who have BN, use an approach that addresses aggressive difficulties.</td>
<td>2</td>
<td>27</td>
<td>APA</td>
</tr>
<tr>
<td>6</td>
<td>100. Use CBT treatment manuals in the treatment of BN.</td>
<td>2</td>
<td>28</td>
<td>APA</td>
</tr>
<tr>
<td>7</td>
<td>101. Use CBT-BN (manualized CBT program specifically for BN) for clients with BN.</td>
<td>2</td>
<td>28</td>
<td>NICE</td>
</tr>
<tr>
<td>8</td>
<td>102. Offer CBT for binge eating disorder (CBT-BED) to adults with BED.</td>
<td>2</td>
<td>26</td>
<td>NICE</td>
</tr>
<tr>
<td>9</td>
<td>107. Consider using cognitive analytic therapy for AN (CAT).</td>
<td>2</td>
<td>25</td>
<td>NICE</td>
</tr>
<tr>
<td>10</td>
<td>103. Treat adolescents with EDs with CBT (adapted as needed to suit patient’s age, circumstances and level of development, and including the family, as appropriate).</td>
<td>2</td>
<td>27</td>
<td>NICE</td>
</tr>
<tr>
<td>11</td>
<td>111. Use interventions based on addictions models blended with features of other psychotherapeutic approaches</td>
<td>2</td>
<td>27</td>
<td>APA</td>
</tr>
<tr>
<td>12</td>
<td>114. Encourage patients with BN or BED to follow an evidence-based self-help program as a possible first step.</td>
<td>2</td>
<td>26</td>
<td>NICE</td>
</tr>
<tr>
<td>13</td>
<td>121. Evaluate the benefits and effectiveness of computer-based treatments and self-help manuals for mild to moderate eating-disordered patients.</td>
<td>2</td>
<td>27</td>
<td>Ideal Th.</td>
</tr>
</tbody>
</table>
### Professional Responsibility

#### Education & Training

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Panelists</th>
</tr>
</thead>
<tbody>
<tr>
<td>169</td>
<td>Have obtained specialized training in CBT for the treatment of BN.</td>
<td>28 APA</td>
</tr>
<tr>
<td>17</td>
<td>Be trained and experienced in EMDR with disordered eating symptomology in dealing with PTSD contributing factors.</td>
<td>27 Participant</td>
</tr>
</tbody>
</table>

#### Other

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Panelists</th>
</tr>
</thead>
<tbody>
<tr>
<td>146</td>
<td>Advocate against the use of controversial treatment modalities.</td>
<td>28 ABECSW</td>
</tr>
</tbody>
</table>


Approximately 9% of the total literature-derived items and approximately 8% of the participant-generated items were deemed “useful but not essential.” The most salient feature of these items (other than that the majority fall into one subcategory of Skills – Approach & Interventions) is that they were all subject to two rounds of ratings before a consensus was reached.

One item on this list (“Be able to assess primary adaptive feelings vs. maladaptive feelings and secondary feelings [a la Les Greenberg]” - PI22) had a relatively low valid n of 23 (see asterisk), indicating that less than 80% of the Round 3 panelists had provided an opinion on it. Several participants commented that they were unfamiliar with the...
terms in the item. Therefore, its status as a “consensus” item is unclear and it may, in fact, be more appropriately designated as a non-consensus item.

**Items that Did Not Reach Consensus**

There were 29 items for which consensus was not reached after two rounds of the Delphi process. Table 11 presents these items and includes the number of participants who provided an opinion in the last round in which it was rated, and the item's source.
<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Number of Rounds to Reach Consensus</th>
<th>N</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td><strong>Non-Consensus Items</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Specialized Knowledge Base</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>For basic, independent practice with clients who have EDs, the therapist should:</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Definitions, Epidemiology, Etiology, &amp; Organizing Theory</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>2. Know the diagnostic criteria for Binge Eating Disorder.</td>
<td>-</td>
<td>26</td>
<td>APA</td>
</tr>
<tr>
<td>2</td>
<td>3. Know the prevalence and distribution of EDs.</td>
<td>-</td>
<td>26</td>
<td>ABECWS</td>
</tr>
<tr>
<td>3</td>
<td>14. Have knowledge of temperament and genetics so as to help clients understand inborn traits, extroversion/introversion, and genetic underpinnings, to the degree we understand them.</td>
<td>-</td>
<td>28</td>
<td>Participant</td>
</tr>
<tr>
<td>4</td>
<td>16. Understand the notion of “ingestive disorders” as they relate to PTSD.</td>
<td>-</td>
<td>*22</td>
<td>Participant</td>
</tr>
<tr>
<td></td>
<td><strong>Treatment Approaches and Interventions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>18. Familiarize her/himself with CBT treatment manuals for the treatment of BN.</td>
<td>-</td>
<td>28</td>
<td>APA</td>
</tr>
<tr>
<td>6</td>
<td>19. Be familiar with body image treatment protocols.</td>
<td>-</td>
<td>28</td>
<td>ABECWS</td>
</tr>
<tr>
<td>7</td>
<td>22. Recognize the utility of non-verbal therapeutic methods such as creative arts and movement therapy programs.</td>
<td>-</td>
<td>29</td>
<td>APA</td>
</tr>
<tr>
<td>8</td>
<td>27. Recognize that 12-step programs may be helpful adjuncts to treatment.</td>
<td>-</td>
<td>29</td>
<td>APA</td>
</tr>
<tr>
<td>9</td>
<td>52. Be knowledgeable about primary prevention and early intervention programs and research.</td>
<td>-</td>
<td>29</td>
<td>APA</td>
</tr>
<tr>
<td>10</td>
<td>116. When providing psychological treatments for BED, consider providing concurrent or consecutive interventions focusing on management of comorbid obesity.</td>
<td>-</td>
<td>25</td>
<td>NICE</td>
</tr>
<tr>
<td>11</td>
<td>16. Possess knowledge of state-of-the-art treatment approaches.</td>
<td>-</td>
<td>29</td>
<td>ABECWS</td>
</tr>
<tr>
<td></td>
<td><strong>Specialized Skills</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Assessment</strong></td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>68. Ask about and objectively quantify weight control measures (e.g., dieting, laxative use, etc.)</td>
<td>-</td>
<td>29</td>
<td>ABECWS</td>
</tr>
<tr>
<td>13</td>
<td>159. Use pretreatment and outcome measurement tools to evaluate treatment efficacy.</td>
<td>-</td>
<td>28</td>
<td>ABECWS, Ideal Th.</td>
</tr>
<tr>
<td></td>
<td><strong>Treatment Approach &amp; Interventions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>118. Use family therapy as the treatment of choice for clients with AN who are 18 or younger and living at home.</td>
<td>-</td>
<td>28</td>
<td>ABECWS</td>
</tr>
<tr>
<td>15</td>
<td>99. Use CBT as the treatment of choice for clients with BN.</td>
<td>-</td>
<td>27</td>
<td>ABECWS</td>
</tr>
</tbody>
</table>
16 104. Be skilled in the use of behavioural techniques (e.g., self-monitoring, planned meals).
17 112. Use psychoeducation in therapy sessions.
18 115. Inform patients that all psychological treatments for BED have a limited effect on body weight.
19 20. Teach how to evoke and contain emotion at the same time.
20 21. Make working with conflicting feelings a focus of therapy.

Interdisciplinary Collaboration
21 4. If private practitioner, should have access to seeing treatment resources and orientation to be involved in ongoing training.

Professional Responsibility

Education & Training
22 170. Have had specific training in CBT or IPT at a minimum, with knowledge of supportive, educational, and dynamic techniques.
23 167. Have received supervision on the assessment of at least 12 cases.

Supervision & Consultation
24 3. Attend group support/supervision with other clinicians.

Therapist Characteristics

Self-Awareness
25 23. Have experienced one’s own therapy, to be more self-aware.

Other Personal Qualities
26 186. Have the viewpoint that EDs are completely curable.
27 93. Not discuss own past experience of having had an ED with her/his patients.

Other
28 145. Advocate against the use of clinically unproven treatment modalities.
29 52. Not carry a caseload with only/all ED patients, to prevent burnout.


Approximately 11% of the total literature-derived items and approximately 16% of the participant-generated items did not reach the cut-off for consensus. The literature-
derived items are likely to be of more interest because they were drawn from existing treatment guidelines and other published opinions. In contrast, many of the items on this list that were suggested by participants could reflect the idiosyncratic special interests and approaches/interventions they favoured (e.g., “Be trained and experienced in EMDR with disordered eating symptomology in dealing with PTSD contributing factors” - PI17) or could simply be worded poorly (e.g., “If private practitioner, should have access to seeing treatment resources and orientation to be involved in ongoing training” - PI4).

One item (“Understand the notion of “ingestive disorders” as they relate to PTSD - PI16) had a valid n of 22 (see asterisk), indicating that less than 80% of the Round 3 participants had not provided an opinion on it. Several participants commented that they were unclear about the meaning of “ingestive disorders.” As there was no consensus reached on this item, a low valid n was not of particular concern.

Participant Comments

On all three questionnaires, participants were provided with limited space to write brief comments or explanations for their rating choices. In the interest of keeping the completion time for each questionnaire to 60 minutes or less, they were encouraged to write a comment only (a) if they felt strongly disposed to do so, or (b) when, during the re-rating phases of the study, they did not change their rating to match the group median rating.

On Questionnaire 1, participants provided a total of 307 comments on the items. The number of comments provided by each participant ranged from 0 to 25, with an average of approximately 11 comments ($M = 10.59; SD = 8.12; Mdn = 8$). On Questionnaire 2, participants provided a total of 331 comments about the items. The
number of comments provided by each participant on Questionnaire 2 ranged from 0 to 52, with an average of approximately 11 comments ($M = 11.41; SD = 11.71; Mdn = 8$). On Questionnaire 3, participants provided a total of 81 comments. The number of comments provided by each participant ranged from 0 to 11, with an average of 3 comments ($M = 3.00; SD = 3.28; Mdn = 2$). Participant response patterns with respect to comments varied considerably. For example, one participant offered no comments whatsoever about the items throughout the Delphi process, while another offered more than 80. All comments appear verbatim in Appendix M. Some comments are presented in the Discussion section in order to highlight various aspects of the results.

Summary

Using a Delphi process, 188 competency items were identified by a diverse panel of 29 experts in the field of EDs treatment as being “essential” for basic, independent therapeutic practice with clients who have EDs. Another 21 items were identified as being “useful but not essential.” No items were identified as being “not useful.” Consensus was not reached on 29 items. After two rounds of rating, approximately 80% of the total literature-derived items and approximately 76% of the total participant-generated items had been identified as “essential.” Several hundred brief comments were generated throughout the data collection process, which may add to the understanding of the numerical results.
Chapter 5 – Discussion

In this study, a consensus process was facilitated via a series of questionnaires with a group of individuals who had expertise on the treatment of EDs. The specific question that guided this research was: **According to experts in the treatment of EDs in British Columbia, what competencies are essential for basic, independent therapeutic practice with clients who have EDs?**

In this chapter, I will discuss the results of the consensus process: the items that were identified as “essential,” those that were identified as “useful but not essential,” and those for which a consensus was not reached. I will discuss each of these item groups in relation to the existing treatment guidelines and other EDs literature, but also in relation to the design of the study. In the various sections below, participant comments have been included to illustrate the points made. I will conclude the chapter by presenting the limitations of the study, the implications for counselling practice, and recommendations for future research.

**“Essential” Consensus Items**

The Delphi process produced an extensive list of competencies (n = 188) for which consensus was reached on their being “essential” for basic, independent practice with clients who have EDs. The general features of this list have been summarized in the Results section. Therefore, I will (a) focus the discussion on an examination of the factors that may have had an impact on the length of the “essential” list; and (b) highlight three item clusters on this list that I feel may have particular relevance for EDs therapist competencies: scope of practice, interdisciplinary approach, and the therapeutic relationship.
The Complexity of EDs

There was consensus that 149 (79.7%) of the literature-derived items were “essential” for basic, independent therapeutic practice with clients who have EDs. Thirty-nine items that had been suggested by participants also appeared on the “essential” list, for a total of 188 “essential” items. Taken at face value, the length of the list could be interpreted to mean that the panel viewed psychotherapy with clients who have EDs as a multifaceted activity that requires myriad competencies. If the treatment of EDs is considered to be complex, it would not be unreasonable to assume that a competent EDs therapist would possess a substantial knowledge and skill base commensurate with this complexity. The following comments by participants suggested potential support for this idea:

[The study] made me appreciate some of the complexity involved in working with EDs...

I was impressed by the depth and complexity [of competencies] that I and other EDs therapists possess.

The study made me realize how many issues are involved with treating ED clients.

The literature does contain widespread acknowledgment that EDs are etiologically complex and that they therefore require similarly complex assessment and interventions (e.g., APA, 2000; Crowther & Sherwood, 1997; Garner, 1997; Holt & Espelage, 2002; Hotelling, 2001; Kreipe et al., 1995; Strober, 1997; Vandereycken & Beumont, 1998). Crowther and Sherwood (1997) refer to EDs as “multifaceted behavior problems that require comprehensive, multidimensional assessment” (p.34). The multidimensional
nature of EDs has been acknowledged and there has been relatively widespread adoption
of a biopsychosocial model that includes individual, psychological, biological, familial
and cultural factors (e.g., Attie et al., 1990; Garner, 1997). Gleaves, Miller, Williams and
Summers (2000) state that, when planning and providing treatment, the therapist must
consider individuals with EDs as a heterogeneous group in terms of demographics,
family dynamics, comorbidity, personality, and etiology. Implied in these examples from
the literature is support for the idea that the EDs therapist may require a substantial
knowledge base and highly developed clinical skills.

Garner (1985) suggested that if the therapist does not possess the requisite
knowledge of EDs, this could contribute to iatrogenesis. As a potential remedy, he
advised that practitioners should undertake specific training in the treatment and
management of EDs. Thompson and Sherman (1989) voiced their support for Garner’s
opinion and stated that receipt of specialized training with respect to the therapeutic
relationship with the ED client was of particular importance because certain therapist
behaviours could unwittingly reinforce and/or maintain the disorder. Clearly, this could
lead to devastating effects on the health of some clients.

Yager and Edelstein (1987) voiced the need for the production of more trained,
competent EDs professionals. They suggested that the education of practitioners-in-
training should be comprehensive and systematic, and should ideally take place within a
multidisciplinary ED clinic setting. Moreover, they argued that students should be
encouraged to gain as much knowledge as possible from both the professional and
popular literature on EDs, not only to build their expertise but also keeping in mind that
the clients themselves are often extremely knowledgeable about the disorders. Although
the opinions described above were expressed in the 1980s, the concerns and suggestions they highlight still seem to have relevance in the EDs field today where relatively few truly definitive answers have been provided regarding etiology and treatment (particularly with respect to AN [see Kaplan, 2002 for a review]), despite the tremendous amount of research that has been generated over the last 20 years.

If it is necessary that EDs therapists possess a comprehensive understanding of EDs, deliver complex interventions based on this knowledge, and have received systematic training in a specialized setting, this implies participation in advanced education. It was therefore interesting to note that the only questionnaire item in this study that pertained specifically to level of education ("Possess at least a Master's degree") barely reached consensus as being "essential" after two rounds (71.4% in Round 1, 86.2% in Round 2). Upon closer inspection of the data, 3 out of the 4 panelists who felt that a Master's degree was "useful but not essential" possessed a bachelor's degree or less and 2 of the 4 had indicated that they had not provided psychotherapy to individuals with EDs. Their opinion could be interpreted in the following ways: perhaps they were unfamiliar with the typical training requirements for psychotherapists (Master's or PhD), or they had referenced their own experiences as individuals who had gained expertise in the treatment of EDs without completing an advanced degree, or they simply did not hold the opinion that advanced education was necessary to provide therapy for EDs.

**Content of the Source Documents**

Another factor to consider regarding the list of "essential" literature-derived items is that the items' source documents had themselves been informed by the opinions and views of practitioners and scholars who specialized in EDs treatment. Therefore, if
specialists with expertise in the EDs field had included in these documents what they thought was important information, it is likely that other experienced professionals in the field might share their opinions. Indeed, the APA's Practice Guideline was authored by a group of psychiatrists who are respected scholars, researchers, and providers of treatment in the EDs field (APA, 2000). A group of clinical social work practitioners and scholars who specialized in the study of the treatment of EDs were responsible for the development of the ABECSW Draft Position Statement (B. Booth, ABECSW, personal communication, October 26, 2004). The development of the NICE Guideline was guided by a multidisciplinary committee that included a community organization and a consumer (NCCMH, 2004). Each document contained a review and presentation of empirical literature that had served to guide its development, and was also subject to an extensive review and consultation process with stakeholders prior to being published. Therefore, it is highly likely that the documents reflect their authors view of current best practices in the field of EDs treatment with which a majority of other specialists would concur. As such, the strong endorsement of the literature-derived items in this study as being "essential" could also be seen as support for the idea that the source documents contained valid content pertaining to the psychosocial aspects of EDs treatment.

Study Design

The large number of items on the "essential" list was also almost certainly a function of the design of the study itself. The choices I made regarding: (1) the number of initial items included on Questionnaire 1; (2) the level of agreement for consensus; (3) the Likert scale used for rating items; (4) the inclusion of some generically-worded literature-derived items (despite efforts to avoid this); and (5) the wording of the study's
aim and the questionnaire instructions provided to participants were all potential factors. These factors will be described and discussed in more detail in the section entitled “Limitations and Delimitations” because they have implications for the trustworthiness of the Round 2 data in particular. Ultimately, however, the long list of “essential” items likely reflects a combination of all the factors discussed above.

I will now move the discussion to three topic areas I have chosen to highlight that are based on several item clusters appearing on the list of “essential” items. These topics are: the ED therapist’s scope of practice, an interdisciplinary approach, and the therapeutic relationship. I selected these topics for discussion because they seemed to be associated with aspects of competent therapeutic practice with clients who have EDs that may benefit from further exploration and/or clarification.

Therapist’s Scope of Practice

Issues pertaining to the therapist’s scope of practice involve the ethical principles of beneficence and nonmaleficence. Several literature-derived items on the “essential” list seemed to have implications for the therapist’s scope of practice. Specifically, these items referred to aspects of psychotherapeutic treatment that could be seen to involve knowledge and skills associated with other disciplines. For example, there were several items that referenced nutrition:

Understand the role of nutritional rehabilitation. (I34) (consensus after first rating)

Understand the physiological and psychological consequences of starvation. (I30) (consensus after first rating)

Recognize that attempts to conduct formal psychotherapy with starving patients may be ineffective. (I31) (consensus after first rating)
Have basic knowledge of nutritional principles in order to reinforce them in therapy. (133) (consensus after second rating)

Incorporate nutritional prescription from a physician or a nutritionist into treatment. (1151) (consensus after second rating)

A basic, working knowledge of nutrition and how it relates to EDs could be very important indeed when working with ED clients, who may possess more knowledge about nutrition than the average client (or the average therapist, for that matter), or who may have misperceptions about nutrition, the effects of dieting, etc. that pose obstacles to their recovery. It should be noted that a consensus was reached on each of the first three items in their first round, whereas Items 133 and 151 did not reach the cut-off for consensus until after a second rating. This indicates that there was initially less agreement that these latter two items were “essential.” Participants’ comments about Items 133 and 151 may provide some explanations:

Or work collaboratively with qualified nutritionist.

Not always possible.

I keep this separate if possible.

It is possible that some panelists felt there was a difference between (a) the therapist possessing a general understanding of the importance of nutrition and his/her ability to use this general understanding to enhance the therapeutic goals (whatever they may be for that particular client) and (b) the therapist doing specific work with the client on aspects of nutrition. One participant offered a new item (similar to first the comment above) that emphasized collaboration: (Work collaboratively with qualified nutritionist - PI39). However, even this item reached consensus only after two rounds of rating,
indicating that it did not receive strong initial endorsement. One panelist noted that whether or not they worked with a nutritionist would depend on the ED symptoms (presumably the nature and severity), thus implying the use of clinical judgment to make such a decision.

In contrast to the idea that the client’s nutrition should be the domain of the nutritionist, a manualized CBT treatment for BN (Wilson et al., 1997) instructs the therapist to use the first 8 sessions of therapy to provide psychoeducation on nutrition-related topics, among others. Specifically, the therapist is expected to:

...educate the patient about body weight regulation; the adverse effects of dieting; and the physical consequences of binge eating, self-induced vomiting and laxative abuse...[and] to introduce a pattern of regular eating and the use of alternative behavior (p.70-71).

These activities in manualized CBT could well be perceived as the responsibility of a qualified dietitian or nutritionist. The issue is just as relevant for therapists who do not provide manualized CBT for BN because the understanding and practice of good nutrition can be a crucial component in recovery from any ED, for obvious reasons. If the therapist does collaborate with a nutritionist, will some of their interventions overlap and how will this be managed? What if the nutritionist and the therapist are providing conflicting information? If the therapist does not collaborate with a nutritionist, how much knowledge is required to ensure competence in delivering nutrition-related interventions? These considerations suggest that, with respect to the ED therapist’s scope of practice, further clarification may be required concerning ED therapist competencies that incorporate nutritional aspects of treatment.
Perhaps even more illustrative of the scope of practice issue were literature-derived “essential” items that referred to medical issues:

Have knowledge of physical issues related to EDs (e.g., dental, pregnancy, osteoporosis, EDs & diabetes, etc.). (I43) (consensus after first rating)

Understand the role of medications in treatment. (I42) (consensus after second rating)

Screen for dangerous, but not always evident, medical problems associated with EDs. (I69) (consensus after second rating)

Possessing some knowledge of the physical issues and “dangerous” medical problems (e.g., dehydration, electrolyte imbalances, arrhythmias, etc. [APA, 2000]) related to EDs could be important for the EDs therapist, for the following reasons: In a worst case scenario, the therapist might be the only person who is aware of the client’s ED. If the therapist is somewhat knowledgeable about these physical problems and conditions, he/she would be more likely to encourage the client to make an appointment with a doctor. The client may be unaware of the ramifications of these problems for her health, and increasing her awareness might encourage her to seek medical help. Obviously, the therapist’s professional responsibility to the client’s well-being (beneficence) figures here, as does protecting her from harm (nonmaleficence). However, an additional consideration is that, if a client dies due to medical complications from an ED, the therapist may have set him/herself up for a complaint and/or an ethical review if important questions were not asked about the client’s physical health during the course of therapy.
With respect to medications, it could be important for therapists to know what medications are efficacious in ameliorating ED symptoms in order to encourage clients to speak to a doctor or psychiatrist about pharmacological treatment options. Furthermore, it would likely be helpful to have some understanding of the side effects of the medications typically used in the treatment of EDs (and for the more typically occurring comorbid disorders) and their potential impact on the client’s mental and emotional state. For example, there is recent evidence to suggest that SSRIs, which have demonstrated efficacy in reducing bingeing/purging in BN, may increase the risk of suicidality in adolescents (United States Food and Drug Administration, 2004).

Some participants, however, questioned whether the aspects of medical treatment described in the above items were the responsibility of the therapist:

I’m not an MD and therefore can’t assess for this accurately.

Refer to physician/Refer. (Hypokalemia or diabetes?)

I assume they have an MD and a psychiatrist, or [I] help them get one.

I try to collaborate with clients’ MDs.

This is the purview of a physician, not a therapist./Physician’s role.

Screen, but also refer to MD to screen.

Keeping in mind the ethical principles of beneficence and nonmaleficence, the questions that arise with respect to the issue of medical knowledge include: To what extent must the EDs therapist know about medical issues in order to practice competently and safely? To what extent must the EDs therapist be able to assess the physical health of a client? One option is referral, and one item on the “essential” list (“Know when and how to refer to a physician for medical treatment” – 144) reached consensus in Round 1, indicating
that there was strong endorsement that referral was an important aspect of practice in terms of medical issues. However, further clarification may be required concerning the identification of ED therapist competencies that incorporate medical aspects of treatment.

Another issue that emerged in the data that related to the therapist's scope of practice was that of diagnosis. Several items on the "essential" list referred to the therapist diagnosing the client. These were:

- Make clinically responsible diagnoses. (I71) (consensus after first rating)
- Master the integration of assessment and differential diagnostic skills relevant to EDs field. (I85) (consensus after second rating)
- Be able to accurately diagnose separate comorbid diagnoses. (I80) (consensus after second rating)
- Be able to determine whether comorbidities are preexisting or secondary to ED symptomology. (I81) (consensus after second rating)
- Keep up with changes in diagnostic assessment. (I4) (consensus after second rating)

The sources of these items were the ABECSW Draft Position Statement and the "Ideal Therapist" article. Consensus was reached after two rounds for all of these items except for "Make clinically responsible diagnoses," which reached consensus after one round, indicating a general lack of initial agreement about items concerning diagnosis.

Diagnosis is a "reserved act" under the Health Professions Act of British Columbia (Government of British Columbia, 2004). Psychologists may diagnose, but it may be beyond the scope of practice of other therapists to diagnose. Indeed, some
participants did not agree that items pertaining to diagnosis belonged on the “essential” list:

[This is an ] MD’s skill.

Not all disciplines can provide a diagnosis.

I believe making medical diagnoses/differential diagnoses are a protected medical function under the BC Medical Act. The group median “3” is surprising to me. (RNs/nurses do not make medical diagnoses but may provide “diagnostic impressions” which is essential to this work.)

One participant questioned the need for making diagnoses at all, and asked: “Why [diagnosis]? Do you think this is essential to [the] treatment plan?” Another participant provided a questionnaire item that implied there could be negative consequences on the client and the therapeutic relationship with respect to diagnosis: “Avoid pathologizing and distancing via labelling and/or categorizing (PI7).” It appears that the inclusion of diagnosis-related items on the “essential” list and the content of participants’ comments may indicate that further clarification of this issue may be warranted with respect to the scope of practice of EDs therapists. Certainly, there would be implications for the scope of practice of counsellors, who are not trained (or legally permitted) to diagnose. These implications will be discussed further in the section entitled “Implications for Counselling Practice.”

In summary, the appearance of these item clusters on the “essential” list may indicate the need to clarify ED therapist competencies that pertain to scope of practice, particularly with respect to potential points of overlap with other disciplines. Although the item groupings discussed above did appear on the “essential” list, the content of
participants’ comments and the fact that many of the items achieved the cut-off for consensus only after two rating rounds suggest that there may be disagreement, confusion, or ambiguity concerning the therapist’s role concerning the nutritional and medical aspects of treatment, and diagnosis. This lack of clarity may point to the advantage of the ED therapist’s involvement on an interdisciplinary team, which could potentially alleviate role ambiguity. Therefore, I will now discuss the subject of interdisciplinarity.

An Interdisciplinary Approach

Several items that appeared on the “essential” list were related to interdisciplinary collaboration. These items were:

Collaborate on recommendations/treatment with professionals from other disciplines (e.g., nutritionists, physicians, etc.). (I150)

Develop and appropriately make use of a referral base of other specialized health care professionals. (I149)

Assemble a team of professionals to provide the best care for clients with EDs. (I148)

Each of these items reached consensus after one rating, indicating that there was strong, early agreement on their being “essential.” That EDs require multidisciplinary treatment is well established in the literature (e.g., APA, 2000; Garner & Garfinkel, 1997; Kreipe et al., 1995; Yager & Edelstein, 1987). The ability to participate on an interdisciplinary team depends on the therapist’s place of work, community size, and the availability of funding. Large, hospital-based EDs programs are typically comprehensive in their treatment (e.g., psychiatric, medical, nursing, psychological, and nutritional care are
provided). As such, the therapist working in this setting has the advantage of continuous on-site access to a multidisciplinary team of professionals as well as regular team meetings regarding clients' progress. The therapist who works at a non-hospital based EDs clinic (or at an EDs program at a small hospital) may also have access to other professionals, but perhaps not to the same extent. For example, the East Kootenay Eating Disorder Clinic Team located in Cranbrook, B.C. has just 3 staff members: a registered nurse, a physician, and an adult mental health therapist (E. Dearden, Clinical Nurse Coordinator, personal communication, July 7, 2004). This small number of staff is in stark contrast to B.C. Children's Hospital in Vancouver, where more than 25 staff members from various disciplines work in the Eating Disorders Program (Eating Disorder Resource Centre of BC, 2004).

The therapist in independent private practice may encounter further challenges in working collaboratively with a team of ED specialists. He or she may need to actively research, develop, and liaise with a variety of health care professionals for each client who has an ED in order to ensure that the multiple aspects of treatment are being adequately addressed. One participant's comment may serve to illustrate that the therapist in independent private practice may have special considerations in terms of ensuring multidisciplinary care for their clients with EDs:

On further thought, "independent" practice is not considered "best practice" but if someone is in independent practice, then that person should possess [a] greater body of knowledge, skills, than perhaps members of a multidisciplinary team. This is a recipe for "burnout."
Not only is the therapist at risk for burnout due to the extra responsibilities and concomitant worries that can associated with being an ED client's sole support, he or she may potentially be risking the physical well-being of the client, which could have devastating effects if the client were to experience a health crisis. However, it is duly noted that therapists who practice in rural communities may not have adequate access to even one other health professional who is a specialist in EDs. These therapists may be in the unenviable position of needing to make decisions about taking clients with EDs in the absence of on-site opportunities for team consultation and/or appropriate referral.

The desirability of interdisciplinary teamwork has also been associated with training. Yager and Edelstein (1987) commented that the training of competent EDs professionals should ideally take place within a multidisciplinary ED clinic setting. They suggest that no less than 9 months to one year of training in this setting is required, and that the student should have opportunities to participate in inpatient and outpatient assessment, observe and conduct intake evaluations, provide individual psychotherapy, co-lead groups, and receive supervision, in addition to reading key pieces of EDs literature. The authors note that aspects of countertransference and the therapeutic relationship should be monitored closely via supervision due to the complexity of feelings that may be evoked in students by clients with severe EDs. These types of training experiences suggest that the therapist-in-training might need to carefully evaluate, and be selective about, the training experiences available to him/her.

In summary, interdisciplinary training and teamwork may well be crucial elements contributing to competent therapeutic practice with clients who have EDs. Practitioners who work in smaller communities and/or in private practice may face
additional challenges in terms of the ability to develop a team of professionals who can monitor the physical and nutritional well-being of the client and with whom the therapist can consult on a regular basis.

The Therapeutic Relationship

Several items on the "essential" items list referred to the relationship between the therapist and the client with an ED. Two of the interesting features of this group of items are that consensus was reached for all of them (both literature-derived and participant-generated) in the first round in which they were rated, and that half of them attained 100% agreement (which is fully one-quarter of the total items in the study that reached 100% agreement as being "essential"). The literature-derived items had been drawn from all four source documents and included:

- Establish a strong therapeutic alliance characterized by acceptance, honesty, and reassurance throughout the therapeutic process. (187) (100% agreement)
- Build trust, establish mutual respect, and develop a therapeutic relationship with the patient that will serve as the basis for ongoing exploration and treatment of the problems associated with the ED. (188) (100% agreement)
- Monitor the quality of the therapeutic relationship. (189) (100% agreement)
- Be able to discuss frankly with the patient any concerns the patient has in relation to the therapist’s weight or shape. (192)
- Avoid competition with the patient (e.g., concerning body size). (194)

Participants provided several new items, including two that contained suggested modifications to existing literature-derived items. These were as follows:

- Be skilled in building a therapeutic alliance. (P18) (100% agreement)
Be competent in managing, in a genuine and caring way, the challenges that arise in the therapist-client relationship. (PI9) (100% agreement)

Have [the] ability to create a space of safety and trust. (PI29) (100% agreement)

Provide a therapeutic relationship that will impact on client’s self development and other relationships. (PI10)

Be able to discuss frankly with the client any concerns the client has in relation to the therapist’s weight or shape, but only if client expresses this as an issue. (PI45)

If client names it, address competition (e.g., concerning body size) at a level the therapeutic bond can handle. (PI46)

Have an understanding of the biopsychosocial experience of an eating disorder because, in order to gain rapport/a therapeutic alliance, the client needs to have a sense of being understood from the inner experience of conflicting feelings, thoughts, behaviours. (PI37)

The therapeutic relationship is thought to be a vital component of successful therapy regardless of the presenting issue(s) (e.g., Lambert & Barley, 2001; Martin, Garske, & Davis, 2000). There are many examples in the EDs literature that identify the therapeutic relationship as being particularly critical to the recovery process from an ED (e.g., Beumont & Vandreycycken, 1998; Freedman & Leichner, 2001; Garner, 1985; Herzog, Hamburg, & Brotman, 1987; Johnson, Connors, & Tobin, 1987; Thompson & Sherman, 1989; Yager & Edelstein, 1987). For example, Johnson and colleagues (1987) concluded that symptom management in BN is not likely to occur without a strong therapeutic alliance. They suggested that, in a strong therapeutic relationship, the
therapist can use a strong connection to promote behaviour changes and challenge the client's (often entrenched) ambivalence about these changes. Regarding adolescent clients, Freedman and Leichner (2001) emphasize that without a therapeutic relationship "characterized by trust, warmth, and genuineness" (p. 60), there can be little potential for therapeutic impact. Furthermore, they suggest that the therapeutic alliance may be compromised if the treatment approach and the client's stage of change (see Prochaska & DiClemente, 1992) are at odds.

Thompson and Sherman (1989) discuss other aspects of the therapeutic relationship that can be counterproductive, for example the therapist setting unrealistic expectations, or subtly seeking reassurance from the client that they are doing a good job (a major error, they argue, because clients with ED are often inordinately deferential and compliant), or trying to take too much control rather than taking a collaborative stance with respect to treatment decisions. Garner (1985) and others (e.g., Vandereyken & Beumont, 1998; Thompson & Sherman, 1989; Zerbe, 1998) have noted that clients with EDs tend to evoke strong feelings in the therapist such as anger and helplessness. Such feelings arise due to the perception that clients with EDs are challenging to work with (e.g., resistant, controlling, manipulative, requiring too much time) (e.g., Burket & Schramm, 1995). Thompson and Sherman argue that, along with the therapist's lack of adequate knowledge about EDs, therapists errors with respect to the relationship can contribute treatment ineffectiveness, client resistance, and premature treatment termination.

These examples from the literature provide support for the notion that the therapeutic alliance in the treatment of EDs can be a powerful helpful or hindering force
in the client’s recovery. It is therefore not surprising that the panelists in this study appeared to endorse an alliance characterized by genuineness, compassion, and an understanding of the client’s experience as being “essential” for basic, independent practice with individuals who have EDs. In fact, the strength of this endorsement (100% agreement on several items, consensus reached for all items after the first rating) may be an indication that the therapeutic relationship deserves substantial attention in terms of the specific competencies that EDs therapists would ideally bring to their work.

Summary

The above sections of the discussion have focused on the items that were considered “essential” for basic, independent therapeutic practice with clients who have EDs. First, I discussed some of the factors that may have had an impact on the length of the “essential” list. Secondly, I discussed several clusters of items that appeared within this list that I felt had particular relevance with respect to competent practice: the therapist’s scope of practice, an interdisciplinary approach, and the therapeutic relationship.

A few concluding comments about the “essential” list are in order. As the study was designed to be exploratory and to reflect a preliminary consensus, a lengthy list of “essential” literature-derived competencies is perhaps an advantage in terms of practical value. For example, it may indicate that that potentially important competency items were not prematurely ruled out. Future examination of these items (e.g., via discussion, rating, and/or sorting) might result in a more nuanced ranking of items in terms of criticality, and could constitute a step towards creating a competency profile for EDs therapy.
According to Dr. David Cane, a consultant who was hired to facilitate the development of competency profiles for the College of Massage Therapists of B.C., the Canadian Association of Registered Diagnostic Ultrasound Professionals, and the proposed college of counselling therapists in B.C., it is not uncommon for a finalized competency profile to contain in the neighbourhood of 250-300 separate items or "statements," depending on the complexity of the job. There may be more statements if their repetitive aspects are not consolidated into an appendix (D. Cane, personal communication, November 9, 2004). For example, in a competency profile that was published in the U.S. for addictions counselling, there are 9 general competency areas (Transdisciplinary Foundations; Clinical Evaluation; Treatment Planning; Referral; Service Coordination; Counselling; Client, Family, and Community Education; Documentation; and Professional Responsibility). Within these 9 areas are 122 competency statements (e.g., under Treatment Planning, "Obtain and interpret all relevant assessment information"), and within these statements are more than 1,000 competency sub-statements that are categorized into knowledge, skills and attitudes (e.g., under the statement above, a "Knowledge" sub-statement was "Stages of change and readiness for treatment") (Addiction Technology Transfer Centres National Curriculum Committee, 1998).

The list of "essential" literature-derived items in this study looks to be comprised of both statements and sub-statements, and would likely benefit from being consolidated in some areas and expanded in others. Nevertheless, as it stands, the list has identified some potentially important areas of competence and specific competencies for EDs therapists. The items that reached consensus as being essential after one rating may be
particularly helpful because they reflect a relatively strong group endorsement that was unencumbered by some of the potential complications introduced by the study's design with respect to the re-rating of items (see the section entitled "Limitations and Delimitations" for a detailed discussion of these concerns).

"Useful but Not Essential" Consensus Items

There were 21 items (17 literature-derived and 4 participant-generated) for which consensus was reached on their being "useful but not essential" for basic, independent therapeutic practice with clients who have EDs. Most of these items fell into the categories of approach/intervention (n = 15 items). It is perhaps worth noting that the appearance of just 4 participant-generated items on this list indicates that approximately 92% of the items suggested by participants were endorsed as either "essential" or did not reach consensus at all, which is a very polarized response (with an unclear meaning). I will focus the discussion in this section on one segment of the list, namely a cluster of items that refers to the use of empirically supported treatments (ESTs).

Empirically Supported Treatments

There are 5 items on the "useful but not essential" list that refer specifically to CBT for the treatment of BN and BED, as follows:

Use CBT treatment manuals in the treatment of BN. (I100)

Use CBT-BN (manualized CBT program specifically for BN) for clients with BN. (I101)

Offer CBT for binge eating disorder (CBT-BED) to adults with BED. (I102)
Treat adolescents with EDs with CBT (adapted as needed to suit patient’s age, circumstances and level of development, and including the family, as appropriate). (I103)

Have obtained specialized training in CBT for the treatment of BN. (I169)

It is interesting to contemplate the meaning of this group of items relative to the promotion of CBT as the “first line treatment of choice” for BN (Mussell et al., 2000, p.231; Fairburn et al., 1992; Wilson, 1996; Wilson et al., 1997). The APA Practice Guideline (2000) and the other guidelines reviewed for this study cite CBT as the therapy that currently demonstrates the most evidence of efficacy for treating BN, followed by IPT. There is also preliminary support that both CBT and IPT are effective for treating adults with BED (e.g., Wilson & Fairburn, 2000; Wilson et al., 1997). However, there is evidence that CBT is underutilized by practitioners in the EDs field (e.g., Arnow, 1999; Mussell et al., 2000; Tierney, 2004).

Various explanations have been offered for this phenomenon including the lack of training opportunities (Arnow, 1999), therapist misconceptions about manual-based treatment for EDs (Wilson, 1998), and the inadequate dissemination of manual-based treatments for EDs (Mussell et al., 2000). There are several other possible explanations for this trend that reflect a more general debate about the use and promotion of ESTs in psychology in counselling psychology. This debate is far too complex to be described here in detail; however, in general, it concerns the methods (i.e., randomized clinical trials [RCTs]) and criteria used to designate treatments as empirically supported, and the movement to compile a list of empirically supported therapies and mandate their use in clinical practice (Waehler et al., 2000).
The use of ESTs in therapy has been identified as an ethical issue. In the opinion of some scholars (e.g., Ollendick & Davis, 2004; Persons & Silberschatz, 1998), therapists have an ethical responsibility to recommend and use ESTs for reasons related to the ethical principles of beneficence and nonmaleficence. For example, Persons quite rightly noted that if a therapy has not been demonstrated to be effective in a controlled study, this is not evidence of its ineffectiveness. However, she also argued that unless a therapy has been investigated in a controlled study, there is no compelling evidence that it is effective (beneficence) and therefore there is no certainty that it is not harmful (nonmaleficence). She therefore advocated recommending ESTs to clients before other treatments that are either not supported by evidence from RCTs or not evaluated at all in RCTs. She also suggested that clients should be informed about the findings from RCT studies that are relevant to their condition (Persons & Silberschatz, 1998), which pertains to informed consent (and therefore to the ethical principle of autonomy).

The endorsement of items related to CBT for BN in this study as being “useful but not necessary” does not seem to be out of step with literature that suggests that the majority of EDs therapists do not use ESTs in the treatment of BN. What is curious is that panelists did endorse the item “Be skilled in evidence-based therapies for the treatment of EDs” (197) (consensus after second rating, 96.3% agreement). It is possible some of them had IPT in mind when they endorsed this item as being “essential”; however, only one participant identified using IPT as part of an integrated/eclectic approach. In contrast, 3 participants stated that CBT was their primary orientation, and an additional 5 indicated that they used CBT as part of their integrated/eclectic approach. Alternatively, in a panel that so strongly endorsed issues of the therapeutic relationship,
these results could perhaps be contextualized by Arnow’s (1999) comment that relationship factors are underemphasized in many manualized therapies. In addition, it could be speculated that some panelists had seen evidence in their own practice that the long term efficacy of CBT for BN was questionable, as suggested in a recent review that noted that clients who received CBT for BN often remained symptomatic, sought further treatment, and/or relapsed 1-2 years after receiving manual-based CBT interventions (Westen et al., 2004).

The participants’ comments may provide some clues as to the panel’s consensus on these items. Some participant comments appeared to strongly endorse the use of CBT for BN, while others questioned it. Supportive comments included:

Evidence-based practice [rating of 3].

CBT is the treatment that WORKS!

I believe in the efficacy of CBT for treatment of BN.

CBT is an empirically supported treatment. Very important to be familiar with this.

Given the current research on effectiveness of CBT in BN, it should be important to gain training and expertise in this area.

This is one of the empirically supported treatments – I think it is very important to be familiar with treatments that have been shown to work.

Comments that were less supportive of CBT for BN included:

Don’t believe this is the best approach.

Other therapies are not yet studied statistically (i.e., how to study art therapy?)
It may not be more useful than therapies not yet studied or that don’t lend themselves to statistical analysis.

If CBT is the main therapeutic intervention. Seems to be a bias towards CBT in these questions.

Again, CBT bias. Yes, it’s evidence-based and there are other effective therapies. IPT is more researched, as is CBT.

The content of these latter comments suggests that some panelists did not endorse CBT for reasons of individual choice/clinical judgment regarding what is efficacious, the existence of another effective therapy (IPT), and the idea that other therapies (presumably those that they use themselves) have not shown evidence of effectiveness because they have not yet been studied. All these arguments appear in the literature as potential reasons for the underutilization of ESTs (for EDs and for other issues). These items and the comments generated about them may point to implications for an EDs therapist competency profile that included items specifically endorsing the use of ESTs, because there is clearly a gap between research and practice in this area that has yet to be bridged.

*Non-Consensus Items*

Twenty-nine items did not reach the cut-off for consensus in this study after two rounds of the Delphi process. As noted in the Results section, the literature-derived items on this list are likely to be of more interest because they were drawn from existing treatment guidelines and other published opinions whereas many of the items this list that were suggested by participants could reflect the idiosyncratic interests and approaches/interventions they favour or were simply poorly worded. This section will
focus briefly on two observations: ESTs and the therapist’s own disordered eating/ED/body image issues.

*Empirically Supported Treatments*

Three literature-derived items that referred to ESTs received an ambivalent response from the panelists:

Familiarize her/himself with CBT treatment manuals for the treatment of BN. (118)

Use CBT as the treatment of choice for clients with BN. (I99)

Have had specific training in CBT or IPT at a minimum, with knowledge of supportive, educational, and dynamic techniques. (I170)

This is unsurprising given the trend noted above of the EST items being rated as being “useful but not essential.”

*Therapist’s ED/Disordered Eating/Body Image Dissatisfaction*

Another item of interest was “Not discuss own past experience of having had an ED with her/his patients” (I93) because it elicited the most detailed comments from participants:

Depends on therapist’s ability to appropriately navigate boundaries.

Sometimes this can be therapeutic./ Only if it somehow benefits client.

Done with therapeutic value in mind, preferably if client asks, “limited dose” so focus still on client.

[Depends on] theoretical orientation.

I believe a lot of caution must be exercised in deciding why one’s own experience with ED would be discussed. In general, it should not be discussed, and
only in some **clearly** therapeutic circumstances (which I cannot pinpoint) should there be an exception.

Sometimes this is appropriate – provided the practitioner is recovered.

Question could be framed as “use self-disclosure carefully when deemed therapeutic.”

Take a conservative approach to [illegible] disclosure. Too often, I hear stories from clients of previous therapists overdisclosing. I understand the positive role model as a benefit. However, I believe this must be clinically assessed to ensure it is in the best interest of the client. ED clients struggle (often) with chronic comparison. I prefer not to disclose and believe this is in the best interest of my clients. If I am asked directly, we can review where the question comes from and I may disclose.

Patient may compare self to therapist’s experience. May feel inferior if can’t do as well as therapist.

In addition, this item stimulated a participant to generate another item: “Not be personally experiencing even disordered eating/body image dissatisfaction” (PI53) which, interestingly, did reach consensus after two rounds (69.0% “essential” after one rating and 92.6% “essential” after two ratings), and resulted in another flurry of comments:

Ah well, there would be no practitioners at all…

Is perfection our goal?

Be aware!

Body image dissatisfaction is a matter of degree. Most women experience some at some point. Let’s allow ourselves to be human and not perfect! If I am
not adoring my body one day, surely I can work with my clients. This is a fine point and a matter of degree. I agree [regarding] no active ED.

Not realistic – we all go through this to some degree.

Realistic? Re: BI [body image]?

This can create transference.

Ideal but not realistic. It’s a life-long struggle.

This would eliminate a lot of very good therapists.

The majority of women have some degree of body image dissatisfaction. I believe a standard that demands therapists to have none of this is not realistic and sets the clinician up with some of the perfectionistic standards/dilemmas we are supporting and encouraging our clients to overcome. I would consider some body image dissatisfaction to be normal – not clinically significant such that it is deeply tied to an eating disorder or anxiety disorder.

Andersen and Corson (2001) emphasize that being an ideal therapist means being “completely adequate, not perfect” (p.357). Furthermore, they note that, for clients, recovery means “attaining cultural normality with no identifiable EDs, not human perfection...a woman who does not at least occasionally mention to friends the desire to diet is uncommon.” One would assume that the same standard of resolution would apply to therapists (particularly women therapists) who have been socialized within the context of a normalized preoccupation with appearance, thinness, and an unattainable standard of attractiveness (Brown, 1989).
However, the panel was much less ambivalent about the therapist who is currently experiencing an ED. The item “Not be personally experiencing active ED symptoms” (I84) was strongly endorsed by participants after one rating (100% agreement). The issue of the therapist’s having a history of an ED is not well researched. There exist one or two opinion pieces (e.g., Johnson, 2000) and the occasional personal perspective of recovered practitioners (e.g., Goldkopf-Woodtke, 2001; Bloomgarden, 2000). Johnson discussed the possible pros and cons of hiring staff with the history of an ED at an EDs program. He concluded that such individuals have useful contributions to make to the field but that guidelines should be developed by the Academy for Eating Disorders (AED) and the International Association of Eating Disorder Professionals (IAEDP) that propose benchmarks regarding readiness to enter the field. Goldkopf-Woodtke (2001) discussed her own experience of being an individual who had recovered from AN from the perspective of her role as a therapist, including her views on self-disclosure regarding the ED. Bloomgarden (2000) presented her personal process around decisions to self-disclose to clients about her experience with an ED. Certainly, along with items related to self-awareness, the therapist’s disordered eating/ED history and level of body dissatisfaction would be important therapist characteristics to consider in terms of the development of a competency profile for EDs because they have direct relevance to the ethical principles of beneficence and nonmaleficence.

*The British Columbia Context and the Independent Practitioner*

As discussed previously, acquiring some of the competencies the panel deemed “essential” (e.g., those referencing interdisciplinary collaboration) could be more challenging for the therapist in independent, private practice. It is my impression that
private practitioners in B.C.’s urban areas would have more opportunities to acquire competencies because they have easier access to networking opportunities and specialized continuing education than private practitioners in rural or remote areas of the province (i.e., less travel, less expense). The tertiary treatment care centres have been designated by the provincial government to be responsible for the specialized treatment for the most severely ill individuals, and for the training and evaluation of health care professionals in the EDs field (Birmingham, n.d). To support this mandate, the majority of provincial funding for EDs is directed towards tertiary care facilities, which are located in hospitals in Vancouver’s Lower Mainland. These centres have offered conferences and workshops for health care professionals who work in the treatment of EDs, and these events have been an excellent opportunity for therapists who can attend to make contacts and obtain specialized continuing education.

However, opportunities for community therapists from rural and remote communities that are delivered in those areas are much more infrequent. One exception was Eating Disorders Project North, a program developed through a one-time funding opportunity from Health Canada in the amount of $278,000. The project was “designed to build community-based teams (comprised of health professionals, peers and family members) with the skills to detect eating disorders and make early interventions in a way that was appropriate to each community's circumstances” (Health Canada, 1998).

In this study, some panelists may have been sensitized to the particular challenges of working in rural and remote areas. Some participants worked in rural areas themselves (n = 6 in communities of less than 100,000, 20.7%). The following comments were made about the feasibility of some competencies:
Does not work in rural [areas].

I agree with this approach, but may not be practical in very remote areas.

If [you] have access to family therapy.

Influenced by what is available./Not always available./Not always possible.

The appropriateness of a candidate is only a useful piece of information if alternatives are available.

Difficult to provide this to all private practitioners without the resources.

These comments suggest that there may be fewer options available to the practitioner who works in a rural or remote area of B.C., particularly in terms of the ability to offer certain types of treatment. It could be speculated that the authors of the practice guidelines (from which many items were drawn in this study) did not have rural therapy practitioners in mind when they were developing the guidelines, and perhaps the majority of the panelists did not either. Therefore, despite appearing on the “essential” list, it is possible that some items may not represent feasible practice for rural and remote practitioners in British Columbia.

**Summary**

In this Delphi study, a consensus was reached by a panel of 29 experts in the EDs treatment field in British Columbia on 188 competency items that were thought to be essential for basic, independent therapeutic practice with clients who have EDs. Consensus was also achieved for 21 items thought to be “useful but not essential.” Twenty-nine items did not reach consensus.

The majority (approximately 80%) of the items on the “essential” list had been drawn from existing EDs treatment guidelines and literature; the remaining items had
been generated by the study's participants. The extensiveness of the "essential" list may be an indication that psychotherapy with ED clients requires myriad competencies and that the source documents from which the majority of items were drawn reflect current best practices to which other ED specialists would agree. The design of the study itself also has implications for the extensiveness and meaning of the "essential" list.

Several item groupings on the "essential" list were seen to have particular relevance for ED therapist competence. A few clusters were thought to point to potential role confusion or ambiguity for the ED's therapist if aspects of nutritional management, physical health, and diagnosis are required for competent practice. Involvement with an interdisciplinary team could be an asset in terms of helping to mediate role confusion and has additional implications for the training and practice of ED's therapists (i.e., an interdisciplinary setting may be preferable for both activities). This may be a particular challenge for therapists in independent private practice (especially those in rural areas) who may need to find innovative ways to access opportunities for consulting and liaising with ED's specialists, and specialized continuing education and training. The strength of consensus on items pertaining to the therapeutic relationship may indicate that this aspect of the ED therapist's competence requires special attention. Not only does the strength of the therapeutic relationship have an impact on treatment outcomes for EDs, but the ambivalence and rigidity displayed almost universally by ED clients may present unique challenges in developing and maintaining a helpful therapeutic relationship.

The panel's endorsement of items referencing CBT for BN as being "useful but not essential" (in addition to the lack of consensus achieved on other similar items) appeared to be consistent with literature that points to therapist ambivalence about, and
underutilization of, ESTs in the treatment of EDs. In addition, the therapist's personal experience of an ED, disordered eating, or even body image dissatisfaction (and the issue of self-disclosure regarding these experiences) seemed to be of particular interest to participants who provided relatively detailed comments about items that referred to these topics. Finally, the issue of urban versus rural/remote practice was discussed with respect to the feasibility of some consensus items.

Limitations and Delimitations

Delimitations

This study was delimited in two main ways. First, the panel of participants in this Delphi study consisted of “non representative, knowledgeable persons” (Gordon, 1994, p.6) whose consensus of opinion could, in theory, be different from the consensus of another, equally expert group of people (Hasson et al., 2000). Therefore, in this study, caution should be used in applying the conclusions about the consensus reached in this study to other groups of EDs experts. Lopez and Rogers (2001) suggest that this concern can be partially addressed by comparing the results to the results of future Delphi investigations on the same topic with a different panel.

A second delimitation was that participation was restricted to individuals who lived and worked in the province of British Columbia. Thus, caution should also be used in applying the conclusions of this study to regions other than British Columbia.

Limitations

The limitations of this investigation must be considered: the length of the “essential” competencies list (and the potential factors involved therein), the non-inclusion in Round 3 of literature-derived items for which consensus had not been
reached after the first two rounds, the panel selected for the study, and the decision to not edit the participant items for clarity.

*Length of the “Essential” List.*

The first major limitation concerns the large number of items identified by panelists as being “essential” (n = 188). Lopez and Rogers (2001) also noted this “ceiling effect,” whereby a majority of competency items were rated very highly. They argued that the phenomenon was likely related to the expertise of their panel, whose common knowledge and considerable experience resulted in substantial agreement. Applying this logic to the present study, the long list of “essential” items could be viewed as a strength. However, a long list also reduces the possibility of being able to distinguish truly crucial competencies from very important (but not as crucial) ones. Several choices and decisions I made (including the definition of consensus and Likert scale selected, the length of the questionnaires, the potential effects of demand characteristics, and the inclusion of relatively generic items) almost certainly had an impact on the length the list.

First, if the definition of consensus had been selected to be 90% or greater (rather than 85% or greater), this may have resulted in a shorter list for which there was a more clear and meaningful endorsement of essentiality. However, this would also have necessitated that participants re-rate many more items on already lengthy questionnaires, thus increasing the potential of participant attrition.

A second factor to consider was that the 3-point rating scale offered panelists limited flexibility in terms of rating choice. Therefore, its use may have contributed to an artificial consensus on some of the items appearing on the “essential” list due to a forced lack of variability in ratings.
Third, the considerable length of the questionnaires could have felt overwhelming for some panelists who, in order to speed up the completion of the task, may not always have carefully considered their ratings. Perhaps this was the point of one participant who commented that the process was a “rewarded consensus” whereby one could complete the questionnaires more quickly if one chose to go with the group. Therefore, the trustworthiness of the consensus items must certainly be viewed with this in mind.

In addition, the study’s stated focus on consensus building (e.g., on the letter of introduction and questionnaire instructions) may have influenced panelists to endorse the group median rating and thus may have increased the number of consensus items (i.e., the length of the “essential” list may have been influenced by demand characteristics).

A final consideration concerning the length of the “essential” list was the inclusion of questionnaire items that would likely be considered sound therapeutic practice regardless of the client’s presenting issue. Some relatively generic items were suggested for retention by two thesis committee members and other generic items were suggested by the participants themselves. Although a formal analysis was not undertaken, a cursory glance of the “essential” list indicates that potentially one-third of the “essential” items could be classified as general therapy practitioner competencies. It is not clear, however, whether these items have been inappropriately included on the list. Further research could serve to illuminate aspects of these items that are of special importance in therapy with individuals who have EDs.

*Questionnaire 3 Items.*

A second major limitation of the study was, in Round 3, the non-inclusion of literature-derived items for which consensus had not been reached after two rounds.
Although this decision was intended to help ensure a strong response rate in Round 3 and had the added benefit of equalizing the number of ratings each item received, the consensus process may have concluded prematurely as a result. However, since the general trend in this study was always towards consensus and not away from it, another round would likely have served to further increase the length of the "essential" list, thus potentially adding further ambiguity to its meaning.

This non-inclusion issue also has implications for the ability to discern finer meaning among the list of consensus items (i.e., items that had not reached consensus after one rating were re-rated and may have achieved an even higher level of agreement than items that had initially received a strong endorsement). A partial remedy for this concern might be to consider the level of agreement achieved after the first rating as the most reliable indicator of endorsement.

_Panel Selection._

Another limitation of the study was the purposeful selection of panelists from a wide variety of disciplines involved in treatment delivery for EDs rather than psychotherapists only. While a diverse panel is typically cited as a strength in the Delphi literature (Delbecq et al., 1975; Mamalakis, 2000; Powell, 2002), the implications of this practice were mixed in this study. On one hand, the panel chosen was a relatively accurate approximation of the expertise seen on a typical multidisciplinary EDs team in B.C.'s tertiary care centres and, therefore, was likely to represent a variety of relevant expert opinions that were informed by knowledge of therapy for EDs. After all, prospective participants (regardless of discipline) self-selected to participate knowing the study's aim. On the other hand, despite understanding the aim of the study _therapist_
competencies, not competencies involved in other professions), panelists may have introduced bias into the results if, for whatever reason, they lost sight of the study’s goal and/or referenced practices in their own discipline (e.g., dietetics, medicine). This may have implications for the applicability of certain consensus items to EDs therapy practice, particularly those that may be relevant to the activities of other professions (e.g., diagnosis).

**Verbatim Participant Items.**

A final limitation of the study was the use of unedited participant items on Questionnaires 2 and 3. This practice does appear in the Delphi literature (e.g., Burns et al., 2000; Hasson et al., 2000; Larson & Wissman, 2000) and is said to permit the panelists to be the judge of the items (rather than the researchers). In this study, however, it may have prevented consensus from being reached on some items that may well have contained valuable ideas.

**Implications for Counselling Practice**

The results of this preliminary investigation have implications for the practice and training of future and existing counsellors in British Columbia who wish to provide services to clients with EDs. The study has added to the EDs literature by framing the ED therapist’s activities as an issue of competence. The investigation focused on the competencies of therapists who work with ED clients as a starting point for beginning to delineate the role of counsellors with respect to this population. The list of “essential” competencies endorsed by the panel suggests that great breadth of knowledge and skills is likely required to meet the professional challenges and ethical responsibilities of
working with ED clients. Counsellors would do well to bear this in mind as they contemplate their practice (or desired practice) with this population.

The ethics codes of counselling (e.g., CCA [1999], CPA [1989]) indicate that counsellors should only provide those services for which they have developed competence for the benefit of clients. However, the codes have been written to apply to a broad range of counselling types and therefore contain little explicit information about how competency is defined in various specialty areas. Therefore, it may be that the list of therapist competencies identified in this study could be used to help define more clearly the areas of professional counselling competence with respect to the issue of EDs, and the boundaries of that competence. Without a clear understanding of the necessary competencies for working with ED clients, counsellors could unwittingly reinforce the ED behaviour of their clients and impede their recovery, or worse, make clinical errors that could result in serious harm to the client’s physical and/or emotional health. It may be that a counsellor who does not possess the majority of “essential” competencies identified in this study may need to focus on basic, supportive counselling with the ED client, and then help her to find other resources to intervene with respect to the ED itself. Another option might be for the counsellor to arrange for regular, ongoing supervision with a specialist in therapy for EDs.

In addition, the potential importance of diagnosis as a component of assessment and treatment for EDs suggests that counsellors (who are neither trained nor legally permitted to perform diagnoses in B.C.) may need to refer clients with EDs to a professional or team of professionals who can provide a thorough assessment and diagnosis. These considerations underline the importance of consulting and liaising with
EDs specialists from other disciplines when seeing a client who has an ED, particularly for counsellors in independent practice who may need to create such systems in the absence of an ED team in their community. Projects like Eating Disorders Project North (developed to build caregiver capacity in B.C.'s rural northern communities) have helped to build linkages between EDs health care professionals in private and clinic settings. However, such projects have been rare. Ultimately, counsellors working in EDs who are unable to develop an interdisciplinary network may be practicing unsafely. Indeed, one participant who was responding to an item about interdisciplinary collaboration commented: "Independent practitioners should not work alone."

For counsellors and counsellors-in-training, the process of identifying the knowledge and skills necessary for work with clients who have EDs could be a challenging endeavour when one "doesn't know what one doesn't know." Thus, the results of this study could potentially serve as a basis for counsellor self-examination regarding counselling clients with EDs. As Davis (1997) pointed out, "behavioral indicators of competence...force practitioners to think clearly about their goals, how to achieve them, and how to know when they have succeeded" (p.181). It must be emphasized that, based on the limitations and delimitations of the study, counsellors should not construe the list as the final word on the competencies needed for basic, independent practice with clients who have EDs. However, counsellors could use the list to help them act on their responsibility to decide if they possess adequate competence to work with clients who have EDs. They would be doing this with the knowledge that a group of professionals in British Columbia who possessed expertise in the treatment of EDs had identified these competencies as being important. For counsellors who are
already practicing, the list could help them to identify the competencies they already possessed and those they would like to develop in their continuing education and training.

Participants commented:

[Participating in the study] reminded me of the need to stay connected with the medical issues and... of the need for affective work.

Although I believe I am doing important and useful work with my clients along with our team members, I recognize more of what is missing in my practice and my team members’ practice. As well, these competencies can help guide our ongoing professional development.

I reevaluated my practice as a therapist to ensure that the ways in which I was currently practicing accurately reflected the answers I had put. I do need to do some more work in some areas.

It made me evaluate how I do this work, which is extremely trying and yet very rewarding. I find that those of us in this area are “pioneers” of sorts, in that there isn’t a lot of guidance or knowledge re: working with clients in the field of EDs.

I brought competencies to my team (by raising the statements where my rating was different from the median or mean) and we debated issues. I plan to continue bringing competencies forward for discussion as we have a multidisciplinary team where our diversity is an asset and a source of disagreement at times.

[Participating in the study] had me look more closely at my own practice and the key areas to build on for the ED Program.
Particularly for counsellors-in-training, the list could be helpful in making choices about course assignments and training experiences that would enhance the development of their competencies with ED clients. A participant commented:

For those new to the field or students interested in getting into the field, the competencies offer an excellent guide for curriculum planning.

Ultimately, the list may serve to increase the quality of services for treating EDs in B.C. by helping counsellors to correctly gauge their competence to work with this population. Community counsellors often fill the important gap between when an individual identifies having difficulties with food/eating and when more intensive treatment (e.g., hospital, clinic) is accessed. After receiving intensive treatment in a tertiary care setting, clients return to their home communities. Community counsellors and treatment teams who maintain a dialogue about the client’s progress are helping to ensure continuity of care for the client.

With respect to education, the study’s results suggested that advanced education and training is likely a requirement for working with clients who have EDs. For counsellors in British Columbia, this type of opportunity would be offered through graduate programs in Counselling Psychology where students have opportunities to select appropriate and relevant course assignments, clinic, practica, and/or internship opportunities that will aid in the development of their knowledge and skills with clients who have EDs. Of particular importance may be accessing some training in an interdisciplinary setting. If the strength and quality of the therapeutic or counselling relationship has particular implications for recovery from an ED, the student would likely need to receive ample supervision from a therapist with expertise in therapy for EDs who
would be knowledgeable about building, monitoring, managing, and ending the therapeutic relationship with ED clients. Conversely, supervisors in ED treatment settings could also find the list useful when prioritizing the acquisition of competencies for students.

Future Research

Future research is needed that would examine, refine, and prioritize the competencies identified in this Delphi study in order to identify a set of core competencies for EDs therapists and/or counsellors and to delineate more clearly the role of the therapist/counsellor vis a vis the activities of various other professions involved in the treatment of EDs. Such core competencies could be incorporated into inventories designed to help practitioners self-assess their level of competence to work with clients who have EDs, or to help supervisors assess how well their students are acquiring the necessary competencies for this work.

Because this is the first known study to identify therapist/counsellor competencies for working with ED clients, other investigations that continue to conceptualize essential competencies for this work would be helpful. Another Delphi study using a different panel of experts (perhaps drawn from a wider geographical pool and/or consisting of single-profession panels) could help to validate these results. Within the context of training, research could also be conducted to determine how to best educate and train both students and current practitioners (e.g., supervision versus case-based courses or workshops; in-service programming versus external workshops, etc.). This study was not designed to access the views of clients who have EDs. Therefore, an important addition to the literature could be an investigation of therapist and/or counsellor competencies that
clients with EDs consider to be important, relevant, and helpful. The present investigation constituted one step toward the empirical identification of counsellor competencies for working with clients who have EDs. Therefore, future investigations are needed that continue to conceptualize the essential competencies for this work and assess the impact of these competencies on service delivery.
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Appendices
Appendix B: Letter of Introduction

July 14, 2004

«Title»«First_Name» «Last_Name»
«Company_Name»
«Address»
«City», BC
«Pcode»

Dear «First_Name»,

We would like to inform you of a study that proposes to identify the therapist competencies that are essential for the provision of psychotherapy to individuals with eating disorders. This research is being conducted as a Master’s thesis. While it has been recognized that eating disorders require treatment expertise, there has been a lack of empirical research investigating this particular aspect of eating disorders treatment.

We anticipate that the information from this study will be important because it will (a) potentially aid therapists and counsellors in evaluating their scope of practice with clients who have eating disorders, (b) enable clinicians-in-training who wish to specialize in eating disorders to make choices regarding their continuing education, and (c) perhaps ultimately serve to increase the eating disorder treatment resources in British Columbia by helping to identify practitioners who are able to correctly gauge their competence to provide services to this sensitive population.

To complete this research, we are seeking a panel of experts who will provide their opinions on this topic. We are hoping to recruit panelists from a wide variety of disciplines (e.g., psychiatrists, clinical psychologists, social workers, counselling psychologists, counsellors, psychiatrists, nurses, child and family workers, etc.) who will bring diverse perspectives to this topic. Eligible panelists must live and work in British Columbia and must meet ONE of the five following criteria:

1. Has practised in EDs treatment for at least 5 years and completed a practicum and/or internship in a related area.
2. Has supervised therapists-in-training in an EDs treatment setting.

(continued on next page)
3. Has published scholarly work on the topic EDs treatment, ethics, and/or professional competence between 1995 and 2003 (first, second or third author).
4. Has taught about EDs treatment at the graduate level.
5. Has presented one or more refereed national conference presentations on EDs treatment, ethics, and/or professional competence.

If you meet 1 of the 5 criteria described above and have an interest in participating in this project, the participation commitment is outlined below.

The study will use the Delphi method to collect panelists’ opinions and move towards a consensus. There will be three phases to this process. Over the course of 6-8 weeks, you will be asked to complete three questionnaires that address the research topic. It is anticipated that each of these three questionnaires will take one-half hour to 1 hour to complete (for a total up to 3 hours). You will also be asked to fill out a brief demographic questionnaire. The first questionnaire will ask you rate competencies drawn from the eating disorders literature. The second and third questionnaires will ask you to review your previous responses to each item while taking into consideration group statistical information. The study is seeking your expert opinion and we think you will find the process interesting. A summary of the results will be made available to you at the conclusion of the study.

For your participation, you will receive a $15.00 Chapters/Indigo gift card for each questionnaire you complete (for a total of up to $45.00). These gift cards can be redeemed online or at a Chapters/Indigo retail outlet.

Your confidentiality will be strictly maintained. It is anticipated that the study will begin in late Summer of 2004. If you wish to participate, please contact Meris Williams toll-free at 1-877-321-1904 or at malw@interchange.ubc.ca. Thank you for considering your involvement in this study.

Sincerely,

Meris Williams, B.Sc.
M.A. Student
Department of Counselling Psychology
Psychology
University of British Columbia
Toll-free: 1-877-321-1904
malw@interchange.ubc.ca

Dr. Beth Haverkamp
Associate Professor
Department of Counselling
University of British Columbia
Telephone: 604-822-5259
Appendix C: Listserve Recruitment Advertisement

Research Participants Wanted

My name is Meris Williams and I am a Master’s student in the Department of Educational & Counselling Psychology, and Special Education at the University of British Columbia. My research supervisor is Dr. Beth Haverkamp.

For my Master’s thesis, I am hoping to identify the therapist competencies that are essential for basic, independent therapeutic practice with clients who have eating disorders. While it has been recognized that eating disorders require treatment expertise, there has been a lack of empirical research investigating this particular aspect of eating disorders treatment.

We anticipate that the information from this study will be important because it will (a) potentially aid therapists and counsellors in evaluating their scope of practice with clients who have eating disorders, (b) enable clinicians-in-training who wish to specialize in eating disorders to make choices regarding their continuing education, and (c) perhaps ultimately serve to increase the eating disorder treatment resources in British Columbia by helping to identify practitioners who are able to correctly gauge their competence to provide services to this sensitive population.

To complete this research, we are seeking a panel of experts who will provide their opinions on this topic. We are hoping to recruit panelists from a wide variety of disciplines (e.g., psychiatrists, clinical psychologists, social workers, counsellors, psychologists, counsellors, psychiatrists, nurses, child and family workers, etc.) who will bring diverse perspectives to this topic. Eligible panelists must meet ONE of the five following criteria:

1. Has practised in EDs treatment for at least 5 years and completed a practicum and/or internship in a related area.
2. Has supervised therapists-in-training in an EDs treatment setting.
3. Has published scholarly work on the topic EDs treatment, ethics, and/or professional competence between 1995 and 2003 (first, second or third author).
4. Has taught about EDs treatment at the graduate level.
5. Has presented one or more refereed national conference presentations on EDs treatment, ethics, and/or professional competence.

If you meet 1 of the 5 criteria described above and have an interest in participating in this project, the participation commitment is outlined below.

For your participation, you will receive a $15.00 Chapters/Indigo gift card for each questionnaire you complete (for a total of up to $45.00). These gift cards can be redeemed online or at a Chapters/Indigo retail outlet.
The study will use the Delphi method to collect panelists' opinions and move towards a consensus. There will be three phases to this process. Over the course of 6-8 weeks, you will be asked to complete three questionnaires that address the research topic. It is anticipated that each of these three questionnaires will take 30 minutes to 1 hour to complete (for a total up to 3 hours). You will also be asked to fill out a brief demographic questionnaire. The study is seeking your expert opinion and we think you will find the process interesting. A summary of the results will be made available to you at the conclusion of the study.

If you wish to participate in the study or have any questions about it, please contact Meris Williams at malw@interchange.ubc.ca or call (toll free) 1-877-321-1904. It is anticipated that data collection will commence in late Summer of 2004. Thank you for considering your involvement in this study.

Sincerely,

Meris Williams, B.Sc.
M.A. Student
Department of Educational & Counselling Psychology, and Special Education
University of British Columbia
malw@interchange.ubc.ca
Toll free: 1-877-321-1904

Dr. Beth Haverkamp
Associate Professor
Department of Educational & Counselling Psychology, and Special Education
University of British Columbia
Telephone: 604-822-5259
Appendix D: Participant Informed Consent Form

**Consent Form for Research Participation**

**Title:** Conceptualizing Therapist Competencies in the Treatment of Eating Disorders: A Delphi Study

**Principal Investigator:** Dr. Beth Haverkamp, Associate Professor, Department of Educational and Counselling Psychology and Special Education, Faculty of Education, University of British Columbia. Telephone: 604-822-5259.

**Co-Investigator:** Ms. Meris Williams, M.A. student, Department of Educational and Counselling Psychology and Special Education, Faculty of Education, University of British Columbia. Telephone: 604-321-1904.

**Purpose:** The purpose of the study is to identify and evaluate the competencies required for the provision of psychotherapy to individuals who have eating disorders. This study is for the master's thesis of Ms. Meris Williams.

**Study Procedures:** The research design employs Delphi methodology. You will be asked to complete a total of three questionnaires over a period of approximately 6-8 weeks. Each questionnaire should take a maximum of 1 hour to complete. You will also be asked to provide some demographic information about yourself at the beginning of the study. If, at any point in the study, you wish to withdraw your participation, please inform the investigators and your request will be honoured with no penalty.

**Confidentiality:** Your identity will be kept strictly confidential. The following steps will be undertaken to ensure that your confidentiality is maintained:

1. All research team members will sign a written contract agreeing to maintain strict confidentiality;
2. All information obtained in this research study will be stored in a locked filing cabinet;
3. The locked filing cabinet containing the research materials will only be directly accessible by Ms. Meris Williams;
4. All computer files will be locked with a password;
5. All documents will be identified with only a code number;
6. A research assistant who is unfamiliar with the eating disorders field will assign the code numbers;
7. You will not be identified by name in any reports of the completed study.

In accordance with the 2002 Code of Conduct of the College of Psychologists of British Columbia and the 1996 Child, Family and Community Service Act, research team members are legally and/or ethically required to breach confidentiality in the case of child abuse or neglect, self-harm or imminent harm to another individual.

As per university policy, all information and data obtained in this research study cannot be destroyed until at least five years after the publishing of the research in a refereed academic journal. The data in this study will not be kept past this period unless future university approval is obtained for the further use of the data. Should you wish, the information you provide can be destroyed and erased from our records after this 5-year period, regardless of whether future use of the data is approved. In the future, we may wish to use the data from this study in a nation-wide Delphi study on the same topic. Please indicate your consent with respect to the use of your data in this future study in the Consent section, below.

Compensation: For each questionnaire you complete, you will receive a gift card for Chapters/Indigo bookstore in the amount of $15.00, which can be redeemed online or at a retail outlet. As the project consists of three questionnaire rounds, your completion of all three rounds is preferred. However, if you choose to withdraw your participation from the study, please inform the investigators and your request will be honoured with no penalty. In this case, you will receive a $15.00 gift card for each questionnaire you have completed prior to your notifying us of your wish to withdraw.

Contacts: If you have any questions or desire further information with respect to this study, you may contact Ms. Meris Williams at 1-877-321-1904 or Dr. Beth Haverkamp, at 604-822-5259. If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Consent: If you have any questions about the research study or your participation in it, please address them to Ms. Meris Williams or Dr. Beth Haverkamp at the numbers provided before signing this consent form.

I consent to the use of my data in an expanded Delphi study on this topic in the future (please circle one): Yes No

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time.

I have received a copy of the consent form for my own records.

My signature below indicates that I consent to participate in this study:

Name (please print) Signature Date
Appendix E: Questionnaire Consent Form

Conceptualizing Therapist Competencies in the Treatment of Eating Disorders: A Delphi Study

Principal Investigator: Dr. Beth Haverkamp, Associate Professor, Department of Educational and Counselling Psychology and Special Education, Faculty of Education, University of British Columbia. Telephone: 604-822-5259.


Purpose: The purpose of this questionnaire is (a) to obtain demographic information from you and (b) to determine how essential you think various competencies are in the delivery of psychotherapy to individuals with eating disorders. This is the first of three questionnaires that you are being asked to complete over the next 6-8 weeks.

Procedure: As mentioned in the consent form, this questionnaire should take up to 1 hour to complete. Upon completion, please seal this in the pre-stamped, addressed envelope and return it to the researchers. Feel free to call the researchers should clarification of any question be needed.

Confidentiality: The information provided in this questionnaire will be kept strictly confidential, as detailed in the consent form.

Consent: If the questionnaire is completed, it will be assumed that consent has been given.
Questionnaire 1
Demographics

A. INTRODUCTION

We would like to collect some demographic information about each of the participants in this study. The information you share here, and on all other questionnaires in this study, will be kept confidential. Once you have completed this demographics section, please begin completing the attached questionnaire. Thank you for your assistance.

B. PROFESSIONAL EXPERIENCE

Please provide us with the following information about your work in the eating disorders field.

B1. What is the approximate size of the city or town in which you work primarily? (circle one)
   1. Less than 20,000 people
   2. 20,000 – 100,000 people
   3. 100,001 - 500,000 people
   4. More than 500,000 people

B2. What is your profession? (circle one)
   1. Family & Youth Worker
   2. Clinical Psychologist
   3. Counsellor
   4. Counselling Psychologist
   5. Dietitian
   6. Nutritionist
   7. Nurse
   8. Psychiatrist
   9. Social Worker
   10. Other (please specify) ________________

B3. In what context do you work?
   1. Eating disorders program
   2. Private practice
   3. Both eating disorders program & private practice
   4. Other (please specify) ________________

B4. If you provide therapy, what is your primary therapeutic orientation? _________________________

B5. What are your primary areas of practice or research specialization? _________________________

B6. How many years of experience do you have in the eating disorders field? ________

(continued on next page)

Version Date: April 5, 2004
B7. Please circle all the eligibility criteria that apply to you:

1. I have practised in EDs treatment for at least 5 years and have completed a practicum and/or internship in a related area.
2. I have supervised counsellors- or therapists-in-training in an EDs treatment setting.
3. I have published scholarly work on the topic of EDs treatment, ethics, and/or professional competence between 1995 and 2003 (first, second or third author).
4. I have taught about EDs treatment at the graduate level.
5. I have presented at least one refereed national conference presentation on EDs treatment, ethics, and/or professional competence.

C. DEMOGRAPHIC INFORMATION

Please provide us with the following demographic information.

C1. You are: 1. Male 2. Female

C2. Your ethnic heritage:

1. African 5. Latin/Hispanic
3. Caucasian/European 7. Other (please specify) ________________
4. First Nations

C3. Please circle the highest level of education that you have completed:

1. High School 4. Master's Degree
2. Bachelor's Degree 5. Ph.D., M.D. or equivalent doctoral degree
3. Diploma Program

Thank you for your help!
Please begin completing Questionnaire 1 →
Questionnaire 1

PART A: INTRODUCTION

We appreciate your participation in this study. This is the first of three questionnaires that you will be completing over a period of 6-8 weeks. It should take a maximum of 1 hour to complete.

The questionnaire is comprised of items that were drawn from the eating disorders literature. Each item represents a potential competency that may be relevant to therapists who work individually with clients who have eating disorders (EDs). Using the scale provided, we would like you to rate each item based on whether you think it is essential for basic, independent (i.e., unsupervised) therapeutic practice with ED clients. There is also space for you to write a very brief comment on, or rationale for, each of your ratings (although this is not required). At the end of the questionnaire, you may provide up to 10 additional competencies that you would like to add to the list (and which will be included on the next questionnaire).

Once you have completed the questionnaire, please return it in the pre-addressed stamped envelope enclosed by September 1, 2004. Your timely return of this questionnaire is appreciated, as all the panelists' questionnaires must be returned before the next questionnaire can be sent out. The information you provide here and your responses to all other questionnaires will be kept confidential. Thank you for your assistance!

Would it be all right for a research team member to contact you in the event that clarification of your response is required? (circle one)

1. Yes - please contact me at this telephone number/e-mail address: _____________________________

2. No

PART B: ORIENTING STATEMENT

Please read the following orienting statement before completing the remainder of the questionnaire.

Orienting Statement

Treating clients who have eating disorders requires expertise\(^1\). The ethics codes governing the helping professions typically include a standard that addresses professional competence, wherein professionals are urged to carry out only those activities for which they have established their competence to benefit others. Therapists who wish to work with clients who have eating disorders must be able to determine their competence (and limits of competence) to work with this sensitive client population. **Competencies** can be thought of as the specific skills and areas of knowledge needed to perform the tasks of therapy competently, but they can also include other therapist characteristics deemed important for the provision of competent psychotherapy services. In this study, we hope to ascertain the competencies that are essential for therapists who wish to do basic, independent practice with eating disordered clients.

\(^1\) American Psychiatric Association, 2000

Version Date: April 5, 2004
PART C: SUGGESTED COMPETENCIES FOR BASIC, INDEPENDENT THERAPEUTIC PRACTICE WITH ED CLIENTS

We would like to know what competencies you think are essential for therapists to possess in order to do basic, independent practice with clients who have eating disorders. Please keep this goal in mind as you complete the questionnaire. To rate each competency, please circle a number on the 3-point scale provided, where 1 = "Not Necessary", 2 = "Useful but Not Essential", and 3 = "Essential" (4 = "Don't Know").

If you wish to comment briefly on or provide a rationale for a rating, there is space provided to the far right of each item for this purpose; however, this is not required. As there are many items to rate, and we do not want you to have to spend more than one hour completing the questionnaire, we suggest that you allocate the majority of your time to completing the ratings and that you add comments only when you feel strongly disposed to do so. Please note that all items refer specifically to the provision of individual therapy to clients with EDs.

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<tbody>
<tr>
<td>1</td>
<td>not necessary</td>
<td>useful but not essential</td>
<td>essential</td>
</tr>
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</table>

I. SPECIALIZED KNOWLEDGE BASE

For basic, independent practice with clients who have eating disorders, the therapist should:

| 1. Know the diagnostic criteria for AN, BN and EDNOS. | 1 | 2 | 3 | DK |
| 2. Know the diagnostic criteria for Binge Eating Disorder. | 1 | 2 | 3 | DK |
| 3. Know the prevalence and distribution of EDs. | 1 | 2 | 3 | DK |
| 4. Keep up with changes in diagnostic assessment. | 1 | 2 | 3 | DK |
| 5. Recognize that, when doing assessment, theories other than bio-psycho-social are incomplete. | 1 | 2 | 3 | DK |
| 6. View assessment as a process that takes place over several sessions. | 1 | 2 | 3 | DK |
| 7. View assessment as a process that focuses on gathering specific information (e.g., current weight, weight history, and degree of body image disturbance, weight control measures). | 1 | 2 | 3 | DK |
| 8. Have an overall organizing concept of the causes and progression of EDs. | 1 | 2 | 3 | DK |
| 9. Understand the rationale for sequencing and integrating treatments. | 1 | 2 | 3 | DK |
| 10. Consider client risk in treatment planning. | 1 | 2 | 3 | DK |
| 11. Integrate ethical principles and legal requirements (e.g., client autonomy, informed consent) in treatment planning. | 1 | 2 | 3 | DK |
| 12. Acknowledge that many people with EDs are ambivalent about treatment, and recognize the consequent demands and challenges this presents. | 1 | 2 | 3 | DK |
| 13. Be knowledgeable about the implications of comorbid disorders. | 1 | 2 | 3 | DK |
| 14. Know how to rate EDs and comorbid symptoms qualitatively. | 1 | 2 | 3 | DK |
| 15. Demonstrate knowledge of range of treatment programs/resources relevant to client needs. | 1 | 2 | 3 | DK |
| 16. Possess knowledge of state-of-the-art treatment approaches. | 1 | 2 | 3 | DK |
| 17. Be knowledgeable about evidence-based therapies for EDs treatment. | 1 | 2 | 3 | DK |
| 18. Familiarize her/himself with CBT treatment manuals for the treatment of BN. | 1 | 2 | 3 | DK |
| 19. Be familiar with body image treatment protocols. | 1 | 2 | 3 | DK |
| 20. Be knowledgeable about behavioral techniques (e.g., planned meals, self-monitoring). | 1 | 2 | 3 | DK |

Version Date: April 5, 2004
**For basic, independent practice with clients who have eating disorders, the therapist should:**

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<thead>
<tr>
<th></th>
<th>1 not necessary</th>
<th>2 useful but not essential</th>
<th>3 essential</th>
<th>DK don't know</th>
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<tbody>
<tr>
<td>21.</td>
<td>Have knowledge of other clinically useful treatment modalities (e.g., self-help, feminist therapies, body image therapy, dialectical behaviour therapy, 12-step approaches).</td>
<td>1</td>
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<td>22.</td>
<td>Recognize the utility of non-verbal therapeutic methods such as creative arts and movement therapy programs.</td>
<td>1</td>
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<tr>
<td>23.</td>
<td>Recognize utility of occupational therapy programs at various stages of recovery.</td>
<td>1</td>
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<td>24.</td>
<td>Recognize that psychoeducation alone can help clients with mild symptoms.</td>
<td>1</td>
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<td>25.</td>
<td>Be aware of self-help resources.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>26.</td>
<td>Recognize that support groups may be helpful adjuncts to treatment.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>27.</td>
<td>Recognize that 12-step programs may be helpful adjuncts to treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>28.</td>
<td>Recognize that support groups are not recommended as the sole initial treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>29.</td>
<td>Recognize that programs that focus exclusively on abstinence (e.g., 12-step) are not recommended as the sole initial treatment approach.</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>30.</td>
<td>Understand the physiological and psychological consequences of starvation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>31.</td>
<td>Recognize that attempts to conduct formal psychotherapy with starving patients may be ineffective.</td>
<td>1</td>
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<tr>
<td>32.</td>
<td>Recognize that psychotherapy alone is not sufficient to treat severely malnourished patients with AN.</td>
<td>1</td>
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<td>33.</td>
<td>Have basic knowledge of nutritional principles in order to reinforce them in therapy.</td>
<td>1</td>
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<td>34.</td>
<td>Understand the role of nutritional rehabilitation.</td>
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<td>35.</td>
<td>Recognize that avoiding food issues in therapy is not adequate or ethical.</td>
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<td>36.</td>
<td>Have, as a general treatment goal, the stabilization of eating patterns.</td>
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<td>37.</td>
<td>Have, as a general treatment goal, the identification of the relationship between eating and pertinent issues.</td>
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<td>38.</td>
<td>Have, as a general treatment goal, the client's mastering of conflicts directly, rather than through the use or avoidance of food.</td>
<td>1</td>
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<td>39.</td>
<td>Have, as an aim of psychological treatment, psychological and physical recovery.</td>
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<td>40.</td>
<td>Have, as an aim of psychological treatment, the reduction of risk to the client.</td>
<td>1</td>
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<td>41.</td>
<td>Encourage weight gain as an aim of psychological treatment for AN.</td>
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<td>42.</td>
<td>Understand the role of medications in treatment.</td>
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<tr>
<td>43.</td>
<td>Have knowledge of physical issues related to EDs (e.g., dental, pregnancy, osteoporosis, EDs &amp; diabetes, etc.).</td>
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<td>44.</td>
<td>Know when and how to refer to a physician for medical intervention.</td>
<td>1</td>
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<td>45.</td>
<td>Consider family therapy as an important adjunct to individual therapy with adult clients, especially when family conflicts are a major issue and when individuation/autonomy issues are still clinically relevant.</td>
<td>1</td>
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<td>46.</td>
<td>Be aware of both the benefits and drawbacks of group psychotherapy.</td>
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<td>47.</td>
<td>Be knowledgeable about issues specific to males with EDs.</td>
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<tr>
<td>48.</td>
<td>Be knowledgeable about issues specific to EDs in athletes.</td>
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<td>49.</td>
<td>Be knowledgeable about issues related to age and EDs (e.g., age of onset, EDs and the elderly).</td>
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For basic, independent practice with clients who have eating disorders, the therapist should:

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<tr>
<td>50. Be knowledgeable about cultural factors concerning weight and shape.</td>
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<tr>
<td>51. Have an understanding of culture-bounded disorders and sociocultural norms (e.g., gender-specific pressure for thinness and shape change, differences within different demographic, ethnic, and racial groups, and within sexual orientations).</td>
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<td>52. Be knowledgeable about primary prevention and early intervention programs and research.</td>
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<tr>
<td>53. Understand the boundaries of psychotherapy.</td>
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<tr>
<td>54. Recognize boundaries of her/his competence when working with EDs clients.</td>
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II. SPECIALIZED SKILLS

For basic, independent practice with clients who have eating disorders, the therapist should:

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<td>useful but not essential</td>
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<tr>
<td>55. Utilize bio-psycho-social theories when assessing clients.</td>
<td>1</td>
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<td>56. Use a multimodal assessment process (e.g., client/family/peripheral sources).</td>
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<tr>
<td>57. Ensure that the client receives an adequate assessment based on face-to-face contact of sufficient duration to gather information about the client's biological, psychological, environmental, and cultural qualities and conditions.</td>
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<td>58. Use standardized self-report instruments (e.g., EAT, EDI) to obtain information in addition to the clinical interview.</td>
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<td>59. Include, in assessment, an examination of psychodynamic factors which may be the underlying cause, or sustaining factors, of the ED.</td>
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<td>60. In assessment, identify appropriate candidates for a given approach and format (e.g., individual vs. group therapy).</td>
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<td>61. Include family psychiatric history in assessment.</td>
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<td>62. With younger clients, assess dynamic issues of lack of autonomy, incomplete individuation, and failure to tolerate painful affect.</td>
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<td>63. With older clients, assess issues of living independently.</td>
<td>1</td>
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<td>64. Evaluate trauma history in clients presenting with an ED.</td>
<td>1</td>
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<td>65. Conduct careful assessment of patient's level of motivation for change.</td>
<td>1</td>
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<tr>
<td>66. Accurately assess client's physical risk.</td>
<td>1</td>
<td>2</td>
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<td>DK</td>
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<tr>
<td>67. Accurately assess client's risk to self.</td>
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<td>68. Ask about and objectively quantify weight control measures (e.g., dieting, laxative use, etc.)</td>
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<td>DK</td>
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<tr>
<td>69. Screen for dangerous, but not always evident, medical problems associated with EDs.</td>
<td>1</td>
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<td>DK</td>
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<tr>
<td>70. Use qualitative descriptions of key ED symptoms so that documentation of therapeutic responses may be made.</td>
<td>1</td>
<td>2</td>
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<td>DK</td>
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<tr>
<td>71. Make clinically responsible diagnoses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
</tr>
<tr>
<td>72. With children and adolescents, be alert to indicators of abuse throughout treatment.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>73. Apply ED theories creatively and flexibly to develop multiple treatment strategies.</td>
<td>1</td>
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<tr>
<td>74. Demonstrate expertise in sequencing and integration of treatment planning.</td>
<td>1</td>
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<td>75. Provide clients with information regarding treatment choice.</td>
<td>1</td>
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<td>DK</td>
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</table>
For basic, independent practice with clients who have eating disorders, the therapist should:

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<th>essential</th>
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</tr>
</thead>
<tbody>
<tr>
<td>76.</td>
<td>Discuss the sequencing and integrating of treatments with clients to increase client participation in the therapy plan.</td>
<td>1</td>
<td>2</td>
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<td>77.</td>
<td>Provide clients with a rationale for level and type of care.</td>
<td>1</td>
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<td>3</td>
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<td>78.</td>
<td>Listen to and discuss the patient’s concerns about the proposed treatment in a supportive fashion.</td>
<td>1</td>
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<td>79.</td>
<td>Implement treatment interventions based on accurate assessment and evaluation process.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>80.</td>
<td>Be able to accurately diagnose separate comorbid diagnoses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>81.</td>
<td>Be able to determine whether comorbidities are preexisting or secondary to ED symptomology.</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>82.</td>
<td>Determine whether comorbid disorders should be treated prior to or simultaneously with ED interventions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>83.</td>
<td>Incorporate comorbidity information when making a decision about medication referral for the client.</td>
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<td>84.</td>
<td>Use interventions that incorporate an understanding of comorbid disorders.</td>
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<td>85.</td>
<td>Master the integration of assessment and differential diagnostic skills relevant to EDs field.</td>
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<td>86.</td>
<td>Determine most appropriate level of care, which is assessment driven</td>
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<td>87.</td>
<td>Establish a strong therapeutic alliance characterized by acceptance, honesty, and reassurance throughout the therapeutic process.</td>
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<td>88.</td>
<td>Build trust, establish mutual respect, and develop a therapeutic relationship with the patient that will serve as the basis for ongoing exploration and treatment of the problems associated with the ED.</td>
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<td>89.</td>
<td>Monitor the quality of the therapeutic relationship.</td>
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<td>90.</td>
<td>Use a collaborative approach (e.g., actively involve client in planning, goal development, etc.) to maximize client participation in the treatment process.</td>
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<td>91.</td>
<td>Communicate an awareness of the ambivalence about treatment that many clients with EDs experience.</td>
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<td>92.</td>
<td>Be able to discuss frankly with the patient any concerns the patient has in relation to the therapist’s weight or shape.</td>
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<td>93.</td>
<td>Not discuss own past experience of having had an ED with her/his patients.</td>
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<td>94.</td>
<td>Avoid competition with the patient (e.g., concerning body size).</td>
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<td>95.</td>
<td>Employ motivational enhancement techniques with patients who initially lack motivation.</td>
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<td>96.</td>
<td>Adopt a style of empathic engagement versus a forceful approach.</td>
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<td>97.</td>
<td>Be skilled in evidence-based therapies for the treatment of EDs.</td>
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<td>98.</td>
<td>Demonstrate mastery of multiple treatment modalities.</td>
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<td>99.</td>
<td>Use CBT as the treatment of choice for clients with BN.</td>
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<td>100.</td>
<td>Use CBT treatment manuals in the treatment of BN.</td>
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<td>101.</td>
<td>Use CBT-BN (manualized CBT program specifically for BN) for clients with BN.</td>
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<td>102.</td>
<td>Offer CBT for binge eating disorder (CBT-BED) to adults with BED.</td>
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<td>103.</td>
<td>Treat adolescents with EDs with CBT (adapted as needed to suit patient’s age, circumstances and level of development, and including the family, if appropriate).</td>
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<td>104.</td>
<td>Be skilled in the use of behavioural techniques (e.g., self-monitoring, planned meals).</td>
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<td>105. Not use rigid behaviour modification programs with clients with BN.</td>
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<td>106. Use psychodynamic therapy, especially if CBT or IPT are ineffective.</td>
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<td>107. Consider using cognitive analytic therapy for AN (CAT).</td>
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<td>108. Use psychological treatment for AN that focuses on eating behaviour, attitudes to weight and shape, and wider psychosocial issues.</td>
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<td>109. Consider more intensive forms (or combinations of) of treatment if there is significant deterioration or no significant improvement during psychological treatment.</td>
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<td>110. Use psychodynamic and psychoanalytic approaches in individual or group format once binging and purging are improving.</td>
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<td>111. Use interventions based on addictions models blended with features of other psychotherapeutic approaches.</td>
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<td>112. Use psychoeducation in therapy sessions.</td>
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<td>113. Appropriately integrate self-help into treatment.</td>
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<td>114. Encourage patients with BN or BED to follow an evidence-based self-help program as a possible first step.</td>
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<td>115. Inform patients that all psychological treatments for BED have a limited effect on body weight.</td>
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<td>116. When providing psychological treatments for BED, consider providing concurrent or consecutive interventions focusing on management of comorbid obesity.</td>
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<td>117. Appropriately refer individuals and/or families to support groups.</td>
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<td>118. Use family therapy as the treatment of choice for clients with AN who are 18 or younger and living at home.</td>
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<td>119. Give carers (e.g., family, friends) the opportunity to ask about EDs (e.g., general information, specific risks in involved, best ways to help, etc.).</td>
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<td>120. Consider the needs of carers (e.g., family, friends).</td>
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<td>121. Evaluate the benefits and effectiveness of computer-based treatments and self-help manuals for mild to moderate eating-disordered patients.</td>
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<td>122. Use psychotherapy to help patients understand how to avoid or minimize risks of relapse.</td>
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<td>123. Use psychotherapy to help patients understand how to better deal with salient developmental and other important life issues in the future.</td>
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<td>124. Use psychotherapy to help patients understand the developmental, familial, and cultural antecedents of their illness.</td>
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<td>125. Use psychotherapy to help patients understand how their illness may have been a maladaptive attempt to cope and emotionally self-regulate.</td>
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<td>126. Engage women patients in informed and sensitive discussions regarding their struggles and personal experiences about what it means to be feminine and what it means to be &quot;perfect&quot; in the modern world.</td>
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<td>127. Be sensitive to and inquire about how weight and shape concerns are experienced by patients who are minorities from non-Western or other cultural backgrounds, or who are transitioning and assimilating into Western societies.</td>
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<td>128. Use interventions that incorporate an understanding of cognitive development.</td>
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</table>
For basic, independent practice with clients who have eating disorders, the therapist should:

1. Use interventions that incorporate an understanding of psychodynamic conflicts.  
   | 1 | 2 | 3 | DK |
2. Use interventions that incorporate an understanding of psychological defenses.  
   | 1 | 2 | 3 | DK |
3. Use interventions that incorporate an understanding of the complexity of family relationships.  
   | 1 | 2 | 3 | DK |
4. Use an approach that addresses developmental issues.  
   | 1 | 2 | 3 | DK |
5. Use an approach that addresses identity formation.  
   | 1 | 2 | 3 | DK |
6. Use an approach that addresses body image concerns.  
   | 1 | 2 | 3 | DK |
7. Use an approach that addresses sexual difficulties.  
   | 1 | 2 | 3 | DK |
8. Use an approach that addresses gender role expectations.  
   | 1 | 2 | 3 | DK |
9. Use an approach that addresses interpersonal conflicts.  
   | 1 | 2 | 3 | DK |
10. Use an approach that addresses family dysfunction.  
    | 1 | 2 | 3 | DK |
11. Use an approach that addresses coping styles.  
    | 1 | 2 | 3 | DK |
12. Use an approach that addresses problem solving.  
    | 1 | 2 | 3 | DK |
13. With clients who have AN, be prepared to provide ongoing treatment with individual psychotherapeutic interventions for at least one year and perhaps up to 5-6 years.  
    | 1 | 2 | 3 | DK |
14. With clients who have BN, use an approach that addresses aggressive difficulties.  
    | 1 | 2 | 3 | DK |
15. Advocate against the use of inappropriate treatment modalities.  
    | 1 | 2 | 3 | DK |
16. Advocate against the use of clinically unproven treatment modalities.  
    | 1 | 2 | 3 | DK |
17. Advocate against the use of controversial treatment modalities.  
    | 1 | 2 | 3 | DK |
18. Provide (or make a referral to) family therapy whenever possible, especially for adolescents still living with parents or older patients with ongoing conflicted interactions with parents.  
    | 1 | 2 | 3 | DK |
19. Assemble a team of professionals to provide the best care for clients with EDs.  
    | 1 | 2 | 3 | DK |
20. Develop and appropriately make use of a referral base of other specialized health care professionals.  
    | 1 | 2 | 3 | DK |
21. Collaborate on recommendations/treatment with professionals from other disciplines (e.g., nutritionists, physicians, etc.).  
    | 1 | 2 | 3 | DK |
22. Engage in analysis of larger social-cultural system as advocate for client with ED.  
    | 1 | 2 | 3 | DK |
23. Offer particular help to EDs patients who are themselves parents by paying attention to their parenting skills, and assessing and, if necessary, aiding their children.  
    | 1 | 2 | 3 | DK |
24. Inquire about patients' use of electronic support (e.g., chat rooms, websites, etc.), and other alternative and complementary approaches.  
    | 1 | 2 | 3 | DK |
25. Be prepared to discuss information and ideas that patients and their families have gathered via electronic means, and from alternative and complementary sources.  
    | 1 | 2 | 3 | DK |
26. Carefully monitor patients' experiences with OA and similar groups.  
    | 1 | 2 | 3 | DK |
27. Be able to evaluate and determine integrity/quality of other ED treatment providers and programs.  
    | 1 | 2 | 3 | DK |
28. Attempt to influence decision-making at multiple levels to implement program development and policies beneficial to ED clients.  
    | 1 | 2 | 3 | DK |

Version Date: April 5, 2004
## III. TRAINING, SUPERVISION, & CONTINUING EDUCATION

### For those independent practitioners who have not been considered necessary but essential for the treatment of eating disorders (e.g., treatment and outcome measurement tools to evaluate treatment efficacy, etc.)

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### For those independent practitioners who have been considered useful but not essential (e.g., supervision or consultation, evidence-based scientific study versus anecdotes or fads)

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### For those independent practitioners who have been considered necessary but not essential (e.g., a basic knowledge of eating disorders, the therapeutic relationship)

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### For those independent practitioners who have been considered necessary for the treatment of eating disorders (e.g., possession of specialized training in CBT for the treatment of BN)

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### IV. THERAPIST CHARACTERISTICS

For basic, independent practice with clients who have eating disorders, the therapist should:

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<td>182. Not be frustrated easily by the long-range nature of EDs.</td>
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<td>3</td>
<td>DK</td>
</tr>
<tr>
<td>183. Have high self-nurturance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
</tr>
<tr>
<td>184. Not be personally experiencing active ED symptoms.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
</tr>
<tr>
<td>185. Have sufficient professional sense of self (e.g., concerning his/her own food, eating, and body attitudes, as well as other personal issues), to avoid projection of personal &amp; cultural issues interfering with assessment, diagnosis, treatment planning and intervention process.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
</tr>
<tr>
<td>186. Have the viewpoint that EDs are completely curable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>187. Accurately represent level of competence, education, training and experience.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>

### PART D: ADDITIONAL COMPETENCIES

While completing the questionnaire, you may have thought of additional competencies that you deem essential for a therapist who is doing basic, independent practice with ED clients to possess. If so, please provide up to 10 additional items here and, if you wish, provide an explanatory comment. Please make the items as succinct and specific as possible. You may use the back of this page if you need more space.

<table>
<thead>
<tr>
<th>Suggested competency</th>
<th>Explanatory comment</th>
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<td>8.</td>
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<tr>
<td>9.</td>
<td></td>
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<tr>
<td>10.</td>
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</tr>
</tbody>
</table>
Thank you very much for your help!

Please seal in the addressed, stamped envelope enclosed and return to the Department of Counselling Psychology by September 1, 2004.
Questionnaire 2
(reduced from legal sized paper)
Questionnaire 2

PART A: INTRODUCTION

We appreciate your continued participation in this study, which aims to determine the essential competencies for therapists who wish to do basic, independent practice with individuals who have eating disorders. Thank you for completing and returning Questionnaire 1.

Your continued participation is vital for the successful completion of the project, as the validity of a Delphi study rests on participants completing all questionnaires in the series. This questionnaire should take you a maximum of 1 hour to complete. It contains the original items from Delphi Questionnaire 1, minus those items for which consensus was reached. For this study, "consensus" has been defined as 85% or greater agreement among participants that the item is "essential". This questionnaire also contains new items that participants generated on Questionnaire 1. For your interest, a list of these items has been appended to the survey.

You will notice that this questionnaire includes some additional columns, and these changes are important for you to note. Please read the instructions on the next page carefully.

Once you have completed the questionnaire, please return it in the pre-addressed stamped envelope provided by October 4, 2004. Once again, your timely return of this questionnaire is appreciated, as all the panelists' questionnaires must be returned before the final questionnaire can be sent out. The information you provide here and your responses to all other questionnaires will be kept confidential. Thank you for your assistance.

Would it be all right for a research team member to contact you in the event that clarification of your response is required? (circle one)

1. Yes - please contact me at this telephone number/e-mail address: ______________________________
2. No

Please turn the page to begin completing Questionnaire 2.
<table>
<thead>
<tr>
<th>Your previous rating of this item</th>
<th>PLEASE CONSIDER THIS INFORMATION</th>
<th>PLEASE CIRCLE YOUR RATING FOR THIS ROUND</th>
<th>If your previous rating did not match the median rating and you did not change it to the median rating, we invite you to provide a brief explanatory comment.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>group median rating</td>
<td>group mean rating</td>
<td>group standard deviation</td>
</tr>
<tr>
<td>4. Keep up with changes in diagnostic assessment.</td>
<td>2</td>
<td>3</td>
<td>2.69</td>
</tr>
<tr>
<td>5. Recognize that, when doing assessment, theories other than biopsychosocial are incomplete.</td>
<td>2</td>
<td>3</td>
<td>2.73</td>
</tr>
<tr>
<td>6. View assessment as a process that takes place over several sessions.</td>
<td>3</td>
<td>3</td>
<td>2.76</td>
</tr>
<tr>
<td>7. View assessment as a process that focuses on gathering specific information (e.g., current weight, weight history, and degree of body image disturbance, weight control measures).</td>
<td>3</td>
<td>3</td>
<td>2.69</td>
</tr>
<tr>
<td>14. Know how to rate EDs and assessed symptoms qualitatively.</td>
<td>3</td>
<td>3</td>
<td>2.65</td>
</tr>
<tr>
<td>16. Possess knowledge of state-of-the-art treatment approaches.</td>
<td>2</td>
<td>3</td>
<td>2.52</td>
</tr>
<tr>
<td>17. Be knowledgeable about evidence-based therapies for EDs treatment.</td>
<td>2</td>
<td>3</td>
<td>2.75</td>
</tr>
<tr>
<td>18. Familiarize her/himself with CBT treatment manuals for the treatment of BN.</td>
<td>2</td>
<td>3</td>
<td>2.36</td>
</tr>
<tr>
<td>19. Be familiar with body image treatment protocols.</td>
<td>2</td>
<td>3</td>
<td>2.48</td>
</tr>
<tr>
<td>20. Be knowledgeable about behavioral techniques (e.g., planned meals, self-monitoring).</td>
<td>2</td>
<td>3</td>
<td>2.66</td>
</tr>
<tr>
<td>21. Have knowledge of other clinically useful treatment modalities (e.g., self-help, feminist therapies, body image therapy, dialectical behavior therapy, 12-step approaches).</td>
<td>2</td>
<td>3</td>
<td>2.72</td>
</tr>
<tr>
<td>22. Recognize the utility of non-verbal therapeutic methods such as creative arts and movement therapy programs.</td>
<td>2</td>
<td>3</td>
<td>2.34</td>
</tr>
<tr>
<td>23. Recognize utility of occupational therapy programs at various stages of recovery.</td>
<td>2</td>
<td>3</td>
<td>2.26</td>
</tr>
<tr>
<td>24. Recognize that psychoeducation alone can help clients with mild symptoms.</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>25. Be aware of self-help resources.</td>
<td>3</td>
<td>3</td>
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</tr>
<tr>
<td>26. Recognize that support groups may be helpful adjuncts to treatment.</td>
<td>2</td>
<td>3</td>
<td>2.72</td>
</tr>
<tr>
<td>27. Recognize that 12-step programs may be helpful adjuncts to treatment.</td>
<td>2</td>
<td>2</td>
<td>2.33</td>
</tr>
<tr>
<td>28. Recognize that support groups are not recommended as the sole initial treatment.</td>
<td>2</td>
<td>3</td>
<td>2.68</td>
</tr>
<tr>
<td>33. Have basic knowledge of nutritional principles in order to reinforce them in therapy.</td>
<td>3</td>
<td>3</td>
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</tr>
<tr>
<td>36. Have, as a general treatment goal, the stabilization of eating patterns.</td>
<td>3</td>
<td>3</td>
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</tr>
<tr>
<td>41. Encourage weight gain as an aim of psychological treatment for AN.</td>
<td>3</td>
<td>3</td>
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Version Date: Sept 13, 2004
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<td>42.</td>
<td>Understand the role of medications in treatment.</td>
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<tr>
<td>45.</td>
<td>Consider family therapy as an important adjunct to individual therapy with adult clients, especially when family conflicts are a major issue and when individuation/autonomy issues are still clinically relevant.</td>
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<tr>
<td>46.</td>
<td>Be aware of both the benefits and drawbacks of group therapy.</td>
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<td>3</td>
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<td>47.</td>
<td>Be knowledgeable about issues specific to males with EDs.</td>
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<td>3</td>
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<tr>
<td>48.</td>
<td>Be knowledgeable about issues specific to EDs in athletes.</td>
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</tr>
<tr>
<td>49.</td>
<td>Be knowledgeable about issues related to age and EDs (e.g., age of onset, EDs and the elderly).</td>
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<td>3</td>
</tr>
<tr>
<td>50.</td>
<td>Be knowledgeable about cultural factors concerning weight and shape.</td>
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</tr>
<tr>
<td>51.</td>
<td>Have an understanding of culture-bound disorders and sociocultural norms (e.g., gender-specific pressures for thinness and shape change, differences within different demographic, ethnic, and racial groups, and within sexual orientations).</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52.</td>
<td>Be knowledgeable about primary prevention and early intervention programs and research.</td>
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### II. SPECIALIZED SKILLS

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<td>56.</td>
<td>Use a multimodal assessment process (e.g., client/family/peripheral sources).</td>
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<td>DK</td>
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<tr>
<td>58.</td>
<td>Use standardized self-report instruments (e.g., EAT, EDE) to obtain information in addition to the clinical interview.</td>
<td>2</td>
<td>3</td>
<td>1.85</td>
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<td>59.</td>
<td>Include, in assessment, an examination of psychodynamic factors which may be the underlying cause, or sustaining factors, of the ED.</td>
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<td>3</td>
<td>2.61</td>
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<td>60.</td>
<td>In assessment, identify appropriate candidates for a given approach and format (e.g., individual vs. group therapy).</td>
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<td>61.</td>
<td>Include family psychiatric history in assessment.</td>
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<tr>
<td>62.</td>
<td>With younger clients, assess dynamic issues of lack of autonomy, incomplete individuation, and failure to tolerate painful affect.</td>
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<td>With older clients, assess issues of living independently.</td>
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<td>2.48</td>
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Version Date: Sept 15, 2004
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**If your previous rating did not match the median rating and you did not change it to the median rating, we invite you to provide a brief explanatory comment.**

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**Variation Date: Sept 15, 2004**
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<tr>
<td>108</td>
<td>Use psychological treatments for AN that focuses on eating behaviour, attitudes to weight and shape, and wider psychosocial issues.</td>
<td>2</td>
<td>3</td>
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<tr>
<td>110</td>
<td>Use psychodynamic and psychoanalytic approaches in individual or group format once bingeing and purging are improving.</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>111</td>
<td>Use interventions based on addiction models blended with features of other psychosocial approaches.</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>112</td>
<td>Use psychododuction in therapy sessions.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>113</td>
<td>Appropriately integrate self-help into treatment.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>114</td>
<td>Encourage patients with BN or BED to follow an evidence-based self-help program as a possible first step.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>115</td>
<td>Inform patients that all psychological treatments for BED have a limited effect on body weight.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>116</td>
<td>When providing psychological treatments for BED, consider providing concurrent or consecutive interventions focusing on management of comorbid obesity.</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>117</td>
<td>Appropriately refer individuals and/or families to support groups.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>118</td>
<td>Use family therapy as the treatment of choice for clients with AN who are 18 or younger and living at home.</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>119</td>
<td>Consider the needs of carers (e.g., family, friends).</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>120</td>
<td>Evaluate the benefits and effectiveness of computer-based treatments and self-help manuals for mild to moderate eating-disordered patients.</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>121</td>
<td>Use psychotherapy to help patients understand the developmental, familial, and cultural antecedents of their illness.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>122</td>
<td>Use psychotherapy to help patients understand how their illness may have been a maladaptive attempt to cope and emotionally self-regulate.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>123</td>
<td>Encourage women patients in informed and sensitive discussions regarding their struggles and personal experiences about what it means to be feminine and what it means to be &quot;perfect&quot; in the modern world.</td>
<td>3</td>
<td>3</td>
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<tr>
<td>124</td>
<td>Use interventions that incorporate an understanding of cognitive development.</td>
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Version Date: Sept 15, 2004
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<th>Rating</th>
<th>Rating</th>
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<td>Use interventions that incorporate an understanding of psychodynamic conflicts.</td>
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<td>2.50</td>
<td>0.64</td>
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<td>2</td>
<td>3</td>
<td>DK</td>
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<tr>
<td>130.</td>
<td>Use interventions that incorporate an understanding of psychological defenses.</td>
<td>3</td>
<td>3</td>
<td>2.75</td>
<td>0.32</td>
<td>1</td>
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<td>3</td>
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<td>132.</td>
<td>Use an approach that addresses developmental issues.</td>
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<td>3</td>
<td>2.75</td>
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<td>Use an approach that addresses identity formation.</td>
<td>3</td>
<td>3</td>
<td>2.79</td>
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<td>Use an approach that addresses body image concerns.</td>
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<td>3</td>
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<td>3</td>
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<td>Use an approach that addresses sexual difficulties.</td>
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<td>3</td>
<td>2.54</td>
<td>0.58</td>
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<td>136.</td>
<td>Use an approach that addresses gender role expectations.</td>
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<td>3</td>
<td>2.73</td>
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<td>2</td>
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<td>138.</td>
<td>Use an approach that addresses family dysfunction.</td>
<td>3</td>
<td>3</td>
<td>2.79</td>
<td>0.42</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
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</tr>
<tr>
<td>141.</td>
<td>With clients who have AN, be prepared to provide ongoing treatment with individual psychotherapeutic interventions for at least one year and perhaps up to 5-6 years.</td>
<td>2</td>
<td>3</td>
<td>2.67</td>
<td>0.48</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>142.</td>
<td>With clients who have BN, use an approach that addresses aggressive difficulties.</td>
<td>2</td>
<td>2</td>
<td>2.22</td>
<td>0.67</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>143.</td>
<td>With clients who have BN, use an approach that addresses affect regulation.</td>
<td>3</td>
<td>3</td>
<td>2.83</td>
<td>0.57</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>144.</td>
<td>Advocate against the use of inappropriate treatment modalities</td>
<td>2</td>
<td>3</td>
<td>2.58</td>
<td>0.58</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>145.</td>
<td>Advocate against the use of clinically unproven treatment modalities</td>
<td>2</td>
<td>2</td>
<td>1.88</td>
<td>0.80</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>146.</td>
<td>Advocate against the use of controversial treatment modalities</td>
<td>2</td>
<td>2</td>
<td>2.64</td>
<td>0.77</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>147.</td>
<td>Provide (or make a referral to) family therapy whenever possible, especially for adolescents still living with parents or older patients with ongoing conflicted interactions with parents.</td>
<td>2</td>
<td>3</td>
<td>2.75</td>
<td>0.44</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>151.</td>
<td>Incorporate nutritional prescription from a physician or a nutritionist into treatment.</td>
<td>3</td>
<td>3</td>
<td>2.85</td>
<td>0.37</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>152.</td>
<td>Engage in an analysis of larger social-cultural system as advocate for client with ED.</td>
<td>2</td>
<td>2</td>
<td>2.20</td>
<td>0.58</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>153.</td>
<td>Offer particular help to ED patients who are themselves parents by paying attention to their parenting skills, and assessing and, if necessary, aiding their children.</td>
<td>2</td>
<td>3</td>
<td>2.73</td>
<td>0.43</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
<tr>
<td>154.</td>
<td>Inquire about patients’ use of electronic support (e.g., chat rooms, websites, etc.), and other alternative and complementary approaches.</td>
<td>2</td>
<td>2</td>
<td>2.33</td>
<td>0.49</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
<td></td>
</tr>
</tbody>
</table>

*Version Date: Sept 15, 2004*
PLEASE CONSIDER THIS INFORMATION

<table>
<thead>
<tr>
<th>YOUR PREVIOUS RATING OF THE ITEM</th>
<th>GROUP MEAN RATING</th>
<th>GROUP MEAN RATING</th>
<th>GROUP STANDARD DEVIATION</th>
<th>PLEASE CIRCLE YOUR RATING FOR THIS ROUND</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>155. Be prepared to discuss information and ideas that patients and their families have gathered via electronic means, and from alternative and complementary sources.</td>
<td>2</td>
<td>3</td>
<td>2.68</td>
<td>0.44</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>156. Carefully monitor patients' experiences with OA and similar groups.</td>
<td>2</td>
<td>3</td>
<td>2.75</td>
<td>0.44</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>157. Be able to evaluate and determine integrity/quality of other ED treatment providers and programs.</td>
<td>2</td>
<td>3</td>
<td>2.63</td>
<td>0.63</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>158. Attempt to influence decision-making at multiple levels to implement program development and policies beneficial to ED clients.</td>
<td>2</td>
<td>3</td>
<td>2.50</td>
<td>0.58</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>159. Use pre-treatment and outcome measurement tools to evaluate treatment efficacy.</td>
<td>1</td>
<td>2</td>
<td>2.32</td>
<td>0.61</td>
<td>1 2 3 DK</td>
</tr>
</tbody>
</table>

III. TRAINING, SUPERVISION, & CONTINUING EDUCATION

<table>
<thead>
<tr>
<th>PREVIOUS RATING OF THE ITEM</th>
<th>GROUP MEAN RATING</th>
<th>GROUP MEAN RATING</th>
<th>GROUP STANDARD DEVIATION</th>
<th>PLEASE CIRCLE YOUR RATING FOR THIS ROUND</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>160. Have received supervision, after training, of several cases.</td>
<td>2</td>
<td>2</td>
<td>2.82</td>
<td>0.33</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>161. Have received supervision on the assessment of at least 12 cases.</td>
<td>2</td>
<td>2</td>
<td>2.44</td>
<td>0.58</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>162. Have obtained specialized training in CBT for the treatment of BN.</td>
<td>2</td>
<td>2</td>
<td>2.24</td>
<td>0.51</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>163. Have had specific training in CBT or IPT at a minimum, with knowledge of supportive, educational, and dynamic techniques.</td>
<td>2</td>
<td>3</td>
<td>2.40</td>
<td>0.71</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>164. Have training in evaluating the soundness of the many publications in the field of EDs, including what makes an evidence-based scientific study versus anecdote or fad.</td>
<td>2</td>
<td>3</td>
<td>2.61</td>
<td>0.57</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>165. Have at least one-third of his/her practice comprised of patients with EDs (i.e., does not treat EDs only occasionally)</td>
<td>2</td>
<td>3</td>
<td>2.58</td>
<td>0.58</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>166. Have specific training in CBT or IPT at a minimum, with knowledge of supportive, educational, and dynamic techniques.</td>
<td>2</td>
<td>3</td>
<td>2.68</td>
<td>0.55</td>
<td>1 2 3 DK</td>
</tr>
</tbody>
</table>

IV. THERAPIST CHARACTERISTICS

<table>
<thead>
<tr>
<th>PREVIOUS RATING OF THE ITEM</th>
<th>GROUP MEAN RATING</th>
<th>GROUP MEAN RATING</th>
<th>GROUP STANDARD DEVIATION</th>
<th>PLEASE CIRCLE YOUR RATING FOR THIS ROUND</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>167. Have at least one-third of his/her practice comprised of patients with EDs (i.e., does not treat EDs only occasionally)</td>
<td>2</td>
<td>3</td>
<td>2.58</td>
<td>0.58</td>
<td>1 2 3 DK</td>
</tr>
<tr>
<td>168. Have the viewpoint that EDs are completely curable.</td>
<td>2</td>
<td>3</td>
<td>2.42</td>
<td>0.81</td>
<td>1 2 3 DK</td>
</tr>
</tbody>
</table>
A number of additional competencies were generated by participants in Round 1. We would like to know which of these competencies you think are essential for therapists to possess in order to do basic, independent practice with clients who have eating disorders. To rate each competency, please circle a number on the 3-point scale provided, where 1 = "Not Necessary", 2 = "Useful but Not Essential", and 3 = "Essential" (4 = "Don't Know"). If you wish, you may comment briefly in the space provided to the far right of each item, however, this is not required. In the interest of time, we suggest that you add a comment only when you feel strongly disposed to do so.

### Suggested Competencies

For basic, independent practice with clients who have eating disorders, the therapist should:

<table>
<thead>
<tr>
<th>Competency</th>
<th>1: Not Necessary</th>
<th>2: Useful but Not Essential</th>
<th>3: Essential</th>
<th>DK: Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have an awareness of substance abuse issues.</td>
<td></td>
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<td>3. Assess group supervision with other clinicians.</td>
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<td>4. Be aware of the issues that could arise in engaging clients.</td>
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<td>5. Have awareness of personal assumptions re: body shape to avoid countertransference or collusion with clients.</td>
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<tr>
<td>6. Assume that the client has resources as it is therapeutic and engages him in the process.</td>
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<td>7. Avoid pathologizing and distancing via labeling and/or conceptualizing.</td>
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<tr>
<td>8. Be skilled in building a therapeutic alliance.</td>
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<tr>
<td>9. Be competent in managing, in a genuine and caring way, the challenges that arise in the therapist-client relationship.</td>
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<tr>
<td>10. Provide a therapeutic relationship that will impact on client's self-development and other relationships.</td>
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<tr>
<td>11. Use DBT skills - mindfulness, distress tolerance, affect regulation, and interpersonal skills.</td>
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<tr>
<td>12. Have knowledge of effective bridging between inpatient and outpatient services.</td>
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<tr>
<td>13. Use expressive skills with all clients, so as to enable them to identify feelings and feel less restrained expressing themselves in the world.</td>
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<tr>
<td>14. Have knowledge of temperament and genetics so as to help clients understand inborn traits, exo- and endo-traits, and genetic underpinnings, to the degree we understand them.</td>
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<tr>
<td>15. Have addressed one's own food/body issues to a high level of resolution.</td>
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<tr>
<td>16. Understand the notion of &quot;stressful disorders&quot; as they relate to PTSD.</td>
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</tr>
<tr>
<td>17. Be trained and experienced in EMDR with disordered eating symptomology in dealing with PTSD contributing factors.</td>
<td></td>
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<tr>
<td>18. Assess client's ability to tolerate distress and pay attention to this when evoking emotion.</td>
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<tr>
<td>20. Teach how to evoke and contain emotion at the same time.</td>
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<td></td>
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<tr>
<td>21. Make working with conflicting feelings a focus of therapy.</td>
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<tr>
<td>22. Be able to assess primary adaptive feelings vs. maladaptive feelings and secondary feelings (à la Les Greenberg).</td>
<td></td>
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<tr>
<td>23. Have experienced one's own therapy, so as to be more self-aware.</td>
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<td></td>
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<tr>
<td>24. Have a colleague in the field you feel totally comfortable with to share mistakes/blanders and counter-transference issues.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25. In family therapy, be comfortable discussing how and why you won't hold secrets of family member.</td>
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<td></td>
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</tr>
</tbody>
</table>

Version Date: Sept 15, 2004
For basic, independent practice with clients who have eating disorders, the therapist should:

<table>
<thead>
<tr>
<th></th>
<th>1 not necessary</th>
<th>2 useful but not essential</th>
<th>3 essential</th>
<th>DK don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.</td>
<td>In family therapy, be comfortable not letting the patient hold the others hostage by threats, particularly that of telling them they can’t participate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27.</td>
<td>Understand patience as a virtue generally but not always (i.e., weight gain needs to happen. All talk and no gain needs to be addressed.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28.</td>
<td>Have the ability to recognize client’s strengths.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29.</td>
<td>Have ability to create a space of safety and trust.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30.</td>
<td>Recognize the sense of “difference” “specialness” these clients often feel and the high degree of “intuition” that this may signal, and help them “ground.”</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31.</td>
<td>Be able to address the total lack of self-worth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32.</td>
<td>Consider the patient suicidality or longing for death masked by anorexia in some cases.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33.</td>
<td>Role play in a safe way to encourage self-assessment/protection - especially for those abused.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34.</td>
<td>Realize how truly terrifying changing eating disorder behavior can be.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35.</td>
<td>Be aware of the AN/BN “voice”. What it hears, thinks, says, feels.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36.</td>
<td>Have strategies to deal with the AN/BN “voice”, what it hears, thinks, says, feels.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37.</td>
<td>Have an understanding of the biopsychosocial experience of an eating disorder because, in order to gain rapport a therapeutic alliance, the client needs to have a sense of being understood from the inner experience of conflicting feelings, thoughts, behaviors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38.</td>
<td>Consider client’s level of distress tolerance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39.</td>
<td>Work collaboratively with qualified nutritionist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40.</td>
<td>Help client get an MD and/or psychiatrist if they don’t already have one.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41.</td>
<td>Issue that a patient have medical monitoring.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42.</td>
<td>Assess and work with parents’ inability to tolerate painful affect.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43.</td>
<td>Be knowledgeable enough about separate connected diagnoses to refer accordingly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44.</td>
<td>Do not wait for the client to raise any concerns client may have in relation to the therapist’s weight or shape.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.</td>
<td>Be able to discuss frankly with the client any concerns the client has in relation to the therapist’s weight or shape, but only if client express this as an issue.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.</td>
<td>If client names it, address competition (e.g., concerning body size) at a level the therapeutic bond can handle.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.</td>
<td>Consider using a more focused approach if useful or necessary with, for example, very medically compromised patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48.</td>
<td>Refer cases to written materials or other information.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49.</td>
<td>Recommend cases seek support for themselves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50.</td>
<td>Re: inappropriate treatment modalities, help clients explore options they’ve interested in and encourage them to make informed decisions (but it is not the counselor’s place to make the decision for the clients).</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>51.</td>
<td>Be aware/careful of client’s “splitting” of health care providers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52.</td>
<td>Not carry a caseload with only all MD patients, to prevent burnout.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>53.</td>
<td>Not be personally experiencing disordered eating/ body image dissatisfaction.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>54.</td>
<td>Know the outcome statistics regarding recovery vs. partial/incomplete recovery vs. chronicity, and how this is evaluated.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>55.</td>
<td>Present to the client knowledge re: partial/incomplete recovery vs. chronicity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
It took me [ ] to complete this questionnaire.

(please write the amount of time)

Thank you very much for your help!

Please seal in the addressed, stamped envelope enclosed and return to the Department of Counselling Psychology by October 4, 2004.
Questionnaire 3
(reduced from legal sized paper)
We appreciate your participation in the final phase of this study, which is aiming to determine the essential competencies for therapists who wish to do basic, independent practice with individuals who have eating disorders. Thank you for completing and returning Questionnaire 2. Your continued participation is vital for the successful completion of the project as the validity of a Delphi study rests on participants completing all questionnaires in the series. We hope you will be encouraged by the fact that this questionnaire is considerably shorter than the previous two you have completed – it should take no more than 30 minutes to complete.

The only items appearing on this questionnaire are those generated by participants themselves for which consensus has not been reached. You may remember that “consensus” was defined as being 85% or more agreement among participants that the item is “essential”. In this round, that definition also includes any item for which there is 85% agreement on any rating (i.e., also “useful but not essential”, “not necessary”).

Once you have completed the questionnaire, please return it in the pre-addressed stamped envelope provided by November 2, 2004. Once again, your timely return of this questionnaire is appreciated. When we receive this last questionnaire, we will send you the final Chapters/Indigo gift card in the amount of $15.00. The information you provide here and your responses to all other questionnaires will be kept confidential. Thank you for your assistance.

**To clarify a question from the first questionnaire regarding your orientation, please circle one answer:**

1. In my work with individuals who have EDs, I provide (or have, in the past, provided) psychotherapy.
2. In my work with individuals who have EDs, I do not provide psychotherapy.
3. Other (please explain):  

Would it be all right for a research team member to contact you in the event that clarification of your response is required? (circle one)

1. Yes
2. No
The items included on this questionnaire are the participant-generated items for which consensus was not reached in Round 2. In this section, you will see the rating you previously gave each item as well as group statistics for each item. These group statistics include:

- the group's median response for each item.
- the group's mean response for each item.
- the group's standard deviation for each item. This is included to give you an idea of the variability of ratings for each item. For example, a relatively small standard deviation value (e.g., 0.19) would indicate little variation in participants' ratings, and a relatively larger standard deviation (e.g., 0.77) would indicate more variation in participants' ratings.

Please:

1. Consider the statistical information for each item and then change your previous rating for each item to the median rating (if, in fact, your previous rating was different from the median response).

2. However, you should not feel pressured to change your response to the median rating. If your previous rating is different from the median rating and you decide to not change it to match the median rating, we invite you to provide a brief explanatory comment in the last column.

3. If your previous rating already matches the median rating, please simply circle your previous rating again—do not leave it blank as it this be recorded as missing and unusable data (however, no comment is required).

If you have any questions or require clarification regarding this process, please do not hesitate to contact us at 604-321-1904/1-877-321-1904 or malw@interchange.ubc.ca

Note that all items refer specifically to the provision of individual therapy to clients with EDs.

***BEGIN HERE:

<table>
<thead>
<tr>
<th>PLEASE CONSIDER THIS INFORMATION</th>
<th>PLEASE CIRCLE YOUR RATING FOR THIS ROUND</th>
<th>If your previous rating did not match the median rating and you did not change it to the median rating, we invite you to provide a brief explanatory comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>your previous rating of this item</td>
<td>group median rating</td>
<td>group mean rating</td>
</tr>
</tbody>
</table>

1. For basic, independent practice with clients who have eating disorders, the therapist should:

2. Attend group supervision with other clinicians.

3. If private practitioner, should have access to seeing treatment resources and education to be involved in ongoing training.

Version Date: October 18, 2004
<table>
<thead>
<tr>
<th>Item</th>
<th>Your previous rating</th>
<th>Group mean rating</th>
<th>Group standard deviation</th>
<th>Please consider this information</th>
<th>Please circle your rating for this round</th>
<th>If your previous rating did not match the median rating and you did not change it to the median rating, we invite you to provide a brief explanatory comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>For basic, independent practice with clients who have eating disorders, the therapist should:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Assume that the client has resources as it is therapeutic and engages them in the process.</td>
<td>3</td>
<td>3</td>
<td>2.80</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>11. Use DBT skills - mindfulness, distress tolerance, affect regulation, and interpersonal skills</td>
<td>3</td>
<td>3</td>
<td>2.54</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>12. Have knowledge of effective bridging between inpatient and outpatient services.</td>
<td>3</td>
<td>3</td>
<td>2.81</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>13. Use expressive skills with AN clients, so as to enable them to identity feelings and feel less restrained expressing themselves in world.</td>
<td>3</td>
<td>3</td>
<td>2.58</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>14. Have knowledge of temperament and genetics so as to help clients understand inborn traits, extraversion/introversion, and genetic understandings, to the degree we understand them.</td>
<td>2</td>
<td>2</td>
<td>2.46</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>15. Understand the notion of &quot;cognitive disorders&quot; as they relate to PTSD.</td>
<td>2</td>
<td>2</td>
<td>2.99</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>17. Be trained and experienced in EMDR with disordered eating symptomology in dealing with PTSD contributing factors.</td>
<td>2</td>
<td>2</td>
<td>1.72</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>21. Make working with conflicting feelings a focus of therapy.</td>
<td>2</td>
<td>2</td>
<td>2.44</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>22. Be able to some primary adaptive feelings vs. maladaptive feelings and secondary feelings (a la Lee Greenberg).</td>
<td>2</td>
<td>2</td>
<td>2.45</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>23. Have experienced one's own therapy, to be more self-aware.</td>
<td>3</td>
<td>3</td>
<td>2.42</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>24. Have a colleague in the field you feel totally comfortable with to share mistakes/blunders and counter-transference issues.</td>
<td>2</td>
<td>3</td>
<td>2.76</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>27. Understand patience is a virtue generally but not always (i.e., weight gain needs to happen. All talk and no gain needs to be addressed).</td>
<td>2</td>
<td>3</td>
<td>2.58</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>30. Recognize the sense of &quot;difference&quot;/&quot;specialness&quot; these clients often feel and the high degree of &quot;intimacy&quot; that this may signal, and help them &quot;ground.&quot;</td>
<td>3</td>
<td>3</td>
<td>2.60</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>33. Role play in a sch way to encourage self-assertion/protection - especially for those abused.</td>
<td>3</td>
<td>3</td>
<td>2.67</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
<tr>
<td>39. Work collaboratively with qualified nutritionist.</td>
<td>3</td>
<td>3</td>
<td>2.67</td>
<td>1, 2, 3, DK</td>
<td>1, 2, 3, DK</td>
<td></td>
</tr>
</tbody>
</table>
Please consider this information. Your group's previous median rating of this item is 2.81, with a standard deviation of 0.40. Please circle your rating for this round:

<table>
<thead>
<tr>
<th>Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not useful but essential</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>DK</td>
</tr>
</tbody>
</table>

If your previous rating did not match the median rating and you did not change it to the median rating, we invite you to provide a brief explanatory comment.

### Table: For basic, independent practice with clients who have eating disorders, the therapist should:

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
<th>Group Median Rating</th>
<th>Group Standard Deviation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>40. Help client get an MD and/or psychiatrist if they don’t already have one.</td>
<td>2</td>
<td>3</td>
<td>2.74</td>
<td>0.45</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. Insist that a patient have medical monitoring.</td>
<td>2</td>
<td>3</td>
<td>2.52</td>
<td>0.31</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. Assess and work with parental inability to tolerate painful affect.</td>
<td>2</td>
<td>3</td>
<td>2.08</td>
<td>0.72</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Do not wait for the client to raise any concerns client may have in relation to the therapist's weight or shape.</td>
<td>2</td>
<td>3</td>
<td>2.77</td>
<td>0.53</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. Consider using a more forceful approach if useful or necessary with, for example, very medically compromised patients.</td>
<td>2</td>
<td>3</td>
<td>2.81</td>
<td>0.60</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. Refer caregivers to written materials or other information.</td>
<td>2</td>
<td>3</td>
<td>2.41</td>
<td>0.64</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Not carry a caseload with ed and/or ED patients, to prevent burnout.</td>
<td>2</td>
<td>3</td>
<td>2.67</td>
<td>0.48</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. Not be personally experiencing even disordered eating/binge eating disorder.</td>
<td>2</td>
<td>3</td>
<td>2.52</td>
<td>0.39</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48. Know the outcome statistics regarding recovery vs. partial/incomplete recovery vs. chronicity, and how this is evaluated.</td>
<td>2</td>
<td>3</td>
<td>2.36</td>
<td>0.64</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Patient Comments

1. Did participating in this study lead you to reflect on your own practice(s) with clients/patients who have eating disorders?

   1. Yes
   2. No
   3. Unsure

Version Date: October 18, 2004
C2. Please explain your answer to C1:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

C3. Any other comments?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

It took me to complete this questionnaire.

(Please write the amount of time)

☐ Please check the box to the left if you would like to be mailed a summary of the final results and discussion for this study (likely available Spring 2005).

Thank you very much for your help!

Please seal in the addressed, stamped envelope enclosed and return to the Department of Counselling Psychology by November 2, 2004.

Version Date: October 11, 2004
Appendix L: Questionnaire Items
<table>
<thead>
<tr>
<th>#</th>
<th>Item # &amp; Competency</th>
<th>Consensus Level</th>
<th>Round Reached</th>
<th>Valid N</th>
<th>R1 Mdn</th>
<th>R Mdn</th>
<th>R3 Mdn</th>
<th>R1 Mean</th>
<th>R2 Mean</th>
<th>R3 Mean</th>
<th>R1 SD</th>
<th>R2 SD</th>
<th>R3 SD</th>
<th>Item Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10. Consider client risk in treatment planning.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td></td>
<td></td>
<td>3.00</td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
<td></td>
<td>ABECSW</td>
</tr>
<tr>
<td>2</td>
<td>11. Integrate ethical principles and legal requirements (e.g., client autonomy, informed consent) in treatment planning</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td></td>
<td></td>
<td>3.00</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>ABECSW</td>
</tr>
<tr>
<td>3</td>
<td>32. Recognize that psychotherapy alone is not sufficient to treat severely malnourished patients with AN.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td></td>
<td></td>
<td>3.00</td>
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<td></td>
<td>0.00</td>
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<td>APA</td>
</tr>
<tr>
<td>4</td>
<td>39. Have, as an aim of psychological treatment, psychological and physical recovery.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td></td>
<td></td>
<td>3.00</td>
<td></td>
<td></td>
<td>0.00</td>
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<td></td>
<td>NICE</td>
</tr>
<tr>
<td>5</td>
<td>44. Know when and how to refer to a physician for medical intervention.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td></td>
<td></td>
<td>3.00</td>
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<td>Ideal Th.</td>
</tr>
<tr>
<td>6</td>
<td>57. Ensure that the client receives an adequate assessment based on face-to-face contact of sufficient duration to gather information about the client’s biological, psychological, environmental, and cultural qualities and conditions.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
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<td>3.00</td>
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<td>ABECSW</td>
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<tr>
<td>7</td>
<td>78. Listen to and discuss the patient’s concerns about the proposed treatment in a supportive fashion.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
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<td>3.00</td>
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<td>APA</td>
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<tr>
<td>8</td>
<td>79. Implement treatment interventions based on accurate assessment and evaluation process.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
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<td>ABECSW</td>
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<tr>
<td>#</td>
<td>Item # &amp; Competency</td>
<td>Consensus Level</td>
<td>Round Reached</td>
<td>Valid N</td>
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<td>R1 Mean</td>
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<td>R3 Mean</td>
<td>R1 SD</td>
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<td>Item Source</td>
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<tr>
<td>&quot;ESSENTIAL&quot; cont.</td>
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<tr>
<td>9</td>
<td>87. Establish a strong therapeutic alliance characterized by acceptance, honesty, and reassurance throughout the therapeutic process.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
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<td>3.00</td>
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</tr>
<tr>
<td>10</td>
<td>88. Build trust, establish mutual respect, and develop a therapeutic relationship with the patient that will serve as the basis for ongoing exploration and treatment of the problems associated with the ED.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3.00</td>
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</tr>
<tr>
<td>11</td>
<td>89. Monitor the quality of the therapeutic relationship.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
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<td>3.00</td>
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</tr>
<tr>
<td>12</td>
<td>162. Practice within the limits of his/her competence.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
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<tr>
<td>13</td>
<td>163. Monitor own practice, identify own problem areas, and initiate intervention strategies, including referral, when indicated.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
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</tr>
<tr>
<td>14</td>
<td>164. Effectively resolve ethical dilemmas (e.g., in assessment, diagnosis and/or treatment).</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
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<td>3.00</td>
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</tr>
<tr>
<td>15</td>
<td>165. Evaluate resolution of ethical dilemmas to see if they adhere to generally accepted professional values.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
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<td>3.00</td>
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<tr>
<td>16</td>
<td>173. Monitor own practice and identify own strengths and limitations and address same.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
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<td>3.00</td>
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<tr>
<td>17</td>
<td>179. Seek consultation in difficult cases in order to decrease client risk.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
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<tr>
<td>18</td>
<td>184. Not be personally experiencing active ED symptoms.</td>
<td>100%</td>
<td>1</td>
<td>28</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3.00</td>
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<td>R1 Mdn</td>
<td>R Mdn</td>
<td>R3 Mdn</td>
<td>R1 Mean</td>
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<tr>
<td>19</td>
<td>185. Have sufficient professional sense of self (e.g., concerning his/her own food, eating, and body attitudes, as well as other personal issues), to avoid projection of personal &amp; cultural issues interfering with assessment, diagnosis, treatment planning and intervention process.</td>
<td>100%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3.00</td>
<td>-</td>
<td>-</td>
<td>0.00</td>
<td>-</td>
<td>-</td>
<td>ABEC SW</td>
</tr>
<tr>
<td>20</td>
<td>12. Acknowledge that many people with EDs are ambivalent about treatment, and recognize the consequent demands and challenges this presents.</td>
<td>95%-99%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.97</td>
<td>-</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
<td>-</td>
<td>NICE</td>
</tr>
<tr>
<td>21</td>
<td>30. Understand the physiological and psychological consequences of starvation.</td>
<td>95%-99%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.97</td>
<td>-</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>22</td>
<td>40. Have, as an aim of psychological treatment, the reduction of risk to the client.</td>
<td>95%-99%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.97</td>
<td>-</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
<td>-</td>
<td>NICE</td>
</tr>
<tr>
<td>23</td>
<td>67. Accurately assess client's risk to self.</td>
<td>95%-99%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.97</td>
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<td>24</td>
<td>75. Provide clients with information regarding treatment choice.</td>
<td>95%-99%</td>
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<td>25</td>
<td>90. Use a collaborative approach (e.g., actively involve client in planning, goal development, etc.) to maximize client participation in the treatment process.</td>
<td>95%-99%</td>
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<td>26</td>
<td>150. Collaborate on recommendations/treatment with professionals from other disciplines (e.g., nutritionists, physicians, etc.).</td>
<td>95%-99%</td>
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<td>27</td>
<td>160. Take into account both formal and informal feedback from clients (e.g., about intervention strategies, when evaluating clinical efficacy)</td>
<td>95%-99%</td>
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<td>28</td>
<td>187. Accurately represent level of competence, education, training and experience.</td>
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<td>29</td>
<td>53. Understand the boundaries of psychotherapy.</td>
<td>95%-99%</td>
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<td>30</td>
<td>174. Accept responsibility for updating clinical skills and seek training where learning is needed to stay current in field.</td>
<td>95%-99%</td>
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<td>31</td>
<td>54. Recognize boundaries of her/his competence when working with EDs clients.</td>
<td>95%-99%</td>
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<td>32</td>
<td>64. Evaluate trauma history in clients presenting with an ED.</td>
<td>95%-99%</td>
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<td>33</td>
<td>71. Make clinically responsible diagnoses.</td>
<td>95%-99%</td>
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<td>34</td>
<td>94. Avoid competition with the patient (e.g., concerning body size).</td>
<td>95%-99%</td>
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<td>35</td>
<td>161. Actively evaluate and process transference/countertransference issues as they arise (e.g., via supervisor or consultant).</td>
<td>95%-99%</td>
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<td>36</td>
<td>37. Have, as a general treatment goal, the identification of the relationship between eating and pertinent issues.</td>
<td>90%-94%</td>
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<td>37</td>
<td>38. Have, as a general treatment goal, the client's mastering of conflicts directly, rather than through the use or avoidance of food.</td>
<td>90%-94%</td>
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<td>38</td>
<td>77. Provide clients with a rationale for level and type of care.</td>
<td>90%-94%</td>
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<td>39</td>
<td>148. Assemble a team of professionals to provide the best care for clients with EDs.</td>
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<td>40</td>
<td>149. Develop and appropriately make use of a referral base of other specialized health care professionals.</td>
<td>90%-94%</td>
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<td>41</td>
<td>172. Understand own knowledge deficits and seek out appropriate regular supervision/consultation with more experienced practitioners.</td>
<td>90%-94%</td>
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<td>42</td>
<td>175. Actively pursue continuing education to keep abreast of the literature, latest developments, and knowledge in the EDs field.</td>
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<td>43</td>
<td>177. If an advanced practitioner, take responsibility for his/her own professional development (e.g., updating clinical skills, seeking training), and seek consultation and supervision as needed.</td>
<td>90%-94%</td>
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<td>44</td>
<td>109. Consider more intensive forms (or combinations of) of treatment if there is significant deterioration or no significant improvement during psychological treatment.</td>
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<td>45</td>
<td>82. Determine whether comorbid disorders should be treated prior to or simultaneously with ED interventions.</td>
<td>90%-94%</td>
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<td>46</td>
<td>182. Not be frustrated easily by the long-range nature of EDs.</td>
<td>90%-94%</td>
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<td>47</td>
<td>72. With children and adolescents, be alert to indicators of abuse throughout treatment.</td>
<td>90%-94%</td>
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<td>48</td>
<td>15. Demonstrate knowledge of range of treatment programs/resources relevant to client needs.</td>
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<td>49</td>
<td>73. Apply ED theories creatively and flexibly to develop multiple treatment strategies.</td>
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<td>50</td>
<td>76. Discuss the sequencing and integrating of treatments with clients to increase client participation in the therapy plan.</td>
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<tr>
<td>51</td>
<td>119. Give carers (e.g., family, friends) the opportunity to ask about EDs (e.g., general information, specific risks in involved, best ways to help, etc.).</td>
<td>85%-89%</td>
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<tr>
<td>52</td>
<td>176. Continuously integrate current knowledge in field into clinical practice.</td>
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<tr>
<td>53</td>
<td>178. If a beginning practitioner, receive supervision from an experienced practitioner in the area of EDs who is a member of a professional EDs organization.</td>
<td>85%-89%</td>
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<tr>
<td>54</td>
<td>183. Have high self-nurturance.</td>
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<td>55</td>
<td>137. Use an approach that addresses interpersonal conflicts.</td>
<td>85%-89%</td>
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<tr>
<td>56</td>
<td>139. Use an approach that addresses coping styles.</td>
<td>85%-89%</td>
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<tr>
<td>57</td>
<td>140. Use an approach that addresses problem solving.</td>
<td>85%-89%</td>
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<tr>
<td>58</td>
<td>13. Be knowledgeable about the implications of comorbid disorders.</td>
<td>85%-89%</td>
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<td>59</td>
<td>31. Recognize that attempts to conduct formal psychotherapy with starving patients may be ineffective.</td>
<td>85%-89%</td>
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<tr>
<td>60</td>
<td>55. Utilize bio-psycho-social theories when assessing clients.</td>
<td>85%-89%</td>
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<tr>
<td>61</td>
<td>84. Use interventions that incorporate an understanding of comorbid disorders.</td>
<td>85%-89%</td>
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<td>62</td>
<td>91. Communicate an awareness of the ambivalence about treatment that many clients with EDs experience.</td>
<td>85%-89%</td>
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<td>63</td>
<td>122. Use psychotherapy to help patients understand how to avoid or minimize risks of relapse.</td>
<td>85%-89%</td>
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<tr>
<td>64</td>
<td>123. Use psychotherapy to help patients understand how to better deal with salient developmental and other important life issues in the future.</td>
<td>85%-89%</td>
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<td>65</td>
<td>29. Recognize that programs that focus exclusively on abstinence (e.g., 12-step) are not recommended as the sole initial treatment approach.</td>
<td>85%-89%</td>
<td>1</td>
<td>26</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.88</td>
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<td>-</td>
<td>0.33</td>
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<tr>
<td>66</td>
<td>9. Understand the rationale for sequencing and integrating treatments.</td>
<td>85%-89%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
<td>-</td>
<td>-</td>
<td>0.44</td>
<td>-</td>
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<td>ABECWS</td>
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<tr>
<td>67</td>
<td>35. Recognize that avoiding food issues in therapy is not adequate or ethical.</td>
<td>85%-89%</td>
<td>1</td>
<td>28</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
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<td>-</td>
<td>0.36</td>
<td>-</td>
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<td>ABECWS</td>
</tr>
<tr>
<td>68</td>
<td>43. Have knowledge of physical issues related to EDs (e.g., dental, pregnancy, osteoporosis, EDs &amp; diabetes, etc.).</td>
<td>85%-89%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
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<td>-</td>
<td>0.35</td>
<td>-</td>
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<tr>
<td>69</td>
<td>65. Conduct careful assessment of patient’s level of motivation for change.</td>
<td>85%-89%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
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<td>0.35</td>
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<tr>
<td>70</td>
<td>66. Accurately assess client’s physical risk.</td>
<td>85%-89%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
<td>-</td>
<td>-</td>
<td>0.35</td>
<td>-</td>
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<tr>
<td>71</td>
<td>96. Adopt a style of empathic engagement versus a forceful approach.</td>
<td>85%-89%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
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<td>0.35</td>
<td>-</td>
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<td>NICE</td>
</tr>
<tr>
<td>72</td>
<td>127. Be sensitive to and inquire about how weight and shape concerns are experienced by patients who are minorities from non-Western or other cultural backgrounds, or who are transitioning and assimilating into Western societies.</td>
<td>85%-89%</td>
<td>1</td>
<td>28</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
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<td>0.45</td>
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<tr>
<td>73</td>
<td>168. Possess training and experience commensurate with the severity of the cases seen.</td>
<td>85%-89%</td>
<td>1</td>
<td>28</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
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<td>0.36</td>
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<tr>
<td>74</td>
<td>131. Use interventions that incorporate an understanding of the complexity of family relationships.</td>
<td>85%-89%</td>
<td>1</td>
<td>28</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.86</td>
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<td>0.36</td>
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<tr>
<td>75</td>
<td>92. Be able to discuss frankly with the patient any concerns the patient has in relation to the therapist's weight or shape.</td>
<td>85%-89%</td>
<td>1</td>
<td>27</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.85</td>
<td>-</td>
<td>-</td>
<td>0.36</td>
<td>-</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>76</td>
<td>34. Understand the role of nutritional rehabilitation.</td>
<td>85%-89%</td>
<td>1</td>
<td>29</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.83</td>
<td>-</td>
<td>-</td>
<td>0.47</td>
<td>-</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>77</td>
<td>8. Have an overall organizing concept of the causes and progression of EDs.</td>
<td>85%-89%</td>
<td>1</td>
<td>28</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.82</td>
<td>-</td>
<td>-</td>
<td>0.48</td>
<td>-</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>78</td>
<td>83. Incorporate comorbidity information when making a decision about medication referral for the client.</td>
<td>85%-89%</td>
<td>1</td>
<td>27</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.81</td>
<td>-</td>
<td>-</td>
<td>0.48</td>
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<td>-</td>
<td>ABECJSW</td>
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<tr>
<td>79</td>
<td>8. Be skilled in building a therapeutic alliance.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
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<td>3</td>
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<td>3.00</td>
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<tr>
<td>80</td>
<td>9. Be competent in managing, in a genuine and caring way, the challenges that arise in the therapist-client relationship.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
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<td>3.00</td>
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<td>0.00</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>81</td>
<td>29. Have ability to create a space of safety and trust.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>3.00</td>
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<td>0.00</td>
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<tr>
<td>82</td>
<td>34. Realize how truly terrifying changing eating disorder behaviour can be.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
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<td>3.00</td>
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<td>83</td>
<td>19. Balance evoking emotion with containment.</td>
<td>100%</td>
<td>2</td>
<td>26</td>
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<td>3</td>
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<td>3.00</td>
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<tr>
<td>84</td>
<td>5. Have awareness of personal assumptions re: body shape to avoid countertransference or collusion with client.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.97</td>
<td>-</td>
<td>-</td>
<td>0.19</td>
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<tr>
<td>85</td>
<td>10. Provide a therapeutic relationship that will impact on client's self development and other relationships.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.97</td>
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<td>0.19</td>
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<tr>
<td>86</td>
<td>15. Have addressed one's own food/body issues to a high level of resolution.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.97</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
<td>-</td>
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<tr>
<td>87</td>
<td>28. Have the ability to recognize client's strengths.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.97</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>88</td>
<td>32. Consider the passive suicidality or longing for death masked by anorexia in some cases.</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.96</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>89</td>
<td>43. Be knowledgeable enough about separate comorbid diagnoses to refer accordingly.</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.96</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
<td>-</td>
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<td>Part.</td>
</tr>
<tr>
<td>90</td>
<td>51. Be aware/careful of client’s “splitting” of health care providers.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.93</td>
<td>-</td>
<td>0.26</td>
<td>-</td>
<td>-</td>
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<td>Part.</td>
</tr>
<tr>
<td>91</td>
<td>46. If client names it, address competition (e.g., concerning body size) at a level the therapeutic bond can handle.</td>
<td>90%-94%</td>
<td>2</td>
<td>25</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.92</td>
<td>-</td>
<td>0.28</td>
<td>-</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>92</td>
<td>18. Assess client’s ability to tolerate distress and pay attention to this when evoking emotion.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.93</td>
<td>-</td>
<td>0.26</td>
<td>-</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>93</td>
<td>2. Assess for substance abuse issues.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.93</td>
<td>-</td>
<td>0.26</td>
<td>-</td>
<td>-</td>
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<td>Part.</td>
</tr>
<tr>
<td>94</td>
<td>45. Be able to discuss frankly with the client any concerns the client has in relation to the therapist’s weight or shape, but only if client expresses this as an issue.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2.93</td>
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<td>0.26</td>
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<tr>
<td>95</td>
<td>50. Re: inappropriate treatment modalities, help clients explore options they're interested in and encourage them to make informed decisions (but it is not the counsellor's place to make the decision for the client).</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.93</td>
<td>-</td>
<td>0.26</td>
<td>-</td>
<td>-</td>
<td>Part.</td>
</tr>
<tr>
<td>96</td>
<td>31. Be able to address the total lack of self-worth.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.93</td>
<td>-</td>
<td>0.26</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>97</td>
<td>1. Have an awareness of substance abuse issues.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.90</td>
<td>-</td>
<td>0.31</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>98</td>
<td>49. Recommend carers seek support for themselves.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.90</td>
<td>-</td>
<td>0.31</td>
<td>-</td>
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<td>Part.</td>
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<tr>
<td>99</td>
<td>36. Have strategies to deal with the AN/N BN “voice”, what it hears, thinks, sees, filters.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.89</td>
<td>-</td>
<td>0.31</td>
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<tr>
<td>100</td>
<td>37. Have an understanding of the biopsychosocial experience of an eating disorder because, in order to gain rapport/ a therapeutic alliance, the client needs to have a sense of being understood from the inner experience of conflicting feelings, thoughts, behaviours.</td>
<td>85%-89%</td>
<td>2</td>
<td>27</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>2.89</td>
<td>-</td>
<td>0.32</td>
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<tr>
<td>101</td>
<td>7. Avoid pathologizing and distancing via labelling and/or categorizing</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
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<td>2.86</td>
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<td>0.44</td>
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<td>Part.</td>
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<tr>
<td>102</td>
<td>35. Be aware of the AN/N BN “voice”, what it hears, thinks, sees, filters.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
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<tr>
<td>103</td>
<td>49. Be knowledgeable about issues related to age and EDs (e.g., age of onset, EDs and the elderly).</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.66</td>
<td>3.00</td>
<td>0.55</td>
<td>0.00</td>
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<tr>
<td>104</td>
<td>134. Use an approach that addresses body image concerns.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>3.00</td>
<td>0.42</td>
<td>0.00</td>
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<td>105</td>
<td>136. Use an approach that addresses gender role expectations.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.75</td>
<td>3.00</td>
<td>-</td>
<td>0.52</td>
<td>0.00</td>
<td>-</td>
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<tr>
<td>106</td>
<td>138. Use an approach that addresses family dysfunction.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>3.00</td>
<td>-</td>
<td>0.52</td>
<td>0.00</td>
<td>-</td>
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</tr>
<tr>
<td>107</td>
<td>144. Advocate against the use of inappropriate treatment modalities</td>
<td>100%</td>
<td>2</td>
<td>27</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.58</td>
<td>3.00</td>
<td>-</td>
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<td>0.00</td>
<td>-</td>
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<tr>
<td>108</td>
<td>166. Have received supervision, after training, of several cases.</td>
<td>100%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.82</td>
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<td>-</td>
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<td>Ideal Th.</td>
</tr>
<tr>
<td>109</td>
<td>5. Recognize that, when doing assessment, theories other than bio-psycho-social are incomplete.</td>
<td>95%-99%</td>
<td>2</td>
<td>27</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.71</td>
<td>2.96</td>
<td>-</td>
<td>0.55</td>
<td>0.19</td>
<td>-</td>
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<tr>
<td>110</td>
<td>24. Recognize that psychoeducation alone can help clients with mild symptoms.</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.70</td>
<td>2.96</td>
<td>-</td>
<td>0.47</td>
<td>0.19</td>
<td>-</td>
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<tr>
<td>111</td>
<td>36. Have, as a general treatment goal, the stabilization of eating patterns.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.66</td>
<td>2.97</td>
<td>-</td>
<td>0.55</td>
<td>0.19</td>
<td>-</td>
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<tr>
<td>112</td>
<td>41. Encourage weight gain as an aim of psychological treatment for AN.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.72</td>
<td>2.97</td>
<td>-</td>
<td>0.59</td>
<td>0.19</td>
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<tr>
<td>113</td>
<td>42. Understand the role of medications in treatment.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.76</td>
<td>2.97</td>
<td>-</td>
<td>0.44</td>
<td>0.19</td>
<td>-</td>
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<tr>
<td>114</td>
<td>50. Be knowledgeable about cultural factors concerning weight and shape.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.97</td>
<td>-</td>
<td>0.41</td>
<td>0.19</td>
<td>-</td>
<td>APA</td>
</tr>
<tr>
<td>115</td>
<td>62. With younger clients, assess dynamic issues of lack of autonomy, incomplete individuation, and failure to tolerate painful affect.</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.81</td>
<td>2.96</td>
<td>-</td>
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<td>0.19</td>
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<tr>
<td>116</td>
<td>70. Use qualitative descriptions of key ED symptoms so that documentation of therapeutic responses may be made.</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.59</td>
<td>2.96</td>
<td>-</td>
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<td>0.19</td>
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<tr>
<td>117</td>
<td>85. Master the integration of assessment and differential diagnostic skills relevant to EDs field.</td>
<td>95%-99%</td>
<td>2</td>
<td>27</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.77</td>
<td>2.96</td>
<td>-</td>
<td>0.43</td>
<td>0.19</td>
<td>-</td>
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</tr>
<tr>
<td>118</td>
<td>86. Determine most appropriate level of care, which is assessment driven.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.76</td>
<td>2.97</td>
<td>-</td>
<td>0.51</td>
<td>0.19</td>
<td>-</td>
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<tr>
<td>119</td>
<td>97. Be skilled in evidence-based therapies for the treatment of EDs.</td>
<td>95%-99%</td>
<td>2</td>
<td>27</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.62</td>
<td>2.96</td>
<td>-</td>
<td>0.49</td>
<td>0.19</td>
<td>-</td>
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</tr>
<tr>
<td>120</td>
<td>105. Not use rigid behaviour modification programs with clients with BN.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.63</td>
<td>2.97</td>
<td>-</td>
<td>0.69</td>
<td>0.19</td>
<td>-</td>
<td>NICE</td>
</tr>
<tr>
<td>121</td>
<td>117. Appropriately refer individuals and/or families to support groups.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.97</td>
<td>-</td>
<td>0.42</td>
<td>0.19</td>
<td>-</td>
<td>ABECSW</td>
</tr>
<tr>
<td>122</td>
<td>120. Consider the needs of carers (e.g., family, friends).</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.96</td>
<td>-</td>
<td>0.41</td>
<td>0.19</td>
<td>-</td>
<td>NICE</td>
</tr>
<tr>
<td>123</td>
<td>125. Use psychotherapy to help patients understand how their illness may have been a maladaptive attempt to cope and emotionally self-regulate.</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.96</td>
<td>-</td>
<td>0.42</td>
<td>0.19</td>
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<td>APA</td>
</tr>
<tr>
<td>124</td>
<td>147. Provide (or make a referral to) family therapy whenever possible, especially for adolescents still living with parents or older patients with ongoing conflicted interactions with parents.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.75</td>
<td>2.97</td>
<td>-</td>
<td>0.44</td>
<td>0.19</td>
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<td>APA</td>
</tr>
<tr>
<td>125</td>
<td>151. Incorporate nutritional prescription from a physician or a nutritionist into treatment.</td>
<td>95%-99%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.85</td>
<td>2.96</td>
<td>-</td>
<td>0.37</td>
<td>0.19</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>126</td>
<td>155. Be prepared to discuss information and ideas that patients and their families have gathered via electronic means, and from alternative and complementary sources.</td>
<td>95%-99%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.68</td>
<td>2.97</td>
<td>-</td>
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</tr>
<tr>
<td>127</td>
<td>17. Be knowledgeable about evidence-based therapies for EDs treatment.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.75</td>
<td>2.93</td>
<td>-</td>
<td>0.44</td>
<td>0.26</td>
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<td>APA</td>
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<tr>
<td>128</td>
<td>21. Have knowledge of other clinically useful treatment modalities (e.g., self-help, feminist therapies, body image therapy, dialectical behaviour therapy, 12-step approaches).</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.72</td>
<td>2.93</td>
<td>-</td>
<td>0.45</td>
<td>0.26</td>
<td>-</td>
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</tr>
<tr>
<td>129</td>
<td>25. Be aware of self-help resources.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.76</td>
<td>2.93</td>
<td>-</td>
<td>0.44</td>
<td>0.26</td>
<td>-</td>
<td>ABECASW</td>
</tr>
<tr>
<td>130</td>
<td>28. Recognize that support groups are not recommended as the sole initial treatment.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.68</td>
<td>2.93</td>
<td>-</td>
<td>0.55</td>
<td>0.26</td>
<td>-</td>
<td>APA</td>
</tr>
<tr>
<td>131</td>
<td>33. Have basic knowledge of nutritional principles in order to reinforce them in therapy.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.83</td>
<td>2.93</td>
<td>-</td>
<td>0.38</td>
<td>0.26</td>
<td>-</td>
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<tr>
<td>132</td>
<td>46. Be aware of both the benefits and drawbacks of group psychotherapy.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.83</td>
<td>2.93</td>
<td>-</td>
<td>0.38</td>
<td>0.26</td>
<td>-</td>
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</tr>
<tr>
<td>133</td>
<td>48. Be knowledgeable about issues specific to EDs in athletes.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.55</td>
<td>2.93</td>
<td>-</td>
<td>0.63</td>
<td>0.26</td>
<td>-</td>
<td>APA</td>
</tr>
<tr>
<td>134</td>
<td>51. Have an understanding of culture-bounded disorders and sociocultural norms (e.g., gender-specific pressure for thinness and shape change, differences within different demographic, ethnic, and racial groups, and within sexual orientations).</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.62</td>
<td>2.93</td>
<td>-</td>
<td>0.56</td>
<td>0.26</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>135</td>
<td>59. Include, in assessment, an examination of psychodynamic factors which may be the underlying cause, or sustaining factors, of the ED.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.61</td>
<td>2.89</td>
<td>-</td>
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</tr>
<tr>
<td>136</td>
<td>61. Include family psychiatric history in assessment.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.75</td>
<td>2.93</td>
<td>-</td>
<td>0.52</td>
<td>0.26</td>
<td>-</td>
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<tr>
<td>137</td>
<td>63. With older clients, assess issues of living independently.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.68</td>
<td>2.93</td>
<td>-</td>
<td>0.48</td>
<td>0.26</td>
<td>-</td>
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<tr>
<td>138</td>
<td>69. Screen for dangerous, but not always evident, medical problems associated with EDs.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.71</td>
<td>2.90</td>
<td>-</td>
<td>0.53</td>
<td>0.41</td>
<td>-</td>
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<tr>
<td>139</td>
<td>95. Employ motivational enhancement techniques with patients who initially lack motivation.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.97</td>
<td>-</td>
<td>0.42</td>
<td>0.33</td>
<td>-</td>
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<tr>
<td>140</td>
<td>98. Demonstrate mastery of multiple treatment modalities.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.59</td>
<td>2.93</td>
<td>-</td>
<td>0.57</td>
<td>0.26</td>
<td>-</td>
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<tr>
<td>141</td>
<td>113. Appropriately integrate self-help into treatment.</td>
<td>90%-94%</td>
<td>2</td>
<td>27</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.61</td>
<td>2.93</td>
<td>-</td>
<td>0.57</td>
<td>0.27</td>
<td>-</td>
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<tr>
<td>142</td>
<td>130. Use interventions that incorporate an understanding of psychological defenses.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.75</td>
<td>2.93</td>
<td>-</td>
<td>0.52</td>
<td>0.26</td>
<td>-</td>
<td>APA</td>
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<tr>
<td>143</td>
<td>132. Use an approach that addresses developmental issues.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.75</td>
<td>2.93</td>
<td>-</td>
<td>0.44</td>
<td>0.26</td>
<td>-</td>
<td>APA</td>
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<tr>
<td>144</td>
<td>133. Use an approach that addresses identity formation.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.93</td>
<td>-</td>
<td>0.42</td>
<td>0.26</td>
<td>-</td>
<td>APA</td>
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<tr>
<td>145</td>
<td>135. Use an approach that addresses sexual difficulties.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.54</td>
<td>2.90</td>
<td>-</td>
<td>0.58</td>
<td>0.41</td>
<td>-</td>
<td>APA</td>
</tr>
<tr>
<td>146</td>
<td>141. With clients who have AN, be prepared to provide ongoing treatment with individual psychotherapeutic interventions for at least one year and perhaps up to 5-6 years.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.67</td>
<td>2.93</td>
<td>-</td>
<td>0.48</td>
<td>0.26</td>
<td>-</td>
<td>APA</td>
</tr>
<tr>
<td>147</td>
<td>143. With clients who have BN, use an approach that addresses affect regulation</td>
<td>90%-94%</td>
<td>2</td>
<td>27</td>
<td>3</td>
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<td>2.85</td>
<td>2.93</td>
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<td>0.37</td>
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<tr>
<td>148</td>
<td>153. Offer particular help to EDs patients who are themselves parents by paying attention to their parenting skills, and assessing and, if necessary, aiding their children.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.73</td>
<td>2.93</td>
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<td>0.45</td>
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<tr>
<td>149</td>
<td>156. Carefully monitor patients’ experiences with OA and similar groups.</td>
<td>90%-94%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.75</td>
<td>2.93</td>
<td>-</td>
<td>0.44</td>
<td>0.26</td>
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<tr>
<td>150</td>
<td>157. Be able to evaluate and determine integrity/quality of other ED treatment providers and programs.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.63</td>
<td>2.93</td>
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<td>0.63</td>
<td>0.26</td>
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<tr>
<td>151</td>
<td>171. Have training in evaluating the soundness of the many publications in the field of EDs, including what makes an evidence-based scientific study versus anecdotes or fads.</td>
<td>90%-94%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.61</td>
<td>2.93</td>
<td>-</td>
<td>0.57</td>
<td>0.26</td>
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<td>Ideal Th.</td>
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<tr>
<td>152</td>
<td>1. Know the diagnostic criteria for AN, BN and EDNOS.</td>
<td>85%-89%</td>
<td>2</td>
<td>27</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.83</td>
<td>2.85</td>
<td>-</td>
<td>0.38</td>
<td>0.36</td>
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<tr>
<td>153</td>
<td>4. Keep up with changes in diagnostic assessment.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.69</td>
<td>2.86</td>
<td>-</td>
<td>0.47</td>
<td>0.35</td>
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<td>Ideal Th.</td>
</tr>
<tr>
<td>154</td>
<td>6. View assessment as a process that takes place over several sessions.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.76</td>
<td>2.90</td>
<td>-</td>
<td>0.44</td>
<td>0.31</td>
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<tr>
<td>155</td>
<td>7. View assessment as a process that focuses on gathering specific information (e.g., current weight, weight history, and degree of body image disturbance, weight control measures).</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.69</td>
<td>2.90</td>
<td>-</td>
<td>0.54</td>
<td>0.31</td>
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<tr>
<td>156</td>
<td>14. Know how to rate EDs and comorbid symptoms qualitatively.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>3</td>
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<td>-</td>
<td>2.65</td>
<td>2.89</td>
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<td>0.63</td>
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<td>157</td>
<td>20. Be knowledgeable about behavioural techniques (e.g., planned meals, self-</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.66</td>
<td>2.90</td>
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<td>0.48</td>
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<td>monitoring).</td>
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<tr>
<td>158</td>
<td>26. Recognize that support groups may be helpful adjuncts to treatment.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.72</td>
<td>2.90</td>
<td>-</td>
<td>0.45</td>
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<tr>
<td>159</td>
<td>45. Consider family therapy as an important adjunct to individual therapy with</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.68</td>
<td>2.90</td>
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<td>0.48</td>
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<td>adult clients, especially when family conflicts are a major issue and when</td>
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<td>individuation/autonomy issues are still clinically relevant.</td>
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<tr>
<td>160</td>
<td>47. Be knowledgeable about issues specific to males with EDs.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.66</td>
<td>2.86</td>
<td>-</td>
<td>0.55</td>
<td>0.44</td>
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<tr>
<td>161</td>
<td>56. Use a multimodal assessment process (e.g., client/family/peripheral sources).</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.68</td>
<td>2.89</td>
<td>-</td>
<td>0.48</td>
<td>0.31</td>
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<td>162</td>
<td>60. In assessment, identify appropriate candidates for a given approach and</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.63</td>
<td>2.90</td>
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<td>0.56</td>
<td>0.31</td>
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<td>format (e.g., individual vs. group therapy).</td>
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<tr>
<td>163</td>
<td>74. Demonstrate expertise in sequencing and integration of treatment planning.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.72</td>
<td>2.90</td>
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<td>0.45</td>
<td>0.31</td>
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<tr>
<td>164</td>
<td>108. Use psychological treatment for AN that focuses on eating behaviour,</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.59</td>
<td>2.90</td>
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<td>0.50</td>
<td>0.31</td>
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<td>NICE</td>
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<td>attitudes to weight and shape, and wider psychosocial issues.</td>
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<td><strong>&quot;ESSENTIAL&quot; cont.</strong></td>
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<tr>
<td>165</td>
<td>124. Use psychotherapy to help patients understand the developmental, familial, and cultural antecedents of their illness.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.89</td>
<td>-</td>
<td>0.42</td>
<td>0.31</td>
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<td>APA</td>
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<tr>
<td>166</td>
<td>126. Engage women patients in informed and sensitive discussions regarding their struggles and personal experiences about what it means to be feminine and what it means to be “perfect” in the modern world.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.76</td>
<td>2.90</td>
<td>-</td>
<td>0.44</td>
<td>0.31</td>
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<td>APA</td>
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<tr>
<td>167</td>
<td>128. Use interventions that incorporate an understanding of cognitive development.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.79</td>
<td>2.86</td>
<td>-</td>
<td>0.42</td>
<td>0.44</td>
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<td>APA</td>
</tr>
<tr>
<td>168</td>
<td>129. Use interventions that incorporate an understanding of psychodynamic conflicts.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.50</td>
<td>2.86</td>
<td>-</td>
<td>0.64</td>
<td>0.45</td>
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<tr>
<td>169</td>
<td>158. Attempt to influence decision-making at multiple levels to implement program development and policies beneficial to ED clients.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.50</td>
<td>2.90</td>
<td>-</td>
<td>0.58</td>
<td>0.31</td>
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<td>ABECSSW</td>
</tr>
<tr>
<td>170</td>
<td>181. Possess at least a Master’s degree.</td>
<td>85%-89%</td>
<td>2</td>
<td>29</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.68</td>
<td>2.86</td>
<td>-</td>
<td>0.55</td>
<td>0.35</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>171</td>
<td>80. Be able to accurately diagnose separate comorbid diagnoses.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.64</td>
<td>2.86</td>
<td>-</td>
<td>0.49</td>
<td>0.36</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>172</td>
<td>180. Have at least one-third of his/her practice comprised of patients with EDs (i.e., does not treat EDs only occasionally)</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.58</td>
<td>2.82</td>
<td>-</td>
<td>0.58</td>
<td>0.48</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>173</td>
<td>81. Be able to determine whether comorbidities are preexisting or secondary to ED symptomology.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.56</td>
<td>2.86</td>
<td>-</td>
<td>0.65</td>
<td>0.36</td>
<td>-</td>
<td>Ideal Th.</td>
</tr>
<tr>
<td>174</td>
<td>48. Refer carers to written materials or other information.</td>
<td>100%</td>
<td>3</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>2.81</td>
<td>3.00</td>
<td>-</td>
<td>0.40</td>
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<td>Part.</td>
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<tr>
<td>175</td>
<td>12. Have knowledge of effective bridging between inpatient and outpatient services.</td>
<td>95%-99%</td>
<td>3</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.81</td>
<td>2.97</td>
<td>-</td>
<td>0.40</td>
<td>0.19</td>
<td>Part.</td>
</tr>
<tr>
<td>176</td>
<td>24. Have a colleague in the field you feel totally comfortable with to share mistakes/blunders and counter-transference issues.</td>
<td>95%-99%</td>
<td>3</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.81</td>
<td>2.96</td>
<td>-</td>
<td>0.40</td>
<td>0.19</td>
<td>Part.</td>
</tr>
<tr>
<td>177</td>
<td>6. Assume that the client has resources as it is therapeutic and engages them in the process.</td>
<td>90%-94%</td>
<td>3</td>
<td>24</td>
<td>-</td>
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<td>3</td>
<td>-</td>
<td>2.80</td>
<td>2.92</td>
<td>-</td>
<td>0.41</td>
<td>0.28</td>
<td>Part.</td>
</tr>
<tr>
<td>178</td>
<td>27. Understand patience is a virtue generally but not always (i.e., weight gain needs to happen. All talk and no gain needs to be addressed.)</td>
<td>90%-94%</td>
<td>3</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.76</td>
<td>2.93</td>
<td>-</td>
<td>0.52</td>
<td>0.26</td>
<td>Part.</td>
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<tr>
<td>179</td>
<td>39. Work collaboratively with qualified nutritionist.</td>
<td>90%-94%</td>
<td>3</td>
<td>27</td>
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<td>3</td>
<td>3</td>
<td>-</td>
<td>2.67</td>
<td>2.93</td>
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<td>0.48</td>
<td>0.27</td>
<td>Part.</td>
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<tr>
<td>180</td>
<td>41. Insist that a patient have medical monitoring.</td>
<td>90%-94%</td>
<td>3</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.74</td>
<td>2.93</td>
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<td>0.45</td>
<td>0.26</td>
<td>Part.</td>
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<tr>
<td>181</td>
<td>47. Consider using a more forceful approach if useful or necessary with, for example, very medically compromised patients.</td>
<td>90%-94%</td>
<td>3</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.77</td>
<td>2.93</td>
<td>-</td>
<td>0.53</td>
<td>0.26</td>
<td>Part.</td>
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<tr>
<td>182</td>
<td>53. Not be personally experiencing even disordered eating/body image dissatisfaction.</td>
<td>90%-94%</td>
<td>3</td>
<td>29</td>
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<td>3</td>
<td>3</td>
<td>-</td>
<td>2.67</td>
<td>2.93</td>
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<td>0.48</td>
<td>0.26</td>
<td>Part.</td>
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<tr>
<td>183</td>
<td>11. Use DBT skills – mindfulness, distress tolerance, affect regulation, and interpersonal skills.</td>
<td>85%-89%</td>
<td>3</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.54</td>
<td>2.89</td>
<td>-</td>
<td>0.51</td>
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**Note:** The table appears to be incomplete or contains errors in formatting.
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<td>184</td>
<td>13. Use expressive skills with AN clients, so as to enable them to identify feelings and feel less restrained expressing themselves in the world.</td>
<td>85%-89%</td>
<td>3</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.58</td>
<td>2.86</td>
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<td>185</td>
<td>33. Role play in a safe way to encourage self-assertion/protection – especially for those abused.</td>
<td>85%-89%</td>
<td>3</td>
<td>27</td>
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<td>186</td>
<td>40. Help client get an MD and/or psychiatrist if they don’t already have one.</td>
<td>85%-89%</td>
<td>3</td>
<td>29</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.81</td>
<td>2.86</td>
<td>-</td>
<td>0.40</td>
<td>0.35</td>
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<td>187</td>
<td>30. Recognize the sense of &quot;difference&quot;/&quot;specialness&quot; these clients often feel and the high degree of &quot;intuition&quot; that this may signal, and help them &quot;ground&quot;.</td>
<td>85%-89%</td>
<td>3</td>
<td>27</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>2.58</td>
<td>2.85</td>
<td>-</td>
<td>0.51</td>
<td>0.36</td>
<td>Part.</td>
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<tr>
<td>188</td>
<td>54. Know the outcome statistics regarding recovery vs. partial/incomplete recovery vs. chronicity, and how this is evaluated.</td>
<td>85%-89%</td>
<td>3</td>
<td>28</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
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<tr>
<td>1</td>
<td>114. Encourage patients with BN or BED to follow an evidence-based self-help program as a possible first step.</td>
<td>100%</td>
<td>2</td>
<td>26</td>
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<td>2</td>
<td>-</td>
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<td>121. Evaluate the benefits and effectiveness of computer-based treatments and self-help manuals for mild to moderate eating-disordered patients.</td>
<td>100%</td>
<td>2</td>
<td>27</td>
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<td>-</td>
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<td>3</td>
<td>106. Use psychodynamic therapy, especially if CBT or IPT are ineffective</td>
<td>95%-99%</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2.16</td>
<td>1.96</td>
<td></td>
<td>0.69</td>
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<td>4</td>
<td>110. Use psychodynamic and psychoanalytic approaches in individual or group format once bingeing and purging are improving.</td>
<td>95%-99%</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2.20</td>
<td>2.04</td>
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<td>5</td>
<td>107. Consider using cognitive analytic therapy for AN (CAT).</td>
<td>95%-99%</td>
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<td>2</td>
<td></td>
<td>1.85</td>
<td>1.92</td>
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<td>6</td>
<td>103. Treat adolescents with EDs with CBT (adapted as needed to suit patient's age, circumstances and level of development, and including the family, as appropriate).</td>
<td>90%-94%</td>
<td>2</td>
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<td>2.16</td>
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<td>111. Use interventions based on addictions models blended with features of other psychotherapeutic approaches</td>
<td>90%-94%</td>
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<td>8</td>
<td>152. Engage in analysis of larger social-cultural system as advocate for client with ED.</td>
<td>90%-94%</td>
<td>2</td>
<td>2</td>
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<td>2.20</td>
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<td>9</td>
<td>108. Use standardized self-report instruments (e.g., EAT, EDI) to obtain information in addition to the clinical interview.</td>
<td>85%-89%</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>1.85</td>
<td>1.96</td>
<td></td>
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<td>10</td>
<td>100. Use CBT treatment manuals in the treatment of BN.</td>
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<td>1.88</td>
<td>1.89</td>
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<td>11</td>
<td>101. Use CBT-BN (manualized CBT program specifically for BN) for clients with BN.</td>
<td>85%-89%</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>1.88</td>
<td>1.89</td>
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<tr>
<td>12</td>
<td>102. Offer CBT for binge eating disorder (CBT-BED) to adults with BED.</td>
<td>85%-89%</td>
<td>2</td>
<td>26</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>2.16</td>
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<td>-</td>
<td>0.55</td>
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<td>13</td>
<td>142. With clients who have BN, use an approach that addresses aggressive difficulties.</td>
<td>85%-89%</td>
<td>2</td>
<td>27</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>2.22</td>
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<td>14</td>
<td>169. Have obtained specialized training in CBT for the treatment of BN.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>2.24</td>
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<td>15</td>
<td>146. Advocate against the use of controversial treatment modalities.</td>
<td>85%-89%</td>
<td>2</td>
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<td>2</td>
<td>2</td>
<td>-</td>
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<td>0.77</td>
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<td>16</td>
<td>154. Inquire about patients' use of electronic support (e.g., chat rooms, websites, etc.), and other alternative and complementary approaches.</td>
<td>85%-89%</td>
<td>2</td>
<td>28</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>2.35</td>
<td>2.14</td>
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<td>17</td>
<td>23. Recognize utility of occupational therapy programs at various stages of recovery.</td>
<td>85%-89%</td>
<td>2</td>
<td>27</td>
<td>2</td>
<td>2</td>
<td>-</td>
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<td>2.15</td>
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<td>22. Be able to assess primary adaptive feelings vs. maladaptive feelings and secondary feelings (a la Les Greenberg).</td>
<td>95%-99%</td>
<td>3</td>
<td>23</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>2.25</td>
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<td>44. Do not wait for the client to raise any concerns client may have in relation to the therapist’s weight or shape.</td>
<td>85%-89%</td>
<td>3</td>
<td>28</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>2.08</td>
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<td>-</td>
<td>0.72</td>
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<td>17. Be trained and experienced in EMDR with disordered eating symptomology in dealing with PTSD contributing factors.</td>
<td>85%-89%</td>
<td>3</td>
<td>27</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>1.72</td>
<td>1.85</td>
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<td>55. Present to the client knowledge re: partial/incomplete recovery vs. chronicity</td>
<td>85%-90%</td>
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<td>2.36</td>
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<td>2. Know the diagnostic criteria for Binge Eating Disorder.</td>
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<td>16. Possess knowledge of state-of-the-art treatment approaches.</td>
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<td>3</td>
<td>-</td>
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<td>3</td>
<td>68. Ask about and objectively quantify weight control measures (e.g., dieting, laxative use, etc.)</td>
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<td>3</td>
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<td>2.72</td>
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<td>104. Be skilled in the use of behavioural techniques (e.g., self-monitoring, planned meals).</td>
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<td>112. Use psychoeducation in therapy sessions.</td>
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<td>115. Inform patients that all psychological treatments for BED have a limited effect on body weight</td>
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<td>170. Have had specific training in CBT or IPT at a minimum, with knowledge of supportive, educational, and dynamic techniques.</td>
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<td>186. Have the viewpoint that EDs are completely curable.</td>
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<td>27</td>
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<td>9</td>
<td>3. Know the prevalence and distribution of EDs.</td>
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<td>2.31</td>
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<tr>
<td>10</td>
<td>18. Familiarize her/himself with CBT treatment manuals for the treatment of BN.</td>
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<td>28</td>
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<td>2.36</td>
<td>2.21</td>
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<td>0.62</td>
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<tr>
<td>11</td>
<td>19. Be familiar with body image treatment protocols.</td>
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<td>2.48</td>
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<td>0.46</td>
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<td>12</td>
<td>22. Recognize the utility of non-verbal therapeutic methods such as creative arts and movement therapy programs.</td>
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<td>13</td>
<td>27. Recognize that 12-step programs may be helpful adjuncts to treatment.</td>
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<td>14</td>
<td>52. Be knowledgeable about primary prevention and early intervention programs and research.</td>
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<td>15</td>
<td>93. Not discuss own past experience of having had an ED with her/his patients.</td>
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<tr>
<td>16</td>
<td>99. Use CBT as the treatment of choice for clients with BN.</td>
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<td>17</td>
<td>116. When providing psychological treatments for BED, consider providing concurrent or consecutive interventions focusing on management of comorbid obesity.</td>
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<tr>
<td>18</td>
<td>118. Use family therapy as the treatment of choice for clients with AN who are 18 or younger and living at home.</td>
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<td>19</td>
<td>145. Advocate against the use of clinically unproven treatment modalities.</td>
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<td>20</td>
<td>159. Use pretreatment and outcome measurement tools to evaluate treatment efficacy.</td>
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<td>21</td>
<td>167. Have received supervision on the assessment of at least 12 cases</td>
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<td>22</td>
<td>20. Teach how to evoke and contain emotion at the same time.</td>
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<td>23</td>
<td>4. If private practitioner, should have access to seeing treatment resources and orientation to be involved in ongoing training.</td>
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<td>3. Attend group support/supervision with other clinicians.</td>
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<td>25</td>
<td>14. Have knowledge of temperament and genetics so as to help clients understand inborn traits, extroversion/introversion, and genetic underpinnings, to the degree we understand them.</td>
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<td>16. Understand the notion of &quot;ingestive disorders&quot; as they relate to PTSD.</td>
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<tr>
<td>27</td>
<td>21. Make working with conflicting feelings a focus of therapy.</td>
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<td>28</td>
<td>52. Not carry a caseload with only all ED patients, to prevent burnout.</td>
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<td>0.64</td>
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<td>29</td>
<td>23. Have experienced one's own therapy, to be more self-aware.</td>
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