



Perspectives

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Cognitive-behavioral therapy for the eating disorders:

Some principles to help guide us in delivering evidence-based practice

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I have worked with the eating disorders since 1988. My initial training was very much in the radical behaviorist tradition, but I soon decided that my own style was more of a cognitive-behavioral one. At the time, this was almost rebellious, as my boss was very definite that cognitive work was a passing fad and not to be pursued – how many people these days can say that choosing to be a cognitive-behavioral therapist makes them a rebel?

Now, of course, there is a bit of idiocy here. Simply deciding to be a cognitive behavior therapist does not actually make one a cognitive behavior therapist. Labels are no substitute for the real thing - a theme that I shall be returning to... Over the past quarter of a century ¹, I have been through a different patterns of clinical practice and thought. First, I think I was really more of a behavior therapist who called his work CBT. That did not really work very well, so I took up more of a schema-focused, cognitive approach. While that was more challenging intellectually, it did not really work very well. Throughout, I would read material about evidence-based CBT for the eating disorders, and conclude that the patients

¹ Did I really just say that?

in the treatment trials were a weirdly easy bunch to work with. Certainly, they could not be as complex as the cases I worked with every day. However, I tend to get a nagging voice in my head when I try to ignore the really, really obvious. So I tried thinking about whether I could get better at what I did. I hooked up with a wonderful supervisor (she knows who she is), started reading what the manuals said, felt like a fool, and started doing more of what the books said. In short, I stopped hiding behind the label of CBT and started doing CBT with my patients. And it worked much better. Even with the complex cases. Just like the books said.

To this day, I retain a strong sense of embarrassment about just how awful a therapist I was back then ². I had the opportunity to apologise to a former patient a little while ago. She was very gracious about it. I have decided that the best way of avoiding (or reducing) such embarrassment is to do as good a job as I can, so that I do not end up with too much to apologise for. And to make sure that others do as good a job as they can.

Who can I upset first...?

Therein lies an issue - trying to get others to do the best that they can for our patient group. I am aware that a lot of people will not read this article, seeing it as irrelevant to their practice in the eating disorders. I am also pretty certain that others will actively reject what I have to say, snorting at the nonsense that I have come out with ³. Many do and will reject the scientist-practitioner model, seeing it as cramping their desire for artistic or intellectual stimulation. I did that myself early in my career, as I have outlined above. While I am aware that I might be expected to name and shame specific therapies here, to do that would simply be silly. I can get far more widely irate than that. Such rejection is not found only among those who practice more psychodynamic treatments, but also among all those who hide behind stances and labels. While that does encompass a lot (not all) of psychodynamic approaches, it also includes those who call themselves cognitive-behavioral therapists while

² I suspect that it will be no bad thing if I am just as embarrassed in ten more years when I think how awful I was in 2012. I am not sure that I can avoid that embarrassment if I want to get better at what I do, so I had better embrace it.

³ I think that I prefer the latter, following the Oscar Wilde dictum of "The only thing worse than being talked about is not being talked about."

doing nothing that looks like CBT. To sacrifice evidence-based practice for our own intellectual, artistic and emotional satisfaction seems unacceptable to me ⁴.

That rejection can be even more powerful when there is a culture that is self-perpetuating, and which resists the implementation of more evidence-based approaches. As a Briton, I am used to the concept of ‘heroic failure’, but I stand in awe of the experience detailed by Lowe, Bunnell, Neeren, Chernyak & Greberman (2011), who tried to bring some elements of CBT into a much more eclectic therapeutic setting. My awe is a consequence of knowing just how typical that pattern of institutional resistance is – most of us would be too scared to try what Lowe and colleagues did ⁵.

In short, a lot of clinicians express the opinion that using CBT (and evidence-based methods in general) would make them focus on technique and specific benefits for the patient, suppressing their natural inclination to be more of an artist in delivering therapy that has ill-defined (or intangible) benefits. One even hears: “We cannot measure outcomes, because for our patients to get better means that they have to get worse during treatment.” There comes a point where we have to face the danger that hiding behind an anti-scientific stance is to sacrifice any desire to help patients to get better.

Delivery of evidence-based CBT for the eating disorders

All of which brings me to the point of this paper...just what is needed to be a good cognitive-behavior therapist? What are the principles that I would emphasise, based on my own history of ineptitude? Though many describe CBT as a ‘simplistic’ approach, Wilson (2012) has described CBT as “a complex therapy, with lots of moving parts”, which I think is very apt. Fairburn (Fairburn & Dalle Grave, 2011) has pointed out that CBT is not one method, but a “family” of methods, only some of which have any evidence base ⁶. I am going

⁴ When I go to presentations that are outside my comfort zone (as I often do – there is always learning to do), I commonly find myself thinking: “Go and write a novel, rather than taking it out on your patients under the guise of effective treatment”, but that might just mean that I need to take more holidays.

⁵ Brave people, and I hope they had a holiday after that piece of work, too.

⁶ I would take that a little further – the family really do not get on, and communicate only intermittently, with a degree of misunderstanding and occasional venom.

to focus on evidence-based approaches to CBT for the eating disorders, which do have a lot of moving parts and which require a lot of skill to implement them to best effect. However, a word of warning. In these days of CBT-E (Fairburn, 2008), I have reached the conclusion that there are many clinicians who practice CBT-H, where the H stands for ‘homeopathy’ – take a remedy, water it down, success it, water it down again, until you get to a level where there is effectively none of the active ingredient left, and then expect it to work ⁷. Clinicians routinely report ‘watering down’ their use of evidence-based treatments into part of a more ‘eclectic’ mix, on the basis of their clinical judgement (e.g., Tobin, Banker, Weisberg & Bowers, 2007; Wallace & von Ranson, 2012). In short, remove the hard parts from CBT and it gets easier to do but less effective. We can do better than placebo effects, but evidence-based CBT is hard work for clinician and patient alike.

Just as problematic, there are clinicians who start off using evidence-based CBT (and those who use other therapies), but who drift off into doing something that is not evidence-based CBT (Waller, 2009). Sometimes that drift appears to be so inexplicable and uncharted that it reminds me of the Marie Celeste – found in the middle of the ocean, with no explanation for how it got there, no crew, and no idea what had happened to them.

Principles underlying evidence-based CBT for the eating disorders

So, here are some principles that I have found to be useful – how to take the basic practice of CBT for the eating disorders and make it work for the patient’s benefit. Most of these principles have been developed through a long process of learning with my patients, my peers, my supervisors, and my supervisees, to all of whom I owe both lots of gratitude (and some heartfelt apologies). Most of these principles are based on my work with adult outpatients, and I leave it to those who work with younger cases and in more intensive settings to determine how to translate them to those groups ⁸.

⁷ Yes, I am being short on detail, but so are most accounts of how homeopathy is meant to work. Besides, if I gave more detail, that might mean that it stopped working.

⁸ Note – I did not say that they should ‘ignore’ the evidence base.

Principle 1: Attend to the evidence base

The evidence base has gaps, but that is no reason for not knowing about it or using it. There are plentiful reviews, which reach broadly similar conclusions (e.g., Bulik et al., 2007; National Institute for Clinical Excellence, 2004; Shapiro et al., 2007), and there is good evidence that this approach works outside research settings (Ghaderi, 2006). Just because something does not work for everyone (and CBT does not work for everyone), we should not ignore CBT in favour of other therapies where trying CBT would be the most appropriate option. The evidence for treatment matching in adult cases is pretty negligible. Similarly, we should not over-simplify, and assume that we can stop enquiring and developing where there is a treatment that works for some or even most patients. An understanding of the complexities of the eating disorders explains why we need to be able to adapt the therapy to the individual case (Strober & Johnson, 2012).

Principle 2: Read and use the manuals

There are lots of manuals to guide CBT for the eating disorders (e.g., Fairburn, 2008; Gowers & Green, 2009; Waller, Cordery, Corstorphine, Hinrichsen, Lawson, Mountford & Russell, 2007). Clinicians who use those manuals are more likely to deliver the relevant elements of CBT (Waller, Stringer & Meyer, 2012). This sounds obvious. However, a scarily small number of clinicians use manuals when working with the eating disorders, whatever the therapy that is being delivered (e.g., Tobin et al., 2007; Wallace & von Ranson, in press; Waller, Stringer & Meyer, 2012). Clinical judgement should be combined with the use of manuals, rather than being used to supplant them.

Principle 3: Do the basics

At heart, CBT is more of a 'doing therapy' than a 'talking therapy'. The effective elements include helping the patient to eat appropriately, monitoring intake, weighing the patient, using exposure, behavioral experiments, etc. Yet only a minority of CBT clinicians report using these methods on a regular basis (Waller, Stringer & Meyer, 2012). So is

everyone focusing on cognitive restructuring? Again, this seems to be a minority activity among clinicians (Waller, Stringer & Meyer, 2012). I often find myself facing the question of what is it that goes on under the label of 'CBT'. Then I assess a patient who has been treated using 'CBT' several times before, and I ask about what happened in the therapy, and I am none the wiser. Being blunt, it seems to me that the best way of avoiding embarrassment about what we do is to give the patient the most effective therapy possible, so that they never need to go on to a further therapist and demonstrate that they had an incomprehensible treatment before. Do the basics.

Principle 4: Understand the link between the therapeutic alliance and treatment outcome

While there is a lot of opinion about the importance of the therapeutic alliance in driving positive outcomes, the evidence is relatively weak, especially where the treatment is a relatively structured one (Crits-Christoph, Baranackie, Kurcias, Beck, Carroll, Perry, Luborsky, McLellan, Woody, Thompson, Gallagher & Zitrin, 1991). Indeed, in some areas of psychopathology, the evidence is that the link is the other way round. The best predictor of a good therapeutic alliance is a positive change in behaviors and symptoms as treatment progresses (Webb, DeRubeis, Amsterdam, Shelton & Hollon, 2011). Whatever the direction of causality, patients undertaking evidence-based CBT for the eating disorders report a good working alliance with their clinicians early in treatment (Waller, Evans & Stringer, 2012). Always bear in mind the notion of the therapeutic relationship in CBT requiring a "judicious blend of empathy and firmness" (Wilson, Fairburn & Agras, 1997).

Principle 5: Tolerate uncertainty

I have often reflected that the best CBT clinicians are those who are not afraid to try change, wait for long enough to find if it works, and then plan the next step. In other words, they tolerate uncertainty. If you need to know the answer now, then being a cognitive-behavioral therapist is probably not a good career choice. After all, you have to be calm while

the patient does all the worrying – and CBT will not work unless the patient experiences anxiety about change (e.g., eating more, facing body image). Another term for this is “Be boring”. Embrace your boring side, because the patient needs you not to be anxious. When the patient’s weight changes between meetings, stick to your guns and do not get excited, because the patient needs to know that you meant it when you said “This is going to take several weeks...” Remember that anxious CBT clinicians are more likely to be those who avoid using core CBT techniques (Waller, Stringer & Meyer, 2012).

Principle 6: Treat motivational enhancement as an ongoing process

There is (at best) minimal evidence that pre-treatment motivational work is effective in enhancing therapy outcomes (Waller, 2012), and yet over half of CBT clinicians report using this approach (Waller, Stringer & Meyer, 2012). Motivational work can be really valuable, but not when one treats it as a precursor to therapy. CBT clinicians need to avoid being part of the problem, and should not delay starting therapy until the motivational work has woven its (presumed) magic. Early behavioral change (and positive feedback from the clinician and the world) is much more likely to encourage further improvement (see below) and a positive therapeutic alliance (see above).

Principle 7: Review progress (or the lack of it)

CBT is not a ballistic approach to therapy. We cannot simply start it, and then assume that it will continue on its planned course. We need to respond to positive change by being reinforcing (many patients have never before had a successful dose of therapy, and need to learn that success is down to their own efforts). We need to respond to stuckness by being clear about it, and helping the patient to identify ways around it. There is evidence that early behavioral change is a key determinant of later progress in different therapies for the eating disorders (e.g., Agras, Crow, Halmi, Mitchell, Wilson & Kraemer, 2000; Doyle, Le Grange, Loeb, Doyle & Crosby, 2010; Wilson, Loeb, Walsh, Labouvie, Petkova, Liu & Waternaux, 1999), so be firm about the need to change from very early on – give the patient a choice

about having the best chance to get well. It is possible that such a review will result in deciding to change therapeutic direction – that is fine, as long as the patient had the best chance of recovery in the first place. In short, if you have been delivering CBT-H, then all that says is ‘try an evidence-based form of CBT’.

Principle 8: Get out of the rut

Even if practiced in the most appropriate way possible, CBT for the eating disorders is not perfect by any means. So we should always be aiming to improve what we deliver by keeping up to date. However, we also need to get ahead of the game. I commonly find that attending general CBT conferences, reading more widely in the field of CBT, and plundering ideas from colleagues who know nothing of the eating disorders means that I find new ideas (well, new to the eating disorders, anyway), which can be invaluable in working with my patient group.

Conclusions

Earlier, I mentioned the anticipated reactions of different people on reading this article. I missed out one very important group. Some people did not need to read this article - it will have told them nothing new and will not have added one little bit to their practice, because they are already doing all this. Ironically, those are the people who are most likely to have read this far, in case there was something new that they needed to learn. Sorry to disappoint you, but delighted to meet you. I just wish there were more of you.

There are many wonderful clinicians in this field. There are some great treatment approaches – not just CBT. However, most clinicians do not use them, making all the mistakes that I made myself back in those first few years. Within CBT, there is an evidence-practice gap – many CBT clinicians miss the point of what they need to do and why, resulting in scary failures to deliver empirically-supported treatments. The manuals are easy to obtain and can guide us towards better practice (Waller, Stringer & Meyer, 2012), but are not as widely used as they should be (Tobin et al., 2007). This pattern of manual use is not random

(Wallace & Von Ranson, in press), meaning that there are clear opportunities for improving uptake. However, simply having the tools is not enough. We need to be able to reflect on why we do what we do when we do it. The aim of this review has been to address that need in just one area of treatment for the eating disorders – identifying therapeutic principles that can help us to keep CBT on target, rather than drifting as cognitive-behavioral therapists. I hope that there have also been ideas that will prove useful to those using other therapies as well. What I would most like to see would be for all clinicians to have a set of principles underlying their use of the best possible practice for their patients, regardless of the therapy concerned. However, that requires us all to be focused on being scientist-practitioners rather than artists.

Speaking of artists, there is a line at the end of the Beatles' 'Let It Be' film where one of the Moptops concludes by saying "I'd like to say thank you on behalf of the group and ourselves and I hope we've passed the audition". I have this horrible idea that I might get to the end of my career and feel that I have failed the audition, but I hope the many clinicians who are better than me will be pushing the envelope of evidence-based practice, and that the principles outlined here will help.

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