Cognitive-behavioural therapy for the eating disorders: A refresher course

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Who can benefit from CBT for the eating disorders?

- The NICE guidelines and recent research give the answer to this

- Adults
  - guides by Fairburn (2008), Waller et al. (2007)
  - in addition, CBT is well established as a treatment method with most of the common comorbidities

- Adolescents
  - guide by Gowers & Green (2009)
  - recent work by Schmidt and colleagues

What can get in the way of these results?

- Comorbidities?
  - little evidence of this
  - but look out for extreme social anxiety
- Gender?
  - no evidence that males and females respond differently
- Setting?
  - research setting findings well replicated in regular clinical practice if the therapy is done right
  - outpatient setting is easier, as there is less mandatory pressure for weight gain
  - self-help gives weaker outcomes

What can get in the way of these results?

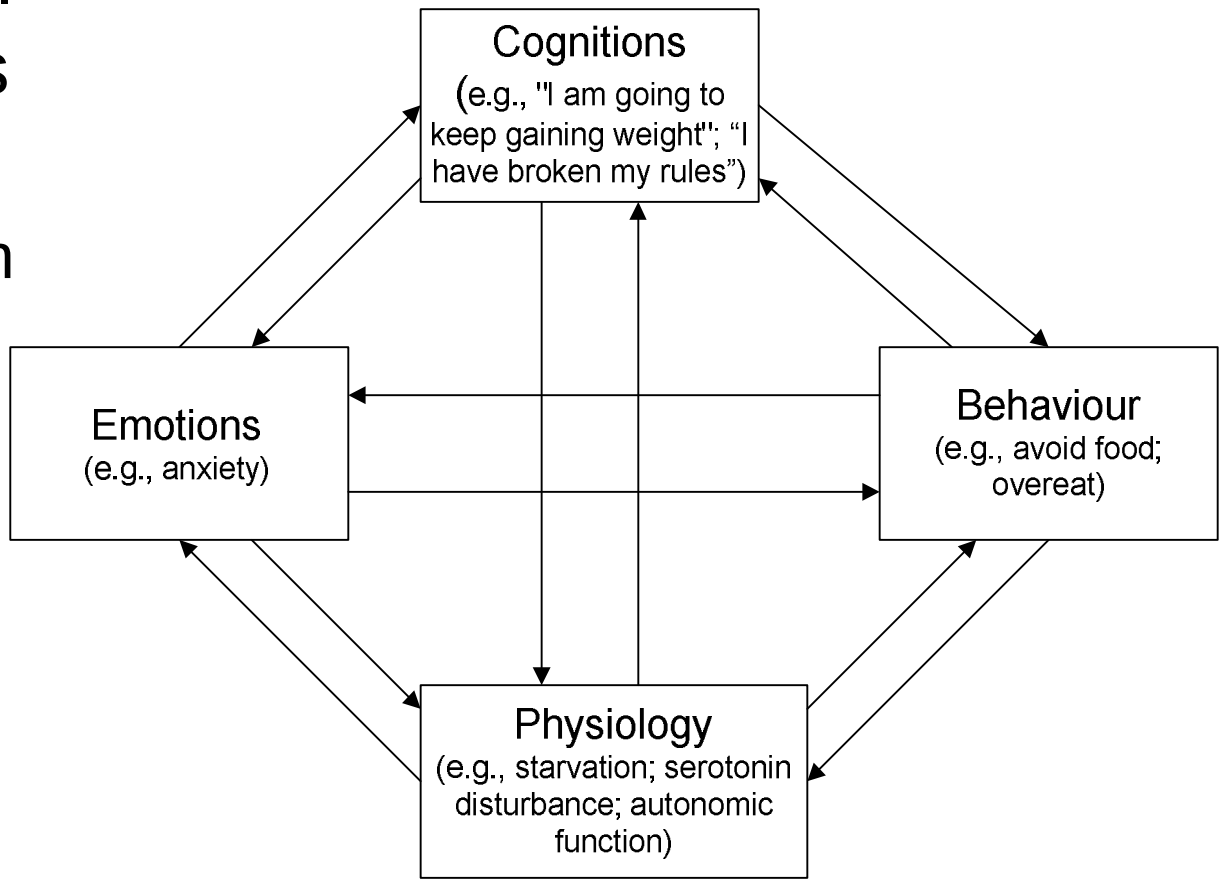
- Patient factors?
  - e.g., motivation
  - not as clear cut as we assume…
- Clinician factors?
  - not so well understood
  - but clear evidence that they get in the way in other disorders
- Can see both as manifestations of therapy-interfering factors

Principle 1

Where to start change in the CBT model

Where to work on the hot cross bun?

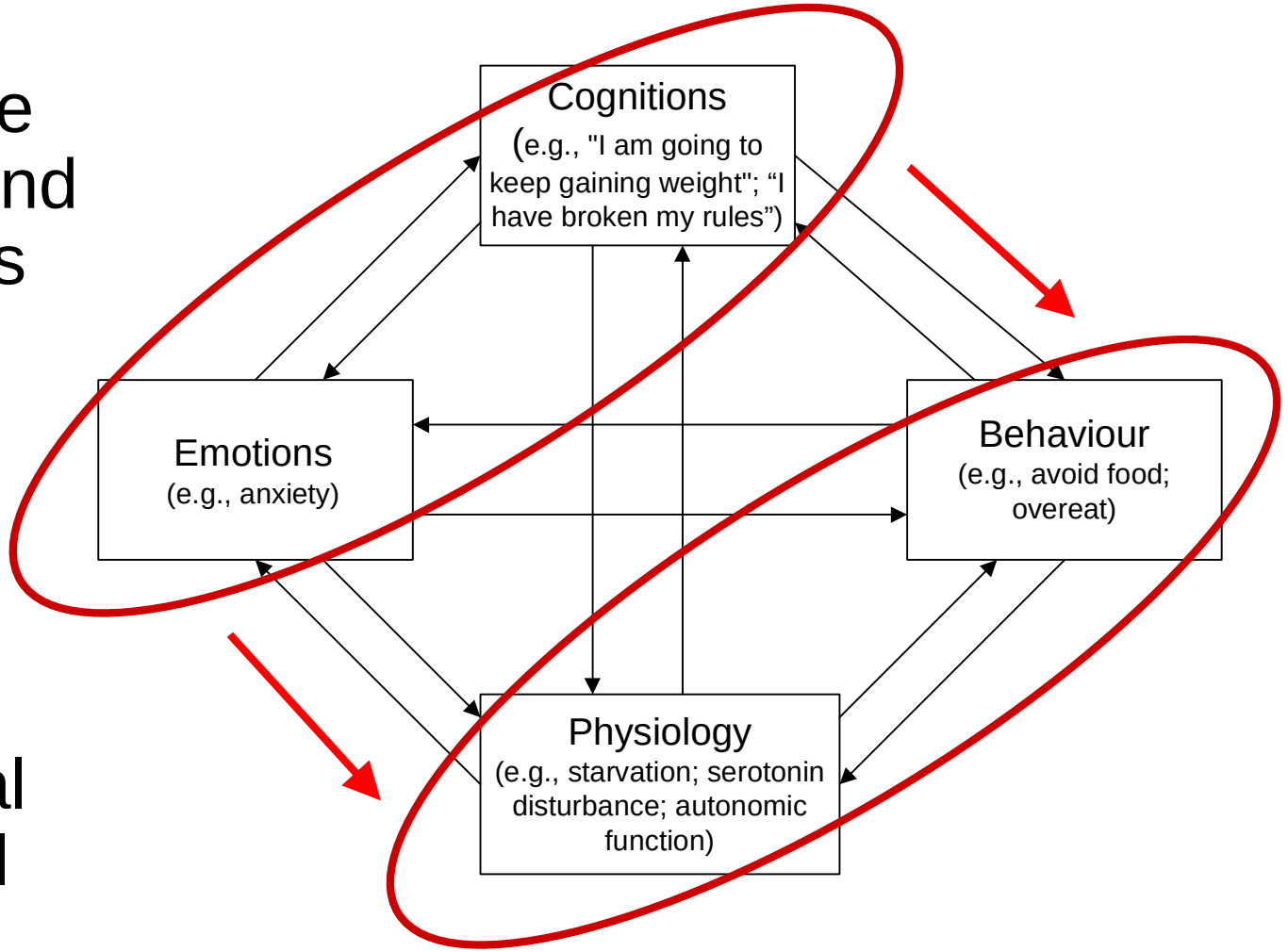
- The CBT model is based on this structure
  - the individual in social context
- But this model is not always used in the eating disorders



A common assumption in ‘CBT’

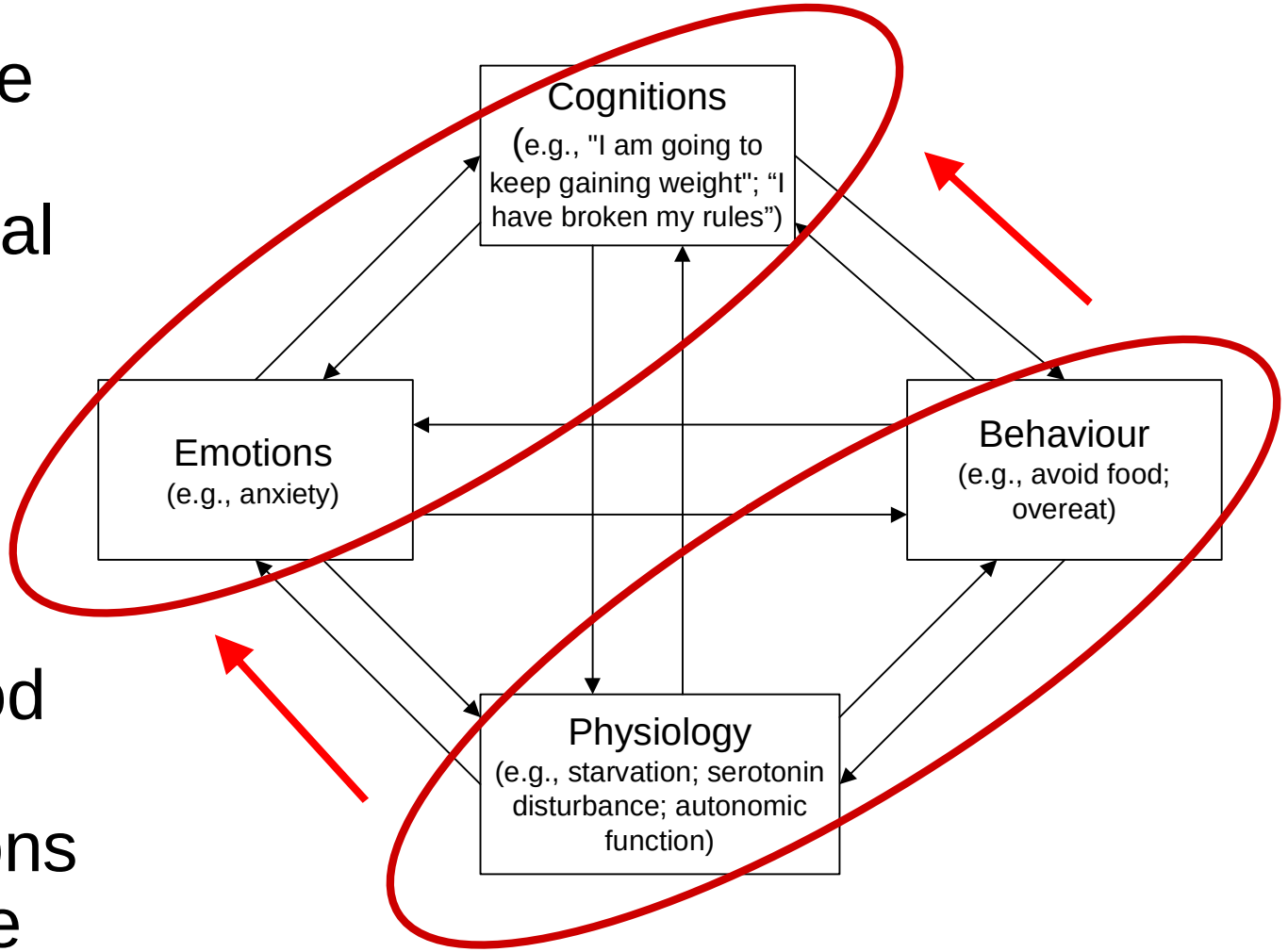
- Start with the cognitions and the emotions

- Behavioural change and physiological recovery will follow



What is needed for evidence-based CBT

- Start with the behavioural and biological

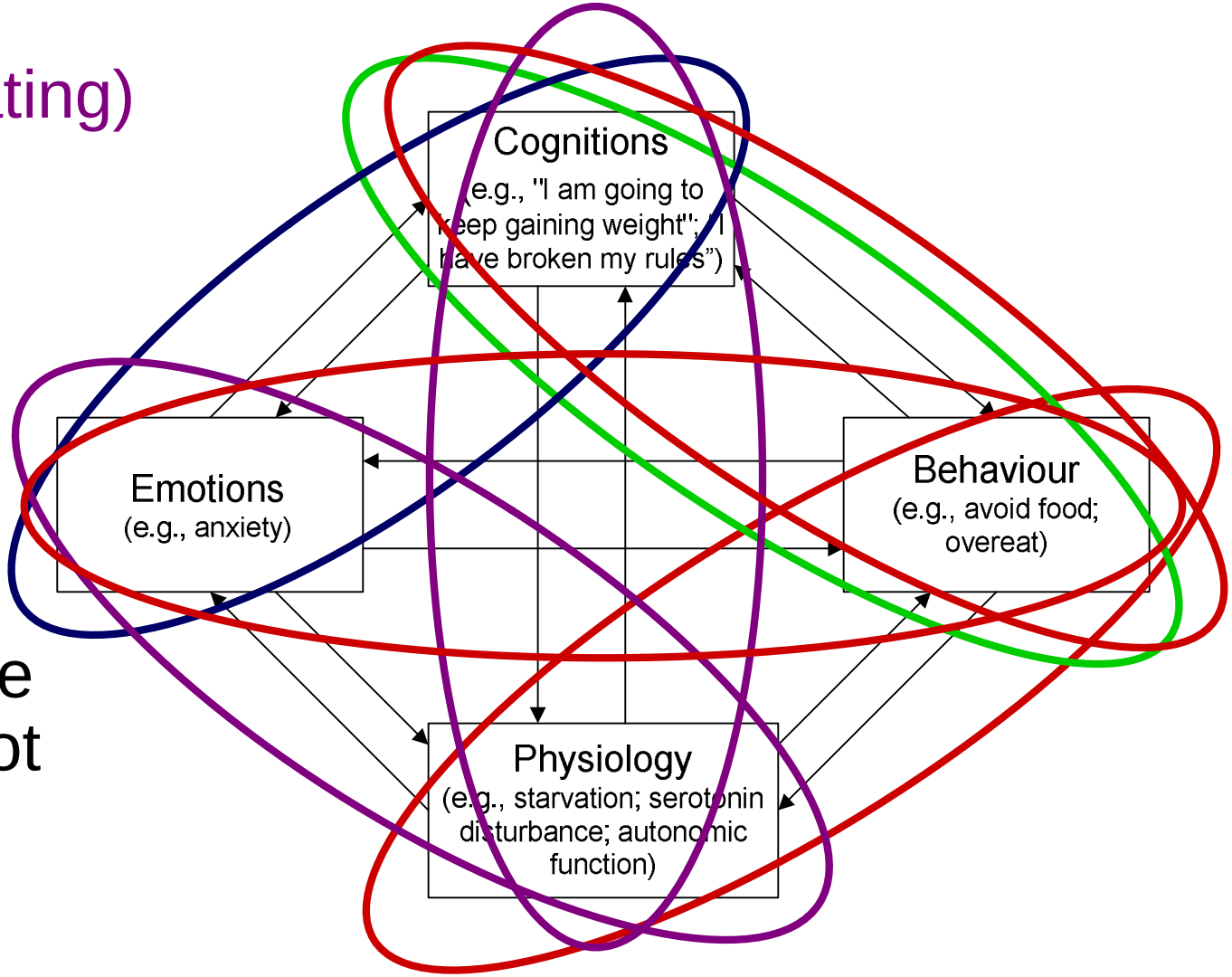


- Making mood more stable and cognitions more flexible

Methods that address these elements

- Exposure (eating)
- Cognitive restructuring
- Behavioural experiments
- Surveys

- Order of these methods is not fixed, but exposure is usually first…



A common theme: Working with anxiety

- A huge amount of what we do is about triggering and working with anxiety
  - exposure, safety behaviours, social anxiety and mind-reading
- If the patient is not scared of the changes, then they are unlikely to learn
- The key is to find the zone where the patient is anxious enough to learn from the changes, but not so anxious that they run away from change

Principle 2

Motivational interventions have to be inherent in CBT

Motivational myths to beware of

- Motivation comes in neat stages
- That we know all about motivational states
  - Freeman & Dolan (2001)
- There is good evidence that motivational interventions are effective in the eating disorders
  - Knowles (2009)
- Clinicians or patients are good at identifying motivation
  - Geller (2002)

Motivational stance

- Need to think about motivation as being something that is continuously addressed
  - not just a start point
- Consider motivational ‘states’ whenever things are going slowly
  - make no assumptions about linear progression through ‘stages’
- Be prepared to back off in a strategic way
  - disinvestment
  - disability training
- The best indicator of motivation is whether the patient is changing…

Principle 3

The therapeutic relationship matters

What does the therapeutic relationship do in CBT?

- It facilitates change
  - keeps the patient in therapy
  - keeps the patient on task
- It does not produce change
  - works as an agent of change, but only in therapies that are not clearly structured
  - Crits-Cristoph et al. (1991)
- A good therapeutic relationship might be a *consequence* of therapeutic change
  - Safer & Hugo (2006)

The therapeutic relationship in CBT for the eating disorders

- Attachment-based model (Bordin, 1979)
- Shared goals, shared tasks of therapy, and an attachment bond
  - better value if rated by patients

- CBT model (Wilson, Fairburn & Agras, 1997)
- "A judicious blend of empathy and firmness"

- So are these incompatible?
- Not at all
  - Olverman (2009)

Principle 4

The Socratic approach

Socratic questioning

- Start by understanding the patient's perception, emotion and behaviour
- Understand the underlying beliefs
- Consider evidence in favour
- Consider evidence against
- Develop alternative belief
- Seek evidence that allows the beliefs to be contrasted

Principle 5

Stop trying to be a therapist

Therapist or coach?

- Our job is to get CBT to happen at the maximum dose
- Yet we meet the patient for an hour a week…
  - unlikely to be effective
- Aim to get the patient to take on the role of therapist
  - our role is to be a coach
  - driving 168-hour a week therapy

Principle 6

Know some stuff…

Psychoeducation

- Be authoritative, rather than authoritarian
  - know what you can (and be prepared to find out the rest in collaboration with your patient)
  - “I don’t know, but I know a way of finding out…”
- Use existing psychoeducation resources
  - e.g., effects of different behaviours; impact of starvation; risks of permanent damage
  - but allow that individuals differ in their biology, etc.
- Encourage scepticism about ‘rogue’ sources of information

Principle 7

What is broken, and what are we trying to do to fix it?

The core cognitive deficit

- Most people have a belief that there is a rough correspondence between what they eat and what happens to their weight
- For most people with eating disorders, that cognitive link is broken
  - assume that even small amount of eating will lead to disproportionate weight gain
  - assume that any weight gain will be uncontrollable and unstoppable
- So we are working to rebuild that link

1. Exposure

Principles of exposure

- Anxiety and stress occur when we feel vulnerable
  - mismatch of stress and coping levels
- The human body responds to stress by preparing to fight or to run away
- Safety behaviours
  - short term relief of anxiety
  - long-term maintenance of feared object
- But anxiety is a short-lived biological reaction
  - sit it out without using the safety behaviour, and it tends to subside
  - i.e., exposure

The main uses of exposure in the eating disorders

- Eating differently
  - adding structure
  - adding quantity
- Weight (re)gain
- Taking risks
  - e.g., eating a buffet
  - e.g., facing emotional situations rather than running away from them

Examples of when we use exposure

- Body image work
  - mirror work
- Fill in the diary when you get the urge to binge
  - make bingeing an active choice
- Reducing compensatory behaviours
  - waiting for 30-40 minutes after eating to allow the anxiety to subside
- Adding structure to the diet
- Eating ‘forbidden’ foods
- etc., etc.

2. Cognitive restructuring

Remember the central beliefs

- Overevaluation of eating, shape and weight
  - *"If I eat normally, then my eating will go out of control."*
  - *"I will reach my target weight and then keep going."*
- Clear links to behaviours and affect
- Targets for cognitive and behavioural change

What are the key cognitive targets?

- If you are normal weight or above
  - learning that you eat normally without weight gain
- If you are underweight
  - learning that your weight does not shoot up
  - learning how hard weight regain is
  - learning to stop weight gain
    - start-stop-start-stop approach
- Both require eating…

Useful measures of central cognitions

- Eating Disorders Examination-Questionnaire
  - Version 6 (Fairburn, 2008)
  - gives a range of negative automatic thoughts around eating, shape and weight
  - change within six sessions
  - self-assessment of bulimic behaviours
    - beware of the objective binges measure

- Testable Assumptions Questionnaire-Revised
  - gives a measure of dysfunctional assumptions that are amenable to being tested using surveys, experiments, etc.
  - Dhokia et al. (2009)

Other cognitions to look out for

- Permissive cognitions
  - Cooper et al. (2000)
- Safety beliefs and behaviours
  - e.g., beliefs about body checking (Mountford et al., 2006)
- Cognitive distortions
  - magical thinking (e.g., thought-shape fusion)
  - black and white thinking
- Schema-level beliefs
  - more commonly an issue during relapse prevention

Remember the cognitive distortions

- *Selective abstraction*
  - "The only way I can be in control is through eating”
- *Overgeneralisation*
  - "I was unhappy when I was normal weight. Therefore, I can't get to a normal weight now"
- *Magnification*
  - "If I put on a pound, that would be unbearable"
- *Dichotomous thinking*
  - "If I put on a pound, then I'll put on a hundred pounds"
- *Personalization*
  - "When I see someone fat, I worry that I will become like her"
- *Superstitious thinking*
  - "Anything that I eat will instantly turn into fat on my hips"

Examples of ‘crooked thinking’

- “Vomiting and purging are effective”
- “My weight will shoot up if I do not restrict”
- “50 extra calories will make me gain four kilograms”
- “No-one needs more than 500kcal per day”
- “I can keep my weight stable if I try”

- Hence, the basics of self-monitoring
  - food diaries; regular weighing
- Establish the eating-weight correspondence
  - link back to psychoeducation

Cognitive restructuring

- Aim to enable the patient to amend the initial (distorted) thought
  - based on a review of the evidence
- Generate an alternative, balanced thought
  - not ‘positive thinking’
- Change is unlikely to be immediate
  - introducing a seed of doubt
  - possible the initial thought may not be 100% accurate
  - can enable the introduction of behavioural experiments where necessary

Cognitions behind safety behaviours

- Explaining the reason that the patient holds onto her behaviours
- Doing the behaviour used to be seen as an asset
  - e.g., positive ‘buzz’ from weight loss
- Now, afraid of the consequences of not doing the behaviour
  - e.g., restricting because of fear of weight increase
- Use the example of playing the lottery
  - what stops people from stopping?

Working with beliefs about weight

- Address beliefs about the accuracy of weight estimates
  - also see body image/body checking
- Graph cumulative weight estimates
  - get predictions and strength of predictions
- Is the patient any good at estimating whether her weight has gone up or down?
  - consider with her why she is poor at this

Working with beliefs about food

- Forbidden foods vs OK foods
- Change the headings
- ‘Liked’ vs ‘Disliked’ vs ‘Don’t know’
- This task on its own can cause a lot of confusion
- Then save those lists for behavioural experimentation…

Working with beliefs about food

- Examine beliefs about bulimic behaviours
  - e.g., “If I eat cheese, then I always binge”
- Find conflicting evidence
  - “What was the last time you ate cheese without bingeing?”
- Reframe the belief to make it less food-centred
  - “I am more likely to binge when I feel that I have broken one of my rules – it is not about the type of food itself”

Working with beliefs about shape

- Psychoeducation about body composition
  - e.g., what is fat for?
- Media scepticism
  - why do those magazines show those pictures?
- Mindfulness re body image

- More impact of other methods
  - exposure (e.g., mirror work)
  - surveys (e.g., how others see you)
  - behavioural experiments (e.g., body checking)

Continuum thinking

- Address ‘black and white’ thinking
- Conditional beliefs (“if…then….” statements)
- e.g., “I can only be a success if I am thin”
- Testable Assumptions Questionnaire-Revised is useful for identifying such cognitions
  - see your disk

Continuum thinking: linked beliefs

- Pin down the cognition
  - e.g., “Only thin people are successful.”
  - get the patient to rate her belief in it (e.g., 90%)
- Develop an alternative belief
  - “thin is not equal to successful”
  - get the patient to rate her belief in it (e.g., 5%)
- Select ten people who she knows…

The limits of cognitive restructuring

- Works less well when the beliefs are unconditional
  - see schema-level work
- Less effective than behavioural experiments
  - particularly ‘intentional’ behavioural experiments
  - ‘accidental’ behavioural experiments are more likely to be discounted

3. Behavioural experiments

What is a behavioural experiment?

- Aim to test out beliefs, rather than simply change behaviour
  - therefore different to behavioural activation, skills training and exposure-based methods
  - getting the patient to learn the skills
- "For the behaviour therapist, the modification is an end in itself: for the cognitive therapist it is a means to an end – namely cognitive change"
    - Beck (1979)

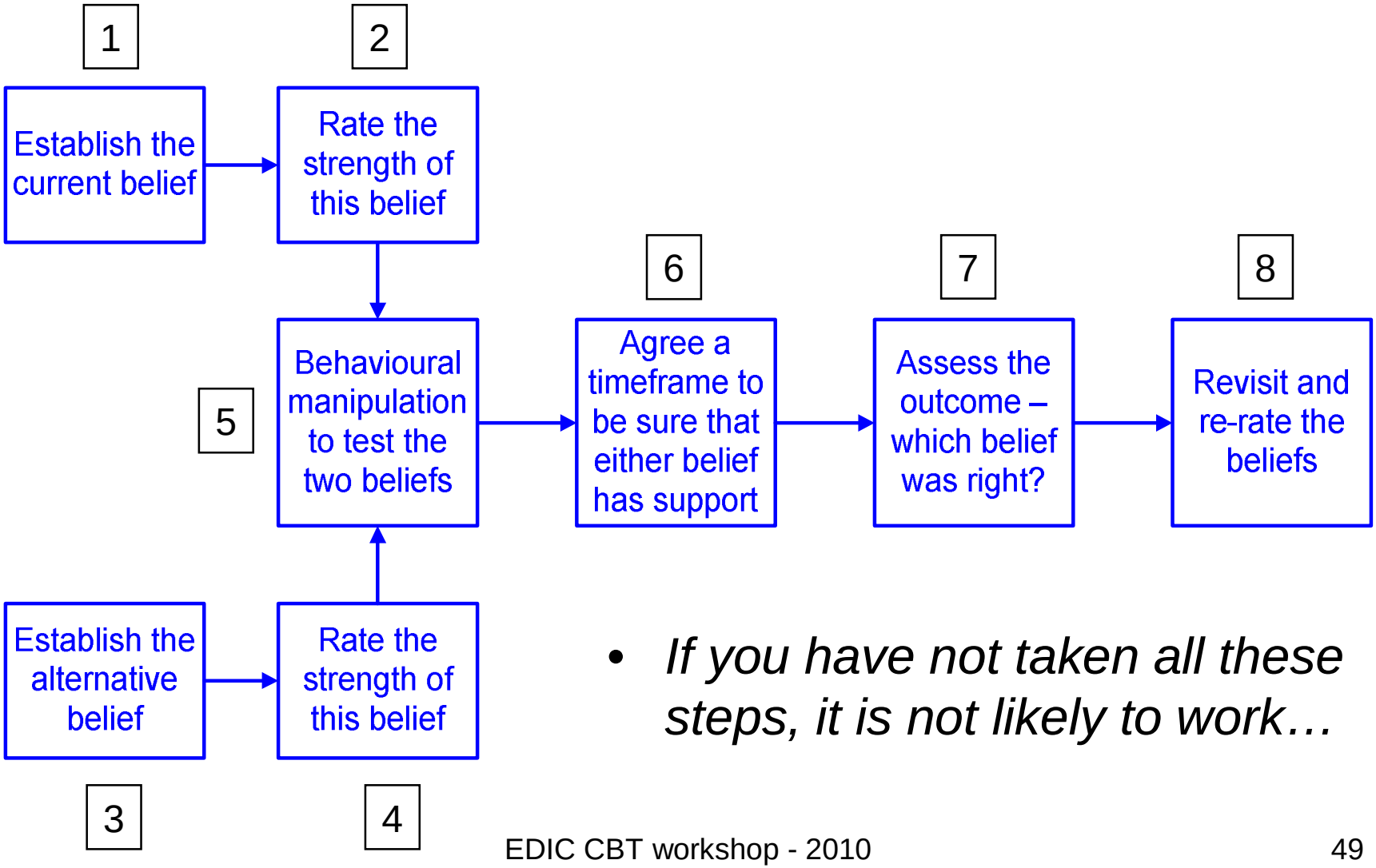
What is a behavioural experiment?

- Trying out changes in a systematic way
- Use of planned behavioural change to:
  - test existing beliefs about the self, others and the world
  - develop and test more adaptive beliefs
- Commonly used to address eating, weight and shape cognitions
  - also valuable in working with cognitions regarding interpersonal issues and failure
- Challenging safety behaviours/cognitions

Preparation

- Agree to stick to eating plan
  - not to compensate, as that would nullify the experiment
- Anticipate obstacles and solutions
  - e.g., thinking errors
- Plan the ‘safest’ time to start the experiment
- Prepare flashcard for cognitive challenges
- What to do afterwards?
  - whether it goes right or wrong

Going through the steps



- *If you have not taken all these steps, it is not likely to work…*

Vignettes: Eating, weight and shape

Belief to test out

- ‘‘If I eat dessert, people will think I’m greedy and say so’’ (95%)

Alternative belief

- “Maybe no-one will care enough to notice or comment” (5%)

Possible methods

- *Try eating dessert, and see if people make the anticipated comments*

Vignettes: Eating, weight and shape

Belief to test out

- ‘‘If I don’t weigh myself three times a day, my weight will go out of control’’ (100%)

Alternative belief

- “Maybe weighing myself is not affecting my weight, but is making me more anxious” (5%)

Possible methods

- *Reduce weighing frequency, and see if my weight goes up as a result, or if my weight stays the same, but I get less anxious*

Vignettes: Interpersonal/emotional

Belief to test out

- ‘‘If I make a mistake at work, people will spot it and criticize me for being useless’’ (110%)

Alternative belief

- “Maybe it is possible that no-one will care if they even see it” (5%)

Possible methods

- *Make a deliberate error, and identify how many criticisms are made*

Vignettes: Interpersonal/emotional

Belief to test out

- ‘‘If I take time for myself, my mother will not be able to cope’’ (80%)

Alternative belief

- “Maybe she is fine on her own, and all I am doing is trying to cover for a non-existent problem” (20%)

Possible methods

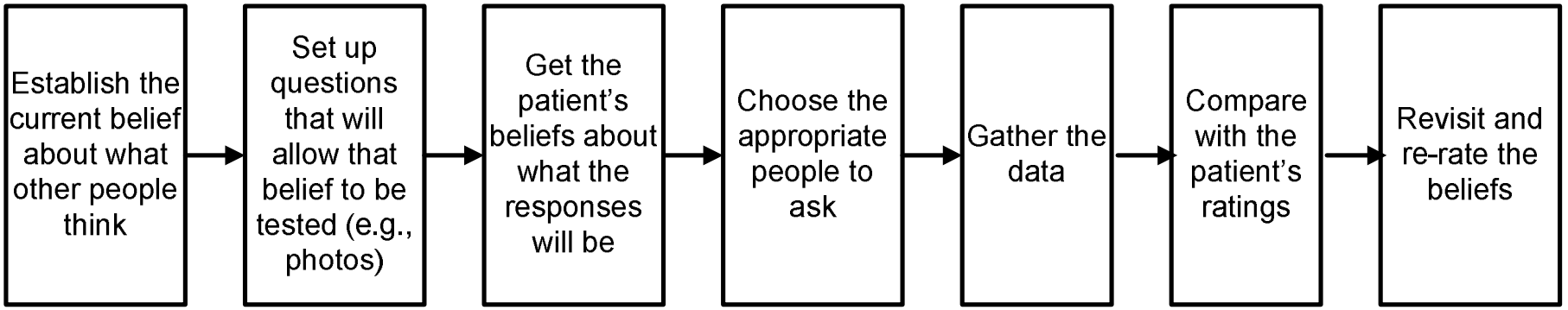
- *Create planned personal time, and see if mother has the predicted problems*

4. Surveys

Surveys

- When the problem is one of the patient ‘mind-reading’
  - e.g., “I know that they think I am fat, but they would never tell me that”
- Test patients’ beliefs about what other people consider important
  - particularly useful where the individual has a lot of social anxiety
- Collecting data through:
  - observation of events
  - interviewing other people

Going through the steps



- *Again, if you have not taken all these steps, it is not likely to work…*

The next steps

- Tighten up the beliefs
- “Well, maybe they would not say anything nasty”
  - find people who would…
- “Maybe they do not mean the same thing as I do when I say ‘fat’”
  - do it again, with refined questions…
- Chase the belief to death

The take home message?

- Evidence-based CBT for the eating disorders involves a careful, patient-centered use of these techniques
- There is no magic here
  - anyone can apply these methods
  - though many do not
- The principles matter
  - they guide the practice

The take home message?

- Your stance matters
  - optimism and realism combined
  - honesty at all times (good or bad)
- Your relationship with the patient matters
  - firm empathy…
- Your use of the techniques matters
- And always pay attention to whether it is working…

References

- Cooper, M. J., Whitehead, L., & Boughton, N. (2004). Eating disorders. In: J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller, & D. Westbrook (Eds). Oxford guide to behavioural experiments in cognitive therapy (pp. 267-286). Oxford, UK: Oxford University Press.
- Fairburn, C.G. (2008). Cognitive behavior therapy and eating disorders. New York NY: Guilford
- Fairburn, C. G., & Harrison, P. J. (2003). Eating disorders. Lancet, 361, 407-416.
- Ghaderi, A. (2006). Does individualization matter? A randomized trial of standardized (focused) versus individualized (broad) cognitive behavior therapy for bulimia nervosa. Behaviour Research and Therapy, 44, 273-288.
- Gowers, S. G. & Green, L. (2009). Eating disorders: Cognitive behaviour therapy with children and younger people. London, UK: Routledge.
- National Institute for Clinical Excellence (2004). Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (Clinical Guideline 9). London, UK: National Collaborating Centre for Mental Health.
- Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V., & Russell, K. (2007). Cognitive-behavioral therapy for the eating disorders: A comprehensive treatment guide. Cambridge, UK: Cambridge University Press.