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

Glenn Waller and Emma Butler

Vincent Square Eating Disorders Service, London and Institute of Psychiatry, King’s College, London

Central and North West London NHS Foundation Trust
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

1. Establish the current belief
2. Rate the strength of this belief
3. Establish the alternative belief
4. Rate the strength of this belief
5. Behavioural manipulation to test the two beliefs
6. Agree a timeframe to be sure that either belief has support
7. Assess the outcome – which belief was right?
8. Revisit and re-rate the beliefs

- 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 nonexistent 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

- Establish the current belief about what other people think
- Set up questions that will allow that belief to be tested (e.g., photos)
- Get the patient’s beliefs about what the responses will be
- Choose the appropriate people to ask
- Gather the data
- Compare with the patient’s ratings
- Revisit and re-rate the beliefs

• 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