Brief CBT for eating disorders (CBT-T): How to adapt our skills to get good outcomes in half the time

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Overview of the workshop

- Introduction (TW – 5 minutes).
- Principles of CBT-T (TW - 10 minutes)
- Addressing the 'broken cognitive link' (GW – 15 minutes)
  - Exposure to eating and food
  - Behavioural experiments
  - Working with emotional triggers
- Addressing body image (TW – 15 minutes)
- Ending therapy (TW – 5 minutes)
  - Blueprints
  - Using follow-ups as an active part of therapy
- Supervision and monitoring (GW – 15 minutes)
- Discussion time
  - questions on CBT-T and how to address it in your service

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If you want a copy of the slides…

1. Go to the website for CBT-T
   - *http://cbt-t.shef.ac.uk/*
2. Go to the following link on there:
   - *WCBCT Presentation 2019*
   - click to download
4. The slides are there for you to download
   - along with lots of other CBT-T resources
   - *Downloadable Resources* link

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Introduction

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If you want to know more

- Our manual is out now
- The full protocol for non-underweight patients
  - flexible, to fit the individual case
- Checklist for guiding you through the methods needed over the 10 sessions
  - see the website to get this
- Covers all of the core skills needed
- Lots of case examples of how to implement skills

Subliminal advertisement

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Introduction to CBT-T (the T stands for 'Ten')

- Developed because we have been failing our patients too long
- We have good therapies, but few of us use them
- We offer unsupported therapies for far longer than necessary
- We have long waiting lists, which reduce hope and progress
- For the sake of our patients, carers, and others, we need to improve our turnover of patients, reduce waiting times, etc.

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The origins of CBT-T

- In the UK system, we mirrored a lot of the Improving Access to Psychological Therapies (IAPT) model
  - Brief, evidence-based therapies
  - Robust supervision
  - Progress and outcome monitoring
- In Australia, the 10-session limit fitted well with the health insurance model
- In the UK, this has the potential to fit the FREED early intervention model
  - can't see people quickly if you do not discharge people quickly too…

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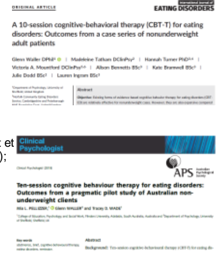
Does it work?

- Yes, it does
  - Waller et al. (2018); Pellizzer et al. (2019)
- As effective as 20-session forms of individual CBT-ED
  - e.g., Byrne et al. (2011); Fairburn et al. (2009); Knott et al. (2015); Signorini et al. (2018); Turner et al. (2015); Waller et al. (2014)
- Lower attrition rates than other effectiveness studies
- Cheaper to deliver


ORIGINAL ARTICLE

A 10-session cognitive-behavioral therapy (CBT-T) for eating disorders: Outcomes from a case series of nonunderweight adult patients

Clinical Psychologist

Ten-session cognitive behaviour therapy for eating disorders: Outcomes from a pragmatic pilot study of Australian non-underweight clients

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CBT-T is not just for the 'easy' or 'simple' cases

- Pretty much every non-underweight adult patient
  - we work in routine clinical settings, so we do not exclude
  - we have included BN, atypical AN, atypical BN, BED, ARFID, purging disorder, other OSFED cases…
- Our only exclusion criteria are active suicidality and serious self-harm
  - about 4% of cases
- Acceptability is about 90%
- Well-received by patients
  - Hoskins et al. (2019)

ORIGINAL ARTICLE

Patients' experiences of brief cognitive behavioral therapy for eating disorders: A qualitative investigation

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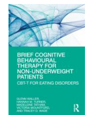
Principles of CBT-T

(all of this needs to be addressed from Session 1)



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Principles to follow to make CBT-T effective

- Use the protocol and the checklist
  - but flexibly, as with all protocols
  - make therapy fit the patient, not vice versa
  - patient-focused supervision is key
- A 'doing' therapy (not a 'talking' therapy)
  - behavioural change from the start
  - not just 'in therapy' or 'going to therapy'
  - alliance and motivation follow such change
- Offer four sessions at first, and review
  - continuation dependent on behavioural change
  - countdown from the start

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Principles to follow to make CBT-T effective

- Aim for the patient attributing success to themselves
  - we are coaches: the patient is the therapist
- Cope with our own anxiety about change
  - it is OK for the patient to hate us sometimes
  - as long as they get well
  - 'firm empathy' is key (Wilson et al., 1997)
- Clear cognitive targets
  1. 'broken cognitive link' between eating and weight *(Glenn)*
  2. overvaluation of weight and shape *(Vicki)*
- Know what you are trying to repair, and use the right tool

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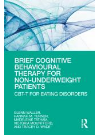
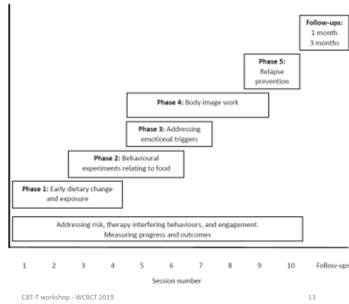
Overall structure of CBT-T





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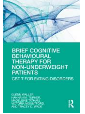
Addressing the ‘broken cognitive link’

(Session 1 to about Session 6/7)



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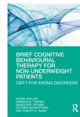
Core tasks in this part of therapy

- Dietary normalisation
- Exposure
- Weighing and diaries
- Behavioural experiments
- Addressing emotional triggers
- *All aimed at repairing that broken cognitive link*



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Starting with exposure and nutrition (sessions 1-4)

- Aim for normalisation of diet within the first four sessions
  - use ‘The Real Food Guide’ (Hart & McMaster – see manual)

- Two effects
- Biological normalisation
  - cognitive flexibility; emotional stability; physical safety
- Psychological mechanism of exposure to fears about food
  - using the principles of inhibitory learning
  - faster, broader learning
  - more robust change

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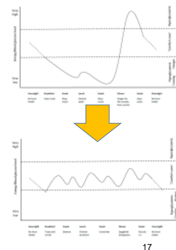
Starting with exposure and nutrition

- Key tasks
- Link eating to weight
  - diaries
  - weekly, open weighing
  - weight chart to show data-schema gap



- Normalise eating as quickly as possible
  - using energy graphs
  - meaningful, anxiety-inducing dietary change from the beginning
  - aim for maximum tolerable anxiety from the start, to get maximum change

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Behavioural experiments (sessions 3-7)

- Start when nutrition and exposure have been largely effective
  - when anxiety has come and bingeing and purging are largely gone
  - when the patient is not hampered by cognitive inflexibility
  - able to maintain core diet while introducing experimental foods
- Addressing specific beliefs about what food does to weight
- Commonly used to address eating, weight and shape cognitions
  - e.g., weight gain if I change eating; impact of body checking
  - also valuable in working with other cognitions
    - e.g., interpersonal issues, perfectionism and failure

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What is a behavioural experiment?

- Trying out changes in a systematic way, to learn the outcome
- Use of planned behavioural change to:
  - test existing beliefs about the self, others and the world
  - develop and test more adaptive beliefs
  - learning that food intake is the best predictor of weight
- Brief experiments (1-2 sessions), with high intake changes resulting in high predicted weight gain
  - maximum tolerable change in diet, with maximal tolerable anxiety
  - pushing the patient to add more scary foods and more quantity
  - learn that weight does not do what is expected

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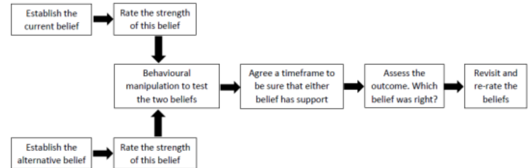
Template for behavioural experiments

- Make sure that you use the full template
  - many forget key elements
  - you might need these skills again later (body image), so learn them now



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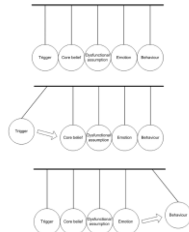
Working with emotional triggers (sessions 3-7)

- Only do this if it is necessary – might not be
- Do not start it before removing starvation effects
- Often used earlier where the patient has binge-eating disorder or ARFID
- Use the Newton's cradle model to understand the role of the emotion in the behavioural chain



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Tasks in working with emotional behaviours

- Identifying emotional triggers using diaries
  - change triggers/situations
- Using exposure with response prevention to delay bingeing/purging
  - sit with the emotion
  - distraction (e.g., mega-diaries; alternative, incompatible behaviours)
  - addressing the function of the emotion directly
- Address core beliefs where exposure does not work
  - imagery rescripting
  - challenging attributions
  - historical review
  - evidence gathering

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Addressing overvaluation of body image

(Session 5 to about Session 9)

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When to start this phase and why?

- Only do body image work if it is necessary
  - might not be
  - not all patients have this problem
  - poor body image at the start might be normalised by later on in therapy
- But if it *is* going to be a problem, you can usually tell key information from the first session (and from the ED-15)
- Targeting maintaining behaviours
  - rarely attend to the factors that caused the problem
  - long ago, and far away...

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Linking treatment to the pathology

Maintenance mechanisms/ safety behaviours	CBT-ED approach
Ignorance	Education
Misperception	Identify misperception and mechanisms (e.g., emotion) and offer corrective feedback
Body checking	Behavioural experiments
Body comparison	Behavioural experiments
Mind-reading	Surveys
Body avoidance	Exposure/flooding

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Specific tasks linked to the safety behaviour used

- Mind-reading addressed using surveys
- Checking and comparison addressed via behavioural experiments
  - cannot be used at the same time as each other or other experiments if the targets are the same (e.g., testing weight gain; anxiety reduction)
- Avoidance is usually best addressed using mirror exposure
  - flooding, using guided or pure exposure
    - stay away from calming approaches…distraction, mindfulness, etc.
  - can use graded exposure earlier if appropriate to the problem
    - e.g., going out in more or less exposing clothes

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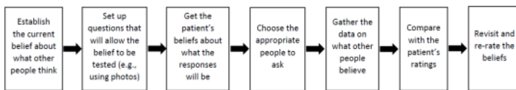
Surveys

- Used to address **mind-reading**
  - e.g., "I know that they think I am fat, but they would never tell me that"
  - technique adapted from CBT for social phobia
- Test patients' beliefs about what other people consider important
- Following this structure:



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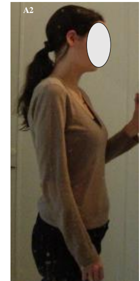
An example of a survey

Look at this photo:

1. Write down the first thing you notice about Jessica
2. Rate her stomach on a 1 to 10 scale (flat – protruding)
3. Is there anything you like about Jessica's appearance?



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Behavioural experiments

- Used to address **body checking** and **body comparison**
- Each behaviour is used to relieve anxiety in the short term
- Each makes body image worse in the medium to long term
- So we address the belief that checking/comparison is a good thing
  - use/don't use the behaviour
  - determine how each makes the patient feel
  - usually, one experiment is plenty…

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Addressing body checking and comparison

- General structure of experiments is as outlined earlier
- One week of using the checking/comparison behaviour as often as possible
  - rate how you feel short-term and long-term
- One week of trying to avoid using the checking/comparison behaviour totally
  - rate how you feel short-term and long-term
- Often can used just one week to do both

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A behavioural experiment for 'checking'

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*

A behavioural experiment for 'comparison'

Belief to test out

- "If I compare myself with others, I will feel happier about my body because I look better than them" (85%)

Alternative belief

- "Maybe comparing myself with others actually just means that I end up feeling worse, because there is always likely to be someone better looking and I have a poor image of my own body" (10%)

Possible methods

- *Have a week of comparing myself with other people as much as I can, and a week of no comparison, and see which makes me feel better/worse*

Exposure with response prevention

- Full length mirror exposure
- Scan and describe the whole body
  - neutral description or 'pure' exposure
  - 30-40 minutes
- Scary at the time for patient and therapist
  - but we see a drop in anxiety both during and between sessions
- Inhibitory learning approach
  - do this multiple times in multiple locations to get the full effect
  - at home, clothes shopping, visiting friends, etc.

Ending therapy and follow-ups

(sessions 9-10 and thereafter)

When to start this phase and why?

- Start in the penultimate session (usually in the second half)
- Usually session 9, but about 10-20% do not need the whole 10 sessions, so can be done earlier
- <u>Themes</u>
- Attributing success to the patient
- Beginning to address residual comorbidity

Ending therapy: Themes and tasks

- Attributing success to the patient
  - reinforcing the change out of learned helplessness
  - lots of positive reinforcement
- Review what has gone well
  - stress what the patient has done within therapy as their own therapist
  - stress what they have shown that they can continue to do
- Develop a therapy blueprint
  - preparing for future maintenance and trouble-shooting
  - ask the patient to work on this between the two sessions, with help from others if appropriate

Therapy blueprint: Headers

- What were my problems when I was first referred?
- What did I do to change?
- What changes do I still want to make, and how will I achieve them?
- What might lead to a setback in the future?
- What will be the symptoms of a setback?
- How will I overcome the setback?
- What if that doesn't work?

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Specific tasks

- Obtain appropriate self-help reading in the case of any residual issues, e.g.:
  - self-esteem (Fennell)
  - anxiety (Kennerley)
  - social anxiety (Butler)
  - perfectionism (Wade)
  - core beliefs (Young)
- Start to read it between sessions

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Specific tasks

- Final session – used to stress that follow-up is an active element of therapy
- Review the blueprint and the reading
  - use as the basis for planning follow-up
  - discuss how we expect the patient to solve problems if they occur
- Stress need to keep going and developing strengths and skills for discussion next time (follow-up)
- Often write the patient a letter after session 10 to reinforce progress

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Follow-up as an active element of therapy

- First follow-up
- Where we allow for slips, so that we can learn from them
  - stress that slips are OK, and that they can be good learning experiences
  - warn the patient that we expect them patient to come in with how they solved the problem, too
- Second follow-up
- Where we reinforce positive change
  - push the reattribution element
  - problem-solving if necessary
- If there are other problems that need to be addressed, refer for another therapy as appropriate
  - not common, so beware of keeping the patient in therapy forever…

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Monitoring and supervision issues

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Why monitor, and when?

EMPIRICAL ARTICLE
Development, Psychometric Properties and Preliminary Clinical Validation of a Brief, Session-by-Session Measure of Eating Disorder Cognitions and Behaviors: The ED-15

- Clinicians get better outcomes if they:
  - routinely monitor clinical outcomes
  - respond to those outcomes
  - share those outcomes (e.g., in supervision; with other team members)
- But…
- We should also monitor clinical progress session-by-session
  - allows us to modify our approach for the individual patient
- Eating attitudes (ED-15), behaviours, mood

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Supervision to keep us on our toes…

- Supervision in CBT-T is very active and patient-centred
  - weekly supervision meetings, as we expect weekly progress for the patient
  - check safety, progress and planning
  - professional and experiential issues come later in the session (as with the agenda for CBT-T therapy sessions)
- One-to-one supervision, so that there is time for all patients
  - clinician develops a written agenda covering all patients and where they are up to against the protocol
- Supervisor monitors both patient progress and therapist drift

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Supervision to keep us on our toes…

- As with the clinician-patient relationship…the supervisor-clinician relationship will sometimes be a tough one
- Be careful about 'halo effects'
  - we often overrate our supervisees' skills and understanding (Denhaag et al., 2012)
  - important to focus on measurable progress and outcomes
  - is your supervisee getting their patients better at the expected rate?
- Supervisors need supervising too…

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Tips for supervisors

- Clinicians should present all cases (one-to-one works best)
- Group discussion enhances overall engagement and outcomes
- Address life-threatening or therapy interfering issues first
- Address under-preparation by the clinician
- Patient outcomes are the key index of supervisory success
- Set specific tasks for the coming week
- Don't let supervisor anxiety get in the way of supervising
- Your supervisee does not have to love you
- Monitor progress, outcomes, adherence and competence

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What tips can supervisors give to clinicians?

- **Do**
- Use the protocol and checklist
  - in a patient-centred way
- Use supervision to discuss cases
- Monitor progress and outcomes
- Talk to patients about their experiences of CBT-T
- Share experiences with colleagues, to enhance learning
- Consider further training in CBT-T

- **Don't**
- Throw in elements of other therapy models because we like them (can impair outcomes)
- Respond to our own anxiety by backing off on the task demands
- Focus on pleasing the patient in the short term
- Sacrifice firmness for empathy

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And finally…

- You can use CBT-T to get more patients well
  - shorter treatment times
  - shorter waiting lists
  - less expensive treatment
- You have to learn how to deliver it, and cope with your own anxieties about not being the nicest therapist/supervisor in the universe
- We recommend…giving it a try
  - make CBT-T a part of your treatment offer
  - and please tell us how this works in your setting

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Questions?

Contact us on:
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Slides available for you at:
- http://cbt-t.shef.ac.uk/

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Key references

- The manual
- Waller, G., Turner, H. M., Tatham, M., Mountford, V. A., & Wade, T. D. (2019). *Brief cognitive behavioural therapy for non-underweight patients: CBT-T for eating disorders.* Hove, UK: Routledge

- Evidence of outcomes (with more on the way)
- Pellizzer, M., Waller, G., & Wade, T. D. (2019). Ten-session cognitive behaviour therapy for eating disorders: Outcomes from a pragmatic pilot study of Australian non-underweight patients. *Clinical Psychologist, 23,* 124-132.
- Waller, G., Tatham, M., Turner, H., Mountford, V. A., Bennetts, A., Bramwell, K., Dodd. J., Ingram, L. (2018). A 10-session cognitive-behavioral therapy (CBT-T) for eating disorders: Outcomes from a case series of non-underweight adult patients. *International Journal of Eating Disorders, 51,* 262-269.

- That weekly measure of eating pathology to examine progress
- Tatham, M., Turner, H., Mountford, V. A., Tritt, A., Dyas, R., & Waller G. (2015). Development, psychometric properties and preliminary clinical validation of a brief, session-by-session measure of eating disorder cognitions and behaviors: The ED-15. *International Journal of Eating Disorders, 48*, 1005-1115.