Behaviour Research and Therapy 106 (2018) 57–63

Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

To deliver or not to deliver cognitive behavioral therapy for eating disorders: Replication and extension of our understanding of why therapists fail to do what they should do

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ARTICLE INFO

Keywords:
Cognitive behavior therapy
Eating disorders
Therapist drift
'Non-delivery'
Evidence-based practice
Therapeutic alliance
Clinician anxiety

ABSTRACT

Objective: This study investigated the extent to which therapists fail to apply empirically supported treatments in a sample of clinicians in The Netherlands, delivering cognitive behavioral therapy for eating disorders (CBT-ED). It aimed to replicate previous findings, and to extend them by examining other potential intra-individual factors associated with the level of (non-)use of core CBT-ED techniques.

Method: Participants were 139 clinicians (127 women; mean age 41.4 years, range = 24–64) who completed an online survey about the level of use of specific techniques, their beliefs (e.g., about the importance of the alliance and use of pretreatment motivational techniques), anxiety (Intolerance of Uncertainty Scale), and personality (Ten Item Personality Inventory).

Results: Despite some differences with Waller's (2012) findings, the present results continue to indicate that therapists are not reliably delivering the CBT-ED techniques that would be expected to provide the best treatment to their patients. This 'non-delivery' appears to be related to clinician anxiety, temporal factors, and clinicians' beliefs about the power of the therapeutic alliance in driving therapy outcomes.

Discussion: Improving treatment delivery will involve working with clinicians' levels of anxiety, clarifying the lack of benefit of pre-therapy motivational enhancement work, and reminding clinicians that the therapeutic alliance is enhanced by behavioral change in CBT-ED, rather than the other way around.

1. Introduction

As eating disorders are severe conditions with significant psychological and physical consequences, it is extremely important that patients receive the appropriate treatment. Cognitive-behavioral therapy (CBT) for eating disorders has been investigated in many randomized controlled studies and community studies, and has demonstrated efficacy and effectiveness (e.g., Brownley et al., 2016; Fairburn et al., 2013, 2015; Hilbert & Brähler, 2012; Poulsen et al., 2014; Wonderlich et al., 2014; Zipfel et al., 2014). The latest guidelines on eating disorders worldwide (Hay et al., 2014; National Institute for Health and Care Excellence NICE, 2017; Netwerk Kwaliteitsontwikkeling GGZ, 2017) advise CBT for eating disorders (CBT-ED) as the first choice of treatment for bulimia nervosa, binge eating disorder and anorexia nervosa, and for use with similar atypical cases that do not meet full diagnostic criteria.

Given that there are well-established protocols and guidelines for using CBT in eating disorders, it is possible to define best practice for these disorders as involving specific CBT–ED techniques, despite the lack of dismantling studies (Waller, Stringer, & Meyer, 2012). Two decades ago, Wilson (1998) observed that manualized protocols were underutilized in the treatment of eating disorders. Several studies have since investigated the use of empirically supported treatment for eating disorders (e.g., Haas & Clopton, 2003; McAlpine, Schroder, Pankratz, & Maurer, 2004; Mussell et al., 2000; Simmons, Milnez & Anderson, 2008; Tobin, Banker, Weisberg, & Bowers, 2007; von Ranson & Robinson, 2006). Such studies indicate that therapists routinely use less well-supported or non-evidence based approaches, despite being trained in CBT-ED. Waller et al. (2012) showed that clinicians used core techniques (e.g., exposure, weighing patients) far less than could be justified in the context of the evidence base, and some unproven techniques (e.g., schema therapy) were used far more than the evidence would suggest. Furthermore, Waller et al. (2012) demonstrated that clinicians fall into distinct 'clusters' (i.e., groups of therapists who used different styles, such as a 'behavior-oriented', 'mindfulness-oriented', and 'motivation-oriented' style), delivering CBT-ED more or less adequately.

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https://doi.org/10.1016/j.brat.2018.05.004
Received 12 December 2017; Received in revised form 17 April 2018; Accepted 3 May 2018
Available online 04 May 2018
0005-7967/

Clinicians often cite the assumption that manualized approaches require very rigid implementation (Waller et al., 2013), although that assumption is not supported by the literature (Wilson, 1996). This assumption does not appear to be associated with the 'behavioral cluster', in which evidence-based techniques (often well described in manuals) are applied more often.

Why do clinicians omit key elements of CBT-ED when they are delivering that therapy to patients with eating disorders? The answer appears to be multifaceted. First, Waller et al. (2012) found that clinician characteristics such as age and level of anxiety are associated with poorer use of key CBT-ED techniques – particularly those that are more behavioral in nature. Second, therapists have negative attitudes towards manuals, that interfere with treatment delivery (Waller et al., 2013). That is, many clinicians assume that intuition and judgement are more important determinants of a positive outcome than the material in manuals, despite evidence to the contrary (Grove, Zald, Lebow, Snitz, & Nelson, 2000). Third, there is a tendency for clinicians to assume that their skill level is better than it actually is (Walfish, McAlister, O'Donnell, & Lambert, 2012), making clinicians more likely to attribute therapy failure to the patient than to their own failure to use an evidence-based approach (Waller & Turner, 2016). Finally, clinicians routinely overestimate the impact of less well supported treatment elements, such as pre-therapy motivational work and the therapeutic alliance (Dray & Wade, 2012; Graves et al., 2017), at the expense of carrying out evidence-based CBT-ED techniques.

Given the apparent impact of clinician characteristics on their delivery of evidence-based treatment, it is important to replicate and extend the key findings outlined above. Therefore, this study uses the survey-based methodology and questions used by Waller et al. (2012) with a sample of Dutch CBT clinicians. It will also extend that study, examining other potential intra-individual factors that might be associated with the level of use of core CBT techniques when working with eating disorders (belief in the impact of the alliance, personality, and assumed skill level compared to peers).

Thus, the first aim was to determine how routinely CBT therapists use evidence-based CBT techniques when delivering CBT for eating disorders, to test the replicability of Waller et al.'s (2012) UK-based findings among Dutch clinicians. The second aim was to extend previous research by determining whether any 'non-use' of evidence-based treatments is associated with clinician characteristics, including age, treatment experience, perception about their own functioning, beliefs about the importance of the therapeutic alliance, anxiety, and personality traits.

2. Method

2.1. Ethical issues

The project was authorized by the Ethical Review Committee of the Faculty of Psychology and Neuroscience (ERCPN), Maastricht University (ERCPN-171_05_09_2016). All participants gave informed consent.

2.2. Participants

The participants were therapists, working in the field of eating disorders. Between the end of December 2016 and the end of May 2017, N = 185 therapists entered the survey. Informed consent was given electronically, and two participants withdrew at this stage. Of the remaining 183 participants, 143 reported that they used CBT to treat their eating-disordered patients. A further four were removed from the sample because they indicated that they had no such experience when asked how long they had been working with this client group.

Thus, the final sample consisted of 139 clinicians (127 females) who indicated that they used CBT in the treatment of eating disorders. Their mean age was 41.4 years (*SD* = 9.71, range = 24–64), and their mean time working with patients with eating disorders was 8.32 years (*SD* = 5.70, range = 1–25). Almost half of the sample (48.2%) currently worked between 16 and 32 h per week in eating disorders treatment. Only a small proportion (6.5%) worked full-time (i.e., 32–40 h per week) with this population, and 36.7% worked only one day per week or less with eating disorders. The clinicians were from a range of professions, including psychiatry (n = 63), psychology (n = 59), nursing (n = 2), dietetics (n = 4), somatic care (n = 1), and other (n = 10). Seventeen stated that they provided CBT-ED supervision to other clinicians working with eating disorders. Of the 139 clinicians, 110 (79.1%) worked with adult patients, 29 (21%) with children, and 78 (56.1%) with adolescents.

2.3. Procedure and measures

The data were collected via an online survey (using the Qualtrics platform). Potential participants were approached via the email lists, newsletters and website announcements of three associations that have a large proportion of CBT practitioners as members - the Dutch Academy of Eating Disorders, the SIG Eating Disorders of the Dutch Association for Cognitive Behavioral Therapies, and the Dutch Association for Health Care Psychologists - asking them to participate in an online survey. We used the following invitational text, similar to that in Waller et al.'s (2012) study: "*Dear Colleague, CBT has a good record in the treatment of eating disorders. However, we know that in the treatment of other disorders, CBT is delivered in ways that differ between therapists. We are interested in how CBT clinicians prioritise different CBT techniques when working with eating disorders. We are also interested in whether there are therapist variables that influence what we decide to do when in the room with a patient. Therefore, we would like to ask you to undertake a survey of your CBT practice, and to provide some information about yourself. All responses will be totally anonymous. If you are willing to do so, please click on the link HERE. Thank you for your help. If you would like a brief report on the outcome of the study, please email the researcher separately*". Two reminder emails were sent to clinicians on the email lists. It is not possible to determine a response rate, as it is not known how many people were contacted using this method.

The survey consisted of four parts - questions on demographics and therapeutic background; questions on the use of specific techniques in the treatment of eating disorders; questions about the clinicians' beliefs (e.g., importance of the therapeutic relationship; their own level of functioning and patient recovery rate); and established psychometric measures of clinicians' anxiety and personality. The demographic and therapeutic background questions included: age; gender; time spent in different aspects of therapeutic work with eating disorders; profession; professional registration; age group of patients worked with; and whether they used CBT with their eating-disordered patients.

The CBT-ED techniques enquired about are listed in Table 1. Each was rated on a scale ranging from 0%-10% to 91%–100%, regarding the proportion of patients they used this technique for (as used by Waller et al., 2012). The techniques were divided into those that are: *widely* supported (routine weighing, food diaries, cognitive restructuring, exposure, structured eating); *partially* supported (behavioral experiments, surveys [i.e., the use of photo-based inquiries to test their negative beliefs about what other people think about them]; and *unsupported* (schema therapy, mindfulness). Dialectical Behavior Therapy (DBT) was added to the list of *partially* supported techniques, as this technique has some preliminary empirical support (e.g., Bankoff, Korpel, Forbes, & Pantalone, 2012). Eye Movement Desensitization and Reprocessing (EMDR) was added to the list of *unsupported techniques*, as it is not supported by any empirical study to date, but is used by some clinicians. As with Waller et al. (2012), clinicians were also asked how long they would continue to see patients who declined to be weighed or failed to return food diaries (each was rated 0, 1, 2, 3, 4 or more than 4 further sessions). Finally, the clinicians were asked whether they prefaced CBT-ED with sessions dedicated primarily to motivational work,