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Shorter communication

Cognitive-behavioural therapy for outpatients with eating disorders: Effectiveness for a transdiagnostic group in a routine clinical setting

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ABSTRACT

Whilst there is a growing evidence to support the impact of cognitive-behavioural therapy (CBT) in the treatment of adults with eating disorders, much of this evidence comes from tightly controlled efficacy trials. This study aimed to add to the evidence regarding the effectiveness of CBT when delivered in a routine clinical setting. The participants were 203 adults presenting with a range of eating disorder diagnoses, who were offered CBT in an out-patient community eating disorders service in the UK. Patients completed measures of eating disorder pathology at the start of treatment, following the sixth session, and at the end of treatment. Symptoms of anxiety, depression, and psychosocial functioning were measured pre- and post-treatment. Approximately 55% of patients completed treatment, and there were no factors that predicted attrition. There were significant improvements in eating disorder psychopathology, anxiety, depression and general functioning, with particular changes in eating attitudes in the early part of therapy. Effect sizes were medium to large for both completer and intention to treat analyses. These findings confirm that evidence-based forms of CBT can be delivered with strong outcomes in routine clinical settings. Clinicians should be encouraged to deliver evidence-based treatments when working in these settings.

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There is growing evidence to support the use of cognitive-behavioural therapy (CBT) in the treatment of adults with eating disorders. Whilst early trials demonstrated the impact of focused forms of CBT for the treatment of bulimia nervosa (e.g., Bulik, Sullivan, Carter, McIntosh, & Joyce, 1999; Fairburn et al., 1995), recent studies have demonstrated the efficacy of an enhanced form of the treatment (CBT-E) that is suitable for a broader range of eating disorder presentations (e.g., Fairburn et al., 2009). CBT has since been shown to be more effective than psychodynamic psychotherapy in the treatment of bulimia nervosa (Poulsen et al., 2014), and is also suitable for use with underweight patients (Fairburn et al., 2013; Watson & Bulik, 2013; Zipfel et al., 2014). However, the majority of the evidence for CBT has come from *efficacy* studies – well-controlled treatment studies that often have tight inclusion criteria and are delivered under strict conditions with high levels of supervision. It is unclear as to whether similar outcomes can be obtained from *effectiveness* studies, where treatments are delivered in routine clinical settings. In such conditions, clinician adherence to protocols is less closely monitored and the diversity of cases is likely to be greater (e.g., higher levels of comorbidity).

To date, very few studies have considered the effectiveness of CBT for the eating disorders in routine clinical settings. Byrne, Fursland, Allen, and Watson (2011) conducted an open trial of CBT-E for patients presenting with a broad range of eating disorders, including patients with a body mass index (BMI) of 14+. They reported significant improvements in eating disorder and general psychopathology, with changes in scores on a range of treatment measures indicating medium to large effect sizes. Of those who completed therapy, two thirds were in full or partial remission at the end of treatment. In another effectiveness study of CBT for bulimia nervosa and atypical cases, Waller, Gray, et al. (2014) reported similar remission outcomes to those found in efficacy studies, with approximately 50% of patients being in remission at the end of treatment. However, those effectiveness studies were

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not conducted with the same rigor as existing efficacy studies (e.g., lack of follow-up). They varied substantially in attrition rates, with the Byrne et al. study having a higher rate than the Waller et al. study, probably due to the presence of anorexia nervosa patients in the former.

These preliminary studies of effectiveness indicate that CBT can be delivered with strong outcomes in routine clinical settings. However, it is well-established that clinicians routinely fail to use CBT when working with the eating disorders (e.g., Tobin, Banker, Weisberg, & Bowers, 2007) or that they deliver it in sub-optimal ways (Waller, Stringer, & Meyer, 2012), expressing concerns about the use of core CBT techniques (e.g., Turner, Tatham, Lant, Mountford, & Waller, 2014) and discounting the use of evidence-based manuals to support their work (e.g., Waller et al., 2013). Therefore, there is a need for further evidence from other routine clinical settings to demonstrate that CBT for the eating disorders is an effective treatment, which others can use in their own clinics. This study aims to build on previous work by testing the effectiveness of CBT in a further routine clinical setting. It reports clinical outcomes for a large group of transdiagnostic patients who were offered CBT in a community eating disorders service in the UK. Unlike previous studies, there were very few exclusion criteria and no BMI cut-off. In this case, the variant of CBT used was based on a combination of elements from the relatively similar approaches of Fairburn (2008) and Waller et al. (2007), as used by Byrne et al. (2011) and Waller, Gray, et al. (2014) respectively.

1. Method

1.1. Participants

The sample consisted of 203 patients (190 women and 13 men) who had been referred to a specialist National Health Service eating disorder service in the UK. Other referrals were not included because they did not meet criteria for an eating disorder. All of the 203 patients were offered a course of outpatient CBT between 2010 and 2013. Each was assessed using the Eating Disorders Examination, version 16 (Fairburn, Cooper, & O'Connor, 2008) and was diagnosed using DSM-IV criteria (American Psychiatric Association, 1994). Of the 203 patients, 56 (28%) had a diagnosis of anorexia nervosa, 58 (29%) bulimia nervosa, and 89 (43%) eating disorder not otherwise specified. The mean age of the sample was 27.6 years ($SD = 9.2$, range = 17–59 years) and their mean BMI at the start of treatment was 21.0 ($SD = 6.8$, range = 12.6–59.4).

1.2. Measures

Patients completed the Eating Disorders Examination (EDE, Fairburn et al., 2008) at initial assessment, and measures of eating disorder pathology at the start of treatment, following the sixth session, and at the end of treatment. Anxiety, depression and psychosocial functioning were measured at the start and on completion of CBT. These measures are administered routinely at the clinic for all patients receiving outpatient psychological therapy. As is common in routine settings, a small proportion of the data were not collected, and therefore the numbers vary across some analyses (see Tables).

The Eating Disorder Examination (EDE, version 16, Fairburn et al., 2008). The EDE generates the following four subscales: dietary restraint, weight concern, shape concern and eating concern, as well as frequency ratings for key eating disorder behaviours, including objective bulimic episodes, self-induced vomiting, laxative misuse and excessive exercise. It can be used to generate DSM-IV diagnoses and has good psychometric properties (e.g., Berg, Peterson, Frazier, & Crow, 2012).

The Eating Disorders Examination–Questionnaire (EDE-Q, version 6; Fairburn & Beglin, 2008). The EDE-Q is a self-report questionnaire assessing key cognitive and behavioural aspects of eating disorders. It generates frequency ratings for key eating disorder behaviours (e.g., objective binge-eating, self-induced vomiting, laxatives misuse, and excessive exercise), as well as the following attitudinal subscales: dietary restraint, weight concerns, shape concerns, and eating concerns. A global attitudinal score can be calculated by averaging the four subscales. The EDE-Q has good psychometric properties and validity (e.g., Mond, Hay, Rodgers, Owen, & Beumont, 2004).

Clinical Impairment Assessment Questionnaire (CIA; Bohn & Fairburn, 2008). The CIA is a 16-item self-report questionnaire, assessing severity of psychosocial impairment due to eating disorder features. Respondents rate the impact that exercise, eating habits and feelings towards eating, shape and weight have on their ability to function in the world. A higher total score indicates a greater level of clinical impairment. The CIA has good reliability and validity (Bohn et al., 2008).

Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). The HADS has two seven-item subscales measuring anxiety and depression. Respondents rate their experiences over the past week. The following categories are used: 0–7 = normal; 8–10 = mild; 11–15 = moderate; and 16–21 = severe. The HADS has been shown to be suitable for use with eating disorder populations (e.g., Padierna, Quintana, Arostegui, Gonzalez, & Horcajo, 2000; Seed et al., 2004).

Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Barkham et al., 2001). The CORE-OM is a self-report questionnaire measuring general psychological problems (including an assessment of risk) in those presenting for psychological therapy. It can be used as a measure of individual change over time, and hence clinical effectiveness. The CORE-OM has good psychometric properties (e.g., Barkham, Gilbert, Connell, Marshall, & Twigg, 2005; Evans et al., 2002) and is suitable for use with people with eating disorders (Jenkins & Turner, 2014).

1.3. Procedure

Participants completed the following measures at the start and end of therapy (EDE-Q, CIA, HADS & CORE-OM). They also completed the EDE-Q after the sixth treatment session. These measures are administered as part of routine clinical practice, and aim to monitor early clinical change, as well as the overall effectiveness of treatment. All patients gave consent for data collected as part of routine service evaluation to be used to monitor the progress and effectiveness of therapy.

1.3.1. Treatment

The CBT delivered within this clinic followed that described in published evidence-based manuals (Fairburn, 2008; Waller et al., 2007). It included key elements of evidence-based practice such as: engagement; psychoeducation; developing a formulation; keeping a food diary; weekly weighing; dietary change; exposure; surveys; and cognitive restructuring. The treatment aimed to normalise eating, and to reduce weight controlling behaviours, abnormal eating attitudes, and body image concerns. Where necessary it also aimed to address broader psycho-emotional-social functioning, including identifying and managing emotions, replacing the functions of illness with more adaptive means, improving self-esteem, reducing pathological perfectionism, and reducing inter-personal difficulties. All clinicians had regular individual supervision (frequency varied between weekly and monthly, and was determined by factors such as individual clinician need, level of experience and clinical outcomes). Trainees and newly

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