Behaviour Research and Therapy 57 (2014) 38–42

Contents lists available at ScienceDirect

Behaviour Research and Therapy

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

Shorter communication

# Clinicians' concerns about delivering cognitive-behavioural therapy for eating disorders

Hannah Turner [a], Madeleine Tatham [b], Marie Lant [c], Victoria A. Mountford [d,e], Glenn Waller [f,*]

[a] Southern Health Eating Disorders Service, Southern Health NHS Foundation Trust, Southampton, UK
[b] Norfolk Community Eating Disorders Service, Norwich, UK
[c] Barnsley Specialist Adult Learning Disability Health Service, South West Yorkshire Partnership NHS Foundation Trust, UK
[d] South London and Maudsley Eating Disorder Service, South London and Maudsley NHS Foundation Trust, London, UK
[e] Institute of Psychiatry, King's College London, London, UK
[f] Clinical Psychology Unit, Department of Psychology, University of Sheffield, Western Bank, Sheffield S10 2NT, UK

ARTICLE INFO

*Article history:*
Received 27 January 2014
Received in revised form
5 April 2014
Accepted 9 April 2014
Available online 18 April 2014

*Keywords:*
Eating disorders
Cognitive-behavioural therapy
Clinician
Anxiety
Effectiveness

ABSTRACT

Despite research supporting the effectiveness of evidence-based interventions in the treatment of eating disorders, those interventions are under-utilised in routine clinical practice, possibly due to clinicians' concerns about delivering the relevant techniques. This study examined what elements of therapy clinicians worry about when delivering cognitive-behavioural therapy (CBT) for the eating disorders, and what clinician variables are associated with such concerns. The participants were 113 clinicians who used individual CBT with eating disorder patients. They completed a novel measure of concerns about delivering elements of CBT, as well as demographic characteristics and a standardised measure of intolerance of uncertainty. Clinicians worried most about body image work and ending treatment, but least about delivering psychoeducation. Their concerns fell into four distinct factors. Older, more experienced clinicians worried less about delivering the CBT techniques, but those with greater levels of prospective and inhibitory anxiety worried more about specific factors in the CBT techniques. Clinicians' capacity to tolerate uncertainty might impair their delivery of evidence-based CBT, and merits consideration as a target in training and supervision of CBT clinicians.



Cognitive-behavioural therapy (CBT) can be effective in the treatment of adult women with eating disorders across the diagnostic spectrum (e.g., Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Fairburn & Harrison, 2003; National Institute for Clinical Excellence, 2004). Over the past 25 years, CBT approaches have been refined, resulting in the widespread availability of manualised approaches (Fairburn, 2008; Gowers & Green, 2009; Waller et al., 2007). While much of the evidence of efficacy of those approaches derives from tightly-controlled research trials (e.g., Fairburn et al., 2009; Fairburn et al., 2013; Poulsen et al., 2014; Zipfel et al., 2014), recent studies have demonstrated its effectiveness in routine clinical settings (e.g., Byrne, Fursland, Allen, & Watson, 2011; Waller et al., 2014). However, such effectiveness depends on the use of the core techniques developed in efficacy studies, and particularly the use of manual-based methods (e.g., Addis & Waltz, 2002; Cukrowicz et al., 2011). The use of manuals to direct CBT for the eating disorders is associated with greater use of core techniques, such as cognitive restructuring, goal setting, problem solving techniques, relapse prevention, self-monitoring, nutritional counselling, stress management, and homework assignments (Simmons, Milnes, & Anderson, 2008). However, relatively few clinicians use manuals and evidence-based techniques with the eating disorders (von Ranson, Wallace, & Stevenson, 2013; Tobin, Banker, Weisberg, & Bowers, 2007; Wallace & von Ranson, 2011; Waller, Stringer, & Meyer, 2012).

In order to address this research-practice gap, it is vital to understand why clinicians choose not to deliver evidence-based interventions in routine clinical practice. Meehl (1986) suggests that a common reason is that clinicians are not aware of the evidence base, but also identifies reasons that are more centred in the clinician's own nature. For example, Shafran et al. (2009) suggest that commonly-held clinician beliefs might impede the use of evidence-based treatment (e.g., 'the therapist is more important than the treatment protocol in determining outcome'; 'it is more valuable to

* Corresponding author. Tel.: +44 114 222 6568.
*E-mail address:* g.waller@sheffield.ac.uk (G. Waller).

http://dx.doi.org/10.1016/j.brat.2014.04.003
0005-7967/

mix and match parts of different interventions'). Other factors include levels of therapist training, clinical competence and supervision, all of which are pertinent to efforts to bridge the research-practice gap (Fairburn & Cooper, 2011; Fairburn & Wilson, 2013).

Another characteristic that has been considered is the emotional component of therapist 'drift' (Waller, 2009). In particular, there is evidence that clinicians who are more anxious are less likely to deliver the more effective elements of CBT for the eating disorders (Brown, Mountford, & Waller, submitted for publication; Waller, Stringer, et al., 2012). It can be hypothesised that clinicians' failure to encourage the patient to engage in clinical change represents a safety behaviour, where their concerns about distressing the patient make them less likely to push for the key elements of change. This pattern is likely to make the patient feel safer in the short term, but to make them less likely to recover in the long term. What is not clear is which elements of evidence-based CBT for the eating disorders are of greatest concern to the therapist, and what clinician characteristics might be related to their worry about implementation of different elements of CBT. For example, it might be the case that clinician experience, age and trait anxiety are all associated with level of worry about different elements of CBT for the eating disorders.

The aim of this study is to identify what elements of therapy clinicians worry about when delivering CBT for the eating disorders, whether those elements form natural groupings, and what clinician characteristics are associated with their concern about different parts of CBT. It is hypothesised that older, more experienced clinicians will be less worried about delivering the different elements of CBT. However, it is also hypothesised that clinicians with greater levels of anxiety traits (intolerance of uncertainty) will be more likely to worry about the different elements of CBT for the eating disorders.

## Method

### *Ethical clearance*

The research was approved by the research ethics committee of the Department of Psychology, University of Sheffield, UK.

### *Participants*

The participants were 113 clinicians (99 female, 14 male), all of whom reported using individual CBT with at least part of their eating disorder clientele. A further 12 clinicians were excluded because they reported not using CBT with any eating disorder patients. Their mean age was 41.1 years ($SD = 11.8$, range = 23–75), and they reported a mean of 11.8 years of experience working with the eating disorders ($SD = 11.0$, range = 0–40). They came from a wide range of professions, including clinical psychology, psychiatry, nursing, social work and occupational therapy. The mean proportion of patients who they treated using CBT was 69.7% ($SD = 27.3$). The participants were recruited from teaching sessions on CBT for the eating disorders ($N = 89$) and from eating disorder services within the UK ($N = 24$). Those attending the teaching sessions had opted to do so as part of their continuing professional development. Given the nature of the data collection approach, it was not possible to determine how many people were approached overall. The number approached for the teaching sessions was 145 (with 89 CBT practitioners and a further 18 non-CBT clinicians completing the survey – a response rate of 73.8%). However, the data from other clinicians was collected using a snowball strategy, so there was no evidence of how many were approached, and no overall participation rate could be calculated. Each participant completed a paper questionnaire (prior to the teaching session, in relevant cases).

### *Measures and procedure*

Each participant gave demographic details and then completed two measures. First, they rated how much they worried about the delivery of each of 14 elements of CBT for the eating disorders (listed in Table 1). The elements of CBT were selected because they are reported to be used routinely in clinical practice (Waller, Evans, & Stringer, 2012; Waller, Stringer, et al., 2012). However, it is acknowledged that some of the elements lack an evidence base (e.g., mindfulness) and others have been demonstrated to have little or no value (e.g., pre-therapy motivational enhancement work) in work with the eating disorders (e.g., Waller, 2012; Waller, Evans, et al., 2012; Waller, Stringer, et al., 2012). The 14 items were rated on a 1-5 scale ('not at all worried', 'a little worried', 'fairly worried', 'pretty worried', 'highly worried'), such that higher scores indicated greater worry about delivering CBT elements.

The second measure completed was the short form of the Intolerance of Uncertainty Scale (Carleton, Nordon & Amundson, 2007). This is a well-validated self-report measure of responses to uncertainty and ambiguity. It has 12 items, rated on a five-point Likert scale (1 = 'not at all characteristic of me'; 5 = 'entirely characteristic of me'). It has strong psychometric properties (Carleton et al., 2007), and reflects two factors. The first of these is 'prospective anxiety' (the inability to tolerate unpredictable events), and the second is 'inhibitory anxiety' (the inability to act due to uncertainty). Higher scores indicate greater levels of intolerance of uncertainty. The mean scores of this sample were prospective anxiety = 15.7 ($SD = 4.84$) and inhibitory anxiety = 10.1 ($SD = 3.27$), which are very similar to non-clinical norms (Carleton et al., 2012). The internal consistencies (Cronbach's *alpha*) of the prospective anxiety and inhibitory anxiety scales were .885 and .847 respectively, which is comparable to the levels reported in the development of the measure (.85 for each scale; Carleton et al., 2007).

### *Data analysis*

Where items were missed on a measure, there was no replacement of data. The relevant $N$ is shown in Table 1. Non-parametric analyses were used where available, due to the non-normal distribution of some scores. The dimensional relationship between worry about delivering elements of CBT and clinician

**Table 1**
Clinicians' levels of worry (1 = not at all worried; 5 = highly worried) about different individual elements of CBT for eating disorders, and association with clinician characteristics.

| Element of CBT | *N* | *M* | (SD) |
|---|---|---|---|
| Motivation block pre-CBT | 109 | 1.67 | (0.73) |
| Motivation in therapy | 112 | 1.70 | (0.71) |
| Information on food, eating, and weight | 112 | 1.42 | (0.62) |
| Information on life threat | 113 | 1.56 | (0.74) |
| Information on other physical effects | 112 | 1.32 | (0.54) |
| Weighing at first session | 104 | 1.74 | (0.82) |
| Weighing subsequently | 101 | 1.68 | (0.88) |
| Start diet change | 112 | 1.86 | (0.84) |
| Normal eating | 111 | 1.76 | (0.81) |
| Cognitive restructuring | 110 | 1.74 | (0.80) |
| Behavioural experiments | 111 | 1.98 | (0.83) |
| Mindfulness work | 94 | 1.86 | (0.89) |
| Body image work | 108 | 2.19 | (0.88) |
| Ending treatment | 109 | 2.28 | (0.84) |