The effectiveness of enhanced cognitive behavioural therapy for eating disorders

Introduction

This essay will review the evidence evaluating the effectiveness of enhanced cognitive behavioural therapy (CBT-E), a transdiagnostic form of therapy for eating disorders (EDs) (Fairburn, Cooper, & Shafran, 2008). According to the fifth edition of the *Diagnostic and statistical manual of mental disorders (DSM-5)*,EDs are "characterised by a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning" (American Psychiatric Association (APA), 2013, p. 329). The most commonly diagnosed EDs include anorexia nervosa (AN), characterised by body dysmorphia, restricted caloric intake, and significantly low weight; bulimia nervosa (BN), characterised by episodes of binge-eating followed by compensatory behaviours to prevent weight gain; and binge-eating disorder (BED), characterised by recurrent episodes of uncontrolled intake of large amounts of food within two hours (APA, 2013). New to the DSM-V is avoidant restrictive food intake disorder (ARFID), which is characterised by restricted intake of solid foods, resulting in nutritional deficiency (APA, 2013). Individuals who do not meet all the criteria for one of the above but who are experiencing significant distress or impairment may be diagnosed with ED not otherwise specified (ED-NOS) (APA, 2013): this is usually treated according to whichever disorder the individual's ED features most closely match (Fairburn et al., 2008).

Enhanced CBT

Prior to the development of CBT-E, previous guidelines had recommended separate forms of treatment for each type of eating disorder: refeeding combined with psychosocial interventions for AN, CBT for BN (CBT-BN), and CBT for BED (CBT-BED) (National

Collaborating Centre for Mental Health, 2004). Fairburn, Cooper, and Shafran (2003) suggested that EDs could be viewed and treated from a transdiagnostic perspective, as their behaviours were maintained by common mechanisms. Fairburn et al. (2008) developed the new formulation of 'enhanced' CBT (CBT-E), which is designed to treat any form of eating disorder. This may be given in a focused form (CBT-Ef) targeting the specific ED pathology, or a broad form (CBT-Eb) that also targets psychosocial difficulties that tend to contribute to or maintain ED pathology (Fairburn et al., 2008). National Institute for Health and Care Excellence (NICE, 2017) guidelines refer to the focused form as 'ED-focused CBT' (CBT-ED).

Based on transdiagnostic theory, CBT-E is designed to be delivered individually to adult patients who have clinically significant ED that can be treated on an outpatient basis (Murphy, Straebler, Cooper, & Fairburn, 2010). For patients with a BMI of over 17.5, therapy normally consists of 20 sessions over 20 weeks; for those with a BMI of under 17.5, this is extended to 40 sessions over 40 weeks. The default version is used for most patients, reserving the broad version for those with pronounced clinical perfectionism, core low self-esteem, or interpersonal difficulties (Murphy et al., 2010). After a collaborate assessment which includes a personalised formulation or case conceptualisation, stage one initiates collaborative weekly weigh-ins, self-monitoring, education, and establishing regular eating. Stage two involves a transitional stage where ongoing problems and barriers are addressed. Stage three, the main body of treatment, addresses key cognitive processes maintaining the problem, including over-evaluation of shape and weight, dietary rules, and event-related changes in eating. For CBT-Eb, clinical perfectionism, low self-esteem, and interpersonal problems are also addressed. Stage four, the final phrase, involves planning to maintain progress. For underweight patients, modifications are made to address motivation, restoring

normal body weight through a nutrition program, and involving other family members if appropriate.

An initial evaluation of CBT-Ef and CBT-Eb included patients with a body mass index over 17.5 with either BN, BED, or ED-NOS; patients with AN were excluded (Fairburn et al., 2009). Participants were randomly assigned to one of the two forms of CBT, to start immediately or after a waiting period of 8 weeks. Those on the waiting list showed no change in symptoms, while about half of those receiving either form of treatment showed a reduced symptomology to within one standardised deviation of a community sample. Planned exploratory analysis showed that those with more complex psychopathology responded better to CBT-Eb, whereas those with simpler psychopathology responded better to CBT-Ef. Therefore, it was recommended that the focused form be used for most patients with ED, reserving the broader form for those with more complex psychosocial difficulties. In another study comparing the effectiveness of CBT-Ef with interpersonal psychotherapy (IPT) among patients with BN, BED, or ED-NOS, significantly more participants met criteria for remission after CBT-Ef than IPT (Fairburn et al., 2015).

According to a systematic review of RCTs testing the effectiveness of available treatments for EDs, CBT has consistently been shown to be the most effective treatment for BN, but few randomised controlled trials (RCTs) have been conducted with AN, and none have been conducted with ARFID (Hay, 2013). Hay (2013) identified two studies indicating that CBT was not as effective as other known forms of treatment, but those RCTs did not include CBT-E. Studies with AN tend to be small in sample size and suffer from high attrition rates (Murphy et al., 2010). This is due to difficulties obtaining participants for research, high dropout rates, lack of motivation to change, and the high resistance of AN to treatment (Fairburn et al., 2013; Murphy et al., 2010). Because of the lack of robust evidence for

treatments for AN, smaller studies needed to be conducted to justify larger RCTs (Fairburn et al., 2013).

Preliminary findings from a three-site study using CBT-E to treat outpatients with AN and a BMI of 15.0 to 17.5 showed that 60 percent completed the treatment; of these, 60 percent achieved a good outcome, with a low relapse rate (Fairburn, 2009). In the first open trial to include all ED including AN, full remission was achieved by two-thirds of those who completed treatment, or 40 percent of the sample (Byrne, Fursland, Allen, & Watson, 2011). Further investigation of high dropout rates in that study revealed that the three predictors included long wait-list time, history of very low weight, and avoidance of affect (Carter et al., 2012). Thus, the treatment was effective for most participants who completed the program; the primary difficulty was motivation to continue.

The Anorexia Nervosa Treatment of Out-Patients (ANTOP), a large multicentre RCT comparing the efficacy of 10 months of CBT-E, focal psychodynamic therapy (FPT), and optimised treatment as usual (outpatient psychotherapy plus structured care from a doctor) in 727 adults with AN, showed that all three treatments were equally effective in bringing BMI to normal (Zipfel et al., 2014). However, FPT showed better recovery after 12-month follow-up and CBT-E resulted in faster weight gain and improved ED psychopathology. In a two-country study, 99 adults with AN completed 40 weeks of CBT-E; of the 64 percent who were able to complete treatment, all significantly increased their weight and BMI and improved ED features (Fairburn et al., 2013). A preliminary study with 49 patients also demonstrated that CBT-E could be used as an alternative to family-based therapy for adolescents with AN; two-thirds completed the program and significantly increased their weight while decreasing ED pathology (Dalle Grave, Calugi, Doll & Fairburn, 2013). Further study with patients with severe AN found that of 26 (out of 27) patients that completed a 20-week CBT-E program,

all showed significant improvements in weight, ED features, and general psychopathology after completion and at 6- and 12- month follow-up (Dalle Grave, Calugi, El Ghoch, Conti, & Fairburn, 2014). At present, evidence shows that the efficacy of CBT-E is at least as good as the other recommended forms of treatment. Although RCTs directly comparing CBT-E with 'treatment as usual' and other forms of treatment are necessary, these findings suggest that CBT-E is a promising treatment for use in AN.

The most recent NICE (2017) clinical guidelines recommend either ED-focused CBT (CBT-ED), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), specialist supportive clinical management (SSCM), or ED-focused FPT for AN; BED-focused guided self-help or group or individual CBT-ED for BED; and BM-focused guided self-help or individual CBT-ED for BM. CBT-ED is supported by robust evidence for the treatment of either BED or BM for those who do not initially respond to guided self-help (NICE, 2017). Thus CBT-ED is the treatment of choice for most ED except for AN, for which there are several options similar in efficacy. There are currently no published guidelines for ARFID.

In conclusion, there is very good evidence that CBT-E is an effective treatment for people with EDs other than AN. Studies have been more inconclusive for AN, which is more resistant to treatment, primarily due to lack of motivation which leads to nonadherence and drop-out (Murphy et al., 2010). There is moderate evidence suggesting that CBT-E is equally as effective as MANTRA, SSCM, or FPT, although there is not robust evidence for the effectiveness of any of these treatments. Further head-to-head trials are necessary to further establish the efficacy of CBT-E in comparison with other treatments for AN. Due to the difficulty of treating AN, it is imperative that such research be carried out. No RCTs have been conducted with ARFID for any form of treatment.

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