Section I

Introduction

This section details issues that need to be addressed before we outline the cognitive behavioral treatment of the eating disorders. We begin with the philosophical and theoretical basis of the CBT approach. We then consider the broad stages of treatment and the formats in which CBT can be delivered. Finally, we consider what the clinician will need to establish before starting to implement the CBT approach.

1

The philosophical and theoretical stance behind CBT

This chapter outlines key philosophical points that drive our use of CBT: the use of evidence; a focus on the person and not the diagnosis; clinician stance; themes that emerge repeatedly in CBT; clear formulation; and the central role of behavioral experiments. The techniques outlined in later chapters follow from this clinical philosophy.

1.1 The importance of evidence

We believe strongly in the philosophy of evidence-based clinical practice. To ignore the relevant evidence is to deny the best treatment to the patient. However, this philosophy has two difficulties.

First, it does not allow for patient variables – particularly the importance of patient expectations about treatment effectiveness and patient preference for particular therapeutic approaches (National Institute for Clinical Excellence, 2004). We find that an explanation of likely outcomes from different approaches is usually sufficient to allow the patient to make clinically appropriate choices (or to understand the limitations of the chosen approach). Sometimes, the patient will indicate a preference for a treatment that is unlikely to be effective. For example, there might be indicators in the formulation that make one approach unlikely to be unsuitable, or the patient might set limits that make it impossible to modify cognitions, emotions or behaviors (e.g., refusing to be weighed, meeting only once a month). In either case, we would discuss the limits to any change that are imposed by such behaviors that interfere with the process of therapy (Linehan, 1993).

Second, evidence-based practice requires good evidence regarding the best treatments, and that evidence base is currently inadequate. While there is evidence that CBT is the fastest, most effective form of psychological intervention for bulimia nervosa and binge eating disorder patients (e.g., Fairburn & Harrison, 2003), many patients with those disorders do not improve with this approach

(e.g., Wilson, 1999). Furthermore, there is little to support the specific use of CBT with anorexia nervosa or with the very large number of atypical cases (Fairburn & Harrison, 2003; National Institute for Clinical Excellence, 2004).

Therefore, as well as evidence-*based* practice, we advocate evidence-*generating* practice. We are aware of many excellent CBT practitioners who are undertaking innovative work that is beneficial to patients where there is no clear evidence base. We believe that it is important that clinicians report on their findings, in order to enhance the evidence base on the treatment of both routine and complex cases. The routine identification and recording of key clinical variables (e.g., cognitions about loss of control over weight; body checking) allows clinicians to demonstrate ways in which practice should be changed.

1.2 Dealing with the whole person in treatment

We take the stance that rather than treating a stereotypical "eating-disordered patient," we are treating an individual with an eating disorder. This theme is one that is reflected in the way that we write about CBT throughout this book. Holding this view enables the clinician to see the patient as an individual, rather than as a host of symptoms to fit into a model. Although there is a limited number of relevant symptoms, the range of reasons why people use those symptoms is wide and varied, and those reasons need to be understood to enable the patient to change. In taking the stance of treating an individual with an eating disorder, we aim to enable the patient not to be defined by his or her problem or by stereotypes that accompany such a diagnosis.

1.3 Clinician stance: the curious clinician

Geller, Williams & Srikameswaran (2001) point out the importance of having a "clinician stance" – a philosophy underlying treatment approaches (see below). Such a philosophy is needed to guide decisions and actions in new settings. It allows us to explain the importance of our actions to ourselves, to patients and to others. Such an understanding requires us to be clear about the elements of CBT that have to be there if we are to work in this framework – the "non-negotiables."

The clinician's stance in therapy should be consistent and coherent. This is much easier to achieve if the stance is underpinned by a clear treatment philosophy. Without such a philosophy, the risk is that actions in therapy become inconsistent and reactive (and hence much less likely to be effective). This stance should be one that is shared by all clinicians involved in the patient's care, and such an approach requires a collaborative team approach

that has the patient at the heart of the generalized philosophy of care. Geller, Williams & Srikameswaran (2001) describe this approach as having a "mission statement."

In keeping with Geller, Williams & Srikameswaran (2001), we advocate that the clinician's stance should be one that:

- fosters self-acceptance (allowing that there is a reason for the disorder, but also accepting the need for change)
- is active rather than passive
- is collaborative (based on the assumption that the client is responsible for change)
- involves curiosity, and a willingness to learn from the patient
- is transparent.

We also draw from the work of motivational interviewing when developing our stance. We aim to:

- be authoritative rather than authoritarian, so that the patient sees the clinician as a useful source of information, techniques and strategies, rather than as a further person issuing orders or prescribing behavioral or dietary change
- avoid being critical or confrontative (e.g., about impulsive behaviors)
- avoid intellectualization (e.g., engaging in a discussion with the patient about the general validity of body mass index norms means that the patient has distracted from his or her own core issues)
- avoid arguments with the patient, as this is likely to polarize the clinician and patient rather than facilitating collaboration.

We present this stance to our patients as requiring us to move from being "head to head" with them to being "shoulder to shoulder" in collaborating towards common goals.

1.3.1 Collaborative working relationships

Our stance involves a strong advocacy of true multidisciplinary working, with the patient at the heart of the professional and clinical structure. Indeed, we see the most important collaboration as that between the clinician and the patient. CBT is only really viable when the patient can be helped to become her or his own therapist, and this is an early part of our discussions with the patient.

The clinician needs to be strategically minded, in order to focus on helping the patient to win the war with the eating disorder, rather than being drawn into fighting (and losing) the immediate battle for supremacy in the session. There is no benefit to keeping this strategic approach from the patient. An open clinician is more likely to earn the patient's trust.

Our CBT involves collaboration with the whole range of professions within our team (psychologists, dietitians, nurses, occupational therapists, medical staff,

psychotherapists, administrative staff) who can contribute to the patient's care. We also see it as important to liaise with other clinicians in the case (e.g., general practitioners) and carers, particularly where the patient has complex needs. Again, in keeping with the spirit of collaboration, work with other clinicians and carers should aim to be authoritative rather than authoritarian.

1.4 The transdiagnostic approach

Historically, the eating disorders have been described in terms of diagnostic groups, with early attention focused on anorexia nervosa (e.g., Russell, 1970), followed by bulimia nervosa (e.g., Russell, 1979). The only other such category to receive such attention has been binge eating disorder, which is categorized as one of the atypical eating disorders, or eating disorders not otherwise specified (EDNOS; American Psychiatric Association, 1994). However, existing diagnostic schemes are of limited utility to the clinician. In particular, it has become clear in recent years that the largest single "group" is the EDNOS cases, and that patients do not remain in the same diagnostic group over time (e.g., Fairburn & Harrison, 2003). These limitations mean that our best therapies are not geared up to be effective with the majority of our patients, although this issue is being addressed in current work (e.g., Fairburn *et al.*, 2003).

While it can be important to understand what is meant by diagnostic labels, we find that the most effective clinical approach is to focus on cognitions, emotions and physical states that relate to the individual's restrictive and bulimic behaviors. Many of our patients have both forms of eating pathology, and so we need to consider their common roots and their interaction.

One response to this inadequacy of diagnostic schemes is to develop more and more complex diagnostic schemes (e.g., Norring & Palmer, 2005). However, those schemes do not seem to promise greater precision (e.g., the definition of a binge has become less definite over time). Therefore, an alternative approach has been proposed. Waller (1993) has suggested dispensing with diagnosis, and focusing on the core cognitive content that is common to behaviors across the eating disorders. This change of focus has led to the development of models more specific to behaviors that are common across diagnoses (e.g., Heatherton & Baumeister, 1991; McManus & Waller, 1995).

More recently, Fairburn *et al.* (2003) have formalized this approach under the title of a "transdiagnostic" CBT model of the eating disorders. This model is based on understanding the core pathology of patients presenting with a wide range of disturbed eating patterns. It has many characteristics in common with Slade's (1982) functional analytic approach to the eating disorders, with a similar stress on

the use of food to re-establish perceived control in the context of poor self-esteem and perfectionism. However, the model also has a cognitive component that was lacking in Slade's model. The transdiagnostic model departs from Fairburn's previous models (e.g., Fairburn, 1997; Fairburn *et al.*, 1999), in that it considers some general antecedents that are not specific to the eating disorder (especially "core low self-esteem"). It also incorporates elements from other therapeutic models, including dialectical behavior therapy (Linehan, 1993) and interpersonal psychotherapy. Such developments are leading to a convergence between maintenance models (e.g., Fairburn, 1997) and models that take account of early antecedents to eating pathology (e.g., Slade, 1982; Waller *et al.*, in press).

These transdiagnostic models center on beliefs relating to the overevaluation of eating, weight and shape (especially the perceived consequences of loss of control over eating and weight change). The other cognitive, emotional, physical and behavioral elements of the eating disorders are understood in terms of how they lead to and maintain these cognitions.

1.4.1 Using the transdiagnostic model in practice

As proposed by Waller (1993) and Fairburn *et al.* (2003), the transdiagnostic model results in CBT that links cognitions, emotions and behaviors regardless of diagnosis. This allows for a much more flexible use of therapy, which can be targeted on the individual patient's presentation, whether or not that patient fits a sub-category. We find it important to avoid being distracted by diagnosis, as many individuals can meet the same diagnostic criteria while requiring very different formulations and interventions. Therefore, in common with Ghaderi (2006), we aim to build a formulation around the central cognitions (e.g., "If I eat outside my normal, very rigid diet, then I will not be able to stop and I will inevitably gain huge amounts of weight."). We find it critical to get the patient's own expression of those cognitions, and to fit them to the broader formulation (see Chapter 8). Our experience is that patients readily understand the concept of a formulation that is independent of their diagnosis, as many are already unconvinced by the relevance of diagnosis. Avoiding a focus on specific diagnoses also helps those patients with partial syndromes, who are often anxious about whether they merit treatment because they do not feel that they have a serious enough problem (e.g., "But I don't binge that often, so the vomiting must be my own fault.").

1.5 Themes in the process of treatment

When thinking about the process of treatment, we find it useful to hold a number of themes in mind. These function to link the component parts of the treatment

in a comprehensive whole. They act as unifying constructs that set the scene for CBT, provide a context for understanding difficulties and create a vehicle for refocusing treatment.

1.5.1 Short-term discomfort in order to achieve long-term gain

Successfully negotiating change always involves tolerating short-term discomfort in order to reach longer-term chosen goals. Such change not only requires an ability to withstand a certain level of distress, but also the capacity to keep those longer-term goals in mind (see Chapter 6 on motivation and Chapter 25 on distress tolerance). This task of change is more complex for patients with eating disorders. Not only must they tolerate the short-term distress of developing a regular pattern of eating and weight stabilization/gain, but (in order to initiate this process and as a result of it) they are exposed to their thoughts and feelings. These are the very aspects of themselves that they have been trying so hard to avoid through their eating behaviors (see Chapter 8 on formulation).

It is useful to discuss this theme at the outset of therapy, to prepare patients for the fact that initially treatment may result in an increase in behaviors and distress (the opposite of what most expect). It is also useful to return to this theme when working with anxiety triggered by the introduction of new tasks and strategies (e.g., weekly weighing; the introduction of a previously avoided food into an eating plan). In discussing the likely experience of therapy with the patient, we use the "Coast of South America" analogy, usually introducing it at the beginning of treatment and referring to it throughout treatment (using a map where the person does not have the necessary mental map).

A trek along the coast of South America

This is one way in which we think about the process of treatment of and recovering from an eating disorder. Often, when people start treatment, they think that they are at their worst point and that the situation is going to improve in a straightforward linear style.

However, it does not work like that. Instead, the process of recovery can best be likened to a trek along the coast of South America. Often, people will find that the situation tends to get a bit worse at the beginning (equivalent to being in southern Chile and then dropping down to the southernmost tip of South America). This is to be expected, as you have spent a long time trying to avoid thinking about your difficulties, and now we are asking you to focus on your eating, cognitions and other behaviors. Also, your eating disorder has been helping you in some ways, and now we are talking about taking this away.

After you have been in treatment for a while, you will begin to see positive changes (beginning to trek up the coast of Argentina). However, these will not be in a straight line. You will have good weeks and more difficult weeks. This is perfectly normal. Sometimes people plateau for a while and then continue upwards. Overall, the trend will be improvement. Sometime external factors such as relationships or work will flare up, affecting your eating disorder treatment.

You are likely to be coming to the end of your treatment when you are about halfway up Brazil. As you can see from the map, this means that your progress does not stop here. We believe that you will continue your recovery – or trek along the coastline – by putting into place all the work that we have done together, such as challenging your negative thoughts and keeping to your eating plan, and you will reach the top tip of the coast of South America.

1.5.2 The patient becoming his or her own therapist

In a sense, this theme is more similar to a concrete goal than the others because it is something that can be worked towards and measured. However, it is discussed here because it is the central tenet that underlies treatment, recurring throughout and providing continuity to the process.

CBT is most likely to be effective if the clinician and patient work towards the patient becoming his or her own therapist. This theme runs through most of the strategies employed in CBT, from those occurring within sessions (e.g., agenda setting) to those occurring outside of sessions (e.g., homework). Successfully negotiating this shift in responsibility for change makes the difference between "one-hour-a-week therapy" and "168-hours-a-week therapy." This theme is also made evident in negotiating the time-limited nature of treatment, and in detailing expected progress and the process of recovery (e.g., complete symptom relief is not necessarily expected by the end of treatment, as it is anticipated that patients will continue to work towards resolving their difficulties long after they have stopped attending sessions, consolidating the gains they have made in treatment and building upon them).

Delegating responsibility for behaving therapeutically to the patient is a particularly useful theme to hold in mind during work on motivation, as this shifts patients' beliefs (or hope) that therapy can simply be "done" to them. Of all the themes, it can be the one that the patient is most reluctant to take on board, at least initially. The patient may see the responsibility for being the therapist as lying exclusively with the clinician. Here it can be useful to return to the theme of short-term relief versus long-term costs (e.g., the avoidance of responsibility for change is a short-term coping mechanism, with negative longer-term consequences).

1.5.3 Continuum thinking

Another theme underlying CBT is the need to escape from rigid, black-and-white thinking. All thoughts, feelings and behaviors can be seen to exist on a continuum, reflecting the fact that there are degrees of intensity to our experiences. Problems occur when the intensity of our experiences is too far towards either end of this continuum. For example, anxiety serves an important function in terms of alerting us to problems and motivating us to resolve them. However, it becomes an unhelpful experience when it becomes too intense, beginning to interfere with our day-to-day functioning.

The opposite of such a perspective is one that considers experiences as black and white. For example things are either good or they are bad, people are either successful or they are failures. This all or nothing way of viewing things does not allow for degrees of experience, or shades of gray. It is rigid and does not allow a consideration of change. It is also not an accurate representation of experience and thus will impact upon an individual's functioning in all aspects of their lives.

Black-and-white thinking moderates the impact of risk factors and the person's responses to treatment. Therefore, this theme needs to be discussed with the patient at the outset of treatment, in order to understand the patient's expectations about the process and goals of CBT. For example, the goal of treatment is one of moving slowly from one state towards another, rather than making an immediate switch between two opposite and conflicting positions. This theme can also be returned to throughout treatment when black-and-white thinking, feeling and behaving are encountered, so that the patient can be encouraged to see the benefits of partial change rather than focusing on the failure to change completely. Perceiving thoughts, feelings and behaviors in this way means that patients can become more flexible, more easily adapting to their environment.

1.5.4 Goal-setting

Most of our patients have black-and-white thinking patterns that permeate their lives. Therefore, it is not surprising that they bring this way of considering the world to their expectations of treatment. Many want to make the immediate jump from having an eating disorder to being well, and it is important to use Socratic questioning to consider whether that is possible (or even desirable, since it could leave patients feeling that they have no relapse strategy when they make small slips back). Hence, we stress the importance of short-, medium- and long-term goals, where the steps are always achievable. We also stress that we are likely to be working with short- and medium-term goals in therapy, as the patient's long-term goals are likely to take many years to achieve. Therefore, when we address short- and medium-term goals, we encourage the patient to think about whether his or her long-term goals can be achieved without going though this intermediate stage.

However, in keeping with the transfer of the role of therapist from clinician to patient, we stress that he or she needs to bring this thinking into his or her dealing with everyday life. We also encourage patients to consider long-term goals as potentially flexible, as they are allowed to change their mind as they develop (as most people do).

1.6 The value of case formulation

Case formulation is essential to ensure that a working collaboration is established with the patient, and to guide CBT. We address formulation in detail in Chapter 8. However, it is important to be clear with the patient about the rationale for focusing on this element of CBT. We aim to make four key points in discussing the formulation with the patient.

First, the formulation should be seen as "work in progress." We discuss it as a preliminary understanding of patients' problems, with the caveat that it will be amended with them during treatment, as new information emerges. Such an approach signals to the patient that this is their treatment, and that they will need to play an active role in recovery, rather than being a passive recipient of the clinician's wisdom. Second, the formulation enables a working alliance to be built with the patient, as this can be the first time that some sense has been made of what may appear to the patient to be a raft of unconnected behaviors. Third, having such an understanding can make the problem seem more solvable to both patient and clinician. Fourth, our patients often present with comorbid problems, and a formulation can help to guide the order in which those problems are treated. Finally, and most importantly, case formulation guides effective treatment, helping the clinician to take a general theory or model and to apply it to the individual patient. Our eating-disordered patients present with many complex behavioral difficulties. A good formulation should provide a "road map" for treatment. Returning to the formulation throughout treatment (and modifying it where necessary) can help the clinician to monitor that all remaining maintaining factors have been addressed.

1.7 The importance of behavioral experiments

In this book, we stress the importance of integrating the cognitive and behavioral elements of CBT for the eating disorders. We agree with the view (with its strong empirical backing) that the eating disorders are characterized by specific cognitions about eating, weight and shape (e.g., Fairburn *et al.*, 2003). However, changing those cognitions effectively depends on behavioral experiments, as has