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Cognitive-behavioral therapy for eating disorders in primary care settings:

Does it work, and does a greater dose make it more effective?

Charlotte Rose, PgDip (1)
Glenn Waller, DPhil (2)

1. AWP – First Step, Primary Care Eating Disorder Service, Bristol, UK
2. Department of Psychology, University of Sheffield, UK

Address for correspondence:

Glenn Waller, Department of Psychology, University of Sheffield, Cathedral Court, 1 Vicar Lane, Sheffield, S1 2LT, UK. email: g.waller@sheffield.ac.uk

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Running head: CBT - EFFECTIVENESS AND DOSE-RESPONSE

1 **Cognitive-behavioral therapy for eating disorders in primary care settings:**

2 **Does it work, and does a greater dose make it more effective?**

3
4
5 **Abstract**

6
7 **Objective:** This study aimed to determine whether cognitive behavioral therapy (CBT) for
8 eating disorders can be effective in a routine, primary care clinical setting, and to assess
9 dose response.

10 **Methods:** The participants were 47 patients who commenced treatment with a publicly-
11 funded primary care eating disorder service. They attended 7-33 sessions of individual CBT
12 (mean = 17), using an evidence-based approach. Routine measures were collected pre- and
13 post-therapy.

14 **Results:** Three-quarters of the patients completed treatment. Using intention to treat
15 analysis (multiple imputation), the patients showed substantial improvements in eating
16 attitudes, bulimic behaviours and depression. However, there was no association between
17 the level of improvement and the length of therapy past the 8th to 12th session

18 **Discussion:** The level of effectiveness shown here is comparable to that previously
19 demonstrated by more specialist services in secondary and tertiary care. The non-linear
20 association between number of sessions and recovery highlights the importance of early
21 change, across the eating disorders.

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24 Key words:

25 Cognitive-behavioral therapy; community sample; treatment dose; eating disorders

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Cognitive-behavioral therapy for eating disorders in primary care settings:**Does it work, and does a greater dose make it more effective?**

Eating disorder services are configured differently both within and between countries, according to national and local patterns of provision. Many are specialist services at secondary or tertiary levels of care, taking referrals from more generalist primary care level services. However, such specialist services are not always present, and they do not always have the capacity to see the full range of patients with eating disorders (e.g., not accepting referrals for individuals with binge-eating disorder; not treating non-underweight cases). Where services have to select which patients they have the capacity to see, they are likely to focus on anorexia nervosa cases, given their higher risk levels. Such services also tend to see patients for extended periods of time. While existing evidence-based protocols recommend relatively long periods of treatment for eating disorders compared to anxiety and depressive disorders, it is clear that clinicians routinely extend therapy so that it is substantially longer than those recommendations (e.g., Cowdrey & Waller, 2015). Consequently, many clinicians and services have a relatively slow turnover of cases, making it even less likely that patients in the community will be able to access treatment.

As a result of this limited access to specialist services, some primary care eating disorders services have been established (Devlin, 2014) with the intention of providing treatment for normal-weight patients within non-specialist services. They do not have the range of professional backgrounds that are common in specialist eating disorders teams, but usually have training in appropriate therapies. For adult patients, this therapy base is commonly cognitive behavioral therapy (CBT), given its proven benefits in clinical trials (Fairburn et al., 2009) and in routine practice in specialist eating disorder services (Byrne, Fursland, Allen & Watson, 2011; Knott, Woodward, Hoefkens & Limbert, 2015; Turner et al., 2015). However, no studies to date have explored the effectiveness of CBT for eating disorders when delivered in a primary care setting. This study addresses the effectiveness of CBT in such settings, in order to determine whether such services are able to provide outcomes that are comparable to those in secondary and tertiary care levels.

1 In addition to providing access to services, it is also important to consider the
2 duration of therapy in such settings. If therapy can be delivered over a shorter time frame,
3 this would allow for more patients to be treated from within the same resources. While
4 recommendations for length of treatment for CBT for eating disorders vary from 15-40
5 sessions (depending on the version of CBT and the patient's BMI - Fairburn, 2008), there is
6 provision within protocols for CBT to be extended if appropriate (Fairburn, 2008; Waller et
7 al., 2007). However, effectiveness studies have also suggested that the therapy might be
8 shortened in response to early changes, as well as allowing for extension (e.g., Turner et al.,
9 2015). While it might be assumed that adding more sessions would have a stronger clinical
10 effect, there is some indication that therapy effects are not linear with time. There is usually a
11 dose-response effect at first, which tails off to show limited or no gains thereafter. For
12 example, Delgadillo et al. (2014) have demonstrated that the optimal length of therapy for
13 mild to moderate anxiety and depression is approximately 4-6 sessions, and that additional
14 sessions do not result in better outcomes. In the eating disorders, Bell et al. (2017) have
15 shown a similar pattern in a specialist service – within a group of patients receiving a mean
16 of 16.2 sessions of one of a range of therapies, there was no link between treatment
17 duration and outcomes, even among anorexia nervosa cases. Such a pattern stresses the
18 importance of early gains, so that greater change levels are in place before the dose
19 response effect has faded. However, the possibility of such a pattern is yet to be established
20 in non-specialist eating disorders services of the type outlined above, to allow clinicians to
21 plan for the optimum number of sessions to be offered.

22 Given the limited evidence base regarding eating disorder services in primary care
23 settings, this study has two aims. First, it will determine whether CBT for eating disorders
24 can be effective in a routine, primary care setting. Second, it will assess dose response -
25 does the provision of more treatment sessions continue to facilitate further recovery gains?

26 **Method**

27 **Ethics**

28 The local National Health Service (NHS) Research and Development Office

1 approved collection of these outcome data as a service evaluation. Thus, NHS Research
2 Ethics Committee approval was not required. Service users provided consent for their data
3 to be used for this purpose.

4 **Participants**

5 The patients were aged 18 years or above at the point where they were referred to
6 the service by their General Practitioner. All referred patients were triaged to ensure that
7 they met the criteria for the service (body mass index ≥ 17 ; not requiring multiagency/
8 multidisciplinary care to address additional psychiatric or social needs; no alcohol or
9 substance abuse; no psychotic diagnosis; medically stable and monitored by the responsible
10 family physician). Each had a DSM-5 (American Psychiatric Association, 2013) diagnosis of
11 anorexia nervosa, bulimia nervosa, atypical anorexia nervosa or atypical bulimia nervosa.
12 Other OSFED cases and binge-eating disorder cases were not eligible for the service, due to
13 local service commissioning arrangements. Unlike Knott et al. (2015), motivation to engage
14 in therapy was not an eligibility criterion.

15 All patients who attended for assessment and met the criteria agreed to participate in
16 therapy (though some dropped out later – see below). At the time of data collation, the case
17 series consisted of 47 patients who started CBT for eating disorders with a UK primary care
18 eating disorders service. Forty-four were female and three were male. Eleven had a
19 diagnosis of anorexia nervosa and six had a diagnosis of atypical anorexia nervosa (BMI
20 above 18 and below 20, with marked restriction of intake and current weight loss), while 29
21 had a diagnosis of bulimia nervosa and one had a diagnosis of atypical bulimia nervosa
22 (frequency of bulimic behaviour below the DSM-5 criteria).

23 **Treatment**

24 All patients were treated individually in primary care settings. They were seen by
25 therapists who had been trained in the delivery of CBT via the UK Improving Access to
26 Psychological Therapies (IAPT) programme, which is a scheme focusing on the delivery of
27 evidence-based treatments (particularly CBT) for common psychological disorders (though
28 not eating disorders). Each of the therapists was supervised weekly from within the team

1 (i.e., by other eating disorder clinicians with the same training background) rather than by
2 external specialists. The therapists included one counsellor, two occupational therapists, a
3 trainee clinical psychologist and one nurse.

4 The CBT was based on individual case formulations, as described by Ghaderi
5 (2006). Treatment included: conceptualisation of beliefs about food, eating, body image and
6 emotion; sharing of information about regular eating, food and weight; in-session open
7 weighing; support in identifying triggers to eating disorder behaviors through food records;
8 and exposure/behavioral experimentation to address barriers to regular balanced, flexible
9 eating. Where formulation identified maintenance caused by specific beliefs relating to the
10 meaning of body image, those beliefs were targeted. Where behaviors such as body
11 checking or avoidance were identified as maintaining body image importance, then
12 behavioral experiments were planned as homework tasks. In-session mirror exposure was
13 not used.

14 Early sessions included completion of assessment and formulation, moving to the
15 focus on behavioural change outlined above. When patients stated that they wanted to
16 control their weight in a maladaptive way (e.g., restrict; remain underweight; avoid dietary
17 normalisation), formulation and psychoeducation was used to Socratically explore the
18 potential impact of making changes (e.g., reduced preoccupation, bingeing and purging;
19 positive effect on relationships) in order to enhance motivation for change.

20 Those starting treatment with a BMI of 17-18 were offered up to 30 weekly sessions
21 in order to allow sufficient time for weight restoration. Other patients were usually offered up
22 to 20 weekly sessions. Sessions were booked in 4-6 week blocks. 6 If the patient failed to
23 develop motivation towards constructive change (e.g., they maintained efforts towards
24 weight loss), therapists were advised to discontinue CBT after eight sessions. If recovery
25 goals were achieved early (i.e., before the 20-30 sessions were concluded), therapists were
26 advised to aim to complete sessions sooner, following completion of maintenance planning.

27 **Measures**

28 As indices of the dose of CBT, the number of sessions completed and the number of

1 weeks in therapy were recorded. Height and weight were measured at the outset of
2 treatment, and weight was measured at each session thereafter. The duration of the eating
3 disorder was recorded from clinical assessment. Each patient completed the following two
4 well-validated measures at the beginning and end of therapy.

5 **Eating Disorders Examination-Questionnaire** (EDE-Q, version 6; Fairburn &
6 Beglin, 2008). The EDE-Q is a 33-item self-report questionnaire, which measures disordered
7 eating attitudes and behaviors over a 28-day period. The EDE-Q Global score is a summary
8 of the four attitudinal subscales (Eating Concern, Shape Concern, Weight Concern, and
9 Restraint). The Global score was used in this case because it has better psychometric
10 properties than the subscales (Allen, Byrne, Lampard, Watson & Fursland, 2011). The EDE-
11 Q was also used to provide frequencies of objective binge-eating, vomiting and laxative
12 abuse (over the previous 28 days).

13 **Patient Health Questionnaire** (PHQ-9; Kroenke, Spitzer & Williams, 2001). The
14 PHQ-9 is a nine-item self-report questionnaire, which measures symptoms of depression
15 over a two-week period.

16 **Data analysis**

17 Ten patients did not complete therapy, and two negotiated leaving therapy early due
18 to reluctance to engage in change (loss to therapy rate = 25.5%). A further three patients
19 completed the treatment but did not provide final outcome data (loss to research rate =
20 32%). Prediction of attrition was tested using chi-squared and independent sample *t*-tests.

21 Intention to treat analyses were used to determine the outcome of treatment. Multiple
22 imputation (SPSS v.24 – Fully Conditional Specification method, based on linear regression)
23 was used to deal with missing data. Paired *t*-tests were used to determine changes in
24 symptoms, and Cohen's *d* was used as the measure of effect size. Remission was defined
25 by the patient meeting the following criteria at the end of therapy – BMI > 18.5, absence of
26 any binge or purge behaviours over the previous month, and an EDE-Q Global score of <
27 2.77 (one SD above the mean for a UK non-clinical female population).

28 Partial correlations (controlling for initial EDE-Q score) were used to determine the

1 association of temporal factors (age, duration of disorder, number of sessions, duration of
2 treatment in weeks), initial BMI and initial PHQ-9 scores with final EDE-Q and PHQ-9
3 scores. Finally, curve fit estimates were used to determine whether there was a relationship
4 between therapy dose (number of sessions; number of weeks) and the level of change
5 across therapy (completer sample only). Independent samples t-tests were used to
6 determine whether those receiving more therapy sessions had different outcomes to those
7 who received fewer, based on the cut-point suggested by those curve fit estimates.

8 **Results**

9 **Sample characteristics**

10 Initial EDE-Q and PHQ-9 scores were available for the 47 patients who started
11 treatment. Demographic details were available on all of these patients, apart from duration of
12 treatment for three patients and weight for four patients. All four with missing weights had
13 diagnoses of bulimia nervosa and were at a normal weight (as confirmed at subsequent
14 therapy sessions). At the beginning of treatment, the mean BMI of the sample was 22.5 ($N =$
15 43; $SD = 3.87$; range = 17.04-32.94). Their mean age was 27.1 years ($N = 47$; $SD = 6.64$;
16 range = 18-42), and the mean duration of the eating disorder was 9.22 years ($N = 44$; $SD =$
17 6.53; range = 1-23). Thirty-five of these patients completed treatment. End of therapy EDE-Q
18 and PHQ-9 scores were available for 32 patients.

19 **Predictors of attrition**

20 Twelve patients did not complete therapy. This included both those who stopped
21 attending sessions without prior discussion, and those who negotiated early termination of
22 therapy sessions due to being unwilling or unable to work on recovery goals within the
23 service. Thus, there was an overall drop-out rate of 25.5%. There was no evidence that
24 completer status was associated with diagnosis (chi-squared = 2.73, $df = 6$, NS) or with any
25 temporal characteristic (age, duration of eating disorder, number of treatment sessions,
26 number of weeks in treatment – $F < 2.4$, $P > .11$ in all cases). Independent sample t-tests
27 were used to compare those who completed therapy and those who dropped out on BMI,
28 EDE-Q and PHQ-9 scores, but no comparison approached significance ($t < 1.7$, $P > .12$ in all

1 cases). Therefore, as with other such studies (e.g., Byrne et al., 2011; Waller et al., 2014),
2 there was no evidence of pre-treatment characteristics that predicted attrition.

3 **Outcome of treatment for eating disorders**

4 The mean length of treatment for the patients who completed treatment was 17
5 attended sessions ($SD = 5.84$; range = 7-33), delivered over a mean of 25.2 weeks ($SD =$
6 10.2 ; range = 10-51.7). It is noteworthy that there was no significant difference in either the
7 length of treatment in weeks or in the number of sessions completed by anorexia nervosa or
8 bulimia nervosa cases ($t < 1.4$ for each of these two treatment duration variables).

9 Table 1 shows the patients' BMIs, frequency of bulimic behaviours (objective binges,
10 vomiting and laxative abuse), EDE-Q and PHQ-9 scores at the beginning and end of
11 treatment. Their pre- and post-therapy scores were compared using paired t -tests (multiple
12 imputation used to correct for missing data). Effect sizes are shown using Cohen's d
13 (corrected for paired samples). BMI and frequency of laxative abuse were unchanged across
14 treatment, but there were significant reductions in eating attitudes, depression and bulimic
15 behaviours. The effect sizes were small to medium for reduction in binge-eating, medium for
16 the reductions in eating attitudes and vomiting, and large for the reduction in depression
17 levels. Mean PHQ-9 and EDE-Q total scores both fell to below the clinical scores that have
18 been identified as indicating a shift to more healthy ranges.

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Insert Table 1 about here

21
22
23 The pre-treatment EDE-Q Global score of this sample (mean = 3.89) was very similar
24 to the comparable intention to treat figures for Byrne et al.'s (2011) and Turner et al.'s (2015)
25 clinical samples (means = 3.96 and 4.17, respectively). The end of treatment score for this
26 group (mean = 2.33) was slightly lower than those of Byrne's and Turner's samples (mean =
27 3.00 and 2.92, respectively), which might reflect the more limited inclusion criteria used in
28 this clinical setting.

1 **Remission rate**

2 Eleven patients met the full remission criteria at the end of therapy. This represents
3 23.4% of the 47 patients who started therapy, and 34.4% of the 32 patients who completed
4 therapy and provided the necessary data. These results are similar to the remission rates
5 reported from specialist eating disorders services in effectiveness studies (Turner et al.,
6 2015).

7 **Association of patient characteristics with level of improvement**

8 Table 2 shows the associations (partial correlations, controlling for initial EDE-Q
9 scores) of pre-treatment characteristics (age, duration of eating disorder, BMI, PHQ-9) and
10 therapy duration (weeks in treatment; number of sessions attended) with post-treatment
11 EDE-Q Global and PHQ-9 scores. The analyses involving treatment duration were carried
12 out for the treatment completers only. None of the associations with initial characteristics
13 approached significance, indicating that treatment outcome was not moderated by initial
14 severity.

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Insert Table 2 about here

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19 **Association of treatment duration with level of improvement**

20 The duration of treatment (measured either in terms of number of sessions or
21 number of weeks) was also not associated with the final levels of eating attitudes or
22 depression (Table 2). Such a lack of associations might be explained by therapy effects
23 being non-linear. For example, effects of early treatment gains might result in a non-linear
24 pattern of association, where there was less change to be made later in therapy. Therefore,
25 curve fit estimates were calculated, to determine whether the best explanation of treatment
26 outcomes (change in EDE-Q total; change in PHQ-9; change in BMI) was a linear, quadratic
27 or cubic association with each therapy duration variable (length in weeks; number of
28 sessions). The curve estimates showed that the length of treatment in weeks was not

1 associated with change in EDE-Q total score, regardless of whether one considered the
2 linear, quadratic or cubic effects ($F < 0.6$ in all cases). Nor was there any effect of length of
3 treatment on change in PHQ-9 scores ($F < 1.7$ in all cases) or BMI ($F < 0.45$ in all cases).
4 Similarly, the number of sessions was not associated in any of these ways with change in
5 EDE-Q total scores ($F < 0.5$ in all cases), PHQ-9 scores ($F < 1.5$ in all cases), or BMI ($F <$
6 1.0 in all cases). Examination of the curves demonstrated that the optimum length of therapy
7 was between eight and 12 sessions, with gains by that point but no pattern of further gains
8 thereafter.

9 To test this examination of the curves, the degree of change in clinical characteristics
10 was compared between those patients who received up to 12 sessions ($N = 14$) and those
11 who received more ($N = 23$), using independent sample t-tests (multiple imputations used to
12 correct for missing data). The improvement in EDE-Q scores was slightly greater among
13 those patients who had fewer sessions (mean reduction = 1.89, $SE = 0.38$) than among
14 those who had more sessions (mean reduction = 1.23, $SE = 0.45$). BMI change also differed
15 slightly between those who had fewer sessions (mean increase = 0.48, $SE = 0.73$) and those
16 who had more (mean reduction = 0.18, $SE = 0.73$). Finally, the reduction in PHQ-9 scores
17 was slightly lower among those patients who had fewer sessions (mean reduction = 5.29,
18 $SE = 1.50$) than among those who had more sessions (mean reduction = 6.76, $SE = 1.25$).
19 However, in none of these cases did the difference approach significance ($t < 1.0$; *NS* in all
20 cases). These findings support the conclusion that additional sessions did not result in better
21 outcomes.

22 Discussion

23 This study aimed to establish whether CBT could be effective in the treatment of
24 eating disorders when delivered within a primary care setting, and to determine whether
25 there is a dose-response effect. The retention rate (c.75%) was strong relative to other
26 effectiveness studies (e.g., Byrne et al., 2011; Turner et al., 2015). CBT was effective in this
27 setting, reducing eating disorder symptoms and depression. The level of remission was
28 similar to that shown in effectiveness studies conducted in specialist eating disorder

1 services. There was no dose-response effect within this sample, despite the wide range of
2 sessions (7-33) and despite the fact that clinicians were able to extend the therapy duration
3 on a case-by-case basis, if they judged that the patient would benefit from more sessions.

4 These findings add to the evidence (e.g., Byrne et al., 2011; Fairburn et al., 2009;
5 Knott et al., 2015; Turner et al., 2015) that the effects of CBT for adults with eating disorders
6 are generalizable across settings and service configurations, although this conclusion would
7 be firmer if there had been a waiting list control group. It is possible that the impact would
8 have been even greater if mirror exposure work had been used for patients with body
9 avoidance issues. It is worthy of note that these benefits were achieved despite the mean
10 duration of the patients' eating disorders (9.22 years) being longer than is commonly used in
11 definitions of 'severe and enduring' eating disorders, adding to the evidence that the duration
12 of eating disorders is not related to poor outcomes (e.g., Wildes et al., 2017). The lack of
13 reliable predictors of attrition is similar to findings in the wider literature (Byrne et al., 2011;
14 Turner et al., 2015), though it is possible that studies with a larger number of participants will
15 find such predictors, possibly pointing to heuristics that might be used for treatment matching
16 purposes.

17 The findings also confirm the finding from the eating disorders and other disorders
18 (e.g., Bell et al., 2017; Delgadillo et al., 2014) that adding sessions beyond a basic level
19 does not automatically enhance therapy outcomes. It is well-established that early change in
20 CBT for eating disorders is very important for longer-term outcomes (Raykos et al., 2013;
21 Turner et al. 2015; Waller et al., 2014). If treatment gains are limited after 8-12 sessions,
22 then the importance of making substantial early gains is even more vital than has been
23 suggested previously. However, such a conclusion will depend on these findings being
24 replicated with a wider range of outcome measures, and with a well-validated diagnostic
25 interview (which was not available for this clinical sample). Constructs that were not
26 specifically measured in this clinical study (e.g., quality of life; longer-term abstinence and
27 remission) might be influenced more by longer therapy, and therefore merit consideration in
28 future.

1 There are a number of ways in which this research needs to be extended. For
2 example, studies of single diagnostic groups of patients would be helpful, as it is possible
3 that the findings will differ according to the ego syntonicity or dystonicity of the disorder (e.g.,
4 anorexia nervosa patients might need longer to engage with the treatment). It will also be
5 important to understand whether the pragmatic considerations that were implemented in this
6 real-life setting (e.g., shortening therapy when it was clear that the patient was not
7 demonstrating motivation to change or when the patient improved rapidly; lengthening
8 therapy when further work appeared likely to be useful) mean that the findings partially
9 reflect clinician decisions rather than patient change per se. Schibbye et al. (2015) suggest
10 that it is possible to develop algorithms for use in progress monitoring and supervision to
11 enhance such clinical decisions. It should also be noted that this study's generalisability was
12 limited by the fact that the service was not commissioned to treat patients with binge-eating
13 disorder. Finally, it will also be important to consider how one could measure therapist
14 competence and treatment fidelity in such real-life settings, as the lack of such
15 measurements is a weakness in this and most such studies. Measures of competence and
16 fidelity that can be applied readily using the resources available in everyday clinical settings
17 would be an asset for demonstrating the viability of rolling out evidence-based therapies to
18 real-life clinical practice.

19 If these findings are replicated and extended, they support treatment of eating
20 disorders within primary care settings, delivered by individual practitioners working in clinical
21 teams consisting only of CBT therapists. However, they also raise the important
22 consideration of how long such therapies should be. If the maximum dose response can be
23 achieved in a much shorter number of sessions than recommended (e.g., Fairburn, 2008),
24 then the commonly perceived clinical drawback of shorter therapy (weaker outcomes) might
25 be invalid, while the potential economic and quality of life benefits of offering fewer sessions
26 (less time per patient spent on treatment; greater access to treatment for more patients)
27 could be substantial. There is clearly a strong case for investigating the potential of briefer
28 versions of CBT and other therapies, given these findings and those of Bell et al. (2017).

1 Certainly, the case for longer therapies is weakened by such research, and any clinical case
2 for extension of treatment should be considered in supervision and monitored in practice
3 (e.g., Schibbye et al., 2015). Finally, clinicians should be encouraged to use frequent
4 measures of progress, focusing on weekly changes in behaviors and attitudes (e.g., Tatham,
5 Turner, Mountford, Tritt, Dyas & Waller, 2015). Detailed monitoring of this sort should be
6 used to identify and drive early change, to indicate when change is slowing, and to measure
7 whether any extension of therapy is justified.

8

9

10 **Authors' declaration of interest**

11 The authors have no interests to declare.

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1 Table 1

2 Outcome of treatment for eating disorders in terms of body mass index, eating pathology
 3 (EDE-Q Global score), bulimic behaviours (per month) and depression (PHQ-9), using
 4 multiple imputations to replace missing data ($N = 47$).

5

	Start of		End of		Paired t-test		
	treatment		treatment		<i>t</i>	<i>P</i>	<i>d</i>
	Mean	(<i>SD</i>)	Mean	(<i>SD</i>)			
Body mass index	22.5	(3.98)	22.5	(3.70)	0.37	<i>NS</i>	-
EDE-Q total	3.89	(4.04)	2.33	(3.98)	5.88	.001	0.52
Objective binges (month)	8.55	(10.6)	4.31	(8.78)	2.21	.03	0.33
Vomiting (month)	6.47	(9.18)	2.55	(7.88)	3.48	.001	0.56
Laxatives (month)	0.41	(1.71)	0.47	(1.72)	0.21	<i>NS</i>	-
PHQ-9 depression	13.5	(5.48)	7.42	(6.38)	7.73	.001	1.22

6

7

1 Table 2

2 Partial correlations, testing the association between pre-treatment scores and end of
 3 treatment scores on measures of eating pathology (EDE-Q Global), depression (PHQ-9) and
 4 treatment duration, controlling for initial scores on the EDE-Q. Multiple imputation scores
 5 were used for the correlations with initial scores ($N = 47$), while completer analysis was used
 6 for associations with duration of treatment ($N = 32$). No associations were significant.

7

	End of treatment scores ⁸	
	<i>EDE-Q Global</i>	<i>PHQ-9</i> ⁹
Initial scores		10
BMI	.172	.185 ¹¹
Age	.156	-.220 ¹²
Duration of eating disorder	.203	-.081
PHQ-9	.323	-
Duration of therapy		
Number of sessions	-.002	-.302
Weeks in treatment	-.068	-.056