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**Are we really delivering evidence-based treatments for eating disorders? How eating-disordered patients describe their experience of cognitive behavioral therapy**

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**Are we really delivering evidence-based treatments for eating disorders? How eating-disordered patients describe their experience of cognitive behavioral therapy**

**Abstract**

Psychotherapists report routinely not practising evidence-based treatments. However, there is little research examining the content of therapy from the patient perspective. This study examined the self-reported treatment experiences of individuals who had been told that they had received cognitive-behavior therapy (CBT) for their eating disorder. One hundred and fifty-seven such sufferers (mean age = 25.69 years) were recruited from self-help organisations. Participants completed an online survey assessing demographics, clinical characteristics, and therapy components. The use of evidence-based CBT techniques varied widely, with core elements for the eating disorders (e.g., weighing and food monitoring) used at well below the optimum level, while a number of unevidenced techniques were reported as being used commonly. Cluster analysis showed that participants received different patterns of intervention under the therapist label of 'CBT', with evidence-based CBT being the least common. Therapist age and patient diagnosis were related to the pattern of intervention delivered. It appears that clinicians are not subscribing to a transdiagnostic approach to the treatment of eating disorders. Patient recollections in this study support the conclusion that evidence-based practice is not routinely undertaken with this client group, even when the therapy offered is described as such.

**Keywords:** eating disorders; cognitive behavior therapy; therapist drift; patient perspectives

**Are we really delivering evidence-based treatments for eating disorders? How eating-disordered patients describe their experience of cognitive behavioral therapy**

Clinicians have access to a number of effective evidence-based psychological therapies for a range of disorders. However, those therapies are not routinely delivered in clinical settings (e.g., Shafran et al., 2009). Clinicians' self-report of their use of psychotherapy techniques show that evidence-based therapies are not consistently known about or used (e.g., Becker, Zayfert, & Anderson, 2004; Hipol & Deacon, 2012; Mussell et al., 2000; von Ranson, Wallace, & Stevenson, 2013). Such clinician reports would benefit from triangulation via patient accounts of what is delivered under the label of evidence-based treatments. However, there is a paucity of research examining the content of therapy from the patient perspective.

To date, only two studies have assessed the specific therapeutic techniques reported by patients and how their experience compares to the evidence base (Serpell, Stobie, Fairburn, & van Schaick, 2013; Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). The findings of these studies add to the evidence that there is a mismatch between what psychological treatment patients are told they are receiving and what they are actually being offered. Initially, a proportion of patients had no memory of being told what therapy they had received. Furthermore, of those who reported having received cognitive behavior therapy (CBT), that therapy deviated from an adequate version for a large proportion of cases. Both studies found high levels of unevidenced integrationist approaches, with crucial therapeutic techniques being used inconsistently or omitted altogether, even where the therapy was labelled as an evidence-based one. Clinicians' digression from the evidence base becomes even more important to understand given that specific techniques (e.g., exposure-based methods) are routinely omitted by clinicians despite potential patients recognising their benefit (Becker et al., 2009).

The omission of disorder-specific techniques is common within the treatment of the eating disorders (Forbush, Richardson, & Bohrer, in press; Simmons, Milnes, & Anderson,

2008; von Ranson et al., 2013; Waller, Stringer, & Meyer, 2012). CBT is the recommended treatment for most eating disorders in adults (National Institute for Health and Clinical Excellence [NICE], 2004). Despite this, fewer than a third of clinicians use CBT as their primary approach for eating disorders (Mussell et al., 2000; Tobin, Banker, Weisberg, & Bowers, 2007; von Ranson et al., 2013). Moreover, clinicians are inconsistent in their use of cognitive-behavioral strategies (Waller et al., 2012), tending to say that they incorporate CBT techniques as a component of an 'eclectic' therapy amongst other less empirically supported techniques (Simmons et al., 2008; von Ranson et al., 2013).

Serpell et al. (2013) provide an initial summary of what eating disorder patients recall having experienced as part of CBT. However, the study was limited by its exclusive focus on patients with bulimia nervosa. Despite suggestion that a transdiagnostic approach is more suited to treatment of eating disorders (Fairburn, 2008; Murphy, Straepler, Cooper, & Fairburn, 2010), this contention remains to be proven. The evidence to date is that outcomes for anorexia nervosa are weaker than for non-underweight eating disorder cases, even when applying similar CBT principles (e.g., Fairburn et al., 2009, 2013). Therefore, it cannot be assumed that the same CBT methods are equally effective across eating disorders. However, even if such an assumption were to be accepted, it is not clear that CBT is delivered in the same way to all such patients. Therefore, while the Serpell et al. (2013) study is informative about bulimia nervosa patients' experiences, it is important to consider the full range of eating disorder patients who might benefit from CBT, and whether the therapy that they receive maps onto evidence-based approaches. Therefore, the primary aim of the current study was to examine what techniques patients recall having experienced in their most recent episode of CBT for an eating disorder, in order to determine whether that version of CBT deviates from evidence-based guidelines and whether it reflects clinicians' reports. The secondary aim was to determine whether distinct patterns of CBT techniques were used by different clinicians, and whether they were applied differently to patients with specific eating disorder diagnoses (i.e., whether or not clinicians appear to use a transdiagnostic approach in everyday practice).

## **Method**

### **Ethical Issues**

Ethical approval was granted for the study by the University of Sheffield's Department of Psychology Research Ethics Committee. Participants provided informed consent.

### **Design**

An on-line survey was designed to retrospectively assess the specific contents of participants' most recent CBT treatment for their eating disorder. Potential participants were made aware of the study through their affiliation with one of three eating disorder support organisations (see Procedure).

### **Participants**

Participants were aged 18 or over at the time of participation, were affiliated with one of three sufferer support organisations, and reported having received CBT (as labelled by their therapist) for their eating disorder at least once. Their affiliation with the three organisations (which offer support for individuals with eating disorders and seeking treatment) indicates that these individuals were likely to have current eating disorders, though their diagnostic status at the time of participation was not assessed.

The participants commented on the most recent episode of CBT that they had already completed, rather than current therapy. Being in active CBT treatment for their eating disorder at the time of completing the survey was an exclusion criterion, to reduce the risk of the participant's memory of previous CBT being contaminated by current therapy. The survey was activated by 420 individuals, of whom: 58 did not consent; 16 were under the age of 18; 31 had had no previous therapy; 78 had no previous experience of CBT; and 80 did not complete the survey. This resulted in 157 individuals who completed the survey.

Sample size analysis was used to calculate the number of participants needed, using G\*Power version 3.1.5 (Faul, Erdfelder, Lang, & Buchner, 2007). Assuming three patterns of intervention emerging from the cluster analysis (see below), a medium effect size (0.25), an

alpha of .05, and a power of 80%, a total sample size of 159 would be required. The sample obtained was very close to that number, with 157 participants who met all inclusion criteria and completed the survey.

### **Procedure**

Data were collected via an online survey (using the Qualtrics website)<sup>1</sup>. Participants were recruited from three eating disorder sufferer support organisations: Beat (based in the United Kingdom); Project Heal (based in the United States and Canada); and the Butterfly Foundation (based in Australia). Awareness of the study was raised through online methods. Participants received email invitations from the relevant organisation or accessed the online survey via web links on their organisation's Facebook and Twitter posts to complete the survey. If a participant indicated that they had not previously received CBT treatment, the survey collected only basic information (age, gender, location, type of therapy received). All other participants completed questions about their CBT treatment. To reduce the risk of participants completing the survey more than once, the IP addresses of computers used (collected automatically by Qualtrics) were checked. There was no case of the same computer being used twice, although this cannot guarantee that no individual completed the survey more than once, using different computers. The survey was available for participants to complete from April 2014 to February 2015, with 307 visits to the survey following the preliminary announcements, and a further 113 following a further announcement via the same sites in November 2014. The second announcement was planned from the outset, to allow individuals to participate if they were unable to do so at the first stage of recruitment, due to still being in therapy at that point.

### **Measure**

The survey was devised for the purpose of this study to examine participant recollections of the most recent CBT treatment they had received for their eating disorder. The format of the survey was developed from previous research into patients' experiences of therapy for obsessive-compulsive disorder (Stobie et al., 2007). The individual items in the

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<sup>1</sup> The full survey is included as supplementary material.

survey were devised by the lead researcher and research supervisor (who specialises in CBT and research in the field of eating disorders). These items were modified based on the feedback of one of the contacts from the charitable organisations, who themselves had personal experience of an eating disorder and treatment. The three sections of the survey examined: (a) participant demographics (e.g., age, gender, location); (b) course of the problem (e.g., diagnosis at the time that the index episode of treatment commenced, time elapsed since ED developed and receiving treatment); and (c) what was done as part of their CBT therapy (techniques used, with brief descriptions of methods where there was any risk of incomprehension due to the use of technical terms). Some other data were collected, which are not reported in this study (see supplementary material). Among those who completed the whole survey, the median time taken was 18 minutes (recorded automatically). Items relating to the specific therapeutic techniques used were based on two evidence-based CBT manuals (Fairburn, 2008; Waller et al., 2007), as well as previous studies that have examined what interventions and techniques therapists report using when delivering CBT to this clinical group (e.g., Waller et al., 2012). Thus, the list included both evidence-based and non-evidence-based items. Table 3 provides a full list of these items.

The response format for the items in the survey varied according to the nature of the information being sought. Categorical responses were used where appropriate (e.g., genders of participant and therapist; country of residence; label given to the therapy received; diagnosis given to the patient). In some cases, it was more appropriate to use ordinal scales, where precision would not be easy to achieve (e.g., duration of eating disorder prior to treatment; time since the therapy ended; estimate of the therapist's age). The remaining items were rated dimensionally (e.g., number of sessions received; patient's perception of the therapist's personality and emotions). Each therapeutic technique used (Table 3) was rated categorically by the patient as being present/absent and explained/not explained, and was rated ordinally on how useful the patient found it/would have found it. Finally, the perceived effectiveness of the therapy was rated on a number of ordinal scales.

The participants were asked what diagnosis they had been given by their clinician at

the start of therapy (or to state what they believed it to be, if none had been given), using the responses: 'anorexia nervosa'; 'bulimia nervosa'; 'binge eating disorder'; 'atypical eating disorder/eating disorder not otherwise specified (EDNOS)'; 'obesity with no other eating disorder'; or 'other'. No further detail was given of the diagnoses, as the primary interest was in the experience of the patients (i.e., what they had been told by clinicians).

### **Data Analysis**

SPSS (Version 21.0) was used to analyse the data. Missing data were not replaced, resulting in different sample sizes across analyses. Preliminary examination of the data showed several items were not normally distributed. However, parametric analyses are reported as the data were also analysed using non-parametric equivalents, with no appreciable change in pattern of findings. Following descriptive data on the use of specific therapeutic techniques, the use/absence of specific techniques was used in two-step cluster analysis (the most effective form of cluster analysis when including categorical/non-parametric variables) to determine whether participants received differing patterns of intervention under the therapist's label of 'CBT'. The number of clusters was set by identifying where the Schwarz Bayesian Criterion becomes small and the change between clusters is small. The resulting clusters were then validated using participant characteristics (diagnosis) and therapist characteristics (gender, perceived age), using one-way ANOVAs and chi-squared tests.

## **Results**

### **Final Sample Characteristics**

In total, 157 participants met all inclusion criteria and completed the survey. The demographic and clinical characteristics of the final sample are shown in Table 1. They consisted largely of females in their mid-20s, and included a high proportion with a self-reported diagnosis of anorexia nervosa.

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Insert Table 1 about here

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### **Nature of the CBT Experienced**

Recalled characteristics of the CBT experienced by participants are summarised in Table 2. Over a third of participants (36%) had been suffering from their eating disorder for over five years before receiving CBT. The age at which they started therapy ranged from 12–56 years. Over half the participants (55%) had completed their CBT within the last 12 months. The majority of participants (68%) reported receiving weekly sessions. The total number of sessions varied widely, ranging from 1-400, with the mean number of sessions exceeding the evidence-based recommended treatment timescales for all diagnostic categories (but particularly bulimia nervosa, with 45 sessions, rather than 20).

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Insert Table 2 about here

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### **What Techniques Were Recalled as Part of Participants' CBT Sessions?**

Table 3 illustrates what techniques participants recalled having been used during their CBT. Those techniques are divided into those that are generic to CBT across disorders (e.g., drawing a formulation diagram), elements of evidence-based CBT for eating disorders (e.g., keeping food monitoring records), and those that are not part of evidence-based CBT for eating disorders (e.g., use of silence in the sessions).

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Insert Table 3 about here

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Some core elements of generic and evidence-based CBT were reported as being used with the majority of participants (e.g., thought records, introducing regular eating, homework tasks, behavioral experiments, and working on changing the meaning attached to

thoughts). However, some elements were used far less frequently than would be expected (e.g., weighing the patient; agenda-setting; food monitoring), despite all being techniques that the relevant evidence-based manuals stress as being essential elements of CBT for the eating disorders.

Equally important, there were a number of non-evidence based techniques reported by the patients. Some of these lack support for use in CBT for eating disorders, even though they are integral to other evidence-based approaches. In particular, three-quarters of participants recalled the use of techniques labelled as 'mindfulness' in their CBT. While mindfulness work is part of evidence-based dialectical behavior therapy for eating disorders, it is not an element of evidence-based CBT at present. Some other techniques that were commonly reported here lack support more broadly across therapies (e.g., approximately half reported the regular use of relaxation exercises, and over two-thirds reported regularly talking about whatever was on their mind at the time). Indeed, over a quarter of patients reported that their therapist was routinely silent throughout most of the session. None of this group of techniques have adequate support within evidence-based CBT for eating disorders at present.

### **Did Respondents Receive Different Patterns of Intervention Under the Label of 'CBT'?**

Two-step cluster analysis demonstrated that the most meaningful solution consisted of three clusters, with a silhouette score of 0.2. Table 4 shows the therapeutic techniques that distinguished clusters (all at or beyond the 95% confidence interval from the sample mean). The first cluster (47.6%) consisted of participants reporting interventions consisting of high use of CBT techniques such as thought records, behavioral experiments, and psychoeducation, but unusually low use of core exposure-based CBT elements such as routine weighing and food monitoring. Therefore, the first cluster was labelled 'CBT-Lite' intervention. The second cluster (34%) was distinguished by lacking prominent use of any CBT techniques. However, this group had an unusually low level of use of the same two core CBT techniques – routine weighing and food monitoring. Therefore, this cluster was labelled 'Non-specific' intervention. The third cluster (18.4%) consisted of participants who

reported receiving a pattern of intervention that most closely resembled that of evidence-based CBT, including much higher use of routine weighing and food monitoring, and a lesser emphasis on exploring problems in childhood. Therefore, this approach was labelled as a 'CBT' intervention.

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Insert Table 4 about here

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**Validation of the three groups.** The clusters were compared on levels of participant characteristics (reported diagnosis given at the start of the index therapy) and therapist characteristics (gender, age), using chi-squared tests and one-way ANOVAs. A significant relationship emerged between diagnosis at the time and the pattern of intervention participants received,  $\chi^2$  (df = 4,  $N$  = 146) = 11.36,  $P$  < .05. Participants with a diagnosis of anorexia nervosa were more likely to receive a 'CBT Lite' intervention (51.7%). Those with atypical presentations were equally likely to receive a 'Non-specific' intervention or a 'CBT-Lite' intervention (42.9% each). However, those with a diagnosis of bulimia nervosa were more likely to receive a full 'CBT' intervention (41.7% vs 13.4% and 14.3% for anorexia nervosa and atypical presentations respectively).

There was no association of cluster membership with the therapist's gender,  $\chi^2$  (df = 2,  $N$  = 146) = 1.45,  $P$  = .48. However, there was a significant relationship between the perceived age of the therapist and the pattern of intervention delivered,  $\chi^2$  (df = 4,  $N$  = 146) = 20.8,  $P$  < .001. The evidence-based CBT was more likely to be delivered by a younger therapist aged between 21-30 years (36.7%) than by the two older age groups (31-40 years = 13%; and 40+ years = 14.9%). Consistent with this pattern, having a therapist who is seen as being between the ages of 31-40 years was associated with a greater use of a 'CBT-Lite' intervention (63.8%) than in the other two groups (30% and 34.4%). Finally, those therapists who were seen as being aged over 40 were much more likely to adopt an 'Non-specific' approach (50%) than the other two groups (33.3% and 23.2%).

## **Discussion**

This study has examined the treatment experiences of eating disorder patients who were told that they had received CBT. Patient recollections of their therapy indicated that the use of evidence-based CBT techniques (both generic and specific to the eating disorders) varies widely. The techniques that patients most commonly recalled included well-supported CBT elements (e.g., behavioral experiments, setting homework tasks between sessions, introducing regular eating), but also included methods that lack evidence in CBT for eating disorders (e.g., mindfulness; the therapist remaining largely silent). Even though these specific techniques lack such evidence (e.g., Wanden-Berghe, Sanz-Valero, & Wanden-Berghe, 2010), many were used more routinely than techniques that are central to evidence-based models of CBT for eating disorders, such as weekly weighing, food monitoring records, and exposure to feared foods and situations (e.g., Fairburn, 2008; Waller et al., 2007). In short, when describing the CBT they received for their eating disorder, few of this group of patients recalled receiving the set of techniques that are recommended as central to that therapy.

Furthermore, the use of these techniques was non-random, with three patterns of therapeutic intervention identified under the label of 'CBT'. The intervention that most resembled evidence-based CBT was the one least likely to be received by patients. Those with anorexia nervosa were particularly likely to receive 'CBT-Lite', while those with atypical eating disorders were more likely to receive a 'Non-specific' version of CBT. Patients with bulimia nervosa were more likely to receive a more evidence-based version of CBT, but on average their therapy lasted over twice the recommended number of CBT sessions for this disorder.

It is important to remember that these were individuals who largely had not benefitted from the therapy in a sustained way (as evidenced by their current affiliation to support/treatment-seeking groups), so it cannot be concluded that the proportions of patients receiving different forms of CBT in this study is fully representative of the therapy that is

delivered across services. However, the finding that fewer than 20% of patients received a pattern of intervention that resembled the evidence-based version of CBT is consistent with the broader literature, which indicates that clinicians routinely fail to implement the recommended treatment protocols for psychological disorders. For example, the low use of exposure-based techniques is consistent with findings for a range of clinical groups, including post-traumatic stress disorder (PTSD; Becker et al., 2004), obsessive-compulsive disorder (Stobie et al., 2007), and eating disorders (Simmons et al., 2008; von Ranson et al., 2013; Waller et al., 2012). von Ranson et al. (2013) found that self-identified CBT clinicians often prefer to combine techniques and approaches instead of delivering evidence-based CBT. The same applies to other psychological therapies for eating disorders, such as family-based therapy (Couturier, Kimber, & Szatmari, 2013; Kosmerly, Waller, & Robinson, 2015). In summary, these findings support the conclusion that clinicians' use of the label 'CBT' is often not a reliable indicator of the therapy that is being offered to individuals with eating disorders.

Why would clinicians label their work as 'CBT' but then seemingly drift away from protocols and avoid key therapeutic tasks? A number of factors have been implicated including: clinician anxiety about distressing the patient (e.g., Waller et al., 2012); negative attitudes towards treatment manuals (Addis & Krasnow, 2000); negative attitudes towards specific therapeutic techniques, such as exposure (e.g., Meyer, Farrell, Kemp, Blakey, & Deacon, 2014); and an (ill-founded) belief that clinical judgement outweighs empirical evidence (Meehl, 1954). It is also possible that when presented with patients with anorexia nervosa, clinicians modify their approach in response to the limited success rates for treating this clinical group. However, whilst it is accepted that there is no universally effective treatment for anorexia, protocol-based CBT results in somewhat better outcomes than other psychological therapies at present (e.g., Fairburn et al., 2013; Galsworthy-Francis & Allan, 2014). These findings highlight the need to focus on the dissemination of exposure-based techniques in particular, as opposed to enhancing other CBT techniques that are already utilized with considerable frequency. However, it will also be important to discourage the

inappropriate use of unevidenced techniques or the use of techniques that are specifically counter to CBT (e.g., the therapist remaining silent for most of the session). Obviously, one cannot conclude that these are not effective methods in the appropriate context. However, to label them as 'CBT' is potentially to encourage both clinician and patient to see CBT as ineffective when evidence-based CBT has not actually been delivered.

While this study has added to the limited quantitative literature that examines the content of psychological therapies from the patient's perspective, it is important to acknowledge its limitations. Retrospective accounts are subject to memory biases, and this study relied on participants' accounts of the most recent therapy they had received (the majority had completed their CBT within the last 12 months). However, future studies will need to address the issue of potential recall bias and the reliability of self-report. This issue could be addressed through triangulation of patient accounts with session documentation, clinician reports, and validated outcome measures. Additionally, future research could address the issue of formal diagnosis of participants, to determine whether the therapy had been successful or not in terms of ensuring long-term recovery. Other natural extensions of this literature will be to examine patient reports of other evidence-based treatments for eating disorders (e.g., family-based therapy) and for other clinical disorders. Finally, this study did not identify criteria that would determine 'adequate CBT' for the eating disorders based on a transdiagnostic model, and this would be a logical focus for future research of this kind.

This research has further highlighted that the label provided by clinicians is not always the same as the actual therapy delivered. This discrepancy might be due to clinicians' lack of training in eating disorder treatment (as shown in other studies - e.g., von Ranson et al., 2013), or due to their anxious avoidance of delivering certain techniques (e.g., not weighing the patient, for fear of distressing them – e.g., Waller & Mountford, 2015). Emphasis needs to be placed on clinicians not only learning the techniques central to the therapy, but also implementing them consistently (unless, of course, those clinicians can actively demonstrate that their 'variant' on CBT is as effective as the full-blown version).

Otherwise, clinicians risk misleading patients, who might finish their therapy believing that they have had the best possible treatment and that they are beyond help because they did not recover. In planning treatment, clinicians should ask their patients for details of previous therapy, as it might not match its label.

Finally, it is important to note that the mean number of sessions reported exceeded the recommended treatment length across all diagnostic categories in this study. It will be important for clinicians to consider how long to continue with therapy when it is not working. There might be a case for ending therapy early. However, it is equally possible that clinicians who are getting poor outcomes in the individual case will need to reflect on whether it is possible that failure to change might indicate that the therapy that they are delivering really does not match the evidence-based form, and how they might change their approach to enhance the patient's chance of benefitting. This level of self-reflection would be enhanced by supervision that considers patient outcomes and therapists' use of appropriate techniques.

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Table 1Characteristics of the final sample ( $N = 157$ )

	Final Sample
Mean age (years) and SD	25.69 (7.52)
Gender, $n$ (%) female	156 (99.4%)
Location, $n$ (%)	
UK	71 (45.2%)
Australia	31 (19.7%)
US	43 (27.4%)
Canada	9 (5.7%)
Other	3 (1.9%)
Self-reported diagnosis, $n$ (%)	
AN	92 (58.6%)
BN	28 (17.8%)
Atypical	37 (23.6%)

Table 2

Characteristics of the CBT treatment (total N = 157)

	<i>n</i>	%
Duration of eating disorder before receiving index course of CBT		
<6 months	12	7.6
6-12 months	24	15.3
1-3 years	44	28
3-5 years	20	12.7
5+ years	57	36.3
Time elapsed since index course of CBT ended		
<12 months	85	54.1
1-3 years	41	26.1
3-5 years	14	8.9
5+ years	17	10.8
Age at start of index course of CBT (mean; SD)	21.85	(7.60)
Number of sessions (mean, SD)		
Total sample	43.82	(58.67)
AN	49.53	(68.61)
BN	45.20	(46.84)
Atypical	25.38	(23.58)

Table 3

Percentage of participants who reported particular therapeutic techniques as having been part of their CBT treatment.

Technique	Technique used %
<u>Generic CBT techniques</u>	
CBT formulation diagram	65.6
Coping in present and future	88.5
Homework tasks	87.7
Looking at links between thoughts, feelings and behaviors	90.4
Thought records	73.9
Thought challenging	79.9
Surveys/Questionnaires	28.0
Behavioral experiments	80.3
Agenda setting	29.0
	Mean 68.3
<u>Eating disorder specific CBT techniques</u>	
Concentrated on beliefs about eating/shape/weight in most sessions	66.0
Exposure to feared situations/foods	59.9
Food monitoring records	53.2
Introduce regular eating	81.5
Psychoeducation about eating disorders and how they develop	65.4
Weekly weighing	38.9
	Mean 60.8
<u>Unsupported techniques</u>	
Mindfulness	76.8
Diagram drawn showing patterns in relating to people	28.2
Explored childhood as therapist implied this in where problems originated	59.2
Explored patterns of relating to others	63.7
Therapist silent for majority of sessions	28.7
Looking at problems other than eating difficulties for most of the sessions	53.5
Relaxation exercises	54.1
Talking about past/childhood for majority of sessions	28.7
Majority of sessions spent talking about whatever was on patient's mind	70.1
Motivational interviewing	77.7
	Mean 54.1

Table 4

Cluster membership in the three-cluster solution, based on participants' recollections of therapeutic techniques used during their CBT treatment for their eating disorder

Cluster Label (95% CI)		
CBT-Lite Intervention ( <i>n</i> = 70; 47.6%)	Non-specific Intervention ( <i>n</i> = 50; 34%)	CBT Intervention ( <i>n</i> = 27; 18.4%)
• Low use of weighing	• Low use of weighing	• High use of weighing
• Low use of food monitoring	• Low use of food monitoring	• High use of food monitoring
• High use of focusing on patterns of relating to others		• Low use of focusing on patterns of relating to others
• High use of behavioral experiments		• Low use of focusing on problems in childhood

*Note:* 95% CI = 95% confidence interval.