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

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Abstract

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

Key words: eating disorders; cognitive-behavioural therapy; clinician; anxiety; effectiveness

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

Cognitive-behavioural therapy (CBT) can be effective in the treatment of adult women with eating disorders across the diagnostic spectrum (e.g., Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Fairburn & Harrison, 2003; National Institute for Clinical Excellence, 2004). Over the past 25 years, CBT approaches have been refined, resulting in the widespread availability of manualised approaches (Fairburn, 2008; Gowers & Green, 2010; Waller, Corstorphine, Cordery, Hinrichsen, Lawson, Mountford, & Russell, 2007). While much of the evidence of efficacy of those approaches derives from tightly-controlled research trials (e.g., Fairburn, Cooper, Doll, O'Connor, Bohn, Hawker, Wales, & Palmer, 2009; Fairburn, Cooper, Doll, O'Connor, Palmer, & Dalle Grave, 2013; Poulsen, Lunn, Daniel, Folke, Mathieson, Katznelson, & Fairburn, 2014; Zipfel, Wild, Groβ, Friederich, Teufel, Schelberg, Giel, de Zwaan, Dinkel, Herpertz, Burgmer, Löwe, Tagay, von Wietersheim, Zeeck, Schade-Brittinger, Schauenburg, & Herzog, 2014), recent studies have demonstrated its effectiveness in routine clinical settings (e.g., Byrne, Fursland, Allen, & Watson, 2011; Waller, Gray, Hinrichsen, Mountford, Lawson, & Patient, 2014). However, such effectiveness depends on the use of the core techniques developed in efficacy studies, and particularly the use of manual-based methods (e.g., Addis & Waltz, 2002; Cukrowicz, Timmons, Sawyer, Caron, Gummelt, & Joiner, 2011). The use of manuals to direct CBT for the eating disorders is associated with greater use of core techniques, such as cognitive restructuring, goal setting, problem solving techniques, relapse prevention, self-monitoring, nutritional counseling, stress management, and homework assignments (Simmons, Milnes, & Anderson, 2008). However, relatively few clinicians use manuals and evidence-based techniques with the eating disorders (Tobin, Banker, Weisberg & Bowers, 2007; von Ranson, Wallace & Stevenson 2013; Wallace & von Ranson, 2011; Waller, Stringer & Meyer, 2012).

In order to address this research-practice gap, it is vital to understand why clinicians choose not to deliver evidence-based interventions in routine clinical practice. Meehl (1986)

suggests that a common reason is that clinicians are not aware of the evidence base, but also identifies reasons that are more centred in the clinician's own nature. For example, Shafran, Clark, Fairburn, Arntz, Barlow, Ehlers, Freeston, Garety, Hollon, Ost, Salkovskis, Williams and Wilson (2009) suggest that commonly-held clinician beliefs might impede the use of evidence-based treatment (e.g., 'the therapist is more important than the treatment protocol in determining outcome'; 'it is more valuable to mix and match parts of different interventions'). Other factors include levels of therapist training, clinical competence and supervision, all of which are pertinent to efforts to bridge the research-practice gap (Fairburn & Cooper, 2011, Fairburn & Wilson, 2013).

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

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

worry about the different elements of CBT for the eating disorders.

Method

Ethical clearance

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

Participants

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

Measures and Procedure

Each participant gave demographic details and then completed two measures. First, they rated how much they worried about the delivery of each of 14 elements of CBT for the eating disorders (listed in Table 1). The elements of CBT were selected because they are

reported to be used routinely in clinical practice (Waller et al., 2012). However, it is acknowledged that some of the elements lack an evidence base (e.g., mindfulness) and others have been demonstrated to have little or no value (e.g., pre-therapy motivational enhancement work) in work with the eating disorders (e.g., Waller, 2012; Waller et al., 2012). The 14 items were rated on a 1-5 scale ('not at all worried', 'a little worried', 'fairly worried', 'pretty worried', 'highly worried'), such that higher scores indicated greater worry about delivering CBT elements.

The second measure completed was the short form of the Intolerance of Uncertainty Scale (Carleton, Nordon & Amundson, 2007). This is a well-validated self-report measure of responses to uncertainty and ambiguity. It has 12 items, rated on a five-point Likert scale (1 = 'not at all characteristic of me'; 5 = 'entirely characteristic of me'). It has strong psychometric properties (Carleton et al., 2007), and reflects two factors. The first of these is 'prospective anxiety' (the inability to tolerate unpredictable events), and the second is 'inhibitory anxiety' (the inability to act due to uncertainty). Higher scores indicate greater levels of intolerance of uncertainty. The mean scores of this sample were prospective anxiety = 15.7 (*SD* = 4.84) and inhibitory anxiety = 10.1 (*SD* = 3.27), which are very similar to non-clinical norms (Carleton, Mulvogue, Thibodeau, McCabe, Antony & Asmundson, 2012). The internal consistencies (Cronbach's *alpha*) of the prospective anxiety and inhibitory anxiety scales were 0.885 and 0.847 respectively, which is comparable to the levels reported in the development of the measure (0.85 for each scale; Carleton et al., 2007).

Data analysis

Where items were missed on a measure, there was no replacement of data. The relevant *N* is shown in Table 1. Non-parametric analyses were used where available, due to the non-normal distribution of some scores. The dimensional relationship between worry about delivering elements of CBT and clinician characteristics (demographic details; Intolerance of Uncertainty Scale scores) was tested using Spearman's *rho*. The factor structure of the set of 'worry about CBT' items was determined using principal components

analysis with varimax rotation, and the emerging scales were tested for internal consistency using Cronbach's *alpha*.

Results

Table 1 outlines clinicians' levels of worry (range = 1-5) when delivering different elements of CBT. The most concerning elements of delivering CBT when working with people with eating disorders were undertaking body image work and ending treatment, where scores varied from 'a little' to 'fairly worried'. In contrast, the least worrying elements of delivering CBT were giving information (e.g., on food, eating and weight, on life threat, and on other effects), where scores varied between a 'not at all' to 'a little worried'.

Insert Table 1 about here

Factor analysis was used to determine whether there were underlying constructs that subsume the individual worry items. Using both an eigenvalue of > 1 and scree analysis as criteria, four factors emerged. The factor loadings are shown in Table 2. All items were retained, on the grounds that each loaded uniquely on one scale at above the 0.4 level, and none had loadings that were within 0.1 of that on another scale. These factors fell into four scales: cognitive approaches (including behavioural experiments, which have cognitive change as the goal); exposure-based methods (around being weighed and changes in eating); education (provision of information); and process-related methods (motivation and endings). Table 2 also shows the item mean scores and the internal consistency ratings (Cronbach's *alpha*), which were moderate to strong. The weaker alpha on the 'process' scale might be explained by the small number of items that loaded on it.

Insert Table 2 about here

Table 3 shows the association between these four scales and the clinicians' own characteristics. Older, more experienced clinicians were less likely to experience worry about most of the factors, but current exposure to CBT cases was not linked to such worry. Considering intolerance of uncertainty, neither form was associated with worries about the education element of CBT. Prospective anxiety was correlated with worry about the cognitive- and exposure-based elements of CBT for the eating disorders. In contrast, both prospective and inhibitory anxiety were related to worries about process-related elements of therapy.

Insert Table 3 about here

Discussion

Evidence-based treatments such as CBT can yield positive outcomes for the eating disorders when delivered in routine clinical practice (Byrne et al., 2011; Waller et al., 2014). However, they are commonly not delivered adequately in such settings (von Ranson et al, 2013; Wallace & von Ranson, 2012; Waller et al., 2012). This study extended existing research into the potential reasons why evidence-based CBT for the eating disorders is not implemented appropriately, considering the reasons for clinicians' concerns about delivering different elements of the therapy.

The elements of CBT that therapists worried most about were undertaking body image work and ending treatment, while psychoeducation was the least worrying element of delivering CBT. Clinician's concerns fell into four distinct factors – process-, education-, cognitive- and exposure-related. Older, more experienced clinicians were less worried about delivering most elements of CBT, though this was not related to current CBT caseloads. There was no general link between trait anxiety and concerns about techniques, as there was no link to psychoeducational methods. However, clinicians with higher levels of

prospective anxiety (as reflected in intolerance of uncertainty) were more likely to worry about cognitive- and exposure-related elements of change. In contrast, both inhibitory and prospective anxiety were associated with greater concerns about process-related elements of treatment (motivation and endings).

These findings help us to understand why clinicians might avoid delivering some of the core aspects of CBT for the eating disorders (e.g., Waller et al., 2012). Age and experience are clearly associated with lower concerns about using CBT techniques. However, clinicians' trait anxiety characteristics are also relevant. Clinicians' fears about the results of action (prospective anxiety) were linked to greater concerns about using the more impact-laden cognitive and behavioural methods (e.g., cognitive restructuring, behavioural experiments, weighing and dietary change). Their inhibitory anxiety levels (fear of initiating change) were linked only to process-related concerns. Thus, clinician characteristics are likely to have an impact on the effective delivery of evidence-based CBT for the eating disorders. A particular issue is that the clinicians were most concerned about addressing the end of therapy and body image. While the former might mean that therapy is extended unnecessarily, a failure to address body image effectively in therapy is an established risk factor for relapse (Keel, Dorer, Franko, Jackson & Herzog, 2005). Therefore, the clinician's own characteristics (lack of experience, prospective anxiety) might have a substantial impact on patient outcome.

It is important to note that the sample in this study included a high proportion of clinicians who were attending training. Although attendance at the training was voluntary, it is possible that their seeking training reflected an existing concern about the delivery of therapy. Therefore, it is possible that these clinicians had higher scores than might be the case elsewhere. Future research should consider whether the recruitment method involves such biases. A further limitation lies in the conclusions that can be reached regarding the process-related elements of therapy, given the lower internal consistency of that scale in this study. Further work and studies with other disorders might include further items (e.g., engagement, repairing therapeutic ruptures) that could load on this construct, to enhance the

internal consistency and utility of the measure.

Further exploration is needed regarding the reasons why evidence-based CBT techniques might cause concerns to specific clinicians, and how clinicians' own cognitions, emotions and other characteristics might interfere with the use of such methods (e.g., Farrell, Deacon, Kemp, Dixon, & Sy, 2013; Harned, Dimeff, Woodcock, & Contreras, 2013). For example, it might be the case that clinicians see exposure-based work (e.g., helping the patient to change eating patterns) as likely to distress the patient. Addressing this concern requires accepting that the clinician is partly correct, in that the patient probably will experience this change negatively in the short term. However, there is also evidence that those patients who make this change in their diet experience positive outcomes in the longer term (Waller, Evans & Pugh, 2013). Similarly, clinicians are correct to anticipate that effective body image work will make the patient anxious in the short term. However, to avoid critical techniques such as exposure with response prevention (e.g., Wilson, 2004) because of that short-term anxiety means that the body image disturbance is unlikely to change longer-term. In short, if clinician's own trait anxiety drives concerns about the use of effective techniques, then the risk is that the clinician will engage in the safety behaviour of not pressing the patient to change. Such avoidance has the short-term perceived benefit of not distressing the patient, but also means that the patient has little imperative or ability to change or recover in the long term.

It might be argued that clinicians' concerns reflect a desire to maintain the therapeutic alliance by not prioritising behavioural change that might reduce the strength of that relationship. However, it is important to note that the eating-disordered patients of CBT clinicians rate the working alliance relative positively (Waller, Evans & Stringer, 2012), and that the alliance might be driven by behavioural change rather than vice versa (Brown, Mountford & Waller, 2013), as found in CBT for other disorders (e.g., Tang & DeRubeis, 1999).

These findings have implications for the training, supervision and development of clinicians delivering CBT for the eating disorders in routine clinical practice. As Fairburn and

Cooper (2011) have indicated, it is clearly important for trainers and supervisors to support clinicians in the development of core knowledge and technical skills (e.g., how to do good behavioural experiments; what techniques to use to facilitate cognitive restructuring). However, it is also necessary to attend to how clinicians *feel* about delivering these aspects of therapy. As such, supervision could usefully provide a safe space for discussion of the process of therapy in combination with the development of technical competence, so that those aspects of treatment that might be more anxiety-provoking can be regularly discussed. Training and supervision will require understanding of the basis of the clinicians' concerns, as well as the planning of changes in practice (e.g., exposure-based methods and behavioural experiments for clinicians) to assist in evaluating and overcoming such concerns (e.g., Farrell, Deacon, Dixon, & Lickel, 2013). Thus, training and supervision would play key roles in the implementation and monitoring of evidence-based methods.

It will be important for future research to establish the concerns that clinicians have about the implementation of evidence-based therapy techniques in other disorders (e.g., Harned et al., 2013). Such work will determine whether these findings relating to CBT for the eating disorders apply to other disorders and therapies where there is evidence of therapist drift (e.g., Becker, Zayfert, & Anderson, 2004; DiGiorgio, Glass, & Arnkoff., 2010; Stobie, Taylor, Quigley, Ewing, & Salkovskis, 2007). The role of supervision in the effective delivery of therapy also merits investigation, given that there is some evidence that supervisors overestimate clinicians' competence and adherence to treatment model, relative to independent judges (Dennhag, Gibbons, Barber, Gallop, & Crits-Christoph, 2012). A more objectively driven pattern of feedback to supervisees (e.g., an eating disorders specific version of the Cognitive Therapy Rating Scale; Young & Beck, 1980) might help to increase the likelihood of evidence-based interventions being delivered in routine clinical settings

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Table 1

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

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

Table 2

Factor structure (principal components analysis; varimax rotation) of clinician worries about elements of CBT for the eating disorders, with statistics for the resulting scales

	Factor			
	1	2	3	4
	Cognitive	**Exposure**	**Education**	**Process**
Element of CBT				
Motivation block pre-CBT	.119	.059	.293	**.822**
Motivation in therapy	.020	.181	.248	**.829**
Information on food, eating and weight	.044	.120	**.686**	.333
Information on life threat	.137	.343	**.761**	-.009
Information on other effects	.287	.115	**.800**	.186
Weighing at first session	.031	**.881**	.190	.097
Weighing subsequently	.045	**.800**	.104	-.066
Start diet change	.226	**.705**	.203	.286
Normal eating	.287	**.710**	.069	.413
Cognitive restructuring	**.789**	.068	.185	.093
Behavioural experiments	**.749**	.100	.070	.144
Mindfulness work	**.779**	.033	.267	-.140
Body image work	**.748**	.224	-.030	.241
Ending treatment	.326	.156	-.259	**.434**
Eigenvalue	4.97	1.85	1.46	1.30
% variance explained	35.5	13.2	10.4	9.31
Item mean score	1.96	1.76	1.44	1.88
(*SD*)	(0.70)	(0.70)	(0.55)	(0.58)
Cronbach's *alpha*	.826	.846	.806	.650

Table 3

Association of domains of clinician worry with clinician characteristics (Spearman's *rho*)

		Demographic characteristics			**Intolerance of Uncertainty Scale**	
Factor	*N*	Age	Years of experience	Proportion of CBT cases	Prospective	Inhibitory
Process	105	-.29**	-.28**	-.01	.21*	.24*
Education	111	-.31**	-.41**	-.12	.13	.04
Exposure	99	-.38**	-.36**	-.11	.20*	.14
Cognitive	93	-.23*	-.18	-.14	.27**	.16

* $P < .05$; ** $P < .01$