The Model & Clinician: Who comes first?

The model OR the Clinician. One must come first!!

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The Evidence Base in Eating Disorders

It may not be much, but it is what we have.

Evidence to the rescue

Synthesis!
Policy briefs!
Influencing!
Advocacy!

Knowledge-sharing portals!
Publications!
Engagement with end users!
Communication capacity!

Press releases!

What can be asserted without evidence can also be dismissed without evidence.

Christopher Hitchens
Guidelines

- American Psychiatric Association (3rd 2006)
- Royal Australian and New Zealand College of Psychiatry (2004)
- Cochrane Reviews of literature (2008)
Anorexia Nervosa Treatment: A Systematic Review of Randomized Controlled Trials

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ABSTRACT

Objective: The RTI International-University of North Carolina at Chapel Hill Evidence-based Practice Center (RTI-UNC EPC) systematically reviewed evidence on efficacy of treatment for anorexia nervosa (AN), harms associated with treatments, factors associated with treatment efficacy, and differential outcome by sociodemographic characteristics.

Conclusion: Evidence for AN treatment is weak; evidence for treatment-related harms and factors associated with efficacy of treatment are weak; and evidence for differential outcome by sociodemographic characteristics is limited.


Phillipa Hay, PhD\textsuperscript{1,2}\textsuperscript{*}

ABSTRACT

Objective: To update new evidence for psychotherapies in eating disorders (EDs) since 2005–September 2012.

Method: Completed and published in the English language randomized controlled trials (RCTs) were identified by SCOPUS search using terms “bulimia” or “binge eating disorder” (BED) or “anorexia nervosa” (AN) or “eating disorder” and “treatment,” and 36 new RCTs met inclusion criteria.

Discussion: The evidence base for AN has improved and CBT has retained and extended its status as first-line therapy for BN. However, further research is needed, in particular noninferiority trials of active therapies and the best approach to addressing ED features and weight management in co-morbid BED and obesity. © 2013 by Wiley Periodicals, Inc.

Keywords: anorexia nervosa; bulimia
Adolescent Anorexia Nervosa.

- Cochrane Review of Evidence (Fisher et al 2008)
  - Evidence for family treatment over individual treatment.
    {Cochrane Review}

- Hay (2013)
  - “The evidence for FBT (with notably low attrition rates) compared to individual therapy has strengthened both in AN and in one trial for BN”.

Wednesday, 13 November 13
Findings: Full Remission

- FBT is superior to AFT in promoting full remission at follow-up (intention to treat)

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<thead>
<tr>
<th></th>
<th>FBT</th>
<th>AFT</th>
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<tr>
<td>EOT</td>
<td>42%</td>
<td>23%</td>
<td>0.055</td>
</tr>
<tr>
<td>6 mo</td>
<td>40%</td>
<td>18%</td>
<td>0.03</td>
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<tr>
<td>12 mo</td>
<td>49%</td>
<td>23%</td>
<td>0.02</td>
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- First line treatment - 49% full recovery over 12 months.
Bulimia Nervosa and Binge Eating in Adults.

- Cognitive Behaviour Therapy
- NICE (2004)
- RANZCP (2004)
- APA (2006)
- Cochrane Review (2007)
Bulimia Nervosa and Binge Eating in Adults.

- Hay (2013; IJED)
- 48 studies (n = 3054 participants)
  - CBT (quicker acting)
  - \{and 40% - 50% still symptomatic EOT\}
  - IPT (equivalent over time in BED)
  - Self-Help (CBT)
  - Some evidence for DBT (BED).
- CBT-E \{Broad\} may be helpful for those with greater vulnerabilities. (Hay, 2013)
Adult Anorexia Nervosa

- Cochrane review (Hay 2007) - No specific approach can be recommended from this review.

- Hay (2013; IJED)
  - Studies
    - SSCM (quicker acting than IPT)
    - SSCM outcome declined over time whilst IPT improved
    - Equivalent outcome from CBT, IPT, SSCM.
    - McIntosh et al (2005): 9% good outcome; 21% improved; 70% dropped out or poor outcome.
  - 6yr follow up 50% poor outcome.

- Schmidt et al (2012) SSCM = MANTRA - strictly defined outcome for recovery at follow up was 19% & 14%.
Anorexia Nervosa Treatment of OutPatients (ANTOP)

- Zipfel et al (2013; Lancet online)
  - 242 patients
  - Manualised Focal Psychotherapy (FPT)
  - Manualised CBTE
  - Optimised Treatment as Usual.
    - BMI 16.5
    - Age 28
    - LOI 6 years (40%)
    - 22% drop out.
• No Difference between treatments on weight.
• BMI 16.5 – 17.5 – 18.1.
ANTOP

- “When applying a strict definition of recovery ... recovery rates were 7–13% at 6 months and 14–19% at 12 months. Again, no differences with respect to recovery rates were noted between treatments”.
  - (Zipfel et al 2013 p9.)
Summary of Manuals in Eating Disorders

• The manual seems to be helpful in guiding our treatments in:
  • Adolescent Eating Disorders
  • Binge Eating Disorders
  • Bulimia Nervosa

• The outcomes are less than desirable.

• Manuals do not guide our treatments in adult anorexia nervosa.
We have treatments that work for some Eating Disorders. Use of Manuals in Clinical Practice. Who does, who doesn’t and why not?
The Research-Practice Gap

- The majority of clinicians do not adhere to the published CPG’s. Lilienfeld et al (2013; IJED)
- Tobin et al (2007; IJED)
- “I know what you did last summer.. and it wasn’t CBT”
  - 6% manual
  - 73% “Flexible”
  - 21% “Manual?”
Uptake of Treatment Manuals

- Wallace & von Ranson (2011; BRAT)
  - 36% use of manuals for BN
  - younger,
  - CBT orientation {47%},
  - research orientation,
  - ClinPsy
Why not manuals?

• What Manual?

• RCT’s exclude most patients.

• The models that drive the manuals are “ignorant”.

• Prescriptive and restrictive of therapist creativity and freedom of choice. (Psychotherapy is an art).
Lack of exposure to manual.

- Pederson et al (2000; IJED)
  - 39% CBT primary modality.
  - but 78% no formal training in CBT manual (similar for IPT).
What about clinical expertise?

- Evidence-Based Practice traditionally conceptualised as a three-legged stool comprising:
  - research evidence for manual based interventions (empirically supported treatments)
  - clinical expertise
  - client preferences and values.
• Beware of being “disseminated upon” (Westen, 2005) or “tyrannised by the evidence” (Hay, 2012).
LET'S BEGIN THE MEETING, BUT BE AWARE THAT I AM DOCUMENTING ALL OF YOUR BULLYING BEHAVIOR.

UM... I'M NOT EVEN CLOSE TO BEING A BULLY, BUT NOW YOUR CONFIRMATION BIAS WILL MAKE EVERYTHING I SAY SOUND LIKE BULLYING TO YOU.

CAN YOU REPEAT THE PART AFTER YOU IMPLIED THAT I'M A DELUSIONAL WITCH?
• Science is a systematic set of methods for reducing inferential error.
  • O’Donohue et al (2007)

• Science is a prescription for “arrogance control” because it forces us to keep
  in check our confidence regarding our most cherished assumptions.
  • Tarvis & Aronson (2007; “Mistakes were made (but not by me)”.
  • eg dietary restraint in bingeing
  • motivation & mindfulness
Is Flexible Manual Use Necessarily a Bad Thing?

• What does “flexible” and “sometimes” mean?
• I am a flexible manual user (or do I use manuals well?)
• Manuals do restrict the length of treatment.
• When does flexibility become another word for therapist drift or eclecticism?
  • Waller et al (2012; JCCP). Less than half of CBT therapists appeared to be doing CBT.
    • Behavioural/Motivational/Mindfulness groups
    • Little overlap between groups.
    • Manual use anchored against therapy drift.
Practice-Based Evidence

• Flexible treatment may be better than manualised treatment.

• “What should we (do) if what we do seems to work as well as or even better than FBT? ... far more than half of my patients appear to be weight restored in less than 2 years and doing generally well” - comment on the AED listserve

• Great, brilliant, I want to too. What do you do? How to you evaluate it? How can you teach me to do that?
Practice-Based Evidence and Evidence-Based Practice

- Measure your own outcomes.
- Both the APS and the APA have argued for “Practice Based Evidence”.

[Graphs showing comparison between men and women on various measures of eating behaviors and concerns.]

[Image of the Eating Disorder Inventory-3 (EDI-3) Professional Manual.]
"No, we don't have any outcome studies, only income studies. Dr. Katz makes a good income."
Is Flexible Manual Use Necessarily a Bad Thing?

• “a flexible application of treatment manuals may be defensible if guided by scientific considerations, but if it runs counter to broader evidence-based principles (e.g., the need for anxiety to habituate substantially before terminating exposure), it may detract from the effectiveness of the intervention. Lilienfeld et al (2013)
Next Steps

• What are the ‘key ingredients’ we can take from the manuals?

• Can we develop modules based on these ingredients?
  • Mood Intolerance, Perfectionism, Interpersonal, Self Esteem (Fairburn)
  • Unified Therapy for Emotional Disorders - Cognitive Reappraisal; Avoidance of Negative Affect; Behavioural Avoidance. - Barlow
  • How to deal with thinking, feeling and behaviour.
Conclusion

• Provide training in Empirically Supported Treatment.
• Become trained in EST.
• When in doubt use the manual to guide you.
• Is clinical experience a help to using the manual or hindering the manual?
• Be able to describe what you do in treatment. Be able to describe why you do it (particularly if it is not in the manual)
• Measure what you do.
• If it works, disseminate what you do.
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What is the essence of a checklist.

- Manuals could be seen as a “checklist” of what are the necessary ingredients in a psychological therapy.
What is the essence of a checklist.

- Checklists “are not comprehensive how to guides... They are .. tools aimed to buttress the skills of expert professionals” (p128).

- ‘a tool for people to try in hopes of improving their results’ (p151).

- Practitioners are encouraged to modify the checklists to fit into their usual procedures. (e.g cultural differences in operating rooms).
Ideas for Integration

• Modual treatment (Fairburn 2009; Barlow’s group)

• Develop a manual for eccentric practice incorporating these techniques.

• We need to know what eccentric therapists do? Can it be written down, evaluated and disseminated?

• “ESTs reflect our field’s current best consensus regarding the evidenti- ary basis for interventions. Hence, the burden of proof rests with practitioners who depart from ESTs to justify their choice of alternative interventions”. Lilienfield et al (2013)
Gap or Lag.

- In traditional medicine, there is an average lag of 17 years between the acquisition of new knowledge regarding treatment efficacy derived from RCTs and their application to routine practice. (e.g. pneumococcus vaccine)

• The dodo bird *seems to be* alive and well in AN research
  1 ✿ Cannot yet tell whether improvement is due to “specific” treatment effects
     over and above the impact of “non-specific” factors
  2 ✿ Might it be that ‘common’ factors – specialist expertise, therapist qualities,
     appropriate and timely intervention to reverse starvation are the key components?
  3 ✿ Or is it that there *are* differences (between specific and non-specific
     psychotherapies) but due to theoretical and methodological limitations, studies to
     date have been unable to detect these differences?