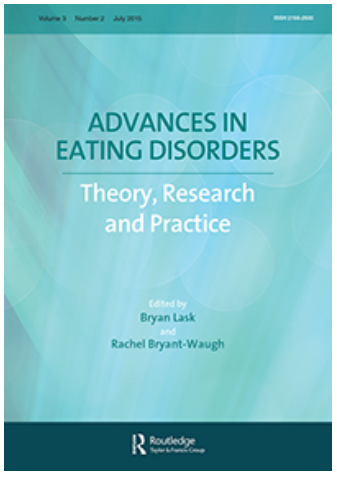

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What effective therapies have in common

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PERSONAL PERSPECTIVE

What effective therapies have in common

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In light of current debates about best practices in the eating disorders, at the 2013 *International Conference for Eating Disorders*, each speaker from the treatment plenary was asked to answer three questions: (i) How does the therapy in your trial engage and motivate patients? (ii) How does the therapy help patients develop skills and alternate ways of coping? and (iii) What are the boundaries and therapeutic expectations of the therapy? The treatments that were included in the plenary included Enhanced Cognitive Behaviour Therapy, the Maudsley Anorexia Nervosa Treatment for Adults, Specialist Supportive Clinical Management, Integrative Cognitive Affective Therapy and Internet-based therapies. Interestingly, there were far more similarities than differences across the treatment modalities. Practices that were common to all of the therapies included the use of a collaborative framework, the importance of psychoeducation, emotion regulation, examining relationships, identifying higher values and the use of behavioural experiments. The discussion also raised interesting points to consider regarding treatment non-responders such as flexibility vs. firmness of therapeutic boundaries and behavioural expectations. This paper recognises and celebrates the established common ingredients of effective treatments, while challenging us to ask more complex research questions.

Keywords: eating disorders treatment; best practices; engagement; therapeutic boundaries

> … what treatment by whom is most effective, for this individual, with those specific problems, and under what circumstances … (Arnold Lazarus)

Recently, Prof. Bob Palmer, former editor of the *European Eating Disorders Review*, wrote a thoughtful piece entitled 'Leftovers' (Palmer, 2013). In it, he drew an analogy between the leftovers at the end of a good meal and leftover questions he had about clinical research in the eating disorders (EDs). He noted that, despite significant increases in our knowledge as a result of 'big research' clinical trials, there are important remaining questions to address in 'little research' studies.

Palmer drew from his experience as co-investigator of the Oxford–Leicester Enhanced Cognitive Behaviour Therapy (CBT-E) clinical trial, in which significant pre-post treatment improvements in Eating Disorders Examination-Questionnaire (EDE-Q) scores were demonstrated and maintained at 60-week follow-up. In the context of the impressive overall results, he described three study participants, depicted below, whose EDE-Q recovery curves were not aligned with the overall group mean (Figure 1).

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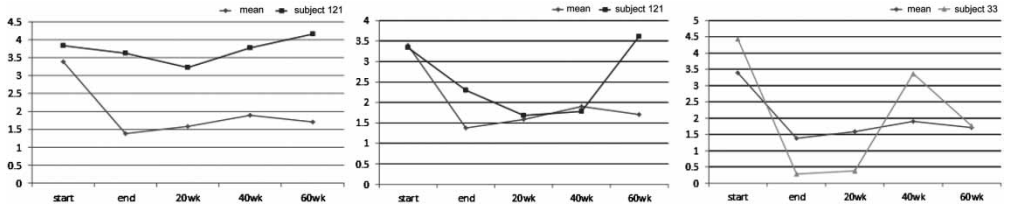

Figure 1. Three study participants as described in Palmer (2013).
Note: Reprinted with permission from *Advances in Eating Disorders: Theory, Research and Practice*.

In the first, the patient failed to engage in symptom change; in the second, a bumpy recovery path is depicted. In the third, after some initial improvement, symptoms returned to pre-treatment levels. Palmer asks, in light of current state-of-the-art treatments, how do we help patients like these? The purpose of this paper is to generate hypotheses for future research that address these questions by examining common ingredients in our current best treatments.

Method: key dimensions of effective treatment

At the 2013 *International Conference for Eating Disorders*, the task of the Discussant of the treatment plenary was to summarise common ingredients in our current most effective therapies. The treatments included CBT-E, the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), Specialist Supportive Clinical Management (SSCM), Integrative Cognitive Affective Therapy (I-CAT) and Internet-based therapies. In order to do this, each plenary speaker was asked to answer three questions regarding the treatment(s) they presented:

(1) How does the therapy engage and motivate patients?
(2) How does the therapy help patients develop skills and alternate ways of coping?
(3) What are the boundaries and therapeutic expectations of the therapy?

To broaden the scope of this discussion, and also include a well-known treatment for children and adolescents, the same three questions were asked of experts in Dialectical Behaviour Therapy (DBT) and Family-Based Therapy (FBT). It was hoped that the answers provided may help to address Palmer's query.

Engagement: how does the treatment engage and motivate patients?

Table 1 summarises responses to this question for each of the therapies. Consistent with research showing that both ED patients and care providers prefer a collaborative stance and consider it to be more acceptable and likely to retain patients (Geller et al., 2008), all of the treatments indicated the use of a collaborative and/or motivational interviewing (MI) approach, particularly at the beginning of treatment.

As indicated in Table 1, other methods for engaging patients were also noted. A significant feature of I-CAT, for instance, is its discussion of engagement and disengagement in the therapeutic relationship. Another noteworthy point is that though all treatments use a collaborative stance, some emphasised *firmness* and *patient commitment* (e.g. CBT-E, DBT) while others emphasised *flexibility* (e.g. MANTRA, I-CAT).

Table 1. How does the treatment engage and motivate patients?

	Collaborative framework	Other descriptors	Flexibility/firmness
CBT-E	√ Collaborative, decisional balance	• Active, empathic	• *Firm* if needed to make progress
MANTRA	√ Treatment focus negotiated collaboratively, client-centered, MI stance	• Focused, strategic	• *Flexible*, tailored to patient
SSCM	√ Patient-directed	• Warm, supportive, reassuring	
I-CAT	√ MI stance, patient tailored	• Discussion of dis/engagement within the relationship, emotional focus	• *Flexible* therapist modes
DBT	√ MI stance, collaborative		• *Commitment* secured *prior* to engaging in change
FBT	√ Collaborative partnership with parents	• Externalising the problem, increasing anxiety, creating a crisis	• *Firm* focus on child weight gain

Notes: The presence of a check mark indicates that the treatment addresses the theme in the column. A standard bullet indicates a feature that was not mentioned across all treatments.

The discussion of engagement raised a few additional points:

(1) *Engagement to action*. A well-known finding is that early behaviour change is a positive prognostic indicator (Fairburn, Agras, Walsh, Wilson, & Stice, 2009). What is less well understood is whether people who change their behaviour early in treatment are a distinct population, perhaps in terms of their pre-treatment symptom profile or readiness, whether a 'critical level' of engagement only occurs for some individuals, or whether some other explanation accounts for positive outcomes in only some patients. All treatments in this review used a collaborative MI stance to address engagement issues, particularly at the beginning of treatment. It may be useful to consider at what point it is most therapeutic to move from collaborative engagement interventions, in which behaviour change is typically not expected (e.g. decisional balance, exploring barriers to recovery), to action phase interventions (e.g. keeping thought and food records, working on weight gain), in which behaviour change is part of the therapeutic frame. A related question is whether there are consequences (e.g. drop-out or relapse) to moving into action too quickly and/or too slowly.

(2) *Treatment packaging*. Many of the therapies provided patients with a frame in which the treatment model and proposed mechanism for change were explicitly delineated (e.g. CBT-E, FBT). An additional question is the extent to which this treatment 'packaging', in which a clear and acceptable rationale is provided, is instrumental to engagement and/or subsequent behaviour change.

(3) *Patient commitment*. Finally, in some therapies (CBT, DBT and FBT), there is an explicit understanding or agreement during the engagement phase in which the client (or parents, in the case of FBT) is/are asked to commit to behaviour change. A final question is whether securing this verbal commitment is important and/or predictive of recovery.

Skills: How does the therapy help patients develop skills and alternate ways of coping?

Table 2 summarises the skills that patients or families learn. Once again, a number of common themes emerged. First, all of the therapies offered some form of education. Most provided information about proposed mechanisms for the development and maintenance of the ED and a rationale of how the

Table 2. Skills and alternate ways of coping: what will patients learn?

	Psycho-education	Emotion regulation	Relationships	Higher values
CBT-E	√ Core psychopathology and associated maintaining factors of disordered eating	√ Addressing mood intolerance	√ Addressing interpersonal difficulties	
MANTRA	√ Intra- and interpersonal maintaining factors of disordered eating	√ Understanding and utilising emotions in social contexts, self-compassion	√ Understanding and using emotions in social contexts, involving significant others in treatment	√ Exploring how AN affects life goals, encouraging flexible and bigger picture thinking
SSCM	√ Relearning healthy eating		√ Involving significant others in treatment	
I-CAT	√ Relations among emotions, life situations and ED behaviours	√ FEEL (focus, experience, examine, label), and SPA (self-protect, accept) skills	√ SAID (sensitively assert ideas and desires) skills	√ REAL (realistic expectations affect living) skills
DBT	√ Dialectical balance, mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness	√ Distress tolerance (crisis survival, self-soothing, improving the moment) and emotion regulation (reducing vulnerability) skills	√ Interpersonal effectiveness (objectiveness effectiveness)	√ Structuring and prioritising when multiple issues are present. Understanding dialectical balance
FBT	√ Need for parents to prioritise weight gain in their children	√ Providing family with skills to implement weight gain non-negotiables		

Note: The presence of a check mark indicates that the treatment addresses the theme in the column. AN, anorexia nervosa.

therapy brings about change. For instance, education in CBT-E focused on the core psychopathology and maintaining factors, and in I-CAT on relations among emotions, thoughts and behaviours. Nearly all therapies provided tools for working with affect. DBT and I-CAT were especially comprehensive in this area. For instance, DBT modules address distress tolerance and affect regulation. As relational issues can trigger ED behaviours, most therapies also provided assertiveness skills and addressed relationship difficulties. Interpersonal effectiveness was a focus of DBT and I-CAT and involving significant others in treatment was emphasised in MANTRA, SSCM and FBT. Finally, many of the therapies addressed higher values, with MANTRA placing emphasis on helping the individual focus on bigger picture thinking.

Once again, the overall finding in this review was that there were more similarities than differences, and agreement that recovery from an ED requires developing alternate coping strategies to ED symptoms across several domains.

Therapeutic expectations: What does the therapy require of patients?

Non-negotiable treatment elements were investigated and summarised in Table 3. A noteworthy point is that the treatments reviewed were not developed to treat the same ED diagnosis. That is,

Table 3. Therapeutic expectations: what are patients expected to do in treatment?

	Behavioural experiments	Timing/adherence expectations
CBT-E	√ Prescribed regular eating, behavioural experiments, weighing at each session	• Weight gain is *expected* from Week 5 onward (*0.5 kg per week*)
MANTRA	√ Behavioural experiments	
SSCM	√ Prescribed regular eating	
I-CAT	√ CARE (Calmly Arrange Regular Eating)	
DBT	√ Comprehensive skills manual with behaviour change expectations	• *Flexible collaborative stance* with respect to weight gain
FBT	√ Parents implement non-negotiables for their children	• Weight gain is *top priority* in Phase 1 of treatment, all other goals are secondary

Notes: The presence of a check mark indicates that the treatment addresses the theme in the column. A standard bullet indicates a feature that was not mentioned across all treatments.

CBT-E, MANTRA and SSCM were (in this case) being offered to individuals with AN. FBT has been most extensively investigated in an adolescent AN population, I-CAT was developed for bulimia nervosa and DBT (in this case) was being used with multi-diagnostic individuals with a chronic illness course. Despite differences in population, all the therapies had behaviour change expectations, in many cases involving prescribed regular eating (CBT-E, SSCM and I-CAT). In the case of FBT, parents have the responsibility of ensuring that their child gains weight. However, as shown in Table 3, there was variability in emphasis on a firm vs. flexible expectation with respect to weight gain, raising some interesting questions:

(1) *Firm vs. flexible*. The topic of behavioural expectations regarding weight gain or symptom cessation is one of the more controversial in the field. Possibly, the appropriateness of a firm vs. flexible approach depends upon factors such as illness severity, stage of therapy, developmental status, individual personality factors and/or treatment setting. What are the consequences of a mismatch between patient and care provider wishes (e.g. care provider is flexible when patient would benefit from a firm expectation or vice versa)? Conversely, what is known about the maintenance of change when the expectations are mandated by the treatment provider/programme vs. when they are developed collaboratively?

(2) *What are the consequences of lack of change?* Finally, what occurs when patients do not adhere to therapeutic expectations? In some treatments (CBT-E and FBT), a recommendation to end treatment may be made. In others, expectations may be renegotiated. What are the consequences of terminating vs. re-negotiating? Perhaps the answer to this question also depends upon factors such as illness severity, stage of therapy, developmental status, individual personality factors and/or treatment setting.

Palmer's leftovers

In the first scenario, the patient failed to engage in treatment. Hypotheses include the treatment packaging being insufficiently compelling or perhaps there was a mismatch between behavioural contingencies of treatment and patient readiness (e.g. patient unwilling to adhere to firm weight gain expectations). Empirical evidence suggests that across diagnoses and treatment settings, readiness predicts a wide range of clinical outcomes (Cassin, Ranson, Heng, Brar, & Wojtowicz, 2008; Geller, Drab-Hudson, Whisenhunt, & Srikameswaran, 2004; Steele, O'Shea, Murdock, & Wade, 2011; Wade, Frayne, Edwards, Robertson, & Gilchrist, 2009).

Future research focusing on effective treatment packaging, moving from engagement into action and securing patient/family commitment to change may improve patient engagement.

In the second scenario, the patient had a bumpy recovery path. Perhaps, this was a result of insufficient skills, or a lack of consolidation of skills to navigate life stressors. There is considerable evidence for this in the substance use literature and some links demonstrated between stressful life events and the return of symptoms in the EDs (Grilo et al., 2012; Sohlberg, 1990). Perhaps providing some patients whose recovery may otherwise have been bumpy with more time, support and practice using skills in a variety of life circumstances will help smooth their recovery path.

In the third scenario, the patient relapsed. Perhaps this was because change did not occur in the context of higher values, locus of control was external or weight gain occurred too rapidly. There is some evidence that in adults, changing for others (rather than self) predicts relapse (Geller et al., 2004). By ensuring that there is a good match between behavioural expectations and patients' higher values, we may be able to maximise internal locus of control and reduce the risk of relapse.

Integration

Our effective treatments have common ingredients. Within each, there may be merit to ensuring the best fit and match between patient and treatment offered. In homage to Palmer, a cooking metaphor seems apt. When learning to cook, we need to follow the recipe. That is, treatment manuals describe the necessary ingredients (e.g. engage, teach skills and have behavioural expectations) for successful patient outcomes. Ensuring that care providers receive the best training and supervision to successfully implement best-practice treatments is essential. More sophisticated cooks know the recipe, and mix and add ingredients according to their experience, which usually results in a better tasting dish. Likewise, as clinicians and scientists, perhaps we need to integrate our clinical expertise and knowledge of effective treatments to tailor ingredients to patients. This paper is meant to encourage us to recognise and celebrate the established common ingredients of effective treatments, while challenging us to ask more complex research questions.

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