

Utilization of Empirically Supported Psychotherapy Treatments for Individuals with Eating Disorders: A Survey of Psychologists

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Abstract: Objective: *The purpose of this study was to assess the primary methods used by psychotherapists in treating individuals with eating disorders and to determine the extent to which certain empirically supported psychotherapies (i.e., cognitive behavioral therapy [CBT] and interpersonal psychotherapy [IPT]) are used in clinical settings. Method:* Surveys developed for this study were sent to 500 psychologists randomly selected from a list of all licensed doctoral-level psychologists in an upper midwestern state. **Results:** *Despite the findings that CBT techniques were reported to be frequently used, most respondents identified something other than CBT or IPT as their primary theoretical approach. In addition, the majority of respondents indicated not having received training in the use of manual-based, empirically supported treatment approaches for working with individuals with eating disorders, although most reported a desire to obtain such training. Conclusions:* Although commonly referred to as the “treatments of choice” in research literature, manual-based, empirically supported approaches to working with individuals with eating disorders has not received adequate dissemination. © 2000 by John Wiley & Sons, Inc. *Int J Eat Disord* 27: 230–237, 2000.

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INTRODUCTION

Cognitive behavioral therapy (CBT) is commonly referred to as the first-line “treatment of choice” (e.g., Fairburn, Agras, & Wilson, 1992; Wilson, 1996; Wilson, Fairburn, & Agras, 1997) for individuals with bulimia nervosa. Such statements are based on the empirically demonstrated efficacy of CBT when delivered in standardized, manual-based form (Fairburn, 1981; Fairburn, Marcus, & Wilson, 1993; Mitchell et al., 1990, 1993) as a robust finding in the eating disorders comparative psychotherapy literature (Wilson, 1997). The use of CBT is often recommended for other types of eating disorders, such as anorexia nervosa (Garner, Vitousek, & Pike, 1997) and binge eating disorder (Marcus, 1997). Additional empirical support is accumulating for the efficacy of interpersonal psychotherapy (IPT; Klerman, Weissman, Rounsaville, & Cheveron, 1984) modified for the treatment of individuals with bulimia nervosa (Fairburn, 1993; Fairburn et al., 1995) and binge eating disorder (Wilfley et al., 1993).

The rationale for selecting therapeutic interventions based on empirical support has received increasing attention. For example, the Division 12 (Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures (1995; Chambless et al., 1996) published guidelines recommending that empirically supported treatments be adopted as part of the criteria for decision-making purposes such as determining third-party payment, approval of continuing education credits, and accreditation of graduate programs and internships. According to the Task Force, the use of treatment manuals, once referred to as a “small revolution” in psychotherapy research (Luborsky & DeRubeis, 1984), is one of the defining features of an empirically supported treatment. Yet almost two decades ago, Parloff (1979) stated that “there appears to be an inverse relationship between the frequency with which a treatment form is actually used by practitioners and the frequency with which that treatment has been studied” (p. 304). Indeed, research findings suggest that empirically supported therapies for a variety of disorders continue to be uncommonly employed in clinical practice outside of academic clinics (Barlow, 1994; Crow et al., 1999; Goisman et al., 1993; Miller et al., 1994; Mylan et al., 1996; Persons, 1997; Wilson, 1995).

This study investigated the types of psychotherapeutic modalities used by psychologists who conduct psychotherapy with individuals with eating disorders. Specifically, we sought to determine the extent to which manual-based, empirically supported psychotherapeutic interventions are used in clinical settings. We hypothesized that such treatments would be used by a minority of respondents, possibly due to lack of training in the application of manual-based, empirically supported treatments.

METHOD

A 16-item, one-page paper-and-pencil survey instrument designed for health care professionals was developed for this project. Initial items assessed demographic information about the respondents and number of years since receiving their most advanced degree. The next set of items assessed whether the respondent was currently practicing psychotherapy and the percentage of the respondent’s typical caseload that comprised individuals with an eating disorder (i.e., anorexia nervosa, bulimia nervosa, binge eating disorder). Those who reported that their clinical work did not involve psychotherapy and/or that their typical caseload did not include individuals with an eating disorder were informed

that they had completed the survey, instructed to return it using an enclosed postage-paid envelope, and thanked for their participation. Respondents who responded affirmatively to these questions were instructed to complete the rest of the survey.

The remaining items invited the respondents to report on their clinical work with an eating disorder population. They were asked to specify their primary theoretical approach, as well as the frequency with which they use various theoretical approaches and psychotherapeutic techniques with this population. They also were asked to indicate if they had received training (i.e., as part of coursework, clinical training, workshops, or self-education) in the use of any of the following empirically supported, manual-based psychotherapy interventions: CBT (Fairburn et al., 1993; Mitchell et al., 1990, 1993; other) or IPT (Klerman et al., 1984 [as modified by Fairburn]). In addition, items were included to assess whether respondents used such therapies, as well as reasons for using or not using them. The final items on the survey assessed respondents' interest in obtaining training in the use of empirically supported, manual-based psychotherapy for individuals with eating disorders and their willingness to be recontacted in the future to provide additional information about these topics.

A survey packet was mailed to 500 psychologists who were randomly selected from a list of all doctoral-level licensed psychologists ($N = 1,309$) obtained from the Board of Psychology in the state of Minnesota. The survey packet included a letter explaining the purpose of the survey; a copy of the survey; a preaddressed, postage-paid return envelope; and two preaddressed, postage-paid postcards (used for allowing respondents to provide recontact information separately from the survey data provided). Approximately 2 months after the initial survey mailing, a follow-up letter was sent. Participants were thanked for completing the survey and encouraged to return it if they had not yet done so. They also were advised to contact the study research coordinator if replacement forms were required.

RESULTS

Description of Sample

Eight of the 500 surveys were undeliverable because of inaccurate addresses. Completed surveys were received from 271 respondents comprising 125 women (46.1%) and 146 men (53.9%), yielding a 55% response rate. The mean number of years reported since receiving their most advance degree was 14.7 ($SD = 8.9$) years. One hundred respondents (36.9%) indicated that their typical caseload included individuals with an eating disorder and 84 of these indicated that their clinical work included psychotherapy; the mean percentage of eating disorder caseload was 11.0% ($SD = 19.8$) with a range of 1–100%. However, 24 respondents indicated that their typical psychotherapy caseload involved very few individuals with eating disorders (i.e., constituted less than 5%). The data presented below are based on the 60 respondents who reported that at least 5% of their typical psychotherapy caseload included individuals with eating disorders ($M = 14.5\%$; $SD = 22.5$; range = 5–100).

Therapeutic Approach and Techniques Used

In response to an item asking respondents to select the single primary approach that best describes their work with this population, the most commonly endorsed approach

was CBT (38.8%), followed by eclectic (28.3%), “other” (13.3%), family systems (10.0%), psychodynamic (5%), IPT (3.3%), and narrative (1.7%) (as shown in Table 1). When asked about the frequency with which various approaches were used, the majority of respondents (65.0%) reported using a CBT approach “always” (31.7%) or “often” (33.3%). The comparable percentages for the other techniques that were endorsed as “always” or “often” included family systems (46.7%), eclectic (42.0%), psychodynamic (23.4%), IPT (21.7%), “other” (8.4%), and narrative (6.7%). For those who indicated that CBT was their primary approach, a few of the respondents indicated that they “always” or “often” also used other approaches, including family systems (3.5%), eclectic (2.2%), IPT (<0.1%), psychodynamic (<0.1%), and other (<0.1%).

As depicted in Table 2, the CBT techniques that were most frequently reported as being used “always” or “often” include cognitive restructuring (71.7%), self-monitoring (68.4%), relapse prevention strategies (55.0%), and written homework assignments (50.0%). Respondents were less likely to report “always” or “often” using formal problem solving (46.6%), prescribing distracting activities (45.0%), and stimulus control techniques (36.7%).

The majority of respondents (70.0%) indicated that they use “empirically based psychotherapy techniques” in their clinical work with individuals with eating disorders. The most commonly endorsed primary reason provided for this course of action was support by research (35.7%), followed by consistency with theoretical orientation (31.7%), personal experiences of clinical effectiveness (23.8%), compatibility with own psychotherapeutic style (16.0%), and previous training in this approach (11.9%). The most commonly endorsed reason provided for not using empirically based psychotherapy techniques in their clinical work with individuals with eating disorders was lack of training in such approaches (62.5%), followed by uncertainty about how to obtain such training (23.1%), and inconsistency with one’s own psychotherapeutic style (23.1%).

Despite the frequent endorsement of the use of CBT among this sample of psychologists, the majority of respondents (78.3%) reported that they had not received training in the use of empirically supported, manual-based CBT for working with individuals with eating disorders. This was also found to be true for most (65.2%) of those who reported using CBT as their primary theoretical approach. Similarly, when asked about training using empirically supported, manual-based IPT for this population, 73.3% indicated a lack of training.

The majority of respondents indicated a desire to receive training in the use of empirically supported, manual-based psychotherapy for individuals with eating disorders using both CBT (73.3%) and IPT (78.3%). In addition, 83.3% of the respondents returned a postcard indicating that they would like to be notified if such a training opportunity becomes available.

Table 1. Percentage of psychologists ($n = 60$) reporting primary approach used, techniques frequently used, and training received and desired for various psychotherapeutic approaches

	CBT	IPT	Eclectic	Family	Psychod.	Narrative	Other
Primary approach used	38.8	3.3	28.3	10.0	5.0	1.7	13.3
Techniques frequently used	67.0	21.7	42.0	46.7	23.4	6.7	8.4
Training received	21.7	27.7	—	—	—	—	—
Training desired	73.3	78.3	—	—	—	—	—

Note: The sum of the percentages do not equal 100% in some cases due to multiple responses in different categories or missing data. CBT = cognitive behavioral therapy; IPT = interpersonal psycho therapy; Family = family systems; Psychod = psychodynamic.

Table 2. Percentage of psychologists ($n = 60$) indicating frequency with which they use various CBT techniques

CBT Techniques	Always	Often	Sometimes	Never
Self-monitoring	31.7	36.7	21.7	1.7
Written homework	18.3	31.7	33.3	10.0
Cognitive restructuring	35.0	36.7	21.7	1.7
Formal problem solving	13.3	33.3	40.0	3.3
Stimulus control techniques	10.0	26.7	30.0	16.7
Prescribing distracting activities	11.7	33.3	33.3	13.3
Relapse prevention strategies	23.3	31.7	28.3	5.0
Other techniques	0.0	1.7	1.7	5.0

Note: The sum of the percentages do not equal 100% in some cases due to missing data. CBT = cognitive behavioral therapy.

DISCUSSION

The results of this study indicate that CBT, the treatment that has received the most empirical support for treatment of individuals with an eating disorder, was endorsed as the primary approach employed by about one third of the psychologists surveyed who conduct psychotherapy with an eating disorder population. The findings that many psychologists used CBT techniques, but relatively few endorsed CBT as their primary approach, is consistent with increasing evidence that practicing psychotherapists rarely adhere to a single orientation (Norcross & Goldfried, 1992) and that the majority of practicing psychotherapists are eclectic or integrative (Garfield & Kurtz, 1974; Norcross, Prochaska, & Gallagher, 1989). This may indicate that certain aspects of interventions that have been empirically supported for working with an eating disorder population are being integrated into common clinical practice. However, it is noteworthy that the majority of respondents indicated never having received specific training in empirically supported, manual-based approaches to working with individuals with eating disorders. In fact, this was the case even for most respondents who indicated using CBT as their primary theoretical approach. These results were consistent for IPT, although less commonly used than CBT. It may be that some of the respondents had received CBT training not specifically focused on eating disorders, which was not directly assessed by this survey. Yet, lack of training was found to be the most commonly endorsed reason for not using empirically based approaches.

The data suggest that despite the accumulated empirical support for the use of CBT in treating individuals with eating disorders, few psychologists surveyed in this study have received specific training in such approaches, including exposure to the treatment manuals used in efficacy studies. These findings support the position that, within the field of eating disorders, the number of therapists skilled in the use of CBT based on empirically supported standardized methods remains small (Arnou, 1999; Wilson, 1995, 1998a). They also illustrate the need for improved transmission of knowledge of empirically supported treatments to clinicians. Indeed, the majority of psychologists surveyed indicated a desire to receive training in the use of manual-based, empirically supported treatments. This is consistent with previous findings that clinicians are interested in incorporating empirical findings in clinical practice (Beutler, Williams, Wakefield, & Entwistle, 1995), yet empirically supported treatments are underemphasized in psychology doctoral training programs and internships (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1994). Clinical researchers could further increase the likelihood that trainees will employ empirically supported approaches by assisting with the inclusion of exposure to training manuals in

academic curricula, internship training, and continuing professional education seminars. Additional research is warranted to determine the impediments for psychologists to receive such training.

Beutler et al. (1995) and Sobell (1996) suggest that lack of implementation of empirically supported interventions in clinical practice may be due to problems in communication. Researchers communicate findings in scientific journals in a manner that is perceived to be unappealing and of limited usefulness to the practitioner (Goldfried, & Wolfe, 1996; Hayes, 1998). In addition, clinicians may believe that their wisdom and experience are too often overlooked. Sobell (1996) draws the analogy to business, stating that "innovative companies get their best product ideas by listening to what their customers say. If scientists want to see their science translated into wide-scale practice, they too need to listen to customers - the practitioners" (p. 301). She provides specific suggestions for developing a working alliance between researchers and clinicians. For example, she recommends open communication that involves practitioners in the planning, development, and implementation of clinical trials; allows the intervention to be tailored to fit the needs of different community agencies and practitioners; provides ongoing clinical support by the research team; conducts infield training workshops; and makes relevant clinical materials readily available to practitioners and community agencies.

In addition to developing mechanisms to translate science into practice, it is important to increase the relevance of research to clinicians by incorporating their suggestions for improvement in revisions of the treatment manuals (Beutler et al., 1995; Wilson, 1998b; Arnow, 1999). Indeed, according to the Task Force (1995), "(t)he rift between practitioner and researcher can best be mended by discarding the notion of dissemination and thinking instead in terms of knowledge exchange...Clinicians... need to be treated as partners in the research enterprise if they are to value the ultimate findings" (p.11). In addition to developing "partnerships" with practitioners (Wilson, 1995), it is possible to make research more useful and relevant to practitioners by demonstrating clinical utility via effectiveness studies (Chambless & Hollon, 1998; Seligman, 1995; Seligman & Levant, 1998) and emphasizing clinical (in addition to statistical) significance (Chambless & Hollon, 1998).

Caution is warranted in generalizing the results of this study due to limitations of geographic location and the moderate (55%) response rate. Accuracy and richness of the data obtained may be limited by the use of self-report and brief survey questionnaire methods. Lack of specificity in the survey instrument regarding clientele age and type of eating disorder diagnosis presents a degree of ambiguity given the limited data available regarding efficacy of CBT in the treatment of eating disordered adolescents (Mitchell, Hoberman, Peterson, Mussell, & Pyle, 1996) and those with anorexia nervosa (Garner et al., 1997). Items on the survey tended to focus on techniques versus general psychotherapeutic processes (e.g., empathy, alliance). In addition, it is possible that responses (e.g., use of CBT techniques) may have been biased due to demand characteristics.

The results of this survey highlight a nagging concern that significant efforts devoted to psychotherapy research have been translated into the actual practice of psychotherapy to a limited extent (Goldfried & Wolfe, 1996). There is little data to determine whether manualized treatments maintain efficacy or produce results that exceed treatment as usual (Addis, 1997) when applied in a clinical setting outside of controlled research parameters. This is an important point: "nonvalidated" does not necessarily equate with "ineffective" (Kazdin, 1996; Hollon, 1996) and it is possible that untested strategies in clinical practice would fare well if empirically tested (Chambless & Hollon, 1998).

Relatively little is known about the decision-making processes used by psychologists "in the trenches" in selecting and obtaining training in various treatment interventions. It

may prove beneficial for eating disorder researchers to further contemplate this issue. Our group is investigating further the responses of therapists who specialize in treating individuals with eating disorders regarding their choice of treatment selection and the possible “friction between technical proficiency and meaningful encounter” (Lambert, 1998, p. 392). Information obtained from those who have supervised experience in using empirically supported approaches may be of particular relevance in elucidating issues related to use of such approaches. It is important to consider potential implications of promoting empirically supported treatments (e.g., restriction of practice) with regard to issues of ethics, reimbursement, and training (Silverman, 1996; Kendall, 1998). The extent to which specifically following a manualized approach promotes favorable outcome in treatment of individuals with eating disorders remains an empirical question (Wilson, 1998a). Considerable effort has been devoted to developing and empirically testing manual-based treatments for individuals with eating disorders. In order to make a meaningful impact on service delivery, dissemination efforts are clearly needed. It is incumbent on eating disorders researchers to promote the availability of such training. Such endeavors may prove to be most fruitful if, in the process, bidirectional exchange of knowledge is emphasized.

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