

## Eating disorder psychotherapy research – beyond the brand: Introduction to a Special Section

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### Abstract

Psychological interventions and research for eating disorders tend to be complex, and outcomes on average are modest. Given the frequency and severity of eating disorders, these levels of outcomes are disconcerting. Adding to the current state of research is evidence that practicing clinicians do not tend to use evidence-based psychotherapies consistently for eating disorders. This is a problem not only of dissemination and uptake of research, but also one of knowledge translation. More practice-based research, in which clinicians are equal partners in developing interventions and designing research, may be necessary in order to solve the problems of modest outcomes and low research uptake. The psychotherapy research of eating disorders in this special section presents examples of research that takes place in real-world clinical contexts with complex patients and that can be more easily translated into clinical practice.

**Keywords:** eating disorders

One of the things that can be said about the psychological treatment of eating disorders is that it is complex and challenging, and that outcomes tend to be modest. Some meta-analyses and reviews suggest that at best 40% of those who complete treatment for bulimia nervosa (BN) recover at the end of treatment (e.g., Thompson-Brenner, Glass, & Westen, 2003). More recent meta-analyses that used up-to-date statistical approaches, focused on well controlled studies, took a transdiagnostic perspective, and used multiple indicators of outcomes suggest that the average weighted effect size in favor of eating disorder psychological treatment versus control conditions is statistically significant but small ( $d = .33$ ) (Hubbard, 2013). Such outcomes are at or below the low end of the 40%–60% range of average recovery rates for psychotherapy patients in general (Lambert, 2013). These average treatment outcome findings for eating disorders are disconcerting given the seriousness and prevalence of the eating disorders.

Anorexia nervosa (AN), for example, affects 0.9% of women (Smink, van Hoeken, & Hoek, 2012), and has the highest mortality rate of any psychiatric disorder (Arcelus, Mitchell, Wales, & Nielsen, 2011). The lifetime prevalence for BN, based on

both US (Hudson, Hiripi, Pope, & Kessler, 2007) and European (Preti et al., 2009) large-scale studies, is .9% to 1.5% among women. Although AN and BN are the two specified eating disorders according to the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (APA, 2000) the most common eating disorder diagnosis amongst those seeking treatment falls in the category “eating disorder not otherwise specified” (EDNOS) (Rockert, Kaplan, & Olmstead, 2007). The point prevalence of EDNOS in a nation-wide community sample of young women was 2.4% (Machado, Machado, Gonçalves, & Hoek, 2007), and the prevalence of binge eating disorder (BED) is estimated at 3.5% in community samples (Hudson et al., 2007). Proposed changes in DSM diagnostic criteria will alter the diagnostic categories and their frequencies as well (e.g., Machado, Gonçalves, & Hoek, 2013). Eating disorders are also characterized by high levels of psychiatric comorbidity, such as depression and anxiety, and eating disorders have a complex association with trauma (Tasca et al., in press), substance abuse (Harrop & Marlatt, 2010), and also serious medical complications (Mitchell & Crow, 2006).

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To add to the current and complex state of research and practice in treating individuals with eating disorders is the apparent finding that clinicians do not readily incorporate evidence-based treatments into their everyday practices. A paper in this special section by von Ranson, Wallace, and Stevenson (2013) reaffirms that community clinicians infrequently use evidence-based psychotherapy when treating their patients with eating disorders. Such a finding is not specific to the eating disorders, and mirrors what occurs in other areas of psychotherapy research and practice (e.g., Cook, Schnurr, Biyanova, & Coyne, 2009). In fact, the gap between research and practice occurs in many areas of health care, including cardiac care, family medicine, and infectious diseases, among others (Westfall, Mold, & Fagnan, 2007). Is this simply a problem of dissemination by researchers and of uptake by clinicians, so that clinicians should learn the evidence and then practice accordingly? We argue that the problem is not entirely about dissemination and uptake, but also one of knowledge translation (Strauss, Tetroe, & Graham, 2009). By knowledge translation we mean a sustained exchange between practicing clinicians and researchers on what is important to research, how to conduct meaningful and clinically applicable research, and how to go about translating the research into clinical practice. There are at least two barriers to knowledge translation of eating disorders psychotherapy research and practice.

First, clinicians may perceive that randomized controlled trials (RCTs) of psychotherapies are not representative of their clinical practice or relevant to the clients with eating disorders whom they treat. Surveys indicate that practicing clinicians have tended not to embrace the list of evidence-based psychotherapies (EBP) or incorporate treatment manuals into their daily clinical practice with patients with eating disorders (e.g., Tobin, Banker, Weiseberg, & Bowers, 2007; von Ranson & Robinson, 2006). One concern among practicing clinicians may be that while EBPs are based on highly internally valid studies, these findings may not generalize to the more diverse and heterogeneous real-world populations that clinicians indicate that they treat (Westen, Novotny, & Thompson-Brenner, 2004). As a result, researchers may express concern about psychotherapy practitioners paying little heed to research findings (von Ranson & Robinson, 2006), and practitioners may counter that eating disorder psychotherapy research is not always relevant to real-world practice (Tobin et al., 2007; Westen, et al., 2004).

A second related barrier to implementing psychotherapy research is a lack of communication

between clinicians and researchers, thus resulting in a translational gap between clinical trials and clinical practice. Community-based clinicians may feel disconnected from research that is designed and implemented in health science centers (Beutler, Williams, Wakefield, & Entwistle, 1995). On the other hand, researchers may place a lower premium on information gleaned from clinicians, and may not readily use this information to inform their research (Beutler, et al., 1995). Despite this, there is now a small but growing group of psychotherapy researchers who are designing research protocols based almost exclusively on clinician input (Castonguay, Barkham, Lutz, & McAleavey, 2013).

We are pleased that many of the eating disorder studies in this special section of *Psychotherapy Research* are examples of practice-based research, and research on client variables that may lead to improved psychotherapy processes and outcomes. Many of these studies are excellent examples of what can be learned about eating disorder treatment by engaging clinicians in research within their practice settings.

The study by Kelly and colleagues (Kelly, Carter, Zuroff, & Borairi, 2013) investigated relatively new patient variables, self-compassion and fear of self-compassion, as predictors of treatment outcomes in a transdiagnostic eating disorder sample admitted to an intensive day hospital or inpatient treatment program. The participants had moderate to severe symptoms. Self-compassion and fear of self-compassion are thought to reduce an individual's ability to overcome shame related to eating disorder psychopathology. The authors found that the combination of low self-compassion and high fear of self-compassion was associated with poorer treatment outcomes. The results suggest that clinicians may do well to assess for these patient variables and to focus aspects of their treatment on self-compassion to improve outcomes among their clients with eating disorders.

In the second paper, Obeid and colleagues (Obeid et al., 2013) conduct the first study to look at the trajectories of eating disorder maintenance factors from pre-treatment to 1-year follow-up. Participants were a transdiagnostic sample of 275 adolescents with moderate to severe symptoms receiving interventions at specialized intensive eating disorder programs. The authors asked if factors thought to maintain an eating disorder (i.e., low self-esteem, perfectionism, mood intolerance, interpersonal problems) change over the course of intensive treatment and beyond, and if refractory status (i.e., returning for further treatment) was associated with these changes. They found that as a group, the maintenance factors became worse at the outset of

treatment but improved by post-treatment. However, on average there was a rebound at 1-year follow-up indicating some worsening of the maintenance factors. Sustaining change in adolescents with eating disorders receiving intensive treatment may involve developing and testing interventions that specifically target the factors that maintain eating disorder symptoms.

The paper by Olmsted and colleagues (Olmsted, McFarlane, Trottier, & Rockert, 2013) continues the theme of evaluating intensive treatments by practice-oriented research in naturalistic settings. Using data from 801 patients collected over a period of 24 years, Olmsted and colleagues assessed whether providing intensive day treatment in a 4 day a week versus a 5 day a week format is most effective. Using a quasi-equivalence ABA design, the authors assessed the impact on outcomes of changing the program from being offered 5 days a week (A: from 1985 to 1994) to 4 days a week (B: from 1995 to 1999) back to 5 days a week (A: from 2000 to 2009). Providing day treatment 5 days versus 4 days a week resulted in greater abstinence in terms of bingeing and vomiting (49% versus 26%, respectively), and better outcomes regarding depression and body dissatisfaction. There was no advantage, however, in terms of weight restoration. Although offering lower-intensity day treatment (i.e., 4 days per week) is less expensive, the authors concluded that nearly doubling abstinence from bingeing and purging justifies the added cost of a 5 day a week program.

Providing patient progress feedback to therapists is receiving a great deal of attention in the clinical and research literature (Lambert & Shimokawa, 2011), and yet its use in eating disorder treatment and in inpatient treatment has been non-existent until now. The study by Simon and colleagues (Simon et al., 2013) of a transdiagnostic sample of 133 women with an eating disorder was conducted in an inpatient treatment unit. Patients were assigned to treatment as usual or to an experimental condition in which their therapists received patient progress feedback using the Outcome Questionnaire-45 (OQ-45; Lambert et al., 2004). Patients in the therapist feedback condition compared to the no-feedback condition experienced significantly improved mental health functioning. The size of the effects was large from pre to post treatment for the feedback condition. However, eating disorder outcomes did not differ between conditions. The results are consistent with previous research on providing regular progress feedback to therapists (Lambert & Shimokawa, 2011), and suggest the possible utility of doing so within an eating disorder inpatient program.

Tasca and colleagues (Tasca et al., 2013) tackle the tricky issue of matching patients with BED to

treatment based on their level of attachment anxiety. In previous research these authors found that those with high attachment anxiety had better treatment outcomes in terms of binge eating if they received Group Psychodynamic Interpersonal Psychotherapy (GPIP; Tasca, Mikail, & Hewitt, 2005; Tasca et al., 2006). In the current study, they created outpatient therapy groups that were homogeneously composed of those with high or low attachment anxiety. Matching to homogeneous treatment groups based on level of attachment anxiety did not result in better outcomes for women with BED. However, women with BED and higher attachment anxiety appeared to require their group's level of cohesion to increase across treatment sessions in order for them to achieve better outcomes. In other words, clinicians may improve outpatient group treatment outcomes for women with BED and high attachment anxiety by specifically working to develop and grow the group's cohesion throughout the course of treatment.

Treatment studies of AN are relatively infrequent despite AN being associated with significant comorbidity and mortality (APA, 2000). Those with AN are also very reluctant to enter into treatment and to participate in research trials (Tasca et al., 2012). Calugi and colleagues (Calugi, Dalle Grave, & Marchesini, 2013) looked at a sample of 95 severely underweight patients who were offered inpatient treatment that included a modified version of enhanced cognitive behavioral therapy (CBT-E; Fairburn, 2008). Patients were classified as having a long-standing eating disorder ( $\geq 10$  years;  $n = 37$ ) or an eating disorder of shorter duration ( $n = 58$ ). At pre-treatment those with a long-standing eating disorder had significantly higher age and BMI, and greater purging symptoms. There were no differences on personality traits. At post treatment, participants were classified as having a good treatment outcome (i.e., body mass index (BMI)  $> 18.5$ ; 53.7%) or a poor treatment outcome (i.e., BMI  $< 18.5$ ; 46.3%). Treatment outcomes and drop out rates were not different between short- and long-duration eating disorders. The authors suggest that CBT-E may be an effective treatment within an inpatient program for underweight AN, including those with long-standing eating disorders.

In the last of the treatment-focused papers in this special issue, Vaz and colleagues (Vaz, Conceição, & Machado, 2013) tested a guided self-help intervention based on a CBT model for BN and BED. Self-help interventions demonstrate some promise in providing low-intensity, cost-effective, and easy to administer treatments. This mode of intervention may be particularly useful in primary care settings prior to referring to expensive specialist eating

disorder treatment. In this one-group repeated measurement naturalistic trial that focused on clinically significant outcomes, between 8% and 30% of patients were classified as “recovered” on a range of outcomes at 6 months following guided self-help. Binge eating symptoms significantly reduced from pre-treatment to 6 months follow-up. The study demonstrates that there may be a subgroup of individuals who have clinically elevated binge eating who might benefit from low-intensity treatment.

As we described above, von Ranson and colleagues (von Ranson et al., 2013) reported that community-based clinicians who treat eating disorders often do not exclusively follow evidence-based methods. Even those who reported that they used CBT interventions may infrequently used CBT techniques (see also Tobin et al., 2007). It is tempting to conclude that community-based practitioners who treat eating disorders are not doing what they should be doing. However, there may be another possible narrative—i.e., perhaps some of the research generated from RCTs may not speak to realities of everyday practice. Here we return to the notion of knowledge translation. Practicing clinicians are probably not passive consumers waiting for dissemination of research from the health science centers. Community-based clinicians may be actively deciding what they believe works within their practice contexts. One could argue that these decisions could be flawed, but nevertheless they are taking place. Evidence from RCTs and current modes of disseminating this evidence are apparently not persuasive for community-based clinicians. Further, given the modest outcomes found on average in treatment trials for eating disorder (Hubbard, 2013; Thompson-Brenner et al., 2003), and the burden of these disorders on patients and families, treatment researchers may need to consider alternate strategies for developing, researching, and translating interventions.

We believe that it is time for eating disorder psychotherapy researchers and clinicians to assume their share of responsibility for the current research practice gap, and for researchers in particular to move beyond only disseminating their research in academic journals to engaging clinicians in knowledge translation. Academic health science eating disorder treatment researchers can: (a) incorporate clinicians within their research teams at the initial stages during which interventions are developed and study design is discussed; (b) develop and research interventions that clinicians can flexibly apply in real-world contexts, and then study the impact of the flexible application of these interventions; (c) engage in intervention studies within clinical practices with patients who have complex comorbidities; (d) foster collaborations to conduct practice-based research in

clinical practices and in which clinicians are equal partners (see (a) above); and (e) find ways to provide financial, academic, and other incentives for clinicians to participate in practice-based research programs. Some of this may already be occurring as evidenced by the research presented in this special section. Further, journal editors and reviewers of eating disorder treatment research should place a premium on effectiveness research conducted in clinical practices with complex patients. None of these ideas are particularly new or original, and their time has come (see Castonguay et al., 2013, for a review).

Practice-based research may be one alternative to improve treatment outcomes for eating disorders and to improve knowledge translation of the findings into community practice (Castonguay et al., 2013). Many of the studies in this special section took place in busy clinical contexts, with moderately to severely ill patients, who for the most part received interventions as they occurred in everyday practice. Local clinicians were probably involved in conceptualizing, designing, and implementing the interventions and/or research. And it is very likely that the practices of these local clinicians have changed because of the findings that they helped to generate *and* because of their involvement in the research (Castonguay et al., 2010). The studies in this special section are focused not so much on the brand of therapy being offered, but on the patient, the context of treatment, and the process of therapy. The end result is a group of studies that we feel have immediate practice implications for clinicians who treat individuals with eating disorders in inpatient, day treatment, outpatient, and primary care settings.

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