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The Evolution of "Enhanced" Cognitive Behavior Therapy for Eating Disorders: Learning From Treatment Nonresponse

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In recent years there has been widespread acceptance that cognitive behavior therapy (CBT) is the treatment of choice for bulimia nervosa. The cognitive behavioral treatment of bulimia nervosa (CBT-BN) was first described in 1981. Over the past decades the theory and treatment have evolved in response to a variety of challenges. The treatment has been adapted to make it suitable for all forms of eating disorder—thereby making it "transdiagnostic" in its scope— and treatment procedures have been refined to improve outcome. The new version of the treatment, termed enhanced CBT (CBT-E) also addresses psychopathological processes "external" to the eating disorder, which, in certain subgroups of patients, interact with the disorder itself. In this paper we discuss how the development of this broader theory and treatment arose from focusing on those patients who did not respond well to earlier versions of the treatment.

In recent years there has been widespread acceptance that cognitive behavior therapy (CBT) is the treatment of choice for bulimia nervosa (National Institute for Health and Clinical Excellence, 2004; Wilson, Grilo, & Vitousek, 2007; Shapiro et al., 2007). The cognitive behavioral treatment of bulimia nervosa (CBT-BN) was first described in 1981 (Fairburn, 1981). Several years later, Fairburn (1985) described further procedural details along with a more complete exposition of the theory upon which the treatment was based (Fairburn, Cooper, & Cooper, 1986). This theory has since been extensively studied and the treatment derived from it, CBT-BN (Fairburn, Marcus, & Wilson, 1993), has been tested in a series of treatment trials (e.g., Agras, Crow, et al., 2000; Agras, Walsh, et al., 2000; Fairburn, Jones, et al., 1993). A detailed treatment manual was published in 1993 (Fairburn, Jones, et al., 1993). In 1997 a supplement to the manual was published (Wilson, Fairburn, & Agras, 1997) and the theory was elaborated in the same year (Fairburn, 1997a).

CBT-BN has evolved over the past decade in response to a variety of challenges: Its procedures have been refined, particularly those addressing patients' overevaluation of shape and weight, and it has been adapted to make it suitable for all forms of eating disorder, thereby making it "transdiagnostic" in its scope (see Fairburn, 2008; Fairburn, Cooper, & Shafran, 2003). The new version of the treatment, termed *enhanced CBT* (CBT-E), also addresses psychopathological processes "external" to the eating disorder, which, in certain subgroups of patients, interact with the disorder itself. In this paper we discuss how the development of this broader theory and treatment arose from focusing on those patients who did not respond well to earlier versions of the treatment.

The Cognitive Behavioral Theory of Bulimia Nervosa

According to the cognitive behavioral theory of bulimia nervosa, central to the maintenance of the disorder is the patient's overevaluation of shape and weight, the so-called "core psychopathology" (see Fig. 1, which shows in schematic form the core eating disorder maintaining mechanisms). Most other features can be understood as stemming directly from this psychopathology, including the dietary restraint and restriction, the other forms of weight-control behavior, the various forms of body checking and avoidance, and the preoccupation with thoughts about shape, weight, and eating (see Fairburn, 2008).

The only feature of bulimia nervosa that is not obviously a direct expression of the core psychopathology is binge eating. The cognitive behavioral theory proposes that binge eating is largely a product of a form of dietary restraint (attempts to restrict eating), which may or may not be accompanied by dietary restriction (actual undereating). Rather than adopting general guidelines about how they should eat, patients try to adhere to multiple demanding, and highly specific, dietary rules and tend to react in an extreme and negative fashion to the (almost inevitable) breaking of these rules. Even minor dietary slips are viewed as evidence of lack of self-control. Patients

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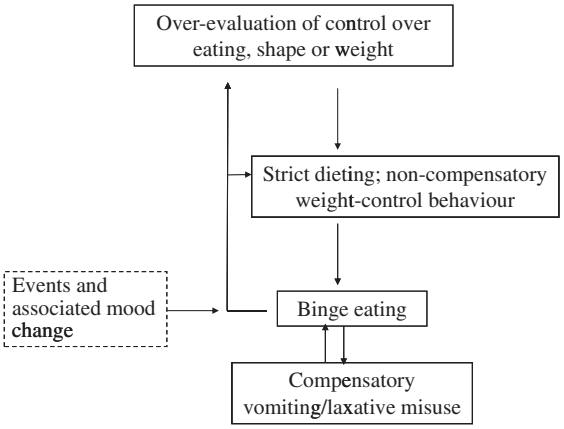

Figure 1. A schematic representation of the cognitive behavioral theory of the maintenance of bulimia nervosa (modified from Fairburn, Cooper, & Shafran, 2003).

respond to such rule-breaking by temporarily abandoning their dietary restraint, thus succumbing to the urge to eat that arises from the restraint (and any accompanying dietary restriction), the result being a short-lived period of uncontrolled eating (i.e., an episode of subjective or objective binge eating). This produces the distinctive pattern of eating that characterizes bulimia nervosa in which attempts to restrict eating are interrupted by repeated episodes of binge eating. The binge eating in turn maintains the core psychopathology by intensifying patients' concerns about their ability to control their eating, shape, and weight. It also encourages yet greater dietary restraint, thereby increasing the risk of further binge eating. Patients' dietary slips and binges are particularly prone to occur in response to adverse day-to-day events and negative moods, in part because it is difficult to maintain dietary restraint under such circumstances and in part because binge eating both temporarily ameliorates negative mood states and it distracts patients from thinking about their difficulties.

A further process maintains binge eating among those who practice compensatory purging (i.e., those who induce vomiting or take laxatives in response to specific episodes of binge eating). Patients' belief that purging will minimize weight gain results in the undermining of a major deterrent to binge eating. They do not realize that vomiting only retrieves part of what has been eaten, and laxatives have little or no effect on energy absorption (see Fairburn, 1995).

This cognitive behavioral theory is supported by a variety of lines of evidence (for details, see Fairburn et al., 2003) and it has clear implications for treatment. It suggests that if treatment is to have a lasting impact on binge eating and purging, the one aspect of the disorder that most patients want to change, it also needs to address extreme dieting, overevaluation of shape and weight, and any tendency for a patient's eating to change in response to adverse events and negative moods.

CBT of Bulimia Nervosa

CBT for bulimia nervosa is designed to address each of the maintaining processes outlined in the cognitive behavioral theory above. The treatment is outpatient-based and, as evaluated in treatment trials, involves 15 to 20 sessions over approximately 5 months. A range of cognitive behavioral procedures are used with the cornerstone being a specific sequence of cognitive behavioral tasks and "experiments" set within the context of a personalised version of the cognitive behavioral theory of maintenance.

As noted there is a substantial body of evidence supporting CBT-BN, and the findings indicate that CBT-BN is the leading treatment. However, at best, half the patients who start treatment make a full and lasting response. Between 30% and 50% of patients cease binge eating and purging, and a further proportion show some improvement while others drop out of treatment or fail to respond (Wilson & Fairburn, 2007). These findings led us to ask the question, "Why aren't more people getting better?" (Fairburn et al., 2003).

Why Aren't More People Getting Better?

We examined various explanations (for a detailed discussion of these see Fairburn et al., 2003) for why there has not been a greater response to CBT-BN and, on the basis of our clinical experience, concluded that the cognitive behavioral theory needed to be extended to embrace four additional maintaining mechanisms that, in certain subgroups of patients, contribute to the maintenance of the eating disorder: clinical perfectionism, mood intolerance, low self-esteem, and interpersonal difficulties. We provide two case illustrations of patients treated using the focused form of the intervention (see Table 1 for an outline of treatment) that highlight how failure to address these additional mechanisms might account for treatment nonresponse. This is followed by a brief description of the revised theory and the evidence that supports it.

Two Case Illustrations[1]

Patient A

Patient A was a 27-year-old woman referred by her primary care physician for the treatment of an eating disorder. Initial assessment indicated that she was suffering from an eating disorder that met *DSM-IV* (American Psychiatric Association, 1994) diagnostic criteria for bulimia nervosa. She had been dissatisfied with her weight since adolescence and began dieting to

[1] Details about the cases have been modified to protect the identity of the clients.