Questions and Answers on CBT-E for Adolescents

Riccardo Dalle Grave, MD & Rebecca Murphy, DClinPsych

We have written responses to some of the additional questions which followed the AED webinar on CBT-E for adolescents below

Training and Other resources

- Please can we have details of online training and the CBT-E website?

https://www.cbte.co

https://www.cbte.co/for-professionals/training-in-cbt-e/

After the main "course" there are supplementary modules which can be requested and these include working with adolescent patients.

The book "Cognitive Behaviour Therapy for Adolescents with Eating Disorders" will provide comprehensive practical guidance.

https://www.cbte.co/for-professionals/the-cbt-e-manuals/

Ambivalence & Engagement

- What strategies might you use to engage an ambivalent adolescent?
- Would you please elaborate on how you would engage young patients in treatment if they are ambivalent towards weight gain/ addressing their dietary restraint?

This topic is covered in the book "Cognitive Behaviour Therapy for Adolescents with Eating Disorders" (see especially chapter 9 "Deciding to Change"). Ambivalence is an expected characteristic of someone with an eating disorder, particularly those who are underweight. It tends to be especially prevalent in adolescents as the negative effects of having an eating disorder may be less apparent. Fortunately, CBT-E is especially well suited to addressing ambivalence since helping patients decide to change is a crucial phase in treatment in many cases. The goal in CBT-E is that patients make the decision to regain weight themselves and that this decision is not imposed on them. Several sessions are dedicated to a detailed discussion of the pros and cons of stage, taking the vantage point of "the present" and "the future". For many adolescents it is important to look beyond the current situation and consider the consequences of a continued eating disorder mindset and behaviour on the immediate future and on how they would like their lives to be. The therapist helps the patient to take an inquiring approach to fully considering all the pros and cons, and where necessary helps the patient to consider matters that they may not have considered. It is explained that it is not possible to pick and choose aspects of the eating disorder to keep and those to give up. Instead CBT-E takes the stance that in order to become well and stay well that all aspects of what is keeping the eating disorder going must be addressed.

Outcomes

- How long does it take to become a healthy person with CBT? Approximately?

At the end of CBT-E (around 6 months) most people with eating disorders will have recovered i.e. will no longer meet criteria for an eating disorder and will be within the normal range on key features of an eating problem. However, we usually explain that it is important for patients to keep working hard on staying well for at least 20 weeks after treatment ends. After this the eating disorder can be like an achilles heel and the patient should be mindful of possible lapses.

- Has inpatient CBT E for adolescents had an impact on duration of admission, the need for NG feeding or relapse rates?

Intensive CBT-E, as it has been tested in clinical studies, is delivered in 20 weeks (13 weeks of inpatient followed by 7 weeks of day-hospital). CBT-E is a collaborative treatment and never uses NG feeding or other form of coercive procedures. The body weight at inpatient CBT-E discharge is the most important predictor 12-month outcome.

- At the post-treatment review sessions, how often in clinical practice do you find you need to add more treatment sessions, for example, if the patient is showing signs of relapse?

In around 5-10% of cases a small number of CBT-E booster or maintenance sessions are required.

Other Team members

- When you treat your patient with CBT, can be a dietitian helpful about healing process? how can they be helpful?

Dietitians trained in CBT-E can be involved with very underweight patients and in the intensive versions of CBT-E to help the patient in the process of weight restoration, or in patients with celiac disease, type 1 diabetes and other medical conditions requiring specific dietary recommendations.

Target Weight

- You mentioned physical health. How do you decide on a target weight for patients who were overweight with atypical AN?

We use the same strategies adopted once the underweight patients reach the minimum BMI threshold (i.e., a BMI percentile corresponding to an adult BMI of 19). We collaboratively involve the patients in reaching a range of body weight of about 3 kg that satisfy the following two conditions: (1) it can be maintained without adopting extreme weight control behaviours; (2) it is not associated with physical and psychosocial impairment.

Involving families

This topic is covered throughout the book "Cognitive Behaviour Therapy for Adolescents with Eating Disorders"

- How might you approach a family where there is significant hostility?

This may be best addressing during the "joint sessions" with the patient and family members. CBT-E takes the view that families can be helpful in the implementation of CBT-E and does not blame families for the development or maintenance of an eating disorder. We would enquire about the reasons for any apparent hostility. Sometimes it is an understandable reaction to an unhelpful view about the eating disorder. Once the CBT-E

view of what is keeping the eating disorder is shared, and questions about it invited, then this may help to reduce hostility.

- I wondered, if through your research, the amount of parental involvement in CBT-E had an impact on outcomes? (i.e. if the adolescent was open to having parents help with meals, did that lead to better outcomes in your studies?)

Unfortunately, we have no data to answer at this important clinical question.

- What do you do when parents disagree on the treatment procedure or do not cooperate?

Wherever possible we would try to get parents "on board" with treatment by sharing the rationale and having an open discussion about any concerns. This can happen during one of the regular "joint sessions". In rare cases it may not be possible to come to a shared understanding. In this case it may still be possible for treatment to continue by empowering the young person to take as much control as possible in recovery and using a CBT-E approach. This is likely to be easier with older adolescents.

Other approaches

Please see paper below for a discussion of CBT-E versus FBT:
Dalle Grave, R., Eckhardt, S., Calugi, S., & Le Grange, D. (2019). A conceptual comparison of family-based treatment and enhanced cognitive behavior therapy in the treatment of adolescents with eating disorders. *Journal of Eating Disorders, 7*(1), 42. doi:10.1186/s40337-019-0275-x Full Text

- If a patient is unable to accept a formulation of an eating disorder, would FBT then be more appropriate?
- What do you think about combining FBT with CBT? Doing FBT at the beginning to regain the weight and CBT later to deal with cognitions?
- Can you give more details on the involvement of parents and how to preserve the adolescent's autonomy in the treatment?
- One of the aspects discussed was about externalising and not as differences between FBT and CBTE. It is helpful to have some more elaboration for the same please

A crucial part of CBT-E is a shared and agreed understanding of what is keeping the eating disorder going. In most cases it is possible to achieve this. If CBT-E is not possible other approaches should be considered. In many cases (e.g. in the UK) CBT-E is a second line treatment after FBT has been considered. FBT and CBT-E have an entirely different understanding of the eating disorder and as such cannot be combined. However, if one approach is not successful then the other may be used. This may be best achieved with a break in between these two approaches and the transition needs to be carefully addressed with all parties clear on the change in treatment approach and new roles.

- Is there a problem with cognitive restructuring when patient is very emaciated and have serious difficulties with psycho-rigidity and central coherence?

The main strategy of CBT-E to bring about cognitive change is asking patients to make gradual behavioural changes and analyse their effects and implications on their way of

thinking. This strategy often still works in very emaciated patients and where thinking is rigid.

- How CBT-E works with internalization of sociocultural attitudes towards appearance such as internalization low body fat, pressure from peer & significant others and media? Is there any resource or published paper that you can recommend?

The body image module describes several strategies and procedures to address comparison checking with peers and media. In our clinical experience this procedure is very effective in reducing the preoccupation about shape

- You have used the term junk food, is the term "junk food" ok to use with ED patients, considering their black and white thinking?

We don't use this term with patients. The treatment helps the patients to address the extreme and rigid dietary rules to develop a healthy and flexible eating pattern. This includes eating, in moderation, the foods typically avoided by patients with eating disorders. Language is very important in CBT-E and it is unhelpful to apply all-or-nothing terms to food (no food is considered inherently "bad" or "unhealthy" and individual have differing health needs).

- I am interested in eating disorders in adolescents with severe obesity. Include binge, emotional eating, and body image concerns. Can we apply CBT-E or there is any modification for this population?

CBT-E can be used for obese adults and adolescents, adding therapeutic procedures to help patients to develop an active lifestyle, to address binge-eating and to deal with overvaluation of shape and weight.