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Therapists' self-reported drift from Dialectical Behaviour Therapy techniques for Eating Disorders

Authors

1. **Lucene Wisniewski**

19910 Malvern Rd, Rm 220, Shaker Heights, OH, 44122, United States,

E-mail: lucene.wisniewski@gmail.com. Tel: +1 2165441321

2. **Maria Elena Hernandez Hernandez (Corresponding author)**

Department of Psychology, University of Sheffield. 1 Vicar Lane, Cathedral Court, Floor E. Sheffield, S1 2LT. UK.

E-mail: mehernandezhernandez1@sheffield.ac.uk. Tel: +44 1142222000

3. **Glenn Waller**

Department of Psychology, University of Sheffield. 1 Vicar Lane, Cathedral Court, Floor D. Sheffield, S1 2LT. UK.

E-mail: g.waller@sheffield.ac.uk. Tel: +44 01142226568

Highlights

- Several DBT techniques are underused by DBT therapists who treat eating disorder patients
- The pattern of use of DBT techniques is bimodal – most are used a lot or a little
- More experienced clinicians are more likely to use more DBT techniques
- Clinicians are encouraged to implement the techniques in an integrated way

Abstract

Objective: Research has shown that clinicians underuse or omit techniques that constitute an essential part of evidence-based therapies. However, it is not known whether this is the case in DBT for eating disorders. The aims of this study were; 1) exploring the extent to which DBT techniques were used by self-identified DBT clinicians treating eating disorders; 2) determining whether therapists fell into distinct groups, based on their usage of DBT techniques; and 3) examining whether clinician characteristics were related to the use of such techniques. **Method:** Seventy-three clinicians offering DBT for eating disorders completed an online survey about their use of specific DBT techniques. They also completed measures of personality and intolerance of uncertainty. **Results:** In relation to the first aim, the pattern of use of DBT techniques showed a bimodal distribution – most were used either a lot or a little. Considering the second aim, clinicians fell into two groups according to the techniques that they delivered - one characterized by a higher use of DBT techniques and the other by a higher use of techniques that were specific to the treatment of eating disorders, rather than DBT methods. Finally, more experienced clinicians were more likely to be in the 'DBT technique-focused' group. **Discussion:** DBT clinicians are encouraged to implement both sets of techniques (DBT techniques and standard techniques for the treatment of eating disorders) in an integrated way. Training, supervision and the use of manuals are recommended to decrease therapist drift in DBT.

Keywords: Dialectical Behaviour Therapy; Eating Disorders; Therapist Drift

Therapists' self-reported drift from Dialectical Behaviour Therapy techniques for Eating Disorders

1. Background

Cognitive behavioural therapy (CBT) is currently the most strongly evidenced treatment for adults with eating disorders, especially for binge eating disorder and bulimia nervosa (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Spielmans et al., 2013; Vocks et al., 2010), though the effects are less powerful for patients with anorexia nervosa (Dalle Grave, Calugi, Conti, Doll, & Fairburn, 2013). Family based treatment (FBT) is more effective with younger cases with a more recent onset (Lock et al., 2010). However, neither CBT nor FBT works for all patients. Therefore, developing an evidence base for other therapies has been crucial.

An alternative treatment that has achieved widespread implementation and positive outcomes for patients suffering from an eating disorder is dialectical behaviour therapy (DBT) (Bankoff, Karpel, Forbes, & Pantalone, 2012; Lenz, Taylor, Fleming, & Serman, 2014). DBT is a cognitive behavioural treatment that was originally developed to treat chronically suicidal patients diagnosed with borderline personality disorder (BPD) (Linehan, 1987), and is now recognized as the leading psychological treatment for this population (National Guideline Clearinghouse, 2012).

DBT assumes that the patient has low self-regulation and tolerance to stress, and that environmental and intrapersonal factors influence such deficits (Dimeff & Linehan, 2001). The therapy combines behavioural techniques with eastern mindfulness, which is intended to replace rigid, dichotomous thinking with acceptance and validation (Dimeff & Linehan, 2001). DBT aims to improve behavioural skills and motivation, to extrapolate the acquired skills to the patient's context, and to provide an effective therapy structure for both the patient and the therapist. For this, key factors in the treatment are individual therapy, skills group training, telephone coaching, and the support of a consultation team (Dimeff & Linehan, 2001). The models of DBT for the eating disorders that are currently most

commonly used are those of Safer, Telch & Chen (2009) and Wisniewski, Bhatnager, & Warren (2009).

Research has shown that DBT is effective in treating a wide range of disorders, such as substance dependence (Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999), depression (Harley, Sprich, Safren, Jacobo, & Fava, 2008), post-traumatic stress disorder (Harned, Korslund, & Linehan, 2014), and eating disorders (Federici & Wisniewski, 2013; Lenz, Taylor, Fleming, & Serman, 2014; Lynch et al., 2013; Masson, von Ranson, Wallace, & Safer, 2013).

The strong outcomes of evidence-based therapies in research settings can also be reached in clinical settings if clinicians adhere to manuals and protocols (Pederson Mussell et al., 2000; Wilson, 2005). Unfortunately, there is clear evidence that protocols and manualized approaches are underused by clinicians across a number of therapies for eating disorders (Tobin, Banker, Weisberg, & Bowers, 2007; Wallace & von Ranson, 2011; Waller, Stringer, & Meyer, 2012). This relatively infrequent use of manuals has been linked to a phenomenon conceptualized as ‘therapist drift’ (Waller, 2009), and occurs when clinicians, consciously or inadvertently, omit or underuse techniques that are an essential part of the therapy. Such techniques can also be underused or inaccurately applied over time, implying a failure to learn the prescribed techniques in the first place and/or a tendency for their use to erode. Clinicians’ own cognitive biases, emotions and safety behaviours can interfere with the appropriate delivery of the therapy. However, the underuse or omission of techniques is usually seen by the clinician as being ‘protective’ with their patients (e.g. not wanting to deliver exposure techniques in order to avoid patient’s distress) (Waller, 2009).

In the field of eating disorders, therapist drift has been related to a range of different factors, such as clinicians’ anxiety, age and training (Meyer, Farrell, Kemp, Blakey, & Deacon, 2014; Waller et al., 2012). Personality traits such as openness to experience (Peters-Scheffer, Didden, Korzilius, & Sturmey, 2013) have also been related to lower therapy adherence in the treatment of autistic spectrum disorders. Although therapist drift has been clearly demonstrated in CBT and FBT (Kosmerly, Waller, & Lafrance Robinson,

2015; Waller et al., 2012), it is not yet known whether it applies to other evidence-based therapies for eating disorders, and particularly DBT. DiGiorgio, Glass & Arnkoff (2010) have studied the degree to which clinicians report delivering the core techniques of DBT, although not specifically in the treatment of eating disorders. They demonstrated that DBT clinicians regularly fail to implement core techniques, with differences according to factors such as the client's diagnosis and the intensity of the therapist's DBT training. Therapists showed a greater adherence to protocols when clients had borderline personality disorder as a comorbidity, and if the therapists had a background in applied behaviour analysis or radical behavioural approaches, or had received intensive DBT training.

It is not known yet whether these findings of therapist effects would apply to the use of DBT with eating disorders. It is also unclear whether DBT clinicians working with eating disorders form a homogeneous group (all delivering techniques in a similar pattern), or whether they fall into heterogeneous groups (each group delivering a distinct pattern of techniques). Although it is clear that CBT and FBT clinicians each fall into such groups when working with eating disorders (Kosmerly et al., 2015; Waller et al., 2012), it is possible that this finding will not apply to self-identified DBT practitioners in the field of eating disorders (Federici, Wisniewski, & Ben-Porath, 2012; Safer, Telch, & Chen, 2009).

Therefore, the primary aim of the present study was to determine the extent to which core DBT techniques are used by DBT clinicians treating patients with eating disorders. It also examined whether therapists fall into distinct groups, based on their usage of different DBT techniques. The final aim was to determine whether clinician's characteristics, specifically intolerance to uncertainty, personality and age, are related to the use of such techniques, given that previous research has shown that these factors might increase the patterns of drift (Meyer, Farrell, Kemp, Blakey, & Deacon, 2014; Peters et al., 2013; Waller et al., 2012).

2. Method

2.1 Ethics

The project was approved by the Department of Psychology's Ethics Committee at the University of Sheffield

2.2 Participants

One hundred and twelve participants who self-identified as DBT clinicians offering DBT to patients with eating disorders initiated the online survey. Of that group, two excluded themselves from the study by not providing informed consent, 14 withdrew at the stage of declaring their age, six due to not working with the appropriate therapy or patient group, and 17 by failing to complete the survey. Therefore, data were available from 73 participants, though the N varies across analyses due to missing data. No compensation was offered to the clinicians for their participation in the study.

The final sample's mean age was 42.2 years (SD = 10.95; range = 26-66). Eighty-nine percent of the participants were female. The majority of the participants were psychologists (56.2%) or social workers (20.5%), while the remaining 23.3% consisted of professionals from other disciplines (e.g., counselling, psychiatry). Their mean duration of experience treating eating disorders was 9.92 years (SD = 6.89; range = 1-26).

2.3 Measures and Procedure

Clinicians were approached via an online listserv for clinicians working with eating disorders. This listserv is hosted by the international Academy for Eating Disorders, which represents a diverse range of clinicians working with eating disorders across the lifespan. Given this methodology, it is not possible to provide an accurate response rate for the study. Potential participants were provided with an outline of the study, as an investigation of the patterns of technique use in DBT for eating disorders. If they decided to take part, they could click on a hyperlink, to take them to the consent form and the full survey (using the Qualtrics platform). Following the provision of consent and demographic details, the participants answered questions regarding their use of specific DBT techniques. They then completed brief measures of personality and anxiety.

Use of DBT techniques. The clinicians provided details of their use of a range of DBT techniques when treating eating disorders, taken from a DBT manual for eating disorders (Federici et al., 2012; Safer et al., 2009). These are detailed in Table 1 and in the Results. They include general DBT methods, similar to the techniques assessed by DiGiorgio et al. (2012), that are applicable across disorders (e.g., validation, Behavior chain analysis), as well as eating-disorder-specific techniques (e.g., weighing the patient). Each was rated by the clinician regarding how often they used it with their patients with eating disorders ('1-10% of the time' to '90-100% of the time'). This approach is similar to that utilized in previous therapist drift studies (DiGiorgio et al., 2010; Kosmerly, et. al, 2015; Waller, et. al, 2012), though it lacks the potential validity of observational methods.

Ten-Item Personality Inventory (TIPI). The TIPI (Gosling, Rentfrow, & Swann, 2003) is a brief personality test that measures the 'big five' personality dimensions (extraversion, agreeableness, conscientiousness, emotional stability, and openness to experience). Participants indicated their level of agreement with a series of short self-descriptions. The scale is rated on a seven-point scale, ranging from strong disagreement (1) to strong agreement (7). It has acceptable convergent validity (mean r = 0.77) with the NEO Personality Inventory (Costa & MacCrae, 1992), and acceptable test-retest validity (mean r = 0.72).

Intolerance of Uncertainty Scale - Short Version (IUS-12). The IUS-12 (Carleton, Norton, & Asmundson, 2007) measures the individual's response to uncertain situations. Responses are given on a Likert scale from one (not at all characteristic of me) to five (entirely characteristic of me). It has a good internal consistency ($\alpha = 0.91$) and a high convergent validity with the original 27-item version ($r = 0.96$). Confirmatory factor analysis demonstrates that it yields two scales - prospective anxiety (anxiety over not knowing what is going to happen if one acts) and inhibitory anxiety (avoidance of action due to not knowing the outcome).

2.4 Data analysis

Statistical analyses were carried out using SPSS v.21. Due to missing items, the N varies across analyses. To address the first aim, frequency of use of each technique was calculated. For the second aim, two-step cluster analysis was used to determine whether the participants fell into distinct groups, based on their use of the different techniques (categorical and continuous). Finally, a mixture of t-tests, correlations (Pearson's r) and chi-squared tests were used to determine whether the use of techniques and cluster membership were related to clinicians' own characteristics.

3. Results

3.1 Use of DBT techniques by DBT clinicians working with eating disorder patients

As can be seen in Table 1, the majority of the techniques showed bimodal patterns of response, with many clinicians implementing them either rarely or very frequently. Several categorical responses were also considered (e.g., signing a DBT treatment agreement), and showed variable patterns of DBT implementation. For example, only about 50% of clinicians indicated implementing techniques such as the requirement of filling out diary cards, signing a DBT treatment agreement, and obtaining a verbal commitment to abstain from binge eating. Other core issues considered were responses to situations in which the patient had engaged in the therapy-interfering behaviours of refusing to be weighed or failing to complete diary cards. Clinicians were asked how many sessions will they continue seeing a patient who refuses to complete these tasks. More than a third of clinicians reported that they would continue seeing clients for six or more sessions despite ongoing non-compliance with these treatment elements. Only 54.8% of the clinicians reported belonging to a consultation team. Skills training in emotion regulation, interpersonal effectiveness, distress tolerance and mindfulness was implemented by 75% of the clinicians. Finally, 25% of these DBT therapists answered "No" when asked to indicate if they used a DBT manual for the treatment of eating disorders.

Table 1.
Percentages of therapists using specific DBT techniques in eating disorders

Percentage of DBT clinicians using different DBT techniques for eating disorders

Technique	N	Frequency of use of each technique									
		0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
Clients weighed every time or nearly every time	72	43.1%	2.8%	2.8%	2.8%	2.8%	1.4%	4.2%	4.2%	2.8%	33.3%
Use of diary card from the beginning	72	27.8%	6.9%	1.4%	4.2%	5.6%	5.6%	1.4%	1.4%	9.7%	36.1%
Cognitive restructuring	60	10%	3.3%	3.3%	3.3%	8.3%	10%	6.7%	3.3%	6.7%	45%
Exposure	60	6.7%	6.7%	3.3%	10%	10%	3.3%	3.3%	5%	5%	46.7%
Behavioural experiments	60	13.3%	3.3%	1.7%	5%	6.7%	6.7%	8.3%	6.7%	8.3%	40%
Structured eating	60	8.3%	3.3%	0%	6.7%	8.3%	5%	6.7%	8.3%	5%	48.3%
Telephone coaching	60	51.7%	3.3%	3.3%	0%	3.3%	0%	3.3%	1.7%	1.7%	31.7 %
6 months - 1 year commitment	57	57.9%	1.8%	1.8%	0%	3.5%	1.8%	1.8%	0%	0%	31.6%
Review of biosocial theory	58	24.1%	0%	6.9%	3.4%	5.2%	1.7%	1.7%	8.6%	0%	48.3%
Session for treatment targets	58	24.1%	1.7%	5.2%	1.7%	6.9%	5.2%	1.7%	6.9%	6.9%	39.7%
Validation	58	29.3%	0%	1.7%	0%	0%	0%	0%	6.9%	0%	62.1%
Behaviour chain analysis	58	29.3%	1.7%	1.7%	1.7%	3.4%	0%	1.7%	8.6%	1.7%	50%
Acceptance and change work	58	31%	0%	0%	0%	0%	0%	1.7%	1.7%	5.2%	60.3%
Diminish interfering behaviours	58	32.8%	0%	0%	0%	1.7%	1.7%	0%	3.4%	5.2%	55.2%

3.2 Do DBT clinicians fall into natural groups?

In the two-step cluster analysis, based on the variables identified above, two meaningful groups emerged. The silhouette score was 0.5, indicating a fair level of cohesion and separation. Table 2 details the items that differentiated the groups at the 95% CI level. The larger cluster consisted of 66.7% of the clinicians, who were distinguished by a greater use of DBT techniques, but low use of classical techniques for treating eating disorders

(group labelled as 'DBT-oriented'). By contrast, the second cluster (33.3%) used more core techniques for eating disorders, but fewer core DBT techniques (group labelled 'eating disorder-oriented').

Table 2.
Groups formed by the two-step cluster analysis based on DBT clinicians' usage of DBT techniques for eating disorders

DBT-oriented n=38, 66.7%	Eating disorder-oriented n=19, 33.3%
High use of acceptance and commitment change	Higher use of exposure
High use of reduction of interfering behaviours	Higher use of behavioural experiments
High use of validation	Higher use of diary cards
High use of behavioural chain analysis	

3.3 The role of personality, anxiety and demographic factors

There was no association between clinicians' use of individual DBT methods or cluster membership and their levels of anxiety, personality type, or sociodemographic factors such as age, gender or profession ($p > .05$, in all cases). However, there was a significant difference in levels of experience between the two clusters. The DBT-oriented group had more years of experience treating eating disorders than the eating disorders-oriented group (mean = 11.8 and 5.42 years, respectively; $t = 4.40$, $p < .005$).

4. Discussion

The primary aim of this study was to determine the extent to which DBT therapists use DBT techniques when working with patients with eating disorders. The pattern that emerged was one of a bimodal distribution – most individual DBT methods were used either a lot or a little. Thus, many DBT techniques appear to be underused by a large number of DBT therapists who say they provide DBT for eating disorders, such as client weighing, commitment for 6-12 months, or telephone coaching.

We might speculate that there are two distinct groups of clinicians who use DBT in their work with eating disordered patients – a group of primarily DBT trained therapists who see DBT as their prime therapeutic modality and a group of therapists who use traditional

eating disorder interventions as their primary mode of intervention with eating-disordered patients. Such a possibility would fit well with Meehl's (1986) suggestion that clinicians are commonly bound by their theoretical orientation, resulting in limited ability to integrate the DBT and eating disorder elements that are needed to deliver DBT for this clinical group (Federici et al., 2012; Lynch et al., 2013; Safer et al., 2009). Some techniques that would be expected to be seen more often in routine practice for the treatment of eating disorders were weighing the patient, the use of diary cards, behavioural chain analysis, and diminishing interfering behaviours. Although techniques like exposure, structured eating and cognitive restructuring were the most utilized by the clinicians, these were routinely used by fewer than a half of the participants.

A further aim was to determine whether clinicians naturally fall into distinct groups, marked by the techniques that they routinely deliver. Two such groups emerged - one characterized by a higher use of core DBT techniques (e.g., validation), and the other by a higher use of standard techniques for the treatment of eating disorders (e.g., exposure to change in dietary intake). The final aim was to determine whether the use of specific techniques or membership in either cluster was related to clinician variables. The only such factor was length of experience, with more experienced clinicians being more likely to be in the 'DBT technique-focused' group.

These findings show some similarities with the existing literature. Kosmerly et al. (2015) found the same bimodal pattern of usage of some techniques in FBT for eating disorders. They also found two clusters of clinicians, one of which demonstrated fairly good compliance to evidence-based FBT, while the other seemed to use few or no FBT techniques at all. In contrast, Waller et al. (2012) found that three clusters emerged from their group of CBT clinicians, with one group appearing to focus on mindfulness and one on motivational work (as well as a group that delivered CBT more appropriately for this clinical population). The most common clinician characteristic related to the use of techniques in the three studies was the level of clinician experience. The more experienced clinicians

implemented more techniques, but to different degrees according to the specific technique under consideration.

An important clinical implication of this work lies in the fact that two separate clusters of clinicians emerged – one focusing on core DBT techniques and one focusing more on classical methods for working with eating pathology. Existing DBT protocols (Federici et al., 2012; Safer et al., 2009) recommend that clinicians should work with both sets of techniques in an integrated way. Although adapting protocol-based therapies is recommended to make them suitable for the individual patient (Wilson, 1996), the therapy should not be distorted to such an extent that it loses its core components. As it stands, the evidence is that DBT is often delivered without the implementation of techniques that are an essential part of the therapy (DiGiorgio et al., 2010). The use of manuals and DBT protocols is recommended, to ensure a more comprehensive delivery of the therapy. Similarly, training in DBT should be updated regularly, and consultation teams and supervision should be used as a means of ensuring that such drift does not take place.

Limitations

This research had a number of limitations. Notably, it did not assess therapists' levels of training or supervision, which could influence how one understands the findings. For example, it is possible that some participants had no training or supervision in DBT, despite describing this as the modality that they used. Therefore, limitations in the delivery of DBT might not be related to the nature of DBT or a problem of 'drift'. Rather, the clinicians' failure to adhere might imply that they did not learn the principles or practice of DBT appropriately. This problem of clinicians describing themselves as delivering a therapy in which they have had no training is widespread, with the Royal College of Psychiatrists (2013) identifying that approximately 30% of psychological therapists have no training in the therapy that they claim to deliver.

Furthermore, studies have previously shown that the self-report approach utilized in this study can underestimate the prevalence of therapist drift (Carroll, Nich, & Rounsaville, 1998; Martino, Ball, Nich, Frankforter & Carroll, 2009; Miller, Yahne, Moyers, Martinez, &

Pirritano, 2004). Although self-report is one way to assess therapy fidelity, it potentially has major limitations. Those limitations include response bias due to social desirability, issues of terminology differing, or lack of awareness of the techniques. However, this approach provides targets for more intensive investigations in the future, where more objective methods can be utilised. An alternative approach to the assessment of therapy fidelity is the live evaluation of therapy sessions (recorded or observed), using a therapy rating scale. This line of research would benefit from such an approach. It is also possible that not all DBT-practicing clinicians in this sample intended to practice DBT with all patients, but only with a subset. This possibility relates to DiGiorgio et al.'s (2010) findings, where adherence differed according to whether patients had comorbidities. This could mean that clinicians might be intentionally using DBT selectively for the subset of their ED patients who show comorbidities, while not intending to apply the approach with clients for whom such features are absent – resulting in 'averaged' endorsements of technique usage. Finally, similar investigations into such therapist 'drift' are needed for other therapies and disorders. Further research is needed to consolidate and extend these findings, with a larger sample and with sufficient male and female therapists to allow comparison of the use of DBT techniques by gender.

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Competing Interests

Lucene Wisniewski is a trainer for the Behavioral Technology Transfer Group, which provides DBT trainings. Maria Elena Hernandez Hernandez and Glenn Waller have no competing interests to declare.

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