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Patients' experiences of brief cognitive behavioural therapy (CBT-T) for eating disorders: A qualitative investigation

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Abstract

Background: While it is important to analyse the effectiveness of new therapies, it is also necessary to consider how patients experience them. This is particularly important if we are to maximise treatment acceptability and reduce attrition. This study examined patient experiences of a new 10-session cognitive-behavioural therapy (CBT-T), using a qualitative approach.

Method: The sample were 17 patients with a diagnosis of bulimia nervosa who had received CBT-T (including treatment completers and non-completers) within the previous two years Sample size was determined by saturation of the emergent themes. Responses were analysed using a six-step thematic analysis process.

Results: Rated acceptability and effectiveness of CBT-T were high. Five themes emerged, with subthemes. The key elements of patient experience of the therapy were: the therapeutic relationship; the nature of the therapy; its challenging but beneficial aspects; ending therapy; and the overall experience of CBT-T (including comparison with other therapies).

Conclusions: The findings build on the effectiveness research for CBT-T, suggesting that it is an acceptable therapy that addresses many of the same themes that matter to patients as other therapies. The findings show that patients were positive about CBT-T relative to other therapies, and offer suggestions as to how CBT-T might be delivered to emphasise the importance of the time-limited nature of the therapy.

Keywords

cognitive-behavioural therapy; bulimia nervosa; patient experience

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Psychological therapies are the most effective approach to treating eating disorders, though medical support and risk management need to be used appropriately (e.g., National Institute for Health and Clinical Excellence [NICE], 2017). However, it is also important to consider ways in which the acceptability of treatments can be enhanced, given that attrition rates are relatively high in the treatment of eating disorders (ranging from 29% to 73% for outpatient treatment - Fassino, Pierò, Tomba, & Abbate-Daga, 2009).

In order to address the acceptability and uptake of therapies, one should consider the potential contribution of patients' perspectives on existing and newly-developed therapies and use such feedback to inform further treatment development (e.g., Crawford, Weaver, Rutter, Sensky, & Tyrer, 2002; Newton, 2001; Peterson, Black Becker, Treasure, Shafran, & Bryant-Waugh 2016). Such research might include identifying what patients find obscure or challenging in therapies, as well as understanding what they see as positives. Qualitative designs can be useful in understanding patients' perspective in this way. Hence, a range of qualitative methods have been used to understand the key elements of effective therapies across a range of disorders (e.g., Crawford et al., 2002).

Such qualitative approaches have been used in understanding patients' experiences of a number of therapies for eating disorders. Those therapies include: the Maudsley Model for Treatment of Adults with Anorexia Nervosa (MANTRA; Lose et al., 2014); Specialist Supportive Clinical Management (SSCM; Lose et al., 2014); guided self-help (Traviss, Heywood-Everett & Hill, 2011); internet-based cognitive behavioural treatment (iCBT; Sánchez-Ortiz, House, Munro, Treasure, Startup, Williams, & Schmidt, 2011); and online cognitive behavioural therapy (online CBT; McClay, Waters, McHale, Schmidt & Williams, 2013). Across therapies, these studies of patient perspectives tend to yield similar themes and subthemes, relating to: the therapeutic relationship (whether contact is face-to-face or indirect - Lose et al., 2014; McClay et al. 2013; Sánchez-Ortiz et al., 2011; Traviss et al., 2011); the

nature of the therapy (Lose et al., 2014; McClay et al., 2013); and the outcomes of treatment (Lose et al., 2014; McClay et al., 2013; Sánchez-Ortiz et al., 2011). It can be argued that new therapies could benefit from being examined in this way, to identify whether they yield the same or different themes.

A current direction in psychological therapies is the development of briefer, more accessible therapies that are effective (e.g., the UK Improving Access to Psychological Therapies system - Clark, 2011), because they have the potential to be less expensive and therefore more accessible. Such a brief therapy has recently been developed in the field of eating disorders, in the form of a 10-session cognitive-behavioural therapy (CBT-T) for non-underweight patients with eating disorders (Waller, Tatham, Turner, Mountford, Bennets, Bramwell, Dodd, & Ingram, 2018). At half the length of existing recommended versions of CBT for eating disorders (e.g., Fairburn, 2008; Waller, Cordery, Corstorphine, Hinrichsen, Lawson, Mountford, & Russell, 2007) and achieving comparable results (Pellizzer, Wade & Waller, in press; Waller et al., 2018), CBT-T has the potential to achieve those improvements in cost and access. However, while CBT-T results in positive therapeutic alliance scores (Waller et al., 2018), it remains to be seen how patients experience this new, brief therapy. Understanding that experience would allow CBT-T to be improved or promoted to clinicians and patients alike, in the hope of optimizing clinical outcomes and quality of life (De La Rie, Noordenbos, Donker, & van Furth, 2006).

The aim of this study was to understand patient experiences of CBT-T, using a qualitative thematic approach to yield a more complete representation and contextualisation of the therapy's effects (Crawford et al., 2002).

Method

Design

This research used a qualitative analytic approach to explore the experiences of individual patients who had undertaken CBT-T. Thematic analysis of questionnaire responses was used, to derive common themes across patients. To ensure the most representative set

of themes, participant recruitment continued until saturation was achieved (where no new themes were found in the experiences of new participants).

Ethics

Using the UK National Health Service National Research Ethics Service guidance (National Health Service Health Research Authority, 2011), this study was determined to be service evaluation. The purpose of the questionnaire was outlined in a cover letter and potential participants were informed that all responses would be analysed anonymously and that the findings would be shared with the local team and possibly with wider audiences through conference presentations/publications. Potential participants were encouraged to contact the service if they had any questions.

Participants

Participants were patients with a diagnosis of bulimia nervosa who had been referred to a specialist eating disorders service, and who had been offered CBT-T. Diagnosis was determined using a semi-structured interview (Waller et al., 2007) or the Eating Disorder Examination (Fairburn, 2008). They were included regardless of whether they had completed, dropped out or opted out of a course of CBT-T, in order to reflect the full range of patient experiences. Each patient was treated by one of three graduate psychologists trained in the CBT-T protocol (though without a clinical qualification), under the supervision of a clinical psychologist.

Participant recruitment ceased when thematic saturation was reached. In order to get to this point, 45 individuals were sent the questionnaire pack, and 17 responses were received and analysed. All respondents were female, with a mean age of 32.2 years at the time of the study (SD = 11.71). It is not possible fully to compare these patients with the wider clinical case series to determine whether they were representative of that larger group. However, the mean age of the case series was approximately 28 years (roughly the same as that found in other non-underweight case series), suggesting broad comparability on age.

Four of the 17 had undertaken at least one previous therapy for an eating disorder (allowing them to compare their CBT-T experiences with other therapies), and at least seven

had experienced therapies for other psychological problems. Of the 17 patients, 14 had completed the index course of CBT-T therapy, one had dropped out prior to the session 4 review, and two dropped out after that point.

Materials and Procedure

Each patient had been screened for suitability and offered CBT-T. This therapy and its outcomes are described more fully in Waller et al. (2018). In brief, the therapy consists of a relatively behaviourally focused version of CBT-ED, delivered over 10 sessions (with two follow-ups). The key elements of the therapy are: exposure and restoring appropriate nutrition; behavioural experiments to modify cognitions; addressing emotionally-driven behaviours, body image work; and relapse prevention.

Patients who had undertaken CBT-T (up to two years previously) were posted a questionnaire, cover sheet and reply-paid envelope. The cover sheet explained that the aim was to obtain individual's views of CBT-T, whether they completed therapy or not, so that patients' views could be taken into account in future developments of CBT-T. The questionnaire collected demographic information, including details of prior therapy for their eating disorder or other disorders. Considering their experience of CBT-T (which was the first experience of this particular therapy in all cases), participants indicated on an 11-point Likert scale how acceptable they found it (0 = 'not at all acceptable'; 10 = 'completely acceptable') and how much they felt the treatment helped to reduce their eating disorder behaviours (0 = 'not at all'; 10 = 'completely'). Following this, participants were asked to write about their experience of CBT-T, under categories of: what was beneficial and challenging; the therapeutic relationship; comparisons to previous therapy experiences; and free comments/suggestions for improvement. The questionnaire is included as supplementary material.

Data analysis

Qualitative survey responses were analysed using Braun & Clarke's (2006) six-phase process of thematic analysis (familiarising oneself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing a

report). Responses were transcribed (removing any therapist names), and then printed and coded by hand. Succinct labels were used to identify important features, and these were then collated into potential themes and subthemes. To reduce the risk of overemphasising idiosyncratic comments, three or more quotes under the same label were required for it to be reported as a theme. Themes were reviewed in relation to the quotes and the entire data set in order to create a thematic map, and the final labels and definitions were applied. New patients were recruited until saturation was achieved. No new themes emerged after the 13th patient out of 17. An independent researcher coded the data to check validity of the themes. Any discrepancies were resolved by discussion until a consensus was reached. These codes were then organised into higher-level themes using a thematic map. A second independent researcher then coded the data to check validity further.

Results

Patient ratings of acceptability and effectiveness of CBT-T

Acceptability and effectiveness were each rated on a 0-10 scale. The mean rating of acceptability was very high (mean = 9.00, SD = 1.41), while the rating of effectiveness was lower but still positive (mean = 6.44, SD = 3.10). The lower rating of effectiveness might reflect the fact that not every patient completed therapy, and that no therapy is effective in all cases, including CBT-T (Waller et al., 2018). These figures are highly similar to patient ratings of the acceptability of MANTRA (mean = 8.50, SD = 1.41) and SSCM (mean = 8.00, SD = 2.2) and credibility, which was measured in the same manner as effectiveness in this study, MANTRA (mean = 6.40, SD = 3.10) and SSCM (mean = 5.80, SD = 2.70) (Zainal et al., 2016). While it is acknowledged that a direct comparison is not possible, it is noteworthy that the effectiveness score is proportionally similar to Fairburn et al.'s (2015) reported patient ratings of treatment expectancy (M = 68.1, SD = 20.5) and suitability (M = 78.2, SD = 24.4), in an efficacy trial using experienced therapists.

Thematic structure of patients' experiences of CBT-T

Five main themes arose from service users' descriptions of CBT-T. These were

labelled: Therapeutic relationship; Nature of therapy; Challenging but beneficial; Ending therapy; and Overall experience of therapy. Each of these themes had several underlying sub-themes. Figure 1 illustrates this thematic structure.

Insert Figure 1 about here

Content of the themes and subthemes in patients' experience of CBT

The following are representative statements by participants, which made up each theme and sub-theme. In each case, the number of individual patients who contributed to each sub-theme is given, to demonstrate its prevalence in this group. For each statement, the patient is identified by a distinct number, to demonstrate that the comments come from a range of patients.

Theme 1: Therapeutic Relationship (four subthemes)

Sub-theme 1: Therapist characteristics. Ten of the 17 patients (59%) discussed what they liked about the nature of the therapist and/or service. They noted positive characteristics about their therapist, such as being caring, understanding and approachable:

Participant 11: *'*She was certainly very sympathetic and empathised when I got upset.*'*

Participant 12*: 'I never felt judged or like I was wasting the* clinic's time and she was really *understanding and encouraging'*

Therapists were also seen as having expert knowledge and good problem solving abilities, which was helpful within therapy:

Participant 5*: 'I felt like she understood me and came up with creative ideas on how to tackle things'*

Participant 15*: '[Therapist] was very open and approachable. She knew what she was talking about.'*

Subtheme 2: Felt comfortable in therapy. Over half of patients (9/17, 53%) commented on feeling comfortable with the therapist, which enabled them to trust their therapist and feel able

to discuss topics within therapy without feeling judged. This appeared to facilitate honesty around eating, binges and self-induced vomiting:

> Participant 2: 'My relationship with [Therapist] really allowed me to feel comfortable at each session and share personal experiences / problems throughout my therapy.'
>
> Participant 12: '[Therapist] made me feel comfortable talking with her, despite being embarrassed about a lot of my eating habits.'

Subtheme 3: No longer alone. Four out of the 17 participants (23%) said that therapy allowed them to feel that they were no longer alone in coping with their eating disorder. This was sometimes due to not feeling able to talk to others about their eating disorder thoughts or to disclose that they had an eating disorder to family and friends:

> Participant 4*: 'Being able to ask any questions and to actually talk about the thoughts I* have and not feel ridiculous/alone.'
>
> Participant 12*: 'Also just having someone to talk to about my issues helped me so much* as I *didn't feel I could speak to family and friends.'*

Subtheme 4: Firm but fair. Seven of the 17 respondents (41%) believed that the therapist upheld firm boundaries within therapy whilst maintaining a kind, fair nature:

> Participant 10: 'She was encouraging and supportive, yet knew when to push me to get the most effective results for me.'

Only one participant reported that they felt the therapist needed to be firmer:

> Participant 13: 'Maybe could have been a bit firmer.'

<u>Theme 2: Nature of therapy (four subthemes)</u>

Subtheme 1: Timing. Six of the 17 participants (35%) mentioned strengths and weaknesses associated with timing within therapy or with its length. Several of those felt that that they needed more than 10 sessions of therapy:

> Participant 15*: 'The* first session – review and brief introduction – *I don't think this should be* counted as a proper session*…Not sure 10 sessions is enough'*
>
> Participant 13*: 'Need something longer and maybe 'check-ups''*

This was expanded by one participant who felt that due to the structure of ten sessions they were limited in time towards the end of therapy:

Participant 11*: 'Some things I found more difficult and* it took me longer to do…hence we were pushed for time when it came to body image which is the area I struggled wit*h the most.'*

One participant discussed the difficulty of fitting therapy appointments into their schedule:

Participant 8: 'They could only offer sessions on Wednesday/Friday afternoons and unfortunately this was too difficult to fit in with my work schedule.'

However, one participant conveyed a positive experience of the timing and structure of therapy, particularly reflecting the weekly meetings:

Participant 11: 'Weekly sessions helped me break down week by week goals and allowed me to stay in touch with my therapist'

Subtheme 2: Personalisation. Four of the participants discussed whether or not the therapy sessions felt personally tailored to them and their needs. Three felt that therapy worked on goals specific to them and their life:

Participant 5: 'Ideas on how to achieve my goals which were specific to my life rather than general goals. Discussing my specific schedule and behaviours and how to best move forwards.'

However, one did not feel that the therapy process was tailored to their personal needs at all stages:

Participant 9: 'Felt at the beginning I was just another number/patient and we were just going through the same process again and again'

Subtheme 3: Personal effort. Seven of the 17 participants (41%) mentioned how they needed to put in individual work outside of treatment sessions. That work was often in relation to the homework tasks set, but was also in relation to their cognitions and allowing themselves to get better:

Participant 6*: 'I had to go away and actually make the changes happen myself.'*

Participant 2*: 'I was able to tackle personal demons and allow myself to get better.'*

Subtheme 4: Therapy structure and interventions. Nine of the 17 (53%) participants made specific comments around how the therapy was conducted, including the structured therapeutic approach and particular interventions and tools used (including food diaries, feared food experiments, body image and psycho-education):

Participant 2*: 'The most helpful part of my treatment was the 'experiments' me and [Therapi*st] *created in order to face 'fears' or 'problem areas' in my life.'*

Participant 6*: 'Food diaries also helped me find a healthier routine and allowed me* to document and see my progress.*'*

Participant 12*: 'She also always backed up advice with articles and* guidance which I could read at home and helped normalise my views on food.*'*

Theme 3: Challenging but beneficial (three subthemes)

Subtheme 1: Hard but necessary. Five of the 17 (29%) respondents discussed how CBT-T (and specific aspects of the therapy) were difficult but ultimately necessary for a positive outcome:

Participant 6: *'*The first couple of weeks were HARD because I needed to make immediate changes straight away. But ultimately this was a good thing.*'*

Participant 2: *'…overcome them by c*arrying out experiments (such as a survey on my appearance). Although this was my worst nightmare, [Therapist] knew that it would benefit me to face [it], and was right. *Without the little push, I would never have done this.'*

Subtheme 2: Challenges. Eleven out of the 17 (65%) talked about challenges that they faced during therapy, including challenges that are inherent in any effective therapy addressing an eating disorder:

Participant 1: *'*Increasing food intake at lunchtimes has been and still is a c*hallenge!'*

Participant 12: *'*I found listing my bingeing episodes and the exact volume of what I had eaten really difficult and was embarrassed to show this a*nd discuss it with my therapist.'*

Three of these found that personal circumstances outside of the eating disorder therapy were challenging and ultimately interfered with them fully recovering:

Participant 7: *'*I was very depressed at the time and my therapist and I decided I should tackle that first and then come back when I was able to tackle my eating problem.*'*

Subtheme 3: Initial scepticism. A few participants (3/17, 18%) mentioned that the therapy and interventions used were more beneficial than they had initially expected:

Participant 6*: 'Initially I was quite sceptical but [Therapist] was so* positive and encouraging that I *learnt to push my boundaries and made a lot of progress.'*

Participant 9*: 'I felt quite irritated and cross in the beginning, I felt I was being told to eat more which didn't help me but I did understand it was to establish a* sensible eating pattern which worked in the end, probably all part of my healing process.*'*

Theme 4: Ending therapy (two subthemes)

Subtheme 1: Outcome. Twelve of the 17 (70%) participants discussed their broader experience of completing therapy. This included their eating disorder symptoms, what they learnt through the process, and how the CBT-T process has affected their life generally:

Participant 2*: 'It has allowed me to slowly get my life before bulimia back and be happy again.'*

Participant 12*: 'Intervened at just the right time and provided me support and coping* mechanisms to pull me back to a normal healthy life-style.*'*

However, two also felt that they were still experiencing difficulties after therapy:

Participant 15*: 'Thoughts about self-image/beliefs remain very tangled'*

Subtheme 2: After therapy. Four of the 17(23%) participants discussed events such as completing home therapy and receiving end of treatment letters on what they have achieved through therapy, as well as thoughts that they had surrounding therapy coming to an end:

Participant 2*: '[Therapist] gave me tips on how to carry on with 'home-therapy' which allows me* to carry on tackling this eating disorder confidently on my own.*'*

Participant 13*: 'Feel scared/anxious about 'support' once my last follow*-up [appointment] had happened.*'*

Theme 5: Overall experience of CBT-T (two subthemes)

Subtheme 1: Comparison to other therapies. Ten of the 17 participants (59%) detailed how they felt CBT-T compared to other therapies that they had previously undertaken for either their eating disorder or other mental health difficulties (four with prior eating disorder treatment, and six with non-eating disorder treatment):

Participant 2*: 'The only previous therapy I had was counselling and I didn't find dwelling on* horrible past events helpful at all. CBT-T focussed on the present and the future, which gave me a much more positive outlook on the situation.*'*

Participant 6*: 'I have had therapy for depression before and hated it*. Nothing really changed from *it. But CBT has actually changed my behaviour and thought process for the better.'*

Subtheme 2: Compliments. Seven of the 17 respondents (41%) wished to give general compliments and thank the service and their therapist:

Participant 2*: 'I am so, so pleased that I carried out this programme*.'

Participant 12*: 'I really appreciate all your time and effort and can't thank you enough for helping* me.'

Discussion

The aim of this study was to understand patients' experiences of CBT-T – a recently developed, brief form of CBT-ED for non-underweight patients. The themes that emerged demonstrated that the key areas to consider were: the therapeutic relationship; the nature of the therapy; its challenging but beneficial aspects; ending therapy; and the overall experience of CBT-T (including comparison with other therapies). The patients were generally positive regarding their experience of CBT-T. This included having someone to discuss their issues with who was both firm but fair, feeling that CBT-T was tailored to their needs, and finding that it had a positive effect on their eating behaviours and general quality of life. Those who compared CBT-T with previous experiences of therapy were strongly positive about this treatment. The negative aspects were mostly about timing issues, including fitting appointments around their daily life and wanting more than 10 sessions.

In line with a large proportion of qualitative research, this work has focused on generating hypotheses about the mechanisms and acceptability of CBT-T rather than developing definitive conclusions about the nature of the therapy and how it is experienced. However, the fact that the thematic analysis reached saturation and the themes were robustly developed suggests that these themes are worth considering in future research. One limitation to this work is that it was not possible to associate these qualitative findings with how well or poorly participants did in therapy, given the anonymous collection of data and the nature of the consent obtained. However, future work might consider validation of the qualitative themes through association with clinical outcomes. It was also not clear whether this subset of patients was representative of wider case series, and such data should be collected in future work.

This work would also benefit from replication using a more open interview approach and from comparison to themes generated from analysis of therapists' perspectives of CBT-T. However, the key comparison would be with existing, 20-40 session versions of CBT-ED. In particular, do patients undertaking longer versions of CBT-ED experience that therapy as being more adequate in length, or would any duration of therapy be regarded as too short by a substantial proportion of people? If so, are there characteristics of that group that should be considered (e.g., are they more likely to be patients who were less responsive in the early stages of treatment?), and is that pattern of experience unique to CBT-ED or is it found in all therapies? According to the findings in relation to that question, one might need to attend to early signs that the patient is going to be dissatisfied with the duration of therapy, in order to enhance effective engagement and potentially reduce attrition.

It is also important that the time between therapy and gaining feedback regarding patients' experiences of treatment is investigated, as that interval can influence how acceptable treatment is seen as being by patients (Griffiths et al., 1998). In this study, patients who had completed the treatment up to two years previously were contacted, and the treatment was generally perceived as highly acceptable and suitable. Future work should consider whether the time since therapy influences patient evaluations of CBT-T positively or adversely, as this might affect when one should assess patient perspectives on outcomes. The moderating effect of positive patient expectations of treatment should also be considered, as they have been shown to be linked to the therapeutic alliance and outcomes in the eating disorders (Constantino, Arnow, Blasey & Agras, 2005; Peterson et al., 2016). The present study analysed data from completers and non-completers collectively. However, future work might usefully explore themes in these groups separately in order to further understand why some individuals discontinue therapy. Furthermore, this study was completed in an adult setting, and future research might usefully explore patients' experiences of treatment within adolescent settings.

CBT-T has strong clinical outcomes, comparable to those from other forms of CBT-ED (Pellizzer et al., in press; Waller et al., 2018). This study has shown that patients also

experience the therapy positively in terms of outcome and alliance. However, some patients wanted the therapy to be longer. This is a common theme within therapy (e.g. Lose et al., 2014; Sánchez-Ortiz et al., 2011), with a culture of people expecting therapy to be open-ended. Developments of CBT-T should consider whether there are individuals who are more suited to longer therapies, but given the comparability of outcomes of CBT-T and other forms of CBT-ED it is not clear that this will be the case or how one might determine who would benefit from the longer or shorter therapies. Direct comparison of CBT-T and longer therapies would be needed, considering the possible moderating role of individual differences (though these have not been found in previous therapy comparisons (e.g., Fairburn et al., 2009). Without evidence that longer therapies could be more effective for some patients, the issue of limited therapy resources should be considered in making any decisions about the length of treatment to be offered to patients with bulimia nervosa and other eating disorders.

Patients in previous CBT-T studies also reported a strong therapeutic alliance, which is compatible with the findings of this study. This finding is not incompatible with the patients' experience of CBT-T as 'firm', as the CBT-ED alliance is reported to be more likely to be effective if it combines firmness with empathy (Wilson, Fairburn, & Agras, 1997). Therefore, as with CBT-ED more broadly, therapists delivering CBT-T should not be reluctant to be firm in their approach, as patients experienced that positively here. Rather, the balance of firmness and empathy appears to be important. This need for an emphasis on 'firm empathy' means that clinicians should not assume that the patient's perception of a strong therapeutic alliance reflects a key change element. The benefits of methods such as exposure are more likely to be the result of the therapist and patient having a rapport that encourages the patient to undertake perceived risky changes, rather than any attachment bond per se.

To conclude, patients' experience of CBT-T shares many themes with those of other effective therapies for eating disorders. They reported positive experiences of the nature and outcome of the therapy. These findings support the use of CBT-T among adults with bulimia nervosa, and it is likely to be acceptable to patients with other non-underweight eating disorders. Issues regarding the duration of therapy need to be considered in future research,

as it is not clear that longer therapies are associated with better outcomes (e.g., Rose & Waller, 2017). It is also important to note that those patients who had experienced other therapies previously were positive about CBT-T in comparison. That viewpoint needs to be followed up in future research, comparing CBT-T to other therapies for eating disorders.

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