THE NEED FOR CHANGE: A PLURALISTIC PSYCHOTHERAPEUTIC APPROACH TO ADULT OUTPATIENT TREATMENT FOR ANOREXIA NERVOSA - A CRITICAL LITERATURE REVIEW

by

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Abstract

Eating disorder anorexia nervosa has the highest mortality rate of any mental health condition and is historically viewed as one of the most challenging to treat. Recommended psychotherapeutic treatment offered to adult outpatients with a moderate form of the condition via the National Health Service in Wales is exclusively based on an enhanced form of cognitive behavioural therapy (CBT-ED). This research is presented as a standalone critical review of post-2015 literature concerning CBT-ED and its variant CBT-E as an outpatient treatment for adults with anorexia nervosa in order to answer the research question: Could a pluralistic psychotherapeutic approach fulfil a need for an alternative NHS adult outpatient treatment for moderate anorexia nervosa? It critically explores: (a) A need for alternative forms of therapy to be offered to the above patient demographic; and (b) Whether a pluralistic approach could fulfil that need. Findings in relation to (a) include: (i) CBT effectiveness can be interpreted as moderate at best in routine outpatient practice, with high levels of drop-out at around 50%; (ii) Many patients find CBT unsatisfactory or unsuitable, however, their experience and preferences are neglected by researchers and healthcare policy makers despite being key to improving or developing treatments; and (iii) Tentative links may therefore be implied between high levels of outpatient drop-out and treatment dissatisfaction. Findings in relation to (b) suggest: (i) a pluralistic approach may fulfil a need for an alternative intervention which could contribute to reducing drop-out due to its focus on tailored, individualised treatment and client-therapist collaboration strongly support patient preferences; and (ii) The approach also allows for a variety of different therapeutic modalities to be practiced which may better suit patients' needs than the 'one-size-fits-all' model currently offered. Being a relatively new approach, recommendations are strongly made for further research in relation to working pluralistically with AN, with a particular focus on patient preferences.

Keywords: Anorexia nervosa, CBT-ED, pluralistic, outpatient, NHS, drop-out, psychotherapy

Declarations and statements

Declaration

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed:

Date: 20 June, 2022

Statement 1

This dissertation is being submitted in partial fulfilment of the requirements for the degree of Master of Arts Psychotherapeutic Practice (Humanistic)

Signed:

Date: 20 June, 2022

Statement 2

This dissertation is the result of my own independent work / investigation, except where otherwise stated.

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Statement 3

I hereby give consent for my dissertation, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Introduction

Anorexia nervosa (AN) has been described as a deadly, disabling and costly mental disorder (Brockmeyer, Friederich and Schmidt, 2018) and a severe psychiatric illness (Frank and Shott, 2016) which is one of the most challenging to treat (Zipfel et al., 2015). Associated with harmful eating behaviours such as purposefully restricting calorie intake to maintain a low body weight (National Institute for Health and Care Excellence (NICE), 2019a), AN is classified as an eating disorder (ED) (APA, 2013) characterised by psychological and physical comorbidities which compound its complexity (Treasure et al., 2015). The condition is likely to take a chronic course and has the highest mortality rate of any mental health condition due to an increased risk of suicide or starvation-associated medical complications (Harding, 2017; Schmidt, Wade and Treasure, 2014); consequently, the disease burden on those with AN, their carers and society is substantial (Schmidt et al., 2016).

Support on an outpatient basis is offered by the National Health Service (NHS) for most patients with AN; this includes psychoeducation and monitoring of weight with the goal being to help patients reach a healthy BMI for their age (NICE, 2020). Understandably, weight gain is considered a vital first step to reduce the physical effects of starvation (Murray, Loeb and Le Grange, 2018). Psychotherapy is also offered in the form of ED-focused cognitive behavioural therapy (CBT-ED), specialist supportive clinical management (SSCM) and Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) (NICE, 2020). Focal psychodynamic therapy (FPT) is also available if the above treatments are ineffective (NICE, 2020). However, CBT-ED is recommended as the sole mild to moderate AN intervention in Wales as a means of developing “universal approaches to service delivery” (NICE, 2020; Matrics Cymru, 2017), an approach broadly researched with randomised controlled trials (RCTs) and meta-analyses championing its efficacy (Linardon et al., 2017). Moreover, advances have led to the development of what is described as a comprehensive treatment suitable for both adults and adolescents, outpatients and inpatients with AN, and the delivery of clinical services wholly based on CBT-ED (Dalle Grave et al., 2016). CBT-ED is therefore considered the ‘gold standard’ therapeutic intervention for all levels of AN; a comprehensive, ‘one-size-fits-all’ treatment selected by policy makers due to its strong evidence base.

It can therefore be assumed that for any psychotherapeutic treatment to be considered ‘gold standard’, proving its efficacy is essential, yet such evidence is not as robust as many researchers have claimed (Leichsenring et al., 2018). In addition, good therapeutic outcomes for outpatients with AN are inconsistent (Byrne et al., 2017), with none of the NICE-endorsed psychological therapies (2020) being found substantially superior (Byrne et al., 2017). Such findings question the justification for regarding CBT-ED as the ‘gold standard’ AN treatment, while underscoring a need to explore other treatment options (Le Grange, 2016), the premise being that more patients could benefit from a new generation of treatments (Munro, Randell and Lawrie, 2017). Meanwhile, interest in more holistic approaches to ED recovery is growing (de Vos et al., 2017), echoed by recommendations for treatment being more person-centred and relationship-based (Welsh Government Eating Disorder Service Review, 2018). Crucially, these preferences have also been highlighted by patients who, in their experience of CBT-ED, believe too much focus is placed on food and weight and that there is too little acknowledgment of AN being a whole-person condition (Rance, Moller and Clarke, 2017). Such criticisms indicate this revered approach may not in fact be suitable for all. It can also be suggested that a departure from ‘one-size-fits-all’ treatment monoculture could herald more favourable outcomes for many, since statistically it has been found that on average less than half of patients recover (46%), a third improve (33.5%) and 20% remain chronically ill (Beat Eating Disorders, 2022; Steinhausen, 2002). Additionally, substantial levels of patient drop-out in CBT-ED treatment have been identified as an issue that needs to be urgently addressed (Linardon, Hindle and Brennan, 2018). Drop-out has typically been attributed to patients' ambivalence towards change and recovery (Schmidt and Treasure, 2006; Vitousek, Watson and Wilson, 1998), however, resistance could arguably be due to unsuitability of therapeutic approaches rather than AN characteristics.

A lack of therapeutic frontrunner in mainstream health services, coupled with high drop-out levels, is concerning given the likely chronicity of AN and its associated health risks. An urgent need for alternative treatment options has already been identified, with leanings towards person-centred, humanistic approaches. However, the author considers it naïve to believe one single, alternative approach could be sufficient to substantially improve treatment effectiveness and minimise drop-out given the complexities of the condition. This work therefore aims to critically explore a pluralistic psychotherapeutic approach as a means of fulfilling the need for alternative AN outpatient treatment. An integrative form of practice which emphasises collaboration and accommodating patient preferences, the approach acknowledges there may be many contributory factors to mental health issues, therefore individuals require different interventions at different times during the therapeutic process (Cooper and Dryden, 2016). It also implies a prizing of diversity through tailoring therapy to the individual, and the consequent rejection of single-track views that stifle individuality and difference (Cooper and Dryden, 2016). The author views this stance as a positive challenge to the treatment monoculture and dogmatism prevalent in the psychotherapy field, championing the concept that a bespoke approach, contrary to the ‘one-size-fits-all’ recommendations currently prescribed, would offer a greater chance of AN treatment success. Moreover, outpatients not receiving their most suited treatment could lead to increased necessity for inpatient treatment, escalating the burden on the health service, plus impacting on caregivers and society. A pluralistic approach could therefore potentially lower drop-out levels and increase the likelihood of treatment success, preventing further chronicity. This work offers a valuable contribution to current research by presenting a necessary alternative to current treatment which may benefit a larger cohort of patients, a relatively new approach considered the future direction of psychotherapy (Fernández-Álvarez and Fernández-Álvarez, 2019), thus creating a shift away from CBT-ED monoculture. Moreover, the author considers the research to be particularly timely due to many with EDs experiencing worsening symptoms during lockdowns associated with the Covid-19 pandemic (Schlegl et al., 2020), leading to a likely increase in referrals to treatment services. The number of patients being diagnosed with AN is also likely to have increased in recent years due to relaxation of classification criteria (Mustelin et al., 2016) which would also place an additional burden on an already under-pressure health service.

The author has no personal connection to AN, however she is a humanistic psychotherapy student who, true to the values of the approach, believes the client/patient is the ‘expert’ on their condition rather than the practitioner since they have the lived experience of it. It therefore follows that collaboration with the ‘expert’ during treatment and feedback on their experience, which incidentally are cornerstones of pluralistic therapy (Cooper and Mcleod, 2007; 2011), may be key to improving outcomes. However, preliminary searches support that research regarding AN outpatient experience is limited (Rance, Moller and Clarke, 2017); such paucity arguably needs to be addressed since such evidence could provide vital insight into how services should be improved. It can also be suggested that failure to explore and address reasons for drop-out from a patient perspective thus far means ‘blame’ for challenges in AN treatment continues to be placed at the door of the patient rather than apportioned to the type of treatment available.

This work stems from research carried out by the author towards a previous assignment exploring potential tensions humanistic psychotherapists may experience in working with anorexic patients within an NHS setting. The research was therefore influenced by this paradigm; however, ethical consideration was given to avoiding bias through evaluating literature written from a variety of standpoints rather than solely those with humanistic leanings. This, combined with the use of text-matching portals in order to avoid plagiarism, serves to strengthen the credibility of the work. It will take the form of a standalone critical review of the literature concerning CBT as an outpatient treatment for adults with the condition. A scoping search of the keywords ‘anorexia’, ‘treat*’, ‘therap*’, ‘outpatient*’ (and) ‘CBT’ and ‘adult’ from the databases Wiley Online, Elsevier Science Direct, ProQuest Central and Sage Journals yielded 787 results. The secondary literature was discounted if duplicated, not peer reviewed or related to the following: severe AN; randomised controlled trials; inpatients; adolescents. Research published before 2015 was also discounted for the work to be considered current. Data selected according to the above criteria included both quantitative (four) and qualitative (one) literature in order to present a broader, multi-faceted view of the research landscape in relation to the topic; a manual search yielded a second suitable qualitative study. The comparative lack of qualitative data subsequently contributed to the discussion. Information from books and ‘grey’ literature such as reports, policy and government documents were also utilised, plus credible internet sources such as the BBC and eating disorder charity websites. Further manual searches of the university’s online library were also undertaken in relation to literature regarding i) AN in general; and ii) pluralistic therapy. Chapter 1 will explore the signs and symptoms of AN and its aetiology from different perspectives in order to highlight its many complexities. Chapter 2 will critically discuss the efficacy and effectiveness of CBT-ED in relation to the chosen demographic, while Chapter 3 will focus on patient experiences and a growing body of research which supports treatment change. Chapter 4 will discuss pluralism in relation to AN treatment and the work will conclude in Chapter 5, along with recommendations for further research. An Appendix concisely presents the main themes which support the arguments and conclusions.

Chapter 1: Overview of AN

AN symptoms and aetiology will be outlined in this chapter, along with an exploration of its incidence and prevalence, plus risk factors in relation to gender, sexuality and ethnicity. While primarily informative, serving to highlight the condition's complexities, it will also demonstrate a need for improvements to ED services, creating a foundation for discussion in the following chapters regarding current treatment approaches.

1.1 Symptoms of AN

AN is characterised by acute fear of weight gain and a distorted body image which drives severe calorie restriction or other behaviours facilitating weight loss, such as purging or excessively exercising (Zipfel et al., 2015). Relentless pursuit of thinness drives a dread of food, with individuals becoming distressed if asked to eat (Schmidt, Wade and Treasure, 2014). Substance misuse is also a feature (World Health Organization, 2021), including the use of diuretics, laxatives and appetite suppressants to curb weight gain (NHS, 2021). Those with AN are underweight for their age and sex (APA, 2013), often with an unusually low body mass index (BMI); other physical symptoms may include dizziness, hair loss and menstruation cessation in females (NHS, 2021). Further indicators include low self-esteem, depression, obsessive compulsive disorder, perfectionism, self-harm (APA, 2013; World Health Organization, 2021) and, in particular, anxiety (Mehler and Brown, 2015). Serious long-term physical effects of AN include osteoporosis, infertility, heart problems, seizures, kidney and bowel damage and a weakened immune system (NHS, 2021), leading to increased risk of premature death (Franko et al., 2013).

1.2 Aetiology of AN

Pressure to be slim experienced, for example, by jockeys, gymnasts and models, is often supposed to contribute to AN onset (Harding, 2017). Further common assumptions include that AN is self-inflicted for vanity reasons, such as in societies that equate thinness with attractiveness (Bannatyne and Stapleton, 2018). Indeed, a study of American female undergraduates found attitudes towards AN were a combination of irritation due to perceived self-infliction, and admiration due to weight loss achieved (Geerling and Saunders, 2015). However, perceptions of the extent to which sociocultural factors cause AN have been found to vary significantly between those who have the condition and those who do not. For example, only 8% of participants with AN felt media and culture ideals were the underlying cause of their condition, while 47% of participants without EDs believed the opposite (Blodgett Salafia et al., 2015), although, interestingly, this sample was a fairly homogenous in terms of gender and ethnicity, so results cannot be generalised to males and non-whites. Nonetheless, while exposure to media messages is indeed considered a contributary factor to EDs (Sidani et al., 2016) with links between higher social media usage and lower body satisfaction having been observed (Strother et al., 2012), AN aetiology is considerably more complex, arising from interaction of multiple biological, psychological, developmental and sociocultural risk factors (Rikani et al., 2013). These include depression or substance misuse within the family, sexual abuse, puberty onset and criticism, perceived or otherwise, relating to weight or eating behaviours (Harding, 2017).

Advances in understanding the underlying psychobiology contributing to the onset and maintenance of AN have led to the contention that genetic vulnerability influences risk, psychosocial and interpersonal factors may trigger onset, and neural network changes maintain it (Zipfel et al., 2015). For example, twin and adoption studies estimate AN heritability as between 28% and 74%, with personality characteristics such as perfectionism, reward and punishment sensitivity and obsessional propensity – all believed to increase the risk of developing the condition – between 27% and 71% (Thornton, Mazzeo and Bulik, 2010). Moreover, genetic vulnerability is more likely to lead to AN onset during mid to late adolescence; an Australian twin study found this a potentially critical time for heritable risk of disordered eating to increase due to the possibility of non-shared environmental risk factors and weight-related peer teasing having a more detrimental impact on an individual (Fairweather-Schmidt and Wade, 2015).

AN is also broadly accepted as a brain-based disorder with suggestions of neurobiological overlaps between AN, anxiety disorders and addictions (Treasure et al., 2018; Dunlop, Woodside and Downar, 2016; Steinglass and Walsh, 2016; Vannucci et al., 2015; O'Hara, Campbell and Schmidt, 2015). Different phases of the condition have been recognised, with brain responses believed to be most malleable in the early stages (Treasure, Stein and Maguire, 2015). As AN becomes more persistent there is neurobiological evidence of habitual and compulsive behaviours (Steinglass and Walsh, 2016; O'Hara, Campbell and Schmidt, 2015). Indeed, response to treatment tends to be poor and drop-out high once AN is well established, approximately three years after onset (Schmidt, Wade and Treasure, 2014).

1.3 Incidence and prevalence of AN

AN incidence and prevalence are estimated to be up to 15 times higher in women than men (Treasure et al., 2015). However, it is believed AN rates in males are likely to be underestimated because the stigma of having both a psychiatric and 'female-specific' condition means cases remain under-detected (Raevuori, Keski-Rahkonen and Hoek, 2014). The condition most often emerges in adolescence, with highest rates around age 15 (Petkova et al., 2019). Indeed, adolescents, alongside young adults and women, have been identified as being most at risk of disordered eating (Rosenvinge and Pettersen, 2015); the perimenopausal period of a woman's life is also considered a high-risk time (Mangweth-Matzek and Hoek, 2017). However, AN onset is also evidenced in the elderly (Taylor, Gill and Harripaul, 2015), hence it does not necessarily affect a 'typical' demographic.

AN is considered more common in Western countries where food is not in short supply (Pilgrim, 2019), with some studies finding white adult women have a higher lifelong prevalence (Udo and Grilo, 2018) compared to other ethnic groups, predominantly due to the greater value believed to be placed on the 'thin ideal' (Warren et al., 2005). Non-whites also tend to experience greater body positivity and lower body dissatisfaction (Grabe and Hyde, 2006). It has been suggested certain cultural factors may protect ethnic minorities from EDs; for example, some east Asian societies associate thinness with poverty and poor health and therefore tend to prefer larger body sizes (Jung and Forbes, 2007). Similarly, a larger, voluptuous body is considered more attractive among African American and Hispanic communities (Gordon et al., 2010), with dieting considered racially incongruent behaviour among these groups (Oyserman et al., 2012). In contrast, studies have found no significant ethnic differences in AN prevalence (Marques et al., 2011; Swanson et al., 2011), and no differences in body dissatisfaction between whites and Asian Americans (Grabe and Hyde, 2006), with exposure to Western media linked to female adolescents in Asian and Pacific Islander cultures experiencing increased body image and eating disturbances (Watters, 2010).

A cultural study comparing eating and general psychopathology in individuals from China, Spain and the UK diagnosed with AN found more similarities shared by those from Western societies than from China (Agüera et al., 2017). While participants from Spain and the UK showed greater body dissatisfaction, somatisation and general psychopathology, Chinese patients tended to minimise or deny psychopathological symptoms such as anxiety and depression (Agüera et al., 2017). Meanwhile, gender comparison studies in relation to AN have also found some differences, for example, men overexercise more than women to lose weight (Murray, Griffiths, Rieger and Touyz, 2014) and women are more concerned about body shape and weight (Darcy et al., 2012). Men are also usually older at AN onset and have higher rates of mortality (Gueguen et al., 2012).

However, EDs have more recently been found to occur at higher rates among sexual/gender minorities (SGMs) (McClain and Peebles, 2016; Watson et al., 2017). Although most consistently evident in SGM men (Calzo et al., 2017; Diemer et al., 2015), higher rates of EDs have been found among SGM women, who are also more likely to engage in disordered eating behaviours than cisgender heterosexual women (Meneguzzo et al., 2018). These differences have been linked to Minority Stress Theory (Meyer, 2003), which posits that marginalised groups experience stigmatisation and social exclusion which causes higher rates of chronic conditions and poorer health outcomes (Brewster et al., 2019; Calzo et al., 2017). Persistent discrimination can lead to vulnerability which puts individuals at a greater risk of victimisation through, for example, bullying, abuse and violence (Kann et al., 2011); risk factors for the development of EDs. However, risk factors also vary for SGM groups (Duffy, Henkel and Earnshaw, 2016; Wang and Borders, 2017). For example, gender dysphoria contributes to EDs in transgender individuals (Duffy, Henkel and Earnshaw, 2016), homophobic bullying during childhood has been linked to disordered eating in SGM men (Wiseman and Moradi, 2010), while higher rates of EDs have been identified in SGM men who experienced abuse in childhood (Feldman and Meyer, 2007).

1.4 Impact of pandemic

A 95% increase in individuals accessing support from a UK ED charity from February to December 2020 was recorded (Beat Eating Disorders, 2021), coinciding with the spread of the Covid-19 pandemic and subsequent nationwide lockdowns. Indeed, studies have found lockdowns negatively impacted those with EDs, with symptoms worsening for 87% of participants (Branley-Bell and Talbot, 2020). Reasons for worsening symptoms included social isolation, reduced access to support networks and healthcare services; disruption to routine; exposure to public health initiatives promoting exercise and healthy eating; and weight gain fears amongst the general public due to a decrease in activity sending triggering messages. The study also found lockdowns provided timely justification for a having a shortage of food at home (Branley-Bell and Talbot, 2020). Since data were collected during the early stages of lockdown and participants recruited opportunistically via social media, the sample may arguably be biased towards those experiencing difficulties at that point in time, therefore longitudinal research may provide a more accurate picture of the full effects of the pandemic on those with EDs. Notwithstanding, acknowledging that an increased risk of developing an ED and the aggravated challenges faced by those already suffering with one had led to increased numbers seeking help, 40 UK MPs and lords signed a letter calling on the government to ensure more appropriate support for its physical and mental impacts (BBC, 2021). The letter urged investment in research for future treatments alongside a consistent approach for all age ranges to provide support at the earliest opportunity, citing that demand for specialist healthcare services for EDs was outstripping capacity even before the public health crisis. Furthermore, prior to the pandemic, government-commissioned reviews had concluded that NHS ED services were lacking; Welsh services, for example, were found to be substantially under-resourced with only the most acute cases being treated appropriately (Welsh Government Eating Disorder Service Review, 2018).

Moreover, while research into treatment of EDs such as bulimia nervosa and binge eating disorder has been successful in identifying treatments with improved recovery rates, progress has been substantially slower for AN (Draxler and Hiltunen, 2012). Indeed, it is believed no improvements in treatments have been proven in more than 50 years (Steinhausen, 2002). Scepticism surrounds the usefulness of outpatient therapy with suggestions its efforts to help adults achieve weight restoration has been largely unsuccessful (Attia and Walsh, 2009). Meanwhile, the past 40 years has seen a significant increase in the incidence of AN in females, mainly from Western countries, and especially in outpatient healthcare services (Martinez-Gonzalez et al., 2020), however, greater public awareness, better detection and broader diagnostic criteria have been offered as an explanation for the increase (van Eeden, van Hoeken and Hoek, 2021). The latest Diagnostic and Statistical Manual of Mental Disorders (DSM-V), used to define and classify psychiatric disorders (APA, 2013), introduced three changes to AN diagnosis; a study exploring their impact found that out of 92 participants meeting the criteria for AN diagnosis according to the DSM-V, 55 fulfilled previous DSM-IV criteria while 37 were new DSM-V cases (Mustelin et al., 2016). The findings suggested earlier diagnosis according to the DSM-V, when the condition is less likely to cause severe damage to physical health, but also an increase in cases diagnosed.

1.5 Summary

Beliefs that AN arises due to a preoccupation with an aesthetic, sociocultural ideal can be described as simplistic, although common. Nonetheless, the contributory role of Western media, including social media, in the creation, influence and maintenance of the notion that thinness equals attractiveness must be acknowledged, particularly in relation to females during vulnerable developmental periods of their lives. While the assumption that AN mainly affects young, white females is not unfounded, ethnic minorities are also influenced by pressures of the Western ‘thin ideal’ even if it opposes cultural norms. Moreover, more widespread acknowledgement that higher rates of EDs have in fact been found among sexual/gender minorities is needed in order to facilitate a move away from the young, white, female stereotype. In addition, stigma often prevents males with AN from seeking treatment, rendering them statistically under-represented, again contributing to the generalisation that AN is a female-specific condition. Furthermore, although diagnosis may be the same for all individuals, AN is a complex, brain-based condition, with the risk of and pathways to its development influenced by the interplay of genetic, interpersonal and psychosocial elements unique to each individual. Differences also exist in the psychopathology comorbid to the condition, suggesting a need for therapeutic treatment to be modified not only according to culture, gender and sexuality but also to the individual. Consequently, it can be suggested that no single treatment has the capacity to meet this need.

Outpatient healthcare services in Western countries have seen a significant increase in the number of female patients with AN over the past four decades, however, the usefulness of therapeutic approaches utilised within them has been questioned, with slow progress in identifying treatments yielding better recovery rates. In the UK, increasing patient numbers could place a greater burden on an already pressurised health service, leading to increased waiting times for treatment. Such pressures are likely to be compounded by the effects of the Covid-19 pandemic which has seen the onset or worsening of AN symptoms for many. Concerns are so great that MPs have demanded improved support and funding made available for research into future treatments. Furthermore, an increase in diagnoses and subsequent referrals, coupled with high drop-out and relapse rates, offers a timely opportunity for alternative treatment approaches to be made available via NHS services. Chapter 2 will include a critical literature review of current AN outpatient treatments, specifically CBT-ED, since it is considered the ‘gold standard’ therapy.

Chapter 2: Quantitative CBT research

Psychotherapy as an outpatient is the first-line treatment recommended for most adults with AN (Zipfel et al., 2015). While it is beyond the scope of this chapter to evaluate each of the four interventions available via the NHS (NICE, 2020), research has focused on CBT-ED since clinical guidelines recommend it as the sole treatment for mild to moderate AN in Wales (Matrics Cymru, 2017). The chapter will critically evaluate CBT's standing as the 'gold standard', CBT for EDs, efficacy and effectiveness trials for AN treatment, including a critical literature review of CBT-E for adult outpatients in 'real-world' settings. Its aim is to challenge CBT's premier status in terms of AN treatment and highlight gaps in research. Literature surrounding treatment comparisons and a need for improvements will also be acknowledged.

2.1 CBT for EDs

CBT has been described as a logical choice for treatment since it is concerned with shifting dysfunctional thinking, behaviours, and emotional responses commonly associated with EDs (Galsworthy-Francis and Allan, 2014). According to cognitive behavioural theory, symptoms are maintained by the overvaluation of body shape, weight and their control (Fairburn, Cooper and Shafran, 2003). This overvaluation is believed to develop when personal characteristics such as perfectionism and asceticism interact with sociocultural ideals relating to appearance (Vitousek, 1996). Other features of EDs, for example excessive and compulsive exercising, strict dieting and laxative misuse, stem from this core psychopathology and reinforce it (Fairburn, Cooper and Shafran, 2003).

Clinical guidelines for adult outpatients with AN recommend CBT-ED is delivered weekly for up to 40 weeks, with twice-weekly sessions in the first two or three weeks (NICE, 2019b). Aims are to reduce risks to physical health and other condition-related symptoms; encourage healthy eating and achieving a healthy weight; explain the risks of malnutrition and being underweight; and that treatment encompasses nutrition, cognitive restructuring, mood regulation, body image concerns, self-esteem, social skills, self-efficacy and relapse prevention (NICE, 2020). Further targets include the creation of a treatment plan based on the processes maintaining the patient's condition, self-monitoring of food intake and associated thoughts and feelings, and homework to help the patient practice what they have learned in their daily life (NICE, 2020).

Initially designed as an outpatient treatment, CBT-E is one of the principal examples of CBT-based therapies for EDs which is covered by the umbrella term CBT-ED (Murphy et al., 2020). Based on a transdiagnostic interpretation of EDs (Fairburn, Cooper and Shafran, 2003), the first phase focuses on increasing patients' motivation to recover; in the second, patients are helped to regain weight while also tackling their ED psychopathology, while the third and final phase helps patients develop strategies to identify and correct setbacks (Fairburn et al., 2013).

2.2 The 'gold standard'

CBT is considered the 'gold standard' treatment – the best currently available – since it is the most researched form of psychotherapy with no other systematically found superior to it (David, Cristea and Hofmann, 2018). Indeed, CBT-E has been extensively researched with RCTs, meta-analyses (Linardon et al., 2017) and systematic reviews (Atwood and Friedman, 2019) supporting its efficacy. Advances in the past 15 years have also led to a comprehensive AN treatment being developed which is considered suitable for adults as well as adolescents, inpatients and outpatients, and the delivery of entirely CBT-E-based clinical services (Dalle Grave et al., 2016). Since healthcare providers must base their clinical decisions on the best available evidence (Singal, Higgins and Waljee, 2014), CBT-E is recommended as the sole intervention for mild to moderate AN in Wales in an aim “to develop universal approaches to service delivery” (Matrics Cymru, 2017, pp. 6).

However, the modality’s status has been challenged on the grounds that many RCTs are of low quality and/or have weak comparator conditions (Fernández-Álvarez and Fernández-Álvarez, 2019). In response to attestations that CBT provides the most solid evidence in terms of both efficacy and effectiveness (David, Christea and Hofmann, 2018), it is argued that an approach’s theoretical consistency cannot be demonstrated by the mere accumulation of empirical evidence (Dozois and Quilty, 2014). Moreover, even supporters of CBT acknowledge there is clearly room for improvement in the approach’s efficacy and effectiveness, as well as its theories and mechanisms of change (David, Christea and Hofmann, 2018).

2.3 The research-practice gap

RCTs are considered the most reliable means of determining treatment efficacy (Vickers, 2014); how well the intervention performs under ideal and controlled conditions (Revicki and Frank, 1999). It is suggested efficacy studies are conducted first for internally valid results to be established and, once a treatment’s efficacy has been proven, effectiveness studies should be carried out in the form of real-world clinical trials (Singal, Higgins, and Waljee, 2014). However, critics believe RCT design is unfit for purpose due to factors including failure to meet patient enrolment targets (Vickers, 2014). Indeed, it can be said that most AN treatment studies are compounded by small, homogeneous sample sizes, along with high drop-out rates, and no control condition (Agras and Robinson, 2010). Research limitations may partly be due to difficulty in recruiting participants, low AN prevalence rates, and AN-related medical complications which may necessitate study withdrawal for inpatient care (Agras and Robinson, 2010). Ambivalence towards recovery is also believed to hamper research efforts (Brauhardt, de Zwaan and Hilbert, 2014). It has also been suggested that many RCTs fail to answer clinically relevant questions (Vickers, 2014) and may overestimate an intervention's effect when it is applied in routine clinical practice (El-Serag, Talwalkar and Kim, 2010). Interestingly, an effectiveness review (Groff, 2015) highlighted that available CBT-E research had mostly been carried out by its primary founder, Christohper G. Fairburn, which posed problems due to the allegiance effect possibly influencing results, in other words:

> "The tendency of the investigators to favour their own preferred treatment in conducting studies" (Prochaska and Norcross, 2014, pp. 133).

Nonetheless, whether evidence-based interventions can be translated adequately into delivery in real-world settings, where clinicians are less specialised, patients are likely to be more complex, and multidisciplinary teams less co-ordinated has been frequently questioned (Anderson et al., 2021) and is of particular concern in the treatment of EDs (Lilienfeld, 2013). For example, in the real world, treatment for patients with EDs depends largely on clinicians' judgement and training, and although evidence-based interventions such as CBT-E are available, they may not be delivered well (Shafran et al., 2009) or adhered to with the same rigour as in clinical trials (Dalle Grave et al., 2016).

2.3 CBT-ED/E for adult AN outpatients in real-world settings

CBT-E has considerable empirical evidence to support its efficacy, however, few studies have examined its effectiveness in routine clinical practice (Turner et al., 2015). Only two evaluating CBT-E and CBT (Byrne et al., 2011; Waller et al., 2014) had been identified before 2015 (Turner et al., 2015); these focused on patients presenting with a broad range of EDs, and bulimia nervosa, respectively. Nonetheless, Fursland et al. (2012) championed

CBT-E’s effectiveness in such settings despite drawing this conclusion from the earlier of the two above studies, hence there was little evidence to support such claims. Post-2015 has yielded four further CBT-ED/E studies; two specifically relating to AN and two to EDs, within which AN is included. These will be reviewed with a view to establishing commonalities and identifying areas for further research.

One study of 63 adults with AN who began CBT-ED as outpatients in an NHS setting (Jenkins, Morgan and Houlihan, 2019) found that of the 34 (54%) who completed treatment, there were significant changes in ED symptoms, psychological distress and psychosocial impairment, in addition to the treatment having a substantial effect on body weight, therefore the results were hailed as a good outcome. However, almost half of participants (46%) dropped out of treatment; among the reasons given for non-completion, 41.3% stated it was because they failed to engage in the therapy.

Similar results were recorded by Frostad et al. (2018); 44 adult patients with AN started CBT-E in a hospital outpatient ED unit. Those who completed treatment had achieved a substantial weight gain with 77.3% reaching their target BMI. Consequently, CBT-E was deemed effective for outpatients in this capacity. However, 50% of participants dropped out of treatment, with 40.9% of those stating non-completion was because they did not wish to continue with psychotherapy, although no reasons were given as to why. Despite both studies describing CBT-ED/E as effective in outpatient settings, approximately only 50% of participants completed treatment and 40% of those who dropped out did so because they did not wish to continue with therapy or could not engage with it. It is therefore apparent that many patients’ needs were not met through the treatment and suggests a ‘universal’ approach to AN treatment is not in fact suitable for all patients regardless of its evidence base.

A further study (Turner et al., 2015) involved 179 adults who received CBT-ED in a UK outpatient community EDs service, 100 (55.9%) of whom completed treatment with significant improvements observed in ED psychopathology, depression, anxiety, and general functioning, confirming CBT-ED “can be delivered with strong outcomes in routine clinical settings” (Turner et al., 2015, pp. 74). However, 79 participants (44.1%) dropped out, with no factors that identified attrition being identified, leading to the assertion that research should no longer be preoccupied with whether the treatment is effective in the ‘real world’, but on the need to increase retention in such settings so more patients can benefit from evidence-based therapies (Turner et al., 2015).

Minimising dropout was also an important conclusion drawn from similar research evaluating the effectiveness of CBT-E within an outpatient service in Brisbane, Australia, which involved 114 women with a diagnosed ED (Signorini et al., 2018). Significant improvements in ED and general psychopathology were observed in those who completed treatment; hence the study was described as providing further support for using CBT-E to treat all EDs in routine clinical settings (Signorini et al., 2018). However, 50% of participants dropped out, with environmental and psychosocial issues predicting drop-out, leading to the implementation of strategies to enhance client engagement being recommended (Signorini et al., 2018). Positive outcomes were recorded in both studies, such as improvements in ED psychopathology, however, attrition was comparable at 44.1% and 50% respectively. Similarities in rates of attrition can also be drawn with the above research (Jenkins, Morgan and Houlihan, 2019; Frostad et al., 2018). However, drop-out levels were acknowledged, with psychosocial and environmental issues cited as contributary factors, and a need to enhance client engagement and increase retention highlighted.

Evidently, half of the included studies noted that CBT-ED/E drop-out rates need to be addressed, implying a large percentage of patients are not benefiting from this particular treatment. Indeed, studying and addressing treatment drop-out is also deemed necessary elsewhere in the literature, before further RCTs of AN are carried out (Halmi et al., 2005). A systematic review of treatment drop-out in outpatients with AN found rates typically ranging from 20% to 46% (DeJong, Broadbent and Schmidt, 2012), however, it is clear from this review that rates are consistently at the higher end of this scale, if not greater. In support of Groff (2015), it appears potential bias may indeed be a factor in the reporting of results. For example, a UK-Italy study (Fairburn et al., 2013) of 99 adults receiving CBT-E as outpatients found 64% completed treatment, while the open trial conducted by Byrne et al. (2011), as noted by Turner et al. (2015), which featured 49 adult participants recorded a completion rate of 63%. Hence drop-out levels were 36% and 37% respectively – substantially lower than the 44.1%-50% observed in subsequent studies. However, the former involved CBT-E's primary founder, Fairburn, while Fursland, who contributed to the latter study, also co-wrote a journal article championing CBT-E as a single treatment for all EDs, indicating strong allegiances to CBT-E and therefore potential bias in favour of the approach.

High drop-out levels in AN treatment have also been acknowledged as a significant concern for patients, their families and services, given the likelihood of serious morbidity and elevated risk of fatality associated with the condition (Abd Elbaky et al., 2014). Indeed, worse long-term prognoses is associated with those who drop out of treatment; they also tend to be referred again when their condition has become more chronic, and relapse is also more likely (Fassino et al., 2009). However, few studies have examined patients' reasons for dropping out or their experiences of treatment, yet this information could help to identify those likely to benefit from other approaches or how treatments may be tailored or improved (Danielsen et al., 2016). For example, potential reasons for drop-out may include dissatisfaction with the treatment model, poor therapeutic alliance, experiencing unsatisfactory results from the therapy, not feeling capable of completing required homework tasks, and issues such as work, family or health problems (Danielsen et al., 2016).

It is said that evidence-based practice in EDs comprises three vital components: research evidence, clinical expertise, and patient preferences, values and characteristics. Described as a ‘three-legged stool’ (Sackett et al., 1996), all three are deemed essential for the best care in ED treatment to be provided, however, the extent to which each of these components is valued varies among clinicians and researchers, with each of the stool’s ‘legs’ at times being neglected (Peterson et al., 2016). Failure to identify reasons for drop-out in real-world trials beyond patients’ inability to engage with the treatment (Frostad et al., 2018; Turner et al., 2015) can therefore be considered not only a missed information-gathering opportunity but the neglect of one of the important aspects which contribute towards evidence-based practice. While effectiveness studies in real-world settings have seen results consistent with RCT findings, drop-out rates are higher (Cooper and Bailey-Straebler, 2015), hence the most important focus appears to no longer be whether CBT-E works in routine clinical practice, but the need to improve patient retention. It could therefore be suggested a focus on qualitative studies in relation to CBT-E, with a focus on drop-out, would provide such vital information. It could also be argued that given the likely chronicity of AN, identifying reasons for such high levels of drop-out and using that knowledge to develop alternative means to combat it may prevent AN taking a chronic course for many.

2.4 Treatment comparisons; need for change

Overall, clinical improvements in adults with AN have been described as modest and outcomes disappointing, with high drop-out and relapse rates (Khalsa et al., 2017; Riesco et al., 2018; Van den Berg et al., 2019). Furthermore, no difference in outcome between any of the current adult AN treatment options has been found (Zeeck et al., 2018), hence no clear evidence supports superiority of psychotherapeutic treatments recommended in clinical guidelines (Solmi et al., 2021). For example, an RCT of psychological therapies for adult AN outpatients found CBT-E, FPT and optimised treatment as usual (TAU) outcomes were comparable (Zipfel et al., 2014), while Dalle Grave et al. (2016) commented that CBT-E is yet to withstand comparison against other recommended treatments such as MANTRA or SSCM, confirming a need for further examination to determine if it deserves its place as a ‘gold standard’ treatment for EDs (Groff, 2015). Moreover, there appears little convincing evidence to suggest any psychological intervention for adults with AN consistently produces good outcomes (Byrne et al., 2017), suggesting treatments are not reliably effective even for patients who complete them. For example, research has identified only one-third of AN cases as being in recovery two years post-treatment (Murray et al., 2019; Zeeck et al., 2018). Consequently, a need to improve the efficacy of AN outpatient therapies has been highlighted, particularly for those with a lower BMI (Wade et al., 2021). It is also considered timely and necessary to explore other options in order to inform new treatments which could benefit more patients (Byrne et al., 2017; Le Grange, 2016; Munro, Randell and Lawrie, 2017), with an urgent need for funding for new research to develop and improve adult AN therapies continuing to be underscored (Solmi et al., 2021).

2.5 Summary

CBT-ED is considered the ‘gold standard’ form of psychotherapy for all levels of AN and a ‘one-size-fits-all’ treatment suitable for all EDs selected by healthcare policy makers due to its strong evidence base. While healthcare providers must use the best available evidence on which to base clinical decisions, studies collecting such evidence have been criticised for their poor design and potential researcher bias. Moreover, the mere existence of evidence relating to a particular treatment is not considered enough to demonstrate its strength. In addition, no single type of therapy available in mainstream healthcare services for adult outpatients with AN has been found superior, despite CBT-ED being recommended as the first line of treatment, demonstrating the approach cannot be viewed as the ‘gold standard’.

While available treatments help to improve symptoms and promote weight gain, drop-out rates are high and a need to improve patient engagement and minimise attrition has been highlighted. It has been suggested drop-out is due to patient ambivalence towards treatment and recovery, believed to be characteristic of EDs, and clinicians straying from treatment protocol in their delivery, with research also finding psychosocial and environmental factors influential. However, it can be argued that high drop-out rates imply CBT-ED is not suitable for everyone and thus not a ‘universal’ intervention; those who drop out of treatment because they cannot engage with it may simply not be suited to the type of therapy offered, however, the ‘blame’ appears to have been placed on clinicians’ failures and patients’ ED characteristics.

Nonetheless, given the condition’s likely chronicity and associated health risks, there is a clear need to minimise outpatient treatment drop-out. Funding for new research into more effective treatments which could benefit more patients, consequently reducing drop-out, has been highlighted as a matter of urgency, yet it is the very patients who dropped out of treatment who arguably should be asked to share such vital information regarding their reasons for dropping out. In relation to the ‘three-legged stool’ of evidence-based practice, it appears the patient ‘leg’ has been neglected. Consequently, Chapter 3 will evaluate qualitative studies of patients’ experiences of CBT-ED/E with the aim of discovering which components of the treatment may facilitate or impair AN symptom improvement and recovery, and why.

Chapter 3: Qualitative CBT research

Qualitative studies aiming to better understand factors impacting patient experiences during AN treatment (Fogarty and Ramjan, 2016; Rance, Moller and Clarke, 2017) have found common themes offering a valuable insight into potential reasons for disappointing treatment outcomes and high drop-out rates. These, plus clinicians' perspectives, will be critically evaluated in order to establish alternative views of AN treatment, in particular CBT-E/ED. The aim is also to highlight the extent to which patient preferences and clinical expertise have been neglected in research which has potentially informed treatment policy.

2.1 Patient experience

Treatment challenges are believed to be due to the egosyntonic nature of AN – the value individuals place on the condition – creating avoidance and lack of engagement in treatment (Gulliksen et al., 2015; Keski-Rahkonen et al., 2007) and ambivalence about seeking help, change and recovery, even when AN becomes potentially life-threatening (Gregertsen, Mandy and Serpell, 2017). While patients acknowledge ambivalence as a barrier (Rance, Moller and Clarke, 2017), treatment avoidance may also be linked to fear of stigma, such as others' beliefs that AN is a voluntary condition or self-inflicted for vanity-related reasons (Bannatyne and Stapleton, 2015) when its aetiology is actually incredibly complex (Treasure et al., 2015). Yet patients' apparent lack of desire to recover can create frustration in busy healthcare settings (Neale and Hudson, 2020) with knowledge, training and understanding of AN and how to work with patients often missing (Hudson et al., 2012), highlighting a need for better understanding and collaboration to improve services (Neale and Hudson, 2020). It is also important to understand what those with lived experience of AN consider reliable and efficient treatment (Fogarty and Ramjan, 2016) since this has the potential to enhance recovery (Hay and Cho, 2013) or hinder it (Ramjan and Gill, 2012). This knowledge also has the potential to inform interventions that align with patients' values and needs (Zeeck et al., 2018). However, such experience is at the bottom of the hierarchy in relation to evidence-based practice, with RCTs firmly at the top (Pilgrim, 2019).

Informed by AN prognosis and changing treatment needs over time (Hay, Touyz and Sud, 2012; Lacey and Sly, 2016), a metasynthesis of adult AN treatment experiences focused on literature published between 2010 and 2020 (Conti et al., 2020) in order to extend a previous review of pre-2005 studies (Espindola and Blay, 2009) and further understand key aspects of adult AN treatments. Of the 30 studies featured in the two reviews (14 and 16 respectively), only one had been published since 2015 and met the necessary criteria for this work of involving UK outpatients (Rance, Moller and Clarke, 2017). A second (Fogarty and Ramjan, 2016) was discovered during a manual search. Themes from these will be critically discussed in subsequent paragraphs.

2.2 Treatment 'too weight and food-focused'

Monitoring of weight is recommended alongside psychotherapy and psychoeducation to help patients reach a healthy BMI (NICE, 2020). Weight gain is seen as key to support other quality of life changes necessary for AN recovery (NICE, 2020) and an essential, obvious target of treatment to reduce the physical effects of starvation and associated health risks (Murray, Loeb and Le Grange, 2018). However, weight gain alone is considered insufficient for long-term recovery (Orsillo and Batten, 2002). Interestingly, a systematic review and meta-analysis of AN treatment outcomes in RCTs (Murray et al., 2019) found a distinct discrepancy between the trajectory of weight and psychological symptoms, indicating current treatments are more proficient at successfully addressing the former than the latter. Moreover, individuals who reached their ‘target weight’ but who still felt the same emotionally reported feeling treatment was incomplete (Fogarty and Ramjan, 2016). Psychological symptoms are believed to be central maintaining mechanisms in AN psychopathology (DuBois et al., 2017) and a precursor to treatment drop-out (Woodside et al., 2004) and relapse (Keel et al., 2005), hence their persistence post-treatment is likely to be detrimental to long-term recovery, regardless of improvements in terms of weight gain (Murray et al., 2019).

Treatment focusing on weight and eating may also not be viewed as a priority by those with AN since quality-of-life improvements may be more important to them (Touyz et al., 2013) and suggests factors other than weight gain are less important (Orsillo and Batten, 2002). Crucially, NHS treatment has been experienced as overly focused on food and weight (Rance, Moller and Clarke, 2017), reflecting previous AN treatment research (Escobar-Koch at al., 2010; Offord, Turner and Cooper, 2006). These findings may be due to patients’ reluctance to discuss eating habits (Rance, Moller and Clarke, 2017), however, treatment perceived as only addressing weight was viewed as hindering recovery (Fogarty and Ramjan, 2016), potentially encouraging further restriction and reinforcing of AN behaviours and increasing suicidality (Rance, Moller and Clarke, 2017), corroborating prior research on the potentially negative impacts of AN treatment (Gowers et al., 2000). For example, one participant stated she had developed new weight-related AN behaviours in order to remain in therapy so she could discuss her psychological issues; another fought for treatment to address her depression rather than her eating behaviours, believing that:

> “Eating disorders are not about food, they’re about life … [but] a lot of people want them to be about food” (Rance, Moller and Clarke, 2017, pp 588).

2.3 Holistic treatment; addressing underlying factors

Study participants with AN who had received CBT were consistently dissatisfied by the approach, viewing it as too rigid and formulaic, like “being pushed through a machine” and as a “one-size-fits-all approach” which carried the implicit message that if they followed the regime they would get better, and if they were not getting better they were simply not trying hard enough (Rance, Moller and Clarke, 2017, pp. 58; Fogarty and Ramjan, 2016, pp.5). Since participants in both studies were self-selected groups, the possibility they may have had their own agenda for taking part must be acknowledged, for example, as a means of complaining about negative experiences or blaming healthcare services for unsuccessful treatment. However, many also noted the difficulties practitioners face in working with clients ambivalent about their recovery and therefore often unwilling to engage (Rance, Moller and Clarke, 2017), suggesting they were taking some responsibility for treatment difficulties and not wholly blaming the system.

Objections regarding treatment rigidity were linked to desires to explore and treat underlying factors contributing to their AN rather than just their symptoms, allowing them to focus on what their ED represented and explore personality traits, life and interests (Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016). This supports research that a holistic approach to treatment is preferred by AN patients (Smith et al., 2016) and growing interest in the development of a broader, more holistic definition of recovery in EDs (de Vos et al., 2017). Interestingly, it contradicts assertions that CBT is ideal for individuals with AN due to its structured, present-focused and time-limited nature (Galsworthy-Francis and Allan, 2014), and because they are often reluctant to revisit the past (Freeman, 2002). Opposition also exists between healthcare professionals viewing weight gain and physical status as key measures of recovery (Zipfel et al., 2015) and patients focusing more on psychological markers such as improved well-being, creating tension which manifests in descriptions of treatment as being too concerned with food and weight (Clinton et al., 2014). Indeed, a report on a review of the Eating Disorders Framework for Wales (Sidhu, 2016) highlighted service users' need for a holistic approach to care and belief that not only weight change is valuable. The report added all aspects of an individual's life are affected by EDs, such as education, employment, family, and housing, and service users stressed these should be at the forefront of the treatment model to ensure a broader focus than purely weight gain (Sidhu, 2016).

Continuing the holistic theme, patients also wanted to be treated as a "whole person" rather than an "object" or "diagnostic tick box" in their treatment (Rance, Moller and Clarke, 2017, pp. 589), echoing previous research in which participants expressed a desire to be seen as an individual and not simply as 'an anorexic' (Offord, Turner and Cooper, 2006). Individuals also felt "alienated," "wrong and stupid" and not "normal" if they were not listened to or understood (Fogarty and Ramjan, 2016, pp. 5), compounding the fundamental experience of those with EDs in feeling unheard, invisible and worthless (Shelley, 1997; Reindl, 2001). Conversely, feeling understood and heard made participants feel worthy, validated and supported to be more open and make changes, with hopefulness, increased self-worth and having input or control in recovery important in AN treatment being viewed as positive (Fogarty and Ramjan, 2016).

2.4 Tailored treatment; preferences, values and choice

Dissatisfaction and low patient-rated treatment credibility has been linked to drop-out, increased risk of relapse and treatment inefficiency (Clinton et al., 2014; Lindstedt et al., 2015; Jordan et al., 2017), with unsatisfactory treatment viewed as not being tailored to individuals' needs (Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016), which is consistent with earlier studies (Offord, Turner and Cooper, 2006; Eli, 2014). Individualised treatment may therefore make a positive difference to AN recovery, with quantitative studies recommended to test this hypothesis (Fogarty and Ramjan, 2016). Indeed, meta-analyses demonstrate that tailoring psychotherapy to patient preferences leads to decreased drop-out rates and improved treatment outcomes (Lindheim et al., 2014; Swift et al, 2019). For example, patients who received their psychotherapy preferences were almost half as likely to drop out of treatment (Swift et al., 2019). This research is reflected in healthcare changes in the USA which has seen emphasis placed on a patient-centred philosophy (Kazak et al., 2016) in which patient values, including characteristics, culture and preferences (APA, 2006), are a determining factor in medical and psychological treatments (Norcross et al., 2017).

With research into patient preferences – the specific conditions and activities clients want in their treatment experience (Swift et al., 2019) – primarily conducted at treatment level (Cooper et al., 2019), a study of patients who wanted to choose the type of therapy they received found approximately 60% expressed a preference for CBT, whereas 40% chose a non-directive approach (King et al., 2000). Drawing on evidence of high AN outpatient treatment drop-out rates of up to 50% (e.g., Frostad et al., 2018) and dissatisfaction with CBT (Rance, Moller and Clarke, 2017) a non-directive approach may have been preferential. Demographic factors may also be influential, with 74% of men expressing a preference for CBT and 64% of women choosing non-directive counselling (Lee, 2009). Given that AN is conceptualised as a ‘female-specific’ condition (Raevuori, Keski-Rahkonen and Hoek, 2014), with studies comprising only female participants (e.g., Rance, Moller and Clarke, 2017), it is a reasonable assumption that non-directive therapy such as a person-centred approach may have been preferred over CBT.

According to the Welsh Government Eating Disorder Service Review (2018), principles "clearly articulated by the public, which will underpin all recommendations" (pp. 5) are relationship-based and person-centred, involving shared decision making between clinicians and patients, considering their preferences, views and values. However, Matrics Cymru (2017) recommends CBT as the sole intervention for mild to moderate AN within the Welsh NHS, indicating a contradiction which neglects the principles outlined in the above review and fails to consider evidence of patient experience of AN treatments and their preferences, for example, more tailored therapy (e.g., Conti et al., 2020). This lack of choice is believed to stem from NICE's refusal to take non-RCT evidence into consideration when making recommendations, suggesting a more pluralist approach to what constitutes evidence should be adopted, similar to the APA in the USA (Guy et al., 2012). Meanwhile, individualised and integrated approaches have been mooted as alternative AN treatment options, however, plurality is considered the future direction of psychotherapy (Fernández-Álvarez and Fernández-Álvarez, 2019).

2.5 The medical model

NHS interventions such as CBT are justified via terms such as 'empirically-supported' and 'evidence-based' which legitimise them as 'most effective' (Goodman, 2016). This premise is entrenched within the medical model, which asserts that the method or medicine is the curative power (Bohart, 2005). The medical model assumes psychological issues, like physical ailments, require expert diagnosis for the correct treatment to be prescribed (Joseph, 2017). Consequently, there is a hierarchical structure to the relationship which dictates the clinician is the expert and the patient's role is to comply (Bohart, 2005) rather than collaborate (Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016). Conversely, psychological diagnoses are considered damaging and unnecessary due to the weight of responsibility on the practitioner as the sole expert; rather, the client is viewed as the expert because they have the lived experience of their issue (Rogers, 1951). Rogers (1995), acknowledged as the founder of person-centred theory, perceived EDs to arise from conditions of worth, striving for the goals and ideals of others and the inability to be oneself; the result is a state of incongruence which leads to psychological distress. Such distress, however, is labelled mental illness due to its “medicalisation” (Sanders, 2017). Indeed, pathologising psychological distress implies “abnormality” within the individual, the practitioner’s role being to make the mental experience of that individual “normal” in the eyes of society (Freeth, 2017). This “abnormality” is arguably compounded using CBT as the dominant model of psychotherapy, since it blames clients’ distorted patterns of thinking for their mental health issues (Proctor, 2017). Rogers (1967) further posits that clients are rendered ‘fixed’ by their diagnosis, which is exacerbated by practitioners’ acceptance of that diagnosis. This form of labelling, and treatments that focus on the label, fail to acknowledge that the client is a person (Hawkins, 2017), confounding patients’ experiences of being treated by practitioners as, for example, an “abnormal” “object” (Rance, Moller and Clarke, 2017, pp. 589) and arguably stifling opportunity for change.

2.6 The therapeutic relationship

The above argument evidences a paradigm war between those who treat psychotherapy as if it were a drug and those who consider it a dialogue (Guy et al., 2012). The current biomedical monopoly also removes the possibility of there being multiple ways of healing (Kirmayer, 2012). Alternatively, the psychosocial model rejects monocultural treatments for a particular diagnosis in favour of individually tailored care; it views the healing power as resting not only within the treatment method but also in the patient as having an active role in the process and the relationship between clinician and patient (Norcross and Cooper, 2021).

The influence of the therapeutic relationship is considered instrumental in successful outcomes regardless of the treatment approach used (Mogorovich and Caltabiano, 2018). Defined as the bond between therapist and client, it comprises emotional trust, agreement on the goals of therapy, and commitment to collaborating on the work or tasks of treatment (Bordin, 1979), plus the therapist's demonstration of the Rogerian core conditions of empathy, positive regard and congruence (Norcross and Lambert, 2011, Rogers, 2007), paucity of which are believed to predict treatment failure and drop-out (Norcross and Lambert, 2018). Some of these factors or qualities were arguably lacking in AN treatment experiences, particularly regarding collaboration and understanding (Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016). For example, a lack of collaboration was indicated when clinicians made choices on behalf of participants; perceiving control to be taken away, they experienced powerlessness which exacerbated "out-of-control" feelings (Fogarty and Ramjan, 2016, pp. 5) intrinsic to AN (Lawrence, 1979). Lack of control subsequently negatively impacts the therapeutic relationship and potentially exacerbates AN patients' ambivalence towards change (Smith et al., 2016; Ramjan and Gill, 2012). Meanwhile, feeling misunderstood eroded trust in the therapist, making participants feel unsupported in their recovery (Fogarty and Ramjan, 2016). A desire to have a "real" relationship with their therapist was also expressed, in which the therapist was authentic, cared and was genuinely interested in them (Rance, Moller and Clarke, 2017, pp. 590), implying this was not their experience and also supporting the importance of congruence and positive regard in promoting positive therapeutic experiences.

These findings reflect research on patient preferences regarding the importance of the therapeutic relationship in AN treatment (Westwood and Kendal, 2012), such as patients viewing a strong personal connection with their therapist as helpful in promoting motivation for recovery (Venturo-Conerly et al., 2020). Hence healthcare providers working with adults with AN are advised to persevere with developing and maintaining the relationship because this is believed to be the catalyst for change (Ramjan and Fogarty, 2019). This supports the relationship-based principles of health care outlined in the Welsh Government Eating Disorder Service Review (2018) and emphasis placed on the importance of the quality of the relationship between therapist and patient (Matrics Cymru 2017), however, qualitative studies (Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016) have evidenced such directives may not translate into clinical practice.

2.7 Clinicians' perspectives

Clinicians have expressed reservations over the use of evidence-based approaches for EDs, modifying treatment in routine practice due to concerns over the generalisability of research findings, with few adhering closely to a manual (Tobin et al., 2007; Simmons, Milnes and Anderson, 2008) synonymous with CBT. Clinicians reportedly also do not use CBT as their primary approach (Mussell et al., 2000) and combine some evidence-based treatment elements with those not empirically supported, perceiving manual-based treatments as too constraining and rigid to suit their patients (Wallace and von Ranson, 2012). Furthermore, clinicians working in UK publicly-funded ED clinics expressed negative attitudes towards treatment manuals, believing they did not emphasise the therapeutic alliance and were imposed for financial reasons, whether by the local public health service or insurance firms (Waller et al., 2013). Additionally, CBT was not used to treat EDs because it did not align with clinicians' theoretical orientation, or was viewed as inflexible and ineffective (Von Ranson, Wallace and Stevenson, 2013). Moreover, that CBT practitioners did not view manuals any more positively than therapists of other theoretical orientations (Waller et al., 2013) is of particular note.

2.8 Summary

Treatment dissatisfaction offers an alternative explanation for poor AN treatment success and high drop-out rates, for example, many describe CBT as too rigid, formulaic and structured to be helpful, and unable to accommodate desires to explore underlying factors contributing to their condition. Further reasons for lack of effectiveness include too strong a focus on food and weight, compounding such issues and potentially increasing co-morbid symptoms. The emerging picture indicates a struggle between the competing priorities of patients and the healthcare system; while weight gain is undoubtedly important in order to offset the physical effects of food restriction, there is a need for patient autonomy and a collaborative, tailored and holistic approach that focuses more on individuals' emotional needs, wants and values, rather than the weight-focused goals set out by policy makers and their recommended modalities, which consequently may better engage and retain them in treatment. These findings are significant since the importance of understanding what those with lived experience of AN deem effective treatment cannot be underestimated, given the prognosis of the condition, having the power to inform more suitable interventions. However, a lack of qualitative research must also be acknowledged, particularly in comparison to the number of RCTs, an inequality which overlooks those with lived experience in favour of hierarchy in which researchers and clinicians are considered the experts, subsequently demonstrating that each aspect contributing to evidence-based practice is not considered of equal importance. Taking the, albeit limited, qualitative findings into account, Chapter 4 will critically explore a pluralistic approach as a means of much-needed change in AN treatment.

Chapter 4: A pluralistic approach

Continuing to assume a single therapeutic model is the ‘right’, ‘best’ and ‘only’ option for outpatients with AN (Matrics Cymru, 2017) excludes the needs and wants of a potentially high proportion of patients who find the treatment offered unsatisfactory, while also failing to meet NHS requirements that the patient receives what they need, rather than what is on offer (Cooper and McLeod, 2011). This disservice is of particular concern given the condition’s likely chronicity and associated health risks, the consequences of which may involve more costly inpatient rather than outpatient care and an increased burden on the NHS (NICE, 2017; Striegel Weissman and Rosselli, 2017). A pluralistic approach opposes the view that there is one complete treatment for each condition, rather that there are many interventions that can benefit a patient; essentially, different processes help different individuals at different times (Cooper and McLeod, 2007; 2011). Pluralistic practice therefore involves the clinician drawing on a variety of methods and means of understanding in order to tailor therapy based on what they and the patient think may be most helpful (Cooper and McLeod, 2007; 2011). This chapter will critically evaluate plurality in psychotherapy in reference to AN treatment.

2.1 From single models to plurality

Single psychotherapeutic models continue to dominate in the UK with specific orientation-based interventions explicitly recommended for particular forms of psychological distress (Cooper and McLeod, 2007), most notably the NHS’s CBT-centric IAPT (Improving Access to Psychological Therapies) programme in England (Carlyle, 2017), which treats issues including depression, anxiety, panic and agoraphobia, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (NHS, 2022). Forms of CBT are also the sole recommendation in Wales for treating varying severities of substance misuse, OCD, panic disorder, social anxiety disorder and AN (Matrics Cymru, 2017). However, the assumption that a single model can offer a complete, correct explanation for EDs is considered flawed since their complexity renders them impossible for one model to explain (Hawkins-Elder and Ward, 2020). Moreover, it is suggested that CBT's 'transdiagnostic' approach to ED treatment (Fairburn, Cooper and Shafran, 2003) attempts to explain too much within a single model, sacrificing the depth necessary to elicit different understandings which may warrant other approaches (Hawkins-Elder and Ward, 2020). Furthermore, the assumption that in the unlikely event that a favoured model is incorrect in ED treatment, the correct explanation will be another single model is also viewed as flawed (Hawkins-Elder and Ward, 2020) since each have their weaknesses; indeed, most modalities can be considered as largely equal in merit (Wampold and Imel, 2015). Hence in treating more chronic psychopathological issues with high rates of comorbidity, such as AN, it is argued that multiple therapeutic approaches are likely to be more beneficial (Ehrenthal and Benecke, 2019), each of which may offer a unique and valuable perspective (Hawkins-Elder and Ward, 2021). Consequently, support for a paradigm shift from unitary models which "pit themselves against others" to a pluralistic approach to ED treatment has been expressed (Hawkins-Elder and Ward, 2020, pp. 106).

2.2 Pluralistic practice

Pluralism is an ethical and philosophical understanding that no single perspective or truth is universally valid and, in advocating and encouraging the acceptance of multiplicity and disagreement, can be viewed as dialectically opposite to monism (Rescher, 1993). A pluralistic therapeutic framework acknowledges there may be many contributory factors to mental health issues – problems arise from complex interactions between sources of adversity and multiple life events (Smith et al., 2021) – and that no single modality is ‘best’ to treat them; instead, individuals need different approaches at different times (Cooper and McLeod, 2007; 2011). This ethos arguably complements the complexity of AN while offering the potential for a more robust, ‘whole’ means of intervention than that currently on offer, thus meeting the needs of more patients. The framework allows for therapy to be practiced from different orientations, thereby acknowledging the variety of potentially helpful approaches available, plus that each has its own strengths, for example a focus on interpersonal relationships, cognitions and learning, or experiential processes (Leichsenring et al., 2018; Cooper and McLeod, 2007). Indeed, it is an integrative form of practice in that it utilises techniques and concepts from established modalities, such as cognitive-behavioural, humanistic and psychodynamic (McLeod and Cooper, 2015). In relation to AN treatment, it can be suggested that patients who expressed a desire to explore the underlying causes of their condition, which lay beyond the theoretical framework of CBT (Rance, Moller and Clarke, 2017), may have benefited from a pluralistic approach which provided, for example, a more humanistic focus, in order to have this desire met.

Despite being an integrative form of practice, a pluralistic approach does not comprise a fixed set of procedures or theory (Smith et al., 2021) and the extent to which patient preferences and resources are taken into account differs from integrative models (McLeod and Cooper, 2015), reflecting research that prioritising patient preferences is most likely to positively impact treatment satisfaction and success (Norcross and Cooper, 2021). Operating within a patient-centred framework, which meets Welsh Government Eating Disorder Service Review (2018) recommendations for AN treatment, the therapeutic process is tailored to meet patients’ needs, the premise being:

> “If we want to know what is best for clients, we should start by asking them” (Cooper and McLeod, 2011, pp. 13).

Hence there is a collaborative process based upon clarifying the patient’s therapeutic goals, followed by identifying tasks which may contribute to achieving those goals and agreeing methods for the tasks to be accomplished (Smith et al., 2021), alongside regular reviews of the therapeutic work; the aim is to practice in the best interests of the patient while offering choice and flexibility (Cooper and Mcleod, 2007; 2011). Means of promoting collaboration and shared understanding include transparency around what the clinician can offer and techniques to elicit patient preferences (Norcross and Cooper, 2021), plus the discovery and application of patient knowledge (Smith et al., 2021). Strategies including routine use of metacommunication (Papayianni and Cooper, 2018) and process and outcome feedback tools are employed to ensure therapy and patient goals remain aligned. Forming the cornerstones of a pluralistic metatheoretical framework, the above domains (goals, tasks and methods) conceptualise therapy for client and therapist (Cooper and McLeod, 2007), and within it, different therapies can be organised, contrasted and evaluated, providing a means for empirical research to inform practice (Cooper and McLeod, 2007). This may appear unproblematic in the first instance, however difficulties in promoting a pluralistic approach via research to policy makers who traditionally support a more monistic ‘answer’ such as CBT must be acknowledged. Indeed, it has been argued that such an approach is unlikely to produce any clear *solution* (McLennan, 1995, italics in original). Consequently, it could be suggested that pluralism may struggle to have any impact on the counselling and psychotherapy field on a pragmatic level; that the answer to any given question might be plural instead of singular does not correspond with the medical model which dictates there must be one true answer. For example, whether CBT is more effective than any other type of therapy is viewed by policy makers as requiring a simple 'yes' or 'no' answer, with the strategy employed for researching its effectiveness assuming there will be constant 'efficacy' similar to drug interventions; not only is this strategy considered ill-suited to psychological interventions, as opposed to medical ones (Philips and Falkenström, 2021), but opposes pluralistic views that challenge single 'truths' about what works in therapy (Smith and de la Prida, 2021), a stance which echoes the philosophical foundations of qualitative research methodology, the lens through which this research was viewed, in which the ontological assumption is that there is no single truth or reality but multiple realities based on an individual's interpretation of a phenomenon (Smith, 1983).

Emphasis on collaboration suggests an attempt to maximise the benefits of the therapeutic relationship, viewed as key to therapeutic effectiveness (Flückiger et al., 2018). The approach is also more explicitly acknowledged as being informed by person-centred, humanistic and post-modern values, yet also embraces "the whole range of effective therapeutic models and concepts" (Cooper and McLeod, 2010, p. 11). The collaborative process also incorporates the existential ethic of engaging with patients and their way of being in a valuing way, while tailoring sessions respects diversity and difference (Cooper and McLeod, 2007; 2011). An investigation into collaboration in pluralistic therapy for depression (Gibson et al., 2019) supported that clients felt listened to and understood when involved in decisions relating to their treatment, which was empowering, although the researcher's acknowledgment of their positive predisposition towards shared decision-making may be interpreted as bias, despite efforts to counter it through choosing methods deemed less likely to be influenced by author preference. As previously discussed, feeling listened to and understood was also of particular importance in AN treatment (Fogarty and

Ramjan, 2016). A need for collaborative, tailored AN treatment has also been strongly highlighted via patient experiences (Rance, Moller and Clarke, 2017), while a collaborative and patient-centred approach has been emphasised as leading to positive AN treatment outcomes (Johns et al., 2019), indicating further benefits of pluralistic practice for AN patients.

A pluralistic approach also assumes a patient has personal strengths which can be accessed and applied to help resolve their issues, such as ideas that will aid them in making sense of their situation, or personal characteristics (McLeod and Cooper, 2015), corroborating a need to rethink current treatment strategies by utilising patients' competencies and strengths instead of focusing on what is 'wrong' with them (Touyz and Hay, 2015). Moreover, it fulfils AN patients' desires to be seen and treated as a "whole" person, rather than "an anorexic" (Rance, Moller and Clarke, 2017). While the absence of research examining the adaptation of therapy to the patient as a person, beyond their diagnosis, has been highlighted (Norcross and Wampold, 2019), this standpoint appears to be a positive shift away from CBT-based priorities regarding correcting 'dysfunction' towards a more holistic view of recovery for AN patients, the need for which has been highlighted in research and by patients themselves (de Vos et al., 2017; Rance, Moller and Clarke, 2017).

2.3 A pluralistic perspective

Since a single clinician is unlikely to be able to offer an array of therapeutic approaches, distinctions have been made between pluralistic practice and a pluralistic perspective, supported by research (Thompson, Cooper and Pauli, 2017). Clinicians may work from a single modality yet still hold a pluralistic viewpoint (Cooper and McLeod, 2011a), the difference between a pluralistic and non-pluralistic clinician who only practices one modality being that the former appreciates the value of other approaches and is prepared to refer on if theirs is deemed unsuitable, whereas the latter is fixed in their view that their ‘brand’ of therapy is best for all (Cooper, 2019). It emphasises that patients must be understood as unique, therefore their therapeutic needs are likely to be diverse and impossible to know in advance, thereby opposing a ‘one-size-fits-all’ model and demanding clinicians are open to and appreciative of the variety of ways in which they may be helped (Cooper and McLeod, 2011). While clinicians referring patients on for more suitable treatment may be beneficial given the nature of AN, the feasibility of doing so is questionable within an NHS setting unless wholesale changes are made to its policies regarding treatment, such as in Wales where alternative options appear particularly limited. Furthermore, a pluralistic perspective being understood as “a form of humanistic-existential ethic” (Cooper and McLeod, 2007, pp. 136) may create a problematic bias for clinicians whose orientation is not so broadly humanistic-existential. It may also be seen as a move to rebrand humanistic approaches in a way which is more acceptable to NHS policy makers. It must also be acknowledged that a pluralistic approach to therapy was largely conceived in an attempt to create a person-centred approach to the field as a whole (Cooper, 2019); a development critiqued as “old wine in a new bottle” (Ong, Murphy and Joseph, 2020, pp. 168). Notably, however, the concept of pluralism in counselling and psychotherapy has been praised as “one of the most exciting trends to emerge recently in the field” by an eminent CBT practitioner and trainer (Dryden, 2013, pp.122), indicating positive recognition by a leading figure within the orientation deemed the ‘gold standard’, while McLeod (2013) claims the concept potentially solves issues of fragmentation within the field; issues arising from the existence of many different types of practitioners and approaches, presenting an organising framework for practice.

2.4 Common criticisms

Some common criticisms of the framework include that: (i) clients do not understand therapy enough; (ii) the therapist does know best sometimes; (iii) the approach is incoherent; (iv) most therapists describe themselves as ‘pluralistic’, so this ‘new’ approach is not that important; and (v) viewing pluralism as a better way to practice therapy is itself a monism (Cooper and McLeod, 2011a). However, the authors claim: (i) collaboration does not mean clients need to understand therapy, more so that they begin to co-create a “culture of feedback” with therapists (pp. 154); (ii) therapist expertise can be communicated as long as what the client wants remains respected; (iii) there is coherence in client goals being the principal focus of pluralistic therapy (iv) therapists often practice pluralistically, but the authors argue they are the first to comprehensively articulate such a perspective and practice, and that their version is unique in its inclusivity and collaboration; and (v) they remain open to the possibility that single approaches may be more effective (Cooper and McLeod, 2011a). Another charge which could be levelled against a pluralistic view that all types of therapy are equal (but different) is that it supports the “dodo bird” verdict in which “all must have prizes” (Cooper, 2008, pp. 52); this acceptance and inclusivity has also been criticised for advocating an ‘anything goes’ outlook, incorporating a potentially infinite number of valid ideas (McLennan, 1995). However, Cooper and McLeod (2011a) assert that their approach recognises some methods may be more or less beneficial for different clients at different times therefore, in that sense, does not advocate ‘anything goes’.

2.5 A pluralistic approach to EDs

Being a relatively new concept, studies exploring a pluralistic approach to AN, or EDs, have yet to be conducted. However, its perspective views EDs as arising in response to life’s difficulties, acknowledging that disordered eaters may feel ashamed and self-critical about their condition, have low self-esteem and feel conflicted about their body image, with recurrent themes being perfectionism, control, dichotomous thinking and a history of insecure attachments leading to relationship difficulties (McMillan, 2016). Suggested therapeutic tasks and methods involve making sense of the problem and its development, exploring limiting beliefs and attitudes, learning how to eat ‘normally’, self-care and learning distress tolerance, healing old wounds, finding alternatives to food and improving interpersonal relationships (McMillan, 2016), with patient issues being addressed through methods and strategies from multiple resources, including community support (Smith et al., 2021). It is believed clients often feel self-critical and confused rather than able to acknowledge their behaviour as meaningful, therefore increasing understanding helps to build self-compassion and decrease shame (McMillan, 2016). Making sense of the issue also includes exploring the existence of barriers, for example, health, financial, environmental or relational factors, limiting beliefs and attitudes such as rigid thinking habits, self-critical internal dialogues and perfectionist tendencies or feelings of ambivalence and fear (McMillan, 2016). These arguably contribute to the fulfillment of a need for a more holistic approach to recovery (Sidhu, 2016). It is suggested, for example, that ambivalence towards change may be addressed through solution-focused approaches (De Shazer et al., 2021), with ‘miracle questions’ such as: “What would life be like if you woke up tomorrow and the problem had disappeared?” being a useful starting point (McMillan, 2016), while rigid thinking may be attended to through CBT (Neenan and Dryden, 2011). Transactional analysis may be employed to address problematic ‘parent’ and ‘child’ ego states and strengthen helpful ‘adult’ responses (Leach, 2006); the task of the clinician being to nurture and encourage the patient’s real self, obscured by sophisticated layers of adaptation, while the patient’s task is to develop a sense of self and discover who they really are (Brunt, 2005). Rather than using rigid control, the patient can be helped to discover their own needs and wants and to make decisions based on these, instead of on their restrictive view of themself and others (Brunt, 2005).

Disordered eaters often express a desire to be able to eat ‘normally’, therefore pluralistic therapy would see patient and clinician collaborating in order to determine the meaning of ‘normal’ to the patient and how this may be achievable (McMillan, 2016). Learning self-care and distress tolerance – the ability to withstand and accept painful feelings so problems can be dealt with rather than suppressed (Linehan, 1993) – may also help disordered eaters become more attuned to their feelings, since they often neglect their own needs or are unable to recognise them (Koenig, 2008), with helpful methods potentially including breathing exercises, visualisations and the formation of safety plans (McMillan, 2016). If disordered eating has developed in response to significant loss or trauma, patients may be encouraged and helped to reveal the full story of the trauma, with methods including externalising feelings through chair work (McMillan, 2016), which has been tentatively employed in the treatment of EDs and is a well-established task used in emotion-focused therapy (EFT) (Pugh, 2019), to be discussed later in this chapter. Viewing the patient as resourceful and understanding the use of food as a creative but no longer beneficial response to stressful circumstances, patients could also be helped to find an alternative focus through, for example, discussions about aspirations and researching and utilising community resources and support in order to achieve them (McMillan, 2016; Smith et al., 2021). This, it can be suggested, reflects AN literature promoting that treatment should utilise patients’ competencies and strengths (Touyz and Hay, 2015). It is acknowledged, however, that disordered eaters may be incredibly self-reliant, distrustful or keen to avoid burdening others, therefore making use of social support can be difficult, yet such support is considered vital to the maintenance of psychological well-being (McMillan, 2016). It is also suggested that the strength of close relationships plays an essential role in the success of ED treatments (Timulak et al., 2013), therefore patients could be helped to improve their relationships with others, particularly since EDs may be symbolic of deeper interpersonal issues (McMillan, 2016).

2.6 EFT

Emotional problems are central in AN development and maintenance (Lavender et al., 2015), with studies finding those with the condition have deficiencies in the recognition, regulation, expression, and integration of emotional states (Oldershaw, Startup and Lavender, 2019), affecting social processes and overall functioning (Caglar-Nazali et al., 2014). EFT (Greenberg, 2011), an evidence-based humanistic psychotherapy, integrates person-centered, gestalt, and existential approaches (Elliott and Greenberg, 2016), thereby complementing a pluralistic perspective as "a form of humanistic-existential ethic" (Cooper and McLeod, 2007, pp. 136). EFT focuses on assisting clients in accessing, exploring, regulating, and transforming emotions in order to improve adaptive functioning (Greenberg, 2008). In brief, EFT theory proposes that emotions are formed through 'schemes' shaped via environmental interactions. Applied to EDs, the recurrent and rigid activation of negative emotional schemes coupled with limited access to, or absence of healthy emotions is thought to be the source of problematic eating (Dolhanty and Greenberg, 2009). Consequently, EFT aims to transform 'maladaptive' emotions, for example, fear and shame, by activating 'adaptive' emotions, such as assertive anger and compassion (Greenberg, 2011). This can be achieved through a range of therapeutic 'tasks' suggested in response to specific client behaviours ('markers') which aim to aid experiential processing and emotional development (Greenberg, 2011). EFT has been evaluated for the treatment of EDs, including AN, because it focuses on assisting emotional processing and regulation (Glisenti, Strodl, and King, 2018); for example, a systematic review concluded EFT is potentially feasible and effective for adults and adolescents with AN (Sala, Heard and Black, 2016). Moreover, a case study of EFT for AN documented improved ED symptoms, overall mood, and emotional regulation, plus weight maintenance (Dolhanty and Greenberg, 2009).

Many experience AN as an often distressing internal 'voice' (Pugh, 2016) which appears to be highly prevalent (Noordenbos, Aliakbari and Campbell, 2014). Indeed, similar 'voices' have been reported across ED groups, suggesting it may be a transdiagnostic eating psychopathology feature (Pugh, Waller and Esposito, 2018; Noordenbos, Aliakbari and Campbell, 2014). The 'anorexic voice', described as a commentary in the second or third person relating to shape, eating and weight (Pugh, 2016), changes in intensity and nature over time; it may be identified as functional during the early stages of AN, offering security and comfort, becoming hostile and critical as the condition becomes more embedded (Williams and Reid, 2012; Tierney and Fox, 2010). Chair work may be suitable for AN treatment since the 'anorexic voice' is experienced dialogically and because it allows patients to separate from this experience of the self (Pugh, 2019). Two-chair dialogues would entail the patient repeatedly moving between seats, representing the 'anorexic voice' in one chair, and then responding from the second chair, similar to working with self-evaluative splits (Greenberg, Rice and Elliott, 1993), with the focus being on the patient's feelings in response to the 'anorexic voice's' attacks. Outcomes would typically involve either the attacks diminishing in their severity following the patient's expression of healthy sadness, or adaptive anger being used to help the patient assert themselves in response to the attacks (Greenberg, 2011). Addressing the 'anorexic voice' through chair work may therefore be highly beneficial due to its prevalence among patients, while chair work's link to EFT must also be acknowledged due to EFT having a strong evidence base which, as discussed, is revered by policy makers.

2.7 Qualitative comparisons

An examination of helpful aspects of pluralistic therapy for depression explored alternatives to standard evidence-based interventions (Antoniou et al., 2017), finding that empowering clients to believe in the possibility of change through non-intrusive guidance and reassurance was considered beneficial. This can be contrasted with participants who had received evidence-based treatments for AN (Rance, Moller and Clarke, 2017) who felt their interventions were based on the belief that no 'cure' was possible, and their ED would have to be managed for the rest of their lives. Arguably, if symptom 'management' is the optimum outcome a patient with AN can hope for, it is plausible treatment should focus on weight restoration and the establishment of healthy eating patterns. However, such a belief results in a focus on symptoms rather than causes and, crucially, removes hope of recovery for AN patients – a concern since research has emphasised the importance of hope in AN recovery (Dawson et al., 2014), however, another potential reason for a pluralistic approach to be beneficial.

Clients receiving pluralistic therapy also perceived a sense of control which was considered helpful; this was achieved through being able to communicate their choices and preferences to therapists (Antoniou et al., 2017). Control, however, was notably lacking in AN evidence-based treatment experiences (Rance, Moller and Clarke, 2017). In addition, the use of techniques from a range of modalities was described as helpful by participants who received pluralistic therapy, highlighting the diversity of individuals' needs (Antoniou et al., 2017); such diversity, it is suggested, remains neglected in 'one-size-fits-all' AN interventions despite a need for tailored treatments being emphasised (Fogarty and Ramjan, 2016).

Therapist-related factors contributing to positive experiences of pluralistic therapy included being respectful and accepting, responding to clients' needs, making them feel comfortable, reassuring, challenging and empowering them, using techniques such as psychoeducation and problem-solving, and being flexible (Antoniou et al., 2017). Meanwhile, helpful outcomes for clients involved changes in behaviour, perspective and responses to problems, as well as increased insight (Antoniou et al., 2017). These findings support pluralistic perspectives which include different clients benefiting from different approaches, respect towards client preferences, and flexibility and collaboration between therapists and clients (Cooper and McLeod, 2007; 2011). Evidently, however, limitations of the study include that only positive aspects of the therapy were explored and one of the researchers was Mick Cooper, who co-conceptualised the pluralistic framework, indicating potential bias.

2.8 Research and funding

Calls have been made for research into what patients benefit from which treatment to establish whether those who do not respond to one approach benefit from another (Leichsenring et al., 2018), a process common to pharmacotherapy but barely studied in psychotherapy (Markowitz and Milrod, 2015) despite such evidence being beneficial in identifying alternative treatment options for AN patients. Such studies must be supported by funding organisations since there is no industry funding psychotherapy research, unlike pharmacotherapy (Leichsenring et al., 2018), however it is apparent these organisations prefer mainstream research (Nicholson and Ioannidis, 2012). It has also been stated that committees tasked with reviewing, funding and creating psychotherapy guidelines tend to be dominated by CBT researchers, suggesting a risk of allegiance bias and hampering research in alternative approaches (Abbass et al., 2017). Funding bias is evident in UK data (Leichsenring and Steinert, 2017) which reveals psychodynamic therapy as one of the least well-funded forms of psychotherapy with 1.96% of total research funding, compared to 40.6% of funding for CBT and its variants. Remarkably, humanistic therapies were not included in the list, suggesting no funding was allocated to its research during the 2008 and 2013 timeframe studied (MQ Landscape Analysis, 2015). For a pluralistic approach to be considered a serious contender in the future of psychotherapy it is therefore paramount different types of evidence-based therapies are acknowledged and valued equally (Roy-Byrne, 2017), therefore an urgent change in funding policy is required in order to achieve parity in research before any changes to policies regarding treatment within healthcare services will be considered. It is also noted that the annual amount invested in research into EDs is limited and varies significantly between mental health conditions. For example, between 2014 and 2017, depression received the most research funding with an average of £11.2 million per year, with EDs receiving almost the lowest at just £1.2 million (MQ Transforming Mental Health, 2021). The playing field of research “spend per condition” is therefore also far from level, however this may be attributed to the relative rarity of EDs compared with more prevalent mental health conditions such as anxiety and depression (World Health Organization, 2017).

2.9 Summary

Pluralistic practice acknowledges that different patients may benefit from different approaches at different times throughout the therapeutic process, hence, in contrast to current policies regarding AN treatment, ‘one size’ does not ‘fit all’. Consequently, many aspects appear to fulfil the needs of AN patients who expressed dissatisfaction with current treatment methods, for example, those who wanted a more holistic form of treatment, to explore the causes of their AN, to focus on aspects other than food and weight and to be treated as a ‘whole’ person rather than ‘an anorexic’. The concluding chapter will bring together the key themes from this and previous chapters in order to answer the research question.

Chapter 5: Concluding comments

This research critically evaluated an alternative, relatively new approach to AN treatment which focuses on patient needs, wants, values and preferences, rather than the goals set out by a specific therapeutic modality, while highlighting shortcomings in current interventions, namely CBT-ED. Essentially, the work was split into two parts; firstly, establishing through reviews of recent literature a need for alternative therapeutic options, and, secondly, exploring whether a pluralistic approach could fulfil that need. This chapter will broadly summarise and reflect on the most important insights and suggest further research opportunities.

2.1 Main findings

Increasing numbers of outpatients are accessing AN treatment, potentially due to growing awareness of the condition, better detection, and the broadening of diagnostic criteria. Further increases are also anticipated following the Covid-19 pandemic, with associated national lockdowns leading to many experiencing worsening symptoms. MPs have consequently demanded improved support and funding made available for research into future treatments since increasing referrals are likely to place a greater burden on a pressurised health service. However, pre-pandemic demand for ED services was already outstripping capacity (BBC, 2021); in Wales, for example, significantly under-resourced services had resulted in only the most severe cases being treated appropriately. Under-resourced services and increasing patient numbers also suggest increased waiting times for treatment, a concern given the likely chronicity of AN and its accompanying health risks. Funding for new research to improve therapies for adults with AN has also been highlighted as a matter of urgency since treatment outcomes are poor, drop-out and relapse rates are high, and, while several forms of therapy are available via mainstream health services for adult outpatients with AN, studies have found none superior. The current situation therefore offers a timely and necessary opportunity for change.

A critical review of all NHS forms of psychotherapy for AN was beyond the scope of this research, which consequently focused on CBT-ED following the emergence of a dichotomy between the approach's lack of superiority over other AN therapies and its status as the 'gold-standard' psychotherapy for all levels of AN, as well as its apparent 'one-size-fits-all' suitability for all EDs. Indeed, such faith is held in the evidence supporting CBT-ED that clinical guidelines in Wales recommend it as the only form of psychotherapy for mild to moderate AN. Clinical decisions must be based on the best available evidence, however the mere existence of evidence relating to a particular treatment does not demonstrate its strength, particularly since CBT-ED efficacy studies – RCTs – can be criticised for potential researcher bias. Coupled with evidence of CBT-ED's lack of superiority over other AN treatments, the approach's 'gold-standard' status can therefore be opposed. Moreover, CBT-ED's efficacy in clinical trials compared with its effectiveness for AN outpatients in the 'real world' highlights a research-practice gap which further supports criticisms of RCTs since drop-out rates were particularly high in the latter studies, at around 50% (Signorini et al., 2018; Frostad et al., 2018). This disparity indicates a need to minimise outpatient AN treatment drop-out, particularly given that the condition's prognosis is likely to result in a need for more costly inpatient treatment, further burdening health services.

Due to a lack of qualitative evidence regarding reasons for drop-out, it was hypothesised that, opposing CBT-ED's rubber-stamping as a 'one-size-fits-all' intervention, attrition may simply imply treatment unsuitability and/or dissatisfaction, yet it appeared that the 'blame' was placed on clinicians straying from treatment protocol in their delivery and patients' ambivalence towards recovery. Post-2015 qualitative studies suggested treatment ineffectiveness is due to patients' needs not being met via available approaches, for example, CBT was viewed as too rigid, formulaic, and structured to be helpful in facilitating recovery; unable to accommodate strong desires to explore underlying factors contributing to AN; and places too strong a focus on food and weight, compounding such issues and potentially increasing co-morbid symptoms. Despite the importance of weight gain in offsetting the physical effects of starvation, a need for patient autonomy and a collaborative, tailored and holistic approach that focuses on emotional needs, wants and values was preferred to the weight-focused goals set out by policy makers and their recommended modalities, indicating a struggle between the competing priorities of patients who, for example, wanted to be treated as a 'whole' person rather than 'an anorexic', and a healthcare system bound by the constraints of working under the medical model which views psychological distress as a biomedical rather than psychosocial issue.

The research thus far suggested continued assumptions that one psychotherapeutic model is the 'right', 'best' and 'only' option for all outpatients with AN in Wales excludes the needs and preferences of those who find the treatment offering unsuitable or unsatisfactory; this may consequently be linked to high drop-out and relapse rates and widely acknowledged difficulties in successfully treating the condition. This is echoed in literature regarding the future of psychotherapeutic treatments within the NHS, which argues that a single modality cannot meet health service requirements that the patient receives what they need, rather than what is on offer (Cooper and McLeod, 2011). Indeed, evidence supports that accommodating patient needs and preferences contributes to better engagement and retainment in treatment, subsequently improving treatment outcomes (Swift et al., 2019). Yet despite rhetoric in governmental reviews regarding the importance of collaboration with AN patients (Welsh Government Eating Disorder Service Review, 2018), their treatment preferences have clearly not been incorporated into practice. It seems a logical assumption that a move away from a CBT-centred monoculture which, at worst, is delivered in a rigid, formulaic, ‘off the shelf’ way towards treatment which focuses on the needs and preferences of each patient and includes patient-clinician collaboration would be more beneficial.

Discussion regarding the future direction of psychotherapy finds growing support for plurality, which rejects a ‘monist’ view to treatment, and therefore opposes AN treatment recommendations in Wales which solely champion CBT. A pluralistic approach acknowledges that since there may be many contributory factors to mental health issues, individuals need an array of approaches at different times during the therapeutic process. Therapy is practiced from a variety of orientations, thereby acknowledging the existence, variety and strengths of other approaches, utilising techniques and concepts from established therapeutic modalities. Unlike a single-model approach, this ethos potentially complements the complexity of AN while potentially offering a more robust, ‘whole’ means of intervention; for example, patients wanting to explore underlying causes of their condition, which lay beyond the theoretical framework of CBT, may have preferred a more humanistic focus offered through a pluralistic approach. Consequently, the needs of more patients could be met, thereby reducing drop-out rates.

Meeting Welsh Government recommendations for AN treatment by operating within a patient-centred framework, the pluralistic therapeutic process is tailored to meet patients’ needs and preferences through offering choice and flexibility; its primary focus being on collaboration. A collaborative, patient-centred approach has been emphasised in the literature as leading to positive AN treatment outcomes, potentially since both maxmise the benefits of the therapeutic relationship, regarded as key to successful therapeutic outcomes. Collaboration engages patients in a valuing way, leading to them feeling listened to, understood, and consequently empowered. Tailoring treatment honours their diversity and difference, both of which AN patients found particularly important but lacking in current available treatments. A pluralistic approach also focuses on utilising patients' competencies and strengths instead of focusing on what is 'wrong' with them, fulfilling AN patients' desires to be seen and treated as a "whole" person, rather than "an anorexic". It also appears to be a positive shift from CBT-based priorities regarding correcting 'dysfunction' towards a more holistic view of recovery, a need highlighted in research (de Vos et al., 2017).

This work supports that many AN outpatients' needs, wants, values and preferences may indeed be fulfilled via a pluralistic approach to treatment, thereby fulfilling the research statement. Its emphasis on collaboration, individualisation, diversity and difference also satisfies calls for ED treatments to be more person-centred and relationship based. Being relatively new, its effectiveness in relation to AN has yet to be established; nonetheless, methods of working pluralistically with EDs have been suggested in the literature, for example, addressing conflict with the 'anorexic voice' through chair work associated with EFT, which has been studied with some success (Dolhanty and Greenberg, 2009). However, while EFT is an evidence-based form of therapy, for a pluralistic approach to be seriously considered as the future of psychotherapy it is vital different types of evidence-based therapies are acknowledged and valued equally, therefore changes in funding policy is required in order to achieve parity in research before any changes to policies regarding treatment within healthcare services will be considered. This may prove problematic due to the limited amount invested in research into EDs compared with other mental health conditions. Moreover, the existence of funding bias in favour of CBT research in the UK restricts the availability of funding for studies in alternative approaches. It is paramount this imbalance is addressed, with a view to creating much-needed plurality in research before policy makers have the required evidence to allow the same in treatment.

2.2 Contributions to the field; recommendations for future research

This research challenges the assumption that CBT is the 'gold standard' form of AN treatment and therefore its adoption as the best or only recommended form of therapy, underscoring the contribution of funding and research bias towards its revered status. Such findings may encourage repurposing of funds to address the imbalance in psychotherapy research which could subsequently have a notable impact on future policy and practice. It also identifies a significant gap in knowledge regarding reasons for patients' AN treatment attrition and identifies a paucity of studies involving patients' AN treatment experiences, particularly in relation to RCTs. It is therefore suggested that future research addresses this deficit in order to expand the body of qualitative literature, thereby offering a more robust contribution towards evidence-based research; and because it is essential to establish what patients deem effective treatment, particularly given the condition's prognosis; such knowledge holds the power to inform more suitable interventions which better meet patients' needs.

Nevertheless, this research suggests that incorporating patient preferences, needs and values in a tailored and collaborative therapeutic approach – cornerstones of pluralistic therapy – may be key to more successful AN treatment experiences, hence more focused work examining preferences in relation to AN treatment is strongly recommended. Drawing on promising previous work examining pluralistic therapy for depression (Antoniou et al., 2017), similar research is recommended in relation to AN, for example, involving therapists who favour working eclectically with such clients, since they may already practice from a pluralistic perspective. Since this approach is a relatively new therapeutic concept, such works may be a valuable contribution to the field in terms of their originality, delivering novel findings which may ultimately help to shape future AN treatment services.

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Appendix – Main themes

Why change is needed	**Sources**
AN treatment outcomes are disappointing; improvements are modest; drop-out and relapse rates are high	Khalsa et al., 2017; Riesco et al., 2018; Van den Berg et al., 2019
Outpatient services have seen patient numbers increase significantly; this is likely to continue due to impact of Covid-19 pandemic and relaxation of classification criteria used for diagnosis	Martinez-Gonzalez et al., 2020; Schlegl et al., 2020; Beat Eating Disorders, 2021; Branley-Bell and Talbot, 2020; Mustelin et al., 2016; APA, 2013
Demand for ED services outstripped capacity even before the pandemic; e.g., Welsh services found to be substantially under-resourced pre-pandemic	BBC, 2021; Welsh Government Eating Disorder Service Review, 2018
Many patients are dissatisfied with current treatments	Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016
Without effective treatment, risk of mortality, disease burden on the patient, care givers and society increase	Harding, 2017; Schmidt, Wade and Treasure, 2014; Schmidt et al., 2016
AN chronicity is likely to necessitate more costly inpatient care, increasing burden on health service	NICE, 2017; Striegel Weissman and Rosselli, 2017
Why CBT is not the 'gold standard'	**Sources**
No differences in outcome between current AN treatments, hence no evidence supporting superiority of those recommended in clinical guidelines – e.g., CBT-ED/E as the sole treatment in Wales	Zeeck et al., 2018; Zipfel et al., 2014; Dalle Grave et al., 2016; Solmi et al., 2021; Matrics Cymru, 2017; Byrne et al., 2017
RCTs championing CBT for AN are often of poor quality, have weak comparator conditions and/or fail to answer clinically relevant questions, therefore are not fit for purpose/robust enough to base clinical guidelines upon	Fernández-Álvarez and Fernández-Álvarez, 2019; Agras and Robinson, 2010; Vickers, 2014; El-Serag, Talwalkar and Kim, 2010; Leichsenring et al., 2018
Risk of researcher bias in the reporting of RCT results; efficacy overestimated when applied in routine clinical practice; mere accumulation of empirical evidence is not enough to demonstrate an approach's strength	Fairburn et al., 2013; Groff, 2015; ; El-Serag, Talwalkar and Kim, 2010; Dozois and Quilty, 2014
Funding bias towards CBT research; committees creating psychotherapy guidelines are dominated by CBT researchers, suggesting risk of allegiance bias, and hampering research in alternative approaches	Leichsenring and Steinert, 2017; Abbass et al., 2017

Patient experience of CBT for AN is limited, particularly in comparison with RCTs and in relation to reasons for drop-out, hence an essential component of the 'three-legged stool' of evidence-based practice supporting CBT's status is missing	Sackett et al., 1996; Rance, Moller and Clarke, 2017; Danielsen et al., 2016; Pilgrim, 2019
Gaps in current research	**Sources**
Few studies have examined CBT-ED/E effectiveness in routine clinical practice despite there being considerable empirical evidence supporting its efficacy – there is not much support for how well it translates in the 'real world'	Turner et al., 2015
Effectiveness studies fail to comprehensively record reasons for treatment drop-out despite acknowledging it as an issue that needs to be addressed – this is a missed information-gathering opportunity	Jenkins, Morgan and Houlihan, 2019; Frostad et al., 2018; Turner et al., 2015; Signorini et al., 2018
Patient experience of CBT for AN is limited, particularly in comparison with RCTs – hence an essential component of the 'three-legged stool' of evidence-based practice supporting CBT's status is missing	Sackett et al., 1996; Rance, Moller and Clarke, 2017; Danielsen et al., 2016; Pilgrim, 2019
Patient experience/preferences	**Sources**
CBT viewed as too rigid, formulaic and structured to be helpful; unable to accommodate desires to explore underlying factors contributing to AN; too focused on food and weight – therefore not suitable for all, which opposes current recommendations e.g., Matrics Cymru	Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016
Patients would prefer a collaborative, tailored and holistic approach to AN treatment that focuses on emotional needs, wants and values rather than weight-focused goals – similarities can be drawn with pluralistic approach	Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016; Sidhu, 2016
Benefits of a pluralistic approach	**Sources**
Therapy utilises techniques and concepts from a range of established modalities, offering a more robust, holistic means of intervention than is achievable via a single model – also potentially complementing complexity of AN	Cooper and McLeod, 2007, 2011; Hawkins-Elder and Ward, 2020
Therapy focuses on collaboration and is tailored to the patient based on what therapist and patient think may be most helpful – patients expressed a desire for collaborative, tailored treatment	Cooper and McLeod, 2007, 2011; Rance, Moller and Clarke, 2017

A collaborative and patient-centred approach which accommodates patient needs and preferences contributes to better engagement and retainment in treatment, subsequently improving treatment outcomes, and is recommended in AN treatment guidelines and reports	Swift et al., 2019; Johns et al., 2019; Welsh Government Eating Disorder Service Review, 2018; Sidhu, 2016
What sort of change is needed?	**Sources**
Funding for new research to develop AN treatments which have the potential to minimise drop-out; drop-out urgently needs to be addressed	Le Grange, 2016; Linardon, Hindle and Brennan, 2018; Solmi et al., 2021
More holistic approaches to ED recovery; treatment to be more person-centred and relationship-based	de Vos et al., 2017; Welsh Government Eating Disorder Service Review, 2018; Rance, Moller and Clarke, 2017; Fogarty and Ramjan, 2016; Sidhu, 2016
Better understanding of what those with AN consider reliable and efficient treatment in order to inform interventions which align with their needs and values	Fogarty and Ramjan, 2016; Zeeck et al., 2018;
Parity in funding allocation and research so different types of evidence-based therapies are acknowledged and valued equally; only then could such evidence enable changes to NHS treatment policies for AN to be considered	Leichsenring and Steinert, 2017; Roy-Byrne, 2017