

**Enhanced Cognitive
Behavioral Therapy
(CBT-E) as an
Intervention for
BIPOC Adolescent
Girls with Eating
Disorders**

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ABSTRACT

Eating disorders (ED) have some of the highest mortality rates of any mental health condition due to medical complications and high rates of suicidality. Black, Indigenous, and People of Color (BIPOC) adolescent girls and women are at especially high risk for developing EDs, which can have numerous negative mental and physical health consequences. Enhanced Cognitive Behavior Therapy (CBT-E) is a transdiagnostic cognitive behavioral treatment for EDs that, although originally designed to work with adults, has been shown to be effective with adolescents. Despite CBT-E's proven efficacy across age populations, there is limited research on its effectiveness with BIPOC individuals. We argue that with culturally informed, competent, and sensitive clinicians, CBT-E can be used to treat underdiagnosed and undertreated BIPOC adolescent girls, whose EDs have been unjustly overlooked.

Eating disorders (EDs) are serious mental health diagnoses within the United States, warranting the attention of social workers and clinicians due to their high mortality rates (Arcelus et al., 2011; Johnson et al., 2002; National Institute of Mental Health, 2021; Striegel-Moore & Bulik, 2007). Many EDs begin in adolescence and can have negative consequences on mental and physical health (Micali et al., 2014; Verschueren et al., 2020). Women and adolescent girls are especially at risk due to societal pressure to conform to the “thin ideal” (Striegel-Moore & Bulik, 2007). Black, Indigenous, and People of Color (BIPOC) women and girls are even more vulnerable because the existence of EDs among them has been ignored by researchers and practitioners alike, leading to a general lack of research and treatment (Gilbert, 2003; Rodgers et al., 2017; Sonnevile & Lipson, 2018; Striegel-Moore & Bulik, 2007; Talleyrand, 2015).

It is vital that social workers have an adequate, evidenced based intervention to address the gap in treatment for BIPOC adolescent girls. This paper proposes Enhanced Cognitive Behavioral Therapy (CBT-E) as an effective intervention for treating BIPOC adolescents with EDs, as it is highly adaptable and has been shown to be effective with adolescents (Fairburn, 2008; Cooper & Grave, 2017). Although there is little research on CBT-E’s effectiveness with BIPOC individuals, we argue that the inclusion of culturally competent care will allow for accessible and effective treatment.

EATING DISORDERS

Eating disorders (EDs) are a serious mental health concern globally and within the United States. About nine percent of all Americans will be diagnosed with an ED at some point in their life, and more than a quarter of individuals with an ED will attempt suicide (Arcelus et al., 2011; Deloitte Access Economics, 2020). EDs are more prevalent among women than men, mostly due to societal pressures placed on them.

Although men are also faced with pressure to conform to an ideal body type, women face constant exposure to society’s “thin ideal,” or the notion that worth and beauty are dependent upon body size and shape (Striegel-Moore & Bulik, 2007). This pressure can cause women mental distress about their current weight and body shape, which can lead to the development of extreme and unhealthy attitudes or behaviors around food and eating habits. There are multiple types of EDs, the three most common being binge eating disorder, anorexia nervosa, and bulimia nervosa (National Institute of Mental Health, n.d.).

EATING DISORDER TYPES

Of the multiple ED diagnoses in the DSM-5, anorexia nervosa and bulimia nervosa are most likely to begin in adolescence (Striegel-Moore & Bulik, 2007). Anorexia nervosa, which has the highest mortality rate of all EDs, is commonly characterized by extremely restrictive eating and food avoidance, an obsession with one’s weight, and a significantly low body weight (Arcelus et al., 2011; Johnson et al., 2002; National Institute of Mental Health, 2021; Striegel-Moore & Bulik, 2007). There are two subcategories of anorexia nervosa: restrictive type, which is described above, and binge-eating/purging type, which includes episodes of binging—consumption of a large amount of food in a short amount of time—and purging through vomiting, laxatives, or diuretic use (National Institute of Mental Health, 2021). Bulimia nervosa is characterized by episodes of eating large amounts of food in a short period of time followed by purging through vomiting or use of laxatives or diuretics, fasting, or excessive exercise. Binge eating disorder, which is the most common ED in the United States, is characterized by an individual losing control and eating a large amount of food in an unusually short time, without any form of purging, fasting, or excessive exercising afterwards.

ADOLESCENTS

ED symptoms often begin to present in adolescence (Micali et al., 2014; Verschueren et al., 2020). Adolescent girls experience the dual stressors of societal pressure to ascribe to the “thin ideal” and a natural

increase in weight as they transition through puberty, which may lead to discontent with their body shape (Verschueren et al., 2020). Thus, ED symptoms such as body dissatisfaction, restrictive eating, and purging begin to appear. Adolescents are particularly at risk if they suffer from perfectionism or low self-esteem, which can increase the likelihood of internalizing the “thin ideal” due to an increased reliance on the opinions of others (Keel & Forney, 2013). Social media exposure and peer influences, namely through the selection of peers with shared insecurities about weight and body shape, also work to perpetuate EDs by reinforcing these insecurities.

The onset of EDs in adolescence can have numerous negative consequences on an individual’s mental health (Micali et al., 2014; Johnson et al., 2002; Verschueren et al., 2020). For example, EDs are closely correlated with anxiety and depression in what appears to be a cyclical relationship, wherein one perpetuates the other (Verschueren et al., 2020). Adolescents with EDs are also more likely to have difficulty regulating their own behavior, as well as having a dysfunctional self-evaluation caused by placing too much value on their body weight and shape. EDs are also related to feelings of being a burden to one’s family and can negatively impact one’s social relationships (Micali et al., 2014). Finally, EDs are associated with higher levels of suicidality and mortality (Johnson et al., 2002).

BIPOC CONSIDERATIONS

Historically, researchers have falsely believed that EDs are most common among White, upper-class women (Striegel-Moore & Bulik, 2007). This belief is in part because ED symptoms can differ by race or ethnicity; some researchers argue that this perceived difference in the prevalence of EDs between White women and BIPOC women may be due to cultural differences in beauty standards and ideal body types, with White cultures placing more value on the “thin ideal,” resulting in differences in body dissatisfaction and ideal body weight (Gilbert, 2003; Striegel-Moore & Bulik, 2007; Talleyrand, 2015). Symptoms may therefore manifest differently for BIPOC women than they do for

White women (Talleyrand, 2015). However, many experts posit that globalization and the spread of Western culture will cause the thin ideal to become more prevalent, thereby diminishing cultural differences in rates of EDs (Striegel-Moore & Bulik, 2007).

The false belief that EDs exist only among White women has led to a lack of research on EDs in the BIPOC community (Striegel-Moore & Bulik, 2007). BIPOC women and girls are also less likely to seek or receive treatment for an ED for a variety of reasons, including clinician stereotyping or bias, limited resources, and mistrust of the health and mental health systems (Gilbert, 2003; Sonnevile & Lipson, 2018; Striegel-Moore & Bulik, 2007; Talleyrand, 2015). In addition, Black and Latinx adults and children have the highest rates of obesity in the US and are therefore less likely to be diagnosed with EDs, as clinicians working with overweight women often focus on weight loss and therefore fail to recognize symptoms of EDs among this population (Stierman et al., 2021).

Despite the fact that BIPOC women have comparable rates of EDs to White women, many risk factors are specific to BIPOC women (Talleyrand, 2015). These include level of acculturation, low levels of racial or ethnic identity, and experiences with racial oppression. High levels of acculturation appear to be a risk factor for Latina women, for example, because their culture of origin may place less value on thinness than mainstream White American culture, while the opposite appears to be true for Asian American women (Gilbert, 2003; Talleyrand, 2015). High levels of racial and ethnic identity, on the other hand, may protect women from mainstream White beauty standards, while experiences of oppression can create feelings of powerlessness that may result in the development of EDs as a coping mechanism (Talleyrand, 2015). Thus, the presentation of EDs for BIPOC women may differ from the current clinical understanding, which centers the experiences of White, upper-class women. More research is needed to understand the complexities of EDs and best treatments for BIPOC women.

RESEARCH LIMITATIONS

There is little research available regarding EDs among BIPOC adolescent girls. Rodgers et al. (2017) studied the prevalence and expression of EDs among overweight adolescent girls and found that overweight Asian American girls, compared to Black, Latina, and White girls, had the highest risk of overeating; White overweight girls had the second highest risk. Black overweight girls were most at risk for partaking in unhealthy behaviors such as fasting, purging, and food restriction to control their weight, and Latina and White overweight girls had the highest rates of dieting. Interestingly, the findings suggest that Black girls may be at greater risk for binge eating in early adolescence, while risk among White girls increases with age.

Overall, it appears that BIPOC women and adolescent girls experience EDs at similar rates to their White counterparts. Despite an increase in the number of studies that are beginning to demonstrate this fact, BIPOC women are still underdiagnosed and undertreated, due to a variety of factors (Gilbert, 2003; Sonnevile & Lipson, 2018; Striegel-Moore & Bulik, 2007; Talleyrand, 2015). It is vital to understand the different ways EDs develop and present based on an individual's culture, race, or ethnicity in order to more effectively treat the diverse women and girls who experience EDs. This is especially important for adolescent girls, who are in a highly vulnerable developmental period at the age that EDs often begin (Micali et al., 2013; Verschuere et al., 2020). Studies suggest that adolescent girls are at equal, if not higher, risk for developing such disorders compared with adult women (Rodgers et al., 2017).

ENHANCED COGNITIVE BEHAVIORAL THERAPY (CBT-E)

Enhanced Cognitive Behavior Therapy (CBT-E) is a leading empirically supported transdiagnostic cognitive behavioral treatment for EDs (Fairburn, 2008). The transdiagnostic theory of EDs is based on the finding that the primary maintaining processes for each ED diagnosis largely overlap (Atwood & Friedman, 2020). Because of this, CBT-E

was developed to address the psychopathology of EDs as a whole. It is a treatment for all forms of EDs, including anorexia nervosa, bulimia nervosa, and binge eating disorder (Fairburn, 2008). CBT-E also allows patients with EDs to learn how their disorder functions, how it is maintained, and how to disrupt the self-reinforcing cycle of the ED (Murphy et al., 2010).

CBT-E was initially developed for individuals in outpatient treatment settings, but there are also guidelines for implementation as an intensive form of day treatment, inpatient treatment, or group therapy (Fairburn, 2008). According to the Centers for Disease Control and Prevention (CDC), adults 20 years old and older with a BMI under 18.5 kg/m² are considered underweight (CDC, 2022). Individuals with a BMI of 17.5 kg/m² or more, who are not significantly underweight (Murphy et al., 2010), are advised to attend twenty therapy sessions over twenty weeks. For individuals with a BMI between 15.0 and 17.5 kg/m², who are significantly underweight and are subject to marked physical and psychosocial effects (Fairburn, 2008), weight restoration is the main treatment aim, and forty sessions over forty weeks are advised. Similar to other evidence-based CBT treatments, CBT-E is highly individualized, which requires patients and clinicians to work together to develop a personalized treatment plan based on an individual's symptoms, core pathology, and triggers. The psychoeducation component of CBT-E addresses the distorted beliefs that contribute to patients' EDs.

TREATMENT STEPS OF CBT-E

According to Fairburn (2008), CBT-E usually starts with a one-and-a-half to two-hour evaluation session, followed by twenty fifty-minute therapy sessions over the course of twenty weeks. The first eight sessions, including the evaluation session, are held twice a week, followed by ten weekly sessions and three final sessions every other week.

There are four stages associated with CBT-E (Fairburn, 2008). Stage one is the intensive initial stage, called "starting well." During this stage, patients meet clinicians twice a week for four weeks. They spend

the first few weeks of the treatment gathering information about the disorders and carefully considering the reasons for and against change. Then an individualized treatment plan is developed, and patients are informed of its utility, structure, and homework. Research on EDs has shown the magnitude of change in the first few weeks of treatment is a strong predictor of treatment outcomes, so these initial weeks are especially crucial.

Sessions in stage one include weekly weigh-ins to help patients understand natural fluctuations in weight; this data is plotted on a graph to give individuals a better understanding of weight trends. Patients may not weigh themselves outside of these sessions (Fairburn, 2008). Homework between sessions includes self-monitoring forms to record everything consumed, cognitions and emotions while eating, any excessive eating or drinking, use of laxatives or diuretics, bouts of purging, and any compensatory actions in response to eating. Self-monitoring forms not only increase patients' self-awareness around eating behaviors, but also provide a structured log for practicing skills so they can address any barriers. Clinicians also introduce regular eating to patients, which entails eating three meals and three snacks per day in regular intervals, not exceeding four hours without eating.

Stage two of the treatment, the transitional stage, is called "taking stock" (Fairburn, 2008). In these sessions, clinicians review progress and help patients identify and address any barriers they encountered between sessions, such as resistance to change, not prioritizing the treatment, depression, poor planning, and low self-esteem. Then, clinicians and patients review and modify the initial formulation of the disorder based on the information collected over several weeks of self-monitoring. For example, if patients are not able to follow their dietary plan when they are angry or anxious, they would need to add mood changes as a trigger for binge eating to their existing formulation.

After modifying the initial formulation, clinicians and patients must decide whether to use a broad or focused version of CBT-E for the remainder of the treatment (Fairburn, 2008). The focused version

exclusively addresses ED psychopathology, while the broad version is only recommended if one or more external mechanisms, such as clinical perfectionism, core low self-esteem, or marked interpersonal difficulties, are identified to be maintaining the disorder and preventing change (Cooper & Grave, 2017). Normally, the focused form is the default because it is more effective and easier to implement; it is used with most patients who can be safely managed as outpatients. Once clinicians and patients determine which mechanisms to address and in what order, based on the patient's needs and presentation, they develop a treatment plan (Fairburn, 2008).

In stage three, the intensive treatment stage which comprises eight weekly sessions, clinicians and patients address key mechanisms that maintain the ED: body image; dietary restraint; and events, moods, and eating (Fairburn, 2008). The clinician addresses patients' overvaluation of body shape and weight by providing psychoeducation about overvaluation and its consequences. This helps to develop formerly ignored domains of self-evaluation; reduce unhelpful body checking and avoidance (e.g., mirror checking and comparing bodies); relabel unhelpful thoughts (e.g., feeling fat); examine the origins of the overvaluation; and learn to identify and modify the mindset surrounding the ED (Cooper & Grave, 2017). Additionally, clinicians help patients change rigid dietary rules into flexible guidelines for eating, introduce previously avoided foods, and develop problem-solving and mood-regulation skills. If clinicians decide to use the broad version mentioned in stage two of the treatment, they address the external mechanism in addition to the general psychopathology.

Stage four, called "ending well," is the final stage of CBT-E (Fairburn, 2008). It consists of three sessions that take place every other week. During the final part of stage three and in stage four, the emphasis shifts from treating the existing problem to looking toward the future. In this stage, patients work with clinicians to address their reactions and concerns about ending treatment and find ways to maintain progress. The goal is for patients to be able to apply learned skills independently,

so as to handle setbacks and maintain the changes that have already been made in order to minimize the risk of relapse. Together they devise a short-term maintenance plan for patients to utilize until their review appointment, which occurs twenty weeks after the final session.

In stage four, clinicians help patients phase out treatment procedures and homework (Fairburn, 2008). For example, patients stop self-monitoring records and in-session weighing in week eighteen. Patients learn to be aware of what they eat, what happens throughout the day, and their urges to engage in ED behaviors without the aid of self-monitoring forms. Patients also start to weigh themselves at home with an open mind about their weight and identify strategies to prevent relapse, including listening to joyful music, reaching out to friends and family for support, exercising (CBT-E, n.d.), and engaging in relaxation techniques, such as deep breathing and mindfulness practices. They may also identify helpful preventive strategies such as avoiding certain people, places, or stimuli when they experience urges to binge eat. Finally, during this final stage, clinicians educate patients about realistic expectations for recovery, devise a long-term maintenance plan to deal with setbacks, and encourage patients to seek help from professionals to address these issues (Fairburn, 2008).

Twenty weeks after the conclusion of treatment, patients are asked to return for a post-treatment review session (Cooper & Grave, 2017). A questionnaire is used to assess the present state of the ED and whether daily function is impaired by the ED (Fairburn & Beglin, 1994; Bohn & Fairburn, 2008). In addition to the assessment, the review also includes a recap of patients' progress throughout the entire treatment, a short-term plan for how patients can continue to address the remaining symptoms, and strategies to handle setbacks. Clinicians also review the long-term maintenance plan with patients to see if any necessary changes are needed (Fairburn, 2008).

EVALUATION AND MEASUREMENT IN CBT-E

In CBT-E, patient outcomes are observed through pre- and post-assessments as well as session-by-session symptom measurements. These measures include the Eating Disorder Examination (EDE), with versions available for both children and adults (Cooper & Fairburn, 1987; Hilbert et al., 2013); the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn, 2008); the Clinical Impairment Assessment (CIA; Bohn & Fairburn, 2008); the Clinical Perfectionism Questionnaire (CPQ; Fairburn et al., 2003); the Eating Problem Checklist (EPCL; Dalle Grave et al., 2019); and the Starvation Symptoms Inventory (SSI; Calugi et al., 2017).

CBT-E WITH ADOLESCENTS

The content of CBT-E for adolescents is similar to that of adults, although it tends to be shorter because adolescents are typically capable of changing their behaviors faster than adults (Cooper & Grave, 2017). For example, underweight adolescent patients may only need thirty sessions to complete the treatment, instead of the typical forty sessions. A major modification of the treatment for adolescents is parental involvement. Because a significant number of adolescents receiving treatment are younger than eighteen, parental involvement is necessary. In the first two weeks of the treatment, the clinician has assessment sessions alone with the parents. Afterward, fifteen- to twenty-minute joint sessions with the adolescent and parents are conducted throughout the course of treatment to update parents on treatment progress. The joint sessions also educate parents about the nature of their child's ED, the rationale of treatment interventions, and how they can help their child during the treatment process. The number and frequency of these joint sessions depend on each patient's situation.

EFFECTIVENESS AND LIMITATIONS OF CBT-E

There are many reasons CBT-E is useful in both clinical and social work practice: it can be used in both inpatient and outpatient settings, has a fixed length, and uses specified strategies and procedures to address ED psychopathology through four well-defined stages (Fairburn, 2008). Additionally, it encourages the establishment of "therapeutic momentum" that is needed early in treatment to make inroads in addressing the ED, helps ensure clinicians and patients keep working to achieve change, and increases the likelihood that treatment will have a formal ending.

Additionally, although there is limited research on the effectiveness of CBT-E among younger patients, many considerations support the proposal that CBT-E might be especially suitable for them (Cooper & Grave, 2017). CBT-E is designed to increase patients' self-control, which can benefit most adolescents, and enhance motivation, a goal that is particularly relevant for underweight adolescent patients. CBT-E also adopts a flexible and individualized approach that is easily adaptable to the needs of adolescents' cognitive development; moreover, it promotes autonomy, which is particularly relevant to adolescents, who respond favorably to collaborative treatment. Finally, CBT-E has been adapted for adolescents in a way that takes their physical health into account because the prevalence of medical complications associated with EDs is particularly severe for adolescents. As a result, there is a lower frequency of hospital admissions among adolescents in CBT-E treatment.

Studies on CBT-E with adolescents have shown a significant improvement in the BMI in adolescent participants with anorexia nervosa, as well as decreases in their clinical impairment scores, ED psychopathology, and general psychopathology scores (Dalle Grave et al., 2013; Dalle Grave et al., 2020; de Jong et al., 2020). They have also demonstrated that patients are able to maintain improvements even after treatment is completed (Signorini et al., 2018). Although this

research is primarily focused on anorexia nervosa, the transdiagnostic feature of CBT-E suggests its effectiveness with all EDs.

Even with the many benefits of CBT-E, some limitations need to be addressed through additional research. Despite a low remission rate for individuals who participate in CBT-E, it does not work for everyone. Around 50% of individuals do not fully recover using CBT-E, with some showing no improvements at all (Linardon et al., 2018). Similarly, around 25% of individuals drop out of treatment prematurely due to dissatisfaction. The current research does not specifically address multiple comorbidities that individuals with EDs may experience and does not address other relevant factors to the disorder, such as shame or trauma. More importantly, there is a lack of evidence that CBT-E treatment works across ethnic, racial, and socioeconomic groups.

Despite the lack of research on the effectiveness of CBT-E with BIPOC individuals, we argue that the individualized and cooperative nature of the treatment allows clinicians to assist individuals in constructing culturally appropriate treatments. As such, we suggest adding a component during the initial planning stage that addresses patients' culture and beliefs around mental health and EDs. This addition would allow patients to bring up any culturally specific concerns, barriers, or accommodations they would like to include in their treatment. In the case of BIPOC adolescents, this component would involve parent and caregiver input as well. It is also vital for all clinicians working with BIPOC individuals to receive cultural competency training and speak the same language as those they are working with, preferably the client's first language, to maximize effectiveness.

CONCLUSION

Evidence-based treatments such as CBT-E are crucial for addressing EDs and their symptoms, which can lead to fatal consequences. We argue that CBT-E is efficacious in treating adolescents because it is highly individualized and promotes engagement in order to produce change. We believe our recommendations would aid in improving

the quality of care for BIPOC adolescent girls and ultimately reduce further negative outcomes. However, due to a lack of evidence on the effectiveness of CBT-E for BIPOC adolescent girls in particular, further research is needed to examine the efficacy of the treatment and to develop CBT-E to be more culturally competent.

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