Cognitive behavioural therapy for eating disorders: past, present and future

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Abstract

Cognitive behavioural therapy (CBT) is a first-line treatment for eating disorders, including anorexia nervosa, bulimia nervosa and binge eating disorder, as approved by the National Institute for Health and Care Excellence (NICE). CBT addresses the cognitive and behavioural factors that maintain eating disorders. It offers patients tools to overcome difficulties. It is flexible to accommodate different presentations and complex comorbidities. CBT has a well-documented efficacy in treating eating disorders; research has shown that it significantly reduces symptoms and improves maintenance of long-term remission. The history and development of CBT for eating disorders began with Christopher Fairburn's interest in the application of CBT for eating disorders, followed by his development of evidence-based psychological treatments and the creation of enhanced CBT (CBT-E), which is appropriate for all types of eating disorders. CBT-E has four major goals: to engage patients in the treatment, to remove eating disorder psychopathology and behaviours, to correct the mechanisms maintaining eating disorder psychopathology and to ensure lasting change. CBT-E is a structured, patient-centred therapy suitable for a variety of settings, including outpatient and inpatient care, making it a flexible option for treating eating disorders in adults and adolescents. This paper summarises current applications of CBT for eating disorders and recent developments in the field.

Keywords: cognitive behavioural therapy, eating disorders, anorexia nervosa, bulimia nervosa, binge eating disorder, self-help, inpatient, outpatient treatment

Introduction

General practitioners (GPs) play a critical role in the early identification, initial management and referral of patients with eating disorders. This guide aims to equip GPs with essential knowledge of cognitive behavioural therapy (CBT) for eating disorders (CBT-ED), enabling them to support patients effectively throughout the treatment process. CBT-ED is approved by the National Institute for Health and Care Excellence (NICE) as the first-line treatment for eating disorders across the diagnostic spectrum, including anorexia nervosa (AN), bulimia nervosa (BN) and binge eating disorder (BED).

Eating disorders are complex health conditions characterised by abnormal eating behaviours and related psychological distress. They often co-occur with other mental disorders such as anxiety, depression and obsessive-compulsive disorder, as well as with physical comorbidities or complications, highlighting the need for comprehensive treatment approaches. CBT-ED addresses the cognitive and behavioural factors that maintain eating disorders and offers patients tools to overcome difficulties. It is also flexible, to accommodate complex comorbidities (1). It has well-documented efficacy in treating eating disorders; research has shown that CBT significantly reduces symptoms and improves long-term remission (2).

This paper outlines the historical development and fundamental principles of CBT-ED and highlights its theoretical foundations, key therapeutic strategies and practical considerations for GPs, including evidence-based self-help materials for patients and their families.

The history and development of CBT-ED

Christopher Fairburn became interested in the application of CBT-ED when he was a junior psychiatrist in Edinburgh, following a chance encounter with a patient who, despite having cognitions typical of AN, also binged and purged but maintained a healthy body weight. A few years later, in 1979, Gerald Russell named this presentation "bulimia nervosa", describing it as a rare condition with poor prognosis (3). After seeing several such patients in his clinic, who responded to a CBT approach, Fairburn launched a public campaign via Cosmopolitan magazine to estimate the prevalence of BN. The overwhelming response demonstrated its widespread prevalence and the urgent need for effective treatment (4).

After finishing his clinical training, Fairburn devoted his career to the development of evidence-based psychological treatment for eating disorders, working in the Department of Psychiatry in Oxford and supported by the Wellcome Trust. He led some of the first randomised controlled trials of psychological treatments in the world (5, 6). He further developed the model for BN in collaboration with patients and colleagues, creating CBT-BN, a groundbreaking model that revolutionised treatment and was approved by NICE in 2004. His subsequent work resulted in the development of enhanced cognitive behavioural therapy (CBT-E), a transdiagnostic model (2, 7, 8) which is appropriate for all types

of eating disorders. He also pioneered the integration of digital technologies to increase global access to training and delivering effective psychological treatments.

Fairburn's groundbreaking contributions have transformed the psychological treatment landscape for eating disorders; they have been recognised with an OBE in 2021 and the Distinguished Scientific Application of Psychology Award from the American Psychological Association in 2022 (9). His research and commitment to disseminating effective therapies have influenced clinical practices worldwide, providing hope and better outcomes for people with eating disorders.

In the last 30 years, the application of CBT has been further developed for different patient groups and treatment settings (Table 1). NICE refers to "CBT for eating disorders" to encompass these recent variations. Nevertheless, Fairburn's team's development of CBT-E remains empirically the most robust intervention to help people across the diagnostic spectrum of eating disorders (10). While there is no current treatment model that can achieve 100% remission, the 65% response rate of CBT-E has transformed outcomes for adults with eating disorders, both for non-underweight outpatients (11) and for patients with severe AN, requiring hospitalisation across the age range (12-17). Comparative studies of outpatient models for AN suggest that CBT demonstrates efficacy equivalent to other NICE-approved treatments (18, 19). However, systematic reviews indicate lower response rates in real-world studies, with approximately 50% response for BED and 40% to 45% for BN (20, 21). Notably, Solmi et al. (22) reported recovery rates improving over time, reaching 67% at 10 years with consistent use of evidence-based treatments.

CBT-E has four major goals:

1. To engage patients in the treatment and actively involve them in the process of change.
2. To remove eating disorder psychopathology and behaviours – that is, dietary restraint and restriction (and low weight if present), extreme weight-control behaviours and preoccupation with shape, weight and eating.
3. To correct the mechanisms maintaining eating disorder psychopathology.
4. To ensure lasting change.

There are several treatment manuals, a self-help book and online training and handouts for clinicians available (23-26).

Table 1 summarises the versatility and adaptability of CBT for different patient groups. This includes online self-help interventions for subthreshold eating disorders, guided self-help sessions with face-to-face or email support and short-form individual or group CBT sessions for BED and BN. For more severe cases, CBT-E is tailored to meet the needs of patients with AN, including adolescent adaptation that incorporates parental involvement. Additionally, intensive outpatient and inpatient CBT-E options offer improved outcomes for patients with severe and complex illnesses (1). These varied approaches underscore the flexibility of CBT-E, making it a robust treatment option that is adaptable to different clinical environments and patient needs.

General principles of CBT-E

CBT-E focuses on the specific psychological processes and behaviours that maintain an individual's eating disorder. This approach empowers patients to take control of their recovery and to participate actively in treatment decisions. To prevent patient resistance, CBT-E avoids prescriptive strategies, fostering a joint understanding of the psychological processes that drive disordered eating behaviours.

CBT-E is a structured, patient-centred therapy suitable for a variety of settings, including outpatient and inpatient care, making it a flexible option for treating eating disorders in adults and adolescents. CBT-E is delivered in stages, starting with early behavioural changes to reduce preoccupation with body shape, weight and eating habits (Figure 1).

The first stage focuses on understanding the patient's eating problems and helping them change and stabilise their eating patterns. Personalised education and addressing weight-related concerns are emphasised. The initial sessions should take place twice a week, to help with both engagement and focus on treatment.

The second stage involves reviewing progress and planning for the main treatment.

The third stage consists of weekly sessions addressing the mechanisms maintaining the eating disorder, including concerns about shape and eating, managing day-to-day events and moods and addressing dietary restraint. The patient and therapist can choose between focused and broad versions of CBT-E. Research suggests that the focused version is effective, even when the patient has additional problems (23, 43).

In the fourth stage, the focus shifts to maintaining progress and dealing with setbacks. A review session is held several months after treatment ends to assess progress and address any new issues.

For underweight patients, treatment usually requires 40 sessions over 40 weeks, incorporating weight regain into therapy. Early sessions involve considering the pros and cons of weight regain, aiming for patients to decide on

Setting		Study	Description	Patient group	Duration
	Online self-help	Toro et al. (27)	Online intervention for subthreshold EDs	Subthreshold ED	10 sessions
Outpatient CBT	Guided self-help	Jenkins et al. (28) Thiels et al. (29) Schmidt et al. (30) Grilo et al. (31) Melisse et al. (32)	Face-to-face vs. email/CD-ROM support in guided self-help sessions	BED, BN	10 - 16 sessions
	CBT-T	Tatham et al. (33) Wade et al. (34)	Short-form individual CBT sessions	BED, BN	10 weeks
	CBT groups	Moore and Waller (35)	Short-from group CBT sessions	BED, BN	10 weeks
	CBT-E	Fairburn et al. (5, 6) Mitchell et al. (36)	CBT-E for non-underweight EDs	BED, BN	Varies: BED 16 weeks, BN 20 weeks
	Broad or focused CBT-E	Fairburn et al. (7, 37) Frostad (38)	Treatment approach adapted for AN	AN (mild to moderate severity)	40 weeks
	Adolescent adaptation CBT-E	Dalle Grave et al. (14, 39, 40)	Incorporates physical health considerations and parental involvement, adjusted for faster weight restoration in adolescents	Adolescents	30 weeks
Intensive CBT-E	Multi-step or integrated CBT-E	Dalle Grave et al. (26) Ibrahim et al. (17)	Multi-step CBT tailored to the patient's progress	Severe AN or BN	Up to 20 weeks
	Intensive outpatient CBT-E	Dalle Grave et al. (26) MacDonald et al. (41)	Designed for patients needing more support than standard outpatient care but not severe enough for hospitalisation	Severe AN or BN	Up to 12 weeks, flexible
	Inpatient CBT-E	Dalle Grave et al. (26) Ibrahim et al. (17) Calugi et al. (42)	For patients not responding to less intensive treatments or needing close medical supervision	Severe AN or BN with comorbidities	13 weeks as an inpatient plus 7 weeks as a day patient
	Post-inpatient outpatient CBT-E	Dalle Grave et al. (26) Ibrahim et al. (17)	Supports the transition from hospital to home and reduces relapse rates		20 sessions over 20 weeks

Table 1. Overview of CBT for eating disorders in different treatment settings

Abbreviations: AN = anorexia nervosa; BD = bulimia nervosa; BED = binge eating disorder; CBT = cognitive behavioural therapy; CBT-E = enhanced cognitive behavioural therapy; CBT-T = 10-session cognitive behavioural therapy; ED = eating disorder

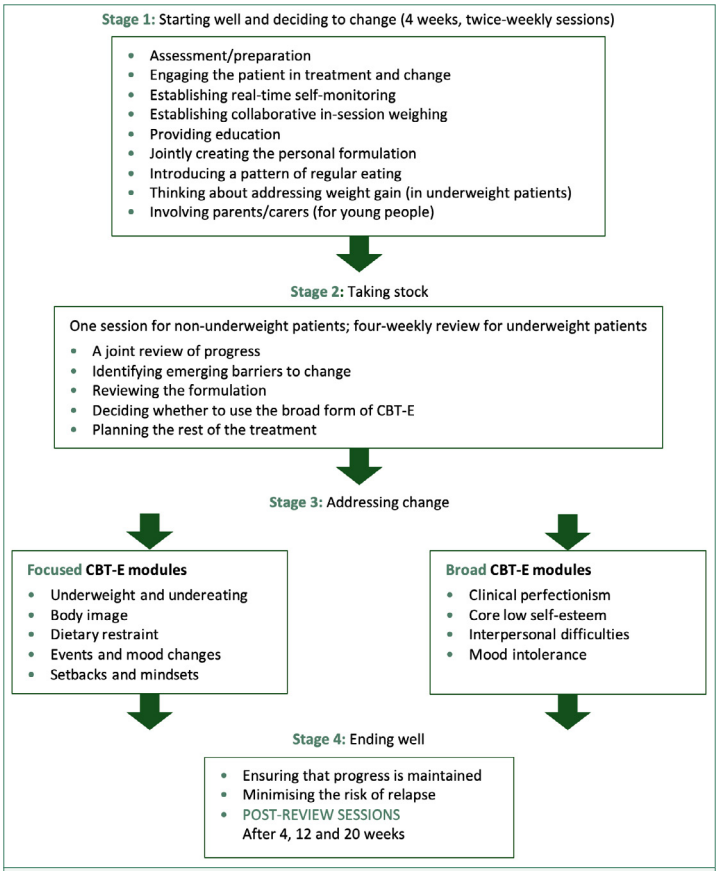

Figure 1. CBT-E process diagram (40)

weight regain themselves. In the final stage, the patient learns to maintain a healthy body weight.

CBT-E is an effective treatment for a range of eating disorders, including AN, BN and BED. Recent adaptations for avoidant/restrictive food intake disorder have been developed. Originally a one-to-one individual outpatient treatment for adults, CBT-E now includes intensive versions for day patients, inpatients and younger patients, with detailed treatment manuals (26).

CBT-E is highly individualised, with therapists tailoring the therapy to each patient's specific difficulties. A key technique of CBT-E is to create a personalised formulation of the patient's eating disorder. This formulation addresses specific processes, adapts to emerging issues, and actively educates and engages the patient. Figure 2 shows a schematic illustration of the structure of the formulation, which is adapted for the individual. Treatment involves a variety of adaptable cognitive and behavioural interventions with a focus on simplicity and effectiveness. This includes recording targeted thoughts and feelings as part of self-monitoring to address body image concerns. The treatment is flexible to include patients with different types of eating disorders and has no exclusion criteria.

CBT-E is time-limited. It typically consists of an initial assessment consultation followed by weekly 50-minute therapy sessions for 20 weeks or 40 weeks for people who are underweight.

Treatment for underweight patients

For underweight patients, the treatment extends to approximately 40 sessions over 40 weeks, reflecting the additional complexity and challenges associated with achieving and maintaining healthy weight. This extended treatment is structured into three steps.

1. **Step one** focuses on the decision-making process regarding weight gain. Given that underweight individuals often do not perceive their weight as a problem, this step emphasises the importance of collaboratively assessing the implications of change and fostering a sense of agency and ownership over the decision to pursue weight regain.
2. **Step two** is dedicated to the practical aspects of regaining a healthy weight. It involves personalised strategies and support to facilitate weight restoration in a manner that respects patient readiness and pace.
3. **Step three** centres on weight maintenance and relapse prevention. It aims to equip patients with the skills and confidence needed

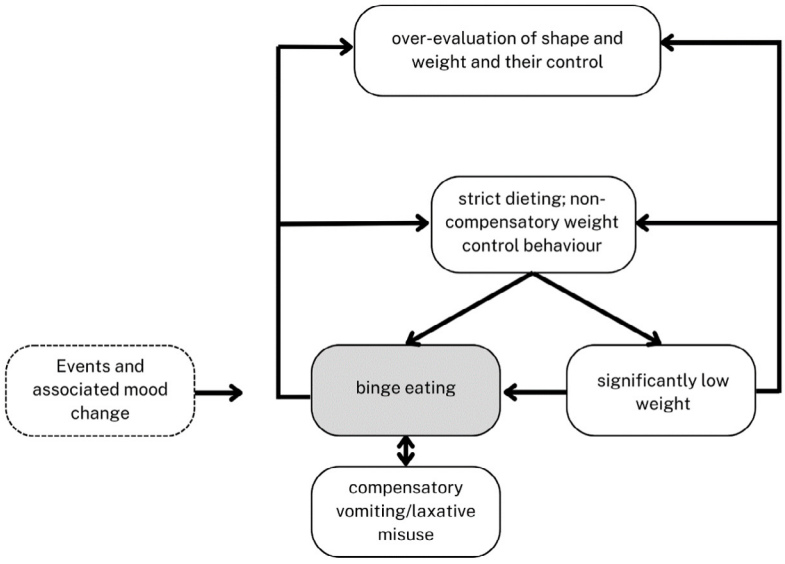

Figure 2. The transdiagnostic CBT-E formulation overview (44)

to sustain their healthier weight and proactively manage challenges.

This phased approach in CBT-E, particularly for underweight patients, is crucial for patient empowerment and collaboration. It ensures that individuals are not merely passive recipients of care but active participants in their journey towards recovery, making decisions that align with their values and goals.

The distinct stages and steps of CBT-E, tailored to meet the specific needs of non-underweight and underweight patients, reflect a structured, yet flexible framework that facilitates a comprehensive, focused and empathetic therapeutic process, offering a pathway for sustained remission and wellbeing.

Application of CBT for specific patient groups in different treatment settings

Self-help: Books and online resources for self-help CBT are available and further resources are being developed by the Oxford team. GPs can direct patients and carers with new presentations to these resources, providing accessible support for the initial management of eating disorders. The cbte.co website is an excellent resource both for the general public and clinicians (44).

Guided self-help: Patients receive structured support through face-to-face or digital sessions which guide them in applying CBT principles independently. There is robust evidence that guided self-help is effective in a significant proportion of patients with BEDs and less severe BN. Guided self-help is provided not only by secondary services but also by charities, such as Beat, or in some areas in the country, by Improving Access to Psychological Therapies. Online delivery has been shown to be cost-effective for BED (45).

CBT-T: This is a short-form individual CBT designed for non-underweight eating disorders, providing cheaper therapy with promising results for mild cases.

CBT groups: Group sessions offer peer support and collective learning, addressing common issues related to BEDs.

Outpatient CBT-E: This is the preferred treatment option for most adults with moderate eating disorders with a time-limited structure. Non-underweight patients typically undergo treatment for approximately 20 weeks, whereas underweight patients may require up to 40 weeks. Although some may worry that a fixed duration might compromise the personalised nature of CBT-E, having a set timeframe offers significant advantages. It enhances therapeutic focus and motivation, creates a sense of urgency for change, ensures that treatment progresses towards a formal conclusion and addresses critical future-oriented topics essential for long-term remission.

Adjustments to treatment duration are sometimes necessary. Patients with BEDs who show rapid improvement may have shorter treatment periods. Conversely, patients experiencing significant disruptions (such as clinical depression or interpersonal crises) or those who relapse shortly after completing treatment may require extended therapy. Treatment can be extended for several months in such cases, and regular four-week reviews should be conducted to assess the need for continued therapy.

Intensive outpatient CBT-E

Intensive outpatient and inpatient CBT-E are tailored to meet the needs of patients with more severe eating disorders. Each level of care incorporates specialised strategies to address specific challenges and promote progress and recovery.

This level of treatment is suited for individuals who require more support than traditional outpatient care offers but do not require hospitalisation. Intensive outpatient CBT-E maintains the core principles and strategies of its outpatient counterpart while introducing the following additional components.

- **Duration:** It is designed to last up to 12 weeks with flexibility based on the patient's progress, in areas such as weight regain or reducing binge eating episodes.
- **Daily structure:** Patients typically spend weekdays at the treatment facility, with the programme potentially including supervised meals, biweekly individual CBT-E sessions, dietary planning with a dietitian trained in CBT-E and regular medical reviews.
- **Transition to outpatient care:** As patients improve, they are gradually encouraged to eat meals outside the unit, transitioning towards conventional outpatient CBT-E.

This approach allows for more intensive treatment, with the goal of addressing specific difficulties more effectively than standard outpatient care.

Adaptation for adolescents

Dalle Grave's adaptation of CBT-E for adolescents acknowledges the unique challenges and needs of this demographic, particularly the potential long-term health implications of eating disorders and the critical role of parental involvement. Adolescents with eating disorders are at a heightened risk of developing severe medical complications such as osteopenia and osteoporosis, making the integration of regular medical assessments and a more cautious approach to hospital admissions crucial components of the treatment plan.

Duration of treatment for adolescents

For adolescents, CBT-E duration is tailored to their specific needs and recovery pace. While non-underweight patients undergo a 20-week programme similar to that of adults, underweight adolescents typically engage in a slightly longer treatment duration of approximately 30 weeks. This adjustment reflects the observation that adolescents often regain healthy body weight more quickly than adults do. However, the shortened timeframe does not compromise the treatment's effectiveness or thoroughness; it is designed to match the developmental and physiological responsiveness of adolescents.

Parental involvement

Parental involvement is a pivotal aspect of CBT-E for adolescents. Recognising the importance of a supportive home environment in the recovery process, the treatment model mandates significant parental participation. Initially, parents are engaged in a dedicated 90-minute session without the adolescent during the first week of treatment. This session aims to inform parents about the nature of the disorder, the treatment process and how they can support their teenager's recovery journey.

Subsequent treatment phases include joint sessions with the adolescent and their parents. These sessions, occurring in weeks 4 to 6 for non-underweight patients and weeks 8 to 10 for underweight patients, are designed to facilitate open communication, address familial dynamics that may impact eating disorders and develop a unified approach to recovery. These joint sessions, held immediately after the patient's individual session for approximately 15 to 20 minutes, are critical for ensuring that parents are equipped to provide appropriate support at home, reinforcing the principles and practices of the treatment.

Core elements of adolescent CBT-E

The core elements of the adolescent version of CBT-E, especially for underweight patients, are meticulously structured to address the multifaceted nature of eating disorders within this age group. This approach includes the following.

- **Educational components** are tailored to the adolescents and their parents, emphasising the importance of nutritional balance, risks of disordered eating behaviours and physical and psychological consequences of eating disorders.
- **Behavioural strategies** focus on normalising eating patterns, addressing body image concerns and developing healthy coping mechanisms for stress and emotions.
- **Cognitive interventions** aim to challenge and modify distorted beliefs and thoughts related to body image, self-worth and food.
- **Parental guidance and support** include providing parents with strategies to encourage healthy eating habits, improve communication and foster a positive and supportive home environment conducive to recovery.

By adapting CBT-E to the specific needs of adolescents and involving parents in the treatment process, this approach offers a comprehensive framework that not only addresses the immediate challenges of eating disorders but also promotes long-term recovery and wellbeing.

Complex comorbidities

All eating disorders have a high rate of comorbidities and complications. Common psychiatric comorbidities include affective and anxiety disorders, neurodevelopmental disorders and suicidality across the diagnostic spectrum. Chronic malnutrition in AN leads to progressive multiorgan damage, which is reversible with weight restoration. Gastrointestinal and endocrine complications are also common. CBT-E has been adapted for managing comorbidities and a manual is available for clinicians (1).

Dalle Grave recommends that some conditions, such as alcohol or substance dependence, need to be treated first, while others, such as diabetes and coeliac disease, require integrated treatment. His recently published guide for clinicians on the treatment of common comorbidities offers a rich overview for practitioners (1).

Inpatient treatment and integrated care

The number of patients requiring hospital treatment for severe eating disorders is increasing (16, 46, 47). However, hospitalisation is controversial owing to poor long-term outcomes and high costs. Inpatient treatment should be available for those who do not respond to outpatient treatment, but the threshold for admission, as well as the length and model of treatment, varies greatly depending on local historical arrangements (48).

UK inpatient treatment models

Inpatient programmes in the United Kingdom typically adhere to the NHS England Standard Contract for Specialised Eating Disorder Services and NICE guidelines, which are mandatory for both NHS and independently commissioned providers. The contract defines three types of admissions:

1. Unplanned or emergency admissions aiming to restore modest weight.
2. Short-term admissions for medical stabilisation.
3. Admissions focused on symptom recovery, such as achieving a weight that allows for less intensive future weight maintenance as well as improved eating behaviours and psychological understanding.

In practice, these admission categories frequently overlap. The eclectic multidisciplinary interventions were originally designed for outpatient settings and have not been thoroughly tested in inpatient settings. This can result in mixed messages and high disengagement rates, with up to 60% of patients self-discharging before achieving a healthy weight. Studies show that most adult patients are discharged at suboptimal weights after lengthy stays (49, 50).

Dalle Grave's team in Garda, Italy, has developed an inpatient and multistep programme based on CBT-E that improves patient experience and outcomes by prioritising individualised patient formulations and promoting autonomy (12, 26). This approach ensures consistency across the multidisciplinary treatment team, all of whom are trained in CBT-E, allowing the patient to overcome their disorder rather than coercing change. The programme includes an initial 13-week inpatient stay followed by 7 weeks of intensive day treatment and ongoing outpatient care. Treatment begins prior to admission and consists of 40 continuous sessions to ensure that care is uninterrupted (Figure 3).

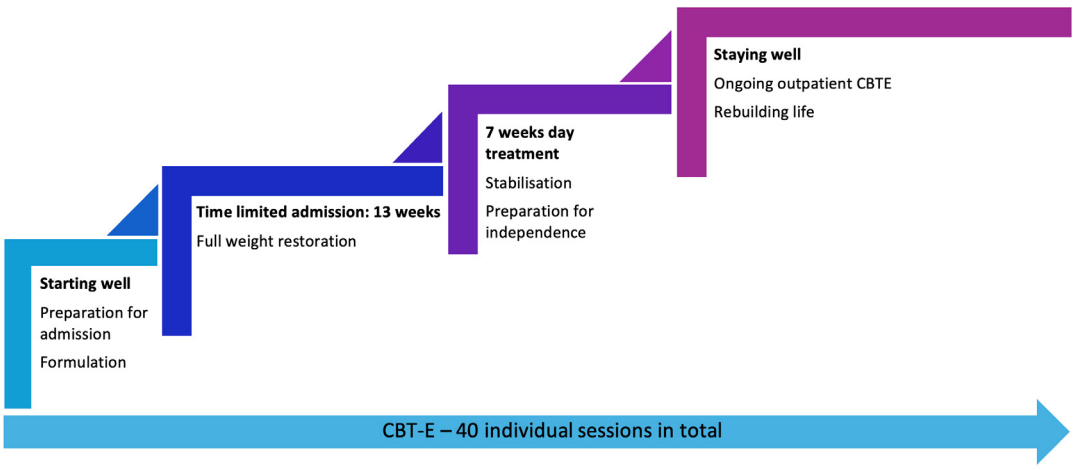

Figure 3. Conceptualisation of the multistep CBT-E developed by Dalle Grave et al. (12, 26)

Dalle Grave's manual (26) and papers on the method and outcomes show superior outcomes and completion rates compared to traditional eclectic models (14).

The model has been implemented in Oxford and demonstrated much improved outcomes compared with other approaches, including treatment as usual (TAU) and crisis admission (17). The differences between TAU and integrated CBT-E include:

- Integrated CBT-E across the care pathway without any interruption
- Time-limited and planned admission
- Full weight restoration, 1.5 kg/week
- Recovery focus
- 7 weeks of intensive support for weight maintenance
- Ongoing outpatient CBT-E without interruption

Inpatient CBT-E builds on traditional specialist eating disorder units by integrating psychological treatment within the multidisciplinary team and the care pathway

Inpatient CBT-E is reserved for those who have either not benefited from less intensive treatments or require immediate, intensive medical supervision.

- **Multidisciplinary team:** Treatment is delivered by a team of professionals, including physicians, psychologists, dietitians and nurses, all trained in CBT-E, ensuring a comprehensive and unified approach.
- **Assistance with eating:** Initial support is provided to overcome eating challenges in real time, helping patients adjust to healthier eating behaviours.
- **Relapse prevention:** Features aimed at reducing relapse include maintaining an open unit to allow exposure to external triggers while offering support, preparing for environmental challenges post-discharge, and involving significant others in creating a supportive home environment.

These additional elements of inpatient CBT-E focus on providing a safe and structured environment for intensive treatment while also preparing patients for a successful transition back into their daily lives, aiming to sustain the progress made during treatment and minimise the risk of relapse.

Both intensive outpatient and inpatient CBT-E represent critical components of a comprehensive care continuum for eating disorders, designed to provide an appropriate level of support and intervention based on individual patient needs. Through these tailored approaches, CBT-E seeks to facilitate recovery, encourage healthy behaviours and support the long-term maintenance of eating disorder remission.

Admission preparation

Inpatient CBT-E requires admission preparation, including appropriate preparation for physically compromised patients. Patients with AN are often fearful and ambivalent about treatment and recovery. Diet, weight and shape control are central to psychopathology; therefore, premature discharge is a risk unless the patient is fully committed to treatment. If possible, patients should start psychological treatment before admission or have a care coordinator to coordinate inpatient and outpatient treatments. The patient and carers should be able to visit the unit and meet the team to learn about the treatment. This helps to manage anxiety and engagement. Admission preparation may require more than one visit, but it is time well spent.

Refeeding

Extremely malnourished patients require safe refeeding. Underfeeding is as dangerous as refeeding syndrome, which tends to occur in patients with significant comorbidities. This has been highlighted in the MEED guidelines (51). Usually, patients tolerate an introductory 30–40 kcal/kg/day diet and gradually increasing amounts, depending on weight gain. According to NICE guidelines, the expected rate of weight gain in a hospital setting is approximately 0.5–1 kg per week. Slower weight restoration lengthens the hospital stay and is associated with poorer outcomes. Faster weight restoration (approximately 1.5 kg/week) is biologically safe and has been recommended by Dalle Grave (26). Most refeeding complications can be safely managed by expert medical and dietary support. The safety of higher calorie refeeding has also been established in adolescents (52, 53).

Patients with AN who have insulin-dependent diabetes require joint working between the diabetic and inpatient teams.

Mealtime support

Dietary restriction is a major maintaining factor in eating disorders. Therefore, introducing regular meals is an essential component of treatment, both for physical health and for addressing psychopathology. Regular eating is one of the most important CBT-E interventions and inpatient units can assist patients in regaining their normal eating patterns. Most specialist units in the United Kingdom provide intensive nursing support and supervision during mealtimes. Anxiety management is a critical component of this and requires a collaborative team effort (54). Smaller, but more frequent, meals are easier to digest for severely malnourished people at the beginning of weight restoration, and eating every few hours helps maintain energy levels; hence, most units have three main meals and three snacks, but later on having three larger main meals and one snack is usually satisfactory and easier to maintain after discharge (26). Dalle Grave recommends live self-monitoring and using distraction strategies to manage intrusive thoughts during mealtimes. These can also be incorporated into NHS settings, instead of nursing supervision.

In preparation for discharge, it is essential to include a variety of foods that reflect family traditions and lifestyles, and to practice eating outside of the hospital.

Psychological treatment follows CBT-E principles but is delivered by an entire team instead of one-to-one sessions only. This includes CBT-E group therapy and carer support.

Compulsory treatment

Most countries have legal frameworks that allow for compulsory treatment of people with severe mental illnesses. The Care Quality Commission issued a guidance note on the treatment of AN under the Mental Health Act 1983 in England and Wales to assist clinicians with treatment decisions when a high-risk patient refuses treatment. In this document, the patient's physical risk is prioritised. AN has a high suicide rate, so risks to oneself or others (e.g., while driving) also need to be considered. Treatment needs to be as collaborative as possible, both for the outpatient and for the detained patient (55, 56).

However, compulsory treatments have rarely been studied. Long-term outcomes studies do not support the presumption that compulsive treatment is inherently harmful, but additional research is required for this population of patients who are at extremely high risk (57).

The inpatient CBT-E programme can be motivating for patients who receive compulsory treatment. As explained above, CBT-E is highly collaborative and all efforts should be made to engage the patient informally. However, there are circumstances (usually late presentations) in which this is not possible. Nevertheless, an integrated psychological

approach using the multidisciplinary team can be highly effective in engaging initially non-consenting patients. This requires further study.

Transition and prevention of relapse

The risk of relapse after discharge is highest in the first year, particularly within the first 60 to 90 days (58). Integrated treatment produces better results. Our longitudinal cohort study in the UK showed that integrated CBT-E performed significantly better in real-world settings than traditional inpatient treatment models. Seventy percent of patients with severe and extreme AN in this study who received integrated CBT-E throughout the care pathway had good outcomes at least one year later, compared to less than 5% who received TAU or through crisis pathways. Integrated CBT-E, discharge BMI and legal status were the most important predictors of good outcomes, but not age, comorbidity or admission BMI (17). These findings suggest that weight restoration to a healthy weight range is necessary, but not sufficient, for good outcomes. Integrated CBT-E and ongoing psychological treatment are required for long-term changes. Alternative transition models are being investigated (59, 60).

The effectiveness and cost effectiveness of CBT-E

CBT-E has proven effective in treating a range of eating disorders in several countries, including England, Australia, Denmark, Germany, Italy and the United States (22, 61, 62). Research has shown some variation in outcomes and highlighted factors that improve efficacy. The most effective studies were those trained and supervised by the Oxford group, indicating the importance of supervision and treatment fidelity. The Oxford team has developed a treatment fidelity scale to help supervisors and therapists with treatment delivery (63).

Trials show that CBT-E is highly effective for patients who are not significantly underweight, with approximately 80% completing treatment and two-thirds achieving full remission, which is well maintained over time (2). For underweight patients, remission rates were comparable; however, treatment completion rates dropped to approximately 65%. It has also been adapted for inpatient and day settings, with approximately 70% of non-underweight patients (BN or BED) achieving complete remission and others showing partial response.

Future directions and guidance for GPs

In order to refer patients with eating disorders accurately to the appropriate level of care, it is necessary for GPs to have a thorough understanding of the different methods by which CBT is administered. Early recognition of symptoms and prompt referral can significantly affect outcomes, and low-key, less intensive interventions, such as guided self-help, may be sufficient. However, intensive CBT-E models may be necessary for patients with severe and complex presentations. Coordination with mental health professionals and ongoing support are essential components of comprehensive care.

Future research needs to focus on improving outcomes for patients with severe and complex comorbidities and to compare CBT-E with other evidence-based treatment models (64). The aim will be to examine the most effective implementation strategy in practice.

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Conflict of interest declaration

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