







EMPIRICALLY GROUNDED CLINICAL GUIDANCE PAPER

# Evolving perspectives on CBT-E for eating disorders: clarifying ten key points – misconceptions and communication gaps explored

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## Abstract

Drawing on extensive experience in training and supervising clinicians in enhanced cognitive behaviour therapy (CBT-E), we have identified ten prevalent misconceptions and communication gaps. These misunderstandings can impact the implementation of CBT-E and may potentially reduce its effectiveness. They include misconceptions regarding CBT-E's flexibility, suitability for certain patient groups, real-world applicability, and alignment with anti-weight stigma principles. Such misunderstandings may make clinicians hesitant to recommend or deliver CBT-E appropriately. In the present paper, we address these misconceptions and gaps in communication and provide evidence-based guidance on CBT-E practice. We aim to enhance clinicians' confidence in using CBT-E flexibly and appropriately, with the hope that this will improve its effectiveness.

## Key learning aims

- (1) Recognise common misconceptions and communication gaps about enhanced cognitive behaviour therapy (CBT-E) for eating disorders.
- (2) Develop an understanding of how CBT-E can be implemented across diverse clinical settings and patient populations.
- (3) Strengthen therapists' confidence in delivering CBT-E flexibly while maintaining fidelity to its evidence-based framework.

**Keywords:** CBT-E; eating disorders; enhanced cognitive behaviour therapy; evidence-based treatment; therapy; training

## Introduction

Enhanced cognitive behaviour therapy (CBT-E) is a leading evidence-based treatment for eating disorders (National Institute for Health and Care Excellence, 2020). It is transdiagnostic in scope, designed to address the core maintaining mechanisms of anorexia nervosa, bulimia nervosa, binge eating disorder, and other similar eating disorders. The latest UK national guidelines (National Institute for Health and Care Excellence, 2020) endorse eating disorder-focused cognitive

behavioural therapy (CBT-ED) as the recommended treatment approach for these eating disorders, with CBT-E being one of the most prominent examples of such treatment. CBT-E has been disseminated globally, and thousands of therapists have been trained in its delivery.

Drawing on our experience developing the treatment, using it in diverse settings, and helping therapists to implement it, we have identified recurring misunderstandings that may affect clinical practice and patient outcomes. Our work spans in-patient units, day programmes and out-patient clinics, and includes patients from a wide range of racial, ethnic and socioeconomic backgrounds, many with complex co-occurring conditions. We currently work within different healthcare systems – including nationalised, private, and insurance-based models – in the UK, Italy, and the US. Through providing international training and supervision, we have also seen how CBT-E is implemented in varied global contexts, including Europe, Asia, Australia, and South America. Our work involves direct engagement with neurodivergent, gender-diverse, and other individuals who are often marginalised or under-represented in eating disorder research and care.

Misconceptions and misunderstandings may prevent suitable patients from receiving CBT-E, or receiving the treatment as intended, thereby reducing effectiveness. Similarly, patient misconceptions could lead to delayed treatment-seeking, disengagement, or reduced adherence. A recent qualitative study found that misconceptions about CBT more broadly can hinder patient engagement between sessions (Bennion *et al.*, 2025). Addressing both clinician and patient misunderstandings is, therefore, likely important to improve access to and outcomes from CBT-E.

Misunderstandings about CBT-E arise both from a lack of awareness about the treatment and its potential effectiveness across a wide range of patients, as well as from the way it has been communicated and presented, particularly in published materials and training settings. Rather than viewing these as misconceptions to be corrected, we see them as opportunities to refine and improve how the treatment is communicated, understood, and applied. We hope that by addressing these issues in this way, we will be contributing to the evolution of the treatment.

Over the nearly two decades since the original CBT-E guide was published (Fairburn, 2008), the field of eating disorders has advanced, and our understanding of treatment and its implementation has evolved. Certain elements of CBT-E may now warrant reconsideration or refinement – not as corrections, but as part of the natural progression of clinical knowledge and experience.

The present paper is inspired by Murray *et al.* (2022), who identified and addressed ten common misconceptions about trauma-focused CBT for PTSD. These authors emphasised that misconceptions among therapists should not be a cause for shame as they often stem from compassionate intentions, lack of confidence, limited experience, or inadequate training. They acknowledge that even experienced clinicians, including themselves, sometimes deviate from evidence-based treatments. We wish to adopt a similar perspective and hope this work becomes a valuable tool for self-reflection and professional growth.

While CBT-E is not a cure-all, when implemented correctly, it can lead to significant improvements for many. We outline ten key misunderstandings and miscommunications. By doing so, we aim to ensure that CBT-E remains a robust, accessible, and effective treatment option for individuals with eating disorders.

## 1. CBT-E is rigid and requires strict adherence to a fixed protocol

CBT-E is sometimes viewed as overly rigid and as a ‘one-size-fits-all’ treatment. Some clinicians express concern that its structured format is difficult to apply in diverse real-world contexts, especially with patients who present with co-occurring conditions or varying levels of insight and motivation. Research reflects this perception, with clinicians doubting whether research findings generalise to their patients and whether CBT-E is flexible enough to fit individual patients (Cooper and Bailey-Straebl, 2015).

This perception misses the core principles of CBT-E. While the treatment offers a clear structure, it is fundamentally formulation-driven and explicitly designed to be both individualised and flexible. Each formulation is bespoke to the individual, whilst being drawn from a cognitive behavioural theory that addresses a range of maintaining mechanisms across eating disorder presentations (Fairburn *et al.*, 2003). This aligns with the concept of ‘flexibility within fidelity’ (Kendall *et al.*, 2008) – maintaining the key therapeutic procedures of evidence-based treatment while adapting delivery to suit the person’s unique context and presentation.

Individualisation begins in the assessment phase, where therapists consider a patient’s specific circumstances – such as neurodivergence, developmental stage, co-occurring mental or physical health conditions, food insecurity, cultural background, race, ethnicity, gender identity, sexual orientation, disability, socioeconomic status, trauma history and intersectionality – which may influence how the eating disorder presents, how the individual engages in treatment, and how treatment is shaped.

The formulation acts as a dynamic roadmap to guide treatment, evolving as patient and therapist learn what is maintaining the eating disorder. This personalised ‘diagram’ (as it is sometimes called with patients) allows treatment to be tailored to different maintaining mechanisms, such as low weight, binge eating, mood-related eating changes, and dietary restraint. While rooted in a shared transdiagnostic model, the formulation content is individualised for each patient. The formulation – both the main and extended form (for over-evaluation) – is co-constructed with careful attention to the patient’s own language or method of expression, reflecting only the mechanisms relevant to their experience. Clinical jargon such as ‘over-evaluation’ or ‘marginalised domains’ and generic templates are not intended to be used directly with patients.

Examples of personalisation include the ‘significantly low weight’ mechanism being adapted for individuals with atypical anorexia nervosa by using a description that is meaningful to the individual, such as ‘being at a low weight for my body’, reflecting the effects of weight suppression, prolonged undereating, or rapid weight loss. These factors can perpetuate the eating disorder through physical, psychological, and social consequences that can serve to keep the individual ‘locked in’ to their eating disorder.

Understanding the function of behaviours is central to formulation. Therapists and patients consider whether a given behaviour is maintaining the disorder based on its function. For example, food avoidance due to cultural, religious, or sensory reasons may not need to be addressed unless it interacts with the eating disorder. If it does, this can be explored collaboratively and reflected in the formulation.

CBT-E is a principle-driven model, not a rigid manual, and consists of a coordinated collection of therapeutic procedures, each designed to target specific maintaining mechanisms of the eating disorder. Consequently, it does not prescribe identical content session-by-session. Although the treatment is organised into four structured and sequential stages, the specific procedures, their content, and the order in which they are implemented – particularly in Stage 3 – are tailored to the individual’s formulation and evolving needs.

Stage 1 includes relatively universal procedures designed to promote engagement and establish a foundation for change. Stage 2 involves reviewing progress, identifying barriers to change, and preparing for Stage 3. Stage 3 is the most flexible and individualised phase of treatment. It targets the specific maintenance mechanisms identified in the patient’s formulation, delivered in a carefully considered sequence. This sequencing is guided by clinical judgement and patient input and aims to maximise therapeutic impact – for example, by prioritising mechanisms that are likely to unlock the most widespread change and considering whether early progress in a particular area is likely to enhance the patient’s sense of self-efficacy and hope, and thereby build momentum for change and progress.

Therapists are encouraged to understand the role of each procedure so that it can be delivered flexibly. For example, self-monitoring is intended to enhance real-time awareness and convey the

notion that different choices can be made. If the standard recommended format is not feasible – due to cognitive or literacy barriers, for example – voice memos or other formats may and should be considered. Such adaptations should preserve the intervention’s purpose while avoiding distracting or inconsistent elements (e.g. methods that record too much detail about food quantities and energy intake).

This flexibility extends and is enhanced in Stage 3, where CBT-E employs a modular approach allowing clinicians to select modules and their procedures based on individual needs. Some modules – like body image – apply to nearly all patients. Others – like mood intolerance – are used only when relevant maintaining processes are identified. The model can also accommodate a number of factors external to the eating disorder (clinical perfectionism, low self-esteem and interpersonal difficulties), which are sometimes encountered as further maintaining mechanisms.

In practice, this modular formulation-driven approach ensures that treatment is personalised and grounded in the mechanisms driving the patient’s particular problems. This approach not only allows for tailored treatment paths but also promotes additional innovation in CBT-E, as new modules can be developed (for example, for co-occurring trauma) and, if evidence supported, integrated to address further obstacles or specific needs.

## 2. CBT-E is simply standard CBT applied to eating disorders

CBT-E is often mistakenly assumed to be generic CBT applied to eating disorders. In fact, it is a highly specialised treatment, grounded in a particular transdiagnostic cognitive behavioural theory of eating disorders (Fairburn *et al.*, 2003).

Like other evidence-based, disorder-specific CBT treatments (e.g. social anxiety; Clark and Wells, 1995), CBT-E is based on a clearly defined theory of the disorder in question and explicitly targets the mechanisms that maintain it, such as dietary restraint and over-evaluation of eating, weight, and shape. Only versions of CBT that directly target the unique maintenance processes of eating disorders have demonstrated effectiveness. This aligns with the NICE guideline recommendation for ‘CBT-ED’ (National Institute for Health and Care Excellence, 2020), which is an umbrella term that includes CBT-BN (developed specifically for bulimia nervosa) and its expanded and more up-to-date transdiagnostic version, CBT-E (Fairburn, 2008). While CBT-BN focuses on binge eating and purging in bulimia nervosa, CBT-E is the more up-to-date version, which extends this approach to address the core maintaining mechanisms across the spectrum of eating disorders.

Around one-half to two-thirds of out-patients who receive CBT-E experience significant symptom reduction after treatment, and these effects are sustained one year later (Fairburn *et al.*, 2009; Fairburn *et al.*, 2015). Multiple meta-analyses and systematic reviews have provided support for CBT-E (Atwood and Friedman, 2020; Dahlenburg *et al.*, 2019; de Jong *et al.*, 2018; Groff, 2015), with the most comprehensive review (Atwood and Friedman, 2020) concluding that there is support for the efficacy and effectiveness of CBT-E for the spectrum of eating disorders with respect to reducing eating disorder behaviours and core psychopathology and increasing weight in individuals with anorexia nervosa. Furthermore, therapist-led CBT-ED has been found to be more effective when ‘manualised’ CBT-BN or (its later version) CBT-E is delivered (Linardon *et al.*, 2017), and this was confirmed in a recent review of systematic reviews, which also found manualised CBT-ED (CBT-BN, CBT-E) to be more effective than adapted forms of CBT-ED (Kaidesoja *et al.*, 2023).

To help patients identify whether they are receiving CBT-E, a checklist of core features has been developed (<https://www.cbte.co/for-the-public/how-to-know/>). This checklist outlines the essential components of CBT-E, including the use of a co-constructed diagram of maintaining features, self-monitoring, regular eating, and a focus on addressing other elements (if relevant) such as body image, eating more flexibly, and coping with life situations that influence eating.

Additionally, a Therapist Self-Rated CBT-E Components Checklist has been developed to enable therapists to self-assess their adherence to CBT-E (Bailey-Straebl *et al.*, 2022).

### 3. CBT-E only addresses observable behaviours without tackling underlying issues

CBT-E is sometimes thought to focus solely on behaviour, neglecting cognitions and emotions. This perception likely stems from CBT-E's early emphasis on behavioural strategies in Stage 1. This strategy, which CBT-E shares with other evidence-based CBT treatments, is based on the rationale that meaningful cognitive change often follows behavioural change, and that achieving early behavioural change can be a powerful way to engage individuals in the treatment process and build momentum for further change. For example, CBT-E uses behavioural procedures, such as establishing regular eating to reduce pre-occupation with food and to begin to address dietary rules, and procedures for reducing body checking or avoidance to help patients to re-evaluate shape and weight concerns.

In addition to behavioural interventions, CBT-E incorporates cognitive techniques such as de-centring. Early interventions – including collaboratively constructing a formulation and engaging in real-time self-monitoring – help patients gain insight and distance from the eating disorder. As treatment progresses and maintaining behaviours are disrupted, patients are encouraged to adopt a more direct strategy of cognitive distancing. They are encouraged to learn to recognise when their eating disorder mindset re-emerges and to deliberately take steps to replace it. By becoming aware of shifts in their thinking and behaviours, they can develop methods of manipulating their frame of mind and displacing their eating disorder mindset. This ability enables them to promptly manage setbacks and reduces the risk of a full-scale relapse.

CBT-E addresses emotional processes and life stressors from the outset. During the formulation and self-monitoring, therapists and patients examine if and how mood and external events influence eating behaviours. For individuals who use eating disorder behaviours to modulate intense emotions – such as binge eating or purging – CBT-E focuses on building more sustainable, adaptive alternatives to help them to manage their moods.

A further misconception is that CBT-E disregards the origins of eating disorders. While the model prioritises current maintaining mechanisms, it also acknowledges that past experiences – such as trauma or early body-related criticism – may have contributed to the eating disorder. CBT-E is based on the principle that meaningful change occurs by targeting the processes that are active in the present and aiming to reverse these to help the patient overcome the disorder. The formulation (or 'diagram') is intentionally focused and does not aim to capture every possible contributing factor. This helps keep treatment focused, clear and manageable, especially given that several maintaining mechanisms are likely to need to be addressed. CBT-E typically incorporates a structured historical review in the later stages of treatment, when symptom change has occurred, and patients are developing insight and psychological distance from the disorder. Through this procedure, patients are supported in exploring how their eating difficulties may have developed with the goal of making sense of the origins of their eating disorder and fostering further psychological distance to help them to 'move on'.

This historical review can also help the patient see that the eating disorder can be considered as an understandable response to lived experiences, perhaps once serving a useful function, even if it no longer does so now. Framing it in this way fosters self-compassion and provides a valuable depathologising function, especially if the individual has come to view the eating disorder as a personal failing. So, while CBT-E aims to help patients recover by modifying the features currently maintaining the eating disorder, it also promotes understanding of the origins of the disorder as part of the process of achieving change and staying well in the longer term.

As with most CBT-E procedures, there is flexibility in how and when this process of historical review is introduced. Although it is typically conducted later in treatment, towards the end of Stage 3, it may be brought forward if past events are clearly acting as a major barrier to change.

Occasionally, patients identify specific events that appear to have played a critical role in sensitising them to body image concerns or in the development of the eating disorder. In such cases, the therapist can help the patient reappraise the event from the vantage point of the present, taking a compassionate stance and gently encouraging a reconsideration of conclusions drawn at the time.

#### 4. CBT-E has limited applicability in real-world clinical settings, where it often fails to achieve positive outcomes

Contrary to the view that CBT-E has limited applicability in real-world settings, a body of international evidence demonstrates that CBT-E can be successfully implemented across a wide range of clinical settings and patient populations. Effectiveness studies from a range of different countries, including the Netherlands (de Jong *et al.*, 2020; van den Berg *et al.*, 2020), Italy (Dalle Grave *et al.*, 2020), and Australia (Byrne *et al.*, 2011) have demonstrated that it is feasible and effective for a broad range of eating disorders. Studies such as these, with unselected consecutive patients seeking treatment in real-world eating disorder out-patient clinical services, demonstrate that CBT-E can be successfully implemented outside controlled research environments.

CBT-E has also shown promising outcomes in more challenging contexts – for example, among low-income populations in the US (Bailey-Straebl *et al.*, 2024), in Italy with individuals with anorexia nervosa and a body mass index (BMI) below 16, and within the UK's National Health Service using an integrated stepped-care approach (Ibrahim *et al.*, 2022).

Despite evidence supporting its effectiveness in real-world settings, CBT-E is often associated with relatively high drop-out rates (Byrne *et al.*, 2011; Signorini *et al.*, 2018). For example, one transdiagnostic study reported a drop-out rate of 47%, which was linked to longer waiting times for treatment (Byrne *et al.*, 2011). Similarly, Kessler *et al.* (2022) observed a high drop-out rate among adult out-patients with anorexia nervosa in a public specialised eating disorder service. These findings underscore the importance of timely access to care and highlight the need for strategies specifically designed to enhance patient retention, particularly in routine clinical settings.

The misconception that CBT-E is only suitable for highly motivated patients or, in some way, does not address the underlying motivations or reasons for an eating disorder can lead to the assumption that CBT-E has limited utility in everyday clinical settings, where ambivalence about change is common. In fact, CBT-E is specifically designed to address and enhance motivation, fostering engagement from the outset. A central feature of this approach is that treatment always begins with a consideration of something the patient themselves wants to change or wishes were different, and this is used as the starting point for developing an individualised formulation.

For patients who are underweight – or those presenting with low motivation – the initial phase of treatment is devoted to helping them make an informed decision about whether to pursue change, including weight regain if indicated. This involves assisting patients to explore both their reasons for wanting to change and, critically, their reasons for not wanting to. In other words, not only are the costs of the eating disorder explored, but also the perceived benefits or the role(s) it may have played in the person's life. For example, the eating disorder may have provided a sense of control or a way of expressing distress that felt too difficult to articulate directly. Each individual's reasons may be different, and understanding them is an essential part of CBT-E. By understanding this, patients are better positioned to consider whether their needs could be met in other ways. For instance, if maintaining a low weight has become a way of signalling distress, the therapist can support the patient in identifying and using alternative strategies, such as expressing needs openly or seeking support more directly and assertively. This approach also promotes autonomy and informed choice. It emphasises collaboration and shared understanding, supporting patients in making informed decisions about their recovery.

A key concern about implementing CBT-E in real-world settings is the practicality of delivering twice-weekly sessions in the initial phase. This intensity may be perceived as challenging to accommodate, as it could limit the number of patients seen at one time, increase patient costs, and, in some healthcare systems, raise insurance coverage issues (Cooper and Bailey-Straebl, 2015). In our experience, however, twice-weekly sessions are generally feasible and beneficial, as they enhance patient engagement and outcomes. Both therapists and patients value this frequency, and when clinically justified, insurance coverage is typically not a problem. If twice-weekly sessions are impossible – whether due to therapist capacity, patient circumstances, or systemic constraints – we would recommend approximating this as closely as possible. This might include combining one in-person session early in the week with a second brief online or telephone-based session later in the week. Although this adaptation has not been formally tested, it may help preserve the therapeutic momentum intended by the twice-weekly format and provide additional support to facilitate change in the early stages of treatment.

Another challenge to real-world implementation is the limited availability of accessible training in CBT-E. To address this, the Centre for Research on Eating Disorders at Oxford (CREDO) developed a comprehensive web-based training programme. Designed to overcome geographical and other barriers to in-person training, the programme offers detailed guidance and a library of illustrative clinical demonstrations – an element rarely included in traditional workshops. Evaluations have demonstrated the programme is effective, acceptable, and scalable (Cooper *et al.*, 2017; Fairburn *et al.*, 2017; Khera *et al.*, 2021; O'Connor *et al.*, 2018). While some parts of the training website need updating to reflect current thinking and the recent developments discussed in this article, it remains a valuable resource.

A related issue is the limited availability of expert supervision, which can contribute to ‘therapist drift’ – the gradual erosion of treatment fidelity (Waller, 2009). Kessler *et al.* (2022) similarly observed that effective learning often depends on supervision from experienced CBT-E therapists. While such supervision may be ideal, it is not always accessible. In these cases, peer supervision groups and the use of structured self-rated checklists (Bailey-Straebl *et al.*, 2022) may help clinicians maintain adherence to the treatment model.

## 5. CBT-E is unsuitable for ‘complex’ patients, particularly those with co-occurring conditions

CBT-E is often seen as unsuitable for ‘complex’ patients with co-occurring medical, psychological, or psychiatric conditions. This belief does not reflect the evidence base.

Complexity is the norm in eating disorders, with many individuals having at least one additional psychiatric disorder, such as mood, anxiety, or substance use disorders (Hudson *et al.*, 2007; Udo and Grilo, 2018). In addition to these co-occurring disorders, other common co-existing features include affect regulation difficulties, perfectionism, impulse control difficulties, and deliberate self-harm behaviour (Halmi, 2018; Warne *et al.*, 2021). Around two-thirds of people receiving treatment for an eating disorder report at least one past traumatic event (Kjaersdam Tellús *et al.*, 2021).

Importantly, the research supporting CBT-E, including the main randomised controlled trials (Fairburn *et al.*, 2009; Fairburn *et al.*, 2013; Fairburn *et al.*, 2015) and studies from everyday clinical practice, involved few exclusion criteria (e.g. Byrne *et al.*, 2011; de Jong *et al.*, 2020; van den Berg *et al.*, 2022), making the findings applicable to a wide range of patients, including those with co-existing conditions.

Although there is evidence suggesting that co-occurring conditions are associated with higher levels of eating disorder psychopathology and poorer outcomes across treatments (Linardon *et al.*, 2017; Lydecker and Grilo, 2021; Vall and Wade, 2015), this does not necessarily imply that these conditions moderate the treatment response to CBT-E. Instead, reduced benefit may be attributable to therapist drift – that is, deviating from the core treatment model in an effort to ‘mix

and match' interventions across disorders. Unfortunately, such an approach is not supported by empirical evidence (Wade *et al.*, 2024). In contrast, when therapists maintain a focus on the eating disorder and its maintaining mechanisms, CBT-E has been shown to yield improvements not only in eating disorder symptoms but also in mood, anxiety, and self-esteem, even when these areas are not directly targeted (Kaidesoja *et al.*, 2023; Mulkens and Waller, 2021; Voderholzer *et al.*, 2021).

CBT-E offers practical, principle-driven general clinical guidelines for addressing some of these co-existing conditions within its evidence-based framework (Fairburn *et al.*, 2008). In many cases, treatment can proceed as usual using the standard CBT-E approach, particularly when co-existing conditions do not interfere with treatment engagement. Where co-occurring conditions are likely to interfere with CBT-E, such as an independently occurring clinical depression, then we recommend treating the co-occurring condition first. Conversely, when co-existing conditions are unlikely to disrupt treatment – and may even improve as a result of treatment – they can be monitored and re-assessed after CBT-E has been completed to determine whether additional intervention is needed.

The broad form of CBT-E was developed specifically for patients who do not respond well to the standard (focused) version, and who present with external maintaining mechanisms – in particular clinical perfectionism, interpersonal difficulties, or core low self-esteem – that interfere with change. These mechanisms are not specific co-morbid diagnoses, but transdiagnostic constructs that often feature in complex presentations. The broad version includes optional modules designed to address these issues in a structured way within Stage 3. Whilst the currently available broad form only addresses these specified external maintaining mechanisms, its modular structure creates the possibility for the careful integration of additional modules, once these have been evaluated. The research on how to best address interacting co-occurring conditions in the treatment of eating disorders is still emerging. Mitchell *et al.* (2021) describe an integrated cognitive behavioural model addressing post-traumatic stress disorder (PTSD) and eating disorders, and Wade *et al.* (2024) discuss these issues more generally and suggest a general guiding framework.

## 6. CBT-E is only suitable for out-patients and not applicable to intensive treatment settings

Although CBT-E was initially developed for out-patient care, it has since been successfully adapted for use in more intensive settings, including day treatment and in-patient programmes (Dalle Grave, 2012; Dalle Grave, 2013). These versions are particularly relevant for patients requiring closer medical supervision or those who have not responded to less intensive interventions.

Intensive day-treatment CBT-E retains all the core CBT-E strategies and procedures from standard out-patient treatment but adds more support features. It involves a multi-disciplinary 'non-eclectic' team of trained CBT-E professionals, including physicians, psychologists, dieticians and nurses who provide initial eating assistance to help patients manage real-time difficulties (Dalle Grave, 2012; Dalle Grave, 2013). The treatment duration for this intensive approach is generally around 12 weeks but is adjusted to be shorter or longer based on the patient's progress. Those who respond well then transition to standard out-patient CBT-E sessions to complete their treatment. The subsequent out-patient sessions focus on consolidating progress, managing home-based challenges, and addressing any remaining factors that could lead to relapse.

Evidence from uncontrolled studies has shown promising results for both adolescents and adults in day hospitals and more intensive settings. Approximately 85% of patients complete treatment, and about 50% maintain full remission at 60-week follow-up (Dalle Grave *et al.*, 2013; Dalle Grave *et al.*, 2014; Dalle Grave *et al.*, 2020; Dalle Grave *et al.*, 2022), with full remission defined in these studies as a global EDE-Q score within one standard deviation of the community mean and weight restoration to a BMI  $\geq 18.5$ .

## 7. CBT-E is a lengthy and resource-intensive treatment, making it impractical for widespread use

Contrary to this view, CBT-E is intentionally designed to be flexible, scalable, and adaptable across various clinical settings and levels of care. While individuals at a low weight may require a longer course of treatment, CBT-E can be delivered in a shorter format – with 20 sessions (or fewer) – for those who are likely to respond more quickly.

In addition to therapist-delivered CBT-E, guided self-help formats have also been developed. For example, the programme-led printed version of CBT-E, *Overcoming Binge Eating*, delivered alongside guidance, is consistent with NICE guidelines for the treatment of bulimia nervosa (BN) and binge eating disorder (BED). More recently, a digital, programme-led version of CBT-E has also shown promising early results (Murphy *et al.*, 2025), offering a focused, scalable option that may help expand access to care for those with binge eating.

CBT-E was designed to be delivered by a single therapist and generally does not always require a multi-disciplinary team. A broad range of healthcare professionals can and have been trained to deliver the treatment effectively. As noted earlier, CREDO offers a comprehensive web-based training programme (<https://www.cbte.co/for-professionals/web-based-training/>), which has been completed by professionals across disciplines and levels of experience.

CBT-E is a time-limited treatment, typically delivered over 20 weeks, with an extended version of around 40 weeks for those requiring weight restoration. The longer format allows time for patients to make an informed decision about change, reach a sustainable weight, and consolidate progress. While these recommendations are based on research protocols, clinical experience suggests that a degree of flexibility may be needed – for example, patients with a smaller amount of weight to restore may benefit from approximately 30 sessions, while those who have had prior treatment may not require the full 40, and treatment may be shortened if rapid improvement occurs. Nonetheless, a defined time frame is helpful: it focuses therapeutic effort, encourages early momentum, and increases the likelihood of a structured and purposeful ending, which is essential for consolidating gains and planning for the future.

## 8. CBT-E is designed for adults and is not suitable for treating young people with eating disorders

As adolescents and adults generally share similar eating disorder psychopathology (Calugi *et al.*, 2020), it has been possible to adapt CBT-E for adolescents aged 12 years and over (Dalle Grave and Calugi, 2020). The treatment is engaging for young people as it promotes the pursuit of control and autonomy by actively involving them in the decision to change and in planning their treatment. As with adults, treatment can be individualised to meet the particular needs of each patient.

Adolescents with eating disorders are particularly vulnerable to serious medical complications – including impaired bone density, arrested or delayed growth, and structural and functional brain changes. Because these issues can become severe and potentially permanent if not promptly addressed, regular medical monitoring and a lower threshold for hospital admission are integral components of CBT-E for this age group. Parental involvement is a key component. Parents are invited to participate as ‘helpers’ to create a supportive home environment and assist in implementing treatment with the adolescent’s consent (Dalle Grave and el Khazen, 2022). Treatment can also be tailored to the young person’s level of cognitive development.

The NICE (National Institute for Health and Care Excellence, 2020) guideline recommends considering CBT-ED for adolescents with eating disorders as an alternative to the first line, family-based treatment (FBT), when FBT is not suitable, contra-indicated, or ineffective. Although no randomised controlled trials (RCTs) have yet been completed, there are positive findings from several uncontrolled cohort studies which have yielded positive findings to support the use of

CBT-E with adolescents. Studies of those with anorexia nervosa (Dalle Grave *et al.*, 2013, Dalle Grave *et al.*, 2019) showed significant weight regain and improvements in symptoms and psychological functioning, with these results maintained at follow-up among completers (66% and 70%, respectively). Among adolescents who were not underweight, results indicated a marked treatment response, with two-thirds (67.6%, intent-to-treat) exhibiting minimal residual eating disorder psychopathology and a higher completion rate (75%) by the end of treatment (Dalle Grave *et al.*, 2015).

Intensive CBT-E was also found to be an effective treatment for adolescent patients with anorexia nervosa, regardless of their duration of illness (Calugi *et al.*, 2024). A non-randomised study comparing CBT-E and FBT for young people, who chose their preferred treatment, found no significant differences in weight regain or symptom improvement at 6- and 12-months post-treatment (Le Grange *et al.*, 2020). Of interest, CBT-E has also proven helpful for adolescents who did not recover following FBT. A study comparing adolescents who had previously received FBT with those who had not, found comparable rates of treatment completion and symptom improvement in both groups (Wilson *et al.*, 2025).

Currently, a large non-inferiority RCT (the Norwegian CogFam study) is underway to formally compare CBT-E and FBT in adolescents aged 12–18 years (Øyvind, 2023). This multi-site trial aims to evaluate the acceptability, clinical outcomes, and sustainability of both treatments. Importantly, it also seeks to identify treatment moderators that may help personalise treatment recommendations for young people in the future.

## 9. CBT-E is inherently weight-stigmatising, reinforcing negative views about higher weight

CBT-E is a treatment for eating disorders and as such is designed to be, amongst other things, anti-diet. One of the fundamental aims of CBT-E is to encourage patients to cease relying on controlling their eating, weight, and shape as their primary source of self-worth. It promotes the development of new, meaningful sources of self-evaluation while also reviving previously neglected ones. CBT-E opposes strict dieting, promotes flexible eating, and emphasises that ‘dieting is risky’ and often likely to contribute to perpetuating the eating disorder. However, we acknowledge that some aspects of past communications about CBT-E have contributed to weight stigma. To ensure alignment with these fundamental aims, we have updated our clinical approach and are updating the guidance provided to therapists.

One of the important changes is no longer relying on body mass index (BMI) as a primary measure of individual health. Originally developed in the 19th century as a population-level statistical tool – not as a measure for individual health – BMI does not account for important factors such as age, ethnicity, race, lifestyle, body fat distribution, and muscle mass. Additionally, it does not consider the functional state of tissues and organs, nor does it reflect an individual’s ability to perform everyday tasks. Importantly, BMI also does not indicate whether someone is at the body weight or composition necessary to support their psychological health, an essential consideration especially in the context of eating disorder recovery.

This shift is consistent with updated guidance on the definition and diagnostic criteria of clinical obesity (Rubino *et al.*, 2025). In line with this modification, we no longer recommend using BMI thresholds on individual graphs. Instead, we now adopt a more individualised approach by determining a sustainable and functional weight range on a case-by-case basis, guided by two core criteria:

1. *Does not contribute to the maintenance of the eating disorder:* the weight range can be sustained without reinforcing or contributing to the maintenance of the eating disorder. Recovery is unlikely if disordered behaviours (e.g. restrictive eating or compensatory practices) are required to maintain a specific weight, or if the weight itself functions as a

maintaining mechanism. For example, being at a low weight for one's body may contribute to features that keep individuals 'locked in' to the eating disorder mindset, such as feeling full when eating even small amounts of food.

2. *Lack of impairment across domains*: the weight is not associated with significant impairment in functioning in physical (e.g. effects of starvation syndrome or other complications related to low weight, with special consideration given to the developmental needs of adolescents), psychological (e.g. pre-occupation with food and eating), or social (e.g. avoidance of eating with others) domains.

If a patient's weight is below their individualised sustainable weight range, then a key goal of CBT-E is to support weight restoration as part of recovery. In other cases, treatment focuses on helping the patient overcome their eating disorder. In these instances, weight change is not a treatment goal, and weight is not a relevant outcome – weight may increase, decrease, or remain stable, depending on the individual. We acknowledge that removing reliance on BMI as the main indicator of health, and putting much greater emphasis on this individualised method, is a departure from the way we previously proceeded.

To minimise the risk of reinforcing weight stigma or contributing to fat shaming, we recommend a change in the language used in the intervention historically referred to as 'feeling fat'. While this phrase may resonate with some patients and describe a common subjective experience, it also carries the risk of reinforcing anti-fat bias and may contribute to the internalisation of societal stigma. A particular concern arises if therapists state 'feeling fat is not the same as being fat', as this may imply that being fat is something negative – thereby reinforcing the very weight stigma the intervention seeks to counter. Instead, therapists may refer to the experience of sudden spikes in body image concern and suggest that this experience may be linked to the experience of a range of other emotional or physical states (e.g. boredom, loneliness, low mood) or physical sensations (e.g. feeling hot, bloated, or noticing tight clothing). We recommend that the terms used during this intervention be individualised and guided by the patient's own words. We now refer to this as 'addressing spikes in body image concern' to reflect a more weight-neutral approach.

We have also removed reference to 'binge-proof dieting' to reinforce CBT-E's fundamentally anti-diet stance (please see further discussion below).

An important aspect of CBT-E that may evoke memories of weight-stigmatising experiences is 'collaborative in-session weighing'. For some individuals, being weighed in treatment may be associated with previous unhelpful or distressing encounters, such as participation in weight loss programmes or interactions with health professionals where they were blamed and shamed for their weight, or where major decisions about their care were made based solely on a single weight reading, including instances of medical gatekeeping. These experiences can shape how patients perceive in-session weighing, making it essential for clinicians to approach this procedure with care with a full understanding of how to use this procedure.

Therapists should be alert to these concerns and take care to differentiate collaborative in-session weekly weighing from practices that may have previously been unhelpful or even distressing. Instead, they should carefully explain the CBT-E rationale for in-session weighing and discuss its potential therapeutic benefits. Briefly, collaborative in-session weighing serves the following functions:

- *Helping patients to observe what is happening with their weight alongside changes in eating*: as patients' eating habits will be changing in treatment, they are likely to be concerned about any resulting change in their weight. In-session weighing provides consistent, week-by-week data, enabling patients to relate any weight trends over time to changes to their eating (and in some cases to make sure that weight increases when it is an agreed part of treatment).

- *Helping patients to accurately understand weight fluctuations:* regular in-session weighing provides an opportunity for the therapist to help patients interpret the number on the scale, ignoring small fluctuations and focusing on trends over time.
- *Addressing one form of body checking, namely, weight checking or avoidance:* many patients weigh themselves frequently – sometimes multiple times per day – which increases pre-occupation with day-to-day fluctuations that would otherwise go unnoticed.

Others actively avoid knowing their weight but remain highly concerned about it. Avoidance of weighing may be as problematic as frequent weighing, as it results in patients having no data about their weight and may lead them to rely on highly unreliable forms of shape checking. Collaborative weekly weighing involves obtaining accurate – but not overly frequent – information and using it in-session to help patients understand what is happening with their weight and thus disrupting an important maintaining process of the eating disorder (weight checking and weight avoidance).

As always, CBT-E should be individualised and there may be exceptional occasions when it is not indicated. For example, if a patient has a trauma history directly tied to weighing – such as being required to weigh themselves in distressing or punitive circumstances – it may be clinically appropriate to delay in-session weighing. In such cases, the decision should be made collaboratively with the patient, with sensitivity to past experiences, and regularly reviewed. The collaborative weekly weighing procedure may be introduced later in treatment, when therapeutic rapport is established and the patient feels more able to engage with this aspect of the intervention in a safe and supported way. Another rare scenario where weekly weighing may be omitted could involve a patient who expresses no concern about their weight throughout treatment, has no interest in the number on the scale, and for whom weight does not feature in the formulation.

It is important to remember that the fundamental aim of CBT-E is to help patients evaluate themselves in broader, more flexible, and more meaningful ways – not primarily through the lens of shape, weight, or eating. A more detailed discussion of when and how to adapt CBT-E procedures such as weighing lies beyond the scope of this paper but warrants further consideration in future work.

It should be noted that collaborative weighing is sometimes confused with other forms of in-session weighing (including in some other forms of CBT), in which patients are asked to predict their weight before being weighed. This is often designed as a behavioural experiment to challenge ‘distorted’ beliefs and demonstrate that weight has not increased as expected. In our view this approach carries several risks and should be avoided. First, it may be experienced as invalidating, as many patients are, in fact, accurate in their weight predictions. Second, it may inadvertently reinforce the notion that weight gain is a negative outcome – even in cases where weight gain is a necessary and explicitly agreed-upon goal of treatment. Third, it conveys the misleading impression that a single weight reading is meaningful, when in fact, weight is a naturally fluctuating biological variable, influenced by a range of factors, including levels of hydration, that must be interpreted across multiple measurements to identify meaningful trends.

We generally place little emphasis on formal, hypothesis-testing behavioural experiments in CBT-E, especially when weight or shape change is the likely primary outcome, as these outcomes do not lend themselves to short-term experimental testing.

We also recognise that some aspects of CBT-E, such as ‘real-time self-monitoring’ may remind patients of past weight-stigmatising practices, such as ‘food logs’ or ‘diet sheets’ from weight loss programmes. Therapists should be aware of these concerns and clearly understand and explain the rationale behind CBT-E procedures such as self-monitoring, emphasising their therapeutic role in understanding and addressing the psychological mechanisms maintaining the eating disorder. These therapeutic procedures need to be clearly differentiated from similar interventions intended to control weight.

The damaging impact of diet culture is addressed in the section below.

## 10. CBT-E is not appropriate for individuals with an eating disorder in larger bodies, as it may not address their specific needs

In principle, there is no reason why CBT-E would not benefit individuals with eating disorders across the full spectrum of body sizes. However, empirical research specifically evaluating its effectiveness in individuals with higher body weight remains limited, highlighting the need for further investigation in this important area.

The perception that CBT-E may not be suitable for individuals in larger bodies typically stems from two key concerns. The first is that CBT-E might inadvertently reinforce weight stigma, thereby increasing harm for people who already face societal weight discrimination. Specific aspects of treatment – such as the use of BMI to define health status, in-session weighing, or real-time self-monitoring – which have been cited as potentially harmful are discussed above. The second concern is whether CBT-E is sufficiently equipped to help individuals in larger bodies reduce over-evaluation of shape and weight in a society that continues to reinforce thinness as a cultural ideal. People in larger bodies often face weight stigma on multiple levels: structural (media, legal, and policies), interpersonal (teasing, bullying, and discrimination), and intrapersonal (anticipation of experiencing stigma and internalisation of weight stigma). These influences can powerfully maintain an over-evaluation of weight and shape, making it especially difficult to achieve body neutrality.

In our clinical experience individuals in larger bodies frequently describe these additional challenges. While CBT-E promotes developing ways of valuing oneself largely independently of weight or shape and these societal prejudices, we acknowledge that societal pressures can make this aspect of treatment extraordinarily challenging for those in larger bodies and the therapists who are working with them. Furthermore, we realise that this type of stigma was not described in earlier descriptions of CBT-E.

The concept of over-evaluation in CBT-E refers to the tendency to judge self-worth primarily or exclusively based on weight, shape, or eating control. While CBT-E refers to this as the core psychopathology – the central process that maintains the eating disorder – this system of self-evaluation is often an understandable response to powerful external influences, including internalised weight stigma, exposure to diet culture, and early life experiences that have made eating, body shape, or weight feel especially important.

Internalised weight stigma occurs when individuals absorb weight-biased society's negative attitudes about body size and apply them to themselves, often leading to shame and self-criticism. These issues are explored in greater detail in a newly published guide to evidence-informed group CBT-E (Bailey-Straebl and Sproch, 2025). While widespread, internalised weight stigma is harmful and is likely to play a significant role in the development and maintenance of eating disorders. CBT-E does not correct or criticise patients for holding these beliefs. Instead, it aims to understand how this system of self-evaluation may have developed, for example, as a response to societal pressures, weight-based teasing, or exposure to diet culture, and to support the patient in moving beyond it. Through this process, patients are helped to develop a broader and less shape- and weight-focused basis for self-worth.

This therapeutic exploration typically begins during assessment and formulation and continues throughout Stage 3 when examining the individual's system of self-evaluation and what contributes to its maintenance. In particular, the historical review provides an explicit opportunity for patients to reflect on earlier experiences – such as exposure to diet culture or appearance-related criticism – that may have shaped their concerns about weight, shape, and eating. This helps patients see their eating disorder as an understandable, albeit typically no longer useful, response to their lived experiences. Such framing of their experiences fosters compassion and psychological distance, which are essential for long-term recovery.

CBT-E promotes a body-neutral rather than body-positive approach. The goal is to reduce the centrality of body weight and shape in self-evaluation and to promote acceptance and self-worth through the development of other valued goals.

To achieve a shift in self-evaluation, with a reduced emphasis on body shape and weight, CBT-E uses a three-pronged approach. While these strategies apply to all patients with shape and weight concerns, the third strategy requires particular attention for those living in larger bodies.

1. *Developing other domains of self-worth*: many individuals with eating disorders have limited areas from which they derive self-worth. CBT-E encourages patients to invest in and value themselves through aspects of life other than weight, shape and eating – such as relationships, hobbies, and work. This approach is important for all individuals, including those in larger bodies, who may have, because of societal pressures, put their life ‘on hold’ until ‘I lose the weight’.
2. *Addressing maintaining mechanisms*: CBT-E helps individuals recognise how unhelpful behaviours such as body checking, comparison-making, and body avoidance contribute to maintaining their focus on body shape. This keeps them locked into their eating disorder. Rather than focusing on ‘correcting distortions’, which may well be invalidating for all patients, but particularly for those facing weight stigma, CBT-E encourages individuals to make strategic behavioural changes that lead to different ways of thinking.
3. *Addressing diet-culture, the weight-loss narrative, and weight bias*: diet culture falsely equates thinness and specific body shapes (e.g. muscular) with health, self-control, and superiority, placing undue pressure on all individuals – but especially those in larger bodies. This culture complicates eating disorder recovery and reinforces weight bias. Similarly, the weight-loss narrative refers to the widespread societal belief that losing weight is inherently good and a sign of improved health, further perpetuating harm.
  - a. *Challenging diet-culture and the weight-loss narrative*: patients may have encountered direct or indirect criticism from those who hold the false and harmful belief that anyone can achieve a desired body size with enough determination and willpower. Therapists should provide psychoeducation that body weight is under strong genetic and physiological control, making sure to counter the harmful societal narratives that suggest otherwise. Patients should be encouraged to critically assess so-called ‘health’ and weight-loss advice and trends, and to understand that many of these are financially driven by industries that profit enormously from body dissatisfaction. CBT-E emphasises, and needs to be unequivocal in its message, that bodies naturally vary in size and shape, and that striving for a narrow, unrealistic ideal is both unattainable and harmful. To achieve this goal, it helps patients recognise how unrealistic beauty standards are reinforced through digital manipulation in the media and on social media. We acknowledge that resisting societal and media pressures, particularly through social media, can be especially challenging – especially for younger patients, who may be more vulnerable to these influences and peer expectations. All patients should be supported in being mindful of their online environment, limiting social media use, curating the content they engage with, or in some cases deleting accounts if exposure to harmful messages is difficult to avoid.
  - b. *Separating weight bias and self-worth*: CBT-E therapists should also help patients critically examine how weight bias, stigma, and discrimination have shaped their self-evaluation. Patients are encouraged to recognise that these societal prejudices reflect poorly on those who perpetuate them rather than on them. Recognising that it is common for individuals in larger bodies to have internalised societal weight stigma and to evaluate themselves negatively as a result, CBT-E needs to be especially vigilant in helping patients question this way of thinking. This involves supporting patients in building their personal self-esteem through the development of other valued goals and rejecting the values of diet culture.

It is also our impression, based on anecdotal feedback from patients, that this treatment is helpful for those living in larger bodies. Patients have described the therapeutic benefit of

**Table 1.** Misconceptions and communication gaps with corresponding clarifications

Misconception and communication gap	Clarification
1. CBT-E is rigid and requires strict adherence to a fixed protocol	CBT-E is a flexible, formulation-driven approach that tailors treatment based on the patient's individual maintaining mechanisms
2. CBT-E is simply standard CBT applied to eating disorders	CBT-E is a specialised, transdiagnostic treatment designed specifically for the particular maintaining mechanisms for eating disorders
3. CBT-E only addresses observable behaviours without tackling underlying issues	CBT-E addresses behavioural, cognitive and emotional maintaining mechanisms. It considers the meaning and function of the eating disorder for the individual and recognises the contribution of past experiences
4. CBT-E has limited applicability in real-world clinical settings, where it often fails to achieve positive outcomes	CBT-E is effective in real-world settings and includes strategies to support engagement and motivation. International studies confirm that CBT-E can be successfully implemented across diverse clinical contexts
5. CBT-E is unsuitable for 'complex' patients, particularly those with co-occurring conditions	CBT-E is designed to address maintaining mechanisms of eating disorders, including in individuals with complexity and co-occurring conditions
6. CBT-E is only suitable for out-patients and not applicable to intensive treatment settings	CBT-E has been successfully adapted for in-patient and day-treatment settings, maintaining its core principles while addressing more intensive treatment needs
7. CBT-E is a lengthy and resource-intensive treatment, making it impractical for widespread use	CBT-E is scalable and adaptable, with shorter and longer treatment durations based on patient needs. It can be delivered by a wide range of healthcare professionals
8. CBT-E is designed for adults and is not suitable for treating young people with eating disorders	An adapted version of CBT-E has been developed for adolescents to support their needs, with growing evidence supporting its effectiveness
9. CBT-E is inherently weight-stigmatising, reinforcing negative views about higher weight	CBT-E actively discourages weight stigma and promotes an anti-diet, weight-inclusive approach. It encourages flexible eating and reduces the emphasis on shape, weight, and eating as primary sources of self-evaluation
10. CBT-E is not appropriate for individuals in larger bodies, as it may not address their specific needs	CBT-E is applicable across body sizes and addresses weight stigma directly. It challenges diet culture and explores internalised weight bias and helps patients broaden their system of self-evaluation beyond shape, weight, and eating

discussing the harmful effects of diet culture and of broadening their system of self-worth. They also valued being encouraged to eat more flexibly, particularly as many reported that their prior healthcare experiences had focused narrowly and unhelpfully on weight loss.

Table 1 provides an overview of the ten misconceptions and communication gaps we identified, along with corresponding clarifications.

## Summary and conclusions

Therapists hold beliefs about CBT-E that may, alongside factors such as organisational constraints on implementation, influence their delivery and use of the approach. In the case of CBT-E, misconceptions and communication gaps may lead clinicians to alter, dilute, or avoid key aspects of the treatment, potentially reducing its effectiveness and limiting patient outcomes. Similarly, when patients misunderstand CBT-E, they may struggle with engagement, delaying or limiting their recovery. This paper has explored and clarified common misconceptions and communication gaps surrounding CBT-E, aiming to foster a more accurate and nuanced understanding of the treatment.

### Key practice points

- (1) CBT-E is a flexible, principle-driven treatment that can and should be adapted to individual patient needs while maintaining fidelity to its evidence-based therapeutic procedures.
- (2) The treatment directly addresses common barriers to engagement, including low motivation, through collaborative formulation and discussion, empowering individuals to make informed decisions about change.
- (3) CBT-E can be effectively delivered across diverse clinical settings – including out-patient, day-patient, and in-patient services, and is suitable for adolescents and adults with complex or co-occurring difficulties.
- (4) A weight-inclusive, anti-diet stance should be central to CBT-E. Therapists are encouraged to explore and address internalised weight stigma and diet culture while supporting patients to develop broader systems of self-worth beyond eating, shape and weight.
- (5) Effective implementation of CBT-E is supported by accessible web-based training, tools to support fidelity, and strategies to enhance engagement in routine clinical practice.

### Further reading

**Bailey-Straebl, S., & Sproch, L.** (2025). *Group Cognitive Behavior Therapy for Eating Disorders*. Taylor & Francis.

– *Offers a practical and up-to-date guide to delivering CBT for eating disorders in group settings.*

**Kaidesoja, M., Cooper, Z., & Fordham, B.** (2023). Cognitive behavioral therapy for eating disorders: a map of the systematic review evidence base. *International Journal of Eating Disorders*, 56, 295–313.

– *Offers a comprehensive mapping of the existing systematic review literature on CBT for eating disorders, identifying knowledge gaps and priorities for future research and clinical innovation.*

**Murray, H., Merritt, C., Grey, N., Wild, J., & Clark, D. M.** (2022). Ten common therapist misperceptions about trauma-focused CBT for PTSD. *the Cognitive Behaviour Therapist*, 15, e40.

– *A clear example of how therapist misconceptions can impact practice; this paper served as the original inspiration for the structure and aims of the current article.*

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