The Roots of Craving Change Inc.

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"An important key to progress in combating the obesity epidemic is the extent to which effective interventions can be widely disseminated".
Svetkey et al, 2008, JAMA

Craving Change™ is a structured licensed program developed by a clinical psychologist and registered dietitian that teaches allied health care professionals to incorporate cognitive-behavioral strategies into group and individual practice with patients who struggle with what they eat, when they eat, and how much they eat. The cognitive-behavioural approach used in the program is considered an essential pillar for weight loss and maintenance, and for eating changes for health and disease management. The reality is that few programs have access to adequate psychological expertise to meet the needs of the tremendous proportion of people who struggle with their eating. Craving Change™ is one of the sole programs that teach non-psychologist professionals how to help fill that gap, and is the most widely used cognitive-behavioural program for problematic eating in Canada.

What does "cognitive-behavioural" mean, and why does Craving Change™ use it?

The most prolific and researched psychological interventions for understanding and changing behaviour are rooted in the "cognitive-behavioural" model. This model examines the thoughts and emotions that underlie and directly impact behaviour, and it is the gold standard for interventions in countless health care settings including mental health and disease management. Interventions based on this model have been repeatedly demonstrated as effective in individual and group interventions, and in long and short-term service delivery models.

Historically, behavioural therapies were defined and researched first. Behavioural modification techniques are somewhat action-oriented, including self-monitoring and goal setting, stimulus control, and reward systems. They have been identified in well-established research for decades as significant components of successful weight management programs. Cognitive techniques are more "abstract" in nature, examining patterns of thoughts including beliefs and expectations and exploring their impact on emotions and behaviours. Cognitive interventions include stress management, cognitive restructuring, and thought-stopping. Current practice generally involves a blend of the two approaches, "cognitive-behavioural". Cognitive-behavioural strategies target factors that research has clearly identified as playing a critical role in obesity and weight management and the self-management of chronic disease (Bynre et al, 2004, Ellis et al, 2004, Hollis et al, 2007, Niemeier et al, 2007, O'Rourke et al, 2005, Stahre, 2005).

Not surprisingly, recommendations for the incorporation of this model into clinical interventions have been observed across several medical conditions, across several countries. For instance, diabetes (the Canadian Diabetes Association Clinical Practice Guidelines for Diabetes Prevention and Management, 2008), obesity (CMAJ Canadian clinical practice guidelines on the management and prevention of obesity in adults and children, 2006, Australian Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, 2004, and Cochrane database Systemic Review, Shaw et al, 2005), depression and coronary heart disease (American Heart Association, 2008), hypertension and ICD recipients (Canadian Association of Cardiac Rehabilitation and Cardiovascular Disease Prevention, 3rd Edition), and insomnia (Silversten et al, 2006).

What's the difference between cognitive-behavioural *therapy* (CBT) and a cognitive-behavioural *approach*?

Depth. Cognitive-behavioural *therapy* requires specialized psychotherapy training for most non-psychologist professionals. That is, professions such as social work and clinical nutrition must meet specialized training and experience criteria set by their provincial colleges to incorporate psychotherapy into their practice (Ontario College of Social Work, 2008, Alberta College of Dietitians, 2011).

However, numerous professions currently use a cognitive-behavioural *approach* and strategies in their practice. This involves drawing on cognitive-behavioural theory and techniques for education and general interventions, and is now applied in a variety of allied health care professions including occupational therapy and physiotherapy (Donaghy et al, 2008), nursing (Freeman, 2004), and pharmacy (Ahmad et al 2010).

What is stepped care?

Stepped care is a model of service delivery first articulated in the disordered eating literature that attempts to address the significant chasm between demand for professional services and supply of specialized professionals. In the area of problematic eating, demand for services far outstrips supply (Loeb et al, 2000). Stepped care argues that a general intervention offered by non-specialists will help a significant number of people. Those requiring further services afterwards can be referred on for more specialized care. In other words, "start with the simplest, least intrusive and least costly treatment" (Wilson et al, 2000). Craving Change™ is stepped care in action.

A 2012 randomized controlled study published in JAMA demonstrated that a stepped-care intervention produced clinically meaningful weight loss over 18 months at less cost than a standard behavioural weight loss intervention (Jakicic et al, 2012).

Are manualized programs popular? Are they appropriate in health care?

Yes, other highly credible programs have led this charge. For instance, the Stanford Chronic Disease Self-Management Program (CDSMP) is a manualized program that has achieved worldwide recognition and implementation, with clearly beneficial outcomes over two decades of research. The goal of the CDSMP is to improve the physical and emotional health of patients while reducing health care costs.

The Changeways program based out of Vancouver has been offering manualized materials for professionals and clients for evidence-based mental health interventions since 1993. The program has been offered extensively across Canada and internationally. The group program for depression management is now the most widely used group protocol for depression in Canada.

What is the current status of research on the Craving Change™ program?

As reviewed the curriculum, format, and theoretical basis of Craving Change™ is based on decades of research.

The co-founders of Craving Change Inc, Dr. C. Cannon, R.Psych and W. Shah, RD, partnered with faculty at the University of Calgary to undertake one of the few published studies to examine a manualized cognitive-behavioural group intervention for subclinical disordered eating. The research demonstrated positive outcomes in cardiac rehabilitation, hypertension, high cholesterol and diabetes patients. Specifically, the program resulted in a decrease in disordered eating behaviours, increased eating self-efficacy, and lower shame and guilt (von Ranson, Stevenson, Cannon & Shah, 2010). Self-efficacy is one of the strongest known predictors of health behaviour change.

Several sites across Canada are collecting outcomes in their settings. Due to their commercial interest in Craving Change™, the co-founders are not involved in this process to avoid a perception of bias. To date, three organizations across Canada in a Primary Care Network and Family Health Teams have shared their data with Cannon & Shah. Data from all three reported high levels of patient engagement (high attendance, low attrition, and high satisfaction). Two of the sites have provided quantitative analyses on the Eating Self-Efficacy Scale results showing significant improvement after attending a workshop. These gains are maintained at follow-up (one site measured follow up at 3 months, the other at 6 months). Please go to the “Research” page at www.cravingchange.ca for a summary of these results.

As of April 2016, the Association of Family Health Teams in Ontario (AFHTO) is in the process of launching a multi-site study of Craving Change™ eating self-efficacy outcomes across dozens of clinics across the province.

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