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Cognitive-Behavioral Therapy for Bulimia Nervosa and Atypical Bulimic Nervosa: Effectiveness in Clinical Settings

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ABSTRACT

Objective: The efficacy of cognitive-behavioral therapy (CBT) for bulimic disorders has been established in research trials. This study examined whether that efficacy can be translated into effectiveness in routine clinical practice.

Method: Seventy-eight adult women with bulimic disorders (bulimia nervosa and atypical bulimia nervosa) undertook individual CBT, with few exclusion criteria and a treatment protocol based on evidence-based approaches, utilizing individualized formulations. Patients completed measures of eating behaviors, eating attitudes, and depression pre- and post-treatment. Eight patients dropped out. The mean number of sessions attended was 19.2.

Results: No pretreatment features predicted drop-out. Treatment outcome was similar whether using treatment com-

pler or intent to treat analyses. Approximately 50% of patients were in remission by the end of treatment. There were significant improvements in mood, eating attitudes, and eating behaviors. Reductions in bingeing and vomiting were comparable to efficacy trials.

Discussion: The improvements in this "real-world" trial of CBT for adults with bulimic disorders mirrored those from large, funded research trials, though the conclusions that can be reached are inevitably limited by the nature of the trial (e.g., lack of control group and therapy validation). © 2013 Wiley Periodicals, Inc.

Keywords: bulimia nervosa; atypical bulimic disorders; cognitive-behavioral therapy; effectiveness

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Introduction

There is substantial evidence that cognitive-behavioral therapy (CBT) is efficacious in the treatment of adult women with bulimia nervosa and atypical bulimic disorders.^{1–7} However, that evi-

dence has come from funded research studies. Such findings are not necessarily generalizable to the wider range of clinical settings, due to factors such as the exclusion of comorbidity or atypical cases, treatment being delivered under highly stringent conditions, and the need to adhere strictly to protocols. Thus, such evidence of efficacy in the research environment needs to be translated into evidence of effectiveness in less specialized clinical practice, in order to avoid clinicians ignoring the evidence as being irrelevant to their client group.⁸ This attitude might explain the common omission of core techniques when delivering CBT for adults with eating disorders⁹ and the fact that only a minority of clinicians report using manuals when working with bulimia nervosa.¹⁰ There is evidence for the clinical applicability of research-based CBT for anxiety and depression.^{11,12} However, that is not the case in the eating disorders. Therefore, this study considered whether the efficacy of CBT for bulimic disorders (as shown by existing research trials) can be translated into clinical effectiveness in routine clinical settings, where none of the exclusion- and protocol-based constraints outlined above apply.

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Method

Participants

All patients were treated in a publically-funded outpatient eating disorder service in the UK. The only exclusion criteria were psychosis, learning difficulties, or an inability to work in English. The participants in the trial were a case series of those patients with bulimic disorders who opted to undertake CBT when assessed and when treatment options were discussed. A small number of patients opted to undertake a psychodynamic therapy, while another group attended for assessment but declined or failed to attend for treatment. However, the numbers in these groups were not recorded. Therefore, this is a study of those who opted to begin CBT, rather than all who attended the clinic or who had bulimic disorders. None were excluded from the trial due to missing data (see below).

The sample entering treatment were 78 adult women with bulimic disorders: 55 with bulimia nervosa (52 purging subtype; three nonpurging subtype) and 23 with EDNOS involving bulimic behaviors (nine with subthreshold bulimia nervosa, involving bingeing and purging at least once per week over three months; 10 with binge eating disorder; and four with purging in the absence of bingeing). None were in the anorexic weight range. All were assessed using a semistructured interview protocol,¹³ and diagnosed using DSM-IV criteria.¹⁴ The mean age of the sample at assessment was 27.8 years (SD = 7.11) and their mean body mass index (BMI) was 22.1 (SD = 3.26).

A minority of the bulimic sample ($N = 9$) were receiving SSRI antidepressants (stabilized prior to treatment and maintained throughout the treatment period) and a small number had occasional dietetic reviews, but none were receiving any other form of treatment in parallel with CBT. A high proportion had some comorbidity (major depressive disorder: 44% of cases; obsessive-compulsive disorder: 26%; other anxiety disorders: 32%; and substance misuse: 23%). The levels for anxiety and depressive disorders are higher than in some efficacy studies,³ but comparable for substance misuse.

Measures

Height and weight were measured objectively. Diaries were used to assess frequency of bingeing and vomiting. The women also completed measures of eating pathology and depression at the beginning and end of treatment.

Eating Disorders Inventory. The EDI¹⁵ is a self-report measure of eating and related attitudes. Scores are responsive to changes over treatment. Scores on the eating-related scales (Drive for thinness; Bulimia; Body

dissatisfaction) were summed to provide an overall score reflecting eating attitudes.

Beck Depression Inventory. The BDI¹⁶ is a self-report measure of depressive symptoms, with good psychometric properties.

Treatment. This version of CBT¹³ is based on techniques employed in evidence-based approaches to bulimia nervosa (I,2,4). In keeping with those approaches, this programme includes: individualized formulation, taking into account different maintaining factors across cases (e.g., nutritional and/or emotional drivers for binging); agenda setting; homework; change in diet (particularly to improve carbohydrate intake); diary-keeping; exposure; behavioral experiments; cognitive restructuring; and surveys. Comorbidity was usually addressed once the core eating disorder symptoms were substantially reduced, unless there was evidence that the patient was not changing eating behaviors in the early part of CBT.

The clinicians were all clinical psychologists with at least four years of experience in delivering CBT for eating disorders, and were supervised routinely on these cases (individually and in groups). The usual assumption was that there would be around 20 one-hour CBT sessions. However, this was reduced if the patient improved rapidly, and was increased if the patient had substantial comorbidity (such increases were reviewed by the team after each additional set of 10 sessions). Whatever the duration, behavioral change was maintained as a focus, along with changes in mood and cognitions. The mean number of sessions delivered per patient was 19.2 (SD = 12.4; range = 7–80). Three follow-up sessions were offered in addition.

Patients were regarded as in remission if they no longer had a diagnosis of any eating disorder by the end of treatment (including being free of bulimic behaviors for at least a month prior to the last session, and not having pathological concerns about eating, weight, and shape). This latter criterion was established through clinical review. Drop-out was defined as the patient ending treatment before the agreed termination point (defined by patient and clinician), whether early or late in treatment.

Data Analysis

Binary logistic regression was used to identify any pre-treatment factors that predicted drop-out.¹⁷ Change was measured in three ways—as the proportion of patients ceasing individual and all bulimic behaviors (objective binge-eating, vomiting, and laxative abuse) by the end of treatment; as the proportion of patients who changed or no longer met diagnostic criteria at the end of treatment (remission); and as the dimensional differences in frequencies of behaviors, BMI level, eating attitudes, and depression. As the data were not sufficiently normal, changes in symptom levels were tested using Wilcoxon

tests. This final analysis is done as both a treatment completer analysis and an intent-to-treat analysis (carrying forward the most recent data to substitute for missing data where a patient dropped out). At the end of treatment, there were nine missing EDI scores and 12 missing BDI scores. These were treated as absent for the completer analysis.

Results

Predictors of Attrition

Eight of the 78 patients dropped out over the course of treatment. This rate is similar to that reported in protocol-driven research studies.^{3,4,18} Binary logistic regression was used to determine whether drop-out was related to pretreatment age, BMI, frequency of bingeing or vomiting, EDI scores, or BDI scores. The overall model was not significant ($X^2 = 11.5$, df = 6, $p = 0.075$), and no individual variable approached significance ($p > 0.16$ in all cases). Therefore, no identified pretreatment variables predicted attrition from CBT.

Cessation of Bulimic Behaviors Following CBT

Among the completer group, 66 engaged in objective binging at the beginning of treatment, and 28 at the end of treatment (abstinent = 58%), 51 engaged in vomiting at the beginning and 25 at the end (abstinent = 51%), and 17 engaged in laxative abuse at the beginning and three at the end (abstinent = 82%). 56% were free of all binging and purging behaviors by the end of treatment (all patients had at least one of these behaviors at the start of treatment). These reductions are comparable with those reported across treatment in clinical trials.³

Change in Diagnosis Following CBT

Table 1 shows shifts in diagnoses from beginning to end of CBT. Overall, 37 (52.9%) of the 70 patients who reached the end of treatment were diagnosis-free by that point (no bulimic behaviors, alongside

normalized eating attitudes). Assuming no such changes among the eight patients who had dropped out, this represents 47.4% of the 78 patients who started CBT. This remission rate is similar to that found in comparable research.²⁻⁴

Diagnostic group at the outset of treatment was not broadly predictive of change in diagnosis. However, those with purging disorder showed a mixture of positive and negative outcomes, suggesting that this form of CBT is more suitable for those who binge-eat.

Dimensional Change in Symptoms Following CBT

Table 2 shows changes across therapy in body mass index, frequencies of bulimic behaviors, eating attitudes, and depression. This is done separately for treatment completers ($N = 70$) and as an intent to treat analysis ($N = 78$). Regardless of the form of analysis, there were significant changes on all of these measures, with a small increase in BMI and larger reductions in objective binges, vomiting, eating attitudes, and depressed mood. The effect sizes ($tau = Z/\sqrt{[N]}$) for these changes varied between medium and large in both sets of analyses. The frequency of objective bingeing fell by 59% in the treatment completer analysis (intent to treat: 64%), and vomiting levels fell by 72% (intent to treat: 65%). These findings are similar to levels of change reported.⁷

Discussion

Research trials have demonstrated the efficacy of CBT for bulimic disorders. However, clinicians commonly regard such findings as irrelevant to their practice.⁸ Therefore, this study tested whether those findings can be translated into evidence of effectiveness in healthcare settings where there are few exclusion criteria and where the implementation of the therapy is less intensively scrutinized. It

TABLE 1. Diagnostic outcomes at end of treatment, among those completing CBT ($N = 70$)

Diagnostic Group at Beginning of Treatment	Diagnostic Group at End of Treatment					
	No Eating Disorder	Purging Subtype	Nonpurging Subtype	Atypical Bulimia Nervosa	Binge Eating Disorder	Purging Disorder
Bulimia nervosa						
Purging subtype ($N = 46$)	22 (47.8%)	22 (47.8%)	0	2 (4.3%)	0	0
Nonpurging subtype ($N = 1$)	1 (100%)	0	0	0	0	0
EDNOS						
Atypical bulimia nervosa ($N = 9$)	5 (55.6%)	0	0	4 (44.4%)	0	0
Binge eating disorder ($N = 10$)	8 (80.0%)	0	0	0	2 (20.0%)	0
Purging disorder ($N = 4$)	1 (25.0%)	0	1 (25.0%)	1 (25.0%)	0	1 (25.0%)

TABLE 2. Symptom change across treatment among those completing CBT (N = 70) and using intent-to-treat analysis (N = 78)

Type of Analysis	Treatment Completers								Intent-to-Treat							
	Beginning of Treatment		End of Treatment		Wilcoxon Test		Effect Size Tau	Beginning of Treatment		End of Treatment		Wilcoxon Test		Effect Size Tau		
Point in Treatment	Mean	SD	Mean	SD	Z	P		Mean	SD	Mean	SD	Z	P		Mean	SD
Symptom*																
Body mass index	22.8	(3.58)	23.3	(3.80)	2.98	.003	0.36	22.1	(3.26)	22.8	(3.67)	3.61	.001	0.41		
Objective binges per week	4.45	(6.51)	1.84	(5.07)	3.25	.001	0.39	5.51	(9.65)	1.98	(4.86)	4.93	.001	0.56		
Vomiting per week	5.31	(7.96)	1.49	(3.28)	2.93	.003	0.35	6.88	(10.1)	2.41	(5.29)	2.83	.005	0.32		
Eating disorders inventory	46.0	(15.4)	26.3	(21.0)	2.39	.02	0.29	37.6	(21.8)	24.1	(22.5)	2.58	.01	0.29		
Beck depression inventory	22.7	(9.95)	12.2	(11.0)	4.78	.001	0.57	21.9	(9.46)	12.1	(10.5)	4.59	.001	0.52		

*No missing data for body mass index, objective binges, or vomiting episodes, and no missing start of treatment data for other variables. Missing data for eating disorders Inventory and Beck depression inventory mean that completer N = 61 and 58, respectively.

also included atypical bulimic cases. The findings were broadly comparable to those found in research trials—the drop-out rate was low (10.3%), the remission rate was ~50%, and there were substantial reductions in levels of pathological eating attitudes and depression. In short, these findings demonstrate that this form of CBT for bulimia nervosa¹³ is effective in treating the eating disorders in “real-life” clinical settings. However, it is important to note that these results were achieved by clinicians within a specialist eating disorder clinic, who had relatively high levels of training, experience, and supervision. Its effectiveness in other settings or as delivered by less experienced clinicians remains to be demonstrated. It is also necessary to note that this was an uncontrolled trial, with no validation checks (beyond routine supervision) to confirm that the therapy delivered actually was CBT. While these features are inevitable consequences of delivering treatments in real life settings, they limit the strength of any conclusions that can be reached regarding the effectiveness of CBT.

Several forms of CBT for adults with eating disorders have been shown to be efficacious to a comparable degree in research settings.^{1–4} Each shares themes with the form used here—particularly the foci on individualized formulation, exposure, behavioral change, recording, and cognitive restructuring. Therefore, these findings suggest that other evidence-based forms of CBT for the bulimic disorders might have similar levels of effectiveness in purely clinical settings, although the lack of a control group in studies of this sort makes it impossible to conclude definitively that it is elements of CBT that are responsible for the positive outcomes seen. Clinicians could be encouraged to use existing manualized forms of CBT for bulimia nervosa more than they currently do,^{9,10} on the grounds that these relatively structured forms of treatment for the eating

disorders can be as effective in everyday clinical settings as they are efficacious in research settings. Further work is needed to determine whether these effects are maintained in the long term, as they are in research trials. Such research would also benefit from a wider range of measures of eating pathology (e.g., body image, other purging behaviors), as the measures used here were relatively crude, and might have omitted key indices of change. It should also consider the potential role of factors such as duration of disorder, previous treatment experiences, and socio-economic status, to allow for comparison with existing and future clinical trials. Finally, it will be important to determine whether the efficacies of other therapies for bulimic disorders (e.g., interpersonal psychotherapy; dialectical behavior therapy) are matched by their effectiveness.

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