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Outcome of group cognitive-behavior therapy for bulimia nervosa: the role of core beliefs

Newman Leung[a,b,*], Glenn Waller[c], Glyn Thomas[b]

[a]*Eating Disorders Service, Queen Elizabeth Psychiatric Hospital, Mindelsohn Way, Edgbaston, Birmingham B15 2QZ, UK*

[b]*School of Psychology, University of Birmingham, Birmingham, UK*

[c]*Department of Psychology, University of Southampton, Southampton, UK*

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Abstract

It is hypothesized that individuals who benefit less from CBT will be those who have more pathological core beliefs (unconditional beliefs, unrelated to food, shape and weight). Twenty bulimic women were treated using 12 sessions of conventional group CBT. Eating behavior and attitudes were assessed pre- and posttreatment. Core beliefs were assessed at the beginning of the programme, and were used as predictors of change across treatment (once any effect of pretreatment psychopathology was taken into account). Group CBT was effective, with reductions of over 50% in bulimic symptoms. Outcome on most indices was associated with pretreatment levels of pathological core beliefs. Possible reasons for these findings are discussed.

Keywords: Bulimia nervosa; Cognitive-behavioral therapy; Core beliefs

1. Introduction

Cognitive behavioral therapy (CBT) is generally considered to be the treatment of choice for bulimia nervosa (e.g. Fairburn, 1988; Craighead & Agras, 1991; Wilson & Fairburn, 1993). For example, in a survey of clinicians, Herzog, Keller, Strober, Yeh and Pai (1992) found that 85–94% of respondents indicated that they would consider using cognitive behavioral therapy alone or in conjunction with other approaches in the treatment of bulimia nervosa. This strong

* Corresponding author.

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preference of clinicians is supported by empirical findings, which indicate a high efficacy for CBT. In a review of its effectiveness, Vitousek (1996) concluded that individual CBT typically produces an 80% reduction of bingeing and purging symptoms, and a total elimination of bulimic episodes in 50% of treated clients. In addition to its use in individual treatment, CBT has been used in group settings. Group CBT has been demonstrated to be highly cost-effective (e.g. Garner, 1987; Mitchell et al., 1990; Agras et al., 1992; Fettes & Peters, 1992), although the degree of reduction in bulimic symptomatology may be more modest than with individual treatment (Freeman, 1995).

Despite these suggestions that CBT should be considered as the treatment of choice for bulimia nervosa, there is a substantial amount of evidence in the literature that calls such claims into question. First, there is comparatively little evidence that CBT in its existing form is better than other therapies (rather than simply effective in its own right). Meta-analytic studies have consistently shown that the overall effects of different psychotherapeutic approaches to bulimia nervosa (including individual and group CBT) are very similar (e.g. Fettes & Peters, 1992; Hartmann, Herzog & Drinkmann, 1992). Few studies directly compare outcomes across psychotherapies. However, in the most rigorous of such studies, Fairburn et al. (1995) have shown that interpersonal therapy is at least as effective as CBT at long-term follow-up. Similarly, Cooper, Cooper and Hill (1989) conclude that adding a cognitive component to a behavioral intervention programme for bulimic individuals does not substantially improve outcome. The second reason for doubting the claim that CBT (as currently practiced) should be considered as the universal first line of treatment is that it is known to have limited success with particular groups of bulimics, particularly those with comorbid borderline personality disorder (e.g. Johnson, Tobin & Dennis, 1990; Sansone & Fine, 1992). This limitation is an important one, given the high incidence of borderline personality disorder amongst bulimics (e.g. Skodol et al., 1993; Braun, Sunday & Halmi, 1994; Wonderlich, 1995; Carroll, Touyz & Beumont, 1996).

The failure of CBT in some instances might be explained by its cognitive focus. The essence of existing cognitive behavioral models (e.g. Fairburn & Cooper, 1989; Vitousek, 1996; Cooper, 1997; Fairburn, 1997) is that bulimic symptoms are precipitated and maintained by a set of maladaptive thinking patterns (negative automatic thoughts and dysfunctional assumptions) regarding body weight, size and shape. Within this model, the individual typically overvalues slimness, usually as a means of restoring self-esteem. However, there is evidence to suggest the presence of a broader, more general dysfunctional thinking style in bulimics, rather than just maladaptive beliefs regarding food, weight and shape (e.g. Phillips, Tiggemann & Wade, 1997). Apart from their content, the key element of these other cognitions is that they can be seen as unconditional, reflecting core beliefs rather than negative automatic thoughts or dysfunctional assumptions. Relevant patterns of core belief include: insufficient self-control (e.g. Newton, Freeman & Munro, 1993), vulnerability to threat and harm (Root & Fallon, 1989; Waller & Ruddock, 1995; McManus, Waller & Chadwick, 1996) and shame (Andrews, 1997).

Such core beliefs, along with others, have been considered by Young (1994) in his work with individuals with personality disorders. Young's schema-focused model was developed to explore this deepest level of cognitive representation (which he terms 'early maladaptive schemas'), as it was recognized that people with personality or characterological problems might not benefit from conventional cognitive therapy, with its focus on primary and