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Does individualization matter? A randomized trial of standardized (focused) versus individualized (broad) cognitive behavior therapy for bulimia nervosa

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Abstract

Does higher level of individualization increase treatment efficacy? Fifty patients with bulimia nervosa were randomized into either manual-based (focused) or more individualized (broader) cognitive behavioral therapy guided by logical functional analysis. Eating disorders Examination and a series of self-report questionnaires were used for assessment at pre-, and post-treatment as well as at follow-up. Both conditions improved significantly at post-treatment, and the results were maintained at the 6 months follow-up. There were no statistically and clinically significant differences between the two conditions at post-treatment with the exception of abstinence from objective bulimic episodes, eating concerns, and body shape dissatisfaction, all favoring the individualized, broader condition. Both groups improved concerning self-esteem, perceived social support from friends, and depression. The improvements were maintained at follow-up. Ten patients (20%) did not respond to the treatment. Notably, a majority of non-responders (80%) were in the manual-based condition. Non-responders showed extreme dominance of rule-governed behavior, and lack of contact with actual contingencies compared to responders. The study provided preliminary support for the superiority of higher level of individualization (i.e. broader CBT) in terms of the response to treatment, and relapses. However, the magnitude of effects was moderate, and independent replications, with blind assessment procedures, and a larger sample sized are needed before more clear cut conclusions can be drawn. © 2005 Elsevier Ltd. All rights reserved.

Keywords: Bulimia; Treatment outcome; Efficacy; Eating disorders

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Introduction

Fairburn's early formulation of a cognitive behavioral approach (Fairburn, 1981) for bulimia nervosa (BN) set the standard for the treatment of BN and binge eating disorder. Cognitive behavior therapy (CBT) for BN is a structured and manual-based treatment that has expanded and evolved (e.g. Fairburn, 1985; Fairburn, Marcus, & Wilson, 1993; Wilson, Fairburn, & Agras, 1997) as a result of further experience and empirical findings from efficacy and effectiveness studies (e.g. Agras et al., 1992; Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Carter & Fairburn, 1998; Fairburn et al., 1991; Treasure et al., 1996; Wilfley et al., 1993; Wilson, Eldredge, Smith, & Niles, 1991; Wilson, Vitousek, & Loeb, 2000).

As a result of accumulated research, CBT is now suggested to be the treatment of choice for BN (e.g. American Psychiatric Association Work Group on Eating Disorders Washington, 2000; Dingemans, Bruna, & van-Furth, 2002; Mizes & Bonifazi, 2000; National Institute for Clinical Excellence, 2004; Wilson & Fairburn, 2002).

Reviews of the CBT outcome literature show an approximate 40%–55% recovery rate (remission) (Anderson & Maloney, 2001; Wilson, 1996b), with broad and durable effects (Wilson, 1996b). However, it is also known that no more than roughly 50% of patients recover after receiving CBT, although some of those who do not cease binge eating and purging show partial improvement. CBT is insufficiently helpful for a significant proportion of patients. Thus, the present study investigated an important question in this context: “would a larger number of patients benefit from CBT if the treatment is more individualized (broader) than what is usually done when using the standardized CBT (i.e. focused on the specific psychopathology of BN)?”

Debate has ensued regarding the use of manual-based treatments versus the individualized approach typically found in practice (Kendall, Holmbeck, & Verduom, 2004). Many good arguments have been presented in favor of using manuals. Manual-based treatments are often empirically supported, more focused, and more disseminable (Wilson, 1996a). Critics of manual-based treatments suggest that the use of manuals preclude idiographic case formulation, and undermine therapists' clinical artistry. However, no clear-cut empirical evidence supports the superiority of individualized treatment. As an example, a sophisticated study comparing manual-based treatment, individualized treatment, and yoked control condition (in which each patient receives the therapy individualized for another patient in the individualized condition) showed that the standardized manual-based treatment was superior to the other two treatments (Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992). Similar findings has been reported in other studies (e.g. Emmelkamp, Bouman, & Blaauw, 1994). On the other hand, there are also studies showing superiority of individualized treatment to standardized interventions (e.g. Jacobson, Schmalings, Holtzworth-Munroe, Wood, & Follette, 1989). After summarizing empirical findings, and pointing to the limitations of individual case formulation, Wilson (1996a) argues that standardized treatment is no less effective than individualized therapy. When the first line manual-based treatment fails, the therapist should use other empirically supported treatments, and if they don't work or are not available, then the therapist should resort to the problem solving (hypothesis testing) approach that characterizes CBT (Wilson, 1996b). However, more concrete ways of following such an approach are needed, and there are no empirical studies comparing the efficacy of manual-based CBT compared to a more individualized CBT for BN (i.e. focused vs broader CBT). Behaviorally trained therapist use functional analysis as a way of identifying the

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