

Attrition and outcome in self-help treatment for bulimia nervosa and binge eating disorder: A constructive replication

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Abstract

The aim of the study was to assess the efficacy of a 12-week CBT-based pure and guided self-help among 29 patients with full and subthreshold bulimia nervosa, and binge eating disorder. In the intention-to-treat analyses, self-help had a moderately positive and sustained effect on the patients' eating problems. The patients reduced their mean number of objective bulimic episodes and purging behavior by 26% and 22% over the course of treatment. The corresponding reduction levels for the treatment completers ($n=21$) were 41% and 34%, respectively. As in the previous study, there were no significant differences between the pure and guided self-help mode in terms of outcome, and the results were sustained 6 months after the end of the treatment. The findings are discussed in relation to the shorter duration of the self-help, the lower rate of attrition, and the characteristics of the sample compared to the earlier trial.

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1. Introduction

Although Cognitive behavior therapy (CBT) is considered to be the first line treatment of choice for bulimia nervosa (BN) (e.g. Wilson, 1996), skilled therapists with CBT competence are in short supply.

The published randomized studies investigating CBT-based self-help for BN and binge eating disorders (BED) (e.g. Bailer et al., 2004; Carter & Fairburn, 1998; Carter et al., 2003; Cooper, Coker & Fleming, 1994; Durand & King, 2003; Ghaderi & Scott, 2003; Hsu et al., 2001; Loeb, Wilson, Gilbert & Labouvie, 2000; Mitchell et al., 2001; Palmer, Birchall, McGrain & Sullivan, 2002; Peterson et al., 1998; Treasure et al., 1994) with a program duration (pre- to post-assessment) between 8 and 24 weeks (Mean=14.7, Median=16, Mode=16, based on the studies cited above) suggest self-help to be a viable first step in the treatment of BN. Taken together, these studies show that self-help may not only contribute to improvements in the targeted problems in question, but also related psychopathology and the overall level of functioning. Although several studies (e.g. Carter & Fairburn, 1998) show the guided self-help to be superior to pure self-help (no guidance from a professional), some studies show no significant differences between the two modes of delivery of self-help (e.g. Ghaderi & Scott, 2003). Self-help has been shown to be as

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effective as group CBT or Fluoxetine (e.g. Mitchell et al., 2001; Treasure et al., 1996), although in one study (Bailer et al., 2004) self-help showed a slightly better effect among the completers, at follow-up, compared to group CBT. In stepped care models of treatment of eating disorders, it has been shown (Palmer et al., 2002) that patients initially offered guided self-help have a lower long-term drop-out rate. Although self-help is becoming incorporated in treatment guidelines (e.g. National Collaborating Centre for Mental Health, 2004) as a first step, its efficacy and effectiveness is hampered by failure to engage in treatment (pre-treatment drop-out) and attrition. It has been shown that the length of time patients had waited between being referred to a service and the appointment date, to some degree explains pre-treatment drop-out (Bell & Newns, 2004). Less is known about attrition after the start of the self-help treatment. The principal aims of the present study, which is a constructive replication (Lykken, 1968) of a previous trial (Ghaderi & Scott, 2003), were to 1) investigate the efficacy of self-help in a 12-week program compared to the previous 16-week trial, and 2) to investigate the level of drop-out/attrition after shortening both the waiting time before receiving self-help, and the treatment period.

Would a shortening of the waiting and the treatment period contribute to enhanced focus in terms of a larger portion working through all the modules in the program compared to when the participants are reassessed after 16 weeks? Would a higher number of the participants relapse after a 12-week self-help program compared to 16 weeks? It was hypothesized that a shortening of the time waiting to receive active treatment, and a shortening of the treatment period itself, might decrease the drop-out and attrition, and not negatively affect the rate of relapse compared to the earlier trial.

2. Method

2.1. Participants and drop-out

Participants were recruited by advertising in a local, and a regional newspaper (to increase generalizability), and by referrals from local practitioners. The principal requirement for participation was to meet the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for BN, BED or eating disorders not otherwise specified (EDNOS) characterized by binge eating. Exclusion criteria were age below 18, previous CBT treatment for eating disorders (ED), current alcohol or drug dependence, pregnancy, severe problems with reading and writing, concurrent treatment for ED, risk for suicide attempts, use of psychotropic medication, and a body mass index (BMI) below 18. Fifty-nine individuals contacted the department after reading the ad, and 4 were referred by professionals. Of those, 32 were excluded due to following reasons: concomitant psychotherapy ($n=4$), not accepting randomization ($n=1$), previous CBT in group for ED ($n=3$), not fulfilling diagnostic criteria for BN, BED or EDNOS of bingeing type ($n=9$), BMI <18 ($n=6$), using psychotropic medication ($n=6$), transportation difficulties ($n=1$), severe repetitive self-injurious behavior ($n=1$), and recurrent suicide attempts ($n=1$). Of the remaining 31 potential participants (all females) 2 did not return the screening questionnaires. In total, 29 were eligible and were randomized by means of an online research randomizer, and enrolled in the study. Randomization resulted in 16 participants be assigned to the guided self-help (GSH) condition and 13 to the pure self-help (PSH) condition. In the GSH, participants dropped out of the program. Two of them were offered psychotherapy elsewhere, short after enrollment in the self-help program. Another participant dropped out after four weeks because she felt markedly improved. The fourth participant worked through the major part of the program, but had to discontinue, because of increased somatic pain that demanded intensive somatic day care. The last two presented no reasons for dropping out, two weeks after the start of the treatment. In the PSH condition, all the participants seemed to be engaged in the treatment, but by the 12th week, when they were invited for post-treatment interview, two of them declined and explained that they had not been working with the program seriously, although they had filled in and returned several symptom checklists.

The total drop-out rate was then 27.6% ($n=8$). Twenty-one completed the treatment, filled in the questionnaires, and attended the post-treatment interview. At follow-up, 19 participants answered to the questionnaires (total drop-out at follow-up=34.5%).

2.2. Instruments

Key behavioral aspects of eating disorders and frequency ratings for their occurrence were measured by means of the *Eating Disorders Examination (EDE: version 12.0D)* (Fairburn & Cooper, 1993), which is a semi-structured

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