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Evaluation of a healthy-weight treatment program for bulimia nervosa: A preliminary randomized trial

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Abstract

Objective: Conduct a randomized treatment trial to test whether healthy dieting maintains bulimic symptoms or effectively reduces this eating disturbance.

Methods: Female participants ($n = 85$) with full- and sub-threshold bulimia nervosa were randomly assigned to a 6-session healthy dieting intervention or waitlist condition and assessed through 3-month follow-up.

Results: Relative to control participants, intervention participants showed modest weight loss during treatment and demonstrated significant improvements in bulimic symptoms that persisted through follow-up.

Discussion: These preliminary results suggest that this intervention shows potential for the treatment of bulimia nervosa and may be worthy of future refinement and evaluation. Results also provide experimental evidence that dieting behaviors do not maintain bulimia nervosa, suggesting the need to reconsider maintenance models for this eating disorder.
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Keywords: Bulimia; Dieting; Maintenance; Treatment

Introduction

Bulimia nervosa is characterized by a chronic course, medical complications, and functional impairment, and increases risk for future onset of obesity, depression, suicide attempts, anxiety disorders, substance abuse, and health problems (Johnson, Cohen, Kasen, & Brook, 2002; Stice, Cameron, Killen, Hayward, & Taylor, 1999; Wilson, Becker, & Heffernan, 2003). Thus, much effort has been devoted to identifying risk and maintenance factors for this pernicious disorder.

Theorists have suggested that dieting increases risk for the onset and maintenance of bulimia nervosa (Fairburn, 1997; Hawkins & Clement, 1984; Polivy & Herman, 1985; Stice & Agras, 1998). Dieting has been defined as intentional and sustained restriction of food intake for the purposes of weight loss or weight maintenance (Herman & Polivy, 1975; Laessle, Tuschl, Kotthaus, & Pirke, 1989; Wadden, Brownell, & Foster, 2002). According to Polivy and Herman (1985), ‘‘Successful dieting produces weight loss, which in turn might

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create a state of chronic hunger, especially if such weight loss leaves the dieter at a weight below the set-point weight that is defended physiologically'' (p. 196). The chronic hunger experienced by dieters putatively increases the likelihood of binge eating. Polivy and Herman (1985) also argue that a reliance on cognitive controls over eating leaves dieters vulnerable to uncontrolled eating when these cognitive processes are disrupted. Binge eating putatively precipitates redoubled dietary efforts and use of radical weight-control techniques, such as vomiting, which develop into the self-maintaining binge–purge cycle (Fairburn, 1997). In support, longitudinal studies have found that self-reported dieting is a potent predictor of future onset of bulimic symptoms and full- and sub-threshold bulimia nervosa (Field, Camargo, Taylor, Berkey, & Colditz, 1999; Killen et al., 1994, 1996; Stice, 2001; Stice & Agras, 1998; Stice, Presnell, & Spangler, 2002). Elevated self-reported dieting also predicted maintenance of bulimic symptoms in one study (Stice & Agras, 1998), but this effect did not replicate in a second study (Fairburn et al., 2003).

Based on this theory, the treatment of choice for bulimia nervosa, cognitive-behavioral therapy (CBT), aims primarily to reduce dieting (Fairburn, Marcus, & Wilson, 1993). However, the evidence that interventions that do not focus on reducing dieting also decrease bulimic symptoms relative to assessment-only control conditions, including interpersonal therapy, dialectical-behavior therapy, and exercise-based interventions (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993; Safer, Telch, & Agras, 2001; Sundgot-Borgen, Rosenvinge, Bahr, & Schneider, 2002), seems incompatible with the assertion that dieting is the primary factor that maintains bulimia nervosa. In addition, randomized trials have found that assignment to low-calorie weight loss diets (e.g., 1200 calories a day) results in significantly greater decreases in binge eating and bulimic symptoms for normal weight, overweight, and obese adolescent and adult women relative to waitlist controls (Goodrick, Poston, Kimball, Reeves, & Foreyt, 1998; Klem, Wing, Simkin-Silverman, & Kuller, 1997; Presnell & Stice, 2003; Reeves et al., 2001). Participants in the weight loss diet conditions of several of these trials showed significant weight loss, thereby confirming that dietary restriction was manipulated. Assignment to a more moderate weight-maintenance diet likewise resulted in greater decreases in bulimic symptoms in normal weight adolescent females over a 1-year period, relative to assessment-only controls (Stice, Presnell, Groesz, & Shaw, 2005).

It appears that the prospective studies generated results that conflicted with the experimental trials because the dietary restraint scales used in the former studies are not valid measures of dietary restriction. Dietary restraint scales do not show substantively meaningful or statistically significant inverse correlations with objective and unobtrusive measures of acute or longer-term caloric intake (Bathalon et al., 2000; Jansen, 1996; Martin et al., 2005; Stice, Fisher, & Lowe, 2004; van Strien, Cleven, & Schippers, 2000), as was suggested by the original validity studies that used self-reported caloric intake (Laessle et al., 1989; van Strien, Frijters, van Staveren, Defares, & Deurenberg, 1986). The evidence that individuals with elevated scores on these scales gain more weight over both short and long periods of time than their low-scoring counterparts (Klesges, Isbell, & Klesges, 1992; Klesges, Klem, & Bene, 1989; Stice, 2001; Stice et al., 1999) also suggests these measures are not valid measures of longer-term caloric restriction. This analysis suggests that more confidence should be placed in the randomized trials that confirmed that participants were on a weight loss diet, as reflected by significant weight loss relative to controls.

Based on the promising evidence from controlled trials suggesting that weight management interventions result in decreased bulimic symptoms in various populations, the primary objective of this study is to examine the efficacy of a healthy weight control intervention for the treatment of bulimia nervosa. This new intervention, the Healthy Weight Program, has two advantages over extant treatments, such as a shorter duration (thereby reducing time commitment for clients) and a secondary possible benefit of weight loss, which will not only increase the appeal of the program to those dissatisfied with current body weight, but might also reduce health risks associated with elevated weight. If the present study were able to establish initial evidence for the efficacy of this 6-session intervention, it would provide preliminary empirical support for an alternative, effective treatment that is less costly to implement.

This trial might also be conceptualized as an experimental psychopathology test of the theory that dietary restriction maintains bulimia nervosa. We believe it is vital to resolve the question of whether dieting maintains bulimic pathology or is an efficacious intervention for this eating disturbance because of the diametrically opposed clinical implications. This is a particularly important question from a health perspective because obesity results in considerably more morbidity and mortality than eating disorders and dietary

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