

Remote treatment of bulimia nervosa and binge eating disorder: A randomized trial of Internet-assisted cognitive behavioural therapy

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Received 21 February 2006; received in revised form 1 June 2006; accepted 9 June 2006

Abstract

The present study investigated the efficacy of self-help based on cognitive behaviour therapy in combination with Internet support in the treatment of bulimia nervosa and binge eating disorder. After confirming the diagnosis with an in-person interview, 73 patients were randomly allocated to treatment or a waiting list control group. Treated individuals showed marked improvement after 12 weeks of self-help compared to the control group on both primary and secondary outcome measures. Intent-to-treat analyses revealed that 37% (46% among completers) had no binge eating or purging at the end of the treatment and a considerable number of patients achieved clinically significant improvement on most of the other measures as well. The results were maintained at the 6-month follow-up, and provide evidence to support the continued use and development of self-help programmes.

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Keywords: Bulimia; Bibliotherapy; Internet; Self-help-techniques; Treatment

Introduction

Cognitive behaviour therapy (CBT) is considered the treatment of choice for bulimia nervosa (BN) and binge eating disorder (BED) (NICE, 2004). However, far from all sufferers receive CBT due to the lack of skilled therapists, and long waiting lists. Therefore, a major challenge has been to increase the accessibility and affordability of evidence-based psychological treatments for BN and BED. One solution is to also deliver treatment in self-help format. Several studies have shown promising results for both pure and guided self-help (e.g. Carter & Fairburn, 1998; Ghaderi & Scott, 2003b; Grilo & Masheb, 2005; Loeb, Wilson, Gilbert, &

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Labouvie, 2000; Palmer, Birchall, McGrain, & Sullivan, 2002; Peterson et al., 1998; Wells, Garvin, Dohm, & Striegel-Moore, 1996). Generally, guided self-help seems to produce larger treatment effects than pure self-help (e.g. Carter & Fairburn, 1998; Loeb et al., 2000), and approximates conventional therapist-delivered CBT for a subgroup of patients (Bailer, de Zwaan, Leisch, Strnad, Lennkh-Wolfsberg, & El-Giamal, 2004; Carter & Fairburn, 1998; Peterson et al., 2001; Thiels et al., 1998).

Although the majority of studies have evaluated face-to-face guidance (Carter & Fairburn, 1998; Ghaderi & Scott, 2003b; Loeb et al., 2000), some findings indicate that telephone-based guidance might be as effective (Palmer, et al., 2002; Wells et al., 1996). A new self-help guidance approach would be to use the Internet. A recent study by Carlbring et al. (2005) compared a conventional 10-week CBT-program for panic disorder with an Internet-based self-help treatment with minimal therapist contact via e-mail. The study found large within-group effects both immediately following treatment and at 1-year follow-up, but only a negligible between-group effect. Providing CBT via the Internet has advantages over self-help books since advice and feedback can be given promptly, but does not require synchronicity as with telephone guidance (Carlbring & Andersson, 2006). Furthermore, it has been suggested that therapist-delivered CBT can be unnecessarily intensive for a subgroup of patients for whom self-help is sufficient (Fairburn, Marcus, & Wilson, 1993). Generally, delivering self-help to all patients could therefore be the first intervention in stepped care, an approach to treatment recommended since it effectively allocates resources after patient needs (Wilson, Vitousek, & Loeb, 2000). Finally, patients receiving self-help have been suggested to be more likely to attribute success to their own efforts (Fairburn, 1997).

Patients seeking treatment for eating disorders constitute a diverse group with a large variation in frequency and composition of symptoms. A substantial number of patients seeking treatment do not meet the criteria for full eating disorder diagnosis. It is also common for patients to migrate between the diagnoses (Fairburn & Harrison, 2003). Broadening the inclusion criteria in randomized controlled studies is therefore a way to mimic the actual population of patients with eating disorders and thereby increase the external validity of the study. As it has been suggested that different eating disorders share the same maintaining mechanisms, they can be treated transdiagnostically (Fairburn, Cooper, & Shafran, 2003).

The primary aim of this study was to evaluate the efficacy of self-help with Internet-based guidance in the treatment of full and sub-threshold BN and BED. In addition to eating disorder symptoms, the purpose was to investigate the effects on the general variables depression, quality of life and self-esteem.

Method

Patient selection

Patients were recruited by contacting two Swedish newspapers, one major tabloid and a local newspaper, which wrote articles about the study. People fitting the description of binge eaters were encouraged to apply to the study by visiting a homepage with an online application form. A link to the homepage was also published on the homepage of a Swedish anorexia/bulimia patients association. Applicants who agreed to the terms of the study—first an online screening, then an assessment interview, randomization to treatment or waiting list, and treatment administered via Internet and email—were given access to the online screening after submitting written consent for participation. The screening consisted of the following assessment forms: Survey for Eating Disorders (SEDs; Ghaderi & Scott, 2002), Eating Disorders Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994), Montgomery Åsberg Depression Scale Self-assessment (MADRS; Svanborg & Åsberg, 1994), Quality of Life Inventory (QOLI; Frisch, Cornell, Villanueva, & Retzlaff, 1992) and Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987).

To participate, applicants were required to be 18 years or older, have a BMI of at least 18, not be more than moderately depressed (MADRS score < 30), not be currently suicidal (MADRS item 9 < 4), and meet full or sub-threshold diagnoses of either BN or BED. Sub-threshold BN was defined as at least twice-monthly episodes of binge eating and compensatory behaviours during the last 3 months. Similarly, sub-threshold BED, which was the most inclusive diagnosis, required at least 2 days with objective bulimic episodes (OBE) per month during the past 6 months. To receive the sub-threshold BED, the participant had to rate the binge eating episodes as markedly stressful. Applicants were also excluded if they were going through another

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