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A comparison of ethnic groups in the treatment of bulimia nervosa☆

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Abstract

This exploratory study investigated whether White and ethnic minority bulimic participants differ on key features of eating psychopathology and treatment outcome. Data from a randomized controlled multi-site study comparing the efficacy of either cognitive–behavioral therapy (CBT) or interpersonal therapy (IPT) for 219 women with bulimia nervosa were analyzed. A significant baseline ethnic difference for body mass index (BMI) ($p < .001$) was found as well as an ethnicity by center interaction for a prior history of depression ($p < .05$). In addition, there was a significant ethnic difference for the Weight Concerns subscale of the Eating Disorder Examination (EDE). However, once BMI was controlled, this difference did not retain significance. At post-treatment, while all ethnic groups responded with higher abstinence rates to CBT than IPT, an ethnicity by treatment effect was found for the reduction of objective binge eating episodes. Black participants, compared to other groups, showed greater reductions in binge eating episodes when treated with IPT than CBT. Other findings related to secondary outcome measures, though limited by small sample size, are discussed as providing directions for future research.

Keywords: Ethnicity; Bulimia nervosa; Eating disorders; Treatment response; Baseline characteristics

1. Introduction

Eating disorders have historically been characterized as affecting primarily White, middle-class women in Western societies and research has tended to focus on this population until more recent years (Crago, Shisslak, & Estes, 1996; Ritenbaugh, Shisslak, Teufel, Leonard-Green, & Prince, 1994; Root, 1990). Although there has been growing interest in the potential impact of ethnicity on the presentation of eating disorders and on treatment response, research on the topic is limited.

Several studies have reported differences among White and ethnic minorities on key features of the different eating disorders. Some studies show Whites having a greater degree of eating disturbances than non-Whites. For example, as

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compared to White college women, two studies found lower scores of eating psychopathology as measured by the Eating Attitudes Test (EAT: Garner, Olmsted, Bohr, & Garfinkel, 1982) and the Bulimic Diagnostic Instrument (BDI: Nevo, 1985) among Asian college students (Lucero, Hicks, Bramlette, Brassington, & Welter, 1992) and Black college students (Nevo, 1985), respectively. Additional studies found Black college women to have lower dietary restraint, fear of fatness, drive for thinness, and body dissatisfaction (Abrams, Allen, & Gray, 1993) as well as lower purging frequency and less preoccupation, fear, and depression associated with food and weight (Gray, Ford, & Kelly, 1987) than White college women.

In contrast, other studies have found evidence suggesting that Whites have a lesser degree of eating pathology than ethnic minority populations. Two British studies found Asian (Dolan, Lacy, & Evans, 1990) and Black (Reiss, 1996) women in community samples to score higher on pathological eating attitudes and behaviors as measured by the EAT and the Bulimic Investigatory Test, Edinburgh (BITE: Henderson & Freeman, 1987), respectively, than Whites. In community samples in the U.S., Striegel-Moore, Wilfley, Pike, Dohm, and Fairburn (2000) found Black women reported more recurrent binge eating and purging behavior compared to Whites while Fitzgibbon et al. (1998) found Hispanics had more severe binge eating as compared to Whites and all other ethnic minorities.

Illustrating this complex pattern of findings is a literature review by Crago et al. (1996) that not only suggested ethnic differences between non-minority and minority groups, but also between different minority groups. Based on a literature review of research pertaining to eating disturbances among U.S. minority groups, they found a trend for eating pathology to occur as frequently in Hispanics as Whites, less frequently among Blacks and Asians than Whites, and more frequently among Native Americans than Whites. The conclusions they drew, however, were tentative due to the small pool of research available for review on the topic.

In direct contrast to the findings reporting ethnic differences in eating disorder psychopathology are a number of studies indicating no differences across ethnicities (Haudek, Rorty, & Barbara, 1999; le Grange, Telch, & Agras, 1997; Mazzeo, Saunders, & Mitchell, 2005; Mitchell & Mazzeo, 2004; Pemberton, Vernon, & Lee, 1996).

While the number of studies examining ethnic differences in eating disorder psychopathology is few, there are even fewer studies that have examined ethnicity and treatment outcome. In one small study, Hiebert, Felice, Wingard, Munoz, and Ferguson (1988) conducted a retrospective chart review of 30 patients with anorexia nervosa and found no difference in treatment outcome, as measured by weight and menstrual function, in Hispanic and White women. Marcus (1994) also found no difference in treatment response for binge eating disorder between Black and White women in a behavioral weight-control or cognitive–behavioral binge eating program.

This paper presents an exploratory investigation of whether White and ethnic minority (Black, Hispanic, and Asian) bulimic participants differ on key features of eating psychopathology as well as treatment outcome using data from a controlled multi-site study comparing the efficacy of either cognitive–behavioral therapy (CBT) or interpersonal therapy (IPT) for women with bulimia nervosa (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000).

2. Methods

2.1. Participants

Participants were part of a larger study involving a multi-site investigation of the efficacy of two psychological treatments, CBT and IPT, in treating women with bulimia nervosa (BN) (Agras et al., 2000). Detailed information regarding recruitment and study design are available in previous reports (Agras et al., 2000; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002). The research was reviewed and approved by institutional review boards for all participating sites.

There were 2 treatment sites (Stanford University, Stanford, CA, and Columbia University, New York, NY) and a quality control center (Oxford University) to minimize risks that the treatments and assessments might be implemented differently across the 2 sites. Two hundred twenty participants meeting DSM-IV criteria for BN were randomized, 110 to CBT (54 at Columbia and 56 at Stanford) and 110 to IPT (56 at Columbia and 54 at Stanford).

Of the 220 participants, 169 (77%) were White, 24 (11%) were Hispanic, 13 (6%) were Black, 11 (5%) were Asian, and 1(0.5%) was Native American. The one Native American participant was excluded from subsequent analyses due to inadequate sample size for the ethnicity group. Ethnicity data was gathered via self-report; participants selected one ethnic category (Black, not of Hispanic origin; Hispanic; White, not of Hispanic origin; American Indian or Alaskan native; Asian or Pacific Islander) they most identified with.