

## A randomized trial comparing the efficacy of cognitive–behavioral therapy for bulimia nervosa delivered via telemedicine versus face-to-face<sup>☆</sup>

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### Abstract

**Objective:** A major problem in the delivery of mental health services is the lack of availability of empirically supported treatment, particularly in rural areas. To date no studies have evaluated the administration of an empirically supported manual-based psychotherapy for a psychiatric condition via telemedicine. The aim of this study was to compare the relative efficacy and acceptability of a manual-based cognitive–behavioral therapy (CBT) for bulimia nervosa (BN) delivered in person to a comparable therapy delivered via telemedicine.

**Method:** One hundred twenty-eight adults meeting DSM-IV criteria for BN or eating disorder—not otherwise specified with binge eating or purging at least once per week were recruited through referrals from clinicians and media advertisements in the targeted geographical areas. Participants were randomly assigned to receive 20 sessions of manual-based, CBT for BN over 16 weeks delivered either face-to-face (FTF-CBT) or via telemedicine (TV-CBT) by trained therapists. The primary outcome measures were binge eating and purging frequency as assessed by interview at the end of treatment, and again at 3- and 12-month follow-ups. Secondary outcome measures included other bulimic symptoms and changes in mood.

**Results:** Retention in treatment was comparable for TV-CBT and FTF-CBT. Abstinence rates at end-of-treatment were generally slightly higher for FTF-CBT compared with TV-CBT, but differences were not statistically significant. FTF-CBT patients also experienced significantly greater reductions in eating disordered cognitions and interview-assessed depression. However, the differences overall were few in number and of marginal clinical significance.

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*Conclusions:* CBT for BN delivered via telemedicine was both acceptable to participants and roughly equivalent in outcome to therapy delivered in person.

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## Introduction

There is general consensus among researchers in the field of eating disorders that at this time cognitive-behavioral therapy (CBT) is the treatment of choice for individuals with bulimia nervosa (BN) (Mitchell, Agras, & Wonderlich, 2007). Although undoubtedly not the final stage in the development of effective therapies for BN, CBT remains the most widely studied and the best-supported treatment for BN.

Despite this finding there is considerable evidence that most patients who are treated for BN do not receive an empirically supported psychotherapy for their condition (Arnow, 1999). In a survey of psychologists, Mussell, Crosby, Knopke, Peterson, and Mitchell (2000) found that the vast majority of clinicians who said that at least 5% of their practice included eating disorders reported not using CBT as the treatment of choice, and only 21.7% reported any significant training experience in CBT for any condition. In another study (Crow, Mussell, Peterson, Knopke, & Mitchell, 1999), a cohort of 353 potential subjects who called an eating disorders research program requesting treatment were asked about prior therapy. Of these, 65.4% had received treatment before and 96.7% of these had received psychotherapy but only 6.9% reported that the treatment they received included even minimal elements of CBT. Most recently, von Ransom and Robinson (2006) found that clinicians who work with eating disorders reported that they preferred to tailor their treatment to the patient rather than choose an approach based on the level of empirical support. Therefore, although CBT may be the treatment of choice for these patients, many therapists working with BN patients choose not to use it, and do not know how to deliver it. Furthermore, most patients who have been treated for BN have not received it.

A related problem is the lack of availability of empirically supported treatments for patients with BN and other forms of psychopathology in rural areas. This is particularly true in the region in which this study was conducted (e.g., North Dakota and Minnesota), where much of the population lives in smaller urban and rural settings. In attempting to identify ways to deliver therapies to this population, several possibilities exist. One would be to train therapists in these areas; however, this would be expensive and impractical and many therapists would not have the time or economic resources to undertake such training. Also, their skills would likely atrophy over time if they were not seeing a critical number of such patients. A second possibility would be to utilize a traveling therapist who would periodically go to various rural areas to provide treatment. However, this would typically be considered undesirable work and third party payors would not reimburse for travel time, resulting in a major financial disincentive. A third possibility, and the one we studied in this protocol, is to deliver therapy through new technologies such as telemedicine.

Two prior studies have examined the utility of telemedicine in treating psychiatric patients. A modest study by Nelson, Barnard, and Cain (2003) assigned a series of 28 depressed children to in-person therapy or telemedicine therapy and found no evidence of a difference in outcomes. A second, larger study by Ruskin et al. (2004) was reported in which a series of 119 depressed patients were randomized to in-person versus telemedicine-delivered therapy. The therapy delivered was supportive psychotherapy, psycho-education and medication management. Again, no significant differences were found in outcome and both approaches were helpful.

Although, several reports have detailed the use of psychotherapy via telemedicine (see for example, Frueh, Henderson, & Myrick, 2005; Cluver, Schuyler, Frueh, Brescia, & Arana, 2005; Griffiths, Blignault, & Yellowlees, 2006; Metropolitan Life Insurance Table, 1983; Passik et al., 2004; Shepherd et al., 2006; Ugarriza & Schmidt, 2006), to our knowledge there have been no studies testing telemedicine administration of an empirically supported manual-based psychotherapy for a psychiatric condition. In this research, we studied the relative efficacy and acceptability of a manual-based psychotherapy for BN, CBT, delivered in person by a

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