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Shorter communication

A randomized wait-list controlled pilot study of dialectical behaviour therapy guided self-help for binge eating disorder

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ABSTRACT

This study examined the efficacy of guided self-help based on dialectical behaviour therapy (DBTgsh) for binge eating disorder (BED). Individuals (88.3% female; mean 42.8 years) were randomized to DBTgsh ($n = 30$) or wait-list (WL; $n = 30$). DBTgsh participants received an orientation, DBT manual, and six 20-min support calls over 13 weeks. All participants were assessed pre- and post-treatment using interview and self-report; also, DBTgsh participants were re-assessed six months post-treatment. At treatment end, DBTgsh participants reported significantly fewer past-month binge eating episodes than WL participants (6.0 versus 14.4) and significantly greater rates of abstinence from binge eating (40.0% versus 3.3%). At six-month follow-up, DBTgsh participants reported significantly improved quality of life and reduced ED psychopathology compared to baseline scores. In addition, most improvements in the DBTgsh group were maintained, although binge eating abstinence rates decreased to 30%. These preliminary positive findings indicate that DBTgsh may offer an effective, low-intensity treatment option for BED.

Despite the existence of empirically supported treatments (ESTs), evidence suggests that therapists often do not use ESTs (Wallace & von Ranson, 2012). In addition, when therapists do attempt to use ESTs, the evidence suggests that treatment is not consistently carried out as specified by treatment manuals (Waller, Stringer, & Meyer, 2012). Without the use of ESTs, it is not possible to ensure clients are receiving the most effective treatments.

Fortunately, self-help manuals allow for ESTs to be accessed by individuals within the community, regardless of whether those treatments are available from mental health professionals. Self-help can also be used in conjunction with support, which is termed *guided self-help* (GSH). Evidence-based self-help manuals, whether used as pure self-help or GSH, may provide one avenue through which the dissemination of ESTs can occur in a cost-effective manner, both at the local level as well as a globally (see Wilson & Zandberg, 2012).

Growing evidence suggests that self-help and GSH interventions are effective for treating binge eating disorder (BED; Wilson & Zandberg, 2012). For example, face-to-face cognitive behaviour therapy GSH (CBTgsh) has been found to reduce binge eating in individuals with BED, with CBTgsh resulting in superior improvement compared to pure self-help (Carter & Fairburn, 1998; Loeb, Wilson, Gilbert, & Labouvie, 2000). CBTgsh has also been found to be more effective than a behavioural weight loss program for reducing binge eating (Grilo & Masheb, 2005; Wilson, Wilfley, Agras, & Bryson, 2010) and computer-delivered self-help CBT has been found to be more effective than a wait-list group for individuals with BED (Carrard, Crépin, Rouget, Lam, Golay, et al., 2011; Carrard, Crépin, Rouget, Lam, Van der Linden, et al., 2011). Further, face-to-face CBTgsh has been found to be comparable to individually-delivered, manualized interpersonal psychotherapy for BED (Wilson et al., 2010) as well as more effective than treatment as usual for individuals with BED (Striegel-Moore et al., 2010). These findings support the use of six to ten session CBTgsh interventions for BED and have led to the recommendation that CBTgsh be a first line treatment option for most patients with BED (Wilson et al., 2010).

Despite CBTgsh's efficacy, many individuals who receive CBTgsh continue to report binge eating. For example, approximately 38% of participants in Wilson et al.'s (2010) study who had received CBTgsh had not stopped binge eating by the two year follow-up, which is consistent with previous research (e.g., Striegel-Moore et al., 2010). As some individuals may respond better to treatments other than CBT delivered through GSH, self-help manuals based on different approaches should be developed and validated.

Over the last decade, treatment for BED and bulimia nervosa based on an adapted version of dialectical behaviour therapy

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(DBT; Linehan, 1993) has been under development. The purpose of this DBT based treatment is to reduce binge eating by teaching individuals how to regulate affect (Telch, Agras, & Linehan, 2000). Findings from an uncontrolled trial of group DBT for BED and a randomized controlled trial of group DBT for BED comparing DBT for BED against wait-list have demonstrated abstinence rates of 56%–70% at six months post-treatment (Telch et al., 2000; Telch, Agras, & Linehan, 2001). A larger, randomized controlled trial with 101 adults was recently completed which compared 20 sessions of DBT to 20 sessions of an active control group therapy (ACGT; Safer, Robinson, & Jo, 2010). The DBT group showed higher rates of binge eating abstinence at the end of the treatment program than the ACGT group (64% versus 36%), although this difference was not sustained at 12-month follow-up (64% versus 56%). The drop-out rate in the DBT group was significantly lower (4%) than the ACGT group (33%; Safer et al., 2010), and individuals with more severe psychopathology responded better to DBT than ACGT (Robinson & Safer, 2012). These additional findings suggest DBT should be investigated further.

The purpose of this study was to compare a GSH adaptation of DBT to a wait-list control condition for individuals with BED, thereby potentially increasing treatment options. Adults with BED were randomized to either a DBTgsh (*treatment*) condition, or a wait-list control (*wait-list*) condition. It was hypothesized that the treatment group, in comparison to the wait-list group, would show reductions in binge eating and eating disorder psychopathology and increases in emotional regulation and quality of life by the end of treatment.

Method

Participants

An *a priori* power analysis using a Cohen's *d* of 1.2 to estimate effect size (Telch et al., 2000), with an estimated attrition rate of 45%, determined that 60 participants would result in appropriate power (0.95), with an alpha of 0.05. One hundred and twenty-two participants were recruited from Calgary, Alberta through local media and screened (see Fig. 1 for participant flow; see Table 1 for inclusion and exclusion criteria). This study was approved by a university ethics review board.

Table 1
Study inclusion and exclusion criteria.

Inclusion criteria	
1	Meet BED criteria or BED criteria with binge eating occurring at least once a week for six months
2	18 years of age or older
3	Able to speak English
4	High school graduate or equivalent
Exclusion criteria	
1	Involvement in concurrent psychotherapy for binge eating
2	Active psychosis
3	Body mass index less than 17.5 kg/m^2
4	Use of compensatory behaviours at least once a week over the past three months
5	Unstable dose of psychotropic medication over the last three months
6	Inability to commit adequate time to assessment and treatment (approximately 2–3 h a week for 16 weeks total)

Eligible participants were first contacted by an assessor (LMW) for an initial assessment, then randomized to either the treatment or wait-list condition by another researcher (PCM) using an urn randomization program that stratified randomization based on age (age under 35 years versus age 35 years and older) and gender to help ensure equal distribution of age and gender among the groups despite the small sample size. After 13 weeks, participants in both groups were assessed again; participants in the wait-list group then received the treatment protocol. The assessor was blind to group assignment for baseline and post-treatment assessments. Only individuals in the treatment group were assessed six months after the end of treatment. Recruitment and data collection for the study spanned from February 2011 through March 2012.

Treatment

A DBT for BED self-help manual was given to individuals in the treatment condition. The manual is an adaptation of the treatment

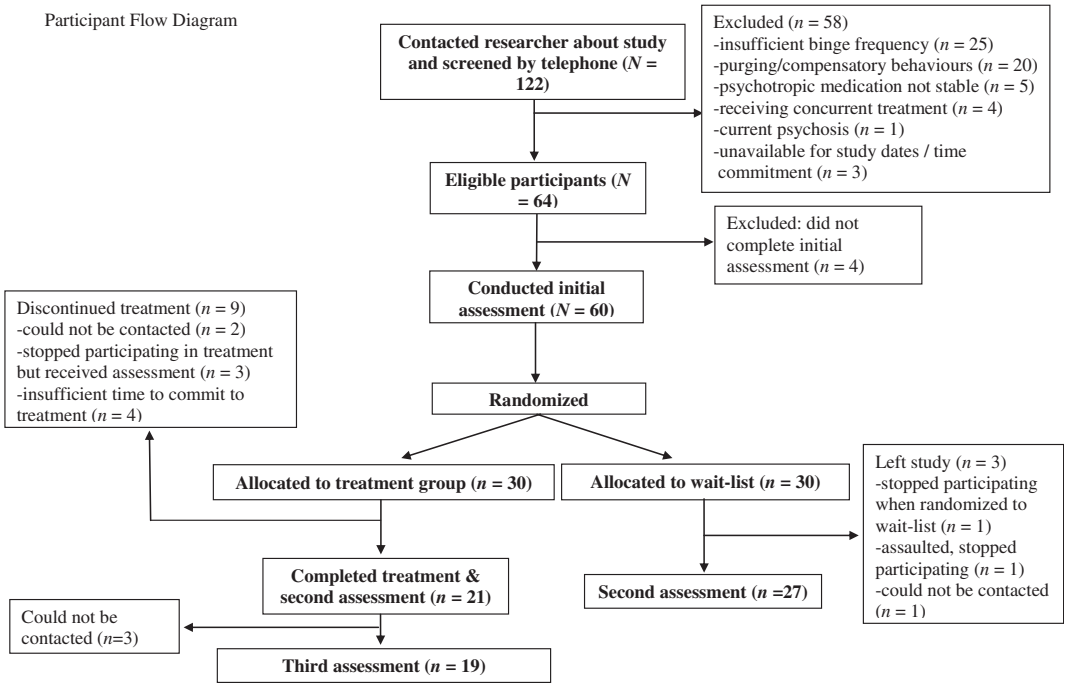

Fig. 1. Participant flow diagram.