



Review

Evolution of cognitive-behavioral therapy for eating disorders

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ABSTRACT

The evolution of cognitive-behavioral therapy (CBT) for the treatment of bulimic disorders is described in this review. The impacts of successive attempts to enhance CBT such as the addition of exposure and response prevention; the development of enhanced CBT; and broadening the treatment from bulimia nervosa to binge eating disorder are considered. In addition to developing advanced forms of CBT, shortening treatment to guided self-help was the first step in broadening access to treatment. The use of technology such as computer-based therapy and more recently the Internet, promises further broadening of access to self-help and to therapist guided treatment. Controlled studies in this area are reviewed, and the balance of risks and benefits that accompany the use of technology and lessened therapist input are considered. Looking into the future, more sophisticated forms of treatment delivered as mobile applications (“apps”) may lead to more personalized and efficacious treatments for bulimic disorders, thus enhancing the delivery of treatments for eating disorders.

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In this paper, we trace the evolution of cognitive-behavioral therapy (CBT) for the treatment of bulimic disorders. The applications of a particular psychotherapy can be broadened in two ways. First, the treatment itself can be strengthened to become more effective. This may be achieved by strengthening identified or hypothesized mechanisms underlying the treatment's effects, more precisely identifying for whom the treatment works best, by adding new modules to the treatment or removing ineffective modules, or by broadening effectiveness to treat a wider array of disorders. Second, the original treatment can be modified to provide easier access for a greater number of affected individuals or be modified to reduce costs associated with the treatment, for example, by reducing therapist contact time. Shortening treatment duration and reducing the role of the therapist in the interest of reduced cost and wider availability does however raise ethical and pragmatic issues in terms of implementation, safety, and effectiveness. Unless otherwise stated, intent-to-treat analyses are presented throughout this paper.

1. Bulimia nervosa

Russell in his seminal paper in 1979 drew attention to the clinical characteristics of bulimia nervosa (BN), and like most clinical scientists at the time, linked the syndrome to anorexia nervosa (AN) (Casper, Eckert, Halmi, Godlberg, & Davis, 1980; Guiora, 1967; Russell, 1979). However, the first application of cognitive-behavioral therapy (CBT) (Fairburn, 1981) to this disorder recognized the distinctive treatment targets for BN such as dietary restriction and shape and weight concerns. Two early randomized controlled trials (RCTs) compared CBT to short-term focal therapy, behavior therapy, and interpersonal psychotherapy (IPT) (Fairburn et al., 1991; Fairburn, Kirk, O'Connor, & Cooper, 1986). Another early trial compared CBT and supportive-expressive psychotherapy (Garner et al., 1993). Overall, CBT appeared more effective than alternative treatments in these studies although the differences were not large. Typical of an early stage of development, sample sizes were small (12–30 participants per group), and two studies used completer analyses (Fairburn et al., 1986; Garner et al., 1993). Although CBT was more effective than IPT post-treatment, longer-term follow-up suggested that IPT might be equally effective, although at 12-months only about half the sample (N = 37) was available for assessment from the original sample (N = 75) (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993).

While at the Center for Advanced Study in the Behavioral Sciences in 1976, Wilson, Fairburn and Agras designed a study to test

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whether CBT was in fact superior to other treatments for BN. The only other psychotherapy contender at the time was IPT. Hence the final design chosen was a comparison of CBT and IPT for the treatment of BN with a sufficient sample size ($N = 220$). This sample size required two treatment sites in order to recruit enough participants in a reasonable timeframe, together with an external quality control center at Oxford University focused on treatment fidelity. CBT was found superior to IPT at end-of-treatment, with 29% vs. 6% recovered, but at follow-up there was not a statistically significant difference between groups with 40% recovered with CBT and 27% with IPT (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). These findings confirmed those of the previous comparisons of the two treatments (Fairburn, Jones et al., 1993; Fairburn et al., 1986).

In a follow-up analysis of these findings, Wilson, Fairburn, Agras, and Walsh (2002) found that early response to treatment, measured by a decrease in self-induced vomiting during the first few weeks of treatment, predicted outcome, with CBT significantly superior to IPT by week 4 of treatment. Early identification of poor response to treatment allows for early addition of a new or modified treatment for those individuals. In addition, change in dietary restraint was found to mediate treatment outcome, with CBT significantly superior in reducing dietary restraint compared with IPT. This was the first time that a mechanism underlying the effectiveness of CBT in treating BN had been found and suggested that CBT had a specific effect on restraint. No mechanism underlying the effects of IPT on BN was found, for example, change in interpersonal interactions did not mediate outcome as might have been expected. Wilson et al. (2002) raised the question whether IPT did in fact “catch-up” with CBT over time. Part of the catch-up as illustrated in the primary paper (Agras et al., 2000) was due to a slight decrement in the mean effect of CBT on binge eating and vomiting over the follow-up period. As Wilson noted, however, “The posttreatment course of patients who received IPT does not appear different from that of patients who received CBT when the posttreatment levels of symptoms are considered. Similar fractions of patients who were recovered, remitted, or not remitted at the end of treatment had recovered by the end of follow-up in both treatments.” Hence, there was no evidence of a catch-up effect.

2. Enhancing CBT

An early effort to enhance CBT involved adding a module to increase exposure to feared foods, hence reducing dietary restraint. In-vivo exposure was added to some or all treatment sessions, allowing the anxiety associated with exposure to dissipate within session when compensatory behavior such as self-induced vomiting was prevented. The first study to examine the effects of this treatment compared CBT to an exposure/response prevention condition (Wilson, Rossiter, Kleifield, & Lindholm, 1986). This was a small-scale study ($N = 17$) with four dropouts precluding comparative analyses of binge eating and purging. There was, however, some indication of advantage for exposure/response prevention in terms of reducing binge eating and purging. A further study (Leitenberg, Rosen, Gross, Nudelman, & Vara, 1988) compared 24 sessions of exposure/response prevention to CBT to a wait-list control in 47 women with BN. No difference was found between response prevention and CBT in reducing self-induced vomiting at post-treatment in a completer analysis. However, at follow-up response prevention showed a within-group change in self-induced vomiting whereas CBT did not, again a possible signal of efficacy. A third study with 77 participants randomly allocated to 4 groups found (in a completer analysis) that CBT was superior to no treatment in reducing self-induced vomiting whereas exposure/response prevention added to CBT was not (Agras, Schneider, Arnou, Raeburn, & Telch, 1989). This finding may have been due

to the displacement of elements of CBT by exposure/response prevention thus weakening the effect of CBT in that group. It should be noted that these studies differed in the amount of exposure/response prevention given within treatment and that the studies were small. Thus, the evidence for the effectiveness of exposure/response prevention was weak and was not adequately tested by today's standards.

3. Broadening the application of CBT

Clinical and epidemiological studies suggested that binge eating often occurred separately from purging suggesting the existence of a hitherto unrecognized eating disorder (Halmi, Falk, & Schwartz, 1981). Later, Spitzer drew attention to the new syndrome in a comment on a controlled study of desipramine for “non-purging BN” (McCann & Agras, 1990). In his comment, Spitzer noted that a field trial for DSM-IV had found that “Binge Eating Disorder” (BED) was prevalent in weight-loss clinics and particularly affected women (Spitzer, 1991). A controversy then arose as to whether there was enough evidence for the new syndrome to be included in DSM-IV (Fairburn, Welch, & Hay, 1993; Spitzer et al., 1993) with the ultimate decision that further evidence was needed before inclusion of the disorder in the DSM. However, similarities between BN and BED in terms of symptoms, i.e. binge eating, dietary restraint, and weight and shape concerns, suggested that CBT and IPT might be effective treatments for BED, paving the way for a new series of controlled clinical trials. Hence, research into the treatment of BED was largely focused on the comparative effectiveness of CBT and IPT. The first small-scale study compared CBT provided in a 10-session group format to a wait-list control condition for the treatment of BED (Telch, Agras, Rossiter, Wilfley, & Kenardy, 1990) finding in a completers analysis that 79% of those receiving CBT were abstinent at the end-of-treatment compared with none of the controls. This study was followed by a comparison of CBT and IPT, both in a group format, together with a wait-list control group (Wilfley et al., 1993). The sample size was small ($N = 56$) but both active treatments were superior to the wait-list control group but were not statistically different from each other in reducing binge eating either at end-of-treatment or at 12-month follow-up. Larger studies confirmed these early results. In one such study, 162 patients with BED were randomly assigned to either CBT or IPT (Wilfley et al., 2002). The two treatments were equivalent in reducing binge eating and in producing abstinence from binge eating at both end-of-treatment (CBT 79%, IPT 73%) and 1-year follow-up with some relapse (CBT 59%, IPT 62%). As in most studies, abstinence rates were higher than those obtained in the treatment of BN. This may be due to the high placebo response rate of BED compared to BN (about 38%–8%) (Blom et al., 2014).

4. Refining CBT

Fairburn, in his revision of the original CBT manual describing Enhanced Cognitive Behavioral Therapy (CBT-E), laid out the most ambitious effort to enhance the effectiveness of this treatment (Fairburn, 2008). CBT-E is embedded within a transdiagnostic view of the eating disorders and is therefore aimed at all eating disorders with some adaptations for different disorders and ages. Two forms were described: A focused treatment similar to the original manual (CBT-Ef) and a broad treatment (CBT-Eb). The broad form contains extra modules to address perfectionism, low self-esteem and interpersonal difficulties issues that contribute to the maintenance of eating disorders. In both forms, the therapist checks progress early in the course of treatment and makes appropriate adjustments to treatment if progress is not satisfactory. In a controlled comparison of the two forms of CBT and a waiting list in a

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