Behaviour Research and Therapy 47 (2009) 628–635

Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: www.elsevier.com/locate/brat

Shorter communication

The efficacy of a short version of a cognitive-behavioral treatment followed by booster sessions for binge eating disorder

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ARTICLE INFO

Article history:
Received 15 May 2008
Received in revised form
31 March 2009
Accepted 6 April 2009

Keywords:
Binge eating disorder
Short-term CBT
Stepped-care approach
Obesity

ABSTRACT

This waitlist-controlled study evaluated the efficacy of a short version of a group CBT for BED followed by booster sessions after the active treatment phase. Thirty-six females with BED were randomly assigned to CBT (eight weekly sessions during active treatment plus five booster sessions during follow-up) or a waitlist condition. At the end of the active treatment, binge eating was significantly reduced relative to waitlist. Furthermore, at 12-month follow-up short-term CBT produced significant improvements in binge eating symptoms relative to baseline. Findings suggest that the short-term CBT followed by booster sessions may provide a valuable treatment option for patients with BED.

Introduction

Cognitive-behavioral therapy (CBT) is the best-established psychological treatment for BED (National Institute for Clinical Excellence [NICE], 2004; Wilson, Grilo, & Vitousek, 2007). Treatment efficacy studies have reported similar effects on binge eating for different lengths and structure of treatments. Standard CBT treatments for BED typically range from 12 to 20 sessions (e.g., Grilo, Masheb, & Wilson, 2005; Munsch et al., 2007; Nauta, Hospers, & Jansen, 2001; Wilfley et al., 2002). Short-term treatments for BED generally consist of guided self-help approaches lasting 10–12 weeks with six to eight brief individual meetings (Carter & Fairburn, 1998; Grilo & Masheb, 2005; Loeb, Wilson, Gilbert, & Labouvie, 2000), or lasting 8 weeks, but including twice weekly held sessions (Peterson et al., 2001, 1998). Shorter treatments are likely to be more cost-effective than longer interventions, assuming they produce comparable outcomes both in the short- and long-term (Wilfley, 2002).

This waitlist-controlled study is the first to evaluate the efficacy of a non-self-help group CBT for BED in a short-term format followed by booster sessions. Our expectation of the efficacy of a short-term treatment is based on studies reporting a rapid response to treatment in patients with BED (Grilo, Masheb, & Wilson, 2006; Masheb & Grilo, 2007) and to the results of a previous treatment study of our group (Munsch et al., 2007) showing a fast and significant reduction of binge eating within the first 8 weeks of CBT. The abbreviated treatment in the present study consisted of eight weekly sessions during the active treatment phase, followed by five booster sessions spread out over the period of 12 months. To our knowledge, the use of booster sessions is a novelty in the treatment literature for BED, as no such structure of treatment delivery has been documented in previous studies. Booster sessions aimed at consolidating behavior changes by the rehearsal and reinforcement of the strategies developed during the active treatment phase, while not introducing any new material. We analyzed treatment outcomes between baseline and end of treatment relative to waitlist and in addition the entire temporal course of treatment between baseline and 12-months follow-up. We hypothesized the shortened version of CBT to be efficacious for treating binge eating and thus expected participants in the treatment condition to show significant improvements relative to waitlist. We further assumed that these effects would be maintained at the 12-month follow-up relative to baseline.

Methods

Participants

The study was conducted at the University of Basel, Switzerland, between December 2004 and June 2007. Participants were recruited through newspaper advertisements and flyers for

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doi:10.1016/j.brat.2009.04.003

a treatment study on binge eating and obesity. Study inclusion criteria required that participants be between 18 and 70 years old and meet full diagnostic criteria for BED according to DSM-IV-TR (American Psychiatric Association, 2000). Participants were excluded if they met DSM-IV-TR criteria for severe mental disorders warranting immediate treatment, such as major depression with acute suicidal risk, psychosis, bipolar disorder, or current substance use disorder. Further exclusion criteria were pregnancy, participation in a diet program or another psychotherapy, treatment with weight loss medication (current or during the past 3 months), or previous surgical treatment of obesity. Since only a small number of men ($n = 5$) contacted our department for the study, we did not include male participants in our study. Studies show that men are less likely to report distress over binge eating and may therefore be less likely to seek treatment for their eating disorder (Lewinsohn, Seeley, Moerk, & Striegel-Moore, 2002). One hundred and thirty-two subjects contacted the department and underwent a telephone screening, and 36 participants were available for randomization (Fig. 1, Table 1). A power analysis yielded that a minimum of 21 or 51 participants per group was required when assuming a large (Cohen's $d = 0.8$) or medium ($d = 0.5$) treatment effect size, respectively (based on a one-sided t-test for independent samples with *alpha* = .05, *beta* = 0.2). For practicality reasons we had to finish the recruitment procedure when 36 participants (18 per group) were available for randomization, therefore limiting our ability to detect large to medium treatment effect sizes.

Study design

The study was approved by the local ethics committee for medical research. All participants were offered free treatment for their participation in the study. Prior to initial assessment, all participants provided written informed consent. Participants meeting DSM-IV-TR criteria for BED were randomly assigned to either the immediate treatment or the waitlist condition using a permuted block design. Participants in the waitlist condition entered the treatment condition after completion of the 8-week waiting period. A waitlist control group was chosen because both between- and within-subject comparisons allow testing for treatment efficacy (Lambert, Shapiro, & Bergin, 1986).

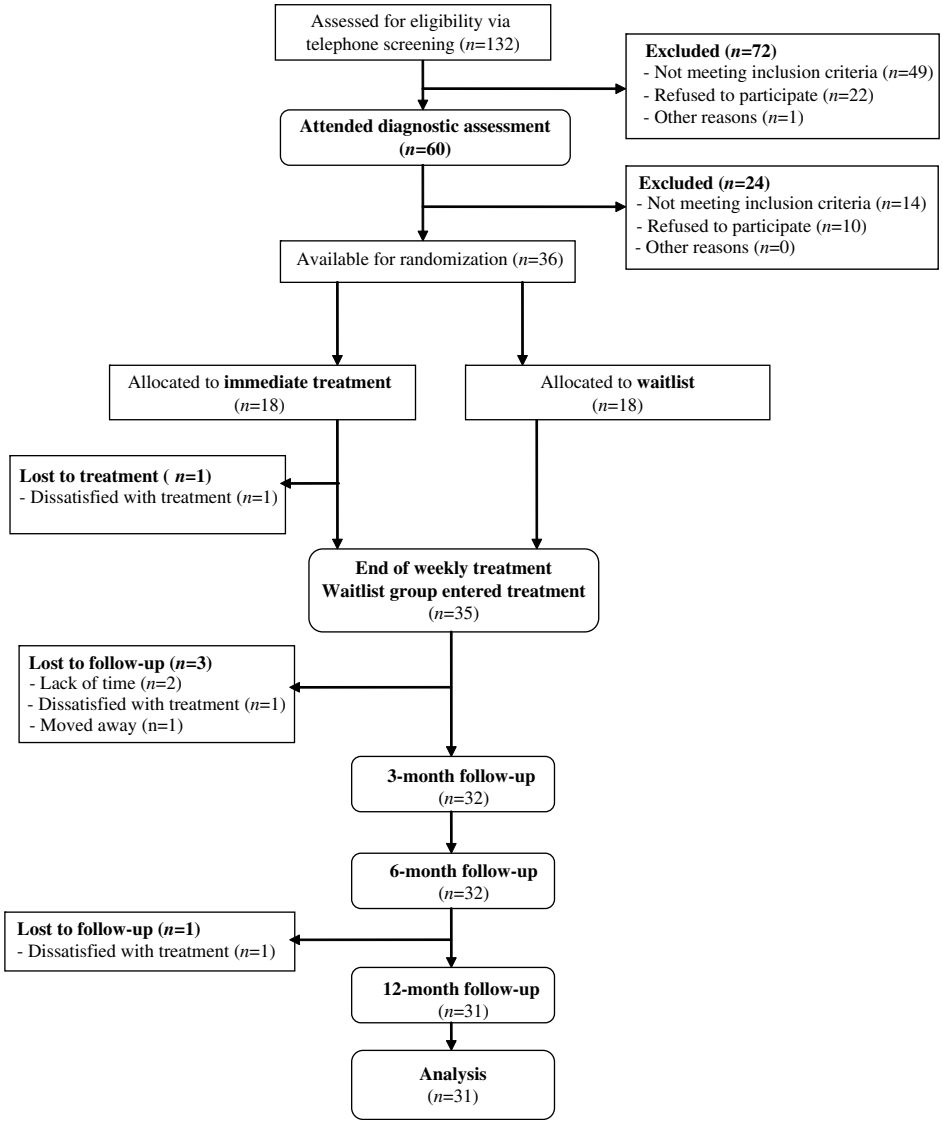

Fig. 1. Flow chart of participants.