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TITLE: Client Pretreatment Characteristics as Predictors of Outcome in Brief Therapy for Bulimia

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ABSTRACT

An overview for college counselors of the literature on bulimia treatment outcomes is presented for purposes of screening, treatment, and referral. Pretreatment characteristics that seem amenable to success in brief therapy are outlined, as are those that do not lead to a positive outcome.

The prevalence of bulimia nervosa, often referred to simply as bulimia, has received a vast amount of attention on college campuses during the past decade. A study of 643 college women found that as many as 3% of college students meet the diagnostic criteria for bulimia, 33% reported inappropriate and unhealthy forms of weight control (i.e., vomiting, commonly called purging, and use of laxatives), and 38% had problems with bingeing or consuming large amounts of food in a short amount of time (Mintz & Betz, 1988). The traditional approach to treatment of bulimia has been long-term psychotherapy that incorporates many hours of in-depth individual, group, and family counseling in both inpatient and outpatient treatment settings. These models of treatment pose a serious challenge to college counselors who are increasingly mandated to meet with students briefly (Gyorky, Royalty, & Johnson, 1994; Quintana, Kilmartin, Yesenosky, & Macias, 1991). These counselors must make the best use of limited time with clients who have bulimia. One manner in which this may be accomplished is through brief therapy.

Brief therapy, the current treatment of choice in many college counseling centers (Gyorky et al., 1994) is defined as "counseling in which time is an intentional aspect of treatment planning" (Steenbarger, 1993, p. 8). Brief therapy models offer an alternative to more traditionally accepted methods of counseling. Instead of seeking to uncover and deal with deep-seated issues thought to be at the root of bulimic symptoms, brief therapy for bulimia often focuses on understanding the primary function that the symptoms fulfill in the client's life. Through active involvement with the therapist, clients learn to reframe their disorder, engage in behavioral and cognitive therapeutic interventions, and seek to focus on other areas of their lives outside of their eating disorder (Moley, 1987).

In examining the effectiveness of brief therapy for bulimia, Johnson, Tobin, and Dennis (1990) concluded that it might be beneficial to identify subgroups of clients who may require differing levels of intervention. This type of systematic method of client referral and treatment matching has also been recommended by Quintana et al. (1991).

Although dozens of studies have begun to identify client characteristics that may lend themselves to successful treatment (with both brief and nonbrief approaches), there has yet to be a synthesis of the information available for practitioners. This article reviews the outcome literature on bulimia treatment and cites those pretreatment client characteristics that seem amenable to brief therapy and those characteristics that do not. It is hoped that addressing the promises and limitations of brief therapy for bulimia will better equip college counselors to meet the challenges of appropriate triage and referral.

OVERALL EFFECTIVENESS OF BRIEF THERAPY FOR BULIMIA

Research on treatment and outcomes of bulimia has suggested that brief therapy may be appropriate for some clients suffering from bulimia nervosa (Bologna, Barlow, Hollon, Mitchell, & Huppert, 1998; Bulik, Sullivan, Joyce, Carter, & McIntosh, 1998, 1999; Fahy, Eisler, & Russell, 1993; Fahy & Russell, 1993; Johnson et al., 1990; Walsh et al., 1997). For example, after 8 weeks of brief cognitive-behavioral treatment, 42% of clients exhibited significant reductions in abnormal eating behaviors and psychopathology, and these reductions were maintained at 16 weeks and after 1 year (Fahy & Russell, 1993). Bulik, Sullivan, Joyce, et al. (1998) found that brief cognitive-behavioral therapy (CBT) produced broad improvement in several outcome areas: 53.4% of clients greatly improved their food restriction, and 52.9% improved on a measure of body dissatisfaction. Also, studies by both Fairburn et al. (1991) and Walsh et al. (1997) revealed that most of the clinical change was seen in clients by the eighth session, suggesting that brief treatments may provide positive gains. In addition, although not empirically tested, practitioners at the Mental Research Institute's Center for the Treatment of Eating Disorders in Palo Alto, California, have concluded that bulimia can be successfully treated briefly if the client can view himself or herself as in control and responsible for a cure (Moley, 1987; Vognsen, 1985).

DETERMINING WHO BENEFITS

The following categories of client characteristics have been studied to determine their relationship to the treatment outcome for bulimia: demography, family characteristics, behavioral symptoms, psychological or cognitive factors, Axis I comorbidity, and Axis II comorbidity (Bulik, Sullivan, Carter, McIntosh, & Joyce, 1998). Research indicates that neither demography nor family characteristics play a significant role in outcome for brief therapy with bulimia. By examining outcome literature in the remaining four areas, we attempt to identify clients who may benefit from brief interventions as well as those clients who may require longer term care.

We used stepwise methods in selecting client pretreatment prognostic indicators. First, we selected outcome articles indicating predictive factors associated with successful or unsuccessful outcome in brief therapy (defined as 16 sessions or fewer) for bulimia. Then, the search was broadened to include findings from other large-scale outcome studies that incorporated long-term treatment or did not indicate treatment length. Selected among these studies were only those pretreatment characteristics that could serve as predictors of negative outcome. We inferred that if a particular characteristic was predictive of poor outcome in long-term therapy, it could be assumed that it would be a predictor of poor prognosis in brief therapy. Finally, we eliminated studies that did not delineate type of eating disorder (e.g., bulimia, anorexia, binge-eating disorder) when describing treatment outcome because each eating disorder is different and is associated with different treatment regimens (Herzog et al., 1999; Herzog et al., 1993).

BEHAVIORAL SYMPTOMS

One indication of whether brief therapy is appropriate for a client is the client's pretreatment history. This history can be broken down into the following three categories: (a) amount of pretreatment severity (bingeing and purging; pretreatment weight), (b) prior treatment history, and (c) duration of illness. Studies of brief therapy are generally in agreement that high pretreatment severity negatively affects treatment outcome (Baell & Wertheim, 1992; Bulik, Sullivan, Joyce, et al., 1998; Bulik et al., 1999; Fahy et al., 1993; Fahy & Russell, 1993; Lacey, 1983). For example, in an outcome study of brief CBT, Bulik et al. (1999) concluded that lower frequency of bingeing (less than 5.1 times per 2-week period) and purging (less than 6.1 times per 2-week period) indicated a more rapid response to brief treatment. In a similar study of brief CBT with bulimic patients, Fahy and Russell also concluded that poor response was predicted by greater pretreatment severity.

In research attempting to determine effectiveness of brief psychoeducational groups for bulimia, investigators have found similar patterns of client behavioral predictors. For example, Davis, Olmsted, and Rockert (1990) concluded that higher frequency of purging produced a poorer outcome, whereas Olmsted, Davis, Rockert, Irvine, and Eagle (1991) concluded that individual CBT may be a necessary addition to the group for those patients who are purging more than 42 times per month at the beginning of treatment.

Low body weight at entrance has also been found to have a negative effect on treatment outcome (Davis et al., 1990). This led Fahy et al. (1993), in their study of brief CBT with bulimic patients, to conclude that underweight clients may require long-term therapy that challenges dysfunctional weight beliefs and anorexic attitudes such as drive for thinness and body image distortions. Finally, large fluctuations in weight before clients present for treatment (Mitchell et al., 1989) and a prior history of client obesity (Bulik, Sullivan, Joyce, et al., 1998; Fairburn et al., 1995; Maddocks & Kaplan, 1991) have been associated with poor outcome for clients with bulimia. Because low body weight, large fluctuations in weight, and prior history of obesity have, in general, been deemed poor predictors of outcome, it can be hypothesized that these characteristics would not be amenable to brief treatment for bulimia.

An additional factor to consider when assessing pretreatment behavioral symptoms is the history of prior treatment for bulimia. Evidence suggests that those who have experienced failure in prior treatment may not be viable candidates for brief treatment (Lacey, 1983). Maddocks and Kaplan (1991) concluded that those with prior history of treatment did better in an intensive program, such as one that may include hospitalization and more frequent counseling and treatment spanning a longer period of time. Similarly, Gleaves and Eberenz (1994) found that prior inpatient treatment for bulimia with three or more outpatient therapists was a poor indicator of success.

The third category of prior behavior symptoms to consider is the duration of illness. Hsu and Holder (1986), in an outcome study of long-term psychotherapy, found that a longer duration of illness was predictive of a less successful outcome. They concluded that the more ingrained the behavior, the less likelihood of change. Similarly, in a comprehensive study of long-term outcome, Keel, Mitchell, Miller, Davis, and Crow (1999) found that longer duration of the disorder predicted a less successful long-term outcome to therapy. These authors suggested that seeking treatment early may improve prognosis. More recent studies of brief treatment for bulimia have found conflicting results, however. Bulik et al. (1999) and Bulik, Sullivan, Carter, et al. (1998), in studies of brief (8-week) CBT, concluded that duration of the illness was not a factor. Similarly, Baell

and Wertheim (1992), in a study of 16-week CBT with clients who have bulimia, also concluded that duration of the illness did not predict outcome to treatment.

Finally, an interesting note regarding the overall prognosis of clients with a diagnosis of bulimia is that, when compared with individuals diagnosed with anorexia, clients with solely bulimic symptoms had a significantly better recovery rate. Herzog et al. (1993) found that 56% of clients with bulimia attained full recovery at 1-year follow-up whereas only 10% of those individuals with anorexia reached the same recovery level. These investigators concluded that an accurate assessment of client behaviors before and after treatment is essential in predicting client recovery.

PSYCHOLOGICAL OR COGNITIVE FACTORS

According to Bulik, Sullivan, Joyce, et al. (1998), another group of pretreatment characteristics that are important to consider when deeming brief therapy appropriate for clients is client psychological or cognitive factors. One such area of importance is client self-directedness, defined as "a developmental process that encompasses several distinct aspects, including acceptance of responsibility for one's own choices, identification of individually valued goals and purposes, resourcefulness and self-acceptance" (Bulik, Sullivan, Joyce, et al., 1998, p. 212). Bulik et al. (1999) and Bulik, Sullivan, Joyce, et al. (1998) concluded that those clients who respond rapidly to brief treatment show high levels of self-directedness. In addition, impulsiveness (Sohlberg, Norring, Holmgren, & Rosmark, 1989) has been found to be predictive of negative outcome for bulimia treatment. Finally, results of a study by Freeman, Beach, Davis, and Solyom (1985) indicated that dissatisfaction with one's body image was a significant predictor of relapse and, therefore, indicates poor outcome for clients with bulimia. From this evidence, it can be concluded that several psychological and cognitive characteristics may be associated with outcome in bulimia. Thus, paying particular attention to these characteristics at treatment onset may aid in facilitating clients' recovery.

AXIS I COMORBIDITY

The fifth area of consideration in assessing appropriateness of brief therapy for eating disorders is client Axis I comorbidity. In general, research suggests that if clients with bulimia do not present comorbid psychopathology, they may be appropriate for brief therapy (Bologna et al., 1998). One area, however, in which appropriateness for brief therapy seems to differ from other types of treatment is comorbid depression. Keel and Mitchell (1997), in a comprehensive review of bulimia outcome studies, concluded that clinical depression did not seem to be a predictor of outcome. Studies specific to brief therapy, however, have found that those clients suffering from comorbid depression are less likely to have successful outcomes in brief treatment (Bulik, Sullivan, Joyce, et al., 1998; Davis et al., 1990; Fahy et al., 1993; Fahy & Russell, 1993; Maddocks & Kaplan, 1991; Mukia, 1996). This led Fahy et al. to conclude that clients with bulimia who are suffering from depression may be more likely than clients with bulimia not suffering from depression to benefit from longer term treatments focusing on mood-altering interventions, as well as the use of antidepressant medication. Finally, suicidal behavior has been associated with poor outcome for persons with bulimia (Abraham, Mira, & Llewellyn-Jones, 1983). On the basis of the present literature, it seems that those individuals suffering from comorbid depression or its related factors symptoms (i.e., suicidal thinking and behaviors) would not be viable candidates for brief intervention.

Another Axis I disorder that may affect treatment outcome, yet has been the focus of much less research than that of depression, is alcohol or other drug abuse. Although several studies have linked a history of alcohol or other drug abuse, or both, to poor treatment outcome (e.g., Gleaves & Eberenz, 1994; Keel et al., 1999; Lacey, 1983), the majority of outcome studies that included this variable have not found a relationship between the two (Keel & Mitchell, 1997). When examined in comparison with brief therapy, however, Bulik, Sullivan, Joyce, et al. (1998) concluded that those individuals with a history of successful treatment for alcoholism actually had an increased chance of successful treatment outcome for bulimia. Therefore, alcohol use in and of itself may not preclude clients with bulimia from successful outcome in brief therapy. Rather, their ability to overcome their addiction may be the key factor in predicting positive prognosis.

Finally, citing a high incidence of impulse-related psychopathology among bulimics, Lacey and Evans (as cited in Herzog, Nussbaum, & Marmour, 1996) suggested that those bulimics with impulse-related disorders (e.g., kleptomania) experienced a less positive treatment outcome than did those without these comorbid disorders. On the basis of the research presented, it is recommended that when considering treatment options for clients with bulimia, counselors conduct a thorough assessment of clients' overall psychopathology, paying particular attention to depressive symptoms, alcohol and other drug use and treatment history, and impulse-related problems.

AXIS II COMORBIDITY

Similarly, it is also important to assess Axis II disorders when considering appropriateness of brief therapy for the client who is bulimic. Most researchers suggest that clients with bulimia who are also suffering from personality disturbances are less likely to benefit from brief therapy (e.g., Fahy et al., 1993; Fahy & Russell, 1993; Fairburn, Jones, Peveler, Hope, & O'Connor, 1993; Johnson et al., 1990). Johnson (1991) has surmised that the subgroup of clients with bulimia who also suffer from an Axis II disorder account for most of the poor outcomes in brief treatment.

Alternatively, Bulik et al. (1999) and Bulik, Sullivan, Joyce, et al. (1998), in outcome studies of brief interventions, found that personality disturbances were not a factor. In addition, Davis, Olmsted, and Rockert (1992), in a study of a brief psychoeducational groups, also found that personality disorders were not related to outcome. Recognizing the discrepancy of their results to that of the individual therapy literature, David et al. hypothesized that "there may be some unique aspect of the group psychoeducation which attenuates an association between borderline organization and clinical outcome" (p. 210). They further theorized that clients diagnosed with borderline personality disorder may have a difficult time establishing individual relationships, a skill crucial to the success of individual therapy, but that they may be successful in making change in groups in which one-on-one bonding is not emphasized.

Johnson et al. (1990), in a study comparing treatment outcomes of clients with borderline personality disorder versus those without, found that those clients without borderline personality disorders responded better to treatment in significantly fewer sessions than those clients with borderline personality disorders. In addition, they found that within the borderline personality disorder client group, those with the most positive outcomes tended to be in therapy longer. Although the studies by Bulik et al. (1999) and Bulik, Sullivan, Joyce, et al. (1998) did not find this to be a predictor of outcome, on the basis of the present review, it is recommended that if personality disturbances are found, this indicates a need for different and perhaps more intense services than most brief therapy can effectively provide.

IMPLICATIONS FOR COLLEGE COUNSELORS

We assert that knowledge of the client characteristics that are amenable to brief treatment of bulimia nervosa can be invaluable for the counselor working with the college population. As the summary in Table 1 indicates, this overview of the outcome literature reveals that successful intervention with brief therapy is associated with less severe behavioral symptoms, more intact psychological and cognitive functioning, and the absence of Axis I or II diagnoses.

Counseling centers that are equipped with such information during intake sessions will be better prepared to coordinate treatment plans and to make appropriate referrals. Thus, it is recommended that counselors include this information as an integral part of the triage process in an effort to make the most appropriate decisions for clients. Table 2 presents possible questions to aid in the triage process. These questions are to be asked directly of the client and are intended to augment intake procedures already in place. The questions are not intended to replace a thorough depression screening, assessment of other Axis I and II disorders, or a medical referral.

As a result of the present review of the outcome literature, brief therapy has been found to be a viable treatment for bulimia nervosa in clients presenting with specific pretreatment characteristics. College counselors who assess pretreatment characteristics identified on intake will be better equipped to determine the treatment options that are most appropriate for their clients.

SUGGESTIONS FOR FUTURE RESEARCH

The majority of research examining brief therapy in the treatment of bulimia has focused on the effectiveness of cognitive-behavioral techniques. Future research might explore the effectiveness of other modes of brief therapy used in the treatment of bulimia, including both solution-focused and brief dynamic therapies. In addition, investigation of the effectiveness of brief therapy for bulimia in the college counseling setting may be helpful. It is clear from the literature that issues facing college students may differ from those not in college environments (Pascarella & Terenzini, 1991). Therefore, research regarding treatment of clients with bulimia conducted outside of the college environment may not be generalizable to the college setting.

ADDED MATERIAL

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TABLE 1 Pretreatment Characteristics and the Appropriateness for Brief Therapy

Appropriate	Inappropriate
Low pretreatment severity for bingeing and purging	High pretreatment severity for and purging
Lack of history of obesity, fluctuations in fluctuations in weight, and presents with sufficient entry body weight	History of obesity, large weight, and low body weight at
Prior success in overcoming addictions	Prior history of failed treatment
Short duration of illness	Long duration of illness
Lack of comorbid depression	Depression
Absence of an Axis II diagnosis	Presence of an Axis II diagnosis
Client exhibits high levels of self-directedness	Impulsivity
	Dissatisfaction with body image
	Presence of anorectic symptoms

TABLE 2 Possible Questions to Aid in the Triage Process

Current	Historical
Are you dieting?	Have you had any major weight fluctuations in the past year?
How much do you currently weigh?	Do you have a prior history of obesity?
Are you experiencing feelings of depression?	Have you ever been treated successfully for an eating disorder or an addictive disorder?
Are you bingeing? Are you purging? If so, how frequently?	If you are bingeing or purging, or both, how long has it been going on?
How do you feel about your body?	Have you ever been diagnosed with a mental or emotional disorder?

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