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Attachment scales predict outcome in a randomized controlled trial of two group therapies for binge eating disorder: An aptitude by treatment interaction

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Abstract

Patients ($N = 135$) with binge eating disorder (BED) were randomized to a control condition or to one of two 16-session group treatments: group cognitive-behavioral therapy (GCBT) or group psychodynamic interpersonal psychotherapy (GPIP). The two treatments performed equally well, and each resulted in reduced days binged compared with the wait-list control condition. Twelve-month follow-up indicated that improvements were maintained in days binged and in other outcome variables. For women who completed GPIP, higher attachment anxiety was related to improvements in days binged by posttreatment. On the other hand, for women who completed GCBT, lower attachment anxiety was associated with improvements in days binged by posttreatment. Higher attachment avoidance was related to dropping out of GCBT. Although both GPIP and GCBT reduced binge eating, the results indicated that individual outcomes differ across treatments based on level of attachment anxiety and avoidance.

Binge eating disorder (BED) is identified in the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition; *DSM-IV*; American Psychiatric Association [APA], 1994) as a disorder requiring further study. BED is associated with obesity and is characterized by persistent and recurrent episodes of overeating, experience of loss of control during an overeating episode (i.e., a binge), and significant distress regarding binge eating but with no compensatory behaviors (e.g., vomiting). It is estimated that between 1% and 3% of the general population, 8% of obese individuals, and 20% to 30% of obese patients in weight loss programs meet criteria for BED (Striegel-Moore & Franko, 2003). Those with BED report more fear of gaining weight, more lifetime weight fluctuations, greater preoccupation with food and weight, and more body dissatisfaction than obese individuals who do not binge eat (Marcus, 1997). Long-term follow-up indicates that obese individuals with BED tend to continue to gain weight throughout their lives (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000). Obesity is associated with a number of medical problems

such as cardiovascular diseases and type II diabetes (National Institutes of Health [NIH] and National Heart and Lung and Blood Institute [NHLBI], 1998). Individuals with BED were reported to have a higher lifetime incidence of depression (49%) compared with a matched community sample (Telch & Stice, 1998).

Treatment approaches to BED and its associated depression and obesity have to date relied on cognitive and interpersonal psychotherapy conceptualizations of the disorder (Wilfley, 1993; Wilfley, Stein, Friedman, Beren, & Wiseman, 1996). From a cognitive therapy point of view, distorted beliefs about obtaining an idealized weight and shape play a critical role in maintaining binge eating (Wilfley et al., 1996). Cognitive-behavioral therapy (CBT) is designed to address these factors involved in the maintenance of the disorder through a sequence of educational, behavioral, and cognitive interventions. Another treatment for BED is interpersonal psychotherapy adapted for group (IPT-G; Wilfley, 1993), based on interpersonal psychotherapy (IPT), which was originally developed for the

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treatment of depression (Klerman, Weissman, Rounsaville, & Chevron, 1984). IPT-G assumes that current social roles play a pivotal role in maintaining binge eating because of the relationship among interpersonal functioning, mood, and binge eating. In two treatment trials, Wilfley et al. (1993, 2002) demonstrated the probable efficacy of both IPT-G and group CBT (GCBT) in reducing days binged among those with BED. Despite these results, and looking at the intent-to-treat data, 41% of those receiving GCBT and 38% of those receiving IPT-G continued to binge eat 12 months after treatment (Wilfley et al., 2002).

For the current study, group psychodynamic interpersonal psychotherapy (GPIP) for BED was tested (Tasca, Mikail, & Hewitt, 2002). From an interpersonal–psychodynamic point of view, binge eating is precipitated by negative moods, which are triggered by interpersonal stressors. In turn, binge eating acts as a means of coping with negative moods. A number of studies point to negative affect as antecedents to binge-eating episodes among those with BED (e.g., Stickney, Miltenberger, & Wolff, 1999). Others understand binge eating as a means of coping with negative affect by regulating mood states (e.g., Ardoivini, Caputo, Todisco, & Dalle Grave, 1999). Wonderlich, Mitchell, Peterson, and Crow (2001) suggested that those with BED engage in repetitive maladaptive interpersonal interactions as a means of avoiding rejection or abandonment. According to GPIP, these interactions perpetuate cyclical relational patterns (CRPs; Strupp & Binder, 1984) and reinforce negative introjects (Benjamin, 1996) or internal working models (Bowlby, 1988). GPIP targets CRPs and introjects to reduce recurring problems with mood, resulting in a reduced need to binge eat as a means of coping (Tasca et al., 2002). GPIP is conducted in a group therapy format because groups act as a social microcosm in which interpersonal patterns can be observed to occur in vivo, and there is immediate feedback from therapists and peers (Yalom, 1995).

There were two objectives for this study. First, a new manualized group therapy for BED, GPIP (Tasca et al., 2002, in press), was tested to provide broader treatment options for those with BED. GPIP was compared with a shorter version of a probably efficacious treatment for BED, GCBT (Wilfley et al., 1996), and both treatments were compared with a control condition. The second objective was to examine whether levels of attachment insecurity, measured at pretreatment among women with BED, were related to outcome depending on type of treatment. De Rubeis and Crits-Christoph (1998) stated that it would be useful “to go beyond diagnosis to additional patient character-

istics that would indicate whether or not a given treatment is likely to be helpful” (p. 38).

Attachment

Attachment theory is well situated to provide a framework for understanding psychotherapy process and outcome (Mallinckrodt, 2000). Bowlby (1988) hypothesized that, based on the attachments they experience, children build mental models for future relationships that influence interpersonal interactions and perceptions and affect regulation and expression.

Individuals whose attachment styles are insecure tend to respond to their therapeutic milieu in manners that are similar to their established patterns of defenses and emotional regulation (Slade, 1999). Dozier (1990) reported that individuals who used avoidant strategies were rated by clinicians as being less likely to engage in help-seeking behaviors and less likely to use self-disclosure and made poorer use of treatment than individuals with more anxious attachment styles. In a study of individual brief psychodynamic therapy, Horowitz, Rosenberg, and Bartholomew (1993) reported that individuals with dismissing (avoidant) attachment styles were less likely to benefit from this type of therapy, and they recommended cognitive therapy. Tasca, Taylor, Bissada, Ritchie, and Balfour (2004) found that women with the bingeing or purging subtype of anorexia nervosa tended to drop out of partial hospital group treatment if they experienced relationships as secondary (an index of attachment avoidance). Slade (1999) suggested that, although individuals with anxious attachments are highly responsive to emotions in themselves and in others, they lack the capacity to reflect on these emotions. One might conclude from Slade’s (1999) comments that individuals with attachment anxiety might benefit from therapy that uses self-reflection as a means of modulating affect and altering relationships, such as GPIP.

Hypotheses

Regarding the first objective, it was hypothesized that GPIP and GCBT would result in greater reductions in days binged, psychological distress, and eating-disordered attitudes among individuals with BED at posttreatment compared with the control condition, in which no change was expected. It was hypothesized that any improvements at posttreatment would be maintained at 6 months and 12 months posttreatment. Moderate weight loss was expected at 12 months posttreatment compared with pretreatment for patients in both therapy

conditions. Regarding the second objective, and based on the conclusions drawn by Horowitz et al. (1993), it was hypothesized that attachment avoidance, measured at pretreatment, would be associated with greater benefit from GCBT and less benefit from GPIP. On the basis of Slade's (1999) conclusion, individuals with higher attachment anxiety might derive greater benefit from a group therapy that specifically focuses on self-reflection (i.e., GPIP) and less benefit from GCBT. Finally, on the basis of Tasca et al.'s (2004) findings, individuals who experience relationships as secondary (attachment avoidance) will be more likely to drop out of both GPIP and GCBT.

Method

Participants

Participants in this study were 135 individuals (123 women, 12 men) who met *DSM-IV* (APA, 1994) diagnostic criteria for BED. Mean age was 42.75 years ($SD = 10.76$), mean body mass index (BMI) was 41.11 ($SD = 9.95$), and mean years of binge eating was 19.62 ($SD = 9.19$). Most participants (132, or 97.7%) were Caucasian. Of the total, 38 (27.8%) were single, 57 (42.5%) were married or living with a partner, 22 (16.5%) were separated or divorced, and three (2.3%) were widowed. Most were employed, either full time ($n = 72$ [53.4%]) or part time ($n = 19$ [14.3%]), and the median family income was 50,000 to 59,000 Canadian dollars. Regarding education, 14 (10.4%) had at least some graduate training, 84 (62%) had at least some undergraduate education, 27 (20.1%) completed high school, and 10 (7.5%) did not complete high school. No differences among the conditions were found on these variables.

Patients had to report a minimum of two days of binge eating per week for at least the previous six months to qualify for the study. Exclusion criteria included current problems with substance use, bipolar disorder, psychotic disorder, current suicidality, current other medical or psychological treatment for BED, history of an eating disorder other than BED, current purging behavior, and age less than 18 years. Obesity, defined as a BMI (k/m^2) greater than 30, was not a specific inclusion criteria. Potential participants also had to agree not to engage in any new treatment, psychological or pharmacological, while they were waiting to receive treatment or actively receiving treatment in this study. More than half of the participants (62.08%) were on antidepressant medication when they started the study. Patients reported that they started taking antidepressant medication a median of 26 ($M = 38.40$,

$SD = 39.84$) months before the study, and no patient started antidepressant medication sooner than three months before their participation in the study. Hence, it is likely that any therapeutic effects of the antidepressants occurred in advance of patients enrolling in the study (Gelenberg & Chesen, 2000). To assess the potential impact of antidepressant medication further, the outcome analyses reported later were repeated with antidepressant medication use as the comparison variable. There were no significant effects on any outcome variable as a result of antidepressant medication use.

Ten therapists (nine female PhD psychologists and one female psychiatrist, each with at least three years experience in group therapy and therapy of eating disorders) conducted the groups (mean age = 40.46 years, $SD = 9.59$). Five of the therapists identified themselves as working predominantly within a CBT mode, and they each chose to facilitate one GCBT group. The other five therapists identified themselves as working primarily from within a psychodynamic or interpersonal therapy mode, and they each chose to facilitate one GPIP group. Each therapist attended a 2-day training workshop that focused on the relevant manualized treatment. Therapist supervision occurred weekly on an individual basis and monthly in a group supervision format. Supervision for each treatment modality was provided separately by two senior psychologists, each with at least 10 years experience in group therapy, supervision, and treatment of eating disorders.

Measures

Days binged. The main outcome variable was the number of days binged in the past seven days. Days binged were assessed by a psychologist unaware of patients' random assignment to study condition. The diagnostic items of the Eating Disorder Examination (EDE), a semistructured interview, were used to define binge eating (Fairburn & Cooper, 1993). A calendar recall method was used to aid the assessment of binge eating by interviewing the patient and asking specifically about each meal and eating episode in the past seven days. EDE assessment of days binged in the past 28 days has demonstrated good test-retest (Spearman's ρ [ρ_s] = .71) and interrater ($\rho_s = .99$) reliability for a BED sample (Grilo, Masheb, Lozano-Blanco, & Barry, 2004). In the current study, the test-retest reliability of days binged in the past seven days was assessed by correlating the pre- and the post-16 week waiting data of patients in the control condition, $r(33) = .67$, or $\rho_s = .68$. To assess interrater reliability of the assessment of binge eating, 15 of the pretreatment interviews were randomly selected,

audiotaped, and reassessed by an independent rater unaware of the original assessment. An intraclass correlation coefficient using a two-way random effects model (Shrout & Fleiss, 1979) indicated very high agreement between the two assessments ($\rho = .97$). To assess for clinically significant change at posttreatment, six months posttreatment, and 12 months post-treatment for days binged, patients who binged one day or less in the past week were categorized as “improved” and those with no days binged in the past seven days were categorized as “abstinent” for that week. These categorizations are consistent with previous research (*DSM-IV* (APA, 1994) diagnostic requirements for BED).

BMI. Body weight was self-reported. Masheb and Grilo (2001) found that the correlation between self-reported and actual body weight was very high for obese adults with BED ($r = .99$). BMI was calculated by dividing weight in kilograms by height in meters squared. Clinically significant weight loss at 12 months posttreatment was also assessed. The NIH and NHLBI (1998) recommended that obese individuals lose 10% of their initial body weight, and research indicates that this amount of weight loss is associated with significant improvements in cardiovascular risk factors (NIH and NHLBI, 1998). Hence, obese patients in this study were dichotomously categorized as having achieved clinically significant weight loss if they lost 10% of their pretreatment weight by 12 months posttreatment. Otherwise, they were categorized as not having achieved clinically significant weight loss.

Psychological distress and eating disorder-related attitudes. We used the Center for Epidemiological Studies–Depression Scale (CES-D; Radloff, 1977) to measure depression. The CES-D is a 20-item self-report measure with a 4-point Likert-type scale; higher total scores indicate greater depressive symptoms. The mean total score for a normative sample was 9.25 ($SD = 8.58$) and for a clinical sample 24.42 ($SD = 13.51$; Radloff, 1977). In this study, coefficient alpha was .75.

The mean item total score of the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) was used as an assessment of interpersonal problems; higher scores indicated greater problems. The IIP has 64 items scored on a 5-point Likert-type scale. The mean for a normative sample was .97 ($SD = .48$) and for a clinical sample 1.48 ($SD = .56$; Hansen & Lambert, 1996). In this study, coefficient alpha for the total score was .93.

To assess self-esteem, the total score of the Rosenberg Self-Esteem Scale (RSES; Rosenberg,

1979) was used. The RSES is a 10-item measure scored on a 4-point Likert-type scale in which higher total scores represented greater self-esteem. The mean for a normative sample was 31.46 ($SD = 4.80$; Reynolds, 1988) and for a sample of individuals with BED 27.05 ($SD = 5.75$; Wilfley et al., 2002). Coefficient alpha for the sample in the current study was .90.

Eating disorder-related attitudes were assessed with the Three-Factor Eating Questionnaire (TFEQ; Stunkard & Messick, 1985). The TFEQ has 51 items scored dichotomously as true or false. The TFEQ has three subscales: Cognitive Restraint of Eating (21 items), Susceptibility to Hunger (14 items), and Disinhibition of Eating (16 items). Following Wilfley et al. (1993), higher scores on the Restraint scale indicated temperate food restraint among binge eaters. Higher scores on the other scales represented greater problems in those areas. Rizvi, Stice, and Agras (1999) reported normative TFEQ scale means as follows: Restraint = 9.3 ($SD = 4.8$), Hunger = 3.5 ($SD = 2.5$), and Disinhibition = 4.8 ($SD = 3.4$). Means for a BED sample were as follows: Restraint = 7.3 ($SD = 3.5$), Hunger = 10.4 ($SD = 2.4$), and Disinhibition = 14.1 ($SD = 1.5$; Wilfley et al., 1993). Coefficient alphas for the current sample were .79 for Restraint, .77 for Hunger, and .51 for Disinhibition. Coefficient alpha and mean interitem correlation ($r = .07$) for the Disinhibition scale were lower than commonly acceptable (Clark & Watson, 1995), so the Disinhibition scale was not used in this study.

Attachment. To predict treatment outcome, the Attachment Styles Questionnaire (ASQ; Feeney, Noller, & Hanrahan, 1994) was used at pretreatment. The ASQ is a 40-item self-report measure with a 6-point Likert-type scale. The ASQ can be scored as five scales: Confidence in Relationships, which measures secure attachment; Preoccupied and Need for Approval, both of which measure aspects of anxious attachment; and Discomfort With Closeness and Relationships as Secondary, both of which measure aspects of avoidant attachment. Brennan, Clark, and Shaver (1998) conducted a factor analysis and examined the factor loadings of 60 different attachment scales on two higher order factors of avoidance and anxiety. Of all of the self-report attachment measures, the ASQ Preoccupied and Discomfort With Closeness scales emerged with the first (.86) and second (.90) highest factor loadings on the anxiety and avoidance factors, respectively. The Need for Approval scale also had a high loading (.62) on the anxiety factor as did the Relationships as Secondary scale on the avoidance factor (.61). In the current sample, coefficient alphas

ranged from .70 to .83, and mean interitem correlations ranged from .20 to .41. Tasca et al. (2004) reported item means for a sample of women with anorexia nervosa: Confidence in Relationships, 3.04 ($SD = .98$); Preoccupied, 4.35 ($SD = .52$); Need for Approval, 4.25 ($SD = .58$); Discomfort With Closeness, 4.63 ($SD = .72$); and Relationships as Secondary, 3.07 ($SD = .62$).

Adherence to the manuals. The Tape Rating Instrument for Psychotherapy of Eating Disorders (TRIPED; Olmsted, Isaacs, Bemis, & Garner, 1988) was used to assess therapist adherence to the manuals. The TRIPED includes two scales that assess adherence to cognitive therapy (six items) and psychodynamic therapy (seven items) specifically designed for the treatment of eating disorders (Cognitive Therapy Adherence scale and Psychodynamic Therapy Adherence scale). Items were rated on a 7-point Likert-type scale (0–6); higher mean item ratings indicate greater adherence. Videotapes were assessed by two independent judges who were unaware of the treatment modality. The judges were one PhD clinical psychologist and one advanced graduate student in clinical psychology, who rated tapes independently of each other. Three sessions, one each from the early, middle, and late stages of treatment, were assessed by each judge. Judges attended four training sessions for a total of 30 h of training. Each scale achieved adequate coefficient alpha (Cognitive Therapy Adherence scale = .81; Psychodynamic Therapy Adherence scale = .93). Interrater reliability measured by intraclass correlation coefficient for the two raters using a two-way random effects model (Shrout & Fleiss, 1979) was high for each scale (Cognitive Therapy Adherence scale $\rho = .97$; Psychodynamic Therapy Adherence scale $\rho = .93$).

Procedure

Participants were referred by a health care professional or were self-referred by responding to a newspaper advertisement for treatment of binge eating at a center for eating disorders in an urban teaching hospital. Participants were screened by telephone by a research coordinator, who described the nature of the study, assessed for exclusion criteria, and assessed for the presence of binge eating and for *DSM-IV* criteria for BED with a semistructured interview. A total of 418 individuals were contacted by the research coordinator. Of those, 253 were not interested in participating in a study, met exclusion criteria, or did not meet criteria for BED by binge eating fewer than two days per week. The remaining 165 individuals were given an in-

person semistructured interview with a clinical psychologist to assess for BED. If there was agreement between the telephone interview and the in-person interview, then participants were randomized to one of the conditions. Nineteen individuals who passed the telephone screening did not meet diagnostic criteria for BED at the interview. Eleven individuals who were randomized to one of the conditions elected not to proceed, so no further assessments were conducted or no intervention was offered (GPIP $n = 2$; GCBT $n = 3$; control $n = 6$). As a result, 135 individuals assessed at pretreatment for study inclusion were randomized to one of the three study conditions (GPIP $n = 48$; GCBT $n = 47$; control $n = 40$).

In the control condition, patients were assessed, waited 16 weeks without treatment or any other contact from the center, and then were reassessed. After the reassessment, these individuals were offered group therapy for binge eating, so only their prewaiting and 16-week postwaiting data were used in this study as a control for the pre- versus posttreatment conditions. Individuals randomly assigned to one of the group treatments (GPIP or GCBT) were assessed pretreatment, given a pregroup preparation session, and then were given 16 weeks of one of the group therapies. In total, 10 therapy groups were formed (five GPIP and five GCBT). Participants in the GPIP and GCBT treatment groups were reassessed at posttreatment and at six months posttreatment with the same psychometric battery and interview. At 12 months posttreatment, patients in the GPIP and GCBT treatment conditions were contacted by telephone and were given a semistructured interview to assess for binge eating and self-reported weight. None of the therapists conducted any of the interview assessments. Group therapy sessions were videotaped for supervision and for the assessment of therapist adherence to the manuals. Patients provided informed consent, and the study was approved by the institution's research ethics board.

The Group Therapies

GPIP was conducted in a pregroup preparation plus 16 group therapy sessions using a detailed treatment manual (Tasca et al., 2002, in press). In GPIP, group therapy interactions are used as examples and prototypes of the patients' CRPs (Strupp & Binder, 1984) and of how CRPs may be modified. The pregroup preparation session was conducted by a psychologist who was not one of the group therapists. During the pregroup preparation, patients' CRPs, including their introject, were assessed. At the pregroup preparation, the roles of CRPs, attachment

needs, and negative affect in perpetuating binge eating were defined for each patient. The potential impact of each patient's CRP in group therapy interactions was also discussed. This information about each patient's CRP was given to the group therapist before the start of the therapy. In the early stage of the group, the therapist focused on understanding patients' CRPs and on helping to develop a cohesive working group (Yalom, 1995). In the middle stage, therapists challenged patients' CRPs as they were expressed in the group interactions, with the intent of modifying the interactions in the group and outside of the group. The late stage of therapy focused on loss and separation as universal stressors, and new CRP patterns and accompanying introjects were reinforced. Diet, weight-related issues, and dysfunctional cognitions specific to dietary restraint were not directly addressed by the therapist in this type of group therapy. This modality differs from IPT-G for BED (Wilfley et al., 1993) because GPIIP (a) focuses on here-and-now interactions among group members and with the therapist (Yalom, 1995) as well as relevant historical material from the patient's life; (b) uses the CRP and circumplex models and not social roles as defined by IPT (Klerman et al., 1984) to understand interpersonal patterns and introjects; and (c) uses a modified version of Malan's (1979) triangle of conflict to help patients understand the relationship among attachment needs, negative affect, and binge eating as a means of coping.

GCBT was conducted in a pregroup preparation session plus 16 group therapy sessions using a detailed treatment manual (Wilfley et al., 1996). This represented a modification of the original 20-session GCBT manual. This was done so that the GCBT and GPIIP treatments were delivered in the same number of sessions. The modification to the GCBT manual was accomplished by introducing the model and concepts in a pregroup preparation session and by condensing material on exercise, problem solving, and relapse prevention that was repeated across sessions. Treatment was aimed at reversing excessive dietary restriction, exposing participants to a wider range of foods, reducing rigid food rules and body image problems, and addressing cognitive distortions specific to eating disorders. The pregroup preparation was conducted by a psychologist who was not one of the group therapists. In the first stage of treatment, binge eating was addressed by establishing regular and flexible heart-healthy eating patterns. Moderate exercise and barriers to exercise were discussed. An eating and cognitions self-monitoring daily diary was used to highlight dysfunctional eating patterns and thinking. During the second stage, alternative coping strategies and

cognitions were presented, and fears associated with eating and loss of control were confronted. Identifying and challenging dysfunctional thought processes were discussed. There was an emphasis on problem solving of situations or events that may trigger a binge. The final stage was concerned with addressing reasonable weight expectations, lifestyle approaches to weight loss, and relapse prevention strategies. Thus, GCBT did not focus on dysfunctional interpersonal patterns.

Results

Preliminary Analyses

Mean item adherence ratings of three or less on TRIPED scales were considered suboptimal adherence. No GCBT therapist or GPIIP therapist had a mean item rating of three or less for their respective treatment modalities. Mean item ratings of GCBT and GPIIP therapists ($\pm SD$) were as follows: for Cognitive Therapy Adherence scale, GCBT = 4.11 ± 0.78 and GPIIP = 0.26 ± 0.33 , $F(1, 8) = 77.07$, $p < .001$, $d = 6.43$; for Psychodynamic Therapy Adherence scale, GCBT = 1.09 ± 0.52 and GPIIP = 4.06 ± 0.68 , $F(1, 8) = 45.52$, $p < .001$, $d = 4.91$. The effect size was calculated using Cohen's d (1988), which indicates a small ($> .20$), medium ($> .50$), or large ($> .80$) effect. The means for the two treatment modalities on their respective adherence scales were significantly different with a large effect and in the expected directions. To assess potential therapist effects, two additional assessments were conducted. First, all of the differences among GPIIP therapists' means and among GCBT therapists' means on their respective Adherence scales were small in size (all $d_s \leq .42$). Second, likelihood ratio χ^2 tests indicated no differences in the proportion of patients who dropped out of therapy among all therapists.

Equivalence of Conditions at Pretreatment

Table I shows the outcome data of treatment completers by study condition. There were no significant differences among the conditions at pretreatment on any of these variables. Treatment dropouts were defined as those who attended fewer than half of the sessions and who did not attend beyond the 12th session. Treatment dropouts were evenly distributed among the treatment conditions (GPIIP $n = 11$ [22.9%]; GCBT $n = 10$ [21.3%]). In the control condition, seven (17.5%) individuals who completed the assessment did not return for the reassessment after the 16-week wait. The three conditions did not differ in the distribution of missing data because of dropout, $\chi^2(2, N = 135) = .40$, $p = .82$. Patients who dropped out of treatment or the

Table I. Means and Standard Deviations of Outcome Variables by Study Condition for Treatment Completers.

Variable	Pretreatment		Posttreatment		6 months post.		12 months post.	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Days binged								
GPIP	4.11	1.35	1.11	1.90	1.06	1.81	1.46	2.10
GCBT	3.95	1.70	0.57	0.93	0.59	1.13	0.62	1.46
Control	4.00	1.52	3.58	2.03				
BMI (k/m ²)								
GPIP	40.03	9.69	39.85	9.37	38.09	8.75	37.67	8.93
GCBT	42.59	12.95	42.65	12.82	41.32	13.06	41.02	12.61
Control	42.58	9.57	41.63	9.57				
CES-D								
GPIP	24.65	9.14	16.81	13.13	17.81	6.55		
GCBT	25.19	13.32	19.03	13.62	19.61	11.30		
Control	23.84	9.93	23.30	12.28				
IIP								
GPIP	1.39	0.48	1.23	0.52	1.13	0.54		
GCBT	1.56	0.53	1.29	0.61	1.29	0.63		
Control	1.53	0.61	1.50	0.67				
RSES								
GPIP	25.14	5.72	25.72	2.27	31.39	3.61		
GCBT	24.66	6.40	26.17	2.64	23.76	3.46		
Control	26.07	5.54	26.32	1.97				
Dietary restraint (TFEQ)								
GPIP	7.86	4.28	8.75	3.94	8.79	4.29		
GCBT	6.69	4.01	8.52	3.75	8.97	4.19		
Control	8.10	4.20	6.63	3.82				
Hunger (TFEQ)								
GPIP	10.21	2.76	9.40	3.02	7.61	3.46		
GCBT	10.32	2.89	7.73	3.82	7.38	3.62		
Control	9.95	3.44	9.54	3.37				

Note. GPIP = group psychodynamic interpersonal psychotherapy ($n=37$); GCBT = group cognitive-behavioral therapy ($n=37$); BMI = body mass index; CES-D = Center for Epidemiological Studies-Depression Scale; IIP = Inventory of Interpersonal Problems; RSES = Rosenberg Self-Esteem Scale; TFEQ = Three-Factor Eating Questionnaire. Data were not collected six months post- and 12 months posttreatment for the control condition ($n=33$). Only days binged in the past seven days and BMI were collected at 12 months posttreatment for GPIP and GCBT conditions. At six months posttreatment GPIP $n=35$, GCBT $n=32$.

control condition did not provide data beyond pretreatment. At six months posttreatment, an additional five people from GCBT and two from GPIP did not provide follow-up data. At 12 months posttreatment, the interviews to evaluate days binged and BMI were done by phone. All of the completers provided data at 12 months, including those who did not provide follow-ups at six months posttreatment.

There were no significant differences in treatment attendance between the therapy conditions. GPIP participants attended a mean of 12.35 ($SD=4.41$) sessions and GCBT participants a mean of 11.77 ($SD=4.11$) of 16 sessions, $t(93)=0.68$, $p=.50$, $d=.13$. All patients attended the pregroup preparation.

Initial Inspection of the Data

Burlingame, Kircher, and Taylor (1994) indicated that there may be dependent observations in group

therapy research because of the nested nature of the data. To assess for the potential random effect of each therapy group, an intraclass correlation for each outcome variable at all time points was calculated using hierarchical linear modeling (HLM; Raudenbush & Bryk, 2002) for individuals nested within groups for each treatment condition. It was estimated that an intraclass correlation of .05 to .15 was a moderate violation of the independence assumption, which required an adjustment of the p value to .01 for that analysis (Stevens, 2002). The intraclass correlation coefficient was less than .05 for each variable at each time point except for the Hunger scale at posttreatment ($\rho=.11$). So analyses were not nested within groups, but the p values of analyses involving the Hunger scale at posttreatment were adjusted to .01.

Variables were normally distributed (z scores, $p<.001$), and there were no univariate (z scores,

$p < .001$) or multivariate (Mahalanobis D , $p < .001$) outliers, with two exceptions. First, post-, 6-month post-, and 12-month posttreatment days binged were positively skewed for each treatment condition and there were outliers. Because of the diagnostic and clinical importance of this outcome variable, parametric tests were conducted as planned, and nonparametric tests were conducted comparing the study conditions on the number of individuals with no days binged in the past seven days (abstinent) versus those who continued to binge. Second, one case was a univariate outlier for BMI for the GCBT condition at all time points. There were no differences in the results when analyses of BMI were conducted with or without this case. So the case was retained and reported in all analyses.

Outcomes at Posttreatment and Follow-Ups

Data from treatment completers are presented and analyzed next. Parallel analyses were conducted with an intention-to-treat approach to missing data resulting from dropouts. That is, when there were missing data, the last available observation (e.g., at pretreatment) for that individual was carried forward (e.g., entered as the posttreatment score; Montori & Guyatt, 2001). When the parallel analyses were repeated with the intention-to-treat data, the statistical significance did not change for any of the results reported here. Pretreatment correlations among outcome variables for the total sample of completers ($N=107$) and among attachment variables for women who received treatment ($n=66$) appear in Table II.

An HLM approach to the data was deemed appropriate because the variability of pretreatment outcome measures was assessed at Level 1, and in all cases the variables were found to be random across individuals. HLM allowed the assumption of fixed effects at pretreatment to be relaxed and to test a model with random intercepts at Level 2. To test pre-

to posttreatment outcomes across the three conditions (GCBT, GPIP, control), the interactions between the linear slopes of the outcome data (pre- to posttreatment) and condition (GCBT, GPIP, control) were evaluated. Conditions were dummy coded, and pairs of conditions were compared in each analysis. A linear slope was modeled at Level 1: $Y = \beta_0 + \beta_1(\text{time}) + r$, and the interaction between the linear slope and comparisons among pairs of conditions was modeled at Level 2: $\beta_1 = \gamma_{10} + \gamma_{11}(\text{GCBT}) + \gamma_{12}(\text{GPIP})$ or $\beta_1 = \gamma_{10} + \gamma_{11}(\text{GCBT}) + \gamma_{12}(\text{control})$. The top half of Table III indicates the coefficients and associated t values for the interaction between linear slope and each pair of compared conditions at Level 2. Both GCBT and GPIP showed significant positive change from pre- to posttreatment compared with the control condition in days binged, IIP, and Cognitive Restraint of Eating. No differences were noted in the slopes of these variables when GCBT and GPIP were compared. The GPIP condition resulted in significantly lower depression (CES-D) scores at posttreatment compared with the control condition, but no differences were noted between GPIP and GCBT or between GCBT and the control condition. As stated, a p value $< .01$ was used for Hunger. The GCBT condition resulted in marginally significantly lower Hunger scores than the control condition at posttreatment ($p = .014$). No difference in the Hunger slopes were noted when GPIP was compared with the control condition or the GCBT condition. There were no significant differences in BMI slopes across conditions.

To assess whether significant changes occurred from pretreatments to follow-ups, linear and quadratic slopes and their interactions with treatment type (GCBT and GPIP) were evaluated for each outcome variable. The lower half of Table III indicates the coefficients and t values for the slopes and interactions of treatment type and slopes. Linear and quadratic slopes were modeled at Level 1: $Y = \beta_0 + \beta_1(\text{linear}) + \beta_2(\text{quadratic}) + r$, and the inter-

Table II. Pretreatment Correlations Among Outcome Variables for the Entire Sample ($N=107$; Bottom of Diagonal) and Among Attachment Style Questionnaire Variables for Women in the Treatment Conditions ($N=66$; Top of Diagonal).

Scale			Preoccupied	Need for Approval	Discomfort Closeness	Relationship Secondary Variable	
BMI	.13	—	-.49 ^a	-.67 ^a	-.69 ^a	-.17	Confidence
CES-D	.18	.17	—	.36 ^b	.38 ^b	.07	Preoccupied
IIP	.12	.04	.51 ^a	—	.51 ^a	.29 ^c	Need for Approval
RSES	.00	-.17	-.63 ^a	-.47 ^a	—	.25 ^d	Discomfort Closeness
Restraint	-.09	-.23 ^c	-.11	.07	.11	—	
Hunger	.05	.11	.16	.20 ^d	-.12	-.10	
Variable	Days binged	BMI	CESD	IIP	RSES	Restraint	

Note. BMI = Body Mass Index; CES-D = Center for Epidemiological Studies—Depression Scale; IIP = Inventory of Interpersonal Problems; RSES = Rosenberg Self-Esteem Scale. ^a $p < .001$. ^b $p = .003$. ^c $p = .02$. ^d $p = .04$.

Table III. Hierarchical Linear Modeling Coefficients (γ) and t values for Pre- to Posttreatment Linear Models and for Pre-Treatment to Follow-Ups Linear and Quadratic Models.

	Days binged		BMI		CES-D ^a		IIP		RSES		Restraint		Hunger	
	γ	t	γ	t	γ	t	γ	t	γ	t	γ	t	γ	t
Compared conditions: pre- to posttreatment linear modeling of outcome variables ⁱ														
GCBT vs.C	-1.41	-7.71 ^b	.71	.80	-2.47	-1.60	-.15	-2.42 ^f	-.32	-.62	1.09	2.20 ^d	-.96	-2.48 ^h
GPIP vs. C	-1.43	-5.75 ^b	.24	.28	-3.64	-2.36 ^c	-.14	-2.25 ^g	-.40	-.78	1.14	2.33 ^c	-.15	-.39
GCBT vs. GPIP	.27	1.37	-.46	-.55	-1.17	-.79	.01	.19	-.09	-.17	.07	.14	.81	2.19
Slopes: pretreatment to follow-ups linear and quadratic modeling of outcome variables ^k														
Linear	-5.50	-9.09 ^b	1.35	.56	-14.81	-2.51 ^h	-16	-2.69 ⁱ	4.44	1.43	1.82	.81	-4.21	-2.35 ^c
Treatments	.18	.61	-1.10	-.75	-2.56	-.87	.02	.42	-2.87	-2.44 ^f	1.01	.98	1.21	1.44
Quadratic	.86	6.14 ^b	-.29	-.59	2.70	1.61	.02	.23	-2.29	-2.44 ^f	-.08	-.12	.72	1.39
Treatments	.00	.05	.14	.30	.79	.88	.04	.91	1.73	3.80 ^b	-.39	-1.15	-.32	1.19

Note. BMI = body mass index; CES-D = Center for Epidemiological Studies–Depression Scale; IIP = Inventory of Interpersonal Problems; RSES = Rosenberg Self-Esteem Scale; GCBT = group cognitive–behavioral therapy; GPIP = group psychodynamic interpersonal psychotherapy; Treatments = GCBT and GPIP conditions only; C = control.

^aHeterogenous Level 1 error variances were used for these variables because of a significantly lower deviance statistic compared with the homogenous Level 1 model. ^b $p < .001$. ^c $p = .018$. ^d $p = .028$. ^e $p = .02$. ^f $p = .016$. ^g $p = .024$. ^h $p = .014$. ⁱ $p = .008$. ^jLevel 1: $Y = \beta_0 + \beta_1(\text{time}) + r$; Level 2: $\beta_1 = \gamma_{10} + \gamma_{11}(\text{GCBT}) + \gamma_{12}(\text{GPIP})$, or $\beta_1 = \gamma_{10} + \gamma_{11}(\text{GCBT}) + \gamma_{12}(\text{Control})$. ^kLevel 1: $Y = \beta_0 + \beta_1(\text{linear}) + \beta_2(\text{quadratic}) + r$; Level 2: $\beta_1 = \gamma_{10} + \gamma_{11}(\text{treatment type})$ and $\beta_2 = \gamma_{20} + \gamma_{21}(\text{treatment type})$.

actions were modeled at Level 2: $\beta_1 = \gamma_{10} + \gamma_{11}(\text{treat- treatment type})$ and $\beta_2 = \gamma_{20} + \gamma_{21}(\text{treatment type})$. There was a linear and quadratic effect for days binged but no interactions of these slopes with treatment type. This indicated that both treatments resulted in significant reductions in days binged from pre- to posttreatment, that these changes were maintained to 12 months posttreatment, and that there were no differences between treatments in the linear or quadratic curves. No significant effects were evident for BMI, suggesting no significant change from pretreatment to 12 months follow-up. There was a significant linear slope for depression and interpersonal problems, indicating that across both treatments there were reductions in these symptoms from pretreatment to six months posttreatment. For self-esteem, the Treatment \times Quadratic Slope interaction suggested that patients improved by post-treatment and maintained improvements to six months posttreatment. However, the significant interaction indicated that the significant quadratic slope was due to improvements for patients in the GPIP condition only. There were no significant effects noted for the Cognitive Restraint of Eating scale, suggesting no change from pretreatment to six months posttreatment. The significant linear effect for Hunger suggested that patients improved from pretreatment to six months posttreatment on this variable across both treatments.

Clinical Significance

Patients were categorized as improved if they binged fewer than two days/week in the past week and as abstinent if they did not binge in the past week. There were fewer individuals in the control condition who were classified as improved, $\chi^2(2, N = 107) = 46.05$, $p < .001$, or abstinent, $\chi^2(2, N = 107) = 24.74$, $p < .001$, of binge eating compared with the GPIP and GCBT conditions (Table IV). Separate chi-square analyses showed no differences between the GPIP and the GCBT conditions in the distribution of improved or abstinent individuals at posttreat-

ment, six months posttreatment, or 12 months posttreatment. At 12 months posttreatment, 26.2% of obese participants receiving treatment achieved clinically significant weight loss (i.e., 10% weight loss or greater compared with their pretreatment weight). There were no differences between the two therapy conditions in the distribution of those achieving this weight loss, $\chi^2(1, N = 65) = 1.79$, $p = .181$.

Attachment Scales \times Treatment Interaction

Some attachment researchers have reported that women are more likely to be preoccupied (anxious) and men more likely to be dismissing (avoidant; Alexander, Feeney, Hohaus, & Noller, 2001; Bartholomew & Horowitz, 1991; Lessard & Moretti, 1998). Because of the gender differences that have been found, only data from women in the current study were analyzed. Of the 135 participants in this study, 95 were randomized to one of the two treatment conditions; of those, 85 were women. Sixty-seven women completed the treatments and 19 dropped out (GCBT $n = 8$, GPIP $n = 11$). Of the 67 women completers, one had incomplete attachment data, and so the sample for these analyses consisted of 66 women (GCBT $n = 33$; GPIP $n = 33$).

To assess whether the women with BED who completed treatment versus those who dropped out differed on the attachment scales at pretreatment, a 2 (GCBT vs. GPIP) \times 2 (completers vs. dropouts) multivariate analysis of variance was conducted on the five ASQ scales (Table V). The multivariate test indicated a significant Treatment Type \times Dropout interaction, $F(5, 77) = 4.42$, $p = .001$, $\eta^2 = .22$. Univariate tests of the interactions indicated that the significant effect was for the Relationships as Secondary scale only, $F(1, 81) = 3.96$, $p = .05$, $\eta^2 = .05$. Follow-up univariate tests indicated that, for those receiving GCBT, higher scores on the Relationships as Secondary scale were associated with dropping out of treatment, $F(1, 39) = 8.10$, $p = .007$,

Table IV. Percent of Binge Eating–Disordered Patients Improved and Abstinent for Days Binged in the Past 7 Days by Study Condition.

Condition	Posttreatment		Six months post.		12 months post.	
	Improved	Abstinent	Improved	Abstinent	Improved	Abstinent
GPIP	75.7	59.5	86.5	62.2	78.4	56.8
GCBT	86.5	62.2	75.7	64.9	73.0	67.7
Control	12.1	9.1				

Note. GPIP = group psychodynamic interpersonal psychotherapy ($n = 37$); GCBT = group cognitive–behavioral therapy ($n = 37$). These data represent treatment completers only. Data were not collected 6 months posttreatment and 12 months posttreatment for individuals in the control condition ($n = 33$), who were offered group treatment after the 16-week waiting period. At 6 months posttreatment GPIP $n = 35$, GCBT $n = 32$. “Improved” indicates fewer than 2 days binged in the past 7 days, and “abstinent” indicates no days binged in the past 7 days. Those categorized as “abstinent” are also counted in the “improved” category.

$\eta^2 = .17$. The follow-up univariate test for GPIIP was not significant.

An Aptitude \times Treatment interaction design (Pedhazur, 1997) was used to assess whether pretreatment attachment scales interacted with therapy type to predict change in days binged. Residual change scores of days binged from pre- to posttreatment were used as the outcome variable; lower residual change scores indicate better outcomes. Treatment type (GCBT or GPIIP) was dummy coded and entered first in a hierarchical multiple regression. Attachment scores from each of the five ASQ scales were entered in the second step, and the interactions of each attachment scale with treatment type were entered in the third step. The hierarchical regression yielded nonsignificant effects for treatment type (Step 1: $R^2 = .021$), $F(1, 64) = 1.39$, $p = .243$, and for attachment scales (Step 2: $R^2_{\Delta} = .058$), $F(5, 59) = 0.74$, $p = .594$. As predicted, a significant effect was found for the Attachment Scales \times Treatment Type interaction (Step 3: $R^2_{\Delta} = .184$), $F(5, 54) = 2.70$, $p = .03$. The Need for Approval Scale \times Treatment Type interaction was significant, $B = -0.56$, $t(54) = -3.37$, $p = .001$, $pr = -.42$. The positive correlation between Need for Approval and residual change in days binged within the GCBT condition ($r = .48$, $p < .003$) and the negative correlation within the GPIIP condition ($r = -.36$, $p = .02$) were each significant and medium sized. These results suggested that there was a difference between the two treatments in the way in which outcome varied as a function of this scale of attachment anxiety. Higher need for approval was related to greater treatment gains in GPIIP and to less treatment gains in GCBT. Lower need for approval was related to greater treatment gains in GCBT and less treatment gains in GPIIP. The hypothesis that those with attachment avoidance would benefit more from GCBT was not supported but, as noted, those

with higher Relationships as Secondary scores tended to drop out of GCBT.

Discussion

The first goal of this study was to test a new therapy for BED to provide broader treatment options for patients and to test a shorter version of GCBT. The results indicated that GPIIP and GCBT resulted in greater reductions in days binged than a control condition at posttreatment and these gains persisted to 12 months posttreatment for both modalities. This suggests that GPIIP is a potentially useful treatment for BED, with outcomes in the range consistent with those achieved by GCBT. When examining the percentage of patients who were abstinent for the past seven days at 12 months posttreatment, the results were consistent with those reported by previous studies using GCBT (Agras, Telch, Arnow, Eldredge, & Marnell, 1997; Wilfley et al., 2002).

Other outcome variables also indicated that both GPIIP and GCBT resulted in improvements compared with a control condition for psychological distress and eating disorder-related attitudes, and these improvements were evident up to six months posttreatment. However, there were some differences between the two modalities. GPIIP resulted in significantly lower depression scores compared with the control condition at posttreatment, whereas GCBT and the control condition were not significantly different. In addition, GPIIP, and not GCBT, had a significant positive impact on self-esteem at six months posttreatment. The greater emphasis on the exploration of affect and self-concept in GPIIP treatment compared with GCBT may have contributed to these differences. On the other hand, improvement was noted in susceptibility to hunger for GCBT, and not GPIIP, at posttreatment. The specific emphasis placed on loss of control of eating

Table V. Item Means and Standard Deviations of Attachment Variables by Completion Status for Women With Binge Eating Disorder at Pretreatment.

	Completers				Dropouts			
	GCBT		GPIIP		GCBT		GPIIP	
Attachment	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Confidence	3.63	0.84	3.77	0.97	3.43	0.69	3.72	0.68
Preoccupied	4.16	0.74	3.55	0.74	3.90	0.93	4.01	0.55
Need for Approval	3.39	0.95	3.43	0.67	3.88	0.88	3.29	0.67
Discomfort with Closeness	3.99	0.78	3.81	0.79	3.89	0.78	4.26	0.45
Relationships as Secondary	2.60	0.57	2.65	0.66	3.27	0.69	2.67	0.62

Note. GPIIP = Group Psychodynamic Interpersonal Psychotherapy; GCBT = Group Cognitive-Behavioral Therapy. Completer, $n = 66$ (GCBT $n = 33$; GPIIP $n = 33$); dropouts $n = 19$ (GCBT $n = 8$; GPIIP $n = 11$).

and improved diet during GCBT treatment may account for this finding.

The sample sizes in each of the treatment conditions were not large enough to test a hypothesis of treatment equivalence. However, the small effect sizes for differences between GCBT and GPIP on days binged at all time points (all d s $< .23$) suggested that the two treatments may be equivalent for these outcomes. Future research examining differential outcomes and active ingredients could shed light on whether there are differing therapeutic elements of GPIP or GCBT that result in positive outcomes.

There was no statistically significant effect of the treatments on BMI in this study. However, the two therapy conditions in this study were associated with weight loss in the range necessary for positive health outcomes among more than 25% of obese individuals in this sample (NIH and NHLBI, 1998). For these individuals, the treatments may have stemmed the risk of increased obesity over time that often is associated with BED (Fairburn et al., 2000).

The second goal of the study was to test an Attachment Scales \times Treatment interaction. As predicted, the results of this study indicated that lower need for approval (attachment anxiety) was associated with more benefit at posttreatment from a therapy that focused on learning skills to overcome binge eating (i.e., GCBT). Individuals with lower attachment anxiety likely had the personal and emotional resources available to benefit from a structured therapy geared toward skill development. Higher need for approval was associated with less therapeutic progress in GCBT. The didactic nature of GCBT may not have been challenging enough emotionally to alter the relationship patterns underlying binge eating for those with higher attachment anxiety.

Higher need for approval was associated with greater benefits at posttreatment from a therapy that required affective expression, self-reflection, and interpersonal exploration (i.e., GPIP). Slade (1999) suggested that a central therapeutic task for those with anxious attachments might be to reflect on affective experience rather than simply to respond to affect. GPIP may have allowed individuals with greater attachment anxiety to make more use of group therapy. On the other hand, those with lower attachment anxiety may have found the GPIP treatment modality useful but not directly pertinent to their need to learn the skills necessary to overcome bingeing. These results are consistent with a distinction drawn by Mallinckrodt (2000) between skill deficits versus dispositions. Dispositional problems are related to insecure attachments (Mallinckrodt, 2000). Future research on skills deficits versus dispositional problems and their relationship

to differential responses to psychotherapies could shed light on these issues.

Wonderlich et al. (2001) reported that as many as 40% of individuals with BED may not benefit from treatments in clinical trials. A potential remedy to this problem is to match patients to a therapy type that is best suited to their specific attributes. The results of the current study, although based on a small sample, point to future research in which patients with BED are matched to treatment type based on their pretreatment level of attachment anxiety. Those with BED who report lower levels of attachment anxiety could be matched to GCBT, and those who report higher levels of attachment anxiety could be matched to GPIP. Matched individuals could be compared with those who were mismatched to treatment. One could hypothesize that matched individuals would realize better outcomes in binge eating than those who were mismatched.

The hypothesis that individuals with high levels of attachment avoidance would benefit more from GCBT than those with low levels of attachment avoidance was not supported. Further, there was evidence that those with higher Relationships as Secondary scores dropped out of GCBT at a higher rate. It is possible that GCBT treatment completers were underrepresented by those with higher avoidant attachments. Thus, any relationship between attachment avoidance and binge eating outcomes among those receiving GCBT may have been difficult to find.

The finding that women who dropped out of GCBT had higher Relationships as Secondary scores is similar to those reported by Tasca et al. (2004), who found that women with anorexia nervosa purging subtype who reported higher Relationships as Secondary tended to drop out of a group-based partial hospital treatment. These studies suggest that attachment avoidance, and the devaluation of relationships in particular, may indicate a high risk of dropping out of group treatment, and GCBT in particular. The results of the current study are contrary to Horowitz et al.'s (1993) suggestion that those with attachment avoidance may benefit more from CBT. GCBT as delivered in this study was educational in nature and did not focus on problematic interpersonal interactions. The tendencies among those with attachment avoidance to be less sensitive to positive therapeutic interactions and to disengage from help providers (Chen & Mallinckrodt, 2002; Dozier, 1990) were not directly addressed by GCBT. These tendencies, however, were likely identified and targeted in GPIP. A better understanding of the interaction between attachment avoidance and treatment modalities is needed to help reduce the tendency among these individuals

to disengage from help providers and to drop out of treatment (Dozier, 1990; Tasca et al., 2004).

There are several limitations to this study. First, for compassionate and ethical reasons, group therapy was offered to patients in the control condition after waiting 16 weeks. Hence, there were no follow-up data beyond posttreatment for the control condition. This limits conclusions that can be made about the longer term impact of GPIP and GCBT. Also, although patients in the control condition agreed not to seek new treatment while waiting, some may have done so, and this may have reduced differences between the treatment and control conditions. Second, one could argue that because therapists did not cross over treatment modalities a potential therapist effect bias was introduced. It was decided to recruit therapists who identified specific allegiances and expertise in psychodynamic–interpersonal or cognitive–behavioral therapies to test the treatments as they may be delivered by experts and in a clinical setting. Multiple therapists within each condition and the requirement that therapists adhere to a manual likely attenuated any individual therapist effect. There was no evidence, for example, that patients dropped out of any group at different rates. Third, researcher and therapist allegiance to one of the therapeutic modalities may have introduced some bias (Robinson, Berman, & Neimeyer, 1990). Recruiting therapists with specific therapeutic allegiances to GCBT or GPIP and the evaluation of therapist treatment fidelity likely reduced the potential influence of investigator allegiance to one of the therapy modalities. Future outcome trials could bypass this potential bias by having multialliance research teams (Westen, Novotny, & Thompson-Brenner, 2004). However, it is possible that the positive outcomes for GPIP in this study may have been influenced by the research team's bias in favor of this treatment modality. Fourth, participants from this study were predominantly women, Caucasian, from middle-income families, and well educated, thus potentially limiting the generalizability of the results. However, these sample characteristics are similar to those found in a community-based sample (Striegel-Moore, Wilson, Wilfley, Elder, & Brownell, 1998) and a treatment sample (Wilfley et al., 2002). Fifth, body weight was collected by self-report, which was likely not as accurate as direct measurement by scale, potentially limiting the validity of these data. However, correlations between self-report and direct measurement have been shown to be extremely high for adults with BED (Masheb & Grillo, 2001).

Sixth, one could argue that the 7-day evaluation period was too short to provide a reliable assessment of a symptom that may fluctuate over time (Stunkard

& Allison, 2003). Studies have used seven days, 14 days, or 28 days as the period for which binge eating was assessed (e.g., Agras et al., 1997; Wilfley et al., 1993, 2002). Loeb, Pike, Walsh, and Wilson (1994) reported a very high correlation between 7-day and 28-day self-report assessments of binge eating ($r = .96$). The 7-day period was used in this study because patients often had difficulty remembering specific daily eating and binge eating episodes beyond that period of time. This is consistent with research suggesting that detailed memories for complex behaviors such as binge eating are difficult to recall accurately one week to several weeks later (Friedman & deWinstanley, 1998; Stein & Cortes, 2003). The accuracy of the assessment of binge eating is an important underresearched area that has implications for the concurrent validity of its measurement.

Finally, Axis I and Axis II comorbid disorders were not thoroughly assessed. If these comorbid disorders varied across conditions, then outcomes may have been affected.

This research adds to the growing evidence of the utility of GCBT for the treatment of BED and for GCBT provided in a slightly shortened format. The current study provides the first test of the potential value of GPIP as another treatment option for patients with BED. GPIP yielded outcomes that were comparable to those achieved by GCBT, both treatments were better than receiving no treatment for 16 weeks, and treatment effects were maintained up to one year posttreatment. Women with BED who had lower attachment anxiety and who received GCBT had decreased binge eating symptoms at posttreatment possibly because the more structured nature of the therapy targeted skills deficits that may have precipitated and perpetuated their binge eating. Also, those with high attachment avoidance tended to drop out of GCBT at a higher rate. Women with BED with higher attachment anxiety and who received GPIP tended to have decreased binge eating symptoms at posttreatment possibly because GPIP focused on expressing affect, exploring relationship patterns, and encouraging these patients to be self-reflective. Women with BED are likely diverse and may respond best to different treatment modalities at posttreatment based on their pretreatment level of anxious and avoidant attachment.

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References

- Agras, W. S., Telch, C. F., Arnow, B., Eldredge, K., & Marnell, M. (1997). One-year follow-up of cognitive-behavioral therapy for obese individuals with binge eating disorder. *Journal of Consulting and Clinical Psychology, 65*, 343–347.
- Alexander, R., Feeney, J., Hohaus, L., & Noller, P. (2001). Attachment style and coping resources as predictors of coping strategies in the transition to parenthood. *Personal Relationships, 8*, 137–152.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC.
- Ardevini, C., Caputo, G., Todisco, P., & Dalle Grave, R. (1999). Binge eating and restraint model: Psychometric analysis in binge eating disorder and normal weight bulimia. *European Eating Disorders Review, 7*, 293–299.
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality & Social Psychology, 61*, 226–244.
- Benjamin, L. S. (1996). *Interpersonal diagnosis and treatment of personality disorders* (2nd ed.). New York: Guilford Press.
- Bowlby, J. (1988). *A secure base*. New York: Basic Books.
- Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). New York: Guilford Press.
- Burlingame, G. M., Kircher, J. C., & Taylor, S. (1994). Methodological considerations in group psychotherapy research: Past, present and future practices. In A. Fuhrman & G. M. Burlingame (Eds.), *Handbook of group psychotherapy* (pp. 41–80). New York: Wiley.
- Chen, E. C., & Mallinckrodt, B. (2002). Attachment, group attraction, and self-other agreement in interpersonal circumplex problems and perceptions of group members. *Group Dynamics, 6*, 311–324.
- Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment, 7*, 309–319.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.
- De Rubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology, 66*, 37–52.
- Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology, 2*, 47–60.
- Fairburn, C. G., & Cooper, Z. (1993). The Eating Disorder Examination (12th ed.). In C. G. Fairburn & G. T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment* (pp. 317–360). New York: Guilford Press.
- Fairburn, C. G., Cooper, Z., Doll, H. A., Norman, P., & O'Connor, M. (2000). The natural course of bulimia nervosa and binge eating disorder in young women. *Archives of General Psychiatry, 57*, 659–665.
- Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment. In M. B. Sperling & W. H. Berman (Eds.), *Attachment in adults* (pp.128–151). New York: Guilford Press.
- Friedman, W. J., & deWinstanley, P. A. (1998). Changes in the subjective properties in autobiographical memories with the passage of time. *Memory, 6*, 367–381.
- Gelenberg, A. J., & Chesen, C. L. (2000). How fast are antidepressants? *Journal of Clinical Psychiatry, 61*, 712–721.
- Grilo, C. M., Masheb, R. M., Lozano-Blanco, C., & Barry, D. T. (2004). Reliability of the eating disorder examination in patients with binge eating disorder. *International Journal of Eating Disorders, 35*, 80–85.
- Hansen, N. B., & Lambert, M. J. (1996). Brief report: Assessing clinical significance using the Inventory of Interpersonal Problems. *Assessment, 3*, 133–136.
- Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of Interpersonal Problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*, 885–892.
- Horowitz, L. M., Rosenberg, S. E., & Bartholomew, K. (1993). Interpersonal problems, attachment styles and outcome in brief dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 549–560.
- Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression*. New York: Basic Books.
- Lessard, J. C., & Moretti, M. M. (1998). Suicidal ideation in an adolescent clinical sample: Attachment patterns and clinical implications. *Journal of Adolescence, 21*, 383–395.
- Loeb, K. L., Pike, K. M., Walsh, B. T., & Wilson, G. T. (1994). Assessment of diagnostic features of bulimia nervosa: Interview versus self-report format. *International Journal of Eating Disorders, 16*, 75–81.
- Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics*. London: Butterworths.
- Mallinckrodt, B. (2000). Attachment, social competencies, social support, and interpersonal process in psychotherapy. *Psychotherapy Research, 10*, 239–266.
- Marcus, M. D. (1997). Adapting treatment for patients with binge eating disorder. In D. Garner & P. Garfinkel (Eds.), *Handbook of treatment of eating disorders* (pp. 484–493). New York: Guilford Press.
- Masheb, R. M., & Grilo, C. M. (2001). Accuracy of self-reported weight in patients with binge eating disorder. *International Journal of Eating Disorders, 29*, 29–36.
- Montori, V. M., & Guyatt, G. H. (2001). Intention-to-treat principle. *Canadian Medical Association Journal, 13*, 1339–1341.
- National Institutes of Health and National Heart, Lung and Blood Institute. (1998). Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults: The evidence report. *Obesity Research, 6* (Suppl.), 5–210.
- Olmsted, M. P., Isaacs, P., Bemis, K., & Garner, D. M. (1988). Tape rating instrument for psychotherapy of eating disorders (TRIPED). Unpublished manuscript.
- Pedhazur, E. J. (1997). *Multiple regression in behavioral research* (3rd ed.). Orlando, FL: Harcourt.
- Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385–401.
- Raudenbush, S. W., & Bryk, A. S. (2002). *Hierarchical linear models* (2nd ed.). London: Sage.
- Reynolds, W. M. (1988). Measurement of academic self concept in college students. *Journal of Personality Assessment, 52*, 223–240.
- Rizvi, S. L., Stice, E., & Agras, W. S. (1999). Natural history of disordered eating attitudes and behaviors over a 6-year period. *International Journal of Eating Disorders, 26*, 406–413.
- Robinson, L. A., Berman, J. S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: A comprehen-

- sive review of controlled outcome research. *Psychological Bulletin*, 108, 30–49.
- Rosenberg, M. (1979). *Conceiving the self*. New York: Basic Books.
- Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin*, 86, 420–428.
- Slade, A. (1999). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. R. Shaver (Eds), *Handbook of attachment* (pp. 575–594). New York: Guilford Press.
- Stein, K. F., & Corte, C. M. (2003). Ecologic momentary assessment of eating disordered behaviors. *International Journal of Eating Disorders*, 34, 349–360.
- Stevens, J. (2002). *Applied multivariate statistics for the social sciences* (4th ed.). Mahwah, NJ: Erlbaum.
- Stickney, M. I., Miltenberger, R. G., & Wolff, G. (1999). A descriptive analysis of factors contributing to binge eating. *Journal of Behavior Therapy and Experimental Psychiatry*, 30, 177–189.
- Striegel-Moore, R. H., & Franko, D. L. (2003). Epidemiology of binge eating disorder. *International Journal of Eating Disorders*, 34(Suppl.), 19–29.
- Striegel-Moore, R. H., Wilson, G. T., Wilfley, D. E., Elder, K. A., & Brownell, K. D. (1998). Binge eating in an obese community sample. *International Journal of Eating Disorders*, 23, 27–37.
- Stunkard, A. J., & Allison, A. C. (2003). Binge eating disorder: Disorder or marker? *International Journal of Eating Disorders*, 34(Suppl.), 107–116.
- Stunkard, A. J., & Messick, S. (1985). The Three-Factor Eating Questionnaire to measure dietary restraint, disinhibition and hunger. *Journal of Psychosomatic Research*, 29, 71–83.
- Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy*. New York: Basic Books.
- Tasca, G. A., Mikail, S., & Hewitt, P. (2002). Group psychodynamic interpersonal psychotherapy: A manual for time limited treatment of binge eating disorder. Unpublished manuscript.
- Tasca, G. A., Mikail, S., & Hewitt, P. (in press). Group psychodynamic interpersonal psychotherapy: Summary of a treatment model and outcomes for depressive symptoms. In M. E. Ablon (Ed.), *Trends in psychotherapy research* (chapter 7). Hauppauge, NY: Nova Science.
- Tasca, G. A., Taylor, D., Bissada, H., Ritchie, K., & Balfour, L. (2004). Attachment predicts treatment completion in an eating disorders partial hospital program among women with anorexia nervosa. *Journal of Personality Assessment*, 83, 201–212.
- Telch, C. F., & Stice, E. (1998). Psychiatric comorbidity in women with binge eating disorder: Prevalence rates from a non-treatment-seeking sample. *Journal of Consulting and Clinical Psychology*, 66, 768–776.
- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130, 631–663.
- Wilfley, D. E. (1993). Interpersonal psychotherapy adapted for group (IPT-G) and for the treatment of binge eating disorder: Therapist manual. Unpublished manual.
- Wilfley, D. E., Agras, W. S., Telch, C. F., Rossiter, E., Schneider, J. A., Cole, A. G., et al. (1993). Group cognitive-behavioral therapy and group interpersonal therapy for the nonpurging bulimic individual: A controlled comparison. *Journal of Consulting and Clinical Psychology*, 61, 296–305.
- Wilfley, D. E., Stein, R. I., Friedman, M. A., Beren, S. A., & Wiseman, C. V. (1996). Group cognitive-behavioral therapy for binge eating disorder. Unpublished manuscript.
- Wilfley, D. E., Welch, R. R., Stein, R. I., Spurrell, E. B., Cohen, L. R., Saelens, B. E., et al. (2002). A randomised comparison of group cognitive-behavioral therapy and group interpersonal psychotherapy for the treatment of overweight individuals with binge eating disorder. *Archives of General Psychiatry*, 59, 713–721.
- Wonderlich, S. A., Mitchell, J. E., Peterson, C. B., & Crow, S. (2001). Integrative cognitive therapy for bulimic behavior. In R. H. Striegel-Moore & L. Smolak (Eds), *Eating disorders: Innovative directions in research and practice* (pp. 173–195). Washington, DC: American Psychological Association.
- Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.

Zusammenfassung

Bindungsskalen sagen den Erfolg in einer randomisierten und kontrollierten Studie mit zwei Gruppentherapien für Essanfallstörungen voraus: Eine Interaktion von Fähigkeit und Behandlung

135 Patienten mit Essanfallstörungen wurden dem Zufall nach entweder einer Kontrollbedingung oder einer von zwei 16-stündigen Gruppentherapien zugeordnet: kognitiv verhaltensmäßige Gruppentherapie (group cognitive-behavioral therapy, GCBT) oder psychodynamisch interpersonelle Gruppentherapie (group psychodynamic interpersonal therapy, GPIIP). Die beiden Behandlungen waren in gleichem Maße erfolgreich und erbrachten im Vergleich zur Kontrollbedingung eine Reduzierung bezüglich der Tage mit Essanfällen. Eine Katamnese nach zwölf Monaten erbrachte stabile Werte hinsichtlich dieses Ergebnisses und auch bezüglich anderer Ergebnisvariablen. Frauen, die GPIIP durchlaufen hatten, zeigten aber in der Katamnese Leser eine höhere Bindungsangst im Zusammenhang mit der Reduktion ihrer Essanfälle. Bei Frauen mit GCBT war das anders: eine Reduktion der Essanfälle wies eine Beziehung zu geringer Bindungsangst auf. Höhere Werte in der Bindungsvermeidung waren bei GCBT mit Drop-out Verhalten verbunden. Obwohl GPIIP und GCBT beide Essanfälle verringern, stellen sich die individuellen Ergebnisse aufgrund von Bindungsangst und Bindungsvermeidung bei einem Therapievergleich doch unterschiedlich dar.

Résumé

Des échelles d'attachement prédisent les résultats dans une étude contrôlée randomisée de deux thérapies de groupe pour le binge eating : une interaction aptitude / traitement

Des patients (N=135) souffrant de binge eating (BED) étaient attribués au hasard à soit une condition de contrôle soit un des deux traitements de groupe à 16 séances chacune : thérapie de groupe cognitivo-comportementale (GCBT) ou thérapie de groupe psychodynamique interpersonnelle (GPIIP). Les deux traitements se valaient en efficacité, et chacun aboutissait à un nombre diminué de journées avec binge eating, en comparaison avec le groupe de contrôle. La catamnèse de 12 mois indiquait que les améliorations concernant les journées de binge eating et d'autres paramètres de résultats étaient maintenues. Pour des finisseurs de GPIIP féminins, une anxiété d'attachement plus élevée avait un lien avec les améliorations de binge eating à la catamnèse. De l'autre

côté, chez des finisseurs féminins de GCBT, une anxiété d'attachement plus faible était liée à une amélioration du binge eating à la catamnèse. Un attachement évitant élevé était lié à une rupture précoce en GCBT. Alors que GPIIP et GCBT réduisaient le binge eating dans la même mesure, les résultats indiquent que les issues individuelles diffèrent entre les traitements en fonction des niveaux d'attachement anxieux et évitant.

Resumen

Terapias para desórdenes bulímicos. una aptitud para la interacción de tratamientos

se randomizaron pacientes ($n=135$) con desorden bulímico (bed) para control o para uno de dos tratamientos grupales de 16 sesiones: terapia cognitivo-comportamental grupal (gcbt) o terapia gupal psicodinámica interpersonal (gpip). los dos tratamientos funcionaron igualmente bien y redujeron los días de bulimia comparados con los pacientes control en lista de espera. el seguimiento a los doce meses indicó que las mejoras se mantenían en cuanto a días de bulimia y otras variables de resultado. para mujeres que completaron el gpip, la mayor ansiedad de apego se relacionó con mejoras en los días de bulimia en el postratamiento. por otra parte, para las mujeres que completaron el gcbt, la menor ansiedad de apego se asoció con mejoras en los días de bulimia posteriores al tratamiento. una mayor evitación del apego se relacionó con la deserción del gcbt. si bien tanto el gpip como el gcbt redujeron la bulimia, los resultados indicaron que los resultados individuales difieren de los de tratamientos basados en el nivel de ansiedad de apego y evitación.

Resumo

Escalas de Vinculação predizem o Resultado Terapêutico num Ensaio Clínico Controlado de Duas Terapias de Grupo para a Perturbação de Ingestão Alimentar Compulsiva: Uma Interação do Aptidão-Tratamento

Pacientes ($N=135$) com perturbação de ingestão alimentar compulsiva (IAC) foram aleatoriamente distribuídos para uma condição de controlo ou um de dois tratamentos de 16 sessões de grupo: terapia cognitivo-comportamental de grupo (TCCG) ou terapia interpessoal psicodinâmica de grupo (TIPG). Os dois tratamentos foram igualmente eficazes e em ambos se verificou uma redução dias com episódios de ingestão alimentar compulsiva quando comparados com a condição de controlo dos pacientes em lista de espera. Doze meses de seguimento revelaram que as melhorias se mantiveram em relação ao número de dias com ingestão alimentar compulsiva e a outras variáveis terapêuticas. Para as mulheres que completaram o TIPG, maior vinculação ansiosa estava relacionada com melhoria no número de dias com ingestão alimentar compulsiva no

período de pós-tratamento. Por outro lado, para as mulheres que completaram o TCCG, uma baixa vinculação ansiosa estava associada com melhorias no número de dias com ingestão alimentar compulsiva no período de pós-tratamento. Uma elevada vinculação evitante foi relacionada com o abandono na TCCG. Embora tanto a TCCG como a TIPG tenham reduzido a ingestão alimentar compulsiva, os resultados indicaram que os resultados terapêuticos individuais diferem entre os dois tratamentos baseados no nível da vinculação ansiosa e evitante.

Sommario

In un esperimento controllato randomizzato, le Attachment Scales (scale dell'attaccamento) predicono l'esito di due terapie di gruppo per il disturbo da alimentazione incontrollata: una possibilità mediante interazioni tra i trattamenti

I pazienti ($n. 135$) con disturbo da alimentazione incontrollata (Binge Eating Disorder - BED) sono stati assegnati casualmente ad un gruppo di controllo o ad uno dei seguenti due trattamenti di gruppo di 16 sedute: terapia cognitivo-comportamentale di gruppo (Group Cognitive-Behavioral Therapy - GCBT) o terapia interpersonale psicodinamica di gruppo (Group Psychodynamic Interpersonal Therapy - GPIIP).

I due trattamenti hanno avuto esiti ugualmente buoni e ciascuno ha prodotto una riduzione dei giorni di alimentazione incontrollata rispetto alla situazione di controllo della lista d'attesa. Il *follow-up* a 12 mesi ha indicato che i miglioramenti erano mantenuti sia nei giorni di alimentazione incontrollata, che in altre variabili di esito.

Per le donne che hanno completato la GPIIP, l'ansia da attaccamento più elevata è stata correlata con i miglioramenti, dopo il trattamento, nei giorni di alimentazione incontrollata. D'altra parte, per le donne che hanno completato la GCBT, è stata l'ansia da attaccamento più bassa ad essere associata con i miglioramenti, dopo il trattamento, nei giorni di alimentazione incontrollata.

Il più elevato evitamento nell'attaccamento è stato correlato con il *drop-out* della GCBT.

Sebbene sia la GPIIP che la GCBT hanno ridotto il disturbo da alimentazione incontrollata, i risultati indicano che nei trattamenti gli esiti individuali differiscono a seconda del livello di evitamento e di ansia nell'attaccamento.

摘要

135 位被診斷為暴食暴食症 (BED) 的患者被隨機分派到控制組或是兩個認知行為治療團體之一 (GCBT, 各均是 16 次), 或是心理動力人際取向治療團體 (GPIIP)。兩組治療體的療效均一樣好, 各組和等待組的控制組相較, 每日飲食的攝取量均減少。經過 12 個月的追蹤調查, 亦發現二組每日飲食攝取量以及其他療效均持續。對女性患者而言, 那些接受 GPIIP 者, 後測時的飲食攝取量有進步者, 其依附焦慮程度較高; 對於接受 GCBT 者, 其後測時的飲食攝取量有進步者, 其依附焦慮程度較低。從 GCBT 中途退出者, 其依附逃避程度較高。雖然 GPIIP 和 GCBT 均能有效降低暴食情形, 研究結果顯示個體的療效會依著患者的依附焦慮與逃避之情形而有所不同。