

Rapid response predicts binge eating and weight loss in binge eating disorder: Findings from a controlled trial of orlistat with guided self-help cognitive behavioral therapy

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Abstract

Objective: It is important to find ways to predict response to treatments as this may inform treatment planning. We examined rapid response in obese patients with binge eating disorder (BED) who participated in a randomized placebo-controlled study of orlistat administered with cognitive behavioral therapy delivered by guided self-help (CBTgsh) format.

Methods: Fifty patients were randomly assigned to 12-week treatments of either orlistat + CBTgsh or placebo + CBTgsh, and were followed in double-blind fashion for 3 months after treatment discontinuation. Rapid response, defined as 70% or greater reduction in binge eating by the fourth treatment week, was determined by receiver operating characteristic curves, and was then used to predict outcomes.

Results: Rapid response characterized 42% of participants, was unrelated to participants' demographic features and most baseline characteristics, and was unrelated to attrition from treatment. Participants with rapid response were more likely to achieve binge eating remission and 5% weight loss. If rapid response occurred, the level of improvement was sustained during the remaining course of treatment and the 3-month period after treatment. Participants without rapid response showed a subsequent pattern of continued improvement.

Conclusion: Rapid response demonstrated the same prognostic significance and time course for CBTgsh as previously documented for individual CBT. Among rapid responders, improvements were well sustained, and among non-rapid responders, continuing with CBTgsh (regardless of medication) led to subsequent improvements.

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Introduction

Binge eating disorder (BED), a research category in the DSM-IV (American Psychiatric Association (APA), 1994), is characterized by recurrent binge eating without inappropriate weight control behaviors. BED is a prevalent (Hudson, Hiripi, Pope, & Kessler, 2007), stable problem (Pope et al., 2006) associated with

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heightened medical (Johnson, Spitzer, & Williams, 2001) and psychological problems (Grilo, Masheb, & Wilson, 2001a; White & Grilo, 2006). Not only do obese persons with BED have significantly greater eating and psychological disturbances than obese persons without BED (Allison, Grilo, Masheb, & Stunkard, 2005), but new evidence also suggests that BED represents a distinct familial phenotype in obese individuals (Hudson et al., 2006). Although effective treatments have been identified for BED (National Institute for Clinical Excellence (NICE) 2004; Wilson, Grilo, & Vitousek, 2007), even in studies with the best outcomes, a substantial proportion (one-third to one-half) of patients do not achieve abstinence from binge eating and most clinical trials have reported little to no weight loss (Grilo, Masheb, & Wilson, 2005; Wilfley et al., 2002). Thus, it is important to find ways to predict response to treatments as this may both inform treatment planning and lead to more effective decision making about treatment prescriptions for patients with BED.

Finding reliable patient predictors of treatment outcome for BED and other eating disorders has proven to be difficult (Wilson et al., 2007). One promising predictor may be initial treatment response. Studies of bulimia nervosa (BN) have identified rapid response to treatment as a significant predictor of positive treatment outcome (Agras et al., 2000; Fairburn, Agras, Walsh, Wilson, & Stice, 2004; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002; Wilson et al., 1999). More broadly, findings regarding the predictive value of rapid response in treatment for BN echo those of the emerging literature on “sudden gains” as a predictor of outcomes in depression across different interventions, including psychological (Hardy et al., 2005; Tang & DeRubeis, 1999; Tang, Luborsky, & Andrusyna, 2002) and antidepressant (Taylor, Freemantle, Geddes, & Bhagwagar, 2006) treatments.

In the first such study with BED, Grilo, Masheb, and Wilson (2006) found that patients characterized by rapid response (defined as 65% or greater reduction in binge eating by the fourth week of treatment) were more likely to achieve binge eating remission, had greater improvements in eating disorder psychopathology, and had greater weight loss than patients without rapid response. Grilo et al. (2006) also found that rapid response had different prognostic significance and distinct time courses for cognitive behavioral therapy (CBT) and medication treatments. If rapid response occurred in CBT, the level of improvement was sustained or improved further during the remaining course of treatment, whereas if it occurred with medication there was a trend for some of the improvement to be subsequently lost. Importantly, among non-rapid responders to treatment, those receiving CBT showed a subsequent pattern of continued improvement whereas those receiving medication were unlikely to derive any further benefit from continuing that medication. These findings for BED (Grilo et al., 2006) have some interesting parallels to the “sudden gains” literature for depression. Tang et al. (2002) reported that sudden gains in CBT for depression were significantly more robust than those for an alternative psychological therapy. Collectively, these findings highlight the need for research on rapid response across different treatment methods.

CBT is currently considered the best established treatment for BED (NICE, 2004; Wilson et al., 2007). CBT, however, requires specialized training and resources and is not readily available in many clinical settings (Crow, Peterson, Levine, Thuras, & Mitchell, 2004). Recent research has supported the clinical utility of CBT delivered using guided self-help methods (e.g., Carter & Fairburn, 1998; Grilo & Masheb, 2005). Such promising findings have led to treatment guidelines (NICE, 2004) suggesting that while CBT is currently considered the best established treatment for BED (NICE, 2004; Wilson et al., 2007), CBT delivered in a self-help format may in fact be the most practical first-line treatment for the disorder.

Research on rapid response in “first-line” treatments such as guided self-help CBT is important for various reasons. First, it is important to ascertain whether the robust, rapid response findings observed for CBT delivered by intensive individual sessions are observed for CBT delivered by less intensive guided self-help (CBTgsh) sessions (i.e., less clinician contact). One study with depression, for example, found that sudden gains in response to CBT delivered in busy routine clinical settings were less stable and robust than those reported in clinical trials using intensive standardized CBT (Hardy et al., 2005). Second, it is important to determine whether the lack of an early rapid response to CBTgsh should signal immediate consideration of alternative treatments. For example, two studies of antidepressant medications have found that patients with BED (Grilo et al., 2006) and with BN (Walsh, Sysko, & Parides, 2006) who fail to show a rapid response are very unlikely to show a subsequent response and should therefore be switched to another treatment, whereas patients receiving individual CBT who do not have a rapid response should not be switched because they are quite likely to show a subsequent improvement (Grilo et al., 2006). Third, it is important to determine whether

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