



Research report

Comparison of individual and group cognitive behavioral therapy for binge eating disorder. A randomized, three-year follow-up study

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ABSTRACT

Few long-term follow-up studies evaluated the response to psychotherapeutic interventions in binge eating disorder (BED). The effectiveness of individual and group cognitive-behavioral therapy, and the possible predictors of outcome were evaluated in a randomized controlled trial. At the beginning, at the end of treatments, and three years after the end of treatments, 144 patients affected by threshold or subthreshold BED were assessed using a clinical interview and self-reported questionnaires evaluating the eating attitudes and behavior, emotional eating, and general psychopathology. The following outcome measures were considered: recovery at 3-year follow-up, weight loss, treatment resistance, relapse, and diagnostic change. Both treatments showed similar response in terms of all outcome measures in the long-term, and determined a significant reduction of binge eating frequency, and a mild reduction of weight. The absence of a history of amphetamine derivatives consumption, lower emotional eating and binge eating severity at baseline were predictors of full recovery in the long-term. A low Emotional eating was found to be the only predictor of weight reduction. Overweight during childhood, full blown BED diagnosis, and high emotional eating were predictors of treatment resistance. Treatments considering the relationships between binge eating and emotional eating could improve the outcome of BED patients.

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Introduction

Binge eating disorder (BED) is a stable syndrome (Pope et al., 2006) characterized by frequent and persistent overeating episodes that are accompanied by feelings of loss of control and marked distress, in the absence of regular compensatory behaviors. Binge eating episodes occur on average at least 2 days a week within a time interval of 6 months (American Psychiatric Association, 1994). BED patients are overweight or obese, and they often show a relevant psychiatric and medical comorbidity (Striegel-Moore & Franko, 2008), as well as psychosocial impairment (Wilfley, Wilson, & Agras, 2003). A substantial proportion of overweight individuals seeking weight loss treatment fulfil the DSM IV criteria (American Psychiatric Association, 1994) for BED except for the frequency criterion of the objective binge eating episodes (less than twice a week), and are classified subthreshold BED (s-BED). It is generally considered that BED and s-BED patients

do not substantially differ in terms of overweight, eating specific and general psychopathology, psychiatric comorbidity and response to treatment (Friederich et al., 2007; Javaras et al., 2008; Mond, Peterson, & Hay, 2009; Striegel-Moore et al., 2000; Striegel-Moore, Wilson, Wilfley, Elder, & Brownell, 1998). Cognitive-behavioral therapy (CBT) is a well-established psychological treatment for BED (NICE, 2004; Wilson, Grilo, & Vitousek, 2007). Individual and group CBT have been found to reduce the number of binge days and the actual number of binge episodes and to improve some relevant psychopathological features of BED patients, such as overconcerns with body shape, eating and weight (Devlin, Goldfein, Petkova, Liu, & Walsh, 2007; Grilo, Masheb, & Wilson, 2005; Hay, Bacaltchuk, Stefano, & Kashyap, 2009; Munsch et al., 2007; Nauta, Hospers, & Jansen, 2001; Nauta, Hospers, Kok, & Jansen, 2000; Peterson et al., 2001; Wilfley et al., 2002; Wilson et al., 2007). Both treatments seem to be ineffective in determining a significant and lasting weight loss (Brownley, Berkman, Sedway, Lohr, & Bulik, 2007; Vocks et al., 2010).

Moreover, a substantial proportion of patients do not achieve abstinence from binge eating, and the evidence on the long-term efficacy of CBT, as well as the information on the moderators of its

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effects in BED patients, are still scant (Berkman, Lohr, & Bulik, 2007; Hilbert et al., 2007; Masheb & Grilo, 2008). Considering the possible predictors of outcome, the severity of binge eating at baseline (Agras et al., 1995; Agras, Telch, Arnow, Eldredge, & Marnell, 1997), earlier onset of BED (Agras et al., 1995; Safer, Lively, Telch, & Agras, 2002), younger age at time of presentation for treatment (Agras et al., 1997), high tendency of trying to feel better by eating, drinking, or smoking (Dingemans, Spinhoven, & van Furth, 2007) predict a low remission rate of binge eating episodes in the short term. As far as the long-term outcome is concerned, only few studies have been published so far. A naturalistic study on a community-based cohort of patients with BED found that after 5-year follow-up, only 18% had an eating disorder of clinical severity and just 10% had binge eating disorder, even if the most part of the sample gained weight, with 39% eventually meeting criteria for obesity (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000). A prospective-longitudinal study suggested that high levels of psychiatric comorbidity, body dissatisfaction, predict a poor outcome, after 12-year follow-up and an extensive multimodal inpatient treatment including CBT (Fichter, Quadflieg, & Hedlund, 2008).

Moreover, different psychological factors and data related to the clinical history of the patients have to be taken into account, considering their reported effect on binge eating severity, such as the levels of emotional eating (Dingemans, Martijn, Jansen, & van Furth, 2009; Ricca, Castellini, Lo Sauro, et al., 2009) a history of overweight during childhood (de Zwaan, 2001; Fairburn et al., 1998; Reas & Grilo, 2007) or a history of amphetamine derivatives use (Ricca, Castellini, Mannucci, et al., 2009).

Despite the possible similar or different psychopathological and clinical results achieved by means of individual and group CBT, to our knowledge no study comparing the long-term effects of these treatments in BED and s-BED patients has been published so far.

The aims of the present study were as follows:

- (1) The comparison of the effects of individual and group cognitive-behavioral therapy in outpatients with threshold and subthreshold binge eating disorder, in the short and long term.
- (2) The identification of the different predictors of outcome at the end of treatments and three years after the end of treatments.

Methods

Patients

The study was conducted at the Outpatient Clinic for Eating Disorders (ED) of the Psychiatric Unit of the Department of Neuroscience of the University of Florence. Participants were recruited from referrals by family doctors and other clinicians. All the diagnostic procedures and the psychometric tests are part of the routine clinical assessment performed at our clinic. Before the collection of data, during the first routine visit, the procedures of the study were fully explained; after that, the patients were asked to provide their written informed consent to the participation to the study. The study protocol was approved by the Internal Review Board of the Department of Neuroscience of the University of Florence.

All patients attending the clinic for ED between January 2000 and June 2003 were enrolled in the study, provided they met the following inclusion criteria:

- Age between 18 and 60 years.
- Diagnosis of current binge eating disorder (BED) according to DSM-IV criteria (American Psychiatric Association, 1994), or

diagnosis current subthreshold BED (s-BED) assessed by Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 1995). BED diagnosis was determined by a minimum average frequency of binge eating twice a week for a minimum duration of six consecutive months; s-BED diagnosis was performed when binges occurred at a minimum average frequency of once a week for a minimum duration of six consecutive months, according to Striegel-Moore study (Striegel-Moore et al., 1998).

- To accept not to participate to CBT programme other than the experimental one.

The exclusion criteria were as follows:

- Recurrent severe compensatory behaviors (fasting, purging, excessive exercise for weight control). Individuals were excluded from the BED or subthreshold BED groups if they reported a lifetime history of such behaviors at a frequency exceeding five times in any consecutive six-month period (Striegel-Moore et al., 2000).
- Current comorbid severe mental disorders, such as schizophrenia, bipolar disorder, severe major depression, suicide ideation, psychoactive substance dependence, assessed by means of the Structured Clinical Interview for DSM-IV (First et al., 1995).
- Severe medical conditions that preclude an outpatient treatment, such as severe heart, renal and/or liver failure.
- Prior cognitive behavioral treatments for eating disorders and/or obesity.
- Current or recent (3 months) use of psychoactive medications.
- Previous surgical treatment for obesity.
- Illiteracy and mental retardation.

The final sample consisted of 144 individuals (72 per condition). I-CBT group showed mean age \pm SD of 46.5 ± 12.4 years, and it was composed by 62 (86.1%) women, while G-CBT group showed mean age \pm SD of 47.4 ± 11.9 , and it was composed by 65 (90.3%) women. The average (\pm SD) number of clients treated by each therapist in I-CBT was 14 (± 1), and 10.2 (± 2.8) clients for G-CBT. The average number of participants per group (G-CBT) was 9 (range 8–12). The average attendance for I-CBT and G-CBT was 95.4% and 95%, respectively.

Design of the study

Psychopathological, behavioral and sociodemographic data were collected through a face-to-face interview on the first day of admission (baseline: T0), at the end of treatment (T1; 24 weeks), and three years after the end of treatment (T2), by two expert psychiatrists who were unaware of kind of treatment (G.C., C.L.S.) who had no therapeutic relationship with any of the participants they assessed. At T2, all the patients (completers and drop-out patients) were contacted by telephone and invited to the clinic for a follow-up visit. Inter-rater reliability (κ coefficient) for diagnosis at baseline was 0.91 for BED and 0.94 for s-BED. During the visits, Body Mass Index (BMI) was calculated, and the psychopathological evaluation was performed. After the first visit, eligible patients were randomly assigned to either individual (I-CBT) or group CBT (G-CBT). A randomization procedure used randomly permuted blocks of subjects to allocate patients to the two treatment conditions, balancing gender, eating disorder diagnosis, and BMI. The randomization list was prepared with a table of random numbers and kept separate from those involved in the conduct of the study. The treatment assignment was determined after completing all assessments and after acceptance into the study. Neither the research-clinicians nor participants knew the

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