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Does rapid response to two group psychotherapies for binge eating disorder predict abstinence?

Debra L. Safer [a,*], Erin E. Joyce [b]

[a] Stanford University School of Medicine, Department of Psychiatry and Behavioral Sciences, 401 Quarry Road, Stanford, CA 94305-5722, United States
[b] Pacific Graduate School of Psychology-Stanford Psy.D. Consortium, 1791 Arastradero Road, Palo Alto, CA 94304, United States

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ABSTRACT

Objective: Extend understanding of a rapid response (RR) to treatment by examining its prognostic significance at end-of-treatment (EOT) and 1 year follow-up within two group treatments for binge eating disorder (BED): Dialectical Behavior Therapy for BED (DBT-BED) and an active comparison group therapy (ACGT).
Methods: 101 adults with BED randomized to 20-weeks DBT-BED versus ACGT (Safer, Robinson, & Jo, 2010). RR defined as ≥65% reduction in the frequency of days of binge eating by week 4. RR across and within treatment conditions used to predict binge eating abstinence and secondary outcomes (e.g., binge eating pathology, treatment attrition) at EOT and 1 year follow-up.
Results: (1) Significantly higher binge eating abstinence for rapid responders (RR; $n = 41$) vs. non-rapid responders (non-RRs; $n = 60$) at EOT (70.7% vs. 33.3%) and 1 year follow-up (70.7% vs. 40.0%), respectively, as well as improvement on most secondary measures (2) Significantly less attrition among RRs vs. non-RRs (3) Significantly higher binge eating abstinence rates at both time points for DBT-RRs vs. DBT-non-RRs, but not for ACGT-RRs vs. ACGT-non-RRs.
Conclusions: Current study extends prognostic significance of RR to 1 year follow-up. RR more prominent for those randomly assigned to DBT-BED than ACGT. Implications discussed.
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The phenomenon of a rapid response (RR) to treatment by certain patients during therapy is gaining increasing interest and study. Rapid response, an early substantial decline in symptomatology within the first 1–4 weeks of treatment found in approximately one-third of research subjects, has been described in a number of treatments for depression (Ilardi & Craighead, 1994; Tang & DeRubeis, 1999), alcohol use disorders (Breslin, Sobell, Sobell, Buchan, & Cunningham, 1997), panic disorder (Penava, Otto, Maki, & Pollack, 1998), irritable bowel syndrome (Lackner et al., 2010), bulimia (BN; Fairburn, Agras, Walsh, Wilson, & Stice, 2004; Jones, Peveler, Hope, & Fairburn, 1993; Marrone, Mitchell, Crosby, Wonderlich, & Jollie-Trottier, 2009), and, more recently, binge eating disorder (BED; Grilo & Masheb, 2007; Grilo, Masheb, & Wilson, 2006; Masheb & Grilo, 2007; Zunker et al., 2010). There is no accepted explanation as to why some persons have an early substantive treatment response and not others.

Four studies have examined the role of rapid response to BED treatment. Three of these were carried out by Grilo and colleagues, who examined the role of rapid response in BED across various individual psychotherapy treatment conditions including Cognitive Behavioral Therapy (CBT), CBT guided self-help (CBTgsh), and Behavioral Weight Loss guided self-help (BWLgsh) (Grilo & Masheb, 2007; Grilo et al., 2006; Masheb & Grilo, 2007). Psychotherapies were compared to one another (Masheb & Grilo, 2007) as well as in combination with different pharmacotherapies, (e.g., fluoxetine, orlistsat, and placebo) (Grilo & Masheb, 2007; Grilo et al., 2006). To summarize, these three Grilo et al. studies found: (1) no consistently identified differences between rapid responders (RRs) and non-rapid responders (non-RRs) on baseline demographic and clinical characteristics; (2) no difference (when examined) in the rate of treatment attrition; (3) higher rates of BED abstinence for RRs compared to non-RRs at EOT and 3 month follow-up (when reported); and (4) similar percentages of RR rates within BED subgroups, despite receiving quite different psychotherapy and pharmacotherapy treatments.

Abbreviations: RR, Rapid response; RRs, Rapid responders; Non-RRs, Non-rapid responders; EOT, End-of-treatment; BED, Binge eating disorder; DBT-BED, Dialectical Behavior Therapy for BED; ACGT, Active comparison group therapy; OBE, Objective binge eating episode; EDE, Eating Disorder Examination.

* Corresponding author. Tel.:/fax: +1 650 723 7928.
E-mail address: dlsafer@stanford.edu (D.L. Safer).

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A recently published fourth study by Zunker et al. (2010) examined the role of rapid response among participants receiving CBT for BED in a group format. Randomization was to three active treatments: therapist-led, therapist-assisted, or self-help. Abstinence at the end-of-treatment (EOT) was best predicted at the end of week 1 among early responders. Interestingly, the week 4 threshold previously utilized by Grilo and colleagues (Grilo & Masheb, 2007; Grilo et al., 2006; Masheb & Grilo, 2007) was not predictive of later abstinence.

The current study examines findings for RRs at the end of Dialectical Behavior Therapy adapted for BED (DBT-BED) and at the 12 month, or 1 year, follow-up. The analysis makes use of an existing database from a randomized control trial comparing DBT-BED delivered in a group format with an active comparison group therapy (ACGT). This use of an "active placebo" psychotherapy was to control for the "common factors" in psychotherapy (Frank, 1961; Goldfried, 1980).

Specifically, the current study aims to: (1) examine the prognostic significance of RR in two additional treatments not yet investigated for RR (e.g., DBT-BED and ACGT); (2) extend the assessment of RR as a predictor of outcome at EOT to 1 year follow-up; and (3) assess RR as a predictor of treatment attrition.

Method

Participants

The current sample was drawn from a recent study in which 101 patients with BED were randomly assigned to receive twenty 2-h sessions of one of two group treatment conditions: DBT-BED ($n = 50$) or ACGT ($n = 51$). A detailed description of the aims, design, methods, and outcomes of this study has been reported elsewhere (Safer et al., 2010), but is briefly described here. Binge eating abstinence and reductions in binge eating frequency at EOT were achieved to a greater degree for DBT than for ACGT (EOT abstinence rate 64% for DBT vs. 36% for ACGT), although these differences did not persist over the 3-, 6-, and 12-month follow-up assessments. (The 12-month follow-up binge eating abstinence rate = 64% for DBT vs. 56% for ACGT).

All participants were 18 years of age or older, met DSM-IV research criteria for BED, and, among those on medication, had been on a stable psychotropic regimen for at least the prior three months. Exclusion criteria were: having a history of bipolar disorder or schizophrenia, meeting current criteria for alcohol or drug dependence, showing evidence of current suicidality, and/or being unwilling to discontinue concomitant weight related medications (e.g., sibutramine, phentermine, amphetamines, insulin, or topiramate)or eating-disorder/weight related psychotherapy treatment. See Safer et al. (2010) for further details.

Procedure

One hundred and one participants were randomly assigned either to DBT adapted for BED or ACGT, as described below. Participants were assessed at pretreatment (which included baseline demographic information), EOT (after 20 weekly sessions), and at the 12-month follow-up. In addition, binge eating frequency was assessed at weekly time points throughout the 20 sessions of treatment.

Measures

The *Eating Disorder Examination* (EDE), a structured interview that assesses the main behavioral and attitudinal features of eating disorders (Fairburn & Cooper, 1993), was used to document the BED diagnosis and assess the frequency of days on which objective binge episodes (OBE) took place. Its four subscales are: Dietary Restraint, Eating Concern, Weight Concern, and Shape Concern. Items are rated from 0 to 6, with higher scores reflecting greater severity. The *Three Factor Eating Questionnaire* (TFEQ) is a 51-item questionnaire that measures three dimensions of human eating behavior: (1) cognitive restraint, (2) disinhibition, and (3) hunger (Stunkard & Messick, 1985). The *Beck Depression Inventory* (BDI; Beck & Steer, 1987) is a 21-item established inventory of the symptoms of depression and negative affect (Beck, Steer, & Garbin, 1998). The *Questionnaire on Eating and Weight Patterns* (QEWP-R; Spitzer et al., 1992), a self-report instrument, was used to obtain demographic data as well as information on weight history and the onset of binge eating, dieting, and obesity.

Weight and *height* were measured in lightweight clothing with shoes removed on a balance beam scale. All participants were weighed at baseline, EOT, and at follow-up.

A *weekly self-report monitoring form* was used to assess the frequency of days on which at least one OBE took place (i.e., OBE days) over the prior week.

A post-randomization questionnaire regarding *treatment expectations and suitability* was completed at the conclusion of the pre-treatment orientation. Previously participants had received written and verbal rationales for both DBT-BED and ACGT. Post-randomization they were oriented in greater detail to their assigned treatment condition. Using a 10 point visual analogue scale, participants were asked to rate, "How successful do you think your treatment here will be?" from 1 ("Not at all successful") to 10 ("Extremely successful"), and "How suitable do you think the treatment group you were assigned is for your eating problems?" from 1 ("Not at all suitable") to 10 ("Extremely suitable").

Psychological interventions

Dialectical behavior therapy for binge eating disorder (DBT-BED)

DBT is an affect regulation behavior therapy initially developed by Linehan (1993a, 1993b) and adapted for BED by Telch and colleagues (Telch, Agras, & Linehan, 2000, 2001; Wiser & Telch, 1999). Treatment consisted of 20 weekly 2-h sessions of group psychotherapy aimed at teaching emotion regulation skills to reduce binge eating behaviors. A published treatment manual is available (Safer, Telch, & Chen, 2009).

Active comparison group psychotherapy (ACGT)

This manual-based supportive group therapy was expressly developed to control for nonspecific therapeutic factors (e.g., therapeutic alliance, patient expectations, etc.). For more details, see Safer and Hugo (2006). The ACGT condition was matched to the DBT treatment arm on pertinent variables including length of treatment, number of sessions, etc. A supportive psychotherapy manual originally written by Markowitz and Sacks (2002) for chronic depression was used as a model and adapted for BED. In this therapy, binge eating is conceptualized as both the result of low self-esteem and the cause of additional problems. ACGT participants were expected to monitor their binges and self-esteem and complete a weekly diary card (as done by DBT participants). ACGT therapists were provided with explicit instructions to avoid employing any techniques consistent with DBT-BED and other therapeutic approaches such as CBT, IPT, BWL, and psychodynamic psychotherapy.

Overview of analyses

Determination of participants in current dataset

Of the entire sample of 101 participants, 82 had complete data for every single time point over the first four weeks. Of the 19

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