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**Priority Updates from the Research Literature** from the Family Physicians Inquiries Network

# Suspect an eating disorder? Suggest CBT

Unless your patient is seriously underweight—with a BMI ≤17.5—cognitive behavioral therapy may be her best bet.

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## Practice changer

Refer patients with eating disorder not otherwise specified (NOS) for cognitive behavioral therapy. CBT, which has proven to be the most useful behavioral treatment for bulimia,[1] has now been shown to be effective for patients in the NOS category.[2]

Strength of recommendation
**B:** 1 high-quality, randomized controlled trial (RCT).

Fairburn CG, Cooper Z, Doll HA, et al. Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: a two-site trial with 60-week follow-up. *Am J Psychiatry.* 2009;166:311-319.

### ILLUSTRATIVE CASE

A 23-year-old patient with a body mass index (BMI) of 18 tells you she's fat and she's afraid of gaining weight. Further questioning reveals that your patient binges on cookies and potato chips about once a week, then compensates for overeating by taking laxatives or exercising excessively—a practice she's been following since she started college several years ago. The eating disorder she describes does not meet the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) for bulimia or anorexia nervosa, although it has elements of both. Rather, it fits the diagnostic criteria for eating disorder NOS. You're aware that CBT is the first-line behavioral treatment for bulimia, and wonder whether it would be helpful for your patient.

Eating disorders often go undetected and untreated in primary care practices,[3] as many patients don't volunteer information about their weight or behaviors related to food, and physicians often fail to ask. Overall, as few as 10% of those with eating disorders receive any form of treatment.[1]

## Would you recognize this loosely defined disorder?

In the United States, the lifetime prevalence of eating disorders is 0.6% for anorexia nervosa (0.3% for men and 0.9% for women), 1.0% for bulimia (0.5% for men and 1.5% for women), and 2.8% for binge-eating disorder (2.0% for men, 3.5% for women).[4] Eating disorder NOS, which encompasses subthreshold cases of anorexia or bulimia, patients with elements of both anorexia and bulimia, and patients with binge-eating disorder, accounts for 50% to 80% of eating disorder diagnoses in outpatient settings. Yet

**Eating disorder clues you can't afford to miss**
Go to jfponline.com and listen to Katherine A. Halmi, MD, professor of psychiatry at Weill Cornell Medical College and founder of the Cornell Eating Disorder Program

**FAST** TRACK

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there have been few studies of the treatment of these patients.[2,5,6]

### A review of DSM-IV criteria

The diagnostic criteria for anorexia nervosa include a refusal to maintain a weight of at least 85% of normal body weight (or having a BMI ≤17.5), intense fear of gaining weight, disturbance in the way one's body shape is experienced, and amenorrhea in females who are postmenarche.

Criteria for bulimia include recurrent episodes of binge eating (consuming a large amount of food with a sense of lack of control over eating) and recurrent inappropriate compensatory behaviors to prevent weight gain (self-induced vomiting, excessive exercise, fasting, laxatives, diuretics, or enemas) at least twice weekly for 3 months; and self-evaluation that is unduly influenced by body shape and weight.[7] Most patients with eating disorder NOS have clinical features of both anorexia and bulimia.[6]

### APA guidelines are silent on NOS

CBT has consistently proven to be the most useful behavioral treatment for patients with bulimia.[1] Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine—the only medication with Food and Drug Administration approval for the treatment of an eating disorder[8]—are about as effective as CBT, and the combination of CBT and an SSRI is superior to either treatment alone.[9] CBT has also been found to be somewhat effective in treating binge-eating disorder.[10]

Anorexia nervosa, the most deadly eating disorder (the mortality rate is 6.6%[11]) and the most difficult to treat, is the exception. Several studies have assessed CBT for treating anorexia, but it has not been found to be very effective.[10,12,13]

The 2006 American Psychiatric Association practice guidelines for the treatment of patients with eating disorders feature recommendations for anorexia, bulimia, and binge-eating disorder, but do not address eating disorder NOS.[10] The National Institute for Clinical Excellence (NICE) in the United Kingdom issued guidelines for the treatment of eating disorders in 2004. In response to the lack of evidence for treating eating disorder NOS, NICE recommended basing treatment on the form of eating disorder that most closely resembles the patient's presentation.[14] Fairburn et al addressed the lack of evidence for treatment of eating disorder NOS with the study summarized here.

STUDY SUMMARY

## Both broad and focused CBT delivered results

Conducted at 2 eating disorder centers in the United Kingdom, this RCT included 154 patients, 18 to 65 years of age, who met DSM-IV criteria for either bulimia or eating disorder NOS. Exclusion criteria included prior treatment with CBT or other evidence-based treatment for the same eating disorder, and a BMI ≤17.5.

Most of the patients were female (95.5%) and white (90.3%), with a median age of 26 years and a median duration of eating disorder of 8.6 years. Sixty-two percent of the patients had a diagnosis of eating disorder NOS, and 38% were diagnosed with bulimia. Half of the patients had another current psychiatric diagnosis—a major depressive disorder, an anxiety disorder, or substance abuse.

The patients were randomized into 4 groups: Two received immediate treatment, and the other 2, referred to as waiting list controls, waited 8 weeks before beginning treatment. Treatment consisted of 1 of 2 forms of CBT-E, an enhanced form of CBT used to treat adult outpatients with eating disorders. Patients either received CBT-Ef, a focused form of CBT that exclusively targets eating disorder psychopathology, or CBT-Eb, a broader form of therapy that also addresses other problems that are common in patients with eating disorders, such as perfectionism and low self-esteem.

Both types of CBT-E featured a 90-minute preparatory session, 20 50-minute sessions, and 1 review session 20 weeks after completion of treatment. In the first 4 sessions, CBT-Ef and CBT-Eb were identical—addressing the eating disorder exclusively. CBT-Ef continued to focus on the eating disorder for the rest of the sessions, while subsequent CBT-Eb sessions also dealt with mood intolerance, interpersonal difficulties, and related issues. Five therapists—4 psychologists and 1 nurse-therapist—conducted the treatments.

Patients were weaned from ongoing psychiatric therapy during the study, but those who were on antidepressant therapy (n=76) were able to continue it. Patients were assessed before treatment, at the end of the waiting period for those in the control groups, after 8 weeks of treatment, at the end of treatment, and 20, 40, and 60 weeks after completion of treatment. (Twenty-two percent of the enrollees did not complete treatment.)

Primary outcomes were based on the Eating Disorder Examination (EDE), administered by assessors who were not involved in the treatment and were blinded to the patients' group assignment. Change in severity of eating disorder features was measured by the global EDE score (0-6) and attaining a global EDE score <1.74 (<1 standard deviation above the community mean).

**No treatment vs CBT.** The waiting period left little doubt of the short-term efficacy of CBT: After 8 weeks, there was significant improvement in eating disorder behaviors and overall severity in both the CBT-Ef and CBT-Eb groups (EDE scores fell from 4.15 at baseline to 3.26 and from 4.04 to 2.89, respectively). In the same time period, scores for the waiting list control groups remained flat (from 4.08 at baseline to 3.99).

At the end of treatment and at the 60-week follow-up, patients in both forms of CBT-E showed significant improvement across all measures, with no significant difference between treatments. By the end of treatment, 66.4% of those who completed all of the CBT sessions had global EDE scores <1.74 (considered clinically significant).

### Subgroup analysis offers opportunity for fine-tuning

When analyzed separately, the patients with bulimia and those with eating disorder NOS did equally well at the end of treatment: 52.7% of those with bulimia and 53.3% of those with eating disorder NOS had global EDE scores <1.74. At the 60-week follow-up, the patients with bulimia maintained their improvement slightly more: 61.4% had global EDE scores <1.74, compared with 45.7% of the patients with eating disorder NOS.

The researchers also compared the outcomes of patients with the most complex additional psychopathology with those of patients with less complex problems. Greater complexity was defined as moderate ratings in at least 2 of the following domains: mood intolerance, clinical perfectionism, low self-esteem, and interpersonal difficulties.

**Broad focus more effective for high complexity.** Overall, those in the more complex subgroup did not respond as well; 48% had global EDE scores <1.74, vs 60% of those in the less complex group. However, those in the more complex subgroup did better with the broad form of CBT (at 60-week follow up, 60% had scores <1.74 with CBT-Eb, compared with 40% in the CBT-Ef treatment arm), while the less complex subgroup did better with the more tightly focused CBT-Ef. [2]

WHAT'S NEW

## Evidence supports CBT for NOS diagnosis

The most recent (2004) Cochrane review of "psychotherapy for bulimia nervosa and binging" included 40 RCTs of patients with bulimia, binge-eating disorder, and eating disorder NOS with recurrent binge-eating episodes (included in 7 studies). While the review confirmed that

CBT is effective for bulimia and "similar syndromes," it identified a need for larger and higher quality trials of CBT, particularly in patients with eating disorder NOS.[1] The study reviewed in this PURL—the first large, high-quality trial to include a number of patients with eating disorder NOS—provides strong evidence that CBT is effective for this group of patients.[2]

CAVEATS

## Limited wait time leaves unanswered questions

One limitation of this study is the lack of a control group beyond the 8-week waiting period. Prior studies of CBT for bulimia that delayed therapy for those in the control groups for a longer duration have consistently shown that patients receiving CBT did significantly better than those in the control group.[9] While a "no treatment" group would have made the results more robust in this case, it would not have been ethical to withhold treatment for the entire length of the study.

It is noteworthy, too, that this study only included patients with a BMI >17.5. Patients with a diagnosis of anorexia nervosa, who by definition have a lower BMI, will need other treatments, including hospitalization in some cases.

CHALLENGES TO IMPLEMENTATION

## Identifying patients and therapists

The primary challenge is to determine which of your patients have eating disorders. When discussing diet, adding a simple question such as, "Are you happy with your current weight?" can help you identify those who meet the criteria for an eating disorder or are at high risk.[3]

Identifying local mental health providers who are trained to provide CBT for patients with eating disorders is another concern. Insurance coverage for this intensive treatment may also be a limiting factor in some cases.

Many studies support the use of fluoxetine for patients with bulimia, and combined treatment with SSRIs and CBT has been shown to be superior to either treatment alone.[8,10,14] Consider starting the patient on an antidepressant while she (or he) awaits the start of CBT. ■

**FAST** TRACK

**Patients with the most complex psychopathology did better with broadly focused CBT than with therapy dealing exclusively with eating disorders.**

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