

Large Study of Binge-Eating Disorder Is a First

BY SARAH PRESSMAN
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Contributing Writer

CHICAGO — Treatment outcomes for obese patients with binge-eating disorder differ by disease severity and negative affect, a large study of patients with this disorder shows.

"We are trying to identify a particular subset of the population [that responds to a particular treatment]," Denise E. Wilfley, Ph.D., director of the Weight Management and Eating Disorders Program at Washington University in St. Louis, said at the annual meeting of the Association for Behavioral and Cognitive Therapies.

The study evaluated three treatments for binge-eating disorder (BED): interpersonal therapy (IPT), behavioral weight loss (BWL), and guided self-help (GSH). "This is the first study to compare three different treatments for binge-eating disorder," Dr. Wilfley said. Participants were also stratified by high versus low negative affect and by severity of bingeing.

According to the DSM-IV, people with BED eat a large amount of food with loss of control on at least 2 days a week for at least 6 months; they do not regularly engage in compensatory behaviors.

Dr. Wilfley said people with this disorder

tend to have low self-esteem and very high rates of health care use, traits similar to people with anorexia and bulimia nervosa. But unlike people with those conditions, people with BED are more likely to be male and less likely to be white. Given the large amount of food they consume, people with BED are associated with overweight or obesity. "They're not just obese individuals," said Dr. Wilfley, also professor of psychiatry at the university. "They are obese individuals with an eating disorder."

The trial involved 205 participants and was conducted at three sites: Stanford (Calif.) University (data coordinating center), Washington University (clinical site), and Rutgers University (clinical site) in Piscataway, N.J. Participants were at least 18 years old, met the DSM-IV criteria for BED, and had a body mass index (BMI) between 27 and 45 kg/m². Patients who had a psychiatric or physical impairment that would preclude full participation, such as active suicidality, were excluded. Of the participants, 85% were female, and the average age was 48.5 years.

In terms of race, 82% were white, 13% were black, 4% were Hispanic, and 1%

was Native American. Slightly more than half of the participants were college educated, and the average BMI among the participants was 36.4.

The participants were randomized to one of the three treatments. Participants in both the interpersonal therapy and the behavioral weight loss groups had 20 60-

minute therapy sessions over a 24-week period. Those in the guided self-help group used bibliotherapy. They were asked to read "Overcoming Binge Eating," by Dr. Christo-

pher G. Fairburn (New York: the Guilford Press, 1995), a book aimed at teaching behavior change. This group also had one 55-minute and nine 25-minute therapy sessions over 24 weeks. The IPT group included 75 patients, the BWL group had 64 patients, and the GSH group had 66 patients. There were no significant differences in patient characteristics among the three groups.

The researchers used the Beck Depression Inventory to stratify the participants according to high negative affect (HNA) and low negative affect (LNA). Although they were apt to stay with interpersonal therapy, patients with HNA were significantly more likely to drop out of the be-

havioral weight loss treatment group than those with LNA. Those with LNA were much more likely to drop out of guided self-help.

Overall, treatment retention rates were significantly better among those treated with interpersonal therapy (93%) than with behavioral weight loss (72%) and guided self-help (70%). Patients in BWL had a significantly better short-term weight loss than those in the other two groups, but this advantage disappeared by the 1-year follow-up.

The primary outcome measures in the trial were binge frequency and remission rates, defined as no binge eating in 28 days. The results showed that all three treatments had similar outcomes in treating binge eating disorder, associated eating disorders, and general psychopathology after 24 weeks.

The researchers followed the patients for 24 months and have analyzed the results for the first 12 months. The post-treatment data showed that interpersonal therapy was superior to the two other treatment options in those patients with severe binge eating. In addition, HNA participants were more likely to do poorly on binge eating outcomes when the behavioral weight loss approach was used, compared with the IPT or guided self-help approach, over the course of the 1-year follow-up period. ■

The study evaluated three treatments for binge-eating disorder: interpersonal therapy, behavioral weight loss, and guided self-help.

Oncology Nurses Reduce Depression in Cancer Patients

BY JANE SALODOF MACNEIL
Southwest Bureau

TUCSON, ARIZ. — A psychiatric intervention conducted by specially trained oncology nurses significantly reduced depression for cancer patients enrolled in a clinical trial presented at the annual meeting of the Academy of Psychosomatic Medicine.

Dr. Michael Sharpe reported that patients randomized to problem-solving therapy reached lower mean scores on the Symptom Checklist-20 (SCL-20) and were more likely to achieve a 50% reduction in clinical symptoms, compared with patients given optimized usual care. The randomized group also had twice the rate of complete remission.

"That tells us we can make a difference in depression in cancer patients with this kind of model," said Dr. Sharpe, a professor of psychological medicine and symptoms research at the University of Edinburgh where the 200-patient trial was conducted.

Depression is common but poorly managed in cancer patients, according to Dr. Sharpe. It is associated with nonadherence to cancer treatment, increased medical costs, and suicide, he said. Yet it is often not detected or, if recognized, discounted as a normal response to having cancer.

"We still have the view of some primary care doctors that if you've got cancer, you've got depression—that it's normal," he said.

Therefore, the investigators recruited oncology nurses in an attempt to integrate depression care into cancer care. A psychiatrist supervised the nurses, who coordinated drug treatment, delivered psychological treatment, and monitored patient progress.

As described by Dr. Sharpe, the psychological component was a problem-solving therapy in which the patients would list cancer and noncancer concerns. They would choose one concern to focus on with the nurse, identifying what a solution would look like and brainstorming on how to achieve it. Next, they would choose and try out a strategy.

One nurse worked full time in a pilot study testing the model. A full day of depression and cancer care turned out to be "too much," Dr. Sharpe said. Therefore, nurses worked half-time in the randomized trial.

Selection and training of nurses without a psychiatric background was also a challenge. "We had problems. We recruited people who could not do it," Dr. Sharpe said. "We had a core of three nurses who did treatment. One could not do it and had to leave."

The trial population was drawn from a pool of patients who underwent computerized screening

DR. SHARPE

for depression before consultation with their oncologists. Depression diagnoses were based on subsequent structured clinical interviews of patients who scored above 14 on the Hospital Anxiety and Depression Scale.

Two hundred patients were randomized: 99 to optimized usual care and 101 to optimized usual care plus the Symptom Management Research Trials (SMaRT) intervention by the oncology nurses. Dr. Sharpe noted that primary care physicians were notified of all depression diagnoses and could prescribe antidepressants to patients in both groups.

Breast cancer was the most common malignancy, accounting for more than 40% of the patients enrolled. The study population was generally female with an average age of 56 years. About two-thirds were disease free, and more than 80% were visiting oncologists for follow-up

care after completing cancer therapy.

Data analysis was done at 3 months' follow-up for all 99 usual-care patients and 97 who received the added intervention (4 patients, including 2 who died, were excluded because of incomplete data).

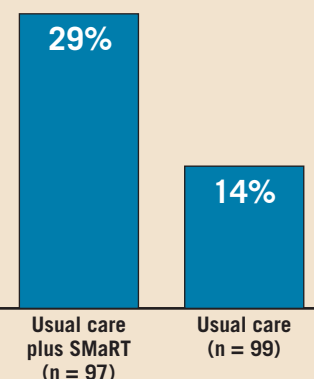
The intervention group had lower mean SCL-20 scores, compared with the usual-care group: 1.25 vs. 1.54. More than half (53%) of the intervention group achieved a 50% clinical reduction of depression symptoms compared with about a third (34%) of the control group. Twice as many had a complete remission on the SCL-20: 29% vs. 14%. Remission rates were also significantly higher based on structured clinical interviews: 67% vs. 45%, respectively.

Although he did not report statistics in detail, Dr. Sharpe said the effects "were maintained and possibly increased" at 6 months. The next step, he said, will be to duplicate the study with more nurses and patients at multiple centers. ■



Depression is poorly managed in cancer patients. It is associated with nonadherence to cancer treatment.

Rate of Complete Remission Doubled With Intervention



Note: Data based on a 3-month follow-up.
Source: Dr. Sharpe