

Severity of Binge-Eating Disorder and Its Effects on Treatment Outcome

To the Editor: A valuable overview by Carlos Grilo¹ published in a recent supplement to the *Journal* provides an important update on the psychological and behavioral treatments of binge-eating disorder (BED), reviewing also the evidence about predictors of treatment outcome. This overview can possibly be complemented by recent evidence on the severity of BED, as defined by the *DSM-5*,² and its impact on treatment outcome.

BED, like other eating disorders, is characterized by substantial within-diagnosis heterogeneity such that different individuals with the same disorder may exhibit variation in terms of symptom severity, underscoring the need for reliable indicators of disease severity.^{3,4} Importantly, the *DSM-5* introduced a new severity specifier for BED,² whose reliability, validity, and clinical significance have been recently established,³ to address within-group heterogeneity and variability in severity of the disorder and assist clinicians in tracking patients' progress. Specifically, 4 BED severity groups based on the weekly frequency of binge-eating (BE) episodes were defined in the *DSM-5*² as follows: mild, 1–3 episodes/week; moderate, 4–7 episodes/wk; severe, 8–13 episodes/wk; and extreme, > 14 episodes/wk.

In his overview of psychological and behavioral treatments for people with BED, Grilo¹ suggested therapist-led cognitive-behavioral therapy (CBT) as the best-supported treatment option. The recent meta-analytic⁵ evidence that more participants achieved abstinence from BE with therapist-led CBT versus waiting list (58.8% vs 11.2%) is in favor of CBT. However, and despite empirical evidence providing partial support of the theoretical model on which CBT is based,⁶ the absence of attention to durability of effects⁷ is among several factors requiring consideration when interpreting Grilo's¹ assertions. Further, the aforementioned meta-analytic⁵ finding highlights that although CBT is regarded by Grilo¹ as the treatment of choice for BED, a substantial proportion of patients do not achieve BE abstinence. This picture represents only a general tendency if further refined by just-published research³ that contributes to gaining insight into the severity-dependent response to CBT. Specifically, significant differences were observed in abstinence from BE (treatment outcome) achieved by 6.7%, 38.7%, 66.7%, and 98.5% of adults who were classified with *DSM-5* extreme, severe, moderate, and mild severity of BED² (see above) based on their pretreatment clinician-rated (weekly) frequency of BE episodes.³ While, according to Grilo,¹ the overvaluation of shape and weight signals greater severity, factors external to eating disorder features addressed in CBT,⁶ such as deficits in coping with aversive emotional states and psychiatric-disorder comorbidity, have recently emerged as the most relevant variables distinguishing the *DSM-5*-defined severity groups of BED that, as noted, showed a differential treatment outcome.³ These findings are relevant also

because the existing/alternative severity approaches for BED, such as subtyping based on overvaluation of shape and weight, were not predictive of BE remission.⁸

Two questions arising from the above and needing consideration in future treatment research for BED are whether (a) second-level treatment would be effective for those in whom first-level (eg, CBT)¹ treatment fails and (b) psychological/behavioral¹ and pharmacologic⁹ interventions should be combined to promote more appropriate treatment for severe-to-extreme BED, since this should differ from treatment regimens for mild-to-moderate presentations.^{3,10}

REFERENCES

1. Grilo CM. Psychological and behavioral treatments for binge-eating disorder. *J Clin Psychiatry*. 2017;78(suppl 1):20–24.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Washington, DC: American Psychiatric Association; 2013.
3. Dakanalis A, Colmegna F, Riva G, et al. Validity and utility of the *DSM-5* severity specifier for binge-eating disorder [published online ahead of print February 28, 2017]. *Int J Eat Disord*.
4. Dakanalis A, Bartoli F, Caslini M, et al. Validity and clinical utility of the *DSM-5* severity specifier for bulimia nervosa: results from a multisite sample of patients who received evidence-based treatment [published online ahead of print July 19, 2016]. *Eur Arch Psychiatry Clin Neurosci*.
5. Brownley KA, Berkman ND, Peat CM, et al. Binge-eating disorder in adults: a systematic review and meta-analysis. *Ann Intern Med*. 2016;165(6):409–420.
6. Dakanalis A, Carrà G, Calogero R, et al. Testing the cognitive-behavioural maintenance models across *DSM-5* bulimic-type eating disorder diagnostic groups: a multi-centre study. *Eur Arch Psychiatry Clin Neurosci*. 2015;265(8):663–676.
7. Wilfley DE, Fitzsimmons-Craft EE, Eichen DM. Binge-eating disorder in adults. *Ann Intern Med*. 2017;166(3):230–231.
8. Masheb RM, Grilo CM. Prognostic significance of two sub-categorization methods for the treatment of binge eating disorder: negative affect and overvaluation predict, but do not moderate, specific outcomes. *Behav Res Ther*. 2008;46(4):428–437.
9. McElroy SL. Pharmacologic treatments for binge-eating disorder. *J Clin Psychiatry*. 2017;78(suppl 1):14–19.
10. Regier DA, Kuhl EA, Kupfer DJ. The *DSM-5*: classification and criteria changes. *World Psychiatry*. 2013;12(2):92–98.

Antonios Dakanalis, MD, PsyD, PhD^{a,b}
antonios.dakanalis@unimib.it
Massimo Clerici, MD, PhD^{a,c}

^aDepartment of Medicine and Surgery, University of Milano Bicocca, Monza, Italy

^bDepartment of Brain and Behavioral Sciences, University of Pavia, Pavia, Italy

^cMental Health Department, San Gerardo Monza Health and Social Care Trust, Monza, Italy

Potential conflicts of interest: The authors report no financial or other affiliation relevant to the subject of this letter.

Funding/support: None reported.

Role of the sponsor: None reported.

J Clin Psychiatry 2017;78(7):e841
<https://doi.org/10.4088/JCP.17lr11589>

© Copyright 2017 Physicians Postgraduate Press, Inc.

You are prohibited from making this PDF publicly available.

Dr Grilo Replies

To the Editor: The Grilo¹ overview of psychological/behavioral treatments for binge-eating disorder (BED) concluded that cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are the most strongly supported interventions and that behavioral weight-loss (BWL) produces good outcomes plus modest short-term weight-loss. Grilo¹ noted that combining medications with CBT/BWL produces superior outcomes to pharmacotherapy-only but does *not* substantially improve CBT/BWL-only outcomes² and suggested that research on predictors/moderators of outcomes could provide important guidance to clinicians about which patients might require extra attention or how to rationally match treatments.

In their letter to the editor, Dakanalis and Clerici³ argue that “the absence of attention to durability of effects⁴ is among several factors requiring consideration when interpreting Grilo’s¹ assertions.” Dakanalis and Clerici³ also suggested the importance of “severity-dependent response to CBT”; specifically, they (a) highlighted that the *DSM-5*⁵ severity specifier of binge-eating frequency was associated with poorer outcomes in their naturalistic treatment study⁶ and (b) questioned my assertion that overvaluation of shape/weight was predictive of binge-eating remission outcomes by citing 1 negative study.⁷ Finally, Dakanalis and Clerici³ noted the importance of finding ways to help nonresponders to initial treatments and suggested that clinicians “should” combine psychological/behavioral with pharmacologic approaches for more severe cases, without citing any evidence. The present reply letter refutes each of these assertions and offers evidence-based clarifications regarding BED treatment outcomes and predictors.

First, Dakanalis and Clerici’s³ comment regarding “the absence of durability of effects” reflects a *mis*-citation of Wilfley and colleagues,⁴ who in fact argued the clear longer-term superiority of CBT for BED based on documented longer-term outcomes.^{8,9} Additionally, I emphasize that CBT has demonstrated clear superiority to antidepressant pharmacotherapy both acutely and over the longer term in both blinded^{10,11} and unblinded¹² comparative trials.

Second, Dakanalis and Clerici’s³ assertions regarding the “significant” prognostic significance of the *DSM-5* severity specifier for BED (based on binge-eating frequency) versus the “null” prognostic significance of overvaluation of shape/weight in one study⁷ require clarification. Although there are isolated previous reports that higher binge-eating frequency predicts nonremission,¹³ most controlled trials have not found that.^{14,15} In contrast, shape/weight overconcern has been reliably associated with nonremission in several rigorous trials^{15–18}; importantly, the negative prognostic significance of overvaluation of shape/weight has been documented through 12-month follow-ups^{16,17} and even after adjusting for other indicators such as depression and self-esteem.^{15,16}

Third, as reviewed critically,² findings from 11 published controlled trials testing combination treatments indicate that combining medications with CBT/BWL produces superior outcomes to pharmacotherapy-only but does *not* substantially improve outcomes achieved with CBT/BWL-only. Moreover, I am unaware of *any* empirical data supporting the claim¹ that clinicians “should” combine psychological/behavioral with pharmacologic approaches for more severe BED cases. I emphasize, however, that early “nonresponse” to treatment has reliably predicted poor outcomes (including nonremission) in several trials with

psychological and medication approaches.^{19–22} Early nonresponse, which is not associated with patient characteristics or BED severity,^{19,21} represents a strong signal to clinicians that they consider alternative treatments.

REFERENCES

1. Grilo CM. Psychological and behavioral treatments for binge-eating disorder. *J Clin Psychiatry*. 2017;78(suppl 1):20–24.
2. Grilo CM, Reas DL, Mitchell JE. Combining pharmacological and psychological treatments for binge eating disorder: current status, limitations, and future directions. *Curr Psychiatry Rep*. 2016;18(6):55.
3. Dakanalis A, Clerici M. Severity of binge-eating disorder and its effects on treatment outcome. *J Clin Psychiatry*. 2017;78(7):e841.
4. Wilfley DE, Fitzsimmons-Craft EE, Eichen DM. Binge-eating disorder in adults. *Ann Intern Med*. 2017;166(3):230–231.
5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Washington, DC: American Psychiatric Association; 2013.
6. Dakanalis A, Colmegna F, Riva G, et al. Validity and utility of the *DSM-5* severity specifier for binge-eating disorder [published online ahead of print February 28, 2017]. *Int J Eat Disord*. 2017.
7. Masheb RM, Grilo CM. Prognostic significance of two sub-categorization methods for the treatment of binge eating disorder: negative affect and overvaluation predict, but do not moderate, specific outcomes. *Behav Res Ther*. 2008;46(4):428–437.
8. Wilson GT, Wilfley DE, Agras WS, et al. Psychological treatments of binge eating disorder. *Arch Gen Psychiatry*. 2010;67(1):94–101.
9. Hilbert A, Bishop ME, Stein RI, et al. Long-term efficacy of psychological treatments for binge eating disorder. *Br J Psychiatry*. 2012;200(3):232–237.
10. Grilo CM, Masheb RM, Wilson GT. Efficacy of cognitive behavioral therapy and fluoxetine for the treatment of binge eating disorder: a randomized double-blind placebo-controlled comparison. *Biol Psychiatry*. 2005;57(3):301–309.
11. Grilo CM, Crosby RD, Wilson GT, et al. 12-month follow-up of fluoxetine and cognitive behavioral therapy for binge eating disorder. *J Consult Clin Psychol*. 2012;80(6):1108–1113.
12. Ricca V, Mannucci E, Mezzani B, et al. Fluoxetine and fluvoxamine combined with individual cognitive-behaviour therapy in binge eating disorder: a one-year follow-up study. *Psychother Psychosom*. 2001;70(6):298–306.
13. Peterson CB, Crow SJ, Nugent S, et al. Predictors of treatment outcome for binge eating disorder. *Int J Eat Disord*. 2000;28(2):131–138.
14. Masheb RM, Grilo CM. Examination of predictors and moderators for self-help treatments of binge-eating disorder. *J Consult Clin Psychol*. 2008;76(5):900–904.
15. Grilo CM, Masheb RM, Crosby RD. Predictors and moderators of response to cognitive behavioral therapy and medication for the treatment of binge eating disorder. *J Consult Clin Psychol*. 2012;80(5):897–906.
16. Grilo CM, White MA, Gueorguieva R, et al. Predictive significance of the overvaluation of shape/weight in obese patients with binge eating disorder: findings from a randomized controlled trial with 12-month follow-up. *Psychol Med*. 2013;43(6):1335–1344.
17. Hilbert A, Saelens BE, Stein RI, et al. Pretreatment and process predictors of outcome in interpersonal and cognitive behavioral psychotherapy for binge eating disorder. *J Consult Clin Psychol*. 2007;75(4):645–651.
18. Sysko R, Hildebrandt T, Wilson GT, et al. Heterogeneity moderates treatment response among patients with binge eating disorder. *J Consult Clin Psychol*. 2010;78(5):681–690.
19. Grilo CM, Masheb RM, Wilson GT. Rapid response to treatment for binge eating disorder. *J Consult Clin Psychol*. 2006;74(3):602–613.
20. Grilo CM, White MA, Wilson GT, et al. Rapid response predicts 12-month post-treatment outcomes in binge-eating disorder: theoretical and clinical implications. *Psychol Med*. 2012;42(4):807–817.
21. Grilo CM, White MA, Masheb RM, et al. Predicting meaningful outcomes to medication and self-help treatments for binge-eating disorder in primary care: the significance of early rapid response. *J Consult Clin Psychol*. 2015;83(2):387–394.
22. Hilbert A, Hildebrandt T, Agras WS, et al. Rapid response in psychological treatments for binge eating disorder. *J Consult Clin Psychol*. 2015;83(3):649–654.

Carlos M. Grilo, PhD³
carlos.grilo@yale.edu

³Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut

It is illegal to post this copyrighted PDF on any website.

Potential conflicts of interest: Dr Grilo reports no financial or other conflicts of interest with respect to the content of this letter. More generally, Dr Grilo reports grants from the National Institutes of Health; consulting fees from Shire and Sunovion; honoraria from the American Psychological Association and from universities and scientific conferences for grand rounds and lecture presentations; speaking and preparation fees for various CME activities; consulting fees from American Academy of CME, Vindico Medical Education CME, General Medical Education CME, Medscape/WebMD Education CME, and CME Institute of Physicians Postgraduate Press; and academic book royalties from Guilford Press and Taylor Francis Publishers.

Funding/support: Preparation of this letter was supported, in part, by National Institutes of Health (NIH) Grant K24 DK070052.

Role of the sponsor: The NIH had no role or influence on the content of the this letter, nor does the content reflect the views of the NIH. No academic, pharmaceutical, or industry entity of any kind influenced the preparation of this letter in any manner.

J Clin Psychiatry 2017;78(7):e842–e843
<https://doi.org/10.4088/JCP.17lr11589a>

© Copyright 2017 Physicians Postgraduate Press, Inc.

You are prohibited from making this PDF publicly available.