Clinical predictors of early response to treatment in an Outpatient Intensive Program for Eating Disorders

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INTRODUCTION

Even if several studies have established the predictive value of early weight gaining in treatment response of patients with AN, and the suppression of binges and purges in patients with BN, there are few data that allow the prediction of early response to an Intensive Outpatient Program (IOP) and the role that other variables could play in the outcome.

It is very important to identify clinical subtypes according to early response to treatment in an outpatient intensive setting.

OBJECTIVES

- To identify subgroups of ED patients assisting to an intensive ambulatory program after the 4th and 16th weeks of treatment, according to the response to the therapeutic objectives and the clinical characteristics at admission.
- To know the role of chronicity, family dysfunction, comorbidities, abuse history and BMI at admission, in early response to treatment.

METHODS

Study Population: Response to treatment to an Intensive Outpatient Program (IOP) , was analyzed in 107 women between 11 and 61 years old with a DSM V diagnosis of AN, BN, BED and EDNOS .

Procedure: All patients were medically evaluated to exclude vital risk that would imply in-patient treatment. They assisted to IOP 5 days a week, between 12 and 6:30 p.m. Each of them had 2 individual psychotherapist (psychiatrist and psychologist), for psychoanalytic oriented therapy and medical follow up and CBT respectively. The multimodal protocol for IOP is summarized in table 1.

At admission, the DSM V diagnostic criteria for ED and Axis I and II comorbidities were used. Other scales as Hamilton Depression Scale, Yale Brown for Obsessions and Compulsions Scale and it´s variant YBC-EDS for ED symptoms, were applied. Weight control and vital signs were controlled daily.

Predictor Variables :Table 2 show the main variables included in the analysis.

Outcome: The main outcome variable was the response to treatment defined at week 4 and 16. Response criteria are listed in Table 3.

Table 1. Outpatient Intensive Program protocol.

CBT group sessions: Twice a week
DBT group session: Four times a week
Expressive group therapy: Once a week
Body Image group: Once a week
Artistic Therapy: Once a week
Nutritional counseling: Twice a week with exposure to meals
Therapeutics meals (lunch and snack) every day
Body Conscious : Daily
Therapeutic journal: Once a week
Record revision and discussion: Once a week

Table 2. Predictors of response to Outpatient Intensive Treatment.

Age
Chronicity of ED symptoms
BMI at admission
Comorbidities
Family Dysfunction
Suicide Attempt
History of sexual or physical abuse
Self-injury behaviors
Previous inpatient treatment

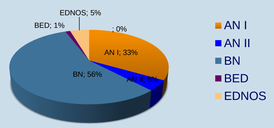
Table 3. Response criteria* at weeks 4th and 16th

ANOREXIA NERVOSA Week 4	ANOREXIA NERVOSA Week 16	BULIMIA NERVOSA Week 4	BULIMIA NERVOSA Week 16
Detention of weight lose curve and gaining of 300-500 gr./week	BMI normal.		
Flexibility in eating patterns with 5 eating moments, a day	Flexibility in eating patterns with 5 eating moments, and all the food groups included	Flexibility in eating patterns with 5 eating moments, and all the food groups included	Flexibility in eating patterns with 5 eating moments, and all the food groups included
Reduction in purge and any other compensation behaviours	Suppression of purge and any other compensation behaviours	Reduction of at least 70% of binges and purges as well as compensatory exercise	Suppression of binges /purges and any other compensation behaviours
Motivation for change in action stage	Motivation for change in maintenance stage	Motivation for change in action stage	Motivation for change in maintenance stage

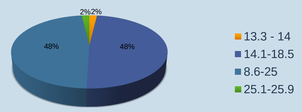
* All criteria must be fulfilled

RESULTS

Graphic 1. Distribution by ED type in 107 women with ED.



Graphic 2 . BMI at admission



They were 107 women with ED. Distribution by ED Type is seen in graphic 1; 53.3% were less than 18 years old, (Mean 18.3 ± 5.7 years). Twenty percent were hospitalized prior to admission at IOP.

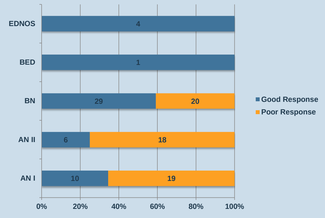
At the beginning of treatment program weight was between 32.3 y 67.9 Kg (Mean 49.8 ± 8.9). BMI was between 13.3 y 25.9 (Mean 19.1±2.9). Chronicity of ED symptoms was less than a year in 39% of the patients, 29.5% had between 1 and 3 years, 16.2% between 3 and 5 years, and 15.2% more than 5 years of chronicity.

After 4 weeks in treatment, 50 (46.7%) had good response to treatment. At week 16, 73 (68.2 %) had it. Between the non-responders, 19 (17.7%) were referred to the hospital during the first weeks of treatment due to worsening in eating symptoms or to any vital risk situation.

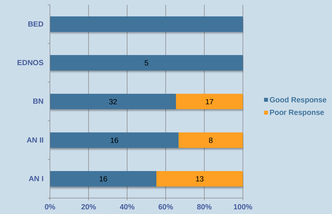
At week 4th, most of good responders were bulimic (59.2%) versus 16 with AN (30.2%) and the differences were statistical significant (X^2=14.5 P= 0.006), but at week 16th, the differences for ED type were not significant (X^2=6.7 P= 0.24).

All patients with incomplete ED or with BED responded since week 4th.(Graphics 3 and 4).

Graphic 3. Response at week 4th by ED Type



Graphic 4. Response at week 16th by ED Type



- Nor family dysfunction, antecedents of abuse and maltreatment, MDD, OCD, substance abuse, PTSD, BD, self harm or having intended suicide, were associated with poor response at weeks 4 or 16.
- Patients less than 13 years old, did not respond at week 4, and 71.4% of them neither did it at week 16. The proportion of no response descended in an inverse proportional way to age: at higher the age, higher early response to treatment (p 0.047).
- In the 23 patients that came from the hospital, only 17.4% responded at week 4th vs. 82.6% that did not get better (X^2 10.1, p<0.001). At week 16th there were no differences between them (p<0.06).
- In patients with BMI <14 there was no good response at week 4 (X^2 12.2, p<0.007). At week 16 this condition did not affect the response in a significant way. (X^2 5.851, p<0.11).

CONCLUSIONS

1. Patients with BN had an earlier response to treatment that anorexic ones.

2. Incomplete forms of AN and BN, and BED responded in a quicker way and the response tend to be maintained in time.

3. BMI <14 at admission to **IOP,** is a factor associated with poor response in the first 4 weeks of treatment.

4. Coming to **IOP** from the hospital, is a factor associated with poor early response in the first 4 weeks of treatment.

5. The presence of comorbidities, chronicity, history of maltreatment or abuse, family dysfunction or impulsive behavior did not alter the response to treatment in this sample.

6. For young patients, aged <12 years old, IOP does not seem to be the treatment of choice. Maybe an individual intensive therapy added to family therapy can be better suited for this population.

References

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