Is Binge Eating Disorder Tied to Obesity? Maybe

Patients diagnosed with BED are demographically different from those with either anorexia or bulimia.

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The dramatic rise in obesity over the last decade has heightened debate among psychiatrists about whether "binge eating disorder" is a distinct clinical entity that deserves to move from the appendix of the DSM-IV up to a full-fledged psychiatric diagnosis in the DSM-V.

Since the DSM-IV was published in 1994, the prevalence of obesity among adults in the United States has risen by at least 30%. One-third of the U.S. population is currently considered obese, with a body mass index of 30 kg/m^2 or greater, and more than two-thirds are overweight, with BMIs at or above 25.

Largely hidden in these statistics are roughly 2% of the population who meet the proposed binge eating disorder (BED) criteria (See box)—and who make up about one-third of individuals who seek help in weight loss treatment programs—as well as the unknown but undoubtedly huge number of people who don't meet the BED criteria but exhibit abnormal eating behavior linked to negative emotional states.

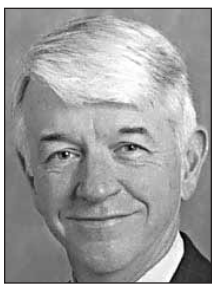
"There's a lot of interest in this topic, much of it related to how the fields of behavioral medicine and psychiatry can make a contribution to both the understanding and treatment of obesity," said B. Timothy Walsh, M.D., who chaired the DSM-IV committee on eating disorders.

The term "binge eating disorder" is widely used in research and clinical settings, but BED is not an official diagnostic category. It is included in the DSM-IV under "criteria sets and axes for further study." Patients who now meet the definition are classified either by other comorbid conditions such as depression or anxiety, and/or under the heading of "eating disorders not otherwise specified" (EDNOS).

The EDNOS category has proved problematic, because it lumps BED in the same category with a young woman who meets all the criteria for anorexia nervosa except that she still menstruates. It also refers to the patient who binges and purges but not quite often enough to qualify for bulimia nervosa. "There's been a lot of discussion about how to handle the EDNOS issue. It's a heterogeneous mix," noted Dr. Walsh, director of the eating disorders research unit at New York State Psychiatric Institute/Columbia University, New York.

And BED patients are demographically very different from those with either anorexia or bulimia. They tend to be middle-aged at the time of diagnosis as opposed to an adolescent or young adult, and are as likely to be black or Hispanic as white, while patients with the other common eating disorders are primarily white. And, although BED is seen more often in women than in men, the ratio is about 60/40, compared with the 90/10 female/male ratio seen with anorexia and bulimia.

So, although BED is a distinct entity—these patients eat more in a shorter period of time than do other obese individuals—the primary reason that it didn't make it into DSM-IV is that "there are not compelling data that people who meet the criteria have a different need for treatment and/or a different prognosis than people who could be described equally well by existing categories. That evidence is still lacking," Dr. Walsh said.



"The fact that most people with BED are obese, and most have some symptoms of anxiety or depression makes one wonder if those labels aren't sufficient. I don't think we should be casual about applying labels. We have to be rigorous in our insistence that the evidence backs up the utility of labels, because once they get created and formally approved, it's very hard to erase them," he remarked.

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DR. WALSH

Carlos M. Grilo, Ph.D., professor of psychiatry and director of the eating disorders program at Yale University, New Haven, Conn., agrees. "There is still active debate about the BED term. There is a clinical reality: Patients do suffer from problems described by the term. The research shows that persons who binge eat have increased psychiatric problems and psychological distress. But, do they benefit less from obesity treatment programs than do obese individuals who don't binge eat? That's not clear."

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DR. GRILO

Indeed, the only clear conclusion about BED treatment is that both cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) effectively reduce binge eating behavior. Both seem to work equally well, although more data are available for CBT. In one randomized comparison of CBT and IPT conducted in group settings for 20 weeks, binge eating recovery rates were equivalent among 81 patients in each group: 64 (79%) with CBT, compared with 59 (73%) with IPT post treatment. At 1 year follow-up, 59% who received CBT and 62% with IPT were still in remission (Arch. Gen. Psychiatry 2002;59:713-21).

But neither CBT nor IPT alone has proven useful for weight loss. Thus far, however, adding concurrent pharmacologic agents or other therapeutic modalities to CBT has yielded inconsistent results.

In a recent randomized, placebo-controlled study by Dr. Grilo and his associates, CBT was significantly superior to fluoxetine, and the addition of fluoxetine to CBT did not produce any further benefit than did the addition of placebo to CBT in either binge eating behavior or weight loss among 108 patients (Biol. Psychiatry 2005;57:301-9).

In an older randomized study that compared the addition of fluoxetine or placebo to behavior modification in 45 obese subjects—22 with binge eating problems and 23 without—weight loss was significantly greater among those taking fluoxetine, but the results did not differ between the binge eaters and the nonbinge eaters (Am. J. Psychiatry 1990;147:876-81).

In another of Dr. Grilo's recent studies, 50 obese BED patients on guided self-help CBT were randomized to receive 12-week concurrent treatment with either 120 mg orlistat three times a day or placebo. In the intent-to-treat analysis, 36% of the orlistat group achieved weight loss of 5% or greater, compared with just 8% of the placebo group. At 3 months' follow-up, those rates were 32% and 8%, with comparable rates of improvement in both eating disorder psychopathology and psychological distress (Biol. Psychiatry 2005;57:1193-201).

Studies of sibutramine (Meridia), an antiobesity medication (Arch. Gen. Psychiatry 2003;60:1109-16), and the antiepileptic topiramate (Topamax) have also shown significant reductions in binge eating and weight loss compared with placebo, although the latter had a high discontinuation rate (J. Clin. Psychiatry 2004;65:1463-9).

Finally, recent data have reinforced the benefits of guided self-help CBT over guided self-help behavioral weight loss (BWL) programs in reducing the frequency of binge eating (Behav. Res. Ther. 2005;43:1509-25) and of individual CBT in reducing binge eating behavior, compared with those who did not receive CBT among 116 overweight/obese BED patients who all received BWL treatment over 20 weeks (Obes. Res. 2005;13:1077-88).

"It's very clear that CBT is the best available treatment for obese persons who binge eat," Dr. Grilo said. "It's superior to medications and behavioral weight loss in producing remission in binging and improving psychological profile. But, it does not appear to be useful for weight loss. Adding orlistat might be one way to go, but we need more data."

But Dr. Walsh pointed out, there are no data looking at the efficacy of commercial weight loss programs such as Weight Watchers in people who meet the BED criteria. "Do they really need CBT, or are standard weight loss programs just as good? That's a very important question."

Dr. Grilo and Dr. Walsh think the answers might come from two particular ongoing studies, both funded by the National Institutes of Health. One, being conducted at Washington University in St. Louis, is looking at the long-term impact of 24 weeks' treatment with the three major psychological approaches (CBT, interpersonal therapy, and behavioral weight loss) in BED. The other trial, from Dr. Grilo's group, is comparing CBT and BWL ("dieting") separately and also in sequence to see whether CBT followed by BWL is effective in reducing both binge eating and weight for up to 1 year post treatment.

Data from both studies are expected in mid-2007. ■

DSM-IV Research Criteria for BED

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge eating episodes are associated with three (or more) of the following:

(1) eating much more rapidly than normal

(2) eating until feeling uncomfortably full

(3) eating large amounts of food when not feeling physically hungry

(4) eating alone because of being embarrassed by how much one is eating

(5) feeling disgusted with oneself, depressed, or very guilty after overeating

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least 2 days a week for 6 months.

Note: The method of determining frequency differs from that used for bulimia nervosa; future research should address whether the preferred method of setting a frequency threshold is counting the number of days on which binges occur or counting the number of episodes of binge eating.

E. The binge eating is not associated with regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

Source: Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision