Bringing binge eating disorder into focus: The sidelined eating disorder

Australia and New Zealand Academy for Eating Disorders (ANZAED)

Binge eating disorder (BED) is characterized by recurrent and distressing episodes of overeating, accompanied by a sense of lack of control. It is the most common of the eating disorders (point prevalence of 1.5% with a further 10.8% meeting criteria for sub-threshold/unspecified BED) and is almost equally likely to present in men and women. BED is associated with significant mental health impairment and psychiatric comorbidity (80%). People with BED are also more likely to have a body mass index (BMI) >40, indicating higher risk for cardiovascular disease and all-cause mortality. Public misconceptions about the prevalence and seriousness of BED, a tendency for individuals and health professionals to focus on weight loss rather than disordered eating behaviors, and shame and stigma surrounding binge eating, have led to poor detection of BED by individuals and health professionals alike.

Over the past decade, numerous treatment trials for BED have been developed, along with clinical practice guidelines (www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Eating-Disorders-CPG.aspx), and most recently, the first medication for treatment of any eating disorder has been approved for BED. These advances, however, are not without controversy which is most clearly illustrated in discourse regarding whether weight loss should be pursued as a target of treatment, and questions around the use of amphetamine treatment. This article presents a brief summary of available evidence regarding treatment approaches for BED, highlighting these debates.

Weight loss as a treatment target

The fact that BED is disproportionately experienced by people with larger bodies, and that the recommended treatment for BED—cognitive behavioral therapy (CBT)—does not address weight loss, has led to development of alternative treatments that concurrently target weight loss alongside eating disorder symptoms. Proponents argue that weight loss is important for the physical health recovery of people with BED who are higher in weight. Furthermore, weight loss is often viewed by patients with BED as an important goal. Evidence to support this approach comes from treatment trials in adults with BED and a BMI >30. These trials show that behavioral weight loss (BWL) interventions produce improvements in binge eating, while being superior to CBT in reducing weight (Peat et al., 2017). This approach challenges a core tenet in eating disorder theory, namely that dieting promotes eating disorder psychopathology (Fairburn et al., 2003). Rather it is suggested that when a diet is supervised by a health professional and involves cognitive restructuring of maladaptive beliefs around eating and body image (i.e. the BWL approach), the two goals of reducing eating disorder symptoms and weight may not necessarily be incompatible.

On the other hand, researchers and clinicians who disagree with the incorporation of weight loss into treatment of BED cite the considerable literature indicating that dieting is a risk factor for eating disorder development. They argue that pursuing weight loss in treatment is indeed counterproductive to recovery, will maintain eating disorder symptoms and may even lead to weight gain. Evidence from the follow-up of BWL trials demonstrate that any weight loss achieved by participants who receive BWL is regained, typically within 12 months (Peat et al., 2017). Furthermore, the psychological effects of sequential unsuccessful weight loss efforts for these participants remain unstudied. Some researchers argue that the majority of impairment associated with being at a higher weight is due to the stigma experienced (i.e. ‘weight stigma’) rather than the weight itself. Thus, preliminary research has turned to prevention and health promotion efforts that aim to reduce stigma of higher weight in the population at large, as well as clinical interventions that aim to inoculate individuals who are in larger bodies against effects of the stigma to which they are exposed.

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Amphetamine treatment

A new medication recently approved for treatment of BED has raised concerns regarding its use in people who are of a higher weight. Lisdexamfetamine dimesylate (LDX; Vyvanse), best known for treatment of attention-deficit hyperactivity disorder (ADHD), was approved to treat BED in the United States in 2015 following evidence that it reduced binge eating episodes relative to placebo over a 12-week trial (Reas and Grilo, 2015). This potentially promising development may in time increase the current success rates for BED treatment and also open up access to treatment for people who are at financial and/or geographic disadvantage. However, the administration of LDX, especially in individuals of a higher weight, requires careful monitoring due to known associated side effects (Coghill et al., 2014). Directions state that it is not to be used for weight loss, due to risk of cardiovascular events associated with other sympathomimetic drugs when administered in this way. Given the increased likelihood that BED patients will be of a higher weight coupled with the common desire to lose weight, a situation can be envisaged where health professionals may be prescribing LDX for binge eating whereas patients may be taking LDX for its known weight loss qualities. Relatedly, LDX is also contraindicated in people with several health conditions including arterial disease, heart disease, and moderate–severe hypertension. This limits the proportion of people with BED who may be helped by LDX, especially those at a higher weight, who are especially likely to present with these co-occurring conditions.

A further complication for clinicians considering LDX is that it is contraindicated for bulimia nervosa. Bulimia nervosa is easily misdiagnosed as BED, especially in higher weight clients, as high weight can erroneously be assumed to indicate absence of compensatory weight loss behaviors, or these behaviors may be actively hidden by patients. Furthermore, diagnostic crossover is common between BED and bulimia nervosa. Indeed, around 15% of BED clients will meet criteria for bulimia nervosa after just 2 years (Fichter and Quadflieg, 2007). Thus, continued diagnostic and medication review will be essential to individuals prescribed LDX. Finally, concerns regarding longer-term efficacy and understanding of mechanisms of action of amphetamine-based treatment on appetite regulation and for addressing psychological eating processes have not been resolved.

Concluding remarks

A number of factors may lead to the conclusion that weight loss interventions in their current form should not be recommended in the treatment of BED. These include the presentation of BED in both smaller and larger bodies, the lack of effectiveness of current behavioural interventions to achieve long-term weight loss, and the potentially negative physical and psychological consequences of weight regain, may suggest that weight loss interventions, in their current form, should not be recommended for BED treatment. However, this suggestion is tempered by the need to provide medical assessment and management to all clients with BED, regardless of weight status, which may include dietary intervention for co-occurring health conditions (e.g. concurrent meal plan supervised by a dietitian for a client with comorbid Type II Diabetes). As research developments, it is perhaps most prudent to retain an open mind regarding the potential for new interventions that may result in long-term weight loss without exacerbating eating disorder symptoms or causing additional distress. The current debate highlights the importance of treatment guided by a thorough formulation, alongside careful consideration of treatment goals, and sensitivity in the way weight is discussed. Similar to trials integrating weight loss interventions into established BED treatments, future research may also benefit from studies that explore whether explicitly addressing weight stigma leads to improved health outcomes. Clinicians should take care in the prescription of LDX to individuals with BED who are actively seeking weight loss, as it is not indicated for this purpose. Furthermore, weight loss attempts may also be indicative of bulimia nervosa psychopathology, and thus, possessing a sound understanding of this differential diagnosis is also critical.

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