

BINGE EATING DISORDER:



CUTLER

Evidence-based treatments

Alone or combined, pharmacotherapy and CBT can reduce bingeing, psychopathology

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Binge eating is consumption of an unusually large amount of food coupled with a feeling of loss of control over eating. Binge eating disorder (BED) is characterized by recurrent episodes of binge eating without inappropriate compensatory behaviors (eg, self-induced vomiting, misuse of laxatives, diuretics, or other agents, excessive exercise).¹ It is the most common eating disorder in the United States, with a lifetime prevalence of approximately 3.5% in women and 2% in men.² The diagnosis falls within the DSM-IV-TR category of eating disorders not otherwise specified,¹ but clinicians often view it as a distinct clinical phenomenon. In DSM-IV-TR, an individual would meet criteria for BED if he or she engages in regular binge eating behavior in the absence of recurrent compensatory behaviors ≥ 2 days per week over 6 months.¹ Proposed changes for DSM-5 recognize a distinct BED diagnosis, reduce the frequency criterion to once per week and the duration criterion to the past 3 months, and shift the focus from binge days to binge episodes (*Table 1, page 34*).³

BED can occur in individuals of all body mass indices (BMI), but is common among individuals who are overweight or obese as well as those with depression or type 2 diabetes; BED can complicate treatment of these conditions.^{2,4,5} Primary treatment goals are:

- abstinence from binge eating
- improved psychological functioning
- appropriate weight regulation in overweight patients.

We report on 3 approaches to BED treatment: medication only, behavioral intervention only, and medication plus behavioral intervention. This article provides insights about emerging changes in diagnostic criteria for BED as well as evidence-informed treatment options and recommendations.

continued



Binge eating disorder

Clinical Point

Several psychotropics, including escitalopram, atomoxetine, zonisamide, and topiramate, can decrease binge eating frequency



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Table 1

Proposed DSM-5 criteria for binge eating disorder

- | |
|--|
| A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: <ol style="list-style-type: none">1. eating, in a discrete period of time (for example, 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 circumstances2. a sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating) |
| B. The binge-eating episodes are associated with ≥ 3 of the following: <ol style="list-style-type: none">1. eating much more rapidly than normal2. eating until feeling uncomfortably full3. eating large amounts of food when not feeling physically hungry4. eating alone because of feeling embarrassed by how much one is eating5. feeling disgusted with oneself, depressed, or very guilty afterwards |
| C. Marked distress regarding binge eating is present |
| D. The binge eating occurs, on average, at least once a week for 3 months |
| E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, or avoidant/restrictive food intake disorder |

Source: Reference 3

The evidence base

We conducted a review of 23 BED studies: 7 medication only, 5 medication plus behavioral, and 11 behavioral only. We focused on studies conducted since September 2005 that included binge frequency, weight, and depression as primary outcomes (see Berkman et al⁶ for a review of BED treatment studies before 2005). The studies included 2,527 participants (2,216 women and 311 men). Although the sex distribution of BED in the general population tends to slightly favor women,² the proportion of women presenting for treatment generally is considerably higher than that of men. In studies that reported on race and/or ethnicity, 1,639 participants were identified as white, 191 as African American, 25 as Hispanic, 2 as Asian, 1 as Native American, and 25 as "other." Ages ranged from 18 to 77.

Several medications are effective

In placebo-controlled studies, a high-dose selective serotonin reuptake inhibitor (escitalopram⁷), 2 anticonvulsants (zonisamide⁸ and topiramate⁹), a selective norepinephrine reuptake inhibitor (atomoxetine¹⁰), and an appetite suppressant (sibutramine¹¹) were associated with significant decreases in

binge eating frequency, weight, and BMI in overweight/obese patients diagnosed with BED (Table 2). In an open-label trial, memantine—a *N*-methyl-D-aspartate receptor antagonist often used to treat symptoms of Alzheimer's disease—was associated with a significant reduction in binge eating but no change in weight.¹² Lamotrigine was not significantly different from placebo in reducing binge eating or weight, but showed promise in reducing metabolic parameters such as glucose and triglyceride levels commonly associated with obesity and type 2 diabetes.¹³ Because BED often is comorbid with obesity and type 2 diabetes, lamotrigine augmentation when treating obese individuals with BED warrants further investigation. As with any pharmacologic agent, carefully consider potential side effects and interactions with other drugs before prescribing medications for BED. Informing patients of potential side effects is crucial for patient safety and accuracy of the data collected in well-controlled treatment studies.

CBT vs other behavioral approaches

Cognitive-behavioral therapy (CBT), which focuses on identifying and modifying un-

Table 2

Pharmacotherapy for binge eating disorder

Study	Drug/dosage	Comments
Guerdjikova et al, 2008 ⁷	Escitalopram, 10 to 30 mg/d, vs placebo for 12 weeks	Escitalopram was significantly better than placebo in reducing weight, BMI, and illness severity
McElroy et al, 2006 ⁸	Zonisamide, 100 to 600 mg/d, vs placebo for 16 weeks	Zonisamide was significantly better than placebo in reducing BE, weight, BMI, and various aspects of unhealthy eating behavior
McElroy et al, 2007 ⁹	Topiramate, 25 to 400 mg/d, vs placebo for 16 weeks	Topiramate was significantly better than placebo in reducing BE, weight, BMI, and related psychological features of BE
McElroy et al, 2007 ¹⁰	Atomoxetine, 40 to 120 mg/d, vs placebo for 10 weeks	Atomoxetine was significantly better than placebo in reducing BE, weight, BMI, and obsessive-compulsive features of BE, and in achieving remission
Wilfley et al, 2008 ¹¹	Sibutramine, 15 mg/d, vs placebo for 24 weeks	Sibutramine was significantly better than placebo in reducing BE, weight, BMI, and related psychological features of BE
Brennan et al, 2008 ¹²	Open-label memantine, 5 to 20 mg/d, for 12 weeks	Memantine was associated with decreased binge frequency and related psychological features of BE
Guerdjikova et al, 2009 ¹³	Lamotrigine, 50 to 400 mg/d, vs placebo for 16 weeks	Lamotrigine was not significantly different from placebo

BE: binge eating; BMI: body mass index

Clinical Point

Some studies suggest CBT can help patients abstain from binge eating

healthy thoughts that maintain disordered eating behaviors, is the most widely studied behavioral intervention for BED. Other studied treatments include interpersonal psychotherapy (IPT), motivational interviewing (MI), and structured behavioral weight loss (BWL) (Table 3, page 36).¹⁴⁻²⁴ IPT is a psychodynamically based, time-limited treatment that focuses on the interpersonal context of the disorder and on building interpersonal skills. MI emphasizes exploring and resolving ambivalence about treatment, and works to facilitate change through motivational processes. BWL is centered on making dietary and physical activity changes to achieve weight loss. Behavioral treatments have been delivered in various formats, such as an individual or group setting, by electronic interface, and via self-help approaches. Most studies compared active treatment to a control group, but some compared active treatments head-to-head.

Studies found that CBT and IPT are effective in reducing the frequency of binge eating, whether measured by the number of binge eating episodes or days a patient reports having engaged in binge eating.¹⁴⁻²³ However, some studies suggested that CBT

can help a substantial number of patients achieve abstinence from binge eating.^{16,20} Adding MI to a self-help approach may improve binge eating outcomes,²⁴ and binge eating can be successfully reduced using individual, group, and CD-ROM delivery formats.²¹ In direct comparisons, individual CBT outperformed group CBT in helping patients recover from BED (ie, no longer meeting diagnostic criteria),¹⁹ and CBT delivered via guided self-help outperformed BWL in helping patients achieve remission.¹⁸

Psychological features of BED typically include low levels of cognitive restraint and high levels of disinhibition, hunger, and shape and weight concerns. Improvements in these psychological measures were observed with CBT,^{15-20,22} IPT,²² and MI.²⁴ In direct comparisons, self-help CBT demonstrated greater reductions in perceived hunger and disinhibition than self-help BWL,¹⁸ and individual CBT outperformed group CBT in reducing shape and weight concerns.¹⁹ Isolated studies reported improvements in depression after self-help CBT¹⁸ and MI,²⁴ and sustained improvements²² after group CBT (6 months) and group IPT (12 months). Additional research is needed to determine whether CBT crafted



Binge eating disorder

Clinical Point

Psychological features of BED include low levels of cognitive restraint and high levels of disinhibition, hunger, and weight concerns

Table 3

CBT and other behavioral interventions for BED

Study	Intervention	Comments
Annunziato et al, 2009 ¹⁴	2 groups received CBT and hypocaloric diet for 8 weeks followed by 14 weeks of enhanced nutritional program (ie, reduced consumption of high energy density foods and once-daily liquid meal replacement) or control (normal diet)	Enhanced nutritional program was not significantly different from the control in reducing weight, BE, or psychological features of BE; variability in adherence to the enhanced nutritional program was identified as a significant effect modifier
Ashton et al, 2009 ¹⁵	4 sessions of group CBT in an open trial	CBT was associated with significant reductions in BE and psychological features of BE in post-bariatric surgery patients
Dingemans et al, 2007 ¹⁶	CBT vs wait-list control	CBT significantly better than the wait-list control in reducing BE and psychological features of BE, and in achieving abstinence from BE
Friederich et al, 2007 ¹⁷	15-session CBT blended with elements of interpersonal therapy (IPT), nutritional counseling, and supervised walking program; no control group	Treatment significantly reduced weight, BE, and related psychological features of BE in patients meeting sub-threshold and full criteria for BED
Grilo et al, 2005 ¹⁸	Guided self-help CBT (CBT _{gsh}) vs guided self-help behavioral weight loss (BWL _{gsh}) vs non-specific attention control for 12 weeks	CBT _{gsh} significantly better than BWL _{gsh} and control in BE remission; CBT _{gsh} significantly better than BWL _{gsh} , which was significantly better than control in reducing cognitive restraint; CBT _{gsh} significantly better than control in reducing depression and eating-related psychopathology; no differences between groups in BMI change
Ricca et al, 2010 ¹⁹	Individual (I-CBT) vs group CBT (G-CBT) for 24 weeks in patients meeting subthreshold and full criteria for BED	BE and BMI were significantly reduced in both groups at 24 weeks and 3-year follow-up. I-CBT was not better than G-CBT in reducing BE or weight at 24 weeks or 3-year follow-up; I-CBT was significantly better than G-CBT in reducing eating-related psychopathology at 24 weeks and 3-year follow-up; I-CBT was significantly better than G-CBT in recovery (ie, no longer meeting full BED criteria) at 24 weeks but not at 3-year follow-up
Schlup et al, 2009 ²⁰	8 weekly sessions of group CBT vs wait-list control	CBT was significantly better than wait-list control in reducing BE and eating concerns and in achieving abstinence at end of treatment; CBT was not different than control in reducing BMI; treatment-related reductions in BE and eating concerns were maintained at 12-month follow-up
Shapiro et al, 2007 ²¹	10 weekly sessions of group CBT (G-CBT) vs CD-ROM delivered CBT (CD-CBT) vs wait-list control	G-CBT and CD-CBT were not different from each other but both were significantly better than wait-list control in reducing BE
Tasca et al, 2006 ²²	Group CBT (G-CBT) vs group psychodynamic interpersonal therapy (G-IPT) vs wait-list control for 16 weeks	G-CBT and G-IPT were not different from each other; G-CBT and G-IPT were significantly better than wait list in reducing BE and interpersonal problems (but not BMI) and increasing cognitive restraint post-treatment; depression was reduced in both groups at 6 months but only in G-IPT at 12 months; reductions in BE maintained at 12 months
Wilson et al, 2010 ²³	10 sessions of guided self-help CBT (CBT _{gsh}) vs 19 sessions of IPT vs 20 sessions of behavioral weight loss (BWL) over 6 months	BWL was significantly better than IPT and CBT _{gsh} in reducing BMI and in the number of patients achieving 5% weight loss at post-treatment but effects were not sustained over time; BWL was significantly better than CBT _{gsh} in increasing dietary restraint
Cassin et al, 2008 ²⁴	Self-help book + motivational interviewing (SH-MI) vs self-help book alone (SH) for 16 weeks	SH-MI was significantly better than SH in reducing BE and depression

BE: binge eating; BED: binge eating disorder; BMI: body mass index; CBT: cognitive-behavioral therapy

Table 4

Combining medication with behavioral interventions for BED

Study	Drug/dosage	Comments
Brambilla et al, 2009 ²⁵	3 groups treated for 6 months: Group 1: CBT + setraline (50 to 150 mg/d) + topiramate (25 to 150 mg/d) + reduced calorie diet Group 2: CBT + sertraline (50 to 150 mg/d) + reduced calorie diet Group 3: CBT + nutritional counseling	Weight, BMI, and psychological features of BE reduced significantly only in group 1
Claudino et al, 2007 ²⁶	Group 1: CBT + topiramate (25 to 300 mg/d) Group 2: CBT + placebo 19 sessions over 21 weeks	Significant reductions in BE and depression in both groups; topiramate significantly better than placebo in reducing weight and in achieving BE remission
Devlin et al, 2005 ²⁷	4 groups, all received behavioral weight control intervention for 5 months (20 weeks) plus either: Group 1: CBT + fluoxetine Group 2: CBT + placebo Group 3: fluoxetine Group 4: placebo (fluoxetine dose, 20 to 60 mg/d)	CBT groups (1 and 2) significantly better than non-CBT groups (3 and 4) in reducing BE and achieving abstinence from BE; fluoxetine significantly better than placebo in reducing depression
Molinari et al, 2005 ²⁸	3 groups, all received nutritional and diet counseling for 54 weeks (4 were inpatient) plus: Group 1: CBT Group 2: fluoxetine (20 to 60 mg/d) Group 3: CBT + fluoxetine	At 12 months, CBT (groups 1 and 3) associated with lower BE frequency and greater percentage of weight loss than fluoxetine
Golay et al, 2005 ²⁹	Hypocaloric diet + orlistat (120 mg/d) vs hypocaloric diet + placebo for 24 weeks	Orlistat not different from placebo in reducing the number of patients classified with BED; orlistat significantly better than placebo in reducing weight and body fat

BE: binge eating; BED: binge eating disorder; BMI: body mass index; CBT: cognitive-behavioral therapy

Clinical Point

Evidence suggests that combining medication with CBT may improve binge eating and weight loss outcomes

specifically for BED improves self-rated depression or if enhancements targeting depressive symptoms are required.

The impact of behavioral interventions on weight in overweight patients has been mixed. Although some CBT studies reported a substantial decrease in weight,^{17,19} others suggested that weight loss among patients treated with CBT is not superior to those in a wait-list control group¹⁶ or is not significant over the course of treatment.^{20,21} The impact of BWL on weight outcomes in BED also has been unimpressive: after 12 weeks, self-help BWL was no better than self-help CBT in reducing BMI¹⁸; after 16 weeks, BWL was better than CBT and IPT in achieving clinically significant ($\geq 5\%$) weight loss, but this advantage was not sustained at 1- and 2-year follow-up.²³ It is difficult to determine why successfully treated BED patients fail to lose weight because one would expect decreases

in binge eating to lead to weight loss. It is possible that calories previously consumed during binge eating episodes are distributed over non-binge meals or that patients label binges and non-binge meals differently as a result of treatment.

Combining treatments

BED patients often are treated with a combination of psychotherapy and pharmacotherapy (*Table 4*).²⁵⁻²⁹ When added to CBT, topiramate was associated with improvements in weight and some psychological outcomes,^{25,26} but fluoxetine was not.^{27,28} Direct comparisons also showed that CBT, alone or combined with fluoxetine, was better than fluoxetine alone in reducing binge eating.²⁷ When combined with an individualized hypocaloric diet, the anti-obesity medication orlistat reduced weight in obese



Binge eating disorder

Clinical Point

All BED patients should receive medical management to address possible complications such as hypertension or type 2 diabetes

Related Resources

- Binge Eating Disorder Association. www.bedaonline.com.
- Brownley KA, Berkman ND, Sedway JA, et al. Binge eating disorder treatment: a systematic review of randomized controlled trials. *Int J Eat Disord*. 2007;40(4):337-348.

Drug Brand Names

Atomoxetine • Strattera	Sertraline • Zoloft
Escitalopram • Lexapro	Sibutramine • Meridia
Fluoxetine • Prozac	Topiramate • Topamax,
Lamotrigine • Lamictal	Topiragen
Memantine • Namenda	Zonisamide • Zonegram
Orlistat • Alli, Xenical	

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BED patients but had no appreciable effect on binge eating.²⁹ Collectively, the studies we reviewed suggested that combining medication and CBT may improve binge eating and weight loss outcomes; however, additional trials are necessary to determine more definitively which medications combined with CBT are best at producing sustained weight loss while reducing binge eating frequency.

Recommendations

Evidence suggests that pharmacotherapy and CBT—alone or in combination—are effective in reducing binge eating, and pharmacotherapy is effective in reducing weight in overweight individuals with BED. More research is needed for IPT and MI. It is unclear which medications provide the greatest benefit in terms of binge eating remission; however, pharmacotherapy has a clear advantage in facilitating short-term weight

loss. Also, all BED patients should receive medical management to address possible complications such as hypertension or type 2 diabetes. In addition to reducing binge eating, CBT can improve related psychological comorbidities (eg, eating-related psychopathology and depression) and may have additional benefit when combined with pharmacotherapy.

In light of these findings, we recommend augmenting psychotherapeutic care with pharmacotherapy and medical management to address all relevant psychological and medical domains. Future investigations should address the benefits of coordinated psychological and medical care and evaluate how to maintain treatment gains.

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Bottom Line

Individuals with binge eating disorder (BED) consume large amounts of food without inappropriate compensatory behaviors (such as vomiting or exercise) and feel a loss of control over their eating. Both pharmacologic and psychological interventions, alone or in combination, have demonstrated success in reducing binge eating. All BED patients should receive medical management to address possible medical complications.

This month's instantpoll

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Ms. W, age 32, says that for 9 months she's been binge eating 1 or 2 days a week. Her bingeing is triggered by anxiety and frustration. She's gained weight and now has a body mass index of 25 kg/m². **How would you treat her?**

- Start escitalopram, 30 mg/d
- Start orlistat, 120 mg 3 times a day
- Refer her to group cognitive-behavioral therapy (CBT)
- Refer her to individual CBT
- Start fluoxetine, 60 mg/d, and refer her to individual CBT

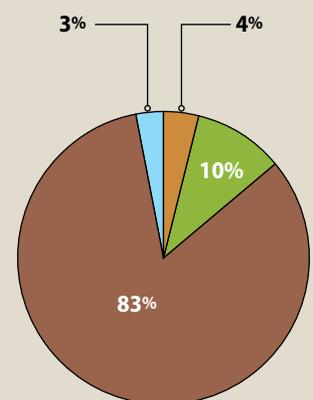
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MARCH POLL RESULTS

Mr. K, age 36, is referred to you by his primary care physician for "treatment-resistant depression." Despite successive courses of fluoxetine, desvenlafaxine, and bupropion, he continues to experience fatigue, feelings of worthlessness, and depressed mood. **How would you proceed?**

- 4% Switch Mr. K to a different selective serotonin reuptake inhibitor
- 10% Restart desvenlafaxine, 50 mg/d, and augment with aripiprazole, 5 mg/d
- 83% Determine if the pharmacotherapy he received used an adequate dosage for an adequate duration, and if not, restart one of the initial medications
- 3% Switch Mr. K to olanzapine/fluoxetine, 6 mg/25 mg



SUGGESTED READING:
Desseilles M, Fava M, Mischoulon D, et al. *CURRENT PSYCHIATRY*. 2012;11(3):26-33.