Binge Eating Disorder and Obesity

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ABSTRACT

Binge eating disorder (BED) is included into eating disorders that are not otherwise specified in DSM-IV. It is more common among overweight women applied to treatment. In the conducted researches it was found that there was high level psychiatric comorbidity in patients with BED. In addition, it has been emphasized that depression caused relapses after BED treatment. In this article, a case of a young woman that failed obesity treatment and therefore referred to psychiatry clinic has been presented. In her treatment fluoxetine and BDT were used and effective results have been obtained. The patient at the same time followed the diet program given by dietician and was controlled by internal medicine department. Multidisciplinary approach is important in the treatment of obesity. Successful results have been obtained with psychiatric evaluation and with the treatment of psychopathologies.

Key words: *Binge eating disorder, eating disorders, obesity*

Tıkınırcasına Yeme Bozukluğu ve Obezite

Tıkınırcasına yeme bozukluğu (TYB), DSM-IV'de başka yerde sınıflandırılamayan yeme bozukluklarına dâhil edilmektedir. Yapılan çalışmalarda TYB olanlarda yüksek oranda psikiyatrik eştanı saptanmıştır. Ayrıca depresyonun TYB tedavisi sonrasındaki nükslere de neden olduğu vurgulanmıştır. Bu yazıda obezite tedavisinde başarılı olamayan ve bu nedenle de psikiyatriye yönlendirilen genç bir kadın olgu sunulmuştur. Tedavisinde hem fluoksetin hem de BDT birlikte kullanılmış ve etkili sonuçlar elde edilmiştir. Hasta aynı zamanda diyetisyenin verdiği diyet ve egzersiz programını takip etmiş ve dâhiliye tarafından kontrol edilmiştir. Obezite tedavisinde multidisipliner yaklaşım önemlidir. Psikiyatrik değerlendirme ve olası psikopatolojilerin tedavisi ile başarılı sonuçlar elde edilmektedir.

Anahtar kelimeler: *Obezite, tıkınırcasına yeme bozukluğu, yeme bozuklukları*

INTRODUCTION

Binge eating disorder (BED) is included into eating disorders that are not otherwise specified in DSM-IV (1). It is similar to bulimia nervosa (BN) in that it has recurrent binge eating disorder episodes, and due to symptoms such as losing control during these episodes. Inappropriate compensatory behavior such as using laxatives during bulimia in order to avoid gaining weight, excessive exercises, and vomiting are not applied to BED. In addition, it has some features such as eating faster than normal, eating without physical hunger and eating till feeling uncomfortable. Eating attacks appear at least twice a week (2).

In clinic we come across in different types of obesity in most of the patients with BED. It is frequently seen in women (65% women, 35% men). It is more common among overweight women applied to treatment. It has been reported that fat intake of obese people with BED in their diets is much more than that of carbohydrates. Negative feelings such as frustration and anger, depression and anxiety, social situations, some certain hours of the day and some food can trigger binge eating disorder (3). There is a positive relation between BED level and obesity. When obese people with BED and without BED were compared, it was shown that obesity in BED started at earlier ages and weight changes and seeking treatment were more (4,5).

In the conducted researches it was found that there was high level psychiatric comorbidity in patients with BED. Major depression, generalized anxiety disorder, panic disorder, alcohol and drug addiction are frequently seen (6). It has been shown patients with BED have more lifetime depressive symptoms. In addition, it has been emphasized that depression caused relapses after BED treatment (3). However, it is difficult to understand the psychopathologic reason of depression in BED and it cannot be distinguished whether it is the reason or result of over eating. Besides, it has been stated that in patients with BED hostility, criticizing, and expressing anger independent from depression levels were higher, impulsive features were more. (7). In this study, a case of a young woman that failed obesity treatment and therefore referred to psychiatry clinic has been presented. It is aimed to emphasize the importance of multidisciplinary approach in the treatment of obesity.

CASE

A 27 year old university graduate, single woman working at a marketing firm was studied. She applied to psychiatry department upon the referral of obesity clinic. Complaint: putting weight, cannot resist eating, unwillingness. She stayed at boarding school at secondary school. Since she was away from her family she felt alone and could not communication with friend easily and started to put on weight. She said that she lost weight at first by doing sports from time to time, yet could not control overeating and put on weigh again. When she was at university she reached up to 80 kilos. She had no application for treatment until she started working life. She started working two years ago. In job interviews she did not have self confident and started to have problems with her weight. She applied to a dietician 6 months ago, yet was not strict about the given program. She especially overate at the ends of the months when sale reports were submitted. She stated that she generally ate chocolate and cake and added that she could finish a cake for six people at one night. She stated that eating relieved her even though she did not feel any hunger, yet she was regretful after eating. She stated that she was unwilling to go to work for the last few months, felt herself tired, had difficulty in waking and did not want to do any exercise. In the first mental examination herself interest and care had decreased. Association of ideas was regular. There were depressive ideas in her reasoning context that she does not like herself and felt her unsuccessful. Her affection was depressed. Beck depression inventory point (BDE) was 28. Height, weight and BMI were measured as 162 cm, 85 kg, BMI: 32,7 (kg/sq m) respectively. In the performed tests pre-prandial blood sugar, thyroid hormone level and blood biochemistry were in normal borders. As the result of the evaluation the diagnose was depressive disorder due to continuing symptoms, everyday for the last few months, and loss of willing, decrease of energy, tiredness, oversleeping, putting weight, the sense of worthlessness, and depressive feelings. In addition to this, some indications such as episodes of recurrent binge eating disorders and uncontrollable eating during these episodes, willing to eat without having any sense of hunger and gaining weight and the fact that she did not have any inappropriate behavior to aviod putting weight(induced vomiting, laxative usage etc.) led to the diagnosis of “binge eating disorder”. Treatment plan: The patient was taken into both diet-exercise

and psychiatric treatment program. She was given a calorie scale and food that she has to take weekly. She was asked to walk 4 days a week, at least 45 minutes each time. Fluoxetine 20 mg/day was started and was increased to 60 mg/day gradually. Weekly interviews were planned. The patient was asked to record what she had eaten during the first weeks. Cognitive behavior therapy was applied to raise awareness for eating behavior timing and type. In the following weeks meetings were carried out on the causes of the problems in the diet- exercise and problem solving methods. At the 6th week there was 6 kilos weight. BDE was 12. Then the following meetings were planned as once a month. At the tenth week of the treatment the patient lost totally 11 kilos, almost all depressive symptoms were improved. The controls of the patient still continue.

DISCUSSION

Obesity is diagnosed according to daily clinical diagnose and body mass index. Although obesity itself is not in eating disorders (ED), it carries common psychological features found in ED. Obese patients are subdivided into two groups by the researchers studying on the issue; obese with BED and without BED (8,9). The weight of obese people with BED is related to overeating habits and their psychopathologies are much more than those of the other group. The rate of depression was found to be higher in those with BED (10). In the case we presented the depressive symptoms increased due to especially associated with unwillingness of weight control trials.

It can be said that still short distances have been covered in obesity treatment. Especially long term results are not very satisfying. Although some people lose weight with treatment, they could gain the weight they lost in a short time. It is shown in the reviewed articles that most of patients regained the weight they lost within 1-5 years and most of them had their initial BMI or even exceeded it (11). Many researchers research approaches of keeping the lost weight as well as losing weight.

The medicines used in the researches for the pharmacologic treatment of binge eating disorder are second generation antidepressants (selective serotonin reuptake inhibitors-SSRI), tricyclic antidepressants, anticonvulsants and sibutramin (2). Among SSRI are fluoxetine, fluvoxamine and randomized controlled studies carried out with sertraline (12-14). In this study it has been emphasized that the mentioned medicine decreased the episodes of BED. However, these studies are generally short term studies (9-12 weeks). Further studies are needed on long term effects. Appetite suppressant features of anticonvulsants are benefited and used for BED treatment. Topiramate can be given as an example. In a study topiramate was given for 14 weeks (on average 212 dose mg/day) and it was observed that it decreased binge eating disorder episodes. However, topriamate was not found effective on depression and anxiety (15). Important decreases have been recorded in weight loss with sibutramin treatment (average 15 doses mg/day) (16). In the case we presented since the depressive symptoms were clear fluoxetine, as an antidepressant, was given. Later on the patient had the benefit of antidepressant. Cognitive behavior therapy (CBT) is the most frequently used method for BED treatment. CBT focuses on body image, inappropriate eating behaviors, and factors triggering eating attacks. It can be applied as one to one or as group therapy (17). It is especially effective on the regulating the eating habit of the patients. In our case CBT methods were highly effective both for increasing awareness on the disease and controlling eating behavior. Studies report that combined treatment became more effective in the treatment. In a comparative study where fluoxetine, CBT and combined treatments (fluoxetine+CBT), it was found that combined treatment was more effective than fluoxetine or CBT treatment alone (18). In this case both fluoxetine and CBT were used together and effective results were obtained. The patient also followed the diet and exercise program given by a dietician and was controlled by internal medicine clinic.

Consequently, multidisciplinary approach is important for obesity treatment. Successful results have been obtained by psychiatric evaluation and psychopathologic treatment.

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