Diabetes services need to improve diagnosis of binge eating disorder in type 2 diabetes

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Eating disorders are common in type 2 diabetes, with 20% of people with the condition meeting the diagnostic criteria for an eating disorder and approximately half of these affected by binge eating disorder (Papelbaum et al, 2005). Despite their widespread occurrence, the majority of diabetes services remain poor at identifying and treating eating disorders. Early identification and treatment are essential.

Dieting is a significant causal factor for binge eating, and it is crucial that people with binge eating disorder are identified and offered an alternative treatment to dietary restriction. Restricting diet will result in an increased incidence of binge eating, and be directly counter-productive to the desired outcomes of reduced circulating glucose and weight loss.

Patients with high scores for emotional eating behaviour will not be able to make changes to their diet, because they generally lack the control necessary to do so (Herpertz et al, 2000). Therefore, the eating disorder must be treated effectively before there is any attempt at weight loss or calorie restriction. Services should use validated screening tools such as the Eating Disorder Examination Questionnaire (EDE-Q) 6.0 to identify eating disorders (Fairburn and Beglin, 2008).

There is a strong relationship between BMI and eating disturbance, with binge eating disorder predating diabetes diagnosis (Crow et al, 2001; Mannucci et al, 2002). Common factors for the development of eating disorders include female gender, increased body weight, body dissatisfaction, a history of dieting and a history of depression (Pinhas-Hamiel and Levy-Shraga, 2013).

The recently updated DSM-5 psychiatric diagnostic criteria now include binge eating disorder as a standalone eating disorder with a lower threshold for diagnosis (De Young et al, 2012). The new criteria differentiate more clearly between binge eating disorder and the common phenomenon of overeating. Binge eating disorder is defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. Someone with binge eating disorder may eat too quickly, even when they are not hungry. The person may have feelings of guilt, embarrassment, or disgust and may binge eat alone to hide the behaviour. This disorder is associated with marked distress and occurs, on average, at least once a week over 3 months (De Young et al, 2012).

Previous studies looking at pathological overeating found that over a quarter of men with type 2 diabetes (27%) and 11% of females with type 2 diabetes reported consistent and pathological overeating or binge eating (Ryan et al, 2008).

Eating disorders have a significant impact on health. Abnormalities of eating attitudes and behaviour are associated with an impairment of metabolic control, higher body weight, and increased HbA_{1c} (Mannucci et al, 2002; Canan et al, 2011). Binge eating disorder has also been closely correlated with emotional eating, increased hunger, and consequently a higher intake of energy and fat (Herpertz et al, 2000). People with type 2 diabetes and an eating disorder may also have considerable psychiatric symptomatology, and body and eating-related psychological distress (Crow et al, 2001).

There is a high-quality evidence base for the treatment of binge eating disorder based on cognitive behavioural therapy (CBT), which will be effective in around 60% of cases (NICE, 2004). First-line treatment using guided self-help interventions can be very useful, but a referral to specialist eating disorder practitioners including a specialist eating disorder dietitian and a psychologist should also be considered.

For those who do not experience significant relief through CBT, alternative treatments based on dialectical behavioural therapy (DBT) should be considered (Wilson, 2005). DBT is a modification of CBT; it focuses on thoughts, feelings and behaviours, combining CBT with other "third wave" techniques including mindfulness and acceptance. In DBT, the therapist aims to balance "acceptance techniques" with "change techniques", assuring the patient that their behaviours and feelings are valid and understandable, while coaching for change at the same time. A key assumption in DBT is that self-

destructive behaviours are learned coping techniques for unbearably intense and negative emotions that make life seem like a roller coaster. Patients learn four sets of skills: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. They are also asked to call their individual therapist for skill coaching and guidance when they experience strong urges to complete self-defeating behaviours such as binge eating; the therapist then walks the patient through the use of the skills as alternative strategies.

From my experiences of working with people with binge eating disorder and type 2 diabetes, I find that people generally feel let down by services that are poor at diagnosing eating disorders and that don't offer any specific interventions to help. Working with skilled practitioners who are able to explain their behaviour from a psychological, physiological and nutritional perspective brings relief from the widespread belief held by many healthcare professionals that the individual simply "lacks willpower".

Shifting the focus of treatment from reducing weight to increasing skills and strategies for managing emotional eating using CBT and DBT approaches is essential for a successful outcome. ■

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