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Brief report

## Classifying binge eating-disordered adolescents based on severity levels



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### ABSTRACT

The new severity criterion for binge-eating disorder (BED), introduced by the most recent (fifth) edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a means of addressing within-group variability in severity, was tested in 223 Italian (13-18-year-old) adolescents (86.1% females) with (DSM-5) BED presenting for treatment. Analyses revealed that participants classified with mild (35.9% of the sample), moderate (38.1%) severe (13.4%), and extreme (12.6%) severity of BED, based on their clinician-rated weekly frequency of binge-eating (BE) episodes, were statistically distinguishable in physical characteristics (body mass index) and a range of clinical variables regarding eating-related psychopathology and putative maintenance factors, health-related quality of life, and mood and anxiety disorder comorbidity (medium-to-large effect sizes). Between-group differences in age-at-onset of BED or demographics were not detected. The findings provide support for the utility of BE frequency as a severity criterion for BED in adolescence. Implications for future studies are discussed.

### 1. Introduction

Binge-eating disorder (BED), characterized by recurrent binge eating (BE) in the absence of extreme compensatory behaviours (e.g., self-induced vomiting) is currently a formal eating disorder (ED) diagnosis in the DSM-5 ([American Psychiatric Association \[APA\], 2013](#)), previously in the DSM-IV appendix ([APA, 1994](#)) as a research criteria set for further study. BED, traditionally considered as an adult disorder, occurs in adolescence with some epidemiological evidence highlighting BED as the most prevalent ED in youth ([Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011](#)). It has been identified in 1.6% of 13-18-year-old adolescents from the community ([Swanson et al., 2011](#)), and in up to 20% of treatment-seeking adolescents (e.g., [Dakanalis, Timko, Clerici, Riva, & Carrà, 2017](#); [Goldschmidt et al., 2008](#)). Similar to BED in adults, this disorder in adolescence is associated with medical complications related to excess body weight, eating-related psychopathology (i.e., restraint, shape, weight, and eating concern), major forms of psychiatric comorbidity (e.g., mood and anxiety disorders) and impairment of health-related quality of life (e.g., [Kessler et al., 2013](#); [Pasold, McCracken, & Ward-Begnoche, 2014](#); [Swanson et al., 2011](#); [Tsappis, Freizinger, & Forman, 2016](#)). Furthermore, several transdiagnostic factors (e.g., low self-esteem, interpersonal problems, perfectionism, body surveillance, mood intolerance) involved in the

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maintenance process of all EDs in adults, BED included (e.g., Dakanalis, Carrà, Calogero et al., 2015; Dakanalis, Clerici et al., 2016; Dakanalis, Timko et al., 2016; Fairburn et al., 2009; Fitzsimmons-Craft, Bardone-Cone, & Kelly, 2011), appear to play a key role in the persistence of BE pathology in youth (e.g., Allen, Byrne, & McLean, 2012; Boone, Soenens, Vansteenkiste, & Braet, 2012; Dakanalis, Timko et al., 2017; Goldschmidt, Lavender, Hipwell, Stepp, & Keenan, 2017; Goldschmidt, Wall, Loth, Bucchianeri, & Neumark-Sztainer, 2014; Ranzenhofer et al., 2014; Tsappis et al., 2016).

The female to male rate ratio is not only less skewed in BED (~ 2:1 to 6:1) than in other EDs (e.g., Raevuori, Keski-Rahkonen, & Hoek, 2014; Smink et al., 2014), but also “the presentation of BED has been shown to be similar in males and females” (Murray et al., 2017, p. 4). Evidence suggests that young females and males with BED did not differ significantly in BE frequency, associated eating-related psychopathology and (aforementioned) putative maintenance factors, accompanying mood and anxiety disorder comorbidity, and impairment of health-related quality of life (e.g., Barry, Grilo, & Masheb, 2002; Dakanalis, Carrà, Clerici, & Riva, 2015; Dakanalis, Favagrossa et al., 2015; Dakanalis & Riva, 2013a,b; Guerdjikova, McElroy, Kotwal, & Keck, 2007; Jambekar, Masheb, & Grilo, 2003; Reas, Grilo, Masheb, & Wilson, 2005; Serino et al., 2016; Striegel, Bedrosian, Wang, & Schwartz, 2012; Udo et al., 2013). Besides gender differences in metabolic dysfunctions and key biological factors (e.g., Klump, Culbert, & Sisk, 2017; Udo et al., 2013), both genders also appear similar in terms of treatment response (e.g., Guerdjikova et al., 2014), as well as age-of-BED onset and body mass index (BMI) (e.g., Striegel et al., 2012; Udo et al., 2013).

BED, like other threshold EDs (e.g., Dakanalis, Bartoli et al., 2016), varies in terms of symptom severity and treatment outcome, and elucidation of factors accounting for this variation is of nosological and clinical significance (e.g., Dakanalis, Colmegna, Riva, & Clerici, 2017; Masheb & Grilo, 2008; Picot & Lilienfeld, 2003). Notably, in addition to changing the minimum frequency and duration of BE episodes “from two days per week over six months (DSM-IV stipulations) to once per week for three months” (Dakanalis, Riva, Serino, Colmegna, & Clerici, 2017, p. 268), the DSM-5 (APA, 2013) added a new *severity indicator* (or specifier) based on BE frequency to “address within-group variability and heterogeneity in severity and help clinicians to track patients' progress” (Dakanalis, Colmegna et al., 2017, p. 917). Specifically, four severity groups based on the frequency of BE episodes were defined (APA, 2013) as follows: *extreme* (> 14 episodes/week), *severe* (8–13 episodes/week), *moderate* (4–7 episodes/week), and *mild* (1–3 episodes/week).

The aforementioned DSM-5 severity groups of BED (APA, 2013) appear valid in terms of the significant between-group differences observed in eating-related psychopathology (i.e., restraint, shape, weight, and eating concern) in a recent study performed with treatment-seeking overweight adults with (DSM-5) BED (Grilo, Ivezaj, & White, 2015). Similar findings have been reported in two more recent studies (Dakanalis, Colmegna et al., 2017; Dakanalis, Riva et al., 2017) performed with (independent) clinical samples of adults diagnosed with (DSM-5) BED, which also revealed that the four DSM-5 severity groups of BED were statistically distinguishable in four putative maintenance factors (low self-esteem, interpersonal problems, perfectionism, and mood intolerance), psychiatric and personality-disorder comorbidity, metabolic abnormalities and end-of-treatment abstinence from (i.e., no episodes of) BE. Despite the (mentioned) fact that BED, which develops over adolescence, was identified in up to 20% of treatment-seeking adolescents and research evidence for a significant association between BED severity and the proportion of community adolescent cases with BED detected and treated by mental health care services (Smink et al., 2014), no research has to date evaluated the utility of BE frequency as a severity indicator for BED in adolescents presenting for treatment. Thus, while existing research provides support for the DSM-5 severity indicator of BED in adults, its clinical utility and validity in treatment-seeking youth remains to be seen.

This study tests the DSM-5 severity indicator for BED in adolescents with (DSM-5) BED presenting for treatment. Driven by the empirical literature on BED mentioned above, we evaluated whether treatment-seeking adolescents sub-grouped based on the aforementioned DSM-5 severity definitions (APA, 2013) would show significant differences in a range of variables (of clinical interest) associated with BED and/or involved in the maintenance process of this condition, as recommended (e.g., Dakanalis, Colmegna et al., 2017; Dakanalis, Riva et al., 2017; Grilo et al., 2015; Stice et al., 2001). These variables (assessed before adolescents are triaged to a treatment programme) include eating-related psychopathology (i.e., restraint, shape, weight, and eating concern) and five putative maintenance factors (i.e., low self-esteem, interpersonal problems, perfectionism, body surveillance, and mood intolerance), mood and anxiety disorder comorbidity, and health-related quality of life. Between-group differences in basic demographic (i.e., age, ethnicity/race, and gender) and physical (i.e., BMI) characteristics and age-of-BED onset were also investigated. We expected that our participants classified with mild, moderate, severe and extreme severity of BED (based on the BE frequency, APA, 2013), would show meaningful differences in eating-related psychopathology, BMI, mood and anxiety disorder comorbidity, levels of health-quality of life and scores on the measures of all putative maintenance factors considered. This hypothesis was based on the already mentioned findings from recent studies that examined the utility of the DSM-5 severity indicator for BED in treatment-seeking adults (see above) and prior adolescent research revealing positive associations between BE frequency and scores on the measures of all putative maintenance factors considered (e.g., Allen et al., 2012; Boone et al., 2012; Dakanalis, Timko et al., 2017; Goldschmidt et al., 2014, 2017; Ranzenhofer et al., 2014; Tsappis et al., 2016) and that more frequent BE was related to greater BMI, eating-related and comorbid (mood and anxiety) psychopathology, and poorer health-quality of life (e.g., Dakanalis, Timko et al., 2014; Glasofer et al., 2007; Goldschmidt et al., 2008; Isnard et al., 2003; Pasold et al., 2014; Tsappis et al., 2016). Between-group differences in age, ethnicity/race, gender and age-of-BED onset were not expected, given prior findings with adolescents and adults highlighting that different degrees of BE frequency are unrelated to the demographic characteristics considered and the age when BED first occurred (e.g., Picot & Lilienfeld, 2003; Smink et al., 2014).

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