Eating Behaviors 21 (2016) 179–188

Contents lists available at ScienceDirect

Eating Behaviors

The role of complementary and alternative medicine in the treatment of eating disorders: A systematic review

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ARTICLE INFO

Article history:
Received 29 August 2015
Received in revised form 23 February 2016
Accepted 1 March 2016
Available online 6 March 2016

Keywords:
Eating disorders
Complementary and alternative medicine
Systematic review

ABSTRACT

This systematic review critically appraises the role of complementary and alternative medicine in the treatment of those with an eating disorder. Sixteen studies were included in the review. The results of this review show that the role of complementary and alternative medicine in the treatment of those with an eating disorder is unclear and further studies should be conducted. A potential role was found for massage and bright light therapy for depression in those with Bulimia Nervosa and a potential role for acupuncture and relaxation therapy, in the treatment of State Anxiety, for those with an eating disorder. The role of these complementary therapies in treating eating disorders should only be provided as an adjunctive treatment only.

Contents

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http://dx.doi.org/10.1016/j.eatbeh.2016.03.002
1471-0153/

1. Background

Complementary and alternative medicine (CAM) refers to a broad range of health practices (National Centre for Complementary and Alternative Medicine N, 2012; NICM, 2011; Weir, 2005) and thus a definition of what constitutes a CAM therapy has at times been unclear. The National Centre for Complementary and Integrative Health separate complementary and alternative medicine with complementary being "a non-mainstream practice used together with conventional medicine" and alternative being a non-mainstream practice used in place of conventional medicine" (National Center for Complementary and Integrative Health, 2008). An operational definition of CAM proposed by Wiedland and colleagues defines CAM based on (i) therapies that rely upon non-allopathic models of health, (ii) exclusion from standard treatment within the dominant medical system, and (iii) self-care or care delivered by alternative practitioners (Wieland, Manheimer, & Berman, 2011). This review uses this definition of CAM as there are therapies that are used, both in combination with conventional medicine, and as the primary treatment. A list of the CAM modalities can be seen in Appendix 1.

Eating disorders according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), include Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), PICA, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder (ARFID) or Other Specified or Unspecified Feeding or Eating Disorder (OSFED or UFED) (American Psychiatric Association, 2013). OSFED/UFED replaces the Eating Disorder Not Otherwise Specified (EDNOS) category.

In the developed world the lifetime prevalence of eating disorders is 1.01% and they appear to be increasing (Mitchison, Hay, Slewa-Younan, & Mond, 2012; Qian et al., 2013). Eating disorder morbidity is also high, and mortality is among the highest of psychiatric disorders (Arcelus, Mitchell, Wales, & Nielsen, 2011). Eating disorders are chronic illnesses with frequent relapses occurring for many individuals (Dawson, Rhodes, & Touyz, 2014). Greater than 20% of individuals continue to have an eating disorder on long term follow up, and many may develop mental illness such as depression (15–60%), anxiety disorders (20–60%), or personality disorders (Lowe et al., 2001).

A multidimensional treatment approach to the treatment of eating disorders is most commonly adopted. Multidimensional treatment addresses the physical, psychological, psychosocial and family needs of the individual, and can include psychiatrists, psychologists, primary care physicians, social workers, nurses and dieticians. Treatment aims to restore the individual's weight within normal range for their height and age, to reduce abnormal eating behaviors, and weight and shape cognitions, and manage co-morbidities (both mental and physical). There is evidence for the use of cognitive behavioral therapy for BN and BED and family based therapy for adolescents with AN (Hay, 2013) and a small base of evidence for pharmacological management of AN (Treasure, Claudino, & Zucker, 2010), however the evidence base underlying these current therapeutic approaches has limitations. Some of these limitations include addressing personal recovery needs such as a personally satisfying quality of life (Mitchison, Morin, Mond, Slewa-Younan, & Hay, 2015) and personal concept of recovery (Dawson et al., 2014). Recovery from an eating disorder varies between individuals but generally involves restoration of healthy eating habits and "a healthier physical and psychological state of being" (National Eating Disorders Collaboration, 2015).

Reported use of CAM is increasing and especially for acupuncture, deep breathing exercises, massage therapy, meditation and yoga (Barnes, Bloom, & Nahin, 2008). CAM use is high among individuals diagnosed with mental health conditions especially anxiety and depression where 56.7% of those with anxiety attacks, and 53.6% of those with severe depression reported using CAM as an adjunct to treat their conditions (Kessler, Soukup, & Davis, 2001). There is an increasing evidence base identifying the adjunctive use of complementary therapies to assist with the management of eating disorders however the prevalence of CAM use among people with eating disorder is unknown (Clarke, 2009; Fogarty & Madden, 2014; Madden, Fogarty, & Smith, 2014). Previous reviews on the use of CAM therapies and eating disorders have not been systematic, are dated and were inconclusive (Fogarty & Madden, 2014; Madden et al., 2014). Qualitative research findings indicate that eating disorder sufferers find CAM therapies acceptable and beneficial as adjuncts to their eating disorder treatment (Fogarty & Madden, 2014; Katterman, Kleinman, Hood, Nackers, & Corsica, 2014; Madden et al., 2014; Vancampfort et al., 2014). Complementary and alternative therapies that improve patient outcomes, reduce the burden of poor health and help facilitate personal recovery needs that are highly desirable. The aim of this review is to examine the role of CAM therapies in the treatment of eating disorders.

2. Methods

2.1. Inclusion and exclusion criteria

Studies were included if they involved CAM treatment of an Eating Disorder (ED). An eating disorder was defined as meeting DSM diagnostic criteria (editions 1–5) (American Psychiatric Association, 2013) or equivalent diagnostic criteria e.g., International Classification of Diseases (World Health Organization, 1992), or clinical assessment by a specialist e.g. psychologist, psychiatrist. Eating disorders included in this criterion are: Anorexia Nervosa, Bulimia Nervosa, Eating Disorder not Otherwise Specified, Binge Eating Disorder, PICA, Avoidant/Restrictive Food Intake Disorder and Other Specified or Unspecified Feeding or Eating Disorders.

Studies also had to involve one of the CAM modalities defined by Wiedland and colleagues (Wieland et al., 2011). Dietary supplements and diet therapy have been excluded as these are frequently used as standard Western medicine treatments for eating disorders (Birmingham & Beumont, 2004) See Appendix 1 for a list of all the CAM modalities.

All published and unpublished randomised controlled trials were eligible for inclusion. Studies were excluded if they were not a randomised controlled trial, if they were not investigating a CAM therapy or they did not include an eating disorder population or sample.

2.2. Search strategy

The electronic databases The Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Registers, Medline (years 1946–2013), EMBASE (1974–2013), CINHL (1950–2015), PsycINFO (1786–2015) and PubMed (1950–2015) were searched for Randomised Controlled Trials (RCT's) investigating CAM therapies and the treatment of eating disorders in September 2013 and again in January 2015. The search strategy can be seen in Appendix 2 and was applied for each CAM therapy excluding dietary supplements and therapy, and for each database.

One author (SF) independently selected articles that met the criteria for the systematic review through scrutiny of all the abstracts of papers identified from the searches after duplicates were removed. The data extraction procedure was performed according to the guidelines outlined by the PRISMA statement (Moher, Liberati, Tetzlaff, & Altman, 2009). Where it was unclear if a paper was to be included, a second reviewer was consulted (PH or CS). Reasons for excluding trials have been stated in Fig. 1. One author (SF) independently reviewed all the studies and two authors (CS and PH) both independently reviewed half of the studies, using the standardised data extraction form. Data was entered into the Review Manager Software by author SF. Any discrepancies were discussed by the three reviewers. Additional searching of conference proceedings, the International Clinical Trial Registry and the Australian, New Zealand Clinical Trial Registry (ANZCTR) and the reference lists of all papers selected was undertaken to identify further relevant studies.