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letter to the editor

Rethinking BMI in Depression: Could It Be Binge Eating or Atypical Depression?

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To the Editor:

The recently-published article "The Impact of Cognitive Behavioral Therapy on Body Mass Index in Patients Treated Exclusively for Depression" provides insight into the interconnection between physical and mental health and assesses whether cognitive behavior therapy (CBT) can provide secondary physical health benefits for individuals with major depressive disorder (MDD) including weight reduction. Although CBT did not statistically decrease body mass index (BMI) in patients with MDD, this study allows us to further the conversation and explore these findings from a psychiatric framework. Thus, we can address the implications of disordered eating in the context of atypical depression.

MDD with atypical features includes symptoms of increased appetite, weight gain, hypersomnia, leaden paralysis, and rejection sensitivity. This explains the associated increased BMI, incidence of obesity, and increased waist circumference.[1] Binge eating disorder (BED) symptoms include discrete and recurrent episodes of overeating due to loss of control.[3,4] These episodes are associated with significant distress and are often associated with depressive symptoms.[3,4] BED is also associated with a high BMI and is the most common eating disorder with a lifetime prevalence of 0.2 to 4.6%.[4] Reviewing this study from a mental health perspective, the higher BMI despite CBT could be indicative of atypical depression, a subtype of MDD. This is significant because it is often underdiagnosed and disproportionately effects individuals from a lower socioeconomic status, ethnic minorities, and males.[4]

Furthermore, the control group in Sunu et al's, study had an increased number of individuals with Medicare and Medicaid insurance compared to the CBT group which had an increased amount of individuals with private insurance. The increase in Medicare/Medicaid could suggest that the control group had an increased amount individuals from lower-income and disadvantaged backgrounds. This highlights the potential mental health equity concerns regarding access to CBT in marginalized groups. Having government-funded insurance could be a barrier to accessing psychotherapy like CBT, which negatively affects mental health outcomes. Additionally, government insurance can limit individuals to a medication-only treatment plan. The associated stigma surrounding mental health medication in underserved and low-income communities could cause hesitation in medication-only treatment.

Notably, CBT is currently the gold standard treatment for BED. In a recent study, CBT was found to decrease the frequency of binging but not decrease BMI when compared to controls.[5] If patients in Sunu et al's, study were experiencing BED, this could account for the nonsignificant increase in BMI even with CBT utilization. This underscores the importance of routine screening for eating disorders in patients with MDD, because it can alter the treatment plan and improve health outcomes.

These considerations highlight the need for an assessment and screening of disordered eating within the depression evaluation. In the study by Sunu et al, CBT did not decrease BMI in patients with MDD which could demonstrate undiagnosed atypical depression or BED. Misdiagnosis leads to potentially ineffective treatment regimens, which subsequently undermines patients' health and wellness. By critically assessing and routinely screening patients with MDD for eating disorders, we can improve health outcomes, especially in marginalized communities.

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