



Research paper

Binge eating behaviours in bipolar disorders



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ABSTRACT

Background: Recent research, especially from the USA, suggests that comorbid binge eating (BE) behaviour and BE disorder are frequent in individuals with Bipolar Disorder (BD). Although basic clinical associations between BD and BE have been investigated, less is known about psychological or temperamental dimensions and qualitative aspects of eating habits. In a French cohort of patients with BD, we investigated the prevalence of BE behaviour and any associations with illness characteristics, anxiety, impulsivity, emotional regulation and eating habits.

Methods: 145 outpatients with BD (I and II) were assessed for the presence of BE behaviour using the Binge Eating Scale (BES). Characteristics identified in univariate analyses as differentiating BD cases with and without BE behaviour were then included in a backward stepwise logistic regression (BSLR) model.

Results: In this sample, 18.6% of BD patients met criteria for BE behaviour. Multivariate analysis (BSLR) indicated that shorter duration of BD, and higher levels of anxiety and emotional reactivity were observed in BD with compared to BD without BE behaviour.

Limitations: Relatively small sample referred to specialist BD clinics and cross-sectional evaluation meant that it was not possible to differentiate between state and trait levels of impulsivity, emotional instability and disinhibition. These dimensions may also overlap with mood symptoms.

Conclusion: BE behaviour is common in females and males with BD. Emotional dysregulation and anxiety may represent important shared vulnerability factors for worse outcome of BD and increased likelihood of BE behaviour.

1. Introduction

Bipolar disorder (BD) is a severe chronic affective disorders associated with significant clinical, social and economic burden, and including high levels of comorbidity. Among these comorbidities, eating disorders such as anorexia nervosa and bulimia nervosa has long been described (Alvarez Ruiz and Gutierrez-Rojas, 2015). More recently, binge eating disorder (BED) has been recognized as a frequent association with BD. BED is characterized by recurrent episodes of binge eating (BE), namely the

consumption of excessively large amounts of food in a short period, associated with a sense of loss of control but without inappropriate compensatory behaviours (American-Psychiatry-Association, 2000). In BD, the prevalence of comorbid BED and repeated episodes of BE behaviour is estimated at 15%, and 17%, respectively (Kruger et al., 1996; McElroy et al., 2013; Schoofs et al., 2011; Wildes et al., 2007), compared with 2–5% in the general population (Bruce and Wilfley, 1996; Dingemans et al., 2002; Rand et al., 1997; Smith et al., 1998; Stunkard et al., 1996). Moreover, comorbid BED during BD is associated with more mood

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instability, residual mood disorders symptoms, comorbid anxiety and addictions, episodes with psychotic symptoms, suicidality, and with obesity, cardiovascular diseases and metabolic syndrome (Hudson et al., 2007; Lundgren et al., ; MacQueen et al., 2003; McElroy et al., 2013; Siqueira et al., 2004; Stunkard et al., 1955).

Studies dealing with this topic have been mainly conducted in the United States, yet it has long been suggested that vulnerability to develop eating disorders varies according to cultural and ethnic differences (Kessler et al., 2013). In addition, only one study investigated qualitative eating patterns of BD patients with comorbid BED (Jacka et al., 2011) and cognitive aspects such as restriction, disinhibition and the influence of emotions on eating behaviours, have not been investigated so far. Although BED affects patients with emotional regulation disorders (Kittel et al., 2015), dimensional aspects of BD patients with BE behaviour remain understudied. This is important as “emotional alimantation” (in reaction to negative emotions) is a recognized phenomenon and has been shown to differ from a usual diet, by its qualitative, quantitative and behavioural aspects (Gibson, 2006; Kaplan and Kaplan, 1957).

Another important issue is the diagnostic threshold for BED as it has been suggested that the categorical diagnostic criteria may be too restrictive and under-estimate the prevalence of BE behaviours; a position that appeared to be acknowledged in the recent modifications incorporated in the DSM-5 criteria (the requirements for the frequency and duration of BE behaviour were reduced to 1 binge eating episode weekly for 3 months in DSM-5 compared with a minimum of 2 binge eating days weekly for 6 months in DSM-IV) (McElroy et al., 2016a). As expected, a study of a representative sample of 22,397 adults in the US demonstrated that the prevalence is higher of BED diagnosed using DSM-5 criteria compared with DSM-IV-TR criteria (Cossrow et al., 2016); interestingly, the study also estimated that BED remained under-recognized. However, a review of published studies found little evidence to support the validity and utility of the frequency criterion of the BED categorical diagnosis (Wilson and Sysko, 2009), as multiple BE episodes are prevalent and associated with negative outcomes (Kruger et al., 1996; Wildes et al., 2008). Furthermore, McElroy et al. (2016b) recently showed that BE behaviour predicted BED or bulimia nervosa with a positive predictive value of 0.90 and specificity of 0.96.

Given the findings and uncertainties from the recent literature noted above, the aim of this study was to investigate the prevalence and characteristics of BE behaviour in a sample of BD cases attending specialist BD clinics in France. Cases with and without BE were compared on socio-demographic, clinical, personality and dimensional variables as well as eating habits. Multivariate analysis was used to determine the best combination of variables that differentiated BD cases with BE behaviour from those without BE behaviour.

2. Methods

An ethical review board approved the assessment protocol and a letter of information was given to each potential study participant. Written informed consent was required from all patients included in the study.

2.1. Sample

The sample comprised of consecutive consenting patients who met criteria for BD I or II and who were referred to two of the nine centres that comprise the French BD network. All the centres use the same protocol to undertake systematic, comprehensive, longitudinal, and multi-dimensional assessments (Henry et al., 2015). The current study was undertaken in Paris and Montpellier and recruitment was undertaken in three phases corresponding to different time periods when the residents involved in undertaking the assessments were working at the BD expert centres (HB, ST, CG). The time periods were: January to September 2013 and June to September 2015 (Paris), and June to September 2015 (Montpellier). (A comparison of the data collected from cases assessed in the Paris and those from Montpellier are shown in Appendix Table A1). The eligibility criteria for the participants were:

a) Inclusion criteria

- Age > 18 years.
- Met DSM-IVR criteria for BD I or II following an assessment interview undertaken by a psychiatrist trained in the use of the Structured Clinical Interview (SCID I).
- Willing and able to give written informed consent.

b) Exclusion criteria

- Met DSM-IVR criteria for a manic, mixed, hypomanic or depressive episode in the last 3 months.
- Lifetime DSM-IVR diagnosis of schizoaffective disorder.

2.2. Measures

1. Socio-demographics: age and gender were recorded.
2. Clinical characteristics of BD

Each centre uses a semi-structured interview and trained assessors to record lifetime BD characteristics. We selected key variables that may be associated with eating habits or severity of BD including: BD subtype, polarity of the first episode, illness duration, and history of: alcohol or substance use disorder (ASUD), hospitalizations (as a proxy of illness severity), suicide attempts and prior history of eating disorders. Depressive, manic and anxiety states were measured by the Montgomery Asberg Depression Rating Scale (MADRS), Young Mania Rating Scale (YMRS) and State-Trait Inventory Anxiety (STAI-Y-A: State version) scales, respectively.

3. Identification of BE behaviours

The presence or absence of recurrent BE behaviours was established using a validated self-reported questionnaire, namely the French version of Binge Eating Scale (BES) (Brunault et al., 2016; Gormally et al., 1982). The BES contains 16 items, each comprising of 3 or 4 statements related to the presence and severity of key behavioural (eating large amount of food, quickly), affective and cognitive symptoms (guilt, incapacity to stop eating, feeling of loss of control) of any BE episodes. The total score ranges from 0 to 46, with higher scores indicating more severe BE behaviours. Individuals can also be categorized as having a significant level of BE behaviour if their BES score > 17 (Grupski et al., 2013; Marcus et al., 1988). A Brazilian study demonstrated that the BES had a Cronbach's alpha of 0.89 for the test re-test reliability, and when the cut-off point of 17 was compared with SCID-defined BED, the BES demonstrated a sensitivity of 0.98, a specificity of 0.48 (Freitas et al., 2006).

4. Evidence of abnormal eating habits and bodyweight

The presence or absence of Night Eating Syndrome (NES) was assessed using the French version of the Night Eating Questionnaire (NEQ), which is a 14 item self-rated questionnaire that measures 4 factors: nocturnal ingestion of food, evening hyperphagia, morning anorexia and mood/sleep perturbations (Allison et al., 2008). Each item is scored from 0 to 4, with a total ranging from 0 to 52. Individuals with an NEQ score > 26 are considered as having a NES (Lundgren et al., 2006).

We also used a French version of the Three Factor Eating Questionnaire (TFEQ-18) (de Lauzon et al., 2004), which is an 18-item self-report questionnaire that measures cognitive and behavioural aspects of alimentation (Stunkard and Messick, 1985). Three factors are assessed: cognitive restriction (conscious restriction of food intake to control body weight), uncontrolled eating / disinhibition (tendency to eat more than usual due to a loss of control over food intake) and emotional eating (inability to resist emotional cues). Higher scores indicate greater restraint, uncontrolled or emotional eating. Studies of the general population in France shows that females (F) have higher average scores than males (M) on all three factors (cognitive restraint- F: 39 ± 21 vs M: 22 ± 18;

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