Binge Eating Disorder

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KEYWORDS

• Binge eating disorder • Female binge eating • Treatment • Gender • Sex differences • Eating dysregulation

KEY POINTS

- Binge eating disorder is more prevalent than anorexia nervosa and bulimia nervosa combined and it is the most common eating disorder in males.
- Binge eating disorder remains underrecognized and undertreated in both sexes.
- Males and females with binge eating disorder are more similar than different in their presentation and treatment response.
- Binge eating disorder is a treatable illness and psychological and pharmacologic treatments are now available.

BINGE EATING DISORDER

Binge eating disorder (BED) is the most common eating disorder (ED) and an important public health problem worldwide. Recent data from the World Health Organization Mental Survey Study, which surveyed adults from 14 countries on 4 continents, found a lifetime prevalence rate of BED to be 1.4%.[1] In the United States, the

Conflict of Interest: Dr L.S. Casuto and Mrs N. Mori have no conflicts of interest to disclose. Dr S. L. McElroy is a consultant to or member of the scientific advisory boards of Bracket, F. Hoffmann-La Roche Ltd, MedAvante, Myriad, Naurex, Novo Nordisk, Shire, and Sunovion. She is a principal or coinvestigator on studies sponsored by the Alkermes, Forest, Marriott Foundation, National Institute of Mental Health, Naurex, Orexigen Therapeutics, Inc, Shire, Sunovion, and Takeda Pharmaceutical Company Ltd. She is also an inventor on US Patent No. 6,323,236 B2, use of sulfamate derivatives for treating impulse control disorders, and along with the patent's assignee, University of Cincinnati, Cincinnati, Ohio, has received payments from Johnson & Johnson, which has exclusive rights under the patent. Dr A.I. Guerdjikova is employed by the University of Cincinnati College of Medicine and is a consultant for Bracket.

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Psychiatr Clin N Am ■ (2017) ■–■
http://dx.doi.org/10.1016/j.psc.2017.01.003 **psych.theclinics.com**

lifetime prevalence of BED has been estimated to be 2.6%; BED continues to be an underrecognized and undertreated condition. Patients rarely spontaneously disclose binge-eating symptoms because of embarrassment or shame. Binge-eating behavior is overlooked, and treatment commonly focuses on obesity and its complications as the presenting problem rather than addressing the core eating psychopathology.

BED is characterized by recurrent episodes of binge eating, defined as eating in a discrete period of time (about 2 hours) an amount of food larger than most people would eat under similar circumstances and having a sense of loss of control over the eating. Additionally, patients do not engage in the inappropriate compensatory behaviors of bulimia nervosa (BN), for example, self-induced vomiting or excessive use of diuretic or laxatives. Binge-eating episodes are associated with feelings of guilt and distress and occur on average at least once a week for 3 consecutive months. During a binge-eating episode, patients might eat large amounts of food when not feeling physically hungry, eat more rapidly than normal, and eat until feeling uncomfortably full. Patients with BED often eat in secrecy; they are embarrassed by the binge-eating behavior and their perceived inability to control the urges to overeat.[2]

HISTORICAL OVERVIEW OF BINGE EATING DISORDER AND OTHER EATING DISORDERS

Anorexia nervosa (AN), BN, and BED are the 3 major types of EDs outlined in *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*).[2] AN is characterized by intense fear of gaining weight or becoming fat resulting in persistent restriction of food intake leading to significantly low body weight. Individuals with BN engage in recurrent binge-eating behaviors followed by inappropriate compensatory weight-loss behaviors, such as self-induced vomiting or abuse of laxatives or diuretics. BED is characterized by recurrent episodes of binge eating that are not followed by the inappropriate weight loss behaviors diagnostic for BN. The estimated lifetime prevalence of *DSM-IV* AN, BN, and BED is 0.9%, 1.5%, and 3.5% among women and 0.3% 0.5%, and 2.0% among men, respectively[3]; thus, BED is more common than AN and BN combined. All EDs are highly heritable illnesses[4] and associated with decreased quality of life and increased disability, morbidity, and mortality.[1,5]

Medical cases describing symptoms of AN appeared in literature in the early seventeenth century with the work of the English physician Dr Morton. Binging with subsequent purging were both known through ancient history with the Hebrew Talmud (AD 400–500) referring to a ravenous hunger that should be treated with sweet foods (boolmot), but the medical term *bulimia nervosa* was not introduced until 1979 and then included as a formal diagnosis in *DSM-III* in 1987. BED was first formally described in 1959 by Albert Stunkard[6] as a form of abnormal eating among obese patients. In his seminal article "Eating Patterns and Obesity," he described a female patient with binge eating as follows: "She usually began to feel a desire for food in the early evening, and would eat a large supper. Only temporarily sated, she soon returned to the kitchen and consumed larger and larger amounts of food at progressively shorter intervals. During these hours, she was assailed by loneliness and anxiety. She rarely fell asleep before midnight, and usually awoke within an hour, anxious and hungry. Then she would eat a pint of ice cream and drink a bottle of soda pop."[6]

Overall, all 3 types of EDs received little systematic attention until the middle of the twentieth century when they were conceptualized as mental illnesses and included in formal disease classifications. As recently as 2013, BED was added to *DSM-5* as a stand-alone psychiatric disorder.