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Binge Eating Disorder: Information for Primary Care

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Summary: Binge eating disorder (BED) is an eating disorder characterized by recurrent binge eating episodes, without compensatory behaviours (such as vomiting) that would be seen in bulimia nervosa. Associated symptoms include depression, anxiety, and interpersonal sensitivity.

Epidemiology

- 12-month prevalence in females is 1.6% and in males is 0.8% (DSM-5)
- Prevalence of BED is more than anorexia and bulimia combined
- Prevalence of 15-50% in participants of weight-control programs (DSM-5)

Case

Ms. A is a 25-yo female who presents wanting help for out of control eating.
Stressors

- Her job
- Her boyfriend unexpectedly left her for her best friend a few months ago.

Since that time, she has been feeling anxious and depressed. Food has always been a comfort for her, and with her recent stresses, she found herself eating more than usual. She would eat an entire bag of chips, or a pint of ice cream. Although it helped with her anxiety initially, her eating has gotten “out of control”, to the point where she has gained significant amounts of weight, which has now become a stress.

History / Screening Questions

General eating disorders quick screen (CWEDP-2010):

- Are you unhappy with your body weight and shape?
- Are you dieting? Have you dieted much in the past?
- Have you lost weight?

- Some people eat large quantities of food in an out of control way. Has this ever happened to you?

Specific for BED screening questions (CWEDP-2010):

- Many people eat large quantities of food in an out of control way. Does this every happen to you? How often?
- How long does each eating session last?
- Many people, after eating in this way feel very badly. Do you ever feel badly about yourself after eating in this way?
- Many people try to compensate for this eating by getting rid of the food or compensating for it somehow. Has this ever happened to you? E.g. making yourself sick/exercising/using laxatives?
- Have you undergone any surgery to help with your weight concerns? E.g. bariatric surgery?

Diagnosis

- Key features:
  - Recurrent episodes binge eating at least 1/week for 3 months
  - A loss of control during the episode
  - No compensatory behaviour following an episode
- Care must be taken to differentiate BED from overeating (SIM LA et al., 2010)

DSM-5 Criteria

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  A. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances
  B. A sense of lack of control over eating during the episode (feeling that one cannot stop eating or control what or how much one is eating)
- The binge-eating episodes are associated with 3 (or more) of the following:
  - Eating much more rapidly than normal
  - Eating until feeling uncomfortable full
  - Eating large amounts of food when not feeling physically hungry
  - Eating alone because of feeling embarrassed by how much one is eating
  - Feeling disgusted with oneself, depressed, or very guilty afterward
  - Marked distress regarding binge eating is present
- The binge eating occurs, on average, at least once a week for 3 months
- The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa

Specifiers for severity of binge eating disorder

- Mild: 1-3 binge-eating episodes per week
- Moderate: 4-7 binge-eating episodes per week
- Severe: 8-13 binge-eating episodes per week
- Extreme: 14 or more binge-eating episodes per week

Differential Diagnosis

Bulimia nervosa	**Are there compensatory bulimic behaviours (such as binging/purging) which might suggest bulimia?** Binge eating episodes can be seen in both BED and bulimia With BED, there is no compensatory bulimia (unlike with bulimia)

Obesity	**Is the patient overweight and/or obese?** Many with BED are overweight and/or obese With obesity, there is overvaluation of body weight/shape, whereas there is not with BED If the full criteria for both BED and obesity are met, both diagnoses should be given.
Bipolar and depressive disorders	**Does the patient have episodes of increased mood with decreased need for sleep?** **Does the patient have depression?** Increased appetite and weight can be seen in both BED and bipolar/depressive disorders
Major depressive disorder	**Does the patient have depressed mood, with neurovegetative symptoms such as problems with sleep, appetite, or weight gain?** Increased appetite and weight gain If the full criteria for MDE and BED are met, both diagnoses can be given.
Borderline personality disorder	**Does the patient have borderline personality disorder, i.e. tendency to feel insecure in relationships?** Binge eating is an impulsive behaviour that is part of the DSM definition of borderline personality disorder If the full criteria for both disorders are met, both diagnoses should be given.

Physical Exam

- Physical status (weight, height, and BMI)

Investigations

Routine investigations include :

- CBC
- BUN
- Creatinine
- Fasting insulin
- Electrolytes
- Fasting blood glucose
- Liver function tests
- Hormone panel

Management: Overall Goals

- Help patients understand disordered eating
- Increase healthy eating habits and decrease unhealthy habits
  - Many BED patients are overweight or obese, however there is debate as to whether patients with BED should first be referred to behavioural weight loss programs or to a BED treatment program (Sim LA et al., 2010)
- Find alternatives to binging
- Better cope with emotional distress
- Develop a long-term plan for relapse prevention
- Monitor for complications related to BED such as consequences of being overweight or obese
- Ensuring healthy lifestyle habits including:
  - Getting enough sleep
  - 3 regular meals along with snacks
  - Removing unhealthy binge foods from the house

Management: Psychological

- Refer to a mental health agency or professional in order to provide counselling/therapy.

Psychotherapy/counselling interventions shown helpful for binge eating disorders include:

CBT

- Focuses on the dysfunctional thought and behaviours that contribute to the binge eating
- Cognitive strategies
- Cognitive distortions: “I’ve already binged, so I might as well eat the rest of this bag of chips” “I didn’t eat lunch, so I an eat this pint of ice cream”, etc.

Behavioural strategies

- Binge eaters tend to have irregular eating habits; thus, there is a strategy to have structure to eating behaviours, for example:
    - Regular meals including breakfast
    - Afternoon snack if needed
    - Never go more than four hours without eating
    - Include foods that they like in the diet

CBT Guided self-help

- CBT guided self-help is a manual-based guided self-help form of CBT delivered in 8 sessions by master’s level clinicians

Interpersonal Therapy (IPT)

- Stresses with relationships may contribute to individuals using binging as a way of coping
- Thus, patients may be helped by improving their relationships, such as by resolving conflicts, or increasing their positive social interactions

Dialectical Behavioural Therapy (DBT)

- DBT helps patients develop alternatives to bing eating as a way of coping with emotional distress
- DBT helps patients develop skills such as acceptance, distress tolerance, and emotional regulation skills

Self-regulation

- Using relaxation techniques instead of food to deal with anxiety
- Stress management
- Patients can identify their top stress with work, school, home, and relationships
- Work with patients to find alternative to binge eating to manage this stress
- Explore problem solving options, distraction strategies, exercise, meditation, mindfulness, relaxation exercises, etc.

Build a support network

- "Are there people in your life that you can turn to for support?”
- Options include joining a support group, talking with family members or friends, or seeing a mental health professional
- Behavioural strategies for weight control
- Structured meal plan that reduces daily intake by 500-700 calories a day, and which allows a few hundred calories from preferred foods

Management: Medications

Medication	**Dosage**
Lisdexamfetamine (Vyvanse)	Starting dose: 30 mg once daily in the morning Target dose: 50-70 mg once daily Maximum: 70 mg daily
SSRIs	
Citalopram (Celexa)	Starting dose: 10-20 mg daily Target dose: 20-40 mg daily Maximum: 40 mg daily
Fluoxetine (Prozac)	Starting dose: 10-20 mg daily Target dose: 20-40 mg daily Maximum: 40 mg daily
Fluvoxamine (Luvox)	Starting dose: 25-50 mg daily Target dose: 100-200 mg daily Maximum: 200 mg daily
Sertraline (Zoloft)	Starting dose: 25-50 mg daily Target dose: 100-200 mg daily Maximum: 200 mg daily
TCA	
Imipramine (Tofranil)	Starting dose: 100 mg daily Target: 100-200 mg daily Maximum 200 mg daily
Desipramine (Norpramin)	Starting dose: 100-200 mg daily Target: 100-300 mg daily Maximum 300 mg daily
Other	
Topiramate (Topamax)	Starting dose: 50 mg daily Target dose: 200 mg daily Maximum 600 mg daily (McElroy et al., 2003)

Reference: APA Practice Guidelines, 2006; McElroy et al., 2003

When to Refer to Mental Health Services

- Patient is medically unwell and needs intensive care and monitoring
- Risk of self-harm or harm to others
- Multiple co-morbid psychiatric or medical conditions

Practice Guidelines

- APA Practice Guideline for the Treatment of Patients with Eating Disorders Third Edition. June 2006.
- Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE Guidelines [CG9], published Jan 2004.

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About this Document

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