BINGE EATING DISORDER (BED)

How to identify, diagnose and talk to your patients about BED

What is Binge Eating Disorder?

Binge eating disorder, or BED, is a clinically defined psychiatric disorder.[1] Binge eating disorder is the most prevalent eating disorder but frequently goes undiagnosed in primary care.[2] In a US survey of 2980 participants, BED was the most common eating disorder with a lifetime prevalence estimate of 3.5% among women and 2.0% among men.[3*]

The American Psychiatric Association (APA) defines BED as **recurring episodes of eating significantly more food in a discrete period of time** (such as a 2-hour period) than most people would eat under similar circumstances, with episodes marked by feelings of lack of control.[4]

DSM-5® criteria for a diagnosis of BED

The DSM-5® diagnostic criteria can help you identify BED in your patients:[1]

A	Recurrent episodes of binge eating, including: • Eating more food than what most people would eat in a discrete period of time • Lack of control over the episode
B	Episodes are associated with ≥3 of the following: • Eating more rapidly than normal • Eating until feeling uncomfortably full • Eating large amounts of food when not feeling hungry • Eating alone due to embarrassment • Feeling disgusted with oneself, depressed, or guilty afterwards
C	Marked distress with regard to binge eating
D	Episodes occur, on average, at least once per week for three months
E	No association with recurrent use of inappropriate compensatory behaviour as in bulimia nervosa; does not occur exclusively during the course of bulimia nervosa or anorexia nervosa

Severity of BED

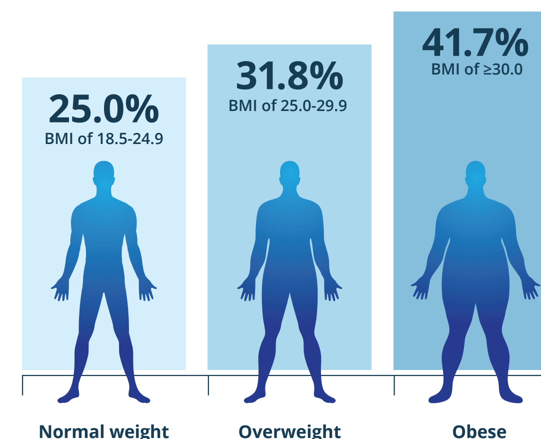
Mild: 1-3 binge-eating episodes per week.
Moderate: 4-7 binge-eating episodes per week.
Severe: 8-13 binge-eating episodes per week.
Extreme: 14 or more binge-eating episodes per week.

The DSM-5® has defined BED as an eating disorder, with specific criteria for diagnosis.

Did you know?

BED is more than occasional overeating. It is a serious psychological condition that can occur in normal weight, overweight or obese adults.[4,5]

In a multinational survey of over 24,000 adults, those with 12-month BED (n=344) had a range of BMIs.[5†]



In a survey of more than 10,000 Canadian adults, more people self-reported that they experienced symptoms of BED in the past 12 months than anorexia and bulimia symptoms combined.[6‡]

- **Anorexia nervosa** affected 0.5% of those surveyed
- **Bulimia nervosa** affected 0.7%
- **BED** affected 1.7% of those surveyed

DSM-5®: *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition
DSM-5® is a registered trademark of the American Psychiatric Association.
BMI: body mass index

* Based on lifetime prevalence estimates of anorexia nervosa, bulimia nervosa and Binge Eating Disorder among adults over the age of 18 years across the United States. Prevalence and correlates of eating disorders from the National Comorbidity Replication, a nationally representative face-to-face household survey (N=9282), conducted in 2001-2003, were assessed using the DSM-IV-TR® diagnostic criteria of the WHO WMH-CIDI (World Mental Health – Composite International Diagnostic Interview). Diagnoses were based on version 3.0 of the WHO-CIDI, a lay-administered diagnostic interview that generates a diagnosis according to the DSM-IV-TR® criteria. Binge Eating Disorder criteria defined in this study was based on the DSM-IV-TR® and the CIDI. Study criteria for Binge Eating Disorder was similar to that of the DSM-5®, with the following difference: individuals displaying more than 3 months, but less than 6 months, of regular binge eating would be classified as having Binge Eating Disorder.

† Based on lifetime prevalence rates of Binge Eating Disorder among adults over the age of 18 years across 14 countries, including the United States, Belgium, France, Germany, Italy, the Netherlands, New Zealand, Northern Ireland, Portugal, Spain, Colombia, Brazil, Mexico and Romania. Prevalence and correlates of eating disorders from nationally representative samples (or those representative of urbanized areas) via face-to-face surveys (N=24,124) were assessed using the DSM-IV-TR® diagnostic criteria of the WHO WMH-CIDI (World Mental Health – Composite International Diagnostic Interview).

‡ Self-reported symptoms of BED, anorexia or bulimia, consistent with the DSM-5®. The VALIDATE survey was conducted online among a representative sample of 10,030 Canadians ranging from 20 to older than 65 years of age. Initial and supplemental data collection took place between May–August 2016. In addition to collecting basic information across all participants, those who indicated that they had been diagnosed with BED, as well as those who indicated a presence of symptoms that were consistent with the DSM-5® criteria for BED, were further evaluated. All measures were self-reported.

BED and comorbid conditions

A retrospective chart review in 202 patients with binge eating disorder in Canadian clinical practice found that comorbidities were common in patients with BED.[7§] These comorbidities were psychiatric and metabolic.

Psychiatric comorbidities[7]

49%	Anxiety
46%	Depression and/or MDD
18%	Insomnia
14%	ADHD
11%	PTSD
7%	OCD

Metabolic comorbidities[7]

50%	Obesity
26%	Dyslipidemia
19%	Hypertension
19%	Sleep apnea
12%	Diabetes mellitus
2%	Heart failure

The DSM-5® states that BED is associated with significant psychiatric comorbidity, comparable to that of bulimia nervosa and anorexia nervosa.

Why screen for BED?

- It may help your patient to know that there is a medical/neurological reason for their condition, and that it is not a lack of willpower.[1]
- BED is associated with a range of functional consequences, including social role adjustment problems, impaired health-related quality of life and life satisfaction, increased medical morbidity and mortality, and associated increased health care utilization compared with body mass index (BMI)-matched control subjects.[1]

Tips for who to screen and how to screen

Who to screen[1]

- BED occurs in normal weight, overweight and obese individuals
- Both men and women are affected
- Equally prevalent in all races
- It is more prevalent among those seeking weight loss treatment
- Consider family history as BED appears to run in families

How to screen

- Begin by asking questions about eating habits, to determine if they fit the criteria for BED in the DSM-5®
- Use a BED self-assessment form with your patients such as the BEDS-7

GAD: generalized anxiety disorder; MDD: major depressive disorder; OCD: obsessive-compulsive disorder; PTSD: post-traumatic stress disorder

§ A retrospective chart review that assessed Canadian adults diagnosed with BED by a community- or hospital-based healthcare provider (HCP) who was either a general practitioner (GP) or psychiatrist. Patients were men and women aged ≥18 years at the time of BED diagnosis. Eligible patients had an HCP visit between July 1, 2017, and August 31, 2018; a current BED diagnosis; ≥1 follow-up visit after treatment initiation (if treated); and no other current documented eating disorder (n=202).

Distinguishing between BED and bulimia nervosa

BED and bulimia nervosa have recurrent binge eating in common, but there are several factors listed in the DSM-5® that can help you distinguish between the two disorders.

SYMPTOM	BED	Bulimia nervosa
Recurrent binge eating	YES	YES
Recurrent inappropriate compensatory behaviours (e.g.: purging, exercise)	NO	YES
Sustained dietary restriction between binge eating episodes to influence body weight and shape	NO	YES

Recognize BED: Have the conversation

One of the challenges of screening for BED is that those suffering from it can find it hard to discuss with their doctor.[2] Creating a non-judgemental dialogue with patients you think may have BED is important. You can begin by asking the patient to describe their relationship with food, and ask about any concerns they may have about their eating.[1]

Once the conversation has begun, ask simple and direct questions to efficiently screen for BED. For those who have positive screening results, use the DSM-5® diagnostic criteria to confirm the diagnosis.[2]

Here are some suggested questions to help determine if your patients are experiencing symptoms consistent with the DSM-5® criteria for BED.

Do you have any concerns about your eating?

If you are comfortable, can we talk a bit more specifically about your concerns about your eating?

How often would you say that you have these episodes of overeating?

When you do overeat, do you feel like you eat faster than normal?

How does your overeating make you feel?

Do you ever eat more than you think you should?

How do you feel about your overeating? Do you feel like you are in control, or is it something you can't help?

Are you open about your eating habits, or do you keep it to yourself? Do you feel like you need to keep it secret?

Does anyone in your family have similar issues with overeating?

Do you ever try to compensate for your overeating in some way?

Do you sometimes eat when you are not hungry, or keep eating when you are full?

If you recognize symptoms of BED in your practice:

- *start the conversation*
- *screen for BED*
- *diagnose using the DSM-5® criteria*
- *create a treatment plan*

Resources for patients with BED

When screening your patients for BED, consider using a self-assessment tool, such as the BEDS-7. While it is not a diagnostic tool, you can use it with your patients to help determine if they may have BED.

Create a touchpoint with your patients with BED by providing them with the BED & YOU booklet.

- It contains information about BED in patient-friendly language, and resources including a journal where they can keep track of days with or without binges and record any BED symptoms they experience.
- Instruct your patients to use the journal to chart their BED story.

Share the BED & YOU booklet with your patients today!

References: 1. American Psychiatric Association. Binge-eating disorder. *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Arlington, VA: American Psychiatric Publishing; 2013: 350-53. **2.** Keshen A, *et al*. Binge Eating Disorder: Updated overview for primary care practitioners. *Canadian Family Physician* 2022;68:416-21. **3.** Hudson JI, *et al*. The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological psychiatry* 2007;61(3):348-58. **4.** American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: Feeding and Eating Disorders Fact Sheet. 2013. Available at https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets. Accessed March 24, 2022. **5.** Kessler RC, *et al*. The prevalence and correlates of binge eating disorder in the World Health Organization World Mental Health Surveys. *Biological psychiatry* 2013;73(9):904-14. **6.** Shire Data on file, Canada VALIDATE Source Data Final. December 20, 2016. **7.** Gill SK & Kaplan AS. A retrospective chart review study of symptom onset, diagnosis, comorbidities and treatment in patients with binge eating disorder in Canadian clinical practice. *Eating and Weight Disorders* 2021;26:1233-42.

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