FEEDING AND EATING DISORDERS

Binge-Eating Disorder

BED

DSM-5-TR 307.51 | ICD-10-CM F50.81

Recurrent binge eating with loss of control and marked distress, without compensatory behavior; the most common eating disorder.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1.2-2.8% (US adults)	Late teens to early 20s	~1.5-2:1 female:male	Remits in ~60% w/ treatment

CLINICAL PICTURE

- Eating unusually fast, past the point of fullness, alone from embarrassment, and when not hungry, followed by disgust, guilt and depressed mood.
- Binges are typically unplanned, occur in the evening or at night, and involve calorie-dense palatable food; daytime grazing can blur episode boundaries.
- Roughly two-thirds of treatment-seeking patients have obesity, but BED occurs across the weight spectrum and is routinely missed at normal weight.
- A weight-cycling history of repeated diets, commercial weight-loss failures and bariatric consultations is common at first presentation.
- Shame and secrecy delay disclosure, and many patients present for metabolic complications rather than for the eating behavior itself.
- Purging, fasting and driven exercise are absent, which distinguishes binge-eating disorder from bulimia nervosa on history alone.

DIAGNOSTIC CRITERIA AT A GLANCE

- Binge episodes with loss of control must occur at least weekly for 3 months and be accompanied by marked distress about the bingeing itself.
- Episodes require at least three of five features: eating rapidly, eating to uncomfortable fullness, eating without hunger, eating alone, and later self-disgust.
- No regular compensatory behavior is present, and the diagnosis is not made exclusively during a course of bulimia nervosa or anorexia nervosa.
- Severity is graded by weekly binge episodes: mild 1-3, moderate 4-7, severe 8-13, and extreme at 14 or more, matching the bulimia thresholds.
- Obesity is not a mental disorder and is neither necessary nor sufficient; the diagnosis rests entirely on eating behavior and associated distress.

NEUROBIOLOGY & PHYSIOLOGY

- Heritability is estimated at 45-57%, and dopaminergic reward circuitry with altered striatal **D2** availability parallels substance use models.
- Heightened ventral striatal and orbitofrontal response to food cues combined with reduced prefrontal inhibitory control drives loss of control.
- Leptin resistance, blunted postprandial GLP-1 and peptide YY signaling, and altered ghrelin dynamics weaken normal satiety termination.
- Opioid and endocannabinoid systems mediate hedonic liking of palatable food, the pathway targeted by naltrexone-bupropion in weight management.
- Physical sequelae mirror obesity: type 2 diabetes, dyslipidemia, hypertension, metabolic syndrome, obstructive sleep apnea and chronic joint pain.
- Chronic stress with elevated cortisol increases intake of palatable food, tying HPA axis activity directly to binge episode frequency.

PSYCHOLOGICAL MECHANISMS

- The emotion regulation model holds that binges briefly reduce negative affect and then amplify shame, producing a self-perpetuating escape cycle.
- Dietary restraint and weight stigma provoke abstinence violation thinking, so rigid dieting reliably precipitates rather than prevents binge episodes.
- Overvaluation of shape and weight is present in about half of patients and predicts worse outcome, warranting explicit assessment at intake.
- Childhood adversity, weight-related teasing and food insecurity are common antecedents that shape reward-based coping with food.
- Trait impulsivity and reward sensitivity, especially food-specific reward drive, predict binge frequency better than general psychopathology does.

DIFFERENTIAL & COMORBIDITY

- Distinguish from bulimia nervosa with compensation, night eating syndrome with a circadian pattern, and grazing that lacks discrete loss of control.
- Rule out hypothalamic injury, Prader-Willi syndrome, Kleine-Levin syndrome, and hyperphagia induced by antipsychotics, mirtazapine or corticosteroids.
- Comorbidity is substantial: major depression near 45-50%, anxiety disorders 35-65%, substance use near 25%, plus ADHD and bipolar spectrum illness.
- Suicidal ideation is elevated independent of body weight, so screen for it even when the presenting complaint is framed as a weight problem.
- Check metabolic labs and sleep apnea symptoms and review bariatric surgery history, since untreated bingeing predicts poorer postsurgical outcome.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **Lisdexamfetamine 50-70 mg/day** is the only FDA-approved agent and substantially reduces binge days; monitor pulse, blood pressure and misuse risk.
- Avoid stimulants in cardiovascular disease, uncontrolled hypertension or active substance use disorder, and never prescribe them for weight loss alone.
- **Topiramate 100-300 mg/day** reduces both binge frequency and weight, but cognitive dulling, paresthesia and teratogenicity limit routine use.
- SSRIs such as **fluoxetine 60 mg/day** or sertraline modestly reduce binge frequency with little weight effect and help comorbid mood or anxiety.
- GLP-1 receptor agonists have no approved indication for BED; treat the eating disorder rather than assuming weight loss will resolve the behavior.

PSYCHOTHERAPY

- **CBT-E** or disorder-specific CBT across 16-20 sessions produces binge abstinence in roughly 50-60% and carries the strongest evidence base.
- Guided self-help CBT delivered in 8-12 brief supported sessions is nearly as effective for less severe presentations and greatly expands access.
- **IPT** matches CBT at longer follow-up and is preferred when interpersonal deficits and low self-esteem dominate the case formulation.
- **DBT** skills groups reduce binge episodes by targeting emotion dysregulation, although long-term maintenance data are weaker than for CBT.
- Behavioral weight loss achieves more weight change but inferior binge outcomes, so treating the eating disorder first is generally preferred.

ADJUNCT & SUPPORTIVE

- Care is almost always outpatient; higher levels of care are reserved for severe comorbid depression, suicidality or destabilized diabetes.
- Structured regular eating with three meals and two snacks interrupts the restriction-binge cycle far more reliably than caloric restriction does.
- Weight-neutral framing and active reduction of weight stigma in the clinical encounter improve engagement, disclosure and treatment retention.
- Track outcome with the **EDE-Q**, Binge Eating Scale, weekly binge logs and metabolic labs, plus vital signs when stimulants are prescribed.
- Coordinate with primary care, sleep medicine and bariatric teams, and ensure presurgical screening identifies and treats active binge eating.

CLINICAL PEARLS

- The most common eating disorder in the US, exceeding anorexia and bulimia combined.
- Prescribing a diet to a binge eater usually worsens bingeing; regularize eating first.
- Lisdexamfetamine treats binge episodes, not obesity, and is not a weight-loss drug.

References

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NOTE

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