A pattern of binge eating episodes associated with marked distress is the defining feature of binge eating disorder, recommended by the Eating Disorders Work Group for inclusion in the Feeding and Eating Disorders section of the forthcoming Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

An episode of binge eating involves consuming a large amount of food (ie, an amount that most people would consider unusually large, given the situation) in a circumscribed period of time (eg, 2 hours). Along with eating a large amount of food, individuals who binge eat experience an accompanying subjective sense of loss of control (eg, loss of control of the amount or types of food consumed...
ADDITION OF SEVERITY RATING

Severity ratings have been recommended for all diagnostic categories of the DSM-5. For BED, the Work Group has proposed severity ratings anchored to the number of binge eating episodes that occur per week. The ratings will be made on a 5-point scale ranging from “none” (no binge eating episodes) to extreme (14 or more binge eating episodes a week). The rating can be increased as a function of the severity of other symptoms (eg, overvaluation of body shape and weight) and degree of functional impairment. This rating provides clinicians with the opportunity to characterize the severity of the disorder over time, providing a method of monitoring and documenting change in symptom frequency.

CLINICAL UTILITY OF BED DIAGNOSIS

Epidemiological findings indicate that BED is the most common eating disorder; individuals with BED represent a substantial proportion of those who present for care at eating disorder treatment centers. BED is distinct from anorexia nervosa and BN in many ways (eg, gender distribution, remission rates), even though these disorders share some clinical features. Further, while many individuals with BED are obese, the diagnosis of BED confers additional clinically useful information. For example, compared with obese individuals without BED, individuals with BED consumed more calories in a test meal and demonstrated higher levels of specific eating disorder psychopathology.

BED is also associated with clinically significant impairments in health-related quality of life, life satisfaction, and overall functioning, as well as specific conditions such as insomnia, early menarche, neck/shoulder and lower back pain, chronic muscle pain, and metabolic disorders, even after accounting for weight status.

Finally, regardless of weight status, individuals with BED are more likely than individuals without BED to exhibit psychiatric comorbidities, including major depressive disorder, generalized anxiety disorder, and panic attacks.

Importantly, the BED diagnosis also conveys information about response to treatment. For instance, a number of studies indicate that individuals with BED benefit more from specialized psychological treatments than generic behavioral weight-loss interventions, although weight-loss outcomes do not differ.

ASSESSMENT TOOLS

BED can be assessed via self-report questionnaires and structured interviews. For example, the Eating Disorder Examination–Questionnaire (EDE-Q), Questionnaire for Eating and Weight Patterns – Revised (QEWP-R), and the Eating Disorder Diagnostic Scale (EDDS) are three brief, easily accessible, self-report questionnaires that can be used to screen for BED. The Eating Concern subscale of the EDE-Q and the Binge Eating Disorder Test (BEDT) subscale of the Bulimia Test-Revised (BULIT-R) can also be used as brief screening instruments for BED.

In addition to these questionnaires, valid semi-structured interviews can be used to assess BED, including the Eating Disorder Examination (EDE) and the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Although these structured interviews provide rich clinical information and may better facilitate differential diagnoses, they are time-consuming to administer and require extensive training to be used appropriately.

Since mood, anxiety, and substance use disorders are all common comorbidities that may impact the course of treatment in this population, clinicians also may wish to assess for symptoms...
of these disorders in cases where BED is suspected. A wide variety of brief, self-report measures exist to assess these symptoms; however, only a few have empirical support for their validity and reliability and are freely available. Specifically, depression can be assessed with the Center for Epidemiological Studies Depression Scale–Revised (CESD-R) or the Patient Health Questionnaire-9 (PHQ-9). Anxiety can be assessed with the State-Trait Inventory for Cognitive and Somatic Anxiety (STICSA). Substance-use disorder assessments typically assess alcohol use or other substance-use disorders separately, and the Alcohol Use Disorder Identification Test (AUDIT) and Drug Abuse Screening Test (DAST) are useful screening instruments.

**PSYCHOTHERAPEUTIC AND PHARMACOLOGIC INTERVENTIONS**

**Specialty Psychological Treatments**

Guidelines released in 2004 by the United Kingdom’s National Institute for Clinical Excellence underscored the efficacy of cognitive-behavioral treatment (CBT) for BED. CBT for BED involves addressing maladaptive cognitions (eg, dichotomous thinking about the violation of idiosyncratic food rules) and normalizing eating patterns (eg, setting regular mealtimes to prevent extended periods without eating that may promote binge eating). Remission from binge eating is achieved by approximately 50% to 70% of individuals in clinical trials of CBT for BED and completion rates are high. Improvements have been found with CBT in related eating disorder and general psychopathology as well. Recent findings indicate that treatment gains are maintained at 2-year and 4-year follow-up. CBT can also be effectively delivered in a guided self-help format (CBTgsh) in which patients meet with therapists for relatively few sessions (eg, six to 10), while otherwise using a self-help manual.

Interpersonal psychotherapy (IPT) has also shown comparable effectiveness to CBT, even though it does not specifically focus on disturbances in eating behavior. Instead, IPT focuses on: identifying the interpersonal problems that may contribute to the disorder, making appropriate changes in problematic interpersonal relationships; and preparing to cope with future interpersonal problems.

**Individuals with BED lose more weight in BWL at post-treatment, but improvements in weight status are not maintained at follow-up.**

**Behavioral Weight Loss**

Given the association between obesity and BED, behavioral weight loss (BWL) has been commonly investigated as a treatment for individuals with BED. BWL interventions include a number of strategies aimed at decreasing caloric intake and increasing physical activity. Compared with specialty psychological treatments, individuals with BED lose more weight in BWL at post-treatment, but improvements in weight status are not maintained at follow-up. Also, BED patients receiving BWL do not experience as much improvement in binge eating as individuals treated with BED specialty treatments. As a result, specialty psychotherapy interventions are currently the recommended treatments for BED.

**Pharmacotherapeutic Intervention**

Several classes of medication have been investigated in BED, including antidepressants (ie, selective serotonin reuptake inhibitors and tricyclics), anticonvulsants, appetite suppressants, and lipase inhibitors. Generally, when compared with placebo, fluoxetine, fluvoxamine, citalopram, sertraline, imipramine, and topiramate demonstrate improvements in mood and binge eating in individuals with BED at the end of treatment, but longer-term follow-up data are not available.

Other studies have compared medications to CBT or examined the effect of medications in combination with CBT. A review of these studies indicated that CBT outperformed fluoxetine, desipramine, and orlistat when administered as the sole treatment agent, but in combination with CBT, desipramine and orlistat demonstrated additional benefits in terms of weight loss above the gains achieved with CBT alone at the end of treatment.

One study found that rapid response (ie, 65% reduction in binge eating within 4 weeks) to treatment (CBT or fluoxetine) was predictive of achieving remission from binge eating by the end of treatment. In addition, rapid response demonstrated different prognostic value for CBT and fluoxetine, with rapid response being an especially strong predictor of success in CBT. Individuals receiving fluoxetine who did not respond rapidly were most unlikely to achieve remission of binge eating by the end of treatment.

Clinicians working in settings that deliver weight-loss interventions may question whether the presence of a BED diagnosis has predictive value in terms of weight-loss outcomes. There has been speculation that the presence of BED, or correlates of BED (eg, personality or coping style), may render weight-loss interventions (eg, behavioral, pharmacological, or surgical) less effective than in non-BED obese individuals. Although the findings have been inconsistent, the overall effect of BED on weight loss appears to be small, and recent studies support the conclusion that the presence of BED does not influence the effectiveness of weight-loss treatments.
CONCLUSION

Research indicates that BED is a clinical syndrome that is distinct from other eating disorders and from obesity. BED will likely be included as a diagnosis in the “Feeding and Eating Disorders” section of the upcoming DSM-5, incorporating revisions to existing DSM-IV criteria, including reducing the required frequency and duration of binge eating to an average of at least one episode per week for 3 consecutive months.

The addition of BED to the DSM-5 will provide clinicians with important information about associated comorbidity and prognosis for a group of individuals with a clinically significant eating disorder. In addition, it will provide direction for recommended treatments that have demonstrated efficacy for BED.

REFERENCES
