# Binge-Eating Disorder

Code: 307.51 (F50.8)

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**Diagnostic Criteria 307.51 (F50.8)**

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
1. 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.
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
B. The binge-eating episodes are associated with three (or more) of the following:
1. Eating much more rapidly than normal.
2. Eating until feeling uncomfortably full.
3. Eating large amounts of food when not feeling physically hungry.
4. Eating alone because of feeling embarrassed by how much one is eating.
5. Feeling disgusted with oneself, depressed, or very guilty afterward.
C. Marked distress regarding binge eating is present.
D. The binge eating occurs, on average, at least once a week for 3 months.
E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.
Specify if:
In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.
In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.
Specify current severity:
The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.
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.

**Diagnostic Features**

The essential feature of binge-eating disorder is recurrent episodes of binge eating that must occur, on average, at least once per week for 3 months (Criterion D). An "episode of binge eating" is defined as eating, in a discrete period of time, an amount of food that is defi-
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nitely larger than most people would eat in a similar period of time under similar circumstances (Criterion A1). The context in which the eating occurs may affect the clinician's estimation of whether the intake is excessive. For example, a quantity of food that might be regarded as excessive for a typical meal might be considered normal during a celebration or holiday meal. A "discrete period of time" refers to a limited period, usually less than 2 hours. A single episode of binge eating need not be restricted to one setting. For example, an individual may begin a binge in a restaurant and then continue to eat on returning home. Continual snacking on small amounts of food throughout the day would not be considered an eating binge.
An occurrence of excessive food consumption must be accompanied by a sense of lack of control (Criterion A2) to be considered an episode of binge eating. An indicator of loss of control is the inability to refrain from eating or to stop eating once started. Some individuals describe a dissociative quality during, or following, the binge-eating episodes. The impairment in control associated with binge eating may not be absolute; for example, an individual may continue binge eating while the telephone is ringing but will cease if a roommate or spouse unexpectedly enters the room. Some individuals report that their binge-eating episodes are no longer characterized by an acute feeling of loss of control but rather by a more generalized pattern of uncontrolled eating. If individuals report that they have abandoned efforts to control their eating, loss of control may still be considered as present. Binge eating can also be planned in some instances.
The type of food consumed during binges varies both across individuals and for a given individual. Binge eating appears to be characterized more by an abnormality in the amount of food consumed than by a craving for a specific nutrient.
Binge eating must be characterized by marked distress (Criterion C) and at least three of the following features: eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of feeling embarrassed by how much one is eating; and feeling disgusted with oneself, depressed, or very guilty afterward (Criterion B).
Individuals with binge-eating disorder are typically ashamed of their eating problems and attempt to conceal their symptoms. Binge eating usually occurs in secrecy or as inconspicuously as possible. The most common antecedent of binge eating is negative affect. Other triggers include interpersonal stressors; dietary restraint; negative feelings related to body weight, body shape, and food; and boredom. Binge eating may minimize or mitigate factors that precipitated the episode in the short-term, but negative self-evaluation and dysphoria often are the delayed consequences.

**Associated Features Supporting Diagnosis**

Binge-eating disorder occurs in normal-weightoverweight and obese individuals. It is reliably associated with overweight and obesity in treatment-seeking individuals. Nevertheless, binge-eating disorder is distinct from obesity. Most obese individuals do not engage in recurrent binge eating. In addition, compared with weight-matched obese individuals without binge-eating disorder, those with the disorder consume more calories in laboratory studies of eating behavior and have greater functional impairment, lower quality of life, more subjective distress, and greater psychiatric comorbidity.

**Prevalence**

Twelve-month prevalence of binge-eating disorder among U.S. adult (age 18 or older) females and males is 1.6% and 0.8%, respectively. The gender ratio is far less skewed in binge-eating disorder than in bulimia nervosa. Binge-eating disorder is as prevalent among females from racial or ethnic minority groups as has been reported for white females. The disorder is more prevalent among individuals seeking weight-loss treatment than in the general population.
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**Development and Course**

Little is known about the development of binge-eating disorder. Both binge eating and loss-of-control eating without objectively excessive consumption occur in children and are associated with increased body fat, weight gain, and increases in psychological symptoms. Binge eating is common in adolescent and college-age samples. Loss-of-control eating or episodic binge eating may represent a prodromal phase of eating disorders for some individuals.
Dieting follows the development of binge eating in many individuals with binge-eating disorder. (This is in contrast to bulimia nervosa, in which dysfunctional dieting usually precedes the onset of binge eating.) Binge-eating disorder typically begins in adolescence or young adulthood but can begin in later adulthood. Individuals with binge-eating disorder who seek treatment usually are older than individuals with either bulimia nervosa or anorexia nervosa who seek treatment.
Remission rates in both natural course and treatment outcome studies are higher for binge-eating disorder than for bulimia nervosa or anorexia nervosa. Binge-eating disorder appears to be relatively persistent, and the course is comparable to that of bulimia nervosa in terms of severity and duration. Crossover from binge-eating disorder to other eating disorders is uncommon.

**Risk and Prognostic Factors**

Genetic and physiological. Binge-eating disorder appears to run in families, which may reflect additive genetic influences.

**Culture-Related Diagnostic Issues**

Binge-eating disorder occurs with roughly similar frequencies in most industrialized countries, including the United States, Canada, many European countries, Australia, and New Zealand. In the United States, the prevalence of binge-eating disorder appears comparable among non-Latino whites, Latinos, Asians, and African Americans.

**Functional Consequences of Binge-Eating Disorder**

Binge-eating disorder 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. It may also be associated with an increased risk for weight gain and the development of obesity.

**Differential Diagnosis**

Bulimia nervosa. Binge-eating disorder has recurrent binge eating in common with bulimia nervosa but differs from the latter disorder in some fundamental respects. In terms of clinical presentation, the recurrent inappropriate compensatory behavior (e.g., purging, driven exercise) seen in bulimia nervosa is absent in binge-eating disorder. Unlike individuals with bulimia nervosa, individuals with binge-eating disorder typically do not show marked or sustained dietary restriction designed to influence body weight and shape between binge-eating episodes. They may, however, report frequent attempts at dieting. Binge-eating disorder also differs from bulimia nervosa in terms of response to treatment. Rates of improvement are consistently higher among individuals with binge-eating disorder than among those with bulimia nervosa.
Obesity. Binge-eating disorder is associated with overweight and obesity but has several key features that are distinct from obesity. First, levels of overvaluation of body
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weight and shape are higher in obese individuals with the disorder than in those without the disorder. Second, rates of psychiatric comorbidity are significantly higher among obese individuals with the disorder compared with those without the disorder. Third, the long-term successful outcome of evidence-based psychological treatments for binge-eating disorder can be contrasted with the absence of effective long-term treatments for obesity.
Bipolar and depressive disorders. Increases in appetite and weight gain are included in the criteria for major depressive episode and in the atypical features specifiers for depressive and bipolar disorders. Increased eating in the context of a major depressive episode may or may not be associated with loss of control. If the full criteria for both disorders are met, both diagnoses can be given. Binge eating and other symptoms of disordered eating are seen in association with bipolar disorder. If the full criteria for both disorders are met, both diagnoses should be given.
Borderline personality disorder. Binge eating is included in the impulsive behavior criterion that is part of the definition of borderline personality disorder. If the full criteria for both disorders are met, both diagnoses should be given.

**Comorbidity**

Binge-eating disorder is associated with significant psychiatric comorbidity that is comparable to that of bulimia nervosa and anorexia nervosa. The most common comorbid disorders are bipolar disorders, depressive disorders, anxiety disorders, and, to a lesser degree, substance use disorders. The psychiatric comorbidity is linked to the severity of binge eating and not to the degree of obesity.
Other Specified Feeding or Eating Disorder
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This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder. This is done by recording "other specified feeding or eating disorder" followed by the specific reason (e.g., "bulimia nervosa of low frequency"). Examples of presentations that can be specified using the "other specified" designation include the following:
1. *Atypical anorexia nervosa:* All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
2. *Bulimia nervosa (of low frequency and/or limited duration):* All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
3. *Binge-eating disorder (of low frequency and/or limited duration):* All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. *Purging disorder:* Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
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5. *Night eating syndrome:* Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.
Unspecified Feeding or Eating Disorder
307.50 (F50.9)
This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The unspecified feeding or eating disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific feeding and eating disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).
Elimination
Disorders
Elimination disorders
all involve the inappropriate elimination of urine or feces
and are usually first diagnosed in childhood or adolescence. This group of disorders includes enuresis, the repeated voiding of urine into inappropriate places, and encopresis, the repeated passage of feces into inappropriate places. Subtypes are provided to differentiate nocturnal from diurnal (i.e., during waking hours) voiding for enuresis and the presence or absence of constipation and overflow incontinence for encopresis. Although there are minimum age requirements for diagnosis of both disorders, these are based on developmental age and not solely on chronological age. Both disorders may be voluntary or involuntary. Although these disorders typically occur separately, co-occurrence may also be observed.
Enuresis

**Diagnostic Criteria 307.6 (F98.0)**

A. Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
B. The behavior is clinically significant as manifested by either a frequency of at least twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
C. Chronological age is at least 5 years (or equivalent developmental level).
D. The behavior is not attributable to the physiological effects of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder).
Specify whether:
Nocturnal only: Passage of urine only during nighttime sleep.
Diurnal only: Passage of urine during waking hours.
Nocturnal and diurnal: A combination of the two subtypes above.

**Subtypes**

The nocturnal-only subtype of enuresis, sometimes referred to as monosymptomatic enuresis, is the most common subtype and involves incontinence only during nighttime sleep, typically during the first one-third of the night. The diurnal-only subtype occurs in the absence of nocturnal enuresis and may be referred to simply as urinary incontinence. Individuals with this subtype can be divided into two groups. Individuals with "urge incontinence" have sudden urge symptoms and detrusor instability, whereas individuals with "voiding postponement" consciously defer micturition urges until incontinence results. The nocturnal-and-diurnal subtype is also known as nonmonosymptomatic enuresis.