



Impact of Binge Eating Disorder on Patient's Quality of Life – A Review

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Magdalena Kwiatkowska¹

<https://orcid.org/0000-0001-6776-6420>

Gabriela Majta¹

<https://orcid.org/0009-0002-7720-9980>

Aleksandra Żabińska¹

<https://orcid.org/0009-0008-0479-0800>

Natalia Kozłowska¹

<https://orcid.org/0009-0008-2330-3756>

Weronika Komala¹

<https://orcid.org/0009-0007-2294-0027>

Zuzanna Pawlus¹

<https://orcid.org/0000-0001-5228-4234>

¹ Faculty of Medical Sciences in Katowice, Medical University of Silesia in Katowice, Poland

Anna Mandecka¹

<https://orcid.org/0009-0000-1264-9809>

¹ Faculty of Medical Sciences in Katowice, Medical University of Silesia in Katowice, Poland

Corresponding author

Magdalena Kwiatkowska
Faculty of Medical Sciences in Katowice, Medical University of Silesia in Katowice, Poland
Poniatowskiego 15, 40-055 Katowice, Poland
magdalenakk2020@gmail.com

Abstract

Background: *Binge eating disorder (BED) is currently the most common form of an eating disorder. BED is characterized by the consumption of large amounts of food in a short period of time, in a manner not controlled by the sick person. Its etiology is not fully known, but it is assumed that the development of the disorder results from psychological, social, and biological factors.*

Objectives: *The aim of the study is to systematize information about BED and raise awareness among the public and health professionals about the issue.*

Material and methods: *This paper is based on a comprehensive review of scientific research conducted worldwide. Our conclusions are informed by the latest reports that explore various aspects of the daily lives of patients with BED.*

Results: *BED is classified into varying degrees of severity, depending on the number of bouts of eating per week. The gold standard for diagnosis is a structured psychological assessment. BED often co-exists with overweight and obesity, increasing the risk of somatic and psychosocial complications. Dietary education is the basis of therapy, and psychotherapy is the first line of treatment. Pharmacotherapy, which includes lisdexamfetamine and antidepressant, antiepileptic, psychostimulant, and anti-obesity drugs, is an important support. Forming proper eating habits is key in BED prevention.*

Conclusions: *The multifaceted nature of BED, which affects many aspects of patients' lives, reduces their quality of life. Increasing social awareness, health education, and countering the stigma on those affected by this disorder are also key.*

Key words: *binge eating disorder, emotion regulation, eating disorders*

Purpose and methods

Purpose

The aim of the study is to summarize information on binge eating disorder, its risk factors, clinical manifestation, diagnosis, and treatments.

Material and methods

The review was based on the analysis of materials collected in online databases including PubMed, Google Scholar, and Scopus. The following keywords were used to search the literature: binge eating disorder, emotion regulation, treatment, eating disorders, and obesity. A total of 67 articles published between 1992 and 2024 were considered for the study and verified for their relevance to the topic of BED. This paper was written based on a review of the knowledge contained in scientific studies conducted around the world. A total of 138 articles were found. The titles, abstracts, and full text of the articles were then independently checked by two researchers. Any disagreements were resolved through consensus discussions or, if necessary, with the assistance of a third researcher. The types of articles that were analyzed in the study were clinical trial, controlled clinical trial, randomized control trial, retrospective cohort study, systematic review, case reports, and meta-analysis. The inclusion criteria for the articles were articles published in peer-reviewed journals or public health reports. We were particularly interested in articles addressing risk factors, clinical manifestations, and diagnosis according to ICD-10 and DSM-5 criteria. We selected studies that assessed diagnoses using self-assessment questionnaires and/or interview tools, as well as publications describing treatment methods, the impact of BED on the behavioral, psychological, and physical aspects of affected individuals, and preventive strategies. The exclusion criteria comprised mixed or inaccurate diagnoses, thesis dissertations, duplicate reports, and conference abstracts. As a result, 67 publications related to the mentioned terms were selected. Hand searching the references of the identified studies and reviews was carried out too.

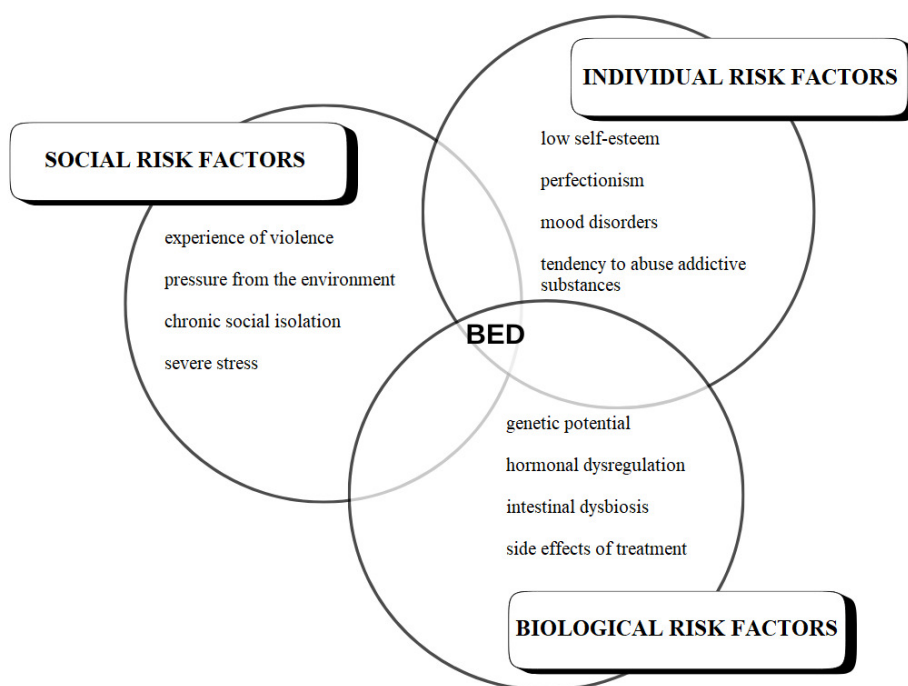
Literature review

Introduction

Obesity is a multi-faceted mental health problem around the world [1]. Binge eating disorder (BED) is the most common form of an eating disorder, with a prevalence of approximately 30% among overweight or obese individuals and significantly higher than in the general population, where it ranges between 2% and 5% [2]. Binge eating disorder is defined as recurrent, uncontrolled episodes of consuming large amounts of food in a short period of time (usually less than 2 hours) [3]. BED is a chronic condition with periods of exacerbation and remission. It can occur in people with any body mass index (BMI) and is two to three times more likely to occur in women than in men, with an average age of onset of symptoms of about 24.5 years [4]. The first symptoms may appear as early as 8 years of age [3]. Patients are at risk of somatic and psychosocial complications, such as depression, obsessive-compulsive disorder, type 2 diabetes, hypertension, or dyslipidemia, which may further complicate treatment for these conditions [5]. Importantly, approximately 79% of people with a diagnosis of BED experience at least one co-occurring mental illness during their lifetime, with anxiety disorders (56.1%) and mood disorders (46.1%) most commonly [5]. Recent research suggests that the lower quality of life of people with BED is more affected by co-existing mental illness than obesity alone [6]. Early detection of patients at risk and treatment is, therefore, crucial to prevent complications and mitigate the risk of binge eating.

Risk factors

BED is a disease with a complex and still not fully understood etiology. Its development is influenced by social, individual, and biological factors (Figure 1) [4].

Figure 1. Risk factors for BED

Source: own elaboration.

Social risk factors

Experiencing violence, both physical and mental, can lead to episodic binge eating. The idealization of a slim figure and the associated social pressures in mass media can have a similar impact [1]. Fairburn et al. have shown that disrupted family relationships, such as excessive expectations from a child, over-protectiveness, and excessive criticism, significantly increase the risk of developing BED [7]. Research published during the pandemic of the acute infectious coronavirus disease 2019 (COVID-19), when social distancing was dominant, indicates a link between social isolation and an increase in BED diagnoses [8]. Severe stress, for example, resulting from a traumatic experience may also contribute to the development of this disorder [9].

Individual risk factors

People prone to impulsive and neurotic behaviors are more likely to develop the disease, as are people with low self-esteem and a tendency toward unhealthy lifestyles [7]. Striegel-Moore et al. have identified perfectionism as a risk factor [10]. Mood disorders also have a key role in the development of the disease. In their article, Arnow et al. examined the mood felt by sufferers before episodes of compulsive eating. The results indicate that frustration and anger dominated (42%), followed by anxiety, depression, and regret [11]. In the literature, special attention is paid to dietary errors, both resulting from excessive food consumption, especially highly processed foods [7] and as a reaction to previous calorie shortages or problems related to food insecurity [12]. An additional risk factor is substance abuse. Studies have shown that people who consume alcohol excessively have an approximately 65% higher risk of developing the condition [13].

Biological risk factors

Genes encoding neurohormones and neurotransmitters, including their polymorphisms, were examined. Changes in the dopaminergic system have been assigned with a key role in the development of BED. Recently published data show that both insufficient and excessive activity of this system may be the basis of eating disorders [7, 14]. Himmerich et al. have shown that genetic conditions may be responsible for the development of BED in 41–57% [15]. The literature also highlights the influence of hormonal disorders on the development of the disease. Gluck et al. have pointed to an increase in cortisol secretion in response to stressors as one of the causes of BED [16]. It is postulated that endogenous estrogen and progesterone may contribute to an increased risk of binge eating [17]. Moreover, the data indicate that commonly used combined oral contraceptives (COCs) (containing synthetic estrogens (ethinyl estradiol) and progestogens) may also raise concerns about the potential increased risk of developing BED, especially in patients with a genetic predisposition to eating disorders. It is worth noting that

women typically start using these medications during the period of highest risk for BED, i.e., late adolescence and early adulthood [17]. Biological risk factors include intestinal dysbiosis, which leads to reduced production of serotonin, responsible for regulating mood and food intake in BED patients [18]. BED can also be induced iatrogenically by the use of antipsychotic drugs [19].

Diagnostic criteria

Despite its importance, BED still remains under-diagnosed and under-treated. As previously mentioned, the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) classifies BED as an eating disorder, characterized by recurrent episodes of overeating. Episodes of overeating must occur at least once a week for a period of three months, and their presence should be accompanied by a sense of distress in the sufferer [20]. Unlike bulimia nervosa (BN), from which this condition should be distinguished, they are not accompanied by compensatory behaviors such as provoking vomiting, abusing laxatives and diuretics, or excessive exercise [5, 21]. The number of bouts of uncontrolled eating per week allows determining the severity of the disorder: mild (1–3 attacks), moderate (4–7 attacks), severe (8–13 attacks), and very severe (14 or more attacks) [5]. Negative emotions (especially anger, fear, sadness) and difficulties in regulating them have a significant role in the development of this disorder. People with BED experience distress associated with the awareness of losing control over the quantity and quality of food they eat. Episodes of binge eating usually occur in the late afternoon and evening [22]. Binge eating attacks are not preceded by feelings of physical hunger, they often occur in solitude and occur at a very rapid pace. They are characterized by difficulty in stopping eating, even despite the perceived discomfort associated with overeating. After the attack, relief appears, which is replaced by negative emotions associated with the awareness that one was eating [23]. Among the conditions from which BED should be differentiated in addition to bulimia are obesity,

night eating syndrome (NES), emotional eating (EE), and food addiction (FA) [22, 24–25].

According to the ICD-10 (International Statistical Classification of Diseases and Related Health Problems), BED does not constitute a separate nosological unit and is included in the category of 'overeating associated with other psychological factors' (F50.4) [26]. In contrast, the US psychiatric classification DSM-5 isolates this disorder as a standalone disease unit (marked 307.51) (F50.8) [20].

Full BED remission is achieved when, after meeting all the criteria for an eating disorder, a patient does not meet any of these criteria for an extended period of time. However, the DSM-5 does not specify how long this period must last. If the frequency of eating episodes decreases to less than one per week for an extended period, the patient is in partial remission according to the DSM-5. On the other hand, ICD-11 does not specify the severity of BED or the phase of partial remission [27].

Screening tools and assessment

There are a number of self-assessment tools used in patients with suspected eating disorders, such as the 7-Item Binge-Eating Disorder Screener (BEDS-7), Eating Disorders Inventory (EDI-3), and Binge Eating Scale (BES). The most commonly used screening tool is the five-item SCOFF (Sick, Control, One, Fat and Food) questionnaire. Structured clinical expert interviews are considered the gold standard in diagnosing BED. An example is the Eating Disorder Review (EDE), which provides reliable diagnostic information and enables a comprehensive assessment of the severity of eating disorders. The assessment includes the current diagnosis of eating disorders, the overall score, and four subscales: restraint, concerns about eating, concerns about silhouette, and concerns about weight [27]. EDE is also the preferred tool for assessing eating disorders in patients prior to planned a bariatric surgery [28]. In addition, further evaluation of potential co-existing diseases should be carried out, especially in the direction of diabetes, hypertension, and coronary artery disease [5].

Treatment and long-term management

According to reports, only 38% of patients diagnosed with eating disorders received targeted treatment for this problem. Appropriate dietary management, which includes psychoeducation, psychotherapy, nutritional counseling, and regular monitoring of the patient's health, is crucial in the care of a patient with BED. A balanced diet, combined with physical activity, improves health and supports the maintenance of a normal weight [29].

Psychological and behavioral therapies

According to current knowledge, psychological and behavioral therapies are the first-line treatment for patients with BED. These include: cognitive behavioral therapy (CBT), interpersonal therapy (IPT), dialectical behavior therapy (DBT), and behavioral weight loss therapy (BWL) [30–31]. According to National Institute of Clinical Excellence (NICE) guidelines, CBT is the therapy of first choice [24, 32]. CBT stands out for its advantage in reducing the incidence of eating disorders compared to other methods. It focuses on modifying learned, non-adaptive responses to various stimuli that have arisen during the patient's lifetime. This therapy is directly aimed at making changes in the patient's behavior and preparing them to cope in stressful situations, which ultimately leads to a reduction in episodes of illness. In addition, it supports patients in building proper eating patterns [32, 33].

The interpersonal therapy (IPT) model focuses on working with the patient's personal difficulties, such as mood disorders or depression, which often contribute to the development and maintenance of eating disorders. Studies indicate that the effectiveness of this therapy is comparable to CBT, with recovery rates ranging from 50–65% [24, 34].

The long-term effectiveness of dialectic-behavioral therapy (DBT), which aims to regulate affection and improve tolerance of negative emotions, has not yet been conclusively confirmed [35].

Due to the high prevalence of obesity in people with BED, studies have been conducted on the effectiveness of behavioral weight loss therapy (BWL).

BWL is based on reducing calories and promoting physical activity. It is considered a form of “general treatment” that is more widely available than “specialized” therapies. Although BWL can be effective in reducing body weight, it is less effective in treating BED than CBT or IPT [36].

Pharmacotherapy

The increase in the number of patients diagnosed with BED leads to an intensive search for effective pharmacological treatments. However, it should be noted that pharmacotherapy is not the primary treatment method for BED, but rather complements other therapeutic interventions [1, 37]. It is recommended to initiate treatment with selective serotonin reuptake inhibitors (SSRIs) or lisdexamfetamine, especially as first-line therapy in patients who do not have access to psychotherapy, refuse it, or prefer pharmacotherapy [4]. Lisdexamfetamine is currently the only drug approved by the Food and Drug Administration (FDA) for the treatment of moderate and severe forms of BED. A 2015 study found that it reduced the frequency of binge eating attacks by 32–48%. The problem that remains are the drug's side effects, especially from the circulatory system, which require close monitoring [38–39]. Antiepileptic drugs achieved better results in reducing overeating episodes than placebo. Moreover, using topiramate aids weight loss. However, it should not be a first-choice treatment, partly because of an increased risk of suicide [40]. Zonisamide also appears to be an effective drug, although less well tolerated by patients [41].

Methylphenidate and amoxetine, drugs used to treat attention deficit hyperactivity disorder (ADHD), have also shown some benefits in BED treatment. These drugs increase the ability of BED patients to control their eating behaviors by affecting their feelings of satisfaction with food [42]. Available scientific evidence suggests that anti-obesity drugs such as liraglutide and the combination of phentermine with topiramate and naltrexone with bupropion may reduce the severity and frequency of binge eating episodes [43]. The combination of naltrexone and bupropion has been shown to be effective in reducing weight, although evidence for its efficiency in treating

BED is inconsistent. A 2022 study published in the *American Journal of Psychiatry* found that these drugs reduce BED symptoms [44]. In contrast, 2023 researchers from Yale University School of Medicine reported no significant improvement in their observations [45].

According to recent reports, glucagon-like peptide 1 (GLP-1) analogues may be useful in the treatment of binge eating disorders [46]. An example is semaglutide, a long-acting GLP-1 analogue similar to liraglutide, which supports better control of food intake and reduces preference for high-fat and high-calorie foods. To date, one retrospective study on the efficacy of semaglutide has been conducted, which suggests promising therapeutic effects and provides a starting point for further analysis. The study showed that semaglutide inclusion resulted in greater reductions in BES scores compared to patients receiving lisdexamfetamine and topiramate [47]. In the case of orlistat, a long-acting lipase inhibitor used in the treatment of obesity, the evidence for its efficacy in BED therapy remains ambiguous [48].

Most anti-obesity drugs represent an interesting therapeutic option for patients with BED, although they act mainly symptomatically, without directly affecting the pathophysiological mechanisms of this disorder [43].

Alternative treatments and promising new therapeutic directions

A study was conducted to assess the effectiveness of combination therapies. The results showed that the combination of cognitive behavioral therapy (CBT) and pharmacotherapy was more effective than the exclusive use of medications (with the exception of anticonvulsants) but not significantly superior to psychotherapy alone. This yielded positive results in the form of more patients achieving remission of eating attacks compared to those taking placebo [49–50]. In some patients, bariatric surgery contributed to a reduction of eating attacks, but in cases where these behaviors persisted after surgery, weight loss was significantly hampered [51].

Digital forms of therapy, mainly CBT, have also begun to be used in treatment. The undeniable advantage of this approach is greater availability and shorter waiting times for treatment. However, studies have shown that

in-person CBT is more effective [52]. Numerous similarities between BED and addiction have also been noted. Strategies successfully used in addiction treatment, such as twelve-step programs, harm reduction, motivational therapy, and an approach to nutrition based on abstinence from certain foods may also prove useful in the therapy of patients with eating disorders, although this issue requires further research [38]. The gut microbiota may influence appetite regulation and, consequently, alleviate BED symptoms. Although the evidence to date on the effectiveness of gut microbiotas or probiotics supplementation in BED therapy is limited, this line of research appears to be promising [53–54].

Medical and psychological comorbidities associated with BED

BED is not only a psychological challenge, but also a condition that significantly affects numerous co-existing diseases, impacting overall health outcomes. Understanding these connections is critical to providing holistic care to those affected by BED.

Obesity and metabolic complications

BED is closely associated with obesity because recurrent episodes of binge eating lead to excessive calorie intake and weight gain. Results of a recent meta-analysis indicate that up to 87% of people with BED are diagnosed with obesity [55]. People with BED have an increased risk of insulin resistance and metabolic syndrome, including its key components such as hypertension, dyslipidemia, and type 2 diabetes, compared to obese people without BED [5, 56]. However, it is suggested that BED may be associated with an increased risk of metabolic syndrome regardless of obesity. Non-obese people with BED may also be at higher risk of ischemic cardiovascular events [56].

Menstrual disorders have also been observed in women with BED [57]. Burnatowska et al. describe a close link between BED and polycystic ovary syndrome (PCOS). They note that symptoms of PCOS, such as hirsutism and infertility, can lead to depression and anxiety, which negatively affect

the functioning of the reward system, exacerbating the symptoms of BED. This creates a vicious circle in which the effects of the disease further exacerbate it [58].

Mehr et al. have described the relationship between BED and sleep dysregulation, particularly in the context of the orexin (hypocretin) system. Chronic overeating leads to overactivity of the orexine system, disrupting the normal, diurnal fluctuations in orexin signaling that regulate the sleep-wake cycle. Sleep dysregulation further exacerbates recurrent episodes of overeating and weight gain, creating a self-propelled spiral [59]. People with BED have been shown to be almost three times more likely to experience clinically significant symptoms of insomnia and to have poorer sleep quality compared to people without an eating disorder. In addition, more frequent episodes of binge eating are correlated with more severe insomnia symptoms [59].

Moreover, a significant association has been found between BED and the likelihood of various diseases, including pulmonary disease, stomach ulcers, liver disease, arthritis, anemia, fibromyalgia, and osteoporosis [60].

Mental disorders

People who suffer from eating disorders with binge eating are more likely to have coexisting mental illnesses. The most common of these are anxiety and mood disorders, depression, and substance use problems. Kowalewska et al. conducted a systematic analysis that confirmed the high cooccurrence of these disorders with BED, especially in the context of mood disorders and anxiety disorders [61].

BED exhibits characteristics common to various forms of addiction, such as addictions to food, alcohol, or drugs. Azevedo et al. point out that the neurobiological mechanisms underlying BED, including dysfunction of the dopamine system, may promote compulsive consumption of both food and psychoactive substances [62]. Studies show that people with BED with a tendency to reach for stimulants are often dissatisfied with their weight and appearance, as well as struggling with eating guilt, fear of losing control of their diet, and a strong desire to lose weight [61–62].

It is unclear whether coexisting mental illnesses precede the development of BED, are its complications, or if both occur simultaneously. Some studies suggest that, at least in some cases, BED may be a separate condition. In addition, there is a lack of conclusive research on whether BED treatment could alleviate the severity of coexisting mental problems [61].

Other coexisting mental illnesses reported in people with BED include bipolar disorder, ADHD, severe stress response, adaptive disorder, and schizophrenia [5, 61]. Importantly, there have been reports that the presence of depressive symptoms in people with BED may adversely affect the rates of suicide and suicidal ideation [62].

Individuals with BED may experience interpersonal difficulties, reduced self-esteem, and excessive self-criticism. They often have a tendency to suppress and ponder unwanted emotions, leading to overthinking and psychopathological symptoms [61]. Senra et al. have identified a high incidence of personality disorders in patients with BED, which highlights its potential association with dysfunctional personality traits [63]. There is a common connection between BED and borderline personality disorder, which may result from the common clinical features of both disorders, such as emotional instability, impulsivity, and problems with interpersonal relationships [5].

Patients with BED tolerate lowered mood less well than healthy individuals. Negative affect has a key role in the disorder and appears to directly precede binge eating. In addition, patients with BED often exhibit increased symptoms of depression and anxiety, which may be both a result of personality disorders and a factor that increases the risk of developing BED. The presence of personality disorders complicates the treatment process, making it difficult to manage emotions and impulsivity, which requires an integrated, multifaceted therapeutic approach [61–63].

Table 1 presents data from selected studies included in the review, their objectives and health outcomes related to BED.

Table 1. Summary of selected studies on BED

Authors, Year of Publication	Country	Type of Study/material	Main objective	Results/conclusion
Agüera, 2020 [1]	Spain	review/ human	a general review of BED, referring to its frequency, etiology, clinical features, treatment options, and treatment outcomes	BED is characterized by a high incidence of co-occurrence with other medical and psychiatric disorders; patients with BED typically feel a strong need to lose weight, which makes psychological therapy difficult and increases the risk of discontinuation of treatment
Gudmundsdóttir, 2023 [6]	Denmark	clinical trial/ human	to evaluate QoL in Danish BED patients compared with healthy controls and to evaluate the potential impact of depression and obesity in patients seeking treatment for BED	disease-specific QoL in BED was associated with depression but not with BMI
Caldirolì, 2023 [8]	Italy	systematic review/ human	to synthesize the impact of the COVID-19 pandemic on the occurrence and course of BED	social restrictions related to the COVID-19 pandemic negatively affected the course of BED; a significant relationship between the imposed restrictions, increased BMI, and the presence of depressive symptoms may have contributed to the development or worsening of binge eating disorder
Mason, 2020 [9]	USA	review/ human	to delineate the role of eating in cancer research and to understand how eating may develop after a cancer diagnosis	there are a number of ways that binge eating may increase the risk of cancer as well as several pathways that may lead to the development of binge eating after cancer diagnosis
Himmerich, 2024 [19]	UK	review/ human	to summarize the evidence for the pharmacological treatment of BED and its comorbid disorders	lisdexamphetamine and topiramate can be recommended for BED if psychological therapies are ineffective or unavailable; for BED with obesity, GLP-1 receptor agonists (liraglutide, semaglutide) or bupropion and naltrexone may be considered; for BED with ADHD, atomoxetine and lisdexamphetamine are options; aripiprazole, lamotrigine, lurasidone, and lumateperone may be used for BED with bipolar disorder; naltrexone or bupropion can be considered for BED with substance use disorder

Authors, Year of Publication	Country	Type of Study/material	Main objective	Results/conclusion
Brytek-Mat- era, 2024 [21]	Australia	cross-sectional/ human	to compare the estimated prevalence of bulimia nervosa, BED, and other specified feeding or eating disorders using the DSM-5 and ICD-11 diagnostic classifications for size and specifiers of binge-eating episodes in general population	a larger number of individuals received the primary diagnosis of BED, but not BN, in the ICD-11 system compared to DSM-5
Riboldi, 2024 [43]	Italy	review/ human	to summarize the available evidence on anti-obesity drugs for BED, highlighting their potential effects on BED-specific mechanisms, as well as the relevant opportunities and challenges associated with their use in clinical practice	most anti-obesity drugs might be considered a promising therapeutic option for people suffering from BED
Grilo, 2022 [44]	USA	randomized controlled trial/human	to test the effectiveness of naltrexone/bupropion and BWL, alone and combined, for BED comorbid with obesity	BWL and naltrexone-bupropion were associated with significant improvements in BED, with a consistent pattern of BWL being superior to no BWL
Grilo, 2023 [45]	USA	randomized controlled trial /human	to test the efficacy of naltrexone/bupropion for treating BED	naltrexone/bupropion did not demonstrate effectiveness for reducing binge eating relative to placebo but showed effectiveness for weight reduction in patients with BED
Aoun, 2024 [46]	USA	review/ human	to summarize the current evidence on the therapeutic potential and risks of using GLP-1RAs to treat BED and BN	GLP-1RAs (liraglutide and dulaglutide) reduce binge eating frequency and comorbidities in addition to favorable psychiatric side effect profile compared to current options

Authors, Year of Publication	Country	Type of Study/material	Main objective	Results/conclusion
Richards, 2023 [47]	USA	retrospective cohort study/human	to examine the effects of semaglutide on BES scores in patients with moderate to severe BED, and compare changes in BES scores in the semaglutide treated group to changes in the group of matched BED patients prescribed either lisdexamphetamine or topiramate, as well as a group that received both semaglutide and other anti-obesity medications	patients receiving semaglutide only showed a greater reduction in BES scores compared to other groups; combination pharmacotherapy with semaglutide and other anti-obesity drugs did not result in a greater reduction in the BES scores compared with the semaglutide alone group
Kowalewska, 2024 [61]	Poland	systematic review/human	to summarize the current knowledge on the co-occurrence of BED with other psychiatric disorders	the most frequently observed comorbidities associated with BED were mood disorders, anxiety disorders, and substance use disorders, they were also related to more severe BED presentations, BED was linked to suicidality and sleep disorders

ADHD – attention deficit hyperactivity disorder

BES – Binge Eating Scale

BN – bulimia nervosa

BWL – behavioral weight-loss therapy

GLP-1 – glucagon-like peptide 1

GLP-1RAs – GLP-1 receptor agonists

QoL – disease-specific quality of life

Source: own elaboration.

Prevention

BED prevention requires a multi-faceted approach that must be implemented at both the individual and social levels. Key elements of prevention include promoting healthy eating habits, building a positive relationship with food, education, raising awareness, and providing social support [27].

Patients should receive educational support to cope with binge eating. Increasing awareness of binge eating episodes and developing self-control skills can effectively counteract the cycle of binge eating and the guilt that accompanies it. Excessive focus on appearance and weight leads to unhealthy eating patterns and restrictive diets, increasing susceptibility to subsequent episodes. Education should include limiting obsessive weight monitoring, identifying triggers (such as mood swings, anxiety, or drug use), monitoring eating patterns, and avoiding environments conducive to binge eating. Support and education of family members are also key – close relationships and strong family ties effectively protect against the development of eating disorders [64].

Developing the skills of mindful eating, emotional awareness, and coping with stress and negative emotions (for example, through physical activity or meditation) are beneficial for people in risk groups [5]. Organizing the day, introducing a routine, and ensuring adequate amounts of sleep can effectively prevent binge eating, while loneliness and lack of social support can exacerbate the symptoms [57]. Limiting time spent on social media is also beneficial for the prevention of eating disorders – just a week off improves self-esteem [65]. Access to healthy food has a key role in prevention. Food insecurity is associated with abnormal eating behaviors, such as lack of control over eating, eating without feeling hungry, unhealthy ways of controlling weight, food selectivity, and binge eating [64, 66].

Awareness of BED is low, and medical staff often do not recognize it as a distinct disease entity [67]. Prevention at the community level can benefit those in at-risk groups. It is worth focusing on improving the quality of available food in workplaces, schools, stores, and restaurants, and on changing marketing strategies of the food industry [27]. Due to the lack of research, the development of effective prevention methods remains crucial to public health.

Summary

Although BED is the most common eating disorder, knowledge about it is still limited. Negative emotional states and inadequate strategies for regulating emotions are the basis for the development and maintenance of abnormal eating patterns. Psychotherapy is considered the most effective form of treatment, while pharmacological interventions often fail to address co-existing psychological problems, including binge eating [5, 37]. People with BED often struggle with low self-esteem and lack of understanding from their surroundings. This leads to a strong sense of embarrassment and shame, which are further exacerbated by social stigma. As a result, sufferers may avoid seeking professional help. This is why it is so important to have community support and raise awareness about this condition to improve the health and quality of life of those affected by this disorder. Further research is needed to better understand the pathogenesis and develop effective therapeutic strategies.

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