

Binge Eating Disorder in Schizophrenia: A Case of Obesogenic Behaviors

Venkata Maruthi*

Department of Psychiatry, Aarupadai Veedu Medical College and Hospital, Puducherry, India

Corresponding Author: Venkata Maruthi, Department of Psychiatry, Aarupadai Veedu Medical College and Hospital, Puducherry, India, E-mail: maruthi@gmail.com

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Description

Eating disorders, particularly binge eating, are closely linked to schizophrenia. Characteristics of the illness, such as disordered eating behaviors, cognitive patterns and behavioral issues, can contribute to the development of eating disorders. Prior research has underscored the neurobiological similarities between these conditions and the influence of hormonal factors, such as hypocretin, in their etiology. Interventions that promote healthy eating styles have proven effective in reducing binge episodes, while antipsychotic medications also significantly influence eating patterns. Adolescents with psychosis exhibit a higher prevalence of eating disorders. This report discusses a unique case of an elderly female with schizophrenia exhibiting obesogenic behaviors alongside binge eating disorder, marked by an atypical onset and presentation and without overt psychopathological symptoms driving her bingeing.

Understanding binge eating disorder

Obesogenic behaviors surround a range of eating patterns, including an inability to leave food uneaten, anger at comments about eating, cravings for food and night eating. Binge Eating Disorder (BED) is defined by the consumption of large amounts of food within a short timeframe, occurring at least once weekly for a minimum of three months, often accompanied by a sense of losing control over eating. This disorder involves behaviors like eating rapidly, feeling uncomfortably full, consuming food when not hungry, eating alone due to embarrassment and experiencing self-disgust post-overeating. The diagnostic and statistical manual describes binge eating episodes as consuming a quantity of food significantly larger than what most individuals would eat in similar circumstances, typically defined within a two-hour window. Unlike other eating disorders, BED does not involve regular compensatory behaviors such as purging.

Research indicates that approximately 16% of individuals with schizophrenia experience binge eating disorder. In various countries, including China, Japan, Africa and Latin America, BED is reported as the most prevalent eating disorder, though there are no documented cases in India. In India, the most frequently observed psychiatric comorbidity (50%) among those with eating disorders is depression.

Diagnosed with schizophrenia two decades prior, patient had been inconsistently treated. For the last 2.5 years, patient had been taking risperidone (4 mg) and amisulpride (50 mg) to control her symptoms. Over the past six months, patient eating behaviors escalated, with significant nighttime eating disrupting sleep. Attempts by family to limit her intake resulted in irritability and quarrels. A expressed an inability to control her hunger and did not feel full despite large quantities of food.

Upon admission to the psychiatric ward, her neurological examination was unremarkable and patient displayed no repetitive or abnormal behaviors. Patient weight was recorded at 90 kg, with a BMI of 35 kg/m². Lab tests were normal and neuroimaging indicated age-related cortical atrophy and lacunar infarcts. Cognitive assessments yielded a mini mental state examination score of 27/30, brief psychiatric rating scale score of 35 and binge eating scale score of 28.

A neurologist assessed her MRI findings, attributing the changes to age rather than symptoms of cognitive decline. A gastroenterologist recommended serotonergic treatment to address her hunger, leading to a regimen that included fluoxetine and topiramate. Dietary modifications focused on meal frequency reduction and portion control. After two weeks, eating frequency decreased significantly and patient nighttime eating ceased, contributing to a 2.5 kg weight loss. Following further adjustments to medication, patient was discharged with improved eating habits and ongoing follow-up for weight management and glycemic control.

Obesogenic behaviors in older adults increase the risk of cardiometabolic issues, cognitive decline and reduced quality of life. Although the link between weight gain and metabolic disorders in schizophrenia has garnered interest, the investigation of eating disorders remains limited. Prior studies have indicated that medications like olanzapine and clozapine can induce disordered eating, while this patient developed condition while on risperidone. Antipsychotics interact with various neurotransmitter receptors, potentially disrupting insulin regulation and contributing to weight gain.

In this case, the presence of binge eating disorder appears to be related to antipsychotic treatment. Altering the obesogenic environment through supervised dietary changes proved effective for the patient. Neurobiological changes related to

binge eating and serotonin activity suggest that serotonin reuptake inhibitors can aid in reducing binge episodes, while topiramate's action on glutamate receptors may help control hunger. This case emphasizes the importance of addressing eating behaviors in patients with schizophrenia, advocating for psychoeducation and dietary interventions customized to their specific needs.

This underscores the significance of understanding eating behaviors in the context of schizophrenia, particularly as obesity rates rise. Practitioners should inquire about patients' eating patterns rather than solely focusing on the quantity consumed to differentiate eating disorders from substance dependencies.