Posttraumatic Stress Disorder and Binge-Eating Disorder: Further Context and Additional Findings From a Nationally Representative Sample of Adults in the United States

To the Editor: Braun and colleagues1 recently published an analysis of associations between trauma exposure, posttraumatic stress disorder (PTSD) symptoms, and binge eating symptoms using data from the third wave (2012–2013) of the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III; N = 36,309). They reported that both subthreshold and threshold PTSD are associated with a great number of binge eating symptoms,2 which represents important new information regarding the associations among DSM-5–defined PTSD and binge eating symptoms.2 However, Braun and colleagues3 did not reference or incorporate relevant epidemiologic findings from NESARC-III3–5 that provide important complementary contexts for their findings regarding the relationship between PTSD and binge eating.

Using NESARC-III data, Udo and Grilo4 previously reported that 31.6% (SE = 2.50) of respondents with lifetime binge-eating disorder (BED) diagnoses also met criteria for PTSD; risks remained significantly elevated after adjusting for sociodemographic variables (adjusted odds ratio [AOR] = 6.24, 95% confidence interval [CI] = 4.66–8.35) and even after additionally adjusting for diagnoses of other psychiatric disorders (AOR = 1.74, 95% CI = 1.21–2.50). Udo and colleagues4 further reported that NESARC-III respondents with lifetime BED who reported histories of suicide attempts were significantly more likely to have lifetime diagnoses of PTSD than those without histories of suicide attempts (58.4% vs 24.1%). Importantly, these previous studies used recoded BED variables created by Udo and Grilo5 (after inspection of the NESARC-III dataset revealed various errors) to calculate prevalence estimates of DSM-5 eating disorder diagnoses in US adults (see supplemental tables of Udo and Grilo5 for detailed operationalization and rescoring of the BED diagnosis, and see Udo and Grilo6 for discussion of assessment complexities). Using these diagnosis variables, Udo and Grilo3 found prevalence estimates of 0.85% (SE = 0.05) for lifetime BED and 0.44% (SE = 0.04) for 12-month BED, which differs from the 0.80% lifetime prevalence reported by Braun et al1 and Afifi et al.7

The symptom-level associations between PTSD and binge eating reported by Braun et al8 in the context of diagnostic-level findings previously reported by Udo and Grilo,3,4 provide further support for clinical findings that persons with these profiles represent a challenging or more severe subgroup. For example, Grilo and colleagues,8 using diagnostic interviews reliably administered by doctoral research-clinicians, found that 24% of a consecutive series of treatment-seeking women with BED met criteria for PTSD and that those women were characterized by significantly elevated rates of mood, anxiety, and drug use disorders along with greater eating symptoms.2 However, Braun and colleagues3 did not reference or incorporate relevant epidemiologic findings from NESARC-III3–5 that provide important complementary contexts for their findings regarding the relationship between PTSD and binge eating.

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REFERENCES


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greater number of BED symptoms. Thus, psychotherapies focused concomitant need to understand how to prevent and efficiently treat underscore the high comorbidity between BED and PTSD and the together, these population-based findings statistician significantly after adjustment for sociodemographic variables and other mental disorders. Similarly, in our study of the NESARC-III cohort, we found the prevalence of BED to be elevated among US adults with lifetime PTSD compared to those without (4.1% vs 0.8%). Together, these population-based findings underscore the high comorbidity between BED and PTSD and the concomitant need to understand how to prevent and efficiently treat their co-occurrence. For example, we found that negative cognition and mood symptoms of PTSD, in particular, were associated with a greater number of BED symptoms. Thus, psychotherapies focused on addressing negative cognitions and emotions that characterize both BED and PTSD may be helpful in mitigating co-occurring symptoms of these disorders.

We wish to emphasize, however, the importance of using a dimensional approach to understanding the association between BED and PTSD symptoms. While Udo and Grilo found that the prevalence of BED in the general population is relatively low, our study results indicated that between 5.5% and 40.0% of US adults endorsed 1 or more BED symptoms, which varied as a function of trauma exposure and PTSD diagnosis. Specifically, we observed a ‘close relationship’ in which the number of BED symptoms was lowest in a non–trauma-exposed group, intermediate in the trauma-exposed and subthreshold PTSD groups, and highest in the PTSD group. These findings suggest that the link between PTSD and BED symptoms extends beyond the presence of either diagnosis and that a much larger subsample of trauma-exposed individuals may experience BED symptoms.

Other work from our group suggests that there may be different maladaptive eating typologies in individuals with PTSD that are not necessarily diagnostic. Specifically, among US adults with lifetime PTSD in the NESARC-III, we identified 5 latent classes of maladaptive eating typologies in 41.1% of respondents: broad eating psychopathology (2.2%), low past weight (9.6%), binge eating (6.0%), overeating (19.9%), and restrictive eating and cognitive distortions (3.4%). Importantly, individuals in all maladaptive eating typologies had increased odds of several medical conditions relative to individuals with no PTSD and no eating disorder and to those with PTSD and no eating psychopathology.

We echo Grilo and Udo’s conclusion that future research should strive to understand the mechanisms driving maladaptive eating behaviors such as binge eating among individuals with PTSD. We add that future research should also continue to examine the mental and physical health sequelae of a full range of maladaptive eating behaviors among individuals with PTSD symptoms. The employment of novel approaches such as machine learning and network modeling may also be informative in elucidating multivariable predictors of PTSD-BED, as well as the complex interplay of these symptoms.

REFERENCES