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Binge Eating Disorder

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DESCRIPTION OF BINGE EATING DISORDER

Definition

The Diagnostic and Statistical Manual of Mental Disorders (DSM–5; American Psychiatric Association [APA], 2013) describes symptoms of binge eating disorder (BED) as "recurrent episodes [of] binge eating that must occur, on average, at least once per week for three months" (p. 350) and accompanied by clinically significant distress or impairment. An episode of binge eating is characterized by eating considerably more than what others would eat in a given time frame and feeling out of control of eating behaviors. Binge eating episodes are characterized by individuals eating more rapidly than normal, eating until discomfort is experienced, and eating when not hungry. Individuals may experience feelings of disgust, depression, guilt, and embarrassment following a binge-eating episode. In addition, binge eating episodes are not associated with the compensatory behaviors performed to prevent weight gain seen in bulimia nervosa. The DSM-5 specifies symptom severity based on frequency of binge eating episodes from mild (one to three a week) to extreme (14 or more episodes per week).

Prevalence

The prevalence rates of binge eating episodes have risen from 2.7% to just under 5% from 1998 to 2008 (Mitchison, Hay, Slewa-Younan, & Mond, 2014) with average lifetime prevalence rates of BED at 1.9% (Kessler et al., 2013). Unlike other diagnosable eating disorders, researchers predicted that males comprise 30-50% of total cases of diagnosed BED (Burton & Abbott, 2017; Kessler et al.). Researchers also found that impoverished and marginalized groups who lack appropriate physical and mental health care are more likely to exhibit symptoms of BED than other eating disorders (Mitchison et al.). In addition, the average age of onset for BED is slightly older than other eating disorders, at 23.3 years of age (Kessler et al.).

Resource:
http://www.anad.org/education-and-awareness/about-eating-disorders/eating-disorder-types-and-symptoms/

IDENTIFICATION/ASSESSMENT STRATEGIES

Clinical Interview

The clinical interview is the most common assessment approach for BED (Berg, Peterson, & Frazier, 2012). Counselors can use informal measures (e.g., unstructured interview) to explore and identify related signs and symptoms (Tanofsky-Kraff et al., 2013). For instance, counselors may ask eating-related questions if a client indicates feeling shame and guilt, isolation, or loss of control regarding eating (Miller & McManus, 2016). Additionally, a counselor may ask general questions about eating habits such as current eating patterns, attitudes toward food, and beliefs regarding eating behaviors. The use of clinical interviews allows researchers to explore and uncover meaningful content and explanations to the phenomena being discussed. However, interviews have a few limitations, as they can take a significant amount of time, rely

on the skill of the interviewer, and depend on the ability of the interviewee to self-report (Tanofsky-Kraff et al., 2013). As such, more formal assessments might be helpful in the diagnostic process.

The Binge Eating Scale

The Binge Eating Scale (BES; Gormally, Black, Daston, & Rardin, 1982) is a 16-item self-report measure used to measure the cognitive, behavioral, and emotional symptoms associated with BED (Grupski et al., 2013). The BES was originally cultivated to evaluate if clients who were seeking bariatric surgery had symptoms and characteristics of BED. The BES includes Likert-type scaled questions, wherein higher scores indicate greater symptom severity. The BES is a commonly used tool to measure binge-eating behaviors and has been translated into multiple languages. However, the BES was created prior to the DSM-5 inclusion of BED, so has some diagnostic alignment issues.

Resources: To view a sample of this instrument, visit:
https://link.springer.com/referenceworkentry/10.1007%2F978-981-287-087-2_9-1
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4874644/

The Binge Eating Disorder Screener-7

The Binge Eating Disorder Screener-7 (BEDS-7; Herman et al., 2016) is a low-cost, seven-item, self-report measure based on DSM-5 diagnostic criteria for BED. This assessment includes six Likert-type questions and one initial question about excessive overeating that can be answered with a 'yes' or 'no' response. The brief nature of the BEDS-7 makes this assessment easy to implement and a feasible tool for clinical practice (Miller & McManus, 2016). Researchers have noted precise responsiveness and specificity of the BEDS-7; however, the self-report nature of the BEDS-7 may be a limitation because interviewees may not fully understand each component of this assessment (Tanofsky-Kraff et al., 2013).

Resource:
To view a sample of this instrument, visit:
https://www.bingeeatingdisorder.com/hcp/media/BingeEatingDisorder_Screener_Apr16.pdf

Eating Disorder Diagnostic Scale

The Eating Disorder Diagnostic Scale (EDDS; Stice, Telch, & Rizvi, 2000) is a 22-item self-report measure that was developed to aid in diagnosing eating disorders, including symptom criteria for anorexia nervosa, bulimia nervosa, and BED (Stice, Fisher, & Martinez, 2004; Stice et al., 2000). The EDDS includes Likert-type questions, open questions, yes/no questions, and frequency of behavior questions. Stice et al. (2000) reported that scores on the EDDS were reliable and valid when assessing diagnostic criteria for anorexia nervosa, bulimia nervosa, and BED. The EDDS is low-cost, self-report, easy to use, and takes a few minutes to complete. However, some of the open questions assess symptoms related solely to anorexia nervosa or bulimia nervosa, and this could affect the nature of a self-report intended for individuals with BED.

Resource:
To view a sample of this instrument, visit http://www.ori.org/files/Static%20Page%20Files/EDDS.pdf
Scoring: https://psycnet.apa.org/doiLanding?doi=10.1037%2F1040-3590.16.1.60

The Eating Disorder Examination Questionnaire

The Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994; Fairburn et al., 2008) was originally derived from the Eating Disorder Examination (EDE) Interview to assess the core characteristics of eating disorder symptoms and behaviors (Berg, Peterson, Frazier, & Crow, 2012; Jennings & Phillips, 2017). The EDE-Q is a brief self-report measure used in clinical and research settings. The EDE-Q's 28 items include Likert-type scales with higher scores indicating significant clinical impairment (Fairburn & Beglin, 1994; Fairburn et al., 2008). The EDE-Q has been empirically validated for assessment and diagnosis of BED and allows counselors to assess behaviors related to BED and determine

the most appropriate options for treatment (Miller & McManus, 2016). However, the EDE-Q may underestimate the frequency of binge eating episodes, and it may overestimate the "levels of associated ED psychopathology" (Barnes, Masheb, White, & Grilo, 2011, p. 161).

Resource:
To purchase this instrument or for more information, visit:
https://www.corc.uk.net/outcome-experience-measures/eating-disorder-examination/

INTERVENTION STRATEGIES

Eating disorder treatment involves decreasing physiological symptom severity and improving psychological functioning. Treatment often includes the use of an interdisciplinary treatment team and various treatment modalities. The following therapeutic modalities have empirical support for helping individuals with BED: cognitive behavioral therapy – enhanced (CBT-E), dialectical behavior therapy (DBT), and interpersonal therapy – eating disorder model (IPT-ED).

Interdisciplinary Treatment Teams

Treatment of any eating disorder often requires an interdisciplinary treatment team of counselors, physicians, and dietitians (Schebendach, 2012). The primary purpose of an interdisciplinary team is to assess, support, and provide appropriate interventions to clients, and make referrals for more intensive treatments if needed. Treatment can be at various levels of care, and the goals of treatment focus on symptom reduction. This includes addressing psychological issues related to eating disorders (e.g., emotion regulation) and reducing binge-eating related behaviors and thoughts. Mitchell et al. proposed that individuals who are receiving interdisciplinary treatment at the highest level of care (e.g., residential or inpatient hospitalization) participate in treatment longer, but have a lower recidivism rate than those who receive a lower level of care (e.g. outpatient treatment).

Cognitive Behavioral Therapy – Enhanced

CBT-E was cultivated as a transdiagnostic approach for the treatment of disordered eating patterns and diagnosed eating disorders (Fairburn, Cooper, & Shafran, 2003). Counselors who use CBT-E work from the perspective that eating disorders are maintained via a dysfunctional thought process for assessing self-worth (Altman, Wilfley, Iacovino, Waldron, & Gredysa, 2013; Fairburn et al., 2003). In other words, individuals who experience negative self-talk or a lack of self-worth may encounter a cycle of disordered eating patterns (Miller & McManus, 2016). To mitigate dysfunctional thoughts and eating-related behaviors, counselors who use CBT-E help clients identify and dispute dysfunctional thought processes while incorporating behavioral modification. In one study, researchers found that over half of the participants (n = 154) had a level of disordered eating behaviors less than one standard deviation above the sample (Cooper & Fairburn, 2011). These findings could indicate the effectiveness of CBT-E, though further studies are necessary.

Resource:
For more information, visit: https://www.guilford.com/books/Cognitive-Behavior-Therapy-and-Eating-Disorders/Christopher-Fairburn/9781593857097

Dialectical Behavioral Therapy

DBT helps clients regulate emotions (Linehan, 2015). Because binge eating episodes and symptoms may be related to an individual's inability to cope with emotional experiences (Iacovino, Gredysa, Altman, & Wilfley, 2012; Segal, Williams, Teasdale, & Kabat-Zinn, 2013), DBT can be an effective approach for reducing symptoms of BED. Counselors working from a DBT perspective encourage clients to build skills to manage their emotions, replace problem behaviors with more adaptive coping mechanisms via

behaviorism, and use intersession phone coaching to generalize skills. Counselors use a dialectical and flexible approach with clients to extinguish binge eating episodes and help clients address other aspects related to binge eating (e.g., trauma; Baer, Fischer, & Huss, 2005; Segal et al., 2013). DBT is a flexible treatment that can be implemented in individual and group counseling settings (Linehan, 2015). In one study researchers found that 64% of participants (n = 50, N = 101) reported abstinence of binge eating after 22 sessions of DBT at 12 month follow-up (d = .54).

Resources:

For more information, visit https://www.guilford.com/books/DBT-Skills-Training-Manual/Marsha-Linehan/9781462516995/reviews

https://www.guilford.com/books/DBT-Skills-Training-Handouts-and-Worksheets/Marsha-Linehan/9781572307810

https://www.guilford.com/books/Dialectical-Behavior-Therapy-for-Binge-Eating-and-Bulimia/Safer-Telch-Chen/9781462530373

Interpersonal Therapy – Eating Disorders Model

The interpersonal therapy – eating disorders model (IPT-ED; Rieger et al., 2010) was cultivated from interpersonal therapy (IPT) to help individuals with BED achieve similar treatment outcomes as individuals who received IPT for other diagnoses. IPT-ED addresses the impact of negative self-appraisal and social evaluation on the development, maintenance, and mitigation of eating disorders and disordered eating patterns (Altman et al., 2013). According to Rieger et al. (2010), binge eating is as a maladaptive coping skill related to unmet interpersonal needs. For example, a client may binge eat to regain comfort after experiencing sadness, frustration, rejection or isolation (Miller & McManus, 2016; Rieger et al., 2010). Counselors encourage clients to cultivate and improve their interpersonal relationships to alleviate instances of binge eating. IPT-ED is used in individual counseling and group counseling. Research indicates that IPT-ED can result in significant symptom reduction after 20 weeks and positive treatment outcomes when working with individuals with BED (Hilbert et al., 2012).

Resource:

For more information, visit: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3886290/

Additional Binge Eating Disorder Resources:

https://www.routledge.com/A-Clinicians-Guide-to-Binge-Eating-Disorder/Alexander-Goldschmidt-Grange/p/book/9780415527187

https://www.guilford.com/books/Casebook-of-Evidence-Based-Therapy-for-Eating-Disorders/Heather-Thompson-Brenner/9781462520688

https://www.guilford.com/books/Dialectical-Behavior-Therapy-for-Binge-Eating-and-Bulimia/Safer-Telch-Chen/9781462530373

https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml

https://www.nationaleatingdisorders.org/learn/by-eating-disorder/bed

https://www.eatingdisorderhope.com/information/binge-eating-disorder

http://www.anad.org/education-and-awareness/about-eating-disorders/eating-disorder-types-and-symptoms/

http://www.eatingdisorderscoalition.org/

https://namedinc.org/

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