Topic Page: Binge eating disorder

Definition: **binge-eating disorder** from *The Penguin Dictionary of Psychology*

An eating disorder marked by binge eating and related distress similar to that seen in BULIMIA NERVOSA but without self-induced vomiting and purging.

Image from: **Eating disorders include anorexia nervosa,...** in *Eating Disorders: An Encyclopedia of Causes, Treatment, and Prevention*

Summary Article: **Binge Eating Disorder**
from *The SAGE Encyclopedia of Abnormal and Clinical Psychology*

Binge eating disorder (BED) is characterized by recurrent binge eating in the absence of inappropriate compensatory behaviors (i.e., self-induced vomiting, extreme exercise, laxative or diuretic misuse). Overconcern about shape and weight is not a required criterion for BED as is the case in other eating disorders; however, marked distress regarding binge eating must be present. In contrast to bulimia nervosa, individuals with BED have less clearly delineated episodes of binge eating and typically report low levels of restrictive eating between binge episodes. For these individuals, binge eating is usually a long-standing, chronic problem, and the frequency of binge eating is directly related to situational factors and stressors. BED has a typical onset during adolescence or young adulthood. The mean lifetime prevalence for BED is 1.6% for females and 0.8% for males. The gender ratio is considerably less skewed in BED than in other eating disorders. Most individuals who present for treatment are middle-aged, and one third of these patients are male (compared with the approximately 10% male population who present with anorexia nervosa or bulimia nervosa). In addition, BED is equally prevalent among ethnic groups. This entry reviews the symptom criteria for BED; discusses the course, treatment, and prognosis; and concludes with a brief review of the functional consequences and medical complications associated with this disorder.

Symptom Criteria

Prior to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*), BED was included in the appendix of the previous edition of the *DSM* (*DSM-IV-TR*) as a criteria set needing further study. Diagnostically, BED was classified as an eating disorder not otherwise specified (now labeled as either “other specified feeding or eating disorder” or “unspecified feeding or eating disorder” in the *DSM-5*). The symptom criteria for BED listed in the *DSM-5* are as follows: (a) recurrent episodes of binge eating; (b) binge eating episodes are associated with three or more of the following: 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 guilty afterward; (c) marked distress regarding binge eating; (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. According to the *DSM-5*, all five symptoms must be present to meet the criteria for a diagnosis of BED.

An episode of binge eating is characterized by eating an objectively large amount of food in a discrete period of time (i.e., within any 2-hour time period). The food consumed must be larger than what most

individuals would eat in a given time period under similar circumstances. In addition, individuals must express a loss of control over eating during the episode (e.g., feeling that one cannot stop eating or control what or how much one is eating). An episode of binge eating is not necessarily restricted to one setting. For instance, an individual may begin a binge at a party or restaurant and then continue to eat when she or he returns home. Repeated and frequent snacking throughout the day on small amounts of food (i.e., "grazing") is not considered to be an episode of binge eating.

An episode of binge eating must be accompanied by a sense of loss of control. Loss of control is defined by an inability to stop eating once started or to refrain from eating. The type of food consumed during binges varies across individuals and can vary within individuals. Most individuals typically binge on foods they would otherwise avoid, oftentimes due to dieting or dietary restraint. Generally, individuals who struggle with this condition experience a significant amount of shame associated with their eating problems and, therefore, attempt to conceal their symptoms and behaviors and generally binge in secrecy. Binge eating usually ceases when the individual feels uncomfortably or painfully full. Negative affect has been identified as the most common antecedent to binge eating. It is typical for individuals to binge eat in response to mood changes and interpersonal difficulties. Additional triggers include dietary restraint, boredom, and negative feelings associated with body shape and weight. Generally, binge eating temporarily distracts the individual from current stressors in the short term; however, negative self-evaluation and dysphoria are common examples of delayed consequences. Severity of the illness is often denoted by mild, moderate, severe, or extreme, based on clinical symptoms, degree of disability, and the need for supervision.

Course, Treatment, and Prognosis

With regard to course, BED tends to be phasic, rather than continuous; individuals typically experience periods in which they are inclined to binge eat and other times in which they are in control of their eating. Few individuals report a history of anorexia nervosa or bulimia nervosa. This disorder occurs in normal-weight, overweight, and obese individuals. BED is differentiated from obesity, as most obese individuals do not engage in recurrent binge eating. Additionally, research comparing individuals with BED and weight-matched obese individuals without BED suggests that those meeting criteria for BED consume more calories and have greater functional impairment, lower quality of life, more subjective distress, and greater psychiatric comorbidity.

As mentioned, BED is a new diagnosis in the *DSM-5*; therefore, little is known about its development. Research suggests that binge eating and loss-of-control eating occur in children and are associated with increased body fat, weight gain, and increases in psychological symptoms. Research also indicates that binge eating is common in adolescent and college-age samples and may represent a prodromal phase (i.e., an early symptom) in the development of an eating disorder for certain individuals. Typically, individuals with BED engage in dieting and dietary restriction following binge eating, whereas individuals with bulimia nervosa engage in dysfunctional dieting prior to binge eating. The majority of individuals with BED seek treatment later than those with anorexia nervosa or bulimia nervosa. In addition, individuals with BED are likely to engage in more objective binges (i.e., a portion that is at least 3 times the typical portion size for that food) than subjective binges (i.e., feeling loss of control while eating an appropriate portion of food) and exhibit less concern with eating, body shape, and weight than those with anorexia nervosa and bulimia nervosa. Overall, research indicates that BED is rather persistent and the course is comparable with that of bulimia nervosa in terms of severity and duration. BED is unlike anorexia nervosa and bulimia nervosa in terms of diagnostic crossover; most individuals with BED never

meet criteria for anorexia nervosa or bulimia nervosa, whereas it is quite common for an individual diagnosed with anorexia nervosa to meet criteria for bulimia nervosa at some point in time.

Epidemiologic research is limited for BED. Prevalence estimates for BED from weight loss–seeking samples range from 15% to 50% (with a mean of 30%) of the population. Prevalence estimates from nonpatient community samples range from 0.7% to 4.0%. Although the majority of patients who present for treatment are female, studies involving community samples indicate that the rates of BED are similar for males and females. Studies also indicate that more racial minority women meet the criteria for BED than for bulimia nervosa. Individuals with BED commonly suffer from additional psychopathology, specifically mood, anxiety, substance use, personality disorders, and, importantly, history of suicide attempts. Personality disorders, in particular, are associated with an increased severity of BED. Individuals also tend to report more psychological symptoms and distress, lower self-esteem, higher impulsivity, and more demoralization. Overall, BED appears to be the most common eating disorder and is of great clinical significance in terms of both medical health and mental health problems.

Research continues to examine the most effective treatment for BED. Cognitive behavioral therapy (CBT) tends to have the most support. CBT focuses on addressing rigid beliefs about eating, shape, or weight, which often includes drive for weight loss, restricted eating, and all-or-nothing beliefs about good and bad foods or weight and shape. Behavioral interventions include examining chains of behavior or functional analysis, stimulus control, normalizing eating patterns (e.g., three meals and three snacks daily), and mindful eating. Dietary counseling can often be helpful in aiding individuals with BED in challenging food rules and developing a healthier relation with food and meal planning. Identifying co-occurring mental health conditions may also be helpful in treating binge eating as research suggests that negative affect is related to the initiation of binge episodes. Addressing these emotional concerns (e.g., depression, anxiety) pharmacologically or psychotherapeutically can often lead to full resolution of binge eating symptoms. Some medications show promise for the treatment of binge eating such as antidepressant, antiobesity, and antiepileptic medications. Most recently, medications typically used for the treatment of attention-deficit/hyperactivity disorder have received some support for the treatment of BED. CBT for BED does not target weight loss and is not a weight loss intervention. Research appears to suggest that weight loss interventions (e.g., behavioral weight loss, bariatric surgery) are more helpful after the treatment and resolution of the binge eating. Interpersonal therapy, dialectical behavior therapy, and self-help treatments also show promise for the treatment of BED. Understanding the nature of an individual's binge eating behavior through functional analysis is often the most helpful way to choose an evidenced-based treatment approach.

Functional Consequences and Medical Complications

Individuals diagnosed with BED experience 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. BED is also associated with an increased risk for weight gain and the development of obesity. In terms of medical complications, extreme stomach expansion due to binge eating may lead to stomach rupture and death in rare circumstances.

See also Body Image; Bulimia Nervosa; Eating and Feeding Disorders: Overview

Further Readings

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Marino, Joanna M., and Diana L. Gaydusek. "Binge Eating Disorder." *The SAGE Encyclopedia of Abnormal and Clinical Psychology*, Amy Wenzel, Sage Publications, 1st edition, 2017. *Credo Reference*, https://search.credoreference.com/content/topic/binge_eating_disorder. Accessed 24 May 2019.