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Binge-Eating Disorder: A Primer for Professional Counselors

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Binge-Eating Disorder (BED) is a primary diagnosis listed in the Feeding and Eating Disorders chapter of the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5; American Psychiatric Association [APA], 2013)*. Although BED is considered one of the most common eating disorders, symptoms often go unrecognized and untreated (Striegel-Moore et al. 2010). In this article, BED criteria are reviewed and guidelines for assessment, diagnosis, and treatment are offered. A case study is also provided to illustrate the application of BED utilizing best practices.

Keywords: binge-eating disorder, eating disorder, DSM-5

Binge-eating disorder (BED) is a new mental disorder in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013)*. Prior to the DSM-5, binge eating was listed under Eating Disorder Not Otherwise Specified (EDNOS) with research criteria listed in appendixes (APA, 2000). Researchers recommended BED be included as an independent diagnosis in the DSM-5 after finding that the diagnosis made up a large percentage of EDNOS diagnoses and had distinct clinical indicators and outcomes (APA, 2013; Citrome, 2015; Tanofsky-Kraff et al., 2013; Wonderlich, Gordon, Mitchell, Crosby, & Engel, 2009).

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Binge-eating disorder is the most common eating disorder in the United States, with lifetime prevalence rates estimated between 1-3% in the general population (APA, 2013; Cossrow et al., 2016; Brownley et al., 2016; Grucza, Przybeck, & Cloninger, 2007; Hudson, Hiripi, Pope, & Kessler, 2007; Iacovino, Gredysa, Altman, & Wilfley, 2012). Recent research suggests prevalence rates have increased further since the publication of the DSM-5 (Cossrow et al., 2016). Women are diagnosed at higher rates than men; however, less of a gender gap in diagnosis exists between men and women than in other eating disorders (APA, 2013). Prevalence rates appear to be similar across African American, Caucasian, and Hispanic racial/ethnic groups in the United States (Franco et al., 2012; Hudson et al., 2007; Iacovno et al., 2012). Kessler et al. (2013) examined BED prevalence rates in international populations and found rates similar to those reported in the United States. Although the average age of onset is slightly later than other eating disorders, estimated at 25.4 years old, researchers suspect symptoms begin more commonly in late childhood and adolescence (Hudson, et al., 2007; Tanofsk-Kraff et al., 2013).

Untreated chronic binge eating is associated with serious psychological, physical, and social problems (Brownley et al., 2016; Tanofsky-Kraff et al., 2013). Individuals with

BED experience a range of negative outcomes, from diminished interpersonal functioning to increased suicidality. The mortality risks related to BED are strongly correlated with medical comorbidities, including obesity, high blood pressure, high cholesterol levels, heart disease, and diabetes (Bulik & Reichborn-Kjennerud, 2003; Grilo, White, Barnes, & Masheb, 2013; Tanofsky-Kraff et al., 2013). Despite the frequency and severity of BED, the condition often goes undiagnosed and untreated in counseling (Citrome, 2015; Cossrow et al., 2016; Hudson et al., 2007). In the following article, we will discuss fundamental principles related to BED diagnosis, screening and assessment, and treatment that will help prepare counselors to identify and work with clients that experience binge eating symptoms.

Diagnosis

Recurrent and persistent episodes of binge eating provide the foundational criteria for BED (APA, 2013). Refer to the DSM-5 for the complete diagnostic criteria for BED. The only change in criteria from the prior edition of the DSM was the reduction in time (from six months to three months) and frequency (from twice to an average of once a week) required for symptom manifestation (Tanofsky-Kraff et al., 2013). Some researchers question the validity and reliability of the new DSM-5 criteria, suggesting the

need for additional research (Klein, Forney, & Keel, 2016). One area of criticism relates to severity measures. Grilo et al. (2015) argued that the current severity specifiers (based solely on frequency of binge eating episodes) are not empirically supported. They conducted a preliminary study and found support for using overevaluation of shape/weight as a severity specifier. Individuals that have this type of negative body image have more pathology and psychological distress than individuals with BED who do not exhibit overevaluation of shape/weight.

Differential Diagnosis

With the exception of pica, current diagnoses within the feeding and eating disorder chapter of the *DSM-5* are mutually exclusive (APA, 2013). Counselors must work to differentiate overlapping symptoms between various eating disorder criteria and other mental health disorders. The most commonly confused disorder with BED is bulimia, as the two disorders share a core symptom of recurrent binge eating (APA, 2013; Citrome, 2015; Grilo et al., 2015; Striegel-Moore & Franko, 2008; Walsh & Boudreau, 2003). Although both disorders include binge eating, individuals with BED do not engage in compensatory behaviors (e.g., vomiting, laxative use, fasting, or excessive exercise) or extreme dietary restrictions aimed

at reducing body weight (APA, 2013). An additional difference includes variation in calories consumed during binge and non-binge meals (Walsh & Boudreau, 2003). Walsh and Boudreau (2003) found that the size of the binge meal was greater in clients diagnosed with BN than BED. People with bulimia also tend to have more disordered patterns of food consumption during binge meals (Walsh & Boudreau, 2003).

Counselors must also work to rule out eating patterns that, although potentially excessive, are more situational and do not meet the threshold for BED. Overeating, in of itself, is not the same as binge eating. For example, eating larger than normal quantity of food during a holiday meal (e.g., Thanksgiving) does not qualify as a binge episode (APA, 2013). Eating small amounts of food frequently throughout the day is also not considered binge eating. Furthermore, although obesity may co-occur with BED, the majority of individuals with BED do not meet the criteria for obesity (Hudson et al., 2007).

Co-Morbidity

Individuals with BED have high rates of psychiatric comorbidity. (Cossrow et al., 2016; Tanofsky-Kraff et al., 2013; Wonderlich et al., 2009). Hudson et al., (2007) found that as many as 79% of adults with BED have at least one comorbid mental health disorder and as many as 50% have more than three co-

occurring conditions. Grilo et al. (2013) found that 67% of individuals with BED had at least one new lifetime psychiatric disorder and 37% had at least one current psychiatric disorder. Notably, the researchers found that African-Americans and Hispanics were more likely than Caucasians to be diagnosed with a co-morbid mood and/or anxiety disorder. Binge eating and related symptoms tend to be worse for individuals with co-occurring psychiatric disorders (Grilo et al., 2013).

Co-occurring rates of BED and bipolar disorder are particularly high and require special consideration for treatment (McElroy et al., 2006). McElroy et al. (2006) noted that conventional treatments for bipolar disorder (e.g., drug treatments for depressed mood and manic episodes) may exacerbate BED symptoms. Conversely, psychopharmacological treatments for BED (e.g., antidepressants) may contribute to manic episodes in individuals with bipolar disorder. Missed symptomology of either diagnosis could lead to treatment resistance and complications. Counselors should attend to symptomology of both diagnoses to increase overall treatment effectiveness and minimize potential complications. Collaboration with other health professionals may be necessary, especially in selecting and managing medications.

Borderline personality disorder (BPD) also co-occurs frequently with BED (APA, 2013; Chen, Matthews, Allen, Kuo, & Linehan,

2008; Marino & Zhanarini, 2001). Binge eating behavior is included in the impulsive behavior diagnostic criteria of BPD in the DSM-5, however, if the full criteria for both disorders are met, both diagnoses should be given (APA, 2013). Complicating factors associated with co-occurring BPD and BED, including heightened impulsivity, suicidal ideation, and interpersonal struggles, can negatively impact the therapeutic relationship and overall treatment progress (Chen et al., 2008; Friborg et al., 2014; Marino & Zhanarini, 2001). Careful attention to screening and assessment can aid in efficient and accurate diagnosis of BED, as well as recognition of any co-morbid conditions.

Screening and Assessment

We recommend counselors screen for BED as part of their normal intake process (Berg, Peterson, Frazier, 2012). Individuals experiencing binge eating episodes are often ashamed of their behavior and hesitant to self-disclose symptoms to people in their lives, including counselors (APA, 2013; Berg et al., 2012). Citrome (2015) noted that “binge eating is often a secretive behavior, and commonly associated with a high degree of embarrassment or shame, it is not ordinarily revealed unless the clinician makes a direct inquiry regarding eating patterns” (p. 45). Furthermore, BED is a relatively new diagnosis, and thus, clients may not be aware their symptoms are part of a condition that can be diagnosed and treated (APA, 2013).

Frequent rates of other co-occurring conditions further complicate the BED assessment process, as binge eating behaviors may be overlooked or overshadowed by other symptoms. We recommend counselors approach BED assessment from a holistic framework, integrating both informal and formal measures.

Informal Measures

Berg et al., (2012) noted that the most common approach to BED screening and assessment is through informal measures, most notably the unstructured clinical interview. Counselors can listen for signs and symptoms of BED during a comprehensive biopsychosocial intake. Common warning signs that warrant more targeted screening and assessment include low self-esteem, obsessive personality traits, perfectionistic personality traits, emotional irregularity, issues with body image and weight, and impulsivity. Obesity and associated medical conditions may also warrant further screening.

Counselors can also integrate specific eating related questions into an unstructured clinical interview (Berg et al., 2012; Tanofsky-Kraff et al., 2013). General questions about eating patterns, history of dieting, and attitudes toward food can provide valuable screening information. Berg et al. (2012) suggested asking the following screening questions to screen for BED during a diagnos-

tic interview (p. 264):

1. Have you ever had a binge eating episode? For example, eating an unusually large amount of food and feeling like your eating was out of control?
2. Have there been any times when you've eaten an amount of food other people might consider unusually large?
3. Have you ever felt like your eating was out of control? For example, like you couldn't stop or resist eating? Or like you felt compelled to eat?
4. Can you think of a specific time when that's happened and describe what you had to eat and how much?
5. How often have episodes like that happened?

These questions are directly related to symptoms of BED and can help identify when further assessment is warranted.

Formal Measures

Use of formal measures can help improve diagnostic accuracy and provide valuable baseline data for assessing client progress and measuring treatment outcomes (Celio et al., 2004). Self-report questionnaires are the most common form of BED-related formal measures. The most widely recognized screening tools for BED include the Binge Eating Disorder Screener-7 (BEDS-7; Herman et al., 2016), the Binge Eating Scale (BES; Celio et al., 2004; Grupski et al., 2013), and the Questionnaire on Eating and Weight Patterns-5 (QEWP-5; Yanovski, Marcus,

Wadden, & Walsh, 2015).

The BEDS-7 is a relatively new self-report tool based on the *DSM-5* diagnostic criteria (Herman et al., 2016). The screener begins with a single yes/no question related to excessive overeating in the last three months. If individuals answer yes, they answer six more Likert-scale questions that align directly with *DSM-5* criteria. Initial research demonstrated 100% sensitivity (i.e., true positives) and 38.7% specificity (i.e., true negatives) for the 7-item questionnaire (Herman et al., 2016). The brief and low cost nature of the BEDS-7 make it a promising tool for use in clinical practice. Potential limitations include concerns common to self-report measures, namely that questionnaires rely on interviewee's accurate understanding and honest reporting (Tanofsky-Kraff et al., 2013).

The BES is a 16-item self-report questionnaire that assesses behavioral, emotional, and cognitive indicators associated with binge eating (Celio et al., 2004; Grupski et al., 2013). Sensitivity and specificity scores are similar to those found with the BEDS-7 (Herman et al., 2016). Although the screening tool has had clinical utility in the past, the BEDS-7 appears to be a more brief and updated screening tool for BED.

The QEWP-5 was originally developed for *DSM-IV* filed trials (Yanovski et al., 2015). The measure was recently updated to align with *DSM-5* criteria. As with the other

two BED screening tools, Yanovski et al. (2015) noted that the QEWP-5 is expected to be "more sensitive and less specific" (p. 2). Other reliability and validity data on the QEWP-5 is not published. The QEWP-5 includes questions not asked on other two BED screeners discussed above, including time of day binge episodes occur, length of episodes, and the type of food or liquids consumed. This extra information could be helpful for managing treatment progress and outcome.

Formal appraisal of BED symptomology can also occur as part of a larger assessment of disordered eating. The most widely used assessment of this type is the Eating Disorder Examination interview (EDE) and its self-report questionnaire version, the EDE-Q (Barnes et al., 2011; Berg, Peterson, Frazier, & Crow, 2012; Striegel-Moore et al., 2010). The EDE is primarily used in research, as the amount of time and interviewer skill required inhibit clinical utility (Tanofsky-Kraff et al., 2013). Barnes et al. (2011) noted that the EDE and the EDE-Q are both relatively accurate tools for diagnosing BED, but that the "EDE-Q may underestimate binge eating frequency and may overestimate levels of associated ED psychopathology" (p. 161). Despite some limitations, the EDE-Q is one of the most well researched and utilized comprehensive eating disorder measures. Once counselors thoroughly assess and accurately

diagnose BED, they can begin considering options for treatment.

Treatment

Treatment of BED often requires an interdisciplinary team of mental health professionals, physicians, and nutritionists (Brownley et al., 2016). In this section, we will discuss interventions most relevant to counselors' role in treatment. Currently, cognitive behavioral therapy – enhanced (CBT-E; Fairburn, Cooper, & Shafran, 2003) and interpersonal therapy (IPT-ED; Rieger et al., 2010) are the most researched and empirically supported therapies for BED (Kass, Kolko, & Wilfley, 2013). Dialectical behavioral therapy (DBT) also has growing empirical support, especially for individuals who do not respond well to CBT-E or IPT-ED (Segal, Altman, Weissman, Safer, & Chen, 2013).

Fairburn et al. (2003) developed CBT-E as a transdiagnostic approach to treating eating disorders. According to this theory, individuals' disordered eating is maintained by "a dysfunctional system for evaluating self-worth" (p. 510). In the case of BED, such negative self-appraisal results in clients engaging in unhealthy cycles of dieting and bingeing (Altman, Wilfley, Iacovino, Waldron, & Gredysa, 2013). In addition to dysfunctional schemes for self-evaluation, Fairburn et al. suggested that a subgroup of clients also have clinical perfectionism, core low self-

esteem, mood intolerance, and/or interpersonal difficulties that need to be addressed. Treatment from a CBT-E perspective primarily focuses on identifying and refuting dysfunctional thoughts (e.g., modifying negative views of body weight and shape and challenging automatic thoughts related to eating) and engaging in behavioral modification (e.g., addressing problematic eating patterns through goal setting and self-monitoring). The approach was designed primarily for one-on-one outpatient treatment, but it can also be implemented in group settings. CBT-E is one of the most researched approaches to treating BED (Altman et al., 2013; Fairburn et al., 2009; Iacovino et al., 2012; Kass et al., 2013).

The IPT-ED model of BED acknowledges the role negative self-evaluation plays in maintaining eating disorders, however, social (vs. self) evaluation is considered more central to etiology and treatment (Altman et al., 2013; Rieger et al., 2010). Rieger et al. (2010) noted that the "central role of negative social evaluation in the IPT-ED model stems from its primacy in triggering poor self-esteem and negative affect" (p. 402). According to this theory, binge eating is primarily a maladaptive coping response to unmet interpersonal needs and the negative affect associated with those unmet needs (Altman et al., 2013). Instead of expressing their feelings of sadness or anger related to rejection or isolation, IPT-ED

proposes that clients with BED turn to food for comfort. Treatment, therefore, is primarily focused on improving and maintaining individuals' interpersonal relationships (Rieger et al., 2016). IPT-ED can be implemented in group or individual outpatient treatment. Research supports IPT-ED as an efficacious approach for treating BED, with research findings similar to those evaluating CBT-E (Kass et al., 2013; Tanofsky-Kraff et al., 2009; Wilson, Wilfley, Agras, & Bryson, 2010).

Although CBT-E and IPT-ED are empirically supported treatments for BED, they are not effective with all clients, all of the time (Segal et al., 2013; Wilson, et al., 2007). Segal et al. (2013) noted that co-occurring personality disorders and suicidal behavior predict poorer outcomes with the traditional treatment options. DBT is a well-matched approach in such instances. Iacovino et al. (2012) noted that "the modification of DBT for BED is based on the regulation effect model of binge eating, which posits that binge eating occurs in response to extreme emotional experiences when more adaptive coping mechanism is not accessible" (p. 6). Treatment, therefore, focuses on building cognitive behavioral skills related to mindfulness, distress tolerance, and emotional regulation (Baer, Fischer, & Huss, 2005). Behaviorism is also key in this treatment- for example, when clients binge, counselors often

ask them to complete a behavior chain analysis that includes identifying thoughts, feelings, and events before, during, and after a binge episode with an emphasis on understanding triggers and brainstorming healthier solutions to problems. Further, clients are encouraged to contact the clinician for skills coaching between sessions, and therefore receive positive reinforcement for using new skills instead of engaging in binge eating (Segal et al., 2013). As with the other approaches, DBT can be implemented in individual or group formats (Segal et al., 2013). Initial research supports the utilization of DBT for BED (Chen et al., 2008; Iacovino et al., 2012; Klein, Skinner, & Hawley, 2013; Safer, Robinson, & Jo, 2010).

A number of emerging alternative and adjunctive approaches are also available, including pharmacology (McElroy et al., 2015; Tanofsky-Kraff et al., 2013), mindfulness (Leahey et al., 2008), yoga (McIver, O'Halloran, & McGartland, 2009), and integration of smartphone applications (Fairburn & Rothwell, 2015). These approaches aim to address symptoms not always adequately addressed in traditional BED treatments. For example, pharmacology aims to directly modify chemicals and hormones that may underlie or drive binge eating behaviors. Mindfulness and yoga teach embodied awareness and acceptance that can reduce negative affect and cognitions that lead to

binge eating. Smart phone applications can help individuals integrate treatment exercises into their daily lives, allowing the phone to serve as another tool for teaching and practicing skills outside of the counseling office. Given the relative new status of BED as a primary diagnosis, we expect even more treatment options to emerge as scholars and practitioners work to better assess, diagnose, and treat clients who present with BED.

In choosing treatment options, counselors should consider their level of clinical expertise and experience with available BED treatments, as well as client characteristics and preferences (Altman et al., 2013). Altman et al. (2013) noted that counselors trained in traditional CBT and IPT can obtain unpublished manuals for CBT-E and IPT-ED from the developers of the approaches in order to increase their competency in working with clients who have BED. Similar materials and training will likely become available for DBT and other emerging approaches. Counselors should also be prepared to work with interdisciplinary partners in treating clients with BED. As has already been noted, BED has many medical morbidities that can complicate recovery and thus treatment often occurs in, or at the very least in collaboration with, medical settings (Bulik & Reichborn-Kjennerud, 2003; Striegel-Moore et al., 2010). In the following section, we present a case study to help illustrate emerging best practices

in BED assessment, diagnosis, and treatment planning. Although client characteristics and symptom presentation can vary greatly, we believe this case represents experiences and approaches consistent with BED literature and our own clinical experiences.

Case Study

Alexa, a 15-year-old Caucasian female, presented to counseling following a physical in which her primary care physician noted a 25-pound weight gain in the last three months without an identifiable medical cause. In the initial parent consultation, Alexa's parents reported they noticed their daughter eating larger amounts of food than normal. They stated that on a few occasions, they found multiple packages of empty food hidden under her bed. Alexa's mother said she approached Alexa about her eating a couple of times, but that Alexa would just put her head down and cry. They told the counselor Alexa had been spending more time alone lately as well.

After consulting with Alexa's parents, the counselor met individually with Alexa. Alexa appeared slightly overweight, dressed in jeans and a loose fitting t-shirt. The counselor utilized a structured clinical interview and asked Alexa what might be causing her to feel more stressed than usual. As Alexa talked, the counselor specifically listened for signs and symptoms of distorted eating and negative

emotions related to eating, as well as potential warning signs related to suicidal ideation. When the counselor began to hear that Alexa's eating patterns aligned with binge eating behavior, she asked Alexa to complete the BEDS-7. Based on the results of the instrument and information obtained during the clinical interview, a diagnosis of F50.8 binge-eating disorder, moderate severity was given.

In their sessions, the counselor and Alexa worked to develop a treatment plan that included twice-weekly individual counseling with the following initial goals: learn about BED, identify three triggers related to binge eating, and learn and practice three coping strategies to utilize when experiencing triggers. The counselor also referred Alexa to two adjunct services: a nutritionist who specialized in disordered eating and therapeutic yoga. In the first few individual sessions, the counselor primarily focused on engagement. The counselor actively listened to Alexa's story, communicating understanding, empathy, and acceptance. The counselor also looked for opportunities to ask open-ended questions that helped lay the foundation for later exploring problematic thoughts and feelings. Alexa began to identify triggers to binge eating, including receiving lower grades in school, feeling rejected by peers, and feeling fat.

Once Alexa identified key triggers, the counselor began introducing terminology and

skills consistent with DBT. For example, the counselor presented the idea of emotional vulnerability and practiced a skill for coping with emotional vulnerability. The counselor also introduced Alexa to a DBT smartphone application (Free DBT Skills Diary Card App, 2015) that she could use to learn, practice, and track use of DBT skills at home. At the 12-week mark, Alexa reported that she was practicing her new skills almost daily, had less than one binge-eating episode per week, and had lost 9 pounds.

Over a period of six months, Alexa engaged in binge-eating behaviors approximately once a month when she experienced unexpected family or school stress, but never met full diagnostic criteria for BED. The counselor and Alexa worked together to develop a risk management plan that included triggers, warning signs, coping skills, and social supports. After one year, Alexa terminated counseling with the support of her counselor. Through the use of a multidisciplinary approach, including evidence-based practices and adjunct treatments, Alexa was able to identify patterns of negative self-evaluation and related affect, develop increased emotional regulation and distress tolerance, and increase healthy coping and positive relationships; effectively reducing the usefulness of binge eating behaviors in her life.

Conclusion

Binge-eating disorder is the most common eating disorder, yet fewer than half of people with BED receive treatment (Kessler et al., 2013). The above primer is intended to give counselors an overview of BED in an effort to increase accurate identification and effective treatment. Literature related to BED is still emerging, however, and many limitations still exist in diagnosis, assessment, and treatment. Diagnostic criteria and assessment tools can be subjective (e.g., “loss of control,” “more than normal”) and culturally insensitive (Citrome, 2015). Furthermore, differentiating between other eating disorder diagnoses is often less obvious than the DSM-5 categories might suggest (e.g., frequency of binge eating, the occurrence of compensatory behaviors). Additional research is especially needed for children, adolescent, and diverse populations. Given the high prevalence and serious consequences of BED, we recommend counselors seek additional training and supervision in BED, as well as consider participating in practitioner-based research projects that allow the knowledge base related to this condition to grow.

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