CHAPTER 1

Diagnosis and Epidemiology of Binge-Eating Disorder

In 1959 Stunkard published the clinical observation that some obese individuals report having distressing episodes of overeating that they experience as outside of their control. Stunkard characterized an eating binge as "having an orgiastic quality" and noted that "enormous amounts of food are consumed in relatively short periods." He noticed that the eating binge is "frequently related to a specific precipitating event, and is regularly followed by severe discomfort and self-condemnation." Forty years later Stunkard's clinical observation led to the delineation of binge-eating disorder (BED).

BED has been included in the appendix of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) as a disorder for further study and is also included as an example of an eating disorder not otherwise specified (EDNOS). The introduction of BED to DSM-IV has stimulated much research over the past decade as well as many critical questions concerning the utility of this new diagnosis. There is no respective diagnostic category in the 10th revision of the *International Classification of Diseases* (ICD-10; World Health Organization, 1992).

The diagnostic criteria currently recommended for BED are presented in Table 1.1. In the current DSM-IV criteria, no distinction is made between obese and nonobese binge eaters. It is important to keep in mind that in clinical settings, the majority of persons with BED have varying degrees of obesity, even though the diagnosis is not limited to overweight or obese individuals (Spitzer et al., 1993a; see Chapter 3 for additional discussion).

Diagnostic Criteria

The definition of a binge-eating episode in DSM-IV is identical for both bulimia nervosa (BN) and BED, including the requirements of the ingestion of an unusually large amount of food

TABLE 1.1. Proposed Diagnostic Criteria for BED

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

   (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time under similar circumstances

   (2) a sense of lack of control during the episodes (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge-eating episodes are associated with three (or more) of the following:

   (1) eating much more rapidly than normal
   (2) eating until feeling uncomfortably full
   (3) eating large amounts of food when not feeling physically hungry
   (4) eating alone because of being embarrassed by how much one is eating
   (5) feeling disgusted with oneself, depressed, or very guilty after overeating

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least 2 days a week for 6 months.

E. The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa.

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and a feeling of loss of control over the eating episode. The diagnosis is restricted to patients who have "objective" binge-eating episodes that are defined in quantitative rather than qualitative terms. How to properly assess binge eating remains particularly problematic. The Eating Disorder Examination (EDE—Cooper & Fairburn, 1987; Fairburn & Cooper, 1993), a semistructured interview developed to assess eating pathology, differentiates between subjective and objective binge-eating episodes, viewing the phenomenon from both the subject's (subjective) and the clinician's (objective) perspectives. In both types of binge eating a feeling of loss of control is required; in an objective episode the interviewer agrees with the patient that the amount of food is more than most people would eat under similar circumstances. The EDE also included the term "picking" or "nibbling," defined as eating in an unplanned and repetitious way between meals and snacks, without a sense of loss of control.

   The Structured Inventory for Anorexic and Bulimic Eating Disorders (SIAB-EX—Fichter et al., 1998; Fichter & Quadflieg, 2001) can be used to assess binge-eating behavior in a structured way. This instrument differentiates between three types of binge eating: objective binge eating, subjective binge eating, and "atypical binge eating," also labeled as "grazing" or "constant overeating." The main characteristic of atypical binges is that food is not consumed in a short period of time but rather ingested, more or less continuously, throughout the day or during part of the day (e.g., in the evening). The amounts of food consumed are small, so that the activity does not constitute an eating binge in the strict sense of the word, and there is only a slight loss of control. The definition of atypical binge eating is unique to the SIAB-EX and is not covered by other published assessment instruments. Fichter and Quadflieg (2001) describe it as an "experimental scale" and consider their definitions of binge eating to be closer to the

DSM-IV criteria, which define binge eating as lasting for "a discrete period of time (e.g., within any 2-hour period)." In line with this definition, Marcus and colleagues (1992) reported that almost 25% of binge-eating episodes by obese binge eaters lasted an entire day, suggesting a great deal of variability. All-day binges appear to violate the DSM-IV specification of occurring "in a discrete period of time." Cooper and Fairburn (2003) acknowledge that it is particularly difficult to distinguish episodes of binge eating from "unstructured overeating." It is also sometimes difficult to determine whether the amounts eaten are truly large, and individuals are often unclear whether they experienced a sense of loss of control. For objective and especially subjective binge-eating episodes, the level of agreement is usually relatively low between self-report and interview assessment in individuals with BED. Interestingly, the self-report questionnaires produce lower frequencies of objective binge-eating episodes and subjective binge-eating episodes than the interview, which contrast with the results seen in BN (see de Zwaan et al., 2004). Nonetheless, the interviewer must be aware of these problems and make a judgment on the basis of the best available guidelines (Table 1.2).

TABLE 1.2. Definitions of Different Aspects of Eating Episodes

Term	Definition
Objective binge-eating episodes[a]	Eating an objectively large amount of food with a sense of loss of control (DSM-IV, EDE, SIAB).
Subjective binge-eating episodes	Eating a subjectively large amount of food with a sense of loss of control (EDE, SIAB).
Loss of control	Feeling that one cannot stop eating or control what or how much one is eating (DSM-IV, SIAB). Feeling driven or compelled to eat, unable to stop eating, unable to prevent the eating episode, no longer trying to control eating. Does not require the agreement of the subject (EDE).
Objectively large amount	More than the usual amount eaten under the circumstances (DSM-IV). Does not require the agreement of the subject (EDE).
Atypical eating binges	Eating more or less continuously throughout the day or during part of the day (e.g., in the evening). The amounts of food consumed are small, so that the activity does not constitute an eating binge in the strict sense of the word. There is only a slight loss of control (SIAB).
Duration of binge-eating episodes	Eating, in a discrete period of time (e.g., within any 2-hour period) (DSM-IV). An hour or more when the subject was not eating terminates a binge eating episode (EDE).
Picking, nibbling	Eating in an unplanned and repetitious way between meals and snacks without a sense of loss of control (EDE).
Snack	Episode of eating in which the amount eaten is modest, known at the outset with some certainty and without the repetitious element (EDE).

Note: DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.); EDE, Eating Disorder Examination; SIAB, Structured Inventory for Anorexic and Bulimic Eating Disorders.
[a]Required in DSM-IV for a diagnosis of BED.

Even though the concept of BED has strong face validity, content and construct validity are less well established especially concerning the usefulness of binge eating as the main symptom of BED. Distinguishing BED from other types of overeating is not straightforward, and in clinical practice many cases are difficult to classify. The diagnostic criteria for BED focus on days per week with binge-eating episodes rather than individual episodes, the rationale being that subjects with BED may have more difficulty recalling discrete binge-eating episodes than those with BN. In purging BN, binge-eating episodes can be defined by the presence of vomiting or laxative abuse that usually terminates the binge-eating episode, whereas with BED, the termination of the eating binge is not punctuated by such discrete, easily recalled behavior. Many patients, therefore, experience difficulties in precisely recalling and labeling discrete binge-eating episodes (Rossiter et al., 1992). Recent studies show that subjects without BED also recorded binge-eating episodes during a period of self-monitoring of food intake (Greeno et al., 2000; le Grange et al., 2001; Yanovski & Sebring, 1994). In addition, the binge-eating episodes of overweight individuals are generally not as large, and may differ in other important ways, from the binge eating described by patients with BN (Brody et al., 1994). Thus the single definition of a binge-eating episode for both disorders, as currently used in DSM-IV, may not fit clinical reality (Gladis et al., 1998b).

The extent to which DSM-IV criteria make meaningful distinctions between full and subthreshold eating disorders has been questioned, and it has been suggested that the diagnostic criteria should be broadened. Individuals with binge-eating problems often do not meet the frequency criterion of two binge days per week. There is evidence that subthreshold BED subjects do not differ significantly from subjects meeting full criteria. They frequently evidence the same risk for psychiatric distress, low self-esteem, impaired social adjustment, and overconcern with shape and weight (Crow et al., 2002; Striegel-Moore et al., 1998, 2000a; Wilson et al., 1993). This finding raises questions about the utility of the frequency requirement, which was arbitrarily chosen to match the BN frequency criterion. In addition, it has been suggested that individuals with BED who interpret the consumption of an objectively small amount of food as a "binge" could be considered more disturbed psychologically than those who use the term only for true "gorging" episodes (Beumont et al., 1994). Overall, there is no sharp demarcation between the full syndrome and the subthreshold groups, and consequently some recent treatment studies have included subthreshold cases.

Distress regarding binge eating is required for the diagnosis of BED. This "distress" includes unpleasant feelings during and after the binge-eating episode, as well as concerns about the long-term effect of the recurrent episodes on body weight and shape and self-esteem. The inclusion of this item in the diagnostic criteria was meant to minimize false positives. In Spitzer and colleagues' (1992) multisite field trial, removal of this item would have markedly increased the number of subjects meeting criteria for BED (by 10%, from 30.1 to 33.8%, in a weight control sample, and by more than 50%, from 2 to 4.6%, in a community sample). However, it is not entirely clear how to measure "marked distress"—a problem shared by the use of this criterion in many disorders in DSM-IV. Does it only require the patient's self-report about her or his emotional state, or does it require some impairment of the patient's functioning in social situations or at work due to binge eating? Also, it seems possible that this criterion identifies individuals with high levels of distress, in general. On the other hand, there are patients who meet all the other criteria for BED but simply deny distress.

Another area of concern is the risk of definitional overlap across related categories. The most problematic boundary is the one between BED and nonpurging BN. In both diagnostic

categories there are recurrent binge-eating episodes in the absence of regular vomiting, laxative, or diuretic misuse. Nonpurging BN is diagnosed by the use of nonpurging compensatory behaviors such as "fasting," defined as not eating anything for 24 hours (which replaced the term "strict dieting" used in DSM-III-R; Spitzer et al., 1993a) or excessive exercising, which is difficult to define. Hay and Fairburn (1998) compared individuals with purging BN, nonpurging BN, and BED cross-sectionally and over the course of 1 year. They could not differentiate nonpurging BN and BED on present state features such as binge-eating frequency or eating-related and general psychopathology, but individuals with purging type BN had the most severe symptoms. Those with BED showed less temporal stability compared to those with nonpurging BN, and they had a more benign 1-year outcome. Purging and nonpurging BN were similar in temporal stability. The authors concluded that this difference in predictive validity justified the diagnostic distinction between nonpurging BN and BED. In addition, they suggested that bulimic eating disorders might exist on a continuum of clinical severity, from BN purging type (most severe), through BN nonpurging type (intermediate severity), to BED (least severe).

Psychosocial Risk Factors

Only retrospective risk studies of BED, conducted in community samples, are available. Fairburn and colleagues (1998) compared putative risk factors preceding the onset of BED in 52 women with BED, 104 without an eating disorder, 102 with BN, and 102 with other psychiatric disorders. Compared to women without eating disorders or other psychiatric disorders, women with BED revealed greater exposure to certain adverse childhood experiences, such as sexual or physical abuse and bullying and family problems (e.g., parental psychiatric disorder, parental criticism, lack of affection, underinvolvement, overprotection). Also, negative self-evaluation and shyness appear to increase the risk for BED, and exposure to risk factors for obesity (e.g., childhood obesity, critical comments by family about shape, weight, or eating) appears to be associated with BED. However, compared with BN, the risk factors for BED are weaker. Even vulnerability to obesity seems to be more pronounced in BN.

Striegel-Moore and colleagues (2002) reported that a history of sexual abuse was associated with BED in a community sample of black and white women obtained from the New England Women's Health Project. Interestingly, a history of sexual abuse was significantly more common in black women (66%) compared to white women (23.8%) with BED.

Alternative Diagnostic Classifications

The DSM-IV as well as the ICD-10 use categorical approaches to describe psychopathology, and the diagnostic criteria were derived through expert consensus. Revisions of these classification systems have changed the diagnostic criteria for eating disorders several times over the past 20 years. Given the continued debate about the diagnostic validity of BED (Cooper & Fairburn, 2003; Devlin et al., 2003; Wilfley et al., 2003; Wonderlich et al., 2003), researchers have tried to assess the optimal set of diagnostic criteria for it and to further examine its predictive and construct validity. Several studies have attempted to regroup the individual symptoms of eating disorders using sophisticated statistical models and have found subgroups of eating

disorders with different symptom profiles that usually resemble the current classifications (Bulik et al., 2000; Hay et al., 1996; Keel et al., 2004; Stice & Agras, 1999; Williamson et al., 2002). However, dimensional models of eating disorders have been proposed (Hay & Fairburn, 1998; Stice & Agras, 1999; Tylka & Subich, 1999). Thus far, neither categorical nor dimensional models of eating disorders have been shown to adequately represent the full spectrum of disturbed eating behaviors (Williamson et al., 2005).

New statistical approaches also have been used, such as taxometric analyses, to determine if a diagnostic entity is best represented as a discrete category or dimensional construct occurring on a continuum with normal behavior. A recent taxometric analysis by Williamson and colleagues (2002) provided evidence that BED is qualitatively distinct from both normal-weight comparison subjects and obese non-binge-eating subjects. A second taxometric study by Joiner and colleagues also provided support for the distinction of BED (Joiner, 1999). In a recent review of diagnostic studies on eating disorders, Williamson and colleagues (2005) endorsed the validity of BED based on the limited but consistent finding of BED as a true taxonic entity.

Dysfunctional attitudes regarding eating, weight, and shape have consistently been shown to be significantly more pronounced in individuals with BED, compared to obese non-binge-eating individuals, and to show comparable values to individuals with BN. Masheb and Grilo (2000a) therefore have suggested incorporating these cognitive diagnostic criteria into the set of diagnostic criteria for BED.

Several authors have attempted to identify meaningful subtypes of BED (Grilo et al., 2001; Peterson et al., 1998a, 2005; Stice et al., 2001). These include subtypes by mood and substance use disorders, subtypes of dietary restraint versus dietary restraint combined with negative affect, and subtypes with and without a history of purging behavior. For example, Stice and colleagues (2001) reported that a subtype of BED characterized by high negative affect was marked by significantly greater concerns regarding weight and shape as well as significantly higher levels of associated psychiatric disturbance and social maladjustment. In addition, the high-negative-affect subgroup did not respond as well to treatment. Likewise, Peterson and colleagues (2005) reported that individuals with BED and a history of affective or substance use disorder may have a more severe form of the disorder. Similar results were observed by Grilo and colleagues (2001). Subtypes concerning the temporal sequence of onset of binge eating versus dieting are described in the next chapter.

A major criticism of BED as a clinically significant disorder has been the lack of treatment specificity. BED seems to respond to a variety of procedurally and conceptually different treatments, including weight loss treatment, which appears to be equally effective in reducing binge eating (Wilfley et al., 2003). Moreover, the phenomenon of binge eating has been reported to be unstable over time (Fairburn et al., 2000). Therefore, Stunkard and Allison (2003) have argued that the construct BED should be viewed as a marker of psychopathology in obese individuals rather than a distinct disorder.

In an interview study with 888 first-degree relatives of overweight and obese individuals with and without BED, Hudson and colleagues (2006) demonstrated that BED aggregates in families independently of obesity. A lifetime diagnosis of BED was found in 20.2% of the relatives of probands with BED and 9.6% of the relatives of probands without BED. This finding suggests that BED is caused, in part, by familial factors distinct from any additional familial factors for obesity. The result of this study somewhat contradicts the view of Stunkard and

Allison (2003) and supports the assumption that BED represents an etiologically distinct behavioral phenotype of obesity and not just a nonspecific eating pattern seen in some obese individuals.

Devlin and colleagues (2003) proposed various models to conceptualize binge eating and discussed the pros and cons of BED as a distinct eating disorder, as a variant of BN, as a behavioral subtype of obesity, and finally as an associated feature that emerges when two primary disorders (e.g., obesity and depression) coexist. The authors concluded that none of the models can be ruled out entirely.

In summary, studies have explored alternative diagnostic items, syndromal threshold, and durations of BED. Other studies have attempted to create meaningful clinical subtypes of BED, and some have questioned the current diagnostic classification systems and suggested new categorical and dimensional classification systems of eating disorders.

Epidemiology

A few prevalence studies have relied on two-stage interview methods, and there are no studies examining the incidence—that is, new cases per year—of BED in representative community samples (Striegel-Moore & Franko, 2003). BED appears to be quite common among subjects attending hospital-affiliated weight loss programs, including weight loss surgery, with an overall frequency of DSM-IV criteria of approximately 30% (de Zwaan et al., 2003b; Grissett & Fitzgibbon, 1996; Kuehnel & Wadden, 1994; Spitzer et al., 1992, 1993b; Yanovski et al., 1994), ranging from 7.5 to 47.4% (Ho et al., 1995). However, estimates based on interviews rather than self-reports are considerably lower, varying between 9% (Stunkard et al., 1996b) and 19% (Brody et al., 1994). BED is more common than BN and anorexia nervosa (AN) in the general population, with approximately a 2% prevalence (Basdevant et al., 1995; Cortufo et al., 1997; Favaro et al., 2003; French et al., 1999; Hay, 1998; Kinzl et al., 1999; Smith et al., 1998; Spitzer et al., 1992, 1993b; Striegel-Moore et al., 2003; Wade et al., 2006; Westenhöfer, 2001). In Spitzer and colleagues' (1992) first multisite study, interestingly, only half of the community sample with BED was obese (BMI > 27.5 kg/m^2); however, Smith and colleagues (1998) reported that the prevalence of BED among overweight participants in a population-based study was almost double (2.9%) that of the overall cohort (1.5%).

Age, Weight, Gender, and Ethnicity

With few exceptions (Bruce & Agras, 1992) most studies have found that obese subjects with BED seem to be significantly younger than non-binge-eating obese subjects, especially among obese patients presenting for treatment (e.g., de Zwaan et al., 1992). Compared to purging bulimics, however, obese binge eaters appear to be significantly older.

BED is associated with overweight and obesity, as evidenced by findings from clinic, community, and population-based studies (Wilfley et al., 2003).

Data indicate that BED is as common among black women as it is among white women—a relationship that appears to hold both within the community (Bruce & Agras, 1992; Striegel-Moore et al., 2000b; Striegel-Moore & Franko, 2003) and among those presenting for treat-

ment (Yanovski et al., 1993, 1994). However, in a two-stage case-finding method, Striegel-Moore and colleagues (2003) found a significantly higher prevalence rate in white women (2.7%) compared to black women (1.4%) participating in the National Heart, Lung and Blood Institute Growth and Health Study. Nevertheless, relatively speaking, more women of minority race appear to meet criteria for BED than for BN. Race seems to play a role as well in the clinical presentation of BED. A study in a community sample of black and white women with BED found significant differences between the two groups. Black women with BED were heavier and reported more frequent binge eating; however, they reported less concern about body weight, shape, and eating and were less likely to have a history of BN than white women with BED (Pike et al., 2001). These results are consistent with survey studies that have shown that black women report less body image disturbance and are less likely to diet than white women (Smolak & Striegel-Moore, 2001). Cultural differences in the acceptance of larger body sizes might account for the lower level of disturbance in black women. Hispanic women appear to have comparable rates of binge eating to white women (Fitzgibbon et al., 1998); however, the prevalence of BED in Hispanic individuals is not known.

Available estimates are that women are roughly 1.5 times more likely to have BED than men (Spitzer et al., 1992, 1993b; Wilson et al., 1993). Thus, the gender imbalance concerning the prevalence of BED is less pronounced than in other eating disorders. Few studies have focused on gender differences in patients with BED (Barry et al., 2002; Lewinsohn et al., 2002; Striegel-Moore et al., 1998; Tanofsky et al., 1997). Men who experience problems with recurrent binge eating do not differ from female binge eaters on a wide range of indices of body image concerns, dieting behavior, and associated psychological distress. However, studies have found a significantly higher rate of substance abuse problems in men. There is also evidence that women struggle with more body image dissatisfaction and drive for thinness and are more likely to eat in response to negative emotions than men, whereas men are less likely to report distress over binge eating.

Binge Eating in Children and Adolescents

Decaluwe and colleagues (2002) administered the questionnaire version of the EDE (EDE-Q; Fairburn & Beglin, 1994) to 126 children and adolescents, ages 10–16 years old, who sought residential treatment for obesity. Binge-eating episodes were reported by 36.5% of the sample, with 6% reporting two or more episodes per week. Similar rates of binge-eating episodes were observed in boys and girls. As in adults, binge eaters reported more eating concerns, weight and shape concerns, and lower self-esteem. Applying the EDE interview, the same authors (Decaluwe & Breat, 2003) found a prevalence of BED of only 1% in a sample of 196 children and adolescents, ages 10–16 years, seeking weight loss treatment. Nine per cent were found to have objective bulimic episodes but did not endorse all of the DSM-IV criteria. The age of the first objective binge-eating episode was 10.8 years, and excessive weight gain appeared to precede binge eating. In a sample of 102 severely obese adolescents, ages 12–17 years, who were seeking treatment for their obesity, Isnard and colleagues (2003) assessed binge-eating symptoms using the Binge Eating Scale (BES; Gormally et al., 1982). They found three adolescent boys with severe binge-eating symptoms ($\geq$ 26), and 16 (17%) adolescents (10 girls, 6 boys) with moderate to severe binge-eating symptoms ($\geq$ 18).

Binge eaters were more depressed, more anxious, and had significantly lower self-esteem than non-binge eaters.

Lamerz and colleagues (2005) reported the results of 1,979 children, ages 5–6 years, who attended an obligatory health exam prior to school entry in Germany. The parents were asked to fill out questionnaires on their child's eating habits and weight development. The parents reported binge-eating episodes in 2% of their children, and there was a significant relationship between binge eating and obesity. In addition, binge eating in the children was strongly associated with eating disturbances in their mothers. In a school-based sample of adolescents, Ackard and colleagues (2003) found that 3.1% of the girls and 0.9% of the boys fulfilled DSM-IV criteria for BED. The available data suggest that clinically meaningful binge eating does occur in community samples and obese samples of children and adolescents. Dieting behavior may not be prominent in early-onset BED.

In order to adequately assess binge eating in children and adolescents, the interview and questionnaire versions of the EDE have been modified with simpler wording (ChEDE, ChEDE-Q; Bryant-Waugh et al., 1996).

It is unclear whether children have a full understanding of their eating behavior. In addition, children's access to food is usually more regulated by their parents. Many authors suggest that it may be appropriate to utilize broader and more flexible criteria that include developmentally appropriate aspects to screen children for eating disorders (Bryant-Waugh & Lask, 1995; Delacuwe et al., 2002; Marcus & Kalarchian, 2003; Nicholls et al., 2000). Eating disorders often present differently in children than they do in adults. Accordingly, modified criteria for BED in children and adolescents younger than 14 years of age have been proposed (Table 1.3; Marcus & Kalarchian, 2003). In children, eating in the absence of hunger, eating to modulate strong or negative affect, eating in secret, or hiding food may be correlates of binge eating. In addition, a shorter duration requirement (e.g., 3 months) might be more appropriate for children.

TABLE 1.3. Proposed BED Research Criteria for Children and Adolescents Younger Than 14 Years

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  (1) food seeking in the absence of hunger (e.g., after a full meal)
  (2) a sense of lack of control over eating (e.g., endorses "When I start to eat, I just can't stop")

B. The binge-eating episodes are associated with one or more of the following:
  (1) food seeking in response to negative affect (e.g., sadness, boredom, restlessness)
  (2) food seeking as a reward
  (3) sneaking or hiding food

C. Symptoms persist over a period of 3 months.

D. Eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

Note. From Marcus and Kalarchian (2003). Copyright 2003 by Wiley Periodicals, Inc., A Wiley Company. Adapted by permission.

Summary

There is some evidence for the validity of BED as a diagnostic entity. Nevertheless, the current diagnostic criteria of BED, as they are outlined in the appendix of the DSM-IV, are still tentative, and alternative diagnostic classifications have been proposed. Studies evaluating new conceptualizations of BED are warranted. There is still much debate as to whether or not it is justified to give BED the status of a distinct diagnostic entity, and it is still unknown if the diagnosis will be included in DSM-V. Modified criteria for children and young adolescents have been proposed and should be evaluated, because binge eating usually begins at a young age and appears to be a prevalent problem even in children ages 5–6. The prevalence of BED in the general population is much higher compared to the prevalence of AN and BN, and the gender differences appear to be small. BED is a frequent phenomenon in treatment-seeking obese populations and needs to get proper attention from the health care professionals working with obese individuals. There is evidence that ethnically different groups are affected; however, most studies have been conducted with white females, and further studies will need to include male and ethnic minority groups. Finally, our knowledge about the psychosocial risk factors of BED is limited, and only prospective studies will help us gain more insight into these factors associated with the development of BED.

Program Overview
and What Is Binge-Eating Disorder?

Session Content

Program overview
Making a commitment to change
What is binge-eating disorder?: Psychoeducation on binge-eating disorder
What to expect as you change your eating behavior
Assign homework for session 2

> Complete Eating Behaviors Self-Monitoring Worksheet daily (Form 1.2).
> Complete Reasons for and against Changing Unhealthy Eating Habits worksheet (Form 1.3).
> Complete Alternatives to Binge-Eating Worksheet (Form 1.4).
> Read Session 2 Lecture Handout (Form 2.1).

Materials Needed for This Session

Form 1.1.   Session 1 Lecture Handout
Form 1.2.   Eating Behaviors Self-Monitoring Worksheet
Form 1.3.   Reasons for and against Changing Unhealthy Eating Habits worksheet
Form 1.4.   Alternatives to Binge-Eating Worksheet
Form 2.1.   Session 2 Lecture Handout

About Session 1

This session provides both an overview of the program, detailing the material to be covered, and psychoeducational information about binge-eating disorder. In this session, as in all sessions, an effort should be made to personalize the material whenever possible and, in particular, to ask patients to illustrate or give examples of points that are made in the reading materials.

The material covered in the section "What to Expect as You Change Your Eating Behavior" is particularly important. Many patients find that when they are struggling with trying to eliminate binge eating that they experience uncomfortable affects that have been suppressed by the binge eating. Their emotional lability may worsen somewhat before they are able to gain

ongoing control of their eating behavior. Anticipating this fluctuation can be quite helpful for patients.

Homework

Three forms are assigned as homework for session 2. The first is Form 1.2, Eating Behaviors Self-Monitoring Worksheet. Patients complete this worksheet regularly throughout treatment. An example of how to fill out this form is shown in the upper-right-hand corner. Patients are asked to indicate meals or snacks with a box, to indicate binge-eating episodes with a line, and to make the length of the line reflect the duration of the binge-eating episode. They are also asked to start identifying cues, and it is useful to illustrate for them what sorts of cues many people frequently report. Examples on the sheet include anger and boredom—the latter being probably the single most common reason for binge eating cited by patients. It is important for patients to start to identify the precipitants or cues for their individual binge-eating episodes. It is also useful for patients to check whether or not they are menstruating because sometimes menstruation precipitates an exacerbation of binge-eating behavior, and also to indicate days in which they are successful in avoiding binge eating. In subsequent sessions, when this form is reviewed it is important to examine not only binge-eating behavior but also the pattern of meals and snacks. For example, if the patient indicates an eating episode at 8:00 A.M., which represents breakfast, it is important to talk about what constitutes breakfast. Many of these patients tend not to eat breakfast or to eat a very small breakfast and a very small lunch, anticipating that they will overeat later in the day. This pattern increases the likelihood that they will actually binge eat.

As with other homework assignments, patients are initially somewhat reticent to complete this form. Much emphasis needs to be placed on the importance of this form, and if necessary, time should be devoted during the session for its completion.

Patients are also asked to fill out Form 1.3, Reasons for and against Changing Unhealthy Eating Habits. Examples of the sort of items that subjects might insert are shown below.

Sample of Form 1.3

REASONS FOR AND AGAINST CHANGING
UNHEALTHY EATING HABITS WORKSHEET

In the left-hand column, list your reasons *for* stopping your unhealthy eating habits. In the right-hand column, list your reasons *against* stopping your unhealthy eating habits.

Reasons for Stopping   Reasons against Stopping

Feel in control   *Food comforts me*

Save money   *Will get angry*

Less depressed   *Hard to quit*

Patients are also asked to fill out Form 1.4, Alternatives to Binge-Eating Worksheet. A number of possible alternatives are already listed on the form, with blanks provided for patient additions.