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Binge Eating Disorder: Causes, effects and counselling intervention

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Abstract
This article explored binge eating disorder. Binge eating is an addictive behaviour. An addictive behaviour is any particular behaviour that has become the major focus of a person's life to the exclusion of other activities. Binge eating is disordered eating which consists of episodes of uncontrollable eating. This paper discusses addictive behaviour, binge eating, causes, symptoms, effects, general management and counselling therapies for the management of the disorder. The causes of this disorder among other things include the following factors: genetic, changes in brain, body size, body image and emotional trauma while some of the symptoms are: eating much faster than normal, eating until feeling uncomfortably full and eating a large amount of food when not hungry. Also, the effects of binge eating include obesity, emotional problems, poor self-image, feelings of shame and guilt. This article in particular highlighted some counselling therapies that seem effective in the management of binge eating disorder. Such counselling therapies include cognitive behavioural therapy (CBT), Interpersonal psychotherapy (IP) and Dialectical behavioural therapy (DBT). The article makes some recommendations which include that parents should monitor their children for signs of binge eating disorder and make prompts referral to specialists where binge eating disorder is suspected.
Keywords: addictive, behaviour, binge, eating, causes, symptoms, management.

Introduction

Binge eating is one of the addictive behaviours that are in existence. Addictive behaviour is a behaviour that is both rewarding and reinforcing. Any behaviour that is repeated in spite of its consequences is referred to as an addiction. This means that the particular behaviour has become the major focus of the person's life to the exclusion of other activities, or that the behaviour has begun to harm the individual or others physically, mentally or socially. Therefore, addiction is a brain disorder characterized by compulsive engagement in rewarding stimuli despite their adverse consequences (Nolen-Hoeksema, 2013). Most definitions refer to addiction as the compulsive need to use a habit-forming substance, or an irresistible urge to engage in a particular behaviour despite the effects of the behaviour on the person (Forman, 2016).

Binge Eating Disorder (BED) is a very serious illness that can have a significant negative impact on those who have it. It is the most common type of eating disorder among people worldwide, though it remains under-recognized. Binge eating refers to a pattern of disordered eating which consists of episodes of uncontrollable eating (Mitchell, Devlin, De Zwaan, Peterson & Crow, 2007; Forman, 2016). During such binges, a person rapidly consumes an excessive quantity of food. A diagnosis of binge eating is associated with feelings of loss of control. Binge Eating Disorder (BED) is characterized by repeated episodes of uncontrolled binge eating and feelings of extreme shame and distress. A binge eating episode is characterized by eating larger than normal amount of food in a relatively short period of time. This behaviour is accompanied by feelings of distress and lack of control.

The prevalence of BED in the general population is approximately 1-3% and it is the most common eating disorder in adults (Marazziti, Corsi, Baroni, Consoli & Catena-Dell'Osso, 2012). Researchers have indicated that binge eating is more in females than males. The lifetime prevalence of binge eating disorder has been observed in studies to be 2.0 percent for men and 3.5 percent for women, higher than that of the commonly recognized eating disorders: anorexia nervosa and bulimia nervosa (Mazzeo, 2009; Forman, 2016). Rates of binge eating disorder have also been found to be similar among black women, white women, and white men while some studies have shown that binge eating disorder is more common among black women than among white women (Mazzeo, 2009).

Causes of Binge Eating Disorder

The causes of BED are likely due to a variety of risk factors which include the following:

Genetics: People with BED may have increased sensitivity to dopamine, which is responsible for feelings of reward and pleasure. There is also strong evidence that the disorder is inherited (Mazzo, 2009; Forman, 2016).

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Changes in the brain: There are indications that people with BED may have changes in brain structure that result in heightened responses to food and less self-control (Wilson, 2012).
Body size: Almost 50% of people with BED are obese, and 25–50% of patients seeking weight loss surgery meet the criteria for BED. Weight problems may be both a cause and consequence of the disorder (Forman, 2016).
Body image: People with BED have a very negative body image. Body dissatisfaction, dieting and overeating contribute to the development of the disorder (Nolen-Hoeksema, 2013).
Emotional trauma: Stressful life events, such as abuse, death, separation from a family member or a car accident, have been found to be risk factors. Childhood bullying due to weight may also contribute (Klerman, Weissman, Rounsaville & Chevron, 1984).
Other psychological conditions: Almost 80% of people with BED have at least one other psychological disorder, such as phobias, depression, post-traumatic stress disorder (PTSD), bipolar disorder, anxiety or substance abuse. Also an episode of binge eating can be triggered by stress, dieting, negative feelings relating to body weight or body shape, the availability of food or boredom (Marazziti, Corsi, Baroni, Consoli & Catena-Dell'Osso, 2012; Merck Manual Professional Version, 2014).

Signs and symptoms of binge eating

According to Nolen-Hoeksema (2013) and Mazzeo (2009), the signs and symptoms of binge eating are as follows:

- ❖ Eating much faster than normal perhaps in a short space of time
- ❖ Eating until feeling uncomfortably full
- ❖ Eating a large amount of food when not hungry
- ❖ Subjective loss of control over how much or what is eaten
- ❖ Binges may be planned in advance involving the purchase of special binge foods and the allocation of specific time for binging, sometimes at night
- ❖ Eating alone or secretly due to embarrassment over the amount of food consumed
- ❖ There may be a dazed mental state during the binge
- ❖ Not being able to remember what was eaten after the binge
- ❖ Feelings of guilt, shame or disgust following a food binge
- ❖ Eating normally in the presence of others but gorging when isolated
- ❖ Experiencing feelings of stress or anxiety that can only be relieved by eating
- ❖ Feelings of numbness or lack of sensation while bingeing
- ❖ Never experiencing satiation; that is not being satisfied, no matter the amount of food consumed.

In contrast to bulimia nervosa, binge eating episodes are not regularly followed by activities intended to prevent weight gain such as self-induced vomiting, laxative or enema misuse, or strenuous exercise. BED is characterized more by over-eating than dietary restriction and over concern about body shape. Obesity is common in persons with BED as are depressive features such as low self-esteem, stress and boredom (Merck Manual Professional Version, 2014).

Effects and consequences of binge eating

Binge eating disorder involves uncontrollable over-eating that can lead to weight gain and other physical and emotional issues. People with binge eating disorder experience the following effects (Wilson, 2012; Nolen-Hoeksema, 2013):

1. **Obesity**: Eating large amounts of food can definitely lead to weight gain, and obesity is a serious health problem. Most binge eaters are often overweight or obese but some are not, because of their body make up. Binge eaters who are obese are at risk for all of the health problems related to obesity, including Type II diabetes, sleep apnoea, high blood pressure, high cholesterol, heart disease, gallbladder disease, and joint and muscle pain (Nolen-Hoeksema, 2013). During a binge eating episode, a person quickly eats abnormally large amount of food. Although binge eaters may feel uncomfortably full after an episode, they do not try to compensate for this large intake of calories; unlike people with bulimia who try to control weight gain through vomiting, laxatives, or other methods. However, women who binge eat and are obese have additional risks, such as irregular periods and infertility. Women are also at greater risk of problems during pregnancy, such as high blood sugar and increased risk of having a caesarean delivery.
2. **Emotional Problems:** Not all health risks associated with binge eating disorder are linked to obesity; many of the risks are related to mental health and emotional problems (Wilson, 2012). Binge eating disorder is commonly associated with depression, which can be both a risk factor for the eating disorder and a consequence of it.
3. **Poor self-image, feelings of shame and guilt:** People who binge eat often struggle with poor self-image as well as feelings of shame and guilt about their behaviour. Although they are in a great deal of distress, people with binge eating disorder typically keep their problem a secret. They eat in closet and often wait until they are alone to eat. They also hide the evidence of eating from other people (Diagnostic and Statistical Manual of Mental Disorders DSM-5 9, 2013).

These feelings can become so severe that binge eating interferes with relationships, sleep and overall quality of life. It has been found that suicide attempts were more common in women with all types of eating disorders, including binge eating disorder (Smink, Van Hoeken & Hoek, 2013).

Management of binge eating disorder

To protect the binge eaters' health and reduce their emotional and physical complications, the following steps can be helpful to them, as suggested by Nolen-Hoeksema (2013): understanding and accepting self, ease anxiety, exercise, help him to make healthier food choices and keeping a food diary.

The first step counsellors may use in managing binge eater is to help him understand and accept that his symptoms indicate an actual disorder that should be treated. Then, the underlying issues that trigger episodes of binge eating can be identified and addressed. It is also important to help him form a healthier relationship with food and become more comfortable and confident with himself in general.

Another one is the use of relaxation techniques. Relaxation techniques like deep-breathing exercises can help ease stress related to depression (Klerman, Weissman, Rounsaville & Chevron, 1984). If a client has anxiety or symptoms of depression due to binge eating disorder, he should be advised to be practising breathing exercise, listening to music, and other relaxation therapies that help in eliminating anxiety.

Making use of exercise can equally help the person. The binge person can be advised to engage himself in regular physical activity that can help him maintain a healthy weight, reduce the risk of certain health conditions, like diabetes and heart disease, and which can also help relieve stress and symptoms of depression.

The person can be referred to a dietician to learn about good nutrition and healthier food choices. A dietician can help him realize how his eating patterns can be harmful and thereby helping him create a healthier food plan. Tracking what one eats and when he eats it can help him recognize how his feelings affect his eating patterns. He can be helped to create a food diary to determine what triggers him to binge eat (Merck Manual Professional Version, 2014).

However, binge eating can also be treated. Seeking professional support and treatment from health professionals specializing in the treatment of binge eating disorder can be helpful too. Such professionals include psychiatrists, nutritionists and counsellors. Such a treatment programme will help to address the underlying issues associated with destructive eating habits, focusing on the central cause of the problem. It is necessary to concentrate on healing from the emotional triggers that may be causing binge eating, having proper guidance in establishing healthier coping mechanisms to deal with stress, depression, anxiety and so on (Wilson, Wilfley, Agras & Bryson, 2010). Different types of therapies that can be especially helpful in the treatment of binge eating disorder include the following: Cognitive behavioural therapy (CBT),

Interpersonal Psychotherapy, Dialectical behaviour therapy (DBT), medication and surgery.

According to Marazziti, Corsi, Baroni, Consoli and Catena-Dell'Osso (2012), medication is a therapy that seems useful in treating binge eating disorder. Lisdexamfetamine is a USFDA-approved drug that is used for the treatment of moderate to severe binge eating disorder in adults. Three other classes of medications are also used in the treatment of binge eating disorder: antidepressants, anticonvulsants, and anti-obesity medications. Antidepressant medications of the selective serotonin reuptake inhibitor (SSRI) class such as fluoxetine, fluvoxamine, or sertraline have been found to effectively reduce episodes of binge eating and reduce weight. Similarly, anticonvulsant medications such as topiramate and zonisamide may be able to effectively suppress appetite. These should however be used only on a prescription by a medical practitioner. The long-term effectiveness of medication for binge eating disorder is currently unknown (Merck Manual Professional Version, 2014).

Trials of antidepressants, anticonvulsants, and anti-obesity medications suggest that these medications are superior to placebo in reducing binge eating. Medications are not considered the treatment of choice because psychotherapeutic approaches, such as CBT, are more effective than medications for binge eating disorder. Medications also do not increase the effectiveness of psychotherapy, though some patients may benefit from anticonvulsant and anti-obesity medications, such as Phentermine/topiramate, for weight loss (Marazziti, Corsi, Baroni, Consoli & Catena-Dell'Osso, 2012; National Alliance on Mental Illness, 2017).

Surgery can also be used in treating binge eating disorder. Bariatric surgery has also been proposed as another approach to treat BED and a recent meta-analysis showed that approximately two-thirds of individuals who seek this type of surgery for weight loss purposes have BED. Bariatric surgery recipients who had BED prior to receiving the surgery tend to have poorer weight-loss outcomes and are more likely to continue to exhibit eating behaviours characteristic of BED (Wilfley, Mackenzie, Welch, Ayres & Weissman, 2000).

Counselling interventions for binge eating disorder

The following are the counselling therapies for managing binge eating disorder: Cognitive behavioural therapy (CBT), Interpersonal Psychotherapy, Dialectical behaviour therapy (DBT).

Cognitive behavioural therapy (CBT)
CBT is a type of therapy which aimed at helping individuals to understand the thoughts and feelings that influence their behaviours. It is a talking therapy that aims to help one deal positively with the underlying thoughts and feelings that cause the illness by breaking problems down into smaller parts. It shows one how to change negative patterns to improve the way he feels (Wilson, Wilfrey, Agras & Bryson, 2010).

Cognitive behavioural therapy (CBT) treatment has been demonstrated as a more effective form of treatment for BED than behavioural weight loss programmes. Fifty percent of BED individuals achieve complete remission from binge eating. CBT has also been shown to be an effective method to address self-image issues and psychiatric co-morbidities (e.g., depression) associated with the disorder. Recent reviews have concluded that psychological interventions such as psychotherapy and behavioural interventions are more effective than pharmacological interventions for the treatment of binge eating disorder (Wilson, 2012).

CBT is a structured treatment. In its most common form, it consists of 20 sessions. Goals are set, sessions are spent weighing the patient, reviewing homework, reviewing the case formulation, teaching skills, and problem-solving.

Mitchell, Devlin, De Zwaan, Peterson and Crow (2007) and National Alliance on Mental Illness (2017) adduce that CBT typically includes the following components:

- Psycho education to understand what maintains the eating disorder and the psychological and medical consequences.
- Replacement of dieting with normal eating typically three meals plus two to three snacks per day. The patient can decide what to eat as long as it resembles a meal or snack.
- Meal planning: The patient should plan meals ahead of time and always know “what and when” his or her next meal will be.
- Completion of food records immediately after eating and noting thoughts and feelings as well as behaviours.
- Regular weighing (usually once per week) in order to track progress and run experiments.
- Development of strategies to prevent binges and compensatory behaviours, such as the use of delays and alternatives and problem-solving strategies.
- Challenge of dietary rules. This involves identifying rules and challenging them behaviourally (such as eating after 8 p.m. or eating a sandwich for lunch).
- Development of continuum thinking to replace all-or-nothing thinking.
- The use of behavioural experiments. For example, if a client believes that eating a cupcake will cause a five-pound weight gain, he or she would be encouraged

to consume a cupcake and see if it does. These behavioural experiments are generally much more effective than cognitive restructuring alone.

❖ Exposure to fear foods: After regular eating is well-established and compensatory behaviours are under control, patients gradually reintroduce the foods they fear.

❖ Relapse prevention to identify both strategies that have been helpful and how to deal with potential future stumbling blocks. Because the treatment is time-limited, the goal is for the Dialectical Behaviour Therapy for Eating Disorders

Interpersonal Psychotherapy (IPT)

Interpersonal Psychotherapy (IPT) for binge eating disorder is another therapy treatment and it is based on an intervention originally developed for the treatment of depression. In IPT, the focus is on interpersonal difficulties in the patient's life. The connection between these problems and the development and maintenance of the eating disorder is identified at the beginning of treatment, but only implied thereafter. IPT for binge eating disorder is administered in either group or individual format, and is conducted in approximately twenty weekly sessions, which encompass three phases.

The first phase of IPT is devoted to identifying specific interpersonal problem areas currently affecting the patient, and choosing which of these areas to focus on for the remainder of treatment (Wilfley, Mackenzie, Welch, Ayres & Weissman, 2000). The four typical interpersonal problem domains are role disputes, role transitions, interpersonal deficits, and unresolved grief. Interpersonal precipitants of current binge eating episodes are highlighted during this phase. In the second phase of IPT for binge eating disorder, the therapist encourages the patient to take the lead in facilitating change in the interpersonal realm. The therapist's role involves keeping the patient aware of the time frame of treatment and focusing on the problem areas, clarifying issues raised by the patient, and encouraging change. The third phase covers maintenance of interpersonal gains and relapse prevention.

Dialectical behaviour therapy (DBT)

Dialectical behaviour therapy (DBT) is another therapy that seems useful in treating binge eating. Dialectical behaviour therapy (DBT) is a specific type of cognitive-behavioural treatment. It was developed in the late 1970s by Marsha Linehan to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD). It is now recognized as the treatment of choice for this population. In addition, it has been proven to be effective for a range of other mental disorders including substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders (Wilson, Wilfley, Agras & Bryson, 2010).

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The word dialectical means that in DBT, therapists and clients work hard to balance change with acceptance, two seemingly opposing forces or strategies. For example, when undergoing dialectical behaviour therapy, the therapist will work with the client so that the client accepts self as he is, and is motivated to change. Wilson, Wilfley, Agras and Bryson (2010) adduce that full adherent DBT treatment requires five components which are as follows: DBT skills training, individual therapy, coaching to ensure generalization of skills, structure the environment with case management, DBT consultation team to support the therapist and support groups.

DBT skills' training usually occurs in a group format and it is being run like a class during which group leaders teach behavioural skills and assign homework to the clients. The homework helps clients practice using the skills in their everyday lives. Groups meet on a weekly basis and it takes 24 weeks to get through the full skills' curriculum and the skills training consists of the following four modules (Wilson, Wilfley, Agras & Bryson 2010):

- Mindfulness: the practice of being fully aware and present in the moment
- Distress tolerance: how to tolerate distressing feelings
- Interpersonal effectiveness: how to express one's needs and set boundaries to build healthy relationships
- Emotion regulation: how to change emotions that you want to change

Mitchell, Devlin, De Zwaan, Peterson and Crow (2007) add that DBT individual therapy focuses on increasing client's motivation and helping clients to apply the skills to challenges and events in their lives. Individual therapy usually takes place once a week for as long as the client is in therapy, and it runs simultaneously with DBT skills training.

DBT uses telephone coaching to provide in-the-moment support and also, case management strategies. The goal for the telephone use is to coach clients on how to use their DBT skills to effectively cope with difficult situations that arise in their everyday lives. Clients can call their individual therapist between sessions to receive coaching at the times when they need help while case management strategies help the client learn to manage his or her own life such as their physical and social environments (Wilson, Wilfley, Agras & Bryson, 2010).

DBT consultation team provides critical support to the different team members who provide the various aspects of the DBT treatment, including individual therapists, skills training group leaders, case managers, and others who help treat the client or patient. The team also uses support group (Mitchell, Devlin, De Zwaan, Peterson & Crow, 2007). Support group is where people with a similar problem get together. It is a warm and welcoming place where they can talk about their experiences and listen to each other's stories. In a support group, people feel safe to share their thoughts and

feelings without fear of being judged. They know that everyone in the group truly understands what they are going through. Support groups are often led by a professional or a trained volunteer. This person helps with the discussion and the organizing of group activities. Support groups are never the main form of therapy for people with eating disorders, but they can be very helpful when used with other forms of therapy.

There are support groups on the internet where the client can connect to online forums or chat rooms. These groups offer people the chance to share with one another even if they are not in the same city or country (Wilfley, Mackenzie, Welch, Ayres & Weissman, 2000).

The individual will probably be offered a guided self-help programme as a first step in treating the binge eating disorder (National Institute of Diabetes and Digestive and Kidney Diseases, 2015). This often involves working through a self-help book combined with sessions with a healthcare professional, such as a therapist. These self-help books may take one through a programme that helps him:

- ❖ monitor what he is eating – this can help him notice and try to change patterns in his behaviour
- ❖ make realistic meal plans – planning what and when one intends to eat throughout the day can help one regulate one's eating, prevent hunger and reduce binge eating
- ❖ learn about one's triggers – this can help one to recognise the signs, intervene and prevent a binge
- ❖ identify the underlying causes of the disorder – this means one can work on those issues in a healthier way
- ❖ find other ways of coping with one's feelings
- ❖ understand and learn how to manage one's weight in a healthy way.

Recommendations

The authors recommend that parents should start early to monitor their children at close range so that they can be able to act promptly when they notice the symptoms of binge eating on them by referring them to a counsellor/therapist or a physician for management or treatment.

Conclusion

From this article one understands that binge eating is a behavioural addiction that can be managed and treated. Some of the therapies include: Cognitive behavioural therapy (CBT), Interpersonal Psychotherapy for Binge Eating Disorder, Dialectical Behaviour Therapy (DBT), Support Groups, Guided help, Medication and Surgery. This paper indicates that there is hope for any person suffering from binge eating addiction. The

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needed help to any of the victims is to direct the client to the appropriate quarters where he can receive proper attention.

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