



Shorter communication

Evaluation of the DSM-5 severity indicator for binge eating disorder in a community sample

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ABSTRACT

Research has examined various aspects of the diagnostic criteria for binge-eating disorder (BED) but has yet to evaluate the *DSM-5* severity criterion. This study examined the *DSM-5* severity criterion for BED based on binge-eating frequency and tested an alternative severity specifier based on overvaluation of shape/weight. 338 community volunteers categorized with *DSM-5* BED completed a battery of self-report instruments. Participants were categorized first using *DSM-5* severity levels and second by shape/weight overvaluation and were compared on clinical variables. 264 (78.1%) participants were categorized as mild, 67 (19.8%) as moderate, 6 (1.8%) as severe, and 1 (0.3%) as extreme. Analyses comparing mild and moderate severity groups revealed no significant differences in demographic variables or BMI; the moderate severity group had greater eating-disorder psychopathology (small effect-sizes) but not depression than the mild group. Participants with overvaluation ($N = 196$; 60.1%) versus without ($N = 130$; 39.9%) did not differ significantly in age, sex, BMI, or binge-eating frequency. The overvaluation group had significantly greater eating-disorder psychopathology and depression than the non-overvaluation group. The greater eating-disorder and depression levels (medium-to-large effect-sizes) persisted after adjusting for ethnicity/race and binge-eating severity/frequency, without attenuation of effect-sizes. Findings from this non-clinical community sample provide support for overvaluation of shape/weight as a specifier for BED as it provides stronger information about severity than the *DSM-5* rating based on binge-eating. Future research should include treatment-seeking patients with BED to test the utility of *DSM-5* severity specifiers and include broader clinical validators.

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Binge-eating disorder (BED), a new formal diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; APA, 2013)*, is defined by recurrent binge eating (i.e., eating unusually large quantities of food accompanied by subjective feelings of loss of control) occurring an average of once-weekly during the past three months, the presence of at least three of five behavioral indicators signaling a loss of control over eating, marked distress about the binge eating, and the absence of extreme weight compensatory behaviors (e.g., purging) that characterize bulimia nervosa (BN). Following the inclusion of BED in Appendix B of the *DSM-IV (APA, 1994)* as a research criteria set requiring further study, research produced empirical support for the clinical utility

and validity of this diagnostic construct (Wilfley, Bishop, Wilson, & Agras, 2007; Wonderlich, Gordon, Mitchell, Crosby, & Engle, 2009) including its distinctiveness from obesity and other eating disorders (Grilo et al., 2009; Grilo, Masheb, & White, 2010).

Leading up to *DSM-5*, there were questions about whether revisions or additions to its criteria would improve the construct (Masheb & Grilo, 2000; Wilfley et al., 2007). Research examined aspects of the *DSM-IV* research criteria for BED including, for example, the frequency and duration stipulation requirements for binge-eating. Research indicated that a once-weekly frequency of binge-eating signaled a clinically relevant problem (Wilson & Sysko, 2009) and *DSM-5* adopted a once-weekly frequency of binge-eating as the new criterion for both BED and BN with a similar duration requirement of three months. Research examining the “unusually large amount” requirement for determining binge-eating received limited support (Mond, Hay, Rodgers, & Owen, 2010) and was not changed in the *DSM-5*. Other components of the

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BED diagnosis received very little empirical attention although they were supported: one study documented the diagnostic efficiency of the behavioral indicators of impaired control used to determine the loss of control aspect of binge-eating (White & Grilo, 2011), one study showed the diagnostic utility of the “marked distress” criterion requirement (Grilo & White, 2011), and one study reported improved test-retest reliability for proposed DSM-5 vs DSM-IV research criteria for BED (Sysko et al., 2012).

The DSM-5, in addition to changing the binge-eating frequency and duration requirements for BED (i.e., from a weekly average of two days with binge-eating episodes during the past six months to an average of once weekly binge-eating episodes during the past three months), made one more change which involved a new “severity specifier” based on the frequency of binge eating. The DSM-5 proposed four severity groups based on the frequency of binge eating episodes: mild (1–3 episodes/week), moderate (4–7 episodes/week), severe (8–13 episodes/week), and extreme (14 or more episodes/week). Although the literature supported the new minimum criterion of once-weekly frequency of binge eating for the diagnosis of BED (Wilson & Sysko, 2009), we are unaware of empirical research supporting the proposed severity specifier for BED.

Although other eating disorder diagnoses include a cognitive criterion pertaining to body image (e.g., in the case of BN, the presence of “undue influence of body weight or shape on self-evaluation”) a body-image criterion was not included as part of the BED diagnosis in either DSM-IV (see Masheb & Grilo, 2000) or DSM-5. Despite consistent empirical findings that the cognitive body-image construct – referred to as “overvaluation of shape/weight” (Grilo, 2013) – should serve as a diagnostic severity specifier for BED (Goldschmidt et al., 2010; Grilo et al., 2009; Grilo et al., 2008; Grilo et al., 2010; Grilo, White, Gueorguieva, Wilson, & Masheb, 2013; Grilo, White, & Masheb, 2012; Hrabosky, Masheb, White, & Grilo, 2007), the DSM-5 did not include a body-image component for BED.

Thus, research has examined various aspects of the validity of the diagnostic criteria for BED but has yet to evaluate the utility of the DSM-5 severity criterion. This study examined the DSM-5 severity criterion for BED based on the frequency of binge eating and tested an alternative severity specifier based on overvaluation of shape/weight.

Methods

Participants

Participants were 338 community volunteers drawn from a larger series of 3283 respondents to online advertisements seeking volunteers aged 18 years or older for a research study about eating and dieting. Participants were selected from the larger sample per criteria used to define our study group of persons with BED. Advertisements with a link to a web survey were placed on Craigslist internet classified ads in various US cities in order to enhance geographic generalizability. The participant group of $N = 338$ consisted of 39 (11.5%) males and 299 (88.5%) females and the racial/ethnic distribution was: 83.7% ($n = 282$) White, 5.6% ($n = 19$) Hispanic, 3.6% ($n = 12$) Black, 4.7% ($n = 16$) Asian, and 2.4% ($n = 9$) reported “other” or missing. Geographically, 22.2% ($n = 75$) of participants were from the Northeast, 30.5% ($n = 103$) from the South, 25.1% ($n = 85$) from the Midwest, 19.5% ($n = 66$) from the West, 1.5% from the Pacific, and 1.2% ($n = 4$) unknown.

Procedures and assessments

Participants provided basic demographic information, self-reported height and current weight, and completed self-report

questionnaires through SurveyMonkey, a secure online data gathering website server. Participants were required to give informed consent but provided no personal identifying information. The study was approved by the Yale IRB.

The *Questionnaire for Eating and Weight Patterns – Revised* (QEWP-R; Yanovski, 1993) assesses specific diagnostic criteria for BED and BN. This measure, used in the DSM-IV field trials for BED (Spitzer et al., 1993), has received psychometric support in diverse eating-disordered groups (Barnes, Masheb, White, & Grilo, 2011; Celio, Wilfley, Crow, Mitchell, & Walsh, 2004; Nangle, Johnson, Carr-Nangle, & Engler, 1994). The *Eating Disorder Examination Questionnaire* (EDE-Q; Fairburn & Beglin, 1994), which focuses on the past 28 days, assesses the frequency of objective bulimic episodes (OBEs; defined as feeling a loss of control while eating unusually large quantities of food; this definition corresponds to the DSM-5 criteria for binge eating episodes), inappropriate weight control and purging methods, and comprises four subscales (Dietary Restraint, Eating Concern, Shape Concern, and Weight Concern) and a global total score. The EDE-Q has demonstrated good test-retest reliability (Reas, Grilo, & Masheb, 2006), convergence with the EDE interview (Grilo, Masheb, & Wilson, 2001a, 2001b; Mond, Hay, Rodgers, & Owen, 2007), and good performance in community studies (Mond et al., 2007). The *Beck Depression Inventory* (BDI; Beck & Steer, 1987) assesses depressive symptoms and levels; it has strong psychometric support (Beck, Steer, & Garbin, 1988) and performs well as a marker for severity and distress (Grilo et al., 2001b).

Creation of binge eating disorder severity groups

The BED study group was created based on responses to the QEWP-R and EDE-Q per DSM-5 (APA, 2013) criteria. The BED study group was created first using a minimum frequency of once-weekly binge-eating (QEWP-R) without any purging (self-induced vomiting, laxative misuse, or diuretics) behaviors. The BED study group also required at least 3 of the 5 behavioral indicators for loss of control along with marked distress about binge eating.

Subgroups based on DSM-5 severity

BED severity subgroups were created using DSM-5 severity definitions based on the frequency of binge eating episodes (i.e., OBE episodes on the EDE-Q): mild (defined as 1–3 episodes/week), moderate (4–7 episodes/week), severe (8–13 episodes/week), and extreme (14 or more episodes/week).

Subgroups based on overvaluation of shape/weight

Overvaluation of shape/weight was measured using two specific items from the EDE-Q: “Over the past four weeks, has your *shape* influenced how you feel about (judge, think, evaluate) yourself as a person?” and “Over the past 4 weeks has your *weight* influenced how you feel about (judge, think, evaluate) yourself as a person?” The two overvaluation items are rated on a 7-point forced-choice scale anchored with 0 (No importance) to 6 (Supreme importance: nothing is more important in the subject’s scheme for self-evaluation) in reference to the past 28 days. Following prior studies with BED using the EDE-Q (Grilo et al., 2010), the overvaluation group included participants who reported that their shape and/or weight are high on the list of things that influence their self-evaluation (i.e., score ≥ 5 on either overvaluation item). Although the suggested clinical cutoff score is four (i.e., moderate importance) when using the EDE interview to assess overvaluation (Grilo et al., 2008), since we used the EDE-Q – which consistently yields higher scores than the EDE interview on those questions (Barnes et al., 2011; Grilo et al., 2001a, 2001b) – we used a cutoff score of five per the Grilo et al. (2010) study.

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