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Preferred descriptions for loss of control while eating and weight among patients with binge eating disorder

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ABSTRACT

Patients with binge eating disorder (BED) typically also have excess weight, making them vulnerable to stigmatizing attitudes about mental illness and obesity. Further, one of the diagnostic features of BED is experiencing a loss of control during binge eating episodes. It is possible that patients feel negatively judged when clinicians assess for loss of control as it may activate stereotypes of patients with obesity lacking willpower. We developed a questionnaire to assess preferences for common loss of control descriptions and gathered data on preferences for weight-related terms among 46 patients with BED. Analyses revealed the majority of common descriptors for loss of control eating were viewed neutrally, with *loss of control* being the most preferred term. Descriptions suggesting patients were addicted to food or did not consider stopping eating once they started binge eating were viewed negatively. The following weight descriptions were viewed negatively: *heaviness, large size, obesity, excess fat,* and *fatness*. Terms such as *BMI,* and *unhealthy body weight or BMI* were viewed more favorably and *weight* was the most preferred term. These findings provide empirical support for healthcare providers' use of terms to use and terms to avoid when talking to patients with BED about eating and weight.

1. Introduction

Part of a healthcare provider's job is to build trust and make patients feel comfortable talking about deeply personal and sensitive issues. This is particularly important for mental healthcare providers who discuss sensitive mental health topics with patients who have historically been stigmatized (Pescosolido et al., 2010; Puhl and Suh, 2015). Similar to those with mental health concerns, individuals with excess weight face stigmatization across a variety of settings (e.g., home, workplace, and healthcare and educational institutions) (Puhl and Suh, 2015; Puhl and Heuer, 2009). Such stigmatization – which can include labeling, stereotyping, status loss, separation, and discrimination (Hatzenbuehler et al., 2013) – has been linked to social isolation, stress, and negative psychological and physical outcomes, including weight gain (Hatzenbuehler et al., 2013; Pescosolido et al., 2010; Puhl and Heuer, 2009; Puhl and Suh, 2015; Udo and Grilo, 2016).

Stigmatization of people with excess weight in healthcare settings is also well-documented (Puhl and Heuer, 2009). Numerous healthcare providers across a range of fields hold negative stereotypes about patients with obesity, viewing them as lazy, lacking in self-discipline, dishonest, unintelligent, annoying, and noncompliant with treatment (Puhl and Heuer, 2009). Such feelings of stigmatization may in part explain why patients with obesity receive sub-standard healthcare, both because clinicians provide lower quality care to patients with obesity and patients with obesity report avoiding care because of their weight (Puhl and Heuer, 2009).

Although most healthcare providers do not intend to stigmatize their patients, some might unknowingly send subtle messages that may be hurtful or discouraging. To assess the possibility that some terms used to describe weight might be viewed negatively, Wadden and Didie (2003) asked 167 female and 52 male participants in an obesity treatment study to rate their perceptions of commonly-used descriptors for weight. Terms such as fatness, excess fat, obesity, large size, and heaviness were rated as very undesirable by both men and women, while terms such as weight, excess weight, and BMI, were viewed more favorably. These results were replicated in a similar study of 390 patients with obesity seen in primary care settings (Volger et al., 2012).

Abbreviations: BED, binge eating disorder; BMI, body mass index; EDE, Eating Disorder Examination; SCID, Structured Clinical Interview for DSM

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Qualitative studies have also found negative reactions to the word obesity (Ward et al., 2009; Gray et al., 2011) and a survey of 1064 US. adults found that unhealthy weight and overweight were preferred terms, while individuals viewed the terms fat, obese, and morbidly obese negatively (Puhl et al., 2013). Together, these studies provide guidance to healthcare professionals on the terms they should use and avoid when discussing weight with patients.

The stigma facing individuals with mental illness and those with excess weight raise special concerns for people with binge eating disorder (BED), the vast majority of whom also has excess weight. Because individuals with BED belong to two groups that have historically been stigmatized (i.e., individuals with excess weight and individuals with a mental health diagnosis), there is reason to think that they might have categorically different or stronger preferences about the terms healthcare providers use when discussing weight. In addition, when clinicians assess for one of the core features of BED, "a loss of control," they might make patients with BED feel particularly stigmatized or judged precisely because common negative stereotypes associated with obesity are lack of willpower and self-control. In the Diagnostic and Statistical Manual of Mental Disorders (*DSM-5*) (American Psychiatric Association, 2013), binge eating is defined as excessive food consumption in a short period of time *and* experiencing "a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)" (p. 350). Although some patients with BED readily endorse feeling "a lack of control" while eating, not all patients do. Such exchanges with patients must be navigated sensitively as clinicians attempt to ascertain important diagnostic information while trying to ensure patients do not feel negatively judged or stigmatized for "lacking control."

One way to learn whether patients with BED view descriptions of weight and loss of control while eating negatively is to ask them. The first aim of this study was to develop a questionnaire to ask patients how they feel about a series of common descriptors used to describe the feeling of loss of control during a binge eating episode. The second aim of the paper was to extend prior work on patients' preferred terms for weight (Wadden and Didie, 2003; Volger et al., 2012) to a patient group with both BED and obesity.

2. Methods

2.1. Participants

Forty-six patients with both *DSM-IV-TR*-defined (2000) BED and obesity (BMI ≥30 based on measured weight and height) received 6-months of evidence-based behavioral treatments. *DSM-IV-TR* BED criteria were used because patients participated in a treatment study that began prior to the release of *DSM-5*. BED diagnoses was established with structured interviews (the SCID-I/P (First et al., 2002) and EDE (Fairburn et al., 2008)) by trained doctoral-level research clinicians. The behavior-based treatments followed manualized protocols with demonstrated effectiveness in previous studies (Grilo et al., 2011). Patients completed a battery of assessments at their final follow-up appointment (12-months post treatment) that included a questionnaire assessing preferences for descriptions of loss of control when binge eating and descriptions of obesity. The sample had a mean age of 47.85 ± 10.80 years, and mean BMI of 35.57 ± 5.81 kg/m^2. Seventy-five percent of participants were women. Participants self-identified race and ethnicity was as follows: 71.7% non-Hispanic White, 15.2% non-Hispanic Black, 8.7% Hispanic White, 2.2% Hispanic Black, and 2.2% Asian.

2.2. Outcomes. Preferred terms for loss of control while eating questionnaire

Based on the Wadden and Didie (2003) preference questionnaire for weight-related terms, we developed a questionnaire to assess preferences for common descriptions of loss of control when eating. To develop the questionnaire, we examined descriptions used in several common eating disorder assessments, including the Eating Disorder Examination Interview (Fairburn et al., 2014), the Structured Clinical Interview for DSM, (First et al., 2002) the self-report Questionnaire for Eating and Weight Patterns-Revised, (Spitzer et al., 1993a,b) and the Binge Eating Scale (Gormally et al., 1982). To help explain what is meant by a loss of control, the Eating Disorder Examination (Fairburn et al., 2014) includes prompts such as "did you have a sense of loss of control at the time? " or "did you feel you could have stopped eating once you had started?". The Structured Clinical Interview for *DSM-5* (First et al., 2016) includes the following prompt to assess binge eating across the spectrum of feeding and eating disorders: "Do you have eating binges in which you eat a lot of food in a short period of time and feel that your eating is out of control? " The *DSM-5* further explains that "an indicator of loss of control is the inability to refrain from eating or to stop eating once started" (p. 351). The *DSM-5* diagnostic criteria for BED also requires that patients endorse at least three of five behavioral indicators of binge eating. We included two of these indicators in the questionnaire because they might reflect feelings of loss of control. These included: eating until uncomfortably full and eating large amounts of food even when not physically hungry. We also had several experienced eating disorder clinicians and researchers review the terms and provide additional suggestions. Ultimately, the questionnaire included 14 descriptions of experiencing a loss of control while eating. Participants rated their liking of each term on a scale from 1 (very undesirable) to 5 (very desirable), and these scores were re-coded from −2 to 2 for ease of interpretation. Table 1 summarizes the descriptions used. Prior to rating the terms, participants read the following introduction to the questionnaire, which was adapted from the preference questionnaire for weight-related terms:

Imagine that you are visiting your doctor for a problem you are having with binge eating. The doctor has asked you a number of questions and determined that you have binge eating disorder. Binge eating disorder is a problem where a person often eats an unusually large amount of food in a short period of time, known as a binge. These eating episodes are also characterized by different kinds of feelings. Doctors can use different terms to describe the feelings that accompany a binge. Please indicate how desirable or undesirable you would find each of the following descriptions about how you might feel during these episodes if your doctor used it.

The descriptions were then preceded by the following statement: *Good morning, I want to talk with you about your binge eating. When you are eating an unusually large amount of food in a short period of time, do you also feel….*

The end of the questionnaire contained two blank lines with the following instructions: "*Please indicate the two terms you would most want your doctor to use. Your response does not need to include any of the terms above.*" The scale in this sample had excellent internal consistency (Cronbach's alpha =0.95) and item-total correlations ranged from 0.517 to 0.869.

Weight Preferences Questionnaire. We used the same questionnaire developed by Wadden and Didie (2003). The weight description terms used appear in Table 1. Participants rated the questions from 1 to 5 and these scores were re-coded to range from −2 to 2. The scale in this sample had excellent internal consistency (Cronbach's alpha=0.921).

2.3. Statistical analyses

First, descriptive statistics were run to characterize the sample size and mean ratings for loss of control eating and weight preference terms. We then ran paired samples *t*-tests across all loss of control eating descriptions and across all weight preference terms. We also compared the number of respondents rating each term as 'very

Table 1
Loss of Control and Weight Description Desirability Ratings (n =46).

	Mean SD	% Rating very desirable	% Rating very undesirable	P value for % very desirable vs. very undesirable
Loss of control eating preference questionnaire				
1. A loss of control	0.74 (1.27)	34.8	8.7	0.002
2. You ate until you were uncomfortably full	0.59 (1.36)	19.6	8.7	0.134
3. Like you kept eating even though you were not physically hungry	0.57 (1.20)	23.9	6.5	0.020
4. Driven or compelled to keep eating even though you wanted to stop	0.41 (1.24)	19.6	4.3	0.024
5. Like you had to keep eating even though you wanted to stop	0.39 (1.20)	13.0	10.9	0.749
6. Like you were on automatic pilot, or detached from what you were doing	0.28 (1.17)	19.6	8.7	0.134
7. Helpless to control your eating	0.28 (1.17)	10.9	10.9	> 0.999
8. Like you couldn't stop eating once you started	0.26 (1.15)	17.4	8.7	0.215
9. Like you were giving in to an urge to eat	0.26 (1.22)	15.2	10.9	0.535
10.Like you were not in control of your eating	0.17 (1.16)	19.6	8.7	0.134
11.Out of control	0.02 (1.09)	10.9	13.0	0.749
12.Like you lost your willpower	0.02 (1.17)	15.2	17.4	0.779
13.Addicted to the food you were eating	−0.22 (1.20)	4.3	13.0	0.139
14.That you knew you were going to eat a large amount of food, so you didn't even consider stopping	−0.24 (1.27)	6.5	19.6	0.063
Weight preference questionnaire				
1. Weight	0.76 (1.21)	32.6	4.4	**< 0.001**
2. BMI	0.35 (1.31)	15.2	8.7	0.337
3. Unhealthy body weight	0.22 (1.18)	17.4	13.0	0.562
4. Unhealthy BMI	0.22 (1.30)	13.0	15.2	0.764
5. Excess weight	0.13 (1.10)	13.0	15.2	0.764
6. Weight problem	−0.02 (1.04)	10.9	17.4	0.368
7. Heaviness	−0.61 (1.28)	4.4	23.9	0.007
8. Large size	−0.76 (1.08)	4.4	34.8	**< 0.001**
9. Excess fat	−0.85 (1.12)	4.4	32.6	**< 0.001**
10.Obesity	−0.89 (1.13)	4.4	32.6	**< 0.001**
11.Fatness	−1.26 (1.12)	4.4	52.2	**< 0.001**

Note. Bolded values are significant at p < 0.001.

desirable' with the number rating each term as 'very undesirable' using chi square tests. Consistent with the Wadden and Didie paper, and because of the large number of tests run, we used a p-value of ≤0.001 as our threshold for statistical significance when comparing preferred terms.

3. Results

3.1. Preferred descriptors for loss of control while eating

Table 1 and Fig. 1 summarize the results for the desirability of descriptions for loss of control while eating. Of the 14 descriptions, only two were viewed as undesirable on average based on a re-coded score less than 0. The undesirable phrases were: *like you knew you were going to eat a large amount of food, so you didn't even consider stopping* and *addicted to the food you were eating*. The four most desirable descriptions were: *loss of control, ate until you were uncomfortably full, kept eating even though you were not physically hungry,* and *driven or compelled to keep eating even though you wanted to stop*..

The results of the pairwise comparisons showed that some loss-of-control descriptions were significantly more desirable than others. Compared to the most desirable description (*a loss of control*), people expressed greater dislike for describing a loss of control while eating as *knew you were going to eat a large amount of food so you didn't even consider stopping, addicted to the food you were eating, out of control, not in control of your eating, lost your willpower, and giving in to an urge to eat*. Several other significant comparisons are displayed in Fig. 1. *Ate until uncomfortably full* was also significantly more desirable than the two undesirable terms.

As shown in Table 1, we also examined the proportion of participants rating each description as either very undesirable or very desirable. Although not significant at the p≤.001 level, the results in Table 1 suggest that some descriptors were more likely to generate very desirable ratings whereas others were more likely to generate very undesirable ratings. For example, whereas four times as many patients rated *a loss of control* to be a very desirable rather than a very undesirable descriptor, three times as many patients rated *addicted to the food you were eating* to be a very undesirable rather than a very desirable descriptor.

3.2. Preferred descriptors for weight

Table 1 and Fig. 2 summarize the results for the desirability of descriptions for weight. Of the 11 descriptions, six were viewed as undesirable on average, based on a re-coded score less than 0. The undesirable phrases included *weight problem, heaviness, large size, obesity, excess fatness, and fatness*. *Fatness* was rated significantly less desirable than all other terms except *obesity*. All the other undesirable descriptions were rated significantly worse than all the desirable terms, with the exception of *weight problem,* which significantly differed only from *weight*. The three most desirable terms were *weight, BMI,* and *unhealthy body weight*. Only one favorable term, *excess weight,* was viewed significantly less favorably than *weight;* there were no other differences across favorable terms..

When examining the percentage rating each term as very desirable or very undesirable, *fatness, obesity, excess fat,* and *large size,* had significantly more very undesirable ratings. *Weight* was the only desirable term that had significantly more very desirable ratings than very undesirable. Pairwise comparisons for all terms are displayed in Table 1.

4. Discussion

The goal of this study was to assess how patients with BED and obesity view terms their healthcare providers may use when discussing

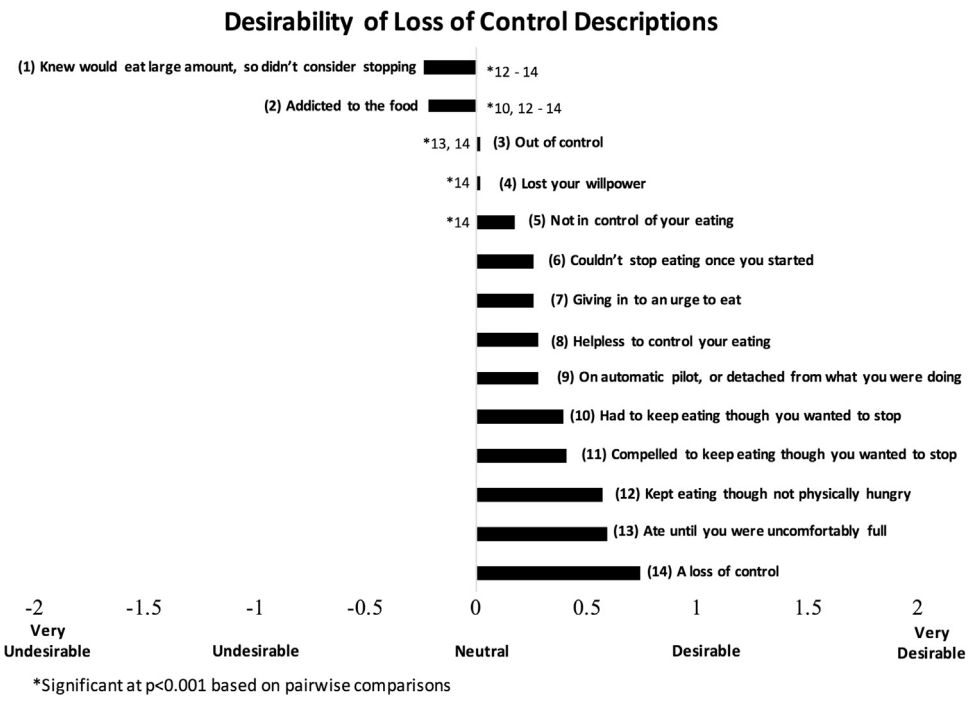

Fig. 1. Desirability of loss of control descriptions.

body weight as well as feelings of loss of control during binge eating episodes. On average, patients with obesity and BED rated the majority of descriptions for loss of control as neutral or better. Of all the descriptions, *a loss of control* was viewed most favorably, although nearly 10% of patients rated the term as very undesirable, suggesting it may be perceived as stigmatizing by some. Clinicians may find it helpful to keep this heterogeneity in mind and to consider introducing such concepts with descriptions like, "people can vary in their experiences of eating troubles. Some people feel a loss of control when eating. Is that something that you ever feel?" Nonetheless, it is encouraging that the most common descriptions of the symptom were perceived neutrally by the patients surveyed. This might simply reflect the fact that the term loss of control best captures patients' experiences of their symptoms. However, there may be subtle nuances when describing a loss of control, as the description *out of control* was rated significantly lower than *loss of control*. This suggests future research is needed to determine whether language in common assessments like the SCID, which asks patients if their eating is "out of control," should be revised. Possible alternative language is to ask whether "you feel you have a loss of control when eating." Reassuringly, other common ways to explain loss of control to patients such as *driven or compelled to keep eating even though you wanted to stop, like you had to keep eating even though you wanted to stop,* and *like you were on automatic pilot or detached from what you were doing* were viewed

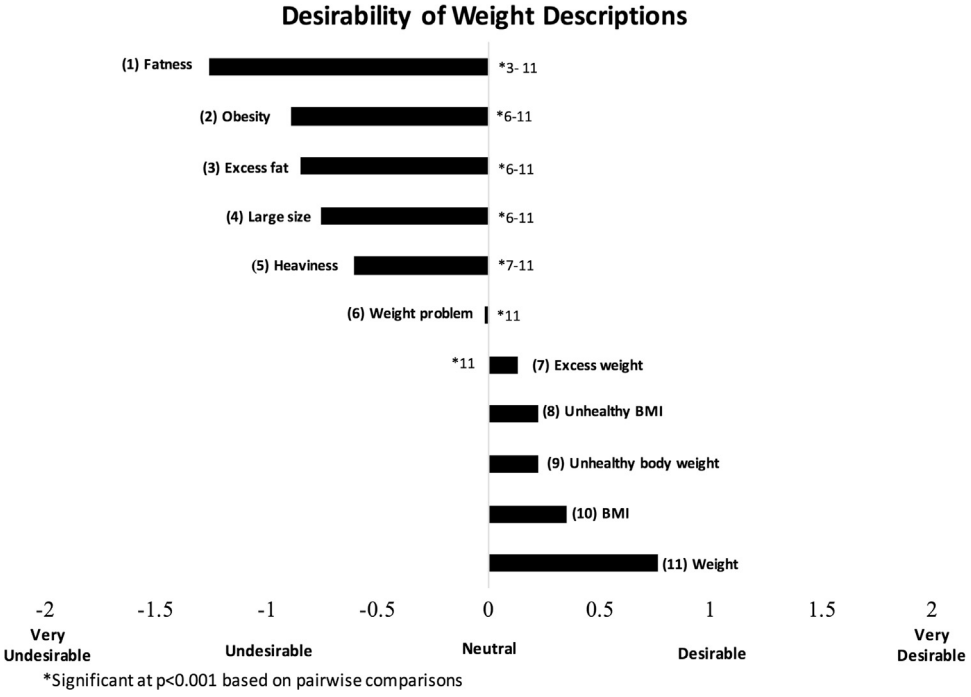

Fig. 2. Desirability of weight descriptions.

favorably.

The two binge-related descriptors *you ate until you were uncomfortably full* and *you kept eating even though you were not physically hungry* were also viewed favorably on average. These descriptors are listed in the *DSM-5* as experiences that may characterize a binge episode. Although there is some support for their diagnostic utility (White and Grilo, 2011), the extent to which they are distinct from experiences of loss of control or are simply other ways to describe loss of control while eating is not well understood and should be explored in future research.

The two descriptors viewed unfavorably were, *like you knew you were going to eat a large amount of food, so you didn't even consider stopping,* and *like you were addicted to the food you were eating*. Nearly one-fifth of the patients in our sample considered these descriptors to be very undesirable. Given the negative connotation "addiction" tends to have in society (Corrigan et al., 2009; Link et al., 1999), it is not surprising that the word "addiction" would generate negative feelings among patients with BED. However, an experimental study that randomized 625 adults (mean BMI 25.40 kg/m^2) to read a paragraph about a person's body weight (either with obesity or normal weight) followed by a vignette framing overeating as either an addiction or not, found that those reading the vignette positing an addiction model of obesity exhibited less stigma towards the person in the vignette. Although these results suggest that framing excess weight and/or problematic overeating behavior as an 'addiction' may reduce stigma, this may be because the vignette provided a detailed description of the physiological process of addiction, comparing it to drug use, and describing its impact on the brain (Latner et al., 2014), whereas in the current study participants simply rated descriptions in isolation. It is possible describing uncontrolled overeating as an addiction without providing further explanation could feel stigmatizing. As more research is conducted on the addictive potential of food (Schulte et al., 2015), and on the emerging construct of 'food addiction' that appears to be relevant to a subgroup of patients with BED (Gearhardt et al., 2012; Ivezaj et al., 2016), these results suggest a need to be sensitive when having conversations with patients regarding their perspectives about food and addiction. Future research should examine the potential stigmatizing implications of the way "food addiction" is discussed with patients. The term *like you lost your willpower* was also viewed unfavorably by patients, perhaps because it is associated with personal blame for one's illness.

The findings for our patients with both obesity and BED largely replicate prior work on preferences for describing weight in patient samples with obesity without co-occurring BED. These findings are especially important because it is well-established in both clinical (Grilo et al., 2008) and non-clinical (Grilo et al., 2010) samples that persons with BED, relative to their BMI-matched peers, have substantially greater shape and weight concerns which might influence sensitivity to different weight-related items. Similar to prior research, (Volger et al., 2012; Wadden and Didie, 2003) our sample of BED patients also rated *heaviness, large size, obesity, excess fat,* and *fatness* as undesirable descriptors, with *fatness* being viewed as the most undesirable and *weight* being the most preferred term. However, unlike the patients with excess weight surveyed in that paper, our sample viewed positively the descriptions *unhealthy body weight* and *unhealthy BMI*. Wadden and Didie (2003) found that women with severe obesity (BMI ≥40 kg/m^2) who were candidates for bariatric surgery rated the descriptors less negatively than women with BMIs between 30 and 40 kg/m^2. This may be because those patients with severe obesity had simply become accustomed to hearing negative terms or that they experienced greater feelings of internalized weight stigma (Durso and Latner, 2008), as many individuals engage in self-blame for their excess weight. These explanations might also apply to our sample of patients with BED.

These findings should be considered within this study's limitations. First, we studied a relatively small group of patients with *both* BED and obesity who had completed treatment for BED. The small sample size limited our ability to sufficiently examine differences in descriptor preferences based on factors such as gender, BMI, age, socioeconomic status, and race/ethnicity. Although the majority of treatment-seeking patients with BED present with excess weight, epidemiological studies find BED distributed across all weight categories; our findings, therefore, might not generalize fully to persons with BED without excess weight. A strength of this study is that participants were rigorously diagnosed with BED, although this might limit generalizability to other individuals with BED (or potential BED) who might have less knowledge, awareness, and experience in talking about these features of their overeating behaviors.

Another limitation of this study is that we assessed preferences 12 months after participants completed a treatment study, rather than before diagnosis or treatment. We felt a useful first step in this line of research was to ask "expert" patients (i.e. those that had been diagnosed rigorously with BED who then engaged in treatment that included repeated discussions of different types of eating episodes) their preferences. However, the exposure to phrases like "loss of control" during treatment might have increased patients' favorable views simply because it was a familiar term used in treatment sessions. We are, however, encouraged by the fact that our results for terms to describe weight largely replicate prior studies on such terms among overweight and obese patients that were assessed before treatment. It is also possible that terms viewed unfavorably are not disliked or experienced as stigmatizing, but are simply viewed as inaccurate descriptors of the feeling of disinhibited eating, and so these terms did not resonate with patients. Although the majority of patients, when prompted to write their own preferred phrases, simply re-iterated phrases provided in the questionnaire suggesting they resonated with their experiences, some made suggestions for other types of descriptions such as, "eating more than you intended or need to." One patient also described the experience as, "like a shark aimlessly looking for prey." Gathering more data on patients' descriptions of loss of control might shed light on additional ways to describe this sometimes complicated experience in a way that resonates with different people. Nonetheless, the fact that some descriptions for the same issue are viewed more positively suggests there is no downside to adopting preferred terms during clinical interactions. However, future research should explore the links between stigma and patient's preferred terms.

An additional limitation is that we did not know what kind of healthcare provider patients were thinking of when we asked them to imagine a conversation about binge eating with their "doctor." It is possible they were picturing a primary care provider with relatively little experience assessing and treating BED, and this generated more negative feelings than a description characterizing an eating disorder specialist accustomed to having sensitive conversations about weight.

There are a number of directions for future research, including examining preferences for loss of control and weight descriptions among non-treatment-seeking community samples with BED and among persons who might be avoiding seeking treatment in part because of concern about feeling stigmatized. It would also be valuable to understand why certain terms (e.g., loss of control) are viewed negatively by some patients and why the term 'food addiction' generated many negative reactions among those with BED, many of whom might also meet diagnostic criteria for 'food addiction.' In addition, the diagnostic criteria for anorexia nervosa and bulimia nervosa also involve querying about loss of control during eating episodes and preferences among these patient populations should be explored.

This work makes a novel contribution by examining preferences for descriptors used for loss of control during eating episodes among patients with BED, a line of questioning that may be viewed as stigmatizing by some patients. In addition, it extends prior research on patients' preferences for terms used to describe weight by examining such descriptions in a sample of patients with BED. Given existing

evidence of weight bias in healthcare settings (Puhl and Heuer, 2009), the results suggest that clinicians should avoid terms such as *weight problem, heaviness, large size, obesity, excess fatness,* and *fatness* when discussing weight with patients with BED. In contrast, common terms used to describe a loss of control were viewed favorably in our sample. Nonetheless, these results suggest clinicians should be mindful to avoid descriptions of loss of control during initial assessments of eating behavior that suggest that patients may be out of control, lacking in willpower, or addicted to food. That being said, as one qualitative study revealed, the most important aspect of a clinician-patient encounter might not simply be the words used, but the way in which they are said (Ward et al., 2009). It is important to remember that talking about eating and weight is a sensitive topic for many people, but a critical one for providers to raise. Concerns with eating and weight should be discussed, but care should be taken not to make patients feel negatively judged or powerless to change.

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Disclosure

The authors declare no conflicts of interest.

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None.

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