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Case Study

Eating the Unspoken: Emotional Dysregulation in Binge Eating Disorder

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ABSTRACT

Recurrent periods of excessive dietary intake without compensatory actions are the hallmark of Binge Eating Disorder (BED), a complicated and frequently neglected illness. This case study looks at Ms. A, a 34-year-old office executive who has been obese, socially isolated, and emotionally distressed due to compulsive excessive eating for three years. The severity of her illness and its psychological effects are highlighted by psychometric tests such as the Yale Food Addiction Scale (YFAS), the Binge Eating Scale (BES), and the Eating Disorders Examination Questionnaire (EDE-Q). Results show that stress, negative body image, and emotional dysregulation are key factors in sustaining BED. The study emphasizes how well cognitive-behavioral therapy (CBT) works to reduce binge episodes, improve emotional regulation, and address inappropriate patterns of thought. Long-term healing also heavily relies on social support, dietary counseling, and modifications to the lifestyle. This instance emphasizes the necessity of an integrative, multidisciplinary strategy to manage the psychological and physiological effects of BED and guarantee long-lasting improvements in general wellbeing.

Keywords: *Food Addiction, Eating Disorders, Cognitive-Behavioral Therapy, the physique Image, being overweight, Emotional Eating, Binge Eating Disorder, Stress, and Eating Behavior*

Frequent episodes of massive calorie intake, frequently coupled with feelings of helplessness and intense mental discomfort, are the hallmark of (BED), a serious mental state. (APA, 2013)

frequent episodes of compulsive having snacks, which include eating too much stuff in a short length of time and losing oversight of one's nutritional intake. For three months, these episodes—which are linked to distress—occur at least once a week and are devoid of compensatory behaviors like purging or strenuous exercise. (APA, 2013, DSM-5).

The most prevalent sort of eating disorder, BED, affects people from a wide range of ethnicities. Obesity, feelings of inferiority, alienation, and other clinical and mental health

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conditions are significantly correlated with it (Hudson et al., 2007). Even if they do not purge frequently, those with BED frequently experience anxiousness, regret, and embarrassment following binge episodes, in contrast to those with Bulimia Nervosa (American Psychiatric Association, 2022).

Research suggests that BED is resulting from a mix of external, physiological, and psychological factors. Important risk factors include genetic predisposition, social stresses, early trauma, and personal dysregulation (Kessler et al., 2013). To enhance emotional regulation and lessen the frequency of binges, therapy strategies include cognitive behavioral treatment (CBT), interpersonal treatment (IPT), and drugs (Grilo et al., 2012).

The characteristic of (BED), an extremely serious and frequently underdiagnosed Recurrent episodes of rapidly ingesting huge amounts of food while losing control are known as eating disorders. BED differs from Bulimia Nervosa in that it does not entail compensatory behaviors such fasting, excessive activity, or purging (APA, 2013). Significant emotional suffering, poor interpersonal skills, and an elevated risk of obesity and metabolic problems are all linked to the illness.

According to studies, the lifetime frequency of BED in the general population is 2.8%, making it the most prevalent digestive disorder (Hudson et al., 2007). With an anticipated female-to-male ratio of 3:2, the condition is more prevalent in women than in men, according to Kessler et al. (2013). BED is commonly observed in clinical samples in people with anxiety disorders, depression, and obesity (Vancampfort et al., 2014).

(BED) can occur as a result of several interconnected circumstances, including:

1. **Psychosocial Factors:** According to Gilo et al. (2012), people with BED frequently struggle with emotion management, humiliation of the body, and low self-esteem. Overeating is a coping strategy for negative feelings.
2. **Escape Theory:** snacking is a coping mechanism for adverse feelings and a means of escaping self-awareness, claim Heatherton and Baumeister (1991). Stressful situations, such family disputes or work-related apprehension frequently set off episodes.
3. **Neurobiological Factors:** BED has been connected to the dysregulation of reward systems and neurotransmitters such as serotonin and dopamine, which results in compulsive calorie intake (Berner et al., 2017).
4. **Influences from the Family:** BED is more likely to occur in families with a history of being overweight or having eating or mood problems, which may indicate a hereditary susceptibility and acquired eating practices (Hudson et al., 2006).

Substantial emotional distress and hazards to one's well-being are linked to (BED). According to Mitchell et al. (2007), people with BED frequently feel anxious, sad, and embarrassed. Obesity and metabolic disorders such as hypertension, diabetes, and arterial heart disease are closely associated with an illness (Hudson et al., 2007), which raises the risk of serious medical problems. Because many people isolate themselves because they are unhappy with their bodies and fear being judged, BED can also result in decreased interpersonal and vocational functioning, which further lowers their overall quality of life (Wilfley et al., 2002).

REVIEW OF LITERATURE

Robbins, T. W., and Smith, R. J. (2023). This study looks into how the prefrontal brain and reward-processing regions work in BED. The results imply that overeating in people with BED is caused by stimulation in their systems of reward. The study's primary focus is on the brain mechanisms that differentiate BED from additional eating disorders and behaviors associated with dependence.

Fairburn, C. G., and Wilson, G. T. (2022). This study reviews the effectiveness of cognitive-behavioral treatment (CBT) in treating BED. It provides evidence that the condition is significantly influenced by distorted perceptions of food, their physical attributes, and feelings of value. The study found that (CBT) is the most effective treatment for improving emotional regulation and decreasing binge eating episodes.

Hudson, et,al (2024) This study investigates the connection between unhealthy eating, tension, and emotion instability. It demonstrates that people with BED have dysregulated emotional reactions and elevated cortisol levels, both of which fuel their binge-like behaviors. The authors emphasized the need of stress-reduction strategies in BED treatment.

Raevuori, et,al (2023). Being overweight, insulin resistance, and cardiovascular illness are among the metabolic risks linked to BED that are highlighted in this thorough analysis. The study emphasizes how crucial it is to incorporate dietary guidance and physical exercise into BED treatment programs in order prevent health problems that last.

METHODOLOGY

Aim

This case study aims to investigate the intricacies of Ms. R's dietary condition (BED), paying particular attention to her indicators, medical background, temperament, and treatment approaches. This study's objective is to assess the effectiveness of her current treatment regimen, which includes help, medication, and lifestyle changes. This study aims to comprehend how individual differences affect outcome of therapy by fusing clinical findings with first-hand experiences. The results are intended to shed light on BED treatment approaches that work well in hospitals.

Research Design

In this longitudinal case study, Ms. R's assessment and treatment are tracked over a predefined length of time after she was diagnosed with snacking disorder (BED). Using recognized psychometric tools, such as the Eating Disorder Evaluation Checklist (EDE-Q) for behavioral and cognitive symptoms and the Binge Eating Scale (BES) for the intensity of excessive eating episodes, the study tracks the development of her symptoms. Clinical records, notes from therapy sessions, and patient talks are the sources of data. Ms. R's feelings of abandonment, starving eating habits, and opinions on the efficacy of the therapy she uses are qualitatively revealed through routine semi-structured interviews.

Tools and Instruments

- **Binge Eating Scale (BES)**: Ms. R's patterns were assessed using the (BES), a 16-item self-reported information survey that measures both behavioral (such consuming large amounts of food quickly) and emotional (like experiencing guilt and embarrassment after bingeing) components. Binge consumption is classified as mild if it is ≤17, moderate if it is 18–26, and severe if it is ≥27 and requires intervention. The range of scores is 0–46. Ms. R's score of 29 was in the severe level,

indicating that she had a significant lack of authority over her eating patterns. This result highlights the need for immediate therapeutic intervention for managing her eating patterns, coping mechanisms, and psychological suffering.

- **Eating Disorder Examination Questionnaire (EDE-Q):** The EDE-Q, a self-report version of the structured Eating Disorder Examination (EDE), was used to assess Ms. R's patterns and concerns. Four important elements are evaluated in this assessment: shape concern, feeding nervousness, weight worry, and constraint. Higher scores imply more serious eating disorders. Responses are recorded on a 7-point Likert scale, where 0 indicates no concerns and 6 indicates severe disorders. The average of the four subscales is used to get the overall score; a score of ≥4 indicates the presence of pathology associated with a clinically severe disorder of eating. Ms. R's overall score of 4.8 demonstrated her body image distress and weight fixation, with particularly high scores for shape and weight worry. This suggests that she needs targeted therapeutic attention.
- **Yale Food Addiction Scale (YFAS)**: Ms. R's eating habits were examined using the (YFAS), which evaluates addictive-like eating habits according to the DSM-5 criteria for drug use disorders. This 25-item scale measures key symptoms, such as lack of authority over the intake of food, withdrawal-like symptoms, and continuing to eat in spite of unpleasant consequences. Responses are graded on a Likert scale (0–4), and "food addiction" tendencies are identified by calculating a cutoff score. When there are more accepted criteria (often ≥3 symptoms + distress/impairment), practices resembling food addiction are present. Ms. R satisfied five requirements, suggesting excessive overeating with addictive characteristics that necessitates a formal therapeutic intervention.

CASE PRESENTATIONS

For the three years preceding this one, Ms. A, a 34-year-old urban office professional who is single, has been suffering from uncontrollable episodes of binge eating. During these moments, Over the last two years, there has been a discernible rise in weight, along with emotions of discomfort and shame. Because she feels ashamed of her eating habits, she deliberately avoids social situations, which lowers a sense of self-worth and causes mood swings. The illness has a chronic, progressive course and a gradual beginning. Ms. A's and her mother's information is trustworthy and sufficient for evaluation.

History of Present Illness

Ms. A stated that she had recurrent periods of eating in excess, in which she would quickly eat a lot of food while frequently feeling out of touch. Even when she wasn't physically hungry, she spoke about eating until she felt uncomfortable. Extreme remorse and emotional distress accompanied these incidents, which mostly happened alone and frequently happened late at night. She eventually started to shy away from social events because she felt ashamed of her dietary habits and her growing weight gain. As her body image issues grew worse, she became even more isolated and experienced a vicious cycle of mental distress and excessive food consumption.

When stressful life events occurred, including pressure at work or family problems, the signs were more noticeable. According to her, binge eating led to feelings of self-loathing after temporarily relieving negative feelings. She tried a number of restrictive eating regimens and diets, but these frequently resulted in worsening binge eating behaviors.

Ms. A acknowledged that she had experienced periods of fasting after binges, but she denied

engaging in purging behaviors like self-induced vomiting or too much activity. Her doctor had diagnosed her with obesity because of the dramatic increase in her weight over the previous two years.

Negative History
Ms. A has never used any drugs, alcohol, or other substances. She has never had hallucinations or delusions, which are signs of psychosis. No notable neurological or medical conditions from the past have been documented. She has also never experienced manic or hypomanic episodes and has no history of self-harm or suicide thoughts.

Past History
Although Ms. A has battled consuming since adolescence, she has never been officially diagnosed with an eating condition. Five years ago, she had therapy for anxiety-related issues, but she stopped treatment too soon.

Medical History
In addition to having a family history of type 2 diabetes and hypertension, the patient is diagnosed as obese (BMI: 33.5). There is no noteworthy surgical history mentioned.

Family History
Ms. A is from a nuclear middle-income family. Her father, a former government worker, has suffered from of high blood pressure. Her mother has a history of emotional eating and is a stay-at-home mom. Her younger sister is a teacher and married. According to family relatives, Ms. A had always suffered with weight issues and had been a quiet child. Her mother saw that when she was under stress, she would frequently turn to food to provide soothing.

Personal History

- **Birth and Development**: No birth problems were noted, and the delivery was full term and typical. At the right age, milestones of development were reached.
- **Childhood and Adolescence**: Ms. A stated that she has been an emotional eater since she was a young child. She was a mediocre student who tended to stay away from athletics and physical exercise. Her weight caused her to be teased and bullied, which lowered her level of confidence.
- **Academic Background**: Earned a commerce bachelor's degree. Although she did well in school, she found it difficult to engage with others.
- **Work History**: I am currently employed as an executive in an office. Her binge eating bouts usually happen after work, and she finds her job to be stressful. Due to mental distress and lack energy, she has been performing worse at work. No past history of intimate relationships, either **sexual or marital**. Ms. A claimed that she was unable to pursue partnerships because she felt self-conscious about her appearance.
- **History of Substance** Use: No past history of drug, alcohol, or smoking.

Premorbid Personality
Given her premorbid personality, Ms. A may be more susceptible to emotional instability and be more sensitive to outside stimuli. She displayed perfectionism, social disengagement, and a strong desire for approval during her early years, all of which contributed to her lack of self-confidence. Her propensity to internalize unpleasant experiences—especially as a

result of bullying and physical appearance issues—reinforced destructive eating practices as a coping strategy. Her vulnerability to stress-related eating patterns was further increased by her inability to manage interpersonal problems and be assertive. Together with a familial history of emotional eating, these elements laid the groundwork for the emergence of (BED), which subsequently worsened in response to personal and professional stressors.

Mental Status Examination

Ms. A is a well-groomed, overweight woman with a dejected countenance. She seemed reticent but helpful. She spoke at a typical volume and pace, but she had a restricted affect and was melancholy and worried. Despite her obsession with food and body image issues, she had a logical and goal-oriented mind process. Her cognitive abilities were unaffected, and she did not have any hallucinations or delusions. She showed fair judgment and a partial understanding of her position.

Diagnosis

Binge Eating Disorder (F50.9)

DISCUSSION

The case of Ms. A demonstrates the complex nature of binge eating syndrome (BED), emphasizing the interaction between nutritional concerns, mood issues, and psychological anguish. She has frequent bouts of binge eating that are characterized by a lack of management and profound distress without compensatory behaviors, and she meets the DSM-5 criteria for BED. Her early experiences with bullying, impulsive eating, and low optimism point to underlying vulnerabilities that aided in the emergence and sustenance of her unhealthy eating practices. These behaviors are further reinforced by the effects of social disengagement, fitness avoidance, and pressures like pressure from the workplace. Her situation is in line with Heatherton and Baumeister's (1991) Escape Theory, which holds that excessive snacking is a maladaptive coping mechanism used to dull emotional pain and self-criticism.

Ms. A's condition is influenced by both hereditary and environmental factors; her mother's impulsive eating and the family's record of obesity point to a combination of acquired habits and genetic susceptibility. Cognitive errors that reinforce shame, guilt, and low self-worth, such all-or-nothing thinking about meals and appearance, are a contributing factor to cycles of restricting calories and binge episodes. This loop can be broken with a comprehensive treatment approach that includes mindfulness-based therapies, (DBT) for handling emotions, and (CBT), which is the gold standard. Lowering cravings and enhancing psychological resilience require addressing stress, encouraging healthy coping strategies, and cultivating self-compassion.

CONCLUSION

The case of Ms. A demonstrates the chronic and intricate nature of BED, impacting her everyday functioning, mental state, and sense of self. If treatment is not received, the illness may exacerbate psychological anguish and raise the risk of obesity and metabolic problems. Correcting regressive thought patterns and promoting better means of coping need a multimodal treatment strategy that includes stress management, dietary counseling, and Cognitive-Behavioral Therapy (CBT). Long-term healing also requires fostering a harmonious connection with food, lowering perceived body image distress, and fostering self-compassion. She can recover control over her food choices with the use of structured behavioral modifications, such as emotional regulation and mindful eating practices. A

comprehensive treatment strategy that includes social support, medical monitoring, and psychotherapy can help her break the habit of overeating, promote self-esteem, and enhance her overall quality of life.

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