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**Binge Eating Disorder: Addressing Disparities in Diagnosis, Treatment, and Research Among Marginalized Populations**

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**ABSTRACT** 2

Binge eating disorder (BED) is a DSM-V diagnosis characterized by episodes of consuming large 3

amounts of food with a loss of control, accompanied by distress, guilt, and shame. Despite its high 4

prevalence, a significant proportion of individuals with BED remain undiagnosed and untreated. 5

This commentary addresses the disparities in BED diagnosis and treatment, particularly among 6

marginalized populations, including racial, ethnic, sex preference, and sex/gender identity 7

minorities. These groups exhibit higher BED risk and prevalence rates but are less likely to 8

receive a diagnosis or treatment. The commentary highlights the impact of systemic issues, 9

stigmatization, and lack of justice, equity, diversity, inclusion, access, and awareness (JEDIAA) on 10

BED research and clinical understanding. The “Me Too” and “Black Lives Matter” movements have 11

raised awareness of these disparities, prompting a shift towards more inclusive and representative 12

BED research. The COVID-19 pandemic further catalyzed this shift by increasing the focus on non- 13

treatment-seeking individuals with BED. This new era of decolonial psychology in BED research 14

aims to capture the diverse experiences of individuals with BED, regardless of formal diagnosis 15

or awareness. This commentary calls for decolonial approaches in BED research and treatment, 16

emphasizing the need for inclusive studies that reflect the full spectrum of BED experiences. By 17

addressing these disparities, we can improve our understanding of BED pathology and develop 18

more effective diagnostic criteria and treatment approaches that are equitable and accessible to 19

all individuals affected by BED. 20

**Keywords: decolonial research, decolonial psychology, binge eating disorder, eating disorder, binge eating, disparities, justice, equity,** 21

**diversity, inclusion, access, marginalization, healthcare** 22

# 1 INTRODUCTION

1. **Binge eating disorder (BED)** is an autonomous DSM-V diagnosis characterized by episodes of rapidly
2. consuming objectively large amounts of food due to loss of control while associated with distress, guilt,
3. and shame, and occurring at least once per week for at least three months (APA, 2013). The disorder is
4. associated with high lifetime prevalence rates (Hudson et al., 2007; Termorshuizen et al., 2020) and a
5. complicated health sequelae that often includes childhood or lifetime adversity as well as high
6. comorbidity with anxiety, depression, obesity, cardiovascular disease, diabetes and significantly impaired
7. quality of life (Apovian, 2016; Bray et al., 2022a, 2022b; Bray et al., 2023; da Luz et al., 2018; Hudson et al., 2007; Kessler et al., 2013; Mustelin et al., 2017; Pawaskar et al., 2017).

# 2 DISPARITIES IN DIAGNOSIS AND TREATMENT

1. Global and national studies suggest 5 – 31% of U.S and global populations experience BED at some point in
2. their lifetime (Hudson et al., 2007; Termorshuizen et al., 2020). However, a variety of emerging studies also
3. find that 93.4–96.8% of individuals who meet DSM criteria for BED never receive a formal diagnosis
4. (Cossrow et al., 2016; Sonneville & Lipson, 2018), 67.3% do not perceive the need for formal treatment
5. (Sonneville & Lipson, 2018), and 56.4–86.8% never receive or pursue standard treatment (Hudson et al., 2007; Sonneville & Lipson, 2018) for a variety of complex reasons (Bray et al., 2025 (submitted December 2024)). Moreover, emerging studies find that treatment-seeking samples for BED tend to be grossly
6. misrepresentative of the full population of individuals who experience this issue (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)). For example, individuals with eating disorder
7. symptoms who are underweight, white, affluent, and/or female are more likely than their respective
8. counterparts to perceive a need for treatment or receive a diagnosis or treatment (Sonneville & Lipson, 2018). As a result, treatment-seeking samples and populations for BED tend to be saturated by white affluent
9. young women, contributing to the “SWAG” stereotype/misconception that ascribes all eating disorders
10. exclusively to “skinny white affluent girls,” (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)). This misconception can result in gross underscreening and missed detection of
11. BED, particularly in individuals who do not meet the SWAG demographic (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)).

# 3 IMPACTS ON MARGINALIZED POPULATIONS

1. More recently, numerous emerging studies find that racial, ethnic, sex preference, and sex/gender identity
2. minorities (e.g., members of the BIPOC and LGBTQ2+ communities and other marginalized populations)
3. have two- to three times higher BED risk and prevalence rates their white, heterosexual, cis-gendered, female
4. counterparts (including higher risk and prevalence rates of experiencing discrimination, stigmatization,
5. unemployment, homelessness, poverty, food insecurity, and direct targeting by tobacco-owned food and
6. beverage marketing programs)(e.g., (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024))). At the same time, these same populations are *less* likely to recognize the need for BED
7. treatment when present, be screened by healthcare providers for an eating disorder, pursue, access, or engage
8. in treatment when needed, and much less likely to be included or represented in eating disorder research (see (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)) and citations therein).

# 4 CALL FOR DECOLONIAL APPROACHES

1. The lack of justice, equity, diversity, inclusion, access, and awareness (JEDIAA) among minority,
2. marginalized, and under-served populations in BED occur at the levels of the patient, healthcare providers
3. and systems, and socioculturally (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)) These pose significant challenges to BED research (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)) and to our current clinical understanding of BED pathology
4. (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)). For example, the
5. clinical understanding of BED is often informed from clinical case findings/experience and from research
6. that historically pulls from clinical (treatment-seeking) populations that – as addressed above – tend to be
7. saturated by the SWAG demographic and are grossly misrepresentative of the full population of individuals
8. who experience BED (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)).
9. It follows then that the current clinical understanding of BED pathology and the diagnostic criteria and
10. approved treatment approaches for BED themselves may be more aligned with the experiences of the ~3 –
11. 46% of individuals with BED who *do* receive a formal BED diagnosis and treatment, and less aligned (or not
12. aligned) with the experiences of the ~54–97% of individuals who lack access to BED detection, diagnostic,
13. and clinical resources and support.

# 5 CONCLUSIONS

1. More recently two concurrent sociocultural phenomena have spawned a new era of BED research methods
2. and designs that begin to paint a new picture of BED pathology. On the one hand, the “me too” and “Black
3. Lives Matter” movements have helped raise and demand awareness of the lack of JEDIAA that exists
4. socioculturally (Siuta et al., 2023; Zimerman et al., 2024), (Goldberg, 2023; Pugh et al., 2022; Ray et al., 2022);(Gyawali, 2016; Lee, 2018; "Me too," 2018; Nahai, 2018; Vaish et al., 2016; Zacharias, 2018),(Brunton, 2020; Dowd, 2021; Harris, 2020; Henwood & Kapadia, 2021; Hodge et al., 2020; Kelly et al., 2020; Lebow, 2020; Lowe, 2021; Negbenebor & Garza, 2018; "Why Black lives matter in science," 2020) and some BED research has begun to reflect and respond in turn (albeit slowly) (Bondü et al., 2020; Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024); Hazzard et al., 2020; Middlemass et al., 2020; Perez et al., 2019; Sonneville & Lipson, 2018). At the same time, the Coronavirus
5. 19 (COVID-19) pandemic (~2019–2023) placed a temporary firewall between BED research recruitment
6. efforts and BED clinicals and treatment centers that, while not completely impenetrable, prompted an
7. increase in observational and qualitative studies that were (and remain) more inclusive of non-treatment-
8. seeking individuals with BED (Bondü et al., 2020; Bray et al., 2022a; Bray et al., 2023; Janse van Rensburg, 2020; Kenny et al., 2020; Keski-Rahkonen, 2021). This new era of decolonial psychology in BED research
9. has helped improve our understanding of the experience of BED from a more complete population of
10. individuals who experience it (Bondü et al., 2020; Bray et al., 2022a; Bray et al., 2023; Janse van Rensburg, 2020; Kenny et al., 2020; Keski-Rahkonen, 2021). These studies align with a growing awareness of the
11. importance for JEDIAA both socioculturally, clinically, and in research broadly and specific to eating
12. disorders and BED (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024); Cossrow et al., 2016; Hudson et al., 2007; Sonneville & Lipson, 2018) .
13. While the call for raising the narrative of the lived experience of BED from those who experience it is a great
14. first step (Bray et al., 2022a; Bray et al., 2023; Bray et al., 2025 (submitted December 2024)), it is far from
15. being complete or even satisfactory at this point. Thus, this commentary aims to highlight the need for
16. decolonial approaches in BED research and treatment, emphasizing the importance of inclusive and
17. representative studies that capture the diverse experiences of individuals with BED, regardless of formal
18. diagnosis or awareness of their condition.

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