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Food Thought Suppression: A Matched Comparison of Obese Individuals with and without Binge Eating Disorder

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Abstract

Preliminary studies of non-clinical samples suggest that purposely attempting to avoid thoughts of food, referred to as food thought suppression, is related to a number of unwanted eating- and weight-related consequences, particularly in obese individuals. Despite possible implications for the treatment of obesity and eating disorders, little research has examined food thought suppression in obese individuals with binge eating disorder (BED). This study compared food thought suppression in 60 obese patients with BED to an age-, gender-, and body mass index (BMI)-matched group of 59 obese persons who do not binge eat (NBO). In addition, this study examined the associations between food thought suppression and eating disorder psychopathology within the BED and NBO groups and separately by gender. Participants with BED and women endorsed the highest levels of food thought suppression. Food thought suppression was significantly and positively associated with many features of ED psychopathology in NBO women and with eating concerns in men with BED. Among women with BED, higher levels of food thought suppression were associated with higher frequency of binge eating, whereas among men with BED, higher levels of food thought suppression were associated with lower frequency of binge eating. Our findings suggest gender differences in the potential significance of food thought suppression in obese groups with and without co-existing binge eating problems.

Keywords

food thought suppression; obesity; binge eating; gender; eating disorder

1.1 Introduction

According to the Ironic Processes Theory, thought suppression may have unwanted consequences such as an immediate increase in thoughts following attempts to suppress those specific thoughts and an increase in target thoughts following suppression (the rebound effect; Wegner, 1994; Wegner & Erber, 1992). Individuals who purposely attempt to avoid unwanted thoughts also may experience an increased priming of the to-be-suppressed thoughts (hyperaccessibility; Wegner & Erber, 1992). Despite the relatively few studies examining the association between thought suppression and eating behaviors,

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existing research does indicate the outcomes of thought suppression, such as hyperaccessibility and rebound, also result from attempting to suppress food-related thoughts (Dejonckheere, Braet, & Soetens, 2003; Smart & Wegner, 1999).

The emerging literature suggests that the consequences of thought suppression may be influenced by various factors including individuals' weight and dieting status. While thought suppression effectively but briefly decreased food craving intensity for normal weight non-dieters, other strategies (such as dynamic visual noise, i.e., "random squares changed from black to white or white to black") was more effective for overweight dieters (Kemps, Tiggeman, & Christianson, 2008, p. 180). Similarly, instructed thought suppression resulted in the rebound effect in obese dieting adolescents but not in obese non-dieters or in healthy-weight persons regardless of their dieting status (Soetens & Braet, 2006).

The consequences of thought suppression may not be limited to increased thoughts but also altered behaviors. Johnston and colleagues (1999) asked cravers and non-cravers of chocolate to suppress thoughts about chocolate. Following the suppression period, and regardless of craving status, participants worked harder at a computer game to earn chocolates when compared to the nonsuppression control group. Similarly, purposely attempting to suppress thoughts of food also resulted in increased food-related thoughts, regardless of participants weight, and increased food intake in dieting overweight/obese participants but not for healthy weight dieters (Pop, Miclea, & Hancu, 2004). Conversely, among a group of binge eaters, suppression of negative affect did not lead to increased food intake (Dingemans, Martijn, Jansen, & van Furth, 2009). The latter study, however, did not focus specifically on suppressing thoughts of food.

Existing research on thought suppression and eating behaviors relied on the White Bear Suppression Inventory (Wegner & Zanakos, 1994), which measures the general use of thought suppression, and not thoughts specific to eating or food. To address and explore this potential limitation, Barnes and colleagues (2010) developed the Food Thought Suppression Inventory (FTSI) and found that the FTSI predicted eating pathology even after accounting for the general use of thought suppression. Also based on the FTSI, overweight/obese individuals were more likely to utilize food thought suppression, with healthy weight, overweight, and obese women endorsing progressively higher levels of food thought suppression (Barnes, Fisak, & Tantleff-Dunn, 2010). The measure recently was validated, and weight differences replicated, with a male sample as well (Barnes & White, 2010). Further, preliminary evidence suggests that food thought suppression predicts (Barnes & Tantleff-Dunn, 2010) and is correlated (Barnes & White, 2010) with binge eating in non-clinical samples.

The association between binge eating episodes and food thought suppression in non-clinical samples (Barnes & Tantleff-Dunn, 2010; Barnes & White, 2010) suggest the importance of examining the significance of food thought suppression in clinical samples of obese persons with co-occurring binge eating disorder (BED). Given well-established differences between obese persons with and without BED on a range of eating and psychological variables (Grilo, Hrabosky, White, Allison, Stunkard, & Masheb, 2008; Grilo, Masheb, & White, 2010), it seems important to compare the presence and significance of food thought suppression in obese persons with and without BED. This seems further indicated in light of emerging findings from so-called "new wave" behavioral interventions (e.g., acceptance and commitment therapy (ACT) and mindfulness) for binge-eating (Kristeller & Hallett, 1999; Telch, 1997; Wiser & Telch, 1999) and obesity (Forman, Butryn, Hoffman, & Herbert, 2009; Lillis, Hayes, Bunting, & Masuda, 2009). Thus, this study aimed to compare food thought suppression in a matched sample of obese persons with BED (i.e., BED group) and individuals who do not binge eat (i.e., NBO group) and to examine whether food thought

suppression is associated with eating disorder psychopathology within the BED and NBO groups and separately by gender. It was hypothesized that the BED group would report greater food thought suppression than the NBO group. Similarly, based on previous research suggesting that women are more likely to endorse general thought suppression, women were hypothesized to report higher levels of food thought suppression than men (Barnes & Tantleff-Dunn, 2010). Lastly, we predicted that food thought suppression would be associated with binge eating frequency and other eating disorder psychopathology.

2.1 Materials and methods

2.2 Participants

Participants were 60 (21 men and 39 women) obese individuals with BED and 59 (20 men and 39 women) obese individuals who do not binge eat (NBO). Overall, participants had a mean age of 47.7 ($SD = 8.2$) years and a mean body mass index (BMI) of 38.7 ($SD = 6.2$). Ethnicity was as follows: 86.6% Caucasian, 8.4% African-American, 3.4% Hispanic, 0.8% Asian, and 0.8% bi/multi-ethnic. All participants provided written informed consent to the study procedures which were IRB approved for both recruitment protocols.

2.3 Procedures

To compare food thought suppression among obese persons with and without BED, two study groups of obese men and women (BED and NBO), matched for BMI, age, and gender, were obtained. The BED group consisted of a consecutive series of participants who were recruited for a treatment study for obese (BMI of 30 or greater) persons with BED being performed at a medical school research program in an urban setting. The treatment study was an “effectiveness” study with minimal exclusionary criteria intended to enhance generalizability; notable exclusion criteria included current anti-depressant therapy, severe medical problems (heart disease, liver disease), severe psychiatric problems requiring alternative treatments (psychosis, bipolar disorder, current substance dependence), and uncontrolled hypertension or diabetes. These participants completed self-report questionnaires and were then interviewed by experienced doctoral-level research-clinicians who were trained in all of the study’s interviews. BED diagnoses (full research criteria per the *DSM-IV*; American Psychiatric Association, 1994) were determined using the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I/P; First, Spitzer, Gibbon, & Williams, 1996).

The NBO group consisted of participants recruited via the internet and at local gyms. At a secure website, they provided informed consent and completed measures about food thought suppression and eating behaviors and psychopathology. The absence of binge eating was determined using the Eating Disorder Examination-Questionnaire (EDE-Q; Fairburn & Beglin, 1993) described below. The initial NBO sample consisted of 213 women and 99 men. Participants were randomly removed from the overall NBO sample to match them to the BED sample (described above). Independent samples t-tests and chi-square analyses were conducted with each random removal, until the two groups (BED and NBO) no longer differed in BMI, age, or gender.

2.4 Measures

Food Thought Suppression Inventory (FTSI; Barnes, Fisak, & Tantleff-Dunn, 2010) is a 15-item self-report measure of the tendency to avoid food-related thoughts. Higher scores indicate higher levels of food thought suppression. The FTSI has a unidimensional factor structure and demonstrated validity. In the present study, the FTSI had good internal consistency in both the BED ($\alpha = .90$) and NBO ($\alpha = .94$) groups.

Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn & Beglin, 1994) is a well-established self-report questionnaire that assesses eating disorder psychopathology with a focus on the previous 28 days. The EDE assesses the frequency of *objective bulimic episodes* (OBES; i.e., unusually large quantities of food with a subjective sense of loss of control). In addition, the EDE-Q comprises four subscales, Dietary Restraint, Eating Concern, Weight Concern, and Shape Concern, and an overall Global score. The EDE-Q also asks participant to report their height and weight. Participants' body mass index (BMI) was calculated based on this self-report information for both groups. The EDE-Q has received psychometric support, including adequate test-retest reliability (Reas, Grilo, & Masheb, 2006), good convergence with the Eating Disorder Examination interview in studies of patients with BED (Grilo, Masheb, & Wilson, 2001a; Grilo, Masheb, & Wilson, 2001b), and has been found to be a good screening measure in non-clinical community studies (Mond, Kay, Rodgers, Owen, & Beaumont, 2004)

3.1 Results

Table 1 shows the descriptive values for the two study groups for the primary variables of interest. Based on independent samples t-tests and chi-square analyses, the BED group did not differ significantly from the NBO group in terms of age ($t(117) = -0.61, p = 0.54$), BMI ($t(113.5) = -1.75, p = .08$), or sex ($\chi^2(1) = 0.02, p = .90$). Within gender, women with BED did not differ significantly from NBO women in terms of age ($t(76) = -0.57, p = 0.57$) or BMI ($t(76) = -1.18, p = .24$). Men with BED did not differ significantly from NBO men either in age ($t(39) = -0.30, p = 0.77$) or BMI ($t(39) = -1.36, p = .18$).

A 2 (sex) by 2 (diagnosis: BED vs. NBO) ANOVA was conducted with the FTSI as the dependent variable (see Table 1). Significant main effects were observed for sex ($F(1,115) = 5.94, p = 0.02, \eta^2 = .049$, medium) and diagnosis ($F(1,115) = 45.42, p < .0005, \eta^2 = .283$, large). The sex by diagnosis interaction was not significant ($p = .09, \eta^2 = .001$).

Table 2 summarizes correlations between the FTSI and the EDE-Q subscales and global score. The FTSI was more widely correlated with the NBO women's EDE-Q scores, and BED men's Eating Concerns. Table 2 also summarizes the relationship between binge eating episodes and the FTSI within the BED sample only. For BED women, the FTSI was positively correlated with OBES; however, for BED men, the FTSI was *negatively* correlated with OBES.

4.1 Discussion

This is the first study, to our knowledge, to examine food thought suppression in a clinical sample of obese patients with BED and in comparison to a matched group of obese individuals without BED. Our study revealed several findings. First, utilization of food thought suppression was higher among BED participants when compared to the NBO sample, and women reported higher levels of food thought suppression than men. Second, food thought suppression was not widely related to eating disorder psychopathology, with the exception of with NBO women. For this group, food thought suppression was positively correlated with overall eating disorder psychopathology, and concerns regarding eating, weight, and shape. The only other significant relationship was the positive correlation between food thought suppression and eating concerns for BED men. Third, the relationship between binge episodes and food thought suppression differed significantly by gender. Greater food thought suppression was associated with more frequent binge eating in women with BED but with less frequent binge eating in men with BED.

There are a number of pharmacological (Reas & Grilo, 2009) and psychological (Wilson, Grilo, & Vitousek, 2007) treatments with efficacy for BED although many patients fail to recover completely. The impact of existing treatments on thought suppression as well as the possible moderation effects of food thought suppression on different treatments are unknown. Presently, the best established treatment for BED is cognitive behavioral therapy (CBT) (Wilson et al., 2007) which generally produces a remission rate of roughly 50% (e.g., Grilo, Masheb, & Wilson, 2005; Grilo & Masheb, 2005). CBT includes a focus on identifying and changing certain maladaptive ways of thinking but does not directly address how to cope with preoccupying thoughts of food. Research suggests the so-called “third wave” of CBT approaches, which incorporate ACT and specific mindfulness techniques have yielded promising preliminary findings regarding reducing binge-eating (Kristeller & Hallett, 1999; Telch, 1997; Wiser & Telch, 1999), food cravings (Forman et al., 2007), and weight (Forman et al., 2009; Lillis et al., 2009). Such approaches may provide patients with tools to cope with preoccupying cognitions, rather than relying on food thought suppression, and this might represent one possible mechanism through which these treatments may help to reduce binge eating (Kristellar et al., 1999) and weight (Forman et al, 2009; Lillis et al, 2009).

The general lack of correlations between food thought suppression and eating disorder symptomatology is somewhat surprising in light of previous research. In samples of university men (Barnes & White, 2010) and women (Barnes et al., 2010), the FTSI predicted eating disorder symptoms as measured by the EDE-Q. The findings were replicated with NBO women but not in the other three groups. The nonsignificant correlations may be due to restricted range or small sample sizes and will need to be examined within larger and clinical samples.

The results provide preliminary evidence that the binge eating outcomes of food thought suppression may differ between men and women with BED. While this is the first study to examine the relationship between food thought suppression and binge eating episodes within a clinical sample, Barnes and Tantleff-Dunn (2010) found the FTSI to be a more robust predictor of binge eating episodes than gender or BMI within a nonclinical community sample. Similarly, within a male university nonclinical sample, there was a positive correlation between binge eating episodes and the FTSI (Barnes & White, 2010). Literature examining the outcomes of coping with weight stigma found differing outcomes between men and women when utilizing the same coping methods (Puhl & Brownell, 2006). There also may be a unique relationship between food thought suppression and binge eating episodes for men who meet diagnostic criteria for BED. Another possibility to consider is that a little bit of food thought suppression might be a good thing. Perhaps a limited amount of food thought suppression prevents binge eating but maladaptive levels trigger bingeing. Examining differences in gender and BED versus NBO groups will be important to inform future treatments.

This study has several strengths and limitations that should be considered. Strengths include a rigorously assessed clinical group of obese patients with BED and a well-matched and relevant comparison group of obese persons without binge eating. Limitations include the reliance on self-report methods to calculate BMI and to determine the absence of binge eating in the NBO group. Previous research, however, does suggest that patients with BED are especially accurate in reporting their height and weight (White, Masheb, & Grilo, in press) and that self-reported weight accuracy is sufficient for studies not examining weight loss interventions (e.g., Bowman & Delucia, 1992). The EDE-Q also correlates well with interview methods assessing disordered eating symptoms (Grilo, Masheb, & Wilson, 2001a, Grilo, Masheb, & Wilson, 2001b). In addition, our limited sample size, particularly for men, may have prevented us from identifying additional possible associations reflecting smaller

effects. Certainly more research is necessary to examine this potential differing clinical pathway for men and women's reliance on food thought suppression. Another potential limitation is the differing recruitment methods for the matched samples. That is, BED participants were treatment seeking while the comparison group was not. Research suggests that treatment seeking obese (Fitzgibbon, Stolley, & Kirschenbaum, 1993) and BED (Wilfley, Pike, Dohm, Striegel-Moore, & Fairburn, 2001) individuals reported higher levels of eating disorder symptom severity when compared to matched nontreatment seekers. Future studies should re-evaluate these findings using different patient groups ascertained similarly to exclude possible confounds due to recruitment or treatment-seeking effects. Lastly, our cross-sectional analyses preclude any statements regarding causality which would require experimental and longitudinal designs.

5.1 Conclusions

In summary, our findings suggest that obese individuals with BED are more likely to utilize food thought suppression than obese individuals who do not binge eat. Greater food thought suppression was associated with more frequent binge eating in women with BED but with less frequent binge eating in men with BED. Interestingly, food thought suppression was not significantly associated with variability in other features of eating disorder psychopathology in individuals with BED individuals. The emergent binge eating and food thought suppression findings highlight the importance of further investigation of these novel findings that differ by gender.

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References

- American Psychiatric Association. Diagnostic and statistical manual of mental disorders-IV. Washington, DC: 1994.
- Barnes RD, Fisak B Jr, Tantleff-Dunn S. Validation of the Food Thought Suppression Inventory. *Journal of Health Psychology*. 2010; 15:373–381. [PubMed: 20348358]
- Barnes RD, Tantleff-Dunn S. Food for thought: Examining the relationship between food thought suppression and weight-related outcomes. *Eating Behaviors*. 2010; 11:175–179. [PubMed: 20434065]
- Barnes RD, White MA. Psychometric properties of the Food Thought Suppression Inventory in men. *Journal of Health Psychology*. 2010; 15:1–8.
- Bowman RL, DeLucia JL. Accuracy of self-reported weight: A meta-analysis. *Behavior Therapy*. 1992; 23:637–655.
- Dejonckheere PJN, Braet C, Soetens B. Effects of thought suppression on subliminally and supraliminally presented food-related stimuli. *Behaviour Change*. 2003; 20:223–230.
- Dingemans AE, Martign C, Jansen ATM, van Furth EF. The effect of suppressing negative emotions on eating behavior in binge eating disorder. *Appetite*. 2009; 52:51–57. [PubMed: 18778742]
- Fairburn CG, Beglin SJ. Assessment of eating disorders: interview or self-report questionnaire? *International Journal of Eating Disorder*. 1994; 16:363–370.
- First, MB.; Spitzer, RL.; Gibbon, M.; Williams, JBW. Structured clinical interview for DSM-IV Axis I disorders - Patient Edition (SCID-I/P, Version 2.0). New York State Psychiatric Institute, Biometrics Research Department; New York: 1996.
- Fitzgibbon ML, Stolley MR, Kirschenbaum DS. Obese people who seek treatment have different characteristics than those who do not seek treatment. *Health Psychology*. 1993; 12:342–345. [PubMed: 8223357]

- Forman EM, Hoffman KL, McGrath KB, Herbert JD, Brandsma LL, Lowe MR. A comparison of acceptance- and control-based strategies for coping with food cravings: An analog study. *Behaviour Research and Therapy*. 2007; 45:2372–2386. [PubMed: 17544361]
- Forman EM, Butryn ML, Hoffman KL, Herbert JD. An Open Trial of Acceptance-Based Behavioral Intervention for Weight Loss. *Cognitive and Behavioral Practice*. 2009; 16:223–235.
- Grilo CM, Hrabosky JI, White MA, Allison KC, Stunkard AJ, Masheb RM. Overvaluation of shape and weight in binge eating disorder and overweight controls: refinement of a diagnostic construct. *Journal of Abnormal Psychology*. 2008; 117:414–419. [PubMed: 18489217]
- Grilo CM, Masheb RM. A randomized controlled comparison of guided self-help cognitive behavioral therapy and behavioral weight loss for binge eating disorder. *Behaviour Research and Therapy*. 2005; 43:1509–1525. [PubMed: 16159592]
- Grilo CM, Masheb RM, Wilson GT. A comparison of different methods for assessing the features of eating disorders in patients with binge eating disorder. *Journal of Consulting and Clinical Psychology*. 2001a; 69:317–22. [PubMed: 11393608]
- Grilo CM, Masheb RM, Wilson GT. Different methods for assessing the features of eating disorders in patients with binge eating disorder: a replication. *Obesity Research*. 2001b; 9:418–22. [PubMed: 11445665]
- Grilo CM, Masheb RM, White MA. Significance of overvaluation of shape/weight in binge eating disorder: comparative study with overweight and bulimia nervosa. *Obesity*. 2010; 18:499–504. [PubMed: 19713949]
- Grilo CM, Masheb RM, Wilson GT. Efficacy of cognitive behavioral therapy and fluoxetine for the treatment of binge eating disorder: a randomized double-blind placebo-controlled comparison. *Biological Psychiatry*. 2005; 57:301–309. [PubMed: 15691532]
- Hudson JI, Hiripi E, Pope HG, Kessler RC. The prevalence and correlates of eating disorders in the NCS Replication. *Biological Psychiatry*. 2007; 61:348–358. [PubMed: 16815322]
- Johnston L, Bulik CM, Anstiss V. Suppressing thoughts about chocolate. *International Journal of Eating Disorders*. 1999; 26(1):21–27. [PubMed: 10349580]
- Kemps E, Tiggemann M, Christianson R. Concurrent visuo-spatial processing reduces food cravings in prescribed weight-loss dieters. *Journal of Behavior Therapy and Experimental Psychiatry*. 2008; 39:177–186. [PubMed: 17470360]
- Kristeller JL, Hallett CB. An exploratory study of a meditation-based intervention for binge eating disorder. *Health Psychology*. 1999; 4(3):357–363.
- Lillis J, Hayes SC, Bunting K, Masuda A. Teaching acceptance and mindfulness to improve the lives of the obese: A preliminary test of a theoretical model. *Annals of Behavioral Medicine*. 2009; 37:58–69. [PubMed: 19252962]
- Mondy JM, Hay PJ, Rodger B, Owen C, Beaumont PJV. Validity of the Eating Disorder Examination-Questionnaire (EDE-Q) in screening for eating disorders in community samples. *Behaviour Research and Therapy*. 2004; 42:551–567. [PubMed: 15033501]
- Pop M, Miclea S, Hancu N. The role of thought suppression on eating-related cognitions and eating patterns. *The International Journal of Obesity and Related Metabolic Disorders*. 2004; 28:S222. Abstract.
- Puhl RM, Brownell KD. Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults. *Obesity*. 2006; 14:1802–1815. [PubMed: 17062811]
- Reas DL, Grilo CM. Review and meta-analysis of pharmacotherapy for binge-eating disorder. *Obesity*. 2008; 16:2024–2038. [PubMed: 19186327]
- Reas DL, Grilo CM, Masheb RM. Reliability of the Eating Disorder Examination-Questionnaire in patients with binge eating disorder. *Behavior Research & Therapy*. 2006; 44:43–51.
- Smart L, Wegner DM. Covering up what can't be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology*. 1999; 77:474–486. [PubMed: 10510504]
- Soetens B, Braet C. 'The weight of a thought': Food-related thought and suppression in obese and normal-weight youngsters. *Appetite*. 2006; 46:309–317. [PubMed: 16631278]
- Telch CF. Skills training treatment for adaptive affect regulation in a woman with binge-eating disorder. *International Journal of Eating Disorders*. 1997; 22:77–81. [PubMed: 9140739]

- Wegner DM. Ironic processes of mental control. *Psychological Review*. 1994; 101:34–52. [PubMed: 8121959]
- Wegner DM, Erber R. The hyperaccessibility of suppressed thoughts. *Journal of Personality and Social Psychology*. 1992; 63:903–912.
- Wegner DM, Zanakos S. Chronic thought suppression. *Journal of Personality*. 1994; 62:615–640.
- White MA, Masheb RM, Grilo CM. Accuracy of self-reported weight and height in binge eating disorder: Misreport is not related to psychological factors. *Obesity*. in press.
- Wilfley DE, Dohm F, Striegel-Moore RH, Fairburn CG. Bias in Binge Eating Disorder: How representative are recruited clinic samples? *Journal of Consulting and Clinical Psychology*. 2001; 69:283.
- Wilson GT, Grilo CM, Vitousek K. Psychological treatments for each disorders. *American Psychologist*. 2007; 62:199–216. [PubMed: 17469898]
- Wiser S, Telch CF. Dialectical behavior therapy for binge-eating disorder. *Journal of Clinical Psychology*. 1999; 55(6):755–768. [PubMed: 10445865]

Table 1

Means and Standard Deviations of Demographic and Clinical Variables.

	BED						NBO					
	Men n = 21			Women n = 39			Overall n = 60			Men n = 20		
	M	SD		M	SD		M	SD		M	SD	
Age	46.5	8.8		49.0	8.0		48.2	8.3		45.7	8.9	
BMI	39.0	6.8		39.8	6.5		39.5	6.5		36.5	6.8	
FTSI	38.3	13.7		45.0	13.0		42.7	13.5		22.6	8.9	
EDE-Q Global	3.3	0.8		3.7	0.9		3.5	0.9		2.3	0.9	
EDE-Q Restraint	2.2	1.7		2.3	1.5		2.3	1.5		2.1	1.3	
EDE-Q Eating Concerns	2.4	1.2		3.4	1.1		3.1	1.2		0.9	1.1	
EDE-Q Shape Concerns	4.5	0.8		4.7	1.0		4.6	0.9		3.3	1.4	
EDE-Q Weight Concerns	3.9	0.9		4.2	0.8		4.1	0.9		2.1	1.1	
OBEs ^b	15.5	9.5		14.4	7.3		14.8	8.1				
OBE days ^b	15.4	9.6		13.6	7.9		14.2	8.5				

Note: BED = Binge eating Disorder group. NBO = non-bingeing group. BMI = Body Mass Index. FTSI = Food Thought Suppression Inventory. EDE-Q = Eating Disorder Examination-Questionnaire. OBE = Objective Binge Episode.

Table 2

Correlations of Binge Eating and Eating Disorder Psychopathology with the Food Thought Suppression Inventory.

	Food Thought Suppression Inventory			
	BED ^a		NBO ^a	
	Men n = 21	Women n = 39	Men n = 20	Women n = 39
EDE-Q Global	0.41	0.19	0.22	0.24 [*]
EDE-Q Restraint	0.30	0.18	0.16	-0.08
EDE-Q Eating Concerns	0.59 ^{**}	0.18	0.05	0.49 ^{***}
EDE-Q Shape Concerns	0.02	0.11	0.21	0.30 ^{**}
EDE-Q Weight Concerns	0.16	0.15	0.07	0.29 [*]
OBEs ^b	-0.33 [†]	0.27 [*]	-	-
OBE days ^b	-0.36 [*]	0.22	-	-

Note:

^a = the FTSI was nonnormally distributed for BED women and NBO participants, therefore nonparametric kendall's tau-b were used for the FTSI and EDE-Q analyses. Pearson's r correlations were used for BED men's FTSI and EDE-Q analyses.

^b = due to significantly skewed and kurtotic data, log transformations were conducted for the OBE and OBE days data. As transformations did not completely address nonnormality, kendall's tau-b nonparametric analyses were used for FTSI and OBE analyses following transformations. BED = Binge Eating Disorder group. NBO = non-bingeing group. EDE-Q = Eating Disorder Examination-Questionnaire. OBE = Objective Bulimic Episode. OBE days = average number of weekly binge days in the past 6 months.

[†]
 $p = 0.05$,

^{*}
 $p < 0.01$,

^{**}
 $p < 0.01$,

^{***}
 $p < 0.001$.