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Achievement motivation profiles and coping styles of women with binge eating disorder. A study of a clinical sample of women in Poland

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Abstract

Introduction and Objective. Today, more and more people struggle with eating disorders. To be able to propose effective therapeutic and treatment interventions for these individuals, scholars need to gain a deeper understanding of the psychological factors that underlie eating disorders. The aim of the study was to determine whether women with binge eating disorder (BED) differed from healthy women in coping styles and achievement motivation.

Materials and Method A total of 86 adult women participated in the study: 43 women with BED and a comparison group of 43 women without an eating disorder (nED). The following instruments were used: Endler and Parker's Coping Inventory for Stressful Situations (CISS) and Schuler, Thornton, Frintrup and Prochaska's Achievement Motivation Inventory (*Leistungsmotivationsinventar,* LMI).

Results. Women with BED were found to predominantly use emotion-oriented coping strategies, while women with nED were more likely to use task-oriented and avoidance-oriented coping styles, in particular looking for social contacts and engaging in substitute activities. The two groups of women also had significantly different scores on the dimensions of Achievement Motivation. Women with BED scored lower than women with nED on as many as 12 LMI scales, and had lower total scores; the only scale on which they had higher scores than their healthy counterparts was Pride in Productivity.

Conclusions. Binge eating women differ from healthy women in both coping styles and the level of achievement motivation. Women who binge eat cannot cope effectively with high levels of stress and tend to respond to stressful situations with intense emotions, which may increase their need for compulsive overeating. They also have difficulty achieving goals and objectives.

Key words

binge eating disorder, achievement motivation**,** coping styles

INTRODUCTION

We live in a world with unlimited access to food, which means we can freely choose from a large assortment of food products available on the market. Food is a topic of social media discourse, face-to-face conversations, and advertisements, often becoming an inspiration for social gatherings, food fairs, and promotions in shops and restaurants. We can eat what we want, when we want, and as much as we want. We can eat when we are hungry, but also when we are at a meeting, when we are watching a film, when we are bored or when we are stressed-out. The consumption of food is not always motivated by the sensation of hunger. It is often an activity that people engage in to calm their emotions or establish social relationships.

Emotions play a particularly important role in shaping people's eating habits. The emotional aspect is associated with the formation of food preferences [1]. Nowadays, much attention is paid to the fact that the unlimited access to food, which, in general, is a boon, creates conditions in which individuals may lose control over eating, which in turn has an impact on their physical health, mental condition and day-to-day lives. It is estimated that the consumption and access to ultra-processed food may be a precursor to binge eating [2]. One study examined the frequency of selecting highly processed foods in a clinical sample of individuals with eating disorders. The estimated frequency of consuming highly processed foods was 69% among individuals diagnosed with BED and 72% among those suffering from bulimia. Furthermore, regardless of the diagnostic category, patients who reported binge-eating episodes, in 100% of cases consumed ultra-processed food, rich in carbohydrates and fats and low in protein [3].

Binge eating can become a way to enhance one's mood, cope with stress, distract oneself from negative emotions, or deal with a sense of insecurity [4, 5]. Likelihood of binge-eating episodes among adults experiencing food insecurity is 1.66 times higher than among food-secure adults [6].

Binge eating disorder (BED) is characterised by frequently recurring episodes of overeating, accompanied by a subjective sense of loss of control over eating. Individuals suffering

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from BED eat quickly, isolating themselves from others, and find it difficult to refrain from eating even when they are full. Uncontrolled consumption of large quantities of food is not associated with the sensation of hunger, and it generates high psychological costs, giving rise to guilt, shame, uneasiness, self-devaluation and general suffering associated with overeating. In addition, it is worth noting that for a person, the subjective benefits from overeating may be greater than the psychological losses they suffer. However, in the final balance, the strategy of coping with stress through emotions does not solve the problem, which generates further negative emotions and another binge episode.

The literature emphasizes that one of the most important known factors underlying BED is a deficiency in adaptive emotion regulation strategies and binge-eating episodes are considered as maladaptive strategies for coping with negative emotions (e.g., sadness, boredom, anxiety) and obtaining satisfying experiences [7, 2]. A central feature of a binge eating episode is the experience of having lost control over eating. Uncontrolled eating does not require social acceptance – individuals experiencing binge-eating episodes typically eat alone, which is also recognized as one of the diagnostic criteria for BED according to the DSM-5. At least three of the following symptoms are present during a binge eating episode: (a) eating much more rapidly than usual, (b) eating until feeling uncomfortably full, (c) eating large amounts of food despite not feeling physically hungry, (d) eating alone because of feeling embarrassed, (e) feeling disgusted with oneself, depressed and/or guilty during and/or after the episode [8]. These symptoms are not due to any medical condition or other mental disorder. They are also not caused by the impact of substance use on the central nervous system [9]. BED may be associated with weight gain and obesity, but it is important to note that there are also people with BED who have a normal body weight [10]. According to the latest data, BED currently affects about 1.5%–1.9% of women and 0.3% of men worldwide [11]. The overall prevalence of BED in the world population is 0.9% [12].

Previous research indicates that people who suffer from eating disorders have difficulty in effectively coping with stress and working towards achieving goals and success. Wiatrowska [13] has shown that women with eating disorders are much more likely to use emotion-oriented coping when compared to healthy individuals. Furthermore, the former rarely show a task-oriented mindset when it comes to dealing with stress. They are also more likely to engage in substitute activities in stressful situations, in contrast to healthy women who channel their actions towards seeking support. In the case of binge eating, focusing on food may help individuals 'escape' or temporarily detach themselves from negative experiences. People with BED report higher levels of stress on binge days [14, 15].

In people with eating disorders who consume food under the influence of emotions, the emotional component strongly affects the level of achievement motivation [13, 16]. Motivation is a mechanism that allows individuals to achieve goals, implement plans, fulfil aspirations, plan activities, start them and bring them to completion despite difficulties and disruptions. One type of motivation is that of achievement, which involves striving towards perfection and broadening one's skills [17]. An individual who is motivated to achieve makes an effort to reach or exceed a certain standard [18]. Studies on mental simulations in individuals with optimal body weight and those with overweight have shown that in the latter group, the effectiveness of a person's efforts largely depends on the way they think about themselves and their ability to deal with challenging situations [5, 19]. In the treatment of people with eating disorders, motivation is a key factor determining the success of the therapy and the patient's ability to cope with problems [20, 21]. However, the literature does not provide any data on achievement motivation or the relationship between achievement motivation and coping styles in people with BED.

OBJECTIVE

The aim of the study was to determine whether women with BED differed from healthy women in coping styles and achievement motivation. Additionally, correlations were searched for between coping styles (CISS) and achievement motivation (LMI) for these two groups of female participants. It was hypothesised that women with BED would be more likely to use emotion-oriented coping, whereas healthy women from the comparison group (nED) would be more likely to cope with stress in a task-oriented manner. It was also assumed that there would be differences in the level of achievement motivation between the two study groups, with BED women scoring lower on this variable.

MATERIALS AND METHOD

The survey was conducted in 2022–2023 in the Świętokrzyskie, Małopolskie and Lubelskie Provinces of south-eastern Poland. The participants were interviewed individually using the paper-and-penl approach. Women with BED were recruited from institutions providing health care services to people who meet the DSM-5 diagnostic criteria for eating disorders: members of Overeaters Anonymous support groups, patients undergoing pharmacological and therapeutic treatment, or individuals using mental health dietitian services. During recruitment, participants were informed about the ethical principles of the study. They were also advised of the purpose of the survey, that the participation was anonymous and voluntary, and that they could withdraw from the study at any time without consequences. After providing consent, the participants were given printouts of the test questionnaires, which they all completed in the same order. Instructions for completing the questionnaires were always provided at the top of the form. No time limit was specified. The approximate average time a participant took to fill in the survey forms was 45 minutes. The comparison group (nED) consisted of women without eating disorders. Women in the nED group were recruited outside healthcare facilities (at their workplaces) and declared that there would be no episode of BED, and represented half (N=43) of the total number of 86 adult female participants. The participants were aged between the ages of 20 – 52 years (M = 28.2, SD = 8.58). The women with eating disorders met the DSM-5 diagnostic criteria for BED [4]. The study received approval from the the Ethical Board for Scientific Research of the Institute of Psychology at Cardinal Stefan Wyszynski University in Warsaw, Poland (Approval No. RDpsy-U-02/ 2016).

The Polish adaptation of Endler and Parker's Coping Inventory for Stressful Situations (CISS) was developed by

Strelau et al. [22] and measures stress coping styles. The questionnaire consists of 48 items, rated by the respondent on a 5-point scale (from 1 'Not at all' to 5 'Very much'), based on how well they describe the participant's own attitude when feeling the tension of stress. Scores are computed for three scales: T – Task-Oriented Style, E – Emotion-Oriented Style, and A – Avoidance-Oriented Style. The last scale assesses two different types of avoidance responses: D – Distraction and SD – Social Diversion. Scores represent levels of usage of the particular coping styles. The CISS has norms for three age groups. The Polish adaptation of the inventory can be used to measure coping styles in people aged from 16 – 79 years. The questionnaire uses a sten scale. The CISS is characterised by high internal consistency (Cronbach's α coefficients ranging from 0.78 – 0.90), high stability (correlation coefficients ranging from 0.73 to 0.80), and factor validity [22].

The Polish adaptation of Schuler, Thornton, Frintrup and Prochaska's Achievement Motivation Inventory (LMI) was developed by Klinkosz and Sękowski [17]. The LMI measures various components of achievement motivation, yielding a comprehensive diagnosis of an individual's achievement motivation profile, and allows identification of the main aspects of achievement motivation in numerous areas of everyday life (work, study, etc.). The basic version of the LMI contains 170 items on 17 scales: Flexibility [FL], Fearlessness [FE], Preference for Difficult Tasks [PDT], Independence [IN], Confidence in Success [CS], Dominance [DO], Eagerness to Learn [EL], Goal Setting [GS], Compensatory Effort [CE], Status Orientation [SO], Flow [F], Pride in Productivity [PP], Engagement [EN], Competitiveness [CO], Internality [IN], Persistence [PE], and Self-Control [SC]. These scales are clustered into three dimensions (factor scales): Self-Assurance, Ambition, and Self-Control. The LMI items are rated on a Likert-type scale, from 1 'Does not concern me at all' to 7 'Fully concerns me'. Separate gender-based standard ten norms are available for four age groups. The instrument can be used in individuals aged 15 – 70 years. The LMI has an internal consistency (Cronbach's alpha) of 0.96 for the total score and shows good test-retest reliability. Factor analysis was used to determine the theoretical validity of the questionnaire [17].

Data were analysed statistically using IBM SPSS Statistics 26. None of the questionnaires used in the study has norms for clinical groups (Eating Disorders), which is why all statistical, quantitative and qualitative analyses were performed using raw scores. Descriptive statistics were calculated, and normality was tested using the Shapiro–Wilk test. The distributions of the variables in both groups were consistent with the normal distribution ($p>0.05$; skewness and kurtosis values for the LMI and CISS scales ranged from –0.84 – 0.56), which meant that parametric tests (Student's *t*-test and Pearson's *r* correlation) were applicable to the present data set [23].

Mean CISS and LMI scores were compared between BED and nED using Student's *t*-test. Next, correlations were obtained between stress coping styles (CISS) and achievement motivation (LMI) for the two study groups. The strength and direction of the relationships between these variables were determined using the Pearson *r*-coefficient [24]. For clarity of presentation (since there was a large number of data), tables only show statistically significant differences in CISS and LMI scores between groups (BED vs. nED), and statistically significant correlations between the CISS and LMI scales.

RESULTS

CISS scores The comparison of mean CISS scores using Student's *t*-test showed that women with nED scored statistically significantly higher than women with BED on Task-Oriented Style (T, $p<0.01$) and two subscales of Avoidance-Oriented Style: Distraction (D, $p<0.001$) and Social Diversion (SD, $p<0.001$). Women with BED scored higher on Emotion-Oriented Style (E, $p<0.001$) compared to their healthy counterparts. The effect sizes (Cohen's d) between groups for the individual scales were as follows: Distraction – very large, Emotions and Social Diversion – large, and Task – medium (Tab. 1).

Table 1. Differences in the Mean Values of coping with stress styles Variables Between the Binge Eating Disorder (BED) and No Eating Disorders (nED) Women's Samples (Student's *t*-test)

Variables	Group	M	SD	t(84)	p	Effect size d Cohen's
Task	BED	51.81	13.03	-3.013	< **0.01**	0.65
	nED	58.26	5.17			
Emotions	BED	58.30	8.99	6.185	< **0.001**	1.33
	nED	46.51	8.69			
Avoidance	BED	46.05	8.39	-1.580	0.118	-
	nED	49.05	9.20			
Social Diversion	BED	22.67	5.37	-9.828	< **0.001**	2.11
	nED	38.95	9.44			
Distraction	BED	14.86	4.77	-3.445	< **0.001**	0.74
	nED	17.81	2.97			

LMI scores. The scores on the individual dimensions of Achievement Motivation differed statistically significantly between the two groups of women surveyed (Tab. 2).

Compared to healthy participants, women with BED scored lower on as many as twelve LMI scales and had lower total LMI scores; the only scale on which they had higher scores was Pride in Productivity (PP, $p<0.001$). The effect sizes (Cohen's d) for the individual scales were as follows: a very large effect size for Flexibility (FL), Fearlessness (FE) and Status Orientation (SO), a small effect size for Pride in Productivity (PP), and strong effect sizes for the remaining nine scales and the total score. The Self-Confidence scores showed that the following competencies to achieve success were decidedly weaker in women with BED compared to those with nED: Flexibility (FL, $p<0.001$), Fearlessness (FE, $p<0.001$), Preference for Difficult Tasks (PDT, $p<0.001$), Confidence in Success (CS, $p<0.001$), Dominance (DO, $p<0.01$). As for the Ambition factor, women with BED scored significantly lower than women in the comparison group on the following scales: Eagerness to Learn (EL, $p<0.001$), Goal Setting (GS, $p<0.001$), Compensatory Effort (CE, $p<0.001$), Status Orientation (SO, $p<0.001$), and Competitiveness (CO, $p<0.001$); however, they had higher scores on Pride in Productivity (PP, $p<0.001$). Women with BED also scored lower on two Self-Control scales: Persistence (PE, $p<0.001$) and Self-Control (SC, $p<0.001$).

Analysis of correlations between CISS and LMI scores. Significant correlations were found between achievement motivation and stress coping styles. With a few exceptions, the following pattern was observed: Task-Oriented Style

Table 2. Differences in Mean Values of the Motivation of Achievements Variables Between the Binge Eating Disorder (BED) and No Eating Disorders (nED) Women's Samples (Student's *t*-test)

Variables		Group	M	SD	t(84)	p	Effect size d Cohen's
I: SELF-ASSURANCE	Flexibility	BED	39.28	10.10	-9.513	< **0.001**	2.05
		nED	55.30	4.48			
	Fearlessness	BED	27.56	10.60	-5.288	< **0.001**	2.04
		nED	43.05	16.02			
	Preference for difficulty	BED	39.00	13.01	-3.923	< **0.001**	0.98
		nED	47.81	6.91			
	Independence	BED	42.95	10.63	-1.864	0.066	-
		nED	46.63	7.36			
	Confidence in success	BED	40.77	12.06	-4.904	< **0.001**	0.98
		nED	52.51	10.06			
	Dominance	BED	41.30	13.59	-3.139	< **0.01**	0.68
		nED	49.65	10.92			
II: AMBITION	Eagerness to learn	BED	45.05	11.22	-3.950	< **0.001**	0.85
		nED	52.07	3.17			
	Goal setting	BED	43.00	12.21	-5.524	< **0.001**	1.19
		nED	53.81	3.95			
	Compensatory effort	BED	46.63	12.45	-5.970	< **0.001**	1.29
		nED	58.21	2.62			
	Status orientation	BED	47.35	10.80	-7.828	< **0.001**	1.69
		nED	60.51	2.21			
	Pride in productivity	BED	55.51	8.761	6.077	< **0.001**	0.25
		nED	40.07	14.17			
	Engagement	BED	42.91	14.40	0.921	0.360	-
		nED	40.07	14.17			
	Competitiveness	BED	43.05	10.57	-4.204	< **0.001**	0.91
		nED	50.67	5.47			
	Flow	BED	52.72	10.70	1.345	0.182	-
		nED	50.44	2.99			
III: SELF-CONTROL	Internality	BED	45.30	9.28	-1.882	0.063	-
		nED	48.35	5.15			
	Persistence	BED	35.95	10.25	-5.207	< **0.001**	1.12
		nED	48.33	11.73			
	Self-control	BED	40.30	11.06	-3.999	< **0.001**	0.86
		nED	49.67	10.67			
General score		BED	728.63	127.63	-4.717	< **0.001**	1.02
		nED	847.16	104.22			

$p < 0.05$; $p < 0.01$; $p < 0.001$

correlated positively with motivational competencies whereas the Emotion-Oriented Style correlated negatively with the LMI scales; however, of note, these associations were weaker and less numerous in the BED group (Tab. 3–5).

Task-oriented coping strategies, which involve finding a solution to a difficult situation, help to achieve one's goals (Task); herefore, learning them can be an effective tool in the psychoeducation of women with BED. It can be noticed that the inability to strive It can be noticed that the inability to strive Dwelling on emotions and wishful thinking, on the other hand, failed to relieve their emotional tension and had a demotivating effect (Emotions). Significant differences between the two groups of female participants were observed in the relationship between Achievement Motivation and Avoidance-Oriented Style (Avoidance). In women with BED, the LMI did not correlate with the CISS Avoidance scale or either of its subscales (Distraction and Social Diversion). It can be observed that in women with BED, the inability to control food intake is associated with a limited ability to refrain from experiencing stressful situations. In addition, they do not have_effective stress-reducing strategies, the ability to escape into positive thinking or social competencies that would allow them to engage in multiple interpersonal relationships in order to relieve negative emotions and Forgetting about stress is mental tension in the company of friendly people.

Standard scores on LMI and CISS in women with BED and nED. Since the LMI and the CISS have norms, it is both important and interesting to analyse the participants' scores by comparing them to standard scores. The norms for CISS, expressed on a sten scale, indicate that low scores correspond to values from 1 – 3, and high scores from 8 – 10. Women with BED scored low on Task-Oriented Style (Task, 3 sten) and high on Emotion-Oriented Style (Emotions, 9 sten). The interpretation of these data is vital for clinical diagnosis and can be helpful in psychological counselling. This pattern of scores may signify that women with BED do not cope effectively with high tension in task-oriented situations, to which they react with strong emotions. They also do not have the ability to take a task-oriented attitude in highly stressful circumstances, in which individuals are generally best guided by a task-oriented mindset.

The scores obtained by the women with BED are also not promising when it comes to their motivation to achieve intended goals. The norms for LMI indicate that the average score is 50 (+/-5). A low score is between 35 – 44, and a high score is between 56 – 64 sten [13]. In terms of the standard ten norms, women with BED had a low general motivation index (Total score = 43 tens), and those from the comparison group had a high one (Total score = 57 tens). The LMI scores of women with BED are highly consistent with the clinically observed pattern of eating disorder-related behaviours. Women with BED scored lower than women with nED on 12 LMI scales and had a higher score on only one LMI scale. The participants' score profile, based on the norms for adults, is especially suitable for interpreting those scores which, when expressed in tens, point to the strengths and weaknesses of the individuals surveyed, and those which are above and below the limits of the average score range (45 – 55 tens).

DISCUSSION

The results obtained demonstrate that women with BED predominantly use emotion-oriented coping, whereas women with nED are more likely to use task-oriented and avoidance-oriented coping styles, i.e. when under stress, the latter tend to resort to seeking social interactions and engage in substitute activities. These findings corroborate the hypothesis regarding coping styles in the women surveyed.

Women from the BED group, compared to control participants, were less likely to vent their stress by getting involved in alternative activities (such as watching films or podcasts, or escaping into the world of dreams and pleasant memories), which would allow them to distance

Table 3. Correlations ***r***-Pearson of results between LMI (factor I) and CISS scales of Binge Eating Disorder (BED) and No Eating Disorders (nED)

Variables	Binge Eating Disorder (BED)					No Eating Disorders (nED)				
I. SELF-ASSURANCE	*Task*	*Emotions*	*Avoidance*	*Social Diversion*	*Distraction*	*Task*	*Emotions*	*Avoidance*	*Social Diversion*	*Distraction*
Flexibility	0.35*	-0.43**				0.44**	-0.60**	-0.59**	-0.67**	-0.41**
Fearlessness	0.31*	-0.60**				0.65**	-0.89**	-0.85**	-0.75**	-0.75**
Preference for difficulty	0.31*					0.62**	-0.80**	-0.75**	-0.64**	-0.66**
Independence	0.38*					0.61**	-0.75**	-0.75**	-0.66**	-0.63**
Confidence in success	0.51**					0.61**	-0.83**	-0.80**	-0.71**	-0.67**
Dominance	0.49**					0.71**	-0.87**	-0.83**	-0.75**	-0.72**

** p < 0.01; * p < 0.05.

Table 4. Correlations ***r***-Pearson of results between LMI (factor II) and CISS scales of Binge Eating Disorder (BED) and No Eating Disorders (nED)

Variables	Binge Eating Disorder (BED)					No Eating Disorders (nED)				
II. AMBITION	*Task*	*Emotions*	*Avoidance*	*Social Diversion*	*Distraction*	*Task*	*Emotions*	*Avoidance*	*Social Diversion*	*Distraction*
Eagerness to learn			-0.30*							
Goal setting	0.35*					0.56**	-0.58**	-0.55**	-0.59**	-0.40**
Compensatory effort	0.65**						0.41**	0.39**	0.27	0.42**
Status orientation	0.31*									
Pride in productivity	0.42**					0.66**	-0.85**	-0.81**	-0.73**	-0.71**
Engagement	0.50**		-0.36*	-0.31*		0.66**	-0.85**	-0.81**	-0.73**	-0.71**
Competitiveness		0.32*				-0.61**	0.75**	0.76**	0.70**	0.62**
Flow	0.42**					-0.32*	0.55**	0.54**	0.41**	0.51**

** p < 0.01; * p < 0.05

Table 5. Correlations ***r***-Pearson of results between LMI (factor III) and CISS scales of the Binge Eating Disorder (BED) and No Eating Disorders (nED)

Variables	Binge Eating Disorder (BED)					No Eating Disorders (nED)				
III. SELF-CONTROL	*Task*	*Emotions*	*Avoidance*	*Social Diversion*	*Distraction*	*Task*	*Emotions*	*Avoidance*	*Social Diversion*	*Distraction*
Internality						0.58**	-0.81**	-0.77**	-0.72**	-0.64**
Persistence	0.34*	-0.37*				0.64**	-0.85**	-0.84**	-0.77**	-0.72**
Self-control	0.46**					0.67**	-0.82**	-0.82**	-0.75**	-0.66**
- ? -										
General score	0.55**					0.66**	-0.86**	-0.82**	-0.75**	-0.69**

* p < 0.05; ** p < 0.01

themselves from unpleasant situations and repress unsettling memories. Women who binge eat are also less likely to engage in social activities, either face-to-face or through social media, in order to forget about the stress they are experiencing. Female participants with BED, unlike women with nED, prefer focusing on unpleasant emotions (anger, guilt, tension) and the experience of going through them to taking specific action in order to test themselves in a difficult situation and cope with it. They may have a proclivity for wishful thinking and fantasising as ways of attenuating the emotional tension associated with the stressful situation they are facing. Concentration on their emotional response to a taxing situation may enhance their feeling of stress, increase tension and depressed mood, and inhibit the cognitive and behavioural processes involved in taking direct action, or refraining from it, which may translate into the women's inability to cope with compulsive overeating [4, 13, 15].

The present findings regarding achievement motivation, clearly show that women with BED are not fully competent to make any changes. They find it hard to cope with novel circumstances and new tasks, and their efforts are fraught with the risk of failure. They have difficulty adapting and overcoming obstacles (Flexibility). They fear being judged by others and anticipate the negative consequences of their own efforts, afraid they will most likely fail. They become nervous in difficult situations and before confronting important tasks, and find it hard to deal with new challenges. They are highly strung when working under time pressure, which may affect the outcome of their efforts. When faced with demanding tasks, they also tend to give up easily or try to lower the level of difficulty (Fearlessness) [13, 25].

The low scores on Preference for Difficult Tasks show that women from the clinical group avoid challenging tasks and minimise the risk when performing tasks that require high qualifications and competencies. What they find particularly challenging are tasks that are hard to grapple with. Memories of past failures and the obstacles standing in the way of achieving their goals quickly discourage them and hinder them from taking action. They lack optimism and the conviction that they can be successful and achieve their goals when carrying out new or demanding tasks. When difficulties arise or competition appears, they do not make use of their own competences and skills since they

lack confidence and self-trust (Confidence in Success). A low score on the Dominance scale indicates that women who binge eat tend to be influenced by others. They do not show initiative and prefer to take a secondary position in a group. Women with BED do not expect to get recognition for their achievements, and their activities are not career-focused. They do not want to perform important social roles or occupy leading positions in the social hierarchy. They do not strive to gain recognition, and their efforts are not oriented towards achieving success, receiving honours or earning recognition in the eyes of others (Status Orientation) [25, 26].

Low scores on the Persistence scale show that women with BED cannot effectively perform actions that require high energy and long-term commitment. Even small obstacles can thwart their efforts and dissuade them from achieving a positive outcome. They may succumb to defeatist thoughts ('doom and gloom' thinking) that manifest themselves as constant anticipation of a fiasco, and thus become easily discouraged by failures. They find it hard to force themselves to work systematically and concentrate on achieving long-term goals (Self-Control).

The very high Pride in Productivity score obtained by women with BED can be construed as the need to repeatedly experience feelings of success, to return to them, to be proud of one's own achievements and to think that, after all, one has managed to accomplish something. It can be hoped that these women do need success, and that even the smallest of their achievements have a positive meaning for them, since they can increase the women's ambitions and self-esteem as well as their belief in the effectiveness of their actions (Pride in Productivity). Still, their lack of ability to effectively cope with difficulties in a task-oriented manner and their low achievement motivation, position women with BED as passive and socially withdrawn [25, 27, 28]. The results obtained are consistent with those obtained by Wiatrowska, indicating relative stability in the pattern of overeating behaviour and health consequences over different time periods.

Limitations of the study and implications for further research. Although the present study fills an important gap in research on women with BED, it has some limitations that should be *considered. First of all, the small sample size (the study group included women who had been diagnosed with BED and were undergoing treatment) means that the conclusions from the present study cannot be straightforwardly generalised to all women with BED. Moreover, the sample consisted of female participants only since men constitute a small minority of BED patients, and the inabilaty to collect an equally large group of male participants with BED (only seven men were surveyed, and their results were not included in the statistical calculations).

CONCLUSIONS

The presented study indicates that women with BED differ from healthy women (nED) in both their preferred coping styles and achievement motivation. The existing literature offers no data on these relationships, yet they have important implications for developing effective therapeutic interventions and support services for women with BED. In this group of patients, successful recovery depends on their commitment to therapy and long-term work on controlling their eating behaviours and coping with situations that encourage compulsive eating. The effectiveness of these women's involvement in controlling their food consumption hinges on their ability to cope with stress, coping style, and motivation to achieve goals. Unfortunately, women with BED cannot efficiently cope with high tension and tend to respond to stressful situations with strong emotions, which may increase their need for compulsive overeating. Also, they are rarely guided by task-oriented strategies, which are known to help people deal with highly taxing situations. Their achievement motivation scores are also not optimistic as they demonstrate that these women have a limited capacity to achieve their goals.

As part of helping women with BED, it is worth considering therapy focused on developing strategies for coping and enhancing motivation to achieve goals. It cannot be excluded that difficulties in achieving goals result from their inadequacy in realizational capabilities, which may be influenced by personal or situational factors (e.g., a professional job in which it is difficult to meet the demands of, or partner expectations, or a sense of inadequacy in the parental role). Therefore, therapy should not be limited only to the issue of excessive consumption, but should also take into account the individual's different life situations and their effectiveness in achieving various goals.

It is hoped the present findings will contribute to increasing awareness of what, psychologically speaking, constitutes a problem for women with BED, and provide some guidance for designing interventions that can effectively help them cope with binge eating. Maintaining a healthy, balanced diet should be seen as a desirable and beneficial behaviour, especially when obesity is a key health problem in modern societies [29, 30].

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