Understanding and Recognizing Eating Disorders

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Roadmap

- Intersection of Eating Disorders and Cardiopulmonary Rehabilitation
- Recognizing and Understanding Binge Eating Disorder (BED)
- Treatment for BED
- Re-examining how to manage eating disorders in a CR environment.

Research

- Cardiopulmonary Rehabilitation and Obesity
- Obesity and Binge Eating Disorder (BED)
- 2004 study of 100 stable outpatients with coronary heart disease, 10% dx'ed with BED vs. 29% with depression, 29% with PTSD, 24% with GAD. Avg # of dx = 1.7. Bankier, 2004 PMID: 15385686
- 2012 study of 25 heart and 3 lung transplant in adolescent patients found 81% had measurable body weight dissatisfaction, but none reported engaging in eating disorder behaivors. Todd, L et al. 2012 PMID: 15385686

Eating Disorders → Cardiopulmonary Care

- AN and BN have significant cardiovascular complications
- arrhythmia related to a prolonged QTc interval (AN) electrolyte disorders (both AN and BN)
- hypotension
- bradycardia
- Structurally, the heart is atrophic
- hypovolemia
- refeeding syndrome - manifested by arrhythmia, tachycardia, congestive heart failure, and sudden cardiac death. Casiero D, Frishman WH. PMID: 16924163

Cardiopulmonary Care → Eating Disorders

- Focus of CR overlaps with ED focus
  - Exercise
  - Nutrition
  - Healthy food choices/life styles
  - Weight loss
- Even if the goal is balance, people often hear extreme black/white or all/nothing messages, especially with weight loss.
- Health anxiety → somatic surveillance →obsessive body focus.
- Chronic health issues associated with poor body image.

Cardiopulmonary Care and Binge Eating Disorder

- Cardiopulmonary health centers around healthy weight and eating practices.
- Obesity occurs *independently* of BED, but

  obese inds w/ BED
  - consume more calories
  - greater functional impairment,
  - Lower reported quality of life
  - more subjective distress & psych comorbidity

  than obese individuals without BED.
- Outcomes with bariatric surgery are significantly worse if the patient has undiagnosed or untreated BED.

Binge Eating Disorder

A. Recurrent episodes of binge eating (Subjective vs Objective binges)
B. Binge eating episodes are associated with three (or more) of the following
    1. Eating much more rapidly than normal.
    2. Eating until feeling uncomfortably full.
    3. Eating large amounts of food when not hungry.
    4. Eating alone because of embarrassment.
    5. Feeling disgusted, depressed, or very guilty after overeating.

C. Marked distress regarding binge.
D. At least once a week for 3 months.
E. No compensatory behavior.

Course of BED

- **Typical onset** = adolescence or young adulthood
- **Binge eating then dieting** (in contrast to BN)
- **Most common antecedent** is negative affect.
  - **Other triggers**
    - Interpersonal stressors
    - Dietary restraint
    - Negative feelings related to body weight, shape, and food
    - Boredom
    - Stress
- **BED tx-seekers typically older** than BN or AN
- **Outcome better** than for AN or BN but course similar to B_N

Functional Consequences

- Social role adjustment problems
- Impaired HRQOL and life satisfaction
- Increased medical morbidity and mortality
- Increased health care utilization compared w/ BMI-matched controls
- Increased risk for weight gain and obesity

Medical Complications

- type 2 diabetes
- high blood pressure
- high blood cholesterol
- gallbladder disease
- heart disease
- certain types of cancer

- joint and muscle pain
- gastrointestinal problems
- sleep apnea
- osteoarthritis
- dental issues (periodontal disease, active decay)
- headaches

Night Eating Syndrome

DSM V and Research Criteria

I. Increased intake in evening and/or nighttime **(night eating)**:
   A. ≥ 25% of daily intake after evening meal **(evening hyperphagia)**
   B. ≥ 2 nocturnal ingestions food/week **(nocturnal ingestions)**

II. Awareness/recall of evening/nocturnal eating episodes

III. Clinical picture: 3+
   A. Lack of desire eat to eat in AM and/or breakfast omitted on 4+ mornings/wk **(morning anorexia)**
   B. Strong **urge to eat** between dinner & bedtime and/or during night
   C. Insomnia 4+ nights/wk **(sleep disturbance)**
   D. Belief that one needs to eat to get to sleep
   E. Mood frequently **depressed** and/or worsens at night

IV. Distress/impairment in functioning

V. 3+ mos duration

VI. Not secondary to substance abuse or dependence, GMC, treatment, or other psychiatric disorder. Not better accounted for by BED.

78% of providers do NOT know ~ night eating syndrome

61% fail to provide treatment

Clinical Interview

24 hour diet recall

Example binges (objective binge episodes and subjective binge episodes)

-planned binges may count

Best Screening Questions:

"Do you have times where you feel like your eating is out of control?

"Do you wake up from sleep and eat?" "Do you feel the need to eat in order to go back to sleep?"

Self-report Questionnaire

EDE-Q

NEQ

***Referral to sleep disorder specialist (NES symptoms)*

Understanding Eating

Why we Eat

- Hungry/need calories
- Enjoy eating
- Bored
- Frustrated
- As a substitute for sex/love
- Stress
- To meet other needs
- To numb or escape

What food means to us

- We spend our whole lives making connections between food and feelings.
- Every individual is different in that way, so we each have to do some soul searching to answer this question.

Body

Hungry
Empty
Unsatisfied
Hollow
Starved

EAT

Emotions

Hungry
Empty
Unsatisfied
Hollow
Starved

?

Case Example

What causes Eating Disorders

Genes

Temperament and Personality

Biological Substrates

Socio-cultural factors

Vulnerability

Stressors

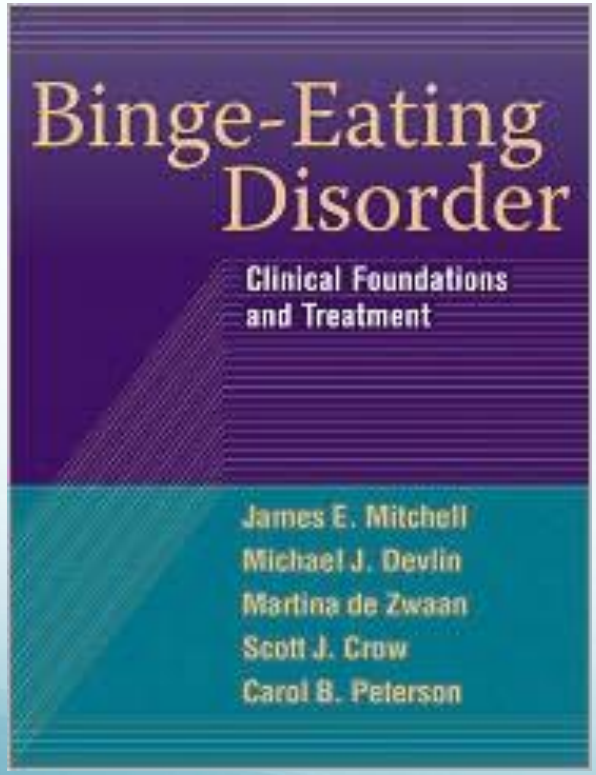
Puberty

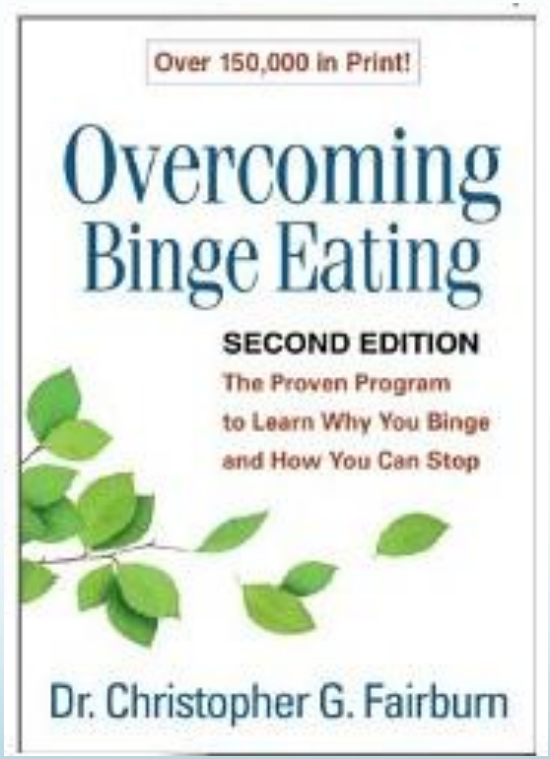
Family

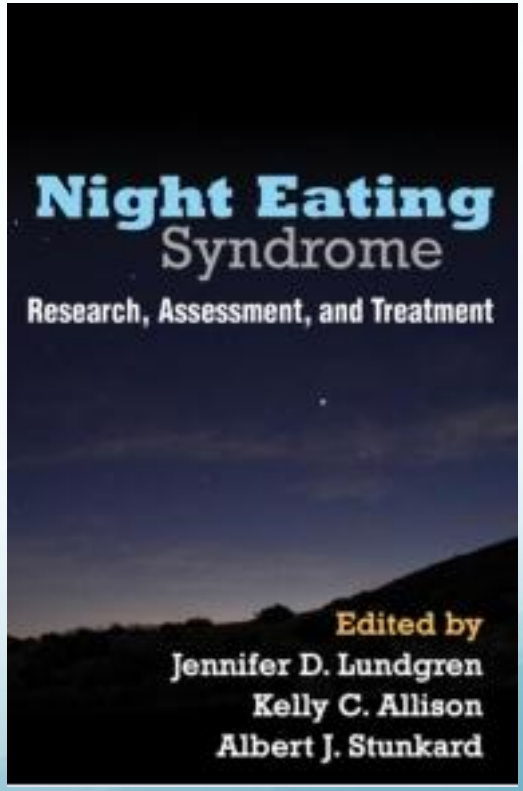
EATING DISORDER


genes load
the gun,
the environment
pulls the trigger.

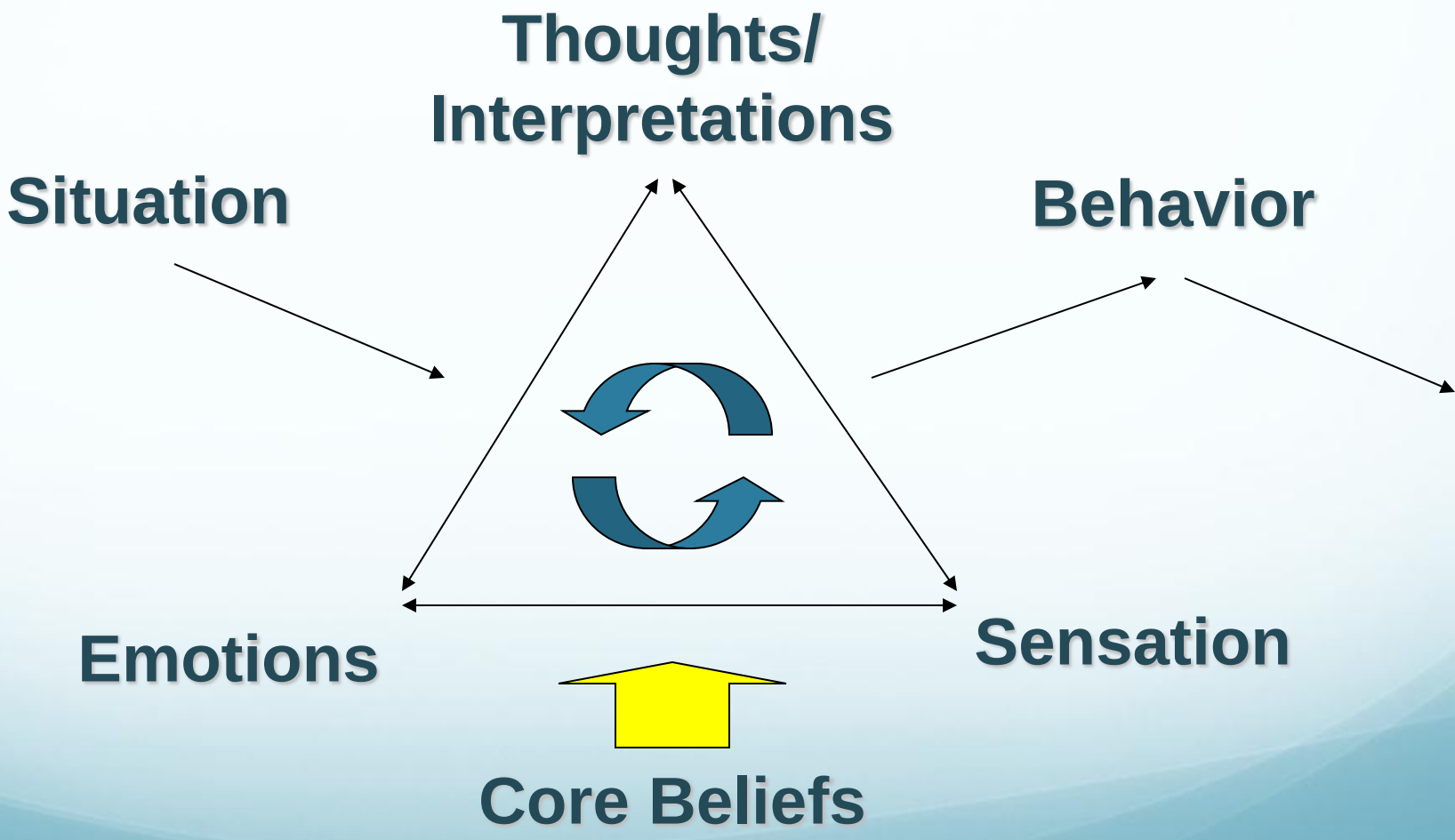
Treatment


Binge-Eating Disorder
Clinical Foundations and Treatment
James E. Mitchell
Michael J. Devlin
Martina de Zwaan
Scott J. Crow
Carol B. Peterson

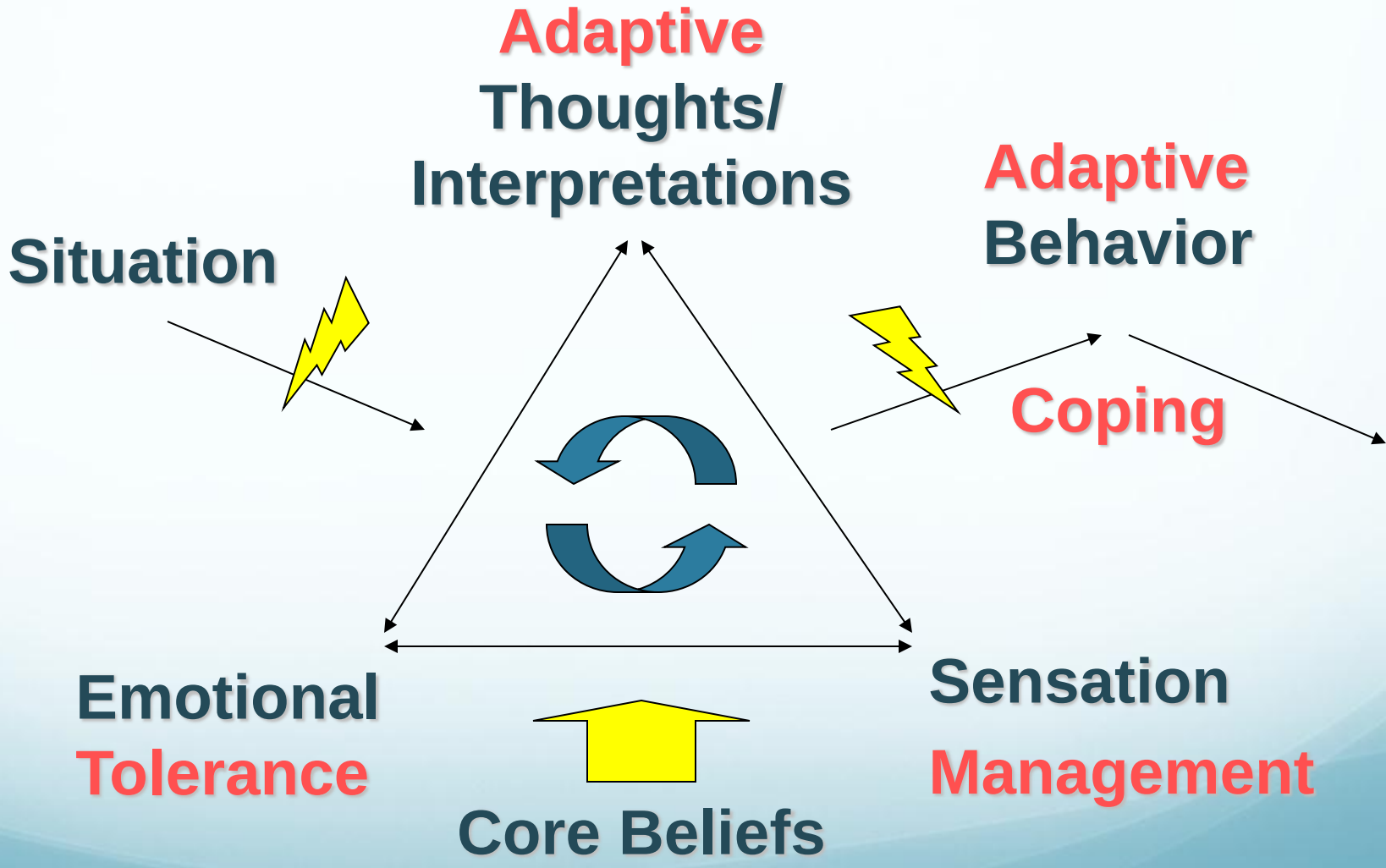

Over 150,000 in Print!
Overcoming Binge Eating
SECOND EDITION
The Proven Program to Learn Why You Binge and How You Can Stop
Dr. Christopher G. Fairburn


Night Eating Syndrome
Research, Assessment, and Treatment
Edited by
Jennifer D. Lundgren
Kelly C. Allison
Albert J. Stunkard

Basic Cognitive Behavioral Model



Points for Intervention



Treatment: Therapy

- **Cognitive Behavioral Therapy (CBT)**
  - CBT Guided Self-Help (CBTgsh)
- **Interpersonal Psychotherapy (IPT)**
- **Behavioral Weight Loss**

Adjunct? (NES)

- Progressive Muscle Relaxation
- Bright light therapy

Weight loss as an outcome?

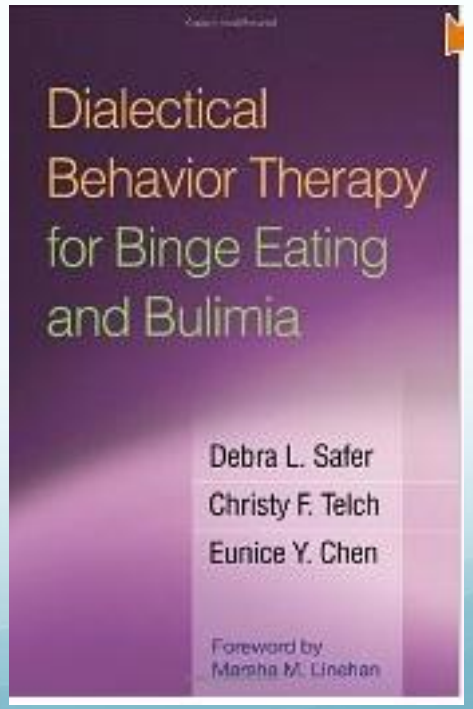
- Weight loss not the focus
  - seen as outcome of healthy lifestyle change
  - deferred until binge eating is under some control
- Accepting larger-than-average body size

Treatment Targets

- Address chaotic eating patterns
  - regular meals and snacks (adding breakfast crucial)
  - Promote moderate restraint (BED)
  - Reduce night snacking (NES)
- Target behaviors: binge eating, night eating, picking & nibbling, restriction, dieting
  - Self-monitoring (flexible but consistent pattern of eating; no calorie counting)
  - Behavioral techniques
  - Cognitive restructuring

Treatment Targets

- Encourage use of healthier behaviors
  - Psychoeducation about exercise
  - Stress management
  - Distress tolerance
  - Emotion regulation
  - Sleep hygiene (NES)



Treatment Targets

- Restructure maladaptive thoughts related to eating, shape, and weight *(and sleep in NES)*
- Loosen connection between self-esteem (SE) and body weight/shape
- Find other sources of support for SE

CBTgsh

- Low cost and require minimal specialist care
- Best for patients with low level pathology
- Patients use self-help manual, “Overcoming Binge Eating” by Christopher Fairburn, as well as have regular, brief meetings with therapist.
- Similar to CBT – targets binge eating by promoting regular eating patterns and moderate dietary restraint through SM and problem-solving strategies.
- Therapist role:
  - Encourage adherence to manual
  - Aid in goal development
  - Provide rationale for CBTgsh

- CBTgsh has superior outcomes to wait-list control, TAU, and guided self help BWL; produces similar outcomes to IPT for individuals with low pathology.

How can I help in my practice?

- Provide therapy with a trained therapist on staff or support retraining of existing staff in BED treatment
- Support, direct, and refer patients for treatment

So why Am I Eating?

- Pay attention to your thoughts and feelings when eating
  Mood Food Logs
- Stay in the moment
  Mindfulness
- Be a spectator/commentator

Emotional eating quiz

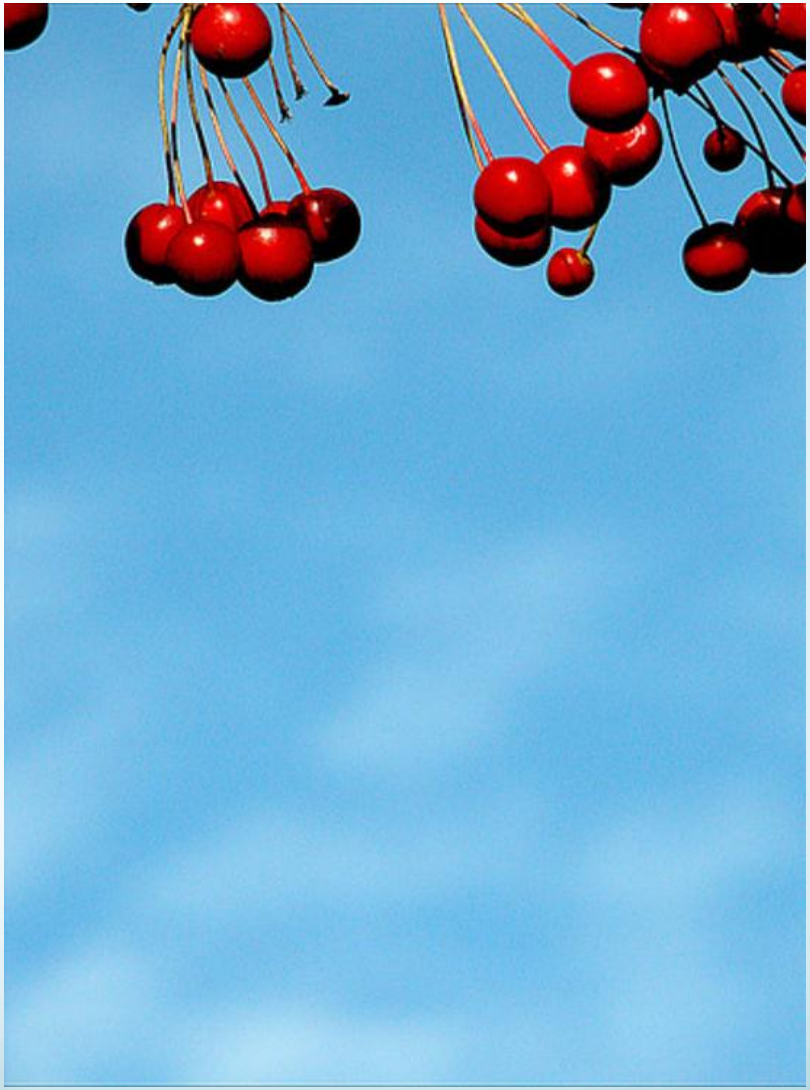
- Do I eat when I come home from work?
- Do I eat when I get into an argument with a specific person?
- Do I eat at certain times of the day, or when I feel rushed?
- Do I eat standing up and/or right out of the package?
- I like to eat when I'm anxious, upset, lonely, or depressed.

Keep a mood food journal

Whenever you eat an unplanned snack or a meal make a note of when you ate, what you ate, where you ate, who you ate with, and how you were feeling at the time you ate.

Low Hanging Fruit

- Eat only at the table
- Make a plate, put the rest away, get seconds if you want a second plate
- Don’t go more than 4 hours without eating
- Do not have taboo foods
- Eat non-comfort foods too

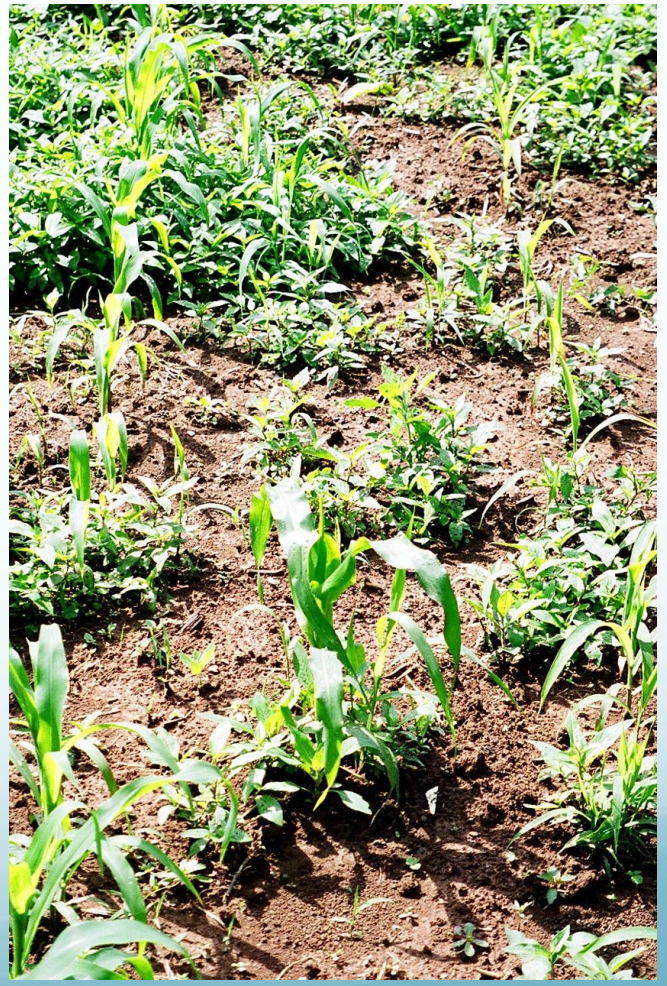


Other ways to nurture yourself

- Use all five sense to soothe
- Go for a short walk.
- Listen to your favorite song.
- Read for 15 minutes.
- Take a shower.
- Play a video game.
- Garden.
- Talk to a friend on the phone

Fertile Ground For Negative mood

- Physical discomfort
- Tired
- Not enough/too much exercise
- Poor nutrition
- Drugs and alcohol
- Not taking/taking wrong medication




STUCK?

UNC Eating Disorder Program

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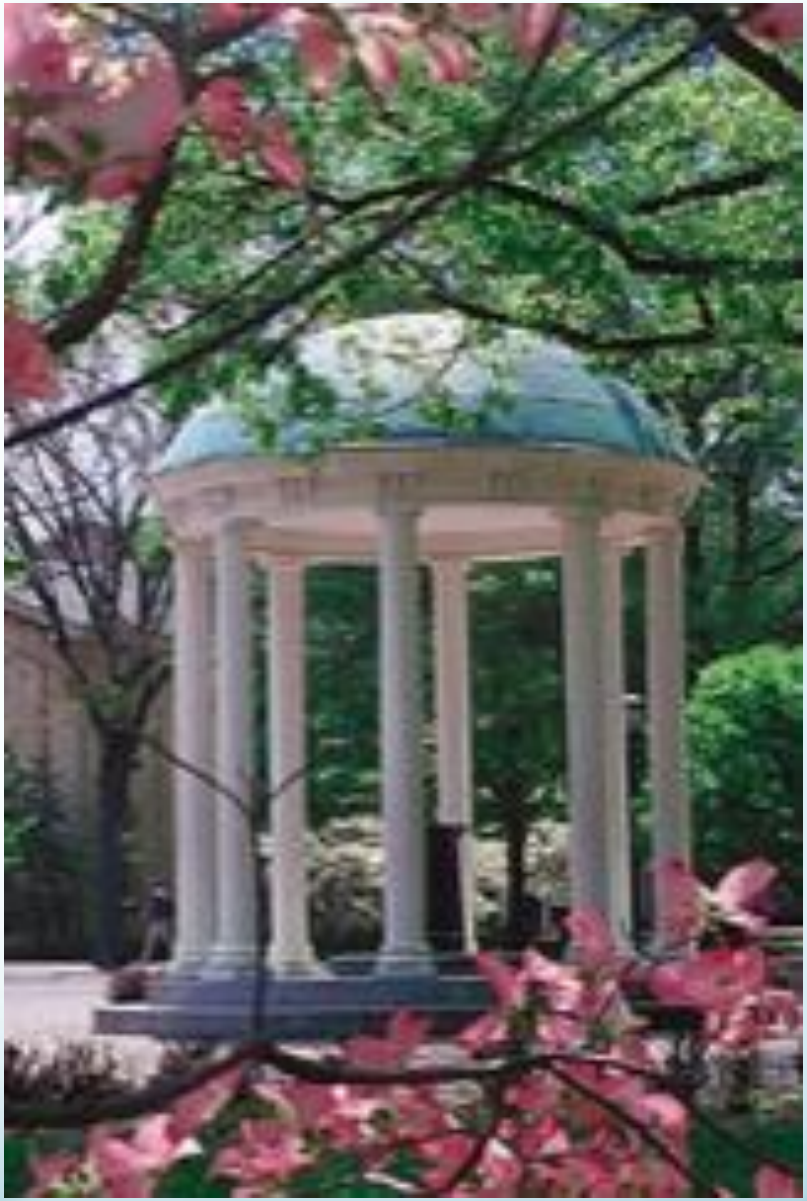

- Assessment/Treatment:
- 919-966-7012