Binge Eating Disorder
The Professional and Individual Perspective
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What is Binge Eating Disorder?

• Recurrent episodes (at least once per week for three months) of binge eating characterized by:
  – eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
  – a sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control what or how much one is eating)
What is Binge Eating Disorder?

• The binge-eating episodes are associated with three (or more) of the following:
  – eating much more rapidly than normal
  – eating until feeling uncomfortably full
  – eating large amounts of food when not feeling physically hungry
  – eating alone because of feeling embarrassed by how much one is eating
  – feeling disgusted with oneself, depressed, or very guilty afterwards
• Marked distress regarding binge eating is present.
• The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course another eating disorder.
Binge Eating Disorder (BED)

• Prevalence:
  – 1% of children and adolescents
  – 2.5 – 5.5% of adults

• Later average age of onset than other eating disorders (EDs)

• More prevalent in males than other EDs

• Equal prevalence across races/ethnicities
Why BED Matters

• The most common eating disorder (ED)
• High rates of comorbidity with other psychiatric disorders
• Associated with
  – Significant functional impairments
  – Decreased quality of life
  – Medical complications
  – Higher utilization of healthcare
BED Facts

• Often mis- or un-diagnosed
• Patient is often blamed for their disorder
• BED is NOT the same as just overeating
• BED occurs in people of all sizes
  – Normal-weight (19%)
  – Overweight (36%)
  – Obese (45%)
Most people in the “overweight” and “obese” BMI categories do not have Binge Eating Disorder.

A substantial number of people with Binge Eating Disorder are in the “normal” BMI range.
What Causes BED?

• Etiology is multifactorial
  – Genetic
  – Neuro-Biological
    • Impulsivity and reward centers
    • Dopamine, opiates
  – Environmental
    • Trauma
  – Personality/temperamental vulnerabilities
• Significantly heritable
Risk Factors

- Dieting
- Neuropsychological and personality traits
  - perfectionism, high harm avoidance, impulsivity
- Early puberty
- Co-morbidity
  - mood disorders, anxiety/OCD, ADD
- Trauma, abuse or neglect
- High BMI
- Bullying, teasing, weight stigma
- History of significant weight changes
- Substance abuse
Weight Stigma and Shame

WARNING

FAT PREVENTION BEGINS AT HOME.
AND THE BUFFET LINE.

WARNING

IT'S HARD TO BE A LITTLE GIRL
IF YOU'RE NOT.
Common Comorbidities

- Medical:
  - Polycystic Ovarian Syndrome
  - Hypothyroidism
  - Cushing’s Syndrome
  - Sleep Apnea
  - Asthma
  - Nutritional Deficiencies
  - Sleep Deprivation

- Psychiatric:
  - Depression
  - Anxiety
  - Attention Deficit Disorder
  - Substance Abuse
  - Post-traumatic Stress Disorder
Treatment for BED

• There are treatments available
• Treatment options do **NOT** include dieting
• Weight loss is **NOT** the primary goal
• Recovery is possible
• Multidisciplinary treatment is best
  – Psychotherapy
  – Education
  – Nutrition counseling
  – Medical and psychiatric evaluation

www.bedaonline.com
Current Medications for BED

• **NOT** the first line recommendations for any eating disorder, including BED
• Limited research on medication and not FDA approved for BED
  – Few randomized controlled trials
  – Small studies
  – Difficult to recruit
  – High rates of attrition
Future Medications for BED

Stimulants

– In review at FDA
– Show reduction of binge episodes
– Adjunct to psychological therapy
Psychopharmacology of Eating Disorders

- SSRIs
- Naloxone
- Baclofen
- Topamax
- Psychostimulants
What About Bariatric Surgery?

- Per the American College of Physicians:
  - "Surgery should be considered as a treatment option for patients with a BMI of 40 kg/m² or greater who instituted but failed an adequate exercise and diet program (with or without adjunctive drug therapy) and who present with obesity-related co-morbid conditions, such as hypertension, impaired glucose tolerance, diabetes mellitus, hyperlipidemia, and obstructive sleep apnea."
What is Bariatric Surgery?

• Reduces the size of the stomach by constriction, removal/re-routing of a portion of the stomach and/or small intestine
Common Complications

- Failure to lose weight
- Regaining of lost weight
- Surgical complications
- Need for reoperation
- Gallbladder disease
- Malabsorption and malnutrition
- Electrolyte abnormalities
- Chronic diarrhea
- Dumping syndrome
- Bowel obstructions
- Eating disorders
In Theory, Bariatric Surgery “Cures”…

- Hypertension
- Hypercholesterolemia
- Type 2 Diabetes
- Sleep apnea
- Low self esteem
- High risk of cancer
- Cardiovascular disease risk
However…

• Bariatric surgery cannot treat psychological aspects of overeating or binge eating
  – Depression, anxiety, shame, self control, impulsivity, difficultly coping with stress, personal trauma, relationship issues, or eating disorders
EDs and Bariatric Surgery

- 50-70% have a history of an eating disorder
- Half have BED
- 30% develop bulimia nervosa post-surgery
Take Home Points on BED

• Serious biologically based mental illness
• BED is treatable
• BED patients come in all shapes and sizes
• Weight loss diets are contraindicated in BED
The “Lived Experience” of BED

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Complexities of BED

- BED is NEVER about willpower!
- BED ALWAYS makes sense: What is the function or purpose of the disorder?
- Causes are complex and unique to each person
Chevese Turner
BED Journey

• Unmet need impacting 9 million lives
• Severely unrecognized and undertreated
  – 83% undiagnosed
  – 7% of diagnosed receive treatment – usually focus on weight and not eating disorder
• Lack of diagnosis and focus on weight in healthcare community further entrenches the eating disorder

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BED Journey Overview

- Family history of eating disorders/substance abuse/trauma/mood disorders
- Experienced size bias, body-hatred, teasing around height and weight at early age
- Early anxiety & depression
- Feelings of being outsider…retreated to food as comfort.
- Restriction and “managed dieting” encouraged early
- Eating disorder took center stage and contributed to delay in adult development
BED Journey Overview

• Preoccupation around weight loss (life begins “x” pounds from now)
• With each binge or diet, sense of failure increased and willingness to engage in life decreased
• Learned that acceptance is first step to wellness and recovery
• Addressing psychological issues, including internalized weight stigma and trauma absolutely necessary
Weight Stigma
Risk Factor

Where it happens
- Families
- Healthcare providers
- Schools
- Athletic Programs
- Work Environment

What it looks like
- Bullying
- Teasing
- Repeated expressions of concern about size as death sentence
- Lower wages than thin counterparts
- Encouragement of extreme weight loss (Biggest Loser)
- Overt & covert expression of disgust of larger bodies through advertising, comedy, etc

Puhl, et al. 2007
Health Consequences

Weight Stigma results in maladaptive eating behaviors:

- Binge eating
- Unhealthy weight control practices
- Coping with stigma by eating more food

Haines, et al., 2006; Neumark-Sztainer et al., 2002; Puhl & Brownell, 2006, Puhl et al., 2007; Puhl & Luedicke, 2011
Health Consequences

Contributes to Higher Weights:

- Higher calorie intake
- More weight gain
- Avoidance of movement
- Increase in cardiovascular problems
- Poor quality of life

Schvey, Puhl, & Brownell, 2011; Carels et al, 2009; Wott & Carels, 2010
Complexities Amongst Sufferers

- Similarities amongst BED population, but not homogeneous.

- Bio-psycho-social disorder that is complicated and never straightforward.

- There are many nuances fueled by things like biology, the type of triggers, age of onset, family systems, and so on.
My History

- Family history of substance abuse, eating disorders, and “fear of fat.”
- Encouraged to diet very early and my weight focus of family.
- Food “good” or “bad” and mood determined by this perception.
My History

• Family concern resulted in physician diets, diet pills, weighing daily, and monitoring of food by parents.

• Guilt and shame resulting in early depressive episodes and inability to function.
My History

• Began to steal and hide food by age 5 and regular secret eating began by age 8.

• Began to use alcohol in teens, but food was always preferred as the method to dissociate and reduce anxiety.
My History

- Weight always focus of what was “wrong.”
- Engaged in many weight management programs to lose weight which was always temporary and fed sense of failure in self.
My History

- Eating disorder treatment identified underlying issues
- Treatment was good step toward recovery, but community and acceptance of body shape and size was final step in living a whole life.
My History

- Years wasted focusing on pursuit of weight loss
- Refocus on stability and health promoting behaviors that are sustainable mentally and physically
First Responders: Do No Harm

- Assessment for relationship with body and food
- Recognize symptoms of BED; do not assume always in higher weight bodies
- Shame contributes to higher weight bodies (Puhl, et al)
- Referral to eating disorder specialist
- Collaboration between primary care and eating disorder team
THANK YOU

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