Binge Eating Disorder

Case Studies

Handout

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EAT LOVE LIVE

ein: education in nutrition

Learning Objectives

- Understand the diagnostic criteria of Binge Eating Disorder (BED) and aetiology.
- Appreciate the current best practice management for BED.
- Understand the dietetic management of BED.

Binge Eating Disorder

Definition:

DSM-5 Diagnostic Criteria for Binge Eating Disorder

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    - Eating, in a discrete period of time (for example, within any two-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)
- 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 occurs, on average, at least once a week for three months.
- 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 of anorexia nervosa, bulimia nervosa, or avoidant/restrictive food intake disorder.

It is extremely important to note that weight or appearance is not part of the diagnostic criteria for binge eating disorder.

Aetiology BED

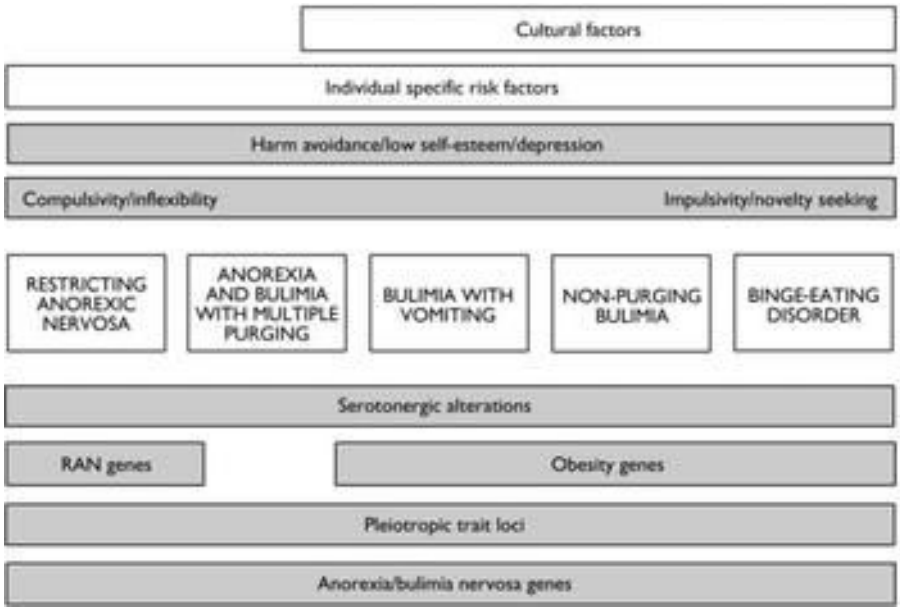
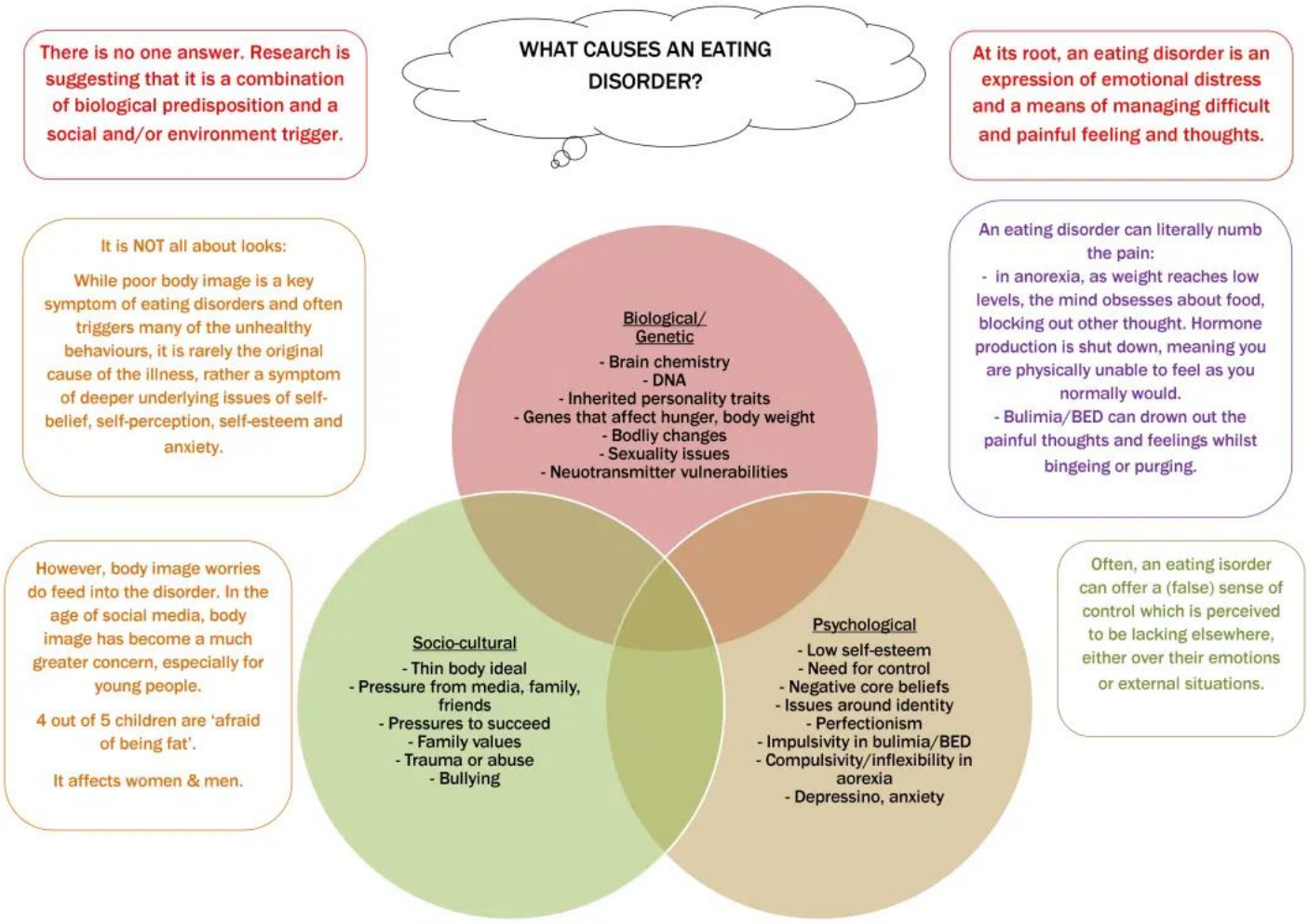


Fig. 1 Empirical structure of eating disorder.Cultural factors include pervasive factors such as diet and Empirical structure of eating disorder.Cultural factors include pervasive factors such as diet and cultural attitudes to weight and shape. Cognitive style and personality are influenced by both genes and cultural attitudes to weight and shape.Cognitive style and personality are influenced by both genes and environment. Correlations exist between biological factors (serotonin function), environment (adverse environment.Correlations exist between biological factors (serotonin function), environment (adverse childhood experiences), personality (e.g. impulsivity) and affect. All of these factors are influenced and childhood experiences), personality (e.g. impulsivity) and affect. All of these factors are influenced and mediated by genes. RAN, restricting anorexia nervosa.

Collier and Treasure (2004)



https://talkingeds.co.uk/2019/02/27/eating-disorder-awareness-week-2019/

Diagnosis

- GP
- Mental Health Practitioner
- EDE-Q: https://insideoutinstitute.org.au/assessment?started=true
- Binge eating disorders screener-7:https://insideoutinstitute.org.au/assets/binge%20eating%20disorder%20screener%20beds-7.pdf
- Binge eating scale

Prevalence In Australia

Eating disorders and disordered eating together are estimated to affect over 16% of the Australian population.

Anorexia nervosa and bulimia nervosa each occur in below 1% of the general population.

Binge eating disorders (BED) and other specified feeding or eating disorders (OSFED) are the most common eating disorders, affecting **approximately 6%** and 5%, respectively.

BED is the most common eating disorder in males.

BED is under recognised and undertreated.

4 out of 5 adults with a lifetime prevalence of BED have at least 1 co morbid psychiatric condition. Most commonly mood, anxiety and substance abuse.

https://www.nedc.com.au/

Guerdjikvoa et al (2019)

Clients

	Suzy	**Mia**
	28 years old, on DSP, Lives with mother and stepfather Supportive family	20 year old university student Lives with supportive family PT work

Past History	Significant Trauma in childhood BPD PTSD Depression OCD Chronic self harm and suicidality Long term psychiatric management and 2-3 psychiatric admission per year Multiple psychiatric medication In past year- prior to initial assessment weekly psychiatric session and no admissions for 11 months Admission to Private Hospital Binge Eating Disorder Program - positive experience	Nil medical issues Nil diagnosed psychological issues

Physical	PCOS Tachycardia Asthma Higher weight body HBA1C within normal range, elevated cholesterol Genetic Cardiac issue under investigation -Nill correspondence Specialist	Decreased 20 % BW in 12 months Some weight restoration already occured Nil Body dysmorphia present
Activity	Inactive at commencement of treatment - social avoidance. Fear of abuse. Over 12 months support started walking and swimming at a local pool with support of NDIS workers and then alone.	Over 12 months prior was obsessive 2 hours per day Has improved this to walking 30 min 5-6 times week and weight training at home 3-4 times week approx. 30 min
Team	Gp, Cardiologist, Psychiatrist, NDIS support worker, inpatient psychiatric team for admission Psychologist, gynaecologist (menstruation significant PTSD trigger)	Gp Looking for psychologist

Frequency for visits	12 sessions over 18 months Returns for review when needed	2- 4 weekly 5 sessions over 6 months to date
Diet histories and behaviours	In significantly higher weight body Weight stigma experienced in health care settings, family, and public Insightful and able to discuss body weight and experiences Related to past abuse and PTSD- feels safe and protected in larger body Family weight centric and focused on dieting Restricts pleasurable and healthy foods as self harm Binge eating as self harm	Commenced restricted intake 12 months ago with goal of being healthier. Information from the internet. Strong focus on weight and health within the family and conflation of the two. Nil awareness body shape size until aged 17/18 when started using social media

Eating Pattern at presentation	Irregular meals during the day Regular dinner with family Frequent binge eating during day or night Inadequate intake macro nutrients Avoidance Fun foods: take away, sweets, cake choc lollies etc	Regular small meals Avoiding Grains and carbohydrates Limited intake fun foods Inadequate fat, dairy Protein ok Binge 2-3 times week (evenings) decreased to 1 week recently

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Evidence based treatment

Psychoeducation

Psychotherapy (+/ - self help tools):

- Cognitive behavioural therapy (CBT) * Strongest evidence
-Interpersonal therapy
- Weak evidence requiring more research: including dialectical behaviour therapy (DBT), schema therapy (ST), acceptance and commitment therapy (ACT), mindfulness-based interventions (MBI), and compassion-focused therapy (CFT).

Pharmacotherapy

-Antidepressant, anti anxiety, antiepileptic, and attention deficit/ hyperactivity (ADHD) disorder drugs
- lisdexamfetamine dimesylate (LDX) approved for treatment BED in the USA.
6% of users have adverse side effects including decreased appetite, insomnia, dry mouth, diarrhea, nausea anxiety, anorexia, feeling jittery, agitation, increased blood pressure, hyperhidrosis, restlessness and decreased weight.

Multidisciplinary team
GP, Mental health clinician, Dietitian, Psychiatrist

Outcomes from systematic reviews cited are decreased incidence binge eating episodes; increased QOL; no impact on weight.

Guerdjikvoa et al (2019), Hilbert et al (2019), Brownley et al (2007), Linardon et al (2017)

Considerations

BED is under recognised and undertreated.

The binge eating behaviour is often overlooked and treatment commonly focused on weight and complications rather than addressing the core eating psychopathology.

Focusing on weight can perpetuate the cycle of binge eating.

Dietetic management

Assessment

-Risk management
-Team
-Discuss options moving forward. Explain what management will look like moving forward. Seek consent. Review prefered language around food and body. Check in and seek consent to move forward throughout sessions.

https://nedc.com.au/assets/NEDC-Resources/NEDC-and-DAA-Eating-Disorders-and-the-Dietitian-Decision-Making-Tool.pdf

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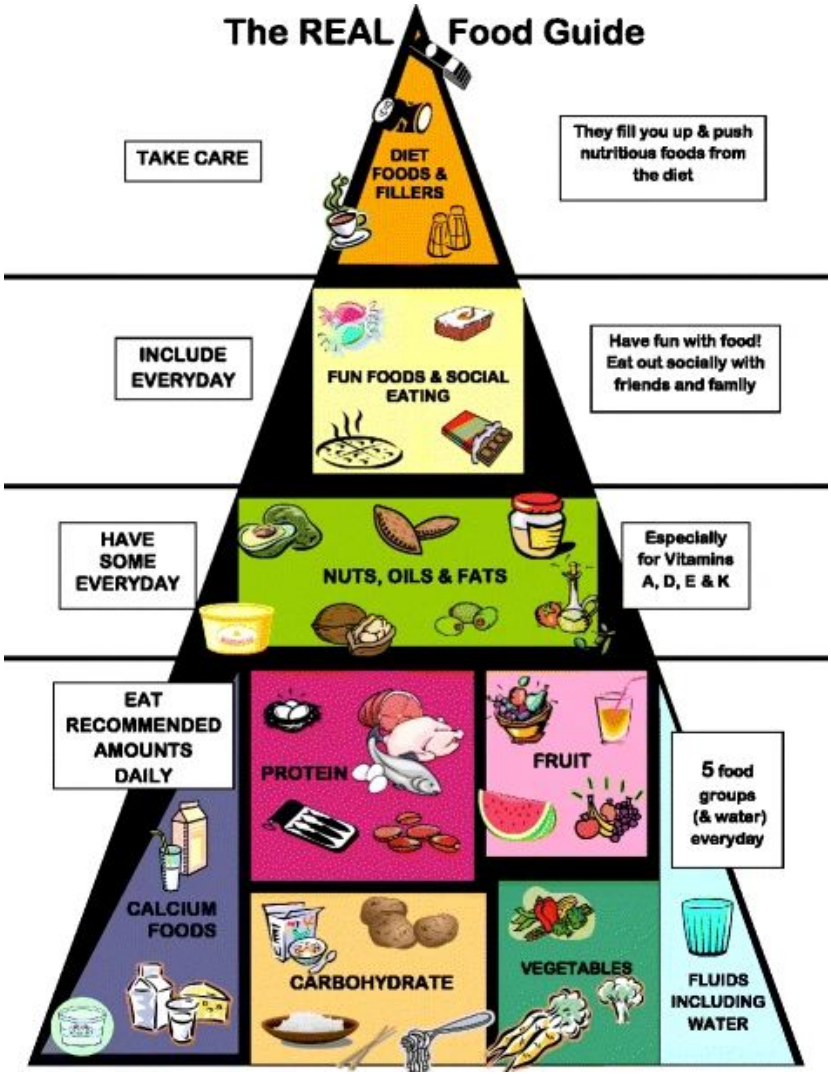
Treatment planning and Goals

Psychoeducation

- Diet/ ED cycle

    - Binge eating is always preceded by restriction, physical and or psychological deprivation
- Metabolism
- Determinants of natural weight and shape
- Physical and psychological impact restriction/ starvation
- Diet / Wellness culture
    - Health Vs Weight
    - Genetic and social determinants of health. What we can and can't control
    - Myth busting
    - Exploring disordered food beliefs
- Gentle Nutrition: Food groups
  What we need, why, how it is used in the body



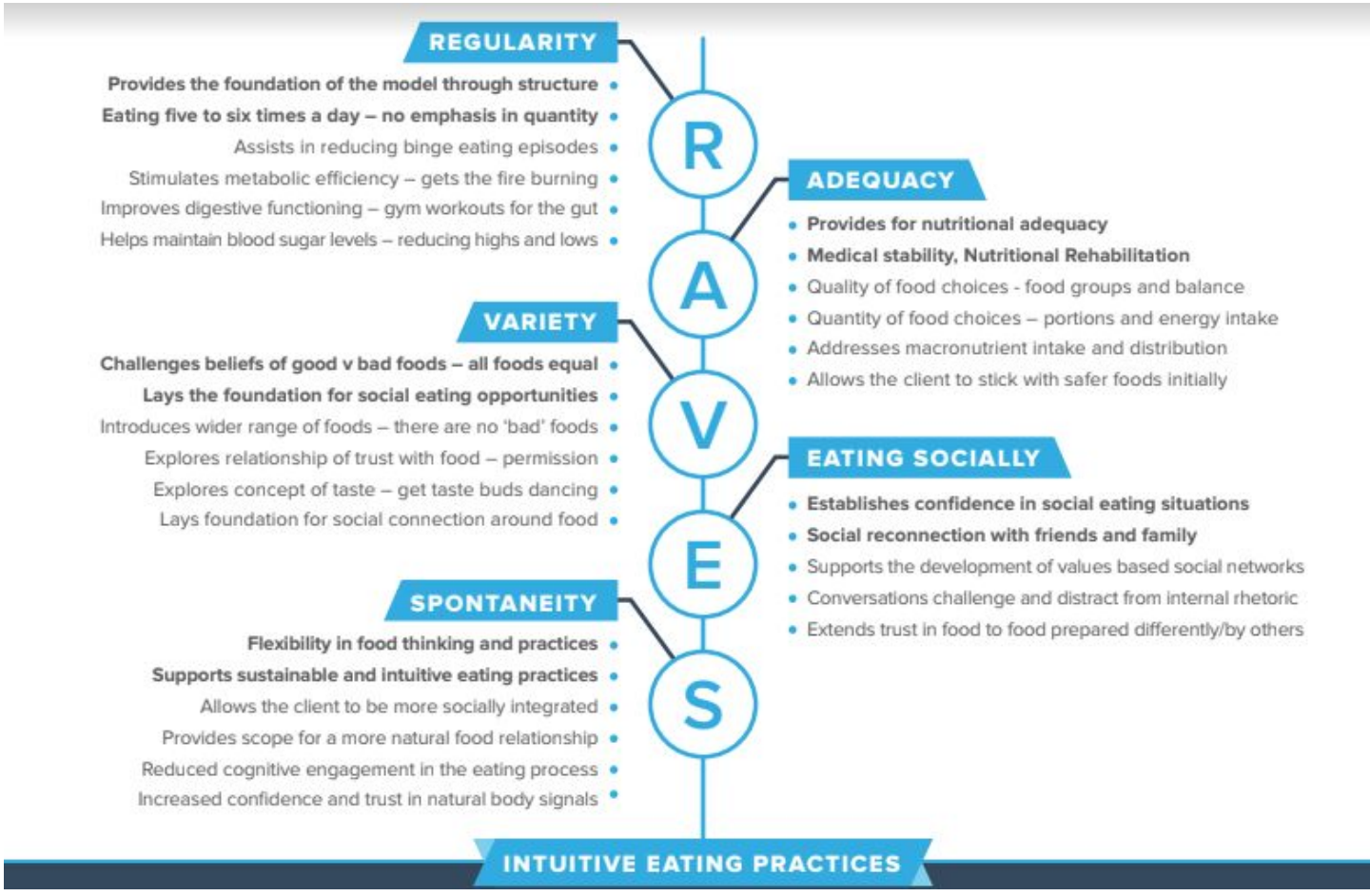
https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-018-0192-4

Changes to food intake:

- No rush
- When client is ready
- Based on RAVES
-
    - **R**egularity
    - **A**dequacy
    - **V**ariety
    - **E**ating Socially
    - **S**pontaneity
    - (Then exploring intuitive eating)

RAVES
https://eatingdisorderscarerhelpkit.com.au/wp-content/uploads/2019/10/RAVES-Model.pdf

Credit: Shane Jeffery APD



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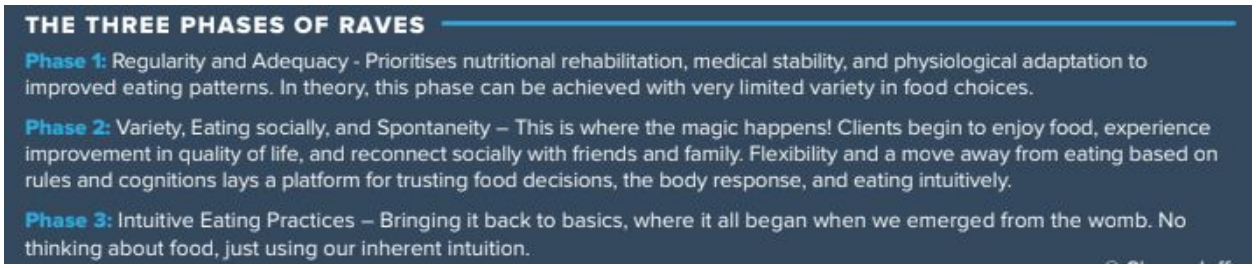

Urge management

- Delay (any delay in commencing a binge is an achievement)
- Distraction

Food diary - to record or not?

Weighing - to weigh or not ?

- Food and thought recording and weighing are part of CBT treatment; which has strong positive evidence for the management of BED).
- They may be helpful for some clients and distressing and triggering for others. If you are not trained in CBT and doing the manualised version there can be a decision made if this is helpful or not.
- Food, thought and behaviours recording can be helpful to get a clear dietary history. For clients to see the links between thoughts, feelings, behaviours and ED behaviours. They can be helpful to track progress over time.
- Regular weighing while normalising intake can help to challenge ED fears that weight will exponentially increase. Consent must be sort, and the purpose of the weighing discussed. If a psychologist is doing this as part of CBT there is no reason to re- weigh.

Fear foods and food rules - Create list and hierarchy of level of fear/ anxiety. Use as the basis of goal setting starting with least least feared.

Goal is not to never binge again - to decrease volume and frequency of the binge.

More considerations from these cases

- Mia Diagnosis - Referred as BED by GP. Psychologist may change diagnosis.
- Family Support and education
- Advocacy

    - support in medical team
    - support workers
    - supporting client to develop skills to advocate for self
- Social media
    - Negative influences
    - Positive recovery tool
- Clothing

Outcomes

Suzy	**Mia**
Regular intake	Addition grains to B L and D
B, MT, L, AT, D, S	Introduction small snacks
Balanced meals	Fear food challenges
Significantly decreased binge eating	Decreased then ceased binge eating
Decreased volume binges	Increasing acceptability of a range of foods
Focus on including more colour into meals (fruit + Veg)	Increased portions at meals and snacks
Explore flavour taste texture for pleasure (Choosing recipes, shopping and cooking)	Increased dairy intake
Inclusion fear foods without binge eating	Increasing fat intake
Eating out alone	Increased awareness of irrational ED thoughts and consequences of restriction
Walking	Ready to commence Psychological support for irrational ED beliefs, emotional dysregulation and anxiety
Swimming at local pool and swimming alone	Decreased compulsive exercise
Improved skills/ confidence planning, shopping and preparing foods	Increased awareness hunger, satiety, appetite
Including trigger foods with no binge eating	Unable to always respond at this time
Eating in cafés etc	Appropriately seeking support with family when distress and using distraction tools
If does binge able to reflect self compassionately and move forward without entering the ED cycle	
Awareness and connection to hunger and satiety cues	
Able to respond appropriately	
When distressed using alternative coping strategies	

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