

# Binge Eating Disorder

Treatment approaches,  
access-to-care and disturbing trends



Chevese Turner  
Founder, President & CEO  
Binge Eating Disorder Association (BEDA)

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## General Overview

1. BED Basics and Overview of treatment goals
2. Chevese BED journey
3. Why BED now? Where are we going?
4. Status of evidence-based treatment for BED. How little we know.
5. Disturbing trends
6. Non-diet approach. Why the bad rap? Alternatives and the goal to do no harm.
7. Barriers to care
8. Weight stigma
9. BED and BEDA: Our mission & responsibilities

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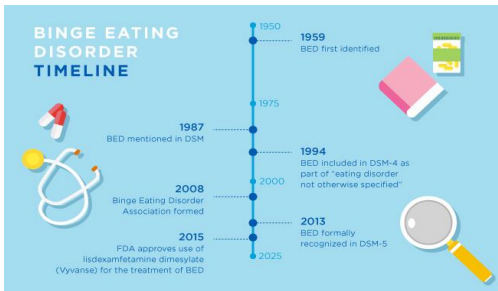
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## Binge Eating Disorder Story



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### The BED Journey

- Unmet need impacting 9+ million lives
- Severely unrecognized and undertreated
  - 17% of 9+ million assessed and diagnosed
  - 7% of diagnosed receiving some sort of 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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### Binge Eating Disorder (BED)

- Recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances with episodes marked by feelings of lack of control
- Marked distress including feelings of guilt, embarrassment, or disgust
- Occurs on average once per week over 3 months
- May binge alone to hide behaviors
- Key Features
  - secretive eating, excessive intake of food, rapid eating
- DSM V: 307.51 ICD-10: F50.8 (OSFED: Other Specified Feeding or Eating Disorder)

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### 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

Thornton LM, Mazzeo SE, Bulik CM. The heritability of eating disorders: methods and current findings. Curr Top Behav Neurosci. 2011;6:141-156

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### 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

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### BED Facts

- Prevalence:
  - 1-3% 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 (40%)
- More prevalent in African Americans, Native Americans, and Hispanic communities.

Hudson, et al. 2007

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### BED Facts

- Often mis- or un-diagnosed
- Patient often blamed for their disorder; “just stop eating” and “go on a diet”
- BED is **NOT** the same as just overeating
- BED occurs in people of all sizes
  - Normal-weight (19%)
  - Overweight (36%)
  - Obese (45%)

Hudson, et al. 2007

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### How Emotions Affect BED

- Eat to stuff them down
- Unresolved carried emotions are soothed through food
- Body Image impact- feeling heavier
- Shame affects self esteem which affects motivation
- "I will feel better about myself if I lose weight"

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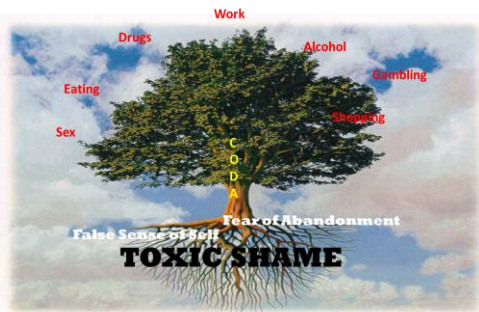
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### Focus on Shame



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### Redefine "Healthy" Eating for BED

**Food As Tool:**  
"NIP-D"

VS

**Food As Food:**  
Appetite Satisfaction & Energy

- "Nipped those feeling in the bud"*
- **Numb:** Quick eating pace, focus on carbs, fullness as a sedative
  - **Insulate:** alone, sleepiness, experiences body as "blanket of protection"
  - **Punish:** painful, depriving. Sense of emptiness is uncomfortable... not for the reasons you might think. Feels powerful for a second but overtaken by need for protection as above.
  - **Distract:** Use of dieting strategies to eat less.
  - Food as fuel to move the body → body awareness → greater compassion
  - Tolerate waves of moderate hunger and satisfaction throughout the day.
  - Give self permission to enjoy eating and the physical sensations that go with it.
  - Move towards a new normal: let go of diet mentality and practice food, weight and body neutrality → acceptance → love
  - Develop non-food related methods of creating safety, comfort, rest.

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### How Eating Style Can Bring Healing in BED

- Emotions and physical feelings of hunger and satisfaction are often deeply held and even the client cannot identify them at first. Therefore mindfulness may not come easily.
- May need to start with structured and balanced eating plan to reveal eating cues.
- Slow the eating: minimum of 15 -30 minutes for a meal and 15 minutes for a snack.
- Eat with others as often as is possible. Journal pre- and post-eating when eating alone.
- Incorporate all foods into plan. Give permission until the client develops confidence.
- Undereating must be addressed and is not okay.
- Intuitive eating methods may be frustrating and ineffective if used before client has reliable cues at least 75% of the time. An intuitive/natural eating style that is flexible and meets nutritional needs is the ideal end goal.
- Co-occurring medical conditions such as Diabetes or Kidney disease potentially trigger deprivation/restricting from past weight loss diets. Compare and contrast.

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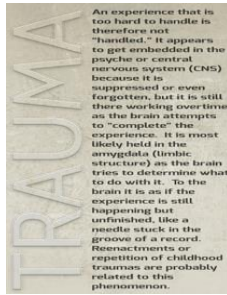
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### History

- Family history of intergenerational trauma, PTSD, divorce, substance abuse, eating disorders, and "fear of fat."
- Encouraged to diet very early by both family and physicians
- First "binge" at age 5
- First diet at age 7



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### My History

- Began to steal food and money to buy food by age 7.
- Increasing conflicts with parents around eating and weight by age 9
- Weighing obsessively and body checking regularly by age 9
- Spent hours in room by myself obsessing over body and looks



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### History

- As "weight concerns" increased so too did physician managed diets, weight watchers camps suggestions, diet pills, and strict monitoring of food by parents.
- Increasing shame resulted in early depressive episodes, increased anxiety, weight cycling (overeat & binge/diet) and loss of interest in school, friends, etc.
- Increased bullying, feeling of being an outsider



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### My History

Teen years brought

- increase in extreme dieting
- sporadic bingeing
- weight cycling,
- substance abuse
- poor grades
- vacillation between isolation and partying
- high risk/extreme behaviors



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### History

Early Adult (20's & 30's)

- Still body checking and weight cycling/dieting
- Still bingeing (subjectively and objectively)
- Am I the only one?
- Peers building lives
- Need help
- Resilience
- Only skill is dieting
- Therapy & BED diagnosis



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**History**

Adult (30's & 40's)

- Married
- Some ED recovery
- Beginning to consider "different way"
- 2 Children
- Struggling to stabilize and reconcile external messages
- Lap Band
- BEDA/Community
- HAES & internalized weight stigma/trauma
- Recovery
- Lap Band Removal

**PROGRESS**  
*is IMPOSSIBLE*  
 WITHOUT CHANGE,  
 & those who cannot  
 CHANGE THEIR minds  
**CANNOT**  
 CHANGE *Anything.*<sup>®</sup>

- George Bernard Shaw

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**Binge Eating Disorder**  
 What remains in the journey and where are we going?



We are learning to resist the external that is largely based in shame and embrace the internal that knows the story and has or will gain the wisdom.

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**Binge Eating Disorder**  
 What remains in the journey and where are we going?

<p><b>Research</b></p> <ul style="list-style-type: none"> <li>• Review current evidence via AHRQ review</li> <li>• Funding</li> <li>• Prepare for DSM-5.1 or 6 (or whatever the APA calls it)           <ul style="list-style-type: none"> <li>- Overvaluation of body shape and weight</li> <li>- Biological/neurological findings</li> <li>- Subjective bingeing</li> <li>- Weight cycling</li> </ul> </li> </ul>	<p><b>Education &amp; Awareness</b></p> <ul style="list-style-type: none"> <li>- What is BED</li> <li>- Similarities/Differences with other eating disorders</li> <li>- People of size can have an eating disorder and not have BED (BN or AN, etc)</li> <li>- Role of weight stigma and diet culture</li> <li>- Pursuit of weight loss doesn't work long term and not necessary for recovery</li> </ul>
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### Binge Eating Disorder

What remains in the journey and where are we going?

**Policy & Regulatory**

- ICD 10
- Insurers & Coverage
- CMS Policies
- Workplace Wellness Plans (Equal Employment Opportunity Commission [EEOC])

**Other**

- Attitudes within the eating disorders community about people of size
  - ✓ Weight stigma & biases
  - ✓ Ability to recover
  - ✓ Credibility of eating disorders clinicians
- Inclusion of BED and other high weight eating disorders in research, policy, education & awareness
  - ✓ Talks/Media
  - ✓ Anna Westin Act
- Food addiction model inclusion??

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### Why BED Matters Politically & Culturally

- The most common eating disorder (ED)
- Its clinical utility and validation changes the “look” of who has an eating disorder
- Intersectionality (body weight, race, age, sexual orientation, social status, etc)
- Stigmas: mental health, eating disorder, BED, weight
- Expands total numbers of people with ED

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### Treatment

- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
- Interpersonal Behavioral Therapy
- Trauma – Somatic Therapies & Internal Family Systems
- Medications
- Health at Every Size
- Community

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## Health at Every Size

- Is NOT about being an *excuse* for being higher weight, obese, fat, a person-of-size
- Is about overall health & wellness
  - Shift from oppression around body size and weight to focus on the pursuit of wellness that works for the individual and supports psychological health
  - Wide variety of food for nutrition, fuel, and enjoyment
  - Movement that honors the body and is enjoyable, ie does not “punish”

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## Aims of HAES

- Let go of preoccupation around weight loss (life begins “x” pounds from now)
- Decrease and end binge/diet cycles where sense of failure increases and willingness to engage in life decreases with each cycle
- Teaches that acceptance of right now is first step to wellness and recovery
- **Encourages attention to psychological issues, including internalized weight stigma as a trauma absolutely necessary**

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## Diet Culture

- Over 50% of teenage girls and 33% of teenage boys are using restrictive measures to lose weight at any given time.[1]
- 46% of 9-11 year-olds are sometimes, or very often, on diets, and 82% of their families are sometimes, or very often, on diets).[2]
- 91% of women recently surveyed on a college campus had attempted to control their weight through dieting, 22% dieted often or always.[3]

1) Neumark-Sztainer, D. (2005). *I'm, Like, SO Fat!* New York: The Guilford Press. pp. 5.

2) Gustafson-Larson, A.M., & Terry, R.D. (1992). Weight-related behaviors and concerns of fourth-grade children. *Journal of American Dietetic Association*, 818-822.

3) National Eating Disorders Association website. *Statistics: Eating Disorders and Their Precursors*. Accessed feb.2012 [http://www.nationaleatingdisorders.org/uploads/statistics\\_tmp.pdf](http://www.nationaleatingdisorders.org/uploads/statistics_tmp.pdf)

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## Diet Culture

- 95% of all dieters will regain their lost weight in 1-5 years.[1]
- 35% of normal dieters progress to pathological dieting. Of those, 20-25% progress to partial or full-syndrome eating disorders. [2]
- 25% of American men and 45% of American women are on a diet on any given day.[3]

1) Grodstein, F., Levine, R., Spencer, T., Colditz, G.A., Stampfer, M. J. (1996). Three year follow up of participants in a commercial weight loss program: can you keep it off? Archives of Internal Medicine. 156 (12),1302.  
 2) Shisslak, C.M., Crago, M., & Estes, L.S. (1995). The spectrum of eating disturbances. International Journal of Eating Disorders, 18 (3), 209-219.  
 3) Sundgot-Borgen J, Torstveit MK. (2004). Prevalence of eating disorders in elite athletes is higher than in the general population. Clin J Sport Med., Jan;14(1):25-32.

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## Disturbing Trends

BED being “treated” with:

Diet and Fitness

Bariatric Surgery

Self-help only

Food addiction model

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## BED & BEDA

### Our Mission & Vision

#### Mission

Through education, advocacy, and leadership, BEDA promotes the pursuit of healing and well-being for those affected by BED.

#### Vision

BEDA will improve recognition of binge eating disorder as a serious mental health condition requiring treatment to support bio-psycho-social well being. BEDA will work to eliminate weight stigma in order to promote healthful body awareness and improved self-esteem.

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## BED & BEDA

### Our Accomplishments & Advocacy

- DSM-5 Inclusion (advocacy efforts)
- Weight Stigma Awareness
- Addressing Weight Shaming in Media (Atlanta/Disney, etc)
- Bringing lack of attention to higher weight individuals with eating disorders field to light
- Leader in movement to build inclusion and intersectionality within ED field
- Consistent voice with adherence to "do no harm" in treatment of eating disorders in people who are fat.
- Building a safe and embracing community of people who have been on the edges of the ED community
- Advocating for some separation of treatment from general milieu in higher levels of care and groups.
- Bringing awareness to the need for additional specialized training for clinicians who want to treat BED and higher weight eating disorders
- Questioning and listening carefully to Food Addiction research and arguments. Even if FA has clinical utility and therefore can be "treated" we cannot say that all with BED or other eating disorders have food addiction and vice-versa.
- Abstinence can be a way of limiting food choices, creating control by putting groups of food in to good/bad categories, and not addressing internalized weight biases.

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### 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**
- Provide team members & families with weight stigma information/education

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### First Responders: Do No Harm

- Do I make assumptions based on weight regarding character?
- intelligence, professional success, health status, or lifestyle behaviors?
- Am I comfortable working with people of all shapes and sizes?
- Do I give appropriate feedback to encourage healthful behavior change?
- Am I sensitive to the needs and concerns of obese individuals?
- Do I treat the individual or only the condition?

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**THANK YOU**

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**Easy Pivot to Weight Stigma**

Can we effectively treat eating disorders and  
body image...

...and not talk about  
weight stigma?

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## Weight Stigma Stems from Beliefs that...

- stigma and shame will motivate people to lose weight
- people are responsible for their own weight and only fail to lose weight because of poor self-discipline or a lack of willpower

### Weight bias also exists because our culture:

- sanctions its overt expression
- values thinness and perpetuates societal messages that obesity is the mark of a defective person
- blames the victim rather than addressing environmental conditions that cause obesity
- allows the media to portray obese individuals in a biased, negative way

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## World Health Organization Definition of "Health"

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.



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## Weight stigma has negative psychological outcomes predictive of

- Eating disorders:
- Psychological distress
- Dysfunctional attitudes about weight and shape
- Body dissatisfaction
- Thin ideal internalization

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## Weight Stigma Predicts Behaviors Related to Unhealthy Restraint & Binge Eating

- Dieting behaviors
- Dietary restraint
- Bulimic behaviors
- Binge-eating
- Unhealthy/extreme weight control behaviors
- Fasting
- Using diet pills, laxatives and/or diuretics
- Vomiting/purging
- Using a food substitute (e.g. powder)
- Skipping meals

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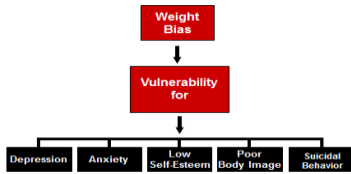
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## Vulnerabilities of Experiencing Weight Stigma



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## Internalization of Weight Stigma

### Study: 1013 Women

- Belong to a national non-profit weight loss organization:
  - Outcome
- women who internalized experiences of weight stigma blamed themselves for stigma – engaged in more frequent binge eating.
- This was true even after accounting for self-esteem, depression, and amount of stigma experienced

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## Internalization of Weight Stigma

Study: 2449 Women who utilized one or more maladaptive eating behaviors

- Binge eating
- Unhealthy Weight Control Practices
- Coping with stigma by eating more food
- Increased caloric intake and weight gain

Asked how they cope with stigma experiences?

79% reported eating; turning to food as coping mechanism

\* Stigma is a stressor \*

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## Impact of Bias, Stigma, and Discrimination

- Decreased Education & Income
- Reduced Use of Health Care
- Compromised Health Care
  - Diminished Self-Esteem
  - Perceived Inadequacy
- Negative Impact on Physiology

Leading to...

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## Impact of Bias, Stigma, and Discrimination

- Impaired ability to stabilize weight
  - Psychological Disorders
  - Elevated Risk Factors
  - Unhealthy Behaviors
- Diminished Social Support

Ultimately leads to decreased morbidity and mortality

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## Where Does Stigma/Discrimination Take Place?

- In the Home
- Fat talk
- "Helping" (concern trolling)
- Healthcare Setting (including eating disorders treatment)
- Coverage by Insurers
- Increased premiums based on weight and BMI, not health status
- Employment Setting
- Hiring Prejudices
- Inequity in Wages, Promotions, and Employment Termination
- Educational Setting
- Rejection
- Harassment
- Dismissal

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## Bullying and Weight

Odds for obese child to be bullied is 63% higher than for a "normal" weight child.

- Reflects prejudices and thin ideal  
Increases stress and likelihood of using food to cope and decrease stress
- 92% of adolescents report that they witness their overweight and obese peers being teased at school.

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## How Would You Feel if Stigmatized by a Healthcare Provider

- I would feel bad about myself  
42%
- I would be upset/embarrassed  
41%
- I would talk to my doctor about it  
24%
- I would seek a new doctor  
21%
- I would avoid future doctor appointments  
19%

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## Reactions of Patients

- Feel berated & disrespected by providers
- Upset by comments about their weight from doctors
- Perceive that they will not be taken seriously
- Report that their weight is blamed for all problems
- Reluctant to address weight concerns
- Parents of obese children feel blamed and dismissed

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## Physician Perceptions of Higher Weight Patients

### View Obese Patients as...

- less self-disciplined
- less compliant
- more annoying

### As patient BMI increases, physicians report

- having less patience
- less desire to help the patient
- seeing obese patients was a waste of their time
- having less respect for patients

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## Physican Descriptions of Higher Weight Patients

Non-compliant  
 Lazy  
 Awkward  
 Lacking in self-control  
 Weak willed  
 Sloppy  
 Unintelligent  
 Unsuccessful  
 Dishonest

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## Sources of Bias/Stigma

Source of Bias	Ever Experienced	More than Once & Multiple Times
Family members	72	62
Doctors	69	52
Classmates	64	56
Sales clerks	60	47
Friends	60	42
Co-workers	54	38
Mother	53	44
Spouse	47	32
Servers at restaurants	47	35
Nurses	46	34
Members of community	46	35
Father	44	34
Employer/supervisor	43	26
Sister	37	28
Dietitians/nutritionists	37	26
Brother	36	28
Teachers/professor	32	21
Authority figure (e.g. police)	23	15
Mental Health Professionals	21	13
Son	20	13
Daughter	18	12
Other	17	13

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## Eating Disorder Specialists Descriptions of Higher Weight Patients

1. Expressed considerable pessimism about treatment outcomes for these patients, including patients' motivation to improve their diet, ability to make behavior changes, and ability to maintain weight loss once achieved.

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### Eating Disorder Specialists Descriptions of Higher Weight Patients

- 2. Only 36% of participants believed that obese patients are compliant with treatment recommendations indicates that a commonly held assumption by professionals is patient noncompliance, a weight-based stereotype that is similarly endorsed by many other health providers.

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### Eating Disorder Specialists Descriptions of Higher Weight Patients

- 3. Those who exhibited stronger weight bias were more likely to (1) believe that obesity is caused by behavioral factors (such as overeating and lack of willpower) rather than environmental or biological/genetic contributors, (2) express negative attitudes and frustrations about treating obese patients, and (3) perceive poorer treatment outcomes for these patients compared to professionals who endorsed less weight bias.

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### Eating Disorder Specialists Descriptions of Higher Weight Patients

- 4. Low personal endorsement of weight based stereotypes and high endorsement of weight bias observed among colleagues and other professionals in the eating disorders field, it is possible that some professionals may exhibit some resistance in response to stigma reduction efforts that involve confronting one's own personal attitudes and assumptions about body weight

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## Eating Disorder Specialists Descriptions of Higher Weight Patients

- 5. Participants who had been a professional in the field for longer expressed lower bias compared to more junior professionals.
- 6. Participants in the present sample with a lower BMI expressed stronger weight bias than those with higher body weights, which is also consistent with previous research demonstrating a negative correlation between BMI and weight bias.

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## Eating Disorder Specialists Descriptions of Higher Weight Patients

- 7. Individuals who reported currently trying to lose weight exhibited stronger weight bias, and more negative attitudes and frustrations about treating obese patients compared to individuals not trying to lose weight

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## Eating Disorder Specialists Descriptions of Higher Weight Patients

- High attrition rate upon presentation of weight bias measures despite being anonymous
- Increasing discomfort with own biases?
  - Social desirability a factor?
  - Does this affect clients of any size?
  - Fear of fat pervasive?

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