

Binge Eating Disorder

Treatment approaches, access-to-care and disturbing trends



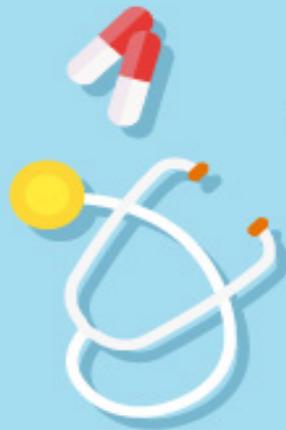
Chevese Turner
Founder, President & CEO
Binge Eating Disorder Association (BEDA)

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

Binge Eating Disorder Story

BINGE EATING DISORDER TIMELINE



1987
BED mentioned in DSM

2008
Binge Eating Disorder Association formed

2015
FDA approves use of lisdexamfetamine dimesylate (Vyvanse) for the treatment of BED

1950

1959
BED first identified

1975

1994
BED included in DSM-4 as part of "eating disorder not otherwise specified"

2000

2013
BED formally recognized in DSM-5

2025



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

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)

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

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

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.

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%)

How Emotions Affect BED

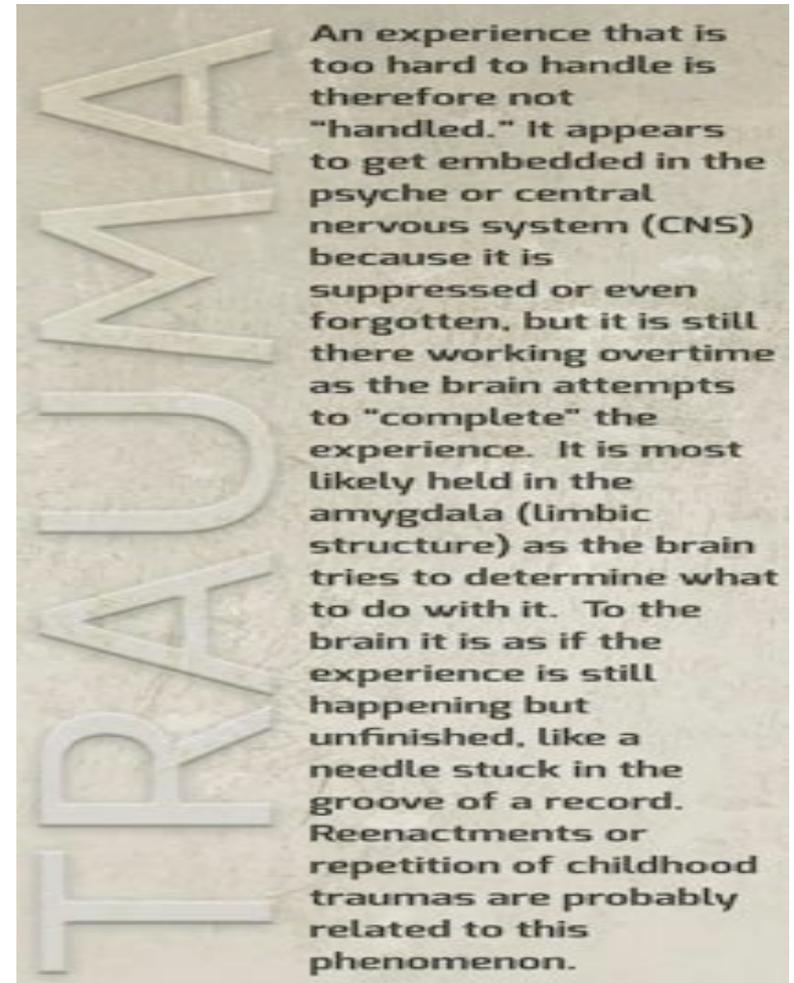
- Eat to stuff them down
- Unresolved carried emotions are soothed through food
- Body Image impact- feeling heavier
- Shame affects self esteem which affects motivation
- “I will feel better about myself if I lose weight”

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.

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



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



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



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



History

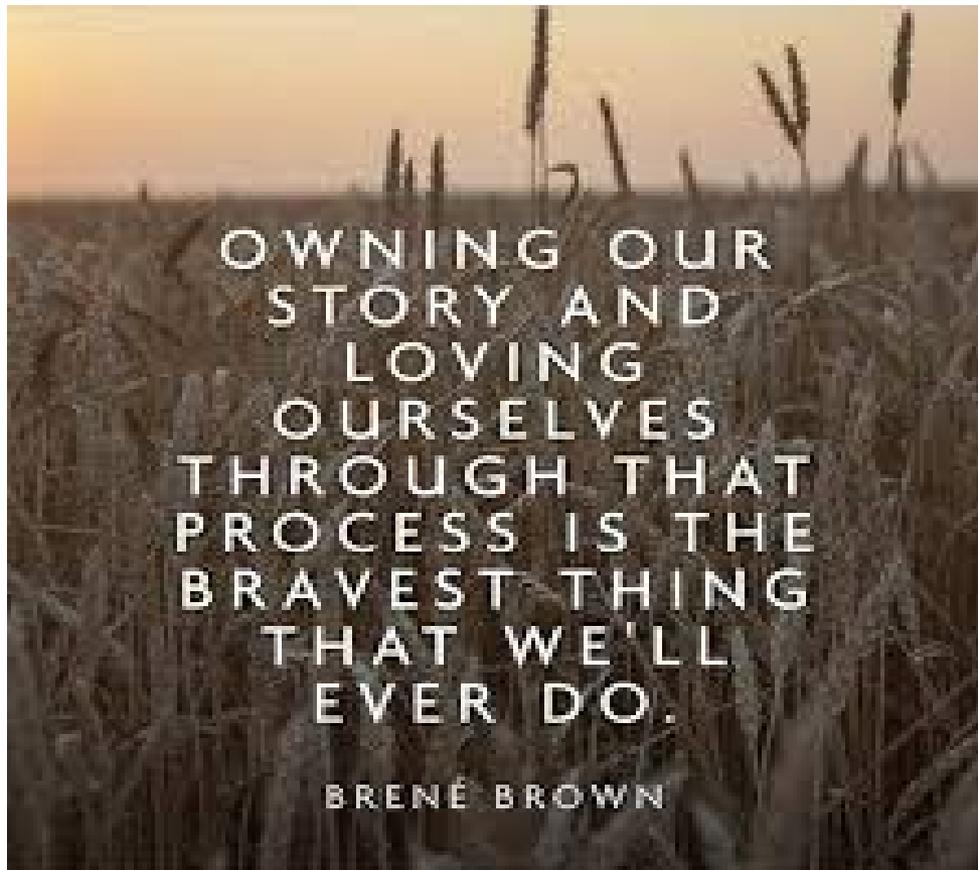
Adult (30's & 40's)

- 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.*
- George Bernard Shaw

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.

Binge Eating Disorder

What remains in the journey and where are we going?

Research

- Review current evidence via AHRQ review
- Funding
- Prepare for DSM-5.1 or 6 (or whatever the APA calls it)
 - Overvaluation of body shape and weight
 - Biological/neurological findings
 - Subjective bingeing
 - Weight cycling

Education & Awareness

- What is BED
- Similarities/Differences with other eating disorders
- People of size can have an eating disorder and not have BED (BN or AN, etc)
- Role of weight stigma and diet culture
- Pursuit of weight loss doesn't work long term and not necessary for recovery

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??

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

Treatment

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

Health at Every Size

- Misconception that paradigm is 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”

Aims of HAES as a Part of BED Tx

- 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**

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

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.

Disturbing Trends

BED being “treated” with:

Diet and Fitness

Bariatric Surgery

Self-help only

Food addiction model

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.

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.

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

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?



DIVERSITY IS LOVEABLE

THANK YOU

Chevese Turner

Founder, President & CEO

Binge Eating Disorder Association

chevese.turner@bedaonline.com

www.bedaonline.com

HELPLine: 855.855.2332

Direct line: 410.570.9577