

# Binge Eating Disorder, Bariatric Surgery and Diabetes

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Solutions Program for Eating Disorders



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**Activity-Type :** Knowledge-based

# OBJECTIVES

1. Binge eating disorder (BED).
2. The night eating syndrome (NES) and "grazing" in bariatric surgery patients.
3. The impact of binge eating and BED in bariatric surgery patients.
4. The relationship between eating disorders, bariatric surgery and diabetes.



# STATISTICS

- \* 65% of Americans are overweight or obese.
- \* Rates of obesity have **tripled** in children since the 1970's
- \* Diseases, such as non-insulin dependent diabetes, have **increased** in children.
- \* This has created more ***desire*** for rapid weight-loss measures such as bariatric surgery.
- \* The presence of an eating disorder may make bariatric surgery **more** risky and **less** likely to be successful.



# Rates of Obesity in America in 2014



HIGHEST: Arkansas 35.9

Georgia 30.3

New York 27.0

LOWEST: Colorado 21.3



# BINGE EATING DISORDER

- \* ***Binge Eating Disorder*** is common among obese people seeking bariatric surgery.
- \* Research groups have studied whether Binge Eating Disorder (BED) might represent a **contraindication** to bariatric surgery or a ***poorer*** outcome in subjects undergoing bariatric surgery.



# HISTORY OF BINGE EATING DISORDER

Binge eating disorder (BED) is the most **common** eating disorder in the United States

1. Effects 75% of people with eating disorders.
2. Binge eating was first acknowledge in the DSM-III, in 1980 and was designated bulimia.
3. The revised version of the DSM-III (DSM-III-R), published in 1987, adopted the term bulimia nervosa.
4. Binge Eating Disorder was included in the eating disorders section of the [DSM-5](#) in 2013.



# HISTORY CONT.

- \* Bingeing and purging were prevalent in ancient history.
- \* Ancient Egyptian physicians recommended periodical purgation as a health practice.
- \* The Hebrew Talmud (A.D. 400-500), referred to a ravenous hunger that should be treated with sweet foods, called boolmot (Gordon, 2000).
- \* The Romans used the word “vomitorium” which was a special room where the wealthy Romans would go to purge themselves after a large meal (Gordon, 2000).



# History cont..

- The disorder was first described in 1959 by [psychiatrist](#) Dr. Albert Stunkard as "[night eating syndrome](#)" (NES),
- the term "binge eating " was coined to describe the same bingeing-type eating behavior without the exclusive [nocturnal](#) component.
- Binge Eating Disorder was included in the eating disorders section of the [DSM-5](#) in 2013.
- BED usually leads to obesity although it can occur in normal weight individuals. There may be a genetic inheritance factor involved in BED



# NIGHT EATING SYNDROME

- \* The concept of the night eating syndrome (NES) is in a state of transition.
- \* The original criteria by Dr. Stunkard in 1955 which included:
  - \* Insomnia, morning anorexia, and feeling tense, upset, or anxious as bedtime nears.
  - \* Research suggests that NES is associated with psychological problems, and that there is overlap with BED.



# OTHER SLEEP RELATED DISORDERS

There is a possible overlap with another syndrome, Sleep-Related Eating Disorder (SRED).

This syndrome is characterized by partial arousal from sleep, which is associated with:

1. eating
2. a reduced level of awareness
3. reduced level of recall
4. ingestion of inedible substances

A variety of other sleep disorders have been described in association with this, including restless legs syndrome.



# DIAGNOSTIC CRITERIA

The binge eating episodes are associated with at least three 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 being embarrassed by how much one is eating
- Feeling disgusted with oneself, depressed, or feeling very guilty after overeating

# DIAGNOSTIC CRITERIA cont..

- Marked distress regarding binge eating.
- The binge eating occurs, on average, at least 2 days a week for 6 months.
- The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

# TRIGGERS FOR EMOTIONAL EATERS

**Social**  
**Emotional**  
**Situational**  
**Thoughts**  
**Physiological**

# Thirty-two studies have addressed the rates of BED

- \* Rates for binge eating have varied from 6% to 75%
- \* BED have ranged from 1% to 49% before surgery
- \* At follow-up, postsurgical rates of binge eating have varied from 0% to 71%
- \* For BED from 0% to 32%, reflecting the markedly divergent methods that have been used to ascertain these phenomena.

# CRITERIA FOR BED

While it is important to understand that:

- Obesity is not a criteria for binge eating disorder
- **Nor do all individuals with obesity have BED**

It can be a serious complication of this eating disorder



# ADAPTIVE FUNCTIONS OF EMOTIONAL EATING SYMPTOMS

- **Nurturance/Comfort**
- **Re-enactment of abuse – “repetition compulsion”**
- **Distraction from emotions and memories**
- **Numbing – “stuff feelings”**
- **Discharge emotions, e.g. anger**
- **Self-punishment**
- **Sedation**

# ADAPTIVE FUNCTIONS OF EATING DISORDER SYMPTOMS (CONT)

- **Self-esteem**
- **Sense of identity**
- **Maintain role of identified patient or position of helplessness**
- **Portray fragile role**
- **Internalization of anger**
- **Creates boundaries**
- **Repress sexual urges and impulses; repel sexual advances**
- **Avoid intimacy**
- **Minimize separation expectations**
- **Competition, envy, achievement, exhibitionism**

# REASONS WHY PEOPLE OVEREAT



# UNDERSTANDING COMPULSIVE and ADDICTIVE BEHAVIOR

- Compulsion is *defined as an irresistible urge to perform a certain act*, regardless of the rationality of the act.
- Compulsive behaviors have an **ability to produce a positive and pleasurable mood change**. They remove us from our true feelings, and can *provide a form of escape*.

# UNDERSTANDING COMPULSIVE AND ADDICTIVE BEHAVIOR (CONT)

- The foundation for compulsive and addictive behavior consists of a normal desire to *live with the least amount of pain and the greatest amount of pleasure possible.*
- A general mistrust of the world we live in and pessimism about life is thought to contribute to this foundation.

# UNDERSTANDING COMPULSIVE BEHAVIOR (CONT)

- Such feelings and beliefs are ***established in childhood, and influenced by relationships within the family.***
- A person with low self-esteem, who has ***learned that other people are not to be trusted*** and therefore has difficulty developing healthy relationships, is more likely to develop compulsive behavior patterns as a way to cope with stress in his or her life.

# TYPES OF BARIATRIC SURGERY

- \* **Roux en-Y Gastric Bypass:** This surgery involves the creation of a small stomach pouch as well as the bypass of a small amount of intestine.
- \* **Sleeve Gastrectomy:** Involves the removal of about 75 percent of the stomach, leaving a narrow “sleeve” and permanently reduces the size of the stomach and does not involve the bypass of intestines.
- \* **Adjustable Gastric Banding:** Involves the insertion of a “belt” around the upper part of the stomach, which functions to separate the stomach into a smaller upper pouch and a larger, lower pouch.

# STATISTICS

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PSYCHOLOGICAL ISSUES

**PSYCHOLOGICAL ISSUES  
WITH  
BARIATRIC SURGERY PATIENTS**

# PSYCHOLOGICAL ISSUES WITH BARIATRIC SURGERY PATIENTS

- ✓ Psychological issues often present in patients with morbid obesity and can **affect** surgical outcomes.
- ✓ Issues include mood and personality disorders, **destructive** eating behaviors, and poor body image.
- ✓ Nearly 1/3 of patients undergoing bariatric surgery also have a **history** of substance abuse disorder.

# PSYCHOLOGICAL ISSUES

Literature suggests that although the mental health of patients **improves** as a result of bariatric surgery, the benefits may be ***transient***, and problems such as:

1. negative personality profiles
  2. detrimental eating patterns
  3. negative body image
- persist to some extent.

# PSYCHOLOGICAL ISSUES CONT.

Bariatric surgery is an **effective** intervention in the morbidly obese to achieve marked weight loss, BUT NOT enough studies have been done to determine the outcome.

# PSYCHOLOGICAL ISSUES CONT.

- Extremely obese individuals are almost **5 times more** likely than their average weight counterparts to have suffered from a major depressive episode a year before surgery.
- Body image dissatisfaction, commonly seen in obese patients, is **heavily correlated** with symptoms of depression, and this is particularly true in women.

# PSYCHOLOGICAL ISSUES CONT.

- \* Repeated failed attempts to lose weight are common in this population and are likely to aggravate depressive illness, hopelessness, and poor self-esteem, perhaps contributing to further weight gain.
- \* 25–30% of bariatric patients report depressive symptoms at the time of surgery and up to 50% report a lifetime history of depression.

# PSYCHOLOGICAL ISSUES CONT.

- Bariatric patients seeking surgery have a **higher** prevalence of psychological distress compared to other obese patients who do not seek surgery.
- They are often **driven** to pursue surgery due to a distressing event. One study found that 38% of patients met diagnostic criteria for dual diagnosis.

# How to treat Patients with BED and Bariatric Surgery





# TREATMENT ISSUES

If surgery takes place without psychological and behavioral treatment, it may only be addressing the symptoms of BED and not dealing with root causes.

# COMPREHENSIVE TREATMENT PLAN

- \* Bariatric surgery options should be a part of a **comprehensive treatment plan** that address the many facets involved with recovery from binge eating disorder, including:
  - \* Weight concerns
  - \* Food-related behaviors
  - \* Underlying issues or trauma that contributed to the development and maintenance of Binge Eating Disorder
  - \* Concerns about the development of eating disorders after bariatric surgery.

# EATING DISORDERS AND DIABETES

## **DISORDERED EATING AND DIABETES**

# Disordered eating and diabetes

## Standard diabetes treatment

- \* dietary intake and exercise habits

## Places women with diabetes at risk

- \* focus on weight, eating and exercise
- \* unhealthy concerns about body shape and weight and/or inappropriate eating and dieting behaviors

# Disordered Eating and Diabetes

## The potential to misuse of insulin

- To control shape and weight
- A unique form of compensatory behavior
- Insulin may be increased to promote calorie loss
- OR a dose may be omitted

## Flexible dosing schedules

- may intentionally fail to increase standard dosage to account for an episode of binge eating to avoid weight gain.

# Disordered eating and diabetes

## Eating to manage mood and stresses

- \* Relationship with food can influence mental or physical health and hinders them from having a normal healthy life

## Long history of trying restrictive diets

- \* to regain control
- \* repeatedly failed and yo-yo up and down
- \* weight is only a ***symptom***, not the ***problem***
- \* intervention that involves dieting or restricting diet alone is destined to fail

# Disordered eating and Diabetes cont..

- \* Ways BED patients self-regulate intense feeling-states
  - \* experts at disconnecting from feelings and from self
  - \* over involvement with food and “food thoughts”
  - \* use “food thoughts” in reaction to and as a defense against stressful life situations
  - \* way of managing moods becomes a habit and a way of life
- \* Suggesting a diet very often adds more stress
  - \* leads to a binge right after the visit to the doctor’s office

# Disordered eating and Diabetes cont..

- \* Newly diagnosed diabetics
  - \* Many go through the typical stages of mourning
    - \* denial
    - \* bargaining
    - \* anger
    - \* depression
    - \* acceptance



# Similarities Between Diabetes and Eating Disorders

Both demand paying **close** attention to:

1. body states
  2. weight management
  3. types and amounts of food consumed  
timing and content of meals.
- **Control** is central issue in both diabetes and eating disorders.
  - Diabetics can feel guilty, anxious and out of control if blood sugar swings more than a few points.

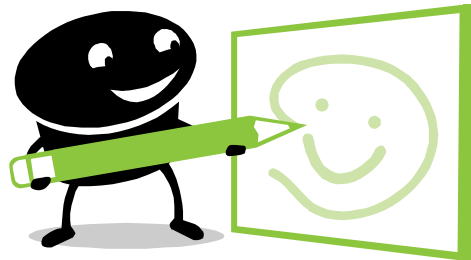
# Similarities Between Diabetes and Eating Disorders

- Binge eaters feel guilty, anxious and out of control if their weight fluctuates.
- Children with diabetes may perceive parents as overprotective and over controlling.
- Children with eating disorders describe parents in similar terms.
- BOTH are Preoccupied with weight, food and diet.

# Tests Available

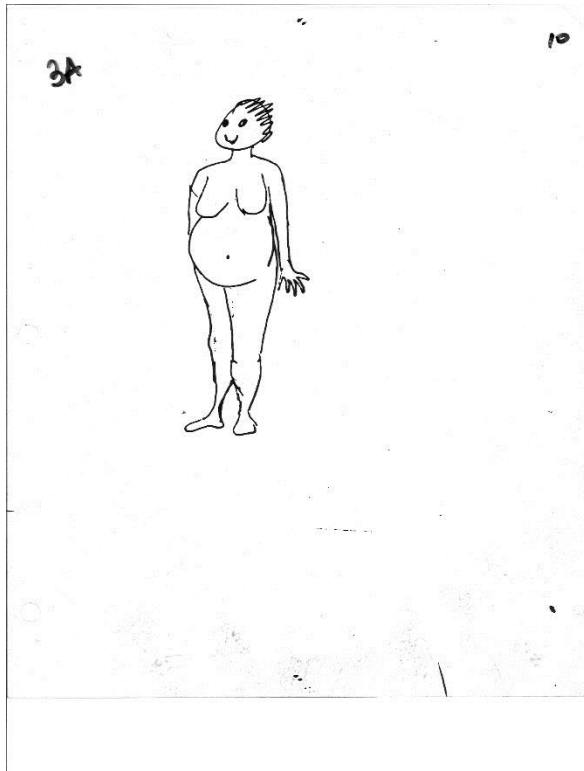
- \* *Many tests are available, the two most popular ones are:*
- \* *The Eating Attitudes Test (Garner DM, Olmstead MP, Bohr, Y, Garfinkel)*
- \* *Eating Disorders Inventory (Garner DM, Olmstead MP, Polivy J)*
- \* *Both provide assessments of the attitudes and behaviors associated with eating disorders and have been widely used in nonclinical populations.*

# The Drawings

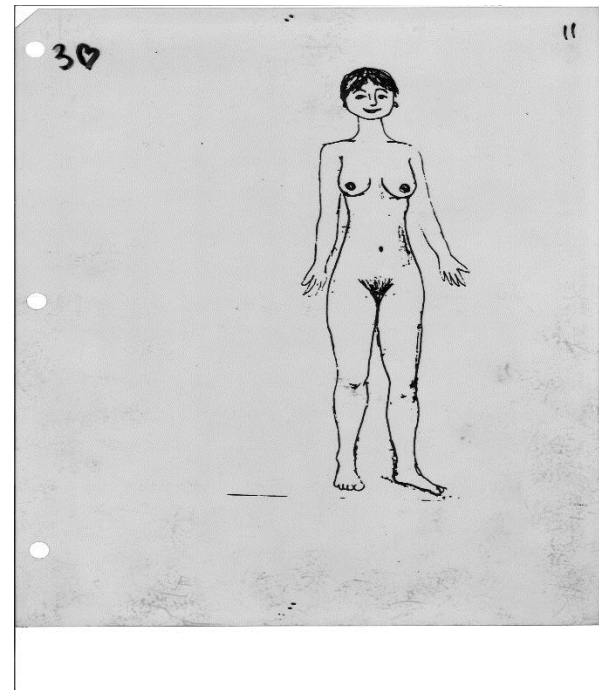


# Mary

Mary Before

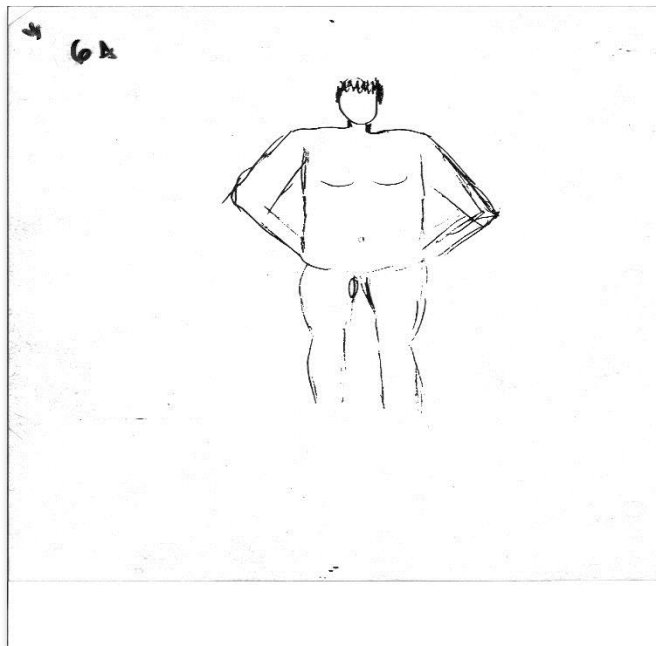


Mary After

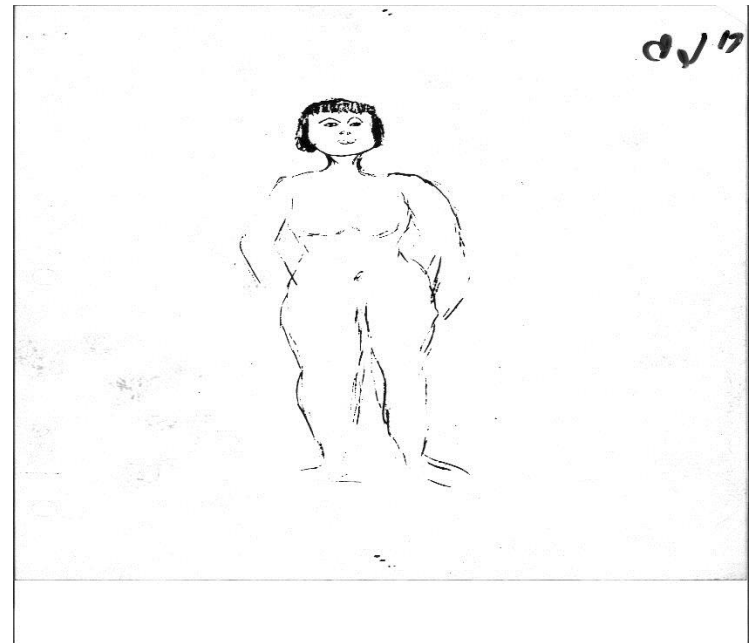


# Jane

*Jane Before*

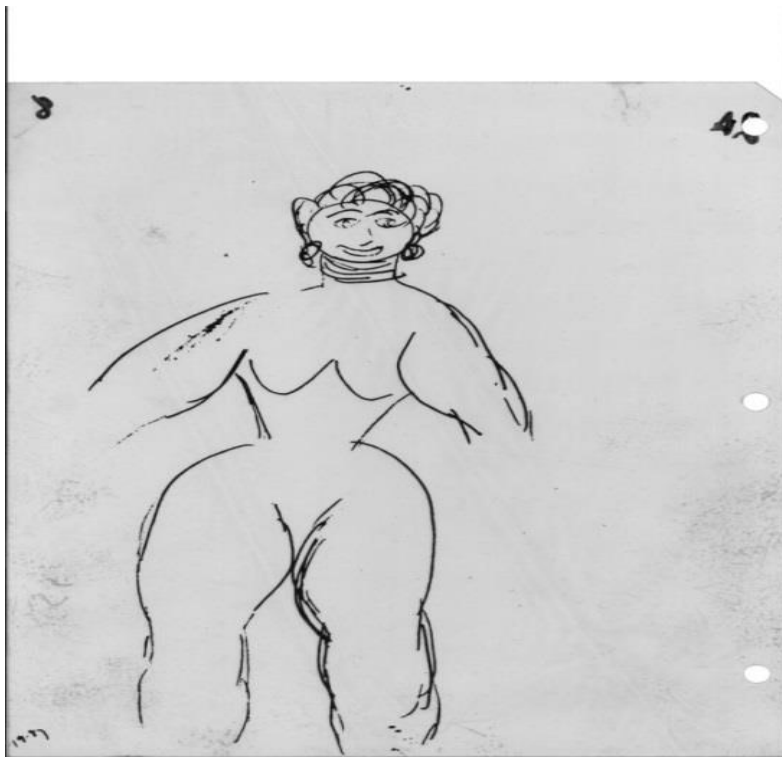


*Jane After*

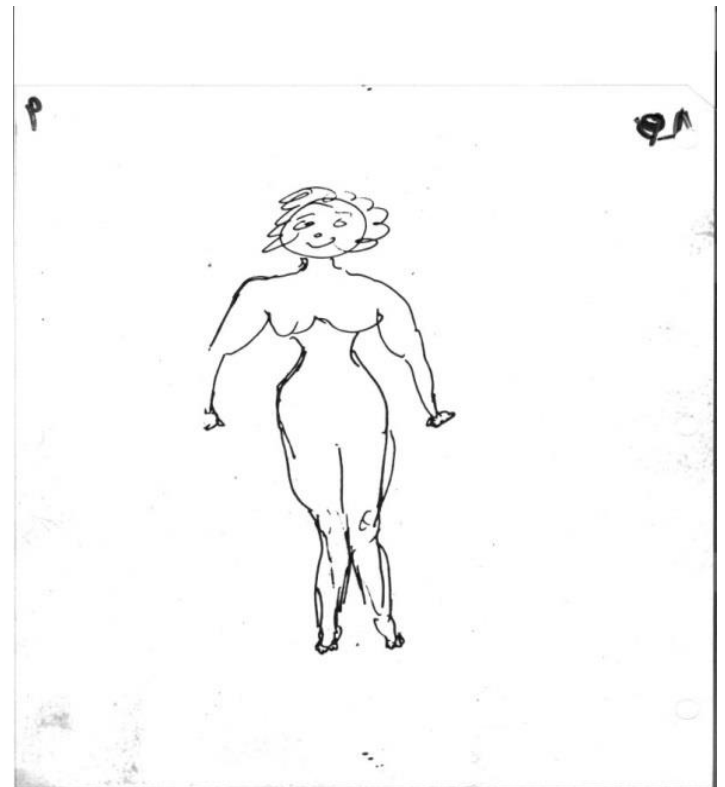


# Ann

Ann Before

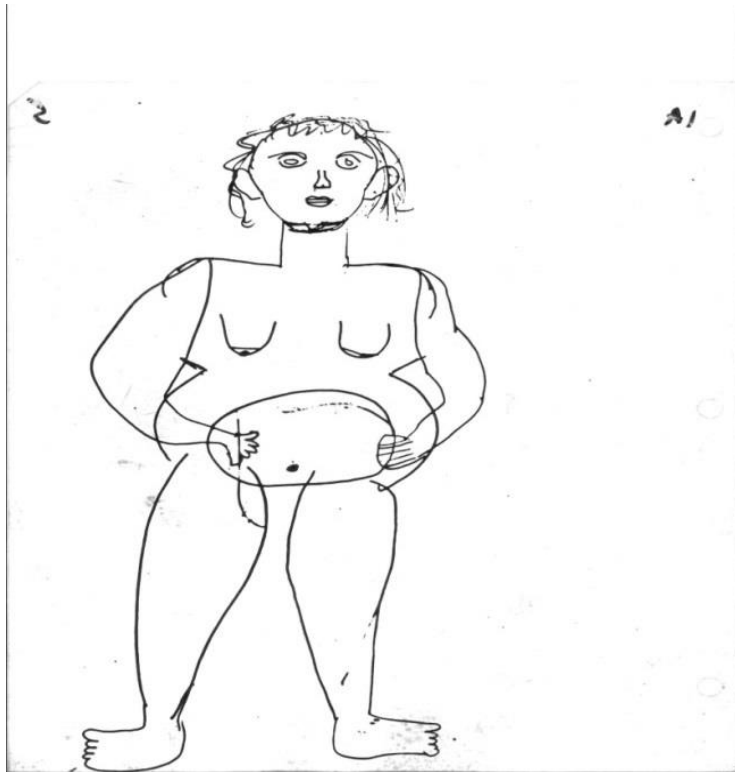


Ann After

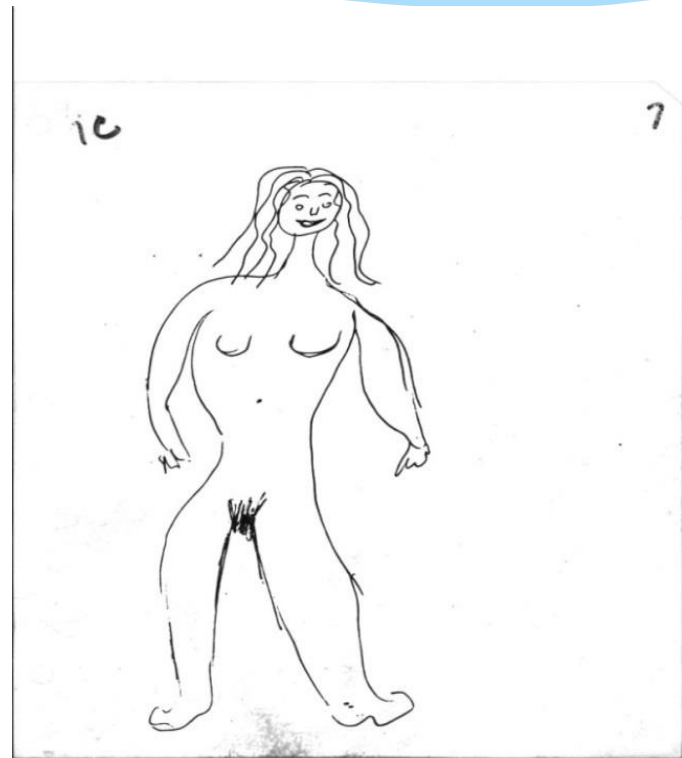


# Joan

Joan Before



Joan After





# SMART Goal Setting

**S** = Specific  
**M** = Measurable  
**A** = Attainable  
**R** = Realistic  
**T** = Timely



# SPECIFIC

- Goals should be straightforward and ***clearly define what the person is going to do.***
- Specific is the What, Why, and How of the SMART model.
- **WHAT** are they going to do? Use action words such as direct, organize, coordinate, lead, develop, plan, build etc.
- **WHY** is this important to do at this time? What do they want to ultimately accomplish?
- **HOW** are they going to do it? (By...)

# MEASURABLE

- **If you can't measure it, you can't manage it.** There are usually several short-term or small measurements that can be built into A LONG TERM goal.
- Choose a goal with measurable progress, **so they can see the change occur.**
- **Establish concrete criteria for measuring progress** toward the attainment of each goal they set.

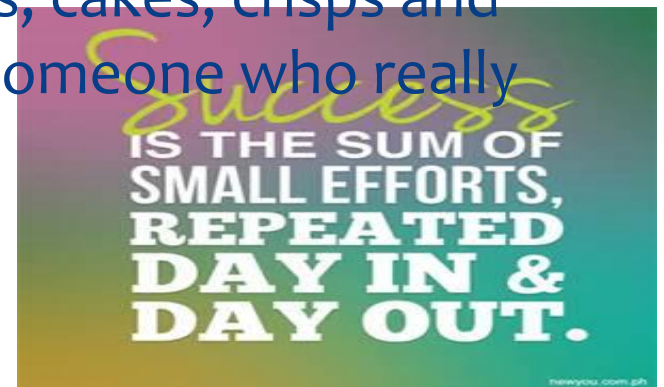


# ATTAINABLE

- Develop attitudes, abilities, skills, and financial capacity to reach them.
- Goals people set which are **too far** out of their reach, they probably won't commit to doing probably won't last.
- **A goal needs to stretch slightly so people feel they can do it and it will need a real commitment.**

# REALISTIC

- ***This is not a synonym for "easy."*** Realistic, in this case, means "**do-able.**"
- ***Devise a plan*** or a way of getting there which makes the goal realistic.
- A goal of never again eating sweets, cakes, crisps and chocolate may not be realistic for someone who really enjoys these foods.



# TIMELY

Set a ***time frame for the goal***: for next week, in three months etc. Putting an end point on the goal gives a ***clear target*** to work towards.

**LOSING WEIGHT IS A MIND GAME.**  
**CHANGE YOUR MIND,  
CHANGE YOUR BODY.**

# Treating BED, Diabetes and Bariatric Surgery Patients

- \* Team treatment most effective
- \* Cognitive behavioral therapy is best psychological treatment studied to date
- \* Interpersonal psychotherapy (IPT)
- \* Antidepressant medication.
- \* Skills training DBT (based on work of Marsha Linehan, Ph.D., 1993)
- \* Group therapy

# GROUP THERAPY

- \* Group can be crucial in the treatment process
  - \* Provides **structure** and **boundaries** with members learning self-regulation, limit-setting in a safe environment
  - \* teaches members to develop a respectful attitude toward the self and the body
  - \* provides the compassionate **safety** in which to explore the risks of emotional connection with other members who also feel isolated.



# ASK FEELING QUESTIONS

How do you feel .....

- \* About receiving compliments from me about losing weight?
- \* About gaining weight?
- \* About my reading your eating journals?
- \* When you know you are coming in to see me?
- \* When I make suggestions that you feel are too difficult but you can't tell me?
- \* When someone tells you not to eat a certain food?
- \* About your body changing, getting smaller, larger?

# ASK FEELING QUESTIONS

Support the client : Don't accept “ I don't know”“ for an answer.

❖ this is the classic resistant “shut off” response for clients! Keep asking... (Ex. “I know you don't know, but what if you did know?”)

Let the client talk in detail (about **emotions** only) about eating binges or rituals.

# IN CONCLUSION



1. Help patients Become conscious of when they are using food to avoid feelings or to manage their moods.
2. Identify the factors that drive (and perpetuate) unhealthy eating behaviors.
3. Develop healthier coping strategies to replace the old eating patterns that have proven to be so painful.