# Taking Hunger Out of the Equation: Binge eating disorder & bariatric assessments

Presented by:
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This workshop is not a substitute for additional training that may be necessary to ensure competence and the ability to provide an appropriate level of care to clients. It is the responsibility of all mental health providers to ensure they practice within their scope of practice, seek consultation when appropriate, and follow the legal and ethical standards set forth by the state and their licensing board. Legal, ethical, clinical, and cultural standards can change quickly, and it is ultimately the responsibility of each individual therapist to remain informed on all relevant changes.



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## ABOUT THE PRESENTER:

**Bren Michelle Chasse, LMFT**

Ms. Chasse is the founder of Anchor Psychotherapy, Inc. and is a leading trauma expert in Pasadena, California. Ms. Chasse specializes in the experience of psychological trauma. She is EMDR-Certified and an EMDRIA Approved Consultant. Additionally, she has trained at a master level in Attachment-Focused EMDR and Ego States (“parts work”).

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# LEARNING OBJECTIVES

- Participants will be able to identify 2 distinct characteristics that make binge eating disorder unique to other eating disorders.
- Participants will be able to distinguish between the 3 most common weight loss surgery procedures.
- Participants will be able to identify 3 types of transitional changes weight loss surgery clients frequently experience.
- Participants will be able to identify 4 critical psychosocial criteria for weight loss pre-surgical assessments.

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# "TYPICAL" EATING DISORDERED PERSON

Young, white, female, Western culture, heterosexual, upper SES, high-achieving, perfectionist, dichotomous thought process

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# Do Eating Disorders Really Require Our Attention?

- Every 62 minutes at least one person dies as a direct result of an eating disorder. (Eating Disorders Coalition, 2019)
- Eating disorders have the 2nd highest mortality rate of any mental health condition → surpassed only by opioid addiction. (Chesney et al., 2014)
- 13% of women over 50 yo engage in disordered eating behaviors. (Gagne et al., 2012)
- 16% of transgender college students report having an eating disorder. (Gagne et al., 2012)
- 35% of female college athletes and 10% of male college athletes were shown to be at risk for anorexia. (National Center on Addiction & Substance Abuse, 2003)
- 58% of female college athletes and 38% of male college athletes were shown to be at risk for bulimia. (National Center on Addiction & Substance Abuse, 2003)
- Significant increased risk for suicide among **ALL** eating disorders → calls for comprehensive assessment by all clinicians. (Fitcher & Quadflieg, 2016)

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# COMORBIDITY

- 2014 Study (*n* > 2400 individuals hospitalized for an ED) (Tagay et al., 2014)
  - 97% had one or more co-occurring conditions
    - 94% presented with a mood disorder (predominantly MDD)
    - 56% presented with an anxiety disorder
      - 20% = OCD
      - 22% = PTSD
      - 22% = alcohol/substance use disorder
  - 1 in 4 presented with symptoms of PTSD
  - 38% regularly engage in self-harm
- Significant correlation between ED's and BPD also shown. (Mangweth et al., 2003; McElroy et al., 2006)

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# MEDICAL SIGNIFICANCE

- Obesity is the epidemic with the greatest prevalence and incidence in the United States. (Hurt et al., 2010; Flegal et al., 2001; Ogden et al., 1999-2000)
  - 60% of adults are currently either overweight or obese. (2.3 billion people worldwide)
  - 19% of minor children are currently obese.
  - Incidence of obesity has doubled in the United States since 1960.
- Annual allocation of healthcare resources for the disease and related comorbidities are projected to exceed $150 billion in the United States. (Hurt et al., 2010)
- Obesity is currently the second leading cause of preventable death in the United States. (Hurt et al., 2010; Flegal et al., 2001; Ogden et al., 1999-2000)
  - Expected to soon surpass tobacco-related deaths.
  - Each year 300,000 deaths in the United States are attributable to obesity.
- Obesity epidemic is no longer limited to Western society.
  - Globally, it's estimated that annually there are 4 million premature deaths related to obesity. (Ogden et al., 1999-2000)

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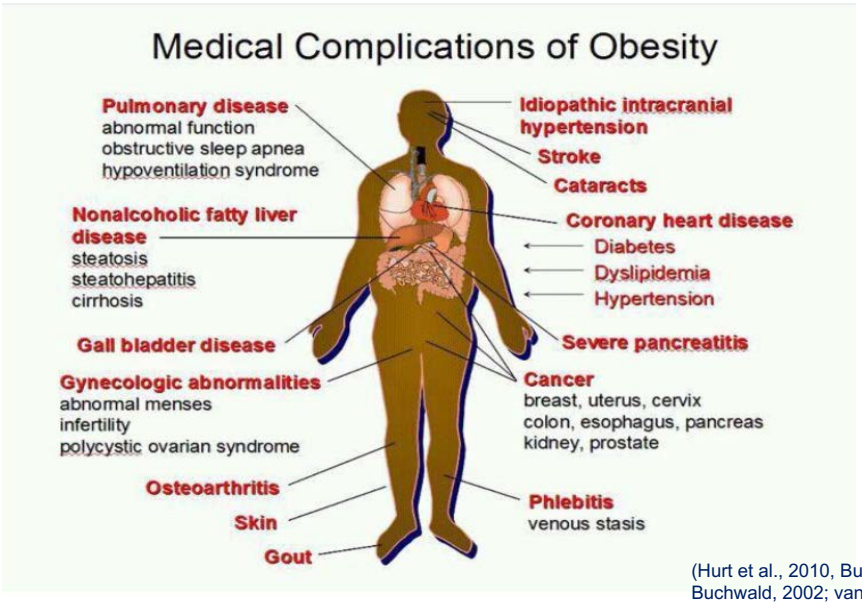


(Hurt et al., 2010, Buchwald & Buchwald, 2002; van Hout et al., 2004)

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# BINGE-EATING DISORDER (BED)

- Recurrent episodes of binge eating, characterized by **both** of the following:
  - Eating, in a discrete period of time (e.g., 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
  - A sense of lack of control overeating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average 1x/week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia or anorexia.

(American Psychiatric Association, 2013; Photo Credit: iStock by Getty Images)

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# LIMITATIONS OF THE DSM 5

- It is **NOT** trauma-informed, nor is it designed to be viewed through a trauma-informed lens.
  - Studies of the DSM over time have consistently shown poor rates of statistical reliability in diagnoses (Chmielewski et al., 2015).
  - Focus is on intake/output, weight, & behavior → all measurable variables
- Within our own field, we continue to refuse to give language to the primary sources of trauma → labeling problematic/undesirable behavior in ways that are stigmatizing and/or blame the victim.
  - e.g., Oppositional Defiant Dx, ADHD, Bipolar, Intermittent Explosive Dx; Disruptive Impulse Explosive Dx, Dysregulated Social Engagement Dx
  - Z-Codes: Most common sources of trauma are given diagnostic labels without any official standing (not reimbursable diagnoses).
  - Dismiss the social causation of many of the contributing factors & replace them with symptom-based diagnoses (labels of dysfunction and mental impairment).

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# RESEARCH

- Because of the challenges of BED being acknowledged as its own distinct disorder, the research regarding BED is significantly more limited than that of anorexia and bulimia. (Hudson et al., 2007)
- 2007 study (*n* = 9,282 English-speaking Americans) inquired about a variety of mental health conditions: (Hudson et al., 2007)
  - 3.5% of women & 2% of men met criteria for BED during their lifetime.
  - Results showed BED is greater than 3x more common than anorexia and bulimia COMBINED!
  - BED is more common than breast cancer, HIV, & schizophrenia.
- BED clients: approximately 60% = female; approximately 40% male (Westerberg & Waitz, 2013)
- 3 of 10 people seeking weight loss treatment show signs of BED. (Westerberg & Waitz, 2013)

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## OBESITY vs. BINGE EATING

- NOT mutually inclusive → Obesity ≠ Binge Eating
- OBESITY:
  - Chronic & progressive disease that affects every organ & system in the body. (Flegal et al., 2001)
  - Obesity impacts an individual's quality of life, as well as one's emotional well-being. (Flegal et al., 2001)
  - Epidemic with the greatest prevalence & incidence in the U.S. (Flegal et al., 2001)
  - Annual allocation of healthcare resources for the disease and related comorbidities are projected to exceed $150 billion in the U.S. (Flegal et al., 2001)
  - Obesity is currently the second leading cause of preventable death in the U.S. (Flegal et al., 2001)

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# How Society Defines the Obese Person

WEAK
LAZY
UNSUCCESSFUL
STUPID
NON-COMPLIANT
POOR SELF-CONTROL
DISGUSTING


DIRTY
INCAPABLE
LACKING WILLPOWER
UGLY
SLOPPY
GROSS
DANGEROUS

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# What I See In My Office

PAIN
SHAME
HORROR
DISGUST
GUILT
ISOLATION

SELF-LOATHING
GRIEF
LOSS
TRAUMA
ABANDONMENT
FEAR

(Photo Credit: iStock by Getty Images)

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## THE POWER OF WORDS

URBAN HIPPO
FRIDGE MAGNET
BUFFET-SLAYER
BACK TITS
MC-LARDO
GOOD YEAR BLIMP
DUMPY
DRAIN ON SOCIETY
CALORIE QUEEN
FAT
CHUNKY
BEACHED WHALE
EMBARRASSING
BUTTERBALL
HOG
PIG
PIGGY
PIGLY
LAZY
MAN BOOBS
UGLY
FUGLY
GROSS

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## BIAS, STIGMA, & DISCRIMINATION

- Negative attitudes toward obese persons are pervasive and are considered an acceptable form of bias. (Flegal et al., 2001)
  - Recent estimates suggest the prevalence of weight discrimination has increased by 66% in the past decade and is now comparable to prevalence rates of racial discrimination in America. (Flegal et al., 2001)
    - NOT a result of increased obesity rates!!!
- Absolutely no current legislation or protection against overt discrimination. (Paul & Townsend, 1995)
  - Cannot file claims under ADA as obesity is not a protected class.
  - Being identified as a protected class may be additionally stigmatizing and perpetuate further bias.
- Societal belief is that weight discrimination is justifiable because obese individuals are personally responsible for their weight—and the belief is that the answer to their problem lies within. (Puhl & Heuer, 2009; Puhl et al., 2008, Puhl et al., 2004)

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# SUBTLE FORMS OF EVERYDAY EXCLUSION

**MEDICAL PROFESSIONALS**

- MRI machines, gowns
- MD's frequently dismiss the concerns of obese patients & attribute their concerns to their weight
- "Mary Kay"
- ER nurse

**RESTAURANTS**

- Booths only; chairs with arms
- "stick figure booth"

**AIRPLANES**

- Seatbelts
- Emergency aisle

**EMPLOYMENT-BASED DISCRIMINATION**

- Clinical Supervisor @ Internship
- Weight loss books on desk

(Photo Credit: iStock by Getty Images)

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Originally aired on HBO on September 6, 2019.

(Real Time with Bill Maher, 2019)

https://www.youtube.com/watch?v=Dm4TAdiEFn0&feature=youtu.be

Photo credit: HBO Network

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Originally aired on CBS on September 12, 2019.

(The Late Late Show with James Corden, 2019)

https://www.youtube.com/watch?v=Ax1U04c4gaw&feature=youtu.be

Photo credit: CBS Network

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# Shame is NOT a Call to Action!

- 79% of weight-loss program participants report coping with weight stigma by eating more food. (Andreyeva et al., 2008)
- American elementary school girls who report they read magazines: (Martin, 2010)
  - 69% report pictures influence their concept of the ideal body shape
  - 47% report pictures make them want to lose weight
- Weight teasing has been shown to be a predictor of weight gain, binge eating, and extreme weight control measures: (Golden et al., 2016)
  - Approximately 40% of overweight girls & 37% of overweight boys are teased about their weight by peers & family members.
- Weight stigma poses a significant threat to one's psychological and physical health.
  - Research shows it is a significant risk factor for an increase in depression, low self-esteem, and body dissatisfaction. (Andreyeva et al., 2008)

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## Hierarchy within the ED Community


Anorexia

Bulimia



Binge Eating Disorder

(Photo Credit: iStock by Getty Images)

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## Personal Disclosure

**October 21, 2015**

**433 pounds**

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# Most Common Weight Loss Surgical Procedures

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- **Roux-En-Y (RNY)** (van Hout et al., 2004; Buchwald & Buchwald, 2002)
  - Malabsorption
  - Re-route intestines to bypass absorption
  - Small pouch created from the original stomach
  - Best outcome long term; greatest weight loss shown
- **Sleeve Gastrectomy**
  - No malabsorption
  - Fewer risks compared to RNY
  - Maintain original physiology
  - Poor outcome long term; significantly less weight loss compared to RNY
- **Lapband**
  - No malabsorption
  - Reversible/Adjustable
  - Requires regular adjustment to maintain
  - Very poor long-term outcomes (complications & weight loss)
  - Many MD's have stopped performing this procedure due to patient abuse

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# Biggest Complaint I Hear From Bariatric Clients:

*"My therapist just doesn't get it!"*

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# Gotta Learn the Lingo!

- RNY & VSG
- WLS
- NSV
- Surgiversary
- Food Funeral
- Dumping Syndrome
- Reactive Hypoglycemia

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## PHYSICAL, EMOTIONAL & RELATIONAL CHANGES

(van Hout et al., 2004; Buchwald & Buchwald, 2002)

- **Physical Changes**
  - Gastrointestinal distress
  - Frequent vomiting
  - Hair loss
  - Excess/Loose skin
  - Rapid change leaves the individual little time to adjust to new body dimensions
- **Emotional Changes**
  - Increase in depression & anxiety
  - Increased risk for suicide
    - Psychological & physiological factors (i.e., gut changes)
  - Grief (loss of best friend & trusted coping mechanism)
- **Relational Changes**
  - "I'm afraid my partner won't be attracted to me anymore."
  - "My partner is insecure because others now find me attractive."
  - "My friends are jealous of me now."

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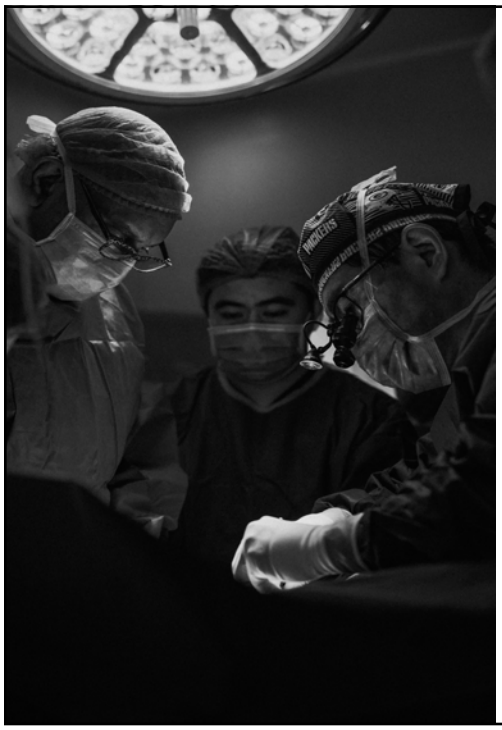

## WLS PRE-SURGICAL PSYCHOSOCIAL ASSESSMENT

- **Procedure**
  - Knowledge of procedure & risks
  - Client's goals
  - Level of impairment
- **Medical History**
  - Patient History
  - Relevant family history
  - First WLS procedure?
  - Comorbid conditions:
    - Diabetes
    - Sleep apnea
    - PCOS
    - Insulin resistance
    - Metabolic syndrome
    - Acid reflux
  - Medications

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- **Substance Use**
  - Caffeine & carbonated drinks
  - Tobacco/Nicotine
  - Alcohol
- **Psychiatric History**
  - Depression (screen for SI/attempts; Hx of self-harm)
  - Anxiety
  - Use of psychotropic meds → medication & treatment compliance
  - Cluster B traits
  - Hx of psychotic features
  - Hx of psychiatric hospitalization
  - Substance abuse/addiction history
  - Therapy → treatment compliance
  - Trauma history (especially Hx of sexual abuse)

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- **Weight/Obesity History**
  - Insight?
  - Goals
  - Dieting history
    - Success in the past
    - Barriers to long-term/sustained success
- **Client's Strengths**
  - Family/Peer support
  - Hobbies
  - Self-care
  - Insight?
- **Potential Barriers to Success**
  - Sleep (e.g., night shift worker)
  - Insight?
  - Stressors (e.g., family systems, cultural implications, surgery disclosure, work, travel, financial)

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- **Client's Mindset**
  - Control issues
  - Belief systems about food (e.g., food = enemy)
  - Negative belief systems about self
  - Quick fix
  - Heavy reliance on the surgical procedure
  - Use of protein shakes as a crutch
  - Behavior modification, expectations regarding recovery, & treatment compliance
  - Rituals & habits
  - Mindful eating
  - Post-surgical goals

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## It's a zoo out there!

- No industry standards or required certification
- No therapy requirement (pre/post surgery)
- Scope of practice issues
- Liability
- Potential pitfalls


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## MULTIDISCIPLINARY APPROACH TO TREATMENT

- Surgeon
- Registered Dietician
  - WLS Informed
  - Trauma Informed
- Psychotherapist
  - WLS Informed
  - Trauma Informed
- Support Network

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# ADDENDUM

- Food Relationship Inventory
- Article by Bren M. Chasse, LMFT (The Importance of Collaborative Mental Health Care in Weight Loss Surgery)
- Article by Matthew Metz, MD, FACS (Bariatric Surgery is NOT the Easy Way Out: A bariatric surgeon's perspective)
- Article by Alexandra Tashman (Seen Not Heard: Experience of overweight students on campus often overlooked)

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**References**

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Andreyeva, T., Puhl, R. M. & Brownell, K. D. (2008). Changes in perceived weight discrimination among Americans, 1995–1996 through 2004–2006. *Obesity, 16*(5)*:* 1129–1134. https://doi.org/10.1038/oby.2008.35

Buckwald, H., & Buchwald, J. N. (2001). Evolution of operative procedures for the management of morbid obesity 1950-2000. *Obesity Surgery, 12*, 705-717.

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry, 13*(2), 153-160.

Chmielewski, M., Clark, L. A., Bagby, R. M., & Watson, D. (2015). Method matters: Understanding diagnostic reliability in DSM-IV and DSM-5. *Journal of Abnormal Psychology, 124*(3), 764-769. https://psycnet.apa.org/doiLanding?doi=10.1037%2Fabn0000069

Eating Disorders Coalition. (2019, April) *Facts about eating disorders: What the research Shows.* Retrieved December 29, 2019, from https://www.eatingdisorderscoalition.org/innertemplate/facts_and_info/facts-about-eating-disorders.html

Fichter, M. M., & Quadflieg, N. (2016). Mortality in eating disorders: Results of a large prospective clinical longitudinal study. *International Journal of Eating Disorders 49*(4), 391-401.

40

Flegal, K.M., Ogden, C. L., Wei, R., Kuczmarski, R. L., & Johnson, C. L. (2001). Prevalence of overweight in US children: Comparison of US growth charts from the centers for disease control and prevention with other reference values for body mass index. *American Journal of Clinical Nutrition 73*(6),1086–1093.

Gagne, D. A., Von Holle, A., Brownley, K. A., Runfola, C. D., Hofmeier, S., Branch, K. E., & Bulik, C. M. (2012). Eating disorder symptoms and weight and shape concerns in a large web-based convenience sample of women ages 50 and above: Results of the gender and body image (GABI) study. *International Journal of Eating Disorders*, *45*(7), 832-844.

Golden, N. H., Schneider, M., & Wood, C. (2016). Preventing obesity and eating disorders in adolescents. *Pediatrics, 138*(3), [e20161649]. doi:10.1542/peds.2016-1649

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry*, *61*(3), 348–358. 10.1016/j.biopsych.2006.03.040

Hurt, R. T., Kulisek C., Buchanan, L. A., & McClave, S. A. (2010). The obesity epidemic: Challenges, health initiatives & implications for gastroenterologists. *Gastroenterol Hepatol, 12*, 780-792.

Mangweth, B., Hudson, J. I., Pope, H.G. Jr., Hausmagn, A., DeCol, C., Laird, N. M., Beibl, W., & Tsuang, M. T. (2003). Family study of the aggregation of eating disorders and mood disorders. *Psychological Medicine, 33*(7)*,* 1319-1323.

Martin, J. B. (2010). The development of ideal body image perceptions in the United States. *Nutrition Today, 45*(3), 98-100. Retrieved December 27, 2019, from nursingcenter.com/pdf.asp?AID=1023485

McElroy, S. L. O., Kotwal, R., & Keck, P. E. Jr. (2006). Comorbidity of eating disorders with bipolar disorder and treatment implications. *Bipolar Disorders, 8*(4)*,* 686-695.

41

National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2003). *Food for thought: Substance abuse and eating disorders.* The National Center on Addiction and Substance Abuse (CASA) Columbia University; New York.

Ogden, C. L., Flegal, K. M., Carroll, M. D., & Johnson, J.L. (2002). Prevalence and trends in overweight among US children and adolescents, 1999-2000. *JAMA, 288*, 1728-1732.

Paul, R. J. & Townsend, J. B. (1995). Shape up or ship out? Employment discrimination against the overweight. *Empl Respons Rights Journal, (8)*, 133-145.

Puhl, R. M., Andreyeva, T., & Brownell, K. D. (2008). Perceptions of weight discrimination: Prevalence and comparison to race and gender discrimination in America. *International Journal of Obesity, 32*, 992-1000. http://dx.doi.org/10.1038/ijo.2008.22

Puhl, R. M. & Brownell, K. D. (2003). Ways of coping with obesity stigma: Review and conceptual analysis. *Eating Behavior, 4*, 53-78.

Puhl, R. M., & Heuer, C. A. (2009) The stigma of obesity: A review and update. *Obesity, 17*, 941-964. http://dx.doi.org/10.1038/oby.2008.636

Real Time with Bill Maher. (2019, September 6). *New rule: The fudge report*. [Video]. YouTube. Retrieved December 29, 2019, from https://www.youtube.com/watch?v=Dm4TAdiEFn0&feature=youtu.be

Tagay, S., Schlottbohm, E., Reyes-Rodriguez, M. L., Repic, N., & Senf, W. (2014). Eating disorders, Trauma, PTSD, and Psychosocial Resources. *Eating Disorders, 22*(1), 33-49.

42

The Late Late Show with James Corden. (2019, September 12). *James Corden responds to Bill Maher's fat shaming take.* [Video]. YouTube. Retrieved December 29, 2019, from https://www.youtube.com/watch?v=Ax1U04c4gaw&feature=youtu.be

Westerberg, D. P., & Waitz, M. (2013). Binge-eating disorder. *Osteopathic Family Physician, 5(6), 230-233.*

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