Eating disorders in obese people

Introduction

The issue of obesity and eating disorders (PPP) has many mutually dependent aspects. Obesity (and even more so-called dieting) can play a significant role in the etiology of eating disorders . Diets then, along with overeating, turn in the development of obesity. Obesity in metabolic syndrome leads to increased cardiovascular mortality and morbidity , bariatric surgeries that treat not only obesity, but also other components of metabolic syndrome, help reduce this risk .

Eating disorders, especially anorexia nervosa and bulimia nervosa, have long enjoyed the interest of psychiatrists, internists get only when complications arise – malnutrition, ion disruption. It is paradoxical that obesity, on the contrary, is treated almost exclusively by internists, unless it is accompanied, for example, by depression. Until now, eating disorders in obese people have been completely out of the focus of internists, so patients have not even been referred for psychiatric diagnosis.

Among the obese, the following eating disorders are most common: binge eating disorder, Night Eating Syndrome and Grazing. Individual failures are further specified in more detail.

None of these eating disorders are specified in ICD 10. In the 10th revision of the International Classification of Diseases, we find the categories Overeating associated with other mental disorders (F50.4) (https://mkn10.uzis.cz/prohlizec/F50.4), Vomiting associated with other mental disorders (F50.5) (https://mkn10.uzis.cz/prohlizec/F50.5), Other eating disorders (F50.8) (https://mkn10.uzis.cz/prohlizec/F50.8) and Unspecified eating disorder (F50.9). Overeating associated with other psychological disorders is described as overeating that led to obesity in response to a stressful event. Loss of a loved one, accidents, surgeries and emotionally stressful events can trigger "reactive obesity", especially in patients prone to weight gain.

Description of individual failures

Binge eating disorder (BED)

The following criteria are listed in DSM IV (Diagnostic and Statistical Manual of Mental Disorders – an internationally used handbook of the American Psychiatric Association, 1994):

A. An overeating attack is defined as eating more food than normal over a short period of time (less than 2 hours). During a seizure, the patient loses control over his eating behavior.

B. Seizures are associated with 3 or more of the following signs:

- the patient eats to an unpleasant fullness;
- consume large amounts of food without feeling hungry;
- food is eaten faster than usual;
- they eat alone because they are ashamed of the amount of food consumed;
- After overeating, there is a feeling of guilt, depression, disgust with oneself.

C. Present anxiety is associated with binge eating.

D. Bouts of overeating occur at a frequency of at least twice a week for the past 6 months.

E. Binge eating is not associated with subsequent compensatory behavior (as with other PPPs).

Research on binge eating is inconsistent, as different criteria have been used to assess the severity of binge eating. Research that used strictly the criteria for diagnosing BED according to DSM IV points to a frequency of occurrence of this disorder in obese people of 4.2% or 7.5% . In those waiting for bariatric surgery, it was 10–27% .

Regardless of the rigor of the criteria used to diagnose BED, studies agree that patients with BED have higher depression scores , earlier onset of obesity and more general psychopathology . In individual researches, we find that patients with this disorder crave more food, use weight loss drugs more, have a greater fear of thickness and lower body satisfaction than obese people without this disorder . More often it is women, younger than 45 years, with a higher BMI (over 42) .

Night Eating Syndrome, (NES)

The NES criteria are not yet specified in the International Classification of Diseases. A.Stunkard is seeking their inclusion in DSM V . In his opinion, it is a complex biobehavioral disorder with a violation of the circadian rhythm.

Stunkard specifies 2 basic diagnostic criteria:

A. eating in the evening (at least 25% of the daily calorie intake is consumed after dinner);

B. and/or awakening associated with food intake at least three times a week.

According to A. Stunkard the incidence of this disorder is 6–16% in the obese population and 8–42% in patients eligible for bariatric surgery. In Italy, 10% of patients with grade 2 and 3 obesity (BMI is greater than 35) were diagnosed with NES, and they also found an increased incidence of depression in these patients . Our clinical experience is best matched by the results of Allison et al.'s research, which narrows the frequency of occurrence of this syndrome in patients prior to bariatric surgery to 1.9–3.9%.

The NES needs to be distinguished from the so-called NES. Sleep related eating disorder (SRED). This disorder is specified by rapid consumption of food (usually within ten minutes), but also non-edible objects (detergents, glue, etc.). Although these seizures also happen at night, they do not shift the circadian rhythm of eating. The patient usually has amnesia for nocturnal eating attacks.

Continuous eating (Grazing)

Newly described symptom so far outside the attention of researchers and clinicians. It is a continuous consumption of smaller amounts of food without voluntary control. To diagnose this symptom, it is not primarily the amount of food consumed that is important, but the quality of experience, i.e. the subjectively negative perception of loss of control over one's eating behavior and excessive food intake. This symptom is very important to monitor especially in patients before bariatric surgery, as it can significantly affect the success of the procedure. Binge eating occurring in a patient before bariatric surgery may change to Grazing after surgery .

Diagnostics

Patients often do not admit to eating disorders, and if they are aware of them, they are ashamed of them and hide them not only from medical staff, but also from their immediate surroundings. Detecting PPP makes it easier to work with the diet, so it is often dietitians who are the first to suspect PPP. The patient also confides in the nurse about his problems more easily than the doctor, in front of whom he often tries to appear in a better light. However, an internist can diagnose PPP with several targeted questions such as: "Does it ever happen to you that you eat at night?", "Do you sometimes eat to an uncomfortable satiety?", "If so, under what circumstances and how often does this happen to you?", "Do you nibble during the day?", "Do you sometimes feel that the way you eat (e.g. the speed of eating) and what you eat, Are you losing control?". If the answers to these questions are positive (eating during the night shift and exceptional overeating at celebrations is not pathological), it is advisable to send the patient to a psychologist or psychiatrist for further diagnosis. Losing control over eating behavior and eating alone with subsequent feelings of shame are good clues to suspected PPP.

The topic of eating disorders and bariatric surgery is beyond the scope of this article. Simply put, when PPP is suspected, we prefer a malabsorption type of surgery (e.g. gastric bypass) to a restrictive one (e.g. gastric banding or gastric tubulization). However, one of the mandatory examinations before bariatric surgery is also a psychological examination, so the detection of eating disorders in bariatric candidates and the subsequent diagnosis procedure is thus ensured.

Therapy

Treatment of obese people with eating disorders requires a specific approach. It turns out to be profitable to work in a multidisciplinary team – internist, dietitian, clinical psychologist, consultant psychiatrist. Psychological treatment of eating disorders consists of psychotherapy. The type of psychotherapy depends on the psychotherapeutic equipment of a particular psychologist (or psychiatrist). In the treatment of eating disorders, both individual and multi-member (couple, family and multifamily) therapy is applied. The direction of therapy is also not strictly given, we can use a spectrum from behavioral types of psychotherapy through psychoanalytic therapies to humanistic and existential psychotherapy.

Psychiatric medication is suitable for long-term untreated and more severe forms of PPP. Of the non-psychiatric drugs, for example, sibutramine (temporarily suspended in distribution in Europe) has proven itself in the treatment of eating disorders in obese people. It not only contributed to the weight loss of patients, but also reduced the incidence of binge eating compared to the control group that took a placebo . A similar effect also has the antiepileptic drug topiramate with a beneficial anxiolytic effect inducing even a slight weight loss. In addition to topiramat, another anticonvulsant lamotrigine was tested . On the same principle, i.e. mainly suppression of impulsivity, dual antidepressants that specifically inhibit the reuptake of serotonin and norepinephrine (SNRIs – e.g. duloxetine) may also be effective.

Conclusion

Eating disorders significantly affect the success of treatment of obese patients. Treatment by only one specialist – whether obesitologist or psychiatrist – is not very effective and exhausting for the aforementioned specialist. In practice, a multidisciplinary approach has proven to be effective, preferably in a team – internist, dietitian, clinical psychologist and psychiatrist.

links

Related Articles

- Psychologické aspekty obezity
- Poruchy příjmu potravy

Source

- SLABÁ, Šárka. *Psychologické poradenství v praxi*[1].

Reference

1. SLABÁ, Šárka. *Psychologické poradenství v praxi*

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