Maladaptive Eating Patterns in Children

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ABSTRACT

Given the increasing frequency of obesity and related maladaptive eating patterns in pediatric populations, health care professionals in a variety of settings must find ways to treat persons who are obese and have maladaptive eating patterns. The authors summarized literature related to binge eating disorder, boredom eating, emotional eating, and night eating syndrome and developed educational handouts designed for children/adolescents and their families who present with these eating problems. These educational handouts may be used by primary care physicians, psychologists, psychiatrists, nurses, and other specialists in medical settings. They are free for use in educational purposes, with permission from the authors, but are not intended to replace appropriate health care and follow-up. J Pediatr Health Care. (2013) *27*, 109-119.

KEY WORDS

Obesity, binge eating disorder, educational handouts

Childhood obesity is a rising concern among health care professionals as the frequency of overweight children presenting in medical settings increases. It is well established that a myriad of physical consequences result from pediatric obesity, including cardiovascular disease (Dietz & Robinson, 2005), hypertension, high cholesterol, and abnormal triglycerides (Reilly et al., 2003), hyperinsulinism (Viner, Segal, Lichtarowicz-Krynska, & Hindmarsh, 2005), Type 2 diabetes (Aye & Levitsky, 2003), asthma (Castro-Rodriquez, Holberg, Morgan, & Martinez, 2001), obstructive sleep apnea (Shine, Coates, & Lannigan, 2005), and musculoskeletal problems such as Blounts disease (Deckelbaum & Williams, 2001). Pediatric obesity also has been linked to reduced quality of life (Griffiths, Parsons, & Hill, 2010), depression (Datar & Sturm, 2004; Swallen, Reither, Haas, & Meier, 2005), low self-esteem (Griffiths et al., 2010), and anxiety (Warschburger, 2005).

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Medical professionals often are called upon to treat obesity, but they have relatively little to no information on how to motivate a child to change eating behaviors successfully or how to assess for maladaptive eating behaviors (e.g., binge eating, emotional eating, boredom eating, and nighttime eating) that are present in a subgroup of obese individuals. Consequently, health care professionals and the patient and family must be informed about how to achieve specific goals of increased physical activity and lowered caloric intake and how to help the patient overcome a variety of barriers that may prevent personal change (Ward-Begnoche & Gance-Cleveland, 2005). The aim of this article is to define each

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maladaptive eating pattern and to discuss appropriate treatment recommendations. This article also provides educational handouts for patients and their parents on each type of eating pattern as a way to provide the information in a clear and concise manner that can be taken home as a reference.

BINGE EATING DISORDER

Binge eating disorder (BED) is not yet a formal diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, text revision (DSM-IV-TR; American Psychiatric Association (APA, 2000), but enough empirical support appears to exist to include it as a new diagnostic category in the DSM-5 (Striegel-Moore & Franko, 2008). BED is approximately 1.5 times more common in females, and it is believed that approximately 1% to 4% of community samples of adults have the disorder, although it may be as high as 15% to 50% among patients seeking treatment at weight-control clinics (APA, 2000). In one international study of a clinical sample of preadolescents and adolescents, approximately 1% of the sample met criteria for BED and 9% had binge-eating episodes (Decaluwé & Braet, 2003).

Currently persons who exhibit the symptoms of BED are diagnosed with "Eating Disorder, Not Otherwise Specified" because no other category is available within the DSM-IV-TR (APA, 2000). Currently, the research criteria for BED include recurrent episodes of binge eating (i.e., eating an amount of food that is larger than most other people would eat in a 2-hour period under similar circumstances) and feeling a lack of control over eating. Binging also is associated with three of the following characteristics: eating more quickly than usual, eating until feeling overly full, eating large amounts when not hungry, eating in isolation so as not to show others how much was eaten, and having feelings of disgust after eating. In addition, the person feels upset by the eating pattern and the binge eating occurs for at least 2 days a week for 6 months. Finally, the person does not display any compensatory behaviors that would occur with anorexia nervosa or bulimia nervosa such as purging, fasting, or excessive exercising (APA, 2000; Hudson, Hiripi, Pope, & Kessler, 2007).

In clinical practice, BED is commonly diagnosed and considered an accepted term for the aforementioned collection of symptoms (Dingemans, Bruna, & van Furth, 2002). One of the central features of BED may be a reported lack of control when eating. Children who reported a loss of control when eating had significantly higher body mass index scores, greater adiposity, more symptoms of anxiety and depression, and greater body dissatisfaction than did those who did not report a loss of control (Morgan et al., 2002). Persons with BED often display negative affect and view themselves as more obese than those who are of equal weight but do not engage in binging behaviors (Dingemans et al., 2002). These findings suggest that persons with BED may have more negative body image and appearance-related self-esteem problems than do those without BED. Similarly, Decaluwé, Braet, and Fairburn (2002) found that children who engaged in binge eating reported more concerns about shape and weight and had lower self-esteem than did children who did not engage in binge eating. Children with BED also may be overly concerned about food and eating behaviors (Allen, Byrne, La Puma, McLean, & Davis, 2008). Although dieting probably does not directly cause BED (Mitchell, Devlin, de Zwaan, Crow, & Peterson, 2007), calorie restriction may lead to later binging episodes in persons who already have the disorder (Mayo Clinic, 2008).

The goals of treating BED include reducing the frequency and severity of binges, improving coping skills related to impulsive behavior, and losing weight if the individual is overweight (Mayo Clinic, 2008). Currently, no medications have been approved by the Food and Drug Administration to specifically treat binge-eating disorder, although some medications, usually antidepressants, are prescribed to treat the disorder (Mayo Clinic, 2008). A recent meta-analysis indicated that psychopharmacotherapy, mostly in the form of antidepressants, resulted in a medium effect size in the reduction of binge eating (Vocks et al., 2010), which is similar to findings from an earlier meta-analysis on this topic (Reas & Grilo, 2008). However, research has not definitively demonstrated the efficacy of medications for BED, and some authors question the clinical significance of findings from medication trials (Wilson, Grilo, & Vitousek, 2007).

Several types of psychotherapy have been found to be effective treatments for adults with BED. One of the most effective forms of psychotherapy appears to be cognitive-behavior therapy (CBT; Dingemans et al., 2002). In their meta-analysis, Vocks et al. (2010) reported that CBT resulted in a large effect size for reducing binge eating. In addition, interventions using self-help strategies based on CBT techniques also were effective in producing positive changes, regardless of whether they were guided with or without the help of a therapist (Carter & Fairburn, 1998; Peterson et al., 1998). Researchers also have found interpersonal psychotherapy to be successful in the reduction of binge eating (Wilfley et al., 2002; Wilson, Wilfrey, Agras, & Bryson, 2010). It should be noted, however, that treatment for eating disorders such as BED can be expensive, frustrating, and take several months/years (Stewart & Williamson, 2004).

Behavioral recommendations are routinely made when treating BED. For instance, children should eat approximately five small meals/snacks a day to avoid excessive hunger that can trigger impulsive eating and should eat slowly to allow for digestion and recognition of fullness. It is recommended that the child chew