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Editorial

Graze eating among bariatric surgery candidates: prevalence and psychosocial correlates

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Abstract

Background: Graze eating is defined as repetitive, unplanned eating of small amounts of food throughout the day. Little consensus exists regarding whether graze eating, like binge eating disorder (BED), is characterized by feelings of loss of control (LOC). Furthermore, little is known about how patients who graze eat with and without LOC differ psychologically.

Objectives: The present study seeks to better characterize graze eating by examining differences between graze eating with LOC (+LOC) and without LOC (–LOC) among presurgical bariatric patients.

Setting: A large, Midwestern academic medical center.

Methods: The sample consisted of 288 adult bariatric surgery candidates (mean age 45.8, standard deviation [SD] 12.57) who underwent a presurgical psychological evaluation. Graze eating, BED, and other mental health diagnoses were evaluated using a semistructured interview. Participants were also administered the Minnesota Multiphasic Personality Inventory–2–Restructured Form (MMPI-2-RF) and binge eating scale (BES). Data were collected using a retrospective chart review.

Results: Among the 33% (n = 95) of the sample who reported preoperative graze eating, 32% (n = 30) also endorsed LOC. Graze eating, particularly with LOC, was associated with Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) diagnoses of anxiety disorders and BED, and multiple measures of internalizing dysfunction on the MMPI-2-RF.

Conclusions: Bariatric surgery candidates who graze eat experience a greater degree of overall distress and psychopathology including anxiety and depression. The minority who experience grazing +LOC appear to have even greater risk of psychopathology. Moreover, there appears to be significant overlap with BED. Future research should explore whether these 2 maladaptive eating patterns benefit from similar treatment. (Surg Obes Relat Dis 2016;■:00–00.) © 2016 American Society for Metabolic and Bariatric Surgery. All rights reserved.

Keywords:

Graze eating; Binge eating disorder; Bariatric surgery candidates; MMPI-2-RF; Binge eating scale; Presurgical psychological evaluation; Obesity

Bariatric surgery is effective in helping patients achieve long-term weight loss and improvements in medical co-

morbidities [1]. However, recurrence of maladaptive eating patterns contributes to poorer weight loss outcomes [2,3]. Presurgical binge eating disorder (BED), or eating large amounts of food in a short period of time with a sense of loss of control (LOC) and other associated symptoms, has been identified as a risk factor for poorer outcomes post-operatively. However, findings are largely mixed based

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upon method of assessment and varying definitions of postoperative binge eating, given that surgery limits the quantity of food that can be consumed and only a subset of postoperative patients continue to experience LOC eating [4,5]. Although it has received much less research attention, graze eating may also lead to excess energy intake, and in turn, suboptimal weight loss outcomes [5].

As a relatively new area of investigation in eating disorders and bariatric surgery literature, various terms (e. g., snacking, picking, nibbling) have been used to refer to graze eating, and formal criteria have not yet been established. In an effort to devise a definition, Conceição et al. [6] asked 18 eating behavior and bariatric surgery experts for opinions regarding the core criteria for grazing and reached the following consensus definition: “an eating behavior characterized by the repetitive eating of small/modest amounts of food in an unplanned manner and/or not in response to hunger/satiety sensations.” Because graze eating appears to be common in community samples and is not associated with distress in and of itself, there has been some question in the field about whether it represents an eating disorder [6]. The clinical picture is further complicated by the difficulty in distinguishing between graze eating and eating 5 to 6 small, planned meals per day as part of the recommended postsurgical regimen. What is more clear is that although most patients can no longer experience binge eating episodes postsurgically due to physical restriction, bariatric surgery does not preclude graze eating [7,8]. That is, postsurgically, patients may engage in picking, nibbling, or snacking consistently throughout the day in response to stress, boredom, or other nonhunger cues [6]. Perhaps due to differences in assessment of graze eating, reported prevalence rates vary widely from 19.5% to 59.8% among presurgical patients, and this pattern appears to continue after surgery [4,5,9,10]. In fact, 80% to 94% of patients who engage in presurgical grazing return to this pattern an average of 6 months after surgery, with an average frequency of 3 to 5 days per week [7,8]. Furthermore, among patients with presurgical BED, as many as 61% develop graze eating after surgery [5].

High rates of postsurgical graze eating have led some to suggest that it is feelings of loss of control over eating, rather than the quantity of food consumed, that best captures eating pathology in this population [3]. The limited research in this area indicates that presurgically, 65% of patients with graze eating patterns also experience LOC [5]. This pattern may continue after surgery, with a substantial minority of patients (20%) experiencing both graze eating and LOC [5]. However, whether LOC is a necessary component of the graze eating construct remains unclear. Of all the core criteria proposed in the study by Conceição et al. [6], there was least consensus among experts surveyed about whether LOC is a core component. Ultimately, the authors proposed that graze eating encompasses 2 subtypes: a) compulsive subtype, characterized by inability to control

urges to eat, and b) noncompulsive subtype, characterized by mindless or distracted eating over time. However, there is a dearth of research on how patients with compulsive and noncompulsive graze eating subtypes might differ with regard to psychopathology or other psychosocial factors.

Extant research suggests that graze eating may be triggered by emotions including underlying anxiety [11] and that binge eating and graze eating may be significantly related [10], but the relationship between presurgical graze eating and psychopathology is largely unexamined. Better characterization of graze eating and LOC is needed, given that they have been linked to a large number of poor outcomes including lower percentage of excess weight loss (%EWL), depression, lower quality of life, gastrointestinal complaints, and nonadherence to postsurgical aftercare (e. g., missing requested appointments, failing to follow providers’ recommendations to change eating habits) [3,5,11,12]. The present study seeks to further characterize graze eating by presenting its prevalence, frequency, and psychosocial correlates among bariatric surgery candidates. It also seeks to provide theoretical clarity into this construct by examining differences between graze eating with and without LOC. We hypothesized that graze eating, like BED, would be associated with a greater prevalence of co-morbid Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) psychiatric diagnoses including depression and anxiety [13], particularly when graze eating was coupled with LOC. We also hypothesized that patients with graze eating would produce higher scale scores on objective psychological measures than patients without graze eating. Specifically, we examined internalizing and externalizing Minnesota Multiphasic Personality Inventory–2–Restructured Form (MMPI-2-RF) [14,15] scales that have been associated with binge eating behaviors in previous studies (e.g., Demoralization, Dysfunctional Negative Emotions, Self-Doubt) [16,17] as well as scores on the Binge Eating Scale (BES) [18] because BED and graze eating may be conceptually similar with regard to LOC and psychosocial correlates.

Methods

Participants

The preliminary sample was composed of 300 consecutive and consented bariatric surgery candidates at a large, Midwestern academic medical center. Of these, 4% of patients (n = 12) were removed from further analyses because they produced an invalid MMPI-2-RF protocol. Patients with invalid protocols tended to be men ($\chi^2(1) = 4.80, P = .028, \phi = .13$). The final sample included 288 patients, of whom 77.4% were women, 68.4% were white, 28.9% were black, and 2.7% were of other ethnicities. The average age was 45.85 (standard deviation [SD] 12.57) years and the average education was 14.30 (SD 3.03) years.

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