B.E.D. RESOURCE KIT

Binge Eating Disorder (B.E.D.) Discussion Guide

Making conversations with adults you suspect of having B.E.D. more comfortable and productive

Two studies demonstrated that discussing eating behaviors can be difficult for adult patients*[1,3]

Patients are often embarrassed by and ashamed of their eating behaviors[1,2]

Because adult patients may find it difficult to initiate or even take part in a conversation about eating behaviors, Shire developed this Discussion Guide to help you address patients' hesitancy. The approaches included may help you conduct more comfortable and productive conversations. General suggestions include:

1. Initiate a conversation about binge eating disorder (B.E.D.) in a manner that sets your patient at ease[1,3]
2. Maintain a considerate, sensitive tone throughout the conversation[1]
3. Consciously use judgment-free language and demeanor[1,3]

Patients with eating disorders may need your help to get the conversation started

Diagnosis should be based upon a complete evaluation of the patient.

B.E.D. is the most common eating disorder in the United States, affecting an estimated 2.8 million adults†[4,5]

- B.E.D. is more than twice as prevalent as bulimia nervosa and anorexia nervosa combined‡[4]
- B.E.D. occurs in both men and women‡[4]
- B.E.D. is observed across racial and ethnic groups in the United States§[6]
- In an online survey of 344 US adults who met *DSM-5*® diagnostic criteria for B.E.D., only 11 (3.2%) reported receiving a diagnosis of B.E.D. by a health care provider in the past 12 months‖[7]

*Both studies were sponsored by Shire and had a combined study population of 63 (N=25 and N=38).

†Estimated 12-month prevalence in National Comorbidity Survey Replication of US adults aged ≥18 years, extrapolated to full US population aged ≥18 years.[4,5]

‡Data from an eating disorder–assessed subsample (n=2,980) of the National Comorbidity Survey Replication, a nationally representative face-to-face household survey of English-speaking adults aged ≥18 years.[4]

§Sample from a combined data set of 3 nationally representative US samples.[6]

‖Data from a 2013 online survey of adults aged ≥18 years. Of the 22,397 respondents, 344 met diagnostic criteria for B.E.D. in the previous 12 months.[7]

Initiating a conversation about B.E.D.

Managing adult patients' reluctance to talk

- Adult patients with B.E.D. may be uncomfortable discussing their eating behaviors and thus unlikely to initiate a conversation about them[1]

Adults with eating issues may be waiting for you to initiate the conversation[1]

3 approaches that may make adult patients more comfortable

Theme—"You aren't alone"

- Patients may find it easier to discuss their eating behaviors and associated feelings once they understand that B.E.D. is the most common eating disorder among US adults

CONSIDER: "B.E.D. is actually the most common eating disorder among adults in the United States—you are not alone."

Theme—"B.E.D. is a real condition"

- Because it is a psychiatric disorder, adults with B.E.D. may feel that it is not the type of ailment they can or should discuss with a physician[1]

CONSIDER: "Please don't feel uncomfortable about this. B.E.D. is a real medical condition and I'm here to help you with it."

Try asking permission

- One way to help adult patients feel more comfortable is to give them the sense that they have some control over the conversation

CONSIDER: "I'd like to discuss your eating behaviors with you, but I recognize that this may be a sensitive topic for some people. Is it okay if I ask you some questions about your eating behaviors?"

Helping adult patients listen, understand, and accept

Below are 3 communication points that may help patients respond positively to their diagnosis.

B.E.D. is a real medical condition

- B.E.D. is a real medical condition, a distinct eating disorder in the *DSM-5*®—it is much less common and far more severe than overeating[8]

CONSIDER: "You didn't choose to have B.E.D. It's a real medical disorder characterized by many of the symptoms you just shared with me."[3]

Binge episodes can be caused by a variety of triggers[2]

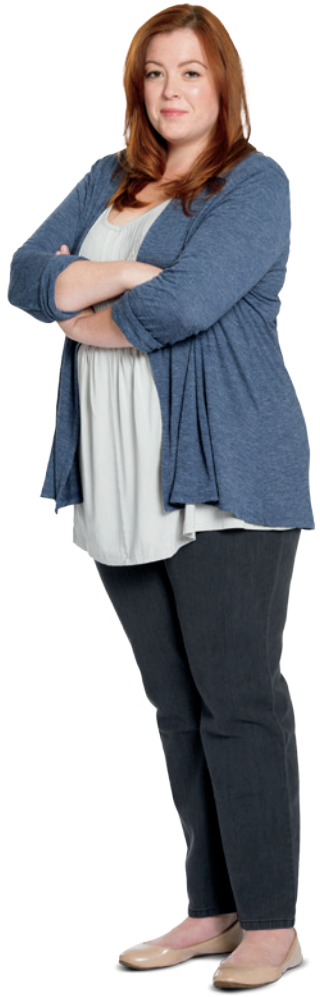
- Working with adult patients to identify their triggers can help

CONSIDER: "Certain triggers can lead to binge eating. Let's focus on figuring out what may be triggering your binge eating episodes."[1,3]

Help diminish adult patients' tendency to feel judged

- One of the barriers to positive and productive communication may be patients' tendency to feel judged when discussing their bingeing behaviors[1]
- A productive conversation may depend on your patient feeling that you are empathizing with—not judging—him or her[1]

CONSIDER: "There's no reason for you to feel self-conscious about this. This is not your fault—it's a real medical condition, and I'm here to help you with it."



Eating behaviors can be difficult to discuss[1]

Adults with binge eating disorder (B.E.D.) may be waiting for you to start the conversation

Conducting comfortable, productive discussions about B.E.D. may depend on managing patients' discomfort by[1,3]:

- Initiating the conversation in a way that sets patients at ease
- Using empathetic, judgment-free language throughout the conversation to lessen patients' sensitivity

Diagnosis should be based upon a complete evaluation of the patient

References: 1. Herman BK, Safikhani S, Hengerer D et al. The patient experience with DSM-5–defined binge eating disorder: characteristics, barriers to treatment, and implications for primary care physicians. *Postgrad Med*. 2014;126(5):52-63. **2.** American Psychiatric Association. Binge-eating disorder. In: *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Association; 2013:350-353. **3.** Kornstein SG, Keck PE, Herman BK et al. Communication between psychiatrists and patients with suspected or diagnosed binge eating disorder: differences in perspectives. Poster presented at: American Psychiatric Association Institute on Psychiatric Services Annual Conference; October 30-November 2, 2014; San Francisco, CA. **4.** Hudson JI, Hiripi E, Pope HG Jr, Kessler RC. The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication [published correction appears in *Biol Psychiatry*. 2012;72(2):164]. *Biol Psychiatry*. 2007;61(3):348-358. **5.** Howden LM, Meyer JA. Age and sex composition: 2010. US Census Bureau; 2011. **6.** Marques L, Alegria M, Becker AE, et al. Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: implications for reducing ethnic disparities in health care access for eating disorders. *Int J Eat Disord*. 2011;44(5):412-420. **7.** Cossrow N, Russo LJ, Ming EE, Witt EA, Victor TW, Wadden TA. Estimating the prevalence of binge eating disorder in a community sample comparing DSM-IV-TR and DSM-5 criteria. Poster presented at: APA 167th Annual Meeting; May 3-7, 2014; New York, NY. **8.** American Psychiatric Association. DSM-5 Fact Sheet. Feeding and eating disorders. http://www.dsm5.org/documents/eating%20disorders%20fact%20sheet.pdf. Accessed May 21, 2014.

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