

Disordered eating and food cravings among urban obese African American women

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Abstract

Objective: The prevalence of night eating syndrome (NES), binge eating disorder (BED), and bulimia nervosa (BN) and the general experience of food cravings were examined in 88 obese urban African American women.

Method: Participants were administered The Questionnaire on Eating and Weight Patterns-R, the Night Eating Syndrome Questionnaire, and the State and Trait Food Cravings Questionnaire, Trait version (FCQ-T).

Results: Twenty-eight percent reported symptoms of eating disorders (18.9% NES, 6.4% recurrent binge eating, 2.2% both NES and recurrent binge eating). Those reporting disordered eating had significantly higher total FCQ-T scores than those not reporting disordered eating. Persons endorsing recurrent binge eating had the highest mean score, followed by those reporting NES. Those who identified themselves as binge eaters and night eaters were not significantly different from each other, but both groups were significantly different than the no eating disorder symptoms group on various subscales of the FCQ-T.

Discussion: Obese African American women report significant levels of NES and binge eating which may contribute to the development and/ or maintenance of obesity.

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The reduction of obesity is one of the most important public health objectives of the 21st century (Center for Disease Control and Prevention, 2006). The prevalence of obesity has reached epidemic proportions with approximately 60 million Americans classified as obese (Hedley et al., 2004). The increasing prevalence and the significant association of obesity with increased risk of hypertension, dyslipidemia, type 2 diabetes, and other chronic conditions (Flegal, Carroll, Ogden, & Johnson, 2002) emphasize the need to identify factors that contribute to the development and maintenance of obesity.

Two disordered eating patterns are disproportionately prevalent among overweight and obese persons—night eating syndrome (NES) and binge eating disorder (Stunkard & Allison, 2003). NES, which is characterized by morning anorexia, evening overeating, nocturnal food carvings, and insomnia, was originally described as a ‘special diurnal response to stress characteristic of some obese individuals’ (Stunkard, Grace, & Wolff, 1955). These original behavioral correlates, reported in the mid 1950’s, have been confirmed in several recent studies (Allison, O’Reardon,

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Stunkard, & Dinges, 2001; Aronoff, Geliebter, & Zammit, 2001; Gluck, Geliebter, & Satov, 2001; Napolitano, Head, Babyak, & Blumenthal, 2001).

Birketvedt et al. (1999) have further defined the behavioral characteristics of NES and identified several biological correlates. Persons who are night eaters consume more food than controls but their food intake lags behind controls throughout the day, with over 50% of their calories being consumed between 8 P.M. and 6 A.M. Persons who are night eaters awaken an average of 3.6 times per night with half of the awakenings associated with the ingestion of a snack averaging 271 kcal. These snacks are high in carbohydrates but much smaller than the binges of obese binge eaters. The mood of those with NES also displays a circadian variation, with mean mood scores falling after 4 P.M. Individuals with NES have lower nighttime levels of melatonin and leptin, higher serum cortisol levels throughout the 24-hour period (Birketvedt et al., 1999) and often describe themselves as chronically stressed (Allison et al., 2001; Stunkard et al., 1955). The elevated levels of cortisol support this possibility. Based on a variety of research, provisional criteria for NES have been formulated and include morning anorexia, even if the subject eats breakfast; evening hyperphagia, in which >50% of the daily energy intake is consumed in snacks after the last evening meal; awakenings at least once a night, at least 3 times per week; consumption of high calorie snacks during the awakenings; and duration of behavior for 3 months or longer (Birketvedt et al., 1999).

The prevalence of NES in the general population is approximately 1.5% (Rand, Macgregor, & Stunkard, 1997), 8.9%–51% in obesity clinics (Aronoff et al., 2001; Gluck et al., 2001; Stunkard et al., 1996), and 10 and 42% in patients presenting for bariatric surgery (Hsu, Betancourt, & Sullivan, 1996; Powers, Perez, Boyd, & Rosemurgy, 1999). Most studies examining such prevalence have not included substantial numbers of ethnic minorities. One purpose of this report is to provide such information.

Binge eating as a distinctive pattern of eating in the obese was also first recognized in 1959. In an early case study, Stunkard (1959) described an obese man who experienced uncontrolled ingestion of enormous quantities of food in a short period of time. The “binges” were terminated when a point of physical discomfort was reached and were thought to be triggered by “life stress.” Spitzer et al. (1992) confirmed that approximately 30% of individuals presenting to weight control programs report what has been termed binge eating disorder (BED). The criteria for BED consist of: a) episodic overeating, defined as eating an amount of food in a short period of time that is definitely larger than most people would eat for at least twice weekly on average for 6 months; b) a sense of loss of control over the binge; c) distress related to the binge; and d) three of five items that include rapid eating, eating until uncomfortably full, feeling depressed or guilty after bingeing, eating when not physically hungry, and eating alone. BED is distinguished from bulimia nervosa (BN) by the absence of inappropriate compensatory behaviors to prevent weight gain including fasting, purging, and excessive exercise and is a provisional eating disorder diagnosis (American Psychiatric Association, 2000).

The prevalence of BED in the general population is approximately 1.5%, but among overweight individuals in the general population, prevalence of BED is 2.9%, which is nearly double the overall prevalence (Smith, Marcus, Lewis, Fitzgibbon, & Schreiner, 1998). BED prevalence in university-affiliated treatment programs ranges from 19 to 30% (Spitzer et al., 1992; Stunkard et al., 1996), while the prevalence in those presenting for bariatric surgery ranges from 11 to 43 % (Adami, Menghelli, & Sopinaro, 1999; Hsu et al., 2002; Powers et al., 1999). Most studies examining BED prevalence have included members of ethnic minorities and no differences have been reported in BED prevalence rates between African American and white women (Fitzgibbon et al., 1998; Smith et al., 1998; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000).

Individuals with BED report more severe and earlier onset of obesity, earlier onset of dieting, and greater incidence of depression, substance abuse, and emotional problems than overweight individuals without BED (Spitzer et al., 1992; Stunkard & Allison, 2003). One study which compared white and African American women reported that overall women with BED were significantly heavier, more likely to be obese, and report more depression and anxiety than those without BED (Pike, Dohm, Striegel-Moore, Wilfley, & Fairburn, 2001). However they noted that obesity was significantly more common among African American women; this difference was significant when comparing African American and white women with BED and also significant when comparing African American and white women in the control group. It was also significant that African American women with BED reported *less* concern about shape, eating, and body weight than white women with BED (Pike et al., 2001).

Few studies of the obese individuals have assessed for the co-occurrence of BED and NES. The proportion of individuals with both BED and NES ranges from 0 in a weight loss sample (Stunkard et al., 1996), 16% in patients entering a medication trial for binge eating (Stunkard et al., 1996), and 16% in an inpatient, university weight loss facility (Napolitano et al., 2001). Both disorders have been described as eating in response to negative affect (Napolitano et al., 2001).

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