

FIGURE 11.2a. Night Eating Diagnostic Questionnaire (NEDQ).

Directions: Please answer the following questions carefully and be sure to answer each question. Thank you for your participation.

1. What time do you usually go to bed in the evening (turn out the lights in order to go to sleep)? _____ P.M.
2. What time do you usually get out of bed in the morning? _____ A.M.
3. On most days, do you experience loss of appetite in the morning? No Yes
4. How often do you typically eat breakfast (after your final morning awakening)? _____ times/week
5. What time do you usually have the first meal of the day? _____ A.M./P.M. (please circle)
6. How much food do you generally eat after 7:00 P.M. as a percentage (%) from 0 to 100? (Please be specific, for example, 15%.) (0–100) _____%
7. What time do you usually have your evening meal? _____ P.M.
8. How much food do you generally eat after your evening meal as a percentage (%) from 0 to 100? (Please be specific, for example, 15%.) (0–100) _____%
 - 8a. For how long have you been consuming at least this much after your evening meal? _____ years
_____ months
9. On most days, do you have a strong urge to eat between dinner and sleep onset and/or during the night? No Yes
10. Do you have trouble falling asleep at night? No Yes
 - 10a. If YES, how many times each week? _____ times/week
11. Do you have trouble staying asleep at night? No Yes
 - 11a. If YES, how many times each week? _____ times/week
 - 11b. If YES, how many times each week do you get out of bed during these awakenings? _____ times/week
12. How many times each week do you awake from sleep during the night to use the bathroom? _____ times/week None
13. Do you awake from sleep during the night and eat food? No Yes
IF NO, SKIP TO QUESTION 14.
 - 13a. If yes, how many times per week? _____ times/week
 - 13b. For how long have you been getting up at this frequency to eat? _____ years
_____ months

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- 13c. Do you believe you need to eat in order to fall back to sleep when you wake up at night? No Yes
- 13d. How aware are you of your eating during the night? Not at all
 Somewhat
 Extremely
- 13e. How often do you recall your eating during the night the next day? Never
 Sometimes
 Always
14. Would you consider yourself a night eater? No Yes
IF NO, SKIP TO QUESTION 15.
IF YES (please answer the following questions):
- 14a. IF YES, how upset are you about your night eating? Not at all
 Somewhat
 Extremely
- 14b. IF YES, how much has your eating at night impaired your functioning and/or interfered with your daily life? Not at all
 Somewhat
 Extremely
- 14c. For how long have you been experiencing this night eating behavior?
 Less than 3 months
 3–6 months
 6–12 months
 More than 1 year
15. Do you have sleep apnea? No Yes
 Don't know
16. Do you work an evening or night shift? No Yes
16a. IF YES, is it: Evening
 Night
 Rotating
- 16b. IF YES, for how long have you been working this shift? _____ years
_____ months
17. Have you been feeling depressed or down nearly every day? No Yes
18. In general, when you are feeling depressed or down, is your mood lower in the:
 Morning
 Afternoon
 Evening/nighttime
 Not applicable
19. Are you currently dieting to lose weight? No Yes
19a. IF YES, how much weight have you lost in the past 3 months? _____ lb.
20. What is your current height and weight (without clothing or shoes)?
_____ Height (in.)
_____ Weight (lb.)
21. Please take a moment to review your responses. Have you answered each question completely? No Yes

FIGURE 11.2b. Night Eating Diagnostic Questionnaire (NEDQ) scoring.

To be diagnosed with NES, the individual must have the following:

- I. The daily pattern of eating demonstrates a significantly increased intake in the evening and/or nighttime, as manifested by one or both of the following:
 - A. At least 25% of food intake is consumed after the evening meal
Q 8 \geq 25% and Q 8a \geq 3 months
 - B. At least two episodes of nocturnal eating per week
Q 13 = yes AND Q 13a \geq 2 d/wk AND Q 13b \geq 3 months
- II. Awareness and recall of evening and nocturnal eating episodes are present.
Q 13d = somewhat or extremely and/or Q 13e = sometimes or always
- III. The clinical picture is characterized by **at least three** of the following features:
 - A. Lack of desire to eat in the morning and/or breakfast is omitted on four or more mornings per week
Q3 = yes OR Q4 \leq 3 times/week
 - B. Presence of a strong urge to eat between dinner and sleep onset and/or during the night
Q 9 = yes
 - C. Sleep onset and/or sleep maintenance insomnia are present four or more nights per week
Q 10 or Q 11 = Yes and Q 10a or Q 11a \geq 4 times/week
 - D. Presence of a belief that one must eat in order to initiate or return to sleep
Q 13c = Yes
 - E. Mood is frequently depressed and/or mood worsens in the evening
Q 17 = yes OR Q 18 = evening/nighttime
- IV. The disorder is associated with significant distress and/or impairment in functioning.
Q 14a OR Q 14 b = somewhat or extremely
- V. The disordered pattern of eating has been maintained for a minimum of 3 months.
14c = 3–6 months OR 6–12 months OR more than 1 year
- VI. The disorder is not secondary to substance abuse or dependence, medical disorder, medication, or another psychiatric disorder: This cannot be assessed using the questionnaire but should be noted.

Standard Scoring Based on Above

Dichotomous

1. **Non-NE** = *normal* (does not meet criteria category below)
2. **NES** = *full-syndrome night eater* has 1 criterion from I **plus** \geq 3 of 5 qualifiers from criteria III **plus** IV and V

Experimental Scoring

Hierarchical

1. **Non-NE** = *normal* (does not meet any criteria category below)
2. **N** = *mild night eater* has 1 criteria from I (but does not meet criteria NE or NES)
3. **NE** = *moderate night eater* has 1 criteria from I **plus** \geq 3 of 5 qualifiers from criteria III (but does not meet criteria for NES)
4. **NES** = *full-syndrome night eater* has \geq 1 from I **plus** \geq 3 of 5 qualifiers from criteria III **plus** IV and V

Directions: Mark an x on the line for how much you are experiencing each feeling before you eat at night.

Day: _____

Time: _____

1. **Physical hunger**—*feeling physical signs of hunger*

not at all

extremely

2. **Craving food**—*desiring specific foods*

not at all

extremely

3. **Compelled to eat**—*having a drive to eat, to put something in your stomach, not necessarily for a specific food*

not at all

extremely

4. **Anxious**—*having anxiety-provoking thoughts, ruminations, racing thoughts, etc.*

not at all

extremely

5. **Agitated**—*having the physical feeling of not being able to sit still or remain in bed, often linked to anxiety*

not at all

extremely

6. **Sad**—*feeling depressed or wanting to eat to help improve depressed mood*

not at all

extremely

7. **Bored**—*looking for an activity to pass the time*

not at all

extremely

8. **Tired**—*feeling fatigued and just wanting to get to sleep*

not at all

extremely

FIGURE 14.1. Nighttime Eating Assessment.

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Directions: Complete the chain for a typical night eating event. Include the circumstances when you started thinking about wanting to eat and each step that was involved in getting to the food, choosing it, eating it, and then what happened and/or how you felt afterward. Think about where you could change the typical chain of events along the way and write these ideas alongside the chain as an alternative activity or course of action to the usual outcome (i.e., night eating). Display the chain or review it each day/night to help reinforce the new behaviors you would like to try instead of eating.

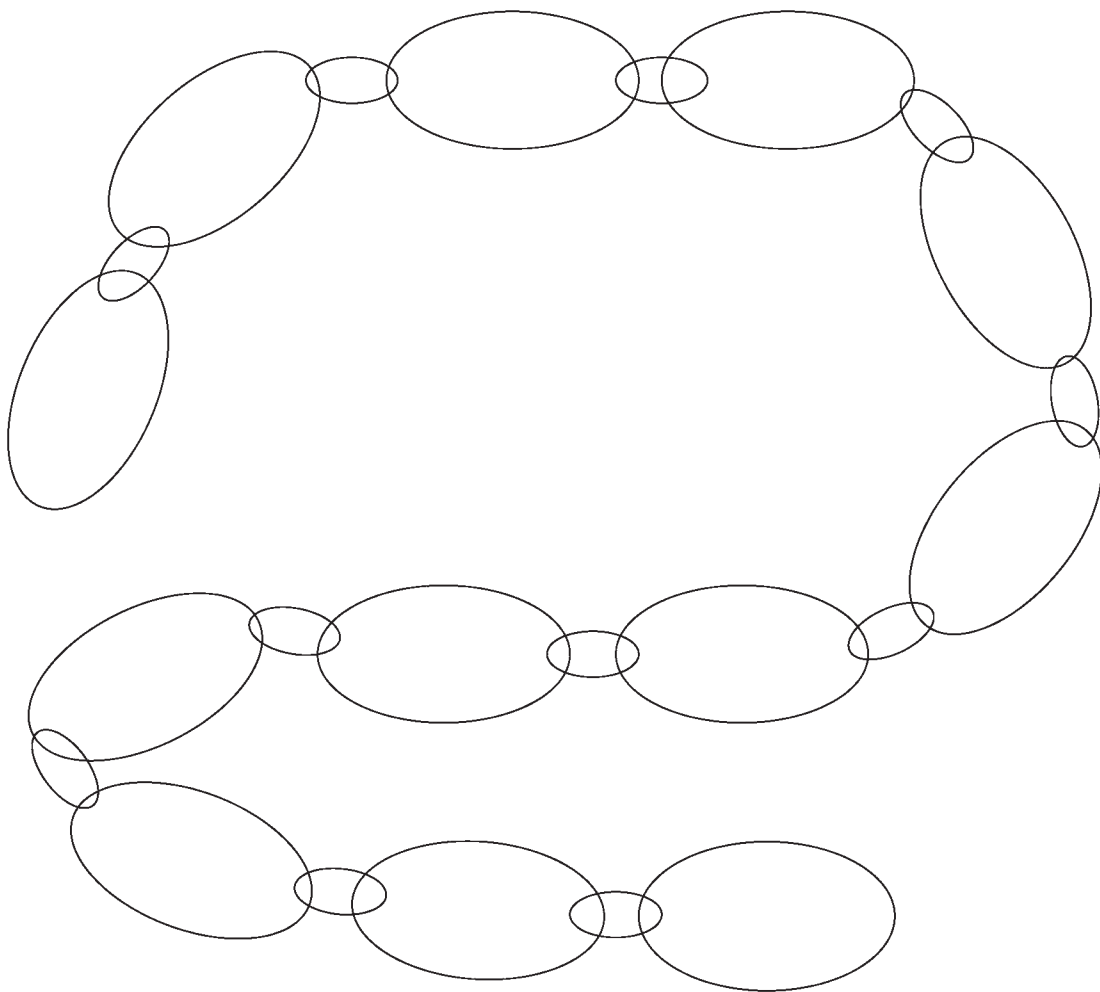


FIGURE 14.5. Blank behavioral chain.

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Situation Where were you and what was happening when you felt the urge to eat or were in an upsetting situation (include date and time)?	Emotions What emotions (sad, angry, anxious, etc.) did you feel at the time? Rate intensity 0–100%	Automatic Thoughts What thoughts and/or images went through your mind? Rate your belief in each (0–100%)	Alternative Responses Use the questions and distortions at the bottom to compose responses to the automatic thoughts. Rate your belief in each (0–100%).	Outcome Re-rate your belief in your original automatic thoughts (0–100%) and the intensity of your emotions (0–100%).

1. What is the **evidence** that the automatic thought is true?
2. Are there **alternative explanations** for that event, or **alternative ways** to view the situation?
3. What are the **implications** if the thought is true? What is most upsetting about it? What’s the most realistic view? What can I do about it?
4. What would I tell a good friend to do in the same situation?

Possible Distortions: All-or-nothing thinking, overgeneralization, discounting the positives, jumping to conclusions, mind-reading, fortune-telling, magnifying/minimizing, emotional reasoning, making “should” statements, labeling, inappropriate blaming.

FIGURE 14.7. Blank Night Eating Syndrome Thought Record.

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Directions: Track your physical activity throughout the week. This can be used together with the food and sleep log to track your progress in treatment, as exercise may help reduce night eating and weight, and more generally improve your health.

Day/date	Type of exercise	How many minutes?
	Weekly total:	

FIGURE 14.10. Blank exercise log.

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