Binge Eating Disorder: Assessment and Treatment

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Assessment of Eating Disorders

- **Dx:** questionnaire + interview
- **Current problems with eating**
  - Eating habits (e.g., daily patterns, binge eating)
  - Weight/shape control measures (e.g., food restriction, excessive exercise, laxatives, diuretics, vomiting)
  - Perceptions and feelings about weight/shape, weighing
- **Impairment from ED** - physical and psychosocial, SLEEP
- **Development and evolution of problem**
  - Weight history and treatment history
- **Comorbid medical/psychiatric problems, current tx**
- **Brief personal history**
- **Personal and family psychiatric history, MSE**
- **Motivation/ambivalence, attitude towards tx**
Useful Self-Report Instruments

- **Eating behavior and cognitions**
  - **EDDS**
    - Eating Disorder Diagnostic Scale by Stice provides diagnostic information, 22 items
    - http://homepage.psy.utexas.edu/homepage/group/sticelab/scales/
  - **EDE-Q**
    - Eating Disorder Exam Questionnaire
  - **CIA**
    - Clinical Impairment Assessment, assesses psychosocial impairment from the eating disorder
  - http://www.psychiatry.ox.ac.uk/research/researchunits/credo/cbt_and_eating_disorders
Assessment of Binge Eating

- Tricky aspects of assessing binge eating
  - Subjectivity of “loss of control”
  - Subjectivity of “large amount of food”
  - Grazing all day versus discrete episodes
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<th>Large amount of food?</th>
<th>Objective Binge Episode</th>
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<td>Objective Overeating</td>
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Treatment: Guided Self-Help

- CBT GSH: Overcoming Binge Eating

- CBT short group + boosters
  - 8 weekly + 5 boosters
  - Better than waitlist and sustained improvements at 12-month follow-up.

Schlup et al, 2009
Treatment: CBT-E

- Same psychopathology seen across ED dx
- Similar severity across ED dx
- Primarily COGNITIVE disorders
  - Over-evaluation of shape and weight and their control
- CBT-E: focus on currently operating maintaining mechanisms
The Transdiagnostic Cognitive Behavioral Theory

Over-evaluation of shape and weight and their control

 Strict dieting: non-compensatory weight-control behavior

 Binge eating

 Events and associated mood change

 Significantly low weight

 Compensatory vomiting/laxative misuse

From Fairburn, C.G. (2008)
The Transdiagnostic Cognitive Behavioral Theory

Over-evaluation of shape and weight and their control

Strict dieting: non-compensatory weight-control behavior

Events and associated mood change

Binge eating
CBT-E Principles

- “Formulation” guides treatment
  - Set of hypotheses re: maintaining processes
- Collaborative empiricism and exploratory questioning
- Patients learn to “de-center” and be interested in ED, understand it, become intrigued
- Therapist provides information, guidance, support, encouragement.
- Responsibility for change resides with patient.
- Therapists must be educated in physiological effects of binge eating and purging and familiar with body weight regulation, dieting, body image disturbance.
CBT-E Contraindications

- Compromised physical health
- Suicide risk
- Severe clinical depression
- Persistent substance misuse
- Major life events or crises
- Inability to attend tx/therapist absence expected
Forms of CBT-E

- Two versions
  - Focused (core treatment)
  - Broad
    - Modules addressing clinical perfectionism, core low self-esteem, interpersonal difficulties

- Two intensities
  - 20-session (BMI over 17.5)
  - 40-session (BMI between 15 and 17.5)

- Other versions:
  - younger patients
  - Inpatient/intensive outpatient
  - group
Temporal Pattern for CBT-E

- Stage 1: initial session and 1-7 (4 weeks)
- Stage 2: sessions 8-9 (2 weeks)
- Stage 3: sessions 10-17 (8 weeks)
- Stage 4: sessions 18-20 (6 weeks)
Goals of CBT BED

➢ Behavior change:
  – Normalize eating
  – Reduce/eliminate binge eating (and any purging)
  – Reduce/eliminate strict dieting and avoidance of specific foods
  – Eliminate weight and body checking/avoidance
  – Reduce mood and event-triggered eating behavior
  – *Weight Loss??

➢ Cognitive change:
  – Reduce extreme shape and weight concerns
  – Reduce perfectionism, all-or-nothing thinking
  – Improve self-esteem
Stage 1: Rationale, Regular Eating

- Detailed assessment
- Establish therapeutic relationship
- Introduction to the model
- Create formulation
- Establish regular weekly weighing
- Psychoeducation (guided reading)
- *Establish regular pattern of eating*
- Self-monitoring
- Involve significant others if warranted
Formulation

- Personalized visual representation/diagram of the processes maintaining the eating problem
- Initial session
- Guide for tx targets
- *Credible* explanation

Feel really bad about my weight and the way I look

Diet; exercise a lot

Occasional binges

Feel unhappy
Feel terrible about my weight and eating, hate myself

Avoid eating as long as possible during day, no sugar or fat at all

Depressed, no one likes me

Binge
Target “Dieting” and Rules

Feel terrible about my weight and eating, hate myself

Avoid eating as long as possible during day, no sugar or fat at all

Depressed, no one likes me

Binge

REGULAR EATING
Target Mood and Event-Triggered Eating

Feel terrible about my weight and eating, hate myself

Can’t stop eating, grazing all day, no structure

Depressed, no one likes me

BINGE ANALYSIS: MOOD/EVENTS

REGULAR EATING

Binge
Diet-Binge-Purge Cycle

Rules/Dieting

Renewed resolve
(Purging)

Guilt/shame

Slip, breaks rule

AVE: “I blew it”

BINGE
Psychoeducation

- Diagnosis
- Health risks and prognosis without treatment
- Treatment options
- Body weight regulation, limitations of control
- Reward-mood-eating links (Kessler book, “The End of Overeating”)
- Impact of binge eating: shame, $, secrecy, intimacy
- Types of dieting and possible adverse effects
- Discuss healthy weight range, normal weight fluctuations, arbitrary nature of weight goals

http://www.psychiatry.ox.ac.uk/research/researchunits/credo/cbt_and_eating_disorders
Stage 2: Taking Stock

- Assess progress
- Identify barriers to change
  - Fear of change
  - Resistance/rigidity
  - Competing commitments
  - External events/interpersonal difficulties
  - Depression/substance misuse
  - Core low self-esteem
  - Clinical perfectionism
  - Dislike of CBT
- Review Formulation
HOW CAN I BE EATING UNCONSCIOUSLY WHEN ALL I THINK ABOUT IS FOOD?
Stage 3: The Heart of CBT-E

- Maintaining Mechanisms
  - Event- or mood-triggered eating
  - Over-evaluation of shape/weight
  - Over-evaluation of control over eating
  - Dietary restraint

- Use Formulation
Binge Analysis

Breaking a dietary rule
Being disinhibited
Under-eating
Adverse event or mood

Binge Eating
Binge Analysis

Breaking a dietary rule
Being disinhibited
Under-eating

Adverse event or mood

Binge Eating
Food is love.
No, food is power.
But, isn't power really a call for love?
I knew it! Food is really love!
So, cake is necessary!

The reigning queen of rationalization.
Mood and Eating

- Explore function of behavior
  - Escape/distraction from emotions
  - Mood modulator
  - Relaxation of control following stress/vigilance
  - “It’s my reset button”
  - Verification of self-criticism, punishment
  - Response to dietary deprivation
  - “I want to have EXACTLY what I want”
  - “I deserve it,” a treat or reward
  - Keeps expectations low

- Help patients deal DIRECTLY with events and moods
- Motivational strategies, highlight costs of behavior
Common Themes

- Difficulty tolerating emotions
- Little trust in ability to manage feelings or urges, desires and needs
- Fear that emotions won't stop and behavior feels like it stops anxiety or anger
- Self-identity
  - What do I want?
  - What do I need?
  - It is OK to express feelings and needs.
  - How do I express them effectively?
Event-Related Eating

- Find example
- Sequence of events (behavior chain)
- Find vulnerable links in chain
- Teach problem-solving
Mood-Related Eating

- Eating may reduce awareness
- Eating may neutralize mood
- Identify sequence
  - Triggering event
  - Cognitive appraisal
  - Aversive mood change
  - Appraisal of mood change/amplification
  - Eating behavior

"You can't find love in a bag of chips. But chips and salsa come close."
Mood-Related Changes in Eating

- Occurrence of triggering events
  - Prevent using problem-solving

- Cognitive appraisal of events
  - Cognitive restructuring and behavioral experiments

- Occurrence of aversive moods
  - "mood acceptance"

- Use of mood modulatory behavior
  - Practice using helpful behavior
  - Put barriers in the way of unhealthy behavior
Stage 3 Continued

- Maintaining Mechanisms
  - Event- or mood-triggered eating
  - Over-evaluation of shape/weight
  - Over-evaluation of control over eating
  - Dietary restraint
Identifying Over-Evaluation

What is important?

- Weight and shape
- Family
- Friends
- School
- Music
- Other
Strategy 1: Enhance Other Domains

More slices, bigger slices

- Weight and shape
- Family
- Friends
- School
- Music
- New Activity
- Volunteering
Strategy 2: Reduce Importance of Shape and Weight

Shrink the green slice

- Weight and shape
- Family
- Friends
- School
- Music
- Other
“Dieting” = problem
- Pattern of rigid rules/breaking rules/behavioral response
- Different types of diets
- Identify rules and plans for breaking them
- Food avoidance (systematic exposure)
- Dichotomous thinking/AVE - “I blew it”

Over-evaluation of Control
- Address as with over-evaluation of shape/weight
- Decrease food checking (counting kcals, checking food labels, weighing food)
Interpersonal Work

- Can add “life” section to sessions, distinct from CBT work
- Based on Interpersonal Therapy (IPT)
- Goals:
  - Resolve specific interpersonal problems
  - Improve overall interpersonal functioning
Effects take TIME
Interpersonal Therapy

- Brief, time-limited, focused on improving interpersonal functioning
  - 15-20 Sessions over 5 months
- Group format for BED
- Social problems and BED
  - Loneliness, lack of perceived social support, poor self-esteem and social adjustment, problems with social problem-solving skills
  - Cycle of interpersonal difficulties, low self-esteem and negative affect, treatment targets these
IPT

- Group: used as “live social network”
  - Decrease isolation
  - Formation of new social relationships
  - Models for initiating and sustaining relationships
- Good retention
- Interpersonal inventory assessment
- Formulation and identification of primary problem area
  - Grief, Role Transitions, Interpersonal Role Disputes, Interpersonal Deficits
IPT

3 Phases
- Initial: identify target problem area(s)
- Intermediate: work on target problem area(s)
- Termination: consolidating gains, future preparation

Goal-focused

Constant focus on the interpersonal context of the patient’s life and its link to the ED symptoms
Treatment: DBT

- Aims to reduce binge eating by improving adaptive emotion-regulation skills
- Alternative for patients who don’t respond to CBT or IPT
- Patients with BPD
- Stanford model for BED has empirical support
  - Single modality – group for BED
  - 20 sessions
  - 3 treatment modules (mindfulness, distress tolerance, emotion regulation)
DBT resource

Dialectical Behavior Therapy for Binge Eating and Bulimia

Debra L. Safer
Christy F. Telch
Eunice Y. Chen

Foreword by Marsha M. Linehan
New Directions

- **Cue exposure training**
  - Decrease responses to food in the environment
  - Toolbox of coping skills to ride out cravings
  - “Stare them down”

- **Appetite awareness training**
  - Improve responses to internal hunger and satiety cues

Kerri Boutelle, 2011
References

- Cognitive Behavior Therapy and Eating Disorders, Christopher Fairburn, 2008.
- [http://www.psychiatry.ox.ac.uk/research/researchunits/credo/cbt_and_eating_disorders](http://www.psychiatry.ox.ac.uk/research/researchunits/credo/cbt_and_eating_disorders)
- [www.dsm5.org/ProposedRevisions/Pages/Eating_Disorders.aspx](http://www.dsm5.org/ProposedRevisions/Pages/Eating_Disorders.aspx)
Michelle

- 34 y/o, married for 11 years, 2 young children, stopped working 1 yr ago
- Has always “felt fat” and that being thinner would make her happier
- History of chaotic eating, dieting, binge eating since high school
- Eats fast food 5-6x/week and hates cooking
- Tries to avoid carbohydrates b/c thinks of them as trigger foods
- Afraid to add breakfast and regular meals/snacks b/c thinks she will gain weight, so delays eating as long as possible each day, feels good/proud when she is able to delay until after 2 pm
- Sedentary, but history of being an athlete
- Challenges in relationship with husband and with family of origin, difficulties communicating, very upset with any conflict
- Focuses on others (people pleaser), not assertive about own needs and wants, ends up resentful and burned out

DO: 1) Formulation, 2) Binge Analysis, 3) Self-monitoring feedback