

# Assessing and Treating Binge Eating Disorder using Enhanced Cognitive Behavior Therapy (CBT-E)

Angela Celio Doyle, PhD

Co-Director, Eating Disorders Center of Seattle

Part of the Evidence Based Treatment Centers of  
Seattle





# Overview

- Briefly describe BED and assessment of BED
- Introduce the basics of providing CBT-E
- Special considerations for co-morbidities when using CBT-E



# Binge Eating Disorder (BED)

- Inclusion in DSM 5
- Affects 16 out of every 1000 women in any 12 month period
  - 8 out of 1000 for men
- Lifetime prevalence: 35 out of 1000 women, 20 out of 1000 men
- Weight-control programs (~ 30%)
- All SES levels
- All ethnicities



# DSM 5 Criteria

- Recurrent episodes of binge eating
  - Eating, in discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
  - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Episodes associated with 3 (or more) of the following:
  - Eating much more rapidly than normal
  - Eating until uncomfortably full
  - Eating large amounts of food when not feeling physically hungry
  - Eating alone because feeling embarrassed by how much one is eating
  - Feeling disgusted with oneself, depressed, or very guilty after overeating
- Marked distress regarding binge eating
- Binge eating occurs, on average, at least once a week for 3 months
- Absence of regular compensatory behaviors (such as purging)



# Co-occurring conditions

- Health conditions include obesity, type II diabetes, hypertension, gastric problems
  - Associations between BE and weight gain, increased health care utilization
- Psychiatric comorbidities in 78.9%\*
  - Any anxiety disorder: 65%
  - Any mood disorder: 46%
  - Any substance use disorder: 23%





# Assessment of BED

- Interview
- Eating Disorder Examination (EDE)





# Assessment of BED

- Binge Eating Scale
  - Quick to administer
  - Good sensitivity and specificity
- Eating Disorder Examination Questionnaire (EDEQ)
  - Norms available, measures weight/shape concerns, dietary restraint, and eating concerns
- Clinical Impairment Assessment (CIA)
  - Measures severity of impairment and “caseness”






# Treatment

- Most efficacious treatments:
  - Cognitive behavioral therapy (CBT) → CBT-E
  - Interpersonal psychotherapy (IPT)
  - DBT? Integrative Cognitive-Affective Therapy (ICAT)?
- Uncertain role of SSRIs, topiramate, Vyvanse, other meds
  - Very inconsistent results and no long term follow up



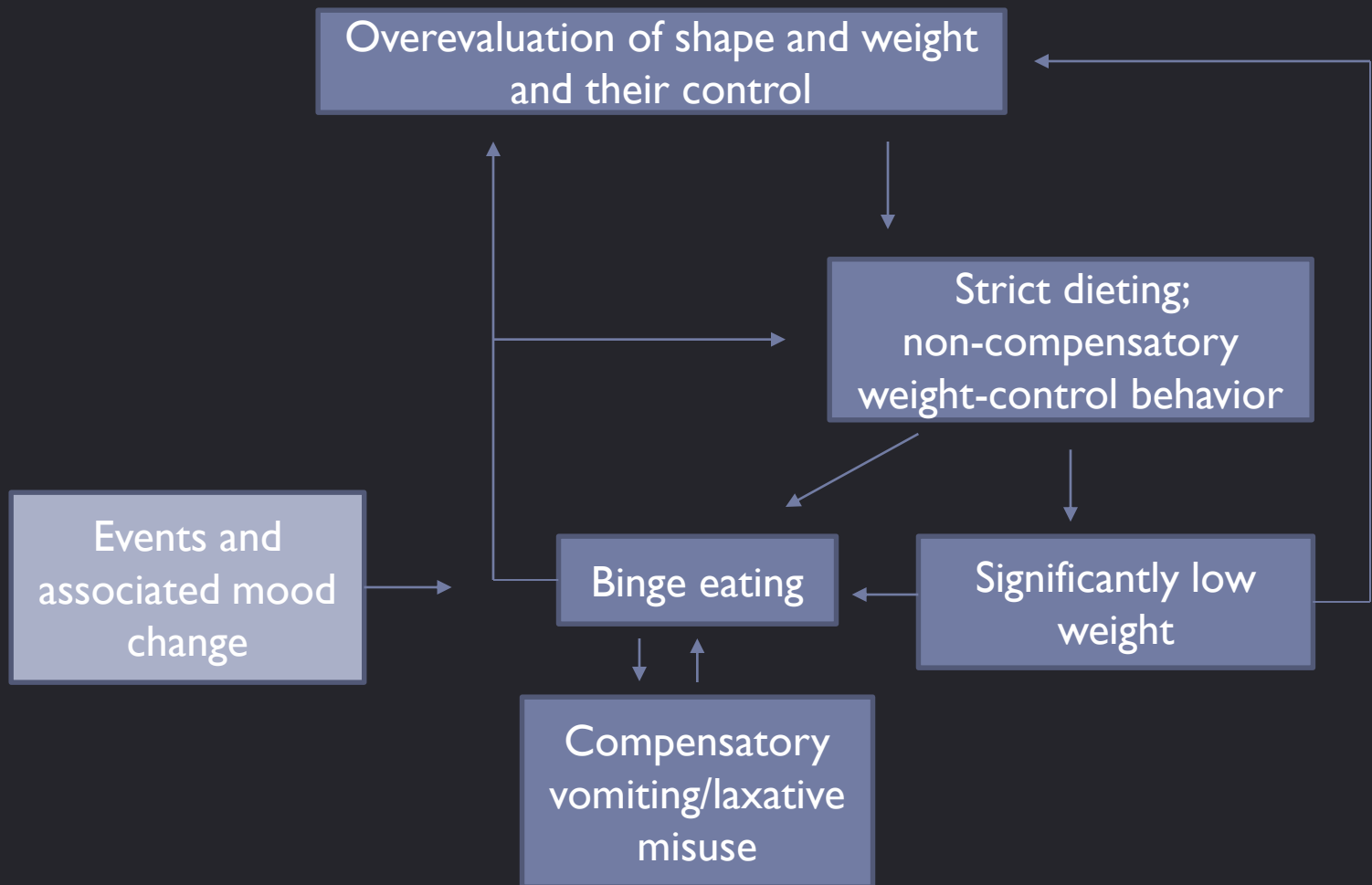


# Enhanced Cognitive Behavior Therapy (CBT-E)

- Thoughts and behaviors maintain eating disorder
- Address these mechanism and eating disorder “falls like a house of cards”
- Can be used for any eating disorder - individualized
- Manualized

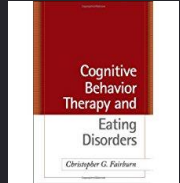
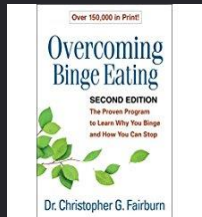


# Transdiagnostic CBT formulation



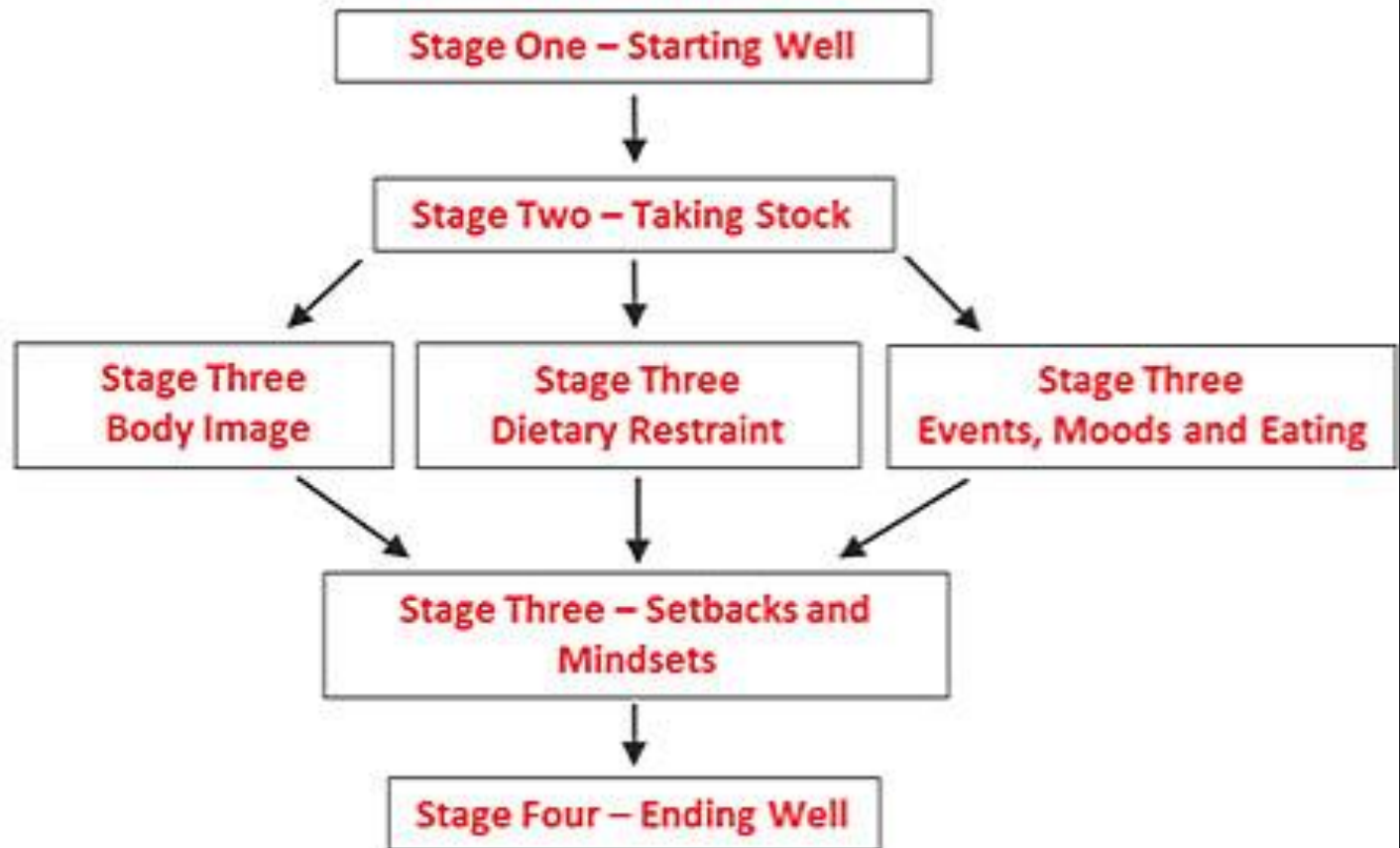


# Frequently mentioned resources


- *Cognitive Behavior Therapy and Eating Disorders* by Dr. Christopher G. Fairburn (2009) 
- Centre for Research on Eating Disorders at Oxford (CREDO): [www.credo-oxford.com](http://www.credo-oxford.com)
- *Overcoming Binge Eating: The Proven Program to Learn Why You Binge and How You Can Stop* by Dr. Christopher G. Fairburn (2013) 



# CBT-E MAP







# Goals of each stage

- Stage 1: Gain mutual understanding of the ED and to stabilize pattern of eating (twice weekly appts)
- Stage 2: Progress reviewed and plans made for main body of treatment, stage 3
- Stage 3: Addressing maintaining factors, including shape concerns, daily events/moods as triggers, dietary restraint
- Stage 4: Relapse prevention





# Focused form versus Broad form

- Focused CBT-E limits itself to eating disorder-specific problems
- Broad CBT-E adds on modules to address broader issues of:
  - Clinical perfectionism
  - Core low self-esteem
  - Interpersonal problems
- Decide in Stage 2





# Overview of CBT-E for BED

- 20 50-minute sessions over 20 weeks
  - 8 sessions over the first 4 weeks
- Aim is not to keep treating until patient is completely asymptomatic, but main maintaining mechanisms have been disrupted
- A review session is held a bit after treatment has ended





# Stage I of CBT-E

- Sessions 0-7, twice/week
- Goals:
  - Engage patient in treatment
  - Jointly create personalized formulation
  - Provide relevant education
  - Introduce two potent CBT-E procedures:
    - In-session weighing
    - Regular eating





# Session 0

## Tasks:

- Engage patient in treatment
- Assess BED
- Jointly create formulation
- Explain what treatment will involve
- Introduce self-monitoring
- Confirm homework assignments
- Summarize and arrange next appt





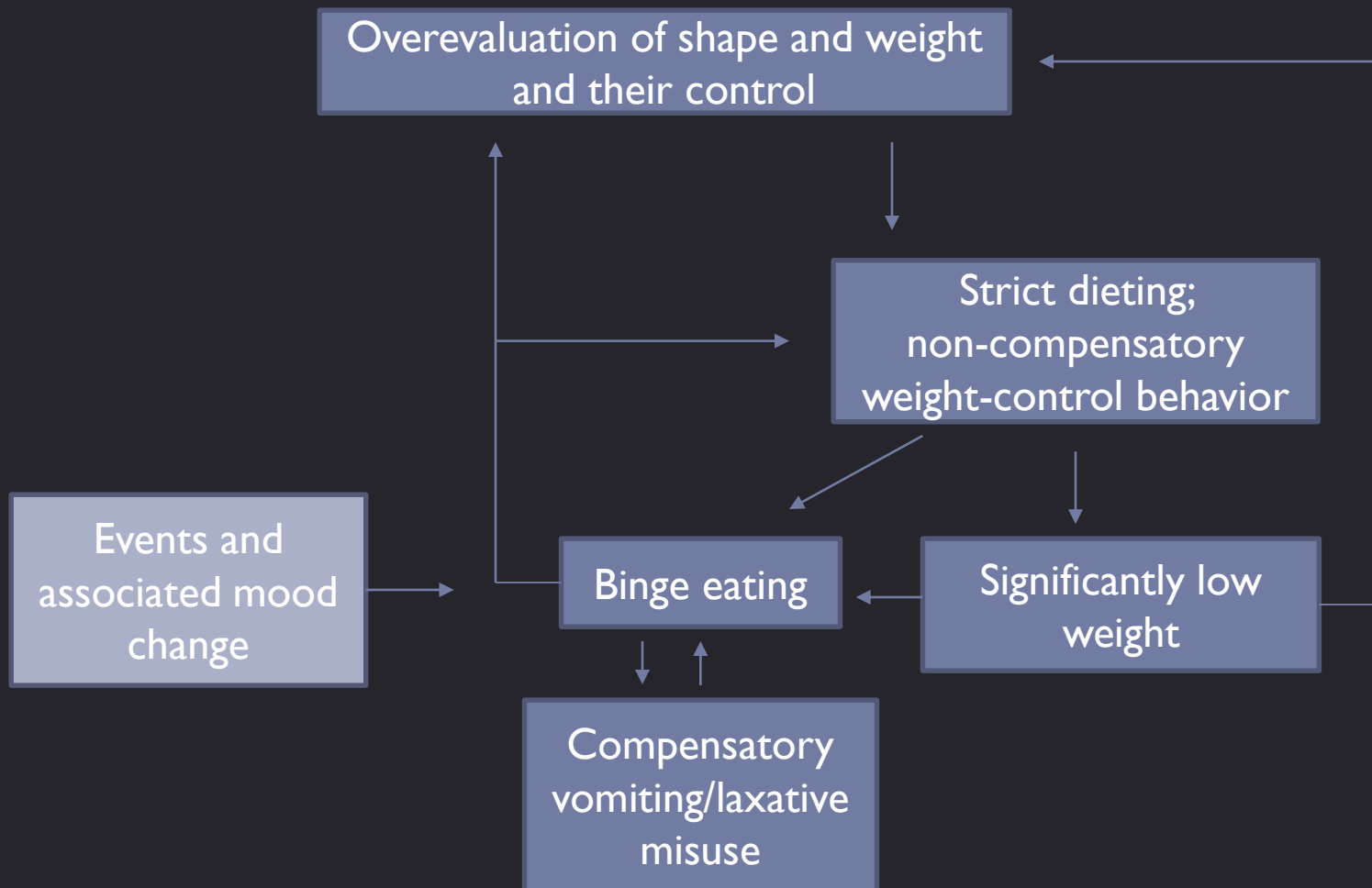
# Session 0

## Tasks:

- Engage patient in treatment
- Assess BED
- **Jointly create formulation**
- Explain what treatment will involve
- **Introduce self-monitoring**
- Confirm homework assignments
- Summarize and arrange next appt

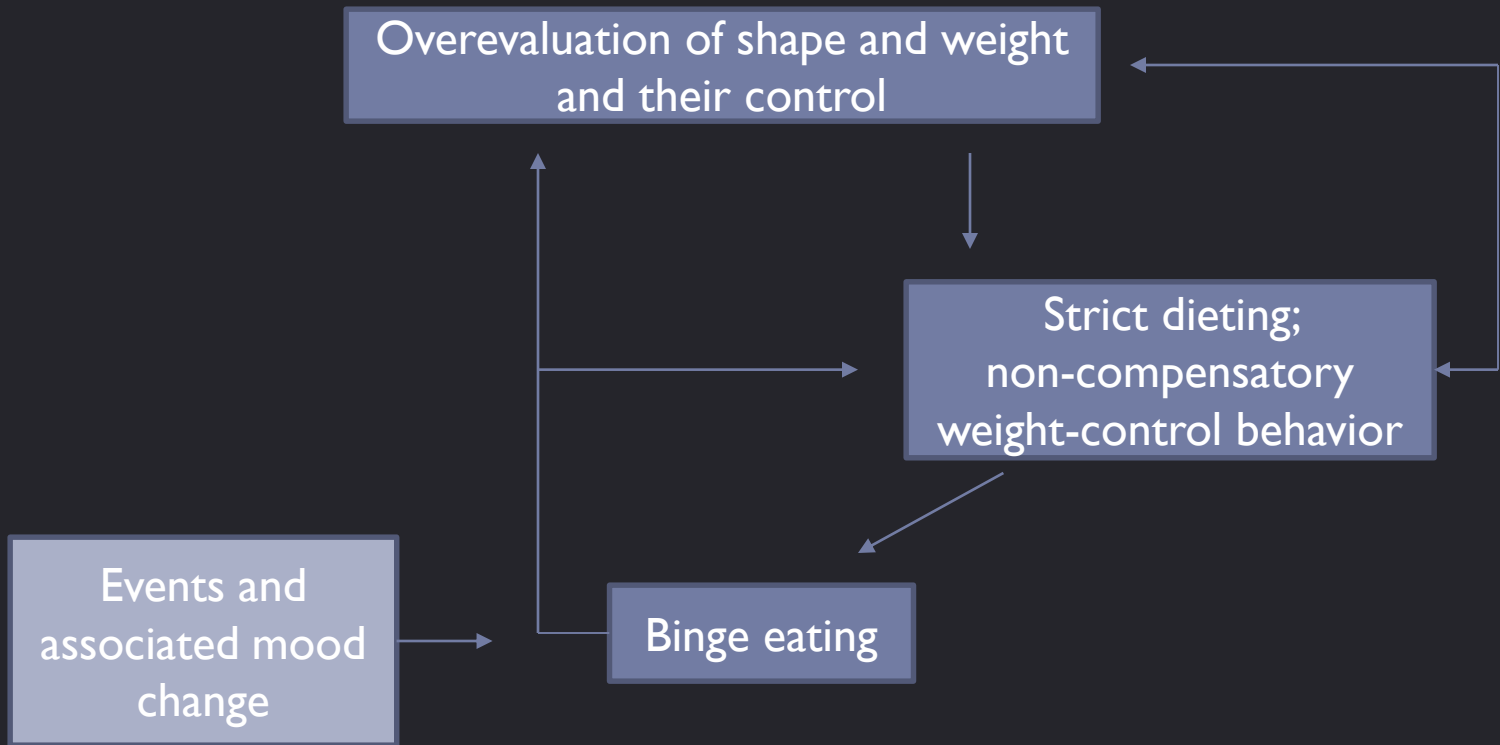


# CBT formulation for all ED



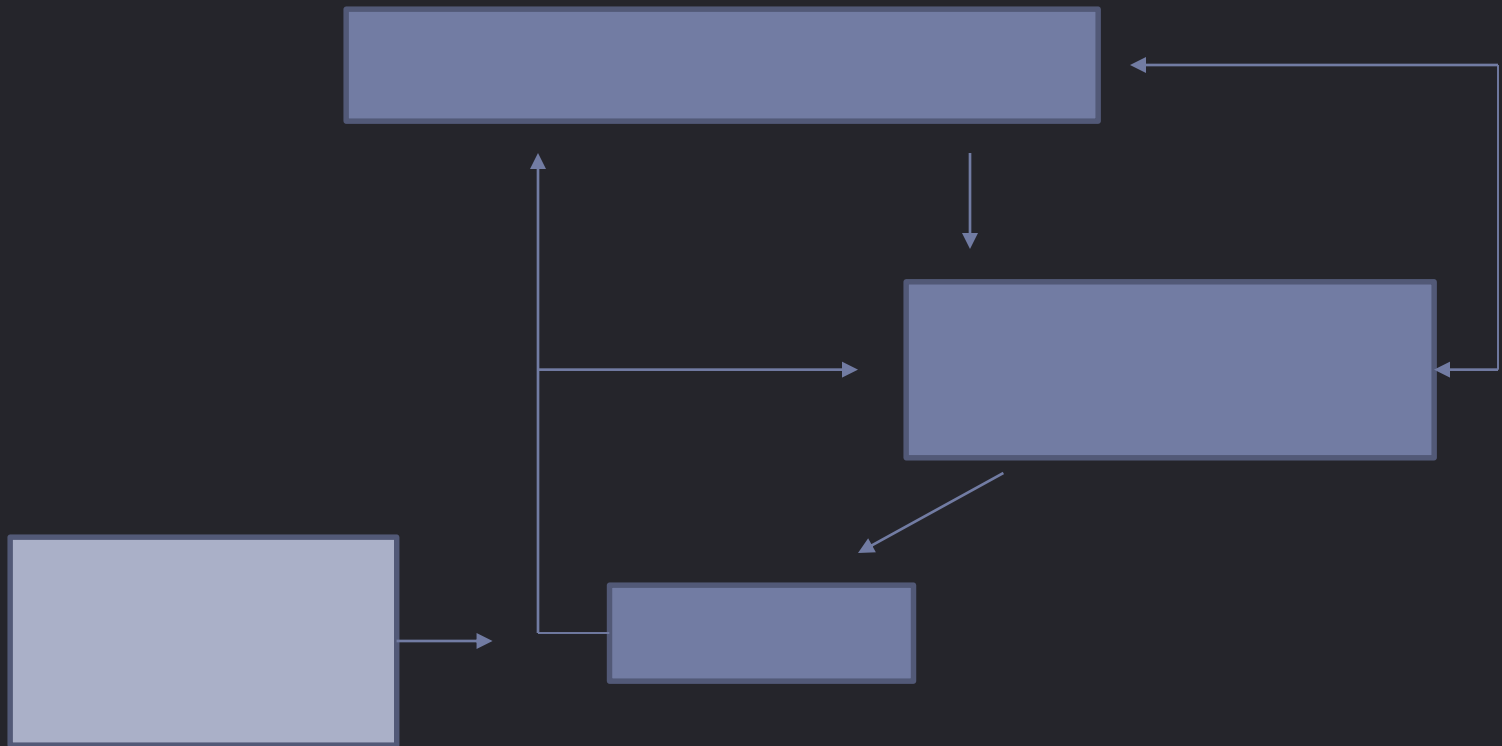


# CBT formulation for BED





# CBT formulation for BED





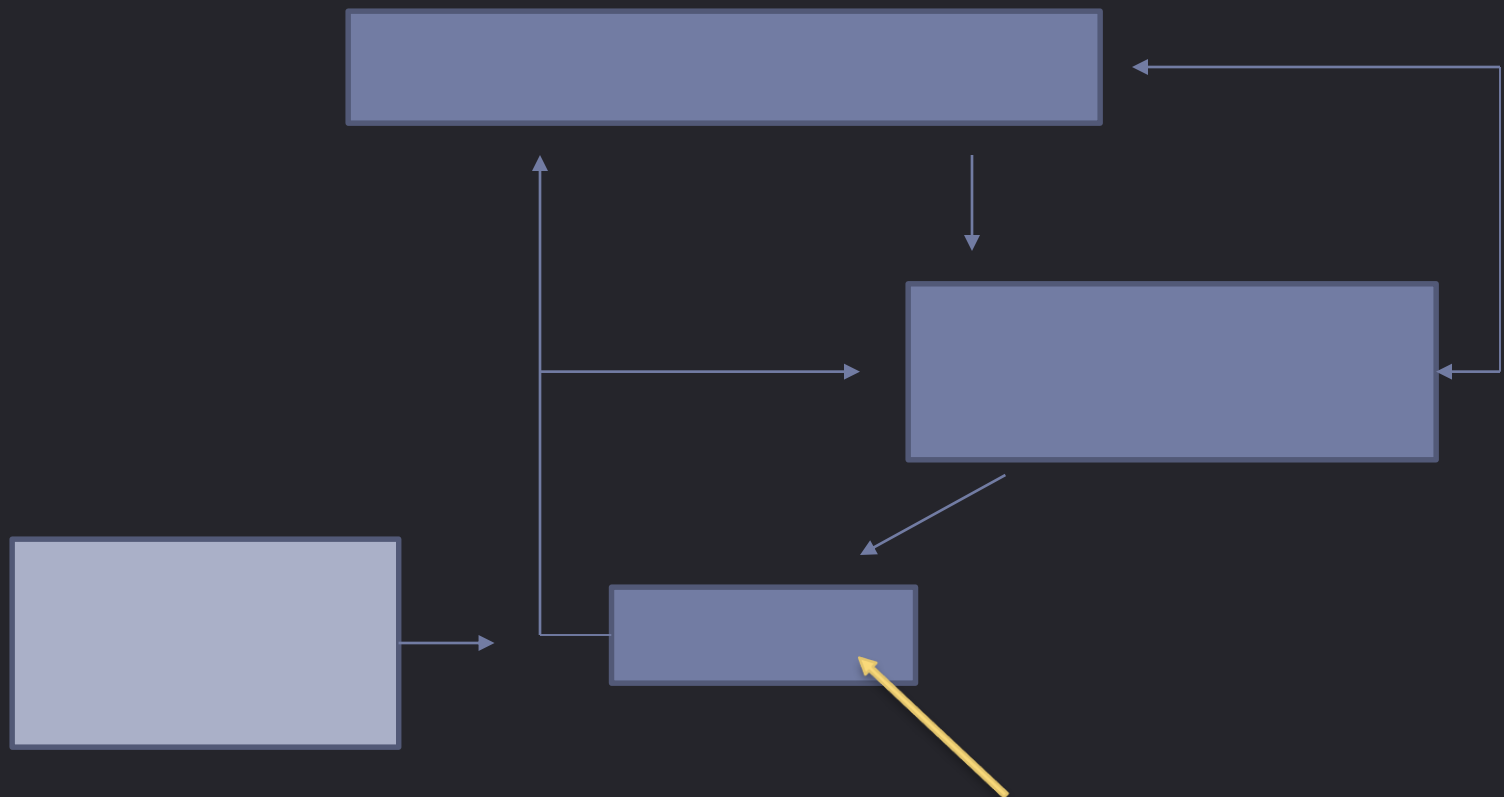


# Case example: Helen

- 55 year old woman
- Lifetime history of BED (binge eating since 15 years old, ebbs and flows)
- Binge eating 5-7 times/week
- Lives with her husband and two elementary-aged children
- Very educated and skilled physician, but taking time off to raise kids



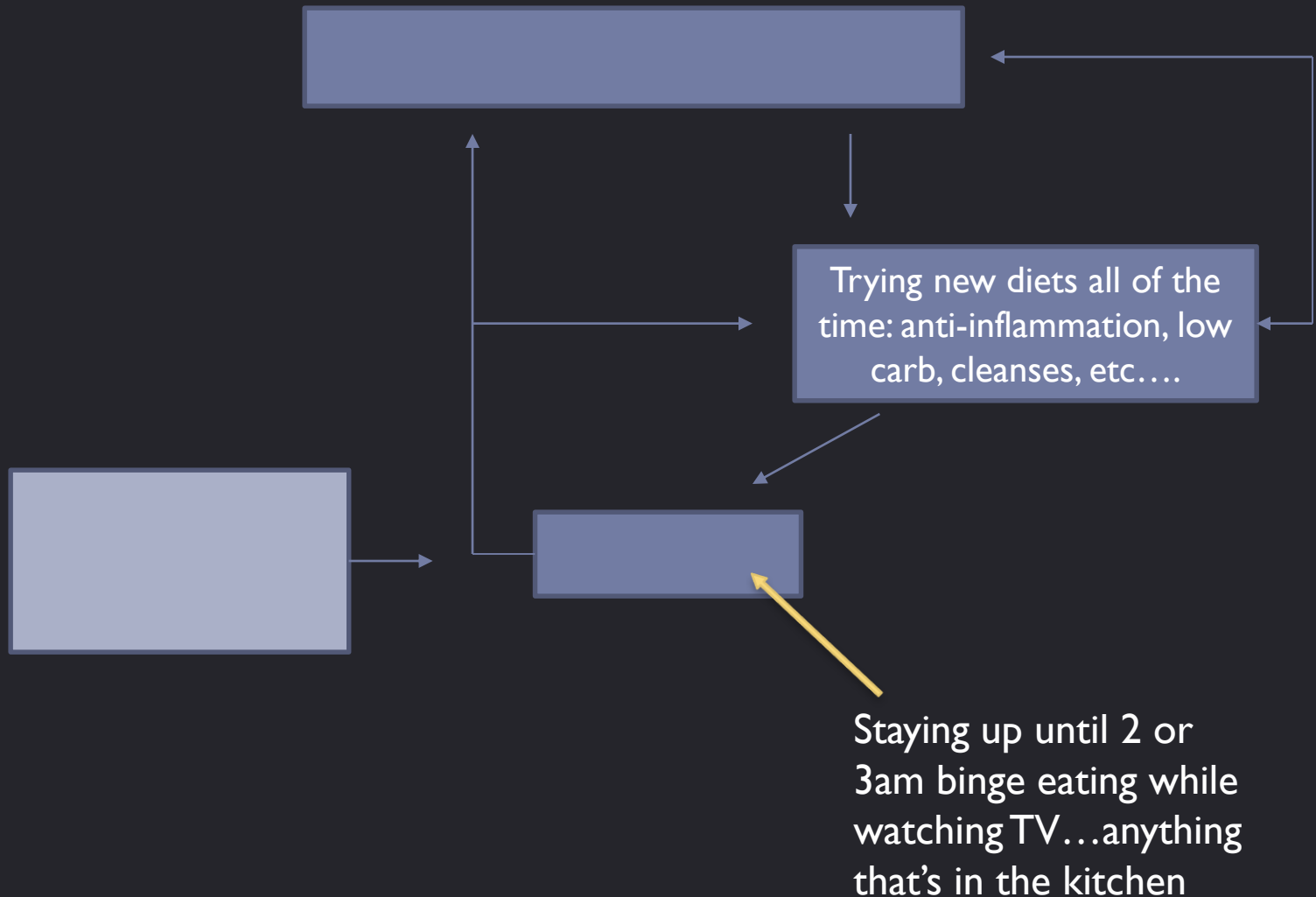
# CBT formulation for BED: Helen



Staying up until 2 or 3am binge eating while watching TV...anything that's in the kitchen

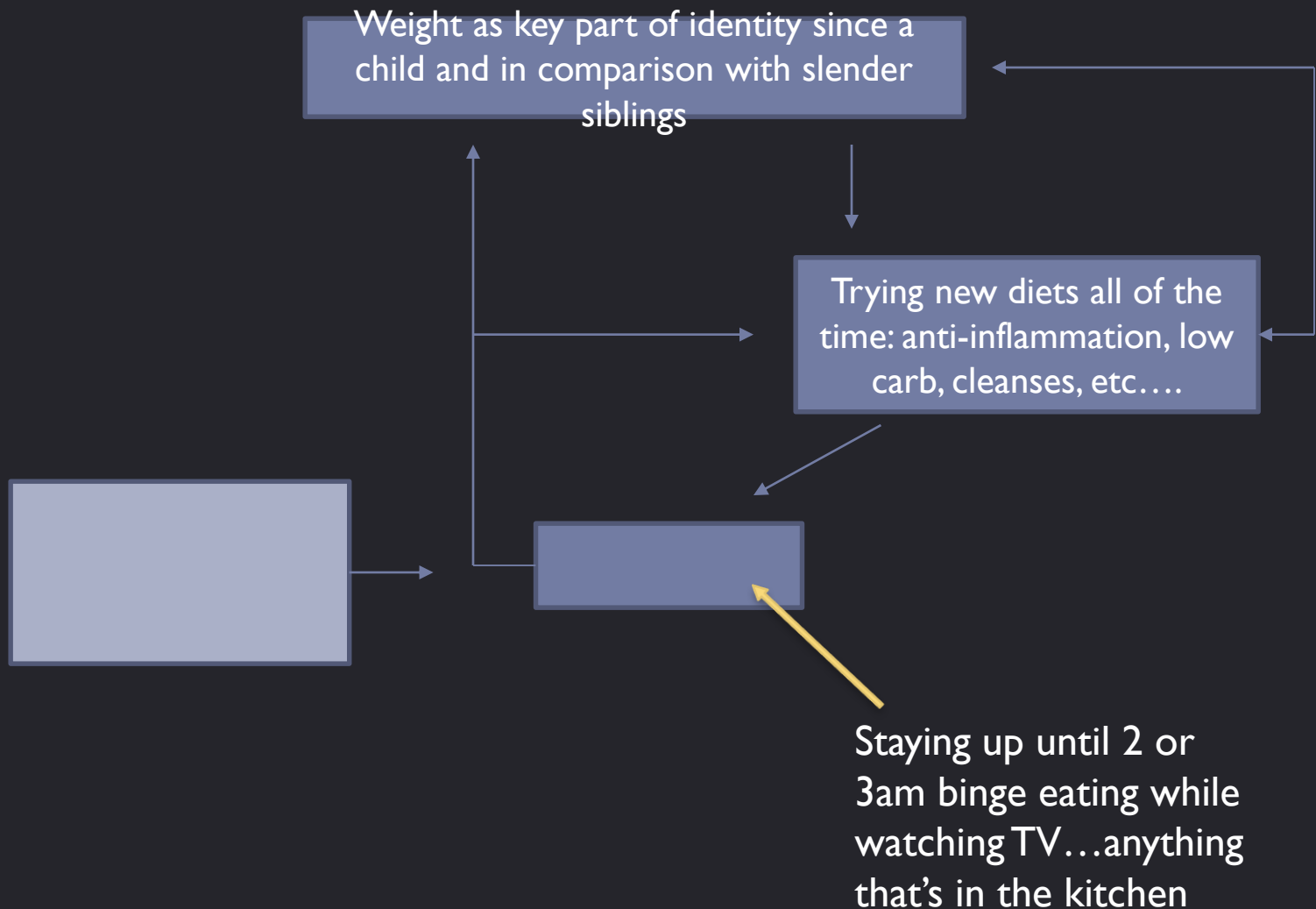


# CBT formulation for BED: Helen



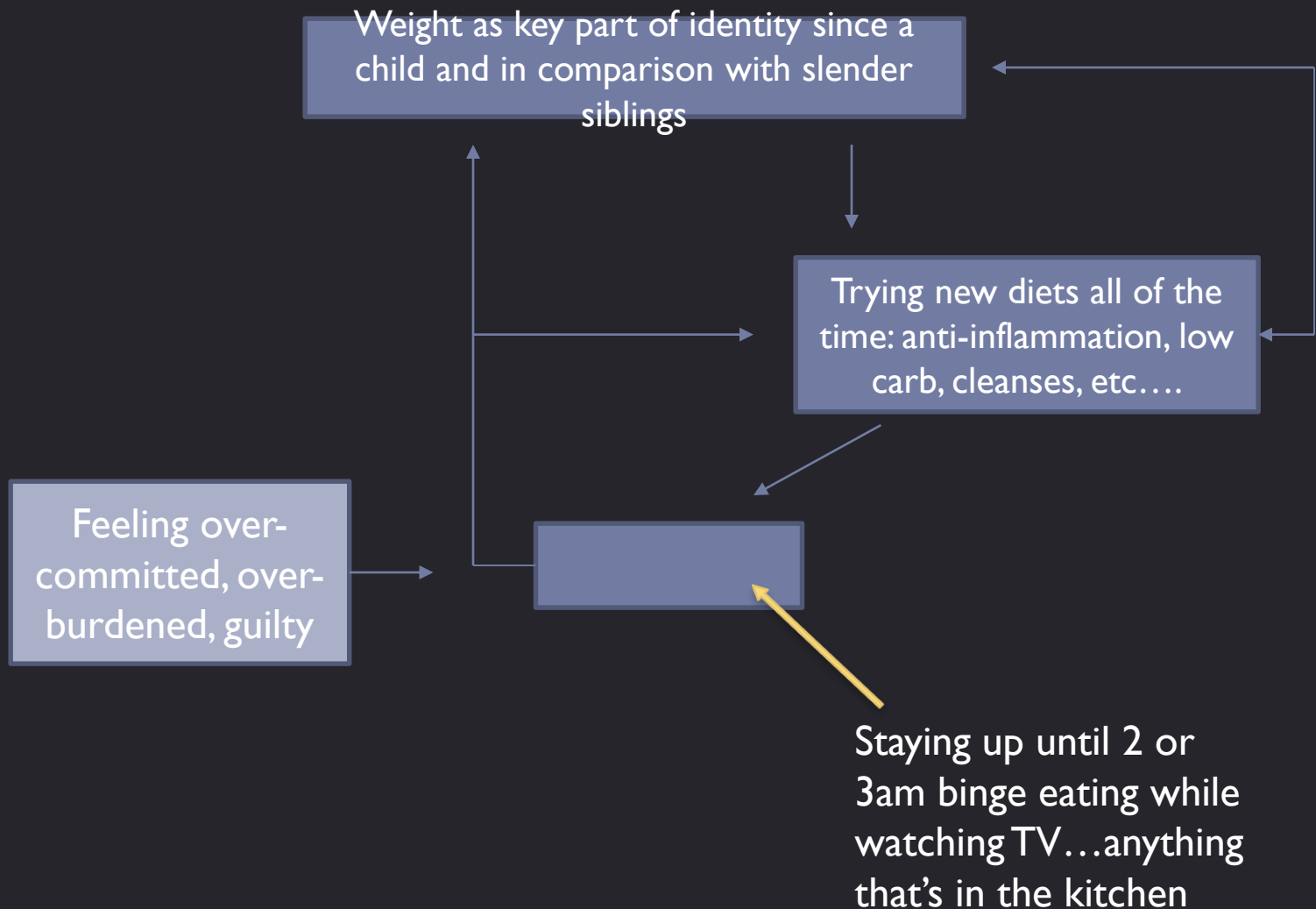


# CBT formulation for BED: Helen





# CBT formulation for BED: Helen







# Self-monitoring

- Central to treatment
- Rationale: Need to be able to see moment-to-moment detail of the process of the eating disorder and need to work together to identify what can change
- Address common concerns





# Instructions for self-monitoring

- Carry forms with you
- Record as soon as possible after you eat or drink and be complete in your recording
- Calories and detailed quantity not included





Day .....

Date .....

Time	Food and drink consumed	Place	*	v/1	Context and comments



Day *Thursday*Date *March 19th*

Time	Food and drink consumed	Place	*	V/L	Context and comments
7:30	Glass water	Kitchen			Thirsty after yesterday
8:10	Half banana Black coffee }	Cafe			Must be good and not binge today!
11:45	Smoked turkey on wheat bread Light mayo Diet coke }	Cafe			Usual lunch
6:40 to 7:30	Piece of apple pie 1/2 gallon ice cream 4 slices of toast with peanut butter Diet coke Raisin bagel 2 slices of toast with peanut butter Diet coke Peanut butter from jar Raisin bagel Snickers bar Diet coke – large	Kitchen	* * * * * * * *	V      V	Help – I can't stop eating. I'm completely out of control. I hate myself.      I am disgusting. Why do I do this? I started as soon as I got in. I've ruined another day.
9:30	Rice cake with fat-free cheese Diet coke	Kitchen			Really lonely. Feel fat and ugly. Feel like giving up.

**FIGURE 5.3.** A monitoring record (patient A; session 2). V = vomiting. L = laxative misuse. See Table 5.2 for a full description of self-monitoring and the abbreviations used.

A blank monitoring record is available online at [www.psych.ox.ac.uk/credo/cbt\\_and\\_eating\\_disorders](http://www.psych.ox.ac.uk/credo/cbt_and_eating_disorders).





# Session I

## Tasks:

- Initiate in-session weighing
- Reviewing self-monitoring
- Reviewing formulation
- Education about weight-checking and weight





# Session I

## Tasks:

- Initiate in-session weighing
- Reviewing self-monitoring
- Reviewing formulation
- Education about weight-checking and weight





# Session 1: In-session weighing

- Collaboratively done to move patient away from over-checking or avoiding weight
- Dispels possible myths about what is happening with weight
- Taught how to regard weight and changes: “one cannot interpret a single reading”



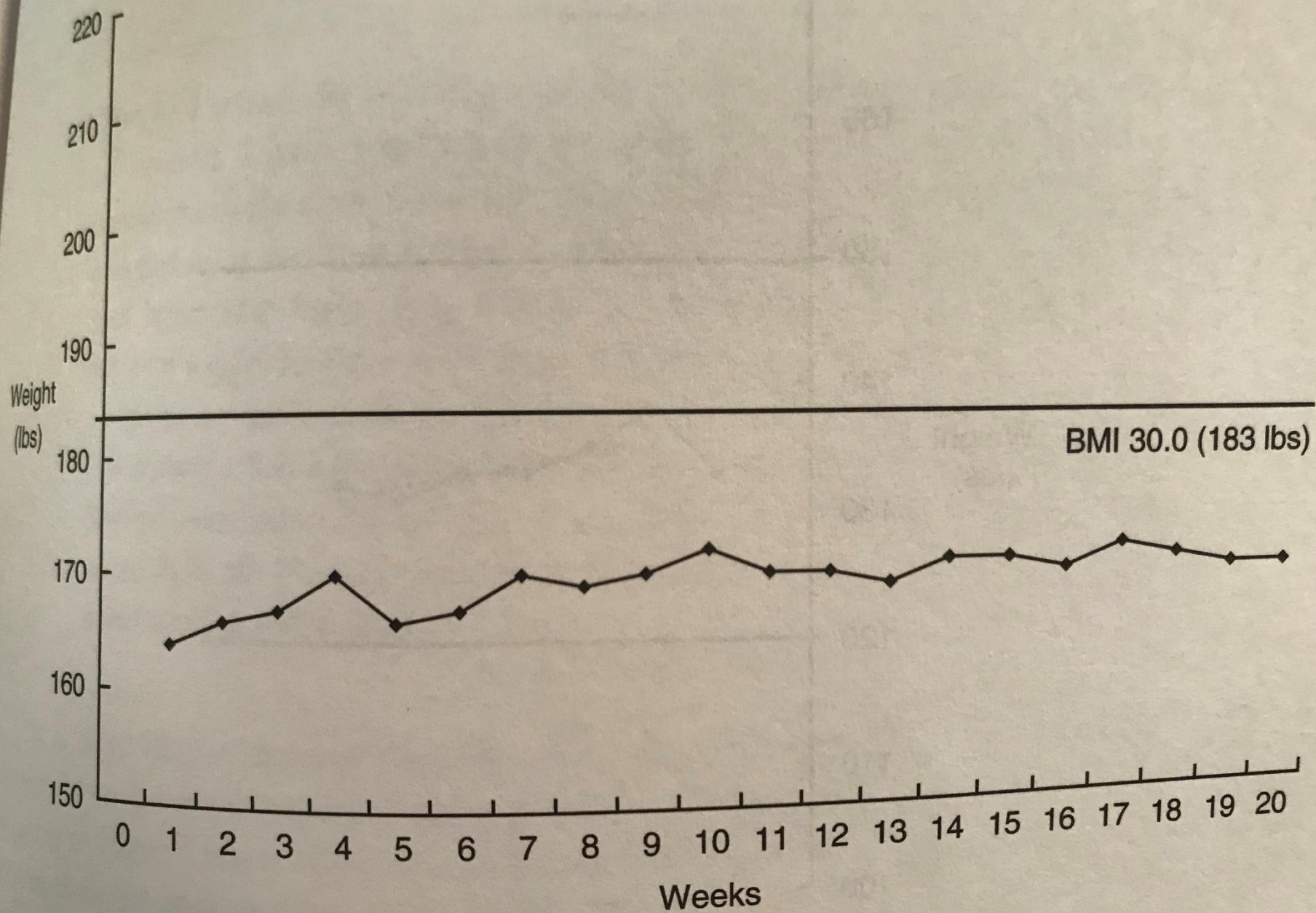


FIGURE 1. Weight (lbs) of an overweight patient.





# Session I

## Tasks:

- Initiate in-session weighing
- Reviewing self-monitoring
- Reviewing formulation
- Education about weight-checking and weight





# Session 1: Education about weight-checking and weight

- Weight fluctuates throughout day
- Frequent weighing leads to preoccupation with unmeaningful changes in weight
- Weight changes tend to be used to support idea that the person should diet
- Instead, the goal weight should be the weight that you are when you are not binge eating;
  - If weight loss is eventually a goal, the second weight range will be based on what your weight is when exercising regularly and eating in a balanced, moderate fashion





# Remainder of Stage I (sessions 2-7)

## Standard structure:

- In session weighing and interpretation (once/week) [up to 5 minutes]
- Review latest monitoring records and any homework assignments [up to 10 minutes]
- Collaborative agenda-setting [3 minutes]
- Working through agenda and agreeing on homework [up to 30 minutes]
- Summarize session, confirm homework, arrange next appointment [3 minutes]





# Remainder of Stage I

- Education on eating disorders
  - Guided reading from Overcoming Binge Eating (Chapters 1, 4, 5 in particular)
  - Review of topics by therapist (Table 6.1)
- Establishing regular eating
- Involving significant others






# Remainder of Stage I

- Education on eating disorders
  - Guided reading from Overcoming Binge Eating (Chapters 1, 4, 5 in particular)
  - Review of topics by therapist (Table 6.1)
- Establishing regular eating
- Involving significant others





# Remainder of Stage 1: Regular Eating

“It is now time to begin making changes to your eating. The first one simply concerns **when** you eat, not **what** you eat. It has been found that eating at regular intervals throughout the day really helps people with eating problems. Doing this, and doing it well, is really important. It is the foundation upon which all other changes will be built.”





# Regular Eating

1) Patients should eat 3 meals and 2 planned snacks each day:

- Breakfast
- Lunch
- Mid-afternoon snack
- Dinner
- Evening snack

2) Patients' eating should be confined to those meals and planned snacks






# Regular eating

## Tips for “meal hygiene”:

- Meals should have clear beginning and end
- Meals should be taken sitting down and not while being distracted by TV or reading
- Slowed down, deliberate





# Remainder of Stage I: Involving significant others (SOs)\*

- \* SO sessions are 45 minutes and are added on to a usual 50 minute session
- Review treatment and discuss ways SO can be helpful, e.g., responding to requests for help when having difficulty resisting eating between meals/snacks





## Stage 2 (sessions 8-9)

- Only 2 sessions, held weekly
- Review progress
  - EDE-Q, CIA
- Discuss what is getting in the way using review of treatment elements
- Update the formulation
- Decide whether to use broad version of CBT-E





## Stage 2 (sessions 8-9)

- Plan Stage 3, the main body of the treatment
- Key maintaining mechanisms identified and plans made for where to start
  - Over-evaluation of shape and weight
  - Dietary restraint
  - Event- or mood-triggered changes in eating





## Stage 3 (sessions 10-17)

- Concerns about weight and shape:
  - Enhancing importance of other domains for self-evaluation
  - Addressing body-checking and avoidance
  - Addressing “feeling fat”



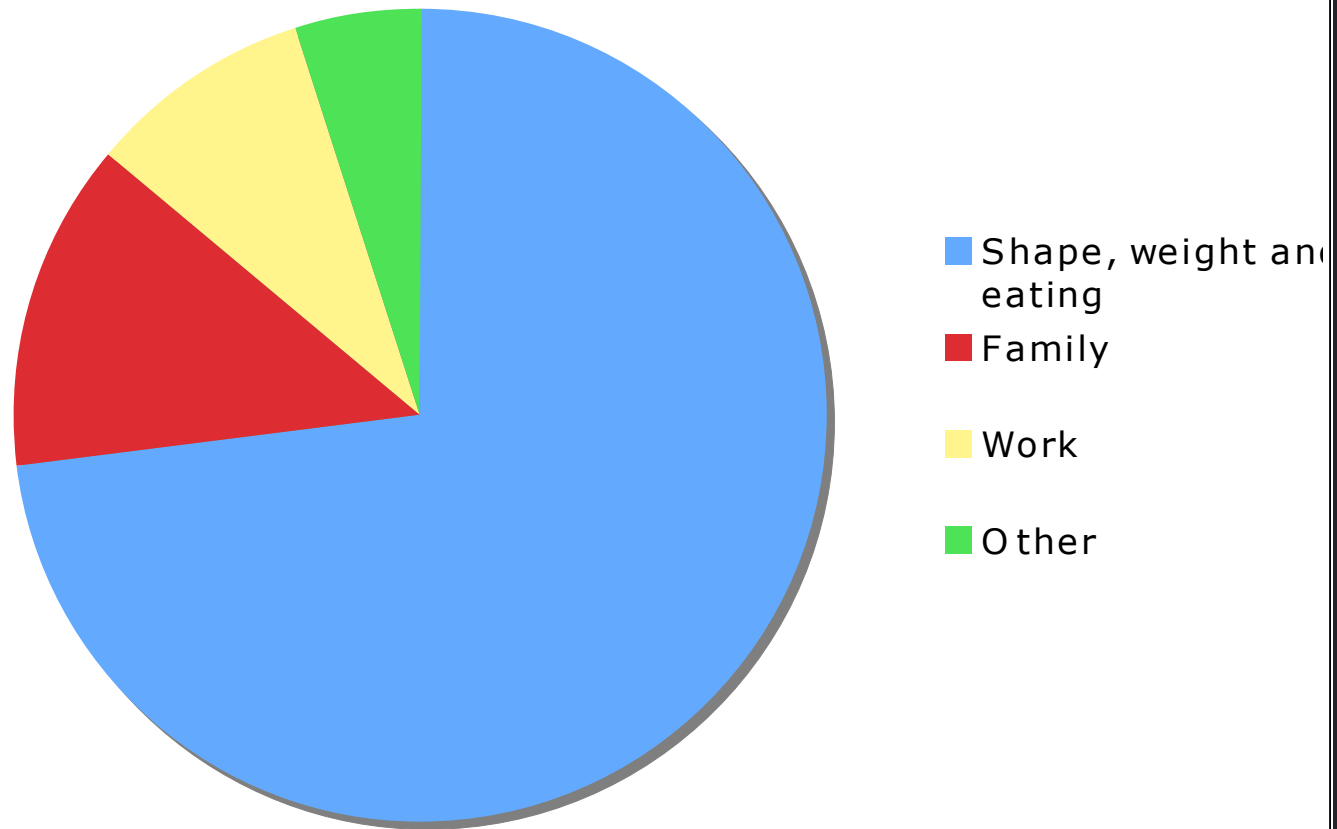


## Stage 3 (sessions 10-17)

- Concerns about weight and shape:
  - Enhancing importance of other domains for self-evaluation
  - Addressing body-checking and avoidance
  - Addressing “feeling fat”

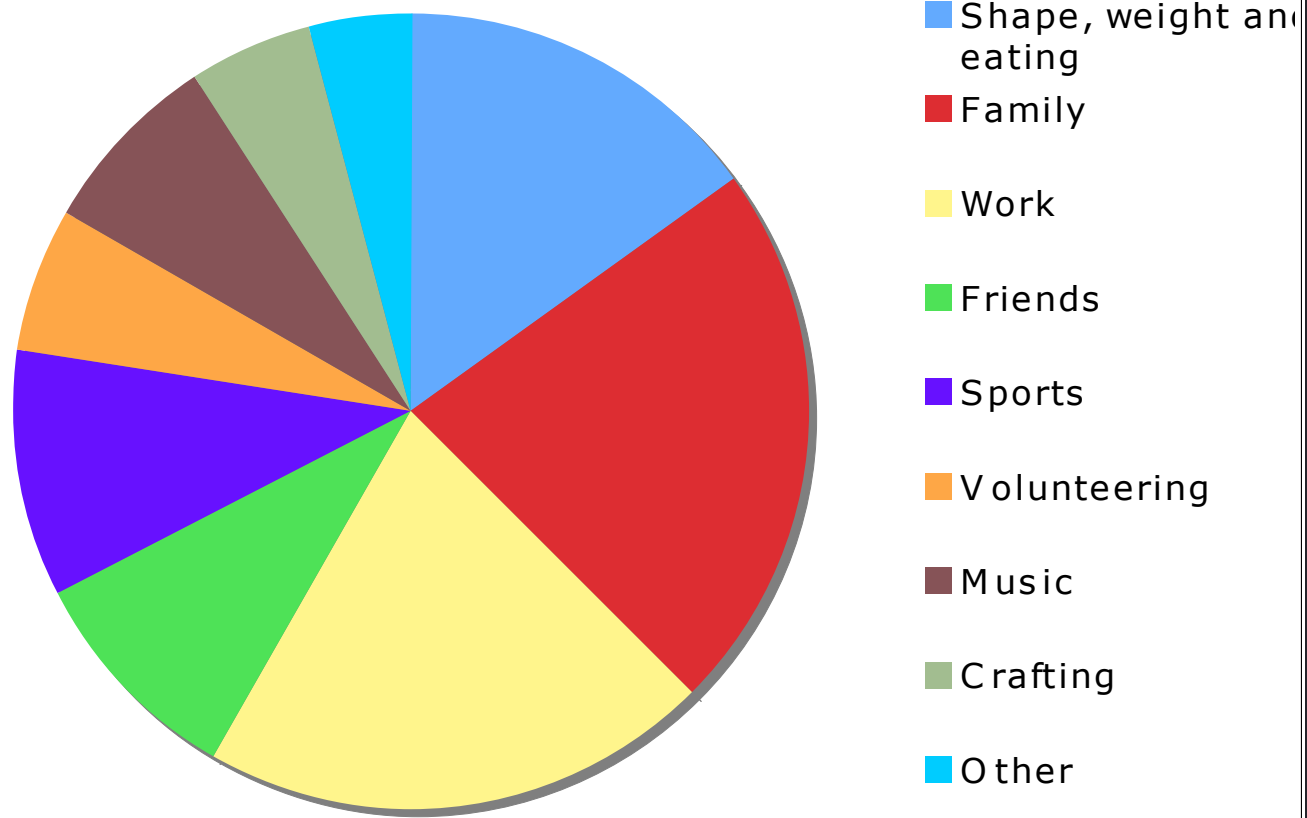


## “Risky” self-esteem pie chart





# Diverse self-esteem pie chart







## Stage 3 (sessions 10-17)

- Dietary restraint
  - Leads to binge eating through psychological mechanisms rather than physical ones
    - Break a rule – “to hell with it!” → binge
- Reduce rigid food rules
- Work on including “forbidden foods”





## Stage 3 (sessions 10-17)

- Events, moods and eating
  - Overeating as a “treat” or reward
  - Binge eating can distract from negative events or moods and has a direct dampening of intense mood states
- 1) Proactive problem-solving to address triggering events
- 2) Strategies for mood modulation





# Example: Helen

- Triggering events: criticism by husband, uncooperative kids at bedtime, nanny not completing job
- Moods: resentful, conflicted, guilty, ashamed
- Problem-solving
- Mood modulation





## Stage 4: Ending well

- Sessions 18-20, every two weeks
- Cease self-monitoring
- Practicing “driving” on own for 20 weeks until follow-up session
  - Short term maintenance plan
- At follow-up session 20 weeks after session 20, long-term maintenance plan is developed





# Broad form of CBT-E

- Perfectionism
- Low self-esteem
- Interpersonal difficulties






# Broad form of CBT-E

- Perfectionism
- Low self-esteem
- Interpersonal difficulties





# Core low self-esteem

- Longstanding and pervasive negative view of the self
- Unconditional
- Cognitive therapy to identify distortions in thinking and challenge these thoughts
- Improve interpersonal functioning -- using Interpersonal Psychotherapy (IPT)



# Co-morbidities in BED

- Most often depression, anxiety, substance misuse
- Questions to ask:
  - Are the symptoms directly attributable to the ED? If so, may just be feature of the BED
  - Will symptoms likely interfere with treatment? If so, need to be addressed before or at same time as CBT-E
  - Are symptoms likely to dissipate once BED is treated? If so, probably do not need direct intervention





# Difficulty of depression

- Interfering symptoms: Hopelessness, low drive, difficulty concentrating
- Treat depression first – medication?
- Other mood disorders – with bipolar I and II, treatment can proceed if mood is stable





# Difficulty of anxiety

- Less likely to interfere with CBT-E
- Need to differentially diagnose – social anxiety or discomfort with eating around others due to shame?
- Agoraphobia could interfere
- Anxiety disorders most often exist independently rather than interact in BED, so can be treated separately in whatever order





# Difficulty of substance misuse

- Disinhibition from substances in the context of binge eating can interfere with treatment
- Some patients able to reduce their use of substances in order to work on BED
- If they are not able to readily control substance use, specialist help to control substances before CBT-E is recommended





# Difficulty of obesity

- Clear definition of treatment goals needed
  - Weight loss?
  - Addressing binge eating first?





# Thank you!

## Contact information:

Angela Celio Doyle, PhD

Co-Director, Eating Disorders Center

Evidence Based Treatment Centers of Seattle

1200 5<sup>th</sup> Avenue, Suite 800

Seattle, WA 98101

(206) 374-0109

[adoyle@ebtseattle.com](mailto:adoyle@ebtseattle.com)