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Developing an Acceptance-Based Behavioral Treatment for Binge Eating Disorder: Rationale and Challenges

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Binge eating disorder (BED), characterized by recurrent eating episodes in which individuals eat an objectively large amount of food within a short time period accompanied by a sense of loss of control, is the most common eating disorder. While existing treatments, such as cognitive behavioral therapy (CBT), produce remission in a large percentage of individuals with BED, room for improvement in outcomes remains. Two reasons some patients may continue to experience binge eating after a course of treatment are: (a) Difficulty complying with the prescribed behavioral components of CBT due to the discomfort of implementing such strategies; and (b) a lack of focus in current treatments on strategies for coping with high levels of negative affect that often drive binge eating. To optimize treatment outcomes, it is therefore crucial to provide patients with strategies to overcome these issues. A small but growing body of research suggests that acceptance-based treatment approaches may be effective for the treatment of binge eating. The goal of the current paper is to describe the development of an acceptance-based group treatment for BED, discuss the structure of the manual and the rationale and challenges associated with integrating acceptance-based strategies into a CBT protocol, and to discuss clinical strategies for successfully implementing the intervention.

Binge eating disorder (BED) is the most common eating disorder, with an estimated lifetime prevalence rate of 2.0% among men and 3.5% among women in the United States (Hudson, Hirpi, Pope, & Kessler, 2007). BED is characterized by eating episodes during which individuals consume an objectively large amount of food in a discrete time period and experience a sense of loss of control over eating, but do not engage in regular compensatory behaviors (e.g., self-induced vomiting, excessive exercise). Diagnostic criteria for BED require that these binge eating episodes must have occurred, on average, at least once per week in the previous 3 months, and must be associated with significant distress (American Psychiatric Association, 2013). BED is also associated with high levels of co-occurring psychiatric disorders, obesity and related medical complications, impaired social functioning, and reduced quality of life (Grilo, White, & Masheb, 2009; Mitchell, Devlin, de Zwaan, Crow, & Peterson, 2008; Rieger, Wilfley, Stein, Marino, & Crow, 2005; Wilfley, Wilson, & Agras, 2003; Wonderlich, Gordon, Mitchell, Crosby, & Engel, 2009). Though evidence-based cognitive-behavioral treatments for BED exist, many patients fail to respond to these treatments, indicating the need for improvements upon existing treatment paradigms. The aim of this paper is three-fold: we will (a) explicate the evidence for limitations of current treatments for BED; (b) describe the development of an acceptance-based treatment approach to address these limitations; and (c) discuss the challenges encountered while integrating acceptance-based approaches with current gold-standard treatments for BED.

Numerous psychological treatments exist for the treatment of BED, including cognitive behavioral therapy (CBT), guided self-help CBT, interpersonal therapy, dialectical behavioral therapy, and behavioral weight loss treatment (for a review, see Iacovino, Gredysa, Altman, & Wilfley, 2012). Effective pharmacotherapies also exist, and can be delivered alone or in combination with psychological treatment (for reviews, see Brownley, Berkman, Sedway, Lohr & Bulik, 2007; Reas & Grilo, 2008). A recent meta-analysis of 38 studies of various psychological and pharmacological treatments for BED revealed that both psychotherapy and structured self-help based on cognitive behavioral interventions resulted in medium to large effect sizes for improvements in binge eating and related outcome variables (e.g., eating and weight concerns; Vocks et al., 2010). Based on these

[1] Video patients/clients are portrayed by actors.

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findings, as well as clinical treatment guidelines (e.g., NICE, 2004), CBT is currently considered the treatment of choice for BED. CBT for BED is delivered in both individual and group formats, and these formats appear to be equally effective in reducing binge eating in the long-term (Ricca et al., 2010).

Although CBT is considered an effective treatment for BED, with binge abstinence rates at posttreatment to 1-year follow-up ranging from approximately 50% to 80% (Grilo, Masheb, & Wilson, 2005; Peterson, Mitchell, Crow, Crosby, & Wonderlich, 2009; Wilfley et al., 2002), room for improvement in long-term outcome remains. In a large randomized control trial evaluating the efficacy of outpatient group CBT for BED, for example, only 52% of patients achieved recovery at 4 years posttreatment, and 72.0% remitted to at least subthreshold symptom severity (Hilbert et al., 2012). Thus, a considerable number of patients with BED continue to experience full- or subthreshold levels of binge eating despite receiving the current gold-standard treatment approach.

Symptom persistence after treatment may be partially attributed to difficulty complying with the prescribed behavioral components of CBT. The cognitive behavioral model of eating pathology posits that overvaluation of weight and shape and resulting dietary restriction are the primary maintenance factors of binge eating (Fairburn, Cooper, & Shafran, 2003; Fairburn, 2008a,b). As such, regularizing eating habits and addressing the dysfunctional scheme of self-evaluation are primary targets of treatment. CBT instructs patients to engage in numerous behaviors to address these treatment targets, such as self-monitoring of food intake and body image, and eating at regular intervals throughout the day (Fairburn, 2013; Mitchell et al., 2008). These behavioral recommendations appear to be effective in reducing symptomology when patients successfully implement them (Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002; Zendegui, West, & Zandberg, 2014), and compliance with homework assignments in CBT, such as self-monitoring, is predictive of treatment success across numerous disorders (Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010). However, some patients may find the behavioral recommendations made in CBT for BED to be effortful or distressing, and may therefore feel unmotivated or unable to implement these key recommendations. For example, some patients may fail to self-monitor their food intake because they find it boring, time-consuming, or feel embarrassed by recording binge episodes. Other patients resist regularizing their eating patterns due to concerns about weight gain. Thus, while compliance with treatment recommendations likely reduces binge eating pathology, successful implementation proves difficult for many individuals. To optimize treatment outcomes, treatment must also provide strategies to overcome the emotional discomfort associated with enacting challenging behaviors (e.g., self-monitoring, regularizing eating), which are critical for reducing binge eating.

Prevailing theoretical models of the development and maintenance of binge eating pathology implicate affect as a primary precipitant of the behavior. For example, the widely accepted dual pathway model includes dietary restriction and negative affect as the two primary mechanisms through which body dissatisfaction increases risk of binge eating (Stice & Agras 1998; Stice, Nemeroff, & Shaw, 1996). Numerous studies support the role of negative affect and emotion dysregulation in binge eating (e.g., Agras & Telch, 1998; Berg et al., 2013; Deaver, Miltenberger, Smyth, Meidinger, & Crosby, 2003; Greeno, Wing, & Shiffman, 2000; Hilbert & Tuschen-Caffier, 2007; Whiteside et al., 2007). Although diagnostic subtypes of BED do not currently exist, some research suggests that there is a subgroup of BED patients for whom emotion dysregulation may be particularly relevant to binge eating; notably, pathology may be greater in this group of patients (Grilo, Masheb, & Wilson, 2001; Stice et al., 2000). High emotional eating has also been found to predict treatment resistance (Ricca et al., 2010), suggesting that individuals for whom the relationship between negative affect and binge eating is stronger may fare less favorably in treatment. Although the cognitive behavioral model of eating pathology posits that mood intolerance is a maintenance mechanism of eating pathology for some individuals, and although mood intolerance is targeted by a newer, more complex version of CBT for eating disorders (i.e., CBT-E; Fairburn, 2008a,b; Fairburn, et al., 2015), it remains a relatively small focus of the overall treatment package, only introduced in later stages of treatment (Fairburn, 2008a,b; Fairburn et al., 2009). Given the apparent role of negative affect in binge eating, especially for some individuals, increased focus on addressing the link between affect and binge eating may improve treatment outcomes. Furthermore, although facilitating engagement with behavioral recommendations and devoting attention to emotion regulation skills may be two separate ways to improve treatment outcome, it is also possible these two avenues may influence each other. For example, provision of distress tolerance and/or emotion regulation skills may also increase the ability to tolerate the difficult process of behavior change.

In summary, although CBT for BED is relatively effective, patients often require additional skills that facilitate engagement with behavioral recommendations, as well as explicit focus on affect regulation and/or distress tolerance. Our acceptance-based behavioral treatment (ABBT) for BED combines key behavioral elements of standard CBT protocols for BED with approaches and skills emphasized in "third wave" cognitive behavioral therapies that can address these two deficits. Generally speaking, third wave therapies utilize psychological acceptance (i.e., a