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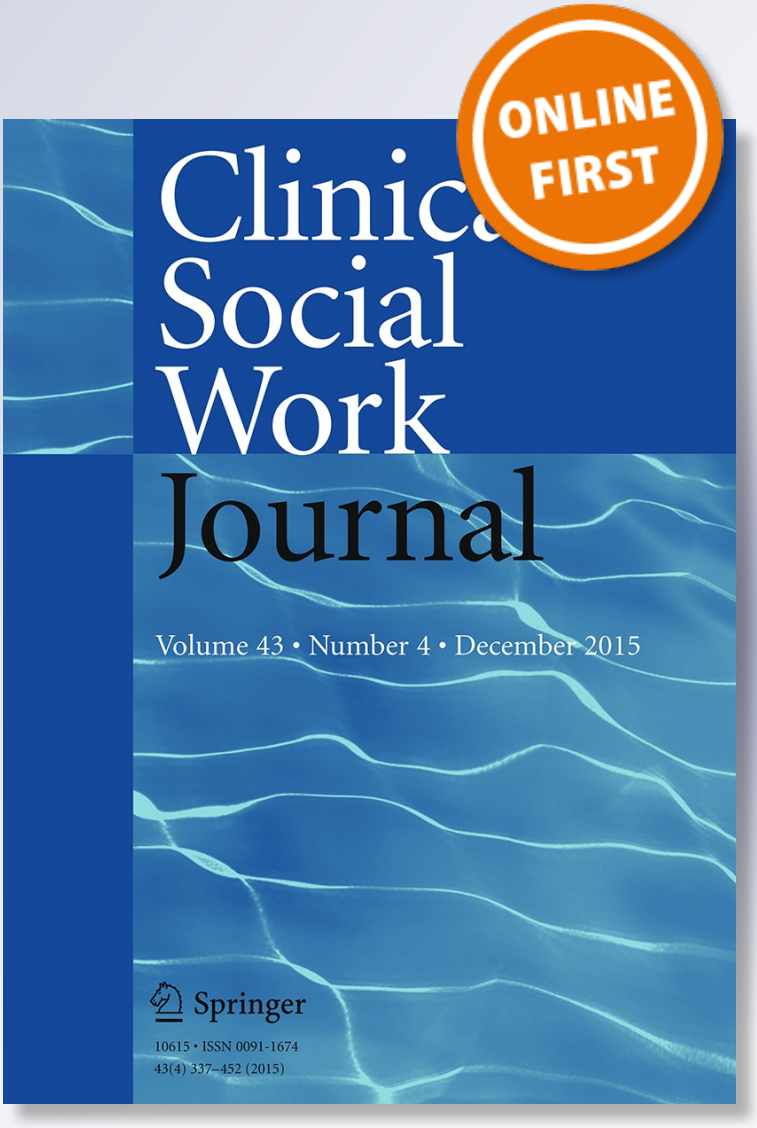

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ORIGINAL PAPER

An Integrative Group Treatment Model for Women with Binge Eating Disorder: Mind, Body and Self in Connection

Holly Starkman[1,2]

Abstract Binge eating disorder (BED) is the most prevalent eating disorder reported among women, and its recent diagnostic recognition in the DSM-5 (APA 2013) calls for further discussion on effective treatment. Women with BED commonly report a diet/binge cycle that can exacerbate a disconnection between mind and body and reinforce feelings of shame and isolation. This article presents an integrative group treatment model for women with BED that has shown positive outcomes in clinical practice. The group model addresses key biopsychosocial factors associated with BED and incorporates mindfulness principles tailored to problems of the disorder. A core foundation of the group model is the relational context that fosters connections between women members and promotes self-efficacy. The discussion includes etiology of BED and current empirical support for integrating mindfulness skills in treatment for binge eating problems, as well as the author's clinical experience in formulating a short-term group model. The eight-session semi-structured group format integrates evidence-based treatments in resonance with treatment-based evidence that reflects the distinct clinical needs of women with BED. Clinical vignettes illustrate how the group model can provide an anchoring therapeutic support to women with BED for linking experiences of mind, body, and self.

Keywords Binge eating disorder · Group treatment for binge eating disorder in women · Mindfulness and binge eating disorder · Women and eating disorders · Biopsychosocial perspective for eating disorders and body image

> Struggling with binge eating the way I do…now I understand that it's not necessarily about size or weight. I'm not a big talker, but I feel good about talking here…and finally, with other women who get it…really understand the struggles over food and how bad it can make you feel about yourself…but you don't know how to stop.
> (Member of group for women with binge eating disorder)

Introduction

Binge eating disorder (BED) is the most prevalent eating disorder, estimated to occur in women twice as frequently as in men (Hudson et al. 2007/2012). Now that the revised DSM-5 (APA 2013) has classified BED as a distinct eating disorder, treatment efficacy is of greater interest than ever. BED features impairments of self-regulation, including a combination of cognitive, affective and physiological factors (APA 2013). Because individuals with BED can have difficulty differentiating between emotional distress and physiological cues for hunger (APA 2013), successful treatment aims to promote increased awareness of mind, body and self. Currently, evidence-based treatment models, including cognitive behavioral therapy (CBT) (Wilson 2010), interpersonal therapy (IPT) (Wilfley et al. 2002, 2012), and dialectical behavior therapy (DBT) (Linehan 1993, 2015; Safer et al. 2009), aim to address some of the

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complex psychological and physical aspects of the eating disorder. Although these interventions have been associated with positive improvement of symptoms, many individuals with BED struggle with sustaining those benefits over time. Furthermore, it remains unclear why some individuals respond well to specific treatment interventions while others do not.

Several researchers have discussed the relationship between emotion regulation and binge eating (Wiser and Telch 1999; Whiteside et al. 2007). These findings support the use of skill-based interventions for self-regulation, particularly in linking bodily sensations and self-states that correspond to hunger and satiety. Clinical interventions that target self-regulation, versus weight management alone, have shown some positive outcomes and point to the significance in addressing connections between mind, body, and self-states. Growing attention has been given to mindfulness-based interventions with BED (Kristeller and Wolever 2011; Katterman et al. 2014) as well as the use of mindfulness skills to enhance ongoing treatment for eating disorders (Baer et al. 2005; Smith et al. 2006; Kristeller et al. 2006; Hepworth 2011). Systematic study is still required on the clinical utility of mindfulness, but current research supports its use in treatment (Grossman et al. 2004; Kristeller et al. 2014). Overall, mindfulness skills provide direction for two central goals of treating BED: improved self-regulation, and an enhanced ability to tolerate negative emotional states. Moreover, mindfulness techniques are not specific to the disorder. Unlike other treatment models for BED, these skills can help sustain the benefits of self-regulation over time.

In BED, a combination of biological, psychological, and social factors have thwarted development of a healthy body self, a core feature of the disorder. The author presents an integrative treatment model that incorporates a three-pronged approach: One, a contemporary biopsychosocial perspective of BED, with treatment reflecting individual needs and experiences; two, mindfulness principles and skills; and three, the relational context of a group. Clinical vignettes highlight some therapeutic outcomes of the group treatment, particularly the mutual empathy that reinforces awareness of the links between negative thinking, emotional distress and eating behavior.

Binge Eating Disorder: Clinical Features, Research and Theory

Definition and Prevalence

The term, *binge eating* was introduced by Stunkard (1959) in a description of behaviors found among a sub-group of overweight individuals. Until 2013, when the DSM-5 (APA 2013) included BED as a unique eating disorder diagnostic entity, researchers long debated whether BED merited its own distinction (Fairburn and Wilson 1993; Spitzer et al. 1993; Grilo 2000; Brownell and Schwartz 2001; Devlin et al. 2003). For the purposes of this paper BED is defined using DSM-5 research criteria. Importantly, the DSM-5 broadened the clinical definition of BED, thus increasing its recognition and prevalence. In the revised definition, the frequency of binge episodes is reduced from two to three times a week for 6 months to once a week for at least 3 months. Additionally, the DSM-5 diagnostic criteria now includes such associated features as shame about eating problems, attempts to conceal symptoms, and secrecy during binging episodes. Negative affect is cited as a common antecedent of binge eating (Clyne and Blampied 2004; Grucza et al. 2007; Goldfield et al. 2008). The DSM-5 further identifies such BED triggers as interpersonal stressors, dietary restraint, and negative feelings related to body shape and weight. Negative self-evaluation and dysphoria are included as frequent delayed consequences of binge eating (APA 2013).

Hudson et al. (2007/2012) discussed findings from a landmark national survey on the prevalence and correlates of eating disorders that provided evidence for the clinical importance of binge eating disorder. The authors cited significant data on BED including: (a) the disorder affects an estimated 2.8 % of adults with less than half (43.6 %) of those individuals receiving treatment, (b) BED occurs at more than twice the rate of anorexia nervosa and bulimia nervosa combined, (c) women comprise an estimated 60 % of the BED population, and (d) BED occurs in normal-weight and overweight individuals with an estimated 45 % reported as being obese (Hudson et al. 2007/2012). Now that the DSM-5 includes BED as an eating disorder, along with the revised criteria, these statistics may reveal higher rates among both men and women.

Etiology of BED and Biopsychosocial Factors

BED is a complex disorder incorporating numerous biopsychosocial factors (Striegel-Moore and Smolak 2001; Barry et al. 2002; Maine and Bunnell 2010). Several researchers have suggested a high rate of comorbidity with BED and depression, anxiety and post-traumatic stress disorder (Zerbe 1993; Grucza et al. 2007; Grilo et al. 2012). Prior investigators and clinicians have identified alexithymia (Krystal 1988; Krueger 1989; van der Kolk 1996; Wheeler et al. 2005) and dissociation (van der Kolk 1996; Bromberg 2001; Hegeman 2002; Beato et al. 2003; Starkman 2005) among individuals with an eating disorder and a history of trauma. Van der Kolk (1996) particularly linked alexithymia with poor impulse control, stating that people who "have problems putting feelings into words

and formalizing flexible response strategies may (be) likely to act on their feelings" (p. 194). Several studies also revealed a high rate of dissociation levels during actual binging episodes (Hallings-Pott et al. 2005; McShane 2005). Empirical research tells us that individuals with BED may experience depression, alexithymia, and dissociative-like self-states. That means interventions must target these co-occurring features. Of course, these studies have limitations: They do not address the neurochemical pathways that interact with these phenomena, nor possible differences among a population without an eating disorder. Nevertheless, the biopsychosocial factors associated with BED underscore the need for an integrative approach in assessing and treating the disorder.

Other bodies of research further illustrate the complex issues that inform BED. Feminist theory and literature, for example, address sociocultural and sociopolitical influences in the development of an eating disorder and body image disturbances in women (Orbach 1978, 2009; Fallon et al. 1994; Gutwill 1994; Zerbe 1996). Orbach (2009) asserts the view that social dictates of body image norms for women place them in *emotional jeopardy*—a struggle in response to internal cues versus sociocultural standards. Early infant research further points to a developmental link of body and self. Over the past two decades, such research suggests that the infant's early affective interactions indelibly impact postnatal maturation of brain structures that will regulate all future socio-emotional functioning (Stern 1985; Beebe and Lachmann 1998; Schore 1994, 2003). Both developmental theory and feminist perspectives are significant for understanding the etiology of BED in women and for providing direction in clinical assessment and treatment. Particularly in a group treatment model, such research provides a framework for integrating gender-specific biopsychosocial and developmental factors with each member's unique experiences associated with developing an eating disorder and body image dissatisfaction.

Mindfulness Skills for Women with BED: Linking Experiences of Mind, Body and Self

Just as researchers have supported the use of integrative clinical treatment for eating disorders, so too has there been an increased acceptance for therapeutic interventions that support a mind–body connection (Baer et al. 2005; Smith et al. 2006; Duros and Crowley 2014). Verbal communication alone eludes somatic engagement, which can limit traditional clinical approaches to treating BED and problems of self-regulation. Therefore, many researchers now support BED interventions that include techniques for promoting calm and increasing awareness of connections between physical and emotional states. These include exercises for breathing, focusing, and of increasing popularity, mindfulness skills. As an adjunct to talk therapy, these techniques provide useful tools for engaging the body for improved self-regulation, a common focus in therapy for women with binge eating problems.

Mindfulness-based interventions are aimed at disengaging from ruminative thought patterns while directly experiencing thoughts, emotions and body sensations on a moment-to-moment basis without judgment (Kabat-Zinn 1994, 2003; Siegel 2010). By emphasizing the present moment, mindfulness interventions aim to improve emotion regulation and thereby enhance awareness of such internal states as hunger and satiety (Kristeller and Hallett 1999). Increased awareness of one's somatic state, and the development of the capacity for affect tolerance, has been discussed by Linehan (2015) and her colleagues (Telch et al. 2001) to help regulate cognitive, behavioral and emotional states—a core aim of treating BED. Moreover, because mindfulness skills are not specific to the disorder, they have the added benefit of sustaining self-regulation over time, an important outcome in treatment for BED. In a meta-analysis of fourteen studies on mindfulness skills as an intervention for binge eating, the investigators found a robust outcome for effectively reducing binge episodes and/or emotional eating (Katterman et al. 2014). The increasingly positive research outcomes on the clinical use of mindfulness skills for eating problems, and particularly binge eating, has provided direction for its use in evidence-based treatment (Kristeller et al. 2006; Smith et al. 2006; Leahey et al. 2008; Dalen et al. 2010; Hepworth 2011). Empirical and clinical studies support its use in addressing problems in self-regulation, as well as its integration into therapies for fostering healthier experiences of one's body and self.

To date, most studies of mindfulness and eating disorders have taken place in a self-contained format for short-term psycho-educational treatment. Given the chronic nature of eating disorders, it has been suggested that ongoing, longer-term treatment can help sustain the benefits of mindfulness over time (Hepworth 2011). The existing positive outcomes from short-term mindfulness-based interventions for BED support adapting its use in a psychodynamic-oriented psychotherapeutic group treatment model.

Therapeutic Value of Group Modality for Women with BED

For treating eating disorders, empirical research frequently cites the distinctive therapeutic value and curative outcomes of group treatment (Ciano et al. 2002; Tasca and Bone 2007; Peterson et al. 2009). Group treatment has particular value in countering isolation and shame,

commonly reported among women with an eating disorder and particularly those with binge eating disorders. Women also benefit from a group's ability to increase self-awareness within a relational context that promotes mutual empathy (Jordan 2001; Tantillo et al. 2001; Comstock 2002). Further, groups provide a unique dynamic interpersonal learning environment for the participants to explore shared concerns and bolster self-efficacy while reinforcing motivation for change. This process, as explained by Yalom and Leszca (2005), allows individuals to challenge their interpersonal distortions and to improve self-awareness within the safety of the group dynamic.

The benefits of group interventions have been cited repeatedly for emotion regulation, body-image acceptance, eating awareness, and overall improved self-care (Telch et al. 2000; Safer et al. 2001). Both interpersonal psychotherapy (IPT) (Agras et al. 1995; Tasca and Bone 2007) and cognitive behavioral therapy (CBT) (Fairburn et al. 1993; Wilfley et al. 2002) have demonstrated moderate effectiveness for group treatment of BED. Increasingly, studies now support treatment of BED that incorporates mindfulness skills for linking mind and body to improve self-regulation (Clyne and Blampied 2004; Hepworth 2011; Kristeller and Wolever 2011; Kristeller et al. 2014).

Integrating Research, Theory and Social Work Perspectives: A Group Treatment Model for Women with BED

The development of a short-term group model integrating psychodynamic psychotherapy and mindfulness skills evolved over two decades of providing psychotherapy to women with chronic binge and emotional eating problems. Incorporating a contemporary biopsychosocial perspective within a psychodynamic framework has illuminated the multifaceted influences associated with BED in women. These influences and experiences have been revealed as particularly relevant for a group treatment model. A core dimension of the group model is to foster mutual empathy through relational connections among women members. For the purposes of the group, empathy is defined within the relational–cultural therapy construct as "…a complex of affective-cognitive skills that allows us to know (resonate, feel, sense, cognitively grasp) another person's experience" (Jordan 2000). As an extension of this definition, mutual empathy is viewed as decreasing one's experience of isolation and shame. Jordan (1992, 2000, 2001) has discussed mutual empathy as being the core of growth-fostering relationships and a way of healing shame by bringing the person back into empathic connection. It has been evident in my own clinical observations, and by client self-report, that the group's ability to foster mutual empathy increases self-efficacy to a degree unmatched by individual treatment alone.

The semi-structured group format incorporates interpersonal learning of specific skills to improve self-regulation through linking experiences of mind, body and self. These include mindfulness principles and skills for focusing and engaging the body and for cultivating an increased ability to observe thoughts and emotions free of judgment. Skill-based interventions include basic yoga breathing exercises, body scan, guided imagery, and pertinent mindfulness exercises (see Table 1). By layering self-compassion atop a mental posture of non-judgment, a goal of the group treatment is to counter negative thinking about one's body and associated self-evaluation.

The eight-session protocol and time frame developed from a combination of three significant factors: research on current similar short-term group models shown to have positive outcomes, my own clinical observation, and the expressed therapeutic needs of clients. While information shared is updated and slightly modified to match each group's needs, the 8 week session has remained intact and overall has been found to be an effective format for the integrative treatment model. Over time, consistent positive self-reports (including verbal narratives and 6 month follow-up questionnaires) supported the use of mindfulness principles and skills. All group participants who used these skills described an improved ability to identify emotional and physical signals prior to a binge, which led to improved eating behavior. Further, the shared support and mutual empathy reinforced motivation for positive change, thereby promoting self-efficacy. Self-efficacy, in turn, can predict lasting change in behavior, given adequate incentives and skills (Prochaska and Velicer 1997). As the group progressed, women members consistently reported strengthened ability to counter binge eating and sustain eating awareness. Overall, my own clinical observations mirrored each member's self-report and was further confirmed by many collaborating therapists, nutritionists and physicians who provided positive feedback.

The BED women's group model developed from information obtained progressively from the members' shared experiences and identified needs. By responding to the unique clinical needs of group members, this process is similar to grounded theory utilized in qualitative studies, as opposed to strictly behavioral–skill based group formats. This core aspect of the group's therapeutic value was revealed as group members reported increased awareness of both their unique and shared experiences of body and self. During the seventh session of the 8 week group, a member reported feeling "…a kind of catharsis in hearing other women put words to experiences about eating and their body that I totally identify with but had not voiced to anyone, including myself."

Further development of the group model included an added support for assimilating mindfulness principles and practices into day-to-day routines. Consistent feedback from the women members indicated the need for a practical method for countering binge eating that corresponded to the skill-based interventions. As part of that process—and based on several member's expressed interest and input—an acronym was developed for reinforcing mindfulness principles and skills. The acronym, *F.E.E.D.—Focus, Engage, Eat, Decide*—provides structure for ongoing support, incorporating both self-regulation and mindful eating skills discussed and reinforced by the experience of mutual empathy within the group. The integration of evidence-based skills and techniques for focusing and engaging one's mind and body was modeled in both a structured and reflexive process. That is, structured introduction of skills for self-regulation was combined with an active incorporation of their use in response to thoughts and feelings women shared in the group. This process provided meaningful connections of mind, body and self experiences for group members. In this way group participants are not only learning useful skills, they are receiving direction for therapeutic application in linking feelings and thoughts with binge eating patterns. Just as importantly, the acronym reinforced the group's kinship and like-mindedness, which increased each member's connection and self-efficacy.

In sum, the treatment model incorporated a three-pronged approach: One, a contemporary biopsychosocial perspective of BED, with treatment reflecting individual needs and experiences; two, mindfulness principles and skills; and three, the relational context of a group. Mutual empathy, in particular, proved significant for both reinforcing and sustaining self-efficacy and positive change.

Description of the Skill-Based *F.E.E.D.* Strategy for Managing Binge Eating

FOCUS: Using simple mindfulness breathing techniques and a traditional yoga pranayama exercise, *Nadi Shodhanan,* to support focusing skills and for enhancing mental clarity.

ENGAGE: Using guided imagery, body scan and mindfulness meditation for quieting the mind and creating awareness of body states, including hunger and satiety cues.

EAT: Emphasizing the quality of the eating experience, with awareness of signals for hunger and satiety. Actual eating behavior is secondary to self-awareness of body sensations, mental preoccupations, and associated emotions.

DECIDE: Supporting a wise mind approach that integrates mindful awareness for interrupting binge-eating patterns. The emphasis is on distinguishing natural physiological cues from emotional distress, and responding with awareness, non-judgment and self-compassion.

As a pragmatic support and guideline, the *F.E.E.D.* acronym incorporates mindfulness principles for countering binge eating while teaching skills for self-regulation. While the group model addresses certain multidimensional aspects women associate with their binge eating, the acronym supports a core value expressed within the group: Past behavior, of others or oneself, need not dictate experiences in the present moment.

BED Group Description and Clinical Vignettes

Group Format and Stages of the Integrative Model

In the book, *Savor*, Thich Nhat Hanh, a Vietnamese Buddhist Zen Master and scholar tells a Zen story about a man and a horse. *The horse is galloping quickly and it appears that the rider is urgently heading somewhere important. A bystander along the road calls out, "Where are you going?" and the rider replies, "I don't know! Ask the horse!"* (Hanh and Cheung 2010, p. 15). This story, which is read aloud in the second of the eight group sessions, has resonated for all the women group members. The lack of control with food and eating, while unique to each woman's own experience, embodies a shared identification that often initiates mutual empathy among the group members.

The semi-structured group model begins with a review of skill-based information and mindfulness principles. In following traditional psychodynamic psychotherapy and social work group models, the 90 min session allows for stages of discussion and processing of content presented with a paralleling psychotherapeutic support. Generally, the group size comprises 6–8 women who are also in weekly individual psychotherapy—an important therapeutic component for processing the group experience.

Each group session includes the introduction of a mindfulness skill that matches with the *F.E.E.D.* acronym and builds upon increasing one's awareness of meaningful connections between mind, body and self. These include breathing exercises, body scan and beginning mindfulness meditation skills (see Table 1). Reinforcing these skills aims to increase one's ability to disentangle mental preoccupations from bodily sensations, and to promote self-regulation, particularly emotion regulation.

In sessions one, two, and three, the first 45 min introduce or review a mindfulness skill or principle that builds a

Table 1 Example of mindfulness principles and skills for clinical application in group for binge eating disorder

Principle	Skill	Psychotherapeutic goal and purpose	Session
Mindful awareness of breath	Nadi shodhanan	Quiet the mind and calm the body	1–3
	Yoga breathing exercise	*Support for focusing and self-regulation*	
	3-min breathing space[a]	*Additional support for present moment awareness with emphasis on reducing automatic pilot eating*	1–8
Mindful awareness of body sensations	Body scan exercise	Increase somatic awareness for identifying hunger and satiety cues	3–4
		Support for distinguishing between physical hunger and emotional distress	
Self-compassion Self-acceptance Non-judgement	Guided imagery	Increase multisensory awareness for observing thoughts, feelings and body sensations	5
		Support for distinguishing neutral detachment from dissociative self-states and to strengthen self-efficacy	
Present moment awareness	Mindful eating exercise	Engage awareness of food and quality of eating experience with emphasis on physical sensations while observing associated thoughts and feelings	6
		Support for self-regulation to counter binge eating and increase awareness of physiological cues for hunger and satiety	
Present moment awareness	Mindfulness meditation	Increase overall awareness of mind, body and self-states	2–8
	(Fundamental skills for developing a meditation practice with resources for formal instruction)	*Support for interrupting thoughts, emotions and habitual behaviors that promote binge eating and body dissatisfaction*	

[a] Teasdale et al. (2014)

foundation for developing a practice of mindfulness and self-care. Group members are encouraged to ask questions and share their responses. During the last 45 min, the focus shifts to processing and integrating any associated biopsychosocial factors or experiences (i.e., new awarenesses). During group sessions four through six, members emphasize skills for engaging the body and weave together combined skills for overall self-regulation. This is typically when mutual empathy becomes evident, and the group cohesiveness further strengthens motivation among individual members during subsequent sessions. The experience of mutual empathy among women members also highlights relational connections that mirror shared needs for self-acceptance and self-efficacy. In the final group sessions, seven and eight, the members focus on mindful eating, and deepening one's awareness of mind, body and self experiences as they make decisions about food and eating.

The chronic nature of BED warrants extended support for reinforcement of skills and rituals for continued self-care. Members who attend the 8 week session are provided a once-monthly 90 min group for up to 12 months, or as needed. The monthly sessions extend the skill-based principles for maintaining an ongoing mindfulness practice and for further developing one's awareness in linking experiences of mind, body and self. This allows members to sustain positive gains with continued reinforcement and secure support.

Clinical Vignette of the Beginning Stage of the 8-Week BED Group Model

Gina, 58, Sally, 52, Terry, 61, Beth, 63, Rose, 59, Sharon, 44 and Kara, 62 waited patiently for 2 months before their group began. Each had contacted me through referral by their individual therapist, primary care physician, or friend who knew of the group. While all the women described unique experiences associated with weight and binge eating, as a group they shared skepticism about a positive long term outcome for countering their eating behavior. That is where we began.

The semi-structured format of the group has two dimensions: One: introducing skill-based interventions and psychoeducational discussion; and two, promoting mutual empathy through interpersonal, psychodynamic, process-focused interaction. This group was typical in that members were therapy savvy yet discouraged about past limits of talk therapy for addressing binge-eating patterns. After the initial brief introductions Gina spoke first:

> *Gina*: I adored my therapist of 7 or 8 years, as she really helped me deal with periodic depression, but we never really got to (talking about) the binge eating with much success. I mean…I'm here because I know I need to do that but this has been a problem since my mother dragged me to Weight Watchers when I was 10 years

old. I want to have hope but, well, it's been 48 years of struggling with food and binging

Therapist: I hear your frustration Gina. The tone of your voice in sharing some of your earlier experiences reflects a quality of that frustration along with a desire to address the long-term struggles. Does anyone else share similar thoughts or feelings?

Sharon: Definitely. This year I will be 44 years old and I can't recall a time in my life when I wasn't preoccupied about food, eating and weight. Being a chubby girl brought many negative experiences with being teased and chronically wishing that I had a different body. In fact, I had bariatric surgery about 10 years ago so that I could have a different body. That was great for several years until I gained all the weight back and then some. I know that I need to get away from the diet mentality—it just hasn't worked for me

Terry: Well, I wasn't sure if I'd be comfortable speaking up or even fit into this group, given my size, but I already feel that I can relate to what Gina and Sharon have said. At 61 years old I've never talked about my preoccupation with food and weight to the extent that I can feel so disgusted with my body and my eating behavior

Therapist: Can you say more about what you had anticipated?

Terry: Well, I may be the smallest woman in this group but I've been a binge eater for most of my adult life, and even during childhood felt totally obsessed with food…and preoccupied with what I could or couldn't eat. Especially, given the frequent reminders from my mother about the need to "slim down."

Therapist: It sounds like there were mixed messages from what you were hearing, in this case from your mother, in contrast to what you were experiencing in your own body and mind. (Pause.) I would like to add that it is a testament to the group's genuine supportiveness that Terry has already recognized that she can feel safe and authentic here

Beth: I did notice, given your size Terry, you don't seem to be someone who would struggle with binge eating the way I do but now I understand that it's not necessarily about size or weight. Well, I'm not a big talker and my psychiatrist has been pushing me to deal with my binge eating for quite some time, but I also feel good about talking here…and finally to be talking with other women who get it…really understand the struggles over food and how bad it can make you feel about yourself…but you don't know how to stop

Members then discussed ways they have struggled to connect body and mind when eating, often resulting in negative self-evaluation. For example, Kara described chronic self-loathing in response to her binge eating and a "mouth hunger" (comfort and self-soothing from eating) despite an absence of physical hunger. At this point, introducing mindfulness principles supported each member's expressed need for skills to quiet the mind (i.e., preoccupation with food) and to increase awareness and regulation of one's body and emotional or self-state (i.e., dissociation). In addition, a description of binge eating as self-care gone awry became an important defining moment in the group. It emphasized each member's identification with a need for improved self-care while developing mutual empathy and group cohesiveness. The focus on self-care helped group members reframe binge eating as an attempt to alleviate suffering and to initiate self-soothing. In this way, the women began to shift typical self-perceptions that were shaming and isolating to those of self-compassion, empathy and connectedness.

Clinical Vignette of the Middle Stage of the 8-Week BED Group Model

Each session routinely began with an initial checking-in among group members, which included sharing experiences related to the group goals. By the mid sessions, it was clear through self-reporting that the combination of mindfulness skills with psychotherapeutic group support had strengthened each member's self-efficacy for countering binge-eating patterns. In the sixth session, Rose, a 59 year-old school teacher, described her own new awareness of eating following a traditional mindful eating exercise in the prior group session.

Rose: I couldn't wait to get here tonight because all week I was so excited about what I was noticing whenever I was eating. (Pause)

Therapist: Please, tell us more…

Rose: Well…(big smile)…I have to say, this sounds so Pollyanna-ish, but I really want so much to do the right thing for myself…I know I told you all that I am a rule follower…(laughs) and so last week when we all did the mindful eating exercise I was amazed at how incredible that little dried cherry tasted. Like I'd never had anything that tasted so rich in flavor and texture…it was quite amazing to me. How could that be, I thought. But then…during the course of the week I brought that same awareness to each bite and even in the way you described imagining where the food came from and the journey to the store, and all that…It really stayed with me and so I found that I wasn't so interested in eating food that tasted badly or was unappealing if it wasn't primo food. You know what I mean…starts laughing…I mean, if it isn't primo tasting, I don't want it in my mouth or in my body. So funny to begin to think and feel that way at almost 60 years old!

Therapist: Rose, your description so eloquently expresses how bringing in a mindful awareness to eating and the opportunity for truly nourishing ourselves can be a uniquely different experience, particularly when a prior relationship with one's body and eating had been absent of that awareness

Gina: I couldn't have said it better Rose; I can't say that all my eating was mindful over the past week but I most definitely had very different experiences and in a strange way felt kinder to my body…hmmmm…almost a type of respect or dignity for how to treat my body better with food. It had previously pretty much been the other way around. That's funny to say out loud

Therapist: In what way?

Gina: Well, food is enjoyable for me but also has for many years been a way to punish myself. I hadn't really thought about it like that before but now see how true that has been…for a very long time

Sally: That's funny to me Gina, because I remember you had said in the beginning how you didn't have much hope for things changing, even though you decided to be in the group. I remember that because I…well I didn't say so at the time, but I thought to myself…Yeah, me too! I agreed with you then and funny to say that I also agree with you now. I am definitely more aware of what I eat and for what purpose, even if I do overeat, it's now with more of…well, noticing like you said about the mindfulness way of noticing…and that has lessened the amount of food. In other words…there isn't that type of automatic-like binge eating, but maybe what you've talked about (pointing to therapist) as normal overeating at times…and it's not even that much more, maybe an extra bite or two beyond satiety, you know…being full and aware that it's time to stop eating and appreciate feeling satisfied in my body

Sharon: That is an alien concept to me, after having bariatric surgery…I don't recall feeling hunger, well that's not true, I do have a memory of it but haven't really felt that way for over 10 years. Yet, I think I am getting this idea of mindful eating because I …well no big breakthroughs here (Laughs), but I have been more planful with my food (pointing to therapist) as you suggested we consider, and also have noticed that when I do eat, there is a kind of slowing down and enjoying the experience instead of a more typical urgency and absence of any feeling…just shoving it down without a thought. That's new

During the middle stages of the group process, members emphasized skill-based principles and behavior; that is, an increased level of body awareness, and a redefinition of self-care with less emphasis on binge eating. Members were encouraged to establish daily rituals for self-care that reflected their unique needs for integrating mindfulness principles and skills. These included a variation of mindfulness meditation, mindful breathing exercises, mindful eating practices and incorporating a focus on self-compassion. Ongoing use of the *F.E.E.D.* acronym was encouraged for improving self-regulation, not only for binge eating, but also for an overall sense of well-being.

Clinical Vignette of the Ending Stage of the 8-Week BED Group Model

Therapist: Next week is our eighth session and, as we know, the weekly group format will be ending. Today we will be talking about planning for each of you and as a group going forward, given the group intention and your own personal goals around food and eating.

Terry: The first thing that comes to my mind is, well…it's okay that you haven't lost any weight because that was my unspoken goal before the group began. What I'm so thrilled about though is that I really feel so much more clear about a more realistic and accurate own felt sense of my body and how my binging is less about hunger, at least a physical hunger. (Pause) Also, I am really surprised, but glad to share that I realized, over the past few weeks, that drinking wine is definitely a trigger for me to binge. I decided to be mindful about that and since I stopped having a glass or two of wine at night, the binging has stopped altogether. There may be some overeating…but not like a binge where I am completely unaware of how much I am eating. That is quite something.

Therapist: Yes, I agree Terry. That is quite something and, I would imagine noticing that connection has opened up other new awarenesses for you…would you agree?

Terry: (Smiles) Definitely. I am finding that nighttime eating is much less laden with secretive eating and feeling out of control. Also I noticed that I am sleeping better…lack of restful sleep may have made binging worse, I think. That breathing exercise and meditation time is definitely helpful for quieting my body and mind…at first, I thought I couldn't ever do that but now look forward to it!

Gina: Well, I also noticed that about alcohol too. I am not a big drinker but my husband and I do enjoy having a glass of wine with dinner. I stopped that and find it also makes a difference. I don't plan to be sober or anything, I don't think that's necessary but I do think, for now, the drinking seemed to lead to a desire for more food. It also just helps me to be mindful in general. As far as going forward…I like the idea of our meeting once a month, as you (pointing to therapist) had offered as an option. Can

we still do that? All of you have become an important part of my doing better with eating and in general and I think it would be good for us to keep the support going for now. I like the once a month idea.

Rose: I was going to say the same about the group still meeting…I'm actually already missing the group, even though we have another week (Laughs). I also want to add that I have definitely been eating in a whole new way and especially notice that I don't really need much food. Becoming better at stopping to eat by using that hunger-fullness scale that you (pointing to therapist) gave us really helped. It was useful to have a barometer or way to know when my body is physically sated. Anyone else notice that? We don't really need to eat so much to be satisfied and …well, feel okay.

Therapist: Each of you has clearly been a significant support for one another and the genuine trust that has developed is an outcome of all that each of us and as a group together has shared. Would anyone else like to say more and add to what Gina and Rose have said?

Beth: Well, I may not be the most talkative in our group and I can't say that I'm there yet with being able to stop eating, still a struggle for me. I am eating less though…and also am happy to say that the binge eating is less frequent…maybe twice a week instead of twice a day. That's not what I expected to happen and also want to continue the group…I have found it very helpful and there's more to gain…(laughs) and I'm going to have to thank my psychiatrist for suggesting this to me, even if I didn't lose weight…my diabetes is much better controlled, which makes my husband happy—makes me happy too.

In the seventh session, members decide whether to continue in a once-monthly process-oriented therapeutic support group. This group would reinforce mindfulness principles for further support of each member's individual eating issues and overall self-care needs. Whether or not members decide to continue, the discussion prepares them for closure of the weekly group sessions and enables them to process the experience with a plan.

The eighth and final group focuses on integrating the skill-based interventions, the group process, and individualized plans for managing binge eating and continued self-care. If fewer than five women choose to transition together to a once-monthly group, they are given an option to attend an existing similar group with a treatment plan that matches their needs. Closure also includes a follow-up with each individual member, including a post-group questionnaire that duplicates the original pre-group form. This form is utilized as a therapeutic guide to monitor eating awareness and behavior over time. Where appropriate, this information is also shared with a collaborating individual therapist or referring physician.

Self-reports from participants have consistently revealed several significant positive outcomes. These include: increased awareness of connections between negative thinking and eating behavior, differentiating emotional eating from biological hunger, improved ability to practice mindful eating, (i.e., eating when physically hungry), and a more informed ability to counter feelings of self-loathing and associated shame about one's body. Significantly, members also report that, by improving eating behavior and self-care, they can more directly address underlying feelings that may have been shielded by the eating disorder. By combining interpersonal psychodynamic psychotherapy with mindfulness principles and skills, the integrative group treatment model promotes healthier behavior for binge eaters, both inside and out.

Conclusion

The recent DSM-5 diagnostic update of BED as a distinct eating disorder highlights the growing need for effective treatment. Self-regulation, rather than weight management, is increasingly the goal of clinical interventions for BED, currently the most prevalent eating disorder in women. An understanding of binge eating problems in women as self-care gone awry calls for a treatment model that fosters a woman's ability to feed herself with mindful awareness of her authentic mind, body and self needs.

This paper first discusses BED from a biopsychosocial perspective, addressing key multidimensional factors associated with the development of BED in women. This perspective incorporates pertinent theory and literature on women's psychological and social development along with contributions from the neurosciences on emotion-regulation. Combined with the author's own clinical experience—two decades of treating women with eating disorders, including binge eating—this perspective led to the development of an integrative treatment model that includes the use of mindfulness principles and skills in a short-term interpersonal psychodynamic psychotherapy group. Clinical vignettes from the beginning, middle and end stages of an eight-session group illustrated the group process and highlight common experiences of the women members. The acronym, F.E.E.D., is introduced as a strategy for countering binge eating and increasing self-awareness, as well as for sustaining self-efficacy. Initially, its therapeutic application is facilitated through clinical direction, which is then reinforced through mutual empathy and support between group members for its continued use in connecting experiences of mind, body and self.

In summary, contemporary research, theory and evidence-based treatment on binge eating disorder provided clinical direction in my formulating the integrative group treatment model presented. While limited in scope, the innovative model has sustained positive outcomes in private practice and can add to the literature on therapeutic interventions for women with BED as well as provide support for future research in this area.

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