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ORIGINAL PAPER

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

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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

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> 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

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