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Theoretical analysis of binge eating disorder through the perspectives of self psychology and cognitive theory/cognitive behavioral therapy, and an explanation of blending these perspectives

Llorin M. Edwards

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Llorin McCoy Edwards
A Theoretical Analysis of Binge
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ABSTRACT

Binge Eating Disorder (BED), generally defined as a disorder with the central component of recurrent binge eating accompanied by marked distress, and without any accompanying compensatory behaviors to control for weight gain, has recently been formally recognized for the first time in the DSM-5, released in May 2013. This thesis traces the evolution of how BED has been understood and discussed as a DSM diagnosis over the course of about fifty years, after it was first identified not as an eating disorder, but as a phenomenon occurring only among overweight or obese populations seeking weight loss treatment. To contribute to the overall efforts of the mental health community seeking to further develop more specific and effective psychotherapeutic treatment approaches for BED, this thesis analyzes BED from the psychodynamic theoretical lens of self psychology and the more behaviorally-oriented lens of cognitive theory and its successor Cognitive Behavioral Therapy. These analyses are followed by an exploration of whether and how these two different theoretical perspectives could be blended.

**A THEORETICAL ANALYSIS OF BINGE EATING DISORDER THROUGH THE
PERSPECTIVES OF SELF PSYCHOLOGY AND COGNITIVE THEORY/COGNITIVE
BEHAVIORAL THERAPY, AND AN EXPLORATION OF BLENDING THESE
PERSPECTIVES**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

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CHAPTER I

Introduction

In 2010, the American Psychological Association (APA) announced that it would include Binge Eating Disorder (BED) as a formal eating disorder diagnosis in the newest, Fifth Edition of the Diagnostic & Statistical Manual of Mental Disorders (DSM-5) which was released in May 2013. This is a change from BED's previous status in the DSM-IV, in which BED was a provisional diagnosis requiring further research included only in the appendix of the manual (APA, 2000; APA, 2010). BED is the most prevalent eating disorder in the United States, impacting approximately 2 to 3 percent of American adults, making it more prevalent than more well-known eating disorders recognized by the DSM such as Anorexia Nervosa and Bulimia Nervosa (Fairburn, 1995; Hudson, Hiripi, Pope, & Kessler, 2007; Wilson, Grilo, & Vitousek, 2007; Wonderlich, Gordon, & Mitchell, 2009).

In DSM-5, released in May 2013, the APA outlined the following criteria for a diagnosis of BED: an individual having recurrent episodes of binge eating in which the amount of food eaten is larger than what “most people would eat in a similar period of time under similar circumstances” and during which the individual experiences a loss of control, and the individual experiences “marked distress” from the binge eating episode (APA, 2013). Additionally, the binge eating cannot be associated with any compensatory weight control behaviors, which are characterized as actions intended to compensate for, or eliminate, the calories taken in during the

binge eating. Compensatory behaviors could include things like purging (self-induced vomiting without illness), laxative abuse, using diet pills, or over-exercising (APA, 2013).

The decision to include BED as a formal DSM-5 diagnosis was not without controversy. Prior to being defined as "Binge Eating Disorder," eating disorder researchers had often identified or described BED as "pathological overeating syndrome" or "compulsive overeating" (Fairburn, 1995, p. 25), or described the population as "obese binge eaters." Much of the early research and theorizing on BED derived from case studies and observations among clinical populations who were overweight or obese, and seeking medical help to lose weight. Beginning in 1959, when the phenomenon was first specifically noted in such research literature, BED was largely positioned as a set of behaviors associated with or contributing to obesity (Stunkard, 1959). Thus, from the earliest articulations of BED, the disorder was not often understood as a mental illness, but more as an over-indulgence in food that resulted in being overweight. Much of the controversy about establishing BED as a new diagnosis was related to the question of whether BED was just a type of behavior present among obese individuals (Wonderlich et al., 2009). Over the course of the past twenty years of psychological and medical research on BED, researchers have established that "binge eating disorder is distinct from obesity" (APA, 2013, p. 351), even though there is a strong association between obesity and BED, and that being overweight or obese is frequently a feature of the presentation of an individual with BED (Bruce & Agras, 1992; Hudson et al., 2007; Iacovino, Gredysa, Altman, & Wilfley, 2012; Spitzer et al., 1993; Striegel-Moore & Franko, 2003; Wilfley, Wilson, & Agras, 2003). The APA, in describing BED in the DSM-5 explained that "most obese individuals do not engage in recurrent binge eating" and that BED "occurs in normal-weight/ overweight and obese individuals" (p. 351).

Further, concerns with body image—dissatisfaction with one's perception of their body weight and shape—are present in many individuals with BED, at rates comparable to individuals who have Anorexia Nervosa and Bulimia Nervosa (Hrabosky, Masheb, White, & Grilo, 2007; Wilfley, Schwartz, Spurrell, & Fairburn, 2000). Researchers have shown that obese individuals with BED, compared with non-BED obese individuals, demonstrate higher and more intense levels of “overvaluation of their shape and weight,” which can be described as individuals giving undue influence to their body weight or shape in terms of how they evaluate their own self-value or self-worth (Wilson et al., 2007). The overvaluation of body weight and shape is a core, underlying psychopathology of eating disorders (Murphy, Straebl, Cooper, & Fairburn, 2010), and the fact that it exists among obese individuals with BED and at much lower rates, or not at all, in obese individuals without BED, played a leading role in BED earning a place as a formal diagnosis in the DSM (other research was also important in leading to the formal diagnosis, as this thesis will discuss).

The purpose of this thesis is to examine the evolution of BED from a subgroup of behaviors associated with obesity to a recognized, formal mental disorder diagnosis included in the guide for mental health care providers—the DSM. This thesis is also intended to help further clinical understanding of this newly emerging diagnosis as a phenomenon and to explore how it is similar, and dissimilar, from the other eating disorders in the DSM-5 (particularly Anorexia Nervosa and Bulimia Nervosa, and, to some extent, Eating Disorder, Not Otherwise Specified).

As new, specific psychologically-oriented treatment programs emerge for BED and as health insurance companies move increasingly to cover such care for BED, a dynamic understanding of BED and the effective treatment approaches for the disorder is called for (Creamer, 2013; Koman, 2013). The psychotherapeutic treatment approaches for BED for which

effectiveness has been evaluated empirically are mostly behaviorally-oriented therapies, largely Cognitive Behavioral Therapy (CBT). In their 2007 review of evidence-based treatments for BED, Wilson et al. posited that “manual-based cognitive behavioral therapy for Binge Eating Disorder is the most researched and, at present, the best-supported treatment” (p. 209). Yet, these authors also pointed out that most of the efficacy studies used CBT protocols that were originally designed for treating individuals with Bulimia Nervosa, with only slight adjustments made for BED, which “may not sufficiently address some important differences in the nature and extent of dietary restraint between BED and bulimia” (Wilson et al., 2007, p. 211; Masheb & Grilo 2000, 2002). Wilson et al. also found that, “there is some empirical support for other specialized psychological treatments, including interpersonal psychotherapy (IPT) and Dialectical Behavior Therapy (DBT)” (p. 209). In a similar review, Iacovino, Gredysa, Altman, and Wilfley reported studies finding CBT to be a robust treatment and DBT also promising, but the authors suggested that more research was needed to determine the long-term effectiveness of DBT, compared to other specialized BED treatments (2012).

Eating disorder researchers have called for these BED evidence-based treatments to be translated into real-world settings, and acknowledge that their outcomes may not be as robust when treatment is conducted outside of specialized, research clinics (Iacovino et al., 2012; Wilson et al., 2007). Iacovino et al. emphasized concerns that the use of these evidence-based treatments outside of research settings is “relatively scarce” (2012, p. 10). With the mental health community's understanding of BED still evolving, there are a limited number of psychologically-oriented (as opposed to behavioral weight loss programs, such as Weight Watchers) specific therapy approaches offered and available for individuals with BED. Thus, this thesis is also intended to help inform the clinical conversation about treatment selection and

application for individuals with BED. With this in mind, this thesis will review and interpret the phenomenon of BED through two different theoretical perspectives—a psychodynamic perspective and a cognitive-behavioral-treatment perspective. First, I will examine BED through the psychodynamic lens of self psychology. Then, I will examine BED through a cognitive theoretical approach, specifically interpreting BED under the lens of cognitive theory and Cognitive Behavioral Therapy (CBT).

Summary

As the most prevalent eating disorder, BED's increasing recognition within the mental health community and official recognition in the DSM-5 are important. More critical thinking and synthesizing of various theoretical conceptualizations of BED is needed as the field of clinical social work considers treatment selection and application for individuals with BED—both from behavioral and psychodynamic approaches. This thesis is intended to contribute to this discussion by examining BED through self psychology and cognitive theory and CBT.

The following chapter, Chapter II, explains my rationale for selecting these two theories and the analytic framework and methodology this thesis uses to interpret BED through these theories and synthesize the interpretations.

CHAPTER II

Conceptualization and Methodology

Conceptualization of Thesis

As a second-year student working toward my Master's in clinical social work (MSW) at the Smith College School for Social Work, I have spent the past eight months (September 2012 through April 2013) working as a clinical social work intern at an eating disorders clinic. At this clinic, I provided individual and group therapy for individuals with eating disorders through a five-day-a-week day-treatment program and an Intensive Outpatient Program (IOP) which is held in the evenings. This clinic offered treatment for individuals with Anorexia Nervosa, Bulimia Nervosa, Eating Disorders, Not Otherwise Specified (EDNOS), as well as a specific, separate IOP for individuals with BED. This BED treatment is offered largely through group therapy and group meals, in which clients eat with the clinic staff and the therapy offered is a mixture of Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT). The BED treatment is generally offered under a short-term timeline, with treatment usually running about five to six weeks. Clients attend the BED program three evenings a week for three hours each evening.

At the same time as working at the eating disorders clinic, my coursework and field education from the Smith College School for Social Work has been grounded in psychodynamic theory and utilizing a psychodynamic orientation in clinical work. This psychodynamic approach often contrasted with the focus on behavioral treatment at the eating disorders clinic, as

it was grounded in CBT and DBT treatment approaches. Throughout my work at the eating disorders clinic, I attempted to blend the psychodynamic and behavioral approaches in working with clients, including clients with BED. This was often a challenge for me, with no clear framework for how to go about using a psychodynamic approach to treatment in a clinical setting that emphasized behavioral treatment.

This challenge prompted me to design a theoretical thesis to explore how a clinician could utilize psychodynamic theory, specifically self-psychology, in working with clients with BED, while working in a treatment setting that was focused on CBT and DBT. In this thesis, I will interpret the phenomenon of BED through both the psychodynamic perspective of self psychology and the behavioral-treatment perspective of cognitive theory and, its successor, CBT. The BED program at the eating disorders clinic at which I worked offered a readily-accessible example of a behaviorally-focused therapy model for BED and the opportunity to undertake a theoretical analysis for considering how clinicians might go about adding a psychodynamic perspective to an existing behavioral model. The timing of this exploration felt especially opportune as BED is a newly-emerging DSM diagnosis.

I selected self psychology, from among the psychodynamic theories, to interpret BED because of its contemporary nature, its prioritization of the individual's development of self-esteem and self-worth, as well as emotional regulation skills, all of which seem highly relevant to eating disorders, including BED. Additionally relevant in interpreting BED is self psychology's inclusiveness of environmental factors and relationships that form following the initial psychological development of childhood as potential sources for developing selfobjects. As I will explain in detail in Chapter IV, selfobjects are needed to repair or build needed aspects of oneself in order to have a healthy, cohesive sense of self. In O'Brien's 2010 Smith College

School for Social Work Master's thesis, which proposed synthesizing object relations and DBT conceptualizations for individuals with difficult-to-treat binge-type eating disorders (defined as individuals with treatment resistant Bulimia Nervosa and Binge Eating Disorder as well as other 'complicating' personality traits or Axis I or II diagnoses), the author suggested that self psychology would be another psychodynamic theory that could "offer important conceptualizations of the problems inherent in eating disorders," such as binge eating disorder, and that this theory could be useful for another researcher to evaluate.

My study could be relevant and useful for the field of social work because as BED continues to evolve as a formally recognized eating disorder, this study could help clinicians better recognize BED in patients, understand the disorder through a psychodynamic perspective, and potentially be better equipped to use psychodynamic elements in implementing a behavioral therapy treatment model for individuals with BED. My hope is that including the psychodynamic perspective in this analysis could help advance clinical and program-level thinking about treatment needs specific to individuals with BED.

Analytical Framework for Interpreting BED

In this section, I describe the framework this thesis uses to interpret BED through the theories of self psychology and cognitive theory/CBT. The thesis first examines both theories by outlining the key principles for each theory and then reviews relevant literature that connects or applies the theory to eating disorders generally, or to BED specifically. Additionally, I use each theory to explore the etiology of BED and specific implications for clinical interventions, such as the theories' approach to therapeutic stance. For the interpretation of BED through CBT, I specifically explore how a manualized form of CBT is applied to BED (based on Fairburn's CBT

guided self help book, *Overcoming Binge Eating*), which formed much of the basis for the BED IOP treatment program at the eating disorders clinic I worked at this past year.

After interpreting BED through each theory, I then explore how to go about synthesizing the two theories. To aid in this, I apply the theories to a fictionalized story of a woman with BED, whom I call Mary. (Mary's story is a fictionalized story intended to provide an illustration of a client with BED, and is not an actual clinical case). I explore a theoretical conceptualization of Mary through both self psychology and through cognitive theory/CBT. Then, I use these case conceptualizations to synthesize the two theories. I discuss how the two different theoretical approaches could complement each other and ways in which they may differ. Part of the goal of this synthesis is to explore how the psychodynamic theory and the behavioral theories might be able to be layered in order to treat individuals with BED.

Summary

This chapter has outlined my rationale behind interpreting and examining BED through both a psychodynamic theory and a behaviorally-oriented theory, and the analytic framework I will use to conduct the interpretation and synthesize the interpretations. The next chapter, Chapter III, will introduce in detail the phenomenon of Binge Eating Disorder (BED) and will present a review of the relevant research literature on BED and trace how BED came to be included as a formal diagnosis in the newly-released DSM-5.

CHAPTER III

Phenomenon: Binge Eating Disorder

As the recognition and understanding of BED has evolved over time, the essence and definition of the disorder has not changed much. For the past fifty years, BED has been generally defined as a disorder with the central component of recurrent binge eating (without any compensatory behaviors to control for weight gain) which is accompanied by marked distress about the binge. Because BED was first recognized largely among overweight or obese populations (who were seeking help to lose weight), BED had not traditionally been seen as an eating disorder. This was especially the case in a field that had its early roots in recognizing anorexia among very underweight individuals. It has taken time for BED to evolve into a phenomenon that is now being researched and actively treated by the eating disorder clinical and researcher communities.

This chapter will give an overview of the empirical and descriptive literature on Binge Eating Disorder (BED) in order to trace its etiology as a phenomenon as recognized in the mental health professional community, and to review the relevant existing literature about BED's prevalence, epidemiology, symptomatology, etiology, and treatment responsiveness as an eating disorder. In the first section, I provide an overview of BED's DSM-5 criteria that have just been released and discuss these new criteria in the context of eating disorders in general. The second section also covers the demographics of individuals with BED, the course of the disorder, and co-morbidity. The next section examines some of the past literature on BED in order to trace the

evolution of how BED has been understood and discussed as a DSM diagnosis over the last fifty years, followed by a discussion of some of the primary areas that were debated (and some are still being debated) when deciding to make BED a formal DSM-5 diagnosis. The fourth section addresses literature on the three currently predominant theories about the etiology of BED, including addiction, dietary restraint, and regulation of negative affect as underlying mechanisms for the development and maintenance of BED. Lastly, I outline literature on the current treatment approaches for BED for which effectiveness has been measured.

BED in the Context of Eating Disorders in General

There are several types of specific eating disorders outlined in the DSM-5, including Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, and several feeding disorders more frequently associated with children that are not addressed in this thesis, including pica, rumination and avoidant/restrictive food intake disorder (these were previously characterized in DSM-IV as "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence") (APA, 2013). For individuals who do not meet the full DSM-5 criteria for Anorexia Nervosa, Bulimia Nervosa, or Binge Eating Disorder, there has been another DSM catch-all diagnostic category called Eating Disorder, Not Otherwise Specified, or EDNOS. It is believed that a sizeable amount of individuals who now meet BED criteria previously fell into the category of EDNOS. In explaining the altered DSM-5 eating disorder categories in a 2013 press release, the APA stated that "studies have suggested that a significant portion of individuals in that "not otherwise specified" category may actually have binge eating disorder."

Eating disorders are a category of psychological disorders characterized by an individual being preoccupied with food or weight (Mayo Clinic, 2013) and "by serious disturbances of eating behavior" (Merriam-Webster, 2013). DSM-5 defines the broad category of eating

disorders as "characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning" (APA, 2013, p. 329). The preoccupation with weight or body shape leads to an individual's perceptions about body weight or shape having an undue influence how an individual's self-evaluation of worth, which Murphy and colleagues (2010) describe as the underlying psychopathology that carries across these eating disorders.

In this chapter and subsequent chapters throughout this thesis, I will refer to Anorexia Nervosa as anorexia, to Bulimia Nervosa as bulimia, and to Binge Eating Disorder as BED. I will refer to the diagnosis of Eating Disorder, Not Otherwise Specified as EDNOS.

Among the three specifically-defined eating disorders for adults outlined in DSM-5 (including anorexia, bulimia, and BED), BED is the most prevalent type of eating disorder in the United States (Fairburn, 1995; Wonderlich et al., 2009), estimated to currently affect approximately 2 to 3 percent of American adults (Hudson et al., 2007; Spitzer et al., 1992; Striegel-Moore et al., 2003; Wilson et al., 2007). In comparison, anorexia impacts less than 1 percent (0.6 percent) and bulimia impacts 1 percent of the general U.S. population (Hudson et al., 2007). BED prevalence has been found to be higher among those seeking medical care. A full six percent of patients at family medicine or internal medicine clinics (N=3,000; 66% female) were found to meet BED criteria (and only one percent met bulimia criterion) (Spitzer, Kroenke, & Williams, 1999). BED prevalence has been measured to be even higher among obesity clinic samples, with studies estimating between eight and nineteen percent of obese individuals seeking treatment at an obesity clinic have BED (Allison, Grilo, Masheb, & Strunkard, 2005; Ricca et al., 2000). Estimates of BED prevalence rates among bariatric surgery

patients range from 5.6 percent (Allison et al., 2006) to 17% (de Zwaan, et al., 2003; Wadden et al., 2011).

The definition of BED, according to the American Psychological Association's (APA's) newly-released DSM-5 requires individuals' symptoms meet the five criteria outlined below in order to be diagnosed with BED:

“A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: 1.) Eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances; and 2.) A sense of lack of control over eating during the episode (for example, a feeling the one cannot stop eating or control what or how much one is eating).

B. The binge eating episodes are associated with 3 (or more) of the following: 1.) Eating much more rapidly than normal; 2) Eating until feeling uncomfortably full; 3) Eating large amounts of food when not feeling physically hungry; 4) Eating alone because of feeling embarrassed by how much one is eating; 5) Feeling disgusted with oneself, depressed, or very guilty after overeating.

C. Marked distress regarding binge eating is present.

D. This binge eating occurs at least once a week, on average, for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging or laxative use) and does not occur exclusively during the course of Bulimia Nervosa or Anorexia Nervosa” (APA, 2013, p. 350).

Thus, BED is distinct from bulimia—which also includes individuals who binge eat and experience a sense of loss of control during the binge episode—in that BED necessitates that an individual cannot exhibit any "inappropriate compensatory behaviors in order to prevent weight gain" following binges in an attempt to control weight, such as purging (self-induced vomiting), laxative or diuretic misuse, or over-exercising (APA, 2013, p. 345). Binging may also occur among individuals with anorexia, but the diagnosis of anorexia requires psychological and biological elements not present in BED, including: "restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health," with significantly low weight defined as "a weight that is less than minimally normal;" an "intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight;" and "disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self" (APA, 2013, pp. 338-339). The undue influence of body weight is also a criterion for bulimia (APA, 2013).

The Current Picture of BED

Demographics

The demographic and clinical picture of BED differs from the two other commonly recognized eating disorders—anorexia and bulimia—in a number of ways, including differences in gender and race distribution, age of onset, Body Mass Index (BMI) levels, levels of dietary restraint, the age of onset of dieting and binge eating, psychiatric co-morbidity and the recovery and duration rates of the eating disorder.

Demographically, the face of eating disorders in general is overwhelmingly female, with lifetime prevalence among all three types of eating disorders (BED, anorexia, and bulimia) being

1.5 to 3 times as high among women than among men (Barry, Grilo & Masheb, 2002; Hudson et al., 2007). Yet, BED stands apart from anorexia and bulimia's highly female-skewed gender distribution (anorexia impacts .9% of women and .3% of men; bulimia impacts 1.5% of women and .5% of men), with BED impacting more men than these other eating disorders, with a 2007 study having shown BED impacting 3.5% of women and 2% of men (Hudson et al., 2007, see also Wilson, Nonas & Rosenblum, 1993). Estimates are that women are about 1.5 times more likely to have BED than men (Mitchell, Devlin, de Zwann, Crow, & Peterson, 2008; Wilson et al., 1993). Men with BED are more likely than their female counterparts to have extreme issues with being overweight, having been found to be more likely to have higher BMI's and to be obese than women with BED (Barry et al., 2002).

Eating disorders have been diagnosed largely among white women in the United States, and early conceptualizations of BED seem to have conceived of BED similarly. More recent research, however, indicates that BED impacts women of color at much higher rates than bulimia or anorexia (Smith, Marcus, Lewis, Fitzgibbon, & Schreiner, 1998; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000; Striegel-Moore et al., 2003). With data published in 2007, researchers found that "BED is the eating disorder diagnosis that occurs with highest frequency in ethnically diverse samples" (Franko, 2007). The data released revealed that African-American women (Taylor, Caldwell, Baser, Faison, & Jackson, 2007), Latinas (Algeria, Woo, Cao, Torres, Meng, & Striegel-Moore, 2007), and Asian-American women (Nicado, Hong, & Takeuchi, 2007) had similar rates of BED (2.36 percent for African American women; 2.31 for Latinas; and 2.67 for Asian-American women), and these rates were only slightly lower than the BED rate for the overall female population in the United States (Franko, 2007). In a 2000 epidemiological review on race and binge eating, Striegel-Moore suggested that many "minority

women who do have an eating disorder are obese" rather than underweight, and thus, are more likely to go undetected, and encouraged researchers and clinicians to conceptualize of eating disorders more broadly (p. 345). In discussing the 2007 data, Franko encouraged that "greater flexibility in defining eating disorder diagnosis" might be needed to improve detection in non-white groups.

Prior to the release of the 2007 data reported by Algeria et al., and Nicado, Hong & Takeuchi, most of the BED studies that analyzed race focused only on African-American women, and few included other women of color. Thus, there is more detailed data available on BED among African-American women. One key study revealed that rates of BED are similar among white women and African-American women of similar ages (Smith et al., 1998; Striegel-Moore et al., 2000). Smith et al.'s 1998 study of men and women participating in a longitudinal study on cardiovascular risk (N=3,948) determined BED rates to be similar among white women, African-American women and white men, but to be much lower among African-American men. Part of the reason for researchers' predominant focus in the past only on African-American individuals with BED is because eating disorders in general are epidemiologically rare to begin with, and studies fail to recruit sufficient numbers of women of color for statistical analysis (Striegel-Moore, 2000).

"People diagnosed with BED typically describe a lifetime struggle with both their binge-eating symptoms and their weight control" (Safer, Telch & Chen, 2009). While some individuals with BED have a normal body weight, it is more likely for those with BED to be overweight or obese and numerous studies show that there is a strong association between obesity and BED (Bruce & Agras, 1992; Hudson et al., 2007; Iacovino et al., 2012; Spitzer et al., 1993; Striegel-Moore & Franko, 2003; Wilfley et al., 2003). Additionally, the research on the weight

distribution of the BED population is still a bit inconsistent. Many studies indicate that many to most in the BED population are overweight or even obese, while some other community studies indicate that only about half of individuals with BED have a body mass index (BMI) that meets typical definitions of overweight (Fairburn, 1995; Hudson et al., 2007; Masheb & Grilo, 2000). In their analysis of the U.S. National Comorbidity Survey-Replication (U.S. NCS-R: a nationally representative survey of U.S. adults conducted from 2001-2003; N=9,282), Hudson et al. reported the BMI distribution among individuals meeting BED criteria was: 57.6% percent having a BMI of 18.5-29.9, 27.6% with 30-39.9 BMI, and 14.8% with a BMI of 40 or more (2007). (U.S. Department of Health and Human Services defines a BMI of 25 or more as overweight, and a BMI of 30 or higher as obese. Retrieved from: <http://nhlbisupport.com/bmi/>). Regardless of the weight distribution of the BED population, being overweight or obese is frequently a feature of BED. The medical health problems often associated with being overweight or obese serve to complicate the health and lives of individuals with BED (Safer, Telch, & Chen, 2009).

Risk factors which serve to make individuals more vulnerable to developing BED include childhood sexual abuse (Smolak, 2011), childhood physical abuse, childhood obesity, family patterns of overeating, highly demanding parents, low parental contact, and negative comments made by family members about weight and body shape (Wildes & Marcus, 2000; Striegel-Moore, et al., 2005). Perceived elevated stress in childhood—age 14 or younger—has also been associated with development of BED and bulimia (Striegel-Moore et al., 2007). Recent research has also indicated that individuals with BED could have biological "alterations" in body systems associated with appetite regulation (Wildes & Marcus, 2010). Evidence also exists that there could be a biological or genetic component of BED (Wildes & Marcus, 2010). Waller pointed

out that the research on many of these risk factors is limited because they are often not specific to BED, but are instead predisposing factors for eating psychopathology in general (2002). Many studies of these risk factors, Waller also discussed, are limited in that they are not longitudinal and do not establish the causality of these factors (2002).

Course of the disorder

BED has a later average age of onset than anorexia and bulimia (Hudson et al., 2007; Pike, Dohm, Striegel-Moore, Wilfley, & Fairburn, 2001; Striegel-Moore et al., 2003). The 2001-2003 NCS-R measured a mean age of onset for BED at 25.4 years old, compared to late teens for anorexia (mean age of onset 18.9) and bulimia (19.7 years old) (Hudson et al., 2007). Within the population of obese individuals seeking treatment for their weight, however, researchers have found that obese individuals with BED tend to be younger than obese individuals without BED (de Zwaan, Nutzinger, & Schonbeck, 1992). This would indicate that the recurrent binge eating in BED could play a role in leading to obesity at an earlier age.

In terms of eating and disordered eating behaviors, researchers have shown that individuals with BED often report an early onset of dieting (Ricca et al., 2000) and a higher percentage of the number of diets they have ever been on (Mitchell et al., 2008). Despite attempting dieting at an early age, individuals with BED generally report lower levels of dietary restraint—being less able to purposively limit caloric intake in an effort to reduce weight or prevent weight gain—than do individuals with anorexia or bulimia (Masheb & Grilo, 2000). Specifically in contrast to bulimia, individuals with BED "generally have chaotic eating behavior that differs from that of persons with bulimia" with individuals with BED often having "low levels of dietary restraint, whereas in bulimia the binge eating alternates with high levels of dietary restriction" (Grilo, 2002, p. 180). Obese women with BED also have higher rates of

disinhibition in their eating than their obese counterparts without BED (de Zwaan et al., 1994).

The lower rates of disinhibition is not necessarily because those with BED do not attempt dietary restraint at all, as some theorize that those with BED may attempt calorie restriction at some parts of the day (often the morning or early part of the day) or parts of the week, but find themselves hungry or deprived in ways that can trigger a binge eating episode later on (Fairburn, 1995). Additionally, researchers have shown that concerns about body weight and shape, and body dissatisfaction, are just as high among individuals with BED as those with bulimia (Masheb & Grilo, 2000).

When comparing overweight individuals with BED to those who do not have BED, those with BED are more likely to have a history of: an earlier onset of obesity and dieting; marked body weight cycling (weight going up and down); more preoccupation with food and weight; and higher levels of body dissatisfaction (Ricca et al., 2000; Safer, Telch & Chen, 2009; Spitzer et al., 1993).

As far as the course of the disorder, Hudson et al. (2007) suggested that BED is as chronic and stable as other eating disorders and Wonderlich et al. (2009) posited that "patients perceive the disorder as stable and enduring, often lasting over a decade" (p. 700). The largest community-based sample that was also a longitudinal study conducted to date on stability of BED and other eating disorders indicated that BED is fairly stable and not dissimilar from anorexia or bulimia (Crow et al., 2002, as cited by Mitchell et al., 2008). Some other studies, however, have found that individuals with BED can exhibit spontaneous remission at rates unlike anorexia or bulimia, and that symptoms (binge eating with loss of control) over a course of several years can ebb and flow (Mitchell et al., 2008).

Research is also somewhat mixed about the length of duration of the disorder when comparing it to other eating disorders. Fichter & Quadflieg found BED has a similar duration to bulimia (following intensive treatment), but that both bulimia and BED had shorter durations than anorexia (2007). In a 1995 study, Mussell and colleagues found that the mean age at which study participants presented for BED treatment was age 45 while they reported the onset of their BED symptoms began at age 25. Recovery rates for BED, with treatment, have been estimated at fifty to sixty percent (Wonderlich et al., 2009), with a 2007 longitudinal study among women with eating disorders by Fichter and Quadflieg having reported BED recovery rates at 78 percent six years following intensive treatment, and 67 percent 12 years after.

Co-morbidity and psychopathology

In terms of co-morbidity, Striegel-Moore & Franko asserted in their 2003 review of BED literature that there was "remarkable consistency" across studies, showing "very high" rates of psychiatric co-morbidity among BED patient samples (p. S20). From analysis of the U.S. NCS-R, Hudson, et al. reported that 78.9 percent of individuals meeting DSM-IV BED criteria also "met criteria for at least one of the core DSM-IV disorders assessed in the NCS-R" (2007, p. 352). Specifically, the most commonly reported Axis I diagnoses among BED individuals were: Anxiety Disorders (65.1%), Major Depressive Disorder (32.3%), PTSD (26.3 %), alcohol abuse or dependence (21.4%), and Bipolar disorder (12.5%) (Hudson et al., 2007). There is considerable evidence of functional impairment and suffering among individuals with BED, including lower overall life satisfaction (Spitzer et al., 1993; Wonderlich et al., 2009). Compared with those who are overweight and do not have BED (using weight-matched controls), individuals with BED are more likely to have reported impairments in social relationships, as well as occupational impairments due to eating and weight distress (Spitzer et al., 1993).

Individuals with BED also exhibit higher levels of utilizing health care services than do those without BED (Wonderlich et al., 2009).

Stages and anatomy of a binge

Eating disorder researchers Polivy & Herman were among the first to conceptualize of binge eating episodes having a structure that consists of several phases. Polivy & Herman encouraged researchers and clinicians to separately consider and analyze each binge phase as to its "determining influences," as they believed that "different psychological factors might operate at different phases of the binge-eating episode" (1993, p. 173). Polivy & Herman identified five specific phases of a binge eating episode, which are the following: 1) *Pre-binge or preconditions for bingeing*, which include personality factors, and social and environmental preconditions for bingeing, such as social pressure to be thin and resulting body image dissatisfaction; 2) *Triggering of the binge*; 3) *Factors maintaining the binge from trigger to completion*; 4) *Termination of the binge*; and 5) *Post-binge*, which include "the consequences of a binge, some of which may serve as exacerbating preconditions for future binges" (1993, p. 174). In a somewhat similar fashion, Waller (2002) identified four psychological factors for a functional analysis of binge eating: 1) *Distal antecedents, or predisposing factors*, which are social, familial, interpersonal and psychological background factors; 2) *Proximal antecedents, or immediate triggers*, which can include things like emotional states or hunger; 3) *Proximal consequences, or short-term reinforcing consequences of binge eating*, which could include, according to Waller, pleasure, blocking of intolerable emotions or cognitions, and/or a reduction in hunger; and 4) *Distal consequences and maintenance processes* (p. 99-101).

The amount of food, type of food, length of the binge, and setting for binge can vary from individual to individual. Research on the anatomy of a binge reveals that there are some patterns

in the timing, setting, length, and types of foods eaten in binge episodes. Allison & Timmerman (2005) measured the trends in binge eating of 48 women with BED in their naturalistic settings, based on food diaries the study participants kept for 14 days. In terms of the timing of bingeing, Allison & Timmerman found that most binge episodes took place during dinner hours, followed by lunch hours (2005). Bingeing was more likely to occur on Friday, Saturday and Sunday than other days of the week. The locations of the binge were split, with about half of the episodes taking place at home and half at restaurants (Allison & Timmerman, 2005).

In terms of the types of foods people eat while bingeing, the APA describes that in BED "the type of food consumed during binges varies both across individuals and for a given individual" so much that "binge eating appears to be characterized more by an abnormality in the amount of food consumed than by a specific nutrient" (2013, p. 351). Despite the variety of types foods consumed in the binge, Allison & Timmerman's study found some patterns in types of food among the women with BED in their study (2005). These researcher found that nearly all binges were comprised of multiple types of food items. The foods the women ate the most of in a binge were high fat meats (such as fried chicken, hamburgers), sweets (particularly cookies, candy, and ice cream), and salty snacks (particularly chips), followed by bread/pasta and pizza. Sweets and fried meat carried particular trends: The women who tended to binge on sweets binged more frequently than other women; the women who binged predominately on fried meats (such as fried chicken, hamburgers) had significantly higher Body Mass Index (BMI) than others (Allison & Timmerman, 2005).

Development of BED as a DSM-5 Diagnosis

The APA arrived at the DSM Fifth Edition definition for BED over a course of about fifty years of the psychological community conducting research on this population and debating

the veracity and clinical utility of BED as an eating disorder diagnosis. In 1959, psychiatrist Dr. Albert Stunkard published the first piece of research which identified a phenomenon of binge eating (without purging) among obese individuals, in which he recognized a subgroup of obese individuals who exhibited recurrent binge eating and related psychological distress, which other obese individuals did not exhibit. Stunkard described this pattern as an "eating binge" in which "large amounts of food are consumed in an orgiastic manner" (p. 294) in a "relatively short period" of time (1959, p. 289). Stunkard also noted that the binge eating is "frequently related to a specific precipitating event," "frequently seem to have highly personalized, if unconscious, symbolic meanings" and are "regularly followed by severe discomfort and self-condemnation" (1959, p. 289).

Prior to the current title for the disorder—BED—eating disorder literature often described the phenomenon as "pathological overeating syndrome," "compulsive overeating" (Fairburn, 1995, p. 25), "recurrent overeating" (Fairburn, Welch, & Hay, 1993), or described the patients as "obese binge eaters" or "non-purging bulimia nervosa" patients" (Spitzer et al., 1991). At times, BED has been conflated with Night Eating Syndrome (NES), which is not currently defined in the DSM, but commonly defined by researchers as eating 25 percent or more of total daily calories after one's evening meal and waking during the night to eat (Allison et al., 2005). Researchers have now collected enough data on the two syndromes to lead to the commonly-accepted notion that BED and NES are distinctly different syndromes (Allison et al., 2005).

It was not until 1994 that the APA first included BED as a provisional diagnosis in the manual's appendix as a "disorder with research criteria requiring further study" (APA, 2000; Wilfley et al., 2003). The Eating Disorders Work Group of the DSM-IV Task Force had recommended including the phenomenon as a provisional diagnostic category and chose to name

it "Binge Eating Disorder" because recurring episodes of binge eating were "the central construct of the new disorder" minus "the characteristic compensatory features of bulimia nervosa" (Spitzer et al., 1991, p. 628). Thus, in 1994 BED was included in the manual as a specific example of Eating Disorder, Not Otherwise Specified (EDNOS) (Striegel-Moore & Franko, 2003). The criteria for the DSM-IV's provisional diagnosis were nearly identical to the current DSM-5 diagnosis criteria (outlined earlier in this chapter), except for the criteria on bingeing frequency. In the previous, DSM-IV binge eating had to occur, "on average, at least two days a week for a six month period" (APA, 2000), whereas in the current DSM-5 BED criteria, the frequency of bingeing required is less stringent, and must only occur once a week for a three month period (APA, 2013). (This is discussed in more detail later in this chapter).

In the years prior to the fourth edition of the DSM in 1994, the research literature gives a perspective into the debates over the inclusion and definition of BED, and the central question often posed of whether BED was a "syndrome of clinical significance" (Wilfley et al., 2003, p. S96). Part of the debate seemed to be about ideology regarding the nosological approach to adding more categories to the DSM, and whether fewer categories or more categories would be beneficial for mental health care providers and clients. Eating disorder researchers also seemed to recognize that the category of EDNOS included a large and heterogeneous number of individuals, especially compared to those with anorexia, bulimia and they differed on how to approach, or whether to even attempt, creating categories within EDNOS.

In 1991, Spitzer et al. called for BED to be included as an official diagnosis, explaining that since Stunkard's groundbreaking 1959 identification of the BED phenomenon, "there has been research and clinical evidence that many individuals with marked distress about binge eating cannot be diagnosed with bulimia because they do not regularly engage in the

characteristic compensatory behaviors, such as vomiting or use of laxatives" showing up in weight loss programs and that it was "impossible to diagnose such patients using DSM-III" or other diagnostic codes (Spitzer et al., 1991, pp. 627-628). Including BED as a diagnostic category in DSM-IV, Spitzer et al. anticipated, could "promote research and the development of effective treatments for these patients" (1991, p. 628). In 1992 and then in 1993, Spitzer and colleagues published two multi-site studies which drew subjects from weight control programs as well as non-patient community samples, assessing BED among 3,500 individuals in total (Spitzer et al., 1992; Spitzer et al., 1993). These studies, according to Stunkard & Allison (2006), essentially defined BED as it came to exist in the fourth edition of the DSM.

Spitzer et al.'s 1992 and 1993 studies established some of the first prevalence rates of BED, as they found 29 to 30 percent of the weight control sample subjects to meet BED criteria, and the prevalence among the community (non-weight control samples) to be two percent. The studies supported the validity of the BED diagnosis, these researchers posed, because BED was "strongly associated with variables that are external to the defining features of the disorder" (such as social and work functional impairments, overvaluation of body weight/shape) and that a BED diagnosis was consistently associated with "general measure of psychopathology" (Spitzer, et al. 1993, p. 147). Other researchers have questioned whether the studies were reliable measure of prevalence, criticizing the methodology for relying more on convenience samples and clinical samples rather than samples statistically representative of the general population (Striegel-Moore & Franko, 2003). Since then, the most recent population-based, non-clinical sample conducted measured 3.5% of women and 2% of men with BED (Hudson et al., 2007).

In 1993, Fairburn et al. published an article arguing that fell on the opposite side of Spitzer et al. 1992 and Spitzer et al. 1993 as it argued against the inclusion of BED as a new

diagnostic eating disorder category in DSM-IV. Fairburn et al. posited, "too little is known about those with recurrent overeating to propose adding binge eating to DSM-IV" and they called for the existing categories of anorexia, bulimia, and EDNOS to "be left intact whilst more data are collected" (1993, p. 159). Fairburn et al. were unfavorable toward the DSM-III developers' nosological "explicit expansionist policy" in creating diagnostic categories and instead espoused the DSM-IV developers' attempts to set a higher threshold and only include new categories in the fourth edition if there was "solid evidence that the diagnosis is useful in predicting prognosis, treatment selection, or outcome" (Pincus et al., 1992 as cited in Fairburn et al., 1993, p. 155). Fairburn et al. claimed there was "no evidence whatsoever" that BED met this threshold (1993, p. 157). The authors further argued against creating a BED diagnostic category because they believed that there was insufficient research on the population individuals with EDNOS (a group of which they considered the BED population to be members), and that there were no clear reasons for focusing on the BED subgroup of EDNOS rather than on other eating disorder subgroups. Fairburn et al. also worried that inclusion of BED could bring about diagnostic confusion in distinguishing between non-purging bulimia and BED (1993).

In 1993, Spitzer and colleagues published a direct response to Fairburn et al. (1993), stating that BED was "a logical outgrowth of Stunkard's original clinical insight and of the research of binge eating among the obese" and that BED did meet the criteria of being useful in predicting prognosis, treatment selection, and outcome. Spitzer et al. argued that "it is hard to imagine a clinician, faced with recommending treatment for a patient seeking help for weight control and overeating, who would be uninterested in knowing whether or not the patient frequently engaged in binge eating" (1993, p. 167). These authors also reasoned that "reducing the heterogeneity of EDNOS by recognizing a relatively pure group" of BED individuals would

be important as this group "probably represents the majority of cases seen clinically that now must be given the nonspecific diagnosis of EDNOS" (1993, p. 163). In fact, Spitzer et al. estimated, "available evidence suggest that patients with BED far outnumber those with either bulimia or anorexia" (1993, p. 162). Finally, Spitzer et al. countered that, "in the history of classification of medical disorders it often is the case that a diagnosis is recognized before any knowledge about effective treatment is available" (Spitzer et al., 1993, p. 162). Spitzer et al. went on to argue:

"New diagnoses have always arisen from clinicians noting certain commonalities among the patients who they are trying to help. These commonalities, or distinctive clinical features, distinguish these patients with the new disorder from other patients who do not have the disorder. The validity of the disorder is the extent to which the defining features of the disorder provide useful information" (1993, p. 167).

This debate was quelled to some degree when BED was included as a provisional diagnosis in the DSM-IV.

As efforts began to gear up for the fifth edition of the DSM, in 2003 Wilfley and colleagues published an article claiming that BED's inclusion in 1994 as a provisional diagnosis "led to a proliferation of research" on the disorder, and that through using five questions to evaluate the "clinical utility" of the BED diagnosis, they had come to the conclusion that BED had established clinical significance to be considered a formal DSM-5 diagnosis (2003, p. S96). Wilfley et al. did acknowledge that questions remained about the course of BED and the best treatment approaches, but that those questions should not bar BED from being an eating disorder of clinical severity (2003). The authors explored and answered their own five questions, concluding that: while BED is correlated with obesity, individuals with BED differ quite a bit

from overweight individuals who do not have eating disorders; that individuals with BED share core eating disorder features with anorexia and bulimia, such as preoccupation and overvaluation of body shape and weight, and resulting low self-esteem; BED is distinct from anorexia, and particularly bulimia; and a BED diagnosis does advance treatment planning and clinical treatment planning (Wilfley et al., 2003).

The whole research community, however, was not completely behind promoting BED to a formal DSM-5 diagnosis. In 2003, eating disorder researchers Stunkard & Allison published an article, *Binge Eating Disorder: Disorder or Marker?*, in which the researchers argued that because BED showed too much variability in terms of symptoms, that clients remit frequently while on waiting lists for treatment, and because the disorder responds to a variety of treatments that do not even specifically address binge eating, that there was little use in a DSM diagnosis, except for serving "as a marker for psychopathology" (p. S114). They concluded that the great variability in how it responds to various treatments (CBT, IPT, psychopharmacology, behavioral weight loss) "limits the implications that can be drawn" from having BED as a diagnosis (Stunkard & Allison, 2003, p. S107). Instead of psychotherapy aimed at treating the binge eating aspect of BED, Stunkard and Allison proposed that clients with symptoms that would be characterized as BED received both behavioral weight loss treatment and treatment to "target specific psychopathologies, such as depression, substance abuse, or anxiety," that plague the client, as this "should yield greater dividends than treatment directed to BED" (2003, p. S114).

In 2008, researchers Striegel-Moore and Franko reviewed existing research literature to assess five criteria, which they self-selected, in an attempt to conclude whether BED should be included in DSM-5. The authors found that BED met the five criteria and concluded that BED be given a formal place in the DSM. The five criteria they found to be met were: there was ample

literature published about BED; that BED diagnostic criteria had been clearly articulated in DSM-IV and that several psychometrically sound assessments exist to measure the BED criteria; there was sufficient evidence that BED could be reliable among two or more clinical assessors; that BED could be differentiated from other similar syndromes (bulimia) and obesity; and that BED demonstrated validity, as researchers could use classification to continually identify a type of eating disordered individuals who matched the descriptions of BED (Striegel-Moore & Franko, 2008).

Largely in concordance with Striegel-Moore's 2008 review, Wonderlich et al. published a review of existing empirical literature in 2009, at the behest of the American Psychological Association, *The validity and clinical utility of Binge Eating Disorder*, to assist the DSM-5 developers in their decision-making around the DSM-5 (this article was co-published by the American Psychological Association and the International Journal of Eating Disorders). Wonderlich et al. (2009) directly addressed Stunkard & Allison's 2003 proposal to exclude BED from DSM-5, countering Stunkard & Allison by citing new research that BED is a stable condition for BED clients and that treatments that specifically target BED psychopathology have been shown to be more effective in decreasing binge eating than purely behavioral weight loss programs (2009). Wonderlich et al. (2009), however, did agree with Stunkard & Allison (2003) that research has not consistently shown that the BED diagnosis has a predictive value regarding clinical outcomes and responsiveness to treatment.

In their literature review, Wonderlich et al. did not prescribe a specific path for whether or not to include BED in the DSM-5, but instead outlined five available courses of action the authors saw APA could take in its decision-making about BED (2009). One was to include BED as a formal diagnosis, which the authors asserted was:

"Supported by the well-documented number of patients who may have a disturbance in binge eating behavior, marked psychiatric comorbidity, functional impairment, and regularly report to psychiatric and eating disorder treatment facilities. Furthermore, there is preliminary evidence that this is a relatively enduring and impairing condition, which may have a currently unspecified familial basis. Additionally, the salient feature of the diagnosis, binge eating, is differentially responsive to treatments" (Wonderlich et al., 2009).

Second and thirdly, these authors also offered options that BED could be included in the DSM with additional criterion or specifiers included for individuals with BED to exhibit overvaluation of body shape. Wonderlich et al. also offered that the APA could keep the status quo of having BED be an example of EDNOS and as a disorder in need for further study, but that this option would "overlook significant amounts of research that have already been conducted, which may provide enough information to make an informed decision" otherwise (2009, p. 700). These authors also offered as a final option that BED could be eliminated altogether as an eating disorder diagnosis, but they pointed out that this option was not well supported because there was extensive empirical evidence that BED could be distinguished from other eating disorders, from obesity, and another psychiatric disorder (anxiety or mood disorders).

Ultimately, in 2010, the APA declared that it would promote BED to a formal diagnosis in the DSM-5 (APA, 2010). In 2012, the APA described further their rationale that BED "distinguishes itself from other eating disorders and obesity" across a range of factors that validate its clinical utility" (APA, 2012). These factors, according to the APA, included: that BED has a "relatively distinct demographic profile" that separates it from the other eating disorders, with BED having "a greater likelihood of male cases, older age, and a later age of

onset;" that BED had a greater likelihood of remission than other eating disorders; that BED has been determined to run in families but "is not a simple familial variation of obesity;" that BED differentiates itself from obesity because individuals with BED express "greater concerns about shape and weight, more personality disturbance, and a higher likelihood of psychiatric co-morbidity in the form of mood disorders and anxiety disorder;" and sufficient evidence that individuals with BED, rather than obesity, "have a more positive response to specialty treatments than to generic behavioral weight loss treatments in terms of reduction of eating disorder psychopathology" (APA, 2012). The APA concluded that all of these validators, established through research, suggested that there was "clinical utility" in creating a BED diagnosis to aid in treatment selection for individuals with this disorder (APA, 2012).

My historical tracing of the BED literature indicates a general level of support for the decision to make BED a formal DSM diagnosis, but there was some dissent voiced in response to the APA's DSM-5 BED decision. There is not a lot of disagreement published in the literature or media (at least that I could find), but the few examples were based on either nosological disagreements about whether and how to increase the categories for eating disorders or on the notion that making the BED DSM diagnosis was making lack of dietary self control, or zeal for gluttony into a mental disorder. One example I could find was an op-ed by psychiatrist Allen Frances (who had chaired the APA's development DSM-IV Taskforce), in which Frances named the inclusion of BED as a formal diagnosis as one of the worst changes to the DSM because it both condemned and approved of "excessive eating" and labeled it a mental illness (Frances, 2012). Frances' dissent, in his own words, was: "Excessive eating 12 times in 3 months is no longer just a manifestation of gluttony and the easy availability of really great tasting food. DSM-5 has instead turned it into a psychiatric illness called Binge Eating Disorder" (2012).

Key Areas of Debate in Developing a DSM Diagnosis for BED

Over the past several decades, there have been three overarching areas of questions at issue in the discussions about making BED a formal diagnostic category in the DSM, in addition to the ideological debate about nosological advantages or disadvantages to adding more specific diagnosis categories. The following section will discuss these three areas of debate in detail. The three areas include: the standards of what qualifies as a binge episode; the boundary between obesity and BED—the difference (or lack thereof) between individuals with BED and obese individuals without BED; and the role of overvaluation of body weight and body dissatisfaction as a criterion for BED.

Defining a binge

The first area where there has been some debate about the DSM BED diagnosis is the definition of a binge and the requirements around the frequency of binge episodes in the diagnosis criteria. Researchers and clinicians have had some questions about how to define a binge, as the potential dimensions of measurement regarding a binge include questions about: How much food or how many calories need to be consumed in order to qualify as a binge? Does the type of food or the speed of eating matter? And, How much or what type of distress related to the binge needs to be present? Some researchers have considered it problematic that the answers to these questions, especially the specific amount of food or calories required to count as a binge have yet to be (or to ever be) specifically defined, even in DSM-5 (Stunkard & Allison, 2006). The DSM-5 does use two hours or less as a general guide of how long a "discrete period" could be for a binge, but this is not to say that a binge episode lasting three hours would not count as a binge (APA, 2013). The discrete period does not, however, require the binge to take place only

in one setting. For example, the APA describes in DSM-5 that the binge could begin at a restaurant and continue once the person returned home (2013).

As per the amount of food, the DSM-5 definition delineates a binge as an "amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances" (APA, 2013, p. 351). The APA in DSM-5 does further counsel that "the context in which the eating occurs" should play a role in "the clinician's estimation of whether the intake is excessive," discerning between a "quantity of food that might be regarded as excessive for a typical meal might be considered normal during a celebration or holiday meal" (2013, p. 351).

Another complicating issue is that eating disorder researchers have found the definition of a binge to be subjective—one eating episode could be perceived as a binge by some, and not by others. The methods used for measuring a binge impact this: whether an individual has to evaluate on their own if their eating episode qualifies as a binge, or whether the food data is collected and researchers or clinicians see if it qualifies. This can be done via direct observation or through the individual keeping a food diary (on paper or through mobile electronic devices) in which they record their caloric intake and the momentary assessment of mood and loss of control (Wonderlich et al., 2009). Adding to the subjective nature of the binge, negative mood can also impact whether or not someone defines their eating episode as a binge. Researchers have determined that clinical depression is associated with the tendency for someone to describe an episode as a binge, no matter how many calories were consumed in the eating episode (Telch & Agras, 1996).

The requisite frequency of bingeing episodes in order to meet the DSM BED criterion has also been a topic of debate for researchers. Under DSM-IV, the binge eating needed to occur, "on average, at least two days a week for a six month period" (APA, 2000). Researchers and

clinicians found this problematic for several reasons. First, many discovered under-reporting problems with the self-reporting and recall accuracy when the measurement unit asked about was the number of binge episodes, so they recommended DSM-5 switch the frequency criterion to measure days on which binge eating occurred, rather than number of episodes a week (Wilson & Sysko, 2009). On this point, the DSM-5 continues to be somewhat vague, as it requires a binge to occur "once a week for a three month period," which could mean one day or one episode (APA, 2013). The second issue with the DSM-IV binge frequency was that, as researchers were able to collect more data about BED and recurrent binge eating, they found that a two-day a week binging threshold was high enough that it was excluding individuals who binged only once a week but who otherwise were very similar to those with BED who binged more than once a week (Wilson & Sysko, 2009). In this way, researchers found that once a week binging was a "clinically meaningful entity," and this helped lead to the DSM-5 be changed to have only a once a week threshold (Wilson & Sysko, 2009, p. 607).

This is not to say that the frequency of binge episodes is unimportant. In fact, researchers have found that among individuals with BED there is a relationship between frequency of binging and negative affect and lower self-esteem, with the greater the number of binge episodes coming with lower self-esteem and stronger negative affect (Wilson & Sysko, 2009). Relatedly, researchers who conducted a large sample of obese men and women to measure BED rates and binging episode frequency described finding "a continuum of vulnerability" regarding binging, in which more binging begets more sadness, "with a higher frequency of binge eating reflecting a greater severity" of BED (Striegel-Moore, Wilson, Wilfley, Elder, & Brownell, 1998, p. 34). In a similar study of obese females seeking weight-loss treatment, researchers found that the more frequent the women with BED reported binge eating the more they reported "feelings of

ineffectiveness, stronger perfectionistic attitudes, more impulsivity, less self-esteem, and less interoceptive awareness" (de Zwaan et al., 1994, p. 43).

Controversy over real differences between BED and obesity

Another topic of debate in creating this new diagnosis has been in establishing that BED is not just a subtype of behaviors associated with obesity or obese individuals, or "an eating disordered subtype of obesity" (Wonderlich et al., 2009). Beginning with Stunkard's original recognition of recurrent binge eating among obese individuals in 1959, there has been skepticism among some researchers that those with BED were not just obese individuals with some form of concurrent psychiatric disturbance. Thus, recurrent binge eating was not readily recognized as an eating disorder, but more as a behavior of overweight individuals who also had some other psychological disorders, such as depression or anxiety, or as a behavioral subtype of obesity (Mitchell et al., 2008).

While the overlap of binge eating and obesity has clouded the picture to some degree, researchers over time have tended to find that "persons with BED are not simply obese individuals with comorbid psychiatric disorders" (Wilfley et al., 2003), but that there are many substantial differences between individuals with BED and those who are equally overweight but do not have BED. First, and prior to the 1994 DSM-IV, eating disorder researchers demonstrated that individuals with BED exhibit differences from non-BED overweight individuals, showing that those with BED have an earlier average age of onset of both being overweight and onset of significant dieting than non-BED overweight individuals, higher lifetime total of number of diets, and more frequent weight cycling (Spitzer et al., 1992; Spitzer et al., 1993). Compared to obese individuals without BED, those with BED have also been found to have higher rates of mental disorders, including DSM Axis I and Axis II diagnoses (Fichter, Quaedflieg & Brandl,

1993; Ricca et al., 2000; Yanovski, Nelson, Dubbert, & Spitzer, 1993). Of particular importance were the findings, established in 1993-94, that it is the presence of the specific behavior of binge eating that predicts having a comorbid mental disorder, rather than the presence of obesity (Telch & Agras, 1994; Yanovski et al., 1993). Researchers have also found that is the severity of bingeing, rather than the degree of the obesity, which increases psychiatric comorbidity among those with BED (Wilfley et al., 2003).

Further distinguishing BED from obesity, obese individuals with BED have been found to be heavier (with higher Body Mass Index levels) (Ricca et al., 2000) and to consume more calories on a daily basis than their non-BED obese counterparts. Wonderlich et al. reported in their BED literature review that numerous studies over the past fifteen years supported that individuals with BED "clearly consumer more calories than obese non-BED subjects," (2009, p. 701). Although research is mixed on whether obese individuals with BED binge eat more frequently than obese individuals without BED (Greeno, Wing & Schiffman, 2000; Wonderlich et al., 2009), those with BED do report experiencing more loss of control and emotional turmoil and distress associated with their binge episodes than those without BED (which is a key component of the BED diagnosis criteria) (Greeno et al., 2000).

There continues to be some debate over whether obese individuals with BED are truly different, or different enough, from other obese individuals because they have BED. Even with this debate, Wonderlich et al. argued that BED does not necessarily need to "distinguish itself from obesity in order to have clinical utility" as a diagnosis (2009, p. 699). In describing BED in the DSM-5, the APA highlights that "binge-eating disorder is distinct from obesity; most obese individuals do not engage in recurrent binge eating" (2013, p. 351).

Inclusion of overvaluation as a criterion

The third topic at issue in the development of BED for the DSM has been considering the inclusion of the overvaluation of body weight or shape in BED criteria. Overvaluation is defined as "the excessive influence of shape or weight on one's self-evaluation," in which an individual defines "their self-worth by body shape or weight judgments" (Hrabosky et al., 2007). In Masheb & Grilo's words, overvaluation is a cognitively-oriented phenomenon of "overvalued ideas regarding weight and shape that unduly influence self-evaluation" (2000, p.162). Overvaluation is generally associated with having low body satisfaction, which is then strongly connected with one's sense of self-worth. Overvaluation is a central psychological component of diagnosis and assessment for other eating disorders, including anorexia, bulimia (bulimia diagnosis requires one's ideas about weight and shape to unduly influence self-evaluation; anorexia diagnosis requires that one have a distorted body image or have undue influence of body weight or shape on self-evaluation and persistent fear of fatness) (Masheb & Grilo, 2000; APA, 2013). Yet, neither the DSM-IV or the DSM-5 criteria for BED include body weight or shape overvaluation.

Overvaluation has been measured at high levels among individuals with BED, comparable to that experienced in bulimia (Hrabosky et al., 2007; Masheb & Grilo, 2000). Obese individuals with BED demonstrate higher and more intense levels of overvaluation of their shape and weight than obese individuals who do not have BED, specifically those with BED "felt fatter, feared gaining weight more, were more dissatisfied with their weight, and avoided seeing their bodies," and "thought more about food and their weight...to the point where it interfered with their concentration" at higher levels than those without BED (Wilson et al., 2007, p. 30). Additionally, among individuals with BED, higher levels of shape/weight overvaluation were associated with more disordered eating patterns and worse psychological

status, indicating that overvaluation "does not simply reflect concern commensurate with being overweight, but is strongly associated with eating-related psychopathology and psychological functioning" (Hrabosky et al., 2007, p. 175). Researchers have also found that there are gender differences among individuals with BED regarding overvaluation and body image, with women with BED reporting significantly greater body image dissatisfaction and a stronger drive to want to be thin than men with BED (Barry et al., 2002). Higher body image dissatisfaction, Barry et al. suggested, may contribute to making women with BED more "prone to extreme dieting" than their male counterparts, which could play a role in the course of BED for women (2002, p. 64).

There was some debate about how and whether to include overvaluation of shape and weight in the BED DSM-5 diagnosis, either as a criterion or specifier. Based on their study findings of high overvaluation levels in those with BED, Masheb & Grilo (2000) and Hrabosky et al. (2007) proposed overvaluation be included as a diagnostic criteria in the DSM-5.

Wonderlich et al. also discussed including overvaluation as a BED specifier as a potential option for the APA to take in the DSM-5, citing that there were a "small number of studies, which have consistently suggested that overvaluation of shape and weight has clinical utility" and helps to predict outcomes (2009, p. 701). Wonderlich et al. also summarized that including overvaluation as a criterion could be helpful as "BED patients with overvaluation regarding shape and weight show the clearest discrimination" from obese patients who do not have BED, but ultimately warned that including overvaluation as a criterion for BED could serve to exclude a significant number of individuals from BED diagnosis who exhibit recurrent bingeing accompanied by marked distress and impairment (2009, p. 701). Hrabosky (2011) also pointed out in an article discussing body image and BED, that while BED patients with high overvaluation levels

reported greater distress over binge episodes, researchers so far have not established that overvaluation has an impact on the frequency of binge episodes.

Overview of BED Causation Theories

There are a variety of theories about the underlying mechanisms that drive the development and maintenance of BED (Waller, 2002; Wildes & Marcus, 2010), prompting Polivy & Herman to assert that "the etiology of binge eating has been the subject of abundant speculation but little consensus" (1993). The three primary etiological theories most commonly used to inform research studies and analysis of BED are the following: 1.) Binging as a way to regulate one's emotions or affect, which includes binging in order to immediately relieve negative emotions. At the same time, however, binging also can be a source of negative feelings because repeated binging can breed exponentially increasing negative emotions and can contribute to weight gain that is problematic in the context of a society that values thinness; 2.) Binging as a result of caloric restriction or dieting; and 3.) Binge eating as an addiction. These three etiological theories have evolved over time, as eating disorder and BED research have provided evidence in support of and evidence against aspects of all three. These theories can occur alongside each other as underlying mechanisms for BED, and some may be applicable for some individuals and not for others (Polivy & Herman, 1993; Waller, 2000). Polivy & Herman warned against using only one etiological approach to conceptualize of the causes or drivers of binge eating, saying: "binge eating is a complex behavioral pattern; accounting for it by reference to a single cause is likely to be futile and misleading" (1993). In the next three subsections I discuss the rationales for each theory, and relevant research regarding each.

Theory of emotional and affect regulation

Emotions, especially negative emotions, mood or affect, are commonly cited as precursors to binge eating (precursors are also referred to in the literature as proximal antecedents, immediate antecedents, or triggers to binge eating) (Greeno, et al., 2000; Masheb & Grilo, 2006; Polivy & Herman, 1993; Waller, 2000; Safer, Telch, & Chen, 2009, Stickney, Miltenberger, & Wolff, 1999). A study conducted in 2000 found that women with BED were more likely to experience negative mood in general than were weight-matched controls without BED, and that women with BED were also far more likely to experience negative moods before binge eating, as tracked in the moment through participants carrying portable microcomputer devices to track their moods and eating behavior (Greeno et al.). In another study researchers found that the more intense the negative emotions were among overweight individuals with BED, the more frequent their binge episodes were and the more likely individuals were to report feeling disinhibition around eating (Masheb & Grilo, 2006).

The central assumption in the emotional regulation theory is that when individuals feel negative emotions or stress, or are in a negative mood, and are unable to regulate or calm themselves in an adaptive way, they turn to binge eating as a way to "feel better" (Safer, Telch, & Chen, 2009; Waller, 2000). If the immediate consequences of the binge include at least temporary relief from the negative emotions or thoughts, this model asserts, then reinforcing conditions are set for the bingeing behavior, and the binge cycle is maintained (Hilbert & Tuschen-Caffier, 2007; Stickney et al., 1999). Then, following the binge episode, "the person's mood reverts to a depressed state, often compounded by feelings of shame and guilt associated with the binge" and "such negative mood states then increase the likelihood of a future binge episode" (Ochner, Geliebter, & Conceicao, 2009, p. 90). In the theoretical conceptualization of

Telch, Agras, & Linehan, binge eating is seen as "a maladaptive affect-regulation strategy that is maintained by the temporary reduction in distressing affective states" (2000, p. 570-571).

Stress, negative emotions, feelings, or thoughts can all contribute, to "intolerable emotional states," for which individuals can use bingeing to temporarily avert or block awareness (Waller, 2000, p. 349). Researchers have found intolerable emotional states can include depression or sadness, anger at others or self, loneliness, hopelessness, dissatisfaction, shame, boredom, tiredness, and anxiety or worry (Masheb & Grilo, 2006; Stickney et al., 1999; Waller, 2000). Masheb & Grilo's 2006 study of individuals with BED notably found that anxiety was the most common emotion to trigger binge eating, above five other emotions—sadness, loneliness, tiredness, anger and happiness. These researchers also found that a positive emotion—happiness—could trigger binge eating, although it was the least likely from among six emotions (Masheb & Grilo, 2006).

In addition to negative emotions, negative core beliefs about oneself, such as, 'I am fat,' or 'I am a bad or unworthy person,' are hypothesized to contribute to negative emotions (Waller, 2000). It has been suggested that bingeing can provide relief from self-awareness of these critical thoughts (Stickney et al., 1999). Some study findings indicate that one potential reason for individuals with BED dealing with their negative emotions through bingeing may be that they have "deficits" in their ability to regulate their emotions, as compared to individuals who do not binge. Whiteside et al. found strong associations with binge eating and difficulty with identifying emotions, feeling confusion about emotional states, and having limited strategies for emotional regulation (2007). In fact, these researchers found that these emotional regulation deficits were much more likely to be associated with binge eating, above overvaluation or caloric restriction (Whiteside et al., 2007). These emotional regulation deficits include individuals having

"difficulty changing negative moods, and that when they were upset this negative mood persisted" and hypothesized this could mean that individuals who binge eat could have "stronger, longer lasting emotions" than those who do not binge (Whiteside et al., 2007, p. 166). The researchers went on to suggest that individuals who binge eat could "have broader emotional regulation difficulties which are not tied exclusively to the time period preceding a binge" (Whiteside et al., 2007, p. 167). It follows then, that individuals who had low self-esteem and negative evaluation of their appearance even after DBT treatment were more likely to relapse in binge eating than those with higher self-esteem (Safer, Lively, Telch, & Agras, 2002).

While the research literature generally supports that negative emotions can serve as precursors or preconditions to binge eating, research is more mixed about how much binge eating brings relief or improves negative affect for individuals with BED. Stickney et al. (1999) found that binge episodes did improve mood temporarily. Other recent research findings by Hilbert and Tuschen-Caffier (2007), however, do not fully support the hypothesis that bingeing behavior in BED is reinforced by relief from negative emotion after bingeing. Hilbert and Tuschen-Caffier pointed out that the behavioral maintenance theory of binge eating was originally developed with bulimia in mind, which includes purging or other post-bingeing compensatory behaviors. The compensatory behaviors play an important role in the maintenance and reinforcement of bulimia, as they can often function as a relief to negative emotion arising after binge eating (Hilbert & Tuschen-Caffier, 2007). The relief from purging is not part of BED. Hilbert & Tuschen-Caffier conducted a study in Germany among 20 women with BED, 20 women with bulimia, and 20 non-eating disordered control women, in which women used portable microcomputers to record mood throughout and following regular eating and binge eating (Hilbert & Tuschen-Caffier, 2007). They found negative emotion or affect to be a

proximal antecedent to binge eating for both women with BED and women with bulimia (their moods were also more negative than before regular, non-binge eating). Yet, for both women with BED and bulimia, the consequences of bingeing were further deterioration of mood (increase in negative mood), rather than improved mood or relief (Hilbert & Tuschen-Caffier, 2007). One might expect different findings (as did the researchers in their study hypothesis): that for individuals with BED the binge would bring relief, improved mood, and greater decrease in negative mood than for individuals with bulimia, because those with BED will not utilize purging symptoms after bingeing. This study highlights the limitations of utilizing only emotional regulation theory to conceptualize the maintenance of bingeing for BED, as bingeing did not seem to provide relief, or make individuals with BED in this study feel "better."

In DSM-5, the APA acknowledged that binge eating may "minimize or mitigate factors that precipitate the episode in the short-term," such as negative affect, interpersonal stressors, negative feelings related to body weight and shape, and boredom, "but negative self-evaluation and dysphoria often are the delayed consequences" (2013, p. 351). This is supported by Telch and Agras' 1994 study of obese women with BED, in which the researchers found that the severity of binge eating was highly related to psychological distress: the women who did more frequent and intense binge eating had "significantly greater depressive symptomatology, lower self-esteem, more general psychiatric symptomatology, and greater interpersonal distress" (pp. 58-59).

Research also indicates another difference between binge eating in bulimia and BED, in a study in which women with BED and bulimia both reported distress associated with binge episodes, but those with BED also experienced "more positive concomitant experiences during bingeing eating related to the hedonic quality of food" (Hilbert & Tuschen-Caffier, 2007, p. 522).

Compared to the women with bulimia, the women with BED were "more likely to report that they enjoyed the food, the taste of the food, and the smell and texture of the food while binge eating" (Mitchell et al., 1999, p. 165). Mitchell and colleagues' study also found something different from Hilbert & Tuschen-Caffier (2007), however, in that they did find BED clients experienced more relaxation, less anxiety and less physical discomfort after bingeing than their counterparts with bulimia.

Even though the research does not fully explain how negative affect would be the maintaining mechanism for bingeing in BED, that there is well-established evidence that negative affect and mood are antecedents to bingeing. Under this conceptualization, it follows, that clinicians would work to identify and analyze the antecedents to a binge in order to understand the psychological function of a binge for an individual with BED, as treatment interventions are likely to be more effective the more they are individualized to be relevant for the function of the binge for each individual (Polivy & Herman, 1993; Stickney et al., 1999).

Theory of dietary restraint

The theory that dietary restraint or caloric restriction—defined to as "the intention to restrict food for weight loss or maintenance" and commonly referred to as dieting—is an underlying mechanism for binge eating in BED is controversial (Whiteside et al., 2007). The bulk of the recent research indicates that while dieting may be a precursor to bingeing (and then subsequent compensatory behaviors) for individuals with bulimia, the evidence does not show this holds for individuals with BED.

For individuals with *bulimia*, eating disorder research literature has generally accepted that dieting or caloric restriction has a strong association with bingeing, with dieting usually preceding bingeing (Marcus, 1997; Polivy & Herman, 1993; Wilson, 2002; Yanovski, 2002). The

current formulation for understanding bulimia is a combination of the dietary restraint model and the emotional regulation model for binge eating. Under this conceptualization of bulimia, individuals with bulimia restrict caloric intake, which can lead to hunger, negative mood, and then bingeing. In other words, as described by Manwaring, et al., "in this restraint model, dietary restriction is exercised by adopting a cognitively regulated eating style, causing susceptibility to dis-inhibition and consequent binge eating" (2006, p. 102). Also at work in this formulation is the theory that body dissatisfaction and desire to change body weight/shape plays a role in motivating individuals to begin dieting. Part of restriction is ignoring one's internal stimuli, which include hunger cues as well as satiety cues. Thus, once food is allowed following restriction, there can be over-arousal and difficulty following internal cues about being full. The binge can then lead to frustration and worsened self-esteem because the calories taken in during the binge are counteractive to the original desire to lose weight (Polivy & Herman, 1993). This frustration and anxiety contribute to compensatory, purging behaviors and can work to maintain the binge-purge cycle, for individuals with bulimia.

It was from this etiological framework for bulimia that the dietary restraint model came into being for BED, as Manwaring, et al. explained, "it was originally believed, due to similarities in symptomatology with bulimia, that the etiology of BED would conform to a model initially proposed for bulimia that emphasizes restraint," but the authors went on to say that this model may not be appropriate for BED as affect regulation and family conflict seem to play a strong etiological role (2006, p. 102). Marcus cites numerous studies among individuals with BED that have shown that "as many as 50 percent of BED patients report the onset of binge episodes before any effort to diet or lose weight" (1997, p. 486). Masheb & Grilo (2006) also recognized that dietary restraint theory "has been widely applied to the maintenance of BED"

and express displeasure that restraint theory "posits that negative moods play a secondary role to dieting" as an underlying mechanism for BED (p. 142). Masheb & Grilo bemoaned that dietary restraint has been promoted as primary in the etiology and maintenance of BED, over emotional regulation and dampened exploration of the role emotions play in binge eating (2006).

While the literature seems to have reached consensus that weight and shape concerns lead to caloric deprivation from dieting and restraint, and that both have been associated with binge-eating for individuals with bulimia (Polivy & Herman, 1993; Whiteside et al., 2007), the research specific to individuals with BED shows that dietary restraint is not often the variable that leads to binge eating in BED (Wilson, 2002). In studies of obese or overweight individuals with BED, very small numbers of recounted that they were dieting before they started binge eating (Ochner et al., 2009; Wilson, 2002; Yanovski, 2002) and overweight individuals with BED are no more likely to diet than overweight individuals with BED (Wilson, et al., 1993). Researchers have also consistently established that moderate and severe caloric restriction, or Very Low Calorie Diets (VLCDs), as measured in treatment settings, did not worsen bingeing among obese individuals with BED (Marcus, 1997; Wilson, 2002).

As opposed to dietary restraint, research has more commonly established that it is disinhibition around eating, defined as "loss of control over eating" in response to stimuli (emotions, cognitions, environment), that is strongly associated with binge eating (Yanovski, 2002).

Theory of addiction

The theory of addiction to food as a mechanism for the development and, or, maintenance of BED draws similarities between excess food consumption (binging) and excess use or abuse of drugs or alcohol, as both can be pleasant experiences and can be mapped to similar parts of

the brain that are related to pleasure, craving, reward, and dependence, all in a cycle resulting in addiction (Wilson, 1993). The addiction model for BED "asserts that 'food addiction' results from physiological, biochemical condition of the body that creates cravings for refined carbohydrates and [or] other food substances, such that the patient depends on and is unable to control his or her intake of certain food substances" (von Ramson & Cassin, 2007, p. 3). The addiction theory also compliments the emotional regulation framework for BED, as substances like drugs or alcohol—or food—can be used to regulate emotions and in addictions are accompanied by a loss of sense of control over one's cravings or consumption (Wilson, 1993). Further, addictions can result in impairments in social, physical, and occupational functioning, which Wilson suggests may involve secrecy or denial (Wilson, 1993, p. 97). Severe BED can resemble an addiction in that individuals with BED "often spend a great deal of time engaging in behaviors related to their eating disorder, recovering from its effects, or engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations" (von Ramson & Cassin, 2007, p. 17). The addiction model is the underlying rationale for treatment of BED through 12-Step programs for overeating such as Overeaters Anonymous (designed to model Alcoholics Anonymous) (Wilson, 1993).

Parallels between substance abuse and food withstanding, the addiction theory for BED can be a controversial perspective. Fairburn referred to the addiction model as a "myth" and argued that "only superficial similarities exist between binge eating and substance abuse" (1995, p. 108). Von Ramson and Cassin, among other, asserted that "the validity of the addiction model of eating disorders has received little empirical study" (2007, p. 1). Wilson argued against the addiction model, saying that the behavioral characteristics that are similar between binge eating

and substance addiction are not unique in their overlap, but fall under a more general category of "automatic actions" involving stimulus triggers that are difficult to overcome (1993, p. 98).

There are a number of specific arguments made against the addiction construct. Wilson also argued that the central addiction concept of tolerance—conditioned responses in which an addict builds a tolerance to the substance—does not carry over to food tolerance (1993, pp. 98-99). Several BED researchers also have argued that the concepts of physical dependence and withdrawal in an addiction model also do not translate into binge addiction or food addiction (von Ramson & Cassin, 2007). Further separating food and other substances (alcohol/drugs), the primary way to cope with dependence to substances is typically to abstain from them, but food is unlike drugs or alcohol as it is necessary to live (Gearhardt et al., 2012). Additionally, a central treatment component to interrupting bingeing, in a CBT model, is to have individuals learn "moderation" by taking regular and predictable meals, without rigid abstention from particular foods and without extreme caloric restriction (von Ramson & Cassin, 2007; Wilson, 1993).

Research to establish support for the addiction model for BED seems to be in earlier stages of development than the other two theories discussed in this section. Gearhardt et al. (2012) conducted a study to measure "food addiction" among obese individuals with BED (seeking weight loss treatment) using the Yale Food Addiction Scale (YFAS). The YFAS (developed by Gearhardt and colleagues) measures food addiction symptoms to high fat/sugar foods and "translates the substance abuse dependence diagnostic criteria outlined in the DSM-IV-TR to apply to eating behavior" (Gearhardt et al., 2012, p. 657). The researchers found overlap between BED and food addiction among roughly half of the study participants (N=81). They also discovered that those with BED who had higher food addiction scores appeared to

"suffer from greater eating disorder psychopathology and associated difficulties with negative affect and emotional dysregulation" than those with lower scores (Gearhardt et al., 2012, p. 661).

The theoretical framework from which clinicians (and researchers) approach the development and maintenance of BED is not inconsequential. Von Ramson and Cassin (2007) pointed out the danger in the lack of evidence to support an addictions theoretical framework, and a field of community health professionals who often work from an addictions perspective about eating disorders, citing surveys that have measured "approximately one-third of eating disorder treatment programs and clinicians [using] addictions-based psychotherapies to treat eating disorders" (p. 1).

Current Treatment Approaches for BED

Current treatment methods for BED are quite varied. As a relatively newly recognized phenomenon, even though treatment for BED is available, treatment does not seem yet to be well utilized or easily accessible. In their analysis of the National Comorbidity Survey Replication (NCS-R) data, Hudson et al. determined that less than half of individuals with BED had ever tried to seek treatment for their BED (43.6%) (2007). In Striegel-Moore et al.'s research among women with eating disorders, they found that few women with BED reported having received treatment for their BED, and found this to be especially infrequent among African-American women with BED (2003). Potentially contributing to the low numbers of individuals with BED seeking treatment could be the way they see their problem defined, or how it is defined by health care providers, as primary care providers can often be the first line of action in mental health care screening and referrals. Race could play a role in this as well. In their 2001 study, as part of the New England Women's Health Project which gathered data from across the country from females aged 18-40, Pike et al. reported that white women and African-American women with

BED were equally likely to report having been treated for a weight problem (28.8% and 30.6%, respectively), yet African-American women with BED were significantly less likely to have been treated for an eating problem (7.7%) compared to their white counterparts (22.4%).

Widely accepted treatment approaches for BED currently include psychotherapy, Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Interpersonal therapy (IPT), as well as other treatment modalities or support resources that individuals with BED may utilize, which may or may not include a psychological therapy or support component, such as Overeaters Anonymous or Behavioral Weight Loss (BWL) programs. Pharmacological treatments also exist for BED, but this is not explored in this literature review. From a strictly medical approach, bariatric surgery also called gastric bypass surgery, is commonly utilized by obese individuals who have BED (30 percent of obese individuals seeking bariatric surgery meet BED criteria), but this is also not explored in this literature review because I categorize this as a medical treatment for obesity, not a treatment for BED (Saunders, 1999). Research does highlight the importance of psychological treatment for BED for individuals receiving bariatric surgery, as obese individuals with BED are "likely to retain the eating pathology" after the surgery, and thus, to "have poorer weight loss outcome" as these individuals often report "continued feelings of loss of control when eating small amounts of food" (Niego, Kofman, Weiss, Geliebter, 2007, p. 349). Niego et al. concluded that while the bariatric surgery may "alter the body's physiology, claims that the psychological aspects of binge eating are 'cured' by obesity surgery must be viewed with caution" (2007, p. 349)

Research, via randomized controlled trials, supports the effectiveness of behaviorally-based therapies of CBT and IPT modified to treat BED, especially for individuals with more severe BED (Iacovino et al., 2012). DBT has also been shown to be effective for BED

treatment, but the initial studies require more study to measure its effectiveness for clients in the long-term explore long-term efficacy (Iacovino et al., 2012). CBT stands apart from these other therapy models as the "most studied and well-established psychological treatment for BED" (Iacovino et al., 2012). When group therapy formats of CBT and IPT for BED were compared (study included 62 individuals with BED), both types of treatment were found fairly effective, with 79% of CBT clients abstinent from binge eating, and 73% of IPT clients abstinent after 20 group treatment sessions (Wilfley, et al., 2002). Following up after one year revealed abstinence rates dropped off somewhat, to 59% abstinence for CBT and 62% for IPT (Wilfley, et al., 2002). Studies also have shown CBT to be more effective than a BWL program for individuals with BED (Iacovino et al., 2012). IPT, according to Iacovino et al., is "the only treatment that has shown comparable long-term outcomes to CBT" for treatment of BED individuals. IPT has also been demonstrated to be more effective than BWL treatment (Iacovino et al., 2012, p. 5).

Another common form of CBT is Guided Self-Help CBT (CBTgsh), in which the participant is provided with a self-help manual (such as Fairburn's *Overcoming Binge Eating*, the book which is utilized by the BED treatment program in which I did my recent internship, along with brief but regular therapist meetings (Iacovino et al., 2012). Studies have shown CBTgsh is better than no treatment (via wait-list control) and is more effective than guided self help BWL treatment (Grilo & Masheb, 2005; Iacovino et al., 2012). CBTgsh can be compelling because it can be more accessible, lower in cost, and requires a low level of services from a mental health specialist. Wilson & Fairburn advised that CBTgsh could be a good first step in treatment, especially as the research on treatment effectiveness is still emerging and as "the disorder appears to respond to a wide variety of interventions" (2000).

DBT has also been modified in order to treat BED. In a study comparing DBT treatment completers with a control group, 89 percent of DBT participants (N=22) reported abstinence from binge eating after treatment, compared with only 12.5 percent of the control group (N=22). Yet, researchers found that at a six-month follow-up that abstinence rates dropped to 56 percent for those who had DBT treatment (Telch, Agras, & Linehan, 2001). The primary goal of DBT treatment for BED is to "eliminate binge eating by ameliorating the emotion dysregulation hypothesized to be central in women with BED" which is largely "accomplished by teaching adaptive emotion-regulation skills" (Telch, Agras, Linehan, 2000, p. 574). In another Telch, Agras, & Linehan study of DBT for women with BED conducted in 2000, the researchers found the women had improved in emotional regulation at the end of treatment and surmised that "DBT skills treatment may have enhanced these women's general emotion-regulation abilities as well as specifically targeted the maladaptive urges to eat, overeat, and binge eat in response to negative emotional states" (Telch, Agras, Linehan, 2000, p. 579).

Wilson and Fairburn, in a review of studies on effective psychological treatments for BED, pointed out that the research on the effective treatments for BED are still "at an early stage" (2000, p. 351). They highlighted an important limitation of the scope of much of this research that it is "restricted to those patients who also meet criteria for obesity" and may not apply to the range of BED clients (Wilson & Fairburn, 2000, p. 351).

BWL treatment for BED is the most frequently used treatment for adults with obesity (who overlap with some but not all of individuals with BED), and is the only treatment (excluding surgery) that "has been found to bring about significant weight reduction" (Mitchell et al., 2008). BWL treatment, according to Iacovino et al., "focuses on weight loss through moderate reductions in caloric intake and increased physical activity, rather than targeting binge

eating directly," as it is based on the belief that more structured eating and increased activity can motivate individuals not to binge eat, as will the expected and/or resulting weight loss (2012, p. 5). Yet BWL, Iacovino et al. summarized in their review of BED treatments, is not as effective in reducing binge eating as specialty treatments, including CBT, IPT, and DBT (2012). There is also research which indicates that individuals with BED are perhaps more likely to quit, or drop out of, purely BWL treatment (Wilfley et al., 2003). Wonderlich et al. also reported "accumulating evidence that individuals carrying a BED diagnosis show greater reduction in binge eating and associated psychopathology with specialty treatments that target such psychopathology than with more generic and non-specific weight loss treatment," including BWL (2009, p. 699).

Summary

As the recognition and understanding of BED has evolved over time, the essence and definition of the disorder has not changed much. For the past fifty years, BED had been generally defined as a disorder with the central component of recurrent binge eating (without any compensatory behaviors) which is accompanied by marked distress about the binge. Because BED was first recognized largely among overweight or obese populations (who were seeking help to lose weight), BED has not traditionally been seen as an eating disorder, and it has taken time to evolve into a phenomenon that is now being researched and actively treated by the eating disorder clinical and researcher communities. As a group, individuals with BED often have a higher body weight, as compared to those diagnosed with anorexia, bulimia, or EDNOS, which can serve to lower awareness and acceptance of BED as an eating disorder—a term which often connotes someone being very thin, or underweight. That withstanding, many elements central to the definitional understanding of an eating disorder hold true for BED, including disordered

patterns of eating that contribute to functional impairments and social and emotional distress, as well as overvaluation of one's body shape and weight. Due to BED's relative newness, treatment approaches for the disorder and evidence for their effectiveness are still being developed. The primary theories about the etiological development and underlying mechanisms for BED have also evolved over time along with the research and understanding of BED. The research-based evidence is most substantial for the negative affect and emotional regulation theory of BED.

CHAPTER IV

Self Psychology and Binge Eating Disorder

This chapter examines Binge Eating Disorder (BED) through the perspective of the theory of self psychology, a contemporary theory that is part of the broader category of psychodynamic theory. This chapter describes how self psychology fits within psychodynamic theory as well as how it stands apart, and explores the key concepts of self psychology. This chapter then investigates how the phenomenon of BED can be conceptualized through a self psychology lens. Finally, the chapter explores some implications a self psychology perspective could have for treatment approaches and interventions when working with individuals with BED.

Psychodynamic Theory

Psychodynamic theory encompasses a number of theories that are connected by their shared aim to understand humans and human behavior through examining the "psychological forces," or dynamics, and contends that these forces are key players "in the mysterious internal world that governs human behavior" (Berzoff, Melano Flanagan, & Hertz, 2008, p. 4).

Psychological dynamics, as defined by contemporary psychodynamically-oriented psychiatrist Irvin Yalom, are psychological forces within a person that are in conflict (1998, p. 171). These forces, or dynamics, can be explained as "inner energies that motivate, dominate, and control people's behavior" and the energies can both be "based in past experiences and present reality" (Berzoff et al., 2008, p. 5). Berzoff et al. also called upon *Webster's Third International Dictionary's* (1963) definition of psychodynamic, in which Webster's described the theory as

concerned with "the science of dealing with the laws of mental action" and "motivational forces, especially unconscious motives, and relating to or concerned with mental or emotional forces or processes developing especially in early childhood and their effects on behavior or mental states" (as cited in Berzoff et al., 2008, p. 5).

Acknowledging Sigmund Freud as the founder of this "dynamic model of mental functioning," Yalom described Freud's belief that thoughts, feelings, and behaviors—both "adaptive and psychopathological"—are "the resultants of these conflicting forces" or dynamics (1998, p. 171). These internal, conflicting forces are not always realized by the individual, but "exist at varying levels of awareness; some, indeed are entirely unconscious" to the individual experiencing them (Yalom, 1998, p. 171). It follows then, that psychodynamic theories posit that "individuals may be driven by desires or fears that they do not understand, that people may act out conflicts about which they are unaware, or that they may be compelled to enact old relational templates" (Berzoff et al., 2008, p. 2).

Psychotherapy, per Yalom (1998), is simply "a series of the techniques" (p. 169) based on psychodynamic theory which pay heed to the forces within a person which "include the various unconscious and conscious forces, motives, and fears that operate within him or her" (p. 171). Psychodynamic theories and psychodynamically-oriented psychotherapy "do not purport to be all-inclusive; they look through a rather narrow lens deep into an individual's inner psychic world" (Berzoff et al., 2008, p. 2).

As Yalom's (1998) definition of psychodynamic theory referenced, one of the central starting points of psychodynamic theory was Freud's drive-conflict theory describing the internal struggle between intrinsic, naturally-occurring aggressive and libidinal drives or appetites within each individual. Another theory of Freud's offered a structural conceptualization that these

intrinsic drives are expressed in one's id, largely suppressed by one's superego as it follows moral, societal, or personal rules for how one believes one should be, with the conflict between these two structures being managed and compromises being formed by one's ego. An individual may be conscious of some of this conflict and management within one's self, but is also unaware of much of this as it happens below conscious thoughts and feelings (Goodsitt, 1997; Mitchell & Black, 1995). Under Freud's structural theory, the essence and coherence of one's self and identity is largely determined by how these three elements—id, ego, and superego—negotiate conflicts and internal struggles (Goodsitt, 1997). In Freudian formulation, psychopathology or symptoms that are maladaptive for an individual in their environment reflect the ego's attempts to deal with conflict and "imbalance in these necessarily conflictual internal forces" (Mitchell & Black, 1995, p. 149). Drive-conflict theory and structural theory work under the "assumption of the relative intactness of the mind, as opposed to deficits in structure" (Goodsitt, 1997, p. 205). In this way, psychopathology for Freud derives not from the absence of psychological structures, but is portrayed in symptoms that are symbolic expressions of the "intrapsychic conflict between biological aims seeking discharge and culturally influenced constraints against this discharge" (Goodsitt, 1997, p. 205).

Self Psychology in the Context of Psychodynamic Theory

Self psychology, as first articulated by Heinz Kohut in the 1970's, was built on Freudian and other psychodynamic theories, including object relations theory which de-emphasizes an individual's need to satiate a drive, but instead focuses on an individual's need to successfully incorporate accurate representations of self and others/objects in order to feel whole (Goodsitt, 1997; Melano Flanagan, 2008). Yet, self psychology also departed from Freud's view of the self as tortured with internal conflict, and saw the central psychological struggle as one against

isolation, alienation, meaninglessness, and the search to feel an inner vitality, in which one has a sense of adequacy and connection to others (Franz Basch, 1984; Mitchell & Black, 1995). Under his theory of self, Kohut saw humans as motivated more out of developing a sense of self cohesion, relationships, and connections within oneself and others, compared to Freud's theory of conflicting drives as motivation (unconscious motivation). Kohut believed problems derive from how people "experienced themselves *as selves*" in terms of how they perceive and feel about their "self-organization, self-feeling, and self-regard" (Mitchell & Black, 1995, p. 158).

Kohut's self psychology also departed from classic Freudian theory around the nature of clinical interventions and analysis (analysis essentially meaning interpreting what the client says, feels, and does). Classical Freudian analysis called for the psychoanalyst to act neutral, yet with positive regard, during therapy sessions in order to have a blank slate for transference (the clients' feelings toward the therapist) and countertransference (the therapists' feelings toward the client) to take place and for the analyst to provide interpretations to the client around this (Mitchell & Black, 1995). Kohut envisioned clinical interventions making a different use of transference and countertransference, with the therapist moving away from classical interpretations and moving towards purposefully bringing about a transference that met the client's developmental needs in order to help them develop a more cohesive sense of self (Mitchell & Black, 1995).

Heinz Kohut was originally from Vienna (born in 1913), but spent most of his adult life in Chicago, where he was trained in neurology and psychiatry at the University of Chicago (Kohut, 1971; Strozier, 2001). He had a career as a classically trained psychoanalyst, a believer in Freudian theory, and as a practicing psychoanalytic psychiatrist and lecturer at the University of Chicago. In 1971, Kohut published *The Analysis of the Self: A Systematic Approach to the*

Psychoanalytic Treatment of Narcissistic Personality Disorder, as he grew "increasingly dissatisfied with the limitations of a classical approach" of psychoanalysis (Mitchell & Black, 1995, p. 153). Kohut particularly felt that in working with patients with Narcissistic Personality Disorder that a classical, Freudian approach led him to leave out important elements of the patients' experience and made the therapy less-than-successful (Franz Basch, 1984). Kohut then went on to publish more works to establish his theory of self psychology, principally *The Restoration of the Self* and *How Does Analysis Cure?* (Kohut, 1977, 1984).

Freud's theory on libidinal energy was especially problematic for Kohut as he worked with narcissistic clients. Freud posited there was an "inverse relationship between self-love and love of others" because he believed that an individual had a quantitatively limited amount of libidinal energy (or love) to exert inwardly and/or outwardly (Mitchell & Black, 1995, p.156). Kohut did not envision such limits, and instead believed that one can have love for oneself (narcissism) and others without either decreasing (Mitchell & Black, 1995). Kohut believed that an individual could develop his or her own healthy sense of narcissism and at the same time develop successful love relationships with others, and these actually depend on each other for strength, rather than detracting from each other (Mitchell & Black, 1995). Narcissism, under Freudian theory, was a type of maladaptive ego defense, while Kohut began to believe that a healthy form of narcissism was possible and rather than being maladaptive, was important for an individual to have a healthy sense of self. Thus self psychology is well-described as a theory of "the maturation of the self," which encompassed but also "transcended Freud's instinct theory" (Franz Basch, 1984, p. 15).

Through *The Analysis of the Self* and his subsequent works in the 1970's and early 80's, Kohut articulated a new sub-type of psychodynamic theory called, self psychology. Kohut chose

the term self psychology because his theory was largely concerned with how healthy narcissism feeds development and promotes maturation of the self, and explains which elements the self needs to develop and evolve in order to allow an individual to have a sense meaning and vitality in life (Mitchell & Black, 1995; Strozier, 2001). Kohut's theory was thought-provoking for the field of psychoanalysis, and began what Melano Flanagan described as a "revolution" in psychodynamic thinking (2008, p. 183).

Core Theoretical Elements of Self Psychology

Early development of the tripolar self

Kohut's self psychology posits that human beings are "designed to flourish in a certain kind of human environment" (Mitchell & Black, 1995, p. 149). The first crucial stage for that flourishing to take place, Kohut articulated, is in one's early developmental processes in childhood. Kohut believed a child's environment "must in some way provide necessary experiences that allow a child to grow up not only being human but *feeling* human—an energized, connected member of the human community" (Mitchell & Black, 1995, p. 149). Thus, self psychology is based on the theory that psychological difficulties or psychopathology derived from early experiences which deprived the opportunity for one to develop psychic structures that would constitute a coherent sense of self (Goodsitt, 1997; Mitchell & Black, 1995). The result of these immaturities or deficiencies, per Kohut, are "painful experiential states of devitalization—emptiness and numbness; a sense of going through the motions, not feeling alive, and not really living, dysphoria, and tension" (Goodsitt, 1997, p. 206). Kohut's ideal environment under which a child would thrive would include necessary experiences allowing a child to develop a cohesive sense of self that consisted of a three-part, or tripolar, self, including: the Grandiose Self, the Idealized Parent Imago, and the Alter Ego (Kohut, 1971, 1984). To develop these three parts of

the self, a child needs to experience a sense of grandiosity and omnipotence and feel “totally perfect and capable of anything” and needs to see their caregivers “as larger than life and all-powerful” in a positive way (Mitchell & Black, 1995, p. 159). As very few individuals would experience a perfectly optimal environment in childhood to develop one's self, Kohut's theory posited that reparative experiences can allow the self to mature during adulthood (Mitchell & Black, 1995).

Kohut, similar to other psychodynamic thinkers, saw early childhood as a time full of "vitality, an exuberance, an expansiveness, and a personal creativity" and "robust self-regard"—essentially an early narcissistic state—which is often diluted or withered away by adulthood (Mitchell & Black, 1995, p. 159). A child needs to experience this “infantile vitality and robust self-regard,” according to Kohut, in order to mature into a healthy adult that can feel vitality and joy (Mitchell & Black, 1995, p. 159). Through self psychology, Kohut explored what was needed in an individual's psychological developmental process to either maintain this "infantile vitality and robust self-regard" into and through adulthood or how to reconstitute it if it has been disrupted (Mitchell & Black, 1995, p. 159).

Selfobjects & transmuting internalization

Kohut's self psychology posited that the optimal environment for maturation of the self comes through selfobject experiences that meet a child's needs in three primary areas. Through having the selfobject experiences in order to have these three needs met—the need of having someone to idealize, and the need for mirroring, and the need for twinship—the child would have fully developed each corresponding pole of his or her three-part self: the Grandiose self, the Idealized Parent Imago, and the Alter Ego (Kohut 1971, 1984). In self psychology a *selfobject* is "a person or object that fulfills certain needs for an individual that the individual cannot provide

for himself or herself" (Barth, 1991, p. 227) and that in the relationship between the self and the object "there is either a total or a partial lack of differentiation of the self from the other" (White & Weiner, 1986, p. 13). Another definition of selfobject is an "intrapsychic object or function that references the caregiving functions originally provided by caregivers" (Goodsitt, 1997, p. 206). Under Kohut's formulation, these caregiving functions, if provided adequately by the caregiver, can then be internalized by the young child through the "process of structure formation" Kohut called "transmuting internalization" so that the child can gain a realistic view of his or her own capacities and can access these functions as his/her own selfobject when separated from the caregiver (Kohut, 1971, p. 49; see also Goodsitt, 1997; White & Weiner, 1986). Kohut's transmuting internalization happens over time in the child-caregiver relationship, in which a child repeatedly experiences inevitable frustrations, but learns to tolerate the frustration by accessing the supportive caregiver for assistance, and eventually builds an internal structure—or internalizes the function of caregiver—that helped the child tolerate the frustration. Through this process, a selfobject is formed (Mitchell & Black, 1995; White & Weiner, 1986).

Idealized Parent Imago

Per Kohut, idealization is one of the first types of selfobject experiences a child needs to have provided by a caregiver. The idealized selfobject experience can occur when the young child feels helpless and scared, and thus needs to idealize their caregiver as all-powerful and able to protect them. As the child desires to have the power to protect and soothe themselves, he or she begins to identify emotionally with an admired figure (Goodsitt, 1997; Kohut, 1971; Mitchell & Black, 1995). When the child begins to internalize the protecting, good, and soothing emotional functions offered by his or her caregiver, the child develops in Kohut's terminology, an "Idealized Parent Imago" (Kohut, 1971, p. 25; see also White & Weiner, 1986).

Grandiose Self

Second, but actually simultaneous to the development of the Idealized Parent Imago, is the child's need to experience mirroring (to develop the Grandiose Self), which entails having his or her caregiver or admired figure(s) reflect the child's worth and value back to them, or mirroring the child's "archaic but developmentally normal grandiosity" (Goodsitt, 1997, p. 206). Mirroring selfobject experiences require attuned caregivers, Kohut & Wolf (1978) described, "who respond to and confirm the child's innate sense of vigor, greatness, and perfection, who, looking upon him with joy and approval, support the child's expansive states of mind" (as cited in Mitchell & Black, 1995, p. 159). Through adequate mirroring a child cultivates the mirroring selfobjects, and then self functions, needed to have a fully developed Grandiose Self (Kohut, 1971).

Idealization and mirroring are inter-related, or "counterparts," as the frustration of learning the parent is fallible and imperfect (whether the parent unintentionally fails the child or allows the child to try and fail) allows the child to gradually rely on their own capacities to soothe or protect one's self (developing an Idealized Parent Imago) and to strengthen their Grandiose self (Kohut, 1971; White & Weiner, 1986). Kohut argued that an optimal degree of frustration—not too frustrating—in this dynamic learning process was most effective in building the Grandiose Self and Idealized Parent Imago (1971). Kohut described the catalyst of "unavoidable shortcomings of maternal care" as leading to this dynamic when, "the child replaces the previous perfection (a) by establishing a grandiose and exhibitionistic image of the self: the grandiose self; and (b) giving over the previous perfection to an admired, omnipotent (transitional) self-object, the idealized parent imago" (1971, p. 25).

The Alter Ego

The third selfobject experience—which Kohut added to self psychology theory some years after idealization and mirroring—is a child's need for twinship. The twinship selfobject need is essentially the "need for positive recognition" by someone like oneself (White & Weiner, 1986, p. 11). Successful twinship selfobject experiences allow the child to experience the "validation that occurs when another is like oneself and thus reflects oneself" (Goodsitt, 1997, p. 206), which Kohut termed the Alter Ego part of the tri-polar self (Kohut, 1984). The Alter Ego's twinship functions also allow the child to experience someone who shares his or her feelings, enthusiasm, talents and skills and to have a sense of "self-validation", which can be described as "the sense of being understood by someone like oneself" (White & Weiner, 1986, p. 103, 107). Kohut described this original source of twinship as a person "next to whom the child felt alive" (1984, p. 204).

Disorder of the self

With these three selfobject experiences met, an individual can then internalize and access selfobject functions important for a healthy sense of sense or self-organization, which primarily include "the capacity to provide one's own cohesiveness, soothing, vitalization, narcissistic equilibrium (sense of well-being and security), tension regulation, and self-esteem regulation" (Goodsitt, 1997, p. 206). If the caregivers are not responsive in a way that provides these three selfobject experiences, self psychology deems that "the capacities to provide vitalization, cohesion, tension, and self-esteem regulation are relatively deficient, and a disorder of the self results" (Goodsitt, 1997, p. 206).

Self Psychology in Practice: The Therapeutic Relationship

Kohut believed therapists could use the therapeutic relationship as an environment to help the client develop mirroring, idealization, and twinship selfobject experiences, through developing these transferences with the therapist, which can be described as the therapist providing “a needed extension of the patient’s weakened self” (Mitchell & Black, 1995, p. 161). In a therapeutic relationship, Kohut "saw the patient as attempting to reanimate a disrupted developmental process" in terms of attempting to find and access selfobjects to meet their idealizing, mirroring, and twinship needs (Mitchell & Black, 1995, p. 162). Kohut believed that therapy under self psychology should be a reparative experience to rescue the derailed developmental processes all in an attempt to help the client be able to internalize these functions and develop selfobjects that would support a cohesive sense of self. Thus, he believed it was the role of the therapist to provide himself or herself as the object providing the selfobject functions "in lieu of deficient internalization" in childhood (Goodsitt, 1997, p. 206). In this process, the client would experience the therapist, "as a part of oneself, not as a separate human being with his or her own initiatives, interests, or qualities" (Goodsitt, 1997, p. 206).

As referenced earlier in this chapter, this was a radical departure from Freudian psychodynamic interventions, as Kohut de-emphasized and at times discouraged the therapist from making interpretations for a client through using transference or countertransference, but instead emphasized the therapist using transference to intentionally provide him or herself as the selfobject appropriate to the developmental needs of the client—a process Kohut referred to as the "working-through" process (Kohut, 1971). Mitchell and Black describe the process as "articulating how the patient is needing to regard the analyst's function in the transference, openly accepting this need, and empathizing when the patient experiences the analyst's

shortcomings in this role" (Mitchell & Black, 1995, p. 162). With the "ultimate aim of righting a derailed psyche or mobilizing an undeveloped one" self psychological clinical interventions may "emphasize interpretation that moves toward insight, but the content of these interpretations focuses on...previously unmet needs of human connection that are vitalizing or self-enhancing," with some self psychologists arguing that meeting the client's unmet needs "is more important than insight via interpretation" (Goodsitt, 1997, p. 206).

As the client's relationship with the therapist evolves, the goal is for the client to achieve transmuting internalization of the needed selfobject functions. A self psychologically-oriented therapist offers his/her patient "a second chance to believe in and then to internalize a good, reliable selfobject which the patient never had" (White & Weiner, 1986. p.13). In working through these three transference states with the therapist, Kohut believed, clients can "gradually develop a more reliable sense of vitality or well-being" and begin to develop a more substantial, cohesive sense of self (Mitchell & Black, 1995, p. 161).

For Kohut, empathy was a crucial clinical tool for therapists to use in understanding which developmental stage and needs a client presents with, and providing for their heretofore unmet needs. Self psychologically-oriented eating disorder clinician Diane Barth reminded her audience that although "Kohut and his followers did not invent the concept of empathy as a psychotherapeutic tool," they do stand apart in the way they use it in therapy, going beyond building rapport or therapeutic alliance, to using empathy "to understand the patient's experience from the patient's point of view" (Barth, 1991, p. 226). Kohut described this method as *empathic immersion*, by which empathy would be employed as an investigative tool to allow the therapist to put themselves, or immerse themselves, into their client's shoes in order to maximize understanding of the client's perspective and state of mind (Mitchell & Black, 1995; White &

Weiner, 1986). Kohut stressed empathy or empathic attunement as a "necessary precondition to being successfully attuned" in therapy because the immersion allowed the therapist to see the client's world as true or right (White & Weiner, 1986, p. 12). Kohut (1984) described this in the following way:

"If there is one lesson that I have learned during my life as an analyst, it is the lesson that what my patients tell me is likely to be true; that many times when I believed that I was right and my patients were wrong, it turned out, though often only after a prolonged search, that *my* rightness was superficial whereas *their* rightness was profound" (pp. 93-94).

Clinical empathic failures, per self psychology theory, occur when the therapist breaks out of empathic immersion, and fails to provide the selfobject functions in the areas of self in which the client has unmet needs.

Binge Eating Disorder through the Lens of Self Psychology

This next section interprets the phenomenon of Binge Eating Disorder (BED) through the perspective of self psychology theory. In examining BED through a self psychological lens, there are four primary areas in which interpretations fall, including: 1) developmental failures in tripolar self resulting in vulnerability to having the eating disorder; 2) fragmentation of the self being a person's worst fear; 3) symptoms as restorative, or as attempts to restore the fragmentation to a more cohesive sense of self; and 4) the physical body not being integrated into one's self-organization.

Tripolar developmental failures leading to vulnerability to BED

The first area of interpretation contends that the vulnerability to developing BED comes from an individual not having had his or her early selfobject needs met, or because of

"developmental failures in the provision of mirroring, idealizing, and validation (twinship)" (Goodsitt, 1997, p. 209). Unmet needs, due to the early caregiving environment or non-reparative adult environment, lead to an individual being unable to successfully internalize the three selfobject functions, and not fully able to develop the structures needed for a healthy, cohesive sense of self. Tobin offered a specific example of a child who had low self-esteem because she did not have her mirroring and admiration needs met to develop her Grandiose Self (1993). Without this pole developed, Tobin described, "the child's acceptance of realistic ideals and standards is never achieved" and "without realistic modification of early grandiose ideals and standards, self-esteem is out of reach" (1993, p. 298).

Having insufficient selfobjects to draw upon leaves an individual lacking reliable, internal capacities to self-soothe, regulate tension and self-esteem, and provide the self with "vitalization and cohesion" when experiencing powerful negative emotions (Goodsitt, 1997, p. 206), all which can be preconditions or triggers to binge eating as a way to self-soothe or regulate—to defend one from feeling their self is disintegrating (Polivy & Herman, 1993). BED research (as outlined in Chapter III) supports that individuals with BED are more likely to experience negative affect and emotions, and to lack capacity to identify and effectively deal with their negative emotions. Additionally, insufficient selfobjects can play a role in maintaining a binge eating episode or in reinforcing recurrent binging, as individuals with BED may often feel guilt and shame during and after the binge episodes which can lead to a cycle of more binging to self-soothe or to punish oneself.

Further, insufficient selfobjects can result in an unstable sense of self overall, which can result in low self-esteem, low self-worth, and low self-confidence, all contributing to vulnerability to developing an eating disorder (Barth, 1991). This may further feed a general

vulnerability to feeling negative emotions of "devitalization" (including emotions like emptiness, numbness, loneliness, not feeling alive, and dysphoria) which can trigger binge eating or set up an environment that makes one more vulnerable to binge eating (Goodsitt, 1997, p. 206).

Another concept in the area of vulnerability to BED is Kohut's belief that if one of the parts of the tripolar self is weak, or less developed, then the other two poles may grow stronger in order to compensate. Yet, if all three areas of self are weak then the vulnerability for psychopathology is high because the individual will attempt to gratify his or her selfobject needs using methods that are maladaptive (Kohut, 1977). In terms of BED, if an individual has unmet needs in all three areas of self, binge eating can be seen as a way to meet these needs. Potential protective factors against BED could be a sufficiently developed selfobject functions in one or two poles of self, so that the client would not need to rely on bingeing to meet the needs of the weaker pole.

The fact that women make up a disproportionate percentage of individuals with BED, and thus are disproportionately vulnerable to developing BED, deepens the developmental perspective of a self psychological interpretation of BED. As women face particular challenges of living in American society with a thin standard of beauty for women, they are particularly more vulnerable to feeling negative about their bodies, having poorer self-esteem and having a weaker sense of self when their bodies do not meet this standard (Striegel-Moore, 1993). This is the case with many individuals with BED who are overweight. The critical stance on one's body weight or shape takes two forms. First, women are informed by socio-cultural and media messages that their self-worth is highly connected to their body shape and weight; and the weaker one's sense of self and self-worth, the more vulnerable one is to society's and the media's messages promoting the thin beauty standard (Striegel-Moore, 1993). It would seem that the thin

standard of beauty would impact female development most in terms of the grandiose self, which would be filled by the selfobject function of mirroring, followed by Alter Ego/twinship needs. For example, if a young girl or teenage girl receives messages from society or her family that she is not wonderful or special unless her body meets a certain type of shape, her specialness is not being mirrored back to her. She is also not likely to feel well-validated by a peer or "twin" who also probably finds value and worth most in the thin beauty standard.

Fearing fragmentation of the self

The second area of interpretation of BED is the tenet from self psychology that the biggest stressor or underlying fear for an individual is fragmentation of the self (Barth, 1991; Kohut, 1977, 1984). Kohut described this fear of losing one's sense of self as "disintegration anxiety" and as a fear that is not often conscious (Kohut, 1977). Even if a person had his or her developmental selfobject function needs met in childhood, if in adulthood the person's selfobject needs are failing to be met or are endangered, disintegration anxiety will be present. Thus, the individual's main priority will be to achieve a more cohesive sense of self, as self psychology considers the need for self-esteem and basic self-cohesion to be a universal human need (Barth, 1991). Human nature, in a self psychological perspective, is "to strive for self-esteem and for a cohesive, stable sense of self over time and across stressful situations" (Barth, 1991, p. 225).

Thus, through a self psychological interpretation, an individual will prioritize acting to promote their sense of self even if this means doing so through actions or ways of being that are maladaptive or with negative consequences which can contribute to a further weakening of elements of the self, such as weakened self-esteem or self worth. Lacking a cohesive sense of self or strong self-esteem, an individual with BED's binge eating symptoms would be interpreted as attempting to achieve or maintain some more integrated sense of self, as bingeing can help, at

least in the short-term, to provide some relief from anxiety, self-hatred, disorganization, confusion, and feelings of fragmentation (Barth, 1991). In this way, self psychologist Diane Barth argued that bingeing can work to confirm a stable sense of self for an individual even though that sense of self is often quite negative. When feeling strong disintegration anxiety, having a negative sense of self is better for an individual than having no sense of self at all. Barth paraphrases a female, eating disordered client's description of this as, "It's better to hate yourself than not to have a self at all" (1991, p. 225).

Symptoms an attempt to maintain self-cohesion

The third area of self psychological interpretation of BED follows from disintegration anxiety and the reactive motivation to feel less self-fragmentation, which views symptoms as restorative, or as "attempts to restore and or maintain one's self-esteem and self-cohesion" (Barth, 1991, p. 225). In interpreting BED from a self-psychology perspective, the symptoms of BED, which would include frequent bingeing (with a sense of loss of control), accompanied by marked distress about the bingeing, would be interpreted largely under the assumption that the individual is attempting to promote self cohesion. In self psychologist Alan Goodsitt's interpretation, this is someone taking "desperate or emergency measures to restore a sense of vitalization, wholeness, or effectiveness" or meeting their "emergency need to drown out painful self-states" in order to avoid fragmentation (1997, p. 206). The binge itself would be an individual's attempt to achieve a more cohesive sense of self, or to maintain a more integrated sense of self by providing relief when a stressful situation or crisis makes them feel disintegrated. In addition or as an alternative to bringing about relief, the binge can also be interpreted as an effort to "drown out states of overstimulation and/or fragmentation" (Goodsitt, 1983, p. 51). The

marked distress accompanying and/or following the binge could also be interpreted as the self avoiding fragmentation that could come from taking too much comfort from the binge.

Self psychologists' viewing of symptoms as restorative is similar to viewing symptoms as adaptive rather than maladaptive. Barth encouraged an espousal of ego psychologist Heinz Hartmann's view of symptoms as the most adaptive response an individual can create in response to a maladaptive environment (1991). Thus while the main component of BED—frequent binging to the point of discomfort, guilt and distress related to the binging—may be maladaptive from an outsider's perspective as this behavior would appear to cause the individual pain and contribute to weakened cohesion of self, these are adaptive for the individual with BED (Barth, 1991). In this interpretation, binge eating is an individual adapting, or coping, with a stressful, painful, or damaging environment over which he or she feels little control or in which the individual does not have access, or cannot access, any other self-soothing techniques. According to Barth, the damaging symptom (binging) "can also be highly successful method for protecting a damaged self in a frightening world" (1991, p. 226). As BED research (outlined in Chapter III) shows that strong emotions, and usually negative emotions and negative mood, are frequent triggers of a binge for an individual with BED, this would indicate that as negative emotions crest and the self feels the least cohesive or in danger of disintegrating, that binging would be adaptive to help one feel less disintegrated.

A self psychological view sheds some light on resistance or ambivalence to giving up binge eating encountered in some individuals with BED. It puts the ambivalence to giving up binging in the perspective of removing or giving up a method for cohesion, striking close to the fear of disintegration (Barth, 1991). In Barth's words: "no matter how much an individual may

hope that therapy will help her, she will also fear (consciously or unconsciously) that it will disrupt the very sense of herself that her symptoms maintain" (1991, p. 226).

Physical body not integrated into psychic self-organization

The fourth area of a self psychological interpretation of BED comes through considering the meaning of the physical body for an individual with BED, the central role the physical body plays in BED's symptoms, and the body's integration, or non-integration, into one's self organization. The interpretation would be that someone struggling to feel self cohesion and to regulate their self-states, would also lack some control of their body as an entity that is not fully integrated into their psychological self (Caparrotta & Ghaffari, 2006; Goodsitt, 1997). Lacking psychological and bodily self integrity, can lead to a sense of "bodily helplessness" and can make outside stimuli or forces too overwhelming, which can lead to the "out-of-control experiences"—as experienced during the sense of loss of control in a binge eating episode (Caparrotta & Ghaffari, 2006, p. 188). Self psychologist Alan Goodsitt posited that individuals with eating disorders, which would include BED, struggle to feel their physical body as integrated into their self organization (1997). This is a deeply-rooted phenomenon, Goodsitt reasoned, because the "self is at its core a body self," with the beginnings of self at infancy (or the "nucleus of self") consisting first and only of bodily sensations (1997, p. 210). When the physical body is not well-integrated into one's self organization, this can lead to a feeling of disconnectedness and exacerbate feelings of loss of control over the body, as well as one's emotions. Goodsitt contended that the lack of integration between physical and psychic self can result in difficulty dealing with stimuli that come from within the self, including physical sensations such as hunger or fullness or emotions related to these sensations. These sensations, which Goodsitt described as "interoceptive deficits," make it especially difficult for individuals with BED to deal with strong

internal stimuli or emotions, as well as stimuli outside the body, particularly stimuli related to food (1997, p. 210).

Implications for Treatment Interventions for BED from Self Psychological Approach

Two additional aspects of self psychology theory focus on the nature of clinical interventions: the development of selfobject functions through the use of the therapist, and the use of empathy as a clinical tool for achieving the selfobject function development. This section explores how these two aspects of self psychological interventions could apply to individuals with BED.

Development of selfobject functions through use of therapist

First, is the clinical tenet of self psychology that promotes enabling the client to utilize and develop selfobjects through the relationship with the therapist, with the goal of building more self-cohesion and a stronger sense of self (Barth, 1991). Per self psychology this would entail assessing an individual with BED's unmet self needs and which selfobject functions are immaturely developed. The therapist would work with the transference (the client's feelings toward the therapist) in order to provide for the development of the client's self needs—in terms of mirroring the client's worth and feeding their Grandiose self needs, to serve as an idealized parent figure that the client can utilize for the Idealized Parent Imago, and/or to provide twinship and validation for the Alter Ego's self needs. As the therapist provides the consistent input to build the client's mirroring, idealizing, and twinship transferences, the client can begin to internalize these functions as their own selfobjects. Goodsitt describes this as therapists making themselves "available as transitional objects ready to fill the deficits of the patient" (1983, p. 59). The selfobject function needs for someone with an eating disorder such as BED could include

self-soothing or self-esteem regulation, which could include actions or behaviors to boost self-esteem or helping place limits on one's feelings or actions to achieve the same (Barth, 1991).

Once the therapist becomes a successful selfobject, they gradually are less needed by the client (Barth, 1991). As selfobjects are something individuals need their entire lives, Kohut believed that the therapy is curative when it helps the client to discover useful selfobjects and to learn how to employ them and successfully internalize them (Barth, 1991; Kohut, 1984).

Empathy as a tool for developing selfobject functioning

The second tenet is the use of empathy in helping the client utilize the therapist to develop selfobject functions. Kohut promoted empathy as a therapist's primary therapeutic tool (Barth, 1991) because it has the "potential to promote emotional growth in the present" which may have been hindered by early development experiences (Melano Flanagan, 2008, p. 187). The use of empathy, through empathic immersion, emphasizes the importance of the therapist "actively attempting" to understand the patient's experience from the patient's point of view (Barth, 1991, p. 226). Self psychological theory posits that this empathic immersion is central in allowing the client to use the therapist as a selfobject and for the needed idealizing, mirroring, and twinship transferences to develop. An optimal level of empathic engagement is important in this theory, through which the therapist will inevitably fail the client, providing some frustrations, which are needed for the transmuting internalization process to occur. Self psychologist Paul Tolpin contended that optimal empathic engagement was the "indispensable ingredient for the development of a healthy self-organization or for a successful analytic endeavor" (1988, p. 162).

A key technique for staying within empathic immersion and successfully working in the selfobject transference, as described by Diane Barth, is for the therapist to avoid making

"distance-making comments" or "experience-distant" comments (1991, p. 227). These would be comments that are not based in empathic immersion or with the goal of meeting unmet self needs. Kohut seemed to see classical psychoanalytic interpretations as experience-distant. Kohut espoused that when working with a client in early stages of selfobject development—in other words a client who has much ground to cover in having their three selfobject needs met through the transference with the therapist—that classical interpretation of thoughts and symptoms were "not only unnecessary, but destructive" (Mitchell & Black, 1995, p. 162). This was because interpretations "may call attention to the analyst's separateness and thus interfere with the patient's immersion in the developmentally necessary selfobject experience" (Mitchell & Black, 1995, p. 162).

Barth drew parallels between individuals with eating disorders and the clients Kohut described as "hypochondriacal" (or hypochondriacs) (1991). Using self psychology, Kohut did not interpret hypochondriacal clients' constant descriptions or complaints of their somatic symptoms as resistance to their underlying problem, nor was his stance one of viewing the somatic symptoms as maladaptive. Rather, Kohut took the stance of great interest in learning more about the symptoms themselves and considered the somatic complaints as communications from his clients about what their selfobject needs were (Barth, 1991). Barth described Kohut's technique with hypochondriacs as:

"his interest and his understanding of the messages communicated helped his patients develop a sense of safety in the therapeutic relationship, as well as a greater self-awareness; With this, they were able to achieve a greater sense of continuity and self-cohesion over time" (1991, p. 233).

Barth suggested that because individuals with eating disorders, such as BED, often have trouble identifying how they are feeling and articulating those feelings, that pressing them to recall feelings and conduct feelings identification often can be distance-making, and not working in empathic immersion (1991). This, Barth argued, was because it led to clients feeling more distant from the therapist who is not understanding their point of view, leading to feelings of criticism and failure. Barth's alternative was to explore the elements of the binge with the client, exploring things such as specifically what one ate, how much, what they were doing before and after, and where the binge took place. In this stance, the therapist would take great interest and empathically attune oneself in these elements as a way to help seek out—along with the client—what his or her emotions were as related to the precursors of the binge, the binge itself, and the binge's aftermath. Barth described this as focusing on the aspect of the patient's experience that "she *can* talk about rather than one that theory indicates she *should* talk about" (p. 228).

Another role of the empathic immersion, according to Barth, is to help the client be more empathetic toward him or herself. Because individuals with eating disorders, such as BED, are "often highly critical of their own feelings and thoughts" this can interfere with their ability to explore and identify their own thoughts and feelings (Barth, 1991, p. 226). In self psychology, the role of the therapist would be to offer that empathy as a model and help the client identify with the therapist's empathic stance, and thus develop "empathy for their own feelings and needs" (Barth, 1991, p. 227). Goodsitt summarized the self psychologically-oriented therapist's role in working with someone with an eating disorder, such as BED, as the following:

"Instead of criticizing her defensive adaptations, the therapist conveys that there are good reasons for all her behavior, incapacities, and feelings. By doing all this and more, the therapist lends the patient his or her self-organization—his or her capacity to anticipate;

delay gratification; use sound judgment; relate to another person; care for and forgive oneself; regulate tension and moods; and integrate affect, cognitions, and behavior" (1997, p. 219).

Summary

Within this chapter, I reviewed relevant literature on psychodynamic and self psychology, as well as explored a self psychology treatment conceptualization of BED. Using self psychology to examine the phenomenon of BED is revealing as it positions the disorder of BED as a set of symptoms that derive from an individual facing disintegration anxiety and a fragmented sense of self. A self psychological perspective promotes viewing the symptoms of BED, primarily in terms of the bingeing on food, as an attempt to restore or maintain a more cohesive or integrated sense of self, even if the symptoms maintain a negative sense of self. The self psychological perspective also highlights how the environmental and societal influences in an individual's development can contribute to vulnerability to developing BED. It also provides a useful framework for considering how a fragmented psychological self also contributes to an individual with BED's struggle to integrate their physical body into this non-cohesive self. Within this interpretation, self psychology theory provides clinical insights and guidance for how to work with individuals under the goal of restoring a client's sense of self, through empathic immersion and using of the therapist as a selfobject.

In the following chapter, Chapter V, I review the literature on cognitive theory and Cognitive Behavior Therapy in order to explore and interpret Binge Eating Disorder (BED), in terms of understanding it as a disorder and approaches to treatment.

CHAPTER V

Cognitive Theory & Cognitive Behavioral Therapy and Binge Eating Disorder

This chapter utilizes the theory and principles behind cognitive theory and Cognitive Behavioral Therapy (CBT) to explore and interpret Binge Eating Disorder (BED). With the purpose of providing context, this chapter first traces the development of cognitive theory as a theoretical framework and CBT as a therapy which derived from cognitive theory, and then outlines its central principles and clinical stances. This chapter then interprets BED through the lens of cognitive theory and CBT, in terms of understanding it as a disorder and considering potential approaches to treatment.

History & Development of Cognitive Theory

Cognitive theory is a theory about how and why human beings process information and how this processing impacts thoughts and behaviors, and subsequently, one's affect, personality, and sense of self. The theory posits that individuals process information by forming thoughts, or cognitions, that form conceptual representations of how they perceive the world. In cognitive theory, cognitions drive emotions and behavior, and if change in behavior or emotions are desired, then changing one's thoughts is required (Clark, Beck & Alford, 1999; Dowd, 2004). In cognitive theory, the word "cognitions" and "thoughts" are used interchangeably.

Aaron Beck, an American psychiatrist, is recognized as the founder of cognitive therapy (Dowd, 2004). Beck was trained as a psychoanalyst (trained to provide traditional psychodynamic therapy) and he was also a researcher, interested in understanding the roots of

depression. In analyzing his observations of the depressed individuals with which he was working, Beck stumbled upon recurring themes of the depressed individuals holding negative thoughts and beliefs about themselves which were distorted by entrenched, negative patterns in their thinking (Dowd, 2004). From studying these individuals with depression in-depth, Beck developed cognitive therapy in the 1960's and 1970's and he was "the first person to fully develop theories and methods for using cognitive and behavioral interventions for emotional disorders" (Wright, Basco, & Thase, 2006, p. 2). Beck has continued to further develop and refine the theory and related therapeutic techniques to this day (Dowd, 2004).

In addition to Beck, a number of other individuals in the psychological and medical fields also made sizeable contributions to the development of cognitive theory, including most notably Karen Horney, Albert Ellis (an American psychologist who developed Rational Emotive Therapy in the 1960's), Donald Meichenbaum (whose 1970's work was rooted in behaviorism but also recognized individuals had inner dialogues that impacted their behavior), Albert Bandura (who articulated social learning theory in the 1960's), and Judith Beck who has worked to further articulate and develop her father's work (Dowd, 2004).

Development of Cognitive Behavioral Therapy

Though cognitive theory began with an emphasis on thoughts, the concept of behavior played an increasingly larger role as the theory developed further. While cognitive therapy was largely concerned with exploring and changing cognitions in order to improve an individual's psychological symptoms, by 1979 Beck and his colleagues were describing cognitive therapy as also including behavioral therapy to some degree, describing cognitive theory and related therapeutic approach as utilizing "a variety of cognitive and behavioral strategies" (Beck, Rush, Shaw, & Emery, 1979, p. 4). These theorists acknowledged that the behavioral therapy

movement had "contributed substantially to the development of cognitive therapy" (Beck et al., 1979, Preface, iii). Behavioral therapy can be defined as attempting to understand what motivates behavior and designing strategies to directly change one's behavior (with the idea that all behavior is learned and can therefore be unlearned), without much emphasis on an individual's cognitions (Dowd, 2004). In their 1979 work, Beck et al. noted, perhaps with a note of hesitancy, that "cognitive therapy probably reflects gradual changes that have been occurring in the behavioral sciences for many years but have only recently emerged as a major trend" (Preface, i). Beck and his colleagues acknowledged that other writers had been "relabel[ing] our approach as 'cognitive behavior therapy'" because behaviorism had added a number of "new dimensions" to cognitive therapy including its "emphasis on specifying discrete goals, delineating the concrete procedures instrumental for achieving these goals, and providing prompt tangible feedback" to both client and therapist (Beck et al., 1979, Preface iii).

Beck and his colleagues recognized and made room for behavioral aspects emerging in cognitive theory, but also saw the two theories—behaviorism and cognitive theory—as distinct perspectives. Cognitive therapy, Beck et al. explained, "contrasts with behavior therapy in its greater emphasis on the patient's internal (mental) experiences such as thoughts, feelings, wishes, daydreams, and attitudes" (1979, p. 7). At the same time, cognitive theory is based on the belief that investigating and working to shift the patient's dysfunctional ideas could lead to behavior change (Beck et al., 1979). Beck and his colleagues also acknowledged that behavioral psychology was also growing closer to cognitive therapy in that it was also beginning to "emphasize the importance of the patient's cognitions" (1979, p. 9). These theorists reminded therapists, however, that even if a therapist's intervention or technique is largely behavioral in nature, the therapist is still practicing cognitive therapy as long as they are operating from the

cognitive model of conceptualizing the client and the goal is to help change the client's cognitions (Beck et al., 1979). Behavioral interventions used in the cognitive model, "can be regarded as a series of small experiments designed to test the validity of the patient's hypotheses or ideas about himself; as the negative ideas are contraindicated by these 'experiments,' the patient gradually becomes less certain of their validity" (Beck et al., 1979, p. 118). Based on these demonstrations, the ultimate goal of a behavioral intervention in cognitive therapy would be "to produce change in negative attitudes" to help the patient improve (Beck et al., 1979, p. 118). As cognitive therapy gained popularity, it became increasingly integrated with behavioral therapy so that much of what is understood today to be cognitive therapy has evolved into Cognitive Behavioral Therapy (CBT), which aims to modify both cognitions and behaviors (Dowd, 2004).

Development of CBT-Related Models & CBT Models Specific to Eating Disorders

In addition to CBT, many types of therapy derived from cognitive theory and are combinations of cognitive and behavioral therapy, including but not limited to, Dialectical Behavior Therapy (DBT), Rational-Emotive Therapy, Rational Emotive Behavioral Therapy (REBT), and Acceptance and Commitment Therapy (ACT) (Beck et al., 1979; Clark et al., 1999; Wright, et al., 2006). Though cognitive theory informs a range of cognitively and behaviorally-oriented therapies, this chapter focuses on cognitive therapy, and CBT as one of the most prominent derivatives of cognitive theory.

CBT is often referred to as one of the primary evidence-based practices currently utilized in psychotherapy (Wright et al., 2006). In this context, evidence-based practice is defined as a practice on which scientifically-sound studies have been carried out, under which data (evidence) representing client outcomes (for example, improvement in symptoms) have been collected

during the course of a clinician using CBT with a client. Many scientifically-designed studies have measured CBT's impact and repeatedly shown it to be effective in bringing about client improvement, and found it to be more effective than control groups of clients who were on a waiting list and not receiving treatment, or to be more effective than other psychotherapeutic types of treatments for a wide range of mental disorders (Wright et al., 2006).

A number of specialized models of CBT have evolved since Beck first formulated the major tenets of cognitive therapy as a treatment for depression. There are CBT treatment models specifically designed to treat a number of psychological disorders, including eating disorders (Fursland et al., 2012; Murphy, Straebl, Cooper & Fairburn, 2010). There are CBT models specifically for treating Anorexia Nervosa, Bulimia Nervosa, and BED.

In 1993, Christopher Fairburn, Marsha Marcus, and G. Terence Wilson developed a specific model of CBT to treat binge eating and bulimia nervosa, which was modeled off of earlier CBT treatment models for bulimia nervosa (Fairburn, Marcus & Wilson, 1993; Marcus, 1997). Fairburn, a British psychiatrist and eating disorder researcher, also developed a CBT-guided self help (CBT-gsh) treatment for binge eating (intended for individuals who only binge and also for those who take compensatory measures after bingeing). Fairburn's gsh book, *Overcoming Binge Eating*, is commonly used as the basis for CBT-gsh treatment for individuals with BED (Fairburn, 1995). This chapter of my thesis draws largely on CBT designed for binge eating more broadly (and for individuals with BED) as well as Fairburn's CBT-gsh work to interpret the phenomenon of BED from the cognitive-behavioral perspective.

In 2008, Fairburn developed the newest model of CBT specifically for eating disorders, CBT-Enhanced (or CBT-E), which is designed to treat a variety of eating disorders (Fursland et al., 2012; Murphy, et al., 2010). CBT-E is often referred to as a transdiagnostic or multi-

diagnostic treatment approach, as it is designed to treat the multiple diagnoses that currently exist under the broader category of eating disorders, including Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder (Fursland et al., 2012; Murphy et al., 2010). CBT-E is based on the principle of treating eating disorder psychopathology—including body image and overvaluation of body weight—rather than treating the specifics of each eating disorder diagnosis and "includes modules to address certain obstacles to change that are 'external' to the eating disorder, namely clinical perfectionism, low self-esteem, and interpersonal difficulties" (Murphy et al., 2010, p. 616).

Central Principles of Contemporary Cognitive Theory and CBT

This section identifies seven underlying principles of cognitive theory and Cognitive Behavioral Therapy (CBT). The primary principles of cognitive theory include the following: 1) individuals process information from the stimuli in their environment by forming cognitive representations, which assign meaning to the stimuli, and it is from these representations that individuals construct their personal realities; 2) emotions come from how stimuli are evaluated and processed cognitively and are thus, secondary to thoughts; 3) the cognitive representations individuals construct are only approximate representations of reality, and include distortions or errors that can be systematic for individuals; 4) individuals make or assign meaning through a cognitive structure called a schema; 5) individuals also make or assign meaning with another cognitive structure called an automatic thought; and 6) the stress-diathesis model incorporates all of these elements and acknowledges the role stress plays in information processing and the activation of dormant schema. The seventh principle is rooted more solely in CBT, as cognitive theory began to incorporate more and more behavioral components. This principle states that information processing, and resulting cognitions and emotions, guide and impact behavior, and

behavior also has an influence on thoughts and emotions (all while cognitions remain primary over these other elements).

Information processing

The first central principle of cognitive theory is that information from one's internal and external environment is processed through the formation of cognitive representations.

Information processing is defined as the psychic "structures, processes, and products involved in the representation and transformation of meaning based on sensory data derived from the external and internal environment" (Clark et al., 1999, p. 77). In processing information from the environment and stimuli, individuals assign meaning to the stimuli, by "perceiving, assimilating, and elaborating the meaning of our experiences" to form cognitive representations of the stimuli or events in their environment (Clark, et al., 1999, p. 57). Cognitive theory locates information processing as taking place in both the preconscious—at an "unintentional, automatic level"—as well as in conscious states that are "highly effortful," aware, and elaborate (Clark et al., 1999, p. 58).

It is the cognitive structures—one's "conceptualization[s] of an event, person, or experience that provides meaning or understanding to the individual"—that represent what everything in one's environment means (Clark et al., 1999, p. 104). Unlike other mammals who act largely through unconscious reflexes, humans adapt to the environment through forming mental representations, meaning that humans "respond primarily to cognitive representations of the environment rather than to the environment itself" (Clark et al., 1999, pp. 57-58). Thus, cognitive representations, and the structures that come from the representations, are central to how people understand themselves and perceive the rest of the world.

Under cognitive theory, a key function of information processing is to construct an individual's personal reality (Clark et al., 1999). The construction of reality through an individual's information processing system is a creative and synthetic process of deriving meaning from stimuli and events, rather than "simply an act of representing, copying, or coding fixed objects" from the environment (Clark et al., 1999, p. 60). An individual, it is assumed, creates meaning based on: his or her previous experiences; the features of the present content; and the cognitive structures the individual has already developed (which are called schema, to be addressed later in this chapter). Since individuals create their own realities in this conceptualization, the theory acknowledges that there are "multiple personal realities as well as an objective physical reality or context within which the subjective realities interact;" and that all of "these 'realities' are equally valid in the sense that they are part of what exists" (Clark et al., 1999, p. 61).

Emotions deriving from cognitions

In cognitive theory, emotions are defined as, "a subjective state resulting from the appraisal or evaluation of internal or external stimuli" (Beck, 1976, as cited in Clark et al., 1999, p. 77). Thus, the second core principle of cognitive theory is that emotions follow from how external and internal stimuli are processed and are considered secondary to thoughts. Clark et al. described this as cognitions (or thoughts) being primary, while emotions and behaviors are secondary, or happening after cognitions: "Cognition is primary among the various psychological systems (i.e., emotion, behavior) in terms of providing an interpretation of the meaning of the activation of the other systems as a function of adaptation to changing circumstances" (1999, p. 62). The content of the emotion is determined by how our psychic structures evaluate, appraise, and interpret meaning out of information and events. Clark et al.

articulated that the character and intensity of the emotion is determined by the cognitive interpretation of the information from the environment: "The cognitive content or meaning of an event determines the type of emotional experience or psychological disturbance an individual experiences" (1999, p. 62). Yet, cognitive theory does not assert that thoughts directly result in emotions. Instead, cognitions lead an individual to evaluate the "personal significance" of an event and consider how it impact's one's well-being, which then can lead to subjective emotion (Clark et al., 1999, p. 77).

Cognitive distortions

The third core principle of cognitive theory is that cognitive structures are only "approximate" representations of one's experience (Clark et al., 1999, p. 63) and that an individual's cognitive appraisals of a situation are biased, or "involve some degree of inaccuracy or inconsistency" apart from objective, physical reality (Clark et al., 1999, p. 103). Cognitive theory asserts this is so in part because "all human information processing is egocentric and so results in a biased or 'filtered' representation of reality" (Clark et al., 1999, p. 63). Consequently, every individual will interpret "reality" based on their own personality, experiences, and the cognitive structures he or she already has in existence. These biases and filters lead to individuals having "specific tendencies or predispositions to interpret experiences in certain ways" (Clark et al., 1999, p. 60). This can lead to vulnerability to processing errors, or *cognitive distortions* or *cognitive errors*, which Clark et al. defined these as "susceptibilities to reinterpret certain types of experiences in a faulty fashion" (1999, p. 60). Beck et al. described these as "systemic errors" in information processing which work to maintain one's belief in the validity of their negative concepts "despite the presence of contradictory evidence" (1979, p. 14). Wright et al. offered the definition of "characteristic errors in logic" (2006, p. 9).

Beck et al. identified a variety of categories of cognitive errors, or systematic errors in thinking (1979). Other cognitive and CBT theorists have further developed and added to Beck's six original types of systematic errors, but Beck's following six categories remain at the core of contemporary CBT: 1) *arbitrary inference*—"drawing a specific conclusion in the absence of evidence to support the conclusion or when the evidence is contrary to the conclusion"; 2) *selective abstraction* (also called "mental filter" or "ignoring the evidence")—"focusing on detail taken out of context, ignoring other more salient features of the situation and conceptualizing the whole experience on the basis of this fragment" 3) *overgeneralization*—"the pattern of drawing a general rule or conclusion on the basis of one or more isolated incidents and applying the concept across the board to related and unrelated situations;" 4) *magnification and minimization*—"reflected in errors in evaluating the significance or magnitude of an event that are so gross as to constitute a distortion" 5) *personalization*—"proclivity to relate external events to oneself when there is no basis for making such a connection;" 6) *dichotomous thinking*—"the tendency to place all experiences in one of two opposite categories" (Beck et al., 1979, p. 14; see also Wright et al., 2006). Cognitive theory assumes that when individuals are under high stress or experience intense emotions, these biases or cognitive distortions can become even more extreme or dramatic (Clark et al., 1999, p. 104).

Meaning-making structures: Schemas and automatic thoughts

Another underlying principle of cognitive theory includes the theory's two primary meaning-making, or meaning-assignment structures—*schemas* and *automatic thoughts*. Both of these are viewed as cognitive structures in which there is "relatively autonomous information processing" and both are subject to, or products of, cognitive errors in information processing (Wright et al., 2006, p. 7).

Schemas

In this section, I will first discuss schemas in detail and the following section will explore automatic thoughts in-depth.

Defining schemas

Clark et al. defined *schemas* as "the basic elements or building blocks for the internal representation of meaning" and as consistent and "relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experience that are used to organize new information in a meaningful way thereby determining how phenomena are perceived and conceptualized" (1999, p. 79). Beck et al. defined schemas as "stable cognitive patterns" which individuals use in "screening out, differentiating, and coding the stimuli that confront" them (1979, pp. 12-13). Schemas are "hypothetical structures containing the stored representation of meaning," and "are pivotal in guiding the selection, encoding, organization, storage, and retrieval of information," a process which is "imposed on new information entering the cognitive system" (Clark et al., 1999, p. 79). Thus, once a schema is in place, new information gets organized and stored into already-existing structure of the schema. In this way, schemas are "core beliefs that act as templates or underlying rules for information processing" as they allow "humans to screen, filter, code, and assign meaning to information" deriving from the environment or from within oneself (Wright et al., 2006, p. 7). Put another way, schemas "contain internal representations or beliefs" that form the foundations for how people interpret their daily experiences (Clark et al., 1999, p. 81).

Beck et al. described individuals having a variety of schemas, or a "matrix of schemas" through which they "categorize and evaluate" their experiences (1979, p. 13). Schemas generally reside in the sub or pre-consciousness, largely unaware or unaddressed by an individual on a

daily basis (Wright et al., 2006). Core schemas are "enduring principles of thinking" that begin to take root in early childhood and evolve through one's lifetime, influenced by biopsychosocial factors including things such as family, socio-cultural environment, and traumas (Wright et al., 2006, p. 10). This theory of an individual having a set of enduring psychic templates is similar to psychodynamic theoretical concepts of attachment styles and object relation states, in which an individual has a psychic template of how they relate to others and the world which formed in childhood.

Clark et al. outlined two dimensions of schemas: 1) schema structure—how the structure organizes information internally; and 2) schema content—the actual beliefs or information of the schema (1999). Depending on the substance and structure of the schema and the individual's circumstances, the schema's filtering function can be helpful, or adaptive and encouraging of healthy function, while other schema can be unhelpful, negative, or maladaptive (Wright et al., 2006). Because schemas have evolved from one's life experiences and environment, it naturally follows that an individual will hold schemas that reflect or are rooted in both their positive experiences and their negative experiences. Examples of a positive, or adaptive, schema content would be, "I am worthy" or "I am lovable." In contrast, examples of a negative or maladaptive core schema content would be "I am worthless" or "I am unlovable" (Wright et al., 2006). In cognitive behavioral therapy, a central goal of treatment is often "to identify and build up the adaptive schemas while attempting to modify or reduce the influence of maladaptive schemas" (Wright et al., 2006, p. 12).

Schema structure: Activation and permeability

The structure of schemas is important as they play a role in how easily a schema can be activated for an individual, as well as how modifiable a schema is. When a schema is activated,

it increases in prominence as it takes the lead in processing stimuli and information through its template. This is particularly likely to happen when "the content of a situation or experience matches the information" already contained in the schema (Clark et al., 1999, p. 97). An example would be if an individual's schema was "I am ugly" and they got turned down for a second date with a potential romantic partner, this event would be interpreted as matching or confirming the already existing schema. This schema could have been fairly dormant, but was activated by the rejection. Also, the more that schema elements are inter-related to each other, or "tightly-knit," the more easily activated they can be, which could result in a schema "dominating" how all information is processed once activated (Clark et al., 1999, p. 80). It follows that more complex schema—composed of many interrelated elements or beliefs—can have a "greater influence on the information processing system because they are activated by a wider range of stimuli and experiences" (Clark et al., 1999, p. 80). So, the individual who was turned down for the second date could now be interpreting all information and events through the schema of "I am ugly" and because this schema is linked closely to "I am unlovable" this has an even greater influence in how they interpret events. Activated schemas can be "self-perpetuating" and put clients in a "vicious cycle" because, per Clark et al., "activated schemas or modes will tend to dominate the information processing system, thereby making it difficult for other meaning structures to operate" (1999, p. 98).

Another aspect of schema structure is the degree of flexibility or permeability, with a rigid schema consisting of "specific absolutistic ideas or statements" that if impermeable would not be modifiable by information showing the cognitive distortions in the schema (Clark et al., 1999, p. 80). The more rigid and impermeable a schema, thus, the more difficult it can be to change even if "disconfirming information" is offered (Clark et al., 1999, p. 80).

Schema content

In terms of schema content, Clark et al. asserted that the content of schemas are "crucial to determining the type and intensity of our emotional response through its symbolic representation of situations or stimuli" (1999, p. 81). These authors identified three categories of schemas based on their content, including: 1) simple schemas; 2) intermediary beliefs and assumptions; and 3) core beliefs about the self (1999). Simple schemas are not very abstract and would be those "that deal with single objects or very specific ideas in our physical and social world" and these often do not play a major role in psychopathology because "they have minimal relation to personal values or goals" (Clark et al., 1999, p. 82). Secondly, are schemas whose content are more abstract and concern "intermediate beliefs and attitudes" which "often take the form of rules which people use to evaluate themselves, other people, and their experiences" (Clark et al., 1999, p. 82). Clark et al. described that intermediary beliefs often are comprised of conditional rules ("If I do something, than this will happen") or imperative beliefs ("I should do this" or "I must do that") (1999). These can play a role in psychopathology.

Core schemas and self schemas

Lastly, are schemas that are based on and include an individual's core beliefs, which usually refer to beliefs individuals hold about themselves, and are "self-concepts" (Clark et al., 1999). Core belief schemas are often absolute and often have a "positive/negative polarity" (Clark et al., 1999, p. 83). The negative side of the polarity could be something like an individual believing he or she is helpless or ineffective ("I am stupid" or "I am weak") while a positive side of the polarity could be beliefs of effectiveness ("I am smart" or "I am strong") (Clark et al., 1999). An individual would usually have a core belief that was predominantly negative or predominantly positive, but can shift between the two positions depending on the

circumstances. Clark et al. asserted that the core beliefs of self-concept often develop in childhood, and "positive concepts of the core beliefs are acquired as a person matures and proves their efficacy and acceptance by others" (1999, p. 83). Under many circumstances for an individual, one's positive self-concepts or schema "can neutralize the negative self-concepts but when experiencing stress or an adverse life circumstance, the negative polarity of the core beliefs will often emerge" (A. Beck, in press, as cited by Clark et al., 1999, pp. 83-84). Thus, once a negative core belief or schema is activated, it can "dominate the cognitive organization so that they influence the individual's susceptibilities, reactions and behavior" (Clark et al., 1999, p. 84). In this way, the schema can become all-encompassing, dominating all the ways in which the individual processes information and deals with the world (Clark et al., 1999).

One particular sub-type of core schema are self-schemas, which contain "cognitive generalizations about the self, derived from past experience, that organize and guide the processing of self-related information contained in the individual's social experience" (Clark et al., 1999, p. 106). One's self concept—who they think they are—is a "mosaic" of schemas that one uses to represent the many domains of their life (Clark et al., 1999, p. 106). Self-schemas may be quite realistic or they may represent "possible, idealized, or hoped-for views of the self" (Clark et al., 1999, p. 106). One's concept of self draws on many schemas that are often tightly-knit and inter-related, and thus "tend to have a greater effect on behavior and emotion" (Clark et al., p. 106). Self-schemas are maladaptive tend to be "rigidly based on a few primarily external sources of information, whereas healthier self-schemas would be based on more varied and flexible internal sources of information" (Clark et al., 1999, p. 206).

Schema modes

Advanced cognitive theory also conceptualizes schemas as organized into modes.

Cognitive theory posits that inter-related schemas are organized into specific modes, or clusters, in order to deal with particular types of demands (Clark et al., 1999). Clark et al. envisioned three primary modes, which include primal, constructive, and minor modes (1999). Primal modes deal with "immediate or basic issues related to the evolutionarily derived objectives of the organism" including things like safety, self-preservation, procreation, dominance, and sociability (Clark et al., 1999, p. 88). These things are clustered, or connected, as they are linked with an individual's survival and the needs must be met by "a rapid, efficient, and automatic cognitive processing system." This automation can result in efficiency and survival, but it can also lead to over-reactions or under-reactions to the actual demands of the current environment (Clark et al., 1999, p. 89).

Second is the constructive mode, which include schemas "acquired or constructed through life experiences" that work together in clustered modes to "promote productive activities aimed at increasing the vital resources of the individual" (Clark et al., 1999, p. 91). These would include how well we relate to other people, being productive, and "creatively meeting the changing demands of our information," and could include the "capacity for intimacy or romance, effectiveness in interpersonal relations, achievement strivings, sense of personal mastery and effectiveness, creativity, independence, and other adaptive characteristics involving resilience, optimism, and rationality" (Clark et al., 1999, p. 91). Because fulfilling personal goals and expanding one's vital resources are often related to positive emotions, the constructive mode plays an important role in contributing to positive emotions. In the inverse, if an individual experiences strong negative emotions, and their constructive modes are inactive or weak, a

negative affect and related sense of helplessness or lacking efficiency may continue or grow as the schemas are connected through the mode's clustering (Clark et al., 1999).

The third, and final, type of mode are minor mode schemas which largely represent "information related to prosaic activities in our everyday life such as reading, writing, conversing with others, driving a car" and focus "narrowly on the immediate situation" (Clark et al., 1999, p. 92). People develop minor mode schemas as they learn skills and store procedural or operational information that allows them to "move and live adaptively in the [our] immediate environment" (Clark et al., 1999, p. 92). The cognitions from this mode are "under flexible conscious control" in that they are often so operational they can feel automatic but it can easily be made conscious (Clark et al., 1999, p. 92). Eating can, at times, fall under the minor schema mode and other times fall under the primal mode.

Automatic thoughts

Automatic thoughts are the second of the primary meaning-assignment structures within cognitive theory. Automatic thoughts are closely related to schemas and they often derive from schemas. Wright et al. described automatic thoughts as "cognitions that stream rapidly through our minds when we are in the midst of situations (or recalling events)" (2006, p. 7). These thoughts are generally autonomous or at least seem to happen independent from one's intentions as "part of a stream of cognitive processing that is just below the surface of the fully conscious mind" (Wright et al., 2006, p. 7). Thus, automatic thoughts, similar to core schemas, can exist in one's consciousness, but they often pass by without one noticing or subjecting them to "careful rational analysis" (Wright et al., 2006, p. 7). Because automatic thoughts occur largely in the preconscious, cognitive theory contends that these thoughts can be identified and examined in the conscious state if an individual focuses on them (Wright et al., 2006).

When Beck first began to formulate his cognitive theory, it was the phenomenon of negative automatic thoughts that first drew his attention, as he observed his clients having unintended thoughts that seemed to "run parallel to their more reflective thoughts" (Clark et al., 1999, p. 102). He also discovered automatic thoughts to be "transient," "highly specific and discrete," "spontaneous and involuntary," "plausible," "consistent with the individual's current affective state or personality disposition" and to be "a biased representation of reality including the self" (Clark et al., 1999, p. 102). Beck believed that negative automatic thoughts arise when schemas, or modes of schemas are activated (Clark et al., 1999).

Like schemas, automatic thoughts can be adaptive and maladaptive for an individual. They can be adaptive in helping an individual quickly sort, categorize, and react to information from environmental and internal stimuli. This could be something like, "That car looks scary, it is moving fast" or "That salesperson seems phony. The deal he/she is offering is too good to be true." In contrast, automatic thoughts can be maladaptive when they filter information or facts in a way that has harmful impacts on one's emotions or behaviors. Examples of negative automatic thoughts would include: "Of course they won't want to hear what I have to say" or "I always mess up on this task."

Cognitive theory posits that automatic thoughts have a clear connection to, and derive from, core schemas. At the same time, however, automatic thoughts can play a powerful role in reinforcing and expanding core schemas because they are constant and often unexamined (Wright et al., 2006). For much of the work done in CBT, automatic thoughts of most concern are those that are negative thoughts. A goal for CBT is to help clients identify and bring awareness to their negative automatic thoughts, and work to counter or de-emphasize the

negative thoughts with facts or positive, alternative thoughts (Clark et al., 1999; Wright et al., 2006).

Stress-diathesis model

Another key principle of contemporary cognitive theory is the "stress-diathesis" model, which involves both automatic thoughts and core schemas. The stress-diathesis model, posits that stressors (newly occurring or intensified current stressors) in one's life can activate an individual's maladaptive schemas, trigger negative automatic thoughts, which then influence non-automatic cognitions, emotions, and behaviors in ways that are often maladaptive (Clark et al., 1999; Wright et al., 2006, p. 12). Wright et al. described that maladaptive core belief schemas "may lie under the surface and have relatively few negative effects during periods of normality" but at times of stress, especially a trauma or loss, these once dormant schema can "become potent controllers of thinking and behaviors" (2006, p. 174). The newly re-activated schema can be magnified and maintained by negative automatic thoughts, negative emotions, and ineffective behaviors (Wright et al., 2006). Addressing the maladaptive schema is crucial to address in clinical interventions for the short-term, as it can offer an individual symptom relief, but attempting to modify these schema are important for the long-term as they offer "improved resistance to stressors in the future" (Wright et al., 2006, p. 174).

Inter-relatedness of thoughts, emotions, and behaviors

The final key principle introduces behavior as a central aspect to cognitive theory, and is more emphasized in CBT than in cognitive therapy. This principle asserts that cognitive structures or meaning-making structures do not just influence emotions, but also have a deep impact on behavior (Clark et al., 1999). This includes the assumption that cognitions, emotions, and behaviors of individuals are inter-related, with each impacting and influencing each other.

Wright et al. described this principle in two parts: first, "our cognitions have a controlling influence on our emotions and behavior," and second, "how we act or behave can strongly affect our thought patterns and emotions" (2006, p. 1). Contemporary cognitive behavioral theory and practitioners of the therapy often utilize a multi-directional triangular or circular model to describe the inter-relatedness of the three elements of emotions, thoughts, and behaviors (Wright et al., 2006). The inter-relatedness of these three elements can seem to contradict the principle that cognitions or thoughts are primary to behavior and emotions. Yet, in this model the primacy of cognitions can stand while it also allows for emotions and behaviors to have a feedback loop in which they influence cognitive structures.

Wright et al. also emphasized that contemporary CBT practitioners must also take into account other influences on the multi-directional triangular model of thoughts-emotions, behaviors, to include biological and neurological processes, environmental influences, and interpersonal and socio-cultural influences (2006). Clark et al. also encouraged making a "person-environment synthesis" which acknowledges the interaction of personality, environment, and context in how cognitions form in a dynamic process and how they impact emotions and behaviors (1999, p. 78).

Becoming conscious

The processes in the multi-directional, circular model happen both in one's consciousness and in sub-or pre-consciousness. Thus, the ultimate goal of CBT is to bring clients' thoughts into their consciousness, or into a "state of awareness in which decisions can be made on a rational basis" and where clients can attempt to develop more adaptive cognitions that would assist rational decision-making (Wright et al., 2006, p. 7). In bringing cognitions and thinking into conscious awareness, the objective is for thoughts to become less autonomous, and more under

the control or adaptation of the individual, which can then impact behavioral change. For example, a clinician practicing CBT would work with clients to "encourage the development and application of adaptive conscious thought processes such as rational thinking and problem solving" and focus on helping "patients recognize and change pathological thinking" at the level of automatic thoughts and core schemas (Wright et al., 2006, p. 7). Cognitive theory and CBT assume, then, that changing thoughts could also work to change an individual's schema, which Clark et al. asserted is central to achieving change in overall mental functioning and health (1999).

Central Clinical Stances & Techniques of CBT

From a cognitive theoretical standpoint, as well as in practicing Cognitive Behavioral Therapy (CBT), a therapist would initially assess the client by: measuring the client's behaviors, cognitions and emotions relevant to their presenting concern and symptoms; identifying some of the client's automatic thoughts and cognitive distortions; and beginning to hypothesize about the client's core schemas and how these may relate to their automatic thoughts, cognitive errors, emotions, and behaviors per the identified concerns (Wright et al., 2006). Following from the initial assessments, Beck et al. broke down into five parts the therapist's job in cognitive therapy (and this carries for CBT as well), including teaching the client:

"1) to monitor his negative, automatic thoughts; 2) to recognize the connections between cognition, affect, and behavior; 3) to examine the evidence for and against his distorted automatic thought; 4) to substitute more reality-oriented interpretations for these biased cognitions; and 5) to learn to identify and alter the dysfunctional beliefs which predispose him to distort his experiences" (1979, p. 4).

Beck et al. described the ultimate goal of the therapeutic techniques as being "designed to identify, reality-test, and correct distorted conceptualizations and the dysfunctional beliefs (schemas) underlying these cognitions" and to help the client "learn to master problems and situations which he previously considered insuperable by reevaluating and correcting his thinking" (1979, p. 4). In achieving the desired goal, a cognitive therapist would be able to help the client learn to "think and act more realistically and adaptively" about his problems (Beck et al., 1979, p. 4).

There are several clinical stances and techniques central to the practice of CBT and the role of the therapist in CBT which follow from cognitive theory. Many of CBT's techniques are "designed to help patients detect and modify their inner thoughts" that are ineffective, negative or maladaptive for them (Wright et al., 2006, p. 7). While the focus of the techniques for CBT is on helping clients think about their own thinking, CBT and cognitive therapy also give highest priority to developing a solid therapeutic alliance with clients which would include empathy, genuineness, warmth, and unconditional positive regard (Beck et al., 1979; Wright et al., 2006).

Four clinical techniques

The four central clinical techniques or stances for cognitive therapy and CBT include: 1) a problem-oriented and here-and-now focus for the therapy; 2) utilizing an empirical lens collaboratively with the client, through collaborative empiricism; 3) practicing accurate empathy; and 4) the utilization of homework as extended self-therapy and experimentation.

Problem-oriented approach

The first key clinical stance of cognitive therapy and CBT is that it is intended to be focused on the present problem which leads therapeutic interventions to concentrate on providing solutions focused only on the presenting symptoms (or problems) themselves. A problem-

focused stance requires the therapist to provide the client "with symptom relief by translating his major complaints into solvable problems" (Beck et al., 1979, p. 167). This stance leads to the therapist focusing on one or two problems at a time, often the target symptoms, avoiding dealing with problems that are not solvable, and being careful not to veer too far from discussions and interventions unrelated to target symptoms (Beck et al., 1979). Beck et al. contrasted cognitive therapy with psychoanalytic therapy, explaining that cognitive therapy focuses on the "'here and now' problems," as the "major thrust is toward investigating the patient's thinking and feeling during the therapy session and between therapy sessions" rather than giving attention to early childhood recollections (1979, p. 7). As a result of all these factors, a cognitive-behavioral therapist is often considered to be more "active" in interviewing, directing questioning and examination of topics than compared to a therapist with a psychodynamic approach (Beck et al., 1979; Wright et al., 2006).

Collaborative empiricism & the Socratic Approach

Another central clinical stance of CBT is that of empirical investigation combined with collaboration with the client to achieve "collaborative empiricism." Wright et al. described collaborative empiricism as a "highly collaborative process in which there is shared responsibility for setting goals and agendas, giving and receiving feedback" between the therapist and the client, in which problematic thoughts and behaviors are targeted and "scrutinized empirically for validity and utility" (2006, p. 30). Engaging in empirical investigation, Beck et al. articulated, is almost an experimental stance, as the therapist investigates the client's automatic thoughts, cognitions and assumptions, and then "formulates the patient's dysfunctional ideas and beliefs about himself, his experiences, and his future into hypotheses and then attempts to test the validity of these hypotheses in a systematic way" with

the client (1979, p. 7). In this way, nearly every experience can "provide the opportunity for an experiment relevant to the patient's negative views or beliefs" to hopefully show their lack of support in reality (Beck et al., 1979, p. 7). In this stance, the therapist models, and the client learns to use an empirical or investigative lens to "view cognitive distortions and unproductive behavioral patterns" to "reveal opportunities for increased rationality, symptom relief, and improved personal effectiveness" (Wright et al., 2006, p. 30).

Beck et al. emphasized the importance of the collaborative nature of this stance, as the therapist needing to actively work to "engage the patient's participation and collaboration" (Beck et al., 1979, p. 6). The primary goal of collaborative empiricism is for the client to begin to incorporate, or internalize, the therapist's cognitive techniques, particularly in learning and implementing self-questioning to counter some of their conclusions and to move away from "thoughtless thinking" (Beck et al., 1979, p. 5).

The Socratic Approach is a specific CBT technique to assist in employing collaborative empiricism. Socratic questioning involves the therapist helping a client change his or her beliefs by leading them to use their own logic to find a new belief (Wright et al., 2006). It can be used to help clients "stimulate a sense of inquiry" to help them shift from "a fixed, maladaptive view of self and the world to a more inquisitive, flexible and growth-promoting cognitive style" (Wright et al., 2006, p. 187). Socratic questions can "often help clients see inconsistencies in their core beliefs, appreciate the impacts of schemas on emotions and behavior," and help clients see how it does not make logical sense to generalize his or her beliefs across all situations (Wright et al., 2006, p. 187). The Socratic approach is also referred to as guided discovery, which involves the therapist asking "a series of inductive questions to reveal dysfunctional thought patterns or behaviors (Wright et al., 2006, p. 20). This stance also can involve a specific

technique called examining the evidence, which involves therapist and client together "listing evidence for and against the validity of an automatic thought or other cognition, evaluating this evidence, and then working on changing the thought to be consistent with the newfound evidence" (Wright et al., 2006, p. 111). Through collaborative empiricism techniques, cognitive distortions can be identified and attempts can be made to shift the distorted cognitions by introducing alternative thoughts that are more accurate or positive.

Accurate empathy

Another central clinical stance of CBT is the therapist employing "accurate empathy," which Wright et al. described as the therapist placing him or herself in the shoes of the client in order to "sense what he is feeling and thinking while retaining objectivity for sorting out possible distortions, illogical reasoning, or maladaptive behavior that may be contributing to the problem" (2006, p. 28). Accurate empathy, therefore, represents a balance between showing enough personal warmth so as not to seem to distant or removed from the client, but to also be careful not to "overdo" the exhibition of empathy so that the therapist can help the client observe and learn the slight distancing required of an empirical investigation into his or her unhelpful thinking patterns (Beck et al., 1979; Wright et al., 2006). Being overly empathetic toward a painful negative automatic thought or schema, Wright et al. argued, could work to "reinforce negatively distorted cognitions" (2006, p. 29). Further, it could also "mislead the therapist into accepting the veridicality of the patient's automatic negative representation of himself" (Beck et al., 1979, p. 48). The balancing act of accurate empathy involves being "diplomatic in giving constructive feedback" but not avoiding the truth (Wright et al., 2006, p. 29), and questioning to objectively check "the patient's introspections against other sources of information and testing the logic involved in the patient's inferences and conclusions" (Beck et al., 1979, p. 48). Wright

et al. described accurate empathy in CBT as involving "a vigorous search for solutions," achieved by "asking questions that help the patient see new perspectives, instead of simply going along with the flow of a dysfunction stream of thinking" (2006, p. 29).

Homework

The fourth, and final, key clinical technique of CBT is putting behavioral and cognitive change into action, outside of the therapy session. This is often referred to as homework, as it is to be done outside of therapy and reported on in the following therapy session (Wright et al., 2006). Beck et al. described homework as "extended self therapy" (1979). This extended self-therapy could be a range of assignments from the therapist, including clients keeping diaries, tracking automatic thoughts, emotions, and behaviors related to events—often referred to as a thought record, eliciting feedback from others to test the validity of one's thoughts or assumptions, setting up a behavioral experiment to disprove one's assumption or inaccurate predictions, eliciting feedback from others about behaviors or changes the client makes in his or her behavior, and actually working to alter one's behavior and recording those attempts (Beck et al., 1979; Wright et al., 2006).

Binge Eating Disorder through the Cognitive Lens

This next section uses cognitive theory and the perspective of CBT to interpret the phenomenon of Binge Eating Disorder (BED). As a treatment approach for eating disorders such as BED, CBT attempts "to change patients' system of beliefs about themselves and their environment through a semi-structured, problem-oriented method, focusing directly on the patients' dysfunctional beliefs and values concerning their shape and weight" (Fairburn, 1985, as cited in Polivy & Federoff, 1997, p. 463). The primary features of CBT treatment for eating disorders include "helping patients identify circumstances that lead to a loss of control; obtaining

specific changes in eating patterns; and reconsidering distorted beliefs associated with eating, weight, and body shape" (Polivy & Federoff, 1997, p. 463). Marcus (1997) warned that because "initial attempts to understand and treat BED have derived from the work in bulimia nervosa" due to some similarities in symptoms, that clinicians treating individuals with BED should be sure to adapt CBT specifically to the needs of individuals with BED (p. 484).

CBT for BED, as a problem-oriented therapy, focuses on binge eating as the problem and theorizes that "disturbed eating patterns and problematic thoughts and beliefs about eating, shape, and weight contribute to binge eating" (Theim & Wilfley, 2009, p. 192). Thus, under the goal of reducing binge eating, CBT acts on two fronts: first on changing the behaviors of eating and bingeing, and second, on changing the cognitions that contribute to these behaviors that involve food and cognitions about one's self that lead an individual to overvalue his or her weight and body shape.

Behavioral front

On the first front, CBT for BED works behaviorally to replace "chaotic eating patterns characteristic of BED with healthier patterns" (Theim & Wilfley, 2009, p. 192), with the primary goal communicated to clients as "normalization of eating" (Marcus, 1997, p. 487). Working toward normalized eating is important for individuals with BED as these individuals can often "have a general inability to regulate eating behavior both within and between binge episodes," as they tend to "display a pattern of chaotic eating with high levels of consumption at and between meals" (Marcus, 1997, p. 485). CBT acknowledges to clients that they may "feel that food is both their best friend and their worst enemy" but since food is central to everyday life, the task at hand is to normalize their relationship with food and address their maladaptive beliefs about food (Marcus, 1997, p. 487). Weight loss, however, is not a stated goal of the treatment, and clients

are advised to not expect to lose weight, though some patients do lose weight as they learn to limit or cut out binge eating (Marcus, 1997). Clients are strongly encouraged not to diet and to change their thinking to consider dieting (dietary restriction) as problematic, because dieting can provoke "feelings of deprivation" and clients feeling overly hungry, which can trigger binge eating (Theim & Wilfley, 2009, p. 192).

Utilization of the Socratic approach to questioning and collaborative empiricism would be encouraged, as "the Socratic method in therapy operates on the principle that the patient's own insights into her eating are more likely to motivate change than a prescription from the therapist" (Goebel-Fabbri et al., 2003, p. 46). This approach is "recommended to help patients elicit their own dichotomous, or black and white thoughts as they apply to the consumption or restriction of certain foods" (Goebel-Fabbri et al., 2003, p. 46).

Cognitive front

On the second, more cognitively-focused front, CBT takes into account the maladaptive cognitions that individuals with BED have about food, as well as their bodies. In relation to food, the focus is working to change cognitive distortions about food and eating that contribute to the general tendencies of individuals with BED "both to overrestrict and underrestrict" their food intake (Marcus, 1997, p. 487).

In terms of maladaptive thoughts about the body, CBT works to shift "dysfunctional thoughts about the self and the importance of weight and shape" which entails disconnecting one's self-value and body shape/weight (Theim & Wilfley, 2009, p. 192). This would include working to identify automatic negative thoughts clients have about themselves, their bodies, and food, and then working to formulate and identify the range of schema—core belief schema—that these clients hold about themselves, which work to feed the automatic thoughts, emotions, and

behaviors. In working with individuals with BED, the CBT would likely aim to modify the client's "extremely negative views about being overweight," working toward achieving "greater body acceptance" and encouraging cognitions that support healthy weight-control behaviors, such as moderation and self-monitoring (Theim & Wilfley, 2009, p. 192). As with any type of CBT, the goal would be to help clients identify these cognitions through collaborative empiricism, see relationships and consequences of the cognitive distortions, and attempt to change their thinking patterns.

The concept of overvaluation of shape and weight is central in interpreting BED through cognitive theory because overvaluation contributes to many of the symptoms related to BED, including "preoccupation with thoughts about food and eating, weight and shape" and "repeated body checking or avoidance" (an individual avoiding looking at their body or reflections in mirrors), attempts at dietary restraint, and current or past history of "extreme methods of weight control" (Murphy et al., 2010, p. 615). Through a cognitive lens, overvaluation could be interpreted as: 1) a cognitive distortion deriving from faulty information processing in which individuals' thoughts are only approximate representations of reality and filled with biases (cognitive distortions) in terms of how they filter, process, organize, and assign meanings to internal and environmental stimuli; and 2) deriving from schemas, or core beliefs, that individuals hold about themselves. This could look like an individual having a negative self schema related to being overweight (for example, "I am ugly"), or many negative self schema that were interrelated ("I am worthless because I am ugly") and thus easily activated by many events or stimuli. Also, an individual who is overweight would likely encounter any number of events or stimuli on a daily basis that he or she could interpret as slighting, embarrassing, mean, or discriminating. Thus, with a negative core schema of ugliness activated, the individual would

interpret and filter the information they receive to confirm their ugliness and their worthlessness because they connect their body/appearance with their worth.

Schemas & BED

When it comes to BED, one of the most highly activated schemas may likely be one that refers to the self in a negative way. In this way, an individual with BED, "may be perfectly capable of processing information about others in a reasonably realistic fashion, but show a systematic bias to generate negative interpretations with self-reference information because of the dominance of negative self-referent schemas" (Clark et al., 1999, p. 81). Applying a cognitive lens to BED also calls for a therapist to keep in mind that many core beliefs—that seem maladaptive—may have been developed for self-protection, as the client may have developed these to protect her from other painful ideas, struggles, or personal experiences. An example could be, a protective (yet maladaptive) core schema of "I am sad because I am fat" when it may also be that "I am sad because I am unhappy with my relationship with my spouse/feel unloved by a parent," which could be harder things to accept than being "fat."

Part of the cognitive therapeutic interpretation would also involve pointing out and exploring with clients how these self-schema impact them negatively. In their CBT treatment manual for bulimia and binge eating, Fairburn, Marcus & Wilson recommended therapists encourage their BED clients "to expand their definition of self-worth in order to diminish the importance attached to shape and weight" (1993, p. 399). This does not mean therapists should suggest clients like their bodies when they do not, but to instead point out that a self-schema based on "self-contempt" intensifies one's problems, as it increases negative emotions, which encourages poor self-esteem, which worsens feelings of ugliness, which all impact self-efficacy (Fairburn et al., 1993, p. 399).

From the cognitive perspective, the opportunity for change for an individual with BED would be to begin to modify self-contemptuous core schema and to promote schemas that fall within the constructive modes. The more the therapist and client can engage collaboratively to "monitor, evaluate, and reconsider" cognitive distortions and replace them with constructive thoughts, the more these thoughts can help activate "alternative, more constructive modes of thinking," which would include schemas about self-worth and self-efficacy (Clark et al., 1999, p. 103).

Negative automatic thoughts, negative affect, & BED

In another vein, an additional way to interpret BED through cognitive theory would be to explore the relationship between maladaptive schema, negative automatic thoughts, negative emotions, and bingeing. Under this lens, maladaptive core schemas around shape/weight overvaluation would be viewed as fueling negative automatic thoughts, which in turn fuel negative emotions, which research shows are common triggers for bingeing in BED. As BED research supports that individuals with BED are more likely to experience negative affect and emotions, and to lack capacity to identify and effectively deal with these negative emotions (as outlined in Chapter III), an interpretation could be that these individuals have a great deal of negative automatic thoughts and maladaptive self-schema. Clark et al. pointed out that the self-referring thought content of automatic thoughts among BED clients could actually be thematic or similar across individuals with BED, as "a distinct cognitive profile is evident in the automatic thought content associated with different affects and psychological disorders" (1999, p. 103).

The overvaluation of weight and shape can also be articulated by individuals saying they "feel fat." Individuals with ED, and with BED, may equate feeling fat with being fat, a cognitive error of emotional reasoning—in which individuals may feel something and consider it a fact

(Fursland et al., 2012). For someone with BED who may be overweight or obese, the distinction should be made that fat is not actually an emotion, but is a cognition ("I feel fat; I feel bad") that has been triggered by perhaps another negative emotion such as sadness or anxiety or perhaps by unpleasant bodily sensations (sweating, thighs rubbing, feeling uncomfortable in tight clothing) (Fursland et al., 2012).

Three phases of treatment in manualized CBT for BED

In its manualized form, CBT for treating binge eating and CBT-gsh (as articulated in Fairburn's 1995 self-help manual: *Overcoming Binge Eating*) consists of three overarching phases. Each stage should be mastered before clients progress to the next stage (Fairburn, 1995).

Stage one

The first stage of the treatment is both behaviorally and cognitively-oriented. The two primary goals are achieving moderated control over eating and over bingeing behaviors (Polivy & Federoff, 1997; Marcus, 1997).

Self-monitoring

Clients begin by "self-monitoring" or tracking to help "the individual identify and alter disordered eating habits" (Slane & Klump, 2009, p. 214). The tracking consists of clients making a daily, detailed record of their eating—types of food and drink, quantity, and place and time of eating, as well tracking their feelings and thoughts at the time of their eating (Fairburn, 1995). Clients also record any bingeing they engage in as part of this self-monitoring. Consequently, the interventions attempt to link the behaviors with cognitions by having clients track the thoughts and feelings they were having while eating regularly or bingeing during their day and night. Another goal of the monitoring is to begin to show individuals with BED that bingeing does not

have to be an automatic, or "out-of-control" behavior and that they can have other options other than binge eating (Fairburn, 1995, p. 145).

Psychoeducation & nutritional education

Clients also receive psychoeducation about BED and food/eating, as well as general nutritional education during this phase. This entails helping clients adopt "a plan of regular eating," that involves creating a regular schedule for when eating happens (Marcus, 1997, p. 487). A "normalized" eating schedule would usually involve three adequate meals a day, plus two or three planned snacks in between, with the plan to eat every three to four hours to avoid getting overly hungry (Fairburn, 1995). Eating should be based on the pre-determined schedule, and "not by sensations of hunger or other urges to eat" because the stimuli that individuals have depended on to signal hunger have been disturbed by erratic eating—binging and dieting, and for them "the normal mechanisms that control sensations of hunger and fullness" are not yet "a reliable guide for when to eat" (Fairburn, 1995, p. 158). Normal sensations of hunger and fullness will return with normalized eating. According to Fairburn, "introducing this pattern of regular eating displaces binges" and the result should hopefully be that "binge eating that was once frequent now becomes intermittent" (Fairburn, 1995, p. 158). Developing this "normal," regular pattern of eating can clients learn to moderate their food intake, to help prevent or exclude their binging, and to fight tendency for uncontrolled eating aside from binging that is common among individuals with BED (Marcus, 1997).

Distraction or alternative behaviors

At this point in manualized CBT for BED, clients are also coached on how to use "alternative behaviors" to help resist urges to binge eat. The first task in this is for clients to identify automatic thoughts or cognitions that have fed their urge to binge. Then, clients are

coached to have a ready plan or list of activities that are distracting and that "are either incompatible with eating or make eating very difficult" (Fairburn, 1995, p. 172). These would include activities such as showering or bathing, exercising moderately, playing with children, or calling a friend on the phone. This is all intended to help reduce bingeing urges, as well as introducing a healthier pattern of eating (Fairburn, 1995).

Weighing oneself

Beginning to weigh oneself on a weekly basis is also encouraged at this phase (Fairburn, 1995). Fairburn acknowledged to individuals with BED that weighing oneself may be uncomfortable, and that perhaps the individual has struggled with weighing themselves very frequently in the past (for example, weighing themselves daily or multiple times per day). Yet, this behavioral intervention is important to provide the client with objective feedback that—over time—can help to show that normalized eating (three meals a day plus planned snacks) "does not tend to result in weight gain" and that if bingeing is reduced then weight loss could be expected (Fairburn, 1995, p. 161). In addition, many clients are instructed to take up, if they do not already have one, an exercise regime often including walking or biking, dependent on the individual's health and circumstances (Marcus, 1997).

Stage two

The second phase has more of a cognitive emphasis, where treatment focuses on identifying and changing "dysfunctional thoughts, beliefs, and values" (Polivy & Federoff, 1997, p. 463). The focus at this stage is on helping clients identify and modify cognitive distortions, or "maladaptive thoughts about [their] body weight and shape" (Slane & Klump, 2009, p. 214). Primary in this stage is identifying negative automatic thoughts clients have about their weight

and shape, and working to counter these with external information that works to counter their overvaluation of weight/shape and to offer alternative, more positive, self-affirming thoughts.

Cognitive distortions and deeper exploration

The therapist and client would also work to identify cognitive distortions around food, such as: dichotomous thinking in terms of dietary restriction and bingeing—either complete over-control with restriction or losing all control during bingeing (Fairburn, 1995). Individuals with BED may have "forbidden foods" or other stringent beliefs about which foods to restrict or how to restrict them, thus in this stage clients are "instructed that normalization of eating involves learning to say no to food (i.e., binge eating, overeating, chaotic eating) as well as learning to say yes to food (i.e., to healthy and moderate consumption of all foods)" (Marcus, 1997, p. 487). As part of this instruction, clients learn to identify dichotomous, unhelpful cognitions about "good" or "bad" foods and learn to see food itself as less dichotomous (Fairburn, 1995).

Another aspect of identifying problematic ways of thinking encourages clients at this phase to also "consider the "origins of the binge eating problem and the role of family and social factors" (Fairburn, 1995, p. 119). This would include a deeper exploration of triggers for bingeing as well as events and interpersonal situations that can activate maladaptive self-schemas about their worth, their weight/shape, and eating.

Eliminating dieting

There are also several behavioral components of the second phase, in which clients are coached to gradually eliminate any forms of strict dieting in which they may have previously engaged (Fairburn, 1995). CBT for BED identifies three types of dieting: "avoiding eating for long periods of time," "restricting the overall amount of food eaten," and "avoiding certain types of food" which would be addressed by re-introducing previously "forbidden" foods (Fairburn,

1995, p. 190). Clients are reminded that these types of dieting make them vulnerable to binge eating, as the diets are often "governed by highly specific rules that tend to be applied in an all-or-nothing fashion" and that the rules are inevitably broken which can lead to overeating or binging (Fairburn, 1995, p. 190).

Problem solving

In this stage clients also work to develop "skills for dealing with difficulties that might otherwise trigger binges," (Fairburn, 1995, p. 119), which in CBT for BED largely involves coaching clients on problem-solving skills. Problem-solving involves: realizing early when one has a problem, such as detecting an urge to binge eat; correctly identifying the problem, for example one could be having an urge to binge but this is not a reaction to "the true problem," which could be that "that you have nothing to do all evening and you are tired" (Fairburn, 1995, p. 179) considering all the potential behavioral and cognitive solutions and thinking through the implications of each option; and then choosing and acting on the best identified solution.

Stage three

The third, and final, phase incorporates both cognitive and behavioral approaches, working to consolidate and maintain the behavioral and cognitive shifts that have been made in treatment (Polivy & Federoff, 1997, p. 463). This would include continuing to work to counter the maladaptive thoughts and schemas with clients and helping them plan to prevent relapse (Fairburn, 1995; Slane & Klump, 2009).

Summary

Within this chapter I reviewed literature on cognitive theory, cognitive therapy, and CBT and explored a cognitive behavioral treatment model for BED. The chapter outlined the seven underlying principles of cognitive theory, including cognitive distortions, automatic thoughts,

schemas, the role of emotions, and the stress-diathesis model of schema activation. The chapter also discussed the key clinical stances of cognitive therapy (and CBT), as a problem-oriented therapy that employs collaborative empiricism, accurate empathy, and homework to extend therapy outside of the therapy session.

This chapter has discussed the manualized form of guided self-help CBT treatment that is commonly used with individuals with BED. Using cognitive theory and CBT to examine the phenomenon of BED reveals that the current treatment approach in Fairburn's *Overcoming Binge Eating* CBT-guided self help manual is a true blend of cognitive and behavioral interventions. As cognitive therapy and CBT are problem-oriented therapies, they interpret binge eating as the primary problem of BED and position problematic thoughts and beliefs about eating, shape, and weight, and the self, as one of the main contributors to binge eating. It also positions disturbed, irregular eating patterns (through binging and restricting) as the other main, yet behavioral, contributor. Thus cognitive therapy and CBT would first work to change the behaviors of eating and binging, and second, to change the cognitions that contribute to these behaviors that involve food and cognitions that overvalue one's weight and shape in evaluating one's self-worth.

In the following chapter, Chapter VI, I will discuss how the perspectives of cognitive theory and CBT, and the related treatment approaches for BED compare and contrast with a self psychological conceptualization for understanding and treating BED.

CHAPTER VI

Discussion

In this chapter, I will synthesize my review of the literature on Binge Eating Disorder (BED) with my interpretations of the disorder through the theory of self psychology and cognitive theory and Cognitive Behavior Therapy (CBT). To help with this synthesis, I tell the fictional story of Mary, a woman with BED. This story is fiction, which I created based on what is known about typical histories and presentations of individuals with BED through the research and through my own clinical observations. This is *not* a presentation of a real case. I use Mary's story to provide an illustration of a client with BED that I then utilize to explore how the two theories—self psychology and cognitive theory/CBT—can complement each other in interpreting BED and ways the theories differ, for clinicians who may be interested in using both cognitive-behavioral and psychodynamically-oriented theoretical approaches to provide mental health treatment to individuals with BED. This chapter then goes on to discuss the limitations and strengths of the project and the methodology used to synthesize the theories and to explore this topic overall. Finally, this chapter draws from all of these points to discuss the implications these ideas can have on social work practice, specifically for BED psychotherapy treatment programs and clinicians working with individuals with BED.

Summary of the Phenomenon of Binge Eating Disorder

Prior to BED even being recognized as a mental health disorder or included in the DSM, BED has been generally defined as a disorder with recurrent binge eating being the principle

defining component. Binge eating, in relation to BED, is defined as eating substantially more food within a given time period than someone else would in similar circumstances, accompanied by marked distress about the binge, but *without* the binging being accompanied by any compensatory behaviors, such as vomiting, laxatives, diuretics, or over-exercising. Individuals with BED tend to stand apart from those with anorexia and bulimia as they often have a higher body weight, which has served, until recently, to dampen the awareness and acceptance of BED as an eating disorder. Further, because BED was initially recognized largely among overweight or obese populations who were often seeking medical help to lose weight, BED has not until recently been viewed as an eating disorder characterized as a mental disorder.

Researchers have shown that BED also stands apart from other eating disorders in terms of age, gender and race/ethnicity. BED has a later average age of onset than do anorexia and bulimia (Hudson et al., 2007; Pike et al., 2001; Striegel-Moore et al., 2003). Researchers have shown that African-American women, Latinas, and Asian-American women have BED at rates only slightly lower than the overall female population in the United States (Franko, 2007). While BED also impacts more women than men, BED is much more common among men than are anorexia or bulimia (Hudson et al., 2007). These epidemiological differences notwithstanding, many elements central to the definitional understanding of an eating disorder hold true for BED, including preoccupation with food and eating, disordered patterns of eating that contribute to functional impairments and social and emotional distress, preoccupation with body weight, and overvaluation of one's body shape and weight.

Summarizing the etiology of BED, theories regarding the disorder's underlying mechanisms generally fall into three categories, or models. The first theory positions binging as a way to regulate one's emotions or affect, which includes binging as a way to temporarily

relieve negative emotions, but also of bingeing as another ultimate source of negative feelings that can maintain the binge eating. Under this model, individuals with BED are considered less capable than non-disordered individuals in handling any negative emotions, and in identifying their emotions and in regulating their emotions. The second theory positions binge eating as deriving from caloric restriction or dieting, as individuals turn to bingeing when they are unable to sustain caloric restriction. The third model positions binge eating as an addiction, either an addiction to consuming large amounts of any type of food, or addiction to certain elements of food, such as sugar. As eating disorder and BED research has provided evidence in support of and evidence against various aspects of these three models, the models have blended and shifted over time. Using multiple perspectives simultaneously to understand the etiology of BED can be useful, particularly as the theories of dietary restraint and the addiction of underlying mechanisms for BED are too narrow and limited to stand alone. In working with individuals with BED, I believe that gaining an understanding of a client's capacity to identify and regulate their negative emotions should be a central part of examining the etiology of the disorder.

Over the course of the past twenty years, the understanding of BED has evolved within the eating disorder clinical and research communities into being recognized as an eating disorder and into being researched and actively treated as such. Due to BED's relative newness, treatment approaches for the disorder and evidence for their effectiveness are still being developed. Much of the existing efficacy studies have been focused on behaviorally-oriented therapies, largely Cognitive Behavioral Therapy (CBT). CBT, and (Dialectical Behavior Therapy) DBT, to a somewhat lesser extent because there have not been as many studies or few studies measuring the long-term impacts of treatment, have been shown they can be effective in treating BED. The CBT studies, however, utilized CBT protocols that were modeled off of treating bulimia, and

individuals with BED, and their symptoms, differ in many ways from individuals with bulimia (Masheb & Grilo 2000, 2002; Wilson et al., 2007). Empirical evidence exists that also indicates that Interpersonal Psychotherapy (IPT) could be promising in helping individuals with BED (Wilson et al., 2007). Eating disorder researchers have called for these BED evidence-based treatments to be translated into real-world settings, outside of research settings (Iacovino et al., 2012; Wilson et al., 2007).

Additionally, mental health clinicians often use an array of treatment models in treating eating disorders, rather than just choosing one singular model under which to work. A 2007 study of clinicians from across the world found that very few mental health clinicians who specialize in eating disorder treatment—13 percent—reported using only one therapeutic treatment model when treating clients with eating disorders (Tobin, Banker, Weisberg, & Bowers, 2007). In fact Tobin et al.'s research revealed that 98 percent of the clinicians studied used both behavioral and dynamic approaches with their eating disorder clients (2007). (It is important to point out here, though, that Tobin et al. found it problematic that so few eating disorder therapists were not "closely adhering" to the CBT treatment manuals, and instead were practicing with methods that were disconnected from cognitive-behavioral theory.)

Thus, with the intention of helping inform the clinical conversation about treatment selection and application for individuals with BED, and considering how to blend multiple approaches, I have considered BED through two different theoretical perspectives in this thesis—a psychodynamic perspective of self psychology and a cognitive-behavioral-treatment perspective, specifically interpreting BED under the lens of Cognitive Theory and Behavioral Therapy (CBT). In the rest of this chapter, I use the fictionalized story of Mary to assist in

thinking about how one might blend a psychodynamic approach and a more behaviorally-oriented approach, such as CBT.

The Story of Mary

Here I present the story of Mary, who is a fictional character I developed to provide a richer illustration of what the research literature tells us about typical histories and presentations of individuals with BED. This is *not* a presentation of a real case. Mary is a 50 year-old Caucasian woman with Binge-Eating Disorder. Mary weighs 300 pounds, and has a Body Mass Index of 46, which qualifies as obese. Her weight impacts her health: she has high blood pressure, is at high risk for developing diabetes, and is often short of breath after walking short distances, such as into her house from her car. Mary also has advanced arthritis in her knees which causes her considerable pain. Mary's primary care provider will not approve a knee replacement procedure until she loses a significant amount of weight. Mary reports that she often feels judged and treated negatively by health care providers because of her weight.

Mary has had a long history of dieting, and having her weight cycle up, and down, and then back down, from an early age. She went on her first diet when she was 13 years old. She had always felt chubby and bigger than the other girls her age. Her mother was frequently on a diet and was weight conscious, and her brothers made comments and teased her about her weight. Mary's dieting would usually consist of restricting calories and desserts, and for a short-period her weight would decrease. But, Mary would find she was unable to sustain the dieting—as she would feel hungry and deprived all the time.

Since she was about 35 years old, Mary has been binge-eating at least twice per week. Prior to that, Mary would binge once a week or once every two weeks, and overeat much of the time, punctuated by periods (days/weeks) of restriction, and then periods of increasingly more

frequent and larger binging. Much of her substantial weight gain began after age 35. Mary has attempted Weight Watchers (which would be classified as Behavioral Weight Loss treatment), attended Overeaters Anonymous meetings, and more recently has tried the iPhone app of MyFitnessPal, but none of these were effective for her. In her daily eating, Mary is constantly punishing herself whenever she indulges in "treats" or eats too much, as she is constantly reminded by herself and the world around her that she is overweight. She feels the world sees her as lazy, fat, and lacking self-control, and she generally sees herself this way as well, which contributes to her having low-self-esteem. Low self-esteem is common among individuals with BED, as they "tend to evaluate themselves in a negative, self-critical manner," specifically "they exaggerate their weaknesses and minimize their strengths" (Solemani, Ghasemzadeh & Ebrahimnezhad, 2012, p. 1091). This low self-esteem, tends to contribute to further binge eating, as "many individuals end up eating to make themselves feel better or as a form of self-punishment; but people usually end up feeling even worse about themselves after binge eating" (Solemani et al., 2012, p. 1091; also see Mitchell, Devlin, de Zwaan, & Crow, 2008).

By age her late forties, Mary weighed about 280 pounds and she decided to undergo bariatric surgery to help her lose weight. Prior to getting the surgery, the surgeon's office screened her for health and eating behaviors and asked several questions about her mental health, Mary reported that she answered the questions honestly, but she was not screened out of the procedure due to her binge eating (the best practice is for individuals with frequent binge episodes to be screened out because ingesting large amounts of food could harm the stomach, once its size/volume has been altered). Mary lost about 100 pounds following the surgery. Within two years, however, she had gained back the 100 pounds, and in two more years she had gained about another 25 on top of that. In her early 40's Mary had enjoyed walking outside,

especially walking her dogs, but now following her bariatric surgery and regaining the weight she feels too defeated, ashamed, and in pain to take up these activities again. Mary cannot keep up with her grandchildren and struggles to accomplish household chores efficiently because she feels over-tired and her knees are too painful. Mary wants to lose weight, but she sees so many barriers to this that it deflates her sense of self-efficacy. Mary's psychiatrist has also diagnosed her with Major Depressive Disorder (MDD) and she sees the psychiatrist about once every two months, largely to obtain her anti-depressant medication. On and off during her forties, Mary had attended outpatient psychotherapy for her depression.

Food has always been Mary's greatest comfort. Her binges usually occur at home in the evening, after she gets home from work during dinner, or after dinner. Nighttime is the most challenging time for Mary: she often begins with a normal dinner, which then evolves into a full-out binge. Mary binges on different types of foods during a binge, but her top picks are usually sweet breads (raisin toast, doughnuts), pasta, pizza, fried chicken, and salty snacks, like chips, as well as cookies and candy. Her binges often last from half-an-hour to 45 minutes. Occasionally, Mary takes leftover food from an event at work, and eats it at her desk when no one is looking, or takes food to binge on it at home.

Mary has considerable trouble identifying her emotions, but she is able to see general trends—that prior to binging she often feels bored, or tired, or sad/lonely, or stressed about work or family or finances. She feels a loss of control around food, particularly when she begins binging and during the binge. Following the binge she feels bad about herself, shameful, guilty, and full of self-recrimination. Post-binge, she frequently ruminates about how she needs to return to stringent dieting. Mary's shame contributes to her telling very few people in her life about her binge eating. She strongly believes that if she just had enough will-power and was

tough enough on herself that she should be able to stop herself from binge eating. The fact that she cannot make herself stop on her own adds to her guilt, shame, and furthered decreases her self-efficacy about her ability to change her situation.

In terms of Mary's background, she identifies as heterosexual and has had several serious relationships with men earlier in her life, but never partnered or married. She lives alone. Mary has an adult daughter and several grandchildren whom she sees frequently and loves spending time with. Neither Mary nor her daughter have much of a relationship with her daughter's father. When Mary was pregnant with her daughter in her 20's, Mary felt excited to have a child, but also suffered from depression and felt very disconnected from her body while being pregnant and in labor.

Mary has an older brother and two sisters who live in the same area as Mary. Mary's mother also lives near her, but after her parents divorced when she was a teenager Mary largely lost touch with her father. Mary keeps an emotional distance from her siblings and mother. Her family environment was fairly stressful when she was growing up, especially around the divorce, and now her siblings often fight over who is helping out more with their elderly mother, about long-standing grudges, and competition for power in the family. Mary is closest with her younger sister, but she has not revealed her struggles with binge eating to her. Mary often feels judged by her siblings, as she feels she is by far the "fat-est one." Adding to her distance and secrecy, Mary was sexually molested by a male family member when she was in elementary school, and spent much of her childhood and teen years worrying whether she was pregnant, and thought that her stomach always felt large and round related to pregnancy. Mary never revealed the abuse to anyone in her family and it was not something she wanted to reveal now.

Mary works full-time for a small company doing administrative work. She has not been promoted for about ten years at the company, despite her being a competent and diligent worker. She feels she could not even discuss a promotion or raise with her supervisors, as she feels lucky to have a job at all in this economy. She imagines that her employer's only complaint with her would be her time she takes off for medical appointments.

Analysis of Mary's Story through Self Psychology

Applying self psychology to Mary's story would first entail considering the development of Mary's BED through a self psychology lens. It would also include assessing the level of cohesiveness and integration of Mary's sense of self, utilizing self psychology's core principle that building or strengthening an integrated sense of self is the primary goal for treatment and clinical intervention. Per Kohut's original theory, I would analyze Mary's early development for clues on whether she experienced an optimal early childhood environment for maturation of a cohesive self. The optimal environment would have come through Mary having selfobject experiences that would usually have been provided by parents or caregivers (she could not have provided this for herself) and these experiences would have met the needs to fully develop each part of her tripolar, self (Barth, 1991; Goodsitt, 1997). A fully developed tripolar self would consist of three mature poles: the Idealized Parent Imago (needing someone to idealize and get protection from), the Grandiose self (which needs mirroring to reflect one's value or worth), and the Alter Ego (the need for twinship in another like her) (Kohut 1971, 1984). If Mary's early environment was optimal, she would have these three selfobject experiences met, and she could then have internalized and accessed selfobject functions crucial for her to have a healthy sense of sense or self-organization. These functions would have armed Mary with the ability and capacity to provide her own "cohesiveness, soothing, vitalization, narcissistic equilibrium (sense

of well-being and security), tension regulation, and self-esteem regulation" (Goodsitt, 1997, p. 206).

Examining the early development of Mary's tripolar self and her resulting selfobject needs reveals that Mary did not—like most of us do not—have the optimal early childhood environment in order for her to develop a cohesive sense of self. In looking back to Mary's early development, I can see two important things: 1) how Mary's developmental, environmental, and societal environments contributed to her vulnerability to developing BED; and 2) I can begin to conceptualize what type of further psychic development Mary needs either to maintain the selfobject functions she has developed or how to reconstitute or develop aspects that have been disrupted.

Mary needs help in maturing the three parts of her self. In terms of Mary's Idealized Parent Imago, I imagine that because Mary was sexually abused as a young child that she may not have felt her father or mother as all-powerful and able to protect and soothe her, and thus transmuting internalization did not occur for Mary to be able to internalize the protecting and soothing emotional functions as selfobjects for herself. Mary's parents' divorce also may have played a role in disrupting her development of this selfobject. Mary's inability to be able to soothe herself adequately when she experiences distress or intense negative emotions often lead to her binge eating. Mary also feels she is not controlling her eating enough if she even overeats a little bit or had just one "treat," and she is not be able to sit with feeling uncontrolled, (which could be interpreted as feeling disintegrated), and this triggers her binges as well. Food serves as her soothing selfobject, but she cannot control it in order to make it into a protective selfobject.

Mary's very low self-esteem indicates a suffering, or underdeveloped, Grandiose Self. In Mary's childhood and teens, she felt fat and criticized by others for her appearance. She never felt smart in school or "good" at anything in particular. Earlier in Mary's life, she seemed to have looked to external things to reflect her worth back to her because she had not internalized grandiosity as her own selfobject, in which case she could have reflected her own grandiosity to herself. She had looked for activities and people, especially her daughter and grandchildren, that could provide mirroring or things that would reflect her worth back to her. Now, at age 50, and with her depression, Mary has almost seemed to have stopped even seeking external reflections of her self-worth. Mary's poor estimation of her work performance and her reticence to ask for a raise are reflections of this. Her negative body image also seems to be a painful indication of this, as Mary hates her body, her appearance, and links them largely with fatness and pain. She nearly always feels "spat on" by everyone around her and feels she deserves such disdain, as she feels "too fat to be worthy." This feeling of despair also leads her to want to punish herself, and these are also triggers for Mary's binge eating.

In terms of Mary's Alter Ego, and twinship needs, Mary does not have many close friends and had not developed a long-term committed romantic relationship that would have provided the twinship selfobject experiences which could help her have helped her have a sense of the "validation that occurs when another is like oneself and thus reflects oneself" (Goodsitt, 1997, p. 206). Mary's obesity also distances her and makes her feel very different from many of those around her, including her being the "fat-est" one in her family. She also keeps a number of secrets, about which she feels very shameful, including her binge eating and the sexual abuse she endured as a child. This too interferes with the potential twinship experiences she could have had with her sisters, other women, or other individuals with BED. If Mary could participate in

group therapy for BED, she may have the opportunity to have twinship experiences with others with BED in treatment with her. Mary's lack of fully developed selfobject functions in all three areas of her tripolar self and a less-than-cohesive sense of self have made Mary vulnerable to developing BED.

Under the self psychological lens, Mary's greatest, but unconscious, fear would be self-fragmentation (Barth, 1991; Kohut, 1984). Based on this underlying and unconscious disintegration anxiety, Mary's binge eating can be interpreted as restorative, or as her attempting to restore or sustain her self-cohesion (Barth, 1991). Mary prioritizes acting to promote an integrated sense of self for herself, even if this means acting in maladaptive ways or doing things that have negative consequences which lead to even more weakening of elements of herself. Thus, Mary's binge eating can be interpreted as her attempting to achieve or maintain a more integrated, cohesive sense of self, and/or to provide some short-term relief, or "drowning out" of her self-hatred, loneliness, sense of deprivation, confusion, and feelings of fragmentation (Barth, 1991; Goodsitt, 1983). This is the case even as her binging further contributes to and maintains a very negative sense of herself.

On another note, self psychology also provides a useful framework for considering how Mary's fragmented psychic self could also contribute to her interoceptive issues, in which she seems to struggle to feel and understand her own internal stimuli that derive from within her body. Mary, as many individuals with BED often have, does not have normalized hunger and satiety cues—which were put out of whack by her frequent binge eating, but also are contributed to by what seem to be interoceptive issues, in which Mary reports feeling disconnected from her physical body. This was particularly evident during Mary's pregnancy with her daughter and is exacerbated by her severe knee pain—which she deals with by trying to disconnect from her

body altogether. Her childhood sexual abuse also seems like it could play a role in this, and could be a topic to explore in therapy. It would make sense that Mary has trouble figuring out how to make her physical body fit into her psychic self, as the aspects of her psychic self are already poorly integrated.

Using a self psychological approach in treatment interventions for Mary would include utilizing empathy, and empathic immersion, to build the therapeutic relationship so that Mary can develop selfobject functions through using the therapist, all under the goal of helping Mary build a more integrated sense of herself. The relationship between Mary and her therapist will need to allow Mary to attempt to return to some of her disrupted, or derailed, developmental processes so that she can find and access selfobjects that can be reparative and meet her idealizing, mirroring, and twinship needs. The therapeutic relationship would help Mary develop mirroring, idealization, and twinship selfobject experiences, through developing these transferences first with her therapist. The therapist must provide his or her self so that Mary experiences the therapist, as part of herself, and "not as a separate human being with his or her own initiatives, interests, or qualities" (Goodsitt, 1997, p. 206).

Analysis of Mary's Story through Cognitive Theory & Cognitive Behavioral Therapy

Conceptualizing Mary's story through a cognitive/CBT lens

Applying cognitive theory and Cognitive Behavior Therapy (CBT) to Mary's story would include conceptualizing of Mary's BED using the underlying principles of cognitive theory (explained in Chapter V of this thesis), including cognitive distortions, automatic thoughts, schemas, the role of emotions, the stress-diathesis model of schema activation, and including CBT's perspective of multi-directional relationships between cognitions, emotions, and behaviors.

We would begin with conceptualizing how Mary processes information, which entails Mary assigning meaning to internal and external stimuli by forming cognitive representations that interpret the stimuli. Mary's emotions—be they loneliness or self-loathing—largely derive from her cognitions. The cognitive representations that Mary constructs, however, include distortions or errors that impact how she forms the cognitions, as Mary's thoughts are only approximate representations of reality. Many of these distortions in stimuli interpretation are systematic or recur in a similar pattern for Mary, which then become cognitive distortions.

In getting to know Mary under a CBT approach, the therapist would work to identify Mary's cognitive distortions. Some of Mary's more common cognitive distortions, as evident from the description of her case, are *selective abstraction* through which she mentally filters out some of the aspects of a situation, and only focused on one fragment. This usually results in Mary filtering out much about the positive aspects of herself, her body and appearance, her behavior, her job, and her family. Mary also employs *overgeneralization*, in that she sees herself as disgusting or unworthy after binge eating, and she then extends that to think she is disgusting all of the time. She also exhibits a fair amount of *dichotomous thinking*, in which she puts her behavior and attitudes about herself in black and white categories. For example, Mary believes that if she ate one treat then her behavior is all bad and out of control (which could often trigger her binge eating). In this distortion, Mary is either eating only healthy foods and restricting calories, or she is out of control. It follows that Mary also believes that she is either thin, and valuable, or not-thin and worthless. There is little grey area for a more realistic perspective in some of these distortions.

Next, we would explore and identify Mary's automatic thoughts and schemas—her two primary meaning-making cognitive structures. Mary's automatic thoughts are usually happening

"just below the surface of the fully conscious mind" (Wright et al., 2006, p. 7). Mary's automatic thoughts are informed by her cognitive distortions, and in turn, the thoughts can work to reinforce her cognitive distortions. Some of Mary's automatic thoughts would be things like her negative thoughts about her body or her eating, for example thinking, "You are undeserving of that and you should not eat it because you are already fat," after a dessert or "treat."

Following from automatic thoughts, we would then identify Mary's core schemas, which are her core beliefs about herself. Schemas are a critical part Mary's information processing and subsequent cognitions as they are templates for how any new information Mary takes in gets screened or filtered. One of Mary's core schemas is that she was unworthy, undeserving, and essentially unlovable. This schema, seems to be both adaptive and maladaptive for Mary. It is protective in that it provides some degree of protection for Mary from the rather severe degradation and stigmatization she feels from those around her, due to her obesity. In this way, her logic is something like, "If I am, in fact, unlovable and unworthy, then of course everyone finds me so." Then, Mary does not have to be constantly angry or hurt when she receives these messages from others. At the same time, her unlovable and unworthy schema are maladaptive as they feed a realm of cognitive distortions, in which Mary filters out affection from others and other positive input from others about her worth. Also, in finding herself unworthy of love, she cannot muster the self-esteem or self-efficacy to make progress in many areas of her life. The binge eating plays a role in building and maintaining this schema, but also in helping Mary self-soothe. Her unlovable, unworthy schema is complex and tightly-knit, which means it is more easily activated and more connected to other negative core schema, all of which could lead to the negative schema dominating how Mary processes a great deal of information throughout her day.

On a positive note, Mary's unlovable schema have indications of having some permeability, as Mary can allow herself to feel loved by her daughter and grandchild.

Through the lens of CBT, Mary's thoughts, behaviors and emotions would be thought of as tightly connected: Mary's information processing—and resulting cognitions and emotions—guide and impact her behavior, and in turn, her behavior has an influence on her thoughts and emotions. In other words, thoughts and emotions influence Mary's actions, but Mary's actions also strongly impact her thoughts. Employing this model to analyze a scenario of Mary's binge eating could look like the following: Mary is alone after work and thinks about how it is dinnertime. She feels tired from the day, lonely and overwhelmed by being alone and in pain, and unhappy with her body. She thinks, "Here we go again, I will try to make some dinner. Maybe eating some food would make me feel better." She may intend to begin with a regular meal, or intend to binge eat, all while automatic thoughts run through her head about her being fat, not needing to eat at all, and being unworthy in general. Then Mary binge eats, which leads to more feelings of self-recrimination and hatred. These lead to more thoughts that she is not worthy of love and compassion from anyone because she finds herself so disgusting, and this may even lead her to binge eat more. In using this model, other influences must be included such as biological and neurological processes, such as Mary's depression and her medical issues and knee pain, Mary's more introverted personality, environmental influences, as well as inter-personal and socio-cultural influences, which would include her childhood sexual abuse.

What CBT for Mary might look like

As cognitive therapy and CBT are problem-oriented therapies that focus on the problems of the present, a therapist using CBT would interpret Mary's binge eating as the primary problem of focus, or target symptom for change. The therapist would analyze both the cognitive and the

behavioral contributors to the binge eating. The main cognitive contributor to Mary's binge eating would be her "problematic" or distorted thoughts and beliefs about eating, her body shape and weight, and her self-worth. Equally as important would be the behavioral contributors to Mary's BED, which would be her irregular eating patterns—her binging and efforts to restrict. Under a CBT approach, the therapist would first work to change Mary's eating and binging behaviors. Secondly, the therapist would work to change her cognitions that contribute to these behaviors, involving her thoughts about food and about her body that lead to her overvaluing her weight and shape in her evaluation of her sense of self. This is the treatment approach utilized in Fairburn's book, *Overcoming Binge Eating* (which I discuss in detail in Chapter V).

CBT for Mary's BED would also include the therapist utilizing the therapeutic stance of collaborative empiricism and accurate empathy. Collaborative empiricism, for example, could include the therapist using the Socratic approach, or guided discovery, to help Mary identify her automatic thoughts, as well as cognitive distortions. The client-therapist pair would trace what impact these thoughts have on Mary's behavior, particularly her eating and binging. Over time, the therapist would work to shed empirical light onto Mary's core schemas of being unworthy and unlovable. The therapist would also employ accurate empathy, which would entail showing consistent and genuine empathy for Mary's struggles and anguish, particularly her shame, but doing it in a way that is not reinforcing of her maladaptive thoughts and schemas.

Additionally, the therapist would also likely give Mary homework as a tool for extending therapy outside of the clinical setting, which would focus both on behavioral change and changing cognitions. The homework could include activities or exercises intended to have Mary explore or experiment with changing her behavior or cognitions in her daily life. Some of the first homework Mary might complete would be to fill out daily food diary cards—on which she

would track her food intake for the day, her location while eating, and her emotions at the time. She would include binge eating in this tracking. The intent would be to help Mary see connections between her thoughts, emotions, and her eating behavior, as well as to help Mary put her current eating into context to help her see how it compares to normalized eating.

Synthesis of the Two Theories

Clear areas of complementarity: Ways self psychology and CBT blend well

This section discusses areas in which I see self psychology and CBT as clearly complementing each other and as potentially compatible in a clinical setting.

Relationship between tripolar self and core schemas

I see a strong connection between CBT's concept of the core schema and self psychology's tripolar self, in which all three parts of the self need to be fully developed in order for an individual to have an integrated and vital sense of self. Core schemas, or core beliefs about the self, are representations of the self. In synthesizing the two approaches, core schemas could be conceptualized as components that comprise one's tripolar self. In this way, the three poles of the self—and their accompanying needs—can be seen as overarching structures, and then core beliefs about oneself are part of the building blocks of the three aspects of self that. It follows that identifying and working on amplifying adaptive, or positive, core schemas could help develop and improve selfobject functions. Negative or maladaptive schemas could be hindering the development of the three parts of the self. The self psychological approach aims to help develop the three parts of the self, and a CBT approach aims to change core schemas in ways that can assist in maturation of the tripolar self.

A therapist employing both conceptualizations could work to help the client improve their adaptive core schemas and de-emphasize, dampen, and maybe eventually do away with

maladaptive core schema, through self psychological empathic attunement and helping the client internalize needed selfobjects. Amplifying and building up positive, or adaptive, core schemas could help to mitigate or even neutralize negative schemas, and further assist in clients' internalization of selfobject functions. Part of this blending may require seeing that some of the client's core schemas may need to be flexible, or permeable, in order for the client to adapt and adjust to life's circumstances. At the same time, some positive schemas, or aspects of those schemas, may need to be impermeable so that the client can get her selfobject needs met. For example, a positive core schema, such as "I am lovable, worthy and valuable" needs to be rather rigid in order to support the maturation of the Grandiose Self.

Self-esteem

Both theories place importance on the role of self-esteem in improving the client's mental health, and this is particularly important in treating clients with BED, as they often suffer from low self-esteem. Under self psychology, self-esteem is a vital part and by-product of the needs required by the Grandiose Self and Alter Ego. When the Grandiose Self has its mirroring needs met, the client would internalize this mirroring and the mirroring of her value would take the form of self-esteem. Self-esteem is also fed by having the Alter Ego needs of twinship met, as self-esteem and worth can increase when one finds solace in one like oneself. A CBT approach complements this conceptualization, as it provides the opportunity to build a client's self-esteem through addressing self-defacing or negative core schema and automatic thoughts that often work against the client having a healthy self-esteem.

Increasing insight: Bringing things into consciousness

One of the central goals of both self psychology and CBT are to increase a client's insight by bringing aspects of the client's thoughts and emotions into the client's consciousness. Both

theories acknowledge that things happen in one's pre-or sub-conscious and unconscious (though CBT puts little focus on the unconscious), and aim for therapy and the therapeutic relationship to bring these things into consciousness. Under a CBT lens, automatic thoughts happen at times in pre- or sub-conscious, and the therapist, in collaboration with the client, utilize an empirical lens and Socratic approach to unearth, or identify, the automatic thoughts and related emotions so that the client can be consciously aware of them and examine them with rational analysis. Similarly, schemas often live in the domain of the pre- or sub-conscious much of the time and bringing these into consciousness so they can be examined is also an important aspect of CBT. The goal is that when cognitions are brought into a client's conscious awareness, the client can increase her control over her thoughts and can move toward behavioral change.

In the self psychology perspective, as with many psychodynamic theories, unconscious emotions, motivations, and drives play a sizeable role in a client's conscious thoughts, feelings, and behaviors, and, thus, in the client's degree of integration of his or her self. Self psychology utilizes empathic immersion and careful attention to transference and countertransference to help the therapist better understand what may lie in the client's unconscious. The unconscious is also where much of the tripolar self resides. A self psychological approach works to bring aspects of the tripolar self and selfobject functions that need further development into client consciousness.

Interoceptive issues

Both approaches—self psychology and CBT—allow for the assessment and considerations of clients' interoceptive challenges, defined as difficulty feeling and interpreting stimuli or sensations that come from within one's body, especially related to one's stomach and feelings related to hunger and satiety (Goodsitt, 1997). Self psychology provides a useful way to conceptualize of this challenge for clients with BED, while CBT provides some potential behavioral and cognitive restructuring skills for improvement in this area.

A self psychological lens conceptualizes individuals with eating disorders already struggling to feel their physical body as integrated into their self organization, as there a psychic self is rooted in the body and in bodily sensations (Goodsitt, 1997). If one's physical self is not well-integrated into one's self organization, feelings of disconnectedness and lacking control over one's body can result. This can carry over to feeling a lack of emotional control. This conceptualization is useful, but self psychology does not provide much guidance for how to help client's improve their connectedness or increase control over their sensations and emotions. CBT, however, especially through Fairburn's CBT-Guided Self Help manual for binge eating, provides guidance on interventions that can help clients with this, through the behavioral and cognitive interventions related to eating and meals. Specifically, tracking what one eats and one's emotions while eating, as well as tracking binges and associated emotions and triggers can build client insight and help them better have a better sense of their own bodily sensations, and how these relate to other internal and external stimuli.

Areas of overlap: Ways self psychology & CBT could complement each other

This section discusses areas in which self psychology and CBT overlap but not in ways that are obviously complementary. These may be areas where the theories focus on different things or

omit certain things from their perspectives, but these are also areas where I see room for blending the theories in ways that could be beneficial in a therapeutic setting.

Role and timing of behavior change

CBT explicitly includes behavior change in its perspective, and in doing so provides a way for the therapist to directly work to help the client change her behavior, which in the case of BED is to stop binge eating (as well as helping the client change her thoughts—as a way to achieve behavior change). In contrast, self psychology does not include clear guidance for a way that the therapist could help the client achieve behavior change, and it is unclear whether self psychology would espouse such direct or active counseling on how to change one's actions. A self psychological approach would likely have behavior change evolve more indirectly, as an outcome of one developing more mature selfobject functions in each of the three areas of self. If CBT behavioral change methods were possible to employ in empathically attuned ways, adding CBT to self psychology could help clients make progress toward behavior change in ways that are informed by insight development (self psychology), as well as informed by seeing one's cognitive distortions that serve as barriers to behavior change (CBT). Perhaps the behavior change elements of therapy would need to happen later on in the therapeutic relationship, in order to have achieved a solid level of empathic attunement.

Ultimate goal of therapy

The ultimate goal of therapy and path to improving mental health under self psychology is to help the client gain a more cohesive sense of self. CBT aims for clients to achieve an overall more positive viewpoint, self-efficacy, and positive sense of self—measured by behavioral change as well as cognitive changes—as the goal for therapy and improvement in mental health. In this way, the two theories can complement each other in treating BED, as

developing a more positive sense of oneself and feeling more self-efficacious in controlling one's behaviors (and thoughts) would likely complement and help to build a more integrated, vital sense of self. At the same time, CBT's focus on behavior change, especially at the beginning stages of treating BED, could potentially lead to a client feeling a less cohesive sense of self—as it essentially encourages individuals to act in ways that are counter to how they may be feeling or thinking. CBT could also, one might worry, focus narrowly on the binge and eating behaviors, and cognitions associated with those, at the expense of addressing other selfobject function needs which an individual may need to develop further in order to scaffold changes in their binge-related cognitions or behaviors.

Self-efficacy

Both perspectives, in their ultimate views of success for a client, would lead to the client being more self-efficacious, but each perspective has a different timeline for this. In CBT, the approach is to make the client more immediately self-efficacious. This would be done through using the Socratic approach to help the client become more aware of her cognitions, specifically automatic thoughts and cognitive distortions, and to help the client bring about changes in their behavior. In self psychology, the approach is more therapist-dependent, in which the therapist must build and achieve empathic attunement with the client first, and the client must begin to utilize and then internalize the three types of need-fulfillments into their own selfobject functions. One could see how both effective self psychology treatment and effective CBT could build clients' self-efficacy skills and functioning approaches that could translate from improving BED into helping with other diverse mental health problems the clients may face.

Areas of difference: Ways self psychology and CBT could be irreconcilable

This section discusses areas in which self psychology and CBT stand apart in ways that could pose problems in attempts to blend the theories in a therapeutic setting.

Therapeutic stance

One way the two theoretical approaches prove to be relatively far apart is their differences in terms of therapeutic stance. Under CBT, the therapeutic stance is one of empirical investigation, in collaboration with the client, described as "collaborative empiricism." In this, almost an experimental stance is required on the part of the clinician, in which the therapist investigates the client's automatic thoughts, cognitions and assumptions, brings unproductive (or productive) patterns to the clients awareness and then engages in the Socratic approach or guided discovery—helping the client use their own logic and reasoning—to demonstrate to the client inconsistencies in her self-thoughts or how her cognitive distortions are not valid or rational. The primary goal of collaborative empiricism is for the client to begin to incorporate the therapist's cognitive techniques for themselves, particularly in learning and implementing self-questioning to counter some of their conclusions (Beck et al., 1979). Thus, under a CBT approach, the therapist is in a powerful position of being the only one who can see and determine what is rational, valid, and "true." The therapist then serves as a Socratic guide to help the client learn this.

The CBT therapeutic stance is quite different from the self psychological therapeutic stance in ways that do not seem to complement CBT. Self psychology requires full empathic immersion in the therapeutic stance, which would have the therapist use empathy to fully understand the patient's point of view, allowing the patient to almost be the expert on their perspective or problem, and require the clinician to truly understand the client's truth.

These two stances seem to be different, to the point of almost being contradictory. While CBT requires the therapist to hold the "truth" and to impart this truth to the client—largely through modeling and collaboration, self psychology positions the client holding the truth and almost puts the therapist in the dark, giving the therapist the task to fully understand the client's perspective. Specifically in treating an individual with BED, the role of empathic immersion sounds particularly important, as it would help the therapist avoid making the "distance-making" or "experience-distant" comments, which can be particularly unhelpful with eating disordered clients (Barth, 1991). Such comments could call attention to the therapist's separation from the client and interfere with immersion. Barth suggested that because individuals with eating disorders, such as BED, often have trouble identifying how they are feeling and articulating those feelings, that pressing them to recall and identify their feelings can be distance-making as it could lead not just to clients feeling the therapist is not understanding their point of view, but also resulting in feelings of criticism and failure (1991).

This is not to say that empathy is not a part of the CBT therapeutic stance, but in CBT empathy must be applied accurately. "Accurate empathy," does ask the therapist to see the situation from the client's perspective but only in order to get a better sense of the client's thoughts and feelings. While doing this, the therapist must remain objective so that they can keep an eye out for the client's potential cognitive distortions, illogical reasoning, or maladaptive behavior. Accurate empathy involves a balance between showing enough personal warmth and empathy so as not to seem to distant or removed from the client, but to also be careful not to "overdo" the exhibition of warmth and empathy because this could work to reinforce maladaptive schema or cognitive distortions.

Problem-focus

One aspect of CBT being a problem-focused therapy is that under this approach the clinical relationship and the intervention are focused on translating the clients' concerns or complaints into a problem that the client (and the therapist) can perceive of as "solvable" (Beck et al., 1979). The problem-focus, then, also entails keeping therapeutic discussions and interventions from veering too far from target symptoms, or the solvable problems. As we could imagine in Mary's story, this could result in a therapist utilizing CBT to focus on one or two problems that are her target symptoms—reducing binge eating, improving normal eating patterns, or reducing Mary's negative thoughts about her body—and avoiding focusing on problems that seem "un-solvable."

In contrast, a self psychological approach, would not necessarily frame a client's complaints into problems, and then only address complaints that could be translated into solvable problems. Instead a client's complaints would be met with curiosity (not to say that curiosity is not present or encouraged in CBT's Socratic approach), engaged in with full empathic attunement on the part of the therapist, and explored in terms of how this complaint plays a role in the client's tripolar self, their selfobject function needs, and the role this issue plays in the client's overall integration of their sense of self. For example, Mary's childhood sexual abuse could potentially be at high-risk for not being addressed in CBT therapy focused on treating her BED. This may not be the case, as a clinician practicing CBT could frame the childhood sexual abuse as the problem contributing to Mary feeling guilty or angry at her family, and the treatment could be focused around reducing the guilt or anger, or to boost Mary's low self-esteem as a result of the sexual abuse. But, in CBT treatment for BED, especially in a group

therapy setting, the ramifications from the sexual abuse could likely not be considered targeted symptoms to treat for BED.

Length of Treatment

Another realistic consideration is the issue of how much time is allotted, or needed for treatment of BED under self psychology versus the time needed under CBT. In my work to apply a self psychology conceptualization in the eating disorder clinic, with those with BED and those with other forms of eating disorders, I found that the timeline oriented to the CBT and DBT-oriented treatment—which was on average about five to six weeks—was a bit of a barrier to utilizing self psychology in treatment in its brevity. I found I could use self psychology to conceptualize the cases, but that the treatment timeline felt too short to achieve empathic attunement and to provide the selfobject functions needed by BED clients to help them fully develop their own selfobject functioning to develop needed aspects of their tripolar self.

Summary of the Synthesis

Overall, I was mildly surprised by how complementary I found self psychology and cognitive theory/CBT to be in terms of conceptualizing BED and in potential clinical implementations. As I discuss in the next section, in which I explore the role of my personal perspectives in this study, I have been in a position of working with individuals with BED in which I see the strengths of both theoretical approaches, but was often at a loss for how the two could be blended, or even if this would be appropriate. In conducting this analysis and synthesizing the two theories, I have found places where one theory might be useful to emphasize at different points in time. I have also found ways that aspects of one theory could be a building block, or component, for elements of the other theory. I have been able to shift my thinking somewhat, from tending to focus on the perceived resistance to blending

psychodynamic theory and cognitive-behavioral theories among the clinical and academic environments, to seeing great opportunity to this blending. I am also encouraged, and assuaged, by information that very few mental health clinicians work solely under one treatment model when working with clients.

In Wagner & Reinecker's (2003) theoretical and anthropological considerations of both behavioral and cognitive therapies, as well as Cognitive Behavioral Therapy (CBT), the authors concluded that no one treatment method or theory can be ubiquitous. Wagner & Reinecker reminded therapists that it is a "partnershiplike therapist-patient" relationship that is truly the most significant factor of effectiveness in therapy, and should not be neglected in cognitive and behavioral therapy (2003, p. 409). These authors also asserted that CBT as currently practiced needs to be adjusted to recognize and work with unconscious processes, as well as conscious cognitions (Wagner & Reinecker, 2003). Following from Wagner & Reinecker's point that no therapy or theory is ubiquitous, this synthesis helped me see that neither self psychology nor CBT provides in-depth clinical guidance for how to help BED clients tolerate or mediate negative affect which research shows they often struggle with tolerating. I instead found my work with DBT in the eating disorders setting to be useful for this particular treatment need.

Strengths and Weaknesses of Methodology

In terms of the strengths of this methodology, my personal experience adds some familiarity to the phenomenon of BED. For my clinical training for my second-year Master's in Social Work, I have spent the past eight months working as a clinical intern at a clinic that specializes in treating eating disorders (and this is the clinic's sole treatment focus). This means I conducted this research and analysis while working with clients with eating disorders, and specifically individuals with Binge Eating Disorder.

In terms of weaknesses of this project, one limitation is that the definition of binge eating episodes for individuals with BED varies across some areas of the research literature, which means that the research may be covering a more heterogeneous group of individuals and symptoms than intended. Part of the reason for this is that before BED was understood as distinct from bulimia nervosa, or from the general behaviors of obese individuals, empirical and theoretical research often folded many different types of bingeing individuals together in data collection. As much as possible, data that is not specific to individuals meeting DSM (IV or 5) BED diagnostic criteria has been excluded from this thesis.

Two things add to the limitations regarding my attempting to use one definition of binge eating in individuals with BED. First, the criterion for an eating episode to be considered a binge as outlined by the DSM criteria is a subjective criterion, as it has no objectively measurable aspects to it. The DSM-5 BED criteria for whether an eating episode is a binge include: 1) the amount of food eaten "is definitely larger than most people would eat in a similar period of time, under similar circumstances" and 2) that the individual experiences a "lack of control over eating during the episode" (APA, 2013). Thus, if researchers were not directly collecting data from participants on their food intake, time lapsed during intake, and emotion recording during intake, but instead relying on clients/research participants to determine whether their eating qualified as a binge—they could have included individuals as meeting BED criterion in their research with a very wide range of eating or "binging" behaviors. Second—contributing to potential weakness of the variations in the definition of the binge—the binge frequency required for BED diagnosis has changed slightly as BED has moved from a provisional diagnosis in DSM-IV to a formal diagnosis in DSM-5, moving to twice a week in DSM-IV to once a week in DSM-5. Some of

the research included in my review of the BED literature uses the older frequency requirement and some uses the newer.

Another methodological weakness of this undertaking is that it only uses two theories to explore and interpret BED. Focusing on only two theories—Cognitive Theory/Cognitive Behavior Therapy and self-psychology—can be limiting, as it omits other theories that also seem they could be relevant to BED. There are a range of psychodynamically-oriented theories that could be highly relevant for interpreting BED, especially family theory and therapy, object relations, ego psychology, and narrative therapy. This thesis also does not examine the behavioral approach of Dialectical Behavior Therapy (DBT), which is another widely-accepted type of behavioral therapy for treating eating disorders.

My personal perspective as a researcher may introduce two biases—and points of weakness but also of strength—into this thesis's interpretive presentation and analysis. The first potential bias is that as I am currently a clinical social work graduate student in a program with a psychodynamic focus (Smith College School for Social Work), I am being trained to practice clinical social work in way that promotes intentionally incorporating psychodynamic perspectives into therapy. Thus, my graduate coursework and graduate faculty and advisors tend to present incorporating psychodynamic theory as inherently beneficial to practicing effective therapy.

The second potential bias—which can also be a counterbalancing force to the weakness listed directly above—is that the eating disorder clinic where I did this clinical training largely operates through a behavioral treatment approach, which is a mixture of using Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT). Specifically, the clinic I have been working at operates one of the few psychologically-oriented treatment programs (as

opposed to behavioral weight loss, like Weight Watchers) specifically designed for individuals with BED. My training clinic's BED treatment program closely follows the treatment model outlined in Fairburn's CBT-Guided Self Help manual, in the book: Overcoming Binge Eating (Fairburn, 1995). Therefore, I have gained a level of familiarity and skill in working in the CBT and DBT treatment modes, as well learning from other clinicians who have helped to develop and implement the treatment program.

Overall, I believe my perspective of providing treatment to individuals with BED through a CBT/DBT framework, but also simultaneously conducting graduate coursework and having field advising that find great benefit in psychodynamic conceptualizations and treatment approaches have been an asset as I have conducted this theoretical analysis of BED.

Implications for Social Work Practice

It is my hope that my review of the BED literature, my interpretation of BED through both the psychodynamic lens of self psychology and through the lens of cognitive theory and CBT, and my synthesis of these two theoretical perspectives have identified potential opportunities for clinicians to include the psychodynamic perspective of self psychology as a way to understand BED and for approaching layering a psychodynamic understanding of BED into a behaviorally-focused BED treatment approach. Further areas of research or theory that could be explored would be considering how it might be useful to include other psychodynamic theories, particularly object relations, to conceptualize BED cases in treatment settings that are more behaviorally-focused. Also, further research could be conducted into the practices of mental health clinicians, to explore more in-depth the treatment models and conceptualizations clinicians are using to treat clients with BED, whether clinicians are blending behavioral and psychodynamic treatment, and if they are blending how they are going about doing so.

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