EAT, ESCAPE, REGRET, REPEAT:

CONCRETE MINDFULNESS INTERVENTIONS FOR BINGE EATING DISORDER

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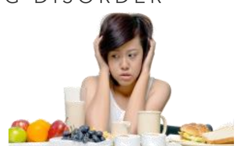


1

Diagnostic Criteria **307.51 (F50.8)**

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 (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (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 afterward.

C. Marked distress regarding binge eating is present.

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

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

2

DSM5 CRITERIA – OTHER SPECIFIED FEEDING OR EATING DISORDER (OSFED)

307.59 (F50.8)

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder. This is done by recording "other specified feeding or eating disorder" followed by the specific reason (e.g., "bulimia nervosa of low frequency").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Atypical anorexia nervosa:** All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
2. **Bulimia nervosa (of low frequency and/or limited duration):** All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
3. **Binge-eating disorder (of low frequency and/or limited duration):** All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. **Purging disorder:** Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

3

WHAT TRIGGERS ON A BINGE?

- Dieting/Irregular Eating- 3 Types
- Isolation
- Poor Body Image/Overvaluation of Weight & Shape
- Substance Use/Abuse
- Distressing Emotions *(food used to enhance and/or distract)*
- Boredom/Lack of Structure

(Grilo, 2012)

4

WHO'S AT RISK FOR BED?

- Estimated to affect 1.5% of women and 0.3% of men worldwide
- A lifetime diagnosis of DSM-5 BED is reported by 0.6–1.8% of women and 0.3–0.7% of men
- Minority/Ethnic Groups: ***equally represented*** with similar prevalence rates (Marques et al., 2011)
- Gender differences ***less pronounced*** than other eating disorders
- *Pre-existing Type 2 Diabetes* (BED & NES)
- Links found between **ADHD and binge eating behaviors**
- Age: *Later Onset*
- BED is *more prevalent than AN and BN combined* (Hudson et al., 2012)
- BED comes in *all shapes and sizes* (Hudson et al., 2012)
- ***Various minority statuses***, deprivation, food scarcity, violence, trauma, and major mental illness may increase the risk (Keski-Rahkonen, 2021)

5

WEIGHT-BASED MICROAGGRESSIONS IN BINGE EATING DISORDER TREATMENT

- Assumption that BED clients are less complicated/less sick, therefore need less care & support
- Presenting problems attributed to weight/size
- Notion that weight loss or "stabilization" will improve emotional well-being

6

The Harmful Effects of Weight Stigma

- Weight stigma poses a significant threat to mental & physical health. Studies suggest it is a significant risk factor for **depression, low self-esteem, and body dissatisfaction.**
- 79% of weight-loss program participants reported coping with weight stigma **by eating more food**.
- Decreases trust & willingness to seek out preventative services.
- Those who experience weight-based stigmatization engage in more **frequent binge eating, are at increased risk for ED symptoms, and are more likely to have a diagnosis of BED.**

Andreyeva, T., Puhl, R. M. and Brownell, K. D. (2008), Changes in Perceived Weight Discrimination Among Americans, 1995–1996 Through 2004–2006. Obesity, 16: 1129–1134. doi:10.1038/oby.2008.35

7

The Harmful Reality of BED Stigma

Stereotype that individuals with BED ***lack self-discipline*** (Ebneter, Latner, and O'Brien, 2011)

A 2013 study found that a character with BED was ***blamed more for their condition*** than characters with anorexia nervosa, bulimia nervosa, and depression (Ebneter & Latner, 2013)

Studies have found that people associate a ***lack of self-control*** with BED more so than other eating disorders or various physical health conditions (O'Connor, McNamara, O'Hara, & McNicholas, 2016)

BED Stigma is ***separate*** from Weight Stigma and can occur at all body sizes (Hollett, K.B. & Carter, J.C., 2021)

8

HOW CAN WE DO AS PROVIDERS?

- Check our own biases with Harvard's free IAT (Implicit Association Test)
  - https://implicit.harvard.edu/
- Weight IAT
- Exercise IAT
- Eating Shame IAT
- Healthy Food IAT

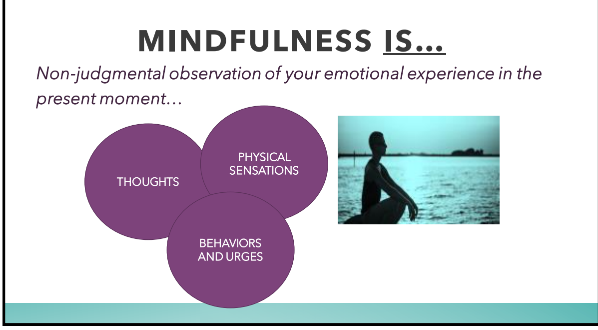
9

COMORBID DIAGNOSES

- Depression
- Anxiety
- Substance Use
- PTSD
- ADHD
- Night Eating Syndrome
- Bipolar Disorder

(Hudson et al., 2012; Grilo et al., 2012; Reinblatt et al., 2014)
American Psychiatric Association. Binge-eating disorder. In: Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013:350-353.

10



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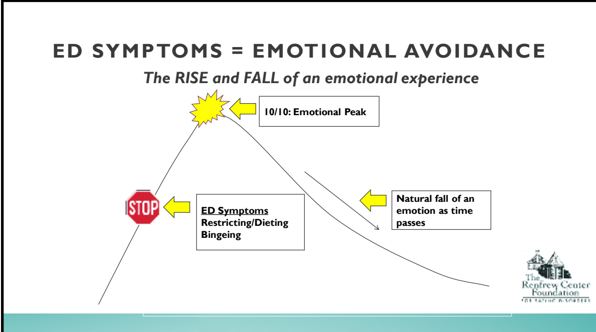

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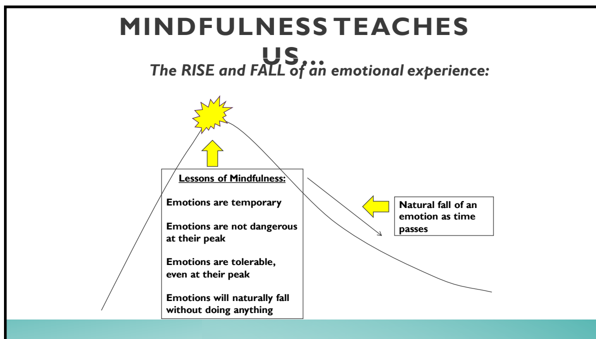

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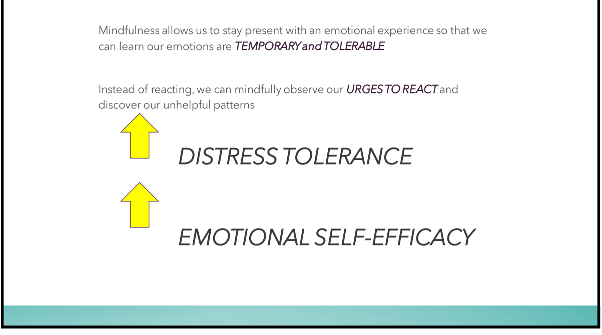

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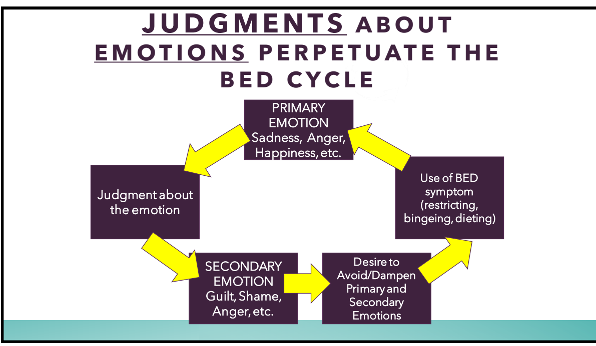

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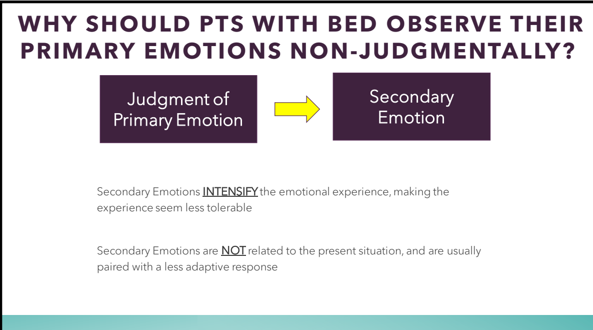

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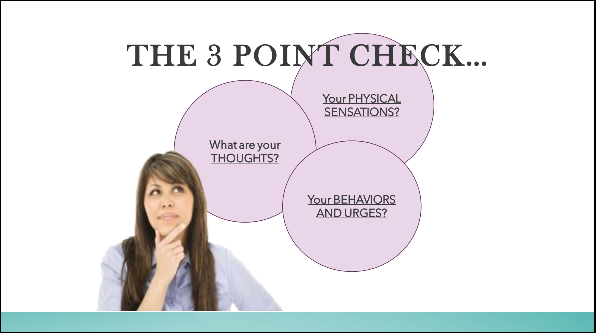
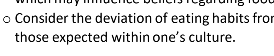


17

DEVELOP A CULTURALLY SENSITIVE APPROACH

- Explore cultural values
- Explore the history of eating patterns within the client's family and culture
- Examine the client's level of acculturation, which may influence beliefs regarding food.
- Consider the deviation of eating habits from those expected within one's culture.



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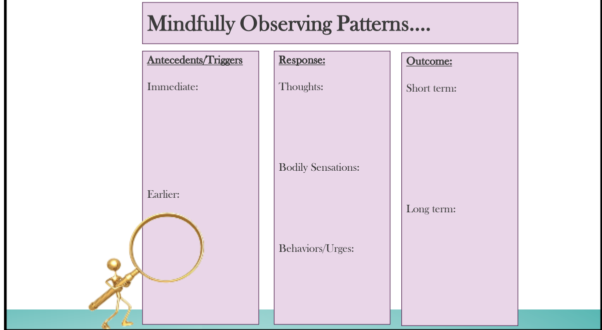


19

TYPES OF EMOTIONAL AVOIDANCE

- Behavioral Avoidance- can be observed
- Cognitive Avoidance- cannot be observed
- Safety Signals- cannot always be observed

20

BINGE FOOD EXPOSURES

Food = Stimulus of Emotion

Exposure to food and associated emotions while refraining from avoidance & Emotionally Driven Behaviors in the present moment <u>WITHOUT:</u>

- Safety signals
- Behavioral Avoidance
- Cognitive Avoidance

(Bulik, Sullivan, Carter, McIntosh, & Joyce, 1998; Steinglass et al., 2009; 2014)

21

COMMON BARRIERS FOR TREATMENT PROVIDERS

- Fear of exposure work "backfiring"
- Fear of increased ED symptoms
- Anticipatory anxiety
- Difficulty tolerating client's distress
- Fear that client (or caregiver of client) will dislike it, refuse it, or drop out of treatment
- Lack of training & education ("Is it out of my scope?")
- Internalized weight stigma, fat phobia, or other internalized diet culture beliefs

(Deacon, B. J., & Farrell, N. R., 2013)
(Waller, G., Walsh, K. D., & Wright, C., 2016)

22

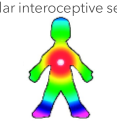
TYPES OF FEAR FOODS

- Food That Evokes Emotion & Avoidance Strategies
- Fear that food will cause weight gain
- Fear that food is "addictive"
- Client Labels It "Forbidden"/"Bad"/"Unsafe"/"Unhealthy/"Impure"
- Food & Trauma
- Must Tease Out Actual Fear Foods and Actual Avoidance Strategies vs. *Preferences/Culture/Values/Sensory Issues Not Related to ED*, etc.

23

INTEROCEPTIVE EXPOSURES

Individuals with ED often have irregular interoceptive sensitivity



Disease	Interoceptive Sensitivity "hypo"	"normal"	"hyper"
Depression			
Anxiety Disorders			
Alexithymia			
Eating disorders			

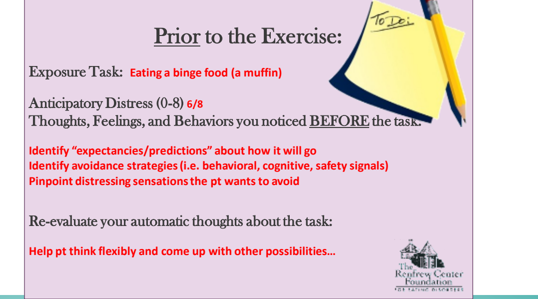
Merwin et al. (2013) Emotion regulation difficulties in anorexia nervosa: Relationship to self-perceived sensory sensitivity. *Cognition & Emotion, 27* (3), 441-452.

24

TYPES OF INTEROCEPTIVE EXPOSURES

- Food That Evokes a Physical Sensation & Avoidance Strategies
- Fullness
- Racing Heart
- Hyperventilating
- Dizziness
- Sweaty palms
- Nausea
- ARFID: Any Physical Sensation Due to Texture, Taste, Smell, Color, etc.

25



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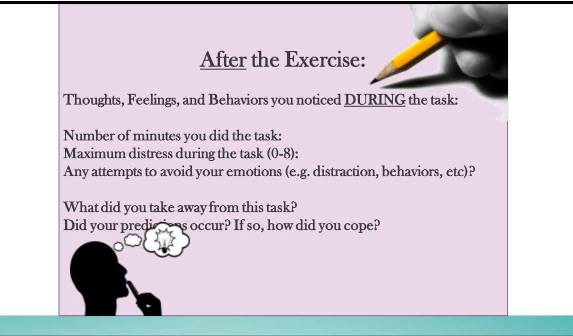

27

POST-EXPOSURE PROCESSING

- 3 Point Check
- Label Emotion(s) & Rate Distress on Likert Scale
- Identify Victories Together (no matter how small)
- Examine Expectancies- Did They Come True?
- ED Voice? Recovery Voice?
- Devise a Plan to Manage Urges?
- What's the Takeaway? Any Discoveries?
- Be Careful with Praise (not all praise feels reinforcing)
- Repeat the exposure or increase level of difficulty?

28

CONTACT INFORMATION

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29

Record of Emotion Exposure Practice Form

Exposure Task: ________________________________

Prior to the task:
Anticipatory Distress (0 - 8): _____
Thoughts, Feelings, and Behaviors you noticed before the task:

____
____
____

Reevaluate your automatic apprasials about the task:

____
____
____

After completing the task:
Thoughts, Feelings, and Behaviors you noticed before the task:

____
____
____

Number of minutes you did the task: ____

Maximum distress during the task (0 - 8): ____

Distress at the end of the task (0 - 8): ____

Any attempts to avoid your emotions (distraction, safety signals, etc.)?

____
____
____

What did you take away from this exposure task? Did your feared outcomes occur? If so, how were you able to cope with them?

____
____
____

ARC

Antecedent	Response	Consequences
Immediate Antecedent:	**Thoughts:**	**Short Term Consequence/ Outcome of the Response:**
	Sensations:	
Earlier Antecedent: What happened earlier in the day/week? In your past?	**Behaviors/Urges:**	**Long Term Consequence/ Outcome of the Response:**

Urge to Binge Scale

Mindfulness takes practice. To improve this skill, set a reminder every ______ minutes to rate your urge to binge. On a scale of 1-10, please rate your urge to use this behavior in the present moment.

If the urge is high (i.e. a 6/10 or higher), now is a great time to practice responding in a different way than you usually do.

What behavior will you choose from your list? After you make a choice, please complete an ARC to examine the short term and long-term outcomes of that behavior.