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Cognitive-behavioral therapy and nutritional counseling in the treatment of bulimia nervosa and binge eating

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Abstract

The goals of manual-based cognitive-behavioral therapy (CBT) and nutritional counseling for eating disorders are similar, namely, eliminating dysfunctional patterns of eating. Modifying these behaviors requires specific therapeutic expertise in the principles and procedures of behavior change that is not typically part of the training of nutritionists and dieticians or mental health professionals without specific expertise. We discuss ways in which principles of behavior change can be applied to eating disorders by non-CBT experts. Specific nutritional rehabilitation programs have the potential to augment CBT in addressing the array of appetitive abnormalities present in eating disorder patients. The dysfunctional appetitive, hedonic, and metabolic characteristics of patients with bulimia nervosa (BN) and binge eating disorder are reviewed. These abnormalities constitute potential target areas that might be more fully addressed by nutritional interventions designed to restore normal appetitive function. © 2000 Elsevier Science Ltd. All rights reserved.

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Cognitive-behavioral therapy (CBT) is the most intensively investigated and best empirically supported treatment for bulimia nervosa (BN) (American Psychiatric Association, 2000). CBT is quick-acting; produces a clinically significant degree of improvement across all four of the specific features of BN, namely, binge eating, purging, dietary restraint and abnormal attitudes about body shape and weight; reduces associated psychopathology (e.g., depressed mood); and is associated with good maintenance of change at 1-year follow-up (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Fairburn et al., 1995). CBT is significantly more effective than either pharmacological or alternative psychological treat-

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ments with which it has been compared (Wilfley & Cohen, 1997; Wilson & Fairburn, 1998). As such, it is the first-line treatment of choice for BN (Walsh et al., 1997).

CBT is based on a cognitive model of what maintains BN (Fairburn, 1997). Social pressures on women to be thin results in overvaluation of body weight and shape. This leads them to restrict their food intake in rigid and unrealistic ways, a process that leaves them physiologically and psychologically susceptible to periodic loss of control over eating, namely binge eating. Purging and other extreme forms of weight control are the person's attempt to compensate for the effects of binge eating. Purging helps maintain binge eating by reducing the individual's anxiety about potential weight gain and disrupting learned satiety that regulates food intake. In turn, binge eating and purging cause distress and lower self-esteem, thereby reciprocally fostering the conditions that will inevitably lead to more dietary restraint and binge eating. Treatment is directed at reducing dietary restraint in favor of more normal eating patterns, developing cognitive and behavioral skills for coping with high risk situations that trigger binge eating and purging, and modifying dysfunctional thoughts and feelings about the personal significance of body weight and shape (Fairburn, Marcus, & Wilson, 1993).

Manual-based CBT has also been shown to be effective in treating BED, although, unlike the case of BN, it is not superior to alternative treatments such as interpersonal psychotherapy (IPT) or traditional behavioral weight loss control programs (Marcus, Wing, & Fairburn, 1995; Wilfley, 1999).

1. CBT and dietary restriction

Manual-based CBT for BN is designed to overcome three forms of dysfunctional dieting: skipping meals, avoiding entire classes of foods thought to be fattening ("forbidden foods"), and limiting overall number of calories consumed. The course of treatment is deliberately sequenced. Developing a regular, more normal pattern of eating (three meals plus two planned snacks per day) is the first dietary target. In this stage, the focus is on when patients eat, not on what they eat. Modification of the two other forms of dysfunctional dieting follow later in the treatment.

The introduction of forbidden foods into patients' meal patterns is designed to empower them — to prove that eating normally will not result in an automatic loss of control. The change is made in a planned and deliberate manner. The goal is not to incorporate high fat or unhealthy foods into the daily diet. In BN, a disorder characterized by excessive dietary restriction, treatment is also designed to increase the overall amount of food consumed. This is obviously also the case in AN.

The strategies used to make these major changes in eating behavior and attitudes include self-monitoring, education, the use of alternative behavior to binge eating, self-control strategies, the exposure principle, problem-solving, cognitive restructuring, and relapse prevention (see Fairburn et al., 1993 & Wilson, Fairburn, & Agras, 1997 for details). Controlled studies document that CBT has been more effective than alternative treatments in reducing dietary restraint (Agras et al., 2000; Wilson & Fairburn, 1998). This is not surprising, given that specific CBT strategies are used to effect such changes. We also know

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