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A learning model of binge eating: Cue reactivity and cue exposure

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Abstract

In the present article, a learning model of binge eating is presented. It has been hypothesized that, parallel to drug intake, the craving and excessive food intake of binge eaters is cue controlled. Research in support of the model is reviewed and a series of predictions about clinical and non-clinical issues is derived from the model. Amongst other things, the model predicts that binge eating might be successfully treated with cue exposure and response prevention. Practical issues are discussed and preliminary pilot studies on cue exposure for bingers are reviewed. © 1998 Elsevier Science Ltd. All rights reserved.

1. Introduction

One of the major developments in psychotherapy during the past decades is the systematic and successful application of exposure therapy to anxiety disorders. For most individuals with phobias and obsessive compulsive disorders, in vivo exposure is highly effective in reducing fear and avoidance behavior (Rachman and Hodgson, 1980; Emmelkamp, 1982; Marks, 1987). Exposure therapy follows from the idea that the anxiety and avoidance behavior are typically cue-controlled. During exposure the subject is exposed to the feared cue (stimulus) and avoidance behavior is prevented. Recent research in the field of addictive disorders suggests that, analogous to the anxiety and avoidance behavior of phobic patients, the craving and substance intake of many addicts is cue-controlled (e.g. Childress et al., 1992; Drummond et al., 1995). And although the work on exposure treatment in addictive behaviors is still in its infancy, preliminary data from clinical cue exposure trials are promising (Rohsenow et al., 1995; Dawe and Powell, 1995).

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In the present article it is hypothesized that the craving and excessive food intake of binge eaters is also cue controlled and might be successfully treated with cue exposure and response prevention. An eating binge refers to the consumption of a large amount of food in a discrete period of time during which loss of control is experienced (APA, 1994). Mostly, high-calorie food which is perceived as “forbidden food”, is eaten during a binge. Before the binge, subjects experience intense feelings of craving (an almost irresistible urge to eat) and after the binge they feel guilty, disgusted with themselves and depressed (Jansen et al., 1990; Bruce and Agras, 1992; APA, 1994).

Binge eating may occur in all eating disorders. It is a main diagnostic criterion of bulimia nervosa and nearly half of the patients with anorexia nervosa (Wardle and Beinart, 1981; Polivy and Herman, 1985) as well as 15% to 50% of the obese participating in weight-control programs (Marcus et al., 1985) are characterized by recurrent episodes of binge eating. Recently, research criteria for the Binge Eating Disorder were included in the DSM IV section “criteria sets and axes provided for further study” (APA, 1994). From the prevalence rates of the eating disorders (APA, 1994), it might be derived that about 2 to 8% of the female population suffer from clinically relevant binge eating episodes. Atypical eating disorders (including binge eating) are considered to be much more common (Fairburn and Walsh, 1995), but how common is currently unknown. Wardle and Beinart (1981) found that, in the late seventies, one in every five of a sample of British women (20%) binged once a month, and 10% of these women regurgitated after bingeing in order to get the quantity of food eaten out of the system as quickly as possible. Bruce and Agras (1992) found that 12% of a large female population sample reported binge eating.

To put it shortly, in order to be diagnosed as suffering from binge eating, a large amount of food is eaten during a binge and a sense of lack of control over eating is experienced. Prevalence rates for clinical binges in women are supposed to be about 2 to 8%, and it is estimated that even 20% of the female population suffers from non-clinical binges. Which psychological mechanisms are responsible for binge eating? Findings from drug research suggest fresh answers.

2. Cue reactivity

Phenomenological, binge eating has repeatedly been considered very similar to drug abuse: subjects feel addicted to food and both drug and food abuse are characterized by an almost irresistible urge to use, preoccupation with the substance and loss of control over intake (Jansen et al., 1989b; Wardle, 1990; Wilson, 1991). Relapse is one of the main problems in the treatment of addictive behaviors: after reaching abstinence, about 80% of the subjects relapse within a year (Beck et al., 1993; Siegel, 1983). Several authors emphasize the contribution of learning processes to substance abuse and relapse (Drummond et al., 1995).

“Peter had been using heroin for six years. During detoxification he experienced severe withdrawal symptoms for 4 or 5 days. These were heavy days. However, further hospital treatment was relatively easy and very successful: now, 6 months after entering the detox and admission, Peter feels fine and looks forward to start a new life with his wife, children and job. He is finished with heroin. After discharge, Peter went home by train. Approaching the Central Station of his hometown, Peter started thinking of heroin; this was the place he was used to get his heroin. He felt nauseated. At the moment the train entered the station, Peter broke out in sweat, his eyes watered, his nose run and he gagged. After vomiting he bought heroin from “his” dealer to get rid of this sickness (Childress et al., 1992).”

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