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## Acceptance and Commitment Therapy for Women Diagnosed With Binge Eating Disorder: A Case-Series Study

Mary L. Hill, Akihiko Masuda, Hailey Melcher, Jessica R. Morgan, *Georgia State University*  
Michael P. Twohig, *Utah State University*

*Binge eating disorder (BED) is an eating disorder marked by a recurrence of eating unusually large amounts of food in one sitting along with feeling a loss of control over eating and experiencing marked distress. Outcomes from two adult women with BED who voluntarily participated in 10 weekly sessions of Acceptance and Commitment Therapy are presented. Binge eating was self-monitored daily prior to and throughout treatment. The average frequency of weekly binge eating across both participants at pretreatment was 5.7 times, which decreased to 2.5 per week at posttreatment, and 1.0 per week at follow-up. The improvements were particularly significant for Participant 1, who no longer met criteria for BED at posttreatment and follow-up. Similarly, both participants demonstrated improvements in body image flexibility throughout the course of study. A discussion of the results is presented along with implications for clinical practice and future directions in research.*

**B**INGE eating disorder (BED) is an eating disorder marked by a recurrence of eating unusually large amounts of food, feeling a loss of control over eating, marked distress about binge eating, and the absence of compensatory behavior(s). BED most commonly occurs among individuals between the ages of 20 and 30 (Striegel-Moore & Franko, 2003), with a lifetime prevalence for females and males at 3.5% and 2.0%, respectively (Hudson, Hiripi, Pope, & Kessler, 2007). BED is twice as common as bulimia nervosa (BN) and anorexia nervosa (AN) combined and is strongly associated with obesity, psychosocial distress, and elevated psychiatric and medical comorbidity (Hudson et al., 2007). Interpersonal problems, such as hostile family interactions, submissiveness, and social avoidance, are also associated with the onset and maintenance of BED (Ansell, Grilo, & White, 2012; Blomquist, Ansell, White, Masheb, & Grilo, 2012).

A well-established treatment of choice for BED is cognitive behavioral therapy (CBT; Grilo, Masheb, Wilson, Gueorguieva, & White, 2011; Wilson, Wilfley, Agras, & Bryson, 2010). Conventional CBT models of disordered eating often focus on irrational thoughts and feelings and negative evaluations about weight, body size, and body shape (M. Cooper, 1997). From this conceptual account,

binge eating is occasioned by distorted thinking related to food and weight combined with negative affect. As such, a major treatment goal of conventional CBT is to promote normal eating habits and to eliminate binge eating through undermining dysfunctional cognitions (Fairburn, Marcus, & Wilson, 1993). More recently, a new version of CBT, called enhanced CBT (Z. Cooper & Fairburn, 2011; Fairburn, 2008), was developed to target transdiagnostic psychopathological processes, such as clinical perfectionism, mood intolerance, low self-esteem, and interpersonal difficulty in the context of eating disorder treatment. While many individuals who complete CBT for binge eating show improvement, some continue to engage in binge eating at follow-up assessments (Baer, Fischer, & Huss, 2005; Fairburn, 2008; Grilo et al., 2011; Wilfley et al., 2002; Wilson et al., 2010). Additionally, issues regarding patient preference and second-line treatments suggest that there is room for additional treatments for BED.

Newer varieties of CBT have emerged in recent years that include acceptance, mindfulness, and values in their theory and practice (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Villatte, Levin, & Hildebrandt, 2011). This acceptance and mindfulness movement is, in part, a response to growing empirical evidence demonstrating that psychological health can be fostered by adaptive emotion and behavior regulation processes (e.g., how people respond and relate to their internal and external experiences; Aldao, Nolen-Hoeksema, & Schweizer, 2010; Gross, 1998; Kashdan & Rottenberg, 2010). Conversely, many forms of psychopathology, including eating pathology, are theorized to arise when individuals excessively and rigidly

<sup>1</sup> Video patients/clients are portrayed by actors.

*Keywords:* binge eating disorder; Acceptance and Commitment Therapy; binge eating; mindfulness; acceptance

engage in maladaptive regulation strategies, such as rigid emotional control and experiential avoidance (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). From this conceptual standpoint, binge eating is viewed as a behavioral attempt to escape or distract from difficult thoughts and emotions (Hayaki, 2009; Polivy & Herman, 2002). Unfortunately, such efforts are typically futile long term, and they are often followed by greater psychological distress, other negative effects on quality of life, and perpetual cycles of binge eating (Hilbert & Tuschen-Caffier, 2007).

Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012), an acceptance- and mindfulness-based CBT, may be particularly suitable for individuals diagnosed with BED because it directly targets ineffective emotion and behavior regulation processes in order to promote daily functioning. Specifically, ACT is designed to promote full and vital living with openness to difficult thoughts and feelings in the service of values-directed actions. This goal is accomplished by undermining pervasive efforts to regulate unwanted emotional experiences (including problematic eating behaviors or other nonfunctional methods to regulate internal experiences) and by promoting alternative behaviors of experiencing the present moment openly and freely. Specific to disordered eating and body image, ACT targets an individual's entanglement with difficult body image, such as the avoidance of situations that provoke body image-related thoughts and feelings (e.g., social situations where food is served) and the degree to which body image-related psychological experiences negatively impact the person (Sandoz, Wilson, Merwin, & Kate Kellum, 2013). In addition, ACT does not focus primarily on body image but the extent to which one engages in values-consistent activities regardless of negative body image. In ACT literature, these alternative and adaptive behavioral patterns in the context of disordered eating and body dissatisfaction are termed *body image flexibility* (Hill, Masuda, & Latzman, 2013; Sandoz et al., 2013).

Extant findings, although limited, suggest that ACT may be a useful treatment option for disordered eating problems (Juarascio et al., 2013; Manlick, Cochran, & Koon, 2013; Masuda & Hill, 2013), including BED. A number of case studies have revealed that ACT delivered on an individual, outpatient basis improves the daily functioning of individuals with full or subthreshold AN (Berman, Boutelle, & Crow, 2009; Heffner, Sperry, Eifert, & Detweiler, 2002; Masuda, Muto, Hayes, & Lillis, 2008). A preliminary randomized controlled trial of individual ACT demonstrated a reduction of comorbid eating pathology in treatment-seeking clients (Juarascio, Forman, & Herbert, 2010). In addition, completion of a 1-day ACT workshop was associated with increased body image acceptance and

decreased eating pathology in females with body image concerns (Pearson, Follette, & Hayes, 2012). ACT workshops have also helped to improve quality of life and reduced binge eating episodes in individuals with obesity (Lillis, Hayes, Bunting, & Masuda, 2009; Lillis, Hayes, & Levin, 2011). Finally, the reductions in binge eating in individuals with obesity were mediated by changes in psychological inflexibility, an underlying maladaptive regulation process targeted in ACT (Lillis et al., 2011).

In order to extend the current knowledge, it is necessary to accumulate empirical evidence of ACT for BED. One way to accomplish this goal is to track daily self-reported binge eating and ACT-specific processes of change in people being treated for BED. The present study employed a case-series design in which two adult females diagnosed with BED reported the frequency of binge eating behaviors on a daily basis as well as a measure of body image flexibility on a weekly basis. Additionally, standardized assessments at pretreatment, midpoint, posttreatment, and 3-month follow-up were administered to track broader disordered eating concerns and psychological functioning.

## Method

### Participants

Participants were recruited using flyers posted around the university campus, including the university counseling center. Recruitment flyers advertised free therapy for body image concerns and disordered eating problems (e.g., food intake restriction, binge eating, purging, and excessive exercise) and provided details about research participation, commitment, and assessment procedures. Two individuals enrolled in the study. Both participants were White American women and completed a screening assessment, including a diagnostic assessment of eating disorders, conducted by the second author. Both participants' weight measurements met criteria for obesity, according to Body Mass Index (BMI) computed using self-reported height and weight. They also met DSM-5 criteria for BED (American Psychiatric Association, 2013) assessed by the Structured Clinical Interview for DSM-IV-TR Axis I Disorder (First, Spitzer, Gibbon, & Williams, 2002).

Assessments of comorbid psychological conditions were not formally conducted, except for the diagnosis of borderline personality disorder and schizophrenia by the Structured Clinical Interviews (First, Gibbon, Spitzer, & et al., 1997; First et al., 2002): neither participant met diagnostic criteria for these disorders. Screening interviews revealed that both participants denied suicidal ideation or intent or substance use problems at intake. Both participants had previously received psychotherapy for depression. Finally, neither of the participants reported using any psychotropic medications at intake or throughout the

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