

Integrative Response Therapy for Binge Eating Disorder

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Binge eating disorder (BED), a chronic condition characterized by eating disorder psychopathology and physical and social disability, represents a significant public health problem. Guided self-help (GSH) treatments for BED appear promising and may be more readily disseminable to mental health care providers, accessible to patients, and cost-effective than existing, efficacious BED specialty treatments, which are limited in public health utility and impact given their time and expense demands. No existing BED GSH treatment has incorporated affect regulation models of binge eating, which appears warranted given research linking negative affect and binge eating. This article describes Integrative Response Therapy (IRT), a new group-based guided self-help treatment based on the affect regulation model of binge eating, which has shown initial promise in a pilot sample of adults meeting DSM-IV criteria for BED. Fifty-four percent and 67% of participants were abstinent at posttreatment and 3-month follow-up, respectively. There was a significant reduction in the number of binge days over the previous 28 days from baseline to posttreatment [14.44 (\pm 7.16) to 3.15 (\pm 5.70); $t=7.71$, $p<.001$; $d=2.2$] and from baseline to follow-up [14.44 (\pm 7.16) to 1.50 (\pm 2.88); $t=5.64$, $p<.001$; $d=1.7$]. All subscales from both the Eating Disorder Examination-Questionnaire and Emotional Eating Scale were significantly lower at posttreatment compared to baseline. One hundred percent of IRT participants would recommend the program to a friend or family member in need. IRT's longer-term efficacy and acceptability are presently being tested in a NIMH-funded randomized controlled trial.

Prevalence and Consequences of BED

Binge eating disorder (BED), a diagnostic research category in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), is a chronic disorder characterized by recurrent episodes of binge eating without the requisite compensatory behaviors seen in bulimia nervosa. BED impacts approximately 2% to 5% of the general population (Bruce & Agras, 1992), up to 30% of weight control program participants (Spitzer et al., 1992; Spitzer et al., 1993), and up to 49% of those undergoing bariatric surgery (de Zwaan et al., 2003; Niego, Kofman, Weiss, and Geliebter, 2007). Findings from clinic, community, and population-based studies note that BED is associated with overweight and obesity (Bruce & Agras; Fairburn, Cooper, Doll, Norman, & O'Conner, 2000; Smith, Marcus, Lewis, Fitzgibbon, & Schreiner, 1998; Spitzer et al., 1992; Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000) and the prevalence of binge eating increases with the Body Mass Index (Telch, Agras, Rossiter,

1988). Through its association with overweight and obesity, BED includes a greater risk for many serious medical conditions (Pi-Sunyer, 1993; Pi-Sunyer, 1998). In addition, when compared to overweight persons without BED, overweight persons with BED have increased rates of Axis I and Axis II psychopathology (Marcus et al., 1990; Mitchell & Mussell, 1995; Yanovski, 1993) and increased rates of interpersonal and work impairments due to weight and eating concerns (Spitzer et al., 1993).

Existing Treatments for BED

Existing treatments for BED include pharmacological approaches and psychotherapeutic treatments including cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT), dialectical behavior therapy for BED (DBT-BED), behavioral weight loss (BWL), and various forms of guided self-help (GSH). While pharmacotherapy and specialty psychotherapeutic treatments (e.g., CBT, IPT, DBT-BED) have demonstrated at least moderate efficacy (Vocks et al., 2010), an impetus remains for the development of new BED treatments and further BED research. First, existing treatments yield a significant number of patients who are still symptomatic at posttreatment and follow-up (Munsch et al., 2007; Safer, Robinson, Jo, 2010; Wilfley et al., 2002; Wilson, Grijo, & Vitousek, 2007). Second, specialty treatments are expensive, time-

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intensive (often administered in 6 months of weekly 1- to 2-hour therapy sessions), and require expert delivery (e.g., therapists typically hold at least a master's degree and have received advanced training in eating disorders), and therefore are limited in ease of dissemination and patient access. Next, pharmacological treatments, while appearing superior to placebo, yield approximately 50% symptomatic individuals at posttreatment and data on longer-term abstinence rates postmedication cessation are limited (Reas & Grilo, 2008). Last, BWL offers a less-expensive treatment option than specialty treatments, yet BWL may not be effective in the treatment of BED over the long term (Grilo et al., 2011; Wilson, Wilfley, & Agras, 2010).

BED self-help research has varied in terms of methodological quality (e.g., sample size, pathology assessment), settings, and intervention implementation details (Wilson, 2005). Consequently, strikingly different outcomes have been reported. Nonetheless, GSH is short term and generally less expensive and more easily disseminable than the specialty treatments (Vocks et al., 2010). Research indicates that GSH programs, including Cognitive Behavioral Therapy Guided Self-Help (CBT-gsh), are superior to wait-list conditions and may be equivalent to specialty treatments in reducing binge eating and related eating disorder symptoms. Reviews investigating GSH and Pure Self-Help (PSH) for BED and BN agree on the utility of GSH and PSH, and recommend further investigation of self-help approaches (Perkins, Murphy, Schmidt, & Williams, 2006; Stefano, Bacaltchuk, Blay, & Hay, 2006; Vocks et al.). Perkins et al. (2006) found no significant differences between GSH or PSH and other formal, specialty psychological treatment approaches at posttreatment or follow-up on bingeing or purging, other eating disorder symptoms, level of interpersonal functioning, or depression. In addition, while GSH and PSH were not significantly different than a wait-list condition at posttreatment on bingeing and purging, they yielded significantly greater improvements at posttreatment on other eating disorder symptoms, psychiatric symptomatology, and interpersonal functioning. Moreover, no significant differences were found in dropout rates between GSH and formal therapist-delivered psychological therapies, or between GSH and PSH (Perkins et al.; Stefano et al., 2006; Vocks et al.). A recent trial compared CBT-gsh, IPT, and BWL and found no significant differences among the three treatments in remission from binge eating, reduction in number of days of binge eating, or no longer meeting *DSM-IV* criteria for BED at posttreatment and 1-year follow-up (Wilson et al., 2010). While IPT and CBT-gsh were not significantly different from one another at 2-year follow-up, both were superior to BWL. Other studies have similarly documented GSH's durability of binge eating reduction through follow-up (Carter & Fairburn, 1998; Peterson et al., 2001). Perkins et al. (2006) concluded that (a) evidence,

though limited, supports the use of self-help in the treatment of recurrent binge eating disorders and (b) insufficient evidence supports any particular self-help approach (e.g., PSH or GSH) over another, and (c) additional self-help research, including randomized controlled studies that apply standardized inclusion criteria evaluation instruments and self-help materials, are needed. A third review of various guided and unguided self-help treatments for BED and BN concluded that self-help yields maintained improvements in eating disorder symptoms at follow-up (between 3 and 18 months posttreatment; Sysko & Walsh, 2008). In addition, limited studies were found that implemented variations of GSH in a group therapy modality (Peterson et al., 1998; Peterson et al., 2001; Peterson et al., 2009). Thus, self-help is a promising yet understudied approach to the treatment of BED.

Affect Regulation in BED Treatment

There is an extensive literature investigating the relationship between negative affect and binge eating that repeatedly cites significant associations between the presence of negative mood and the onset of a binge eating episode (Abraham & Beumont, 1982; Agras & Telch, 1998; Polivy & Herman, 1993; Stice & Agras, 1998; Stickney, Miltenberger, & Wolff 1999; Telch & Agras, 1996; Wegner, Smyth, Crosby, Wittrock, Wonderlich, & Mitchell, 2002). For example, negative mood was found to be significantly higher at pre-binge compared to nonbinge times among women with BED, and participants attributed their binge episodes to mood more frequently than hunger or binge-abstinence violation (Stein et al., 2007). The affect regulation model of binge eating conceptualizes binge eating as an attempt to alter painful emotional states (Linehan & Chen, 2005; Polivy & Herman, 1993; Waller 2003; Wisner & Telch, 1999) and postulates that binge eating is maintained through negative reinforcement as it provides temporary relief from aversive emotions (Arnou, Kenardy, & Agras, 1995; Smyth et al., 2007; Wisner & Telch). Stein and colleagues, conversely, question the purpose of binge eating as relief from negative mood given their data indicating significant elevations in negative mood at post-binge times. However, one might postulate that binge eating's temporary relief from pre-binge negative mood occurs only during the act of bingeing, and subsequently negative mood returns quickly, perhaps in greater force, upon the individual's dawning self-awareness of the "damage done" via the binge and subsequent feelings of guilt and shame. In this way, binge eating itself might be considered an ineffective coping strategy for pre-binge negative affect, thus explaining the increase in negative affect post-binge. Regardless of the time length of relief from negative affect that binge eating may provide, the literature agrees that negative affect often precedes binge

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