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Pepperdine University  
Graduate School of Education and Psychology

THE USE OF COGNITIVE BEHAVIORAL THERAPY TO ADDRESS SHAME IN BINGE  
EATING DISORDER

A clinical dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

Lauren Harb, M.A.

July, 2014

Judy Ho, Ph.D., ABPP – Dissertation Chairperson

This clinical dissertation, written by

Lauren Harb

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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## DEDICATION

To my parents, George and Caryn Harb, for their love, support and encouragement. Thank you for passing on the value of hard work and the love for learning.

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Finally, I would like to thank my partner, Matthew Bowne, for your unwavering love, support and encouragement, and for bringing much-needed balance into my life.

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## ABSTRACT

To date, research on Binge Eating Disorder is limited compared to studies on other eating disorders, including Anorexia Nervosa and Bulimia Nervosa. Given that Binge Eating Disorder recently became an independent diagnosis in the DSM-5, has significant medical implications, and commonly involves psychiatric comorbidity, it is worthwhile to explore contributing factors and evidence-based treatment for the disorder. Cognitive Behavioral Therapy is an evidence-based treatment for Binge Eating Disorder, and most experts agree that while it yields positive treatment results, there is room for improvement in treatment. Shame is an important contributing factor in the development and maintenance of Binge Eating Disorder. The purpose of this review of the literature was to examine shame literature in order to explore potential methods for improving evidence-based Cognitive Behavioral Therapy for Binge Eating Disorder. The importance of researching Binge Eating Disorder is reviewed, and then shame is explored from a cognitive behavioral standpoint. Cognitive Behavioral Therapy for Binge Eating Disorder is outlined, and limited techniques that address shame in treatment are identified. Recommendations for addressing shame more directly in Cognitive Behavioral Therapy for Binge Eating Disorder are then made prior to suggestions for future research.

*Keywords: Binge Eating Disorder, Cognitive Behavioral Therapy, Shame, Eating Disorders, BED, CBT, binge eating*

## **Chapter 1: Introduction**

Extensive research has been conducted around the development, course, and treatment of eating disorders within the field of psychology. The majority of available research on eating disorders has historically focused on Anorexia Nervosa (AN) and Bulimia Nervosa (BN) (Agras, Walsh, Fairburn, Wilson & Kraemer, 2000; Casper, 1983; Habermas, 1989), in part because these disorders were recognized earlier than Binge Eating Disorder (BED) (Fairburn, 2008). Another reason eating disorder research has centered around AN and BN is because these disorders are known to have long-term health effects and fatalistic consequences (Papadopoulos, Ekblom, Brandt, & Ekselius, 2009). However, the consequences of the excessive bingeing associated with BED can be life-threatening, as well, particularly if untreated.

BED sufferers often experience coexisting physical and mental health problems, somewhat poorer standards of care, and a number of barriers to receiving effective treatment. Given the many health consequences associated with BED and the comparatively small body of literature about the disorder, it is worthwhile to explore BED further, including contributing factors and available treatment options. This dissertation will endeavor to define and describe BED, explore shame as a main contributing factor, and discuss the current evidence-based treatment for BED, Cognitive Behavioral Therapy (CBT). This writer will argue that shame plays an important role in the development and maintenance of BED, and should be highlighted and addressed much more than it currently is in CBT treatment.

### **Purpose of the Study**

Given that shame is a primary emotion felt by individuals with eating disorders, CBT is a primary mode of treatment for eating disorders, and BED is a new DSM-5 diagnosis with minimal research, a review of literature on shame and CBT as they relate to BED is warranted in

order to explore potentially helpful treatment options. In this dissertation, shame from a CBT perspective will be described and the ways CBT treatment addresses shame in the treatment of BED will be explored, although somewhat limited. This dissertation will then endeavor to identify and recommend other ways that CBT can address shame in future treatment of BED. Finally, areas for further study will be suggested.

### **Definition of Binge Eating Disorder**

While BED has a shorter history as an official DSM diagnosis than AN or BN, it is an equally important area of study given how little we know about it to date and the serious impact on those who suffer from it. BED is an eating disorder that involves regular overconsumption of food in a short period of time without compensatory strategies. The definition of BED has changed since its introduction as an area for further study in the DSM-IV-TR to its inclusion in the DSM-5 as a diagnosable eating disorder. The shift in diagnostic criteria from the DSM-IV-TR to the DSM-5 is outlined below.

**Eating disorders.** BED falls under the DSM-IV-TR and DSM-5 diagnostic category of Eating Disorders. According to the DSM-IV-TR, an Eating Disorder was considered to be a “severe [disturbance] in eating behavior” (4th ed.; text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000, p. 583). Disorders included in this category were Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified. In short, Anorexia Nervosa was characterized by an intense fear of weight gain, a refusal to maintain body weight, and a disturbance in the way one experiences body weight or shape. Bulimia Nervosa, on the other hand, was considered to involve recurrent binge eating episodes followed by inappropriate compensatory strategies (e.g., vomiting or laxative use) to prevent weight gain. Eating Disorder NOS included those disorders that were sub-threshold or did not meet criteria for any specific

eating disorder (4th ed.; text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). In the *DSM-IV-TR*, BED was a subcategory under Eating Disorder Not Otherwise Specified (NOS), but was considered by researchers and clinicians to be an important area for future clinical focus with growing support for this syndrome to be classified as a separate diagnostic entity.

***DSM-IV-TR.*** Research criteria for BED as suggested in the *DSM-IV-TR* involved recurrent episodes of binge eating, with binge eating characterized by both eating in a discreet period of time an amount of food that is larger than most people would eat in a similar period of time under similar circumstances and a sense of lack of control over eating during the episode. Binge eating episodes were to be associated with three or more of the following: eating much more rapidly than normal, eating until uncomfortably full, eating large amounts of food when not physically hungry, eating alone because of embarrassment about how much one is eating, or feeling disgusted with oneself after overeating. Marked distress regarding the binge eating had to be present, and the binge eating was to occur on average at least 2 days a week for 6 months. The binge eating could not be associated with the regular use of inappropriate compensatory behaviors (e.g., laxative use or vomiting). While in *DSM-IV-TR* BED did not fall under the Eating Disorder category except as an example of an Eating Disorder NOS, it was considered an important area for future study (4th ed., text rev.; *DSM-IV-TR*; APA, 2000). In fact, support for BED as its own specific entity has grown significantly in the psychological community over the past two decades (Treasure, Claudino, & Zucker, 2010). Wilfley, Wilson and Agras (2003) evaluated the utility of BED as a separate diagnosis and found through a critique of the literature that BED is indeed distinct from other eating disorders, like BN. According to them, “Existing research supports the concept of the BED diagnosis as significant and important. Individuals with BED meaningfully differ from individuals with AN and BN,” (p. S103). In addition to this

study, many other research findings have supported the clinical utility and validity of such a diagnosis (APA, 2013; Bulik, Sullivan, & Kendler, 2000; Hilbert, et al., 2012; Wilson, Wilfley, Agras, & Bryson, 2010; 5<sup>th</sup> ed.; *DSM-5*), and this was reflected in its inclusion as a separate disorder in the *DSM-5*.

*DSM-5*. After researchers found that BED was not only distinct from other eating disorders, but also carried with it significant health risks (Wilfley et al., 2003), it was included in the *DSM-5*. According to the *DSM-5*, the description of binge eating is nearly unchanged from the *DSM-IV-TR*, with only some minor modifications (5<sup>th</sup> ed.; *DSM-5*). Specifically, the criteria have changed so that the *DSM-5* requires binge eating to occur only 1 day a week on average for 3 months in order to receive the diagnosis rather than twice weekly for 6 months. According to the American Psychiatric Association, “this change is intended to increase awareness of the substantial differences between binge eating disorder and the common phenomenon of overeating. While overeating is a challenge for many Americans, recurrent binge eating is much less common, far more severe, and is associated with significant physical and psychological problems” (APA, 2014). In summary, the main difference between the way BED was characterized in the *DSM-IV-TR* as compared to the *DSM-5* is that BED is now a separate diagnosis and the criteria are less stringent than they were as proposed in the *DSM-IV-TR* so that more people experiencing BED can have an accurate diagnosis (APA, 2014).

### **Prevalence Rates**

Given that BED initially fell under the category of Eating Disorder NOS in the *DSM-IV-TR*, there is still limited research documenting BED prevalence rates. According to Fairburn and Bohn, the prevalence rates of Eating Disorder NOS are unclear, “in large part...because there are



no positive diagnostic criteria for the diagnosis and so there is no agreed way of determining what constitutes a ‘case,’” (Fairburn & Bohn, 2005, p. 692).

Lifetime prevalence of BED as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) has been estimated at 3.5% for women and 2.0% for men in the United States (Hudson, Hiripi, Pope, & Kessler, 2007; Trace et al., 2012). However, it is likely that many more Americans suffered some degree of these symptoms, even if they did not meet diagnostic criteria for an eating disorder. Additionally, BED lifetime prevalence rates (2.0% in men; 3.5% in women) are higher than those reported for Anorexia Nervosa (.3% in men; .9% in women) and Bulimia Nervosa (.5% in men; 1.5% in women), further supporting the rationale for clinical study as it affects a larger proportion of the population (Hudson et al., 2007). Interview-based studies of treatment-seeking obese individuals suggested that rates of prevalence were between 8.9% and 18.8% and that earlier studies may have underestimated the prevalence of BED, with more severely obese individuals at a greater risk for BED (Stunkard, 2011). Additionally, it is estimated that between 20% and 40% of people in medical treatment for weight control also meet diagnostic criteria for BED (Brody, Walsh & Devlin, 1994; Gormally, Black, Daston, & Rardin, 1982; Marcus, Wing, & Lamparski, 1985; Telch & Stice, 1998). Overall, prevalence rates using DSM-IV-TR criteria appear to vary from study to study, but hover between 0.7-3.5% in community-based studies and are as high as nearly 30% in weight control samples (Hudson et al., 2007; Munsch et al., 2007; Trace et al., 2012).

BED is no longer subsumed under the category of Eating Disorder NOS, but it has only been its own diagnostic category since May 2013. As yet, little is known about how the shift in diagnostic criteria will impact documented prevalence rates. The recent changes to the criteria

for eating disorders in the DSM-5 will likely result in more individuals meeting criteria for BED, in part because patients who previously were subthreshold of a BED diagnosis will now meet full diagnostic criteria (Trace et al., 2012). Specifically, with the criteria changes to BED in the DSM-5 that would require binge eating to occur only 1 day a week on average for 3 months in order to receive the diagnosis (APA, 2012), prevalence rates can be expected to increase (Trace et al., 2012). This further adds to the rationale that BED affects a large proportion of Americans and deserves empirical focus.

### **BED Risks and Concerns**

The limited studies available reveal that prevalence rates are quite high for BED compared to AN and BN in the U.S. In addition, BED sufferers experience health risks, limited treatment access, high comorbidity with other disorders, and poor treatment outcomes (Agras & Apple, 2008; Fairburn, 2008; Wilfley, Wilson, & Agras, 2003). Given that BED is now an official diagnosis and that it appears to be affecting a large portion of the population, it is important to better understand some of the risks and concerns associated with the disorder.

**Health risks.** Binge eating carries with it significant, if not fatal, health risks. Although many binge eaters are of normal weight, research has demonstrated through clinical, community, and population-based studies that BED is associated both with obesity and being overweight (Mitchell, Devlin, Crow, & Peterson, 2008). Obesity is a very serious problem in this country, with nearly 37.5% (Centers for Disease Control [CDC], 2011) of Americans significantly or dangerously overweight. Binge eating may certainly contribute to obesity and other health-related problems (Deaver, Miltenberger, Smyth, Meidinger, & Crosby, 2003), especially given the consumption of large amounts of food in short periods of time with no compensatory strategies to account for the surplus of calories. Further, research has demonstrated a strong

association between binge eating and severe obesity (Body-mass index = 40 or > 40) (de Zwaan, 2001; Hudson et al., 2007). In fact, the majority of people with BED are either overweight (BMI=25.0-29.9) or obese, (BMI=30 or above) (Fairburn, 2008, p.15). Although not all obese people binge eat, and not all binge eaters are obese, binge eating is a common behavioral component of obesity (de Zwaan, 2001; Stunkard, 1959). Patients with BED frequently gain weight over time, and many become obese throughout the course of their lifetime (Agras & Apple, 2008). This is problematic because obesity carries adverse health risks and other implications such as heart disease, impaired social functioning, and higher levels of disability (Wilfley, Wilson, & Agras, 2003). In a population-based study by Smith, Marcus, Lewis, Fitzgibbon, and Schreiner (1998), they reported that the prevalence of BED among overweight participants was nearly double (2.9%) that of the overall cohort (1.5%). More than one third (37.5%) of adults in the United States are considered to be obese, according to the Centers for Disease Control (and Prevention) (2011).

Obesity has been thought to cause approximately 300,000 deaths per year in the United States alone, and is the second most preventable cause of death, with smoking being the first (Flegal, Williamson, Pamuk, & Rosenberg, 2004). While obesity treatments are available in medical, surgical, and pharmaceutical forms, they tend to be rare and expensive. Additionally, the costs related to treating obesity are not limited to obesity itself, but to the many diseases obesity promotes, such as diabetes, heart disease, stroke, and certain types of cancer (CDC, 2011; Finkelstein, Trogon, Cohen, & Dietz, 2009). Other medical risks associated with being overweight or obese include high cholesterol, high blood pressure, gallbladder disease, osteoarthritis, sleep apnea, and some cancers (Agras & Apple, 2008). In 2008, the annual medical burden of treating obesity in the United States was estimated to be as high as \$147

billion per year. Additionally, annual medical costs for obese people were, on average, \$1,429 higher than medical costs for people of normal weight (Finkelstein et al., 2009). Thus, the possible co-occurrence of BED with obesity and other related serious diseases contributes to an even stronger rationale for empirical and clinical attention.

**Under-identification.** Adding to the rationale for further focus on BED, sufferers of BED are at risk of being under-identified and undertreated despite the many health risks. In addition to BED being a new diagnosis in the DSM-5 and the slow transition to the most recent diagnostic manual, there are several other factors contributing to the under-identification of BED, as outlined below.

*Difficulties with differential diagnosis.* It is crucial that clinicians have a greater understanding of binge eating as a distinct syndrome in order to make more accurate differential diagnostic decisions. Crow, Peterson, Levine, Thuras and Mitchell (2004) state that physicians rarely assess their patients for binge eating behaviors, perhaps because they do not always recognize BED as a specific disorder (Johnson, Spitzer, & Williams, 2001). Diagnostically, binge eating can be challenging to clearly assess for and identify. For one, it is difficult to objectively measure what exactly constitutes “excessive” eating for any given person. A large amount of food in one sitting means different things for different people. Additionally, many individuals may become distressed (as evidenced by shame or guilt feelings) by “subjective binges,” which are episodes of overeating that are not classified as objective binge eating episodes (4<sup>th</sup> ed., text rev.; *DSM-IV-TR*; APA, 2000).

Some BED features significantly overlap with symptoms of Bulimia Nervosa, further adding to problems for clinicians trying to discern accurate diagnosis (4<sup>th</sup> ed., text rev.; *DSM-IV-TR*; APA, 2000; Deaver et al., 2003). Bulimia Nervosa looks very much like BED, in that it

involves eating an amount of food larger than most people would eat in a discrete period of time accompanied by a lack of control over eating. The key difference is that a binge eating client does not engage in inappropriate compensatory strategies, such as excessive exercise, purging, or laxative use, whereas these behaviors are required to meet a diagnosis of Bulimia Nervosa. BED may be especially difficult to differentiate from Bulimia Nervosa, Non-purging type given significant symptom overlap and inconsistencies in patient self-reporting (Brewerton, 1999, p. 359).

Binge eating may also be a symptom or feature of another eating or emotional problem such as depression or anxiety. Patients with depression may present with the symptom of overeating or increased appetite. Major Depressive Disorder symptoms may involve an increase in appetite and/or significant weight gain over a short period of time (an increase of 5% of one's body weight within the period of one month; 5<sup>th</sup> ed.; *DSM-5*). The above examples illustrate why it may be difficult to make an accurate diagnosis of BED even when a clinician assesses for self-reported BED symptoms. Further, BED sufferers often present concurrently with other disorders which adds to the difficulty of arriving at an accurate diagnosis of BED (Agras & Apple, 2008; Fairburn, 2008).

***High comorbidity with other disorders.*** Much like Anorexia Nervosa and Bulimia Nervosa, BED is commonly comorbid with other psychiatric diagnoses (Agras & Apple, 2008; Fairburn, 2008; Keel, Klump, Miller, McGue, & Iacono, 2005). It is likely that a significant proportion of clinicians will at one point in their careers encounter a client who experiences and suffers from binge eating as well as another disorder. For example, while binge eating may be a symptom of one's depression, it may also be diagnosed concurrently with Major Depressive Disorder. Major Depressive Disorder is the most common psychiatric diagnosis associated with

BED, with lifetime prevalence rates estimated between 41% and 56% (Specker, de Zwaan, Raymond, & Mitchell, 1994; Telch & Stice, 1998). There are other associated problems for individuals who present with a clinical diagnosis alongside BED, as well. In a 1994 study conducted by Telch and Agras, the investigators discovered that severe binge eaters were not only significantly more depressed, but they also presented with more interpersonal problems, lower self-esteem, and more problems in their interpersonal functioning than moderate binge eaters (Telch & Agras, 1994). Yanovski, Nelson, Dubbert and Spitzer (1993) also found that the lifetime prevalence rates of a number of psychiatric disorders, including Major Depression, Bulimia Nervosa, Borderline Personality Disorder, Panic Disorder, and Avoidant Personality Disorder were higher in study participants that met criteria for BED (using DSM-III criteria) than those that did not. Research literature clearly shows that BED is frequently accompanied by depressive diagnoses, anxiety disorders, personality disorders, and substance abuse (Agras & Apple, 2008; Fairburn, 2008; Keel et al., 2005).

BED may present comorbidity with a number of other clinical problems as well. For example, individuals with BED who present with a comorbid psychiatric diagnosis may be either resistant to treatment (Wilfley et al., 2000) or may have poorer treatment outcomes (Rossiter, Agras, Telch, & Schneider, 1993), particularly because they may not respond as well to treatment designed specifically to treat BED alone without comorbid symptoms. Therefore, it is important to recognize patients who present with binge eating behaviors, even if they are seeking therapy for other symptomatology. All of the above examples suggest that therapists are likely to encounter a client with BED in their practice, and it behooves therapists to be familiar with symptoms of binge eating and evidence-based treatment for BED.

**Under-treatment (due to under-identification and barriers to treatment).** Even when diagnosed correctly, many patients are still not receiving the treatment they need. For example, one study that looked at the prevalence and correlates of eating disorders showed that only 28.5% of respondents who met DSM-IV-TR criteria for BED in the past 12 months had received any treatment for emotional problems in the previous year (Hudson, Hiripi, Pope, & Kessler, 2007). Additionally, only about 43.6% of the binge eating disordered participants in the study had sought treatment specifically for their binge eating symptoms (Hudson et al., 2007). Most of those that did obtain treatment for their binge eating sought it in the general medical sector, indicating they may not have received specialized mental health services to specifically address emotional distress (Hudson et al., 2007). Another study that looked at the stability of BED over time within a community showed that the mean lifetime duration of BED was 14.4 years, significantly longer than the mean lifetime duration of Anorexia Nervosa or Bulimia Nervosa (Pope et al., 2006). Studies related to CBT treatment efficacy for BED are limited to date, particularly using the new DSM-5 criteria. However, the few studies available that examine efficacy of CBT for BED symptoms (including individual, group or guided self-help treatment) indicate long-term rates of recovery hovering around 50% (Hilbert et al., 2012; Atras & Apple, 2008). Therefore, not only is BED undertreated, it also seems to present with poorer prognosis even when intervention has been initiated.

The under-treatment of BED may also result from reduced help-seeking of BED sufferers. Binge eating can cause a great deal of distress and shame for the affected individual, which may prevent potential clients from seeking mental health treatment. There is a heavy emphasis in Western culture on thinness and “healthy” body image (Haworth-Hoepfner, 2000; Kadish, 2012), and presenting to therapy to share experiences about out-of-control eating may

feel too stigmatizing or humiliating for some people. Many people are either not referred for services because their problem is not recognized as a treatable disorder or because they are too ashamed to disclose behavioral details of their eating disorder within a culture that values thinness and appetite control (Deaver et al., 2003). Clearly, there are multiple problems in the identification, help-seeking, and help-using pathway.

### **Shame: A Contributing Factor in BED**

Given the serious health and social implications of BED combined with the limited research, under-identification, and under-treatment, it is important to examine the contributing and maintaining factors associated with bingeing, in addition to effective available treatments. For the purposes of this research project, the focus will be on one important contributing factor—shame. Researchers have found that shame contributes to low rates of treatment-seeking in individuals with BED. According to one Australian research study, shame was found to be a significant barrier to treatment-seeking behavior for women with bulimic and binge eating symptoms (Hepworth & Paxton, 2007). An episode of binge eating is characterized by feelings of guilt, embarrassment and disgust toward the self (4<sup>th</sup> ed., text rev.; *DSM-IV-TR*; APA, 2000). These shame-based affective experiences are likely to be endured in private (Tangney & Salovey, 2010), which leads to a lesser likelihood of seeking professional help. The shameful feelings surrounding their eating behaviors probably also contribute to the cycle of binge eating since binge eaters are shown to binge when they are experiencing negative affect (Deaver et al., 2003).

Eating disorder literature clearly demonstrates that guilt plays an important role in the maintenance of the disordered eating cycle (McFarland & Baker-Baumann, 1990; Tribole & Resch, 2012). There is less of a focus on the role shame plays in the perpetuation of eating



disorder behaviors, though it is arguably equally as important to consider. Current treatments for BED seem to address, to varying degrees, depressive symptomology, emotional avoidance, and interpersonal difficulties. Yet, few treatments, if any, focus on the shame associated with binge episodes and negative body image. Additionally, shame can interfere in the cognitive behavioral therapeutic process (Tone, 2011), which is currently the treatment of choice for BED (Fairburn, 2008). More specifically, clients who experience shame may have difficulty accessing treatment, describing their problems accurately, developing accurate goals for therapy, and identifying and expressing their emotions appropriately (Tangney & Salovey, 2010; Tone, 2011). All of these issues relate directly to the client's ability to engage fully in cognitive behavioral treatment (Tone, 2011).

Because binge eaters typically experience a great deal of shame about their eating behaviors, they may be less likely to report accurately about the frequency and severity of their bingeing (Agras & Apple, 2008; Fairburn, 2008; Tangney & Salovey, 2010). In fact, decreasing feelings of shame associated with eating and binge eating may be a crucial component of obtaining more reliable self-report data and a key ingredient of a targeted treatment plan.

## **Summary**

In summary, researching BED is important for a number of reasons. BED is more prevalent than many people think and it has significant diagnostic overlap with other disorders, making it an important area of study for the purpose of being able to make accurate differential diagnoses. Because of high comorbidity with other disorders, it is likely that many clinicians will encounter patients who engage in binge eating behaviors at some point in their practice. We also do not understand how DSM-5 changes to BED will impact diagnosis and treatment of the disorder. Additionally, binge eating represents a significant health risk as it is tied to obesity, a

leading, and preventable, cause of death in the United States. Finally, more knowledge both at the professional and community level about BED may lead to increased help-seeking behavior and better-informed treatments and reduce the stigma experienced by those who need help.

## Chapter 2: Shame

### Brief Overview of Shame

Shame has been defined in a variety of ways by different theorists across disciplines and theoretical orientations, and is too broad a concept to fully review here. However, a brief overview of shame will be provided before a cognitive behavioral definition is offered below. Collins English Dictionary defines shame as “the painful feeling arising from the consciousness of something dishonorable, improper, ridiculous, etc., done by oneself or another,” (Shame, 2012). According to social psychologists Tangney and Salovey (2010), shame is part of a family of “self-conscious” emotions. Self-conscious emotions, which also include guilt, jealousy, and envy, have received little attention from researchers in comparison to other emotions commonly seen in therapy, like anger and sadness. This is in part because “initial research on emotion focused on so called ‘basic’ emotions that emerge early in life and that are readily identified by unique facial expressions,” (Tangney & Salovey, 2010, p. 245). However, self-conscious emotions merit equal attention given that they are normal, frequently experienced human emotions and are frequently encountered in clinical settings.

Shame has also been described as a negative evaluation of the self as a whole (Lewis, 1987; Tangney, Burggraf, & Wagner, 1995). McFarland and Baker-Baumann (1990), feminist psychologists, note that shame, “a powerfully painful and complex feeling state,” (p. 1) has a separate pathway to the autonomic nervous system, often producing physiological responses like increased heart rate and blushing, suggesting that the experience of shame is more strongly linked to awareness of the body than in other emotional states. They go on to outline two distinct characteristics of the shame experience: exposure and defectiveness. According to the authors, shame results after an experience of being exposed or uncovered in some way that

results in increased self-awareness. Almost immediately, there is a rush of “intense feelings” of inferiority, defectiveness, and feeling at the very core like a bad person (McFarland & Baker-Baumann, 1990, p. 3).

Psychodynamic theorists might argue that before shame is a response to an exposure experience, it is an innate quality experienced by all people as a result of simply being. In other words, there is shame in existing, before any one experience necessarily *elicits* shameful feelings. Gilbert (1998) differentiates between external shame, which relates to a fear of being judged by others, and internal shame, relating to a focus on internal self-evaluation.

In contrast to the psychodynamic concept that shame is inherent, some theorists describe self-conscious emotions as “secondary,” and consider them to arise later in the course of development, meaning they require a number of fundamental cognitive abilities to be in place before they can develop. According to this view, the development of a sense of self is needed in order to experience self-conscious emotions. In addition to an understanding of the self as separate from others, self-conscious emotions would also require the existence of a set of standards against which to evaluate or judge the self, including what is considered good, bad, right, wrong, appropriate, and inappropriate. In other words, this view asserts that an individual cannot experience shame without the development of a sense of self as distinct from others and a set of values to understand and evaluate the self (Tangney & Salovey, 2010).

Both shame and guilt, then, are evoked when an individual recognizes a transgression from one or some of these standards they have for themselves, or that they believe society has. Because of this, these emotions have the potential to inhibit socially undesirable behavior. The distinction is that guilt may be considered a more “public” emotion while shame is thought to be a “private” emotion, although most research suggests that both emotions are experienced in both

public and private domains (Tangney & Salovey, 2010, p. 248). According to Helen Block-Lewis (1971), people negatively evaluate the self when they feel shame; with guilt, the focus is instead on a negative evaluation of the behavior. Note the difference in the emphasis in the following sentences: *I* did that horrible thing (shame) vs. I *did* that horrible thing (guilt). The experience of shame is exceptionally painful because of the emphasis on the *I*, and the sense that the self is fundamentally bad, corrupt, wrong, or unworthy, for example. In eating disorder terms, guilt might look like this: “I wish I didn’t eat so much.” Shame, on the other hand, might be expressed in this way: “I am weak, disgusting, and bad because I ate so much.” So, the emotion-triggering event (in this case, over-eating) is the same in both cases. However, it is the way in which the event is interpreted by the individual that leads to the experience of one emotion or the other.

Clearly, shame is a complex emotional experience that has been explained and understood in a number of ways by many theorists from different backgrounds. Differing viewpoints on the origins, manifestations, and even definition of shame suggest that it is a perplexing emotion with no one easy way to understand it. Shame is a vastly researched concept, and it cannot be comprehensively reviewed within the confines of this dissertation. Therefore, going forward in this dissertation, shame will be discussed mainly as construed in CBT given that CBT is the most well-researched treatment for BED.

### **Shame from a CBT Perspective**

According to cognitive behavioral theories, shame, like any other feeling, is interconnected with a person’s thoughts and behaviors. Shame, as it is understood from a cognitive behavioral framework, is a self-conscious emotion that involves “internal attributions” that often have a moral theme or undertone, much like guilt (Tone, 2011, p. 133). “Shame is a

multifaceted, self-conscious emotion that involves affective, social, cognitive, behavioural and physiological components. It blends the different emotions of anger, anxiety and disgust, involves social comparison and can have different foci; for example one's physical appearance, behaviours or emotions," (Goss & Allan, 2009, p. 303-304). From a CBT perspective, both shame and guilt are evaluative emotions, but the focus of the evaluation differs in each. In guilt, the focus of the negative evaluation is on the *behavior*, whereas in shame, the focus of the negative evaluation is on the *self* (Tone, 2011). According to CBT, a person experiencing shame would experience some form of evaluation of the self ("internal evaluation") as negative or flawed, along with the expectation that others are negatively evaluating or looking down upon them as well ("external evaluation") (Goss & Allan, 2009). For the purposes of this dissertation, shame as a construct is defined as a complex, evaluative, self-conscious emotion with a focus on negative evaluation of the self.

Cognitive behavioral therapists place high value on better understanding their clients' thoughts so they can begin to connect these to their more deeply held beliefs about themselves, others, and the world around them (Beck, 2011). According to Yvonne Tone, teasing out clients' thoughts in order to identify whether they pertain to the evaluation of the self (shame) or the evaluation of the behavior (guilt) is of utmost importance (Tone, 2011). This way, the therapist can better identify the underlying meaning of the feeling for the client, and the associated thoughts. Without correctly identifying the underlying assumptions connected to the feelings, modifying problematic and unrealistic ideas about the self, the world and others can be very difficult. While it is not realistic to attempt to eliminate all shame-based feelings in any client, identifying misattributions and overly broad generalizations related to their shameful experiences can be very helpful in treatment. For instance, a belief like, "I'm a bad person" related to a binge

episode can be challenged and modified to reflect a more accurate thought, like “I ate more than I wanted to but it will be ok.” In order to make modifications like this, it is crucial that the therapist understand the nature of the thought and the associated feelings in the first place, particularly when it is a feeling that clients have a difficult time discussing in therapy, like shame (Tangney & Salovey, 2010).

### **Shame and BED**

Shame has been linked to a multitude of psychological symptoms and syndromes, including depression, anxiety, obsessive thinking, low self-esteem and eating disorders. Not only is shame associated with eating disorder symptomatology, (Sanftner, Barlow, Marschall, & Tangney, 1995; Sanftner & Crowther, 1998) but it has also been shown to have an important role in the development and maintenance of BED (Goss & Allan, 2009). There is a small, emerging literature base indicating that shame is an important factor that needs addressing during the course of BED treatment. In this dissertation, the importance of shame as it relates to BED and binge eating behaviors will be explored, with a specific focus on a number of relevant areas, including how shame creates 1) avoidance thoughts and behaviors, 2) body shame, and 3) barriers to the therapeutic process.

**Avoidance thoughts and behaviors.** Shame plays a significant role in the perpetuation of BED, in part because shame is likely to result in avoidance thoughts and behaviors. When someone experiences shame, they also have the experience of being devalued (Tangney & Salovey, 2010). They become hyper aware of others’ (actual or imagined) negative appraisals, and their very sense of self is damaged. To manage the pain and discomfort that follows, the tendency is to hide or withdraw in an attempt at self-protection, which can result in avoidance of interpersonal relationships, job or schoolwork duties, or even going out in public. Since shame is

a socially inhibiting emotion that typically leads to withdrawal and avoidance, it is not likely to propel an individual to take reparative action or to alter their behavior. This is clinically relevant given that an individual who experiences shame, and consequently avoids interpersonal contact, is not likely to seek therapy, will not consistently attend therapy sessions, will not report accurately, and is unlikely to seek support. “Given that shame is an affect associated with a painful sense of the self as being flawed or undesirable in some way, then it is not surprising that such important issues may be avoided or concealed” in therapy (Goss & Allan, 2009, p. 306). Although not surprising, shame-related avoidance can have a very negative impact on social functioning and treatment compliance.

**Body shame.** The core psychopathology of nearly all eating disorders involves an over-evaluation of shape and weight. Accordingly, sufferers of eating disorders often experience body image disparagement, meaning they view their bodies as repulsive and shameful. It should be noted that this is slightly different than body shape dissatisfaction, which is quite normative and widespread in the general population. The differentiation is that those with eating disorders often judge their self-worth largely in terms of how able they are to control their shape or weight. The resulting inability to exert control over the body’s natural shape and weight can lead to the experience of self-shame (Fairburn, 2008, p. 11-12).

Adding another layer to body shame is the fact that many binge eaters are obese, and obese people tend to feel more body-shame than non-obese people (Goss & Allan, 2009; McFarland & Baker-Baumann, 1990). This may be due to cultural expectations, particularly of women, related to health and body image (McFarland & Baker-Baumann, 1990). Still, it is also likely that people who appear to meet cultural standards of physically attractive body types still feel ashamed during or after binge eating episodes (Jambekar, Masheb, & Grilo, 2003). The



therapeutic implication is that therapists may incorrectly assume that a client of normal weight and shape does not experience shape related to their body or eating behaviors, even though body shame is quite common in BED regardless of actual shape and weight (Goss & Allan, 2009).

**Barriers to the therapeutic process.** Additionally, therapy is in and of itself shame-provoking because it involves a critical inward focus, particularly on problematic aspects of the self. This process of looking inward takes place in front of a stranger who may provide painful feedback on parts of the self that are difficult to accept. The therapeutic relationship may also be shame-eliciting via “transference” that may bring up painful past relationships. Also, clients often idealize therapists as being perfectly psychologically healthy and emotionally stable. It may be even more shameful to reveal things about the self in the presence of someone who is perceived as emotionally “healthier,” an assumption many clients may make.

Finally, shame may negatively impact treatment outcomes because it is so rarely discussed explicitly (Tangney & Salovey, 2010). The therapist, then, must be aware of and attuned to listen for shame-based experiences, as the client may not readily offer up the information or easily acknowledge when they are feeling ashamed. Potential signals that a client is experiencing shame in the moment include gaze aversion, lip manipulation, slumped posture, downcast eyes or nervous laughter.

## Chapter 3: CBT for BED

### Current Available Treatments for Binge Eating Disorder

**Brief Overview of Evidence-Based Treatment.** Current evidence-based psychological interventions available for the treatment of BED include Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT) and Interpersonal Therapy (IPT) (Bulik, Brownley, & Shapiro, 2007; Mitchell et al., 2008; Wilson, 2011). CBT is one of the most studied psychological interventions for BED, making it a treatment of choice (Bulik et al., 2007; Mitchell et al., 2008; Wilson, 2011). Additionally, CBT has been found to be more effective in reducing binge eating than manualized psychodynamic therapy, supportive-expressive therapy, non-directive therapy, stress management, and the use of antidepressant treatment alone (Agras & Apple, 2008). CBT treatment of BED involves attempting to restructure an individual's maladaptive thought patterns about food and body image that may lead to overeating (Agras & Apple, 2008; Fairburn, 2008). It is important to note that while CBT has been proven to reduce overall number of binges, it does not necessarily result in weight loss for overweight individuals with BED (Bulik et al., 2007; Fairburn, 2008). In fact, patients with BED often gain weight at first during CBT treatment for their eating disorder (Agras & Apple, 2008) because treatment focuses on reducing binges, but not on weight loss, exercise, or "healthy" eating (Agras & Apple, 2008; Munsch et al., 2007). Additionally, it does not necessarily address the emotional regulation problems that seem to be common in those with BED. Thus, although CBT successfully addresses some BED symptoms, there are other symptoms that do not appear to be directly helped by CBT as it is currently implemented.

IPT, originally a manual-based short-term depression treatment, has been adapted for the treatment of both BN and BED (Wilson, 2011). In the treatment of BED, IPT aims to help

clients recognize and modify problematic interpersonal relations that contribute to the maintenance of the disorder. Along with CBT, IPT is considered a treatment of choice for BED because of the high post-treatment binge eating remission rates (79% and 73%, respectively). Compared to CBT, IPT yields similarly rapid results in the treatment of BED, although it has not been proven effective for patients with BED who did not respond well to CBT treatment (Agras & Apple, 2008).

DBT focuses on skill building in emotional regulation, interpersonal effectiveness, mindfulness, and distress tolerance (Bulik et al., 2007). In other words, it teaches skills necessary for tolerating painful or unpleasant affect that may typically be avoided or “stuffed away” in a binge episode. Like CBT, DBT has been shown to reduce the overall number and frequency of binge episodes, but does not necessarily lead to weight reduction (Bulik et al., 2007). Early research has shown that DBT may have comparable recovery rates as CBT and IPT in the treatment of BED. Despite this, studies have also shown that a significant proportion of individuals with BED who received DBT treatment relapsed within just a few months post-treatment (Agras & Apple, 2008).

### **Why CBT is Highlighted in This Dissertation**

While research has shown that several types of therapy, as described above, are effective in the treatment of BED, CBT is widely considered the treatment of choice because it leads to reduced binge eating and cognitive changes in those who complete therapy (Agras & Apple, 2008; Fairburn, 2008). Eating disorders are considered to be “cognitive disorders” that share a core psychopathology that is cognitive in nature (Fairburn, 2008, p. 12; Murphy, Straebl, Cooper, & Fairburn, 2010). Given that BED is a largely a cognitive disorder (Fairburn, 2008, p. 12; Murphy et al., 2010), the bulk of BED literature resides in CBT approaches (Fairburn, 2008;

Fairburn, Cooper, & Shafran, 2003), CBT is the BED treatment of choice (Fairburn, 2008; Fairburn, Cooper, & Shafran, 2003), and CBT yields relatively high remission rates compared to other available treatments (Agras & Apple, 2008; Fairburn, 2008), this dissertation focuses on cognitive behavioral conceptualization and treatment for BED.

Despite CBT's proven effectiveness in the reduction of BED symptomology, there is still considerable room for improvement with regards to treatment. About half of patients with BED who complete CBT treatment will recover, and about a quarter more will show very good improvement at the end of treatment, meaning their bingeing becomes subclinical (Agras & Apple, 2008, p. 45; Hilbert et al., 2012). While this is promising, treatment outcomes could be improved with further research in this area. Notably, controlled treatment studies of CBT for BED show that approximately 25% of study participants will drop out of treatment. Further research may also contribute to a reduction in dropout rates (Agras & Apple, 2008, p. 83).

There is no clear consensus on how to improve treatment, although some researchers have suggested treating comorbid symptoms prior to addressing BED symptoms or simply using more tailored approaches with each patient (Agras & Apple, 2008; Fairburn, 2008). Given that shame plays such a prominent role in the development and maintenance of BED (Goss & Allan, 2009), and given that shame can serve as a major obstacle to treatment-seeking (Goss & Allan, 2009; Tangney & Salovey, 2010), this dissertation argues that one way to improve CBT treatment of BED is to focus more closely on shame in treatment.

## **Cognitive Behavioral Therapy**

### **Brief Overview of the Cognitive Model**

It may be useful to frame the current discussion by overviewing the general tenets of the CBT approach. CBT is based on the cognitive model, which posits an interrelationship between

thoughts, feelings and actions. It further reasons that dysfunctional thoughts are at the heart of most psychological problems, and negatively impact clients' moods and behaviors. In other words, situations do not inherently create distress; rather, it is the way a person thinks of a situation that determines how they feel and behave (Beck, 2011). There are a number of common cognitive distortions, and it can be useful to teach clients to identify and label these errors in thinking. Cognitive therapists work with their clients to evaluate and modify distorted thought patterns in order to improve their overall mood states and increase adaptive behaviors. The cognitive model recognizes three specific levels of thought. *Automatic thoughts*, the most superficial level of cognition, are the words and images that go through someone's mind in a given situation (e.g., "People are looking at me because I am fat"). *Core beliefs*, the deepest level of cognition, are global, inflexible, and overgeneralized beliefs about the self, others and the world (e.g., "I am unlovable"). In between these two levels of thought are the *intermediate beliefs*, which are the attitudes, rules, and assumptions a person holds that are often reflective of core beliefs and can serve to guide thoughts and behaviors (e.g., "If I eat as much as other people, I will get huge") (Beck, 2011).

### **Cognitive Behavioral Conceptualization of BED**

Within the CBT framework, various disorders can be conceptualized and key thoughts and behaviors that perpetuate these specific disorders can be identified. The cognitive behavioral conceptualization of BED is adapted from the theory's view of Bulimia Nervosa, which, according to Christopher Fairburn (2008), can be extended to understanding all eating disorders. Cognitive behavioral theory posits that eating disorders often begin with an over-valuation of weight and shape, leading to some form of strict dieting and/or weight control behavior. The theory understands that BN typically results in response to this dietary restraint. Essentially, BN

patients with frequent binge eating behaviors have often tried to follow highly specific and strict dietary rules, leading them to react in an “extreme and negative fashion” to the inevitable breaking of these rules (Fairburn, 2008, p. 18). Even a minor infraction of these highly restrictive dietary rules is seen as a loss of self-control or willpower, and can lead to feelings of guilt or shame and a consequent lowering of self-esteem. The urge to eat, a natural response to restrictive eating, is temporarily indulged with an uncontrolled eating experience (either a subjective or objective binge). The shame and disappointment that arise then lead to a return to restrictive eating in the hopes that, if adhered to more judiciously, the restrictive eating will be finally be effective in reaching weight loss goals. Overall, a distinctive pattern arises in which attempts at unsustainable restrictive eating are interrupted by episodes of binge eating, which, in turn, maintain the patient’s core psychopathology of overvaluation of shape and weight by intensifying these concerns.

There is a key difference separating CBT conceptualizations of BN and BED, however. Unlike BN sufferers, BED patients do not typically exhibit compensatory weight-control behavior, such as laxative use or vomiting. (Agras & Apple, 2008; Fairburn, 2008). Instead, patients with BED are more likely to binge in reaction to non-compensatory weight control behavior, such as dieting or restricting certain “trigger” or “danger” foods from their diet. “Food avoidance,” or avoidance of specific foods is common to BED sufferers, particularly given the overvaluation of shape/weight (Murphy et al., 2010). These “trigger foods” are often the foods consumed most during binges (Fairburn, 2008).

According to cognitive behavioral theory, binge eating behaviors are influenced by cognitions about weight, shape and food, among other things (Agras & Apple, 2008). At each point in the cycle of binge eating, there is thought to be an associated cognition. For instance, “I

am worthless” may follow a binge episode or “If I lose weight, I will be happier” may be connected to the overvaluation of weight and shape.

Cognitive behavioral theory also posits there is an emotional component to the binge cycle. Episodes of binge eating do not appear to occur randomly. Instead, they are more likely to occur in response to unpleasant emotions or events. This is largely because a binge can serve to distract from negative feelings in the moment (Fairburn, 2008).

### **CBT Treatment of BED**

**Goals of CBT treatment for BED.** Given the conceptualization of BED from the CBT perspective, treatment may focus on several specific goals. The first goal of CBT with most eating disorders, including BED, is to identify and reduce restrictive eating, since this is often what leads to binge behavior in the first place (Agras & Apple, 2008). Most likely, restrictive eating plays a bigger role in AN and BN than in BED, but is still important to assess thoroughly at the start of treatment (Fairburn, 2008). Next, CBT aims to reduce other factors that contribute to binge eating, including thoughts and concerns about weight and shape, faulty cognitions about eating, and emotional and environmental triggers for binge eating (Agras & Apple, 2008; Fairburn, 2008). Disordered eating thoughts are targeted and modified to reflect more balanced and realistic thoughts throughout the course of treatment. Generally, a complete CBT treatment for BED takes 18-20 sessions and lasts over a period of six months, with individual sessions lasting approximately 50 minutes (Agras & Apple, 2008; Fairburn, 2008). If successful, a patient who has completed CBT treatment for BED will develop more normalized eating habits, will have greater awareness of their triggers for bingeing, will engage in more pleasurable activities rather than bingeing and will maintain gains made in therapy (Agras & Apple, 2008).

**Phases of CBT treatment for BED.** CBT Treatment for BED will likely involve three structured phases: behavior change, identifying binge triggers, and relapse prevention (Agras & Apple, 2008; Fairburn, 2008). Prior to the beginning of treatment, thorough assessment is conducted with a focus on eating disorder symptoms and comorbid Axis I and II pathology (Agras & Apple, 2008; Fairburn, 2008). Next, the patient is typically sent for a medical evaluation in order to rule out general medical conditions and identify medical problems associated with the eating disorder, including heart disease, obesity, and diabetes (Agras & Apple, 2008; Fairburn, 2008). The assessment process can be informal, involving a semi-structured interview, or formal, using specific eating disorder measures (e.g., the Eating Disorder Examination) (Agras & Apple, 2008; Fairburn, 2008). An important part of the assessment process is learning a detailed history of the patient's binge eating episodes, and helping the patient discriminate between an objective binge and a subjective binge (Agras & Apple, 2008; Fairburn, 2008). This is also the time to identify restrictive eating habits and determine if there are compensatory strategies in use, even if subclinical (Agras & Apple, 2008; Fairburn, 2008). It is not uncommon to introduce self-monitoring food-mood logs in the first session in order to help clarify the patient's dietary patterns, as well as any associated cognitions and emotions (Agras & Apple, 2008; Fairburn, 2008). Once a diagnosis of BED has been confirmed treatment can proceed (Agras & Apple, 2008).

As the first phase of treatment begins, the focus is on behavioral change. Perhaps most importantly, "normalized" eating is introduced and encouraged. The cognitive behavioral therapist must help the patient to modify old patterns of eating and establish a new pattern, consisting of three meals and two snacks per day, with no longer than three to four hours between eating and no grazing between prescribed meals and snacks. The rationale for



emphasizing regular eating at the onset of treatment is that it allows the patient to relearn hunger and satiety signals that may have been obscured by restrictive eating and/or bingeing. Many patients are likely to resist trying normalized eating, as they fear it will cause weight gain or that they will not be able to control their food intake. For this reason, CBT therapists describe the CBT model of binge eating, and collaboratively work with the patient to personalize the model. This may include identifying associated cognitions that resonate with the patient, such as “I am such a pig” or “I deserve a treat.” Psychoeducation is also an important part of the first phase of treatment, and generally involves providing information about dieting, bingeing and the cognitive model (Agras & Apple, 2008).

Once normalized eating has been established and a personalized CBT model has been developed with the patient, the second phase of treatment can begin (Agras & Apple, 2008). The second phase is the longest phase of treatment and involves a shift in focus to identifying and reducing other binge eating triggers. This may include introducing previously feared or avoided foods (e.g., carbohydrates or sugar), which are typically triggers for binges. Therapy also involves the utilization of behavioral exercises to identify and modify distortions in perceived body shape and weight (Agras & Apple, 2008; Fairburn, 2008). Additionally, efforts are made to reduce compulsive behaviors that contribute to the binge cycle, including “body checking” (e.g., grabbing areas on the body that “feel fat”), frequent weighing and looking in mirrors excessively (Agras & Apple, 2008).

Another important component of Phase 2 is the restructuring of faulty cognitions related to food and the body. Often, this process involves breaking rigid rules about food, changing deeply held beliefs about food and nutrition, and modifying unhelpful thoughts associated with

non-food-related triggers. For instance, a patient may have distorted cognitions related to interpersonal interactions that contribute to their disordered eating (Agras & Apple, 2008).

Phase 3, spanning approximately the last three sessions of treatment, involves reflection on progress made throughout treatment as a result of the patient's cognitive and behavioral changes (Agras & Apple, 2008). Lingering problems are addressed so that the patient can plan to handle future obstacles effectively while avoiding lapses. Often, these last three sessions are spread out over two week intervals so that there is sufficient time to identify these challenges.

**How shame is addressed in current CBT approaches to BED.** As it stands, shame is not very well-addressed in CBT treatment of BED. Goss and Allan note that while CBT for eating disorders has developed significantly over the past several decades, “the focus of these developments and new treatment models have primarily been aimed at addressing the meaning of size and shape, rather than addressing shame directly,” (Fairburn et al., 2003; Goss & Allan, 2009, p. 305). Thus, CBT methods for addressing shame in BED treatment are limited, and not explicitly outlined in the treatment protocol. However, shame is addressed in several indirect ways in CBT treatment of BED, and these methods are outlined below.

One way that shame is approached is through initial assessment questions that relate to body-shame. For instance, a CBT therapist is likely to ask a new patient presenting with BED symptoms if they tend to hide their body from others (e.g., by wearing baggy clothing or avoiding swimwear) (Agras & Apple, 2008). If the patient does tend to avoid exposing their body to others, the therapist will aid the patient in increasing appropriate levels of exposure to others (Agras & Apple, 2008, p. 98-99) by reducing their body-hiding behavior. In other words, the therapist helps “expose” the patient to the feared (shameful) experience of wearing clothes that fit him or her properly, or wearing swimwear in public, for example. The hope is that the

anxiety related to feeling ashamed will subside once the patient realizes that others are not paying close attention to them or judging them negatively.

Another way that shame is addressed in treatment is through self-monitoring. Self-monitoring logs are commonly used in the CBT treatment of eating disorders in order to closely observe food intake, binge episodes, frequency of eating, feelings associated with eating and other aspects of eating behavior (Agras & Apple, 2008). Many self-monitoring food logs include a column for the patient to identify feelings associated with binges or to note events that influenced eating. While this column does not explicitly assess for shameful feelings on most food-mood logs, it does promote thoughtfulness in the patient regarding a connection between food and mood, and therefore may elicit responses related to shame (Agras & Apple, 2008; Fairburn, 2008).

However, self-monitoring in and of itself can feel shaming for some patients with BED. It is common for patients who binge to fear negative feedback and critical remarks regarding their eating habits, which they usually go to great lengths to hide (Agras & Apple, 2008). CBT therapists address shame about self-monitoring in a number of ways. One, they often attempt to normalize a patient's disordered eating behavior by reminding the patient that their behavior is both common and similar to other patients with BED. Second, a therapist may encourage the patient to keep food-mood monitoring records without asking them to share their findings directly with the therapist. Until the patient is comfortable, the therapist may ask him or her to read the information aloud rather than to show the therapist written records (p. 72).

In summary, despite the central role shame plays in the development and maintenance of BED symptoms (Goss & Allan, 2009), the focus on addressing and reducing shame in CBT

treatment of BED is rather minimal (Goss & Allan, 2009). This appears to be an important area for focus and a potentially meaningful way to strengthen CBT treatment of BED.

## **Chapter 4: Recommendations**

### **Recommendations for Addressing Shame in BED with CBT Techniques**

As discussed, CBT interventions for addressing shame in BED are limited, despite recognition that shame is an important contributing and maintaining factor in the disorder. Therefore, it would be useful for CBT therapists to address shame more directly and explicitly in the treatment of BED. A comprehensive literature review reveals some promising methods from various therapy modalities to address and reduce shame. Based on this research and on the gaps identified in the CBT treatment protocol for BED, several suggestions are made as follows. It is hoped that by integrating some shame-based techniques from other theoretical modalities and by implementing suggestions based on the extant CBT treatment for BED, therapists will be able to increase positive treatment outcomes for BED sufferers.

### **Suggestions Based on Gaps in CBT Treatment Protocol for BED**

In this section, suggestions will be made based on the areas of the CBT for BED treatment protocol that this author identifies as having potential for including shame-related interventions.

First, directly assessing for feelings of shame may help bring private feelings regarding shame to light, which is important as shame is a self-conscious emotion (Tangney & Salovey, 2010). Early assessment of BED symptomology in CBT treatment traditionally involves questions related to body-shame and hiding behaviors. While some CBT therapists likely already do this, it may be useful to standardize the use of explicit assessment regarding shame followed by validation and normalization of feelings. For instance, the therapist might say something to the effect of, “Tell me about the relationship between shame and food for you. Now tell me how shame affects your view of your body.” Research demonstrates that shame in

therapy can lead to reduced disclosure, which can negatively impact the treatment process (Goss & Allan, 2009). Directly asking about shameful feelings and experiences may allow the therapist to set the framework for open and productive conversation about topics the patient might otherwise avoid discussing in treatment. Of course, directly asking about shame would be most useful if this is done in a gentle, empathic and encouraging way (Tangney & Salovey, 2010). This would also provide the therapist with the opportunity to encourage attendance and treatment compliance, even when shameful feelings have been evoked. This may ultimately reduce drop out rates, which average about 25% for BED and BN patients in CBT treatment (Agras & Apple, 2008, p. 9). By discussing shame directly at the very start of treatment, the clinician is also acknowledging and bringing to light the fact that therapy in and of itself can be shame-provoking (Tangney & Salovey, 2010). Expecting, assessing for, and normalizing shameful feelings from the outset could potentially impact treatment and the treatment relationship positively. This is especially important given that shame is common yet rarely do patients openly announce feeling it (Lewis, 1971; Tangney & Salovey, 2010)

Second, self-monitoring is another area where shame could be addressed more explicitly and systematically. Self-monitoring is a form of disclosure in that it requires a patient to record their specific eating behaviors, foods consumed, and thoughts and feelings. As established, disclosure can be limited when the patient feels ashamed (Goss & Allan, 2009). Because self-monitoring logs are typically introduced as early as the first session of treatment and help the patient identify feelings that trigger binges (Agras & Apple, 2008), it may be useful to develop self-monitoring food logs that include shame in the list of emotional triggers. Typically, food-mood logs either have a blank column for identifying emotions or specify feelings such as sadness, loneliness, boredom, anxiety and even guilt, but not shame (Agras & Apple, 2008;

Fairburn, 2008). Explicit inclusion of shame on a food-mood log might help to increase the patient's awareness of feelings of shame both before and after binges. Additionally, it would open dialogue between the clinician and patient about shameful feelings that might otherwise be concealed in therapy. In fact, patients with BED often "conceal" either what they have eaten (e.g., by underreporting) or what their body looks like (e.g., by wearing baggy clothing) in therapy as a result of shame (Goss & Allan, 2009, p. 308). Including a space to record and discuss shameful feelings may reduce "concealment" in BED patients by encouraging self-disclosure around binge episodes or eating experienced alongside shame.

Third, eliminating in-session weighing may reduce shame in the therapy room. Clinical research has also shown that patients with BED are likely to gain weight during cognitive behavioral treatment, which may contribute to an increase in body-shame (Agras & Apple, 2008, p. 31). Body-shame may also be exacerbated when the patient is asked to weigh in during weekly therapy sessions beginning in Phase 1 of treatment. The rationale behind weekly weighing is that patients with BED often weigh themselves either too frequently, and become discouraged by fluctuations in weight that are actually meaningless, or avoid weighing themselves altogether (Agras & Apple, 2008). Weighing once weekly helps to create a more normalized view of the relationship between food intake and body shape. However, weight gain, even if minor, may be experienced as humiliating for the patient who does not want to disappoint their therapist or be viewed as having "lost control" of their eating. In-session weighing may also encourage dieting or restricting behavior prior to therapy sessions, which would be counterproductive to treatment. For these reasons, it is recommended that weekly weigh-ins be managed by medical professionals outside of the therapy environment. Alternatively, if this is

not feasible for the patient, the therapist may brainstorm ways for the patient to weigh themselves once, and only once, weekly.

Fourth, normalizing imperfect eating or lapses in binge behavior may reduce shame. Phase 3 is an optimal time to do this, as this is when future challenges are identified prior to termination. Here, therapists can anticipate and normalize lapses post-treatment in order for the patient to feel reduced shame in the inevitable event that they have an episode of over-eating. Normalization of the patient's expected lapses down the line can prevent overwhelming shameful feelings that might trigger a full relapse of clinically significant binge eating.

In summary, the four recommendations based on gaps in the CBT treatment protocol for BED are: 1) directly asking about the relationship between shame and food, bingeing, and body image 2) explicitly assessing for shame within self-monitoring records 3) eliminating in-session weighing and 4) normalizing lapses in binge eating behavior post-recovery.

### **Suggestions Based on Shame Research**

Recommendations in this section are made based on shame research from CBT and other modalities. Please note that while these recommendations are a start, they are not comprehensive as there are likely many potential ways to address shame in treatment that should be explored in future research.

First, knowledge of and willingness to process non-verbal shame communications may help to address shame in therapy. A CBT therapist treating a patient with BED may attune to common non-verbal signs of shame, including averted gaze/downcast eyes, nervous laughter, poor posture, expressions of anger, abrupt subject changes, and lip manipulation (Tangney & Salovey, 2010; Goss & Allan, 2009). By having awareness of, noting and gently remarking on these behaviors in treatment, the therapist has an opportunity to validate and explore shame-



based thoughts and feelings that are contributing to binge eating and potentially inhibiting successful treatment.

Second, using cognitive behavioral techniques to restructure or modify shame-based thoughts that contribute to eating disorder thoughts may directly address shame in treatment of BED. Given that CBT focuses largely on modifying unhelpful thoughts and beliefs that contribute to unpleasant feelings (Beck, 2011), the CBT clinician can use some of the many available cognitive behavioral interventions to evaluate and restructure thoughts that tend to elicit shameful feelings in patients with BED (e.g., thought records, socratic questioning or behavioral experiments). Automatic thoughts, intermediate beliefs, and core beliefs can be challenged and changed at every level to reduce shameful feelings. According to Tangney and Salovey, “it’s a fact that most flaws, setbacks, and transgressions really *don’t* warrant global feelings of worthlessness or shame,” (p. 264). Therefore, CBT clinicians treating patients with BED should consider going beyond addressing disordered eating thoughts in order to also modify shame-inducing thoughts, as well.

Third, directly assessing for any feelings of shame that are seemingly unrelated to disordered eating, body image, shape or weight will be important to gain a comprehensive picture of functioning for the client. Gilbert (1997) has suggested centering treatment around the aspects of the self that are the primary focus of shameful feelings. Further, Goss and Allan (2009) point out that there are several aspects of the self that become the focus for shame in individuals with eating disorders, some of which include body shame, shame about so-called failure to control eating, or shame about how others perceive them. They argue that clinicians should go beyond these aspects of shame and assess for other “strong shame concerns” that are relevant to the client, but may not be directly or obviously related to eating disorder thoughts or

feelings (p. 306). This may fit well into early assessment of BED symptoms in CBT treatment, and may involve the clinician directly asking about common contexts in which shameful feelings emerge, both related to the eating disorder and not. It may also be an area for continued assessment throughout treatment as a patient's shame concerns may change throughout therapy or a patient may be more willing to disclose shameful feelings once rapport is stronger.

In summary, the three recommendations made based on shame research from CBT and other modalities are 1) attunement to and discussion of non-verbal shame signals 2) modifying shame-based thoughts in addition to eating disorder thoughts and 3) directly asking about shame that is unrelated to disordered eating and body image.

## **Summary**

CBT for BED is an evidence-based treatment that has yielded positive treatment results and led to improvement in symptoms for many patients. Certainly, changes to the treatment protocol should not be made in place of using actual evidence-based treatment techniques. However, it is strongly recommended that future research focus on ways to address shame in treatment in order to increase successful treatment outcomes and reduce the risk of drop out or relapse down the line.

## **Recommendations for Future Research**

Fairburn, who developed the CBT model of binge eating, has acknowledged that there is still a need to improve upon treatment for BED, especially because not everyone that receives the treatment actually gets better (Fairburn, 2008). It is recommended that future studies focus on ways to improve CBT treatment of BED by identifying alternative approaches for addressing shame. It may also prove useful to study the differences between addressing external shame and internal shame in participants with BED. Finally, identifying differences in typical shame-based

cognitions in patients with BED versus patients with AN or BN may help us better understand useful areas for cognitive restructuring among people with different eating disorders.

## **Chapter 5: Conclusion**

In summary, this dissertation aims to increase awareness of diagnostic and treatment issues related to shame and BED, while highlighting the potential for improvement in CBT, the most evidence-based treatment for BED. CBT treatment for BED has led to considerable success, but also has considerable room for improvement, and increasing attention to shame in treatment may be one way to improve treatment outcomes. BED is clearly an eating disorder with wide-reaching effects, serious health implications, and limited research compared to other DSM-5 eating disorders. Although there is an extensive literature base related to eating disorders, there is a smaller body of current literature with respect to BED. Further, no prior studies have focused solely on the relationship between shame, BED, and CBT. CBT addresses shame in several subtle ways throughout treatment, but does not directly target shame in most interventions. Shame is an important contributing and maintaining factor that has been traditionally under-addressed in the treatment of BED, even in CBT, which is the best available treatment at this time. There are a number of potential benefits to directly addressing shame in CBT treatment of BED. By addressing the affective components of shame that occur before, during, and after binge eating, as well as in the therapy room, the therapist may encourage patient disclosure and improve overall prognosis. Outside of the therapy room, a greater understanding of BED may also lead to increased public education and decreased shame around help-seeking. In sum, shame has important implications in the development, maintenance and treatment of BED, and is a critical variable for future research.

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APPENDIX A  
IRB Exemption

# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

April 1, 2014

Lauren Harb

Protocol #: n/a

Project Title: The Use of Cognitive Behavioral Therapy to Address Shame in Binge Eating Disorder

**Re: Research Study Not Subject to IRB Review**

Dear Ms. Harb:

Thank you for submitting your application, *The Use of Cognitive Behavioral Therapy to Address Shame in Binge Eating Disorder*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). Upon review of your IRB application, the GPS IRB Faculty Chair Dr. Bryant-Davis has determined that your research is **not** subject to review because as you stated in your application your dissertation research study is a "critical review" of the literature and does not involve interaction with human subjects. If your dissertation research study is modified and thus involves interactions with human subjects it is at that time you will be required to submit an IRB application.

Should you have additional questions, please contact the Kevin Collins Manager of Institutional Review Board (IRB) at 310-568-2305 or via email at [kevin.collins@pepperdine.edu](mailto:kevin.collins@pepperdine.edu) or Dr. Bryant-Davis, Faculty Chair of GPS IRB at [tbryant@pepperdine.edu](mailto:tbryant@pepperdine.edu). On behalf of the GPS IRB, I wish you continued success in this scholarly pursuit.

Sincerely,



Thema Bryant-Davis, Ph.D.  
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives  
Mr. Brett Leach, Compliance Attorney  
Dr. Judy Ho, Faculty Advisor