Cognitive Behavioral Therapy for the Treatment of Binge Eating Disorder: What Constitutes Success?

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In the historical development of psychiatric nosology, as in the rest of medicine, more severe disorders tend to be recognized before disorders with milder symptom profiles. Thus, psychiatric classifications recognized schizophrenia and melancholia before schizotypal personality disorder and dysthymia. So, too, with the classification of eating disorders; anorexia nervosa, which may result in death, was recognized many years before bulimia nervosa. The most recent addition to the psychiatric classification of eating disorders is "binge eating disorder." The diagnosis of binge eating disorder is given to the many obese individuals who are distressed by recurrent binge eating, yet do not regularly engage in the compensatory behavior (e.g., vomiting or use of laxatives) that is seen in individuals with bulimia nervosa. Although binge eating disorder is not an official DSM-IV diagnosis, a variety of studies support its validity (1–4). *A description of the disorder and its diagnostic criteria appear in DSM-IV Appendix B, titled "Criteria Sets and Axes Provided for Further Study."*

Binge eating disorder is common among study groups drawn from weight-control programs (15%–50%), which show women are approximately 1.5 times more likely to have the disorder than men. In nonpatient community samples, a prevalence rate of 1%–4% has been reported (1, 3). *Typically, the disorder begins in late adolescence or in the early 20s, often after weight loss from severe dieting. Common associated features include marked fluctuations in weight over time and a history of depression, anxiety, low self-esteem, somatic concern, and interpersonal sensitivity.*

Along with the recognition of binge eating disorder and its clinical features, there has been increasing interest in developing effective treatments for the disorder. Several studies have examined the relative efficacy of psychotherapeutic and psychopharmacological approaches (5). *This case conference illustrates some of the challenges and rewards involved in the treatment of a patient with binge eating disorder.*

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History of Current Illness

Ms. A was a 38-year-old African American woman who was single, lived alone, and was employed as a personnel manager at a hotel in New York. Her height was 6 feet, 0 inches, and she weighed 292 lb (body mass index=39.7) when she was seen initially at the eating disorders research clinic of a university hospital for the treatment of binge eating disorder and obesity. She learned of the program from a friend who was a health professional. Her chief reason for coming to the clinic was that she felt her eating was out of control and, as a result, she had gained approximately 80 lb over the previous year.

Ms. A's current and past history were evaluated by means of semistructured clinical interviews. Eating- and weight-related attitudes and behaviors were assessed by means of a modified version of the Eating Disorder Examination (6). Psychiatric diagnoses were established by means of the Structured Clinical Interview for DSM-IV (SCID) (7).

Ms. A reported a lifetime history of obesity and a history of binge eating beginning at approximately age 11. At her intake session, she described her eating. She felt out of control and ate large amounts of food nearly every day, typically in the evenings when she was on her way home from work or alone at home. She tended to feel out of control throughout the day ("I start to get afraid that if I eat something I like, then I'll just go the whole nine yards"), which contributed to snacking on three or four regular candy bars or three or four medium cookies and one ice cream bar during the day. Ms. A then felt as if a binge episode was inevitable. "It's gonna' happen. It's just a matter of when."

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A typical binge episode consisted of the ingestion of two pieces of chicken, one small bowl of salad, two servings of mashed potatoes, one hamburger, one large serving of french fries, one fast-food serving of apple pie, one large chocolate shake, one large bag of potato chips, and 15–20 small cookies—all within a 2-hour period. During her binge episodes, Ms. A ate much more rapidly than usual until she felt uncomfortably full, ate large amounts of food when she didn't feel physically hungry, ate alone because she was embarrassed by how much she was eating, and felt disgusted with herself and very guilty after eating. She was also extremely distressed about her weight and acknowledged that her weight and shape were the most important factors that affected how she felt about herself.

Ms. A's psychiatric history was significant for current major depression with symptoms of depressed mood, insomnia, feeling "slowed down," difficulty concentrating on reading, and thoughts of death. This episode had its onset after the sudden and unexpected death of a younger brother 1.5 years before. At her initial assessment, she reported that her depressive symptoms had abated somewhat in the past 1–2 months. For 6–9

months after her brother's death, she also met the criteria for posttraumatic stress disorder, including recurrent intrusive memories and nightmares, diminished involvement in meaningful activities, feeling of not having a future, and being on guard and easily startled. Her psychiatric history was also significant for a longstanding fear of heights, which she avoided at all costs. Her medical history was notable for high blood pressure, controlled with medication, and discoid lupus, currently resolved.

Despite her longstanding history of binge eating and distress concerning her weight, Ms. A functioned at a high level in her occupation and social relationships. She had done well in school, was quite successful at her job, and had a large group of close friends but was not actively dating.

Our patient's initial history is typical of patients with binge eating disorder in several ways. Although she had fewer rigid rules about her eating than most patients with anorexia nervosa or bulimia nervosa, she nonetheless exhibited the classic "counter-regulatory" pattern; whereas individuals typically regulate their intake by eating relatively less after a large meal, those with the counter-regulatory pattern actually eat more (8). In our patient's case, once she violated her strict dietary rules, she reacted by "going the whole nine yards" and binge eating. Also, like patients with anorexia nervosa and bulimia nervosa, she placed inordinate emphasis on weight and shape in evaluating her worth and attractiveness. However, unlike all anorexia nervosa and most bulimia nervosa patients, she was statistically overweight and had to therefore deal with the very real biases that exist in our culture regarding those who are overweight and obese. Research suggests that obese individuals in our society suffer from discrimination in many areas of functioning, including job opportunities, college acceptance, job earnings, housing availability, and marriage opportunities (9, 10). It is also not uncommon for patients with binge eating disorder to have other psychopathology, particularly in the depressive spectrum (11).

There are also medical risks associated with obesity. On the basis of her body mass index of 39.7, our patient was considered to have class II obesity, which is associated with significantly elevated risk for medical complications, such as hypertension, diabetes mellitus, coronary heart disease, osteoarthritis, and certain forms of cancer (12). Thus, a sustained weight loss would have been expected to have health benefits for our patient.

It is notable that her diagnosis of binge eating disorder and comorbid psychiatric diagnoses were established by means of validated clinical instruments—the Eating Disorder Examination and the SCID—which are commonly used in clinical research settings. Such instruments, particularly when used to supplement a clinician's psychiatric evaluation, can assist a clinician in obtaining a reliable diagnostic assessment as well as a comprehensive overview of the patient's problems.

Past History

Ms. A remembered having a lifelong weight problem and being singled out by her family as "the only one who wasn't...very athletic and very thin....I was always told I was heavy. I was the first fat baby we ever had." However, recently she had looked at pictures of herself as an adolescent and felt "confused...everybody thought I was fatter than I ever really was. I was not heavy. I was maybe 5 feet, 11 inches, and weighed 155 lb. So I don't know what they saw...something was really weird about that period of time." She was also singled out at meals. "When we'd sit down at the dinner table, the rule was everyone had to clean their plates before dessert, except for me. I never had to clean my plate."

When shopping for clothes, she remembered "always going to the 'chubby' section. And I can remember my mother always saying, 'If you would just watch what you're eating, you wouldn't have to be in this size. You could be in the normal sizes.'" Ms. A also remembered being teased by her family about her weight. "'Chubby' was the first thing that I was always called as a kid, by my sister and brother. My nickname as a kid was 'Checker' from 'Chubby Checker,' and it's funny I never thought anything of it. It's just what they called me, and I never knew it was from 'Chubby Checker' until I was a teenager, when my mother explained that was what it was from. That's when it started bothering me, and I made them stop calling me that."

Ms. A began binge eating at approximately age 11 or 12, after her family enrolled her in a commercial weight-loss program.

> ***I remember one time my sister and I were watching television…this has turned into a family joke, but she was eating a bag of potato chips, and I couldn't have them. I was eating celery or carrots, or whatever. And all of a sudden, I just dove off the couch into the bag of potato chips, grabbed them from her, and I was shoving them in my mouth as fast as I could. My sister went tearing down the stairs to my grandmother. "Amanda has the bag of potato chips, and she won't stop." And my grandmother comes running upstairs. "What are you doing?" And I just couldn't stop…I would not let them take them away from me. Then I finished them. I would have fought anybody that touched me and that bag of potato chips. I really would have.***

Subsequently, Ms. A began to develop a sense that she needed to be secretive about her eating. She recalls

> ***Coming home from [the weight-loss program]—I had lost weight for that week—and there was chocolate cake in the refrigerator. And I went in the refrigerator, and I got just the little teeniest piece of chocolate cake, ate it with the refrigerator door open, and then I just kept going and going and going and going. And I remember realizing that they were gonna be able to tell how much I had. Later on, when somebody asked me did I have any cake, I said, "No." It must have been my grandfather. I hadn't had any. With that cake, there was just no way I was gonna tell anybody. No way. I knew I'd be in trouble.***

Ms. A's intense concern about her appearance and history of extreme weight fluctuations also date from the time she began dieting. "That's what I remember more than anything...just really being embarrassed about what my body looked like, unless [the weight-loss program] said I was at the right weight. If I was at goal

weight, then I felt fine." Over the years, she went on and off numerous diets. In addition to enrolling several times in the first weight-loss program, she also joined another program and tried a vegetarian diet, as well as fad diets such as the grapefruit diet. Each time she would lose and then regain 25–90 lb through binge eating and overeating large amounts of fast food. Before treatment, Ms. A avoided wearing shorts, pants, and swimsuits at all costs, even if it meant depriving herself of opportunities to swim, which had been one of her favorite activities. Ms. A had never received any form of treatment focusing specifically on her binge eating problem.

This portion of the history illustrates beautifully the assumption, still common in our culture, that body habitus reflects willpower or the lack thereof. Our patient was seen by her family as responsible for her weight and shape; they truly did not understand why she could not just control her eating and look like the rest of them. The important knowledge they were lacking is that obesity is largely genetically determined (13). In keeping with this, our patient's overeating in comparison to her siblings could be more usefully viewed as a natural response to a compelling biological drive to eat rather than a lack of willpower. The shame and secretiveness around eating that developed in our patient are frequently observed in individuals with binge eating disorder and contribute substantially to the erosion of self-esteem that accompanies the development of the syndrome.

Our patient's vivid descriptions of her first uncontrolled binge episodes were strikingly reminiscent of the experiences described by some of the participants in the Minnesota semistarvation study (14). In this study, a group of conscientious objectors to World War II volunteered to lose 25% of their body weight and to undergo a variety of physiological and psychological tests. The following is a description of one subject's not atypical experience. "During the seventh week of the semistarvation period, he became unsettled and restless. One evening while working in the grocery store, he suffered a sudden 'complete loss of will power' and ate several cookies, a sack of popcorn, and two overripe bananas before he could 'regain control' of himself'" (p. 36). In light of the similarities between this description and our patient's experience, one might well view Ms. A's experience as a normal reaction to starvation, despite her higher-than-average weight. It appears that the progression from starvation to binge eating can occur across the weight spectrum: in starving individuals, such as those just described, in normal-weight patients with bulimia nervosa, and in overweight patients with binge eating disorder like our patient.

Course of Treatment

Ms. A participated in the pilot phase of a treatment study for binge eating disorder and obesity. The study was designed to assess whether fluoxetine treatment enhances the documented effectiveness of psychotherapies for binge eating disorder by using published manuals (5). The treatment consisted of a combination of group behavioral weight-control treatment and individual cognitive behavioral therapy. The psychological treatments were based on published programs: the LEARN manual (15), modified somewhat for binge eating disorder (group therapy), and Fairburn, Marcus, and Wilson's cognitive behavioral therapy manual for binge eating (16) (individual psychotherapy). In addition to the psychological treatments, Ms. A was randomly assigned to receive either 60 mg of fluoxetine or placebo. The goals of treatment included cessation of binge eating, weight loss, and enhanced self-acceptance. After the initial 20-week phase, Ms. A entered the maintenance phase of treatment, during which she attended monthly maintenance group sessions and continued the study medication.

From the outset of treatment, Ms. A was quite articulate and shared her experiences openly both in group therapy and in her individual psychotherapy. In the second group session, she became tearful and reported having difficulty keeping food diaries. These diaries are a crucial component of treatment as they serve to enhance awareness of eating patterns. In her individual session the next day, Ms. A's self-monitoring records were reviewed, and it became clear that although she was writing detailed, prospective food records, the process was difficult for her emotionally. "It really upsets me. I don't like looking at it after it's written down. I forced myself to get as much down as I can, but I don't want to look at it. I don't want to see any patterns. I don't want to know about it. Burning it would be good. That would be my first choice." She initially tended to complete her food records retrospectively, at the end of the day. However, by the third month of treatment, as she became more confident about her ability to control her eating, Ms. A was keeping food records throughout the course of the day. Whenever she stopped self-monitoring or kept the records inconsistently, as occurred periodically throughout treatment, she tended to make poor food choices but was able to avoid binge eating. Early in treatment, Ms. A identified two types of triggers that typically initiated her binge episodes: long gaps between meals and distressing emotions, such as sadness, anxiety, anger, or frustration ("When I feel bad, what I do is eat"). Among the high-risk situations for binge eating that she later identified were work stressors (e.g., long hours, deadlines) and familial stressors (e.g., pressure to eat, negative reactions to her 80-lb weight gain over the previous year), anxiety about applying to graduate school, buying clothes, and special events.

In the initial phase of treatment, the most important goal was to raise our patient's consciousness of her eating behavior by means of self-monitoring. Like many patients, she initially experienced difficulty with this because it interfered with her avoidance of painful thoughts and affects associated with eating. The intensity of these feelings was revealed in the patient's fantasy of burning the self-monitoring records. Completing the records at the end of the day, when the feelings are less intense, is a frequent avoidance maneuver. The therapist dealt with this by adopting a nonjudgmental stance, encouraging the patient to view the records, along with her associated thoughts and feelings, as "data" that would allow identification of patterns and designing of strategies to deal with these patterns. These data could also serve as a basis for behavioral experiments and provide an objective means of evaluating the results of these experiments. For example, if, rather than attempting to minimize eating early in the day and binge eating in the

evening, the patient ate a full breakfast, lunch, afternoon snack, dinner, and evening snack, would she, as she feared, gain weight, or would she not? Like most patients, our patient found that eating according to a regular schedule did not produce weight gain. Once our patient overcame her resistance to self-monitoring, she found it to be both useful on a practical level and symbolic of her commitment to developing a healthier lifestyle.

Ms. A had numerous rigid rules about "good" and "bad" foods and calorie limits. "In my head [it] is wired up that the number of calories means I'm a bad person. That's just the rules." She was initially reluctant to review the self-monitoring forms with her individual therapist because "I'm worried that I'll 'get in trouble' 'cause either you're eating right or you're not. And if you're not, you're in trouble in some way, shape, or form, and somebody's upset about it." To begin to counteract these attitudes, Ms. A found it helpful to write at the top of her food records, "This is not a diet. This is just information...the calories equal calories. They are not the kind of person I am. They do not equal that."

Ms. A's all-or-nothing attitudes toward food and eating interfered with her developing of flexible, moderate, and consistent eating patterns rather than alternating periods of strict dieting with periods of binge eating and accompanying weight gain. After about 4 weeks of treatment, she had several days of poorly controlled eating and associated increased body image concerns and considered dropping out of the study. However, once she realized that she had been able to maintain her weight that month instead of continuing her pretreatment weight gain trend, she chose to continue the program. Ms. A then decided to stop counting calories, which made it easier for her to plan ahead and give herself permission to eat three meals and up to three snacks a day. This enabled her to eat a variety of foods in moderation without triggering either "diet head," as she described it, or binge episodes. Ms. A's binge frequency varied from one to three times per week for the first 6 weeks of treatment. However, by week 7, she was no longer binge eating and has remained abstinent since that time, except for one binge episode before the last group session of the active treatment phase.

An additional task in this early phase of treatment was for our patient to examine the ways in which she was attempting to restrain her eating and to assess the utility of her dietary rules. Like many patients, she found that flexible guidelines were more useful than rigid rules. These allowed her to exercise a more consistent, moderate degree of dietary restraint, rather than an alternation between high restraint (strict adherence to dietary rules) and low restraint (binge eating). Of interest, our patient found calorie counting to be counterproductive, at least at this stage, in that it promoted, for her, a high degree of restraint that she was unable to maintain. As is often the case, the combination of self-monitoring and the introduction of a regular meal pattern was sufficient to suppress binge eating—at least for the short term. Our patient's written reminders to herself that "calories equal calories.…They are not the kind of person I am" anticipated the cognitive phase of treatment, in which thoughts and attitudes linking self-esteem to dietary control and to shape and weight are systematically identified and challenged.

Once she had stopped binge eating and had maintained a stable weight for 2 months, Ms. A felt as if she had "been released" from the "prison" of extreme dieting and binge eating. Continued work on changing her eating habits and negative attitudes toward her body began to take precedence over losing weight, which was initially her primary goal. This enabled her to begin focusing more on making healthy food choices, such as incorporating more fruits and vegetables into her diet and experimenting with lower-fat alternatives. Nonetheless, finding a middle ground between the two extremes of dieting and binge eating remained an important topic throughout both the active and maintenance phases of treatment, and much time was spent helping her continually evaluate and, if necessary, readjust her dietary restraint to a level that worked well for her.

In addition to self-monitoring and maintaining a regular meal pattern, Ms. A found that other behavioral techniques, although difficult to practice consistently, were extremely beneficial. She experimented with such methods as eating in one place, doing nothing else while eating, putting her fork down between bites, waiting at least 15 minutes to eat, or removing food from her immediate environment when she experienced cravings or felt at risk for binge eating. She expressed great relief about her growing "arsenal" of techniques to control her eating, and she began feeling more hopeful and confident about her ability to continue to improve on and maintain the changes she was making.

After the first 3 months of treatment, Ms. A started to lapse in the context of several stressful weeks when she worked long hours at her job and spent Christmas with her family. She stopped keeping food records, decreased her exercise, and began skipping meals and snacks, which left her feeling more vulnerable to binge eating. Fortunately, however, she was able to prevent any binge episodes from occurring by using some of the other behavioral techniques. This experience reinforced for her the utility of self-monitoring, as well as planning regular meals and snacks, which she resumed the following week.

Once she had broken the pattern of binge eating alternating with extreme dieting, our patient was able to avail herself of widely available behavioral techniques to control eating. Her successful use of these techniques added to her growing sense of self-efficacy, thereby enhancing her self-esteem. At this point, weight loss became a more attainable goal.

The occurrence of a lapse at this phase of treatment can be very useful in a number of ways. It serves as a reminder that maintaining a healthy eating pattern requires ongoing effort and vigilance, particularly during stressful periods. It lays the groundwork for the relapse-prevention phase of treatment, in which the patient is asked to anticipate future high-risk situations and to develop plans to cope with these situations. The occurrence of a lapse also provides the patient with the opportunity to practice coping with temporary lapses with a focus on preventing the progression to full-blown relapse.

Ms. A also made very effective use of the cognitive techniques she learned in the program. For example, in

one of her individual sessions, she used structured problem solving to develop practical solutions for coping with a distressing group interaction, which she then applied to other difficult interpersonal situations. Another group member had commented on Ms. A's lack of weight loss and had attributed it to an assumption that she was taking placebo rather than fluoxetine. Ms. A felt hurt and angry and began doubting both her ability to make long-lasting changes in her eating patterns and the value of the treatment goals she had chosen to pursue (i.e., focusing on controlling binge eating rather than weight loss).

Using cognitive restructuring, Ms. A began to identify and modify problematic thoughts about dieting, her weight, and her negative body image. One of her dysfunctional thoughts was a belief that she would "inevitably fail" to maintain control of her eating or to lose weight. Exploring her beliefs regarding what constitutes "dieting" helped decrease her anxiety about using techniques that she associated with dieting, such as self-monitoring, weighing and measuring food, and weekly weighing. Other problematic thoughts included, "I'm a failure [as a person] because I have to wear a size 20," "If I lose weight, I'm a success. If I gain weight, I'm a failure," and "If I'm not on a strict diet, I must not want to lose weight or be happy."

Ms. A became quite anxious when she realized, after 4 months of treatment, that she had actually lost 12 lb. Her anxiety manifested as increased urges to binge, followed by a single binge episode several weeks later that she experienced as a "relief." She initially did not want to write the binge episode in her food records or discuss it in group therapy or with her individual therapist. But once she decided to do so, she was able to recognize and practice cognitive restructuring for the thought that triggered the binge. "I'm losing weight, so I should be dieting. Just get the weight off in 3 months and be done with it." She also found it helpful to evaluate the advantages and disadvantages of strict dieting versus making incremental and gradual changes in her eating and exercise patterns in order to promote weight loss. This enabled her to resume maximizing opportunities to make healthier food choices, decrease her fat intake, and increase her lifestyle activity (e.g., climbing the stairs rather than using the elevator whenever possible).

As Ms. A's desire for rapid weight loss diminished, she began to focus more directly on increased self-acceptance and developing a more positive body image. Her homework assignments included cognitive restructuring for thoughts such as "I can't wear pants because I'm fat," which was derived from her mother's belief that "fat people shouldn't" wear pants or shorts. She also spent a week observing overweight woman wearing pants and was surprised to find that her perceptions did not confirm her belief that overweight women in pants "look sloppy." She began buying more attractive clothes, including pants, and was astonished by comments from friends and co-workers about how "great" she looked and that she "must be in love." Ms. A attributed the positive attention not to the 12 lb she had lost, but to her increased self-confidence and improved body image. During the maintenance phase of treatment, she enjoyed articulating such fantasies as "What if I were the standard of beauty" in Western society, which the other group members also found helpful.

The development of a higher level of self-acceptance, regardless of body weight, is a central goal of this phase of treatment. It has been convincingly argued that having done their best to make adaptive nutritional and lifestyle changes, patients are best served by learning to accept the weight these lifestyle changes have yielded (17); however, the process of helping patients attain this degree of self-acceptance is usually long and difficult. Patients often enter treatment with the belief that feeling better about themselves is tantamount to giving up on the possibility of change and that self-loathing will provide the needed motivation to "shape up." Thus, the first order of business is to enlist the patient's support in the task of working on self-acceptance. This is best accomplished by reviewing the patient's own experience with using self-loathing to stimulate change. Typically, this will have been effective in the short term but will ultimately have led to demoralization and weight regain.

Once the patient agrees to make enhanced self-acceptance a goal, the process of cognitive therapy involves the identification of multiple automatic thoughts linking weight to self-worth. Our patient reported several typical problematic thoughts: judgmental "should" thoughts about her dress and behavior, negative predictions about her ultimate failure, disparagement of herself and other overweight individuals, and self-critical, culturally reinforced thoughts based on false beliefs about obesity (e.g., that it reflects a core lack of willpower on her part). As she became more proficient at identifying these thoughts as they occurred throughout the day, our patient also developed her skills in testing and challenging these thoughts. Our patient's increasing ability to see cultural ideals as arbitrary ("What if I were the standard of beauty?"), to appreciate her attractiveness, and to accept the compliments of others had a dramatic effect on her mood and willingness to experiment with new clothes and new social opportunities.

After completing 1.5 years of treatment, Ms. A's medication blind was broken, at her request, approximately 6 months before scheduled medication discontinuation. This was done because a situation had arisen in which Ms. A needed to know for professional reasons whether she was taking active medication or placebo. It was decided that Ms. A's needs superseded the requirements of the research protocol. She was very pleased to discover that she had been taking placebo rather than active medication, which confirmed for her that the substantial changes she had made in her eating behavior and attitudes toward her weight and appearance were due to her own efforts rather than the medication. Among her accomplishments, she had stopped binge eating and had improved the nutritional content of her diet, her body image and degree of self-acceptance had improved considerably, and she had begun to carve out more time to focus on herself, which included decreasing her work and social commitments and rewarding herself by scheduling more pleasurable activities. The primary challenges that remained continued to be weight loss, because she had gradually regained most of the 12 lb she had lost during the active treatment phase, and incorporating regular exercise into her daily routine.

Was This Treatment Successful?

One question that naturally arose at this point was whether our patient's treatment was successful. Had this been primarily a weight-loss program, our patient's outcome would be viewed as unsuccessful because she had lost only a modest amount of weight and had regained most of this within 1 year. However, one might argue, even from a weight-loss standpoint, that her achievement of relative weight stability was a desirable outcome compared to her previous pattern of large, "yo-yo" weight fluctuations, with a gradual trend in the direction of increasing weight, which was particularly notable in the period immediately preceding treatment. On the basis of our experience with patients like this patient, we would argue strongly that a limited weight-loss perspective minimizes the importance of her very real accomplishments in treatment. Our patient's cessation of binge eating and her dramatically improved body image contributed greatly to her increased sense of physical and emotional well-being. In addition, her more regular and controlled eating pattern would be expected to minimize future weight gain, since much of her past weight gain had taken place during periods of uncontrolled binge eating.

In fact, this outcome—i.e., binge cessation in the absence of significant weight loss—is not unusual in programs using psychotherapeutic interventions for binge eating disorder, although programs emphasizing weight loss or the use of medication sometimes yield weight loss, usually modest, in at least a subgroup of patients (5). From a medical standpoint, weight loss is of course still desirable. Normalization of eating patterns may be an important first step in this endeavor. In fact, studies suggest that stopping binge eating may have a positive effect on the outcome of further psychotherapy (18), a liquid fast (19), or surgery (20) for weight loss.

In sum, although our patient has achieved a great deal in her treatment, it is clear that her work is ongoing. Like most patients with binge eating disorder, she has found that achieving and maintaining weight loss requires a level of ongoing effort and commitment that is exceedingly difficult to sustain in the context of a demanding personal and professional life. Nonetheless, she has been largely successful in breaking her previous pattern of periods of binge eating alternating with periods of dieting and in developing healthier attitudes toward weight and shape that reinforce her commitment to a healthier lifestyle.

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