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A Brief Strategic Therapy protocol for Binge Eating Disorder

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Abstract

Background: Obesity and being overweight are often associated with Binge Eating Disorder (BED). Cognitive-Behavioral Therapy (CBT) has shown solid results in reducing binge eating, but it does not traditionally encourage weight loss. Since Brief Strategic Therapy (BST) has shown to be effective in treating obese people suffering from Binge Eating Disorder (BED), our objective is to compare the BST protocol as an alternative and/or integrative treatment to the traditional Cognitive-Behavioral Therapy, for inpatient and telephone-based outpatient treatment.

Method: A two arm randomized controlled clinical trial including 6, 12 and 18 months post-treatment follow up is proposed. 60 participants meeting criteria for obesity and BED will be recruited from a single clinical center (Saint Joseph Hospital - Istituto Auxologico Italiano IRCCS) and randomly allocated in the CBT or BST group. The primary end point is the global change of patients' progress score (Outcome Questionnaire - OQ 45.2), while the secondary outcome measures are patients' weekly binge episodes and weight loss. Data will be collected before and after hospitalization (after 1 month) as well as at 6, 12 and 18 months from the end of the in-hospital treatment. Data at follow-up time points will be collected through tele-sessions.

Conclusion: The present study represents the first randomized controlled trial aimed at comparing the effectiveness of BST with the gold standard CBT. These findings will advance current knowledge in both treatment for BED and telecommunication providing distant clinical healthcare.

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Background

The global epidemic of obesity and overweight (Globesity) is rapidly becoming a major public health problem in many parts of the world, since it is often associated to several medical and psychological problems. Obesity and overweight are also frequently connected with Binge Eating Disorder (BED), a psychopathological disorder characterized by frequent and persistent episodes of binge eating with loss of control over eating behaviours. The typical binge eater unnaturally consumes large amounts of food in a short time period, but unlike a bulimic, he/she does not regularly engage in any inappropriate weight-reducing behaviours, following binges (Pietrabissa, Manzoni et al. 2012).

Due to the multifactorial aetiology of obesity, effective interventions to cope with it are typically combined treatment options (dietetic, nutritional, physical, behavioral, psychological, pharmacological). However, important difficulties have been underlined with regards to availability, costs, treatment adherence, and long-term efficacy. In fact, most overweight and obese individuals regain about one third of the weight lost during treatment within 1 year, generally returning to baseline in 3–5 years (Castelnuovo, Manzoni et al. 2011), and psychological factors play an important role in influencing long-term weight loss maintenance. Due to the negative cognitive processes (thoughts, beliefs, and images) that can psychologically “lock” people into unhealthy eating and (low) activity patterns, traditional Cognitive Behavioral Therapy (CBT) represents the treatment of election for obesity and eating disorders (Brownley, Berkman et al. 2007). It is aimed at changing how people think and react to their problems and it is widely recommended both in inpatient and outpatient settings. However, even if showing marked effect on binge eating, CBT does not traditionally encourage weight loss. Instead, favorable results in order to deal with weight gain problems have recently been obtained by the application of the Brief Strategic Therapy (BST) protocol for BED.

Also, Information and telecommunication Technologies (ICT) have been satisfactorily used in order to avoid relapses and to keep on continuity of care in outpatient settings (Castelnuovo, Gaggioli et al. 2003).

Research objective

The study is aimed at comparing the effectiveness of the BST (Nardone and Portelli 2005) with the gold standard CBT (Murphy, Straebler et al. 2010) through an inpatient and telephone-based outpatient program for obese people with BED seeking treatment for weight reduction.

Method and Design

The current study was approved by the Medical Ethics Committee of Istituto Auxologico Italiano.

The rehabilitation program considered will have a total duration of 7 months, consisting in two stepped down phases: inpatient (1 month) and outpatient (the following 6 months) (Castelnuovo, Manzoni et al. 2011).

The comparison between the CBT and BST will be assessed in a two-arm randomized controlled clinical trial, and participants will be randomly allocated in 2 groups:

- 1) CBT group, receiving in-hospital treatment (diet, physical activity, dietitian counselling, 4 group and individual sessions of CBT) plus 8 outpatient (up to 6 months after discharge) telephone-based sessions of CBT-oriented psychological support, implemented by the same in-patient psychotherapists.
- 2) BST group, receiving in-hospital treatment (diet, physical activity, dietitian counselling, 4 group sessions of BST) and 8 outpatient telephone-based sessions (up to 6 months after discharge) of BST-oriented psychological support, implemented by the same in-patient psychotherapists.

Treatments will be delivered by 4 psychotherapists, specifically trained in CBT and BST, respectively.

Participants

Inpatients referred to a single clinical center (Saint Joseph Hospital - Istituto Auxologico Italiano IRCCS) for losing weight, will be sequentially recruited for the current study according to the following criteria: 1) being 18-65 years of age; 2) having BMI ≥ 30 (WHO criteria); 3) having a DSM-IV diagnosis for BED and 4) signing written and informed consent to participate. Exclusion criteria for the study will be: 1) having psychiatric disorders diagnosis on SCID (Structured Clinical Interview for DSM-IV-TR Disorders) 2) presenting medical condition non obesity-related.

The cognitive behavioral account for Binge Eating.

Cognitive behavioral therapy (CBT) represents a "problem focused" (undertaken for specific problems) psychotherapeutic approach aimed at addressing dysfunctional emotions, maladaptive behaviors and cognitive processes, through a number of "action oriented" (therapist assists the client in selecting specific helping strategies) systematic procedures (Lambert, Bergin et al. 2004). The name refers to behavior therapy, cognitive therapy, and to therapies based upon a combination of basic behavioral and cognitive principles and research. Due to its clinical effectiveness in treating several conditions, including eating disorders, the health-care trend of evidence-based medicine, has favored CBT over other psychological approaches (Castelnuovo 2010). Particularly, it helps individuals with Binge Eating Disorder monitoring their eating habits and avoiding situations that will make them want to binge. CBT assists people to cope with stress in ways that don't involve food as well as to eat regularly reducing food cravings (Agras, Telch et al. 1997). Persons suffering from Binge Eating Disorder are also encouraged in better understanding their dysfunctional and broken beliefs concerning their own self-image, weight, body shape and dieting (Murphy, Straebler et al. 2010). This is chased through traditional cognitive-behavioral techniques such as challenging black-or-white, all-or-nothing thinking, and other irrational beliefs commonly held by people with BED. CBT also helps a person to better recognize the connection between their emotional and eating state, such as turning to food when feeling bad (Wilfley, Welch et al. 2002). Nonetheless, a substantial proportion of individuals either fail to respond to CBT, only respond partially, or drop out prematurely. This is especially true for individuals with eating disorders (Mahon 2000), characterized by ambivalence about change (Vitousek, Watson et al. 1998). In fact, working best with voluntary, motivated clients, CBT is not very useful in resolving the uncertainty that most of patients bring to treatment (Agras, Telch et al. 1995). Specifically for what concern the treatment of Binge Eating Disorder, CBT has been demonstrated to have a sustained and marked effect on blowouts, but not in encouraging weight loss, which is typically raised in binge-eaters. As a result, among eating disorders, even if considered the treatment of election

for bulimia nervosa, CBT has not yet been established as the most effective action for BED (Murphy, Straebler et al. 2010; Vancampfort, Vanderlinden et al. 2013).

The Advanced Brief Strategic Therapy Protocol for Binge Eating: change prospective to change reality.

Since 1985, the action-research method (Lewin 1946) carried out at the Centro di Terapia Strategica (Strategic Therapy Center) in Arezzo, Italy, have led to progressively development, from general models of therapy, specific protocols of treatment for particular pathologies, with the scientifically recognized highest efficacy and efficiency actually found within the psychotherapy field (87% of solved cases in 7 sessions median duration of therapy) (Nardone and Watzlawick 2004). These protocols represent fixed sequences of therapeutic maneuvers with heuristic and predictive power, capable to guide the therapist to break, through particular therapeutic stratagems, the specific pathological rigidity. To this aim, the strategic diagnostic approach goes beyond the traditional nosographic classifications of psychiatry and clinical psychology by operating a description of the individuals' "perceptive-reactive system" (PRS), the redundant modalities of people perceiving and reacting in regards to personal and interpersonal reality (Nardone and Watzlawick 2004; Nardone and Portelli 2005). In fact, trying to solve a certain problem, persons have a habit of either reapplying interventions that have been successful in solving similar difficulties in the past or attempt new solutions. If these strategies do not work, rather than looking for alternative ways to face the difficulties, natural tendency is to apply the initial solutions more vigorously, believing that doing "more than before" will be more effective. This inclination eventually causes a complex process of retroactions in which the efforts to achieve change actually keep the problematic situation unchanged. From this point of view, the "attempted solutions" (AS) become the problem (Watzlawick, Weakland et al. 1974). Thus, of fundamental importance becomes not to understand *how* a problem has been formed in the past, but *what* is maintaining it in the present. Interrupting the vicious circle that nourishes the persistence of the problem, the Strategic intervention both eliminates symptoms and dysfunctional behaviors and produces modifications in the way a person creates his/her own personal and interpersonal reality, making the change inevitable and permanent. (Bartoletti and Nardone 2007).

Every human interaction, even the therapeutic one, is considered unique and unrepeatable, and once the structure of the problem is known, every single maneuver is formulated and adapted to the patient's logic and language. The need of treatments able to "fit" to the different patients' realities become particularly evident with regards to eating disorders, a category of pathology in rapid evolution and resulting from many factors, including cultural and family pressures, as well as emotional and personality disorders (Milanese 2004). Specifically, the perceptive-reactive system of persons suffering from Binge Eating or Uncontrolled Eating Disorder is based on the continuous alternation of long periods of over-controlled diets and limited time of intense transgression, followed by another long "punitive" period of abstinence; then the cycle starts off again. The attempted solution of postponing contact with food magnifies the desire of it, causing loss of control, and the awareness of pure pleasure winning on trying to manage it represents something unbearable for those who have made control the cornerstone of their stability.

Moreover, people affected by BED usually search for therapeutic help only when blowouts become too frequent, upsetting their pre-existent supposed equilibrium. The widespread tendency to control also turns into residence to therapy, making necessary specific therapeutic strategies aimed not at simply explaining but allowing patients to

feel and perceive (Alexander and French 1946) that, even if fasting might seem the best way to manage weight, is abstaining from eating that prepares the next binge, losing control and gaining even more weight. Though the use of the strategic dialogue (Nardone, Salvini et al. 2007), a flexible and self-corrective communication technique, the perception of the problem is completely revolted. The maneuver devised to unblock this symptomatology is a reframe known as fear of abstinence, through which people discover what they had been attempting to do so far to protect themselves from bingeing (abstinence), representing something threatening and dangerous, because it is by restraining from food that they end up having to binge. Creating fear against the fear, recalling the Latin saying *ubi major minor cessat*, the tendency to control is driven against the control itself and the perception of the problem completely reversed. It represents a paradoxical mechanism where the more the person forces him/herself to keep control over food, the more he/she ends up losing it, leading to further complicating the problem. In the majority of the cases this intervention is sufficient to make patients start to eat regularly perceiving that if they allow themselves to eat, this will permit them to control what they mostly fear, that is to say, bingeing. Another attempted solution that needs to be reframed is the belief that losing weight, exclusively low-fat health food has to be eaten. This constriction will increase the desire of “sinful” food, with the catastrophic result of losing control and excessively bingeing, usually between meals. Once again, is the attempted solution that maintains and complicates the problem and the secret, which is no secret at all, is to eat only and exclusively what one likes best.

Table 1: Similarity between CBT and BST

Similarity between CBT and BST
– Highlight prevention of relapses and personal development.
– Emphasize clients’ activity outside the meeting.
– Consider therapeutic relationship as essential.
– Provide empirical support for efficacy, strong evidence-base and culture of evaluation.

Table 2: Differences between CBT and BST

Cognitive-Behavioral Therapy (CBT)	Brief Strategic Therapy (BST)
Emphasizes the primacy of cognition in mediating psychological disorder.	Works on perceptions and emotions.
Interprets the change as impression of the client’s awareness on his/her problem.	Believes client’s awareness on his/her problem being subsequent the change. It represents a bottom-up “knowing through changing” process, where the solution defines the problem (“learning by doing” principle).
Is based on the Aristotelian ordinary logic.	Is based on the non-ordinary logics of self-deceiving (logic of contradiction, logic of paradox and logic of belief).
Is interested in understanding how the past may have affected current beliefs and behaviors; in <i>why</i> the problem exists (linear causality principle).	Is interested in <i>how</i> the problem works and is maintained in the present (circular causality principle).
Uses logical-rational strategies to directly challenge maladaptive thoughts.	Based on the constructionist idea of human learning.
Is goal-directed and focused on the pathology (problem-focused therapy). Solutions are pre-selected.	Looking to the client as the expert, the focus is on his/her competence (solution-focused therapy). The emphasis is placed on building exceptions to the presenting problem, identifying and developing specific and intrinsic solutions for each person, sharing with the client the responsibility for change.

Uses nosographic/descriptive diagnosis.	Uses operative-strategic diagnosis, first identifying the symptomatic regularity, then the originality of the subject.
Regards resistance as a barrier to the therapeutic change.	Regards resistance as a vehicle of change.
Represents an educative and skill building process (educative).	Elicits client's strengths and resources for changing, exploring his/her point of view (evocative).
Uses direct communication.	Uses indirect communication (metaphors, narrations and aphorisms), as well as injunctive and performative language.
Requires the therapist being direct, assuming the position of the expert (one up position), and empathetic at the same time.	Require maximum flexibility of the therapist, depending on the characteristics of the patient's perceptive-reactive system.
The therapeutic process is sequentially structured.	Through the use of behavioral prescriptions, concrete experiences of change outside the therapeutic setting are created, giving to clients a demonstration of their ability to face problematic situations.

Table 3: Differences between CBT and BST in their stages according to the current protocol

Stage	CBT	BST
1	Aims of this first stage are mainly to engage the patient in treatment and change, to derive a case conceptualization and to provide education about both treatment and disorder.	Represents the most critical phase of treatment. More than a mere assessment stage, it is aimed at constructing the therapeutic relationship and investigating the client's perceptive-reactive system, for setting subsequent therapeutic maneuvers (<i>learning by doing</i>).
2	Represents a brief but essential transitional stage, in which is conducted a joint review of progresses in order to identify problems and barriers still needed to be addressed.	Constitutes the main part of treatment, in which therapeutic interventions are carried out for defining the problem, managing resistance to change and enhancing a real corrective emotional experience in the patient (these goals can be also reached during the first stage).
3	Is the body of treatment, aimed at addressing the maintaining processes of patient's eating disorder.	Constituting the longest stage of the therapy, it is aimed at cognitively stabilized patient's results, making the change an acquisition.
4	Is focused on nourishing progresses already reached, reducing risks of relapse.	The final phase is required to reinforce the autonomy of the client, awarding to him/her the responsibility of the change.

Outcome measure

The primary end point will be the change in the Global Index of the Outcome Questionnaire (OQ 45.2), while the secondary outcome measures will be the percentage of BED patients remitted, considering the number of weekly binge episodes and the total amount of weight loss (Castelnuovo, Manzoni et al. 2011). Outcome measures of all participants will be collected at similar time points (baseline, discharge, after 6, 12 and 18 months).

Data and statistical analysis

Representing a pilot study, since there have been no previous trials investigating the effects of BST for the treatment of patients with Binge Eating Disorder, 10% of the sample traditionally required (788 individuals, n = 394 per group) will be considered good enough (80 persons; n = 40 per group) (Lackey and Wingate 1986). The null hypothesis is that there will be no improvement in the outcome measure for the BST group relative to the CBT one. All data analyses will be performed using the Statistical Package for the Social Sciences (version 16.0; SPSS, Inc., Chicago, IL).

Conclusion

Considering that traditional interventions for BED patients typically fail because of the patients' low compliance with clinical programs, alternative-integrative psychological approaches need to be considered and continuous monitoring is required.

With the support of decades' worth of research, investigators reported that people with severe eating disorders, such as binge eating, can be effectively treated using of Cognitive Behavioral Therapy (CBT), that explicitly addresses the need to prioritize cessation of blowouts over immediate weight loss and helps patients to establishing a regular pattern of eating as well as an appropriate weight monitoring schedule.

However, directly targeting the cardinal features of BED, it may be not very effective with resistant or ambivalent towards change patients.

Instead, analyzing and reframing both the perceptive-reactive system and the ineffective solutions revealing the structure of the problem by the use of specific procedures, the Strategic intervention allows the professional to go beyond resistance to change, subverting the dysfunctional equilibrium that has been created, then leading to the establishment of a new perception of the reality (Nardone and Watzlawick 2004). Making the client experience and feel differently rather than provide education about the disorder, BST also appears crucial fostering and maintaining long-term results in weight loss.

Even adopting a specific treatment protocol, every maneuver is always different though remaining the same, changing in its communicative way, but following the same strategic procedure of problem solving. As G. Bateson (1984) stated "*Rigor alone leads to death due to asphyxia but creativity on its own is sheer folly*" (Nardone 2004). The therapeutic intervention with patients suffering from Binge Eating Disorder mainly reframes the attempted solution that drives someone to binge eating, leading the person to eat less and with more pleasure, as well as and to cease regarding food as the greatest enemy.

BST presents a high level of efficacy (88%) with an efficiency equivalent to less than 10 sessions. The measurement of effects, are not detected only between the beginning and the end of the therapy, but looking at the accomplishment of every single maneuver, checked for every single phase of therapeutic process. "Knowing a problem by its solutions" or, in other words, knowing a reality through the strategies that can change it, Brief Strategic Therapy appears not only effective and efficient but even predictive (Nardone and Barbieri 2010). In fact, during the inpatient phase patients are not necessarily expose to binge temptations and, after being discharged, they need to be prepared for still cope with them.

By the use of Telemedicine, a new care approach which allows clinical psychologists to deliver extensive monitoring and psychological support treatments in outpatients settings, continuity of care can be best persecuted, preventing relapses and enhancing the likelihood of success of long-term results. Besides helping patients to face daily resistances and barriers during the outpatient phase, using a range of tools such as web-sites, e-mail, chat lines (e.g., IRC, internet relay chat), videoconference, telephone, and UMTS-based mobile-phone (Castelnuovo 2008), Information and telecommunication Technologies also support clients' sense of autonomy and self-efficacy, reducing expensive and time-consuming clinical visits (Castelnuovo, Gaggioli et al. 2003; Goulis, Giaglis et al. 2004)

If BST will show to be effective in reducing participants' symptomatology and weight, further trials should extend both the use of alternative models of psychological support or psychotherapy, and the implementation of new technologies, in order to find the best treatment combination (psychotherapeutic model, level of technology, number of sessions, etc.) for Binge Eating Disorder.

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