(Dis-)solving the Weight Problem in Binge-Eating Disorder: Systemic Insights From Three Treatment Contexts With Weight Stability, Weight Loss, and Weight Acceptance

Treatment for binge eating disorder (BED) is frequently accompanied by weight loss interventions, with a focus on changing the body and achieving an “ideal weight,” as decided by an individual’s treatment team. Many believe that shame associated with body size is a method by which individuals can be motivated to lose weight. However, the evidence does not back up this theory.

There is little research that has explored how different attitudes towards our bodies affect treatment outcomes, including weight. In the study that we are highlighting this month by Meyer et. al (2018), the researchers examined the relationship between weight in participants with BED, their attitudes towards weight, and how that affected their weight outcome. They sought to better understand how effective it is to promote weight loss for individuals struggling with BED.

Meyer et. al (2018) designed a multimethod study with two phases, the first of which focused on 20 weekly sessions of systemic and narrative therapy and five sessions of dietetic counselling. The therapeutic process within this phase focused on externalizing the eating-disorder voice from the self, required participants to keep a food journal and to monitor their weight, and to investigate and process any weight gain that occurred. All participants had the option of terminating treatment at any time.

Phase two of the study asked participants who wanted to continue with treatment to choose one of two tracks: the “Weight Loss Group” or the “Wellbeing/Weight Acceptance Group.” Participants followed treatment protocol within Phase 2 for 6 months. The “Weight Loss Group” met weekly and followed a weight-centric protocol in which their weights were recorded, binge-eating behavior was prohibited, and dietetic guidance was given along with therapeutic guidance. Participants had the goal of losing 1.1 pounds per week.

The “Wellbeing Group” met bi-weekly and focused less on weight loss and more on the relationships that participants had with their bodies, following the Health at Every Size(R) model. Participants were weighed, but no weight loss requirements were prescribed. Treatment encouraged a joyful relationship with food and movement, and supplemental therapeutic treatment was given to process BED behaviors. This group also explored mindful eating and meditation.
Participants for the study were 111 participants entering the study in Phase 1, 82 participants completing Phase 1, and 35 participants going on to Phase 2. Within Phase 2, 19 participants joined the “Weight Loss Group” and 16 participants joined the “Wellbeing Group”. Of this group, 27 participants completed the study, with 14 participants finishing with the “Weight Loss Group” and 13 participants finishing with the “Wellbeing Group.”

Patients (n=22) who completed Phase 1 or 2 during a 6-month observation period were asked to do in-depth interviews. Of those 22 participants, 20 accepted. Participants who accepted were three men and 17 women, aged 22 to 58 (M = 34.8), and BMI ranged from 28 to 55 (M = 39). During the interviews, participants were asked to assess how their BED and weight concerns developed, how they felt about the demand of weight stability during treatment, why they decided to continue on to Phase 2 (for those that did), and what reflections they had about the multiple treatment modes.

Findings from these interviews indicated that shifting the perspective from weight loss to weight stability had an overall calming effect, and acceptance for self and others was a more effective pathway for change. Profoundly, those in the "Wellbeing Group" were able refocus their central identity from a weight-based one to one that focused more on the inner self. Relational weight problems (discussion by family and friends about the participants’ weight) emerged as a significant issue for all participants, and resolving these conflicts resulted in a more positive experience for participants. Overall, regardless of which group the participants entered in the second phase of the trial, removing weight loss as a goal was more effective than continuing to pursue weight loss.

This study underscores the importance of moving away from a weight-based model and towards a weight-inclusive model that emphasizes acceptance in the treatment of BED. It seems that the best way to support patients diagnosed with BED and encourage behavioral change is to minimize (or ideally eliminate) a focus on weight and instead encourage more mindful and joyful connections with food and body at any size. There are limitations to this study, mainly the lack of integration of weight stigma into the findings and study design.

What do you think? Should weight loss be included in treatment of binge eating disorder? Join the conversation in our Facebook community and let us know what you think.