EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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Binge Eating, Depression, and Cognitive Therapy

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Binge-eating disorder is not currently a recognized diagnosis in DSM-IV, but is listed under eating disorder not otherwise specified. Interestingly, DSM-IV lists research criteria for binge-eating disorder, and current research is clarifying clinical features and treatment. The criteria include a sense of lack of control over eating and a feeling of being depressed, guilty, or disgusted with oneself after eating. It therefore makes sense to screen for depression in this population and to consider short-term cognitive therapy to target guilt and behavior control. Like the other eating disorders, binge eating usually afflicts adolescent and young adult females who tend to be high achievers. Not surprisingly, this often means a higher prevalence in college and postgraduate programs.

The subject of this article, a 21-year-old single white female college student, was initially seen in a primary care setting, the student health clinic, and then referred to our university clinic for evaluation and treatment.

CASE PRESENTATION

The patient is in her fourth year of college and is currently applying for postgraduate programs in biochemistry. She has a good relationship with her parents and a younger sister, although all live out of state and she finds it difficult to visit as often as she would like. She describes an unremarkable childhood marked by her academic success, which she has been able to maintain in college with discipline and hard work.

With the added stress of studying for the Graduate Record Exam (GRE) and working as a research assistant for the past 3 months, she reports an increasing number of "bad days." These are days that include at least 1 episode of binge eating, described as consuming an inappropriate number of calories during 1 sitting until she feels uncomfortable. She believes that she has no control over this eating pattern, which may include eating half of a cake or pizza even when she does not feel particularly hungry. She denies using any compensatory behaviors, such as purging, taking laxatives, or over-exercising. After these binges, she feels guilty and sad and often takes long naps that prevent her from getting work done. Also during these days, she feels depressed, with decreased motivation and energy, an inability to concentrate while studying, and frequent episodes of tearfulness. Although her grades and work have not suffered, the patient feels a great deal of distress about these bad days, now occurring 4 to 7 days a week, and is concerned that she may have an eating disorder.

The patient is currently 5 ft 8 in tall (173 cm) and weighs 181 lb (81 kg). She believes she is overweight, but seems more concerned with her pattern of eating. Her highest weight in the past was 190 lb (86 kg) during her freshman year of high school. She has been slightly overweight for much of her adult life, except for an 8-month period at the beginning of college when she was able to maintain her weight at 160 lb (72 kg). She described this time as "happy and stress-free." She has had several

episodes of dieting, none lasting more than a week. She has binged occasionally during the past 6 years, and this is usually associated with periods of depression. She consulted a school counselor for "stress" while in high school, but was never formally diagnosed with depression or treated with medication.

My diagnostic impression for this patient was eating disorder not otherwise specified and major depressive disorder. The patient agreed to a course of weekly cognitive therapy. We discussed the possibility of treatment with antidepressants, but, as the patient was reluctant to start a medication and had no thoughts of self-harm, we agreed to revisit this in a later session, if necessary.

PSYCHOTHERAPY

During the second session, I asked the patient to describe in detail one of her recent "bad days." She was able to identify a trigger of worrying about an upcoming test. She came home from school and sat down to eat. After eating until she was uncomfortably full, she felt guilty and worthless. She described a voice that "put her down" by saying things like, "You're not good enough." We discussed negative self-talk, and she observed that she could frequently identify thoughts that attack her self-esteem or abilities. She realized that she is often listening to this voice when she sits down to eat. I explained the cognitive model of automatic thoughts leading to feelings and behaviors. Toward the end of the session, she described what she did on her "good days," such as walking her dog and talking with her sister on the phone. For homework, she agreed to listen for negative self-talk, identify triggers, and attempt to replace eating with those activities she does on her good days.

During our third session, it was apparent that the patient had started to recognize how her thoughts, feelings, and behaviors are linked. She was able to successfully prevent a binge by leaving the house to visit a friend. She continued to discuss her cognitions and described thinking that if she does poorly on her GRE, she will "be a failure and never get into graduate school." This is an example of the cognitive distortions of over-generalizing and catastrophizing. I asked her how realistic this statement was, and she was able to discuss possible outcomes of doing poorly on the exam and the low likelihood of this occurring, based on her academic success in the past.

In subsequent sessions, we continued to identify and discuss cognitive distortions. The patient gave examples of all-or-none thinking and mind reading, which she was successfully able to refute by identifying a range of possibilities and testing reality. Although her "bad days" were becoming more infrequent, she continued to have tearful episodes and now agreed to a trial of a selective serotonin reuptake inhibitor (fluoxetine, 20 mg/day). With further evaluation of her binge eating, she was able to state, "I equate what I eat with my value as a person." This realization led her to change her diet to include more "healthy" choices and to gain more control over binge eating. It became clear that her binge eating was a behavior stemming from a distorted cognition of low self-worth. As her self-esteem continued to improve, her binge-eating episodes decreased, and disappeared by session 5. By session 11, the patient's depressive symptoms were in remission, and we decreased the frequency of sessions to every 2 to 3 weeks.

This case report describes successful cognitive therapy treatment of a motivated patient. In this case, one diagnosis (binge eating) was inextricably linked with another (depression). As the patient's cognitive distortions were examined and refuted and negative thinking was reframed, self-esteem improved. This, in combination with antidepressant medication, alleviated symptoms of depression, as well as binge eating.