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The "Addiction Model" in the Sense of Philosophy of Self-Help Support Groups and Cognitive Behavioural Therapy in the Treatment of Binge Eating

ABSTRACT

Addictions may appear in many normal and even everyday human behaviours. Mechanisms typical of addiction can also be seen in other disorders identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), for example, binge eating.

The article points out the similarities between the symptoms of binge eating and addiction to psychoactive substances. The traditional understanding of addiction is adopted, referring to the philosophy of self-help groups and the strategic and structural concept. Next, the differences between these disorders are discussed. The article then presents the differences between the adopted model of addiction and cognitive behavioural therapy in the treatment of binge eating. Reference is also made to research on the mechanisms underlying the disorder. Subsequently, based on these differences, which primarily concern cognitive, affective and behavioural aspects, the implications for therapy in people with binge eating disorder are presented.

For the purpose of the article, the diagnostic criteria for binge eating disorder and for alcohol use disorders presented in the DSM-5 are used. In addition, the literature on the subject was analysed and

KEYWORDS
binge eating, addition, therapy, control, clinical differences

SPI Vol. 26, 2023/2
e-ISSN 2450-5366

DOI: 10.12775/SPI.2023.2.004en
Submitted: 16.02.2023
Accepted: 13.04.2023

the collected information was supplemented with observations from the author's clinical practice.

Introduction

Nowadays, there are a growing number of observations and studies indicating the prevalence of various addictions, referred to colloquially as dependencies (Cierpiałkowska 2018). Words such as "alcoholism," "drug addiction," "pharmacophilia," "nicotine addiction," "sex addiction" and "workaholism" are appearing more and more frequently, not only in specialised therapeutic institutions, but also in everyday conversations and the media. The best known types of these disorders are related to the use of drugs which influence human mental states. Some people think that addictions are limited only to pathological use of these and similar substances. However, it turns out that addiction, understood as a serious and dangerous disorder of an individual's health, can also involve many behaviours that belong to a normal and even basic way of life. Thus, in certain circumstances, behaviours related to sexual life, work, physical exercises, playing games or eating may take an addictive and dangerous form. Common denominators can certainly be found for these disorders, which does not exclude the possibility of differences.

The aim of this article is to point out similarities and differences between psychoactive substance use disorder and a new disorder introduced in the DSM-5, called binge eating. The article adopts a traditional understanding of addiction, referring to the philosophy of self-help groups and the strategic/structural concept. The following analysis outlines the differences between the adopted model of addiction and cognitive behavioural therapy in the treatment of binge eating. To this end, reference was made to research on the mechanisms underlying this disorder. Learning about these relationships is of an applied nature, as it may be relevant to the treatment of problems associated with binge eating.

In view of the selected assumptions, the question arises as to whether, even if binge eating as such is not an addiction, the similarities between it and substance abuse point to a potential dependence. Could both problems be the result of the same underlying disorder?

Binge eating disorder is a newly identified eating disorder, included in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The disorder is characterised by a recurrent loss of control over the amount of food eaten and the manner in which it is eaten, as well as the psychological consequences of overeating. According to the DSM-5 classification, the basic criteria of binge eating are as follows:

A. recurrent episodes of uncontrolled eating
B. co-occurrence with episodes of at least four of the following symptoms:
    1. eating much faster than normal
    2. eating until uncomfortably full
    3. eating large portions despite not feeling physically hungry
    4. eating alone due to embarrassment/anxiety about eating
    5. feelings of self-loathing, depression or guilt after overeating
C. marked distress because of uncontrolled eating
D. unrestrained eating at least once a week for three months
E. lack of repetitive compensatory activities in relation to unrestrained eating.

Binge eating disorder is diagnosed among 15.7%–40% of obese individuals. In the general population, the percentage is much lower, between 1.12% and 6.6% (Bok-Sosnowska 2017). In the scientific and medical fields, due to a certain analogy with alcohol addiction, one may find oneself thinking of binge eating as if it were alcohol dependence. Therapists and researchers have been arguing about the definition of addiction for many years. According to the DSM-5, psychoactive substance use disorder is defined as the underlying behaviour of people who misuse substances. It should be noted that in the DSM-5, the criteria for alcohol use disorder are the same as for any other psychoactive substance use disorder. In the revised version of the DSM-5, alcohol use disorder is categorised into degrees of severity according to the number of symptoms observed in the last 12 months. These symptoms of alcohol use disorder include:

- drinking alcohol in larger quantities or for longer periods than intended
- a persistent desire to drink alcohol or accompanying unsuccessful attempts to reduce or control drinking

- spending a lot of time obtaining alcohol, drinking and dealing with the consequences of these actions
- experiencing cravings for alcohol or a strong need to drink
- recurrent use of alcohol that results in neglecting major responsibilities at work, school or home
- consumption of alcohol despite continuing and recurring social and interpersonal problems caused or aggravated by alcohol
- limiting or abandoning important social, occupational or leisure activities because of alcohol
- repeated consumption of alcohol in situations where it is risky to do so (e.g. driving a car or operating machinery under the influence of alcohol)
- use of alcohol despite continuing or recurring physical or mental problems, possibly caused or aggravated by the use of alcohol
- the development of alcohol tolerance: needing to drink significantly more to achieve the desired effect, or with an apparent significant reduction in the effect when using the same amount of alcohol
- the presence of characteristic withdrawal symptoms due to cessation or reduction of drinking, or drinking alcohol/taking similar substances with the intention of easing or avoiding withdrawal symptoms.

Method

The diagnostic criteria for binge eating disorder and the diagnostic criteria for alcohol use disorders in the DSM-5 were used to achieve the goal formulated in this article. In addition, an analysis of the literature on the relevant issues was conducted. The resulting information was supplemented with observations from the author's own clinical practice.

The similarities between the symptoms of binge eating and substance abuse are first pointed out. Then, the differences between these disorders are discussed. Next, the differences between the traditional addiction model and cognitive behavioural therapy in the treatment of binge eating are presented. Also, reference is made to research on

the mechanisms underlying the disorders in question. Finally, based on the differences, suggestions for the treatment of people with binge eating disorder are presented.

Discussion

There are theories which assume that compulsive overeating involves three aspects: physical, emotional and spiritual (Pawłowska, Kalka 2015). According to these theories, compulsive overeating, like addiction, can be stopped but not cured. The traditional model of addiction in the treatment of compulsive overeating refers to a physiological mechanism that is also found in alcohol addiction. People who experience compulsive overeating usually have a biological inclination towards certain foods, which makes them addicted to them. They are unable to control the consumption of such foods, as a result of which their consumption of these foods increases. Due to the biological nature of this problem, it is impossible to cure it. Rather, such people must accept their tendency and adjust their lives accordingly.

The term *addiction*, on the other hand, is nowadays used in a haphazard and vague way to refer to almost any form of repetitive behaviour (Wilson, Zandberg 2012). This strips it of its value. Using it in such a casual way suggests that everyone has an addiction of some kind.

Parallels can be seen between traditional substance abuse and binge eating, which can lead to thinking of binge eating as an addiction. In the case of binge eating, as in the case of addiction to narcotics, a person craves or desires to engage in this behaviour. Also, in both cases we can see a loss of control over the behaviour, as well as irresistible and recurring thoughts about the behaviour. Each of these behaviours can be used to get rid of unpleasant emotions. In addition, people experiencing the disorders in question deny and try to hide the problems that arise. Despite the harm they experience, they are unable to refrain from this behaviour. This usually manifests in unsuccessful attempts to cope with the problem.

These similarities do not mean that these behaviours are the same. By focussing solely on similarities, one may overlook differences that are relevant to their understanding and treatment. The first significant difference between binge eating and substance abuse that can

be pointed out is that binge eating does not involve eating a specific type of food. People suffering from binge eating do not favour certain foods over others (Hebebrand, Albayraki et al. 2014). If the disorder was an addiction, a person would likely prioritise selected foods over others. The primary symptom of a disorder manifested by binge eating is the amount, and not the type of food consumed.

Another difference is the existence, in the case of binge eating, of a determination to rigorously control the food consumed. In contrast, alcohol addicts are not internally motivated to avoid alcohol, which leads to a loss of control (Mellibruda, Sobolewska-Mellibruda 2013). The degree to which an addicted person feels ready to change depends on the influence of intrinsic and extrinsic motivational factors, making them go through specific phases of readiness to change (Holt, Kranitz, Cooney 2013). It can be concluded that, as with weight loss, the real challenge in the context of addictions is to maintain change. There are a variety of self-help groups that aim to help addicts in the process of change. They differ in the degree of emphasis they place on abstinence. The largest and most popular self-help institution for addictions is groups based on the 12-step programme (Miller, Forcehimes, Zweben 2022). In their programmes, the primary goal of addiction treatment is to arouse a determination to abstain from the addictive behaviour (Miller, Forcehimes, Zweben 2022). In the case of binge eating, when an individual comes for help, this determination is already present in the form of desire for strict food control (Ziauddeen, Farooqi, Fletcher 2012). Then, the patients themselves often claim that "they want to control their control". The irresistible desire to control the food is itself a problem because it sustains binge eating (Gearhardt, White, Potenza 2011).

An additional difference that can be identified between binge eating and substance abuse is that overeaters feel fearful of engaging in this behaviour. The desire for a lower body weight among most binge eaters is accompanied by an overestimation of the importance of one's figure and weight (Łuszczyńska 2016). One's self-esteem is primarily influenced by one's appearance and weight. Observed weight loss has a rewarding effect and encourages a consistent, strict diet. This leads to a reinforcement of the disorder. There is no similar mechanism in substance addiction; people who are addicted to substances do not reach for them because they want to avoid them. Their

process of returning to health rarely boils down to one resolution that is never broken. Most commonly, we observe increasingly long periods of abstinence interrupted by shorter and less intensive episodes of substance use (Klingemann H., Klingemann J. 2013). In contrast, people suffering from binge eating overeat due to a strong desire to curb this behaviour (Fairburn 2013).

Therefore, it can be seen that different mechanisms underlie binge eating and substance abuse. This means that different therapeutic interventions should be applied for these disorders. In most problems associated with binge eating, therapy should focus on restraining self-control; in addiction therapy, on the other hand, the focus should be on strengthening it.

It is noteworthy that some people with binge eating disorder are not following a particularly strict diet. For them, overeating attacks may not be triggered by dieting or it may be of lesser importance. It is recognised that stress management problems are probably of greater importance in this case (Kupeli, Norton et al. 2017). This allows us to conclude that there may be some correlation between the mechanisms that trigger binge eating and those leading to alcohol dependence. The desire to gain control over one's emotional state in order to alleviate distress and provide a sense of pleasure appears to be key in addiction (Miller, Forcehimes, Zweben 2022). The presence of this aspiration in people's lives seems understandable, but some ways of pursuing it can lead to serious dangers. Ways of excessively controlling the state of one's feelings can turn into traps of addiction. A person becomes a slave to these ways as they lose the capacity to use them at will, and become used by these ways instead. These modern ways leading to the attainment of "happiness" can be divided into two categories: stimulants (alcohol, medicine, drugs or cigarettes) and certain behaviours (food, work, sex, entertainment, games or physical exercise). When the persistent search for happiness, increasingly identified with the pursuit of pleasure, begins to dominate an individual's life, pleasure reveals its other side and turns into compulsive, desperate attempts to alleviate suffering. Thus, the persistent search for pleasure leads a person to suffering which cannot be avoided except by repeating the activity that causes them suffering (Linehan 2016).

Research indicates that alcohol consumption is higher among people with binge eating disorder, but this finding is difficult to interpret because it is no different from the rate of alcohol abuse among people with other mental disorders (Karacie et al. 2011). The situation is similar with the prevalence of eating problems among substance abusers. It is recognised that there is a higher rate of eating disorders in addicts, but it could be argued that this is non-specific as such problems also occur in people with other mental disorders such as anxiety or depression (Ziauddeen, Farooqi, Fletcher 2012).

Some studies have shown the higher rates of substance abuse among family members of people experiencing eating disorders, but again, as in the aforementioned studies, the rate is no higher than for family members of people with other mental disorders (Kupeli et al. 2017). This leads us to conclude that they differ in the underlying mechanism. If they were the same, differences would be observed between these disorders and other mental disorders.

Also of interest is the timing and sequence of the disorders in question. Research suggests that eating disorders tend to occur among drug addicts first (Fairburn 2013). The result of this research is predictable, as eating problems tend to occur earlier in life than problems resulting from drug use. However, the two problems may co-occur. It may then be more difficult to treat these individuals (Fairburn 2013). Therapy for such patients requires a holistic approach and attention to whether alleviating one disorder negatively affects the co-occurring problem. Research conducted on therapy for people with eating disorders and excessive alcohol consumption has shown that those people experiencing eating disorders respond similarly to cognitive-behavioural trauma regardless of the amount of alcohol they consume. In addition, during the course of treatment, alcohol intake decreased to normal limits in the majority of alcohol abusers (Kupeli et al. 2017). In individuals whose alcohol consumption increased during eating disorder therapy, it was observed that despite improvements in eating, these individuals also functioned poorly in other areas of their lives (Kupeli et al. 2017). This indicates that a symptom substitution effect did not occur.

Treatment of binge eating and the model based on traditional addiction therapy

The principles of addiction therapy based on the 12-step programme differ from binge eating disorder therapy, which seems to be successful. Assuming that the underlying mechanisms of binge eating are different from those underlying drug addiction, different treatment principles should be applied. Those adopting the binge eating therapy model based on the traditional approach to addiction also recommend using the 12-step programme designed for Alcoholics Anonymous, changing the words "alcohol" and "alcoholic" to "food" and "compulsive eater". They believe that treatment should use the output of Alcoholics Anonymous groups. This approach differs from cognitive-behavioural therapy for binge eating, which currently has a reputation for being the most effective. The differences are related to four issues.

The 12-step programme assumes that an eating disorder is a disease that cannot be cured. Following the philosophy of Alcoholics Anonymous, it is assumed that an eating disorder is a progressive disease which continually worsens. In contrast, the cognitive-behavioural therapy model assumes that most people with complaints of binge eating can recover (Fairburn 2008).

Another assumption of the 12-step programme is that immediate abstinence is necessary. It places a strong emphasis on stopping overeating as soon as possible. Group pressure can be used to achieve this goal, in which abstainers receive praise and those who have not been able to maintain abstinence are socially sanctioned, for example, deprived of the opportunity to speak or even being asked to leave a meeting.

According to the ideas of cognitive behavioural therapy, the immediate cessation of overeating is unrealistic and unlikely to be achieved. The insistence on abstinence is inhumane and irrational. Even if some people are able to cope with the problem with good advice and support, there are others who do not succeed. They need more time. Cognitive-behavioural therapy does not require an immediate cessation of binge eating. In contrast, therapy for binge eating based on the traditional model of addiction takes total, lifelong avoidance of foods that lead to overeating as the best strategy for achieving

abstinence. According to the cognitive-behavioural approach, such a strategy encourages eating rather than promoting avoidance. The belief that certain foods encourage people to overeat is not based on any proof. Research and therapeutic practice indicate that it is the attempt to avoid a certain type of food that cause individuals to manifest a tendency to overeat (Ziauddeen, Farooqi, Fletcher 2012). That is why cognitive-behavioural therapy seeks to eliminate food avoidance instead of encouraging it. According to the assumptions of the traditional addiction model, this would lead to further overeating. Research indicates that some evidence supports restraint as a precursor to negative outcomes such as binge eating (Fairburn 2013).

It is worth noting that, until recently, it was assumed in addiction therapy that one could not have partial control over the addiction one experiences (Klingemann H., Klingemann J. 2013). It was approached in a zero-sum manner, meaning that one either has control or not at all. The concept of impaired control, initially understood solely as a difficulty with abstaining from drinking, has come a long way. The publication of the revised DSM-5 brought significant changes to the field of addiction. According to it, alcohol use disorder was wrongly considered an incurable condition. Understanding alcohol use as an escalating process has made it possible to define the severity of the disorder, the main aspect of which is impaired control. The WHO has reduced the criteria for alcohol dependence to flexible pathways. Its diagnosis requires the presence of two or three main features, one of which is impaired control of substance use. This refers to the amount of alcohol consumed and to the circumstances and timing of starting or stopping drinking. It is often accompanied by a subjective, strong need or craving for alcohol. Consequently, understanding the phenomenon and determining the severity of impaired control has become an important skill in clinical practice (Modrzyński 2019).

The belief regarding the treatment of binge eating that was in place until the DSM-4 classification generated the belief that eating is either safe or harmful. Similarly, one is either abstinent or not. Such thinking is recognised in cognitive-behavioural therapy as a cognitive distortion—a problem which needs to be addressed. The "all-or-nothing" mindset causes any failure to be seen as a relapse of the disorder rather than a "step back". As a result, when a person

succumbs to weakness, they immediately become unreasonably discouraged and prone to giving up.

It is worth noting that for those suffering from binge eating, the "all-or-nothing" approach makes everyday life difficult and affects various aspects of life. Therefore, given that the previous thinking about addiction is still ingrained in society, despite the changes introduced in the DSM-5, it seems reasonable to help people recognise this pattern of thinking in order to eliminate rather than reinforce it.

Summary

For some people, binge eating is a simple deviation from their diet or a lack of moderation. However, there are those who see it as a partial or total loss of control. Binge eating is a problem for many people, but despite this, their knowledge of it seems to be insufficient. This is a source of much ambiguity and different views of treatment. Undoubtedly, the traditional model of addiction treatment is much more complex, and encompasses many more aspects and interventions than those presented in the article. It has many strengths, such as long-term support and a sense of belonging. In addition, the transparency of its premise makes it attractive to some people. However, it is not the form of delivery that should determine which therapy is provided, but its effectiveness. The use of the traditional addiction model in the treatment of binge eating has not yet been fully evaluated, unlike other forms of therapy. Cognitive-behavioural therapy is regarded as one of the best researched treatments for binge eating. It is considered an appropriate treatment method for overeating problems because its cognitive components address the cognitive aspects of these problems—such as overestimating the importance of one's figure and weight, dietary rules and dichotomous thinking—while its behavioural components refer to the disordered way of eating.

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