Mindfulness Approaches to Relapse Prevention in Eating Disorders and Addictions

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Abstract

This writing will briefly look at Bandura's theory of self-efficacy and continue with an explanation of Alan Marlatt's Abstinence Violation Effect and Relapse Prevention Models pertaining to addiction treatment. The theory of poorly regulated emotions and a dissociative state of mind as influencing relapse in addictions will be examined. Treatment using mindfulness practices and a dialectical approach, which seeks to bring the individual to a heightened state of awareness and presence, is explored. The dialectical struggle in the individual is the acceptance of oneself while maintaining a commitment to change behavior. The goal of the process is to limit the relapse period and/or severity once the abstinence violation is experienced. This dialectical approach to therapy is derived from eastern meditation practices and arose out of the work of Marsha Linehan.

Contents

Marlatt's Abstinence Violation Effect and Relapse Prevention Model

Albert Bandura proposed that perceived self-efficacy to be the primary determinant of emotional and motivational states which bring about change in an individual's behavior (1977). It is the level of belief or confidence in one's own ability to create goals and achieve desired results toward those goals. Along with various social modeling and learning theories developed, Bandura was the first to demonstrate the effects that self-efficacy had on the individual. He argued that it affected what an individual chooses to do, the amount of effort he/she puts into doing it, the way he/she feels as it is being done, and the likelihood of achieving the task. Changes in self-efficacy are closely correlated to changes in actual performance. Bandura theorized that efficacy expectations stem from four major sources: performance accomplishment, vicarious experience, verbal persuasion, and emotional arousal. But self-efficacy can also expand beyond control of behavior to control of thoughts, emotions, or even environment (1977).

Alan Marlatt followed Bandura's cognitive and social learning theoretical orientation while expanding upon the theory of perceived efficacy applying it to the study of addictions, specifically in the area of relapse prevention. Marlatt (1985) argued that efficacy was inversely related to the desire or craving of the substance or behavior that was being extinguished. He later classified efficacy judgments into two specific models, one he called resistance self-efficacy beliefs which is the judgment of the individual to avoid the substance or behavior prior to first use. The second model he called harm reduction self-efficacy beliefs which is the judgment of one's ability to reduce the risks of the substance or behavior after addiction has occurred (1996).

Marlatt proposed that it was destructive internal cognitive processes which caused the probability of relapse in addictions. Through socially learned constructs, certain beliefs, expectations, or judgments about the self, become engrained as fact to the individual, which in

turn determines the level of self-efficacy. These attributions associated with or blamed for the

cause of the lapse in abstinence, mixed with feelings of guilt or shame associated with the cause

or lapse, increase the probability of a complete relapse back to a much earlier point on the stage

to recovery. This process, Marlatt first coined as the Abstinence Violation Effect (1979).

The AVE often accompanies a feeling of loss of control that results when one has first

violated a self-imposed rule of abstinence of a specific and often addictive drug, food, or

behavior. It is a psychologically demoralizing process which may begin with environmental

factors or external stimuli but quickly feeds on internal negative factors or cognitive causal

attributions. This shift then triggers a downward spiral effect propelling the individual to an

uncontrolled use of the substance or behavior which was initially being abstained from. So what

might begin with a minor lapse from complete abstinence may result in a full blown relapse on

the stage of change continuum.

Marlatt (1979) proposed that it is internal, stable and global attributions for the cause of

the lapse and feelings of guilt thereafter greatly increasing probability of a return to prior

behaviors. Those who attribute the lapse to personal failure feel guilt and may continue with the

violation in an attempt to escape the pain of the failure. Those who blame factors beyond one's

control (disease model) are more likely to have full blown relapses and keep repeating the

abstinence relapse scenario over and over. Those who consider it a personal failure and a lack of

effective coping skills learn from each episode, hence develop better coping skills for the next

time. This process of trial and error with each abstinence violation will help in developing

coping mechanisms which in turn will begin to break down the power of the AVE process. Self-

efficacy will improve with each successful occurrence related to the AVE.

The success of preventing a relapse is greatly influenced by the individual's perception of, and reaction to, the first violation or how the AVE was handled. Marlatt's (1984) cognitive-behavioral analysis of relapse, using his Relapse Prevention Model proposes that relapse is strongly influenced by the interaction of environmental risk factors, skills to cope with those risk factors, the level of perceived personal control (self-efficacy), the anticipated effect of returning to the addictive substance or behavior, and a contingency plan if relapse occurs. Marlatt and Gordon (1985) were among the first to develop what is known as the Cognitive-Behavioral Relapse Prevention Model which is based more on principles of prevention than on the treatment itself, arguing that many RP programs fail to make the distinction between goals of abstinence initiation and goals of relapse management.

Ward, Hudson, and Bulik (1993) in a study of the AVE pertaining to Bulimia Nervosa specifically looked at the link between attributions and emotions and found a causal effect. They found that the cognitions that defined the relationship between restraint and binge onset are critical determinants to the lapse or relapse construct with negative affect being the factor which decides the direction and/or severity of the lapse. The stage of change that the individual is on at the time of the lapse also is a strong determining factor to the severity. It is a dynamic rather than static process with cognition continuously restructuring. Shame and guilt as affect also leads in divergent directions, with the former emotion associated with internal attributions of personal uncontrollability, and the later emotion internal but controllable, such as lack of effort. Often these two emotions are treated as equivalent, but may lead to different outcomes concerning the level of self-efficacy or experienced cognitive dissonance.
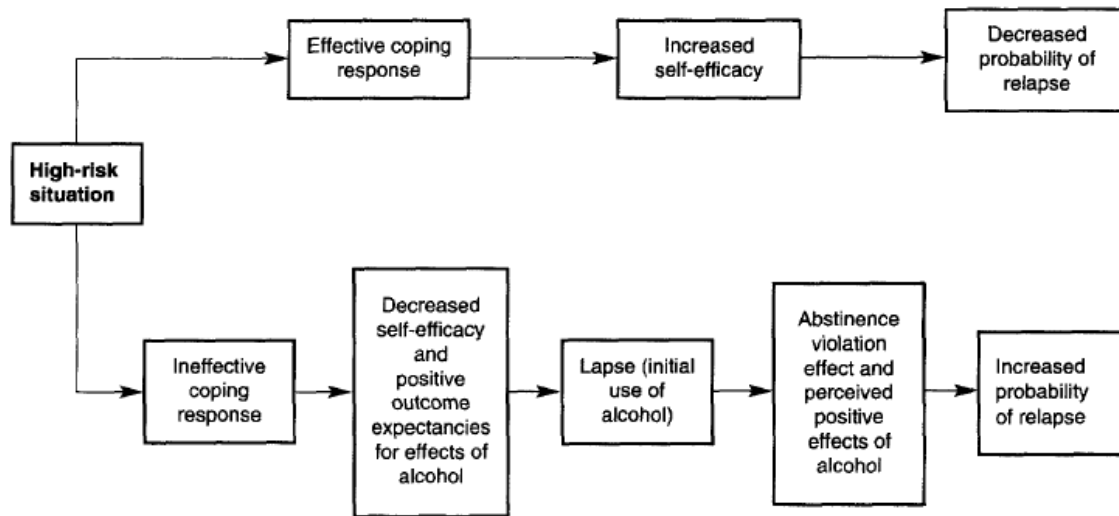
Figure 1 The cognitive-behavioral model of the relapse process posits a central role for high-risk situations and for the drinker's response to those situations. People with effective coping responses have confidence that they can cope with the situation (i.e., increased self-efficacy), thereby reducing the probability of a relapse. Conversely, people with ineffective coping responses will experience decreased self-efficacy, which, together with the expectation that alcohol use will have a positive effect (i.e., positive outcome expectancies), can result in an initial lapse. This lapse, in turn, can result in feelings of guilt and failure (i.e., an abstinence violation effect). The abstinence violation effect, along with positive outcome expectancies, can increase the probability of a relapse.

NOTE: This model also applies to users of drugs other than alcohol.

Marlatt and Gordon's 1985 Relapse Prevention Model (Larimer, Palmer, Marlatt, 1999)

Relapse prevention procedures can be initiated as either a maintenance strategy to strictly lessen relapse episodes or to broadly encourage complete lifestyle changes. The former specifically focuses on the addictive behavior and prevention of a relapse regardless of the strategy used to achieve abstinence. The later approach is to encourage and/or facilitate changes in lifestyle and personal habits, with the intention of also reducing disease, physical or medical problems and more easily manage life stress. One constructive way of handling a lapse is to identify circumstantial factors that lead up to the lapse and use it as a learning experience to develop contingency plans for future high risk situations. (Marlatt 1984)

In this RP model, based on social-cognitive psychology, a relapse is viewed as a transitional process rather than a dichotomous success or failure proposition. This belief concludes that one cannot fail but merely bring oneself closer to, or further from, the desired goal. By breaking down the wall that the AVE builds, the all or nothing thinking that so often tricks the individual into thinking that there is an internal reason or a disease that is preventing abstinence, slowly recovery can begin. This model offers behavior modification through cognitive-behavioral strategies by finding out what works and what doesn't work through trial and error during lapses creating a more controllable situation. The pendulum swinging from one extreme (abstinence) to another (relapse) or as Marlatt (1984) explained it, the oscillation of perceived control, is merely total restraint or total indulgent, but little control over anything.

Marlatt and Gordon's RP model is based on social-cognitive psychology which proposes relapse factors fall into two distinct categories, immediate determinants and covert antecedents. The immediate factors include high-risk situations, personal coping skills, self-efficacy or outcome expectancies, and the AVE. The covert antecedents are things such as the individual's lifestyle balance, urges and cravings toward the addictive substance or behavior, and the need or desire for immediate gratification (Larimer, Palmer, Marlatt, 1999).

The RP model postulates that placing oneself in high risk situations after abstinence to be the leading immediate precipitator to triggering a lapse. However, the trigger is not merely the high risk situation itself, but the person's response to it. Positively learned coping skills of high risk situation, heightens the perceived self-efficacy in the individual. Marlatt found that the highest risk for relapse was found with intrapersonal negative emotional states such as depression, anger, anxiety, frustration and boredom. Interpersonal conflict was also found to be high on the list in relapse situations.

Although high risk situations are generally immediate determinants to relapse, covert antecedents are less obvious factors but can also sabotage success in relapse prevention. These include two cognitive components which encourage overt risks such as rationalization and denial. Also, AID's (apparently irrelevant decisions) which are often used to test ones control.
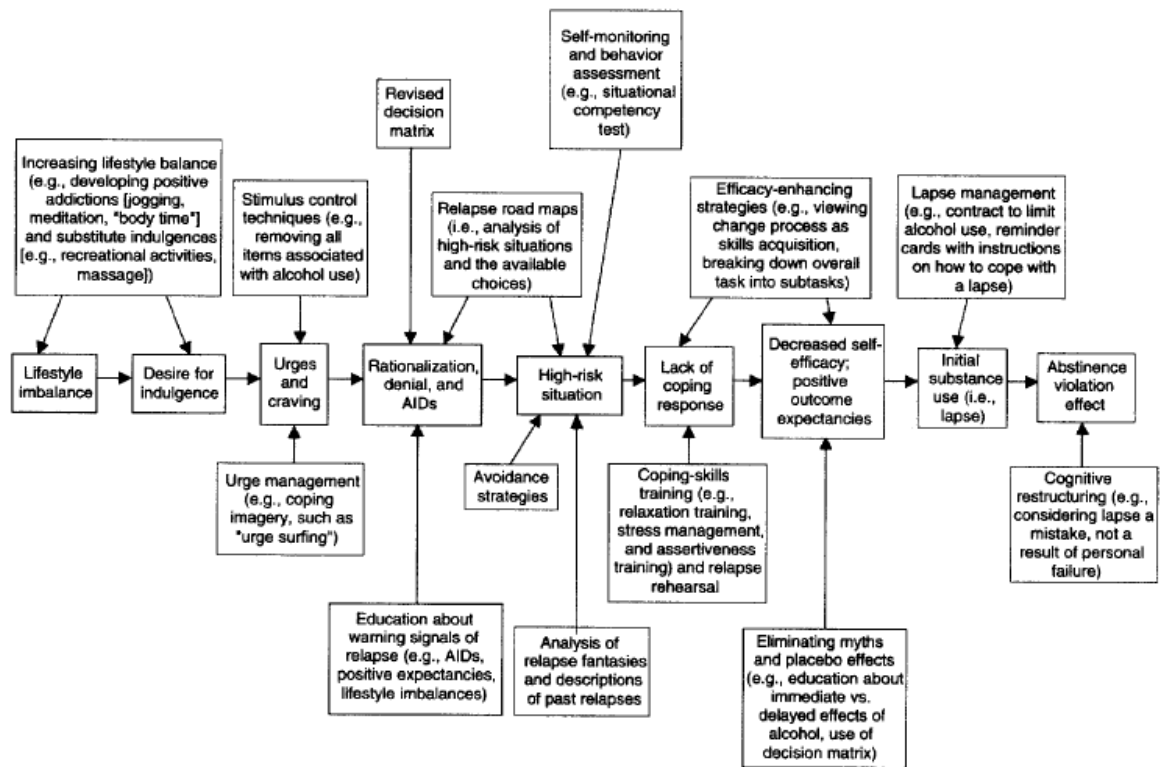
Figure 2 Covert antecedents and immediate determinants of relapse and intervention strategies for identifying and preventing or avoiding those determinants. Lifestyle balance is an important aspect of preventing relapse. If stressors are not balanced by sufficient stress management strategies, the client is more likely to use alcohol in an attempt to gain some relief or escape from stress. This reaction typically leads to a desire for indulgence that often develops into cravings and urges. Two cognitive mechanisms that contribute to the covert planning of a relapse episode—rationalization and denial—as well as apparently irrelevant decisions (AIDs) can help precipitate high-risk situations, which are the central determinants of a relapse. People who lack adequate coping skills for handling these situations experience reduced confidence in their ability to cope (i.e., decreased self-efficacy). Moreover, these people often have positive expectations regarding the effects of alcohol (i.e., outcome expectancies). These factors can lead to initial alcohol use (i.e., a lapse), which can induce an abstinence violation effect that, in turn, influences the risk of progressing to a full relapse. Self-monitoring, behavior assessment, analyses of relapse fantasies, and descriptions of past relapses can help identify a person's high-risk situations. Specific intervention strategies (e.g., skills training, relapse rehearsal, education, and cognitive restructuring) and general strategies (e.g., relaxation training, stress management, efficacy-enhancing imagery, contracts to limit the extent of alcohol use, and reminder cards) can help reduce the impact of relapse determinants. Shaded boxes indicate steps in the relapse process and intervention measures that are specific to each client and his or her ability to cope with alcohol-related situations. White boxes indicate steps in the relapse process and intervention strategies that are related to the client's general lifestyle and coping skills. High-risk situations are related to both the client's general and specific coping abilities.

(Larimer, Palmer, Marlatt, 1999)

White, Masheb, and Grilo (2008) completed a study on restraint practices in Binge Eating Disordered patients using data from over 500 obese patients all diagnosed with BED using the Three Factor Eating Questionnaire (Stunkard & Messick 1985) and the Eating Disorder Examination Questionnaire (Fairburn 1994). Analysis indicted a two factor specific model of restraint. Regimented restraint was defined by rule directed behaviors and rigid food rules with specific attempts to limit food intake. This construct was associated with increased eating disorder symptomatology, higher levels of body image distortions, and elevated food and weight concerns. Lifestyle restraint was defined as assessment of the environment on a broader scale and the preplanning food intake through overall environmental management. This construct was associated with lower levels of eating, food, and body image psychopathologies and more favorable weight outcomes. The study suggests that interventions should be focused on lifestyle changes and restraint attempts using a more holistic or wellness approach to weight management.

Miller (1996) studied a sample of 122 individuals seeking outpatient treatment for alcohol problems. Potential problems concerning relapse were assessed at various points covering five domains: occurrence of negative life events; cognitive appraisal of self-efficacy, abstinence expectations, and motivation for change; client coping resources; craving experiences; affect and/or mood status.

His study concluded that a lack of coping skills and resources on hand were found to be the greatest problem influencing a relapse. In another theoretical writing Miller (1996) called for the abandonment of the term "relapse" concluding that it is a demoralizing concept that denotes failure and creates negative affect and a self-defeating and self-fulfilling prophecy. He argued that successful behavior change called for successive approximations to goals which are not adequately described in the currently understood concept of relapse.

Emotion Dysregulation and Disassociation

Eating disorders, specifically those which involve the process of food binging (Bulimia Nervosa & Binge Eating Disorder), are closely associated with substance addictions, and therapy and treatment methods of ED are sometimes consistent to Substance Use Disorders treatment. Due to common onset situations of trauma or abuse, often from childhood, addiction comorbidity is common between SUD and food addiction (Vanderlinden & Vandereycken 1997). The Addiction model of eating disorders focuses on the issue of impulse control often initiated by periods of fasting or obsessive food restraint. Although it most often remains a learned conditioned response to stressful circumstances or a lack of coping skills, it can be initiated by either physical urge and craving, or an emotional response to thoughts or environmental stimuli. Theories of SUD's recognize the importance of environmental and cognitive factors, although focus is more often placed on addiction as a brain disease. Like SUD's food binging can also be due to predisposition to food allergies or sensitivities with simple sugars and highly processed carbohydrates being the most common addictive foods. Research has shown that brain chemistry changes after highly refined foods enter the body, affecting neurotransmitters, endorphins, and levels of serotonin (McAleavey 2001). However, the focus for causes of ED's remain predominately on psychosocial and family influences arising from psychoanalytic, feminist and family theory.

Theories of SUD's and binge eating disorders (BED & BN) often suggest that negative emotional states or a general dysregulation (positive or negative) of emotion leads to the initial lapse and thereafter the AVE takes over. Much recent research on addictions suggests that a dissociative state of mind takes over which is linked to self-perception and self-awareness. One study (Burton 2005) postulated SUD's as being completely embedded in dissociated self-states.

Dissociation is generally viewed as a defense mechanism which threatening ideas, memories or conflicting impulses are separated from the rest of the psych. The various groups of dissociative disorders in the DSM-VI-TR are characterized by a disruption in the normal integrative functions of consciousness, memory, or perception of the environment. It can be sudden, gradual, transient or chronic, and which may last for minutes or for years.

Escape theory (Heatherton & Baumeister 1991) proposes that binge eating is motivated by a desire to escape from self-awareness due to the high standards and expectations that are placed on the individual, which are self-perceived and often distorted. When the person fails to live up to the high standards that are placed, low self-perceptions are accompanied by emotional distress, which often includes anxiety and depression. This cognitive dissonance creates an unpleasant state in which binge eaters attempt to cognitively respond by narrowing attention to the immediate stimulus environment and avoiding any meaningful rational thought. This narrowing of attention is referred to as *cognitive narrowing* which disregards inhibitions concerning food and fosters an uncritical acceptance of irrational beliefs and thoughts.

The affect regulation model argues that it is the negative moods or thoughts which cause the lapse and the binge itself plays the instrumental role in regulating the negative emotions. Both models lead to a dissociative state in order to alleviate current or past trauma, stress, anxiety, or panic. One study (Lyubomirsky, Casper, & Sousa 2001) determined an increased dissociative state in bulimics, especially as the binge progressed, as was found in the binge eater.

Mindfulness Approaches to Addiction

The word *mindfulness* was initially translated into English from Pali and Sanskrit, two of the Indo-Aryan languages. The concept arose out of the philosophy of Buddha, founder of the religion of Buddhism in India, present day Nepal, during the fifth century B.C. Buddha rejected basic concepts in Hinduism the practiced religion in that place and time and set out to reform the religion. Buddhism is more of an experience rather than a doctrine or belief system. Karma in Buddhism is the force that drives the cycle of suffering and rebirth for each being. Suffering is caused by craving and suffering ends when craving ends. A strong guiding principle is the *middle way* or *middle path*, the practice of non-extremism, the path of moderation away from the extremes of self-indulgence and self-mortification (Kennedy 1984).

Mindfulness is considered necessary on the path to enlightenment (nirvana) meaning being free from suffering. The way to this in Buddhism is the *Eightfold Path*: understanding, thought, speech, action, livelihood, effort, mindfulness, and concentration. Mindfulness is an attentive awareness of the current moment, being fully present in reality, and which completely conflicts with delusion. The Buddha promoted mindfulness practice in day-to-day life which maintained calm awareness of one's bodily functions, emotions, feelings, and any objects of consciousness, such as thoughts and perceptions. This was a key teaching of the Buddha, a meditative stabilization combined with liberating discernment, which he considered the ultimate consciousness. Enlightenment in Buddhism is the state of being in which delusion has been overcome and complete clarity is experienced.   For Hindus and Buddhists, enlightenment ends the cycle of reincarnation, therefore earthly suffering, which is somewhat related to but also distinct from ideas such as salvation and transcendence in Christian philosophy (Morse 1962).

The use of mindfulness approaches to remedy psychological and physical illnesses has been exponentially increasing over the last three decades in mainstream medicine and areas of mental health. Mindfulness psychology is the process of intentionally bringing one's awareness to the internal and external experiences occurring in the present moment in a nonjudgmental and accepting way. It maintains no specific goals or direction. Instead it focuses on pondering, while observing, the ongoing stream of stimuli being experienced at the time such as thoughts, emotions, sights, sounds, and body sensations. It does not apply critical thought or judgment, only simple awareness to consider. It is distinctly different than a concentration based approach, such as transcendental meditation (TM) which arose out of Hinduism. TM directs the participant to restrict the focus to one particular stimulus. Mindfulness conflicts with TM because it offers awareness of constantly changing internal and external stimuli as they arise (Baer 2003).

Mindfulness meditations have been increasingly becoming integrated with traditional cognitive-behavioral approaches to relapse maintenance in substance use disorders. Recent research (Bowen....Marlatt 2009) suggests that certain methods have helped to develop a detached and de-centered relationship to thoughts and feelings, which help to dismantle destructive cognitive patterns often leading to relapse. This process increases self-efficacy and enhances one's ability to more easily cope with cues and stimuli interrupting the automatic response cycle, decreasing the need to alleviate emotional discomfort with substance abuse. By increased self-acceptance and decreased critical condemnation, which hinders the abstinence violation process, previous automatic reaction to poor choices develop into more skillfully made decisions. The therapeutic goal of mindfulness training is to enhance awareness so clients are able to *respond* to situations rather than *react* to them.

Gestalt

The application of using a mindfulness approach to psychology was originally rooted in the philosophy of Christian von Ehrenfels, an Austrian, in an essay in 1890. His thought ran against the then popular atomistic structural approaches to explain experience; specifically concerning perception, memory, and abstract thinking. His work led to the Berlin school of Gestalt psychology which investigated neural networks in cognitive science (Craig 2005). The German word gestalt meaning *shape* or *form*, signifies a *perceptual configuration* made of integrated and interactive elements, which confers properties of the whole, but which are not possessed by any one of the individual elements. It is a holistic approach to understanding human perception. During the early 20th century, three German psychologists, Kohler, Koffka, and Wertheimer continued with this theory (VandenBos 2007).

Contemporary Gestalt theory and practice arose in NYC in the middle of the 20th century. Behaviorists criticized it, arguing that psychologists should be investigating human behavior rather than sensation or conscious experience. Empirical experimentation was difficult, if done at all, and the theory took much criticism from structural and positive psychologists. Fritz and Laura Perls along with Paul Goodman developed it further through the 1950's. It became more popularized through the 1960's, and training centers emerged through the 70's and 80's. But because of the lack of formal research, academia never would embrace it, and it stayed outside of mainstream university psychology departments.

Gestalt therapy focuses on behavior, thought, emotions and feelings occurring in the present moment rather than the past or future. It combines a phenomenological, humanistic and existential approach emphasizing personal responsibility, character structure, experiential freedom, and interpersonal relationships, specifically the client-therapist experience.

Mindfulness-Based Stress Reduction (MBSR)

In 1979 Jon Kabat-Zinn began the Mindfulness-Based Stress Reduction (MBSR) program at the University of Massachusetts' Medical School and continued developing it over a ten-year period. The program offers an 8-10 week intensive training program in mindfulness meditation. The program creates an awareness of the unity between mind and body and the impact that unconscious thoughts, feelings and behaviors can have on mental, physical, and spiritual health. Many medical centers have adopted this approach to managing the chronic pain and stress that comes with illness (Baer 2003).

Stress impacts attention, concentration, and decision making and even in the healthy individual can lead to occupational burnout. Mindfulness meditation has the potential to increase the immune system's ability to ward off disease, ease chronic pain and illness, anxiety and panic, sleep disturbances, fatigue, high blood pressure, and headaches. Mindfulness-Based Cognitive Therapy (MBCT) is a form of MBSR and specifically used to treat depression which focuses on cognitive based exercises and links thinking with the results of feeling.

Stress related psychological problems among counselors and therapists or those working in the helping professions are especially common. One study (Shapiro 2007) looked at 83 graduate counseling students in an attempt to measure three areas: the efficacy in enhancing the mental health of therapists in training; increased mindfulness; and positive affect and outcome. Concerning perceived stress, negative affect, anxiety, and rumination decreases were found. In the areas of positive affect, levels of attention, and awareness, an increase was seen. But what was most interesting in this study, which sampled future mental health therapists, was that self-compassion was also measured and was found to increase with MBSR practices.

Linehan's Dialectical Behavior Therapy (DBT)

Although there are various mindfulness techniques being used in the mental health field today, dialectical behavior therapy is probably the most notable and often used in addictions and disordered eating. DBT was initially catapulted into development and use by Marsha Linehan in 1993 with two groundbreaking books on treatment and skills training of borderline personality disorder. BPD often involves high levels of emotional instability, extreme moods, black and white thinking, chaotic behavior, unstable interpersonal relationships, self-image and identity issues, and often lead to periods of dissociation. It is very much influenced by the social environment and often related to traumatic events during childhood and to post-traumatic stress disorder (PTSD). Linehan had much success using DBT in treating BPD, which is characterized by the inability to regulate emotions properly, a focus of DBT. This mindfulness therapeutic approach also proved successful, and quickly caught on, in other areas such as addictions, eating disorders and post trauma stress disorder.

The word *dialectic* originated in Ancient Greece in literary works of Plato called the Socratic dialogues. This was dialogue between two or more people holding different moral and philosophical views with the goal of establishing the truth through reasoned arguments. Kant later attempted to unite reason with experience and Hegel continued with Kant's work to develop the triad: thesis (statement), antithesis (contradiction) and synthesis (reconciliation). This philosophy built on Platonic Idealism was developed in the 17th century and was called German Idealism (VandenBos 2007). It postulates that reality is made up of two competing forces and the synthesis of these forces lead to a new reality, which in turn consists of two new competing forces and so on. This is the process that creates change.

Concerning Linehan's DBT the competing dialectic is *acceptance* and *change*; an acceptance of oneself non-judgmentally, but also recognition of the need and willingness to change behavior. The synthesis of this contradiction is the central goal of DBT which mixes predominately cognitive and behavioral methods of therapy, although with some psychoanalytic and humanistic concepts. Methods usually consist of a mixture of individual and group meetings and goals are established individually between the client and the therapist (Baer 2003).

Four modules are: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

Acceptance and Commitment Therapy (ACT)

Another mindfulness therapy closely related to DBT is *acceptance* and *commitment* therapy (ACT), originally called *comprehensive distancing*. ACT is based on a theory of language called relational frame theory (RFT). Both ACT and RFT have philosophical roots in functional contextualism, a modern philosophy of science rooted in pragmatism and contextualism. The approach is sometimes viewed as an extension Skinner's work in behaviorism with a focus on predicting and influencing psychological events such as thoughts or feelings. RFT looks at how human language is learned through interaction in the environment.

Steven Hayes originated ACT in the late 1970's which uses strategies of mindfulness, acceptance, and behavior change. There seems to be little noticeable difference between ACT and DBT which both maintain a dialectical approach of personal acceptance and a commitment for behavioral change while employing mindfulness methods. With ACT the focus is on the language between the therapist and client. The therapist reframes the client's words so as the client's task is to observe his/her thoughts without being active in them therefore making it easier to relinquish control of them (Baer 2003).

ACT focuses on cognitive defusion or deliteralization in the therapeutic process. The goal is to accept difficult thoughts and feelings without taking them to be literally true and to see thoughts as what they are, not as what they say they are. The theory argues that ineffective strategies that control or suppress thoughts and feelings lead to problem behaviors. The core of ACT is the acronym FEAR (fusion, evaluation, avoidance, reasons). ACT's six core principles are: cognitive defusion, acceptance, contact with the present moment, observation of the self, values, and committed action. {www.contextualpsychology.org}

Mindfulness Based Eating Awareness Training (MP-EAT)

Mindfulness Based Eating Awareness Training (MP-EAT) was developed by Jean Kristeller specifically for treatment of Binge Eating Disorder with a primary goal of re-regulating the balance between physiological and emotional factors that drive eating. BED is characterized as eating an unusually large amount of food at one time and eating much more quickly during binge episodes than during normal eating. Internal and intense struggles concerning approach and avoidance of food are common. Emotional instability, identity issues and body image problems are common as well as low self-esteem, self-loathing, and co-morbidity (depression, substance abuse). Food is used to regulate emotions whether positive or negative (Kristeller & Wolever 2011).

The program is a group intervention designed to help moderate reactionary responses to emotional and dissociative states through mindfulness eating techniques. The process develops improved conscious food choices and an increased awareness of hunger and satiety cues while improving self-acceptance and sense of one's self-control. (Kristeller & Wolever 2011)
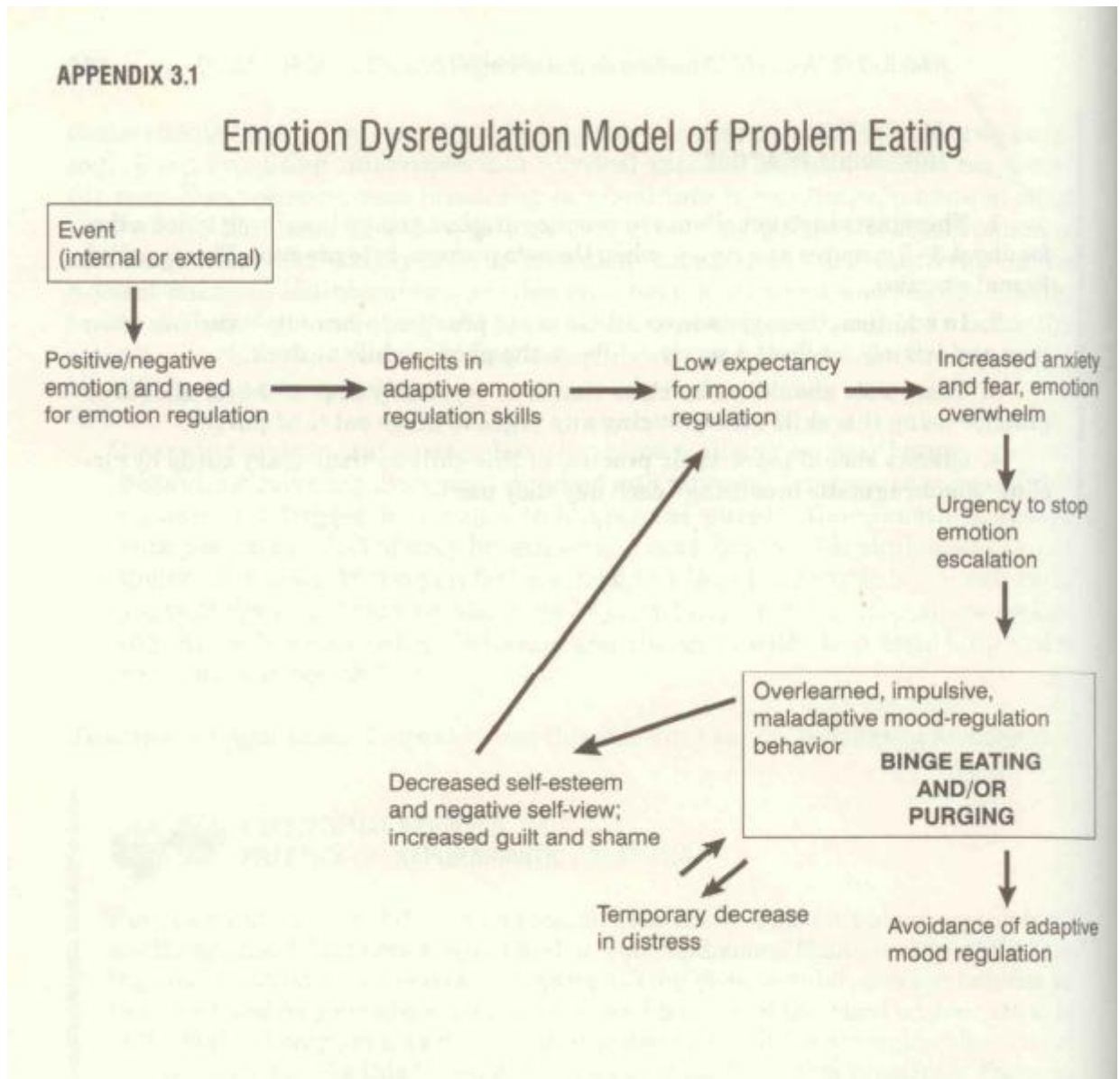
Kristeller developed the program from three theoretical paradigms of food intake regulation:
- interplay of internal (psychological) and external (physiological) control processes
- self-regulation theory and biofeedback
- neuro-cognitive models of mindfulness meditation

The program focuses in four specific areas:
- cultivate mindfulness habits (capacity to direct attention, disengage reactivity)
- cultivate mindful eating (taste, hunger, satiety awareness)
- cultivate emotional balance (emotional awareness, reactivity)
- cultivate self-acceptance (acceptance, non-judgment, empowerment)

(Kristeller & Wolever 2011)

APPENDIX 3.1

Emotion Dysregulation Model of Problem Eating

Event
(internal or external)

↓

Positive/negative emotion and need for emotion regulation → Deficits in adaptive emotion regulation skills → Low expectancy for mood regulation → Increased anxiety and fear, emotion overwhelm

↓

Urgency to stop emotion escalation

↓

Overlearned, impulsive, maladaptive mood-regulation behavior
BINGE EATING AND/OR PURGING

Decreased self-esteem and negative self-view; increased guilt and shame

Temporary decrease in distress

Avoidance of adaptive mood regulation

(Safer, Tech, Chen 2009)

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