

Eating Disorder: Bulimia Nervosa

Tracy was a 22-year-old junior in college when she was referred to the group therapy program for people with eating disorders. She had entered individual psychotherapy at the Student Health Centre 3 months earlier, hoping that her therapist could help her deal more successfully with the stress of university life. Their sessions had focused on the development of better study skills and on issues surrounding Tracy's low self-esteem. Although she was very bright and had managed to earn a 3.2 grade point average, Tracy's academic performance was slipping. Planning and organization were not among her strengths. She attended classes only sporadically and regularly found herself staying up all night to finish writing papers or to prepare for tests.

Her depressed mood and pattern of increasing social isolation were also a source of some concern, perhaps more to her therapist than to Tracy. She lived by herself in an apartment near the campus. Relatively few activities gave her any pleasure. She had developed a small circle of both male and female friends during her 2 years at the university. She had gone out with several different men but had not been involved in a serious romantic relationship for almost 3 years. Her feelings about these dating experiences were largely ambivalent. Occasional casual sexual encounters were more a source of puzzlement than pleasure for her. She couldn't understand why these men found her attractive. Further discussion of this issue revealed Tracy's pervasive concerns about her appearance and her strong, negative feelings about her body. She told the therapist that she had tried to lose weight for several years. It eventually became apparent that Tracy had a serious eating disorder. After several extended conversations with her therapist, she finally agreed to join an eating disorders group while she continued her individual psychotherapy sessions.

During her first meeting with the woman who ran the therapy group, Tracy was obviously self-conscious and embarrassed while describing the nature of her eating problems. She was a reserved, attractive young woman, dressed neatly in casual clothes. Her graceful, athletic build (5'6" tall and 135 pounds) gave the impression of a person who might be more comfortable with her body than she actually was. Her muscular hips and thighs were especially upsetting to her. She thought they were ugly and said that she very much wanted to lose 15 pounds. Tracy reluctantly provided more complete descriptions of her problems with food as the conversation continued. For the past 2 years, she had been going on private eating binges in which she consumed very large quantities of food and then forced herself to throw up. These episodes currently happened three to four times per week. At its worst, this binge-purge cycle had occurred 8 to 10 times per week.

Tracy took four to six diet pills each day in a largely unsuccessful effort to control her appetite. She hoped that the pills would prevent her binge eating, but they did not. She also took laxatives on a regular basis, usually once a day. This practice was based on her erroneous assumption that the laxatives would decrease her body's absorption of food. Taking the laxatives made Tracy feel that she was somehow losing most of the food that she consumed.

Tracy's notion of an appropriate diet bordered on the concept of starvation. She tried not to eat all day long. After skipping breakfast and lunch, she would invariably experience intense hunger pains during the afternoon. Not trusting these signals from her body, she would manage to fight them throughout the rest of the day. Tracy usually returned to her apartment around 7 or 8 o'clock at night after a hectic day of classes, meetings, and work. By that point, she would be starving. That was the point at which her binges were most likely to occur.

A typical binge would begin with a trip to the nearby grocery store. Tracy would buy a whole chicken and take it home to prepare. The process usually began with a glass of wine, which made her feel more relaxed (particularly on an empty stomach). As she sipped her wine, Tracy would bake the chicken and prepare a large batch of stuffing and mashed potatoes—almost like a Thanksgiving dinner. Then she would order two large sausage pizzas to be delivered from a local restaurant. While she was waiting for the chicken to bake and the pizzas to be delivered, she would eat cookies and potato chips while finishing her bottle of wine. Whenever she started to feel full, she would go in the bathroom and make herself throw up. This lengthy process of eating and regurgitation would continue until all the food was consumed.

Tracy felt helpless and out of control during these binges, which often lasted 2 hours and sometimes as much as 3 hours. Once the process started, it seemed to demand completion. Tracy seldom ate sitting at a table. She ate quickly, pacing about her apartment. At times she felt as if she were outside her body, watching the process unfold. She usually turned her phone off so that she wouldn't be interrupted by calls from any of the few friends she still had.

After purging, her mood would go from bad to worse. Tracy felt awful about herself, particularly at these moments. Her stomach hurt, but physical pain was not as debilitating as the psychological consequences of the episode. She invariably felt disgusted by her own behavior and deeply ashamed of her complete inability to control her binge eating. She felt guilty both because she had eaten so much and also because she didn't have the control that others had. Tracy had read extensively about anorexia nervosa and now told her therapist that she envied the control that those women had over their appetites. If only she could do that!

She began to experience several harmful physical effects from the repeated vomiting. Her dentist noticed that the enamel had begun to erode on the inner surface of her front teeth. He had asked Tracy about the pattern at her last checkup. She denied any eating problems, but the concern that she detected in his voice left her feeling even more unsettled about her problem. The skin over the knuckles on her right hand was now scarred; she put those fingers down her throat to stimulate the gag reflex when she wanted to throw up. She knew that her throat was beginning to suffer, as indicated by recurrent hoarseness and sore throats. Perhaps most alarming was the fact that she had begun throwing up blood on occasion, a sign that the walls of her esophagus were tearing.

The wine that Tracy consumed at the outset of her binges was also a source of some considerable concern and reflected a drinking problem that intensified and complicated her eating disorder. Tracy found it annoying that some of her friends had begun to criticize her drinking, but she privately shared the feeling that she ought to cut back. She often drank quite heavily when she went out socially with other people, and she sometimes engaged in casual sexual relations that contributed to her already ample feelings of guilt, confusion, and lack of control. This aspect of her interpersonal relationships seemed particularly self-destructive.

Social History

Tracy's parents were divorced when she was 2 years old. Their separation was messy and painful for everyone. Her father was awarded custody of Tracy because of her mother's substance-use problems and because she had abandoned the family to live with her boyfriend. That relationship didn't last much longer than the divorce proceedings, but her mother eventually remarried and had two additional children.

Tracy grew up living with her father, who provided her with a comfortable home. Unfortunately, he was so preoccupied with his job that he spent little time with her. While she was in elementary school, she was supervised by a housekeeper who lived with Tracy and her father. This woman was fond of Tracy, but was also rather rigid and aloof. Tracy spent most of her time alone when she returned home after school. She watched TV and played games until her father got home from work at 8 or 9 o'clock. She looked forward to his arrival because that was when he would spend time with her. Unfortunately, he didn't show much interest in her life. They would fix a meal of frozen dinners and snacks and desserts, then sit down and watch TV together.

When Tracy was 13 years old, her mother—who was now 36—suddenly reappeared. She and her second family had moved back to the city in which Tracy lived. She wanted to spend time with Tracy and become friends with her. Tracy's father was understandably opposed to this idea, but the original divorce agreement had stipulated that Tracy could see her mother on weekends. That agreement was still in effect, even though her mother had never before followed through on the plan. In fact, Tracy had always been curious about her mom and was now anxious to meet her. They agreed to meet for lunch on a couple of occasions.

Tracy was initially struck by her mother's stunning appearance. She was beautiful—still very thin and exquisitely dressed. Tracy was charmed by her mother's warm and friendly manner as well as by her physical appearance. Her mother was intrigued by Tracy's interests, her accomplishments, and her friends. This concern was a welcome change from the indifference that her father had always shown her. Tracy and her mother began to spend more time together on weekends and holidays. It was fun to have a mom who would take her out to lunch and dote on her. As they got to know each other better, however, Tracy's mother became more intrusive and critical of Tracy's behavior and appearance. She began to tell Tracy that it wouldn't hurt for her to lose a few pounds. Tracy's younger half-sister was also very thin, like their mother. She and Tracy soon found themselves competing for their mother's attention.

Like most other teenagers, Tracy was self-conscious about her body and the changes that she was going through at this time. Whatever doubts she already had about her own figure and appearance were seriously exacerbated by these competitive interactions with her mother and half-sister. Tracy was built more like her father—muscular and stocky. At her mother's suggestion, Tracy started to experiment with various kinds of diets. Her mother recommended a sequence of diets that had worked for her. Unfortunately, nothing worked for very long when Tracy tried it. If she did manage to lose 10 pounds, she would gain it back within 3 months. Her weight fluctuated for the next few years between 120 and 145 pounds.

Tracy eventually found herself spending time moving back and forth between her mother's and father's homes. Her patterns of eating became even more inconsistent, perhaps largely because there were different ways to eat in these different places. Her dad lived on packaged cereal, snack food, and late, precooked dinners. Her mom's family ate carefully prepared, nutritious meals that emphasized low-fat foods, including lots of fruits and vegetables. The latter pattern was obviously more healthy, but the atmosphere at these meals frequently made Tracy uncomfortable. Her half-sister seemed to be able to eat more than Tracy without gaining weight. Her half-sister and stepfather were always given bigger servings than Tracy, as her mother reminded her to watch what she ate. Whenever Tracy expressed an interest in having a light dessert, her mother would smile at her and ask, “Do you really think you should do that?” For obvious reasons, Tracy experienced a lot of negative emotional responses—guilt, shame, and anger—when she ate with her mother's family.

Like many of her peers, Tracy was rebellious as a teenager. Her father was quite lenient with her as she entered adolescence, allowing her to run with a crowd of wild boys and girls. Her friends were unconventional and viewed themselves as outsiders in their high school. Their group drank alcohol and smoked marijuana regularly, beginning in their early teens. Her father's house was occasionally the site for these gatherings because he was seldom around to supervise. After smoking marijuana, Tracy and her friends would get "the munchies" and consume large quantities of snacks and desserts. This pattern of sporadic binge eating subverted more than one of her diet plans. Her weight increased noticeably.

Tracy found her first serious boyfriend at age 16. She fell head-over-heels in love with Jerome, who was 21 years old and working as a clerk at the video store where Tracy and her friends rented movies and games. Their relationship quickly became sexual, which was both exciting and anxiety provoking for Tracy, who had not had any previous sexual experience. When Tracy's father found out that she was dating Jerome, he became angry. He told her mother, and soon everyone was embroiled in the conflict over this new romance.

When Tracy was 17 years old, she dropped out of high school in her senior year and moved to southern California to be with Jerome. He had moved there 3 months before she decided to go. Their romance had actually faded in recent months. Her decision to leave was perhaps more motivated by the desire to avoid high school and her family than by her feelings for Jerome. Once she'd arrived in California, Tracy realized that he no longer cared for her. She started to feel depressed when it became apparent that Jerome did not want to spend much time with her. She realized that she now had no family, no friends, and no job. One night, after she had spent an entire day sitting alone in their small apartment, Tracy told Jerome that she felt like she might be better off dead. His only response was to say, "If that's how you feel, go ahead and kill yourself."

Tracy's binge eating and purging evolved gradually while she was living with Jerome in California. As she became more seriously depressed, she often ate snack foods to make herself feel better. Within 2 months, she had gained eight more pounds. Renewed concern about her appearance and guilt about her inability to control her snacking caused a further decline in her mood. In an attempt to lose the new weight, Tracy went back to some of her earlier diets. Nothing seemed to work. Increased efforts to control what she ate seemed to produce a paradoxical increase in her consumption of food. One day, after eating two large bags of pretzels, Tracy began to feel nauseated. Rather than waiting to find out whether she would vomit spontaneously, she decided to go to the bathroom and stick her fingers down her throat. The process itself was upsetting, but she felt much better after it was over. Then it dawned on her: maybe self-induced vomiting was a way to avoid gaining weight. It was easy to do. Because she didn't have a job, she was usually alone with plenty of time and privacy. She couldn't control what she ate, but she could be sure that it didn't sit on her stomach. At first she only threw up once or twice a week. The frequency progressed slowly over the next year.

Three months after she had moved to California, Tracy returned to live with her father. It was difficult to admit that she had made a mistake, but she was shocked by Jerome's lack of concern for her feelings and disgusted by the dismal quality of their relationship. She returned in a better mood than when she left. Her decision to leave Jerome had given her new energy and confidence. She got a part-time job and went back to high school classes at night. She was able to earn her high school equivalency degree and went on to school at a local community college. From there, she transferred to the university.

Unfortunately, Tracy also returned home in the early stages of an expanding eating disorder. She was already starting to experience some physical consequences from throwing up

repeatedly. She had severe stomach pains. One of her friends commented on the fact that she frequently had very bad breath. As her secret problem escalated, she became more embarrassed and ashamed.

Although she had managed to pass all her classes since entering the university, Tracy knew that she was falling behind. She was taking courses in the School of Commerce, which was a very demanding curriculum. Pressure from assignments was becoming overwhelming. Her feelings of depression were beginning to return. Tracy's father suggested to her that she might find it useful to see a therapist at the Student Health Center, in the hope that psychotherapy would help her cope with stress. She was not enthusiastic about going to see a therapist, and she wasn't willing to acknowledge the severity of her eating problems. When Tracy did finally make an appointment with a therapist, she said that she wanted to develop her study skills. Her goal was presumably to become a more effective student. She spent several weeks in treatment before she and her therapist eventually recognized the nature of her eating disorder.

Conceptualization and Treatment

Tracy's individual therapist referred her to a group for people suffering from bulimia nervosa. The group was based on a cognitive-behavioral approach to treatment outlined by Fairburn (2013) in his book *Overcoming Binge Eating*. The book provides a useful summary of information about the disorder and can also serve as a self-help manual for those people who are able to change without entering professional treatment. This is an important option because the secretive nature of this problem causes many people to be reluctant to seek help. The short-term approach represents a blend of cognitive procedures that were originally used to treat depression and behavioral approaches for the treatment of obesity. The cognitive elements of the program are aimed at factors such as low self-esteem and extreme concern about body size and shape. The behavioral elements are designed to alter maladaptive patterns of eating.

The group included Tracy and four other women who also suffered from bulimia. Led by a clinical therapist who specialized in the treatment of eating disorders, they met once a week for 10 weeks and followed a prearranged sequence of topics.

Week 1: Self-Monitoring

The therapist began their first session by acknowledging the difficulty that they all must have had in deciding to participate in this process. Up to this point, the most common reaction that they had all had from friends and family members involved accusations of weakness and provocation of guilt. Most had been asked over and over again, "Why can't you just stop?" as if it were actually quite simple. This group would be a place where they could all share their feelings with people who understood quite clearly why they couldn't stop.

The first step of the program involved self-monitoring. Participants were asked to keep a careful, daily record of everything they ate or drank. The record included information about binge eating and purging. This information would be used as a baseline against which subsequent progress could be measured. The instructions were to keep a careful record but not to change anything about her eating. The therapist also asked each woman to begin weighing herself once a week (and no more than once a week).

Tracy was more reserved than the other group members during this first session. She had trouble connecting to the other women. The others felt good about being in the group, but Tracy did not. She said that she did want to stop binge eating and purging, but she also insisted that she still needed to lose five pounds before she would be happy with her body.

Week 2: Cues and Consequences

During the second session, group members discussed their self-monitoring records from the preceding week. Did they notice any situations or foods that regularly triggered their binges? Most found it relatively easy and helpful to share their experiences with the group. One woman said that, if she ate one french fry, she would say to herself, “Now it's over.” Another said that her binges were set off by fights with her boyfriend.

Unfortunately, Tracy reported that she had experienced trouble with the assignment. She claimed that she was too busy to keep detailed records of her eating. In fact, the biggest problem was that she was not comfortable sharing descriptions of her binges with the group. She had been struck by the intensity of her negative feelings around binge eating. She was also beginning to understand how negatively she thought about herself.

The therapist also asked the women to generate a list of other activities that could be used to replace binges. They generated many options, including calling friends on the phone, going for a walk, reading a book, and doing a relaxation exercise. Passive activities would clearly be less effective. For example, watching television did not seem like a useful option because many said that they usually ate while watching TV. The therapist explained that by doing something active in response to an urge to binge, the person is also likely to reduce the duration of any strong, negative feelings that are associated.

For the next week, each woman was encouraged to begin replacing binges with a pattern of regular eating throughout each day. This pattern would include breakfast, lunch, and dinner as well as a planned snack within 2 or 3 hours after each meal. The women were urged not to skip any planned meals or snacks, and also not to eat any unplanned foods. This step was discussed at great length because it is, in fact, the most important element in the treatment program.

Eating on a schedule struck some as being a bad idea. Tracy expressed concern that she should only eat when her body told her that she was hungry. The problem with this argument is that hunger signals are often disrupted in people who have been involved in binge eating and purging. The therapist explained that until they had returned to normal patterns of eating for a substantial period of time, it would be better to eat at prearranged times. They were encouraged to weigh themselves only once each week. And they were asked to take a leap of faith—to let their weight fluctuate to wherever it was supposed to be, given a regular pattern of eating. This could mean that their weight would go up or down a little bit, even in the first week or two.

Week 3: Thoughts, Feelings, and Behaviors

Tracy called the group's leader before this session to say that she would have to miss the meeting because she had a lot of work to do. She apologized and explained that school had been especially stressful this week. In truth, she had not been doing her self-monitoring and had not been able to begin a regular pattern of eating—even at breakfast. She was too embarrassed to tell the other group members that her binge eating and purging had continued unabated. Tracy was not yet committed to the treatment program.

Everyone else spent the session talking about distorted patterns of thinking. Cognitive therapists assume that if a person is extremely upset, she may not be aware that certain thoughts could have produced her negative emotional state. For example, the women were asked to suppose that they had just eaten a piece of cake that was not on their meal plan. What do you think to yourself? Some volunteered that they would say, “Now I just ruined everything. One piece of cake is as good as a binge. I hate myself! I screwed up, and now I

should just finish the binge. I'll start being 'good' again tomorrow." The goal of this session was to help them learn to interrupt the chain that leads from distorted, self-deprecating thoughts to negative feelings and then to bingeing and purging behavior.

Week 4: Perfectionism and All-or-Nothing Thinking

At the beginning of the fourth session, the other members of the group asked Tracy about her absence from the previous meeting. She tried to tell them that she was too busy to attend, but they didn't buy her excuse. She finally confided tearfully, and with great difficulty, that she had become increasingly depressed over the past 2 weeks. Frustrated and disappointed with her inability to engage with the program, she wondered openly whether she would ever be able to eat normally. Tracy confessed that she had stopped monitoring completely and had not been able to follow even the simplest elements of regular eating. She was engaging in binge eating and purging at least as often as before she entered the group. Having disclosed these secrets to the rest of the group, Tracy was overwhelmed with feelings of shame and guilt. She got up and quietly walked out of the room, halfway through the session. She went home to her apartment and immediately ordered food to be delivered. While she was waiting for it to arrive, she had a glass of wine and wrote in her previously empty self-monitoring journal about feelings of giving up.

The other members of the group had mixed reactions to Tracy's message and her early departure. They were all sympathetic, but some also expressed disappointment at her lack of commitment to the therapy process. There was also a feeling of failure and rejection associated with their own apparent inability to make Tracy feel that they could help her succeed in the treatment program. These issues were discussed at length before the therapist continued with their planned agenda for the week.

The remaining portion of this session was devoted to a further discussion of personality traits and distorted thinking patterns that are often associated with binge eating. Examples were, "I need to be thin in order to be liked and successful" and "If I eat regular meals, I will turn into a blimp." Another example followed from Tracy's current distress: "If I don't succeed in the first 2 weeks of treatment, it means that I will never be able to change." Group members were asked to discuss a series of questions: Are these thoughts really accurate? And do you plan to make yourself miserable unless every aspect of your appearance is perfect?

Week 5: Assertive Behavior

To some people's surprise, Tracy appeared on time for the group's next meeting. She was composed and cheerful, in stark contrast to the state in which she had fled their last session. Tracy explained that, 2 days after their last session, she had an experience that promised to change her entire outlook on her eating disorder.

The fateful event took place while she was babysitting for a neighbor's little girl. The next day was the girl's fifth birthday. A party was planned, with 20 of the little girl's best friends scheduled to attend. Her mother had ordered a special birthday cake and left it in the refrigerator. Tracy hadn't eaten all day when she arrived to babysit. She was starving. As soon as she saw the cake, she knew it was going to be a serious problem. The girl talked about the cake all night, telling Tracy how beautiful it was and what a nice party she was going to have the next day. She repeatedly took Tracy to the refrigerator to look at the cake and talk about its decorations. Tracy resisted the temptation to eat a piece of the cake for 2 hours after the little girl went to sleep. Then she completely lost control. Before she realized what she was doing, Tracy had eaten the whole cake. Horrified and ashamed by what she had done, she quickly found herself in the bathroom. She sobbed uncontrollably as she threw up in the toilet. When she finally stood up, she was staring directly at her face in the mirror.

Tears were streaming down her face. Tracy told the group that at that moment she finally acknowledged the reality and the severity of her eating problems. Her eating was so far out of control that she could devour a child's birthday cake the day before her party. Tracy knew then that she would have to take responsibility for changing her own feelings and behavior.

Tracy had not binged or purged since that night. She started monitoring what she ate the next morning and had not missed a day. Although she had not previously kept written records, the discussions in weeks 1 and 2 had been enough to help her recognize that, in her own case, she would have to start eating regularly throughout the day if she wanted to control her late-night binges. She forced herself to eat at least a small breakfast on each of the remaining days. She still skipped lunch on most days, but she did eat a regular evening meal without escalating into a binge. Her decision to avoid having a glass of wine when she arrived home was undoubtedly one important part of that success.

The group listened to her story with rapt attention. Some cried, knowing that they could easily have done the same thing if they found themselves in the same situation. They praised her lavishly for the positive changes that she had already accomplished. Their sympathetic responses helped Tracy to feel that she had finally become part of the group.

For the remaining time in the session, the group returned to a discussion of the topics that had originally been planned: assertive behavior. This issue represents a logical extension of the preceding discussions of negative emotional triggers for binge eating. For some people, anger can be a stimulus for uncontrolled eating. By training the women to behave more assertively, the therapist hoped that they would be able to solve interpersonal problems more effectively and minimize emotional distress.

For the first time, Tracy participated actively in this discussion. The relevance to her own situation was quite apparent. Throughout adolescence, she had been afraid to stand up for herself. She received frequent critical messages from her parents, teachers, and peers. For example, her mother's criticism of her appearance and weight had been a common source of irritation and embarrassment. She role-played with the group ways in which she could tell her mother that these critical remarks made her feel bad, without becoming rude or hostile.

Week 6: Body Image

This session was devoted to a discussion of the women's images of their own bodies. The women had already made it clear to one another that their lives were, in many ways, dominated by concerns about their appearance and their weight. Some said they believed that unless they found a way to keep themselves thin, they would be depressed and lonely for the rest of their lives.

In an effort to help group members identify and challenge their own negative feelings about their bodies, the therapist reviewed a number of facts about physiology. For example, women need a certain amount of body fat to enable reproduction. Their bodies need more fat than men's bodies. Women also have a lower resting metabolism rate than men. Dieting suppresses metabolism even further.

Each member of the group was asked to write down five things about her body that she liked. These were not to be aspects of her appearance. Rather, they were to list things that their bodies did for them. This became a very challenging exercise. Tracy was unable to think of a single thing. Others were able to generate a few items, such as "My body allows me to run for 30 minutes every day. It makes me feel strong." The difficulty that the women had in constructing this particular list helped them realize the extent of the distorted and imbalanced views that they had come to hold about their own bodies.

The session ended with each person reporting her own progress toward the introduction of regular patterns of eating. Tracy noted that she was now eating three regular meals and two scheduled snacks each day. She had completely eliminated her late-night binges. When she experienced an urge to have a glass of wine or bake a batch of cookies, she would record the urge in her journal and then distract herself by doing “stomach crunches.” The exercise made her feel better about herself, and she found that the urge to binge usually passed by the time she was finished.

Week 7: Dieting and Other Causal Factors

In the first portion of this session, the group discussed the relation between different types of dieting and the onset of binge eating. Dieting plays a crucial role in most cases of bulimia. People who set dietary restraints make themselves feel food deprived. When they do eat, they are more likely to binge.

There are many forms of dieting. The women were instructed to identify any food groups that they had been trying to avoid. All said that they avoided sweet desserts. Others stayed away from dairy foods, fatty meats, and simple carbohydrates. The therapist told them that they should gradually introduce small amounts of each type of food into their planned meals and snacks. This process was designed to diminish the probability of further binges by eliminating extreme forms of dietary restraint.

Week 8: Problem Solving and Stress Reduction

The women's self-monitoring records indicated clearly that their binge episodes did not occur at random. Rather, their binges were much more likely to occur during moments of increased stress. Their next discussion focused on the development of problem-solving skills that might then serve to decrease the frequency of future binge eating. They began by talking about ways of spotting problems before they became unmanageable. Warning signals would include the onset of negative mood states (particularly sadness or anger) as well as particular situations, such as being alone with nothing to do. After recognizing the presence of a problem situation, the therapist worked with them on ways to generate a large number of potential solutions to the problem.

Week 9: Healthy Exercise and Relapse Prevention

In their next-to-last session, the women worked on two topics that would help them maintain progress once the group treatment was completed. First, they talked about the benefits of *healthy* exercise. The women listed several considerations, including stress reduction, mood elevation, social interaction with friends, and the regulation of metabolism. The damaging effects of compulsive exercise were also discussed. Exercise should be pleasurable, not a punishment for overeating.

The second half of this session was devoted to the prevention of relapse. Minor setbacks are virtually inevitable in this type of program. It may be unrealistic to assume that, after a person has recovered from binge eating, she will never overeat again. The women acknowledged that eating problems might be their Achilles' heel for the rest of their lives. Particularly during stressful times, they would still be tempted to binge. How would they react when that happened? They were encouraged to distinguish between temporary lapses and full-blown relapses. If they did slip up, it would not mean that they were back where they had started before the group. It would simply mean that they should address the problem right away and reinstate those aspects of the program that had been most successful initially.

Week 10: Coping with Future Events

The final session was devoted to a review of earlier steps and a discussion of ways that they could reduce their vulnerability to future binge eating. What kinds of situations might contribute to their own relapse? One crucial consideration was obviously the continuation of eating regular meals and avoiding all forms of dieting. They also discussed methods that they had learned to use when coping with stressful events, negative emotions, and self-defeating thoughts.

By the time the group ended, Tracy had made significant improvements with regard to her eating problems. She had eaten regular meals on a daily basis for 5 weeks. She had not binged or purged since the traumatic night when she ate the birthday cake, and she had stopped taking diet pills and laxatives. Somewhat to her surprise, her weight had remained fairly steady for the first couple of weeks and then leveled off at five pounds less than it had been when she entered the group. Her mood was much improved, but she still experienced periods of marked sadness and loneliness. Her concerns about drinking as well as difficulties in relationships with boyfriends and her parents had not been resolved. She continued to discuss these issues with her individual therapist.

Discussion

Tracy's disorder, bulimia nervosa, is one of several feeding and eating disorders described in *DSM-5* (APA, 2013). The key to the diagnosis of bulimia nervosa is recurrent episodes of binge eating coupled with compensatory behavior, such as vomiting, to prevent weight gain (Fairburn & Cooper, 2007). Literally, bulimia means “ox hunger,” or voracious appetite, but it now refers to binge eating and purging. Although many people report occasional binges, the *DSM-5* diagnosis requires that binges and compensatory behavior occur at least once per week for at least 3 months. The binges, which are often triggered by stress, typically involve eating high-calorie, easily ingested food in a short period of time (e.g., 2 hours) and in secret. During the binges, the person feels out of control and may consume 2,000 to 4,000 calories, more than someone would usually eat in an entire day. The binges end when the person becomes uncomfortably full or when the person is interrupted or falls asleep. Vomiting frequently follows the binge, either terminating it or allowing further eating to take place. Heavy laxative use and excessive exercise are other ways of trying to compensate for the large number of calories that have been consumed.

People being treated for bulimia nervosa are usually intensely concerned about their weight and fear becoming fat. They realize that their eating is abnormal but report that they cannot control themselves. Their inability to control their eating often leads to feelings of depression, guilt, and low self-esteem (Garner & Magana, 2002).

The exact prevalence of bulimia nervosa is not known, principally because it is a secretive problem. Approximately 2 to 3 percent of women and much less than 1 percent of men will qualify for a diagnosis of bulimia nervosa at some point in their lives (Nagl et al., 2016). The disorder typically begins during late adolescence. Evidence regarding the long-term course of bulimia suggests that many people eventually have a good outcome, even though they continue to experience some symptoms of the disorder (Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006).

Bulimia nervosa can occur either by itself, as in Tracy's case, or as an accompanying symptom of anorexia nervosa. About 50 percent of patients with anorexia nervosa also have episodes of binge eating. The frequency of binges and vomiting in these patients, however, is less than was true for Tracy. Bulimia also is comorbid with several other diagnoses, including depression, personality disorders (especially borderline personality disorder), anxiety

disorders, and substance-use disorders (Baker, Mazzeo, & Kendler, [2007](#); van Hanswijck, van Furth, Lacey, & Waller, [2003](#)).

Several serious physical complications may result from bulimia nervosa (Mehler, [2011](#)).

Tracy experienced several of these problems, including sore throat, swollen salivary glands, and destruction of dental enamel, which occur as a result of the frequent presence of stomach acid in these areas. Repeated vomiting can also lead to potassium depletion, which, in turn, can produce seizures. Urinary infections and kidney failure also occur in some patients. Menstrual irregularity is also common.

Etiological Considerations

Bulimia nervosa is undoubtedly the product of a complex interaction among biological, psychological, and social factors. These include various sorts of antecedent conditions and predispositions to the disorder, such as negative self-evaluations and fear of gaining weight. In the presence of these vulnerability factors, the stress of dieting often triggers the full-blown symptoms of the disorder and sets off a cascade of related biological reactions (Halmi, [2011](#); Pearson, Wonderlich, & Smith, [2015](#)).

Biological Factors

Supporting the possible importance of genetics, bulimia nervosa clearly runs in families. Data from twin studies also show higher concordance for monozygotic than for dizygotic twins (Bulik et al., [2010](#)).

At a neurochemical level, interest has focused on the neurotransmitter serotonin (Kaye, [2008](#)). Several factors make serotonin an appealing possibility for playing a role in bulimia. First, drugs that block serotonin receptors lead to increased food intake and appear to do so by reducing feelings of being satiated after eating. Patients with bulimia binge, of course, and also report less satiety after eating. Second, low levels of serotonin are associated with both depression and increased impulsivity. Depression is often found in patients with bulimia, and their binge eating could well be regarded as reflecting a high level of impulsivity. Studies of serotonin in patients with bulimia provide more direct support. Research has found a low level of serotonin in patients with bulimia (Ferguson & Pigott, [2000](#)).

Psychological Factors

A fear of being fat is a primary feature of the eating disorders, including bulimia nervosa. This fear is likely to lead to dieting, which is an important precursor of binge eating problems (Brewerton, Dansky, Kilpatrick, & O'Neil, [2000](#)). Fear of being fat arises from several sources. First, there are sociocultural influences. Over the past several decades, there has been a steady progression toward thinness as the ideal shape, although this trend now seems to have leveled off. We know that this ideal has been internalized by large numbers of women because many normal-weight women perceive themselves to be overweight. At the same time that society was becoming preoccupied with being thin, the prevalence of bulimia increased markedly (Hoek & van Hoeken, [2003](#)). This cultural influence has had greater impact on women than men and may thus account for the gender difference in the prevalence of bulimia. As would be expected if cultural effects are important, the frequency of eating disorders is particularly high among women, such as gymnasts and dancers, who are under extreme pressure to keep their weight down.

Several other factors also contribute to fear of being fat. For example, being overweight or having overweight parents are risk factors for bulimia. Being teased by peers or criticized by parents about being overweight can also contribute (Cooper, [2005](#)). In Tracy's case, her mother's persistent comments about Tracy's weight undoubtedly contributed to her own

exaggerated concerns about being fat, as well as her low self-esteem. A distorted view of the size of one's body is another risk factor. For example, in one study, women with bulimia were shown silhouettes of very thin to very obese women. They were asked to select the one closest to their own body size and the one they would most like to be. The women with bulimia overestimated their current body size and chose thinner ideal body sizes than control women (Williamson, Cubic, & Gleaves, [1993](#)).

One psychological explanation for the development of bulimia nervosa suggests that the disorder is a combination of extreme weight concerns and dieting practices (Svaldi & Tuschien-Caffier, [2014](#)). Fear of becoming fat leads to restricting food intake, which then sets the stage for the development of the binge–purge cycle. Dietary restraint paradoxically increases the likelihood of binge eating when the person is stressed (Polivy, Herman, & Boivin, [2008](#)). Emotional arousal increases eating among people who are trying to restrict their food intake. The binge-eating pattern for patients with bulimia is similar but more extreme. Dieting frequently precedes the onset of bulimia, and it also appears to be triggered by episodes of stress. After the binge, the patient with bulimia feels anxious, and the purge is then a way of reducing this anxiety.

What function did binge eating serve for Tracy? Several processes could be involved. First, Tracy was afraid of becoming fat and did often restrain her eating, for example, by skipping breakfast and lunch. Second, Tracy's early binges seemed, at least in part, to be stress related. Binge eating could have been established as a way of coping with stress. Her binges may have filled up a life that was devoid of many other pleasurable activities.

Treatment

Many patients with eating disorders do not seek treatment for their disorder because they do not believe that anything is wrong. Others fail to enter therapy because they are ashamed of their condition or feel hopeless about it. When patients with bulimia do enter therapy, they are treated with both biological and psychological treatments.

Because bulimia is often comorbid with depression, it is not surprising that it has been treated with antidepressant medication, especially selective serotonin reuptake inhibitors (SSRIs). Medication is beneficial for some patients, but up to one-third of bulimic patients drop out of therapy because of unpleasant drug side effects, and relapse is the rule when medication is discontinued (Sysko, Sha, Wang, Duan, & Walsh, [2010](#)).

The major psychological intervention, as was the case with Tracy, is cognitive-behavior therapy (Cooper & Fairburn, [2010](#)). Patients are encouraged to question society's standards for physical attractiveness and learn that normal weight can be achieved without extreme dieting. Patients must also learn that dieting can trigger a binge and that all is not lost by eating a high-calorie afternoon snack. Another crucial step involves determining the situations that elicit binges and developing alternative ways of coping with them. The goal, then, is to establish a normal pattern of eating three meals a day and even snacks between meals. Regular meals control hunger and thus make it less likely that a person will binge and then become anxious and purge. Results from these cognitive-behavioral interventions are more favorable than those from treatment with antidepressant medication (Slade et al., [2018](#)). For some patients, the optimal treatment may involve a combination of both drugs and cognitive-behavior therapy.

Unfortunately, only about half of bulimic patients improve significantly during treatment. One year after the end of treatment, only one-third are maintaining their treatment gains (Franko et al., [2018](#)). What factors might explain these high rates of treatment failure? Long-term recovery among patients being treated for bulimia nervosa is best predicted by the length of time during which the person met diagnostic criteria for the disorder. Desire to change is another crucial element in any program aimed at the treatment of eating disorders.

Relatively little is known about factors that influence these patients' ability to appreciate the severity of their problems. Some people seem to accept their binge eating and adjust their lives around it. They are not motivated to change. Tracy was unable to benefit from her experience in group therapy until the dramatic evening when she devoured the birthday cake and found herself staring in the mirror of her neighbor's bathroom. This event clearly played a crucial role in her subsequent recovery.

The *abstinence violation effect* can also contribute to continued binge eating and relapse in bulimia nervosa (Schlam & Wilson, 2007). This phenomenon was initially observed among people who are recovering from substance dependence. A single violation of abstinence is often sufficient to wipe out totally any treatment gains that had occurred. When a person violates his or her commitment to stop using drugs, a state of dissonance is created between the behavior and the self-image of the person. This dissonance motivates attempts to reduce it, for example, by changing the self-image: "I guess I haven't really recovered." Furthermore, the transgression is attributed to personal weakness, and thus the person is likely to expect future failures.

Recognition of the impact of the abstinence violation effect led to the inclusion of relapse prevention elements in the type of group therapy that Tracy received. Tracy and the other members of her group were trained to recognize situations that could create pressure for them. Furthermore, she was given specific training in coping with stress, including skills to handle problematic life situations and ways to deal with negative emotional states. Finally, she was told that minor lapses were likely and that they would not indicate that the treatment had failed or that she was a weak person. Within this framework, she was instructed on ways to cope with a single binge to reduce the likelihood that a single abstinence violation would lead to a complete resumption of her old pattern.

Discussion Questions

1. How would you draw a distinction between Tracy's behavior during an episode of bingeing and purging and the behavior of a person who is suffering from obsessive compulsive disorder? Could her purging behavior be considered a compulsion? Why or why not?
2. Discuss the differences between bulimia and anorexia, especially with regard to issues related to impulse control.
3. Why was Tracy's emotional experience with the little girl's birthday cake an important turning point in her treatment? What was the most important factor in changing her motivation for treatment?
4. What are the connections among cognitive factors, emotion regulation, and binge eating? How are these issues related to dieting and restricted intake of food?

Reference: Martin, M., & Ottoman, T. F. (2019). *Case Studies in Abnormal Psychology*. [VitalSource Bookshelf]. Retrieved from <https://bookshelf.vitalsource.com/#/books/9781119504528/>

Note: Some words and details have been deleted or modified.

