OUTPUTATIENT TREATMENT OF BULIMIA NERVOSA: AN ILLUSTRATIVE CASE STUDY

B L Low

ABSTRACT
The salient features of bulimia nervosa is highlighted. Essential principles of an effective outpatient treatment programme is illustrated using an uncomplicated case history. Cognitive, behavioural and psychodynamic principles are illustrated in the course of therapy. The treatment programme is short-term, can be effectively carried out by non-medical personnel under medical supervision and is therefore likely to be cost-beneficial compared to longer term psychotherapies for the treatment of this disorder.

Keywords: *bulimia, clinical features, case history, outpatient treatment, eclectic therapy*

SINGAPORE MED J 1995; Vol 36: 92-95

INTRODUCTION

Bulimia nervosa, first described in 1979 by Russell[1], was initially regarded as an ominous variant of anorexia nervosa. Since then, there are now over 50 studies into its clinical boundaries and epidemiology and more than 25 controlled treatment trials[2]. It has since been found that with appropriate treatment, the prognosis of bulimia nervosa is much better than that of anorexia nervosa. In studies that included more than 20 patients undergoing psychological therapies, between 80% to 95% had reduction in binge-eating frequency and 45% to 80% were abstinent in the last week of treatment[2].

Epidemiological studies in developed countries estimated that between 1% to 2% of women aged 14 to 40 suffer from bulimia nervosa[2,3]. No formal studies on the epidemiology of eating disorders in Singapore have been reported. Anorexia nervosa, as it presents to the psychiatric services, is more common and bulimia thought to be rare. Bulimics are however known to be highly secretive about their condition. Few seek treatment and those who do, do so only after several years of eating difficulties[4]. Unlike anorexia nervosa, where obvious emaciation will prompt others to urge medical attention upon them, the majority of bulimics are of average body weight[4]. In addition, most function normally in their occupations, even while quite impaired in social and psychological areas[4,5].

There are three key features in bulimia[2,6-8]. Firstly, patients manifest recurrent episodes of binge eating, defined as the rapid consumption of large amounts of food, often of high caloric content, in a short period of time. Occurring mostly in secret, binge-eating is followed by guilt, self-disgust, depression and in some cases, self-mutilation. DSMIII-R requires a minimum of two binge-eating episodes per week for three months to satisfy the diagnostic criteria for bulimia nervosa[6]. The next feature is the compensatory behaviour bulimics engage in to prevent weight gain. Most induce vomiting immediately after the binge. In between binge-eating days, they fall back to a pattern of strict dieting. Others may additionally take large doses of laxatives, abuse diuretics and slimming pills and a number of them overexercise. The third key feature is their disturbance of attitude to body weight and size. Bulimics perceive themselves as overweight, fat, flabby and ugly, although most are within the normal weight range. They show persistent overconcern about their shape and weight. The core psychopathology is that patients judge their self-worth largely, or even exclusively, in terms of their shape and weight[2].

The aim of this paper is to highlight the salient features of bulimia nervosa through a case study and demonstrate an effective outpatient treatment programme. This treatment programme which is modelled after that developed by J.H. Lacey[9], consists of 10 weekly sessions, lasting 50 minutes each with follow-up sessions after 3 months and a year later. Eclectic in orientation, it employs cognitive, behavioural and psychodynamic principles.

CASE REPORT

MG, a Caucasian law lecturer, aged 31, sought help for bulimia in March 1991. She had been binge-eating and vomiting three times a week. Her eating difficulties started at age 15, when she spent an unhappy month in another country as an exchange student. Feeling lonely and isolated, she comforted herself by eating and her weight increased from an initial 63 kg to 76 kg. Her subsequent attempts to diet escalated into recurrent episodes of binge eating. From age 17, she started inducing vomiting after each binge. From age 18 to 23, her weight would rise during university holidays and decline during term time. Between episodes of binge eating she followed a strict diet and exercised vigorously. From age 23, she noticed that her weight tended to drop at the beginning of new relationships and jobs and increased once she had become established in the new situation. She managed to maintain her weight between 70 to 76 kg. She had never abused laxatives, diuretics or diet pills. Her bulimia worsened in March 1991 after her father was hospitalised for a severe lung condition, which was when she decided to seek medical attention. She had an ambivalent relationship with her father and a poor relationship with her mother. Parental relationship in her younger days were poor with frequent verbal and physical violence. Describing her adolescence as very troubled in the context of an unhappy home life, she took an overdose at 15, an angry gesture. At 17, she tried to kill herself with 100 tablets of aspirin. She received psychiatric help and had no more self-harming incidents after this. While in university, she drank and smoked heavily and used marijuana occasionally. Academically, she excelled and obtained a first class honours at the Solicitors examinations. She however found it difficult to sustain emotionally intimate relationships, especially with men. She had a period of sexual promiscuity from age 18 to 21. At 24, she had a serious relationship but when her partner wished to marry she broke it off. For the next three years, she had an affair with a married middle-aged law professor. In the last year she

**Institute of Mental Health/
Woodbridge Hospital
10 Buangkok Green
Singapore 1953**

B L Low, M Med (Psychiatry)
Senior Registrar

ended a difficult relationship with a male colleague because the latter insisted on carrying on with an ex girlfriend. In her past medical history, she was diagnosed as suffering from "ME" (Myalgic Encephalomyelitis) by a neurologist. She had felt totally exhausted and laid in bed for two days. No specific physical cause was found and she was advised that there was no specific treatment apart from bed rest. MG continued to suffer fatigue whenever she felt under stress.

From the assessment, MG was found to have normal weight bulimia nervosa without physical complications. In her early twenties, she showed signs of impulsivity but has since "matured" and presently has no evidence of a borderline personality disorder. Her self-esteem was low despite having done well professionally. She had some insight into the psychological origins of her eating disorder and was found suitable for the treatment programme.

MG began therapy in November 1991 and completed the 10-session outpatient programme which covered a period of two and a half months. She attended every session punctually except the eighth which she missed because of illness.

THE THERAPY

Session 1

The contract was discussed whereby MG agreed to attend the stated number of sessions. She was to stop eating in binges and vomit but to eat three regular meals daily, including two snacks, at pre-determined times according to a prescribed diet sheet. The diet, designed to meet her daily caloric requirements, included "carbohydrate" foods that were clearly marked and which she was contracted not to avoid. The aim of the diet was to remove any physiological urge to binge resulting from starvation brought about by dieting. She was also given a dietary diary which she was instructed to keep with her at all times. Each page in the diary was divided into columns into which she was to record all food and drink consumed, instances of vomiting and her feelings and thoughts in temporal sequence to the details of food consumed or eating symptoms displayed. The purpose of this was to self-monitor her eating behaviour and provide feedback on physical and psychological triggers of binge eating. When recording her feelings and thoughts, she may address the therapist as if the latter was there in person and so use the diary as a "transitional object", a substitute for the presence of the therapist in between therapy times. Her weight at the beginning of therapy was 77kg and her height 1.78m. MG was to maintain this weight throughout the ten sessions and instructed not to weigh herself. She would be weighed at the beginning of each session. This is to help take her mind off weight control so that she may pay attention to thoughts and feelings fuelling her erratic eating behaviour. If her weight were to drop in the course of therapy, it would suggest she was dieting. Weight increase would mean that she has continued to binge. Both ways, she would be sabotaging her own recovery as she would continue to be unable to look into psychological issues.

The material recorded in her diary would then be used in subsequent sessions as a structure around which pertinent issues were to be discussed.

Agenda: contract making, education, establish regular eating pattern, diary recording.

Session 2

MG expressed panic and fear of loss of control when eating the dessert prescribed in the diet. She felt that eating the bar of chocolate had made her put on a lot of weight and hence pointless to control herself further. She had binged and vomited once in the week and felt a failure. We addressed her distorted perception concerning weight gain and her "all-or-none" thinking error and how it might prevent her from continuing with therapy (Most bulimics set high standards for themselves and perceived themselves as having failed everything when they fail to achieve their initial goals). MG noted that her binge occurred subsequent to lack of sleep and tiredness resulting from heavy work commitment. Both factors contributed to diminished self-control and comfort-eating. MG also found herself relatively unoccupied in the evenings, which were times normally spent bingeing, thinking about food and her body or following a drill to avoid bingeing. Alternative behaviours were explored whereby she could attempt activities that were enjoyable and rewarding eg a relaxing warm tub bath, calling on or phoning up a friend etc. Through diary recording, MG recognised binge feelings provoked by interactions with her parents. She felt angry at their over-intrusiveness but was unable to express this resentment openly. She recognised that these are some of the psychological issues that she must begin to deal with, which hitherto had been camouflaged by her eating preoccupations.

Agenda: thinking errors, physiological factors, behavioural methods, inability to express anger

Session 3

We discussed her fear of loss of control when faced with left-over food from a party which in the past she used to binge on. To prevent this, it was decided that she should purchase just enough food and throw or give away left-overs. She had binged and vomited in the evening after her father turned up unexpectedly at her work place and insisted on having lunch with her. Prior to her father's visit, she remembered feeling upset with her ex-boyfriend colleague who had made sexual advances towards her. She recognised her bingeing being associated with her internal conflicts and inability to express hostility openly towards these two men.

Agenda: behavioural techniques, recognising fear of expressing hostile feelings

Session 4

MG had begun a sexual relationship with TM who was five years younger. This was against the condition set at the beginning that she should avoid any new relationship during the course of therapy in order to focus on existing problems with current relationships. She had also not written anything in her diary for several days. When this was addressed during the session, it became clear that she was avoiding getting close with me, the therapist, which was an enactment of her fear of intimacy. Even in this new relationship, she had already told TM that it would not be long-term. Looking into past relationships, she noted her tendency of becoming involved with men who were unable to offer her long term commitment.

Agenda: recognising fear of emotional intimacy

Session 5

She had binged once but stopped herself from vomiting as she remembered my advice that vomiting would result in potassium loss. This binge occurred after TM left her after their weekend together. She also felt a strong urge to binge after a male tenant, with whom she got along well, informed her of his decision to move out. She recorded in her diary: "men always leave you just when you trust and confide in them". We examined this statement for the cognitive error of "overgeneralisation" and tried to look into the origins of this belief. Work pressure was also the cause

of her urges to binge. MG saw that her self-esteem came largely from academic and professional achievements and linked it to her early days when her father would only praise her when she did well in her school work. I brought to her attention her tendency to drink alcohol excessively whenever she entertained and educated her on the disinhibiting effect of alcohol and of a post-alcoholic hypoglycaemia in precipitating a binge. As we were half way through the therapy programme, she was instructed that she had to stop binge eating completely, as she had progressed enough for this goal to be achievable.

Agenda: education on effects of vomiting, excessive alcohol; thinking error of overgeneralisation, issues of self-worth, review treatment goals.

Session 6

MG recorded that she had felt fatigued after each therapy session, which she identified as recurrence of "ME". This session covered events occurring during the period 20 Dec to 2 Jan, which had been a difficult time for her. She had initially felt pleased that for the first time in years, she could control binge-eating on Christmas eve. However she succumbed at the Christmas family lunch when she ate continuously. This was linked to her angry thoughts that her parents were only interested in their children living out their lives for them. Bingeing the day after Christmas was related to TM inviting himself over for dinner. She felt resentful of his "turning up whenever, expecting to be fed". We explored the reasons for her inability to express anger towards significant persons in her life and the various possible consequences should she take the risk of expressing her true feelings. MG now also saw TM as a selfish snob but was unable to reconcile this with his ability to give her satisfaction sexually, unlike other men in her past. This tendency to "black or white" thinking about people being "all good or all bad" was discussed. MG also felt she had failed therapy because I had told her "no more binges" and she was "worse than ever". At the end of the tumultuous two weeks, MG decided that she wanted more emotionally significant relationships with men and to be less career orientated. During the session, she expressed her anger at me for setting an almost impossible goal when not to binge was expected to be tough because of the festive season. To encourage her, I remarked that she had made progress, eg in daring to express negative feelings about me (who represent to her a significant "other" and an authority figure) and coming for therapy despite having felt she had failed.

Agenda: expressing negative feelings, "black or white thinking", re-evaluating self-worth.

Session 7

MG continued to have "mild ME" symptoms after session 6. She binged after waking to find TM by her side and feeling "it is not my space anymore" and "is it all worth it?". We discussed her fears about the demands and obligations of emotionally intimate relationships. We also explored her feelings about termination of therapy, whether "it is all worth it?" (ie having come together this far, I was to leave soon, like other important persons in her life).

Agenda: issues surrounding termination

Session 8

MG phoned to cancel because of "flu".

Session 9

MG had binged when she felt painfully inadequate and doubted whether she could cope with life without binge-eating. Her bout of flu made her realise that this was real physical illness and that her "ME" symptoms were "definitely psychologically triggered". She had returned home to be looked after by her parents when she had the flu. Starting to binge when she felt the tension between her father and her, she realised that she had to tell at least one of her parents about her bulimia or she would never stop. She decided to tell her mother, crying a lot while doing so. She found her mother surprisingly understanding and felt comforted and relieved. She felt that therapy had brought back unhappy childhood memories of being hit and shouted at by her parents and being told she was no good. She recalled a vividly disturbing incident when she was 13, kneeling and apologising in tears to her father for something that she was blamed for between her parents, and her father then started to kiss her breast and would not let her go. MG was afraid that therapy might expose more painful memories of her childhood and make her so physically ill she could not cope. We discussed about this and decided that self revelations would only go at the pace she thought she could cope with.

Agenda: Insight into psychological triggers of physical symptoms, dealing with painful memories, improved relationship with mother through self-revelation and risk-taking.

Session 10

Realising binge feelings centred around resentful feelings towards her ex-boyfriend colleague, she decided to concentrate on exploring her feelings instead. Although this made her sad and quiet the whole day, she had felt a certain calmness. It also dawned on her that she never wanted to do law but did it to please her parents and school and to prove her self-worth. However a change of career may mean a less secure future. MG was advised that there was no necessity to rush into making future plans. At the close of the session, MG expressed her appreciation for the help the therapy had given her and felt that she was now in better control of her life than she ever had been.

Agenda: surviving painful feelings, self-evaluation and planning for the future, termination.

Follow-up at 3 months

MG continued to do well with only a couple of binge eating episodes. She noted a tendency to comfort eat at times of stress but continued to feel she has a hold on her eating problem.

DISCUSSION

MG presented as an uncomplicated case of normal weight bulimia. Marked weight fluctuations as in her case is quite usual in the natural history of bulimic sufferers[5]. Doctors noticing this tendency in young female patients should enquire about bulimia. A subgroup of bulimics have problems with impulse control[10]. Such patients abuse alcohol and/or drugs and a number of them harm themselves. In North America, many such patients are classed as having a "borderline personality disorder"[11]. MG had some degree of poor impulse control in her teens and early twenties but appeared to have "matured" at presentation, with only a tendency to alcohol abuse occasionally. It is important to assess this aspect of patients' functioning as inpatient treatment may be necessary to contain acting out behaviour. Those who abuse laxatives and diuretics and suffer physical complications eg cardiac arrhythmias, often require hospitalisation.

At the end of therapy, MG became adept at differentiating

physiological and psychological precipitants of binge and comfort eating. She is now able to eat normal amounts of carbohydrates without fear or guilt and had entirely stopped induced vomiting. Recognising that hunger, excessive alcohol, tiredness and tension predispose to binge eating, she could now circumvent it by adopting more adaptive behaviour. She became aware of the role bulimia played in blocking out painful emotions, begun allowing herself to feel these feelings and discovering that it did not hurt her in the way she feared it might. She also decided she wanted better relationships with people and real emotional intimacy with a man. She had begun to develop a better relationship with her mother whom she previously had discounted, denying herself of the love and support her mother could provide. She is able to express some negative feelings towards significant persons and made an important psychological discovery that her "ME" symptoms were triggered by psychological reasons.

Chronic fatigue syndrome (CFS) is the preferred term for myalgic encephalomyelitis (ME) as the latter embodies unproven aetiological assumptions. CFS has been used as a diagnostic label for patients who suffer from chronic disabling fatigue, for which medical investigation can find no adequate physical explanation. Available evidence suggests that treatable physical disorders are found only in a minority of cases whilst psychiatric diagnosis can be made in a high proportion[12]. It was probable that bulimia was the cause of MG's fatigue (eg muscle weakness due to low potassium); it is also apparent that psychological factors had played a major role. By session 6, therapy had begun to uncover painful emotions which, in my opinion, she unconsciously tried to fend off by "somatising" (ie complaining of fatigue) since the defence of binge-eating was disallowed.

The treatment programme does not promise to solve all her problems. The roots of MG's fear of emotional intimacy remained hidden. Interestingly, a significant number of bulimics were reported to be afraid of emotional intimacy, although causes were not mentioned[13]. Helping MG gain insight into the nature of her relationship difficulties was however a step towards recovery. She could be encouraged to seek further cognitive therapy which might reveal underlying maladaptive basic assumptions such as "You cannot trust anybody. They only make use of you". Long term psychotherapy would also help but she should be cautioned that it might be ineffective as long as her bulimic symptoms remain. The therapy had also uncovered a hint of possible childhood sexual abuse, which had been reported to be a risk factor in bulimia[14,15]. In session 9, MG had expressed fear of possible devastation by the recall of painful memories. I postulate that revelation of more extensive abuse might be too painful that it remained submerged beneath her conscious memory. It was not the aim of the therapy to delve deeper into that direction as the contracted number of sessions would be inadequate. What the therapy aimed to do and had achieved was to help her link underlying psychological conflicts or trauma to her bulimia and that she could seek further therapy focusing into these issues should she feel ready. At the end of therapy, MG continued to find it stressful to relate with her parents and still had to decide what she really wanted for her life. All that had been discussed perhaps reflect the limitations of such a treatment programme. However, the therapy, in helping her gain a sense of control of eating as well as her life, of knowing what could be wrong and the ways in which she could go about correcting it, had achieved its goal.

CONCLUSION

This case study illustrates typical features of bulimia nervosa and how an effective outpatient treatment programme could be carried out. The treatment in the initial stages dealt mainly with educating the patient about bulimia and employed cognitive and behavioural techniques. The style is directive and emphasises on problem solving in the "here and now". As therapy progresses, underlying psychological conflicts are revealed. Transference feelings towards significant persons in her life, which are directed at the therapist, are interpreted. The pace of personal revelation and the degree to which the patient can tolerate the attendant emotional distress are decided by the patient. Whenever appropriate, cognitive and behavioural techniques continue to be employed. The treatment programme would suit most patients suffering from bulimia nervosa.

ACKNOWLEDGEMENT

My heartfelt thanks to Dr Sara McCluskey, Senior Registrar, Department of Psychiatry, University of Newcastle Upon Tyne. She had provided invaluable supervision in the management of this case and greatly encouraged and supported me in the preparation of this paper.

References

1. Russell G. Bulimia nervosa: an ominous variant of anorexia nervosa. Psychol Med 1979; 9:429-48.
2. Freeman CP. ed. Recent advances in the treatment of bulimia nervosa. J Psychosomatic Res 1991; 35 (Suppl 1):1.
3. Fairburn CG, Beglin SJ. Studies of the epidemiology of bulimia nervosa. Am J Psychiatry 1990; 147:401-8.
4. Fairburn CG, Cooper PJ. The clinical features of bulimia nervosa. Br J Psychiatry 1984; 144:238-74.
5. King MB. Eating disorders in general practice. Br Med J 1986; 293:1412-4.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd ed. Revised. Washington DC: American Psychiatric Association, 1987.
7. Consumers' Association. Bulimia nervosa – common in women. Drug and Therapeutic Bulletin 1992; 30:13-4.
8. World Health Organisation. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: World Health Organisation. 1992.
9. Lacey JH. Bulimia nervosa, binge eating and psychogenic vomiting: a controlled treatment study and long term outcome. Br Med J 1983; 286:1690-13.
10. Lacey JH, Evans CDH. The impulsivist: a multi-impulsive personality disorder. Br J Addict 1986; 81:641-9.
11. Pope HG, Frankenburg FR, Hudson JI, Jonas JM, Yurgelun-Todd D. Is bulimia associated with borderline personality disorder?: A controlled study. J Clin Psychiatry 1987; 48:181-4.
12. Sharpe M. Chronic fatigue syndrome: Can the psychiatrist help? In: Hawton D, Cowen P. eds. Dilemmas and difficulties in the management of psychiatric patients. Oxford University Press 1990: 231-40.
13. Pritt JA, Kappius RE, Gorman PW. Bulimia and fear of intimacy. J Clin Psychol 1992; 48:472-6.
14. Connors ME, Morse W. Sexual abuse and eating disorders: a review. Int J Eat Disord 1993; 13:1-11.
15. Pope HG Jr, Hudson JI. Is childhood sexual abuse a risk factor for bulimia nervosa? Am J Psychiatry 1992; 149:455-63.