Introduction: Treating Bulimia

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Treating Bulimia: A Psychoeducational Approach

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Introduction

This chapter presents an overview of bulimia, including a description of the syndrome and its effects, as well as a review of the research findings on its etiology and treatment. The chapter also discusses the research on which the authors' treatment program is based and the rationale for that program. Although the handbook is intended primarily for the clinician, a review of the research findings on this eating disorder is important because media reports on the syndrome have sensationalized it and have blurred the distinction between fact and myth. In addition, this chapter provides an outline of the rest of the book and an introduction to the treatment program.

DEFINITION

In 1980, "bulimia," literally "ox hunger," was included as a diagnostic entity in the *Diagnostic and Statistical Manual III* (*DSM III*) (APA, 1980). The features of bulimia include episodic eating patterns involving rapid consumption of large quantities of food in a discrete period of time, usually less than 2 hours; awareness that this eating pattern is abnormal; fear of being unable to stop eating voluntarily; and depressed mood and self-deprecating thoughts following the eating binges. The presence of three of the following are also needed: eating in private during a binge; termination of a binge through sleep, social interruption,

self-induced vomiting, or abdominal pain; repeated attempts to lose weight by self-induced vomiting, severely restrictive diets, or use of cathartics and/or diuretics; and frequent weight fluctuations due to alternating binges and fasts. In addition, the bulimic episodes must not be due to anorexia nervosa or any known physical disorder (APA, 1980).

Unfortunately, the *DSM III* criteria were developed after work on this disorder had begun. Therefore, the use of the term "bulimia" has been confusing. For example, bulimia has been used to describe both a symptom (binge eating) and a syndrome. As a symptom, the term bulimia has been used to describe binge eating in subgroups of patients with anorexia nervosa (Casper, Eckert, Halmi, Goldberg, & Davis, 1980; Garfinkel, Moldofsky, & Garner, 1977) and to describe an eating pattern in patients who are overweight or obese (Loro & Orleans, 1981; Stunkard, 1959). Whether these groups of patients bear any clinical similarities to people with bulimia who are of normal weight is not clear. As a syndrome, bulimia has been studied under a variety of different names, which makes interpretation of the literature difficult. In addition to the *DSM III* label bulimia, terms include thinfats (Bruch, 1973), bulimarexia or binge-starvers (Boskind-Lodahl, 1976; Boskind-Lodahl & Sirlin, 1977), bulimia nervosa (Rosen & Leitenberg, 1982; Russell, 1979), vomiters and purgers (Beumont, George, & Smart, 1976), and compulsive eaters (Green & Rau, 1974). Additionally, there has been much media distortion as to what constitutes bulimia. When we use the term, we are referring primarily to women of average weight who are suffering from the *DSM III* defined

syndrome, bulimia.

EPIDEMIOLOGY

Although binge eating and purging has been considered a rare disorder (Bruch, 1973), recent studies suggest increased frequency in both clinical and college samples. Stangler and Printz (1980) reported that 3.8% of college students treated at a university psychiatric clinic were bulimic, using the *DSM III* criteria. They considered this to be a "strikingly frequent" diagnosis, one which was significantly more common among women than men. In other, more recent research with female college students, prevalence figures for bulimia have ranged from 3.9% to 19% (Halmi, Falk, & Schwartz, 1981; Katzman, Wolchik, & Braver, 1984; Pyle, Mitchell, Eckert, Halvorson, Neuman, & Goff, 1983). Johnson, Lewis, Love, Lewis and Stuckey (1983), who report one of the few studies on a non-college population, found that 8.3% of high school females met *DSM III* criteria for bulimia.

Although these figures suggest that bulimia occurs in a high percentage of women, these estimates mostly pertain to college populations. Little information exists for the general population. Another problem with these estimates is that there are few objective diagnostic criteria. Researchers differ on the definition of a binge, as well as on the frequency required to distinguish normal binge eating levels from pathological levels. Also at issue is the inconsistency of including

"purging" in a working definition; some researchers have used purging in their definition, whereas others have not. Researchers have found that prevalence estimates decreased from 4.5% to 1.0% for female college students (Pyle et al., 1983) when criteria were changed from weekly binge eating to weekly binge eating *and* weekly vomiting or laxative use.

The fact that bulimic behaviors typically occur in private, followed by feelings of guilt or shame, may account for an additional proportion of unidentified bulimics, and several authors caution that their findings may underestimate prevalence due to patients' reluctance to report their eating disorder (Halmi et al., 1981; Stangler & Printz, 1980). Although the number of published reports dealing with bulimia has increased considerably in the last few years, it is not known whether this increase parallels an increase in the frequency of the disorder or whether it merely indicates that patients with the disorder are just now receiving professional attention (Mitchell & Pyle, 1981).

In addition to studying the prevalence of women meeting *DSM III* definition of bulimia, several authors have examined the occurrence of binge eating. These studies suggest that binge eating is common. Prevalence figures have ranged from 54% to 86% for college women (Halmi et al., 1981; Hawkins & Clement, 1984; Katzman et al., 1984; Ondercin, 1979). The definition in most prevalence studies has generally been a "yes" response to the question "Do you binge eat?" or variations thereof. Hawkins and Clement (1984) asked their subjects, "Do you

ever binge eat?" Halmi et al. (1981) asked, "Have you ever had an episode of eating an enormous amount of food in a short space of time (an eating binge)?" Katzman and Wolchik (1984) asked "Do you binge eat?", and Ondercin (1979) asked, "Would you label yourself a compulsive eater (i.e., overeating without regard to actual physical hunger)?" When a stricter definition of binge eating was employed (for example, binge eating at least eight times in the past month) the prevalence estimate dropped to 7.2% (Katzman et al., 1984). Although several researchers have studied the personality and behavioral characteristics of binge eaters (Dunn & Ondercin, 1981; Hawkins & Clement, 1984), the similarity in symptomology between women who report binge eating and bulimics is unclear and has been addressed in only one study (Katzman & Wolchik, 1984). Although it is possible that therapists may treat binge eaters, normal weight women who report binge eating are less disturbed by their eating habits than bulimics and less likely to seek therapy (Katzman & Wolchik, 1984).

Descriptions of the typical bulimic have been remarkably similar across studies. The average bulimic can be characterized as a white, single, college-educated woman from an upper- or middle-class family (Fairburn & Cooper, 1982). The age of onset is commonly in the late teens (Fairburn & Cooper, 1982; Johnson & Berndt, 1983; Katzman & Wolchik, 1984; Leon, Carroll, Chernyk, & Finn, 1985; Russell, 1979; Pyle, Mitchell, & Eckert, 1981), with a duration of about 4 (Leon et al., 1985; Pyle et al., 1981; Russell, 1979) to 5 (Fairburn & Cooper, 1982; Johnson, Stuckey, Lewis, & Schwartz, 1982) years before the woman first

seeks treatment (Johnson et al., 1982; Russell, 1979; Pyle et al., 1981). Many of these women have a history of disordered eating. Katzman and Wolchik (1984), Leon et al. (1985), Pyle et al. (1981), and Russell (1979) reported that at least 33.3% of their samples had histories of extreme weight loss, whereas Johnson et al. (1982) reported that 50% of their sample had a history of being overweight. In almost every case the women were struggling to obtain a below normal ideal weight (Katzman & Wolchik, 1984; Leon et al., 1985; Pyle et al., 1981; Russell, 1979; Weiss & Ebert, 1983). Although bulimics view their eating habits as abnormal, many learned the binge/purge behaviors from friends or from the media (Fairburn & Cooper, 1982; Katzman & Wolchik, 1984). Once a woman begins the binge-purge cycle, she commonly continues to experience hunger, is preoccupied with food, and feels guilty after a binge (Katzman & Wolchik, 1983; Leon et al., 1985; Mizes, 1983; Pyle et al., 1981; Russell, 1979). These women also generally maintain a normal weight (Abraham & Beumont, 1982; Johnson et al., 1982).

Whereas the eating habits of bulimic women often enable them to maintain a normal weight, they also produce other, less desirable results. In three studies of normal weight bulimics, subjects described their eating pattern as very disruptive of their daily lives (Johnson et al., 1982; Katzman & Wolchik, 1983; Leon et al., 1985). Clinicians also note that this eating pattern can have serious effects, citing interference with social relationships and school or job performance (Leon et al., 1985; Pyle et al., 1981; Wooley & Wooley, 1981), as well as medical problems such

as urinary tract infection (Russell, 1979), gastric dilation (Mitchell, Pyle, & Miner, 1982), parotid gland swelling (Levin, Falko, Dixon, & Gallup, 1980), electrolyte abnormalities (Mitchell & Pyle, 1981), hair breakage, amenorrhea (Johnson et al., 1982; Pyle et al., 1981), destruction of dental enamel (House, Grisius, & Bliziotes, 1981), and fatigue (Abraham & Beumont, 1982; Johnson et al., 1982).

TOPOGRAPHY OF BINGE EATING

Behavioral Description

Although information on the cognitive and affective antecedents and consequences of binge eating is limited, several researchers have investigated binge eating behavior. The frequency of binge eating episodes varies widely across studies; however, approximately 50% of the bulimic women in treatment sampled in studies by Johnson et al. (1982), Leon et al. (1985), and Pyle et al. (1981) reported binge eating at least daily. Studying 14 normal weight nonclinical bulimic women, Katzman and Wolchik (1982) reported a mean of 23 binges a month. Using a predominantly normal weight clinical sample, Mitchell, Pyle, and Eckert (1981) reported a mean of 11.7 binges per week, with a range of 1-46 episodes. The caloric intake during binges has been reported to range from 1,200 calories (Mitchell et al., 1981) to 55,000 calories (Johnson et al., 1982). Katzman and Wolchik (1983a) and Leon et al. (1985) reported an average consumption of 2,500 calories per binge in samples of normal weight bulimics. On the average,

women report spending $8.30 per binge (Johnson et al., 1982), with some spending as much as $70.00 per binge (Wooley & Wooley, 1982).

Data on the frequency of binges and total caloric intake during binges are difficult to interpret. These data are retrospective and, in most reports, the binge is not clearly differentiated from food consumed during meals. Additionally, although consumption of large amounts of food is most common, patients may label consumption of small amounts of a forbidden food (i.e., one cookie) as a binge (Leitenberg, Gross, Peterson, & Rosen, 1984; Mizes, 1983).

Five investigations have described the details of binge eating behavior (Johnson et al., 1982; Katzman & Wolchik, 1983; Leon et al., 1985; Mitchell et al., 1981; Pyle et al., 1981). Across these reports, the mean duration of a binge was roughly 1 hour. The majority of women reportedly binged alone and preferably at home. Women generally ate late in the day, or at night, and consumed foods that were highly caloric and required little preparation (for example, ice cream, candy, and doughnuts). The food consumed during a binge often included items that the women would not typically eat given their dieting concerns (Abraham & Beumont, 1982).

In addition to the binge eating itself, bulimics display other eating disturbances. They frequently alternate between binge eating and periods of very low food consumption or fasting (Loro & Orleans, 1981; Weiss & Ebert, 1983).

Pyle et al. (1981) reported that bulimics frequently do not eat for more than 24 hours after a binge and then find themselves famished, thereby prompting another binge. Bulimics may also fail to eat in a systematic manner (e.g., three meals a day) on the days they do eat (Leon et al., 1985; Mizes & Lohr, 1983).

It is interesting to note that studies on the eating habits of binge eaters reveal behaviors similar to bulimics (Crowther, Lingswiler, & Stephens, 1983; Hawkins & Clement, 1984; Katzman & Wolchik, 1983; Ondercin, 1979). However, the groups differ on the frequency of binge eating and the use of purging to counteract the caloric intake.

Data on the purging aspect of bulimia suggest that the use of evacuation techniques follows the onset of binge eating from 1 (Fairburn & Cooper, 1982; Johnson et al., 1982) to 4 (Katzman & Wolchik, 1984) years. Vomiting was reported in 94%, 92%, 83%, and 81% of the women in studies by Pyle et al. (1981), Mitchell et al. (1981), Fairburn and Cooper (1982), and Johnson et al. (1982), respectively. Across these studies, approximately 50% of the women who vomited did so daily. About 50% of the women in these four studies also abused laxatives. Johnson et al. (1982) reported that of the women who used laxatives, 24.5% did so daily. Diuretics, enemas, and appetite suppressants were also employed for weight control, although not as frequently. Johnson et al. (1982) also reported that of those women who did not currently exhibit purging behavior, 79.4% were tempted to do so.

Emotions and Cognitions

Two different methodologies have been employed to gain information on the antecedents and consequences of binge eating, namely, retrospective reporting by bulimic women and naturalistic self-monitoring. Both Abraham and Beumont (1982) and Leon et al. (1985) asked normal weight women in treatment for bulimia or binge eating to recall their feelings before and after binge eating. Women in both studies indicated that they ate when feeling anxious or depressed. Similar results were found in nonclinical samples of binge eaters. Both Crowther et al. (1983) and Ondercin (1979) reported that binge eating episodes were associated with the negative affective states, anxiety and depression. Pyle et al. (1981), however, found that only 18% of the women in their study reported anxious feelings prior to eating.

The effect of binges on these negative emotional states has also been studied. Binge eating has positive reinforcement aspects in terms of the pleasant taste of food and relief from pre-binge negative emotional states (Loro & Orleans, 1981). Ondercin (1979) found that the questionnaire item "eating seems to calm me down or make me feel better" was the best predictor of binge eating on a stepwise multiple regression analysis. Leon et al. (1985) reported reductions in depression and anger during the binge and reductions in anxiety, depression, and feeling driven to eat shortly after the binge. Whereas Abraham and Beumont (1982) reported that 100% of the women in their study ate to reduce tension, only

66% indicated that they felt relieved from anxiety after a binge. These data tentatively suggest that although some women may eat to relieve anxiety, many do not achieve the desired relief.

Although some emotional states appear to decrease during or after the binge, others increase, mainly in the post-binge period. Both Leon et al. (1985) and Pyle et al. (1981) report that most bulimics related negative emotions such as anger, disgust, and guilt when asked about their feelings following a binge. Rosen and Leitenberg (1982) have hypothesized that these post-binge negative emotional states serve as a cue for purging, which allows the binger to reverse the eating act, thus decreasing negative affect caused by the binge eating itself.

Several studies have employed naturalistic self-monitoring to assess the cognitive and affective states associated with binge eating. Johnson and Larson (1982) used an innovative method to explore the impact of binge eating and purging episodes on various affective states among bulimics. Fifteen bulimic women were given electronic pagers to wear for 1 week. The pagers were used to signal participants at various times of the day to complete a self-report questionnaire on their situations and emotional states at those times. The data suggest that uncontrolled eating, possibly once employed as a means of modulating negative mood states, becomes a stimulus for more negative feelings once women realize that they are out of control.

Katzman and Wolchik (1983a) also conducted a naturalistic assessment of the affective cognitive and behavioral antecedents and consequences of binge eating. A nonclinical college sample of 12 bulimic women completed self-monitoring forms for 4 days or four binges, whichever came first. The self-monitoring data indicated that binge eating was often precipitated by food-oriented thoughts accompanied by anxious or depressive affective states. School-related events, such as poor grades or exams, often occurred prior to the binge. Following binge eating, many women felt out of control and negatively about themselves. In addition, relief and/or negative emotions such as anger or guilt frequently occurred.

In summary, both the historical and self-monitoring data gathered on normal weight bulimics tentatively suggest that binge eating episodes are precipitated by feelings of anxiety and negative emotional states, as well as by hunger. They also suggest that the binge eating, initiated in response to tension or negative affect, does not successfully alleviate the bulimic's negative state.

PERSONALITY AND BEHAVIORAL CHARACTERISTICS

Only two studies have compared normal weight bulimics (recruited from a university community) with controls on a number of standardized measures (Katzman & Wolchik, 1984; Weiss & Ebert, 1983). Katzman and Wolchik (1984) compared the personality and behavioral characteristics of 30 women who met

the *DSM III* criteria for bulimia with those of 22 women who reported binge eating but did not fulfill these criteria and with 28 controls. The measures used included: the Herman and Polivy Restraint Scale (1978), the Hawkins and Clement Binge Scale (1980), the Rosenberg Self Esteem Index (1979), the Levenson and Gottman Dating and Assertion Questionnaire (1978), the High Self Expectations and Demand for Approval subscales of the Jones Irrational Beliefs Test (1968), the Kurtz Body Attitude Scale-Evaluation Dimension (1970), the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the Personality Attributes Questionnaire (Spence, Helmreich, & Stapp, 1979). In comparison with both binge eaters and controls, bulimics were more depressed and had lower self-esteem, poorer body image, higher self-expectations, higher need for approval, greater restraint, and higher binge scores. No significant differences were found on measures of dating, assertion, or sex-role orientation.

Weiss and Ebert (1983) compared 15 normal weight *DSM III* bulimics to 15 controls using the Symptom Check List (SCL) (Deragotis, Lipman, & Covi, 1973), the Piers-Harris Self-Esteem Scale (1969), the Nowicki-Strickland Locus of Control Scale (1973), the Maudsley Obsessive-Compulsive Inventory (Rachman & Hodgson, 1980), the Holmes and Rahe Social Readjustment Scale (1967), the Social Network Index (Berkman & Syne, 1979), the Goldberg Anorectic Attitude Scale (1980), and the Goldberg Situational Discomfort Scale (1978). In comparison with controls, bulimics reported themselves to have significantly more psychopathology on all nine symptom dimensions of the SCL-90—somatization,

obsession-compulsion, interpersonal sensitivity, depression, anxiety, anger, phobic anxiety, paranoid ideation, and psychoticism. Bulimics also exhibited a greater external locus of control, rated themselves as more compulsive, expressed greater fear of fat, and indicated more anxiety in situations related to eating than controls. Measures of social adjustment and support were not significantly different between groups.

The results reported by both Katzman and Wolchik (1984) and Weiss and Ebert (1983) offer substantial evidence of pathology in normal weight bulimics. Their finding that bulimia in a nonclinical population coexists with personality deficits is supported by large scale research on bulimics seeking treatment. Both Fairburn and Cooper (1982) and Johnson et al. (1982) noted greater depression for bulimics when compared with the mean for a normal population. In addition, Fairburn and Cooper (1982) reported high scores for anxiety, while Johnson et al. (1982) reported high scores on interpersonal sensitivity.

There is a great deal of research suggesting that bulimia and depression are related. Russell (1979) reported that after preoccupation with eating, dieting, and weight, depressive symptoms are most prominent with bulimia. Herzog (1982), using *DSM III* criteria for depression, found that 75% of the bulimic women reported significant depressive symptoms. Johnson and Larson (1982), investigating the emotional experiences of bulimics and normals, found that bulimics experience significantly more negative mood states, notably depression

and anxiety. In another study, Johnson et al. (1983) found that bulimics scored significantly higher than normals on depression on the Hopkins Symptom Checklist. In addition, more than half of the sample reported they often felt depressed and over half reported a history of suicidal ideation. Also, 5% had attempted suicide, indicating significant psychological distress. Similarly, studies employing the Minnesota Multiphasic Personality Inventory (MMPI) (Hatsukami, Owen, Pyle, & Mitchell, 1982; Leon et al., 1985; Pyle et al., 1981; Ross, Todt, & Rindflesh, 1983) have found elevations or near elevations of the Depression Scale (Scale 2) for bulimics.

The studies that have reported a decrease in bulimic symptoms using antidepressants (Pope, Hudson, Jonas, & Yurgetun-Todd, 1983; Walsh, Stewart, Wright, Harrison, Roose, & Glassman, 1982) lend further support to the contention that bulimia and depression are related. There has not been sufficient research in the area to warrant any firm conclusions, but studies of family history (Pyle et al., 1981; Hudson, Laffer, & Pope, 1982) and of response to the dexamethasone suppression test (Hudson et al., 1982) have demonstrated a similarity between patients with bulimia and patients with major depression.

Consistent with the findings that bulimics are depressed, there is evidence to suggest that the life adjustment of bulimics is poor. Johnson and Berndt's (1983) findings indicated that bulimics had a poorer life adjustment in the areas of work, social and leisure activities, and family relations compared with a normal

community sample.

Although bulimics frequently report a desire to be thinner than their current weight (Leon et al., 1985; Katzman & Wolchik, 1984; Pyle et al., 1981; Russell, 1979), little research has been conducted on the bulimics' perceived weight. Ruff (1982) compared bulimics' judgments of physical dimensions to normals by asking subjects to adjust the size of a light line projected on the wall to represent the width of five body areas. Even though the groups did not differ on actual physical dimensions and both groups were within 10% of ideal weight, bulimics overestimated their physical dimensions significantly more than controls. This comparison with normal females is important because college females generally feel that their ideal weight is lower than their current weight (Katzman & Wolchik, 1984). The importance of perceived weight to bulimia is further highlighted by Halmi et al. (1981), who found that a belief that they weighed more than their actual weight distinguished those who fulfilled bulimic criteria from those who did not.

Although many researchers have suggested that the bulimics' difficulties in interpersonal relationships are most salient in their dealings with the opposite sex, little systematic research has been done in this area. The only available information comes from two studies that employed weak criteria and unstandardized measures. However, the results of these studies will be reported because they suggest important areas for future research. Rost, Neuhaus, and

Florin (1982) and Allerdisson, Florin, and Rost (1981) found that when compared with matched controls, women who reported eating binges followed by purges were significantly less "liberated" in both sex-role attitudes and behavior. The eating disordered group also showed a significant attitude-behavior gap, with sex-role behavior being more traditional than sex-role attitudes (Rost et al. 1982). Binge-purgers also indicated less enjoyment of sexual relationships, more difficulty in expressing sexual wishes, and more fear of not meeting partners' sexual expectations. In addition, these women expressed the belief that their enjoyment of sex would improve if they were slimmer and more attractive (Allerdisson et al., 1981). The finding by Rost et al. (1982) that bulimics endorsed significantly more traditional sex-role attitudes than controls differs from the results of Katzman and Wolchik (1984). However, the differences in assessment measures and group definition may account for this discrepancy. Clearly, more research on this variable is needed.

Several studies have suggested that bulimics have a difficulty with impulse control as reflected by self-reports of stealing (Leon et al., 1985; Pyle et al., 1981; Russell, 1979), alcohol use (Leon et al., 1985; Pyle et al., 1981), and drug use (Leon et al., 1985 ; Russell, 1979). However, these studies failed to compare bulimics with controls. When bulimics were compared with controls on use of alcohol and cigarettes, no significant differences were found (Katzman & Wolchik, 1984). This finding is consistent with the findings of Johnson et al. (1982), who reported infrequent drug, alcohol, and cigarette use among 316 bulimics.

Four studies have assessed the Minnesota Multiphasic Personality Inventory (MMPI) scores of bulimics and have found remarkably similar results (Hatsukami et al., 1982; Leon et al., 1985; Pyle et al., 1981; Ross, Todt, & Rindflesh, 1983). Across studies, the findings were elevations or near elevations of the Depression Scale (Scale 2), Psychopathic Deviate Scale (Scale 4), Psychasthenia Scale (Scale 7), and Schizophrenia Scale (Scale 8). Notably low scores have been found on the Masculinity-Femininity Scale (Scale 5). Overall, these findings are representative of significant depression, anxiety and worry, feelings of alienation and impulsivity.

Leon et al. (1985) specifically commented on the masculinity-femininity scores. This score represents concern about physical attractiveness and passive, home-oriented pursuits (Lachar, 1974). Of particular interest is the general findings of high psychopathic deviate and low masculinity-femininity scores. This profile is characterized by overemphasis on the stereotypic female role, including an excessive concern about appearance. People obtaining these elevations need affection and are easily hurt. Heterosexual dissatisfaction and/or dysfunction is common (Lachar, 1974).

These MMPI findings are consistent with previously discussed research suggesting that bulimics suffer from anxiety and depression, have a high need for approval, experience sex role difficulties, have problems with impulse control, and place an overemphasis on physical appearance. Overall, these MMPI results lend even greater support to the notion that bulimia occurs with personality and

behavioral deficits. Although these studies provide a first step in understanding the personality characteristics correlated with the development of bulimia, they provide no information on the role of stress or limited coping ability as an etiological variable.

BULIMIA AND COPING

At present, the relationship between bulimia and stress can only be extrapolated from clinical impressions and patients' self-reports. Clinical researchers such as Fairburn have noted that bulimic behavior represents "a difficulty coping with disturbing feelings and thoughts in patients who rely on binge eating as a means of relieving distress" (Fairburn, 1982, p. 631). This view is shared by Mitchell and Pyle, who indicated that "many patients who binge-eat do not seem to do so in response to hunger, [and] in some individuals the phenomenon appears to be related to stress" (Mitchell & Pyle, 1981, p. 70), and by Lacey, who reported that "bulimic bouts of overeating become more frequent or more violent when the patient is emotionally stressed" (Lacey, 1982, p. 62).

Loro and Orleans (1981) and Gormally (1984) suggested that, because binge eating provides immediate negative reinforcement in that it reduces high levels of tension, eating acquires the power to relieve stress and becomes a habit that is difficult to break. Many clinicians concur with this view and add that binge eating is further complicated by some women's lack of alternative coping mechanisms.

Although the binge eating may provide temporary relief from anxiety states, in some cases the overeating leads to a subsequent increase in negative feelings. As a result, the emphasis of some women's struggle becomes the disordered eating rather than the factors that initially elicited the stress (Fairburn, 1982; Hawkins & Clement, 1984; Stunkard, 1959; Wilson, 1978).

As mentioned previously, researchers have suggested that within this context, bulimia continues to be a mechanism of adaptation and coping, although not a very effective one (Coffman, 1984; Hawkins & Clement, 1984; Mizes, 1983; Ondercin, 1979). Although the hypothesis of limited coping skills has often been repeated, a review of the literature reveals only two studies on the relation between disordered eating patterns and coping strategies. Hawkins (1982) assessed 340 female undergraduates of varying weights on coping styles and eating behavior. Although his study tentatively suggests that eating behavior may be correlated with coping style, because of the many methodological problems it is difficult to generalize the results to normal weight bulimic women. Katzman's (1984) study suggests that bulimics may not exhibit a unique coping style when compared with other women with frequent binge eating or depression. Her findings also suggest that bulimics may not demonstrate a lack of coping strategies but rather the inability to select styles that they can use effectively. Alternatively, it is possible that bulimic women possess the appropriate coping resources but fail to see their coping attempts as effective. This study suggests that treatment for the bulimic may need to focus on refining existing coping

strategies other than eating and/or altering the bulimic's evaluation of her ability to handle difficult situations.

THEORIES OF ETIOLOGY

Biological, psychological, and social factors have been hypothesized to play a role in the development of bulimia. Drawing upon clinical and experimental experience, researchers have given different emphasis to each of these factors in developing etiological models. This section will review the various theories of etiology and conclude with a discussion of the empirical support for existing theoretical models.

Boskind-Lodahl (1976) was one of the first to develop a theory of etiology for bulimia. Based on her clinical observations of 36 female clients seen at a university mental health clinic, she hypothesized that an overacceptance of the feminine stereotype was causal in bulimia. She speculated that the pursuit of thinness reflects perfectionist strivings to achieve an ideal of femininity through which the bulimic hopes to gain the approval of others and validate her own self-worth. As well as striving to perfect and control their physical appearances, these women display a strong need for achievement in other areas. According to Boskind-Lodahl, the binge-purge behavior, which begins as a means of dieting, may generalize into a tension reduction strategy in the face of concerns about sexuality, dating, and achievement. "For the person who is struggling to meet

unrealistic goals by imposing severe and ascetic control over herself, the binge is a release" (Boskind-Lodahl, 1976, p. 351).

This theory of etiology has served as a point of departure for other researchers who also view the development of bulimia from a psychosocial perspective. Based on research conducted with college students who reported binge eating, Hawkins and Clement (1984) have suggested that cultural expectations for weight consciousness are particularly salient to females and that compliance with these expectations causes a constant pursuit of thinness. Binge eating results only when there is the addition of certain "pathogenic predispositions" that are biological, such as an elevated "set point" for body fat (Nisbett, 1972), or cognitive, such as a distorted body image. The co-action of these pathogenic predispositions and the psychosocial pressure result in a particular personality pattern, which includes low self-esteem, compulsive rigidity, dieting as a high priority, preoccupation with food, and a histrionic fear of loss of control of eating. In addition, Hawkins and Clement (1984) suggest that bulimics have depressive tendencies and perceive themselves as socially incompetent.

Within this context, Hawkins (1982) has suggested that the binge is best understood using a stress-coping framework that examines the "person by environment fit." Hawkins hypothesizes that the college life-style poses a tension between work orientation and dieting concerns for late adolescent females.

Drawing upon the depression literature (i.e., Coyne, Aldwin, & Lazarus, 1981), Hawkins suggests that unpleasant events and "daily hassles," such as rejection in romantic relationships or academic difficulties, may precipitate overeating mediated by a faulty cognitive approval of the stressor. The bulimic's negative assessment of the event may result in a sense of loss of control over the stressor. Feeling helpless to change the situation, the bulimic turns to food hoping that "eating will make me feel better." Underlying this model are several assumptions: (a) binge eating is seen as part of an on-going coping process; (b) binge eaters have a faulty cognitive appraisal of stressors and experience events as more negative than non-binge eaters; (c) binge eaters hold irrational beliefs and are less efficient in cognitive problem solving than non-binge eaters; and (d) effective treatment strategies must involve the acquisition of alternative, positive coping strategies (Hawkins, 1982).

Although Hawkins presents an elaborate model, most of his hypotheses and assumptions lack empirical validation. In a preliminary study, Hawkins (1982) reported the results of an assessment battery distributed to 340 female undergraduates of varying weights. Included in this battery were measures of coping styles, negative life events, eating attitudes, and weight fluctuations. Women obtaining high scores on the Eating Attitudes Test (EAT) (Garner & Garfinkel, 1979), a measure of diet preoccupation and loss of control over eating, reported significantly more negative life events. Also, high scores on the restrictive diet subscale of the EAT were significantly positively correlated with

the use of problem-solving and social-support seeking coping strategies. In contrast, high scores on the loss of control or bulimic tendencies subscale were significantly positively correlated with the use of passive, inner-directed coping mechanisms. However, none of the scales of the coping measure were correlated with weight fluctuation.

Although this study tentatively suggests that attitudes toward eating may be correlated with coping style, its many methodological problems make it difficult to generalize the findings to normal weight bulimics. First, it is unclear how many of the women in the sample were bulimic or even reported binge eating. The only assessment of disordered eating was a high score on a scale of "bulimic tendencies." Also, the author reported that the women were of varying weights and did no elaborate further. Thus, the number of subjects who were underweight, overweight, or normal weight is unclear. In addition, the psychometric properties of the coping assessment battery, developed by the author, are unknown. Clearly, more work needs to be done to assess the utility of this model.

Based upon clinical experience and a review of the literature on bulimia, Mizes (1983) has proposed a model for bulimia that draws heavily upon the theories of Boskind-Lodahl (1976) and Hawkins and Clement (1984). This model emphasizes that irrational beliefs and self-control deficits are central to the pathogenesis of the disorder. Mizes suggests that the familial environment may

foster certain irrational beliefs and may over endorse traditional female sex roles. He hypothesized that a familial emphasis on passivity and the need for a man to take care of a woman may inhibit the bulimic's development of global self-management skills. In addition, irrational beliefs, such as excessive need for approval (e.g., "everyone must like me or I am worthless") or high self-expectations, are hypothesized to give rise to many interpersonal difficulties such as assertion deficits, sex role disturbance, and body image distortion. These factors may lead to poor heterosexual relationships in which sex is distressing or dysfunctional. Irrational beliefs may also cause the bulimic to evaluate her self-worth and her dieting behavior according to overly perfectionist standards. The combination of high self-expectations and poor self-management skills may result in either actual or perceived failure and subsequent anxiety or depression, which precipitate binge eating. "At least one potential reason for the bulimic's almost exclusive reliance on binging as a coping strategy is her general deficit in self-control coping strategies" (Mizes, 1983, p. 34).

Contrary to Hawkins and Clement (1984) and Mizes (1983), who hypothesized that strained relationships and ineffective methods of handling tension lead to binge eating, Wooley and Wooley (1981) suggested a reverse relationship between these factors. Based on clinical experience with six bulimics, they hypothesized that young women with histories of weight concern discover vomiting as a means of weight control and a way to reduce the anxiety caused by eating. For these women, college represents freedom from parental observation,

increased access to food, and greater psychological pressures. The pattern gradually shifts from vomiting after meals to planned episodes of secret eating. For some women the entire sequence becomes identified as a generalized means of reducing anxiety.

Wooley and Wooley (1981) liken this excessive food intake to regulate tension to a form of substance abuse. They view bulimia as similar to other addictive behaviors in which an individual develops a tolerance, indulging in increasingly greater amounts of food, and in which there is deterioration of life-style and personal relationships because the habit requires more and more time and money to support it. However, unlike other addictions, there is no subculture of users; instead, food abuse generally occurs in private.

Wooley and Wooley (1981) do not believe that learning alone can account for the remarkable similarities among case histories, which leads them to suggest that the "understanding of this disorder is to be found primarily in study of the physiology of the regulation of food intake and the conditioning of anxiety reduction" (Wooley & Wooley, 1981, p. 50).

Similarly, Russell (1979) stated that pathophysiological mechanisms interact with psychological mechanisms in the development of bulimia. His model is based on case materials and prospective observations of 30 bulimic women, 24 of whom had a history of anorexia nervosa. In his view, some psychological disorder leads

the woman to reject her "healthy" weight and to opt for a thinner ideal. Urges to eat result in emotional distress, and fear of weight gain leads to vomiting or laxative use after overeating. Vomiting and/or laxative use keeps the weight at a reduced level, a suboptimal weight that may produce electrolyte disturbance, gastric dilation, renal failure, urinary infections, and most importantly, hypothalamic disturbances. Russell postulated that the hypothalamus responds to the suboptimal body weight by triggering bouts of overeating. This hypothalamic response may also play a part in influencing attitudes toward food either during or before eating. Although Russell's model fails to specify the exact nature of the emotional and hypothalamic disturbance, it does highlight the self-perpetuating mechanisms involved in this disorder.

An alternative perspective is offered by Rosen and Leitenberg (1982) and Leitenberg, Gross, Peterson, and Rosen (1984). Their model, which is based on clinical experience with five bulimics, suggests that binge eating and self-induced vomiting are linked in a vicious cycle by anxiety. Similar to Russell (1979), these authors have suggested that bulimics harbor a morbid fear of weight gain. Eating elicits this anxiety whereas vomiting following food intake reduces anxiety. Vomiting for the bulimic is viewed as having an anxiety reducing function similar to compulsive rituals such as hand washing and lock-checking in obsessive-compulsive neuroses. Thus vomiting, rather than binge eating, is considered to be the driving force in bulimia. A person who fears gaining weight might not binge eat if the food could not be expelled afterwards. This model focuses exclusively on

the eating behavior and is restricted to women who purge following a binge.

The view that purging is the major factor in the maintenance of bulimic behavior is shared by Johnson and Larson (1982), who present a model based on their research with 15 bulimic patients. They concur with Wooley and Wooley's (1981) suggestion that uncontrolled eating may best be understood as an addictive behavior; however, they believe that bulimia develops in an attempt to modulate dysphoric mood states. They suggest that a combination of predisposing factors, including biochemical and familial variables, may influence the bulimic's selection of food as a mechanism of tension reduction. However, in response to the cultural emphasis on thinness for women, bulimics use evacuation techniques as a protection against the stigma of becoming overweight. Johnson and Larson (1982) hypothesize that over time, unrestrained eating leads to a sense of loss of control and begins to elicit its own negative affective states. At this point, a transformation occurs whereby purging behavior replaces binge eating as the primary mechanism for tension reduction.

Two common themes are apparent in each of these theoretical models. First, each theory suggests that bulimics may differ from controls in more than just their eating habits, and that bulimia may develop against a backdrop of deficits in personality and behavioral characteristics. Second, with the exception of Russell (1979), each theory suggests that the reduction of anxiety becomes an important factor in the maintenance of this aberrant eating behavior. However, the

pervasiveness of the binge/purge cycle as a tension regulator differs across models. Restricting their theorizing to bulimics who purge, Rosen and Leitenberg (1982) suggest that the purge response develops as a means of controlling the stress elicited by feelings of hunger and subsequent eating. According to their model, treatment for the bulimic would best be focused on coping with the anxiety of eating. Contrary to this opinion, Hawkins and Clement (1984), Johnson and Larson (1982), and Mizes (1983) suggest that binge eating and/or purging may serve a broader tension reducing function and is used as a means of reducing anxiety for women with limited coping abilities. It follows from these latter theories that treatment must be aimed at the development of alternative means of reducing stress or anxiety.

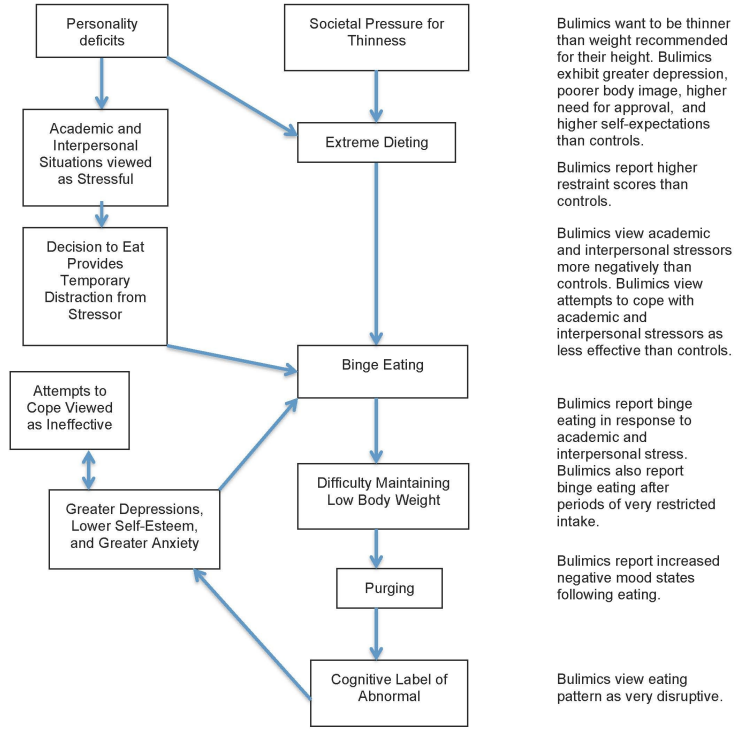
The studies reviewed in the previous section on the personality characteristics of bulimics provide some empirical support for various components of these theoretical models. The suggestion made by Boskind-Lodahl (1976), Hawkins and Clement (1984), and Mizes (1983) that bulimic women demonstrate an overidentification with the feminine stereotype and difficulties in heterosexual relationships is supported by studies employing the MMPI (Hatsukami et ah, 1982; Leon et al. (1985) ; Pyle et al., 1981; Ross et al., 1983) and other measures of sex-role attitudes (Allerdisson et al., 1981; Rost et al., 1982). Similarly, the hypothesis that bulimics hold irrational beliefs such as an excessively high need for approval and perfectionist standards (Boskind-Lodahl, 1976; Mizes, 1983) was supported by Katzman and Wolchik (1984). The

suggestion in all of these models that dieting is a high priority was also supported (Katzman & Wolchik, 1984; Weiss & Ebert, 1983) as was the observation by Mizes (1983) and Hawkins and Clement (1984) that bulimics have a poor body image (Katzman & Wolchik, 1984; Weiss & Ebert, 1983). In addition, the hypothesis that bulimics display depressive tendencies (Hawkins & Clement, 1984; Johnson & Larson, 1982) received empirical validation (Fairburn & Cooper, 1982; Katzman & Wolchik, 1984; Johnson et al., 1982; Weiss & Ebert, 1983).

After a careful review of the literature, we have used previous research and theories (Beck, 1967; Boskind-Lodahl, 1976; Coyne, Aldwin & Lazarus, 1981; Hawkins & Clement, 1984; Russell, 1979; Wooley & Wooley, 1981) to design our own empirically based model for the development of bulimia. This model includes two interacting, positive feedback loops. As shown in Figure 1.1, two factors contribute to the bulimic cycle. First is the extreme dieting behavior, subsequent binge eating, and purging. The second factor is the bulimic's ineffective use of both food and alternative coping strategies to deal with stressful academic and interpersonal situations. According to our model, certain personality characteristics such as poor body image, low self-esteem, high need for approval, high self-expectations, and depression predispose women to develop maladaptive methods of weight control when confronted with societal pressure to conform to a thin ideal. Initially these women engage in highly restrictive dieting that ultimately results in binge eating and difficulty maintaining a low body weight. Purging may begin as an attempt to counteract the weight gain, but when women

view their eating habits as out of their control and abnormal, greater depression, lower self-esteem, and anxiety result. These negative mood states lead to a further increase in binge eating. The above mentioned personality deficits are also associated with how women cope with interpersonal academic stressors. When stressed, bulimics use binge eating and/or purging as one method of stress reduction. In addition to binge eating, bulimics use many other coping behaviors, few of which are evaluated as effective. Although binge eating provides a temporary distraction from anxiety, this behavior causes additional tension for bulimics who view their eating habits as abnormal, disruptive, and physically harmful. The inability to cope successfully exacerbates their low self-esteem, depression and anxiety, and leads to further binge eating. In addition, increased difficulty handling stressful situations and a more negative evaluation of their coping behaviors ensue.

Figure 1.1 Diagram of a Working Model of Bulimia[1]



1 An earlier version of this model was presented by Katzman and Wolchik (1983 b)
2. Data supporting this model are provided by Katzman and Wolchik (1983) , Katman and Wolchik (1984), and Katzman (1984).

Our model suggests that bulimia occurs with personality and behavioral deficits as well as with ineffective coping strategies, and that treatment programs need to address cognitive, affective, and behavioral problems as well as the dysfunctional eating patterns. Our treatment package was designed specifically to address each of these deficits in a systematic manner. Before describing our treatment program, we will review some of the current treatments for bulimia.

TREATMENT

Despite the increasing awareness of bulimia and its negative psychological and physical consequences, there has been very little written on the treatment of this disorder. In the past, bulimic symptoms have been treated as part of more general approaches to weight control or anorexia nervosa. In general, there has not been a correspondence between proposed etiologies and treatment approaches. Treatment has included hospitalization (Garfinkel & Garner, 1982; Russell, 1979), pharmacological approaches using anticonvulsants (Green & Rau, 1974; Weiss & Levitz, 1976; Greenway, Dahms, & Bray, 1977; Wermuth, Davis, Hollister, & Stunkard, 1977) or antidepressants (Hudson et al., 1982; Walsh et al., 1982; Pope et al., 1983), behavior therapy (Kenny & Solyom, 1971; Rosen & Leitenberg, (1982), cognitive behavioral treatment (Fairburn, 1981; Linden, 1980; Long & Cordle, 1982), and group therapy (Boskind-Lodahl & White, 1978; White & Boskind-White, 1981).

Many of the existing treatment studies have often been limited to small samples, usually single-case studies (e.g., Grinc, 1982; Kenny & Solyom, 1971; Linden, 1980; Long & Cordle, 1982; Rosen & Leitenberg, 1982), and most of the available studies have methodological problems (cf. Mizes, 1983) that make it difficult to generalize from them. These methodological weaknesses have included uses of quasi-experimental designs, use of treatment packages that preclude causal inferences to specific procedures, as well as measurement problems. In addition, most of the treatment programs have focused primarily on the modification of the binge eating and/or purging (e.g., Grinc, 1982; Kenny & Solyom, 1971; Leitenberg et al., 1984; Mizes & Lohr, 1983) rather than the behavioral deficits that coexist with this disorder. A description of some of the treatment approaches used with bulimics follows.

Pharmacological Treatment

Pharmacological studies have investigated the use of anticonvulsant and antidepressant medications for treating bulimia. The results of the studies using anticonvulsants have been mixed. Green and Rau (1974) reported 90% success using the anticonvulsant diphenylhydantoin. However, the criteria for success were not specified. Wermuth et al. (1977) found only 40% of their subjects reported some improvement. Other researchers (Weiss & Levitz, 1976; Greenway et al., 1977) have found that anticonvulsant medication had no effect on binge eating.

Bulimia has been seen as a form of an affective disorder that may respond to antidepressant treatment (Hudson et al., 1982; Walsh et al., (1982). Hudson et al., however, provide no treatment data. Walsh et al. used monoamine oxidase inhibitors with six bulimic women and reported an improvement in eating behavior. However, they do not describe how this improvement was measured. Furthermore, the use of monoamine oxidase inhibitors with bulimics is problematic because it requires the elimination of certain foods from a diet, as ingestion of these foods along with the drug can have serious side effects. Bulimics, with their chaotic eating habits, may not adhere to a strict dietary regimen and may experience the negative side effects as a result. Pope et al. (1983) used imipramine with 22 bulimic women and found it effective in reducing the frequency of binge eating.

Behavioral Treatment

The majority of treatment studies have been behavioral studies, although those are broadly defined to encompass cognitive behavioral approaches. Most of these studies, however, have been limited to a small sample size. Many of these studies have focused mainly on the vomiting response.

Rosen and Leitenberg (1982) have used a behavior therapy approach to prevent the vomiting response. They treated a female university student, using an exposure plus prevention model of intervention. During every session, the bulimic

ate until she experienced a strong urge to vomit, at which time her therapist had her focus her attention on her discomfort until the urge to vomit disappeared. Treatment with this woman was quite successful. She ceased vomiting on the 44th day of treatment with only one relapse during the 10-month follow-up. Prior to treatment, she had binged and vomited on a daily basis.

Johnson, Schlundt, Kelley, and Ruggiero (1984) also used exposure with response prevention to reduce vomiting frequency in a sample of six women. Inconsistent self-monitoring and the small sample size, however, limit definite conclusions about this treatment.

Kenny and Solyom (1971) reported successful treatment of vomiting behavior using an aversive conditioning approach. The subject was instructed to formulate a mental "still life" of each of the steps leading to vomiting and received electroshock to her middle finger as she pictured the image. The woman stopped vomiting after the 15th session and had not resumed at the 3-month follow-up.

Other behavior therapy strategies have included systematic desensitization (O'Neill, 1982) with three bulimics to reduce the anxiety associated with consumption of "forbidden" high caloric foods. The results for the three women were mixed. One showed only slight improvement at the end of treatment but a more dramatic decrease in binge eating at follow-up, another showed the reverse pattern, and the third ceased binge eating and maintained her gains at follow-up.

Linden (1980) describes a multicomponent behavioral treatment of a bulimic woman. In this case, the components of behavior therapy included assertiveness training, developing alternative food choice responses, stimulus control, and response delay. The woman had ceased vomiting and overeating after 9 weeks and maintained this at a 6-month follow-up.

Grinc (1982) has used a cognitive behavioral model in the treatment of a 26-year-old bulimic. In addition to stimulus control techniques, such as avoiding foods and situations related to vomiting and self-monitoring of behavior, Grinc used a technique involving cognitive restructuring of the woman's beliefs about vomiting. The woman showed a steady decrease in vomiting and ceased vomiting altogether after beginning cognitive restructuring. She maintained her therapeutic gains for the most part during the 1-year follow-up period.

Fairburn (1980) also reported the use of a cognitive behavioral approach for the treatment of bulimia. The treatment had two focuses: behavioral and cognitive. The behavioral aspects of the intervention required the bulimic woman to self-monitor her food intake and explore alternative responses. The cognitive focus of the intervention focused on changing maladaptive attitudes. Fairburn (1981) reported promising results with 11 women, using this cognitive therapy approach.

Long and Cordle (1982) describe an individualized therapeutic approach

using behavioral techniques with cognitive modeling and dietary education. They provide case studies of two clients who ceased binge eating after 7 and 32 treatment sessions, respectively.

As we can see from the studies described so far, the majority of investigations have been behaviorally oriented, with few measuring personality characteristics that may occur along with the eating disorder. Many authors have provided working models for the treatment of bulimia (Coffman, 1984; Gormally, 1984) and suggest interventions that focus on more than the circumscribed eating response. Gormally states that bulimia has more to do with effective living and less to do with eating. Similarly, Coffman stresses the importance of *not* focusing on the binge-purge behaviors exclusively.

Multifaceted Group Treatment Approaches

Of the investigations that have included attention to behavioral deficits as well as to the maladaptive eating pattern (e.g., Boskind-Lodahl & White, 1978; Fairburn, 1981; Johnson, Connors, & Stuckey, 1983; Linden, 1980; Long & Cordle, 1982; White & Boskind-White, 1981), only one (Boskind-Lodahl & White, 1978) has employed a control group. Using a multifaceted treatment approach that included attention to social competence, sex-role stereotypes, acceptance of one's body image, and problems with one's parents as well as behavioral techniques of self-monitoring and contingency contracting, Boskind-Lodahl and White (1978)

reported few significant effects of treatment relative to a no-treatment group. This "experiential-behavioral" approach to the treatment of bulimia is also described in a later study (White & Boskind-White, 1981) that did not employ a control group. In this study, binge eating decreased or ceased in 10 of 14 cases. The authors suggest that bulimia is more than simply an eating disorder. They feel it is a "struggle to achieve a perfect, stereotypic female image in which women surrender most of their self-defining powers to others" (p. 501). Given the promising outcomes reported by Boskind-Lodahl and White (1978) as well as other researchers who have used broad based treatments in a less controlled manner (e.g., White & Boskind-White, 1981; Fairburn, 1981; Johnson et al., 1983), additional controlled studies in this area are clearly needed.

Several other studies have used a group treatment approach with bulimia. Roy-Byrne, Lee-Benner, and Yager (1984) conducted a yearlong therapy group with nine bulimics using combined behavioral and psychodynamic approaches. In this group format, group members kept diaries of their eating habits. In addition, therapy focused on cognitive restructuring of thoughts as well as some social skills training. By the end of the year, six had ceased or decreased their binge eating. However, no systematic description of the group program is offered and no control group was used. The authors emphasize the importance of group treatment in that it provides an opportunity for interpersonal learning, education, and receiving support.

Lacey (1983) also describes a group program for controlling bulimia. Relative to a no-treatment group, the women in the treatment group showed a significant improvement in binge eating. Although no systematic description of the program is provided, it appears that some attention is given to factors other than the eating behavior. The group is described as "insight oriented" and helping the patient to "deal herself with emotional and relationship problems." Although the therapists in this case had "knowledge of psychiatric patients and psychiatric methods," they had "no specialist training in group techniques" (p. 1610).

Johnson et al. (1983) treated 10 bulimic patients in a 12-session psycho-educational format. A more detailed description of their sessions is provided than in the previous two studies mentioned. The treatment consisted of three phases. The first phase focused on self-monitoring and presentation of didactic information related to the syndrome, the second phase introduced short-term goal contracting concerning the binge eating, and the third phase focused on assertion and relaxation training and on using coping strategies other than binge eating. Results indicated that all patients reduced the frequency of their binge eating-purging episodes. However, due to the small sample size, a statistical analysis of the findings was not conducted. The authors conclude that "short-term group treatment may be a moderately effective treatment intervention for bulimia" (p. 199).

It appears that several authors have found group therapy to be an effective

modality for the treatment of bulimia, with most of the group treatment studies mentioned having addressed issues wider than the eating behavior. Some of the groups have been relatively unstructured. Very few of the studies have used a control group, and none of the studies describe a program in detail that can be replicated by other therapists. Similarly, few researchers have used the findings on the characteristics of bulimics in designing their treatment program.

RATIONALE FOR OUR TREATMENT PROGRAM

A review of the literature suggests that although bulimia was once considered a rare disorder (Bruch, 1973), there appears to be an increase in its frequency in both clinical (Stangler & Prinz, 1980) and subclinical (Halmi et al., 1981; Katzman et al., 1984; Pyle et al., 1983) populations. In spite of growing attention to bulimia and its negative consequences, there is very little written on the treatment of this disorder, and as we noted before, existing treatment has focused primarily on the modification of eating habits rather than the personality deficits that may coexist with this disorder.

Despite an awareness of clinical features associated with bulimia as indicated in this review, no treatment program for bulimia has systematically addressed them in its approach. As a result, we decided to develop a treatment program for bulimia based on the previously reported research findings that bulimic women suffer from depression, low self-esteem, poor body image,

perfectionist tendencies, and a high need for approval, as well as difficulty in handling negative emotional states such as anger or anxiety, and the setting of unrealistic goals for thinness.

In addition to these research findings, we also incorporated information suggesting that bulimic women need to refine their existing coping styles and to develop competencies. In each session of our 7-week self-enhancement program, a clinical feature found to have been associated with bulimia was addressed. Although we used behavior modification to help the bulimic gain control over her maladaptive eating pattern, most of the attention was on developing new competencies rather than on the binge-purge cycle itself. We designed a treatment packet for each session consisting of reading materials, exercises, and homework for that particular session. It was intended to be used as a workbook and as a self-help guide for maintenance after the termination of the program.

The program includes seven group sessions as well as two additional individual sessions during the course of the group. We have used this program with very encouraging results, finding that relative to no-treatment controls, women who received treatment showed significant improvements in their number of binges per month, self-esteem, and depression (Wolchik, Weiss, & Katzman, in press). Also, the number of purges per month showed a tendency to decrease for the women in the treatment group whereas this behavior increased for women in the no-treatment group. In the 10-week follow-up period, the

treatment gains were maintained, with most women continuing to improve during the follow-up period. Our work empirically demonstrated that a short-term psycho-educational approach focusing on personality and behavioral deficits wider than the eating pattern is an effective treatment strategy for bulimia.

Several features of our program deserve attention. First, the presentation of bulimia as a learned habit and the emphasis on building competencies forced the bulimic women to take responsibility for their behavior and instilled hope for change. We would like to emphasize this point, as many of the women who participated in our treatment program were very depressed, a few were suicidal, and some could be described as having long-term character problems. Our emphasis on building positive competencies rather than on pathology helped women make changes in their eating behaviors as well as in how they felt about themselves. Second, the use of a packet containing material similar to that discussed in the therapy session helped to extend the therapeutic value of the sessions and provided material for the clients to refer to following the end of treatment. Also, the group sessions seemed important because they provided opportunities for the women to give each other support and honest feedback and for the women to reduce feelings of isolation and shame. The individual sessions were valuable because they allowed more concentrated focus on each client's unique concerns. Finally, the program is described in detail here and can be used easily by other therapists.

OUTLINE OF THE BOOK

The structure of the book follows the general structure of the group therapy program. Each chapter addresses a particular topic, which is covered during the 7-week program. Chapter 2 discusses the preliminary interview, and Chapters 3-9 describe the topics for each week of the program:

Week 1—Education and overview

Week 2—Eating as coping: developing alternative coping strategies

Week 3—Self-esteem, perfectionism, and depression

Week 4—Anger and assertiveness

Week 5—Cultural expectations of thinness for women

Week 6—Enhancing body image

Week 7—Summing up: where you are now, and where do you go from here?

The therapist's role for each week is discussed in each chapter, and at the end of the chapter a summary is provided. Also included at the end of each chapter are homework assignments for that particular week, including handouts for the client. A weekly binge-purge diary is in the appendix. The homework section is addressed to the client. In the homework section, we have sometimes assigned readings from certain books or journals. These materials are easily attainable in

libraries and bookstores. However, to spare our clients the cost and inconvenience of attaining this material, we have made copies of the readings for them. We also have loaned them copies of Geneen Roth's book *Feeding the Hungry Heart* (1982) if they did not wish to buy it themselves. We suggest that the therapist using this manual do the same.

The handbook provides practical guidelines, which we have found very useful in working with bulimic women. The program can be used in working with bulimics either individually or in groups. Although we developed it originally for group treatment, it has also been used very successfully with clients treated on an individual basis. There are advantages and disadvantages associated with group and individual treatment, and we do not necessarily endorse one over the other. Practical matters such as time considerations frequently necessitate the use of one mode over another. For this reason, we will discuss issues pertaining to both group and individual treatment. We will primarily describe the group treatment, but modifications can easily be made when working with a client individually.

We will initially review some practical matters such as screening and general format of sessions before discussing treatment. Then we will describe the therapist's role in each session, as well as issues that are likely to come up.

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