

Bulimia: Cognitive-Behavioral Treatment and Relapse Prevention

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The authors review the assumptions about processes that maintain bulimic behavior. Specific treatment package recommendations are made on the basis of selected outcome literature. Special issues, such as Axis II diagnosis, hospitalization, and psychopharmaceutics, are addressed.

Bulimia is a complex syndrome consisting of cognitive, behavioral, physiological, and family system processes. To date, a variety of cognitive (e.g., Fairburn, 1984) and behavioral (e.g., Rosen & Leitenberg, 1984) approaches have been evaluated for treating bulimia. Any approach by itself may be insufficient. A comprehensive treatment package is needed to effect change. An integrated, cognitive-behavioral treatment package offers promise in treating the bulimic client. The purpose of this article is to review assumptions about the processes that maintain bulimic behavior and to make recommendations concerning specific integrated treatment packages.

COGNITIVE-BEHAVIORAL ASSUMPTIONS

There seems to be considerable variability in behaviors manifested by people with bulimia. Although the diagnosis requires that binge eating be present, there is a wide variance in the frequency and intensity of binge eating and purging behavior, as well as among specific foods considered to be binge foods. Situational factors such as time of day, location, and environmental cues for binge eating vary, as do factors that terminate the binge episodes. Although vomiting is the most frequent method of purging, other techniques include laxative use, use of diuretics, fasting, and excessive exercise (Russell, 1979). The onset of bulimia is almost invariably related to dieting behavior or restraint (Abraham & Beumont, 1982), and people with bulimia report having difficulty in recognizing internal cues for hunger or satiety (Pyle, Mitchell, & Eckert, 1981).

There may be less variability in cognitions shared by people with bulimia. Numerous authors have identified cognitive variables as salient in maintaining eating disorders (Grinc, 1982; Loro & Orleans, 1981; Russell, 1979). Such descriptors as restrained eating and abstinence violation have been used to describe aspects of cognitive processing germane to the maintenance of eating disorders (Herman & Mack, 1975; Marlatt, 1985).

Bulimic clients tend to share a set of irrational cognitions about body image, self-concept, and control (Abraham & Beumont, 1982). They have an intense fear of becoming fat, and their self-esteem depends on how they perceive their outward appearance. Fear of weight gain leads to anxiety and irrational cognitions related to purging behavior. Self-statement cues to purge are related to the bulimic's belief that purging is a reliable method of weight management and a way of coping with negative feelings (Rosen & Leitenberg, 1984). The bulimic's decision to vomit is governed by her own set of rules about what foods are safe and acceptable to keep down. (Because the vast majority of bulimic clients are women, female pronouns are used in this article.) The vomiting, in turn, sustains the binge behavior.

In summary, bulimic behavior has been viewed as a maladaptive coping response, a result of poor eating habits, or an escape response to the fear of becoming fat (Rosen & Leitenberg, 1984). Cognitive factors associated with the behavior are (a) irrational beliefs regarding the effectiveness of purging; (b) distorted body images; (c) fear of fat; (d) perfectionistic, all or nothing thinking styles; and (e) poor intrapersonal problem-solving skills (Merrill, 1984, 1986; Mines & Merrill, 1986; Winstead, 1984). Based on these assumptions and selected literature, we recommend a cognitive-behavioral treatment package.

COGNITIVE-BEHAVIORAL TREATMENT COMPONENTS

We have treated over 150 bulimic clients using various modalities (e.g., individuals, group, family) in outpatient as well as inpatient settings. Also, we have conducted research on the group treatment of bulimia for the last 5 years. The following treatment recommendations are based on an integration of the treatment literature and our clinical experience. Fairburn (1984) and Marlatt (1985) suggested that treatment be divided into three phases: (a) behavioral control of the binge-purge cycle, (b) cognitive restructuring, and (c) relapse prevention. The treatment techniques and phases need to be adapted and modified on a case-by-case basis. The length of treatment may vary from 16 to 18 weeks (e.g., Fairburn, 1984; Grinc, 1982) to 2 to 5 years, depending on the severity of the disorder and on complicating factors such as history of incest or other trauma.

Phase 1: Behavioral Strategies

The primary objective in Phase 1 is to assist clients in gaining control over their eating behaviors. During a baseline period, clients are taught self-monitoring techniques that include reporting the time of the day, amount, content, and location of each eating episode and rating, on the Subjective Unit of Discomfort Scale (SUDS) (ranging from *no anxiety* [0] to *extreme anxiety* [100]), their anxiety relative to weight gain, beliefs about eating, body awareness (e.g., hungry, tired), affective state, and purge behavior. These data are used to structure the treatment components. The purge frequency needs to be taken into account when selecting behavioral strategies (Rosen & Leitenberg, 1984). Those who purge less frequently (fewer than five times per week) are better suited to a treatment approach involving maladaptive coping style, whereas those who purge more frequently (more than five times per week) are better suited to an exposure with response prevention approach.

Below are examples of behavioral strategies for clients who purge fewer than five times a week. We give these strategies to our clients in written form as an easy reference list.

Setting

1. Eat only at planned mealtimes.
2. Eat only in one designated room and sit at the table.
3. Avoid eating in other rooms in your home.

Food

1. Eat a portion from each of the major food groups each day.
2. Plan your meals for the week, including the type of food and size of portion.
3. Make your shopping list from the meal plan and stick to it. No spontaneous items, please.
4. Buy small quantities and individually packed portions.
5. There are no forbidden foods, only excessive quantities. Forbidden foods will get you into an all or nothing thinking style (e.g., if you have a chocolate kiss, then you might as well eat the entire bag because you just blew it). You would be better off giving yourself one or two chocolate kisses every day than to get into a good food-bad food mentality.
6. If you eat refined sugar, candy, and so forth, eat it with a meal rather than by itself so that you do not get wide blood sugar fluctuations, which can result in fatigue, depression, or cravings.

Eating

1. Try the Japanese Tea Ceremony—it's the first and second bite of a food that has the most flavor. Focus your total attention on the first two bites.
2. Chew the food slowly, savor it. Don't gorge. This will help digestion, relieve mouth hunger, and allow your stomach to tell your brain when you are full without overdoing it.
3. You need to find the amount of food that will sustain your body at its optimal weight. Your optimal weight is the point at which your energy and vitality are at their highest. For many people, this may be 10 to 15 pounds higher or lower; for some people (e.g., those who are anorexic or obese), it may be 50 to 100 pounds higher or lower. Therefore, you need to add or cut portions of every food at each meal until you find the best balance for maintaining your weight. This experiment will take a few (or many) weeks.
4. Take individual portions each time you want food rather than eating out of a bag or the serving dish.
5. Ideally, the purpose of eating is to provide fuel and building materials. Minimize eating for entertainment, meeting emotional needs, business purposes, and family expectations. Eat when you're hungry. Don't eat when you're emotionally upset or there is disharmony around your food.
6. Finally, avoid snacking, munching, nibbling, or binge eating.

Not Necessarily Random Suggestions

1. Exercise moderately to burn excess calories and increase your metabolism. Dieting slows your metabolism so that you need fewer calories to live on, and when you return to normal eating levels you gain weight. Exercise prevents the weight rebound (assuming your weight is reasonable).
2. Do some type of relaxation, meditation, or prayer before eating. This will minimize emotional eating or anxious, tension-filled eating.
3. The key to gaining or losing weight is not to cut or add foods but to cut or add portions of each food and to exercise. Your body needs a certain amount of calories, vitamins, and minerals to live. Too many and you gain weight; too few and you lose.
4. Make up a forbidden food list and systematically sample (a few bites or one portion) each one. If it's not forbidden, it will not be special.
5. Only weigh yourself once per week. Weight is often not the true issue; muscle tone is. Yoga, weight lifting, and aerobic dance will tone your muscles so that you will look healthy, weigh more, and actually lose a size or two in your clothes.

6. Above all, start: Do something. Any positive action is better than none at all. Remember, as long as you are moving, you are not stuck.

These strategies are designed to (a) gain stimulus control; (b) modify eating skills; (c) provide behavioral experiences that will aid in refuting irrational beliefs; (d) regulate physiological cues; (e) maximize the use of satiety centers in the mouth, stomach, and liver; and (f) assist in teaching alternative coping skills (e.g., relaxation, exercise).

The behavioral treatment of choice for the client who is purging five or more times per week is exposure with response prevention (Giles, 1985). This technique is based on the assumption that the purging behavior drives the bingeing behavior and is an escape response to the fear of becoming fat. The purging behavior is an attempt to cope with the fear of weight gain related to binge eating or eating forbidden foods. If the client can eat the food and keep it down, she will discover that a significant weight gain does not occur, thus reducing her anxiety level.

During the initial phase of treatment, it is desirable to schedule three sessions per week. The therapist first explains the rationale for treatment and describes how the treatment technique works. Then, baseline information is obtained from the client, including frequency of binge eating and purging and anxiety ratings (SUDS) relative to different foods.

During the second phase of treatment, the client brings a nondiet food to the first session. The purpose of the food is to evoke moderate amounts of anxiety (40 to 60 on the SUDS). The client eats the food and reports SUDS levels at 5-minute intervals, agreeing to refrain from vomiting for 3 hours. Also, she is instructed to practice daily between sessions. After improvement occurs on the moderate anxiety-related foods, she brings food with greater SUDS values and repeats the procedure.

During the sessions, while the client is eating, the therapist discusses the client's thoughts and feelings using cognitive techniques of information sharing and disputing irrational beliefs. Giles (1985) recommended that as treatment progresses, the client should be instructed to eat with a 1,500 to 2,000 calorie band as a means of regulating weight. The therapist and client use the above procedure to reduce the binge-purge frequency to zero. The client who purges everything she eats may need external control (e.g., hospitalization) to reduce the frequency of her purging.

Phase 2: Cognitive Strategies

After behavioral control of the eating and purging has been obtained, the client is ready to emphasize more of a cognitive approach. The behavioral control is achieved relatively easily (i.e., 4 to 18 weeks), whereas the cognitive components may be more recalcitrant, possibly because of the ease of overlearning and rehearsing irrational beliefs and poor problem-solving skills.

Fairburn (1984) recommended that the second phase focus on maintenance of regular eating patterns and reduction of dietary restraint (rigid dieting). During this phase it is important to identify circumstances that lead to binge eating, help the client cope more effectively with such circumstances, and reduce the frequency of the occurrences. In addition, therapeutic tasks include identifying and challenging the thoughts, beliefs, and values perpetuating the eating problem and body image distortions and deprecations.

Furthermore, Merrill (1984) recommended that problem-solving skills be taught as a means of identifying and learning alternative coping skills. Extended training in coping skills may be needed in this phase and could include exercise, meditation, time management, and communication skills.

The cognitive phase can typically vary from 5 to 18 sessions up to a couple of years. The cognitive factors associated with relapse prevention are important to consider.

Phase 3: Relapse Prevention

Marlatt (1985) defined *relapse prevention* "as a self-management program designed to enhance the maintenance stage of the habit change process" (p. 3). Relapse for a bulimic can be defined as a return to pretreatment base rate. The goals of relapse prevention are to (a) anticipate and prevent the occurrence of a relapse after treatment and (b) help the client recover from a lapse (e.g., a purge on one occasion) before it escalates into a full-blown relapse (e.g., return to base rate). According to Marlatt's (1985) perspective, bulimic behavior would be viewed as an over-learned, maladaptive habit pattern—a maladaptive coping mechanism.

The relapse prevention phase represents the most difficult aspect of the change process because the client is faced with numerous cues, stressors, and the pull of old habit patterns. Failure to anticipate and cope with cues can set the client up for an early relapse (Marlatt, 1985).

Marlatt (1985) suggested using microanalysis on lapses and implementing an extended analysis of general relapse situations. If a bulimic client slips, then it is important to teach the client, using specific intervention strategies, to anticipate and cope with high risk situations and to modify cognitions and reactions so as to prevent the lapse from becoming a major relapse. The specific intervention strategies include self-monitoring, relaxation training, stress management, efficacy-enhancing imagery, contracting to omit the extent of relapse, skill-training relapse rehearsal, programmed relapse, and cognitive restructuring regarding relapse. Extending the strategies beyond the microanalysis of initial lapse to strategies designed to assist the client in identifying and coping with covert determinants of relapse (early warning signals, cognitive distortions, and relapse setups) will increase the probability of treatment gains. Examples of these global self-control strategies are balanced daily lifestyle, positive addictions, coping imagery, substitute indulgences (e.g., massage), labeling and detachment, relapse rehearsal, avoidance strategies, and decision matrixes.

Relapse prevention is of utmost importance with bulimic clients, particularly given the long-term course of the problem. In addition to general treatment guidelines, we discuss below some related issues.

RELATED TREATMENT CONCERNS

Based on our experience, a significant subgroup of bulimic clients will also have an Axis II diagnosis (e.g., borderline personality disorder) (American Psychiatric Association, 1980). Also, these clients often will carry a diagnosis of posttraumatic stress disorder, given the high prevalence of emotional, physical, or sexual abuse (more than 80% in our clients). These clients will not fit the typical treatment time parameters but will require a longer course of treatment. In addition, our experience has been that they work better individually than in groups, because they can be disruptive to the group process.

A second subgroup of bulimic clients may have a primary diagnosis of depression (Hudson, Laffer, & Pope, 1982). These clients will benefit from a course of antidepressant medication. The results will be relatively quick (3 to 6 weeks) if the medication is effective. Clients who may benefit the most from a

medication referral are those with a multigenerational history of depression or those with symptoms of an "agitated depression" (i.e., more anxiety, symptoms of panic).

Some bulimic clients will not experience success with any of the above techniques on an outpatient basis. These clients will need the external structure of an inpatient program. A second group for which hospitalization is indicated includes those clients who are at risk medically (e.g., severe electrolyte imbalance) or who are suicidal (Fairburn, 1984).

The cognitive-behavioral treatment of bulimia has shown encouraging preliminary results. Significant clinical progress has been made in the treatment of bulimia over the last 6 years. Sophisticated treatment regimes can be developed to contribute to improvement in most bulimic clients.

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