

# Symptom Management of Bulimia

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This article describes a treatment approach for the symptom management of bulimia that is a synthesis of various techniques, including cognitive-behavioral therapy, response prevention, relapse training, and psychodynamic therapy. The model has been a useful teaching tool for both staff and patients in both group and individual formats. In addition to describing the treatment model, this article briefly addresses some of the challenges of integrating behavioral and psychodynamic interventions in the treatment of this patient population.

The recent increase in the incidence of bulimia (American Psychiatric Association, 1980) has created a significant clinical demand for treatment (Johnson, Lewis, Love, Lewis, & Stuckey, 1984; Pyle, Mitchell, Eckert, & Halverson, 1983). Although literature has begun to emerge demonstrating the relative effectiveness of several different interventions (Johnson & Connors, 1987), clinicians are continuing to search for guidelines about how to treat this group.

A consensus has emerged over the last several years that bulimia is a paradigmatic, psychosomatic disorder (Johnson & Maddi, 1986) in which biological (e.g., Hudson, Pope, Jonas, & Yurgelun-Todd, 1983), familial (e.g., Johnson & Flach, 1985; Kog & Vandereycken, 1985), sociocultural (e.g., Garner, Garfinkel, & Olmstead, 1983), and intrapsychic factors (e.g., Bruch, 1973; Johnson & Connors, 1987; Sours, 1980) interact to predispose certain individuals to develop eating disorders. Furthermore, among the bulimic patient group, there is a range of severity of characterological (e.g., Johnson & Connors, 1987; Swift & Stern, 1982) and behavioral symptoms (e.g., Fairburn & Cooper, 1982; Johnson, Stuckey, Lewis, & Schwartz, 1982; Pyle, Mitchell, & Eckert, 1981; Russell, 1979). The heterogeneity of the patient group and the multidetermined nature of the disorder require therapists to use sophisticated initial evaluations to assess which unique function the eating-related symptoms serve for each individual (Johnson, 1984). Treatment programs then need to be comprehensive and flexible enough to offer multidisciplinary interventions such as individual, group, family, and psychopharmacological therapies that are specifically indicated for each patient.

Despite the heterogeneity of the patient group and the multi-determined nature of the disorder, however, there are data and techniques that facilitate symptom management with this group. This article will present a schema that synthesizes the concepts and techniques that we use during treatment. The concepts and techniques are not new. We draw from cognitive-behavioral (e.g., Beck, 1976; Garner & Bemis, 1984; Fairburn, 1981), psychoeducational (e.g., Connors, Johnson, & Stuckey, 1984; Garner, Rockert, Olmstead, Johnson, & Coscina, 1985),

self-management (e.g., Kanfer & Schefft, 1987), response prevention (e.g., Rosen & Leitenberg, 1982), relapse prevention (e.g., Marlatt & Gordon, 1978), and psychodynamic conceptualizations (e.g., Bruch, 1973; Johnson & Connors, 1987; Sours, 1980). The value of the schema lies in its synthesis of these pieces into a teaching model that can be communicated to both patients and staff.

Before proceeding with the presentation of the model, we would like to reflect on what we perceive to be the delicate issue of integrating behavioral and psychodynamic treatment principles in order to accomplish symptom management. We feel that it is important to comment on this issue because it has been our experience that effective symptom management of this patient population requires an artful integration of behaviorally focused symptom management techniques and an analysis of transference.

## ART OF SYMPTOM MANAGEMENT

When we first began working with eating-disordered patients, our approach was predominantly psychodynamic. At that time, serious debate was emerging over the relative effectiveness of behavioral versus psychodynamic interventions. Cases were reported of patients who had been in long-term psychoanalytic treatment in which no active symptom management was being attempted, which resulted in life-threatening side effects from the disturbed eating behavior. Similarly, high relapse rates were being reported in behavioral treatments that focused on target symptoms without regard to underlying dynamics. Very little was written about whether one could simultaneously manage symptoms and address underlying dynamics through the analysis of transference: It appeared that one had to make a choice between two sharply divided camps. As a result of this clinical and theoretical dilemma, we developed some firm beliefs about the ingredients necessary for the effective treatment of this patient population.

## Dual Need for Symptom Management and Analysis of Transference

Most of our patients present with specific, identifiable, and (often) life-threatening symptoms, including low weight, the abuse of purgatives such as laxatives and diuretics, or self-in-

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duced vomiting. Unquestionably, therapists must intervene to correct these symptoms. This usually means actively utilizing a range of cognitive-behavioral, psychoeducational, and psychopharmacological interventions. However, we have also found that, with many patients, symptom management will not be effective unless it occurs in the context of a strong therapeutic alliance. Furthermore, we feel the therapeutic alliance is consolidated by analyzing transference. The dual need for active symptom management and the analysis of transference has provoked substantial controversy between psychodynamic and behavioral therapists. Unfortunately, a detailed review of the controversial debate is beyond the scope of this article (e.g., Messer, 1986; Wachtel, 1977, 1982). However, we would like to comment on some of the common impasses that surface when one is attempting to integrate these two techniques.

### Facilitating Symptom Management Through the Analysis of Transference

The term *analysis of transference* may evoke an image of a passive and silent therapist. When this imaginary therapist does speak, it is to offer genetic interpretations regarding "unconscious, impulse-laden motives" (Garner & Bemis, 1984, p. 112). Although this characterization of psychodynamic therapy has certainly persisted over the years, we do not consider it to reflect a good technique for exploring transference (e.g., Gill & Hoffman, 1982). For us, the term *analysis of transference* is used to describe the process whereby a therapist is committed to attempting to understand, on an ongoing basis, how the patient is experiencing the immediate actions or nonactions of the therapist. This process operates on the assumption that, whenever a therapist engages in a therapeutic relationship, patients will respond in ways that reflect their characteristic perceptions of self and others. These perceptions are amalgams of years of interactions with others, some of which may have been quite destructive. Unquestionably, these previous experiences with others will bias the patient's experience of the therapist, perhaps in a negative way. Thus, when a therapist offers a symptom-management suggestion, the patient can experience that offer in a multitude of ways, some of which might deviate from what the therapist intended. Unless the therapist is alert to this possibility and is willing to process it with the patient, the transference issues arising in the interpersonal interaction may prevent patients from using the suggestion. We cannot overemphasize the importance of this process in symptom management. We believe it is attentiveness to understanding the patient's experiences of the therapist and the therapeutic interaction that consolidates the therapeutic alliance and facilitates the patient's ability to use symptom-management techniques.

Recent cognitive-behavioral work has focused more attention on the problem of the therapeutic alliance (Beck, 1976; Garner & Bemis, 1984; Guidano & Liotti, 1983). Garner and Bemis noted that attention to the therapeutic alliance "becomes a key source of data for assessment of beliefs" and facilitates helping "the patient become aware that they constitute patterns of expectations" (1984, p. 111). Although Garner and Bemis differentiated cognitive-behavioral approaches to understanding and making use of the therapeutic relationship from current psychodynamic approaches, we see much consistency between

the goals of the two schools. What distinguishes cognitive-behavioral from psychodynamic approaches to the therapeutic alliance, however, is the cognitive-behavioral theorist's relative lack of attention to how the therapist can make use of the relationship between therapist and client (Messer, 1986).

### Facilitating the Analysis of Transference Through Symptom Management

Objections from our psychodynamic colleagues follow a different path. Historically, analytically oriented therapists have argued that activity from the therapist disturbs the therapeutic frame, thus precluding the possibility of analyzing transference (Langs, 1978). This classical "blank screen" view of transference assumes that the therapist can create a bias-free setting, which subsequently allows the patient to project onto the situation his or her characteristic way of relating to others. We have serious doubts about the ability of any therapist to create an influence-free environment. In reality, all therapists offer directions to patients that they believe will be helpful (i.e., meeting regularly for prescribed amounts of time, requesting that the patient talk freely and openly about their thoughts and feelings, and remembering dreams, etc.).

It has been our experience that the introduction of symptom-management techniques actually facilitates rather than interferes with the therapist's ability to analyze transference. Offering specific cognitive and behavioral skills can often help to frame a pattern of interpersonal difficulty or to illustrate the functional nature of a symptom. For example, giving up binge-purge behavior may allow the patient's feelings to surface or may increase the patient's awareness of expectations about receiving help from others. If therapists are committed not only to offering behavioral symptom-management suggestions but also to understanding the patient's experience of being offered these suggestions, they are in what we consider to be the most favorable position to facilitate behavior change and to analyze resistance to behavior change.

In summary, we conclude that the effective treatment of bulimic patients requires therapists to artfully integrate the analysis of transference with behavioral symptom management. Therapists must communicate to the patient through continuous alertness and inquiry that they are attempting to understand how the patient is experiencing the interaction with the therapist. At the same time, they must actively utilize the range of interventions that have been demonstrated to be helpful in reducing symptomatic distress.

## SYMPTOM-MANAGEMENT THEORY

The theoretical base for our approach to symptom management has been developed and articulated by the proponents of social learning theory (e.g., Bandura, 1977) and self-management theory (e.g., Kanfer & Scheffl, 1987). This approach emphasizes a reciprocally determined relationship between four dimensions: cognition, social and physical environments, physiological processes, and behavior. Such a model is necessary for the symptom management of bulimics because of the complex linkage between self-destructive patterns of behavior, social and environmental cues, beliefs and expectancies about food and

physical appearance, and physiological cues and reinforcements that result from the binge-purge cycle. The techniques we use have been taken from a wide body of behavioral literature, including self-management (e.g., Kanfer & Scheff, 1987), cognitive-behavioral (e.g., Beck, 1976; Garner & Bemis, 1984; Fairburn, 1981), response-prevention (e.g., Rosen & Leitenberg, 1982), and relapse-prevention (e.g., Marlatt & Gordon, 1978) approaches. The following model is neither a canned program nor a blueprint for treatment but rather a heuristic for guiding choices about clinical goals and strategies for change. Therapeutic goals for self-control include (a) the learning and performance of self-management skills (e.g., self-monitoring); (b) the enhancement of beliefs that are likely to promote behavioral change (e.g., self-efficacy); and (c) the enhancement of environmental conditions that promote self-control (e.g., family and social networks, therapeutic alliance).

### ASSUMPTIONS

A number of observations regarding bulimic patients provide a rationale for our approach to symptom management. Many investigators have documented that bulimic patients experience significant affective instability (e.g., Johnson & Larson, 1982). A number of factors seem to contribute to this instability, including a biological predisposition to major affective disorder (e.g., Hudson et al., 1983), patterns of early parent-child difficulties, and disturbed family environments (Humphrey, 1986; Johnson & Flach, 1985; Kog & Vandereycken, 1985).

As a result of this biogenetic and environmental predisposition, many patients may experience highly variable moods that they have difficulty identifying, articulating, and controlling (e.g., Bruch, 1973). The feelings of ineffectiveness (Love, Ollendick, Johnson, & Schlesinger, 1985) and low self-esteem (e.g., Connors et al., 1984) that have been observed in bulimic patients are predictable side effects of the repeated feeling of being out of control. As many researchers have argued (e.g., Garner et al., 1983; Johnson & Connors, 1987), the culturally prescribed body shape for women over the last two decades has resulted in young women developing concrete beliefs that, if they accomplish low body weight, they will experience self-control. Weight loss is achieved through prolonged calorie restriction (dieting). Research has demonstrated that repeated and prolonged calorie restriction results in physiological and psychological side effects that destabilize thoughts and moods (Keys, Brozek, Henschel, Mickelson, & Taylor, 1950). Consequently, many bulimic patients appear to solve self-control/self-esteem problems and ineffectiveness problems by accomplishing thinness. Eventually, however, the biological and physiological side effects from constant dieting (self-starvation) begin, once again, to destabilize their thoughts and moods. They become caught in what we have called the *psychobiological impasse* (Johnson & Maddi, 1986). The bulimic definition of self-control, which is to achieve and maintain thinness through self-starvation, is at odds with bulimic biology. Their original solution to self-regulatory problems (thinness) paradoxically begins to exacerbate their original difficulties with affective instability. Initially, the bingeing and purging behavior is experienced as an adequate compensatory compromise between the need to pursue self-control through achieving thinness and the need to eat. Gradually, the frequency

and duration of the binge-purge behavior increases as patients progressively rely on it for a variety of reasons, including mood regulation. Eventually, the binge-purge behavior deteriorates until patients are again feeling profoundly out of control, despite thinness or normal body weight.

At some point, usually early in treatment, we have found it helpful to provide patients with an understanding of how these biogenetic and environmental factors may predispose them to difficulty with self-regulation and how the pursuit of thinness and bingeing-purging behavior may have emerged as adaptations to this vulnerability. This understanding often creates a framework that facilitates integration of symptom-management goals.

The following symptom-management strategy is designed to challenge bulimics' beliefs about accomplishing self-control through the destructive control of their bodies (starvation) and to suggest alternative methods that will allow bulimics to feel in control. Because there is usually a predictable sequence to a binge-purge episode, we have divided the schema into four components that target different self-regulatory skills, which can be taught at different points in the sequence: prevention, prebinge state, postbinge stage, and post-binge-purge state (see Figure 1).

### SYMPTOM-MANAGEMENT STRATEGY

#### Prevention

The overall task of the prevention phase is twofold. First, the therapist wants to encourage patients to develop regular eating habits that will minimize the physiological and psychological factors that make them vulnerable to binge eating. This requires not only helping them to restructure eating habits but also challenging their beliefs about the consequences of normal eating. Second, the therapist must help patients learn thoughts and behaviors that will result in more effective management of their moods. This can be accomplished by helping patients gain self-awareness about how particular circumstances affect them. This awareness will allow patients to develop beliefs that certain behaviors result in predictable outcomes, thus enhancing feelings of personal efficacy.

#### *Normalizing Food Intake*

##### *Psychoeducation*

The first and most logical place to begin symptom-focused work is on trying to establish an adequate and routine feeding schedule. We emphasize to patients that their binges are often caused by a combination of physiological and psychological needs. We present information from semistarvation studies (e.g., Keys et al., 1950) and restraint theory (Herman & Polivy, 1980), which suggests that prolonged calorie restriction can result in counterregulatory binge eating. Most bulimic patients have a belief that the best way to protect themselves from being out of control with food is to avoid it. It must be pointed out to patients that, paradoxically, the more they avoid food, the more preoccupied and compelled to eat they are going to feel. We often (with humor) attempt to establish the perspective with patients that the best defense against binge eating is to eat.

*Self-Induced Stimulus Change*

**Meal planning.** We feel that it is important to err in the direction of being quite concrete and structured with meal planning in the early stages of treatment. We emphasize to our patients that the meal plans are not diets and that the goal of the meal plan is not to lose weight but rather to develop a way of eating that they can comfortably rely on throughout their lives.

The most frequent question bulimic patients ask about meal planning is, How much can we eat without gaining weight? We honestly tell them that there is no precise way of knowing. We inform them that weight regulation is affected by many variables, including genetic predisposition to weight gain and loss, amount of exercise, and history of feeding behavior. We suggest to them, however, that we can offer an informed guess about what a reasonable meal plan would be. In negotiating the meal plan with the patient, it is important that the therapist assure normal-weight patients of the intention to protect the patient from runaway weight gain.

We try to avoid excessive emphasis on calories and focus instead on meeting nutritional needs from the basic food groups. The food diary gives baseline information on types and quantities of food eaten. The task then becomes to patiently negotiate gradual changes in both the type and quantity of foods eaten.

**Portion control.** Because most patients report that it is difficult to stop eating once they begin, it is useful to develop strategies for controlling portions. Overall, we try to deemphasize weighing food. Instead, we rely on food models and visualization techniques to help patients learn how average portions appear.

It is also our experience that patients will generally eat whatever amount appears before them. Consequently, we encourage them to become assertive and to take control of the amount of food on the plate before them. For patients who have difficulty establishing boundaries around meal sizes, we encourage portioning food in separate containers. For example, if they are going to eat cereal each morning, we ask them to divide the large cereal box into individual portions. This effort enables patients to avoid making difficult decisions about portion size at the moment they are trying to eat, which is usually a high-anxiety time that can affect their perception of meal size.

**Timing of meals.** Many of our patients attempt to avoid food during the day, usually the time when their lives are most structured, and instead attempt to feed themselves when they are alone at home in the evening. Essentially, they are trying to handle food at peak hunger in the setting in which they are most vulnerable. We emphasize to patients that we would like them to do most of their food handling during the day, which is usually their most structured time.

We focus on the importance of eating breakfast, both from a biological and a psychological perspective. Once again, we inform them of how low calorie intake early in the day can adversely affect mood states. The psychological advantage of eating breakfast is that the individual begins the day in a nondepriving manner. Generally, this is also an action that challenges patients' routine diet mentality. Many patients find it easier to eat smaller quantities several times per day. The smaller but more frequent meals protect them from feeling too full at one time.

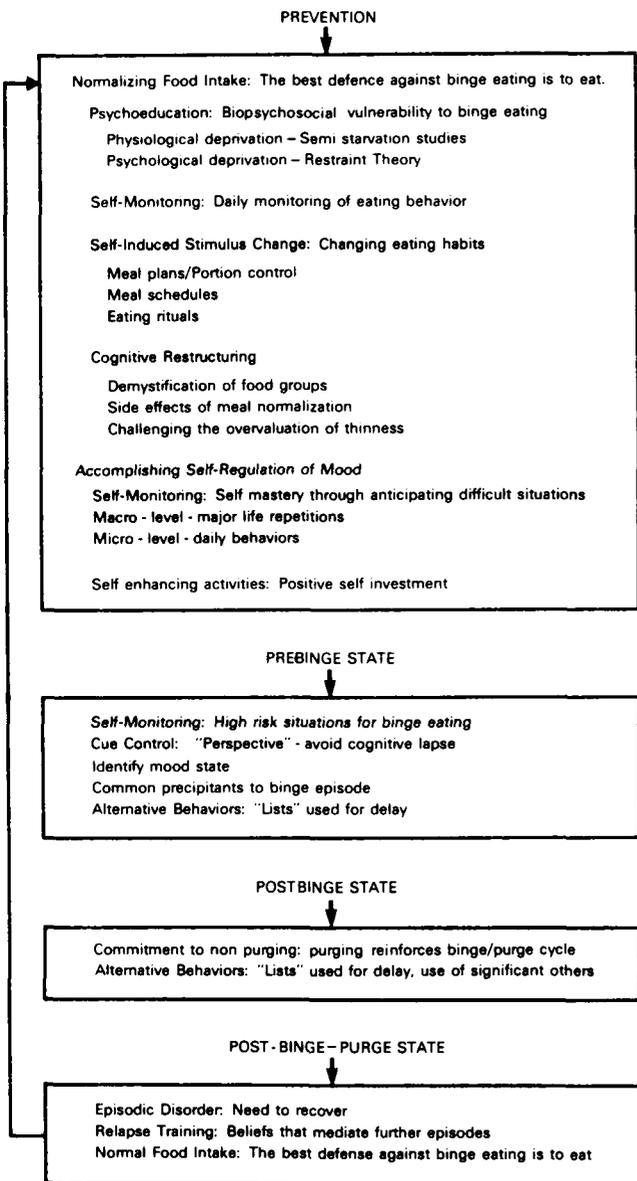


Figure 1. Symptom-management strategy.

*Self-Monitoring*

Our specific approach to normalizing food intake varies according to the patient's needs. Self-monitoring records are utilized to give both the therapist and the patient an opportunity to evaluate patient eating habits. By evaluating self-monitoring records with a patient, the therapist can communicate that behavior change will be a collaborative effort, thus facilitating the development of a therapeutic alliance. After obtaining a detailed record of the patient's daily eating habits through the use of self-monitoring records, the therapist can begin to recommend changes. We generally focus on several areas, including meal size, timing of eating, eating rituals, and the demystification of food groups.

*Eating rituals.* Patients often unwittingly establish eating rituals that are counterproductive. Once again, we ask patients to detail their thoughts and behaviors before, during, and after a meal. After exploring their existing routines, we attempt to formulate new rituals at these times.

Before a meal, we essentially want patients to orient themselves before they prepare or eat food. We want them to visualize the process of food preparation and eating before they begin. We do not want them to initiate the process either impulsively or when they feel hassled or disorganized. Many patients enter their homes and reflexively stop in the kitchen, where they quickly grab food. This usually triggers chaotic and impulsive eating. We encourage patients to avoid the kitchen when they enter their homes. We ask that they establish some other entry ritual, such as straightening their home, sorting mail, watching television, being with their children, reading the front page of the paper. Once they feel that they have made the transition into the home, they can then approach the kitchen.

Food preparation can be a dangerous time because patients often begin to pick at food. They can also become overwhelmed if too much food is out at one time. We ask that they not eat during food preparation and that they work on one thing at a time during food preparation. We also ask that they put up extra food as they go along so that when they begin their meal, food is not visually strewn throughout the kitchen. This also minimizes the amount of food handling necessary after the meal, when they may be vulnerable to continued eating.

During the meal, we ask that patients sit down in a place that is designated as the dinner table. They should not eat standing up or in a place where they characteristically binge eat. We ask patients to minimize watching television or reading during the meal. It is our experience that this distracts patients and causes them to feel that they did not eat or that they have lost track of what they have eaten. For patients who eat too quickly, we suggest that they pace themselves by doing such things as putting their fork down between bites. For patients who eat too slowly, we suggest that they put a time limit on their meal.

After the meal, some patients find it helpful to avoid clearing the dishes until later. As a rule, we encourage patients to engage themselves in some activity postmeal because this is the high-risk time for feeling anxious and vulnerable to purging.

### *Cognitive Restructuring*

*Demystifying food groups.* Along with beliefs about timing, portion control, and rituals, as treatment proceeds the therapist must challenge the patient's beliefs about different food groups. We ask patients to identify high- and low-risk foods and to try to explore their beliefs about these foods. Some patients simply have bad information, whereas others have more psychotic thoughts regarding different foods. The pace at which one challenges these beliefs obviously depends on the function the belief serves in the patient's overall psychic economy.

Most patients are carbohydrate avoidant and regard this food group as their worst enemy. We aim at this misconception and attempt to argue that, contrary to their belief, carbohydrates are perhaps their best friends. Although we are not keen on the nutritional value of sweets, we also feel that suggesting total abstinence from these foods may paradoxically provoke an attrac-

tion to them. Consequently, as patients feel more comfortable with their eating, we encourage them to include desserts in their overall scheme for lifetime eating habits.

*Side effects of meal normalization.* Changing patients' eating habits inevitably creates panic about bodily changes. Patients commonly complain about bloating and feeling that food is sitting in their stomachs, and they fear rapid weight gain. These are often predictable side effects of the change in eating habits, and it can be useful for the therapist to mention that these events may occur. We inform patients that, as they decrease their vomiting or laxative use, they may experience rebound edema. We explain that the body has experienced the repeated dehydration from the purging as a drought and that its adaptive response to newly available fluids is to retain fluids above the normal level. As the body becomes more convinced that fluids will be consistently available, fluid regulation normalizes. Likewise, the body has experienced the calorie restriction as a famine. The organism has responded by becoming hypometabolic in order to make effective use of each calorie. When more food is made available, the body initially attempts to store reserves. Sometimes this results in a rapid but brief weight gain. As calories are more consistently made available, metabolism and weight regulation normalize. It has been our experience that many patients over the long-term actually lose weight after they stop bingeing and purging. We also explain to patients that if they have repeatedly evacuated over several years, the stomach loses part of its efficiency in digesting food (Dubois, Gross, Ebert, & Castell, 1979). Consequently, it may actually take longer for food to digest, resulting in a prolonged feeling of fullness postmeal. Once again, as the stomach becomes more active, the delayed gastric emptying decreases.

*Weight expectations.* Any effort to normalize eating patterns will quickly focus fears regarding weight gain. The question of what is a reasonable weight expectation for the patient is one of the most delicate that the therapist will confront. We explain to patients our overall perspective on weight expectation and regulation: Once patients' calorie intake has been stabilized and reasonable exercise patterns have been established, their body weight will normalize in a range that is biogenetically appropriate for them (Keesey, 1980; Mrosovsky & Powley, 1977; Nisbett, 1972; Herman & Polivy, 1980). We emphasize to the patient that this is our way of avoiding an arbitrary weight expectation. Likewise, we hope that patients will also learn to avoid choosing weight goals that may be a bad fit with their biology and psychology. This perspective generally requires substantial justification because it threatens fundamental beliefs about the importance of weight control and how it is accomplished. We inform patients about what we have learned regarding how the body regulates weight and how much control we seem to have over weight regulation (Nisbett, 1972).

*Challenging the overvaluation of thinness.* Challenging the patient's beliefs about the importance of dieting or thinness may also require that the therapist explore the meaning that thinness has for the patient. Many women have simply internalized the prevailing cultural norm that thinness equals beauty, success, and control. They have not considered the psychological, biological, political, and economic implications of their endorsement of the current norm. We have found discussions of how expectations of women's body size have vacillated histori-

cally and how a multibillion dollar industry exploits women's preoccupations with thinness to be quite helpful.

### *Accomplishing the Self-Regulation of Mood*

Positive self-esteem and feelings of effectiveness occur when one learns how to successfully manage one's life. Feelings of mastery accrue when one repeatedly and successfully navigates through challenging life situations. Learning how to anticipate difficult situations and how to manage one's feelings in reaction to these events can contribute significantly to an increased sense of mastery.

### *Self-Monitoring*

Patients can be taught a two-tiered model of self-monitoring. At a macrolevel, the task is to explore and identify major life repetitions. More specifically, one must try to learn with the patient how he or she has historically responded to major life events, such as loss or separation from significant others, major transitions, experiences of failure and rejection, intimate relationships, and the assumption of challenging responsibilities. The purpose of the inquiry is to help the patient respond to these circumstances more effectively when they occur. At a microlevel, the task is to help patients learn how to anticipate difficult situations and to help them monitor their internal states on a daily basis. It is often useful to have patients fill out daily monitoring sheets several times per day over the course of a week. Patients often discover recurring patterns of mood fluctuation and disturbed eating behavior related to predictable daily or weekly events. Coming home at night, beginning to prepare food, visiting with family, eating in restaurants, shopping for food, drinking alcohol, watching television, weighing oneself in the morning, skipping lunch, being alone—all of these are mundane events that may have a predictable effect on the patient. Once again, being able to identify and anticipate vulnerable contexts allows patients to think about developing alternative strategies for coping with these situations, thus facilitating a sense of mastery.

### *Self-Enhancing Activities*

Many bulimic patients have become withdrawn and isolated as a result of food-related behavior and low self-esteem. As they become more enmeshed in the binge-purge cycle, their range of involvement with different activities narrows dramatically, and often they quit doing the things they once enjoyed. Overall, it seems apparent that the frequency of bulimic episodes is highly correlated with the patient's self-esteem. When bulimics feel better about themselves, they binge less, and vice versa. Exploring and encouraging patients to develop or reintroduce self-enhancing activities is extremely important.

### **Prebinge State**

As a result of self-monitoring, most bulimic patients learn to identify situations that make them vulnerable to binge eating. Nonetheless, they will continue to feel the pressure of the impulse to binge eat at different times. The overall task expressed in the second phase of the model is to provide specific strategies

for the patient to use to manage the immediate impulse to binge eat. The primary goal is to introduce mechanisms that will facilitate the delay of this impulse.

### *Cue Control: Helping Patients Maintain Perspective*

Bulimic patients often lapse cognitively under the pressure of strong affects. It is useful to suggest a single word that might help the patient become organized during these times. We use the word *perspective* to teach the patient to focus away from the immediacy of her or his affective state, to recall the self-control strategies rehearsed during therapy, and to evoke a memory of the therapist or the therapeutic environment. For character-disordered patients who appear to have difficulty with evocative object recall, the association between the word and the therapeutic environment is sometimes sufficient to help soothe them when they are feeling vulnerable to losing control. After patients become oriented to the word, they must next identify their mood states.

### *Identifying Mood States*

We teach patients that the urge to binge is a signal that they need to attend to some internal state. The task for patients then becomes to recognize what they are feeling. By specifying the mood state, patients may find appropriate and gratifying alternative responses to binge eating. Ultimately, we wish to have patients reframe the urge to binge as a signal of some disruption in affect that requires attention rather than as the first step in an experience in which they feel out of control.

Obviously, among a patient group that is characterized by its difficulty identifying and articulating internal states, the task of specifying feelings will be enormously demanding. In fact, for some patients it will be the essence of treatment. Given that this is a significant deficiency among many bulimic patients, it is important for the therapist to be persistent but patient with this task.

Some patients cannot initially generate labels to describe how they feel. When attempting to do so, they become overwhelmed and may become even more confused. Providing these patients with a series of scaled adjectives or with a menu of potential affective states can be quite helpful in teaching them how to evaluate their feelings.

### *Common Precipitants to a Binge Episode*

We have observed a number of affect-laden and stressful situations that make patients particularly vulnerable to binge episodes. These situations call for a variety of interventions.

*Anger.* Anger is a mood state that is frequently troublesome for bulimic patients. Most bulimic patients avoid expressing anger because they fear interpersonal consequences such as disapproval, rejection, or retaliation. It is our experience that most bulimic patients can benefit from assertiveness training. Cognitive-restructuring exercises can help to resolve irrational fears about losing control of their anger and about criticism, rejection, and retaliation. The role-playing of difficult social situations, particularly in group-treatment settings, can be useful in teaching new coping skills. We tell our patients that the more

they express themselves verbally, the less they will experience the urge to manage their feelings via binge eating and purging.

*Capacity to be alone.* Our research has indicated that the greater a patient's capacity to tolerate aloneness, the less likely she is to have trouble with binge eating and purging (Larson & Johnson, 1985). We have found two common types of difficulty with being alone. For patients with more severe self-regulatory difficulties, being alone is experienced as a highly anxious and disorganizing time when they feel lost, out of control, and abandoned. Boredom is also a term that can be used to describe this state. Binge eating is used to create a predictable structure that is soothing or distracting. Effective symptom management with this group must occur in the context of an extended period of consistent and reliable contact with a therapist.

In contrast, among patients who are more obsessive and are highly achievement-oriented, time alone provokes excessive rumination about the things they are supposed to do and about the things they have failed to accomplish. The relentless drive to achieve usually prevents them from relaxing, particularly when they are alone. Binge eating among this group is often used as a mechanism to "space out" or to distract themselves from the obsessive drive to achieve. Challenging patients' beliefs about the need to achieve and giving them permission to be lazy can help reduce the urge to binge eat.

*Problem-solving difficulties.* Many patients binge when they are faced with the need to make a decision. Their perfectionistic and obsessive tendencies can keep them swinging back and forth between alternatives until they become virtually immobilized. Procrastination and paralysis result when individuals believe catastrophe will ensue unless they make the perfect decision. Often, patients need to be taught basic problem-solving skills, such as constructing a list of the pros and cons of each possible decision. The therapist can also stress that most decisions are not irrevocable, nor do they influence the entire course of an individual's life, which may help alleviate some of the pressure to make the right as opposed to the wrong decision.

*Self-nurturance difficulties.* Patients who have great difficulty being self-nurturing or who feel that they must be productive constantly often suggest activities like cleaning or studying as alternatives to bingeing. These patients frequently set up a choice between a disliked activity, such as waxing the kitchen floor, and bingeing. After reaching for the ice cream rather than the mop, they conclude that alternatives will not work for them and that they simply must binge when the urge strikes. The therapist must point out that most people would choose an activity that affords some measure of satisfaction over one that is total drudgery. The necessity of giving oneself something pleasurable must be stressed, along with the long-term nature of the alternative satisfactions.

### *Alternative Behaviors*

Once the mood state has been identified, the next step in the model is to engage in an alternative behavior rather than binge eat. It is crucial that the patient experience this intervention as a collaborative effort. In this regard, it is often useful for the therapist to actually write out or record the listed alternatives with the patient. We have found that the concrete presence of the therapist's handwriting or voice often helps the patient

maintain a feeling of connectedness when she or he is feeling panicky or at risk for losing control. The selection of specific alternative behaviors can be presented to patients as an exploratory process to see what feels better or worse for them during these high-risk times. Framing the task as exploratory often helps to minimize performance anxiety among these patients. As patients become more adept at identifying specific mood states, the list must also be revised to reflect their more sophisticated ability to discriminate between moods.

When the therapy is initially trying to interfere with the binge-eating behavior, the agreement with the patient should not be to completely avoid bingeing. Instead, the agreement should be that the patient will engage in the behavior on the list before binge eating. This safeguards against patients' feeling that they have failed if they binge, it minimizes the psychological feeling of being restrained, and it relieves the potential fear that something is being taken away from the patient that is necessary for her or his self-maintenance.

### Postbinge State

No matter how adept patients become at attempting to prevent a binge episode, there will be times when they feel they have eaten too much. Following such an episode, the patient once again has an opportunity to interfere with the chain behavior. We encourage our patients to make a central commitment to themselves to stop purging. We feel that if an abstinence model is to be helpful with this patient population, it must focus on purging behavior. We mention to patients that, although it is impossible for them to abstain from food, it is not physiologically impossible for them to abstain from purging. For some patients, it is useful to explain what we have learned about how the continued use of evacuation techniques exacerbates the binge-purge cycle (Johnson & Larson, 1982). We emphasize that purging is a behavior that they can take a stand with. There are no gray zones of interpretation about whether they have engaged in the behavior or not, as there are with overeating versus binge eating. If, at some point in treatment, the therapist feels that he or she needs to confront patients about taking responsibility for their actions, this is a good behavior to focus on. Some patients have been remarkably successful with an abstinence approach. They seem to organize themselves around the commitment to avoid this behavior. The sense of self-discipline they once derived from starving themselves is shifted to a dogged determination not to purge what they have eaten.

As with the construction of alternatives to binge eating, it is useful to construct a list that guides the patient during the high-stress time postbinge. We usually inform patients that if they can avoid purging for 45–60 min after bingeing or eating, the urge to purge will significantly decrease. During this postbinge time, any suggested alternative behaviors should be action-oriented. Because most patients have difficulty being alone when they feel panicky after a meal, having a reliable significant other available to patients during this time can also be very useful.

### Post-Binge-Purge State

The overall task of this phase is to challenge the thoughts and feelings that perpetuate the repetition of the binge-purge se-

quence once it has occurred. We have found the relapse-prevention concepts of Marlatt and Gordon (1978) to be very useful. We emphasize to patients that there will be times when they both binge and purge. We teach them that, following a binge-purge episode, there are a variety of self-statements bulimic patients tend to make that render them vulnerable to further episodes. Self-statements that characteristically predispose the patient to further relapses include, (a) My binge this afternoon has spoiled all of my progress to date—now I have to completely start over; (b) My binge this afternoon is evidence that I am out of control in all areas of my life; (c) Because I lost control this morning, the rest of the day is ruined, so I might as well binge again; or (d) Because I could not stop binge eating today, I will never be able to stop. It is important to teach the patients that the preceding statements generally provoke another binge episode because they undermine one's self-esteem, promote feelings of helplessness, and generate a sense of despair. Instructing patients to monitor postepisode statements is the first step to challenging their frame of reference regarding their binge eating. It is useful to reframe maladaptive thoughts by informing patients that bulimia is an episodic disorder that they have come to rely on for a variety of reasons. The behavior is not mysterious; instead, it is understandable and linked to generally predictable circumstances. Because bulimia is an episodic disorder, it is likely that, over the course of time, patients will have relapses.

The first binge-purge episode or relapse following a period of abstinence represents a crucial point. The patient must be taught to utilize the episode as a learning experience rather than as evidence that she is out of control. The goal is not total abstinence from bingeing and purging episodes but rather the quick recovery from an episode and the avoidance of progression into further days and weeks of bingeing. Predicting the behavior may reassure the patient that all is not lost should an episode occur and may also function, paradoxically, to promote the patient to do the opposite of what was predicted.

It is our experience that body dissatisfaction persists long after symptom remission. Bulimics who have been binge-free for some time remain vulnerable to panic over weight gain and to the reinstatement of stringent dieting. As mentioned earlier, the deprivation engendered by this may trigger a relapse. Should this occur, it is vital that the patient return to normal eating, with the therapist reminding her or him that the best defense against binge eating is normal eating. Many patients automatically skip the next meal following a binge-purge episode. We point out that skipping meals is the first step in initiating a repetition of the sequence and that, by making the commitment to eat a meal following an episode, the patient has successfully gotten back on track. Eating the next meal is an active behavior that interferes with the habitual pattern and realigns the patient with the first phase of the recovery model, which involves prevention.

## CONCLUSION

In this article, we have presented a clinical model for the symptom management of bulimia. The schema represents a synthesis of techniques that have proven to be helpful with this patient population. Controlled studies using combinations of

cognitive-behavioral and psychoeducational techniques have resulted in significant symptom reduction in approximately two thirds of patients within 3–6 months (Connors et al., 1984; Fairburn, 1986; Leitenberg, Gross, Peterson, & Rosen, 1984; Wilson, 1986). What this article does not address is for whom and under what circumstances this type of symptom management strategy is indicated or specifically contraindicated. As mentioned earlier, consensus has emerged over the last several years (a) that bulimia is a paradigmatic, psychosomatic disorder that is multidetermined and (b) that there exists a wide range of character pathology among the population. Given the multidetermined nature of the disorder, we emphasize the importance of a sophisticated initial evaluation.

Clearly, the current task for clinicians and researchers is to identify which combinations of treatment interventions are most effective with which subgroups of patients. For example, it is becoming clearer to distinguish which clinical features indicate the use of antidepressant medications within the eating-disorder population (Pope & Hudson, 1984). Likewise, some of our recent work has focused on identifying subgroups of patients with character pathology and on how various dynamics impact on treatment outcome (Johnson & Connors, 1987). Unquestionably, as research becomes more sophisticated, it will become clearer who can best use the type of symptom-management strategy that we have presented.

We also place considerable emphasis on the importance of the therapeutic alliance and, specifically, on how to facilitate it through the analysis of transference. Although some readers may feel that this debate is passé, we continue to see many clinicians struggling with the integration of these theoretical orientations. We also specifically chose to use the phrase, "the art of symptom management." This phrase represents an attempt to capture our strong beliefs about the need for the therapist to show flexibility and breadth of understanding in adapting symptom-management techniques to the unique constellation of transference themes that exist with each patient.

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