2 Counseling Patients With Bulimia Nervosa

Tricia Cook Myers and James E. Mitchell

KEY POINTS

- The first step of treatment is careful evaluation of physical, behavioral, and psychiatric status of the patient.
- The patient needs periodic monitoring of physical, behavioral, and psychiatric status as part of therapy.
- Counseling includes self-monitoring, prescription of regular and balanced meals, and behavioral and cognitive therapy.

1. INTRODUCTION

This chapter is designed to provide an introduction to the basic principles of counseling outpatients with bulimia nervosa who are being seen in a general medical setting. A summary of these principles and chapter outline is presented in Table 1. The purpose is not to make psychiatrists or counselors out of family physicians or other generalists, but rather to improve patient care and to briefly review some basic principles that can be useful in an office setting when working with these patients. Emphasis is placed on a few issues that may significantly increase the likelihood that cases of bulimia nervosa will be detected and that individuals with bulimia nervosa will become engaged in treatment and will take the first steps in the process of recovering from this disorder.

2. ASSESSMENT OF THE PATIENT

The first step for the physician is a thorough assessment of the patient. In the case of an individual with bulimia nervosa, this requires a detailed assessment of the various normal and abnormal eating and eating-related behaviors that may be present *(1)*. This assessment (*see also* Chapter 1) will lead the physician logically into treatment planning. Here, we discuss the issues that should be addressed in the assessment.

2.1. Weight

A careful weight history is essential. This includes an assessment of the patient's current height and weight (and calculations of the percent of ideal body weight), as well

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as high and low weight during adulthood, and, in particular, any history of being markedly overweight or underweight. Also, a family history of obesity is useful information in that there is a high heritability for adult body weight. As a corollary, it is very useful to evaluate how these patients feel at their current weight in general, and how they feel about specific body parts in particular. Many patients with eating disorders are very concerned about body weight, but others worry specifically about certain body parts, particularly their waist, hips, buttocks, and thighs. It is of note that these are the areas with which many young women in the general population are dissatisfied even if they are of normal weight.

2.2. Meal Pattern

It is useful to sketch out the meal pattern, including what the patient is eating and the frequency and timing of meals and snacks. Obtaining a specific dietary history is generally superior to a generalization about "usual" intake. Does the intake appear adequate? Most individuals with eating disorders markedly restrict food intake when not binge eating, and important goals of treatment are not only to suppress or eliminate binge eating, but also to increase the number of regular meals and snacks as a way of minimizing the dietary restriction that leads to binge eating.

2.3. Eating-Related Behaviors

There should be a very careful assessment of the presence of abnormal eating-related behaviors such as binge eating *(2)*. This includes the age of onset, duration and frequency of the symptoms, and any periods of remission. Behaviors that should be assessed in addition to binge eating are as follow: self-induced vomiting, use of laxatives for weight control, use of diuretics or diet medication pills (number per day, type), and any use of serum of ipecac to stimulate vomiting *(3)*. In obtaining this information, it is important to use a straightforward, nonjudgmental approach when questioning.

It is also important to elicit information about other behaviors that at times are associated with eating disorders, including excessive exercise, protracted fasting, chewing and spitting out food without swallowing it, ruminating food, and, in rare situations, the use of saunas or enemas for weight control.

2.4. Associated Psychiatric Problems

Many patients with eating disorders have other associated psychiatric problems *(1,4)*. Most commonly, these include mood disturbances (usually depression), problems with anxiety, substance use disorders, including alcohol abuse, and personality disorders. The assessment should also evaluate the presence or absence of each of these associated problems, and appropriate diagnoses should be made when indicated. This again may impact significantly on treatment planning.

2.5. Current Symptoms

In obtaining information about current symptoms, the review of systems should focus on areas that are often problems for patients with eating disorders. In bulimia nervosa, these would include salivary gland hypertrophy, abdominal bloating and postprandial distress, symptoms of dehydration, constipation and diarrhea, edema, and any evidence of blood loss with vomitus or through laxative-induced diarrhea.

2.6. Screening

Generally, patients not only hesitate to initiate discussions about their bulimia nervosa, but they may also deny behaviors that might lead to diagnosis; there is evidence that fewer than 30% of general medical patients choose to discuss their eating disorder with their physician *(5)*. Many patients with bulimia nervosa make every attempt to keep their disorders secret and because, unlike anorexia nervosa, there are often no overt signs of bulimia nervosa, many cases go undetected in primary care settings. Instead of discussing their eating behaviors, patients may complain of menstrual disturbances or generalized abdominal distress. As a consequence, physicians should routinely elicit information about dieting, patterns of eating, and body-image concerns, and may want to consider adding a two- to five-item screening tool to their review of systems when they routinely evaluate patients. Although there is no gold standard, validation is under way on several brief screening measures *(6–8)*.

3. MEDICAL MONITORING

Fortunately, most patients with bulimia nervosa are medically stable, and the medical mortality from this disorder is very rare. However, there are certain issues that may be of concern and several laboratory parameters that often require monitoring *(9)*.

3.1. Laboratory Evaluation

Serum electrolyte determination is usually the most important test for patients with bulimia nervosa. The classical pattern seen in bulimia nervosa patients is hypochloremic, and possibly hypokalemic, metabolic alkalosis. Evidence of severe alkalosis or hypokalemia is indicative of predisposition to organ failure. Fortunately, such severe abnormalities are rare. In attempting to correct a dehydration-associated alkalosis and hypokalemia, potassium supplementation should be accompanied by the strong advice to increase fluid intake because much of the potassium loss is attributable to the volume concentration. The presentation and physical examination can guide the choice of other laboratory tests. Any suggestion of pancreatitis or salivary gland changes should be evaluated with serum amylase, and lipase, and ipecac abuse should be evaluated with careful assessment of cardiovascular status *(3)*.

3.2. Dehydration

Laxative and diuretic abuse frequently results in profound dehydration acutely and reflex edema when they are discontinued. In managing abuse of these medications, the best approach is abrupt discontinuation of these drugs. In the case of laxative abuse, one sees reflex constipation after discontinuation; therefore, patients should be counseled to eat a high-fiber diet, avoid adding salt to their diet, and, if necessary, use a stool softener. Lactulose can be added if needed, but stimulant-type laxatives should be avoided if at all possible. Generally, fluid retention will remit within 7 to 10 d, and most patients will start having relatively regular bowel movements by then. Although some clinicians have advocated gradual reduction in the use of these drugs, this probably only prolongs the process and abrupt discontinuation should be encouraged.

4. SPECIFIC COUNSELING STRATEGIES

The following interventions should be considered: teaching the patient to begin self-monitoring *(10,11)*; the prescription of a pattern of regular, balanced meals *(12)*; and behavioral and cognitive-behavioral techniques for behavior control *(13–16)*. All of these can be inititiated by the physician; however, one-third of the cases probably will eventually require the involvement of a psychotherapist.

4.1. Self-Monitoring

Self-monitoring is very important for several reasons. Many patients with bulimia nervosa are not completely aware of the severity of their behavior. Thus, self-monitoring can be very useful to help patients begin to realistically appraise their current pattern. It also significantly improves eating behavior in bulimia nervosa. Patients are asked to record all food intake and any episodes of binge eating and vomiting with the times indicated. Patients can self-monitor using specific forms provided to facilitate this process or on a plain sheet of paper. It is important to have patients monitor not only the problem eating behaviors such as binge eating and vomiting, but also the healthier eating behaviors in hopes that these records can be used to point out both deficiencies and strengths in dietary intake *(13)*. It is important to remember, and to communicate to the patient, that dietary restriction during most of the day is a very important determinant of binge eating and that many patients will markedly decrease the frequency of their binge-

eating and purging behavior if they develop a more regular pattern of intake. Self-monitoring forms can be very useful in shaping this improved pattern.

4.2. Prescription of Regular, Balanced Meals

The prescription of regular food intake, with at least minimal intake every 4 h, can be helpful for patients in terms of gaining control of their eating behavior *(12)*. It is also important to remember that many patients seem to have lost a normal sense of hunger and satiety, and most try to restrict their intake early in the day knowing that they may binge eat later when returning home from work or school. Therefore, the physician, or the dietitian working in cooperation with the physician, should prescribe the regular intake of three meals and two to three small snacks, with enough calories to ensure that the patient will not be severely hungry at the end of the day, when binge eating is most likely to occur.

4.2.1. Flexibility

It is also important to try to encourage flexibility in the diet *(12)*. Many patients with bulimia nervosa avoid certain "feared" foods. Often, these are foods that they perceive as high in fat content. Although it is important to encourage flexibility and variety from the beginning, often it is helpful to recommend that patients avoid feared foods early in treatment because these foods may precipitate binge eating. Thus, initially patients should eat only those foods that they are willing to eat without purging. Patients should later be encouraged to gradually reintroduce these foods into their diet.

4.2.2. Sympathetic But Firm Approach

It is important for the clinician to remember that both of these interventions-self-monitoring and nutritional counseling-are confrontational issues that patients with bulimia nervosa may strongly resist. Many bulimic patients will not self-monitor when initially asked to do so, and most will have a great deal of difficulty instituting a pattern of regular, balanced meals. A tolerant and sympathetic, yet firm, approach will often yield improved results. In particular, the physician must make sure that the records or homework assignments from the previous week are carefully reviewed with the patient. If the practitioner does not clearly place importance on the records, neither will the patient. Problems with self-monitoring and with the meal pattern should be pointed out, and specific suggestions should be offered.

4.3. Behavioral and Cognitive-Behavioral Counseling

The third intervention—the behavioral and cognitive-behavioral component—has been effective in controlled trials *(1,4,10,13–15,17–22)*. Nevertheless, the typical practitioner will not have the time or expertise to embark on a full course of psychotherapy using these techniques. However, there are certain techniques that can be used if the opportunity arises while the practitioner sees the patient.

4.3.1. Concentrate on Success

Have patients concentrate on "what works." For example, if patients come in for an appointment and report that they have been able to go for several days without binge eating, it is important to focus on how this was accomplished. Were they busy doing other things? Were they able to eat regular meals and therefore were not as hungry? Were they feeling better about themselves for some other reason? If something works, it is a good idea to try to figure out what it was and to use it again.

4.3.2. Teach Normal Weight Expectations

Most patients with bulimia nervosa are convinced that if they start eating regular, balanced meals, they will gain weight. With the exception of those patients who retain fluid during withdrawal from laxatives or diuretics, most patients with bulimia nervosa do not gain weight when they start eating regularly, although there are exceptions. It is best to encourage tolerance of minor weight gain or fluctuations but to stress that overall they should not gain a substantial amount of weight. Patients should be instructed to weigh themselves one morning each week in order to reassure themselves that the recommended dietary changes have not resulted in inordinate weight gain. Indeed, patients may be better able to control their weight, and their weight will be more stable over time, if they are able to control the binge-eating and vomiting behavior.

4.3.3. Maintain an Active Lifestyle

Put simply, it is important for patients to stay busy at the times when they are most prone to binge eating and vomiting, a strategy known as behavioral alternatives. Typically, patients engage in binge eating in the evening, when they are home alone. Therefore, if they engage in activities that are incompatible with binge eating and purging (e.g., call a friend, go to a public place), the behaviors will be much less likely to occur. Identifying high-risk periods and developing a repertoire of alternative behaviors at those times can prove quite useful.

4.3.4. Identify Cues

Many patients are able to identify specific cues in their environment that seem to be associated with binge-eating episodes. A frequent stimulus is hunger induced by a long period of dietary restriction. Another common trigger is boredom. Patients with bulimia nervosa tend to binge eat, and then vomit, during periods of time when nothing much else is going on. The behaviors often become institutionalized; individuals tend to engage in binge eating and vomiting at set times, such as right when they return home after work or school. Therefore, preplanning alternatives for high-risk times can be a very powerful deterrent to binge eating and vomiting.

4.3.5. Highly Structured Counseling

Although all of these techniques can be quite useful, the literature suggests that the best counseling approach for patients with bulimia nervosa is a highly structured one. This includes individual or group therapy sessions conducted once or twice each week and involves a therapist specifically trained in cognitive-behavioral techniques *(23)*. Such therapy can result in dramatic reductions in the frequency of target behaviors and, in the majority of cases, will result in a complete remission of symptoms, as well as improvement in associated problems such as depression, self-esteem, and impaired interpersonal relationships.

4.4. Self-Help Manuals and Internet-Based Counseling

Recently, self-help manuals and Internet-based counseling (*see* Chapter 8) have been used to supplement treatment. Drug therapy has been combined with the use of a self-help manual provided to the patient, and use of a manual alone as the first choice in a stepped care approach to treatment has also been used. Internet-based counseling has also been

used as an adjunct to office treatment. The results thus far obtained have been mixed, and further study is necessary before these strategies can be recommended.

5. MEDICATIONS AND REFERRAL FOR COUNSELING

Relative to initial treatment, however, the preferred sequence remains a matter of debate. Some advocate conservative management including the use of antidepressants; others favor an initial approach including psychotherapy with or without antidepressants *(21,23–29)*. The use of medications in treating bulimia nervosa is discussed in Chapter 3.

The practitioner should certainly consider referring patients to a professional counselor if cost is not an obstacle to obtaining these services and if therapists well trained in the techniques shown to work with these patients are available. Unfortunately, well-trained therapists are often unavailable, because many therapists are not formally trained in the specific forms of therapy shown to help these patients in controlled trials. Fortunately, medications that are helpful for many of these patients are widely available and decrease the need for referral.

The primary physician can encourage the patient to engage in self-monitoring, stress the importance of regular meal intake, and prescribe an antidepressant such as fluoxetine hydrochloride. Fluoxetine has been shown to help reduce binge-eating episodes in bulimia nervosa patients when prescribed at higher dosages (60 mg/d) *(21,25–26)*. Even at the higher dosage, most patients experience minimal or no side effects, and if any occur, such as nausea or insomnia, they are usually transitory. Therefore, the physician should be aggressive in escalating the dosage or might initiate treatment at 60 mg/d. Alternative selective seratonin reuptake inhibitors have not been studied systematically but are used clinically. However, if this regimen of physician encouragement, education, monitoring, and medication management is not found to be helpful, the patient may be referred to a professional counselor to facilitate recovery.

In the event that referral is necessary, communication between the general practitioner and counselor can be beneficial in several ways. This interplay can ensure that both professionals are receiving the same "message" from the patient regarding his or her progress in recovery. It also permits both professionals to provide the patient with a common approach. Additionally, this communication can keep counselors aware of any physical symptoms the patient may be experiencing and any changes in medication that may affect the patient's mental state.

However, it is important to remember that the advice and encouragement of the primary physician, who places a strong emphasis on improving the pattern of regular food intake and on self-monitoring of problematic and normal eating behavior, can go a long way in starting the patient in the process of recovery.

6. CONCLUSION

Treatment of bulimia nervosa begins with the initial evaluation. Because patients with bulimia nervosa often try to hide their eating behaviors, screening questions should be incorporated as a routine evaluation of patients. Eliciting specific eating behaviors during an initial evaluation will serve as an early guide to self-monitoring. Although many aspects of the disorder and its therapy can be generalized, each patient needs to be treated as an individual, with the patient's symptoms guiding both the laboratory evaluation and therapeutic recommendations. During therapy, the patient's behaviors should be periodi-

cally reevaluated. As treatment progresses, successful interventions and circumstances that produce setbacks to therapy need to be addressed in the treatment plan. Many patients will benefit from medication, although others will require referral to experts.

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REFERENCES

1. Lacey JH. Bulimia nervosa, binge-eating and psychogenic vomiting: a controlled treatment study and long-term outcome. Br Med J 1983; 286:1609–1613.
2. Mitchell JE, Hatsukami D, Eckert ED. Characteristics of 275 patients with bulimia. Am J Psychiatry 1985; 142:482–485.
3. Mitchell JE, Pomeroy C, Huber M. A clinician's guide to the eating disorders medicine cabinet. Int J Eat Disord 1988; 7:211–223.
4. Mitchell JE, Pyle RL, Pomeroy C, et al. Cognitive-behavioral group psychotherapy of bulimia nervosa: importance of logistical variables. Int J Eat Disord 1993; 14:277–287.
5. Fairburn CG, Cooper PJ. Self-induced vomiting and bulimia nervosa: an undetected problem. Br Med J 1982; 284:1153–1155.
6. Morgan JF, Reid F, Lacey JH. The SCOFF questionnaire: assessment of a new screening tool for eating disorders. Br Med J 1999; 4:1467–1468.
7. Freund KM, Boxx RD, Handleman EK, Smith AD. Secret patterns: validation of a screening tool to detect bulimia. J Women's Health Gend Based Med 1999; 8:1281–1284.
8. Anstine D, Grinenko D. Rapid screening for disordered eating in college-aged females in the primary care setting. J Adolesc Health 2000; 26:338–342.
9. Halmi KA. Medical aberrations in bulimia nervosa. In: Kaye WH, Gwirtsman HE, eds. A Comprehensive Approach to the Treatment of Normal Weight Bulimia. American Psychiatry Press, Washington, DC, 1985, pp. 37–46.
10. Agras WS, Rossiter EM, Arnow B, et al. Pharmacologic and cognitive-behavioral treatment for bulimia nervosa: a controlled comparison. Am J Psychiatry 1992; 149:82–87.
11. Connors ME, Johnson CL, Stuckey MK. Treatment of bulimia with brief psycho educational group therapy. Am J Psychiatry 1984; 141:1512–1516.
12. Boutacoff LI, Zollman MR, Mitchell JE. Healthy Eating: A Meal Planning System. Unpublished manual. University of Minnesota, Minneapolis, MN, 1984.
13. Fairburn CG, Kirk J, O'Connor M, Cooper PJ. A comparison of two psychological treatments for bulimia nervosa. Behav Res Ther 1986; 24:629–643.
14. Fairburn CG, Jones R, Peveler RC, et al. Three psychological treatments for bulimia nervosa: a comparative trial. Arch Gen Psychiatry 1991; 48:463–469.
15. Fairburn CG, Jones R, Peveler RC, Hope RA, O'Connor M. Psychotherapy and bulimia nervosa: the longer term effects of interpersonal psychotherapy, behavioral therapy, and cognitive behavior therapy for bulimia nervosa. Arch Gen Psychiatry 1993; 50:419–428.
16. Mitchell JE, Pyle RL, Hatsckami D. Bulimia Nervosa: Individual Treatment Manual. Unpublished manual. University of Minnesota, Minneapolis, MN, 1987.
17. Freeman CPL, Munro JKM. Drug and group treatments for bulimia/bulimia nervosa. J Psychosom Res 1988; 32:647–660.
18. Garner DM. Cognitive therapy for bulimia nervosa. Adolesc Psychiatry 1986; 13:358–390.
19. Kirkley BG, Schneider JA, Agras WS, Bachman JA. Comparison of two group treatments for bulimia. J Consult Clin Psychol 1985; 5:43–48.
20. Mitchell JE, Pyle RL, Eckert ED, Hatsukami D, Pomeroy C, Zimmerman R. A comparison study of antidepressants and structured intensive group psychotherapy in the treatment of bulimia nervosa. Arch Gen Psychiatry 1990; 47:149–157.

21. Mitchell JE, Raymond N, Specker S. A review of the controlled trials of pharmacotherapy in psychotherapy in the treatment of bulimia nervosa. Int J Eat Disord 1993; 14:229–247.
22. Ordman AM, Kirschenbaum DS. Cognitive-behavioral therapy for bulimia: an initial outcome study. J Consult Clin Psychol 1985; 53:305–313.
23. Crosby RD, Mitchell JE, Raymond N, Specker S, Nugent S, Pyle R. Survival analysis of response to group psychotherapy in bulimia nervosa. Int J Eat Disord 1993; 13:359–368.
24. Abbott DW, Mitchell JE. Antidepressants vs. psychotherapy in the treatment of bulimia nervosa. Psychopharmacol Bull 1993; 29:115–119.
25. Fluoxetine Bulimia Nervosa Collaborative Study Group. Fluoxetine in the treatment of bulimia nervosa. Arch Gen Psychiatry 1992; 49:139–147.
26. Goldstein DJ, Wilson MG, Thompson VL, Potvin JH, Rampey Jr AH for the Fluoxetine Bulimia Nervosa Research Group. Long-term fluoxetine treatment of bulimia nervosa. Br J Psychiatry 1995; 166:660–666.
27. Herzog DB, Keller MB, Lavori PW. Outcome in anorexia nervosa and bulimia nervosa: a review of the literature. J Nerv Ment Dis 1988; 176:131–143.
28. Walsh T. Pharmacological treatment of bulimia. In: Halmi KA, ed. Psychobiology and Treatment of Anorexia Nervosa and Bulimia Nervosa. American Psychiatric Press, Washington, DC, 1992, pp. 329–431.
29. Walsh BT, Devlin MJ. The pharmacologic treatment of eating disorders. Psych Clin N Am 1992; 15: 149–160.

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