Preliminary Interview

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SCREENING FOR BULIMIA

We see our clients for an initial interview to assess if they are bulimic and to give them some information about the program. We have used the *DSM III* criteria to assess bulimia and to differentiate bulimic women from binge eaters and anorexics.

The diagnostic criteria for bulimia are as follows:

1. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than 2 hours).

2. At least three of the following: (a) Consumption of high-caloric, easily ingested food during a binge, (b) Inconspicuous eating during a binge, (c) Termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting, (d) Repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics, (e) Frequent weight fluctuations greater than 10 pounds due to alternating

binges and fasts.

3. Awareness that the eating pattern is abnormal and fear of not being able to stop voluntarily.

4. Depressed mood and self-deprecating thoughts following eating binges.

5. The bulimic episodes are not due to anorexia nervosa or any known physical disorder.

Even these stringent criteria, however, leave some ambiguity. For example, how much should one eat for it to qualify as a "binge?" How frequent should those binges be? What constitutes "repeated" attempts to lose weight? For our purposes, we developed operational criteria, which retained the requirements of the *DSM III* (Katzman & Wolchik, 1984), yet quantified them and placed them within a time frame. "Large quantities of food" was defined as a minimum of eight binges per month, and "repeated attempts to lose weight" was defined as two or more attempts in the last month. These parameters were chosen to reflect the lower end of the ranges reported in previous studies of bulimia (Mitchell et al., 1981; Pyle et al., 1981). In addition, women could not have been diagnosed as having anorexia nervosa within the last year.

We have used these criteria to define the bulimics included in our treatment studies submitted for publication. We have also included in our groups women whose frequency of binge eating was less than twice a week. However, we have called these women binge-eaters rather than bulimics and have not included their data in our research reports. They seem to have derived some benefit from the group as well.

We have had some problems, however, when we have inadvertently included anorexics in our groups. The dynamics of women with anorexic tendencies are very different from those of bulimics, and the issues of control around food can lead to acting out anorexic tendencies in a group setting and undermining treatment. We have described an example of this situation in another paper (Weiss & Katzman, 1984) in which an anorexic-like woman moved in a diametrically opposite direction from the rest of the group. In a post-group interview with her, she related her "oppositional tendencies," which were reflected in the fact that she abused food as a means of undermining authority. When we included a woman with anorexic tendencies in another group, the control issues were prominent as well, and the woman's "differentness" from the rest of the group was so apparent that it undermined group cohesiveness. However, this woman appeared to benefit from some of the other aspects of the

group. We have used parts of this program with a small number of anorexic patients in individual therapy and adapted it to their unique circumstances. In those cases, it was rather successful. It may be that certain aspects of the program can be helpful for women with other eating disorders if used individually rather than in a group setting. However, we have not seen a sufficient number of anorexic women to make any definitive statement. The program was developed specifically for bulimics and based on the research findings on the dynamics of bulimic women, which are clearly different from the dynamics of women with other eating disorders. In view of some of the difficulties we have encountered with anorexic-like women in group settings, it would be important for the therapist to screen out those women from their groups.

It may be difficult to differentiate anorexics and bulimics because of their many similarities and because many bulimics have a history of anorexia. However, there are actually many differences between the two as well. The anorexic woman is at least 25% below normal weight, whereas the bulimic woman is of normal weight. The onset for bulimia, usually in the late teens, is generally later than that for anorexia, which is in the early teens. The anorexic is also less socially and sexually experienced than the bulimic (Pyle et al., 1981). In addition, a disturbed

body image is necessary for the diagnosis of anorexia but not for bulimia, according to *DSM III* criteria.

The therapist may be able to screen out women with anorexic tendencies by having them give examples of specific foods consumed in a couple of binges. Frequently, anorexic-like women report "binges." When they are questioned about the amount of food eaten, however, it is determined that the amount does not come close to 1,200 calories. For example, one of the women we inadvertently included in our group listed "five almonds" as a binge in her binge diary. In addition, if the therapist senses much resistance from the client or feels that there may be a power struggle going on, further questioning may be needed before including her in the group.

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After ascertaining that the woman fits the operational *DSM III* criteria for bulimia, we attempt to gain a good understanding of her behavior, establish rapport, and introduce her to the group or individual program. A history of the binge-purge behavior is obtained, as well as information on the current binge eating behavior, including the antecedents and functions

of the binge. Besides the information on the symptomatic behavior, we obtain a weight history, a family weight history, and a psychiatric history. A sample brief intake form (Table 2.1), which we usually use, is provided.

After noting the history of past and current binge eating behavior, we describe the treatment to the bulimic woman. We stress several factors when describing the program to a potential member. We state that the focus of the group is on feelings rather than on eating. Although we deal with eating and nutrition in the group, our emphasis is on helping women find other coping strategies. We discuss how binge eating is frequently used as a way of coping and that in the program we will teach them other ways to deal with stress. We also mention that our program is based on the research findings that bulimic women tend to be depressed, perfectionist, have a low self-esteem, a poor body image, as well as unrealistic expectations of thinness and that each of the sessions focuses on one of these topics. We tell them that the group is a psycho-educational one, with homework assignments after each session.

It is important to provide hope in this and in other sessions by presenting bulimia as a habit that is not beyond one's control and by counteracting some of the popular press coverage that presents it as an

"epidemic" that comes upon people suddenly. We stress that the person has control and responsibility for her own treatment. This point cannot be emphasized enough, and we underscore it in our words and actions throughout the program. Bulimic women have tended to see themselves as helpless and out of control. Press reports describing them as "victims" and clinical descriptions of them as "unstable, impulsive personalities," as well as their own negative perceptions of the chronicity and intractableness of their symptoms, can lead to feelings of despair and hopelessness. The instilment of hope and the taking of responsibility in their own treatment is an essential first step toward making changes.

To convey this feeling of hope and sense of responsibility requires certain attitudinal beliefs on the part of the therapist as well. When we initially interviewed women for our program, we were overwhelmed by the "all-consuming" nature of their behavior. How were we ever going to make any inroads into a habit that appeared to pervade every aspect of their lives? The situation seemed even more overwhelming when we looked at the number of years that many of these women had engaged in this behavior and the extent of depression they felt. Most of the women we saw were clinically depressed, and two were suicidal.[1] In addition, they suffered from low self-esteem and had a poor body image. It is important

that the therapist not become discouraged and develop a pessimistic prognosis. A pessimistic attitude only confirms the woman's belief that she is beyond hope. An overly optimistic attitude on the part of the therapist is not helpful either. Such an attitude can lead to the bulimic's setting unrealistically high goals for change and becoming discouraged. We have tried to encourage bulimics to set realistic goals and not to engage in all-or-nothing thinking. We will elaborate on this approach in a later chapter.

Instilling hope for change goes hand-in-hand with stressing the person's control and responsibility in her own treatment. When the therapist places the responsibility for change in the client's hands, the bulimic begins to realize that she can take charge of her life and begins to develop a sense of her own power. Although the group program is structured and provides direction, we attempt to have the patient do at least 50% of the work in therapy.

In the initial interview, we also outline the structure and format of the program to the bulimic woman. The group is both didactic and experiential, consisting of education, readings, exercises, and discussion in an atmosphere of trust and sharing. The group consists of two co-therapists and a small number of bulimic women, usually from five to

seven. It includes seven weekly one-and-a-half-hour sessions as well as a follow-up session 10 weeks after the end of treatment. In addition, each woman has two individual sessions during the course of the group. We included two individual sessions because so much material was "packed" into each group session that we wanted to make sure we had a chance to review each woman's unique problems. These sessions are "booster" sessions to the group; they do not replace group treatment. One of the individual sessions is scheduled after the second session, and the second one is usually scheduled after the fourth or fifth session.

To encourage commitment and regular group attendance, the fee for the entire program is paid at the beginning of the group. We have found that this usually results in regular attendance. Other leaders of bulimic groups (Roy-Byrne et al., 1984) also suggest a system of monthly payments in advance to "screen out dilettantes and increase the motivation and commitment to attend for those who sign up" (p. 14). They reported a relatively high drop-out rate when payment was not required in advance. Because many of our bulimic patients are college students with limited funds, we have generally used a modest fee ($75.00) to cover the eight group and two individual sessions. For individual psychotherapy, fees are set on a sliding scale and paid after each session. Therapists will of

course set a fee in line with their own particular setting. We suggest that even under circumstances that do not require payment (e.g., some university counseling or student health centers), clients should make a monetary commitment that will be returned at the end of the program. Regular attendance and a commitment to the program are stressed at the initial interview.

SUMMARY

1. Screen for bulimia, using operational *DMS III* criteria. Binge-eaters who do not strictly fit these criteria in terms of frequency of binge eating (eight times a month) can also benefit from this program, although in our opinion should not be included in any research data about bulimics. Women with anorexic tendencies are not likely to benefit from group treatment and may undermine it.

2. Take a history of binge eating and purging and information on the current behavior. (See Table 2.1.)

3. Present the program to the client: (a) Emphasize feelings and developing coping strategies other than binge eating, (b) Instill hope and emphasize the client's responsibility for her behavior, (c) Describe the structure and format, (d) Set fees so as to encourage regular attendance and commitment to the program.

Table 2.1. Intake Form for Bulimics

1. Identifying data and referral

    Age: Marital Status: Referral Source: Occupation:

2. Current height and weight:

3. Weight history

    Duration of binge eating: History of anorexia: History of obesity:

4. Psychiatric history (including current treatment):

5. Familial weight history:

    Mother: Father: Siblings:

6. Medications:

7. Frequency and caloric intake of binge:

8. Functional analysis (antecedents, where and when, function of binge, consequences):

9. Purging

    Kind used: Duration: Frequency:

10. Motivation

11. Fee Arrangements

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