Psychotherapeutic Strategies for Bulimia Nervosa

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Psychotherapeutic strategies for bulimia nervosa have included behavioral, cognitive-behavioral, psychodynamic, and educational treatments used in individual, family, and group settings. Controlled studies have demonstrated the efficacy of behavioral and cognitive-behavioral approaches for these disorders, and extensive clinical experience suggests a role for individual psychodynamic and family approaches as well, particularly in the treatment of frequently encountered complex clinical conditions in which bulimia nervosa coexists with other mood, anxiety, personality, and interpersonal disorders. Guidelines for clinical management have emerged from both research studies and the cumulative experiences of specialists.

Biological and psychodevelopmental vulnerabilities, maladaptive learning experiences, pathological family patterns, and cultural pressures for thinness are all thought to contribute to the appearance and persistence of bulimia nervosa. Available evidence suggests that psychotherapeutic and psychosocial treatment approaches are currently important and effective intervention methods and that they are at least equivalent in efficacy to medication approaches for these disorders.

Assessment

Before determining what psychotherapeutic and psychosocial strategies to include in an overall treatment plan for the patient with bulimia nervosa, a comprehensive multidimensional assessment is essential. Such assessment requires a complete psychiatric, developmental, and psychosexual history, as well as detailed information regarding eating habits, attitudes toward food, body image disturbances, and desired weight in relation to height. In-depth behavioral descriptions, including antecedents and consequences, should be elicited regarding pathogenic thoughts, ritualistic and compulsive behaviors involving regular and binge eating, self-induced vomiting, laxative abuse, exercise,
and other symptoms of eating disorders. Family history should be elicited regarding attitudes toward eating, exercise and physical appearance, family weights, eating disorders in other family members, other psychiatric disorders, substance abuse, attitudes and behaviors toward the patient regarding eating and other spheres of life, physical and sexual abuse, the nature and extent to which both negative and positive emotions are expressed in the family, and other family interactional dynamics that may have contributed to the initial appearance of the disorder or that may influence recovery.

In conducting such an assessment, the clinician must assume a high probability of comorbid psychiatric problems, difficult early histories, and frequent family dysfunction in the lives of these patients. Some patients are seen whose bulimia nervosa appears in relatively “pure culture”—bulimics whose personalities, families, and pasts are otherwise reasonably untrammeled and who ordinarily are relatively easy to treat and who have good outcomes almost regardless of the methods of treatment used. However, more complicated cases are the rule rather than the exception at most treatment centers. In patients with bulimia nervosa, comorbid major depression or dysthymia has been reported in 70%, anxiety disorders in 43%, chemical dependency disorders in 34%, personality disorders (or at least substantial personality trait disturbances) in 62% to 75%, and sexual abuse in 34%. In addition, dysfunctional families are common, with reported prevalences of 37% for substance abuse and 32% for affective disorders in family members.

Many patients have an admixture of ill-defined clinical problems, including tension-regulating difficulties; these result in a variety of impulsive behaviors that frequently involve money and sexual behavior, self-mutilatory behaviors that do not neatly fit into current borderline personality disorder diagnostic categories, poor self-concepts, and low self-esteem.

DEVELOPING A STRATEGY AND TREATMENT PLAN

Given this high prevalence of comorbidity, it should be evident that many patients present with mixtures of very complicated and intertwined problems, often meeting criteria for three or more distinct DSM-III-R disorders. In these instances the clinician is faced with having to attempt to unravel and understand the interrelationships of the various problems—to separate figure from ground, causes from effects, historically primary problems from subsequently appearing phenomena (perhaps initially epiphenomena) that may have achieved autonomous psychological structure. Even when a carefully developed case formulation teases apart the various psychopathological components and manages to place the onset of events in proper historical perspective—say a preexisting personality disorder that preceded the onset of a major depressive episode, which in turn preceded the appearance of bulimia nervosa, which in turn preceded the onset of a substance abuse disorder—this dissection by itself offers no a priori rationale for a treatment strategy. One cannot assume, for example, that treatment of any one of the earlier onset conditions is either necessary or sufficient for the resolution of a later onset condition. But clearly the entire psychopathological picture is relevant when psychotherapeutic and other psychosocial strategies are being planned.

Further, psychotherapeutic and other psychosocial treatments for bulimia nervosa must be considered within the context of a comprehensive overall treatment plan that includes medical management, psychiatric medications if indicated, and the appropriate use of dietary and rehabilitative services. Studies of the help-seeking patterns of patients with bulimia nervosa reveal that these patients often enter several different kinds of treatment programs, often concurrently.

In contrast to the purely psychoanalytically oriented long-term treatment programs
of previous decades, where the treatment expectation was "talk first, stop symptoms later," most authorities now agree that behavioral and medical control of symptoms such as binge eating and purging, and weight restoration if the patient is severely underweight, should be a central goal for early treatment. For example, in patients with concurrent major depression, anxiety disorders, or family histories of major depression, the prescription of antidepressant medications should be considered from the very beginning of treatment in addition to psychotherapy and other interventions. Symptom control alone may improve several of the core physiological and psychological features of bulimia nervosa, including electrolyte and endocrine abnormalities, obsessional thinking, and mood and personality trait disturbances.

The specific, individualized type of treatment program to be designed must take into account the details and degree of initial symptomatology. For example, in the United States today few scrupulous eating disorders experts would require patients with "uncomplicated" normal-weight bulimia nervosa to be treated initially in a hospital setting. Hospitalization is ordinarily limited to patients who have failed repeatedly in good efforts at outpatient treatment or who experience concurrent major depression with suicidality, serious medical problems, unyielding substance abuse problems, or some other complications or comorbid conditions that, in conjunction with the bulimic symptoms, demand inpatient treatment. Consequently, in evaluating available treatment studies one must carefully consider the populations being described. Normal-weight bulimic college students who are fully functional and who come for treatment at a student health service can be expected to differ considerably from chronic patients who, after many failed treatment attempts and with deteriorating social functioning, find themselves on a psychiatric inpatient service. The latter are under most conditions a more chronic and impaired group with a poorer prognosis.

**Empirical Studies of Psychotherapy for Bulimia Nervosa**

Several excellent recent reviews are available. Psychosocial treatments for bulimia nervosa have included individually based and group-based cognitive-behavioral, behavioral, psychodynamic, educational, and family interventions. None has been shown to be clearly superior to all the rest for all patients, and many psychotherapeutic strategies appear to complement one another in contemporary treatment. The behavioral and cognitive-behavior therapies, however, have been subjected to better-designed and better-evaluated studies than the other modes of treatment, so greater confidence can be placed in the documented efficacy of these approaches.

**Early Programs**

Since Fairburn's initial report of good results for bulimia nervosa using a cognitive-behavioral approach, several additional studies have used this therapeutic model. However, although over the years many of Fairburn's patients have had concurrent personality disorders and major depression, some other research studies have tended to exclude patients with serious suicidality, personality disturbances, or substance abuse, and the majority do not specify the extent to which such comorbid problems have been present. Therefore, these methods cannot be said to have been systematically tested on such complex populations; in fact, clinical experience and some research findings suggest that results using cognitive-behavioral programs with more complicated patients, those with more comorbidity and/or dysphoria, for example, are often less favorable. This approach does generally work nicely, however, with the majority of bulimia nervosa patients.

Fairburn's original therapy program warrants detailed description, since it has served
Bulimia nervosa

as the basis of a large number of subsequent individual and group programs and studies. The program consisted of three stages, each consisting of eight individual therapy visits scheduled twice weekly. The first eight visits were designed to provide patients with control over their eating by prescribing set meal patterns and by introducing behavioral techniques such as self-monitoring and stimulus-control measures intended to help them avoid the stress-inducing, tempting, or habit-laden situations that usually precipitate eating binges. Patients kept detailed diaries, noting all their eating and their eating-related behaviors and feelings, and they were educated about weight regulation, dieting, and the adverse effects of bulimia. The purpose of the prescribed eating program is to reduce patients' experiences of hunger and thereby reduce the cravings that frequently trigger binge eating. (Because patients with bulimia nervosa frequently restrict their diets severely when they aren't binge eating, they often get very hungry, and the hunger in turn frequently triggers eating binges.)

During the second stage, therapy sessions focused on cognitive restructuring—identifying and attempting to modify the persistent maladaptive and irrational self-statements that maintain and reinforce bulimic patterns—and on alternative methods of problem solving. The third stage of the therapy concentrated on maintaining symptomatic gains through careful monitoring, on preventing relapses by preparing and "immunizing" patients prior to their inevitable encounters with stressful situations that were likely to trigger old bulimic patterns, and on minimizing backsliding if occasional binge eating and purging recurred, as is often the case.

In another early, influential paper, Lacey reported a study in which patients were treated for 10 weeks in a program that combined individual and group therapy, using cognitive-behavioral, behavioral, and psychodynamic approaches. Treated patients improved much more than waiting-list controls; indeed, after treatment 80% of his patients reported no further binge eating or vomiting, and the other 20% were much improved as well. Lacey's program was initially used with a population of relatively uncomplicated bulimia nervosa patients, and the program is likely to be much less effective as a total treatment for more difficult patients.

Group Therapy Programs

Several published group psychotherapy studies for bulimia have all shown that treatment is superior to no treatment. In conducting such groups, most clinicians advocate and use an eclectic combination of cognitive-behavior, psychoeducation, psychodynamically informed exploratory and supportive elements in their group methods. Commonly used techniques in groups include providing education in the psychology and biology of eating disorders and nutrition, the keeping of detailed food and behavior diaries, individual explicit weekly goal setting, cognitive restructuring, discussing relationships, role playing, group feedback, advice and counseling, support, relaxation training, assertiveness training, and various other behavioral techniques. Most workers agree that both leaders and members should be active and that the group should focus on affect-laden current issues.

Groups are usually scheduled for about an hour and a half each week and run from 3 months to a year; some run indefinitely, with patients entering and leaving at different times. Because most relapse occurs within 6 months following the initial cessation of eating binges and purging episodes, follow-up for a year is generally recommended in both group and individual treatment to help prevent or minimize the extent of relapse.

The success of these group programs varies considerably, with 50% to 90% reported reductions in bingeing and purging rates, averaging about 70% for those who completed treatment. However, the dropout problem was considerable in many groups. The
few available long-term follow-up reports of these studies, generally conducted less than 3 years after treatment, indicate that although some relapse is seen, many patients retain their gains. In a report that described the treatment of 14 patients in psychodynamically oriented group psychotherapy (treated also with antidepressants and individual psychotherapy "as needed"), the 12 patients who achieved remission required an average of 21 months of treatment.

Although much more research is needed to better characterize those bulimia nervosa patients who will do best in group therapy programs, favorable prognostic features are currently presumed to include younger age, less chronic symptoms, high motivation for treatment, interest and capacity to work in a group, and absence of severe concurrent disruptive psychopathology (e.g., severe borderline, histrionic, or narcissistic features). Although a prior history of anorexia nervosa does not rule out effective use of group treatment, severe concurrent anorexia nervosa with malnutrition and obsessional self-absorption is often problematic.

Comparisons of Psychotherapeutic Techniques

In a later study of bulimic patients free from serious concurrent psychopathology who were randomly assigned to 18 weeks of individual cognitive-behavior therapy or to a form of short-term focal psychodynamic psychotherapy, Fairburn et al. found that patients in both groups improved impressively and maintained their gains at a 1-year follow-up. The "psychodynamic" therapy was actually akin to interpersonal psychotherapy, not to more traditional exploratory intensive psychodynamic psychotherapies.) Those treated with the cognitive-behavioral approach showed greater improvement on several measures of overall outcome and adjustment. The only pre-treatment patient characteristic to predict poorer outcome with cognitive-behavior therapy was low self-esteem. Other studies have also shown the superiority of cognitive-behavior therapy over "nonspecific" psychotherapy.

Further research has attempted to delineate more precisely the specific effective components of behavioral, cognitive-behavioral, and psychodynamic techniques for these patients. Preliminary studies that compared "directed" (i.e., including specific behavioral suggestions) and "non-directed" cognitive-behavioral approaches for bulimia nervosa found that neither approach seemed markedly superior to the other, particularly a few months after the termination of treatment. However, several recent studies that have attempted to tease apart specific behavioral therapy from cognitive therapy components have generally found the behavioral treatments to be superior. Combined behavioral and verbally mediated cognitive restructuring therapy has been shown by Wilson et al. to be more effective than verbal therapy alone. Their study used exposure with response prevention as the behavioral procedure; patients were encouraged to eat "forbidden" foods (but not in overwhelming quantities) and then to delay or refrain from purging. This technique had been previously shown to be effective in small case series. Others have successfully used exposure with response prevention behavioral techniques in group settings, and some have focused specifically on preventing binge eating as opposed to preventing purging.

In a recent study, Freeman et al. randomly assigned 112 women to one of four treatments: individually administered behavior therapy or cognitive-behavior therapy, group therapy, or a control waiting list. Each therapy was administered for 15 weeks. All three treatments were superior to control. Behavior and cognitive-behavior therapy were superior to group on most dimensions assessed, but behavior therapy showed several specific advantages: those treated with behavior therapy had the fewest dropouts and tended to have the most rapid modification of symptoms. These authors concluded that
adding cognitive elements did not produce either greater or more sustained behavioral change. Even though several advantages for cognitive therapy were noted on a number of the psychological scale scores, these authors were left with the distinct impression that tackling directly the presenting behaviors of binge eating, self-induced vomiting, and laxative abuse was the most common and important element, and that attitude change followed behavioral change rather than vice versa.27

Their observations are consistent with those of Cooper et al.,50 who treated eight patients with behavior therapy alone in a program from which cognitive components were specifically excluded. In this report the improvements immediately following treatment and at a 1-year follow-up were comparable to those reported in Fairburn’s early series. Improvement occurred not only in eating behaviors but also in eating attitudes and general psychiatric disturbance.

It must be pointed out that although the behavior therapy techniques of exposure plus response prevention have shown promise in some controlled studies, in other studies these behavioral techniques have not shown any great advantage over cognitive-behavioral therapies alone.51 At this point, additional research is necessary to resolve the controversy and to better delineate the types of patients most likely to benefit from each approach.

Specific therapeutic strategies ordinarily included in behavioral and cognitive-behavioral aspects of treatment are listed in Table 1.

**Comparisons of Psychotherapy and Medication**

Taken as a whole, the improvement rates for bulimia nervosa treated by psychotherapeutic and psychosocial interventions are quite comparable to those reported in medication studies. One review of 32 individual and group therapy studies found that 38% of the patients in group therapy and 42% of those in individual psychotherapy were totally abstinent from binge eating and purging at follow-up.19 But once again, the extent to which the patient samples in the various psychotherapy and medication studies are comparable is not at all clear. Although one often gets the impression that patients treated in the medication studies tend to have more psychopathology than those taken into the psychotherapy studies, and that those taken into the medication studies have failed previous attempts at psychotherapeutic treatment more often than the reverse is true, such statements cannot be made conclusively. In any event, a large number of double-blind

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<th>TABLE 1. Treatment components in behavioral and cognitive-behavioral approaches to bulimia nervosa</th>
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<tr>
<td><strong>Behavioral</strong></td>
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<tr>
<td>• Self-monitoring diaries of regular eating, binges,</td>
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<td>and purges, including behavioral, cognitive, emotional,</td>
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<td>and physiological antecedents, concomitants, and</td>
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<td>consequences of each behavior.</td>
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<tr>
<td>• Planning and eating regularly scheduled, nutritionally</td>
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<td>balanced meals.</td>
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<td>• Stimulus-control measures such as avoiding binge-</td>
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<td>inducing settings and situations and controlling</td>
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<td>hunger.</td>
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<td>• Systematic modification of eating habits, using</td>
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<td>graded tasks.</td>
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<td>• Exposure with response prevention: the patient eats an</td>
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<td>amount of food approaching the amount usually likely to</td>
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<td>provoke purging but is then prevented from purging for</td>
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<td>several hours, to assure absorption of most nutrients.</td>
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<tr>
<td>• Relaxation training.</td>
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<td>• Assertiveness training.</td>
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<td><strong>Cognitive-Behavioral</strong></td>
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<tr>
<td>• Educating patient about the disorder.</td>
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<td>• Providing informational feedback regarding weight,</td>
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<tr>
<td>caloric intake, changing health status.</td>
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<tr>
<td>• Focusing on patient’s distorted beliefs and preoccupations</td>
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<tr>
<td>regarding weight, body shape, nutrition, exercise.</td>
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<tr>
<td>• Teaching patient to identify and focus on negative</td>
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<tr>
<td>thoughts and related emotions associated with mal-</td>
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<tr>
<td>adaptive beliefs.</td>
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<tr>
<td>• Teaching patient to substitute more functional and</td>
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<tr>
<td>adaptive positive thoughts for the negative ones.</td>
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<tr>
<td>• Conducting problem-solving discussions.</td>
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<td>• Teaching alternative coping strategies.</td>
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placebo-controlled studies using a variety of antidepressants, including tricyclics, mono-
amine oxidase inhibitors, trazodone, and fluoxetine (C. P. Freeman, J. E. Morris, K. E.
Cheshire, et al., unpublished data) have now shown medication treatment without concur-
rent psychotherapy to be more effective than placebo in ameliorating and sometimes elim-
inating the binge eating and purging symp-
toms, both in patients with concurrent depression and in patients in whom concurrent depression has been explicitly ruled out. Many psychiatrists have found these medications to be useful in the treatment of bulimia nervosa patients in clinical practice, although sometimes several medication trials are required.

To date, only one controlled treatment study has compared medication with any kind of psychotherapy. Mitchell et al. randomly assigned 174 patients to four treatment groups for 12-week interventions: imipra-
mine, placebo, imipramine plus intensive outpatient group treatment, or placebo plus intensive outpatient group treatment. The intensive group treatment program consisted of a manual-based treatment that began with a 4-week phase scheduled as two 2-hour group sessions per week. The initial sessions dealt with meal planning and an introduction to cognitive-behavior therapy techniques, followed by an interruption phase that started with a week in which the patients met from 5:00 p.m. to 8:00 p.m. each night for 5 nights in a row for a lecture, group dinner, and group psychotherapy. The results suggested that all three treatment programs were superior to placebo, but they also suggested that this form of intensive group treatment was superior to imipramine alone. Adding imipra-
mine to the group treatment program did not improve outcome with respect to eating behaviors per se, but it did result in more improvement in symptoms of depression and anxiety.

Consistent with these findings regarding the primary importance of the psychosocial interventions for bulimia nervosa, a 3-year follow-up study of over 300 bulimic patients conducted in Germany showed that fluoxetine did not add any value to an inpatient behavior therapy program. In contempo-
rary practice, however, many psychiatrists—perhaps the majority—currently combine medication and psychotherapeutic interventions in the treatment of patients with bulimia nervosa.


Psychodynamically oriented psychotherapies for bulimia nervosa have been based on pathogenic models that view this disorder as in part representing developmental strug-
gles for autonomy, competence, self-esteem, and self-control. These themes provide the focus of discussion during therapy sessions. The symptoms are seen both as expressions of attempts to control and regulate anxiety and other tension states, and as failing defenses. The specific defensive constellations seen in bulimia nervosa are attributed to both constitutional and developmental processes. Although in initial stages of treatment buli-
mia symptoms often cannot be controlled through psychodynamic psychotherapy alone—such control requiring added educa-
tional and behavioral components—many experienced clinicians consider psychody-
namically informed psychotherapies to be very beneficial in helping patients maintain symptom control and develop the psychological maturation and coping skills necessary to prevent relapse. However, although a growing and rich clinical descriptive and theoretical literature exists in this area, there have been no systematic studies, so empirical evidence to support these assumptions is lack-
ing.

Most psychodynamically oriented clini-
cians have found the empathic stance cur-
rently espoused by self psychologists to be more useful and effective with these patients than the more neutral and distancing stances
of classic psychoanalysis. Specific techniques depend on the personality and cognitive style of the patient and on the details of her history. Some evidence suggests that the role of the parents, especially the father, may be particularly important in the development of the patient’s body image, sense of adequacy and self-esteem, life goals, and feminine identification. The patient’s perception of the family atmosphere has some prognostic importance. In a study of individual psychodynamically oriented psychotherapy with 25 bulimic women, of 18 pre-treatment family factors assessed, those factors associated with maternal warmth explained an appreciable proportion of the variance in outcome. The authors attributed this finding to the greater ease with which those patients with good maternal images could establish positive transferences and better working alliances with their therapists.

As in other psychodynamic psychotherapies, key activities include uncovering of and abreaction to traumatic events; emotional responses to real, imagined, and anticipated losses; realizations regarding the existence of conflictual attitudes and self-deceptions; analysis of typical maladaptive emotional reactions and defensive styles; examination of negative transference reactions when they present clear resistances to therapeutic advances; and the development of new perspectives in relation to these discoveries. With patients whose personalities tend to be chaotic—falling within cluster B on Axis II of DSM-III-R—the clinician may need to provide structure and concrete limits to help them cope with hyperemotional and impulsive storms. With patients who are persistently pessimistic and empty, the clinician may need, in addition to serving other functions, to provide advice and support. With patients who are constricted and rigid, the clinician may need to adopt a variety of expressive and emotion-enhancing techniques.

We can look forward in the future to treatment studies for bulimia nervosa that employ better-defined variations of psycho-dynamically informed psychotherapies, such as interpersonal psychotherapy, recently proven to be useful in the treatment of non-psychotic unipolar depressions. Family assessment and often family therapy should be used in cases where the patient is still living in the parental home, since eating disorders often generate distress that reverberates among all family members and since they often signal more widespread family dysfunction. Highly critical and blaming families adversely influence prognosis for anorexia nervosa, depression, and other major psychiatric disorders. Families experiencing high levels of distress and burden may benefit from behavioral family therapy techniques in which the patient and relatives learn structured communication and problem-solving skills. In cases where the interactions of patients and their families are unrelentingly conflictual, separation of patients from their parents and siblings for varying lengths of time may be helpful. Family support groups and multiple-family therapy groups may help families achieve more realistic perspectives regarding the problems they face and ways of contending with them. Family members may also gain additional insights into their own contributions to sustaining or ameliorating the patient’s plight. Successful family therapy approaches for bulimia nervosa have been described for large series of cases.

In this regard, in one of the most carefully designed psychotherapy treatment studies for eating disorders yet reported, Russell and his colleagues randomly assigned patients about to be discharged from the hospital, 23 with bulimia nervosa and 57 with anorexia nervosa, either to carefully conducted and supervised family therapy or individual therapy. Disappointingly, at 1-year follow-up few patients with bulimia nervosa or anorexia nervosa had a good outcome. Patients with bulimia nervosa had similar results with both therapies. (Those patients whose anorexia nervosa began at or before age 18 and whose duration of illness was less than 3
years clearly improved more with family therapy than with individual psychotherapy. Furthermore, older anorexia nervosa patients tended to improve more with individual psychotherapy than family therapy.) Unfortunately, this study did not examine the effectiveness of concurrent individual and family psychotherapy, a combination commonly used in practice.

For married patients with bulimia nervosa, assessment of the marriage and conjoint therapy with the spouse may be very important. Since available evidence suggests that the psychotherapeutic treatment of unipolar depression in married women can be considerably enhanced by marital therapy, and that marital therapy may sometimes be even more helpful than individual psychotherapy, this approach is frequently useful for bulimia nervosa, where comorbid depression is so prevalent.

Although some clinicians are wary about using family therapy for some patients with bulimia nervosa who are in the process of emancipating from their families of origin, I am unaware of any systematic demonstration that family interventions, carefully planned and effected, have ever been harmful—especially when combined with concurrent individual therapy for the patient. Further research is necessary to demonstrate the relative efficacy of these approaches when they are combined versus when each is administered singly.

In addition to these approaches, an exceptionally wide variety of other experiential

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<th>TABLE 2. Suggested strategies in the psychotherapeutic treatment of bulimia nervosa</th>
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<tr>
<td>1. Comprehensive assessment should take into account physical status, eating disorder history and phenomenology, associated psychiatric disturbances, substance use patterns, developmental history, family history, and a family interview.</td>
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<td>2. Calendars can increase the accuracy of patients’ self-reports by helping them recall specific behaviors such as symptom-free days or multiple-episode days.</td>
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<tr>
<td>3. Inpatient treatment is rarely required for patients with bulimia nervosa. Indications for hospitalization include concurrent severe medical problems, laxative abuse, psychiatric disturbances such as suicidality, or other severe symptoms that have not responded to adequate attempts at outpatient care.</td>
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<td>4. Concurrent substance abuse disorders should be attended to first, since successful treatment for bulimia nervosa is unlikely in the presence of an active substance abuse disorder.</td>
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<td>5. Individual and/or group psychotherapies that combine behavioral, cognitive-behavioral, educational, psychodynamic, and interpersonal methods may be successful modes of treatment for patients who are not abusing laxatives, alcohol, or drugs; who are not suicidal, antisocial, or overly chaotic; and who can cooperatively complete self-monitoring forms. Interrupting the binge-purge behaviors should have first priority; for this initial control of symptoms, behavioral learning principles appear to be most critical. Such approaches should be successful within 2 to 4 months of treatment for the majority of patients and often produce accompanying changes in self-esteem and mood.</td>
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<td>6. Concurrent work with a registered dietitian for purposes of meal planning may be helpful.</td>
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<td>7. Therapy for recovering patients should continue for approximately a year to help prevent relapse. Psychodynamic approaches are most useful during this period. Therapeutic work focuses on common themes of development, identity formation, family dysfunction, coping styles, and problem solving.</td>
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<td>8. Family psychotherapy is indicated for virtually all younger patients and should be conducted to reduce hostile blaming and to improve direct communications regarding major family conflicts. Family therapy should not be used in cases where one or more family members are rigidly destructive.</td>
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<td>9. Individual and family psychotherapies should be tailored to the cognitive and defensive styles, psychological-mindedness, and belief systems of the participants.</td>
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<td>10. Antidepressant medications should be considered and in some instances initiated along with psychotherapy in patients who 1) have concurrent heavily symptomatic major depressive and/or anxiety disorders, 2) have strong family histories of affective disorders, or 3) have failed previous attempts with psychological therapies. For patients who have actively participated in but who have failed to respond to 2 months of comprehensive outpatient educational, dietary, and cognitive-behavioral therapy, a medication trial is warranted.</td>
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therapies have been described for these patients, ranging from hypnosis and imagery through psychodrama, art therapy, dance-movement therapy, and music therapy, but these therapies have not been systematically evaluated.

Table 2 summarizes recommendations for psychotherapeutic strategies to be used in treating bulimia nervosa and includes an integration of these approaches with pharmacotherapy based on current research and experience.

**Problems of Comorbidity**

As mentioned above, the presence of concurrent mood, anxiety, personality, and substance abuse disorders is quite common, so much so that "pure culture" bulimia nervosa may be more the exception than the rule. Many studies, particularly medication studies, have commented on either the effect of comorbid depressive symptoms on the efficacy of treatment or the effect of treatment in reducing non-eating disorder symptomatology. Generally speaking, the effective treatment of bulimia nervosa tends to ameliorate depressive mood symptoms concurrently, but the chicken-egg controversy remains unresolved. Virtually no studies have systematically examined the interactions of comorbid diagnoses, particularly regarding anxiety, personality, or substance abuse disorders. Yet these problems engage clinicians most of the time.

Clinical approaches to the treatment of bulimic patients with chemical dependency problems have recently been suggested by several authors. These authors stress the need for treatment planning that attends to elements of both problems; for example, 12-step approaches for the chemical dependency and nutritional rehabilitation for the eating disorders. Many semantic and, in the absence of good data, conceptual and philosophical controversies exist in the eating disorders field regarding the propriety of using addiction models, especially 12-step programs, for eating disorders (e.g., "Vomiting Anonymous" programs organized by Overeaters Anonymous groups, or 12-step counseling methods in organized eating disorders treatment settings). Partly as a result of these controversies, staffs that are comfortable in dealing with both problems concurrently are few and far between.

With regard to concurrent personality disorders, many clinical impressions and a smattering of research data point to the additional treatment burden and the more difficult course of patients who struggle with both bulimia nervosa and these disorders. Treatment approaches used with the DSM-III-R cluster B, the dramatic-erratic cluster (the histrionic-narcissistic-antisocial), and with cluster C (the dependent-avoidant group) seem most relevant to patients with bulimia nervosa. The specific treatment implications of the individual personality disorder types coexisting with bulimia nervosa must await further research.

**Conclusions**

Many aspects of the etiology and pathogenesis of bulimia nervosa remain unclear. All levels of biopsychosocial organization appear to be involved in the appearance of these disorders. Nevertheless, at present the major therapeutic approaches are psychotherapeutic and psychosocial treatment methods, and for the relatively uncomplicated case they are at least as effective as psychopharmacological approaches. Effective psychotherapy programs utilize techniques derived from several different traditions, including cognitive-behavioral, behavioral, educational, psychodynamic, and family systems approaches. Current evidence suggests that behavioral principles are vital for initial symptom control for patients with bulimia nervosa, but that "complete psychotherapists" are obliged to be familiar with several approaches if they are to provide patients with effective and satisfying therapy programs.
REFERENCES