

Bulimia Nervosa : A Case Study in Cognitive Psychotherapy

Josephine Kanfer

Rhodes University  
Grahamstown

1989

Submitted in partial fulfilment of the requirements  
for the degree of Master of Arts in Clinical Psychology

"Knowledge is not enough: we must apply.  
Willing is not enough: we must do".

Goethe

## Index

Acknowledgements	(1)
Abstract	(11)
Introduction	1
The Case Study Method - it's appropriateness and validity	3
Bulimia Nervosa - symptomology, theoretical understandings and intervention guidelines	7
The case study:	26
Identifying data and highlights of history	27
Diagnosis, case conceptualization and therapeutic strategies	34
Results and Discussion	36
Conclusion	60
Appendix :	
1. Illustration of behavioural change and Beck Depression Inventory indicators	63
2. Beck Depression Inventory and Beck Anxiety Inventory	64
3. Self-monitoring sheet sample	66
4. Young's Questionnaire for Early Maladaptive Schema Identification	67
References	74

Acknowledgements

I wish to thank Professor David Edwards for his invaluable supervision of the therapy in the case presented. I also wish to express my gratitude to him for his patience, guidance and encouragement in the writing up of this presentation.

I wish to acknowledge the Human Sciences Research Council for their financial assistance.

Abstract

This project uses the case-study method to illustrate the application of integrating varied accepted modes of psychotherapeutic interventions. It concentrates on the first 22 out-patient sessions of therapy with a diagnosed bulimic, spanning a 6 month period. A brief summary of the subsequent 10 follow-up sessions is also given.

The case presented is of a 22 year old female student diagnosed as bulimic (of 7 year duration), dysthymic and with a dependent personality disorder. She has symptoms of anxiety. She has a history of anorexia nervosa.

Fairburn's (1985) cognitive-behavioural programme for bulimia was used initially. Its structured framework with the emphasis on the eating behaviour was an essential aspect in contributing to the success of the initial phase of the therapy. This patient had had previously experienced 8 sessions of non-directive depth psychotherapy which had confused and compounded her problems. The structure had provided her with a sense of control.

In implementing the second stage of Fairburn's programme, where the focus is cognitive, the patient could not longer work in this structured manner. The attempts to implement the standard cognitive techniques provided the catalyst for activating deeper underlying emotions and cognitions. Furthermore, this gave impetus to

work actively with the interpersonal aspect of the therapeutic relationship. Young's (1989) model for identifying Early Maladaptive Schemas could be applied. The focus then moved from the behaviours and dealt with these schemas as activated in the therapeutic relationship. The patient was able to make links to her family and her past.

The therapy proved successful, as not only were the behavioural symptoms alleviated, but also the patient's interpersonal problems which underlay her personality disorder were accessed. The patient had become more self-assertive, her mood had improved considerably, she was less concerned with body image and more accepting of herself. She had become more reality based and her interpersonal relational ability had improved.

This research project describes and analyses, the experience of a person, diagnosed as having "Bulimia Nervosa" (D.S.M. III-R) who voluntarily accepted the challenge of attempting to ameliorate her condition through the medium of psychotherapy on an out-patient basis, essentially based on a cognitive-behavioural framework. It illustrates the need for flexibility in the technical application of therapeutic theory in working with such conditions, by utilizing varied modes of therapeutic access. As psychotherapy is a co-constituted enterprise, this study likewise attempts to elucidate the experience of the therapist in facilitating the therapeutic process. The significance of the interpersonal aspect of the therapeutic relationship is shown. It is for these reasons, that the case-study method as a research tool was chosen as it is the only valid means of presenting such individualized data, as well as an appropriate forum for presenting the praxis of the integration of varied modes of therapy. Furthermore, this method, places the therapist into the privileged position of being a "participant observer" in the research endeavour.

The leitmotif of this presentation can be defined as an attempt to heal rifts, i.e. between scientist and practitioner through the case-study method, and, between psyche and soma in the praxis of the psychotherapy, in

dealing with the bulimia by gaining a deep understanding of the underlying psychological foundations of the symptomology. The symptomology of bulimia nervosa presents a psyche-soma split, and the psychic life has become literalized in the conflict accorded to food (bingeing and vomiting) and money (recklessly squandering it on the habit). In taking the behaviour seriously and attempting to change it through standard behavioural interventions, access to cognitions surrounding the behaviour is gained, leading onto a greater understanding of the emotions underlying her behaviours and identifying the personality profile. This allows the patient to gain an understanding of the function of the bulimic ritual in her life. Hence the aim is to conceptualize for the client her 'way-of-Being-in-the-world' and to work towards a greater 'openness-to-the-world' leading to a more integrated existence.

Case study method - its appropriateness and validity

The prominent personality theorist, Gordon Allport (cited in Sundberg, 1977, p. 7) claimed that "Psychology is truly itself only when it can deal with individuality." He made the distinction between "idiographic" and "nomothetic" disciplines in the study of human knowledge, where the former seeks the principle of individuality and the latter seeks universal laws. He does not discredit nomothetic research but reminds us that as its major thrust is towards generalities, individuality is treated as a "chance variation". The importance of individuality in psychological research is highlighted by Colliazi (1978, p.57), who claims that "idiographic research provides rich textural descriptions, which are lost in the generalizations of nomothetic research" and that "human experience is an essential and indispensable constituent of human psychological phenomena". Valle and King (1978) describe this approach as exemplifying the principles of existential phenomenology, which replaces cause and effect and focusses on the phenomena "in their perceived immediacy" relating to the structure or relationships of the particular "way-of-Being" that is attempting to be illustrated and hence understood. The design of the case study method, as a single case research methodology provides space for such descriptive data, which by its very

is idiographic.

Edwards (1989 1) states that the aims of the case study researcher are

to develop a conceptualization to open up the essential qualities of the case being investigated, which includes a number of assumptions about the categories or constructs used to frame it, and the relationship between them.

Bromley (1986) concurs with this view by stating that the case study can make a sound contribution to the understanding of an area of inquiry, through description and analysis of the data of a singular case or incident.

Kratochwill (cited in Bellak and Hersen, 1984) claimed that single case methodology is uniquely suited to evaluation of treatments involving a single client - a primary aim in clinical psychology.

The single case study method can provide an expose of therapy cases and hence a forum for clinical psychologists to share their experiences in dealing with specific symptomology as well as varied personalities. Bromley (1986) envisages the establishment of a documented systematized "case-law" of applied psychology as in jurisprudence, whereby clinical practice could benefit from individual clinical research cases. As Edwards (1989 1) has pointed out, the the case study method is not to be assumed

to be a typical representation of a particular method but rather that certain essential elements will be elucidated which could then contribute towards the conceptualization of other cases. As the validity of this type of research thus does not rest on statistical inference, its validity is in fact based on the analysis of the event, i.e. on "analytical inference" (Mitchell cited in Edwards, 1989 1).

All case studies are descriptive. However, as Mitchell (cited in Edwards, 1989 2) argues the case study method can go further than this by stating that

a case study is essentially heuristic, as it reflects in the events portrayed features which may be construed as a manifestation of some general abstract theoretical principle,

thus contributing to the development of new theoretical principles. The case study method can further elucidate or test existing theories in practical terms.

The very nature of the therapeutic encounter, pleads for the case study method as the most suitable methodology for presentation of the praxis of clinical psychology as a research methodology. The experience of psychotherapy viz. the building up of an alliance, the commitment to the task at hand, the exploring and basic verbal listening skills, the interpersonal co-constitution of the therapy between therapist and client, as well as the underlying

theoretical orientation of the therapist, can thus be described within the case study framework.

The type of case study that will be utilized in this project can be termed a "working case study" (Edwards, 1989 2, p.17) where a particular clinical programme based on a previously developed theory is applied to a new case. viz. a cognitive-behavioural programme for bulimia. This type of case study provides fresh insight and novel ways of overcoming any obstacles in the implementation of the programme. This method thus contextualizes an individual in therapy revealing idiosyncratic phenomena which can thus test the internal validity of the theory and therapy being offered.

Bulimia Nervosa - theoretical understandings and  
intervention guidelines

Symptomology:

In 1980, the Diagnostic and Statistical Manual of Mental Disorders, categorised Bulimia Nervosa as an "Eating Disorder" within the major category of "Disorders Usually First Evident in Infancy, Childhood and Adolescence". This order first typically begins in adolescence or early early adult life.

The bulimic typically indulges in cycles of binge eating followed by self-induced vomiting, laxative or diuretic abuse, vigorous exercise or strict dieting or fasting. The binge eating is characterized by the rapid consumption of a large amount of food within a short period of time. Eating binges may be planned, but they are made as inconspicuous as possible or done secretly. The food consumed usually has a high caloric content and a texture that facilitates rapid eating. The food is gobbled down with little chewing. Although the eating binges may be pleasurable, disparaging self-criticism and a depressed mood often follow. The bulimic experiences a lack of control during the binge. The binge is terminated by abdominal discomfort, sleep or social interruption. Self-induced vomiting decreases the abdominal distention. In some cases, the vomiting itself may be desired, so that the

bulimic will binge in order to vomit, or will vomit after eating only a small amount of food.

The bulimic is persistently overconcerned with body shape and weight, although, most bulimics are within the normal weight range. Often these people feel that their life is dominated by conflicts about eating.

Physiological complications, like dental erosions, electrolyte imbalance, dehydration, cardiac arrhythmias can occur. Sudden death, has been reported and this places the bulimic at a severe risk (DSM III-R, 1987, p.67).

#### Treatment interventions and understandings of Bulimia

A cognitive-behavioural conceptualization and treatment for bulimia:

Fairburn (1985) has developed an outpatient, short term (5 month) treatment programme for Bulimia based on a cognitive-behavioural approach. The rationale underlying this approach stresses that the bulimic holds intense and prominent dysfunctional beliefs and values as regards her shape and weight. Fairburn (1985) provides examples: "a morbid fear of fatness", a "pursuit of thinness" and "a weight phobia". He argues that these beliefs and values are of primary importance in the maintenance of the condition of bulimia. He claims that the extreme dieting, vomiting, the preoccupation with food and eating, and the sensitivity

to body shape and weight, can be all be understood in cognitive terms. This cognitive-behavioural treatment programme for bulimia has been designed to produce change in these beliefs and values. Fairburn (1985) has used his programme on 50 patients. He confirms that the majority of patients do indeed benefit from this treatment, showing marked changes in their eating habits, accompanied by a decrease in levels of anxiety and depression, and a lessening in the intensity of their dysfunctional thoughts concerning body shape and weight. He cites three contraindications to such treatment viz. the risk of suicide, the patient's physical health requires inpatient care and the patient's desire to change is questionable. The programme is semi-structured, problem oriented. It is primarily concerned with the patient's present and future rather than their past. The responsibility for change resides in the patient, thus requiring the patient to be active. The therapist provides information, advice, support and encouragement.

Although the treatment procedure is clearly prescribed, Fairburn (1985), emphasises that in clinical practice it should be adapted to suit the individual's needs. Three stages in the treatment are distinguished, each designed to deal with a relatively specific area of difficulty. Stage one emphasises a behavioural focus, while stage two is

cognitively oriented, and stage three focusses on the maintenance of change.

Fairburn (1985) emphasizes the fact that many of the behavioural tasks could prove difficult and run counter to the patients basic beliefs and values. He thus stresses the need for the establishment of an effective collaborative working relationship between therapist and patient based on mutual trust and respect.

Stage 1 lasts 4 weeks and appointments are twice a week. The aims are:

1. To establish a sound therapeutic relationship. Fairburn emphasises the need for the therapist to be caring but also to be firm and authoritative, particularly when discussing homework assignments.
2. To disrupt the habitual binge eating and self-induced vomiting, through the use of daily self-monitoring sheets (see Appendix 3). The purpose of this is to provide an overall picture for the patient of her eating habits. Every treatment session includes a review of these sheets. Each sheet is to be discussed in length, with the patient guiding the therapist through the day's events. The therapist should anticipate the patient's reluctance to monitor as patients are often embarrassed by their own eating patterns. The therapist must stress that this

recording is an essential intervention in the first stage in beginning to confront the eating problem. The patient should also be taught to make a realistic appraisal of her day to day progress on these sheets. She should be able to commend herself when things have gone well and learn to analyze and learn from her apparent failures. The therapist should counter any tendency for the patient to think in diurnal units as then the patient regards a failure in a particular day as a time to abandon any further effort for that day. The patient should be encouraged to think in hourly units.

3. To introduce a pattern of regular eating. The patient should be asked to restrict her eating to three or four planned meals each day, plus planned snacks in between meals. This eating pattern should take precedence over other activities, irrespective of circumstances or appetite. This pattern displaces the characteristic alternating overeating and dietary restriction. A common problem is that patient's are likely to feel uncomfortable after eating a regular meal or foods that they perceive as being fattening, Fairburn (1985) claims this is largely cognitive in nature and suggests that patients involve themselves in alternative behaviours when these feelings of fullness arise. Patients are requested to construct a list of pleasurable activities which are incompatible with binge

eating, to occupy the time between the meals and the snacks. This encourages an active attitude in the patient as it keeps them one step ahead of the problem. Furthermore, the patient is provided with techniques for controlling the act of eating (e.g. slowing the rate by placing utensils down after each mouthful, chewing meticulously, savouring the food).

4. To establish regular weekly weighing. This is an essential element of the treatment as it alleviates the patient's obsessive overconcern with weight as her weight is regularly recorded. With the change in eating patterns the patient becomes scared of gaining weight, the record gives evidence for or counter to her impressions.

5. To inform the patient of the physical consequences of binge-eating and self-induced vomiting.

6. To enlist the cooperation of friends and relatives. This encourages the patient to bring the problem out into the open, thereby relieving her guilt over the continuing secrecy and deceit. Furthermore, friends can aid in establishing an environment that will facilitate the patient in dealing with her problem.

7. To examine the function of the binge eating and self-

induced vomiting. This is novel to most patients and Fairburn (1985) claims that this notion is quite reassuring, as it helps to make sense of the eating problem for the patient. This aspect should be dealt with once the bingeing has become more intermittent. Examples of functions are: binge eating can provide benefits, including distractions from unpleasant thoughts, occupying spare time, or to spite others who are trying to help them. The analysis of these functions should be recorded on the monitoring sheets.

Progress during this first stage results in marked reduction of binge eating and improvement of mood. The focus is on controlling the bingeing, and in this way the need to induce vomiting is removed. Fairburn (1985) claims that if this has not been achieved, the therapist should not implement Stage 2 of the programme.

Stage 2 of the programme is more cognitively oriented and appointments are held once weekly for 8 weeks. The aims of Stage 2 are:

1. To establish and maintain a pattern of regular eating as learned in Stage 1.

2. To reduce dietary restraint. The therapist must encourage the patient to eat a full array of foods, particularly those that the patient has been avoiding as

these, Fairburn (1985) claims, cause most problems of control for the patient. Moderate amounts of these should be eaten. Patient misconceptions about certain foods should be discussed.

3. To identify the circumstances that tend to result in binge eating, and to help the patient:

- a. to cope more effectively with such circumstances
- b. to reduce the frequency of their occurrence.

In cognitive-behavioural terms this is referred to as problem solving ~~is~~ and is accomplished in the following sequence: The problem is identified.

Alternative ways of coping with the problem should be identified.

The implications of each solution should be identified.

One solution should be chosen.

The steps to carry out the solution should be considered.

The solution should be executed.

The entire problem solving process should be evaluated.

These problem solving skills can be taught in a didactic manner and encouraged to be used as homework assignments.

4. To identify and challenge thoughts, beliefs and values that are perpetuating the eating problem. This is the basic thrust of the cognitive-behavioural approach which views the psychopathology of bulimia in terms of cognitive dysfunctions. These dysfunctions are evident in terms of a profound fear of gaining weight or an intense need to remain thin. Fairburn (1985) has found that associated features that often emerge at this stage of therapy are perfectionist tendencies which revolve around shape and weight. This stage of the therapy requires considerable sensitivity on the part of the therapist. In working this way, the patient will be hesitant and scared, as feelings that have not been identified before will begin to emerge. These feelings usually consist of shame and self-condemnation. There are four stages in this process (based on Beck's model for depression):

i. The identification of dysfunctional thoughts. The patient is instructed to write down her thoughts at the times when she is reluctant to adhere to an agreed behavioural instruction, or just prior to weighing herself, or when she feels fat.

ii. The examination of dysfunctional thoughts. The patient is then taught to question the validity of these thoughts, e.g. to check whether she is not confusing subjective impressions (feeling fat) with objective reality

(the weigh in schedule). The therapist should help the patient to check out her interpretation of events. Such interpretations are often clouded by errors in the way of thinking of the patient e.g. dichotomous thinking, where the patient takes an 'all or nothing' view of the circumstances, or selective abstraction, where the patient only remembers what is required to perpetuate the self-defeating behaviours, or overgeneralization, where the patient exaggerates and extends negative thoughts into all areas of her life. (Beck, et al. 1979, Garner and Bemis, 1982, cited in Fairburn, 1985).

iii. The identification of dysfunctional beliefs and values. Patients are generally not aware of these, as they are so much part of the patient's implicit and inarticulated way of being. They must be inferred from the patient's behaviours as the patient is not able to stand back and analyze them. Through the use of Socratic dialogue the patient and therapist can begin to identify them, eg. "I must be thin, because to be thin means to be successful, attractive and happy," or, "self indulgence is bad and is a sign of weakness," or, "anything less than total success is utter failure."

iv. Examination of dysfunctional beliefs and values. The validity of these is put to the test in the therapy. The advantages to the patient for holding these beliefs are

discussed, eg. by judging her self worth in terms of her shape and weight, the patient can measure her strengths and weaknesses. The disadvantages of holding such beliefs should be looked at and this often refers to the more long term effects e.g. most patients will admit that they are never satisfied with their shape or weight and thus remain perpetually dissatisfied. Furthermore, with this preoccupation with shape and weight, often deeper underlying problems are not dealt with by the person, viz. lack of assertion, low self esteem, interpersonal problems. The origin of these beliefs and values can be explored. The patient should attempt to look for factors that contributed to the start of her eating problem and identify those factors that maintain it e.g. the influence of family and other social pressures. Fairburn cites the influence of sociocultural factors as has been researched by feminist psychotherapists. (This issue will be taken up later).

Stage 3 is the final stage in Fairburn's (1985) treatment programme and focusses on the maintenance of practicing the techniques learned in Stage 2. It also prepares the patient for any difficulties in the future, through the formal construction of a blueprint by the patient for dealing with any possible future problems.

Bruch (1985), (Fairburn, 1982, Russell, 1979, Stunkard, 1980, cited in Fairburn, 1985) claim that people with eating disorders are very difficult to work with. The cognitive-behavioural approach as outlined above does not make provision for understanding factors that may impede the successful implementation of skills, or retraining or what is being offered in this type of therapy. Young (1989) addresses this problem in outlining the assumptions that these cognitive-behavioural therapies rely on and which difficult patients violate.

These assumptions are: that patients can gain access to thoughts, feelings and images through brief training; that the patient has motivation and can sustain this to carry out homework assignments and self help strategies; that the patient is able to engage in a collaborative relationship with the therapist within a few sessions; that difficulties in the therapeutic relationship are not a major focus; and finally, that all cognitions and behaviour patterns can be changed through empirical analysis, logical discourse, experimentation, gradual steps and practice.

A psychodynamic formulation of eating disorders as put forward by Johnson (1985), addresses a deeper level of understanding. He found that people with eating disorders were highly dependent, having an intense need to be

directly connected to a "need-satisfying object". He found that they are unable to be alone and feel lost and disorganized when alone. This is due to the fact that they are not aware of their internal resources to direct themselves when others are not present. Johnson (1985) found that underlying all these conflicts was an intense fear of being abandoned. All these issues that have been raised by Johnson (1985) are addressed by Young (1989) in his conceptualization of working with deeper cognitions: Young's (1989) therapy for working with difficult patients based on Early Maladaptive Schema identification incorporates this.

Young (1989) in extending the cognitive therapy model to deal with difficult patients and personality disorders, argues that therapy with these patients needs to work at the deepest level of cognition. He refers to this level as the Early Maladaptive Schemas (EMS). Young (1989) defines EMS defines as:

the extremely stable and enduring patterns of thinking that develop during childhood and are elaborated throughout an individual's lifetime. These schemas serve as templates for the processing of later experience.

The personality of a person is thus a conglomerate of these early schemas. Orbach (1986) holds the psychoanalytic feminist point of view in relation to

personality development as being an adaptation to the environment. She argues that eating disorders are as a result of the female child's need to live up to the societal expectations of females as always needing to appear to be perfect and good. The underlying conflicts of the eating disorder relate to the inability of the female to express her needs honestly without fearing social sanction. People with eating disorders have thus developed early patterns of maladaptation. These are the issue that Young (1989) addresses.

Young (1989) has identified fifteen EMS. For purposes of this study the EMS's that are pertinent are:

- a) "Abandonment/Loss" which relates to the area of functioning termed "connectedness" and is defined as "fear that one will imminently lose significant others and be emotionally isolated forever.
- b) "Fear of losing self-control" which relates to the area of functioning termed "autonomy" and is defined as "the fear that one will involuntarily lose control of one's own behaviour, impulses, emotions, mind, body, etc."
- c) "Dependence" which relates to the area of functioning termed "autonomy" and is defined as the "belief that one is unable to function on one's own".
- d) "Subjugation/lack of individuation" which relates to the area of functioning of "autonomy" and is defined

as "the voluntary or involuntary sacrifice of one's own needs to satisfy others' needs, often with accompanying failure to recognize one's own needs".

EMSs are unconditional beliefs about oneself in relation to the environment. Underlying assumptions (as defined and identified in Beck's cognitive-behavioural approach) hold out the possibility of success for an individual: e.g. "If I can be perfect, then I can be worthwhile." Schemas, in contrast, are rigid: e.g. "No matter what I do, I'm ugly and I'll be abandoned." They are self-perpetuating and therefore much more resistant to change.

Young (1989) defines "schema maintenance" as the process whereby EMS's are strengthened, viz. through cognitive distortions and self-defeating behaviours. He defines "schema avoidance" as a process (similar to psychoanalytic defence mechanisms) where a person attempts to avoid any thoughts or images that may trigger the schema. This relates to Lawrence's (1987) contention that the bulimic uses her body and food as a means of controlling her expressions. Lawrence (1987) claims that the binge is the "disaster" and the vomit the "rescue operation" and that this gives the bulimic a sense of power. The bulimic attempts to define all her problems as a food problem, with thoughts e.g. "I have a problem controlling my weight". She uses this way of thinking to avoid confronting her

underlying fears of having a problem related to being alone and rejected. She thus avoids dealing with it directly, as she believes that if the problem is outside herself, i.e. in relation to other people, she is not able to contain or control it.

A third related process is "schema compensation" (similar to psychoanalytic reaction formation), where the person acts in alternative ways in total contrast to the schema e.g. to hide dependency needs a person gives to others what he would like to receive himself but cannot ask for.

The process of "schema compensation" can be illustrated in the bulimic's behaviours by understanding the role of appearances as argued by the psychoanalytic feminists Dana (1987) and Cooper (1987), whereby the development of a successful, organized and good self compensates for the bad, ugly unacceptable self. Dana (1987) substantiates this by stating that the bulimic sees herself as having two sides:

a) the competent, successfully, organized, good side that appears 'normal' to the world and is thus acceptable;

b) the messy side, which is bad and unacceptable, out of control, needy and greedy, and encapsulated in the covert bulimic behaviour.

Thus by having these two sides so clearly split, the

bulimic views herself as a 'fraud'. She feels as though her 'normal' side is a facade i.e. what she pretends she is to others. Public acclaim of her good side is not well received by the bulimic as she does not feel worthy of this, due to her underlying belief of being bad. Cooper (1987) has referred to the behaviour of bulimia as "false separation and false individuation". She claims that the bulimic has not fully worked through issues of separation from the family of origin but is required by them or by society to appear as though she has been successful. The appearance is in keeping with this, but the issues of loss and separation are symbolized in the covert bingeing and vomiting. Individuation, is expressed through the social appearance of coping well. This social self is an example of a schema driven behaviour as it is a compensation that is resorted to when the other self attempts to emerge.

The application of Young's (1989) theory requires the initial identification of EMS. This can be achieved through:

- a) the use of a schema questionnaire (see appendix 4);
- b) the triggering of schemas during the therapy sessions through the use of imagery and discussion of upsetting events in the past and present;
- c) to activate the schema through discussion of the therapeutic relationship and to identify what schema is

being activated in this relationship. This is referred to as 'working in the transference' in psychoanalytic terms. Young (1989) claims this to be an essential component to this therapy as it focusses directly on the interpersonal interactions of the therapist and patient. He argues that it is in the interpersonal sphere that most difficult patients problems lie. Safran (1984) and Arnkoff (1981) (cited in Edwards 1987) have argued that the interpersonal aspect of therapy can be integrated into standard cognitive-behavioural therapy and has a significant impact on the patient. Bruch (1985) endorses the need to work with the therapeutic relationship, as this can give these patients an experience of a new way of relating.

d) Confronting schema avoidance and schema maintenance

e) Use of emotional catharsis, whereby the patient is encouraged to express feelings associated to the issues raised in the triggering of schemas.

f) Linking the present and the therapeutic relationship to the past and family. Fairburn (1985) also subscribes to the importance of making the link to the family in searching for the etiology of the problem, but he does not link this with the therapeutic encounter.

Young (1989) focusses on working with behavioral and environmental change after the identification of the EMS. However, Yager and Edelstein, (1985) in reviewing the

outpatient management of bulimia, found that as few patients harbour the illusion that all their problems are resolved with the amelioration of their symptoms, the associated problems of affect, self esteem and interpersonal, improve and are able to be more profitably examined once the bulimic behaviours per se have abated. This supports Fairburn's (1985) model with the initial emphasis on bringing about changes in the eating behaviours before working with the thoughts and beliefs underlying these behaviours.

In working with people with eating disorders, Garner and Garfinkel (1985) stress the need for an eclectic therapeutic approach. However, regardless of what approach is taken, Kruger (1980) reminds us that

there is no therapy in itself, only a psychotherapy as structured by a specific therapist and a specific client. Every client is a new challenge and the therapeutic situation constituted between therapist and client is always a new situation.

### The Case Study

The case presented herein and the subsequent psychotherapy was undertaken at the Rhodes University, Psychology Clinic - a psychotherapy and psychological assessment training institution for students studying towards the Masters degree in Clinical Psychology. All contact with patients/clients is on an outpatient basis, whereby the students work directly with the clients. The students work under close supervision of a qualified clinical psychologist, as well as participate in regular case conferences with other students and qualified staff.

In this particular case, the initial diagnostic interviews were carried out by the therapist presenting this case.

The confidentiality of the patient has been respected and thus identifying data have been masked.

Identifying data:

Anna, a 20 year old single female student, studying for her final year towards a B. Soc. Sc. degree, presented herself at the Clinic on the recommendation of one of her professors, to whom she had sought help. She previously had had eight psychotherapy sessions with a private clinician for the problem to be described. This therapy had been non-directive insight oriented therapy, but these had left her "more confused and very scared". Anna had confided in her close friends, but had felt that she had overwhelmed them and hence decided to seek further professional help for her problem. She requested that her parents remain uninformed as she wanted to be responsible financially for the psychotherapy.

Presenting problem:

Anna described her problem as an eating disorder related to her need to "be thin". She had a poor body image and described her body as being "gross and ugly" and "somehow just getting in the way". She predominantly binged on junk food, which she would devour eagerly. She felt to be out of control when bingeing. This would be followed by the copious drinking of water, which would then make her feel bloated and full. By placing her forefingers in her throat, she would induce a vomit of all this food.

She experienced a tremendous sense of relief, albeit shortlived after carrying out this ritual. She would covertly carry out this ritual up to five to six times per day. She had not had a clear day over the last year. She structured her life around the procurement of the food and the seeking of a secret place to binge and vomit. She had resorted to stealing food or money when she was desperate.

Underlying all this behaviour she experienced a great sense of guilt at the "waste" and the "deceitfulness" of her behaviour which she felt she could not control. She also felt very afraid of the future as she could see no other way to live except to be "caught-up" in this ritual. She also suffered from a sense of low self esteem, and was feeling very lonely. The Beck Depression Inventory (see Appendix 2) reading was 29 which falls into the category of "severe depression". She had not ever attempted suicide, or experienced suicide ideation per se, but she had had thoughts about death, which had frightened her.

She also experienced many somatic symptoms of anxiety. She experienced heart pounding, difficulty in breathing, face flushes, feelings of choking and trembling hands. She was unable to relax and feared losing control. (See Appendix 2 for Beck Anxiety Scale). She related this to social situations as well as to work, where in both areas she always felt "inadequate, inappropriate and very clumsy".

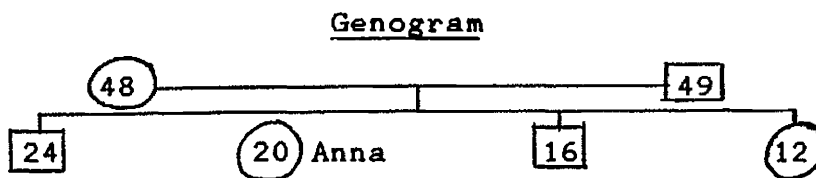
General appearance and mental state at initial interview:

Anna appeared very timid and scared. She initially made very little eye contact and continuously covered her mouth with her hands as she spoke. She found it difficult to ask for help or even to describe her presenting problem. She constantly apologised for the "time" she was taking up in the interview. She was quite tearful and embarrassed by this throughout the initial interview.

She was notably overdressed for the hot weather. She looked in reasonable physical health and could be described as having a normal weight for her height and body structure.

A full medical examination by a local General Practitioner, following this initial interview, revealed no physical problems.

Family of origin:



Anna described her parents as being "very hard working people". They needed to work this hard so as to provide all the material needs of the family. She described them as "very caring", despite the fact that they spent most of their time away from the home. The children, while young,

were left in the care of a nanny.

Anna idealizes her father, and feels she has to work hard to gain his admiration. She does not feel "good enough" for him, and is quite jealous of the relationship between her elder brother and her father.

She also idealizes her mother. Her mother has always had a weight problem and thus has been quite involved in different diets. Anna would like to spend more time with her mother, but her mother constantly attempts to "push" Anna into being more sociable with her peers. She would like to see Anna as "popular". Her mother is a very sociable person.

Anna is very close to all her siblings. She claims that while growing up she "mothered them", particularly her youngest brother, and found this role to be most satisfying and comforting.

Anna holds a distorted perception of how close they family are. On the one hand Anna constantly describes it as being very "close and caring" and yet on the other hand, with the parents and children being constantly physically apart, there was always a pervasive sense of "longing for more of each other".

#### Personal History:

Anna, the second eldest child, was a planned baby. The pregnancy went well as did the birth. Anna was bottle fed

as her mother went back to work when she was 3 months old, as her mother had done likewise with the previous child and would do with the subsequent ones. Anna was described, by her parents as being a "good and quiet, undemanding baby".

Her milestone development was normal. She was always physically healthy, although slightly on the "plump side".

At primary school, she was described as a "slow learner", but she coped academically, passing all her grades. Socially, she had many friends and was a "very pleasing" and "sweet natured" girl.

At 13 years of age Anna was sent to boarding school. (This decision had been a calculated one, by the parents, for all the children in this family, as it was felt boarding school was a "good way of developing independence"). She hated boarding school, was desperately homesick, crying herself to sleep nightly, becoming more and more withdrawn from her peers and teachers and by the end of her first year had to be hospitalized being diagnosed as having Anorexia Nervosa.

She remained in hospital for 1 year - where a behavioural programme to induce eating was implemented. She was discharged on making a considerable weight gain.

She returned to school having lost a full academic year and experienced great difficulty in adjusting back to school and to new friends, and it was at this time that she

began to covertly binge on junk foods as a solace. Due to the bingeing, she began to gain considerable weight and thus it was a relief for her to discover self-induced vomiting after a binge, as a practical solution to her problem of weight gain. The bulimic ritual began to work for her.

The following year, she was moved to a smaller school as she was not coping academically. Here she felt she was "somebody", made many new friends, worked well academically and became involved in many sporting activities and teams. She was to all outward appearances "successful". However, throughout this "good" period, she was bingeing and vomiting up to two to three times per day, and became quite adept at keeping this a secret. Her physical health was good, however, she only began menstruating at 18 years of age. This had bothered her but she had never sought help, as she feared this would draw attention to her and cause "others to worry about me (her)".

After leaving school and gaining a University Entrance pass, her parents decided that she should study Social Work and go to a small university where she could live in residence. She found her studies very interesting, but she experienced many difficulties academically and thus worked many long hours compared to her "friends". She experienced

great pressure from her work load, as she had claimed that she had never felt academically "good enough". However, she managed to gain credits in the subjects she registered for.

It was during her second year that she met her first boyfriend. She fell "head over heels in love" with him. It was not a sexual relationship, or a very physical one, but she felt it to be "very emotionally intimate". It lasted for 10 months, after which he "ditched her". She was devastated as she felt that she had trusted him so deeply and had understood him so well. At the initial interview, she claimed that she was still grieving over this loss. This has been her only heterosexual relationship.

During her university career, she became more "covert and clever" about indulging in her bulimic behaviour. She was having up to six or seven binge-vomit episodes per day. She was bingeing and vomiting on both junk food and would also vomit up her regular meals which appeared to be very meagre and selective.

She has always been popular with her peers and describes herself as "being liked by all". She does not understand this and never feels worthy of popularity. She always experiencing much anxiety when with people, yet she claims that she desperately needs friends around her, as she enjoys doing things for them. She hates being alone unless she is bingeing and vomiting.

Diagnosis:

Axis I : Bulimia Nervosa

Dysthymia

Axis II : Dependent Personality Disorder

Case conceptualization and therapeutic strategies as at  
in initial interviews

At presentation to the Clinic, Anna was bingeing and vomiting up to five to six times per day, without a clear day within the past year. She felt out of control when bingeing, as once she began to devour the food, she could only stop once she felt physically uncomfortable. The self-induced vomiting was a solution to these uncomfortable feelings and gave her a sense of control. It helped her to control her physical appearance, by maintaining her weight and shape. This is very important to her as being thin assures her of acceptance by others.

The bulimia was hypothesized as being a result of Anna's inability to cope with separation and growing up. She has not been able to resolve her separation anxiety from her parents. She is unable to express this anxiety to anyone for fear of rejection. The bulimia has thus become an adaptation to her need to be accepted, while at the same time to contain all these anxieties.

The therapeutic strategy decided upon was to initially

address the behaviour, viz. the eating patterns. It was felt that by focusing on this behaviour, Anna could begin to gain a sense of mastery over her eating problem as the issue of control is very central to Anna's predicament. The specific tactics to be employed would follow Fairburn's programme, whereby Anna would need to detail and record her eating behaviours. Anna would be made cognisant of its structure and format, thus relieving her of the anxiety that she had experienced in her previous non-directive therapy. Concurrently, the issue of her personality disorder would begin to be addressed, through her developing a trust in the therapeutic relationship by allowing her to begin to share her secret world with another, viz. the therapist. The underlying dependency needs could then be addressed directly once the overt behavioral patterns had been dealt with. The final aim of the therapy would be to help Anna become aware of her own inner resources and become more self-assertive.

### Results and Discussion

This presentation will provide a detailed analyses of the first 22 sessions of therapy carried out over a period of 6 months. The remaining period of therapy (10 sessions) will then be summarized briefly in the conclusion.

The first four weeks of therapy : the significance of the implementation of a structured, behaviourally oriented programme.

Anna's previous attempt at therapy had left her both confused and bewildered. This therapy had been non-directive, and Anna had felt overwhelmed as a result of the emotions that it had released. She was not able to understand them at the time, and the therapy did not provide her with the appropriate tools to deal with them. This experience had, however, motivated her into accepting alternative ways of working with her problem. At the initial diagnostic interview, Fairburn's programme (1985) was presented to Anna. The fact that the programme was structured gave her a sense of its credibility. After her past experience of non-structured therapy, she felt that she needed to work within specific guidelines. She also felt empowered by the fact that the pace to be set hinged on her own motivation and action. Her motivation to change

was made clearly visible by the way she diligently carried out the programme steps, during the first stage (four weeks) of the therapy. Furthermore, as is indicated in the graph (see appendix 1), this stage was successful in terms of behavioural change, as her binge-vomit cycle became intermittent. This is very significant in the light of the fact that for the past year, Anna had been bingeing and vomiting on an average of five to six times a day, year without a day free.

The initial aim in stage one is to establish a sound therapeutic relationship. Anna's mental state at the initial presentation at the Clinic was of a highly anxious picture. This focussed around her need to ask for help. These initial diagnostic interviews were crucial in creating a working therapeutic alliance, in which Anna could begin to experience that asking for help implied a positive action on her part. It reflected a movement towards the development of some self esteem in that, in the asking, she was indirectly saying that she was possibly worthy of help and attention from a therapist. Anna, clearly set the therapist up as her mentor at this stage of therapy which facilitated the implementation of the of the first stage of the programme.

For the first 10 days after implementation of the programme, Anna was able to fulfil all the behavioural

requirements of the programme aimed at breaking the binge cycle. She diligently filled in the self-monitoring sheets, she made use of her list of alternative behaviours when the urge to binge appeared, she managed to implement a regular three meal a day structure as well as adhering to having an in-between meal snack. She complied with the weekly weigh-in schedule.

During this period her anxiety was visible and she was able to articulate it into: "This is too good to be true, I can never keep this up". This feeling would always emerge during the times when she was able to control the binges. After maintaining control over her bingeing and vomiting for 10 days, i.e. 10 days clear of bingeing and vomiting, Anna lost control. She binged and vomited on an average of six to seven times per day for the next five days. This was devastating for her. She said that she was a "total failure", that "this is how it will always be", that she "was useless" Her thoughts were all negative, and she became depressed with feelings of low esteem and helplessness. For the therapy, the significance of this "crash," was that this was the first time that Anna was able to expose her weakness to another person. At the time this was not articulated by the therapist, but it was taken as a good prognosis of the therapeutic alliance that was to be established.

Anna was "coaxed" into attempting to try again. The therapist attempted to help her think in terms of taking one step at a time, i.e. that one crash does not obliterate the good clear times that she had achieved. Cognitive distortions, like dichotomous thinking, as were illustrated above, were clearly evident but were not formally worked with at this stage, as the focus was strictly behavioural. However, the process of the therapy provided an informal way of dealing with these thoughts. The concrete evidence of the record of good times on the self-monitoring sheets did, Anna claimed, encourage her to continue trying to break her binge-vomit cycle. Anna found it extremely difficult to accept any credit or commend herself for the good days. The therapist's encouragement was not accepted by Anna, it made her feel uncomfortable. She found it very much easier to see her failures as being a part of what she had expected. The therapist found it extremely difficult to counter this response but constantly made reference to the monitoring sheets to remind Anna of what she was capable of achieving.

Anna's mood swings were related to the degree of control she experienced. When she was in control, i.e. during good times, she was clearly anxious. She likened this feeling to being "like a coiled up spring ready and waiting to pounce out". When she was out of control, i.e.

bingeing and vomiting, she was depressed. The Beck Depression Inventory was presented at each session and used to assess the shifts in the level of depression (see graph in appendix 1). Her body language provided a clear indication of her mood. During her good phases, she would sit upright and smile sweetly and be quite open towards the therapist. During the bad phases she would slouch and almost 'spill' all over the chair, constantly covering her face with her hands in an attempt to hide away. These body expressions reflect the two sides of the bulimic that Dana (1985) speaks about, viz. the socially appropriate side and the covert inappropriate side.

A significant aspect of this programme was the weight record chart. Over the four week period, her weight did not fluctuate, it remained at 67kg, which is the amount she weighed at the initial interview. This was most illuminating for Anna, as she realized that without her regular five to six times a day binge and vomit behaviour, she could maintain a constant body weight. Furthermore, it indicated to her that despite the fact that she was eating regular meals and snacking and was reducing the self-induced vomiting she was not gaining weight. Thoughts of: "If I vomit then only will I stay thin" and "By eating three full meals a day, I will get fat" were counteracted by this concrete evidence.

The fact that the therapy concentrated on the eating behaviours throughout this phase, gave Anna the first opportunity ever to discuss her eating problem. She was able to begin to view it from a distanced perspective. This, she claimed was due to the act of writing it down in the monitoring sheets. This very act gave her a sense of relief. She experienced the focus of the therapy on her actual behaviour as a relief compared to the way she had felt in her previous therapy where she claimed she was too scared to "talk too much about her actual eating patterns". As she was unsure of the expectations and aims of the previous therapeutic experience, she also felt uncertain about the importance of the eating behaviours. She assumed that she was required to offer "more meaningful psychological input". She was, however, unable to fulfil this assumption that she had made about the expectations of this type of therapy. She regarded her first attempt at therapy as her own failure. Hence the offer of a different focused way of working gave her a sense of hope. It also helped to allay her anxiety by making her feel safer and more secure by having an explicit structure to work within. She found the experience of exposing her bulimic world to another, not as threatening as she had expected to. Anna was indicating that she could trust the therapeutic relationship.

At this stage of the programme Anna was not very eager to explore the 'function' of the bulimia as is suggested by Fairburn (1989). The discussion would only revolve around the self induced vomiting which she said she saw as a means for "keeping in shape". This relates to "the vomit as the rescue" that Lawrence (1987) refers to. She could not identify the function of the binge, all she could say was 'I just have to do it'. She was not able to carry this thought further. It was at this stage that the first resistance against the programme began to emerge. In attempting to look for the function, the therapy was moving a little deeper and away from the behavioural focus. Anna was becoming hesitant.

The implementation of Stage 1 of Fairburn's (1985) programme had been very successful. The behavioural orientation had given the therapist and Anna a specific focus and goal. Anna was able to experience a taste of her potential for being active in the world.

Implementation of Stage 2 of Fairburn's (1985) programme where the orientation becomes more cognitive and the need to adapt the therapy to the patient's needs becomes the focus.

The initial aims at this stage of Fairburn's programme are: (1) to maintain a pattern of regular eating that she had learned from Stage 1 and; (2) to effect

dietary restraint through the introduction of a variety of foods into the diet. These discussions were held in an informal manner and were enjoyable as Anna claimed that it made her feel "like a naughty child" when the therapist encouraged her to eat foods that she avoided most. The foods that she had held the most misconceptions about were the carbohydrates. The therapist explained to her that she needed to incorporate wholesome carbohydrate food into her meals so as to allay any cravings she would have for highly sweetened foods as these are the main content of her binges. She understood this logic and felt quite indulgent while eating potatoes and bread. She displayed a very tight control over her eating of these foods. She was still rather frightened of them. She experienced visual images of herself, for example, actually looking like a potato, each time she ate a potato. She could share this imagery with the therapist and in the sharing she began to find it quite amusing.

The subsequent aims of Fairburn's (1985) programme in this stage of the therapy are to teach the patient how to use the basic cognitive-behavioural skills of: (1) problem solving and, (2) of identifying and challenging thoughts, beliefs and values that are perpetuating the problem. These skills were taught to Anna during the first two sessions of the second phase of the therapy and practice

runs were carried out. During the sessions she worked well and appeared to be able to understand the instructions and follow them through. However, she was not prepared to use these newly acquired skills as was illustrated in her refusal to implement them into homework. The actual sessions were then used to implement these skills.

In retrospect, this implementation illustrates an important shift in the therapy. The therapist's attempts to adhere strictly to the structure of the standard cognitive-behavioural techniques of problem solving and working with dysfunctional thoughts and beliefs were unsuccessful. The specific techniques were applied superficially in that the analysis was not rigorous enough, and the solutions reached and closure were premature. This could have been due to the therapist's experience of a change in Anna's motivations to work in this way. In response to this, the therapist wanted to provide quick answers and solutions for Anna in an attempt to sustain her motivation. At this stage the therapist's anxiety was directing the therapy. Although these exercises were not carried out fully in the technical sense, they were significant for the therapy in that they activated underlying emotions in Anna. These emotions could be identified with the underlying schemas of loneliness, helplessness and incompetence. As will be seen from the

examples given here below, these were expressed in two ways: firstly, from her responses towards the actual implementation of the cognitive-behavioural techniques, and secondly, through addressing the interpersonal aspect of the therapy. Fairburn (1985), however, failed to address the significance of the latter.

The steps taken in implementing the standard cognitive-behavioural procedure for problem solving are outlined below:

1. Identification of the situation: During the session, Anna was asked to identify a situation that had prompted her into bingeing as an outcome or resolution to that situation. She identified a situation, a ball game, in which she had been unfairly treated. According to her report to the therapist, this appeared to have been the case. She was ready to shoot a goal, when someone deliberately tripped her. She did not fall but lost the contact with the ball. She was unable to deal with this humiliation and immediately after the game, she went off on her own and binged and vomited several times.

2. Finding alternative ways of dealing with the problem: Anna and the therapist listed the following:

- a) that she could have just dismissed the whole incident as trivial, and thus let it pass,

b) that she could have expressed to the other players the humiliation that she had felt.

3. Choosing one solution: Anna admitted that she would have liked to choose (b) but that it was totally beyond her capabilities to follow it through. She knew that this solution was the right one i.e. her reasoning was sound but there were underlying emotions that were blocking implementation of her logic. She began to cry very softly and became reticent in the session. The therapist could not prompt her into working this way any longer. Anna was coming up against very sensitive issues and working with them in a didactic manner was inappropriate.

From the above example where a specific situation was identified Anna was for the first time confronted with her own lack of assertion and helplessness. These emotions were too powerful for her to deal with in a didactic manner at this stage of the therapy.

A further triggering of the underlying emotions through an unsuccessful, in the technical sense, implementation of a technique is shown in the attempt to work with dysfunctional thoughts and beliefs.

The steps are outlined as follows:

Step 1: Identifying dysfunctional thoughts. Fairburn (1985) suggests that this type of thinking is provoked when the patient does not comply with a behavioural programme

instruction, or is about to weigh herself or when she is feeling fat. The therapist attempted to coax Anna into identifying such thoughts. The only response that she would give was in response to the therapy. She continued to repeat thoughts like: "Why should I be doing this?" "It's too difficult for me, I'm not winning so what's the use", "I can't keep this up any longer", "I don't care".

Step 2: Analysis of the thoughts. Anna would not respond to Socratic questioning. From her behaviour it appeared as if she had just given up. The therapist interpreted this behaviour. Anna responded with "You see I always fail, I am not good enough". In questioning the validity of this statement, the therapist explained to Anna that she was using generalizations and that she had not been a failure in all aspects of her life. The therapist encouraged her to talk about her successes, for example, in the behavioural programme stage of the therapy. Anna's response was that "Maybe it appears to you as if I have been successful, but that is not how it's been for me". Anna began to panic, she said that she did not want to talk about this any longer. The therapist respected this request and the therapy room remained silent (about 15 minutes) until the end of the session. During this silence, Anna appeared petulant, a new expression that had not been witnessed in the therapy before. She left the session

apologising for her behaviour, by saying "I'm sorry that I did not work that hard today".

The above illustration indicates how the therapist's anxiety at needing to adhere too strictly to the technicalities of the programme, led to a loss of empathy in the therapy. This is reflected in Anna's petulance as a reaction to not being understood when she was attempting to express her underlying schemas of helplessness. The therapist did not at the time realize this and dogmatically adhered to the specific steps of the technique. The triggering of Anna's underlying emotions is significant. She had begun to experience these feelings within the therapy. Her apology at the end of the session, could retrospectively be hypothesized as a way of placating the therapist for fear of rejection. Anna feared that because she had not worked well i.e. within the specific tasks set, she would be rejected. Furthermore, she had exposed a very different side of herself to the therapist and was not sure of the outcome of this. Thus the interpersonal aspect of the therapy was becoming very significant. Dana (1987) has highlighted the importance of appearance in the social sense for the bulimic, i.e. that she constantly needs to show only a good part of herself. In this session, Anna's social facade was beginning to waver.

After the first three sessions of this second stage

of the therapy, Anna phoned in and cancelled two appointments, she also began to arrive about 10 minutes late for subsequent appointments, and stopped bringing any self monitoring sheets to the therapy as she had stopped doing any homework. She also claimed that she was vomiting and bingeing regularly but that she had no record of the times. Anna was clearly resisting therapy yet did not leave. At this stage of the therapy, Anna's schemas of helplessness had been activated and although the therapy was not directly addressing this, she remained in therapy. The hypothesis for this behaviour was that ~~she~~ her feelings of dependence were being activated within the therapeutic relationship. Thus indicating that although the therapy at one level was not succeeding, at a deeper level, she was being touched and the therapy was becoming much more emotional. On the one hand Anna was beginning to realize that she needed the therapist yet was compensating for this overwhelming feeling by not fulfilling the therapist's requirements and tasks by making an autonomous statement.

This shift in the therapy can be illustrated in the following vignette, where the emphasis is more on affect and the therapist is no longer using the technical steps of problem solving and working with dysfunctional thoughts in a formal manner.

The vignette presented uses the same situation as previously, viz. the incident at the ball game:

Therapist: Lets imagine that you are at the ball game now and the game is coming to an end. Can you relate exactly what was happening to you at the time?

Anna: I'm just going to shoot for a goal, when Tom slips his foot in front of me.  
I can't see the ball properly as my eyes are full of tears, I'm not really playing anymore and I just can't wait for the game to end. I want to go away.

Therapist: The game has ended, now what?

Anna: I'm picking up my track suit, I don't want any one to see my face.... so I just start to walk away..... someone is calling my name but I pretend not to hear.... I walk faster.....

Therapist: Are you feeling scared?

Anna: Yes, I'm afraid that they will see me like this, (she is beginning to cry in the session). I look so ugly.....now  
I'm so damn pathetic.....and stupid to make such a fuss over nothing. Look at me

I'm falling apart again. I hate this.....  
you must think me so stupid and pathetic...

Therapist: Is this how you think your friends at the  
game feel about you?

Anna: They don't want me around, because I'm so  
pathetic.....

Anna continued to cry for awhile, the therapist just remained present to her, giving her the space to express emotions without analyzing them. After some time, she then went on to talk about how she actually went about the binge. It was as if, after this emotional outburst, she needed to go back to some structure to contain herself and finish this story. Anna became distanced and aloof, covering her face with her hands, while relating to the therapist how she then went to her room and vomited and binged. She went into the details of what she ate and how she needed to drink water to fill herself up, and then she put her finger down her throat and vomited it all up. Anna became overly apologetic about the expressive outburst. It had made her feel very bad as she felt that she had upset the therapist. She also added that she would understand if the therapist wanted to end the therapy. The therapist had to reassure her that she had not felt this way but was pleased that Anna was able to share these emotions with the therapist. In terms of Young's (1989) recommendations in working



with the transference, the therapist realized that this distanced attitude of Anna's was a way of telling the therapist that Anna could not share the immediacy of the experience of bingeing and vomiting with anyone. The therapist felt it necessary to express to Anna how distanced the therapist had felt while Anna was relating the second part of her story, in comparison to the shared emotions of the first part. Anna used this interpretation by adding that she cannot ever expose the bingeing and vomiting to anyone as she fears they would reject her.

The above example of the therapy illustrates how the Early Maladaptive Schema of a "Fear of Rejection/Loss" (see page 20 of this report) was identified through the active exploration of an event, whereby emotions were triggered and actually re-experienced within the therapy session. This pre-empted the opportunity to use the interpersonal structure of the therapy. The interpersonal domain is a core problem area for people who have developed strong Early Maladaptive Schemas (Young, 1989). The fear of rejection was experienced within the therapy. "Schema compensation" (Young, 1989) was explicitly used by Anna in her attempt to placate the therapist because of her expression of emotions and the exposure of her ugliness to the therapist. This relates to Dana's contention that the bulimic needs to have a social self which

acts as a facade for the ugly parts of herself. In order to protect herself against loneliness and rejection, Anna placates others as a coping strategy. Thus she is avoiding the underlying schema, as well as compensating for it, through her social self.

#### Identification of the Early Maladaptive Schemas.

At this stage of the therapy, (the 16th session) an attempt was made to verify the hypotheses that were beginning to take form in relation to Anna's adaptive schemas, Young's Questionnaire for Identifying Early Maladaptive Schemas (appendix 4) was given to Anna.

The schemas that were identified were:

1. Abandonment and Loss
2. Fear of losing control
3. Dependence
4. Subjugation.

Anna felt that having identified these schemas, helped her to make sense of her anorexia and bulimia. This was a turning point in the therapy. She began to make meaningful links to her past and family and to understand her adaptations to the particular circumstances in her life.

From the subsequent therapy the foundations of Anna's anorexia began to emerge. She identified its precipitant as being sent to boarding school and the

consequences of being away from home. The anorexia could be linked to the following combinations of Early Maladaptive Schemas, which highlight the conflict that Anna must have experienced as the two combinations counteract each other.

1. Abandonment/loss and dependence

2. Fear of losing control and subjugation.

1. Abandonment/ loss and dependence: Anna believed that by being sent to boarding school, she had been rejected and abandoned by her family. Her statement of anorexia was an expression of the underlying beliefs that "I am so small and fragile... I am so helpless.... I need you .....I am not ready to leave home ..... don't leave me alone....".

2. Fear of losing control and subjugation: The anorexia also relates to her fear of losing control, as it was through the symbolic control of eating that she managed to keep her emotions in control. "If I am in control, then I won't need anyone and I won't be a burden to anyone" The need for control also relates to her need to subjugate her needs to that of her parents. The underlying core beliefs about her parents being "They are so good.... so perfect.... they know whats right.... I feel so bad about making demands on them".

These core beliefs of fear of losing control and the consequent possibility of being rejected were also expressed

in the episode of the ball game, as well as within the therapeutic relationship.

The statement of bulimia can be viewed as a process of schema compensation and schema avoidance in relation to the identified Early Maladaptive Schemas. In attempting to understand her shift from anorexia into bulimia, it became apparent to Anna that the attention that she had called to herself from her parents when she was in the anorexic state was, as she articulated retrospectively "not their concern but their fear". Her strategy for coping had backfired for her. Her schema of subjugation had been activated by her parent's reaction as she had felt very bad. Her thoughts were: "I have been bad and have made them suffer". The ill effects that she had caused, made her feel guilty. As compensation for this, she placated them by moving into the bulimic phase. This process of schema compensation relates to Cooper's (1987) statement that bulimia is a false separation and a false individuation. The bulimia was an adaptation which allowed her to appear independent and yet contained all her neediness in the covert bulimic behaviour. Thus she gave the appearance that all was well to both her parents, and her peers.

The binge was her way of distracting herself from her conflicts, and also a way of taking in the love and care she felt denied of. Furthermore, as food is inanimate, Anna

felt she could control it. She thus compensated through food the overwhelming fear of losing control that she experienced with people. The need for control was further played out in the self-induced vomiting, which could be viewed as the "rescue" (Lawrence, 1987). It gives her a sense of control and prevents her from getting fat, thus helping to maintain her social facade.

The most disconcerting realization that Anna came to during this stage of the therapy was that her dependency needs and her fear of abandonment had not been resolved and the bulimia was a process of schema avoidance of these particular EMSs. This was highlighted when she attempted to explore the bad feelings she had about the money she was wasting on her habit: "The worst part of this bulimia is that I am using my parent's money to support it". She then realized that the money was symbolic of the love and care she wanted from them. She likened it to "an umbilical cord", as through it she managed to maintain a strong dependent link with her parents. She still feared abandonment. Anna's overwhelming feelings while talking about these issues were of anger. In focusing on whom it was directed at, Anna found to her amazement that it was directed at her parents. She was squandering their money as a symbolic way of expressing her anger and taking revenge against them, for as she expressed it: "not giving

me what I want". She had always seen them as perfect and now suddenly she was feeling let down by them and beginning to see their shortcomings as parents. Anna still needs to work through the issue of disillusionment, as it is very new for her.

An overview of the changes that occurred in Anna's eating patterns during the six months, is relevant.

This therapy began with the behavioural focus, which was maintained and worked with successfully for the first nine sessions. For the three following weeks of therapy, where the focus was on implementing the technical cognitive-behavioural skills of problem solving and working with dysfunctional thoughts, Anna withdrew from monitoring her eating patterns, but did inform the therapist that she was bingeing and vomiting regularly. At this stage of the therapy, Anna appeared to be ambivalent about the therapy. This could have been due to the fact that the therapist was so intent on following the cognitive-behavioural programme, that empathy was lost. On the other hand, it could be hypothesized that emotions were being triggered that shifted the emphasis for Anna onto a deeper level of functioning.

Throughout the whole therapy Anna was weighed regularly by the therapist, and her weight over the whole period only fluctuated within a 1 Kg. range (67 Kg. to 68 Kg.). This

formal record of her weight stability was most satisfying to Anna as she expressed the thought: "that my body is not letting me down" and "it is a good to look at the chart to remind me that I am not changing so much as I used to do".

It was during the last six sessions within the 22 session block of this report, that Anna's behavioural eating problems had been reduced to occurring on weekends only. At this stage, Anna was prepared to work with this problem using the standard cognitive-behavioural problem-solving skills that had been presented to her earlier in the therapy. She worked well and came to the realization that because of the lack of structure on the weekends, she often just binged and vomited, as she said: "to break the monotony". She could cope well during the week when she was in a strict routine and thus was busy. She decided to solicit her friends to help her overcome her weekend problems. They helped her plan and structure her weekends in advance. The new experience of being able to express her needs and ask for help from her peers, was significant for Anna. Her beliefs about herself had changed in that she said: "I don't really mind if they know that I can't cope" and "That's what friends are for". She was beginning to feel that she could ask for help without feeling the fear of rejection, hence she was no longer avoiding this schema. The schema compensation of having a

perfect social image was beginning to break down. Anna's needs were becoming integrated into her social world. She was learning to become self-assertive.

### Conclusion

The subsequent 10 therapy sessions were used to consolidate the insights gained from the past 22 sessions.

The easy and comfortable flow of the therapy made evident that some fundamental shifts had taken place for Anna. She had become more able to engage freely with the therapist. She admitted that she could now express her emotions without feeling the fear of losing control or rejection from the therapist. She no longer needed to use her schema compensations, that is to keep up the good, sweet, placating image, as she was no longer avoiding the early maladaptive schemas.

Anna was also able to extend these new found insights into her social world, which she now described as being: "richer and better" as she felt that could now be more authentic with others. She said she felt quite relieved about not having to: "always be nice to everyone" and "to be able to express my honest opinions". Her friends appeared to have responded positively and she felt met. She also realized that it was not imperative for her to always, as she put it: "be giving" to ensure friendships and that the "give and take from both sides of these relationships was essential". Anna was becoming more reality based. She was experiencing her own autonomy as she was able to

articulate that: "I feel I can make decisions more easily as I now what I want". She was able to now implement the problem solving skills presented during the early phases of the therapy. Previously, the attempt to tackle problems through this technique had activated her sense of helplessness, now she was able to use these techniques appropriately.

Thus this case study has shown how the underlying personality maladaptions were accessed and provided insight into the foundations of the eating disorder. Once these understandings were reached, the symptomology began to fade and gave the patient the freedom to experience a richer emotional and interpersonal life.

This case-study has also illustrated how a depth psychotherapy was attained through a combination of psychotherapy models, viz. Fairburn's (1985) standard cognitive--behavioural programme which works at a rather superficial level of cognitions and Young's Schema Focussed Therapy for Personality Disorders (1989) which moves into deeper cognitions. Initially the highly structured and fairly superficial level of working at a behavioural level provided the impetus for the development of trust and security within a therapeutic encounter. This then activated the underlying early maladaptive schemas to be experienced within the therapy. Finally the patient was

able to test her new found insights in her day to day existence.

Therapy needs to be able to live with what is presented and in this case, the patient's needs were the guiding factor towards the attainment of its success.

	<u>Self report</u>
<u>Number of Binges and Purges</u>	5-6 binge- purges per day for 1 year without a day free
<u>Therapy sessions</u>	
<u>Beck Depression Inventory</u>	
<u>Therapy models</u>	

Illustration represents

## Appendix

**BECK INVENTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

- |   |  |
|---|--|
| <p>1 0 I do not feel sad.<br/>1 I feel sad.<br/>2 I am sad all the time and I can't snap out of it.<br/>3 I am so sad or unhappy that I can't stand it.</p> <p>2 0 I am not particularly discouraged about the future.<br/>1 I feel discouraged about the future.<br/>2 I feel I have nothing to look forward to.<br/>3 I feel that the future is hopeless and that things cannot improve.</p> <p>3 0 I do not feel like a failure.<br/>1 I feel I have failed more than the average person.<br/>2 As I look back on my life, all I can see is a lot of failures.<br/>3 I feel I am a complete failure as a person.</p> <p>4 0 I get as much satisfaction out of things as I used to.<br/>1 I don't enjoy things the way I used to.<br/>2 I don't get real satisfaction out of anything anymore.<br/>3 I am dissatisfied or bored with everything.</p> <p>5 0 I don't feel particularly guilty.<br/>1 I feel guilty a good part of the time.<br/>2 I feel quite guilty most of the time.<br/>3 I feel guilty all of the time.</p> <p>6 0 I don't feel I am being punished.<br/>1 I feel I may be punished.<br/>2 I expect to be punished.<br/>3 I feel I am being punished.</p> <p>7 0 I don't feel disappointed in myself.<br/>1 I am disappointed in myself.<br/>2 I am disgusted with myself.<br/>3 I hate myself.</p> <p>8 0 I don't feel I am any worse than anybody else.<br/>1 I am critical of myself for my weaknesses or mistakes.<br/>2 I blame myself all the time for my faults.<br/>3 I blame myself for everything bad that happens.</p> <p>9 0 I don't have any thoughts of killing myself.<br/>1 I have thoughts of killing myself, but I would not carry them out.<br/>2 I would like to kill myself.<br/>3 I would kill myself if I had the chance.</p> <p>10 0 I don't cry any more than usual.<br/>1 I cry more now than I used to.<br/>2 I cry all the time now.<br/>3 I used to be able to cry, but now I can't cry even though I want to.</p> <p>11 0 I am no more irritated now than I ever am.<br/>1 I get annoyed or irritated more easily than I used to.<br/>2 I feel irritated all the time now.<br/>3 I don't get irritated at all by the things that used to irritate me.</p> | <p>12 0 I have not lost interest in other people.<br/>1 I am less interested in other people than I used to be.<br/>2 I have lost most of my interest in other people.<br/>3 I have lost all of my interest in other people.</p> <p>13 0 I make decisions about as well as I ever could.<br/>1 I put off making decisions more than I used to.<br/>2 I have greater difficulty in making decisions than before.<br/>3 I can't make decisions at all anymore.</p> <p>14 0 I don't feel I look any worse than I used to.<br/>1 I am worried that I am looking old or unattractive.<br/>2 I feel that there are permanent changes in my appearance that make me look unattractive.<br/>3 I believe that I look ugly.</p> <p>15 0 I can work about as well as before.<br/>1 It takes an extra effort to get started at doing something.<br/>2 I have to push myself very hard to do anything.<br/>3 I can't do any work at all.</p> <p>16 0 I can sleep as well as usual.<br/>1 I don't sleep as well as I used to.<br/>2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.<br/>3 I wake up several hours earlier than I used to and cannot get back to sleep.</p> <p>17 0 I don't get more tired than usual.<br/>1 I get tired more easily than I used to.<br/>2 I get tired from doing almost anything.<br/>3 I am too tired to do anything.</p> <p>18 0 My appetite is no worse than usual.<br/>1 My appetite is not as good as it used to be.<br/>2 My appetite is much worse now.<br/>3 I have no appetite at all anymore.</p> <p>19 0 I haven't lost much weight, if any, lately.<br/>1 I have lost more than 5 pounds. I am purposely trying to lose weight.<br/>2 I have lost more than 10 pounds. by eating less. Yes _____ No _____<br/>3 I have lost more than 15 pounds.</p> <p>20 0 I am no more worried about my health than usual.<br/>1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.<br/>2 I am very worried about physical problems and it's hard to think of much else.<br/>3 I am so worried about my physical problems that I cannot think about anything else.</p> <p>21 0 I have not noticed any recent change in my interest in sex.<br/>1 I am less interested in sex than I used to be.<br/>2 I am much less interested in sex now.<br/>3 I have lost interest in sex completely.</p> |
|---|--|

Reproduction without author's express written consent is not permitted. Additional copies and/or permission to use this scale may be obtained from: CENTER FOR COGNITIVE THERAPY, Room 602, 133 South 36th Street, Philadelphia, PA 19104

© 1978 by Aaron T. Beck, M.D.

## Appendix

**Beck Anxiety Inventory**

Name \_\_\_\_\_ Date \_\_\_\_\_

Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY by placing an X in the corresponding space in the column next to each symptom.

		Not at all	Mildly It did not bother me much	Moderately It was very un- pleasant but I could stand it	Severely I could barely stand it
1	Numbness or tingling.				
2	Feeling hot.				
3	Wobbliness in legs.				
4	Unable to relax.			X	
5	Fear of the worst happening				
6	Dizzy or lightheaded.				
7	Heart pounding or racing.				X
8	Unsteady.				
9	Terrified.				
10	Nervous.				
11	Feelings of choking.				X
12	Hands trembling.				X
13	Shaky.				
14	Fear of losing control.				X
15	Difficulty breathing.				X
16	Fear of dying.				
17	Scared.				
18	Indigestion or discomfort in abdomen.				
19	Faint.				
20	Face flushed.				X
21	Sweating (not due to heat).				

Appendix

FOOD CONSUMPTION RECORD

Date _____ Day _____					
Time	Food and liquid consumed	Place	B	V/P	Situation/Feelings/ Behaviour

## Appendix

## SCHEMA QUESTIONNAIRE

Developed by  
Jeffrey Young, Ph.D. & Gary Brown, M.Ed.

Name \_\_\_\_\_ Date \_\_\_\_\_

**INSTRUCTIONS:** Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When there is a conflict, base your answer on what you emotionally feel, not on what you rationally believe to be true.

If you desire, reword the statement so that the statement would be even more true of you. Then choose the highest rating from 1 to 6 that describes you during your life (including your revisions), and write the number in the space before the statement.

**RATING SCALE:**

- 1 Does not fit me at all during my life.
2. True of me for a period during my life, but not for a major part.
3. True of me right now, but has not generally been true during my life.
4. Somewhat true of me for a major part of my life.
5. Mostly true of me for a major part of my life.
6. Describes me perfectly for most of my life.

**EXAMPLE:**

  4   I worry that people <sup>I care about</sup> will not like me.

**AUTONOMY****I. DEPENDENCE**

- 6   1. I do not feel capable of getting by on my own.
- 6   2. I need other people to help me get by.
- 6   3. I do not feel I can cope well by myself.
- 6   4. I believe that other people can take care of me better than I can take care of myself.
- 6   5. I have trouble tackling new tasks unless I have someone to guide me.
- 6   6. I think of myself as a dependent person.

## II. SUBJUGATION/LACK OF INDIVIDUATION

- 5 7. I let other people have their way.
- 5 8. I think that if I do what I want, I'm only asking for trouble.
- 6 9. I feel I have no choice but to give in to other peoples' wishes.
- 6 10. I put others' needs before my own.
- 6 11. In relationships, I let the other person have the upper hand.
- 5 12. I find it difficult to be myself with other people.
- 5 13. I really don't know what I want for myself.
- 6 14. I can't express my anger because others will disapprove or leave me.
- 6 15. I feel the major decisions in my life were not really my own.
- 6 16. I feel guilty because I let people down or disappoint them.
- 6 17. I give more to other people than I get back in return.
- 6 18. I worry about pleasing other people.
- 5 19. A lot of anger and resentment builds up inside of me that I don't express.
- 6 20. I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.

## III. VULNERABILITY TO HARM OR ILLNESS

- 4 21. I can't seem to escape the feeling that something bad is about to happen.
- 1 22. I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.
- 1 23. I worry about becoming a street person or vagrant.
- 1 24. I worry about being attacked.
- 1 25. I am very careful about money or else I might end up with nothing.
- 1 26. I take great precautions to avoid getting sick or hurt.
- 1 27. I worry that I'll lose all my money and become destitute.
- 1 28. I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.

2 29. I am a fearful person.

     30. I prefer to take the secure or familiar way of doing things rather than risk the unexpected.

3 31. I think a lot about the bad things happening in the world: crime, pollution, etc.

#### IV. FEAR OF LOSING SELF-CONTROL

6 32. I worry about losing control over my actions.

4 33. I often feel that I might go crazy.

6 34. I often feel that I'm going to have an anxiety attack.

6 35. I worry that I might start blushing or sweating in front of other people.

6 36. I often feel on the verge of crying uncontrollably.

2 37. I worry that I might not be able to resist my sexual urges.

6 38. I worry that I might seriously harm someone physically or emotionally if my anger gets out of control.

6 39. I feel that I must control my emotions and impulses or something bad is likely to happen.

#### CONNECTEDNESS

#### V. EMOTIONAL DEPRIVATION

5 40. No one is there to meet my needs.

5 41. I don't get enough love and attention.

     42. I have no one to depend on for advice and emotional support.

5 43. I don't have anyone to nurture me, share themselves with me, or care deeply about everything that happens to me.

3 44. I don't have anyone who wants to get close to me and spend a lot of time with me.

1 45. I could disappear from the face of the earth and not really be missed.

? 46. My relationships are basically superficial.

? 47. I don't feel as if I am a special person to anyone.

4 48. No one really listens to me, understands me, or is tuned into my true needs and feelings.

#### VI. ABANDONMENT/ LOSS

5 49. I'm destined to be alone forever.

     50. I worry that someone I love will die soon, even though there is little medical reason to support my concern.

6 51. I find myself clinging to people I'm close to.

6 52. I worry that people I feel close to will leave me or abandon me.

5 53. I feel that I lack a stable base of emotional support.

6 54. I don't feel that important relationships will last; I expect them to end.

#### VII. MISTRUST

4 55. I feel that many people are out to hurt me and take advantage of me.

4 56. I must protect myself from other people's attacks and put downs.

1 57. The best way for me to avoid being hurt is to attack first.

3 58. I feel that I must get revenge for the way people have treated me.

6 59. I feel that I cannot let my guard down in the presence of other people.

2 60. If someone acts nicely toward me, I assume that they must be after something.

2 61. It is only a matter of time before someone betrays me.

     62. Most people only think about themselves.

     63. I have a great deal of difficulty trusting people.

2 64. I am quite suspicious of other people's motives.

#### VIII. SOCIAL ISOLATION/ALIENATION

? 65. I don't fit in.

? 66. I'm fundamentally different from other people.

- ? 67. I don't belong; I'm a loner.
- ? 68. I feel alienated from other people.
- 6 69. I feel isolated and alone.

#### WORTHINESS

#### IX. DEFECTIVENESS/ UNLOVABILITY

- 4 70. No man/woman I desire could love me once he/she saw my defects.
- 4 71. No one I desire would want to stay close to me if he/she knew the real me.
- 4 72. I am inherently flawed and defective.
73. No matter how hard I try, I can't get a significant man/woman to respect me or feel that I am worthwhile.
- 4 74. I'm unworthy of the love, attention, and respect of others.

#### X. SOCIAL UNDESIRABILITY

- ? 75. I'm not sexually attractive.
- 6 76. I'm too fat.
- 6 77. I'm ugly.
- 1 78. I can't carry on a decent conversation.
- 1 79. I'm dull and boring in social situations.
80. People I value wouldn't associate with me because of my social status (e.g., income, educational level, career).
- 4 81. I never know what to say socially.
- 1 82. People don't want to include me in their groups.

#### XI. INCOMPETENCE/ FAILURE

- 5 83. Almost nothing I do is as good as other people can do.
- 5 84. I'm incompetent.
- 6 85. Most other people are more capable than I am.

- 2 86. I screw up everything I try.
- 2 87. I'm inept.
- 6 88. I'm a failure.
- 3 89. If I trust my own judgment, I'll make the wrong decision.
- 3 90. I lack common sense.
- 3 91. My judgment cannot be relied upon.

## XII. GUILT/PUNISHMENT

- 3 92. I'm essentially a bad person.
- 3 93. I deserve to be punished.
- 2 94. I don't deserve pleasure or happiness.
- 3 95. When I make a mistake, I deserve strong criticism and punishment.
- 3 96. I can't let myself off the hook easily or make excuses for my mistakes.
- 3 97. I feel very guilty over mistakes I have made.
98. I can't seem to live up to my religious or moral principles in certain ways, no matter how hard I try.
- 3 99. I often feel guilty without knowing why.

## XIII. SHAME/EMBARRASSMENT

- 6 100. I am humiliated by my failures and inadequacies.
- 4 101. I am too inferior or unacceptable to reveal my failings to other people.
- 4 102. If others found out about my defects, I could not face them.
103. I often feel embarrassed around other people because I don't measure up to them.
- 4 104. I am very self-conscious around other people.

## XIV. UNRELENTING STANDARDS

- 4 105. I must be the best at most of what I do; I can't accept second best.

- 3 106. I strive to keep almost everything in perfect order.
- 4 107. I must look my best most of the time.
- 2 108. I try to do my best; I can't settle for "good enough."
- 2 109. I have so much to accomplish that there is almost no time to really relax.
- 4 110. Almost nothing I do is quite good enough; I can always do better.
- \_\_\_ 111. I must meet all my responsibilities.
- \_\_\_ 112. I feel there is constant pressure for me to achieve and get things done.
- \_\_\_ 113. My relationships suffer because I push myself so hard.
- \_\_\_ 114. My health is suffering because I put myself under so much pressure to do well.
- \_\_\_ 115. I often sacrifice pleasure and happiness to meet my own standards.

#### XV. ENTITLEMENT/ INSUFFICIENT LIMITS

- \_\_\_ 116. I have a lot of trouble accepting "no" for an answer when I want something from other people.
- 2 117. I often get angry or irritable if I can't get what I want.
- 2 118. I'm special and shouldn't have to accept many of the restrictions placed on other people.
- 2 119. I hate to be constrained or kept from doing what I want.
- 6 120. I have great difficulty accepting aspects of my life that aren't the way I want them to be, even though objectively my life is good.
- 6 121. I have great difficulty getting myself to stop drinking, smoking, overeating, or other problem behaviors.
- 2 122. I can't seem to discipline myself to complete routine or boring tasks.
- 2 123. Often I allow myself to carry through on impulses and express emotions that get me into trouble or hurt other people.

COPYRIGHT 1989 Jeffrey Young, Ph.D., and Gary Brown, M.Ed. Unauthorized reproduction without written consent of the authors is prohibited. For more information, write: Cognitive Therapy Center of New York, 111 West 88th St., New York, NY 10024.

References

- Bromley, D.B. (1986). The Case-Study Method in Psychology and related disciplines. Chichester: Wiley.
- Bruch, H. (1985). Four Decades of Eating Disorders. In Garner, D.M. and Garfinkel, P.E. (Eds.) Handbook of Psychotherapy for Anorexia and Bulimia. Chap. 2. New York: Guilford Press.
- Colliazi, P. (1978) Psychological Research as the Phenomenologist Views It. In Valle, R. and King, M. Existential Phenomonological Alternatives for Psychology. Ch. 3. New York: Oxford University Press.
- Cooper, T. (1987) Anorexia and Bulimia: The Political and the Personal. In Lawrence, M. Fed up and hungry - Woman, Oppression and Food. Chap. 12. Aylesbury, Bucks.: The Woman's Press.
- Diagnostic and Statistical Manual of Mental Disorders (1987) - Revised Edition, Washington, D.C.: American Psychiatric Association.
- Dana, M. (1987) Boundaries: One-way mirror to the Self. In Lawrence, M. Fed up and hungry - Woman, Oppression and Food. Chap. 3. Aylesbury, Bucks.: The Woman's Press.

- Edwards, D.J.A. (1989 1) Case Study Research Method:  
The Hidden Cornerstone of Theory and Practice in  
Cognitive therapy. Poster presentation at World  
Congress of Cognitive Therapy, Oxford.
- Edwards, D.J.A. (1989 2) Case Study Research Method.  
Honours Practical Programme, Grahamstown, Rhodes  
University.
- Edwards, D.J.A. (1987) Cognitive-behavioural and  
Existential-phenomenological Approaches in therapy:  
Complimentary or Conflicting Paradigms?. Paper  
presented at the Annual Congress of the Psychological  
Association of South Africa, University of Cape Town.
- Fairburn, C.G. Cognitive-Behavioral Treatment for Bulimia.  
In Garner, D. and Garfinkel, P.E. (1985) (Eds.)  
Handbook of Psychotherapy for Anorexia and Bulimia.  
Ch. 8. New York: Guilford Press.
- Garner, D. M. and Garfinkel, P. E. (1985) (Eds.)  
Handbook of Psychotherapy for Anorexia Nervosa and  
Bulimia. New York: Guilford Press.
- Johnson, C. (1985) Initial Consultations for Patients  
with Bulimia and Anorexia. In Garner, D.M. and  
Garfinkel, P.E. (Eds.) Handbook of Psychotherapy for  
Anorexia Nervosa and Bulimia. Ch. 3 New York:  
Guilford Press.

- Kratochwill, T.R., Mott, S.E. and Dodson, C. L. (1984) Case Study and Single-Case Research in Clinical and Applied Psychology. In Bellack A.S. and Hersen. M. (Eds.) Research Methods in Clinical Psychology. New York: Pergamon.
- Kruger, D. (1980) The White Therapist and the Black Client - a problem of cross cultural contact. Psychotherapeia, 6, (3), July.
- Lawrence, M. (1987) Fed Up and Hungry - Woman, Oppression and Food. Ayelsbury, Bucks.: The Woman's Press.
- Orbach, S. (1986) Fat is a Feminist Issue. London: Arrow.
- Sundberg, N.S. (1977) Assessment of Persons. New Jersey: Prentic Hall.
- Valle, R. and King, M. (1978) Existential Phenomological Alternatives for Psychology. New York: Oxford University Press.
- Yager, N. and Edelstein, P. (1985) The Outpatient Management of Bulimia. In Kaye, W.H., Gwirtsman, H.E. (Eds.) A Comprehensive Approach to the Treatment of Normal Weight Bulimia. Washington, D.C.: American Psychiatric Press.

Young, G. (1989) Schema-Focused Cognitive Therapy for  
Personality Disorders and Difficult Patients.  
Sarasota, Florida: Professional Resource Exchange, Inc.

