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A Thematic Guide To Bulimia Nervosa

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This article offers a thematic guide to bulimia nervosa for both therapists and clients. It explores the relationship of common themes — developmental, interactional, sociocultural and behavioural — to the central issue of control. It uses examples from therapy sessions to highlight the themes as they emerge in therapy and to illustrate the ways in which the problem may be addressed.

INTRODUCTION

Bulimia nervosa is multifaceted; it is a disorder in which complex interactional, sociocultural, developmental and behavioural themes interact to predispose certain individuals to develop the problem. Successful treatment of bulimia nervosa requires careful path finding through the therapeutic terrain formed by these recurrent therapeutic themes. The thematic guide presented in this article maps the somewhat rocky and confusing terrain of bulimia nervosa. Path finding is enhanced by the adoption of a systems based analysis of the problem, one that considers this often interactional problem from multiple perspectives.

The central issue from all perspectives is that of control, that is, the perception by the client that an external event or person is restraining the client's action. This central issue of control is crucial in understanding women who have bulimia nervosa and presents dilemmas for both client and therapist.This paper explores these dilemmas, using examples from case studies to illustrate ways in which the problem may be addressed.

THEMATIC GUIDE OVERVIEW

Interactional themes

This theme usually relates to the client's relationship with a controlling 'significant other'. This may be a parent, friend, husband or boyfriend who is perceived by the client as 'controlling', or attempting to control some aspect of her behaviour. This theme also recognises the issues of control and power between therapist and client.

Sociocultural themes

Sociocultural issues include all the cultural and social forces that play a part in the formation of the problem. These issues arise from the constraints imposed on women by the notion of femininity and the ideal of womanhood actively promoted in our culture, predominantly through the media.

Developmental themes

Developmental sub-themes are reflected in the client's transition from late adolescence to early adulthood. She must come to terms with the dilemmas presented by the developmental stage and complete the tasks characteristic of this passage. The most complex dilemma centres on the changing roles of women in a rapidly changing society. The most common tasks arise from the need to resolve her ambivalence about her dependence on and independence from her family of origin.

Behavioural themes

Behavioural themes are revealed in the addictive habit of bingeing and purging and the secrecy that grows up around this habit. It is ironic that a behaviour that begins as a way to control weight ultimately ends by extending its control into every facet of their lives. A number of behavioural tasks are useful for coming to terms with this aspect of the problem.

INTERACTIONAL THEMES

Control, or attempted control by others, presents as the constellating issue in the interactional domain. During therapy clients often speak of a parent who is 'controlling', or showing some controlling behaviour, in relation to his or her daughter's problem. One client depicted her mother as 'super achieving' and her father as 'controlling'. The mother had been off and on diets most of her life and was so attuned to the regulation of own weight that she could look at any photo of herself and know exactly what she weighed. She often used food as a reward for the children's good behaviour. The father was 'very self controlled' — he was obsessive about fitness and tried to control his family's access to the kitchen.

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Parents still exert their controlling influence, or try to, even with children well into their adulthood. One mother, understandably alarmed by her daughter's problem, attempted to control her daughter's bulimic symptoms by questioning her after she suspected her daughter had been bingeing and vomiting. Unfortunately, given the client's sensitivity to issues of control, this attempted solution exacerbated the problem and a related problem grew up about the control or ownership of the bulimia. If the daughter perceived that mother was questioning too much, she increased the frequency of bingeing and vomiting.

In this case, it seemed important to encourage a two-sided and circular description of events (Selvini Palazzoli *et al.*, 1978). Both mother and daughter were asked to consider their mutual interaction around the problem. For example, I asked the daughter: *How does your not speaking about the problem encourage your mother to ask you lots of questions?*. I asked the mother: *How does your asking questions when your daughter comes home encourage her to keep the problem a secret from you?*

Similar circular patterns have occurred for other clients in response to 'over involvement' by boyfriends, husbands or friends. When one client's boyfriend took it upon himself to rebuke his girlfriend whenever he thought she had binged, she responded by deliberately defying his rebuke with another and often more severe binge. Concurrently he was attempting to reduce his alcohol intake. However, in turn, he responded to this covert message of defiance with an alcoholic binge. Unfortunately, both people in this interaction, though well intentioned, increased their addictive behaviour in response to each other's attempts to help them. The attempted solution exacerbated the difficulties and another problem grew up about ownership of the original problem. Open disagreement with the other's emotional incursion was never entertained, the need for compliance being too strong to allow the expression of outright anger or even disapproval.

Another client's sense of control over her acceptability and desirability was given over to others — that is, friends exerted indirect control as she compared herself to their unexpressed standards and found herself wanting. She was acutely aware of what she perceived to be her peers' mocking eyes: eyes that seemed to dictate a strict adherence to norms about dress codes, acceptable weight levels and physical appearance. Her perception of the eyes of others was that they were like fun-parlour mirrors distorting and magnifying her body. Another client compared herself physically, emotionally and professionally to others, often feeling envious of their achievements or physical appearance. She was encouraged to reframe feelings of envy as indicators of her own ambition, beacons pointing the way to her desires, and to use the energy released by such emotion as a strong motivating drive for achieving goals she set for herself.

If control presents as a contentious issue in relationships with family, friends and lovers, it follows that it will also present as a central theme in the therapist-client relationship. As Tamar Selby (cited in Lawrence, 1987, page 97) writes:

> Many women who come from a controlling environment will either go on being in one all of their lives, by exchanging fathers or mothers for husbands or lovers, or they will create a controlling environment for others. They may marry husbands whom they feel they can coerce or live with lovers whom they can control. They will also behave in a controlling manner with their own children. In therapy, maybe for the first time in their lives, women with these sorts of difficulties will be faced with the possibility of neither of these alternatives. It is a hard struggle for the woman and her therapist to get out of this pattern, but it is only when the client, through understanding, lets go of her need to control or be controlled that change can begin.

Clients commonly believe that they are not in control of the counselling process; they often feel they do not have any choices no matter how client-centred an approach the therapist may adopt. It is almost as if the therapeutic process of itself will fulfil some prearranged plan with preordained outcomes, none of which are of the client's construction.

Once the client knows she can influence the process she will take a more active role in the choice of subject to be discussed. One client said she was not aware she had options until I asked if she would like to make time in the session to talk about something of particular significance to her. Until that time she did not realise she could define the parameters of our discussion.

Many clients are not aware of their own power and influence in the therapy sessions. They feel they are emotionally invisible and so much of their time is spent searching for clues from the therapist as to their own worthiness that they are unaware of the effect of their own contribution to the process. Pleasing the therapist becomes a damaging game where both lose out on a deepening of the relationship to a more authentic level. Attempts at control are indirect and powerful and often inversely proportional to the degree of the client's unconsciousness about them.

There are many examples of clients' covert attempts at control within therapy. The client may attempt to control the conversational stream by indirect and frustrating (for the therapist!) methods. Questions are ignored and topics inexplicably changed. Tasks, even though suggested by the client, are forgotten by the following session. The therapeutic hour comes and goes with the client yet again forgetting to attend, or arriving late. If the therapist, in a weaker moment, accepts the invited position of all powerful expert, the client will work hard to kick him or her back down as quickly as she/he was elevated. Even the client's own suggestions are countered with that persistent and elusive game of *yes-but.*

This sensitivity to control in the client-therapist relationship necessitates influencing the client without controlling her. It also means that room should be made for mutual influence in a matching symmetrical stance. If the client perceives my actions or words as a direct controlling force, I alienate the client or become an unwitting participant in an endless symmetrical game of 'cure me — you can't cure me' (Selvini Palazzoli, 1978). The use of an enquiring attitude, an attitude of curiosity on

the part of the therapist, is an extremely useful ally in the avoidance of symmetrical games and underpins the therapeutic practices suggested here.

Questions are the chief tool. Tomm (1988, page 2) proposed that

> the predominant linguistic form will have an important effect on the nature and direction of the evolving conversation.

If the predominant linguistic form is questioning, then the client will take 'centre stage' as her experiences, goals, perceptions and concerns are repeatedly called forth. Explicitly at least, the therapist takes back stage. If the question is genuinely a question and not a disguised statement, then clients may access their own resources about a problem. Client autonomy is fostered. The client may also feel a sense of personal achievement when problems are overcome, in that she has not relied on the 'expert knowledge' of the therapist. *What would be useful for you to talk about today? How would you like to approach this topic? What tasks would you like to try this week?* These are the kinds of questions that allow the psychological space necessary for client autonomy.

SOCIOCULTURAL THEMES

Sociocultural themes emerge either directly or indirectly at some point during therapy. The emergence of these themes signals the need for both therapist and client to challenge perceived societal prescriptions about femininity. Some of these themes are pertinent to bulimia nervosa; some would apply to the development of many psychiatric disorders.

Five sociocultural sub-themes cluster around clients' notions of femininity.

1. Passivity as a gender linked characteristic

Many clients depict themselves as passive observers of their own lives rather than as active agents. For example, one client, a student, would not consider asking a lecturer for guidance, would not speak up in tutorials for fear of saying the wrong thing, and befriended her boyfriend's friends rather than pursuing friends of her own. If one views this theme from an individual perspective, a passive, reactive stance and a feeling of being ineffective in the world are predictable companions to repeated feelings of being out of control with food.

From a societal viewpoint, theorists (Wolf, 1990; Orbach, 1986; Duker and Slade, 1988) argue that this sense of ineffectiveness, and the face of passivity that it presents to the world, stems from the invalidation and marginalisation of many women's experience. They argue that this externally imposed invalidation is reinforced by a female cultural tradition of denying a woman's own wants and emotions in order to nurture others. The client's emotional invisibility damages her expression of self through not feeling free to communicate her desires and feelings. A woman unconsciously steeped in this self-effacing heritage often feels protected by a mantle of moral 'good' if she can control such 'bad' desirous feelings.

One of the first tasks of therapy is the cultivation of a sense of self replete with likes and dislikes and the identification of emotional options and opportunities for decisive action. The exercise of effective choice is an affirmation of self. Here a woman gives to her own experience the currency she offers to the experiences of friends, family, husband and lovers. A client can be assisted to become aware of herself and to exercise choice, and thus combat passivity through the therapist encouraging the client to

- define the problem
- construct goals for her own life
- choose tasks she will perform in between sessions
- control the rate of therapeutic progress.

Particularly helpful are the therapist's use of a coherent attitude of enquiry, through appropriate questions rather than therapist advice, and the encouragement of the client as an active agent in the struggle with bulimia nervosa. On this latter point, it is productive to search for ways in which the client has had past wins over the bulimia nervosa, because it is through these ways that she may find long-term solutions. The search for solutions in the client's own experience is often helped by externalising the problem (White, 1987), that is, using language to locate the problem outside the person. For example, calling the problem 'the bulimia' both objectifies and personifies it, and often works to pit the client against the problem. This is particularly so if the therapist uses fighting metaphors when describing the problem to the client. For example, "You were defeating it so it decided to sneak up on you and fight back". Later in therapy, an exploration of the societal messages about women's roles and the cultural and religious traditions that link ascetism and aesthetics with denial and passivity may be needed (Chernin, 1989; Lawrence, 1987).

2. Indirect emotional expression

The second sociocultural theme involves societal restraints against female direct expression of emotions, particularly anger. Clients frequently confuse emotional 'hunger' with physiological hunger; they 'eat over emotional feelings' rather than 'talk the feelings up'.

Sometime early in therapy I set the task of distinguishing between hungry feelings and emotional feelings. Some clients report back the following session that they were simply hungry from food restriction. Others use food to handle strong emotion. If clients perceive they have committed emotional 'sins' by demanding too much, or asking for redress for a slight by another, then food becomes a vehicle for handling the turbulent and conflicting emotions that ensue. One client, after her father threw her belongings out the door, to which she responded by demanding that he show her respect, quelled her strong conflicting feelings with a binge. Another, after being told of her incompetence at work, went home to both comfort and punish herself with a lengthy binge. The comfort/punish dichotomy reflects the client's conflicted feelings about nurturing herself.

Abuse of food intake attempts to cope with emotional upset. The client should be encouraged to 'feed' all her different emotional needs from a variety of sources other than food rather than 'stuff or dull down the emotions with food'. It is common that a client who is getting on top of the bulimia will begin to feel very angry. Feelings of anger towards another can be usefully reframed as a positive sign, an affirmation that the client is winning the fight against the bulimia. Ways of expressing emotions and dissatisfaction to another, without getting the other offside, are provided by the principles and practices of assertiveness training and conflict resolution. Clients benefit from awareness and practice of 'I' statements and 'detoxified' messages (Bloom, 1975). Where anger arises from deep within the psyche, as with abuse in childhood, more intensive anger management strategies may be needed (Bass, 1988; Lerner, 1986).

Even when clear about the nature of the feelings they experience, clients often feel that their emotional needs are of less importance than the emotional needs of their boyfriends, friends, husbands or family members and that they are less entitled to the attention and validation of others. Anger is less common for them. In the words of Brownmiller (1986, page 163):

> Anger in a woman isn't 'nice'. A woman who seethes with anger is' unattractive'. An angry woman is hard, mean and nasty; she is unreliable, unprettily out of control. The endless forbearance demanded of women, described as the feminine virtue of patience, prohibits an angry response.

For women trained in this tradition, the immediate response to disappointment and hurt is to feel hopeless and helpless and to continue in the feminine tradition of compliance and agreeability (Boskind-Lodahl and White, 1983, page 50). Orbach (1986, page 140) observed "in woman after woman..... a pattern in which needs and initiations are ignored, disparaged or thwarted in some way".

Like Orbach's clients, most of my bulimic clients report feeling that they need to control their own responses in order to answer the needs of others. For example, one client felt that she must not 'speak up' about her boyfriend's continual lateness. She felt that she did not have a right to express her anger, indeed, that she did not have a right even to feel angry let alone request a change of behaviour. Her confusion in initial sessions centred on what she called "inappropriate emotions"; her response to the boyfriend's lateness was that her emotion, her anger, was inappropriate. Her role, as she perceived it, was to be emotionally invisible — to control the expression of her feeling and occasionally to obliterate that feeling. Unfortunately, this response to strong emotion also damages the sense of self, because a sense of entitlement to feelings and emotions is intrinsic to personal choice and the definition of oneself in the world.

3. The 'ideal' versus the 'real'

The third sociocultural theme involves the prescription about idealised weight and appearance that predominantly comes from the media.

Despite an intellectual awareness of the damaging effects of these images on their self-image, my bulimic clients invariably feel inadequate about their weight and want to be thinner. Each perceives herself as if through the eyes of a critical phantom onlooker and finds herself wanting.

She does not seem to know herself from the *inside out* — from the sense of unique rightness about one's body that is the lot of children — but rather from the *outside in,* from critical eyes that stretch endlessly onwards as in a long hall of mirrors (Orbach, 1986). Because she has an *outside in* perspective, she is an ardent watcher of others, so that the slightest nuance — an expression on the face, a movement of the hands — is perceived as confirmation or rejection by the other. Her self is validated or otherwise by what others think she should be and feel. This perceived critical gaze by others puts this facet of the theme within the strong tradition of a woman regarding herself as a commodity, an item to secure a man. Though societal conditions are changing, a woman's position in life is still economically, socially and politically precarious.

Since the core of her being is built around pleasing others, she is faced with the sometimes impossible task of making her body into whatever is currently acceptable. The struggle to close the gap between the ideal and the real represents another facet of the central issue of control in that it discourages self determination and opts for comparison and rejection. If the client could gaze through eyes that were located in the female tradition of nurture and acceptance the goal of therapy, the client's self-acceptance and self-nurture, would be greatly enhanced.

The cultivation of an awareness and acceptance of difference presents as an important task for therapy. Social practices that construct women in distinct categories by lumping them into 'the ideal' or 'the unattractive' constitute an external logic, one that converts an average difference into a categorical difference (Connell, 1987). 'The ideal' disregards the tremendous degree of difference in the human form. 'The ideal' constricts, denies and excludes. 'The ideal' is an *outside in* perspective — a curious one given the different historical and geographical constructions of the human form. As Brownmiller (1986) comments, Botticelli's Venus is slender enough by today's standards but Tintoretto's *Susannah,* or the harem women in the *Turkish Bath* by Ingres, while *de rigeur* in their day, are very much larger and far from today's 'ideal'.

Direct challenges to societal norms of 'the ideal' are likely to be met by an equally intense defence of them. This is particularly true for those in the late adolescent age group, even when the client intellectually understands the damaging effects of attempting to conform to the 'ideal'. The presentation of dilemmas (White, 1986a, page 64; White 1986b, page 174), however, allows the client to realise that she can choose whether she wants to live for herself or according to others' ideas of who she should be. Dilemmas are two-sided descriptions that reflect the client's ambivalence about change although the language selected by the therapist is often biased towards one of the options. For example: *Should you move forwards to a life*

where you are independent and trying out new and risky things or should you mark time in a more dependent life, one where you need others' approval before you can try a new behaviour and where you must always look to others to get what you need? presents two possible future developmental pathways subtly highlighting one as more preferred.

Younger adolescent clients who still live at home under the control of and dependent on their parents can be invited to question the validity of 'the ideal' portrayed in the media and reinforced by peer group pressure. They can also be encouraged to examine the attempts of the media to manipulate them and their peers.

4. Food restriction as a career — a full-time job

'The ideal', as pursued through body and food regulation with my clients, often takes on the patina of a career. The dynamic play between effectiveness and ineffectiveness, achievement and failure finds expression in food. The cyclic episodes of stuffing and purging polarise her days between the domination of 'the good self' (that is self-denying, nurturing others, self-absent) and 'the greedy self' (that is, full of self, self-indulgent self-nurturing). Achievement is epitomised by a day of being 'good', of going without, and stands in sharp relief to 'bad' days of gluttony. The client aspires to greater and greater success and in the process feels worse and worse because the success she aspires to seriously damages her self, as does her self-castigation when she 'fails to deny' her self yet again.

The construction of goals is crucial in directing energy away from this mirage of a life. In light of the dilemmas posed, the client is then encouraged to look at her life and find out where she wants to go. Goals are identified through positive outcome questions (de Shazer, 1985; Kowalski, 1989). For example: *How will you know when things are going better for you?* or *How will you know when the problem is solved?* These questions use language that assumes a positive outcome, one where change is not only possible, it is inevitable. The structure of the question *How will you know....?* invites the client to identify indicators that the goal has been achieved. 'Miracle' questions and 'video' questions are also beneficial here. For example: *"If a miracle happened overnight while you were asleep and tomorrow morning you found yourself (insert client-generated goal such as free from the symptoms, happy, satisfied with your life) what would be happening differently?* and the video question: *If I had two videos of you, one where the problem was gone and one where you had the problem, what would I be noticing about the one without the problem?* then *What would I notice that is different about you in that one?* These questions can be followed by 'first sign' questions or 'first step' questions. For example, *What will be the first sign that this goal has been achieved?* or *What will be the first step towards this goal?* Once the client begins to substitute achievement in the outside arena for success with food regulation, the search for satisfying work and the clarification of values becomes very important. Encouraging the pursuit of her values helps set the client up for success, whereas encouraging the pursuit of certain positions or jobs may set the client up for failure and distress, and perhaps a return to the bulimic pattern. For example, I encouraged a client, who had set as her goal a certain senior public service position, to discover the values underlying that particular position. For her these were to make a contribution to society, to have financial success and to receive acknowledgment from others for what she did. Many jobs and positions could have fitted this value description and she gradually opened out to different potentialities and possible sources of career satisfaction. A broad value orientation allows the perception of satisfaction from many different positions. This is an *and/also* approach to life rather than the characteristic bulimic *either/or* approach; the latter unfortunately impoverishes life's complexity.

5. The existential way station

Ironically, the cyclic episodes of stuffing and purging provide a sense of order and purpose in the client's life. So much so that the prospect of the existential vacuum left by a 'cure' is frightening, and is often enough to send the client scuttling back to the safety of earlier predictable patterns. One client found the absence of polarised tensions in her cure profoundly disturbing, as if the future was a great void, empty of purpose. It was as if food had fuelled the engine that had hurtled her around a circular railway for many years; abandoning the ritualistic grooves left her stranded at an existential way station, bereft of meaning.

Authenticity — being true to herself and acknowledging the full potential within her — demands that the client let go of rigid ways of being. Authenticity demands that she face the subsequent anxiety, terrifying though it is. However, like the bright gash of a fanned ember, the anxiety can shed its death-like shell and reveal itself as a catalyst for growth, urging her to take action for change.

Bugental (1978, page 79) says

> the client must go out of control for at least a brief period because the ways in which control has previously depended have been bound up with old patterns of being. Until they are truly let go of, they cannot be replaced.

Here, the prediction of temporary relapse by the therapist can help cushion the inevitable angst that the client must go through in order to find a more solid sense of self. I often verbalise the prediction that a change in her behaviour, attitude or feeling might be marked by confusion and accompanied by a brief return to the former bulimic behaviour. I 'normalise' this relapse, if it does occur, by saying that it is acceptable given the radical change in direction. In preparing for a relapse the client is asked how she will cope if a relapse occurs. Contingency plans can be developed by client and therapist by asking how she will remember to keep on the right path. Metaphors that describe the process of recovery as a search for new meaning, or the beginning of a journey, and that allow a period of confusion while the client finds her feet, are useful.

One effective image is that of the client clinging to wreckage after a shipwreck. In this metaphor the client decides to abandon the safety of the life raft because it is being swept out to sea and to swim to shore. Just when she is the most tired and very close to shore, she must battle huge waves that might sweep her back out to sea. The final struggle finds her at the shore disoriented and exhausted, needing to rest and to ready herself for the beginning of the journey home.

DEVELOPMENTAL THEMES

There are three sub-themes to the developmental theme that often accompany bulimia nervosa: the societal, the interactional and the intrapersonal.

1. The societal: rites of passage

From a developmental perspective, the significant social and emotional changes that accompany late adolescence and early adulthood mark a transitionary period in life. White's reference (1983) to developmental crises, from the perspective of Gennep's rites of passage for pre-industrial peoples, is pertinent here. It is not unusual in these societies for adolescents to move through periods of disordered relationships with food. Certain foods will be taboo or prepared in a special way and the teenager excluded from everyday society and guided through initiation by designated elders. Perhaps part of the explanation of bulimic behaviour is associated with restrictions and excesses that are played out in our society today: for example, parental prohibitions on type (e.g. 'junk food') and amount, plus conflicting media messages — simultaneously advertising products and warning against empty calories, pimples and weight gain. Abrahams' (1982) study suggests that disordered eating patterns are characteristic of a large proportion of older adolescents.

2. The interpersonal: independence and dependence

Developmental dilemmas are often embodied in clients' ambivalence about desires for dependence on and independence from family of origin. Many clients show these dilemmas in the shift from the safety of the problem and the family to greater risk taking behaviour in the social sphere.

One client's pivotal dilemma, her ambivalence about moving from dependence on to independence from her family of origin, invoked notions of perceived powerlessness. She did and did not want to leave her mother. Leaving would signal her emergence as a female adult with all the responsibilities and risks that this involves. Also, she identified with the perceived powerlessness of her mother and she did not like this. She wanted to do more than move outside the orbit of her mother; she wanted to move outside the orbit prescribed by her mother's domestic female role. This thought often led to shaky and nervous feelings, shifting ground where the client realised she must construct her own rules outside those of her immediate society. The way in which this theme interlocks with the larger societal theme of women's development is reflected in the often difficult relationships between mothers and daughters.

And what of the mother's ambivalent feelings towards her daughter? Her daughter's independence often signals the rejection of the mother's role. The daughter rejects mother's nurturing role and simultaneously reproaches her mother for inadequate nurturing. Some argue that the mother's conflict expresses itself in inadequate emotional feeding of the daughter. Eating becomes the way for daughter to express the many conflicting aspects of the conundrum that is their relationship.

Too often fathers are left out. Luepnitz (1988) cautions us to be wary of the 'mother-bashing' and 'father coddling' that abounds in the clinical literature. Absent fathers impinge on a girl's sense of herself, her psychic conflicts played out with one parent alone, with all the knotted density that this concentration invokes. The father's contribution may be conspicuous by its absence.

3. The intrapersonal: role confusion expressed through food

According to Erik Erikson (1968), the establishment of identity versus role confusion is the core struggle in the period ranging from late adolescence to early adulthood. Young adults are pressured to make occupational choices, to compete in the job market or at university, to become financially independent and to commit themselves physically and emotionally to intimate relationships.

In developmental crises, young women look to their mothers to provide the model for their identity. They may then turn away, confused and ambivalent about the mother's role of nurturing and the role of achieving demanded by a growing section of the society. Given women's history, it is not surprising that food becomes an arena in which this confusion plays itself out. Unfortunately, for some the confusion becomes a habit into which the young woman slips, repeating the same ritualistic taking in and casting out, moving forwards and moving back, risking and scuttling back to the safety of old ways.

BEHAVIOURAL THEMES

Bulimia nervosa has an increasing and insidious hold over the lives of many young women in terms of acquiring food, consuming it and ruminating over it. The link between addiction and bulimia nervosa is well noted in the literature.

Workers in the field have identified apparent similarities between binge-eating and alcohol or substance abuse (Wilson cited in Hawkins, 1984, page 268). Similarities in client descriptions of the problem include 'craving', 'loss of control', post consumptive guilt and depression, and domination of the substance over their lives. Similar to the addiction of an alcoholic or drug-dependent person, women with bulimia nervosa become increasingly driven by their cravings for food. As more and more time is taken up with the consumption, elimination and obsessive ruminations over food, important life choices may be shelved. Indeed, it is not unusual to hear clients speak

about food and weight regulation as if it were a career in itself. Achievement is epitomised by the attainment of a target weight.

Loss of control is the chief feature of the behavioural dimension of the problem. The moments between desire and satiation grow ever more short and triggers for bingeing episodes include a host of seemingly innocent events. Often a night out is a trigger. This is where a client may deny or indulge herself. If she denies herself, she may indulge as soon as she reaches the secrecy of her home. Other stimuli to binges include stepping on the scales and finding a couple of extra kilos or simply remaining at the familiar location of gorging and purging, usually the kitchen. The late afternoons are notoriously difficult, particularly if the client has dieted all day or had a stressful time. Or some days are 'bad' through to the end; breakfast stretches into lunch and lunch into dinner. Discrete meal times become a forgotten routine. The client often feels that she is out of control. Indeed, life contracts to a pristine white fridge glowing in a dark room, dominating every facet of her life with the obsessive ruminations, consumption and elimination of food.

Behavioural tasks designed specifically for the problem need to be addressed by the client predominantly between sessions. These tasks have far more chance of being successful if they are based on the ways in which the client has been successful in the past, and if they are linked in with the client's goals. The following first few therapeutic goals relate to the establishment of good eating habits.

Dieting leads to bingeing: Establish that dieting often leads to bingeing. There is a growing body of research to suggest a causal link between dieting and bingeing so it is sometimes useful to show the client these journal articles. One client found that this was a breakthrough — once she saw the literature she decided to stop dieting.

Three meals a day: Encourage the client to have three meals a day with in-between snacks. We should not forget how radical a departure from the norm this behaviour is, so a gradual introduction is best. Instituting breakfast is a good first step and later, if the client feels able, two meals a day, then three. The important point here is that the meal is discrete, that it has a distinct beginning and end. Ignore the continuation of bingeing during this phase. A useful metaphor is that the client is building up a new life as one would build the scaffolding on a building. The old life will eventually and naturally fall away once the stronger new structures are in place.

Incorporate a taboo food into the diet: Encourage an "and also" approach to food by asking the client to incorporate into her diet a food she has hitherto rejected as taboo. Severe restriction of the variety of foods only invites excess. If the client can experiment with different foods while she is in control, they will not be a trigger to out of control eating.

Normalise the link between eating and social discourse: Offer to conduct a counselling session over lunch. This can be very difficult for the client but the positive benefits are numerous; she trusts you and will follow your lead. You model a discrete beginning and end to the meal, eat slowly and show that sharing a meal can be pleasant with someone you like. You break the stranglehold of secrecy that accompanies eating behaviour. You can talk about how normal it is for the stomach to distend with food and how this should not be taken as a sign of overeating (which is often a cue for a binge).

The reactive effects of record keeping: A useful first session task is to ask the client to keep a diary of bingeing/purging for some time during the ensuing week. I often ask the client during the first phone call to begin recording the number of times she binges and purges. In a sense, this is a paradoxical task because you are asking the client not to change so that you can observe the pattern of bingeing and vomiting. The reactive effects of record keeping are well noted in the behaviourist literature; the very act of observing and noting frequencies, places, emotions and thoughts preceding to and subsequent to the binge-purge episode often decreases the behaviour's occurrence.

Weighing in: Promote the gradual decrease in the number of times the client weighs herself as this is also a common cue for bingeing and purging. Establish a baseline frequency at the beginning of counselling and promote the rewarding of a decrease with a favourite activity (not eating!).

Paradoxical tasks: If the client is not responding to direct attempts to reduce the frequency of bingeing and purging, indirect and paradoxical tasks may be useful. These include asking the client to plan a binge and carry it out with the list of prescribed food. Clients often report not making it through their carefully arranged list and wondering what it was that intrigued them so much in the first place about bingeing after trying this task. Another paradoxical task is to ask the client to have a spontaneous binge when she does not feel like bingeing. The logic here is that the client is asked to try the very thing that she feels she has no control over. If a symptom, by definition, is beyond control then the client is exercising control by choosing to have the symptom. Sometimes the thought of this is enough to avert a binge-purge episode for the client without necessarily carrying out the actual binge.

Do something different: Encourage the client to 'do something different' the next time she feels like a binge. Usually this takes the form of a delay or substitution strategy such as "walk in the garden", "phone a friend" "have a bath" "play your favourite music" or "play with the cat or dog or some children" If the client decides to binge then go through the same strategies before purging.

Identify the gradation of good days and bad days in relation to food: Many clients divide their days into 'good' and 'bad' depending on their ability to restrict food or their ability to go without bingeing. It is good to encourage the client to begin to classify these days along a continuum from 1 to 10. A continuum has the advantage of implying movement or progression and challenges an 'either-or' approach to food.

Dealing with stress: Where the cycle seems to be fuelled by stress, then some of the best remedies are very simple and easily found in the client's life — taking the time for

leisure activities, rest and recreation, exercising regularly, getting enough sleep. Prioritising the day's tasks into 'must do', 'nice to do' or 'don't do' will help to cope with great demands.

Tasks relating to secrecy: This category of tasks addresses the secrecy of bulimia and encourages closer relationships with others. Because bulimia 'feeds on secrecy', the client is asked to tell someone she trusts: this will 'starve' the problem. I usually also ask the client to break the secrecy by a visit to the doctor. This is done to allay health fears as many clients are fearful of the long term effects on their health.

Encourage an attitude of experimentation: Rather than assessing the client's response to tasks as 'pass' or 'fail', clients are encouraged to view their efforts to reduce the bulimic behaviour as experiments, and to consider themselves as experimenters receiving valuable feedback about their efforts to reduce the behaviour.

CONCLUSION

It is hoped that the above analysis assists both therapists and clients to negotiate the confusing and often conflicting terrain of bulimia nervosa. That control is the central issue to be addressed in the successful treatment of bulimia nervosa is borne out by the predictable recurrence in client after client of dilemmas about control in the four domains described in this article: developmental, interactional, sociocultural and behavioural. It is the position of this article that all four domains need to be addressed in order to treat the problem effectively. In the interactional domain the client brings her need for control into the therapeutic relationship. Establishing a therapeutic relationship of mutual influence without control contributes significantly to the therapeutic process. The therapeutic orientation outlined here assists the client's passage from dependence to independence and addresses the habitual nature of the problem. It redirects the client's focus from control — and paradoxical lack of control — over food, her body, her mind and her emotions, to control over her life as a whole. Through goal setting, values clarification, encouragement of risk taking, self-expression and self-nurture she moves forward into a life where control, or otherwise, becomes a matter of choice rather than compulsion.

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