

Psychology Research & Training Clinic

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INTAKE REPORT

Pseudonym: Aimee Liang
Sex: Female **Age:** 18

Interviewer: Stephanie B. Ward, MS
Supervisor: Katherine Schaumburg, PhD

IDENTIFYING INFORMATION AND REASON FOR REFERRAL

Aimee self-identified as a cisgender, heterosexual, Asian woman and 18-year-old undergraduate student at a large public university. Her local primary care physician referred Aimee to care management, who then referred her to the training clinic for diagnostic evaluation and subsequent treatment for bulimia nervosa.

PROCEDURES

Semi-Structured Clinical Interview
Structured Interview for Specific Eating Disorder Symptoms
The Eating Pathology Symptoms Inventory (EPSI)
Alcohol Use Disorders Identification Test (AUDIT)
Patient Health Questionnaire-9 (PHQ-9)
Personality Assessment Inventory (PAI)
HiTOP-Digital Assessment and Tracker (HiTOP-DAT)
Wechsler Abbreviated Scale of Intelligence—Second Edition (WASI-II)

PERSONAL AND PSYCHIATRIC HISTORY

Patient reported having “bad body image” since childhood and early pubertal maturation, both of which increase risk for bulimia nervosa (DSM-5-TR; American Psychiatric Association, 2013). Aimee described her body changing ahead of her same-aged peers and recalled learning early on, “I don’t look like everybody else.” For example, she was taking dance classes in elementary school and all the other girls were wearing “tiny [ballet] tops,” but when she tried on those same tops her mother poked her exposed stomach and stated that she was “pudgy.” Beyond comments from family, Aimee described no childhood eating concerns or bullying for her weight.

Starting early in middle school and continuing into high school, Aimee started restricting through a rotation of fad diets, including the keto diet and the “egg” diet. Concerns about her body weight and shape persisted through 9th grade, when she started experimenting with laxatives (e.g., “Chinese slim tea”). Also, Aimee recalled deciding she was “too fat” to ever wear a bathing suit and her preexisting aversion to eating in front of other people intensified. In high school, Aimee reported gaining weight during the COVID-19 lockdown because her competitive cheerleading squad was shut down and she was stuck in the house surrounded by food with little else to do besides snack. To address this weight gain, Aimee spent several months working out with a personal trainer in addition to practicing with her high-school cheerleading squad. Said trainer limited her energy intake to 1200 calories per day and tracked her calories using a smartphone application, which ultimately led to what Aimee considers her earliest binges, as she would eat at night when her eating habits were not being monitored.

Later in high school, Aimee recalled primarily misusing laxatives as a compensatory measure in order to facilitate weight loss. Patient noted that she gradually increased the number of laxatives as her tolerance to their effects

increased, until she was using 20 laxatives per day but no longer losing weight. Aimee stated it was around this time (at approximately age 15) when she first engaged in self-induced vomiting, a different type of compensatory behavior and generally the only behavior her purge episodes consisted of from that point forward.

In her junior year of high school, Aimee reported engaging in 1 binge and 1 purge episode per evening. She then described the frequency of her bingeing and purging escalating, such that she was bingeing and purging twice each night, but only at night. During her senior year, Aimee recalled “pushing school aside” as the binge-purge episodes crept into the daytime. When she could not purge at school, Aimee stated that a typical day would involve her eating granola for lunch, leading her high school cheerleading team through workouts after school, eating a bag of pickles as a snack, attending her competitive cheerleading team’s practice in the evening, then cycling through three binge-and-purge episodes at night, which left time for 5 hours of sleep or less.

Toward the end of her senior year, Aimee reported a 3-week inpatient hospitalization for medical and nutritional stabilization. Patient noted that she had “no intention of getting better” at that time but agreed to the hospitalization because it was the only condition under which she was permitted to attend senior prom or her final, overnight cheer competition. Aimee stated that she “lasted three days” post-release before bingeing and purging again, and that she has engaged in these behaviors nearly every day since. Notably, the only days that Aimee reported not bingeing and purging since then were during the “three or four” times when she had been hospitalized for low potassium. In the past 28 days, Aimee reported consuming no meals outside of binge and purge episodes. She described typically purging once after each binge, except for at dinnertime, which is followed 2 purges per binge, resulting in a range of 2-7 binge-purge episodes per day.

MENTAL STATUS

Patient was oriented to person, time, and place. Her mood was anhedonic and she demonstrated a limited range of affect appropriate for the situation (e.g., blushing). Though her energy was low, Aimee remained thoughtfully engaged throughout the intake process. She deflected with humor and fidgeted in her seat, both of which were expected during a lengthy and invasive psychological assessment. Patient’s body language fluctuated with session content, as she appeared more guarded (e.g., seated with arms crossed and knees pulled close to her chest) when discussing sensitive information. Aimee denied current or recent homicidal ideation or non-suicidal self-injury but reported passive suicidal ideation. Consideration of means was limited to some speculation that she could “down a bottle of pills,” though the patient had not considered what kind of pills or how to access them, and firmly denied any level of intent. Across intake sessions, her thought content appeared logical and linear and gross memory appeared intact. Based on observations of her behavior and the pattern of test scores, the current results appear to be a reliable and valid estimate of Aimee’s current psychosocial functioning.

TEST RESULTS AND INTERPRETATION

The Eating Pathology Symptoms Inventory (EPSI) is a 45-item self-report measure developed to assess eating disorder pathology among a wide variety of populations. The EPSI has demonstrated strong evidence for test-retest reliability, internal consistency, measurement invariance, and discriminant validity across a range of samples (Forbush et al., 2014; Richson et al., 2021). This multidimensional questionnaire has eight scales and the patient’s scores and percentile ranges for Adult Women in the Recovery Record App (Richson et al., 2021) were as follows: body dissatisfaction (17, 21–23%), binge eating (16, 43–45%), cognitive restraint (4, 12–18%), purging (7, 66–69%), muscle building (0), restricting (2, 12–17%), excessive exercise (0, 1–9%), negative attitudes toward obesity (11), and total score (57). Aimee’s scores suggest binge eating and purging represent areas with greater eating disorder pathology relative to other domains, which aligns with the patient’s self-report. Of note, her cognitive restraint and restricting scores likely underestimate the salience of these subscales (and the phenomena they represent), as Aimee reports eating nothing between binge-purge episodes.

The Personality Assessment Inventory (PAI) is a self-report, objective test of personality and psychopathology designed to provide information on critical aspects of adult patients. Scales yield T-scores with a mean of 50 and a standard deviation of 10. Scale scores greater than 70 are unusual in the general population and likely indicate problems of clinical significance. PAI scales do not, on their own, provide adequate evidence for specific diagnoses. Rather the symptoms and behaviors documented by the PAI can support diagnostic conclusions.

Upon inspection of the validity scales, Aimee's profile appears to be valid. Her scores indicate that she attended appropriately to item content and responded in a consistent fashion to similar items. With respect to impression management, there is no evidence to suggest that Aimee was motivated to portray herself in an especially favorable or pathological light.

Aimee's full-scale profile revealed elevations across several scales, including Depression (DEP, T-score = 82) and Suicidal Ideation (SUI, T-score = 70). She endorsed a number of difficulties consistent with a significant depressive experience such as thoughts of worthlessness and personal failure, though elevations in the Depression subscales appear to stem from the affective domain (DEP-A, T-score = 85). Aimee admits openly to feelings of sadness, a loss of interest in normal activities, and a lack of pleasure derived from experiences she previously enjoyed.

Aimee also endorsed responses indicating recurrent suicidal thoughts, consistent with her self-report during the clinical interview and risk assessment. Safety planning and regular follow-up regarding the details of her suicidal ideation and the potential for suicidal behavior is warranted. Finally, Aimee indicated some concerns (Somatic Concerns, SOM, T-score = 65) about physical functioning and health matters in general, consistent with her self-report during the intake process regarding fear of physical health problems associated with disordered eating behaviors (i.e., restricting, bingeing, and purging). Collectively, this constellation of symptoms impairs Aimee's ability to participate fully in life.

The HiTOP-Digital Assessment and Tracker (HiTOP-DAT) is an electronically administered series of self-report measures that assess many of the elements of the Hierarchical Taxonomy of Psychopathology (HiTOP) model for adults. Briefly, the HiTOP model is a system in which to diagnose and assess psychopathology, though it does so by utilizing different structures than traditional diagnostic systems such as the Diagnostic & Statistical Manual of Mental Disorders (DSM). The Hi-TOP-DAT includes portions of the following self-report measures: Comprehensive Assessment of Traits relevant to Personality Disorders (CAT-PD), Inventory of Depression and Anxiety Symptoms (IDAS-II), Community Assessment of Psychic Experiences (CAPE), Alcohol Use Disorders Identification Test (AUDIT), Drug Use Disorders Identification Test (DUDIT), Patient Health Questionnaire Physical Symptoms (PHQ-15), and the World Health Organization Disability Assessment Schedule (WHO-DAS). Scores on the HiTOP-DAT are reported as T-scores, which have a mean of 50 and a standard deviation of 10.

Aimee's profile revealed elevations in the Distress factor within the internalizing spectra, namely Appetite Gain (IDAS-II, T-score = 77) and Appetite Loss (IDAS-II, T-score = 75), as well as heightened Anger (CAT-PD, T-score = 69) at the trait-level. Elevations were also observed under the Detachment factor, including Romantic Disinterest (CAT-PD, T-score = 77), Depressiveness (CAT-PD, T-score = 71), and Anhedonia (CAT-PD, T-score = 68). Collectively, patient's profile suggests she is experiencing intense distress, especially as it relates to her body weight and malnourished physical state. In addition, she is likely to be angry with the unfairness of her current circumstances.

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item self-report screening tool designed to assess alcohol consumption, drinking behaviors, and alcohol-related problems in the past year. Scores range from 0 to 40, with a score of 8 or higher suggestive of an alcohol problem. Patient's AUDIT score was a 9, suggesting that she may be at increased risk of encountering negative consequences associated with her alcohol use.

The Patient Health Questionnaire-9 (PHQ-9) is a 9-item, reliable and valid metric utilized to assess current depressive symptom severity. Aimee's responses are summed, which associate with minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20+) depressive symptoms. Aimee's PHQ-9 score was 14, which fell in the moderate range.

The Wechsler Abbreviated Scale of Intelligence – Second Edition (WASI-II) is an abbreviated scale designed for individuals aged 6-90 years and provides an estimate of general intellectual ability. The WASI-II provides composite scores that estimate intellectual functioning in two areas (i.e., Verbal Comprehension and Perceptual Reasoning) and two composite scores that estimate general intellectual ability (i.e., Full Scale IQ-4 Subtests [FSIQ-4] and Full Scale IQ-2 Subtests [FSIQ-2]), all generated from four subtests: Block Design, Vocabulary, Matrix Reasoning, and Similarities. The Block Design subtest measures the ability to analyze and synthesize abstract visual stimuli; the Vocabulary subtest measures word knowledge and verbal concept formation; the Matrix Reasoning subtest measures things such as fluid intelligence, broad visual intelligence, and spatial ability; and the Similarities subtests measures verbal concept formation and reasoning.

The WASI-II yields several useful scores. Subtest scores describe the main ability measured by the subtest and are used to compute composite scores. Primary subtest scores are generated as T-scores but are converted to scaled scores in this report for ease of interpretation. Scaled scores range from 1-19, with a mean of 10 and a standard deviation of 3. Average scores range from 7 to 13. Subtest scores are standard scores and can be compared to each other, but not to composite scores. Subtest scaled scores are used to form composite scores representing broad areas of intellectual functioning. Composite scores range from 40-160, with a mean of 100 and a standard deviation of 15. Average scores range from 85 to 115. The confidence interval indicates there is a 95% likelihood that a score representing Aimee's true ability lays within that range.

Aimee attained a Verbal Comprehension Index (VCI) score of 109, placing her in the Average range compared to her same-age peers. The VCI is comprised of the Vocabulary and Similarities subtests. Aimee attained a Perceptual Reasoning Index (PRI) score of 97, placing her in the Average range compared to others of her same age. The PRI is comprised of the Block Design and Matrix Reasoning subtests.

Calculation of the FSIQ-4 shows that Aimee attained a FSIQ-4 score of 104, placing her in the Average range compared to others of her same age. The FSIQ-4 is comprised of all four WASI-II subtests.

Wechsler Abbreviated of Intelligence – Second Edition (WASI-II) Composite and Scaled Scores:

<i>Verbal Comprehension Index = 109</i>		<i>Perceptual Reasoning Index = 97</i>	
Vocabulary	13	Block Design	8
Similarities	11	Matrix Reasoning	11

SUMMARY & DIAGNOSIS

Based on information gathered through the clinical interview and psychological testing, it is determined that Aimee currently meets diagnostic criteria for **Bulimia Nervosa (BN; F50.2), Extreme Severity**, as she engages in ≥14 episodes of inappropriate compensatory behaviors per week on average.

Major Depressive Disorder (MDD) is a potential rule-out. Overeating is common in MDD with atypical features, but individuals with this disorder do not engage in inappropriate compensatory behaviors and do not exhibit the excessive concern with body shape and weight characteristic of bulimia nervosa (DSM-5-TR; American Psychiatric Association, 2013), all of which are salient features of this patient's presentation.

In considering the social environment of the respondent with respect to perceived stressors and the availability of social supports with which to deal with these stressors, her responses indicate that both her recent level of stress and her perceived level of social support are about average in comparison to normal adults. The reasonably low-stress environment and the intact social support system are both favorable prognostic signs for future adjustment.

However, Aimee’s energy intake is completely restricted outside episodes of binge eating and she is engaging in self-induced vomiting, a type of purging behavior, 2-5 times per day every day, which is well above the threshold for the extreme severity specifier. There also is substantial evidence to suggest that her weight is suppressed and nutrition levels are inadequate relative to her body’s requirements. For example, fluid and electrolyte abnormalities can occur in bulimia nervosa as a consequence of purging, and such abnormalities have been observed in Aimee’s case. She has been hospitalized 3-4 times for hypokalemia, which can provoke cardiac arrhythmias, and she now receives regular bloodwork to check her potassium levels.

INITIAL TREATMENT PLAN

The respondent's interest in and motivation for treatment is typical of individuals being seen in treatment settings, and she appears more motivated for treatment than adults who are not being seen in a therapeutic setting. Her responses suggest an acknowledgement of important problems and the perception of a need for help in dealing with these problems. She reports a positive attitude towards the possibility of personal change, the value of therapy, and the importance of personal responsibility. In addition, she reports a number of other strengths (e.g., social support, insight) that are positive indications for a relatively smooth treatment process and a good prognosis.

Immediate treatment goals will focus on getting Aimee medically stable and nutritionally balanced using graduated exposure. Patient and clinician will create a fear hierarchy starting from least to most feared stimuli, which in this case will involve eating low-calorie snacks without purging and moving up to full meals. A more long-term goal for the next 4-8 weeks is for Aimee to eat 3 meals and 3 snacks per day without purging. Recommended treatments include cognitive behavioral therapy or integrative cognitive-affective therapy for BN with weekly sessions 60-90 minutes in length. It is possible that Aimee’s case will need to be escalated to a higher level of care, such as intensive outpatient, partial-hospitalization, residential, or inpatient hospitalization, so regular monitoring of treatment response will be paramount. Tentative treatment outcome measures to monitor progress include physical lab work (e.g., potassium levels) and the EPSI. Close collaboration with Aimee’s other care providers (i.e., her dietician and primary care physician who specializes in the medical aspect of eating disorders) is indicated, as well as family involvement in the treatment and recovery process.

Lastly, as noted earlier, safety planning and regular risk assessment is warranted. Thus, clinician will discuss with patient the need to develop a safety plan and complete a release of information to maintain regular contact with her primary care physician at her university’s health center.

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Date

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