Bulimia Nervosa: A Short Theoretical Review of the Cognitive-behavioral Conceptualization and Approach

Silvia Ristea

Titu Maiorescu University, Bucharest, Romania

Alexandra Ioana Drăgoi

Titu Maiorescu University, Bucharest, Romania

Abstract

The present article approaches within a well-defined sequencing the issue of bulimia nervosa diagnosis, emphasizing the theoretical and empirical cognitive – behavioral frame. Starting by defining and developing the content of problematic met in bulimia nervosa, continuing by explaining the DSM – IV – TR and DSM 5 criteria, the theoretical endeavor is pointed towards a few essential aspects of understanding this psychopathological diagnosis. Thus, the paper firmly points out the organic reactions along with the medical complications which might interfere once bulimia nervosa emerges. Further, we mention part of the cognitive – behavioral models along with the empirical studies which address the same approach with proven efficiency in diminishing the dysfunctional behavior specific to the discussed pathology.

Keywords: *bulimia nervosa, diagnosis criteria, binge eating episodes, the cognitive-behavioral approach*

Corresponding author: Alexandra Ioana Drăgoi

Phone number: -

E-mail address: dragoi.alexandra@gmail.com

I. INTRODUCTION

Bulimia nervosa is an eating disorder characterized by binge eating episodes followed by compensatory behavior such as self-induced vomiting, abuse of laxatives, diuretics or diet pills, excessive physical activity or periods of starvation. Bulimia is one of the mental disorders which exposes the suffering subjects to significant mortality risk (3%, according to Toy and Klamen, 2012). The same authors emphasize that bulimia is an issue to be approached within a long – term treatment of five to ten years, while 50% of the subjects have full chances of recovery.

The diagnosis criteria for bulimia according to DSM - IV- TR (2000) are the following:

A. Recurrent episodes of binge eating. Such episodes are characterized by both of the following items:

(1) consumption under a short period of time (for example, within two hours) of a quantity of food larger than most people would be able to eat in the same amount of time and under similar circumstances;

(2) feelings of lacking control over eating during the episode (for example: the feeling that the person cannot stop eating or control what or how much they eat).

B. Recurrent inadequate compensatory behavior with the purpose of preventing gaining weight, such as self-induced vomiting, laxative, diuretics abuse, enema or of other types of medication, excessive exercising or fasting.

C. Binge eating and inadequate compensatory behavior both occur at least twice a week, within three months.

D. Self-evaluation is falsely influenced by body weight and shape.

E. The disturbance does not interfere exclusively during the episodes of anorexia nervosa.

According to the American Psychiatric Association (2013), DSM 5 has reduced the frequency criteria of identifying binge eating and compensatory behavior. Also according to DSM 5 such episodes should occur one time a week, instead of a two – times a week frequency mentioned by DSM IV as criteria.

Criteria of DSM 5 (2013) are the following:

A. Recurrent periods of compulsive eating. Such episode presents the following characteristics:

(1) frequent eating, in a limited period of time, by consuming a larger quantity of food than other people could ingest in the same period of time and under similar circumstances;

(2) the feeling of lack of control over the binge eating episodes (the subject feels they cannot stop eating and/or cannot control what and how much they eat).

B. The inadequate recurrent and compensatory behavior aimed to prevent gaining weight: self-induced vomiting, excessive use of laxatives, diuretics and other diet type medication; restraining oneself from eating, excessive physical exercises.

C. Excessive eating and compensatory behavior manifesting, as a mean, at least once or twice a week, on a three month's period.

D. Self-evaluation is influenced by body shape and weight.

E. The disorder does not exclusively interfere during the anorexia nervosa episodes.

Bulimia nervosa has an echo both on the psychological and the organic area, with consequences with are other socially and relationally disturbing both for the subject which suffers from this disorder and the family.

It has been noted (Toy and Klamen, 2012) that bulimia usually debutes during the late adolescence but the first symptoms may also occur in adulthood. Other observations emphasized by the authors show that the weight of subjects suffering from bulimia may vary: they may be underweight, of normal weight or overweight. Also, one of the challenges specialists may face is that purging/compensatory behavior can be manifested separately from other criteria of diagnosing bulimia, as such behavior seems to be common among young population, both adolescents and adults, mostly represented by women.

On an organic level, the disorder mostly affects the organism, as the binge eating episodes and the compensatory behavior triggers medical reactions and complications. For example, the nature of gastric-intestinal complications is found in: the increase of salivary glands, especially parothiroidism (in response to self-induced vomiting, which interferes with the salivary production), abdominal pain (which may lead to installing medical affection such as the ulcer), gastric dilatation, ileus, esophagitis, gastritis, pancreatitis, etc (Mitchell, Specker, & de Zwaan, 1991; Anderson, Shaw, & McCargar, 1996; Sansone, Naqvi, & Sansone, 2005; Mathevon, Rougier, Ducher, Pic, Garcier, & Schmidt, 2004).

Another type of reaction refers to the destruction of the dental enamel (because of the excessive gastric acid caused by vomiting) which lead to frequent caries and dental erosion (Aranha, Eduardo, & Cordás, 2008), dehydration (caused by excessive vomiting, laxative and/or diuretics abuse) and cardiac arrhythmia, caused most often by electrolytic disruptions which may lead to problems related to metabolism (Mitchell, 1995; Lasater, & Mehler, 2001).

In the cardiovascular area complications may occur such as hypotension, hypovolemia and ventricular tachycardia (Casiero & Frishman, 2006).

We may also encounter symptomatology related to fatigability, hair loss and mineral and vitamin deficiency, including menstrual cycle deregulation, which manifests through

amenorrhea, oligomenorrhea, infertility, and last but not least libido decrease (Specker, de Zwaan, Raymond, & Mitchell, 1994; James, 2001).

On a psychological level, the effects of compulsive eating accompanied by compensating behavior induce among the patients profound guilt feelings and culpability, low self-esteem, installing depressive and anxious states, mostly determined by main beliefs of lacking control (Mitchell, Burgard, Faber, Crosby & de Zwaan, 2006; Bergin & Wade, 2012). The negative thoughts related to the self and self-evaluation from the point of view of body weight and shape often affect the life and activity of the subjects (Schwartz & Brownell, 2004), as they often feel insecure, rejected or unworthy of success.

The perfectionist trait and dichotomous thinking are part of the tableau of the subjects suffering from bulimia (Abramson, Bardone-Cone, Vohs, Joiner & Heatherton, 2006; Hewitt, Flett, & Ediger, 1995; Flett & Hewitt, 2006), characteristics which emphasize the negative affects and thoughts related to the self and self-image. Perfectionism is also mentioned in relation to bulimia by Toy and Klamen (2012) who describe subjects suffering from bulimia as being high achievers but also add risk factors such as a history of depression within the subject's family and the response to social pressures related to body weight.

II. THE COGNITIVE-BEHAVIORAL PERSPECTIVE FOR BULIMIA NERVOSA

From a cognitive-behavioral perspective, bulimia is based on a theoretical model based on the action of irrational thoughts regarding food and weight (Cooper, Wells, & Todd, 2004).

According to the cognitive model of bulimia nervosa presented by Cooper, Wells and Todd (2004) a binge eating episode is often triggered by a series of contexts related to the individual weight or shape, or by a remark made by another person regarding the subject, their body or their alimentary habits – how much they eat, what they eat, etc. or in the case where personal difficulties interfere. Thus, the context activates automatic negative thoughts related to one's self ("I am a loser", "I am no good", "I don't deserve to be loved", "I cannot control myself", etc). Automatic thoughts trigger strong emotional distress, and the concern related to food and eating itself becomes a temporary distraction which allows the subject to detach himself from such distress. Eating, only by itself, provokes the deactivation of the sympathetic nervous system, reducing the emotional distress. Such experience is initially interpreted as positive, but really soon, the subject will activate negative thoughts regarding the consequences of eating ("I will get fat"), being caught between two types of evaluation, one positive, related to the temporary detachment and another negative evaluation (Cooper, 2005).

The activation of permissive thoughts ("This will be the last time I ever eat like this"), associated to positive interpretation (of detachment, distressing) leads to triggering compulsive

eating. Although, as Cooper, Wells and Todd (2004) have mentioned, the detachment which follows eating is a temporary one, as on a long term it provokes an enforcement of negative thoughts of self ("I am a failure", "I cannot control myself", "I will become obese"). The compensating behavior occurs in response to the binge eating episode, as a desperate attempt to counter-balance its effects and re-establishing the subject's self-image and also the feelings of lack of control over the situation.

Bergin and Wade (2012) have conducted a cross-sectional analysis in order to study the cognitive model of bulimia nervosa. They have attempted to identify the associations between the negative self - beliefs and the negative emotions; the correlations between negative emotions and positive beliefs and/or negative beliefs related to eating; beliefs related to eating and specific behaviors specific to the eating disorder, compulsive eating and self-related negative thought. In order to do so, the researchers have used scales which measure negative thoughts related to one's self, the positive thoughts, negative and permissive thoughts related to eating, negative affects and behavior specific to eating disorders in which the participants are involved.

The mentioned study has included the participation of 298 women recruited from the campus of the Psychology Faculty and 44 patients diagnosed with bulimia nervosa. Data has been analyzed using the multiple regression, and the results of the study were consisted with the cognitive model of bulimia, except the correlation between the compensating behavior and negative thoughts related to one's self; on the other hand the role of the permissive type of thoughts was not clarified within the study.

Often a distinction is made within the diagnosis of bulimia between type I (which utilizes self-induced vomiting and the compensating behavior, eventually, but not necessary associated with other methods) and type II bulimia in which no self-induced vomiting is present). Future research is due in order to shape a more detailed model of bulimia according to such specifications.

Earlier, in 2001 Mitchell, Peterson, Myers and Wonderlich have conducted an analysis of the published articles regarding the treatment of combining medication management and psychotherapy in the treatment of patients with eating disorders. Thus, the objectives of the treatment consist most often from: eliminating the binge eating pattern and compensatory behaviors; reestablishing the normal and adaptive alimentary pattern (most often based on the three-meals a day plan and two or three snacks); sparing and treating the physical effects or possible disorders or organic disorders which interfere because of bulimia (nutritional, electrolytic unbalance, etc), sparing and treating psychological aspects such as low self-esteem, distorted body image, presence of negative and irrational thought among this type of subjects; and diminishing co-morbid conditions (in the case they are present) such as depression, anxiety or substance abuse in preventing relapse.

According to Toy and Klamen (2012), the psychiatric approach may usually be based on using an antidepressant which should result in lowering the vomiting and binging behavior frequency and that the medication should be continued for 9 to 12 months after symptoms are no longer present; on the other hand, same author reminds that the absence of a psychotherapeutic approach might put the subject at risk of purging behavior relapses.

As part of the treatment, nutritional counseling is often used in order to re-establish a normal alimentary program and to compensate the nutritional deficiencies (Salvy, & McCargar, 2002). Also, the nutritional counseling triggers the psychological level, helping the patient to counter-balance the fear related to the fact that once again they will gain weight once they start eating normally (Latner, & Ciao 2014). Nutritional counseling may be conducted by a nutrition specialist, but sometimes the psychotherapist or the patient's current medic may play this role (Glanz, 1997).

As a psychotherapeutic method, the cognitive – behavioral approach (individual or group therapy) seems to be particulary effective in the case of bulimia, compared to other types of psychotherapy (Garner, Fairburn, & Davis, 1987; Fairburn, Cooper, & Shafran, 2003).

The same idea is supported by Toy and Klamen (2012) who strongly recommend cognitive – behavioral therapy as complementary treatment of bulimia, next to specific medication. The authors note this type of intervention as the most efficient in operating over cognitive distortions specific to such disorder and also emphasize the importance of including family therapy in the cases where the subject is still living at home with the parents/caregivers.

A first step in a plan specific to the cognitive – behavioral approach is based on the complex restructuring of thoughts and negative beliefs. In time, those negative thoughts and beliefs lead to the emergence and establishing of low self-esteem. Also we notice that the personal history of patients with bulimia nervosa, the relationship between body food, body weight and shape becomes a dysfunctional and problematic one (Collins, & Ricciardelli, 2005).

Cognitive – behavioral psychotherapy also uses techniques such as self-monitoring in order to identify the internal, interpersonal or contextual factors related to the presence of bulimia (Vitousek, 1996). At the same time, cognitive – behavioral therapy addresses the connections between automatic negative thoughts which trigger binge eating (Cooper, Todd, & Wells, 1998). Another utilized technique is related to educating the patient regarding the cognitive model of bulimia (psycho-education) along with the Socratic dialogue and the counter-balance of the negative automatic thoughts (Cooper, Todd, & Wells, 2008).

Therefore the therapists explain the patients the fact that binge eating sometimes occurs as an organic response to drastic methods of maintaining an as low as possible body weight (Robinson, 2009). The compensating methods, especially self-induced vomiting are behaviors which maintain the disorder, so that in the therapeutic context usually the purpose would be to

stop them and re-establish a normal alimentary program, fact which leads to the decrease of episodes frequency of binge eating (Bruch, 2001). Also the method of gradual exposure for the patient to types of food which are considered to be dangerous or forbidden is used with precaution (Holdevici, 2011).

Also, scientific research has focused on emphasizing the difference between therapeutic approaches based on age differences of the patients who are in treatment (Cooper & Fairburn, 2012). The reason why such difference is important is the fact that personalized treatment, adapted to the development stage in which the patient find himself, influence their efficiency (Holmbeck, 2002; Williams, 2003).

Lock (2005) illustrates the modifications which can be made based on the cognitive – behavioral intervention protocol in the case of bulimia, in order to make it more efficient among the teenagers. The modifications firstly include the high intensity of the contact (by setting more frequent therapy session appointments) during the first phase of the treatment in order to promote the therapeutic alliance. Another important condition is to educate and include parents or legal tutors in the process along with other significant people (friends, brothers/sisters, professors) in the therapeutic context with the subject's accord (Lock, 2005). Also, criteria such as simplifying one's language and the utilized communication style, the higher flexibility in the case of using homework and self-monitoring represent specific directions of the cognitive – behavioral protocol.

Another important aspect of modifying such a protocol is represented by the approach of issues which are not directly related to the alimentary disorder and are part of the package of difficulties which an adolescent confront, which can be illustrated by conflicts with parents and friends, school – related difficulties (Schmidt, Lee, Beecham, Perkins, Treasure, Yi,... & Eisler, 2007).

Such adjustments do not modify the main course of therapy, but they bring a plus of efficacy by personalizing the treatment according to the sighted population (Mitchell, Agras & Wonderlich, 2007).

An important part of the treatment besides the pharmaceutical intervention is based on relapse prevention (Bulik, Sullivan, Carter, McIntosh, & Joyce, 1998) having known the fact that the presence of the diagnosis of bulimia nervosa represents a long term effort for most of the patients diagnosed with this disorder (Bonnie Bruce, Pen & Koran, 1992; Zweig & Leahy, 2012).

In 2004 Mitchell, Agras, Wilson, Halmi, Kraemer, and Crow have conducted a study in order to analyze a prevention strategy for the benefit of patients who have successfully overcome binge eating episodes and compensatory behavior – a cognitive – behavioral treatment.

Within the study, the participants have been randomly divided into two follow – up conditions: one group in which only one follow – up session was fixed after finishing the

treatment and one group in which the patients had access to an intervention plan which included future sessions and additional support in the case of relapse. The results have shown the fact that none of the patients which confronted relapse would have contacted the support team for ulterior help. Thus, it seems that only telling patients they do have access to additional support in the case of relapse does not show strong evidence as a viable strategy of relapse preventing.

In the case of such disorder a more useful approach would be to utilize schedule and follow – up consultations (every three months, six months and eventually one year), established since the ending of the therapeutic process. Other relapse prevention strategies include the management of expectations and setting them into realistic limits (Agras, Crow, Halmi, Mitchell, Wilson & Kraemer, 2000). Thus, a patient who expects to no longer experience a binge eating episode is more exposed to relapse because of the perfectionist expectations they have settled, being more vulnerable to failure and ulterior, to relapse (Mitchell, Agras, & Wonderlich, 2007). Also, the people who represent the support system and who can be identified as being part of the social group of the patient may play a major role in backing up and motoring the subject until the treatment comes to an end (Yates, 2013).

III. CONCLUSIONS

As we have intended to show in the present paper, sources such as professional literature, mental health experience and research come to emphasize the actual depth of the bulimia nervosa clinical tableau. The discussed disorder does not only affect one's general well being, self image, life style and relationship but in quite many cases it puts the patient's life at risk due to medical complications.

Fortunately clinical research and experience have succeeded in proving the efficiency of several approaches in treating bulimia but there are still solutions to be found, such as elaborating and promoting prevention programs. Thus, the most effective treatments seem to be involving the patient in long term cognitive-behavioral psychotherapy, along with prescribing antidepressant medication in order to support the process of obtaining results related to emergency issues caused by the symptomatology.

In addition, we strongly support the idea of approaching the bulimic patient from a multidisciplinary and collaborative manner, whether we speak of a team of professionals including the psychotherapist, psychiatrist, generalist, nutrition specialist or we focus our attention on the patient's social support system which should include both close family members and keeping the contact with other significant persons capable of a healthy, supportive attitude towards the patient.

References

Abramson, L. Y., Bardone-Cone, A. M., Vohs, K. D., Joiner Jr, T. E., & Heatherton, T. F. (2006). Cognitive vulnerability to bulimia. *Cognitive vulnerability to emotional disorders*, 329-364.

Agras, W. S., Crow, S. J., Halmi, K. A., Mitchell, J. E., Wilson, G. T., & Kraemer, H. C. (2000). Outcome predictors for the cognitive behavior treatment of bulimia nervosa: Data from a multisite study. *American Journal of Psychiatry*, *157*(8), 1302-1308.

American Psychiatric Association (2013). *Highlights of Changes from DSM-IV-TR to DSM-5*. Arlington, VA: American Psychiatric Association.

American Psychiatric Association. (2013). *DSM 5*. American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic And Statistical Manual Of Mental Disorders DSM-IV-TR Fourth Edition (Text Revision)*. Author: American Psychiatr.

Anderson, L., Shaw, J. M., & McCargar, L. (1996). Physiological effects of bulimia nervosa on the gastrointestinal tract. Canadian journal of gastroenterology. *Journal canadien de gastroenterologie*, *11*(5), 451-459.

Aranha, A. C., Eduardo, C. D. P., & Cordás, T. A. (2008). Eating disorders. Part I: Psychiatric diagnosis and dental implications. *J Contemp Dent Pract*, *9*(6), 73-81.

Bergin, J. L., & Wade, T. D. (2012). A cross-sectional analysis of the cognitive model of bulimia nervosa. *International Journal of Eating Disorders*, *45*(6), 776-786.

Bonnie Bruce, R. D., Pen, M., & Koran, M. D. (1992). Pharmacologic and cognitive-behavioral treatment for bulimia nervosa: a controlled comparison. *Am J Psychiatry*, *149*, 82-87.

Bruch, H. (2001). The golden cage: The enigma of anorexia nervosa. Harvard University Press.

Bulik, C. M., Sullivan, P. F., & Kendler, K. S. (2002). Medical and psychiatric morbidity in obese women with and without binge eating. *International Journal of Eating Disorders*, *32*(1), 72-78.

Bulik, C. M., Sullivan, P. F., Carter, F. A., McIntosh, V. V., & Joyce, P. R. (1998). The role of exposure with response prevention in the cognitive-behavioural therapy for bulimia nervosa. *Psychological Medicine*, *28*(03), 611-623.

Casiero, D., & Frishman, W. H. (2006). Cardiovascular complications of eating disorders. *Cardiology in review*, *14*(5), 227-231.

Collins, R. L., & Ricciardelli, L. A. (2005). Assessment of eating disorders and obesity. *Assessment of addictive behaviors*, 305-333.

Cooper, Z., & Fairburn, C. G. (2012). Cognitive behavior therapy for bulimia nervosa. Treatment of Eating Disorders, 243.

Cooper, M. J., Wells, A., & Todd, G. (2004). A cognitive model of bulimia nervosa. *British Journal of Clinical Psychology*, *43*(1), 1-16.

Cooper, M., Todd, G., & Wells, A. (2008). *Treating bulimia nervosa and binge eating: An integrated metacognitive and cognitive therapy manual.* Routledge.

Cooper, M. J. (2005). Cognitive theory in anorexia nervosa and bulimia nervosa: Progress, development and future directions. *Clinical Psychology Review, 25*(4), 511-531.

Cooper, M. J., Todd, G., & Wells, A. (1998). Content, origins, and consequences of dysfunctional beliefs in anorexia nervosa and bulimia nervosa. *Journal of Cognitive Psychotherapy*, *12*(3), 213-230.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour research and therapy, 41*(5), 509-528.

Flett, G. L., & Hewitt, P. L. (2006). Positive Versus Negative Perfectionism in Psychopathology A Comment on Slade and Owens's Dual Process Model. *Behavior modification, 30*(4), 472-495.

Garner, D. M., Fairburn, C. G., & Davis, R. (1987). Cognitive-Behavioral Treatment of Bulimia Nervosa A Critical Appraisal. *Behavior Modification, 11(*4), 398-431.

Glanz, K. (1997). Review of nutritional attitudes and counseling practices of primary care physicians. *The American journal of clinical nutrition, 65*(6), 2016S-2019S.

Hewitt, P. L., Flett, G. L., & Ediger, E. (1995). Perfectionism traits and perfectionistic self-presentation in eating disorder attitudes, characteristics, and symptoms. *International Journal of Eating Disorders, 18*(4), 317-326.

Holdevici, I. (2011). Tratat de psihoterapii cognitiv-comportamentale, Editura Trei, Bucureşti.

Holmbeck, G. N. (2002). A developmental perspective on adolescent health and illness: An introduction to the special issues. *Journal of Pediatric Psychology, 27*(5), 409-416.

James, D. C. (2001). Eating disorders, fertility, and pregnancy: relationships and complications. *The Journal of perinatal & neonatal nursing, 15*(2), 36-48.

Lasater, L. M., & Mehler, P. S. (2001). Medical complications of bulimia nervosa. *Eating behaviors, 2*(3), 279-292.

Latner, J. D., & Ciao, A. C. (2014). Weight-loss history as a predictor of obesity treatment outcome: Prospective, long-term results from behavioral, group self-help treatment. *Journal of health psychology, 19*(2), 253-261.

Lock, J. (2005). Adjusting cognitive behavior therapy for adolescents with bulimia nervosa: results of case series. *American Journal of Psychotherapy.*

Mathevon, T., Rougier, C., Ducher, E., Pic, D., Garcier, J. M., & Schmidt, J. (2004). Distension abdominale aiguë, une complication à redouter en cas d'anorexie mentale. *La Presse Médicale, 33*(9), 601-603.

Mitchell, J. E., Specker, S. M., & de Zwaan, M. (1991). Comorbidity and medical complications of bulimia nervosa. *Journal of Clinical Psychiatry.*

Mitchell, J. E. (1995). Medical complications of bulimia nervosa. Eating disorders and obesity: A comprehensive handbook, 271-275.

Mitchell, J. E., Peterson, C. B., Myers, T., & Wonderlich, S. (2001). Combining pharmacotherapy and psychotherapy in the treatment of patients with eating disorders. *Psychiatric Clinics of North America, 24*(2), 315-323.

Mitchell, J. E., Burgard, M., Faber, R., Crosby, R. D., & de Zwaan, M. (2006). Cognitive behavioral therapy for compulsive buying disorder. *Behaviour research and therapy, 44*(12), 1859-1865.

Mitchell, J. E., Agras, S., & Wonderlich, S. (2007). Treatment of bulimia nervosa: Where are we and where are we going?. *International Journal of Eating Disorders, 40*(2), 95-101.

Mitchell, J. E., Agras, W. S., Wilson, G. T., Halmi, K., Kraemer, H., & Crow, S. (2004). A trial of a relapse prevention strategy in women with bulimia nervosa who respond to cognitive-behavior therapy. *International Journal of Eating Disorders, 35*(4), 549-555.

Robinson, P. (2009). *Severe and Enduring Eating Disorder (SEED): Management of Complex Presentations of Anorexia and Bulimia Nervosa.* John Wiley & Sons.

Sansone, R. A., Naqvi, A., & Sansone, L. A. (2005). An unusual cause of dizziness in bulimia nervosa: a case report. *International Journal of Eating Disorders, 37*(4), 364-366.

Salvy, S. J., & McCargar, L. (2002). Nutritional interventions for individuals with bulimia nervosa. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 7*(4), 258-267.

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., ... & Eisler, I. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry, 164*(4), 591-598.

Schwartz, M. B., & Brownell, K. D. (2004). *Obesity and body image. Body image, 1*(1), 43-56.

Specker, S., de Zwaan, M., Raymond, N., & Mitchell, J. (1994). Psychopathology in subgroups of obese women with and without binge eating disorder. *Comprehensive psychiatry, 35*(3), 185-190.

Toy, E. C., & Klamen, D. (2012). Case Files Psychiatry, Fourth Edition. McGraw-Hill Medical, United States.

Vaz, A. R., Conceição, E., & Machado, P. P. (2013). Guided self-help CBT treatment for bulimic disorders: Effectiveness and clinically significant change. *Psychotherapy Research, 23*(3), 324-332.

Vitousek, K. M. (1996). The current status of cognitive-behavioral models of anorexia nervosa and bulimia nervosa. *Frontiers of cognitive therapy*, 383-418.

Williams, C. (2003). New technologies in self-help: another effective way to get better?. *European Eating Disorders Review, 1*1(3), 170-182.

Yates, A. (2013). *Compulsive exercise and the eating disorders: Toward an integrated theory of activity*. Routledge.

Zweig, R. D., & Leahy, R. L. (2012). *Treatment plans and interventions for bulimia and binge-eating disorder*. Guilford Press.