GUIDELINES TOWARDS THE DESIGN AND IMPLEMENTATION OF AN INPATIENT TREATMENT PROGRAM FOR BULIMICS: A COGNITIVE BEHAVIOURAL APPROACH

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ABSTRACT

Bulimia nervosa, which is characterised by binge eating followed by vomiting and/or purging, and a morbid fear of becoming fat (Russell, 1979) has only recently been identified and accepted as a discrete clinical syndrome (DSM III classification, 307.51), separate from the other major eating disorder classified in the DSM III, anorexia nervosa (307.10).

This has important implications for management; what is most appropriate for anorexics is not necessarily appropriate for bulimics as was previously assumed.

This thesis begins with a review of the literature on bulimia nervosa, focussing particularly on clinical features, aetiology and current management strategies.

In the light of this, the inpatient treatment program for bulimic patients currently implemented by a local teaching hospital is reviewed and assessed, and recommendations for adjustments are made.

It is argued that a cognitive behavioural model is very suitable when planning intervention.

CHAPTER I

A REVIEW OF THE CURRENT STATE OF KNOWLEDGE

1.1 Definitions

Although anorexia nervosa has been recognised and established as a clinical syndrome for a number of years, being first described in all its essentials by Gull and by Lasegue just on 110 years ago (Bruch, 1973), until about 10 years ago the pattern of binge-eating followed by vomiting and/or purging, currently referred to as bulimia or bulimia nervosa, was not identified as a discrete syndrome.

Vomiting and/or purging was often noted within the context of anorexia nervosa as one possible strategy employed by patients to keep their weight down; whereas episodes of compulsive eating variously referred to as bulimia, binging or binge-eating were most often referred to in the literature on obesity (Swartz, 1982).

In 1976, Peter Beumont and his co-workers divided their cohort of 31 anorexic patients into "dieters" and "vomiters and purgers", and noted that, although both groups shared a concern about weight, "dieters" tended to be more obsessional, intense, introverted and socially withdrawn, whereas the "vomiters and purgers" were generally more normal in their social and sexual interactions, tended to be more extroverted and histrionic, and were more likely to have a premorbid history of obesity (Beumont *et al*, 1976).

This marked the beginning of the debate as to whether the triad of binging, vomiting and/or purging could be said to constitute a separate psychiatric syndrome and how it could best be conceptualised and named.

Through various contributions, a map of the area began to be pieced together. It became clear that there is a high and growing incidence of women in Western industrialised societies who have overvalued ideas concerning weight and appearance and whose relationship to food is markedly disturbed (Bruch, 1973; Button and Whitehouse, 1981; Crisp, 1981; Fairburn, 1982, in press ; Palmer, 1979; Russell, 1979). Binging and/or vomiting can be seen as an extreme manifestation of this phenomenon.

It also emerged that binging and/or vomiting were not only associated with anorexia or obesity but occurred in a large group of normal-weight women (Boskind-Lodahl and White, 1978; Halmi et al, 1981; Stangler and Printz, 1980). The features of this group began to be explored.

In 1979, George Russell, in an important paper, argued for the term bulimia nervosa; he emphasised the association between binging, vomiting and/or purging, distinguishing it from binging alone or followed by fasting. He too noted these patients' preoccupation with weight and body-size (Russell, 1979).

The outcome of the spate of research has been general agreement that the distinctive symptom cluster and associated features justifies labelling and construing bulimia separately (Casper et al, 1980; Garfinkel et al, 1980; Nogami and Yabana, 1977;

Strober et al, 1982; Vandereycken and Pierloot, 1983). This was officially recognized by the DSM III which categorised bulimia as an eating disorder separate from anorexia nervosa (APA, 1980). The DSM III's emphasis, however, is on the binging with the vomiting and/or purging described as a possible concomitant although it is these latter symptoms which are the more alarming, and more likely to demand clinical intervention. It is also notable that the key feature of a morbid fear of getting fat is missing, although it could possibly be inferred from the "repeated attempts to lose weight" (APA, 1980, p.71).

Researchers have tended to prefer Russell's (1979) economical criteria, namely: "(i) powerful and intractable urges to overeat; (ii) followed by avoiding the "fattening" effects of food by inducing vomiting or abusing purgatives or both; (iii) plus a morbid fear of becoming fat" (Russell, 1979, p.445).

For the purpose of this thesis, I shall also adopt Russell's diagnostic criteria. However, for the sake of convenience I shall use the abbreviated term bulimia to refer to the syndrome and will use the terms binging or binge-eating when referring to the symptom.

This thesis is mostly concerned with normal-weight bulimics and not with the group who lose enough weight by binging and vomiting to be classifiable as anorexic, referred to in the literature variously as "binging" or "bulimic" anorexics, to distinguish them from "fasting", "restricting" or "abstaining" anorexics. For the present purpose, they will be included under the general term of "anorexia".

1.2 The Clinical Picture

As appropriate management plans are contingent on the presenting symptoms and an understanding of the aetiology of a disorder, it is necessary to first review the information concerning the presenting picture that has accrued through research, and then to make sense of it in terms of an aetiological understanding.

1.2.1 Demographic features

Bruch (1973) noted how "the young, the college crowd, have renewed the Roman custom of regurgitating after indulging in large meals. This method has become commonplace. When I first heard about it more than 20 years ago, it was considered unconventional, to say the least" (Bruch, 1973, p.205).

Both of her observations - that bulimia is on the increase and is more common among students in tertiary education - seem to have been confirmed. 2 surveys conducted among college populations found that 13% and 3,8% (respectively) of students met the DSM III diagnostic criteria for bulimia (Halmi et al, 1981; Stangler and Printz, 1980), as against an incidence of 1 to 2% in the general population (Fairburn and Cooper, 1982).

Bulimics are likely to be Caucasian females from social classes I and II (Fairburn and Cooper, 1984; Garfinkel et al, 1980; Garfinkel and Garner, 1982). More of them have had heterosexual experience than anorexics, but only about 20 to 25% have been married and, of these, many are divorced or unsatisfactorily married (Fairburn and Cooper, 1984; Pyle et al, 1981; Russell, 1979).

Bulimics presenting for treatment tend to be in late adolescence

or early adulthood. The mean age from different surveys ranges from 18 to 24, which is significantly later than the presenting age for anorexics (14 to 17 years).

On average, the presenting illness seems to have begun 2 to 5 years previous to presentation and approximately 12 to 19 months after the onset of dieting (Fairburn and Cooper, 1984; Garfinkel et al, 1980; Johnson and Larson, 1982; Pyle et al, 1981; Stangler and Printz, 1980).

1.2.2 Weight history

The later mean age of presentation, together with Russell's initial finding, that almost 68% of his patients had a previous history of true or cryptic anorexia nervosa, has led to speculation that bulimia is a chronic complication of anorexia. However, this has been found to be true in only a minority of cases (Fairburn and Cooper, 1984; Johnson and Larson, 1982).

Many bulimics, however, report a long-standing weight problem. Often they have been previously overweight (Abraham and Beumont, 1982; Halmi et al, 1981); or obese (Fairburn and Cooper, 1984; Garfinkel et al, 1980); whereas others report marked fluctuations in weight especially since the onset of the disorder (Abraham and Beumont, 1982; Pyle et al, 1981).

Generally, on presentation they are within the normal range for their age and height.

1.2.3 Dieting and eating habits

The disorder is usually precipitated by a conscious decision to diet in response either to a traumatic event, loss or separation from a significant person, change, a developing interest in the opposite sex, or comments on their weight (Abraham and Beumont, 1982; Casper et al, 1980; Crisp, 1981; Pyle et al, 1981; Wardle, 1980; Wardle and Beinart, 1981).

Whereas fasting anorexics deny hunger, bulimics readily admit to a strong appetite. Many of them report distorted eating habits such as spitting food out and wide fluctuations in intake (Casper et al, 1980; Fairburn and Cooper, 1984; Pyle et al, 1981; Weiss and Ebert, 1983).

1.2.3.1 Binge-eating

Binge-eating is most often done alone, if not in secret, at home; binges most often occur late in the day, on returning home from school or work, and on week-ends. They are usually planned (Abraham and Beumont, 1982; Beinart, 1979, cited in Wardle and Beinart, 1981; Pyle et al, 1981). The rate ranges from daily to a few times a month and the average binge lasts 1 to 2 hours (Fairburn and Cooper, 1984; Garfinkel et al, 1980; Johnson and Larson, 1982; Mitchell et al, 1981; Pyle et al, 1981).

Preferred foods tend to be soft sweet foods that are easy to injest and to vomit up again, and that patients do not allow

themselves to eat at other times. The amount, type and nutritional content of food eaten varies widely within and between individuals (Abraham and Beumont, 1982).

Despite the fact that bulimics tend to report having strong appetites, they clearly distinguish between true hunger and the urge to binge and employ various strategies to stave off the impulse (Abraham and Beumont, 1982; Casper et al, 1980; Chiodo, in press; Russell, 1979).

Precipitating factors may be either situational, cognitive and/or affective; Abraham and Beumont's (1982) sample identified as precipitants (in descending order of frequency) tension, eating something (i.e. anything at all but especially 'forbidden' food), being alone, thinking of food, craving specific food, going home (either after school or work, or returning to the parental home after living away), feeling bored or lonely, feeling hungry (44%), drinking alcohol, going out with the opposite sex, eating out, and going to parties (Abraham and Beumont, 1982; Russell, 1979; Wardle and Beinart, 1981).

Although the gorging may allay the dysphoric feelings temporarily, over time the affective state generally worsens during the binge in that they feel panicky, disgusted, helpless and guilty with physical concomitants of anxiety; some patients report feelings of depersonalisation and derealisation, dissociation and an altered state of consciousness (Abraham and Beumont, 1982; Johnson and Larson, 1982).

These feelings continue after the binge, and appear to be relieved only by the ability to vomit (Johnson and Larson, 1982).

Resolutions to diet, to exert greater willpower in refraining from eating, and thoughts of suicide are common following a binge (Abraham and Beumont, 1982; Chiodo and Latimer, reported by Chiodo, in press).

1.2.4 Purging behaviour

Not all patients who binge vomit; binges may be terminated by social interruption or falling asleep (Abraham and Beumont, 1982). However, in terms of Russell's definition, concern here is with those who do.

The idea of vomiting, as a means of counter-acting the effects of binging, is often suggested to patients by friends, the media or professionals, or after weight loss consequent on illness (Chiodo and Latimer, 1983; Russell, 1979). Patients initially use fingers or spoons to induce the gagging reflex but may graduate to being able to induce vomiting simply by flexing their abdominal or thoracic muscles. Vomiting further encourages over-eating because it is easier to vomit when the stomach is full (Abraham and Beumont, 1982).

Initially, patients are often relieved at the prospect of being able to eat without gaining weight and at being able to relieve the abdominal discomfort caused by binging. Binging also relieves the negative feelings of guilt and shame by restoring a sense of alertness, control and adequacy, plus a reduction in anger (Johnson and Larson, 1982). However, the initial relief often disappears when the vomiting becomes habit-forming and out

of control, akin to an addiction to alcohol or drugs (Johnson and Larson, 1982; Russell, 1979). Physical damage caused by repeated vomiting may include electrolyte disturbance (producing muscle weakness, constipation, lethargy, headaches, dizziness, heart, chest and back pains, hypothermia, tetany and convulsions, anaemia); urinary infections and renal damage; damage to the throat and stomach (for example, gastric dilation); amenorrhea or irregular menstruation, and dental problems (Harris, 1983; Pyle et al, 1981; Russell, 1979; Weiss and Ebert, 1983).

Purgative abuse is an accompanying or alternative method of getting rid of the food but is far lower in frequency; it is not as immediately reinforcing in providing relief.

Vigorous exercise and fasting, taking slimming tablets and thyroid medication, and disposing of food are other methods used by patients to counteract the effects of binging (Abraham and Beumont, 1982).

1.2.5 Associated psychiatric signs and symptoms

It has been noted that bulimics present with a wider range of more severe psychiatric symptoms than fasting anorexics, and are more likely to have a history of previous hospitalizations for psychiatric problems (Weiss and Ebert, 1983). Although they have often been maintaining an outwardly adequate school or work performance for years, it is a surface adjustment with marked social and financial impairment and deep personal distress

(Johnson and Berndt, 1983; Pyle et al, 1981; Russell, 1979).

Affective: Of particular prominence are severe depressive features. The depressive symptoms noted are not those associcated with "endogenous" depression, namely psychomotor retardation, diurnal variation of mood and inability to cope, but rather manifest as subjective feelings of gloom and guilt, suicidal thoughts, impaired concentration, irritability, decreased libido and initial insomnia (Ben-Tovim et al, 1979; Eckert et al, 1982; Fairburn and Cooper, 1984; Hudson et al, 1982; Johnson and Larson, 1982; Pyle et al, 1981; Russell, 1979).

Researchers seem agreed that this depression is secondary to the eating disorder,[1] possibly as a result of the electrolyte disturbance or weight loss and starvation (Eckert et al, 1982; Fairburn and Cooper, 1984; Mitchell et al, 1982).

However, the risk of suicide is greatly aggravated by bulimics' tendency to be impulsive and to act out.

The other disturbance of affect often noted is emotional instability and lability (Dunn and Ondercin, 1981; Garfinkel et al, 1980).

Impulse control: Bulimics have been reported to present with a range of symptoms and behaviours suggestive of an impulse disorder, notably kleptomania, alcohol or drug abuse, suicide

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[1] The term "secondary depression" is rather loosely used; seemingly it is referring to depression resulting from the binging and vomiting.

attempts and self-mutilation (Casper et al, 1980; Crisp et al, 1980; Pyle et al, 1981; Weiss and Ebert, 1983). Fairburn and Cooper's (1984) findings did not support this, however; in their sample there was no evidence of vulnerability to dependence on drugs or alcohol either in the patient or her family.

Neurotic features: Neurotic features often reported include anxiety (particularly concerning food and eating), obsessive-compulsive behaviour, increased somatic complaints, lower extraversion and self-esteem, more guilt and hostility (Ben-Tovim et al, 1979; Dunn and Ondercin, 1981; Fairburn and Cooper, 1984; Weiss and Ebert, 1983).

Interpersonal: Bulimics commonly present with social and interpersonal difficulties. The disorder exacerbates this by increasing social withdrawal. Bulimics tend to spend more of their time alone, usually in food-related behaviour (Johnson and Larson, 1982).

Their sexual relationships tend to be transient and unsatisfactory and they report a lack of pleasure and a feeling of being used. Extreme swings from intimacy to withdrawal, from idealisation to critical rejection, seem to characterise their sexual and personal relationships. Extreme sensitivity to the reactions of others, together with a lack of trust in self and others, often results in evasiveness and secretiveness, which evokes anger and frustration, thus creating a vicious cycle. In sexual relationships, their wariness manifests in 'testing' partners, only engaging in superficial relationships or searching for the ideal secure relationship. They manifest passivity,

dependence and unassertiveness in their intimate relations that leads to further personal devaluation and anger (Garfinkel, 1981; Garfinkel and Garner, 1982; Guidano and Liotti, 1983; Rost et al, 1982).

1.2.6 Cognitive factors.

All bulimics are intensely preoccupied with food, weight and body size. They complain of intrusive thoughts of food to the extent that their concentration is impaired. They are plagued by fears of becoming compulsive eaters and not being able to stop eating, and describe bizarre notions and revulsion concerning food and bodily processes. They strongly experience a sense of loss of control over eating which leads to feelings of guilt and inadequacy (Abraham and Beumont, 1982; Casper et al, 1980; Eckert et al, 1982; Fairburn, 1983; Russell, 1979; Strober et al, 1979).

They all display Russell's core feature of a "morbid fear of getting fat" and overvalued ideas concerning their shape and weight. They weigh themselves frequently and are extremely sensitive to changes in body shape and the tightness of their clothes. They express a common fantasy that their lives would be successful if only they were thin (Fairburn and Cooper, 1982; White and Boskind-White 1981).

Their desired goal weights are usually at variance with a healthy weight but they are unconcerned that their ideal weight would be too thin (Pyle et al, 1981; Russell, 1979; Weiss and Ebert, 1983).

Fairburn notes their tendency to dichotomous thinking; they tend to view themselves as either in control or out of control, fat or thin, and to view food as forbidden or safe. "Their lives are governed by a series of arbitrary but rigid rules" (Fairburn, 1983, p.538).

Bulimics have also been found to exhibit a significantly more external locus of control than controls or fasting anorexics (Garfinkel, 1981; Hood et al, 1982). External locus of control has been found to be predictive of greater maladjustment, and to correlate highly with the inability to delay gratification, poorer interpersonal relations related to an inability to de-centre, higher neuroticism scores and greater distortion of body image (Garner, et al, 1976; Gilmor, 1978; Hood et al, 1982).

1.2.6.1 Perceptual disturbances

Bruch maintained that perceptual distortion of body cues, both external and internal, was pathognomic of eating disorders and that no lasting cure is achieved without correction of the body image misperception (Bruch, 1974, cited by Touyz et al, 1984).

Body image is defined as "the mental image that a person has of the physical appearance of his body" which includes the attitudes and feelings of the individual to his/her body (Garner et al, 1978, p.249).

Research findings have been contradictory and inconclusive (Button,

Fransella and Slade, 1977; Garner et al, 1976; Halmi et al, 1977; Pearson et al, 1981; Slade and Russell, 1973), leading Hsu (1982) to suggest removing distortion of body image as a diagnostic feature of anorexia.

It is likely that given the concern with weight and appearance in our culture, many women tend to be inaccurate in assessing body size, but that women with eating disorders are more sensitive to this and it has a greater significance to them. In fact, it is not so much a perceptual as a cognitive disturbance. Garner and Garfinkel (1982) support this by distinguishing 3 definitions of the concept of "body image". Chiodo summarises them:

> The first type is perceptual to the extent that the individual inaccurately estimates her body size ... In the second case, (she) correctly assesses her body size but reacts negatively by either criticising or aggrandising her body shape. Rather than demonstrating perceptual involvement, these individuals exhibit cognitive and affective disturbances. The third body image disturbance is an over-evaluation of a thinner size in which thinness is perceived as an exceptional achievement.
>
> (Chiodo, in press, p.42)

It would seem that this symptom cannot be ignored. Overestimation at discharge has consistently been found to be a poor prognostic indicator (Garfinkel et al, 1977) so it is significant that bulimics have been found to overestimate more than restrictors (Button, Fransella and Slade, 1977) and to show more severe and refractory body image disturbances in the form of body de-

personalisation, weakness of body boundaries, lack of sensitivity to bodily sensations, and vulnerability to outside intrusions (Strober _et al_, 1979). This goes with complaints of experiencing no pleasure in their bodies.

1.2.7 Family history

Palazzoli's impression of the families of her bulimic patients was that they were more chaotic, demonstrating "psychotic confusion, violence and a complete breakdown of family communication" (Selvini Palazzoli, 1974, p.205).

This impression has been supported by research findings: families of bulimics have been found to have a higher incidence of affective disorder in first and second degree relatives; a higher incidence of alcohol and drug abuse; greater conflict, less cohesion and higher levels of marital discord; and a higher familial predisposition to weight problems and obesity, particularly in the mother (Fairburn and Cooper, 1984; Garfinkel, 1981; Pyle _et al_, 1981; Strober, 1981, cited by Garfinkel et al, 1983; Strober _et al_, 1982).

Strober _et al_ (1982) found fathers of bulimic anorexics to display more hostility, immaturity and impulsiveness, and mothers to exhibit more depression and emotional lability.

1.2.8 Prognosis

Results of outcome studies of patient populations reveal that prognosis for eating disorder patients is poorer if they manifest

(among others) the following symptoms: binging, vomiting, depression, acute body perceptual disturbances, high rates of physical complaints, premorbid obesity, anxiety when eating with others, a disturbed relationship between the patient and other family members, chronicity, and acting out behaviour, especially just prior to onset (Crisp et al, in Vigersky, 1977; Morgan and Russell, 1975; Steinhausen and Glanville, 1983). All of these have been listed above as characteristic of bulimic patients.

However, it must be borne in mind that there have been major criticisms of these outcome studies with regard to sample, design and validity (Hsu, 1980; Steinhausen and Glanville, 1983). It is also uncertain to what extent these results can be extrapolated to normal-weight and non-hospitalised bulimics. Halmi (1983) suggests that a full outcome study would include, besides patients treated in hospital, those who refuse medical treatment and those who see only their G.Ps.

Good prognostic features are early onset, no previous psychiatric treatment, good premorbid school and/or career adjustment, and employment in a professional or skilled occupation (Halmi et al, 1973).

1.3 Aetiology

As the main focus in this thesis is on treatment, an explanation of the aetiology of the disorder would most usefully include an explanation of why, in spite of the great similarities in aetiological factors between anorexics and bulimics, the path-

ways of symptom formation lead to very different behaviours with different social and personal implications which, in turn, lead to the behaviours being differentially reinforced.

The discussion on aetiology therefore has been divided into the traditional predisposing, precipitating and maintaining factors, but includes a fairly detailed functional analysis of the behavioural, affective and cognitive aspects of the symptoms.

While acknowledging the valuable contribution made by the psychodynamic theorists towards an understanding of eating disorders, and recognising the importance of psychodynamic factors in the aetiology of the disorder, psychodynamic theory is very complex and will not be discussed here. There are other models and a cognitive behavioural framework has been chosen as most appropriate. It has the advantage of a level of discourse accessible to the staff and patients on the unit under consideration here. However, the discussion on aetiology will contain some psychodynamic terms drawn from writers who have been fairly eclectic in their approach.

1.3.1 Predisposing factors

It seems that in families of both anorexics and bulimics, disturbed transactional styles and poor subsystem boundaries tend to produce circumstances unconducive to the children separating and individuating. Parents do not provide the context for stimulating the child's initiative and fostering her ability to monitor and interpret bodily and emotional cues so that she

learns to identify and trust her own feelings, to rely on inner resources and ideas, to feel a mastery of her own body , and to make autonomous decisions (Bruch, 1973; Selvini Palazzoli, 1974). This results in impaired ego-strengths, a blurred personal identity, low self-esteem and sense of effectiveness, a feeling of impotence and lack of control, permeable ego boundaries, an external locus of control, marked field dependency and a distorted attributive style (Guidano and Liotti, 1983).

In childhood, this manifests in excessive obedience, compliance, shyness and a striving for high achievement, which masks a need to be accepted (Casper et al, 1980; Nogami and Yabana, 1977; Russell, 1979); but at adolescence these patients' resources are likely to prove inadequate to cope with the life task of puberty which is to establish a secure separate personal and gender identity. They are likely to be highly vulnerable to the social prescription on women to be slim, which makes the body a likely arena for the expression of conflicts concerning identity, control and effectiveness (Boskind-Lodahl, 1976; Cooper et al, 1984; Crisp, 1981; Halmi et al, 1981; Selvini Palazzoli, 1974; Swartz, 1982; Worsley, 1981).

1.3.2 Precipitating factors

Precipitating events involving change or loss, although not more frequent for eating disorder patients, have more significance because they threaten an already precarious sense of self-esteem, leading to a need for control that becomes focussed on body

weight and shape, one area they can control (Crisp, 1981).

So they turn to dieting to enhance a shaky sense of self-worth. However, here there is a divergence. Whereas fasting anorexics (with a higher internal locus of control) defend against the sense of ineffectiveness by denial, obsessionality, rigid control over the bodily drives, and over-accentuating the boundary between self and others (Sugarman and Quinlan, 1982), bulimics have to contend with a tendency to obesity and a stronger appetite, which makes them more likely to turn to methods other than simple restriction to induce weight loss.

Furthermore, their tendency to anxiety, tension or anger, consequent on lowered self-esteem and unsatisfactory interpersonal relationships as well as boredom or emptiness arising from a fragmented core identity and a vagueness in identifying feeling states, make them more likely to turn to food to assuage these dysphoric mood states (Johnson and Larson, 1982).

Their inadequate models of impulse control, difficulty tolerating negative affect and a greater external locus of control (accompanied by an inability to delay gratification) makes their mastery over eating and sexual and aggressive drives far more erratic (Garfinkel and Garner, 1982).

This erratic impulsive style characterises many areas of functioning. It is contributed to by their dichotomous either/or cognitive style.

These factors make them more vulnerable to a dietary pattern veering between binging, fasting and purging.

Even in people without these vulnerabilities, a link has been noted between dietary restraint and binging as the result of physiological deprivation and the fact that cognitive responsiveness to external cues is increased by restraint (Herman and Polivy, 1975; Polivy and Herman, 1976a, 1976b; Spencer and Fremouw, 1979; Wardle, 1980; Worsley, 1971). Bulimics, who are often not very good at identifying internal body cues, and who categorise food in terms of 'safe' and 'forbidden' food, being in control or out of control, are likely to have extreme reactions to anything perceived as breaking their control. So having injested a small amount of 'forbidden' food, they are likely to panic or to reason that they might as well 'go the whole hog' (Wardle and Beinart, 1981).

As already described, many bulimics then resort to vomiting to undo the effects of the binging. Their field dependency is apparent in their suggestibility.

1.3.3 Maintaining factors

For the restricting anorexic, the gratification afforded by the sense of control and triumph over her body, the virtue of ascetism plus the tangible reward of weight loss are all very positively reinforcing.

For the bulimic it is different. However, despite the negative consequences in terms of shame and guilt, she cannot easily break out of the cycle of binging and vomiting. Loro and Orleans (1981) warn that one must not under-estimate the compulsive nature of the behaviour. The negative reinforcement provided by

binging in the form of relief from negative emotional states makes it exceedingly resistant to extinction, like conditioned avoidance responses, and is compounded by the food-related positive reinforcement.

The binge-purge sequence begins to take up more and more time and attention, restricting social and inter-personal contact. This reinforces the patient's distress but also serves as an excuse to remain isolated (Boskind-Lodahl and White, 1978).

Whereas the DSM III has focussed on the binging as primary, Johnson and Larson (1982) argue that it is the vomiting which, by undoing the effects of the binging, brings relief and serves an integrative function. However, it is often difficult to tease out which component of the cycle is primary as each reinforces the other; the shame and guilt resulting from the binge-purge sequence leads to renewed despair and hopelessness together with resolutions to restrict food intake, thus setting up the circumstances for the next binge, with the excessive concern over food as the hub.

The secondary depression commonly accompanying the binging and purging can be understood as fostered by the sense of despair and lack of control plus anger at herself (Boskind-Lodahl, 1976), exacerbated by nutritional deficiencies and metabolic disturbances. Beck has described clearly how negative self-ascriptions create adverse feelings which then lead to self-fulfilling prophecies (Burns and Beck, 1982).

The cases of bulimia arising from anorexia or iatrogenically after treatment will not be dealt with here. The interested

reader may consult Slade (1982) and Vandereycken and Pierloot (1983).

1.4 Management

1.4.1 Inpatient treatment

Hospitalisation is indicated in the case of suicide risk, excessive weight loss, severe physical damage resulting from electrolyte imbalances, eating habits that prove refractory to outpatient treatment, or a pernicious psychosocial setting (Fairburn, 1982), to stabilise eating patterns and break the cycle of binging and purging (Crisp, 1981; Russell, 1981).

A review of the literature reveals little on inpatient management designed for normal-weight bulimics. As bulimia, until recently was not considered separately from anorexia, and hospital treatment was mainly of fasting or bulimic anorexics, they were managed in much the same way with nurses taking responsibility for the amount and choice of food, and supervising slow but steady weight gain. Patients are encouraged to eat regular meals and, either by being put to bed or being closely supervised, their opportunity to binge or vomit is controlled (Crisp, 1981; Russell, 1981). This is supplemented by supportive psychotherapy.

Both Russell and Crisp advocate treatment in the psychiatric unit of a teaching hospital because of the necessity for skilled nursing. They emphasise that staff need to be experienced, supportive, consistent in limit-setting; able to resist manipulation, to avoid being punitive in turn and to confront non-

judgementally; sensitive to issues of control and intimacy; aware of not recreating the pathological parent/daughter relationship nor of using emotional manipulation, for instance, exploiting the patient's need to please them; and understanding the intense fears concerning weight gain and food (Crisp, 1981; Garfinkel and Garner, 1982; McNamara, 1982; Russell, 1981). The clear separation between the roles of therapist and nursing staff is also very important, to minimise ambiguity and communication problems (Rampling, 1978).

The hospital phase is regarded as only the first stage and the importance of follow up is emphasised. Crisp (1980) and others recommend groups to supplement individual psychotherapy. Groups provide support, models of coping, peer feedback and education, and help in the transition period from hospital to home (Garfinkel and Garner, 1982).

However, in reviewing the hospital program, Russell (1981) found patients uncooperative and improvements short-lived; he felt there was a need to develop a more effective management plan.

Other writers have recommended a multi-dimensional approach combining medical, behavioural, family and individual therapy as well as group work, social skills and movement therapy to promote a positive body image, within the context of a therapeutic milieu setting. These all help to defocus the emphasis on eating and address the underlying issues rather than providing only symptomatic relief which tends to lead to an early relapse (Garfinkel and Garner, 1982; Selvini Palazzoli, 1974; Pierloot et al, 1982).

Some aspects of a multidimensional management plan pertinent here will be focussed on below.

1.4.1.1 Medication

Chlorpromazine, first recommended by Dally in 1960, is probably the most commonly used medication in the treatment of eating disorders. However, the recent trend is to use it less often (Garfinkel and Garner, 1982).

Anti-depressants are used to treat the depression common in bulimics but one has to be aware of the effect anti-depressants have on weight (Fairburn, 1982).

1.4.1.2 Behaviour modification

Behavioural programs have been popular in the treatment of eating disorders. The patient is put to bed in isolation and her eating behaviour is directly modified by positive and negative reinforcement and/or informational feedback (Azerrad and Stafford, 1969; Bachrach *et al*, in Ullman and Krasner, 1965; Blinder *et al*, 1970; Monti *et al*, 1977).

The advantages are quick short-term results without the need to resort to invasive methods such as force-feeding. But it has been argued that unless broadly conceived, such programs may prove inadequate to ensure longer-term eating normalisation.

Bruch (1974) criticised behaviour modification as a form of "brutal coercion" which is totally unsuited to the personality

and character patterns of patients whose core issue is that of control (Bemis, 1978).

Wolpe (1975), in response to Bruch's attack, blamed the failure of particular behavioural programs on an incomplete behavioural assessment of the patient to identify all pertinent variables currently maintaining the problem so that contingencies can be tailored accordingly (Garfinkel and Garner, 1982; Wilson, 1976). If the patient genuinely feels that she is entering into the program voluntarily and collaborates in the setting-up of the contingencies, she will feel that she has a measure of control (Garfinkel et al, in Vigersky, 1977).

Despite the initial enthusiasm, researchers have found that behaviour modification is not more effective than other forms of intervention (Eckert et al, 1979; Hsu, 1980; Steinhausen and Glanville, 1983).

Garfinkel and Garner (1982) conclude that behaviour modification should only be used when weight gain is an immediate concern "and then maximal attention must be paid to enlisting the patient's cooperation and participation in setting up a reward program which she does not find excessive" (Garfinkel and Garner, 1982, p.234).

1.4.1.3 Body image work

There are reports in the literature of the use of videos and movies to help correct patients' distorted body perception (Agras and Werne, in Vigersky, 1977; Gottheil et al, 1969)

but these have not been found to be very effective and are only appropriate for severely emaciated patients. Focussing on the patient's distorted concepts about her body is more effective (Garfinkel and Garner, 1982).

1.4.2 Family therapy

Family therapy is usually regarded as an important part of the total treatment plan or may be chosen as the preferred form of intervention in its own right, especially if the patient is going to return to the family. Selvini Palazzoli (1974) reported dramatically improved results when she switched from individual psychotherapy to treating the patient within the family. Minuchin and his colleagues also reported good results from using a combination of family therapy and a behavioural program (Liebman, Minuchin and Baker, 1974).

However, in both cases, results were better with young anorexic patients. For bulimics who have usually separated physically if not psychologically from their families, the focus is more appropriately on helping them to redress the damage done by a pathological family situation in terms of impaired self-image and maladaptive defences and behaviour.

1.4.3 Individual psychotherapy

It seems to be generally agreed that psychotherapy is a cornerstone in the treatment of eating disorders especially over the long-term. However, many writers report disappointing results

with psychodynamic therapy. In view of bulimics' fragile ego resources and difficulty tolerating anxiety, dealing with unconscious primitive material before the ego has been strengthened, is likely to overwhelm it, causing intolerable anxiety and leading to acting out.

These writers recommend a more cognitive approach in which the primary goals of therapy are to strengthen the ego and increase the patient's coping strategies; to help her to develop more competent, less painful and destructive ways of dealing with the problem of living; to correct defective cognitions and self-perception; and to improve disturbed interpersonal relationships.

This is best done by engaging the patient in a collaborative, fact-finding approach in which therapist and patient together formulate a clear contract and goals, thus creating structure and limits. Communication should be in clear language, avoiding jargon and simplistic interpretations, and therapy should be largely reality oriented.

These factors, in an atmosphere of acceptance and support, are most likely to promote a feeling in the patient of effectiveness and confidence in her own perceptions and abilities (Bruch, 1973; Garfinkel and Garner, 1982; Guidano and Liotti, 1983; Selvini Palazzoli, 1974; Russell, 1979).

1.4.4 Cognitive behavioural therapy

In many ways the approach outlined above is in line with the

principles of the cognitive behavioural school of therapy except that the above writers do not directly deal with the symptoms on a practical level.

Christopher Fairburn has designed a cognitive behavioural out-patient treatment program specifically for normal-weight bulimics which works on two levels: (1) Focussing on breaking the cycle of binging and vomiting, and (2) helping the patient to modify her abnormal attitudes to food, eating, body weight and shape, and to improve problem-solving skills. In his program, the emphasis is also on support, structure and increasing self-control; the patient's responsibility for behavioural outcome is stressed. She is assured that progress made during therapy tends to be maintained but that she must not expect to be cured in that she will remain liable to transitory relapses in times of stress.

Initially the patient is seen several times a week and is asked to keep a record of her eating, noting the times and settings, which are planned meals, and so on. She is then directed to restrict her eating to conventional mealtimes; difficulties in doing so are examined and means of increasing self-control explored, such as stimulus control methods and enlisting the help of people she lives with. Realistic goals are set up and reviewed at each session. No attempt is made at this stage to restrict the vomiting; Fairburn maintains that this ceases once the eating is under control.

After about 8 weeks, the focus shifts to identifying the circumstances under which loss of control occurs and to helping the patient develop more adaptive ways of coping with these

events. She is given training in problem-solving, and she is taught to identify self-defeating thoughts and to develop alternatives.

The third stage is concerned with maintaining her progress by preparing strategies for future times of poor control.

Fairburn reports a fair outcome in terms of reduction of symptoms and of abnormal attitudes to food, eating, body weight and shape (Fairburn, 1981, 1982, in press) which compares very favourably with the success rate of the self-help groups reported on by Boskind-Lodahl and White (1978), White and Boskind-White (1981), and Orbach (1978).

These groups have a feminist perspective and also use a cognitive approach, using techniques such as role play, assertion training and guided fantasy exercises to explore the issues of sexuality, low self-esteem and insecurity in relationship to men and to help clarify what function binging serves for the individual.

Although Boskind-Lodahl and White note some progress in dealing with symptoms and in attitude change, in many cases patients had to seek additional help. Fairburn (in press) also notes that those individuals who vomit in addition to binging tended not to benefit from the groups run by Orbach. It seems that for the more severely distressed individual, treatment must include practical help on how to gain control of the symptoms.

1.5 Summary and Conclusions

To summarise so far, the clinical picture of bulimia has been

reviewed and an aetiological explanation of these facts offered which it is hoped will be most useful when approaching the management of such patients. Finally, current treatment programs on an inpatient and outpatient basis were summarised.

It can be concluded that in planning treatment for bulimics, one has to be aware that they generally present with a wider range of severe pathology than anorexics, more fragile ego resources, a tendency to use external defences and symptoms that are well-embedded.

Until recently, treatment on an inpatient basis has been along similar lines to that for anorexics; however, results have been disappointing and prognosis regarded as poor. Given the severity of their disorder this may be to be expected.

However, another explanation could be that as bulimics are in many ways different from anorexics, management designed for the latter might be unsuitable for bulimics.

This hypothesis will be explored further in Chapters 2 and 3 by examining what happens to a bulimic patient who enters the treatment program in the local hospital setting which is very similar in many features to the hospital programs run elsewhere.

Fairburn, with his cognitive behavioural treatment approach, seems to offer the most fruitful direction to pursue when attempting to design a treatment plan for bulimics. This will be followed up in Chapter 4 when discussing a possible treatment plan along cognitive behavioural lines tailored to the needs and characteristics of bulimics.

CHAPTER II

INPATIENT TREATMENT FOR BULIMICS IN THE LOCAL HOSPITAL SETTING

2.1 The Unit

The program to be reviewed is run on the psychiatric ward of a teaching hospital in Cape Town. The unit has beds for 17 patients, including 3 eating disorder patients, at any one time. Ages of patients range from 14 to 70 but most are between 16 and 36.

Patients are referred from private psychiatrists, the outpatient and casualty departments of the hospital or other agencies in Cape Town. They may be admitted for a 3-week assessment or for treatment; this lasts approximately 3 months except for the eating disorder patients who will be discussed separately below. Problems treated generally include neuroses, personality disorders, "adolescent turmoil", and drug abuse. As the program is an intensive one, patients must have reasonably good ego strengths and a good prognosis.

The ward is run as a therapeutic community. Patients take turns doing duties, for instance, setting and clearing the tables, and regular community meetings are held to discuss issues affecting staff and patients. The treatment program includes individual, group and family therapy, social skills and evocative techniques such as projective art, role play and growth games. The weekly program in included in Appendix A.

The staff, under the supervision of a psychiatric consultant and clinical psychologist, comprises:

- a psychiatric registrar who acts as ward doctor and has patients for individual therapy. Registrars rotate every 6 months.
- 2 intern psychologists who have patients in individual therapy. They rotate every 4 months.
- a psychiatric social worker who does family work.
- an occupational therapist who supervises O.T., evocative techniques, social skills and exercise.
- the sister in charge of the ward who supervises the nurses running the behavioural program for eating disorder patients.
- 2 to 3 trained psychiatric nurses who, besides looking after the patients' physical needs, run evocative techniques and supervise the behavioural program. They are designated "program nurses".
- 2 to 3 nurses on orientation.
- 2 nurse aids who socialise with the patients and look after the eating disorder patients while they are at bed rest, for example, giving them bed-baths, serving their meals and keeping them company.
- housekeeping and clerical staff.

The staff has a largely psychodynamic understanding and approach, but they also incorporate behaviour modification (in the eating disorder program) and systems theory (in family therapy).

2.2 The Eating Disorders Program

The impetus for this program was initially provided by Peter Beumont but the nurse who designed the program in 1976 based it on that run in Crisp's unit where she had previously worked. It was originally designed for emaciated anorexic patients and has been little modified except that the length of stay has been reduced; currently patients stay for 6 to 9 months.

It is run separately from the ward program. Except for individual therapy which begins immediately, patients work towards integration into the normal ward program. The running of the program is largely the responsibility of the psychiatric nurses supervised by the sister-in-charge. They may consult with other team members, particularly the patient's therapist.

The program was renamed the "eating disorders program" to include bulimia which was recognised as a separate syndrome after 1981. However, although most of the staff differentiate between anorexics and bulimics in terms of personality and behaviour (see table in Appendix C), the program is still basically the same for both groups; the following description of what happens therefore applies to both unless otherwise stated.

This outline of the treatment program is derived from clinical records, interviews with staff members directly involved in running the program, the written guide intended for new staff, and Gail Luiz Riccitelli's (1982a) guide, based on her experience as a nurse working on the unit.

It was decided to interview only staff directly involved in the day-to-day running of the ward on the grounds that it is their understanding and perspective which determines how the program is interpreted and actually carried out. Thus the consultant in charge and clinical psychologist were excluded. 7 of the staff were interviewed. These include the sister-in-charge, a program nurse, a nurse aid, the occupational therapist, the psychiatric social worker, an intern and a registrar. All except the registrar were involved with Marianne (the case illustration) when she was on the ward.

The interviews were semi-structured around a set of core questions (see Appendix B) but allowing for elaboration depending on the staff members' varying roles. For example, the sister-in-charge and the program nurse were questioned in detail about the behavioural program. Interviews were taped and transcribed. Besides finding out exactly what happens to patients on the program, it was hoped to elicit information about:

- how staff members construe the goals of treatment, based on their understanding of the aetiology of the disorder.
- their perception of bulimic patients and whether they differ from anorexics.
- any criticism they may have of the program either in general or as it pertains to their roles.

The table in Appendix C presents some of this information.

Below, the ward policy and usual procedure are set out. This is followed by a description of a sample case drawn from clinical

records and an interview with the patient (See Appendix B for questions).

2.2.1 Admission Policy

The sister-in-charge listed the following indications for admission for inpatient treatment:

(i) the patient's physical state, whether in the form of severe emaciation or of physical damage caused by excessive vomiting.

(ii) severe depression, particularly if accompanied by the risk of suicide or actual attempts.

(iii) a crisis in the family in reaction to the eating disorder.

50% of the patients come from outside Cape Town as this is the only unit (besides Tara Hospital in Johannesburg) which offers specialised treatment. Many of them could have been managed on an outpatient basis if they had been living locally.

If the patient is under age, her parents can admit her. Otherwise she comes in as a voluntary or consent patient.

2.2.2 Preadmission

Before a patient is admitted, ideally the sister-in-charge or the program nurse interview the patient and at least the parents, if not the whole family. The patient is interviewed with her parents and alone.

The aim of the interview (according to the sister-in-charge) is two-fold:

(a) to assess the patient's degree of motivation and the severity of her illness, and to ascertain whether it is the patient or her parents who want the treatment.

(b) to briefly outline the program to the patient and her parents, to show them around and to advise them about necessary arrangements for a long admission, for instance, obtaining study or work leave of absence, seeing a dentist and so forth.

They are told that the patient will be at strict bed-rest for at least 3 weeks and will have no contact with the family for a 6-week assessment period. According to the sister-in-charge, this is to give the patient time to bond with the staff. The patient and family are then sent away to think it over.

If the patient is from out of town, the above does not always happen, in which case it takes place on the day of admission.

2.2.3 Admission Procedure

The sister-in-charge explained that, if the patient and family decide to undertake treatment, on the day of admission the social worker sees the whole family for an initial interview and assessment. If the patient lives at home, a meal may be served to the family who are then observed from behind a one-way mirror to see what happens in the family interactions; this is similar to the procedure in Crisp's unit. After this,

the family says "Good-bye" to the patient.

The registrar does a physical examination in the presence of the program nurse. The patient is weighed, measured and photographed, and her vital signs are checked. Most patients are put on a short course of Chlorpromazine.

After this, she is taken to a single side ward and put to bed. Her belongings are checked for laxatives and then removed.

2.2.4 The behavioural program

The program nurse explains the various aspects and rationale of the program in full to the patient - she is isolated from contact except for the nurses and her therapist, and is not allowed out of bed (she receives bed-baths and uses a bedpan). The reasons given for this by the sister-in-charge and the program nurse interviewed were that it allows the patient a period of regression, of letting go and having no social pressures, and of accepting caring for themselves, besides instigating the program and removing any opportunity to binge or vomit. They spoke of some disadvantages in the form of sensory deprivation, negative aspects of regression and (in the case of anorexics), exacerbation of social isolation.

The immediate goal of the program for bulimics is to break the pattern of binging and vomiting and stabilise eating patterns, normal metabolic and electrolyte functions and menstruation. A list of rewards (called "privileges") is drawn up by the program nurse and patient; initially these are mostly material

reinforcers, contingent on appropriate eating behaviour, that is eating 3 meals and a snack per day in a set period of 20 minutes, without fuss. Nasal gastric tubes or force-feeding is resorted to only if the patient has been refusing to eat for 2 to 3 days and there is a danger of dehydration.

The nurse and patient also discuss her diet; she has some choices and religious eating rules are respected. Meals are served and removed in a neutral atmosphere and staff members do not sit with patients while they eat. Everything in the room is thoroughly checked to forestall attempts to dispose of food or to vomit. The program nurse spoke of the need to be extremely firm at this stage so that the patient knows where the limits are.

The patient's target weight is decided by the program nurse according to what is the lowest acceptable weight for her age and body frame. It is the nurse's responsibility to get the patient to target weight and this is not discussed with the patient during the initial phases of treatment as it is considered too anxiety-provoking. The sister-in-charge explained that by the time the patient is told her weight, she has had time to get used to herself, has had feedback and worked on her body image and so finds it easier to accept the increased weight. In the first 3 phases the program nurse will tell her if she is not gaining weight fast enough and make adjustments accordingly. She is weighed 3 times a week, with her back to the scale, and a record of weight gain is kept in graph form in the nursing notes.

The program nurse, when interviewed, said that the patient may

discuss weight and food only with the program nurse otherwise she stands to lose a privilege. The reason she gave for this is that "otherwise they use weight and food to talk about a lot of other aspects and one tries to get them rather to talk in terms of feelings and emotions and things, rather than talk food and weight."

In Phases 1 and 2 (which usually last 6 weeks), the patient earns 3 privileges a day, given immediately after each meal; these usually include access to her personal belongings such as toiletries, and to forms of entertainment or activities such as use of the radio or embroidery and O.T. The staff ensure that the patient is occupied to avoid the possibility of sensory deprivation; nurse aids also keep the patient company. The program nurse also sets her tasks (such as making a collage or doing a projective art exercise) which the nurse may then explore with her. After about 4 weeks, she may receive patient visitors.

The sister-in-charge said that it is very common for patients to rebel at 3 to 6 weeks into the program so that she now builds in a compromise; the patient is offered some change (e.g. an extra hour out of bed) that will give her more freedom and responsibility. This phenomenon commonly occurs again at about 10 to 12 weeks. Some patients decide to sign themselves out.

In the next phase of the program, the patient earns one privilege a day. These include social reinforcers such as family visits and social contact out on the ward, for example spending one hour in the patients' lounge.

Usually by 8 weeks, she is being integrated into the milieu program, joining groups and evocative techniques (described below). By now her target weight is usually achieved so the goal becomes weight maintenance; privileges are contingent on eating and weight maintenance, the responsibility for which begins to be handed over to the patient. She serves up her own meals under supervision and is told her weight.

Bulimics now have access to food and toilets so a contract is made with them to report if they feel the urge to binge or vomit, or if it actually happens. Her program nurse or another nurse will help the patient to calm down and then explore with her what stress might have precipitated the urge. Staff may also use disapproval or threats, e.g. of making the patient eat what she has vomited. The sister-in-charge commented "The bond they've built with their therapist or nurse by that stage is such that they often will come and talk about it". The patient will not lose a privilege.

In the next phase, maintaining her weight and appropriate eating behaviour are solely the responsibility of the patient. She serves her meals unsupervised and is put on a contract to maintain her weight to within 0,5kg of her target weight. She now gains 3 privileges a week, usually in the form of outings with staff and family. She moves into a dormitory with other ward patients.

In the final phase of treatment, all privileges are faded and the patient is fully integrated into the normal ward program. With time out she begins to be reintegrated into her normal life.

2.2.4.1 Body image work

This is the other aspect specific to the eating disorders program and done by the program nurse, and usually begins in Phase 2.

At present, it includes:

(i) education concerning body functioning (including digestion, menstruation, the relation of food intake to weight maintenance, and how hormonal changes at puberty affect body and mood changes).

(ii) (once a comfortable rapport has been established), discussing body image and related feelings concerning how the patient perceives her body and feels about herself. This is done via mirror work, i.e. with the program nurse the patient examines the different parts of her body and expresses her reactions. The nurse then directs her to find one feature that she likes (for example, her hair) and to build on that, in this way encouraging the expansion of a positive attitude to her body. The nurse will also draw on outline of the patient on a sheet of newsprint to help the patient begin to develop a more realistic percept of her body size. Patients are also encouraged to begin to wash themselves with their hands rather than with a cloth.

(iii) exploring their attitudes to clothes, and the reasons why they tend to hide their bodies, and helping them to deal with reactions from others when they wear more close-

fitting and flattering clothes.

The program nurse will continue with this for as long as she deems necessary.

2.2.5 Milieu therapy

The behavioural program and body work, focussing on weight and eating attitudes, are supplemented by the milieu therapeutic program to help the patient build up "the basic confidence" (as the sister-in-charge expressed it) in self and relating to others. Besides groups and occupational therapy, the ward program includes projective art, social skills, growth games, role play and games. A brief outline of some of these will be given to fill out the complete picture. This information was given by the occupational therapist.

In projective art, the patients are given a theme or subject to express in paints, pencil crayons or other media. An example of a theme might be "Draw yourself as a container." Patients then discuss their drawings and are given feedback (including interpretations) by staff and patients.

A course in social skills is run once every 3 months for 6 to 8 weeks. Sessions are 1½ hours long. In the first few sessions, the patients practise making conversation; assertive skills (making and refusing requests, handling criticism, etc.); public speaking and putting across one's point of view without being dogmatic; and non-verbal communication. Depending on patients' choice, they may also deal with self-defence or discuss issues around sex and relating intimately.

Role play (like psychodrama) is aimed at the expression of feelings around conflictual issues, for example, confronting one's mother about controlling one's life. An eating disorder patient may choose to role play handling comments about her extra weight.

2.2.6 Individual psychotherapy

Patients have twice weekly sessions with their individual therapists who do psychodynamic or client-centred therapy according to their frameworks.

The therapist will liase with the program nurse as to what issues the patient is dealing with in therapy. The program nurse gave an example of dealing with the menstrual cycle, sexuality and femininity in the body image work while the therapist was concurrently dealing with issues of rejection, guilt, anger, destructiveness and greed in therapy.

2.2.7 Family therapy

Another important thrust of treatment is working with the family.

The family is seen every week for support and to gather collateral until the patient is judged by the team to be ready for family therapy. The focus of treatment is to explore the family's interactional patterns, dysfunctional subsystems and

the central issue of control.

2.2.8 Discharge and follow-up

The goals described by the team for the patient by discharge seem fairly uniform (see the table in Appendix C) and in line with what has been advised in the literature. They are (in summary):

(i) a normalisation of eating patterns and a feeling of control in the patient although it is not expected that the preoccupation with food or weight will be completely extinguished so the symptoms may re-emerge under stress.

(ii) "building up strengths", learning to identify factors precipitating symptoms and to replace them by more constructive ways of dealing with these precipitants.

(iii) improving interpersonal relationships and developing new interests.

(iv) an improvement in family communications.

After discharge, the ward recommends that the patient continues in individual therapy for at least a year, and participates in the eating disorders group run by the ward. This provides feedback, support and contact with peers. Family or marital therapy may be recommended.

Staff, in interviews, spoke of the problems of lack of experienced clinicians willing to take on such patients both in Cape Town and other centres.

They showed an awareness of the patient's need for support while making the transition back to their everyday lives away from the structured environment of the ward where they have been receiving constant support.

2.3 Case illustration

An example case of a bulimic patient treated in the unit will now be presented.

Most of the information has been drawn from therapist and nursing notes in the clinical folder, supplemented by interviews with the staff and the patient herself.

2.3.1 Identifying information

Marianne*, a schoolgirl, was admitted to the ward with a 1-year history of disordered eating and of depression.

In the year prior to admission, Marianne had decided to go on diet after a comment by her mother that she was too fat. Within 4 months, she lost 16kg (which represented 28% of her body weight). She also became amenorrhoeic. At that time she felt in control of her life and was achieving well at school. However, her family and the school psychologist, in alarm, were putting pressure on her to eat.

In response to these pressures she had her first major binge.

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* Names have been changed

She began binging regularly and in 2 months had regained the 16kg she had lost. After a binge, she would feel hopeless and suicidal at having given in to food, and full of self-deprecatory thoughts. She could not concentrate and therefore was having trouble coping with her school work; she also withdrew socially.

To counteract the effects of the binging, she taught herself to vomit and also began abusing laxatives. This had been going on for 2 months when the school psychologist referred her to a private therapist and she was eventually seen by the consultant in charge of the unit, who advised that she be admitted to the unit.

2.3.2 Admission

Marianne had no prior contact with the ward and knew very little about the behavioural program. She understood that the length of stay would be 2 to 3 weeks, which at that stage was the longest she was prepared to consider.

The clinical records note that on admission she was "clearly depressed" and very ambivalent about coming into hospital, denying that there was any need for it. She was described in the nursing notes as resistant, uncooperative and stubborn, vague and evasive in giving information, suspicious, tearful and distressed, demanding and angry. When interviewed she described having many frightening fantasies about being trapped, "sedated out of her mind" and used as an experiment.

It was a shock to discover that her length of stay would probably be about 6 months.

Most of the staff, when interviewed, seemed to agree that from the beginning her behaviour was characterised by a histrionic style, much "acting out", and testing (e.g. trying to pass a note to a fellow-patient and hoarding her medication with the intention of taking an overdose). However, the therapist also noted that she was an attractive, bright, warm, talented girl who made many efforts to be liked and succeeded in winning over most of the staff and patients during her stay. She was given special status and a lot of attention.

2.3.3 Course in hospital

Marianne was put on Chlorpromazine and began the program from her first day. She was put to bed and her list of privileges was drawn up, largely by her program nurse, according to her. Her list of privileges is included in Appendix D. One can see that, compared with the other example, the choice is fairly standardised.

Her program nurse also decided on her target weight; she had to lose 2kg.

The main aim of the initial phase of the behavioural program therefore, was to establish appropriate eating patterns. She earned no privileges on her first day but thereafter she began to earn privileges although she was reported as reluctant to eat, and "stubborn and demanding" in the first few weeks,

according to the nursing notes and her program nurse.

It appears that after about 3 weeks she settled down, became more compliant, her motivation increased and she "accepted her need for help". The nursing notes at this time record more than once "No testing".

She had her first change of therapist at 3 to 4 weeks due to the rotation of interns. She continued to express anxiety about eating and the resultant weight gain; during this period while she was confined to bed she was described as sad, insecure, frustrated and bored. She expressed fears about "force feeding" with which she was threatened by one of the night nurses.

She began working on her body image with her program nurse but recalls that because she felt so negative about her body she was not very receptive and it does not seem to have had much effect on her.

From very early on, there is mention, in individual therapy and groups, of a strong transferential relationship which she developed towards the sister-in-charge who was closely involved with her program in its early stages. The sister discussed it with her privately on occasions. However, both she and Marianne's therapist felt that it was still unresolved.

There are records of psychodynamic interpretations being made to Marianne by this sister, by her program nurse and by one of the night nurses who used to encourage Marianne to express herself in drawing and poetry which they would then

explore. At one stage, there was concern among some staff members that Marianne was having too much attention from different staff members.

Her program nurse remembers her moving quite quickly in the first phase of the program. At 5 weeks, she began to move out of her room and to socialise with the patient community for limited periods. She expressed apprehension about this and again later when the time came for her to move into a new room and to join a patient group.

At 7 weeks she entered phase 3 of the program where she was earning 1 privilege a day; in theory patients should at this stage have achieved target weight but Marianne's weight was still fluctuating to the extent that she dropped below her target weight. Her program nurse recalls that she got "stuck" at this phase.

She had now earned supervised access to the toilet; at this time she vomited a small amount into her waste paper basket. The program nurse dealt with this by exploring associated feelings and contracting with her to report any urge to vomit in the future. It is interesting that in retrospect, Marianne feels that she never had a strong urge to binge or vomit while on the ward. In fact she almost forgot about it. She saw the above incident as a sort of test trial resulting from her anxiety as to what would happen if she felt an urge to vomit once she had left the ward.

At 9 weeks, she appears to have been approaching a "breakout".

The notes record her needing a lot of attention, being sad, distressed, tearful, anxious and restless, and threatening to leave. This culminated in her running out of the ward but being stopped just outside the door.

At approximately twelve weeks she was continuing to earn more access to community activities and contact with outside visitors. Her program nurse and the nursing notes report her as attention-seeking and very jealous of the new anorexic admission, "wanting to be No, 1 Special on the ward".

At this time she joined the eating disorders group in which she continued until after discharge. There are reports of distress, "sad and empty" feelings, and token self-mutilation. Again she absconded and was confronted on her return by the sister-in-charge and the night nurse. The notes state: "She shared a fantasy of having given birth on the mountains When asked to depict the feelings in drawing was able to do so with containment, explored the aspects of sexuality and fear of growing up - fantasy of oral impregnation, i.e. food and implication of growth. More contained but tearful after the interaction."

At fifteen weeks she was eating all meals in the patient dining room and beginning to serve her own meals under staff supervision. By the nineteenth week this had been extended to include all meals. She had also earned free access to the toilet. During this time she is reported as expressing the desire "to regress to the early days ofthe program when she took little responsibility"; fears of growing up and taking

responsibility; and urges to binge and vomit. Her weight dropped quite dramatically.

She had earned the privilege of knowing her target weight. She remembers being very angry at this as her ideal weight was about 2kg below the target weight. As she was below her target weight, her earning of privileges was made contingent on her gaining 0,2 to 0,5kg per week. By this stage she should have been at weight maintenance.

At weeks nineteen to twenty, the sister-in-chage and her program nurse were going away and Marianne had a scheduled move to a new room. She expressed fears of her weight getting out of control while her program nurse was away, and of relapsing on discharge, and reported feeling suicidal. She became withdrawn and defended.

At week twenty-one, she finally entered the stage of weight maintenance and began serving her own meals unsupervised. She remembers feeling angry at this enforced independence. There is a record of her being angry with herself for "binging" on chocolate and an extra cup of Milo. She had another change of therapist.

At this time she was put on an anti-depressant which seems to have had the side-effect of making her hyperactive. Again she threatened to leave if not given time out. (If one compares the other sample program included in the Appendix, this usually occurs at about twelve weeks but was delayed so long in Marianne's case because of her weight fluctuations).

The notes report her as distressed and still suicidal, "child-like, whining and tearful", lonely, miserable and inadequate, angry over being "fat", expressing fears of not coping and reporting physical complaints. The nursing notes mention "issues of control" and report that she was "encouraged to look at what she was avoiding dealing with on a feeling level."

She began to spend weekend time out in the care of her parents. She is reported as manifesting reluctance to take responsibility, "fearing loss of staff affection and attention due to more responsible status in the community."

At twenty-eight weeks (7 months) she was finally off the program and entered a contract with her program nurse to maintain her target weight in order to achieve day patient status.

She was reported as coping with her time out, being less demanding, supportive of and giving appropriate feedback to other patients, taking responsibility in the community and "coming across as quite adult"; however, it was also noted that she was "therapising and identifying with authority." It would appear that she was trying to be a "good girl".

Day patient status was planned followed by reports of dizziness and blackouts. She also binged over one weekend. (Both indicate her anxiety).

At thirty-two weeks (8 months) she became a day patient, i.e. sleeping at home and attending the community program during the day. Again she began to express fears about having to

carry on despite suicidal wishes and her therapist reported her as saying that she "doesn't want to disappoint anyone by not coping" after her discharge. There was "a mild recurrence of bulimic symptoms"; she was binging but not vomiting.

2.3.3.1 Family therapy

Family therapy had begun once Marianne was out of bed, and continued throughout her stay. By the time of discharge, it was felt that Mother and Father were relinquishing control over Marianne, allowing her space to develop autonomy.

2.3.4 Discharge and follow-up

At thirty-four weeks (just short of 9 months), Marianne was discharged. At the time of discharge there was a feeling on the ward that she had done very well and she was left feeling that she was now "cured" and "perfect".

The follow-up plan was that (i) she continue in individual psychodynamic psychotherapy with the intern who had been her last therapist on the ward, and (ii) continue in the eating disorders group. The social worker did not think further family therapy was necessary. (Most of the following information comes from therapy notes).

For the first month her weight remained stable and she was coping well with family and social relations but binging

mildly (about once a week), and experiencing moodswings.

In the second month, she began to binge and vomit more often and her weight began to increase which made her feel panicky. During the third and fourth months she reverted to binging alone interspersed with dieting so her weight rose and dropped. In the fifth month her school performance dropped and she began to withdraw socially. She became depressed and suicidal, her mood fluctuating with her weight. Eventually she had to be admitted to a private nursing home for 10 days which meant missing exams. After being discharged she decided to drop out of the eating disorders group.

At the time of interviewing her, she felt depressed and that she was not coping. Her therapist's opinion was that re-hospitalization at some future date will be necessary.

2.4 Summary and Conclusion

A description of the general principles and implementation of the treatment program was followed by a detailed case history of one bulimic patient who was treated on this program.

Marianne reflects many of the features typical of bulimics noted in the literature: depression; low self-esteen and consequent need for approval; poor body image; impulsivity; manifested in her self-mutilation and parasuicide attempts; permeable ego boundaries; field dependency, shown in her quickly adapting to her milieu; a premorbid anorexic episode;

family history of depression; dichotomous all-or-nothing thinking and attitudes reflected in her tendency to idealise; mood swings; a more out-going personality and flirtatiousness; and externalised defences.

In reviewing her progress on the ward, much of what happened and proved problematic could be predicted in the light of these features, although exacerbated by other more atypical features, notably the circumstances in which she was admitted, her questionable motivation, and her histrionic style. In all she was likely to be a difficult patient and her prognosis doubtful. However, she had youth, intelligence, an ability to verbalise and to establish bonds with others on her side.

It is possible to understand many features of her behaviour differently from the way they were explained in the records. Her initial reaction to being isolated is a common one and to be expected in view of the reality of the situation.

It could be argued that her compliance after the first 3 weeks was to be expected in view of her powerless situation and great need for attention and approval; her true motivation would be difficult to judge in such circumstances.

It would seem that in her case the secrecy surrounding the issue of her target weight was unncesssary and that some of her anxiety about being made too fat could have been alleviated by a more open approach.

Her early history of deprivation would make one expect her deep needs for attention and nurturance to quickly emerge in

a situation of bedrest accompanied by a lot of physical care. Having enjoyed this attention for 4 to 6 weeks, it is understandable that she was apprehensive about leaving this situation and later frequently expressed the desire to return to it.

The intimacy created by this situation makes Marianne's feelings towards the sister-in-charge, who was acting as her caretaker, predictable. It is likely that discussing the relationship and Marianne's feelings privately would only have served to heighten rather than dissipate the intensity of the feelings.

Being intelligent and quite field dependent, as are most bulimics, she seems to have adapted to the level of discourse in the ward quite easily, speaking of 'regression' and 'envy and jealousy'. This is possibly what prompted the many interpretations concerning primitive phenomena from a number of the staff as, in her need to be accepted, she probably appeared able to understand and work with them. It was obviously a successful way of getting the attention of the staff. However, her fragile ego resources, depression and impulsivity are all contraindications for interpretative work and make her acting out in the face of the anxiety stirred up predictable. Interpretations concerning her envy and jealousy and other such negative concepts is also likely to have aggravated her already low self-esteen (Garfinkel and Garner, 1982).

Once having bonded with the ward, it is likely that Marianne would quickly become dependent. Her erratic progress could

be at least partly due to her ambivalence about getting better and having to leave. As the time got closer to discharge, she seems to have been clearly expressing her fears of not being able to cope; yet they were not acknowledged and dealt with as such but rather she was "encouraged to look at what she was avoiding dealing with on a feeling level". Thus it seems likely that by the time she left she had not gained the confidence and belief that she had control over her situation and that it was not still in the hands of the staff.

Her expectations on leaving seem to have been unrealistic, indicating that she had not modified her all-or-nothing style style of thinking. She was still overly concerned with weight and food, and seems to have been inadequately prepared to cope with relationships with her family (especially siblings) and with men.

In all, it seems that in many ways the circumstances set up by the program fed into her problems. Her example seems to indicate that the program as it stands is not suitable for bulimic patients with their weak ego resources and many associated complications. This will be explored further in the next chapter.

CHAPTER III

A CRITICAL ASSESSMENT OF THE TREATMENT PROGRAM

3.1 Introduction

In critically assessing the treatment program for bulimic patients, it is necessary first to consider the structure and framework within which it is set and implemented, both on a practical and a theoretical level.

Firstly, the structure of the ward and how it is staffed will be considered and secondly, the problem of running a behavioural program in a ward where the theoretical understanding and approach of the staff is largely psychodynamic will be explored.

The program itself will then be examined to see whether it achieves what it sets out to do in its own terms (i.e. applied behavioural principles) and whether it is the most appropriate method for treating bulimics. The staff have been questioning this.

The issue of the suitability of bulimic patients for psychotherapy will also be addressed. Constraints of space have resulted in a decision to exclude other aspects of the program such as family therapy where it is felt that there is little need for adjustment.

The analysis is conducted from a cognitive behavioural perspective (Bandura, 1977; Mahoney, 1974; Meichenbaum, in Schwartz and Shapiro, 1976, 1977; Meichenbaum and Genest, in Kanfer

and Goldstein, 1980; Wilson, in Foreyt and Rathjen, 1978). This approach recommends itself in many ways as offering a framework within which to reconcile a psychodynamic and strictly behavioural approach, and a basis for the planning of a treatment program for bulimics. A description of this approach will be outlined in the next Chapter.

3.2 The Structure of the Ward

The present staffing arrangements on the ward are such that a small core of permanent nurses, together with the occupational therapist and social worker, provide continuity while the interns and registrars rotate through. The patients spend most of their time with the nursing staff whereas they only see their therapists twice a week.

These factors are likely to make the nurses feel obliged to be acting therapeutically towards the patients although they do not have the training to do this. This is particularly likely in the case of the nurses who run the eating disorders program as they are in close contact with their patients over a long period. The sister-in-charge saw their role as that of a surrogate mother figure, providing consistency and attempting to be "all understanding and all giving". Both she and the program nurse, when interviewed, commented on the danger of their getting over-involved with and over-protective of their eating disorder patients, and on the difficulty of remaining objective. Little supervision or feedback is available except on a peer basis from the other nurses running programs.

The present structure also affects the power dynamics among the staff. The nurses are in charge of the program and have more experience with eating disorders than the interns and registrars who have to take time to familiarise themselves with the program. The sister-in-charge and the program nurse spoke of their concern if they felt that a patient was being "held back" because of the inexperience or unfamiliarity of an intern or registrar. This might also prompt the nurse to therapise the patient herself.

From the other side, the intern and registrar interviewed spoke of the problem of a confusion of role boundaries and being uncertain of their brief because nurses are doing therapy outside of the context of individual therapy.

Further ramifications of some of these effects will be explored below.

3.3 The Articulation between a Psychodynamic and a Behavioural Approach

Although it is not inevitable, there is the potential for clashes at some points between a psychodynamic and a behavioural approach. In considering the present interface between these two modes in the ward, attention will be focussed on assessment, the level of discourse on the ward and the effect this has on the nature of the staff/patient relationship.

For the purposes of this thesis there is necessarily much over-simplification in presenting the 2 different approaches.

It is acknowledged that the psychodynamic and behavioural schools are not monolithic structures and the reader interested in more detail is referred to Marmor and Woods (1980).

3.3.1 Assessment

Psychodynamic therapy is usually based on a traditional psychiatric assessment in which a description of the presenting problem and the family and personal history is elicited, possibly supplemented by psychometric and/or projective tests to enable the clinician to test his hypotheses and reach a diagnosis; he will then formulate an understanding of the presenting problem in psychodynamic terms.

There is often little direct relationship between a psychiatric diagnosis and treatment whereas a behavioural assessment entails a more direct sampling of the target behaviours themselves, which are the very ones to be subjected to modification procedures in treatment (Hersen, in Hersen and Bellack, 1976). The purpose of the assessment is clearer to the patient who will probably be involved in the assessment by monitoring her own behaviour (Morganstern, in Hersen and Bellack, 1976).

On the ward a traditional psychiatric assessment is done. At present, no behavioural analysis of the target behaviours (which requires special training) is undertaken; this makes it impossible to tailor the treatment program to the individual's specific symptom pattern, an essential tenet of behavioural therapy (Lazarus, 1976). Generally a diagnosis is of little use in making a functional analysis because apparently homo-

geneous problems may be caused and maintained by different contingencies (Emmelkamp, 1982).

The psychodynamic formulation has the effect of setting the tone and shaping the staff's conceptualisation of the patient's problem, and therefore their approach, in psychodynamic rather than behavioural terms. Generally this conceptualisation and understanding is not shared with the patient.

3.3.2 Level of discourse

Both psychodynamic and behavioural therapists teach the patient a therapeutic language, through what Meichenbaum terms a process of "translation" whereby the patient comes to conceptualise her problem in terms of the therapist's frame of reference. This may be more or less directly communicated (Meichenbaum, in Schwartz and Shapiro, 1976).

On the ward the level of discourse is largely psychodynamic as illustrated by the case notes in the previous chapter. Nurses and other staff make frequent interpretations to patients during the various ward activities.

This has a number of consequences generally on the ward. Firstly it reinforces the separateness of the ward from everyday life by creating a language or code composed of highly specialised words and terms that is particular to the ward. This makes the transition back to the ordinary world more difficult. The behavioural level of discourse, on the other hand, remains closer to the level of everyday discourse.

Secondly it places the staff who are in possession of this specialised language in a one-up position *vis-a-vis* the patients who must adopt it in order to fit in to the community. This power differential is reinforced by the staff's apparent access to the patient's unconscious motives and dynamics manifested in their interpretations. This all coalesces to keep the patients in a dependent position which militates against the equal power and information sharing which is supposed to pertain in a therapeutic milieu (Abroms, 1969).

Making interpretations is also likely to stimulate transferential feelings towards the staff (Malan, 1979). However, nursing staff are not trained to do therapy or to handle transferences constructively, nor are they supervised as the interns and registrars are. There is no appropriate context to resolve these feelings, as is illustrated by Marianne's case.

Patients with poor ego-strengths (such as bulimics) are likely to experience intense anxiety when presented with such interpretations early in treatment, unless carefully modulated. This is likely to prompt them to revert to their usual external defences and to act out (which is also exemplified by Marianne).

A valuable consequence of the therapist or helper sharing the patient's level of discourse is that it allows the patient a more equal share in conceptualising her problem and collaborating in her treatment. The behaviourists have generally emphasised the patient's responsiblity for and control over the treatment which promotes a sense of competence and confidence (Bandura,

1977; Fairburn, 1981, 1982, 1982 in press; Karoly, in Kamfer and Goldstein, 1980; Mahoney, 1974; Meichenbaum, in Schwartz and Shapiro, 1976).

In principle this spirit of cooperation informs the behavioural program on the ward but, as will be illustrated below, the patient actually has little real share in or control over drawing up, or implementing, her program.

So, all in all, in considering the interface between the predominantly psychodynamic approach of the ward and the behavioural program, it seems that the assumptions and ethos created by the psychodynamic approach largely predominates so that the behavioural program is being conducted out of context and several aspects important in a behavioural approach are missing or discouraged, notably (i) beginning with a functional analysis, (ii) engaging the patient as an active collaborator, (iii) working on a shared understanding of the patient's problem, and (iv) keeping the level of discourse on the ward as close to the everyday as possible.

3.4 The Eating Disorders Program

3.4.1 Goals

As has been noted in the literature, the presenting symptoms of bulimics are not likely to remit without focussed and specific intervention (Fairburn, 1981, 1982; Loro and Orleans, 1981; Wardle and Beinart, 1981). On the ward the importance of addressing the symptoms and reshaping behaviour directly

is acknowledged by putting patients on a behavioural program. while the underlying issues are dealt with by more exploratory therapy.

However, the expressed goals of "appropriate eating behaviour" bear a rather indirect relationship to the primary symptoms of binging and vomiting.

Although putting a bulimic patient to bed, and removing all opportunity to binge and vomit, breaks the cycle thereby affording the patient some relief, the removal of the primary symptoms is so complete that they are not directly dealt with; they are only temporarily deleted.

The point of a behavioural intervention is to provide a structured situation, as close to normal as possible, in which the patient, with support and direction, can confront and grapple with the symptoms, and gradually learn to control them through her own efforts (Karoly, in Kanfer and Goldstein, 1980; Meichenbaum, 1977; Wilson, in Foreyt and Rathjen, 1978).

3.4.2 The initial and middle stages

In terms of early operant conditioning theory, the program reinforces appropriate eating behaviour by setting up negative and positive contingencies.

Negative reinforcement is in the form of hospitalisation, isolation and deprivation of personal belongings (although, strictly speaking, the removal of the first two are too long-term to act as negative reinforcers which should be removed immediately

on production of the desired behaviour). Positive reinforcement is applied in the form of the graded privileges which are earned. Punishment is applied by withholding privileges which means an extension of the isolation period and of time in hospital. No discussion of eating or weight is intended to help extinguish this concern (Luiz-Riccitelli, 1982).

These principles all assume a passive patient mechanically reacting to the imposition of reinforcers. But people are not so passive; they collate information so as to make sense of their world and to be able to make predictions (Breger and McGaugh, in Marmor and Woods, 1980). How then is a patient likely to perceive and experience the program?

Putting a patient to bed in isolation, cut off from her family and only having contact with the staff, together with the possibility of force-feeding, and of extended isolation and hospitalisation, if she does not cooperate, is likely to impress the patient as punitive[1] and make her feel very helpless. For bulimics this is likely to be exacerbated by their weak body boundaries which makes them very sensitive to any threat of being intruded on (Strober et al, 1979).

When presented with the program, patients are given a limited choice of privileges as these are graded in a predetermined way (see Appendix D). Marianne commented that she had the choice of whether to have access to her toothbrush, hairbrush or toothpaste first. She recalled that, at another

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[1] The word 'privilege' applied to her own belongings implies that she is bad.

stage, she had to earn a poster even though she didn't want one so as to be able to proceed. She commented on the irony of their being called "privileges". "They were just steps". In fact, the program is administered in an inflexible ritualised way that takes little account of the fact that what acts as a reinforcer for one does not serve the same function for another (Karoly, in Kanfer and Goldstein, 1980).

The program nurse controls the program in terms of speeding it up or holding a patient back, and in granting concessions or withholding privileges for "misbehaviour" which she defines (Luiz-Riccitelli, 1982). All this, plus the refusal to discuss weight or food, is likely to reinforce the impression that the staff is not open to negotiating. Being in control of the patient's weight increases the nurse's power. (The fact that so much depends on eating and weight makes it unlikely to extinguish it as a focus of concern. Rather it is likely to reinforce the patient's overvalued ideas of weight as a yardstick of success and acceptability).

In such a situation it seems unlikely that patients can truly feel that they have a share in the control of and responsibility for their treatment. The privileges are only token and the real reinforcer is the approval of the staff, particularly that of the program nurse with whom the patient usually develops a close bond. Patients soon learn that to progress they must comply so what is actually being reinforced is obedience (thereby recreating the pathological situation of constraint that Crisp (1981) warns against).

The patient's effective choices are restricted to compliance, or "deceit" and "manipulation" (in the staff's terms). From another perspective they may be seen as bids for autonomy which perhaps should be reinforced. The sister-in-charge noted that attempts to abscond are standard. Karoly (1980) points out that if choosing to use punishment, one must be prepared to deal with the client's frequent efforts to avoid or "escape" the treatment (Karoly, in Kanfer and Goldstein, 1980) 1980).

Such drastic measures are perhaps justified in the face of an anorexic's denial and impenetrable control but the staff seem in agreement (see Appendix C) that bulimics are generally more accessible because of the discomfort caused by their symptoms and their desire to help in being relieved of them. Being in hospital should be aversive enough to spur them to make progress.

However, what seems to happen is that (like Marianne) once patients have resigned themselves to being in bed and have given over control, having their needs for nurturing met is satisfying. (Bulimics particularly, as a result of early deprivation, often have strong needs for nurturance). Besides the attention and company provided by the nurses and nurse aids, there are other unintentional reinforcers in the form of music from other dormitories and the noises and snatches of conversation overheard from the corridor. But in particular there is the special status. The program nurse said she thought they enjoyed being somebody different ("That's one of their whole things, being special"); the sister-in-charge spoke of their

difficulty in letting go of being special and the attention they get for "sick behaviour"; Marianne spoke of the positive reinforcement provided by patient visitors who had elected to visit her and of being "quite content in my own little world, doing my own little thing."

When the time comes for them to join the community they are commonly reluctant. The sister-in-charge noted that they often spontaneously withdraw to their rooms, begin to lose privileges and become distressed at this stage. Much of this behaviour could be understood as efforts to return to that special position.

In a proper behavioural approach this would call for a reassessment. Karoly advises:

> If over time, the individual is not making reliable avoidance or escape responses, ... determine if unknown contingencies ... are interfering with the program or if the aversive consequences are indeed functionally aversive.
>
> (Karoly, in Kanfer and Goldstein, 1980, p.228)

This is also pertinent to the patients' reluctance to leave the ward. Marianne spoke of being quite content during the middle phase (5 to 6 months) of her stay.

This special attention and status which makes the situation involving loss of control so attractive makes it very difficult for the patient to have to take up responsibility again and to have to start from scratch in attempting to gain control. This is particularly problematic for bulimics for whom control and loss of control is such a central issue.

For bulimics, access to toilets is graduated by being supervised initially. The threat of staff disapproval seems to be the strongest contingency preventing the bulimic patient from binging or vomiting while on the ward. Marianne spoke of not wanting to disappoint anyone by binging and the occupational therapist noted that vomiting is strongly disapproved of on the ward. If the patient does binge or vomit, staff use their influence and authority in a combination of approval, support and threat to deal with it, but offer little practical guidance on how to control the urges. Most of their focus is on feelings.

The power of the staff's influence is particularly strong in the case of the program nurse. Even after leaving the sideward, the tie between program nurse and patient remains strong. The patient still goes to her "special" nurse for support and to talk problems over. There is a difficulty in letting go on both sides. This dependence was manifested in Marianne's case by her distress when her program nurse was due to go on holiday. An advantage of a behavioural program is that it should be able to be administered by any members of staff and be primarily in the hands of the patient herself.

Being dependent on the approval of her program nurse, a patient is likely to feel constrained from being honest about any lack of understanding or "slips". It is falling into the danger of exploiting bulimic patients' need for approval as warned against in the literature. The occupational therapist observed that it also makes the patient less accessible to feedback and confrontation from other patients and staff.

3.4.3 Maintenance stage

Once a patient has free access to toilets and food, the problem arises of maintaining treatment effects after the reinforcement contingencies change. It is useful here to consider Karoly's suggests on the establishment of long-term learning and transfer. Among them the most relevant are:

- to teach patients to monitor their own activities and to control contingencies that affect them.
- to establish conditions that permit (patients) to attribute success or failure to their own efforts (rather than fate, lack of power and others).
- by instructing significant individuals in the (patient's) natural environment, to attempt to reprogram the natural contingencies (e.g. the behaviour of teachers, parents and peers) in therapeutic directions.

(Karoly, in Kanfer and Goldstein, 1980 p.241)

In reflecting on the ward program in the light of the above, it is apparent that the patients get little chance to "attribute success or failure to their own efforts" and are far more likely to ascribe most of the credit to "powerful others". This makes it diffucult for them to believe that this effect will continue outside the setting of the ward. As Marianne sums it up:

> You went in there without having control
> so they should have made you stand on your
> own feet straight away. Say "we'll help you

> get control but you've got to do it yourself." But what they did was put you in bed, took away everything, got you right, fixed you up nicely. All you had to do was do nothing. And they did everything for you. And then they put you outside and say "Cope, now that you're perfect." And you deteriorate again.

It is only during the stage of contracting that patients take over real control. Contracting has been found to work well (Monti et al, 1977; Pierloot et al, 1982) but at present occupies a very limited period in the program. Some staff expressed concern that this period be extended.

3.5 Assessment for Psychotherapy

As it emerges that many bulimics have quite severe and wide-ranging pathology, it cannot be assumed that they are suitable candidates for intensive psychodynamically oriented psychotherapy.

Dickman (1983) points out the need for a careful assessment of patients' suitability for therapy, and what kind, in view of the fact that therapy with unsuitable patient causes deterioration. She considers the necessary conditions for a patient undergoing brief reconstructive, re-educative or supportive therapy (using Wolberg's (1977) 3 categories); the reader is referred to Dickman (1983) for a full discussion of these conditions and inclusion criteria.

In assessing bulimics in inpatient treatment in terms of these inclusion criteria, it is clear that they are not likely to

be good candidates for insight oriented therapy. Although they often have certain features considered necessary, such as motivation, intelligence, the ability to form a bond and "psychological-mindedness", they also have many other features which contraindicate attempting insight therapy.

Their problems tend to be diffuse and affecting many parts of their lives rather than focussed and circumscribed; they are often depressed and suicidal; they are not gratifying their biological and social needs in an acceptable way without aggression, self-punishment or guilt, which is an important indicator of ego function; they tend to polarise the world into all good or all bad; they tend to have an external locus of control and have difficulty taking responsibility which militates against their taking an active part in exploring; they use primitive defences such as projection and denial, and tend to act out when anxious; they have difficulty tolerating frustration and discomfort; they often do not have access to their feelings in being able to identify them; their all-or-nothing cognitive style makes it likely that they will have unrealistic expectations of a total cure; they are ambivalent about letting go of their sick role which has made them special and unique; and their sexual and personal histories show difficulty in sustaining relationships.

These patients are more likely to fit into the groups suited to re-educative[1] or supportive therapy with the main focus on rebuilding ego-strengths and coping skills and reinforcing

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[1] Behaviour therapy is included here.

their sense of self-worth and effectiveness. Once this has been done, if the patient is to be followed up in long-term therapy, reconstructive work may be considered.

3.6 Summary and Conclusion

After examining the present structure of the ward and the interface between the psychodynamic approach practised on the ward and the applied behavioural program, the program itself was considered in terms of current behavioural principles.

It may be concluded that in many ways the treatment program has problems. It feeds into the core problems of many bulimics, namely early deficiencies in nurturing, difficulties in taking responsibility and with control, the need for approval, and extreme field dependency. The psychodynamic level of discourse on the ward and the diffusion of therapy among so many staff members is threatening to their fragile egos and thus prompts acting out. The program does not address the primary symptoms nor does it create sufficient opportunity for the patient to take responsibility for and a share in her treatment and to learn to cope with her symptoms in a normal setting.

It is therefore proposed that a restructuring of the treatment program for bulimics along the lines of a cognitive behavioural approach is advisable. This will be enlarged on in the next chapter.

CHAPTER IV

RECOMMENDATIONS AND GUIDELINES TOWARDS DESIGNING AN INPATIENT TREATMENT PROGRAM FOR BULIMICS

4.1 Introduction

On the basis of the foregoing assessment of the current program and in the light of present trends in the treatment of bulimics, some recommendations and guidelines will be outlined as to improving the treatment plan used at present.

There is available a range of possible treatment plans and approaches. It seems that a psychodynamic approach is costly in terms of time and expertise, and is not the most suitable for the circumstances and resources of the local hospital setting where (i) much of the treatment is in the hands of psychiatric nurses, who are untrained in psychodynamic theory and therapy, and (ii) treatment is short-term (i.e. 3 to 6 months) which is not long enough for the reconstructive work that a psychodynamic approach aims at.

Besides these considerations, bulimics who are severely disturbed enough to require hospitalization are not likely to have the ego-strengths required for insight oriented psychodynamic work and projective techniques. They will probably require containment rather than reconstruction and their treatment plan needs to take account of their weak ego-strengths and to focus primarily on building these up.

A cognitive behavioural approach, which has been used successfully with bulimics (Bruch, 1973; Fairburn, 1981, 1982, in press; Garner and Garfinkel, 1982; Guidano and Liotti, 1983), lends itself to the ward's circumstances and is readily compatible with a psychodynamic and systems understanding currently employed by most of the staff on the ward (see Appendix C).

After briefly defining cognitive behavioural therapy, overall aims for the treatment program will be outlined followed by suggested methods for achieving these, translated into the ward's situation.

As a basic tenet of a cognitive behavioural approach is flexibility in adapting the treatment to the individual, it is not possible to set out rigid directives.

4.2 Cognitive Behavioural Treatment Program

4.2.1 Definition

An important extension of applied behaviourism has been the recognition of the important part played by cognitive and symbolic processes in learning (Mahoney, 1974; Meichenbaum, 1977; Wilson, in Foreyt and Rathjen, 1978).

This has led to exploring cognitions, inner language, imagery and fantasies, and hidden assumptions in understanding pathological behaviour, and to an acknowledgement of the close reciprocal relationship between behaviour, cognitions, affect

(Burns and Beck, in Foreyt and Rathjen, 1978; Ellis, 1962), and physiological states (Gendlin, cited by Weitzmann, in Marmor and Woods, 1980; Meichenbaum, 1977).

Cognitive behavioural therapists, therefore, are aware of addressing all these modalities in treatment. However, they argue that it is not enough to aim to change behaviour by intervening only at the cognitive level as the cognitive therapists such as Beck and Ellis do (Burns and Beck, in Foreyt and Rathjen, 1978; Ellis, 1962). The most powerful method of behavioural change is still performance based. The feedback resulting from behavioural change modifies the subject's cognitive constructs and self-perception with an overall increase in self-efficacy (Bandura, 1977; Meichenbaum and Genest, in Kanfer and Goldstein, 1980; Wilson, in Foreyt and Rathjen, 1978).

4.2.2 Aims of the program

In planning intervention one needs to first set up outcome goals. A tentative outline of aims for a bulimic patient might be:

Behavioural

- to control binging and purging.

Cognitive

- to control preoccupation with food and weight, and to correct distorted ideas and attitudes concerning food, weight and body image.

- to improve coping strategies and ego strengths.

Affective and physiological

- to manage anxiety over eating as well as in other situations.
- to identify and change self-defeating cognitive strategies that lead to depression or anxiety.
- to improve the ability to recognise and monitor body cues and feeling states.

Interpersonal

- to improve relationships with others and reduce social anxiety.

Familial

- to improve family transactional patterns and change those that hinder the patient from separating and individuating.

4.2.3 Information gathering

Treatment must be founded on a proper functional analysis and ongoing assessment. Lazarus maintains that "faulty problem identification (inadequate assessment) is probably the greatest impediment to successful therapy" (Lazarus, 1976, p.14). This includes behaviours; antecedent and consequent variables; thoughts, feelings and images preceding, accompanying and following the behaviour; a developmental history of the problem; factors that make the patient resistant to giving up the behaviour; and factors and circumstances that reduce the behaviour.

A familiarity with behavioural principles is necessary to carry out a functional analysis. As the nurses on the ward are not trained in behaviour modification, it would be best done by the clinical psychologist, intern or registrar (Hersen, in Hersen and Bellack, 1976). He/she should make contact with the patient prior to admission so as to set the self-monitoring in progress. This involves the patient keeping a record of behaviour, stimuli, duration and frequency to establish a baseline. Often, in itself, it helps lend some measure of control to the behaviour one wishes to modify (Lazarus, 1976).

A number of schemes for functional analysis are available. Emmelkamp's (1982) macroanalysis and microanalysis might suit the circumstances on the ward as it offers a way of combining the standard psychiatric history-taking with a functional analysis. The macroanalysis focuses on the larger matrix of current interpersonal, working and family factors within which the presenting symptoms are embedded, whereas the microanalysis involves a more strictly behavioural analysis of contingencies prompting and maintaining behaviours.

Lazarus' multimodal scheme, known by the acronym BASIC ID, which stands for behaviour, affect, sensations, imagery, cognitions, interpersonal factors and drugs, has been popular though it provides a rather rough outline (Lazarus, 1973, in Lazarus, 1976). As applied to Marianne, it would yield the following profile:

> <u>BEHAVIOUR</u>. Binges occur daily in late afternoon (after patient arrives home from school), evening or during the night. Occur in secret, if family is at home she conceals binging from

them. Binges on food taken from kitchen, i.e. does not buy food and bring it home. Usually craves particular food, e.g. expensive chocolate, or sandwiches and Oros such as she used to take to primary school. When she feels the urge, may try to distract herself by going for a walk, exercise, dancing to a record, phoning someone, or eating lettuce and carrots. Only temporarily distracts her. Eventually has to satisfy the urge so often will not bother trying to distract herself. Binge usually lasts one to two hours, and is terminated by interruption, falling asleep or vomiting.

AFFECT: (i) Anxiety can precipitate urge to binge which relieves the feeling. After binge, feels alert. Anxiety may be created by efforts to stave off binge. Feels restless, panicky, and frantic.

(ii) Depression or despondency. When severely depressed, has no interest in food. When "coming up" out of it, feels urge to binge. After binge, will sleep (escape). After a heavy day, feeling tired and sense of control low can precipitate a binge.

(iii) Anger. Feeling revolted at herself, desire to get so fat that friends will stop asking her out can precipitate a binge.

During binge, can enjoy food if, for example, it is chocolate. At other times eats food mechanically. Feels angry and guilty. Takes about 4 days for her to feel "clean and light", confident and uninhibited again.

<u>SENSATIONS</u>. Hunger may precipitate binge by prompting her to eat a snack which then makes her feel guilty but is not part of the urge itself. Describes compulsion as like an addiction. During binge gets hot. Cheeks get puffy, takes about 4 days to subside.

<u>IMAGES</u>. Dreaming about food can precipitate a binge. Patient pictures the food she is craving, "can almost smell it".

<u>COGNITIONS</u>. Constant thoughts of food. She will fix on certain foods, usually expensive food such as chocolate. Guilt about eating outside of regular meals or eating forbidden foods can prompt desire to get rid of the food by vomiting. To do this she has to fill her stomach which precipitates a binge. A sense of not coping can precipitate a binge or follow one. Relates moods and feeling of being in control to weight.

<u>INTERPERSONAL</u>. Before an evening out, often feels urge to binge. After the binge, will phone and cancel arrangement. After an enjoyable evening out, will come home and binge, especially if she has had a lot of attention from males. When starting a relationship with a new boyfriend, before it settles, often experiences increased urges to binge. Being in mother's company when feeling fat, or feeling that others do not like her or are angry with her, may precipitate a binge.

Relations with the family bad. All trying to get her to stop binging but she is resisting. Has a lot of friends who give her support. They do not know of binging. No

current boyfriend. Has been withdrawing from friends lately.

DRUGS. Has been on a number of different anti-depressants. Cannot relate changes of medication to changes in binging pattern.

From the above, Marianne's therapist might decide that binging rather than vomiting is the primary target behaviour to address and that social situations, especially those involving the opposite sex, seem to feature high as precipitants so will require particular focus; the patient might benefit from assertion and interpersonal skills training rather than straight social skills. Cognitive restructuring is also a priority to modify the patient's concern with weight and her guilt about eating certain categories of food.

When assessing bulimics, it might also be useful to include Kanfer and Saslow's (1969) category of level of self-control (for example, asking oneself "Is constant supervision or drug administration necessary to supplement self-control?") (Hersen, in Hersen and Bellack, 1980). A home visit can also yield much valuable information (Emmelkamp, 1982).

4.2.4 Practical considerations

The approach to treatment being suggested will involve some changes in the present organisation on the ward. The clinician, whether intern or registrar, will have to have far more contact with the patient, consulting with her and reviewing

her program on a daily basis. He/she will also have to work closely with the team who will need to be fully acquainted with the treatment program, partly so that they do not inadvertently sabotage it and partly because they will be involved in carrying out aspects of it, for instance social and assertion skills training (if this is necessary). It will require flexibility on the part of the staff and the ward program. Ideally the other patients should also be involved in the treatment program.

It is not necessary or advisable that the patient be medicated or put to bed; this means that she will not need a special nurse or have any special status. Rather she should be an ordinary patient in a situation as close to ordinary life as possible.

If the patient is judged to be a suitable candidate for psychodynamic therapy, this should be carried out only within the context of individual therapy where the transference can be dealt with. However, it is more likely that re-educative therapy where the therapist is working with the patient in a more collaborative, fact-finding relationship will be more appropriate.

Bearing in mind bulimic patients' frequent ambivalence about giving up their symptoms and their despair that it is possible, it is likely that initially a lot of structure and direction by the therapist and other staff will be required but without taking over from the patient completely. It is important to convey to her a confidence that, with direction and support, she can cope with her symptoms.

It is also important to be as open and honest as possible. For instance, if it is considered necessary for her to gain weight she should know her weight. In fact, the feedback provided by keeping a record of her weight or rate of binging or vomiting in the form of graphs or charts has been found to work very well in treatment (Agras and Werne, in Vigersky, 1977; Garfinkel and Garner, 1982; Monti _et al_, 1977).

4.2.5 Behavioural aspects

The initial thrust of the treatment will be helping the patient gain control of her symptoms. Once the target behaviour has been decided on, the therapist may draw from a number of behavioural techniques such as stimulus control (Fairburn, 1982); relaxation training (Wolpe, 1973); anxiety management (Lazarus, 1976; Wolpe, 1973); response delay therapy ((Leitenberg _et al_, 1984; Rosen and Leitenberg, 1982); and desensitisation and behavioural rehearsal (for example, taking the patient to lunch and other _in vivo_ situations) (Flowers and Booraem, in Kanfer and Goldstein, 1980).

If vomiting is the target behaviour it might be advisable initially that the patient be supervised quite closely for two hours after meals.

4.2.6 Cognitive aspects

In helping the patient to control obsessive thoughts about food, thought stopping may be tried. Snapping a rubber band

around the wrist whenever the obsessive thoughts begin has also been found useful (Kanfer, in Kanfer and Goldstein, 1980, p.372).

The patient should be continually helped to become aware of her self-destructive maladaptive cognitive strategies and misconceptions and to alter them. Garner and Bemis (1982) have drawn up a useful list of the cognitive patterns common in eating disorder patients, based on Aaron Beck's work.

The therapist may also decide that the patient could benefit from training in problem solving and decision making (Goldfried and Goldfried, in Kanfer and Goldstein, 1980) and in coping skills and stress inoculation (Meichenbaum, 1977).

Basic education about nutrition, diet, physiology, the relationship between food deficiencies and mood states and between weight control and exercise (Cannon and Enzig, 1983) such as is already given on the ward will probably be necessary. Instead of dealing with a distorted body image via mirror work, it could be better approached on a cognitive level (Garner and Garfinkel, 1982).

4.2.7 Affective and physiological aspects

Anxiety management techniques, systematic desensitisation and behavioural rehearsal (already referred to above) will help the patient to face and cope with anxiety related to food and eating. It is important that situations be graded and the patient taught to reinforce herself for having coped (Meichenbaum, 1977).

Aaron Beck (Burns and Beck, in Foreyt and Rathjen, 1978) and Albert Ellis (1962) provide useful guidance on helping patients to identify and alter distorted cognitions (both verbal and pictorial) that adversely affect their self-perceptions and view of the world, leading to depression or anxiety.

In helping patients become more aware of bodily sensations and feeling states, the work of Gendlin (cited by Weitzman, in Marmor and Woods, 1980, p.121) is useful. Body work such as yoga and the Alexander method is also valuable in sensitising patients to body cues while movement therapy, dance and exercise encourages a more positive attitude to the body (Crisp, 1980).

4.2.8 Interpersonal aspects

Assertion training and social skills which are already part of the ward program could be emphasised and extended for bulimic patients (Cotler and Guerra, 1976; Wolpe, 1973).

It might also be helpful to explore the patient's expectations of others and point out unrealistic expectations, magnification, and dichotomous all-or-nothing thinking (Garner and Bemis, 1982; Burns and Beck, in Foreyt and Rathjen, 1978), with the aim of assisting the patient to decentre, to have more realistic expectations and to be able to ask appropriately for her needs to be met.

It is important to actively help the patient to build up her social support system, and to engage the people she lives with by counselling them on understanding her problem and on

how to help her cope with it without taking over (Fairburn, 1981, 1982).

4.2.8.1 Familial aspects

If the patient is still living in the family home, family therapy will be an important component of the treatment program.

4.2.9 Discharge and follow-up

By discharge the patient should have had many opportunities for graded exposure to threatening situations so as to allow her to gain mastery in small manageable steps. She should have learnt a variety of cognitive and behavioural strategies; coping devices are complex and need to be flexible (Meichenbaum, 1977). She should also have been prepared for possible crises in the future. This may include re-establishing monitoring, reducing the availability of food and enlisting the help of others (Fairburn, 1982). Treatment outcome should be conceptualised in terms of maintenance strategies rather than the traditional quasi-disease model of "cure" or "relapse" (Wilson, 1980). Cameron (in Foreyt and Rathjen, 1978) describes 2 useful attitudes that the therapist aims to inculcate in the patient. The first is "What I have learned is a coping skill" as against "I have overcome my problem and never expect to experience it again" and the second is "I am responsible for the changes I have experienced" versus "My improvement resulted from external factors".

The current ward policy of recommending that the patient continue in long-term therapy and join a group will help her to make the transition back to normal life.

4.3 Summary

A cognitive behavioural treatment program for bulimic in-patients in the local hospital psychiatric unit, more suited to the circumstances pertaining on the ward and to the needs of bulimic patients, has been proposed.

REFERENCES

Abroms, G.M. Defining milieu therapy. In Archives of General Psychiatry, 1969, 21, 553-560.

Abraham, S.F. and Beumont, P.J.V. How patients describe bulimia or binge eating. Psychological Medicine, 1982, 12, 625-635.

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (3rd ed.). Washington: American Psychiatric Ass. Press, 1980.

Azerrad, J. and Stafford, R.L. Restoration of eating behaviour in anorexia nervosa through operant conditioning and environmental manipulation. Behaviour Research and Therapy, 1969, 7, 165-171.

Bandura, A. Self-efficacy: toward a unifying theory of behavioural change. Psychological Review, 1977, 84(2), 191-215.

Bemis, K.M. Current approaches to the etiology and treatment of anorexia nervosa. Psychological Bulletin, 1978, 85(3), 593-617.

Ben-Tovim, D.I., Marilov, V, and Crisp, A.H. Personality and mental state (PSE) within anorexia nervosa. Journal of Psychosomatic Research, 1979, 23, 321-325.

Beumont, P.J.V., George, G.C.W. and Smart, D.E. "Dieters" and "vomiters and purgers" in anorexia nervosa. Psychological Medicine, 1976, 6, 617-622.

Blinder, B.J., Freeman, D.M.A. and Stunkard, A.J. Behaviour therapy of anorexia nervosa: effectiveness of activity as a reinforcer of weight gain. American Journal of Psychiatry, 1970, 126(8), 1093-1098.

Boskind-Lodahl, M. Cinderella's stepsisters: a feminist perspective on anorexia nervosa and bulimia. Signs: Journal of Women in Culture and Society, 1976, 2(2), 342-356.

Boskind-Lodahl, M. and White, W.C. The definition and treatment of bulimarexia in college women - a pilot study. American College Health Association Journal, 1978, 27(2), 84-87.

Bruch, H. Eating disorders: obesity, anorexia nervosa and the person within. New York: Basic Books, 1973.

Bruch, H. Perils of behaviour modification in treatment of anorexia nervosa. J.A.M.A., Dec.1974, 230(10), 1419-1422.

Button, E.J., Fransella, F. and Slade, P.D. A reappraisal of body perception disturbance in anorexia nervosa. Psychological Medicine, 1977, 7, 235-243.

Button, E.J. and Whitehouse, A. Subclinical anorexia nervosa. Psychological Medicine, 1981, 11, 509-516.

Cannon, G. and Einzig, H. Dieting makes you fat. London: Sphere, 1984.

Casper, R.C., Eckert, E.D., Halmi, K.A., Goldberg, S.C. and Davis, J.M. Bulimia: its incidence and clinical importance in patients with anorexia nervosa. Archives of General Psychiatry, 1980, 37, 1030-1035.

Chiodo, J. Assessing anorexia nervosa and bulimia. Chapter to appear in M. Hersen, R.M. Eisler and P.M. Miller (eds.), Progress in behaviour modification. New York: Academic Press.

Chiodo, J. and Latimer, P.R. Vomiting as a learned weight-control technique in bulimia. Journal of Behavioural Therapy and Experimental Psychiatry, 1983, 14(2), 131-135.

Cooper, P.J., Waterman, G.C. and Fairburn, C.G. Women with eating problems: a community survey. British Journal of Clinical Psychology, 1984, 23, 45-52.

Cotler, S.B. and Guerra, J.J. Assertion training. Champaign, Illinois: Research Press, 1976.

Crisp, A.H. Anorexia nervosa: let me be. London: Academic Press, 1980.

Crisp, A.H. Anorexia nervosa at normal body weight - the abnormal/normal weight control syndrome. International Journal of Psychiatry in Medicine, 1981, 11(3), 203-233.

Crisp, A.H., Hsu, L.K.G. and Harding, B. The starving hoarder and voracious spender: stealing and anorexia nervosa. Journal of Psychosomatic Research, 1980, 24, 225-231.

Dickman, B.J. Assessment for psychotherapy within local psychiatric training units: some guidelines. Unpublished Masters thesis, U.C.T., 1983.

Dunn, P.K. and Ondercin, P. Personality variables related to compulsive eating in college women. Journal of Clinical Psychology, 1981, 37(1), 43-49.

Eckert, E.D., Goldberg, S.C., Halmi, K.A., Casper, R.C. and Davis, J.M. Depression in anorexia nervosa. Psychological Medicine, 1982, 12, 115-122.

Ellis, A. Reason and emotion in psychotherapy. New York: Lyle Stuart, 1962.

Emmelkamp, P.M.G. Phobic and obsessive-compulsive disorders. London: Plenum Press, 1982.

Fairburn, C.G. A cognitive behavioural approach to the treatment of bulimia. Psychological Medicine, 1981, 11, 707-711.

Fairburn, C.G. Binge-eating and its management. British Journal of Psychiatry, 1982, 141, 631-633.

Fairburn, C.G. Bulimia nervosa. British Journal of Hospital Medicine, 1983, 29, 537-542.

Fairburn, C.G. The place of a cognitive behavioural approach in the management of bulimia. In Anorexia nervosa, edited by P.L. Darby, P.E. Garfinkel, D.M. Garner and D.V. Coscina. Alan Liss, New York (in press).

Fairburn, C.G. and Cooper, P.J. Self-induced vomiting and bulimia nervosa: an undetected problem. British Medical Journal, 1982, 284, 1153-1155.

Fairburn, C.G. and Cooper, P.J. The clinical features of bulimia nervosa. British Journal of Psychiatry, 1984, 144, 238-246.

Foreyt, J.P. and Rathjen, D.P. (eds.), Cognitive behaviour therapy. New York: Plenum Press, 1978.

Garfinkel, P.E. Some recent observations on the pathogenesis of anorexia nervosa. Canadian Journal of Psychiatry, 1981, 26, 218-223.

Garfinkel, P.E. and Garner, D.M. Anorexia Nervosa: a multidimensional perspective. New York: Brunner/Mazel, 1982.

Garfinkel. P.E., Garner, D.M., Rose, J., Darby, P.L., Brandes, J.S., O'Hanlon, J. and Walsh, N. A comparison of characteristics in the families of patients with anorexia nervosa and normal controls. Psychological Medicine, 1983, 13, 821-828.

Garfinkel, P.E., Moldofsky, H. and Garner, D.M. Prognosis in anorexia nervosa as influenced by clinical features, treatment and self-perception. Canadian Medical Journal, 1977, 117, 1041-1045.

Garfinkel, P.E., Moldofsky, H. and Garner, D.M. The heterogeneity of anorexia nervosa: bulimia as a distinct subgroup. Archives of General Psychiatry, 1980, 37, 1036-1040.

Garner, D.M. and Bemis, K.M. A cognitive-behavioural approach to anorexia nervosa. Cognitive Therapy and Research, 1982, 6(2), 123-150.

Garner, D.M., Garfinkel, P.E. and Moldofsky, H. Perceptual experiences in anorexia nervosa and obesity. Canadian Psychiatric Association Journal, 1978, 23(4), 249-263.

Garner, D.M., Garfinkel, P.E., Stancer, H.C. and Moldofsky, H. Body image disturbances in anorexia nervosa and obesity. Psychosomatic Medicine, 1976, 38(5), 327-336.

Gilmor, T.M. Locus of control as a mediator of adaptive behaviour in children and adolescents. Canadian Psychological Review, 1978, 19(1), 1-26.

Gottheil, E., Backup, C.E. and Cornelison, F.S. Denial and self-image confrontation in a case of anorexia nervosa. Journal of Nervous and Mental Disease, 1969, 148(3), 238-250.

Guidano, V.F. and Liotti, G. Cognitive processes and emotional disorders. New York: Guildford Press, 1983.

Halmi, K.A. Anorexia nervosa and bulimia. Psychosomatics, 1983, 24(2), 111-129.

Halmi, K.A., Brodland, G. and Loney, J. Prognosis in anorexia nervosa. Annals of Internal Medicine, 1973, 78, 907-909.

Halmi, K.A., Falk, J.R. and Schwartz, E. Binge-eating and vomiting: a survey of a college population. Psychological Medicine, 1981, 11, 697-706.

Halmi, K., Goldberg, S.C. and Cunningham, S. Perceptual distortion of body image in adolescent girls: distortion of body image in adolescence. Psychological Medicine, 1977, 7, 253-257.

Harris, R.T. Bulimarexia and related serious eating disorders with medical complications. Annals of Internal Medicine, 1983, 99, 800-807.

Herman, C.P., and Polivy, J. Anxiety, restraint and eating behaviour. Journal of Abnormal Psychology, 1975, 84(6), 666-672.

Hersen, M. and Bellack, A.S. (eds.) Behavioural assessment: a practical handbook. Oxford: Pergamon Press, 1976.

Hood, J., Moore, T.C. and Garner, D.M. Locus of control as a measure of ineffectiveness in anorexia nervosa. Journal of Consulting and Clinical Psychology, 1982, 50(1), 3-13.

Hsu, L.K.G. Outcome of anorexia nervosa: a review of the literature (1954 to 1978). Archives of General Psychiatry, 1980, 37, 1041-1046.

Hsu, L.K.G. Is there a disturbance in body image in anorexia nervosa? Journal of Nervous and Mental Disease, 1982, 170(5), 305-307.

Hudson, J.I., Laffer, P.S. and Pope, H.G. Bulimia related to affective disorder by family history and response to the dexamethasone suppression test. American Journal of Psychiatry, 1982, 139(5), 685-687.

Johnson, C. and Berndt, D.J. Preliminary investigation of bulimia and life adjustment. American Journal of Psychiatry, 1983, 140(6), 774-777.

Johnson, C. and Larson, R. Bulimia: an analysis of moods and behaviour. Psychosomatic Medicine, 1982, 44(4), 341-351.

Kanfer, F.H. and Goldstein, A.P. Helping people change: a textbook of methods. New York: Pergamon Press, 2nd ed., 1980.

Lazarus, A.A. Multimodal behaviour therapy. New York: Springer, 1976.

Leitenberg, H., Gross, J., Peterson, J. and Rosen, J.C. Analysis of an anxiety model and the process of change during exposure plus response prevention treatment of bulimia nervosa. Behaviour Therapy, 1984, 15, 3-20.

Liebman, R., Munuchin, S. and Baker, L. An integrated treatment program for anorexia nervosa. American Journal of Psychiatry, 1974, 131(4), 432-436.

Loro, A.D. and Orleans, C.S. Binge eating in obesity: preliminary findings and guidelines for behavioural analysis and treatment. Addictive Behaviours, 1981, 6, 155-166.

Luiz Riccitelli, G.K. Designing a guide for nurses to use in planning and implementing a behaviour modification program with patients suffering from anorexia nervosa. Unpublished Applied Learning Theory practical, 1982a.

Luiz Riccitelli, G.K. Behaviour modification in anorexia nervosa: a guide for planning and implementing a behaviour modification program with patients suffering from anorexia nervosa. Unpublished undergraduate essay, 1982b.

Mahoney, M.J. Cognition and behaviour modification. Cambridge, Mass.: Ballinger, 1974.

Malan, D. Individual psychotherapy and the science of psychodynamics. London: Butterworth, 1979.

Marmor, J. and Woods, S.M. (eds.) The interface between the psychodynamic and behavioural therapies. New York: Plenum Press, 1980.

McNamara, R.J. The role of the nurse at the bedside. The Canadian Nurse, November, 1982, 35-40.

Meichenbaum, D. Cognitive-behaviour modification. New York: Plenum Press, 1977.

Mitchell, J.E., Pyle, R.I. and Eckert, E.D. Frequency and duration of binge-eating episodes in patients with bulimia. American Journal of Psychiatry, 1981, 138(6), 835-836.

Monti, P.M., McCrady, B.S. and Barlow, D.H. Effect of positive reinforcement, informational feedback and contingency contracting on a bulimic anorexic female. Behaviour Therapy, 1977, 8, 258-263.

Morgan, H.G. and Russell, G.F.M. Value of family background and clinical features as predictors of long-term outcome in anorexia nervosa: four-year follow-up study of 41 patients. Psychological Medicine, 1975, 5, 355-371.

Nogami, Y. and Yabana, F. On Kibarashi-gui (binge-eating). Folia Psychiatrica et Neurologica Japonica, 1977, 31(2), 159-166.

Orbach, S. Fat is a feminist issue: how to lose weight permanently - without dieting. London: Hamlyn, 1978.

Palmer, R.L. The dietary chaos syndrome: a useful new term? British Journal of Medical Psychology, 1979, 52, 187-190.

Pearson, G.D., Flournoy, L.H., Simonson, M. and Slavney, P.R. Body image in obese adults. Psychological Medicine, 1981, 11, 147-154.

Pierloot, R., Vandereycken, W. and Verhaest, S. An inpatient treatment program for anorexia nervosa patients. Acta Psychiatrica Scandinavica, 1982, 66, 1-8.

Polivy, J. and Herman, C.P. Clinical depression and weight change: a complex relation. Journal of Abnormal Psychology, 1976a, 85(6), 338-340.

Polivy, J. and Herman, C.P. Effects of alcohol on eating behaviour: influence of mood and perceived intoxication. Journal of Abnormal Psychology, 1976b, 85(6), 601-606.

Pyle, R.L., Mitchell, J.E. and Eckert, E.D. Bulimia: a report of 34 cases. Journal of Clinical Psychiatry, 1981, 42(2), 60-64.

Rampling, D. Anorexia nervosa: reflections on theory and practice. Psychiatry, 1978, 41, 296-300.

Rosen, J.C. and Leitenberg, H. Bulimia nervosa: treatment with exposure and response prevention. Behaviour Therapy, 1982, 13, 117-124.

Rost, W., Neuhaus, M. and Florin, I. Bulimia nervosa: sex role attitude, sex role behavior and sex role related locus of control in bulimarexic women. Journal of Psychosomatic Research, 1982, 26(4), 403-408.

Russell, G. Bulimia nervosa: an ominous variant of anorexia nervosa. Psychological Medicine, 1979, 9, 429-448.

Russell, G. The current treatment of anorexia nervosa. British Journal of Psychiatry, 1981, 138, 164-166.

Schwartz, G.E. and Shapiro, D. Consciousness and self-regulation: advances in research, Volume 1. New York: Plenum Press, 1976.

Selvini Palazzoli, M. Self-starvation: from the intrapsychic to the transpersonal approach to anorexia nervosa. (A. Pomerans, transl.) London: Human Context Books (Chaucer Publishing Co. Ltd), 1974. Adapted from the edition, Milan: Feltrinelli Editore, 1963.

Slade, P. Towards a functional analysis of anorexia nervosa and bulimia nervosa. British Journal of Clinical Psychology, 1982, 21, 167-179.

Slade, P.D. and Russell, G.F.M. Awareness of body dimensions in anorexia nervosa: cross-sectional and longitudinal studies. Psychological Medicine, 1973, 3, 188-199.

Spencer, J.A. and Fremouw, W.J. Binge eating as a function of restraint and weight classification. Journal of Abnormal Psychology, 1979, 88(3), 262-267.

Stangler, R.S. and Printz, A.M. DSM-III: psychiatric diagnosis in a university population. American Journal of Psychiatry, 1980, 137(8), 937-940.

Steinhausen, H-C and Glanville, K. Editorial : Follow up studies of anorexia nervosa: a review of research findings. Psychological Medicine, 1983, 13, 239-249.

Strober, M., Goldenberg, I., Green, J. and Saxon, J. Body image disturbance in anorexia nervosa during the acute and recuperative phase. Psychological Medicine, 1979, 9, 695-701.

Strober, M., Salkin, B., Burroughs, J. and Morrell, W. Validity of the bulimia-restricter distinction in anorexia nervosa. Parental personality characteristics and family psychiatric morbidity. Journal of Nervous and Mental Disease, 1982, 170, 345-351.

Sugarman, A., and Quinlan, D.M. Ego boundary disturbance in anorexia nervosa: preliminary findings. Journal of Personality Assessment, 1982, 46(5), 455-461.

Swartz, L.P. Psychological aspects of bulimia nervosa in women. Unpublished thesis, UCT, 1982.

Touyz, S.W, Beumont, P.J.V., Collins, J-K., McCabe, M. and Jupp, J. Body shape perception and its disturbance in anorexia nervosa. British Journal of Psychiatry, 1984, 144, 167-171.

Ullman, L.P. and Krasner, L. (eds.), Case studies in behaviour modification. New York: Holt, Rinehart and Winston, 1965.

Vandereycken, W. and Pierloot, R. The significance of subclassification in anorexia nervosa: a comparative study of clinical features in 141 patients. Psychological Medicine, 1983, 13, 543-549.

Vigersky, R.A. (ed.), Anorexia nervosa. New York: Raven Press, 1977.

Wardle, J. Dietary restraint and binge eating. Behavioural Analysis and Modification, 1980, 4, 201-209.

Wardle, J. and Beinart, H. Binge eating: a theoretical review. British Journal of Clinical Pyschology, 1981, 20, 97-109.

Weiss, S.R. and Ebert, M.H. Psychological and behavioural characteristics of normal-weight bulimics and normal weight controls. Psychosomatic Medicine, 1983, 45(4), 293-303.

White, W.C., and Boskind-White, M. An experiential-behavioural approach to the treatment of bulimarexia. Psychotherapy: Theory, Research and Practice, 1981, 18(4), 501-507.

Wilson, G.T. Obesity, binge eating, and behaviour therapy: some clinical observations. Behaviour Therapy, 1976, 7, 700-701.

Wilson, G.T. Toward specifying the "non-specific" factors in behaviour therapy. In Psychotherapy process: current

issues and future directions, edited by M.J. Mahoney, New York: Plenum Press, 1980.

Wolberg, L.R. The technique of psychotherapy (3rd ed.) New York: Grune and Stratton, 1977.

Wolpe, J. The practice of behaviour therapy. New York: Pergamon Press, 1973.

Wolpe, J. Behaviour therapy in anorexia nervosa: letter in reply to Hilde Bruch. JAMA (1975), 233, 317-318.

Worsley, A. In the eye of the beholder: social and personal characteristics of teenagers and their impressions of themselves and fat and slim people. British Journal of Medical Psychology, 1981, 54, 231-242.

APPENDIX A

Weekly Ward Program

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
07h00 - 07h30 Rise & Shine	07h00 - 07h45 Rise & Shine	07h00 - 07h45 Rise & Shine	07h00 - 07h45 Rise & Shine	07h00 - 07h45 Rise & Shine
07h30 - 08h00 Feelwall	07h45 - 08h00 Feelwall	07h45 - 08h00 Feelwall	07h45 - 08h00 Feelwall	07h45 - 08h00 Feelwall
08h00 - 08h30 Breakfast	08h00 - 08h30 Breakfast	08h00 - 08h30 Breakfast	08h00 - 08h30 Breakfast	08h00 - 08h30 Breakfast
08h30 - 09h30 * GROUP	08h30 - 09h30 * GOALS	08h30 - 09h00 * Community Meeting 09h00 - 10h00 * GROUP	08h30 - 09h30 P.T.	08h30 - 09h30 O.T.
09h30 - 10h00 Tea	09h30 - 10h00 Tea	10h00 - 10h30 Tea	10h00 - 10h15 Tea	09h30 - 10h00 Tea
10h00 - 11h45 * P.T.	10h00 - 11h45 * PROJECTIVE ART	10h30 - 11h45 * ROLE PLAY/MOVEMENT	10h15 - 11h15 GROUP * 11h30 - 12h00 Free time	10h00 - 11h00 GROUP * 11h15 - 12h00 Admin.
12h00 - 13h00 LUNCH	12h00 - 13h00 LUNCH	12h00 - 13h00 LUNCH	12h00 - 13h00 LUNCH	12h00 - 13h00 LUNCH
13h00 - 13h30 Free time	13h00 - 13h30 Free time	13h00 - 13h30 Free time	13h30 - 14h30 O.T.	13h00 - 13h30 Free time
13h30 - 15h00 * GROWTH GAMES	13h30 - 15h00 O.T.	13h30 - 15h00 O.T.	14h30 - 15h00 * Community Meeting	13h30 - 15h00 O.T.
15h00 - 15h30 Tea	15h00 - 15h30 Tea	15h00 - 15h30 Tea	15h00 - 15h30 Tea	15h00 - 15h30 Tea
Free time	Free time	Free time	Free time	Free time
17h00 - 17h30 Supper	17h00 - 17h30 Supper	17h00 - 17h30 Supper	17h00 - 17h30 Supper	17h00 - 17h30 Supper
17h30 - 19h30 VISITING	17h30 - 19h30 VISITING	17h30 - 19h30 VISITING	17h30 - 19h30 VISITING	17h30 - 19h30 VISITING

No therapy in activities marked *

Outing on Tuesdays once a month 08h30 - 15h00

APPENDIX B

Questionnaires for Staff and Patient

APPENDIX B

Questionnaire for Staff

1. How long have you been working in this unit?
2. How much did you know about eating disorders before you came here? In what form - e.g., direct professional or personal experience, lectures, reading?
3. Could you please describe your role in this program and your contact with the patients. What are your major problems?
4. What is your understanding of the roots of these patients' problems? Do you differentiate between anorexics and bulimics? (Expand: Have you noted any differences in their response to (e.g.), the behavioural program, therapy, the community, associated problems, your response and that of other staff and patients, level of motivation, policy in handling them. What about X (the selected patient)?
5. How do you see the goals for these patients, i.e., aims at discharge and long-term?
6. Are you satisfied with the program and how it is being run? Do you have any suggestions for changing it?

Questionnaire for patient

1. Weight

What is your current weight? By how much has your weight fluctuated since leaving the ward? Has your weight been a worry to you? To what extent (e.g., thinking about it often, all the time)? More or less than before you were in D12? What (if anything) have you done about it (i.e. your weight?

2. Eating Habits

Have you resorted to the things you did before going ino hospital (e.g. vomiting)? How often? (estimated per week or month). At certain times only or regularly? Have you been eating with the family? (Probe further where indicated).

3. Social Adjustment

How are you getting on with your family? And with friends? Are there any things that bother you? How is school?

4. Experience in Hospital

I'd like to ask you about being in hospital.

- What led up to your being admitted?
- What contact did you have with the hospital before being admitted?
- How did you feel about going into hospital?
- When you were admitted, on the first day, what happened?
- How did you feel about being in a side ward?
- What do you think of the program - earning privileges, etc.?
- How much do you think it helped?
- What parts helped most?

- What parts do you think could be left out?
  (Explore fully and carefully how the program was set up and worked - problems with eating, impulse to vomit etc., contact with staff and family).
- What happened when you got to the stage of leaving your room - how did you feel about joining the community? Going into group? (Explore the various facets of the normal milieu therapy program).
- How did you feel about leaving - how was your discharge date decided? What were your biggest problems after discharge?
- What sort of help did you have? How much has it helped?

APPENDIX C

Table of Comparisons

APPENDIX C : Table of comparisons between staff members interviewed

	Sister-in-Charge	Program Nurse	Nurse Aid	Intern.	Registrar	Occupational Therapist	Psychiatric Social Worker
Length of time on the ward	4 years In charge, 1 year	2 years	6 years	4 months	3½ months	10 months	19 months
Experience with eating disorders	4 years	2 years	6 years	8 months	3½ months	12 months	23½ years family and individual work
Theoretical exposure	"Quite a lot of reading" Visit to Crisp's Unit, 1983	A little reading (autobiographies) Supervision by Sister-in-Charge	Trained by sisters on the ward	Lectures and a lot of reading	Few lectures Crisp's book	Lectures during training	
Theoretical framework	Systems theory model. Poor bonding between mother & child leads to issues of autonomy & control. Bulimia advanced stage of anorexia.	Object relations theory and systems theory. Dominant mother, issues of splitting and projection	Systems theory Problems in the family cause symptons as way of getting attention. No explanation of bulimia.	Psychodynamic/object relations. Issue of control/loss of control	Systems theory model. Overinvolved family At puberty issues of separation & sexuality. Symptoms a way of avoiding issues.	Behavioural framework. Bulimics satisfying emotional needs by overeating. Binging analogous to alcohol addiction	Systems theory overcontrolling mother, issues of control and separating
Difference between anorexics and bulimics	Anorexics younger, need mothering. Bulimics have more life experience, more accessible, usually seek	Anorexics more obsessional & rigid. Anorexics terrified to take in anything, bulimics craving the good but feel	Bulimics more deceitful	Anorexics have complete control, bulimics oscillate between control & loss of control. Bulimics not in same	Anorexics in control. Bulimics experience fear & anxiety about losing control Bulimics more assertive,	Bulimics more accessible, willing to introspect & make connections For anorexics, control is the ultimate issue	No difference in family dynamics

	Sister-in-charge	Program Nurse	Nurse Aid	Intern	Registrar	Occupational Therapist	Psychiatric Social Worker
	help. Anorexics have absolute control, bulimics swing from over-indulgence to abstinence	bad & guilty so have to get rid of it		life-threatening situation, more accessible dissatisfied & ashamed, want help. Anorexics obsessional, bulimics histrionic. Different dynamics	histrionic, extrovert. Anorexics introvert passive-dependent, schizoid		
Goals at discharge	To understand precipitants of symptoms. Expect a recurrence of symptoms at times	Build up strengths, recognise precipitants, coming to terms with good & bad feelings, integrating good & bad. Expect a recurrence of symptoms at times	Self-control & taking responsibility	Containment, dealing with presenting problem. Expect a recurrence of symptoms	Ability to control weight. Improved structure & understanding in family. Unrealistic to expect disappearance of preoccupation with food & bodily image	Eating & vomiting under control. Social relationships improved. Improved understanding in family. Counselling of family about handling patient	Family able to talk about feelings. Daughter able to separate. Improve marital subsystem. Involve disengaged father
Follow up	Ongoing therapy, at least one year. Eating disorders group. Family or marital therapy	Individual therapy, at least one year Eating disorders group. Family or marital therapy	To maintain and practise what they have learnt inside	Ongoing therapy, 18 months to 2 years	Individual therapy to develop insight Extend interests, set goals for the future Family therapy	Ongoing therapy	Patient to become independent of the family
Criticisms & suggested improve-	Not enough professionals with experience of eating	Lack of support for program nurses. Role boundaries	Patients very demanding. Program very strict "almost	Bulimics should not be put to bed, no opportunity to	Program too rigid, doesn't cater for patients' needs.	Program too long. No point in putting bulimics to bed,	Control in hands of team too long. Patient should be

	Sister-in-Charge	Program Nurse	Nurse Aid	Intern	Registrar	Occupational Therapist	Psychiatric Social Worker
-ments	disorders in Cape Town & other centres. Lack of support for program nurses. Lack of experience of interns & registrars.	between program nurse and therapist. Patient should be off the program and functioning as an ordinary patient for longer,	like a punishment" Difficult for patients.	to deal with central problem Program shaping obedience not eating. Rationale not clear Scrap standard program, do behavioural analysis, design individual programs. Difficulty of being new, knowing what is going on. Nurses keep control. Role boundaries diffused, nursing staff doing therapy. Transference diluted Psychodynamic interpretations made too soon after patient admitted. Patient should be assessed for therapy. Replace psychodynamic therapy with supportive therapy.	Need for initial behavioural analysis. Power of nurses position, they stay while interns & registrars rotate Control program. Fitting in a problem. Role boundaries between staff not clear After being in bed, control not sufficiently returned to patient. Staff have difficulty letting patients go. Come down punitively on autonomous gestures	encourages regression, inadvisable in short-term unit Patients get too much special attention and status. Nurses too protective of their patients, don't give enough feedback to team, not open to criticism. Need to engage patients responsibility	off the program & taking responsibility for longer period. Treating families from outside Cape Town in spates, difficult for everyone. Follow up family therapy facilities limited.

APPENDIX D

Privilege List Examples

Example 1

Example 2 - Marianne

APPENDIX D : PRIVILEGE LIST

Example 1

PHASE I (a) 22.3.82

1. May have access to toothbrush and paste 2 x per day.
2. May have free access to tissues.
3. May have access to hairbrush and comb for 20 mins daily.
4. May have free access to pen.
5. May have free access to panties.
6. May have access to diary for ½ hour daily.
7. May have free access to snoopy.
8. May have access to chair in room.
9. May have access to book for ½ hour daily (not school book).
10. May have free access to watch/clock.
11. May have free access to locker.
12. May have free access to 4 photographs.
13. May have access to body lotion for 20 mins. once a day.
14. May have access to drawing pad and pencils for ½ hour daily.
15. May have free access to lip-ice.
16. May have access to mirror for 20 mins daily.
17. May have access to deoderant 2 x daily for 20 mins. daily.
18. May have tape recorder and tapes for ½ hour daily.
19. May receive 2 messages per week.
20. May do O.T. for ½ hour 5 x weekly.

29 3 82

______: Phase 1 (a)

29.3.82
1. May have access to writing material for ½hour daily.
2. May wash hair twice a week under supervision.
3. May read Bible for 1/4hr. daily.

30-3-82
4. May read newspaper/magazine for ½hr. daily.
5. May have access to feelwall for ½hr. daily (material issued by staff).
6. May listen to radio for ½hr. daily.

31 3 82
7. May have access to one poster in bedroom.
8. May have access to slippers for activities.
9. May have access to gown for activities.

10. May see therapist in his office.
11. May read for 1 hour daily.
12. May use bedpan on chair.

2.4.82
13. May send 2 messages per week.
14. May do O.T. for ½hr. daily.
15. May have free access to hair clips.

3-4-82
16. May receive 2 letters weekly.
17. May have access to cupboard in room.
18. May have free access to note pad.
19. May have access to drawing pad and pencils for 1 hr. daily.
20. May have free access to toothbrush.
21. May send feelings to feelwall.

5.4.82.

PHASE 1(c)

1. May have free access to feelwall unaided.
2. May do O.T. for 1 hour daily.
3. May receive 4 letters weekly.
4. May have access to mirror for 1 hour daily.
5. May have access to diary for 1 hour daily.
6. May have free access to brush, and comb.
7. May listen to radio for 1 hour daily.
8. May receive messages freely.
9. May have free access to deoderant.
10. May receive flowers/pot plant Xonce a week.
11. May use hair conditioner 3Xper week.
12. May have access to magazines for 1 hour daily.
13. May have free access to body lotion.
14. May listen to tapes for 1 hour daily.
15. May have free access to toothpaste.
16. May have access to book for 1/2 hour daily.
17. May have free access to own pyjamas.
18. May have free access to own dr essing gown.
19. May send messages freely.
20. May have access to table in room.
21. May bath 3Xper week under supervision (before 12 midday)

PHASE 2(a) 12.4.82

1. May post 3 letters weekly.
2. May have access to razor 3 times per week.
3. May have patient visitor for 15 minutes once a day.
4. May have dustbin in room.
5. May do O.T. for 1½ hrs. daily (may split time).
6. May listen to radio for 1½ hrs daily.
7. May have carpet in room.
8. May have access to clothes for 1 hour daily.
9. May eat supper at table in room daily.
10. May spend ½ hour out of bed daily (in room).
11. May receive all letters.
12. May have free access to photo album and photos.
13. May read for 2 hours daily (may split time).
14. May exercise for 5 mins daily.
15. May write letters for 1 hour daily.
16. May post all letters.
17. May listen to tapes for 1½ hours daily.
18. May have access to library 10 mins weekly (Librarian to go into room).
19. May bath daily under supervision (before 12 midday).

19.4.82

PHASE 2 (b)

1. May wash hair in bathroom under supervision 3 x weekly.
2. May have access to clothes for 2 hours daily (may split time).
3. May make bed with assistance daily.
4. May sit with feet off bed.
5. May have 2 patient visitors for 15 mins separately or together.
6. May have access to 2nd poster.
7. May see the beautician in room on Wednesdays.
8. May change room around with assistance.
9. May listen to radio for 2 hours daily (may split time).
10. May eat lunch at table.
11. May spend 1 hour out of bed daily.
12. May have free access to mirror.
13. May drink teas at table in room.
14. May listen to tapes for 2 hours daily.
15. May write letters for 1½ hours daily.
16. May give tape to Mother once a week of 30 min (may only tape for 5 - 10 min daily).
17. May drink tea in lounge on Sunday morning (15 mins).
18. May go to toilet between 7 - 12 midday under supervision staff to flush toilet.
19. May have access to clothes for 2½ hours daily.
20. May attend feelwall daily.
21. May have breakfast at table in room daily.

PHASE 2 (c) 26.4.82

1. May have access to clothes for 3 hours daily.
2. May have free access to newspaper/magazine.
3. May make own bed daily.
4. May have free access to flowers/potplants.
5. May have access to music books for 15 mins daily.
6. May play piano in staff lounge for 15 mins daily (Mon.Tues & Wed, between 10.30 a.m. and 12 noon and Thursday and Friday before 10 a.m. - Sat & Sun when it suits staff).
7. ~~May drink all teas at table~~. May spend 2 hours out of bed daily
8. May contribute to word magazine.
9. May have free access to radio.
10. May do laundry for 15 mins 3 x weekly (to notify staff).
11. May have free access to tapes and tape recorder.
12. May do O.T. for 2 hours daily (may split time).
13. May have free access to diary.
14. May write letters for 2 hours daily (may split time).
15. May have free access to shampoo.
16. May drink tea in lounge on Sat. & Sun mornings for 15 mins.
17. May have free access to books.
18. May have free access to O.T. material
19. May have access to clothes for 4 hours daily.
20. May do O.T. (not games) with other patients.
21. May have free access to writing material.

PHASE 3 (a) 2.5.82

5|82 1. May have access to clothes between 7.00 a.m. and 5 p.m. daily.

-5-82 2. May receive 2 presents per week.

5.5.82 3. May go to toilet between 7 a.m. and 7 p.m. under supervision (staff to flush toilet).

.5.82 4. May make 2 x 5 min telephone calls per week.

15 82 5. May move to room 19.

5 82 6. May spend 1 hour in lounge daily. (in bed by 9 pm)

1.5.82 7. May have free access to clothes.

PHASE 3 (b) 9.5.82

1. May have access to all personal belongings.

2. May play piano in staff lounge for 1 hour daily (when it suits staff and programme).

3. May have 1 outside visitor for ½ hour 2 x weekly (over and above parents visits).

4. May have free access to telephone.

5. May have tea with other patients every morning and afternoon for 20 mins.

6. May have free access to patient visitors.

7. May have free access to laundry.

PHASE 3 (c) 17.5.82

1. May have access to 2 outside visitors for ½ hour daily (this includes Mom & Dad).

2. May move freely in and out of room until 10.30 p.m. (May stay up later over weekends Fri and Sat).

3. May bath unsupervised.

4. May have meals in Dining room over weekends (Friday supper until Sunday supper).

5. May go for walks with patients over weekends and during week within hospital grounds.

6. May go to toilet unsupervised.

7. May pour tea unsupervised and take control of H_2O.

PHASE 3 (d) 24/5

1. May have free access to outside visitors.
2. May eat supper in Dining room daily.
3. May play piano freely.
4. May take part in all ward activities (including P.T.) except outings and admin duties.
5. May go for walk on Saturday/Sunday and Public Holiday for ½ hour within hospital grounds, with visitors.
6. May move to room 34.
7. May eat ~~lunch~~ all meals in Dining room daily.

PHASE 4 (a) 31/5

Privileges earned for weight maintenance between
48 kg and 49,5 kg.

9/5 1. May earn actual weight

3/6 2. May serve lunch under supervision.

3/6 3. May offer to do admin. duties.

PHASE 4 (b) 7.6.82

PRIVILEGES EARNED FOR WEIGHT MAINTENANCE BETWEEN
48 kg and 49 kg

1. May go on outings with community.
2. May spend 6 hours out over weekend - in for meals.
3. May serve all meals under supervision.

Phase 4(c) 14.6.82.

14/6/82 ✓. May serve lunchoen unsupervised.

16/6/82 ✓. May spend Saturday and Sunday out from 8.30 a.m. until 5 p.m.

18/6/82 ✓. May serve all meals unsupervised as per menu sheet.

14

PHASE IV (d) 21.6.82.

21/6 1. May go out from 4 p.m. to 8 p.m. on Friday.

23/6 1. May go out from Saturday 8 a.m. to Sunday 8 p.m.

25/6/82 3. May discontinue progr_amme.

APPENDIX D PRIVILEGE LIST

Example 2 : Marianne

12.4.83

PHASE 1 (a)

1. Tissues - 1 box.
2. Pencil and Notepad.
3. Diary for ½ hour daily.
4. Newspaper/Magazine ½ hour daily.
5. Free access to watch/clock.
6. May have free access to moisturiser.
7. May have free access to deoderant.
8. May have 1 chair in room.
9. May have access to sketch pad for ½ hour daily.
10. May use bedpan on chair in room.
11. May have access to book for ½ hour daily.
12. May wash hair with assistance in room 2 x week.
13. May have free access to hairdryer.
14. May have access to hobby (O.T.) for ½ hour daily.
15. May receive all messages.

18/4/83

Phase 1(b)

1. May sit out of bed whilst bed being made 1 x day.
2. May brush teeth 3 x daily after meals for 10 mins.
3. May have access to diary for ½ hour 2 x daily.
4. May have access to pencil case (viz: rubber/pencil/ruler/glue).
5. May have one poster in room.
6. May have access to razor/hair remover 1 x weekly for ½ hour.
7. May have access to book for 1 hour daily (may not split time)
8. May have access to gown and slippers for activities.
9. May have free access to perfume.
10. May have access to Newspaper/Magazine for 1 hour daily (may split time).
11. May have 5 cottonwool balls per day
12. May have access to manicure/pedicure accessories 1 x weekly (for ½ hour).
13. May have free access to clock-radio.
14. May have a carpet in room.
15. May have free access to own nighties.
16. May have access to sketch pad for 1 hour daily.
17. May have access to sketching materials when using sketch pad.
18. May do exercises for 5 mins daily under supervision.

21.4.83

23/4/83

24/4

25/4

PHASE 1 (c)

1. May receive one patient visitor for 5 minutes 1 x daily.
2. May have free access to toothbrush and toothpaste.
3. May have access to mirror for 20 mins 2 x week.
4. May have free access to cellotape.
5. May make own bed with assistance every morning.
6. May send one message per day.
7. May have a table in room.
8. May have access to O.T. for 1 hour daily.
9. May send feelings to feelwall daily.
10. May have lunch at table in room 3 x week (20 mins).
11. May have a tablecloth on table in room.
12. May have access to nailvarnish and remover for ½ hour 1 x week.
13. May bath/shower under supervision 2 x week (for 20 min between 7 - 8 a.m.).
14. May have a coloured bedspread on bed.
15. May have a dustbin in room.
16. May have free access to own facecloth.
17. May have free access to one pair of earrings.
18. May receive 2 letters per week.
19. May have free access to potplant/flowers.
20. May attend therapy in therapist's office at set time.
21. May have access to writing materials for ½ hour 2 x week.

2.5.83/8.5.83

PHASE 11 (a)

1. May have free access to Newspaper/Magazine.
2. May have free access to dressing gown & slippers.
3. May have access to mirror for 20 mins 4 x week.
4. May receive 6 letters per week.
5. May receive 2 patient visitors for 5 mins each daily.
6. May have free access to cottonwool.
7. May have access to O.T. (Hobby) for 2 hours daily (may split time).
8. May bath/shower under supervision 4 x week (20 mins).
9. May have access to sketch pad for 2 hours daily (may split time).
10. May wash hair when showering/bathing.
11. May have supper at table in room 3 x week (20 mins).
12. May have access to book for 2 hours daily (may split time).
13. May have free access to photo albums.
14. May sit out of bed for 30 mins daily.
15. May have a second poster in room.
16. May post 1 letter per week.
17. May have breakfast at table in room daily.
18. May have free access to bath oil/bubble bath.
19. May do exercises for 5 mins daily on carpet in room (supervised).

5

9.5.83/15.5.83

PHASE 11 (b)

1. May send all messages.
2. May make own bed in the morning unsupervised.
3. May receive 2 patient visitors for 10 mins each daily.
4. May have access to O.T. (Hobby) for 3 hours daily (may split time).
5. May have lunch at table in room daily.
6. May receive all letters.
7. May have free access to manicure/pedicure accessories.
8. May have access to mirror for 20 mins daily.
9. May spend 1 hour up in room daily.
10. May have supper at table in room daily.
11. May bath/shower daily under supervision between 7 - 8 a.m. (20 mins).
12. May have access to book for 3 hours daily (may split time).
13. May have free access to razor./havemove
14. May have tea in lounge Sat. morning for 10 mins.
15. May have access to sketch pad for 3 hours daily (may split time).
16. May have access to writing materials for 1 hour 2 x week.
17. May have tea in lounge on Sunday morning for 10 mins.
18. May have access to games, e.g. puzzles/scrabble for 2 hours daily (may split time).
19. May post 2 letters per week.
20. May use toilet under supervision 1 x daily.

16.5.83/22.5.83

PHASE II (c)

1. May receive present from parents.
2. May have free access to Clearisil Lotion
3. May receive 2 patient visitors for 30 mins each daily.
4. May have access to O.T. Project for 4 hours daily (may split time).
5. May have free access to yellow jewellery pouch.
6. May have access to writing materials for 1 hour 3 x week.
7. May spend 2 hours up in room daily (may split time).
8. May hang pin board up in room;
9. May attend feelwall daily.
10. May have free access to straw pot basket.
11. May have free access to mirror.
12. May do exercises for 10 minutes daily (supervised).
13. May have access to book for 4 hours daily (may split time).
14. May spend 30 minutes in lounge on Saturday mornings.
15. May post 4 letters per week.
16. May have access to sketch pad for 4 hours daily (may split time).
17. May spend 30 minutes in lounge on Sunday mornings.
18. May have free access to games, e.g. scrabble, puzzles.
19. May have free access to Nailvarnish and remover.
20. May have free access to diary.
21. May wear own clothes for 1 hour daily (may split time).

23/5/83-29/5/83.

PHASE III (a).

5/83 1. May receive gift from grandparents.

5/83 2. May wear own clothes for 2 hours daily.(may split time).

5/83 3. May spend 1 hour in lounge on Saturday and Sunday mornings.

5/83 4. May spend 4 hours up in room daily.(may split time).

15/83 5. May use toilet under supervision between 7a.m.-12 noon.

PHASE III (b) 30.5.83 - 5.6.83

5-83 1. May have free access to hair fasteners.

5-83 2. Reason. 6-83 May have access to clothes for 4 hours daily (may split time).

6-83 3. May watch 1 TV programme of own choice 2 x weekly after 7.30 p.m. (in bed by 9.30 p.m.)

6-83 4. May move to Room 19 over the weekend.

-83 5. May have lunch at table in Dining room on Sundays (30 mins)

3 6. May make one 5 minute phone call 2 x weekly before 4 p.m.

6-83 7. May have morning tea with patients in lounge daily (30 mins).

(9)

6.6.83/12.6.83

PHASE III (c)

6.83 1. May use toilet under supervision between 7 a.m. - 7 p.m.

6.83 2. May spend time up in room as desired.

6.83 3. May have lunch at table in Dining room on Saturday (30 mins).

6.83 4. May watch 1 T.V. programme of own choice 4 x weekly after 7.30 p.m. (In bed by 9.30 p.m.)

6.83 5. May wear own clothes for 8 hours daily (may split time)

6.83 6. May open all gifts (use of contents as earned).

13.6.83/19.6.83

PHASE III (d)

1. May have free access to books.
2. May have free access to patient visitors.
3. May fetch own medication from treatment room.
4. May have supper in Dining room on Fridays and Saturdays (30 mins).
5. May have afternoon tea with the patients in the lounge daily (30 mins) except Farewell teas).
6. May use toilet as desired under supervision.
7. May watch 1 TV programme of own choice daily after 7.30 p.m. (in bed by 9.30 p.m.)

20.6.83/26.6.83

PHASE IV (a)

2·6·83 1. May have access to lounge for outside visitors.

3·6·83 2. May have access to 2 outside visitors together for 15 mins 1 x week.

4·6·83 3. May have free access to writing materials & may post all letters.

5-6-83 4. May spend 1 hour in lounge after morning tea daily.

6-6-83 5. May spend ½ hour in O.T. room 3 x weekly according to ward programme.

27.6.83/3.7.83

PHASE IV (b)

7.6.83. 1. May have free access to all personal belongings.

8.6.83. 2. May attend community meetings according to ward programme.

9.6.83 3. May make and receive 1 x 5 minute phone call daily (3 - 5 p.m.)

Re. earn ... .6.83 Req. -7-83 -7-83. 4. May have breakfast in dining room Saturday and Sunday (30 mins).

-7-83 5. May spend 7.30 p.m. to 10 p.m. in lounge on Saturday evenings.

-7-83 6. May have access to laundry for ½ hour 2 x weekly.

.7.83. 7. May have free access to hospital library.

4.6.83/10.6.83

PHASE IV (c)

·7·83 1. May attend O.T. Tues, Wed. Thurs as per ward programme.

7·7-83. 2. May spend 7.30 - 10 p.m. in lounge on Friday evenings.

3. May do exercises for 15 mins daily unsupervised (notify staff).

·7·83 4. May have free access to the Beautician.

1·7-83. 5. May have access to 2 outside visitors together for 30 mins 2 x weekly (within visiting hours).

11-7-83 - 17-7-83

PHASE IV (d)

-7-83 1. May attend goals as per ward programme.

-7-83 2. May have lunch in the dining room daily.

7-83 3. May bath/shower unsupervised 1x daily (in the morning).

-7-83 4. May take responsibility for own water under supervision.

-7-83 5. May make/receive 2 x 5 minute phone calls daily (before 7 p.m.).

7-83 6. May have access to 2 outside visitors for 30 mins 3 x weekly (within visiting hours).

18.7.83 - 24.7.83

PHASE IV (e)

·7·83. ✓1. May have supper in the dining room daily.

1·7·83 ✓2. May come to office to speak to staff as needed.

·7·83. ✓3. May spend time in the lounge from 1 - 5 p.m. daily.

·07·83 ✓4. May attend relaxation on Fridays as per ward programme.

·7·83 ✓5. May go for ONE short walk over weekend accompanied by staff.

·7·83 ✓6. May eat all meals in the dining room daily.

·7·83 ✓7. May have access to 2 outside visitors for 30 mins 4 x weekly. (within visiting hours)..

25/7 - 31/7

PHASE IV (f)

1. May spend time in the lounge from 7.30 - 10 p.m. daily.
2. May serve own tea a.m. & p.m. under supervision.
3. May have free access to the laundry.
4. May have free access to all incoming phone calls for 5 mins before 7 p.m. (within hours).
5. May have access to 2 outside visitors for 30 mins 5 x weekly (within visiting hours)
6. May have free use of handbasin in room.
7. May serve own supper under supervision.

1.8.83/7.8.83

PHASE IV (g)

1. May serve own tea under supervision 9 p.m.
2. Free access to telephone (within hours).
3. May attend Admin meeting as per ward programme
4. May have access to 2 outside visitors for 30 mins daily (within visiting hours).

8.8.83/14.8.83

PHASE IV (h)

1. May have free access to bathroom and toilet.
2. May serve own lunch under supervision.
3. May spend time out of room as desired.
4. May go on all ward outings.
5. May attend Social Skills.
6. May know Target weight.

(19)

150

15.8.83/21.8.83
22.8.83/23.8.83

PHASE V (a)

PRIVILEGES EARNED FOR WEIGHT GAIN BETWEEN 0,2 AND 0,5 ONLY

.83 ✓1. May know actual weight.

.83 ✓2. May serve all teas and H2O unsupervised.

.83 ✓3. May serve all meals (under supervision).

29/8/83 - 4/9/83

PHASE V (b)

PRIVILEGES EARNED FOR WEIGHT GAIN BETWEEN 0,2 AND 0,5 KG

1. May move to Room 35 with assistance.
2. May spend ½ hour in Hospital grounds 1 x week (during weekend).
3. May have free access to visitors.

PHASE VC 9.9.83

May earn priviledges for weight maintenance between 49 - 50 kg only.

9.83 1. May attend all ward activities as per ward program.

23.9.83 2. May attend fairwell teas and select one snack under supervision.

30.9.83 3. May go for a drive for 1 hour with family over the week-end (in for teas and meals back by 4.30 pm).

1.10.83 4. May serve own lunch daily unsupervised.

3-10-83

PHASE V (d)

May earn privileges for weight maintenance between 49 - 50 kg only.

0831. May have one 3 hour outing with family over weekends - between 8.30 - 11.30 or 1 - 4 pm.

0832. May have two 3 hour outings with family over weekends between 8.30 - 11.30 am or 1 - 4 pm.

0833. May do ward duties as per ward programme.

0834. May serve own supper daily unsupervised.

17.10.83

PHASE V (e)

May earn privileges for weight maintenance between 49 - 50 kg only.

- May spend time out on Saturday 8.30 - 11.30 am, or 12.30 - 4.30 pm.
- May serve all meals unsupervised.
- May spend time out on Sunday 9am - 4.30 pm.

24.10.83

PHASE V (f)

1/10/83✓. May serve all snacks unsupervised.

0/83✓. May spend time out on Saturday 9 am - 7.30 pm.

0/83✓. May spend time out on Sunday 9 am - 8 pm.

31.10.83

PHASE V (g)

1. May spend time out on Friday 3.30 pm - 7.30 pm.

2. May negotiate a written contract to replace programme after gaining last privilege.

3. May spend time out on Saturday 9 am - Sunday 6 pm.