A Model for Relapse Prevention in Bulimia

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LOYOLA UNIVERSITY CHICAGO

A MODEL FOR RELAPSE PREVENTION IN BULIMIA

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THE FACULTY OF THE GRADUATE SCHOOL
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MASTER OF ARTS

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BY
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CHAPTER 1
INTRODUCTION
Defining Bulimia Nervosa

According to the Fourth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994, page 545), bulimia nervosa, also called bulimia, may be defined as an eating disorder which is characterized by "binge eating" and "inappropriate compensatory methods to prevent weight gain". A binge may be defined as the consumption of food in a quantity that is larger than what most persons would normally eat in a discrete time period, usually less than two hours. The foods consumed typically include high-calorie items and consumption is typically rapid. The binge often continues until the individual is painfully full. Binging is usually triggered by stress among interpersonal relationships, depressed and anxious moods, intense hunger due to previous dietary restraint, or feelings regarding food, body shape, and weight.

There may be multiple settings in a single binge episode. Bulimics tend to feel ashamed of their eating patterns and will attempt to appear as inconspicuous as possible which may include eating in secrecy. Individuals with bulimia often feel a lack of control over their eating problems.

The compensatory behaviors, previously mentioned, some of which are considered purging, may include self-induced vomiting, misuse of laxatives, diuretics, or enemas, fasting, and/or excessive exercise. Individuals with bulimia tend to place a excessive importance on body shape and weight when evaluating themselves. These factors become of primary importance in the determination of self-esteem.

Approximately 90% of individuals with bulimia are female. The onset of bulimia
usually occurs in late adolescence to early adulthood after a period of dieting and in clinic samples continues for at least a few years. The long term outcome is unknown (American Psychiatric Association, 1994).

Herzog, Keller, Lavori, and Sacks (1991) reviewed the course and outcome of bulimia. They found that studies of outpatient programs of a minimum duration of 12 months’ reported recovery rates between 30% and 70% while inpatient studies observed rates of 13% to 40%. Such studies confirm the conceptualization of bulimia nervosa as an episodic disorder with a high frequency of relapses and remissions.

Defining Lapse and Relapse

“Relapse by definition involves a failure to maintain behavior change, rather than a failure to initiate change.” (Annis & Davis, 1991, p. 204). A model of relapse in addictive behaviors has been suggested that distinguishes between a lapse and a relapse (Brownell, Marlatt, Lichenstein & Wilson, 1986; Health, Rollnick & Winton, 1983; Marlatt & Gordon, 1980). In this two stage model a lapse may be defined as a single slip followed by a regain of abstinence. A relapse is then considered a continued, prolonged occurrence of the behavior. Individuals who lapse have been found to make fewer internal characterological attributions than those who relapse. For smoking and drinking behaviors, evidence has shown that negative emotion states, such as anxiety, depression, and frustration have most commonly preceded relapse whereas social-situational factors have preceded lapses. Evidence has indicated that negative emotion states may increase the likelihood of a lapse becoming a relapse (Annis & Davis, 1991).

For the purpose of this paper a relapse may be defined as a continued, prolonged occurrence of a behavior occurring after an initial decision to change the behavior and a
period of change in the behavior. A remission may be defined as the continued, prolonged non-occurrence (i.e., disappearance) of a behavior subsequent to a continued prolonged occurrence of the behavior. According to these definitions and the previously mentioned study (Herzog et al., 1991), an individual may throughout the course of bulimia experience periods of normal eating behavior and periods of binging and purging.

Process of Change

For the purpose of providing a framework for understanding the course of bulimia, the theory of process of change will be reviewed. This theory is basically an idea that addresses the question of how an individual transitions from disordered and/or addictive behavior to normal behavior. The theory of process of change originated in research on addictive behaviors, such as alcohol and smoking cessation (Annis & Davis, 1991; DiClemente, 1993; Velicer & DiClemente, 1990). Since then the principles have been applied to other domains including bulimia nervosa and binge eating disorder (Grilo & Shiffman, 1994; Ward, Hudson & Bulik, 1993). The theory of process of change provides a conceptual framework for understanding how change occurs and its ideas have numerous theoretical implications.

DiClemente investigated the process of intentional change in addictive behaviors (DiClemente, 1993). He proposed a five stage cycle of change which was conceived as a dynamic process during which different multiple processes were critical at certain stages. This process of change which follows a specific sequence was conceived as being cyclical in nature, such that persons might cycle and/or recycle through these stages numerous times before successfully sustaining change.

The stages DiClemente identified were precontemplation, contemplation,
preparation, action, and maintenance (DiClemente, 1993; Velicer, DiClemente, Rossi & Prochaska, 1990). The precontemplation stage includes individuals who do not recognize the problem nor do they see a need for change. Contemplators are persons who seriously consider the problem and the possibility for change. The preparation stage consists of individuals who have made a commitment to attempt to change and are preparing for action. The action stage includes persons who have implemented a plan for modifying the addictive behavior. In the maintenance stage the individual's focus is on altering his/her lifestyle to accommodate change and avoid relapse (See Appendix A).

Persons categorized in these stages predictably differ on decision making, attitudes, and ten processes (DiClemente, 1993). These processes include consciousness raising, self-reevaluation, self-liberation, counter-conditioning, stimulus control, reinforcement management, helping relationships, emotional arousal and dramatic relief, environmental reevaluation, and social liberation. During the stages of precontemplation, contemplation, and preparation decision making may focus on the evaluation (e.g., pros and cons) of the behavior. During the action and maintenance stages behavioral processes are most salient. These include counterconditioning, stimulus control, reinforcement management, self-liberation, and helping relationships. During the maintenance stage self-efficacy is most prevalent (DiClemente, 1993).

The correlation on an individual level between process of change stage (e.g., action stage) and processes (e.g., helping relationships) predicts likelihood of successful change. Stages, processes of change, decision making, and evaluations of self-efficacy have been more predictive of successful change than historic and demographic variables (Prochaska & DiClemente, 1986; Prochaska & DiClemente, 1992). The relationship between stages and processes has been used to develop interventions that are stage responsive and specific. In other words these interventions are specifically designed to help the individual at the level of growth at which they are functioning. For example, it would be appropriate
to teach a child age 3 how to count. However, it would make little sense to try to teach a child who does not know how to count to complete calculus equations, as they would not have the mathematics foundation from which to understand calculus. Similarly, it makes little sense to teach a chronic bulimic relapse prevention skills if they do not recognize their problem nor see a need for change. Under those circumstances it would be more appropriate to educate them on the symptoms and effects of bulimia.

According to the theory of process of change, relapse prevention would be most important during the action and maintenance stages and in the recycling process. Little information is available on the recycling process. Therefore, this paper will address the processes occurring solely in the action and maintenance stages of the processes of change. The processes most prevalently researched in these eating disorders are the role of self-efficacy in relapse and the abstinence violation effect. Both processes theoretically occur most prominently in the action and maintenance stages.

Purpose

Minimal attention has been given to developing models of relapse prevention specifically addressing the processes which interfere with post-treatment maintenance in bulimic individuals. Much of the relapse prevention literature is vague and lacks a theoretical framework. In this thesis the components of a model for relapse prevention will be discussed.

The purpose of this paper is to explore a model of relapse prevention in bulimia nervosa by utilizing research on the process of change, abstinence violation effect, self-efficacy, attribution, and cognitive-behavioral treatment outcome literature. In the second chapter a suggestion will be made that attribution, abstinence-violation, and
self-efficacy all play critical roles in the later stages of the relapse prevention phase of process of change, contributing to both persistence of eating disordered behavior and the maintenance of restraint or abstinence. It will be suggested that cognitive-behavioral therapy in combination with relapse prevention training and attributional restructuring may effectively intervene on the processes contributing to the persistence of eating disordered behaviors resulting in the maintenance of restraint or abstinence.

In the third chapter a model of relapse prevention will be outlined, which specifically applies the previously mentioned theories. A program following this model will be discussed. The components of this program include four key assessments followed by cognitive-behavioral therapy, attributional restructuring, traditional relapse prevention training, and support groups. These interventions are designed to enhance conscious awareness of cognitions and behaviors relevant to the binge/purge cycle, to prevent lapse and relapse through awareness and application of individualized relapse prevention plan, and to provide means of coping effectively with lapse to prevent relapse. A method of program evaluation based on the suggested theory will be provided.

Examining the topic of relapse prevention in bulimia will contribute enhanced understanding of the recovery process to the clinical field. From this greater understanding we may develop more effective interventions and treatment programs, thus decreasing the rate of chronic bulimia.
CHAPTER 2
THE BINGE/PURGE CYCLE
Abstinence Violation Effect and Relapse Prevention

As previously discussed, a lapse is a single slip followed by a regain of abstinence and a relapse is a continued, prolonged occurrence of the behavior. Marlatt (1978) proposed that the transition from lapse to relapse is mediated by the abstinence violation effect (AVE). There are two aspects to the AVE, an initial attribution regarding the cause of the lapse and an affective response to the attribution. Thus, the manner in which the individual views the initial lapse is predictive of their ability to follow the lapse with restraint or abstinence (Ward, Hudson & Bulik, 1993).

Weiner's Attribution Theory

Causal attributions play a crucial role in the abstinence violation effect. Weiner's attribution theory will be discussed for the purpose of understanding the role of attribution in this process (Weiner, 1972, 1986, 1988). Weiner defined an attribution as a causal explanation diverging along the dimensions of locus, stability, and controllability, occurring subsequent to an unexpected, negative and/or important outcome.

The dimension of locus of control is the extent to which the individual considers the cause to be internal or external of the person. Weiner suggested that when an internal attribution is made regarding a negative outcome, the result is a decrease in self-esteem. If the attribution is external, self-esteem most likely will not be affected. However, external attributions may result in a feeling of hopelessness. Additionally, if the attribution is
external to a person, anger may follow contributing to a retaliative relapse (Ward, et al., 1993).

The dimension of controllability refers to the individual’s belief regarding the potential influence of effort on the cause. When a internal controllable attribution is made, guilt may result such that the individual takes responsibility for not avoiding the unfavorable outcome and blames him/herself. If an internal, uncontrollable attribution is made the individual is most likely to experience shame. The extent to which the cause is seen as controllable effects motivation. For example, when the attribution is internal and controllable the resulting guilt is likely to motivate the individual to attempt to reduce the probability of a future unfavorable outcome. However, if the attribution is internal and uncontrollable the individual is unlikely to be motivated by the resulting shame due to the perceived lack of ability (Ward, et al., 1993).

The dimension of stability concerns the endurance of the cause. The dimensions are central to the resulting emotional reaction and hence the AVE. The AVE value will be greater when attributions are stable, internal, global, and uncontrollable. The AVE value may be considered proportional to the probability of relapse (Ward, et al., 1993).

Weiner additionally distinguishes the possibility for non-attributional event occurrences. In this scenario the individual gives into a lapse based purely on the hedonistic value of the ensuing joy and pleasure. The lapse occurs in a positive emotional state, and the mediating cognitive factors are minimal. The resulting AVE value is insignificant because an attribution is unlikely to occur. However, the possibility of relapse remains significant.
Abstinence Violation Effect, Attribution, and the Binge/Purge Cycle

Grilo and Shiffman (1994) studied the AVE in non-purging, normal weight, binge-eating females and found that when participants made internal, global, and uncontrollable attributions following a binge, an ensuing binge was more likely to follow significantly sooner. Variations in attribution and ensuing emotion states (e.g., guilt) were significant predictors of binge cycle escalation representing nearly one-fourth of within-subject variation for binge latencies. They additionally found that stable differences in attributional style were less predictive of repetitive binges than were cognitive AVE states produced by specific outcomes. In other words, if we were to monitor an individual’s attributions repetitively and found similar results over time (i.e., attributional style), this style would be less predictive of repetitive binges (i.e., relapse) than the individual’s AVE state produced by each binge. These findings replicated the results of Curry, Marlatt, and Gordon (1987) in a sample of smokers, negating the theory that personal attributional styles support high AVE values predisposing persons to repetitive binges. The results support the idea that cognitive states resulting from event specific attributions yielding the AVE value are more predictive of a lapse becoming a relapse than attributional style.

The manner in which AVE is present in eating disorders is likely to depend upon the stage of the process of change of the individual person. For example, an individual in the earlier stages of the process of change, especially precontemplation, would theoretically be more likely to participate in non-attributional event occurrences. However, in the later stages, especially maintenance, the role of AVE would dramatically increase and be a valid predictor of abstinence or relapse. Assuming that a non-attributional lapse does not occur, a bulimic in maintenance stage would attempt to understand or explain why a lapse occurred, since it is an important, negative event. The attribution the individual makes will affect the progression (i.e., to relapse or attempt to cope) and the affective state of the
individual (Ward, Hudson & Bulik, 1993). If the binge, after binge, purge, and after purge are viewed as separate, important, negative events, it would follow that through attributional search the AVE value, mood, attribution dimensions, especially of controllability and efficacy expectation, would fluctuate during the cycle. This is congruent with the finding that mood fluctuates rapidly throughout the binge/purge cycle (Davis, Freeman & Garner, 1988).

The research on the abstinence violation effect suggests that event specific cognitive states may be more accurate predictors of abstinence and relapse than global attributional styles. The research suggests that these cognitive states and moods fluctuate throughout the binge/purge cycle. AVE findings suggest the need for situation focused interventions. Supplementary to cognitive-behavioral interventions, research and treatment may focus on specific relapse prevention techniques (Grilo, Shiffman & Wing, 1989, 1993; Marlatt & Gordon, 1985) and attributional retraining (Andrews & Debus, 1978; Grilo & Shiffman, 1994). Affective reactions occur given certain attribution clusters. Assessment in treatment may focus on identifying these attributions for restructuring in attributional therapy (Fosterling, 1986; Weiner, 1988; Ward, Hudson & Bulik, 1993).

Self-Efficacy and Treatment Outcome:
Research and Implications

Numerous studies have shown the predictive value of the concept of perceived ability (efficacy expectation) as related to change in smoking behavior (Coeldo, 1984; Condiotte & Lichenstein, 1981; DiClemente, 1981, 1986; DiClemente, Prochaska & Gibertini, 1985; McIntyre, Lichenstein & Mermelstein, 1983; Prochaska, DiClemente, Velicer, Ginpil & Norcross, 1985; Stuart, Borland & McMurray, 1994; Supnick &
Self-efficacy may be defined as an individual's belief in their ability to successfully execute specific behaviors. As specifically applied to bulimia, self-efficacy may be considered an individual's belief in their ability to avoid binging and/or purging by utilizing alternative coping skills. Research has shown that self-efficacy assessed at the end of treatment is a valid predictor of length of time before first relapse (Condiotte & Lichenstein, 1981), and post treatment smoking status at five months (DiClemente, 1981) and six months (McIntyre, Lichenstein & Mermelstein, 1983). Low situational self-efficacy assessed at the end of treatment has been a valid predictor of situations of first relapse (Condiotte & Lichenstein, 1981). With regard to drinking, self-efficacy has been found to be a valuable predictor (Annis, 1990). Toward this end, the Alcohol Abstinence Self-Efficacy (AASE) scale was developed and found to be a sound measure of efficacy to abstain from drinking (DiClemente, Carbonari, Rosario, Montgomery & Hughes, 1992).

Numerous studies have examined self-efficacy in relation to eating disorders. Stotland, Zuroff & Roy (1991) found that high self-efficacy dieters ate significantly less than low self-efficacy dieters. Mizes and Christiano (1995) reviewed the current measures of eating self-efficacy, which included the Eating Self-Efficacy Questionnaire (ESQ; Glyn & Ruderman, 1982, as cited in Wilson, Rossiter, Kleifield & Lindholm, 1986), Eating Self-Efficacy Scale (ESES; Glyn & Ruderman, 1986), and the Self-Efficacy Questionnaire (SEQ; Schneider, O'Leary & Agras, 1987). The ESQ can identify changes in self-efficacy resulting from cognitive-behavioral therapy. The ESES, consisting of two factors labeled negative affect and socially acceptable circumstances, has been shown to be correlated with measures of weight, eating restraint, and self-esteem. The SEQ, focusing on factors relevant to bulimia recovery, has been shown to correlate with changes in vomiting frequency during treatment.

Schneider et al. (1987) examined several areas of self-efficacy in bulimic
participants. These areas included “ability to resist the urge to binge”, “ability to refrain from binge eating while consuming various meals and types of foods, including ‘forbidden foods’”, “perceived ability to replace the urge to binge with other activities, such as hot bath, exercise, and relations”, “perceived ability to refrain from binge eating in various mood states such as loneliness, boredom, depression, anger, and tension”, “perceived ability to employ various stimulus-control techniques in order to eat normally”, and “ability to accept body shape and the need for larger clothing.” Social self-efficacy for the “perceived ability to be assertive and develop close, personal relationships” was also assessed. Perceived self-efficacy in the areas of mood state, stimulus-control techniques, and body shape were significantly negatively correlated with vomiting frequency. Perceived self-efficacy for refraining from binge eating given the presence of ‘forbidden’ foods approached significance. The social self-efficacy and the control of urge to binge domains were not correlated with vomiting frequency. In this study, cognitive-behavioral therapy effectively increased perceived self-efficacy for “refraining from binge eating at various meals and in the presence of ‘forbidden’ foods”, “refraining from binge eating in negative mood states”, “replacing the urge to binge with other activities”, “employing stimulus control techniques”, and “forming satisfactory relationships”. Perceived self-efficacy for “resisting the urge to binge” and “replacing the urge to binge with other activities” was not related to treatment outcome, suggesting that difficult, triggering situations can be effectively surmounted despite urges to binge. Increased self-efficacy was related to positive treatment outcome in the areas of refraining from binge eating in high-risk situations, use of stimulus control techniques, acceptance of body shape and the need for larger clothing. The authors of this study pointed out the need to assess mood-specific and situation-specific self-efficacy to address individual treatment needs (Schneider et al., 1987).
Model of the Binge/Purge Cycle

The theories of abstinence violation effect, attribution, and self-efficacy provide a framework from which to view the binge/purge cycle (Appendix B). Event A is a binge/purge or abstinence. The binge/purge is followed by the AVE, consisting of an attribution and an affective response to the attribution. The AVE then influences self-efficacy beliefs regarding the future ability to avoid binging/purging and to utilize alternative coping skills. This is followed by a triggering event, emotion, situation, or cognition. Next is a decision a bulimic makes as to whether they will binge/purge. This decision is moderated by the external environment (e.g., whether food is available, whether there is a supportive individual available to assist the bulimic in avoiding the binge, etc.) and the internal state (e.g., emotional state, cognitions regarding body image, etc.) of the individual. This is then followed by Event B, a binge/purge or abstinence. At this point the individual has returned to the beginning of the cycle. One unaddressed question this model suggests; is there an AVE or some other attributional occurrence and affective response that follows abstinence? I would suggest that under these circumstances a similar attribution and affective response occurs which then results in enhanced self-efficacy beliefs and greater persistence, motivation, and future performance.

For the purpose of understanding the long term process the bulimic individual goes through it may be helpful to view the binge/purge cycle within a vertical spiral where the individual is either cycling towards a healthy state or further into chronic bulimia. It is important to note that in this model the individual is either moving upward or downward but there is no point at which the individual is not moving at all. Grasping this notion is of grave significance because it requires us to then recognize that every thought, every emotion, every event in the recovering bulimics life may be a part of this cycle. This allows clinicians to begin to understand the pervasiveness of this disease in the client’s life. It presents bulimics with an awareness of how each and every thought and decision they
choose to make can either help them or hurt them. This is the crux of the answer to the question “How does an individual transition from a state of chronic bulimia to psychological health?”
Research suggests that cognitive-behavioral therapy in combination with relapse prevention training, and attributional restructuring, may be effective in enhancing maintenance of abstinence in bulimic and binge eating disordered individuals (Andrews & Debus, 1978; Fosterling, 1986; Grilo & Shiffman, 1994; Grilo, Shiffman & Wing, 1989, 1993; Marlatt & Gordon, 1985; Ward et al., 1993; Weiner, 1988). The above mentioned interventions effectively target processes occurring in the maintenance stage. The specific processes of the maintenance stage that attributional restructuring may address are attribution, abstinence violation, and self-efficacy. These interventions target the processes by addressing the problematic and distorted thought patterns occurring in eating disordered individuals.

If one considers the bulimic and binge eating disordered person's preoccupation with food, body weight, and body shape, and the relation of these factors to self-esteem and the development of such a disorder, logic dictates that these same factors would play a role in the later stages of the process of change. The writer hypothesizes that these factors which contribute to the development of the disorder also play a significant role in the early phase of the maintenance stage. For example, if a bulimic individual is focused on restraint from "forbidden foods" and abstinence from binging and purging, the occurrence of a lapse in restraint will be a significant, negative event resulting in a series of attributions. As the person progresses through the binge/purge cycle these attributions will continue to be made during each phase of the cycle. Each attribution will influence self-efficacy for future abstinence and AVE value. However, due to the severe preoccupation of the individual regarding food and body shape or weight, the attributions, if internal, would also effect self-esteem, due to the over identification of self with food consumption and body image.
Other factors of relevance to eating disorders may be conceptually understood within the framework of the process of change. Cognitive-behavioral therapy in combination with mood and situation specific relapse prevention and attributional restructuring, may effectively intervene on the processes which play a critical role in the maintenance of eating disordered symptoms and compromise the potential for effective change.

Minimal attention has been given to developing models of relapse prevention specifically addressing the processes of the binge/purge cycle occurring in bulimic individuals and much of the relapse prevention literature is vague at best. In this chapter the writer will discuss a model for relapse prevention incorporating the areas of self-efficacy and attribution through cognitive behavioral therapy. This model will be composed of two sections, assessment and treatment. In the section addressing assessment the writer will discuss three areas of assessment; process of change stage, self-efficacy, and attribution. The areas discussed must be considered as an addition to the traditional psychosocial assessment and eating disorder history assessment. In the section about treatment the author will discuss cognitive-behavioral therapy specifically pertaining to relapse prevention, relapse prevention training, and the process of modifying self-efficacy beliefs through attributional restructuring. Throughout the chapter the writer will suggest areas of further research in the treatment of bulimia.

Assessment

Process of Change Stage

As was previously discussed in Chapter 1, the processes that initiate change are not the same as those which support the maintenance of change. Therefore, it is imperative
that we begin a relapse prevention program by assessing clients’ appropriateness, more specifically answering the question “Has this bulimic individual reached the maintenance stage of process of change?” Knowing the answer to this question gives us some assurance that the proposed interventions will produce the targeted effect. As suggested in the previous example a teacher wants to make sure this person knows how to count (i.e., has the appropriate mathematical background) before trying to teach them calculus, otherwise any effort will be futile or perhaps even detrimental. Attempting relapse prevention training before a client is ready may result in failure to maintain abstinence, ineffective attributions, decreased self-efficacy, and a spiraling downward in the binge/purge cycle leading to more severe chronic bulimia. To date there is not a test that adequately measures process of change stage in the field of eating disorders. Such a test may be based on the ten processes researched by DiClemente (1993) in the field of addictions (Appendix D). Future research may address the assessment of process of change stage. As there is no test currently available, clinicians may address this issue by conducting a eating disorder history, with special attention to periods of abstinence, current abstinence, previous treatment, and awareness of self-defeating thoughts and behavior patterns.

Mood and Situation Specific Self-Efficacy

In addition to assessing stage of process of change, the literature suggests that self-efficacy is a valid predictor of treatment outcome. Schneider, O’Leary, and Agras (1987) suggest the need for mood and situation specific self-efficacy. While several tests (i.e. ESQ, SEQ, and ESES) measure self-efficacy, they do not fully allow for the identification of mood and situation specific self-efficacy. Ideally, a test may identify
self-efficacy for refraining from binging on a variety of foods, for refraining from binging in various mood states, for utilizing stimulus-control techniques, and for accepting body shape. When assessing self-efficacy, it would be useful to engage clients in creating a list of safe foods, moderately safe and forbidden foods as well as creating a list of safe, moderately safe, and difficult mood states and situations. While certain moods (i.e., anger or loneliness), certain foods (i.e., items high in fat and sugar), and certain situations (i.e., eating alone or holiday feasts) tend to be very difficult for most bulimics, there may be variance among other emotions (i.e., excitement and boredom), foods (i.e., favorite foods from childhood), and situations (i.e., eating a meal with a best friend).

**Attribution**

The importance of attribution in the binge/purge cycle has been shown. However, literature suggests that attributions vary across time and situation and that general attributional styles are not correlated or predictive of outcome. Therefore, the writer suggests that the most effective and realistic method for monitoring attribution may be through writing in a journal. Ideally, we would want to test mood and situation specific attribution on dimensions of locus, stability, and controllability in a single form and encourage journalling for the purpose of monitoring. As such a test does not exist, journalling may suffice. While this method of monitoring is subject to the pitfalls of all self-report measures it seems most applicable and practical. Additionally, if incorporated appropriately into a relapse prevention program, it should fulfill the purpose of monitoring assuming the client is literate and willing to write. Such a journal should be kept on a daily basis during which the client records in narrative form their attributions regarding maintenance of abstinence, lapse, and relapse (See Appendix C). This brings us to the
obvious need to educate the client prior to journaling on the definition of attribution while providing examples of each type of attribution and explanation of the categorization of attributions on the dimensions of locus, stability, and controllability. Future research may focus on the role of additional factors in attribution from the conceptual perspective of process of change. These factors may include self-esteem, body image, and effect of gender role expectations as dictated by sociocultural setting.

Cognitive-Behavioral Therapy and Relapse Prevention

"Women with bulimia nervosa exhibit problematic and distorted thinking styles and beliefs that may be causally linked to both the maintenance of their symptoms and to the relapse process" (Ward, et al., 1993, p. 671; Fairburn, 1985; Garner & Bemis, 1985; Jansen, Merckelbach, Oosterlaan, Tuiten & Van Den Hout, 1988; Johnson & Conners, 1987; Orleans & Barnett, 1984; Ruderman, 1985). Cognitive-behavioral therapy programs have utilized self-management procedures developed from the process of change literature in addictions in the treatment of bulimia nervosa with successful results (Agras, 1987; Agras, Schneider, Arnow, Raeburn & Telch, 1989; Fairburn, 1988; Telch, Agras, Rossiter, Wilfley & Kenardy, 1990; Ward, et al., 1993; Wilson, 1992; Wolf & Crowther, 1992). Treatment outcome studies on cognitive-behavioral therapy have shown several findings relevant to process of change. Maddocks, Kaplan, Woodside, Langdon and Piran (1992) found positive long term outcome correlated with abstinence at the end of treatment. Thackwray, Smith, Bodfish, and Meyers (1993) found that at six months follow-up 69% of subjects with bulimia nervosa, receiving a cognitive-behavioral psychotherapy approach were abstinent, compared to 38% of behavioral therapy subjects. However, at the end of treatment, 92% of cognitive-behavioral subjects were abstinent,
versus 100% of behavioral subjects. From this result Thackwray et al. concluded that bulimia is best treated through addressing coping skills, behaviors, and cognitions. Telch, Agras, Rossiter, Wifley, and Kenardy (1990) found that non-purging bulimic subjects in a cognitive-behavioral therapy approach, showed a 94% decrease in binge eating with 79% of subjects reporting abstinence. Clearly, cognitive-behavioral therapy is a superior form of treatment for addressing the issues of the eating disordered individual.

The writer believes it is important from the perspective of relapse prevention to continue cognitive-behavioral therapy throughout and beyond the relapse prevention portion of treatment. As previously discussed, this part of treatment occurs when the individual is in the action and maintenance stages of process of change. Cognitive-behavioral therapy may be combined effectively with alternate techniques to address the issues of self-efficacy, attribution, and relapse prevention, as will be discussed in the later sections of this chapter. The following suggestions are several topics relevant to the cognitions of bulimic individuals hoping to avoid relapse.

Distinguishing Between Lapse and Relapse

Educating clients on the distinctions between maintenance, lapse, and relapse may be a powerful tool for intervening on the cognitive distortions, or all-or-nothing thinking, occurring in bulimic persons. This reinforces the idea that if you have a bad morning, it doesn’t have to be a bad day. A lapse may become a relapse because the individual makes an attribution that they are incapable of avoiding relapse simply because they have lapsed. A client may think that because they have not performed perfectly on one occasion that they are incapable of accomplishing the long term goal of consistent abstinence.
**Body Image and Change in Body Size and Shape**

It is important to discuss with clients their thoughts and feelings around body image and change in body size. While this specific topic is not included in the model of relapse prevention, it is of relevance to self-concept. As a characteristic feature of bulimics is an excessive importance placed on body shape and size in self-evaluation and self-concept (American Psychiatric Association, 1994). It was previously suggested that self-concept may be linked to the binge/purge cycle through attributions and self-efficacy. Depending on the severity of bulimia, clients may experience initial weight gain, water weight gain (bloated feeling), and changes in body size. It is important that the client see the need for abstinence as a priority above body weight, size, and shape. Often clients maintain distorted cognitions around the subject of body size/weight. As clinicians it is imperative that we explore these distortions with our clients and discuss alternatives and coping skills. Such distortions may include: they will gain enormous amounts of weight if they eat normally, instead of starving, binging, and purging; or they will not change size or need larger clothing; or they can maintain abstinence without any weight fluctuations or fluctuations in water weight. Additionally, it is important to discuss frequency of weight monitoring and effective ways of adjusting to changes in body composition. The author suggests limiting weigh-ins to a maximum of one time weekly. It may be helpful to encourage clients’ exploration of areas which may provide them with an enhanced awareness of their bodies. These areas may include meditation, spirituality, exercise, body movement (e.g., dance, yoga, Tai Chi), and three-dimensional modalities of artistic expression working with shape (e.g., clay sculpture).
Current Relapse Prevention Training Programs

There are three basic components included in most currently applied relapse prevention program. These components are identification of triggering moods and situations, identification of alternate coping skills, and enhancement of social support network (Mitchell, 1990).

The component of identification of triggering moods and situations may overlap to some extent with areas of low self-efficacy. This component includes; identifying forbidden foods, identifying triggering emotions (e.g., anger, boredom, lonesome, sad, and happy), identifying triggering situations (e.g., grocery shopping, meals eaten by self, meals in the company of friends or family, and being alone at home with food), and identifying changes in thought patterns that precede relapse (e.g., all-or-nothing thinking, invincibility, choices to starve or skip meals, and negative thoughts about body image).

The second component of relapse prevention training involves identifying alternate coping skills. This component should address the following areas; meal planning utilizing safe foods, planning for eating forbidden foods under safe circumstances for the purpose of desensitization, planning effective ways to handle triggering situations, identifying coping skills and methods of dealing with triggering emotions, planning methods for monitoring thought patterns and choosing alternate thought patterns.

The third component of relapse prevention training involves enhancing social support network. This may be achieved by identifying current, positive, healthy relationships, attending weekly or biweekly eating disorders support groups for the purpose of establishing relationships with other people who have maintained abstinence for a significant time period, and attending sessions with a therapist who is familiar with issues involving eating disorders.
Enhancing Self-Efficacy through Attributional Restructuring

As discussed in the section addressing assessment, it is vital to this model that we develop methods of assessing self-efficacy and attribution for the purposes of initial evaluation and monitoring of progress. From the results of such a test the clinician may target areas of low self-efficacy and mood and situation specific attributional sets. As previously mentioned, areas of self-efficacy shown to be correlated with positive outcome include; acceptance of body shape, mood state, and forbidden foods. Therefore, it is pertinent that we address these topics.

Ideally, with the appropriate assessment devices clinicians may identify each clients areas of low self-efficacy pertaining to mood states and forbidden foods, and each clients attributions about lapses occurring around these items. As one component of a relapse prevention program, the author suggests addressing self-efficacy through attributional restructuring. One way to restructure attributions may be to request that clients participate in a program focused on monitoring attributions through journalling around targeted low self-efficacy areas, then participating in a weekly group of one hour duration. This type of group may focus on: 1) identifying from journal entries healthy attributions around significant event occurrences, 2) counting each clients weekly healthy, positive attributions and posting tabulations on a board as positive reinforcement and, 3) discussing healthy attribution alternatives to situations where clients journalled ineffective or unhealthy attributions. Under these circumstances, the clinician would be hoping to increase attributions regarding lapses that are external, unstable, non-global, and controllable. Future research may focus on further exploring the role of attribution in enhancing self-efficacy replicating studies regarding lapses and exploring attribution about positive event occurrences. The writer hypothesizes that internal, global, uncontrollable attributions regarding positive event occurrences (i.e., the choice of abstinence at the decision point in
the binge/purge cycle) may be most effective in supporting maintenance. One point of interest on the subject may be that the literature on attribution appears to correspond to the notion of powerlessness in twelve-step programs from the addictions field. Further research may explore this idea.

Conclusion

The model of the binge/purge cycle gives clinicians a theoretical framework from which to approach relapse prevention in bulimia. The components of this model are an event (i.e., binge/purge or abstinence), the AVE (i.e., an attribution, and affective response), which influences self-efficacy beliefs regarding future events, followed by a triggering situation, which result in a decision and an ensuing event (i.e., binge/purge or abstinence). Current relapse prevention programs address some of these components including triggering moods, situations, or emotions, identification of alternate coping skills, and enhancement of social support network. According to the model, an attribution component should be included. The process of change literature suggests more in depth assessment. It suggests that not every individual who has completed a treatment program is ready for relapse prevention training. The literature also suggests the importance of delineating the distinction between lapse and relapse for clients and of approaching self-concept and self-esteem issues in cognitive-behavioral therapy. Current relapse prevention training tends to be included in treatment programs. However, these trainings are generally brief. They do not allow clients necessary time to integrate and apply the information. Relapse prevention has not received needed time or attention in treatment. This may partially explain the chronicity of bulimia in certain sections of the population.
Longer relapse prevention training programs (perhaps even nearing 40 weeks) with a graded exit (i.e., perhaps tapering hours after the first 10 weeks) may offer more successful results. Research is needed to explore this idea.

Program evaluation should be based on results. Reasonable program goals may be to create conscious awareness, prevent lapses, and provide means of coping effectively with lapses, therefore preventing relapses. The goals may be evaluated by tracking client lapses and relapses. This tracking will be helpful to clients in that bulimia is characterized by secrecy. The open tracking of lapses and relapses will break secrecy and give clients the opportunity to effective cope with lapses. It will give clinicians a clear marker as to whether the program offers tangible results.
APPENDIX A: RELAPSE PREVENTION PHASE OF PROCESS OF CHANGE
Appendix A

Relapse Prevention Phase of Process of Change

Persons in different stages predictably differ on decision making, attitudes, and ten processes. Individuals may cycle and/or recycle through these stages numerous times before maintaining successful change (Annis & Davis, 1991; DiClemente, 1993; Velicer, DiClemente, Rossi & Prochaska, 1990).
APPENDIX B: SELF-EFFICACY, ABSTINENCE VIOLATION EFFECT, AND THE BINGE PURGE CYCLE
Appendix B
Self-Efficacy, AVE, Attribution, and the Binge/Purge Cycle

Mood and Cognitive States Fluctuate Throughout Binge/Purge Cycle
APPENDIX C: SAMPLE ATTRIBUTION JOURNAL ENTRIES

Attribution Evaluation Entry #1

Locus: internal

Stability: stable/global

Controllability: uncontrollable

Journal Entry #1: I feel very upset. I went grocery shopping and I bought chocolate cake. I was only going to eat one piece when I got home. I just couldn’t help myself. I ate the whole thing and threw up. I feel so guilty. I am such a terrible person. I will never be able to eat like a normal person. I don’t know why I even bother trying.

Attribution Evaluation Entry #2

Locus: external

Stability: unstable/non-global

Controllability: controllable

Journal Entry #2: I feel very upset. I went to the grocery store. I bought chocolate cake. I ate all of it and threw up. I know I am capable of eating like a normal person. I guess I should not have tried to eat chocolate cake without planning ahead and considering that it may be one of my forbidden foods. Next time I will plan to try eating it under safe circumstances instead of at home by myself.


Coelho, R.J. Self-efficacy and smoking cessation. *Psychological Reports, 54,* 309-310.


Consulting and Clinical Psychology, 55, 145-149.


Eating Disorders, 7, 541-550.


VITA

I received my Bachelor of Arts degree in Psychology from the University of Tampa in May of 1993. While attending University of Tampa, I completed an internship at the Spring of Tampa Bay: Center for the Prevention of Domestic Violence. Upon graduation I immediately entered Loyola University Chicago's Master of Arts program in Counseling Psychology. While completing my Master's degree, I completed an internship at Spectrum Youth and Family Social Service Agency in Hoffman Estates, Illinois. I additionally worked at Interventions-City Girls Program, providing counseling on a residential substance abuse unit serving adolescents in Chicago. I especially enjoy working with adolescents struggling with substance abuse problems and eating disorders.
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The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

4-4-97
Date

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