

Journal of Clinical Psychology Practice

Increasing the Effectiveness of Treatment for Bulimia Nervosa by Incorporating Associated Personality Characteristics

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In 1979, Gerald Russell described and named Bulimia Nervosa (Palmer, 2004). His rich clinical description allowed clinicians and researchers to detect and study the disorder and an explosion of attention and literature followed in the next decade (Palmer, 2004). Bulimia is a disorder characterized by recurrent, episodic binge eating, self-induced purging, restrictive dieting, or excessive exercising in order to prevent weight gain. Bulimia may also include a persistent over-concern with weight, size, and shape, distortion of body image, and a desire to be thin (Thackwray, Smith, Bodfish, & Meyers, 1993). Binge eating is a feature of bulimia and is defined as the consumption of an abnormally large amount of food in addition to the perception of being out of control. Compensatory behaviors aimed at preventing weight gain are common in bulimia. They may include the misuse of laxatives, diuretics, or other agents, dieting, vomiting, and excessive exercise (Shapiro et al., 2007).

The prevalence of Bulimia Nervosa has been estimated to be 1/100 for women and 1/1000 for men across the United States and Western Europe (Shapiro et al., 2007). Sub-threshold cases are those that fall below the threshold of diagnostic criteria for Bulimia Nervosa in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), resulting in a diagnosis of Eating Disorder Not Otherwise Specified (Nauert, 2008). The prevalence of sub-threshold Bulimia Nervosa has been estimated to be 1.5/100 for full syndrome and 5.4/100 for partial syndrome (Shapiro et al., 2007). No one etiological factor in itself is powerful enough to cause an eating disorder, and the emergence of these disorders likely result from an interaction of various influences, such as societal, biological, and cognitive factors, as well as familial characteristics and personality features of the

Summary

Significant associations have been found between particular personality characteristics and Bulimia Nervosa which play a role in the emergence and maintenance of symptoms and predict poor treatment response. The effectiveness of treatment may be increased if personality characteristics associated with Bulimia Nervosa are addressed during assessment and treatment.

Keywords

Bulimia Nervosa
Personality Traits
Personality Disorders
Personality
Assessment
Treatment

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individual (Sherman & Thompson, 1992). Specifically, several studies have investigated personality and eating disorders with many finding a significant relationship between particular personality characteristics and bulimia (Klump et al., 2004). However, most investigations have studied co-morbid personality disorders, whereas considerably less is known about non-clinical personality characteristics (Pryor & Wiederman, 1996).

The identification of bulimia as a new disorder has also been a stimulus for treatment research. There is robust evidence that Cognitive-Behavioral Therapy (CBT) for bulimia is successful in treating the disorder (Palmer, 2004). CBT has been shown to produce reliable improvement with therapeutic effects showing good maintenance over time (Wilson & Fairburn, 1993). Furthermore, this form of treatment is capable of leading to full remission in approximately half of those individuals treated and some improvement in the remaining individuals (Palmer, 2004). Interpersonal psychotherapy (IPT) also has a solid evidence base (Palmer, 2004; Tantleff-Dunn, Gokee-LaRose, & Peterson, 2004). Although it is somewhat slower in effect than CBT, at a one year follow-up, it was equally effective (Shapiro et al., 2007). Various psychopharmacological treatments have also been used, such as tricyclic antidepressants, monoamine oxidase inhibitors, and serotonin reuptake inhibitors (Mitchell, Agras, & Wonderlich, 2007). Although all of these have shown efficacy, serotonin reuptake inhibitors remains the drug of choice with fluoxetine representing the only FDA approved medication for bulimia (Mitchell et al., 2007). More importantly, the National Institute for Clinical Evidence guideline on the treatment of eating disorders has made a clear recommendation in favor of CBT (Palmer, 2004). Although CBT remains the treatment of choice (Wilson & Fairburn, 1993), current manual-based CBT has significant limitations since approximately only 40% to 50% of patients being treated stop bingeing and purging completely (Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002). Furthermore, some patients do not benefit at all (Wilson & Fairburn, 1993). Thus, improving current empirically-based treatments, such as CBT and IPT, needs to be a future research priority (Wilson et al., 2002).

It has been suggested that personality characteristics may play a particular role in the emergence and maintenance of eating disorder symptomatology and may predict poor treatment response (Van Hanswijck De Jonge, Van Furth, Lacey, & Waller, 2003). Specifically, the notion that personality disorders and traits influence the course and outcome of eating disorders has been demonstrated in various studies (Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006). The effectiveness of treatment may be increased if personality characteristics associated with Bulimia Nervosa are addressed during treatment. Specifically, the assessment of personality and therapeutic strategies that address these identified personality characteristics should be incorporated into treatment in order to further increase effectiveness. In this paper, I will first compare those personality characteristics related to eating disorders in general. Next, discussion will focus on those traits and those personality disorders specifically associated with bulimia.

Eating Disorders and Personality

Early research on eating disorders and personality characteristics compared patients with Bulimia Nervosa and Anorexia Nervosa (Pryor & Wiederman, 1996). The individual with anorexia “refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body” (American Psychiatric Association [APA], 2000, p.583). Personality has been utilized to account for Anorexia Nervosa throughout its observed history with remarkable consistent findings (Vitousek & Manke, 1994). Early studies reported a fairly consistent cluster of neurotic features: obsessional traits were found in 27 to 61 percent of sample participants, shyness and dependency in 21 percent to 48 percent, and anxiety in 51 percent to 64 percent (Vitousek & Manke, 1994). The predominant

personality type for patients with anorexia consisted of inhibition, obsessionality, and compliance and was evident in 69 to 87 percent of those examined (Vitousek & Manke, 1994). Interestingly, subjects with anorexia fitting the binge-purge (or bulimic) subtype had an outgoing social disposition, histrionic features, and indicators suggestive of affective instability (Vitousek & Manke, 1994) which is similar to subjects with bulimia. Furthermore, individuals with anorexia have been characterized by high scores on neuroticism, harm avoidance, reward dependence, anxiety, and low scores on novelty seeking behavior (Diaz-Marsa, Carrasco, & Siaz, 2000).

Since bulimia was officially recognized in the DSM-III in 1980, a less consistent clinical stereotype has emerged (Vitousek & Manke, 1994). Individuals with bulimia have been shown to share many of the same characteristics as those with anorexia, such as increased harm avoidance, neuroticism, perfectionism, and obsessive tendencies (Klump et al., 2004). However, bulimia involves the expression of some diametrically different symptoms, such as binge eating and purging, with those behaviors attributed to opposite traits typically found among individuals with anorexia (Vitousek & Manke, 1994). In contrast to those with anorexia, individuals with bulimia have high scores in extroversion, novelty seeking, and impulsivity (Diaz-Marsa et al., 2000). In particular, patients with bulimia often display an erratic pattern that consists of oscillation between restraint and disinhibition. This suggests some combination of underlying characteristics, such as compulsiveness, impulsivity, and instability of affect. Theoretically, the binge-purge cycle serves a functional basis within the context of these traits: it provides a mechanism of affect regulation and facilitates a temporary suppression of painful self-awareness (Vitousek & Manke, 1994).

Research on personality has grown in recent years due to its implications for the development and course of symptoms in eating disorders (Diaz-Marsa et al., 2000). The assumption that specific personality traits may determine classification of either anorexia or bulimia has shaped much of the field's contemporary interest (Vitousek & Manke, 1994). Various theoretical models have identified pre-morbid personality traits in the etiology, symptomatic expression, and maintenance of eating disorders (Cassin & von Ranson, 2005). Prospective studies and other research, including quasi-prospective, retrospective, and family study research, have identified negative emotionality, perfectionism, poor interoceptive awareness, and obsessive-compulsive personality traits as likely pre-dispositional factors that may increase an individual's risk of developing an eating disorder (Lilenfeld et al., 2006). However, to date, no longitudinal study has investigated personality characteristics as predictors of anorexia or bulimia (Klump et al., 2004).

Bulimia Nervosa and Personality Traits

A number of personality traits are specifically associated with Bulimia Nervosa. Current research of the personality traits of individuals with bulimia indicate problems with affect regulation accompanied by the presence of alexithymia -- specifically, difficulty identifying and articulating internal states, low self-esteem, and lower impulse control (Palme & Palme, 1999). There is also increasing evidence that strongly suggests perfectionism may be a predisposing factor for developing bulimia (Lilenfeld et al., 2006). In order to examine personality traits as potential etiological factors, researchers have investigated the presence of pathological or extreme personality characteristics in those who have recovered from an eating disorder. It has been argued that if personality characteristics are present after recovery, then they may have been present before onset and predisposed the individual to the disorder. However, it is also likely they are a continuation of characteristics that accompanied the disorder, and thus, represent a lasting 'scar' of clinical disturbance within the individual (Klump et al., 2004). A study by Klump and colleagues (2004) found that individuals with bulimia scored significantly higher on harm avoidance and

novelty-seeking, and significantly lower on self-directedness in comparison to a control group. Several of these personality characteristics were also observed in women recovered from bulimia, such as lower self-directedness and higher novelty-seeking. These findings suggest that several personality characteristics in women with eating disorders and those in recovery may be different from those who do not display and eating disorder. In other words, personality disturbances in women with eating disorders may be trait-related and contribute to the pathology and development of the disorder (Klump et al., 2004).

Impulsivity

Research has shown patients with Bulimia Nervosa are more impulsive when compared to patients with Anorexia Nervosa and psychiatric controls (Cassin & von Ranson, 2005). Impulsivity is defined as a “lack of forethought and failure to contemplate risks and consequences before acting” (Cassin & von Ranson, 2005, p. 898). Similarly, bulimia is associated with higher levels of negative affect and urgency or the tendency to act rashly when distressed, and these traits distinguish them from controls (Fischer, Smith, Annus, & Hendricks, 2007). Studies of alcohol use, drug use, and deliberate self-harm among individuals with bulimia has led some authors to argue for the recognition of a distinct diagnostic subgroup called “Multi-Impulsive Bulimia” or “Multi-Impulsive Personality Disorder” (Welch & Fairburn, 1996). In particular, the lifetime prevalence of substance abuse or dependence involving stimulants and alcohol is at least 30 percent among individuals with bulimia (APA, 2000). Impulsivity has been used to explain the binge and purge process characteristic of bulimia. During the binge and purge cycle, an individual with impulsive tendencies may be more likely to react to stressful events with a food craving as a conscious symptom of anxiety (Palme & Palme, 1999). Additionally, individuals often find themselves in the act of eating without even realizing it (Wilson and Fairburn, 1993). Wilson and Fairburn (1993) explored stress, negative affect, and impulsivity as proximal determinants of binge eating and argued that emotional states overwhelm the ability to process stimuli consciously. This reduces the conscious-processing required to resist binge eating and has been referred to as “absent-minded relapse” or an unconscious slip (Wilson & Fairburn, 1993). It is important to consider that impulsivity may be attributed to the erratic dietary patterns and emotional instability associated with bulimia rather than reflecting an enduring personality trait. To support this position, emotional lability and other measures of behavioral disinhibition generally decrease following reductions in binge eating and purging (Cassin & von Ranson, 2005).

Perfectionism

Higher levels of perfectionism have been found among recovered bulimia patients and may represent a risk factor for bulimia (Castro-Fornieles et al., 2007). However, perfectionism may also characterize the acute phase of an eating disorder (Halmi et al., 2005). Perfectionism is defined as “a tendency to place excessive emphasis on precision and organization, the setting of and striving for unrealistic personal standards, critical self-evaluation if these standards are not reached, excessive concern over mistakes, and doubts about the quality of personal achievements” (Castro-Fornieles et al., 2007, p. 562). In general, individuals with eating disorders tend to display significantly greater neurotic perfectionism with an over-concern regarding mistakes, anxiety about performance, setting unrealistic personal standards, a belief others evaluate them harshly, and excessive demands for perfection (Cassin & von Ranson, 2005). More specifically, increased concern over mistakes and doubts regarding actions is associated with bulimia (Castro-Fornieles et al., 2007). Castro-Fornieles and colleagues (2007) found that bulimia patients had higher self-

oriented perfectionism consisting of “critical self-scrutiny, unrealistic self-imposed personal standards, and requiring perfection from oneself” (Castro-Fornieles et al., 2007, p. 563) when compared to both controls and psychiatric patients with depressive, anxiety or adaptive disorders. However, the use of a self-report questionnaire and the cross-sectional nature of this study make it difficult to draw conclusions about the role of perfectionism in the outcome of the disorder (Castro-Fornieles et al., 2007). Furthermore, perfectionism is closely associated with obsessive-compulsive personality features and this relationship may be a relevant behavioral feature underlying the vulnerability for developing an eating disorder (Halmi et al., 2005). Although research has consistently supported the relationship between perfectionism and eating disorders, it is still uncertain if perfectionism is associated with disordered eating in particular or with general maladjustment (Cassin & von Ranson, 2005).

Alexithymia and Affect Dysregulation

Alexithymia includes difficulty identifying and describing feelings, difficulty distinguishing feelings from bodily sensations, and difficulty thinking abstractly and introspectively (De Berardis et al., 2007). It literally means “no words for feelings” (Wheeler, Greiner, & Boulton, 2005, p. 115). Elevated levels of alexithymia, and in particular difficulty distinguishing and describing feelings, has been found among patients with bulimia both before and after treatment (Gilboa-Schechtman, Avnon, Zubery, & Jeczmierny, 2006; De Berardis et al., 2007).

Affective dysregulation is related to alexithymia. Affective dysregulation is the inability to manage emotions and self-soothe due to a lack of awareness of emotions (De Berardis et al., 2007). Difficulty in regulating negative mood has been linked to bulimia (Gilboa-Schechtman et al., 2006). For patients with bulimia, the adaptive and informational value of emotions is often not possible due to the presence of alexithymia (De Berardis et al., 2007). A study by Gilboa-Schechtman and colleagues (2006) was the first comprehensive assessment of both emotional awareness and emotional regulation in eating disorders. These authors found that patients with eating disorders reported significantly lower levels of emotional awareness and more deficient emotional regulation strategies in comparison to healthy controls.

Binge eating has also been associated with affect dysregulation. Specifically, the literature has linked binge eating to disturbances in the self-system with the individual bingeing to relieve distress and regulate negative affect (Wheeler et al., 2005) and lower consciousness of painful mental and cognitive states (Gilboa-Schechtman et al., 2006). DeGroot, Rodin, and Olmstead (1995) also found that women with bulimia have difficulties identifying feelings and triggers associated with binge-purge episodes (Gilboa-Schechtman et al., 2006).

The difficulty distinguishing emotional states from bodily sensations is also more prevalent among individuals with eating disorders possibly due to an incapability of being in touch with their inner emotional world (De Berardis et al., 2007). For instance, individuals with eating disorders often mislabel aversive physical and emotional states as “feeling fat” (Fairburn, Cooper, Shafran, & Wilson, 2008) and will focus on negative perceptual aspects of their body in order to avoid emotional experiences (De Berardis et al., 2007). De Berardis and colleagues (2007) found that the relationships between alexithymia, body checking behaviors (looking in the mirror, trying on clothing frequently), and body image were strongly correlated. In particular, patients who scored high on alexithymia reported an increase in eating disorders, a higher frequency of body checking behaviors, and increased body dissatisfaction. It was hypothesized that alexithymia might play an indirect role in the pathology and maintenance of abnormal eating behaviors and the presence of body checking behaviors may create or exacerbate body-image problems. Furthermore, maladaptive eating behaviors may be used to manipulate the experience of positive and negative

emotional states (De Berardis et al., 2007). A prospective study by Leon and colleagues (1995) found that poor interoceptive awareness predicted risk for an eating disorder one year later among junior high and high school students (Lilenfeld et al., 2006). Factor analyses and longitudinal studies have supported the argument that alexithymia is a stable personality trait rather than a state-dependent phenomenon (Speranza, Loas, Wallier, & Corcos, 2007).

Low Self-Esteem

Self-esteem is defined as “a person’s perception of his or her overall worth as a human being” (Peck & Lightsey, 2008, p. 185). Typically, women with disordered-eating behaviors have been found to have lower self-esteem than do women with less severe behaviors or without eating disorders (Peck & Lightsey, 2008). For example, Daley, Jimerson, Heatherton, Metzger, & Wolfe (2008) investigated self-esteem ratings among women recovered from bulimia, currently diagnosed with bulimia, and healthy controls. The self-esteem scores for women with bulimia were lower than those of controls. Also, for recovered women, self-esteem scores were higher than for those with bulimia but lower than scores of controls. Results of a study by van der Ham, van Strien, and van Engeland (1998) indicated that low self-esteem had more to do with general feelings of worthlessness, anxiety, and lack of self-confidence than with feeling helpless in facing the demands of adult life. Interestingly, the self-deprecating feelings of patients with bulimia centered more on their body in comparison to patients with anorexia (van der Ham et al., 1998). Self-esteem and perfectionism have also been linked in several studies (Peck & Lightsey, 2008). Vohs, Bardone, Joiner, Abramson, and Heatherton (1999) found that self-esteem, perfectionism, and perception of weight predicted the presence of behaviors typical of bulimia.

Bulimia Nervosa and Co-morbid Personality Disorders

There has been recent interest regarding Axis II co-morbidity (Vitousek & Manke, 1994). Personality disorders are more common among patients with eating disorders than those with other Axis I disorders (Cassin & von Ranson, 2005). It has been estimated that 20 to 80 percent of patients with either anorexia or bulimia have personality disorders (Diaz-Marsa et al., 2000). Specifically, the average prevalence rate for personality disorders among individuals with bulimia has been estimated to be 34 percent (Hersen, Turner, & Beidel, 2007). However, variations in samples, recruitment, and assessment methods often result in inconsistent co-morbidity rates (Cassin & von Ranson, 2005). Research has found patients with bulimia and anorexia-bulimic type tend to exhibit Cluster B (Antisocial, Borderline, Histrionic, and Narcissistic) and Cluster C (Avoidant, Dependent, and Obsessive-Compulsive) personality disorders (APA, 2000; Cassin & von Ranson, 2005). Those with restrictive anorexia tend to exhibit cluster C disorders (Vitousek & Manke, 1994; Diaz-Marsa et al., 2000). Cluster B disorders have been shown to be associated with high novelty seeking, whereas cluster C disorders are associated with high harm avoidance (Cassin & von Ranson, 2005). Since individuals who engage in binge eating are characterized by high novelty seeking, and high harm avoidance is common among all eating disorders, it is not surprising that both cluster B and C personality disorders are common among those with bulimia (Cassin & von Ranson, 2005). In particular, borderline personality disorder has been the most frequently diagnosed among individuals with bulimia (APA, 2000), with histrionic, dependent, and avoidant disturbances reported often, but at varying frequency (Vitousek & Manke, 1994). Cassin and von Ranson (2005) conducted separate meta-analyses of prevalence rates for bulimia obtained through either self-report inventories or diagnostic interviews. Their results indicated that personality disorders diagnosed through self-report instruments tended to overestimate prevalence rates.

Furthermore, interview studies also generated higher prevalence rates when unstructured formats were used or when clinicians were not blind to an eating disorder diagnosis when determining pathology (Vitousek & Manke, 1994).

The findings of Cassin and von Ranson (2005) regarding personality disorders among patients with bulimia are consistent with those characteristics found among this population. Avoidant personality disorder is a common diagnosis across all eating disorders and patients with bulimia are often overly concerned with acceptance and approval and fear criticism and rejection. The frequency of obsessive-compulsive personality disorder among those with Bulimia supports findings that these individuals are perfectionistic and have high personal standards. There is also a striking correspondence between the diagnostic criteria for borderline personality disorder and attributes associated with bulimia, such as affective instability, impulsivity, and identity disturbance (Vitousek & Manke, 1994). As a consequence, it has been argued that personality traits may influence the type of personality disorder an eating-disordered patient exhibits, since research findings which examine dimensional personality traits and those investigating categorical personality disorders generally are in support of each other (Cassin & von Ranson, 2005).

Implications for Treatment

This review raises a number of questions regarding personality, bulimia, and treatment. First, do personality characteristics associated with Bulimia Nervosa account for non-response to treatment? Second, can treatment providers who use personality assessment identify at the beginning of treatment which patients may be non-responders? Third, would addressing these personality characteristics improve treatment outcome?

Do the Personality Characteristics Associated with Bulimia Nervosa Account for Non-Response to Treatment?

Personality characteristics associated with bulimia have been shown to negatively affect the treatment response of patients (Lilenfeld et al., 2006). The literature suggests that these characteristics may also predict response to treatment in serious and refractory cases (Vitousek & Manke, 1994). Specifically, personality dysfunction may result in increased emotional impairment, greater rate of suicidal features, increased family dysfunction, and higher rates of hospitalization among patients (Diaz-Marsa et al., 2000).

Co-morbid Personality Disorders and Non-Response to Treatment

As discussed earlier, studies investigating the association of personality disorders and the severity of eating disorder symptoms have focused mainly on cluster B personality disorders with a particular emphasis on borderline personality disorders (Cassin & von Ranson, 2005). The presence of borderline personality disorder and other cluster B personality disorders has been shown to be related to poor treatment response and predictable outcome among patients with bulimia (Van Hanswijck De Jonge et al., 2003; Cassin & von Ranson, 2005). Co-morbid personality disorders are associated with a poorer response to CBT and alternative therapies (McGilley & Pryor, 1998). Specifically, borderline personality disorder is associated with poorer therapeutic outcome for group and individual therapy, CBT, and pharmacotherapy (Van Hanswijck De Jonge et al., 2003). Although borderline personality disorder appears to be associated with greater generalized psychopathology and poorer functioning, it is not necessarily associated with greater eating disorder symptomatology (Cassin & von Ranson, 2005). However, many studies have

evaluated personality disorders as a general category instead of examining specific personality disorders and thus limiting conclusions (Lilenfeld et al., 2006).

Personality Traits and Non-Response to Treatment

The concept that personality traits influence the course and outcome of an eating disorder has also been examined (Lilenfeld et al., 2006). Steiger, Stotland, and Houle (1994) found, at one year follow-up, that patients with bulimia and borderline traits showed significantly poorer treatment responses than patients with bulimia only (Joiner, Heatherton, & Keel, 1997). Among patients with bulimia, personality characteristics, such as impulsivity, have been found to contribute to a more chronic course (Keel & Mitchell, 1997). Impulsivity may manifest itself in higher frequencies of binge eating and purging, or a positive history of substance abuse or dependence, which appear to predict a poor response to treatment (Wilson et al., 1999). Moreover, the ability to reduce bingeing and purging successfully during treatment can be difficult if the patient also has difficulty with emotional regulation, which in turn, may cause them to act increasingly impulsive and continue to binge-purge (Wilson & Fairburn, 1993). The findings regarding impulsivity and negative affect by Fischer and colleagues (2007) also have implications for treatment since individuals with binge and purge symptoms have been found to be more prone to acting out when distressed. If a reduction in these individuals' binge eating and purging is found to occur during treatment, it is likely that substance abuse may emerge as another coping mechanism or manifestation of their issue with impulsivity (Fischer et al., 2007).

Alexithymia can also affect treatment outcome through the negative influence it exerts on emotional expression (Speranza et al., 2007). Alexithymia may be related to the severity of an eating disorder (De Berardis et al., 2007). Clear research on the prognostic value of alexithymia is lacking and some studies have failed to demonstrate a specific impact of alexithymia on the treatment outcome of bulimia patients. However, these studies had methodological limitations, such as small samples, a short longitudinal time period, utilization of older scales, and outcome measures that did not account for the degree of clinical change between baseline and follow-up (Speranza et al., 2007). Speranza and colleagues (2007) found that difficulty identifying feelings was a negative prognostic factor for the long-term outcome of patients with eating disorders with these patients more symptomatic at follow-up. They suggested that difficulty identifying feelings may decrease a patient's capacity to adapt to stressful situations within treatment. Second, alexithymia may also be related to a chronic course by its relationship with other pathological addictive behaviors such as drug abuse. Due to these patients' cognitive limitations in emotional regulation they may engage in maladaptive behaviors to self-regulate disruptive emotions. Additionally, their lack of introspective thinking and poor ability to engage in abstract thought may become a problem during treatment. Specifically, a patient's initial view of relevance of treatment predicts the likelihood that they will remain in treatment (Wilson et al., 1999). If the client has poor introspective skills, they may view treatment as irrelevant to their disorder (De Berardis et al., 2007). This lack of insight and externally oriented thinking style may also interfere with the ability to benefit from psychotherapeutic interventions (Speranza et al., 2007). McCallum, Piper, Ogrodniczuk, & Joyce (2003) found that alexithymic features were associated with the worst treatment outcome in short-term group therapy and individual therapy.

There is also evidence that low self-esteem is associated with a worse prognosis (Fairburn et al., 2008). A study by van der Ham and colleagues (1998) found that low self-esteem was the main factor predicting an unfavorable course and predicted poor outcome four years later for patients with bulimia. Silverstone and Salsali (2003) suggested low self-esteem is one of the main factors responsible for maintaining binge eating among eating disorder patients. Additionally,

perfectionism has been found to predict low functioning at follow-up and has been shown to affect the quality of the therapeutic alliance (Joiner et al., 1997).

Can Treatment Providers using Personality Assessment Initially Identify at the Beginning of Treatment those Patients who may be Non-Responders?

Personality assessment may help researchers and clinicians identify individuals who possess those personality features shown to be related to poor treatment outcome. Vitousek and Manke (1994) noted problems with the assessment of eating disorders and recommend that assessment of personality traits occur in addition to assessment of personality disorders. For instance, the administration of a personality inventory, such as the Millon Clinical Multiaxial Inventory, NEO-PI, MMPI-2, Coolidge Axis II Inventory, or Personality Assessment Inventory, could be utilized to facilitate the early identification of personality attributes that may contribute to the maintenance or exacerbation of symptoms of bulimia (McCray & King, 2003). Furthermore, Van Hanswijck de Jonge and colleagues (2003) stated that the accurate in-depth assessment of personality pathology in bulimia is necessary to develop an understanding of the disorder and further the treatment of these features. Since co-morbidity serves as a marker for the need for more intensive psychotherapeutic intervention (Wonderlich, Crosby, Engel, & Mitchell, 2007), Fischer and colleagues (2007) also recommend the alcohol use of patients be assessed initially and throughout the course of treatment. Additionally, understanding predictors of outcome, such as relevant personality features found among individuals with bulimia, could theoretically facilitate matching treatment to the patients based on their clinical profile at assessment (Speranza et al., 2007). Therefore, the assessment of personality should be used as a tool to identify individuals with personality characteristics related to poor treatment outcome so specific therapeutic strategies that target respective maladaptive characteristics can be utilized in treatment.

Would Treating these Personality Characteristics More Directly Improve Treatment Outcomes for Non-Responders?

Regardless of the theoretical orientation or treatment approach, targeting maladaptive personality traits may facilitate change through the use of various therapeutic strategies. First, it may be necessary to complement general treatment with a therapy that specifically addresses perfectionism (Castro-Fornieles et al., 2007). Second, treatment that addresses alexithymia could be aimed toward affect management through maintenance of the therapeutic relationship and supportive psychotherapy (Wheeler et al., 2005). Alexithymia can be treated with specific psychotherapeutic strategies, such as relaxation exercises, imagery, autogenic training, and biofeedback, which may enhance the patient's awareness of bodily sensations and increase their capacity to self regulate. Additionally, journaling may treat alexithymia as it exposes the internal and external stimuli that lead to bingeing (Wheeler et al., 2005) such as the patient's tendency to eat in response to aversive events and moods (Fairburn et al., 2008). The overall goal would be to help the patient identify and manage their feelings (Wheeler et al., 2005). Identifying specific problems in emotion regulation among individuals with bulimia may assist in developing more effective intervention strategies (Gilboa-Schechtman et al., 2006). Third, Diaz-Marsa and colleagues (2000) stated that findings of impulsivity among individuals with bulimia are of importance when designing therapeutic strategies to address underlying personality features. Lacey and colleagues (1993) argued that some patients may have a failure to control impulsive behavior which raises the likelihood of special treatment needs for multiple impulse issues, such as self-harm and substance abuse (Welch & Fairburn, 1996). Although it is essential to consider pathological personality

features, Pryor and Wiederman (1996) also emphasize the importance of considering non-clinical personality characteristics and temperament. Research has shown personality dimensions to be better predictors of outcome than categorical personality disorders, thus supporting further research into non-clinical personality traits (Keel & Mitchell, 1997; Cassin & von Ranson, 2005). In addition to treating personality disorders during treatment of bulimia, it is also important to target personality characteristics with various therapeutic strategies in order to improve treatment outcomes.

Conclusion

In summary, the notion that personality disorders and traits influence the course and outcome of eating disorders has been demonstrated in various studies (Lilenfeld et al., 2006). In particular, studies have found significant associations between particular personality characteristics and bulimia (Klump et al., 2004). It has been suggested that personality characteristics play a specific role in the emergence and maintenance of eating disorder symptomatology and may predict poor treatment response (Van Hanswijck De Jonge et al., 2003). The effectiveness of treatment may be increased if personality characteristics associated with Bulimia Nervosa are addressed during treatment. Specifically, the assessment of personality and therapeutic strategies that address identified personality characteristics should be incorporated into treatment in order to further increase effectiveness.

Despite these promising findings, it is also important to acknowledge the limitations of past research. In general, research examining the effect of personality on symptoms, treatment response, and prognosis among patients with bulimia is limited (Cassin & von Ranson, 2005). Furthermore, research regarding personality disorders and traits is complicated by measurement and methodological issues (Lilenfeld et al., 2006) and suggests that future investigations may benefit from more sophisticated, longitudinal, prospective research designs (Cassin & von Ranson, 2005). To date, most investigations have studied co-morbid personality disorders, however considerably less is known about non-pathological personality features (Pryor & Wiederman, 1996). Further research into non-pathological personality traits needs to be conducted given that these traits have been found to be better predictors of outcome than personality disorders (Keel & Mitchell, 1997; Cassin & von Ranson, 2005). Therefore it is essential to assess and target both pathological and non-pathological personality features during treatment since this may facilitate a more successful outcome (Pryor & Wiederman, 1996).

Future research that examines the relationship between bulimia subtype and the type of treatment may better clarify which treatment components are of most benefit to whom (Thackwray et al., 1993). It is important to note that associating specific personality disorders and traits to certain eating disorders can be problematic if the patient has a history of multiple eating disorders. Future research should also focus on personality variations found within eating disorder subtypes, such as those among individuals with bulimia, as opposed to those between eating disorder types, such as anorexia and bulimia, since preliminary evidence suggests that personality variations may predict eating disorder symptomatology, treatment response, and prognosis (Cassin & von Ranson, 2005). The research regarding the role of personality characteristics among individuals with Bulimia Nervosa has been promising so far, and hopefully, the knowledge gained from continued research can be used to further increase the effectiveness of treatment independent of theoretical approach.

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Acknowledgement

The author wishes to acknowledge Dr. Sharon Hamilton for her assistance in preparation of this article.