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Case Example:

Adult with Bulimia Nervosa (BN) treated using CBTe

Brigid*, 34-year-old female living with partner, no children. Onset of BN at age 17; nil prior treatment. Daily restriction (intermittent fasting) binging and purging up to 4x; regular exercise. Significant over-evaluation of weight and shape and firmly held belief to be loveable she needed to be thin.

Core element of treatment	Telehealth variation
Assessment/Engagement	• *Oriented to telehealth* including: having confidential space; use of headphones to assist if required; regular time for appointments; minimising distractions, turning off email/other alerts; internet requirements and use of telehealth platform; pitfalls and "Plan B's" should the connection fail; turning off digital assistants (Siri/Alexa etc.) which might impact confidentiality; appropriate consent; having pen/paper, tissues, if needed. • *Set treatment expectations*: treatment happens in the "other" 166-7 hours of the week, not the 1-2 we spend together. • *Acknowledged the strangeness of meeting for the first time via telehealth*; spent around the usual amount of time getting to know Brigid; but added exploration of the way COVID-19 had impacted herself and her partner. • *Set limits to out of session access* in much the same way as I typically would (i.e. I am not able to provide crisis intervention as a private practitioner); but added that just because we meet via technology doesn't mean any change to accessibility after hours.

	○ Note: patients are provided with the practice's mobile number; I have not had anyone try to call via mobile or telehealth outside of a session. • Assessment was undertaken as usual; we typically send out eating and mood screens via online link, so was unchanged through COVID-19.
Psychoeducation	• Used email to send relevant chapters of *Overcoming Binge Eating* to Brigid; asked her to read prior to next sessions as usual; and to use PDF highlighter to note points of relevance. • Used screen-sharing to discuss parts highlighted as relevant.
Treatment non-negotiables	• Ensured that Brigid had regular medical review in place because of the frequency of purging and instilled the same bottom lines as I would in person (regular appointment attendance, collaborative open weighing, medical review).
Formulation	• Created this together using the whiteboard function, shared/updated as needed, via whiteboard/screen sharing/email.
Collaborative weighing	• This was challenging. Brigid used to weigh herself "obsessively" (her word); but she was not able to get to her GP weekly. Agreed after some discussion she would: ○ Purchase scales; I would maintain the weight chart and screen share weekly in session to ensure interpretation of a trend not a single weight point; ○ Manage urges to restrict before session using distraction and commitment to the "meal plan" and communicate openly if she struggled with this; ○ Step on the scale at the appropriate time of the session, on screen (using a phone or tablet) so we were both able to see the number together to reduce her risk of minimising weight change/falsifying weight; ○ Ask her partner to manage access to the scale between sessions to reduce urges for more frequent weighing. • Decisions were shared and collaborated throughout and Brigid empowered to propose solutions she felt were most manageable. • There was some avoidance here: it took some 3-4 weeks to acquire the scales. We needed to work through Brigid's fear of seeing the number after years of avoidance. This element of therapy took substantially longer than it might have face to face, if I had been weighing her routinely in the office.
Regulated eating	• No different from in person: provided the rationale and helped Brigid plan to ensure she introduced 3 meals and 2 snacks daily (Brigid was within the healthy range and did not need to restore weight).

	• Problem solving was focused on COVID-19-related impacts such as:
	  ○ Binge urges were situationally triggered by going to particular shops and the gym where she would buy multiple pastries to binge on. Even early in Lockdown, when cafes were providing take away services, she remained at risk of binging if she left the house. We planned how she might leave the house safely, and not buy binge foods. Simple initial strategies included meeting a friend for a gentle walk; taking her pet to the park; using her time out of the house to call a friend rather than shop; shopping with her partner and a pre-planned shopping list.
	  ○ We talked about the foods she felt safe to have at home and those she struggled with. We expanded those throughout treatment as she felt safer, but I felt we gave more consideration to the foods she had at home than I would with a typical face-to-face client.
	  ○ Discussed the importance of not buying into COVID-19-related panic and resisting urges to stockpile.
	• Enlisted her partner's support with distraction around binge behaviours and purge risk.
	• Used online surveys to test out beliefs about eating, e.g. desserts. This helped Brigid shift from avoiding dessert for fear of loss of control to reshaping her belief towards the idea that dessert was normal and common and, if many others enjoyed dessert most nights, she might be able to move towards this. She was able to experiment with what it was about eating dessert that triggered urges to binge and then purge and was able to break this automatic link.

Monitoring	• I typically give clients the choice of monitoring via pen-and-paper forms or using Recovery Record. During this period, I used Recovery Record for all clients.
Over-evaluation of weight and shape	• Used pie charts drawn in session using the whiteboard to identify minimised areas of life as a result of the ED. We spent a substantial amount of Phase 3 exploring potential areas of interest online in developing a more valued life including: ○ Virtual gallery tour; virtual game drive; virtual furniture restoration webinars; virtual bookclub; and many others before starting to move towards points of interest, and found it powerful to have all these options at her fingertips. I would not have considered using virtual exploration of hobbies prior to the pandemic.
Mirror exposure	• Brigid engaged in body avoidance and checking. She initially was unable to look at her image on screen and elected to hide her image in early sessions. In making this decision we discussed the temporary nature of this as a solution and that later sessions would need to involve exposure to her image. ○ Note: While this fits with advice on how to manage screen use during COVID-19 my experience is much like weighing, I prefer to support clients to adjust to seeing their image rather than supporting avoidance/safety behaviours.

	• In Phase 2 we planned to make over-evaluation of weight/shape and core low self-esteem a focus of Phase 3; Brigid agreed to allow her image to remain visible during sessions. We discussed and challenged beliefs she had about this, and commenced exposure with this as the first step on her hierarchy. • Brigid monitored checking and avoidance using her phone as per standard protocols; monitoring was emailed prior to session. • We used the telehealth platform to do "mirror" exposure. Brigid was provided with the same rationale as all patients, and encouraged to practice using a mirror. But doing exposure via the screen allowed me to model how we might describe our bodies neutrally, and to guide her through the practice in vivo. It took a little discussion to set up the camera for full body view during this exercise. • We used social media for social comparisons instead of comparison in real life during lockdown; we discussed the kinds of people she might compare herself to and why this was not helpful; but also who she followed on social media, how to more critically evaluate the photos posted by others, and curating a more diverse newsfeed.
Core low self-esteem	• This is a more cognitive module which was relevant to Brigid, and we continue to work through. The work in this phase has been quite standard, involving her identifying the ED mindset, and learning to challenge her thoughts and behaviours maintaining poor sense of self, and designing experiments to test out beliefs maintaining low self-esteem.
Treatment Progress	• Brigid is binge/purge abstinent; weight increased slightly through treatment as restriction was maintaining binge eating; eating is more regular/flexible; exercise is more balanced. She has been medically stable for months; we plan to move towards Phase 4 and planning for relapse prevention and discharge.
Main treatment challenges	• With this client, actually getting a scale and managing the weigh-ins was one of the biggest obstacles. • While happy to engage her partner's help in managing binge/purge urges, Brigid found it hard to let him in on the more secret aspects of the ED, but subsequently said doing so was helpful. • Resisting urges to exercise have been a challenge throughout lockdown and beyond. • Engagement has been good and momentum around change maintained. My sense is things can progress a little more slowly when working via tele as some elements of treatment need longer or more detailed set-up, and require clinicians to work more flexibly and creatively.

***Please note:** All names and identifying information have been changed; to protect the identity of clients, the cases presented here represent an amalgamation of a number of cases such that no individual could be identified by any element of treatment presented