

Blindness and Bulimia Nervosa: A Description of a Case Report and its Treatment

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ABSTRACT

Objective: Blindness has rarely been described in the eating disorder (ED) literature. In case reports in which this condition has been reported before an ED, it was concluded that visual body image was not essential for the development of the ED. This is the first report in which bulimia nervosa (BN) and its treatment in a blind woman were described.

Method: We report a single diagnosed and treated case of BN in a blind, 47-year-old Spanish woman. This case presented as its main characteristics the late onset of the ED, restrictive dieting, bingeing, and consequent purging behavior characterized by vomiting and great difficulties of coping with stress. From the beginning, the woman's body image was not essential. The treatment consisted of 21 individual outpatient sessions, which followed a non-symptom-oriented cognitive-behavioral approach, in which prob-

lem solving and stress management strategies were employed.

Results: Before, after the treatment, and at the 6-month and 1-year follow-up, the clinical evolution of the patient was assessed.

Conclusion: Although a few descriptions of single case reports on blindness in individuals with anorexia nervosa (AN) have already been reported in the literature, to the authors' knowledge, this is the first reported case in which this condition and its treatment have specifically been reported in an individual with BN. © 2006 by Wiley Periodicals, Inc.

Keywords: bulimia nervosa; blindness; eating disorder; body image; case report

(*Int J Eat Disord* 2006; 39:263–265)

Introduction

Over the last few decades, many authors have postulated the essential role of body image in the etiology of eating disorders (ED). However, other authors have questioned the etiopathologic value of this concept¹ because they believe that other triggering factors are involved in the development of ED, in particular in bulimia nervosa (BN).^{2–4}

In blind individuals, specific problems and disorders, such as behavioral and emotional problems,^{5,6} sleep-wake disorders,⁷ suicide, and depression,^{8,9} have frequently been described. Most of these reports have focused on children and adolescent populations. The few studies that assessed the mental status of blind adult participants described

patients as being characterized by low self-esteem, symptoms of depression, and poor strategies of coping with stress.¹⁰ When congenitally blind women were compared with women blinded later in life, the former showed less body dissatisfaction,¹¹ which indicates that the ability to visualize oneself and others is integrally linked to a person's body dissatisfaction and, consequently, may promote disordered eating attitudes.

In the literature, several cases of blindness have already been reported before the onset of anorexia nervosa (AN).^{12–15} The main hypothesis of these case reports was that body image preoccupations were not essential for the development of AN. To the authors' knowledge, this is the first reported case of BN and its treatment (cognitive-behavioral oriented) in a blind participant.

Case Report

The Ethics Committee of the University Hospital of Bellvitge (Barcelona, Spain) approved this study and informed consent was obtained from the patient. According to criteria in the 4th ed. of the Diagnostic and Statistical Manual of Mental Disor-

Accepted 29 March 2005

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Published online 23 February 2006 in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/eat.20259

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ders (DSM-IV; Washington, DC: American Psychiatric Association; 1994), a blind, 47-year-old woman developed the complete clinical picture of BN (purging subtype). Since the age of 43 years (onset of the ED), the patient described the presence of two to four weekly bingeing and vomiting episodes, which were frequently triggered by psychosocial stressors. The patient did not show any impulsive behavior, alcohol use, or drug abuse. She was overweight (90 kg, 1.57 m, body mass index [BMI] = 36.6) and wished to be thinner (ideal BMI = 28.4), not because of shape concerns, but because of physical reasons. In addition, due to psychosocial stressors, anxious and depressive symptoms were constantly present. During the last 4 years, the patient had gained >30 kg. Before this weight gain, the patient had exhibited a lower weight (BMI = 25.6) and revealed that during the time when she was thinner, she neither exhibited any body image concerns nor wanted to lose weight.

From a behavioral point of view, the patient presented with low self-esteem and deficits in social and problem-solving skills, which were the result of the interpersonal conflicts she had with her family, especially with her children. These variables appear to have contributed to the patient's vulnerability to escape (after a negative reinforcing scheme) from problems by means of bingeing and vomiting, which are considered to be inappropriate coping strategies. According to the DSM-IV criteria, the patient presented the following Axis I diagnoses: BN and dysthymia.

Physical Examination

The patient became blind during her infancy due to a congenital illness of unknown etiology (possibly infectious). She did not present other medical antecedents of interest except allergic asthma to treatment with bronchodilators. Furthermore, the patient exhibited 2–3 daily semiliquid excretions for >3 years, which changed according to emotional factors. The physical exploration and the anamnesis with specific devices did not show any relevant findings. The biochemical profile, including hepatic function, renal function, and the concentration of ions, ferritin, iron, and vitamin B 12, proved to be within normal parameters of functioning. There were no alterations in the blood cell count, level of thyroid hormones, examinations of coagulation, gastrointestinal transit, endoscopy, and abdominal ultrasound scan. The lactose test result was negative. By means of coprocultive methods, no pathogenic agents, which could have explained the symptoms, could be detected. Celiac illness was excluded by means of the determination

of Ac Ig Antiendomiso (IFI technique with monkey esophagus), Ac Ig A antigliadin (enzyme-linked immunosorbent assay [ELISA] technique), Ac Ig A antitransglutaminasa (ELISA technique), and normal values in the serum levels of IgA. The medical diagnostic orientation was an irritable colon, and other possible gastrointestinal pathologies such as the malabsorption syndrome, which could have explained the symptoms.

Personal Antecedents

The patient was the younger of two children (both girls). No parental mental disorders were detected. She had been married for 9 years to her husband and had 2 children (a woman of 25 years and a man of 18 years) from a previous marriage.

Treatment

Twenty-one weekly outpatient cognitive-behavioral sessions plus 4 follow-up sessions (at 1, 3, 6, and 12 months) were conducted. The main goals of the therapy were to increase her motivation, complete a behavioral analysis, and teach behavioral techniques such as coping with stress and solving problems (in spite of escaping from them by bingeing). Due to the patient's symptoms, we decided to conduct non-symptom-oriented cognitive-behavioral therapy (CBT). More than paying attention to the eating symptoms, the therapy was basically centered in the behavioral and emotional background deficits of the patient. Therefore, the following techniques were used: motivational interviewing, awareness of the "bingeing-escaping from problems" vicious circle, coping with negative emotions, social and problem-solving skills, and couple or family counselling. A dramatic reduction in eating symptoms was observed after the maintaining or triggering factors (individual deficits and interpersonal reactions of the family members) had been reduced. During treatment, the rate of binge eating and the consequent vomit episodes started to decline after the 4th session, whereas abstinence of bingeing and vomiting occurred after the 11th session. At 6 and 12 months of follow-up, the patient was still abstinent from ED symptoms.

Conclusion

In the current case, the ED seems to be a consequence of inappropriate coping skills with stress. Indeed, patients who present some behavioral handicaps or deficits are more vulnerable to the development of an ED.^{5,9} As reported in the literature, in many of those cases, the ED is not due to

an overemphasis on physical attractiveness, but to a personal difficulty to cope with stress.¹⁶ In the current case, the onset of the patient's ED was not associated with her body shape dissatisfaction, but with her inadequate coping skills.² The therapy we employed (non-symptom-oriented CBT) demonstrated that flexible ED treatment programs, which try to adapt to the different facets of the patient's ED symptoms, are able to yield favorable results.

This is the first report to describe the clinical picture and therapy of a blind woman with BN.

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