This case involves M.R., a 15-year-old male high school sophomore referred for psychiatric evaluation by the school counselor due to recurrent binge-eating behaviors, self-induced vomiting, and declining academic performance. Over the past year, M.R. reports episodes of consuming large quantities of food in a short period of time, primarily in the evenings, followed by intense feelings of guilt and loss of control. To compensate, he engages in self-induced vomiting several times per week and has experimented with laxative use. Although his weight remains within a normal range for his age and height, he demonstrates significant distress related to body shape and weight and frequently compares himself to peers on social media. These behaviors meet DSM-5 criteria for bulimia nervosa, including recurrent binge eating with compensatory behaviors occurring at least once weekly and excessive influence of body image on self-evaluation (American Psychiatric Association, 2022).

From a medical perspective, M.R. reports sore throats, dental sensitivity, and intermittent dizziness, raising concern for complications associated with purging behaviors. He has no chronic medical conditions but required emergency department treatment once for dehydration. Academically, M.R. was previously a strong student; however, his grades have declined over the past semester, and teachers report reduced classroom engagement and frequent bathroom use. Family history is notable for parental separation within the past two years and ongoing household stress. His mother reports difficulty monitoring eating behaviors due to work demands, while his father has limited involvement. There is a family history of anxiety and depressive disorders, though no documented eating disorders.

Based on this presentation, **cognitive behavioral therapy (CBT)** is recommended as the primary psychotherapeutic intervention, with **fluoxetine** considered as a pharmacologic adjunct. CBT is a first-line, evidence-based treatment for bulimia nervosa and focuses on identifying and restructuring maladaptive thoughts related to food, weight, and body image, while also targeting binge–purge behaviors and improving emotional regulation. In addition to psychotherapy, fluoxetine is the most well-studied selective serotonin reuptake inhibitor for bulimia nervosa and has been shown to reduce binge eating and purging behaviors independent of its antidepressant effects. Although fluoxetine is FDA-approved for bulimia nervosa in adults, current clinical guidelines and recent literature support its off-label use in adolescents with moderate to severe symptoms or comorbid mood and anxiety disorders. Medication initiation should include careful monitoring for side effects, adherence, and suicidality given the adolescent population (Golden et al., 2021).

Two referrals are indicated for this client. First, referral to a pediatric primary care provider or adolescent medicine specialist is necessary for ongoing medical monitoring, including assessment of weight trends, vital signs, electrolyte levels, and potential cardiac or gastrointestinal complications related to purging behaviors. This referral is essential even when weight is within normal limits, as bulimia nervosa carries significant medical risk regardless of BMI. Second, referral to a dental provider is recommended due to reported dental sensitivity and the increased risk of enamel erosion and oral complications associated with recurrent vomiting.

An important ethical consideration in this case involves balancing adolescent confidentiality with caregiver involvement. Adolescents with bulimia nervosa often experience shame and may resist parental involvement; however, ongoing purging behaviors pose medical risks that may necessitate caregiver notification. Clinicians must clearly communicate the limits of confidentiality early in treatment and involve caregivers in a manner that prioritizes safety while maintaining therapeutic trust. Ethical practice requires careful judgment to protect the