Overcoming Common Problems

Bulimia, Binge-eating and their Treatment

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We would like to thank our patients who have taught us everything. They and their families have allowed us to enquire into often painful issues and periods of their lives that they might otherwise have wished to forget. From this generous information the treatment described here has been developed.

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Note to the reader

This is not a medical book and is not intended to replace advice from your doctor. Consult your pharmacist or doctor if you believe you have any of the symptoms described, and if you think you might need medical help.

Preface and acknowledgements

Preface

Just over 30 years ago, a 'new' illness was described in the UK. It was debilitating and it severely affected the lives of young people, particularly women. It was called bulimia nervosa, and soon descriptions of it were reported in the medical and lay press throughout North America and Europe.

Bulimia nervosa sufferers have low self-esteem and feel that control, especially over food, has been removed from them. They are depressed and often angry. Their relationships with both men and women are affected. There are physical complications too, some of which are dangerous. Yet bulimia often remains, to the individual, a secret disorder. Most people who binge-eat do not tell friends or family; they are alone with their disorder. This book, then, is for them: to give them knowledge and to instil hope. Through this book, people with bulimia can understand more about their feelings and behaviours and how they can effect change. In essence, the book shows how they can help themselves.

The approach described in this book is effective, but if you are unable to benefit, you must seek other help. Your GP should always be approached first because she or he will know of local treatment centres. Never forget that bulimia and binge-eating are treatable.

I am grateful for the significant contribution to this book made by Dr Bamford and Ms Brown, who undertook the majority of the writing.

Professor J. Hubert Lacey, London

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Part 1
BULIMIA AND BINGE-EATING

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Introducing bulimia and binge-eating

Eating disorders are increasingly talked-about but still relatively misunderstood disorders. And, even though anorexia nervosa and bulimia nervosa are now quite well known, they are surprisingly less prevalent than a relatively unknown eating disorder known by the acronym EDNOS, or eating disorder not otherwise specified.

These three, in addition to a fourth, binge-eating disorder, which is binge-eating in obesity, are all allied conditions. However, the relationships between them and the diagnostic differences are, to some extent, still unclear. The aim of this book is to bring some clarity to these related disorders, to educate the reader about the factors that cause and maintain binge-eating, a behavioural aspect of each of the named disorders, and to take the reader through a specialized 'treatment programme' designed to help individuals who binge-eat but want to stop.

What is binge-eating?

Binge-eating is eating a large amount of food in a brief period of time. Attempting to define 'large' and 'brief' leads everyone into a mess! They are best left undefined; after all, most people binge, particularly at certain times of year such as Christmas or holidays. In these instances, however, it certainly does not represent an illness. Really it is the frequency and persistence, coupled with distress, that stamps binge-eating as an illness. Eating must be paired with an extreme loss of control for it to be accurately termed a 'binge' – this is what differentiates it from simply overeating. Put simply, you will know when it represents an illness. Equally distressing is when binge-eating is associated with other behaviours such as self-induced vomiting, or taking laxatives as a means of compensating

for the food eaten during binge-eating. This book will also deal with many of these associated behaviours.

What happens during a binge?

Binge-eating, when it is an illness, is a solitary pursuit. The person frequently buys special binge foods. These are easy to eat, requiring little preparation or cooking, and are usually, although not always, high in fats and sugars. Very large amounts of food can be eaten. We have known people eat up to 30,000 kilocalories a day, nearly 15 times the calories needed to maintain normal metabolism. More usually, however, a person will eat two or three times his or her normal dietary intake and often only on certain days of the week.

Bingeing is usually done in private, if not in secrecy. It is, to the person with the condition, the most humiliating behaviour. Frequently no one else will know about it, or if it is suspected it will be vigorously denied. In addition, food is rarely eaten in a socially acceptable way during a binge and occasionally rather bizarre behaviours take place, such as spitting out some of the food, eating extremely quickly or smearing food over the body or elsewhere.

Bingeing usually starts off as an exercise that is enjoyable, guilt-free and often exciting or thrilling. The person may look forward to and plan for his or her binges. Sadly, however, it rarely stays this way. Following a binge, people may view their actions as disgusting, humiliating and degrading. Guilt-ridden, they may engage in further behaviours, such as vomiting or using laxatives in an attempt to neutralize these distressing emotions. These actions, often termed 'compensatory behaviours', are undertaken in an attempt to get rid of the excess and feared calories consumed during the binge. However, it is these behaviours that lead to the even more intense shame, distress and humiliation described by those who binge and purge. It is devastating behaviour which can have a profound effect on the person's ability to conduct his or her working and social life. At its very worst, it becomes all-preoccupying, both a loved and intensely feared behaviour.

Binges are often divided into 'objective binges' and 'subjective binges'. 'Objective binges' refers to the definition of a binge given above, i.e. eating an unusually large amount of food for the situation

you are in, such as a whole family pack of crisps, a whole loaf of bread or a whole pack of biscuits. A 'subjective binge' refers to eating a small or normal amount of food, usually more than you want to eat but not unusual for the circumstances. Both, however, are accompanied by a sense of loss of control, which is what characterizes them as binges.

Diagnosis

The diagnosis of bulimic disorders, whether they occur at normal weight (as in bulimia nervosa), in obesity (as in binge-eating disorder) or at low weight (as in the bulimic form of anorexia nervosa), is confused and contentious. We will try and bring some light to the matter. The treatment section of this book is aimed at those who binge at a normal weight. While we do not consider the treatment programme here to be suitable for those at a low weight, we will none the less describe anorexia nervosa here in order to put the different eating disorder diagnoses into context for the reader.

Anorexia nervosa

Anorexia nervosa is the least common but most severe eating disorder. To be diagnosed with anorexia you have to be at a very low weight (below a body mass index, or BMI, of 17.5; for more on BMI, see pages 86–7). It has a high morbidity, meaning it gives rise to much physical illness. It also has the highest mortality of any disorder in psychiatry and is even more dangerous than alcoholism or drug addiction. It is estimated that between ten and 20 per cent of people with the condition die prematurely, either by suicide or starvation. Anorexia has occurred throughout history, but it only received its name in 1873. Unfortunately it is a rather bad name! Anorexia means lack of appetite, which is particularly inappropriate as most anorectics are ravenous. It occurs in approximately 0.7 per cent of girls and women aged between 16 and 40 years.

Anorexia is essentially a phobia of being a 'normal weight', meaning that the person drives herself to gross emaciation. It is rare for someone with anorexia to ever reach a weight that she is able to feel happy with, however emaciated she becomes. Even at life-threateningly low weight, people with anorexia will still feel

themselves to be and describe themselves as 'fat'. The weight loss in anorexia can be due to dietary restriction, overactivity or self-induced vomiting. It may also follow laxative or diuretic abuse. This weight loss, which commonly starts off as dieting, results in someone who is physically, emotionally and socially impaired, far different from how she was before the disorder took hold.

Anorexia usually occurs in adolescence. It usually begins shortly after puberty. By early adulthood, if untreated, it can become chronic and enduring, and increasing difficult to treat. Treatment for anorexia at any stage is difficult, and for some people the condition will be life-long.

Anorexia, like all the eating disorders, is much more common in women and girls than men or boys. This is probably for biological as well as emotional and social reasons. We look at this later (see pages 10–11). It is sometimes claimed that about ten per cent of anorectic sufferers are male. This is almost certainly an overestimation as the data comes from research centres where it's more likely that an 'unusual' boy would be treated than a 'routine' girl. It is probably the case, however, that the prevalence of anorexia in men is increasing as a reflection of an increased preoccupation with appearance by men or emphasis on sporting achievement.

It used to be that almost all people with anorexia nervosa restricted or 'dieted' to lose weight. Now the majority purge, with or without binge-eating. Indeed, since anorexia in its pure form is so difficult to maintain, the vast majority of people will end up binge-eating, with purging being a resulting, compensatory, strategy. It is in this instance that the illness can be commonly confused with bulimia nervosa.

This book, however, is not directed towards those who have a 'binge–purge' form of anorexia, i.e. those who are bingeing at a low weight. This book is rather aimed at those who experience binge-eating at a normal or higher weight. Binge-eating in this context is discussed next.

Bulimia nervosa

Bulimia nervosa occurs at normal body weight. The person may be very unhappy with his or her body and want to lose weight, but this tends to be less intense than the driven emaciation of anorexia. Although weight is within a normal range, it does fluctuate

in response to the assaults of binge-eating. This fluctuation can be quite marked, often between 5 and 8 kg.

Unlike anorexia nervosa, bulimia normally starts in early adulthood or late adolescence. The average age of onset of binge-eating is 17 to 18 years and on average self-induced vomiting begins about three years after the binge-eating. Most people with bulimia wait up to five years before seeking help. This pattern is quite different from anorexia, where the illness is clear from an early age. Sometimes, however, the picture is confused because normal-weight people with bulimia may have experienced a brief episode of weight loss in mid-teenage years. This is referred to as 'cryptic anorexia'. It rarely lasts more than a few months, but seems to prepare the scene for the future presentation of bulimia nervosa itself.

In their extreme forms, the psychological feelings that exist in bulimia nervosa are quite different from those in anorexia. In bulimia there is not always a driving or preoccupying fear of normal weight. Undoubtedly the person would like to weigh less, but the thought of being emaciated, with skeletal appearance, is usually as undesirable to the bulimic as it is to a normal person. Clearly, though, people with bulimia are not without distressed feelings. Individuals with bulimia will place a huge amount of importance on their weight and shape, and generally will experience an overwhelming desire to be slimmer or to rigidly control their weight. A common concern is the sense of being out of control and the fear of losing control of their weight. Because of the extreme importance that is placed by the person on shape and weight, contemplating losing control over his or her weight is a terrifying experience. Usually this fear of losing control, paired with occasional loss of control, is restricted to eating and food. Sometimes, however, it may extend to other aspects of the person's life. For example, sometimes he or she may feel out of control when drinking alcohol or using other social drugs. It can also lead to overspending or to unwanted sexual experiences. This is known as multi-impulsive bulimia and is a severe variant.

EDNOS

EDNOS, or eating disorder not otherwise specified, is a 'rag-bag diagnosis', and it's estimated that up to ten per cent of adult women are affected. The term is used when a person does not have

all the features of anorexia or bulimia – for instance, someone with anorexia who menstruates regularly, or someone who repeatedly vomits at normal weight but does not binge-eat. Owing to the complexities of diagnosis, around three-quarters of individuals with diagnosed eating disorders will fall into this category.

Binge-eating disorder

Binge-eating disorder is the presence of binge-eating without the resultant compensatory behaviours (i.e. vomiting, laxative abuse, extreme dieting or exercise). This tends to be seen in more overweight or obese people but is different from merely being overweight. The binge-eating again involves the consumption of excessive amounts of food in a short period of time during which the individual experiences a sense of loss of control, to the extent that he or she would not be able to stop eating if interrupted by the phone or doorbell. This is as much an eating disorder as anorexia or bulimia nervosa, but is less commonly recognized.

The differences between anorexia and bulimia

Although both bulimia and anorexia may include recurrent binge-eating, there are differences. Apart from the obvious ones of anorexia being at low weight while bulimia is at a normal or higher weight, in anorexia there is in addition an intense fear of normal weight; in bulimia, although the person's self-evaluation is unduly influenced by weight and shape, which may cause significant distress, fear of weight tends to lack a phobic intensity. In both, the person may be sad or depressed. However, in bulimia, the person tends to be impulsive and to swing between being overcontrolled and abandoning control, whereas in anorexia the person tends to be rigid, often perfectionist and withdrawn. In both, the eating disorder can lead to significant social difficulties. Research also suggests that whereas the anorectic develops her illness in early adolescence, individuals tend to develop bulimic behaviours somewhat later. These behaviours may vary during an individual's illness. If, however, they have the core feelings of anorexia – a phobia of normal weight – these will remain, irrespective of weight.

Because of the obvious low weight in anorexia, people often recognize that the individual has an eating disorder, whereas

bulimia can be hidden much more easily. Some people – even those suffering from bulimia themselves – believe that you can't have an eating disorder if you are at a normal weight, but this is *not* true.

Physical consequences

Binge-eating and vomiting can give rise to a number of physical problems. Indeed, the physical risks associated with binge-eating and the impact on the body can be very serious and should not be underestimated. The majority of the risks associated with bulimia are non-visible, for example the impact on the heart, gastrointestinal system, fertility, brain and kidneys. Some of the consequences, however, are visible. Perhaps the most distressing can be the swelling of the salivary glands in the neck, which some people describe as making them look rather like a hamster. In addition, repeated vomiting can cause a rebound water retention which may cause the legs and thighs to 'swell'. Many people feel that they look bloated, or even fat, as a result of these physical changes. Repeated vomiting is likely to lead to erosion of the teeth, with discoloration and loss of fillings being a common, distressing and expensive consequence of this behaviour. Finally, bingeing can also have an impact on mood, concentration and social life, which can understandably be very distressing for the person and contribute to a reduced quality of life. All of these consequences will be discussed in more detail later in the book.

What causes binge-eating?

There are as many causes of eating disorders as there are people with disordered eating. For each individual, the origin of an eating disorder is a unique blend of underlying and precipitating factors which prompt the urgent need to abuse food. Many of these factors are discussed in detail in the following chapters. The point to make here is that there are many risk factors, which in any one person provide only a partial explanation. For a small minority there is adverse parenting, and sexual abuse may be implicated in an even smaller number. Much more common is the impact of being brought up in a family where there is much interest in dieting, fashion and shape. Often

mentioned by people are critical comments during their teenage years about their shape and weight, while others claim societal pressure to be slim. Other eating disorders in the family, depression or misuse of drugs or alcohol can all provide the background in which binge-eating and bulimia may flourish. All eating disorders are generally linked to a low self-esteem and low mood. Really, though, there is not one factor which marks out the future binge-eater.

Who develops binge-eating?

Certainly anyone can develop binge-eating. It is not restricted to gender, class or culture. It is the case, though, that these disorders tend to be seen more prevalently in women, tend to start in adolescence or early adulthood, and tend to affect those living in Western or modern societies to a greater extent. This is not to say that people outside these categories do not develop binge-eating disorders but, rather, there exists a greater vulnerability or pressure in young Western females. We will discuss why this might be next.

Throughout history, the fashionable body weight has changed significantly. The hourglass figures depicted in paintings from the seventeenth century and displayed by Hollywood actresses until the 1950s are quite different from the ultra-slender and often emaciated figures displayed in the media today. Females, indeed, are 'fattier' than males and this is seen across a number of different species, not just the human form. In humans, however, 'shape' forms the basis of sexual attraction, a difference from any other species, where attraction is more commonly based on smell or colour. The underlying issues of weight and shape are therefore rooted in core aspects of femininity and human sexuality.

Interestingly, there is no evidence to support the notion that any particular body shape or size is more appealing to men than any other. Furthermore, there is no evidence that men are drawn to women who are very slim. Indeed, there is no evidence that men are drawn to any particular shape or weight in their partners. There is, however, evidence that it is women who prefer women to be slim.

The exact influence of the media in disorders of weight and shape is still debated; however, it is clear that there exists a strong message

that women should be appealing on the outside to be valued by others, i.e. that the way they look is central to happiness and success.

In adolescence there exists a vulnerability to confusion, low self-esteem and emotional insecurity. This is a vulnerability that perhaps does not exist in less developed countries where, when young girls become wives or mothers much earlier, there is little gap between childhood and adulthood. It would be unsurprising that those who are unsure and vulnerable develop behaviours which give transient support in the face of an uncertain world. Binge-eating in women can perhaps be mirrored by alcohol misuse in men.

In Western societies, where the role of women has changed dramatically with economic advancement, social and cultural pressures on women have contributed to a backdrop of unsure-ness and low self-esteem in some. More vulnerable women, seeking to enhance their self-esteem and aware that initial social attractiveness is based on appearance, may try to control or restrict their figures to stay 'youthful' or 'more attractive'. This restriction in eating, however, done in order to reduce weight, is the very thing that causes binge-eating, a link that will be explored further in subsequent chapters.

Summary

- A binge is defined as eating a large amount of food combined with an extreme sense of loss of control.
- Bulimia is the presence of binge-eating paired with any number of compensatory behaviours (vomiting, laxative use, excessive exercise and dieting, diuretics) used as a way of influencing shape and weight. People with bulimia tend to base their self-esteem and self-worth on their satisfaction with their shape and weight.
- Bulimia occurs at a normal weight or higher; at lower weights, bingeing occurs within an anorectic pathology.
- While bingeing tends to be more common in Western female adolescents, anyone can develop bingeing disorders for any number of reasons.
- Bingeing in any form is a distressing, guilt-ridden and shameful experience which affected people generally feel unable to tolerate or to stop.

2

Causes and consequences

Risk factors

As discussed in the previous chapter, there are many reasons why people develop a problem with binge-eating. The origin of an eating disorder is complex and unique to each individual, but we are aware of a number of factors which increase the chance of developing a problem with binge-eating, and we term these 'risk factors'. Risk factors include all experiences that put people at risk of abusing food. People often mention, for example:

- having been criticized in the past about their body or eating habits;
- having a problematic or invalidating relationship with their parents or significant others early in their lives;
- involvement in certain sports or leisure activities (such as gymnastics or ballet) which place demands on young women to be a certain weight or size.

In addition to these risk factors, other factors can also play a part in someone developing an unhealthy relationship with food: for example,

- a family history of eating disorders
- depression
- substance misuse
- obesity
- chronic dieting.

Individual characteristics too can be possible risk factors for developing an eating disorder, including:

- low self-esteem
- perfectionism

- anxiety problems
- previous obesity.

Maintaining factors

Once a problem with bingeing has begun, an individual may feel caught in a destructive pattern he or she will never be able to break. There are a number of factors which can keep this vicious cycle going, and we call these 'maintaining factors'.

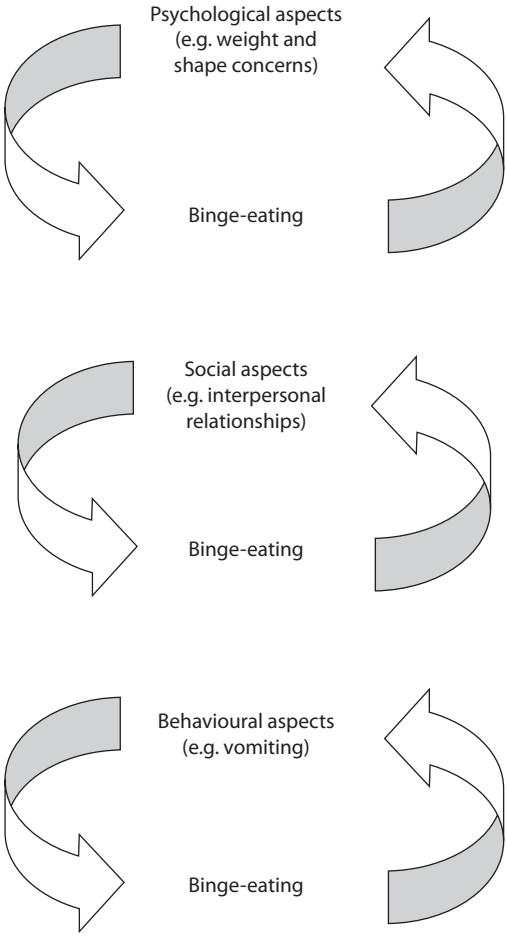

Figure 1 Maintaining factors in binge-eating

for the food eaten during binge-eating. This book will also deal with many of these associated behaviours.

What happens during a binge?

Binge-eating, when it is an illness, is a solitary pursuit. The person frequently buys special binge foods. These are easy to eat, requiring little preparation or cooking, and are usually, although not always, high in fats and sugars. Very large amounts of food can be eaten. We have known people eat up to 30,000 kilocalories a day, nearly 15 times the calories needed to maintain normal metabolism. More usually, however, a person will eat two or three times his or her normal dietary intake and often only on certain days of the week.

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