1989

Characteristics and treatment of bulimia

Cindy Becker

Characteristics and treatment of bulimia

Abstract

Bulimia Nervosa is an eating disorder characterized by the episodic ingestion of large quantities of food in a relatively short period of time and, in most cases, these •binges• are followed by self-induced vomiting, laxative abuse or fasting (Ordman & Kirschenbaum, 1986). The vast majority of bulimic cases are women (only 10% are male) and it is estimated that as much as 20% of high school and collegiate-aged females are actively engaged in bulimic behaviors on a regular basis (Hale & Ware, 1984). More specifically, these behaviors include various aspects of the following according to the Diagnostic and Statistical Manual of Mental Disorders (third edition): 1) consumption of high-caloric, easily ingested food during a binge, 2) inconspicuous eating during a binge, 3) termination of binge eating by abdominal pain, sleep, social interruption or self-induced vomiting, 4) repeated attempts to lose weight through dieting, self-induced vomiting or use of laxatives or diuretics, and 5) frequent weight fluxuations due to alternating binges and fasts. These behaviors are often accompanied by an awareness that the eating pattern is abnormal, fear of not being able to stop voluntarily and self-deprecating thoughts after eating binges (American Psychiatric Association, 1980).

CHARACTERISTICS AND TREATMENT OF BULIMIA

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

---

by

Cindy Becker

December 1989

This research paper by: Cindy Becker

Entitled: CHARACTERISTICS AND TREATMENT OF BULIMIA

has been approved as meeting the research paper requirement for the Degree of Master of Arts.

18 October 1989
Date Approved

Robert L. Frank
Adviser

18 October 1989
Date Approved

Robert T. Lembke
Second Reader of Research Paper

18 October 1989
Date Received

Dale R. Jackson
Head, Department of Educational Administration and Counseling

Bulimia Nervosa is an eating disorder characterized by the episodic ingestion of large quantities of food in a relatively short period of time and, in most cases, these "binges" are followed by self-induced vomiting, laxative abuse or fasting (Ordman & Kirschenbaum, 1986). The vast majority of bulimic cases are women (only 10% are male) and it is estimated that as much as 20% of high school and collegiate-aged females are actively engaged in bulimic behaviors on a regular basis (Hale & Ware, 1984). More specifically, these behaviors include various aspects of the following according to the Diagnostic and Statistical Manual of Mental Disorders (third edition): 1) consumption of high-caloric, easily ingested food during a binge, 2) inconspicuous eating during a binge, 3) termination of binge eating by abdominal pain, sleep, social interruption or self-induced vomiting, 4) repeated attempts to lose weight through dieting, self-induced vomiting or use of laxatives or diuretics, and 5) frequent weight fluxuations due to alternating binges and fasts. These behaviors are often accompanied by an awareness that the eating pattern is abnormal, fear of not being able to stop voluntarily and self-deprecating thoughts after eating binges (American Psychiatric Association, 1980).

This disorder is extremely complex, therefore, to pinpoint one specific cause for its development is impossible. People are influenced by a multitude of biological, familial and sociocultural factors and all must be present in order to predispose someone toward bulimic behavior. If one wishes to understand why so many women resort to this disorder, each factor must be looked at separately and in detail.

Individual Factors

Upon observation, it may be hard to distinguish someone who has bulimia. Physical appearance alone will not provide any clues since most of these women are average weight or even overweight. Typically, however, they are physically attractive and feminine in their dress and manner. They also appear to be calm, poised, well-mannered and modest about their achievements. In contrast to the calm, poised exteriors, many bulimics have opposing views about themselves. They often report feelings of helplessness, low self-esteem, maturity fears, tension management problems and difficulty in identifying or articulating their internal states (Johnson & Flach, 1985).

Many bulimics, indeed, most women in general, view their bodies in a negative fashion. To these women, the body is not an intricate, technical marvel of science. The fact is that these women view the female body as an "ugly lump of

cellulite." On a grander scale, the dreaded feminine curves are actually symbolic of every undesirable quality or shortcoming women hate within themselves. Feelings of ineffectiveness, indecisiveness and helplessness are uncomfortable and hard to face as part of everyday existence. Bulimics choose to refocus their attention on concrete physical characteristics in hopes of escaping their psychic pain and thus food and weight come to be used as a defense mechanism. Since facing personal problems is too threatening, they play it safe by using thinness as a method to obtain competency, control and contentment.

Upon closer analysis, an interesting paradox is created once a woman decides to use bulimia as a coping mechanism. On the one hand, the bulimic wishes to be thin. In order to do this, she must restrict her food intake. On the other hand, she also views food as a substitute for internal coping resources and social support (Humphrey, 1986). Food is a source of comfort. After an extended period of time, however, the bulimic experiences an emotional tug-of-war. Food preoccupation, fatigue and mood swings increase her desire to indulge in the very activity she is trying the most to avoid eating. As a result, food becomes both a best friend and a worst enemy. The bulimic wants to eat, but fears that if she does she will become fat.

Of course there is a compromise to this love-hate relationship. As discussed earlier, one of the distinguishing features of bulimic is purging behavior. Vomiting, laxative/diuretic abuse and compulsive overexercise are ways in which bulimics can "have their cake and eat it too." Not only can they eat all the forbidden food they crave, but they can also get rid of the food in order to relieve "bad" feelings and reclaim a sense of control. All the embarrassed, guilty, angry feelings subside temporarily.

This behavior is extremely stressful on the body. Prolonged periods of purging can have severe medical consequences and in some cases, it can even lead to death. The most critical problem is that purging creates a low electrolyte balance of body chemicals. This balance is necessary to maintain heart, kidney and gastrointestinal functioning. Without this balance, muscle spasms, kidney disease, gastrointestinal disorders and cardiac arrest result (Neuman & Halverson, 1983). Other effects specific to vomiting include swollen glands, destruction of tooth enamel, gastric dilation and irregular menstrual cycles (Cauwells, 1983). Similarly, laxative and diuretic use can damage kidney and bowel functioning if abused.

As horrifying as these complications seem, the bulimic deems purging as a necessary evil in the fight against fat.

She may want to stop, but the fear of weight gain compels her to continue her purging behavior. The fear of becoming fat actually exceeds the fear of dying.

Social Factors

There has been a dramatic increase in the reported incidence of bulimia and its sister disorder, anorexia nervosa, over the last 20 years (Shisslak, Crago, & Swain, 1987, Johnson, Conners & Tobin, 1987; Mitchell & Eckert, 1987). More and more women have actively and willingly embraced the dangerous physical risks such as those mentioned above in order to achieve beauty, success and control. This is not due solely to personal factors, however. Social factors also play a part in this trend.

The foremost social factor for influencing bulimic behavior is the concept of sex role expectations. At the very early age, girls are taught that poise and a well-groomed appearance are important possessions. A specific body shape is more than a mere standard for physical attractiveness. It is a gauge where by all women measure their femininity and self-worth. If a woman does not strive to realize her full potential for beauty, society deems her as a failure both as a woman and as a human being (Lakoff & Scherr, 1984). Girls are fully aware of this. As a matter of fact, elementary school girls have been shown to perceive obesity as being

worse than being handicapped or disabled (National Association of Anorexia Nervosa and Associated Disorders, 1989).

Closely connected to this concept of female sex role expectations is the changing societal standards for feminine attractiveness. As an illustration of this, David Garner recently conducted a study of Playboy center-folds and Miss America contestants. The results were quite interesting: over the past 20 years, both groups have steadily become thinner than the other contestants (Squire, 1983). This trend is especially intriguing when it is also pointed out that the average American woman under 30 has increased in weight by five or six pounds over this same 20 year time period. As the ideal for perfection becomes increasingly unrealistic and unattainable, the numbers of women who literally die trying to obtain this goal increase dramatically.

The third and final factor most often associated with the rise in bulimia is the influence of the media. Examples of this are endless. There are scores of books on the best seller list such as "The Scarsdale Medical Diet" by Dr. Herman Tarnowas and "The Superenergy Diet" by Dr. Robert Atkins which are specifically geared toward weight reduction. Magazines are filled with glossy pictures of anorectic-looking girls in glamorous poses. Television portrays beautiful people with exciting careers and all the success, happiness and

romance they could ever want. These sources promote the myth that to be thin is to have the perfect life. In response to this, the American public embraces this fallacy with tremendous zeal. The diet, cosmetic and fashion industries rake in billions of dollars every year due to slick advertising campaigns which play upon consumer insecurities (Lakoff & Scherr, 1984). Since the public at large desperately wants to change "those little imperfections," they readily buy into a product's false promises.

Family Factors

As the incidence of bulimia has increased in recent years, so too has the professional interest in research on the topic. Currently, investigators have concentrated much effort on the family constellations of bulimics in hopes of shedding more light on this unusual disorder (Root, Fallon, & Friedrich, 1986). Minuchin, Bruch and Pajazzoli are all examples of therapists who contend that certain key dynamics take place within the family environment and these serve as contributing factors toward bulimic behavior. This is not viewed as a strict cause and effect relationship, however. As mentioned earlier, eating disorders are complex in etiology. All biological, familial and sociocultural factors work together in order to influence a woman's life, therefore, no one factor can be said to "cause" bulimia.

Family variables are particularly important because it is the family that gives a woman the morals, values and social skills she needs to function in society. It is also significant because the family plays a major role in the bulimic's life long after she has left home. She tends to remain deeply enmeshed in familial conflict and dysfunction because she has never been allowed to disengage from the unit on an emotional level.

Upon first glance, bulimics seem to come from well-functioning homes. Nevertheless, they find after further scrutiny that little attention is being paid to the bulimic's emotional needs and wants. Typically, these women have mothers who are manipulative, domineering and suffocating and fathers who are emotionally distant, rigid and preoccupied with self-discipline (Sights & Richards, 1984). In this kind of a family, the daughter is unable to find her own identity because the dependent mother refuses to let go of her "little girl" and the disengaged father is unavailable to support his daughter in her separation attempts.

In addition to these characteristics, there are other commonalities which seem to be present in most families of bulimics. For instance, these families report a high degree of tension and conflict yet any disagreement is strongly discouraged. This is commonly referred to as "conflict

avoidance" (Stern et al., 1989). Similarly, feelings such as anger, sadness and fear are never expressed openly. Both of these characteristics seem to serve an important function: to neutralize any perceived threat to the existing family peace. Unconsciously, family members expend a great deal of effort to maintain this calm, if unhealthy, equilibrium because any disruption of this delicate balance would result in chaos and change. Even if the unit is profoundly dysfunctional, they will cling to their problems because they find a certain degree of comfort in the familiar. If the family risks change, they have no guarantee of what will happen. This sense of the unknown is very frightening.

In direct contrast to this high degree of emotional rigidity is a very low degree of cohesiveness (Moos & Moos, 1981). This means there is little evidence of mutual support and concern among family members. As a matter of fact, many bulimics state they feel distant from their parents because as they strive for independence, their parents respond with some form of emotional abandonment or rejection.

Poor organization is yet another common characteristic and is closely associated with conflict avoidance and incohesiveness (Garner & Garfinkel, 1985). Generally speaking, organization is the unit's way of maintaining itself. Everyone is delegated a function within the family so it can function

smoothly. In the bulimic's family, however, everyone is confused by unclear rules and responsibilities. Family members do not know what to do to keep the unit functioning. As an example, parents can be excessively dependent on their children for their own security and self-esteem instead of finding it within themselves or from their spouses. This is a role reversal where the child is valued for the ability to mother mom and take care of the father's self-esteem.

Conflict avoidance, incohesiveness and disorganization all play an important part in the family dynamics of bulimics. It would not be appropriate to close this summary of familial factors, however, without mentioning the latest genetic hypothesis of bulimia.

Research is inconclusive at this point, but evidence shows that most bulimics meet the Diagnostic and Statistical Manual of Mental Disorders criteria for a major affective disorder and there also appears to be a lifetime prevalence of affective disorder in first-and second-degree relatives of bulimics (Stern et al., 1984). Much additional work must be done in order to clarify what part depression plays in the etiology and maintenance of bulimia, but there are factors which support this possible biological link. For instance, bulimics report frequent depressive symptoms (e.g., withdrawal, increased sleep, inactivity) and demonstrate neuroendocrine

abnormalities similar to those found in primary depression (Gwirtsman, Roy-Byrne, & Yaker, 1983).

Treatment Factors

So far, the focus of this paper has been limited to defining bulimia and its etiological factors. Now the question must be asked, "What can professionals do to help bulimic clients live without this disease?" In order to answer this question, the focus must be shifted to treatment philosophy.

There are a multitude of theoretical perspectives which have been used to treat bulimics. The most notable family therapies include Salvador Minuchin's Structural Therapy and Selvini Palazzoli's Strategic Therapy (Vandereycken, 1987). Both types are concerned with the ambivalence that families and individuals have regarding change, the consequences of change and the importance of the sequences of interactions and thinking that surround the symptom (Garner, Garfinkel, Schwartz, & Thompson, 1980). In essence, Structural-Strategic approaches use a wide variety of interventions designed to alter the specific patterns of thinking or interactions that are believed to be maintaining the problem. Paradoxical intervention is an example where clients are directed to maintain their binge-purge behaviors. The rationale is that in prescribing this, the therapist overpowers resistance by forcing family members to rebel and thereby refuse to act

out their symptoms (Nichols, 1984). Similarly, restructuring the dinner scene with eating disorder patients and their families is another example of Structural-Strategic interventions. The focus of this technique is twofold: the therapist develops a concrete picture of the family's interaction patterns and at the same time also treats the patient's eating habits.

At present, the most popular individualized treatment modality is Cognitive-Behavioral Therapy. Composed of three distinct stages, cognitive-behaviorists help the bulimic: a) establish some degree of control over her eating behaviors, b) identify and modify dysfunctional thoughts, beliefs and values, and c) maintain healthy changes once progress is made (Garner, Garfinkel, Schwartz, & Thompson, 1980). Thus, symptoms and underlying dynamics are being addressed simultaneously.

It is easy to distinguish the influence of Rational Emotive Therapy (RET) in this approach. Albert Ellis, its founder, believes it is not a cue or event which determines a person's behavior, but rather the person's own interpretation of that cue or event. Therefore, cognitive-behaviorists challenge the irrational beliefs which perpetuate the bulimic's eating disorder.

In addition to the use of RET, one will find many behavior modification techniques within this approach. Extrinsic and intrinsic reinforcements are used to increase a desired behavior (e.g., promoting the bulimic's normal eating habits) and decrease an undesired behavior (e.g., binging and purging). Reinforcements may take many forms. For inpatient clients, it may be phone or visitation privileges. For outpatient clients, it may be a new record album or a movie. Whatever the motivating force, however, a therapist must always include some degree of verbal praise and acknowledgement when behavioral goals are being met. A bulimic needs constant reassurance that she has the ability to change her behaviors and that she is worthy of a healthy, happy life.

Whatever methodology a therapist uses, therapy in and of itself is not sufficient for treatment. In order to provide comprehensive assistance, educational classes and group support must be incorporated within the overall framework as well (Johnson, Connors, & Tobin, 1987). Educational classes provide the bulimic and the family with the tools for change. Together they can learn adaptive skills for everyday life such as basic nutrition, effective communication and relaxation techniques. Similarly, support group provides a safe forum for participants to put these tools into use. Since all of the group members are bound by the same dilemma of dealing

with an eating disorder, they do not judge or ridicule. Instead, they provide appropriate compassion and feedback when it is needed.

Implications

Because bulimia is a serious illness with complex biological, familial and sociocultural factors, treatment is indeed a challenge. Bulimics have a multitude of issues to deal with ranging from low self-esteem and maturity fears to familial conflict and codependency to societal standards and sex role expectations. Moreover, the possibility of bulimic relapse in the first few months after treatment termination is quite high. Keeping these factors in mind, the necessity for developing some type of eating disorder prevention program is quite obvious. Primary prevention aimed at reducing the incidence of eating disorders may help curb the number of women who turn to bulimia as a way of coping with life. Junior and senior high schools, colleges and community level institutions should all be targeted.

Most junior-senior high schools have health education, home economics and physical education classes, therefore, a health program to prevent eating disorders could be integrated into these existing classes. Training should enhance the student's awareness of her body and her needs while it provides a self-worth framework and a foundation for the future

elaboration of personal identity (Shisslak, Crago, & Swain, 1987). Relevant topics for discussion include specific health consequences of anorexia and bulimia, problems that arise between parents and teenagers and assertiveness skills.

Primary prevention efforts may also be directed toward college dormitories and sororities in much the same way as was indicated for junior-senior high schools. Since college life imposes unique academic and social pressures, presentation of relaxation techniques and time management skills would be very appropriate. Education about the symptoms and consequences of eating disorders and concepts that promote excessive thinness may also be included.

Prevention at a broad community level may use many of the methods already discussed for schools and colleges. Hopefully, the growing number of women who have eating disorders could be reached by providing pamphlets and presentations on the merits of moderation in diet and exercise. Information on the risks of eating disorders could be dispersed at health spas, fitness centers, grocery stores and physicians' and dentists' offices. Currently there are no such programs to meet public need. Despite the overwhelming debate about what prevention should provide for participants, professionals and other community members have done little to put these ideas into action. One of the only prevention programs tested

thus far has been implemented by Shisslak, Swain, Neal, and Dean (1986) for high school level individuals. Results and implications of this two year pilot study are not available at this time.

References

American Psychiatric Association. (1980). Diagnostic and Statistical Manual of Mental Disorders (3rd ed.). Washington: Author.

Cauwells, J. (1983). Bulimia. New York: Doubleday and Co., Inc.

Garner, D., & Garfinkel, P. (1985). A handbook for anorexia nervosa and bulimia. New York: Guilford Press.

Garner, D., Garfinkel, P., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. Psychological Reports, 47, 483-491.

Gwirtsman, H., Roy-Byrne, P., & Yager, J. (1983). Neuroendocrine abnormalities in bulimia. American Journal of Psychiatry, 140, 559-563.

Hale, S., & Ware, S. (1984). The assessment of bulimic symptoms and personality correlates in female college students. Journal of Clinical Psychology, 40, 440-445.

Humphrey, L. (1986). Structural analysis of parent-child relationships in eating disorders. Journal of Abnormal Psychology, 95, 395-402.

Johnson, C., Connors, M., & Tobin, D. (1987). Symptom, Management of Bulimia. Journal of Counseling and Clinical Psychology, 55, 668-676.

Johnson, C., & Flach, A. (1985). Family characteristics of 105 patients with bulimia. American Journal of Psychiatry, 142, 1321-1324.

Lakoff, R., & Scherr, R. (1984). Face value: The politics of beauty. Boston: Routledge and Kegan Paul.

Mitchell, J., & Eckert, E. (1987). Scope and significance of eating disorders. Journal of Consulting and Clinical Psychology, 55, 628-634.

Moos, R., & Moos, B. (1981). Family Environment Scale Manual. Palo Alto, Ca: Consulting Psychologist Press.

National Association of Anorexia Nervosa and Associated Disorders. (1989). Fat anxiety starts at an early age and it's no wonder. Working Together, 7, 1-2.

Neuman, P., & Halverson, P. (1983). Anorexia nervosa and bulimia: A handbook for counselors and therapists. New York: Van Nostrand Reinhold Co., Inc.

Nichols, M. (1984). Family therapy: Concepts and methods. New York: Garner Press, Inc.

Ordman, A., & Kirschenbaum, D. (1986). Bulimia: Assessment of eating, psychological adjustment and familial characteristics. International Journal of Eating Disorders, 5, 865-878.

Root, M., Fallon, P., & Friedrich, W. (1986). Bulimia: A systems approach to treatment. New York: W. W. Norton & Co.

Shisslak, C., Crago, M., & Swain, M. (1987). Primary prevention of eating disorders. Journal of Consulting and Clinical Psychology, 5, 660-667.

Shisslak, C., Swain, M., Neal, M., & Dean, J. (1986). Primary prevention of eating disorders: A high school pilot project. Unpublished Ed.D. manuscript, University of Arizona Health Sciences Center, Eating Disorders Clinic, Tucson.

Sights, J., & Richards, H. (1984). Parents of bulimic women. International Journal of Eating Disorders, 3, 3-13.

Stern, S., Dixon, K., Jones, D., Lake, M., Nemzer, E., & Sansone, R. (1989). Family environment in anorexia nervosa and bulimia. International Journal of Eating Disorders, 8, 25-31.

Stern, S., Dixon, K., Nemzer, E., Lake, M., Sansone, R., Smeltzer, D., Lantz, S., & Schrier, S. (1984). Affective disorder in the families of women with normal weight bulimia. American Journal of Psychiatry, 141, 1224-1227.

Squire, S. (1983). The slender balance. New York: G. P. Putnam's Sons.

Vandereycken, W. (1987). The constructive family approach to eating disorders: Critical remarks on the use of family therapy in anorexia nervosa and bulimia. International Journal of Eating Disorders, 6, 455-467.