

# Bulimia:

## a Food Binger's Time Bomb

By Dr. Dorothy M. Jones

Bulimia may have plagued people for centuries but only recently have medical experts given it a name. Bulimia (pronounced bu-le-mēa) is a food addiction which causes people to engage in whopping eating sprees often followed by self-induced vomiting or the use of laxatives.

Bulimics may be obese or seriously underweight although the majority maintain normal weight. Those affected by the disease ride a perpetual roller coaster — on a high with narcissistic food gratifications and under siege afterwards as the body becomes the enemy.

Bulimia affects primarily women from the middle and upper class. The disorder usually starts in adolescence or young adulthood and may continue for years.

Since bulimia was only recently identified, information on its prevalence is sparse. A recent American Psychiatric Association publication states that it is relatively rare. A study of 500 patients in a university psychiatric clinic also found only a small proportion (3.8 percent) to be bulimic. However, investigators believe that the incidence of bulimia is increasing.

Sometimes leading to serious, even fatal complications, bulimia often coexists with anorexia nervosa (starvation disease). Outcome studies of anorexia reveal fatality in up to 19 percent of the cases. Fatalities are due to such causes as suicide, hypokalemia (potassium depletion), and inanition (exhaustion from lack of food). People with bulimia who induce vomiting (bulimarexia) may also experience serious complications among which are electrolyte imbalance, epileptic seizures, kidney problems, menstrual irregularities, gastric dilation, in rare cases gastric ruptures, enlargement of the salivary glands, and erosion of the teeth.

Bulimics generally consume massive quantities of food in a short period of time. A client in my psychotherapy practice topped a large meal with a whole pie and a gallon of ice cream. Another client often eats everything in sight. In a

letter asking for help, she wrote: "If I start I can't stop. If I start eating something and I can't stop I have to throw the rest away or I will gorge myself until it is all gone." In her recent provocative book, "The Obsession: Reflections on the Tyranny of Slenderness", Kim Chernin described in vivid detail her experience as a binge eater.

*"And then, I am eating. My hand is reaching out. And the movement, even in the first moments, seems driven and compulsive..."*

*Suddenly I realize that I am putting too much butter on my breakfast roll...I notice with alarm that Olga is beginning to clear the table...While Olga looks away...I stuff the two rolls in my pocket, stand up from the table, and leave the room. Once out of the house I begin run-I see one of those stations where you can get a sausage on a paper plate, mustard, a white roll...I slow down and walk up to the window, making every effort to appear at ease. But there is someone in line before me. Suddenly a wave of tremendous anger and frustration comes over me. I think if I do not control myself I shall take this man by the shoulders and shove him aside.*

*I don't want to wait. I can't wait. I can't bear waiting. I must eat now, at this moment, without delay...And I know exactly what I am doing when I suddenly dart forward, grab the plate and begin to run...*

*And so I ran from bakery to bakery, from street stall to street stall, buying cones of roasted chesnuts, which made me frantic because I had to peel away the skins. I bought a pound of chocolate and ate it as I ran. I never went to the same place twice. I acquired a mesh bag and carried supplies with me, wrapped in torn pieces of newspaper. When I felt tired, I sat down on benches, spread out my food next to me, tried to move slowly as if I were enjoying a picnic, felt constrained by this pretense, darted the food into my mouth, ran on..."*

Research shows that bingers typically eat high caloric food with a sweet taste and select foods that allow for rapid eating. The average binge lasts one hour. Bingers eat as inconspicuously as possible or in secret, gobbling the food with little chewing. As Chernin poignantly illustrated, once they get the binge underway they may purchase additional food to prolong it. Usually they stop because of abdominal pain, sleep, interruption by another person, or induced vomiting, although some resume eating after vomiting. Bulimics binge periodically, usually alternating between periods of fasting, bingeing, and normal eating, although in extreme cases, they only binge and fast. How often do they binge? One investigator found that 37 percent overeat daily and 42 percent do so one or more times a week.

Bingers take pleasure in eating but afterwards they feel depressed, out of control, ashamed, disgusted with themselves. Generally they relieve these distressing feelings by planning the next binge or setting a new timetable for dieting.

Preoccupied with weight control, many bulimics commonly resort to vomiting. Those who do not make themselves vomit often use other extreme forms of controlling their consumption of calories. A client wrote a compelling description of her dieting compulsion.

*"My entire world revolves around food, eating, and my weight...I have been heavy all of my life until about 7 years ago when I went from 178 pounds to 117 pounds and remained fluctuating between 120 and 135 until this past year and a half. I live on a rigid eating schedule and if I try to vary even 10 minutes or 1 piece of bread it completely throws me off schedule and I go into a panic. I eat the same exact foods and then if I don't get them — like when I have to eat out, I panic...I eat breakfast at 9 a.m. sharp and dinner between 1 and 2 p.m. I never eat supper...If I do it always turns into a binge of the worst kind...Can you imagine how weird I feel never to be able to eat dinner when my husband and*

*I gain weight 5 pounds at a time and I can lose it the same way. This last time I have dropped the pounds but I haven't had a period in three months."*

What causes such a strange disorder? One expert suggests the possibility of hereditary transmission because bulimia has been found in some twins, siblings and parent-child pairs. But one could just as easily argue environmental influence in these cases.

Feminist writers emphasize the cultural roots of bulimia, the "tyranny of slenderness" that predisposes women to obsession with their weight. The ideal shape of women in Western society looks like a nine-year old child onto whom breasts have been grafted. My colleague, Anne Nevaldine, underscores women's vulnerability to the cultural stereotype about body size and shape. She pointed out that in this society where women are subordinated to men and are treated as less worthwhile, they experience tremendous shame. Because they don't feel good on the inside, they focus their energies on how they look on the outside. Research indicates widespread concern with body size from grade school girls to women of all ages. One study found that a staggering 70 percent of grade school girls were dissatisfied with their bodies and wanted to lose weight, in contrast to the boys who wanted to gain weight. An investigation of high school students revealed that half of the girls believed they were too fat, one third had dieted to cope with this fear, and about 10 percent had experienced physical symptoms associated with dieting such as fatigue, depression, constipation, and mental sluggishness. The preoccupation with diet intensifies with age. In her book, *Fat is a Feminist Issue*, Susie Orbach pointed out that American women spend \$10 billion a year to get and stay thin.

But identification of this cultural pattern does not explain why some individuals develop eating disorders and others do not. For this kind of answer we must turn to the family context in which eating disorders arise. Most research in this area deals with families of anorexics, but it probably also characterizes families of bulimics since often the same person is both bulimic and anorexic. The research that has been done on bulimia as well as my limited experience with treating bulimic clients suggest similar family patterns.

Both parents are usually present in the families. They tend to be highly achievement oriented and excessively

concerned with food and weight.

Hilde Bruch, an authority on eating disorders, observed that in the families she treated the fathers often were overly concerned with body size, physical fitness, and beauty; and the mothers, in turn, were unusually weight conscious. A bulimic client told me that whenever her slender mother gained just a few pounds her father ridiculed and belittled her. Such behavior by the father generated a morbid fear of overweight in the daughter.

Salvador Minuchin and his colleagues, well known for their work with psychosomatic families, identified four closely related characteristics of the bulimic's family. One is its highly enmeshed quality: members are overly involved with one another.

The second characteristic, overprotection, is closely linked to the first. Family members feel responsible for each others' emotions. When parents overprotect children in this way, they deprive them of the opportunity to learn to handle their own emotions. And when daughters feel responsible for their mothers' emotions, which is common among girls and women with eating disorders, they begin to neglect their own emotional needs.

Protecting mothers' feelings is a dominant theme with many clients I've treated.

A third characteristic in these families is the consistent failure to resolve conflicts. Conflict resolution threatens the very foundation of the enmeshed family, for it requires individuals to separate their feelings and interests from one another. Consequently they scrupulously avoid open conflict. Typically, parents will not tolerate the expression of any negative feelings. In many cases fathers are very dictatorial in enforcing this rule. Assertion and defiance are not allowed; negotiating a difference is simply out of the question. The wives submit to their authoritarian husbands without protest and the daughters follow the mother's example.

Of course the consistent suppression of feelings has repercussions; the emotions break out in one form or another. The literature on the psychopathology of family members is scant but it does suggest a high rate of symptoms. For example, a recent study of 34 bulimics who gave information on their families showed that parents and siblings had a high incidence of alcoholism (50 percent of cases), obesity (70 percent), depression (50 percent), and bulimia (12 percent). These symptoms, of bulimics and their relatives, function to detour conflict

and keep the family system intact.

These highly enmeshed families that suppress emotions, deny conflicts, and are excessively concerned about food and weight set the stage for the development of bulimia. Bulimics tend to have a weakly developed sense of self. They have difficulty perceiving their emotional needs as distinct from those of others. As a result they fail to develop internal means for managing their emotions and satisfying their desires. They instead rely on external sources for satisfaction.

Bulimics' obsession with food reflects, in part, their profound loneliness and isolation. As they can't readily confide feelings to other family members, they turn to food for consolation. One client who wrote asking for help gave a cogent description of this process: "the refrigerator is my friend; it never turns me away."

Often eating and dieting become the only arenas in which bulimics feel they can exercise control. This sense of control, however, is illusory, for it fails to give the bulimic what she really wants, an inner sense of self and self control.

A chronic disorder often lasting for years, bulimia can have serious emotional as well as medical complications. Victims have difficulty in intimate relationships and although they actively participate usually they don't enjoy sex.

Individual psychotherapy and self help groups such as Overeaters Anonymous are the most common forms of treatment for bulimia. No consistent success has been reported with drug treatment. In a two-year follow-up study on anorexia investigators found the persistence of weight preoccupation (despite having achieved normal weight) and other symptoms such as depression, drug dependence, and theft. By contrast, Minuchin and his colleagues claim that family treatment renders an 85 to 90 percent success rate.

It is difficult to determine what ongoing studies in the treatment of bulimia will show. Some investigators consider bulimics to be poor therapeutic risks because of the additive and secretive nature of their behavior. Of course all addictions are fraught with despair. But addictions are learned behavior and anything learned can be unlearned.

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