Bulimia Nervosa

People who suffering from bulimia nervosa try to control their weight by severely restricting the amount of food they eat, then binge eating and purging the food from their body by making themselves vomit or using laxatives. The medical term for bulimia is bulimia nervosa but I will refer to it as bulimia for the purpose of this article.

Warning signs

Signs of bulimia nervosa include an obsessive and unhealthy attitude towards food and eating, being overcritical about weight and shape (even though the person may not appear to be overweight) and frequent visits to the bathroom after eating, after which the person might appear flushed and have scarred knuckles (from forcing fingers down the throat to bring on vomiting).

Who is affected by bulimia nervosa?

Bulimia is five times more common than anorexia. Approximately 1% of the population suffer from bulimia. Women are 30 times more likely to suffer from bulimia then men. However, bulimia is becoming increasingly common in boys and men, with evidence that those heavily involved in sport being more at risk.

Recent studies suggest that as many as 8% of women have bulimia at some stage in their life. The condition can occur at any age, but mainly affects women aged between 16 and 40 (on average, it starts around the age of 18 or 19).

Symptoms

The main symptoms of bulimia are binge eating and purging. Purging means ridding your body of food by making yourself sick or taking laxatives.

Binge eating

Binge eating involves eating vast quantities of high-calorie food, without necessarily feeling hungry or needing to eat. The urge to eat can be a way of dealing with emotional problems; it can quickly become obsessive and hard to control. The person often feels guilty and low after binge eating. If binge eating is a problem with bulimia, it usually occurs regularly, it is not usually an occasional thing.

Purging

With bulimia, purging is a response to bingeing as the person tries to rid their body of the food they ate so they will not “put on weight”. After binge eating the person can feel guilty, regretful and full of self-hatred. They may feel physically bloated and unattractive. The main impulse to purge is a powerful, overriding fear of putting on weight. The most common methods of purging involve making yourself sick or using laxatives to encourage your body to pass the food quickly. Less common methods of purging include taking diet pills, over-exercising and extreme dieting.

Cycle of guilt

Bulimia is often a vicious circle. The person often has a low self-esteem making them believe they are not the perfect weight even though their weight is normal. This can lead to an obsession with weight that encourages the person set strict rules about dieting, eating or exercising, which are next to impossible to maintain. This can lead to craving and binging on the things you have denied yourself. After feeling guilty about bingeing, you purge to get rid of the calories and hence get rid of the “guilt”.

Other signs of bulimia

Other signs of bulimia can include:

- regular changes in weight
- an obsessive attitude towards food and eating

- large amounts of money being spent on food
- disappearing soon after eating (usually visiting the toilet to vomit)
- episodes of over-eating
- periods of starvation
- scarred knuckles (from forcing fingers down the throat to bring on vomiting)
- depression and anxiety
- unrealistic opinions about body weight and shape
- isolation

Complications of bulimia

In addition to the psychological effects causes and effects of bulimia, there are physical complications associated with bulimia.

These can include any of the following:

- **Dental problems**. Persistent vomiting causes stomach acid to damage the teeth enamel which can lead to tooth decay. Excessive vomiting can also cause bad breath and a sore throat.
- **Poor skin and hair**. A lack of nutrients through persistent vomiting or laxative use can affect the health of skin and hair. It can cause skin and hair to become dry and fingernails to become brittle.
- **Irregular periods**. Menstrual cycle can become unpredictable or even stop altogether affecting fertility.
- **Swollen glands**. The saliva glands can become swollen from frequent vomiting. This cause the face to appear rounder.
- **Chemical imbalance**. Excessive vomiting and laxative use can cause chemical imbalances. This can result in tiredness, weakness, abnormal heart rhythms, kidney damage, seizures and muscle spasms.
- **Bowel problems**. Excessive use of laxatives can damages bowel muscles causing lazy bowels which can result in permanent constipation. Over use of laxatives cause other serious problems such as potassium loss and protein loss.
- **Poor circulation**. Can cause cold hands and cold or uneven colours on extremities such as the feet.
- **Lack of feeling of pain**.
- **Heart problems**. Long-term, bulimia increases the risk of heart problems.

Differences between anorexia and bulimia

Anorexia nervosa	**Bulimia nervosa**
Low weight	Normal weight
Presents early	Presents later
Rarely seeks help	May seeks help
Onset early to middle teens	Onset in late teens
Can start in younger children (pre-teens)	Rarely occurs in younger children
Can affect boys	Rarely in boys
Acute or chronic	Fluctuating course
No previous illness	Previous anorexia nervosa
Associated with anxiety, obsessive compulsive disorder and depression	Associated with depression, self-harm and substance misuse
Prognosis is poor without early intervention	Up to 60% respond to specific treatments

Causes

There is no one simple commonly identifiable cause. The cause tends to be complex and bulimia tends to be a condition that doesn't appear overnight; it tends to develop slowly with the person gradually becoming more obsessive about their weight which can eventually lead it to get out of control. Many believe that the pressure that people (especially women) have to conform to the "perfect shape" and stay thin is the cause of eating disorders like anorexia. This is partly the cause but the causes are more complex.

As with other eating disorders, bulimia can be associated with depression, low self-esteem, stress, misuse of alcohol and self-harm. Bulimia is often associated with other psychological problems. Research shows that bulimia is more common in people who have anxiety disorders, obsessive compulsive disorder, post-traumatic stress disorder and personality disorders. There may be genetic link, for example, research suggests that people who have a close relative who has or has had bulimia are four times more likely to develop it themselves compared to a person who doesn't have a relative with it.

Diagnosing bulimia

The most difficult step in tackling the problem of bulimia is actually recognising there is a problem and seeking help about it. Most people with bulimia hide their situation for months or years before seeking help. It can often take a change of situation (such as the start of a new relationship, a loved one tackling the person about the problem, a serious deterioration in health due to the condition) to make a person with bulimia want to seek help.

It is common for someone with an eating disorder to be secretive and defensive about their eating and their weight and denial they are unwell or need help. In this way, it is not that dissimilar to other addictive or psychological type disorders such as alcoholism, drug addiction, gambling addiction etc. Initially the person is able to lead a fairly normal life. It is often only in the end stages when the person becomes so physically and psychologically unwell that it is obvious there is a problem and the person can no longer lead a normal life. Losing weight becomes an addiction and like any addiction the point of complete satisfaction (with one's weight in the case of anorexia or bulimia) is never attained. Eating becomes an "evil" thing in the eyes of the sufferer.

A GP often refers the person suffering from bulimia to a specialist mental health team trained in treating eating disorders such a bulimia. This can include specialist counsellors, psychiatrists, psychologists, nurses, dieticians and other healthcare professionals.

To recover, someone with bulimia needs to:

- change their eating habits
- change the way they think about food
- gain weight safely, if necessary

The longer someone has had bulimia, the harder it is to re-learn healthy eating habits and gain weight. It is important to start treatment as early as possible, so the person has the best chance of recovery. There can be setbacks in recovery but this should discourage the person from getting over their condition.

Tips for family members

- Recovery takes years rather than weeks or months. Psychological treatment is core to treatment as patients must be convinced that they need to attain a normal weight. Re-feeding alone will likely lead to relapse.
- Progress should be monitored by weighing. Monitoring needs to be managed skilfully so it does not become a battleground
- No cut off weight or body mass index exists because many other factors influence risk
- Substance misuse (including alcohol, deliberate overdoses, use of laxatives or misuse of prescribed insulin) greatly increases risk
- Weight fluctuations and binge-purge methods rather than pure starvation alone increases risk
- Depression, anxiety, and family arguments are usually caused by the disorder (rather than these factors causing anorexia or bulimia); therefore the eating disorder must be treated first before tackling other issues.
- Medication has little benefit in anorexia and the risk of dangerous side effects is higher in malnourished patients. However, medication has more success in helping treat bulimia. SSRI's such as fluoxetine are used to treat bulimia.
- Involving the family in treatment and care encourages calm firmness and assertive care. Family involvement increases the chances of recovery.

Treatment

Psychotherapies

1. Individual therapy

Structured individual treatments are usually offered as a weekly one hour session with a therapist trained in the management of eating disorders and in the therapy model used. Therapies available include:

Cognitive analytic therapy
This psychotherapy uses letters and diagrams to examine habitual patterns of behaviour around other people and to experiment with more flexible responses.

Cognitive behaviour therapy (CBT)
A form of therapy that emphasises the important role of thinking in how we feel and what we do. CBT challenges the automatic thoughts and assumptions behind behaviour in bulimia.

Interpersonal psychotherapy
A talking therapy that focuses on relationship based issues and aims to provide new techniques in dealing with distress.

Motivational enhancement therapy
This psychotherapy uses interviewing techniques derived from work with substance misuse to reframe "resistance" to change as "ambivalence" about change, and to nurture and amplify healthy impulses.

Dynamically informed therapies
These therapies will only provide weight gain if the patient can be convinced of the risk of irreversible physical damage or death and acknowledges that certain boundaries (for example, that they must be weighed weekly, examined regularly by a doctor, and admitted to hospital if weight continues downwards) are observed. Therapies involved include talking, art, music, and movement.

2. Group therapy

Group therapy is not recognised as an effective therapy type for anorexia and bulimia.

3. Family involvement

The term "family work" covers any intervention that utilises the strengths and support of the family to tackle the patient's disorder. "Family work" also tries to deal with the family's stress due to the disorder. It includes family therapies, support groups and psychoeducational input.

Conjoint therapy
The Maudsley model of family therapy and similar interventions have been found to be effective therapies. Whole families (or at least the parents and the patient) attend counselling sessions together.

Separated family therapy
The patient and the parents attend separate meetings, sometimes with two different therapists. This form of therapy seems to be as effective as conjoint therapy, particularly for older patients, and involves lower levels of expressed emotion.

Multifamily groups
Such groups provide a unique way of empowering parents by means of peer support and help from a therapist. Several families, including the patients, meet together for intensive sessions that often last the whole day and include eating together.

Relatives' and carers' support groups
These groups range from self-help groups to highly structured sessions led by a therapist that aim to teach psychosocial and practical skills to help patients with anorexia and bulimia to recover while avoiding unnecessary conflict. Most aim to provide information and advice about the nature of anorexia and bulimia.

How effective is psychotherapy

Short term structured treatments such as cognitive behaviour therapy and interpersonal psychotherapy are effective for bulimia but are not nearly as effective with anorexia. Expert consensus favours long term, wide ranging, complex treatments using psychodynamic understanding, systemic principles, and techniques borrowed from motivational enhancement therapy and dialectical behavioural therapy (explained above). The guiding principle of motivational enhancement is to acknowledge and explore rather than fight the patient's ambivalence about recovery. Treatment is more effective when the therapist and the patient work together to tackle the eating disorder.

Family work is the only well researched intervention for eating disorders that has a proven beneficial impact. Family work teaches the family and patient to be aware of the perpetuating features of the disorder. Anger and fighting lead to entrenched symptoms but too much tolerance and lenience towards the condition can encourage the condition by allowing it to become accepted. A balance needs to be found which is why families need professional guidance. Studies indicate that therapies involving the family and the patient tend to provide better results in terms of psychological improvement but weight gain was greater when families were seen by the therapist separately from the patient.

Medication

Antidepressants known as selective serotonin reuptake inhibitors (SSRIs) may be used to treat bulimia. SSRIs (specifically fluoxetine) are the drugs of first choice for the treatment of bulimia in terms of acceptability, tolerability and reduction of symptoms. For people with bulimia, the effective dose of fluoxetine is higher than for depression (60 mg daily). As with any antidepressant, an SSRI will usually take several weeks before it starts to work. A low dose is generally started to begin with and then gradually increased to allow the body get used to the medication and reduce the risk of side effects. No other drugs appear to help with bulimia. As well as treating depression and eating disorders, SSRIs are also used to treat other psychological disorders including obsessive compulsive disorder (OCD), anxiety and social phobia.

Antidepressants do not work for everyone suffering from bulimia so it is important that progress is regularly monitored by the doctor. Very few drugs are recommended for children and young people below the age of 18. Antidepressant drugs may be used for the treatment of bulimia nervosa in adolescents but they are not licensed for this age group and there is no evidence base for this practice. They should not be considered as a first line treatment in adolescent bulimia nervosa.

SSRIs are best avoided if suffering from epilepsy or a family history of heart, liver or kidney disease. More detailed information on SSRIs can be obtained in Whelehan's or check out www.whelehans.ie.

How effective are antidepressants compared to psychological treatments?
Antidepressant can reduce the frequency of binge eating and purging, but the long-term effects are unknown. Any beneficial effects will be noticeable within a few weeks of starting treatment. There are few studies comparing the effectiveness of antidepressants compared to psychological treatments for the treatment of bulimia. However in the few studies done, CBT does appear to be more effective than antidepressants. Studies also show that combining antidepressants with CBT is more effective at treating bulimia than antidepressants

alone. However, these studies too small to be 100% conclusive; they also did not take into account the long term success rate after treatment was complete.

Useful organisations

BodyWHYS

Bodywhys is a national voluntary organisation supporting people affected by eating disorders. They aim to ensure support, awareness and understanding of eating disorders amongst the wider community as well as advocating for the rights and healthcare needs of people affected by eating disorders including the families of those affected. They provide support and education through volunteers as well as providing support and advice through their helpline as well as online support through their website (www.bodywhys.ie). For more help and information, you can lo-call Bodywhys at 1890 200 444 or e-mail info@bodywhys.ie.

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References

References for this article are available on request. The article was written and researched by pharmacist Eamonn Brady and Eamonn will forward references upon request.