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## What is an Eating Disorder?

Treatment of the eating disorders has become a major mental health issue of the twenty-first century. Until the early 1980s, most people knew of the existence of anorexia nervosa, but few mental health professionals or dietitians would have considered it necessary to have more than the ability merely to recognize the disorder so that they could pass a case on to a specialist worker or unit.

In the past thirty years, however, help has become increasingly available for people with specific diagnoses of bulimia nervosa and anorexia nervosa. Mental health professionals have also begun to address the problem of binge eating disorder in both normal weight and overweight people. Awareness of the need for specialist care has meant that someone with an eating disorder is more likely than previously to be referred for psychiatric or counselling help or may at least be able to receive advice from a self-help organization.

Yet, despite increased knowledge and interest in this area, clinicians are often reluctant and sometimes anxious or even negative about working with this group of people. A review of 20 studies between 1984 and 2010 describing reactions to patients with eating disorders listed frustration, hopelessness, lack of competence and worry as reflecting the feelings of clinicians, albeit there was an inverse relationship between the strength of these feelings and clinician experience. Negative reactions to patients with eating disorders were associated with patients' lack of improvement and personality pathology (Thompson-Brenner et al. 2012). Even among specialist mental health workers there is still some erroneous information about the nature of eating disorders and confusion about the best ways to treat them as evidenced by a recent survey of National Health Service (NHS) psychiatrists in the UK (Jones et al. 2013).

This book is an attempt to provide a practical basis for helping people with eating disorders both for therapists with a mental health or health

psychology background and for dieticians. Its aim is not only to describe ways of working with people with a specifiable eating disorder, but also to suggest ways to improve the methods by which nutritional advice and therapy are offered to obese people and to those who by virtue of psychological difficulties are unable to eat in a health-promoting way.

This chapter will describe the behaviour, eating habits and physical symptoms seen in people with disorders of eating. It will define the conditions known as 'anorexia nervosa', 'bulimia nervosa' and 'binge eating disorder', and discuss some of the problems which therapists and mental health professionals may meet in people with atypical, less easily definable eating disorders, such as purging and anorexic behaviour in people of apparently normal weight, or inability to eat for reasons other than fear of becoming fat. It will also discuss the relationship between eating disorder and weight and the question of how far people at a very low weight or a very high weight in relation to height may or may not have an eating disorder.

A broad definition of eating disorder is given by Fairburn and Walsh (2002), psychiatrists who have been at the cutting edge of eating disorder research for the past 30 years. They propose: 'a persistent disturbance of eating behaviour or behaviour intended to control weight, which significantly impairs health or psychosocial functioning. This disturbance should not be secondary to any recognized general medical disorder ... or any other psychiatric disorder' (Fairburn and Walsh 2002: 171). This definition implies an understanding that the eating disorders encompass a range of difficulties. People may also be driven to overeat or under-eat for reasons which do not necessarily include the intention of controlling weight. There is increasing evidence that a disturbance in eating or purging behaviour may reflect a need for some individuals to control or escape from intolerable emotions, and the resulting change in weight is merely a side-effect of that behaviour. Eating disorders are largely defined by characteristic behaviours around food and weight control and attitudes to weight and shape. An eating disorder can never be diagnosed from weight or shape alone, although weight is an important feature of an eating disorder (see text box on the relationship between weight and eating disorder).

Recognition of the widespread nature of problems around food and eating stemmed from three areas. The first and perhaps most public of these was the feminist movement. Susie Orbach's book *Fat is a Feminist Issue* (1978) drew a great deal of attention to the movement through its novel discussion of so-called 'compulsive overeating' which talked not so much about 'fat' itself but about the fear of fat and the place held by that fear in the culture of women in the context of their relationship with men. This led to a rash of books around the area of dieting and body image, most of which carried the implication that dieting and obsession with body image have something to do with the place of women in a sexist society.

Another source of recognition was in mainstream psychiatry. Gerald Russell (1979), known for his work with anorexia nervosa, described an

anorexic-like syndrome in women of normal weight. These women had previously been anorexic and, although of normal weight on follow-up, were still obsessed with weight and shape. They binged frequently but went to great lengths to control their weight by means of vomiting, taking laxatives or starving themselves in between binges. He called this syndrome 'bulimia nervosa' as opposed to anorexia nervosa.

A third source of recognition came from epidemiological research. 'Bulimia', as it was called in the United States, or 'bulimia nervosa', as it was called in Britain, was recognized to exist on a wide scale among women who had never approached their doctors for help.

However, there is no doubt that the existence of the popular word 'binge', and the phenomenon itself, has its basis in the obsession with dieting that prevails in the Western world. Very many men and women of all ages diet habitually. In this setting, it is sometimes difficult to assess how far someone is actually suffering from an eating disorder. Dieting and a negative attitude to fat are condoned and often highly valued by people as an indicator of self-control both in themselves and in other people. Hence, it is possible for someone who is suffering intensely with an eating disorder to hide the fact not only from themselves but also from the people who might be able to help.

## A note about psychiatric diagnosis

Psychological disturbances are generally classified under two parallel classification systems. These are the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM, American Psychiatric Association 2013) or the World Health Organization's *International Classification of Diseases* (WHO 1992). In this book, I have used the DSM-5 (2013) classification system as a basis for describing the disorders under discussion and the results of research into the efficacy of their treatment, although most of the research to date is, in fact, based on the DSM-IV and DSM-IV-TR classification systems which have been in use until the time of writing (American Psychiatric Association 1994, 2000).

If we are to work with people and their problems, we need some way of defining the problems so that we all know that we are discussing the same phenomenon. In this regard, psychiatric diagnosis is a useful system. It also helps us to draw conclusions from research into treatment. However, the distinctions between the so-called 'disorders' are by no means firm and immutable. There is much overlap of symptoms and characteristics between disorders and there may be limited utility in producing endless classificatory systems and subsystems which describe but do little to explain or predict (see Fairburn and Cooper [2007] with regard to the utility of classification in eating disorder). It is also important to remember that the conditions to which we are referring are not necessarily illnesses or conditions which a person

can 'have' in the same way as they can 'have' multiple sclerosis or epilepsy, or which they can 'catch' in the same way that they can 'catch' pneumonia or acquire HIV; and there is growing interest in a 'dimensional' approach to the classification of eating disorders based on a model where symptoms may vary in severity on a continuum across diagnoses and with normality (see also Wildes and Marcus 2013). There is some emerging evidence of possible links with physiology and brain chemistry, but as yet there are no clear indicators of medical or genetic aetiology of eating disorder that lend themselves to the development of medical treatment approaches; and, as yet, the major treatments of choice have a psychological basis. As John Marzillier, an experienced psychotherapist and research psychologist, has pointed out:

the experiences that lead people to be diagnosed as 'mentally ill' are experiences that all of us can have in some form at some stage. This is why, despite over a century or more of research, psychiatrists are no further forward in defining and understanding – let alone successfully treating – any major psychiatric 'illness'. (Marzillier 2004: 392)

The people we meet in therapy for eating disorders may have symptoms in common, but the way they respond to therapy will be a function of the complex interaction between their symptoms and many other factors, including physiology, brain chemistry, personality, past experience and current circumstances. Therapists may experience some discomfort in trying to attach labels to the real people they meet in their consulting rooms. However, psychiatric 'diagnosis' is merely a starting point from which to explore the individual needs of clients, develop an individual formulation or 'case conceptualization', and apply the general principles and individual techniques of evidence-based psychological therapy.

### **The relationship between weight and eating disorder**

#### **Body mass index**

Degree of overweight or underweight is commonly described by a measure known as the body mass index (BMI).

This is derived from the formula  $W/H^2$  (weight in kilograms divided by the square of height in metres).

Weight is plotted in relation to height and the resulting graph has been reproduced in widely available table form depicting the upper and lower limits of the weight range.

#### **Normal weight**

The normal range for the BMI of adults is 20–25.

**Low weight**

BMI measurements below 18.5 represent increasing degrees of underweight.

The Maudsley Body Mass Index table (Janet Treasure) defines underweight as follows:

17.5–20	underweight
15–17.5	anorexia nervosa
13.5–15	severe anorexia nervosa
12–13.5	critical anorexia nervosa
> 12	life-threatening anorexia nervosa

**Overweight**

A BMI of 26 and above indicates increasing degrees of overweight:

26–30	grade 1 (overweight)
30–40	grade 2 (clinical obesity)
≥ 40	grade 3 (severe obesity)

Note: BMI varies through childhood and adolescence, decreasing in early childhood and then gradually increasing through adolescence. So, for children, BMI on its own is not a good measure of thinness. A chart is used to depict BMI in boys and girls aged 2 to 20, and individual BMI is expressed as a percentile.

A BMI above the 95th percentile is considered overweight, and below the 5th percentile is considered underweight (WHO 1996; Dietz and Bellizzi 1999).

## Anorexia nervosa

Anorexia nervosa is a state in which the sufferer, usually female, refuses to eat enough to maintain normal body weight for her height. Usually she claims to want to lose weight to be slimmer; sometimes she says that she does not feel hungry or that it is uncomfortable to eat.

A currently accepted definition of anorexia nervosa is given in the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-5, 2013)* and has three criteria. The first specifies that the person takes in less energy than needed to maintain a weight that is normal for their height and age; or for a child or adolescent, their weight is less than expected. The second criterion specifies an 'intense' fear of weight gain or attempts to prevent weight gain. A third criterion specifies a disturbance in

the person's experience of their body weight or shape, or the implication that the person refuses to recognize the risks of being seriously underweight (see American Psychiatric Association 2013).

A weight criterion by which to define anorexia nervosa is given in the tenth edition of the *International Classification of Diseases* (WHO 1992), which specifies that weight is maintained at least 15 per cent below that expected or, in adults, body mass index (BMI) is below 17.5 kg/m<sup>2</sup>. In younger people, instead of actual weight loss, there may be failure to gain weight as expected during puberty or childhood. According to *DSM-5*, the current level of severity of anorexia nervosa is based on current body mass index for adults and on BMI percentile for children and adolescents. Most young women with anorexia nervosa will stop menstruating; and a previous version of the *DSM*, *DSM-IV* (American Psychiatric Association 1994) stipulated the absence of at least three consecutive menstrual cycles when otherwise expected to occur. However, this stipulation has now been removed as children with an eating disorder may have not yet reached puberty; some women, including those who take the contraceptive pill, may continue to menstruate even at a low weight; and amenorrhoea can be experienced by people with all types of eating disorder (see also the review by Pinheiro et al. 2007).

People suffering with anorexia nervosa refuse food or eat very little. Some may count calories or exclude certain food groups from their diet, and many eat as little as 200–300 calories per day. They may also take strenuous exercise, apparently as a means of maintaining a low weight, but also perhaps as a means of keeping warm according to some recent evidence which showed a negative correlation between ambient temperature and physical activity in anorexics who exercise (Carrera et al. 2012). For many people, excessive exercise is maintained as a means of regulating mood. Anorexics also often appear 'faddy' with their food. Some take an immense interest in cookery and in cooking for other people, although they will themselves avoid eating the food they cook.

Individual sufferers vary widely in their presentation, and attempts to characterize types of anorexic have their limitations. For example, it has been assumed until recently that all anorexics have a 'drive for thinness' and fear weight gain, but as now reflected in the most recent version of the *DSM* (American Psychiatric Association 2013), fear of weight gain is not a prerequisite for meeting diagnostic criteria. Several authors have pointed out that up to 20 per cent of anorexics, in particular in the Far East, do not appear to be afraid to get fat: these patients are more likely to attribute fear of eating to some other phenomenon, such as stomach bloating or pain, loss of appetite or lack of hunger (see Ramacciotti et al. 2002 for a discussion). In addition, studies in children and adolescents have pointed to the fact that fear of weight gain is not always endorsed in this group, despite a clear refusal to eat (WCEDCA 2007). The authors of this latter study explain this observation in terms of 'limited verbal capacities, fewer abstracting abilities,

less awareness of emotions ... compared with adults.' (p. S117). However, the same could be said for some adult eating disorder clients too, people in whom the 'breadth and complexity of emotion regulation strategies' may be limited just as it is in individuals at an earlier stage of development.

Anorexics are also thought to have a distorted body image, in that they often appear to grossly overestimate their own size or weight. A great deal of research in the 1970s was devoted to the question of how far anorexics overestimate their body size. This is in common, however, with many other people with abnormal eating habits, and the emphasis more recently has been on sufferers' attitudes to weight and shape. Peter Cooper and Christopher Fairburn (1993) have pointed out the distinction between 'dissatisfaction with body shape', which may or may not be experienced by women with eating disorders, and 'overvalued ideas about body shape and weight', which they hold are a necessary diagnostic feature for both bulimia nervosa and anorexia nervosa.

Anorexics are specified as 'restricting types' or 'binge eating/purging types'. Some anorexics keep their weight down solely by restricting their food intake and are not currently purging or binge eating, while others also binge eat and purge themselves by vomiting or by taking laxatives, diuretics or enemas. Some patients may develop the habit of chewing and spitting out food as a means of purging or of avoiding food intake. The relative number of bingers *vis-à-vis* restrictors is on average about 50 per cent across studies, which have pointed to some consistent differences between the two groups: more of the bulimics have had heterosexual experience and are married, although their social adjustment is no better than that of the restrictors, as they also describe themselves as more anxious and depressed, more guilty about their eating habits, and more aware of difficulties in interpersonal relationships. The bulimics are significantly older when they present for treatment and have been ill for longer. More of the bulimics appear to seek help for themselves, while the restrictors often deny that they have a problem at all. However, the bulimics also appear to carry a worse prognosis, and, in addition, are more likely to exhibit impulsive behaviours, such as stealing, drug abuse, suicide attempts and self-mutilation. Garner and his colleagues (1993) have suggested an entirely different division of anorexics, between those who purge and those who do not. They have suggested that this avoids the problems of defining a binge. It also makes sense in that many anorexics purge without bingeing, and there is a strong association between purging behaviour and level of psychopathology, chronicity and length of illness (Favaro and Santonastaso 1996).

The disorder takes a physical toll on sufferers. Long-term starvation causes muscle weakness and loss of muscle strength, which also affects the heart. Sufferers may develop cardiac abnormalities and arrhythmias which normally improve with weight regain and recovery (see Mehler et al. 2010 for a detailed description of medical complications in eating disorders). They may have dry skin and brittle hair and nails, with scalp hair loss and

excessive growth of dry brittle hair over the nape of the neck, cheeks, forearms and thighs, called 'lanugo' hair. They often have cold hands and feet, and peripheral oedema (swelling). They can suffer from constipation and often complain of feeling 'bloated'. Long-term amenorrhoea (lack of menstrual periods) may lead to premature bone loss and place sufferers at risk of osteoporosis. Indeed, there is evidence that young women with anorexia nervosa have an increased risk of fractures in later life (Lucas et al. 1999).

It is common for people with anorexia nervosa to experience mood and anxiety disorders compared with other people of the same age (Hudson et al. 2007). The experience of low mood is in part a predictable concomitant of severe food deprivation, which can subside when the person is in remission from their eating disorder, but many anorexics are diagnosed as suffering from clinical depression in addition to their eating disorder with a lifetime prevalence of between 36 and 86 per cent (Green et al. 2009). Anxiety is also common, and more prevalent in people with eating disorders than in the wider community. In a review of previous research, anorexics were described as having lifetime prevalence rates of between 23 and 75 per cent for having at least one anxiety disorder. In fact, there is some evidence that anxiety disorders predate the onset of an eating disorder in many people (Swinbourne and Touyz 2007; Pallister and Waller 2008). Up to 40 per cent of anorexics have been described as having an obsessive compulsive disorder (OCD) with compulsive symptoms which cannot be explained entirely by the need to control calorie intake and expenditure (Sallet et al. 2010).

Anorexics share many features with people who suffer with body dysmorphic disorder (BDD). BDD is a condition in which a person is preoccupied with an imagined defect in his or her appearance. The focus of the person's attention often concerns perceived flaws or blemishes which are quite small, for example of the nose, skin, face or hair, but can also centre on a more general complaint, of being 'ugly' or about weight, hips, stomach or thighs. Sufferers typically engage in repetitive and compulsive behaviours, such as mirror checking, camouflaging the defect, or excessive grooming, and may go to extreme lengths to modify the defect, such as strict dieting, or even investing, sometimes repeatedly, in plastic surgery. The diagnosis of an eating disorder, with its emphasis on body shape and weight, can obscure the presence of BDD, as it is possible for sufferers to experience both. In a study of 158 people seeking treatment for their eating disorder, 45 per cent of subjects screened positive for the presence of BDD, although their focus of complaint, like that of other people with eating disorder, was largely around weight and shape and the authors suggest that it is important to be aware of this possibility because of the greater psychopathology that may be carried by BDD and the implications for treatment (Dingemans et al. 2012).

### Who develops anorexia nervosa?

Anorexia nervosa currently has a very high profile. However, it is important to bear in mind that a search throughout the world literature has shown

that it affects on average less than 0.5 per cent of young women (see Table 1.1; Hoek and van Hoeken 2003; Smink et al. 2012). Sufferers are usually in their adolescence, but the disorder can appear at any time between 12 and 44 years. It has also been reported in women over the age of 60, although it is likely that the majority of people identified had suffered with the disorder for most of their life (Scholtz et al. 2010).

**Table 1.1** Incidence and prevalence of eating disorders

<b>Anorexia nervosa</b>	
Incidence	8 cases per 100,000 population per year (1 in 19 male)
Prevalence	0.3 % for young females
<b>Bulimia nervosa</b>	
Incidence	12 cases per 100,000 population per year
Prevalence	1 % in young women 0.1 % young men 90 % are female, 10 % male

Source: Hoek and van Hoeken (2003)

Incidence rates are highest at around 1 per cent per year for females aged 15–19 years, who constitute approximately 40 per cent of all cases, and it is relatively rare both in children under the age of 13 and in middle-aged and older women. However, given that up to one-quarter of presentations of anorexia nervosa first occurred in childhood, it is likely that its occurrence in younger children has been underestimated: there are reports of its appearance in pre-pubescent girls as young as seven (Nicholls et al. 2000) and, in one study in Australia, in children as young as five years old (Madden et al. 2009). In this study of first presentations of eating disorder, it was notable that many of the children had comorbid psychiatric disorders and medical complications, and nearly 80 per cent required immediate hospital admission. One reason for the possible under-identification of children with anorexia nervosa is that very young children are less likely than are older children or adults to be able to verbalize their distress, or to express it if they do, in terms of body shape or weight (Madden 2012). Hence, as the emphasis in the diagnostic criteria moves away from cognitive and emotional symptoms, we may see a rise in numbers of children being identified as having an eating disorder as opposed to another disorder of feeding.

There is a question with regard to all age groups as to whether or not all cases of anorexia nervosa are picked up by health care professionals and whether there are still some cases which go undiagnosed and untreated (see text box).

**Are all cases of anorexia nervosa detected?**

A study in the Netherlands estimated that one-year prevalence rates were higher in the community in general than in mental health care (Hoek 2006).

Researchers in Finland screened questionnaire responses of nearly 3,000 young women who had taken part in a twin cohort for the presence of eating disorder. They conducted telephone interviews with 292 women who screened positive for anorexia nervosa together with their screened negative twins (134). The authors found a lifetime prevalence of *DSM-IV* anorexia nervosa of 2.2 per cent; half of the cases had not been detected in the health care system, although detected and undetected cases showed similar symptoms and rates of recovery (Keski-Rahkonen et al. 2007).

With regard to the question of whether anorexia nervosa is on the increase, a meta-analysis of incidence in mental health care in Europe suggested that it increased up to the 1970s and then stabilized. However, long-term epidemiological studies are sensitive to changes in incidence depending on the methods used and on variations in the methods of detection over time (Smink et al. 2012). Hence, we do not yet know whether the prevalence of anorexia nervosa is really increasing or whether any reported increase in clinical referrals is simply a function of improved detection or changing demographics.

Between one in 16 and one in 19 anorexics is male, although it has recently been suggested that anorexia nervosa is more common in males than previously thought and may be even more frequently undetected in this group than in women (Hoek 2006). The presentation of anorexia nervosa in men is often described as being similar to that of women. Males, like their female counterparts, experience profound physical changes that accompany severe weight loss, including stunting of growth and decreases in libido, and psychological symptoms such as depression and obsessive compulsive behaviours. However, there are some differences. For example, some studies have pointed to more frequent physical activity, such as jogging and working out in the gym, more concern with masculine shape, and less concern with actual weight. There is also a tendency towards later detection, possibly as a result of a stronger involvement with athletics, or because men may be more inclined to hide symptoms which could be viewed as relating to a female disorder and so are more likely to escape the notice of medical practitioners (see also Lindberg and Hjern 2006). Some authors report an increased frequency of 'asexuality'; others have suggested a correlation between anorexia nervosa in boys and men and homosexuality: for example, Feldman and Meyer (2007a) have summarized findings which suggest that between 14 and 42 per cent of male anorexics in both clinical and community samples are gay or bisexual in contrast to the lack of association of eating disorders with sexual orientation in women.

Together with bulimia nervosa, anorexia nervosa has traditionally been described in both clinical and research studies as being overrepresented in the upper social classes. However, there is an increasing awareness that eating

disorders can affect people across boundaries of social class and racial groups and that the people who come to the notice of mental health specialists may not be truly representative of the social class and ethnic backgrounds from which they come (see text box). It is possible that the cultural and family difficulties engendered by immigration and change and exposure to the Western beauty ideal are more salient than are social class or culture *per se*.

### **Eating disorders and social class**

Anorexia nervosa and bulimia nervosa are said to be overrepresented in the upper social classes and to occur more frequently in Western and specifically white people, both in the United States and in Great Britain.

- The social class distribution of anorexia nervosa patients referred to a specialist treatment centre in London over 33 years was consistently weighted towards social classes one and two (McLelland and Crisp 2001).
- In a national survey of health registers in Sweden, where access to health services is fairly equitable, the factors most strongly associated with inpatient treatment of anorexia nervosa were having parents from northern, central or eastern Europe (as opposed to southern Europe, the Middle East or Africa) and coming from a white-collar household (Lindberg and Hjern 2003).

However, the relationship between eating disorder and class is still under debate.

- Anorexia nervosa is reported increasingly in women in all countries, including Japan (see Chisuwa and O’Dea 2010), and in all classes.
- In a study on the Caribbean island of Curaçao, Hoek found no incidence of anorexia nervosa in black women, but the incidence among the minority mixed Asian and white populations was similar to that in the Netherlands (Hoek et al. 2005).
- Anorexia nervosa has been reported to exist at a rate higher than expected in the young homeless (Freeman and Gard 1994).
- In a review of several studies dating back to 1973, Gard and Freeman (1996) noted that the belief that anorexia nervosa in particular is more prevalent in high socioeconomic groups was based on flawed evidence from small, biased samples; there were far more studies which reported either no relationship or the opposite than those which did report a relationship with high social class.
- In a meta-analysis of 119 outcome series of patients with anorexia nervosa, Steinhausen (2002) could draw no definite conclusions as to the relevance of socioeconomic status.

### **Does social class affect service utilization?**

- An American study compared the prevalence and service utilization for eating disorders across Latinos, Asians, and African Americans living in the United States to the non-Latino white population. The prevalence of anorexia nervosa

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was similar across all groups examined, but lifetime prevalence of service utilization was lower for the ethnic groups (Marques et al. 2011).

- In London, referrals to a specialist eating disorder service did not reflect the ethnic composition of the local population (Waller et al. 2009).
- In Leicester, fewer than 5 per cent of female patients referred to a specialist eating disorder service were Asian, even though young Asian women comprised nearly 14 per cent of the local young female population (Abbas et al. 2010).

Some possible reasons for these discrepancies regarding ethnicity and utilization of health services in eating disorder could be:

- ethnic minority women are less trusting of medical professionals and less willing to seek help outside their immediate community;
- inequalities in health care systems;
- physicians in some settings miss the diagnosis of eating disorders in ethnic minority groups (Gilbert 2012).

### What happens to people who have anorexia nervosa?

Most anorexics have just one episode of the disorder and eventually return to a normal weight. Of those who are treated in clinics and survive, between 40 and 80 per cent achieve normal weight between two and ten years after they are first seen. However, many continue to have abnormal attitudes to food and weight for a very long time, and about half of previous sufferers do not return to eating normally. Between 13 and 50 per cent of women do not get their periods back. About 60 per cent of those who continue to maintain a low weight and have problems with eating manage to live apparently normal lives, and hold down jobs.

According to Steinhausen (1999), 5 per cent of anorexics die of anorexia nervosa. About one in five deaths is due to suicide, and the standardized mortality ratio for anorexics (risk of dying compared to the general population) has been estimated at between 5.86 (Arcelus et al. 2011) and 9.6 per cent (Nielsen 2001). The difference in these estimates could be in part due to the differing length of follow-up in the studies, as the longer the follow-up period, the greater the risk of mortality in the comparison population too, or to the introduction of increasing numbers of specialist care units for people with eating disorders, or simply to differences in the reporting of anorexia nervosa as the cause of death (Smink et al. 2012). Nevertheless, the evidence is consistent with the view that anorexics have about three times the risk of dying as people with other psychiatric illnesses (NICE 2004).

Steinhausen (2002) has conducted an exhaustive study of 119 outcome series published between 1950 and 2000, comprising nearly 6,000 patients followed up for varying lengths of time. Poor outcome has been associated with

a later age of onset of the disorder, a longer duration of the disorder before treatment, psychiatric comorbidity, poor family relationships and low body weight at discharge from treatment, vomiting, bulimia and purging, chronicity of illness and obsessive compulsive personality symptoms. Extrapolating from evidence from several studies, there is also a view that people who manage to adhere to programmes of treatment do better than those who do not, and that people who drop out from or reject treatment are more likely to have poorer long-term outcomes (Dejong et al. 2012). A fatal outcome has been associated with longer duration of illness, bingeing and purging, comorbid substance abuse, and comorbid affective disorders (Herzog et al. 2000).

## Bulimia nervosa

Bulimia nervosa is perhaps in some ways a more dangerous condition, if only because it is not easily recognized by other people. Bulimics are usually of normal weight. They are usually young women who have powerful urges to overeat which they alternate with periods of starving themselves or, worse still, of vomiting or purging in order to control their weight. It is possible to suffer from bulimia nervosa for many years without even close family members guessing that the person has a problem. Bulimia nervosa was first described by Gerald Russell (1979) who defined sufferers as experiencing a morbid fear of becoming fat, having powerful and intractable urges to overeat, and avoiding the fattening effects of food by self-induced vomiting or purging, or both.

*DSM-5* criteria for bulimia nervosa require that the person has 'recurrent episodes' of binge eating in which they feel out of control of eating, and where they eat more food in a two-hour period than other people would eat under similar circumstances. In addition, they use 'inappropriate compensatory behaviour' in order to prevent weight gain; for example they purge themselves by inducing vomiting, taking laxatives, diuretics or other medications; they may diet rigidly or starve themselves periodically or take excessive exercise in a bid to counteract the effects of overeating. Binge eaters qualify for a diagnosis of bulimia nervosa if they binge and attempt to compensate for their behaviour once a week or more on average for three months. In addition, their evaluation of themselves is 'unduly influenced' by their body shape and weight (see American Psychiatric Association 2013).

Bulimia nervosa may be of the purging or of the non-purging type. Purgers are currently engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas. Non-purgers have used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but have not regularly purged.

Many bulimics start the day by eating nothing or very little, then possibly are 'good' at lunchtime with a yoghurt or an apple. Typically, bulimics

eat low-calorie meals, with an emphasis on fruits and vegetables when they are not bingeing. As the day wears on, they may be overtaken by the urge to eat more and will find themselves unable to stop. After eating a meal, or perhaps just one snack item, they may go on to eat several meals or several items of food, typically high in calories, carbohydrates and, in particular, fats – packets of biscuits, confectionery, cereals, and so on. They may stop eating only when uncomfortably full, or if interrupted. After an eating binge, they experience extreme guilt and anxiety. Days of binge eating bouts may alternate with several days of strict dieting or starving. Bulimics usually binge in private, hiding the problem from other people, with whom they will appear to eat normally. Often, they do not eat normal meals at all, for fear of overeating, or of eating foods too high in fats or carbohydrates. Some have reached a stage where they have difficulty in experiencing hunger or knowing when they have reached ‘fullness’ at the end of a meal. Others may have come to experience a feeling of fullness after a meal as evidence of overeating and the likelihood of weight gain, thus triggering a purge response after binges or even meals of decreasing size. Ironically, despite repeated attempts to eat less or to diet, many bulimics eat more calories altogether than do normal eaters as their total intake may be larger and consist primarily of dessert and snack foods, containing a large percentage of fat. Some researchers have suggested that bulimics can consume up to 5,000 kcal in one binge, and others have suggested that they can take between three and 27 times the recommended daily caloric intake (for a discussion of binge content, see Fitzgibbon and Blackman 2004).

For many bulimics, eating may be followed immediately by vomiting, perhaps once, or several times, until the sufferer feels her digestive system has been ‘flushed out’. Some vomiters will use this means of purging themselves perhaps on two or three occasions per week. Others find themselves vomiting up to five or six times a day, directly after eating any but the most ‘slimming’ foods. Some bulimics can vomit only after consuming a very large amount of food. They can therefore become trapped in a vicious cycle. Once having discovered the possibility of vomiting, they will use it whenever they have broken their self-imposed dietary restrictions. Hence, if they overeat on only one occasion or eat one item of ‘forbidden’ food, they may decide to vomit and therefore eat to fullness in order to do so. Some patients induce vomiting by inserting their fingers into the throat; this may cause the tell-tale sign of abrasions and calluses on the hand and knuckles (Russell’s sign). Other patients use an implement such as a spoon or toothbrush. For some people, vomiting may be so well practised a habit that sufferers have learned to vomit simply by leaning forward. Many people will have learned also to use specific ‘markers’ in their food; for example, eating tomatoes or red pepper at the beginning of a planned binge in the erroneous belief that when they see red in their vomit this will signify that they have been able to purge themselves of all the food they have consumed.

About 27 per cent of bulimics have used laxatives, most commonly of the stimulant type. A small proportion of people with more severe forms of

eating disorder also use chewing and spitting out food without swallowing as a means of ridding themselves of excess calories (Kovacs et al. 2002).

### Who develops bulimia nervosa?

Sufferers are usually women between the ages of 18 and 34, with an average age of 24 years. The disorder has its onset, on average, between the ages of 16 and 18, and in the majority of sufferers follows a period of extreme dieting and loss of weight. People present themselves for treatment between one and five years after the disorder has started.

Because of the hidden nature of eating disorders, in normal-weight bulimia in particular, there is growing awareness that they may be more prevalent than we currently realize, affecting a wide range of people including anorexics and ex-anorexics. Christopher Fairburn conducted a series of surveys in Oxford to estimate the prevalence of binge eating and bulimia nervosa in the general population. He concluded that the point prevalence of bulimia nervosa among adolescent and young adult women is between 0.5 and 1.0 per cent, with a lifetime prevalence closer to 2 per cent, reflecting the fact that the disorder has a limited lifespan (see Fairburn and Beglin 1990; Fairburn, Hay and Welch 1993). Meanwhile, researchers in the United States have conducted surveys which suggest that the problem is widespread there too.

Estimates of prevalence have varied as widely as between 1 and 20 per cent – largely because of the wide variations in definition. When studies using comparable strict criteria are examined (where minimum frequency of binges is at least eight or four per month), lifetime prevalence of bulimia nervosa appears to be between 1.0 and 1.6 per cent of young adolescent and adult women (see Fairburn and Beglin 1990; Trace et al. 2012).

Little has been said about males with bulimia nervosa, but Carlat and Camargo (1991) have reviewed the literature between 1966 and 1990 and have concluded that it affects approximately 0.2 per cent of adolescent boys and young adult men, and that 10–15 per cent of all bulimics identified in community-based studies are male.

### Bulimia nervosa and purging

Since the early descriptions of bulimia nervosa, there has been a vast amount of interest in the disorder and its treatment and considerable discussion about the criteria necessary for defining it. One reason for this appears to lie with the increasing awareness that there is much overlap between the behaviour of anorexics, bulimics and, indeed, some obese people. For example, about one-quarter of sufferers may have been anorexic in the past, and between 30 and 40 per cent have previously been overweight. Also, there is a large question-mark over the necessity for sufferers to use purging behaviours in order to qualify for a diagnosis of bulimia nervosa.

Nevertheless, most research and treatment studies have focused mainly on bulimics who purge. In a review paper addressing the subtyping of bulimics, Mitchell (1992) noted the suggestion that purgers have more body-image disturbance and more anxiety about eating than do non-purgers, greater problems with concentration, feelings of guilt, worthlessness and more suicidal ideation. Non-purging bulimics, however, tend to be overweight as well as older, and they binge eat less often than do purgers.

However, most people who come for treatment are likely to use purging of some form or other. In one sample of 245 bulimics, nearly 80 per cent used two or more forms of purging behaviour, and only 16 per cent of those who did purge relied on vomiting alone (Tobin et al. 1992). Frequency of purging is often seen as a marker of severity. Keel and her colleagues have suggested that it is associated with general psychopathology – for example, a greater degree of depression, impulsivity, and anxiety and personality disorder diagnoses – and that the use of multiple methods of purging is a better indicator of severity of the eating disorder itself than the frequency of purging (Edler et al. 2007).

### Bulimia nervosa and other problem behaviours

The majority of bulimic patients experience clinical depression at some point (Hudson et al. 2007), and in a national survey in the United States, 27 per cent of adolescents endorsed three or more comorbid disorders (Swanson et al. 2011). Many authors have noted that some bulimics have an increased prevalence of other disturbed behaviour, such as abuse of alcohol and illicit drugs, sexual promiscuity, self-harm and suicide attempts (see Waxman 2009 for a review). In one American study, nearly 40 per cent of inpatients, in particular those with bulimia nervosa, exhibited self-injurious behaviours – for example, hair pulling, scratching, cutting (Claes and Vandereycken 2007) – while, in an extensive review of outpatient studies, Sansone and Levitt (2002) concluded that the prevalence of self-injury in bulimic outpatients was 25 per cent and that of suicide attempts 23 per cent. On the basis of these specific problems with impulse control, Hubert Lacey proposed a subtype of bulimia nervosa called ‘multi-impulsive’ bulimia (MIB) to describe people who exhibit three or more impulsive behaviours (Lacey and Evans 1986).

An alternative way to view this phenomenon is that it is largely part of a continuum linked with severity of clinical disturbance. This notion fits in with clinical experience which suggests that the more disturbed and upset the person, the more likely they are to resort to other means of improving their mood such as drugs and alcohol, the more likely they are to discover the utility of stealing to obtain large supplies of food, and the more likely they are to be driven to attempts at self-mutilation or suicide. In her review, Waxman (2009) cites evidence to suggest that some

individuals with MIB start showing impulsive behaviours well before the development of eating disorder symptoms. Hence, in one study, the author reported that 80 per cent of individuals with MIB engaged in self-mutilation or suicide attempts before displaying eating disorder symptoms. What is more, multi-impulsivity was associated with the loss of a parent in childhood (by divorce, death or separation) and a greater likelihood of having been physically, sexually or emotionally abused as children. These differences suggest that rather than necessarily being the result of eating disordered behaviours, the multi-impulsive behaviours seen in people with eating disorder may themselves be an expression of an attempt to cope with major psychological distress, of which binge eating and purging are just one manifestation.

An additional area for concern has been the nature and extent of the binge eating itself. A binge is, by its very nature, private, inaccessible to the public eye, and diagnosis is therefore reliant on self-report of varying clarity and reliability. In order to ensure some uniformity across cases, the *DSM-5* criteria specify a minimum average of one binge eating episode per week for at least three months, and eating a large amount of food within a two-hour period. It is, of course, possible to experience binge eating without actually fulfilling the *DSM-5* criteria for an eating disorder. Estimates of admitted binge eating in females have ranged from 20 per cent in a community survey of women of reproductive age to 90 per cent in a sample of college students.

### Characteristics of a binge

The term 'binge' is used differently by different people. For example, the following descriptions might be given by three different people to apply to a binge:

- two meals plus a packet of biscuits and a box of cereal;
- a couple of bars of chocolate and two apples;
- a bowl of cereal or a sandwich (i.e., after consuming what others would regard as a normal or even a very small amount of food).

Some researchers in the field have relied on their own varying definitions of a binge, but others have followed those prescribed in successive revisions of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

- 'rapid consumption of a large amount of food in a discrete period of time, usually less than two hours' (*DSM-III*: American Psychiatric Association 1980);
- 'rapid consumption of large amounts of food in a discrete period of time' (*DSM-III-R*: American Psychiatric Association 1987: 68);

(Continued)

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- 'eating, in a discrete period of time, an amount of food that is larger than most people would eat during a similar time period or under similar circumstances' and 'a sense of lack of control over eating during the episode' (*DSM-IV*: American Psychiatric Association 1994: 549; *DSM-5*: American Psychiatric Association 2013).

Many binges in bulimia nervosa and binge eating disorder consist of large quantities of calories, in the range of 2,000–5,000 kcal. However, there is also a wide variation in the size of perceived binge episodes, and many reported binges consist of very small to moderate amounts of calories (Wolfe et al. 2009).

Hence, some clinicians and researchers make the distinction between objective and subjective binges.

Whether bingeing is subjective or objective may make no difference to the outcome of treatment (Dalle Grave et al. 2012).

Like anorexia nervosa, bulimia nervosa can take its toll physically on the health of sufferers. Amenorrhoea has been described in between 7 and 40 per cent of female sufferers, and a higher proportion, between 37 and 64 per cent, are likely to have irregular menstrual cycles (Pinheiro et al. 2007). Some bulimics experience oedema and possible kidney dysfunctions. Potassium, chloride and hydrogen ions are lost in the vomitus, resulting in symptoms of muscle weakness, constipation and headache. Sufferers also experience palpitations, abdominal pain, easy fatiguability, sore throat and swollen salivary glands. The disorder leads to a predisposition to cardiac arrhythmias. Many bulimics have dental problems, and, indeed, their condition may first be picked up by their dentists, as the continual presence of vomitus in the mouth can cause tooth enamel to dissolve.

### What happens to people who have bulimia nervosa?

A large number of outcome studies has been published since the disorder was first described. Steinhausen and Weber (2009) have conducted a meta-analysis of 79 study series covering over five and a half thousand patients between 1981 and 2007. Patients in these studies were followed up for between 6 months and 12.5 years with an average of three months. The course of their eating disorder varied greatly between individuals: about 45 per cent of the patients had a full recovery, 27 per cent improved 'considerably', but nearly 23 per cent had a chronic, protracted course. Just over a fifth of sufferers in 23 studies had crossed over to another disorder at follow-up, chiefly a subclinical form of bulimia nervosa, but with nearly 6 per cent developing anorexia nervosa. The authors of another review of follow-up studies note that the route to recovery in bulimia nervosa is also

characterized by remission and relapse and frequent diagnostic crossover (Crow and Brandenburg 2010).

Bulimia nervosa is not generally seen as presenting as serious a risk to health as the less common anorexia nervosa. Nevertheless, there are some people for whom the disorder can be chronic, long term or even life threatening, with a standard mortality ratio of 1.93 per cent (Arcelus et al. 2011). In a follow-up study of over 900 bulimia nervosa sufferers, 23 per cent of those who died had committed suicide (Crow et al. 2009).

The relationship between other factors and outcome is not clear, with different studies citing different views; for example, with regard to perfectionism, emotional lability and self-esteem. There were, however, consistent findings regarding the relationship between the existence of multi-impulsive behaviours and substance use disorders with poor outcome. Good social adjustment and close relationships were identified as positive prognostic factors in some studies, while a high degree of psychosocial stress and low job status were considered negative factors (Steinhausen and Weber 2009). Also, several authors have concluded that recovery is more likely the earlier the person receives treatment (see Reas et al. 2000; Steinhausen and Weber 2009). Thus, it seems that bulimia nervosa is 'a serious disorder with unsatisfactory recovery and improvement rates' and that many sufferers 'continue to have chronic eating disorder problems and other comorbid psychiatric disorders over extended periods of their lives' (Steinhausen and Weber 2009: 1338). Whether or not people with binge eating or purging problems present themselves for treatment, their behaviour can have a significant effect on their daily life. In a community-based study of 3,000 people in Australia, the number of days participants reported as being unable to fulfil their normal role at home or at work was significantly higher in people who admitted to binge eating or purging (Mond and Hay 2007). At the same time, however, 60–75 per cent of sufferers do not request treatment for an eating disorder even if they have been treated for associated mental and physical problems (see review by Mond et al. 2007).

## Binge eating disorder

A third major category of eating disorder is that of binge eating disorder (BED). Like people with bulimia nervosa, people with binge eating disorder experience episodes of binge eating characterized by eating large amounts of food in a short space of time and a sense of lack of control while eating. Sufferers are likely to eat more rapidly than normal, to eat when not hungry and/or past the point of fullness. Most feel guilty and embarrassed about their perceived overeating and frequently eat in secret. Unlike bulimics however, people with binge eating disorder do not usually compensate for their behaviour by restricting or purging or by other means. The *DSM-5* specifies that episodes of binge eating take place at

least once a week for three months in order to qualify for the diagnosis of binge eating disorder (American Psychiatric Association 2013). Most, but not all, people with binge eating disorder are obese; they experience marked distress about binge eating but cannot be diagnosed as having bulimia nervosa as they binge eat without regularly attempting to compensate for their binge eating behaviour. For many years, questions revolved around whether binge eating disorder is a distinct clinical entity in its own right, separate from bulimia nervosa and other disorders. Questions focused on three areas: how far it can be distinguished from bulimia nervosa or anorexia nervosa; how far it is simply a variant of bulimia nervosa; and how far it is a subtype of obesity, for as body mass increases, so do rates of binge eating (for a fuller discussion see Devlin et al. 2003.) Robert Spitzer, with several other researchers in the obesity field in the United States, conducted a survey of several weight control programmes together with a large community survey. Spitzer's group was the first to suggest that the disorder, which includes the key aspects of loss of control and distress about the binge eating, affects about 30 per cent of people attending hospital-based weight control programmes but only 2 per cent of normal-weight people and 4 per cent of obese people in the community (Spitzer et al. 1992). They concluded that binge eating disorder was associated with a lifetime history of severe obesity and frequent significant weight fluctuations, and may be slightly more prevalent in the general population than purging bulimia nervosa. They proposed that the disorder be treated as a diagnostic category in its own right in the *DSM*; and in a second multi-site study they found that this group of people also experienced several additional problems which could qualify for psychiatric disorder, including impaired work and social functioning, over-concern with body shape and weight, general psychopathology, and a strong history of depression, alcohol or drug abuse and of treatment for emotional problems (Spitzer et al. 1993).

Several other studies have also suggested that people with binge eating disorder experience high levels of subjective distress, impairments in quality of life, and comorbid mental disorders similar to those experienced by people with other eating disorder diagnoses and to a greater degree than do obese people without binge eating disorder (Wonderlich et al. 2009). Unlike bulimia nervosa, according to Spitzer and colleagues, binge eating disorder was only slightly more common in females than in males in the weight-control samples and was equally common in males and females in the community non-patient and college samples. Hudson and colleagues applied the *DSM-5* criteria to an earlier large population study in the United States and estimated that the lifetime prevalence of binge eating disorder could be as high as 3.6 per cent in women and 2.1 per cent in men (Hudson et al. 2012). Meanwhile, in Europe, the lifetime prevalence of binge eating disorder has been calculated as somewhat lower, at 1.9 per cent for women and 0.3 per cent for men (Prete et al. 2009).

Another important difference between people with binge eating disorder and those with bulimia nervosa is found in the temporal relationship between weight worries and dieting behaviour and the start of binge eating. Whereas, for most bulimics, dieting precedes binge eating, for many people with binge eating disorder, bingeing long precedes dieting as a major problem and obesity develops several years later. Of binge eating sufferers, 45 per cent reported dieting before starting to binge eat in one research study, whereas 55 per cent reported binge eating before their first diet (Spurrell et al. 1997). The 'binge-first' group had started binge eating at a younger age than did the 'diet-first' group, and also had a history of more psychiatric problems.

Sufferers of binge eating disorder are likely to have poorer social functioning, higher levels of disability and more health problems than do people without eating disorders (see Wilfley et al. 2003). Although it is linked with obesity, obese and non-obese sufferers have similar characteristics in terms of eating pathology and levels of depression. However, non-obese sufferers are usually younger and less willing to present to mental health services than are their obese counterparts and this raises the question of whether they are indeed the obese people of the future (Dingemans and van Furth 2012).

Any therapist who is asked to treat people with eating disorder is likely to be faced with the need to provide an effective treatment for the condition, however categorized. This consideration becomes increasingly important with the rapid rise in the population of obesity. Obesity is classified as a body mass index (BMI) of 30 kg/m<sup>2</sup> or over. In the United States, surveys in 2009–10 found that over 35 per cent of adults were obese (International Association for the Study of Obesity 2012). The rest of the Western world is fast catching up with this epidemic. In Britain, in 1980, only 7 per cent of the adult population were obese. This figure had more than doubled by 1993 to 15 per cent and in 2010, just over a quarter of adults (26 per cent of both men and women aged 16 or over) were classified as obese. It is likely too that among the remaining 75 per cent of the population, about half has a body weight higher in relation to their height than the desirable range (Wiseman 1996).

### Binge eating in obesity

Possibly 50 per cent of obese people suffer with binge eating problems. The question often arises as to how far obesity is itself an expression of eating disorder, and therefore it is relevant to discuss it briefly here. Obesity results from an excess of energy intake over expenditure. On average, obese people have been found to expend more energy than normal-weight people; therefore they must, on average, take in more food in order to remain obese (see Garrow 1988). This idea has for a long time formed the basis of an assumption that obese people must eat more than lean people in order to be fat. However, the vast amount of research time and effort that has been expended on the question of whether obese people eat more than do people

of normal weight has yielded inconclusive results. Obese people, knowing themselves to be prey to comments such as 'he/she shouldn't be eating that', seldom admit to overeating, or to eating in response to negative mood, even if they perceive themselves as doing so. When bulimia nervosa was first described, the emphasis was on binge eating in people of normal weight and descriptions of obese people distressed by overeating were fairly rare.

One of the first descriptions of binge eating in obese people was that of Stunkard (1959), an American research psychiatrist who noted that a small proportion of his patients (less than 5 per cent) binge ate, some of them at night. Hilde Bruch (1974) pointed to a higher proportion of her patients with similar problems, but her numbers would naturally have been greater as she was a psychiatrist who was known for her interest in people who struggled to control their food intake. More recently, there has been evidence, from both clinical observation and research, that up to 50 per cent of obese people binge eat. At least a small proportion could be said to meet the *DSM-5* criteria for bulimia nervosa or binge eating disorder. In a population survey in South Australia in 2005, one in every five people suffering obesity also admitted to suffering from comorbid eating disorder behaviours, chiefly in the form of binge eating, but also including strict dieting and purging behaviours (Darby et al. 2009). What is more, the prevalence of comorbid obesity and eating disorder behaviours had increased more in the previous ten years than had the prevalence of either obesity or eating disorder alone.

## Feeding or eating disorder not elsewhere classified

Until recently, the term 'eating disorder' applied largely to either anorexia nervosa or bulimia nervosa. As with many classification systems, this produced the difficulty that, if a person had an eating problem, health professionals would try very hard to make it 'fit' one of the two descriptions, possibly ignoring the features that singled the person out as being different; or they would assume that the person did not really have an eating disorder at all. However, it is now recognized that at least 50 per cent of people with eating disorders fit some, but not all, of the criteria for either anorexia nervosa or bulimia nervosa. For example, they may have all the features of anorexia nervosa but, despite significant weight loss, their weight is either within or above the normal range (perhaps in a previously obese or overweight person who has lost a large amount of weight through strenuous dieting); or they may have all the features of bulimia nervosa but with attempts to compensate for overeating that do not reach current *DSM* criteria for duration or frequency.

There has been much discussion about how to characterize people with so-called 'atypical' eating disorders and about whether these people merit assignment to a specific psychiatric diagnosis. This is largely because the nature of the difficulties varies so greatly and because as yet they have no easily definable common 'course' or outcome. Hence, these people are

currently classified in the *DSM-5* in a section entitled 'Feeding or Eating Disorder Not Elsewhere Classified' (FEDNEC).

One such group is the group identified as suffering with 'purging disorder'. Sufferers are people who, like bulimics, regularly purge, ostensibly in order to control their weight, and whose self-evaluation is unduly influenced by body shape or weight or an intense fear of gaining weight or becoming fat (Keel and Striegel-Moore 2009). Unlike bulimics, they either do not binge eat or their binge eating, if it occurs, is subjective rather than objective. Studies have reported average age of onset around 20 years, with estimates of prevalence similar to that of anorexia nervosa and bulimia nervosa (Keel 2007) and higher in girls than in boys (Keel and Striegel Moore 2009). In a Canadian study of nearly two thousand adults referred to a tertiary treatment centre, the authors reported that 6.7 per cent of the people referred met criteria for purging disorder in which the criterion for purging was at least once a week. The patients in this group showed high levels of emotional distress, evidenced by psychological test scores which were comparable to those of people with bulimia nervosa or anorexia nervosa-binge subtype on symptom-related eating disorder scales, and high levels of mood disturbance (Tasca et al. 2012).

Also included in the FEDNEC category is a group identified largely in the United States as suffering with 'night eating syndrome' as originally reported by Stunkard and his colleagues in 1955 (Striegel-Moore et al. 2009). This refers to people who report eating large amounts of food in the evening (between 25 and 50 per cent of their daily intake) coupled with low mood, and/or who wake up to eat at night with varying degrees of severity and duration, and some of whom also suffer with insomnia. Sufferers have full awareness of their behaviour and are distressed by it, but researchers who have described the phenomenon hold that it is not better explained by binge eating disorder. Several studies have suggested that this phenomenon is widely prevalent in the obese population, and estimates are especially high in centres offering specialist treatment for bariatric surgery and in groups of binge eaters. However, cases have been noted in non-obese people also, and it is not known how frequently the syndrome occurs in the general population or how far it overlaps with binge eating disorder.

Categorizing people with eating disorders has some utility in terms of enabling description and in relation to carrying out research into the treatment of groups of patients with a specific presentation. However, in relation to the 1994 version of the *DSM* (American Psychiatric Association 1994), only half of sufferers met the criteria for the chief categories of eating disorder, anorexia nervosa and bulimia nervosa, and the remaining half fell into the broad group entitled 'Eating Disorder Not Otherwise Specified', indicating that there is a range of symptoms and severity demonstrated in the majority of sufferers, who might be better served by investigation of their problems on an individual basis rather than by categorization into a group with which they have only a tenuous similarity. Further subdivision of sufferers into different categories may serve little purpose either for sufferers themselves

or for the mental health professionals who are tasked with attempting to offer treatment. This question is discussed by Fairburn and Cooper (2007) who espouse the idea of a transdiagnostic approach to eating disorders, with a focus on treatment of the problems experienced by sufferers rather than on a disorder-specific approach which attempts to slot people into arbitrary diagnostic categories with as yet few implications for prognosis or treatment.

## Other causes of weight loss or gain or unusual eating behaviours

One possible danger of broadening the characterization of eating disorders is that people with atypical symptoms may slip through the medical net and be referred for therapy when, in fact, the symptoms they have are signs of other psychiatric illness or of underlying medical conditions rather than of a primary disorder of eating or feeding. Even more problematic is the case where a true eating disorder is exacerbated by medical illness which is therefore not diagnosed because of the concordance of its symptoms with that of the original disorder.

Both schizophrenic and depressed patients may lose weight and show signs of food avoidance, the former perhaps in response to delusions about specific foods and possible poisoning, and the latter as a result of true loss of appetite or anorexia; and, in the case of women, both may experience amenorrhoea in response to starvation. Neither, however, will demonstrate the intense drive for thinness nor disturbance in body image seen in anorexics, and the depressed person is unlikely to appear to be starving him- or herself on purpose.

Some medical causes of weight loss or reduced calorie intake include gastrointestinal disorders such as Crohn's disease and coeliac disease, and a variety of central nervous system disorders, including lesions of the hypothalamus (the centre in the brain controlling hunger), many infections such as tuberculosis, and, most commonly, malignancies involving in particular the gastrointestinal tract, pancreas and liver. Most of these sufferers will experience genuine anorexia or lack of hunger, and will deny intentional weight loss. This is in contrast to the person with anorexia nervosa, who may claim to have lost all desire for food or to take pride in the ability to refrain from eating; or who, with careful interviewing, may admit to a voracious hunger accompanied by intense fear of satisfying that hunger and of losing control around food and gaining weight, together with disturbed attitudes and beliefs about weight and shape and their importance in that person's life. Because of the strong tendency of some anorexics to deny hunger, or problems around weight and shape, it is possible for people with some other illnesses to be referred even after a thorough medical or psychiatric assessment. Their very denial will be interpreted as evidence of eating disorder, and they arrive in the consulting room of the therapist with

a diagnosis of eating disorder and a request for psychological treatment. Therefore, it is essential that therapists who express an interest in treating people with eating disorder are on the lookout for such possibilities, which do occur, if rarely (see Winston et al. 2006 for one such example).

Medical causes of overeating may include central nervous system lesions, such as tumours involving the hypothalamus or frontal lobes, traumatic brain injuries and some degenerative disorders, including the later stages of Alzheimer's disease, central nervous system infections and seizure disorders, in particular those involving the temporal lobes. (For a review of medical illnesses associated with weight loss and binge eating, see Kaplan and Katz 1993.)

Other psychological causes of eating difficulties are included in the term 'feeding disorder'. For example, people with 'avoidant or restrictive food intake disorder' may refuse food and suffer significant weight loss or nutritional deficiency due to extreme dislike or a learned fear response, for example with regard to vomiting or choking; and individuals with 'pica' may exhibit persistent eating of non-nutritive, non-food substances such as earth or faeces, possibly in relation to developmental difficulties. It is true that some mental health professionals, with a grounding in theories of learning and behaviour, will be well placed to offer advice and treatment regarding such difficulties. However, for the purposes of this book, the focus will be largely on the person with an eating disorder who exhibits psychopathological features such as a drive for thinness, a fear of fatness, an abnormal preoccupation with body weight and shape, and an unusual investment in these considerations as a basis for their self-esteem and self-confidence. It is towards these features that serve to maintain the disorder and sabotage attempts to change, in addition to the eating behaviours themselves, that therapy must be directed. A major consideration to take into account, then, is that of what features in a client's life or personality may have rendered them vulnerable to acquiring an eating disorder, and what factors might have helped to fix and sustain the behaviour and attitudes that characterize it.

## Conclusion

This chapter has summarized the eating habits, behaviours, and symptoms described by people with eating disorders. Much of the existing research is based on a classification dictated by successive versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. However, the relationships between eating habits, weight and psychopathology are complex and clinicians need to be aware of the limited utility of adhering to a system which is itself the subject of frequent debate and criticism, and bear in mind the individual nature of eating disorders. Many sufferers experience other mental health problems and psychological issues which can influence the course and outcome of their eating disorder.

In this context, it is important for clinicians to bear in mind the notion that a disturbance in eating or purging behaviour may reflect a need to control or escape from intolerable emotions. There is continuing discussion around the incidence and prevalence of eating disorders and the question of whether they are on the increase or are simply detected more frequently today than previously. The chapter has also summarized other causes of over- and under-eating and emphasizes the importance of differentiating between eating disorders and other psychological causes of eating difficulties as well as between difficulties of a psychological nature and those which may stem from a medical condition.

The following chapter will focus on the causes of eating disorders and will pay some attention also to the psychological aspects of obesity and the difficulties faced by people attempting to radically change their eating behaviour in order to lose weight.