ANOREXIA NERVOSA AND BULIMIA NERVOSA: WHAT KNOWLEDGE OF DIAGNOSIS AND PATHOGENESIS HAS TAUGHT ABOUT TREATMENT

Paul E. Garfinkel

Anorexia nervosa (AN) and bulimia nervosa (BN) are complex disorders that have become common in the past 15 years (Garfinkel & Garner, 1982). AN is characterized by an all-consuming pursuit of thinness that overrides the patient's physical and psychological well-being. The person begins to diet ostensibly to alter her weight, but this desire is often a screen that masks a pervasive sense of helplessness (Bruch, 1973). Pursuing a thin body becomes an isolated area of personal control in a world in which the individual feels ineffective; the dieting provides an artificial sense of mastery and control. As the weight loss progresses, a starvation state ensues, which eventually develops a life of its own, leading to the features of AN.

Bulimia is characterized by episodic patterns of binge eating with a sense of loss of control, a preoccupation with a thinner shape and extreme efforts to lose weight, and is usually accompanied by depressive moods. Bulimia can occur as a symptom in many illnesses, including AN, and as a separate syndrome, with little weight loss (BN). In both AN and BN there is a distorted drive for thinness and subsequent dieting based on the person's conviction that the body is too large. There is usually an associated dissatisfaction with one's body, which may reach a level of loathing.

AN occurs in about 1% of young women and BN occurs in 2 to 3% of women. Mild variants of these disorders occur in about 5% of women. About 95% of cases are female. These eating disorders remain serious problems, causing significant mortality (about 5%) and morbidity (about 25% of patients develop a chronic form). Outcome studies regularly report that chronicity is a major variable affecting prognosis (Garfinkel & Garner, 1982). This means that early recognition of incipient cases is of great value. However, because there is often a denial of illness and a sense of shame in some of the symptoms, patients may be very reluctant to come forward for treatment. As a result, many patients go undiagnosed; a recent study from Scotland found that of 146 patients hospitalized for psychiatric illness, 14% had an eating disorder, most often undiagnosed (Kutcher, Whitehouse, & Freeman, 1985).

DIAGNOSTIC ISSUES

Views about the nature of AN have passed through several phases. It was first described
by Gull (1874/1964) and Lasegue (1873/1964) as a psychological disorder with physical manifestations. For the first quarter of this century, however, understanding of AN was greatly influenced by Simmond’s (1914) description of pituitary insufficiency. More recently, there has been a clearer distinction made between the biological and psychological nature of the illness. There has also been some clarification of the relationship between bulimic and purely dietary restricting forms of AN and between AN and BN.

Heterogeneity of Anorexia Nervosa

Subtypes of AN have been recognized since Janet (1919) described obsessional and hysterical forms. He differentiated these on the presence or absence of hunger. This distinction was reintroduced by Dally (1969), but it has not been supported by research, which has shown that true anorexia is rare until late in the starvation process (Garfinkel, 1974). However, Janet’s and Dally’s observation that certain symptoms such as vomiting, bulimia, and mood lability clustered together in one group of patients was an important insight. It led to later differentiation of the bulimic subtype.

Bulimia as a symptom of various illnesses has been recognized at least since its description in the Babylonian Talmud (Kaplan & Garfinkel, 1984), written around the year 400. It was first associated with AN in the 19th century. For example, Gull (1874/1964) mentioned overeating in a patient with AN. He noted: “Occasionally for a day or two the appetite was voracious,” but this was rare.

Recent studies (e.g., Garfinkel, Moldofsky, & Garner, 1980) have described the significance of bulimia in AN. The presence of bulimia has characterized a group of anorexic patients with special features. Garfinkel et al. found that bulimic anorexics were more likely than dietary restricters to have been premorbidly obese, to have mothers who were obese, to vomit, and to abuse laxatives. The bulimic subjects were more impulsive than the restricting group. They were more likely to use alcohol or street drugs, to steal, to mutilate themselves, to be more sexually active, and to have labile moods. They have also been found to have an impulsive cognitive style (Toner, Garfinkel, & Garner, 1987) and frequent borderline-narcissistic character disorders (Piran, Lerner, & Garfinkel, 1988).

The Relationship Between the Bulimic Form of AN and BN

Garner, Garfinkel, and O’Shaughnessy (1983) found that when bulimics who never met weight loss criteria for AN (i.e., BN), anorexic-bulimic, and anorexic-restricter groups were compared on demographic, clinical, and psychometric variables, the normal-weight bulimic group closely resembled the anorexic-bulimic group. They argued that the presence or absence of bulimia could be of greater diagnostic and etiologic significance than a history of weight loss. While there is clinical value in considering patients with BN and the bulimic form of AN to have many similarities, there must also be differences between these groups which at present are poorly understood.

Anorexia Nervosa and the Continuum of Weight-Preoccupied Women

Some investigators have regarded AN as qualitatively distinct, while others support its existence along a continuum (see Garfinkel & Kaplan, 1986). Nylander (1971) was the first to study this systematically. He studied Swedish adolescents and found that 10% had at least three “anorexic” symptoms associated with weight loss, while 0.06% presented with actual AN. He stated that the difference between these “mild” and “serious” cases was of degree only, related to the intensity of the starvation symptoms. Button and Whitehouse (1981) have recently described a group of patients with “subclinical anorexia nervosa.” These