CHAPTER 6

Bulimia —
A Subgroup of Anorexia or a Separate Disease?

“There is no love sincerer than the love of food.”

G. B. Shaw, Man and Superman, 1, 1903

The question of whether bulimia can be classified as a separate disease or as a part of the anorexia nervosa syndrome is still unresolved. The approach taken to this question depends on both the aspects investigated and compared, as well as the school of thought of the therapist and the resulting conception of the development of the disease and its subsequent treatment.

Bulimia is the addictive side of the coin of eating disorders. It is characterized by pure impulse. In contrast, in anorexia, one can only assume the covert, implicit element of impulse. What is observable is only the reaction to the strength of the impulse, the compulsive overcontrol and masochistic behavior. It is in this respect, however, that both diseases exhibit severe fixation or regression to an early developmental phase, in which object relations are more or less of an autistic character. In both diseases the body is a part object, and food is personified as an object, though related to it in different ways.

Boskind-Lodahl et al. (1978) resolved the issue of the classification of bulimia by calling the syndrome “bulimarexia,” thus showing that the disease contained characteristics of classical anorexia nervosa. Others called it “binge-purge syndrome.” I myself tend towards the concept of bulimia being part of the spectrum of anorectic disorders. Anorexia and bulimia belong to the same category with regard to character formation, the extent of regression, and object relation. This conceptualization is similar to that of manic-depressive disease. Just as the manic phase and the depressive phase are actually extreme poles of the same disturbance, so too are anorexia and bulimia extreme poles of the same disorder. This is also true in the psychodynamic sense, in which both impotence and omnipotence are expressed in either the anorectic or bulimic phases. Bulimia can be seen as the direct expression of the impulse while anorexia is the expression of the oversuppression of the very same impulse.

This conceptualization is borne out by the fact that most anorectics, when not in treatment, at times exhibit episodes of bulimic behavior. After such an episode the anorectic practices some sort of purification ritual and then reenters an anorectic phase of behavior. It is interesting to note that when impulsive mechanisms like bulimic episodes prevail, they are shorter than the anorectic phase and show an “attack” form. These attacks are usually sudden, and this characteristic is also demonstrated by the various types of dysrhythmic or other-
wise disturbed EEGs that some anorectics exhibit. Most of these individuals respond well to the administration of an anticonvulsive drug such as DPH, which also has an antiaggressive effect (probably via the pathways of the amygdala).

Many bulimics, though not fat, often have similar or identical delusional body images as anorectics (such as seeing their hips as too big, and having fantasies of cutting off perceived oversized parts of the body). I had a bulimic-anorectic patient who, though not thin, had to eat constantly. At the same time she took close to a hundred laxatives a day in order to “cleanse” her body, at which point she was then able to resume her eating experiences. This need to cleanse the body is essentially similar to the ascetic mechanism of anorectics. In contrast, however, the social element in bulimics is not so disturbed. The bulimic is not perceived as a real anorectic and, therefore, will not be as conspicuous and will be able to achieve superficial object relations.

The fear of being unable to stop eating is common to both anorexia and bulimia; it is the fear of inevitability, of going on and on, the fear of something one cannot break. This cycle is well demonstrated in some of Escher’s artistic expression. There is probably a connection between this fear and that of orgastic feelings in some women.

Bulimic attacks also happen during certain phases of dynamic therapy, especially when patients cannot deal with inner anxiety or when therapy threatens them with the opening up of some aspect which requires the expression of deep emotions. Under these circumstances, food is used to enclose those emotions, by the act of devouring everything. It is, therefore, when overcontrol is broken down that compulsive eating, as well as rage and temper tantrums, result. Kleptomania in bulimics can be seen as a release of stored rage, the expression of excitement of impulses, and the need to relieve tension.

Casper (1980) tried to evaluate the characteristics of patients with bulimic attacks. He studied 105 patients who met the criteria for anorexia nervosa. Bulimia was found to be associated with a typical symptom pattern; bulimic patients manifested greater anxiety, depression, guilt, and interpersonal sensitivity, and had more somatic complaints. Casper also found that vomiting and kleptomania happened exclusively in the bulimics. She concluded that the more outgoing personality characteristics of bulimic patients, in connection with diminished impulse and self-control as apparent in a distinct psychiatric symptomatology, differentiate them from fasting patients into a subgroup of anorexia nervosa.

Pure bulimics (a concept somewhat similar to obesity) behave differently from bulimic-anorectic patients. Their behavior is obviously impulsive and their quality of object relation is somewhat more mature. Pure bulimics do have at least superficial object relations. This distinction is noted by Herzog and Copeland (1985) who stated that:

Anorexia nervosa is a syndrome characterized by extreme weight loss, body-image disturbance and an intense fear of becoming obese. Bulimia is a syndrome distinct from anorexia nervosa.