Bulimarexia - an alternative approach to therapy, involving the general practitioner

— M Haus

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Curriculum vitae

Matthias Haus was born in West Germany in 1949 and emigrated to RSA in 1950. He grew up in Stutterheim and East London and matriculated in 1967. He studied at UCT and obtained the MBChB in 1974. After some hospital experience in the Cape, he became a family practitioner in Stellenbosch, 1976–1980. He then went to Red Cross War Memorial Children's Hospital and obtained the DCH(SA) in 1983, the MFGP(SA) in 1984 and the Dip Mid COG(SA) in 1985. In 1985/86, as a paediatric registrar, he commenced research into Immunogenetic aspects of atopic sensitisation towards his MD thesis. In 1986, he was elected to the Council of the College of Medicine (SA). He has recently been appointed to the board of Janssen Pharmaceutica (SA) as the Director for Medical Research and Development. Dr Haus has special interests in primary care and allergic diseases. He is also an outstanding musician, is married and has 3 children.

KEYWORDS: Anorexia Nervosa; Hyperphagia; Physician-patient relations

Summary

Anorexia nervosa seems to be increasing, as well as bulimia. The GP has a good opportunity and a vital role to play in the treatment of these eating disorders. In an extended case report the author explains how an alternative approach to his patient was successful after the failed traditional therapeutic approach.

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Although anorexia nervosa has been recognised as a definite clinical condition for over 100 years,[1,2] many contemporary researchers have experienced an epidemic increase in its incidence[3,4]. The incidence of Bulimia has been similarly increasing[5]. Halmi et al[6] reported that 13% of college students qualified as bulimics, of which 87% were females.

By corollary, bulimarexia, or bulimia nervosa,[7] which is a combination of these conditions, has become a common variant of these eating and weight disorders.

Definitions

Anorexia Nervosa is a dramatic disorder, characterised by behaviour directed towards losing weight, peculiar patterns of handling food, intense fear of gaining weight, weight loss to less than 75% of the patient's original body weight, a disturbance of the patient's body image and amenorrhoea. In a broader sense, it 'constitutes a drastic miscarriage in personal development, amounting in the most catastrophic cases to nihilistic attacks on growth and the pursuit of life itself'[3].

In contrast *Bulimia*, or "Ox Hunger", is an abnormal craving for food, that often results in the gorging or binging of high calorie 'junk' foods such as ice-cream, chocolate or chips, followed by self-induced vomiting. This food is usually consumed so rapidly that it is not properly chewed. "Binging" episodes generate guilt and anxiety, which initiate a repeat of the cycle. The binges are carried out in

great secrecy, since the patient realises that this behaviour is abnormal. Many express a fear that they will be unable to stop the gorging or to end a binge. Unlike anorexia or obesity, bulimia is not diagnosable by weight. It may be clinically reflected either by massive obesity, starvation or some point in-between. Compulsive "binge-eating" is the hallmark of the syndrome, and not the weight of the patient.

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Bulimarexia is a combination of the abovementioned syndromes. The patients binge periodically, but keep their weight in anorexic proportions by either starving between binges, or by the self-induction of post-prandial vomiting, purging or the use of diuretics[8,9]. In one study of anorexics[7], 47% were also bulimic.

Case Report

The case report of a patient with long-standing bulimarexia follows. She had been resistant to conventional treatment while an in-patient of a large psychiatric hospital for six months. The differences between the failed traditional therapeutic approach and the successful alternative in this patient will be discussed. The methods which lend themselves to use by general practitioners will be highlighted.

A 30 year old divorced woman presented to the author in January 1980 with a clear-cut, established problem of bulimarexia. This diagnosis had its origins 12 years earlier, when she began manifesting the signs and symptoms of anorexia nervosa while in her last year at school.

Binging-episodes generate such guilt and anxiety that they initiate a repeat of the cycle

She had always been of slender build. Her adolescence and early adulthood was punctuated with regular and often catastrophic emotional upheavals. Life-events possibly contributing to the development of her condition included the divorce of her parents while in her last year at school, a stormy marriage at the age of 25 years, terminating in divorce, a disastrous domestic move from Cape Town to Johannesburg, the death of her brother while on military service and deteriorating physical well-being owing to a deficient diet. She gradually lost 30% of her previous body weight, subsisting on bits of cheese, raisins and black coffee.

A year before she first presented she had read an article about the possible fatal outcome of anorexia nervosa. This terrified her, and introduced a new dimension to her illness. She started binging on high calorie 'junk' foods in a desperate attempt "to get some food into her system". Each binge, however, revolted her so much in terms of her anorexia nervosa, that she become proficient at inducing immediate post-prandial emesis.

After initial assessment, the author immediately referred her to a large tertiary care psychiatric hospital, where she was admitted for intensive therapy based on a cognitive-behavioural programme. This included the feeding of relatively large quantities of food, negative reward methods (ie "eat the food and keep it down if you want any more visitors"), and confrontation. The inevitable polarisation of opinion between her and the therapists resulted. According to the patient, the therapists seemed to encourage the innuendo that any protracted period of resistance to eating by the patient, presented a non-verbal form of communication to the therapists that treatment in a more restricted institution or environment may be indicated for the patient. A voluntaristic approach to weight gain was absent, and the boundaries of responsibility towards the contractual therapeutic manifesto seemed, in her perception, to be loaded against her. Her privileges were removed because of her lack of co-operation. In particular, the curtailment of her sport and exercise needs were instituted. Her motivation to get well steadily decreased, as well as her will to live. She felt that the objectives of the programme were designed to "break her down" and she attempted suicide unsuccessfully twice towards the end of her stay.

Compulsive binge-eating is the hallmark of the syndrome, and not the weight of the patient

After four months, she discharged herself, and again presented to the author, now at a weight of 31 kg. She was then in Rockwell's Stage II of the disease[10] (where the patient's body weight is between 15% and 40% less than her ideal body weight) and was physically and mentally worse than before. Since conventional methods seemed to have failed, and she was insistent that she would not go back to hospital, the author agreed, as a last resort, to see her at weekly intervals for an hour. A flexible, intensive co-respondent contractual programme, which was the antithesis of the institutionalised approach, was established.

The following fundamental mechanisms and objectives became integral to the therapeutic contract of this patient.

1. The establishment of disciplined eating habits

Since bulimarexia is an eating and weight disorder related to obesity, it seemed logical that emphasis should be allotted to the establishment of a disciplined eating regime. Three meals a day, with nothing in between was a prerequisite. Calorie counting, with a careful selection of non-junk foods,

Anorexia nervosa is a struggle for a self-respecting identity

was another. Paradoxically, and in complete contrast to the institutionalised programme, the patient was started on a 200 calorie per day diet! Since her intake at that time, in-between bulimic behaviour, was about 100 calories per day, pragmatically this was a diet which nevertheless represented a 100% daily increase in calories. This was totally acceptable to her, both physiologically in terms of her previous pattern of intake, and psychologically in terms of her revulsion of food. This calorie intake was incrementally increased over 6 months, until a daily intake of 1000 calories was achieved in a disciplined and step-wise manner. There was no discussion or emphasis on weight and the patient was weighed only occasionally with minimal fuss.

2. The Diary

In order to accurately reflect the level of her emotional tone from day to day, especially preceding a binge followed by the subsequent auto-emetic behaviour, a detailed diary was kept. This diary was not only a 'dear-diary daily talk-book' (Table I) but also an exact record of every meal the patient ate, what the meal consisted of and which meal developed into binges (Table II). By careful analysis of this diary during their therapy sessions every week, the possible precipitating events and the

Fear of growing up and of assuming adult responsibilities is highly characteristic of anorexia

most initmate unresolved conflicts present in the patient's preoccupations were analysed. Total honesty and a sense of significance permeated the diary.

3. The Exercise Factor

Marathon running has been described as an analogue of anorexia[11], particularly the phenomenon of obligatory running. Conversely, anorexics often manifest a similar obsession to do vigorous exercise. Whether this is a deeply-rooted mechanism designed to perpetuate the pathogenesis of anorexic weight-loss, or whether it is a means of obtaining the tranquillising benefit of endogenous endorphin release, is not clear. In contrast to the institutionalised prerogative of minimising exercise, the author encouraged the patient to continue her daily aerobics classes in the hope that this would help to re-establish some sort of routine, allow a daily

Table I: Extract from Diary

Sunday 19 October 1980

Once I've had a bad *binge* like that (Sat) it takes a great effort to pull all together again. To realise that food is not fattening but necessary - only excess leads to 'binges'. I was on a "down" - I think I have got myself back again. But it still baffles me why this happens. What happens to my will power and control, which predominate to a very real extent in the rest of my life? I truly am so sick of all this I just wish I could gain total control. My balance seems to be so precarious at the moment, I am afraid of losing control again. I must keep trying !!

In books they say that anorexics lose their appetites - in my case, at least this is *not true!*

1. Firstly, I was hungry but had amazing will-power to suppress this hunger, basically by keeping as active as possible, avoiding meals, making excuses about feeling ill and deriving a sense of satisfaction and "one upmanship" in seeing others eat (they would get fat and I wouldn't!!!), whilst I didn't.
2. In the final stages you (I) cannot suppress this hunger/craving for food (especially starches and sweets) any longer - so you give in but cannot live with the feeling of guilt that follows so you (I) force it to come up - then follows feelings of disgust, self-loathing and despair so you become further and further woven into this anorexic web.

Monday, 20 October 1980 - 4 am

I just can't sleep - I am worried - why am I losing control again? Everything seems to be tightening in on me, am I ever going to get out of this maze of despair, self-loathing yet also pity? Is this all just an attention-seeking device on my behalf? Why do I do it? Should I be back at the hospital? I simply don't understand why I lose control now. It just shouldn't happen anymore and yet it does. I find it all so baffling and frustrating, because I just don't seem to be able to overcome this last hurdle. I have coped with all the others ie self-confidence, being a worry-bag, being able to laugh again etc. But the *binge* syndrome just seems to be getting the better of me. It is all so futile, a waste of time and totally and utterly pathetic ie *Binging*. Let's be positive, though. Instead of going backwards, let's make this the last *Binge* of my life - control over everything from now on. The thing that started this off was trying to have some chocolate. 'Keep on fighting'. 'Don't give up, you can and must win - there is more to life than fighting food. Get over this obstacle and start to really live'.

Table II: Extract from Diary - Weekly diet sheet and record of binge/vomiting episodes

	Tuesday 14 Oct	Wednesday 15 Oct	Thursday 16 Oct	Friday 17 Oct	Saturday 18 Oct	Sunday 19 Oct	Monday 20 Oct
Breakfast	Muesli	Muesli	Muesli	Cheese	Muesli (only a little)	Provita & Jam	Provita & Cheese
Lunch	Provita, Cheese and Avo	Sausage, Cottage Cheese, Salad	Cottage Cheese, Salad	Salad & Cheese	Cheese & Salad	Braai (overdid it) **Binge**	Cheese & Salad
Supper	Vegies Sausage Salad	Spinach (Chinese) Egg, Meat Bread **Binge**	Spinach Egg 10 pm **Binge**	Fish Pie	Tuna **Binge**		Sausage and Vegies

Note: 1. The week's diary always began on a Tuesday, since the patient's weekly appointment was on a Tuesday.
2. A **Binge** was very seldom experienced on a Tuesday.
3. Most binges were at night, reflecting both the release of a build up of tension throughout the day and the secretive nature of the behaviour.

release of anxiety and motivate her towards re-integration into society. Again, emphasis was placed on accommodating those aspects of her psychic need which demanded fulfilment, in an effort to "build up" rather than "break down", while simultaneously promoting a sense of well-being.

4. The Upliftment of Self

When considering the therapeutic options open to the treatment of anorexia nervosa, it is well to be aware of the aetiological possibilities. The Individual Psychodynamic theory[12] took root from the insistence of Bruch[13,14] that anorexia nervosa was a struggle for a self-respecting identity, which often stemmed from the failure of the parents to regard the patients as individuals in their own right. The Developmental Psychobiological theory was a result of observations by Brown[15], who observed that a fear of growing up and assuming adult responsibility was highly characteristic of anorexics.

Taking these theories into account, it was decided that the development of an elevated sense of self, the confirmation of a self-respecting identity and a definitive place in society was an important objective of treatment. The patient was encouraged to undertake a demanding one year diploma course in Health and Beauty Therapy, in spite of the fact that the stresses inherent in the rigorous learning programme, as well as the examination, could prove very demanding to her. There was always the danger that the additional pressure could destabilise and aggravate the very delicate "status quo". As it happened the patient not only graduated as top student in 1981, but the course became the watershed for the transition from the insecurity of her symbolic adolescence to the autonomy of meaningful adulthood, a transition which was avoided during the pathogenesis of her anorexic state. The course also subsequently provided her with the skills, qualifications and motivation to open her own Health and Beauty Studio, a situation which has provided the platform for ongoing progress in terms of mastery of her illness. Her ability to counsel and to help similarly afflicted patients together with the platform to maintain an image of beauty, health and fitness was also provided by the Studio.

5. Social desensitisation

It was obvious from the diary that the stresses of inter-personal relationships tended to precipitate bulimic attacks, particularly when, while at restaurants, the patient felt obliged to order and eat quantities and types of foods which she knew had the propensity for precipitating bulimic behaviour. Consequently, avoidance behaviour began to set in and an anti-social lifestyle was established, bordering on the development of agoraphobia.

She was encouraged, not only to go out freely, but to have the confidence and discipline to select her menu with wisdom and fore-sight. She had to learn how to say 'no' to waffles!

This intensive treatment programme lasted for eight months. It was terminated by the fact that the author left general practice. The patient had improved to the extent whereby she was able to implement the principles of treatment which evolved out of her therapy without the constant motivation and guidance of the therapist. In spite of a few setbacks, she became fully re-integrated into society. She is, today, committed to helping other patients with similar problems, and has appeared widely on radio, in magazines and as a speaker on the subject. Her tenacity and courage

has captured the imagination of the media, resulting in various articles in the lay press centering around her struggle to survive[16]. While she emphasises the fact that 'one is never completely cured from the condition', especially when under undue stress, she now has the discipline and knowledge to combat these urges.

Principles and objectives of traditional treatment

Because the aetiology of bulimia is not as well understood as the various theories postulated to cause anorexia nervosa[17], very little is known as to the complexities involved in its development. Treatment protocols and approaches vary widely, and very few controlled clinical treatment studies have been reported.

Behavioural modification of bulimarexic behaviour is a traditional cornerstone of treatment. Many institutions have an implicit form of negative re-inforcement built into their contractual agreement with the patient, an example of which is the confinement to bed or to their room until they have reached certain target weights. The issue of weight, about which the patient is already obsessed and which lies at the very root of the patient's illness, again becomes the focal point of treatment.

This approach is often counter-productive for various reasons. An ongoing obsession with weight in the early therapeutic, institutionalised stage may be seen as a restrictive ultimatum requiring the patient to sacrifice a working and long-negotiated symptom for an unknown therapeutic advantage in the uncertain future.

The helplessness that the patients have already experienced in their inability to control their disease often seems to be further enhanced, and the perceived coercion manifest by the institutionalised

Often the stresses of inter-personal relationships tend to precipitate bulimic attacks

programme may add to the notion of their ineffectiveness which is often primarily at the core of their dysfunction.

In addition, a rigid therapeutic ultimatum may, in fact, hinder the development of an intrinsic or fundamental wish to get better by polarising the therapist and the patient by confrontation. Since this situation is self perpetuating, it propagates the need for the therapist to increase his suppressive manoeuvres and gives the patient ample reason why she should remain ill, if only to deny the therapist the satisfaction of seeing an improvement in the status quo.

Objectives of the alternative therapeutic method

It is generally accepted that, because of the multiplicity of the suggested aetiological factors involved, both in the pathogenesis of the disorder and in its perpetration, a flexible, multimodal and individualistic therapeutic programme is mandatory[18]. This does involve the formulation of a specific therapeutic contract, but it is carefully and individually tailored for each patient. Treatment modalities are specifically defined to deal with the various indices of abnormal behaviour, the primary and secondary somatic pathology and the family environmental milieu.

In view of the fact that the GP often has first-hand experience of the family dynamics of the patient

"... but one is never completely cured from this condition"

concerned, and, in addition, is perhaps less restricted by the formal psychotherapeutic approaches of various treatment centres, it would seem that the informed, interested primary care physician may, in some cases, be best able to deal with this complex disorder. The proviso would be that he had the patient's co-operation and that the patient does not require immediate hospitalisation for life-threatening metabolic or electrolyte disturbances (ie Rockwell stage I[19]). Unfortunately, the general practitioner may be limited as to the amount of time he can spend with the patients[19]. This precludes any single general practitioner from managing a large number of these patients. It is, however, possible for him to accept and treat a few selected patients.

The therapeutic programme which was adopted by the author for this patient emphasised the concept that the fundamental priority was to build up the patient's self-image. Confidence in her ability to effect her own cure and the realisation that she was in control of her own destiny was consistently encouraged. Her contractual obligation towards him was total honesty in their interactions and discussions. Positive re-inforcement and motivation were the cornerstones of his contribution. Progress, in turn, generated its own momentum for further reform and established a sound fundamental basis of self-determined survival which could be called upon at any future time, irrespective of whether the therapist was at hand or not.

Discussion

It is accepted that this approach to therapy will not be effective in all cases presenting for treatment, since there were specific factors operative in this case study which were unusual.

Firstly, the patient was highly motivated for improvement. It is well documented that in most cases of early anorexia nervosa, there is a strong element of denial and a high incidence of deceptive behaviour, particularly in the bulimarexic (the binging is a private affair, as well as the resultant surreptitious post-prandial emesis). It is rare, particularly in the early stages of the disease, for the patients to commit themselves to the totally honest and mature attitude which is necessary for the sort of programme that was designed for our case study. Perhaps the prior experience of hospitalisation and psychotherapy was a prerequisite for the subsequent success of the alternative approach. Perhaps the negative reward system acted to prepare the soil for the ensuing positive self-determined methods which we introduced. It is almost certain that the patient would not have been similarly motivated had she not experienced the destructiveness of her previous behaviour. In addition, the hospitalisation was important in that it defused the family situation by implementing the concept of patient-separation from the family unit in the early stages of therapy. In contrast to this argument, however, it should be noted that Morgan and Russell[20] found that previous admissions to psychiatric hospitals were associated with an unfavourable outcome.

There is a strong element of denial and a high incidence of deceptive behaviour

Secondly, this patient was older than the average bulimarexic patient would be. The older patient's illness is more difficult to treat, since chronicity confers a worse prognosis. Pathological behaviour patterns have often developed by this stage, in association with the illness[20]. In general, the younger the patient, the better the prognosis, since the conditioned response of binging and vomiting are not yet ingrained into the personality[21]. Symptoms and prognosis deteriorate with time. Paradoxically, however, the young bulimarexic who is eminently treatable is usually in the uncooperative, denial phase of the illness, and will not be a suitable candidate for the method described, which is more suitable for an older, less rebellious and more committed subject such as our patient.

Finally, our patient had a high level of intellect. It is well documented that anorexia nervosa affects predominantly upper social class teenage girls in developed countries[22,23]. This "social-cultural" theory of aetiology does not, however, guarantee that all anorexics will always have a superior intellect, although the genetic prerogative and the superior environment operative in the upper social class milieu does tend to provide these qualities. Certain intellectual pre-requisites also need to be operative if the patient is to appreciate the relationship between the quality and quantity of food taken during a binge and the level and quality of her feelings at that time. Insight into the trigger factors during a binge, as well as the primary ability to keep a reliable diary, are mandatory for the success of this approach.

Conclusion

I believe that the informed, committed and interested primary care physician has an important role to play in the treatment of the eating disorders. Provided that the patients are committed to their own rehabilitation, the most successful approach may be one of encouragement, positive re-inforcement and mutual co-operation and trust. Previous hospitalisation may, however, be a necessary prerequisite for this approach. Patients may, consequently not be amenable to this approach until traditional institutionalised methods have seemingly failed.

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From the journals

Proximity to hospital and mortality from motor vehicle traffic accidents

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Abstract Policy in England and Wales has encouraged the concentration of hospital accident and emergency facilities into large units with substantial catchment areas. This means that many rural areas are considerable distances from the nearest hospital providing such services. Analysis of data on mortality from motor vehicle traffic accidents for males aged 15 to 24 reveals that death rates are substantially higher in rural areas than in the cities. It is shown that geographical variations in mortality rate are related to differences in the dependence on private transport, to the social composition of the population and to proximity to hospital accident and emergency facilities. This latter result suggests that policy-makers need to pay more attention to the accessibility of accident and emergency services.