The 'ugly stepsister' of the eating disorder family

Nancy Tucker on bulimia nervosa in the latest in our series for budding writers (see thepsychologist.bps.org.uk/contribute for more information)

> 'It is not hunger. Hunger is a feeling of a gap inside you. You eat something small to stop that feeling. I go on eating after I've satisfied that hunger. I want to keep on eating until I feel full – it's the final limit – you can then eat no more.' (patient quote from Russell, 1979)

The early 1970s saw anorexia nervosa move from the realm of the 'mystifying stunt' to psychiatric disorder with well-defined diagnostic criteria (see, for example, Bruch, 1974). It was not until the end of the decade – when research on anorexia had granted the illness a 'typical course', and most patients were expected to make a full recovery over a period of years (Morgan & Russell, 1975) – that an 'ominous variant' of the malady emerged. This was characterised not by persistent food restriction but by episodes of uncontrolled eating followed by periods of 'compensation': fasting, excessive exercise, or – most commonly – forced vomiting (Russell, 1979).

This cluster of behaviours, initially perceived as deviant and even sinister, eventually came to define what we now understand to be bulimia nervosa: a severe and debilitating eating disorder, and yet still one all too often perceived as 'anorexia's ugly stepsister… not as serious but definitely more disgusting' (Arnold, 2004).

In my experience, 'not as serious but definitely more disgusting' is a hauntingly accurate summation of the subjective experience of bulimia as compared with anorexia. My decade-long struggle with eating disorders (explored in *The Time in Between: a Memoir of Hunger and Hope*, published by Icon Books in April 2015) comprised a bruising eight-year battle with anorexia, but I will always attest that it was the ensuing bulimia that flung me, broken, to the ground.

In many ways, anorexia and bulimia can be thought of as sharing the same core pathology: an over-valuation of thinness (less for reasons of vanity than because emaciation grants an indefinable feeling of 'safety': Serpell et al., 1999); a paralysing inability to eat 'normally'; and a fascination with – and certain contempt for – the physical body. I can certainly confirm that, psychologically, my anorexic and bulimic years were all but indistinguishable from one another: my idolisation of emaciation and disdain for the act of feeding myself remained constant, and I was appalled by the sudden, and seemingly uncontrollable, changes in my behaviour.

Superficially, however, the difference between the two illnesses is stark: anorexia is only diagnosed once an individual's weight has dropped below 'what is minimally expected for age, sex, developmental trajectory, and physical health', and when food restriction is chronic and marked, whilst a diagnosis of bulimia rests only on the frequency of episodes of binge eating/purging (for formal diagnosis, such episodes must occur at least once per week), with no weight criteria (DSM-5). In the most crude of terms: anorexics are always 'thin'; bulimics are not.

Evidence – both experimental and anecdotal – suggests that this superficial difference in symptom manifestation is enough to create a staggering imbalance in perception of the two disorders, by sufferers and normals alike. An anorexia diagnosis can feel like a hard-won badge of honour ('it made me feel special… not

Bulimia can be viewed as a shameful stamp on the skin

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many people have [that] ability' – Evans et al., 2004), whilst a label of bulimia can be viewed as a shameful stamp on the skin. Perhaps this difference results from nothing more complicated than the deeply ingrained moral messages modern society transmits on thinness/fatness: in the Western world, the terms 'obese/overweight' have become 'the biomedical gloss for the moral failings of gluttony and sloth' (Ritenbaugh, 1982) and synonymous with 'dirty or ill-in-effect', whilst an emaciated body is a marker of 'moral superiority [and] empowerment' (Evans et al., 2004).

When describing her time spent receiving inpatient psychiatric treatment for anorexia, author Carrie Arnold recalls:

> ...since most of the other women in the eating disorder programme at the time suffered from bulimia, I was left in a rather interesting position. I found myself the envy of everyone on the floor. Anorexia has a sort of holiness to it, a sanctity of self-denial, and the skeletal figures appear almost superhuman. Here were people that didn't have to eat, who could overcome their bodily urges.

This is not a unique observation: in an ethnographic study of an eating disorder unit, Segal (2002) describes how '[eating disordered] women [need] to establish themselves as pure anorexics rather than bulimics, who rank lower than anorexics in the eating disorder hierarchy'.

The intangible perception of anorexia as hierarchically 'high' – almost spiritually so – and impressive to the point of desirability was also noted in 'Eating like an ox', a seminal paper on femininity and dualistic constructions of anorexia and bulimia. Here, it is noted that 'anorexia brings with it the appearance and feeling of total control and almost total denial. This stimulates pride, and a sense of achievement, perfectionism and of being different (perhaps even better) than other people' (Burns, 2004). Indeed, one of the most recent large-scale experimental studies conducted into the emotional experience of anorexia found that, as well as negative emotions, participants report feeling infused with a sense of pride at being able to achieve their weight loss goals (Selby, 2014), with sufferers observing that 'anorexia is like the top one… you're an exemplar of resilience' and describing the condition as 'an extreme manifestation of willpower' (Mortimer, 2015). This silent, secret superiority is something I remember well: the feeling that my protruding bones marked me out as 'special': that my ability to resist the needs to which others were enslaved elevated me to almost superhuman status.

Far from a source of superiority, bulimia is routinely experienced as degrading (Saftner et al., 1995), 'abhorrent' and 'crazy' (Mortimer, 2015). Caught in the crazed process of bingeing and purging, I remember struggling to judge which I found more shameful: the desperate filling of my body with food, or its eviction through self-induced vomiting. Over time, I came to experience myself as entirely incompetent: incapable of managing even the basic process of eating in a 'normal' way. This sentiment is echoed by the research, with Bardone and colleagues (2003) finding self-competence to be lower in practising bulimics than in normal controls, with improved self-competence predicting reduction in bulimic behaviours more strongly than improved self-liking. This result mirrored the earlier finding of Schneider et al. (1987) that increased perception of self-efficacy in controlling binge states is related to decreased purging frequency in bulimia sufferers. This suggests a certain self-fulfilment model to bulimic behaviour: binge eating is experienced as uncontrollable as a result of deficient self-efficacy, and purging becomes an inevitability.

Interestingly, bulimics seem almost universally inclined to view their behaviours through the prism of anorexia, as if constantly preoccupied with the perception that their behaviours represent the 'grubby underbelly' of the eating disorder spectrum. One participant interviewed for Mortimer's qualitative analysis openly self-identified as 'the worst anorexic ever', whilst another described anorexia as 'a badge of honour that I don't deserve'. Such observations are striking not only in their duality, but in their reinforcement of the 'superior/inferior' relationship between

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anorexia and bulimia – a relationship of which I felt potently and painfully aware during my own struggle. Having 'migrated' from anorexia to bulimia, I saw my bulimic 'failings' only in the light of my anorexic 'successes', and was constantly driven to compare my former 'superior' and current 'inferior' self in terms of weight, calorie consumption and subjective accomplishment.

The socioemotional phenomenon of 'in-group pride' (the sense of achievement one feels in relation to being part of a select group) can be measured according to how willingly individuals identify themselves as members of the in-group (Aboud & Doyle, 1993). The readiness with which sufferers identify with the label 'anorexic' is perhaps most obviously observable in the cult-like 'anorexia communities', both pro-illness and pro-recovery, which abound in social media, allowing sufferers (majorly young girls) to post images and appraisals of their meals and bodies multiple times a day, and receive 'support' from fellow community members. There is widespread lack of consensus on the role of social media of this nature – whilst Dr Tony Jaffa, consultant psychiatrist at the Phoenix Centre for Eating Disorders, praises it as a 'positive idea', Deanne Jade, founder of the National Centre for Eating Disorders, describes online eating disorder communities as '[groups of] people who are mentally sick [and who display] toxic behaviour'. What is undeniable is that anorexia sufferers are vastly overrepresented in these groups, as compared to bulimics, binge eaters and those afflicted with other, 'less mainstream' eating disorders; for example, entry of the search term 'anorexia' into photo-sharing platform Instagram yields close to 5 million posts, compared with 2.5 million tagged 'bulimia' and just 64,000 'binge eating disorder'. Statistically, the most recent analyses suggest anorexia to affect around 0.3 per cent of females over the course of a lifetime, while closer to 1 percent suffer from bulimia (Hoek, 2006), so this marked 'anorexia bias' would appear to reflect an unwillingness amongst bulimia sufferers to openly disclose their status.

According to Gyorffy (2013), popular social media platforms provide fertile avenues through which users can self-promote and create identity, displaying social and cultural capital through the posts they share. This identity-projection is clear on sites Instagram and Tumblr, with the creators of 'eating disorder recovery accounts' often choosing to quote a 'lowest weight' and 'number of hospitalisations' in their online biographies – a stark indicator that this is the information by which they wish to be identified. Research suggests that, whilst both anorexia and bulimia can be triggered by a state of 'identity crisis' (Weinreich et al., 1985), the enactment of anorexotype behaviours *provides* an 'anorexic identity' – without which sufferers come to feel they 'would be nothing' (Evans,et al. 2004), whilst bulimics practising binge/purge type behaviours show no stabilisation of self-concept (Schupak-Neuberg & Nemeroff, 1993).

The perception of anorexia as 'more sanitary' – and, hence, more desirable – than bulimia is, to a certain extent, understandable. Whilst food refusal is disturbing when taken to extremes, it is – for the most part – a variant of normal behaviour. Bulimia, however, violates certain core bodily principles, with intentionally making oneself sick breaching a boundary that most consider sacred. Perhaps it is the violence and self-directed aggression of the latter disorder that leads to observations such as '[anorexia is] a cleaner disorder' (Burns, 2004). The concept of 'cleanliness' is one that pervades the literature, and it has relevance not only to the practical behaviours typical of anorexia/bulimia, but also to the differential 'personality types' associated with the two disorders. The 'typical' anorexia sufferer is uniformly characterised as obsessive, conformist and constricted (Vitousek & Manke, 1994), with a heightened tendency towards industriousness and self-responsibility (Strober, 1980) – these are neat, compact, clean individuals. Descriptions of the 'bulimic personality' exist in stark contrast, with impulsivity (Diaz-Marsa et al., 2000), emotional instability (Vitousek & Manke, 1994) and promiscuity (Burns, 2004) cited as expected presentations – neatness is replaced by sensuality and recklessness. In cases, such as my own, where anorexia diagnosis progresses to bulimia (which Fichter and Quadflieg, 2007, found to comprise 11.2 per cent of sampled cases), one is perhaps left questioning whether the change in pathology indicates a necessary change in personality. But in my experience, whilst my eating disorder symptoms altered dramatically, my 'anorectic' personality tendencies – towards diligence, perfectionism, inflexibility, etc. – remained constant.

It is in this area that it is relevant to examine contemporary constructs of 'expected/acceptable' behaviour and appearance – particularly for women, overrepresented in the eating-disordered population. In *Girls and Media: Dreams and Realities* (2014), Professor Kara Chan reports that the prepubescent young people she interviewed about 'what a woman should be' were quick to stipulate that 'women should be courteous, refrained [*sic*], conservative [and] not out of control'. In their interpersonal interactions, women should 'watch out for their manner in public', 'not be promiscuous' and 'not have too many sex partners', whilst at school/work women should 'achieve highly' and 'not break the rules'. Those interviewed were even more stringent in their stipulations for 'acceptable' female appearance, stating that women should 'be neat and tidy, as well as not messy' and 'look graceful and poised, with proper neat dresses'. This preoccupation with physical and behavioural 'neatness' strongly favours the 'typical anorexic' over the 'typical bulimic', and may give further insight into different views of the disorders.

'Diagnosis hierarchy' is not just

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One means of achieving inter-diagnostic parity would be the removal of separate diagnostic categories altogether, and a move towards an all-encompassing spectrum of 'eating disorder'

inappropriate, but actively destructive. Though bulimia is associated with a dramatic reduction in psychosocial functioning and elevated risk of serious medical complications including heart attack and oesophageal rupture, studies consistently reveal that less than half of all sufferers seek treatment (Mond et al., 2010), with 'fear of stigma', 'low perception of need' and 'shame' cited amongst the most salient reasons for not obtaining help (Hepworth & Paxton, 2007). For me, the obvious weight loss associated with anorexia prompted swift intervention from the medical profession, whilst supportive provision for bulimia – even when actively requested – was limited, with more than a faint ring of 'afterthought'. Bulimia sufferers are trapped in a vicious circle: they internalise widespread lack of understanding and sympathy surrounding their condition, using it to feed their own shame and neurosis, and retreat further into destructive behaviours, becoming more convinced of the impossibility of recovery. As Alyssa Sheinmel, author of *The Stone Girl*, attested: '…every time I looked in the mirror, [I saw] that the throwing up couldn't have been that big of a problem. I didn't care why, I just knew that I didn't want to talk about it; not because I was sick, but because I wasn't sick enough.' Though anosognosia (symptom severity denial) is also a prominent feature of anorexia (Coman et al., 2013), bulimia sufferers face the additional complication of outsiders' perception that 'all is well' due to the lack of visible malnutrition.

The surface-level bias towards the perception of anorexia as 'more serious' and 'more important' than bulimia is instinctive and difficult to combat: emaciation is immediately visually arresting, whilst 'normal weight' is, by definition, perceptually unremarkable. However, beyond this fleeting discriminatory response to different pathologies within the broad category of 'eating disorder', it is of vital importance that efforts are made to 'iron out' the disparities in views of the comparative severity and desirability of these two disorders. One means of achieving inter-diagnostic parity would be the removal of separate diagnostic categories altogether, and a move towards an all-encompassing spectrum of 'eating disorder' (Burns, 2004), with severity determined not according to weight but to level of mental duress and normal life interruption. Such a disruption of contemporary categories might go some way towards dispelling pejorative associations with bulimia in particular (greed, poor self-restraint, deviance, etc.), and drawing attention to the truth that an eating disorder is, first and foremost, a psychologically based illness, the behavioural and physical manifestations of which are, at most, variable symptoms of underlying pathology.

For me, the journey towards accepting and acknowledging my diagnosis of bulimia is, as yet, uncompleted, and I suspect I will never embrace the label as wholeheartedly as I did that of 'anorexic' – though this is, I suspect, positive. For much of the time my bulimia was at its most ferocious, the shame I felt in relation to my behaviour prevented me from accessing the necessary medical and psychological help, and when I did seek support I found very little to be available. My experience of bulimia is still a subject I find difficult to address openly, and one I found challenging to discuss honestly in *The Time in Between*. Ultimately, I feel I was sincere in my presentation of the condition, but it was a presentation that entailed painful vulnerability in comparison to the ease with which I found myself able to describe the horrors of anorexia. This is, of course, part and parcel of the larger problem: discussing bulimia is, for whatever reason, an exposing experience, thus public narratives tend to favour the discussion of anorexia, thus widespread understanding of bulimia remains shallow, thus negative misconceptions are not dispelled.

In today's climate of improving mental health awareness, 'stigma' – and its reduction – has become something of a buzzword, with eating-disorder campaigners frequently bemoaning the misconception that 'anorexia is caused by teenage girls wanting to look like skinny models'. Efforts to reduce this stigma have been successful, and we are moving towards a general understanding that self-starvation is symptomatic of something more complex than the fetishisation of haute couture. However, public knowledge of bulimia is pitifully undeveloped, with most either falsely identifying the condition as an anorexia synonym, or simply as 'having something to do with being sick'. Though my book addressed bulimia only in its final section – as, at the time of its writing, I had only been suffering from the condition for a year – my hope is that an increasing number of sufferers will, in the ensuing years, feel able to share the internal experience of what is a serious psychiatric condition, and not just a 'shameful habit'. For my part, witnessing at first hand the obstacles populating the pathway towards receiving adequate bulimia treatment has given me a determination to provide such treatment in my practice as a registered psychologist. It is my hope that, by the time I hold this qualification, we will have progressed to a point where bulimia sufferers have reason to feel understood, acknowledged and respected by both the medical and social worlds.

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