WHAT ARE THE EATING DISORDERS?

It is safe to assume that most people starting to read this book will already know a fair amount about what the eating disorders are and about how they affect those who suffer from them. Indeed, a majority of the public at large have heard of both anorexia nervosa (AN) and bulimia nervosa (BN) and know something about them. However, this was not the case until fairly recently. Before 1979, the term BN had not been coined, and very few people were aware of the condition it names. AN had been described for well over a century, but it was thought of as a rarity. However, what had, until the 1950s and 1960s, been the subject of brief entries in medical textbooks has now become the stuff of dozens of books and countless articles in magazines and newspapers. The increased prominence – and probably the increased prevalence – of the eating disorders was a phenomenon of the late twentieth century.

This chapter is concerned with defining and describing the main eating disorders. It will outline the history of the development of the concept of the eating disorders and will then describe the key features of these disorders as they are presently defined. The classification used is the fifth version of the Diagnostic and Statistical Manual of the American Psychiatric Association, DSM-5, which was published in the summer of 2013 (American Psychiatric Association [APA], 2013)." What comes before ‘why’.

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CLASSIFICATIONS AND DIAGNOSTIC CRITERIA

The new version of the American system (DSM-5) will be used in the rest of this chapter and indeed in the rest of this book. It helps to have a system as an anchor for discussion. However, it is important to remember that even the broad and well-established diagnostic categories, such as AN, are themselves best thought of conceptual tools. They have value and are ‘true’ inasmuch as they are useful in organising our thinking and clinical practice. But they are inventions and should be thought of as provisional. Only if they were to survive criticism and be bolstered by more and more evidence of their utility, integrity and mechanism should they be accorded the kind of status enjoyed by a disease like syphilis where symptoms, signs, aetiology and pathogenesis can all be wrapped up together into some kind of convincing whole. Indeed, there would be those who would suggest that finding such a disease concept is unlikely when considering a psychological disorder or, perhaps, that the very idea is incoherent even as a goal. In practice with the eating disorders, such theoretical considerations are hardly an issue since the present entities are so clearly provisional and the subject of much tinkering. They are renewed and usually changed every few years. Indeed, DSM-5, which was published in 2013, defined two ‘new’ eating disorder diagnoses. Binge eating disorder (BED) had a long gestation but fully emerged and was added to the canon only with DSM-5. And a further disorder – avoidant/restrictive food intake disorder (ARFID) – was created.

In principle, a classification should comprise a set of categories that are distinct and mutually exclusive and which together cover every case. In practice, an important proportion of people presenting to clinicians with significant eating and weight problems do not have disorders, which fulfil criteria for any of the main syndromes. Most systems can provide a slot for every case only by including a residual ‘rag bag’ category to cater for these diagnostic non-conformists, and DSM-5 is no exception. (See later sections.) The previous version – DSM-4 – was notorious for having a residual category, which was the most common diagnosis in many series of eating-disordered subjects.

A BRIEF HISTORY

Over the centuries, there have been people who have starved themselves. Some could be interpreted from a modern perspective as having had AN or something akin to it. However, AN is a state with psychological aspects which cannot easily be detected in the minds of those who are long dead unless they have themselves written about their inner lives and done so in
What are the Eating Disorders

a way that can be translated into modern terms. In the absence of such accounts, we are left to make rather tenuous inferences about these early ‘cases’ (Habermas, 1989, 1992; Parry-Jones, 1991; Parry-Jones & Parry-Jones, 1995). It is thus difficult to make confident judgements about the fasting saints and others – interestingly often young women – who were noted and sometimes exploited because of their apparent ability to live without eating (Vandercyken & van Deth, 1994). Likewise, there must remain a deal of uncertainty about the nature of the maladies in the very earliest clinical descriptions, such as the famous and often quoted ‘nervous consumption’ described by Thomas Morton in 1689 (Silverman, 1995). Different times may construe similar states in different ways (Brumberg, 1988).

The earliest ‘modern’ accounts of what came to be called AN were made more or less simultaneously – although it seems independently – by physicians Charles Lasegue in France (1874) and Sir William Gull (1874) in England. Both accounts are worth reading, although they are different in style. Lasegue was more concerned with the psychological aspects of the patients he describes. He invoked the then prominent but protean concept of hysteria and called the illness anorexie hysterique – hysterical anorexia. Gull’s paper is more straightforward and descriptive, and it was Gull who invented the name that was to stick – anorexia nervosa.

There was a steady trickle of publications on AN in the last decades of the nineteenth century and the first half of the twentieth century (Mount Sinai, 1965; Silverman, 1997). There was debate as to its nature. It is said that there was a degree of muddling of AN and hypopituitarism (Simmond’s disease) after that disorder was described in 1913. Furthermore, even when AN was construed as a psychiatric disorder, there was continuing debate as to whether it was better thought of as an entity of itself or merely as a variant of some other condition such as obsessional neurosis or schizophrenia (Bliss & Branch, 1960). From the 1960s onwards, the utility of assigning AN to a diagnostic category all of its own became increasingly established. The modern concept of AN had reached maturity (Bruch, 1973; Crisp, 1967; Russell, 1970) However, as sometimes happens to people, no sooner had a measure of maturity been achieved then things began to fall apart. AN started to undergo a nosological mid-life crisis.

Firstly, there were attempts to produce a useful sub-categorisation of the disorder. The most significant split was that between sufferers who maintained a low weight solely by restraining their eating and those who resorted to vomiting (Beumont, George, & Smart, 1976). Many, but not all, of the latter also showed bingeing behaviour (Casper, Eckert, Halmi, Goldberg, & Davis, 1980). The two groups were shown to differ on a number of characteristics of their background and current clinical picture,
the latter seeming to be on average more likely to show a wider variety of troubled or troubling behaviour.

Secondly, a group of people was recognised as suffering from eating disorders which closely resembled this second binging and vomiting group of AN sufferers except that they were of normal or high body weight (Russell, 1997; Vanderycken, 1994). With the publication of Gerald Russell’s classic paper (Russell, 1979), BN had emerged. The wider concept of ‘bulimia’ was included in the DSM-3 (APA, 1980), but Russell’s term and, broadly speaking, his concept came to be included in later revisions of the main classificatory systems. The broad outline of the syndrome seems to have unequivocal utility, although there is still room for doubt about the detailed criteria (Sullivan, Bulik, & Kendler, 1998).

The next sections will be concerned with the definition description and discussion of the three main eating disorders: AN, BN and BED. Each disorder will be illustrated by a case history.5

**THE FEATURES OF ANOREXIA NERVOSA**

The most prominent feature of AN is low weight. This is almost always the result of weight loss. (The exception is when a child comes to be at a lower than average weight because he or she has failed to gain weight in the expected way.) In general, it is best to discuss body weight using an index which takes height into account, usually the body mass index (BMI).6 Some sets of diagnostic criteria specify a level below which a low body weight is thought to be significant even though weight is a continuous variable, and a line is being drawn in order to define a category for practical use.

The weight loss of AN is attained and maintained by inadequate eating. Typically, this is because of motivated eating restraint rather than loss of appetite or of any reduction in the drive to eat. Indeed, the sufferer may feel that her urge to eat is very strong and potentially out of control. She nevertheless attempts to eat little, less than she would normally do and less than is required to maintain a normal weight. She sits on top of her hunger. Of course, for many sufferers the issue of their drive to eat is a touchy topic and their account of it to others – perhaps even to themselves – is variable and may be evasive. Some will acknowledge an urge to eat but will deny being hungry because that word has too positive a connotation for them. Other sufferers will deny having any drive to eat at all. However, whilst it seems that some sufferers do come to experience true anorexia in the sense of loss of appetite, this is not the case for the majority. Of course, ‘anorexia’ means lack of appetite and the inclusion of the word in the name AN is strictly a misnomer. However, after well over a century of use, it is probably too late to change it now.
Some sufferers will give in to their urge to eat more than they intend and may then seek to thwart the effects of this by use of abnormal weight control methods such as inducing vomiting or taking laxatives or diuretics. Sometimes, sufferers will exercise excessively. This may be directly motivated by beliefs about ‘burning off calories’, although there also seems to be some biologically driven connection between food deprivation and overactivity.

Some anorexia sufferers will truly binge. They will have the symptom of bulimia. (The issues involved in what this means will be discussed in the section ‘The Features of Bulimia Nervosa’.) More often, the person will feel that she has binged even though objectively she has eaten only a little. She feels that she has binged because she has transgressed her own personal rules by having given in to her urge to eat. Such behaviour is described as subjective bingeing.

The motivation for the eating restraint of AN typically has something to do with the sufferer’s wish to keep her weight low. Indeed variants of this particular motivation are specified in most sets of diagnostic criteria. They set out attitudes and beliefs which are said to constitute the specific psychopathology of AN. The words used to capture these include ‘intense fear of gaining weight or becoming fat’ (DSM-5) or ‘a dread of fatness’ (International Classification of Diseases, 10th edition (ICD-10)). Of course, such motivation resembles that which underpins much ‘normal’ slimming, although the anorexia sufferer continues with her motivated eating restraint to a point way beyond that to which the typical slimmer aspires. The sufferer may have started out with similar ideas, but she takes them to the extreme. She neither gives up in the face of the negative consequences of eating restraint (not least hunger) nor does she do so when she reaches the body weight that was her original aim. By the time that she fulfils criteria for AN, ideas about body weight and its control have become unusually important for her. Typically, she will have become preoccupied with food – reading about it, often cooking it for others but not eating what she cooks. She will fear loss of control of her weight or eating or both. She may feel that if she allows her weight to rise just a little, she will ‘lose it’, become fat and be unable to regain control. In truth, of course, it is her control that is out of control. The whole thing becomes charged with emotion and meaning, letting go being followed by guilt and self-recrimination and holding on being associated with a fragile satisfaction.

The person who develops AN will typically show other characteristic features, both psychological and physical. Prominent amongst the former is the phenomenon known as body image disturbance. This has become well known and it is one of the clichés of illustrators to depict the emaciated young woman standing before a mirror in which she sees herself reflected as grossly obese. Perhaps something like this is experienced by some sufferers. However, for most, body image disturbance is less stark and more complex.
The usual experience seems to be one involving knowing that the body is thin and having a variable feeling of fatness that exists alongside. The contrast is broadly between thinking one thing and feeling another, although each, of course, influences the other. The concept of body image is itself far from being simple (Smeets, 1997). Nevertheless, simply stated, body image disturbance is included as a criterion in most diagnostic systems. The DSM-5 criteria do not use the term body image disturbance but rather ‘disturbance in the way the which one’s body weight or shape is experienced’ and this is combined with other issues (see Box 1.1).

Another feature which is usually included amongst diagnostic criteria is the physical symptom of amenorrhoea (lack of menstruation) in females. In DSM-5, there is no requirement for amenorrhoea. This is a sensible simplification since, in practice, there are often some problems in judging whether to count amenorrhoea as being present. This is not only because the symptom is usually elicited purely by self-report but also because the issue is complicated by the widespread use of hormonal drugs, most notably the various oral contraceptive pills. What might be called ‘pill periods’ tend to continue to occur at a lower body weight than that which would sustain normal menstruation. However, pill periods do stop if the weight is low enough. Furthermore, the threshold at which menstruation ceases may sometimes be markedly lower than what might be called the threshold for clinical significance of the eating disorder. On recovery of normal body weight, the return of menstruation is sometimes delayed in a way that is not well understood. In most cases, amenorrhoea is secondary in the sense that periods have been present in the past but have now stopped. In cases of early onset, amenorrhoea may be primary.

Although now not a necessary criterion for diagnosis, amenorrhoea is nevertheless a marker for important changes in the female body with weight loss. Underlying the lack of menstruation is a change in function of the axis of neuroendocrine control which involves the brain (mainly the hypothalamus), the pituitary gland and the ovaries. In an anorexia sufferer aged 19, the function of this system, as reflected in levels of the relevant hormones, resembles closely that which might be expected in a girl of 9. The system is effectively switched off, and this switch off tends to be reflected in the experience of a lack of libido as well in a diminution of acne and adolescent angst. Sometimes, the changes which accompany the loss, then recovery, and then loss again of hypothalamic–pituitary–gonadal function in someone repeatedly regaining and losing a normal body weight can be striking for the observer. The person seems to change in all sorts of ways from child to teenager and back in just a few weeks. The experience for the sufferer must be extraordinary and profoundly unsettling. This may also be the case for those who are emotionally involved with the person and the process – notably the family. In male
Box 1.1 DSM-5 Criteria for Anorexia Nervosa

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or persistent lack of recognition of the seriousness of the current low body weight.

*Specify whether:*

**Restricting Type:** During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e. self-induced vomiting or misuse of laxatives, diuretics or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting and/or excessive exercise.

**Binge-Eating/Purging Type:** During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e. self-induced vomiting or misuse of laxatives, diuretics or enemas).

*Specify if:*

**In Partial Remission:** After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but Criterion B (intense fear of gaining weight or becoming fat or behaviour that interferes with weight gain) or Criterion C (disturbance in self-perception of weight and shape) is still met.

**In Full Remission:** After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

*Specify current severity:*

The minimum level of severity is based, for adults, on current body mass index (BMI) – see below – or for children and adolescents, on
sufferers, the parallel system is likewise switched off. For men, the symptomatic effects are confined to the more general changes – for instance, loss of sexual drive – since there is no precise physical equivalent of the cessation of menstruation.

In addition to the diagnostically relevant features outlined above, people suffering from AN typically experience many less specific symptoms. Physically, they may complain of bloating and other gastrointestinal symptoms. They often feel weak, tired and cold but may nevertheless push themselves to be active in their everyday lives and sometimes undertake programmes of special exercise in the belief that it may help to control their weight. Sleep is often disturbed and commonly has an early morning waking pattern which is akin to that in depressive illness. Indeed, in both states, it may be driven by undereating. Psychologically, they often experience depression of mood, anxiety and obsessional symptoms. Sometimes, such additional symptoms are of such a degree and pattern as to fulfil criteria for comorbid major depression or other syndromes. More generally, AN sufferers typically have a poor view of themselves and a low self-esteem, except perhaps in the matter of their eating habits which may sometimes be a source of perverse satisfaction. But mostly they are unhappy and, furthermore, feel trapped because of the fear that things would get even worse in nameless ways if they were to change.

This has been a brief account of the core features of AN. More will be said about some of them later in the book as part of the discussion of possible processes which may bring the disorder about or perpetuate it. Furthermore, later chapters will contain accounts of the main complications which may arise in some but not all sufferers.
The following is the first of three fictional stories that will be used to illustrate the main diagnostic categories.

Faith: A Story of Anorexia Nervosa

Faith was the younger daughter of two schoolteachers. Her earlier childhood was settled and happy, but things began to go wrong when she was 14 and her sister Fiona was 16. Their father, who was then aged 46, had a major heart attack. This was a shock and surprise to the whole family. It brought many changes. The father had continuing angina and other problems. Bypass surgery did not seem to help much. He had to stop work and give up his ambition to become a headmaster. He became prone to bouts of depression. He was touchy and irritable, especially with Fiona. Over the next 2 years, rows between Fiona and her father dominated the household. Faith tended to keep quiet and try to not get involved. However, she felt upset and torn between the two of them.

Much to her parents’ disapproval, Fiona decided to leave school at 17 and get a job in a local department store. At 18 she became pregnant and left home to live with her boyfriend. Her father was devastated and said that he would have nothing more to do with her. Her mother and Faith continued to visit her secretly. When Fiona’s baby was born, there was some reconciliation, but her father continued to be low spirited and upset. He often complained of chest pain. Sometimes he said that Fiona had ruined his life. Faith’s mother struggled to hold things together, working hard at her job, acting as go between and looking after her sick and troubled husband.

Meanwhile, Faith was doing well at school. Her parents were delighted when her teachers suggested she try for a place at Oxford or Cambridge. She was studying modern languages, her father’s subject, and he coached her in the evenings. He described himself as her ‘trainer’ and Oxbridge entrance as the ‘Olympics’. He also encouraged her to go jogging, making pronouncements about a healthy mind in a healthy body. As his disappointment with Fiona became more open, his involvement with Faith became more intense. She valued her father’s interest but was increasingly aware of the extent of his expectation. She began to fear letting him down.

Faith began going out with a boy called Andrew who had been at the same school. It was her first real boyfriend. However, she soon came to feel a sense of conflict between her wish to spend time with Andrew and her wish to devote herself to her studies. She also felt that her father disapproved of her new relationship and feared that she would ‘end up like Fiona’. One weekend, she stayed out late and worried her parents. Her father had a bad angina attack and her mother reminded Faith how important it was that her
father should not be upset. She began to make excuses not to meet Andrew and before long he left her for another girl. Faith felt heartbroken and secretly angry that her father seemed so pleased about the ending of the relationship. She felt upset and uncertain but resolved to pull herself together. She decided to apply for Oxford and dreamed of being a success there. She would wait for her reward. In the meantime, she would work hard, save money, get fit and even lose a little weight as she had been promising herself for months that she would do.

At first things went well. Faith worked hard. Her father was delighted. Her mother seemed more relaxed and even Fiona began to visit more often. Faith produced a timetable for her studies, and her father helped to plan it all out. She lost a little weight by taking up running and following what her mother called a ‘sensible diet’.

Faith felt good for much of the time, but sometimes when studying her mind would wander. She would chide herself for wasting time daydreaming. She worried what would happen if she did not do well. She felt bad one evening when she found that she had eaten a whole packet of biscuits whilst at her studies. She weighed herself and found that she had regained three pounds. She felt that somehow she must get back on track. She produced a new timetable and this time it covered not only her school work but all of her activities, including running and eating. She rationed the times when she would allow herself to have a cup of coffee and just one biscuit. Soon she cut out the biscuit altogether.

As the weeks went by, Faith lost more weight. At 16 she had weighed about nine stones (58 kg). A year later she weighed just six and half stones (42 kg) and her periods had stopped. She was by now preoccupied by just two things – succeeding at her studies and controlling her weight. She feared that she would fail at both. By now, she was studying so much that even her father advised her to ease off. Her mother was worried about her eating, but Faith would lie and say that she had eaten at school when she had not. She wore baggy clothes and avoided letting anyone see her undressed. She knew that she looked thin but often felt fat. She thought about food a lot but distracted herself by studying even more. Once she got up in the middle of the night and ate two packets of biscuits and a tub of ice-cream. She then tried to make herself vomit but did not manage it. This reinforced her feeling that if she allowed herself to eat freely, everything would get out of control.

That autumn, Faith was rejected by Oxford. By now, it was evident that she was very thin. At Christmas, her behaviour led to major rows and upsets. Early in the New Year, her mother persuaded her to see the family doctor. When weighed she was just under six stones (37 kg). It was now clear that she was suffering from anorexia nervosa.
THE FEATURES OF BULIMIA NERVOSA

The core-defining symptom of BN is frequent binge eating. However, in everyday talk, the term ‘binge’ is imprecise. Many of us would admit to enjoying a belt-loosening blowout on occasion, and we might well call it a binge. Those who are especially concerned about their weight may judge themselves harshly in this respect and describe thus any minor indulgence. Such subjective binges may occur in dieters and even more in those suffering from AN, as was mentioned above. However, the kind of objective binge that really counts as such for the diagnosis of BN has two other crucial characteristics. Firstly, the binge should be accompanied by a subjective sense of loss of control. Secondly, it should involve eating an amount of food which would be unusual in the prevailing circumstance. Sometimes the amount eaten may be extraordinarily large, and reports of binges in excess of 10,000 kcal are not unusual. Some sets of criteria also emphasise the idea that a binge should be a discrete episode of eating in this way rather than a long drawn-out excessive graze. DSM-5 suggests that a binge should last for ‘a discrete period of time’, for example, a ‘2-hour period’. Whether specifying such a time limit really captures some important characteristic is rather unclear. Such binge eating is usually secret and occurs when the person is alone. To count for full syndrome BN within the DSM-5 classification, bingeing must occur on average at least once per week for 3 months.

Loss of control and excessive intake taken together are valuable in separating off ‘true’ binge eating from the what might be called normal indulgence. However, they are not without problems. For instance, many people with BN at times plan their binges and deliberately shop for the binge foods that they eat. Such behaviour complicates the meaning of what it is for a binge to involve loss of control. The idea may still be valid but clearly cannot mean that the binge is carried out impulsively and on the spur of the moment. The loss of control is perhaps more like that of the drug addict who finds himself grappling with a continuing additional drive which motivates him to behave regularly in ways which the non-drug dependent person does not. It is part of him, but a part which he would rather not own and against which he sometimes struggles but often succumbs and at times even enjoys. Certainly, details of the experiences of bulimic bingers seem to vary widely between and within episodes of bingeing. Sometimes, the associated affect is of miserable failure and guilt throughout. Sometimes, the experience is of pleasure or catharsis and release of tension. All sorts of feelings are reported.

As with AN, BN characteristically arises against a background of attempted eating restraint. Furthermore, the motivation for such eating restraint usually resembles that of the anorexia sufferer, and thus BN has a similar specific psychopathology. This is described in DSM-5 (Box 1.2) as
Box 1.2 DSM-5 Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   (1) Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
   (2) A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics or other medications, and fasting or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once in a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify if:

In Partial Remission: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.

In Full Remission: After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimal level of severity is based upon the frequency of inappropriate compensatory behaviours (see the following text).

Mild: An average of 1–3 episodes of inappropriate compensatory behaviours per week.

Moderate: An average of 4–7 episodes of inappropriate compensatory behaviours per week.

Severe: An average of 8–13 episodes of inappropriate compensatory behaviours per week.

Extreme: An average of 14 or more episodes of inappropriate compensatory behaviours per week.

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involving self-evaluation which is ‘unduly influenced by body weight and shape’ and other criteria use such terms as ‘morbid dread of fatness’ (ICD-10). Much has been written about the way in which the ideas of BN sufferers may differ from those with AN. However, the words used in the criteria to describe these matters are remarkably similar. Furthermore, many people move from one disorder to the other, and it is not clear that this coincides with a change in their thinking as well as in their behaviour. It may be best to construe the two ‘specific psychopathologies’ essentially as variants of a similar way of thinking occurring within different contexts and histories. When bingeing occurs, the individuals will often reverse the dictates of their dieting and eat the very kind of foods that they do not allow themselves within their non-binge thinking.

The person who ‘dreads fatness’ but who finds herself breaking out of her attempted eating restraint into bingeing will tend to adopt various compensatory behaviours to try to thwart the effects of the excessive eating upon her weight. Their use is a necessary part of the diagnostic criteria for BN. The most common of these compensatory behaviours is self-induced vomiting. Most sufferers do this by putting their fingers down their throat. However, some discover or develop a facility for vomiting without any such mechanical stimulation. Vomiting is effective at getting food out of the body, although many sufferers have an exaggerated idea of its efficiency. Some food is left down and absorbed. Some people elaborate the process of vomiting, for instance, by eating marker foods first in the naïve belief that when the marker appears everything has been brought up. Others engage in the potentially dangerous practice of drinking and then vomiting large quantities of water to wash themselves out. Any vomiting can lead to potentially hazardous electrolyte disturbance. Laxative abuse is another method of trying to get rid of binged food. This, too, can be dangerous and furthermore is rather ineffective. Occasionally enemas may be used. The main result of taking even very large quantities of laxatives – over 50 senna tablets would not be unusual – is to cause loss of fluid and electrolytes from the large bowel rather than to reduce absorption of food (Lacey & Gibson, 1985). However, the sensation of painfully won emptiness perhaps accompanied by feelings of ‘cleanliness’ may itself be rewarding for the guilt-ridden binger. The abuse of diuretics (water tablets) is even less rational as a way of losing fat or other body substance but, nonetheless, may be adopted because of its immediate, if essentially illusory, effect upon apparent body weight. As with the other purging methods, the abuse of diuretics can cause major disruption in body chemistry.

Other methods may be employed by the bulimia sufferer to try to compensate for her overeating. The most common of these are fasting and excessive exercise. Both of these are included in the DSM-4 criteria but neither is easy to define. When does eating restraint become fasting and
when does exercise become definably excessive? These difficulties make these two compensatory mechanisms the ‘soft’ end of the definition of BN. The idea of a ‘non-purging BN’, which had been present in DSM-4, has been dropped for DSM-5.

As with AN, the syndrome of BN is often accompanied by many symptoms of wider physical or psychological discomfort and distress. Depressive symptoms are common, and comorbid major depression or a history of such disorder occurs in as many as a half of sufferers from BN (Cooper, 1995; Cooper & Fairburn, 1986).

Rachel: A Story of Bulimia Nervosa

Rachel was the elder child and only daughter of a policeman and a nurse. When she was aged 11, her father left his family to live with another woman. Rachel was upset and angry and had almost no contact with her father for the next 8 years. She tried to comfort and support her mother. They became very close. Her mother tended to confide in her to an unusual degree and together they looked after Rachel’s brother, Sean, who had been only 6 years when his father left.

Rachel had no major regrets when her parents were finally divorced 2 years later. However, she was not sure how she felt when a little later her mother started going out with John, a colleague from work, and within 6 months announced that they were to marry. Rachel was just 15 when her mother married John and he moved in. She told herself that she was pleased for her mother, but she missed their former closeness. Furthermore, she did not feel comfortable with John. He tried hard to be friendly but tended to tease her about going out on dates, her taste in clothes and about her worry about her appearance. He also teased her about the way in which she was always going on and off slimming diets which lasted for just a day or two.

Over the next year or so, Rachel felt more and more isolated and unhappy at home. She tried to spend as little time there as possible. She went out almost every evening and often ended up drinking a lot. This added to her difficulties at home. She greatly resented it when John started to behave like a strict father. There were many rows between them. That summer she took her GCSE examinations but the results were disappointing. She was unsure what to do but she decided to leave school. She signed up for a business studies course at the local college.

When Rachel was 17, she met Mark, who was 7 years her senior. He was a professional footballer albeit for a lower league team. From the start it was a difficult relationship because, although Mark was lively and glamorous, he also seemed rather unreliable. Just before Christmas, as she was wondering whether to finish with him, Rachel discovered that she was pregnant. To her
surprise, Mark seemed pleased at the prospect of becoming a father and they decided to live together. Her mother and stepfather protested that she was ‘too young’, but Rachel suspected that they were secretly relieved that she was leaving home. At Easter, she dropped out of her college course and in July gave birth to a baby boy, Rory.

Rachel loved her new baby but found motherhood overwhelming. She felt mixed up and uncertain about herself. Furthermore, she had put on a lot of weight during her pregnancy and felt fat and unattractive. She wanted to lose weight but found it difficult. Sometimes she was uninterested in food, but at other times ate more than she intended. She became miserable and mildly depressed. With the start of the football season, Mark was often away and seemed less interested in the baby. As the months went by, the couple had more and more rows. Rachel worried that Mark would meet other women on his trips away from home. And he became more and more jealous and possessive, objecting even when she went out with her old girlfriends. She became increasingly unhappy and isolated just as she had done a year or so before. This time, however, there was no obvious escape route open to her. She certainly did not want to go back to her mother’s house. She also regretted having given up her education. However, when she talked to Mark about going back to college, he accused her of wanting to meet other men. In the midst of one row, he called her fat, ugly and boring. He said that she had ‘let herself go’. She was angry and upset, but secretly these were the very things that she had been thinking about herself.

Rachel made another resolution to lose weight. She started by going on a crash diet. She was pleased to lose some weight quickly but felt unhappy, hungry, preoccupied with food and irritable. One evening, Mark telephoned yet again to say that he would not be home. She felt angry, upset and out of control. She stuffed herself with food until she could physically eat no more. Then she felt guilty and in a panic. She made herself vomit by putting her fingers down her throat. The next day she resolved to eat even less, but a week later, she binged again. Much as she tried to stop, she felt caught up in a pattern, and soon she was bingeing and vomiting several times each week. Although her eating was now wildly erratic, her weight stayed much the same.

Rachel left Mark shortly after Rory’s first birthday. The final break had come when Mark had hit her in an outburst of jealousy. Rachel had recently re-established some contact with her father, and when he heard about Mark’s violence, he had threatened to come around and ‘sort out’ Mark if she stayed. So she left. At first, Rachel moved back to her mother’s house, but after a few weeks, she moved into a flat of her own with Rory. Soon, in some ways, things began to look up for her, although she still felt lonely and unsure of herself. Indeed at times in the first weeks, she felt quite desperate and even thought of trying to kill herself. However, she resolved to rebuild
her life. She resumed some contact with Mark, but just as friends. She went out occasionally with her old friends and attended an aerobics class. She started a new course at the local college and talked of eventually going on to university. To other people, it looked as though things were going well, but secretly her life revolved around a battle with bingeing and vomiting. She was stuck within BN.

THE FEATURES OF BINGE EATING DISORDER

BED was included as a fully fledged diagnostic category for the first time in 2013 with the publication of the DSM-5. But the idea had been loitering around for decades. The concept of a third eating disorder arose from an awareness that many people have problematic binge eating without fulfilling criteria for BN. Most of these fail to qualify for that diagnosis because they do not show the characteristic attempts to thwart the effects of binge eating upon their weight such as vomiting, abusing laxatives and so on. Furthermore, for some, the bingeing does not seem to have arisen following attempts to restrain their eating because of concern about body weight or shape as would be characteristic of people with BN (Mussell et al., 1995).

Many, but not all, people in this category are obese. Binge eating in obese people had, of course, been well recognised for years (Stunkard, 1993), although its close definition and study tended to be hampered by erroneous beliefs about the ubiquity amongst the obese of ‘bingeing’ in the widest sense of any overeating. Clearly, there is a sense in which those who are obese must have ‘over-eaten’ relative to some standard of intake which might have kept them at an average weight. However, it is not the case that most obese people binge in any useful sense of the word and certainly not in the sense defined in the diagnostic criteria for BN or BED.

The idea that this pattern of binge eating without compensation warranted the creation of a new diagnostic category was championed by Spitzer and colleagues who conducted field trials of diagnostic criteria (Spitzer et al., 1992, 1993). The new category, BED, was included in the appendix of DSM-4 as a ‘provisional diagnosis worthy of further study’, and indeed it did stimulate a good deal of interest and some useful research (de Zwaan, 1997) although not universal approval (Fairburn, Welch, & Hay, 1993). Nevertheless, it did seem to provide a place within the official canon for at least some of the behaviours covered by the lay concept of ‘compulsive eating’.

There are some difficulties inherent in defining BED. These include the question of how to define a binge. In purging BN, the issue is to a degree made easier by the relative ease with which vomiting or purging, which, as
What are the Eating Disorders

Discrete behaviours, can be defined and counted. However, overeating is different. Furthermore, although the suggested criteria for BED include the idea that the binge eating should occur in discrete episodes as in BN, there is some evidence that much problematic overeating in the obese has different characteristics, including what might be called all-day binges (Marcus, Smith, Santelli, & Kaye, 1992).

BED occurs in a substantial proportion of obese people presenting at weight reduction clinics and services, but in a lower proportion of the obese in the community at large. Reported percentages range from 30% for the former to 5% or so for the latter, although these figures may be overestimates (Marcus, 1995). Furthermore, in at least one wider community survey, less than a quarter of women with BED were obese (Fairburn et al., 1998).

The BED criteria (Box 1.3) contain little in the way of necessary psychological characteristics. In particular, the attitudes towards weight and shape which are required for BN and AN are omitted, as is any hint of the attempted eating restraint for which they may provide the motivation. (Indeed, such attempted restraint does often seem to be absent.) However, ideas about the importance of body weight or shape do not preclude a diagnosis of BED, and some of those who were previously diagnosed under DSM-4 as having BN non-purging type may be best classified as having BED now that that diagnosis has been abolished. The boundary and relationship between the two disorders – BED and BN non-purging type – had not been entirely clear in practice (Santonaso, Ferrara, & Favaro, 1999).

BOX 1.3 DSM-5 Criteria for Binge Eating Disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   (1) Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
   (2) A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:
   (1) Eating much more rapidly than normal.
   (2) Eating until feeling uncomfortably full.
(3) Eating large amounts of food when not feeling physically hungry.
(4) Eating alone because of feeling embarrassed by how much one is eating.
(5) Feeling disgusted with oneself, depressed or very guilty afterwards.
C. Marked distress regarding binge eating is present.
D. The binge eating occurs, on average, at least once a week for 3 months.
E. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviours as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify if:

**In Partial Remission:** After full criteria for binge eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

**In Full Remission:** After full criteria for binge-eating disorder were previously met, none of the criteria have been for a sustained period of time.

Specify current severity:

**Mild:** 1–3 binge-eating episodes per week.
**Moderate:** 4–7 binge-eating episodes per week.
**Severe:** 8–13 binge-eating sessions per week.
**Extreme:** 14 or more binge-eating episodes per week.

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**TWO CLICHES**

The first cliche is the story of the blind men and the elephant. Each of the blind men touches and describes and makes inferences from the piece of the beast that they feel. The one who feels the trunk says it is like a serpent whilst another who feels the leg thinks it is like a tree. And so on. BED
sometimes seems rather like that. Thus to some – perhaps taking the population view – BED is the least serious of the eating disorders with a changeable course, a tendency to remit although also to relapse and a close relationship to obesity. But others – often from the clinical perspective – number some BED cases as amongst the most difficult to help within their practice.

The second cliché, invokes the well-known, although apocryphal, story that medieval philosophers spent much time debating how many angels could dance on the head of a pin. Some of the discussion about the niceties of eating disorder classification can seem a bit like that. The comings and goings of disorders and sub-types within or between diagnostic and classificatory systems do have some importance, but sometimes it is useful to take a step back, chuckle and not to take the fine print or ourselves too seriously.

Another story may help, although this too is a fiction.

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**Roland: A Story of Binge Eating Disorder**

Roland was the only child of a single mother. He had been ‘big’ for almost as long as he could remember. Early on this was good. His adolescent growth spurt had come a couple of years sooner than expected. When he was aged 9 or 10, he was taller, more muscular and generally more developed than his classmates. He was regularly one of the first to be picked for football teams both for organised school games and for informal kick-abouts in the playground, even though his skills were average at best. He was picked for his strength and his size. In his last year at junior school, he experienced a fragile popularity. But shortly after his move to secondary school when he was not yet 12, his growth in height began to slow and after a further year it had stopped. Roland had to watch his peers continuing to grow. Many overtook him in height. His confidence fell as did his popularity; at the new school, many of the pupils had been to other junior schools and had no experience of Roland being other than a rather anxious boy of average height, slightly plump and with an unusual first name. Roland’s 14th year was an ‘annus horribilis’. Most importantly his mother fell ill and was diagnosed as having multiple sclerosis. Her symptoms varied in severity, and at times she was almost her old self, but often Roland had to look after her, being her support, her nurse and as she put to him the ‘man about the house’. At school, he managed to keep up with his studies, although he did not excel. He had given up sport, had few friends and was increasingly teased. He was teased about his name, some kids calling him ‘Roland Rat’ after a puppet character on television and others ‘Roly Poly’ because of his evidently rising weight. He came to dislike and sometimes to fear going to school and to spend most
of his time at home. It was around this time that in addition to his normal meals, he started eating more in the evenings. Sometimes, he would stuff himself with whatever food was to hand. But soon he was buying extra biscuits and chocolate when he did the shopping and hiding them away from his mother. On occasion, he would steal chocolate bars from the sweet shop. He felt ashamed and out of control but also looked forward to these binging episodes as time when he could lose himself. A pattern was being set that would persist for the next 20 years or more.

Roland left school when he was 17. His sixth form studies had not been going well and he had decided that he did not want to go to university. He felt that he could not leave his mother and wanted to start earning money. After a false start with a job in furniture store, he moved to work in a car dealership. To his surprise, he enjoyed the work and when allowed the chance proved to be a good salesman. At work, he developed a persona as a jolly man, always cheerful and always cracking jokes. Once or twice each week, he would go to the pub with a group of his colleagues but that was his social life. He would rarely meet with his workmates otherwise and never visited their homes. And they never visited his home.

Over the years, Roland’s mother became more disabled and more dependent on her son. She did have some domiciliary services, but she would irritate her son, when she would decline more help, saying ‘We can cope, can’t we, Roland’. Still jolly and cheerful at work, at home Roland was compliant, dutiful, miserable and frustrated. He steadily gained weight, and by the time he was 30, his BMI was 34. Most days he would cook an evening meal, and later he would watch television and eat snacks. Frequently, he would let go and binge. No one knew of his eating problem, although people did comment about his weight. On two or three occasions, he made a major effort to lose weight by following a slimming diet. However, he could not sustain such efforts. He considered joining a slimming group but was teased about it by his colleagues and told not to be silly by his mother.

When he was aged 37, his mother died and he found himself living alone in his family home. He thought he could now build a new life. He dreamt of having a social life, finding a girlfriend and even getting married and having children. But in reality, he found it difficult to change. He became depressed about what he thought of as his wasted life and the feeling of hopelessness about the future. He was scared when he began thinking of ending his life and went to see his general practitioner. The doctor listened and prescribed an antidepressant and mentioned the possibility of counselling. Roland made no mention of his eating problem. He did not like taking tablets but he did so for 2 or 3 weeks and felt somewhat better and binged much less. But did not go back to his doctor for review as had been suggested. For the next few months, he binged only occasionally, but then for no reason that he could come up with fell back into the habit of binging more seriously and
more frequently than before. He went back to see his doctor and this time talked about his eating problem. The doctor referred him to the local mental health services with a provisional diagnosis binge eating disorder.

OTHER DIAGNOSTIC CATEGORIES

The new classification DSM-5 has several other eating disorders including pica, the eating of non-nutritive and non-food items, and rumination disorder with recurrent regurgitation of food. Both of these were established diagnoses, but they are quite different from the three main eating disorders and they fall outside of the scope of this book and will not be discussed.

A third diagnosis ARFID was newly minted. This category has no age limits, but it replaced earlier categories that were for disorders of childhood. It remains to be seen how the new concept of ARFID fits the world as it is and how useful it may be in practice. It does seem to define a small group of patients whom clinicians will recognise and who are markedly different from the three main eating disorders. This disorder will be discussed in Chapter 9.

RESIDUAL CATEGORIES

As stated above, the previous DSM classification (DSM-4) was notorious for having a residual diagnosis – ‘EDNOS’ – that was often the most used category. DSM-5 allows the classification of disorders that resemble one of the main diagnoses but fail to fulfill the criteria by the use of a category ‘Other Specified Feeding or Eating Disorder’. An example given is ‘Bulimia nervosa of low frequency and/or limited duration’. There is another truly residual category named ‘Unspecified Feeding or Eating Disorder’.9

SOME RESIDUAL ISSUES

This chapter is entitled ‘What Are the Eating Disorders?’ and for the purposes of this book the answer may be simplified to be mainly AN, BN and (BED). Indeed, for some purposes, especially treatment, BN and BED are closely similar, and later they will sometimes be lumped together as ‘bulimic disorders’.

There remain three issues to be flagged up at this stage, although each will be touched upon later in the book. They are obesity, comorbidity and transdiagnostic thinking.
Obesity is variously defined but a person with a BMI of over 30 would usually be thought to be obese and a BMI of over 40 warrants the term severe obesity. Some people with eating disorders are obese, but only a minority of obese people have a definable eating disorder. This book will consider obesity only as a background factor or comorbidity for some eating-disordered sufferers rather than as a topic in its own right.

Comorbidity in general is another issue which should be flagged at this stage and revisited later. This meant the coexistence of two or more diagnosable disorders in one person at the same time – for instance, BN and major depression. The need to make such dual diagnoses – especially if they are common pairings such as this – should make us aware of the shaky conceptual rigging that holds up many of our cherished diagnostic concepts.

‘Transdiagnostic’ is the term advocated by Fairburn and his group to express the idea that the features the three main eating disorders have in common are more important than what divides them. Furthermore, there is much migration between categories – especially between AN and BN. They suggest that a common ‘transdiagnostic’ treatment approach is possible and have created such a therapy (Fairburn & Cooper 2011; Fairburn, Cooper, & Shafran, 2003).

This chapter has been concerned mainly with definition. Chapter 2 will look at the results of taking these definitions out into the world and counting and describing the kind of people to whom they apply.

NOTES

1 There are two major diagnostic systems for mental disorders: the International Classification of Diseases, 10th edition (ICD10) which is produced by the World Health Organisation (WHO) and the Diagnostic and Statistical Manual of the American Psychiatric Association now in its fifth edition, known as DSM-5. ICD10 is often used in compiling comparative statistics. However, the DSM system is almost always used in research and, despite flaws, is arguably better for the eating disorders. However, at the time of writing, DSM-5 has been available in its definitive form only for a few weeks and it is too soon to judge how well it works in practice. Nevertheless, it will be used throughout this book. The planned revision of the WHO system – ICD11 – is still months or years away.

2 Non-medics may be surprised at this mention of syphilis. However, syphilis is famous – or infamous – as a chronic disease which can present in many contrasting guises. It was one of the triumphs of diagnostic medicine when these various syndromes were linked together and understood as ultimately aspects of a single pathological process, which is infection with a particular bacterium.

3 DSM-4, the preceding classification, became notorious for having a residual category – EDNOS – which in many clinical series was the biggest category and sometimes was applied to the majority of cases. At the time of writing, it is not yet clear how DSM-5 will perform in this respect.
Both of these papers can be found in the original volumes but both are reprinted in a book called *Evolution of Psychosomatic Concepts – Anorexia Nervosa: A Paradigm* which was published in 1965. This is now itself of historical interest. It contains several other reprints of papers about AN from the early twentieth century. It is included in the reference list under Mount Sinai (1965). A commentary and additional translation of Lasegue’s account may be found in a paper by Vanderycken and van Deth in the *British Journal of Psychiatry* (1990).

The case histories used in this book are fictitious. I have concocted them to avoid problems of confidentiality. Also, invented stories can be fine-tuned to illustrate certain points. They are, of course, merely illustrations – caricatures even – and not evidence. It should be kept in mind that the use of such stories can make things seem too clear and reinforce stereotypes. Real people are less neat.

The BMI is calculated by dividing the weight in kilograms by the square of the height in metres. It is used as a way of trying to remove the issue of height when comparing degrees of thinness or obesity. People with the same BMI have broadly similar degrees of plumpness whatever their height, even though their crude weight may differ markedly. A normal healthy BMI range is usually taken to be that between about 19 and 25. As an example, for a person who is 1.76 m tall, this range would coincide with body weights between 57 and 75 kg. BMI is not a perfect index, but it is much superior to weight alone.

Regular induction of vomiting by this method may lead to one of the few physical signs of psychiatry: Russell’s sign. This is a callous on the back of the hand which has been caused by the repeated impact of the teeth on the skin when sticking fingers down the throat. The sign was described and illustrated in Gerald Russell’s classic paper which first defined and named BN (Russell, 1979). Russell’s sign is not common. However, its recognition can cause a glow in the bosom of the psychiatrist with a nostalgia for physical medicine with its abundance of eponymous signs.

I guess that most eating disorder buffs have their stories about people who have demonstrated their combination of desperation and ingenuity by trying to adopt extreme or unusual methods of weight control. Using enemas or claiming to have taken a drug overdose in order to gain a stomach washout is not that rare. Inducing vomiting by the use of the emetic drug ipecac was not uncommon for a time in North America, although it was never popular in Europe. It caused cardiomyopathy. One of the more unusual stories in my experience was that of a young woman who observed that horses lost condition and weight when infected by the larvae of the bot fly. She decided to eat bot fly eggs in the hope that they would hatch out within her and help her to use up her binged food. Unfortunately for her plan, although fortunately for her health, the bot fly is a discriminating little creature and lays eggs which hatch out happily in the innards of a horse but not in those of a human. Nothing happened.

At the time of writing, the DSM-5 criteria have been published for a few weeks and I do not know how they will work out in practice. I have dithered with regard to how much to discuss the details of classification and have decided to omit further comment. Those who want more should read the DSM-5 itself and the secondary literature that it will doubtless provoke in due course. Furthermore, the next World Health Organisation Classification – ICD 11 – will appear not
long after this book is published. It seems unlikely that there will be much change in the main categories of AN and BN with BED tagging along.

FURTHER READING