

Peter J. Cooper is Professor of Psychopathology at the University of Reading, and Honorary NHS consultant in Clinical Psychology.

The aim of the **Overcoming** series is to enable people with a range of common problems and disorders to take control of their own recovery program. Each title, with its specially tailored program, is devised by a practising clinician using the latest techniques of cognitive behavioral therapy – techniques which have been shown to be highly effective in helping people overcome their problems by changing the way they think about themselves and their difficulties. The series was initiated in 1993 by Peter Cooper, Professor of Psychology at Reading University in the UK whose book on overcoming bulimia nervosa and binge-eating continues to help many people in the UK, the USA, Australasia and Europe.

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OVERCOMING BULIMIA NERVOSA AND BINGE-EATING

*A self-help guide using
Cognitive Behavioral Techniques*

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Important Note

This book is not intended as a substitute for medical advice or treatment.
Any person with a condition requiring medical attention should consult
a qualified medical practitioner or suitable therapist.

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Acknowledgements

The self-help manual which forms the major part of this book is based on the application of cognitive behavior therapy to bulimia nervosa and binge-eating. This application was first described by Dr Christopher Fairburn of the Department of Psychiatry at the University of Oxford in 1981 in an article in the journal *Psychological Medicine*. Over the course of the subsequent fifteen years, I worked with Dr Fairburn and his colleagues to develop and refine this method of treatment, and I am enormously indebted to Dr Fairburn for his advice and support in modifying the treatment program so that it can be presented in the form of a self-help manual.

The manual as it appears in this book has gone through a great many revisions. These have been motivated largely by the comments and criticisms I have received from people with bulimia nervosa who have been using the manual as a means to recovery. I am very grateful to them for their help in shaping the final version. I am particularly grateful to those people who have agreed to my including in this book direct quotations from their accounts of their problems and of their use of the manual.

A number of my colleagues were kind enough to read the original manuscript of this book and offer advice and criticism. For this service I am especially grateful to Sarah Beglin, Sian Coker, Carmel Fleming, Lynne Murray, Jane Steere and Christina Wood.

PJC

Preface

The main aim of this book is to give people with bulimia nervosa and binge-eating problems the means to help themselves towards recovery. To this end the core of it (Part Two) consists of a self-help manual, which sets out detailed guidelines about what steps need to be taken to restore control to one's eating. These guidelines are based on extensive research into the most effective means of treating people with bulimia nervosa.

The self-help manual as presented here has gone through many revisions. These have been made on the basis of the experience of myself and my colleagues in helping patients with bulimia nervosa use the manual. A great many of these patients have now done so and gained considerable benefit from it. It is now clear from research into the effectiveness of the manual, that the great majority of people with bulimia nervosa and binge-eating problems could profitably use the principles spelled out in this manual as a guide towards recovery.

It is important to be clear about what 'recovery' from bulimia nervosa means. Many people do recover fully. They

become able to eat normally without anxiety and without the concerns about their weight and shape which used to dominate their lives. However, many remain vulnerable to difficulties with food and related concerns, even if this vulnerability only becomes evident on rare occasions of stress. The existence of this residual susceptibility does not mean, however, that the person has not recovered. Indeed, a realistic notion of recovery that accepts that difficulties with eating may occasionally recur is both more realistic and more helpful than a rigid definition, and can be a protection against both disappointment and imprudence.

This book is principally intended for people with bulimia nervosa and variations of this disorder. However, it will be of use to some other people as well. The families and friends of people who binge often want to know more about the problem. Part One provides a brief account of the nature of bulimia nervosa and binge-eating problems which will be of use to them, as well as a note on the definition of bulimia nervosa and binge-eating and its relation to other eating disorders. Also, it is helpful to someone who is trying to use this manual if other people in their household are aware of what they are trying to do. By reading the manual, a parent, partner or friend can ensure that they give as much help as possible. Finally, it is suggested in the self-help manual that it is advisable for the person wishing to use it to recruit the assistance of a helper. This could be a friend or relative, but it is preferable if it is someone less closely involved with them, such as a general practitioner, a nurse or a dietitian. Clearly, for such a person to be of most help, they too need to know what advice is contained in the manual.

Introduction

Why a cognitive behavioral approach?

The approach this book takes in attempting to help you overcome your problems with bulimia nervosa and binge-eating is a 'cognitive-behavioral' one. A brief account of the history of this form of intervention might be useful and encouraging. In the 1950s and 1960s a set of therapeutic techniques was developed, collectively termed 'behavior therapy'. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes (traditionally the focus of psychoanalysis, the approach developed by Sigmund Freud and his associates). Second, they were scientifically based, in the sense that they used techniques derived from what laboratory psychologists were finding out about the mechanisms of learning, and these techniques were put to scientific test. The area where behavior therapy initially proved to be of most value was in the treatment of anxiety disorders, especially specific phobias (such as extreme fear of animals or heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that many patients were experiencing. In particular, behavior therapy proved inadequate when it came to the treatment of depression. In the late 1960s and early 1970s a treatment for depression was developed called 'cognitive therapy'. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck. He developed a theory of depression which emphasized the importance of people's depressed styles of thinking, and, on the basis of this theory, he specified a new form of therapy. It would not be an exaggeration to say that Beck's work has changed the nature of psychotherapy, not just for depression but for a range of psychological problems.

The techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a therapeutic approach which has come to be known as 'cognitive behavioral therapy' (or CBT). This therapy has been subjected to the strictest scientific testing and has been found to be highly successful for a significant proportion of cases of depression. However, it has now become clear that specific patterns of disturbed thinking are associated with a wide range of psychological problems, not just depression, and that the treatments which deal with these are highly effective. So, effective cognitive behavioral treatments have been developed for a range of anxiety disorders, such as panic disorder, generalized anxiety disorder, specific phobias, social phobia, and obsessive compulsive

disorders. Indeed, cognitive behavioral techniques have been found to have an application beyond the narrow categories of psychological disorders. They have been applied effectively, for example, to helping people with weight problems, couples with marital difficulties, as well as those who wish to give up smoking or deal with drug or drinking problems. They have also been effectively applied to dealing with low self-esteem and problematic perfectionism. In relation to the current self-help manual, over several years effective CBT techniques have been developed for helping people overcome their problems with bulimia nervosa and binge-eating, and it is now widely accepted that CBT is the first line treatment for these conditions.

The starting-point for CBT is the realization that the way we think, feel and behave are all intimately linked, and changing the way we think about ourselves, our experiences, and the world around us changes the way we feel and what we are able to do. So, for example, by helping a depressed person identify and challenge their automatic depressive thoughts, a route out of the cycle of depressive thoughts and feelings can be found. Similarly, habitual behavioral responses are driven by a complex set of thoughts and feelings, and CBT, as you will discover from this book, by providing a means for the behavior, thoughts and feelings to be brought under control, enables these responses to be undermined and a different kind of life to be possible.

Although effective CBT treatments have been developed for a wide range of disorders and problems, these treatments are not currently widely available; and, when people try on their own to help themselves, they often, inadvertently,

do things which make matters worse. In recent years, with the help of Constable & Robinson, experts in a wider range of areas have taken the principles and techniques of specific cognitive behavioral therapies for particular problems and presented them in manuals (the Overcoming series) which people can read and apply themselves. These manuals specify a systematic program of treatment which the person works through to overcome their difficulties. In this way, cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

The use of self-help manuals is never going to replace the need for therapists. Many people with emotional and behavioral problems will need the help of a qualified therapist. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of these self-help manuals is at an early stage, the work done to date indicates that for a great many people such a manual is sufficient for them to overcome their problems without professional help. Sadly, many people suffer on their own for years. Sometimes they feel reluctant to seek help without first making a serious effort to manage on their own. Sometimes they feel too awkward or even ashamed to ask for help. Sometimes appropriate help is not forthcoming despite their efforts to find it. For many of these people the cognitive behavioral self-help manual will provide a lifeline to a better future.

Peter J. Cooper

The University of Reading, 2009

PART ONE

About Binge-Eating and Bulimia Nervosa

Prologue

A day in my life

I wake up late. It is a quarter past eleven and I have missed my morning classes. I feel terrible. My head aches. My mouth feels dry. My throat is sore. My eyes are puffy. And my face feels swollen. I get out of bed and almost faint I am so dizzy. Remembering last night's binge-eating and vomiting, I feel so ashamed and disgusted with myself. Why do I do it? I go to the bathroom and get on the scales. I do this three times just to make sure. 127 pounds. I have gained two pounds since yesterday. This is terrible.

Today I shall have to make sure I eat absolutely nothing. I have three glasses of water and feel a little better, resolved to fast for the entire day. I consider having a bath but shower instead so that I will not have to look at my thighs spreading out before me. I decide that I am too fat to go out. I pad round my room doing a little tidying and trying to write a letter to my mother. But I can't stick at anything. All I can think about is

how fat I am. At a quarter past two I weigh myself again. Three times. 126 pounds. Hooray!

I drop in on a friend. She is in the kitchen. I join her and, when she offers me a cracker, I have one. I have two more. I am feeling very nervous now because I should not have eaten anything. I excuse myself, go to the toilet, drink water from the tap, and stick my fingers down my throat and get rid of the crackers. I feel better but still a little shaky because I think I am hungry. Thoughts of food go round and round in my head.

I decide it was a mistake to come out and head back to my room. On the way I pass the bakery. In a moment the urge to binge sweeps over me and my resolve crumbles. I buy two Danish pastries, a cheese roll, three doughnuts and, round the corner, two chocolate bars and a large bottle of lemonade. I rush up to my room, spread the lot out before me. I start eating. At first the taste and texture of the pastry is wonderful. I feel thrilled and appalled at the same time. I eat very fast. I drink the lemonade straight from the bottle to wash down the food. I just shovel it in, not tasting it at all. In 20 minutes it has all gone. I feel uncomfortably full. If I try to move I feel a sharp pain in my stomach. I try not to look down because I am aware that my stomach is sticking out.

I go to the toilet, stick my finger down my throat and vomit. I do this again and again to make sure I get rid of as much of the food as possible. I go to my bed and lie down. All I can think about is that I have gained more weight. I try to calm down but this is

impossible and I go and weigh myself. 128 pounds. I feel in despair. I go back to my bed, lie down and cry. I hate myself. I hate my fat body. I am so disgusting.

I doze for a while. When I wake up I feel I must eat. It is night. I go to the corner shop. I feel as if I am almost in a trance. I buy more food. Chocolates, bread, a pack of cereal. Thankfully nobody knows me around here. I return to my room and eat the lot. I vomit again. I feel terrible. I cry myself to sleep.

What are binge-eating and bulimia nervosa?

I began binge-eating when I was about seventeen. I was lonely, shy and lacking in self-esteem. Every binge made me feel worse, made me hate myself more. I punished myself with more and more food. Within months I was binge-eating as a matter of course, and I gained weight rapidly. I loathed myself and only continued with normal life by pretending to be 'normal'.

Almost everyone at some time or other overeats. It is common for people to regret such indiscretions and to feel a little guilty and ashamed about them. Such episodes and feelings are so common that they are perfectly 'normal' and not a source of concern. For others there is a very different quality to their overeating. They would say, with deep shame and remorse, that they lose control of their eating and binge.

Binges are by no means the province of people who are overweight. Indeed, about half those with the eating disorder anorexia nervosa, who are by definition very thin, experience episodes of binge-eating. And some whose weight is within the normal range also binge. Many of these have an

eating disorder which has come to be known as bulimia nervosa. In addition to binge-eating, these people go to great lengths to compensate for overeating and are intensely concerned about their body shape and weight.

Binge-eating

What is a binge?

It starts off with me thinking about the food that I deny myself when I am dieting. This soon changes into a strong desire to eat. First of all it is a relief and a comfort to eat, and I feel quite high. But then I can't stop and I binge. I eat and eat frantically until I am absolutely full. Afterwards I feel so guilty and angry with myself.

The word 'binge' is used differently by different people. It took some time for a consistent definition to be established, but a clinical consensus has emerged. It is now accepted that a true binge is an episode of eating marked by two particular features. First, the amount eaten is, by 'normal' standards, excessively large. Second, and most significantly, the eating is accompanied by a subjective sense of loss of control.

The experience of binge-eating

I randomly grab whatever food I can and push it into my mouth, sometimes not even chewing it. But then I start feeling guilty and frightened as my stomach begins

to ache and my temperature rises. It is only when I feel really ill that I stop eating.

Binges almost always occur in secret. Indeed, this secret can be kept for many years. The binges take place in private and, often, an appearance of 'normal' eating is maintained in front of others. Keeping this secret can involve considerable subterfuge and deception.

Binges typically take place where food supplies are kept, often the kitchen. Some people binge while buying food, eating between shops.

I leave work and go shopping for food. I begin eating before I get home, but it is secret, with the food hidden in my pockets. Once I'm home proper eating begins. I eat until my stomach hurts and I cannot eat any more. It is only at this point that I snap out of my trance and think about what I have done.

Usually, the food eaten in a binge is consumed very quickly. It is stuffed into the mouth almost mechanically and barely chewed. The first moments of a binge are often described as pleasurable; but soon all sense of taste and pleasure is lost. Many people drink large quantities during binges, which contributes to their feeling progressively full and bloated.

When the urge to binge comes I feel hot and clammy. My mind goes blank, and I automatically move towards food. I eat really quickly, as if I'm afraid that by eating

slowly I will have too much time to think about what I am doing. I eat standing up or walking around. I often eat watching television or reading a magazine. This is all to prevent me from thinking, because thinking would mean facing up to what I am doing.

Many people describe their binges as frenetic and desperate affairs. There is a powerful craving for food which they experience as overwhelming. It is this sense of being driven to eat which has led some to use the term 'compulsive eating' to describe binge-eating. The desperation people feel drives them to behave in ways quite alien to their character. They will take food belonging to their friends, steal from shops, or eat food that others have thrown away.

I begin by having a bowl of cereal. I eat it really quickly and then immediately have two or three more bowls. By then I know that my control is blown and that I am going to go all the way and binge. I still feel very tense and I desperately search for food. These days this means running around college looking for food people have thrown out. I know that this is really disgusting. I stuff the food down quickly. Sometimes I go into town stopping at stores along the way. I only buy a little from each store so as not to arouse suspicion. I stop when I have run out of money or, more usually, because I am so full that I physically cannot eat any more.

What is eaten, and how much?

I stop eating when I begin to feel ill. By then I have an overwhelming desire to rid myself of all the food I have eaten. I push my finger down my throat and vomit again and again until I feel completely empty. This makes me feel relieved and cleansed. It also leaves me exhausted.

The amount eaten during a binge varies greatly from individual to individual. Occasionally a patient will describe regularly having binges of 20,000 calories or more. This is not typical. The average calorie content of a binge tends to be between 1,500 and 3,500 calories.

After a binge I feel so full that my stomach hurts and I can hardly move. I feel sick and sometimes, when I have had a particularly bad binge, even breathing is difficult and painful.

Some eating episodes which are not binges in terms of the definition given above are regarded as binges by people who experience them. Although these episodes do not involve the consumption of abnormally large amounts of food, they are nevertheless distressing because the person feels out of control and eats when she would prefer not to do so.* These 'binges' have been called 'subjective binges', to distinguish them from true 'objective binges'.

* Because the majority of people who binge are women, female pronouns are used throughout this book to avoid the clumsiness of using both genders: 'he or she might feel', 'in his or her experience', etc. This is not in any way meant to exclude men.

True binges typically consist of bulk foods which are filling and high in calories. They tend also to be foods that people regard as fattening and which they are attempting to exclude from their diet. Many people believe that binges are especially high in carbohydrates, and that binges are driven by a specific 'carbohydrate craving'. This view is mistaken. Compared to normal meals, binges do, indeed, contain more carbohydrate; but they also contain more fat and more protein. And the proportion of a binge made up of carbohydrates is almost exactly the same as in normal meals.

The food I eat usually consists of all my 'forbidden' foods: chocolate, cake, cookies, jam, condensed milk, cereal, and improvised sweet food like raw cake mixture. Food that is easy to eat. Food that doesn't need any preparation. I never eat these kinds of food normally because they are so fattening. But when I binge I can't get enough of them.

What triggers binges?

Binges tend to be triggered by a characteristic set of events or experiences. These can be divided broadly into three categories:

1 *Those concerned with food and eating, e.g.:*

- breaking a dietary rule;
- having 'dangerous' (i.e. 'fattening') foods available;
- feeling full after eating;
- thinking about food.

The urge to binge usually begins around midday on a 'normal' day – that is, a day on which I am trying not to eat. During the afternoon thoughts of food become more and more of a preoccupation; and eventually at around 4.00 p.m. my power of concentration will be sufficiently non-existent for thoughts about food to be totally overwhelming. So I leave my work and go to the store.

One thing that definitely sets me off is hunger. If I am hungry, instead of eating something to satisfy it, I eat anything I can lay my hands on. It's almost as if I have to satisfy all tastes, even for things I don't like.

2 *Those linked to concerns about body weight and shape, e.g.:*

- brooding about shape or weight;
- discovering weight to be higher than expected;
- feeling fat;
- discovering clothes to be too tight or too small.

If I discover my weight has gone up, or I find that my clothes are too tight, or I look in the mirror and see that I am too fat, immediately I want to eat. I know this is silly when I really want so desperately to be thin, but I just feel as if I can't cope any more and I might as well just give up and eat. Of course, I feel even worse after the binge.

3 *Negative mood states, e.g.:*

- feeling miserable or depressed;
- feeling lonely or isolated;
- feeling tense, anxious or fearful;
- feeling angry or irritable.

Binges start when I'm tired or depressed, or just upset. I become tense and panicky and feel very empty. I try to block out the urge to eat but it just grows stronger and stronger. The only way I know to release these feelings is to binge. And binge-eating does numb the upset feelings. It blots out whatever it was that was upsetting me. The trouble is that it is replaced with feeling stuffed and guilty and drained.

All of the examples given above are reported as triggering binges by the majority of those who binge.

How do people feel after a binge?

After a binge I feel agitated, annoyed and frightened. Fear is a large part of what I feel about my eating, especially when I am totally out of control and horribly alone. My stomach and back ache and I feel hot and panicky. I am terrified about the weight I have gained. I feel full of anger towards myself for allowing it to happen yet again. I feel unclean inside. Dirty. I don't want anyone to see me. I hate myself.

The feelings people have after binges are a complicated mixture of emotions. There is an immediate sense of relief at having given up the struggle not to eat; but this is soon replaced by feelings of shame, guilt and disgust. Depression is common after binges as people feel hopeless about ever being able to control their eating.

These feelings are made worse by the physical effects of binge-eating. Tiredness, abdominal pain, headaches and dizziness are common. Feelings of extreme fullness and bloatedness are almost always present. The fear of weight gain is acute and drives people to adopt extreme methods to compensate for having overeaten.

Methods of compensation

Many people who binge go to considerable lengths to compensate for their episodes of overeating. In fact, such compensation is a defining feature of bulimia nervosa (see page 65). These include strict dieting and fasting, making themselves vomit, and taking laxatives, diuretics and appetite suppressants ('diet pills').

Dieting

Most people who binge are at the same time attempting to diet in order to lose weight. Dieting usually precedes the onset of binge-eating. But it is also an understandable response to binges, in that the fear of weight gain after a binge drives people to cut back on their eating.

There are basically three ways in which people diet in

order to lose weight and all three are typical of the eating habits of people with bulimia nervosa. The first method is fasting: that is, not eating anything at all for long periods of time. The second method is to eat sparingly: that is, to try to restrict eating to a small number of calories each day. The third method is to avoid certain types of food because they are believed to be fattening or because they have been found to trigger binges. (These 'trigger' foods are often described as 'forbidden', 'bad' or 'dangerous' foods.)

All three of these methods of dieting actually *encourage* overeating; and thus the process of dieting becomes inextricably linked to the episodes of loss of control over eating. Dieting makes people vulnerable to binges by creating physiological and psychological pressures to eat. And, as we saw earlier when looking at what triggers a binge, for people who have 'forbidden foods', breaking the rules they have set themselves and eating these foods frequently triggers binges.

Vomiting

I started vomiting after eating too much chocolate one day. It seemed a brilliant way of staying thin without dieting. I could eat as much as I wanted and then get rid of it. It would be so much easier than all that dieting.

The great majority of people with bulimia nervosa compensate for overeating by making themselves vomit. This is done privately and in secret. Typically, vomiting is induced by sticking the fingers or another object down the throat to induce the gag reflex. About a quarter of people with

bulimia nervosa who vomit have voluntary control over the gag reflex: that is, they are able to vomit at will simply by leaning forward or by pressing their hand on their stomach.

I first started vomiting as a way of eating what I liked, without feeling guilty and without putting on weight. Vomiting was surprisingly easy and I was pretty pleased with myself. It was only later that I realized what a problem it had become.

How often people with bulimia nervosa induce vomiting varies considerably. Some people vomit repeatedly throughout the day, vomiting after binges and after having eaten anything they regard as fattening. It is not uncommon for people to be vomiting ten times a day.

While some people vomit just once after a binge, others will do so repeatedly, sometimes for up to an hour. This process is physically and emotionally exhausting. Some use a flushing technique: they vomit, drink water, vomit again, drink again, and so on; and they repeat this process until the water returns clear and they feel confident that they have eliminated all the food they possibly can. This can be physically harmful (see chapter 3).

I eat until I literally cannot eat any more. Then, using my fingers, I make myself sick. Over the next half-hour, drinking water between vomits, I purge all the food from my stomach. I then feel despondent, depressed, alone and desperately scared because I have lost control

again. I feel physically terrible: exhausted, puffy-eyed, dizzy, weak, and my throat hurts. I am also scared because I know it is dangerous.

Usually people begin to induce vomiting as a response to having lost control of their eating. They binge, are terrified of the potential effect on their weight and shape, and therefore make themselves vomit. Many people say that when they first discovered that they could vomit successfully after eating, they felt quite elated, because it seemed to them as if they could now eat what they liked without this affecting their weight. However, this elation is short-lived, because it soon becomes clear that, by removing the psychological and physical barriers restricting eating, vomiting actually encourages overeating. Also, the process of vomiting is easier following the consumption of large rather than small amounts of food; so the size of binges increases. Vomiting, therefore, leads to more frequent binge-eating, and to eating more and more in each binge episode.

Some people who binge established the habit of vomiting before starting to experience loss of control over eating. They have used vomiting in addition to dieting as a method of weight control. People who do this often find that at first it seems to work; that is, that they lose some weight. However, soon the combination of weight loss and hunger drives them to overeat. They respond by further vomiting which in turn leads to more overeating.

Some people who find it difficult to vomit take additional substances to induce nausea 'chemically'. They may drink salt water, or occasionally domestic chemicals, such

as shampoo. Others take syrup of ipecac. All these practices are dangerous and have a variety of adverse effects.

Over the past eight years I have repeatedly said to myself 'This is going to be the last time that I throw up'. At first I was not that bothered: I thought I could control it, if I chose to. But it soon became clear that it had control over me. Now stopping seems completely beyond my reach.

There are a number of reasons why vomiting should not be used as a means of weight control. First, it can be physically damaging, even dangerous (see chapter 3). Second, it can be just as damaging psychologically, with most people who do it suffering feelings of considerable shame and guilt. Third, it often becomes a habit which is difficult to break. Finally, it is not nearly as efficient at eliminating calories as those who do it tend to believe. In fact, while the majority of calories consumed in a binge are usually eliminated by vomiting, a significant proportion are absorbed. Given that binges frequently consist of large amounts of food, the number of calories absorbed can be considerable. For some people who binge and vomit frequently and attempt to fast between binges, their body weight is largely maintained by the calories they absorb from binges.

Misusing laxatives and diuretics

I started taking laxatives because I was scared that because I was eating so much I would get fat really

quickly. I thought that if I took laxatives all the food would go straight through me.

I read in a magazine about people using laxatives as a way of purging themselves. I'd tried vomiting but couldn't do it. So I went out and bought some laxatives and downed ten after every binge. I know deep down that they didn't really do anything to counteract the binge, but they made me feel empty and cleansed inside.

About one in five people with bulimia nervosa attempt to compensate for having binged by taking laxatives in the belief that the laxatives will reduce food absorption. In fact this is not so, because laxatives act on the lower portion of the gut and calories contained in the food eaten are absorbed higher up in the digestive system.

There are a number of complications associated with using laxatives as a method of weight control (see chapter 3). One of these is that, if laxatives are taken regularly, the body gets used to them and higher and higher doses are needed to produce an effect. Some people end up taking considerable quantities (up to 100 times the normal dose). Another complication is that the body responds to the taking of laxatives by retaining fluid. This leads to edema (water retention), which causes puffiness round the eyes and general swelling, especially around the wrists and ankles.

The hardest thing after a binge is waiting for the effects to die down. I hate feeling so useless and unable to do anything. Sometimes I feel I could literally rip open my

stomach and pull out the garbage inside, the disgust and revulsion is so great. Failing that, laxatives are the next best thing.

Some people use diuretics ('water tablets') instead of, or in addition to, laxatives, as a means of reducing their weight. In fact, diuretics have no impact at all on body weight. The small effect they seem to have is solely due to fluid loss; and this 'weight loss' is rapidly reversed when, in response to dehydration, fluids are consumed.

Other methods of compensation

The desire to compensate for overeating and to reduce weight is intense in people with bulimia nervosa. They will do whatever they feel is necessary to avoid eating and to deal with having eaten more than they had wished. Some people exercise excessively, some for many hours every day. Some take appetite suppressants. There is no evidence to suggest that these drugs are an effective way of reducing the frequency of binge-eating.

Attitudes to weight and shape

My confidence and feelings of self-worth are deeply rooted in the idea that I must be physically attractive, i.e., thin. When I put on weight, even one pound, I risk being unattractive, and I see my future as bleak and lonely. This thought fills me with despair, so I force myself to eat as little as possible.

For many people who binge and all of those with bulimia nervosa, concerns about body weight and shape have enormous significance. Their sense of self-worth depends above all on how they feel about their weight and shape; little else, if anything, figures nearly as strongly in their judgments of themselves. Concerns about their shape and weight dominate their lives. Many are consumed by a powerful desire to lose weight and become thin. If they think they have gained weight or have become fat, they see this as a catastrophe and it has a profound effect on their lives. They feel deeply depressed, avoid company and give up attempting to control their eating. As a consequence they binge, become more depressed and fiercely attempt to renew their efforts to diet and lose weight. If, on the other hand, they find they have lost weight they can feel quite elated. Most are acutely sensitive to small changes in weight and shape which are, in truth, undetectable by ordinary means.

I am confident in many ways, yet I hate my body and can't bear to look at it. I feel bloated, wobbly and huge all over. This drives me to binge. My boyfriend loves me. Why can't I like myself?

I am obsessed with my weight. I weigh myself over and over again, sometimes up to fifteen times a day. At other times I am so disgusted with my body that I don't use the scales for weeks or months at a time.

It is these concerns, and the belief that self-worth depends on weight and shape, which drive the disturbed eating habits of people with bulimia nervosa. Thus, dieting follows quite logically from these concerns. And, given these beliefs, it is understandable why extreme measures (such as vomiting) are seen as necessary if overeating has occurred. Indeed, many working on eating disorders consider that beliefs and values about weight and shape are the core disturbance in bulimia nervosa.

People with bulimia nervosa usually have a disturbance in their body image. This takes two forms. First, they commonly feel strongly dissatisfied with their body shape. Typically, despite their weight being perfectly 'normal', they feel that certain parts of their body (for example, the stomach, bottom and hips) are too fat. This often causes great distress and spurs them on to more intense dieting. Second, they tend to overestimate their actual size: that is to say, they see their body as larger than it actually is. On top of this, they have an unrealistically small 'ideal' size.

Figure 1 (see page 25) shows the differences in how a group of patients with bulimia nervosa, and a group of 'normal' weight students not suffering from the disorder, saw their existing and 'ideal' shape.

The top row of outlines shows how the sample of 'normal' weight students saw themselves. Outline A is a representation of an average weight, average height young woman. Outline B shows the average of the students' own estimate of their actual size: and it is apparent that it is slightly more (about 5 per cent more) than the actual average size. Outline C shows the desired size of these students, which is some

10 per cent below their actual size. In other words, it is common for young women of 'normal' weight to want to be 10 per cent slimmer than they actually are. The bottom row of outlines shows the same information for the sample of patients with bulimia nervosa. They overestimated their actual size (Outline D) by, on average, nearly 20 per cent (Outline E); and their desired size (Outline F) was 25 per cent below their actual size. In other words, they saw themselves as substantially larger than they actually were; and they wanted to be significantly smaller than they were. Indeed, they wanted to be almost half the size they thought they were!

I cannot put into words how repulsed I am with my body. I wish it were possible to wear clothes that disguised one's shape completely. I cannot bear to look at my body and will have no mirrors in the house. I take showers instead of baths to avoid having to look at myself. I have not gone shopping for clothes for more than three years.

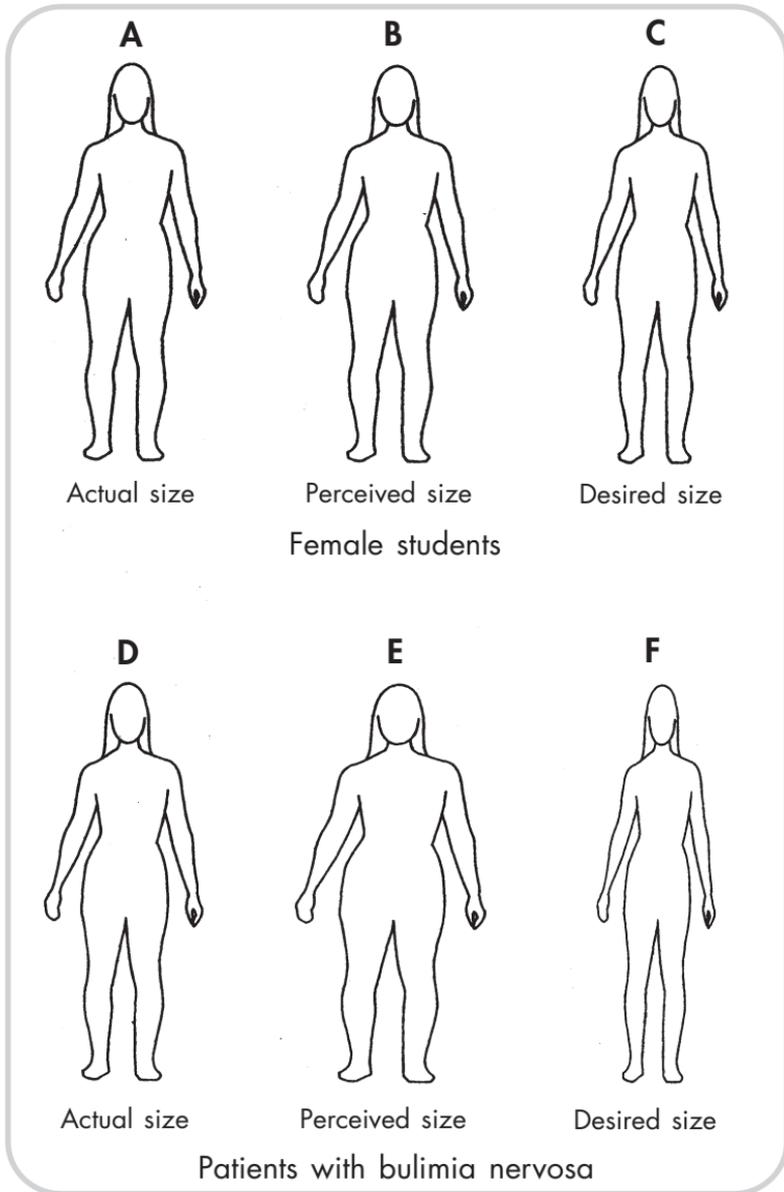


Figure 1 Actual, perceived and desired body size in people with bulimia nervosa and 'normal' female undergraduate students