ANOREXIA NERVOSA

Self-induced Vomiting: I. An Ominous Variant of Anorexia Nervosa

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The findings in this paper are based on 13 patients (12 female and 1 male) under my personal care who all satisfied the criteria for the diagnosis of anorexia nervosa (Russell, 1970). In addition, they had persistently made themselves vomit after most meals, over the course of several years (mean of 5·4 years). There were also episodes of over-eating that culminated in vomiting. The vomiting was done in private and achieved by stimulating the throat with fingers or a toothbrush, drinking large amounts of fluids or bending over, or a combination of these devices.

The aim of this paper is to indicate how self-induced vomiting modifies or complicates the more typical illness of anorexia nervosa.

1. The mean age of onset of the illness in these patients was 21·3 years compared with 15·5 years in a previous series (Morgan and Russell, 1975).

2. The patients were even more fearful of becoming fat and preoccupied with thoughts of food than is usual in anorexia nervosa. This preoccupation gave way to bouts of overeating which led the patient to make herself vomit in an attempt to prevent, as she saw it, the dreaded consequence of eating. This cycle became repetitive, and patients often drew an analogy with the habitual drinking of the alcoholic. Most were very thin or had been so in previous years, but there was sometimes a tendency for weight to rise and yet for vomiting to persist. Another curious feature was the occasional resumption of menstruation at a lower body weight than in uncomplicated anorexia nervosa. Purgative abuse could also be most severe.

3. In contrast with typical anorexia nervosa, most of the patients had been sexually active, at least up to the onset of their illness: some had married and had pregnancies. Yet even the married patients had nearly all experienced serious sexual difficulties and were most reluctant to consider embarking on a pregnancy.

4. In addition to the usual malnutrition of anorexia nervosa, these patients often developed hypokalaemia which led to the serious complications of renal infections and renal failure—and the less important one of epileptic convulsions. Tetany also occurred.

5. The course of anorexia nervosa complicated by intractable self-induced vomiting is ominous. These patients are more difficult to treat. They usually require admission to a psychiatric unit where the mainstay of treatment is nursing care aimed at breaking through the patient's self-imposed weight threshold and controlling her vomiting. Behaviour therapy should be attempted, as described in Dr Slade's paper below.

References

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Self-induced Vomiting: II. Methods of Behaviour Therapy

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When confronted with patients who indulge in frequent self-induced vomiting one has to ask oneself the question 'why do they do it?' At the simplest level the answer to this question is that there are clear advantages to the patient from this behaviour. Patients can indulge their cravings for food to excess while at the same time avoiding the consequences in terms of weight gain. They can literally 'have their cake and eat it'. The first therapeutic requirement is therefore to convince the patient that the disadvantages of self-induced vomiting, in terms of effects on physical health, far outweigh these benefits. Let us assume that we have been successful in this respect; the next step is to undertake a behavioural analysis.

A common sequence of events described by patients with this problem is as follows: the patient begins by eating normally; very soon she reaches a subjective threshold-point at which she feels she has eaten too much and is therefore certain to put on weight; she then takes the decision to vomit afterwards; having made this decision she can then 'let herself go' and eat to excess, which she does; finally she will vomit repeatedly to empty her stomach, and this is followed by a strong sense of relief, both physical and mental.

On the basis of this type of analysis we have formulated three levels of therapeutic attack. The first level is aimed at attempting to help the patient avoid excessive eating, utilizing the basic principles of the Stuart self-control procedure (Stuart, 1967). We have obtained a limited therapeutic effect with this method, in terms of a reduction in frequency of self-induced vomiting, but only in patients with a relatively low frequency to start with, i.e. once per day.

In patients with a high frequency of self-induced vomiting (i.e. 6 to 10 times per day), we have been forced to try out two other, more extreme methods. Both of these were suggested by comments made by patients. The first involves 'direct confrontation', utilizing videotape feedback of an eating and vomiting session. The second involves 'apomorphine aversion' and is based on the observation that regular, self-induced vomiters no longer feel sick and nauseated when they vomit. The aim is to re-associate the act with the normal experiences of vomiting. Both of these produce an immediate improvement, which unfortunately is lost with time.

References

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How Anorexics See Themselves

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The tendency of anorexic patients to overestimate their own body size was one element of Bruch's (1962) concept of body image disorder. The first experimental validation of this tendency was reported by Slade and Russell (1973), who also demonstrated that overestimation was directly related to a poor prognosis and that patients tended to become more accurate with therapeutically induced weight gain.

More recent findings indicate that this disturbance is not specific to anorexia nervosa (e.g. Button *et al*, 1977 and Garner *et al*, 1976). The most recent data obtained in our Department, using larger samples, point to a lack of significant difference between anorexic and normal females except in the area of waist/stomach where there is a marked tendency of anorexics to overestimate to a greater extent than normal females of comparable age. An important difference, however, was that the anorexics were much more variable, reflecting the tendency of a significant minority to markedly underestimate their size.

This more general tendency to overestimate body size amongst young females is seen as being a reflection of the almost universal concern amongst women with the need to be slim. Further data revealed that overestimation amongst anorexics was directly related to subjective feelings of fullness and fatness as well as negative attitudes to the body, supporting an argument that abnormal body perception is not an isolated phenomenon.

Resulting from these data a two-factor theory of perceptual disturbance in anorexia nervosa is proposed. Firstly, feeling of fullness in the stomach, possibly resulting from a decreased tolerance for food associated with semi-starvation, coupled with high sensitivity to such feelings, leads to an abnormal perception of that part, which is capable of generalizing to other parts. Secondly, motivated distorted perception may be occurring, in that patients may be making a desperate communication aimed at warding off the feared weight increase.

Other data presented demonstrated that patients vary considerably in their perceptual response to treatment. In similar vein is the finding that vomiters are more inclined to overestimate than non-vomiters.

Finally, some therapeutic implications were outlined. Firstly there is usually a need for refeeding aimed at helping patients to re-adapt to normal intake levels. For most patients, however, this will not be sufficient, and it is suggested that psychotherapy, aimed at resolving the conflicts the patient experiences surrounding her perception of what it means to be normal weight will be an essential longer-term aim.

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