

Causal Factors of Bulimia in Adolescent Girls: The Impact of Family

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Brief History

As some historical research shows, eating disorders, (or some variation to) have been around since ancient times. After anorexia nervosa became more prevalent in Western Societies in the 1960's, the disorder bulimia nervosa; consisting of self-starvation by bingeing and purging, became even more frequent than anorexia nervosa (Polivy & Herman, 2002). Today the disorder Bulimia Nervosa, 90% of the cases being female, affects 1-3% of women at some point in their lives, typically beginning in adolescence (Manley & Leichner, 2003). Because the majority of the cases begin in adolescence, many studies are done on the causes of the disorder during the lives of adolescent girls. Bulimia nervosa is a growing field of study, being highly studied by many universities around the world.

Personal experience

Through my experience working with adolescent girls for the last seven months at a residential treatment center for troubled youth, I have become very interested in what factors contribute to the adolescent's difficulties. I am privileged to work directly with the girls, acting as a friend, but also as an authority figure. In this process, I have come to love the girls, and am able to see their many positive qualities along with the countless problems they face. The most prevalent disorders we treat, aside from anxiety and depression, are eating disorders, the most common being bulimia nervosa. Working at this treatment center, I quickly found the eating disorder bulimia nervosa to be much more than simply being insecure of physical appearance. In fact, no specific cause has been found (Bonne et al, 2003).

In processing with the students I have noticed a pattern of similar family structures and attributes that differ from what would be normal behavior. After defining bulimia nervosa using the *Diagnostic and Statistical Manual of Mental Disorders*, the paper will cover the many

different causes of Bulimia Nervosa, focusing specifically on how the family effects the adolescent and vice versa.

Diagnostic Criteria

According to the DSM-IV-TR, “The essential features of Bulimia Nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. In addition, the self-evaluation of individuals with Bulimia Nervosa is excessively influenced by body shape and weight. To qualify for the diagnosis, the binge eating and the inappropriate compensatory behaviors must occur, on average, at least twice a week for three months” (America Psychiatric Association, 2000, pp. 589).

One essential feature of Bulimia is binging, which is defined as eating amounts of food in a discrete period of time which are larger than what a normal individual would eat during the same given period of time. The duration of a binge is usually limited to less than two hours and does not have to be at a single sitting. Snacking throughout the day on small amounts of food is not considered criteria to be defined as a binge (America Psychiatric Association, 2000).

A binge episode may or may not be planned in advance and is usually done in secrecy. The binge is done inconspicuously because of the shame that usually is associated with the disorder. Typically a lack of self control, such as not being able to stop eating, is a characteristic of binge eating. The binge usually consists of sweet, high-calorie foods such as ice cream or cake, and lasts until the individual simply cannot eat any more due to pain or discomfort (America Psychiatric Association, 2000).

Typically following a binge episode are two methods of compensating for the fear of gaining weight, which are purging and non-purging types. The difference between the non-purging type and purging type is that the fist does not involve vomiting or abuse of laxatives,

diuretics, or enemas as means of compensating (Polivy and Herman2002). The most common compensation method, used by 80-90% of bulimia nervosa patients, is vomiting. Individuals who perform this type of purging use their fingers or other instruments to cause them to vomit (America Psychiatric Association, 2000). Loss of dental enamel, chipped teeth, increased dental cavities, calluses or scars on the fingers, menstrual irregularity, and enlargement of the parotid salivary gland are all symptoms caused by consistent vomiting (America Psychiatric Association, 2000).

Other compensation methods used by Bulimic patients are excessive exercise or fasting , both which fall under nonpurging type of Bulimia Nervosa (Polivy and Herman 2002). Purging is definitely more common at the treatment center where I work, but a few of the students have noted episodes of obsessive exercise, such as doing aerobics numerous times throughout the day.

Anorexia Nervosa and Bulimia Nervosa differ in very few ways. A few correlative features found more commonly in Bulimia Nervosa patients are: sexual promiscuity, suicide attempts, drug abuse, stealing, and shoplifting. Probably the most common distinguishing feature of bulimia nervosa patients is that of impulsiveness, which many times will lead an anorexic patient to bulimic tendencies. The only true criteria that distinguishes an anorexic patient with that of bulimic is that the later is unable to suppress their weight below 85% of what is considered a “normal” weight for an individual of similar stature (Polivy and Herman, 2002).

Causal Factors

Before an individual with Bulimia is ever born, they may genetically be predisposed to the possibility of having the disorder. Studies show that similar to substance use disorder, bulimia is also an addictive disorder which can be linked to other members in the family. Substance use patients may share a similar common genetic make-up as bulimic patients,

pointing towards the role of genetics (Ranson, McGue & Iacono, 2003). Researchers in this area also question the theory of biology and bulimia, probably because the abnormalities such as disruptive appetite and neuroendocrine systems being solely effects, not causes (Polivy & Herman, 2002).

Media, Peers, and Body Dissatisfaction

The media is so often the first to be attacked as having an influence on the cause of eating disorders. The celebrities in movies, magazines, and TV shows are many times unnaturally thin, or have eating disorders themselves. One study discovered that among girls, body dissatisfaction and a having a drive for thinness were associated with increased exposure to certain types of TV shows (Polivy & Herman, 2002). Peers can have a similar effect on girls with the eating disorder as the media does. A girl can be greatly influenced by her friendship “cliques” which usually share similar ideas with respect to body-image concerns. Some research suggests that peers and family have even a greater influence of causing bulimia than does the media. At the same time exposure to the media is so abundant that the question could be posed as to why more people would have the disorder (Polivy & Herman, 2002).

Dieting and Body Dissatisfaction

Dieting is many times, if not the majority of eating disorder cases, a gateway to developing an eating disorder, especially bulimia. Feelings of body dissatisfaction come as a girl perceives herself negatively in regards to weight and shape, which leads to thoughts of self-disgust, and the desire to diet begins to fill her mind. The more intense the dissatisfaction, (not by how many pounds the individual is overweight), determines the extent to which the individual will attempt to lose weight (Polivy & Herman, 2002).

Childhood Sexual and Emotional Abuse

Childhood abuse has long been studied as a contributing factor to eating disorders, along with countless other disorders. Studies have shown that in comparison to control groups patients with eating disorders had significantly higher rates of child sexual abuse. In a similar study, bulimic patients reported higher rates of rape, sexual harassment, and molestation after age 17, but not of child sexual abuse compared to controls (Jacobi et al, 2004). Another study showed that childhood emotional abuse, through its negative impact on self esteem and anxiety is the only type of childhood trauma that predicts eating disorders later on (Polivy & Herman, 2002). Whatever the form of abuse, the shame and guilt can cause enough pain that the individual begins to turn to other means to dissociate, avoid, or control what she is feeling, which leads to avoidance.

Pain avoidance and control

Bulimic patients will begin to develop coping methods instead of dealing directly with the external and internal problems and stressors they are currently dealing with. A simple example of this would be to pinch your arm after having skinned your knee, or trying to think different thoughts to divert the pain somewhere else. After an individual has felt violated, or a complete loss of control, they will search to gain control back that they had lost. They will do this by focusing on their thoughts and actions to losing weight and having control over their bodies by restricting and also purging. The binge eating can provide temporary relief, then purging afterward will allow them eat without feeling guilty of gaining weight, again diverting their emotions to something other than what is really happening inside (Polivy & Herman, 2002).

Hopelessness and feeling undeserving of receiving help

Especially for an individual who is a high achiever, asking for help with her eating disorder may directly contribute to a sense of failure and shame. The bulimic individual might feel worthless and that she doesn't deserve help, or that her time isn't worth that of another. This can be difficult for a therapist if the bulimic patient assumes she is not worth their time (Manley & Leichner, 2003). If the bulimic individual has a history of neglect, she may feel like she should be able to cope and recover on her own from the disorder, without the help of others. Also the individual may have a fear that she will have to express her emotions if she asks for help, which she feels will lead to shame (Manley & Leichner, 2003).

Because the symptoms of bulimia commonly extend over a number of years, hopelessness to overcome the disorder is common among patients with the disorder. She may feel like giving up, like she can't cope with the eating disorder anymore in her life, especially after the loss of friends, low grades in school and/or sports, and the realization that recovery will be a long road (Manley & Leichner, 2003). This sense of hopelessness can be the cause of or be caused by depression that already existed, hence the high rate of co-morbid psychological problems that are associated with Bulimia.

Co-morbid Psychiatric Disorders

Many studies have examined the co-morbid disorders which occurred prior to the onset of bulimia, sometimes being referred to as "primary underlying conditions" (Jacobi et al, 2004). The most common among these co-morbid disorders are substance abuse disorders, anxiety disorders, and personality disorders (such as borderline disorder), obsessive compulsive disorder, and overanxious disorder. According to a recent study, social phobia was ranked the most prevalent among the mood disorders, which makes sense considering bulimic patients have an extreme fear of being criticized by others (Jacobi et al, 2004).

Co-morbid mood disorders included low self-esteem, depressed mood, irritability, impaired work performance, generalized anxiety, psychophysiological reactivity, phobic avoidance, guilt, and strict dieting (Jacobi et al, 2004). Many times it is more difficult to determine which disorder preceded the other when dealing with disorders co-morbid to bulimia nervosa.

Athletic Competition

Recent reviews of studies conducted over 20 years ago which assumed an increased risk of eating disorders among athletes of sports that emphasize a certain low weight and shape, have been confirmed. Sports such as ballet, gymnastics, wrestling, swimming, and jockeys have been known to produce bulimia in the participants. Another focus of these studies has been on the use of these sports activities in maintaining the eating disorder (Jacobi et al, 2004).

Family Causes

The family has long been studied as a major cause of bulimia, which is no coincidence because, especially in adolescence, girls will spend a good amount of time in their own homes. Families can have huge impacts on children, molding the way they see the world and where they fit in. Many treatment centers, like the one I am employed at, are based around family therapy equal to the girls individual therapy. So many of the causes of Bulimia mentioned thus far are interconnected with the issue of families that studies still have not concluded on what comes first, the bulimic patients problems, or the family's problems. Simply stated, what causes what?

Characteristics of a family with a bulimic child include problematic family structures, interaction and communication styles, and attachment styles (Jacobi et al, 2004). Bulimic adolescent girls tend to perceive their families in a more negative and critical way than their parents. Studies show that Bulimic children are more likely to view their families as more

conflictual, disengaged, less expressive, lacking nurture, and in general the daughter is more likely to feel discouraged from expressing their feelings compared to control families (Okon, Greene & Smith, 2003). Basic communication and nurture seem to be underlying problems faced by these families, which are such simple and sometimes obvious features of what is imagined as a healthy family.

Another family dysfunction that probably roots from the problems mentioned above is that of general safety and the feeling of being needed as well as getting ones own needs met on a regular basis. Every child needs a place where they can escape the dangers and negativity that the world has to offer, and this place is the home. This feeling of safety is a psychological need, and when it is scarce or not present, the chances of mental and psychological disorders increase as well (Latzer et al, 2002). A typical family structure is one that is low in care yet high in protection, being the exact opposite of a healthy family, which is high in care without over protection (Bonne et al, 2003). Sometimes a parent is so afraid of their daughter being hurt, they don't allow their daughter to have a sense of independence, which is closely associated with the level of trust in the relationship. What originally had pure intentions of protecting a child from pain can also have detrimental effects when the child feels a sense of being too controlled by her parents.

Probably the most obvious, yet highly overlooked, family causal factor is the significantly higher rates of bulimia among patients whose family members (usually mother or sister) have had some form of eating disorder prior to the onset of the younger patient, compared to control groups. A study found that elevated rates of alcohol and drug dependence, drug abuse, social phobia, panic disorder, and certain personality disorders were higher in relatives of bulimic patients (Jacobi et al, 2004). Parents who are overweight are also a commonly

overlooked cause of bulimia with studies showing fathers of bulimic patients commonly are significantly overweight (Jacobi et al, 2004).

Parents of bulimic patients are known to belittle and blame their bulimic daughters, leading to the daughters internalizing this guilt the parent has placed on them (Ratti, Humphrey and Lyons, 1996). This blame that the parents generate from the instability of themselves, shows very much the maturity level of these parents, or in most cases, the lack thereof (Wonderlich, Council & Klein, 1996). Parents are not ready to take responsibility for having possibly caused the adolescent bulimic patient to develop the eating disorder, making it easier for them to put the burden on the shoulders of their daughters.

Interestingly enough time spent as a family together can have an effect on bulimic daughters. A recent study showed that families with bulimic daughters spent less leisure time together than those of control groups. Surely this study's results apply to many other family problems such as drug and alcohol abuse, just to name a few.

The difference between father daughter and mother daughter relationships have been numerous, studies showing that the mother has a greater impact. This is because adolescent girls tend to seek and follow the mothers advice, especially when dealing with interpersonal issues, rather than talking to the father (Okon, Greene & Smith, 2003).

Paternal Relationships

Bulimic patients tend to have a significantly different view of their fathers when compared to control groups. The father is seen through the eyes of the daughter as being less friendly and more controlling than control groups. The bulimic daughters also were found to feel less engaged in the relationship with their fathers (Wonderlich, Council & Klein, 1996). When looking at the disorder of Bulimia it makes sense why the daughter might feel less attached to the

father when it comes to talking about weight issues and eating habits. The father is going to be considerably less understanding of dieting and body image issues because the majority of men don't have these problems and have never thought of them. The daughters can sense this lack of sympathy and in turn distance themselves in the relationship with their fathers, leaving them more alone in struggling with the disorder.

Not only do bulimic daughters feel their fathers don't understand them, but the daughters also feel like their father favors other siblings over them. One study found that bulimic daughters perceived their father to be less emotional and more domineering when compared with his attitudes towards their (non-bulimic) sisters (Bonne et al, 2003). This very possibly could be correct, yet one study found that the perceptions of family interactions of the bulimic daughter are more realistic than what the parents describe it to be. Of course a bulimic patient's views of the family can also be distorted as is their perception of their own physical appearance. When dealing with family structure and family interaction, families of the bulimic patient have more discord and conflict than those of healthy control families (Bonne et al, 2003).

Maternal Relationships

More studies exist on the maternal relationship with the bulimic individual than the father's relationship with the child. Studies show the daughter is more likely to interact with the mother when dealing with body image issues, and that fathers of these girls are more likely to be detached in comparison to control groups. In the same study, the mothers with bulimic daughters are described as being over critical, immature, competitive, blaming, and found to struggle with their own weight issues on top of it all.

In a recent study the bulimic daughters perceived (not surprisingly) their mothers to be more blaming than the mothers perceived themselves to be, when compared with control groups.

Whether this study reflects the daughter externalizing, or the mother being defensive, the topic remains to be studied more in depth (Ratti, Humphrey and Lyons, 1996). This study further confirms the evidence of discord and conflict bulimic patients face on the subject of families.

The chance of an adolescent girl obtaining bulimia increases when their mother has had, or currently has, disorder herself. These mothers have an influence on their daughters by thinking their daughters should lose more weight. The mothers of bulimic daughters describe their daughters as being less attractive than comparison mothers describe their own daughters (Polivy & Herman, 2002). The mother's comments and feedback of her bulimic daughter's body will only feed the disorder in the daughter. The daughter will feel overwhelmed with trying to please her mother and the same time deal with her own distorted thinking.

On the other hand mothers of eating disorder patients are themselves more dissatisfied with the family functioning and also are more likely to have an eating disorder than mothers of girls who do not have an eating disorder (Polivy & Herman, 2002). The only thing worse than having one person in the family with an eating disorder is having two of them, both criticizing and judging the other. The effects of healthy parenting will be felt by all the members in the family, in all different aspects of their lives.

Lastly, one study found the mothers of bulimic patients scored low on self-directedness tests, which is the result of immaturity, irresponsibility, and unreliability. These character traits of the mother may be responsible for maternal invasion of privacy, jealousy, competition, and over concern with the daughter's eating habits and distorted body image (Fassino et al, 2003).

Treatment

According to a recent finding, family therapy can decrease bulimic symptoms of adolescent girls by changing family interactions (Okon, Greene & Smith, 2003). Family therapy

can be beneficial in changing the way the family interacts with each other during times of stress, or on a day-to-day basis. The key to family therapy is to avoid focusing on the external motives for the eating disorder, but get to the core of the problem which is many times the lack of love and security.

Today the family structure is being attacked from all sides, including the media, social and economic pressures, drugs, alcohol, and the list goes on. There is no surprise that the parents, being role models and the support of their children, have an incomprehensible effect on the well being of their children. Yet, sadly, parents can have a detrimental effect on the physical and especially emotional outcome of their children.

The best a parent can do for their children is to maintain mutual respect in communication setting reasonable boundaries, and to allow the child to feel comfortable expressing his or her feelings (Ratti, Humphrey and Lyons, 1996). Openness, honesty, and love within the walls of the home can go a long way in preventing a child from developing an eating disorder in the difficult and challenging world we live in today.

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