Leading Article

Eating disorders and alcohol misuse: features of an addiction spectrum

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Bulimia nervosa is a syndrome characterized by episodes of binge eating followed by self-induced vomiting, fasting and abuse of laxatives or diuretics. Anorexia nervosa features self-imposed starvation in the relentless pursuit of thinness and leads to various degrees of emaciation. The prevalence of these two disorders is considerable, affecting as many as 5–10% of adolescent girls and young adult women between the ages of 12 and 30 years. Such women manifest a compulsive pattern of eating and purging behaviour which, in combination with environmental stress (e.g. family, friends, job, etc.), puts them at increased risk of developing such problems as drug abuse, alcohol dependence and other types of addictive behaviour.¹

Life adjustment in areas of work, domestic, social and leisure activities of bulimic women is poorer in bulimic women than in a normal community sample and most similar to a group of alcohol dependent women.² Bulimic women report substantially higher levels of drunkenness, marijuana use, cigarette use, and greater levels of depressive symptoms. They also appear to be more sexually active and more severely and chronically disturbed.³ Over a third report a history of problems with alcohol or other drugs, and 35–40% of alcohol misusers have a previous major eating disorder.^{4,5} Where there is both bulimia and substance misuse higher rates of diuretic use to control weight, financial and work problems, stealing both before and after the onset of the eating disorder, suicide and previous psychiatric inpatient treatment have been reported.

Parents of patients with bulimia are prone to alcohol abuse: rates of 18–32% in fathers and 8–12% in mothers have been found.⁶ Just over 50% of bulimic patients have one or more first-degree relatives who are chemically dependent on

various substances,⁷ alcohol accounting for 20–36%.^{8–10} Less is known about alcohol misuse and anorexia nervosa. Such patients might be expected to be at less risk of developing alcohol dependence because they are young women whose main purpose is to decrease their calorie intake. Yet, there is evidence that they too misuse alcohol.^{11,12} Even less information is available about alcohol misuse in the relatives of patients with anorexia nervosa but figures of 2.5–15% have been found.¹³

Eating disorders are beginning to be seen as part of an addictive spectrum which includes alcoholism, smoking and gambling. Different types of addictions resemble one another (though there are also differences), and individuals often switch from one to another. Both bulimia and alcohol abuse are means of warding off excessive anxiety, and serve to compensate for and counteract feelings of incompleteness, self-disgust and anger. The purpose of addictive behaviour is to obtain pleasure, release tension, and seek comfort.¹⁴ Compulsion, craving and loss of control may stem from motivated behaviour such as hunger and thirst related to activity in the limbic system.⁵ Denial and dissimulation are frequent, and guilt accompanies the compulsion to eat, drink and vomit.

Management is notoriously difficult, though spontaneous remissions are well recognized.¹⁵ There is no good evidence that psychoanalytic psychotherapy, individual psychotherapy, group therapy, various forms of behaviour therapy, family therapy, or the use of drugs is any better than simple advice and support. The relapse rate is high regardless of the treatment used.¹⁶ Acknowledgement of anxiety-producing situations can be approached in a supportive psychotherapeutic setting. Cognitive behaviour therapy may sometimes alter behaviour and attitudes. A high incidence of depression (over 50%) justifies a trial of antidepressants, though neither the eating disorder nor the alcohol problem is likely to be affected. The newer antidepressants, such as fluoxetine – serotonin reuptake inhibitors which interfere with the regulation of food and alcohol intake – may provide a

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new approach but have not yet been sufficiently tested. At least they have no central stimulatory effects and lack the potential for abuse.¹⁷ The best way of integrating drugs and psychotherapy, and identification of predictors of a positive response

have not yet been achieved.¹⁸ In the meantime continued follow-up, self-help groups and voluntary agencies can do much to support these unfortunate individuals.

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