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Bulimia in British Blacks and Asians

A Catchment Area Study

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This paper describes the demographic and clinical features of five non-white, normal body weight bulimics, all from the same catchment area. Comparisons with white bulimic referrals from the same area showed clinical similarities, but the non-white bulimics gave an account of gross emotional deprivation: all came from broken homes; four had been separated for long periods from their mothers; two had been subjected to incestuous abuse; and four had been cared for by white women. Response to treatment was poor. The ratio of non-white referral to white was at most one tenth of the ratio of non-white to white women in the catchment area.

One hundred years ago, anorexia nervosa was an esoteric disorder reported in single case studies. Now it is considered to have an epidemic prevalence. Yet it is an epidemic which affects only certain populations, the populations being white and female. While the history of normal body weight bulimia has been more compressed than that of anorexia nervosa, the same general statement of sexual and racial bias can be made. This paper is the first report of the clinical presentation of normal body weight bulimia in black and Asian women in the UK, all the patients stemming from the same catchment area.

The absence of black and Asian anorectics has been the subject of comment. Kendell *et al* (1973), in a report on the incidence of anorexia nervosa in psychiatric case registers, noted the absence of black subjects in registers in London, North East Scotland and Munroe County, New York state. The only non-white was an Asian woman in London. Crisp *et al* (1978) found no black subjects in a survey of nine British schoolgirl populations. Hall (1978) found none in Australia. The point is well made in a study from South Africa (Norris, 1979), which noted the absence of black anorectics, although patients of both Indian and mixed racial background were recorded. More recently, reports from North America (Hedbolm *et al*, 1978; Garner & Garfinkel, 1982; Pumariega *et al*, 1984; Silber, 1984) have reported the occasional single-figure case report of anorexia nervosa in black girls. In Britain, no cases of anorexia nervosa were reported in black women until Thomas & Szmukler (1985) presented three patients of Afro-Caribbean extraction, all of whom presented with anorexia nervosa of a bulimic subtype (although the diagnosis of anorexia nervosa was not confirmed in one patient, who did not reach the criteria of Feighner *et al* (1972)).

In clinical demographic studies of bulimia in both the USA (Pyle *et al*, 1981; Herzog, 1982) and the UK (Fairburn & Cooper, 1983), no black or Asian patients were described. To our knowledge, bulimia has been reported in only three black women attending clinics in the USA (Johnson *et al*, 1982; Roy-Byrne *et al*, 1984; Lawlor & Rand, 1985). The first of these studies was based on a population of 316 cases. One other study in a highly selected school sample (Johnson *et al*, 1984) found one of 33 Asian (mainly Chinese) girls and three of 161 black girls who could be diagnosed bulimic on DSM–III criteria.

This paper reports on five women of different ethnicity who met diagnostic criteria for normal body weight bulimia and who attended our clinic between January 1982 and March 1985.

Method

Records of all female patients living in Wandsworth, Merton and Sutton catchment areas in south-west London who were referred to the Eating Disorders Clinic at St George's Hospital between January 1980 and December 1985 were studied. Five women were identified who had either one or both parents of Asian or Afro-Caribbean origin. All women met our criteria for normal body weight bulimia (Lacey *et al*, 1985) and DSM–III criteria for bulimia (American Psychiatric Association, 1980). Two of these patients were referred in 1982, two in 1983 and one in 1985.

During the time in which the first two patients were referred (i.e. January 1980 to March 1983), 112 white women were assessed in the Eating Disorders Clinic from within Wandsworth, Merton and Sutton catchment area. Clinical demographics of these 112 women have been collected and analysed. General comparisons were made between this group of women and the five non-white patients.

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Mean matched population weight (MMP weight) was calculated by reference to standard tables (Kemsley, 1953), and a weight index was calculated by expressing actual weight as a percentage of MMP weight.

The case history and treatment response of each patient is outlined.

Case histories

Case 1

Miss A was an 18-year-old single Asian girl, born in Pakistan, who emigrated to England with her parents at the age of two. She was the eldest of five children, born to a strict Muslim family.

Miss A first began to overeat at seven years when she was separated from her mother, when her mother was admitted to hospital with a depressive illness. During a second separation, which occurred almost immediately following the first, Miss A was sexually molested by her father. The molestation continued intermittently for four years, during which time Miss A gained considerable weight (reaching 210% MMP weight).

At 16 years, Miss A left home to live with her maternal grandparents, ostensibly to 'learn the Koran'. During the fast of Ramadan, she overate with spicy food during the family meal after sunset and vomited. At first the vomiting was selective: she was able to eat the 'bland' Western food, but vomited after a Pakistani meal. After eight months, however, she was vomiting after all food, always associated with nausea. There was no binge eating. This pattern continued until two years later (age 18 years), when there was a proposal for an arranged marriage, and a suggestion that her father come and live near her grandmother. Miss A developed binge eating with abdominal pain and vomiting.

On admission Miss A was alternatively sullen and panic-stricken. She was able to stop vomiting and was initially placed on a fluid diet. It took four weeks to return to normal eating. On the ward, she fluctuated between wearing Muslim and Western dress, and at times caused her family much distress by openly smoking and wearing jeans on a mixed-sex ward.

On discharge she did well initially, but 18 months after discharge the bulimia returned within the context of further family pressure for an arranged marriage. She was binge eating four times a day, with vomiting after each binge and after normal meals. Her weight dropped to 95% MMP weight and she was taking around 30 laxatives per day. A further admission brought the symptoms under control, but they returned after discharge to her home. The patient's father and mother refused to become involved, but the grandparents and extended family became involved in therapy. A family decision was made to send Miss A to Pakistan; her father remained in England. While there her symptoms settled. She is unmarried and lives in a strict, controlling family. In her letters she reports contentment and peace.

Case 2

Miss M was a single 26-year-old who presented with a six-year history of bulimia, alcohol abuse and depression. The symptoms varied in frequency: when alcohol was under control, binge eating and vomiting occurred almost continuously through the day; when alcohol was abused, binge eating occurred twice a week. At presentation the patient was drinking daily to be drunk and she abused laxatives. Her presenting weight was 92% MMP weight.

Born in Guyana, Miss M was the illegitimate only daughter of a black African mother and an Indian father. She lived with her mother until she was two years old. Then, when her mother came to England, she was passed to her father and cared for until she was five years old by his Indian girlfriend. The girlfriend was reported to have mistreated her. At five years, Miss M rejoined her mother in England. Her mother had married, and subsequently Miss M had five step-siblings. She has no further knowledge of her natural father.

As a child, Miss M felt unwanted by her mother, claiming she was treated differently from her stepsiblings. She ran away from home five times. Menstruation began at 11 years. At 13 years, she was seduced by her stepfather and became pregnant. She was held responsible for this by her mother, who took her for the abortion. Subsequently, intercourse with her stepfather continued and at times she was raped. The patient's mother continued to declare that her husband was being seduced by the patient's precocious sexual behaviour, and at 14 years she was taken into care. The residential social workers were white. At 16 years she moved in to her own lodgings, and at presentation she had been cohabiting with her West Indian boyfriend for five years. He was a caring and a successful man, clearly on his way up the social ladder; his success making her failure all the more obvious and feeding her low esteem.

The extent of the patient's drinking made out-patient help pointless. She was dried out as an in-patient but then discharged herself. Her relationship with her boyfriend broke up and she dropped out of the clinic.

Case 3

Mrs P was a 24-year-old married woman born in England of an English mother and a Cameroon father. At presentation she was binge eating and vomiting twice daily. Mrs P was the fourth of six siblings and lived with her parents until they separated, when she was four years old. Mrs P was then placed in a children's home until she was 12½ years old, when she went to live with white foster-parents. At 16 she met her future Barbadian husband, with whom she had her first sexual intercourse. After four months she was pregnant by him and left her home to live with, and subsequently marry, him. Her husband is a stiff, formal man, well respected in his community. Mrs P feels unworthy of him and considers herself fortunate that he decided to marry her. She now has four young children.

Although Mrs P began menstruating at 12 years, she claims not to have been aware of sexual feelings until 15. First boyfriends were associated with a desire to lose weight, and she began self-inducing vomiting, which she claims to have learnt from a magazine. Soon afterwards she began to binge eat, vomiting both after that and after regular meals. Apart from pregnancies, her menstruation has been regular. Mrs P's eating disorder has been consistent except

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during her pregnancies, when the frequency of binge eating and vomiting tended to die away, only to resume during breast-feeding. Lactation and weaning were associated with weight gain. Since the birth of her last child eight months prior to presentation, her weight rose from 66 kg to 80 kg.

Mrs P entered the out-patient treatment programme. After five weeks her symptoms were under control. She remained asymptomatic for six months after treatment before defaulting on follow-up appointments. She had reported to her therapist a change in feelings towards her husband, seeing herself more as an individual, becoming more active and resourceful. Arguments became frequent and her husband expressed himself dissatisfied with her 'new ideas'. Binge eating then recurred, and on reattendance at the clinic Mrs P decided not to pursue formal treatment, feeling it would endanger the stability of her marriage.

Case 4

Miss L was an 18-year-old single woman born in south London to Jamaican parents. Miss L was separated from her mother at 18 months, when her mother was admitted for a depressive illness to hospital, remaining there until Miss L was 11 years old. Miss L was cared for by casual friends and neighbours until she was three, when she went, with her elder brother, to live with two unmarried white sisters who lived in the same street. When her mother returned to the family, her brother returned home also, but Miss L stayed on with the two sisters. Miss L reported that during her adolescence she felt increasingly 'different' from her natural family, particularly in terms of education and social class. She also felt confused about race.

Miss L's eating disorder began in the context of her first major relationship, with a white, 40-year-old divorcee also living in the same street. She began to diet, desiring to be slimmer to impress her boyfriend, the relationship with whom was always stormy. (He was also having a sexual relationship with Miss L's 'best friend'.)

On presentation Miss L was binge eating and vomiting three times a day. Her attendance was precipitated by school examinations, vacillation about further education, inability to deal with her boyfriend's unfaithfulness and the admission for depression of one of the two sisters who fostered her. She expressed guilt about the latter, believing that she was responsible for it, "like I was with my mum". (It was a part of the family mythology that Miss L's mother's depression was puerperal in origin, whereas in subsequent therapy it became clear that Miss L's mother was unhappy at emigrating to the UK.)

Miss L was admitted to the out-patient treatment programme and her symptoms came under control; within four weeks all binge eating and vomiting stopped. However, two months after the end of treatment she developed hypomanic symptoms within the context of the break-up of her emotional relationship and being blamed for her foster-mother's illness. She was admitted to hospital, where the hypomanic symptoms settled without medication. She has been symptom-free for the last three years and is successfully following a course at art college.

Case 5

Miss G was a single 21-year-old who presented with an 18-month history of binge eating and self-induced vomiting. Her presenting weight was 118% MMP weight.

Born in London, Miss G was the illegitimate daughter of a white mother and a black West Indian father. She was the fifth of eight children, all of the same father. He was a black community worker. He never lived in the parental home, limiting himself to occasional visits. His relationship with his children was warm and caring. Miss G's mother was obese. The patient recalled that in her adolescence she despised her mother for the cavalier way she allowed herself to be treated by Mr G, and for her fatness. The family first lived in a white area and then a black one, and the patient described being the object of racial abuse in both.

Normal adolescent dieting began at 18 years when she was 128% MMP weight. At 19 she had a white boyfriend and, under sexual pressure, severe dieting started, to be followed shortly afterwards by self-induced vomiting. Body weight dropped to its lowest, at 98% MMP weight. Alcohol intake increased, and at age 20 years she was abusing alcohol, drinking impulsively to be drunk.

Miss G's motivation for change was not good, but on entering our out-patient treatment programme her binge eating reduced markedly, stopping for days at a time. However, she became increasingly distressed, expressing in therapy her uncertainty about her position in society, and demonstrating this in practice by staying alternately with her mother and then her father, suddenly changing one for the other. This came to a head when, following alcohol excess, she walked out on her black boyfriend and put herself in a sexually compromising situation at a party, where she was gang-raped by two white men. The patient felt that with her control of binge eating she was becoming more out of control in other areas, and that her impulsivity and need to degrade herself were dangerously increasing. She therefore elected to return to binge eating, requesting that treatment for her eating disorder stop but that her general therapy continue. She was later discharged from the clinic.

Results

Of the five non-white patients identified, one was Pakistani, one was Jamaican and three were of mixed racial backgrounds (two Afro-Caribbean/English, one African/Indian).

Exact data is not available on the percentage of non-white women living within the catchment area. However, 20% of the population of Wandsworth, Merton and Sutton Health Authority live in households in which the head was born in the New Commonwealth or Pakistan (Office of Population, Censuses and Surveys, 1983). Thus it would not be unreasonable to assume that at least 20% of the female population are non-white, giving an anticipated ratio of referral to our clinic of 5:1 white: non-white women. The rate of referral in 1982–1983 was 55:1.

The demographic and clinical characteristics of the five women are shown in Table I. Our sample is small and thus statistical comparison would not be appropriate.

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TABLE I
Demographic and clinical details of five non-white bulimics

Case	Age	Parents' ethnicity	Weight index: %	Length of illness: months	Severity of binge eating	Severity of vomiting	Menstruation	Treatment	Treatment outcome
1	18	Pakistani	128	24	4 times a day	4 times a day	Irregular	In-patient, 2 admissions	Initially good, then symptoms returned
2	26	Guyanan/ Indian	91	72	Twice a week	Twice a week	Regular	In-patient	No change in symptoms
3	24	Cameroons/ English	132	108	Twice a day	Twice a day	Regular	Out-patient	Initially good, then symptoms returned
4	18	Jamaican	97	24	3 times a day	3 times a day	Amenorrhoea	Out-patient	Good; no symptoms for 3 years
5	21	Afro-Caribbean/ English	118	18	3 times a day	3 times a day	Regular	Out-patient and in-patient	Initially good, then symptoms returned, following rape

TABLE II
Some factors associated with bulimia in five non-white patients

Case	Life events in six months preceding onset of bulimia		Racial complications	Other factors
	Sexual conflict	Change in life circumstances		
1	Proposed arranged marriage; suggestion father move in nearby	Went to stay with grandparents in London	Cross-racial dressing	Incest with father; mother's depression; maternal separation 7–9, 11, 16–18 years
2	First adult sexual intercourse	Moved to live with boyfriend	Mixed-race parents; moved to England aged 5 years	Incest with stepfather; maternal separation 2–5, 14–20 years
3	Marriage; first sexual intercourse; pregnancy	Left home on marriage	Mixed-race parents; childrens' home with white carer 4–12 years; white fostering 12–16 years	Maternal separation 4–16 years
4	First sexual intercourse; boyfriend	—	White foster-mother 3–18 years	Mother's depression; parental separation from 18 months onwards; examinations; foster-mother's admission to hospital
5	First sexual intercourse	Moved between white mother and black father	Mixed-race parents; lived with white mother	Mother obese; intermittent parental separation

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Demographic features and overt behavioural symptoms of the non-white bulimics are similar to those of the 112 white bulimic women seen in our clinic. However, compared with our white patients in general, the non-white sample tend to be younger (21.4 years, s.d. 3.2, cf. 24.8 years, s.d. 5.0), start their binge eating at an earlier age (17.3 years, s.d. 1.9, cf. 18.5 years, s.d. 3.8) and to be heavier on presentation (113.5% MMP weight, s.d. 16.04, cf. 104.2% MMP weight, s.d. 14.1). None of the non-white women had experienced a previous episode of anorexia nervosa, while a history of anorexia nervosa is reported in 33.9% of the white sample.

Four of the non-white women were unemployed, while one (case 4) was a student. Only 4% of the white referrals were unemployed. One of the non-white patients (case 3) was married.

Factors associated with bulimia in the non-white patients are shown in Table II. These are similar to those reported in our white clinic population (Lacey *et al*, 1985). Sexual conflicts are reported by all patients, and two were subjected to incest. Each woman had been separated from one or both parents for a long period of time, and four had lived with white carers.

Treatment response was poor. Although four patients gave up their symptoms for some time, only one sustained this improvement in long-term follow-up.

Discussion

In all five cases, a diagnosis of normal body weight bulimia was made. In none was there evidence of weight phobia or other psychopathology of anorexia nervosa. These five therefore represent the first report of non-white, normal body weight bulimics in the UK. Furthermore, all five come from the same catchment area of Wandsworth, Merton and Sutton in London, an area of high immigration. We believe it would be rare for a bulimic woman living in this area to be referred to somewhere other than our clinic. Patients that are referred elsewhere are usually private referrals, and if bulimics among them were included in our figures, they could be expected to boost the white referral rate particularly. Thus, while calculations of relative prevalence must be tentative, it can be said that the referral of non-white bulimics is very much lower than that of whites living in similar conditions in the same urban area.

Some reasons can be tentatively advanced for the low number of non-white women referred to our clinic. Firstly, it could be that mild bulimia does not exist in non-whites. It has been suggested that non-white women are not under the same cultural pressure as white Western women to value slimness as desirable (Furnham & Alibhai, 1983; Robinson & Andersen, 1985): the non-white women described had white carers and perhaps espoused white cultural values of stereotypic feminine attractiveness. It is also possible that given similar distressing life circumstances and emotional disturbance, non-white women will present with different disorders, such as alcoholism, drug abuse, neurotic disorders, or obesity. In our separate obesity clinic it does appear that non-white women are more prevalent than would be expected.

Secondly, it could be that the low referral rate for non-white women is a reflection of some ethnic groups being less likely to seek help from conventional white carers. The utilisation of the National Health Service by immigrant populations has been the subject of much debate and the position is still far from clear (London, 1986). Cross-cultural studies of the referral of immigrant minorities to psychiatric services have shown an *increased* rate of black and Asian patients compared with white patients as measured by hospital first admission rates (Cochrane, 1977; Carpenter & Brockington, 1980). Studies of hospital admission rates, however, are weighted by the inclusion of the most severe forms of psychiatric disturbance, especially schizophrenia. Researchers considering neuroses and personality disorders have produced inconsistent results. Some studies show reduced rates of disorder in ethnic minorities (Cochrane, 1977; Bebbington *et al*, 1981), while others have found increased rates (Bagley, 1971) or no difference compared with white British populations (Carpenter & Brockington 1980; Dean *et al*, 1981). Given this discrepancy, it is impossible to judge the effect of ethnicity upon referral to our clinic in Wandsworth.

All non-white bulimics reported severe and distressing binge eating and self-induced vomiting, while vomiting is reported by 89.2% of our white patients. In case 1, self-induced vomiting occurred before the onset of binge eating and was the cause of the initial referral. The onset of vomiting preceding the onset of binge eating has been reported as occurring in 18% of our clinic population (Lacey *et al*, 1985). Only one of our non-white patients abused laxatives, while this was reported by over half of our white patients; two non-white bulimics abused alcohol, while a quarter of our general clinic did so.

Factors associated with the onset of bulimia reported by 50 white patients from the same clinical population have been described (Lacey *et al*, 1985). In the six months prior to the onset of binge eating, 72% reported sexual conflict associated with the beginning and ending of relationships, and 70% reported a major change in life circumstances. Similar associated factors can be identified in these non-white patients (Table II). Sexual conflicts were reported by four patients associated with their first adult sexual intercourse, while the fifth patient received a proposal of arranged marriage.

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Racial identity was described by all patients as a major problem and was a prominent feature of subsequent therapy. Three women came from mixed-race partnerships. Two had a white mother and a black father and one had an Indian father and an Afro-Caribbean mother. Most noteworthy, four of the patients were, for a long period, cared for by white women. While one was with her natural mother, two had white foster-mothers and the two who spent time in residential care identified most strongly with women who were white. Care by foster-mothers of different race has been a subject of political discussion.

The non-white bulimics appeared to be very damaged women who gave a history of deprivation. All described family distress and parental marriage breakdown. All five patients were separated from one or both parents. More particularly, four of the five women were separated from their mothers at an early age and for long periods. Three had the added stress of being in contact with their family, although they lived with other carers. The two patients who were reunited with their mothers were subjected to incestuous abuse. Two mothers were depressed and spent long periods in hospital, and a third was massively obese and distant from her children.

Such emotional deprivation suggests another possible clue for the low non-white referral rate to our clinic. The group who seem to be 'missing' are the less disturbed, uni-impulsive bulimics who make up the main body of white referrals (Lacey, 1984*a*).

All referrals to our clinic are secondary, usually from general practitioners. The majority of bulimic women present to their GP voluntarily when they can no longer cope with their symptoms alone. Thus, initially, bulimia is largely self-defined. It is possible that non-white women are less likely to view themselves as ill and only the more disturbed women actually seek help, or perhaps it is only those non-white women who are severely disturbed that are recognised as bulimic by their GP and referred on to our specialist service.

Only one of these patients did well in our treatment programme (Lacey, 1984*b*). Of the other four, three initially improved but then went back to the bulimia, and one had no improvement. Our treatment programme, which uses white women therapists, appeared to rekindle the problems of living in a mixed-race family. End of therapy seemed to resurrect the pain of maternal loss and potentiated racial identity confusion. The memory of abuse by a non-white relative, followed by attention from a white carer, while being non-white oneself, was stressful. The whole seemed to us to be much bigger than the eating disorder and was difficult to solve in a short-term treatment programme.

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