Eating Behaviors 14 (2013) 26–34

Contents lists available at SciVerse ScienceDirect

Eating Behaviors

An exploratory investigation of purging disorder

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ARTICLE INFO

Article history:
Received 14 March 2012
Received in revised form 23 July 2012
Accepted 3 October 2012
Available online 9 October 2012

Keywords:
Purging Disorder
Eating Disorder Not Otherwise Specified (EDNOS)
Bulimia Nervosa
Dietary restraint
Body image

ABSTRACT

Objective: Purging Disorder (PD) is an understudied pattern of behaviors within the Eating Disorder Not Otherwise Specified (EDNOS) category. Such categorization may suggest that PD is not clinically significant as other eating disorders. However, evidence has suggested that PD is associated with significant impairments in psychosocial functioning and well-being. Despite the apparent clinical significance of PD, it remains to be determined if PD is distinct from other clinically significant eating disorders. The present study sought to assess the phenomenology, clinical significance, and distinctiveness of PD.
Method: Group scores on measures of eating pathology, body image disturbance, and psychological correlates were compared using MANOVA among a female undergraduate sample ($N = 94$) meeting diagnostic criteria for PD ($n = 20$), Bulimia Nervosa (BN; $n = 35$), restrained eating ($n = 18$), and healthy controls ($n = 21$).
Results: Overall, results indicated the PD group reported less severe symptoms than BN but more severe symptoms than controls. The PD and restraint groups were similar on most variables (including subjective binge behavior), with the exception of perfectionism and hunger.
Discussion: Findings support the conceptualization of PD as existing along a spectrum of bulimic spectrum disorders rather than as a distinct diagnostic category.

1. Introduction

Although there is a general consensus among psychologists that Anorexia Nervosa (AN) and Bulimia Nervosa (BN) are clinically significant and distinct categories of eating disorders, most individuals who have clinically significant symptoms of eating pathology do not meet the diagnostic criteria for either diagnosis (Keel, Haedt, and Edler, 2005; Machado, Machado, Goncalves, and Hoek, 2007; Wade, Bergin, Tiggemann, Bulik, and Fairburn, 2006). Thus, such individuals most often receive a diagnosis of an Eating Disorder Not Otherwise Specified (EDNOS), which is a category that describes "disorders of eating that do not meet the criteria for any specific eating disorder" (American Psychiatric Association, 2000, p. 594). However, many experts have recognized the problematic nature of this broad categorization, as this is a group of highly heterogeneous patterns of behaviors that are believed to have clinical significance (Crow, 2007; Fairburn and Cooper, 2007; Fairburn et al., 2007; Machado et al., 2007).

1.1. Defining Purging Disorder

Purging Disorder (PD) is one EDNOS category that has been the focus of increasing study. Currently PD is classified as "EDNOS" or "EDNOS-P" in the DSM-IV-TR, yet recent literature suggests that it may be a distinct and clinically significant disorder, with prevalence rates comparable to other eating disorders (Crowther, Armey, Luce, Dalton, and Leahey, 2008; Favaro, Ferrara, and Santonastaso, 2003; Haedt and Keel, 2010; Keel et al., 2005; Wade et al., 2006). In a review of the published literature on PD, Keel and Striegel-Moore (2009) proposed five diagnostic criteria for PD: (1) recurrent purging in order to influence weight or shape (e.g., self-induced vomiting, laxative abuse, enemas, diuretics), (2) purging occurs, on average, at least once a week for three months, (3) self-evaluation is unduly influenced by body shape or weight or there is an intense fear of gaining weight or becoming fat, (4) the purging is not associated with objectively large binge episodes, and (5) the purging does not occur exclusively during the course of anorexia nervosa or bulimia nervosa. Additionally, in an investigation of the syndrome validity of PD, Haedt and Keel (2010) varied the diagnostic criteria by type of compensatory behavior (purging vs. non-purging) and frequency (once vs. twice per week). Results indicated that distinguishing between purging and non-purging behavior (i.e., excluding non-purging behavior from PD diagnostic criteria) was associated with larger effect sizes when PD was compared to healthy controls on external validators (e.g., psychosocial functioning, perfectionism, substance use). However, reducing the minimum frequency of purging behavior from twice to once per week was associated with similar effect sizes when PD was compared to healthy controls on these variables. Thus, this research supports the diagnostic criteria proposed above (Keel and Striegel-Moore, 2009).

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http://dx.doi.org/10.1016/j.eatbeh.2012.10.006

Recent research provides evidence for the clinical significance of PD. Compared to individuals without PD, individuals with PD show increased levels of impairment, including higher levels of general psychopathology, distress, eating pathology, and personality disorders (Keel, Wolfe, Gravener, and Jimerson, 2008; Keel et al., 2005). However, research has yielded mixed findings regarding how individuals with PD compare to individuals with other eating disorder diagnoses, particularly BN. For example, some studies have demonstrated that women with PD do not differ significantly from those with BN on measures of symptom severity, impairment, body dissatisfaction, or dietary restraint (Binford and le Grange, 2005; Keel, Mayer, and Harnden-Fischer, 2001; Keel et al., 2005). In contrast, other literature suggests that compared to individuals with PD, individuals with BN generally report greater shape/weight/eating concerns (Binford and le Grange, 2005), lower levels of self-esteem (Binford and le Grange, 2005), and greater levels of psychopathology, including current mood disorders (Keel et al., 2005, 2008), anxiety levels (Fink, Smith, Gordon, Holm-Denoma, and Joiner, 2009), and impulsive behaviors (Fink et al., 2009; Keel et al., 2001), although other studies have failed to replicate the findings regarding impulsivity (Keel et al., 2005, 2008). These discrepant findings may be due to variations in the criteria used to define PD and a lack of statistical power to find significant differences between PD and other forms of eating pathology. Given these mixed findings and the lack of theoretical conceptualizations of PD, the present study further explored the phenomenology of PD within the framework of empirically supported theories of eating pathology. This included an examination of constructs that may inform the conceptualization of PD, including dietary restraint, subjective and objective binge episodes, and variables which have not previously been compared between BN and PD (e.g., perfectionism, emotion regulation).

1.2. Conceptualizing PD

Though mounting evidence suggests that PD may be a clinically significant and unique pattern of behavior, it is unclear what factors precipitate the purging behavior. In the purging subtype of BN, there is a consensus that objective binge episodes (OBEs) usually precede purging behavior (Stice, 2001); thus, purging behaviors are generally studied in conjunction with binge episodes. However, consistent with PD diagnostic criteria (Keel and Striegel-Moore, 2009), individuals with PD do not engage in OBEs, which potentially challenges the existing theories that conceptualize purging behavior as a response to OBEs. While OBEs require both the consumption of an objectively large quantity of food and a sense of loss of control, subjective binge episodes (SBEs), which are not addressed in current BN diagnostic criteria, only require that the individual experiences a sense of loss of control over eating. Thus, it is possible that SBEs precede purging in PD, that is, individuals with PD may experience a loss of control when they consume an objectively moderate amount of food. On the basis of clinical reports, Fairburn and Garner (1986) have posited that the perception of excessive consumption and the perception of loss of control may be more important than the actual amount of food consumed. Moreover, there is some evidence that the distinction between SBEs and OBEs may not be clinically significant (Mond et al., 2006; Niego, Pratt, and Agras, 1997; Pratt, Niego, and Agras, 1998). Because studies have yielded inconclusive findings regarding the presence of SBEs in PD (Keel et al., 2001), research should investigate the frequency and phenomenology (i.e., individuals' subjective experiences) of such episodes in PD.

The identification of possible antecedents to purging in PD may be elucidated by Restraint Theory, which provides a unifying, empirically supported conceptualization of eating pathology (Engelberg, Gauvin, and Steiger, 2005; Polivy and Herman, 1985; Wilson, 2002). Although studies have evidenced significant dietary restraint among individuals with PD (e.g., Keel, Holm-Denoma, and Crosby, 2011), thus far, no studies have conceptualized PD within restraint theory, which postulates that both the physiological and psychological aspects of restrained eating increase the likelihood of subsequent binge eating (Herman and Polivy, 1975, 1980, 1983; Polivy and Herman, 1985). In an effort to lose weight, restrained eaters adhere to unrealistic, rigid dietary rules in order to restrict their food intake (Polivy and Herman, 1985). Rigid dietary restraint, when coupled with biological (e.g., starvation effects), cognitive (e.g., dichotomous thinking), and affective (e.g., mood fluctuations) factors related to dieting, may lead dieters to feel a loss of control after any lapse in their diet. This increases the likelihood that the person will temporarily abandon all dietary rules and engage in binge episodes (Wilson, 2002).

In support of this theory, empirical evidence suggests that dietary restraint may potentiate binge eating and contribute to the development of eating disorders (Lowe et al., 1996; Stice, 2002; Wilson, 2002). Two findings are particularly relevant. First, using ecological momentary assessment, Engelberg et al. (2005) found that restraint was elevated before binge cravings, but not binge episodes. Such findings support restraint theory, in that dietary restraint potentiates, but does not directly cause, binge eating. Rather, other factors, such as emotional distress, may trigger binge episodes. Thus, in PD, it is possible that restraint is associated with binge cravings, but not necessarily objectively large binge episodes unless other factors are present. Second, Kerzhnerman and Lowe (2002) examined dieting intensity and the frequency of objective and subjective binge episodes; results indicated higher levels of dieting intensity were related to more frequent subjective, yet not objective, binge episodes. This finding suggests that the relationship between dietary restriction and subsequent perceived disinhibited eating (i.e., SBEs) is stronger and more significant than the relationship between dietary restriction and objective caloric consumption (i.e., OBEs).

1.3. The present study

Taken together, it appears that the validity of PD as a distinct category remains unclear. In theory and consistent with previous research, the clinical significance of PD would be evidenced by differences between individuals with PD and healthy controls on various measures of eating pathology and psychosocial variables, while the distinctiveness of PD would be evidenced by relative differences between individuals with PD and other eating disorders. Given the mixed findings of previous studies, it appears that two possibilities exist regarding the significance and distinctiveness of PD from EDNOS. First, PD may be a clinically significant and distinct diagnostic category. That is, the clinical significance of PD would be evidenced by significant differences between PD and control groups on a variety of variables, with PD individuals reporting greater psychopathology than controls. The distinctiveness of PD would be supported by significant differences between PD and both BN and restrained eaters, including a lack of reported SBEs in PD. The latter finding may suggest a different etiology of PD, as this would not support Restraint Theory and current conceptualizations of bulimic spectrum eating psychopathology.

Second, PD may not be a distinct disorder, but rather a disorder that falls on the spectrum of bulimic symptomatology. This conceptualization would be supported by the finding that individuals with PD report subjective binge episodes and differ from controls on variables that are also associated with BN and restrained eating, which would support the possibility that PD exists along a continuum of bulimic eating psychopathology. Thus, the present study sought to compare the core eating disorder symptomatology, body image disturbance, and other psychological correlates of individuals with PD to those of healthy controls, restrained eaters, and individuals with BN. A second purpose of this study was to evaluate the conceptualization of PD within restraint theory by including participants with a range of bulimic spectrum eating pathology and assessing levels of restraint, SBEs, and OBEs. Given the state of the current literature, no specific hypotheses are presented.