

UNDERSTANDING EATING DISORDERS: FOOD FOR THOUGHT

By **Allie Outram** (BACP Accredited Psychotherapist)

Website: www.allieoutram.co.uk

Email: allie_outram@hotmail.com

1. SOME FACTS ABOUT EATING DISORDERS (EDs)

- EDs are serious complex, costly and challenging mental illnesses and include:
 - Anorexia Nervosa (AN)
 - Anorexia Athletica
 - Binge Eating Disorder (BED)
 - Eating Disorder Not Other Specified (EDNOS)
 - Diabulimia
 - Avoidant & Restrictive Food Intake Disorder (ARFID)
 - Bulimia Nervosa (BN)
 - Bigorexia
 - Obesity
 - Orthorexia
- EDs tend to be more common in **females** than in males, with research indicating that less than 10% of those admitted to hospital with eating disorders are male.
- EDs have the **highest mortality rate** of any mental illness claiming precious, promising lives every year. One in five of the most seriously affected will die prematurely.
- EDs of all psychological conditions have the **worst prognosis**- 50% recovery rate

2. THE WHY BEHIND THE WHAT OF EATING DISORDERS

- Creates a sense of **control**.
- Seems like a logical choice to navigate life and **anaesthetize pain** and hurt.
- Can **gain approval** from other people (body shape).
- Can **affirm** the **disgust** that the person feels towards themselves (especially if they are overweight).
- Find **comfort** in eating (especially compulsive/binge disorder).
- Purging **releases tension** and “bad feelings”.
- Rejection from friends or someone who they’d like a relationship with.
 - “Food became the **best friend** I never had”
- **Sense of belonging** to a community (Ana and Mia).

3. DIFFERENT TYPES OF EATING DISORDERS

3.1 ANOREXIA NERVOSA

Diagnostic criteria from DSM V

- Severe weight loss leading to maintenance of body weight less than 85% of that expected or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.
- Intense pathological fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way one's body weight or shape is experienced (distorted body image), undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.

Type

- *Restricting Type*: During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (self-induced vomiting or misuse of laxatives, diuretics, or enemas).
- *Binge Eating/Purging Type*: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour.

3.2 BULIMIA NERVOSA

Diagnostic criteria from DSM V

- Recurrent episodes of binge eating characterized by both:
 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 2. A sense of lack of control over eating during the episode, (such as a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviour to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviour both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Type

Purging Type: During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Non-purging Type: During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviour but has not regularly engaged in self-induced vomiting or misused laxatives, diuretics, or enemas.

3.3 BINGE EATING DISORDER (BED)

The key diagnostic features of BED are:

- * Recurrent and persistent episodes of binge eating
- * Binge eating episodes are associated with three (or more) of the following:
 - Eating much more rapidly than normal
 - Eating until feeling uncomfortably full
 - Eating large amounts of food when not feeling physically hungry
 - Eating alone because of being embarrassed by how much one is eating
- * Feeling disgusted with oneself, depressed, or very guilty after overeating
- * Marked distress regarding binge eating
- * Absence of regular compensatory behaviours (such as purging).

3.4 ANOREXIA ATHLETICA

(aka compulsive exercise, athletica nervosa, obligatory exercise, and exercise addiction)

Physical Symptoms

The Female Athlete Triad refers specifically to three related health problems often found in women athletes:

- Low energy availability / eating disorders
- Menstrual irregularities / amenorrhea
- Bone loss / osteoporosis / stress fractures

Psychological Symptoms

- Desire to control body weight or shape.
- Rarely satisfied with athletic achievements.
- Define self-worth in terms of performance.
- Feeling of inexplicable dread if exercise is not performed.
- Need to achieve an exercise-induced "high."
- Experience withdrawal symptoms similar to those felt by heroin addicts. Commonly reported symptoms include sleep problems, changes in appetite, mood disturbances and depression.
- Increasing dose dependence - Exercise addicts need more and more of a "fix" to get satisfaction. This can lead to injury, fatigue and suppressed immune system.

Behavioural Symptoms

- Always working out alone, isolated from others.
- Always following the same rigid exercise pattern.
- Exercising for more than two hours daily, repeatedly.
- Fixation on weight loss or calories burned.
- Exercising when sick or injured.
- Exercising to the point of pain and beyond.
- Skipping work, class, or social plans for workouts.

3.5 BIGOREXIA

Bigorexia, formally known as Muscle dysmorphic disorder (MDD), is a form of body dysmorphic disorder (BDD). The condition is sufficiently distinct from BDD to have its own sub-category in DSM-5. People with MDD obsessively believe they are physically too small and not muscular enough. They rarely seek help, and their physique helps to counter suspicion that there may be something wrong. Unlike EDs, MDD doesn't kill you, but the long-term effects can be very damaging, socially and psychologically. Risk of suicide, substance misuse and steroid abuse is much higher than for BDD, and quality of life is badly affected, because of the obsessional need to train.

Androgenic steroids occur naturally in the human body; men produce 7-12mg of testosterone a day. They can be prescribed by a doctor for a multitude of reasons, and in low doses are very safe. However, prolonged and high dosages can be hugely damaging (a steroid user can be taking 1500-3000mg of testosterone a week). They can cause hardening of the arteries due to increased cholesterol, resulting in strokes and heart attacks, and can also lead to liver damage, psychosis, severe depression and suicide. HIV and Hep C and B are also on the rise among men who inject steroids, from sharing needles and bad hygiene.

3.6 ORTHOREXIA NERVOSA

“Orthorexia nervosa” literally means “fixation on righteous eating.” Orthorexia starts out as an innocent attempt to eat more healthfully, but orthorexics become fixated on food quality and purity. Eventually food choices become so restrictive, in both variety and calories, that health suffers – an ironic twist for a person so completely dedicated to healthy eating. Eventually, the obsession with healthy eating can crowd out other activities and interests, impair relationships, and become physically dangerous.

Orthorexia is not an officially recognized disorder in the DSM-5, but is similar to other eating disorders – those with anorexia nervosa or bulimia nervosa obsess about calories and weight while orthorexics obsess about healthy eating (not about being “thin” and losing weight).

Following a healthy diet does not mean you are orthorexic, and nothing is wrong with eating healthfully unless...

- 1) It is taking up an inordinate amount of time and attention in your life;
- 2) Deviating from that diet is met with guilt and self-loathing; and/or
- 3) It is used to avoid life issues and leaves you separate and alone.

3.7 DIABULIMIA

Diabulimia is an umbrella term which consists of 3 main features:

1. It only occurs in people with Type 1 diabetes
2. People with Type 1 diabetes have a fear that insulin causes weight gain
3. This fear is so strong it leads them to omit the amount of insulin they take in order to lose weight.

Consequences of omitting insulin include:

- Kidney failure
- Nerve damage
- Loss of limbs
- Blindness
- Heart failure
- Death

- 60% of women with Type 1 diabetes will have experienced an ED by age 25 (Colton et al. 2015)
- There are 400,000 people with Type 1 diabetes in the UK. It is estimated that at least a third of adolescents and young adults with Type 1 omit or reduce insulin in order to lose weight (Hasken et al. 2010)
- Lack of awareness in healthcare services means help for sufferers in the UK is very scarce.

3.8 AVOIDANT AND RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

- ARFID replaces the more general term Childhood Feeding Disorders. This was too broad to be useful.
- It replaces a variety of terms used to describe children with certain common characteristics in their eating and drinking including: picky eating, selective eating, perseverant eating, fussy feeders, food avoidance emotional disorder, selective eating, food phobia, functional dysphagia.
- It is a condition that can occur throughout the human lifespan. ARFID can be used to describe adults showing the same eating characteristics as children.
- As outlined in the DSM V:

A. Eating or feeding disturbance (including but not limited to apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; or concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following:

Significant weight loss (or failure to gain weight or faltering growth in children);

2. Significant nutritional deficiency;

3. Dependence on enteral feeding;

4. Marked interference with psychosocial functioning.

B. There is no evidence that lack of available food or an associated culturally sanctioned practice is sufficient to account alone for the disorder.

C. The eating disturbance does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa, and there is *no evidence of a disturbance in the way of which one's body weight or shape is experienced.*

D. If the eating disturbance occurs in the context of a medical condition or another mental disorder, it is sufficiently severe to warrant independent clinical attention.

4.WHY YOU MIGHT FEEL OUT OF YOUR DEPTH

4.1 AMBIVALENCE

There is part of the client that is eager to get healthy, and another part that is terrified of giving up their disordered eating. There is an internal battle between the *healthy self* and the *eating disordered self*. We know that people who have eating disorders find it hard to change and hard to give up their disordered eating. Some people see their eating disorder as a friend, or a lifeline.

Anorexia Nervosa is described as **EGOSYNTONIC** because individuals experience their symptoms as congruent with their own values. Anorexic individuals have a tendency toward perfectionism and place a high value on thinness and self-control. Most individuals will respond negatively to suggestions that they are ill, and are deeply distraught by efforts to interrupt their ongoing drive toward weight loss. It is therefore very difficult to treat.

(**Egosyntonic** refers to behaviors, values, feelings, which are in harmony with or acceptable to the needs and goals of the ego, or consistent with one's ideal self-image.)

People with EDs, particularly anorexia, seem to have a characteristic cognitive style or share certain personality features. Sufferers tend to be **over-analytical**, seeing only the **detail**, rather than being able to synthesize the moment into the **tapestry** of life. Additionally, people with EDs have a tendency to be rather **single-minded**, enabling them to focus on one thing without distraction. This strategy helps them avoid thinking or dealing with painful issues about themselves, stressful events, or their connections within the world and other people; a very powerful maintaining factor indeed. The downside of this is increasing inflexibility and rigidity and entrapment in their compulsive behaviours and rituals.

4.2 RISK ISSUES

Eating disorders cause both internal and external physical changes. External changes include loss of scalp hair, increase in body hair, dry skin and brittle nails. Internal damage can be caused by vomiting, laxative misuse and malnutrition. People with eating disorders often have electrolyte abnormalities and cardiovascular problems (heart problems as a result of weight loss and/or purging, which cause dizziness or fainting), gastrointestinal changes (digestive problems such as bloating, reflux and constipation), hormonal imbalances (loss of periods in females and low testosterone in males), infertility, immune deficiencies, bone density problems and dental damage.



These physical effects can be dangerous, and some of them are irreversible. Electrolyte imbalances can cause heart attacks or strokes, which can lead to coma or death. Gastro-intestinal damage can include incontinence (loss of bowel control) or oesophageal tears, which cause the vomit to enter the lung and result in suffocation. Vomiting can result in the acid wearing away dental enamel, which can never be restored. (You may have to have teeth replaced or capped.) Being underweight during the years of growth (childhood and adolescence) can cause two permanent forms of damage. First is stunted growth – that is, underweight individuals stop growing taller and may never achieve their potential height. Second (because of the low hormone levels) is compromised bone density, which causes brittle bones and can lead to osteoporosis, or osteopaenia, which it is called in its early stage.

4.3 COMORBIDITY

One of the persistent challenges in diagnosing and treating eating disorders, and indeed in analysing trends in prevalence and reporting, is that it is common for eating disorders to occur alongside other mental health issues. Therefore, eating disorders are often one of a number of conditions that simultaneously impact upon individuals. This is a contributing factor to the difficulty in recognising and ultimately treating eating disorders. Linked conditions include

- Depression
- OCD
- Substance abuse
- Personality Disorders
- Body Dysmorphic Disorder
- Bipolar Disorder

5. KEY POINTS TO TAKE AWAY:

All eating problems are significant and can only be understood as an **expression of underlying issues and difficulties**. They contain a message that goes beyond the limits of the behaviour itself. Eating is never a mere physical function: it contains and carries much more than is evident on the surface. As therapists, if we ignore the meaning of the eating pattern, we miss the essential symbolism of the problem.

Research shows:

- **Model** or **technique** has a minimal impact on outcomes. However **CBT-E** is the **leading evidence-based** and most effective treatment for EDs. Of the 80% who complete treatment $\frac{3}{4}$ make a full recovery that appears to be well maintained.
- Quality of **therapeutic alliance** important.
- Regular **monitoring** of progress and alliance improves outcomes. Build strong culture of clinical feedback and supervision and be prepared to fail “successfully.”
- **Extra-therapeutic factors** such as social circumstances and motivation have biggest impact on outcomes (<87%).

Resources and Contacts

Websites

Books & Articles

- The UK's Eating Disorder Charity
<http://www.b-eat.co.uk>

Provides details about support and services including:

- ✓ **Helplines**
- ✓ **Message Boards**
- ✓ **Treatment Options**
- ✓ **Online Support Groups**
- ✓ **Peer Support Groups**
- ✓ **Regional Projects**
- www.credo-oxford.com
 - What is CBT-E
 - The standing of CBT-E
 - CBT-E resources

- ✓ Getting Better Bit(e) by Bit(e): Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders – Ulrike Schmidt, Janet Treasure..
- ✓ Skills-based Learning for Caring for a Loved One with an Eating Disorder: The New Maudsley Method - Janet Treasure, Gráinne Smith, Anna Crane.
- ✓ Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers - Janet Treasure.
- ✓ Overcoming Binge Eating: The Proven Program to Learn Why You Binge and How You Can Stop – Christopher G. Fairburn.
- ✓ Cognitive Behavior Therapy and Eating Disorders - Christopher G. Fairburn
- ✓ Goss K. & Allan, A. (2010) Compassion Focused Therapy for Eating Disorders. *International Journal of Cognitive Therapy*, 3, 141-158
- ✓ Goss K. (2011) A Compassionate Guide to Beating Overeating: Constable Robinson.
- ✓ Goss, K., & Allan, S. (2011). An introduction compassion focused therapy for eating disorders. In J. Fox & K. Goss (Eds.) *Eating and its disorders* (pp. 303-314). Chichester: Wiley-Blackwell.