Working with the person with disordered eating patterns

-An introductory text for mental health clinicians

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Introduction

This paper was written for the second edition of a Mental Health Nursing textbook. Unfortunately the project was abandoned before reaching print. The text has been redrafted and updated to ensure relevance to all mental health professionals, but the original structure has been retained. The text itself is lightly referenced, but the annotated list of further reading provides suggestions for those readers wishing to widen their knowledge. The discussion and reflection points have also been retained. They are intended to encourage the reader to consider some of the pertinent issues from a more personal perspective.

Although features about anorexia or bulimia nervosa appear regularly in the media, only a small minority of people with disordered eating patterns seek help from health professionals. Consequently, health service staff gain little experience of working with the person with disordered eating patterns and their carers. This paper will help you to understand the person with disordered eating and provides guidance for appropriate mental health care intervention.

Key concepts

Recognising and understanding disordered eating patterns

- The cultural context of problems with eating, body shape and weight
- Definitions of disordered eating patterns
- Demography, incidence and prevalence
- The experience of the person with disordered eating patterns
- Factors that contribute to disordered eating patterns developing and continuing

The needs of the person with disordered eating patterns and of their carers

- How disordered eating patterns affect the person's ability to meet their own needs
- The physical, psychological and social consequences of disordered eating patterns
- The effect of disordered eating patterns on carers
- The needs of carers

Therapeutic strategies for working with the person with disordered eating patterns

- Assessment
- Education
- Monitoring
- Therapy
- Supportive interventions
- Intensive interventions in hospital or day care

Professional issues and dilemmas in working with the person with disordered eating patterns

- Mental health professionals with disordered eating patterns
- Re-feeding the person with disordered eating patterns against their will

Recognising and understanding disordered eating patterns

The cultural context of problems with eating, body shape and weight

Food meets the basic physiological need for energy, but eating also meets other needs. From birth onwards, feeding is a social activity that has meaning on many levels. Culture, religion, gender roles, availability of food, emotional and other factors, will influence the personal meaning of eating. Feasting and fasting have played important roles in most cultures throughout history. Human relationships with food have been dominated by important factors, among them:

- the need to work physically hard every day to ensure sufficient supplies of food
- the experience of famine
- traditions surrounding the content of meals and social rituals at mealtimes.

Modern westernised society has affected each of these factors:

- decreasing the amount of physical work most people do each day
- offering seemingly unending supplies of food from all over the world
- undermining traditions relating to eating and increasing emphasis on personal lifestyle choices.

Similarly, attitudes towards body shape and weight have altered radically in industrialised societies over the past 40 years. Voluptuousness used to be associated with fertility and fertility was highly valued. Reliable contraception has led to the separation of sexuality and fertility, apparently offering women more choice and control over their bodies. Over the same time period, women have experienced dramatic changes in their role expectations. Academic and work success now have to be combined with motherhood and caring for others.

"Ideal" images of women in the media are unrealistically thin. Advertising encourages dissatisfaction with body shape and weight, but the population is getting fatter and more people are becoming clinically obese. Dieting is a common female activity. The word "fat" now implies negative connotations and prejudice towards obese people goes unchallenged. This cultural environment is the context within which disturbed eating patterns develop.

Definitions of disordered eating patterns

Disordered eating patterns are currently classified into two main diagnostic categories, Anorexia Nervosa, Bulimia Nervosa and then atypical eating disorders (World Health

Organisation 1992). Although there are important differences between each diagnosis, most people with disordered eating patterns share similar attitudes, behaviour and feelings, especially the fear of gaining weight. Consequently, patients are often referred to as having an Eating Disorder. Childhood eating disorders are not distinguished from adult definitions within diagnostic manuals. Lask and Bryant-Waugh (2000) have provided useful working definitions for children with disordered eating.

Anorexia Nervosa (AN)

The person with AN:

- purposely loses weight to a point at least 15% below that expected for their age, sex and height
- experiences changes in hormone levels which, in females result in amenorrhoea (if the weight loss occurs before puberty begins, sexual development will be delayed and growth might cease)
- feels driven to lose weight because they experience themselves as fat, even when at a subnormal weight
- is intensely afraid of becoming fat and preoccupied with worries about their body size and shape
- directs all their efforts towards controlling their weight by restricting their food intake, but may also binge eat, self induce vomiting, misuse laxatives or diuretics (purging behaviours), exercise excessively or misuse appetite suppressants

Bulimia Nervosa (BN)

The person with BN:

- experiences frequent episodes of binge eating, during which they consume a large amount of food within a short period of time
- feels overwhelmed by the urge to binge and can only stop eating once it becomes too uncomfortable to eat any more
- feels guilty, anxious and depressed, because they have been unable to control their appetite and they fear weight gain
- tries to regain control by getting rid of the calories consumed (the most common method used is vomiting, but they might misuse laxatives, diuretics or appetite suppressants, fast or excessively exercise)
- is usually within a normal weight range, but might be obese

Atypical Eating Disorders (AED)

The person with AED:

- is likely to be similar to people with AN or BN, but not quite meet those diagnostic criteria
- might vomit after eating small amounts of food
- might chew food and then spit it out
- might binge eat, but not attempt to get rid of the calories consumed (this behaviour is now called Binge Eating Disorder [BED] (American Psychiatric Association

1994), the phrase compulsive eating is sometimes used, but has never been adequately defined)
- might eat for emotional reasons (comfort eating), but not eat large amounts of food at one time

Childhood Eating Disorders

Anorexia Nervosa (and atypical forms)
- Very similar presentation to older sufferers
- There might be failure to gain weight and height instead of weight loss
- Laxative abuse is less common
- Shape and fitness often more important for boys than weight

Bulimia Nervosa (and atypical forms)
- Similar presentation to older sufferers
- Very uncommon below age 13

Food avoidance emotional disorder
- Food avoidance
- Weight loss
- Mood disturbance
- No obsession with weight or shape
- No other explanation for weight loss

Selective eating
- Narrow range of foods
- Unwillingness to try new foods
- No obsession regarding weight or shape

Restrictive eating
- Smaller than usual amounts for age eaten
- Diet is normal in nutritional content
- No obsession regarding weight or shape
- Weight and height tend to be low

Food refusal
- Food refusal tends to be episodic, intermittent or situational
- No obsession regarding weight or shape

Functional dysphagia
- Food avoidance
- Fear of swallowing, choking or vomiting
- No obsession regarding weight or shape

Pervasive refusal
- Profound refusal to eat, drink, walk, talk or self care

- Determined resistance to efforts to help

Demography, incidence and prevalence

People with disordered eating patterns are predominately young and female. However, some children, men and older women also develop disordered eating patterns. Only 5-10% of adults with AN referred to mental health services are male. Disordered eating patterns can start from about age eight upwards, but most begin in adolescence or early adulthood.

The person with disordered eating patterns can come from any social class background. Minority ethnic groups are underrepresented in referrals to mental health services.

Epidemiological studies have focused mainly on young women attending school or college. The prevalence amongst children, men and older women is unclear. The average prevalence of AN, BN and AED amongst young women (aged 15-24) in the community is as follows:

- AN = 0.28%
- BN = 1% (Hoek 1995)
- AED = Up to 5% (Button and Whitehouse 1981)

However, the prevalence of AN peaks in late adolescence, so about 1% of 15-18 year old girls have AN.

Disordered eating patterns are uncommon amongst the total population, but are common amongst young women, especially within certain professional groups such as ballet dancers and fashion models.

Most people with disordered eating patterns do not seek help, so General Practitioners (GPs) and other health workers identify them only occasionally. A study in primary health care found the following incidence rates:

- AN = 8.1 per 100,000 total population (both sexes) per year
- BN = 11.4 per 100,000 (Hoek 1995)

Few people are referred to mental health services, the average being 5 with AN and 6 with BN per 100,000 total population per year (Hoek 1995). These figures have implications for mental health professionals. It is quite possible to complete a professional training without caring for a person with disordered eating patterns. This leaves many professionals lacking skills, experience and confidence. Mental health professionals may even be more likely to know someone with disordered eating patterns in their personal life than in their professional life.

The experience of the person with disordered eating patterns

Life, for the person with a disordered eating pattern, is dominated by concerns about weight, body shape and food. Dieting and vomiting leave the person feeling hungry, so thoughts of food intrude into every waking moment and their dreams at night. The person battles to overcome the urge to eat. When they are "successful", they feel elated and "in control", but if they are unable to resist eating, they experience overwhelming feelings of guilt, anxiety and depression.

The daily priority is to consume as few calories as possible. Other activities and relationships will be sacrificed if they interfere with the aim of avoiding food or burning up calories.

The person becomes obsessed with losing weight because they believe it is the only way to take control of their life and to feel better about themselves. However, feelings of self worth are fragile because any unplanned eating is viewed as total failure, which has to be rectified by vomiting, laxative abuse, exercise or fasting. Even whilst successfully avoiding food, the person lives in fear of breaking their diet. Most people with eating disorders have little or no psychological understanding of their difficulties and explain their behaviour in terms of needing to lose weight because they are fat.

Life is lived either rigidly within set routines that ensure weight loss or becomes chaotic as the person gives in to their impulses and abandons all attempts to maintain control. Many people manage to contain the chaos to times when they are alone. Consequently they can appear competent and happy in social situations, but feel out of control and miserable when alone.

People with disordered eating patterns can feel very ashamed of their behaviour, or fear that other people will try to stop them losing weight. This leads to secretive behaviour and deceit, which in turn reinforces feelings of guilt and isolation. As the disordered eating progresses, its effects take over the person's life. Hours each day can be spent exercising, secretly gorging food, bending over the toilet to be sick, swallowing large quantities of laxatives, sitting on the toilet and clearing up all evidence afterwards. The rest of the day is spent worrying, counting calories, stepping on and off scales and attempting to avoid discovery.

Factors that contribute to disordered eating patterns developing and continuing

The current expert consensus view is that disordered eating patterns are caused and maintained by combinations of predisposing, precipitating and perpetuating factors. Predisposing factors can be:

- Physical (including a probable genetic component)
- Psychological and emotional (including low self esteem and perfectionism)
- Gender based (women are far more at risk)

- Interactional (including relationship difficulties)
- Cultural (including pressures on women to diet)

The causes of low self esteem are multi-factorial. Some people with disordered eating patterns have experienced trauma, but many have not. Whatever the cause, low self esteem leaves some people vulnerable to believing that weight loss will improve their self worth and confidence.

Precipitating factors vary from person to person, but most disordered eating patterns start with dieting. Any event or threatened event that causes stress can lead to a sense of being overwhelmed and out of control, pushing the person to find a way to manage those feelings. Interpretation of events is probably more important than the events themselves, as precipitating factors are often a normal part of growing up.

If the developing disordered eating pattern relieves the stress, the behaviour will continue. Dieting, bingeing, exercise, vomiting and laxative misuse quickly become the only stress management tools used. Whilst losing weight, the person views their behaviour as a solution to their problems and feels better than before. Even if their eating becomes chaotic, they strive to regain control, blaming loss of control for their problems.

Perpetuating factors are:

- Physical (including hunger and the effects of starvation or purging)
- Psychological and emotional (including avoidance of life difficulties, cognitive distortions, depression and anxiety)
- Interactional (including relationship problems and secondary gain)
- Cultural (including pressures on women regarding appearance)

A combination of factors will affect each person's willingness to view their disordered eating pattern as a problem. They will only consider the possibility of change once the disadvantages of staying the same outweigh the advantages. Even then, the perceived disadvantages of change might still outweigh the advantages, leaving them feeling ambivalent, hopeless and unable to alter their behaviour.

The needs of the person with disordered eating patterns and of their carers

How disordered eating patterns affect the person's ability to meet their own needs

The person with a disordered eating pattern is often unable to meet some of their own basic needs. The drive to lose weight takes precedence, resulting in neglect of personal needs. Hunger signals are ignored and physical exhaustion and self denial are

considered virtues. Starvation and purging affect the person's ability to feel warm, rest, eliminate, be physically active, feel sexual, think, experience emotion, communicate, relate and value one's self.

People with disordered eating patterns often have rigid moral rules that govern their behaviour. They will act because they feel they ought to rather than because they want to. Their thinking tends to be dichotomous (all or nothing, black or white), which leads them to behave in extreme ways. For example, starving then bingeing, avoiding intimate relationships, then having sex with a stranger or not allowing themselves to buy food, then shoplifting. The shame and guilt felt regarding their behaviour, combined with their low self esteem, leads them to feel that they are not entitled to meet their own needs and that others' needs should always come first.

Often hyper-sensitive to other people's feelings, they can also be very unassertive, and tend to make very few overt demands within relationships. Paradoxically, others can experience them as demanding, self centred and controlling.

The person with disordered eating patterns needs to be able to replace their disordered eating pattern with healthier ways of coping and relating, taking personal responsibility for improving their own nutritional, mental and physical health. Specific needs will apply in each individual's case, but they will probably include the need to:

- establish a healthy eating pattern
- gradually restore weight to a normal range
- cease purging behaviour
- improve self esteem
- use healthier coping strategies
- develop relationship and communication skills

The physical, psychological and social consequences of disordered eating patterns

A disordered eating pattern can seriously effect quality of life. Although physical, psychological and social effects improve with recovery, chronic problems result when the disordered eating pattern continues over several years.

Physical effects

The physical effects are the result of the different associated behaviours. Consequences will differ, depending upon the frequency and duration of behaviours and the person's constitutional vulnerabilities. For example, some people find vomiting easy, others are unable to do it. Some people's teeth decay more quickly than others.

The effects of starvation

The first effect of insufficient calorie intake is hunger. When food is scarce, the body compensates for the reduction in calorie intake by lowering the basal metabolic rate, thereby reducing the expenditure of energy. Heart rate, blood pressure, temperature and respiration all decrease. Peripheral circulation diminishes, resulting in the person feeling cold. Cuts or bruises heal slowly. Extra (lanugo) hair grows on the body, as it attempts to keep warm and save energy. Sleep becomes disturbed due to hunger, discomfort and hormonal changes that increase urinary output.

As the person loses weight, the effects of starvation increase. Once females have lost more than 15% of average weight, hormonal changes lead to a loss of libido and cessation of menstrual periods. Over time, the lack of oestrogen leads to thinning of the bones (osteoporosis) which can increase the risk of fractures. Males are also subject to hormonal changes that lead to loss of libido, loss of early morning erections and failure to perform sexually. Males also risk osteoporosis. Similar weight loss or failure to make expected weight gain in children will stop or prevent pubertal development and can lead to failure to grow in stature.

The person can become anaemic and prone to infection due to bone marrow failure. Low glucose levels increase the risk of fainting. Physical stamina and muscle control gradually reduces, so that eventually, the person can become clumsy, lethargic and have difficulty climbing hills or stairs.

Emptying of the stomach becomes delayed, leaving people feeling full and bloated, even hours after eating small amounts. The intestine functions more slowly which can lead to constipation. People with AN report experiencing emotional highs and increased energy, which is probably partly the result of changes in brain chemistry due to starvation or excessive exercise. Intense hunger increases the likelihood of bingeing as the body craves sustenance. After starvation experiences, it is usual for people to eat large quantities of food rapidly, until they have replaced the lost weight.

Ultimately, if starvation continues, all supplies of energy will be used and the person will die.

The effects of bingeing, purging, excessive exercise and appetite suppressants

Bingeing can contribute to irregular menstrual periods. Excess consumption of carbohydrate causes a temporary increase in temperature, pulse rate and fluid retention. The large amounts of food eaten cause discomfort and distension of the stomach. The discomfort is often relieved by the person self inducing vomiting. Although vomiting brings physical and psychological relief, it can cause various health problems. The most common consequence is damage to the enamel on teeth. Each time the person is sick, their teeth are bathed in acid from the stomach, slowly causing

dental decay. The damage is compounded if they immediately brush their teeth, as the brushing scours the enamel whilst it is most vulnerable.

Although people with disordered eating patterns believe vomiting to be an effective method of weight control, about half the calories consumed in a binge are usually retained in the body. Frequent vomiting leads to loss of fluid and essential body salts (electrolytes), disturbing the body's chemical balance. Loss of potassium (hypokalaemia) is particularly dangerous, as it can result in cardiac arrhythmias and arrest. Electrolyte imbalance and dehydration can produce tiredness, weakness, pins and needles (parasthesia) and muscle spasms. Occasionally, epileptic fits or kidney damage occurs.

Some people experience an enlargement of their salivary glands. Although this is not dangerous, it can lead the person to think that their face is getting fatter. The throat can become sore after excessive vomiting and sometimes people catch their knuckles on their teeth whilst inducing vomiting, causing abrasions which scar because the scab is constantly dislodged.

Laxative and diuretic misuse can also cause dehydration and electrolyte imbalance due to diarrhoea or increased urinary output. Fluid retention occurs as a response to fluid loss and is particularly noticeable when the person stops taking the laxatives or diuretics. Oedema can cause weight to increase by several pounds overnight. Chronic misuse of laxatives damages the functioning of the bowel.

The amount of exercise undertaken varies considerably from person to person. Excessive strain can cause damage to muscles and bones. Appetite suppressants are not usually prescribed by GPs, but they are sometimes obtained from diet clinics or the black market. Some people use amphetamine sulphate for its effect on appetite. Misuse of appetite suppressants can cause sleep disturbance, nervousness, dependence and depression after abrupt withdrawal.

Psychological effects

Hunger produces constant intrusive thoughts of food that impair concentration. The person becomes preoccupied with food. As starvation continues, alertness, comprehension and judgement worsen, affecting the ability to take in new information and make rational decisions. Mood becomes more labile, with an increase in anxiety and depression. People become less tolerant and more likely to have outbursts of temper. Obsessional behaviour develops with weight loss. Time consuming rituals often surround eating and the obsessional behaviour can extend into other parts of the person's life.

The depression, guilt, anxiety and loss of self esteem, often lead to self harm. It is not uncommon for people with disordered eating to cut themselves as a method of tension

relief or self punishment. This behaviour is usually secretive. Up to half of the deaths related to disordered eating are suicides. People appear to be more vulnerable to suicidal feelings when their eating is out of control. Drugs and alcohol might be misused to alter mood, or to provide some relief from the constant battle with food.

Social effects

Most social activities involve eating or drinking, and therefore calorie consumption. The person with a disordered eating pattern will often find such situations very difficult, so has to find ways to manage the tension and anxiety experienced. The usual strategy used is to avoid eating in public, but if that is not possible then the social event itself might be avoided. Starvation decreases sociability, sense of humour and camaraderie and increases social anxiety. Social withdrawal, anxiety, depression and fear of discovery produce a vicious cycle within which the disordered eating and social confidence gradually worsens.

Intimate relationships are often avoided and even if the person has a sexual partner, they frequently fail to share personal feelings and concerns about their eating behaviour with them. Mothers with an eating disorder can have problems relating with their children regarding feeding and play.

They find it difficult to tolerate mess and get into battles when the child wants to eat more independently. The child can become resistant and feeding and growth problems can ensue.

Whilst successfully starving, the person's behaviour tends to be rigid, obsessional and controlled. However, at times when eating is chaotic, social behaviour can become erratic and disorganised reflecting the emotional turmoil that the person is experiencing. For example, the person might forget prior arrangements or turn up late for appointments, or spend all day bingeing, rather than participate in other activities.

The cost of food for binges might be £10-20 per day. Often people get into debt as a result. If they still live at home, their parents will probably meet the cost of bingeing, but arguments and resentment can build up as the behaviour continues. When living in shared accommodation, other people's food is often secretly eaten, causing bad feeling within the household. Some people are driven to shoplift food for their binges. Others take goods from shops whilst in a dazed state following bouts of bingeing and vomiting.

The effect of disordered eating patterns on carers

The effect on carers depends on whether they are aware of the disordered eating pattern. People respond in very different ways. Their response is also likely to change over time as the problem progresses. Common responses are anxiety, fear, guilt, lack of understanding, disbelief, feelings of helplessness, frustration, irritation, anger and the desire to take control of the situation. Most carers experience a range of responses at

different times and each response will have an effect on the behaviour of the person with disordered eating. Carers manage their uncomfortable feelings in different ways, but it is common for the person's problems to either become the main focus of family life, to the detriment of other activities and relationships, or be denied and ignored in the hope they will spontaneously improve. Carers often find that their attempts to help are unsuccessful, which then leads them to feel increasingly helpless and desperate.

The needs of carers

Carers have several needs relating to the person's disordered eating pattern. The carer seldom identifies these needs themselves because their focus of attention rests on the person with the disordered eating. This pattern is often repeated when the person comes into contact with mental health services, especially services for adults. Individual help is offered to the person with disordered eating, but little or no support or guidance is offered to carers. Many parents feel excluded from the helping process and feel blamed for the state that their child is in.

Recovery can be enhanced and healthier family life facilitated, if the needs of carers are identified and addressed. Commonly, carers need:

- time to tell their story and express their feelings
- the opportunity to ask questions and seek guidance on how to help
- information regarding the causes and effects of disordered eating
- information about the helping process and what to expect in the future
- the chance to address problems and relationship issues specific to their family
- the option to meet other carers for discussion and support

Therapeutic strategies for working with the person with disordered eating patterns

Recovery involves a collaborative effort between the person with disordered eating and their helpers. It requires a combination of sufficient motivation to change and adequate support and guidance. Children and young adolescents have particular needs. They are often unable to collaborate with efforts to help them in the early stages of treatment. The involvement of parents and families is therefore especially important.

Establishing a consistent therapeutic relationship is essential to the process of engaging the person with disordered eating and their family in working towards recovery. Continuity may need to be maintained for long periods of time and across different treatment settings (even once symptoms have improved, as relapse is common unless new coping skills are well integrated).

The broad aim of intervention is to engage the person in working towards their own recovery. An approach that encourages active participation and empowers people to identify, express and meet their needs is more likely to achieve this aim. Therapeutic strategies can be divided into six categories: Assessment, Education, Monitoring, Therapy, Support and Intensive Intervention.

Assessment

- Undertake a comprehensive multi-dimensional assessment. Include assessment of the person's physical and mental health (especially depression, self harm, anxiety, obsessional behaviour and substance use) and family and social relationships.

Rationale

People with disordered eating patterns often have other physical and mental health problems which can be a consequence of the disordered eating, or might pre-date its development. Baseline measurements of health need to be established so that change can be measured.

- Pay particular attention to the assessment of past and present attitudes and behaviour relating to eating, body shape, weight, purging and menstruation.

Rationale

Shame, guilt and embarrassment can prevent people admitting exactly what they do regarding eating and weight loss. Careful exploration of these topics can relieve these feelings and encourage acknowledgement of problem behaviours and attitudes.

- Wherever possible, interview family or carers regarding their relative's problems, personal development and family relationships.

Rationale

The person with disordered eating might deny some aspects of their attitudes and behaviour. Interviewing carers can provide an independent source of information. The needs of carers can also be identified and addressed. Research suggests that younger people with AN are more likely to recover if their parents are actively involved in therapy. (Dare and Eisler 1995)

- Enquire about all aspects of the person's physical health and ensure that necessary physical examinations (minimum: pulse, temperature and blood pressure) and investigations take place.

Physical investigations for Anorexia Nervosa -

- Full blood count.
- Urea and electrolytes, including magnesium, calcium and phosphate.
- Liver function test and protein.
- Thyroid function test and blood glucose.
- Electrocardiogram (ECG).

- Bone density scan (if duration > one year).
- Dental examination (if vomiting).

Physical investigations for Bulimia Nervosa -

- Full blood count.
- Urea and electrolytes.
- Electrocardiogram (if chest pain).
- Dental examination (if vomiting).
- Bone density scan (if amenorrhoea > one year)

Rationale

The person's physical health can be seriously compromised by the consequences of their behaviour. The mortality rate for AN is amongst the highest of all mental health problems. Safety and the appropriate management of physical health risks need to be established as soon as possible. Baseline measurements of physical health need to be established.

- Measure and record the person's current height and weight, and calculate their Body Mass Index (BMI). The equation used to establish BMI is:

$$\frac{\text{Weight in kilograms}}{\text{Height in metres}^2} = \text{Body Mass Index}$$

The normal range for adults is 20-25. The median BMI for a child population reduces with age (see Table 1). Calculate BMI as a percentage of median BMI for age and sex, or BMI 21 for adults. The equation used to establish percentage of average BMI is:

$$\frac{\text{Actual BMI}}{\text{Median BMI for age \& sex}} \times \frac{100}{1} = \text{\% of median BMI}$$

Below 85% the effects of starvation develop and below 65% is considered to be the point beyond which physical health is seriously at risk. Rapid weight loss is more dangerous. Stable weight might be relatively safe.

Rationale

The person with disordered eating is likely to have a distorted view of their weight and might be weighing themselves on inaccurate scales. A baseline measurement needs to be established, so that risk to health can be assessed and change measured. Weighing can elicit anxieties and attitudes that can then be explored.

Table 1 (White et al 1995)

Age	Female	Male
8	16.2	16.1
9	16.7	16.5
10	17.2	16.9
11	17.8	17.3
12	18.5	17.8
13	19.3	18.3
14	20.1	19.0
15	20.9	19.8
16	21.6	20.5

- Assess the client's nutritional intake, and involve a Dietitian in that assessment when necessary. Consider the need for multi-vitamins, calcium and vitamin D, as well as nutritional supplements such as Ensure Plus, Entera, Fortisip or Enlive.

Rationale

People with disordered eating often avoid fat, carbohydrate and protein and their diet might also be lacking in vitamins and minerals. A baseline measurement of dietary intake needs to be established. Although a well balanced diet of food is preferable, supplementation of nutrients is sometimes a sensible temporary measure and can aid the process of weight gain. Nutritional drinks are sometimes accepted as "medicine" where food might not be. Also, parents can ensure "medicine" is taken without the emotional conflicts that arise from their child rejecting lovingly prepared food.

- Administer relevant standardised questionnaires, e.g. The Eating Disorders Examination Questionnaire (Fairburn and Beglin 1994)

Rationale

Questionnaires can aid the assessment process and help to measure outcome.

- Feed back all the results from any examination, investigations, calculations and questionnaires to the person with disordered eating. Offer (written) feedback from the assessment interview and allow time for discussion.

Rationale

Feedback and discussion encourage the person to play an active role in their care, diminishing feelings of powerlessness and increasing personal responsibility for their own health.

- Negotiate a care plan and goals with the person with disordered eating and their carers. Review progress regularly, assessing and exploring the person's motivation and readiness for change.

Rationale

Goals that are shared between the person with disordered eating, their carers and the mental health professional are more likely to be achieved. People with disordered eating are often ambivalent about change, but tend to be unassertive and can agree to goals that they are not ready to work on.

Education

- Educate the person with an eating disorder and their carers regarding the physical, psychological and social consequences of disordered eating.

Rationale

Health education can aid understanding, increase motivation and personal responsibility, and encourage the person's confidence in the mental health professional. Research shows that some people with BN recover following a simple educational intervention. (Olmsted and Kaplan 1995)

- Encourage the person with disordered eating and their carers to read a self help book and discuss it with their therapist.

Rationale

Research shows that some people with BN can recover simply by practising the self-help strategies advised whilst receiving minimal support from a health professional. Information can be read and considered in the person's own time. (Wilson and Fairburn 1997)

- Provide simple dietary advice to encourage regular eating of nutritionally balanced meals.

Rationale

The effects of starvation will only abate once the person improves their nutritional state and regains weight to within a normal range. Bingeing will usually reduce in severity once hunger is no longer a trigger. Many people with disordered eating have little knowledge of their nutritional needs, even though they are knowledgeable regarding calories.

Monitoring

- Decide with the person with disordered eating, whether regular weighing at appointments is to be an ongoing part of their care plan (recommended for all cases of AN). If it is, weigh them at the beginning of each session on the same scales, in

light clothing without shoes. Record the weight and review the general pattern of weight change with them. Ask them to express their current thoughts and feelings regarding their weight and body shape.

Rationale

Regular weighing provides essential information regarding the person's physical and mental state and gives an opportunity to discuss their anxieties regarding weight and shape. It can often reassure them that their weight is not increasing rapidly.

- Ask the person with disordered eating to monitor their dietary intake, bingeing and purging behaviour by keeping a diary. The antecedents and consequences of problem behaviours can also be monitored.

Rationale

People with disordered eating often have difficulty identifying the factors that perpetuate their behaviour. Regular monitoring increases self awareness and can improve the person's ability to communicate their thoughts and feelings. Once triggers for behaviours have been identified, goals can be agreed and alternative coping mechanisms practised.

- Ensure that physical health is monitored by examination and/or investigations every three months (or more often if indicated) whilst they remain below 75% of median BMI or engage in frequent purging behaviour (vomiting once or more per day or significant laxative/diuretic abuse).

Rationale

Starving and purging behaviour can change over time, increasing or decreasing in severity. The person with a chronic eating disorder is more likely to suffer damaging physical effects.

Therapy

- Create a therapeutic relationship within which you exhibit genuineness, non-possessive warmth, accurate understanding and unconditional positive regard.

Rationale

People with disordered eating have low self esteem and are often eager to please. They easily feel judged or criticised and frequently withdraw from therapy prematurely. A warm, genuine, understanding relationship prepares the ground for self exploration and change. You will need a high level of empathic, reflective listening skill, as people with eating disorders are often unable to verbalise emotional states (alexithymia).

- Explore the person's ambivalence surrounding the possibility of change, asking them to identify the possible positive and negative consequences of changing or remaining the same.

Rationale

Ambivalence regarding change is common. Attempts to force change before the person is ready can induce resistance. Research suggests that resistance to change is more likely if a highly confrontitive approach is used. (Miller and Rollnick 1991)

- Identify and discuss possible predisposing, precipitating and perpetuating factors.

Rationale

People with eating disorders often have little understanding of how their disordered eating pattern developed and its relevance to their current life. Understanding can help to motivate the person to change.

- Teach the person with disordered eating to use behavioural strategies to gain control over their eating and avoid purging behaviours.

Rationale

Practising behavioural techniques between sessions reduces reliance on the therapist and allows the person to acquire a sense of mastery over their symptoms and life problems. Research shows that behavioural therapy for people with BN can effectively reduce bingeing and purging. (Agras 1993)

- Explain the cognitive view of disordered eating and teach the person cognitive therapeutic techniques.

Rationale

Research shows that Cognitive Behavioural Therapy (CBT) is the most consistently effective treatment approach for people with BN (Wilson and Fairburn 1997). Cognitive techniques enable the person to identify and change their thought processes, thereby helping to modify their negative self image. Regular practice can help to break out of the vicious cycle of self defeating behaviour and improve self esteem and relationships.

- Model and teach specific life skills such as problem solving, anxiety management, relaxation, assertiveness and communication skills.

Rationale

People with eating disorders tend to use over-eating or under-eating as their only coping mechanism. Life skills can help to improve the person's self esteem and eating pattern.

- Help the person with an eating disorder to explore their current and past relationships.

Rationale

People with disordered eating often have difficulties in relationships. Exploration of relationship and communication patterns can deepen their understanding of the role their illness plays in their life and can provide the opportunity to experiment with alternative ways of relating. It can help to foster independence and maturity in relationships. Research shows that Interpersonal Psychotherapy (IPT) is as effective as CBT for BN at one year follow up (Fairburn et al 1995, Agras et al 2000).

- Where possible, involve family members using family counselling (and conjoint family therapy when appropriate) to provide guidance regarding management of the disordered eating pattern. Once family anxieties have been addressed, relationships within the family can be explored, and interventions aimed at improving communication, supporting healthy boundaries and encouraging age appropriate independence can be utilised.

Rationale

The person's disordered eating pattern can have a damaging effect on family life provoking stress and unhelpful responses from relatives. Relatives often need support and guidance regarding how to help. Research shows that a focused family approach to therapy is more beneficial for people with early onset (before age 19), short duration (less than three years) AN (Dare and Eisler 1995). Parents of children and adolescents need advice, support and encouragement to enable them to take charge of supervision of their child's eating, ensuring adequate nutrition to stop and reverse weight loss.

- Consider liaison with the young person's school.

Rationale

Liaison with school staff is often a necessary part of treatment for adolescents, especially when the young person is at boarding school. School nurses and teachers need advice and support if they are to monitor and supervise eating and other difficulties.

- Encourage the person with disordered eating to complete written exercises designed to provoke examination of their motivation, past and current problems, relationships, feelings and hopes for the future.

Rationale

Written work completed between therapy sessions can promote self help and decrease the possibility of *unhealthy* dependence on the therapist (see Treasure 1997, Schmidt and Treasure 1993, Crisp et al 1996).

Supportive interventions

- Provide the person with disordered eating and their family with information regarding local self-help/support groups (especially the Eating Disorders Association).

Rationale

Disordered eating patterns can lead to people becoming emotionally and socially isolated. People can benefit from sharing experiences with and receiving support from others with similar problems.

- Provide long term support for people who are unable to significantly change their disordered eating pattern.

Rationale

Approximately 20% of people with eating disorders remain severely and chronically ill despite appropriate offers of help. Many others experience relapses or times when they are unable to actively pursue recovery. They may need periods of intensive *or* regular, but infrequent emotional and practical support. Distinguishing between phases of "active therapy" and "support and review" can be helpful to both the therapeutic team, the person with the eating disorder and their family. Realistic goals can be set, reducing the unhelpful pressure of unrealistic expectations.

- Support the person with disordered eating and their family to pursue practical changes in their social life and activities of daily living.

Rationale

People with chronic disordered eating patterns often lose their confidence in social situations and lose touch with the skills required for daily life. Supporting change in these areas can be less threatening and more likely to improve self-esteem at times when they feel unable to change aspects of the disordered eating itself. Supporting carers to lead as active and normal a life as possible discourages the negative effects of the sick role and may improve the whole family's quality of life.

- Provide long term follow-up, once active help has ended.

Rationale

Research suggests that long term follow-up can help to prevent relapse, even if appointments are infrequent. (Lacey 1986)

Medication

Medication plays a minor role in the treatment of the person with disordered eating patterns. Anti depressants have been shown to reduce binge eating, but the relapse rate is high, even whilst people stay on the drug. Anti-depressants have no effect on

attitudes to dieting, body shape or weight. Research trials of CBT combined with anti depressant compared with CBT alone, show little advantage for adding anti-depressants (Wilson and Fairburn 1997). Depression, anxiety and obsessional behaviours usually resolve with re-feeding, but severe co-morbid psychiatric problems should be treated in their own right.

Intensive interventions in hospital or day care

Sometimes people with disordered eating are not able to make changes despite their best efforts. Others may deny the severity of their illness or have complex co-morbidity requiring treatment in its own right. At these times, more intensive intervention might be required. Hospital care of the person with disordered eating focuses on the restoration of nutritional health and weight and the cessation of purging behaviours.

In-patient care is usually indicated in the following circumstances:

- Body Mass Index below 65% of median BMI or a rapid rate of weight loss.
- Other serious physical complications of disordered eating or purging.
- Other mental health problems requiring admission, including suicidal behaviour.

Few districts have a specialist in-patient eating disorder unit, so people with eating disorders are admitted to a general psychiatric or medical ward. Providing nursing care within one of these settings is often problematic, as staff can lack the skills, knowledge, confidence, resources and environment to help effectively. In these circumstances, the goal is often simply to prevent death. The Eating Disorders Association (Hogg 1995) recommend that as a minimum, in-patient care should provide:

- A quiet and safe environment.
- Continuity of care from staff with an understanding of Eating Disorders.
- Staffing levels that enable support to be given during and after eating.
- Expert nutritional management and appropriate food.

In-patient treatment goals need to be agreed by all the parties involved. The costs and benefits of continuing in-patient care should be regularly reviewed. Admission may only need to be relatively short term to diffuse a crisis or initiate change. Continuity of care is important, so that the transition between settings is managed as smoothly as possible.

In-patient care can be very effective in terms of restoration of normal body weight and eating pattern, and general improvement of mental health, providing a consistent treatment approach has been developed by staff who are experienced and confident in the care of people with disordered eating patterns. However, even in these circumstances, admissions are often problematic and the relapse rate after discharge is notoriously high (40-50%).

Intensive psychotherapeutic input within an in-patient unit is usually only viable in a specialist setting. The milieu, group therapy and peer pressure *can* exert a strong positive influence on the person's attitudes and behaviour. Ideally, re-feeding involves the person eating a gradually increasing balanced diet (sometimes supplemented by nutritional drinks) supported by skilled staff. Occasionally, naso-gastric tube feeding is required.

- Supervise regular eating, providing emotional support and encouragement.

Rationale

People with severely disordered eating patterns are intensely afraid of weight gain and will avoid panic by not eating, even when they know the risks involved and want help. Mental health staff can help the person to overcome their fears and start eating again.

- Help the person with disordered eating to verbalise and rationalise their anxieties and negative thoughts relating to eating, body shape and weight.

Rationale

Eating will provoke many irrational thoughts. Mental health staff can utilise this opportunity to help the person understand their thinking processes and challenge negative assumptions.

- Provide supervision after meals to help the person with an eating disorder to avoid purging behaviours.

Rationale

Overwhelming panic after eating will lead the person with disordered eating to use vomiting, laxatives or excessive exercise as methods to avoid weight gain. Supervision time with mental health staff can be usefully spent exploring feelings and thoughts, learning and practising new coping strategies (e.g. relaxation) or using distraction.

- Ensure adequate fluid intake, observing for signs of dehydration or excess fluid consumption at times when the person with an eating disorder is due to be weighed.

Rationale

Some people avoid fluids due to fear of weight gain or self denial. 1 litre of water drunk before weighing will falsely increase weight by 1 kilogram.

The person with an eating disorder will need careful monitoring of their physical health, bearing in mind that re-feeding can itself become dangerous if it rapidly reverses the adaptive state of starvation. Occasionally, people are so ill that they are unable to comply with treatment despite immediate danger to their health. The usual provisions under the Mental Health Act (MHA) 1983 apply and assessment can sometimes be a turning point in the person's illness. Detention under Section Three of the MHA enables essential life saving measures to be taken. The multi-disciplinary team should insist that safety is restored, but be prepared to negotiate the finer details of care.

Professional issues and dilemmas in working with the person with disordered eating patterns

Professionals with disordered eating patterns

Young people with disordered eating patterns are often attracted to work in the caring professions. There is no evidence that professionals with disordered eating patterns are any worse or better practitioners than professionals who eat "normally", or professionals with or without other mental health problems. However, special attention has been paid to nurses since The Allitt Inquiry (Clothier et al 1994).

The Allitt Inquiry recommended that more stringent screening procedures be undertaken prior to the acceptance of people onto nurse training courses. Following advice from the Chairman of the Association of NHS Occupational Physicians, it specifically mentioned eating disorder as one of the grounds for exclusion, saying that applicants for nurse training with eating disorder should not be considered "until they have shown the ability to live an independent life without professional support and have been in stable employment for at least two years" (p84).

Consequently, people with disordered eating patterns have to decide whether to be honest about their problems when they apply. Paradoxically, these measures appear most likely to discriminate against those who have sought and used help, often missing those who deny their problems. Whilst the interests of patients and their carers need to be foremost, it also seems important to recognise that many nurses and other professionals will have mental health problems during their careers. They will require non-judgmental support and supervision that allows them to act in their own and their patients' best interests without fear of prejudice.

During your career, you may at times have to give careful consideration to achieving the correct balance between the welfare of patients and the welfare of a colleague who:

- develops a special interest in eating disorders before they are fully recovered themselves
- experiences conflicts whilst caring for the person with disordered eating, because of their own issues about body shape and weight
- denies that they have a disordered eating pattern, despite the concern of colleagues
- requests supervision and support when personally recovering or recovered

Re-feeding the person with disordered eating patterns against their will

Forced re-feeding can provoke various different reactions from staff, depending on their understanding of disordered eating and the law. The following misconceptions can interfere with effective care for the patient, at the point when they are most physically vulnerable:

- "Anorexia Nervosa is not a mental disorder".

- “Food is not a legal treatment for mental disorder”.
- “Anorexia is a conscious choice”.
- “Forced re-feeding is cruel”.
- “There’s no point re-feeding them, because they only relapse anyway”.

The Mental Health Act Commission (MHAC) has recently issued guidance that clarifies some of these issues (MHAC 1997). Anorexia Nervosa is a mental disorder within the meaning of the Mental Health Act 1983. The decision to detain someone with AN should be taken by clinicians considering all the other criteria that would normally apply.

The MHAC has recognised that occasionally, people with AN will require re-feeding against their will because, although they might understand the treatment being offered, their morbid fear of weight gain, or denial of the effects of their behaviour, might diminish their ability to give valid consent, leading them to refuse effective treatment. In such circumstances, re-feeding of the person with AN detained under the MHA, is legal using Section 63.

It is important not to confuse the conscious choice to diet, with the often unconscious forces that drive the person to lose weight. Perpetuating factors can leave the person unable to eat despite their wish to recover. Care and treatment should always respect the dignity and individuality of the person, but if it is to be effective, it is likely to provoke distress for the client. The challenge is to provide adequate and acceptable support to overcome their distress, rather than avoid upsetting them, but let them die.

Many people admitted to hospital with AN do relapse after discharge. However, recovery is possible even after several admissions. Often people with AN have time on their side, as they tend to be young. As a mental health professional, you will need to guard against therapeutic pessimism and offer hope to your clients by setting realistic goals and ensuring regular personal and team supervision.

Discussion questions

- Consider the possible effects of a mental health professional with a disordered eating pattern, on their patients, their colleagues and themselves. Discuss what appropriate courses of action might be taken after discovering that a colleague has a disordered eating pattern.
- Consider your feelings regarding re-feeding someone against their will. Discuss the possible positive and negative effects on the relationships between the patient, their carers and the staff team.

Annotated further reading

Textbooks

Handbook of Treatment for Eating Disorders: Second Edition. Edited by David M. Garner and Paul E. Garfinkel. Guilford Press 1997.
This text book is the most comprehensive and up to date manual of treatment approaches to eating disorders. Expert contributors provide detailed descriptions of the context for treatment, cognitive-behavioural and educational approaches, psychodynamic, feminist and family approaches, hospital and drug treatments and special topics in treatment. A must for any one serious about treating eating disorders.

Eating Disorders and Obesity: A Comprehensive Handbook. Edited by Kelly D. Brownell and Christopher G. Fairburn. Guilford Press 1995.
This text book offers short chapters summarising the current state of knowledge regarding a comprehensive range of subjects relating to eating disorders and obesity. Each chapter is contributed by an expert with a special interest in the topic and provides a short list of further reading.

Anorexia Nervosa and Related Eating Disorders in Childhood and Adolescence: Second Edition. Edited by Bryan Lask and Rachel Bryant-Waugh. Psychology Press 2000.
Thoroughly revised and updated, this is *the* text book for management of child and adolescent eating disorders. Edited by the original Great Ormond Street team with contributions from others, it comprehensively covers all aspects of assessment and treatment including in-patient care and schooling issues. It also has contributions from a recovered child sufferer and a parent.

Helping People with Eating Disorders: A Clinical Guide to Assessment and Treatment. Bob Palmer. John Wiley and Sons 2000.
Written in his own inimitable style, Bob Palmer shares his experience and views on clinical management as well as presenting an up to date distillation of the research evidence. This book is a very good place to start if you are beginning to treat people with eating disorders. It also provides some useful thoughts on service development.

Self-Help Books

Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers. Janet Treasure. Psychology Press 1997.
Written primarily for carers, but with specific sections added for sufferers, this book continues in the Maudsley style incorporating educational material, behavioural advice and motivational enhancement exercises. A compassionate look at the process of illness and recovery lightened by the addition of illustrations.

Anorexia Nervosa: The Wish to Change. A.H. Crisp, N. Joughin, C. Halek and C. Bowyer. Psychology Press 1996.
This concise self-help book is based on the experience of the St.George’s Hospital team and their clients, over the last three decades. Full of useful exercises, it attempts to engage the person with AN and their family in active self-help and exploration of

their difficulties. The book describes the basic principles of the successful form of out patient therapy used in the St.George's randomised controlled treatment trial.

Eating Disorders: A Parents Guide. Rachel Bryant-Waugh and Bryan Lask. Penguin 1999.
This book is the only one specifically aimed at the parents of children and adolescents with eating disorders. It sensitively explains how parents can deal with their child's eating problems, including taking charge of re-feeding children with Anorexia Nervosa. It provides information about eating disorders and their effects, including the atypical eating disorders of childhood such as selective and restrictive eating.

Overcoming Binge Eating. Christopher Fairburn. Guilford Press 1995.
This self-help book is divided into two parts. Part one presents research based information on the causes and effects of binge eating. Part two is a self-help programme based on the cognitive behavioural therapy manual used in the most successful treatments of Bulimia. The manual has been tested in studies of guided self-help versus self help and a simple therapist manual is available.

Getting Better Bit(e) by Bit(e). Ulrike Schmidt and Janet Treasure. Psychology Press 1993.
This book offers a self-help programme for people who binge eat. It is particularly useful for people who are not sure whether they are ready to change, as it has plenty of exercises to help the person to think about the pros and cons of life with bulimia. Written in a warm and supportive, but challenging style, it has chapters on sexual abuse, alcohol and drug misuse and relationship difficulties. Its effectiveness has been evaluated in a randomised controlled comparison with CBT.

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Reflection point
Do you know anyone who has disordered eating patterns? What feelings have been evoked in your relationship with them? How did those feelings affect the way you behaved? What opinions do you hold about people with disordered eating patterns? What factors influenced the development of those opinions?

Reflection points
Consider your own eating pattern. Do you eat regularly? Which of these factors influence your eating pattern? Habit, hunger, feelings, worries about health or weight, pressure from other people? Do you eat a balanced diet? Which of these factors influence your choice of food? Likes and dislikes, moral convictions, religion or culture, calorie or fat content? What were mealtimes like at home when you were growing up?

Reflection point
Consider your feelings regarding your body shape and size. Which aspects do you like or dislike? How much do your feelings influence your behaviour? What makes you feel better about your body and what makes you feel worse? What judgements do you make about yourself or other people based on body shape or size?

Reflection point
Think about the values or moral convictions that are really important to you in your life. Choose one that you believe in most strongly. Imagine that someone is trying to persuade you that your belief is wrong. Try to list all the arguments that they might use against you. List the arguments that you would use to defend your belief. What feelings might you experience if someone challenged your belief in this way? What effect would it have on how strongly you felt about your belief?

Reflection point
Think about the times in your life when you have felt most afraid. What was it that frightened you? How did you react to being fearful, physically and emotionally? Imagine that you have to live with that fear all day, every day. What effect would it have on your feelings and behaviour?

Reflection point
Do you do something that you would really rather not do anymore? Is there something that you would like to do, but find it hard to do? Consider the mixed feelings that you have. What stops you from changing? What encourages you to stay the same?

Reflection point
What was adolescence like for you? List all the different changes that occurred during the transition from childhood to adulthood. What did you find easy and what was difficult? How did other people respond to you changing? How are you different now? How have your relationships changed since adolescence?

Reflection point
Imagine that you have a sixteen year old daughter. A friend has commented that she has lost a lot of weight and you suspect that she is making herself sick after meals. You find an empty packet of laxatives in her bedroom. What feelings might you experience? What would you do next? Make a list of what help you would want for your daughter and yourself.