

Working with eating disorders



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INTRODUCTION

Eating disorders often elicit feelings of confusion and helplessness, both among carers and professionals, causing a variety of reactions including fear, anger and frustration. Committed staff in caring professions can grow frustrated at a patient's reluctance to help themselves and relatives experience feelings of helplessness, unable to intervene in a loved one's self-destructive path. The following article summarises current thinking about the treatment of eating disorders and suggests some approaches to help professionals cope with their own feelings in working with people with eating disorders. The author has used the feminine pronoun in this article since 90% of people who have eating disorders are female (Hoek 1991).

DEFINING EATING DISORDERS

Anorexia nervosa has been identified as a mental health problem since 1689 (Silverman 1997) and is well known among the population, partly due to the shocking appearance of the illness in its extreme forms. Despite being the better known of the disorders, it is in fact, relatively rare, occurring in only 0.28% of young women (aged fifteen to twenty four) (Hoek 2002). Bulimia nervosa, although more common, is frequently a secret disorder due to the fact that people with bulimia maintain a normal weight.

Bulimia means "the appetite of an ox" and was identified as a separate condition to anorexia as recently as 1979 (Russell 1979). It is characterised by bingeing on unusually large amounts of food. Both anorexia and bulimia can involve "purging", a term used to describe attempts to get rid of food by vomiting, the use of laxatives or vigorous exercise.

Figure one gives the definitions of anorexia, bulimia and other related disorders which are collectively known as atypical eating disorders. Atypical eating disorders make up fifty percent of eating disorders, that is the larger group. Recently some authors have questioned the usefulness of discriminating between definitions and this is for a number of reasons. Over a lifetime, it is common for an individual to swing from anorexia to bulimia, and then to an atypical disorder (Fairburn and Harrison 2003).

Certain psychological traits are common to all eating disorders and treatments are similar. However, low body weight and safety concerns determine the focus of treatment at a given time. The major common factor in all the disorders is that people with eating disorders are driven to control their shape and weight, placing more value on their physical appearance than on other personal characteristics. In view of this, Fairburn et al (2003) advocate a transdiagnostic approach, that is, a common approach across all diagnoses which addresses the common maintaining factors.

Figure 1
Diagnostic criteria for eating disorders

ANOREXIA NERVOSA

- The over evaluation of shape and weight
- The maintenance of low body weight below 15% of expected weight or below a Body Mass Index (BMI) of 17.5
- The absence of menstruation in women or loss of libido in men
- Attempts to control weight through food restriction, vomiting, laxatives or other compensatory behaviours

BULIMIA NERVOSA

- The overevaluation of shape and weight
- Repeated bouts of overeating
- The use of vomiting, purgatives or fasting to compensate for overeating

ATYPICAL EATING DISORDERS

- Disorders which fulfil some of the criteria for anorexia or bulimia but do not fit the precise diagnosis

PREDISPOSING FACTORS

It is commonly accepted that a number of factors contribute to the development of eating disorders. As well as the extreme importance attached to the control of shape and weight, some authors identify a number of traits which appear to make people vulnerable to develop eating disorders. It has been observed that people with eating disorders also experience a need to control other areas of their lives, especially their emotional reactions (Bruch 1978). The denial of emotional needs seems to reflect their denial of the physical need for nourishment (Goodsitt 1985). Underlying this appears to be a low self-worth, a need to control something in one's life and frequently a perfectionist personality. Perfectionism is often seen in other areas of life such as in education or work and often means a highly self-critical attitude which reinforces low self worth. Perfectionism and the drive to lose weight can be a dangerous combination.

The possibility of changing physical appearance is often adopted as a solution to low self esteem - and it appears to work for a short time - contributing to the illusion that it is possible to transform one's self by weight change. Living in this era of diet culture the wish to do this is not unusual - in most workplaces we can identify a number of people who are "on diets", and few people would admit to being completely satisfied with

the shape of their body. However, with “normal” body dissatisfaction (Virdi 2001) the majority of people can identify other qualities in themselves which they value and which are valued by others, for example being a good friend or parent, being fun or good at a particular activity. Someone with an eating disorder is more likely to be highly self critical, focussing their attention on their “fat” tummy or thighs. So, although most people are dissatisfied with their body shape, and much of the population is actively trying to alter their appearance by diets, most people do not develop eating disorders and anorexia nervosa is still relatively rare.

There is some indication that heredity plays a part in conjunction with environmental factors, as it appears that some personality traits are inherited (Strober and Bulik 2002). Individuals may also learn attitudes from, for example, families who put a high value on the importance of outward appearance, including shape and weight.

PRECIPITATING FACTORS

Eating disorders typically start with an attempt to lose weight, often through limiting or restricting food intake in an effort to “diet”. Commonly, they occur around puberty, when major developmental changes are happening. The young person is confronted with issues of sexuality, responsibility and frequently pressures to achieve at school. In addition there may be other stresses such as difficult relationships or losses that add to the pressure of adolescence. For a young person who feels the need to be in control, who is a perfectionist but lacks the emotional language to express distress or disquiet, an eating disorder provides a solution to conflicting internal pressures. Outside of conscious awareness anorexia may become an option, which by its nature reverses or postpones sexual development thus avoiding the demands of growing sexuality (Crisp 1995).

Having embarked on a course of self-improvement by weight loss, a perfectionist young person, is likely to discover that she can manage to slim very well. The price of perfectionism is that she will always fall short of the perfect result and that whatever she achieves will not be good enough, so efforts are continually intensified to maintain the satisfaction of continued weight loss.

MAINTAINING FACTORS

The process is initially reinforced by admiration for her enviable achievement but as comments turn to concern or even abuse, the patient comes increasingly to identify with anorexia as if it is a precious part of herself.



As well as psychological factors which predate the illness, undernourishment brings additional complications as was demonstrated by a piece of research into the effects of starvation undertaken in the 1940s. During the Minnesota study (Keys 1950) semi-starvation was induced in a group of fit and psychologically healthy young men in order to study its effects. Results demonstrated that physical starvation produces psychological disturbance, irrespective of an individual's underlying personality. Effects which were observed included low mood, obsessive,

rigid thinking, ritualistic behaviours, lack of interest in social interaction and low sex drive. When applied to eating disorders the implications are that psychological disturbance is clearly exacerbated by starvation even if it does not exist in advance. Experience shows that as weight becomes lower, rigidity of thinking and obsessiveness increase such that any well-meaning exhortations to eat will have little effect

So a disorder which initially helps someone feel better about themselves, feel in control and protected from uncomfortable emotions becomes increasingly rigid and obsessive with starvation. Under such circumstances the patient has little incentive to seek help, and helping professionals are frequently viewed with suspicion.

Having described how, as anorexia progresses, a patient can become more reluctant to accept treatment, so it follows that the sooner a problem is identified the more effective any intervention will be.

STARVATION AND BULIMIA

I have been describing the progress of anorexia nervosa which generally develops at a younger age than bulimia, but much of the same applies. A major difference is that the bulimic cannot sustain the strict abstinence demanded by anorexia. The Minnesota study showed that uncontrollable bingeing occurred after the period of starvation was over, as it occurs following food deprivation through famine or imprisonment. Bingeing is therefore a natural consequence of starvation, as our bodies drive us towards nourishment. In bulimia, uncontrollable bingeing follows a period of restriction and then purging is a conscious attempt to limit the “damage” of overeating. The next phase is restriction once more, as the bulimic attempts to “be good” to compensate for the previous binge. Fairburn (1995) has called this the binge/purge cycle, where one disordered behaviour occurs as a consequence of the previous one. Fortunately, it is often the distressing sense of being out of control that eventually causes the patient to seek help.

EMPATHY, INFORMATION AND COLLABORATION

The complex interaction of psychological and physiological influences results in patients who may be ambivalent, scared, guilty or ashamed, and the attitude of the helping professional is crucial to engaging the patient in treatment. In working with people with eating disorders close attention needs to be given to the following areas: empathy, information giving and collaboration.

ENGAGEMENT

Initially it is necessary to gain the trust of the patient by trying to understand the conflict she experiences and, while it will not help to join the ranks of people telling her she must eat, the reality of her situation cannot be denied. A caring but neutral position is helpful in enabling her to weigh up the pros and cons of accepting help and gently providing clear information will help her make an informed choice.

TREATMENT

An understanding of the psychological elements driving the patient's fierce resistance to change enables the professional to use skills of empathy in making a therapeutic relationship with the patient. Current approaches to treatment aim to address both the psychological aspects and the behaviour. Palmer (2000) describes the entanglement of these two elements, arguing that it is not enough to address either the eating or the psychological needs alone.

Although admonitions by frustrated carers to “just eat” are not in themselves helpful, unfortunately for the reluctant eater this is indeed part of the solution. She does need to eat adequately if she is to get better so psychological treatment without adequate diet is only half of the solution. Likewise, feeding without psychological treatment is only half of the solution. One of the most important elements of the work is to help the patient to develop the motivation to change. Motivational enhancement skills (Vitousek 2002) can be effectively employed in engaging the patient in her treatment by empathically acknowledging both the discomfort of the eating disorder and the very real fears of getting better, which may include

weight gain. An important part of this is providing accurate information about the needs of the body and effects of starvation. Trust, honesty and collaboration are essential in helping someone to consider the pros and cons of getting better. In working with adults a decision from the patient to at least start the process of change is necessary before embarking on evidence based treatments.

The following approaches to treatment have some evidence of effectiveness and are recommended in the government recommendations for the treatment of eating disorders (National Institute for Clinical Excellence 2004):



Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT) is the best researched treatment for eating disorders and some studies (Fairburn 2003) show that between one third and a half of patients treated make a complete recovery. CBT is a collaborative approach that addresses the **behaviour**, engaging the patient in monitoring and gradually changing her eating patterns, and addresses the **cognitions** that prevent change. These include the over-evaluation of shape and weight, perfectionism and low self-esteem. In treating bulimia, a series of twenty sessions is recommended, and up to forty sessions where there is low body weight, that is with a BMI of less than 17.5.

Interpersonal Psychotherapy

A different approach altogether has been found to be effective in the treatment of bulimia nervosa with the use of Interpersonal Psychotherapy (IPT) (Fairburn 1998). Originally developed as an alternative to the use of antidepressants (Klerman et al 1984), IPT was researched for the treatment of depression but later applied to a variety of disorders including eating disorders. IPT focuses on the significant relationships in the patient's life as a means of increasing personal effectiveness in relationships and problem solving. It addresses issues which may be maintaining the disorder, possibly as it offers a means of dealing with the difficult feelings aroused by interpersonal transactions. Research shows that IPT can be as effective as CBT although change seems to occur more slowly, but continues at least twelve months after the treatment has finished (Fairburn 1997).

YOUNG PEOPLE AND CHILDREN

Although research is limited, there is a consensus that children living in families are most effectively treated within the family setting (NICE 2004). Early identification of the problem and early intervention appear to give a better prognosis and Honig (2000) recommends working in partnership with the parents such that the family becomes the tool for change. Although formal family therapy is not always necessary, parental involvement is essential. Parents are encouraged to take charge of the young person's eating, adopting a position of firmness and love (Lask and Bryant Waugh 2000) which protects the child from starvation and enables her to express her emotional needs in more appropriate ways than restricting her food.

Families frequently need a great deal of support and encouragement to confront the eating disorder as the young person is often well behaved and pleasant in all other contexts. By insisting that she eat adequately they are confronting her worst fear, that of weight gain, and suffer the consequences of unleashing unexpressed adolescent aggression and distress. As with adults, there is the need for psychological support to complement the behaviour change. Initially the young person is not collaborating but merely complying. Parents may need support to develop new skills in understanding and communicating with their distressed daughter or son. In-patient treatment is seen as necessary only where the parents are unable, for various reasons to feed their child.

IN-PATIENT CARE

Specialist in-patient or residential settings are considered in the minority of cases. Bulimia nervosa is rarely treated in a hospital setting unless there are other psychiatric disorders, so most in-patients are of low body weight. The patients who are considered for admission are likely to consist of two groups:

- Those with a degree of insight and a willingness to tackle the eating disorder, and
- Those who need admission for medical treatment of starvation but who are not motivated to give up their eating disorder.

Where weight drops below a BMI of 13.5 and weight restoration in the patient's home is not working then a planned admission for re-nourishment is appropriate.

In the case of adults, in-patient programmes generally offer the two approaches outlined above, re-feeding and psychological treatments. The principles of **empathy, information and collaboration** still apply. Ideally the in-patient is given as much say in her treatment as is safe, as even where physical treatment is required there are frequently some areas for negotiation. Where safety is concerned however, the boundaries need to be clearly and openly established.

For example, where dietary supplements are prescribed there is room for negotiation about the flavours or the timing of the supplements, whether the patient can be trusted to take them or whether she needs close supervision. She will always be entitled to a clear explanation for why decisions are made and clear information about the consequences of not following agreed plans. Given the nature of eating disorders, if someone is ill enough to be in an in-patient setting, staff need to be alert to the likelihood that the patient may attempt to deceive staff at times as she tries to avoid the prospect of weight gain. However, the principles of empathy and collaboration still apply - it is helpful to confront disordered behaviour as a symptom of the illness, eg:

"We understand how hard it is for you to give up this illness, and we know that it will fight to survive, often by trying to deceive us all. When you secretly exercise, (or vomit or hide food) the illness is trying to defeat us, so it is really helpful if you tell us when you are tempted to do these things,

then we can help you find a way of dealing with your difficult feelings.”

Even where naso-gastric feeding is required, some choice of method or timing can be negotiated with the patient while maintaining firm boundaries where safety is concerned. Only in the most unusual circumstances is compulsory treatment under the Mental Health Act necessary and this is made less likely where an open, empathic and collaborative relationship is maintained.

CONCLUSION

Throughout this article I have emphasised the importance of empathy, a collaborative attitude, openness about decision-making and provision of information with clear boundaries. This approach could be summarised as follows:

An eating disorder offers a solution to someone who has low self-esteem and high standards yet feels ineffective. It helps her to feel in control, temporarily increases her self esteem and avoid uncomfortable feelings. With such rewards she is unwilling to give it up and as she starves, her thinking becomes increasingly rigid and inward-looking, at which point she either comes for help or is brought for treatment. The health practitioner will be met by ambivalence or even hostility as representative of an authority wanting to take away her strategy for coping with life. However, inside herself the patient knows that there is something seriously wrong and may feel guilty at the problems she causes others. The task of the professional is to engage in a helping relationship that enables the patient

to consider her own needs and to risk accepting help from a trusted professional. She needs to be provided with enough information to make an informed choice, including the physical risks she takes by not getting better and the necessary information on how to get better. The eventual aim will be to help her find a way of having her needs met in a healthy way. An assessment of risk is important in determining whether urgent medical treatment is required, but in most cases the patient needs to retain responsibility for her own treatment if treatment is to be of lasting benefit. A trusting and open relationship is the vehicle that enables this to happen.



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