What triggers the eating disorder gun?

Understanding the underlying causes of eating disorders will have practical benefits for tackling a disease that's often frighteningly resistant to treatment, writes **Allie Outram**

Eating disorders are serious, complex, costly and challenging mental illnesses. Although often perceived as discrete, subtle and silent conditions, the message they send out is loud, crystal clear and speaks volumes. Individuals may suffer in silence with hidden feelings, neglected thoughts and dismissed emotions, but their message is one of the most powerful examples of non-verbal communications known. All eating disorder symptoms 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.

Eating disorders are frequently seen as difficult to treat. Clients sometimes appear to be reluctant to change, and severe anorexia nervosa is a frightening and confusing disorder for anyone who comes into contact with it. Where the therapist works in a multidisciplinary team, roles can be negotiated and shared, along with the sharing of anxiety, and a team approach enables practitioners to cover the many different aspects of treatment. However, an independent therapist in private practice can feel confused and isolated, particularly so if, as the weeks pass, they witness a client relentlessly losing weight. It is not uncommon to find a cooperative client attending sessions but becoming dangerously thin, leaving the therapist feeling impotent and frustrated.

Some facts about eating disorders

Eating disorders are more common in females than males.[1] Males represent 25 per cent of individuals with anorexia nervosa, and they are at a higher risk of dying, in part because they are often diagnosed later, since many people assume males don't have eating disorders.[2] Subclinical eating disordered behaviours (including binge eating, purging, laxative abuse and fasting for weight loss) are nearly as common among males as females.

Compared with other populations, gay men are disproportionately found to have body image disturbances and eating disorder behaviour. Gay men are thought to represent five per cent of the total male population, but among men who have eating disorders, 42 per cent identify as gay.[3] Eating disorders have the highest mortality rate of any mental illness, claiming precious, promising lives ever year.[4] One in five of the most seriously affected will die prematurely. Of all psychological conditions, they also have the worst prognosis. The sooner someone gets the treatment they need, the more likely they will be to make a full recovery. Treatment is patchy at best, inadequate at worst, and that unacceptable variability nationally is putting hundreds of lives at risk every day.

Eating disorders are characterised by two key features: disturbed eating habits and disturbed weight control behaviours. Disturbed eating habits can include restricted food intake, strict dietary rules, preoccupation with food, binge eating and altered mealtime behaviours. Disturbed weight control behaviours may involve excessive exercise, vomiting or the misuse of laxatives or diuretics. These eating habits and behaviours are termed 'disturbed' when they become harmful through extreme use. Most eating disorders change in form over time; 'diagnostic migration' is the norm, rather than the exception. Two-thirds of clients originally diagnosed with a specific eating disorder had a different diagnosis 30 months later.[5] All eating disorders share:

- clinical features – extreme weight control, purging, preoccupation
- core psychopathology – self-worth judged largely or exclusively in terms of shape and weight
- maintaining features – severe perfectionism, low self-esteem, intense mood states, interpersonal difficulties.

Feeling out of your depth

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 and bipolar disorder.

As a therapist, you will frequently come across ambivalence in clients with eating disorders; the internal battle between the healthy self and the eating-disordered self. There is part of the client that is eager to get healthy, and another part that is terrified of giving up their disordered eating, as it has become their lifeline. Anorexia nervosa is

described as egosyntonic because individuals experience their symptoms as congruent and in harmony 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 will become deeply distraught by efforts to interrupt their ongoing drive towards weight loss. It is therefore very difficult to treat.

People with eating disorders, 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 synthesise the moment into the tapestry of life. Additionally, they have a tendency to be 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. The downside of this is increasing inflexibility, rigidity and entrapment in their compulsive behaviours and rituals.

What causes eating disorders?

The question of cause has two parts:

1. Why do eating disorders begin? (Development phase before onset of the problem.)
2. Why do they persist? (Maintenance phase after its onset.)

This crucial distinction not only helps us understand the role of all possible causes, but it also has significant practical implications. If the goal is prevention, the task is to identify those processes that exert their influence before onset – during the development phase – and to try to stop them from operating (predisposing and precipitating factors/triggers). In contrast, if successful treatment is the goal, the task is to identify the processes that are keeping the problem going (perpetuating factors). Clients will probably come to us at this point. Eating disorders do not have a single identifiable cause. There are psychological, biological and social risk factors that may increase the likelihood of an eating disorder developing, as well as behaviours and traits that can be changed (such as dieting, poor self-esteem, perfectionism).

The theme of the BACP Private Practice conference in September was the links between the mind and body. The origins of anorexia are in both the mind and the body, according to an international study.[6] Up to now, anorexia has been seen as a serious psychiatric disease, but recent research has said that it should now be considered a 'metabo-psychiatric disorder', as it is a disease of mind and body.[6] Doctors at King's College London showed that changes hardwired into some people's DNA alters the way they process fats and sugars and makes it easier to starve their bodies. When most people lose weight, there are signals in the body that stimulate the appetite, but those with anorexia haven't got such strong drivers.

Mutations were also found in the instructions that control the body's metabolism, particularly those involving blood sugar levels and body fat. This groundbreaking research significantly increases our understanding of the genetic origins of this serious illness. There has been a difficulty in knowing what sort of disorder anorexia is. Now, we know it's a complex mixture of physiological and psychological interactions, alongside life events and other factors. This work is really important because it gives the message to sufferers and their families, and professionals delivering or developing treatments, that anorexia may not be conceptualised as a solely psychiatric condition. Rather, metabolic factors may contribute too. Knowing more about what drives anorexia will have real practical benefits in tackling a disease that's often frighteningly resistant to treatment and prone to relapses.

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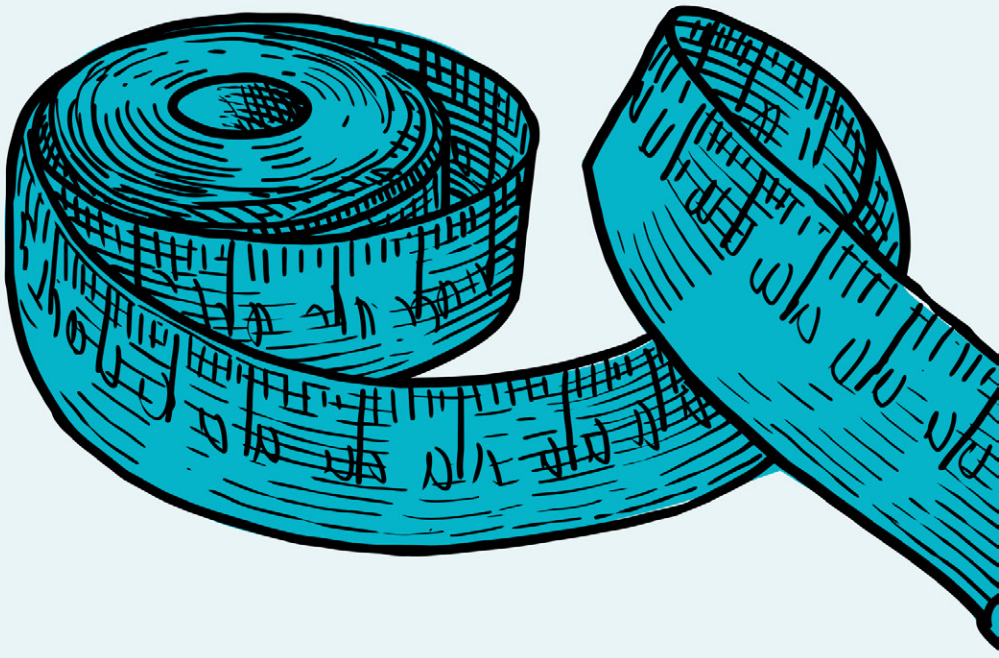
Just because a disease has a genetic component doesn't mean that the environment in which the sufferer is steeped is irrelevant, and in this case, researchers estimate genetics explain only about half of the cases of anorexia. It's a piece of the jigsaw, not the whole of it. But the greater our understanding of the complicated interaction between genes and environment, the more likely we are to find that conditions once blamed on human weakness – the idea that sickness must be someone's fault, or that they could get well if only they chose to snap out of it – have much more complicated pathologies. We're learning that genetic predisposition interacts with the culture to bring about anorexia and other eating disorders. You're born with the gun, and society – your cultural and environmental circumstances – pulls the trigger.

To summarise, all psychiatric conditions, including eating disorders, are caused by an interaction between a person's mind and body;



specifically, their biology, psychological makeup and social context. Gene activity itself can be determined by our environment through epigenetics. Biological processes are increasingly apparent in all mental illnesses through technical advances, such as functional brain scans and genomic studies. Advances in prevention and treatment will come through greater understanding of how both mind and body interact to cause a mental illness.

Athletics

I feel qualified to talk about eating disorders because I don't just know about them via training, research and qualifications. I know them personally, through lived experience. By the age of 13, I had many of the predisposing factors that would place any individual at risk, and I starved my way down to an emaciated 28kg with a BMI of 11. There was no early intervention for me and eventually, when I was diagnosed, my organs were failing, and I was given just a week to live. I was hospitalised immediately.

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My experience of treatment was barbaric, punitive and far from the collaborative approach I use with my clients today. I became very good at talking the talk, being the 'perfect patient', but walking the walk was a different matter. I externally conformed to the rules and regulations of the hospitals, but mere behaviour modification could not bring true change to my life. I cooperated so I could be discharged from treatment, but I remained the same on the inside. I was reluctant to invest in an emotional relationship with therapists due to fears of abandonment, and consequently my therapy became superficial and merely intellectual. I responded to the rationality and logic of cognitive therapy but was not able to access and resolve the emotional distress associated with my underlying beliefs about the world.

Treatment mainly concentrated on the physical side and restoration of my weight to a normal, healthy range. There was a strong emphasis on food, calories and meeting specified weight targets. However, food is not the issue, just a symptom of the underlying cause. My journey to recovery has taken time, but there has been a re-awakening of hope after despair, a breaking through denial and achieving understanding and acceptance.

At age 16, I ran in the World Junior Cross-Country Championships in Beijing and was miraculously placed fourth. I was Captain of the Great Britain team, which comprised six athletes. Shockingly, four of us had an eating disorder. However, this is not entirely surprising. Low body weight and/or low fat-to-muscle ratio (leanness) is of crucial importance for performance in endurance sports, such as running, swimming, cross-country skiing, and cycling. Weight category sports (wrestling, boxing, judo, martial arts and jockeys) and aesthetic sports (rhythmic gymnastics, ballet, figure skating and high board diving) also attract at-risk individuals.

Eating disorders and their associated levels of impairment, morbidity and cost are a significant public health concern.[7] Although they affect people of all demographics, research indicates that some populations are at increased risk.[8] Female athletes represent one such population.[9] As previously mentioned, I ran for Great Britain in 3,000m and cross-country events throughout my teenage years. 'Good athlete' traits, and characteristics of anorexia are very similar, so I could hide and legitimise my eating disordered behaviour for a long time. What appears as dedication to a sport in some women athletes, may actually be compulsive activity masking anorexic behaviour, and misperceived as attributes in the athletic world and therefore encouraged and reinforced.

Pressure to conform to a specific athletic body type can trigger eating disorder risk factors, which can evolve into clinical eating disorder symptoms. Importantly, research suggests that athletes are vulnerable to inadequate calorie intake, given their athletic lifestyles, making this a key target for intervention.[10] Insufficient calorie intake also increases the risk of developing the 'female athlete triad', which consists of low energy availability, menstrual disorders and decreased bone density.[11] The triad is associated with additional health concerns (eg cardiovascular disease, musculoskeletal, and bone stress injury), even in athletes who do not have a clinical eating disorder.[12]

In your work with clients with eating disorders, it may be useful to explore the contribution of exercise dependence. Dysfunctional exercise can be associated with detrimental health effects and complications in treatment outcomes. Exercise dependence comprises seven symptoms:

1. Tolerance – increased exercise needed for the same effects.
2. Withdrawal – exercise used to avoid negative emotions.
3. Continuance – continued exercise despite psychological or physical problems.
4. Lack of control – inability to exercise less.
5. Reduction in other activities – activities given up for exercise.
6. Time – excessive time spent exercising.
7. Intention effects – exercise for longer than intended.

Understanding which components of exercise dependence uniquely relate to eating disorder symptoms may help inform the creation of precise interventions targeting the function of dysfunctional exercise in eating disorders.[13]

Treatment aims

Choosing the most effective intervention for someone with an eating disorder should take account of a number of variables, including physical and psychological risk, motivation, social support, co-morbidity and age. Often, and particularly in anorexia, treatment planning will require coordinated, multidisciplinary, physical and psychological service interventions. Psychological interventions are, however, considered to be crucial in addressing the core attitudes that underlie these disorders and in influencing the longer-term outcomes.

I try to offer an empowering, whole-person approach to treating body image and eating concerns. I provide practical guidance that is deeply respectful of my clients' dignity while also motivating them to abandon destructive behaviours and embody positive change. I help clients understand their bodies' physiology, pay mindful attention to their eating behaviours, replace weight loss-motivated exercise with health-oriented movement, and compassionately transform their critical voices into supportive allies. I teach positive strategies, designed to address their beliefs about beauty and health that underlie their body hatred, and help them to create a community around them that supports their recovery.

Therapist-related factors affecting therapy

The therapist's individual characteristics, eg training level, optimism/pessimism, gender and even size, may influence the therapeutic relationship. Therapists who are very thin may be challenged about their own eating habits and weight. Therapists who are overweight may find these clients hard to engage with, as some have negative attitudes toward people who are overweight. Fat medical professionals are likely to be seen by both medical professionals and clients as less credible and trustworthy, and therefore clients are less likely to follow their professional recommendations.[14] There is an argument that the body shape/weight of a therapist does matter to clients because there is a prohibition on the therapist sharing personal information, so the body assumes

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additional importance for clients, offering a place to read information about the therapist and a rich site for transference.

The counselling relationship is intimately affected by factors such as power, authority, difference, diversity, age, sex, disability and a range of other social issues. The two participants are attuned to many dimensionsin which they can perceive each other as either similar or different. Both of these perceptions can be helpful or destructive to the therapeutic relationship in quite complex ways. There is no doubt that clients with eating disorders evaluate therapists' body size and speculate on their relationship with food. Research has shown that 'healthy-looking' therapists were perceived to be the most helpful.[15] These results hold implications for clinical practice, and it might be useful to reflect on the impact of your body on the therapeutic alliance. Maybe, address the elephant in the room and have a discussion about it. However, at the end of the day, there is little that you can do to either stop clients from making assumptions about your food behaviours and ability to treat, based on your body size, or change your body size to better meet clients' needs. Obviously, diverse bodies are healthy, regardless of which bodies clients perceive to be healthy and thus most able to help them.

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