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AN OVERVIEW OF EATING DISORDERS

"I was in control until 'Control' took control and I lost all control". This statement summarises what our life could become once an Eating Disorder (ED) takes control of all aspects of our lives. Living with 'ED' starts off with a sense of pride and accomplishment but it can very quickly decline into a life lived in secrecy, with many limitations and extreme daily life. It's only when the person or people around them start experiencing the consequence of these actions that help ends up being sought.

In 2013, The Global Burden of Disease study found the significant burden of eating disorders (EDs), was in young women living in high-income countries. However, between 1990 and 2013, the relative ranking of burden of EDs in low - and middle-income countries increased.

Eating disorders are commonly associated with comorbid diseases and EDs together with Substance Use Disorders

was found to be independently associated with the highest mortality rates of all psychiatric disorders.

The main types of ED's include Anorexia Nervosa (AN), Bulimia Nervosa (BN), Eating disorder not otherwise specified (EDNOS) & Binge Eating Disorder (BED). There are also other Feeding and eating conditions that have been noted in the Diagnostic and Statistical Manual – V (DSM-V).

Certain criteria have to be met before a formal diagnosis is made. Each diagnosis will show limitation to two areas of life (e.g. social, occupational, personal).

- AN – Shows evidence of a restriction of energy intake that leads to significant weight loss as well as the intense fear of gaining weight or becoming fat. The individual will also have a distorted body image. There are two types of AN (Restricting and Binge eating/ purging subtype). Restricting type is the restriction of calorie intake **without** binge eating or purging behaviour in the last three months. Binge eating/purging type notes that the person has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas) in the last three months
- BN - The recurrent episodes of binge eating coupled with inappropriate compensatory behaviour (e.g. self-induced vomiting; misuse of laxatives, diuretics, or other medications, fasting; or excessive exercise). The episode is described by eating a significantly large amount of food within a discreet period of time (e.g. two hours). This should not be mistaken as overeating. During this episode the person will feel a sense of lack of control over eating.
- Binge eating disorder (BED) - This is a relatively new diagnosis which also notes recurrent episodes of binge eating as **per** BN but it **does not have** the compensatory behavior.

The DSM-V has now made provision for other ***Feeding and Eating Conditions Not Elsewhere Classified***. These are summarized as follows:

Atypical Anorexia Nervosa

- All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual's weight is within or above the normal range.

Subthreshold Bulimia Nervosa (low frequency or limited duration)

- All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviours occur, on average, less than once a week and/ or for less than for three months.
- Subthreshold Binge Eating Disorder (low frequency or limited duration)
- All of the criteria for Binge Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than for 3 months.

Purging Disorder

- Recurrent purging behaviour to influence weight or shape, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, in the absence of binge eating. Self-evaluation is unduly influenced by body shape or weight or there is an intense fear of gaining weight or becoming fat.

Night Eating Syndrome

- Recurrent episodes of night eating, as manifested by eating after awakening from sleep or excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better accounted for by external influences such as changes in the individual's sleep/wake cycle or by local social norms. The night eating is associated with significant distress and/or impairment in functioning. The disordered pattern of eating is not better accounted for by Binge Eating Disorder, another psychiatric disorder, substance abuse or dependence, a general medical disorder, or an effect of medication.

Other Feeding or Eating Condition Not Elsewhere Classified

This is a residual category for clinically significant problems meeting the definition of a Feeding or Eating Disorder but not satisfying the criteria for any other Disorder or Condition

As the ED worsens, you may notice certain characteristics that could indicate a red flag: These could include (but not limited to):

- Low self-esteem or diminished self-worth
- "All or nothing" thinking e.g. if I don't eat extremely well then it would mean that I am all 'bad'
- Feelings of emptiness
- Desire to be special or unique
- Lack of coping skills
- Need to be in control, need for power
- Difficulty expressing feelings
- Need for escape or a safe place to go
- Lack of trust in self or others
- Terrified of not measuring up
- Needing to leave the table straight after a meal
- Not partaking in meals and not wanting to eat in front of others
- Always calorie counting
- Prefers not to socialise or attend events that include food related activities

It's important to note that no-one asks to have an eating disorder and neither does it discriminate. It can affect males and females, rich or poor. Stigma is usually attached to an ED and those around the individual usually have unhelpful statements such as "why can't you just eat! If you just put the food in your mouth, you'll be okay!"

Mostly there is a lack of understanding of why the person can't partake in the most basic human behaviour. More empathy around an ED needs to be established in knowing that an eating disorder can be an effort to cope, communicate, defend against and even 'solve' other problems. It helps to establish a sense of control, power, provides worth and containment, numbs pain and releases anxiety or anger etc.

E.g. of sense of control…if you feel you have no ability to make choices in your own life and lack the control of things happening in and around your life which is distressing to you…then an ED can occur as 'food' is the only element they have control over

An eating disorder is usually maintained depending on what the individual possibly gains or desires eg:

- To provide comfort, soothing, nurturance
- To numb, sedate or distract
- To gain attention – a cry for help
- To discharge tension, or an angry rebellion
- Gives one a sense of identity
- As a means of self-punishment
- Creating a large body for protection/ safety
- Avoidance of intimacy
- Symptoms prove "I'm bad" instead of looking at one's feelings around the role of others

ED's not only result in psychological, emotional, financial and personal consequences but also impacts the individual's medical status. It's because of this that one has to be very careful when refeeding an extremely low weight individual. Going too fast can result in cardiac issues.

Who can HELP?

Due to the nature of the illness it's the individual contact a psychiatrist or psychologist or a medical doctor for immediate intervention. They will go through a series of questions to confirm a diagnosis. It's also best to seek professional help with those specialising in that area. Psychological, psychiatric, dietetic and medical intervention has to take in the various factors of the ED to know how to treat these disorders optimally.

In terms of psychotherapy, various methods are used with CBT having shown to be one of the most effective. With adolescents as well as children, family therapy is very important. Medication is used as a supplementary approach to the treatment as well, if needed. The support one needs from their family or loved ones is vital in their recovery. The family needs to learn how to respond to the ED individual as their response style can either worsen or maintain the ED behaviour.

Some units that specialise in Eating Disorders include:

Tara H Moross Psychiatric Hospital
Akeso Clinic

References available upon request