**Mental health and society week 26**
**More on ‘eating disorders’ and body image**

Dieting is a 'normal' way of life for significant proportion of women in US and Europe. So are anorexia and bulimia nervosa on a continuum with ordinary dieters? Polivy & Herman (1987) People with eating disorders and weight preoccupied dieters share drive for thinness, may share bulimic symptoms, intense concern with dieting weight and appearance. May however be some features that distinguish dieters from eating disordered people. In research using the eating Disorder Inventory Garner et al (1983), eating disordered people are more likely to score high on ineffectiveness (feeling ineffective or alone) Interpersonal distrust (inability to communicate with others about personal issues) Low interoceptive awareness (of emotions, fear of being emotional, feelings from body like being bloated, confusion over emotions) Fear of maturity, (wish to return to childhood, not feeling that adulthood is a good time). However, as so much normal eating is comparable to eating disorders then maybe we should diagnose and treat 'normal eating' (Polivy and Herman, 1987) to return food intake to physiological normalcy and modify attitudes to weight and appearance. 'Unless society abandons its concern with thinness and dieting, treatment at the individual level will be difficult because the patient's environment will continue to encourage and to reward pathology.' (P&H, p 647).
In a study of young people in Switzerland by Herpertz Dahlman et al (2008) around a third of the girls and 15% of the boys exhibited signs of ‘eating pathology’.

In the cognitive view of these phenomena, this ideational component is primary, in that it is responsible for the accompanying disturbed behaviour (Garner and Beamis, 1982; Fairburn et al, 1986). The development of eating problems seems to follow a pathway which begins with concerns over weight and shape. This has been noted in children as young as nine in a study by Hill et al (1992), In addition, the full range of eating disorder symptoms are developing earlier, as Bryant Waugh and Lask (1995) argue - the syndromes are appearing in children who are pre-pubertal or pre-menarchal.

The course of the problem seems to be based on a progression from concerns about weight and shape to a pattern more suggestive of eating disorders as a whole (Cooper and Goodyer, 1997). In Cooper and Goodyer’s study of girls from 11 to 16 in Cambridgeshire, they detected ‘significant concerns’ about weight and shape in 15% of 11-14 year olds and in 19% of 15-16 year olds. In this older group there were more signs of bulimic symptoms and ideas.
Peer groups are implicated in encouraging preoccupation with weight control, thinness and dieting techniques (Mackey and La Greca, 2008).

**The outcome of eating disorders**
The outcome of treatment for eating disorders is often just addressed in terms of weight gain and menstrual status, (Windauer et al, 1993). When more measures are used the outcome seems less positive - 'excessive' exercise, bingeing, vomiting, laxative 'abuse', concern about eating, shape etc.
However, a more optimistic picture was painted by North et al (1997) who looked at children (average age 14.9 years when they were initially interviewed) and rated their family functioning and looked for significant life events which might have precipitated the onset of eating disorders. Adolescents from families with less ‘pathological’ interaction fared better over the next two years. According to the authors, 55% of patients ‘recovered’ after 2 years. Those who showed a negative life event

immediately before the onset of the eating disorder were more likely to recover rapidly.
Wentz et al (2009) followed up 51 people with eating disorders 18 years later, and whilst all were still alive, several (12%) still met the criteria for having an eating disorder, and 39% had a mental health problem of some sort. 25% were prevented from working by psychiatric problems.
Fichter et al (2008) report that in 264 patients with eating disorders followed up at 12 years around 25% still met the criteria for eating disorders.

**Beliefs and attitudes in people with eating disorders**.
Consensus seems to be that there is a strong component of body image beliefs. Body image as described by Birtchell, Lacey & Harte (1985) as containing 3 components (1) Physiological - ability to detect weight, shape, size & form. (2) Conceptual - the mental picture of one's own body. (3) Emotional - the feelings about body weight, shape, size. Freeman et al (1985) note a distinction between a distorted body image (i.e. problem in the conceptual component) and dissatisfaction (i.e. a problem in the emotional aspect). Mostly in Bulimia it is the emotional aspect that is problematic. Body image dissatisfaction correlated with the development (e.g. Slade, 1985) and maintenance (Freeman et al, 1985) of eating disorders. Striegel-Moore et al (1986) girls being taught family, peers, school and the media that their role is to please others by being attractive. Little is understood about effective therapy for eating disorders. Many programmes are tentative. Seems like changes in body image are pivotal in the effective therapy of eating disorders. Sufferers lament that they can't stand their bodies and can't give up the eating disorder because this is their only hope of achieving a thin body and hence some self esteem. So the eating disorder itself and recovery from it are propelled by a concern over weight and shape.

**Implications of beliefs for therapy**
Brouwers (1990) client must get over the minimisation and denial & recognise that their body image can change. (It's important that the counsellor/therapist believes this too.) Brouwers sees therapy with bulimic clients as having six components (1) Educational component - tell them about physiology of weight maintenance and appetite set points etc. (2) Socio-cultural component - how people have tried to change their bodies to fit in with fashion in history and culture. Make it hopeful - women can rebel against oppressive body styles as they did against e.g. corseting and foot binding - may happen with thinness. 'Fatism' is akin to racism and sexism. Roth (1982, p37) 'In our culture it's unacceptable to be fat... Fat is regarded as a deviation from the norm; it's considered ugly, unfeminine, offensive, even disgusting. Fat sticks out; it's unavoidable, apparent.' (3) Cognitive component - try to relieve some of the negative thoughts about their bodies. Can require sensitivity as it's likely that client will believe that therapist does not understand the nature of the problem, and doesn't view her thoughts as irrational and in need of change. Uncover self defeating thoughts. Value functional, pleasurable aspects of body. Work on issues such as dichotomous thinking (where e.g. fat or thin with no middle ground) perfectionistic thinking (must be perfect) egocentricity ('everyone is always looking at me and judging my body') Overgeneralisation (e.g. making much of individual's comments about her body). (4) Emotional component - feelings like anxiety, depression and fear of gaining weight. Anxious when they feel someone might be judging them. Maybe binge-purge is used to deal with an unpleasant emotion.

Maybe cope with the emotions in another way. (5) Behavioural component - develop a positive, nurturing attitude towards her body that is expressed behaviourally. Focus on how one feels rather than on how one looks. Substitute behavioural alternatives to vomiting. Walking, bathing, sleeping, talking. Feel full rather than feel fat. Do nice things for herself and her body. Baths, massage, sexuality etc. (6) Family issues - negative attitudes to the body may begin in the family. Negative comments from mothers and fathers make a difference when people are vulnerable. May be possible to deal with family as a whole & modify the communications which are causing distress. Or client on own and discuss ways of interacting with her family. Make self accepting statements in the face of parent's criticisms. Clearly, real cases are more problematic and complex. Also therapists own beliefs are important. Many people (therapists included) have residual 'fattist' beliefs. Don't collude with bulimic client in the belief that she should lose weight. Maybe later if she's fat enough to cause health problems.

**The structure and content of bulimic beliefs**

Bauer and Anderson (1989) go into more detail about some typical bulimic beliefs e.g. (1) Becoming overweight is the worst thing that can happen to me - very widespread belief. (2) Certain foods are good, others are bad. (3) Must have control over all my actions to feel safe. Maybe grew up in circumstances which were unstable. (4) Must do everything perfectly or what I do is worthless. (5) Everyone is aware of and interested in what I am doing. (6) Everyone must love me and approve of what I do (7) External validation is everything. (8) As soon as I_____ I will be able to give up bulimia. e.g. lose more weight, get pregnant, get a job, get married. (9) To be successful a woman must combine the traditional values of women with the aggressive career orientation of men.

People who are more depressed at the start of treatment for bulimia are less likely to have a favourable outcome (Maddocks & Kaplan, 1991). Partners of bulimic women - (Lacey, 1992a) partners tended to be slightly older, on average overweight, 27% reported having an eating or weight problem, 25% had been treated for psychiatric or emotional disorder. 'Heavy drinking partners and multi impulsive bulimics sought each other out' [!!]. 11% of the bulimic S's described their relationship as abusive. Predisposition to bulimia and factors associated with it: ‘The belief that the bulimics were relatively overweight at menarche was held not only by the future patients but also by their sisters and mothers. The data suggest a common family myth prior to the illness. ...issues of shape and weight became mutually overvalued and let to the initially aberrant eating behaviour ' (Lacey, 1992b, p307). Self-harm more prevalent in early onset than late onset bulimia (Schmidt et al, 1992).

A study by Waller et al (2002) reported that there were some important beliefs involved in the maintenance of bulimic behaviour that were unrelated to food and eating. As they report “Among bulimics, restrictive eating was associated with perceptions of the self as dependent and incompetent, and as being unable to experience or express emotions. Bulimic attitudes were greater among those women who saw themselves as being deprived of emotional support and being socially different, and were also greater when the individual reported having low levels of self-control.” (p. 176)

**Sexual abuse**

There is some evidence to link eating disorders with unwanted sexual attentions and sexual abuse (Fischer et al, 2010; Smolak &Murnen, 2002; Thompson & Wonderlich,

2004). For example some sufferers explicitly draw the link between early unwanted sexual experience and their later development of eating disorders. Lost control of their lives in having the unwanted experience and the eating disorder permitted some sense of regained control. Maybe wanted to alter their body shape to avoid further unwanted sexual experiences. Feelings of guilt, disgust and self-hatred - said binge eating and vomiting formed a punishment for what they had experienced. Some felt partly responsible for the abuse that had occurred. Some mentioned the way that controlling their appetite was similar to controlling their sexual feelings. Often sexual abuse was reported as taking place at the same time as other life stresses. Maybe when abuse comes from within the family anorexic symptom might be a form of control or punishment directed at an abusing parent, or a parent who the sufferer believes has not been sufficiently protective. Possibly difficult to interpret retrospective self report data - e.g. maybe women prone to develop eating disorders are apt to be very sensitive to instances of sexual abuse.

Waller (1992) reported history of sexual abuse was associated with more frequent bingeing, relationship stronger when the abuse was intrafamilial and happened earlier. Lacey (1993) sample of 112 normal weight bulimic women 25% drank more than 36 units of alcohol a week, 28% 'abused' drugs, 21% repeatedly stole, 18% repeatedly overdosed, 8% regularly cut themselves. Lacey (1993) p193 - '..only by concentrating on all the symptoms can the underlying psychopathology be tackled. ...pathoplasticity of the eating disorders. ...the symptoms are shifting again, this time towards a multiple self damaging behaviour within the context of bulimia - the next wave of eating disorder.'

In a more recent study of bulimia by Hartt and Waller (2002) trying to relate the clients' bulimic symptoms the authors report their findings as follows "Three findings emerged. First, contrary to expectations, severity of reported abuse was not associated with more severe bulimic pathology. Second, as predicted, severity of neglect and sexual abuse were associated with severity of dissociation. Third, severity of abuse was associated with more pathological scores on [a number of] . . .core beliefs. Core beliefs related to abusive experiences (Mistrust/abuse, Vulnerability to harm, Emotional deprivation) and core beliefs about strategies for coping (Emotional inhibition, Subjugation) showed different patterns of association with abuse forms. Emotional abuse and Neglect were associated with core beliefs about Mistrust/abuse, Vulnerability to harm, and Emotional inhibition. Sexual abuse was associated with core beliefs about Mistrust/abuse, Emotional deprivation, Emotional inhibition and Subjugation, and physical abuse was associated with a core belief about Emotional deprivation. In addition, emotional abuse was associated with a core belief about low self-worth (Defectiveness/shame)." (Hartt and Waller, 2002, p. 932).

Kong & Bernstein (2009) examined a sample of 73 eating disordered patients in Korea, discovering that emotional abuse, physical neglect and sexual abuse were predictors of eating pathology in later life.

Carter et al (2006) in a Canadian study found that individuals with a history of CSA reported significantly greater psychiatric comorbidity, including higher levels of depression and anxiety, lower self-esteem, more interpersonal problems, and more severe obsessive-compulsive symptoms. Those who had both anorexic and binging and purging symptoms were more likely to report a history of sexual abuse.

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