



A ROUTLEDGE FREEBOOK

EATING DISORDERS:

COPING WITH CHALLENGES
IN EVERYDAY LIFE





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INTRODUCTION

HOW TO USE THIS BOOK

The prevalence of potentially life-threatening eating disorders – including anorexia nervosa, bulimia, and binge eating – is an ever-growing problem facing children, adolescents and adults across the developed world. Especially in a media-saturated culture, it's difficult to escape prescriptive messages about our bodies. Over 30 million adults in the US alone will suffer from some kind of eating disorder in their lifetime. To support sufferers and their loved ones during National Eating Disorders Awareness week and all year, *Eating Disorders: Coping with Challenges in Everyday Life* provides a handy compendium of direct insights and practical advice for preventing and managing eating disorders.

In this FreeBook, you'll learn how to think about eating disorders in a healthy, constructive way; how to develop and maintain a healthy attitude toward eating and dieting; and how to support friends and family who are struggling with an eating disorder. Feel free to skip around and focus on the topics that are most important to you. And remember that if you're in search of more in-depth coverage of any of these topics, all of the titles featured in *Eating Disorders: Coping with Challenges in Everyday Life* are available in full from our website.

CHAPTERS 1 & 2

In these chapters, June Alexander gives a concise overview of how family and friends can avoid getting caught up in disordered eating behaviors and instead support their loved one on the journey to recovery. In an excerpt from *Anorexia Nervosa: A Recovery Guide for Sufferers, Families and Friends*, co-written with Janet Treasure, you can gain insight on how anorexia develops by reading a series of personal statements from sufferers.

June Alexander is an Australian writer and life writing educator who has a 40-year career in journalism and has battled eating disorders since the age of 11.

CHAPTERS 3 & 4

Alexandra Logue lays out an evidence-based approach to healthy eating patterns in this exclusive interview and excerpt from the 4th edition of *The Psychology of Eating and Drinking*. She simply and clearly lays out the psychological and biological factors at play in deciding what to eat and when. Dr. Logue further expands on how history, environment, media and other such factors can influence the development and course of an eating disorder in her interview.



INTRODUCTION

Alexandra W. Logue, PhD, is an internationally known behavioral scientist. Her general research area is learning and motivation, with special research interests in higher education, choice behavior, self-control, and food aversions and preferences.

CHAPTER 5

This excerpt from *Cut Down to Size* contextualizes dieting, obesity, and the rise of bariatric surgery, as well as the societal pressures and stigma that go along with it. Severe obesity can take a huge physical, emotional and social toll, especially if it's seen as a voluntary condition. Jenny Radcliffe's overview of this last resort for people wanting to change lays out a succinct, thorough framework for bariatric surgery and how it fits in society.

Jenny Radcliffe is a Consultant Clinical Health Psychologist. Since completing her training at University College London she has specialised in working with people with physical health problems.

CHAPTER 6

A parent counseling a child who expresses a desire to diet and lose weight faces a difficult challenge. "So You Want to Go on a Diet?" from Carolyn Costin's *Your Dieting Daughter* anticipates questions and objections while guiding parent and child through a conversation about dieting, food and weight. This excerpt will help parents develop healthy self and body esteem in a child questioning their worth.

Carolyn Costin, MFT, Med, FAED, CEDS, is the founder and executive director of Monte Nido Treatment Center and its affiliates.

RESOURCES

February marks National Eating Disorders Awareness Week [<http://nedawareness.org>] (Feb. 22-28) in the US and Eating Disorders Awareness Week [<http://www.b-eat.co.uk/support-us/get-involved/eating-disorders-awareness-week>] (Feb 23-March 1) in the UK.

Alexandra Logue, author of *The Psychology of Eating and Drinking*, was interviewed by the City University of New York on "What we eat and why we eat it." Listen to the full podcast here:

<http://www1.cuny.edu/mu/podcasts/2015/02/02/what-we-eat-and-why-we-eat-it>



INTRODUCTION

Trained Helpline volunteers are available Monday - Thursday, 9:00 AM to 9:00 PM ET and Fridays, 9:00 AM to 5:00 PM ET to answer your questions about seeking treatment for yourself or a loved one, finding support groups, assessing your options, and finding information and resources about eating disorders. Call (800) 931-2237 or email info@nationaleatingdisorders.org.

A compassionate environment also can be created and strengthened by joining a support organization like these:

Academy for Eating Disorders (AED)

www.aedweb.org

Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.)

www.feast-ed.org

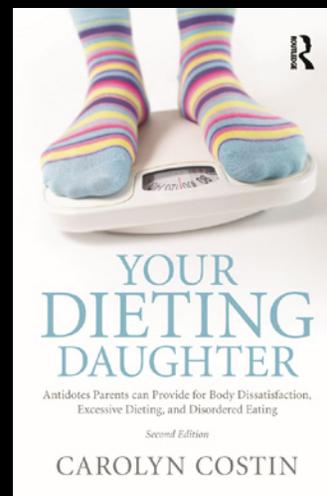
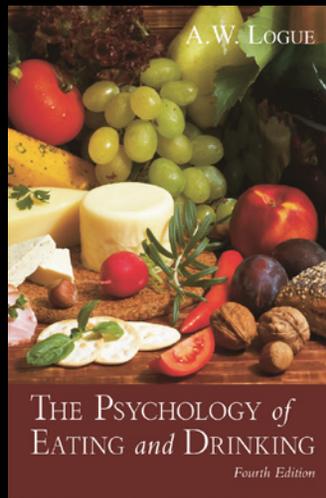
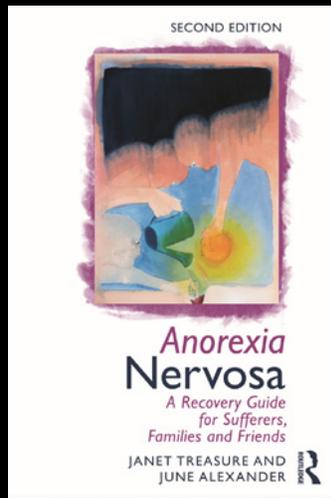
Eating Disorders Mentoring (EDM)

www.eatingdisordermentoring.org

International Association of Eating Disorder Professionals (IAEDP)

www.iaedp.com

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AN INTERVIEW WITH JUNE ALEXANDER



1 :: AN INTERVIEW WITH JUNE ALEXANDER

June Alexander is an Australian writer and life writing educator who has a 40-year career in journalism and has battled eating disorders since the age of 11. www.junealexander.com

A PRISON IN THE MIND

Having an eating disorder becomes a lonely experience, because this illness in the brain is like living in a prison of one's own mind.

Acknowledging there is an illness is a major first step towards recovery but in itself can be an enormous challenge. For instance, the tragedy of the death-rate due to anorexia nervosa, 16 times that of the normal population rate, is compounded by the fact that the sufferer may be unable to understand that they are putting their life at risk.

The eating disorder 'bully' works on convincing the sufferer that they can live according to its impossible-to-keep rules, but with help this bully can be overcome, and a full and purposeful life regained at every age. Giving up must never be an option.

One of the most difficult things about coping with an eating disorder is the feeling of fear, anxiety, isolation and confusion. You may experience peculiar behaviours and unpredictable moods when your brain does not receive adequate nutrition.

FACTORS AFFECTING ONSET

The factors that contribute to the onset of an eating disorder are complex. No single cause of eating disorders has been identified; however, known contributing risk factors include:

- Genetic vulnerability
- Psychological factors
- Socio-cultural influences

The combination of genetic and environmental factors means it is not uncommon for two sisters to have an eating disorder. In one out of 14 families, another family member will be affected. This causes additional difficulties.

Importantly, when an increased genetic risk does exist, steps can be taken to help prevent the illness developing. The environment accounts for something like 50 per cent of the risk. In addition, the genetic vulnerability may need some sort of environmental, psychological or social stress before it expresses itself. By being aware and knowing how to respond, you can help ensure that the family environment is as supportive as possible and that you and your family modify some of the more harmful cultural influences outside the home.



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Most eating disorders start in childhood and adolescence, but can manifest at any age. Challenges on the recovery path may include the addressing of problems that were encountered during childhood, before the eating disorder began. These may include:

- Childhood problems such as school refusal and emotional issues.
- Difficulty in making friends; experiencing severe shyness or alienation.
- Difficulties within the family.

Listening to how other people have struggled and overcome their eating disorder can be useful in becoming aware of the illness. Importantly, there is no set pattern. The stories vary considerably.

MESSAGE TO PARENTS AND PARTNERS

First, repeat *'I am not to blame'* until you accept and believe it. You have not done anything to cause the problem. Hit the delete button on 'blame' and 'guilt' at all times. Guilt is harmful both for you and for your child, for it will 'feed' the eating disorder symptoms.

Remember, an eating disorder is not a choice – nobody can choose to develop this illness, which develops in the brain. When your loved one behaves in an unseemly, embarrassing, outrageous way, that is uncharacteristic of their authentic self, remember that this is their illness.

As a parent, partner or close friend, you can be an important part of the solution by learning as much as you can about the illness, and developing skills to manage the symptoms and behaviours. Love is a powerful tonic. People with eating disorders say that one of the few things that can give them pleasure and reward is time with family. Keep this in mind when the going gets tough. Be aware that social isolation easily develops, for the eating disorder thrives on 'separating and conquering', and is toxic for the person with the illness. Time with family, engaging in pleasant diversionary pursuits that you know the sufferer enjoys, can help ward off this loneliness. Do not try to be a perfect carer. Scheduling time out to relax and recharge is essential. Having support readily available is essential. Often family members have the same strengths in analysis and persistence as the person with an eating disorder. These traits can be used in a positive way to help recovery. High levels of anxiety run in the families of people with eating disorders and looking after yourself is very important. Seek support and allow yourself time out to replenish your ability to nurture. 'Care for carers first' is a useful motto.



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COLLABORATIVE APPROACH

A consistent joint approach is very important for optimum results in the recovery process. Teamwork and collaboration by everyone involved is crucial to outsmart and overcome the eating disorder. This includes the patient, the family/carers and all members of the treatment team. Staying on the same page and keeping each other informed will help defuse the eating disorder's power.

MESSAGE FOR THE PERSON WITH THE EATING DISORDER

Remember that recovery from an eating disorder does not occur overnight. It could take many months, and sometimes, years. The important thing is to hold on to hope and to continually persevere and be open to taking on board new information and skills in seeking solutions. To improve your chances, aim for:

- Collaborative approach – the more people who are supporting your recovery process, the better.
- Compassionate care can help you maintain the effort to achieve recovery.
- Counting daily blessings, rather than thinking about 'what could have been', and envisaging the bigger, brighter picture, helps.
- Encouraging more grey in what has been a black and white view of the world, helps in developing flexibility and the forging of a true identity, and confident personality. It can be fun practising imperfection, such as arriving several minutes late, wearing an un-ironed shirt or a colourful, outrageous skirt, dancing along the street, wearing a ribbon in your hair, or borrowing a library book on a risqué topic and leaving it on the coffee table when friends arrive for a visit. Learning that little things don't matter, and other little things do matter, is liberating.
- Cherish small steps – there are times when the eating of a crumb may resemble the conquering of Everest.

PHASES OF RECOVERY

Three nutritious meals and three nutritious snacks, regularly spaced through each day, are considered an essential element both in recovery and as a relapse-prevention measure.

Treatment of eating disorders usually has three parts, though not necessarily in this order:

- The restoration of a healthy weight to prevent dangerous physical problems.



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- Helping the sufferer recognise and defuse eating disorder thoughts and impulses.
- Understanding the personality features and environmental difficulties which may have increased the risk of developing an eating problem.

EVERYONE HAS THEIR OWN PATH

The extent to which families can help with re-feeding a sufferer depends on the eating disorder's development and level of risk.

The family of an adult sufferer can help by providing information, resources and feedback that facilitate the move into recovery. Family members can encourage and assist recovery by providing guidance, and creating an emotional buffer against the eating disorder bully.

However, younger sufferers may not be at the developmental stage to grapple with the reality of the illness, and parents therefore need to step in and confront the illness on their child's behalf, guiding their child along the recovery path. For example, parents need to supervise meals and prevent compulsions taking control.

This hard but vital work may also apply to carers of adults if insight into the severity of the illness is lost. There are no strict chronological cut-off points – each set of parents, each partner, must assess their own situation with the treatment team. Also, every sufferer, no matter how sick, appreciates being treated as a person first, and illness second.

Early intervention is important because, once the illness sets in, many other problems emerge.

One advantage with early intervention is that links with friends, school and other areas of life are easier to maintain. An advantage of inpatient treatment is that in specialist units other sufferers can give help and support. Problems can be shared, reducing isolation and alienation.

DO PEOPLE WHO ARE 'RECOVERED' GET OVER ALL THEIR SYMPTOMS?

To shake off all abnormal attitudes to food and eating is unusual and after all, even 'normal' people have days when they eat too much or feel like a potato sack. Such feelings are not surprising as eating disorder attitudes to food and eating have merged into Western cultural attitudes about health, body image and attractiveness. However, for the person who has experienced an eating disorder, constant vigilance is necessary.



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Even after a two to three-year period of recovery, relapse can and does occur. Early warning signs must be heeded promptly, and the best way to do this is to reach out and seek help.

Relapse particularly occurs after stressful events, such as losing a job, a relationship breakdown, or death. It can occur as a way of coping with a change in circumstances, such as the empty nest syndrome when children leave home. It can occur if weight loss has been triggered by any reason. For example, after childbirth, the increased stress of looking after a new child, combined with the weight changes after birth, can lead to a relapse. Or perhaps weight loss has occurred following an operation, and the illness behaviours sneak back and people comment that you look better minus 'those few kilos'. Self-awareness is supreme.

AT THE EARLIEST SIGN, SEEK HELP

By being aware of the danger signs and intervening swiftly, you can prevent the illness getting a severe grip. Seek help immediately, for instance, if you recognise the return of eating disorder thoughts (e.g., *'I didn't feel like eating breakfast yesterday, and got through the day okay, so I won't eat it today either. Maybe I can skip lunch, too.'* Or *'I've eaten too much, and now I've started I can't stop. I'll pig out today and won't eat anything tomorrow.'*).

Recovery from an eating disorder becomes more difficult with time because the illness thoughts become entrenched in thought processes and behaviours. Regaining authentic self is hard work. However, people have recovered after more than 30 years of illness. It is never too late. At all times hold on to hope.

SUPPORT ONLINE

Importantly, a supportive environment also can be created and strengthened in the home by joining a parent support organisation. Here are some international links that offer assistance and links to more local support:

- Academy for Eating Disorders (AED) www.aedweb.org
- Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.) www.feast-ed.org
- Eating Disorders Mentoring (EDM) www.eatingdisordermentoring.org
- International Association of Eating Disorder Professionals (IAEDP) www.iaedp.com



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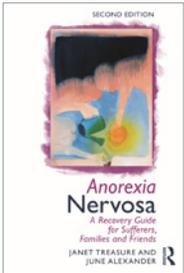
Treasure, J., & Alexander, J. (2013). *Anorexia nervosa: A recovery guide for sufferers, families and friends*: Routledge.



ANOREXIA NERVOSA

AVOID THE BLAME GAME

2 :: ANOREXIA NERVOSA AVOID THE BLAME GAME



The following is sourced from *Anorexia Nervosa: A Recovery Guide for Sufferers, Families and Friends*, 2nd edition by Janet Treasure and June Alexander.

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Anorexia nervosa throws families into confusion. Living with someone who has anorexia nervosa can be difficult, as their behaviour may seem deliberately provocative and selfish. Remembering that the anorexia symptoms are an expression of unhappiness and distress can be difficult. Families may torment themselves wondering 'Where did we go wrong?' There are no simple explanations and asking this question will not help at all because parents do not cause eating disorders. A more helpful approach is to focus on how best to access and support treatment and to contribute to your loved one's recovery.

Remember, the person with the illness is also confused. On one level they can hear others begging them to 'snap out of it and just eat' but on another level the illness has convinced them that they cannot and must not eat, even if their life depends on it.

Anorexia nervosa often arises out of a complex mix of many factors. Rather than a simple 'A causes B', it is more like a pinball machine whereby a vulnerable person may bump into a variety of factors that change their life course and allow an eating disorder to start and more importantly take hold. The illness is definitely not:

- an indication that parents have gone badly wrong in raising their child
- a phase of silly, stubborn naughtiness
- something that sufferers can 'just snap out of'.

Having anorexia nervosa is a wretched, lonely experience. It is not a fad, a phase or a modern phenomenon. Historical medical records reveal that young women and men have had an illness remarkably like modern anorexia nervosa during the past four centuries (Chapter 3 of *Anorexia Nervosa* deals with this in more detail). Although there is no overwhelming evidence that anorexia nervosa is increasing in frequency, evidence shows that it is becoming more difficult to overcome when it does arise. Our present culture, with an emphasis on thinness, tends to lock people into a career of anorexia nervosa.

We will outline some biological and environmental factors that appear to lead to anorexia nervosa. No one mechanism is responsible; instead, combinations of smaller factors, which in isolation are innocuous, appear to precipitate the problem.



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THE CULTURE OF THINNESS

FASHION

Some cultures predispose to anorexia nervosa. Western culture may increase the risk with its emphasis on thinness, skeletal super models and dieting behaviour as a norm for young women.

The number of young women presenting with eating disorders is increasing. The most marked increase is in people with binge eating (binge purge anorexia nervosa, bulimia nervosa and binge eating disorder).

Anorexia nervosa is less likely to be a 'slimming disease' than bulimia nervosa. Clearly, however, a slimming culture perpetuates the problem. Sometimes, a career choice exaggerates the need to be slim, as happened with Sarah:

Sarah

I was training at drama school to be an actress. My tutor drew me aside and said that I needed to control my weight as television work led to everybody looking bigger on the screen than in real life. So I immediately went on a diet and my weight fell. When I returned home to visit my parents they were shocked because I could hardly walk upstairs and had difficulty brushing my hair. They took me to the doctor and I was immediately admitted to hospital.

SELF-CONTROL

Thinness is often regarded as a sign of mastery and self-control, regardless of how the control of body weight is achieved. This fashion for thinness is no different to any other cultural ideal of female beauty. For example, the bound 'lotus' feet of Chinese women were thought to be desirable. In fact they crippled women and led to chronic pain, and ill health. (Read further about this in the novel *Wild Swans* by Jung Chang). It is important to put this fashion for thinness into context.

HEALTH

One message transmitted by the media is 'the lower the weight, the better the health'. This is not true. For mature women, the lowest levels of mortality are associated with a weight above that regarded as the 'normal' range. Also, the typical female pear-shaped distribution of fat, with a thin waist and rounded hips and thighs



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is not associated with any metabolic complications. Instead, the waist-hip ratio rather than weight is a better marker of risk, with the lower the ratio the better. A ratio of 0.75 is typical for women; a ratio of greater than 1 is associated with various health risks.

Treat messages about diet and health with caution. Extremely low fat diets may not be healthy, especially if used with other so-called healthy combinations, such as a no sugar or carbohydrate diet. Forget and ignore diet company advertisements that promise the world if only you will purchase their products. Instead, focus on eating three wholesome meals and three snacks every day to help keep eating disorders away.

FEAR OF FOOD

Advice about healthy eating often becomes confused with the idea that certain foodstuffs such as sugars and fats are bad, but we need some of each to be healthy. Scientific knowledge is incomplete and there are large swings in fashion. Twenty years ago carbohydrates were considered to be 'bad'. The pendulum has swung and carbohydrates are now 'good' whereas fats are 'bad'. The diet that is perceived to be 'good' may not have enough calories, leading to an intolerable hunger and overwhelming need to break the rules. To the best of our knowledge, it makes sense to aim to have a diet with less than 50 per cent fat. Generally speaking, there is no such thing as 'bad' or 'unhealthy' food although fresh home prepared foods are preferable to processed foods and drinks containing high levels of sugar, salt and fat; rather, it is best to eat a combination of foods, which together provide nutritional balance.

Food is now regarded with suspicion and fear. We are bombarded with warnings about eating too much of one food and not enough of another; advertisers encourage us to eat junk food and health authorities encourage us not to do so.

This constant bombardment in the media means that people who are vulnerable to compulsive worrying may become pre-occupied with the dangers that food contains and furthermore be at risk of developing an eating disorder. People who are more sensitive to threat and the opinions of others are more vulnerable to this influence. Also, people with a tendency to follow rules and structure with compulsive behaviours are at risk because they take warnings to heart and implement them.

A global backlash is developing against the culture of thinness and efforts are afoot to counteract the manipulative and exploitative forces of the giant diet food industries. The best we can do is to raise awareness about the risks and dangers of eating disorders, dispel the myths and educate others and ourselves with the facts.



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IT'S ALL IN THE FAMILY, OR IS IT?

Families, often without justification, blame themselves and feel guilty. Although you should tell your doctor or therapist about family or other difficulties that may be relevant, self or family blame is paralysing. Acknowledge and accept the past, whatever it has comprised, and focus your energy where it counts right now – on the present – and what you can do to aid recovery.

As parents, you may feel you are being pulled this way and that way. You see your child locked in behaviour patterns that are causing more and more problems. In Section Three [of Anorexia Nervosa] we provide evidence-based tips on how you can help. Your support is needed and is critical for your child's health.

While searching for the causes within families is rarely productive, a focus on how family reactions and interactions can inadvertently keep the disorder going is of great value. We describe how to use the energy and love of families in a productive way in Section Three.

GENETIC RISK

There is a biological genetic risk to developing anorexia nervosa. It is not uncommon to have more than one affected member in the immediate family – a mother, grandmother or aunt may have had the illness. The vulnerability can come from either the maternal or paternal lines. Anorexia nervosa and obsessive compulsive disorder may share common genes.

Jenny

I developed anorexia nervosa at the age of 17. My family recognised the symptoms, and realised that my behaviour resembled what had happened to my grandmother at the age of 15 in 1945. Grandma had lost weight when she was a schoolgirl. Her weight had fallen from 8 stone to 5 stone. The doctor had found nothing wrong with Grandma that could explain her weight loss. The doctor and the family became worried and admitted Grandma to a nursing home where she gradually gained weight after the nurses were able to persuade her to eat.

Research in the wider animal kingdom reveals not only instances where food preferences and body composition are under genetic control, but also conditions resembling anorexia nervosa. Young female pigs of certain stocks can suffer from



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a condition called 'thin sow syndrome'. Female pigs from these lines become locked into irretrievable emaciation. Their behaviour is similar to that seen in anorexia nervosa. They show a preference for low energy feed (straw) and become hyperactive and infertile. Lines of pigs that are bred for leanness are particularly at risk. Interestingly, stress triggers the problem.

We can conclude that some families have a genetic constitution that puts members at risk of developing anorexia nervosa. However, many other factors contribute to the onset and maintenance of the disorder.

THE TRIGGERS

Stresses such as trauma, deaths or disappointments can trigger anorexia nervosa, particularly in the context of certain personality features. Being aware of these triggers is useful because anorexia nervosa may develop as a coping mechanism. However, this type of coping mechanism is dangerously deceptive. There is a sting in the tail of this form of coping – the sufferer may feel less anxious at first as the illness sets in, but anorexia nervosa thrives on being manipulative and sneaky. It leads to avoidance of the problem rather than finding an effective way of dealing with it. Therefore if we think of the big picture of life course, this form of coping is toxic. Importantly, early intervention may avoid much torment and pain – providing the right support and teaching coping skills may enable the child to process the event in a more adaptive and constructive way, and counteract self-defeating thoughts such as 'If I have a problem, I am bad/imperfect' or 'If I can't solve my problem straight away, then I must be inadequate'.

Stephen

As a teenager, I was enrolled at an all-boys boarding school. I had been slightly podgy before puberty but then I had a growth spurt and became tall and lean. I took up cross-country running, found I loved it and was winning some big races. However, a hip problem began to inflict severe pain and the doctor said I would have to give up running. I hoped the lay-off would not be for long but the pain continued and I had to have an operation. By this time I was very upset as running had been a major source of pleasure and provided a sense of accomplishment and connectedness among my friends who also enjoyed athletics. Things got worse instead of better. At about the same time I developed an ulcer on my penis.



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I was too embarrassed to discuss this problem with the matron at school and soldiered on for several days. Eventually the pain got so bad I called my mother who arranged an appointment with a general practitioner. Surgery was required. Afterwards I became withdrawn and unhappy. I was feeling depressed, out of things, no longer enjoying the company of the other boys and felt unable to take part in the usual fun and games. Instead I became obsessed with my weight and appearance. This seemed to help me cope. I started to avoid school meals and became preoccupied with fitness. I went on a variety of diets and bought books on slimming. My weight fell, though I did not think I was thin. But when my parents saw me, they were worried, and took me to the general practitioner who referred me to a psychiatrist.

Stephen's treatment included discussion on the loss of self-esteem caused by the inability to run and the painful embarrassment caused by the ulcer. He was able to explore these issues in therapy without worrying about appearing a wimp or needing to be macho. He was able to express his sadness and frustration that he would no longer be able to run. Problem-solving strategies enabled him to consider other activities which would provide pleasure and a sense of achievement without putting stress on his legs. He decided to take up rowing. During the revision time for his A-levels, he was able to stay at home where he was surrounded by support and love. Away from the teasing and competitiveness that flourished in the school environment, meals became much easier to eat. During the several months of therapy, Stephen grew 5cm and gained 20kg.

Susan

I developed anorexia nervosa after my grandfather died. I had been particularly close to him as we shared many interests. We loved the outdoors and he took me on fishing trips every weekend. I looked upon Grandpa almost as a father as Dad was frequently away from home on business trips or attending sport events with his mates. My parents had never got on well and I found it easier to talk to and confide in Grandpa – he always listened. When Grandpa died I was very sad but grieving for him was difficult as I felt that I had to be strong to look after Mum, who had more right to grieve and be upset than me.



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Part of Susan's therapy was to grieve and come to terms with the loss of an important person in her life. This involved a long process of acknowledging the love and care that her grandfather had provided and, as a consequence, the loneliness and misery caused by his death.

Part of the normal grief response is to feel anger at the loved one for dying. People with anorexia nervosa often have difficulty accepting that they can be angry with people they love and so they block off or suppress this feeling. This prevents the normal emotional processing from taking place and the sufferer remains stuck as if the loss had just happened. Tears may spill out when talking about the event years later.

People who develop anorexia nervosa, on reflection, often can pinpoint an obvious trigger:

Margaret

I trained to be a nurse and had a good job in a London teaching hospital. Then my mother developed breast cancer and I was the obvious one in the family to be her prime carer. I had to fulfil this role in addition to my ordinary job and began to feel exhausted. Once or twice my professionalism slipped at work and I became irritated. To my horror, I also lost my cool at home and snapped at Mum. I was with her when she died and, although I knew it was hopeless, tried to resuscitate her. At the funeral I managed to appear calm and collected in looking after Dad and my sister. I didn't cry or break down, but carried on supporting my father during the next few months. At the same time my weight began to fall. When I began treatment, my mother's death and my difficulty in grieving for her were identified as important issues to work through.

Recovering from anorexia nervosa is hard work, with many fears to be overcome. When Margaret began to gain weight her anxiety increased. She became plagued by nightmares in which she relived the events surrounding her mother's death. At times she felt tempted to stop eating again as though this would make the torment go away.



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PERSONAL CHARACTERISTICS CAN BE A RISK

Perfectionism is a risk factor that appears in at least one part of the sufferer's life – such as tidiness, academic success or athletic prowess. The sufferer's drive for perfection may seem like an attempt to appease a self-critical part of themselves. A low opinion of the self is central and constant. The perfectionism therefore does not give pleasure but wards off pain.

This fragile sense of self is associated with a strong need to seek approval from others. Extreme external goals of success or achievement are set. For example, getting the top mark in the class, or exhibiting immense stamina in exercise training.

A tendency to value control over normal instincts and pleasures (head over heart) is another risk factor. This is the sort of personality that advocates the puritanical or selfless spirituality associated with asceticism in religion. The trait may come across in some people as stubbornness. It includes the beliefs that if you work hard you can overcome a problem, and that there is moral worth in trying to suppress or overcome your nature, including your need for food. Unfortunately, this characteristic, when combined with the 'Protestant work ethic' culture, can lead to setting unrealistic goals.

This wish for perfection and control and the belief that they are unobtainable or unworthy in some way, may also prevent people with anorexia nervosa from opening up to someone and talking about their difficulties. Also the ability to trust others is impaired. Our social brain is a high-maintenance tool and works inefficiently when not given fuel. This leads to problems decoding interactions and a bias to seeing others as a threat. Isolation and loneliness are a consequence and a barrier to obtaining the kind of emotional support known to be a factor in protecting people against developing psychological problems and, if such problems have evolved, in overcoming them.



AN INTERVIEW WITH ALEXANDRA LOGUE



3 :: AN INTERVIEW WITH ALEXANDRA LOGUE

Alexandra W. Logue, PhD, is an internationally known behavioral scientist. Her general research area is learning and motivation, with special research interests in higher education, choice behavior, self-control, and food aversions and preferences.

Q: How does the way one approaches eating and drinking affect the development of eating disorders?

A: We evolved in an environment in which food was much less easily available than it is now, and what food was available tended to be lower in fat, lower in sugar, lower in salt, and higher in fiber than our current food supply. Therefore our bodies evolved to be very good at eating as much as possible and in storing it as fat as much as possible. We have a strong preference for fatty and sweet foods, as well as for high-salt foods. Thus we have a tendency to consume more calories than we need to maintain a healthy body weight. Trying to counter this tendency can result in many types of eating disorders, such as excessive dieting.

Q: What do you consider an important factor in shaping young people's relationships to food?

A: Young people's relationships to food are shaped by the people around them, including both their family members and their peers. For example, if the people surrounding a young person tend to restrict food, the young person will also tend to do so.

Q: What do you consider an important factor in shaping women's relationships to food?

A: There is much evidence supporting the culture of thinness in many countries as contributing significantly to women's relationships with food in those countries. For a good many decades now in the United States, fashion and popular culture have idolized very thin women as being ideally attractive. This results in a body goal that is very difficult, if not impossible, for most women to attain, and that promotes eating disorders.

Q: What's the most important thing to remember for someone who is close to a person struggling with an unhealthy relationship to food?

A: Eating disorders can be dangerous. They can harm someone's body and even cause death. It is important to get professional help for people who have an eating disorder.

Q: What are some key warning signs to look out for that indicate someone has a disordered relationship with food?

A: Any behaviors that suggest that someone is taking in far more calories than they are expending, or is taking in far fewer calories than they are expending, could indicate an eating disorder. Examples are binge eating, purging, eating very little, or excessive exercise. These behaviors may be done in private making them more difficult to detect.



3 :: AN INTERVIEW WITH ALEXANDRA LOGUE

Q: How does an understanding of the psychology of eating and drinking help understand and treat eating disorders?

A: Psychology is the science of behavior, and psychologists conduct experiments that yield evidence concerning the causes and successful treatments of eating disorders. Basing prevention and treatment of eating disorders on rigorous evidence is the best way to decrease the harm caused by eating disorders.

Q: Any other points you want to make that I haven't asked about?

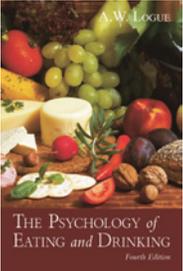
A: There are many factors contributing to unhealthy relationships with food. Some of them have a genetic basis, such as the preference for sweet and the tendency towards obesity of people whose mothers or grandmothers had inadequate food when they were pregnant. Others have more to do with our culture and peers promoting thinness. It is very difficult for anyone to know what is causing another person's difficulties with food, and multiple factors may be involved. Therefore people who are close to someone with an eating disorder should focus on getting that person help rather than on speculating as to what caused that person's eating disorder.



DOWN THE HATCH

HUNGER AND SATIETY

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The following is sourced from
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Drinking, 4th edition*
by Alexandra Logue.

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No animal can live without food. Let us then pursue the corollary of this: namely, food is about the most important influence in determining the organization of the brain and the behaviour that the brain organization dictates.

J.Z. Young (1968)¹

Many of you reading this book are, I'm certain, interested in weight control (most likely your own). In order to modify one's weight, it's extremely helpful to understand the basic factors responsible for the starting and stopping of eating. In other words, you need to understand the basic factors responsible for hunger and satiety. This information will help you understand what might be wrong if someone is eating too much or too little, and will also give you ideas about how to change the amount that someone eats. Perhaps most interestingly, this information will tell you what will not affect the amount that someone eats. For example, this chapter will explain why filling up with water won't decrease how many calories you eat, something that anyone familiar with the basic laboratory research on eating knows.

The story of the scientific investigation of hunger and satiety reads like a minihistory of psychology laboratory technique. For each time period, the hot theories about what was responsible for hunger and satiety were very much a function of what laboratory techniques had been developed at that time. So, in the early 20th century, scientists investigated the relationship of stomach contractions to hunger because they had a way to measure those contractions. Later, in the 1940s and 1950s, as surgical techniques advanced, the effects on hunger of different types of substances in the stomach, substances that had or had not arrived there via the mouth, were investigated. Also around this time, investigations of the brain's effects on eating began, investigations that still continue and use ever more specific methods to determine which part or aspect of the brain affects which precise type of behavior. Most recently, techniques have advanced to the degree that scientists can show how specific parts of the brain and chemicals elsewhere in the body work together to influence hunger. Now, in the 21st century, the number of different aspects of the body shown to affect hunger and satiety is dazzling and still growing. In this chapter I'll organize all of the major findings so that you'll get an idea of the results and the significance of hunger and satiety research over the past 100 years.

As we progress through these experiments and their results, it'll be helpful for you to keep a few principles in mind. First, many animals, including people, don't eat continuously. Instead, there are periods of time—meals— during which food consumption occurs frequently and periods of time during which there's little food

¹ J. Z. Young, "Influence of the Mouth on the Evolution of the Brain," in *Biology of the Brain*, ed. P. Person, Washington, DC: American Association for the Advancement of Science, 1968, p. 21.



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consumption. So this chapter will be looking at what's responsible for a meal starting and stopping. Note that all else being equal, more food will be consumed during a long meal than during a short meal. Therefore, investigations of what causes hunger and satiety are also investigations of what determines how much is eaten.

Second, investigations of how much is eaten have traditionally been classified into two types: investigations of short-term regulation and long-term regulation, that is, animals' abilities to consume both what will satisfy their short-term energy needs and their abilities to maintain fairly constant body weight over long periods of time. Before you scoff at your ability to maintain body weight over a long period, consider this: Suppose every day you eat 2% more calories than you need, approximately the number of calories in one extra pat of butter or margarine. After 1 year, this would be equivalent to a 5-pound weight gain. So, even if you find yourself gaining 2 or 3 pounds each year, you're still doing a pretty good job of eating very close to the amount that your body needs to maintain its current weight.

In both short- and long-term regulation, our bodies have been thought to behave in a way that is similar to a household thermostat. A thermostat is set for a particular temperature, and if the temperature becomes too warm or too cold, air conditioning or heat kicks in to bring the temperature back to the ideal level. Many theories of hunger have postulated that, in our bodies, there's a physiological characteristic (e.g., available energy or stored fat) that has an optimal level, the set point, and whenever there's a deviation from that optimal level, something happens in the body so that the optimal level is restored. Walter B. Cannon, an early 20th-century American physiologist who is mentioned several times in this chapter, coined the term *homeostasis* to describe processes such as these.² In the sections that follow, see if you can identify the theories of hunger and satiety that incorporate the concept of homeostasis, as well as the complications for such theories.

One final caution is in order here. In some of the experiments described in this chapter and in subsequent chapters, people are asked to report how hungry they are or what they have eaten. There has been some disagreement about how meaningful such statements are. Do people's hunger ratings correlate closely with how much they eat, and do people report accurately how much they eat? What people say they felt and what they say they ate don't necessarily correspond to their actual behaviors. For example, sometimes people report eating significantly less than they really ate, sometimes significantly more, and sometimes they can be quite accurate.³ As long as there are at least some situations in which people's self-reports help us predict their eating behaviors, experimenters will continue to use self-report data.

² S. J. Cooper, "From Claude Bernard to Walter Cannon. Emergence of the Concept of Homeostasis," *Appetite* 51 (2008): 419-427.

³ J. Maurer, D. L. Taren, P. J. Teixeira, C. A. Thomson, T. G. Lohman, S. B. Going, and L. B. Houtkooper, "The Psychosocial and Behavioral Characteristics Related to Energy Misreporting," *Nutrition Reviews* 64 (2006): 53-66.



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The number of different factors that have been shown to influence hunger and satiety is truly mind-boggling. To make your comprehension of this material easier, I'm going to divide it into two major categories: investigations of peripheral factors and investigations of central factors. However, as we go along, you'll see that researchers have increasingly looked at the relationships between these two types of factors.

OUT OF YOUR MIND (AND BRAIN): PERIPHERAL FACTORS

Peripheral factors that influence hunger and satiety are those factors involving parts of the body other than the central nervous system (the brain and the spinal cord). Let's follow a piece of chocolate cake as it wends its way from your kitchen table into your mouth, down into your stomach and intestine, to see what peripheral factors might contribute to making you hungry or satiated.

GETTING FROM THE LIVING ROOM TO THE KITCHEN

You're in your living room watching TV. What are some of the factors that might make you start thinking about going into the kitchen to eat the piece of chocolate cake on the table? Thinking about it enough to get up from your nice comfy couch?

Let's suppose that your stomach growls, and it feels as if it's contracting like crazy. Many people believe that a rumbling stomach is synonymous with hunger and a nonrumbling stomach is synonymous with satiation. Such beliefs led scientists to formulate the stomach contraction theory of hunger, which says that the initiation and termination of eating can be predicted on the basis of stomach contractions. Someone whose stomach has been contracting might be more likely to eat and vice versa.

Cannon's 1912 work on this theory with A. L. Washburn was one of the first experimental studies of hunger.⁴ Cannon and Washburn developed a technique for measuring stomach contractions, and Washburn was the first lucky person to experience it. First, Washburn had to become accustomed to having a long tube inserted down his throat into his stomach and left there for several hours each day. One end of the tube was in his stomach, and the other end was outside his mouth. During the experiment, air was passed into the outer end of the tube to inflate partially a balloon attached to the end of the tube that was in Washburn's stomach. (Washburn must have been a very dedicated scientist!) Stomach contractions were measured by monitoring changes in air pressure in the balloon. Washburn pressed a telegraph key whenever he felt hungry. His stomach contractions were closely associated with his reports of hunger. Apparently, Washburn would report hunger at

⁴ W. B. Cannon and A. L. Washburn, "An Explanation of Hunger," *The American Journal of Physiology* 29 (1912): 441-454.



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the height of a contraction, not at the beginning, which suggested that the stomach contractions caused the feelings of hunger and not the other way around. When Washburn wasn't hungry there were no contractions. Follow-up studies with additional subjects obtained similar results.⁵ The stomach contraction theory was the first peripheral theory of hunger to receive experimental support, and it was the dominant peripheral theory for many years.

However, subsequent studies showed that neither stomach contractions nor even a stomach are necessary prerequisites for reports of hunger.⁶ Further, as more sophisticated methods of measuring stomach contractions have been developed, the relationship between hunger and stomach contractions has been found to be extremely weak.⁷ Therefore the stomach contraction theory of hunger now appears to be primarily of historical interest.

You've still got to get from that living room into the kitchen. If stomach contractions won't get you moving, what might? Suppose, in flipping channels, you happen upon a cooking show about how to make the perfect chocolate cake. All of a sudden you're dying for that piece of chocolate cake on your kitchen table. Have you ever noticed that smelling food, hearing cooking noises, or just looking at food makes you feel hungry? You're not imagining this. What's happening to you is related to what happened to Pavlov's dogs. As you will recall, Pavlov showed that dogs would salivate when they heard or saw something that had previously been associated with food. Similar to the dogs, you also salivate when you hear or see or smell things that have been associated with food. And salivation isn't the only response that your body has to these situations. Even if you haven't yet touched the food, your pancreas may secrete insulin, a chemical involved in the metabolism of sugar. The insulin lowers your blood sugar level, which makes you feel hungry. There are several such reflexes that are related to the ingestion and digestion of food and that occur immediately upon—or, with experience, even prior to—our contact with food.⁸

Understanding how these salivation and insulin responses occur can help in understanding the differences in hunger between Muslim men and women during Ramadan. Ramadan is the month during which devout Muslims fast from sunrise to sunset. Researchers have shown that, during the initial days of Ramadan, women report being significantly more hungry than men. However, during the latter days of Ramadan, women and men report approximately equal levels of hunger. As it turns out, during Ramadan, the men aren't usually at home during the fasting periods. In contrast, the women are at home and are involved in preparing food for the children to eat during the day and food for the adults to eat after sunset. Thus, during the

⁵ W. B. Cannon, "Hunger and Thirst," in *The Foundations of Experimental Psychology*, ed. C. Murchison, Worcester, MA: Clark University Press, 1929.

⁶ E. Stellar, "The Physiology of Motivation," *Psychological Review* 61 (1954): 5-22. A. J. Stunkard and S. Fox, "The Relationship of Gastric Motility and Hunger: A Summary of the Evidence," *Psychosomatic Medicine* 33 (1971): 123-124.

⁷ *Ibid.*

⁸ M. L. Power and J. Schulkin, "Anticipatory Physiological Regulation in Feeding Biology: Cephalic Phase Responses," *Appetite* 50 (2008): 194-206.



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fasting periods, the women are probably exposed to far more odors, sounds, and sights that are associated with food than are the men. However, as the month of Ramadan proceeds, the food-related phenomena to which the women are exposed during the day are never accompanied by the women ingesting food. Therefore those phenomena are no longer associated with food ingestion.⁹ This may stop salivation or insulin release and result in decreased hunger.

GETTING THE CAKE INTO YOUR MOUTH

You've taken the big step and entered the kitchen. Now, with that cake staring you in the face, you're releasing more insulin and are feeling hungrier. But the kitchen's window air conditioner breaks, and because it's July and 95°F (35°C) outside, the kitchen quickly becomes unpleasantly hot and stuffy. Suddenly, you're no longer so interested in that chocolate cake.

The surrounding air temperature is well known to affect hunger. If your kitchen is hot, it's likely that you'll eat less than when your kitchen is a little chilly. One explanation for this influence of the surrounding temperature on the amount eaten is that in cold weather the body needs more fuel to keep itself heated to 98.6°F (37°C), and a major source of heat for any animal is the food it consumes. Therefore it's possible that initiation and termination of feeding are related to the maintenance of a specific, optimally efficient body temperature. If this sounds to you like a homeostatic process, you're exactly right! The temperature theory of hunger was proposed in the late 1940s.¹⁰ Since then, experiments with rats and people have supported it—animals do consume more in cold surroundings. Experiments have also shown that exposure to cold surroundings speeds the movement of previously consumed food from the stomach into the intestine. Such a process would, of course, decrease whatever it is about food in the stomach that normally inhibits feeding,¹¹ and thus this finding helps to explain why animals eat more in the cold.

CAKE IN THE MOUTH

Let's suppose that you felt hungry enough that you've now put the chocolate cake into your mouth. Does the food's stimulation of your mouth affect your hunger and satiety?

In order to determine whether oral factors by themselves contribute to hunger and satiety, over 50 years ago researchers developed a particular type of surgery called an esophagostomy. You may find the description of this surgery difficult and unpleasant to read. Performing an esophagostomy was one of the few then-available techniques that could be used to separate the influence of oral and gastric factors on

⁹ G. M. Finch, J. E. L. Day, Razak, D. A. Welch, and P. J. Rogers, "Appetite Changes under Free-Living Conditions during Ramadan Fasting," *Appetite* 31 (1998): 159-170.

¹⁰ J. R. Brobeck, "Food Intake as a Mechanism of Temperature Regulation," *Journal of Biology and Medicine* 20 (1948): 545-552.

¹¹ E. S. Kraly and E. M. Blass, "Increased Feeding in Rats in a Low Ambient Temperature," in *Hunger: Basic Mechanisms and Clinical Implications*, eds. D. Novin, W. Wyrwicka, and G. A. Bray, New York: Raven Press, 1976. J. Le Magnen, *Neurobiology of Feeding and Nutrition*. New York: Academic Press, 1992.

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hunger and satiety. This surgery involves first bringing the subject's esophagus—the tube through which food passes from the mouth to the stomach—out through the neck. The esophagus is then cut, forming an upper and a lower piece. If an animal that has had this operation eats, the food consumed passes out through the animal's neck instead of continuing to its stomach. This is known as sham feeding. An animal that is sham fed has all of the usual oral experiences that accompany feeding but none of the sensations that originate in the stomach. The subject tastes, chews, and swallows the food, but the stomach never receives it.

Scientists Henry D. Janowitz and M. I. Grossman were among the first researchers to use this surgical technique. They reported that sham fed dogs eventually stop eating, but before they stop they consume much more food than usual.¹² Over many sham feedings, the amount of food eaten increases.¹³ Once the animals learn that food in the mouth is no longer associated with food reaching the stomach, the satiating ability of food in the mouth ceases. Thus, oral factors can contribute to the cessation of eating, but by themselves oral factors don't precisely regulate food intake. (See Conversation Making Fact #2.)

Conversation making fact #2

Chewing gum (sugar-free or regular), or just chewing your food more, can decrease both how hungry you then feel and how much you then eat.¹⁴ In middle school my teachers told me that chewing gum would make me look like a cud-chewing cow and I've never been able to chew gum since, which now seems very unfortunate!

Assuming that you're not engaging in sham feeding, what characteristics of that piece of food in your mouth might affect whether or not you feel hungry? One food characteristic that has been widely investigated in this regard is whether the food is sweet. Both rats and people eat more of sweet than nonsweet foods, even if the number of calories in these foods is equal. In other words, even if a food is made sweet using a noncaloric sweetener, animals will eat more of it than had it not been sweet. One possible explanation of these findings is that the presence of a sweet taste causes more insulin to be released than if there's no sweet taste, thus lowering blood sugar to a greater degree and making someone feel hungrier. Another possible explanation is that when we eat food that is sweet, the body makes less of what's eaten available for immediate use and stores more of it than if what was eaten weren't sweet. Therefore, when we eat sweet food, in order to have enough energy for our immediate needs, we have to eat relatively large amounts. There may be similar explanations for the fact that we eat lots of any good-tasting food.¹⁵

¹² H. D. Janowitz and M. I. Grossman, "Some Factors Affecting the Food Intake of Normal Dogs and Dogs with Esophagostomy and Gastric Fistula," *American Journal of Physiology* 159 (1949): 143-148.

¹³ G. P. Smith, "Pregastric and Gastric Satiety," in *Satiation: From Gut to Brain*, ed. G. P. Smith, New York: Oxford University Press, 1998.

¹⁴ M.M. Hetherington and E. Boyland, "Short-Term Effects of Chewing Gum on Snack Intake and Appetite," *Appetite* 48 (2007): 397-401. S. Higgs and A. Jones, "Prolonged Chewing at Lunch Decreases Later Snack Intake," *Appetite* 62 (2013): 91-95.

¹⁵ P. J. Rogers and H. G. Schutz, "Influence of Palatability on Subsequent Hunger and Food Intake: A Retrospective Replication," *Appetite* 19(1992): 155-156. M. G. Tordoff and M. I. Friedman, "Drinking Saccharin Increases Food Intake and Preference IV. Cephalic Phase and Metabolic Factors," *Appetite* 12(1989): 37-56. "Saccharin Consumption Increases Food Consumption in Rats," *Nutrition Reviews* 48(1990): 163-165.

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THE CAKE IN THE GASTROINTESTINAL TRACT

You've chewed up and swallowed that piece of cake and now it's in your stomach, on its way to the small and large intestines. What effects does the presence of food within the gastrointestinal (GI) tract have on your feeling hungry or full? In a survey of college students, most said that the reason they stop eating is because they feel full.¹⁶ But what's responsible for that feeling? What can increase or decrease it?

Investigation of GI effects is complicated because, ordinarily, food gets to the GI tract by way of the mouth. Therefore, effects of food in the GI tract could be due to either the oral or the GI stimulation provided by the food, or both. Nevertheless, just as with oral factors, researchers have come up with ways to isolate the effects of GI factors. For example, researchers can insert food directly into the lower portion of the esophagus following an esophagostomy, thus bypassing oral factors. Alternatively, they can make a hole by which food or an undigestible substance such as an inflated balloon can be inserted directly into the stomach from outside the body. When what's inserted is food, this process is known as intragastric feeding.

Several scientists, including sham feeding researchers Janowitz and Grossman, have investigated the effects of intragastric feeding on dogs' eating behaviors. These researchers have put different amounts of food and other substances directly into the stomach. For example, they have studied the effects of inserting an inflated balloon into the stomach. One finding from this research is that intragastric feeding decreases sham feeding only when intragastric feeding is large and occurs at the same time as sham feeding. Further, a balloon has no effect on feeding unless the balloon is so inflated that it causes nausea and retching. Finally, dogs with holes directly into the stomach or with esophagostomies can eventually learn to eat less when they have been fed intragastrically.¹⁷

In addition, we now know that foods that are very high fat or that have a lot of fiber are more satiating. The precise reasons for this increased satiety aren't known. It may be that a food's viscosity or amount of fiber affects absorption of that food's nutrients or the speed with which that food passes through the GI tract.¹⁸ Further, even with the total number of calories consumed held constant, higher volumes of food are more satiating than lower volumes if the foods contain at least some calories.¹⁹

If you're a good detective you'll have put all of these pieces of evidence together into a fairly consistent story. Here's my version. Putting something in the stomach so that the stomach stretches isn't very influential in getting us to stop eating unless the stretching is extreme or is accompanied by nutrients in the GI tract.²⁰ This explains

¹⁶ D. G. Mook and M. C. Votaw, "How Important Is Hedonism? Reasons Given by College Students for Ending a Meal," *Appetite* 18(1992): 69-75.

¹⁷ Janowitz and Grossman, "Some Factors Affecting the Food Intake of Normal Dogs and Dogs with Esophagostomy and Gastric Fistula." H. D. Janowitz and F. Hollander, "Effect of Prolonged Intragastric Feeding on Oral Ingestion," *Federation Proceedings* 12(1953): 72. I. Share and E. Martyniuk, "Effect of Prolonged Intragastric Feeding on Oral Food Intake in Dogs," *American Journal of Physiology* 169(1952): 229-235.

¹⁸ M. Clegg and A. Shafat, "Energy and Macronutrient Composition of Breakfast Affect Gastric Emptying of Lunch and Subsequent Food Intake, Satiety and Satiation," *Appetite* 54(2010): 517-523. M. Yao and S. B. Roberts, "Dietary Energy Density and Weight Regulation," *Nutrition Reviews* 59(2001): 247-258.

¹⁹ B. J. Rolls, E. A. Bell, and M. L. Thorwart, "Water Incorporated into a Food but Not Served with a Food Decreases Energy Intake in Lean Women," *American Journal of Clinical Nutrition* 70(1999): 448-455. B. J. Rolls, V. H. Castellanos, J. C. Halford, A. Kilara, D. Panyam, C. L. Pelkman, G. P. Smith, and M. L. Thorwart, "Volume of Food Consumed Affects Satiety in Men," *American Journal of Clinical Nutrition* 67(1998): 1170-1177.

²⁰ D. Greenberg, "Intestinal Satiety," in *Satiation: From Gut to Brain*, ed. G. P. Smith, New York: Oxford University Press, 1998. Smith, "Pregastric and Gastric Satiety."



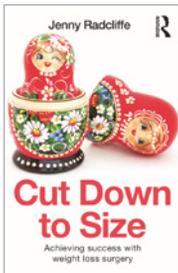
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why drinking lots of water or inserting an inflated balloon into the stomach aren't very effective in decreasing food consumption. Although these substances stretch the stomach, they contain no nutrients, and thus they won't increase satiety effectively.



THE OBESITY EPIDEMIC AND WEIGHT LOSS SURGERY

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The following is sourced from *Cut Down to Size: Achieving Success with Weight Loss Surgery* by Jenny Radcliffe.

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People seeking weight loss surgery are at the end of the line. They have tried all the conventional means of losing weight; they have attended Weight Watchers, Slimming World, Rosemary Conley; they have eaten cabbage, eggs and grapefruits, high protein, low fat, low carbs, no carbs; they have bought CDs from Paul McKenna, milkshakes from LighterLife and tablets over the internet. Many have spent thousands of pounds on their attempts to lose weight but remain obese. They might have lost a substantial amount of weight before it creeps back on and the cycle of hope and despair continues. At some point, when they cannot face another diet failure, they ask their GP to be referred for weight loss surgery, seeing it as a foolproof means of controlling the uncontrollable. Once they have funding and are sitting in front of the surgeon, they face an avalanche of medical information. Heightened anxiety, poor understanding, denial of risks and hopeful fantasies about their alternative future all contribute to people's difficulty in making a thoughtful decision.

Do you recognise yourself or a loved one in the description above? Have you been referred or are you thinking about weight loss surgery as an option? *Cut Down to Size* is written to help you make the best decision you can. It will provide you with detailed information about the process from referral to post-surgery lifestyle changes. Over the course of the book you will be able to build up a clear picture of the challenges of weight loss surgery, embracing practical information about the different procedures, their risks and difficulties and the real experiences of weight loss surgery patients, both successful and unsuccessful. Practical exercises assess your suitability for surgery, help you reflect on your social and emotional resources and prepare you for the changes you will face. By working through this book, hearing about the lessons learnt by others and considering your own situation, you will be in the best position to make an informed decision.

Obesity is not an individual problem, it is a global problem. Worldwide more than *one and a half billion people*¹ are overweight or obese. However much you feel yourself alone with your problem, surrounded by slim people who have no difficulty managing what they eat or controlling their weight, the reality is that obesity is an issue facing increasing numbers of people.

When did the obesity epidemic begin? Scientists differ in their views on this.² Was it with the onset of the motor car, TVs and the new supermarkets in the 1940s; the rise of fast food restaurants in the 1970s; or the advent of daytime TV and cheap processed food in the 1980s? Whatever the answer, we are now faced with a problem of obesity at a level never seen before and as you're reading this book, I assume that you or a loved one, or perhaps a client, are part of this epidemic and are wondering

¹ World Health Organisation (2011) *Obesity and overweight. Fact sheet No 311*. Available at <http://www.who.int/mediacentre/factsheets/fs311/en>.

² Cheltenham Science Festival (2007) *Dating the obesity epidemic*. Accessed at <http://www.telegraph.co.uk/science/science-news/3296662/When-DID-we-start-getting-fat.html>.



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whether weight loss surgery is the answer. This book will not only provide you with all the information you need to make an informed decision about weight loss surgery, but will also prepare you for the pitfalls and problems you could encounter after surgery.

The numbers of obese people rose spectacularly between 2000 and 2005. Over this time, in the USA, there was an overall increase in obesity of almost 25 per cent, but a 75 per cent increase in people who are super-morbidly obese. In 2011 the Health and Social Care Information Centre³ published a report stating that almost a quarter of adults in England are obese (that is, they have a body mass index (BMI) of 30 or more) and another 44 per cent of men and 33 per cent of women are overweight (having a BMI of 25–29). Over a third of the adult population have a raised waist size; when a lot of your weight is carried around your middle it is called *central obesity* and is associated with an increased risk of developing heart problems, metabolic syndrome and diabetes (you can read more about these health problems in Chapter 3 of *Cut Down to Size*). The problem is not restricted to adults; approximately 15 per cent of children between the ages of 2 and 15 are now obese. A government commissioned report by Foresight in 2007⁴ predicted that, if no effective action is taken to deal with overweight and obesity, 60 per cent of men, 50 per cent of women and 25 per cent of children would be obese by 2050.

Up to 15 per cent of the population are thought to be at greatly increased risk of health problems, such as diabetes and coronary heart disease, due to their BMI and raised waist measurement⁵ and this is why severe overweight is termed morbid obesity. *Morbidity* means health problem so when doctors talk about *morbid obesity* they are not making a judgement about your weight, they are saying that your weight is such that it's likely to affect your health.

The increasing weight of the population, or rather the health problems associated with it, is placing ever greater demands on the health service and the wider economy. It has been estimated that obesity and its health consequences cost the NHS £4.2 billion a year and the economy up to £15 billion in lost productivity.⁶ The number of admissions to NHS hospitals of patients with a primary diagnosis of obesity (in other words where the doctor felt weight was the main problem) increased over 800 per cent between 1998 and 2009 and almost one and a half million prescriptions for obesity medication were dispensed in 2009, more than 11 times the number of prescriptions in 1999.⁷

Despite growing numbers, severely overweight people are increasingly stigmatised and denigrated. People who are very overweight are seen as deviating from social rules about being able to control urges.⁸ They have become the other, the people it's okay to

³ The Information Centre for Health and Social Care (2011) *Statistics on obesity, physical activity and diet: England, 2011*. Available at <http://data.gov.uk/dataset/statistics-on-obesity-physical-activity-and-diet-england-2011>.

⁴ Foresight Report (2007) *Tackling obesities. Future Choices Project*. Accessed at www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities.

⁵ The Information Centre for Health and Social Care (2011) *Statistics on obesity, physical activity and diet: England, 2011*. Available at <http://data.gov.uk/dataset/statistics-on-obesity-physical-activity-and-diet-england-2011>.

⁶ National Obesity Observatory (2010) *The economic burden of obesity*. Available at www.noo.org.uk.

⁷ The Information Centre for Health and Social Care (2011) *Statistics on obesity, physical activity and diet: England, 2011*. Available at <http://data.gov.uk/dataset/statistics-on-obesity-physical-activity-and-diet-england-2011>.

⁸ DeJong W (1980) The stigma of obesity: the consequences of naïve assumptions concerning the causes of physical deviances. *Journal of Health and Social Behaviour* 21:75-87.

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shout at in the street; seen as weak, even morally deficient, if they just tried harder they could be thinner, better people. Obese people are discriminated against socially, educationally and in the workplace⁹ and anti-fat attitudes are pervasive across western society. As the average slim person is able to lose a kilo or two without too much difficulty, it is assumed that severely overweight people should be able to do the same. Of course losing and maintaining a loss of 10kg is very different from losing 1kg; everyone can hold their breath for one minute, but who can hold it for ten?¹⁰

Sadly, many obese people internalise these negative attitudes and experience intense distress about their weight and appearance. You may have started to believe these things about yourself – to feel you are weak and out of control and shameful. You may receive little compassion from others and have little sympathy for yourself, making you vulnerable to destructive cycles of over-controlled and uncontrolled eating. The good news is a recent poll in the USA suggested that most people think there should be laws to prevent discrimination on the grounds of weight.¹¹

The more a disease is seen as being under the person's control the more social rejection people face.¹² Obesity is viewed by the public as being highly under personal control, and this affects the public view of weight loss surgery. As the disease of obesity is stigmatised, the public do not necessarily want to support and fund medical or surgical treatment for people who are obese.¹³ In the context of fat as a *moral failure*, a sign of weak will, people demand that treatments for obesity are harsh and punishing – boot camps and starvation diets. In comparison, weight loss surgery is seen as a cheat – an easy way out – and too expensive to be deserved by this devalued group.

The provision of weight loss surgery, both within the NHS and through private health services, has risen dramatically in recent years in response to increasing numbers of people suffering severe weight problems and the failure of current behavioural and dietetic approaches to offer significant and sustained weight loss. As a result of technological advances in surgery, such as keyhole surgery, and improved opportunities for training of surgeons, the balance between the risks of weight loss surgery and the potential benefits has altered dramatically in past decades. As people watch the apparently miraculous changes in the appearance of celebrities who have had weight loss surgery, it's easy to get the impression that the surgeon's knife is a pain-free route to a new life. The reality is that weight loss surgery is not risk free as it can carry considerable physical and psychological challenges, but for some people it can be life changing.

⁹ Puhl R and Brownell KD (2001) Bias, discrimination and obesity. *Obesity Research* 9:788-805.

¹⁰ Welbourn R, Fiennes A, Kinsman R and Walton P (2011) *The United Kingdom National Bariatric Surgery Registry. First Registry Report to March 2010*. Henley on Thames: Dentrite Clinical Systems.

¹¹ Puhl RM and Heuer CA (2011) Public opinion about laws to prevent weight discrimination in the United States. *Obesity* 19(1):74-82.

¹² Crandell CS and Moriarty D (1995) Physical illness stigma and social rejection. *British Journal of Social Psychology* 34:67-83.

¹³ Sikorski C, Lippa M, Glaesmer H *et al.* (2011) The stigma of obesity in the general public and its implications for public health – a systematic review. *BMC Public Health* 11:661.

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BARIATRIC SURGERY

In the 1950s surgeons at the University of Minnesota in the USA, faced with rising numbers of severely overweight patients, wondered whether the weight loss shown after bowel resection could be harnessed as a direct treatment for obesity. The first attempts with intestinal bypass were highly risky, but over the years safe and effective procedures have been developed. Bariatric surgery, from the Greek word *baros* meaning weight, was established. By the 1980s it had become clear that rather than simply producing weight loss, these surgeries also had great benefit for the management of diseases such as type 2 diabetes, high blood pressure and sleep apnoea and, in the USA, the procedures became known as metabolic and bariatric surgery to reflect these outcomes.¹⁴

Bariatrics is the branch of medicine that deals with the causes and treatment of obesity and includes diet, exercise and psychological therapy, as well as medication and surgery. You will hear weight loss surgery called bariatric surgery and the two terms are used interchangeably through this book. Somewhere in the region of 7,000 people had weight loss surgery in the UK in 2009 and 2010,¹⁵ just under 70 per cent through the NHS, 30 per cent privately self-funded and a small proportion paid for through private health insurance. The National Institute for Health and Clinical Excellence (NICE)¹⁶ plan for future services based on the assumption that over a million people have a BMI of over 40 or over 30 with comorbidities, that 60 per cent of these would be considered eligible, and that 40 per cent of these would take up surgery if offered. Within this group it is suggested that around 4,800 could be provided surgery each year, a three-fold increase compared with pre-2007 NHS figures. The same report acknowledged that in 2007 there were almost 50,000 people in England who had a BMI of over 50 and who were, therefore, potentially eligible for weight loss surgery as a *first-line treatment* and that there would be an annual growth in rates of severe obesity of 5 per cent.

The registry of UK bariatric surgery found that a quarter of all bariatric surgery patients had a high level of comorbid disease, including type 2 diabetes and sleep apnoea, and three-quarters had impairment in their day-to-day activities prior to surgery¹⁷ and that these were resolved for around half of all patients one year post-surgery. There is increasing recognition that weight loss surgery can offer savings for the health service. One Canadian study showed that health care costs (including the cost of surgery) were 25 per cent lower in weight loss surgery patients compared with obese people who had not had surgery.¹⁸ It also showed that sick leave and retirement on health grounds decreased five years after surgery.¹⁹

¹⁴ Welbourn R, Fiennes A, Kinsman R and Walton P (2011) *The United Kingdom National Bariatric Surgery Registry. First Registry Report to March 2010*. Henley on Thames: Dentrite Clinical Systems.

¹⁵ Ibid.

¹⁶ National Institute for Health and Clinical Excellence (2007) Commissioning guide. Implementing NICE guidance. Bariatric surgical service for the treatment of people with severe obesity.

¹⁷ Welbourn R, Fiennes A, Kinsman R and Walton P (2011) *The United Kingdom National Bariatric Surgery Registry. First Registry Report to March 2010*. Henley on Thames: Dentrite Clinical Systems.

¹⁸ Christou NV, Sampalis JS, Liberman M *et al.* (2004) Surgery decreases long-term mortality, morbidity, and health care use in morbidly obese patients. *Annals of Surgery* 240:416-423.

¹⁹ Nabro K, Agren G, Jonsson E *et al.* (1999) Sick leave and disability pension before and after treatment for obesity: A report from the Swedish Obese Subjects (SOS) study. *International Journal of Obesity and Related Metabolic Disorders* 23:619-624.

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²⁰ Brownell KD and Wadden TA (1992) Etiology and treatment of obesity: understanding a serious, prevalent and refractory disorder. *Journal of Consulting and Clinical Psychology* 60:435-442.

²¹ Torgerson JS and Sjostrom L (2001) The Swedish Obese Subjects (SOS) study – rationale and results. *International Journal of Obesity* 25(1):S2-54.

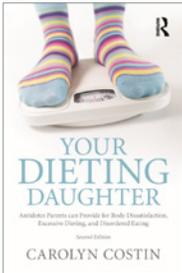
²² Karlsson J, Taft C, Ryden A *et al.* (2007) Ten-year trends in health-related quality of life after surgical and conventional treatment for severe obesity: the SOS intervention study. *International Journal of Obesity and Related Metabolic Disorders* 31(8):1248-1261.

Given the physical, emotional and social impact of severe overweight, it's understandable that people are increasingly looking to weight loss surgery. With celebrity magazines showing the yo-yoing weight of the rich and famous and revelations that for some the weight was lost through a gastric band or bypass, bariatric surgery has become mainstream. While diets continue to come and go – Dukan, acai berry diet, detox diet, zone diet – people are more aware of the dangers and pitfalls of dieting, with its inbuilt vulnerability to weight cycling and binge eating. Even specialist weight treatments struggle to show good results in the long term. With a conventional weight management programme, 90–95 per cent of participants will have regained all the weight lost within five years.²⁰ In one study comparing a group of weight loss surgery patients with patients who had been through a weight management programme, the conventional diet and exercise group had an average *gain* of 0.5kg, while the surgery group showed an average 28kg loss over two years²¹ together with better outcomes in social and psychological functioning.²²



SO...YOU WANT TO GO ON A DIET?

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The following is sourced from *Your Dieting Daughter: Antidotes Parents Can Provide for Body Dissatisfaction, Excessive Dieting, and Disordered Eating, 2nd edition* by Carolyn Costin.

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WHAT IS DIETING?

So that you are clear what I mean when I say dieting, here is my definition:

Trying to lose weight by any number of behaviors that cause a deficiency in the fuel and nutrients necessary for health, including, but not limited to: restricting calories, eliminating whole categories of food, skipping meals, using diet pills or other weight-loss products, or doing anything to lose weight that would not be appropriate to do for the rest of your life.

For a variety of biological and psychological reasons, persistently skipping meals, eating too few calories, using food substitutes, and diet pills have all been shown to actually predict large increases in weight gain both in dieters who started out overweight and in those who were not overweight to begin with. One particularly alarming study of adolescents showed that for those who reported dieting, the hazard for obesity was 324 percent greater than for non-dieters¹ – and it wasn't that those who reported dieting were larger to begin with. Your body is designed to fight against weight loss because starvation was a great threat to our ancestors. When you go on a diet your body doesn't understand you are intentionally trying to lose weight, and so it tries to protect you. When you lose weight, both your resting and non-resting metabolism decrease in an attempt to conserve whatever calories you do eat.² Furthermore, in your body's attempt to "help" you, a variety of hormone changes occur, which make it harder and harder to lose weight and easier to gain it back. These changes also affect your brain, creating an increased obsession with food, increased appetite,³ and a greater emotional response to food, often leading to bingeing. And all these metabolic, hormonal, and other changes don't just return to normal after you stop dieting. Your body actually continues to protect itself by conserving calories and storing fat even after you stop dieting, thus gearing your body up to guard against weight loss. This is clearly a set-up for any diet to fail, inevitably creating feelings of frustration and, in some cases, desperation. The dieting industry does not want you to be aware of or believe the mountain of evidence showing that diets don't work. They make billions of dollars each year convincing you it's your fault if the diet didn't work, and you just need to try the next diet or weight-loss product and work harder. After years of dieting, people generally feel more obsessed, less in control of their eating habits, and weigh more than they did when they first started.

Even with all this negative information about dieting at your fingertips, you, like countless others who defy logic, may agree to start a diet program with thoughts such as, "I just need a quick or easy way to do it," "This will help me get started and

¹ Stice, E., Cameron, R. P., Killen, J. D., Hayward, C., and Taylor, C. B. (1999). Naturalistic weight-reduction efforts prospectively predict growth in relative weight and onset of obesity among female adolescents. *Journal of Consulting and Clinical Psychology*, 67(6), 967-974.

² Dokken, B. B., and Tsao, T. (2007). The physiology of body weight regulation: Are we too efficient for our own good? *Diabetes Spectrum*, 20(3), 166-170.

³ Dokken, B. B., and Tsao, T. (2007). The physiology of body weight regulation: Are we too efficient for our own good? *Diabetes Spectrum*, 20(3), 166-170.



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then I'll learn to keep it off the right way," "This time it's going to be different," or "I am going to be among the few who succeed." Think about this: would you buy sunscreen that failed to work 75 to 95 percent of the time, or buy a CD that failed to play 75 to 95 percent of the time, or a birth control method that had been proven ineffective 75 to 95 percent of the time? I don't think so. But dieting is not a logical business or undertaking. Dieting involves your emotions, insecurities, and fears, as well as your dreams and fantasies. Going on a diet is like buying a lottery ticket, but much worse...not only do you have a minuscule chance of winning, you also pay a very high price.

FOR ANYONE WHO WANTS TO LOSE WEIGHT

Chances are food has become a source of pleasure and pain, your friend and your enemy. Food takes on many meanings in life other than just providing nutrients. Food can provide comfort as well as create problems. To achieve a healthy relationship with food, it's important to realize you should never do anything to lose or control your weight that you aren't prepared to do for the rest of your life.

People who want to be thinner come to me in all kinds of shapes, sizes, and conditions. What I have learned over the last 30 years is that, if you are unhappy with your body and want to improve things, the following is a summary of what will help you find long-term success and freedom:

- Find a way of eating you actually like and you can do forever.
- Eat according to hunger and fullness.
- Don't be too rigid or too chaotic about your eating.
- Eat a variety of foods to get all the nutrients you need.
- Move your body physically in ways you enjoy multiple times per week.
- Accept the natural shape and size of your body that results from doing the above.

You need to learn, listen, and respond to your body's cues when making food decisions. You may have forgotten how to listen to your body's signals, or you simply ignore them. You need to trust that eating when you're hungry is a good thing, and that feeling full is not the same thing as feeling fat and doesn't mean you are going to gain weight. Comfortable fullness after a meal is normal and necessary to calm your brain and shut off the drive to eat. Eating far past comfortable fullness and consistently eating when you are not hungry means you are not attuned to your hunger or fullness signals, or are overriding those signals and eating for other



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reasons. Learning to identify what feelings or conditions drive you to under- or overeat can help you achieve greater balance and control. There are many factors that contribute to your eating behaviors. The more you are willing to explore and learn about yourself, the better off you will be. Any self-worth, esteem, or pride you get from forcing your body into an inappropriate weight is cancelled out by the consequences that result from what you have to do in order to achieve it. If you betray your body and your health to accomplish something, happiness will continue to elude you. Learning to take care of your body, as your earth suit on this planet, accepting what you perceive as imperfections, and striving for balance in all areas of your life will yield much better results. I experienced this in my own life and have seen this over and over in my work with clients.

The best way to achieve and maintain your natural ideal body weight is to create a balanced, healthy relationship with food and exercise that does not include extreme or destructive behaviors and is a lifelong endeavor. To be considered a lifelong plan, it needs to provide what you need and include pleasure and joy. Learning to take care of yourself in this way will enhance the quality of your life and will trickle down into your relationships. I know it might be hard to imagine, but it is true. Trusting new ideas and techniques is difficult, but you won't know unless you try. Once you experience the benefits of the ideas described in this chapter, you will feel safer giving up your old patterns. No one can make you give up your current behaviors or do the work for you. If you want to make a change and are willing to look at the evidence and be honest with yourself and accept help, you will find a better way of living your life. If you aren't quite convinced, try just setting your old ideas and behaviors up on a shelf, begin experimenting with new ones, and see for yourself. To start with there are many myths regarding eating, dieting, and losing weight that you need to be aware of.

COMMON DIETING MYTHS

DIET MYTH #1: REALLY STRICT DIETS OR DETOX DIETS JUMP-START WEIGHT LOSS.

Not true! Strict diets or detox diets are even worse than regular diets. They can quickly cause the body to go into starvation mode and slow down metabolism even more than regular dieting. These diets often result in losing too much lean muscle mass, and since the diets cannot be maintained, you'll gain the weight back.



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DIET MYTH #2: THERE ARE PRODUCTS ON THE MARKET THAT HAVE BEEN PROVEN SUCCESSFUL IN LONG-TERM WEIGHT LOSS.

No such thing. Some fat blockers, diet pills, metabolism boosters, fat burners, and similar products work for a period of time, but none have been proven to lead to successful long-term weight loss. Even worse, they can have dangerous side effects and some can cause irreparable damage to your heart.

DIET MYTH #3: YOU HAVE TO EARN YOUR FOOD THROUGH EXERCISE.

Being alive automatically dictates your need to consume the fuel of human beings – food. Calories are the amount of fuel each food has. Your consumption of food needs to provide the daily caloric requirement that is needed to heat your body, pump your blood, grow your hair, nails, and skin, allow you to menstruate and ovulate, maintain healthy organs and bones, and every other function your body naturally performs, including all those activities going on in your brain. And you must eat even more if you want the fuel to do more, such as running, tennis, or walking on the beach.

DIET MYTH #4: EATING AFTER DINNER MAKES YOU GAIN WEIGHT MORE EASILY.

While it is true that people are more metabolically active earlier in the day, this doesn't mean you will gain weight if you eat at night. Weight loss is a result of how much you eat, not when you eat.

DIET MYTH #5: AVOID CARBOHYDRATES IF YOU WANT TO LOSE WEIGHT.

Eating fewer carbohydrates may make you lose weight, but usually this is because you end up eating fewer calories and lose water weight. Restricting carbohydrates causes the body to shed water weight, because carbohydrates are stored in the body with water. Dehydration is not real weight loss, and any lost water weight will come right back on even by eating more vegetables. Carbohydrates are necessary to fuel bodily functions including burning fat. However, if you frequently overeat carbohydrates, especially those processed with added fat and sugar, this might contribute to a weight problem, so it may help to: educate yourself about carbohydrates; make sure your eating is balanced; and be sure to use your hunger and fullness as guides.

DIET MYTH #6: CERTAIN FOODS ARE FATTENING.

There is no such thing as a fattening food. When you eat a cupcake you don't get fat. There are no good and bad *foods* when it comes to weight. There are good and bad *eating habits*. If you ate a dozen cupcakes every day that would be a bad eating habit,



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and unless you cut back what else you were eating you would probably gain weight. The cupcake would not be responsible for the weight gain, though – your eating habits would. Some foods are better than others health-wise because they are more nutrient-dense. Foods closest to their most natural state contain the most nutrients, vitamins, and minerals and should make up the majority of what you eat. There is plenty of room to have foods that are processed and less “nutritious” or “healthy,” like cupcakes, if you include them in an overall balanced way. Eating enough nutrient-dense foods will make it less likely to overeat those that are not. You will read more about this later. Simply put, weight gain and loss is a simple equation of calories in vs. calories out. Your body doesn’t care if those calories are from protein, fats, or carbs when it comes to weight. When it comes to weight, a 300-calorie cupcake isn’t any different from a 300-calorie turkey sandwich.

DIET MYTH #7: FAT MAKES YOU FAT.

Fat has mistakenly gotten a bad rap for a long time. Fat does not make you fat. Review Diet Myth #6, “there is no such thing as a fattening food.” Eating fat is good for you and gives you healthy hair, skin, nails, and hormone levels. Eating fat helps you get full and satisfied, and stay satisfied for longer. However, some fats are better for you in terms of other health concerns, and this is discussed in further detail later on.

IF YOU SUFFER FROM DISORDERED EATING OR A FULL-FLEDGED EATING DISORDER

The sad reality of using any drastic or unhealthy method to lose weight, such as excessive calorie restriction, taking laxatives, vomiting, or excessive exercise, is that you may find yourself caught up in a habitual pattern that you can’t break and these behaviors, over time, backfire in a number of ways. Restriction leads to a slow metabolism, hair loss, muscle wasting, bone loss, binge eating, and various other unintended consequences. Abusing laxatives ultimately ruins your bowel function and causes kidney damage. I have even seen young women who needed colostomy bags to collect their stool when their own colon no longer functioned due to laxative abuse. Vomiting destroys your tooth enamel, wreaks havoc on your digestion, damages your metabolism, and can tear your esophagus. Excessive exercise actually eats away at your lean muscle mass, slows your metabolism, and in general runs your body down. Add insufficient caloric consumption to excessive exercise and you will lose bone density, develop osteoporosis, and could irreparably or even fatally damage your heart.

If you don’t want to seriously damage your body you have to figure out a way of eating that you can maintain for the rest of your life. You need to be comfortable eating a



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variety of foods, be able to eat freely in restaurants, and be fine eating with friends in various social situations. Many people want to continue engaging in their symptoms until they reach their desired weight and then they plan to eat and socialize normally. The problem is, this day of feeling comfortable with food and your body does not just happen; learning to eat normally and maintain a healthy body, mind, and spirit are skills that don't just materialize once you hit a goal weight. Ideally, you should be able to deal with pizza, salad dressing, parties, holidays, and your refrigerator without feeling out of control or fearful about weight gain. I know well that eating disorders are not just about food and weight, but if you have an eating disorder, controlling your body and weight can take over and become an obsessive focus. An important part of recovery is putting things back into perspective and discovering more important things to focus on in life while staying healthy.

You can get over an eating disorder and become fully recovered, but you most likely will need help to do so. It will probably be a long process and there will likely be times when you feel afraid, lost, resistant, and out of control. You will need to have someone you trust and to whom you can express all of those feelings.

Although it will be difficult, do not weigh yourself. The scale will sabotage you. Whether you need to gain weight, stop bingeing, or stop purging, seeing the numbers on a scale is unreliable and not helpful and will interfere with your progress. A number is not more important than you are. If getting a weight is necessary, let your health professional or treatment team weigh you. Whoever weighs you can tell you about your progress without using numbers.

Many people have had to go through the process of recovery and are on the other side of it now. You can get there. Find people in your life who will give you support, help you go through recovery, and keep you on track when you feel like you can't go on. Keeping a journal is a helpful tool. Journaling supports the process of learning about yourself, allows you to organize and share your thoughts and feelings with others, and helps you prepare for challenges in your recovery. My book, *8 Keys to Recovery from an Eating Disorder*, is a useful self-help guide. The book has a number of journaling assignments along with other useful information and strategies designed to help you in the process of recovery.

Getting well often requires professional help and sometimes the containment and support of a structured treatment program is necessary in order to help you gain control of your symptoms. At my eating disorder clinic, Monte Nido, we specifically make sure our clients not only get the containment and therapy they need but also



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specific exposure to the myriad experiences related to food and eating they will encounter upon discharge. People who come to treatment build skills to successfully negotiate challenges they will face after they leave, including grocery shopping, preparing food, portioning food, and cooking for oneself and others. If you have tried and have been unable to recover on your own, a quality treatment program with an experienced and empathic staff is a gift you need to give yourself. It's not a punishment or last resort for those who have failed, but extra support for those who need it.