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EATING DISORDERS & BODY DYSMORPHIC DISORDER

"Eating disorders" is the term used to describe a category of mental illnesses involving disordered eating and weight problems. This category can then generally be separated into four main disorders Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED) and Other Specified Feeding or Eating Disorder (OSFED).

Some clinicians argue that separating eating disorders into smaller classifications can, in some cases, hinder treatment when new diagnosis labels are needed. Currently the consensus is that these four disorder classifications will be kept in place, while others may be added in the future.

These are serious and often complex disorders that can have significant and long-lasting impacts on a person's life. Whilst most consequences of eating disorders can be reversed with effective treatment, there are some problems such as osteoporosis that will stay with a sufferer for the rest of his or her life. In other cases, eating disorders can unfortunately be fatal, with Anorexia

Nervosa currently having the highest mortality rate for any psychiatric disorder. We therefore encourage anybody reading this leaflet who may be suffering, or suspect someone they know is suffering, to seek professional help as soon as possible.

This brochure will aim to highlight some of the basics of the eating disorder category, but as this is such a complex area we will only be scratching the surface. We therefore encourage sufferers, or those with an interest in the subject, to seek out further additional materials.

Disorders and Symptoms

As we have mentioned, there are four main disorders that make up the eating disorder classification. Here we will discuss some of the symptoms that are used to provide a diagnosis. If you suspect that you may fall into one of these classifications, we encourage you to seek professional assistance in order to clarify your suspicions. This brochure alone should not be used for self-diagnosis.

Anorexia Nervosa (AN)

- An inability or refusal to maintain a body weight that is at or above the minimum healthy weight guidelines for somebody your age, sex and height.
- An intense fear of gaining weight or becoming fat, even when you are underweight.

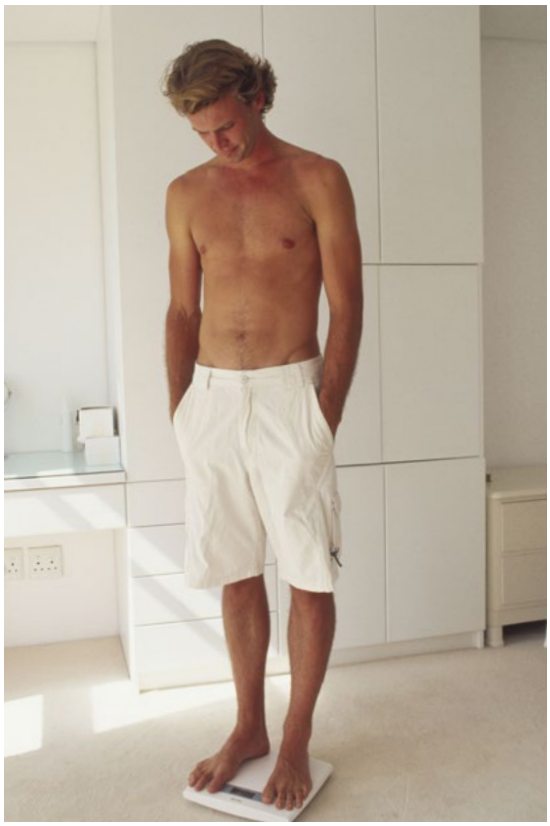
- Experiencing a disturbance in the way you perceive your own body shape or size. This may factor heavily into self-evaluation.
- Experiencing amenorrhoea, which is the missing of at least three consecutive periods in females who have previously had normal menstruation cycles.

AN can be further categorised into the binge eating/purging type or the restricting type. The binge-eating/purging type involves binge eating followed by purging techniques such as vomiting and laxatives to try to reduce weight. The restricting type involves limiting food and caloric intake. A person suffering from AN may have an episode of one type and then a subsequent episode of the other.

Bulimia Nervosa (BN)

- Recurrent episodes of binge eating, which involves eating a large amount of food than what may be classified as normal in a single sitting. These episodes may also be categorised as a lack of control overeating.
- Recurrent inappropriate compensatory behaviours to prevent weight gain, such as vomiting and using laxatives.
- BN behaviours of binging and purging must occur together on average at least twice a week for three months in order to be diagnosed.
- A person's weight will unduly impact the way they self-evaluate.
- The symptoms of BN must be occurring independently of AN.

As with AN there are two sub-classifications of BN: purging and non-purging. Those who fall into the purging category of BN will use techniques such as laxatives and vomiting to try to keep weight down, whilst those in the non-purging group will use techniques such as over-exercising.



Binge Eating Disorder (BED)

Binge Eating Disorder was formerly part of the disorder group below (OSFED) but has since received its own classification. Therefore, some people who read this and match these symptoms may have previously been diagnosed differently.

- BED involves binge eating without purging, with binge sessions lasting longer than those seen in BN.
- There must be recurrent episodes of binge eating with no regular compensatory behaviours such as purging.
- There must be marked distress in the patient when binge eating.
- Episodes of binge eating must occur on average at least two days a week over a six-month period.
- Binge eating episodes are associated with three or more of the following behaviours: eating much more rapidly than normal, eating until uncomfortably full, eating large amounts of food without being physically hungry, eating in solitude due to embarrassment over the quantity being eaten, and feeling disgusted, depressed or guilty about overeating.

Other Specified Feeding or Eating Disorder (OSFED)

Until recently this classification was known as Eating Disorder Not Otherwise Specified (EDNOS) and included BED. This is a catch-all diagnosis for those symptoms and conditions that do not fit into the categories above. Below are some of the criteria that make up OSFED, but these are not exhaustive.

- All criteria for AN are met, except that the sufferer has a regular menses.
- All criteria for AN are met, except the sufferer is in the normal weight group despite a significant weight loss.
- All criteria for BN are met, except at a lower frequency than required for a diagnosis.
- Regular compensatory behaviours like vomiting are used after ingesting a small amount of food by an individual with normal weight.
- Repeatedly chewing and spitting out of food to prevent swallowing.

Suspected Causes

As with many mental health disorders, it is not always possible to pinpoint a specific or definite cause or reason as to why some people will suffer eating disorders whilst others will not, even if they have experienced similar life events. Whilst we will discuss a few causes here briefly, it is important to consider that the real-world causes are often a lot more complex and in many cases intertwined.

The first area to consider is the cultural environment in which a person is living. It is hard to deny that Western culture has placed significant pressure on people (especially but not exclusively women) to look a certain way. Very often this encourages a belief in people that they need to be thin, and, in order to achieve this, go on a diet. This environment is unsurprisingly thought to foster eating disorders within society. It also often leads to people attributing their self-worth to how they look and

making comparisons between themselves and those they see in the media whose images are, in many instances, altered.

This explanation may be most attributable to BN cases, as studies have found that numbers of BN sufferers do increase in urbanised areas compared to rural places. The increased prevalence of eating disorders in Westernised countries, and indeed those countries that are becoming more westernised, is further evidence that this is in fact a substantial cause in many instances. This cultural approach to weight and body shape is especially prevalent in jobs such as modelling and ballet dancing, and so people who work in these professions can be at a greater risk than others in the general public.

Genetics and family can also play significant roles in the development of an eating disorder, with research findings suggesting that a family history of eating disorders, or other disorders such as depression or substance abuse, can increase a person's risk of developing one themselves at some point in his or her life. In addition to genetics, or indeed sometimes instead of them, family relationships can be a contributing factor to eating disorders. Difficult family relationships and a stressful home environment can leave a person more susceptible to developing a problem. This is particularly problematic as family support is often key to the recovery process. Therefore, family difficulties can be both a factor in the development of an eating disorder and a hindrance to recovery.

Trauma or emotional and psychological issues can also increase a person's risk for developing eating disorders. While not an exhaustive list of causes, those suffering with anxiety and obsessional disorders may be at a greater risk, as well as those who are suffering from low self-esteem.

As we have said, there is often a more complex relationship between these causes and other factors that influence whether an eating disorder is going to develop. For example, not everyone in the Western world suffers with a disorder. Also, some non-Western countries also have problems with eating disorders occurring within society. It is, however, useful to be aware of some of the suspected causes of these conditions so that you may make an educated assessment of your own potential risk level; especially if you suspect you may be showing some symptoms.

How common are eating disorders?

As with many mental health problems, there can be great difficulty in establishing accurate statistics for eating disorders. One reason for this is that people may feel shame or fear about reporting their symptoms and so they avoid seeking treatment, which results in them not being included in prevalence rates. It is unfortunate that people opt not to seek treatment due to societal stigmas around mental health as eating disorders are very treatable, especially when treated early. There can also be conflicting data results, especially when data is compared over longer time periods, as the definitions of disorders have changed in the past. This is important to consider when analysing research findings.

Research which investigates anorexia and bulimia indicates that, in North America, there are more likely to be a greater number of males with bulimia than females with anorexia (National Centre for Eating Disorders, 2021). Males may account for approx 1-5% of patients with anorexia nervosa although prior to puberty the risk increases, and approx 50% of sufferers in children are boys. Males account for 5-10% of patients with Bulimia Nervosa. In actual numbers,

bulimia is more common among males than anorexia and will occur in a greater ratio. In actual numbers this means that there are more men with bulimia than there are with anorexia. Known risk factors for the development of eating disorders in men include dieting, a previous history of obesity, homosexuality and participation in a sport that emphasises thinness.

The key statistics on eating disorders are as follows:

- Eating disorders are believed to affect females more, although these mental health issues can affect anyone.
- Eating disorders in general are also believed to affect more sexual minority men (Griffiths et al., 2018).
- Eating disorders are also more common amongst teenagers (NHS, 2021).
- Anorexia Nervosa affects 0.4% of females over a 12-month period (APA, 2013).
- Across the lifespan, it is estimated that Anorexia Nervosa affects 2%-4% of women (Wonderlich et al., 2020).
- Anorexia Nervosa affects approximately 19 per 100,000 men (National Centre for Eating Disorders, 2021).
- Bulimia Nervosa affects approximately 29 per 100,000 men (National Centre for Eating Disorders, 2021).
- Binge eating disorder affects 2% of men (National Centre for Eating Disorders, 2021).
- Binge eating disorder affects 1%-4% of the global population (Ghaderi et al., 2018); with this disorder affecting more heterosexual women and sexual minority men (Calzo, Austin, & Micali, 2018).

What is BDD and what is not BDD?

BDD is often mistaken as vanity, as in many instances, a person suffering from BDD will spend extended time focused on their features. However, this is the opposite of the truth. People who are vain are focused on the idea that they are good looking and want to have attention for this. Those suffering from BDD do not feel this way, they are disgusted by a feature of their appearance and spend a great deal of energy trying to conceal this perceived issue from those around them. They do not want attention for their appearance.

BDD is a body image problem that relates to a preoccupation with perceived deficits in one's appearance

BDD is a body image problem that relates to a preoccupation with perceived deficits in one's appearance. Whilst this perceived deficit may not be noticeable to others, the sufferer experiences extreme distress and anxiety due to the perceived deficit. BDD can occur in relation to any body part and commonly is associated with facial features and genitals. Certain manifestations may occur more frequently due to cultural differences, but the clinical aspects of the disorder are the same across cultures. People with BDD will often check their appearance regularly by touch and in reflective surfaces. They will also avoid social situations in fear of being judged on their appearance and may resort to covering their perceived deficit when in public. BDD can often result in sufferers pursuing cosmetic surgery but due to the nature of the illness this does not relieve symptoms.

How common is BDD worldwide?

Estimates for BDD globally are not always clear due to the secretive nature of BDD, as well as problems with misdiagnoses that have are prevalent in cases of BDD. BDD affects approximately 2% of the general population and

an estimated 6%-15% of dermatologic and cosmetic surgery patients in the US (Sathyanarayana et al., 2020). This appears to affect women more than men, with one study finding 27% of males and 41% of females in a sample of 2,553 people having reported being preoccupied with the appearance of at least one body part (Drüge et al., 2021).

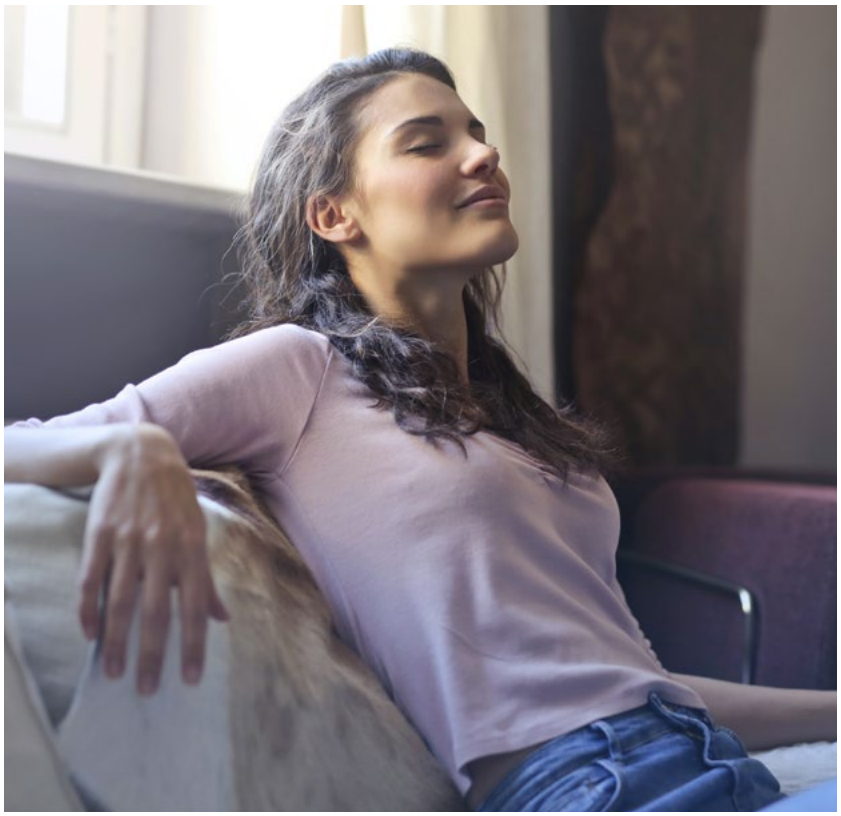
As such, people with this condition may choose cosmetic surgery as a way of dealing with these thoughts. This does not mean that all people who seek cosmetic surgery are mentally ill, it just means that those with BDD are more likely to seek this treatment. They are likely to be repeat users of services as, due to symptoms of BDD, physical surgery will not fix the problem.

How is BDD treated?

The most effective psychological treatment for BDD is Cognitive Behavioural Therapy (CBT) which aims to change the way a sufferer thinks about and acts toward their appearance. A medication-based approach can also be used in conjunction with therapy. The drugs used to treat BDD fall into the selective serotonin Reuptake Inhibitor (SSRI) category and include drugs such as Sertraline and Fluoxetine.

What to do if you are suffering

Firstly, do not feel ashamed that you are suffering. Suffering in silence often makes these conditions worse and leads to extended periods of suffering. As we have mentioned, you are not alone and there are treatments available that are able to treat these disorders. The first step is often the most difficult, but once you take this first step you will be able to get your life back. You may choose to disclose your feelings to a general doctor or to a close family member or friend. Sharing your problem with somebody will give you an outlet to discuss your feelings to help avoid the isolating feeling that these disorders cause. Support groups and helplines are also available worldwide in many areas of the world.



Whilst we have some of these on our website, you may find there are more local groups available to you. Many OCD groups will also cater for those suffering from BDD. You may not feel you want to attend a support group, and whilst we can respect your decision, it can often be beneficial to attend groups to gain moral support from those who are also going through, or have already gone through, treatment.

Once you have spoken with your doctor they will be able to suggest treatments for you, in line with those suggested above. If the above options are not immediately offered then you should enquire about their availability as they are proven to be successful methods for the treatment of OCD and BDD. Remember, there is a road to recovery from OCD and BDD!

Treatments

Recovery from eating disorders is possible with the correct treatment. However, it can be a long road to recovery, with some estimates suggesting that AN lasts for an average of eight years in a sufferer, and BN lasts for an average of five years. The length of time can be longer than this, so it is advised to seek treatment as soon as possible, especially with the long lasting psychical effects these conditions can have. Unfortunately, it is thought that an average of only one in ten people with an eating disorder will seek treatment, despite the fact that early diagnosis and treatment greatly increase a person's odds of recovery.

There are a number of treatment options available for the treatment of eating disorders. These include medication and psychological therapies. Due to the physical impacts of eating disorders it is likely that physical health monitoring will be needed throughout a person's recovery, to ensure they remain safe. In some instances a person may require a hospital stay in order to receive appropriate treatment and to ensure they remain safe and have the best chance of survival. This is especially the case for any person whose weight drops to a dangerously low level. Nutritional counselling is also likely to be built into any eating disorder treatment in order to help a sufferer establish a healthy diet plan going forward.

In terms of medicinal treatments, a person may be prescribed antidepressants known as Selective Serotonin Reuptake Inhibitors (SSRIs) to help them if they are suffering from BN or BED. Whilst these medications do show some success, as with most mental health problems it is always advised that psychotherapy is undertaken in conjunction with them. This is to ensure that the root cause of the problem is treated. However, we urge anyone who needs help to discuss this thoroughly with their GP or mental health practitioner.

When looking into psychotherapy treatments we tend to focus on two approaches: Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy (IPT). Both of these approaches can be adapted for use with the individual's family unit as required. CBT is a common treatment for a number of mental health problems and is shown to be highly successful. CBT focuses on changing the way a person thinks about a situation, and, by changing these cognitions, aims to change behaviours. IPT, on the other hand, focuses on altering a person's interpersonal behaviours with those around them and encouraging adaptation to interpersonal circumstances. Both of these approaches have merit in the field of eating disorders and it may well be that certain individuals experience better results from one approach more than the other. If you feel you are not having the results you desire from one approach, then you may wish to discuss the other approach with your medical professional. They will be able to outline the suitability for each approach relative to your personal circumstances.

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