



EATING DISORDERS

- A HELP PACK

Counselling Department

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Most of us working in any way, with young people are likely to encounter at least one person suffering from an eating difficulty. Those of us working in the Counselling Departments of sixth form colleges, FE and HEd institutions may be forgiven for believing that nearly every student is suffering from an eating difficulty. Certainly the incidence of anorexia, bulimia and associated eating disorders coming to the notice of pastoral staff appears to be increasing sharply.

A great deal of literature exists outlining the symptoms and possible causes of eating difficulty but often finding straightforward information about how to support students or family members is more difficult to track down. This pack aims to offer some practical advice alongside diagnostic information and useful contacts. If, however, you have been searching for a definitive 'cure' or an approach guaranteeing success, then better to disappoint you now! I seek only to share some strategies and approaches that have worked for some of my clients, whilst acknowledging that recovering from an eating difficulty requires patience, determination and perseverance from sufferer, helpers and supporters and what may work successfully for one client may not for the next.

So with that proviso in mind, I hope that sufferers, family, friends, teachers and professional helpers may find something of use in this pack.

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February 2001



Did You Know?

- At any one time 1 in 4 people in Britain (about 14 million) are on a diet.
- About 60,000 people in the U.K. at any one time are suffering from Anorexia or Bulimia. The true figure may be nearer 150,000-200,000.
- 90% of all sufferers are women but in school children as many as 25% may be male.
- Anorexia, Bulimia and Compulsive Eating are conditions found almost exclusively in richer, western societies.
- Anorexia has one of the highest mortality rates for any psychiatric condition, running at around 13-20 per cent per annum of severe cases.
- People suffering from Anorexia may well continue to deny there is a problem even though it is apparent to all around them.
- Many people lead outwardly successful lives whilst struggling daily with Bulimia.
- Complete recovery may take a long time; only 50% of those diagnosed have recovered after 5 years.
- Eating difficulties are not slimmers diseases – sufferers lose their ability to let themselves eat, not their appetite.



WHAT IS EATING DISTRESS?

An Introduction

A person is suffering from Eating Distress if their way of coping with a life difficulty is through control, or lack of control, of food. Anorexia, sometimes referred to as the Slimmers Disease, involves people drastically reducing their food intake. The reference to slimming can be misleading here, however, as this illness is not merely a diet taken too far but the adoption of a complex set of thought processes and control mechanisms. It is true to say, though, that many, if not all, people with Eating Distress would subscribe to the mantra 'If I were slimmer, I would be happier' and it is in this correlation between thinness and happiness that some media and societal responsibility must lie. The constant bombardment by the media of female body images which are very thin reinforces anorexic thinking, although I would question this bombardment as a direct cause of Eating Distress.

Not all people suffering from Eating Distress necessarily starve themselves however. Some people seek to control their lives by eating, or overeating, and then vomiting or purging themselves with laxatives. This behaviour is usually described as bulimic. Sufferers may also chew food and then dispose of it before swallowing. Others may binge constantly and consequently become grossly overweight. The range of behaviour is quite wide but all sufferers can share the same feelings of shame and helplessness about their condition. It is common for sufferers to move in and out of the various behaviours which makes labelling inaccurate as well as being unhelpful, although this pack does make distinction between anorexic and bulimic behaviour, it must be emphasised that divisions can be blurred.

There are three key elements to all eating disorders – weight loss/gain, hormonal changes leading to loss of periods in women and loss of libido and obsessional thoughts based around control of food and about food and weight loss.

ANOREXIA NERVOSA

The main symptom is the relentless pursuit of thinness through self-starvation and a fear of becoming fat.

Symptoms often include:

- Severe weight loss
- Distortions and misconceptions – about weight and body size
- Excessive exercising
- Vomiting/purging
- Isolation – loss of friends
- Rituals attached to eating, such as cutting food into thin pieces
- Emotional irritable behaviour
- Difficulty in sleeping
- Restlessness and hyperactivity
- Loss of menstrual periods
- Depression
- Perfectionism and other obsessions
- Intense fear of gaining weight even of bringing their weight into ‘normal’ ranges
- Feeling cold, poor circulation
- Denial of existence of a problem
- Growth of downy hair all over body
- Changes in personality and mood swings
- Low self esteem
- Secretiveness
- Constipation and abdominal pains
- Dizzy spells and fainting
- Swollen stomach, face and ankles
- Dry, rough discoloured skin
- Loss of bone mass and, eventually osteoporosis (brittle bones)

BULIMIA NERVOSA

Characterised by binge eating followed by self-induced vomiting, periods of starvation and/or purging with laxatives; sufferers often move to bulimia from anorexia.

Symptoms often include

- Binge eating large amounts of food
- Vomiting and/or purging after eating
- Often disappearing to the lavatory after meals in order to get rid of food eaten
- Secretive and ritual behaviour
- Feeling out of control, helpless and lonely
- An obsession with food
- Menstrual disturbances
- Reluctance to socialise
- Sore throat and erosion of tooth enamel caused by vomiting
- Distorted perception of body weight and shape
- Dehydration, poor skin condition
- Lethargy
- Periods of fasting
- Emotional behaviour and mood swings
- Anxiety and depression; low self esteem, guilt and shame
- Devious and deceptive behaviour
- Shoplifting to finance habit
- Feelings of guilt and self hatred
- Frequent weight change
- Swollen salivary glands making the face more round
- Excessive exercise
- Disappearance of food unexpectedly

ANOREXIA NERVOSA

SYMPTOMS AND OUTCOMES

Anorexia Nervosa is characterised by an obsession with thinness and the fear of becoming fat. Sufferers have not lost their appetite but the ability to allow themselves to satisfy their appetite.

The aim of the sufferer is not to starve but to cope with life. People with anorexia are in a conflict between feelings of dependence and independence and are particularly scared of losing control. The fear of failure is hidden beneath the success of controlling her weight. They are often confused. On the one hand, they have a very low self-esteem; on the other, very high expectations and a desire for perfection. Being 'successful' at starving themselves can boost self-confidence. Often anorexia sufferers are secretly very proud of their iron will, of their ability to refuse themselves food, particularly when their bodies are crying out to be fed. The great myth is that sufferers lose their feelings of hunger; there will be many times during the day when their stomachs are screaming for food and if they can deny themselves at those times then their feelings of success will be all the greater. Sleep problems are usually listed in a set of symptoms for anorexia but often it is not made clear that sufferers may find sleep elusive because they are so HUNGRY.

The skin of anorexics may become rough and dry, their hair gets thinner and their nails brittle. Blood pressure can drop, menstruation ceases and sufferers can become sterile. It is possible for osteoporosis to develop. Severe constipation, abdominal pain, dizzy spells and swelling of the stomach, feet and ankles frequently occur. Sleeping patterns are disrupted and a growth of downy hair on the skin is not uncommon.

These side effects usually disappear with time, once a settled pattern of eating is re-established. The human body usually returns to normal with few or no scars to show for its experience. However, not all sufferers from anorexia survive and it has the highest death rate of all mental illnesses.

WHO SUFFERS FROM ANOREXIA NERVOSA?

People of all ages may suffer from Anorexia, but the majority are likely to be young. Sufferers have been reported as young as 10 but the condition is most commonly found in girls around the age of 16-17. They tend to be intelligent, hardworking and high achievers – "good", obedient children from "good" families, anxious to please. Studies

of female students have shown that between the ages of 16-18 about one in every 200 girls suffers from the condition. The greater a college's level of high achievers then presumably the greater number of students suffering from anorexia. Some groups like ballet dancers and models, whose careers reflect stereotyped images of women, have a higher incidence of sufferers. Sufferers are most likely to be girls, indeed this pack uses the pronoun 'she' to describe sufferers, but the incidence in boys seems to be rising steadily too.

Sufferers are also likely to be people who cannot adequately express their anger – they may feel that 'nice' girls aren't angry. When counselling such people it is often amazing to discover just how angry they really feel as opposed to how outwardly meek they can appear.

BEHAVIOUR OF ANOREXICS

A person suffering from anorexia keeps herself at a low weight, striving to make it even lower. She does this by controlling her intake and very often has a detailed knowledge of calorie counts and the dangers of certain kinds of food. Control is so important that she often eats the same amount of food at the same time daily, sometimes even in the same chair or place.

Sufferers can also be addicted to exercise to keep weight down. Getting fit can be equated with getting thinner. Exercise is increased if food intake goes up. A starvation diet can also encourage hyperactivity and a sense of "being high".

Sufferers have a distorted body image. Although the anorexic ranges from on the light side to emaciated, she sees herself as fat and horrible, especially around the thighs and bottom. Having too little weight, her body will be uncomfortable and sitting on a hard chair will make her sore. She will try to carry on exercise even as muscle waste increases. She will be cold and wear thick, loose clothes to keep warm and conceal thinness.

Psychologically, the anorexic is likely to become secretive and evasive, always finding apparently good reasons for not eating. If pressurised into eating, she may break out into a rage, driven by the terrifying prospect of losing control and gaining weight. Even when she appears emaciated, the sufferer may not want to admit that anything is wrong.

The sufferer may also exhibit obsessive-compulsive behaviour. There may be strict rituals around the preparation of food with great distress or outbursts of anger common if the rituals are disturbed. There may also be a great interest taken in the food intake of others – often one person in the family is chosen as the 'benchmark' for food intake i.e. if the chosen person can be persuaded to eat three pieces of chocolate cake then the sufferer may allow herself a slice of apple. Once the chosen person becomes aware of this the family tension can become unbearable. Sufferers may also enjoy buying food and giving it to others or baking or cooking for others. Everything they do or think about has its base in food. Again the family tensions can only be imagined.

TREATMENT

Treatment of the underlying problems is essential if anorexics are to recover. This means that anorexics have to come to accept and like themselves. This is a slow process and may require a series of gradual changes. There is no quick-fix solution and patience and continued support are needed. It is important for family and friends to remain supportive and non-judgmental during difficult times when the sufferer is struggling to accept change.

For some, the best achievements may come as a result of one-to-one sessions. Others may find more help in groups or by working within a family group approach. Whichever approach is used, merely attempting to deal with the weight loss is not appropriate; if there is a weight gain it will be temporary. Only by treating the underlying problem will a long lasting cure be reached. Sufferers should be encouraged to seek regular medical supervision if there is any concern about their health. In extreme cases when weight has reached a very low level a period of hospitalisation may be necessary, but not all anorexics need or wish to enter hospital for treatment. (For further information on sources of help, see the separate sheet.) For some practical ways of supporting recovering anorexic sufferers and some notes on how counselling can help, see 'Supporting Clients'; a note for counsellors.

BULIMIA NERVOSA

Bulimia is a condition in which the sufferer eats large amounts of food (binges) and then purges herself by vomiting, laxatives, diuretics or starvation.

Like the Anorexic, the Bulimic is struggling to cope with life's demands and difficulties. To release the tension she turns to eating large quantities of food. Lack of control over intake is balanced out for her by her control over whether it remains in the body. As some people under stress turn to alcohol or drugs, bulimics turn to food.

WHO SUFFERS FROM BULIMIA?

About 1% of all western women are thought to be affected by it and 2% of women of reproductive age (about 100,000 in the UK) with another 4-5% partially affected.

Bulimia usually begins between the ages of 15 and 20 although many bulimics will have already had problems relating to eating. In many cases it starts with a decision to diet following a distressing event such as a broken romance. The peak age for the onset of bulimia is 16 to 18, at the time of growing independence from the family.

Sufferers are likely to be good students (or employees) who pursue a high level of achievement and who present a public image of self-assurance, happiness and success. The condition can therefore go undetected for a long time.

BEHAVIOUR

Bulimics eat large amounts of food which they consider to be 'illegal' or 'dangerous'; that is, calorie-rich. A 'large amount' varies accordingly to the individual and may not be that excessive.

Secrecy is important for the bulimic. The binge begins with the decision to binge which may come some time before any action is taken. The time after a decision is reached and before the binge begins may be characterised by a period of great restlessness and irritability with a gradual build up of tension and pressure. If this is interrupted the person may get angry (without any apparent reason).

Bingeing is often messy. There are no rules about what to eat, how to eat, in what order to take food (sweet and savoury may be mixed indiscriminately). There may be a lot of urgency in eating in case anyone disturbs the eater. The experience is a mixture of

pleasure and terror. The degree of urgency often means that willpower alone cannot enable the eater to stop the behaviour.

SYMPTOMS AND EFFECTS

The central features are:

- 1 Recurrent episodes of uncontrollable overeating.
- 2 Efforts to undo the effects of binge-eating in various ways, e.g. by self-induced vomiting, excessive exercising, use of laxatives or diuretics, chewing and spitting.
- 3 Chronic anxiety, guilt, depression, tension and shame.

OTHER COMMONLY ASSOCIATED CHARACTERISTICS ARE:

- 1 Drastic weight fluctuation.
- 2 Impulsive behaviour and emotional instability.
- 3 Tendencies to find outlets for tension in behaviours such as substance abuse, theft, self-mutilation, promiscuity or excessive and ritualised exercise.
- 4 Problems with social adjustment.
- 5 Depression.
- 6 A high need to achieve in order to obtain the approval of others.
- 7 Shop lifting to finance the large amounts of food required.

TREATMENT

As with anorexics there is no one way of offering help to bulimics. Most bulimics recognise their problems and want help, yet at the same time may be reluctant to give up the habits developed. Self help programmes or self help groups, backed up by therapy or counselling, can be a successful way of tackling the problem.

The bulimic will be required to face the painful issues she has been avoiding and will experience difficult feelings (e.g. depression, anger, frustration) during the period of recovery, which may be lengthy. She may need help to re-establish 'normal' eating patterns and will need to develop other ways than bulimia of coping with stress.

For more information see separate sheets on Sources of Help or Supporting Clients :A note for counsellors.

COMPULSIVE EATING

Compulsive eating has only recently become recognised as a distinct condition, yet it is estimated that about 50% of western women are overweight, on a diet or feel out of control with regard to food.

BEHAVIOUR

Like anorexia and bulimia, compulsive eating may begin in adolescence. Somewhere in the background of a compulsive eater is some form of deprivation, perhaps not all that obvious. The distress this causes is shown through the eating behaviour which may occur immediately or later in life.

The compulsive eater eats more than her body needs, particularly carbohydrate-rich foods (she could, for example, call herself a pig or a chocoholic). She may well eat normally or even extra-carefully in company but stuffs herself uncontrollably in private, eating anything and everything.

Sometimes the link between eating habits and feelings is clear; the compulsive eater eats when she is upset. But many compulsive eaters are not aware of the connection between their eating habits and their life experience. Nevertheless, they generally eat to hide their unhappiness.

Compulsive eaters are often good carers, putting others first and many are the type of person on whom others lean for help. Characteristically their sense of guilt is so strong that they spend a lot of their time looking after others and atoning for their disgusting eating habits.

SYMPTOMS

The compulsive eater feels greedy and undisciplined, a failure and a liar and therefore is likely to have some of the symptoms of depression. She has a continued need for food and yet a continual fear of it. She feels that getting slim will solve her problems and is likely to try out various kinds of diet which do not work, thus increasing the sense of failure.

TREATMENT

As with anorexics and bulimics, compulsive eaters need to confront the underlying distress, perhaps through support groups or counselling. At some stage, weight loss may be necessary to alleviate medical problems such as high blood pressure or backache.

SUPPORTING CLIENTS – A NOTE FOR COUNSELLORS

For all sufferers of eating distress of whatever kind, I would recognise a six-stage pattern of the development of their condition and their recovery.

1. Life crisis.
2. Development of eating distress
3. Realisation and acceptance of problem
4. Counselling work to uncover and work through the life crisis.
5. Re-establishment of good eating habits.
6. Self-determined and self-controlled recovery and rehabilitation including development of strategies for coping with setbacks.

In my experience no therapeutic movement is possible until stage three is reached although, of course, work can be started at stage 2 which can bear fruit later on.

Working with a client in denial

It may well be obvious to all in contact with a sufferer that something is very wrong but denial is common among sufferers themselves. Counsellors, especially within educational settings, will often find themselves sat opposite clients who have been 'sent' to them. Counsellors will all recognise the sinking feeling that can accompany the thought of working with a 'sent' or unwilling client. Acknowledging the truth of the situation in a straightforward way is always my preferred starting point 'I understand your teacher/tutor/mother has sent you along today and I wonder what you're feeling about being here'. Sometimes we can strike up a reasonable enough relationship for us to talk. For me, this is where I try to be at my most person-centred; offering empathy and acceptance for whatever issues are raised. The highest levels of reflective, empathic work allow the client to feel listened to and understood without judgement. Congruence or genuineness are important aspects of person-centred work too, however, and although I don't mention food or eating unless the client mentions it first, when directly questioned or exhorted for an opinion about their weight or eating habits, I do answer truthfully.

With these clients in particular I tread a very delicate line between offering full empathy and acceptance without collusion on areas of weight or food intake.

Being totally clear about trying to understand how a client feels whilst maintaining a degree of reality is difficult when working with clients with eating distress.

At this stage in the work establishing trust is the only possible course of action. Usually these clients have been told what they should be doing, begged to eat, shouted at and dragged around from pillar to post in search of an answer. Often what hasn't happened is that they've been allowed to talk uninterrupted and have been actively listened to. Their actions are not without logic but that logic is the client's own – if that logic can be understood and accepted, but not colluded with, then the trustworthiness of the counsellor can be established.

Depending on the willingness of the client, and the relationship between client and counsellor some work may begin about the life issues that may have been contributory to the client's illness. Working through these issues may lead to a slow awakening of the realisation that what they are doing to themselves is not actually helping them to feel in control of their lives after all. Other clients may leave after one or two visits and never return. Others again will leave after one visit but return to work again when the time is right for them. Some clients have later shared with me how it felt to come along to counselling initially and a number have confided that they didn't come back straight away because they realised that talking with me could help, and they were frightened that if they continued they would get better. They made a decision that they didn't want to give up their way of life. They may have been desperate, lonely or despairing but at least they knew what that was like – change seemed too frightening to contemplate.

Working with clients who may be ready to change

There are really two stages of this work. Firstly, the issues that began the illness initially have to be worked on. This is everyday counselling work which needs to be done but with the added dimension of facilitating the sufferer to begin to link the past with the onset of her illness. My experience leads me to believe that sufferers need to understand why they began to behave as they do. The dawn of enlightenment for them can also bring with it a sense of how bizarre their behaviour is, how odd their thoughts must appear to others, of how far their life style is from the 'norm'. Understanding why they began this course of action helps to 'normalise' slightly what it is often seemingly inexplicable behaviour. They often admit to feelings of great shame about what they do, mixed, very frequently, with feelings of enormous satisfaction at the results of their work i.e. sufferers may feel deep shame that they purge themselves with laxatives but great satisfaction that they 'control' their binge eating in this way. An acceptance of all their feelings can be very helpful at this stage – an acceptance that they yearn to establish a more 'normal' life together with an acceptance that they will mourn the loss of behaviour that offers them satisfaction and feelings of success. They may hate their eating disorder but treat it as a true and trusted ally at the same time. As counsellors it is not our job to tell clients which feelings are acceptable and which are not, but not more so than when

working with sufferers of eating distress. Accept how they feel but keep firmly in touch with what your own feelings are and express them if asked. Accept, reflect that acceptance empathically but never collude. There is a seductive feel, I find, to eating disordered logic; one which can pull others in with honeyed ease. The keeping of one's own sense of self whilst actively visiting another's world is always difficult but with these particular clients the effort can feel emotionally exhausting.

Re-establishment of good eating habits

Restoring good eating habits will be a slow and painful process. For even the client with an overwhelming desire to regain full health, the process of beginning to eat again will be very difficult.

Anorexic clients

Terror will reign here at the thought of beginning to eat normally again. Their fear is often that should they let go of their resolve then they will not be able to stop and they will become hugely, grossly fat. Any extra food intake that they make should therefore feel totally within their own control. Obviously in extreme cases where death is imminent then force-feeding would seem to be necessary but I can think of nothing more cruel than forcing an anorexic client to eat vast quantities of food. What is more I'm convinced that it does not change their attitude to food in the long term. If slow change can be achieved, with decisions made by the client themselves then results seem to be more successful.

Where a client may need more help is in deciding what food is suitable and how much is enough. Here the therapist can offer advice and support if the client trusts her sufficiently to believe her. Full trust is highly unlikely, in my experience. The client may trust the therapist in any other respect except around issues of how much and how often food is required. All the counsellor can do is to repeat the same advice constantly and without change. An anorexic or bulimic client will pick up on any inconsistency of message about food instantly, often remembering a conversation of many weeks previously. My constantly repeated advice is for the client to consider moving toward a pattern of three meals per day with a couple of snacks, one of which should be near bedtime to encourage a good night's sleep and discourage night waking due to hunger. Initially the pattern is more important than the amount although amounts do have to increase eventually.

How they move toward this pattern, should they wish to, is up to the client. Each will have times of day or places where eating is problematic and they will need to determine for themselves how they are going to achieve the ideal of three meals per day plus snacks. One step at a time seems to work well. At each small increase, however, their terror will be palpable as they battle with the fear of gaining weight. It is often well worthwhile to encourage the disposal of all scales as a first step. This may take some time to achieve as often sufferers weigh themselves endlessly (10 or 20 times daily is fairly average). Again they have to agree to this and decide how to work on it. Maybe

cutting down weighing is a good first step before finally disposing of the scales altogether.

In the beginning, everyone is so absorbed with setting a pattern of eating that the content of the meal seems hardly important but there does come a stage where working on introducing a variety of food should be tackled. Here there will be a hornet's nest awaiting investigation. Patience and a motivational approach is what is needed here especially when faced with the more bizarre patterns of food choice. It is a sign of a true recovery when a sufferer can eat a variety of food with ease, and maybe I'll be accused of being too easily satisfied, but as long as dietary requirements are being met, does it really matter if a client eats the same meals over and over in the early stages? If eating does not stop enjoyment of life, then no, if it does, then possibly more work needs to be done.

Overcoming fear and panic about the possibility of gaining weight is very hard to achieve. Again, however good a therapeutic relationship is and however much you can be trusted over every other area of life, a sufferer will have massive problems believing a counsellor who tells them they aren't fat. They probably believe they are fat all the time irrespective of the weight they are. Often if the weight gain is slow and steady they get through the panic. It is true that the more they eat the more they are able to accept change. Almost as if their brains are beginning to work more 'normally' allowing them to see sensibly what their weight is and to make accurate comparisons between their own, and others, bodies. Despite this there always seem to be times of panic and a desperate desire to go back to old habits especially if their life is stressful at the time. Examinations, emotional upset at home or any of life's stressors will send them back to old ways of coping. New ways of dealing with stress must be found, ones that don't rely on starvation or over-exercising or both. At this stage looking into alternative therapies may help. Aromatherapy or Reflexology, meditation or prayer, an exercise-free new hobby or a career goal can all help distract from eating and focus on the good things that life can offer.

Counselling support is required, at maintenance level at least, for a very long time with these clients, 2 to 3 years not being unusual and access to the occasional drop-in session later also help to allow a recovering client to feel secure even if they never take up the offer. Contact by letter or the occasional phone call can also help. Counselling people with eating difficulties requires a long-term commitment beyond the normal requirement of counselling.

Bulimic clients

The work here has similar stages and patterns to that of working with anorexic clients but there are differences and areas that may need a different approach. Firstly, the overtly bulimic activities will have to stop, that is the purging or vomiting. Laxative misuse is sometimes slightly easier to control and the client may be ready to just stop. If not, then again they may be encouraged to work out for themselves a strategy of cutting down until they are able to stop completely. A similar approach can be taken with vomiting. Reporting back on progress between sessions can give the client an opportunity to assess

when they felt most like inducing vomiting, when they did and when they actively managed not to. Some questioning about how they felt before they either did or didn't vomit, together with their construction of some plans to counter the urge to vomit will probably bear fruit. Avoidance of stressful situations or foods, together with healthy distraction can stop the habits. Some clients have taken themselves out for a walk, some have played electronic key-board (loudly!), others have telephoned a friend or forced themselves to sit downstairs with their families after meals. Often they will turn to rigorous exercise which again is a habit that may become obsessional and require curtailing later but this can be done when the client is stronger and has begun to establish healthier eating habits and is thinking more clearly.

Bulimic clients, too, need to establish a regular eating pattern. Here again the desired pattern should be three meals per day plus a couple of snacks. The choice of food is always going to be problematic, however, with some food directly encouraging bingeing and other food having a knock-on effect later on. For instance a high calorie food may be eaten in a controlled way earlier in the day but will then have to be paid for later by vomiting or purging of other food. If this sounds complicated that's because it is! The logic will be clear for the client but needs to be fully understood also by the counsellor. Clients may often feel deeply ashamed of the way they deal with food and are often reluctant to explain fully the 'dangers' to them of a particular food. This can lead to the counsellor supporting their intake of certain food in a very controlled way without realising the full implications of its ingestion.

Building up food intake, in motivated clients, can be relatively easy during the 'honeymoon' period. However, there always seems to come a place where the client becomes overcome with panic about gaining weight. At this stage a great deal of support will be required, with the counsellor not losing resolve. Having a 'buddy' to help support and encourage, outside of the counselling room may also be a good idea – if such a saint can be found in the sufferer's immediate circle. The client can, in their fear, become very angry and irritable requiring great patience, tolerance and perseverance from everyone. Supporting a person through this stage may well strain the closest of relationships even where both parties accept that it is the illness, not the person, that is causing the reaction.

Slowly food intake and variety can be increased with the client checking at all stages that she is 'safe' with what is being offered. If any food encourages the client to binge again it can be withdrawn temporarily and an attempt at re-introduction can be made later.

Recovery, Relapse and Life

Recovery is complete when food is no longer an issue, a tool for coping or a trap. I suspect that full recovery is quite rare with part recovery being more the norm. This might be where the sufferer leads a full, active life but where in times of stress some food-related behaviour begins to feel appropriate. We all have our stress points and Achilles' heels and for the recovering anorexic or bulimic these are bound to be food-related. My experience is that work needs to be done with clients to help them anticipate

relapse ahead – preparing to tackle the relapse with determination and not seeing it as, necessarily, a return to their darkest hours.

Offering clients a chance to return to you in the future can be a great comfort, and often ex-students will ask for one or two appointments if their lives are under more than average pressure.

It is always important for me as a counsellor to remember that people do get better and go on to university, marriage, career, motherhood, walking across the Sahara, going to live on the other side of the world or whatever it is they've set their heart on. Recovery can be so slow that progress is not always sufficiently remarked upon but often when looking back with a sufferer the changes in their lives can be breathtaking and it is often useful at any stage of the counselling to review progress, especially when there is a 'stuck' period which seems to have gone on for ever.

It is always a humbling experience to talk to ex-clients who have overcome the most difficult of circumstances and who have changed and moved on. Seeing ex-students who have fought the battle with eating distress and won is for me one of the most satisfying sights – despite the tears, the pain and the fear seeing them come through is wonderful; just like the sun breaking through a grey, leaden sky and painting a rainbow in the heavens.

Should you wish to discuss these notes further, or have any queries, please telephone Diane Fitzsimmons on 01695 633244.



EATING DISTRESS IN THE FAMILY

If you are a parent how can you best help your son or daughter?

Firstly by finding out as much as possible about the illnesses. Knowledge can help you understand behaviour that may seem totally inexplicable.

Understanding does help but living day in, day out with a child suffering in this way can put an intolerable strain on the family.

As parents we are nurturers in a physical and emotional sense and the child who becomes withdrawn and who refuses to eat shakes our self-worth as parents to the very foundations. Our anxiety to provide food can very easily turn into anger and resentment, instigating a cycle of discord that can become very difficult to break.

Trying to get your child some professional help is vital. Your GP may prove helpful in referring you to a specialist unit or The Eating Disorders Association can provide you with a list of self-help groups or private counsellors who have an expertise in this work.

Groups for parents can be particularly helpful – talking to someone who personally understands your situation can be a real relief.

You may find, however, that provision is patchy and that waiting lists can be lengthy and this lack of support can add greatly to the strain in the family.

However desperate you are to encourage your child to adopt healthy eating patterns trying to allow them as much autonomy as possible can ease the situation. Positive, encouraging support is always the best but don't feel a failure if this proves impossible to provide all the time. This kind of relentless illness can drive all concerned to despair. Look for support for yourself – from relatives or friends. Often families feel ashamed that this illness is affecting their family and are reluctant to talk about what's happening. Eating disorders thrive in dark, secret places I find and recovery is easier if non-judgemental acceptance and support is offered. Always remember, this is an illness and apportioning blame and indulging in recrimination won't help – either the family or the sufferer. The Eating Disorders Association is a must to join. Their straightforward help and advice will be invaluable to you. Talk to people about how you're feeling – talk to each other within the family as openly as you can and never forget that people do recover and go on to lead happy, healthy lives.

Supporting a partner with an Eating Disorder has its own special difficulties and can strain even the strongest relationships. Again offering support and love without judgement is probably the best help you can offer. Love is a powerful tool in the fight but beware of misusing it. A partner may make promises to a loved one that even whilst struggling her hardest she will find impossible to keep. Knowing that she has let a loved and loving partner down can be intensely painful, and may make her feelings of shame and despair all the greater. Let her choose the path but support her all the way, encouraging her in her good days and helping her move on from her bad days. Remember she shouldn't be doing things for a partner but because she wants or needs to. Be honest too about your own feelings; living with someone who is obsessional about food is never easy and occasionally even the most patient partner will feel resentful, despairing or just plain useless. It is pointless hiding these feelings – admit how you are feeling and let the sufferer support you for a change. Talk to each other, and then talk some more but don't let eating be the only point of reference between you – remind the sufferer about having fun – and make sure you both have some!



SOURCES OF HELP

Eating Disorder Association
103 Prince of Wales Road
Norwich
Norfolk
NR1 1DW

Tel. 01603 619090
Helpline 01603 621414
Website www.edank.com
Recorded message 0906 3020012
(50p per minute)

Eating Disorders Group
Department of Psychology
University of Manchester
Oxford Road
Manchester
M13 9PL

Eating Disorders Service
18 Euxton Lane
Chorley
Lancashire
PR7 1PS
Tel. 01257 245577

Eating Disorders Service
Bickerstaff House
Ormskirk and District General Hospital
Wigan Road
Ormskirk
Lancashire
L39 2AZ
Tel. 01695 583063

Anorexia and Bulimia Care
P O Box 30
Ormskirk
Lancashire
L39 5JR
Tel. 01695 422479

YMCA Information & Counselling
Parr Women's and Girl's Centre
Nunn Street
St Helens
Merseyside
WA9 1SF
Tel. 01744 25813