

CHAPTER 1

Introduction to Eating Disorders and Self-Harm

This chapter will enable you to:

- define the three major eating disorders: anorexia nervosa, bulimia nervosa and binge eating disorder
- understand the range of eating difficulties commonly seen in children under 11
- define self-harm and learn about the most common types
- differentiate between self-harming behaviours and behaviours with suicidal intent.

Eating disorders explained

There are three major types of eating disorder: anorexia nervosa, bulimia nervosa and binge eating disorder. We'll go on to explore each of these in more depth later in the chapter. What all three of these eating disorders have in common is that the sufferer is using their food intake, their weight or their shape as a way of coping with their life day to day. On the outside, eating disorders look very different: some sufferers become so emaciated that they are prescribed complete bed rest, others become so morbidly obese that they are unable to leave their homes, but weight loss, gain or fluctuation is simply an eating disorder symptom. The thoughts, feelings and psychological makeup which accompany the different eating disorders are very similar.

Over the next few pages I've outlined the typical symptoms and characteristics we might expect to see in young people with anorexia nervosa, bulimia nervosa and binge eating disorder. Please note that whilst I think it's helpful to understand the diagnostic criteria of major

eating disorders, I also think that we must take care not to dismiss our concerns about young people who are not suffering with a diagnosable eating disorder. Many young people may either present with an atypical pattern of symptoms, or may be in the early stages of developing an eating disorder and not yet have reached diagnostic levels. In either instance, we should be offering the young person concerned appropriate support regardless of how well they fit with the diagnostic categories presented over the next few pages.

Anorexia nervosa

Anorexia nervosa, commonly referred to simply as 'anorexia', is the most fatal of all mental health disorders with up to 10 per cent of sufferers dying either as a result of suicide or, more commonly, due to complicating factors arising from low weight, such as organ failure or heart attack.

The most apparent symptom of anorexia is low weight – people with anorexia are usually keenly aware of the minimum weight recommendation for their height and will work very hard to keep below this weight. Despite their low weight, many people with anorexia will try to lose more weight by restricting their diet and/or exercising or will be very reluctant to gain weight even if they understand that their weight is abnormally low and putting them in medical danger. Additionally, they tend to have a completely distorted view of their body and genuinely believe they are fat or even obese. The easiest way to try to understand it is that it is like looking in a fairground mirror that distorts your shape. People with anorexia will be looking in the 'fat mirror' by default and have a constantly distorted view of their shape. Additionally, whilst they might be dangerously underweight, people with anorexia tend to be terrified of eating and gaining weight, even if this won't bring them close to the normal weight category for their height and age.

'The thinner I got, the fatter I felt. The pounds were dropping off, but each time I looked in the mirror I could see another roll of fat forming.'

Historically, cessation of menstrual periods in girls was a diagnostic criterion for anorexia. This is no longer the case but it is still worth being aware that where weight loss is extreme girls may have very irregular periods and may cease to have periods altogether unless they are taking the contraceptive pill. Younger girls will generally not start to menstruate if their weight is low.

People with anorexia tend to use their weight and shape as a way of evaluating themselves. They consider being fat to be bad and, although

they are not fat, they think they are and will therefore tend to have very negative feelings about themselves and suffer from very low self-esteem. It's common for people with anorexia to weigh or measure themselves very regularly and their mood often directly reflects how 'well' they are doing with their weight loss. For example, it would not be uncommon for a girl with anorexia to arrive at morning registration in a particularly sad or angry mood if she found she had not lost weight that morning; she might be experiencing feelings of shame, failure and worthlessness. However, if she found she had lost weight that morning, she might arrive at registration in a lighter, more determined mood due to her perceived weight loss 'success'.

'If I'd gained like half a pound, I'd assume everyone was pointing and laughing at the fat girl. It was so hard to force myself to go to school and face the world those days.'

Many people with anorexia know the calorie content and/or nutritional breakdown of hundreds of foods. It is common for people with anorexia to set themselves a calorie limit for the day and obsessively count exactly how many calories they consume. If they consume more than the allotted amount of calories, they suffer immense feelings of guilt and shame and will often try to burn off calories by exercising. In fact, many students suffering with anorexia will keep themselves constantly moving and may insist on standing instead of sitting as it burns more calories, or may constantly jiggle their arms or legs or walk on the spot. Whilst we'd expect extreme weight loss to lead to lethargy, the opposite is true and people with extreme anorexia will often have the motivation and ability to exercise very hard – perhaps as a result of evolution: when humans lived a hunter-gatherer lifestyle in the past, at times when food was in short supply, we would have needed to expend more energy sourcing food before we succumbed to starvation.

Bulimia nervosa

The defining characteristic of bulimia is the binge–purge cycle (see Figure 1.1). A typical pattern is for a sufferer to consume a large quantity of food in a very short period of time. This is called bingeing. The type of food varies from person to person but is frequently very unhealthy food such as chocolates, crisps and cakes, though it can be just about anything the sufferer can lay their hands on. After the binge, the sufferer will try to remove the calories from their body. This is called purging. Purging can take many different forms: most frequently sufferers will make themselves

vomit or will abuse laxatives or diuretics or compulsively exercise. Bulimia usually starts with dieting – and this is almost a ‘default’ setting, but when there is a slip in the diet, or a stressful situation arises and food is sought for comfort, this will often trigger a binge which in turn triggers a purge. Bulimia is typically quite cyclical, though the frequency of the cycle can vary from several times a day to every few weeks.

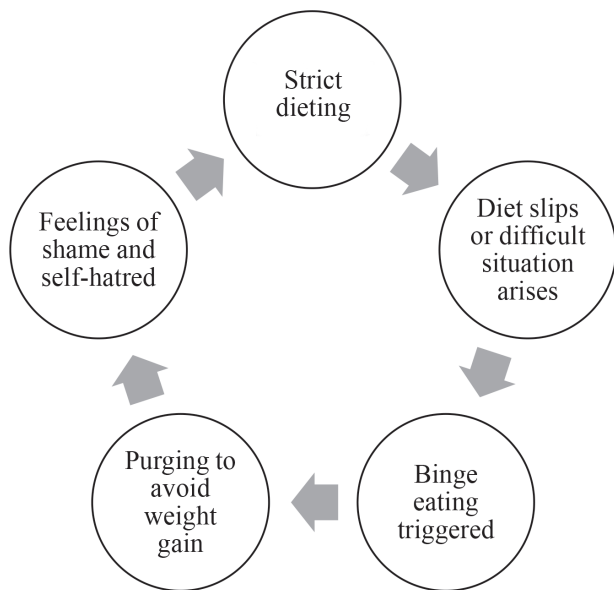


Figure 1.1: The binge–purge cycle

As only about 50 per cent of calories are generally expelled via purging, it does not tend to work as an effective weight-loss tool, but may prevent the weight gain which would otherwise result from bingeing. The result of this is that many people with bulimia maintain a roughly average weight, making the illness incredibly hard to detect. However, some bulimics will experience fluctuations in their weight, as they may gain weight during difficult periods when they are bingeing and purging heavily, and lose a little weight when they are bingeing and purging less or restricting their food intake heavily.

‘I was on a diet ever since I could remember. It never worked because I wasn’t very good at sticking to it. When I started taking laxatives I thought I’d found a magic bullet, but it didn’t work out that way as I started bingeing more and more often and on larger and larger quantities of food. It was like, now I had a way to get rid of the food, it was okay to eat it. But it wasn’t. I was

miserable when I was bingeing. I was miserable when I was purging and I was miserable in between times too. It was an awful time.'

Like people with anorexia, people with bulimia tend to suffer from very low self-esteem and attach a huge importance to their shape and weight. They too tend to consider themselves too fat regardless of how fat or thin they are and they use purging in order to try and control their weight.

Binge eating disorder

Binge eating disorder, sometimes referred to as compulsive eating or emotional overeating, is a disorder typically characterized by a pattern of eating large quantities of, often unhealthy, food over a short period of time, usually within about two hours. It is very similar to bulimia, the key difference being that sufferers do not purge after bingeing. This is the reason why compulsive eaters tend to be overweight whereas bulimics tend to be closer to a normal weight.

Binges tend to involve consuming unhealthy food very rapidly and are associated with a feeling of loss of control. Bingeing usually happens in secret and many people suffering with binge eating will make efforts to control their diet outside of binges – so a young person who is apparently eating healthily but whose weight is increasing constantly may be secretly bingeing.

Binge eating is often dismissed simply as greed. This is not the case. Binge eating is an eating disorder and its sufferers need just as much help and support as people suffering from bulimia or anorexia.

'I felt like I'd succumbed to the wrong eating disorder. If I'd have had the strength to starve myself then people would have cared. With every pound you lose, they care about you more. But when you're gaining weight no one stops to think "Hey, I wonder if she's okay," they just think "fat cow" and walk on.'

As binge eaters consume large volumes of food but do not purge, they tend to be overweight. In some cases they will be very overweight or obese and their weight is likely to continually increase until the underlying issues are addressed. This weight gain will usually be far in excess of the usual weight gain you'd expect to see in a growing child.

When talking about their binges, binge eaters will often refer to a lack of control and a complete inability to stop themselves eating, almost as if their body is working on remote control during a binge and they can't press the stop button. Binges tend to happen in secret with the sufferer often making attempts at a healthy diet outside of their binges

in order to control their weight. A student whose weight is increasing despite apparently healthy eating habits could be secretly bingeing.

As with anorexia and bulimia, binge eaters tend to suffer from very low self-esteem, which is frequently exacerbated by the teasing, bullying and social stigma that is commonly experienced by people who are overweight. This can be a vicious cycle as sufferers' low self-esteem will drive them to eat compulsively and the resulting weight gain will lower their self-esteem further. In most cases, they are aware there is a problem and are often desperate to address it but are completely unable to do so without help and support to address their underlying issues.

Other eating disorders

In addition to the three major eating disorders, individuals can be diagnosed with Other Specified Feeding or Eating Disorder (OSFED – formerly known as Eating Disorder Not Otherwise Specified or 'EDNOS'). OSFED is a diagnosis that is applied to patients who do not meet the diagnostic criteria for one of the three major eating disorders, though this diagnosis is not an indication of a less severe eating disorder, but rather a different combination of symptoms. This is a relatively frequent occurrence as people with eating disorders do not always neatly fit into diagnostic categories and may suffer from symptoms or behaviours typical of more than one of the disorders without reaching the diagnostic criteria for any single disorder.

Whilst it's important to understand the different forms eating disorders can take, I would suggest you forget about the labels and aim to support anyone who is suffering from an eating disorder *or* eating disorder-like tendencies – early support for someone with a subclinical eating disorder can often prevent them from developing a full-blown eating disorder.

Eating problems specific to under-11s

Children under 11 can develop a wide range of food difficulties in addition to the eating disorders outlined above. These patterns of food behaviour may persist into the teenage years and are more likely to do so when a student has special or additional needs. Common difficulties include:

- food refusal
- restrictive eating

- selective eating
- food phobia
- food avoidance emotional disorder.

These difficulties are not all well understood and are commonly misdiagnosed. It's important also to remember that many children will experience difficulties that don't fit neatly into one category or another, but these classifications will help you to gain some understanding of the range of behaviours you could encounter when working with younger children or older children with special or additional needs.

Food refusal

Food refusal is commonly found in pre-school children, where the refusal of food can be used as a way to communicate a message or for a child to 'get their own way'. However, this can persist in slightly older children, where the main feature is an inconsistent refusal of food. These children will tend to eat their favourite foods without any problem at all and may refuse food only when they are with particular people or in a particular situation – for example, refusing to eat at school but eating normally at home or vice versa.

Worry or unhappiness underlies the food refusal in many cases, but the child may not have the capacity to express their concerns using language. These children are usually of normal weight and height, and this problem does not usually pose a threat to the child's health.

'It took us a while, but eventually we understood that he was trying to tell us something by refusing to eat or drink at school. It turned out he was being teased by the other kids at school about his lisp.'

Restrictive eating

These children eat smaller amounts of food than they should do for their age. Their diet is normal in terms of the range of food eaten and the nutrients that it contains and is unusual only in terms of the volume of food consumed. Restrictive eaters are often thin compared to their peers and they tend to be short, but otherwise they generally seem healthy and happy. It's common for other members of the family to have a history of the same pattern of food intake.

Selective eating

The most obvious feature of this condition is the narrow range of food that is eaten – it is sometimes referred to as ‘extreme faddiness’. This can persist for months or even years. Selective eaters are very unwilling to try new types of food and the behaviour of these children, which is usually normal, is likely to deteriorate if they feel that they are being forced to eat a wider range of foods than they feel comfortable with. Social problems may start to occur beyond the age of about five because selective eating causes difficulties when attending birthday parties or visiting a friend’s house.

Additionally, children who eat only a restricted sugary diet may have problems with their teeth. The weight of these children does not give much of an indication as to whether there is a problem – they may be of low, normal or high weight.

Food phobia

Children who have developed food phobias are typically very resistant to eating and drinking, which can cause a great deal of concern. Food phobias are typically developed following a choking or vomiting incident and sufferers tend to avoid foods that have certain textures because they think they will choke, gag or be sick. Some children with food phobias will claim that eating and drinking hurts. Mealtimes often turn into a battleground. The majority of these children do, however, seem to grow and develop because the food and drink that they are willing to consume provides enough calories and nutrients.

‘He was convinced that if he ate he would be poisoned. He got thinner and thinner. At first we thought he needed treatment for anorexia, but in fact he needed talking therapy to overcome his phobia, which started after some food gave him vomiting and diarrhoea on holiday.’

Food avoidance emotional disorder

Children with food avoidance emotional disorder experience a loss of appetite which is usually associated with depression or anxiety and may follow a traumatic incident such as a bereavement. There is often a more general disturbance in behaviour that does not centre on food and mealtimes; for example, in addition to a loss of appetite the child may experience problems with sleeping, poor concentration, tearfulness and a general sense of hopelessness.

Food avoidance emotional disorder is sometimes mistakenly diagnosed as anorexia as these children tend to become very underweight. However, a key distinguishing feature is that, unlike children with anorexia, those with food avoidance emotional disorder recognize that they are underweight and often express a desire to eat more but they simply cannot bring themselves to do so.

‘She was only seven, but you could tell just by looking at her that her spirit was broken. Her father was dying and she had lost the will to carry on. She hated that she was worrying everyone by getting thinner but each time she tried to eat, she just broke down in tears.’

IS IT A PROBLEM?

Eating difficulties in children under 11 and the special needs population are relatively commonplace. Whilst some issues are passing phases and present no real threat to the child’s physical or emotional wellbeing, some cases do require professional support. If a child is displaying unusual behaviour around food, and you’re not sure if you need extra help, ask yourself:

- Are they taking in enough calories/nutrients so that they are not hungry?
- Are they growing normally?
- Do they seem happy and healthy in themselves?

If you can answer ‘yes’ to each of these questions then the behaviour should be monitored but there is no cause for alarm. It is quite normal for children to go through phases with food and most will simply pass with time. However, if you begin to become concerned about the child’s health or wellbeing then you will need to act. In many cases, the child is trying to communicate something that they do not have the skills, language or confidence to communicate, and trying to find alternative methods for the child to communicate their concerns – for example, through art therapy or play therapy – can be the key to overcoming their unusual food-related behaviours.

Self-harm explained

A generally accepted definition of self-harm is causing harm to one’s own body, usually through physical abuse. Self-harm is usually conducted at times of anger, distress, fear, worry, depression or low self-esteem in order to manage negative feelings. Self-harm can also be used as a form

of self-punishment for something that the self-harmer has done, thinks they have done, are told by someone else that they have done or feel they have allowed to be done to themselves.

Common forms of self-harm

Self-harm takes many different forms, but by far the most common type of self-harm we see in adolescents is cutting, followed by burning, aggressive behaviours (punching walls or doors in anger) and self-poisoning (taking non-lethal overdoses). Amongst younger children and the special needs population, the most common forms of self-harm are bruising/battering, hair-pulling, scratching and picking, including not allowing wounds to heal. Some behaviours, such as hair-pulling and scratching, can start out as a deliberate act but become a compulsive habit over time.

Indirect self-harm

There are further behaviours which do not fall neatly under the category of self-harm, but which may indicate similar underlying issues and which you may choose to respond to in the same way as more clear-cut forms of self-harm. These behaviours are sometimes referred to as 'indirect self-harm' and include:

- substance misuse through excessive alcohol or drug consumption
- eating disorders
- physical risk-taking
- sexual risk-taking
- self-neglect
- misuse of prescribed medication (this is relatively common in adolescents with diabetes).

In particular, schools are reporting a rapid rise in the number of adolescent girls repeatedly entering into relationships in which they are sexually, physically or emotionally abused. Some forms of indirect self-harm present a direct safeguarding risk. In these cases, a referral to the child and family assessment team (CAFAT) or equivalent may provide additional support to the young person and their family.

TERMS USED TO DESCRIBE SELF-HARM

You may hear a wide variety of terms used to refer to self-harm including:

- self-harm
- deliberate self-harm
- intentional self-harm
- parasuicide
- attempted suicide
- non-fatal suicidal behaviour
- self-inflicted violence.

Increasingly we tend not to use terms like 'deliberate' or 'intentional' as these terms are felt to place a negative value judgement on the individual concerned and also infer intent and control where this is not always the case.

Self-harm is sometimes considered to include three subtypes:

- self-poisoning
- self-injury
- self-mutilation.

Severity of behaviours

It is common for people to believe that the severity of a student's self-harming or eating-disordered behaviour is a direct reflection of the severity of the underlying psychological difficulties they are trying to cope with. Whilst this is sometimes the case, it is not always so and it is inappropriate for us to dismiss less serious cases out of hand. In some instances, students will even lie about carrying out self-harming or eating-disordered behaviours, pretending that they are self-harming and perhaps even sharing images sourced online of others' self-harm and passing it off as their own. This should not be dismissed as 'attention-seeking' – this student is seeking your attention in an unusual way, but they are clearly indicating that they are in need of support. Students whose invented or lower-level issues are not offered the appropriate support often go on to carry out more extreme behaviours in order both to cope with their underlying issues and/or to help them to access the support they are in need of.

Self-harm and suicide

Self-harm and suicide are often considered under the same umbrella. In fact, the National Collaborating Centre for Mental Health guidelines¹ use the definition 'Self-poisoning or self-injury, irrespective of the apparent purpose of the act' to describe self-harm – which means that someone would be considered to be self-harming even when their intention was to take their own life.

In this book, I approach self-harm separately to acts with suicidal intent because my work with students leads me to understand that these are two very different types of behaviour. In fact many students express the belief that self-harm is the one thing that helps them to cope with day-to-day life enough not to contemplate suicide.

'I would get overwhelmed and feel like I didn't want to be alive any more, but cutting would help me to calm down. It stopped me doing something even more stupid.'

It can, however, sometimes be hard to differentiate between self-harm and suicide attempts. For example, imagine two students who arrive at a hospital: 15-year-old Jenna has taken 20 painkillers whilst 17-year-old Ranj has life-threatening cuts to his arms. Are these examples of self-harm or are they suicide attempts? The only way we can gain any real insight is to ask the student about their intention at the time when the behaviour was taking place. However, they may not be able to remember, may feel ambivalent or may find it difficult to articulate their reasons.

Many people self-harm for months or even years without ever feeling suicidal. Self-harm is a separate behaviour from suicide and the intent is to cope with feelings rather than to end life. However, if people who self-harm don't receive the support and help they need to overcome their underlying difficulties, they may go on to contemplate suicide later on.

If you are at all concerned that a student is feeling suicidal you should seek help immediately. When people suffer with suicidal feelings they can often feel very alone and they are very, very vulnerable. You should also seek immediate help for students with severe physical injuries, whether or not you believe they intended to take their own life.

1 National Collaborating Centre for Mental Health (2004) *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders*. NICE Clinical Guideline 9. London: The British Psychological Society and Gaskell.

LEARNING TO TAKE AWAY FROM THIS CHAPTER

- Whilst different eating disorders may have a markedly different impact on the sufferer's appearance, the underlying thoughts, feelings and psychological distress are often very similar.
- There are three major eating disorders: anorexia nervosa, bulimia nervosa and binge eating disorder. Many young people with food and weight concerns will not fit within the criteria for these disorders, but it is still important that we offer our full support.
- Children under 11 often use food to express concerns/feelings they do not have the language to articulate.
- With common childhood issues such as 'faddiness', if the child is growing normally, is not hungry and is happy then there is often no need for concern.
- Self-harm is an unhealthy coping mechanism students may use to manage difficult feelings or emotions and can be carried out in a variety of ways.
- Most people who self-harm have no suicidal intent. Many people who self-harm express the belief that self-harming protects them from taking more serious measures.